IN THE CORONERS COURT OF VICTORIA

AT MELBOURNE

COR 2020 0021

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

*Amended pursuant to *Section 76 of the Coroners Act 2008* on 1 February 2023

INQUEST INTO THE PASSING OF VERONICA NELSON

Findings of:	Coroner Simon McGregor
Delivered on:	30 January 2023
Delivered at:	Coroners Court of Victoria
Hearing dates:	29 April 2022 – 18 May 2022
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*The finding dated 30 January 2023 contained an incorrectly formulated hearing date

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ACKNOWLEDGEMENT

1. Veronica Marie Nelson (**Veronica**), a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman, passed away in the State's custody on 2 January 2020. She was remanded in custody at the time of her passing, having been refused bail for relatively minor, non-violent offences.

2. I acknowledge the Traditional Owners of the land where the Coroners Court of Victoria (**Coroners Court**) sits, the Wurundjeri people of the Kulin nations. I acknowledge their longstanding connection to Country, and I pay my respects to Elders: past, present, and emerging. The state of Victoria is home to over 47,000 Aboriginal and Torres Strait Islander people.[1] They are descended from approximately 38 clans[2] across 60,000 years of continuous Aboriginal culture.[3]

3. Much of what this inquest has revealed is confronting and traumatic. I would like to acknowledge all the First Nations people who gave their time, evidence, and insights to my investigation. This process has benefited profoundly from their participation, and I acknowledge the emotional toll of their engagement in the coronial process.

4. Veronica was 37 years old at the time of her passing. She was the eldest child of Aunty Donna Nelson, and the second child of her late father, Uncle Russell Walker. She was a sister

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[1] Australian Bureau of Statistics, *2016 Census: Aboriginal and/or Torres Strait Islander Peoples QuickStats*,https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/IQS2.

[2] Victorian Public Sector Commission, *Aboriginal Victoria Today*, (Web Page, 28 June 2019) https://vpsc.vic.gov.au/html-resources/aboriginal-cultural-capability-toolkit/aboriginal-victoria-today.

[3] Uluru Statement from the Heart (National Constitution Convention, 26 May 2017).

to Belinda, Russell, Dwayne, Trisha, Richard and Jodie, and shared a long loving relationship with Percy Lovett, which began in her teenage years. Veronica was loved and respected by those who knew her.

5. Yet Veronica, while alone in a cell at the Dame Phyllis Frost Centre, passed away after begging for assistance for several of the last hours of her life and falling silent during her final communication with a prison officer.

6. That Veronica was separated from her family, community, culture, and Country at the time of her passing is a devastating and demoralising circumstance. Proud Wiradjuri woman Professor Megan Williams explained at inquest:

> It's extremely taboo … Difficult. Inappropriate. Damaging for an Aboriginal person to pass away in an institution, in a colonised setting where Aboriginal people have very little power to shape that system to respond to our needs and to respond to our cultures…
>
> Our understanding in our culture about us being spiritual beings that are connected to our family and to our Country; to our Ancestors, as well as to descendants in our bloodlines; connections to our Song Lines; to our cultural responsibilities... all point to how inappropriate it is for us to die alone, to die in a disempowering institution, and to not pass on Country… to pass without having an opportunity for our spirit to become free and to convey what we need to convey from a cultural perspective.[4]

[4] Professor Megan Williams, T 2237.29.

INTRODUCTION

7. At about 3:30 PM on 30 December 2019, Veronica was with her brother on Spencer Street near Southern Cross train station in Melbourne when she was arrested by Sergeant Brendan Payne (**Sergeant Payne**) of Victoria Police. She was arrested on outstanding warrants and whereabouts notices and accompanied Sgt Payne to the Melbourne West Police Station (**MWPS**).

8. While at MWPS, the warrants relating to matters before the Shepparton Koori Court were executed and Veronica was interviewed about thefts from shops alleged to have occurred in October and November 2019 that had led to the whereabouts notices. While the interview was in progress, Senior Constable Rebecca Gauci (**SC Gauci**) prepared an application to remand Veronica in custody.

9. The police interview ended at 4:45 PM and Veronica was held in the MWPS cells until transferred to the Melbourne Custody Centre (**MCC**), situated beneath Melbourne Magistrates' Court (**MMC**), at approximately 7:20 PM.

10. Although the Bail and Remand Court (**BaRC**) of the MMC usually operates until at least 9:00 PM[5], and Barrister Peter Schumpeter (**Mr Schumpeter**), briefed by Victoria Legal Aid (**VLA**) as duty lawyer that evening, commenced work on Veronica's case, her matter was not reached. Veronica was remanded overnight in the MCC cells in anticipation of an application for bail the following day.

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[5] Schumpeter, CB 2385.

31 December 2019

11. The next morning on 31 December 2019, Veronica's usual lawyer, Jillian Prior (**Ms Prior**) of the Law and Advocacy Centre for Women (**LACW**) briefed Barrister Tass Antos (**Mr Antos**) by phone to appear on Veronica's behalf at the MCC. Mr Antos met with Veronica in the MCC cells for less than 6 minutes.

Veronica's application for bail

12. Shortly after midday, Veronica made an unrepresented application for bail. Her partner Mr Lovett was present in the court room, as was Mr Antos, but he excused himself shortly after the hearing began.

13. Victoria Police opposed Veronica's application for bail. Veronica told the presiding Magistrate that both her brother and mother were unwell and highlighted Mr Lovett's presence in court and her view that he supported her to stay out of trouble.

14. Veronica's application for bail was refused because she was unable to establish exceptional circumstances justifying the grant of bail as required by the *Bail Act 1977* (**Bail Act**). Veronica was remanded in custody to appear at Shepparton Magistrates' Court on 13 January 2020.

15. Although a Koori Court Officer was working at MMC during business hours on 30 and 31 December 2019, she was not notified that Veronica was in custody at MCC or that she had appeared before a court.

16. At about 3:50 PM, Veronica departed MCC for Dame Phyllis Frost Centre (**DPFC**), in a transport van operated by G4S Transport (**G4S**). She lay down in the van and vomited multiple times during transit.

Veronica's arrival at DPFC

17. At about 4:35 PM on 31 December 2019, Veronica arrived at the reception area of DPFC, a maximum-security women's prison managed by Corrections Victoria (**CV**), a business unit of the Victorian Department of Justice and Community Safety (**DJCS**). She was placed in a holding cell until escorted to her reception medical assessment in the co-located Medical Centre[6] at approximately 5:20 PM.

18. Dr Sean Runacres (**Dr Runacres**) conducted the reception medical assessment in a clinical room, assisted by Registered Nurse Stephanie Hills (**RN Hills**). Both clinicians were employed by Correct Care Australasia (**CCA**), a private company contracted by DJCS to deliver primary healthcare in 13 public prisons including DPFC.[7] The contract is managed by Justice Health, a business unit of the DJCS.

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[6] The health facility at DPFC is a 'Health Centre'. At inquest, witnesses predominately referred to the facility as the 'Medical Centre'; therefore, this term has been adopted throughout this finding for consistency. Use of the term 'Medical Centre' is not intended to conflate the distinction between a Health Centre and a Medical Centre, and the different health services offered therein respectively.

[7] The contract remains current until July 2023 and is between GEO Group Australasia and the Minister for Corrections on behalf of the Crown in the Right of the State of Victoria. GEO Group Australasia changed its name to Correct Care Australasia in 2015 after Correct Care Solutions acquired GEO Care in 2014. The original contract term was for five years from April 2012, and it was extended for a further five-year term in June 2017. The total contract amount is over $690 million. For more information, see tenders.vic.gov.au.

19. The reception medical assessment was completed within 15 minutes. Veronica had disclosed opioid dependence and was prescribed a standard withdrawal pack by Dr Runacres. Veronica was placed in a holding cell in the Medical Centre and continued vomiting shortly thereafter.

20. At approximately 5:50 PM, Registered Psychiatric Nurse Bester Chisvo (**RPN Chisvo**) performed a mental health assessment of Veronica. RPN Chisvo was employed by Forensicare, a statutory agency established under the *Mental Health Act 2014* and contracted by Justice Health to provide forensic mental health services in several locations including DPFC.

21. During RPN Chisvo's assessment of Veronica which was conducted in the Medical Centre cell, Veronica struggled to sit up on the bed, was shaking and actively vomiting. RPN Chisvo recommended that Veronica remain in the Medical Centre overnight.

22. At about 6:10 PM, RN Hills gave Veronica the opioid replacement and anti-emetic medications prescribed by Dr Runacres. RN Hills considered Veronica to be too unwell for transfer into the mainstream prison and reportedly recommended to POs in the Medical Centre that Veronica remain there overnight.

23. Veronica did remain in the Medical Centre, where a CCA nurse was on duty overnight. Relevantly, all prison cells within DPFC are equipped with an intercom through which the occupant may communicate with a prison officer (**PO**). Between 6:30 PM and 7:00 PM on 31 December 2019, Veronica used the intercom four times to complain of vomiting and feeling unwell.

1 January 2020

24. Between 3:00 AM and 10:15 AM on 1 January 2020, Veronica used the intercom 20 times to report sickness or request assistance. At 3:20 AM, she projectile vomited into her blanket and onto the cell floor. Using the intercom to report this to a PO, Veronica was told, "we'll have people in to clean it in the morning. At 7:30 AM, she use the intercom to report bad cramps. She requested a drink soon after and was told that the intercom was "for emergencies only".

25. At 8:46 AM Veronica was moved to a clean cell in the Medical Centre. Five minutes later she projectile vomited into her blanket and reported this to a PO by intercom. At 9:20 AM Veronica again reported vomiting. At 9:30 AM Veronica asked how long it would be until she saw a doctor. She asked again at 9:50 AM and 10:08 AM. At 10:11 AM, Veronica vomited into her blanket again and, once more, asked how long it would be until she could see a doctor. She was told, "it's not an emergency, stop asking".

26. At 10:15 AM, opioid replacement medication was administered to Veronica.

27. At 10:48 AM, Veronica was reviewed by Dr Alison Brown (**Dr Brown**) and Registered Nurse Mark Minett (**RN Minett**) in a cell rather than a clinical room. Dr Brown ordered urine, random blood glucose and blood tests (the latter could not be performed on a public holiday). Dr Brown also prescribed electrolytes and anti-emetic medication as required. At about 11:05 AM, RN Minett administered water-soluble electrolytes to Veronica to help with dehydration.

28. At 11:12 AM Veronica projectile vomited onto the cell floor. At 11:17 AM she was moved to a clean cell in the Medical Centre where RN Minett administered an anti-emetic by

intramuscular injection at 11:30 AM. Veronica was moved to another cell in the Medical Centre at 11:35 AM and vomited again, this time into a vomit bag, at 11:37 AM.

29. At 11:50 AM, RN Minett returned to administer a second dose of water-soluble electrolytes; Veronica vomited again 30 minutes later.

30. At 12:37 PM, having been informed that Veronica had vomited, Dr Brown returned to conduct a further review with RN Minett. During the review, a third dose of water-soluble electrolytes was administered, and Dr Brown ordered a nursing review for vital observations to be repeated later in the afternoon.

31. At 1:11PM, and again at 1:34 PM, Veronica vomited.

32. At approximately 4:00 PM, the CV component of Veronica's formal reception into prison was completed by a PO. At 4:43 PM, 24 hours after her arrival at DPFC, the Aboriginal Wellbeing Officer (**AWO**) was notified by email of Veronica's reception.

33. At approximately 5:30 PM on 1 January 2020, Veronica was moved from the Medical Centre to the Yarra Unit. She was accompanied to Cell 40, the cell to which she was assigned in the Yarra Unit, by fellow Aboriginal prisoner Kylie Bastin (**Ms Bastin**). Ms Bastin recognised Veronica as her Aunty,[8] and brought her a bottle of cordial and other supplies from her own cell nearby.

[8] Aboriginal and Torres Strait Islander people refer to community Elders as 'Aunty' or 'Uncle' as a term of respect. These terms are used for people held in esteem by fellow-community members.

34. At 7:06 PM, Cell 40 was locked down for the night. A sign reading, 'LATE RECEPTION – DO NOT UNLOCK' was posted on the outside of the cell door.

35. At 9:09 PM, Veronica used the intercom to contact the PO on post at the Yarra Unit to ask for a blanket. At 9:34 PM, three POs delivered a blanket to Veronica through the trap in the door of Cell 40.

36. At approximately 11:00 PM, PO Tracey Brown (**PO Brown**) began her shift as the second watch officer on post at the Yarra Unit overnight.

2 January 2020

37. At 1:27 AM on 2 January 2020, Veronica used the intercom to report that she needed help and was "cramping something shocking". PO Brown called Registered Nurse Atheana George (**RN George**), the CCA night nurse based in the Medical Centre.

38. At 1:31 AM, Bonnie McSweeney (**Ms McSweeney**), who was accommodated in Cell 39, used the intercom to inform PO Brown that "someone needs help down here". PO Brown replied that she had contacted the nurse and was waiting to hear back.

39. At 1:36 AM, RN George attended Veronica's cell, accompanied by PO Brown and two other prison officers. RN George spoke to Veronica briefly through the trap in the cell door and administered paracetamol and an anti-emetic the same way, after prying open Veronica's fingers to place the tablets in her hand. RN George's interaction with Veronica's lasted approximately two minutes.

40. Ms McSweeney and Ms Bastin heard Veronica wailing in pain for the next two hours. Between 2:00 AM and just before 4:00 AM, Veronica used the intercom 11 times to complain of worsening cramps, continued vomiting and to request assistance. PO Brown told Veronica to drink more water, try stretching, and that she did not think there was any more the nurse could do for her.

41. At 3:56 AM, Veronica contacted PO Brown using the intercom and was heard wailing and calling out for her late father. She was told she needed to stop screaming because she was keeping the other prisoners awake.

42. At 3:58 AM, PO Brown told Veronica via the intercom that her only option was to return to the Medical Centre, but that RN George "probably can't give you anything else". Veronica told PO Brown that she would remain in her cell. When PO Brown attempted to confirm that Veronica wanted to stay in her cell, she did not respond. PO Brown did not hear from Veronica again.

43. At 7:55 AM on 2 January 2020, two prison officers called a Code Black medical emergency when, during the morning count, they found Veronica lying deceased on the flooded concrete floor of Cell 40, in a prison built on the lands of the Wurundjeri and Bunurong people.

CONTEXT

44. The conditions under which Veronica lived out her final days are harrowing. During the inquest, CCTV footage was played depicting Veronica struggling to walk around the cell in the Medical Centre due to severe cramping in her legs and feet. Footage also showed

Veronica projectile vomiting multiple times onto the floor and into her blanket, left to lie in her own vomit for hours.

45. In her approximately 36 hours at DPFC, Veronica used an intercom 49 times to request assistance or complain of symptoms. The sounds of Veronica's last pleading calls for help echoed around the courtroom when played during the inquest, prompting me to ponder how the people who heard them and had the power to help her did not rush to her aid, send her to hospital, or simply open the door of the cell to check on her.

46. The evidence in this inquest cast in sharp relief the special obligation owed by the State when its authority has been exercised to assume control over a person's life. A person in custody is not only deprived of their liberty but is deprived of the ability and resources to care for themself: in short, the State's control over the person is nearly complete. When a death ensues, it is a matter of great public importance that the circumstances of the death are thoroughly reviewed to ensure that this duty of care has been discharged and that powers conferred on entities and individuals entrusted with a public duty are used reasonably.[9]

47. When the passing of an Aboriginal person occurs in custody, it occurs on the continuum of the problematic relationship between the Australian criminal justice system and First Nations peoples. Accordingly, Veronica's passing involved inquiry into some of the historical and persisting systemic issues contributing to the overrepresentation of Aboriginal people in Victoria's criminal justice system, access to equal justice in court, and the capacity of the

[9] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991) Vol 1, Chapter 4.5.41-43.

State and those acting on its behalf to provide non-discriminatory and culturally safe treatment to Aboriginal people in custody, including in the delivery of carceral healthcare.

Royal Commission into Aboriginal Deaths in Custody

48. In 1987, the *Royal Commission into Aboriginal Deaths in Custody* (**RCADIC**) investigated the causes of deaths of 99 Aboriginal people held in the custody of police, prison and juvenile detention centres in each Australian state and territory between 1980 and 1989.[10] The RCADIC was established in response to growing public concern that Aboriginal deaths in custody were too common and poorly explained. Its terms of reference were sufficiently broad to allow it to make recommendations across a wide range of policy areas to address the underlying causes of Aboriginal incarceration and contribute to the reduction of Aboriginal deaths in custody.

49. In its final report delivered in 1991, the RCADIC squarely identified Aboriginal over-representation in the criminal justice system, and particularly over-representation in custody, as producing the large numbers of Aboriginal deaths in custody.[11] The RCADIC found that most Aboriginal people in police custody were held in relation to public drunkenness (29%) and theft related offences (20%). These two main offences were followed by "other good order offences".[12] A large amount of Aboriginal people in prison custody were detained for fine default related offences (39.5%). Aboriginal people made up 20.4% of all sentenced

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[10] Royal Commission into Aboriginal Deaths in Custody (Final Report, April 1991) Vol 1.
[11] Ibid, Vol 1.
[12] Ibid, Vol 1, Chapter 7.1.

prison receptions, which was compared to the percentages of Aboriginal people in prison at the time (15%):

> It can be seen therefore that the flow of Aboriginal people into prison is considerably higher than the number at any one time. This is explained, at least in part, by the higher proportion of Aboriginal people received on fine default or sentenced for offences which attract relatively low penalties. People imprisoned for fine default would normally stay in prison for short periods only, infrequently for periods of months.[13]

50. The RCADIC also authoritatively linked Aboriginal over-representation in custody to the continuing consequences of the colonisation of Australia and its Indigenous peoples, which was underscored by assumptions about the innate superiority of non-Aboriginal people over Aboriginal people.

> Every turn in the policy of government … was postulated on the inferiority of the Aboriginal people; the original expropriation of their land was based on the idea that the land was not occupied and the people uncivilised; the protection policy was based on the view that Aboriginal people could not achieve a place in the non-Aboriginal society and that they must be protected against themselves while the race died out; the assimilationist policy assumed that their culture and way of life is without value and that we confer a favour on them by assimilating them into our ways; even to the point of taking their children and removing them from family …
>
> The policeman was the right hand man of the authorities, the enforcer of the policies of control and supervision, often the taker of the children, the rounder up of those accused …

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[13] Royal Commission into Aboriginal Deaths in Custody (Final Report, April 1991) Vol 1, Chapter 7.2.

> … relations between Aboriginal and non-Aboriginal people were historically influenced by racism, often of the overt, outspoken and sanctimonious kind; but more often, particularly in later times, of the quiet assumption that scarcely recognises itself …
>
> The consequence of this history is the partial destruction of Aboriginal culture and … disadvantage and inequality of Aboriginal people in all the areas of social life ... The other consequence is the considerable degree of breakdown of many Aboriginal communities ... this legacy of history goes far to explain the over-representation of Aboriginal people in custody, and thereby the death of some of them.[14]

51. Among the RCADIC's criminal justice recommendations were:[15]

51.1. greater collaboration with Aboriginal communities;

51.2. close monitoring of bail legislation to ensure the entitlement to bail, as set out in the legislation, is recognised in practice and revision of any criteria which inappropriately restricts the grant of bail to Aboriginal people;

51.3. that imprisonment be used only as a last resort;

51.4. recognition of the legal duty of care owed to persons in police and corrective services' custody;

51.5. the provision of health care to people in custody to a standard equivalent to that available to the general public; and

51.6. the provision of culturally appropriate health care to Aboriginal people in custody.

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[14] Royal Commission into Aboriginal Deaths in Custody (Final Report, April 1991) Vol 1, 1.4.8; 1.4.16, 1.4.14 and 1.4.19.

[15] Ibid, Vol 5.

52. At a meeting of the Ministerial Council on Aboriginal and Torres Strait Islander Affairs in 1992, all governments committed themselves to regular reporting on the implementation of the RCADIC's recommendations.

Key Victorian developments since the RCADIC

The AJA

53. One of the key developments in Victoria, following a 1997 National Summit on Indigenous Deaths in Custody reviewing governmental responses to the RCADIC recommendations, was the Aboriginal Justice Agreement (**AJA**).

54. The AJA is a long-term collaborative agreement between the Victorian government and the Aboriginal community to improve justice outcomes for the Aboriginal community, including reducing Aboriginal over-representation in the criminal justice system. Phase one of the AJA was launched in 2000.[16] The AJA is now in its fourth phase: *Burra Lotjpa Dunguludja: Victorian Aboriginal Justice Agreement Phase 4* (**Burra Lotjpa Dunguludja**).[17]

55. The DJCS' commitment to improving justice outcomes for First Nations peoples is reflected in a range of policies applicable to functions of CV and Justice Health. The *Commissioner's Requirements* and *Deputy Commissioner's Instructions on Aboriginal and Torres Strait Islander Prisoners* require prisons to:

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[16] See generally the joint statement provided by Justin Mohamed, Marion Hansen and Chris Harrison: CB 4372-4791.

[17] Victorian Government, *Burra Lotjpa Dunguludja: Victorian Aboriginal Justice Agreement Phase 4*, (August 2018), page 30-31.

55.1. provide an environment that fosters the maintenance of cultural and community links for First Nations prisoners;

55.2. develop networks that improve justice-related programs and services, making them more responsive, effective and accessible to First Nations Prisoners;

55.3. provide programs for First Nations prisoners that reflect their cultural and which incorporate links to community programs;[18] and

55.4. endeavour to have Aboriginal programs delivered by suitably qualified Aboriginal and Torres Strait Islander people.[19]

56. The *Commissioner's Requirements* and *Deputy Commissioner's Instructions on Aboriginal and Torres Strait Islander Prisoners* also require custodial staff to participate in cultural awareness training at recruitment and refresher training. Custodial staff are also required to manage First Nations prisoners in a culturally relevant and responsive manner, and to treat them with dignity and understanding.[20]

57. The Justice Health Quality Framework (**JHQF**) was adopted to enshrine the standards of custodial healthcare in Victorian prisons, including that:

57.1. prisoners have the right to receive health services equivalent to those available in the general community through the public health system;

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[18] See generally the statement of Acting Commissioner Melissa Westin for examples of the current suite of cultural services and programs available to First Nations prisoners, particularly women prisoners.

[19] Statement of Melissa Westin, CB 4299-4300.

[20] Ibid, CB 4302.

57.2. carceral health services are responsive to the specific needs of Aboriginal and Torres Strait Islander prisoners;

57.3. prisoners receive a comprehensive health assessment by a medical practitioner within 24 hours of their initial reception to prison; and

57.4. prisoners are provided with high quality pharmacotherapy programs to manage and treat opioid dependencies.[21]

58. Moreover, one of Burra Lotjpa Dunguludja's goals is the development of cultural safety standards for custodial health services. Cultural Safety Standards for Prison Health Service Providers were developed by Justice Health and endorsed by the Aboriginal Justice Caucus in 2018. An implementation plan was in development in late January 2021.[22]

59. Since 2012, the Victorian government has also committed to closing the gap between the rates of Aboriginal and non-Aboriginal people under justice supervision, by 2031.[23]

Cultural adaptations to criminal courts

60. The Koori Court was established by statute in 2002 as a division of the Magistrates' Court of Victoria, initially as a pilot in Shepparton and Broadmeadows, to fulfil several criminal justice and community building purposes.[24] Among these purposes are to divert Koori

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[21] Justice Health Quality Framework, CB 1245 – 1374.
[22] See generally the statement of Scott Swanwick, CB 4287-4297
[23] Joint statement provided by Justin Mohamed, Marion Hansen and Chris Harrison: CB 4372-4791.
[24] Magistrates' Court (Koori Court) Act 2002.

offenders away from imprisonment to reduce their overrepresentation in the prison system and increase Koori community ownership of the administration of the law.[25]

61. Koori Courts are sentencing courts that operate with "culturally respectful" adaptations to the configuration of the courtroom and procedures designed to reduce the "feelings of intimidation and alienation" experienced by the "participant."[26] The sentencing process is informed by problem-solving, therapeutic and restorative models of justice to promote rehabilitation and cultural connection of the participant, who has a voice in the hearing; it has been described as a 'sentencing conversation.'[27] Significantly, involved in the sentencing conversation in Koori Court are Elders and Respected Persons who provide the sentencing judicial officer with advice and information on cultural and community matters to contextualise the participant's behaviour and help them understand the reasons underlying the offending.[28]

62. Among other duties, Koori Court Officers[29] perform a key role in preparing a participant for Koori Court. Koori Court Officers meet with a participant in advance, developing a rapport and knowledge of their circumstances, so the Elders and Respected Persons and judicial

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[25] Hollingsworth: T1852-1857.

[26] Hollingsworth: T1854. Joanne Atkinson explained that rather than 'accused', participants in Koori Court are referred to as 'participant' to avoid negative labelling: CB2377.

[27] Mark Harris, 2006, "'A sentencing conversation': Evaluation of the Koori Courts Pilot Program – October 2002 to October 2004," Department of Justice.

[28] Hollingsworth: T1854.

[29] Koori Court Officer positions constitute a special measure under section 12 of the Equal opportunity Act 2010 and section 8(4) of the Charter and therefore only open to Aboriginal and/or Torres Strait Islander applicants.

officer, are alerted to any issues underlying the offending. This preparatory work has the aim of supporting the participant and an appropriate sentencing outcome.[30]

63. The Koori Court now operates in ten Magistrates' Court locations in suburban and regional Victoria, as well as ten Children's Court and five County Court locations.[31]

The Charter

64. The *Charter of Human Rights and Responsibilities* 2006 (**the Charter**) is a Victorian statute setting out the 20 civil and political rights the Parliament seeks to protect and promote by ensuring that when laws are enacted, and their provisions interpreted this is done so far as possible compatibly with those rights.[32] The Charter also obliges public authorities (including courts and tribunals when acting administratively)[33] to act compatibly with relevant human rights and give proper consideration to relevant rights when making decisions.[34] Human rights may only be limited to the extent that can be demonstrably justified in a free and democratic society taking into account all relevant factors.[35]

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[30] Atkinson: CB2378.
[31] Hollingsworth: T1854.
[32] *Charter of Human Rights and Responsibilities 2006* (**the Charter**), sections 1, 28, and 32.
[33] The Charter, section 4.
[34] The Charter, section 32.
[35] The Charter, section 7.

Bail Act

65. The significance of access to bail in the over-representation of Aboriginal people in custody was identified by the RCADIC and has continued to feature in law reform reviews conducted by the federal and Victorian governments since then.[36]

66. In 2010, section 3A was inserted into the Bail Act as a 'special measure' under the Charter to recognise historical disadvantage leading to the overrepresentation of Aboriginal people remanded in custody. Section 3A requires bail decision makers to take into account any issues that arise due to the bail applicant's Aboriginality, including their cultural background, ties to extended family or place, and any other relevant cultural issue or obligation.

67. Sweeping statutory amendments to the Bail Act enacted in 2017 and 2018 following the Coghlan Review commissioned by the Victorian government,[37] were intended to enhance community safety by making access to bail more difficult for violent offenders. However, the changes make it more difficult for *all people* to access bail with Aboriginal and Torres Strait Islander people – particularly women – being disproportionately affected. Between 2015 and 2019, the number of unsentenced Aboriginal and Torres Strait Islander people held in

[36] See for instance, former Law Reform Commission of Victoria (reporting in 1991), VLRC 2007 and ALRC Pathways to Justice in 2018.

[37] The Hon. Paul Coghlan QC, *Bail Review: First Advice to the Victorian Government*, 3 April 2017; The Hon. Paul Coghlan QC, *Bail Review: Second Advice to the Victorian Government*, 1 May 2017.

Victorian prisons tripled.[38] In the same period, the imprisonment rate of Victorian Aboriginal and Torres Strait Islander adults doubled.[39]

Assessing implementation of the RCADIC's recommendations

68. In 2018, the federal government engaged a consultancy firm to review the implementation status of the recommendations of the RCADIC. The desktop review found that, of the 339 recommendations,[40] 64% have been implemented fully; 14% have been mostly implemented; 16% have been partially implemented; and 6% have not been implemented.[41]

69. Significantly, the review assessed the extent to which state, territory and federal governments had acted to implement recommendations, rather than the outcomes of those actions.[42]

70. While RCADIC implementation reviews, strategic and policy initiatives suggest progress towards improved criminal justice outcomes for Aboriginal and Torres Strait Islander people, statistical evidence demonstrates the opposite. Indeed, in Victoria, Aboriginal and Torres Strait Islander people continue to make up more than 10% of the prisoner population, despite

[38] Corrections Victoria, *Profile of Aboriginal People in Prison* (Annual Prisoner Statistics, June 2020).

[39] Sentencing Advisory Council sentencing statistics, Victoria's Indigenous Imprisonment Rates, last updated 4 November 2022.

[40] The review identified that of the 339 recommendation, 29 were the sole responsibility of the Commonwealth government, 194 were the joint responsibility of the Commonwealth and state and territory governments and 116 were the sole responsibility of state and territory governments: Department of Prime Minister and Cabinet, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Final report, August 2018), page 701.

[41] Ibid.

[42] Ibid.

representing less than 1% of the state's total population.[43] In the more than 30 years since the RCADIC, the National Deaths in Custody Program has recorded at least 517 Indigenous deaths in custody.[44] Aboriginal and Torres Strait Islander people now die in custody at a greater rate than *before* the 1991 RCADIC; with an average of 16.6 deaths per year since 1991 compared to 11 deaths per year between 1980 and 1989.[45]

THE CHARTER

71. The Charter influences coronial proceedings due to:

    71.1. the application of the Charter to the Coroners Court itself;

    71.2. the application of the Charter to public authorities (other than the Coroners Court); and

    71.3. the Charter rights engaged by the factual events within the scope of the inquest.

The Charter, the Coroners Court, and its functions

72. I have had the benefit of comprehensive and helpful submissions filed by the Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) about the application of the Charter to the inquest into Veronica's passing. Having considered those submissions, it is sufficient for present purposes to provide the following summary.

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[43] Sentencing Advisory Council sentencing statistics, Victoria's Indigenous Imprisonment Rates, last updated 4 November 2022.

[44] Australian Institute of Criminology, *Dashboard – Quarterly reporting of deaths in custody*, 30 August 2022.

[45] Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, *Indigenous Deaths in Custody: 1989 to 1996* (Report, July 1997) Ch 2.

73. Pursuant to s 4(a)(j) of the Charter, a court or tribunal is not a public authority except when it is acting in an 'administrative capacity'. That expression is not defined in the Charter and there is no direct Australian judicial authority to my knowledge on whether the Coroners Court is a public authority under the Charter when conducting an inquest and exercising the powers in the Coroners Act to make findings, comments and recommendations. Although the VEOHRC submitted that all these functions are administrative, when considered in light of the decided cases on s 4(1)(j) of the Charter, I was not persuaded, and find that a Victorian coroner is exercising judicial power when they preside over an inquest hearing, as distinct from an investigation on the papers.[46]

74. Whilst this conclusion has important consequences for the administration of justice in Victoria, the analysis supporting it could be said to be somewhat esoteric for those readers not versed in constitutional and administrative law, and so has been placed in Appendix A of these findings in the hope that non-legal readers may thereby more readily consider the personal and systemic aspects of this finding. In addition to this specific point, Appendix A also contains more detailed explication of the role of the Charter to coronial proceedings generally.

75. All that said, the Coroners Court is acting administratively when investigating a reportable death and is therefore a public authority at those times and so is required to act compatibly with human rights and give proper consideration to relevant human rights when making those administrative decisions pursuant to s 38 of the Charter.

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[46] *Cemino v Cannan* [2018] VSC 535, [92] ('***Cemino v Cannan***').

76. Irrespective of whether it is a public authority, section 6(2)(b) of the Charter applies directly to the Coroners Court to the extent that it has functions under Part 2 (that is, relating to particular Charter rights), and Division 3 of Part 2 (interpretation of laws, including the *Coroners Act* 2008). The most consistently accepted construction of s 6(2)(b) is that the function of the court is to enforce directly only those rights enacted in Part 2 of the Charter that directly relate to court proceedings.[47]

77. The Coroners Court most evidently has functions under the right to life (s 9 of the Charter), namely, to conduct an effective investigation into a reportable death. In addition, and in common with other courts, the Coroners Court has functions relating to the way matters are conducted, including the rights to a fair hearing and to equality before the law (ss 24 and 8 of the Charter respectively).[48]

78. Finally, section 32(1) of the Charter provides that so far as it is possible to do so consistently with their purpose, all statutory provision must be interpreted in a way that is compatible with human rights. Relevantly, I am satisfied that a compatible interpretation of the power conferred by s 67(1) of the *Coroners Act* 2008 is one that includes investigating breaches of human rights that might have caused or contributed to Veronica's passing. Consistent with

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[47] *Cemino v Cannan*, [110]; *De Simone v Bevnol Constructions* (2009) 25 VR 237, 247 [52] (Neave JA and Williams AJA); *Kracke v Mental Health Review Board* (2009) 29 VAR 1, 63 [250] (Bell J); *Victoria Police Toll Enforcement v Taha* (2013) 49 VR 1, [247]-[248] (Tate JA); *Matsoukatidou v Yarra Ranges Council* [2017] VSC 61 ('***Matsoukatidou***') [32] and references cited in footnote 12; *DPP v SL* [2016] VSC 714, [6]; *Application for bail by HL* [2016] VSC 750, [72] (Elliot J); *DPP v SE* [2017] VSC 13, [12] (Bell J); *Harkness v Roberts; Kyriazis v County Court of Victoria (No 2)* [2017] VSC 646 [21].

[48] If a right applies directly to a court via s 6(2)(b), when assessing whether the court has acted compatibly with the right, s 7(2) should be applied: *Matsoukatidou*, [58]; *Victoria Police Toll Enforcement v Taha* (2013) 49 VR 1, [250].

that view, interpretation of the powers to comment and make recommendations pursuant to ss 67(3) and 72 of the *Coroners Act* 2008, respectively, encompasses powers to make recommendations and comments in relation to human rights issues connected with the death.[49]

The application of the Charter to public authorities (other than the Coroners Court)

79. Section 4 of the Charter defines a 'public authority', relevantly, to include certain individuals and entities having functions of a public nature or that exercise functions on behalf of the State or a public authority (whether under contract or otherwise).[50]

80. Accordingly, Victoria Police,[51] CV,[52] Justice Health,[53] CCA,[54] Forensicare[55] and G4S[56] are all public authorities for the purposes of the Charter, at least so far as their actions and decisions relate to the coronial inquiry into Veronica's passing.

81. The Magistrates' Court of Victoria (here, the Melbourne Magistrates' Court) is a public authority for the purposes of my investigation to the extent that it was acting in an administrative capacity when adopting practices, procedures or creating positions.[57]

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[49] I note that In the *Inquest into the death of Tanya Day*, Coroner English made a Ruling on the scope of the Inquest. At [19] of the Ruling, Coroner English stated that for her to rule on the scope of that inquest it was not necessary to address the question of whether the Coroners Court is a public authority when conducting an inquest and exercising the powers in the Coroners Act to make findings and recommendations on matters connected with a death. Accordingly, Coroner English did not rule on this issue.

[50] Charter, s4.
[51] Charter, s4(1)(d).
[52] Charter, s4(1)(a).
[53] Charter, s4(1)(a).
[54] Charter, s4(1)(c).
[55] Charter, s4(1)(b).
[56] Charter, s4(1)(c).

The Charter obligations of a public authority

82. As mentioned above, section 38(1) of the Charter imposes two distinct obligations to 'act compatibly' on a public authority. It makes it unlawful for a public authority to act in a way that is incompatible with a human right and, in making a decision, to fail to give proper consideration to a relevant human right. These obligations do not apply if the public authority cannot reasonably act differently or make a different decision under law.[58]

Justifiable limits on rights

83. Section 7(2) of the Charter applies to a public authority's obligation to act compatibly with Charter rights. Where a public authority limits a right, but the limit is justified, the human right is not breached and there is no contravention of the obligations under sections 32 or 38 of the Charter. Whether limitation of a right is justified is an assessment made by reference to the inclusive list of factors contained in s 7(2) – including the nature of the right, the nature, extent and purpose of the limitation and any less restrictive means reasonably available to achieve the purpose sought to be achieved by the limitation. Section 7(2) of the Charter embodies a proportionality test.[59]

84. Even if a limitation on a human right is ultimately found to be proportionate, if the public authority has made a decision, it is still required to give proper consideration to relevant human rights: this procedural component of a public authority's obligation to 'act

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[57] Section 4(a)(j) of the Charter.
[58] Charter, s 38(2).
[59] *Momcilovic v R* (2011) 245 CLR 1, 39 [22] (French CJ).

compatibly' is additional or supplementary to any obligation imposed under the primary legislation governing the operations of the public authority.[60] The content of this procedural obligation is now settled in Victorian law[61] such that proper consideration, while it may be discharged in a manner suited to the particular circumstances,[62] cannot be satisfied by merely invoking the Charter 'like a mantra'.[63] Rather, it will involve a review of the substance of the decision-maker's consideration not mere form.[64]

Assessing the lawfulness of a public authority's actions

85. Jurisprudence of the Supreme Court of Victoria provides a useful guide to the questions to ask when determining if a public authority is acting lawfully under s 38(1):

85.1. is any Charter right relevant to the decision or action that the public authority has made, taken, proposed to take or failed to take? (the relevance or engagement question);

85.2. if so, is that limit reasonable and is it demonstrably justified having regard to the matters set out in s 7(2) of the Charter? (the proportionality or justification question);

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[60] *Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue* [2021] VSCA 358 [80].

[61] *Castles v Secretary of Department of Justice* (2010) 28 VR 141 ('***Castles***'), 184 [185]-[186]; *De Bruyn*, 669-701 [139]-[142]; *Bare*, 198-199 [217]-[221] (Warren CJ), 218-219 [277]-[278] (Tate JA), 297 [534] (Santamaria JA) (each of the three Justices of Appeal applied the "Castles test" for proper consideration by way of *obiter dicta*); *Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue* [2021] VSCA 358 [83].

[62] *PJB v Melbourne Health (Patrick's Case)* (2011) 39 VR 373 [311] (Bell J).

[63] *Castles*, 144.

[64] *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 701 [142].

85.3. even if the limit is proportionate, if the public authority has made a decision, did it give proper consideration to the Charter right? (the proper consideration question);

85.4. was the act or decision made under an Act or instrument that gave the public authority no discretion in relation to the act or decision, or does the Act confer a discretion that cannot be interpreted under s 32 of the Charter in a way that is consistent with the protected right (the inevitable infringement question).[65]

Charter rights engaged by the investigation into Veronica's passing

86. It will be clear from the foregoing that I consider relevant to my role as Coroner inquiry into potential breaches of relevant human rights that might have caused or contributed to Veronica's passing. Several of Veronica's human rights under the Charter are engaged by the circumstances of her passing.

Equality rights

87. Several equality rights are protected by s8 of the Charter. Relevantly, s8(2) protects the right of every person to enjoy their human rights without discrimination; while s8(3), which has three limbs, provides that every person is equal before the law, and is entitled to the equal protection of the law without discrimination, and has the right to equal and effective protection against discrimination.

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[65] *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children (No 2)* [2017] VSC 251, [174] ('***Certain Children (No 2)***'); *Minogue v Dougherty* [2017] VSC 724 at [74]. These questions build on the three-step approach articulated in *Sabet* at [108] which was applied by the Court of Appeal in *Baker v DPP* [2017] VSCA 58 at [56].

88. ‘Discrimination’ is defined in s3 of the Charter by reference to its meaning in the *Equal Opportunity Act* 2010 (**the EO Act**) and the attributes in s6 of the EO Act. Veronica possessed several attributes protected by the EO Act and the Charter; direct and indirect discrimination because of protected attributes is prohibited. The most relevant attributes to this inquest are ‘sex’, given Veronica was a woman, ‘race’, given that she was Aboriginal, and ‘disability’, because opioid addiction falls within the EO Act definition of disability.

89. The second limb of s8(3) protects substantive equality by recognising that certain groups may need to be treated differently to ensure they enjoy the equal protection of the law. The third limb of s8(3) provides a right to equal and effective protection against discrimination. It therefore extends beyond only requiring that the law protect people equally and without discrimination to provide every person with a separate and positive right to be effectively protected against discrimination.

90. Accordingly, examination of the circumstances proximate to Veronica’s passing includes consideration of whether decisions made about her, her care and treatment might have been affected by discrimination or stigma based on protected attributes, including any compounding forms of discrimination due to the intersection of these attributes. It is also relevant to consider the extent to which any of Veronica’s other human rights were limited in a discriminatory manner.

Right to life

91. Section 9 of the Charter provides that every person has the right to life and the right not to be arbitrarily deprived of life. It is relevant to the extent that it requires public authorities to take measures to prevent and protect individuals against the arbitrary deprivation of life. As s32(2)

of the Charter permits consideration of international jurisprudence to interpret the scope of Charter rights, I note the European Court of Human Rights has found that the right to life includes an obligation on the State to ensure that the health and wellbeing of people in detention are adequately secured by, among other things, providing requisite medical assistance, prompt and accurate diagnosis and care and regular supervision.[66] It is also relevant to consider whether Veronica's right to life was limited in a discriminatory manner.

Cultural rights

92. Section 19 protects cultural rights and distinct Aboriginal cultural rights. In the absence of any detailed consideration of the scope of the cultural rights protected by s19 in Victorian law, international jurisprudence suggests that positive measures may be necessary to protect against the denial or infringement of the right to culture.[67] Further, that while denial or violation of the right to culture must meet a threshold, when 'interference' becomes 'so substantial' that it amounts to a 'denial' of the right[68] is a question of degree.

93. Veronica's Aboriginal identity raises for consideration the cultural competence of those who interacted with her proximate to her passing, especially whether the treatment and care she received was culturally safe. Care and treatment that is culturally safe for Aboriginal people and delivered by staff who are culturally competent is likely to promote the rights of

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[66] *Case of Pitalev v Russia* (European Court of Human Rights, Fifth Section, Application No 34393/03, 30 October 2009) [54].

[67] *Poma Poma v Peru*, United Nations Human Rights Committee, Views: Communication No 1457/2006, UN Doc.

[68] *Poma Poma v Peru*, United Nations Human Rights Committee, Views: Communication No 1457/2006, UN Doc.

Aboriginal people to enjoy their identity and culture by incorporating Aboriginal cultural practices and holistic understanding of health as well as social, emotional, spiritual and cultural wellbeing and allowing Aboriginal people to safely express their culture and identity when seeking and receiving care.[69]

Right to liberty

94. Section 21 of the Charter provides a right to liberty, except on certain grounds, and in accordance with certain procedures, established by law. As such the right to liberty is not unlimited, but sections 21(2) and 21(6) provide, respectively, that detention cannot be arbitrary or automatic.

95. Examination of the extent of any impermissible infringement of Veronica's right to liberty will require consideration of the interpretation of the Bail Act pursuant to s32 of the Charter. In particular, whether ss4AA, 4A, 4C, Schedule 2 (the reverse onus provisions) and 4E (unacceptable risk) are compatible with or are an unjustifiable limit on the right not to be automatically detained notwithstanding the special protections relating to Aboriginal people in s3A. Consideration of Veronica's right to liberty will also involve the application of the Bail Act on 30 and 31 December 2019 in light of the rights protected by sections 8 and 19.

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[69] See Martin Laverty, Dennis McDermott and Tom Calma, 'Embedding Cultural Safety in Australia's Main Health Care Standards' (2017) 207(1) *Medical Journal of Australia* 15; Judy Atkinson, 'Trauma-informed services and trauma-specific care for Indigenous Australian children', Resource sheet no. 21, 23 July 2013, http://earlytraumagrief.anu.edu.au/files/ctg-rs21.pdf; Finding into Inquest into the Death of Harley Robert Larking (18 September 2020).

Right to humane treatment when deprived of liberty

96. In section 22, the Charter provides that everyone deprived of liberty must be treated with humanity, and with respect for their inherent dignity. While detention will inevitably impose some limits on a person's human rights, this right acknowledges the vulnerability of people in detention. Public authorities are required to take positive measures to ensure that detained people are treated with dignity and humanity.[70] The protection of human dignity encompasses such matters as ensuring adequate conditions of accommodation, food and personal hygiene, clothing and bedding standards and access to medical services.[71]

Protection from torture and cruel, inhuman or degrading treatment

97. Section 10 of the Charter provides that a person must not be subjected to torture, or treated or punished in a cruel, inhuman or degrading way. International jurisprudence informs interpretation of these rights. Thus, while an act of a public authority will constitute 'torture' if it *intentionally* inflicts – including by purposeful omission – severe physical or mental pain or suffering on a person for a prohibited purpose (such as punishment or discrimination),[72] treatment may be cruel, inhuman or degrading whether it is inflicted intentionally or negligently (including by an 'accumulation of errors').[73] To fall within s10(b), the treatment must reach a minimum level of severity, which will depend on all the circumstances of the

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[70] General Comment No 21 at [3]; *Castles* at [100]; *Haigh v Ryan* [2018] VSC 474 at [85].

[71] *Castles* at [94], [106]-[108], [113] (Emerton J).

[72] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) art 1.

[73] *McGlinchey and Others v United Kingdom* (Application no.50390/99), ECHR 21 [1], 23 [7]; *Certain Children v Minister for Families and Children (No 2)* (2017) 52 VR 441, 519 [250].

case;[74] factors like a person's poor health,[75] substance use disorder[76] and Aboriginality[77] may aggravate the effect of treatment to render it cruel, inhuman or degrading.

98. Veronica's right not to be subject to cruel, inhuman, and degrading treatment is engaged by what might amount to the infliction of unnecessary suffering.

99. With this framework in mind, including the additional detail contained in Appendix A, I now turn to my statutory tasks under the *Coroners Act* 2008.

THE CORONIAL INVESTIGATION

Jurisdiction

100. Veronica's death constituted a 'reportable death' pursuant to section 4 of the *Coroners Act* 2008 (**the Act**), as her death was unexpected, and occurred in Victoria, where she was in custody.[78]

Purpose of a coronial investigation

101. The jurisdiction of the Coroners Court is inquisitorial.[79] The specific purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if

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[74] *Certain Children v Minister for Families and Children (No 2)* (2017) 52 VR 441, 519 [250].
[75] *McGlinchey and Others v United Kingdom*, Judge Costa, 22 [4].
[76] *Vogel v New Zealand*, CAT, CAT/C/62/D/672/2015, [7.3].
[77] *Brough v Australia*, HRC, CCPR/C/86/D/1184/2003, [9.4].
[78] The Act, s 4(1); s 4(2)(a); s 4(2)(c).
[79] Ibid, s 89(4).

possible, the identity of the deceased person, the medical cause of death and the circumstances in which the death occurred.[80]

102. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the investigation findings and by the making of recommendations by coroners.[81] This is generally referred to as the coroner's prevention role.

103. Coroners are empowered to:

103.1. report to the Attorney-General on a death;[82]

103.2. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[83] and

103.3. make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[84]

104. These powers are the mechanisms through which the coroner's prevention role can be advanced.

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[80] Ibid, s 67(1).
[81] Ibid, s 1(c).
[82] Ibid, s 72 (2).
[83] Ibid, s 67(3).
[84] Ibid, s 72(2).

The holding of an inquest

105. As Veronica was a person placed in custody or care immediately before her passing,[85] the investigation into passing must include an inquest, pursuant to section 52(2) of the Act.[86]

Findings pursuant to section 67(1)

106. The matters regarding which a coroner investigating a death must make findings, if possible, are set out in section 67(1) of the Act. They include:

106.1. the identity of the deceased; and

106.2. the cause of death; and

106.3. the circumstances in which the death occurred.

107. The Act replaced the *Coroners Act 1985* (Vic) (**1985 Act**), which set out the findings a coroner must make at section 19(1). Notably, prior to the *Coroners Amendment Act 1999*, the 1985 Act included at subsection 19(1)(e) a requirement for the coroner to find "the identity of any person who contributed to the cause of death". The *Coroners Amendment Act 1999* removed this subsection and no equivalent to this subsection was reintroduced in the Act.

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[85] Section 3 person placed in custody of care (e)

[86] I note that by s52(3A) of the Act, the coroner is not required to hold an inquest in the circumstances set out in subsection (2)(b) if the coroner considers that the death was due to natural causes. Further that s52(3A) of the Act provides that for the purposes of subsection (3A), 'a death may be considered due to natural causes if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to natural causes.' The circumstances set out in subsection (3A) do not limit the powers of a coroner to hold, adjourn or recommence an inquest.

108. The circumstances surrounding a death can include several important categories in relation to a person's involvement:

108.1. the courses of action that person undertook;

108.2. any relevant normal practices in that person's profession or party's industry; and

108.3. the likelihood that various courses of action, including the one taken, could have prevented the death.

109. Questions about a person or party's "culpability", in a context where coroners do not assign fault or blame, will necessarily be addressed in comments regarding the relationship between the person or party's course of action and either of the latter two categories above.

110. The power to comment arises from section 67(3): "a coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice".

111. These powers arise as a consequence of the obligation to make findings. They are not free ranging. 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.[87]

[87] *Harmsworth v The State Coroner* [1989] VR 989 at 996.

112. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[88] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[89] A Coroner must, however, report to the Director of Public Prosecutions if they believe that an indictable offence may have been committed in connection with the death.[90]

Causation, proximity and connection

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

114. The circumstances of the death do not refer to the entire narrative culminating in the death, but rather to those circumstances which are sufficiently proximate and causally relevant to the death. Findings as to circumstances will necessarily include findings as to which events caused others, in what combination they played this causative role and to what degree.

115. The standard for making a finding that matters are 'connected with' the death, for the purpose of the power to make comment under section 67(3) of the Act or the power to make recommendations under section 72(2), is not the same as the standard of proximate

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[88] The Act, s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

[89] *Keown v Khan* (1999) 1 VR 69.

[90] The Act, s 49.

connection required for a finding as to the circumstances. In *Thales v Coroners Court*, Beach J adopted the interpretation of Muir J in *Doomadgee v Clements*[91] that "there was no warrant for reading 'connected with' as meaning only 'directly connected with'", and that the range of matters connected with a death, for the purpose of comments or recommendations, can be "diverse".[92]

Standard of proof

116. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[93] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[94]

117. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[95] The effect of this and similar authorities is that a coroner should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that the individual or entity caused or contributed to the death.

118. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of

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[91] *Doomadgee v Clements* [2006] 2 QdR 352.
[92] *Thales Australia Limited v The Coroners Court* [2011] VSC 133.
[93] *Re State Coroner; ex parte Minister for Health (*2009) 261 ALR 152.
[94] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995 (Cth); Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[95] (1938) 60 CLR 336.

evidence commensurate with the gravity of the facts sought to be proved.[96] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[97] Weight must be given to a presumption of innocence.[98]

119. Where I have arrived at an adverse finding or comment in relation to an individual or entity, I have been satisfied that the appropriate standard of proof has been met.

Adverse comments about professionals

120. Determining that a person in their professional capacity has contributed to the death of another person is a serious conclusion for a Coroner to reach. In *DHCS v Gurvich*, where Southwell J addressed the question of the standard of proof for a finding that a person contributed to a person's death:

> To say of professional people that they "contributed to the cause of death" of another person in the course of their professional duties is to make a very serious allegation. It is an allegation of negligence, that by a breach of their professional duty owed to the deceased, they contributed to [their] death. … [N]o such adverse finding should be made

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[96] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[97] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.
[98] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

> unless there exists comfortable satisfaction that negligence has been established which contributed to the death.[99]

121. Similarly, *The Chief Commissioner of Police (Vic) v Hallenstein* warns against making such findings lightly and emphasises that they can only be made when the necessary degree of satisfaction has been established.[100] Insofar as any finding of contribution is made, "some departure from the reasonable standards of behaviour will ordinarily be thought to be required, and must be properly established".[101]

122. However, both of these judgements related to the then-in-force section 19(1)(e) of the 1985 Act. Under the current Act, the question of a person's contribution to a death is a matter for comment rather than findings into circumstances. It will be a comment either:

122.1. that a person's course of action departed from normal professional practices; or

122.2. that there was another course of action available which would have been more likely to prevent the death, or less likely to cause it.

123. A comment of the second type does not necessarily imply that the person had enough information to recognize that this other course of action would have been more appropriate.

124. If the question of contribution to the death arises when making comments such as these, rather than when making findings into circumstances, the issues to consider are different. The

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[99] *The Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 74.

[100] *Chief Commissioner of Police (Vic) v Hallenstein* [1996] 2 VR 1, [19]. (*Hallenstein*).

[101] Ibid, [20].

purpose of making comments is directed toward identifying prevention opportunities. It is particularly important to be able to make comments where systemic prevention opportunities exist that might relate to practices across a profession rather than a single practitioner.

125. A comment that a practitioner had another course of action available to them which had a higher probability of preventing the death, or a lower probability of causing the death, is an adverse one. The standard of proof is therefore heightened in accordance with *Briginshaw*, though not to the degree required to justify a finding of negligence as would have been appropriate for findings under section 19(1)(e) of the 1985 Act.

126. As this is an objective issue, it is not appropriate to shun the benefit of hindsight when addressing it. It is important that a coroner is able to identify opportunities to prevent a death even if they were not apparent at the time – this is central to the coroner's death prevention function.

127. If, however, a further comment is made that the practitioner had enough information at the time to recognise this other course of action, this would be a substantially adverse comment and the standard of proof would be appropriately heightened. This is the step where a coroner should take great care not to confuse what is apparent in hindsight with what was apparent at the time.

128. Normal professional practices will be a factor in considering whether a practitioner had enough information to recognise a better course of action: where I propose to make a specific comment that a health practitioner's conduct was substandard for their profession, then the heightened standard of probability and the heightened wariness of hindsight has been applied. The same heightened standards must also apply to any notification or recommendation to

regulatory or professional bodies that a practitioner's conduct should be reviewed and possibly be made the subject of disciplinary action.

Non-causative substandard conduct

129. A comment that a health practitioner's conduct causally contributed to a death is not the same as a comment that they departed from normal professional practices. If normal professional practices do not correctly address an aspect of the chain of events which led to the death, normal professional conduct might play a causative role in the death. Conversely, a practitioner could depart seriously from normal practices without causing the death, depending on the factual circumstances.

130. Beach J in *Thales* quoted a number of examples of matters "connected with" a death from Muir J in *Doomadgee v Clements*, which included "the reporting of the death" and "a police investigation into the circumstances surrounding the death".[102]

131. A comment about such non-causative substandard conduct would thus still be appropriate as it is a matter 'connected with' the death. It remains an adverse comment, despite not implying causation of the death, and the standard of proof for making it is appropriately heightened.

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[102] *Thales Australia Limited v The Coroners Court* [2011] VSC 133.

Scope of inquest

132. Although the coronial jurisdiction is inquisitorial rather than adversarial,[103] it should operate in a fair and efficient manner.[104] 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 protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[105]

133. In *Harmsworth v The State Coroner*,[106] Nathan J considered the extent of a coroner's 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.[107]

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[103] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*.
[104] The Act, s 9.
[105] The Act, s 8(b).
[106] (1989) VR 989.
[107] Ibid.

134. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[108] 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.

135. Chief Justice Higgins also provided a helpful example of the limits of a coroner's inquiry, suggesting that factual questions related to cause will generally be within the scope of the inquest.[109]

136. 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.[110]

Development of the Scope

137. The scope provided a framework against which to examine Veronica's experience of the courts, and custodial health systems. Following a direction hearing on 11 November 2020, in

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[108] [2009] ACTSC 40.

[109] 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.

[110] 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.

which interested parties were afforded the opportunity to be heard, the scope of the inquest was finalised. Of note, CCA did not seek to make any submissions in relation to the proposed scope when called upon.[111]

138. The scope included:

1. The circumstances of Ms Nelson's arrest and charge on 30 December 2019 by Victoria Police.

2. The circumstances of Ms Nelson's remand in custody and the application for bail made on 31 December 2019, including:

    a. the operation of the Bail Act 1977;

    b. her appearance without legal representation;

    c. what Aboriginal and legal support services were offered and/or available to Ms Nelson at the Magistrates' Court.

3. Did Ms Nelson receive adequate medical assessment, treatment and care while on remand at the Dame Phyllis Frost Centre? In particular:

    a. was there adequate monitoring and observation of Ms Nelson?

    b. why was Ms Nelson transferred to the Yarra Unit?

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[111] *Transcript of Directions Hearing*, 16 November 2020, T48.28-30.

c. was there an appropriate health management response provided to Ms Nelson?

d. was there an appropriate escalation of care response provided to Ms Nelson?

e. was the medical assessment, treatment and care adequate for Ms Nelson as a woman with health issues including a drug dependency?

f. response of Dame Phyllis Frost Centre staff members immediately following the discovery of Ms Nelson's body on 2 January 2020

4. The relevance of:

   a. Ms Nelson's Aboriginality;

   b. Ms Nelson's drug use; and

   c. Ms Nelson's criminal antecedents

   to the decisions made in relation to her from her arrest on 30 December 2019 to her death on 2 January 2020.

5. Was Ms Nelson's treatment from the time of her arrest on 30 December 2019 to her death on 2 January culturally competent?

6. Whether Ms Nelson's death was preventable.

7. Identification of any prevention opportunities.

Interested Parties

139. In the course of the investigation and inquest, I granted leave for 17 applicants to appear as interested parties in accordance with section 56 of the Act:

139.1. Percy Lovett;

139.2. Aunty Donna Nelson;

139.3. the Chief Commissioner of Police;

139.4. CCA;

139.5. the DJCS;

139.6. Dr Alison Brown;

139.7. Dr Sean Runacres;

139.8. the Fitzroy Legal Service (FLS);

139.9. Forensicare;

139.10. G4S;

139.11. Jillian Prior;

139.12. LACW;

139.13. RN Stephanie Hills;

139.14. PO Tracey Brown;

139.15. Tracy Jones;

139.16. the VEOHRC; and

139.17. VLA.

140. During the course of oral evidence from Mr Tass Antos, a legal representative was granted leave to appear on his behalf. Mr Antos was invited by the Court to file an application for leave to appear as an Interested Party, and further invited to make final submissions in response to the draft recommendations and findings, but he waived both the right to file an application in accordance with section 56 of the Act and the right to make final submissions.

141. Throughout the inquest Dr Runacres was represented by legal representatives for CCA. During the process of filing written submissions at the close of evidence he became independently represented.

Witnesses called at Inquest

142. The following nineteen witnesses were called to give oral evidence at the inquest regarding the factual circumstances surrounding Veronica's death:

142.1. Sgt Brendan Payne;

142.2. SC Rebecca Gauci;

142.3. Solicitor Jillian Prior;

142.4. Barrister Peter Schumpeter;

142.5. Barrister Tass Antos;

142.6. Senior Prison Officer Christine Fenech (**SPO Fenech**);

142.7. RN Stephanie Hills;

142.8. Dr Alison Brown;

142.9. Dr Sean Runacres;

142.10. RPN Bester Chisvo;

142.11. RN Mark Minett;

142.12. Prison Officer Leanne Enever (**PO Enever**);

142.13. Ms Kylie Bastin;

142.14. Prison Supervisor Justin Urch (**PS Urch**);

142.15. Prison Supervisor Leanne Reid (**PS Reid**);

142.16. Senior Prison Officer Karen Heath (**SPO Heath**);

142.17. RN Atheana George;

142.18. PO Tracey Brown;

142.19. Prison Officer Michelle Reeve (**PO Reeve**).

143. Witnesses were also called to speak to the systems involved in Veronica's treatment while in custody, including:

143.1. DPFC Governor Tracey Jones (**Governor Jones**);

143.2. CCA Chief Medical Officer Dr Foti Blaher (**Dr Blaher**);

143.3. CCA Deputy CEO and Chief Nursing Officer Christine Fuller (**Ms Fuller**).

144. Yeliena Baber (**Dr Baber**), forensic pathologist, gave expert evidence about the medical cause of Veronica's passing.

145. Aunty Vickie Roach gave evidence as a cultural expert.

146. All of these witnesses were examined and then cross-examined, individually, by representatives for all interested parties, with some time and topic constraints being required for case management purposes.[112]

Certificates granted under section 57

147. Section 57(1) of the Act permits a witness to object to giving evidence, or evidence on a particular matter, at an inquest on the ground that the evidence may tend to prove that the witness has committed an offence or is liable to a civil penalty.[113]

148. If a coroner finds that there are reasonable grounds for such an objection, they can give that witness a certificate under section 57. The effect of such a certificate is that, in any proceeding in a court or before any person or body authorised by a law of the State of Victoria, or by consent of parties, to hear, receive and examine evidence:

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[112] Protocol on the Conduct of Proceedings, Veronica Nelson Inquiry dated 13 April 2022 and circulated to Interested Parties on the same.

[113] The Act, s 57(1).

148.1. evidence given by a person in respect of which a certificate under this section has been given; and

148.2. any information, document or thing obtained as a direct or indirect consequence of the person having given evidence –

cannot be used against the person.[114]

149. However, this does not apply to a criminal proceeding in respect of the falsity of the evidence.[115]

150. A number of witnesses applied for certificates pursuant to this provision. Those witnesses were:

150.1. RN Stephanie Hills;

150.2. Dr Sean Runacres;

150.3. RN Mark Minett;

150.4. RN Atheana George;

150.5. PO Tracey Brown;

150.6. Governor Tracy Jones;

150.7. Christine Fuller; and

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[114] The Act, s 57 (7).
[115] Ibid.

150.8. Dr Foti Blaher.

151. After hearing from their representatives, I was satisfied that the evidence of each of these witnesses may tend to prove that they had committed an offence or make them liable to a civil penalty. Under cover of the certificate, I then compelled each of them to give oral evidence.

Expert evidence

152. The inquest also received two tranches of concurrent evidence: one tranche relevant to medical questions and issues (**Medical Evidence**) and the other to administration of justice issues (A**dministration of Justice Evidence**). Two panels of participants provided concurrent evidence in relation to Medical Evidence and Administration of Justice Evidence respectively: 'Conclave' and 'Stakeholder' panels. Each panel member provided evidence concurrently with other members of their panel, with each panel present in court when the other gave evidence.

153. Medical Evidence and Administration of Justice Evidence conclave panel members, respectively, were provided a briefing pack and questions (**Conclave Questions**) prior to convening to deliberate privately. Conclave panellists were expected to discuss each question and formulate consensus answers as far as possible. No conclave panellist was expected to compromise their opinion for the benefit of agreement. Rather, the process was intended to facilitate collaboration of thought in the development and refinement of opinions, and identify where agreement lay, and where opinions differed.

154. Medical Evidence and Administration of Justice Evidence stakeholder panel members, respectively, were provided with the Conclave Questions in advance of giving concurrent evidence with their panel. Stakeholder panellist were expected to use their knowledge of institutional structures, powers, practices and limitations to inform formulation of prevention-focused recommendations and advice about the feasibility of implementing proposed recommendations.

155. Interested parties were afforded an opportunity to be heard about the composition of the panels, content of the briefing packs, formulation of the Conclave Questions and the Procedure for Concurrent Evidence.[116]

156. Concurrent Medical Evidence and Administration of Justice Evidence was heard on several topics for two days, respectively. While doing so, panel members commented on each other's reports and each other's oral evidence. Interested Parties had an opportunity to cross-examine the panels, however, were confined to putting factual scenarios, particularly to the conclave panels, in the hypothetical only.

157. The Medical Conclave (**Medical Conclave**) comprised of the following expert witnesses, each of whom had also provided expert reports:

157.1. Associate Professor Yvonne Bonomo, Addiction Medicine physician;

157.2. Katya Issa, Correctional Health Operations Manager, St Vincent's;

[116] Procedure for Concurrent Evidence, Veronica Nelson Inquiry dated 7 May 2022. See, for instance, the *Transcript of the Directions Hearing*, 19 April 2022.

157.3. Dr Sally Bell, Gastroenterologist;

157.4. Dr Andrew Walby, Emergency Medicine specialist;

157.5. RN Tracie Ham, Registered Nurse;

157.6. Dr Ric Milner, General Practitioner;

157.7. Professor Carla Treloar, PhD in health psychology;

157.8. Dr Nico Clark, Addiction Medicine specialist;

157.9. Professor Megan Williams, Research Lead and Associate Director of the National Centre for Cultural Competence, University of Sydney;

157.10. Dr Christopher Vickers, Gastroenterologist;

157.11. Dr Dianne Chambers, General Practitioner;

157.12. Dr Matthew Frei, Addiction Medicine specialist;

157.13. Dr Chad Brunner, Medical Practitioner.

158. During the Medical Conclave concurrent evidence, the following stakeholders attended and gave evidence (**Medical Stakeholder Panel**):

158.1. Christine Fuller;

158.2. Victorian Aboriginal Health Service (VAHS) Clinical Director Dr Jenny Hunt;

158.3. Justice Health Director Scott Swanwick; and

158.4. CV Deputy Commissioner Melissa Westin.

159. The Administration of Justice Conclave (**Administration of Justice Conclave**) comprised of the following expert witnesses, each of whom provided expert reports or outlines of opinion:

159.1. Dr Amanda Porter, PhD, Senior Fellow Indigenous Programs, Melbourne University Law School;

159.2. Lee-Anne Carter, Aboriginal Community Justice Manager, Victorian Aboriginal Legal Service;

159.3. Melinda Walker, Accredited Criminal Law specialist;

159.4. Kin Leong, Principal Legal Officer of Criminal Law, Victorian Aboriginal Legal Service;

159.5. Adam Willson, Senior Lawyer Drug Outreach Program, Fitzroy Legal Service;

159.6. Joanne Atkinson, Koori Court Manager;

159.7. Uncle Ted Wilkes, Adjunct Associate Professor, harm minimisation and reduction expert;

159.8. Aunty Marjorie Thorpe, cultural expert;

159.9. Jessica Thomson, Aboriginal Community Engagement coordinator, Victoria Legal Aid;

159.10. Elena Campbell, Associate Director, Centre for Innovative Justice.

160. During the Administration of Justice Conclave, the following stakeholders attended and gave evidence (**Administration of Justice Stakeholder Panel**):

160.1. Victoria Police Assistant Commissioner Russell Barrett;

160.2. Magistrates' Court of Victoria CEO Simon Hollingsworth;

160.3. VLA Associate Director (Aboriginal Services) Lawrence Moser;

160.4. VLA Executive Director (Criminal Law) Dan Nicholson;

160.5. VALS CEO Nerita Waight; and

160.6. CV Deputy Commissioner Melissa Westin.

161. The scope of inquest requires me to consider whether Veronica's Aboriginality, drug use or criminal antecedents were relevant to the decisions made in relation to her from her arrest on 30 December 2019 to her passing on 2 January 2020.

Conceptual tools

162. I have had the benefit of numerous comprehensive and detailed expert reports from a range of disciplines. From these materials emerged three conceptual tools that I considered may be helpful when examining the evidence relating to the issues identified in that part of the scope mentioned above. Those concepts are 'stigma', 'cultural competency' and 'cultural safety'.

163. Both the Medical and Administration of Justice Conclaves were asked, separately, to consider the sufficiency of the definitions I formulated – but significantly abridged – from

the reports filed by Professor Carla Treloar (stigma)[117] and Professor Megan Williams[118] and Dr Amanda Porter (cultural competency and cultural safety).[119] Amendments were recommended by both Conclaves to each term defined; these amendments had the effect of broadening the definitions. The definition of 'stigma' was amended in consistent ways by each Conclave. However, the definitions of 'cultural competency' and 'cultural safety' agreed by the Medical and Administration of Justice Conclaves respectively were setting-specific. Each definition agreed by each Conclave was reached unanimously.[120]

Stigma

164. The following definition of 'stigma' was provided to the Medical and Administration of Justice Conclaves:

164.1. Stigma is the result of social power relations, that drive four processes:

164.2. distinguishing and labelling differences;

164.3. associating negative attributes to those identified differences;

164.4. separating and distancing of 'us' and 'them';

164.5. culminating in status loss and discrimination.[121]

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[117] Treloar: CB3942-3971.
[118] Williams: CB4119-4169.
[119] Porter: CB2303-2356.
[120] Medical Conclave: T2110; 2108 (Williams); T2113 (Treloar); Administration if Justice Conclave: T2423 (Wilson); T2420 (Porter); T2422 (Carter).
[121] Treloar, CB3946.

165. Stigma occurs when elements of labelling, stereotyping, status loss and discrimination occur together in a power situation that allows them.[122]

166. Speaking on behalf of the unanimous Medical Conclave, Professor Treloar expanded the definition of stigma, stating:

166.1. stigma is a multi-level phenomenon that can be embedded in organisational structures and policies, and in laws and media representations (structural stigma); manifest during interactions between people (interpersonal stigma); and individuals can internalise social messages about them or people like them, resulting in feelings of lower self-worth (internalised stigma);

166.2. stigma towards people with multiple stigmatised identities (intersectional stigma) results in multiple and severe disadvantage;

166.3. intersectional stigma in relation to people who inject drugs (especially women who inject drugs) and First Nations people is well-described; and

166.4. stigma has been accepted as a fundamental cause of population health inequalities.[123]

167. Adam Wilson and Jessica Thomson, speaking for the Administration of Justice Conclave, expanded the definition of stigma by emphasising the same three dimensions of stigma

[122] Treloar, CB3946.
[123] Medical Conclave (Treloar): T2113-2114.

identified by Professor Treloar above.[124] They also observed that the labels "drug user" and "Aboriginal woman" were treated as "negative attributes" in "the community."[125]

Cultural competency

168. The following definition of 'cultural competency' was provided to the Medical and Administration of Justice Conclaves:

168.1. the capacity of systems, organisations and individuals to respond to the unique needs of people whose cultures are different to that regarded as 'mainstream';

168.2. it requires acceptance and respect for difference, attention to the dynamics of difference and critical self-reflection about the service provider's attitudes and beliefs and how these may influence interactions in intercultural settings; and

168.3. attitudes, practices and policies must operate impartially, and service delivery should be adapted to reflect diversity between and within cultures and so provide effective services that enable self-determination.[126]

169. Professor Williams, for the Medical Conclave, expanded the definition of 'cultural competency' by adding:

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[124] Administration of Justice Conclave (Wilson and Thomson): T2424.
[125] Administration of Justice Conclave (Wilson): T2424.
[126] Adapted from the reports of Professor Williams and Dr Porter: CB CB4119-4169 and CB CB2303-2356 respectively.

169.1. cultural competence involves knowing and reflecting on one's own cultural values and world views and their implications for making respectful, reflective, reasoned choices, including the capacity to collaborate in cross-cultural contexts;[127] and

169.2. involves the ability to participate ethically and effectively in personal and inter-cultural settings.[128]

170. Dr Porter made the following comments on behalf of the Administration of Justice Conclave about the definition of 'cultural competency':

170.1. it is 'absurd' to suggest a person can be 'competent' in another's culture;

170.2. it is "non-sensical and insensitive" to apply the concept of cultural competence to the criminal justice system in Australia (rather than the health context) given that the "settler criminal justice system … is one of the most significant sites of ongoing … colonisation in Australia;"

170.3. the term risks detracting attention from the culture of the service provider, namely, the settler criminal justice system; and

170.4. a more productive framework than that provided by the rubric of 'cultural competence' – suggested by Aunty Marjorie Thorpe – may be one involving terms

[127] Medical Conclave (Williams): T2108.
[128] Medical Conclave (Williams): T2109.

like ‘humanity’ and ‘respect’ considering international jurisprudence on these issues.[129]

Cultural Safety

171. The following definition of ‘cultural safety’ was provided to the Medical and Administration of Justice Conclaves:

171.1. cultural safety is an environment that is spiritually, socially, emotionally and physically safe; where there is no challenge to or denial of identity or needs;

171.2. it requires some of the same processes as cultural competence - it is about shared respect, meaning, knowledge and experience and learning together with dignity and truly listening; and

171.3. cultural safety is determined by the person positioned to experience it rather than the culture of the service provider.[130]

172. On behalf of the Medical Conclave, Professor Williams added to the definition:

172.1. culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsible health care, free from racism;[131]

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[129] Administration of Justice Conclave (Porter): T2420-2422. Dro Porter also observed that the term emerged in United States of America in the public health and social work context, had been critiqued there, and had little resonance in Australia.

[130] Adapted from the reports of Professor Williams and Dr Porter: CB CB4119-4169 and CB CB2303-2356 respectively.

172.2. a ‘culturally safe workforce’ is one that considers power relations, cultural differences and the rights of the patient and encourages workers to reflect on their own attitudes and beliefs;[132] and

172.3. cultural safety and security for mainstream healthcare governance is the brokerage of moral obligations into every point in the organisation, so that the protocols for cultural safety operate in every service pathway to create and sustain culturally secure environments for Australia’s First Peoples. The primary intent underlying that definition is to bring a cultural voice, the human cultural perspective of Aboriginal peoples into Australian healthcare governance.[133]

173. The spokesperson for the Administration of Justice Conclave was Lee-Anne Carter. She characterised the definition of ‘cultural safety’ provided as “inadequate,”[134] adding that:

173.1. cultural safety is central to everything, but one size does not fit all;[135]

173.2. cultural safety involves more than just being aware and acknowledging your privilege, it is also about understanding the impact of your own culture and your cultural values on Aboriginal people;[136] and

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[131] Medical Conclave (Williams): T2110.
[132] Medical Conclave (Williams): T2110.
[133] Medical Conclave (Williams): T2111.
[134] Administration of Justice Conclave: T2422.
[135] Ibid.
[136] Ibid.

173.3. the person – or their family – is central to determining cultural safety. The 'environment' encompasses everything: particularly for someone who is Aboriginal, nothing can be separated out of what constitutes environment.[137]

174. Given the issues about which expert evidence was to be adduced, and the matters about which I might make findings, it was important for there to be a shared understanding about the content of these key terms. The consensus definitions of stigma, cultural competency and cultural safety, therefore, framed the evidence provided by the Medical and Administration of Justice Conclaves, and in turn, have informed my consideration of the evidence and issues arising in the investigation of Veronica's passing.

Nature of expert evidence

175. On most questions, and in relation to most matters about which I am obliged to make findings, the Medical and Administration of Justice Conclaves resolved to unanimous opinions. On a small number of matters, the Medical Conclave formed a majority view, and the nature and number of any dissenting views was identified.

176. I note two matters arising in final submissions made primarily but not exclusively on behalf of CCA. Firstly, it was submitted that there is no framework or particularisation against which to assess the cultural competence of Veronica's treatment by those responsible for her care between 31 December 2019 and her passing. I reject the submission based on the

[137] Administration of Justice (Carter): T2426. I note that Jessica Thomson noted that there is no set definition of what is or is not culturally safe because it can only be experienced by the person in the moment: T2425-2426.

definitions referred to above and note that interested parties were at some liberty to cross-examine experts, or provide contrary expert opinions, if they were not satisfied.

177. Secondly, I was urged to, and have been cautious before adopting unequivocally opinions of the Medical Conclave. I must be satisfied on each matter within these findings to the requisite standard of proof. I have also considered the Medical Conclave's evidence in the context of the material they had before them, which was necessarily more limited than the evidence upon which I can make findings; I have also borne in mind that the experts did not have the benefit of assessing Veronica in person.

178. The Medical Conclave also acknowledged that a custodial setting created additional burdens in the provision of clinical care.[138] I have had regard to this in the formulation of findings relevant to individual CCA clinicians as well.

View

179. On Saturday 30 April 2022, a view of the reception area, Medical Centre and Cell 40 of the Yarra Unit at DPFC was conducted.

180. Accompanied by members of the legal team assisting me and Troy Williamson, Manager of the Coroners Court's Koori Family Engagement Unit, I was escorted by an employee of CV having no role in the inquiry to the locations relevant to my investigation of Veronica's passing.

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[138] See, for example, the consensus view shared Dr Walby at T2374.30-2375.14.

181. Given the need to minimise the spread of COVID-19 into closed environments like prisons, strict protocols were in place at DPFC and the number of people able to participate in the view was limited to one representative of each Interested Party expressing an interest to do so. A legal representative for Aunty Donna, Mr Lovett, CCA, Forensicare, VEOHRC, FLS and DJCS attended.

Sources of evidence

182. This finding draws on the totality of the material produced in the coronial investigation into Veronica's passing. That is, the court file, Coronial Brief, inclusive of materials sought, obtained and received by the Coroners Court throughout the investigation and inquest and incorporated as Additional Materials, evidence adduced during the inquest, as well as the written submissions of counsel.

183. In writing this finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

Framing of this finding

184. Throughout this finding, I have used the term 'Aboriginal' when referring to Veronica, in recognition of her identity as a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman.

185. I note that preferences in terminology vary across Australia for different Aboriginal and/or Torres Strait Islander individuals, communities, and agencies, and that these

preferences can change over time. I also note that the term ‘Indigenous’ may be considered unacceptable by some, as it is a generic term which was used historically to eliminate any distinction between the different culture, traditions, language, and beliefs of Aboriginal and Torres Strait Islander people.

186. Therefore, the terms ‘Aboriginal and/or Torres Strait Islander people’ and ‘First Nations people’ are used throughout this finding when referring collectively to the peoples or nations of people whose ancestral connections pre-date the arrival of Europeans. The term ‘Indigenous’ is used only where it is necessary to accurately quote a law or policy which adopts this language.

187. Throughout this finding, many of the headings involve use of the term ‘decision’. This term has been consciously chosen. Repeated and routinised practices – whatever the context – are sometimes so well-worn that they appear to lose the characteristics of a ‘decision’. But actions and inactions generally involve decisions.

188. Not all decisions, actions or inactions taken in the events relevant to my investigation were taken by public authorities, though a great many were.

189. Though not always the case, decisions, actions and inactions – big and small – may become inflection points in our own lives or the lives of others. Often inflection points are obvious; sometimes, their significance will only be clear in hindsight. But actions, inactions and decisions generally involve consequences.

190. It is necessary therefore to be reminded – and to remind oneself – of the true character of actions and inactions as decisions; to ensure that as many as possible – whether routine or otherwise – are taken consciously.

191. Use of the term 'decision' throughout this finding also serves to highlight all the decisions Veronica was not able to take for herself in the last few days of her life.

IDENTITY

192. On 6 January 2020, Veronica Marie Nelson, born 18 March 1982, was formally identified by her partner, Percy Lovett.[139]

193. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

194. Forensic pathologist, Dr Yeliena Baber performed an autopsy on Veronica's body at the Victorian Institute of Forensic Medicine (**VIFM**) on 6 January 2020 having reviewed the Police Report of Death Form, scene photographs and post-mortem computer tomography (**PMCT**) scans of the whole body.[140]

195. Dr Baber's external examination revealed a cachectic body weighing 33 kilograms and measuring approximately 160 centimetres in height; Veronica's body mass index (**BMI**) was

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[139] Statement of Identification (COR 2020/21) dated 6 January 2020.
[140] Report of Dr Baber: CB3896.

calculated to be 12.9.[141] Dr Baber explained that cachexia is a medical term used to describe someone who is "very malnourished-looking,"[142] due to loss of weight, body fat and muscle producing the appearance of skin being just over bone.[143] Veronica's BMI was indicative of her being "grossly underweight" and undernourished, as a normal BMI is around 20.[144]

196. The internal examination, confirming findings evident on PMCT,[145] revealed grossly dilated and distended stomach and first and second parts of the duodenum.[146] The extent of the distension observed was likely to have developed over months.[147]

197. No injuries, nor other significant natural disease were identified during autopsy.[148]

198. Routine post-mortem toxicology showed the presence of methylamphetamine, buprenorphine (Suboxone), codeine, paracetamol, metoclopramide[149] and delta-9-tetrahydrocannabinol[150] in blood.[151]

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[141] Report of Dr Baber: CB3897. In Dr Baber's summary of autopsy findings, Veronica's BMI was rounded up to 13: Report of Dr Baber: CB3896.

[142] Baber: T2053-2054.

[143] Baber: T2054.

[144] Baber: T2055.

[145] Forensic Radiologist Dr Chris O'Donnell reviewed Veronica's PMCT who agreed with Dr Baber's diagnosis of Wilkie Syndrome: Report of Dr Baber: CB3897.

[146] Report of Dr Baber: CB3896. The duodenum is the first part of the small intestine that connects to the stomach; the duodenum absorbs nutrients and water from nourishment so that these can be used by the body.

[147] Baber: T2058.

[148] Report of Dr Baber: CB3897. I note that Dr Baber observed mild to moderate narrowing of the left anterior descending coronary artery by atherosclerosis and, on histological samples, emphysematous changes in the lungs, neither of which contributed to the medical cause of Veronica's death.

[149] Metoclopramide is an anti-emetic.

[150] Delta-9-tetrahydrocannabinol is the active form of cannabis.

[151] Report of Dr Baber: CB3903-3904.

199. Analysis of vitreous electrolytes showed that the levels of urea, creatinine and sodium were 'supportive of a finding of dehydration'.[152] Dr Baber observed that she was unable to comment, based on post-mortem electrolytes, on the extent of Veronica's dehydration before her passing.[153]

200. On the basis of the information available at the time of autopsy, in her report dated 9 June 2020, Dr Baber formulated Veronica's medical cause of death as "complications of Wilkie Syndrome".[154]

201. Dr Baber explained that Wilkie Syndrome, or Superior Mesenteric Artery Syndrome, is an uncommon condition "characterised by the compression of the third, or transverse, portion of the duodenum between the aorta and the superior mesenteric artery". The compression occurs because in individuals who are cachectic, there is a loss of the pad of fat that normally sits between the aorta and the duodenum.[155] The consequence of compression of the duodenum is chronic, intermittent incomplete obstruction of the duodenum that prevents the stomach from emptying effectively, causing distention and delaying absorption of nutrients.[156] In life, complete or partial obstruction of the duodenum typically causes pain,

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[152] See generally, the Biochemistry Report dated 20 January 2020 CB 3905 and Baber: T2070.
[153] Baber: T2070.
[154] Report of Dr Baber: CB3897. Dr Baber advised that Veronica's death was due to natural causes.
[155] Baber: T2061.
[156] Baber: T2061.

nausea and voluminous vomiting[157] and can result in malnutrition, dehydration and electrolyte disturbances.[158]

202. On 22 February 2022, Dr Baber produced a supplementary report after reviewing reports provided by Dr Mark Walby, Associate Professor Sally Bell and Dr Christopher Vickers.[159]

203. In her supplementary report, Dr Baber observed that her intention in ascribing the medical cause of death as "*complications* of Wilkie Syndrome" (emphasis added) was to "encompass the complexity of the effects of malnutrition, repeated vomiting and the associated electrolyte disturbances".[160]

204. She agreed that severe vomiting as a result of acute opiate withdrawal would also be capable of leading to fatal electrolyte imbalances leading to cardiac arrythmia.[161] On reflection, Dr Baber opined that it may have been more prudent to formulate Veronica's cause of death as "complications of Wilkie Syndrome in the setting of withdrawal from chronic opiate use" and so expressed the cause of death in this way in her supplementary report.[162]

205. In evidence at inquest, for reasons that will become clear below, Dr Baber was questioned about how deceased are weighed on admission to the VIFM mortuary and the likelihood of significant weight loss in an approximately 36-hour period prior to or shortly after passing.

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[157] Report of Dr Baber: CB3897.
[158] Report of Dr Baber: CB3897.
[159] Supplementary Report of Dr Baber: CB792.
[160] Supplementary Report of Dr Baber: CB4793.
[161] Supplementary Report of Dr Baber: CB793.
[162] Supplementary Report of Dr Baber: CB793.

Dr Baber opined that no weight loss that would "register in terms of kilograms"[163] would occur post-mortem and it would not be possible for an individual to lose 7.7 kilograms,[164] or five kilograms in body weight in 36 hours of life.[165]

206. At inquest, Dr Baber confirmed that Veronica's malnutrition was apparent shortly before she passed because she was "incredibly thin".[166]

207. When asked about the 'change' to the medical cause of death in her supplementary report, which Dr Baber characterised as a "clarification" rather than a change, she observed that it was impossible to determine which condition, chronic opiate use or Wilkie's Syndrome, contributed more to Veronica's state of malnutrition.[167]

208. Indeed, Dr Baber opined that, in fact, malnutrition was the most significant causative factor in Veronica's passing.[168] This was because it would be unlikely for an otherwise healthy individual - that is, one unaffected by the long-term issues of malnutrition - to have passed if they were in the position Veronica was in the last two or three days of her life.[169]

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[163] Baber: T2055.
[164] Baber: T2055.
[165] Baber: T2079.
[166] Baber: T2077.
[167] Baber: T2071.26-31.
[168] Baber: T2076-2077.
[169] Baber: T2076-2077.

209. In light of her evidence during the inquest, Dr Baber accepted the proposition that the medical cause of Veronica's death could be re-formulated as: "complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition".[170]

210. Counsel for CCA submitted that I should adopt the cause of death provided by Dr Baber in her supplementary report. This submission was advanced on the basis that opiate withdrawal and Wilkie Syndrome could not be separated as relevant causes of death and that the evidence did not support a finding that withdrawal from opiate use was the principal cause of death. CCA submitted that there was no basis on which any one cause might be considered the more likely operative cause of death and that, therefore, there is no reason for the order of the causes considered by Dr Baber in her supplementary opinion to be reformulated.

211. Dr Baber gave extensive oral evidence and was cross-examined by interested parties. I do not consider there to have been any ambiguity in her expert opinion of the cause of death. She considered "complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition" to be the most accurate description of Veronica's cause of death and one which effectively captured her evidence.[171]

212. I therefore accept Dr Baber's opinion regarding the cause of death as she provided it at inquest.

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[170] Baber: T2083.
[171] Baber: T2083.13 – 27.

213. I find that Veronica died on 2 January 2020 at DPFC of complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition.

FINDINGS AS TO CIRCUMSTANCES

214. On 12 April 2019, Veronica was released on bail by Shepparton Magistrates' Court on a deferral of sentence. She had entered pleas of guilty to a consolidation of eight charges of theft from a shop and two offences against the Bail Act (**Shepparton consolidation**), and a separate contravention of a Community Corrections Order (**CCO**). At the time of her release on bail, Veronica had spent 82 days in custody over two separate periods of remand.

215. Reviews of Veronica's performance on bail were conducted on 10 May and 21 June 2019 at Shepparton Koori Court. Both progress reports were positive.[172]

216. On 4 October 2019, Veronica's matter was scheduled to return for further plea and sentence at Shepparton Koori Court.[173] Veronica failed to appear as required by her undertaking of bail and warrants for her arrest were issued by the court.[174]

217. The warrants were endorsed by Magistrate Faram with a notation that Veronica may be released on bail upon entering an undertaking to appear at Shepparton Magistrates' Court.[175]

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[172] Statement of Jillian Prior, CB 1907.
[173] Ibid.
[174] Statement of Jillian Prior, CB 1907; Warrants to Arrest, CB 295.
[175] Warrant to arrest, CB 295 – 296.

Melbourne West Police Station

Decision to arrest Veronica

218. On 30 December 2019, Veronica was arrested on the outstanding warrants by Sgt Payne, accompanied by Sergeant Chris Poutney (**Sgt Poutney**), on Spencer Street in Melbourne.[176] Sgt Payne was aware that Veronica was wanted for interview in relation to further allegations of theft from a shop.[177]

219. On the basis of these outstanding warrants, I find that Veronica's arrest by Victoria Police was lawful.

Decision to use handcuffs

220. Veronica was escorted on foot by Sgts Payne and Poutney to the MWPS.[178] Veronica was agreeable and travelled compliantly.[179] At approximately 3.30 PM, SC Gauci and First Constable McMonigle (**FC McMonigle**) took custody of Veronica outside the station. A pat down search was conducted, then Veronica was handcuffed.[180]

221. Sgt Payne gave evidence that there was no obvious need to have Veronica handcuffed but that it was general procedure to handcuff every offender.[181] SC Gauci agreed there was no

[176] Payne: CB42; Warrants to arrest: CB295.
[177] Payne: CB42.
[178] Payne: T70-71
[179] Payne: T71; T72.
[180] McMonigle: CB45; Gauci: CB229.
[181] Payne: T72-73.

obvious need to handcuff Veronica but that it is protocol to handcuff people who are under arrest and going into the custody centre.[182]

222. A number of interested parties submitted that the use of handcuffs in these circumstances was disproportionate. The position of the Chief Commissioner of Victoria Police was that the decision to handcuff Veronica was made in accordance with policy and standard practice and that the members acted reasonably.

223. The Victoria Police Manual (**VPM**) on Operational Safety Equipment provides that people arrested or taken into custody should be handcuffed if it is 'reasonably necessary in the circumstances.'[183] Whether the handcuffing of offenders within the custody centre is standard practice is, in my view, irrelevant. Any standard practice must be consistent with the policy that the use of handcuffs is reasonably necessary.

224. The evidence of Sgt Payne and SC Gauci that Veronica was handcuffed because it is general procedure to do so reflects a repeated issue that arose during the inquest. This is one example of many, in which individuals charged with Veronica's care followed internal (and at times informal) practices, without turning their minds to the justification or proportionality of that practice and whether they had any other less restrictive options available to them.

225. Handcuffing an offender is a use of force and any decision to use force must be made consistent with applicable policy. Although there may be a standard practice or procedure to handcuff an offender in the station, this does not mean that this practice is appropriate in

[182] Gauci: T150.
[183] Vitoria Police Manual – Operational Safety Equipment, Additional Materials (AM) AM417.

every circumstance, or indeed, consistent with policy. Members failed to turn their minds to this.[184]

226. Veronica presented as agreeable, compliant and slight of build. She had been searched and presented with no history of violence. While under arrest, there were at least two police members with her at any time. I am satisfied that the use of handcuffs was not reasonably necessary in those circumstances and was an unjustified and disproportionate restriction of her Charter rights.

227. I find that the use of handcuffs by Victoria Police was unjustified and disproportionate in the circumstances.

Decisions made at Melbourne West Police Station

228. In accordance with the applicable VPM policy and guideline,[185] Veronica was entered onto the Attendance Register (**Attendance**) at MWPS at 3:35 PM.[186] She was then lodged in a cell and a full search was conducted.[187]

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[184] Payne: T116; T117.

[185] VPM Persons in police care or custody (Policy): CB768-777; Attendance and custody modules: CB856-868; Safe management of persons in polic care or custody: CB2859-2880.

[186] Attendance Summary: CB572. Also, in accordance with the VPMs, a Detainee Risk Assessment (DRA) was commenced at 3:58PM and reviewed by a supervisor at 4:33 PM. The DRA is a risk assessment tool that helps Victoria Police identify and manage risks relating to a person's safe custody. No risks were identified, and a minimum observation frequency of four hours was set: CB569-571.

[187] McMonigle: CB45.

Notification to Victorian Aboriginal Legal Service

229. The Attendance process, reflecting the obligation established by s464AAB of the *Crimes Act* 1958 (**Crimes Act**), requires Victoria Police[188] to ask if a person in custody is "an Aboriginal person."[189] This question and answer, when recorded on the Attendance Register, triggers an automatic email notification to the Victorian Aboriginal Legal Service (**VALS**) in accordance with the obligation to do so in s464FA of the Crimes Act.[190]

230. At 3:55 PM VALS received an electronic custody notification via email advising that Veronica was at MWPS for outstanding warrants.[191] The VALS database recorded this notification as processed minutes later for follow up by a VALS Client Notification Officer (**CNO**).[192]

231. VALS' Client Notification Program involves a "welfare check" and a "legal check"[193] of Aboriginal people in custody; it is available all hours, every day of the year. A CNO contacts the relevant police station and, after verifying the details of the notification, will ask to speak to the person in custody. If the person does not wish to talk to the CNO, the CNO will seek to ascertain via Victoria Police whether the person in custody requires legal advice.

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[188] The section refers to an 'investigating official' but I have used the phrase 'Victoria Police' given its relevance to Veronica's circumstances.

[189] Section 464AAB of the Crimes Act.

[190] Section 464FA requires the notification to occur within an hour, or as soon as practicable.

[191] Carter: CB1847.

[192] Carter: CB1847.

[193] Carter: CB1847-1848. The Client Notification Program was implemented in response to the recommendations of the RCADIC – Waight: T2434. The program manages CNOs in respects of about 33 Aboriginal people in custody each day; with around 65,000 welfare checks performed by VALS in the previous year – Waight: T2435.

232. If the person in custody *does* speak to the CNO, the CNO will undertake a welfare and wellbeing assessment by inquiring about a range of welfare issues designed to identify potential risks to their safety in custody.[194] With the person in custody's consent, a CNO will notify nominated family members or others of their whereabouts and wellbeing.[195] Risks identified or known are recorded in the VALS database and relayed to Victoria Police so risks can be ameliorated.[196]

233. The CNO's "legal check" involves asking the person in custody if they understand why they are in custody, and whether they require legal advice.[197] If legal advice is required, the CNO will inform the VALS lawyer on call of the known circumstances so that the lawyer can contact the police station to provide the person in custody with legal advice.[198]

234. Irrespective of whether the person in custody wishes to speak to a CNO (or a lawyer), a CNO will continue to contact the police station to monitor the welfare of the person while they are in custody (including if they are later imprisoned) and maintain records of these contacts.[199]

235. SC Gauci gave evidence that she received a phone call from VALS asking to speak to Veronica for a welfare check at 4:07 PM. She said she took the phone to the cell in which

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[194] Carter: CB1848. The enquiries include questions about any current illness, injuries or required medical attention or assessment; medical and mental health conditions; suicidality or self-harm risks; required medications; cognitive impairment and other disabilities; alcohol or other substance dependence (including "slip and fall" risks) and any other welfare or wellbeing concerns identified the person in custody.

[195] Carter: CB1848.

[196] Carter: CB1848.

[197] Carter: CB1848.

[198] Carter: CB1848.

[199] Carter: CB1847-1848.

Veronica was placed and asked if she wanted to speak with VALS.[200] SC Gauci said that Veronica declined.[201]

236. SC Gauci testified that she made a note of this call, and its time, immediately after in her official diary;[202] the note appears in the coronial brief.[203]

237. The VALS database, in contrast, reflects a first attempt to contact Veronica at 4:27 PM with a note that the CNO was informed that:

> Veronica was now in interview. No to VALS and welfare good.[204]

238. SC Gauci denied advising VALS that Veronica was in an interview and denied entering the interview room to speak to Veronica about a call from VALS.[205]

239. Other evidence establishes that Veronica was in a recorded interview with Sgt Payne and FC McMonigle commencing, according to the time stamp, at 4:23 PM and concluding at 4:43 PM.[206]

240. At about 4:24PM, Veronica responded to a question from FC McMonigle saying that she was Aboriginal. The police member then asked, ”Would you like to speak to VALS or anyone before we proceed today?”[207] Veronica responded, “No.”[208] These questions and answers

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[200] Gauci: CB230; T152-153; T201-202.
[201] Gauci: CB230; T152-153; T201-202.
[202] Gauci Notes: CB274; Gauci: T153.
[203] Gauci Notes: CB274.
[204] Carter: CB1849.
[205] Gauci: T153.
[206] Exhibit 85.
[207] Exhibit 85.

occurred after Veronica had been informed of her communication rights,[209] said she understood them and declined to exercise them before the interview continued.[210] The next question, about Veronica's age, followed immediately and there is no indication that anyone entered or left the interview room around that time.[211]

241. These three pieces of evidence about the timing of the first call from VALS cannot be completely reconciled.

242. SC Gauci's answers in oral evidence were forthright and her credit was unimpeached. This, together with her contemporaneous notes and independent recollection of the call, satisfies me that she received a call from a VALS staff member at 4:07 PM and her account of what occurred in response is accurate.

Communication about Veronica's rights and other available support

243. While I am satisfied that Veronica was asked if she wanted to speak to VALS, it is not clear whether she understood, when the offer was made, that VALS could provide her with support in addition to legal services. It is not clear whether Veronica simply declined to speak with VALS because she already had a lawyer, Ms Prior.[212]

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[208] Exhibit 85.
[209] These are the rights, relevantly, to (attempt to) communicate with a friend or relative to inform them of your whereabouts and to (attempt to) communicate with a legal practitioner.
[210] Exhibit 85; CB2403.
[211] Exhibit 85.
[212] As Carter observed: T2443.

244. Veronica answered, “No” when asked if she wanted to exercise her communication rights during interview.[213] Generally, her responses were short, rarely more than a couple of words. Mr Lovett offered the following insight:

> I've seen Veronica speaking to some white people and people in authority. She would – she would respect what position they were in. She was quiet. She – she doesn't get cheeky. She doesn't get smart. She basically says what they ask her to do. She was always well mannered.[214]

245. Members of the Administration of Justice Conclave testified that it was not uncommon in their experience for Aboriginal or Torres Strait Islander clients to change their mind about accepting opportunities or exercising rights while at a police station, or to report that they would have preferred to have spoken to VALS or another legal service prior to interview, even though they declined the offer when it was made.[215] Veronica’s ‘no’ needs to be understood in context.[216]

246. The Administration of Justice Conclave explained that the context and way in which offers to communicate with VALS or a lawyer are made, and by whom, are often barriers to Aboriginal and/or Torres Strait Islander people in custody accepting these opportunities or exercising rights.[217]

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[213] Exhibit 85.
[214] Lovett: T45.
[215] Carter, Administration of Justice Conclave: T2427-2428; Thomson, Administration of Justice Conclave: T2436.
[216] Thomson: T2436.
[217] Thomson: T2438; Leong: T2438; Moser: T2438-2439; Waight: T2437.

246.1. Ms Thomson observed that these offers are usually made in interview rooms - and even if made elsewhere, still in a police station.[218] The interview is often already underway, and the question is asked by a police member.[219] The power imbalance of this situation[220] may give rise to a perception on the part of the person in custody that the preferred answer is 'no'. [221]

246.2. Likewise, the person in custody may expect that accepting an offer or exercising their right to obtain legal advice will be perceived negatively, cause delay or produce "negative impacts" for them.[222]

246.3. This unbalanced power dynamic replicates[223] the effects of the long history of dispossession and colonisation experienced by First Nations people in which, as Ms Waight explained, "[a]ll they know from state authority is the hard hand of the law and they are more likely to be deferential."[224] In short, the situation is likely to be experienced by an Aboriginal and/or Torres Strait Islander person as culturally unsafe.[225]

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[218] The evidence suggests that two offers to communicate with VALS were made to Veronica at MWPS one at a cell door and the other in an interview room. Ms Carter (uncontradicted by her fellow panel members) said an Aboriginal person having more than one opportunity, including one outside an interview room, did not alleviate her concerns about the barriers identified, Carter: T2441.

[219] Thomson: T2437.

[220] Thomson: T2438.

[221] Thomson: T2437-2437.

[222] Thomson: T2437-2437.

[223] The criminal justice system was identified as one of the most significant sites of ongoing colonisation by Dr Porter: T2421.

[224] Waight: T2437.

[225] Moser: T2439; Porter: T2421.

247. The Administration of Justice Conclave suggested several ways the potential barriers to Aboriginal and/or Torres Strait Islander people having a meaningful opportunity to speak to VALS or exercise their legal rights might be ameliorated. These involved:

247.1. sufficient information about the service or rights to ensure understanding;

247.2. reiteration of information (about available welfare services such as those provided by VALS) and legal rights by an "outside organisation";[226]

(This comment appeared to reflect the need for greater effort to facilitate contact between the person in custody and an Aboriginal Community Controlled Organisation (**ACCO**) given the surrounding discussion of cultural safety, that police interview rooms are antithetical to seeking legal advice, and there's no phone,[227] and the limits of cultural competence training.)[228]

247.3. use of language, particularly in relation to rights, which emphasises that rights are entitlements to be exercised not favours conferred;[229]

247.4. a requirement that the Aboriginal person repeat back in their own words to investigating officials their understanding of the 'caution' and rights to silence and

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[226] Thomson: T2438; Leong: T2459.
[227] Leong: T2438.
[228] Waight: T2440.
[229] Waight: T2448.

of communication to demonstrate comprehension as occurs routinely for other vulnerable individuals;[230] and

247.5. time to consider the information and give a response.

(It was observed that the "expediency of process"[231] in police stations and other criminal justice settings, inhibits the ability to process information and respond).[232]

248. Assistant Commissioner (**AC**) Barrett of the Administration of Justice Stakeholder Panel was asked to comment on the feasibility of removing the barriers identified in the ways suggested.[233] He stated that:

248.1. the legislated CNO process when Veronica was in custody was a "two-step process that occurred on this occasion"[234] and Veronica was offered the chance to 'speak with VALS' more than once and not only while in the interview room;[235]

248.2. structural barriers and safety issues complicate having phones available in interview rooms;[236]

248.3. in circumstances where a First Nations person is asked about speaking to VALS or a lawyer, clearly understands and gives a (negative) response as Veronica did, it

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[230] Walker: T2453, with whom the Administratiion of Justice Conclave concurred unanimously: T2454.
[231] Carter: T2427-2428; Moser: T2439.
[232] Veronica had only seconds to respond to questions about her communication rights during interview.
[233] See generally, T2440-2443.
[234] Barrett: T2443.
[235] Barrett: T2443.
[236] Barrett: T2442-2443.

would be "perverse" to require police to act contrary to the person's response;[237] and

248.4. Victoria Police was "open" to reformulation of questions to improve comprehension and highlighted the efforts within the organization to improve the cultural awareness of its members;[238]

248.4.1. however, he did not consider it a matter for Victoria Police to introduce a requirement that Aboriginal suspects be asked to confirm their understanding of the caution and rights; if the practice were required, Victoria Police would "comply".[239]

249. As will become apparent, despite the measures in place at the police station, court and prison intended to ensure Veronica could access culturally relevant support, her journey through the criminal justice system occurred without speaking to a single Aboriginal person employed in these roles.

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[237] Barrett: T2442.
[238] Barrett: T2450-2451.
[239] Barrett: T2454. I note that the VPM Interviews and statements policy advises that members should confirm comprehension of the caution and rights (of any suspect) by asking the suspect to repeat it in their own words: T869-892.

Decision to charge Veronica with offences

250. During the police interview, Veronica was questioned about the theft allegations the subject of the three whereabouts notices but not the allegation that she had failed "without reasonable cause"[240] to answer bail in October 2019.

251. The decision to charge Veronica, and with which offences, was not central to my investigation though relevant materials appear in the coronial brief.[241] It is worth pausing to note two points. Firstly, the power to 'charge' confers a broad discretion on police, the exercise of which involves balancing the duty to enforce the law and the duty to take appropriate enforcement action (or no action) in relation to a person who has allegedly broken the law.[242] The guidance on "appropriate enforcement action" provided in VPM policy and guidelines emphasize considerations relating to the alleged offender's circumstances (including their human rights), the nature, severity and gravity of the offence, and sufficiency of evidence.[243]

252. Second, a *general* concern was raised by some members of the Administration of Justice Conclave about how charging decisions[244] appear to be made in practice; that is, whether there is a true exercise of discretion that reflects the implied balancing of competing

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[240] Bail Act, s 30; CB1992.
[241] CB276-294; CB295-296; CB2402; AM 447-487; CB929-938; CB925-928; AM1975.
[242] CB929.
[243] CB929-938.
[244] The concerns related specifically to whether to charge and if an accused is charged, whether to proceed by summons, bail or remand.

considerations.[245] Further, the exercise of discretion at successive decision points before and after the police station may accumulate to produce discriminatory outcomes.[246]

253. Police charged Veronica with:

253.1. the indictable offence of theft of fragrances from Chemist Warehouse on 9 October 2019 (**Deschepper theft**);[247] and

253.2. the summary offence of failing to appear on bail at Shepparton Magistrates Court on 4 October 2019 contrary to the Bail Act (**FTAB**).[248]

254. These charges appear to have been prepared by Constable Deschepper of Fitzroy police station on or about 9 November 2019[249] as part of a 'remand package' filed in connection with the whereabouts for the convenience of an arresting member.[250]

2018 Bail Act changes

255. Following amendment of the Bail Act in 2018, an accused person's entitlement to bail was preserved[251] but significantly qualified by provisions requiring bail decision makers to refuse bail. Since then, there is a presumption that bail will be refused if an accused is charged with a Schedule 1 or Schedule 2 offence (**reverse onus**). The range of offences and

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[245] See for instance Walker: CB1424; Carter: CB 1340; Porter: CB2311 and CB2313; Atkinson T2547.
[246] See Porter CB:2311; Carter: CB1374 and T2515; M. Walker CB1424.
[247] Section 74 of the *Crimes Act 1958* (**Crimes Act**).
[248] Bail Act, s 30(1); AM 531 – 532.
[249] CB1991-1992
[250] CB293-294.
[251] Bail Act, s 4.

circumstances of offending that attract *any* and *the highest* reverse onus threshold is considerable. Even if an applicant for bail meets an applicable reverse onus threshold (or none applies), a bail decision maker must refuse bail if satisfied of the existence of an unacceptable risk of one or more of the four types specified in the Bail Act.[252]

256. The reverse onus regime is created by sections 4A, 4AA, 4C and Schedules 1 and 2 to the Bail Act.

257. Where section 4A applies, the bail decision maker (**BDM**) - defined to include a police officer, bail justice and court[253] – must refuse bail and remand the accused in custody unless satisfied, by the accused, that "exceptional circumstances" exist that justify the grant of bail.[254] If satisfied of this, the BDM must then consider s4E of the Bail Act containing the unacceptable risk test.

258. Schedule 1 lists the offences to which the highest bail threshold, "exceptional circumstances," applies; it includes the most serious offences like murder, treason and terrorism.[255]

259. Where section 4C applies, the BDM must refuse bail and remand the accused in custody unless satisfied, by the accused, that a "compelling reason" exists that justifies the grant of bail.[256] If so satisfied, the BDM must then consider s4E of the Bail Act.

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[252] Bail Act, s 4E: the unacceptable risk test applies to applicants for bail.
[253] Bail Act, s 3.
[254] Bail Act, s 4A.
[255] Bail Act, Sch 1.
[256] Bail Act, s 4C.

260. Schedule 2 offences are largely those involving violence or significant risk to public safety. There are two exceptions, each of which expands the reach of the reverse onus provisions. That is by:

260.1. clause 1 of Schedule 2, *any* indictable offence alleged to have been committed while the accused is on bail, subject to a summons, at large awaiting trial or during the operational period of a CCO imposed for another indictable offence;[257] and

260.2. clause 30 of Schedule 2, an offence against the Bail Act.[258]

261. Relevantly, s4AA(2)(c) of the Bail Act expands the reach of the highest, "exceptional circumstances," reverse onus test to a Schedule 2 offence allegedly committed while the accused was on bail, subject to a summons, at large awaiting trial or during the operational period of a CCO in respect of any Schedule 1 or 2 offence.

262. The combined effect of s 4AA(2)(c) and clause 1 of Schedule 2 to the Bail Act, known colloquially as the 'double uplift,' is to require an accused charged sequentially with multiple low-level offences – like theft from a shop – to meet the highest bail threshold to be granted bail rather than enjoy a presumption that bail will be granted.

263. Pursuant to s4E(1)(a), any accused must be refused bail if the BDM is satisfied there is an unacceptable risk that, if bailed, the accused would pose an unacceptable risk of flight,

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[257] Bail Act, Sch 2.

[258] There are three offences against the Bail Act: failure to answer bail (s30); committing an indictable offence while on bail (30B); and contravention of a conduct condition of bail (s30A), which does not apply to children.

further offending, endangering public safety or the administration of justice.[259] The prosecution must prove the existence of a relevant risk and that the risk is an 'unacceptable risk.'[260]

264. When making decisions under the Bail Act, BDMs must have regard to the inclusive list of "surrounding circumstances" in section 3AAA[261] and the mandatory considerations relating to, relevantly, an accused who is Aboriginal in section 3A[262] of the Bail Act. When considering whether a risk mentioned in s4E(1)(a) is an unacceptable risk, BDMs must also consider whether there are any conditions of bail that may be imposed to mitigate the risk(s) to an acceptable level.[263]

Bail threshold applicable to Veronica

265. Each of the offences with which Veronica was charged on 30 December 2019, independently, attracted the highest reverse onus threshold for bail. By operation of s4AA(2)(c) and clause 30 and/or clause 1 of Schedule 2 to the Bail Act the Deschepper theft and the FTAB, respectively, were Schedule 2 offences alleged to have been committed while Veronica was on bail and/or at large for a Schedule 2 offence.

266. Veronica was required to meet the exceptional circumstances test because:

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[259] Bail Act, s 4E.
[260] Bail Act, s 4E(2)
[261] Bail Act, ss 4A(3), 4C(3), and 4E(3).
[262] Section 3A of the Bail Act reads: In making a determination under this Act in eelation to an Aboriginal person, a bail decision maker myst take into account (in addition ro any other requirements of this act) any issues that arise due to the person's Aboriginalist, including (a) the person's cultural background, including the person's ties to extended family or place; and (b) any other relevant cultural issue or obligation.
[263] Bail Act, s 4E(3)(b).

266.1. the FTAB is a bail offence (clause 30 of Schedule 2) and it was alleged to have been committed, pursuant to s4AA(2)(c)(i), while Veronica was on bail for a Schedule 2 offence, namely, a bail offence in the Shepparton consolidation; and/or

266.2. the Deschepper theft was a Schedule 2 offence by virtue of clause 1(c) of Schedule 2 because it is an indictable offence alleged to have been committed while Veronica was at large (awaiting trial) for another indictable offence, that is, a theft charge in the Shepparton consolidation *and* the Deschepper theft was alleged to have been committed while Veronica was at large for another Schedule 2 offence, namely, a bail offence in the Shepparton consolidation.[264]

Decision to apply to remand Veronica in custody

267. Section s13 of the Bail Act contemplates determination of an 'exceptional circumstances' bail application by a court. However, it explicitly provides an exception – to permit other BDMs to grant bail – where the accused is an Aboriginal person[265] and the operation of s4AA(2)(c) is the reason the 'exceptional circumstances' test applies. Accordingly, a police BDM had the power to grant Veronica bail, without bringing her before a court due to s13(4) of the Bail Act.

