IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2016 003108

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF BAZOUNI BAZOUNI

Findings of:	Coroner David Ryan
Delivered on:	2 September 2022
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	28-30 June, 1 July, 12 August 2022
Counsel Assisting the Coroner:	Dan McCredden of counsel
Secretary to the Department of Justice and Community Safety:	Marion Isobel of counsel
G4S Custodial Services Pty Ltd:	Robert Harper of counsel
St Vincent's Hospital (Melbourne) Ltd:	Naomi Hodgson of counsel
Tony Guastalegname:	Fiona Ellis of counsel
Keywords:	Death in custody – Drug ingestion - Medical treatment – Observation – Communication between correctional and medical staff

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BACKGROUND

1. On 6 July 2016, Bazouni Bazouni **(Billy**) was 21 years old when he died at St Vincent's Hospital in Melbourne (**SVHM**) from a hypoxic brain injury after having ingested illicit drugs, including methamphetamines,[1] at Port Philip Prison (**PPP**). PPP is operated by staff from G4S Custodial Services Pty Ltd (**G4S**) and medical services to prisoners at PPP are provided by St Vincent's Custodial Health Service (**SVCHS**).

2. Billy was born at the Royal Women's Hospital in Carlton on 17 May 1995.

3. Billy was the first child of Joe Bazouni and Hanh Tran. He had a younger sister, Belinda, and an older half-brother, Paul. As a child growing up, Billy lived with his parents in the northern suburbs of Melbourne. He went to primary school in Alphington and later attended a number of different high schools. Billy experienced difficulties at high school, and for several years he was assisted by a private tutor arranged by his parents.

4. When Billy was 14 years old, his parents separated. He then lived with his mother but also spent time with his father. Billy attended the Melbourne Polytechnic School for a short period, and he obtained a permit to drive a forklift.

5. Billy started to come to the attention of the police when he was about 14 years old. Unfortunately, his offending escalated over the ensuing years, and he spent time in youth detention and was further imprisoned in 2014 at the age of 19. At the time of his death, Billy had been in prison for approximately 2 years.

6. In a Coronial Impact Statement delivered to the Court by Belinda on behalf of herself and her mother, Billy was warmly remembered as a loving son and brother.

[1] Also known as 'ice'.

CORONIAL INVESTIGATION

Jurisdiction

7. Billy's death constitutes a "*reportable death*" under ss 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death he was a person placed in custody or care. Pursuant to s 52(2)(b) of the Act, an inquest was also required to be held which occurred on 28-30 June, 1 July and 12 August 2022.

8. The Coroners Court of Victoria (**Coroners Court**) is an inquisitorial court.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

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

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

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

12. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[3]

[2] Section 89(4) of the *Act.*
[3] Section 72(1) of the Act.

(b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[4] and

(c) 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.[5]

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

14. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[6] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[7]

15. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[8]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

16. At the time of his death, Billy was serving a prison sentence of 3 years and 6 months at PPP for several offences including armed robbery and negligently causing serious injury. During his time at PPP, Billy had been involved in a number of incidents including assaults on other prisoners as well as prison staff. As a result, he was placed in a management unit of the prison, known as the Charlotte Unit (**Charlotte**), which houses higher risk prisoners who require a greater degree of security and limitation on their

[4] Section 67(2) of the Act.
[5] Section 72(2) of the Act.
[6] Section 69(1) of the Act. 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.
[7] *Keown v Khan* (1999) 1 VR 69.
[8] (1938) 60 CLR 336.

movement. One feature of the higher security is that Charlotte prisoners are required to be handcuffed when being moved from their cell to other parts of the prison.

17. On the morning of 2 July 2016, at about 6.15am, Billy complained to Correctional Officer Clare Harvey in Charlotte that he was experiencing chest pains and difficulty breathing. Billy was observed by Ms Harvey pacing around his cell, with his fists clinched and appearing to grind his teeth. She called a "*Code Black*" – which is the alarm code requiring assistance for a serious medical incident. Based on Billy's appearance, Ms Harvey formed the view that Billy was drug affected, although he denied having taken anything when asked by Ms Harvey.

18. In response to the Code Black, Registered Nurses Tony Guastalegname and Joshua Cutajar from SVCHS attended Billy's cell, as well as Tactical Operations Group (**TOG**)[9] members Chris Ascough and Darren Beckett.

19. The nurses undertook an initial assessment of Billy in his cell. However, Billy was agitated and unable to keep still, with what appeared to be involuntary movements. This interfered with the ability of the nurses to carry out certain basic medical assessments, and the Nurse-in-Charge, Mr Guastalegname, decided to have Billy transferred to the prison's outpatient unit, known as the St Thomas Unit (**St Thomas**), for further assessment.

20. Billy was then transferred to St Thomas and taken to an emergency treatment room. His transfer and a number of subsequent interactions with staff were recorded by the TOG members from their body worn cameras (**BWC**).

21. On the way from his cell to St Thomas, Billy was able to walk unassisted and appeared to be alert. In the treatment room, Billy continued to exhibit involuntary, erratic and jerky movements, and the nurses were again unable to undertake proper assessments. He was asked by Mr Guastalegname whether he had ingested anything but said he had not.

[9] Specialist correctional officers with responsibilities for responding to prison incidents and escorting prisoners around the prison.

22. Billy said on several occasions during the morning that he was experiencing chest pain. One of those occasions was in the treatment room, when he was asked by Mr Cutajar whether he had any pain.

23. Given Billy's condition, the nurses decided to admit him to the prison's inpatient unit, known as the St Johns Unit (**St Johns**), and to speak with the Admitting Officer at SVHM for further advice. At about the same time, Mr Guastalegname was informed that correctional staff in Charlotte had confirmed with a fellow prisoner that Billy had taken ice. Mr Guastalegname spoke by phone to the Admitting Officer at SVHM, who was a Senior Emergency Medicine Registrar. They discussed the presentation and management of a person affected by an ice overdose.

