IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005962

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Chao Liang Mai

Delivered On:	18 December 2025
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, VIC, 3006
Hearing Dates:	18 December 2025
Findings of:	Coroner Kate Despot
Counsel Assisting the Coroner:	Ms Jess Syrjanen, Senior Coroner's Solicitor
Representation:	Ms Jasmine Still on behalf of the Department of Justice and Community Safety, instructed by Mr Richard Atkins. Ms Lisa Klos, Meridian Lawyers, on behalf of GEO Group.

Keywords: Suicide in custody; prisoner screening assessment; prisoner security classification; ligature point in smoke detector

BACKGROUND

1. On 27 November 2018, Chao Liang Mai was 56 years old when he took his own life, while on remand at Ravenhall Correctional Centre (**RCC**).

2. Mr Mai was born in China and moved to Australia with his wife. The couple separated in April 2016 and divorce proceedings were finalised in October 2018.[1]

3. From May to November 2018, Mr Mai was involved in three family violence incidents with his former wife. On 20 September 2018, Mr Mai was arrested and charged with family violence related offences and was remanded in custody. He was first placed in the Melbourne Assessment Prison (**MAP**) on 28 September 2018 where he underwent a medical review. He noted he suffered from a peptic ulcer that was treated with pantoprazole and reported being on a public hospital waiting list for assessment of his enlarged prostate. Mr Mai underwent a mental health assessment, which revealed that he had no previous psychiatric history with any public mental health facilities. Mental health staff documented there were no signs of psychosis, delusions or grandiosity. Mr Mai denied thoughts of suicide or self-harm; however, staff noted a depressive affect, likely in relation to his marriage breakdown. [2] Mr Mai was assigned S3 and P3 risk ratings.[3]

4. On 1 October 2018, Mr Mai was transferred to Port Phillip Prison (**PPP**). He underwent a routine health assessment upon arrival, which noted his history of peptic ulcer and an enlarged prostate. He told staff that his community general practitioner diagnosed him with schizophrenia and a mood disorder. He reported that this was due to his lack of sleep and that he had ceased all medications.[4]

5. On 2 October 2018, mental health staff reviewed Mr Mai and noted that he was relaxed, engaged and made good eye contact. He reported occasional suicidal ideation, however denied any plan or intent and reported that he had good support outside of prison. His suicide/self-harm risk rating was downgraded to S4,[5] and a mental healthcare plan was initiated to monitor his mental health status.[6]

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[1] Coronial Brief (**CB**), Police Summary, 1-1.
[2] CB, Justice Health, Death in Custody Report, 19-4.
[3] S3 refers to potential risk of suicide and self-harm; P3 refers to stable psychiatric condition requiring continuing treatment or monitoring.
[4] CB, Justice Health, Death in Custody Report, 19-4.
[5] S4 refers to previous history of risk of suicide or self-harm.
[6] CB, Justice Health, Death in Custody Report, 19-5.

6. On 15 October 2018, Mr Mai was transferred to Fulham Correctional Centre (**FCC**). He again underwent routine physical and mental health assessments. His risk ratings remained as P3 and S4.[7]

7. On 29 October 2018, Mr Mai was convicted of making threat to kill and persistent contravention of a family violence intervention order (**FVIO**). He received a term of imprisonment of 39 days, equivalent to pre-sentence detention and was released from custody.[8]

CORONIAL INVESTIGATION

8. Mr Mai's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Victoria Police assigned Leading Senior Constable Christopher Egan to be the Coronial Investigator for the investigation of Chao Liang's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence. Further investigations were conducted directly by the Court.

11. This finding draws on the totality of the coronial investigation into the death of Chao Liang Mai including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[9]

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[7] CB, Justice Health, Death in Custody Report, 19-5.
[8] CB, Corrections Victoria, Court Outcomes Report, 24-1.
[9] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

12. Following Mr Mai's release from prison on 29 October 2018, he continued to allegedly breach the FVIO against him. Police arrested him again on 22 November 2018 and held him at the Melbourne Custody Centre.[10]

13. On 23 November 2018, Corrections Victoria's Sentence Management Division (**SMD**) conducted a Pre-Reception Screening Assessment (**PRSA**) on E*Justice. The SMD classified Mr Mai as a medium-security rated prisoner, to be accommodated at RCC. Despite completing the PRSA, E*Justice was not updated, so it incorrectly recorded Mr Mai as a maximum-security rated prisoner.[11]

14. Mr Mai was transferred to the Heidelberg police cells on 25 November 2018. He was held there until he was transported directly to RCC on 26 November 2018.[12]