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[264] I found the VEOHRC Bail Submissions dated 18 May 2022 persuasive on this point.

[265] Or a vulnerable adult or a child: Bail Act section 13(4). I note that s13(4)(b) contains a broader version of the discretion to grant bail from a police station when the operation of clauses 1 or 30 of Schedule 2 to the Bail Act is the reason the exceptional circumstances test applies: both of which independently acted with s4AA(2)(c) to place Veronica in the highest bail threshold. Neither the discretion in s13(4)(a) or (b) was considered.

268. Sergeant Nick MacDonald (**Sgt MacDonald)** was the custody supervisor on 30 December 2019 and so was the police BDM in Veronica's case. He did not recall the circumstances of Veronica's remand application but said that he "would have wanted the court to hear the bail matters."[266]

269. Sgt MacDonald's evidence was that while a custody supervisor at the MWPS for over four years, working two or three shifts per rostered week,[267] he could not recall *ever* granting bail to a person who was required to demonstrate 'exceptional circumstances.'[268] If a court was operating, his preference was to put the accused before a court rather than make a decision about bail himself.[269] SC Gauci[270] and Sgt Payne[271] gave similar evidence about this 'preference' -- or practice, having general application. Sgt Payne went so far as to say that since the Bourke Street tragedy,[272] there was an unwritten internal policy which, in effect, meant that BDMs were less likely to grant bail.[273]

270. The consistency of this practice is also demonstrated by SC Gauci's preparation of the remand brief while Veronica was being interviewed.[274] In fact, Sgt Payne agreed that a decision had already been made during the interview to apply to remand Veronica.[275]

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[266] MacDonald: AM843.
[267] MacDonald: AM843.
[268] MacDonald: AM843.
[269] MacDonald: AM:843.
[270] Gauci: T158.
[271] Payne: T122.
[272] On 20 January 2017, James Gargasoulas drove a stolen vehicle into Melbourne's Central Business District and the Bourke Street Mall, injuring 33 pedestrians, six of whom sustained fatal injuries. Mr Gargasoulas had been bailed three days earlier.
[273] Payne: T130.
[274] Gauci: T173-174.

271. A general practice of the type described in evidence at inquest is wrong in principle and in law, as it precludes exercise of the discretion provided by s13(4)(a). Indeed, neither Sgt Payne nor SC Gauci appeared to know about the discretion.[276]

272. The failure of the police BDM Sgt MacDonald to consider the s13(4) discretion undermined the purpose of it being in the Bail Act. To be clear, the provision does not require bail to be *granted* in cases where it applies. However, police BDMs ought to properly consider the discretion to grant bail when it is available. This failure – to properly consider the exercise of an available discretion – was repeated across the various settings Veronica encountered in her final days.

273. The failure to consider the s13(4)(a) discretion is even more significant in the context of the over-representation of First Nations people in custody, and their vulnerability in the custodial environment. The failure suggests a lack of appreciation that s13(4)(a) of the Bail Act is intended to mitigate the effects of the reverse onus regime and that the mitigation provided is broadest for Aboriginal accused.[277]

274. As a public authority under the Charter, Victoria Police members are required to act compatibly with, and give proper consideration to, relevant human rights in the course of their duties. The power of a police BDM to grant bail is one that must be genuinely exercised when it is available in order to give effect to section 21 of the Charter (right to liberty). The

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[275] Payne: T122.
[276] See Payne: T85; Gauci T158-159.
[277] The s13(4) discretion enjoyed by accused who do not fall into subsection (a) is confined to offences described in clauses 1 and 30 of Schedule 2 to the Bail Act.

practice of refusing bail to any person subject to the exceptional circumstances test amounts to arbitrary detention and to automatic detention, which are incompatible with sections 21(2) and 21(6) of the Charter respectively.

275. The failure of police BDMs to properly consider s13(4) of the Bail Act must be urgently corrected.

276. I find that the police BDM was empowered to grant Veronica bail and failed to give proper consideration to the discretion to do so and this infringed her Charter rights.

277. By failing to give proper consideration to the discretion, I find that the police BDM failed to adequately consider Veronica's vulnerability in custody as an Aboriginal woman.

Failure to take into account Veronica's vulnerability as an Aboriginal woman in custody

278. In addition to the failure to appreciate the existence or significance of s13(4) of the Bail Act, other evidence revealed an insufficient understanding among Victoria Police members that an Aboriginal person is likely to be vulnerable in custody and that Aboriginality is relevant to decisions about bail and more broadly in policing.

279. SC Gauci had no clear understanding of how Aboriginal descent might be relevant to an application for bail.[278] She did not recall informing the court or duty lawyer that Veronica

[278] Gauci: T180.

was Aboriginal.[279] SC Gauci also could not recall any training about issues an Aboriginal person might experience when interacting with police.[280]

280. Sgt Payne said that he treated all offenders with respect[281] and the same, regardless of Aboriginality.[282] He did not recall any training specifically relating to matters to be considered when, for instance, arresting an Aboriginal person.[283] I commend Sgt Payne's determination to treat all offenders with respect in the course of his duties. However, his comment about treating all offenders alike - though clearly well-intentioned - fails to appreciate that different treatment may be required to ensure that some people enjoy the equal protection of the law.

281. Victoria Police provided my investigation with its training materials relating to Aboriginality and bail and remand.[284] The training materials contain errors and omissions: for example, police officers are wrongly advised that s 3A of the Bail Act, requiring BDMs to take into account issues relating to a person's Aboriginality, related only to children.[285] The same error exists in the Victoria Police court remand/bail application cover sheet.[286]

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[279] Gauci: T163.
[280] Gauci: T208-209.
[281] Payne: T 116.
[282] Payne: T121-122.
[283] Payne: T122. Sgt Payne was aware of the relevance of Aboriginal descent to bail decisions; he had been trained and performed as a police BDM, though was not the BDM in Veronica's case.
[284] Training materials relating to training provided following the 2018 changes to the Bail Act was requested and provided.
[285] AM1872.
[286] AM1808.

282. In the guide for police prosecutors appearing in bail applications, sample questions for an informant giving evidence[287] include matters relevant to an accused's personal circumstances, drug or alcohol use and proposed residential address, but no reference to Aboriginal descent.[288]

283. Bail training lecture materials prepared for police prosecutors pursuing a Graduate Certificate in Police Prosecutions refer to a single case concerning the application of s 3A of the Bail Act.[289] While Aboriginal descent was characterised as 'important' in the lecture, the case was highlighted as an authority for the proposition that s3A considerations do not 'swamp' all others; no information was provided about why the section 3A special measure exists.[290]

284. Based on the materials provided, I find that the training provided by Victoria Police on these topics fails to equip its members with an adequate appreciation of the vulnerability of an Aboriginal person in custody.

Decisions about the contents of the remand brief

285. While Veronica was interviewed, SC Gauci prepared the remand application.

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[287] AM1874.
[288] AM1874.
[289] AM 82, Graduate Certificate in Police Prosecutions – Bail Lecture 3: "…one case relevant for our purposes is *Re Reker* [2019] VSC 81 which provides authority for the proposition that Aboriginality is an important consideration but it does not swamp all the other considerations: that's probably one you'll find yourself using most frequently when a bail decision maker is taking into account the Aboriginality of someone", at [23:03 – 24:15].
[290] AM 82, Graduate Certificate in Police Prosecutions – Bail Lecture 3.

286. Although it might be said that this division of labour was intended for efficiency,[291] its outcome was a remand summary that contained numerous errors and omissions. All but one of those errors was presented to the presiding Magistrate in Veronica's remand/bail application, and for reasons explained below, they remained unchallenged.

287. In evidence, SC Gauci was taken to the documents she prepared and conceded they were "riddled with mistakes."[292] She also acknowledged she made no enquiries about Veronica's vulnerabilities, her family ties or other surrounding circumstances relevant under the Bail Act; consequently, no information of that type was included in the remand documents.[293]

288. Of the errors and omissions identified in the documents, two significant errors and one significant omission bear mention. The first significant error is that the remand summary, in so far as it related to the fresh allegations, did not accurately reflect the matters with which Veronica was charged. Rather, by canvassing the allegations contained in all three whereabouts notices, not the single charge of theft from a shop that was filed,[294] the summary was liable to mislead the presiding BDM about the extent of Veronica's alleged further offending. I do not suggest that this was done intentionally.

289. The second significant error, acknowledged as such by SC Gauci, was an allegation that Veronica presented as an unacceptable risk of endangering the safety and welfare of any

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[291] Gauci: T173.
[292] Gauci: T189.
[293] Remand Brief: CB2004-2005; Gauci: T191.
[294] Compare the Remand Summary CB2004 with correspondence from the Magistrates' Court of Victoria confirming that the only fresh charged before MMC on 30 and 31 December 2019 were the Deschepper charges of theft and FTAB: AM1975.

person.[295] Fortunately, this risk was not alleged during the bail hearing on 31 December 2019.[296]

290. Most significant, was the omission of any reference to Veronica's Aboriginal descent in the remand summary given, where applicable, it is a mandatory consideration for BDMs pursuant to s3A of the Bail Act. The omission was not remedied by the police prosecutor who had a copy of the remand brief in which this information appeared. SC Gauci testified that she did not recall alerting VLA, Victoria Police Prosecutions or the the Melbourne Magistrates' Court (**MMC**) registry that Veronica is Aboriginal.[297]

291. There appears to be significant benefit in remand summaries that disclose at the outset that an accused person is Aboriginal. This is information to which Victoria Police readily has access, but the Court may not. As the remand summary is ordinarily read aloud during a remand/bail application, including this detail would ensure that the court BDM is immediately aware that s3A of the Bail Act is relevant.

292. I find that Victoria Police failed to inform the MMC of Veronica's Aboriginality.

Decision to transport Veronica to Melbourne Custody Centre

293. Although Veronica's record of interview concluded at about 4:43 PM, transport was not available to the Melbourne Custody Centre (**MCC**) until about 7:00 PM. This is significant because all necessary paperwork must be filed and the accused person must be lodged in the

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[295] Remand Brief: CB1999; Gauci T188-189.
[296] Transcript of bail application on 31 December 2019: CB2421.
[297] Gauci; T163.16-17.

cells by 8pm, after which a matter cannot be listed at the Bail and Remand Court (**BaRC**) of the MMC.[298] Even if listed in time, depending on the other business of the court, a matter might not be reached before sittings conclude at 9pm. Where matters are not reached on the day they are listed, the accused is held in custody overnight and their case adjourned - or rolled over - to the following day.[299]

294. SC Gauci believed that BaRC may not list new matters after about 7.30 PM.[300] She gave evidence that there were several reasons for the delay between interview and transport, which included fingerprinting, paperwork, a custody sergeant's check and authorisation of the brief, and liaison with the MCC to confirm Veronica could be accommodated.[301] The MCC is a four-minute drive from MWPS. The police communication records show the call requesting transport was made at 6.35 pm.[302] Veronica arrived at the MCC at 7:20 PM.[303]

295. Although Veronica arrived in time for her matters to be listed, it was so late in the sitting day that there was little prospect that her case could also be prepared and presented.[304] Care should be taken by Victoria Police to ensure that, in circumstances where a member declines to make a bail determination and instead the accused is brought before a court, arrangements

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[298] AM424-426.

[299] Mr Schumpeter described a common occurrence at the BaRC since the 2018 Bail Act changes was for a "flood" of matters to be listed between 6.30pm and 8pm with a significant proportion of them being rolled-over because the court did not have capacity to hear them: T T343; 348-350.

[300] Gauci: T161.

[301] Gauci: T161.

[302] D24 recordings: AM43.

[303] Burn: CB234.

[304] Schumpeter: T356.

are made with sufficient efficiency that the person presented has a reasonable prospect of their case being heard that day.

296. If this is not operationally possible, Victoria Police should revisit the question of bail.[305] Indeed, Victoria Police are obliged to consider the question where it is not practicable to bring a person before the court within a 'reasonable time' pursuant to s464A of the Crimes Act. What constitutes a 'reasonable time' should be interpreted consistently with the Charter right to liberty. That is, particularly when an accused is subject to a reverse onus provision of the Bail Act, 'reasonable time' should be interpreted in a way that ensures a genuine opportunity for the person to apply for bail.

297. At some point during her time in the MCC, Veronica was assessed by the Custodial Health Service. The following notation was made:

> Thin build Fit and well looking. Nil injuries nil allergies. Alert and orientated. Well perfused. Breathing unlaboured. GCS 15/15.[306]

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298. SC Gauci arrived at the MMC shortly after Veronica and distributed copies of the remand brief to Victoria Police prosecutions, VLA, and the BaRC registry.[307]

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[305] Bail Act, s10.
[306] CHS Consultation Note from MCC: CB1735.
[307] Statement of SC Gauci, CB 229.

Decision by the VLA Duty Lawyer to progress Veronica's matters on 30 December 2019

299. Peter Schumpeter, a barrister briefed as the VLA duty lawyer for the evening, was allocated Veronica's case. Mr Schumpeter attempted to arrange a Court Integrated Services Program (**CISP**) assessment in support of an application for bail. However, he was advised that it was too late for an assessment to take place and the matter would need to be adjourned if a CISP assessment was required.[308]

300. Mr Schumpeter arranged through the BaRC registry for Veronica's matters to be adjourned to 31 December 2019.[309] Veronica appeared in person for the adjournment and was remanded in custody overnight in the MCC cells.[310]

301. Later that evening, Mr Schumpeter emailed Ms Prior of the LACW, Veronica's usual solicitor, to inform her that Veronica was in custody. He wrote that Veronica had been remanded in custody overnight for a bail application on 31 December 2019.[311] Ms Prior replied that no LACW lawyer was available on that date, but that she would organize something if required.[312]

302. I find that the legal assistance provided to Veronica by the VLA Duty Lawyer service on 30 and 31 December 2019, and particularly by Peter Schumpeter of Counsel, was reasonable and appropriate in the circumstances.

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[308] Statement of Peter Schumpeter, CB 2387.
[309] Ibid.
[310] Extract of court orders, CB 2432; Cell log, CB 595; Statement of Peter Schumpeter, CB 2387.
[311] Emails, CB 2389; Statement of Peter Schumpeter, CB 2387.
[312] Emails, CB 2389.

Decision to brief a Barrister to appear on Veronica's behalf on 31 December 2019

303. On the morning of 31 December 2019, Ms Prior spoke with a VLA Duty Lawyer by phone to arrange legal representation for Veronica. She was advised that barrister Tass Antos was available.[313] A telephone call then took place between Ms Prior and Mr Antos in which Mr Antos was briefed to represent Veronica. It was a brief conversation.[314] Ms Prior sensed that the court was busy and under pressure, and that there was limited time available for a discussion.[315]

304. Ms Prior said that she briefed Mr Antos with the expectation that a bail application would be made on Veroncia's behalf.[316] Ms Prior could not recall whether she spoke with Mr Antos about pursuing the CISP assessment foreshadowed by Mr Schumpeter.[317] Mr Antos recalled very little about his involvement in Veronica's matter. He confirmed being briefed by Ms Prior but did not understand from their interaction that an application for bail would be made.[318] Rather, Mr Antos believed that he was briefed to "see" Veronica and assess how her matters might proceed.[319]

305. I find that the legal assistance provided to Veronica by the LACW, particularly by Jillian Prior, was reasonable and appropriate in the circumstances.

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[313] Statement of Jillian Prior, CB 1908; Statement of Tass Antos, CB 2110.
[314] Ibid, CB 1908; T262.
[315] Ibid, CB 1908; T247.
[316] Prior: CB1908; T247.
[317] Prior: T262.
[318] Antos: CB2110; T393.
[319] Antos: CB2110; T393.

Decision by barrister not to appear on Veronica's behalf

306. Relying on his usual practice, as he was unable to recall whether these events took place with Veronica,[320] Mr Antos testified that he would have read the summaries of alleged offending to Veronica, read her charges and some of her prior history.[321] He said he would have discussed matters personal to Veronica and enquired about her compliance with any supports that were in place.[322] He said he would ask Veronica to sign a VLA form and provide her with the option of a represented bail application.[323] At the conclusion of this process, Mr Antos said he would then seek Veronica's instructions about to how to proceed.[324]

307. Though he did not have a distinct recollection of communications between himself and Veronica, Mr Antos believed that he suggested Veronica make an in-person application for bail because he had formed the view that an application did not have merit.[325]

308. Mr Antos said that he would have taken notes during his discussion with Veronica and that those notes would be included with the documents returned to Ms Prior.[326] A review of the material returned to Ms Prior did not reveal notes of any instructions obtained by Mr Antos.

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[320] Antos: T395.
[321] Antos: T399; T409
[322] Antos: T404; T409.
[323] Antos: T404; T407; T409.
[324] Antos: T410.
[325] Antos: CB2394, T395; T402-3.
[326] Antos: T471.

309. Further, the cell records and the G4S visitor log reveal that Mr Antos saw Veronica for a maximum of six minutes.[327] When presented with this evidence, Mr Antos accepted that given the volume of material in the briefs of evidence, the usual process he outlined could not have been undertaken. Mr Antos accepted that he must not have followed his usual practice with Veronica.[328]

310. I note Ms Prior's evidence of her impression that the court was busy and under strain on the morning of Veronica's remand.[329] She also observed that the BaRC can pressure legal practitioners to be ready to proceed quickly to maximise the number of matters reached in the sitting day.[330]

311. Nonetheless, the six minutes for which Mr Antos saw Veronica was clearly insufficient for him to obtain instructions and provide advice appropriate to her circumstances.

312. Mr Antos did not seek to make submissions at the conclusion of the inquest. Various interested parties made submissions about the inadequacy of the legal service he provided. I am satisfied that, in the circumstances faced by Mr Antos, it is reasonable to expect him to have:

312.1. read through the remand summaries with Veronica and identify the charges before the court;

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[327] Cell log: CB595; G4S visitor log: CB1923.
[328] Antos: T411-413.
[329] Prior: T262; 322.
[330] Prior: T262.

312.2. obtained instructions about:

312.2.1. her personal circumstances, including her Aboriginality, family connections and kinship ties;

312.2.2. her reasons for having failed to appear;

312.2.3. her prior criminal history;

312.2.4. her previous performance on bail; and

312.2.5. any custody management issues;

312.3. taken steps to confirm whether Veronica had any personal or family supports at court or able to be contacted for the purposes of giving evidence;

312.4. considered whether the CISP assessment should be pursued;

312.5. considered whether the charges before the court would result in a term of imprisonment and whether Veronica might spend longer on remand than any term of imprisonment to which she might ultimately be sentenced; and

312.6. when it was determined that Veronica would appear unrepresented, advised her of the matters that should be put to the BDM in support of her application.

313. I am satisfied that Mr Antos could not have undertaken all these tasks in the very short time he spent with Veronica. The failure to perform all these tasks, and the remarkably short period of time spent with Veronica, falls short of the standard expected of a legal practitioner.

314. I find that the legal services provided to Veronica on 31 December 2019 by Tass Antos of Counsel were inadequate.

315. The short time Mr Antos spent with Veronica to consider an application for bail suggests he was not alert to her vulnerability as an Aboriginal woman in custody. It may be inferred from his reporting email to Ms Prior that Mr Antos found Veronica challenging; he described her as "quite aggressive and dismissive."[331] Mr Antos gave evidence that he does not deal with many female Aboriginal clients[332] and could not recall receiving any cultural training that would assist him to manage this client group.[333]

316. It is incumbent upon the legal profession to ensure that lawyers who work with clients in Veronica's position are alert to the range of challenges faced by an Aboriginal woman with a drug dependency in the criminal justice system and equipped to manage the barriers that might impede her capacity to provide instructions. In my view, legal practitioners would be aided by relevant training when they commence legal practice and refresher training at regular intervals throughout their careers.

Veronica's bail hearing

317. During the morning of 31 December 2019, Veronica applied for bail without the assistance of a lawyer before Her Honour Magistrate Bolger.

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[331] Email from Mr Antos to Ms Prior dated 31 December 2019: CB2111-1-2111-2. He is the only witness to characterise Veronica in this way.

[332] Antos: T407.

[333] Antos: T408.

318. The inquest did not examine the judicial officer's decision in Veronica's case, and it would be improper to do so. The inquest did, however, examine the process by which the decision to refuse Veronica's application for bail was reached.

319. After the Magistrate ascertained that Veronica intended to apply for bail in person,[334] the prosecutor advised that Victoria Police opposed bail and the applicable bail threshold was 'exceptional circumstances.'[335]

320. A nominal informant then read aloud the remand summary prepared by SC Gauci. The prosecution case was put on the basis that Veronica had been identified by police as a "recidivist shop thief."[336] The summary included allegations that Veronica posed an unacceptable risk of further offending if bailed because police believed she had been "stealing to support her drug habit and for living expenses."[337] Veronica was also alleged to be an unacceptable risk of failing to appear at court because she "didn't appear to take bail seriously" and police feared, if released, she would not attend court.[338]

321. Veronica's criminal antecedents were tendered.

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[334] Magistrate Bolger asked Veronica if she had spoken to a lawyer (Veronica's reply was 'briefly') and if she had a lawyer who ordinarily represented her. Veronica identified Ms Prior as her usual lawyer and so the Magistrate asked if Ms Prior was aware Veronica was in custody. Veronica was not sure and indicated that she had not spoken with Ms Prior. When asked if she wanted an opportunity to contact Ms Prior, Veronica replied that she wanted to apply for bail: CB2422.

[335] Transcript of bail hearing on 31 December 2019: CB2423. After the bail threshold was announced, the Magistrate asked Veronica again if she wanted to contact Ms Prior. At that point, Mr Antos intervened briefly.

[336] CB2426.

[337] CB2426.

[338] CB2426.

322. The Magistrate asked if Veronica wanted to ask the nominal informant any questions; she declined.

323. The Magistrate then asked, "why do you say that I should place you on bail?"[339] Veronica referred to her partner, Mr Lovett, who was present in court, as someone she could live with and who kept her out of trouble. She also said that her mother and brother were very unwell and had ongoing health issues.[340] The Magistrate asked Veronica where she normally lived, and Veronica told her that she normally lived with her partner in Collingwood.[341] Veronica also informed the Magistrate that her mother lived in Shepparton.

324. The Magistrate enquired as to what stage the Shepparton consolidation had reached, and the prosecutor indicated that the matters were part heard before Magistrate Farram.[342]

325. Bail was ultimately refused.[343] The Magistrate was not satisfied that Veronica had established 'exceptional circumstances' to justify the grant of bail. [344] When explaining the reasons for refusing bail to Veronica, the Magistrate also referred to the risks alleged by police and their relationship to "something going on, either drugs or alcohol."[345]

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[339] CB2427.
[340] CB2427.
[341] Ibid.
[342] CB 2428.
[343] CB2442: on the basis of the information contained in the preceding five paragraphs, bail was refused.
[344] CB2442: the Notice of Order Made also referred to there being an unacceptable risk that Vernica would commit offence while on bail and fail to surrender into custody in accordance with conditions of bail.
[345] CB2430.

326. After bail was refused, Veronica asked that her matters be returned to court in six weeks' time. The Magistrate endeavoured to ascertain why such a lengthy period was sought. Veronica was extremely reluctant to explain, eventually saying, "because I can't do what I need to do [in a shorter period]" and that it was due to her "medical health."[346] An inference can be drawn that Veronica's request was to ensure her eligibility for pharmacotherapy in custody.[347] It is unclear whether the Magistrate drew this inference.

327. Veronica's discomfort during this exchange was palpable. The Administration of Justice Conclave explained that there were likely three reasons for it: firstly, this was not a culturally safe space for Veronica to disclose personal information.[348] Secondly, there was significant stigma associated with any disclosure of the 'real reason' for the request, particularly in a setting where Veronica had just been described as a recidivist shop thief who stole to support her drug habit.[349] Thirdly, it was unclear whether there was a constructive reason for the information to be disclosed;[350] indeed, given the linkage of drug use and risk and that Veronica's drug use was illegal, her response is unsurprising.

328. The orders made at the conclusion of the bail hearing reflected no custody management issues that might have been informed by discussion of Veronica's health needs. Ensuring that judicial officers understand and can manage the barriers to disclosure of health information is

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[346] CB2430-2431.
[347] That is, treatment of opioid dependence; Prior: T260; Wilson: CB4016.
[348] Carter, T2467 (Carter). Veronica was characterised as "shut down" during this exchange. Indeed, it spoke volumes that Veronica told the Magistrate, "It's none of your business:" Transcript of bail hearing on 31 December 2019: CB2431.
[349] T2466 (Wilson).
[350] T2468 (Campbell_).

necessary to safeguard the wellbeing of people in custody. The Magistrate's orders adjourning Veronica's matters to 13 January 2020 at Shepparton Magistrates' Court before Magistrate Farram included the following notation: "the accused is an [A]boriginal person. Recommend all reasonable assessment and supervision to ensure safe custody."[351]

Decision of the prosecutor not to raise relevant factors

329. Veronica's application for bail was absent any express reference to the following matters:

329.1. section 3A of the Bail Act and factors relevant to Veronica's Aboriginality;[352] and

329.2. several matters relevant under section 3AAA of the Bail Act, including:

329.2.1. the nature and seriousness of the alleged offending before the Court;

329.2.2. the length of time Veronica was likely to spend in custody if bail was refused;[353]

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[351] Notice of Order Made: CB2442. I note that what use is ultimately made of the various custody management notations routinely made by judicial officers is unclear. There is no indication that any information recorded on the remand warrant made it to the health service provider at the Dame Phyllis Frost Centre.

[352] It does not appear that Magistrate Bolger was provided with a copy of the remand brief - which would have shown that 'Aboriginal' had been checked - given her indication that she did not have a copy of Veronica's prior history: see transcript of bail hearing, CB 2426. Her Honour may have inferred or assumed that Veronica was Aboriginal because she assumed Ms Prior still worked at VALS, CB 2516. Documents relating to an application to appear at Shepparton Koori COurt were also part of the Magistrates' Court file, though it is not known whether the Magistrate had an opportunity to review the whole file: CB 1925-1994.

[353] Prior: T296.

329.2.3. the likely sentence to be imposed for the alleged offending if she were found guilty;

329.2.4. a fulsome exploration or consideration of Veronica's personal circumstances, associates, home environment or background; and

329.2.5. her reason, if any, for failing to appear at court in Shepparton.

330. Veronica did not address these matters herself, which is understandable. There is no reason to believe she was aware or advised, given the scope of Mr Antos' usual practice, of the matters a BDM must consider when determining an application for bail. However, even though criminal proceedings are adversarial in nature, the prosecutor - an officer of the court and a member of a public authority - failed to identify all or any of these factors or alert the Court to the need to consider them.[354]

331. The absence of any reference to section 3A of the Bail Act is significant. The provision is a special measure under the Charter designed to reflect and, importantly, help redress the historical and continuing disadvantage faced by Aboriginal people in the criminal justice system.[355] It obliges a BDM to consider issues that might arise due to an accused's

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[354] AC Barrett of the Administration of Justice Stakeholder Panel agreed that police prosecutors and lawyers all 'have a duty of being impartial and fair for everyone they come across': T2600. However, whether it was his view that this duty required police prosecutors (or norminal/informants giving evidence during a bail application) to volunteer information or merely respond to 'reasonable questions' was not completely clear: T2530; T2604. He said that police may not know what a BDM 'thinks is relevant' until the question is asked: T2601.

[355] Explanatory Memorandum to the *Bail Amendment Bill 2010*.

Aboriginality. Indeed, "every aspect of the application [for bail] must be heard through that lens."[356]

332. Section 3A, when applied, should have the effect of centring Aboriginality in the procedural and substantive exercise of determining an application for bail. In Veronica's case, this meant at least, that proper weight could – and should – have been given to her kinship ties, the significance of her mother and brother's ill health, her cultural connection to Country and community, and the unique disadvantages she experienced as an Aboriginal woman in the criminal justice system.

333. As noted above, the police prosecutor had information that Veronica was Aboriginal in the remand brief. He would know by virtue of his role and training that s3A of the Bail Act is a mandatory consideration for the BDM where it is relevant, and he did not alert the BDM. The Administration of Justice Conclave considered that the Charter was an important source of duties and obligations for police in the context of bail[357] where the right to liberty – and I would add, in this instance, equality and cultural rights[358] – are engaged.

334. AC Barrett agreed[359] but was concerned by the lack of clarity about what is being asked of police in "terms of positive obligations."[360] He was also concerned that the Aboriginal community would not have confidence in police "representing" an Aboriginal person in the

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[356] Prior: T252.
[357] Administration of Justice Conclave: T2636.
[358] Also, Charter, section 24 (fair hearing).
[359] AC Barrett: T2637.
[360] Barrett: T2637.

bail context.[361] AC Barrett did not dispute that if a prosecutor put known, relevant material before a BDM in a bail application the Aboriginal community may have *more* confidence in Victoria Police.[362]

335. In so far as the prosecutor did not alert the BDM to the relevance of Veronica's Aboriginality during the bail hearing on 31 December 2019, I find that he failed to properly consider Veronica's Charter rights.

The effect of Mr Antos not appearing on Veronica's behalf

336. If Veronica had been legally represented in her application for bail, in addition to the matters relevant to section 3A and section 3AAA discussed above, the following matters might also have been raised:

336.1. that the alleged offending was not objectively serious;[363]

336.2. the significance of Veronica's ill health and/or withdrawal from opioids;[364]

336.3. the relationship between drug dependence, offending and trauma and/or mental health;[365]

336.4. that the alleged offences were unlikely to result in a sentence involving imprisonment if found proven;[366] and

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[361] Barrett: T2637.
[362] Barrett: T2638.
[363] Prior: T294.
[364] Prior: T296.
[365] Wilson: CB4013.

336.5. that Veronica had already served 82 days of pre-sentence detention, and that this was relevant to whether she would be sentenced to any further term of imprisonment when sentenced.[367]

337. Further, a legal representative could have clarified the charges before the court,[368] cross-examined the nominal informant about the strength of the evidence in support of the listed charges and allegations relating to risk if bailed. Submissions highlighting the significant gaps in Veronica's prior criminal history could have provided weight to an argument that her risk of re-offending was not unacceptable.[369] Mr Lovett might have been called to give evidence.[370]

338. The legal practitioners of the Administration of Justice Conclave considered that Veronica would have had a viable argument for bail had all matters relevant to the mandatory considerations in sections 3A and 3AAA of the Bail Act been put before the court.[371]

339. That an accused person should always have effective legal representation available to assist with an application for bail at first remand was supported by the Administration of Justice Conclave.[372] I heard uncontradicted evidence of the unfairness generated by unrepresented bail applications, including that:

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[366] Prior: T298.
[367] Prior: T298.
[368] Schumpeter: T340.
[369] Prior: T295.
[370] M. Walker, Administration of Justice Expert Conclave: T2496.
[371] See generally the comments made by Ms M. Walker on behalf of the Administration of Justice Conclave: T2495-2502; Leong and Wilson: T2504 and 2506-2507; and M. Walker: T2507.
[372] Administration of Justice Conclave, T2495-2497

339.1. often unrepresented accused have not read the remand summary prior to the hearing and do not know that errors appear in the document or which risks are alleged;

339.2. they cannot meaningfully cross-examine an informant or challenge allegations of risk;

339.3. they are disadvantaged by being unlikely to know what factors a BDM is required to consider, including provisions particular to their circumstances, like s 3A;[373]

339.4. they might inadvertently waive their right to silence by making express or implied admissions to offences; and

339.5. the fact that they are unrepresented may convey to the judicial officer that a lawyer has formed the view that the application is without merit.[374]

340. I find that, given Veronica's legal representative of record had been notified by VLA of her remand in custody on 30 December 2019 and arranged for a barrister to appear on her behalf on 31 December 2019, Veronica should not have appeared unrepresented on that date.

[373] Administration of Justice Conclave: T2495-2496.
[374] Prior, T303-319; Administration of Justice Conclave: T2495-2498.

Other issues relating to Veronica's application for bail

The new facts and circumstances impediment

341. The Administration of Justice Conclave considered that s18AA of the Bail Act might have been a barrier to Veronica's application for bail proceeding with the assistance of a lawyer on 31 December 2019.[375]

342. The provision relates to any application for bail following an application made by an accused who was legally represented and refused. In those circumstances, a court must not hear the subsequent application unless satisfied that 'new facts and circumstances' have arisen since bail was refused or revoked.[376] A further complication for the timely listing of a subsequent bail application may occur due to s18(4) of the Bail Act which requires, where possible, that it be heard by the judicial officer who refused bail.[377]

343. Although it was not reflective of the practice of lawyers in the Administration of Justice Conclave[378] (or Ms Prior[379] and Mr Schumpeter[380]), a practice "throughout the profession" was noted where lawyers are deterred by s18AA of the Bail Act from running a represented

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[375] Administration of Justice Conclave: T2498.
[376] Bail Act, s 18AA(1)(a).
[377] Bail Act, s 18(4): see the Administration of Justice Conclave: T2498 and unanimously opposing retention of the requirement that bail applications return to the BDM who refused the previous one where possible: T2646.
[378] For instance, Administration of Justice Conclave: T2504 (Leong and Wilson); T 2506 (M. Walker).
[379] Prior: T251.
[380] Schumpeter: T341.

bail application at the first remand hearing.[381] The rationale for the approach is to preserve the accused's entitlement to be legally represented on an application for bail and present a better prepared and more persuasive application on a later date (especially where the bail threshold is high). The obvious consequences of the approach are to increase the number of in person applications for bail[382] which, for the reasons explained above are unlikely to be granted and extend the time an accused remains in custody.

344. An unlimited entitlement to apply for bail would have insurmountable resourcing implications. Equally, it is unpalatable to accept that an accused will be deprived of liberty because the bail regime is such that legal practitioners feel compelled to present only the 'best possible application' to avoid an additional hurdle to the grant of bail. Often the best possible application will not be necessary. In Veronica's case, the Administration of Justice Conclave[383] (and Ms Prior)[384] considered that a very good argument for bail could have been made on the first day the court could hear it, notwithstanding the exceptional circumstances threshold, using available information, instructions from Veronica and provisions of the Bail Act.

345. The Administration of Justice Conclave recommended amendment of s18AA of the Bail Act to permit two unsuccessful applications for bail with legal representation (one being on the date of first remand if the matter is reached) before there is a requirement to establish

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[381] Leong and Wilson: T2504. See also Joanne Atkinson and Campbell: T2644; Thomson and Carter T2645.

[382] M. Walker, AM1421.

[383] See generally the comments made by Ms M. Walker on behalf of the Administration of Justice Conclave: T2495-2502; Leong and Wilson: T2504 and 2506-2507; and Walker: T2507.

[384] Prior: T263.

new facts and circumstances.[385] This change would reduce the likelihood that an accused will serve short, and harmful,[386] periods in custody while a lawyer prepares the best possible application. It would also reduce the frequency of in person bail applications where the disadvantages are so pronounced[387] as to make most doomed to failure.[388]

The absence of drug and alcohol support at the MMC

346. Substance use disorder is a recognised diagnosable mental disorder. It is a condition that falls within the definition of 'disability' in s4 of the EO Act. However, drug *use* is criminalised and regarded as aggravating the risk of other, particularly low-level, offending.[389] In the criminal justice system, therapeutic interventions are often coercive, with 'non-compliance' having the potential to contravene court orders and attract further criminal penalties. In short, drug dependence is not universally regarded as a health condition and the correctional system becomes a proxy for appropriate social service supports in the community.[390]

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[385] Administration of Justice Conclave: T2498.

[386] Administration of Justice Conclave: T2516; 2521; 2703. Short custodial periods were considered especially damaging by the Administration of Justice Conclave, as they disrupted connections with family, community, work, health and other therapeutic and support services, housing and were culturally unsafe. Administration of Justice Stakeholder Panel: T2520 (Westin).

[387] In addition to the disadvantages canvassed above, accused people in custody have little or no ability to self-refer to bail support programs or communicate with anyone other than a lawyer or court worker: M. Walker, AM1421.

[388] Importantly, the 'very significant system benefit' (reduction in self0represented bail applications and likelihood of bail being granted at the first available opportunity) were acknowledged by Administration if Justice Stakeholder Panel: T2643.

[389] Willson: CB4009; Administration of Justice Conclave T2494-2495 (M. Walker) and T2551-2552 (Willson).

[390] Campbell: T2522.

347. Mr Schumpeter tried to arrange a CISP assessment on 30 December 2019 to support an application for bail made by Veronica because, in his view, it would enhance the prospects of the application being successful.[391] But CISP[392] did not have capacity to conduct an assessment that evening.[393]

348. Many witnesses highlighted the shortage of drug and alcohol supports available to people applying for bail.[394] Although the case management and referral support provided by CISP was acknowledged,[395] the inquest also heard evidence that CISP is not always able to provide comprehensive services[396] and secondary referrals for alcohol or drug dependence services are often not sufficiently timely.[397] Secondary consultations for alcohol and drug treatment routinely take up to six to eight weeks.[398]

349. There is a clear link between a lack of available support or treatment for drug dependency and the remand of accused individuals with drug dependence. The Administration of Justice Conclave observed that in bail applications, substance use disorder is often used by the prosecution to allege that an accused presents an unacceptable risk and should be refused

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[391] Schumpeter: T369.

[392] CISP is a support and referral service available to anyone charged with an offence who is experiencing physical or mental disabilities or illnesses, drug and alcohol dependency, homelessness or inadequate social, family and economic support that contributes to their offending. If assessed as suitable for the program, a case manager will assist the person to access relevant support services with progress monitored by the case manager and presiding judicial officer usually over four months.

[393] Schumpeter: T355-356.

[394] Leong CB4863-4864; Thomson AM379; Willson CB4104; Campbell AM1-260.

[395] Leong: CB4864.

[396] Atkinson, Administration of Justice Conclave: T2677-2678.

[397] Wilson: CB4014.

[398] Wilson: CB4014, [53].

bail,[399] as occurred in Veronica's case. Where bail supports are available, particularly where there is a supervisory component (as with CISP), an application for bail has much more force.[400]

350. The need for culturally specific and gender-specific supports and services for Aboriginal women on bail is not new. There remains a "severe service gap,"[401] with wait periods for the services that are available extending to four or five months.[402] Currently, there are no residential bail support programs for Aboriginal women.[403] Indeed, the *Burra Lotjpa Dunguludja* committed to the development of these supports.[404] Development of a culturally safe, gender-specific rehabilitation facilities for Aboriginal and Torres Strait Islander women must be prioritised.

351. For people with drug dependence, short periods of imprisonment often exacerbate underlying causes of their drug use, disrupt any community supports in place and add to housing and employment difficulties.[405] Any view that short periods in custody can be helpful to persons with drug dependencies so they can 'dry out' is misconceived (to say nothing of it being an improper use of remand).[406] Withdrawal in this context is a "primitive form" of detoxification.[407] Cells are generally not equipped to support people with complex

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[399] Thomson, Administration of Justice Conclave: T2665.
[400] Schumpeter: T369.
[401] Thorpe: AM905
[402] Leong: 4869.
[403] Leong: CB4870.
[404] *Burra Lotjpa Dunguludja: Victorian Aboriginal Justice Agreement Phase 4*: CB2500.
[405] Wilson: T2516.28.
[406] Willson: CB4011.
[407] Wilson, Administration of Justice Conclave, T2514.

health needs and the facilities available to women in prison custody, as will be seen, are not equivalent to those available to men.[408]

352. Judicial officers who preside over bail/remand hearings must have an appreciation of the dangers of withdrawal, especially from opiates, while in custody. Opiate withdrawal can be life threatening.[409] Symptoms can be severe[410] and withdrawal is particularly unsafe for individuals having comorbid conditions or whose underlying health is otherwise compromised.[411] As will be discussed below, the treatment available for opiate withdrawal in custody may be insufficient to manage severe withdrawal.[412] It is important that judicial officers understand this reality and thoroughly canvass and record custody management issues.

The absence of cultural support at the MMC

353. Veronica arrived in the cells at the MCC at 7:20 PM on 30 December 2019 and left at 3:48 PM the following day. She appeared unrepresented in court on two occasions during this period; her only visitor was Mr Antos, who saw her for six minutes.[413] Veronica received no culturally specific support at all.[414]

354. In December 2019, there were two support roles at MMC that were culturally relevant to Veronica: a Koori Court Officer and a CISP Koori Case Manager. The CISP Koori Case

[408] Wilson: CB4011, [46].
[409] Clark, Medical Conclave, T2346.
[410] See, for example, Bonomo, Medical Conclave: T2227.
[411] Clark, Medical Conclave, T2141.
[412] Bonomo, Medical Conclave: T2227.
[413] CB595; CB1923.
[414] A. Walker: T521-522; CB1923-1924.

Manager role had been vacant since mid-2019.[415] The Koori Court Officer role is designed to support the operations of the Koori Court during normal business hours rather than have a broader reach into the 'mainstream' operations of the MMC.[416]

355. Although it was outside the position description, Koori Court Officers were called on a case-by-case basis by Magistrates or Registrars to "support Koori people who have been brought into custody and seeking bail."[417] Referrals of this kind tended to be made by individuals who understood both that cultural support may be needed by the Aboriginal person before the court and the work of Koori Court Officers.[418] Similarly, legal representatives and staff of the MCC who appreciated that cultural support may be required might also alert the Koori Court Officer to the presence of an Aboriginal person at court.[419] The notification system was not automatic, but informal and required the information that the person is Aboriginal to "carry across" from a self-identification made to police all the way to the court.[420]

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[415] Holllingsworth: CB1859. A CISP Koori Case Manager would only have become involved in Veronica's matter if a CISP assessment had been requested or if Veronica had been bailed with a condition that she comply with CISP.

[416] Hollingsworth: CB1852-1866 and Atkinson: CB2375-2383.

[417] Hollingsworth: CB1856.

[418] A. Walker: CB1875-1876.

[419] Joanne Atkinson: CB2474. The Koori COurt Officer might become aware of an Aboriginal person needing assistance by being approached directly at the registry: A. Walker: T518.

[420] Joanne Atkinson: CB2474. In November 2020, a new procedure was implemented where MCC staff notify the Koori Court Officer that an Aboriginal person is in custody and whether the person wants to see the Koori Court Officer: Joanne Atkinson CB2383.

356. Audrey Walker was the Koori Court Officer at the MMC in December 2019. She was working on 31 December 2019 but was never notified that Veronica was in custody and so she did not see her.[421]

357. Ms Walker gave evidence that the role of Koori Court Officer was varied and involved a number of competing responsibilities.[422] She received very little formal training,[423] and as the Koori Court Unit was "short staffed,"[424] she sought guidance from Koori Court Officers based in other metropolitan courts when required.[425] There was a significant administrative burden associated with preparing for Koori Court sittings, which occurred on Mondays, and to ensuring they ran smoothly on the day. This meant there was "no chance" she would have capacity to provide social and emotional support to Aboriginal court users outside of the Koori Court when it was sitting.[426]

358. On days the Koori Court was not sitting, Ms Walker had more capacity to assist Aboriginal court users, and magistrates presiding over 'mainstream' proceedings involving Aboriginal people.[427] If called to assist with an Aboriginal person in custody, the notification was unlikely to occur until after a matter is called into court and a question of bail supports had arisen.[428]

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[421] A. Walker: CB1881 and T521-522. I note that Mr Hollingsworth's statement dated 20 October 2020 refers to Ms Walker working on 30 December 2019: CB1852-1866.
[422] A. Walker: T507-508
[423] A. Walker: T513.
[424] A. Walker: T513.
[425] A. Walker: T514.
[426] A. Walker: T514-515.
[427] A. Walker: T515.
[428] A. Walker: T519.

359. The range of assistance Ms Walker provided included simply attending a hearing so that an accused person or their family members could see there is another Aboriginal person in the room,[429] intensive work to facilitate disclosure of medical, personal, or cultural matters to the court,[430] arranging material support such as accommodation,[431] and visiting a person in custody in the MCC.[432]

360. As the only person performing a culturally relevant support role at MMC at the time, Ms Walker was "overloaded."[433] In her opinion, this level of resourcing was insufficient to meaningfully assist the number of Aboriginal and Torres Strait Islander people appearing before the court.[434] Ms Walker also observed that there were fewer supports for Aboriginal people after hours.[435]

361. In Veronica's case, Ms Walker was the only person at MMC who could have provided culturally specific assistance, even though, strictly, her role was not designed to do so.[436] There should have been a role designed to do so. Despite the Magistrates' Court of Victoria's commitment to "maximising the availability of supports for Koori people, recognising the specific needs of those in custody,"[437] the only measure in place to ameliorate Veronica's

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[429] A. Walker: CB1874.
[430] Administration of Justice conclave panel: T2472-2473.
[431] A. Walker: T520.
[432] A. Walker: T523.
[433] A. Walker: T514.
[434] A. Walker: T514.
[435] A. Walker: T523; Leong: CB4865 [48].
[436] CB1864.
[437] Ibid.

experience of the MMC failed her. The notification process was insufficiently robust to ensure that Veronica was not "culturally isolated."[438]

362. I find that at the time of Veronica's appearance at the MMC on 30-31 December 2019, culturally specific support for Aboriginal court users was under-resourced and designed to address the cultural needs of only some Aboriginal people – those attending Koori Court. The restrictions of the cultural support role as planned by the Magistrates' Court of Victoria, and the inadequate process for identifying people who might need it, failed to give proper consideration to Veronica's rights to equality and culture and those of other Aboriginal court users.

363. That the reach of the Koori Court Officer extended beyond the limits of the role is testament to those performing it and the sense of accountability they feel to the community they serve.[439] It also demonstrates the value of cultural education for non-Aboriginal people to ensure they consider and respond to the vulnerability of Aboriginal people in criminal justice settings.

Consequences of the 2018 Bail Act changes

364. The Administration of Justice Conclave and witnesses in legal practice testified about the profound effects of the 2018 Bail Act changes on individuals and systems, *who* is being disproportionately affected and why. The evidence was consistent:

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[438] A.Walker: T533.
[439] A. Walker: CB 1888.

364.1. three components of the Bail Act – criminalisation of bail offences, the reverse onus regime and the unacceptable risk test - have separate and mutually reinforcing effects increasing the likelihood that an accused will be remanded in custody;

364.2. the effects are widespread but are disproportionately experienced by individuals already marginalised and vulnerable, particularly Aboriginal women; and

364.3. the repercussions include erosion of the presumption of innocence, indirect effects on pleas of guilty and sentencing outcomes, pressure on the legal and correctional systems (among others) and entrenchment of disadvantage.[440]

Interlocking provisions of the Bail Act

365. In 2013, the Bail Act was amended to include two new bail offences: contravention of bail conditions was criminalised[441] and the offence of committing an indictable offence while on bail[442] was created. It was already an offence to fail to appear on bail without a reasonable excuse.[443]

366. For vulnerable individuals whose lives are already marked by uncertainty or unpredictability, there is increased likelihood of non-compliance with conditions of bail.[444] The same can be said of non-compliance by First Nations people with bail conditions that are

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[440] See generally the transcript of the evidence provided by the Administration of Justice Conclave and Stakeholder Panellists: T2412-2724.
[441] Bail Act, s 30A.
[442] Bail Act, s 30B.
[443] Bail Act, s 30.
[444] Nicholson: CB2097.

culturally inappropriate or bail requirements that clash with cultural obligations.[445] Bail offences quickly became the most common secondary offences charged and sentenced in Victoria.[446]

367. Before the 2018 Bail Act changes, only a small number of very serious offences attracted the highest reverse onus threshold for the grant of bail. This is no longer the case. Now, repeated bail offences (particularly) and objectively not serious offences, presenting no risk to community safety and that are unlikely to attract a prison sentence, routinely result in remand[447] because they attract the 'exceptional circumstance' test. Low-level, non-violent offending is frequently directly linked to social circumstances including homelessness, long-term unemployment, mental illness, drug or alcohol dependence, displacement or Aboriginality.[448]

368. Even if an accused person satisfies the BDM that a reverse onus threshold for bail is met, Victoria Police are likely to allege that they would pose, if bailed, an unacceptable risk of one of the four types specified in section 4E of the Bail Act. Those four categories of risk are, broadly, endangering any person, committing a further offence, interfering with the administration of justice and failing to appear on bail.[449] In the Bail Act, no distinction is made between the very different *types* of risks that might be alleged or the *gravity* of consequences that may follow. Moreover, members of the Administration of Justice Conclave

[445] Leong: CB4860. Examples of culturally inappropriate bail conditions might be attendance at a police station (a reporting condition) or one that prohibits contact with family (non-association).
[446] Sentencing Advisory Council, (2017) Secondary offences in Victoria.
[447] M. Walker, AM1420 [1].
[448] M. Walker, AM1420 [1].
[449] Bail Act, s 4E(1)(a)(i)-(iv).

observed that there has been a 'strange slippage' in how risk is conceptualised.[450] Rather than being confined to risks to safety[451] the risk of 'running foul' of the bail laws predominates in a landscape where unmet needs are themselves equated with risk.[452]

369. For instance, the risk of endangering any person is consistent with the amended purpose of the Bail Act but the risk of committing 'an offence' presents distinctly different concerns depending on whether it involves non-violent, objectively not serious offences or involves violence or otherwise has potential to endanger the community. Similarly, the risks (and costs) presented by someone failing to appear on a court date are significantly different to those where an accused has previously fled the jurisdiction to avoid a hearing. Section 4E does not expressly provide for any distinctions to account for these differences.

370. By categorising the 'unacceptable risk' in these broad ways, "needs" have become equated with "risk" with discriminatory effects for people already experiencing social disadvantage.[453] If an accused is homeless, suffering from mental illness or drug or alcohol dependence (or a combination of similar factors), they will present to the court[454] as an increased risk of failing to appear and of committing further offences. They are more likely to be refused bail notwithstanding that they may *not* present with the kind of alleged offending of greatest concern to the community. Similarly, if bailed, this cohort is more likely to be bailed with conduct conditions to mitigate alleged risk, and given their visibility

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[450] Administration of Justice Conclave: T2570.

[451] Even if expansively defined to encompass safety of people, the community and important systems like the administration of justice.

[452] Administration of Justice Conclave: T2570.

[453] Campbell, Administration of Justice Conclave, T2570.

[454] That is, they are likley to be alleged to be and to be perceived as posing these risks if bailed.

in the community, are more likely to come to the attention of police. The sections of the community disproportionately affected by social disadvantage are unsurprisingly disproportionately affected by provisions of the Bail Act.[455]

371. Interpretation of the 'unacceptable risk' test is contextual,[456] and the acceptability of a risk must be assessed with reference to the mandatory factors in s 3AAA and, where it applies, s3A of the Bail Act. I note that despite its inclusion in the Bail Act more than a decade ago and its purpose, jurisprudence on s3A is scant but growing;[457] and interpretation and application of the section remains 'confusing;'[458] and, it has failed to address the over-representation of Aboriginal people remanded in custody.

Disproportionate effects

372. Rate of imprisonment of adults in Victoria was increasing gradually prior to the 2018 Bail Act changes.[459] Notably, at that time, the rate of imprisonment per 100,000 of the adult population was considerably higher for Aboriginal[460] adults than for all adults.[461] Aboriginal

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[455] M. Walker, Administration of Justice Conclave: T2522-2523. Wilson: CB3976-4101; Leong 4856-4871; Campbell AM1-260.

[456] That is, interpretation of both the nature and seriousness of the risk and the likelihood of the risk occurring and the imposition of detention upon a person's liberty, on the other.

[457] Administration of Justice Conclave: T2507.

[458] Administration of Justice Conclave: T2507; AC Barrett concurred that further guidance and training was desirable: T2613.

[459] See generally, Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.3.

[460] In this paragraph and the next, references to 'Aboriginal' include Torres Strait Islander adults on the basis that the statistics quoted amalgamate data for Aboriginal and Torres Strait Islander adults.

[461] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.3 records the rate of imprisonment per 100,000 of the adult population as at June 2016 as 1658.4 for Aboriginal and Torres Strait Islander adults and 138.1 for all adults.

people comprised 8.2% of all prisoners; Aboriginal women comprised 10% of female prisoners in Victoria. Overall, most adults in prison were serving a prison sentence.[462]

373. A year after the 2018 Bail Act changes were introduced, the statistical picture had changed markedly. By June 2019, imprisonment rates for all adults and Aboriginal adults had increased,[463] and the rate at which Aboriginal women were imprisoned had nearly doubled.[464] Aboriginal prisoners comprised more than 10% of all prisoners,[465] and Aboriginal women made up 14% of all female prisoners.[466] By this time more than a third of all adults in prison were unsentenced,[467] nearly half (47.7%) of all Aboriginal prisoners were unsentenced,[468] and 86% of Aboriginal women were unsentenced on reception.[469] Forty-five per cent of unsentenced men and 61% of unsentenced women were remanded in custody for alleged offences not involving violence.[470]

374. Although remand and reception into prison only represent one decision point in the criminal justice process, the statistics quoted demonstrate the widespread effect the 2018 Bail Act changes have had on rates of imprisonment, and their disproportionate impact on First

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[462] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.3 records that as at June 2016 71.1% of all prisoners in Victoria were sentenced and 28.9% were unsentenced.

[463] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.3

[464] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.2. Leong reported data collected by VALS through its Custody Notification Service that shows an increase in the remand of Aboriginal men and women after the 2018 Bail Act changes came into force. That is, between 2017/2018 and 2018/2019, the number of notifications resulting in the person's remand in custody increased 67% from 1424 to 2074: CB4857.

[465] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.4

[466] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.2

[467] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.3

[468] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.4.

[469] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 2.3. I note that 88% of Aboriginal and Torres Strait Islander men were unsentenced on reception.

[470] Corrections Victoria, Statistical profile 2009-10 to 2019-20 Dataset: Table 1.11.

Nations people generally, and Aboriginal women in particular. Unfortunately, notwithstanding the development of caselaw clarifying the meaning of 'exceptional circumstances,' the disproportionate effects of the reverse onus regime of the Bail Act on remand rates have not abated.[471]

375. I find that the Bail Act has a discriminatory impact on First Nations people resulting in grossly disproportionate rates of remand in custody, the most egregious of which affect alleged offenders who are Aboriginal and/or Torres Strait Islander women.

Repercussions

376. The wide reach of the reverse onus regime has caused accuseds to "flood" into the criminal justice system.[472] This flood prompted the creation of the BaRC at MMC: there would be no need for a court that sits for extended hours on weekdays and at weekends were it not for the 2018 Bail Act changes.[473] The demand on bail support and other social services is constantly high with concomitant impacts on waiting periods for assessment and client-service connection. All members of the criminal courtroom work group face considerable workloads. The "churn" of the high volume of unsentenced prisoners caught in custody by the reverse onus regime also impacts the resources of prisons.[474]

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[471] As at June 2021, 61.4% of Aboriginal women in prison were on remand: Corrections Victoria, Monthly Time Series Prisoner and Offender Date: Table 1 December 2021. DC Westin: T2519-2520. There was a dip in remand rates during the first 12 months of the Covid—19 pandemic associated with the very harsh conditions (due to infection suppression measures) and broader concerns about the spread of infection in closed environments.