24. It was decided that Billy would remain at the prison hospital unit, under close observation, until the effects of the suspected ice ingestion wore off, with a transfer to the Emergency Department (**ED**) at SVHM available if his condition deteriorated. It was intended that Billy would be assessed by the SVCHS medical officer, who was due to arrive in a few hours.

25. Billy was first taken to Cell 3 in St Johns, where the TOG members attempted to undertake a strip search of Billy. A strip search was normal procedure whenever a prisoner was admitted to the inpatient unit. Billy was somewhat reluctant to comply with the strip search, and during the procedure, a small package dropped from his groin and buttocks area. The TOG members asked him what it was, but before they could get to it, Billy picked it up and appeared to swallow it. As the officers approached Billy, he attempted to punch one of them, and he was brought to ground and restrained.

26. With Billy restrained, a decision was then made to move him to a holding cell in the Admissions Unit, which was installed with a camera. Cell 3 at St Johns did not have a camera, and with the other two cells in the inpatient unit presently occupied, one of those prisoners needed to be moved before Billy could be housed there.

27. Billy was physically restrained while he was taken to Cell 14 in the Admissions Unit but was able to walk and was communicating with correctional staff. He was placed in Cell

14 naked on the floor, with his hands remaining handcuffed behind him. Billy remained in that cell for approximately 75 minutes. During that time, he was not visually observed by medical staff, although nurses visited the cell on two occasions and could hear Billy making noise, including talking and yelling.

28. At 8.09am, Billy was transferred from Cell 14 to an observation cell, Cell 2, at St Johns. In Cell 14, Billy was found lying on the ground. He was picked up by the TOG members and was walked but also dragged for part of the journey to Cell 2. A sheet was draped around him given that he was naked. He was placed face down, on the floor, in Cell 2 and had his handcuffs removed. During the transfer, Billy did not appear to speak or say anything but could be heard groaning.

29. As Billy was placed in Cell 2, Registered Nurse Kelby Burn observed that he was breathing and his limbs were moving. However, no attempt was made to check Billy's vital signs because of concern for his potential to be violent. Mr Burn was instructed to observe Billy closely, every 15 minutes, using the video surveillance monitor in the nurses' station adjacent to the cell. An observation was undertaken at 8.15am. A further observation was undertaken at 8.20am, at which time Billy was seen not moving, lying in the same position prone on the floor and with what appeared to be a pool of blood next to his head.

30. Mr Burn observed that Billy was not breathing and not responding to his name. He called a Code Black, and TOG members entered the cell, rolled Billy on to his back and placed his hands in handcuffs in front of him.

31. While in the cell, nursing staff undertook a range of emergency treatments, including cardiopulmonary resuscitation (**CPR**). By 8.30am, Billy was observed to have recovered a pulse. Paramedics arrived by 8.37am, and Billy was then transferred to SVHM and admitted to the Intensive Care Unit (**ICU**). At hospital, a computed tomography (**CT**) scan indicated that Billy had a foreign object present in his stomach. A gastroscopy was performed and a small balloon was removed, which was tied in a knot and contained an unknown substance inside it. The contents were later tested and found to contain methylamphetamine.

32. Billy remained in ICU for several days and passed away on 6 July 2016. Toxicological analysis detected a significant quantity of methylamphetamine in Billy's system, described as being consistent with an excessive and potentially fatal use of the drug. A post-mortem examination determined the cause of death to be hypoxic brain injury in the setting of drug toxicity. A report from the surgeon who removed the balloon Billy had swallowed confirmed that it had been sealed with a knot, and there was no evidence that any of its contents had leaked.

OTHER INVESTIGATIONS

33. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

34. G4S conducted an Internal Management Review and also prepared a detailed response dated 21 October 2016 to a Correctional Services Default Notice. As a result, it was determined that relevant policies would be reviewed and updated. G4S conceded in its response to the Default Notice that the TOG members who supervised Billy from the initial Code Black on 2 July 2016 "*were highly security focussed*" which "*interfered with their ability to notice the deterioration of [his] medical condition and led to this being perceived as non-compliance*".[10]

35. Deaths of prisoners in custody at the time of Billy's death were reviewed by the Office of Correctional Services Review (**OCSR**).[11] OCSR was part of the Department of Justice & Regulation (now the Department of Justice & Community Safety) and reported to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[12]

36. OCSR conducted a review into Billy's death and prepared a report dated 21 March 2017. The review was conducted in conjunction with Justice Health.[13]

[10] Coronial Brief (**CB**) 419-420.
[11] Now known as the Justice Assurance and Review Office (**JARO**).
[12] Section 7 of the *Corrections Act 1986*.
[13] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

37. In summary, OCSR made the following relevant findings:[14]

(a) There was no policy in place at PPP in respect of the health management of drug-affected prisoners, other than for narcotic overdose.

(b) There were two communication breakdowns between health and correctional staff. Firstly, health staff reported that they had not been informed that Billy had swallowed a package during a strip search. However, the correctional supervisor stated that health staff were present when TOG staff told him that Billy had swallowed a package. Secondly, health staff and correctional staff did not discuss who would be responsible for monitoring Billy's behaviour and health.

(c) There was insufficient monitoring and visual observation of Billy's behaviour and health when he was in the Admissions Unit.

(d) Health staff did not take Billy's vital signs when he returned from the Admissions Unit to St Johns. The health staff present advised that they were told by correctional staff not to undertake observations for reasons of personal safety, however correctional staff did not concur with this view.

(e) Correctional staff should have been more alert to the risks associated with restraint/positional asphyxia, both from prolonged use of handcuffs and when leaving Billy in a prone position in the St Johns observation cell.

(f) Although correctional staff were not formally assigned to continually monitor Billy while he was in the Admissions Unit, more consideration could have been given to his wellbeing, given that he presented as drug affected and had swallowed a package.

[14] CB368.

38. OCSR made the following relevant recommendations:[15]

(a) That SVCHS develop a standard communication process to ensure that staff in the ED of SVHM are fully informed about the environment and facilities of PPP's bed-based medical services in addition to the overall prison environment in which they operate.

(b) That a standardised communication tool be utilised by health staff at PPP to ensure clarity of information and advice between SVCHS staff and the ED at SVHM.

