IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 4767

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Leveasque Peterson, Coroner
Deceased:	JCS
Delivered on:	1 December 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Melbourne
Hearing date:	9 February 2023
Representation:	Coroner's Assistant, Leading Senior Constable Kelly Ramsay, Police Coronial Support Unit Liam McAuliffe of Counsel for the Secretary to the Department of Justice and Community Safety Edwina Arms of Meridian Lawyers for Correct Care Australasia
Key words	Mandatory inquest, death in custody/care, suicide, plastic bag asphyxia

Pursuant to section 55(2)(e) of the *Coroners Act* 2008, a pseudonym replaces the name of the deceased, and her family members and associates have been deidentified.

INTRODUCTION

1. JCS was 36 years of age when she died in custody at Dame Phyllis Frost Centre (**DPFC**) on 29 August 2019.

2. JCS was born and raised in Melbourne with loving supportive parents and an older sibling. She had a stable home environment and a generally uneventful childhood, with no family history of psychiatric illness. However by Year 7 JCS reported to health practitioners that she experienced intrusive thoughts about wishing to harm or kill people.

3. JCS continued to experience escalating mental illness during her teenage years which resulted in both psychiatric admissions and criminal offending by way of violence toward others.

4. During her hospital admissions JCS had extensive psychological and psychometric assessments which indicated several prominent dysfunctional personality styles, depressive symptomatology, post-traumatic stress reactions and a high emotional experience/behavioural manifestation of anger.

5. In May 2007 JCS entered custody after stabbing a fellow student at university. In April 2008 JCS was convicted of attempted murder and related violence offences. She was subsequently sentenced to a substantial period of imprisonment and recepted at DPFC to serve her time.

6. Whilst serving her sentence JCS committed further acts of serious criminal offending that resulted in the imposition of additional sentences of imprisonment.

7. JCS remained in custody at the time of her death.[1]

8. JCS' family remained supportive of her throughout her life.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[5] or to determine disciplinary matters.

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[1] I have determined not to include in this finding certain background facts related to the circumstances of JCS' detention in custody at the time of her death. I have made this determination in order to uphold the objective of certain legislative restrictions on publication. I am satisfied that despite this determination, I have fulfilled my obligation under section 67(1)(c) of the *Coroners Act 2008* (Vic) to make findings as to the circumstances in which the death occurred.
[2] Section 89(4) *Coroners Act 2008* (Vic).
[3] Preamble and section 67 *Coroners Act 2008* (Vic).
[4] *Keown v Khan* (1999) 1 VR 69.
[5] Section 69(1) *Coroners Act 2008* (Vic).

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

12. For coronial purposes, the phrase '*circumstances in which death occurred*,'[6] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[7] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[8] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

The position of persons in custody or care

15. JCS' death was reported to the Coroner as she was person in care or custody immediately before her death, and so fell within the definition of a reportable death in the *Coroners Act 2008*.

16. Whereas a coroner usually has a discretion as to whether to hold an inquest into a reportable death, a coroner is obliged under section 52 of the Act to hold an inquest into the death of a person in custody or care unless the death was due to natural causes. JCS' death was clearly not from natural causes and so an inquest was mandatory.

17. The reason for this different treatment is to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

18. Deaths in custody are not only investigated by coroners, but they are also routinely reviewed by a business unit within government known as the Justice Assurance and Review Office (**JARO)**. The JARO is a part of the Department of Justice and Community Safety (**DJCS**) and reports to the Secretary of that Department, as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders.[9]

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[6] Section 67(1)(c) *Coroners Act 2008* (Vic).
[7] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[8] (1938) 60 CLR 336.
[9] Section 7 of the *Corrections Act 1986.*

19. In preparing its report for the Secretary, the JARO has regard to a separate report prepared by Justice Health, another business unit of DJCS. Justice Health has responsibility for the delivery of health services to Victoria's prisoners.

20. Whilst coroners are, as a matter of course, provided with JARO and Justice Health reports, the coronial investigation is independent and I have formed my own view on the evidence provided.

Sources of evidence

21. As part of the coronial investigation, the Coroner's Investigator, Senior Constable Nathan Johnstone, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

22. Additionally, the Court received reports from JARO and Justice Health regarding the circumstances leading to JCS' death.

23. Having reviewed the brief of evidence and additional materials I considered there were no areas of disputation or conflicts in the evidence and it was appropriate for the inquest to proceed by way of a summary inquest.