[472] Schumpeter: T343.
[473] Schumpeter: T370.
[474] DC Westin: T2521.

377. However, the "complete and unmitigated disaster"[475] of the 2018 changes to the Bail Act is most obviously inflicted on the accused who are incarcerated, often for short periods and for unproven offending of a type that often ought not result in imprisonment if proven. Short periods in custody are destabilising and often serve to exacerbate issues underlying the person's alleged offending by producing loss of housing, work or income, the breakdown of relationships and support networks, and disrupted access to treatment and other services.[476] These outcomes are plainly antithetical to rehabilitation and adversely affect the underlying social issues that drive offending.

378. The remand rates caused by the reverse onus regime of the Bail Act also increase the likelihood that an accused will plead guilty to offences even where the evidence may not sustain a finding of guilt. The provisions incentivise a plea of guilty to avoid time in custody where the prospects of bail are limited.[477] A guilty plea is the more direct route to freedom.[478]

379. Similarly, remand rates indirectly affect sentencing outcomes because time spent on remand increases the likelihood that a court will ultimately impose a sentence of imprisonment.[479] Further, as time in custody is criminogenic (people are more likely to return to prison once they have been there even for short periods), the current rate of remand might be contributing to the recidivism rate.[480]

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[475] Administration if Justice Conclave: T2569 (Campbell).
[476] Campbell, Administration of Justice Conclave: T2521-2522; Walker AM1421 [4].
[477] Nicholson: CB2096; Leong: CB4858.
[478] Schumpeter: T344.
[479] Nicholson: CB2096; Leong: CB 4858.
[480] Nicholson: CB2096; DC Weston: T2521.

380. Finally, the interpersonal and socio-economic consequences of having a criminal record, conviction or serving a term of imprisonment are broad-ranging and long-lasting and are likely to entrench social disadvantage.

Proposed reform

381. The Administration of Justice Conclave unanimously recommended that:[481]

381.1. the Bail Act is simplified;[482]

381.2. Bail offences are repealed;[483]

381.3. the reverse onus regime is repealed;[484]

381.4. the presumption of bail is restored;[485]

381.5. bail should only be refused (particularly at a police station) where there is a "real risk" of "hurting a member of the community" or "of flight;"[486]

381.6. greater prescription is required in s3A[487] and training for everyone likely to use it should be mandatory.[488]

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[481] In addition to the recommendations already mentioned concerning s3A and s18AA of the Bail Act.

[482] Administration of Justice Conclave: T2497.
[483] Administration if Justice Conclave: T2535.
[484] Administrtation if Justice Conclave: T2537.
[485] Administration of Justice Conclave: T2568.
[486] Administration of Justice: T2568.
[487] Administration if Justice Conclave: T2657.

381.7. before a BDM refuses bail to an Aboriginal person, they are required by law to articulate (and record) what enquiries were made into the surrounding circumstances and what factors relevant to sections s3A and s3AAA of the Bail Act were considered to reach the decision; [489]

381.8. section 3AAA(1)(h) is amended to expressly identify substance use disorders as included in the definition of 'mental illness' (but without requiring proof of a formal diagnosis);[490] and

381.9. amendment of s18AA to allow two applications for bail before new facts and circumstances must be demonstrated.[491]

382. I endorse these proposals to reform the Bail Act.

Incompatibility of the reverse onus provisions of the Bail Act with the Charter

383. I was assisted by detailed and comprehensive submissions filed by the VEOHRC concerning the compatibility of the Bail Act with the right to liberty contained in s21 of the Charter.[492] In its submissions, the VEOHRC identified from an analysis of Australian Capital

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[488] Administration of Justice Conclave: T2510; AC Barrett: T2613; Waight: T2613. It was also considered important that a BDM, if refusing bail to an Aboriginal person, articulate - with reference to s3A and s3AAA - why bail is refused.

[489] Administration of Justice Conclave: T2576.

[490] Administration of Justice Conclave: T2552.

[491] Administration of Justice Conclave: T2569.

[492] Submissions of the Victorian Equal Opportunity and Human Rights Commission in Respect of the Interpretation and Application of the Bail Act (**VEOHRC Bail Submissions**) dated 18 May 2022. In this section I shall only refer to the VEOHRC Bail Submissions in relation to the incompatibility of the reverse onus provisions of the Bail Act with the right to liberty, particularly, s21(6) of the Charter. The

Territory, foreign and international jurisprudence the principles underlying bail and the right to liberty. Those principles are that:

383.1. bail should be the norm for people charged with an offence; and

383.2. the purposes for which a person can be remanded in custody are:

383.2.1. avoiding a real risk that, were the accused to be released, they would:

383.2.1.1. fail to attend trial;

383.2.1.2. take action to prejudice the administration of justice, such as interfere with evidence or witnesses;

383.2.1.3. commit further offences (of such a nature or seriousness as to justify deprivation of liberty notwithstanding the person has not been convicted); or

383.2.1.4. be at risk of harm against which they would not be adequately protected; or

383.2.2. avoiding a disturbance to public order that would result if the person were not remanded in custody;

VEOHRC Bail Submissions canvassed compatibility of the reverse onus provisions with the rights to equality and not to be arbitrarily detained (ss 8(2) and 21(2) of the Charter respectively).

Detention for other purposes or where detention is discriminatory and in breach of the equality right will breach the right against arbitrary detention (s 21(2) of the Charter);

383.3. remand into custody must be reasonable and proportionate in all the circumstances;

383.4. provisions that reverse the presumption or place an onus on the accused to show why bail should be granted amount to a limit upon the right not to be automatically detained in s 21(6) of the Charter;

383.5. for presumptions against bail to be justifiable they should:

383.5.1. be narrow in scope;

383.5.2. be necessary to promote the proper functioning of the bail system and must not be undertaken for any purpose extraneous to the bail system;

383.5.3. evidence a rational connection between the circumstances giving rise to the presumption against bail and the purpose sought to be protected by the presumption against bail; and

383.5.4. retain capacity to fully consider the reasons in favour of granting bail and to grant bail where remand into custody is not necessary to achieve one of the legitimate purposes and is not reasonable and proportionate in all the circumstances; and

383.6. the fact that a person is alleged to have committed an offence whilst on bail is a factor that may be taken into account in determining whether to grant bail but is not, on its own, a proper basis for remanding a person in custody.[493]

384. In light of that jurisprudence, the VEOHRC submitted that the reverse onus regime[494] of the Bail Act is incompatible with the right to liberty because, due to the breadth of offences captured by clauses 1 and 30 of Schedule 2, neither the compelling reasons nor the exceptional circumstances test can be justified as a reasonable limit on the right not to be automatically detained.

385. The VEOHRC observed that the statements of compatibility relevant to the 2017 and 2018 amendments to the Bail Act reveal an assumption that the reverse onus regime would only capture 'serious offences'. It was on this basis that provisions were said to be compatible with the right to liberty.[495] However, as the circumstances of Veronica's remand in custody on 30 and 31 December 2019 illustrate, the description of an offence as 'indictable,' in Victoria, does not necessarily indicate seriousness of offending such as might justify remand of the person in custody notwithstanding that they have not been found guilty of the offence.

386. Though indictable, the offence of theft encompasses anything from low value, opportunistic shoplifting borne of necessity to multimillion dollar organized crime for profit.

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[493] Submissions of the Victorian Equal Opportunity and Human Rights Commission in Respect of the Interpretation and Application of the Bail Act (**VEOHRC Bail Submissions**) dated 18 May 2022.

[494] That is, as noted above, s 4AA(2)(c), s 4A, s4C and clauses 1 and 30 of Schedule 2 to the Bail Act.

[495] VEOHRC Bail Submissions.

As such, an adult (or child) charged with shoplifting a chocolate bar and, while on bail, stealing a t-shirt would be subject to a presumption against bail and be required to show "exceptional circumstances" to be bailed.[496] That such objectively minor offending, and the breadth of such minor offending, may never pose a risk to the safety of the community or attract a sentence of imprisonment requires the accused to establish compelling reasons or exceptional circumstances to avoid remand in custody, is plainly disproportionate to the public safety purpose sought to be achieved.

387. The Commission submitted that I should conclude that sections 4A and 4AA(2)(c), 4C and clauses 1 and 30 of Schedule 2 to the Bail Act are incompatible with the right in s 21(6) of the Charter, in that:

a. the prohibition upon bail and the imposition of a reverse onus:

i. requiring that the accused satisfy the bail decision maker that a "compelling reason" exists to justify bail, upon all persons who are alleged to have committed an indictable offence in the circumstances set out in cl 1 of Schedule 2 or an offence against the Bail Act in cl 30 of Schedule 2; and

ii. requiring that the accused satisfy the bail decision maker that "exceptional circumstances" exist to justify bail upon all persons who are alleged to have committed any Schedule 2 offence in the circumstances set out in s 4AA(2)(c)

[496] Assuming the person was not also found to be an unacceptable risk of the type listed in s4E of the Bail Act.

> regardless of how minor that alleged offending may be and irrespective of the nature of the offending and whether it poses a risk to the safety of the community, is an unreasonable limit upon the right not to be automatically detained.[497]

388. The VEOHRC observed that it is no answer to this analysis of the reverse onus regime to say that an accused is entitled to be brought before a court and will have an opportunity to discharge the burden. Veronica's experience showed starkly the reality of the reverse onus regime: that an accused ensnared by the provisions will be automatically remanded in custody if their case is not able to be put immediately before a magistrate, or additional time is needed to gather material to discharge the burden of either reverse onus test. As observed by the Court of Appeal in *HA (a pseudonym) v The Queen,* the prospect of remanding in custody a person who is unlikely to be sentenced to imprisonment is tantamount to preventative detention, which absent specific statutory provision is "alien to the fundamental principles that underpin our systems of justice."[498]

389. The VEOHRC's analysis is persuasive, and I accept its submission that the reverse onus regime is too broad and imposes an unreasonable limit upon the right not to be automatically detained in custody in s 21(6) of the Charter.

390. I therefore find that ss 4AA(2)(c), 4A, 4C and Clauses 1 and 30 of Schedule 2 of the Bail Act are incompatible with the Charter.

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[497] VEOHRC Bail Submissions.
[498] *HA (a pseudonym) v The Queen* (2021) VSCA 64, 64-65.

Reception at Dame Phyllis Frost Centre

Arrival at DPFC

391. Veronica arrived at the DPFC at 4:35 PM on 31 December 2019. She vomited in transit and arrived at the reception area holding a vomit bag.[499]

392. Shortly after, Veronica entered the shower and was provided clean clothes.

393. Several prison officers observed Veronica to be extremely unwell while she was in reception and the Medical Centre.

394. The evidence before the inquest was that several CV staff in the Medical Centre communicated concern about Veronica's health amongst themselves,[500] however it is not clear that these concerns were ever shared with CCA clinical staff.

Facility and Policy Framework

395. From the point of her arrival at DPFC, Veronica was an unsentenced prisoner in the custody of the Secretary to the DJCS. CV, a business unit of DJCS, was and is the entity responsible for custodial services at DPFC.

396. At all relevant times, CCA was the primary healthcare provider to prisoners at DPFC under contract with Justice Health on behalf of the State of Victoria. CCA employs health practitioners and administrative staff to deliver those services within DPFC.

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[499] Extracts: 005; 006; 007.
[500] Fenech: T557

397. CV, Justice Health and CCA are public authorities for the purposes of the Charter.

398. The DPFC reception and Medical Centre are co-located.[501] The Medical Centre is staffed 24 hours every day by custodial and clinical staff.[502] In addition to a range of clinical and treatment rooms, there are three 'ward' cells and two 'holding' cells in the Medical Centre.[503] Wards 1 and 2 may be used for "medical observations"; cell placement is determined by CV.[504]

399. Non-urgent health services at DPFC may be accessed by prisoners self-referring (by completing an appointment request form) or by request made on their behalf by custodial or program staff or a fellow prisoner.[505] Requests are triaged by clinical staff.

400. Any member of DPFC staff can call a Code Black[506] if they believe a prisoner needs emergency medical care; clinical and custodial staff of the Medical Centre respond to codes.[507] The decision to transfer a prisoner to an external health facility for ongoing care is a clinical decision made by CCA.[508]

Justice Health Quality Framework

401. Minimum standards for custodial healthcare are established by the JHQF. Firstly, and as mentioned above, the "equivalence of care" principle that featured in the recommendations

[501] AM365.
[502] CB1378.
[503] AM365.
[504] CB1380.
[505] CB247.
[506] A Code Black is called where a death or 'serious medical' incident has occurred: CB1378.
[507] CB1379.
[508] CB1097.

of the RCADIC, is repeated in the JFQF such that people in custody have the right to receive health services equivalent to those available in the community through the public health system.[509]

402. Secondly and significantly, the JHQF emphasises the importance of the reception medical assessment as "it is at this time that the health profile of the prisoner is identified and healthcare treatment and planning is commenced."[510] Following this assessment, a prisoner is liable to be locked in a cell overnight without any independent means to obtain medical assistance as they would if they were in the community. Instead, a prisoner may use her intercom to alert a prison officer to a health concern and is dependent on the PO to manage it.

403. The JHQF's minimum requirements for a reception medical assessment include that:

403.1. the assessment tools included in JCare[511] are used to assess the health needs of prisoners;

403.2. the triage component of the assessment tool is used to identify immediate healthcare risks in order to plan and deliver safe, effective, appropriate, person-centred healthcare;

403.3. the comprehensive health assessment component of the assessment tool is used in conjunction with the triage tool to assess the general and mental health needs of

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[509] JHQF CB 1283.
[510] Justice Health Quality Framework, CB1283.
[511] Jcare is the Justice Health medical record which in December 2019 was an electronic record.

prisoners in the first 24 hours following reception so that appropriate healthcare management and/or referral to other clinicians can occur;

403.4. a recognised and validated alcohol and drug withdrawal assessment tool must be used to inform appropriate healthcare;

403.5. regimen, based on assessments, are in place to manage withdrawal from alcohol and other drugs; and

403.6. all health assessments are documented in the prisoner's health record on JCare and used to inform all future assessments.[512]

404. As a result of the standards required by the JHQF, and the nature of their contractual agreement with the State, CCA's policies require that:

404.1. all patients are provided with a comprehensive health assessment upon their reception;[513]

404.2. a full medical assessment is conducted at this health assessment, including a physical examination;[514]

404.3. patients' urgent and physical needs are properly assessed, and treatment planned;[515]

404.4. patients are cared for in a culturally sensitive manner;[516]and

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[512] Ibid.
[513] CB1053.
[514] CB1054.
[515] CB1048

404.5. referrals to Aboriginal Welfare Officers and Health Workers will be made where appropriate or requested. [517]

405. The Medical Assessment Form (**MAF**) sets out which investigations are required for a comprehensive medical assessment. They include:

405.1. standard nursing observations;[518]

405.2. a physical examination requiring an assessment of hearts, lungs and abdomen;[519]

405.3. inspection of teeth;[520]

405.4. enquiries about past medical history,[521] chronic health conditions,[522] medication history,[523] allergies,[524] immunisations,[525] and any blood borne virus history;[526]

405.5. enquiries in relation to drug and alcohol history[527] and drug-related risk-taking behaviours;[528]

405.6. enquiries about smoking;[529] and

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[516] Ibid.
[517] CB1057.
[518] CB1762.
[519] Ibid.
[520] Ibid.
[521] Ibid.
[522] CB1766.
[523] CB1762.
[524] Ibid.
[525] CB1764.
[526] Ibid.
[527] CB1763.
[528] CB1764.

405.7. enquiries in relation to STI history,[530] sexual and reproductive health.[531]

406. I note therefore that, in assessing the adequacy of Veronica's reception medical assessment, I must have regard to the policies outlined above, and that:

406.1. Veronica was an Aboriginal woman who had not had any contact with another Aboriginal person since her arrest;

406.2. a completed assessment of Veronica amounted to 'medical clearance' for fitness to be isolated in a locked cell; and

406.3. the JCare electronic file was the system by which medical staff recorded and accessed medical information about a patient for the purposes of ongoing review and treatment.

Victorian Opioid Substitution Therapy Guidelines

407. It is appropriate to note here one key clinical policy area, namely, the policies in place concerning provision of opioid substitution therapy to prisoners at the time of Veronica's reception to DPFC. Opioid substitution therapy, or pharmacotherapy, is the safest and most effective method to treat opiate withdrawal.[532]

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[529] CB1763.
[530] CB1764
[531] CB1765.
[532] Clark, Medical Conclave: T2135 – 2136; Frei, Medical Conclave: T2269; Clark, Medical Conclave: T2346.

408. The Victorian Prison Opioid Substitution Therapy Program Guidelines (**OSTP Guidelines**) dictates that a six-week stabilisation period is required before a person in custody is eligible for pharmacotherapy.[533] Justice Health issued the OSTP Guidelines in 2015 and it remains current. By virtue of its service contract, CCA was required to implement the OSTP Guidelines and did so through its Opioid Substitution Program Policy (**OSPP**).[534] The OSPP was updated in May 2021.[535]

409. The effect of the 'six-week stabilisation period' is to prevent most people with substance use disorder entering custody for short periods from being prescribed pharmacotherapy. Instead, they will undergo involuntary detoxification/withdrawal and often unnecessary pain and suffering. Significantly, opioid withdrawal is not without risk and places the person at higher risk, when released into the community, of fatal overdose.[536]

410. As will be discussed later, Veronica was prescribed a standard withdrawal pack at DPFC.[537] The OSPP contained suggested doses of Suboxone;[538] CCA doctors appear to have understood the policy to not allow for clinical judgment or discretion when prescribing.[539] Accordingly, it was effectively a 'one size fits all' package, with set dosages of

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[533] CB2263. Unless the prisoner was already prescribed OSTP in the community.
[534] CB2256.
[535] AM953. The OSPP as updated in May 2021 removes any reference to the doses at which suboxone should be prescribed.
[536] Medical Conclave: T2346-2347. See also CB2259 (OSPP) and CB1182 (OSTP Guidelines).
[537] CB1076; Hills: T689-690.
[538] Fuller: T2345; Blaher: T2930.
[539] CB1177 – 1234; CB1231 – 1244; CB 1235 – 1240; CB2256 – 2278; Runacres: T1031.8 – 9; T1108.8 – 10; 114.5 – 9. Brown: T740.

pharmacotherapy, regardless of the prisoner's level of opioid dependence or the severity of withdrawal symptoms.[540]

411. CCA submitted that I should not make any finding that Veronica's withdrawal was improperly managed. They referred me to relevant extracts from reports of Dr Clark and Dr Frei which opine that 4mg of suboxone is an appropriate or reasonable initial treatment for withdrawal.

412. However, it is plain from the evidence of the Medical Conclave that the doses provided in the withdrawal pack would not have been sufficient to manage the severity of Veronica's withdrawal.[541] Dr Bonomo, speaking on behalf of the unanimous Medical Conclave, stated that given the level of Veronica's self-reported opioid dependence, she was likely to suffer moderate to severe withdrawal[542] involving symptoms including cramping, pains, chills in the bones, goosebumps, hot and cold flushes, vomiting and diarrhoea.[543] The severity of her withdrawal could be anticipated,[544] and failing to adequately treat it with a titrated dose was described, again unanimously, as "inhumane".[545]

413. I note here that, if Veronica was in the community, she would have had a range of opioid pharmacotherapies available to her.[546] She would have been able to avoid the painful process

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[540] CB1076; Hills: T689-690.
[541] Bonomo, Medical Conclave: T2227.
[542] Bell, Medical Conclave: T2227.14-18; see also Dr Clark: T2227.5-13.
[543] Bonomo, Medical Conclave: T2227.
[544] Bonomo, Medical Conclave: T2227.14-22.
[545] Clark, Medical Conclave: T2346; see also Bonomo, Medical Conclave, T2227.
[546] Clark, Medical Conclave: T2223.

of withdrawal altogether.[547] Indeed, having regard to Veronica's physical condition, the Medical Conclave opined that medical advice would have discouraged withdrawal if she was in the community.[548]

414. According to Dr Clark, the policy restricting access to pharmacotherapy to individuals remanded in custody for at least six weeks is not clinically necessary.[549] In terms of 'equivalence', this situation would not occur in the community, and certainly not in a well-managed detoxification or substitution therapy program in the community, where a choice of pharmacotherapies is available[550] and these can be titrated to the individual's needs. Addiction Medicine specialists in the Medical Conclave highlighted that the OSTP Guidelines "need to be updated"[551] to incorporate recent developments in the treatment of opioid dependence.

415. I find that Justice Health's OSTP Guidelines in so far as they restrict access to pharmacotherapy deny prisoners equivalent care to that available in the community.

416. I also find that the OSTP Guidelines infringe prisoners' rights to be treated humanely while deprived of liberty and their right to life given the greater risk of fatal overdose upon release contrary to sections 22 and 9 of the Charter.

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[547] Clark, Medical Conclave: T2223.
[548] Clark, Medical Conclave, T2223.
[549] Clark, Medical Conclave, T2233.
[550] Bonomo, Medical Comclave: T2234.
[551] Bonomo and Clark, Medical Conclave: T2235.

417. Although I acknowledge that CCA was obliged to implement the OSTP Guidelines, I am not satisfied that the treatment available to Veronica for her opioid dependence by virtue of the OSPP was adequate to treat her withdrawal and so I find that the treatment she received constituted cruel and inhumane treatment contrary to section 10 of the Charter.

418. I am also satisfied - and I find – that because of the OSPP, Veronica did not have access to health services equivalent to those available to her in the community.

Reception Medical Assessment

Conduct of Veronica's reception medical assessment

419. Dr Sean Runacres was the rostered medical officer[552] at DPFC on 31 December 2019. At 5:21 PM, he escorted Veronica from the reception area to a clinical room in the co-located Medical Centre to conduct her reception medical assessment. CCTV captures a portion of the walk from the reception area; it is unremarkable and shows Veronica walking unassisted.[553]

420. RN Stephanie Hills met Dr Runacres and Veronica at the clinical room to assist. RN Hills recalled that Veronica had an unsteady gait and was assisted by two POs while walking down the corridor of the Medical Centre.[554] There is no CCTV footage of Veronica either walking down the corridor within the Medical Centre or of the assessment itself.

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[552] Dr Runacres was not required, nor did he hold, a specialisation as a general practitioner to perform the role of medical officer. He received a Bachelor of Medicine and Bachelor of Surgery in 2012 and had worked for CCA in some capacity since 2017: Runacres: CB236; T965.

[553] Extract: 009A.

[554] Hills: AM368, [8].

421. Both Dr Runacres and RN Hills gave evidence at the inquest about what occurred during the reception medical assessment.

422. Unlike RN Hills, Dr Runacres could not recall the assessment or how Veronica presented.[555] Indeed, he said that he relied on his clinical notes when preparing his statement in September 2020 and that his notes had not triggered any memory of Veronica.[556]

423. CCA policy requires assessing doctors to enter the results and findings of their assessment directly into an electronic MAF, which is part of the prisoner's electronic JCare file.[557] Clinicians may also enter notes into the running file notes within the JCare file (**JCare Notes**).

424. It is not disputed that parts of the MAF are pre-populated. It is also not disputed that part of Dr Runacres' initial appointment JCare notes (**Initial Appointment Notes**)[558] are also pre-populated. That is, a standard template appears on screen with pre-filled answers and these answers remain unless the clinician alters them.

425. Dr Runacres recorded Veronica's vital signs in the MAF as follows:

425.1. blood pressure: 104 mmHg;[559]

425.2. heart rate 57 bpm;

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[555] Runacres: T1006-1007.
[556] Runacres: T976-977.
[557] CB3229 [5.4]; [6.2]; [12.2].
[558] CB1749.
[559] This record is incomplete as a blood pressure measurement usual comprises of systolic and diastolic pressure measurements.

425.3. temperature 36.7;

425.4. respiratory rate 18; and

425.5. weight 40.7 kg.[560]

426. This section of the MAF was not pre-populated[561] and it is not disputed that the first four of these vital observations were performed by RN Hills and recorded by Dr Runacres. The fifth entry, the record of Veronica's weight, was the subject of dispute.

427. Dr Runacres gave evidence that he did not think these five results were indicative of unwellness or malnutrition.[562] They did not raise alarms or concerns for him.[563]

428. Dr Runacres accepted that the MAF contained the following error:

428.1. date of last opiate use entered as "31/12/19".[564]

429. Dr Runacres altered some of the pre-filled answers in the Initial Appointment Notes relating to a physical examination by entering the following:[565]

429.1. HSDNM;[566]

429.2. Chest clear good a/e to bases;[567] and

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[560] CB1761.
[561] Runacres: T1018.
[562] Runacres: T1019.
[563] Runacres: T1019.
[564] Runacres: T988; T1010.
[565] CB1749.
[566] An abbreviation used by Dr Runacres to indicate 'heart sounds dual no murmur'.

429.3. Abdo SNT.[568]

430. The Initial Appointment Notes also record that Veronica "looked generally well"; was "alert, not drowsy"; and "not toxic looking."[569] These descriptions were pre-populated and remained because they were not altered or deleted by Dr Runacres.[570]

431. Dr Runacres accepted that the following inaccurate entries remained in Veronica's Initial Appointment Notes because they were pre-filled and unaltered:

431.1. not withdrawing from alcohol or drugs;

431.2. no withdrawal scale required;

431.3. "nil" in relation to prior medical history; and

431.4. the recording of Hep B and Hep A.[571]

432. Dr Runacres accepted that there were inaccuracies in his Initial Appointment Notes[572] and did not maintain that he had taken careful and accurate notes.[573]

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[567] An abbreviation used by Dr Runacres meaning, the chest was clear and there was good air entry to the base of the lungs.

[568] This abbreviation is used by Dr Runacres to indicate the abdomen is soft and not tender. JCare assessment notes: CB1749. These notations were also made in the MAF: CB1762.

[569] Runacres: CB236; CB1749.

[570] CB2292; Runacres: T992. I note that these prefilled parts of the JCare notes are inconsistent with records made by Dr Runacres in the MAF where he records Veronica's teeth in 'poor condition' and that her frequency of dental appointments is 'irregular' and that her appearance was 'dishevelled': CB1762.

[571] Runacres: CB237; T985; T989; T997.

[572] Runacres: T1071.

[573] Runacres: T1071-1072.

433. Precisely which aspects of the medical assessment were undertaken by Dr Runacres was a matter in dispute.

434. In response to the error recording Veronica was "not withdrawing from alcohol or drugs" Dr Runacres said that he did not change the pre-populated entry because he did not believe that anyone would ever look at it.[574]

435. Nonetheless, a Short Opiate Withdrawal Scale was marked to reflect that Veronica was suffering withdrawal symptoms recorded by Dr Runacres as moderate to severe.[575] Veronica requested methadone; Dr Runacres advised her if she wanted opioid replacement therapy, she would need to make an appointment with the relevant clinic.[576]

436. In accordance with CCA policy, Dr Runacres prescribed Veronica a rapid withdrawal pack containing metoclopramide, Suboxone and paracetamol to manage opioid withdrawal.[577] This is the standard pack, with standard prescribed doses, provided to all women in custody who are withdrawing from opioids.[578]

437. Dr Runacres left no direction in the JCare file for further observation or review of Veronica.[579] He considered that, subject to administration of the medications he prescribed, Veronica was fit to leave the Medical Centre and be accommodated in an unobserved cell.[580]

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[574] Runacres: T985.
[575] CB1781.
[576] CB237.
[577] CB1787-8; Runacres: 1028-30.
[578] Hills: T689-690
[579] Runacres: T1027.
[580] Runacres: T1026-1027 and1003.

438. RN Hills said that, during the reception medical assessment, she suggested to Dr Runacres that Veronica be transported to hospital, but that Dr Runacres did not agree.[581] Dr Runacres did not recall whether RN Hills suggested that Veronica should go to hospital, but he accepted that it may have occurred.[582]

439. Veronica's reception medical assessment commenced at 5:23 PM[583] and concluded at 5:36 PM; Dr Runacres' professional consultation lasted 13 minutes.[584]

440. Three minutes later, at 5:39 PM, Veronica projectile vomited onto the floor of the Medical Centre cell in which she was placed, and again into a vomit bag.

441. At 5:44 PM[585] Dr Runacres left the DPFC precinct, 16 minutes before the end of his shift.[586]

Resolving discrepancies between the evidence of Dr Runacres and RN Hills

442. Before outlining my conclusions about the conduct and quality of Veronica's reception medical assessment, I will address the significant discrepancies between the evidence of Dr Runacres and RN Hills.

443. The dispute between Dr Runacres and RN Hills is a significant matter, one that is central to the findings I must make about Dr Runacres' assessment, care and treatment of Veronica,

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[581] Hills: AM368 [12].
[582] Runacres: T1100-1101.
[583] CB1767.
[584] CB1767. An assessment for a patient who is unwell should take between 30 and 45 minutes: T971 (Runacres); T681-682 (Hills); T2877 and T2916 (Blaher).
[585] AM866.
[586] AM793.

as well as his role, if any, in her passing. The allegations made by RN Hills are serious and may, if any or all of them are accepted, support findings with the potential to have a deleterious effect on Dr Runacres' professional reputation and livelihood. I have had particular regard to the gravity of these allegations and their possible impact upon Dr Runacres. I have also been mindful of the heightened standard of proof and greater caution required when assessing the available relevant evidence.

444. RN Hills gave evidence that during the reception medical assessment:

444.1. Veronica was not weighed because she was unable to walk to the scales; [587]

444.2. there was no assessment of Veronica's lungs with the use of a stethoscope;[588]

444.3. there was no assessment of Veronica's heart with the use of a stethoscope;[589]

444.4. Veronica was not asked to lie down to be physically examined at any stage;[590]

444.5. there was no assessment of Veronica's abdomen;[591]

444.6. there was no assessment of Veronica's teeth; [592]

444.7. there was no physical examination of Veronica's heart, chest or lungs as documented in the Initial Appointment Notes;[593]

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[587] Hills: T670.
[588] Hills: T675.
[589] Hills: T675.
[590] Hills: T676.
[591] Hills: T675.
[592] Hills: T674.

444.8. Veronica's drug use was not specifically discussed in the consultation;[594]

444.9. there was no examination of Veronica's pupils to see whether they were dilated;[595] and

444.10. Dr Runacres did not move from his chair during the assessment.[596]

445. RN Hills also observed that during the reception medical assessment, Veronica:

445.1. was complaining of vomiting and stomach pain;[597]

445.2. had vomit in her hair and on her clothes; [598]

445.3. was too unwell to sit upright in her chair and was instead draped over the right-hand side of it;[599]

445.4. appeared dehydrated;[600]

445.5. was incoherent and fading in and out of consciousness;[601] and

445.6. was not alert or orientated.[602]

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[593] Hills: T676.
[594] Hills: T680.
[595] Hills: T686.
[596] Hills: T686.
[597] Hills: AM368, [10].
[598] Hills: T690
[599] Hills: T671.
[600] Hills: T691.9-15.
[601] Hills: AM368; T690; T676.
[602] Hills: AM368, [10].

446. Dr Runacres denied these assertions. He maintained that Veronica was not unwell during his assessment of her.[603] He called RN Hills "a liar".[604]

447. Counsel for Dr Runacres submitted that the evidence of RN Hills should be treated with caution and that I should doubt her credibility and reliability on the following bases:

447.1. RN Hills' statement was taken 22 months after Veronica's passing and was drafted over a period of six months, giving her time to reconsider her narrative and change parts of it;

447.2. RN Hills made notes on or around 4 January 2020 to which she referred during a conversation with her lawyer before drafting her statement,[605] however she was unable to locate those notes for the inquest and interested parties had accordingly not had an opportunity to see them;

447.3. RN Hills' evidence about the severity of Veronica's clinical presentation is inconsistent with other evidence;

447.4. RN Hills' evidence was internally inconsistent;

447.5. RN Hills did not conduct herself in a manner consistent with someone who held the concerns she outlined in her evidence; and

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[603] With reference to his notes, that she was "alert; not drowsy and not toxic looking"; and, for example, T996.5-7; T998.3-4.
[604] Runacres: T999.
[605] Hills: T646.19-647.8.

447.6. there was a strained personal relationship between RN Hills and Dr Runacres which may have influenced the way RN Hills portrayed Dr Runacres.

448. My reasoning and conclusions in relation to each of these submissions follows.

Differences between RN Hills' draft and signed statement

449. Counsel for Dr Runacres identified seven differences[606] between RN Hills' draft statement of 21 October 2021[607] and the statement ultimately provided to the inquest on 19 April 2022,[608] to support the submission that her evidence is unreliable.

450. Counsel for Dr Runacres further submitted that RN Hills' evidence may have been affected by hindsight, given the amendments made to the draft statement and the fact that RN Hills received unspecified documents from the DPFC Medical Centre on 28 March 2022.[609]

451. Firstly, I note that RN Hills only requested access to documents when lawyers for CCA, who acted for Dr Runacres at the time, notified her that she was required to provide a statement to the coroner. CCA's lawyers offered to seek instructions to provide her with relevant medical records to help her refresh her memory on 16 October 2021.[610] RN Hills requested copies of the records on 16 December 2021 but only received them, three months

[606] The changes pointed to are: the addition of the words "I was present in the room for the assessment" at paragraph 6; the rewording of the description of Veronica's gait and assisted walk down the corridor at paragraph 8; the rewording of the description of taking Veronica's blood pressure at paragraph 9; the addition of words at paragraph 12; the deletion of words at paragraph 16 of the draft statement; the addition of words describing Veronica's medication at paragraph 20; and the addition of words describing RN Hills' handover at paragraph 21.

[607] Hills: AM383 - 385.

[608] Hills: AM367 – 370.

[609] AM791.

[610] AM791.

later, on 28 March 2022.[611] She provided her draft statement to lawyers for CCA the following day.[612]

452. I note that all clinicians who provided statements to my investigation were assisted by their notes in the JCare file. RN Hills did not have access to Veronica's JCare file at the time she commenced her draft statement. RN Hills stated that the JCarefile "was locked because it was being handed over"[613] at the time she was informed of Veronica's passing and so she had no opportunity to review the records until the offer made by CCA's lawyers roughly two years later.

453. I also note, as discussed below, that RN Hills is not to be criticized for the delay in the provision of her statement or the period over which it was initially drafted and then reviewed. I am satisfied that RN Hills sought to assist any investigation into Veronica's passing from the moment she learned of it. No delay is attributable to RN Hills.

454. As to the identified differences between RN Hills' draft and final statements, I do not consider any of the changes to be of any moment. None of the variations substantively change the meaning or import of her evidence. I consider them to be standard variations that one might expect in a drafting phase when reviewing a document drafted by a lawyer and then reviewed and signed by the person providing the evidence. Indeed, it was not

[611] Ibid.
[612] AM381.
[613] Hills: T897.28.

uncommon to see minor variations between other draft and final statements provided to the investigation.[614]

455. In my view, the amendments do not omit significant detail or change the meaning or substance of the evidence. I do not consider that they form a basis upon which I should find the evidence unreliable, or a basis upon which I should find that the evidence has shifted over time. On the contrary, RN Hills' evidence has remained consistent in its most crucial respects.

456. Accordingly, I reject the submissions of Dr Runacres' counsel on this matter.

RN Hills' notes used to prepare her statement and the purported disadvantage suffered by parties due to their unavailability

457. RN Hills gave evidence that on or around 4 January 2020 she wrote her own "reflection" of Veronica's reception medical assessment[615] and later referred to these notes during a phone conversation with her lawyer.[616] She has since lost these notes and was unable to produce them during the inquest.

458. Counsel for Dr Runacres submitted that, as the parties have not had an opportunity to view these notes, a degree of unfairness exists. It was argued that it is difficult to accept that RN Hills' draft statement subsequently needed revisions, given that she referred to

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[614] See for example, the minor changes made to the statements of CCA clinicians collected by Jeremy Limpens at time of Veronica's passing and the statements those clinicians ultimately provided to the inquest: AM1319 – 1327; Minett: AM1412 - 1414; Runacres: AM1414 – 1415;

[615] Hills: T646.19-30.

[616] Hills: T 647.

contemporaneous notes at the time of drafting it. Counsel for Dr Runacres submitted that it would be difficult for me to conclude which aspects of RN Hills' evidence were supported by her notes.

459. I do not consider that the absence of RN Hills' notes weakens her evidence in any way. I accept RN Hills' evidence that her notes were used by her in a phone conversation with her lawyer, after which her lawyer assisted her to prepare a draft statement. [617]

460. Following Veronica's passing, on 2 January 2020, Ms Fuller directed the then CCA Regional Manager Jeremy Limpens (**Mr Limpens**) to "get statements from the staff."[618] He was told to check the roster, confirm who was working, and "ask them to draft a statement as early as possible so that they [could] remember what happened."[619] Mr Limpens collected statements from all CCA staff who had interactions with Veronica between 31 December 2019 and her passing, except RN Hills.

461. Mr Limpens said "there was a preference expressed by [CCA] executive management to not collect a statement from Stephanie Hills."[620] Ms Fuller denied that this occurred.[621]

462. RN Hills testified that as soon as she was informed of Veronica's passing, she told Mr Limpens that she felt it was important she provide a statement.[622] She tried to give him a

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[617] TN 647.
[618] Fuller: T2950.27.
[619] Fuller: T2952.17.
[620] Limpens: AM1173.
[621] Fuller: T2956-2957.
[622] Hills: T884.24.

statement on two occasions, but he did not want to receive it.[623] Mr Limpens recalled meeting with RN Hills, and that she expressed concern about Veronica's health at the time of the assessment.[624] Mr Limpens confirmed that RN Hills told him that she had felt that Veronica needed to be transferred to hospital at the time of the reception medical assessment.[625]

463. Based on this history, I am satisfied that CCA could have assisted in the collection of any notes prepared by RN Hills. RN Hills' notes and statement could have been in CCA's possession from the time of Veronica's passing, if they had been collected along with the accounts of other clinicians who had direct contact with Veronica. As stated above, I am satisfied that RN Hills sought to assist any investigation into Veronica's passing from the moment that she was advised of it. The absence of her notes is not suggestive of a desire on the part of RN Hills to withhold information.

464. RN Hills' oral evidence was spontaneous and appeared to come from genuine memory and recollection. She could recall most details of the assessment and described events consistently with her statement. RN Hills also took responsibility for her failures; she acknowledged that she failed to document her concerns in detail[626] and that she did not send Veronica to hospital although it was within her power to do so.[627]

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[623] Hills: T880.12.
[624] Limpens: AM1173.
[625] Limpens: AM1173.
[626] Hills: AM369, [20].
[627] Hills: T700.3 – 5.

465. While it is unfortunate that parties are unable to view RN Hills' notes, I do not consider this to be a material unfairness. In my view, any unfairness arising from the unavailability of her notes must be in part attributable to CCA. In the absence of her notes, I have determined that RN Hills' statements should not be strengthened by their purported existence. I have determined that no additional weight should be given to any aspect of her evidence, insofar as it is suggested such evidence is derived from contemporaneous notes.

Purported inconsistencies between the evidence of RN Hills and other evidence

466. Counsel for Dr Runacres submitted that I should have doubts about RN Hills' credibility and reliability because her evidence did not align with other evidence, namely that:

466.1. the CCTV footage of Veronica walking along the corridor to the Medical Centre[628] is inconsistent with RN Hills' evidence that Veronica had an unsteady gait and required assistance as she walked along that corridor; [629]

466.2. the CCTV footage of Veronica at 5:52 PM[630] in which Veronica stands to have her photo taken is inconsistent with RN Hills' evidence that Veronica was unable to stand and walk to the scales during the medical assessment;[631]

466.3. the CCTV footage of Veronica being collected from the reception cell by Dr Runacres[632] does not appear to show vomit on Veronica's clothes and is therefore

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[628] Extract 009A.
[629] Hills: AM368, [8].
[630] Extract 014.
[631] Hills: T670.31.
[632] Extract 009.

inconsistent with RN Hills' evidence that Veronica presented to the clinical treatment room with vomit in her hair and clothes; [633] and

466.4. the CCTV footage of RN Hills' administration of Veronica's medications following the consultation[634] is inconsistent with RN Hills' evidence about the extent of Veronica's physical unwellness during the assessment.

467. To address these purported inconsistencies, I note the following:

467.1. At 5:21 PM, Veronica walked down the hallway between the reception centre and the Medical Centre with a prison officer and Dr Runacres,[635] before turning left into the Medical Centre. She then walked to the treatment room down a corridor roughly three times longer than the hallway she had already traversed.[636] There is no CCTV footage of the walk through the Medical Centre.

467.2. I do not accept the submission that it can be determined from brief, low quality CCTV footage whether Veronica had vomit in her hair or on her clothes at the time she was taken from a cell in the reception centre. In this footage, Veronica had a blanket draped over her shoulders and her long hair appeared to be tucked inside the neckline of her top.[637]

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[633] Hills: T690
[634] Extract 0016.
[635] Extract 009A.
[636] AM365.
[637] Extract 009.

467.3. At 5:37 PM, immediately following her medical reception assessment, Veronica was placed in a Medical Centre cell.[638] She sat down on the bed, slipped off her shoes and lay down on the bed in the recovery position.

467.4. Two minutes later, at 5:39 PM, Veronica projectile vomited onto the floor of the cell, and again into a vomit bag.[639]

467.5. Veronica remained lying in the recovery position on the bed. She did not sit up to take the clean vomit bag delivered by a prison officer at 5:42 PM,[640] nor did she sit up to take the paper towels delivered by a prison officer at 5:45 PM.[641]

467.6. At 5:48 PM she sat up as RPN Bester Chisvo entered the cell to assess her.[642] Veronica then used the paper towel to clean her vomit on the floor, while remaining seated. She lay down again in the recovery position 50 seconds later.[643]

467.7. Veronica remained lying down until a prison officer entered, apparently directing her to stand for a photo at 5:52 PM.[644] She stood, walked to the end of the bed, where her photo was taken before returning to the bed and lying down. She was on her feet for about 50 seconds.[645]

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[638] Extract 009B.
[639] Extract 010.
[640] Extract 011.
[641] Extract 012.
[642] Extract 013.
[643] Ibid.
[644] Extract 014.
[645] Extract 014.

467.8. At 6:03 PM Veronica, while still lying down, used the intercom to ask for some water.[646] She was told "there is a cup in there and you just need to get up and use the tap yourself." Veronica remained lying down following receipt of this information.[647]

468. Except for the 50 seconds she stood while her photo was taken, for the 30 minutes immediately following her reception medical assessment CCTV depicts Veronica lying in the recovery position or sitting to vomit or clean up vomit. Indeed, when she needed water at 6:03 PM and was told to retrieve it herself, Veronica chose to remain lying down.

469. I am not persuaded that the available CCTV footage, as described above, is irreconcilable with RN Hills' evidence that Veronica had an unsteady gait and was unable to stand and walk to the scales during her assessment. I am satisfied that Veronica appears in this footage to be very unwell, and only stood when required to do so.

470. At 6:08 PM, CCTV footage depicts RN Hills and PO Hermans entering the cell in which Veronica is placed to administer medication.[648] Veronica sat up for about one minute and forty-five seconds for this to occur, before lying down again. She appears to be told to sit up, and did so for about a further 30 seconds, before again laying down.[649] During this interaction and after Suboxone is administered, Veronica tried three times to drink from her

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[646] Extract 015.
[647] Exhibit 11 at [6:03 PM].
[648] Extract 016.
[649] Extract 016.

cup but was stopped by RN Hills or PO Hermans on each occasion. Once staff left the cell, Veronica drank from her cup without sitting up.[650]

471. When comparing the interaction described above with RN Hills' recollection of Veronica's presentation during the reception medical assessment, I note that RN Hills observed that Veronica:

471.1. had vomit in her hair and clothes, which was presumably also present in the 6:08 PM footage given that she had projectile vomited 30 minutes earlier;[651]

471.2. was complaining of vomiting and stomach pain, which is unable to be refuted in the absence of footage with audio;

471.3. was too unwell to sit up in her chair and draped over it during the 15-minute assessment, which is not inconsistent with Veronica's keenness to lie down after less than two minutes sitting up in the 6:08 PM footage, and her failure to stand and retrieve water in the 6:03 PM footage;

471.4. was incoherent, fading in and out of consciousness, not alert and not orientated, a description not inconsistent with Veronica's apparent difficulty following instructions to not drink water immediately following administration of Suboxone but which cannot otherwise be refuted without the capture of audio.

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[650] Ibid.
[651] Extract 010.

472. I also note that RN Hills evidence was given as the CCTV footage of the 6:08 PM interaction was played to her in Court. She stated, "*at that point* I would say that she was presenting the same as during the health assessment."[652] It is impossible now to determine with precision whether RN Hills was referring to a particular point in the footage at the time of giving this evidence and, if so, how Veronica appeared at that point.

473. I am therefore not persuaded by Counsel for Dr Runacres' submission that the CCTV footage relating to the 6:08 PM interaction is inconsistent with RN Hills' evidence that Veronica was presenting at this time in the same manner as she says she was during the reception medical assessment.[653]

Purported internal inconsistencies in RN Hills' evidence

474. Counsel for Dr Runacres submitted that internal inconsistencies in RN Hills' own evidence ought to give rise to concerns about her credibility and reliability. The following examples were highlighted in submissions:

474.1. in oral evidence, RN Hills first said she met Dr Runacres for the assessment outside the clinical room[654] before later saying that she could not recall whether Dr Runacres was already sitting at his desk or if he sat at the desk when Veronica came in;[655]

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[652] T901.27.
[653] T901.27.
[654] Hills: T664.18 – 31.
[655] Hills: T668.22-25.

474.2. in oral evidence, RN Hills first said that Veronica's opioid use was discussed at some point[656] before later denying that Veronica was asked about her drug use or withdrawal symptoms;[657] and

474.3. RN Hills' evidence was inconsistent and erroneous about the administration of Veronica's medication,[658] the time of RN Hills' departure from DPFC,[659] the nature of the handover she provided,[660] and her claim that she continued to monitor Veronica after Dr Runacres' departure.[661]

475. In relation to the first two submissions above, it is my view that this evidence needs to be considered more broadly and in context.

475.1. It is clear from the transcript, and the broader context of RN Hills' evidence about Dr Runacres' seated position in the clinical room, that RN Hills was not providing contradictory evidence about where she met Dr Runacres: rather, she was detailing

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[656] Hills: 680.8-9.

[657] Hills: T681.1-10; Hills: T706.26 – 27.

[658] In her statement, RN Hills estimated that she administered the oral metoclopramide to Veronica before returning later to administer suboxone between 5:30 PM and 5:45 PM, see AM369 [18]; however, both medications were administered in the same interaction after 6:00 PM, see Extract 016 and CB1789.

[659] Records from DPFC reveal that RN Hills left DPFC at 7:30 PM, see AM 867; in her statement, RN Hills said she finished her shift at 7:30 PM, see AM369 [2]; RN Hills then corrected her statement in oral evidence stating that she stayed between 8:00 PM and 8:15 PM due to a lack of staff at handover, see Hills: T646.11-14.

[660] In her oral evidence RN Hills said that she stayed back and handed over directly to the night nurse, Hills T646.11; RN Hills later accepted that it was not possible she handed over to the night nurse as Atheana George commenced her shift 20 minutes after RN Hills had left DPFC, T919.19 – 21 and AM876.

[661] Hills: T700.9 – 11.

where each party was in relation to the others once in the treatment room.[662] Indeed, the question was put, "now, *once you came into the medical suite*, Dr Sean, was he sitting behind his desk?"[663]

475.2. Likewise, RN Hills first gave evidence that she "believe[d]" opioid use was discussed at some point" while being shown an exhibit, the part of the MAF where "Opioid Abuse" was noted.[664] On the same page of the transcript of her evidence, while she was being shown the drug and alcohol history section of the MAF, RN Hills stated that details entered by Dr Runacres are incorrect and the specific matters they relate to were not discussed.[665] Her evidence was consistent that the specifics of Veronica's daily drug use and withdrawal symptoms were not discussed by Dr Runacres.[666]

476. On this basis, I do not consider that RN Hills's evidence about these matters, when considered in context, is inconsistent.

477. In relation to the third submission that RN Hills was inconsistent and erroneous about the administration of Veronica's medication, the time of her own departure from DPFC, the nature of her handover, and her continued monitoring of Veronica:

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[662] Hills: T668.22.
[663] Ibid.
[664] Hills: T680.8
[665] Hills: T680.29.
[666] Hills: T706.27.

477.1. I accept that RN Hills was mistaken about the time at which she left DPFC and the number of times she administered medication to Veronica. However, I do not consider these errors to have any meaningful impact on my overall assessment of her credibility and reliability. She conceded the errors without recanting other evidence and this, in my view, engenders confidence in her as a witness.

477.2. In her oral evidence, RN Hills accepted that she could not have handed over to the night nurse RN George because their shifts did not overlap. RN Hills had qualified her evidence by saying she could not recall to whom she handed over, before agreeing that it must have been RN George.[667] I accept that it is not clear who RN Hills conducted handover with[668] or whether she conducted handover at all, but I do not consider this renders the whole of her evidence unreliable or incredible.

478. Finally, it was submitted that RN Hills' evidence about how busy she was late in her shift[669] is inconsistent with her claim that she continued to monitor Veronica.[670] In relation to this submission, I note that the nurses' station in the Medical Centre is directly opposite the cell in which Veronica was accommodated, and its front wall is transparent. Visually observing Veronica from outside the cell would be possible even if RN Hills was occupied with the tasks she identified. Indeed, other evidence suggests a nurse in the nurses' station

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[667] Hills: T697.23.

[668] Matthew Leasing was rostered on until 8:30 PM that evening but I have no statement by him: AM 793.

[669] Hills: T896.11: "…by the time Veronica was moved from the treatment room back to a medical cell, I then had to prepare medications, prepare medication administration sheets, suboxone OSTP sheets which are completely separate, sign out suboxone, then actually administer medications whilst also managing the medical unit because we were down nurses."

[670] Hills: T700.9.

would only have to stand up to see into the cell in which Veronica was placed.[671] I do not attach much weight to this submission as it does not take matters very far.

Purported inconsistencies between RN Hills' actions and her stated degree of concern

479. Counsel for Dr Runacres submitted that RN Hills' evidence about the degree of concern she held for Veronica was effectively undermined by the fact that she left work at 7:30 PM, and did not escalate Veronica's care.

480. RN Hills accepted that the roster showed that she was paid for 12.5 hours of work without a break, concluding her shift at 8:00 PM.[672] However she conceded that DPFC gatehouse activity records confirmed she left the prison at 7:30 PM.[673]

481. I do not consider that her decision to leave half an hour early after working, understaffed, for 12 hours with no break undermines her evidence that she found Veronica's presentation to be "very concerning"[674] and thought her sick enough to warrant transfer to hospital. It was put to RN Hills that, if she really held concerns for Veronica, she would have contacted the on call medical officer before finishing her shift.[675] RN Hills responded that this was

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[671] Fenech: T590.23.
[672] Hills: T895.10.
[673] Ibid.
[674] Hills: T903.17.
[675] Ms Gardner: T913.19 – 31.

incorrect because Veronica had already been reviewed by Dr Runacres and he had overridden her suggestion to send Veronica to hospital.[676]

482. I further note that, at the time RN Hills was preparing to leave DPFC that day, Veronica would have appeared to have been sleeping under blankets in her bed for approximately one hour.[677] Of course, Veronica had used the intercom three times in that hour to complain of further sickness and vomiting.[678] However, as I will explain below, these intercom calls went to the officer's post in the Medical Centre, and there was no CV practice or procedure in place at the time requiring that such communications be relayed to clinical staff.[679]

483. I will discuss below my view that RN Hills should have transferred Veronica to hospital when she formed the view that her condition required it. However, it is sufficient for present purposes to say that I am satisfied that RN Hills sought to escalate Veronica's care initially by suggesting to Dr Runacres that she be transferred to hospital; next, by discussing with RPN Chisvo that Veronica should remain in the Medical Centre overnight;[680] and ultimately, by writing a direction to that effect in the nursing daily handover book.[681] Indeed, the decision to keep Veronica in the Medical Centre overnight is indicative of an unusual or abnormal degree

[676] Hills: T913.31.
[677] Extract 11.
[678] Extracts 020; 022; 024.
[679] Minett: T1233.13 – 29.
[680] Hills: AM369 [19].
[681] Daily handover book: AM 358.

of concern, particularly considering Dr Runacres' and other's evidence that the Medical Centre was not a place where prisoners often stayed overnight.[682]

484. Accordingly, I am not persuaded by the submission that RN Hills' actions do not reflect her stated level of concern. On the contrary, I accept that she did what she thought was best to escalate Veronica's care within the options she perceived to be available to her at that time, and now deeply regrets that she did not do more.[683]

Purported personal motivations for RN Hills' portrayal of Dr Runacres

485. Counsel for Dr Runacres submitted that I should have doubts about RN Hills' credibility and reliability because the strained relationship between her and Dr Runacres might have influenced the way she portrayed him.

486. RN Hills gave evidence that "there was a clear hierarchy between Dr Sean and how he responded to the nurses at DPFC".[684] She also said that there was particular animosity between herself and Dr Runacres which arose from an unrelated incident a few months after Veronica's passing.[685] Although Counsel for Dr Runacres sought to underscore that this incident was not explored in cross-examination, I note that Dr Runacres was represented during the inquest and his Counsel at that time did not pursue this matter.

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[682] Runacres: T1058.14 – 17.
[683] Hills: AM369 [22].
[684] Hills: T887.2 – 6.
[685] Hills: T887.11 – 12.

487. Dr Runacres gave evidence of a fractious relationship with RN Hills: he did not trust her and wrote to CCA indicating that he did not wish to work with her.[686] He detailed a prior occasion when RN Hills had become "elevated" in front of a patient when she perceived Dr Runacres was not performing a procedure correctly.[687] He also gave evidence about a different occasion when RN Hills lay on the floor of the tearoom crying and screaming.[688]

488. Clearly, there was a strained relationship between the pair. In his oral evidence, Dr Runacres repeatedly called RN Hills a liar,[689] and said he had no faith in her professionally.[690] RN Hills was much more professional when discussing their relationship. She resisted the opportunity to criticise him if she could not do so honestly.[691] She was restrained when invited to discuss their relationship.[692] There is simply no evidentiary basis for me to conclude that their strained relationship coloured RN Hills' evidence about Dr Runacres.

Dr Runacres' lack of memory

489. Counsel for Dr Runacres submitted that he should not be criticized for his lack of memory about Veronica and the reception medical assessment on the bases that:

489.1. these events occurred more than two years prior to his oral evidence;

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[686] Runacres: T1046.5 – 7.
[687] Runacres: T1098.27;1099.1 – 6.
[688] Runacres: T1099.18 – 21.
[689] Runacres: T999.9-12.
[690] Runacres: T1046.4-7.
[691] See, for example T.874.2-6 and T888.7-14.
[692] See, for example: T886.20-T887.17.