(c) That SVCHS develop a policy for the management of prisoners who are suspected to have ingested illicit drugs, unprescribed medications or unknown substances, and that health and correctional staff are educated about this policy once it is developed.

(d) That PPP and SVCHS introduce a new procedure requiring senior staff in custodial and health areas to meet at shift changeover to share relevant health and custodial information.

(e) That PPP and SVCHS develop an operating instruction for the management of violent and/or unpredictable prisoners who also require urgent medical attention that defines the responsibility for (i) the performance of behavioural observations by custodial staff, and (ii) the health-related observations and/or monitoring by health staff.

(f) That consideration be given as to how best to ensure that prisoners who are in temporary cells are monitored, and that custodial and health staff be educated about these expectations in their respective roles.

[15] CB368-369.

39. In response to its report, Corrections Victoria advised OCSR that it accepted the recommendations in-principle and that relevant policies would be reviewed and updated.[16]

40. The General Manager of PPP, Patricia Sellman, provided a statement dated 18 September 2020 in which she identified the steps that had been taken by G4S to respond to the findings of the Internal Management Review and the Correctional Services Default Notice and the steps that had been taken to implement the recommendations of the OCSR review.[17]

41. The manager of SVCHS, Kristine Mihaly, provided a statement dated 25 September 2020 in which she identified the steps that had been taken by SVCHS to implement the recommendations of the OCSR review.[18]

SOURCES OF EVIDENCE

42. Victoria Police assigned Detective Senior Constable Drew Corry to be the Coroner's Investigator for the investigation into Billy's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from the forensic pathologist, various correctional officers and medical staff who attended to Billy on the morning of 2 July 2016, additional statements from the interested parties, CCTV and BWC footage and the OCSR report. It also includes an independent expert report by Dr Jason Harney regarding the medical management of Billy while at PPP.

43. The inquest ran over 5 days and evidence was given by the following witnesses:

    (a) Clare Harvey (G4S Correctional Officer);

    (b) Chris Ascough (G4S Tactical Operations Group member);

    (c) Darren Beckett (G4S Tactical Operations Group member);

[16] CB369 and CB392-393.
[17] CB614.
[18] CB690.

(d) Nafez (Nick) Assafiri (G4S Supervisor);

(e) Paul Grimison (G4S Tactical Operations Group member);

(f) Megan Fettke (G4S Tactical Operations Group team leader);

(g) Joshua Cutajar (SVCHS Registered Nurse);

(h) Barbara Cleary (SVCHS Co-ordinator and Registered Nurse):

(i) Dale Bence (SVCHS Registered Nurse);

(j) Kelby Burn (SVCHS Registered Nurse); and

(k) Dr Jason Harney (Emergency Physician).

44. Tony Guastalegname (SVCHS Registered Nurse) was called to give evidence at the inquest but was excused on medical grounds.

45. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief, material tendered during the inquest and the submissions made by counsel assisting and the interested parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

46. The holding of this inquest so long after Billy's death was not ideal. I acknowledge the challenge faced by witnesses in recalling events in evidence so long after they had occurred. Understandably, most witnesses had limited independent recollection of events beyond their more contemporaneously prepared statements.

SCOPE OF THE INQUEST

47. The following issues[19] were investigated at inquest:

    (a) A review of care provided to Billy at PPP on 2 July 2016 between 6.23am and 8.35am relevant to the circumstances of his death, including:

        (i) Consideration of the assessment of his initial complaint of chest pain and difficulty breathing, namely a potential organic illness and his possible substance intoxication;

        (ii) Consideration of the communication between correctional staff and health staff regarding the swallowed package;

        (iii) An assessment of the adequacy of observations when Billy was in the Holding Cell 14 between 6.54am and 8.09am (75 minutes):

        (iv) The medical and nursing response to his apparent deterioration when he was moved from Cell 14 to Cell 2; and

        (v) An assessment of his care given Billy's placement prone, on the concrete floor in Cell 2 and his subsequent rapid deterioration between 8.11am and 8.20am.

    (b) How did Billy's management comply with the relevant policies and processes regarding the management of prisoner/patient suspected of ingesting drugs?

    (c) What, if any, prevention opportunities were available?

IDENTITY OF THE DECEASED

48. On 6 July 2016, Billy was visually identified by his mother, Ms Hanh Tran.

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

[19] These issues were drawn from the settled scope of the inquest which was circulated to the parties by the Court on 6 May 2022 and has been condensed where appropriate.

MEDICAL CAUSE OF DEATH

50. On 7 July 2016, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy upon Billy's body. In a report dated 31 October 2016, Dr Lynch noted that a package of suspected drugs had been removed from Billy by gastroscope.

51. Toxicological analysis of ante-mortem and post-mortem blood and urine samples identified the presence of a number of drugs including methamphetamine, amphetamine,[20] buprenorphine and cannabis. There were also a number of drugs detected which were consistent with administration in the course of emergency medical treatment. The toxicology report stated that the level of methamphetamine detected was consistent with excessive and potentially fatal use.

52. Dr Lynch formulated the cause of death as hypoxic brain injury in the setting of drug toxicity.

53. I accept Dr Lynch's opinion.

REVIEW OF HEALTH CARE

Assessment of initial chest complaint

54. At 6.15am on 2 July 2016, Billy complained through the intercom system from his cell in Charlotte that he was experiencing chest pain.[21] Ms Harvey attended Billy's cell and spoke with him through the "*trap*" in the door. He confirmed to her that he "*had chest pain and trouble breathing*" which he said he had been experiencing for the previous two hours. Ms Harvey observed that Billy was pacing around his cell with his fists clenched. From her observations, she thought that he had "*taken something*" but Billy denied it. Ms Harvey used her radio to call a Code Black.[22]

[20] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as "speed" or "ice". Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.
[21] CB, Exhibit 11.
[22] CB71; T20-26.