15. Upon his arrival at RCC, Mr Mai underwent a reception assessment. He was noted to have two flags, which were documented from his previous period of incarceration:

    a) Psychiatric P3 – Stable psychiatric condition requiring continuing treatment or monitoring

    b) Suicide/Self-Harm S4 – Previous history of risk of suicide or self-harm.[13]

16. The assessing officer noted that Mr Mai was relaxed and coherent, he spoke limited English, he was not withdrawing from any substances, and he had no concerns for self-harm or suicide.[14]

17. Mr Mai also underwent a health assessment, performed by a Medical Officer (**MO**) and a Registered Nurse (**RN**). The MO and RN documented a history of gastro-oesophageal reflux disease (**GORD**) and an enlarged prostate.[15] The MO also prescribed his regular medication (ranitidine). Mr Mai also underwent an initial mental health and risk screening assessment by a Forensicare mental health clinician.[16] Mr Mai reported that he was upset about returning to prison

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[10] CB, Justice Assurance and Review Office (**JARO**) Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-9.
[11] Ibid.
[12] Ibid.
[13] CB, Corrections Victoria, Reception Assessment dated 26 November 2018, Exhibit 27, 27-1.
[14] CB, Corrections Victoria, Reception Assessment dated 26 November 2018, Exhibit 27, 27-5.
[15] CB, Statement of Dr Mohamed Mosa dated 7 March 2019, 13-1.
[16] CB, Justice Health Medical Records, Exhibit 21, 21-6.

and was slightly anxious. There were no signs of depression or paranoia, and he appeared to have insight and cognition. He denied any thoughts of suicide or self-harm.[17]

18. Mr Mai arrived at RCC at the same time as fellow prisoner, **'Prisoner 1'**. They were placed in shared cell number 36, on the Bolinda Unit.[18] Prisoner 1 noted that Mr Mai only spoke limited English so conversation between the pair was relatively limited. Prisoner 1 recalled that they watched television together, however, did not think that Mr Mai understood what was happening on television due to his limited English.[19]

19. Before the prisoners were locked down for the evening, staff asked another prisoner, **'Prisoner 2'**, from the neighbouring Bambra Unit, to attend and help with translation. Prisoner 2 spoke some Cantonese and a minimal amount of Mandarin, so was able to speak to Mr Mai informally. Prisoner 2 helped Mr Mai settle into the unit, explain how the prison worked and explained how to use the computer in his cell. Prisoner 2 gave him some noodles and helped him settle in for the evening.[20]

20. On the morning of 27 November 2018, the officers in charge of Mr Mai's area were informed that they were not permitted to open Mr Mai's cell as he was considered to be a maximum-security prisoner, which meant that he was not permitted to mix with the medium-security prisoners. The officers requested Prisoner 1 leave the cell temporarily, as Mr Mai was meant to be in a single cell as a maximum-security rated prisoner.[21]

21. The officers asked Prisoner 2 to attend Mr Mai's cell again to assist with explaining why his door was locked. When Prisoner 2 attended Mr Mai's cell, he explained that Mr Mai was a maximum-security rated prisoner and would be moved to a maximum-security jail. Prisoner 2 opined that Mr Mai appeared to understand what was happening. Prisoner 2 asked Mr Mai if he needed anything further, and he asked him for food. One of the officers obtained breakfast for Mr Mai.[22]

22. Later that morning, prison officers requested Prisoner 2's assistance again as Mr Mai was repeatedly pressing the intercom button and the officers could not understand what he was asking.

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[17] CB, Justice Health, Death in Custody Report, 19-5.
[18] CB, Statement of Prisoner 1 dated 25 March 2019, 5-1.
[19] Ibid.
[20] CB, Statement of Prisoner 2 dated 25 March 2019, 6-1.
[21] CB, Statement of Correctional Officer Officer 1 dated 25 March 2019, 7-1, 7-2.
[22] CB, Statement of Prisoner 2 dated 25 March 2019, 6-2.

Prisoner 2 spoke to Mr Mai and relayed to the officers that he wanted his electricity switched back on. Prisoner 2 recalled looking through the trap on the door and noted that the cell was dark.[23]

23. At 11.34am, a prison officer provided Mr Mai lunch via the trap on his door. The officer recalled that Mr Mai took the lunch, however the lights were still switched off at the time. The officer also reassured Mr Mai that they would be moving him shortly.[24] No one else attended the cell from 11.34am until 12.22pm.[25] At an unknown time after 11.34am, the lights were switched back on in Mr Mai's cell.