489.2. it was human experience for people to have different capacities to recall events;

489.3. a witness in court who is not comfortable giving evidence without a clear recollection or support from contemporaneous documents is not an unreliable witness but the contrary; and

489.4. Dr Runacres offered an explanation[693] that might account for his lack of recall.

490. It is unclear when Dr Runacres first heard about Veronica's passing, but he accepted that it could have been the next time he worked in the prison, or possibly within weeks. Dr Runacres recalled a meeting with Dr Blaher to discuss Veronica's cause of death after her autopsy report was available. He said, however, that even this meeting did not spark any recollection or curiosity.[694]

491. Dr Runacres stated that referring to his notes and viewing CCTV footage did not prompt any memory of Veronica either.[695]

492. While at DPFC, Veronica had interactions with several CV and CCA staff all of whom were able to give oral evidence at inquest of their recollections, some independently and some only with the assistance of their notes and CCTV footage.[696] Dr Runacres spent the most time of all DPFC staff members interacting with Veronica in person; over 13 minutes. In contrast, RPN Chisvo who assessed Veronica for roughly three minutes vividly recalled

[693] Runacres: T1070.14 – 23.
[694] Runacres: T1066.
[695] Runacres: T 980.31 – 981; T888.7 - 14.
[696] For example: Leanne Enever, Leanne Reid, Christine Fenech, Stephanie Hills, Bester Chisvo, Mark Minett, Alison Brown, Justin Urch, Michelle Reeve, Karen Heath, Tracey Brown and Atheana George.

Veronica; she was a very impressive witness who gave honest, considered and forthright evidence to which I attach significant weight.

493. Dr Runacres was also the only DPFC staff member on 31 December 2019 who maintained that Veronica was not unwell.[697] I do not accept his Counsel's submission that he should be considered a reliable witness because he was not comfortable giving evidence without a clear recollection or support from contemporaneous documents. In fact, I find his inability to provide any evidence of independent recollections to be extremely convenient, given the competing accounts of other DPFC staff members and objective evidence indicating Veronica was very unwell at that time. His evidence on this point was uncorroborated, and at times self-serving and implausible.[698]

494. I also note that on his own account, Dr Runacres' evidence was wholly reconstructed from his notes (which he ultimately admitted were unreliable)[699] and retrospectively reviewed CCTV footage (which prompted no recollection).[700]

495. On the weight of the available evidence, I am satisfied that Dr Runacres was an unreliable witness. To the extent there is inconsistency, I prefer the evidence of RN Hills.

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[697] With reference to his notes, that she was "alert; not drowsy and not toxic looking"; and, for example, T996.5-7; T998.3-4.
[698] See, for example: T1066.16-20; T1069.10-17.
[699] Ibid.
[700] Runacres: T978.

Conclusions about Veronica's medical reception assessment

496. Given my assessment of the competing evidence of Dr Runacres and RN Hills, I draw the following conclusions about Veronica's medical reception assessment.

Veronica's health at the time of reception medical assessment

497. Dr Runacres said, relying on his notes, that Veronica was not very sick at the time of her reception medical assessment:

> Yes, she's vomiting and, yes, she's withdrawing from heroin and I'm sure that's incredibly uncomfortable, but that's not very sick.[701]

498. The distinction made by Dr Runacres in evidence here is important to note. Indeed, he made the same distinction on other occasions during his oral evidence.

498.1. When referring to CCTV footage of Veronica walking to the Medical Centre he said, "that is somebody who is withdrawing from heroin, but generally well."[702]

498.2. Later in evidence, he said, "I wasn't concerned with the presentation that I saw in front of me – I saw somebody who was withdrawing from heroin that needed management of that and that I provided that management."[703]

499. Later I will canvass the impact drug-use stigma had on the quality of care Veronica received while at DPFC. For present purposes however, I highlight the problematic

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[701] Runacres: T1050.7 – 9.
[702] Runacres: T996.5 – 7.
[703] Runacres: T1086.2 – 5.

distinction made by Dr Runacres between someone who he considers 'sick' and someone who presents with a history of substance use disorder and is in withdrawal.

500. Veronica's EJustice M Rating was recorded as 'M3' by Dr Runacres at the time of her reception to DPFC.[704] This rating indicates a prisoner has a "known or suspected medical condition/ symptoms requiring appointment."[705] This is distinguished from an 'M2' rating which indicates a "medical condition requiring regular or ongoing treatment"; and an 'M1' rating which indicates a "serious medical condition/ symptoms requiring immediate assessment/ treatment".[706] This risk rating indicates that Dr Runacres did not consider Veronica's opioid dependence to be a serious medical condition or one requiring ongoing treatment.

501. The World Health Organisation has described people who use injectable drugs as the most stigmatised community on the basis of their health condition.[707]

502. Such stigma is inherent in the CCA and Justice Health policies which governed Dr Runacres' treatment of Veronica's opioid dependence:

502.1. the CCA Drug and Alcohol Assessment Policy describes patients to which the policy applies as "patients with alcohol and/or other drug *issues*";[708]

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[704] CB1767.
[705] CB3461.
[706] Ibid.
[707] R Room, J Rehm, RT Trotter II, A Paglia and TB Üstün, 'Cross-cultural views on stigma valuation parity and societal attitudes towards disability' in TB Üstün, S Chatterji, JE Bickenbach, RT Trotter II, R Room, & J Rehm, et al. (Eds.), *Disability and culture: Universalism and diversity* (Hofgrebe & Huber, 2001) 247, 247-291.

502.2. CCA and DJCS policy permits no clinical discretion in the dosage or type of opiate therapy medical officers can provide,[709] at odds with the clinical discretion a doctor would be expected to exercise in the assessment and treatment of other health conditions; and

502.3. the OSTP Guidelines apply a punitive approach to the provision of opioid pharmacotherapy,[710] in that:

502.3.1. prisoners are inhumanely not afforded the suite of pharmacotherapy that would otherwise be available to them in the community;[711]

502.3.2. most prisoners are forced into involuntary withdrawal,[712] which is not consistent with the standards of patient-informed care-giving; and

502.3.3. prisoners who do access substitution therapy may be removed from the program for non-compliance,[713] which is inconsistent with treatment of drug dependence as a health issue; treatment of any other health condition would not be withdrawn as punishment.[714]

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[708] CB1072 [2.4].

[709] Runacres: T1031.8 – 9; T1108.8 – 10; 114.5 – 9. I note that Ms Fuller (at T2345; T2350; T2353; and T2354) and Dr Blaher (T2930-2391 and T2936) gave evidence that the relevant CCA policy is a guideline to suboxone dosing not a prescription from which clinicians may diverge. If so, the policy does not convey that divergence is permitted and the evidence of Drs Runacres (T1114) and Brown (T782) suggests clinicians do not interpret in this way.

[710] Bonomo, Medical Conclave: T2309.4 – 10.

[711] Bonomo, Medical Conclave: T2227.14 – 22; Medical Conclave: T2228.8 – 10.

[712] Treloar, Medical Conclave: T2304.10 – 2305.3.

[713] Victorian OSTP Guidelines: CB1186.

[714] Clark: CB4195.

503. The assumptions underpinning these policies and the distinction Dr Runacres repeatedly made between someone sick and someone who is withdrawing from heroin are relevant to my assessment of his evidence about Veronica's clinical presentation at the time of her reception medical assessment.

504. Ultimately however, a finding that Veronica was very unwell at the time of her reception medical assessment, as RN Hills testified, is supported by the combined weight of the evidence referred to in the previous section, and the evidence that follows.

505. Supervisor Reid saw Veronica prior to her reception medical assessment and said that:

505.1. she could not complete the formal prison reception on 31 December 2019 because Veronica was too unwell;[715]

505.2. Veronica had one of the worst cases of withdrawal she had ever seen;[716]

505.3. Veronica was "very, very underweight, very lethargic" and was stooped over in what looked like stomach pain;[717]

505.4. Veronica was not engaging with staff much because she was unwell;[718] and

505.5. "everybody could see" that "Veronica was so unwell".[719]

506. SPO Fenech said she could not believe how small, frail and unwell Veronica appeared.[720]

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[715] Reid: T1362.3 – 7.
[716] Reid: T1359 – 1360.
[717] Reid: T1359.
[718] Reid: T1359.20 – 23.
[719] Reid: T1584.

507. PO Watts recalls being shocked at Veronica's emaciation.[721] She observed that Veronica was "very sick", shaking, could not stop sweating and was vomiting consistently.[722]

508. PO Hermans recalls that Veronica was extremely ill, vomiting and quite weak, though she was able to talk and stand.[723]

509. I accept that evidence of POs who are not medically trained is of limited assistance when assessing Veronica's clinical presentation at the time of her reception. However, it is of note that lay people who regularly worked in custodial settings seemingly considered that Veronica's health was particularly concerning compared to other new receptions.

510. The evidence of RN Hills and RPN Chisvo is weightier given they are registered nurses. RPN Chisvo had to conduct Veronica's psychiatric assessment in a cell 10 minutes after her reception medical assessment concluded because Veronica was actively vomiting.[724] During the psychiatric assessment, RPN Chisvo observed that:

510.1. Veronica was "visibly struggling to sit on her bed" and reported feeling "horrible, uncomfortable";[725]

510.2. Veronica told her she could not sit up for her because she was "not feeling well"[726] and that she preferred to lay down;[727] and

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[720] Fenech: T559.
[721] Watts: AM798.
[722] Ibid.
[723] Hermans: AM804.
[724] Chisvo: CB2113, [2.10]; T1160.26-30.
[725] Chisvo: CB2113, [2.10].

510.3. Veronica was "closing her eyes and not fully oriented"[728] and so she scheduled a follow up review for when she was "fully oriented and alert".[729]

511. I further note that RPN Chisvo and RN Hills' agreement that Veronica should remain in the Medical Centre overnight suggests she was suffering from an unusual degree of sickness.

512. In view of the combined weight of this evidence, and the available CCTV footage, I am satisfied that Veronica was very unwell at the time of her reception medical assessment.

Decision of Dr Runacres to record a weight in the Medical Assessment Form

513. Before outlining my findings in relation to the weight recorded in Veronica's MAF, I note the importance of accurately measuring and recording a prisoner's weight, and other physical observations, at the time of their reception medical assessment.

514. Following the assessment, the MAF becomes part of a prisoner's electronic JCare file, which is reviewed by subsequent medical officers and clinicians as a marker against which to assess the person's clinical presentation.[730] In circumstances where a person is grossly underweight and undernourished,[731] their body is "much more vulnerable to other insults."[732] Assessment and treatment of a presenting complaint will be viewed by the clinician in the

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[726] Chisvo: T1160.31 – 1161.1.
[727] Chisvo: T1164.27.
[728] Chisvo: T1163.4 – 6.
[729] Chisvo: CB2113, [2.11].
[730] Indeed, Dr Brown would review Veronica's JCare file the following morning, before making further decisions about her care and treatment. See Brown: T718.
[731] Baber: T2055.26 – 2056.
[732] Runacres: T1080.20 – 22.

light of this physical vulnerability. However, the usefulness of the prisoner's previous records to the clinician when making baseline comparisons is inextricably linked to their accuracy.

515. The MAF completed by Dr Runacres recorded Veronica's weight as 40.7 kg on 31 December 2019.[733]

516. On admission to the VIFM mortuary on 2 January 2020, Veronica weighed 33.0 kg.

517. A discrepancy in weight of 7.7kg is considerable. It is not a discrepancy convincingly explained by the presence or absence of clothing or differently calibrated scales – either singly or in combination. A discrepancy of 7.7kg is equivalent to 19% of Veronica's body weight. Dr Baber gave evidence that no weight loss that would "register in terms of kilograms" would occur post-mortem,[734] and it would not be possible for a living person to lose 7.7 kg,[735] or even five kilograms,[736] in body weight in about 36 hours. I accept Dr Baber's evidence on this point.

518. Dr Runacres, having no *general* recollection of Veronica's reception medical assessment, had no memory of Veronica being weighed; nonetheless, he insisted that she was weighed before he finalised the MAF.[737] He relied on the fact that a weight was recorded in the MAF and that he does not make up numbers.[738] He suggested that there were scales that could have

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[733] Medical Assessment Form: CB1762.
[734] Baber: T2055.7 – 8.
[735] Baber: T2055.
[736] Baber: T2079.22 – 30.
[737] Runacres: T1125.16-1126.11.
[738] Runacres: T1079.

been used to weigh Veronica in one of the clinical rooms, or in the hallway.[739] Thus, his Counsel submitted that Veronica could have been weighed before the reception medical assessment, and in the absence of RN Hills. However, Dr Runacres was clear that it was RN Hills' responsibility, as the nurse assisting him, to weigh patients.[740] He said he does not weigh "these people".[741]

519. In contrast, RN Hills did have an independent recall of Veronica's reception medical assessment and, in evidence at inquest, stated categorically that Veronica was never weighed.[742] She said that she and Dr Runacres did not discuss estimating Veronica's weight[743] and discounted the possibility that Veronica was weighed when she was not present.[744] Indeed, I received no evidence that there was another person present who could have weighed, or did weigh, Veronica.

520. On the basis of Dr Baber's evidence, I find that Veronica weighed around 33kg at the time of her reception medical assessment and that the weight recorded by Dr Runacres in the MAF was inaccurate.

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[739] Runacres: T1125.14-17.
[740] Runacres: T1079.8-13.
[741] Runacres: T1082.20.
[742] Hills: T670; T673.18-22.
[743] Hills: T673.18-22.
[744] Hills: T886.1-2.

Decision of Dr Runacres to record physical assessment notes in Veronica's JCare file

521. In Veronica's MAF and the Initial Appointment Notes, Dr Runacres recorded that Veronica's heart had no murmur, her chest was clear with good air entry to the base of the lungs, and her abdomen was soft and not tender.[745] These notations reflect an alteration to the Initial Appointment Notes pre-populated template so Dr Runacres entered them himself.

522. RN Hills and Dr Runacres agreed that each of these physical assessments are performed by a doctor and not a nurse.[746] RN Hills stated unequivocally that Dr Runacres did not, while in her presence, conduct any physical examination of Veronica.[747]

523. Counsel for Dr Runacres submitted that RN Hills' evidence in this respect should not be accepted because she was not sure what SNT or HSDNM meant.[748] I do not accept that RN Hills cannot give evidence regarding the physical examination simply because she did not understand the abbreviations. She was honest to concede that she was not familiar with the acronyms and when giving evidence she was able to describe how each examination would be performed.[749]

524. Dr Runacres conceded that he did not take care to ensure that his notes in Veronica's JCare file were accurate.[750] Even though he had no independent recollection of Veronica's

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[745] Medical Assessment Form: CB1762; Initial Appointment Notes: CB1749.
[746] Hills: T675; Runacres: T998.
[747] Hills: T675.
[748] Hills: T675.27-676.1-3.
[749] Hills: T674.31-676.28.
[750] Runacres: T985; and generally acknowledging inaccuracies in his records - Runacres: T997.

reception medical assessment,[751] he was adamant that he does not make up data.[752] Dr Runacres stated that because he had to enter the relevant notations, this fortified him in his belief that he conducted the physical assessments. [753]

525. Counsel for Dr Runacres submitted that there was sufficient time for a physical examination to have been conducted when Dr Runacres attended the reception cell wearing his stethoscope at 5:17 PM.[754] However, in evidence, Dr Runacres said that he would never touch a female patient for any reason without a female nurse present. [755] No female nurse was present at 5:17 PM. Dr Runacres accepted when giving evidence that he was only in the cell with Veronica for one minute and 34 seconds at 5:17 PM and stated that not "very much"[756] could have occurred in that time.

526. In light of that evidence, it is not open to me to find that Dr Runacres could have conducted physical examinations while in the reception cell.

527. I also consider that it is not open to me to find that the examinations (including an abdominal examination of the patient whilst lying down)[757] could have occurred at any

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[751] Runacres: T1097.28-31; T1115.20-22
[752] Runacres: T1020.
[753] Runacres: T999.20.25.
[754] Extract 008.
[755] Runcares: T1092.7-11.
[756] Runacres: T1092.28-29.
[757] Runacres: T999.4 – 8.

location between 5:21:47 PM when Veronica left the reception centre corridor,[758] and 5:22 PM when Dr Runacres first opened the JCare file in the clinical room.[759]

528. On the basis of the evidence canvassed above, I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment Notes by Dr Runacres.

Decisions not to transfer Veronica to hospital

529. During the reception medical assessment, RN Hills expressed concerns about Veronica's presentation to Dr Runacres and told him that she thought Veronica should be transferred to hospital, but Dr Runacres did not agree.[760] RN Hills says Dr Runacres told her to "stay in her place".[761]

530. RN Hills said that a patient who required regular nursing observations at DPFC needed to be transferred to hospital,[762] and that it was unusual for someone to stay in the Medical Centre overnight.[763] RN Hills said she did not want to undermine Dr Runacres by calling an ambulance in front of him but conceded that she could have called an ambulance after he left,

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[758] Extract 009A.
[759] Runacres: T1035.17 – 1036.3.
[760] Hills: AM368.
[761] Ibid.
[762] Hills: T878.2 – 9.
[763] Hills: T695.1 – 12.

given her concerns.[764] She accepted that she had the power to arrange Veronica's transfer to hospital and deeply regrets that she did not exercise it.[765]

531. Dr Runacres did not recall whether RN Hills suggested that Veronica should go to hospital, but accepted both that it may have occurred[766] and that there was a great possibility that Veronica would have lived if he had followed RN Hills' advice.[767] Dr Runacres testified that he did not consider it necessary to transfer Veronica to hospital before the medications he prescribed had been administered.[768] Again, relying only on his notes, Dr Runacres maintained that Veronica was well enough to be moved into the main part of the prison and did not need to go to hospital.[769]

532. I am satisfied that RN Hills attempted to advocate for Veronica's transfer to hospital on 31 December 2019 and based on the advice of the Medical Conclave, that it was reasonable to have done so.[770] I also acknowledge that RN Hills' efforts to advocate for Veronica's transfer to hospital occurred within the context of a power dynamic in which the clinical judgement of a doctor is preferred.

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[764]Hills: T700.3 – 5.
[765] Hills: AM369, [22].
[766] Runacres: T1100-1101.
[767] Runacres: T1124.2.
[768] Runacres: T1049.31 – 1059.11
[769] Runacres: T1003.7 – 18.
[770] Medical Conclave: T2119 – T2120; Dr Milner, Medical Conclave: T2123; see also Clark, Medical Conclave: T2205.27 – 29.

Findings in relation to Dr Runacres' treatment and care of Veronica

533. In making findings about the adequacy of Dr Runacres' reception medical assessment, I have had regard among other things to:

533.1. the additional and unique burdens on medical professionals practicing in the custodial setting;[771]

533.2. the assumption that health practitioners go to work with the intention to do good and not harm;[772]

533.3. the fact that the severe deterioration in Veronica's condition cannot of itself render an otherwise adequate assessment inadequate; and

533.4. the standard of proof required to make adverse findings about a professional's conduct.

534. I received extensive submissions on behalf of Dr Runacres, and his employer CCA, opposing any finding that would suggest inadequacy of his care and treatment of Veronica. These submissions proceeded on the basis that his Initial Appointment Notes and the MAF were accurate and that a physical examination was performed. They also refer to expert evidence which relies on the same assumptions.

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[771] For example, the consensus view shared by Dr Walby at T2374.30-2375.14; other comments made by Dr Milner at T2256; AM1331-1332.

[772] Walby, Medical Conclave, T2375.3-6.

535. The Medical Conclave saw the case for Dr Runacres' proficiency of service at its highest because:

535.1. the Medical Conclave was provided with the MAF, Initial Appointment Notes, statements of other DPFC staff members, audio-visual evidence and other materials;

535.2. the Medical Conclave's opinion assumed that the MAF and Initial Appointment Notes were accurate, and that the examinations recorded were conducted;

535.3. the Medical Conclave assumed Veronica's weight at reception medical assessment was accurately recorded as 40.7kg;

535.4. the Medical Conclave was not provided with transcripts of oral evidence or any findings of fact adverse to Dr Runacres; and

535.5. Dr Runacres' credibility and reliability were not called into question.

536. Notwithstanding that it saw Dr Runacres' conduct at its highest, when asked to provide an opinion about the adequacy of Dr Runacres' reception medical assessment the Medical Conclave unanimously[773] held the following concerns:

536.1. his notation was inadequate and at times inaccurate;[774]

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[773] Brunner, Medical Conclave: T2133.26
[774] Brunner, Medical Conclave: T2133; 2134.

536.2. he took an inadequate history,[775] and in particular, failed to make enquiries of Veronica's previous vomiting;[776]

536.3. he failed to conduct a cultural assessment;[777]

536.4. he failed to acknowledge Veronica's frailty;[778]

536.5. he failed to make a forward plan for Veronica's management which should have "at least" included observation;[779] and

536.6. he failed to resolve the difference of opinion with RN Hills about Veronica's need for hospitalisation, and this did not reflect well on Veronica's care.[780]

537. A majority of the Medical Conclave concluded that the assessment and treatment as recorded by Dr Runacres was inadequate.[781] There was, however, a minority view that Dr Runacres' assessment and treatment was adequate.[782]

538. As to the adequacy of Dr Runacres' medical treatment, some members of the Medical Conclave concluded that, given her recorded weight of 40.7kg and history of vomiting alone, Veronica should have been transferred to hospital at the time of her reception medical

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[775] Brunner, Medical Conclave: T2137.
[776] Brunner, Medical Conclave: T2134.
[777] Brunner, Medical Conclave: T2134.
[778] Brunner, Medical Conclave: T2134.
[779] Brunner, Medical Conclave: T2135.
[780] Brunner, Medical Conclave: T2134-2135.
[781] Brunner, Medical Conclave: T2137.
[782] Brunner, Medical Conclave: T2133.26.

assessment.[783] Other members of the Medical Conclave opined that, considering the information available to him, Dr Runacres' decision not to transfer Veronica to hospital at that time was not unreasonable.[784] I note that the latter view assumed access to specialist medical support and the ability to monitor a patient closely.[785]

539. In light of the above, I am satisfied that:

539.1. Dr Runacres' reception medical assessment of Veronica was not comprehensive and his records of it were inaccurate;

539.2. Dr Runacres provided no plan for Veronica's ongoing management and ought to have done so;

539.3. Veronica was unwell at the time of her reception medical assessment and her presentation warranted transfer to hospital.[786]

540. I find that Dr Runacres' medical assessment and treatment of Veronica on 31 December 2019 was inadequate. Dr Runacres' failure to physically examine Veronica, plan her ongoing care and maintain accurate records are significant departures from reasonable standards of care and diligence expected in medical practice.

541. Dr Runacres was the health professional responsible for identifying at reception whether Veronica was fit to be held in an unobserved cell.[787] The reception medical assessment is

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[783] Brunner, Medical Conclave: T2135.9-13.
[784] Frei, Medical Conclave: T2137.24 – 2138.24.
[785] Frei, Medical Conclave: T2138-2139.
[786] Clark, Medical Conclave: T2205.13 – 30.

intended to be a comprehensive health assessment and offered the best opportunity in the prison reception process for the extent of Veronica's unwellness to be identified, recorded, treated and escalated. Dr Runacres' failure to properly utilise this opportunity set in motion a chain of events in which her medical treatment and care was inadequate in an ongoing way.

542. I find that Veronica should have been transferred to hospital at the time of her reception to DPFC, and that CV and CCA staff continually failed to transfer her to hospital thereafter, and this ongoing failure causally contributed to her death.

Forensicare Psychiatric Assessment

543. At 5:48 PM, RPN Chisvo conducted Veronica's initial psychiatric assessment.[788]

544. RPN Chisvo's assessment was conducted in Veronica's cell because she was actively vomiting.[789] RPN Chisvo observed that Veronica was struggling to sit up and reported feeling 'horrible, uncomfortable, I'm withdrawing'.[790] She said that Veronica was not talking fully and did not appear fully orientated.[791]

545. RPN Chisvo arranged for an urgent GP referral for review of Veronica's withdrawal symptoms and for another psychiatric nurse to review her in 24 hours when she anticipated Veronica would be fully oriented, alert and sober.[792]

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[787] Runacres: T1079.4 – 7.
[788] CB1767; Extract 013.
[789] JCare Notes: 1748.
[790] Chisvo: CB2113; JCare Notes CB1748.
[791] Chisvo: T1162.8-14.
[792] Chisvo: CB2113-4; JCare Notes: CB1748-9.

546. RPN Chisvo formed the view that Veronica's withdrawal symptoms were so severe that she needed to remain in the Medical Centre overnight.[793] RPN Chisvo documented this recommendation on the Mental Health Assessment form she completed and provided to CV staff.[794]

547. RPN Chisvo testified that she relayed her concerns about Veronica to Senior Prison Officer Fenech, RN George, and possibly another clinician whom she could no longer identify.[795]

548. I find that the psychiatric assessment and care provided to Veronica by Forensicare at DPFC on 31 December 2019 was reasonable and appropriate in the circumstances.

Decision to keep Veronica in the Medical Centre overnight

549. RN Hills said that completion of Veronica's reception medical assessment effectively meant that she was "cleared" by Dr Runacres out of the Medical Centre.[796] Dr Runacres agreed.[797]

550. RN Hills said that she spoke to the CV officer-in-charge of the Medical Centre following Veronica's assessment and advised that Veronica was too unwell to be sent to the Yarra Unit.[798] She said she advised the officer that Veronica was to have regular nursing

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[793] Chisvo: T1165-6.
[794] Psychiatric Assessment Form: CB2026.
[795] Chisvo: T1168; 1181; 1207.
[796] Hills: AM369 [19].
[797] Runacres: T1079.4 - 7; T1033.
[798] Hills: AM369, [19].

observations and regular checks by POs.[799] RN Hills left a note in the nurse's handover book that Veronica was to be kept in the Medical Centre overnight and wrote: "vomiting ++".[800] However, I note that on the medical assessment form provided to CV staff, the only direction was to notify health staff "if unwell".[801]

551. RPN Chisvo recommended that Veronica "stay in medical due to severe heroin withdrawal symptoms."[802] RN Hills said that she also spoke with RPN Chisvo, who agreed with the decision to keep Veronica in the Medical Centre overnight.[803]

552. RN Hills made no entry into Veronica's JCare file. There is no documentary evidence that she arranged for either nursing checks or for CV staff to observe Veronica.

553. Supervisor Reid said that she decided to keep Veronica in the Medical Centre overnight because she was too unwell to be moved to the Yarra Unit.[804] Supervisor Reid cannot recall whether Veronica had been medically cleared when she made this decision and she cannot recall which nurse she spoke to about it.[805] In making the decision, she did not have access to Veronica's medical file but had the necessary medical and psychiatric assessment forms

[799] Hills: AM369, [19].
[800] Hills: AM369; nurse handover book: AM358.
[801] Hills: CB2025.
[802] Psychiatric Assessment Form: CB2026.
[803] Hills: AM369, [19].
[804] Reid: CB2022; T1353-1354.
[805] Reid: T1362-3; T1366-7.

which confirmed that assessments had been completed.[806] She said that her decision was for Veronica to stay overnight "pending a medical clearance."[807]

554. How the decision to keep Veronica in the Medical Centre overnight was made is unclear. It is clear, however, that various CV, CCA and Forensicare staff were sufficiently concerned by Veronica's physical presentation that they individually if not collaboratively determined she was unfit to be transferred to the Yarra Unit, the area of the main prison where newly received prisoners are placed.

Medical Centre

Systems interface

555. An unwell prisoner occupies a liminal space between two systems, the carceral and the clinical. Although the operators of each system have distinct functions in a prison, they both owe the prisoner a duty of care; discharge of the duty owed by each to an unwell prisoner requires the carceral and clinical systems to interface effectively. Three interface points are of special significance to the investigation into Veronica's passing: information exchange, prisoner transfer and the Medical Centre itself. It is useful to consider how these interface points functioned in practice, given the dearth of policy or procedures governing them.[808]

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[806] Reid: T1365-1366.
[807] Reid: T1522-1523.
[808] The policies produced by CV and CCA were voluminous but, save for a few references to 'shared obligations' and the need for timely notification of certain events, there was scant acknowledgement that the carceral and clinical systems interacted at all.

Information Exchange

556. Dr Bonomo of the Medical Conclave observed that a team approach to care is required in the custodial healthcare setting.[809] This is because it is essential to have a clear clinical picture so that appropriate care, and if necessary escalation of care, may be provided.[810] Communication between health and custodial staff is paramount to a prisoner's clinical management in custody.[811]

557. Apart from limits on the release of a prisoner's health information to CV staff unless necessary and the availability of forms on which to note health information[812] or instructions, there was little evidence of a 'system' to facilitate information exchange between CV and CCA. In Veronica's case, CCA staff were not informed of critical features of Veronica's clinical presentation which were known to the CV staff who received her intercom communications. The reverse was also true: CV staff were not adequately informed by CCA staff of Veronica's condition or the degree to which she was unwell. Information was neither sought by CCA staff, nor volunteered by CV staff, and vice versa.

558. In addition, I received extensive evidence about a poor working relationship between the two entities:

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[809] Br Bonomo, Medical Conclave, T2221.12-18.
[810] Dr Bell, Medical Conclave, T2221.1-7.
[811] Dr Bonomo, Medical Conclave, T2221.10-11.
[812] See for instance, Local Plan File Notes used by CV to note among otherthings 'issues of concern': CB695; and, Prisoner Health Summary (Reception) - Medical Assessment Form used to identify for CV staf when to 'notify health staff': CB2025.

558.1. Mr Limpens identified "cultural problems between CCA staff and Corrections staff that prevented them from working effectively together to attend to women's health that required prompt health issues (sic)";[813]

558.2. Supervisor Reid said that CV staff discussed concerns about the healthcare provided by CCA;[814] that there were occasions on which CV staff requested assistance from a CCA nurse but were repeatedly told that the medical staff were too busy;[815] and occasions when CV staff called a 'Code Black' simply to get a medical response;[816]

558.3. Dr Blaher acknowledged that CCA staff may find it difficult to escalate issues in the face of resistance from custodial officers[817] and indicated that they fear pressing for their patient's welfare in the face of custodial pressures;[818]

558.4. Governor Jones said that there had been challenges with CCA in the past few years and CV staff had lost faith in the health service provider.[819] She said she had raised these concerns with CCA and then escalated them to Justice Health[820] but that, until

[813] Limpens: AM1174
[814] Reid: T1504.
[815] Reid: T1545.
[816] Reid: T1545-1546.
[817] Blaher: T2874.
[818] Blaher: T2875.
[819] Jones: T2739.
[820] Jones: T2741.

recently, there had been a breakdown in communication between the two organisations.[821]

559. These issues speak broadly to a disconnect between CV and CCA staff: gaps in communication staff compromised Veronica's care.[822]

The process for transfer out of the Medical Centre

560. CV is responsible for prisoner placement and movement within DPFC.[823]

561. At the time of Veronica's remand, there was no requirement that a medical officer positively document that a prisoner is fit to be transferred to a mainstream prison cell before that transfer occurred.[824] Likewise, there was no formal requirement that CV staff seek confirmation from a medical officer that a prisoner is fit before moving her to a mainstream cell.[825]

562. Relevantly, at reception, the default position was that the prisoner was effectively 'cleared' for transfer to the mainstream reception unit, Yarra Unit, once her reception medical assessment by CCA, psychiatric assessment by Forensicare, and a reception assessment by a

[821] Jones: T2739.
[822] See for example, Dr Brown's evidence that surrounding information would have come into her judgement had she been aware of it, Brown: T747.
[823] Reid: T1352.
[824] Reid: T1603.
[825] Reid: T1603.

CV officer were completed.[826] Completion of these three assessments gave rise to the assumption that a prisoner was suitable for placement in a mainstream cell.[827]

563. There was confusion amongst CCA clinicians about their role in the transfer/clearance process, both that occurring at reception and subsequently. As mentioned above, Supervisor Reid placed Veronica in the Medical Centre overnight on 31 December 2019 because she was too unwell to be moved to the Yarra Unit but anticipated she would only be transferred after 'medical clearance'. As will be seen, notwithstanding Supervisor Reid's expectation, there is no record of Veronica having been 'cleared' by a clinician, yet she was transferred to Yarra Unit on 1 January 2020.

The Role of the Medical Centre

564. The lack of a formal process for transfer out of the Medical Centre was compounded by an underlying confusion about the nature and purpose of the DPFC Medical Centre. Although most witnesses referred to the Medical Centre as such, CCA's Ms Fuller and Dr Blaher referred to the facility as the 'Health Centre'.[828]

565. Even though the cells in the Medical Centre are known as "wards"[829] and have a translucent wall to facilitate observation, Dr Blaher testified that those cells were not an appropriate location to manage the healthcare of a woman who was too unwell to go to their

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[826] Reid: T1515.28.
[827] Blaher: T2858.12-22.
[828] Blaher: T2856; CB2116.
[829] AM365 – 366.

unit.[830] He stated that women requiring such health care should be sent to hospital.[831] Indeed, the evidence was that there is no acute or subacute inpatient or other bed-based care at DPFC.[832]

566. It is clear that the role of the Medical Centre and the cells therein was not understood by the staff of CV nor all CCA clinicians who gave evidence at the inquest. Ms Fuller accepted that this "blurriness" played a role in the care that Veronica received.[833]

Health Ward Two

567. At 6:08 PM on 31 December 2019, Veronica received her first doses of Suboxone and metoclopramide from RN Hills who was accompanied by PO Hermans.[834]

568. Between 6:30 PM and 7:00 PM, Veronica used the intercom four times to report feeling unwell and vomiting.[835] In the 10 minutes before 7:00 PM, Veronica vomited three times. No one came into her cell to check on her.[836]

569. At 8:00 PM, RN George commenced her shift as the nurse on duty at DPFC overnight.[837]

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[830] Blaher: T2855.
[831] Blaher: T2855
[832] Fuller: CB2115.
[833] Fuler: CB2116.
[834] Extract 016; CB1789; CB1804.
[835] Extract 018; Extract 020; Extract 022; Extract 024.
[836] Extract 021; Extract 023; Extract 025.
[837] George: T1689; AM793; AM876.

570. It is understood that between midnight and 7:00 AM on 1 January 2020, Veronica was communicating with PO Adrian Cole (**PO Cole**) who was stationed in the officer's post in the Medical Centre.[838]

571. At 12:35 AM on 1 January 2020, Veronica used the intercom to request a cup of cordial,[839] and one was delivered to her through the trap in the cell door at 12:36 AM.[840]

572. At 3:21 AM, Veronica projectile vomited into the air while lying on her back in bed.[841] The vomit landed on her pillow, blankets, hair and on the floor of the cell. She used the intercom to alert PO Cole and was told there would be people in to clean up in the morning.[842]

573. At 5:42 AM, Veronica used the intercom to ask for the time. At 6:08 AM she requested cordial, explaining that she had vomited into the cup of cordial she had; she was told that no one could bring her anything.[843]

574. At 6:11 AM, Veronica asked for the time.[844] At 6:37 AM, she asked for a drink and was told that she could not have a drink until more staff arrived.[845] At 6:51 AM, Veronica asked

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[838] AM363; AM394; Reid: T1556.11.
[839] Extract 026.
[840] Extract 027.
[841] Extract 028.
[842] Extract: 029.
[843] Extracts: 030; 031.
[844] Extract 032.
[845] Extract: 033.

for socks because her feet were cramping. PO Cole told her there was nothing he could do until other officers arrived, stating that otherwise "I'd try and help you".[846]

575. At 6:53 AM, Veronica was delivered socks and cordial through the trap in the cell door.[847]

576. PO Cole was replaced on post by PO Victoria Sonda (**PO Sonda**) and PO Michelle Kay (**PO Kay**) from 7:00 AM.[848]

577. Between 7:00 AM and 8:10 AM, Veronica used the intercom five times to request either a drink or the time, and to report bad cramps.[849] She was told she could not be brought a drink, that a nurse would be informed about her cramps, and that the intercom was "for emergencies only".[850]

578. At 8:15 AM, Veronica received a breakfast pack which included a drink.[851]

579. At 8:32 AM, Veronica walked around her cell, appearing uneasy on her feet.[852] Moments later, she used the intercom to exclaim in a distressed tone, "I have bad cramps."[853] A PO responded, "Yeah, we've told the nurse".[854]

580. At 8:43 AM, Veronica received metoclopramide and paracetamol through the trap in the cell door.[855]

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[846] Extract 034.
[847] Extract 035.
[848] AM396; Reid: T1556.12 – 14.
[849] Extracts: 036; 038; 039; 040; 041.
[850] Ibid.
[851] Extract 043.
[852] Extract 044.
[853] Extract 046.
[854] Ibid.

581. At 8:46 AM, Veronica was asked to get up so that she could be escorted to a clean cell.[856]

582. At the time she was moved from Ward Two, Veronica had been lying in a vomit-ridden cell for over 15 hours.

Health Ward One

583. At 8:46 AM, Veronica was moved to Health Ward One.[857] She walked the roughly six steps to the clean cell independently.

584. At 8:51 AM, Veronica projectile vomited into her blanket,[858] and used the intercom to inform a PO that she had "spewed all over [the] bed."[859] Two minutes later, a CCA nurse entered the cell, inspected the blanket and left without removing the contaminated item.[860]

585. Twenty minutes later, Veronica asked for a drink and was told, "we're trying to get you some cordial."[861] At 9:20 AM, Veronica reported vomiting again and was told there wasn't much the POs could do; they were waiting for "bio-clean" to come in, and for the doctor to see her.[862]

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[855] Extract 047; CB1789.
[856] Extract 048; 049.
[857] Extract 049.
[858] Extract 050.
[859] Extract 051.
[860] Extract 052.
[861] Extract 053.
[862] Extract 054.

586. At 9:32 AM, Veronica asked how long it would be until she could see the doctor and was told, “not sure.”[863] She asked whether she could have a drink,[864] and a drink was provided through the trap in the cell door a few minutes later.[865]

587. At 9:50 AM, Veronica asked whether the doctor was going to be much longer and was told the doctor wouldn’t be in until 10:00 AM.[866] She asked for the time, and was told it was ten minutes to ten. Veronica was told to be patient because the doctor would have to read their notes first before seeing her.[867]

588. At 10:08 AM, Veronica asked for the time.[868] She was told it was ten past ten, to which she replied, “is the doctor in?” She received no response.[869]

589. Three minutes later, Veronica projectile vomited again into her blanket.[870] Veronica used the intercom to ask, “when’s the doctor gonna see me?”[871] A PO responded, “it’s not an emergency, stop asking.”[872]

590. At 10:21 AM, Veronica was given Suboxone through the trap in the cell door.[873]

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[863] Extract 056.
[864] Ibid.
[865] Extract 057.
[866] Extract 058.
[867] Ibid.
[868] Extract 059.
[869] Ibid.
[870] Extract 060.
[871] Extract 061.
[872] Ibid.
[873] CB1804; Extract 062.

591. At 10:39 AM, Veronica used the intercom to ask if she could see the doctor yet. [874] When the PO responded, "no," Veronica pointed out that she had been told previously it would be ten minutes. The PO responded, "well, things don't always go to plan, so I will let you know when the doctor's here and ready to see you, ok?"[875]

First assessment by Dr Brown and RN Minett

592. At 10:48 AM, Veronica was seen by RN Minett and Dr Brown in Health Ward One.[876] The assessment was conducted in the cell, rather than a clinical room, because Veronica was unwell.[877]

593. When RN Minett arrived at DPFC at 7:30 AM on 1 January 2020,[878] he received a verbal handover from a nurse on duty, but not from the night nurse.[879] RN George had left at 6:30 AM.[880] The handover he received was brief and to the effect that a person (Veronica) was held overnight in the Medical Centre and reportedly withdrawing.[881] He was told that the patient had been vomiting but was provided no details and so he was unaware of the number of times Veronica had vomited.[882] RN Minett was also not told Veronica had reported

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[874] Extract 063.
[875] Ibid.
[876] Extract 064.
[877] Minett: T1232.18-21.
[878] AM793-1. Although RN Minett has been on shift on 31 December 2019 at DPFC he was not aware that Veronica had been in the Medical Centre or that she had been vomiting: Minett: T1223-4.
[879] Minett: T1224-5.
[880] AM793.
[881] Minett: T1225.
[882] Minett: CB242; T1225-6.

cramping, how many times she had requested a drink overnight, nor of her requests to see a doctor.[883]

594. Dr Brown arrived at DPFC at 10:00 AM.[884] Though she had worked for CCA previously,[885] it was her first time working at DPFC.[886] She was filling a vacancy in the roster and, as a result, is likely to have received a local orientation but would not have received a full induction.[887] RN Minett showed Dr Brown around the reception centre and Medical Centre.[888]

595. Before seeing Veronica, Dr Brown reviewed Veronica's JCare file.[889] The only other information Dr Brown recalls receiving about Veronica was from RN Minett.[890] Dr Brown recalls being advised that there was a patient who was vomiting and had diarrhoea.[891]

596. During the assessment, Veronica told Dr Brown that she had vomited several times overnight and Dr Brown observed that Veronica was very thin.[892] She observed Veronica's tongue to be a little dry and examined her abdomen, noting it was soft, not tender.[893] She noted that Veronica was "alert and oriented, not unwell".[894] Dr Brown accepted, after

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[883] Minett: T1230.
[884] AM793-1.
[885] Fuller: T2172.16 – 20.
[886] Brown: T726.23.
[887] Fuller: T2172.21 – 2173.16.
[888] Brown: T788.31 – 789.5.
[889] Brown: T718.
[890] Brown: T718.
[891] Brown: T722.
[892] Brown: CB238-239; Extract 079.
[893] Brown: CB239; JCare Notes: CB1748.
[894] JCare Notes: CB1748.

reviewing the CCTV footage, that Veronica looked unwell, but in her view, not significantly unwell.[895]

597. Veronica reported that she felt better after taking Suboxone, that her nausea had subsided and she had had no more diarrhoea.[896] Veronica denied any dizziness, chest pain and abdominal pain.[897]

598. The following vital signs were recorded in the JCare Notes by Dr Brown:

598.1. blood pressure 109/70 mmHg;

598.2. heart rate 123 bpm;

598.3. temperature 37.5; and

598.4. blood oxygen levels 98%.[898]

599. Dr Brown's notes of this assessment were the last clinical notes recorded in Veronica's JCare file before she passed.

600. Although in his statement RN Minett wrote that he considered Veronica's vital signs to be unremarkable,[899] in oral evidence he acknowledged that Veronica's heart rate was above a normal rate.[900] Dr Brown acknowledged that Veronica's heart rate was fast and that this can

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[895] Brown: T732.
[896] Brown: CB238, [8].
[897] Brown: CB238, [6].
[898] JCare notes: CB1748.
[899] Minett: CB242.
[900] Minett: T1220.

be a sign that a person is extremely unwell.[901] Dr Brown agreed that it was an "extraordinary" rise in heart rate, from 57 bpm the previous day, but that it did not cause "alarm bells" for her.[902] She considered that opioid withdrawal or dehydration were the most likely precipitants for the tachycardia and did not consider that Veronica's heart rate necessarily required transfer to hospital.[903]

601. Dr Brown considered that Veronica's symptoms were consistent with withdrawal from opiates, but also that she might have gastroenteritis or another medical condition.[904] Dr Brown was fairly confident that there was no surgical basis for Veronica's symptoms.[905]

602. Veronica requested methadone, which she told Dr Brown provided greater relief of her withdrawal symptoms.[906] Dr Brown informed Veronica that she was not authorised to prescribe methadone.[907]

603. Dr Brown prescribed an intramuscular form of the anti-emetic metoclopramide to treat nausea and vomiting. She also prescribed esomeprazole to alleviate nausea.[908] Dr Brown requested pathology tests but was informed that these were unable to be conducted because it was a public holiday.[909]

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[901] Brown: T733.
[902] Brown: T737; T741.
[903] Brown: T735.9-31.
[904] Brown: CB238, [7].
[905] Brown: T729.14-18.
[906] CB238.
[907] CB239.
[908] Brown: CB239.
[909] Brown: CB239.

604. At 10:56 AM, Dr Brown and RN Minett left Veronica's cell; the consultation lasted approximately seven minutes.[910]

605. At 10:59 AM, RN Minett returned to take a sample of Veronica's urine for testing and performed a random blood glucose test.[911] Veronica recorded a random blood glucose level of 9.7mmol/L which Dr Brown noted was slightly above the normal range but not significantly high and thus not indicative of symptomatic diabetic hyperglycaemia or diabetic ketoacidosis.[912]

606. At 11:05 AM, RN Minett returned to give Veronica electrolytes.[913]

607. Following this, Dr Brown entered her notes in Veronica's JCare file. She included a direction that a nursing review be performed later in the afternoon when Veronica's vital observations should be repeated.[914] This review did not occur.

607.1. RN Minett does not recall a conversation regarding a further review but accepted that it should have occurred and that the failure to do so was a missed opportunity to assess Veronica for signs of deterioration.[915]

607.2. Dr Brown also accepted that it would have been reasonable for her to have followed up with RN Minett about Veronica's condition in the afternoon.[916]

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[910] Extract 064.
[911] Extract 065.
[912] Brown: CB239.
[913] Extract: 066.
[914] JCare notes: CB1748.
[915] Minett: T1245-1246.

608. At 11:12 AM, roughly five minutes after being given electrolytes by RN Minett, Veronica projectile vomited across the cell floor.[917] She used the intercom to inform a PO that she had "spewed up everywhere" and was told "yep, no worries."[918]

609. Five minutes later, Veronica was moved to Health Ward One. At the time of being moved on this occasion, she had been lying on a bed in a cell next to a vomit-ridden blanket for over two and a half hours.

Health Holding Cell One

610. At 11:18 AM, Veronica entered Health Holding Cell One. Health Holding Cell One has no bed, only a toilet and a bench. Veronica lay down on the bench holding a vomit bag.[919] At 11:26 AM, she sat up and vomited into the vomit bag, and vomited again two minutes later.[920]

611. At 11:31 AM, RN Minett administered a metoclopramide hydrochloride injection to assist with Veronica's nausea and vomiting.[921]

612. At 11:35 AM, Veronica was moved to Health Holding Cell Two.

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[916] Brown: AM1418.
[917] Extract 067.
[918] Extract 068.
[919] Exhibit 11, Health Holding Cell 1.
[920] Ibid, at [11:26] and [11:28].
[921] Extract 070; Minett: CB243; CB1789.

Health Holding Cell Two

613. Health Holding Cell Two does not contain a bed either; however, a PO had placed a mattress on the floor before Veronica arrived. Upon entering the cell, Veronica laid on the mattress on the floor holding a vomit bag.[922]

614. At 11:37 AM, six minutes after receiving her metoclopramide hydrochloride injection, Veronica vomited into a vomit bag.[923] The CCTV footage shows this was a large vomit. Veronica returned to lying down in the recovery position on the mattress after vomiting.[924]

615. At 11:50 AM, RN Minett returned to administer esomeprazole tablets.[925] Veronica resumed lying down afterwards; RN Minett removed her used vomit bag.[926]

616. At 12:09 PM, a PO entered the cell, leaving Veronica a clean vomit bag and a lunch pack which included an apple.[927] Veronica did not touch the food. Ten minutes later, she vomited again into a vomit bag.[928]

617. At 12:26 PM, Veronica massaged her feet and stretched her legs.[929] Minutes later she stood up and walked up and down the length of the cell, taking a bite of the apple that had

[922] Exhibit 11, Health Holding Cell 2.
[923] Extract 072.
[924] Exhibit 11, Health Holding Cell 2.
[925] Extract 073; CB1789.
[926] Extract 073.
[927] Extract 074.
[928] Extract 075.
[929] Extract 077.

rolled from the mattress onto the cell floor.[930] She massaged her feet and legs again and appeared to be in significant discomfort.[931]

618. Veronica returned to lying on the floor on the mattress in the recovery position until RN Minett and Dr Brown returned.[932]

Second medical assessment by Dr Brown and RN Minett

619. At 12:37 PM, Veronica was reviewed a second time by Dr Brown who was again accompanied by RN Minett.[933] During the second assessment, Veronica reported cramps in her legs and Dr Brown examined Veronica's abdomen while she lay on her side.[934] No formal nursing observations were taken.[935] Dr Brown felt Veronica's pulse to be strong and not rapid.[936]

620. At the time of this review, Dr Brown was aware that Veronica had vomited again. She did not think there was a significant change in Veronica's clinical state or any need to change her management plan.[937]

621. Dr Brown did not record notes of this assessment. She accepted that she should have.[938] The assessment lasted for roughly three minutes, concluding at 12:40 PM.[939] Twenty minutes later, Veronica vomited into a vomit bag.[940]

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[930] Extract 078.
[931] Ibid.
[932] Exhibit 11, Health Holding Cell 2.
[933] Extract 079.
[934] Brown: T751-2.
[935] Minett: T1247
[936] Brown: CB239.
[937] Brown: T750.25– T251.4.

622. At 1:26 PM, Veronica vomited again into a vomit bag.[941] Immediately after this, the CCTV footage depicts her attempting to stretch out cramps in her right hand and using her left hand to unclench her right thumb.[942] She vomited again at 1:34 PM,[943] and a PO and CCA nurse entered the cell half an hour later to replace the used vomit bag.

623. Neither Dr Brown nor RN Minett were aware that Veronica had vomited after their second assessment.[944] There was no system in place in the Medical Centre to record a patient's vomiting or diarrhoea,[945] or otherwise monitor fluid balance.

Initial Reception Assessment by CV and transfer to Yarra Unit

624. At 3:37 PM, Veronica was collected from Health Holding Cell Two by PO Enever.[946] She was escorted to the reception centre for her initial reception assessment.

625. A prisoner's initial reception assessment is usually conducted on arrival at DPFC, but Veronica's was postponed because she had been too unwell.[947] PO Enever said that Veronica looked "extremely thin," and that she had to hold Veronica's arm while walking down the

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[938] Brown: AM1418; T750.29-30.
[939] Exctract 079.
[940] Extract 080.
[941] Exhibit 11, Health Holding Cell 2, at [1:26].
[942] Ibid.
[943] Extract 081.
[944] Minett: T1247; Brown: T754.
[945] Brown: T724
[946] Extract 085.
[947] Enever: CB2009.

corridor to reception.[948] She said that Veronica gave a lot of one-word answers and went to the bathroom, ill, three times during the assessment.[949]

626. PO Enever filled out the initial reception form but did not include any observations of Veronica's physical presentation.[950] In evidence, she accepted that she should have.[951] The form contained a question relevant to a prisoner's health details and whether there is the "presence of medical illness, physical condition/disability affecting placement" in the prison.[952] In Veronica's case, the form is marked 'no'.[953] PO Enever said that a prisoner's physical health is not relevant to this question and that it relates only to physical disability.[954]

627. Veronica's initial reception assessment was completed in under ten minutes, concluding at 4:05 PM.[955]

628. At 4:43 PM, PO Enever notified Aunty Lynne Killeen, the Aboriginal Welfare Officer, by email of Veronica's arrival in custody.[956] In the 36 hours that Veronica was in custody at DPFC, she was not seen by any Aboriginal Welfare Officer and so did not receive any cultural support from anyone employed to provide it.[957]

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[948] Enever: CB2009; T1295-6.
[949] Enever: CB2010; T1304; T1294.
[950] Reception assessment form: CB2012.
[951] Enever: T1306-7.
[952] CB2012.
[953] CB2012.
[954] Enever: T1307-8.
[955] Extract 085A.
[956] CB2020.
[957] I note that Aunty Lynne was on leave at the time Veronica was at DPFC. To ensure cultural support is available to Aboriginal prisoners, in addition to the Aboriginal Wellbeing Officer, at DPFC

629. I find that notification to the Aboriginal Wellbeing Officer of Veronica's reception at DPFC should have occurred shortly after her arrival on 31 December 2019.

630. I further find that Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest on 30 December 2019 to her passing at DPFC on 2 January 2020.

631. Ms Bastin's evidence was that, if Aunty Lynne had seen Veronica, "she would have said, 'no way she's going into Yarra'."[958]

632. At some point between 4:05 PM and 5:10 PM, Supervisor Reid approved Veronica's transfer to the Yarra Unit.[959]

633. Supervisor Reid could not recall when she approved Veronica transfer, nor did she recall a specific conversation or communication with clinical staff member about it.[960] Supervisor Reid testified that clearance from the medical unit is conditional upon receiving 'medical clearance' but that there is no documented system to confirm whether this condition is satisfied.[961]

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there are Aboroiginal Service Officers and Aboriginal Liaison Officers who receive cultrual training from the AWO: AM1192. Unfortunately, Veronica was not assisted by an ALO or ASO while at DPFC.

[958] Bastin: T1413.12 – 15.

[959] Local Plan File Notes: CB661; Reid CB2023.

[960] Reid: CB2023.

[961] Reid: T1528

634. Supervisor Reid cannot recall who provided clearance for Veronica.[962] She says that the usual practice is for a nurse or doctor to discuss the patient with the senior prison officer,[963] however, there is no evidence that any clinician was consulted in Veronica's case.

635. Dr Brown said that she did not approve Veronica being moved out of the Medical Centre. Dr Brown said she was not consulted by any prison or medical staff about the decision[964] and would have voiced an opinion if she had been.[965] Dr Brown assumed Veronica would be staying in a cell in the Medical Centre to facilitate review.[966]

636. RN Minett testified that he was not consulted about the decision to transfer Veronica out of the Medical Centre.[967] RN Minett believed Veronica would be transferred to the Yarra Unit, but he was not informed of any decision to do so by CV.[968]

637. In evidence, Supervisor Reid accepted that she could have placed Veronica on "management observations" upon transfer from the Medical Centre which would have required POs to monitor Veronica in the Yarra Unit.[969] Veronica was not placed on management observations.

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[962] Reid: T1522.
[963] Reid: T1530-1.
[964] Brown: T767-8.
[965] Brown: 768-9.
[966] Brown: 768-9.
[967] Minett: T1254.
[968] Minett: T1253.
[969] Reid: T1540.

Conclusions in relation to adequacy of care and treatment in the Medical Centre

Systemic failings

638. The systems in place at DPFC to manage the healthcare of prisoners at the time of Veronica's reception were significantly flawed. The inquest identified substantial gaps in policies and procedures which are supposed to safeguard the health and wellbeing of prisoners.

639. Any common-sense risk assessment of the structure of healthcare at DPFC ought to have recognised the following dangers:

639.1. a substantial number of women present with medical issues during reception at DPFC;[970]

639.2. there is no sub-acute unit at DPFC;

639.3. women seemingly cannot be adequately cared for in the Medical Centre overnight;[971]

639.4. the intercoms in the prisoners' cells in both the Medical Centre and mainstream units are directed to an officer's post;

[970] Runacres: T1035.3 – 12.
[971] See, for example: Fuller: T2946; T2959; T2960.

639.5. the officer on post receiving intercom communications is responsible for making an assessment about whether the prisoner is unwell enough to warrant contacting a nurse;

639.6. the officer on post has no access to information about underlying health conditions, recent medical presentations or signs of clinical deterioration to inform their decision about the need to escalate a prisoner's care;

639.7. in mainstream units, women are assumed to be 'medically cleared' and so fit for confinement in conditions where they are not ordinarily monitored or observed;

639.8. overnight, the officer on post in a mainstream unit can only access a cell by requesting the attendance of a supervisor who is in possession of the keys;

639.9. CV staff determine the placement of prisoners and approve their transfer from reception to a confined mainstream cell; and

639.10. decisions to transfer a woman to hospital are made by CCA staff.