55. TOG members Chris Ascough and Darren Beckett responded to the Code Black and attended Charlotte and were informed by Ms Harvey that Billy had complained of chest pain and appeared agitated. Mr Ascough and Mr Beckett spoke to Billy through the "*trap*", applied handcuffs and informed him that a medical team was on the way. Mr Beckett noted that Billy was "*holding his chest and saying that he was having pains*".[23]

56. Mr Guastalegname and Mr Cutajar heard the Code Black being called at around 6.25am and attended Charlotte.[24] When they arrived, Ms Harvey stated that she informed them that Billy had complained of chest pain and said that he was having trouble breathing.[25]

57. Mr Guastalegname assessed Billy in his cell. In his statement, he recalled that Billy said he had shortness of breath although he observed that he "*had normal work of breathing*". Mr Guastalegname stated that Billy "*seemed slightly panicky and erratic with movements that appeared to be involuntary*" and he considered that he had ingested a substance. In his amended statement provided to the Court shortly before the commencement of the inquest, Mr Guastalegname said that "*I asked him if he had pain and he gestured in a circular motion and told me he had pain everywhere*".[26] He arranged to have Billy transferred to St Thomas for further examination.[27] Billy was subsequently escorted to St Thomas by Mr Ascough and Mr Beckett, followed by Mr Guastalegname and Mr Cutajar.

58. Billy was further assessed in Emergency Room 1 at St Thomas by Mr Guastalegname and Mr Cutajar. Although he was compliant, they were unable to fully assess his vital signs due to his involuntary movements. On the BWC footage, Billy can be heard telling Mr Cutajar that he was experiencing chest pain. At 6.40am, Mr Cutajar asked Billy, "*Do you have any pain at the moment?*" and Billy responded, "*Pain? Yeah, in the chest*".

[23] CB100.
[24] CB317; CB323.
[25] CB71; T22.
[26] CB836.
[27] CB318.

59. Although he was in the room at the time, it is not clear whether Mr Guastalegname heard this exchange. Soon afterwards, Mr Cutajar left the room and Billy said to Mr Guastalegname, apparently by way of explanation in relation to his involuntary movements, "*That's why I move my feet because I'm in pain*". Mr Guastalegname subsequently stated, "*I know you're in pain but this is a bit unusual*".[28] Mr Guastalegname does not refer to Billy's complaint of chest pain in his statement to the Court or in the contemporaneous clinical notes for Billy that he prepared.

60. Mr Cutajar gave evidence that the fact that Billy complained of chest pain required them to undertake an electrocardiogram (**ECG**) and a full set of observations.[29] This is consistent with SVCHS's June 2016 Protocol for Chest Pain (**the Protocol**), which was in place at the time. Mr Cutajar was unable to provide an explanation as to why an ECG was not conducted.[30] Further, it is noted that Mr Guastalegname was one of the authors of the Protocol.

61. Mr Cutajar recorded Billy's complaint of chest pain on a "Notifiable Incident Form", but the words "*chest pain*" were subsequently crossed out.[31] He was unable to provide an explanation in evidence as to why the reference to chest pain had been crossed out. A further version of the "Notifiable Incident Form", possibly completed later in the morning by Mr Cutajar, did not refer to Billy's complaint of chest pain.[32]

62. Mr Guastalegname decided to have Billy admitted to St Johns for further observation and to seek further advice from the On-Call Medical Officer.

63. While Billy was being strip searched in Cell 3, prior to being admitted to St Johns, Mr Guastalegname telephoned the Admitting Officer at the ED of SVHM to discuss Billy's presentation. At this stage, it had been confirmed with Mr Guastalegname by staff in Charlotte that Billy had recently ingested ice. Mr Cutajar was present during the conversation with the Admitting Officer and recalled that he advised that Billy's

[28] Exhibit 12.
[29] T299.
[30] T301.
[31] CB829.
[32] CB834.

symptoms were consistent with ice consumption and that he needed to be observed for a 6-to-8-hour period until the drug wore off. Mr Guastalegname and Mr Cutajar then agreed that Billy would be subject to visual observations (respiratory and neurological) every 15 minutes. Mr Cutajar does not recall whether the Admitting Officer was advised that Billy had complained of experiencing chest pain.[33] Mr Burn was also present during the conversation.[34]

64. After Billy was transferred to Cell 14 in the Admissions Unit, Mr Guastalegname telephoned Barbara Cleary, who was the SVCHS On-Call Manager at the time, to discuss the Code Black and the plan for Billy's treatment after the discussion with the Admitting Officer. Ms Cleary took contemporaneous notes of the discussion. She stated in evidence that there was no reference in the telephone call to Billy experiencing chest pain.[35]

65. Prior to concluding his shift at 7.50am, Mr Guastalegname provided a handover to the SVCHS staff who were commencing the morning shift, which included a briefing in relation to Billy's circumstances. There is no evidence that the staff commencing the morning shift were advised that Billy had complained of experiencing chest pain. Further, Mr Guastalegname does not refer to it in his email about the Code Black at 7.46am to Registered Nurse Dianne Paul who was taking over from him as the Nurse-in-Charge on the change of shift.

66. It is clear that Billy complained of chest pain in the morning on 2 July 2016 to both G4S staff and SVCHS staff. However, I am satisfied that this information was not communicated to the Admitting Officer at SVHM or to Ms Cleary. Further, contrary to the Protocol, an ECG was not performed or attempted by SVCHS staff and Billy was not subject to a comprehensive pain assessment. Given Billy's agitated presentation, I consider that it is unlikely that it would have been possible for staff to perform an ECG at PPP, which under the Protocol, would then have required him to be transported to

[33] CB323; T316.
[34] T425.
[35] T363.

SVHM for treatment. These matters have been reasonably and appropriately conceded by SVHM.

67. The evidence does not enable me to be satisfied that Mr Guastalegname was aware of Billy's complaint of chest pain. However, it is clear that he was aware that Billy was in pain and despite having the opportunity, there is no evidence that he sought to clarify the source of that pain.

68. I am also satisfied that Billy's complaint of chest pain (or any pain) was not adequately documented by SVCHS staff and was not communicated to the medical staff commencing on the morning shift on 2 July 2016.