24. This finding is based on the coronial brief, additional materials submitted to the Court, the summary of matters put to me by Leading Senior Constable Kelly Ramsay as Coroner's Assistant, and submissions by Counsel for DJCS. It is unnecessary to summarise all this material, which will remain on the Court file.[10] I will refer only to so much of it as is relevant or necessary for narrative clarity.

BACKGROUND

25. DPFC is a maximum security rated women's prison that provides a variety of facilities and services for both remand and sentenced prisoners. At the relevant time, the provision of primary and mental healthcare at DPFC was contracted by Justice Health to private provider Correct Care Australasia Pty Ltd (**CCA**).[11] Psychiatric services were provided by Forensicare.

26. Throughout her period of detention JCS was housed primary at Marrmak and Swan 2. Swan 2 houses high security and special placement prisoners and often houses prisoners who have displayed serious behavioural issues or who are at risk of self harm. Marrmak is DPFC's inpatient mental health care unit. It provides 24 hour, intensive psychiatric care and treatment to prisoners who are in an acute or post acute phase of mental illness.

27. The Victorian correctional system employs a series of risk ratings, which are attached to prisoner and offender records to ensure communication about significant issues experienced by that

[10] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[11] On 20 January 2023, the Victorian Government announced that from 1 July 2023, public health providers would deliver healthcare at DPFC and Tarrengower prisons.

person. According to the Correctional Suicide Prevention Framework [12], the risk rating for suicide is as follows:

- S1: a prisoner is in immediate danger of self-harming or attempting suicide and requires intensive management and support (this includes a prisoner who may have an acute psychiatric illness where there is a high risk of self-harming behaviour).
- S2: a prisoner is at significant risk of suicide or self-harm and requires intermediate management and support.
- S3: a prisoner is not currently at risk but requires follow-up management and support.
- S4: a prisoner is not currently at risk and is assessed due to previous history of self-harm behaviour.

28. Relevantly, JCS had an extensive suicide / self-harm risk (**SASH**) rating history. As a result of her mental ill health, consistent violent offending whilst in prison, and her high management needs, JCS' classifications would cycle from S1 to S4, sometimes within a 24 hour period.

29. Corrections records establish that during her time in custody JCS was involved in over 800 incidents of violence and self harm. JCS' violence was often directed at custodial and clinical staff. JCS also had four periods of admission to Thomas Embling Hospital between 2007 and 2008.

30. Given the serious and dynamic nature of JCS' mental illness it was appropriate that she was subject to daily risk reviews and Risk Review Team Meetings. In addition, JCS received monitoring and services from CCA psychiatric nursing staff and Forensicare consultant psychiatrists and psychologists.

31. At the time of her death JCS' risk rating was S1, however she had cycled through S4 up to S1 at numerous times during the preceding two months, reflecting the challenging nature of her presentation and the appropriately responsive dynamic risk assessment process.

32. The court was provided with a multitude of records that documented JCS' treatment, progress, risk assessments and risk control measures during her imprisonment.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

33. On 29 August 2020 JCS was visually identified by Corrections staff who had known her for approximately two years.

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

[12] Exhibit 17 of the Coronial Brief – Correctional Suicide Prevention Framework – Justice Health

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

35. At approximately 8pm on 29 August 2020, Prison Officer Park (**PO Park**) conducted 60-minute observations of JCS in her cell in compliance with the current agreed risk assessment and risk control measures. Observations were made through the cell door, and JCS was noted to be "*awake, sitting on bed*."

36. At approximately 9pm, PO Park conducted the next 60-minute observations of JCS and saw her on her bed with what appeared to be a plastic bag over her head. JCS was non-responsive when PO Park knocked on the observation window and called out to her.

37. A Code Black was called signalling a medical emergency and the Security Supervisor attended, along with Prison Officers Mai, White and Mamouney.

38. Given JCS' risk profile it was appropriate for staff to formulate a plan before entering her room to remove the plastic bag. The resulting delay in treatment was necessary in the context of JCS' risk management profile. I consider that the delay was reasonable and appropriate and it neither caused nor contributed to her death.

39. The supervisor removed the plastic bag with the assistance of an intervention knife and observed a ligature tied around JCS' neck. The ligature was cut and removed.

40. JCS was observed to have no colour in her face and to be non-responsive. CPR was commenced until Ambulance Victoria attended at 9.36pm.

41. Ambulance Victoria took over CPR however, further resuscitation attempts were unsuccessful. JCS was declared deceased at approximately 9.40p.m.