640. When one considers the scope of these risks, the prospect of a woman dying alone and unattended in a cell at DPFC becomes less remote.

641. I am deeply concerned that these risks were not identified or addressed by DJCS prior to Veronica's passing, as part of either Justice Health's monitoring of the contract with CCA and the JHFQ, or through its oversight of CV and custodial healthcare. Likewise, these risks should have been identified and reported by CCA to Justice Health long before Veronica's passing, as was required by its contractual arrangements.

642. The failure of CV and CCA to establish adequate procedures and systems for information sharing between staff meant that:

642.1. overnight on 31 December 2019, RN George was apparently never notified of Veronica's multiple intercom complaints or vomiting,[972] despite RN George being mere meters from the officer's post where the intercom calls were received;

642.2. CV officers on the morning of 1 January 2020 were not aware that Veronica was to be monitored for deterioration pending a determination of her fitness to be transferred to the Yarra Unit;

642.3. RN Minett was not alerted to the number of times Veronica had vomited before seeing her on the morning of 1 January 2020,[973] nor was he told how many times Veronica had requested a drink or reported cramping;[974]

642.4. at the time of Dr Brown first reviewing Veronica on 1 January 2020, she had no information about the number of times Veronica had vomited since her reception,[975] nor was she aware that Veronica had used the intercom thirty times overnight and during the morning,[976] or that Veronica had asked to see a doctor five times before the assessment;[977]

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[972] George: T1717.25-31.
[973] Minett: CB242; T1225-1226.
[974] Minett: T1230.13-26.
[975] Brown: T724.
[976] Brown: T779.
[977] Brown: T725.

642.5. at the time of Dr Browns' second assessment of Veronica on 1 January 2020, she was not made aware that Veronica had vomited three times voluminously since her last assessment; she was only told that Veronica had "had a vomit";[978]

642.6. CCA and CV staff working from 7:00 PM on 1 January 2020 onwards did not know Veronica had been sick for over 30 hours, nor that multiple people had considered that she might need hospitalization;

642.7. PO Brown was not aware that Veronica had been accommodated in the Medical Centre due to unwellness the night before her transfer to the Yarra Unit;[979] and

642.8. when Veronica further deteriorated in the early hours of 2 January 2020, RN George was not made aware of the number and content of Veronica's intercom calls to PO Brown.

643. The failure of CV and CCA to establish adequate policies and procedure for the medical clearance of a prisoner from the Medical Centre meant that:

643.1. Dr Runacres did not believe he had any role in clearing a prisoner out of the Medical Centre,[980] and said that it was assumed that women would be transferred into the general population unless he intervened and sent them to hospital;[981]

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[978] Brown: T749.
[979] Brown: T1834.7-10.
[980] Runacres: T1167.
[981] Runacres: T1033.

643.2. RN Minett believed that Veronica was going to be transferred to the Yarra Unit because it was the common practice;[982] and

643.3. Dr Brown assumed that Veronica would be staying in the Medical Centre again overnight on 1 January 2020.[983]

644. The failure of CV and CCA to clearly define the role and purpose of the Medical Centre to staff meant that:

644.1. Dr Runacres said that he had been instructed that the Medical Centre played a limited role and that no prisoners could stay there overnight;[984]

644.2. Supervisor Reid, RN Hills and RPN Chisvo all believed that Veronica was too unwell to be transferred out of the Medical Centre and believed that it was best she remain there overnight;

644.3. RN George's understanding was that unwell prisoners should not be staying in the Medical Centre overnight but should instead be going to hospital;[985]

644.4. RN George did not consider it the night nurse's role to provide observation or care to someone staying in the Medical Centre overnight, and that it was the role of CV officers to do observations on them;[986] and

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[982] Minnet: T1253.
[983] Brown: 768-769.
[984] Runacres: T1058-1059.
[985] George: T1791-1792.
[986] Ibid.

644.5. Dr Brown assumed that Veronica would be staying in the Medical Centre again overnight on 1 January 2020 because of her symptoms and that she was due to have a nursing review.[987]

645. On the basis of the evidence outlined above:

645.1. I find that the failure of CCA and CV to establish proper procedures for information-sharing between staff causally contributed to Veronica's passing and meant that decisions in relation to Veronica's medical care and custodial management were made on the basis of incomplete and inaccurate information;

645.2. I find that the failure of CCA and CV to clearly establish an adequate procedure for the medical clearance of a prisoner from the Medical Centre to a mainstream unit causally contributed to Veronica's passing; and

645.3. I find that the failure of CCA, CV and Justice Health to clearly define the role and purpose of the Medical Centre at DPFC causally contributed to Veronica's passing.

Equivalent and equal care

646. The JHFQ requires that prisoners receive a standard of healthcare equivalent to that available in the community through the public health system. As the primary healthcare provider at DPFC, CCA was expected to provide 'equivalent care' - either by delivering it or, if appropriate facilities were unavailable at DPFC, ensuring prisoners received it off-site.

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[987] Brown: 768-769.

CCA's Chief Nursing Officer, Ms Fuller accepted that Veronica's care at DPFC was not equivalent to that she could have received in the community.[988]

647. Specifically, the care available to Veronica at DPFC was not 'equivalent care' in the following ways:

647.1. a lack of opioid pharmacotherapy options available to mitigate the medical dangers of withdrawal and the suffering it causes;[989]

647.2. a lack of access to IV fluids;[990]

647.3. a lack of fluid balance charts;[991]

647.4. a lack of subacute inpatient beds, with monitoring or supervision;[992]

647.5. a lack of capacity to have blood tests completed on the same day;[993]

647.6. excessive waiting times;[994]

647.7. no Aboriginal and/or Torres Strait Islander leadership evident in staff or executive roles;[995]

647.8. no access to an Aboriginal health care worker;[996]

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[988] Blaher: T2980; Fuller: T2980.
[989] Brown: T772.
[990] Hills: T866-867.
[991] Brown: T772.
[992] Fuller: CB2119.
[993] Brown: CB239 [15].
[994] Reid: T1563
[995] Williams, Administration of Justice Conclave: T2296

647.9. a punitive model of health care;[997]

647.10. a lack of access to regular clinical observations;[998] and

647.11. a lack of intensive review following a serious adverse event.[999]

648. If Veronica was in the community, she would have been able to make her own decision about whether and when to go to hospital. She would have been assisted by people who cared for her to make that decision. Mr Lovett gave evidence that when Veronica needed to see a doctor, she would see a doctor.[1000] He said that when she needed to go to hospital, she would go to hospital.[1001] If Veronica was in the community presenting with symptoms similar to those she experienced at DPFC, Mr Lovett said he would have taken her to hospital.[1002]

649. CCA's failure to provide Veronica with care equivalent to that she would receive in the community is a breach of a critical obligation it owed her. It is also a significant failing on the part of Justice Health, given its responsibility to ensure its contractor CCA had implemented the standards prescribed by the JHQF.

650. I find that CCA at DPFC failed to provide Veronica with care equivalent to the care she would have received from the public health system in the community, and that this failing causally contributed to her passing.

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[996] Ibid.
[997] Bonomo, Medical Conclave, T2309.
[998] Fuller: T2960
[999] Milner, Medical Conclave: T2332; Walby, Medical Conclave: T2333.
[1000] Lovett: T48.
[1001] Lovett: T57.
[1002] Lovett: T57.

651. I find that Justice Health failed to ensure that CCA delivered a standard of health care equivalent to that available in the public health system at DPFC, and this failing causally contributed to her passing.

652. I pause here to reiterate that the evidence before me was that there is no acute/subacute bed-based care available to prisoners at DPFC nor any facilities for provision of intravenous fluids, close monitoring and urgent pathology testing.[1003] As such, treatments that would have made a significant difference for Veronica – and other women compelled to withdrawn from drugs at DPFC – were unavailable. That bed-based care is "very needed" at DPFC was also acknowledged in evidence at the inquest.[1004]

653. Subacute units exist in several men's prisons in Victoria. However, neither funding for such facilities at the women's prison DPFC nor sufficient explanation for its absence was forthcoming.[1005] This situation is contrary to section 47(1)(f) of the *Corrections Act* 1986 which provides that every prisoner has the right to "have access to reasonable medical care and treatment for the preservation of health," and is contrary to the positive duty under the right to life in section 9 of the Charter to take measures to prevent arbitrary deprivation of life.[1006] The lack of bed-based care at DPFC infringes the rights of women prisoners to enjoy human rights without discrimination.[1007]

[1003] CB2119; Medical Stakeholder Panel T2159 (Fuller); Hills: T866-868.
[1004] Medical Stakeholder Panel: T2267-2268 (Fuller); T2268 (Westin).
[1005] Medical Stakeholder Panel: T2267 and T2382 (Swanwick).
[1006] Section 9 of the Charter.
[1007] Section 8 of the Charter.

654. I find that the absence of bed-based care at DPFC infringed Veronica's rights to life and equality pursuant to sections 9 and 8 of the Charter.

The influence of drug-use stigma in Veronica's care and treatment

655. Before continuing it is appropriate to consider the relevance of Veronica's history of opioid dependence to the decisions made by CV and CCA staff in relation to her treatment and care.

656. The inquest heard that drug withdrawal is the most common medical issue with which women present upon arrival at DPFC. CCA and CV staff estimated that between 50% – 90% of women arriving at DPFC are withdrawing from drugs.[1008]

657. Given that context, it is relevant to note here the information each CCA clinician possessed or assumed about the reason for Veronica's unwellness, before they ever saw her:

657.1. On the evening of 31 December 2019, RN George interpreted RN Hills' note in the handover book 'Vomiting ++' to mean Veronica was withdrawing.[1009] RN George did not check Veronica's JCare file on 31 December 2019; she simply assumed from the notation in the handover book that Veronica was withdrawing from drugs.

[1008] Hill: T654.9; Runacres: T1105.1-25; Enever: T1340.7-13; Reid: T1360.4-7; Heath: T1633.3-4; Blaher: T2927.31.

[1009] George: T1691.12 – 15.

657.2. At the start of RN Minett's shift on 1 January 2020, his verbal handover was only that Veronica was reportedly withdrawing.[1010] He could not recall discussing particular concerns with Dr Brown about Veronica's presentation, and said they were both aware that they were treating a working diagnosis of withdrawal.[1011]

657.3. Dr Brown said that on arrival at DPFC on 1 January 2020 she received information about Veronica from RN Minett and read her JCare file.[1012] Although Dr Brown was the only clinician to consider a differential diagnosis for Veronica's symptoms,[1013] she was ultimately persuaded that the symptoms were most likely opioid withdrawal based on Veronica's self- report that she had last used opioids about 48 hours before Dr Brown's first assessment.[1014]

658. Of course, each of these clinicians was right about Veronica withdrawing from opioids. However, for reasons I will explain, I am satisfied that this understanding influenced decision making about the care (or absence of care) they provided to Veronica.

659. I am also satisfied that the conduct of CV staff who engaged with Veronica on the morning of 1 January 2020 was negatively influenced by the knowledge she was withdrawing from drugs. In Veronica's Local Plan File Notes, PO Watts recorded on 31 December 2019 that Veronica "was to remain in medical overnight due to heavily

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[1010] Minett: T1225.11-13.
[1011] Minett: T1242.8-14.
[1012] Brown: T718.19 – 30.
[1013] Brown: T729.
[1014] Brown: T729 – 730.

withdrawing".[1015] This information was available to CV staff who came on post in the morning of 1 January 2020.

660. CCA staff knew of the potential fatality of opioid withdrawal, and the severity of symptoms it may cause.

661. RN George said that prisoners withdrawing from drugs:

> …will have severe muscle cramps, they will have diarrhoea and vomiting. Sometimes there will be [fever]. And so then they'll have severe body pain, they feel hot and cold and they always have hot showers all the time… for the first couple of days that's normal for them, then after this if they're on Suboxone program or if they're on Valium drug or something they do calm down.[1016]

RN George stated that she viewed people experiencing these symptoms as "just withdrawing," as opposed to being sick and needing medical treatment.[1017]

662. Dr Brown knew that withdrawing from opioids is generally unpleasant and expected a level of suffering to be experienced by patients.[1018] She understood that opioid withdrawal can be fatal, though considered this rare,[1019] and noted that fatality would likely arise as a

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[1015] CB2399.
[1016] George: T1716.22 – 31.
[1017] George: T1717.1 – 10.
[1018] Brown: T823.
[1019] Brown: T739.1-3.

result of electrolyte disturbances affecting the heart.[1020] However, Dr Brown was accustomed to people having a period of withdrawal, recovering and moving on.[1021]

663. RN Minett considered that a high heart rate is of concern in patients,[1022] however stated that he considered Veronica's recorded high heart rate on 1 January 2020 to be consistent with the symptoms of withdrawal.[1023]

664. CV staff did not record any of Veronica's intercom contacts on 1 January 2020 in her Local Plan File Notes,[1024] and did not pass any information onto CCA clinicians. Likewise, CCA clinicians did not seek information from their CV colleagues. I am satisfied that the failings of both CV and CCA staff to take seriously their obligations to Veronica was linked to an assumption that suffering and unwellness was 'normal' for a prisoner experiencing withdrawal.[1025]

665. Indeed, at the time of conducting his review, Mr Limpens reported that there was no consistency at DPFC when developing care plans for women presenting with acute health issues.[1026] He noted that "[CCA] staff were often 'desensitized' to this type of presentation, and therefore not overly responsive."[1027]

[1020] Brown: T808.3 – 10.
[1021] Brown: T739.28-31.
[1022] Minett: T1237.8 – 10.
[1023] Minett: T1236.29.
[1024] CB2399.
[1025] See for example, Dr Brown's evidence that she was accustomed to people having a period of withdrawal, recovering and moving on, Brown: T739.
[1026] Limpens: AM1174.
[1027] Ibid.

666. Normalisation of the suffering of women experiencing drug withdrawal results in the desensitisation of both CV and CCA staff to this presentation. Desensitisation to suffering rendered CV and CCA staff virtually unresponsive to Veronica's persistent pleas for assistance and blind to her clinical deterioration. They collectively and continually failed to recognise that she was in need of urgent medical care.

667. I am satisfied that this phenomenon is evidence of pervasive stigma at DPFC towards women who use injectable drugs. As Prof Treloar explained:

> …We know from the literature that people who use drugs, and particularly women who use drugs are seen in a stigmatising light and often claim to be drug seeking when they're wanting to access relief for their experiences…[1028]

> …people who are seen to have acted to cause an outcome are seen as more blame-worthy than people who have things happen to them that are seen as 'no fault of their own.' Drug use is a prime example of a practice in which perceptions of controllability of one's actions drives stigma… [1029]

> …Stigma towards people who inject drugs is pervasive and ubiquitous … This is just part of our cultural wallpaper. We don't even see it anymore.[1030]

668. Aunty Vickie Roach spoke of the way in which POs routinely treat drug addiction as a moral issue.[1031] In her expert report she wrote:

[1028] Treloar, Medical Conclave: T2183.20 – 24.
[1029] Treloar, Medical Conclave: T2305.
[1030] Treloar, Medical Conclave: T306.15 – 20.

> There's this underlying ideology throughout corrections that we should suffer, that we need to suffer, to be corrected… that's the caning you get when you're at school for not behaving the way you're told. So, if you've used drugs when you've been told repeatedly not to, and you keep coming to jail for it you know, you deserve to suffer, so suffer you shall.[1032]

669. Ms Bastin said that POs don't care about women experiencing withdrawal; "we're drug users" she said, "we're all looked upon as just scum"[1033] and "they treat us just as junkies".[1034]

670. These sentiments ring true given the contempt with which some POs treated Veronica's requests for assistance on the morning of 1 January 2020:

670.1. when Veronica asked when a doctor was going to see her she was told, "it's not an emergency – stop asking";[1035] and

670.2. when Veronica asked why a doctor hadn't seen her yet she was told condescendingly, "well, things don't always go to plan, so I will let you know when the doctor's here and he's ready to see you, okay?"

671. They also ring true with the interactions Veronica subsequently had with POs, once she was moved to the Yarra Unit and continued to request assistance.

[1031] Roach: T2006.10.
[1032] Roach: CB4231 [88].
[1033] Bastin: T1414.25 – 29.
[1034] Bastin: T1403.21.
[1035] Extract 061.

672. Commenting on the way Veronica was spoken to by POs while in the Medical Centre on the morning of 1 January 2020, Supervisor Reid said, "I think it was just disgusting behaviour, and nobody should be treated [or] spoken to like that."[1036] She said that this treatment was below her expectations of the care that Veronica should have received by a very large margin.[1037]

673. I am satisfied that this treatment of Veronica by CV staff was inhumane and degrading.

674. That said, there were POs who were kind and compassionate towards Veronica. PO Cole overnight on the intercom explained why he could not help her until other officers arrived on post.[1038] He took her cordial throughout the night and delivered her socks in the morning.[1039] PO Fenech stated that she tried to treat each woman in her care like a member of her family.[1040] Supervisor Reid was an honest and forthright witness, and the type of prison officer who would often add sugar to the coffees of women who were withdrawing because she understood that this helped.[1041]

675. Notwithstanding the compassion shown by some CV staff, it was not evident that Veronica's presentation caused them much concern for her wellbeing or caused them to consider the need to escalate her care. The evidence of Ms Bastin and Aunty Vickie suggests that this is a systemic issue of longstanding that routinely influences the decisions CV staff

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[1036] Reid: T1556.26.
[1037] Reid: T1513-1514.
[1038] Extract 026; Extract 027; Extract 029; Extract 030; Extract 032; Extract 033; Extract 034; Extract 035.
[1039] Ibid.
[1040] Fenech: T552-553.
[1041] Reid: T1507.

make about the care and management of prisoners withdrawing from drugs at DPFC. It is a systemic issue embedded in the DJCS and CCA policies governing the treatment and care of these women.

676. On the weight of the available evidence, I find that Veronica's care and treatment by CV and CCA staff while at DPFC was influenced by drug-use stigma, and that this causally contributed to Veronica's passing.

677. I find that Veronica's treatment by some POs in the morning on 1 January 2020 amounted to inhumane and degrading treatment contrary to section 10 of the Charter.

Adequacy of care provided overnight

678. Veronica's intercom calls overnight went to PO Cole stationed in the officer's post barely two metres from the nurse's station.[1042] RN George gave evidence that she and the PO on post can talk to one another without moving from their respective posts.[1043]

679. Other than the half hour during which she was completing her medication rounds,[1044] RN George said she sat in the nurse's station for her entire shift.[1045] From that position, only metres from Ward Two, she would have stood up and seen Veronica through the transparent wall.[1046]

[1042] AM365.
[1043] George: T1711.4.
[1044] AM394.
[1045] George: T1709.3.
[1046] Fenech: T590.23.

680. From the nurse's station, RN George could hear the buzzer in the officer's post when a prisoner in the Medical Centre cells used the intercom but could only hear what the prisoner said if the speaker function was on.[1047]

681. RN George said that PO Cole did not inform her of Veronica's intercom calls or that Veronica was vomiting.[1048] She did not check Veronica's electronic JCare file,[1049] and did not have any contact with Veronica while she was in the Medical Centre.[1050] She considered her role to be more responsive than proactive when on night duty.[1051] She could not remember if she received a verbal handover but saw RN Hills' note in the handover book and inferred from it that Veronica was withdrawing.[1052]

682. I am satisfied that RN George should have informed herself of Veronica's health status and treatment needs on the night of 31 December 2019. By her own evidence, it would have been easy to check Veronica's JCare file, make an enquiry of PO Cole or observe Veronica herself. I consider that her failure to do so not in keeping with the standard of care one would reasonably expect from a health professional while on shift.

683. PO Cole did not record any of Veronica's complaints overnight in the unit logbook or her local plan file, nor was he required by CV policy to do so.[1053]

[1047] George: T1711.9 – T1712.11.
[1048] George: T1717-1718.
[1049] George: T1698.
[1050] George: CB65.
[1051] George: T1722.
[1052] George: TT1690-1691; AM358; T1691.12 – 15.
[1053] AM394 and CB2399.

684. The total absence of clinical care provided to Veronica overnight in the Medical Centre is, in my view, indicative of suboptimal information-sharing between CV and CCA staff, and the ambiguity about the role of the Medical Centre at DPFC.

685. I am satisfied that this was a fundamental systemic failing, and a missed opportunity for Veronica's clinical deterioration to be recorded, assessed, treated and escalated.

Adequacy of care provided by Dr Brown and RN Minett

686. The overwhelming majority of the Medical Conclave regarded Dr Brown's assessment of Veronica as adequate.[1054] Unanimously, however, Dr Brown's treatment was considered to have been inadequate[1055] because the Medical Conclave considered that Dr Brown should have sent Veronica to hospital after her first assessment.[1056]

687. The Medical Conclave's opinion of Dr Brown's treatment of Veronica was based on:

687.1. Dr Brown's record that Veronica's pulse was tachycardic;[1057]

687.2. Dr Brown was aware that Veronica had been vomiting;[1058] and

687.3. taken together, these observations should have prompted Dr Brown to send Veronica to hospital.[1059]

[1054] Milner, Medical Conclave, T2165.
[1055] Milner, Medical Conclave, T2166.
[1056] Milner, Medical Conclave, T2166.
[1057] Milner, T2166.17 – 2167.2.
[1058] Ibid.
[1059] Ibid.

688. The Medical Conclave concluded that RN Minett's assessment and care of Veronica were inadequate[1060] on the basis that he:[1061]

688.1. characterised Veronica's high heart rate of 123 bpm as 'unremarkable';

688.2. provided no acknowledgement or documentation of the multiple vomits overnight;

688.3. failed to ensure that the hydration electrolyte given at 12:40 PM were tolerated; and

688.4. was directed to but did not perform repeat vital observations in the afternoon.

689. In my view, systemic failings significantly undermined the quality of the care provided by both Dr Brown and RN Minett and these were not among the matters considered by the Medical Conclave. That is, the Medical Conclave was not aware that:

689.1. CCA failed to provide Dr Brown with a full induction to DPFC before she commenced her shift on 1 January 2020;[1062]

689.2. there was no system in place in the Medical Centre to record a patient's vomiting or diarrhoea; [1063]

689.3. CCA and CV's failure to implement adequate policies and procedures for information-sharing between staff meant that:

[1060] Medical Conclave: T2197 – 2198.
[1061] Ham, Medical Conclave
[1062] Fuller: T2172.21 – 2173.16; Brown: T788.21 – 24; Brown: T790.21.
[1063] Brown: T724

689.3.1. RN Minett did not receive a detailed handover when he commenced his shift on 1 January 2020[1064] and so while he knew Veronica had been in the Medical Centre overnight and was withdrawing,[1065] he was unaware of the frequency of her vomiting,[1066] cramps,[1067] requests for drinks[1068] and requests to see a doctor;[1069]

689.3.2. RN Minett's handover to Dr Brown before the first assessment was consequently limited;

689.3.3. RN Minett was likely only aware of one of the five times Veronica vomited after the first assessment[1070] and so his handover to Dr Brown before their second assessment was incomplete;[1071]

689.4. CCA failed to provide Dr Brown with adequate information about the ambiguous role of the Medical Centre at DPFC;[1072]

689.5. the failure of CCA and CV to establish a clear policy for the medical clearance of a prisoner out of the Medical Centre meant that Dr Brown did not believe she had

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[1064] Minnet: T1224-1225.
[1065] Minett: T1225.
[1066] Minett: CB242; T1225-6.
[1067] Minett: T1230
[1068] Minett: T1230
[1069] Minett: T1230.
[1070] Minett: T1247 and Extract 072.
[1071] Brown: T724.
[1072] Brown: T790 – 791.

any authority to prevent Veronica's transfer to the Yarra Unit,[1073] and that she was not consulted by CV or CCA staff about the decision.[1074]

690. Notwithstanding that these issues did not inform the Medical Conclave's assessment of Dr Brown and RN Minett management of Veronica, the experts observed that "the primary failings … are system errors and that the focus should not be on individual performance."[1075]

691. I find that Dr Brown's assessment of Veronica on 1 January 2020 was adequate. That she omitted to document her second assessment and confirm the afternoon nursing observations she ordered were completed were acknowledged by Dr Brown as deficiencies in her care. That said, I am satisfied that any other inadequacy in the treatment Dr Brown provided was due to CCA's failure to establish proper systems rather than a departure from a reasonable standard of care and diligence expected in medical practice.

692. Similarly, RN Minett acknowledged the deficiency in the care he provided Veronica by not performing the repeat vital observations ordered by Dr Brown. I am otherwise satisfied that any other inadequacy in the care RN Minett provided was due to CCA's failure to establish proper systems rather than a departure from a reasonable standard of care and diligence expected in nursing practice.

693. I note that at no point did Dr Brown and RN Minett discuss that Veronica might need to go to hospital.[1076] As I have already indicated, I am satisfied that Veronica should have been

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[1073] Brown: T769 – 770.
[1074] Brown: T767-8.
[1075] Bell, Medical Conclave: T2334.11-14.

transferred to hospital at the time of her reception to DPFC and so the failure of Dr Brown and RN Minett to do so on 1 January 2020 is included in that finding.

Record-keeping and handover by CCA clinicians

694. In addition to the many points at which CCA staff failed to escalate Veronica's care, the medical records and handovers completed by CCA staff were deficient, not used appropriately, and at times, were inaccurate.

695. CCA staff were obliged to record observations, treatment and care plans in Veronica's JCare file, to ensure continuity of care.[1077] Each of the five CCA medical staff involved in Veronica's care acknowledged failures to properly record assessments and treatments.

696. Dr Runacres said that he did not take care to ensure that his notes were accurate because he did not believe that other staff would ever look at them.[1078] He left notes in error on Veronica's file, often failing to update pre-populated material.[1079] He also recorded an inaccurate weight in Veronica's MAF and recorded physical examinations that were not performed. Some of these errors were critical in Veronica's care – particularly the incorrect recording of her weight - as they were relied upon by Dr Brown.[1080]

[1076] Minett: T1251.
[1077] Correct Care Australasia Electronic Health Record: CB3229 [5.4]; [6.2]; [12.2].
[1078] Runacres: T985.
[1079] Runacres: T1010; T989.
[1080] Brown: T742-743.

697. RN Hills considered sending Veronica to hospital after concluding she was clearly unwell[1081] but failed to document her specific concerns in the nurse handover book or in Veronica's JCare file.[1082]

698. Dr Brown failed to document her second assessment of Veronica on 1 January 2020 during which she obtained further information from Veronica which she conceded was significant.[1083] None of that information was recorded in Veronica's JCare file.

699. Neither RN Minnet nor RN George recorded anything in Veronica's JCare notes after their interactions with her. RN George gave evidence that she failed to review Veronica's electronic file at all on 31 December 2019.[1084]

700. I find that the medical records maintained by CCA staff were incomplete and, in parts, inaccurate and misleading concerning Veronica's medical history and clinical presentation while at DPFC between 31 December 2019 and 2 January 2020.

701. There were no systems at DPFC to record the vomiting and diarrhoea that Veronica experienced over 36 hours. Fluid balance charts that are common in hospitals were not a feature of healthcare at DPFC.[1085] The failure to capture this information affected medical decisions made by CCA clinicians. For example, Dr Brown said that if she had known the

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[1081] Hills: AM368, [8 – 12].
[1082] Hills: T876-877.
[1083] Dr Brown: AM1418.
[1084] George: T1609.
[1085] Brown: T772; T746.

frequency of Veronica's vomiting in the previous 24 hours, she would have sent her to hospital.[1086]

702. Handover between CCA staff was minimal and so the information they *did* have was not shared among the clinicians charged with Veronica's care.

703. RN Hills said that she provided a verbal handover to a nurse but did not recall precisely who it was.[1087] RN George could not remember whether she was given any handover about Veronica but did observe the note left by RN Hills in the nurse handover book.[1088]

704. When RN Minett arrived on shift on 1 January 2020, he received a brief handover from another nurse, but not RN George.[1089]

705. Dr Brown received a handover from RN Minett.[1090] She did not verbally handover to another doctor after her assessments of Veronica.[1091]

706. When RN George commenced her shift at 8.00 pm on 1 January 2020, she was not provided with any handover information about Veronica, nor did she seek any.[1092]

707. Although there was a clinical handover policy in place at the time Veronica was at DPFC, in practice, handover between clinicians was sparse, their content impoverished by the absence of any system to ensure clinically relevant information was obtained or received

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[1086] Brown: T754.
[1087] Hills: T896; T697.
[1088] George: TT1690-1691; AM358.
[1089] Minett: T1224-1225.
[1090] Brown: T718.
[1091] Brown: T822.
[1092] George: T1723.

from CV staff. Loss of critical information between staff had a deleterious effect on Veronica's treatment and care.

708. I find that CCA's failure to develop an adequate system for the handover of critical information between staff in relation to prisoners at DPFC causally contributed to Veronica's passing.

Yarra Unit

709. At 5:13 PM on 1 January 2020, Veronica left the Medical Centre accompanied by PO Paul Antoniou (**PO Antoniou**).[1093] CCTV footage depicts Veronica pushing a trolley of her prison-issued belongings. She appears to struggle to control the trolley along the path to the Yarra Unit.[1094] Another woman approaches Veronica to help her with the trolley.[1095]

710. On the walk from the Medical Centre to the Yarra Unit, Veronica was approached and hugged by several women.[1096]

711. At 5:17 PM, Veronica entered the Yarra Unit. She was met by fellow Aboriginal prisoner Ms Bastin, who helped Veronica push the trolley to Cell 40.[1097] Ms Bastin recognised Veronica as her Aunty.[1098]

[1093] AM362.
[1094] Exhibit 11, Health Main Entrance, [5:13] – [5:15].
[1095] Ibid.
[1096] Exhibit 10, Undercover Walkway, [5:15] – [5:16]; Exhibit 10, Yarra External Walkway, from [5:16].
[1097] Bastin: T1389.
[1098] Aboriginal and Torres Strait Islander people refer to community Elders as 'Aunty' or 'Uncle' as a term of respect. These terms are used for people held in esteem by fellow-community members.

712. At Cell 40, PO Antoniou placed a sign on the door reading 'new reception – do not unlock'.[1099] He conducted two intercom checks[1100] before closing the door and leaving with the trolley.[1101]

713. Ms Bastin brought Veronica cordial and spoke to her through the door of Cell 40 before it was locked down at 7.06 pm with Veronica inside.[1102]

Cell 40

714. At 9:09 PM, Veronica used the intercom to request a blanket from the officer on First Watch in the Yarra Unit.[1103] She told the PO that she was "cramping up bad".[1104] The PO called Veronica back at 9:12 PM to let her know that a supervisor was going to arrange delivery of a blanket.[1105] The PO told Veronica that she had to wait for a supervisor because she did not have keys to open the cell door.[1106]

715. I note that significant clinical risk may arise when only two prison officers have keys to cells overnight at DPFC.[1107] This interaction is also one of many examples of prison officers advising Veronica that they were unable to assist her because they didn't have any keys.[1108]

[1099] Extract 086.
[1100] Extract 087; Extract 088.
[1101] Exhibit 13, Yarra Unit 1700 to 2100, at [5:22].
[1102] Extract 089; Extract 090.
[1103] Extract 093.
[1104] Extract 094.
[1105] Extract 095.
[1106] Ibid.
[1107] Issa: T2991.
[1108] See, for example, Extracts: 031; 094; 110.

716. About 20 minutes later, Supervisor Urch, PO Halfpenny and PO Varghese brought Veronica a blanket which they fed through the trap in the door of Cell 40.[1109]

717. Supervisor Urch gave evidence that he was unable to see Veronica inside the cell so made no observations of her physical presentation.[1110] He said that Veronica thanked him for the blanket and that there was nothing about this interaction that concerned him.[1111]

718. PO Halfpenny saw that Veronica was moving slowly and did not look well.[1112]

719. The three officers were at Veronica's cell door for less than a minute.[1113]

720. At 11:10 PM, PO Brown commenced shift on post as the Second Watch officer in the Yarra Unit.[1114] She received a handover from PO Halfpenny during which she was advised that Veronica was a new reception and had been given a blanket at 9:30 PM.[1115] PO Brown was not aware that Veronica had stayed in the Medical Centre the previous night because she was unwell.[1116]

[1109] Extract 096.
[1110] Urch: T1454.
[1111] Urch: T1454.
[1112] Halfpenny: CB2029.
[1113] Extract 096.
[1114] CB2040.
[1115] Brown: T1833; 1st watch handover: CB603.
[1116] Brown: T1834.

721. RN George had commenced her nightshift on 1 January 2020 at 8:00 PM.[1117] She was not provided with any handover information about Veronica and did not seek any[1118] but she was aware Veronica had been transferred to the Yarra Unit.[1119]

722. At 1:27 AM on 2 January 2020, PO Brown received an intercom call from Veronica who told her, "I need help", "I'm cramping something shocking".[1120] PO Brown's first question to Veronica was "Ms Nelson, are you withdrawing?"[1121] Veronica replied, "yes, my knees and my feet and my hands and they can't come out". PO Brown asked Veronica whether she had tried drinking some water and said she would ring the nurse. Veronica, sobbing, said "badly miss, badly".[1122]

723. Immediately after this, RN George received a call at the Medical Centre from PO Brown and was advised that Veronica was complaining of muscle cramps.[1123]

724. RN George testified that she checked Veronica's medication charts but did not look at her JCare file.[1124] She accepted that she should have looked at the JCare file before attending Veronica.[1125]

725. A few minutes later, PO Brown received an intercom call from prisoner Bonnie McSweeney (**Ms McSweeney**) in Cell 39 who told her, "Someone needs help down

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[1117] AM793-1.
[1118] George: T1723.
[1119] George: T1723.21 – 26.
[1120] Extract 098.
[1121] Ibid.
[1122] Ibid.
[1123] George: T1729.
[1124] George: T1729; T1732.
[1125] George: T1732.

here".[1126] PO Brown thanked her, and said that the nurse had been called and she was waiting to hear back.[1127]

726. Shortly after, RN George contacted PO Brown to confirm that she was coming to deliver medication to Veronica.[1128] PO Brown contacted Veronica to let her know the nurse was on her way.[1129]

727. At 1:36 AM, RN George, PO Brown, PO Arnaz and SPO Heath attended Cell 40.[1130] RN George administered metoclopramide and paracetamol to Veronica[1131] through the trap in the cell door.[1132] It took Veronica roughly one minute to pick up a blanket to cover herself and walk about four steps to the trap.[1133]

727.1. RN George said that she asked Veronica to come to the trap, and that Veronica walked to her without any problem.[1134] She said that Veronica appeared alert, orientated and spoke without difficulty.[1135] She said that Veronica's hand was not cramped closed and that when she touched her hand, Veronica opened it.[1136] RN George stated that she did not apply any pressure to open Veronica's hand.[1137] She

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[1126] Extract 099.
[1127] Ibid.
[1128] Extract 099A.
[1129] Extract 100.
[1130] Extract 101.
[1131] Medication administration record; George: CB65.
[1132] Extract 101.
[1133] Extract 101; Brown: T1851 – 1852.
[1134] George: T1736.
[1135] George: CB65, [6]; T1741.19-22.
[1136] George: T1738-1740.
[1137] George: T1740.27-28.

said that Veronica was not struggling physically and looked "okay".[1138] Veronica reported she had bad cramps in her legs, with nausea, but no vomiting.[1139]

727.2. SPO Heath said Veronica looked very unwell; more unwell than she was normal among people who were withdrawing from drugs.[1140] She observed Veronica's hand cramped into a claw which she found "alarming".[1141] SPO Heath said that RN George did not make any enquiries of Veronica at the trap.[1142] In evidence, SPO Heath recalled saying to RN George that "she looks very unwell" but said RN George did not respond.[1143]

727.3. PO Brown recorded in her notepad that Veronica had walked to the trap, appeared in to be in pain, and had cramped fingers.[1144] In evidence, PO Brown said she did not have a clear view of Veronica but agreed that she did not look well and said that she had not seen a hand cramped like Veronica's was ever before.[1145] PO Brown corroborated that SPO Heath had communicated concerns about Veronica to RN George and could not recall RN George saying anything in response.[1146]

[1138] George: T1741.
[1139] George: T1742.9 – 15; T1743.7 – 11.
[1140] Heath: CB2039; T1617.
[1141] Heath: T1618.
[1142] Heath: T1620-16211.
[1143] Heath: T1621.
[1144] AM803.
[1145] Brown: T1853.
[1146] Brown: T1857.

727.4. PO Arnaz did not look into the cell because Veronica was naked and he was mindful of her privacy given he is a man.[1147] He remembered Veronica placing her hand through the trap, and that it was "skeletal."[1148] He stated she was "the thinnest individual [he] had ever seen in custody."[1149] He recalled that she had difficulty opening her hand, so RN George helped her.[1150] He stated, "that is the only time I've seen a prisoner unable to open their hand like that."[1151]

728. In the course of giving oral evidence, RN George's description of these events changed.[1152]

729. It was not disputed that RN George did not ask the POs to open the cell door at any stage. She conceded that she should have asked for the door to be opened and that she should have conducted a thorough examination of Veronica.[1153] RN George admitted that failing to have the cell door opened to conduct a full assessment was a missed opportunity to assess Veronica for signs of deterioration.[1154]

[1147] Arnaz: CB2036.
[1148] Arnaz: CB2037.
[1149] Ibid.
[1150] Ibid.
[1151] Ibid.
[1152] She originally said she only touched Veronica's index finger at which point Veronica opened her hand, see George: T1739.17 – 24; after being played CCTV footage, her evidence shifted to agree that she touched all four fingers before Veronica's hand opened, see George: T1739.17 – 24.
[1153] George: T1749.5 – 29.
[1154] George: T1766-7.

730. RN George and the POs departed Cell 40 at 1:39 AM; the interaction lasted less than two minutes.[1155]

731. RN George returned to the nurse's station in the Medical Centre,[1156] where she remained for the rest of her shift, watching a movie on her desktop computer.[1157] RN George did not make any entries on Veronica's JCare file about the attendance at Cell 40. The only notes she made in the JCare file were entered after she was informed of Veronica's passing on 2 January 2020.[1158]

732. At 2:05 AM, Veronica used the intercom to tell PO Brown, "my legs are cramping."[1159] PO Brown told her to have some water and that the tablets would start to work soon.[1160]

733. Three minutes later, Veronica was clearly distressed when she used the intercom to yell, "it's cramping!" PO Brown told her to give the tablets another 15 minutes to work, and to try and keep her legs moving.[1161] Veronica called back one minute later reporting that she thought she might had vomited up the medication.[1162] PO Brown told her, "There's not a lot I can do – the nurse isn't going to come down and give you more." PO Brown admitted in evidence that RN George had not given her that information at that time.[1163] Veronica, still

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[1155] Extract 101.
[1156] Extract 101A.
[1157] AM-35: CCTV – DPFC Health Centre Nurse Station – 0100 to 0500.
[1158] George: T1732.8-17.
[1159] Extract 102.
[1160] Ibid.
[1161] Extract 103.
[1162] Extract 104.
[1163] Brown: T1862.6-20.

distressed asked, “what am I gonna do?” PO Brown told her to drink some fluids to help with the cramping.[1164]

734. At 2:13 AM, Veronica told PO Brown she needed something for her cramps.[1165] When PO Brown responded that the nurse had given her medication and wouldn’t be able to give her anything else, Veronica asked her to try and ring the nurse.[1166] PO Brown told Veronica she would ring RN George, however she did not do so following this exchange.[1167]

735. At 2:42 AM, Veronica told PO Brown, “I’m cramping badly.”[1168] PO Brown told her that the nurse hadn’t gotten back to her yet, and to be patient.[1169] At this point, PO Brown had still not called RN George, and accepted in evidence that her failure to contact RN George between 2:05 AM and 3:05 AM was a missed opportunity in which Veronica’s care could have been escalated.[1170]

736. At 3:05 AM, Veronica used the intercom to tell PO Brown that her legs were “cramping badly”.[1171] PO Brown told her to keep trying fluids, and that she would try to get hold of the nurse.[1172]

736.1. PO Brown did call RN George this time.[1173] She could not recall the exact words of the conversation but they were words to the effect that Veronica was still in a lot of

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[1164] Ibid.
[1165] Extract 105.
[1166] Ibid.
[1167] Extract 105A.
[1168] Extract 106.
[1169] Ibid.
[1170] Brown: T1899.
[1171] Extract 107.
[1172] Ibid.

pain.[1174] She said that RN George told her she had provided Veronica with all of the medication that she could, and that she was prescribed Suboxone which would be administered in the morning.[1175]

736.2. RN George said PO Brown told her Veronica had vomited up her tablets, and asked whether she could be given anymore tablets.[1176] RN George said she said she could not provide her with any more tablets.[1177] RN George said that she could have called a doctor to get an order to administer injectable maxolon to stop Veronica's vomiting, but she did not do so.[1178] She also said that there was no utility in giving Veronica oral electrolytes while she was still vomiting,[1179] and that if Veronica was throwing up continually she could not give her anything orally, and she would have needed to be hydrated by intravenous fluids.[1180] RN George then maintained that Veronica did not need to be transferred to hospital at that stage.[1181] However, she conceded that she should have returned to the Yarra Unit to check on her,[1182] and that her failure to do so was another missed opportunity to assess Veronica for signs of deterioration.[1183]

[1173] Extract 106E; Extract 107A.
[1174] Brown: T1863.29.
[1175] Brown: T1864.
[1176] George: T1769.4 – 8.
[1177] Ibid.
[1178] George: T1769.30 – 1770.3.
[1179] George: T1770.12 –17.
[1180] George: T1770.18 – 26.
[1181] George: T1770.27 – 28.
[1182] George: T1770.29 – 31.
[1183] Letter from Meridian Lawyers to Coroner's Court of Victoria, dated 21 April 2022, AM1416.

737. Following receipt of PO Brown's phone call, RN George immediately resumed watching a movie on her computer in the nurse's station.[1184]

738. PO Brown used the intercom at 3:09 AM to tell Veronica:

> I spoke to the Nurse. She said there's nothing more she can give you tonight; that what she's given you is the maximum she can give you. She did say that you're on the Suboxone program, so in the morning you'll be able to go up and get Suboxone, and that will help. But she said keep drinking plenty of fluid and try and get some sleep – okay?[1185]

739. Two minutes later, Veronica used the intercom to ask PO Brown whether she could ask the nurse if she could have some salt and water.[1186] PO Brown told her she would have to ask "op support" to deliver salt to her and that it may take a little while.[1187] PO Brown continued doing paperwork in the officer's post after this exchange[1188] and did not make any call to operational support.[1189]

740. At 3:33 AM, Veronica asked again whether she could have some salt.[1190] PO Brown told her "I can't get hold of the people that come down – I don't have keys."[1191] PO Brown

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[1184] Extract 107A.
[1185] Extract 108.
[1186] Extract 109.
[1187] Ibid.
[1188] AM 49 – CCTV Yarra Officer's Post, from [3:11].
[1189] Brown: T1868.14 – 15.
[1190] Extract 110.
[1191] Ibid.

accepted in evidence that it was not truthful to tell Veronica that she could not reach operational support officers, because she had not tried to do so.[1192]

741. At 3:55 AM, PO Brown was interrupted while cleaning the officer's post by a sound she heard coming from the B Side of the Unit, where Cell 40 is situated.[1193] She exited the post and listened to the sound for a moment.[1194]

742. Ms McSweeney in the cell next door said that around this time, she heard Veronica scream three times, and then it went "deep quiet".[1195]

743. At 3:56 AM, PO Brown received an intercom call from Veronica. The level of Veronica's apparent pain and suffering at the time of this call can only adequately be understood by listening to the audio recording:[1196]

PO Brown:	Cell 40.
Veronica:	(Loud wailing)
PO Brown:	You need to st-
Veronica:	(Loud wailing)
PO Brown:	Ms Nelson, you need to try and stop 'cause you're keeping the other prisoners awake.
Veronica:	(Loud wailing)
PO Brown:	I can't give you anything else.

[1192] Brown: T1868.22 – 30.
[1193] Extract 110A; Brown: T1869.15 – 19.
[1194] Ibid.
[1195] McSweeney: CB48 [9].
[1196] Extract 111.

Veronica:	(Heavy breathing and sobbing) Daddy, daddy, daddy…
PO Brown:	Just try to have some water. Try and keep moving around. Have you had a shower?
Veronica:	(Crying) Yes.
PO Brown:	Go and have another shower, put some warmth on it.
Veronica:	(Crying) I have!
PO Brown:	I can't give you anything else. I've already spoken to the nurse.
Veronica:	(Crying) Salt!
PO Brown:	I can't get anything to you.

744. PO Brown accepted in evidence that no prisoners had complained about Veronica's crying.[1197] Indeed, Ms Bastin gave evidence that a few women in nearby cells had been talking to Veronica and trying to soothe her throughout the night.[1198] She recalled Veronica saying "help, help help, no one's coming."[1199] Ms Bastin asked her, "Sis, what are you feeling", and Veronica said, "I feel like I'm going to die".[1200]

745. At 3:57 AM, PO Brown called RN George.[1201] RN George paused the movie she was watching, answered the call, and resumed watching the movie immediately after the phone conversation.[1202]

[1197] Brown: T1870.
[1198] Bastin: T1395.22 – 31.
[1199] Bastin: T1395.3 – 12.
[1200] Bastin: T1395.
[1201] Extract 111A.
[1202] Ibid.

745.1. PO Brown said that RN George asked her to ask Veronica whether she would like to move to the Medical Centre.[1203]

745.2. RN George said that she directed PO Brown to bring Veronica to the Medical Centre and to inform the operational manager to organise a transfer.[1204] However, RN George accepted that she should have more forcefully asked for Veronica to be brought to the Medical Centre or she should have gone to the Yarra Unit to check on her.[1205]

746. PO Brown called Veronica back at 3:58 AM.[1206] She told her that the only option was to go and stay in medical, but that the nurse probably couldn't give her anything else. Veronica can be heard breathing heavily, and her voice was shaking as she told PO Brown that she wanted to stay where she was.[1207] PO Brown repeated, the question, "are you going to stay there" but Veronica did not respond.

747. Nineteen seconds into the recording, a thud can be heard. Ten seconds later, Veronica became unresponsive on the call. The relevant CV policy prescribed that a prison officer must attend a cell immediately when clear communication is not established.[1208] PO Brown

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[1203] Brown: T1874.
[1204] George T1772-3.
[1205] George: T1776-7.
[1206] Extract 112.
[1207] Extract 111.
[1208] DPFC LOP 1.11.1 Reception, Care and Control of Prisoners: Maintenance and Testing of Cell Intercom Systems: CB:1482, [3].

accepted in evidence that she should have checked on Veronica after she became unresponsive at the end of this call.[1209]

748. Two minutes after that intercom call, PO Brown conducted a unit patrol.[1210] She shined a torch down the corridor towards Cell 40 but did not walk the estimated ten metres[1211] down it to check on Veronica. In evidence, PO Brown said that she wished she had.[1212]

749. At 4:14 AM, RN George called PO Brown back to check on Veronica.[1213] PO Brown told her that Veronica had settled and was sleeping.[1214]

750. At 5:00 AM, PO Brown conducted another unit patrol.[1215] She walked part way down the corridor, but not far enough to look inside Cell 40.[1216] In evidence, she accepted that this was another missed opportunity to check on Veronica.[1217]

751. RN George finished her shift and left the Medical Centre at 6:30 AM.[1218]

752. PO Brown finished her shift and left the Yarra Unit at 7:40 AM.[1219]

[1209] Brown: T1922.
[1210] Extract 113.
[1211] Brown: T1879.27 -31.
[1212] Brown: T1880.17.
[1213] Extract 113A; Extract 113B.
[1214] George: T1809-1810; Brown: T1885.
[1215] Extract 114.
[1216] Ibid.
[1217] Brown: T1886.17 – 19.
[1218] AM793-1.
[1219] Extract 114A.

Discovery of Veronica's passing

753. At 7:50 AM, PO Michelle Reeve (**PO Reeve**) and PO Michael Pettigrove conducted the morning count at the Yarra Unit.[1220]

754. PO Reeve heard a shower as she approached Cell 40.[1221] After knocking to see if Veronica would exit, PO Reeve moved the cell observation curtain and saw Veronica lying on the floor.[1222]

755. PO Reeve called a Code Black.[1223] When the officers opened the cell door, they found the cell floor flooded and the shower running.[1224] PO Reeve turned off the shower and knelt down beside Veronica, asking Veronica if she could hear her and feeling for a pulse.[1225] Veronica was pulseless and not breathing.[1226] Veronica was naked, and her body was very cold.[1227]

756. This was the first time an officer or nurse had attended Cell 40 in six hours, and the first time the door to Cell 40 had been opened in more than 12 hours.

[1220] Extract 115.
[1221] Reeve: T1645.
[1222] Reeve: T1645.
[1223] Reeve: T1656.3 – 8.
[1224] Reeve: T1646.24 – 29.
[1225] Reeve: T1647.
[1226] Reeve: T1647.15 – 28.
[1227] Reeve: T1647.

757. SPO Allen arrived at Cell 40 at 7:56 AM.[1228] She suggested that Veronica's body be covered with a blanket.[1229] Nine officers responded to the Code Black and were at Cell 40 by 7:58 AM.[1230] Six more officers arrived with two CCA nurses two minutes later.[1231]

758. As the POs and nurses approached Cell 40, a prisoner confined in a neighbouring cell yelled out, "oi she better be alright, I fucking buzzed up for her last night."[1232] A PO told the prisoner, "Shush please."[1233]

759. At roughly 8:00 AM,[1234] CCA nurses directed a PO to call an ambulance.[1235]

760. The ESTA Call Taker (**Call Taker**) confirmed the location of the incident before asking the caller for information about Veronica's vital signs.[1236] The PO could not answer these questions because she was in the officer's post not near Cell 40.[1237] The Call Taker asked that a phone be taken to the patient so that cardiopulmonary resuscitation (**CPR**) instructions could be provided. The PO indicated that she would attempt to acquire a phone;[1238] the call was disconnected soon after.

[1228] Exhibit 13 – Yarra Unit CCTV 0500 to 0900, at [7:56].
[1229] Reeve: T1648.
[1230] Exhibit 13 – Yarra Unit CCTV 0500 to 0900, at [7:58].
[1231] Ibid, at [8:00].
[1232] Extract 116.
[1233] Ibid.
[1234] CB128; Vella: CB90; Elliott: CB91.
[1235] Reeve: T1654.9 – T1655.4.
[1236] Exhibit 17.1.
[1237] Ibid.
[1238] Exhibit 17.1.

761. The Call Taker called back and was unable to get through.[1239]

762. The Call Taker called back again, and the call was answered by a different PO.[1240] The Call Taker reported that before the last call was disconnected they were trying to get a phone near a patient in cardiac arrest. The PO said, "just one moment"[1241] before about 50 seconds of silence.[1242]

763. Eventually, the call was transferred to the Medical Centre where a staff member told the Call Taker that the incident was in "the Unit" and they weren't sure how to transfer the call.[1243] There were three minutes of discussion between DPFC staff about transferring the call to the Yarra Unit, before a PO told the Call Taker, "I have exhausted all of my avenues, sorry."[1244]

764. At 8:10 AM, ambulance paramedics arrived at Cell 40.[1245] Paramedics did not provide any treatment as it was clear that Veronica had been deceased for some time.[1246]

765. Veronica was formally pronounced deceased at 8:16 AM.[1247]

766. I find that at the time of her passing on 2 January 2020, Veronica was in the legal custody of the Secretary to the Department of Justice and Community Safety.

[1239] Exhibit 17.2.
[1240] Exhibit 17.3.
[1241] Ibid.
[1242] Ibid.
[1243] Ibid.
[1244] Ibid.
[1245] Exhibit 13 – Yarra Unit CCTV 0500 to 0900, at [8:10].
[1246] Vella: CB90.
[1247] Verification of death certificate CB629.

Conclusions about the care and treatment provided to Veronica in the Yarra Unit

Failure to escalate Veronica's care on 2 January 2020

767. The right to life necessarily includes the right to appropriate health care within a closed or custodial environment.[1248] As a matter of logic, 'equivalent care' must include access to health service providers and an obligation on prison officers to initiate a health service response for someone who is unwell. Veronica had no way of getting medical help other than through a CV officer. Officers have a duty to safeguard the welfare of prisoners in their care.

768. I am satisfied that CV staff failed to adequately discharge this duty of care by failing to escalate Veronica's care several times overnight in the Yarra Unit. Based on the available evidence:

768.1. I find that CV staff continually and collectively obstructed the provision of 'equivalent care' to Veronica and failed to protect her welfare;

768.2. I find that PO Brown failed to escalate Veronica's care on at least three occasions on the morning of 2 January 2020 between 1:30 AM and 4:00 AM.

768.3. I find that PO Brown's failure to physically check on Veronica at any point overnight, but particularly after Veronica became unresponsive during the final intercom call around 4:00 AM on 2 January 2020, was a further failure to provide appropriate care.

[1248] *McGlinchy & Ors v The United Kingdom* 50390/99 [2003] ECHR 211. See also, Submissions on behalf of Jillian Prior and LACW, [24]-[36].

769. RN George made a number of concessions through her legal representative and during her evidence, including that:

769.1. she did not check Veronica's electronic JCare file at any stage on either 31 December 2019 or 1 January 2020,[1249] and that if she had have done so, it would have prompted her to keep a closer observation of Veronica;[1250]

769.2. there were a lot of things she did not do to provide care to Veronica;[1251]

769.3. 1 January 2020 was a "quiet night"[1252] during which RN George watched a movie on her computer in the nurse's station for multiple hours;[1253]

769.4. her failure to ask for the door of Cell 40 to be opened was a missed opportunity to assess Veronica for signs of deterioration;[1254]

769.5. she did not make any entries in Veronica's JCare file until after she had passed on 2 January;[1255]

769.6. she should have sought to review Veronica at the Yarra Unit when PO Brown called at 3:06 AM on 2 January and that the failure to do so was a further missed opportunity to assess Veronica for signs of deterioration;[1256] and

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[1249] George: T1698.
[1250] George: T1704.28 – T1704.4.
[1251] George: T1790.4 – 8.
[1252] George: T1723.27 – T1724.5.
[1253] George: T1768.4 – 14.
[1254] AM1416.
[1255] George: T1732.8-17.

769.7. she should have sought to review Veronica or more forcefully ask for her to be brought to the Medical Centre for review at 3:57 AM when PO Brown called and accepted that her failure to do so was another missed opportunity to assess Veronica for signs of deterioration.[1257]

770. In evidence, RN George agreed that, had she given due consideration to Veronica's humanity and inherent dignity, she would have spent more than one minute with her at the trap, and would have followed up her care.[1258] At the time RN George gave this evidence, I indicated that I did not interpret her answers as expressing an opinion about the legal ramifications of the evidence given.[1259]

771. The Medical Conclave regarded the assessment and care provided to Veronica by RN George overnight on 2 January 2020 was inadequate because she:

771.1. failed to assess Veronica when administering medication at 1:30 AM;

771.2. failed to recognise the significance of Veronica's clenched hand;

771.3. failed to escalate Veronica's care by calling an ambulance when she attended Cell 40; and

771.4. ignored Veronica's requests for help following the administration of medication.[1260]

[1256] AM1416.
[1257] AM1416..
[1258] George: T1820.16 – 25.
[1259] Coroner: T1820.26 – 31.
[1260] Ham, Medical Conclave: T2201.4 – T2202.9.