Communication regarding the swallowed package

69. At around 6.46am, Billy swallowed a package of methamphetamine which had fallen to the floor from his groin and buttocks area while he was being strip searched in Cell 3 at St Johns.[36] Mr Ascough gave evidence that while Billy was subsequently being restrained on the ground, he told his supervisor who had arrived, Nick Assafiri that "*Billy swallowed something and just tried to assault me*". Mr Ascough conceded that this statement is not able to be heard on the BWC footage, but he nevertheless maintained that he said it.[37]

70. In his statement to the Court dated 4 August 2016, Mr Assafiri stated that he responded to the Code Blue which was called at 6.47am.[38] He said that when he entered Cell 3, Billy was being restrained on the floor and he was informed by "*the TOG Officers*" that Billy had dropped something and swallowed it while being strip searched. G4S have conceded that, having been informed that Billy had swallowed something, it was the responsibility of Mr Assafiri to inform a senior nurse from SVCHS. Mr Assafiri stated that, upon leaving Cell 3, he spoke to Mr Guastalegname and told him that "*he's swallowed something, what do you want to do with him?*"[39]

[36] Exhibit 12.
[37] T48; T73.
[38] A Code Blue is called when an officer or staff member requires assistance. In this instance, the Code Blue was called as a result of Billy's attempted assault on the TOG officers during the strip search.
[39] T164.

71. Mr Assafiri completed a Supervisor Incident Report on 2 July 2016 in relation to the Code Blue incident which does not refer to Mr Guastalegname being advised that Billy had swallowed something. Further, he stated in evidence that he indicated on this form that he did not inform the medical team about the Code Blue because, notwithstanding that he had swallowed an unknown substance, Billy had not sustained any physical injuries.[40]

72. On 7 July 2016, Mr Assafiri participated in a debrief in relation to the Code Black and Code Blue incidents that had occurred on 2 July 2016. The record of that debrief does not refer to Mr Guastalegname, or any other SVCHS staff, being advised that Billy had swallowed something.[41] A further debrief was conducted on 12 July 2016 at which the Medical Director of SVHM is recorded as stating that his staff "*were not aware*" that Billy "*had swallowed something*".[42]

73. Mr Assafiri later completed an Officers Report in relation to the Code Blue, on 15 July 2016, in which he stated that he was informed by the TOG members in the "*St John's Main area*" and in the presence of Mr Guastalegname that Billy had swallowed a package during the strip search. Mr Assafiri had been requested by the Operations Manager, David Jackson, to complete this report in the context of there being uncertainty as to whether G4S staff had had any discussion with SVCHS staff about Billy swallowing something during the Code Blue.[43]

74. In evidence during the inquest, Mr Assafiri initially said that when he entered Cell 3 in response to the Code Blue, Mr Beckett told him that Billy had swallowed something.[44] He later said in evidence that it could have been Mr Ascough who told him, or both of them, but he could not recall.[45] He further said that when he left Cell 3, he told Mr Guastalegname (who was standing near the officers desk in the area outside Cell 3) that Billy had swallowed something.[46]

[40] T214.
[41] T217; Mr Guastalegname and Mr Cutajar were not present at this debrief.
[42] CB165; Mr Assafiri was not present at this debrief.
[43] T221-222.
[44] T179.
[45] T184.
[46] T185.

75. However, when cross-examined by Ms Ellis, Mr Assafiri said that the version of events recorded in his Officers Report completed on 15 July 2016 was the truth.[47] When the inconsistency of the different versions of events in the Officers Report and his statement were put to him, Mr Assafiri said that they were both true. That is, he was told by the TOG officers that Billy had swallowed a package which was overheard by Mr Guastalegname, *and* he also later himself told Mr Guastalegname that Billy had swallowed a package.[48]

76. In his statement to the Court and in Billy's clinical notes, Mr Guastalegname does not refer to being informed by Mr Assafiri or anyone else that Billy had swallowed a package while being strip searched in Cell 3. He also does not refer to overhearing any conversation about the issue. At the time that Billy was being strip searched and subsequently restrained, Mr Guastalegname stated that he was in the nurses' station[49] making phone calls. I am conscious that I do not have the benefit of Mr Guastalegname's sworn evidence on this issue.

77. The evidence from SVCHS staff suggests that they were unaware that Billy had swallowed something until, when Billy was later being prepared for transfer to SVHM, Mr Bence was informed by one of the correctional staff members (whose identity he is now unable to recall) that Billy had "*swallowed a balloon*" earlier that morning.

78. Further, Mr Guastalegname does not refer to Billy having swallowed a package in his email to Ms Paul at 7.46am on 2 July 2016. Later that day in the evening, Mr Guastalegname sent an email to Mr Burn in which he stated that "*[t]he officers have reported that [Billy] had taken more unknown substance after we left this morning which fell out of his bottom and he quickly swallowed. Did you know that?*"[50] This evidence is consistent with Mr Guastalegname not being aware (until later) that Billy had swallowed the package during the strip search that morning.

[47] T227.
[48] T228.
[49] A separate room adjacent to, and overlooking through a window, the open area of St Johns outside Cell 3.
[50] CB828.

79. Weighing up the evidence before me, I am not able to be satisfied that Mr Assafiri told Mr Guastalegname that Billy had swallowed a package. I am conscious of the diminished weight attaching to Mr Guastalegname's untested account of events in his statements and I make this finding primarily on Mr Assafiri's evidence. I have carefully considered Mr Assafiri's evidence on this issue and I find that it is inconsistent and ultimately unpersuasive. In particular, his evidence on this issue was not supported by any of the contemporaneous records or reports, and was inconsistent with his own Officers Report made on 15 July 2016. I was not persuaded by the explanation for that inconsistency which he provided during his oral evidence. The absence of any contemporaneous record or communication from SVCHS staff referring to the swallowed package also weighs against a finding that Mr Guastalegname was made aware of it.

80. Further, while I am satisfied that Mr Assafiri became aware that Billy had swallowed something from Mr Ascough and/or Mr Beckett, and although he may have assumed it in the rapidly evolving and dynamic circumstances, I am not satisfied that this discussion was overheard by Mr Guastalegname.