42. CCTV was subsequently obtained from DPFC. The footage showed the following:

    - At approximately 6.43pm, JCS left the lounge area and entered her cell. She closed the cell door behind her and did not leave the cell after this time. No one entered her cell again until the Code Black was called.

    - Prison Officers attended for hourly observations of JCS including the 9.00pm observation, following which a Code Black was called.

43. Appropriately, there are no CCTV cameras installed inside the prisoners' rooms.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

44. On 1 September 2020 Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination of JCS and found circumstantial evidence of plastic bag asphyxia.

45. Dr Bouwer also noted that JCS had multiple recent and older possible self-harm injuries on the head and neck, arms and legs, and found foreign metal objects inserted into the base of her tongue which were likely paper staples inserted by JCS.

46. Post mortem toxicology was non-contributory to her death.

47. Dr Bouwer considered that the cause of death was reasonably formulated as consistent with plastic bag asphyxia.

48. I accept and adopt Dr Bouwer's opinion.

REVIEWS BY JARO AND JUSTICE HEALTH

49. On 19 March 2021, JARO provided a copy of its review into the death of JCS. The review provided a detailed overview of JCS' management in custody and the circumstances of her death. The report covered the prison incident response, JCS' custodial management, her access to plastic packaging and a ligature which she used to take her own life, and opportunities for improvement.

50. The JARO report found as follows:

    a. JCS' highly complex needs constituted one of the most challenging instances of detention;

    b. The overwhelming number of suicidal and self harm episodes created an ever present risk of suicide;

    c. After discovering JCS custodial officers responded in accordance with agreed processes;

    d. The responders showed JCS compassion and dignity throughout their response;

    e. There was no evidence that a risk assessment was conducted on the pants which JCS purchased that were later found to contain a cord which was used as a ligature;

    f. There was an uncontrolled risk in relation to the availability of plastics and plastic outer packaging on some items in the prison.

51. The report made recommendations including updates to local prison policies intended to improve and strengthen system wide processes. DJCS has confirmed in correspondence to the court dated 30 January 2023 and 9 February 2023 that all recommendations emerging from the JARO report have since been implemented. I commend DJCS for its efforts in this regard.

52. In addition to the JARO review, Justice Health also commissioned an independent review of the mental health care provided to JCS during her time at DPFC.

53. Forensic psychiatrist Dr Heffernan undertook a comprehensive review of JCS, covering her presentation upon remand until her death. Dr Heffernan was provided with electronic medical

records, a summary of the facts and circumstances of JCS' background and offending, specialist medical reports, hospital records and case meeting minutes. These materials were assessed through the lens of the Justice Health Quality Framework (2014).

54. Dr Heffernan found that JCS had access to an array of services which were delivered in a person-centred way despite the restrictive environment of prison which was compounded by the many challenging aspects of her care. Relevantly Dr Heffernan noted that there was "a constant and unavoidable tension in her management where these elements of recovery were unable to be met, not because of a lack of effort by clinicians and services, but due to the nature of JCS' risk management requirements and the legal and custodial restrictions."[13]

55. Dr Heffernan found that overall, the care and management provided to JCS was underpinned by a "consistent theme of progressing interventions to enhance her care and quality of life."[14]

56. He further found that although the final outcome was tragic for JCS, staff involved in her care and management were dedicated and determined, and they delivered a consistently high standard of care to JCS.

57. I accept the conclusions of the JARO and Justice Health reports. I consider that throughout her time at DPFC JCS received a high standard of custodial and medical care, monitoring and management in enormously challenging circumstances and am satisfied that no individual caused or contributed to her death.

[13] Heffernan report p 23-24
[14] Heffernan report p 21

FINDINGS AND CONCLUSION

58. Having investigated the death of JCS I find pursuant to section 67(1) of the Coroners Act 2008 that:

    a. The identity of the deceased was JCS, born 29 November 1983;

    b. The death occurred on 29August 2019 at Dame Phyllis Frost Centre, Ravenhall, Victoria;

    c. The cause of death is plastic bag asphyxia which occurred in the circumstances described above.

59. Having considered all of the circumstances, I am satisfied that JCS intentionally took her own life.

60. Pursuant to section 73(1) of the Coroners Act 2008, I direct that a copy of this finding be published on the internet on the Coroners Court of Victoria website.

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

DJCS
Justice Health
Correct Care Australasia
Senior Constable Nathan Johnstone, Coroner's Investigator.

Signature:

Coroner Leveasque Peterson

Date: 1 December 2023