772. The Medical Conclave further noted that nurses are patient advocates,[1261] and Ms Ham stated that if she had been in RN George's position, she would have demanded that the cell door be opened.[1262]

773. I am satisfied that the poor care provided by RN George to Veronica between 31 December 2019 and 2 January 2020 was influenced by drug-use stigma. RN George gave evidence that she viewed people experiencing withdrawal symptoms as "just withdrawing", as opposed to being sick and needing medical treatment.[1263] RN George said that she considered it "normal" for someone withdrawing to complain of muscle cramps, and that this was why she did not examine Veronica properly when she attended Cell 40.[1264]

774. SPO Heath said that Veronica looked more unwell than she had normally seen among people who were withdrawing.[1265] PO Arnaz said he had never otherwise seen a prisoner unable to open their hand like Veronica could not at that time.[1266] Likewise, PO Brown said that she had not seen a hand cramped like Veronica's had been.[1267] Although these observations were provided by non-clinical observers, they highlight Veronica's 'abnormal' presentation and that RN George was alone in considering her presentation normal. Despite each of these POs regarding Veronica's presentation as outside their expectations none of them intervened to assist or act to escalate her care.

[1261] Ham, Medical Conclave: TT2201.19 – 21.
[1262] Ham, Medical Concalve: T2201.31 – T2202.1.
[1263] George: T1716.22 – 31 and T1717.1 – 10.
[1264] George: T1748. 11 – 18.
[1265] Heath: CB2039; T1617.
[1266] Arnaz: CB2036-2037.
[1267] Brown: T1853.

775. I am satisfied that RN George's failure to ask for the door of Cell 40 to be opened, conduct a proper assessment of Veronica, conduct a follow-up review, or forcefully request that Veronica be brought to the Medical Centre in the morning of 2 January 2020, was informed by a stigmatic assumption that Veronica was "just withdrawing", not sick and needing medical treatment.[1268]

776. I am also satisfied that PO Brown was similarly influenced by stigma. Her first question to Veronica was "are you withdrawing?" which she explained in evidence is something she routinely asked new receptions to "have an understanding".[1269] That understanding in these circumstances resulted in PO Brown not escalating Veronica's care on several occasions, and instead offering advice to keep drinking water, try stretching, or have a hot shower.

777. I am satisfied on this basis, and have found above, that Veronica's care and treatment by CV and CCA staff while at DPFC was influenced by drug-use stigma, and that this causally contributed to Veronica's passing.

778. I am also satisfied, and have found above, that Veronica should have been transferred to hospital from the time of her reception to DPFC onwards, and that DPFC staff continually failed to do so. RN George's failure to do so at any point on 2 January 2020 is included in this finding.

779. In light of the concessions made, and on the basis of the evidence outlined:

[1268] George: T1717.1 – 10.
[1269] Brown: T1839.25 – 29.

779.1. I find that RN George failed to provide Veronica with adequate assessment, treatment and care between 31 December 2019 and 2 January 2020; and

779.2. I find that RN George's conduct in relation to Veronica between 31 December 2019 and 2 January 2020 was not in keeping with the standard of care reasonably expected from a health care professional.

CCA and DJCS reviews and debriefs conducted after Veronica's passing

780. The procedure for CV's response to the death of a prisoner is prescribed under the:

780.1. The Commissioner's Requirements for Reporting and Review of Prisoner Deaths (**Commissioner's Requirements**);[1270] and

780.2. the Deputy Commissioner's Instructions on Death's in Prison (**Instructions**).[1271]

781. The Commissioner's Requirements state that the Justice Assurance and Review Office (**JARO**) is responsible for conducting inquiries on behalf of the Secretary to the DJCS and is assisted by Justice Health to the extent that the issues relating to the death involved the provision of health services.[1272]

782. The Commissioner's Requirements described the purpose of an inquiry following a prisoner's death is to:

782.1. provide oversight and monitoring of the corrections system;

[1270] CB1583 – 1587.
[1271] CB1588 – 1597.
[1272] CB1583.

782.2. identify learnings from major incidents; and

782.3. assist the coroner during the coronial investigation into the death.

783. The coronial investigation into Veronica's passing identified multiple concerning failings on the part of CV, JARO, Justice Health, DJCS and CCA in relation to the conduct of their enquiries.

Formal Debrief

784. The Instructions state that "the purpose of a formal debrief is to learn from the incident."[1273] Similarly, the Commissioner's Requirements state that a formal debrief "should critically examine the incident and related policies, procedures and practice, with a view to supporting staff and identifying ways in which incidents could be avoided or better managed in the future."[1274]

785. The JARO Report states that a formal debrief "is intended to prevent the future occurrence of similar incidents [and that] a root cause analysis should form the basis of the discussion".[1275]

786. The formal debrief in response to Veronica's passing was held in the DPFC Boardroom on 16 January 2020.[1276] Governor Jones candidly said in oral evidence that the debrief did not

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[1273] CB1592. However, the Instructions also note that a prison may determine, in consultation with the Deputy Commissioner or a Manager that a formal debrief is not necessary, "for example, following a death from apparent natural causes" where there are no suspicious circumstances.

[1274] CB1586.

[1275] CB2144.

[1276] CB643.

critically examine the incident[1277] and the minutes of the formal incident debrief (**Minutes**)[1278] confirm it.

787. The Minutes reveal that 34 CCA, CV, JARO and Justice Health staff members were invited to the formal debrief and no apologies were noted.[1279] The following staff members were not present:

787.1. Dr Runacres;

787.2. RN Hills;

787.3. RPN Chisvo;

787.4. PO Watts;

787.5. PO Hermans;

787.6. PO Cole;

787.7. PO Sonda;

787.8. PO Kay;

787.9. Dr Brown;

787.10. RN Minett;

[1277] Jones: T2797.15 – 18.
[1278] CB643 – 651.
[1279] CB643 – 644.

787.11. Supervisor Reid;

787.12. Aunty Lynne;

787.13. PO Antoniou;

787.14. Supervisor Urch; or

787.15. RN George.[1280]

788. Of the 34 attendees, only six attendees had any interactions with Veronica prior to her passing.[1281] Of those six, Supervisor Reid was the only attendee present who had had a face-to-face interaction with Veronica while she was at DPFC, other than through a trap in a cell door.

789. The meeting was chaired by the Governor of the Marngoneet Correctional Centre, Pat McCormick (**Governor McCormick**). The Minutes indicate that the debrief was opened without an Acknowledgement of Country and without any recognition of Veronica's Aboriginality or her identity as a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman.[1282]

790. PO Brown provided a brief outline of her interactions with Veronica and RN George overnight.[1283] CCA nurse Shelly Della Riva (**RN Dalla Riva**) who attended in RN George's

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[1280] RN George is noted in the minutes as being on leave at the time of the formal debrief, see CB644 [3].
[1281] CB643 – 644.
[1282] CB644.
[1283] CB644.

absence, recounted RN George's administration of medication, report of muscle cramps and said Veronica went to sleep afterwards.[1284]

791. The remainder of the debrief discussed the CV and CCA response to the discovery of Veronica's body. There was no discussion of:

791.1. Veronica having stayed in the Medical Centre overnight on 31 December 2019;

791.2. Veronica's clinical presentation, symptoms, treatment or deterioration;

791.3. the CCA clinicians who had treated and interacted with Veronica during her time at DPFC;

791.4. the number of times Veronica had requested assistance between 31 December 2019 and 2 January 2020;

791.5. whether Veronica should have been transported to hospital at any point; or

791.6. whether Veronica's treatment while in custody was culturally safe or culturally appropriate.

792. An attendee discussed that prisoners reported they had seen Veronica's body being removed from the Unit.[1285] It was noted that one prisoner saw Veronica's body being moved into the back of a van from her window.[1286]

[1284] CB 644 – 645.
[1285] CB646 [9].
[1286] CB646 [10].

793. The Minutes noted that Aboriginal prisoners were upset, concerned and asking questions. An attendee noted that he had "deescalated" their concerns and they were provided with a space "to vent".[1287]

794. Aboriginal Wellbeing Officer Jodie Chatfield (**Ms Chatfield**) was present. She reported that other Aboriginal prisoners were "angry," and that they had reported hearing Veronica crying out for help overnight.[1288] Ms Chatfield commended the Yarra Unit staff for reporting that they had moved Aboriginal women out of the Yarra Unit as this showed cultural sensitivity. I note here that Ms Bastin was moved from her cell at the same time as CV staff were placing 'crime scene' tape across the door of Cell 40 inside which Veronica's body lay, less than 10 metres away.[1289]

795. The formal debrief identified one action item for review,[1290] which was to review communications at DPFC with phones and portable devices, due to the difficulties staff had contacting each other after the Code Black was called.[1291] However, the Minute taker noted that "after much discussion, it was decided that communication equipment and processes at DPFC [were] adequate" and "no additional resources or improvements [were] required to be made".[1292]

[1287] CB647 [19].
[1288] CB647 [21].
[1289] Exhibit 13, CCTV Yarra Unit – 0500 to 0900, from [8:33].
[1290] CB650.
[1291] CB646 - 647.
[1292] CB650.

796. The meeting ended with Governor Jones stating that staff had supported the Aboriginal women well and that the smoking ceremony conducted following Veronica's passing was conducted in a culturally sensitive way.[1293] She also noted that she was "proud of [PO Brown] for the way [she] sensitively managed the intercom calls and how Nelson was treated in the last few hours".[1294]

797. Governor McCormick closed:

> I've been around multiple deaths and we try to identify gaps and what could have been done better. After reviewing the incident pack I can't see much that could have been improved. It was text book from the Field Commander. Maybe this incident would not have been handled as well at a different prison. The difference between good and poor prisons is the way you treat the prisoners. Look after yourselves and seek help if you need.[1295]

798. I find that the formal DPFC debrief conducted following Veronica's passing did not critically examine the incident, and that the minutes of the debrief were grossly inadequate and misleading.

Justice Health Review and Death in Custody Report

799. A Justice Health review was conducted involving a review of Veronica's medical records to establish:

[1293] CB649 [33].
[1294] Ibid.
[1295] CB649.

799.1. the nature of the health service provision and the care afforded to the prisoner prior to the death;

799.2. the identification of any systemic and/or emerging issues; and

799.3. whether any systemic health service delivery improvements could be made.[1296]

800. Justice Health sets the standards for health and alcohol and other drug services in prison and youth justice settings, monitors service delivery in these settings, and manages the contracts with prison health service providers.[1297]

801. On 4 September 2020, Justice Health finalised its Death in Custody Report (**Death in Custody Report**) in relation to Veronica's passing.[1298] This review was a desktop review.[1299]

802. The Death in Custody Report contained the following erroneous information:

802.1. that CCA staff recorded Veronica's BMI at the time of reception as 16.5;

802.2. that a clinical review of Veronica was undertaken at 5:30 PM on 1 January 2020 after she was transferred to the Yarra Unit; and

802.3. that RN George was unable to respond to Veronica's request for assistance at 3:00 AM on 2 January because she was busy caring for a number of other prisoners in the Medical Centre;

[1296] CB2149 [2.1].
[1297] CB2149 [2].
[1298] CB 2147 – 2155.
[1299] Swanwick: T2321.

803. The Death in Custody Report was absent any mention of:

803.1. Veronica spending the night of 31 December 2019 in the Medical Centre because she was unwell;

803.2. Veronica's request to be prescribed methadone by Dr Runacres and Dr Brown;

803.3. the number of times Veronica had used the intercom to request assistance and report symptoms overnight in the Medical Centre;

803.4. the number of times Veronica had vomited while in the Medical Centre;

803.5. the fact that Veronica had to be moved multiple times between cells while in the Medical Centre due to vomiting;

803.6. the number of times Veronica had used the intercom overnight on the Yarra Unit to request assistance for ill health;

803.7. that other prisoners had used the intercom overnight on the Yarra Unit to seek medical assistance on Veronica's behalf; or

803.8. that Veronica had not been seen by any Aboriginal Welfare Officer during her time at DPFC.

804. In evidence, Mr Swanwick accepted that the Death in Custody Report lacked relevant information.[1300]

805. The Death in Custody Report contained a review by the Justice Health Principal Medical Officer (**PMO**). The PMO found that:

805.1. the medical assessment conducted on by Dr Runacres was complete and that the Short Opiate Withdrawal Scale was completed with the detail required to provide a clear overview of Veronica's presentation;

805.2. though buphrenorphine had been commenced on a short-term prescription, it was "likely the prescription would have been continued" which the PMO noted "represented a patient-centred decision"; and

805.3. the management provided was appropriate because:

805.3.1. Ms Nelson was reviewed by a medical officer at reception on 31 December 2019 and on 1 January 2020; and

805.3.2. Ms Nelson was also checked by health staff on 2 January 2020 at approximately 2:00 AM, and was found to be fully alert and presenting with symptoms consistent with withdrawal from opioids.[1301]

806. The findings of the Death in Custody Report were said to be "based on a review of Ms Nelson's JCare medical record, interviews with CCA staff and the PMO's clinical opinion

[1300] Swanwick: T2323.
[1301] CB2154.

about Ms Nelson's clinical management".[1302] The Death in Custody Report ultimately found that:

806.1. There is nothing to suggest that the healthcare provided to Ms Nelson was not in accordance with the Justice Health Quality Framework 2014;

806.2. The substance withdrawal assessment and withdrawal regimen prescribed was appropriate and in accordance with best practice; and

806.3. Ms Nelson had not been able to commence OSTP during her previous periods of imprisonment, and she had not been referred to a community OST provider on any of her previous releases from prison.[1303]

807. The Death in Custody Report made one recommendation for systemic improvement, that CCA review its practices to ensure, where appropriate, referrals are made to community OST providers as part of the discharge planning processes when a patient is released from custody.[1304]

808. The finalised Death in Custody report was provided to JARO for the purpose of its review and attached to the final JARO Review Report.

809. I find that the Justice Health Death in Custody Report of Veronica's passing was grossly inadequate and misleading.

[1302] CB2155.
[1303] CB2155.
[1304] Ibid.

JARO Review

810. JARO operates as an "internal review and assurance function to advise the Secretary to the DJCS on the performance of youth justice and corrections systems."[1305] The JARO Review Report (**JARO Report**) states that:

> JARO provides the Secretary with current, objective information on areas of risk, the adequacy of existing controls and opportunities for improvement across the youth justice and corrections systems through activities including: proactive reviews and analysis into areas of risk in youth justice and correctional operations and services; and reviews into serious incidents and allegations within youth justice and corrections systems.[1306]

811. JARO finalised its review into Veronica's passing on 19 October 2020. The review was informed by the autopsy findings, CCTV footage and recordings of intercom calls.

812. The JARO Report:

812.1. accepted the advice of DPFC management that PO Brown had performed her duties as expected and, informed by previous experience managing withdrawing prisoners overnight, had exercised her best professional judgement;[1307]

812.2. accepted that PO Brown might often receive a higher number of intercom calls from prisoners who were withdrawing and that this informed her response to

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[1305] CB2123.
[1306] Ibid.
[1307] CB2140, [7.2].

Veronica,[1308] however made no recommendations about this and failed to recognise the underlying stigmatic assumptions;

812.3. made no criticism of the patrols conducted by PO Brown or her failure to observe Veronica directly and found that the patrols were completed according to expectations and had no effect on Veronica's health;[1309]

812.4. found that Ms Nelson's intercom calls overnight, and her presentation did not indicate that a Code Black overnight was required;[1310]

812.5. agreed that a root cause analysis should "form the basis of discussion" at the formal debrief[1311] but made no criticism of the way the debrief was conducted in this case;

812.6. found that the "incident response" was handled well;[1312]

812.7. commended an officer who reported having placed a pillow over the grille of the adjacent cell for their "compassionate response,"[1313] without noting that when this was done, Veronica's body had been visible to the prisoner in the adjacent cell through the grille for over 20 minutes;[1314] and

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[1308] CB2140.
[1309] CB2142.
[1310] CB2140.
[1311] CB2144, [8.3.1].
[1312] CB2145.
[1313] CB2143, [8.1.1].
[1314] Exhibit 13 – Yarra Unit CCTV 0500 to 0900, at [8:10]

812.8. found that the management of Veronica during her time in custody was "appropriate and in line with Corrections Victoria policies".[1315]

813. The JARO Report made three recommendations:

813.1. that the relevant Local Operating Procedure be updated to ensure it unambiguously reflected the requirement that Aboriginal or Torres Strait Islander prisoners are given access to a culturally-appropriate contact person within 24 hours of reception;

813.2. that a system is developed so that Aboriginal Welfare Officers are always advised of the arrival of an Aboriginal or Torres Strait Islander prisoner; and

813.3. that that system accounts for times when an Aboriginal Welfare Officer cannot be contacted immediately and provides an alternative process to ensure that new arrivals are seen as soon as possible.

814. The JARO Review reported that the incident response from the formal debrief was noted as "handled well despite the tragic outcome" and that "JARO agrees with this assessment."[1316]

815. I find that the Justice Assurance and Review Office (JARO) review of Veronica's passing was grossly inadequate and misleading.

[1315] CB2145.
[1316] CB2144.

CCA's Internal Enquiries

816. At the time of Veronica's passing, CCA Manager Shelly Della Riva (**Ms Della Riva**) entered an incident report on the CCA electronic incident reporting system (**Incident Report**).[1317] The Incident Report details the response of clinicians to the Code Black, and records under the heading 'investigation and followup': "statements from staff obtained, further investigation will be undertaken, cause of death at this point unknown".[1318] Ms Fuller denied that Ms Dalla Riva undertook any review of the incident but confirmed that she was asked to obtain draft statements for this inquest.[1319]

817. On 2 January 2020, Ms Fuller directed Mr Limpens to "get statements from the staff."[1320] As mentioned above, Mr Limpens was to ask staff to draft a statement.[1321] He said that in addition, he was directed to "develop a timeline of events, identify any points of concern that required immediate rectification, ensure all staff involved provided statements, follow up with any post incident support for staff, address any staff performance issues, and partake in ongoing quality improvement planning."[1322] He said that he collected information and "provided to and/or discussed" matters with executive management and human resources.[1323] Ms Fuller said that she did not receive any report from Mr Limpens[1324] and denied that CCA

[1317] Fuller: T2949.21 – 29; AM 1430 – 1431.
[1318] AM1432.
[1319] Fuller: T2949.
[1320] Fuller: T2950.27.
[1321] Fuller: T2952.17.
[1322] Limpens: AM1173.
[1323] Limpens: AM1173.
[1324] Fuller: T2968.28-31.

executive management had expressed a preference that a statement not be obtained from RN Hills.[1325]

818. Dr Blaher confirmed that CCA did not conduct a root cause analysis or any similar internal review following Veronica's passing and acknowledged that not doing so was contrary to the JHQF.[1326] The Medical Conclave gave evidence that internal reviews are "absolutely necessary"[1327] and they immediately occur in public hospitals.[1328]

819. At the time of Veronica's passing, and while the Justice Health review was still underway, CCA possessed significant information concerning Veronica's clinical management at DPFC:

819.1. Dr Brown made notes on the day of Veronica's passing which confirmed that she had considered sending Veronica to hospital during her first assessment on 1 January 2020, but ultimately decided against it;[1329]

819.2. RN Minett prepared a draft statement within two weeks of Veronica's passing[1330] in which he acknowledged that he had reviewed Veronica's file and became aware that Dr Brown had scheduled afternoon observations for Veronica in the afternoon of 1 January 2020, which he did not conduct;[1331]

[1325] Fuller: T2956.16 – T2967.8; T3010.18-26.
[1326] Blaher: T2903.19 – T2905.12. The JHQF requires that 'serious adverse incidents are analysed to determine root causes using contemporary root cause analysis process.'
[1327] Issa, Medical Conclave: T2331.5-11; Milner, Medical Conclave, T2332.16-29.
[1328] Walby, Medical Conclave: T2331.27 – T2332.3.
[1329] Brown: AM839.
[1330] Minett: AM1412.
[1331] Minett: AM1413, [11].

819.3. Dr Blaher realised shortly after Veronica's passing that Dr Runacres' Initial Appointment Notes were inaccurate[1332] and that there were "absences" in Veronica's medical records.

820. None of this information was provided to Justice Health by CCA.[1333] CCA also failed to inform Justice Health that Mr Limpens had been tasked with collecting statements relating to Veronica's clinical management.[1334]

821. Concerningly, Dr Blaher was aware that CCA held statements from its staff that contained more detail than Veronica's JCare file, but did not inform Justice Health[1335] despite knowing that CCA's contractual supervisor Justice Health would be conducting a review into Veronica's passing.[1336]

822. All this information was withheld from the entities tasked with conducting reviews of the circumstances of Veronica's passing in custody. When questioned about this, Ms Fuller agreed that the approach taken by CCA was "they didn't ask, so [we] didn't tell".[1337]

823. I consider this to be an appalling lack of disclosure by CCA, a public authority under the Charter, which was aware of, to some extent at least, its own failings in relation to Veronica.

824. On the basis of the available evidence:

[1332] Blaher: T2899-2901.
[1333] Brown: T713-714; Fuller: T2953-2954; Blaher: T2903.
[1334] Fuller: T2952.8 – T2954.7; T2965.5-20.
[1335] Blaher: T2903.
[1336] Blaher: T2902-2903.
[1337] Fuller: T2965.19-20.

824.1. I find that CCA failed to provide critical information to Justice Health following Veronica's passing;

824.2. I find that CCA's failure to undertake a root cause analysis or similar internal review at the time of Veronica's passing was contrary to the requirements of the Justice Health Quality Framework; and

824.3. I find that Justice Health's failure to ensure that CCA undertook a root cause analysis or similar internal review at the time of Veronica's passing was contrary to the requirements of the Justice Health Quality Framework.

WAS VERONICA'S PASSING PREVENTABLE?

825. Counsel for CCA submitted that there is no evidence before me to support a finding that Veronica's passing was preventable because:

825.1. Dr Baber was unable to separate which element of the cause of death operated "just that little bit more",[1338] so it is inappropriate to draw conclusions about whether Veronica's death was preventable;

825.2. the evidence of the Medical Conclave that "there is a very high chance that [Veronica] would have survived, had she been transferred at approximately 11:00 AM [on 1 January 2020],"[1339] does not provide clear evidence about the kind of management and treatment Veronica could have received at hospital, the timeliness

[1338] Baber: T2072.22 -23.
[1339] Bell, Medical Conclave: T2247.18 – 27.

of such treatment, and whether such treatment would have addressed the causative factors of Veronica's passing; and

825.3. in his expert report, Dr Milner opined that "a sudden death due to electrolyte disturbance from chronic Wilkie's Syndrome and opioid withdrawal may still have occurred,"[1340] even if Veronica had been transported to hospital at some stage following her reception to DPFC.

826. There is no requirement within the scope of the 'common sense' test of causation[1341] that a finding of preventability be supported by counter-factual evidence regarding the nature of the treatment that might have been provided at hospital. Such a submission conflates the question of whether Veronica's death was preventable with the question of the kind of treatment that would have prevented it.

827. I also reject the submission that it is inappropriate for me to make findings on the preventability of Veronica's passing, simply because the medical cause of her death was multifactorial. Veronica died of cardiac failure resulting from electrolyte disturbances.[1342] Whether the vomiting, diarrhoea and malnutrition were predominantly caused by Wilkie Syndrome, or opiate withdrawal, or both equally, is immaterial to this point. The evidence is that Veronica's condition could have been addressed and corrected upon a transfer to

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[1340] Submissions on behalf of CCA, dated 17 June 2022.
[1341] *March v Stramare Pty Ltd (E & MH) Pty Ltd* [1991] HCA 12.
[1342] Dr Vickers: CB4172-4173; Dr Bell: CB2061; Dr Baber: T2078.24-30.

hospital, where Veronica would have received intravenous fluids and electrolyte replacement.[1343] This is a sufficient basis to make a finding that her death was preventable.

828. Moreover, the Medical Conclave was unanimous that Veronica's death was preventable.[1344] Although they could not identify the precise point at which Veronica's passing was no longer preventable, they opined that a transfer to hospital as late as 1:30 AM on 2 January 2020 may have saved her.[1345]

829. I accept the expert opinion of the Medical Conclave that Veronica's death was preventable and, on the balance of probabilities, would have been prevented if she had been transferred to hospital at any point between her arrest and her passing.

830. I am satisfied that there were many missed opportunities to intervene to prevent Veronica's passing had she only been sent to hospital.

831. I find that Veronica's death was preventable.

DECISION NOT TO EFFECTIVELY IMPLEMENT THE RCADIC RECOMMENDATIONS

832. Thirty years ago, the RCADIC recommended that:[1346]

832.1. Police adopt and apply the principle of arrest being a sanction of last resort;[1347]

[1343] Bell: CB2052; Vickers: CB4174.
[1344] Walby, Medical Conclave: T2245.
[1345] Walby, Medical Conclave, T2246.19-25.
[1346] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991) Vol 5, recommendations.

832.2. Police administrators take an active role in ensuring compliance with directives and guidelines aimed at reducing unnecessary custodies;[1348]

832.3. Police procedures should be reviewed to ensure that processes do not encourage arrest and remand rather than the adoption of other options;[1349]

832.4. Police training courses be continuously reviewed to ensure a substantial component of training relates to interactions between police and Aboriginal people;[1350]

832.5. the operation of bail legislation be closely monitored by government to ensure that the entitlement to bail is recognised in practice;[1351]

832.6. governments consider amending bail legislation which inappropriately restricts the grant of bail to Aboriginal people;[1352]

832.7. Judicial Officers whose duties bring them in contact with Aboriginal people be encouraged to participate in appropriate training designed to emphasise the historical and social factors which contribute to the social disadvantage of Aboriginal people;[1353]

[1347] Ibid, Rec 87(a).
[1348] Ibid, Rec 87(c).
[1349] Ibid, Rec 87(c)(v).
[1350] Ibid, Rec 228.
[1351] Ibid, Rec 89.
[1352] Ibid, Rec 91.
[1353] Ibid, Rec 96.

832.8. governments take more positive steps to recruit and train Aboriginal people as court staff;[1354]

832.9. police services, corrective services and other authorities recognise that they owe a legal duty of care to a person in custody;[1355]

832.10. duty of care is understood to mean that authorities may be held legally responsible for the death of the person to whom they owe that duty if it is breached;[1356]

832.11. police and corrective services establish procedures for de-briefing following incidents so that the actions of those involved can be discussed and assessed with a view to reducing risks in the future; [1357]

832.12. the healthcare available to persons in custody be equivalent to that available in the general public, and are adequately resourced and staffed by appropriately competent personnel;[1358]

832.13. carceral healthcare be reviewed to consider the standard of general and mental healthcare available to Aboriginal prisoners and the extent to which services provided are culturally appropriate;[1359]

[1354] Ibid, Rec 100.
[1355] Ibid, Rec 122 (a).
[1356] Ibid, Rec 122 (b).
[1357] Ibid, Rec 124.
[1358] Ibid, Rec 150.
[1359] Ibid, Rec 152.

832.14. Aboriginal Health Services be involved in carceral healthcare for Aboriginal prisoners;[1360]

832.15. detailed guidelines are established to govern the exchange of information between prison medical staff and corrections officers;[1361]

832.16. protocols are developed detailing the specific action to be taken by officers with respect to the care of prisoners identified at the screening assessment as being at risk, and persons with drug or alcohol related conditions;[1362]

832.17. prison medical services be the subject of ongoing review;[1363]

832.18. all staff of prison medical services receive training to ensure they have an adequate understanding of the issues which relate to Aboriginal health, including Aboriginal history, culture and lifestyle;[1364]

832.19. agencies responsible for the delivery of carceral health services employ Aboriginal persons in those services;[1365]

832.20. upon reception to prison, all Aboriginal prisoners receive a thorough medical assessment;[1366] and

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[1360] Ibid, Rec 152 (c).
[1361] Ibid, Rec 152 (f).
[1362] Ibid, Rec 152 (g).
[1363] Ibid, Rec 153 (a).
[1364] Ibid, Rec 154.
[1365] Ibid, Rec 154 (c).
[1366] Ibid, Rec 156.

832.21. police and prison officers be instructed to immediately seek medical attention if any doubt arises about a detainee's condition.[1367]

833. In 2018, a federal government found that only 6% of the RCADIC recommendations were yet to be implemented partially or in full.[1368] The congruence of the recommendations arising from my investigation into Veronica's passing and those of the RCADIC suggests that if this statistic is to be believed, 'implementation' of the RCADIC recommendations has achieved too much policy, and not enough change.

834. Accordingly, I find that, had the RCADIC recommendations been successfully implemented by the Government and its agencies, Veronica's passing would more likely than not have been prevented.

CHANGES IMPLEMENTED FOLLOWING VERONICA'S PASSING

835. I have been informed of a number of procedural, policy, and other changes implemented since Veronica's passing.

Correct Care Australasia

836. CCA implemented a number of procedural and policy changes in response to Veronica's passing.[1369]

837. The CS12.1 Drug and Alcohol Assessment Policy was amended to:

[1367] Ibid, Rec 161.
[1368] Ibid.
[1369] Supplementary statement of Christine Fuller dated 11 May 2022, AM 919 – AM 1164.

837.1. require patients showing signs of drug withdrawal to undergo a formal drug and alcohol assessment, and that a treatment plan is developed and implemented;

837.2. require that patient observation and review frequency is to be determined by the medical officer and documented in JCare;

837.3. require a patient to be seen immediately by the medical officer where they need symptomatic review or transfer to hospital;

837.4. require the decision to manage patients who need ongoing monitoring of withdrawal symptoms in the medical centre at DPFC to be made in consultation between a medical officer and custodial staff, and communication and documentation of observation requirements and when hospital transfer should be considered; and

837.5. specify that symptoms of dehydration include hypertension, tachycardia and anuria which will prompt hospital transfer.

838. CCA also updated its CS12.3 Opioid Substitution Therapy Program policy and associated fact sheets to include that:

838.1. where a patient requests OSTP but is unable to commence OSTP due to a short sentence, consideration is given to a referral to a community alcohol and other drug service or OSTP provider where appropriate; and

838.2. on reception, contact is made with the patient's community OSTP prescriber and pharmacy (if any) to ascertain the patient's progress on the program and the current dosing instructions.

839. CCA has also amended its Clinical Deterioration and Observation Policy to ensure that all decisions made to observe a patient in the Medical Centre, rather than transfer to an emergency department, must be discussed with the nurse in charge and a medical officer (if onsite) and custodial staff informed. Where there is any doubt, the policy prescribes that an ambulance must be called.[1370]

840. CCA has recently partnered with the Eva Burrows College to offer staff an opportunity to complete accredited alcohol and other drug courses.

841. CCA has engaged an Aboriginal Consultant who assists by:

841.1. reviewing and developing the model of care, particularly for Aboriginal and/or Torres Strait Islander men and women in the correctional system;

841.2. receiving feedback from Aboriginal women at DPFC;

841.3. advising CCA on implementation of a Patient Advisory Group;

841.4. facilitating interface between Aboriginal patients and CCA staff; and

841.5. advising the CCA Executive on the development of its Reconciliation Action Plan.

[1370] CCA: Clinical Deterioration and Patient Observation, AM940, [7].

842. CCA has updated its Emergency Guidelines for Registered Nurses to include clear guidance to nurses about assessment and management of patients for a range of emergency situations.

843. CCA has tightened daily handover processes for nurses and now rosters a second nightshift nurse.

844. Nurses in the Medical Centre at DPFC are now permitted to use a mobile phone during a Code Black to facilitate ambulance attendance.

Magistrates' Court of Victoria

845. MCV has introduced an additional role of Court Support Services - Koori Support Practitioner. This practitioner supports Aboriginal and/or Torres Strait Islander court users, with a focus on those in custody.[1371]

846. MCV has also introduced roles of Navigation and Triage Coordinator and Navigation and Triage Officer as part of its new Navigation and Triage (NAT) service. The NAT service provides support to court users and advice to the judiciary, court staff, lawyers, and other stakeholders of the options available to meet a person's support needs either in the community or through mainstream court support or specialist courts.

[1371] Hollingsworth, T2479.22 – T2481.28; correspondence from MCV: AM1429 – AM1448.

Victoria Legal Aid

847. VLA has made changed its bail funding guidelines since Veronica's passing to clarify that bail applications for Aboriginal and/or Torres Strait Islander clients will always be funded.[1372]

848. VLA has also implemented changes to its duty lawyer guidelines to prioritise bail applications at first remand for Aboriginal and/or Torres Strait Islander clients.

Victoria Police

849. Victoria Police has implemented a new Aboriginal Cultural Awareness Training package that is now mandatory for all police and protective service officers. The training aims to strengthen police and Aboriginal community relationships by highlighting the importance of working in partnership to enhance culturally competent policing responses. Victoria Police reports that the training has already been delivered to over 2600 employees.[1373]

Justice Health

850. Mr Swanwick testified that the process for preparing a Justice Health Death in Custody review has changed to require that interviews are conducted with relevant staff.[1374]

851. Mr Swanwick also advised that Justice Health is undertaking a review of the Death in Custody Local Operating Procedure to address the shortcomings identified in the Justice Health review and final report in Veronica's case.[1375]

[1372] Victoria Legal Aid media release dated 22 July 2022, AM 1976 – AM 1979.
[1373] Submissions in Reply filed on behalf of the Chief Commissioner of Police, dated 17 October 2022, [48].
[1374] Evidence of Scott Swanwick, T 2322.1 – T2322.16.

Corrections Victoria

852. Following the close of evidence, I received information from Corrections Victoria about its implementation of the recommendations from the DPFC Optional Protocol to the Convention Against Torture review.[1376] CV's action plan as at April 2022 appears in the coronial brief.[1377]

853. In response to the JARO review into Veronica's passing, Corrections Victoria accepted and implemented the following recommendations[1378]:

853.1. that the General Manager of DPFC review the *2.07.1 Local Operating Procedure for Aboriginal and/or* Torres *Strait Islander Prisoners* to ensure that it unambiguously states the requirement that Aboriginal and/or Torres Strait Islander prisoners are given access to a culturally appropriate contact person within 24 hours of reception;

853.2. that the General Manager of DPFC ensure that a system is developed to ensure an Aboriginal Welfare Officer or Aboriginal Service Officer is advised of the arrival of an Aboriginal and/or Torres Strait Islander prisoner;

[1375] Ibid, T2327.27 – 2328.10.

[1376] Victorian Ombudsman, *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* (Final Report, November 2017).

[1377] Corrections Victoria Action Plan in response to Victorian Ombudsman's *Implementing OPCAT in Victoria: report and inspection of Dame Phyllis Frost Centre*, AM 1982 – 1994.

[1378] Statement of Assistant Commissioner Melissa Westin dated 31 December 2021, CB 4298 – 4323.

853.3. that the General Manager of DPFC ensure that the system accounts for times when neither an Aboriginal Welfare Officer or Aboriginal Service Officer can be immediately contacted and provides an alternative process to ensure that new arrivals are seen as soon as possible; and

853.4. that all staff maintain accurate and contemporaneous records of any interactions with Aboriginal and/or Torres Strait Islander prisoners.

CONCLUSION

854. This investigation provided me an opportunity to consider the factors that led to Veronica's incarceration in the first place. It involved considering the practical implications of the 2018 changes to the Bail Act, and whether the resulting effects have been congruent with the stated aims of the amendments.

855. It required me to look at the limitations of Victoria's criminal justice system, in considering how our system allowed Veronica to appear unrepresented at her bail hearing, whether she was an alleged offender in respect of whom Police should have opposed bail, or at least turned their minds to the question of bail, and whether her Aboriginality and medical history were adequately accounted for by the institutions making decisions in relation to her.

856. This investigation then followed Veronica's custodial path inside Victoria's largest maximum-security women's prison. It allowed me an opportunity to examine how Veronica, and other women in similar circumstances, are treated behind bars by medical professionals and prison officers alike. It necessarily required me to assess whether such treatment is in accordance with our human rights law, community standards, and shared values of human

decency. It required me to consider the extent to which stigma associated with Veronica's Aboriginality, opioid dependency and criminal antecedents influenced the decisions that were made in relation to her care and management inside that prison.

857. Finally, this investigation posed some concerning questions about the operation of custodial healthcare in this state. The apparent flaws in the provision of these services by the hybrid public authority contracted to provide them, in turn raised questions about the Government's monitoring of these substantial funding agreements, for the provision of a service that is legally required to be provided to the equivalent standard that we all should expect to receive in the community.

858. Those systems do not change nor improve when Governments fail to conduct adequate reviews of Aboriginal deaths in custody, as was the case in response to Veronica's passing. Had Veronica's passing not proceeded to coronial inquest, the findings of the JARO Report, Death in Custody Report and formal debrief would have remained as the only official investigations pertaining to this tragedy. It is a deeply concerning prospect to contemplate. The disturbing "don't ask/ don't tell" arrangement that DJCS and CCA appear to have had with one another is a matter of grave public interest and goes part of the way to explaining how so many continual and repeated systemic failings were permitted to occur in this case.

859. Each of these lines of inquiry could not be considered in a vacuum; because Veronica's passing, tragically, is not an anomaly. In the twelve months after Veronica's passing, four

more women died at DPFC. One of those women was also Aboriginal or Torres Strait Islander. In 2020-21 there were at least 15 Indigenous deaths in custody nationally.[1379]

860. The *National Agreement on Closing the Gap*[1380] committed to a reduction of at least 15% in the incarceration rate of Aboriginal and Torres Strait Islander people by 2031. However, recent reporting shows a continuing increase in the Aboriginal prison population nationally since 2019. [1381] It is clear that the current approaches are not working, and these failures continue to carry a human cost.

861. This cost is heightened by the invaluable and irreplaceable cultural wisdom, traditions, and knowledge that our First Nations people offer to the fabric of Australian identity. This country is home to the oldest living civilisation in the world, with Indigenous ancestries stretching back over more than 60,000 years.

862. Our First Nations people are a proud, intelligent, inventive, and deeply spiritual peoples, who were living and thriving on this land long before European settlement. Yet the impacts of historical policies of intervention, removal and destruction have created a legacy of intergenerational trauma that lives on today.

863. What is needed is responsive and culturally informed policymaking: policy which listens to the cries of First Nations voices, and invests the time, energy and resources into truly

[1379] Australian Institute of Criminology, *Deaths in custody in Australia 2020-21* (Statistical Report No 37, July 2021).

[1380] Productivity Commission, *Closing the Gap Annual Data Compilation Report* (Report No 2, July 2022) ('Closing the Gap')

[1381] Productivity Commission, *Closing the Gap Annual Data Compilation Report* (Report No 2, July 2022)

understanding their experiences. The adoption of tokenistic policies of inclusion and anti-discrimination are not going to cut through and have not been anywhere near effective enough. Such policies only work to serve the public relations interests of those with power, and are miles removed from the everyday wants and needs of the vulnerable people they profess to support.

864. Governments have had the answers to the problems identified in Veronica's case for over thirty years. The findings and recommendations of RCIADIC were reasonable and implementable, and they should have resulted in the type of widespread systemic changes that could have prevented the tragedy of Veronica's passing from occurring.

865. Aboriginal and Torres Strait Islander people have been calling on Governments and their institutions for decades: to stop locking up their communities for minor offences, to stop putting their children in prison, and to stop subjecting their people to systemic discrimination. Aunty Donna Nelson opened the inquest saying:

> The lessons learned from this inquest must stop my people from dying in custody.
>
> But let's not lose focus. This inquest is first and foremost about Veronica, and how a broken criminal justice system locked my daughter up to let her die while she begged for help, over and over.[1382]

866. Our criminal justice system must do better for people like Veronica, and it should have done much better for her in this case.

[1382] Aunty Donna: T36.

867. The stories of our First Nations people should highlight their resilience, strength, history, and culture. Too often do we have to tell stories like this one; a story of needless suffering in the custody and care of Government. It is a narrative that needs to change, that the Government has made a commitment to change, and toward which I am hopeful this inquest will have provided further impetus.

868. I reiterate my gratitude to the many First Nations people who have assisted my investigation, and from whom I have learned much about their culture, traditions, beliefs, and experiences.

869. I recognise that this inquest largely involved others telling the story of Veronica's life and passing. Police, judicial officers, prison guards, carceral health workers, and heads of organisations did not know Veronica, and did not understand who she truly was. To remember the person Veronica was, and the daughter Aunty Donna has lost, I allow Veronica to close this finding in her own words:

> My mother is like flowers in the garden of life. Within my mother is my best friend. Never hard to find, hard to lose and impossible to forget. True friendship comes when the silences between two people are comfortable. My mother has always been like my father – someone who knows the song in my heart, and they have always been the ones to sing it back to me when I have forgotten the words. Side by side or miles apart, I've always kept her close in my heart.
>
> …I'm ready to stop failing and falling apart. It's time for me to go home where I belong. For there are some people in life who make you strong, make you laugh a little louder, smile a little bigger, live just so much better.

> When I left her, walking away from her…my life turned to darkness…Life without her is like the sky without the sun. When my father [passed] away I became lost: straying from my path, using drugs to numb the pain time and time again. Now I'm ready to treasure the tears, treasure the laughter, most importantly treasure his memories. I'm ready to take responsibility for my actions.
>
> My mother has always been the one who brings out the best in me.[1383]

870. I wish to convey my sincere condolences to Aunty Donna, Percy, and Veronica's family, friends, and community for their loss. I hope that the close of this inquest brings you some small peace, and that you go from here to tell Veronica's story in your own words, and remember her as she would have wanted to be remembered: a wise, kind, strong, and proud Aboriginal woman, who saw the light of hope, beauty, and goodness in herself and in others, even through darkness.

NOTIFICATIONS AND REFERRALS

The Victorian Legal Services Board and Victorian Legal Services Commissioner

871. On the basis of findings relevant to Tass Antos, I will distribute a copy of my finding to the Victorian Legal Services Board and Victorian Legal Services Commissioner for its consideration.

[1383] CB1943.

The Australian Health Practitioner Regulation Agency

872. On the basis of findings relevant to Dr Sean Runacres and Registered Nurse Atheana George between 31 December 2019 and 2 January 2020, I will distribute a copy of my finding to the Australian Health Practitioner Regulation Agency for its consideration.

Referral of to the Director of Public Prosecutions

873. Section 49 of the Act states that if a coroner believes that an indictable offence may have been committed in connection with a death, then they must notify the Director of Public Prosecutions. This notification is mandatory, not discretionary.

874. For my purposes, the concept of belief has been variously expressed. However, it is settled that it requires something more than suspicion and is an inclination of the mind towards assenting to, rather than rejecting, a proposition, based on facts that are sufficient to create that inclination of the mind in a reasonable person.[1384]

Offence under s 23 of the Occupational Health and Safety Act 2004

875. Section 23 of the *Occupational Health and Safety Act 2004* creates an indictable offence for an employer to fail to ensure, so far as is reasonably practicable, that persons other than employees of the employer are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer. This is an indictable offence and requires that:

875.1. the Accused was an employer at the relevant time;

[1384] *George v Rockett* (1990) 170 CLR 104.

875.2. there was a risk to the health and safety of non-employees from the employer's undertaking;

875.3. the Accused failed to take an identified measure which would have eliminated or reduced the risk (as the case may be); and

875.4. it was 'reasonably practicable' in the circumstances for the employer to have taken those measures.[1385]

876. It is not disputed that CCA was an employer at the relevant time and that there was a risk to the health and safety of non-employees from their undertaking. I have found that CCA lacked a number of clear policies or processes for the safe medical management of their patients, many of whom were regularly presenting to them afflicted by various recognised medical risks. Although I accept that there are structural barriers present in custody which can affect the way healthcare is provided and might, in some circumstances, limit CCA's capacity to mitigate particular risks, those structural barriers do not apply to the creation of clear policies and processes which were absent in Veronica's care.

877. In those circumstances, I am satisfied that there is evidence of a sufficient level, more than mere suspicion or conjecture, for me to form the belief that an indictable offence may have been committed. I must therefore notify the Director of Public Prosecutions of same.

[1385] *DPP v Vibro-Pile* (2016) 49 VR 676 at [6]; *DPP v JCS Fabrications Pty Ltd & Anor* [2019] VSCA 50, [25].

STATUTORY FINDINGS

878. Pursuant to section 67 of the Act, I have made findings relevant to Veronica's passing throughout this document. However, for convenience, a list of all my findings appears in Appendix B.

COMMENTS

879. Pursuant to section 67(3) of the Act, I make the following comments connected with Veronica's passing.

880. The investigation into Veronica's passing highlighted that despite its inclusion in the Bail Act more than a decade ago, section 3A has not had the effect of reducing the number of Aboriginal people remanded in custody. The Administration of Justice Conclave opined that the reason may be that the provision and its application in practice is not well understood by police, the legal profession, and members of the judiciary. To support judicial officers, particularly those presiding in Magistrates' Courts where the highest volume of bail/remand applications are heard, specific training to address the interpretation and application of s3A of the Bail Act should be developed and offered by the Judicial College of Victoria in collaboration with Aboriginal people.

881. I received submissions in relation to the transfer of the oversight of custodial health to the Department of Health.

881.1. It appeared the universal view of the Medical Conclave that the Department of Justice was not well suited to administering health and that the oversight of healthcare in prisons should be moved into the portfolio of the Department of

Health.[1386] They opined that the current model of care appeared to be a "punitive" form of health care reluctant to provide appropriate treatment.[1387]

881.2. The evidence suggests that fundamental failings in Veronica's custodial healthcare were caused by the flaws in the current governance structure of healthcare at DPFC. The expert evidence supports the transfer of governance to the Department of Health, which could draw upon its institutional knowledge as well as its access to a network of public and private health services to establish appropriate referral and oversight pathways, with therapeutic rather than punitive objectives.

881.3. While I do not consider that there is sufficient evidence before this inquest detailing the capacity of each department to satisfactorily oversee custodial healthcare, I agree that the systemic failings evident in Veronica's passing require systemic solutions. One solution is a transfer of responsibility: I urge the Department of Health and the Department of Justice and Community Safety to consider the opinion of the medical conclave and conduct further enquiries in relation to it.

RECOMMENDATIONS

882. Pursuant to section 72(2) of the Act, I make a number of recommendations connected with Veronica's passing which appear in Appendix C.

[1386] Bell, Medical Conclave, T2324.18-23; Clark, Medical Conclave: T2277.13-2278.1.
[1387] Bonomo, Medical Conclave, T2309.3-10.

ORDERS

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

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

884.1. Aunty Donna Nelson, Senior Next of Kin, c/- Robinson Gill Lawyers;

884.2. Percy Lovett, Senior Next of Kin, c/- Victorian Aboriginal Legal Service;

884.3. Chief Commissioner of Victoria Police, c/- Russell Kennedy Lawyers;

884.4. Correct Care Australasia, c/- Meridian Lawyers;

884.5. Rebecca Falkingham, Secretary, Department of Justice and Community Safety;

884.6. Dr Alison Brown, c/- Ball and Partners;

884.7. Dr Sean Runacres, c/- Kennedy's Lawyers;

884.8. Fitzroy Legal Service;

884.9. Forensicare, c/- HWL Ebsworth;

884.10. G4S Custodial Services, c/- GC Legal;

884.11. Jillian Prior, c/- Hall and Wilcox;

884.12. Law and Advocacy Centre for Women;

884.13. Stephanie Hills, c/- Gordon Legal;

884.14. Tracey Brown, c/- Becketts Lawyers;

884.15. Tracy Jones, c/- Clayton Utz;

884.16. the Victorian Equal Opportunity and Human Rights Commission;

884.17. Victoria Legal Aid;

884.18. WorkSafe Victoria;

884.19. Australian Health Practitioners Regulation Agency;

884.20. the Victorian Legal Services Board and Victorian Legal Services Commissioner;

884.21. the Director of Public Prosecutions;

884.22. the Hon Jaclyn Symes, Attorney-General;

884.23. the Hon Enver Erdogan MP, Minister for Corrections;

884.24. Deborah Glass, the Victorian Ombudsman;

884.25. the Judicial College of Victoria;

884.26. the Magistrates Court of Victoria; and

884.27. Senior Constable Chris Egan, Coroner's Investigator.

884.15. Tracy Jones, c/- Clayton Utz;

884.16. the Victorian Equal Opportunity and Human Rights Commission;

884.17. Victoria Legal Aid;

884.18. WorkSafe Victoria;

884.19. Australian Health Practitioners Regulation Agency;

884.20. the Victorian Legal Services Board and Victorian Legal Services Commissioner;

884.21. the Director of Public Prosecutions;

884.22. the Hon Jaclyn Symes, Attorney-General;

884.23. the Hon Enver Erdogan MP, Minister for Corrections;

884.24. Deborah Glass, the Victorian Ombudsman;

884.25. the Judicial College of Victoria;

884.26. the Magistrates Court of Victoria; and

884.27. Senior Constable Chris Egan, Coroner's Investigator.

Signature:

SIMON McGREGOR
Coroner

30 January 2023

APPENDIX A

THE ROLE OF THE CHARTER IN CORONIAL PROCEEDINGS

1. The *Charter of Human Rights and Responsibilities 2006* (Vic) (**the Charter**) influences coronial proceedings in the following:

   a. The application of the Charter to the Coroners Court itself;

   b. The application of the Charter to public authorities (other than the Coroners Court);

   c. The Charter rights engaged by the factual events within the scope of the inquest.

Application of the Charter to the Coroners Court itself

2. The Charter applies to the Coroners Court itself in a number of ways:

   a. Firstly, the Coroner's Court is acting administratively when conducting investigation, even if not whilst conducting an inquest, and is therefore a public authority at those times[1]. Accordingly, pursuant to s 38(1) of the Charter, the Court is required to act compatibly with human rights (known as the 'substantive obligation') and to give proper consideration to relevant human rights when making those administrative decisions (known as the 'procedural obligation').

      i. The obligation to act compatibly with human rights impacts upon the manner in which the Court conducts our proceedings, including in a case such as this, the right to a fair hearing, the right to equality and Aboriginal cultural rights. The Charter also requires that the Coroner's Court to act compatibly with the right to life, which requires an effective investigation into deaths. An effective investigation is one

[1] In *Kracke v Mental Health Review Board* [2009] VCAT 646; [2009] 29 VAR 1 at [418] Bell J held that s 24(1) is not confined to proceedings of a judicial character and can cover civil proceedings of an administrative character. Whilst coronial proceedings are inquisitorial in nature, they are still civil proceedings and parties to the proceedings have a right to a fair hearing in accordance with s 24(1).

the recommendations power in s 72 and comments power in s 67(3) is one that includes the power to make recommendations and comments in relation to human rights issues connected to the death.

3. Accordingly, whether through the direct application of the Charter under s 6(2)(b), through the interpretation of the Coroners Act pursuant to s 32, or through the obligations upon public authorities pursuant to s 38, the Coroners Court has obligations to:

   a. Adopt procedures to ensure that an inquest is conducted in a manner that is compatible with human rights, including the right to a fair hearing in s 24(1) and the right to equality before the law (s 8(3)); and

   b. Consider and investigate breaches of human rights that might have caused or contributed to the death.

The Coroners Court is a public authority when conducting most parts of its investigation, but not when the investigation is being finalised at inquest

4. The Commission submits that the Coroners Court is a public authority when conducting an inquest and when making factual findings and recommendations. This is the only significant issue upon which I was not persuaded by the Commission's comprehensive and helpful submissions.

5. The concept of a "public authority" is a key element in the scheme of the Charter. The Charter defines "public authority" in s 4(1) by identifying a list of persons and bodies that are public authorities. Some persons or bodies are expressly declared by the Charter not to be public authorities. Section 4(1)(j) provides that a public authority does not include:

> a court or tribunal except when it is acting in an administrative capacity;

that considers and properly investigates apparent breaches of human rights that might have caused or contributed to the death.

ii. The obligation to give proper consideration to relevant human rights applies when the Coroner's Court is making a decision during the investigation phase of proceeding. This includes determinations made by the Coroner's Court pursuant to s 67(1) of the Coroners Act as to the cause and circumstances of the death as well as recommendations under s 67(3) and comments under s 72(2). Rights will be 'relevant' where it is apparent that actions incompatible with those rights may have contributed to or caused the death or are relevant to circumstances of the death, comments or recommendations.

b. Secondly, irrespective of whether the Coroners Court is a public authority, pursuant to s 6(2)(b) the Charter applies directly to the Coroners Court insofar as it has functions under the rights in Part 2 of the Charter. As with courts generally, the Coroners Court has functions under a number of rights in Part 2 so as to directly apply to the manner in which hearings are conducted, including the right to a fair hearing under s 24 and the right to equality before the law in s 8. Further, the Coroners Court has functions under the right to life to conduct an effective investigation into deaths. As noted above, an effective investigation is one that considers and properly investigates apparent breaches of human rights that might have caused or contributed to the death.

c. Finally, s 32 of the Charter applies to the provisions of the Coroners Act, such that the powers of the Coroner are to be construed compatibly with human rights. For instance, a compatible interpretation of the power in s 67(1) of the Coroners Act is one that involves the Coroner investigating breaches of human rights that might have caused or contributed to her death. A compatible interpretation of

> Note: Committal proceedings and the issuing of warrants by a court or tribunal are examples of when a court or tribunal is acting in an administrative capacity. A court or tribunal also acts in an administrative capacity when, for example, listing cases or adopting practices and procedures.

6. I shall return to the issue of whether committal proceedings provide any valid comparator for the classification of coronial proceedings below, but it will suffice for now to observe that the Coroners Court is a "Court" within the meaning of the Charter. Indeed, it was added to the Charter's definition of a court by consequential amendments made by the Coroners Act.[2] The obverse is also true, in that coroners themselves are excluded from the definition of a "public official" by section 4 of the *Public Administration Act 2004,* which in turn exempts them from being a public authority under section 4(1)(a) of the *Charter*, and in relation to which section 89(3) of the Coroners Act has some relevance (whereby a coroner will constitute the Coroners Court when exercising functions under the Coroners Act).

7. The key distinguishing factor to determine if a court is a public authority (or not) is whether the court is "acting in an administrative capacity". That expression is not defined in the Charter. However, the note to s 4(1)(j) reproduced above, which forms part of the provision,[3] gives examples of matters that Parliament considers meet the description.

8. There is no direct Australian judicial authority to my knowledge on whether the Coroners Court is a public authority under the Charter when conducting an inquest and exercising

[2] The definition of "Court" in the Charter was amended by the Coroners Act commencing on 1 November 2009. Prior to the amendment, Justice Bell, sitting as President of the Victorian Civil and Administrative Tribunal noted the absence of the Coroners Court from the Charter in Kracke v Mental Health Review Board (2009) 29 VAR 1 at [300]-[301]; see Pound and Evans, *Annotated Victorian Charter of Rights* (Second edition, Lawbook Co, 2019), [CHR.3.80], 22.