Assessment and adequacy of observations in the Holding Cell

81. At around 6.54am, Billy was placed and left handcuffed in Cell 14, a holding cell in the Admissions Unit of PPP. He remained in Cell 14 for approximately 75 minutes until around 8.09am.[51] It had been determined by Mr Guastalegname, in consultation with the Admitting Officer at SVHM, that Billy was required to be visually observed every 15 minutes. Cell 14 was not configured in the same way as the cells in St Johns to enable its occupants to be observed by medical staff. CCTV of the cell, however, could be observed from the staff desk in the Admissions Unit and the PPP's Control Room, which were manned by correctional staff.[52]

82. In his statement to the Court, Mr Guastalegname recorded that he did not consider that it was appropriate for Billy to remain in Cell 14 "*as it would be difficult for nursing staff to*

[51] Exhibit 13.
[52] T66.

maintain frequent observations".[53] Further, there was no formal policy or system in place for the conduct of observations when a patient was taken away from the medical area within PPP to a temporary holding cell in a custodial area.[54] Mr Guastalegname arranged with Mr Assafiri to have Billy transferred to Cell 2, an observation cell in St Johns, once it became available after the current occupant was removed and the cell was cleaned.[55]

83. Mr Cutajar stated in evidence that he took it upon himself to check on Billy's welfare in Cell 14 at around 7.15am. He stated that he was unable to visually observe him, but he could "*hear him talking loudly and making other noises in the cell*".

84. Mr Bence stated in evidence that he checked on Billy in Cell 14 at around 7.20am and that he could hear him "*banging around the cell, and he was yelling and screaming*". He stated that as "*there were no Corrections Officers present at that time, I did not attempt to visualise him through the trap door due to his aggressive and agitated behaviour*".[56] Billy was not observed again by SVCHS staff until around 8.10am when he was being transferred to Cell 2.

85. Mr Beckett stated in evidence that he and Mr Ascough moved the previous occupant from Cell 2 in preparation for Billy's transfer. I find that that occurred after 7.00am but before the "*prisoner count*" commenced at around 7.30am.[57] Mr Bence then diligently and personally undertook the cleaning of Cell 14 once the previous occupant had been removed and after he had attended Cell 14 to check on Billy. He could not recall how long the cleaning process took but I am satisfied that it occurred during the prisoner count and had concluded before the TOG members attended Cell 14 shortly before 8.09am to transfer Billy.

[53] CB320.
[54] Outline of submissions on behalf of SVHM.
[55] T201.
[56] T382; T391
[57] T117; Generally, only emergency prisoner movements are conducted during the prisoner count.

86. Mr Beckett stated in evidence that he observed Billy in Cell 14 at different stages during the prisoner count from the camera in the Admissions Unit and he observed that he was "*walking around the cell, sitting down and sometimes laying down*".[58]

87. At around 7.23am, it appears from the CCTV footage for Cell 14 that Billy becomes fatigued and his movements become slower and less frequent. Shortly afterwards, he can be observed to lie down and his movements become gradually more subdued.[59]

88. Dr Harney expressed the opinion that the monitoring of Billy in Cell 14 was not adequate. He noted in his expert report that there "*appears to [have been] a progressive clinical deterioration in Mr Bazouni's condition that was not appreciated, that being the slowing of his movements and less agitation exhibited at around 7.23am*".[60] He considered that an "*attempt at a repeat assessment of Mr Bazouni's clinical signs and symptoms should have been made at this point*".[61]

89. Ms Hodgson submitted that it was inappropriate for me to rely upon the evidence of Dr Harney, an Emergency Medicine Physician, to assess the adequacy of Billy's assessment by registered nurses working in a correctional environment. She referred me to a number of authorities in a negligence context to support this submission together with an article on the dangers of hindsight and outcome bias.

90. Dr Harney conceded that he did not have experience in working in a custodial environment, but it is clear that he had relevant experience in working with nurses in an emergency context which qualified him to form a view as to the adequacy of Billy's medical care in the circumstances. I consider that it is appropriate to rely upon Dr Harney's evidence for the purpose of assessing the medical care that Billy required, not for the purpose of making critical judgments about the conduct of individual medical staff.

[58] T91.
[59] Exhibit 10.
[60] CB815.
[61] CB814.

91. Further, it is acknowledged that, in making findings and recommendations, this Court has the benefit of hindsight and its examination of the decisions of individuals at the "*coal face*" – decisions often made in challenging and dynamic circumstances – is undertaken with knowledge of the ultimate outcome. This however is an inevitable and necessary feature of the coronial jurisdiction, and it underscores the Court's focus on prevention rather than casting blame or apportioning liability.

92. I find that Billy was not adequately observed by SVCHS staff in Cell 14 after around 7.20am. As a result, the opportunity to observe the deterioration in Billy's condition from 7.23am was missed, as was the opportunity to attempt to assess his clinical signs and symptoms. Further observations ought to have been conducted at around 7.35am and 7.50am, with the assistance of TOG members if necessary. Notwithstanding the atypical circumstance of Billy having to be housed in an admissions cell, G4S staff and SVCHS staff could have co-ordinated to enable medical staff to observe Billy either through the trap, via the CCTV in the Admissions Unit or by entering his cell with the support of TOG officers.

93. The handover between SVCHS staff at the change of shift on the morning of 2 July 2016 occurred at about 7.10am.[62] There is no evidence that a clear plan was formulated during the handover process as to *who* would be responsible for continuing to conduct the required 15 minutely observations of Billy, and *how* those observations were to be conducted.[63] Further, the evidence of SVCHS staff is that they were not aware that Billy could be monitored from the CCTV available in the Admissions Unit.[64]

[62] T389.
[63] T396; T429.
[64] T324; T388.

Transfer from the Holding Cell to the Observation Cell

94. At around 8.09am, Billy was removed from Cell 14 by Mr Ascough, Mr Beckett and Mr Grimison and escorted to Cell 2 at St Johns.[65] The transfer took approximately 70 seconds.[66] Billy can be observed on the BWC footage to be initially walking while handcuffed between the TOG members and then he appears to collapse and is dragged for the remainder of the journey. He can also be heard to be groaning.

Assessment of care in the Observation Cell

95. At around 8.11am, Billy was placed on the floor in Cell 2 by the TOG officers. He was placed in a prone position and his handcuffs were removed before the TOG officers left the cell and the outer and inner doors were closed.[67] Mr Bence and Mr Burn gave evidence that they observed Billy being escorted into St Johns and placed into Cell 2. Mr Burn stated that he "*was able to do a visual assessment noting that he was breathing and moving his limbs about*". However, he could not confirm if Billy was conscious and he did not consider that he was in a safe position having been placed prone.[68] He stated in evidence that there was no time at that stage to attempt to speak with Billy. He further stated that although it would have been beneficial to have checked Billy's vital signs at this stage, it was not done due to "*safety and behaviour concerns*".[69]

96. After Billy was placed in Cell 2, Mr Bence requested the correctional staff to open the outer door so that Billy could be visually monitored through the Perspex inner door. Mr Bence stated that he could see Billy's chest "*rise and fall*" and that he and Mr Burn "*observed him to move his leg slightly*". Mr Bence instructed Mr Burn to visualise Billy every 15 minutes.[70]

[65] Exhibit 13; There is a slight time discrepancy of about a minute between Exhibit 10 and Exhibit 13 in relation to the time at which Billy was removed from Cell 14.
[66] Exhibit 14.
[67] Exhibit 13.
[68] T432; T436.
[69] T433; T437.
[70] T383.

97. In his oral evidence, Mr Bence agreed that it was an important matter to know whether Billy was conscious, but he acknowledged that he was not sure from his observations at that time whether Billy was conscious or not. Further, he agreed that, given his observations of Billy's presentation, it was an important matter to ascertain the strength of his vital signs.[71] He also stated that he did not consider that placing Billy prone was a safe position.[72] He explained, however, that they could not check Billy's vital signs at that point as "*the officers put the prisoner into the cell prone, un-handcuffed him, and walked out and slammed the door, so we couldn't get near him*".[73]

98. Mr Burn stated in evidence that Ms Paul suggested that he monitor Billy "*via the video surveillance monitor in the Nurses Station in case there was a change in his condition*" and that she "*noted that he was to be observed closely*". Mr Burn conducted his first recorded observation of Billy at 8.15am. He checked on Billy again via the monitor at 8.20am and was concerned as he noted that Billy was not moving and remained lying in a prone position. He also noted what looked like a pool of blood under or next to Billy's head.

99. Mr Burn arranged for a correctional officer to open the door to Cell 2, and he visually observed that Billy did not appear to be breathing and was not responding to his name. He arranged for a Code Black to be called and TOG members attended and emergency treatment was commenced and an ambulance called.[74] The emergency response by medical staff after Billy was observed to be unresponsive at around 8.20am was swift, reasonable and appropriate.

100. Dr Harney expressed the opinion that Billy was not left in a safe position when he was placed prone in Cell 2, noting that his conscious state appeared to deteriorate during his transfer from Cell 14. Dr Harney emphasised that his opinion had the benefit of hindsight

[71] T400.
[72] T408.
[73] T410.
[74] T420-1.

that Billy "*was not pretending to be unconscious which is at times with violent patients a reasonable fear or assessment*".[75]

101. Dr Harney also expressed the opinion that the assessment of Billy in Cell 2 was not adequate. He opined that "[*v*]*ital signs measurements and conscious level assessment can be performed or at least attempted whilst a patient is restrained or cuffed*".[76]

102. I consider that Billy should not have been left in a prone position in Cell 2 given his presentation during his transfer from Cell 14. Further, an attempt should have been made at that stage by SVCHS staff, with the assistance of TOG members, to take Billy's vital signs, particularly in circumstances where he had not been visually observed by medical staff for the previous 75 minutes. I rely upon the evidence of Dr Harney and the evidence of Mr Bence and Mr Burn in making these findings.

103. Not unreasonably, G4S staff and SVCHS staff were concerned about the security risk posed by Billy in circumstances where he had earlier that morning assaulted a TOG member. However, I consider that the security risk could have been managed with the assistance of the TOG officers – who are specially trained security personnel and who were present in multiple numbers – to enable at least an attempt to take Billy's vital signs. Further, in my view, closer attention and consideration should have been given to the possibility that Billy's presentation was due to a deterioration in his condition, rather than him simply fatiguing or feigning.

COMPLIANCE WITH RELEVANT POLICIES AND PROCESSES

104. SVHM has conceded that SVCHS staff did not comply with the Protocol which required that an ECG be performed or attempted on Billy after he complained of chest pain in the morning on 2 July 2016 and that he be given a comprehensive pain assessment. It was further conceded that Billy ought to have been transported to hospital for treatment if an ECG could not be performed.[77]

[75] CB815.
[76] Ibid.
[77] Concessions and Submissions on behalf of SVHM dated 6 June 2022.

105. Since Billy's death, the Protocol has been updated and now makes it clear that obtaining an ECG is a clinical priority, stating that ambulance transfer for admission to hospital is recommended for patients with cardiac chest pain regardless of consistency with ECG results.[78]

106. G4S has conceded that, having been informed that Billy had swallowed something, it was the responsibility of the correctional supervisor on duty to inform a senior nurse from SVCHS. Further, since Billy's death and in consultation with SVCHS, PPP has issued an Operational Instruction (**OI.45**) to provide guidelines to staff in order to appropriately manage a prisoner who is known or suspected to have ingested a drug or drugs. The instruction provides that the Duty Supervisor or Area Supervisor supervising the incident will ensure that health staff are notified and attend to assess the prisoner. Further, it provides that relevant information will be recorded on the incident report form.[79]

107. Billy was not adequately observed by SVCHS staff while he was in Cell 14. There was no policy or system in place for the conduct of observations when a patient was taken away from the medical area within PPP to a temporary holding cell in a custodial unit. OI.45 and OI.11[80] now clarify that attending health staff will make a clinical decision regarding the optimal location to treat or further assess the prisoner.