[3] *Interpretation of Legislation Act 1984* (Vic) s 36(3A).

the powers in the Coroners Act to make findings, comments and recommendations on matters connected with a death.[4]

9. Although the Commission submitted that all these functions are administrative, when considered in light of the decided cases on s 4(1)(j) of the Charter, I was not persuaded.[5] The Commission says that whilst some of the Court's functions are clearly judicial in nature, such as ruling on the lawfulness of a subpoena, the task of conducting an inquest is confined to inquiring into the cause and circumstances of the death and making comments and recommendations, not apportioning guilt. The Commission submits these functions and powers conferred on a coroner are consistent with the character of an inquest as an 'inquisitorial' and not 'adversarial' process.[6]

10. Whilst that submission is correct in as far as it goes, it begs the more fundamental question of whether these inquisitorial coronial processes have a judicial character, or an administrative one.

11. In an important passage that gives guidance on this issue, Justice Ginnane, the joint Judge in Charge of the Supreme Court's Judicial Review and Administrative Law List, reminded us in *Cemino v Cannan* [2018] VSC 535 at [92] of the seven indicia of the exercise of judicial power:

> The common law distinction between judicial and administrative power is nebulous, and provides no universal test of when such powers are being exercised.

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[4] In the *Inquest into the death of Tanya Day*, Coroner English made a Ruling on the scope of the Inquest. At [19] of the Ruling, Coroner English stated that for her to rule on the scope of that inquest it was not necessary to address the question of whether the Coroners Court is a public authority when conducting an inquest and exercising the powers in the Coroners Act to make findings and recommendations on matters connected with a death. Accordingly, Coroner English did not rule on this issue.

[5] For a catalogue of cases in which Courts and the VCAT have been held to be acting in an administrative capacity, see Pound and Evans, *Annotated Victorian Charter of Rights* (Second edition, Lawbook Co, 2019), [CHR.4.240], 32-34. Australian coronial cases have been the subject of international human rights jurisprudence, in the 'TJ Hickey' case (UNHCR, Communication No. 2296/2013, Decision adopted by the Committee under the Optional Protocol, 17 December 2018, CCPR/C/124/D/2296/2013, English).

[6] Ibid.

… in Slaveski, Nettle and Redlich JJA stated that 'the function to grant or refuse an adjournment is one which takes its character from the tribunal or court in which the function reposed'...

In R v Debono, Kyrou J, while stating that there is 'no single combination of necessary or sufficient factors that identities what is judicial power', mentioned a number of matters that suggest that power is judicial. These included whether there is a dispute between defined persons or classes of persons that requires a legally binding resolution and whether it will determine for the future in a binding manner the existing rights or obligations or defined persons or classes of persons and result in a legally enforceable order inter partes; whether the exercise of the power involves the making of findings of fact and law and the application of the law to the facts; and whether there is a right of appeal from the exercise of the power.

I consider that for the reasons stated by Nettle and Redlich JJA in Slaveski, the Magistrate was acting in a judicial and not an administrative capacity. His Honour was determining a contested change of venue application and I consider that when such a determination is made by a judicial officer, he or she is acting in a judicial capacity and not an administrative capacity. ...

The refusal of the [adjournment application to allow case transfer into the Koori Court] was a binding determination of the rights of the plaintiff. The exercise of the s 4F discretion is the gateway to unique 'sentencing procedures' outlined in s 4G, which are intended for the benefit of Indigenous accused persons. The decision affects the determination of the punishment that will be imposed. Section 4G permits the Court to consider the evidence of Aboriginal Elders, Koori Court officers and family members of the accused. For an Indigenous person who desires his cultural circumstances to be properly considered, the exercise of the s 4F discretion is determinative of his rights.

The cases dealing with the exercise of administrative power in committals depend on the unique history of the power and the context of particular legislation, rather than revealing any general principle.

I also consider that the legislative intention of excluding courts from the definition of public authorities is of importance.

As the exercise of the s 4F discretion is a judicial power, the Magistrates' Court was

not acting in an administrative capacity when making the decision. ...

12. *Cemino* concerned an application to adjourn a Magistrates Court criminal proceeding for transfer into the Koori Court. It is analogous with the functions being exercised by the coroner at and following inquest, in that the coroner is a judicial officer who has been tasked by Parliament to make a legally binding resolution of all questions concerning the cause of death; in circumstances where the interested parties are disputing this; which exercise of this statutory power involves the making of findings of fact and law and the application of the law to the facts; within a legal framework that granted those parties a right of appeal from the exercise of these powers: and which will determine for the future in a binding manner the existing rights or obligations or defined persons or classes of persons described in the Act.

13. Under the Act, the coroner must make determinative findings on the identity and cause of death in the matters thus reported. Those determinations are binding in all places where the jurisdiction of the State of Victoria is recognised, in that those determinations enter the public record with finality, and no litigant can, with any merit, suggest otherwise from that point onward without mounting an appeal, or amassing fresh evidence and filing an application asking the Court to reopen an investigation. The consequences of these determinations then flow onward through the other legislative machinery of the State as it operates within the common law of Australia.

14. In the Coroners Court, a proceeding takes on a different character once a coroner convenes an inquest rather than completing an investigation ‘on the papers’. Once an inquest is convened, the coroner steps aside as the lead investigator into the death, and instead appoints counsel assisting to finish the statutory tasks in court whilst the coroner presides over the hearing with a duty to accord natural justice to all its participants.

15. The identification of all seven of the *Cemino* indicia of judicial power has satisfied me that whilst the majority of this court's work is performed as an investigative public authority, the decisions made by a coroner during an inquest have a judicial character and are thus not decisions of a public authority. This characterisation of the decision making by judges during the running of court proceedings, such as an inquest, as being judicial rather than administrative, is consistent with the oft quoted passage by Tate JA, who was the Victorian Solicitor General when the Charter was introduced, describing the Coroners Court in *Priest v West*[7] where Her Honour held that the Coroners Court is described under the Act as an 'inquisitorial court'[8].

16. This brings me back to the explanatory note embedded into Section 4(1)(j) of the Charter, which says that Magistrates Courts are acting in an administrative capacity during a committal hearing. Whilst the Commission submitted to me that this was an analogous position with an inquest hearing, as I forsehadowed above, I was not persuaded by this submission and observe that the purpose of the committal hearings, with their low burden of proof, is to provide an efficient screening process, filtering out criminal proceedings without sufficient prospects of obtaining a conviction before they require a resource intensive trial process. These hearings clearly have an administrative function and do not represent any final adjudication of rights. The DPP may directly present any accused for trial, regardless of the result of the committal hearing, and if the accused is discharged at committal, no crime has ever been found to have been committed. As such, the results of committal hearings are intended to improve the efficiency of the judicial functions of courts making final determinations, and so according to the guidance provided by *Cemino*

[7] *Priest v West* (2012) 40 VR 521, 560 [167] – [169].
[8] Section 89(4) of the Act.

and *Slaveski,* can be distinguished from the judicial tasks required from a coroner in an inquest.

17. If there was any ambiguity about the character of a coroner's function when sitting in an inquest, the question of whether the Coroners Court is a public authority under the Charter was considered at the time of the enactment of the Coroners Act. In its review of the Coroners Bill, the Scrutiny of Acts and Regulations Committee (**SARC**) asked the Minister to clarify what capacities of the Court are non-administrative. In his response, the Minister stated "although most of the functions of the Coroners Court would be administrative, some of the Court's powers would be judicial, such as a decision regarding the release of a body (see clauses 47 & 48); and a decision regarding contempt of court (see clause 103)." The Minister continued: "when exercising the majority of its powers, the Coroners Court will be acting in an administrative capacity and will therefore be bound as a public authority by the obligation in s 38 of the Charter."

18. This Court's Annual Reports reveal that 99% of our proceedings are completed as 'investigations' rather than 'inquests', which is consistent with the extrinsic guidance offered by the Minister that most of our functions are administrative.

19. I pause here to observe that this is not to say that the Charter does not bind the Coroners Court in several other ways – as mentioned in paras 2 and 3 - and which I shall develop in the following subheadings.

20. In the same speech, the Minister went on to state that where the Court is acting in a non-administrative capacity, "it will be bound by section 32 of the Charter to interpret all

statutory provisions in a way that is compatible with human rights, so far as it is possible to do so consistently with their purpose."[9]

21. When it is acting as a public authority, the obligations in s 38(1) apply to the Court. Accordingly, the Court is required to act compatibly with relevant human rights (known as the 'substantive obligation') and, in making a decision, to give proper consideration to relevant human rights (known as the 'procedural obligation').

22. The requirement to act compatibly with human rights directly impacts the way the coroner conducts their investigations, makes determinations, recommendations and comments. This includes conducting an inquest in a manner that is compatible with the right to a fair hearing (s 24) and equality before the law (s 8). However, as outlined below, the right to life in s 9 of the Charter has also been interpreted as including a right to an effective investigation. The Coroners Court has an important role in fulfilling this right by investigating the death, pursuing all reasonable lines of inquiry into the cause and circumstances of the death[10] and "do[ing] everything possible" to make a determination of these matters.[11] An effective investigation is one that includes consideration of potential breaches of human rights that might have caused or contributed to the death.

23. As to the obligation of public authorities to give proper consideration to relevant human rights when making a decision, when makings rulings in relation to the scope of the inquest and determining the cause and circumstances of the death under s 67(1), as well as recommendations under s 67(3) and comments under s 72(2), human rights will be 'relevant' where actions incompatible with those rights may have contributed to or caused the death, or relate to circumstances of death.

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[9] Ministerial Response to the Scrutiny of Acts and Regulation Committee, Parliament of Victoria, Alert Digest No. 15 (2008).
[10] *Priest v West* (2012) 40 VR 521, 524 [3]-[4] (Maxwell P and Harper JA); 560 [167]-[172] (Tate JA).
[11] Ibid, 524 [6] (Maxwell P and Harper JA).

Direct application of the Charter to the Coroners Court pursuant to s 6(2)(b)

24. A second way in which the Charter applies to the Court in respect of conducting the inquest is by reason of s 6(2)(b) of the Charter.

25. Section 6(2)(b) states that the Charter applies to "courts and tribunals, to the extent that they have functions under Part 2 and Division 3 of Part 3". The reference in s 6(2)(b) to "functions" includes a power, authority and duty.[12]

26. Three possible constructions of s 6(2)(b) have been proffered,[13] but it is the "intermediate" construction of s 6(2)(b) has been consistently accepted in the Supreme Court. Pursuant to the intermediate construction, the function of the court is to enforce directly only those rights enacted in Part 2 of the Charter that directly relate to court proceedings.[14] Pursuant to the intermediate construction, the function of the court is to enforce directly only those rights enacted in Part 2 of the Charter that directly relate to court proceedings.[15]

27. To be directly applicable under s 6(2)(b), the right can relate to a function of the Court if it relates not only to the procedures of Courts, but also to the determination of a matter before the Court If a right applies directly to the Court via s 6(2)(b), when assessing whether the Court has acted compatibly with the right, s 7(2) should be applied.[16]

28. In *Cemino,* Justice Ginnane confirmed that the rights protected in s 8(3) and s 19(2)(a) were directly applicable to the Magistrates' Court by reason of s 6(2)(b) of the Charter. In that case, the Magistrate was found to have acted unlawfully by not considering the

[12] Section 3(2)(a) of the Charter.
[13] *Victoria Police Toll Enforcement v Taha* (2013) 49 VR 1, [246] (Tate JA) ('***Taha***'), Judicial College Bench Book, 2.5.

[15] *Taha*, [246]; *Cemino v Cannan,* [110].
[16] *Matsoukatidou*, [58]; *Taha*, [250].

functions of the Magistrates Court under s 8(3) and s 19(2)(a) when making the decision to refuse an Aboriginal person's request to be heard in the Koori Court.

29. The Court has functions under a number of rights which impact upon the manner in which it conducts hearings, including the right to equality before the law (s 8(3))[17] and the right to a fair hearing in s 24(1).

30. Further, the Court has functions under the right to life in s 9 of the Charter, which not only impacts upon the manner in which the Court conducts inquests, but the scope of the inquest and the issues examined.

31. When Parliament enacted the Charter, it committed to protecting the right to life. The right to life is modelled on art 6(1) of the International Covenant on Civil and Political Rights. The right is protected in numerous other human rights instruments, including in article 2 of the European Convention on Human Rights. The right to life mandates a scope of coronial investigation into a death in custody that extends "well beyond proximate issues and requires scrutiny of broader precipitants and systemic causes."[18] The requirement imposed by the procedural obligation in s 9 is that the Coroner effectively investigate Veronica's death by subjecting the deprivation of her life to "the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances."[19]

32. The Victorian Parliament also recognised the critical role of the Coroners Court in giving effect to this aspect of the right to life when the Act was passed. In the Statement of Compatibility accompanying the Bill, after referring to the procedural obligation to

[17] *Matsoukatidou*, [40]; *Cemino v Cannan,* [11], [142]-[144], [147]-[149].
[18] Freckleton and McGregor, Coronial law and practice: A human rights perspective (2014) 21 JLM 584, 592.
[19] *Salman v Turkey*, [2000] ECHR 357 (27 June 2000), [99]-[100]. See also *McCann v United Kingdom* (1996) 21 EHRR 97 at [157]-[164]; *Jordan v United Kingdom* (2003) 37 EHRR 2; *R (Amin) v Home Secretary* [2004] 1 AC 653 and *R (Middleton)v West Somerset Coroner* [2004] 2 AC 182.

conduct an effective investigation into certain deaths, the Attorney-General stated: "[a]s the most significant investigative mechanism into reportable and reviewable deaths, the coronial system gives effect to this right."[20]

33. This Court has already recognised the relevance of s 9 of the Charter in Victorian coronial proceedings, in *Coronial Investigation of 29 Level Crossing Deaths - Ruling on the Interpretation of Clause 7(1) of Schedule 1 to the Coroners Act*.

34. The Court has a function to carry out an effective investigation into Veronica's death. This requires the Court to exercise its investigatory powers in a manner that gives effect to the statutory purpose of the Coroners Act, to reduce future preventable deaths by making findings, comments and recommendations. This includes investigation into potential breaches of human rights that might have caused or contributed to the death, and comments and recommendations that flow therefrom.

Section 32 of the Charter

35. Section 32(1) provides:

> So far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights.

36. The operation of s 32(1) of the Charter was extensively examined in *Momcilovic v The Queen* (Momcilovic)[21]. But as Nettle JA (as his Honour then was) has observed:[22]

> The problem is that the judgments of the High Court in Momcilovic v The Queen do not yield a single or majority view as to what is meant by interpreting a statutory provision in a way that is compatible with human rights within the meaning of s 32 of the Charter.

[20] Statement of Compatibility, Coroners Bill, 9 October 2008, Hansard, page 4030.
[21] *R v Momcilovic* [2010] VSCA 50; (2010) 25 VR 436
[22] *WK v The Queen* [2011] VSCA 345 at [55].

37. While the High Court divided sharply in relation to some questions concerning the operation of s 32(1), the following principles are clear following *Momcilovic*:

a. s 32(1) forms part of the body of interpretative rules to be applied at the outset in ascertaining the meaning of a statutory provision. As the Court of Appeal stated in *Slaveski v Smith*, s 32(1) requires "the court to discern the purpose of the provision in question in accordance with the ordinary techniques of statutory construction essayed in *Project Blue Sky Inc v Australian Broadcasting Authority*";[23]

b. in determining what interpretations are possible, the Court should apply the ordinary techniques of statutory construction including the presumption against interference with rights in the absence of express language or necessary implication in the statutory provision;

c. when the meaning of the relevant provision has been ascertained in accordance with the body of interpretative rules, including s 32(1), the Court must then consider whether the relevant provision, so interpreted, breaches or limits a human right protected by the Charter. It is only if such a breach or limit is identified that the Court has occasion to apply s 7(2) and consider whether the limit on the relevant human right is justified;[24] and

d. compliance with s 32(1) means exploring all "possible" interpretations of the provision in question and adopting that interpretation which least infringes

[23] [2012] VSCA 25 [20] (Warren CJ, Nettle and Redlich JJA). See further Julie Debeljak, 'Proportionality, Rights-Consistent Interpretation and Declarations under the Victorian *Charter of Human Rights and Responsibilities*: the *Momcilovic* Litigation and Beyond' (2014) 40(2) *Monash University Law Review* 340-388.
[24] *Slaveski*, at [35(2)].

Charter rights. As the Court of Appeal stated in *Nguyen v Director of Public Prosecutions*:[25]

> Where more than one interpretation of a provision is available on a plain reading of the statute, then that which is compatible with rights protected under the Charter is to be preferred.

38. In *Taha and Brookes*,[26] Tate JA cites from French CJ's judgment, and then states that 'the proposition that s 32 applies to the interpretation of statutes in the same manner as the principle of legality but with a broader range of rights in its field of application should *not* be read as implying that s 32 is no more than a "codification" of the principle of legality.'[27] Tate JA concluded that, although six members of the HCA decided that s 32(1) was not analogous to s 3(1) of the *UKHRA*, and that whilst the statutory construction techniques of Project Blue Sky are favoured:

> [n]evertheless, there was recognition [in the High Court's Momvilovic decision] that compliance with a rule of interpretation, mandated by the Legislature, that directs that a construction be favoured that is compatible with human rights, might more stringently require that words be read in a manner 'that does not correspond with literal or grammatical meaning' than would be demanded, or countenanced, by the common law principle of legality.[28]

39. In the *Inquest into the death of Tanya Day*, Deputy State Coroner English, as she then was, made a Ruling on the scope of the Inquest. In that Ruling, the Coroner agreed to consider whether racism played a role in the decision making and treatment of Ms Day [29] and stated that she will consider "whether Charter obligations were complied with, the

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[25] [2019] VSCA 20.
[26] Taha and Brookes [2013] VSCA 37. Nettle JA did not stray from the VCA Momcilovic and French CJ characterisation of s 32(1): [24] – [27]. Osborn JA did not address the Charter directly. See further Julie Debeljak, 'Proportionality, Rights-Consistent Interpretation and Declarations under the Victorian Charter of Human Rights and Responsibilities: the Momcilovic Litigation and Beyond' (2014) 40(2) Monash University Law Review 340-388.
[27] Taha and Brookes [189] (emphasis added).
[28] Taha and Brookes [190] (citations omitted) (emphasis added).
[29] Ruling on Scope, [18].

extent to which Tanya's Charter rights were engaged and if they were infringed".[30] A compatible interpretation of the power in s 67(1) of the Coroners Act is one that includes investigating breaches of human rights that might have caused or contributed to her death. A compatible interpretation of the recommendations power in s 72 and comments power in s 67(3) is one that includes the power to make recommendations and comments in relation to human rights issues connected to the death. and stated that she will consider "whether Charter obligations were complied with, the extent to which Ms Day's rights under the Charter were engaged and if they were infringed".[31] A compatible interpretation of the power in s 67(1) of the Coroners Act is one that includes investigating breaches of human rights that might have caused or contributed to her death. A compatible interpretation of the recommendations power in s 72 and comments power in s 67(3) is one that includes the power to make recommendations and comments in relation to human rights issues connected to the death.

Application of the charter to public authorities

Public authorities in this inquest

40. The obligations in s 38(1) of the Charter apply to a "public authority" as defined in s 4 of the Charter.

41. The Victoria Police, Corrections Victoria, the Victorian Institute of Forensic Mental Health (Forensicare), Correct Care Australasia and G4S are all public authorities for the purposes of the Charter, at least in relation to their actions and decisions that are the subject of this inquest. More particularly:

[31] Ruling on Scope, [80].

a. Victoria Police, as constituted to include police members,[32] are public authorities listed in s 4(1)(d) of the Charter.

b. Corrections Victoria staff are public authorities by reason of s 4(1)(a) of the Charter as they are public officials within the meaning of the *Public Administration Act 2004*, which includes public servants.[33]

c. Forensicare is a public authority by reason of s 4(1)(b) being "an entity established by a statutory provision that has functions of a public nature"; established under s 117B of the *Mental Health Act 1986* (Vic) and continued by s 328 of the *Mental Health Act 2014* (Vic).

d. Correct Care Australasia and G4S are each what is known as a hybrid public authority, by reason of s 4(1)(c) being "an entity whose functions are or include functions of a public nature, when it is exercising those functions on behalf of the State or a public authority (whether under contract or otherwise).

    i. Section 4(2) sets out a non-exhaustive list of factors relevant to determining whether a function is of a public nature. Omitting the examples, it provides:

> In determining if a function is of a public nature the factors that may be taken into account include –
>
> (a) that the function is conferred on the entity by or under a statutory provision;
>
> (b) that the function is connected to or generally identified with functions of government;
>
> (c) that the function is of a regulatory nature;

[32] See definition of 'Victoria Police' in s 3(1) of the Charter and ss 6 and 7 of the *Victoria Police Act 2013.*
[33] See the meaning of 'public official' in s 4 *Public Administration Act 2004*.

(d) that the entity is publicly funded to perform the function;

(e) that the entity that performs the function is a company (within the meaning of the Corporations Act) all of the shares in which are held by or on behalf of the State.

ii. The example immediately below s 4(2)(b), which forms part of the provision,[34] gives an example of a matter that Parliament considers meets the description of a function connected to or generally identified as a function of government:

> ***Example:*** *Under the Corrections Act 1986 a private company may have the function of providing correctional services (such as managing a prison), which is a function generally identified as being a function of government*

iii. By analogy with the above example given by Parliament, Correct Care Australasia Pty Ltd is a private health services provider contracted by Justice Health (a business unit of the Department of Justice and Community Safety) to provide health care services in Dame Phyllis Frost Centre. G4S is a private company that is responsible for custodial operation and management of the Melbourne Custody Centre pursuant to a contract with the Chief Commissioner of Police, and the provision of prisoner transport services pursuant to a contract with the Department of Justice and Community Safety. The function of operating a safe and secure prison, including providing healthcare services to prisoners, is generally identified as a function of government

Section 38 obligations

42. Section 38(1) of the Charter imposes two distinct obligations on a public authority.[35] It makes it unlawful for a public authority to act in a way that is incompatible with a human

[34] *Interpretation of Legislation Act 1984* (Vic) s 36(3A).
[35] *Baker v DPP* [2017] VSCA 58 (‘***Baker v DPP***’), 13 [48] (Tate JA); *Bare v Independent Broad-based Anti-corruption Commission* (2015) 48 VR 129 at 205 [245] (Tate JA) (‘***Bare***’).

right and, in making a decision, to fail to give proper consideration to a relevant human right. These obligations do not apply if the public authority cannot reasonably act differently or make a different decision under law: s 38(2).

43. A useful roadmap to follow in order to determine whether a public authority is acting lawfully under s 38(1) is to ask the following questions:[36]

    a. is any Charter right relevant to the decision or action that the public authority has made, taken, proposed to take or failed to take (the relevance or engagement question);

    b. if so, has the public authority done or failed to do anything that limits that right? (the limitation question);

    c. if so, is that limit reasonable and is it demonstrably justified having regard to the matters set out in s 7(2) of the Charter? (the proportionality or justification question);

    d. even if the limit is proportionate, if the public authority has made a decision, did it give proper consideration to the Charter right? (the proper consideration question);

    e. was the act or decision made under an Act or instrument that gave the public authority no discretion in relation to the act or decision, or does the Act confer a discretion that cannot be interpreted under s 32 of the Charter in a way that is consistent with the protected right (the inevitable infringement question).

[36] *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children (No 2)* [2017] VSC 251, [174] (‘***Certain Children (No 2)***’); *Minogue v Dougherty* [2017] VSC 724 at [74]. These questions build on the three-step approach articulated in *Sabet* at [108] which was applied by the Court of Appeal in *Baker v DPP* at [56].

Engagement of rights

44. Charter rights are engaged whenever a right is relevant to a decision or action that a public authority has made, taken, proposed to take or failed to take.[37] The threshold for the engagement of a Charter right is low.[38] After construing rights "in the broadest possible way",[39] a public authority must understand in general terms how Charter rights *may* be relevant to their action.

Justified limitations on rights

45. It is well established that s 7(2) of the Charter applies to the obligation on a public authority to "act compatibly" with Charter rights.[40] Where a public authority limits a right but the limitation is justified, the human right is not breached and there is no contravention of the obligation on a public authority to act compatibly with human rights under s 38 of the Charter.[41]

46. The justification question involves an assessment made by reference to the matters set out in 7(2) of the Charter, "including (a) the nature of the right; and (b) the importance of the purpose of the limitation; and (c) the nature and extent of the limitation; and (d) the relationship between the limitation and its purpose; and (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve".[OBJ] Section 7(2) of the Charter embodies a proportionality test.[42]

47. The onus rests on the party seeking to justify a limitation.[43]

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[37] Certain Children (No 2) at [179].
[38] Ibid.
[39] Application Under the *Major Crimes (Investigative Powers) Act* 2004; *DAS v Victorian Equal Opportunity Commission (2009)* 24 VR 415 ('**Major Crimes'**), 434, [80]; *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647 ('**De Bruyn'**), 691 [126]; *DPP v Ali (No 2)* [2010] VSC 503 [29]; *DPP v Kaba (2014)* 44 VR 526 [108].
[40] *De Bruyn* at 682 [100]; *Kracke v Mental Health Review Board* (2009) 29 VAR 1 [99]; *PJB v Melbourne Health* (*Patrick's Case*) (2011) 39 VR 373 [332].
[41] *Baker v DPP* at 15 [57] (Tate JA with whom Maxwell P and Beach JJA agreed).
[42] *Momcilovic v R* (2011) 245 CLR 1, 39 [22] (French CJ).
[43] *Major Crimes*, 449 [148].

48. The first factor in s 7(2) calls for an examination of the nature of the right. This involves considering the quality of the right and the importance of the values that underpin it.[44] The rights engaged in this inquest protect important values including life, liberty, equality and freedom from discrimination, as well as the protection of Aboriginal cultural rights and humane treatment when deprived of liberty.

49. The second factor in s 7(2) requires the purpose of the limitation on a right to be identified. The purpose must both accord with the values of the Charter and be sufficiently important to warrant the limitation. As Bell J said in *Lifestyle Communities*: "[t]he more important is the purpose so understood, the more the limitation is likely to be justified, and vice versa"[45].

50. The third factor identified in s 7(2)(c) is a critical step in the proportionality exercise. It is necessary to identify objectively how greatly the limitation constrains the rights. The greater the constraint, the more compelling must be the justification, and vice versa.

51. Finally, the fourth and fifth factors require that there is a rational connection between the limitation and its purpose and the limitation should impair the right to the minimum extent possible.[46]

Proper consideration of relevant human rights

52. Section 38(1) imposes two obligations on a public authority. Even if a limitation on a human right is ultimately found to be proportionate, if the public authority has made a decision, it is still required to give proper consideration to relevant human rights. The obligation to give proper consideration to relevant human rights does not depend on any determination of compatibility and there is no textual warrant for conflating the two

[44] *Lifestyle Communities Ltd (No 3) (Anti-Discrimination)* [2009] VCAT 1869 [328] (‘***Lifestyle Communities Ltd’***).
[45] *Lifestyle Communities Ltd*, 351 [329].
[46] Ibid.

forms of obligation imposed by s 38(1) of the Charter.[47] Further, the Court of Appeal has confirmed that this "procedural limb" is additional or supplementary to any obligation imposed under the primary legislation governing the operations of the public authority.[48]

53. The principles concerning the content of the procedural obligation are now settled in Victorian law. The test, first stated by Emerton J, as she then was, in *Castles v Secretary of Department of Justice*[49] requires a decision maker to:

    a. understand in general terms which rights would be affected by the decision and how they may be interfered with by the decision;

    b. seriously turn his or her mind to the possible impact of the decision on the person's human rights;

    c. identify the countervailing interests or obligations; and

    d. balance competing private and public interests.[50]

54. Emerton J went on to recognise that there is "no formula" for the proper consideration exercise. It follows that the proper consideration obligation can be discharged in a manner suited to the particular circumstances.[51] However, the obligation imposes a higher standard than the obligation to take into a consideration at common law or under statute.[52] This follows from the obligation to give "proper" consideration to human rights.[53]

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[47] *Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue* [2021] VSCA 358 [80].
[48] *Castles v Secretary of Department of Justice* (2010) 28 VR 141 ('**Castles**'), 184 [185]-[186]; De Bruyn, 669-701 [139]-[142]; Bare, 198-199 [217]-[221] (Warren CJ), 218-219 [277]-[278] (Tate JA), 297 [534] (Santamaria JA) (each of the three Justices of Appeal applied the "Castles test" for proper consideration by way of obiter dicta); Colin Thompson (in his capacity as Governor of Barwon Prison) & Anor v Craig Minogue [2021] VSCA 358 [83].
[49] *Castles,* 184 [185]-[186].
[50] *PJB v Melbourne Health (Patrick's Case)* (2011) 39 VR 373 [311] (Bell J).
[51] *Bare*, 217-218 [275]-[276] (Tate JA), 198-199 [217]-[221] (Warren CJ).
[52] *Castles*, 144.
[53] *De Bruyn*, 701 [142].

55. While assessing proper consideration should not be scrutinised "over-zealously" by the courts, the obligation would not be satisfied by merely invoking the Charter "like a mantra".[54] The review that is necessitated by the obligation of a decision-maker to give proper consideration is a review of the substance of the decision-maker's consideration rather than form.[55]

Conclusions as to Charter rights engaged by Veronica's passing

56. Veronica's arrest and remand engaged the following *Charter* rights: Sections 8, 9, 10, 19, 21 and 22.

57. The provision of healthcare to Veronica in DPFC engaged the following *Charter* rights: Sections 8, 9, 10, 19 and 22.

58. Further, s 47(1)(f) of the *Corrections Act 1986* provides that every prisoner has the right "to have access to reasonable medical care and treatment necessary for the preservation of health".

59. The custodial management of Veronica at DPFC engaged the following *Charter* rights: Sections 8, 9, 10, 19 and 22.

60. The body of this Finding sets out the occasions on which those rights were breached.

[54] *Bare*, 217-218 [275]-[276] (Tate JA), 198-199 [217]-[221] (Warren CJ).
[55] *Castles*, 184 [185]-[186].

APPENDIX B

FINDINGS

1. I find that Veronica died on 2 January 2020 at DPFC of complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition.

2. On the basis of these outstanding warrants, I find that Veronica's arrest by Victoria Police was lawful.

3. I find that the use of handcuffs by Victoria Police was unjustified and disproportionate in the circumstances.

4. I find that the police BDM was empowered to grant Veronica bail and failed to give proper consideration to the discretion to do so and this infringed her Charter rights.

5. By failing to give proper consideration to the discretion, I find that the police BDM failed to adequately consider Veronica's vulnerability in custody as an Aboriginal woman.

6. I find that the training provided by Victoria Police on these topics fails to equip its members with an adequate appreciation of the vulnerability of an Aboriginal person in custody.

7. I find that Victoria Police failed to inform the MMC of Veronica's Aboriginality.

8. I find that the legal assistance provided to Veronica by the VLA Duty Lawyer service on 30 and 31 December 2019, and particularly by Peter Schumpeter of Counsel, was reasonable and appropriate in the circumstances.

9. I find that the legal assistance provided to Veronica by the LACW, particularly by Jillian Prior, was reasonable and appropriate in the circumstances.

10. I find that the legal services provided to Veronica on 31 December 2019 by Tass Antos of Counsel were inadequate.

11. In so far as the prosecutor did not alert the BDM to the relevance of Veronica's Aboriginality during the bail hearing on 31 December 2019, I find that he failed to properly consider Veronica's Charter rights.

12. I find that, given Veronica's legal representative of record had been notified by VLA of her remand in custody on 30 December 2019 and arranged for a barrister to appear on her behalf on 31 December 2019, Veronica should not have appeared unrepresented on that date.

13. I find that at the time of Veronica's appearance at the MMC on 30-31 December 2019, culturally specific support for Aboriginal court users was under-resourced and designed to address the cultural needs of only some Aboriginal people – those attending Koori Court. The restrictions of the cultural support role as planned by the Magistrates' Court of Victoria, and the inadequate process for identifying people who might need it, failed to give proper consideration to Veronica's rights to equality and culture and those of other Aboriginal court users.

14. I find that the Bail Act has a discriminatory impact on First Nations people resulting in grossly disproportionate rates of remand in custody, the most egregious of which affect alleged offenders who are Aboriginal and/or Torres Strait Islander women.

15. I find that ss 4AA(2)(c), 4A, 4C and Clauses 1 and 30 of Schedule 2 of the Bail Act are incompatible with the Charter.

16. I find that Justice Health's Opioid Substitution Therapy Program Guidelines, in so far as they restrict access to pharmacotherapy, deny prisoners equivalent care to that available in the community.

17. I find that Justice Health's Opioid Substitution Therapy Program Guidelines infringe prisoners' rights to be treated humanely while deprived of liberty and their right to life given the greater risk of fatal overdose upon release contrary to sections 22 and 9 of the Charter.

18. Although I acknowledge that CCA was obliged to implement the Guidelines, I am not satisfied that the treatment available to Veronica for her opioid dependence, by virtue of the CCA Opioid Substitution Program Policy, was adequate to treat her withdrawal and so I find that the treatment she received constituted cruel and inhumane treatment contrary to section 10 of the Charter.

19. I find, that because of the CCA Opioid Substitution Program Policy, Veronica did not have access to health services equivalent to those available to her in the community.

20. On the basis of Dr Baber's evidence, I find that Veronica weighed around 33kg at the time of her reception medical assessment and that the weight recorded by Dr Runacres in the MAF was inaccurate.

21. I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment Notes by Dr Runacres.

22. I find that Dr Runacres' medical assessment and treatment of Veronica on 31 December 2019 was inadequate. Dr Runacres' failure to physically examine Veronica, plan her ongoing care and maintain accurate records are significant departures from reasonable standards of care and diligence expected in medical practice.

23. I find that Veronica should have been transferred to hospital at the time of her reception to DPFC, and that CV and CCA staff continually failed to transfer her to hospital thereafter, and this ongoing failure causally contributed to her death.

24. I find that the psychiatric assessment and care provided to Veronica by Forensicare at DPFC on 31 December 2019 was reasonable and appropriate in the circumstances.

25. I find that notification to the Aboriginal Wellbeing Officer of Veronica's reception at DPFC should have occurred shortly after her arrival on 31 December 2019.

26. I find that Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest on 30 December 2019 to her passing at DPFC on 2 January 2020.

27. I find that the failure of CCA and CV to establish proper procedures for information-sharing between staff causally contributed to Veronica's passing and meant that decisions in relation to Veronica's medical care and custodial management were made on the basis of incomplete and inaccurate information.

28. I find that the failure of CCA and DJCS to clearly establish an adequate procedure for the medical clearance of a prisoner from the Medical Centre to a mainstream unit causally contributed to Veronica's passing.

29. I find that the failure of CCA and DJCS to clearly define the role and purpose of the Medical Centre at DPFC causally contributed to Veronica's passing.

30. I find that CCA at DPFC failed to provide Veronica with care equivalent to the care she would have received from the public health system in the community, and that this failing causally contributed to her passing.

31. I find that Justice Health failed to ensure that CCA delivered a standard of health care equivalent to that available in the public health system at DPFC, and this failing causally contributed to her passing.

32. I find that the absence of bed-based care at DPFC infringed Veronica's rights to life and equality pursuant to sections 9 and 8 of the Charter.

33. I find that Veronica's care and treatment by CV and CCA staff while at DPFC was influenced by drug-use stigma, and that this causally contributed to Veronica's passing.

34. I find that Veronica's treatment by some POs in the morning on 1 January 2020 amounted to inhumane and degrading treatment contrary to section 10 of the Charter.

35. I find that Dr Brown's assessment of Veronica on 1 January 2020 was adequate. That she omitted to document her second assessment and confirm the afternoon nursing observations she ordered were completed were acknowledged by Dr Brown as

deficiencies in her care. That said, I am satisfied that any other inadequacy in the treatment Dr Brown provided was due to CCA's failure to establish proper systems rather than a departure from a reasonable standard of care and diligence expected in medical practice.

36. I find that the medical records maintained by CCA staff were incomplete and, in parts, inaccurate and misleading concerning Veronica's medical history and clinical presentation while at DPFC between 31 December 2019 and 2 January 2020.

37. I find that CCA's failure to develop an adequate system for the handover of critical information between staff in relation to prisoners at DPFC causally contributed to Veronica's passing.

38. I find that, at the time of her passing, Veronica was in the legal custody of the Secretary to the Department of Justice and Community Safety.

39. I find that CV staff continually and collectively obstructed the provision of 'equivalent care' to Veronica and failed to protect her welfare.

40. I find that PO Brown failed to escalate Veronica's care on at least three occasions on the morning of 2 January 2020 between 1:30 AM and 4:00 AM.

41. I find that PO Brown's failure to physically check on Veronica at any point overnight, but particularly after Veronica became unresponsive during the final intercom call around 4:00 AM on 2 January 2020, was a failure to provide appropriate care for Veronica.

42. I find that RN George failed to provide Veronica with adequate assessment, treatment or care between 31 December 2019 and 2 January 2020.

43. I find that RN George's conduct in relation to Veronica between 31 December 2019 and 2 January 2020 was lazy, unprofessional, and not in keeping with the standards of care one would reasonably expect from a health care professional while on shift.

44. I find that the formal DPFC debrief conducted following Veronica's passing did not critically examine the incident, and that the minutes of the debrief were grossly inadequate and misleading.

45. I find that the Justice Health Death in Custody Report of Veronica's passing was grossly inadequate and misleading.

46. I find that the Justice Assurance and Review Office (JARO) review of Veronica's passing was grossly inadequate and misleading.

47. I find that CCA failed to provide critical information to Justice Health at the time of Veronica's passing.

48. I find that CCA's failure to undertake a root cause analysis or similar internal review at the time of Veronica's passing was contrary to the requirements of the Justice Health Quality Framework.

49. I find that Justice Health's failure to ensure that CCA undertook a root cause analysis or similar internal review at the time of Veronica's passing was contrary to the requirements of the Justice Health Quality Framework.

50. I find that Veronica's death was preventable.

51. I find that, had the RCADIC recommendations been successfully implemented by the Government and its agencies, Veronica's passing would have been prevented.

APPENDIX C

RECOMMENDATIONS

1. I recommend that the Victorian government consider funding allocations sufficient to facilitate achievement of the recommendations that follow.

2. I recommend that the Victorian Government in consultation with Victoria Police, the Department of Justice and Community Safety, the Department of Health and peak Aboriginal and/or Torres Strait Islander organisations urgently develop a review and implementation strategy for the State's implementation of the 339 recommendations of the 1991 Final Report of the Royal Commission into Aboriginal Deaths in Custody.

Legislative Change

3. I recommend the urgent review of the Bail Act with a view to repeal of any provision having a disproportionate adverse effect on Aboriginal and/or Torres Strait Islander people.

4. I recommend urgent legislative amendment of the Bail Act including that:

    4.1. section 4AA(2)(c) is repealed ('double uplift');

    4.2. clause 1 of Schedule 2 is repealed (including any indictable offence in certain circumstances within reverse onus regime);

    4.3. clause 30 of Schedule 2 is repealed (including bail offences within reverse onus regime);

    4.4. section 18(4) is repealed;

4.5. section 30 is repealed (failure to answer bail);

4.6. section 30A is repealed (contravention of conduct condition of bail);

4.7. section 30B is repealed (commit indictable offence on bail);

4.8. section 18AA is amended so that –

4.8.1. an applicant for bail need not establish 'new facts and circumstances' before making a second application for bail; and

4.8.2. an applicant for bail who is vulnerable (for instance, by virtue of being an Aboriginal or Torres Strait Islander person, a child, or a vulnerable adult as these terms are defined in sections 3 and 3AAAA, respectively, of the Bail Act) need not establish 'new facts and circumstances' before making any subsequent application for bail;

4.9. section 3A is amended to include more guidance to BDMs about the procedural and substantive matters to be considered to ensure application of the section gives effect to the purposes for which it was inserted, including to address the persistent over-representation of Aboriginal people in the criminal justice system;

4.10. revision of section 3A should occur in a manner that is consistent with principles of self-determination of First Nations peoples;

4.11. section 4E(1)(a)(ii) is amended to narrow the scope of commit 'offence' while on bail;

4.12. before a BDM refuses bail to an Aboriginal person, they are required by law to articulate (and record) what enquiries were made into the surrounding circumstances and what factors relevant to sections s3A and s3AAA of the Bail Act were considered to reach the decision;

4.13. BDMs intending to refuse an application for bail are required by law to make all necessary enquiries about, and where necessary note on any remand warrant, any potential custody management issues.

5. I recommend legislative amendment to section 464FA of the Crimes Act 1958 (Vic) (Crimes Act) to require an investigating official to inform an Aboriginal and/or Torres Strait Islander person in custody not only that the Victorian Aboriginal Legal Service (VALS) has been notified that the person is in custody but also that:

5.1. the purpose of the notification is for VALS to perform a welfare and wellbeing assessment on the person including –

5.1.1. identification of any medical, physical and mental health concerns, disability or impairment (including due to substance use); and

5.1.2. communication of any identified risks to the person's safety while in custody to Police so that appropriate management and care is provided;

5.2. the person may communicate with a VALS Client Notification Officer (CNO);

5.3. with the person's consent, CNOs may advise their family members, partner or other people of their wellbeing and whereabouts; and

5.4. with the person's consent, CNOs will contact a VALS on-call solicitor to provide pre-interview legal advice.

6. I recommend legislative amendment to sections 464A(3) and 464C of the Crimes Act, respectively, to require, in accordance with the principles known as the *Anunga Principles*,[1388] an investigating official to explain to an Aboriginal and/or Torres Strait Islander person in custody in simple terms:

6.1. the meaning of the caution and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the caution to ensure that both the right to remain silent and that anything they do or say may be used in evidence is understood; and

6.2. the meaning of each communication right and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the rights to ensure they are understood.

Victoria Police

7. I recommend that the Chief Commissioner of Victoria Police amend any Victoria Police Manual (VPM) policies and guidelines to:

7.1. ensure an Aboriginal or Torres Strait Islander person under arrest has a meaningful opportunity to make an informed decision about whether to accept

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[1388] *R v Anunga and ors* and *R v Wheeler and another* (1976) 11 ALR 412.

an offer to communicate with a VALS CNO, including providing the person with information about the purpose of that contact and what assistance the CNO may be able to provide;

7.2. ensure an Aboriginal or Torres Strait Islander person under caution has a meaningful opportunity to both:

7.2.1. consider whether to exercise their rights to communicate with a friend or relative and a legal practitioner; and

7.2.2. to exercise those rights;

7.3. ensure they prominently identify the circumstances in which Police BDMs are permitted under the Bail Act to grant bail to an Aboriginal or Torres Strait Islander person who is required to demonstrate the existence of exceptional circumstances;

7.4. require a record of all bail decisions made by Police BDMs, including where bail is neither granted nor refused but a person is taken before a court for decision, that reflects who made the decision, the relevant charge(s) and, if bail is not granted, the reasons for the decision and the information that informed the decision;

7.5. require that when preparing a remand brief, members include reference to a person's Aboriginality in the remand summary so that BDMs are alerted to the relevance of s3A of the Bail Act in any remand/bail application.

8. I further recommend that the Chief Commissioner of Police review and if necessary update its training to:

    8.1. all members to highlight the requirement that police members, as a Public Authority under the Charter, are required to act in accordance with the Charter when making decisions in the course of their duties. The training should provide members with knowledge and skills enabling members to us the Charter in the real-life decisions they make in the performance of their duties. Its aim should be to embed the Charter in police practice not merely raise members' awareness that the Charter is 'relevant' to Victoria Police as a public authority; and

    8.2. all police prosecutors to highlight their obligations as officers of the court including their duty to inform the court of all relevant matters within their knowledge, including those favourable to an accused.

9. I recommend that the Victoria Police partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review for all members.

10. I further recommend that the Chief Commissioner of Police urgently correct any misunderstanding suggestive of an 'informal policy' that:

    10.1. requires or encourages members to oppose all bail applications involving the exceptional circumstances test ; or

    10.2. discourages police BDMs from the proper consideration of their discretion pursuant to section 13(4) of the Bail Act when it is available.

11. I also recommend that the Chief Commissioner of Victoria Police require police BDMs undertake periodic training to address the interpretation and application of section 3A of the Bail Act.

12. I recommend that the Chief Commissioner of Police collect and retain statistics that identify:

    12.1. the number of people charged with an offence to which the 'exceptional circumstances test' applies and data relating to:

    12.2. whether those people are bailed by Police or remanded in custody

    12.3. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and

    12.4. the sex of the person; and

    12.5. the number of people charged with an offence to which the 'compelling reasons test' applies and data relating to:

        12.5.1. whether those people are bailed by Police or remanded in custody;

        12.5.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and

        12.5.3. the sex of the person.

    The data relating to these matters should be published and available for use by independent organisations and/or researchers.

Magistrates Court of Victoria

13. I recommend that the Magistrates Court of Victoria ensure that the Court Integrated Services Program (CISP) is staffed whenever the court is open, including throughout Bail and Remand Court sessions.

14. I recommend that the Magistrates' Court of Victoria employ sufficient Aboriginal or Torres Strait Islander staff in roles (however described) within the court to provide assistance to and, where necessary, advocacy for, Aboriginal and Torres Strait Islander court users including people remanded in custody, and develop and implement:

    14.1. a process by which the Position Description for these roles is led by Aboriginal and Torres Strait Islander people with relevant expertise, in consultation with stakeholders including the end users of the service provided; and

    14.2. robust processes to ensure timely notification of Aboriginal and Torres Strait Islander staff about the presence at court of any Aboriginal and Torres Strait Islander people, including people in custody, who may benefit from their assistance.

15. I further recommend that the Magistrates' Court of Victoria collect and retain statistics that identify:

    15.1. the number of people charged with an offence to which the 'exceptional circumstances test' applies and data relating to:

        15.1.1. whether those people are bailed or remanded in custody;

15.1.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and

15.1.3. the sex of the person; and

15.2. the number of people charged with an offence to which the 'compelling reasons test' applies and data relating to:

15.2.1. whether those people are bailed or remanded in custody;

15.2.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and

15.2.3. the sex of the person.

The data relating to these matters should be published and available for use by independent organisations and/or researchers.

Legal education

16. I recommend that the Victorian Legal Admissions Board consider requiring that Practical Legal Training course providers deliver compulsory Aboriginal and Torres Strait Islander cultural awareness training as part of the curriculum.

17. I recommend that the Legal Services Board and Commissioner and the Victorian Bar consider including Aboriginal and/or Torres Strait Islander cultural awareness training as a mandatory requirement of continuing professional development for practising legal practitioners.

Custodial health – Governance and scrutiny

18. I recommend that the Victorian Government revise the system for auditing and scrutiny of custodial health care services to ensure that it is:

    18.1. independent;

    18.2. comprehensive;

    18.3. transparent;

    18.4. regular;

    18.5. designed to enhance the health, wellbeing and safety outcomes for Victorian prisoners;

    18.6. designed to ensure custodial health care services are delivered in a manner consistent with Charter obligations; and

    18.7. that the implementation of any recommendations for improved practice identified by the system for auditing and scrutiny is monitored.

19. I recommend that the Department of Health and the Department of Justice and Community Safety:

    19.1. consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services; and

    19.2. consult with stakeholders (including peak clinical bodies, organisations representing the lived experience of prison, public health services, private health

providers, Aboriginal and Torres Strait Islander community representatives) to determine what model of healthcare delivery in will achieve the best health outcomes for people in Victorian prisons.

Custodial health policy

20. I recommend that Justice Health:

    20.1. immediately amend the Justice Health Opioid Substitution Therapy Guidelines (OST Guidelines) to enable medical practitioners to prescribe opioid substitution therapy to women hose health may be at significant risk by being required to undergo opiate withdrawal; and

    20.2. urgently review of the OST Guidelines to ensure that all women with opioid dependencies are given access to opioid substitution pharmacotherapy upon reception to prison, including the option of methadone or suboxone and their long-acting injectable buprenorphine formulations, irrespective of the length of incarceration.

21. I further recommend that Justice Health review and, if necessary, revise the Justice Health Quality Framework.

Custodial health services

22. I recommend that the Victorian Government establish a subacute unit at the Medical/Health Centre at Dame Phyllis Frost Centre available to all prisoners who require it, and that

includes oversight by a specialist who has completed Advanced Training in Addiction Medicine.

23. As an interim measure, until a subacute unit on site at Dame Phyllis Frost Centre is operational, I recommend that an agreement or Memorandum of Understanding be agreed as a matter of urgency between Corrections Victoria, Justice Health and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre and the most appropriate proximate public hospital for the provision of equivalent community health services not presently provided at the Medical/Health Centre.

24. I recommend that The Victorian Government establish at the Medical/Health Centre at the Dame Phyllis Frost Centre Point-of-Care testing in accordance with requirements that are equivalent to the Royal Australian College of General Practitioners Standards for Point-of-Care testing.

25. I recommend that the Department of Justice and Community Safety and/or Justice Health, in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.

26. I recommend that Justice Health and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre ensure that all Aboriginal and/or Torres Strait Islander prisoners have the option during the reception medical assessment of consulting with an Aboriginal Health Practitioner or Aboriginal Health Worker, either in person or by telehealth, within 48 hours. The prisoner's response to this offer should be documented.

27. I recommend that Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre develop and implement a robust procedure for 'clearance' of a prisoner (at initial reception or subsequently) from the Medical/Health Centre to a cell elsewhere at Dame Phyllis Frost Centre that requires certification in writing by a medical practitioner that the prisoner is fit to be confined in an unobserved cell.

27.1. The medical practitioner's certification should include:

27.1.1. confirmation that the prisoner is medically fit to leave the Medical/Health Centre;

27.1.2. whether the medical practitioner recommends any medical or management observations to ensure the prisoner's health or wellbeing;

27.1.3. identification of any specific clinical deterioration risk indicators the medical practitioner recommends custodial and health staff monitor; and

27.1.4. instructions to guide the response, including escalation of the prisoner's care, if clinical deterioration risk indicators are observed.

27.2. If no medical practitioner is available, written certification may be provided by a registered nurse, but any prisoner cleared by a registered nurse should be placed on 60/60 management observations pending medical practitioner review of the prisoner as soon as practicable thereafter.

28. I recommend that Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre, in collaboration with Corrections Victoria and Justice Health, develop

and implement clear guidelines to assist custodial and clinical staff to identify a prisoner's clinical deterioration, including the indicators that must result in an escalation of a prisoner's care to clinical staff, a medical practitioner or transfer to hospital.

29. I recommend that Justice Health require custodial Health Service Providers to:

29.1. engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities;

29.2. encourage and facilitate the doctors employed by the Health Service Provider to become members of the RACCGP to enable them to access RACGP training programs;

29.3. identify alternative alcohol and other drugs training programs for medical practitioners;

29.4. ensure medical practitioners employed or contracted by the Health Service Provider for a period of more than six months complete training equivalent to the Royal Australian College of General Practitioners' Alcohol and Other Drugs GP Education program within six months of the practitioners commencing.

29.5. ensure registered nurses employed by the Health Service Provider complete the Australian College of Nursing's Continuing Professional Development modules in:

29.5.1. addressing AOD Use in Diverse Communities; and

29.5.2. opioid Withdrawal Nursing Care and Management.

29.6. employ medical practitioners and nurse practitioner qualified to practise opioid pharmacotherapy; and

29.7. employ a full-time specialist who has completed Advanced Training in Addiction Medicine.

Correct Care Australasia

30. I recommend that Correct Care Australasia engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how it can embed culturally safe and culturally appropriate principles into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities.

31. I further recommend that Correct Care Australasia:

31.1. encourage and facilitate the doctors it employs to become members of the RACCGP to enable them to access RACGP training programs; and

31.2. identify alternative alcohol and other drugs training programs for CCA medical practitioners; and

31.3. ensure medical practitioners employed or contracted by CCA for a period of more than six months, have completed training which is equivalent to the Royal

Australian College of General Practitioners' Alcohol and Other Drugs GP Education program;

31.4. ensure registered nurses employed by the Health Service Provider complete the Australian College of Nursing's Continuing Professional Development modules in:

31.4.1. addressing AOD Use in Diverse Communities; and

31.4.2. opioid Withdrawal Nursing Care and Management;

31.5. employ medical practitioners and nurse practitioner qualified to practise opioid pharmacotherapy; and

31.6. employ a full-time specialist who has completed Advanced Training in Addiction Medicine.

32. I recommend that Correct Care Australasia report the deficiencies in care identified in this Finding to its current accreditation providers before it participates in any further tender for the provision of custodial health services in Victoria.

Corrections Victoria

33. I recommend that Corrections Victoria review its practice whereby only two Prison Officers have access to cell keys during the Second Watch overnight at Dame Phyllis Frost Centre and address any impediment to the timely entry to cells that might arise so to ensure prisoner health, welfare and safety.

34. I recommend that the Department of Justice and Community Safety partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review, which is applicable to:

    34.1. CV; and

    34.2. Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre.

35. I recommend that the Department of Justice and Community Safety develop and implement a policy and deliver training to Corrections Victoria staff about the operation of that policy, to ensure that cultural considerations are incorporated into management of a deceased Aboriginal or Torres Strait Islander person in custody and, to the extent possible, the scene of that person's passing.

36. I recommend that the Department of Justice and Community Safety urgently redesign the Justice Assurance and Review Office and Justice Health Death In Custody reviews to ensure reviews:

    36.1. are independent;

    36.2. receive input from relevant staff who interacted with or were responsible for decisions affecting the prisoner proximate to their death;

    36.3. are comprehensive;

36.4. identify opportunities for improved practice and to enhance the wellbeing and safety of prisoners, rather than merely assess compliance with relevant policies;

36.5. if the deceased is an Aboriginal and/or Torres Strait Islander person, that adequacy of their cultural care (including post-death treatment) is assessed by a suitable member of the Aboriginal community; and

36.6. are timely.

37. I recommend that Justice Health, Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre each review, and if necessary, amend any policy or practice relating to staff 'debriefs' following a death in custody or other sentinel events. The review should consider and clarify:

37.1. the purpose of debriefs, including whether they are intended to serve a staff welfare function, evaluate practice and/or policy to identify systems or other deficits, or a combination of these matters; and

37.2. a process to optimise the participation of relevant staff in any debrief.

38. I recommend that the Victorian Department of Health, in collaboration with relevant Aboriginal Community Controlled Health Organisations and other stakeholders, prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence.

39. I recommend that no later than 12 months from the date of this Finding, Corrections Victoria, Justice Health and Correct Care Australasia, as public authorities under the Charter request that the Victorian Equal Opportunity and Human Rights Commission conduct a review under Section 41(c) of the Charter of any improvements to programmes, practises, and facilities made in response to the recommendations above, and provide an overview of the results of that review for publication on the Coroners Court of Victoria website along with the responses to the Recommendations made in this Finding.