108. In accordance with these new Operational Instructions, health staff must also determine the required treatment observations including frequency, type and length of observations to safely and effectively monitor the prisoner based on clinical presentation or the information provided. Further, if there are significant concerns for staff safety due to the behaviour of the prisoner, every effort must be made to facilitate medical observations as a minimum. If it is not possible to relocate the prisoner to a clinical area, health staff must be permitted to remain in the vicinity of the prisoner, in order that they can continue to conduct and record clinical observations.

[78] Concessions and Submissions on behalf of St Vincent's Hospital dated 6 June 2022.
[79] Operational Instruction No 45: Known or Suspected Drug Ingestion dated 29 October 2019; Statement of Patricia Sellman dated 18 September 2020.
[80] Operational Instruction No 11: Chain of Command During Medical Incidents dated 6 June 2019.

PREVENTION OPPORTUNITIES

109. The package of methamphetamines swallowed by Billy during the strip search on 2 July 2016 was surgically removed at SVHM later that day by Dr Gareth Burns. He has provided a statement to the Court in which he recalled that the package consisted of a knotted balloon and that he is "*certain*" that it was intact at the conclusion of the procedure. He further stated that the "*surface of the balloon did not show any signs of tearing or damage on my inspection, and there was no evidence of leakage from the balloon*".[81]

110. Dr Harney expressed the opinion that Billy's ingestion of methamphetamine was not survivable as the level detected in his system post-mortem was consistent with excessive and potentially fatal use. He stated his belief that the fatal use occurred sometime before Billy's presentation of chest pain. Further, he stated his belief that Billy would not have survived even if he had been transferred to SVHM after Mr Guastalegname's telephone call to the Admitting Officer.

111. I accept the evidence of Dr Burns and Dr Harney and conclude that Billy's death was not preventable by the actions of G4S or SVCHS staff on 2 July 2016. I am satisfied that the ingestion of methamphetamines that caused Billy's death occurred prior to his complaint of chest pain on the morning of 2 July 2016, and the package later swallowed by Billy did not lead to any further transfer of methamphetamines into his system. I find that his death was the unintended consequence of his deliberate use of illicit drugs.

112. Notwithstanding this conclusion, I consider that there were a number of missed opportunities to provide Billy with earlier medical treatment. Although these missed opportunities could not have prevented Billy's death, I consider that they are sufficiently connected to the circumstances of his death to authorise me under the Act to include them in this investigation and for them to be the subject of findings, comments and recommendations.[82] Those missed opportunities are as follows:

[81] CB855-6.
[82] *Harmsworth v State Coroner* [1989] VR 989; *Thales Australia v Coroners Court* [2011] VSC 133.

(a) An ECG ought to have been conducted on Billy by SVCHS staff (together with a comprehensive pain assessment) after he complained of chest pain and, if it was unable to be conducted as a result of his agitated state, he should have been transferred to hospital.

(b) SVCHS staff should have been clearly informed by G4S staff that Billy had swallowed the package during the strip search in Cell 3, which would likely have resulted in him being transferred to hospital at that stage.

(c) SVCHS staff, with the cooperation and assistance of G4S staff, should have conducted visual observations of Billy in Cell 14 at around 7.35am and 7.50am, at which times the deterioration in his condition may have been appreciated and attempts made to obtain his vital signs.

(d) Billy should not have been left in a prone position in Cell 2 and SVCHS staff should have attempted at this time, with the assistance of TOG members, to assess his vital signs.

113. It is acknowledged that correctional and medical staff were confronted with a number of unusual and challenging circumstances during their management of Billy on 2 July 2016. The deterioration in Billy's condition coincided with the unavailability of an observation cell in St Johns (which required an unusual placement in a custodial area), the prisoner count, and the change of shift for staff.

114. Further, in terms of assessing Billy's condition, the medical staff commencing on the morning shift were unaware of Billy's complaint of chest pain and none of the medical staff were aware that he had swallowed the package until after Ambulance Victoria had arrived. These difficulties and challenges highlight the need for effective communication, cooperation and coordination between correctional and medical staff.

FINDINGS AND CONCLUSION

115. Having held an inquest into the death of Billy's death, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Bazouni Bazouni, born on 17 May 1995;

(b) the death occurred on 6 July 2016 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria;

(c) from hypoxic brain injury in the setting of drug toxicity; and

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

COMMENTS

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

(a) There was an unfortunate confluence of unusual circumstances which combined to create a challenging environment for the response by G4S and SVCHS staff to the deterioration in Billy's condition on 2 July 2016. Balancing the management of legitimate security risks with the need to provide appropriate medical treatment to prisoners is clearly a complex and dynamic process that requires communication, cooperation and coordination between correctional and medical staff.

(b) In Billy's case, correctional staff had the best opportunity to observe his changing behaviour given their regular contact with him as events unfolded on 2 July 2016. Although they are not medically trained, their observations of prisoners may nevertheless be of great assistance to medical staff in informing their assessment and treatment decisions. The evidence demonstrates that the boundaries of the respective roles of correctional and medical staff may have been too rigidly drawn so as to diminish the opportunity to share valuable information between them through greater communication and cooperation.

RECOMMENDATIONS

117. Pursuant to section 72(2) of the Act, I make the following recommendation:

(a) That Corrections Victoria considers developing and implementing a training program, to be undertaken by correctional staff and medical staff together:

(i) to enhance their mutual understanding of each other's respective roles in Victoria's prison system; and

(ii) to encourage a co-ordinated, timely and effective sharing of information between them, including in relation to circumstances requiring medical assessments and observations of prisoners and assessments of security risks posed to staff by prisoners requiring medical attention.

I convey my sincerest sympathy to Billy's family.

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

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

Hanh Tran, Billy's mother

Detective Senior Constable Drew Corry, Coroner's Investigator

Secretary to the Department of Justice and Community Safety

G4S Custodial Services Pty Ltd

St Vincent's Hospital (Melbourne) Ltd

Tony Guastalegname

Signature:

Coroner David Ryan

Date: 02 September 2022

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