24. At 12.15pm, prison officers commenced a prisoner count. At 12.22pm, the two officers reached Mr Mai's cell and when they opened the trap door to his cell, they observed that it was covered by a mattress. The officers opened the cell door and observed Mr Mai hanging from a bedsheet, attached to the in-cell smoke detector located on the ceiling of the cell.[26]

25. One of the officers called a Code Black via the radio, which alerted other officers to attend cell 36, while the other officer called for a supervisor over the radio. The supervisor and another officer attended the cell and lifted Mr Mai up to support his weight, then removed the ligature from around his neck.[27] The officers noted that Mr Mai was still warm to touch, and the supervisor commenced cardiopulmonary resuscitation (**CPR**).[28]

26. Two RNs and a MO attended cell 36 to assist with CPR efforts. One of the RNs called Triple Zero for an ambulance while CPR continued. [29]

27. Ambulance Victoria paramedics arrived at cell 36 at 12.42pm. Paramedics declared Mr Mai deceased shortly thereafter.[30]

28. Victoria Police members also attended the scene and investigated the circumstances of Mr Mai's death. Inside cell 36, police located (amongst other items):

    a) A severed power cord, still attached to a power outlet;

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[23] Ibid.
[24] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-71, 9-72.
[25] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-74.
[26] CB, Justice Assurance and Review Office (JARO) Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-10.
[27] CB, Statement of Correctional Officer Officer 2 dated 25 March 2019, 8-2.
[28] CB, Statement of Correctional Officer Officer 1 dated 25 March 2019, 7-3.
[29] CB, Justice Health Medical Records, Exhibit 21, 21-5, 21-6.
[30] Ibid.

b) A severed three-prong power cord (the other half of the item listed above);

c) A bent metal fork;

d) Several metal butter knives;

e) One handwritten note (not in English); and

f) Mesh guard from the cell's smoke alarm.[31]

29. One of the investigating members contacted a fellow member who is a native Chinese speaker. This member and translated the handwritten letter and explained that the letter appeared to be a 'suicide note'.[32]

30. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with Mr Mai's death.

Identity of the deceased

31. On 28 November 2018, Coroner Phillip Byrne made a formal determination identifying the deceased as Chao Liang Mai, born 14 December 1961, via fingerprint identification.

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

Medical cause of death

33. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 28 November 2018 and provided a written report of his findings dated 28 November 2018.

34. The post-mortem examination revealed findings consistent with the reported circumstances, including a ligature mark around the neck.

35. Examination of the post-mortem CT scan showed an intact hyoid bone, some anterior rib fractures (in keeping with resuscitation) and nothing else of note.

[31] CB, Statement of Detective Acting Sergeant Christopher Egan dated 10 April 2019, 16-1, 16-2.
[32] CB, Statement of Senior Constable Yuxing Zhao dated 10 April 2019, 15-1.

36. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

37. Dr Lynch provided an opinion that the medical cause of death was 1(a) Hanging.

38. I accept Dr Lynch's opinion.

FURTHER INVESTIGATIONS

39. As part of the investigation, further material was obtained from Corrections Victoria, GEO Group Australia Pty Ltd (**'GEO'**; the operator of RCC) and Correct Care Australasia (the provider of healthcare services to RCC). The Court also obtained a copy of the Justice Assurance and Review Office (**JARO**)'s Review into Mr Mai's death (**'the JARO report'**), Justice Health's Death in Custody Report (**'the JH report'**) and GEO's internal review.

JARO report

Incident response from officers

40. The two officers who discovered Mr Mai called a Code Black over the radio and requested a supervisor attend the scene. Neither officer entered Mr Mai's cell to remove the ligature or commence CPR.[33]

41. RCC policy stipulates that any officer who discovers an apparent death must immediately apply first aid, initiate a Code Black and call the prison's health centre. In the event of a hanging, RCC policy states that the prisoner must receive immediate attention and medical assistance to prevent injury or death and that all life-saving measures must commence.[34]

42. Upon a review of the relevant CCTV footage, the first two officers appeared to be in shock when they first discovered Mr Mai hanging in his cell. JARO opined that this likely impacted their ability to follow the requisite processes.[35] GEO investigated the two officers involved and found that they did not adhere to RCC policy and recommended that the officers complete refresher training.[36]

Medical response from officers

[33] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-11.
[34] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-12.
[35] Ibid.
[36] Ibid.

43. Approximately 37 seconds elapsed between the first two officers discovering Mr Mai and the supervisor and other officers arriving at the cell. The JARO report acknowledged the significant efforts of the two officers who administered prolonged CPR to Mr Mai in distressing circumstances and continued until paramedics could arrive on scene.[37]

44. JARO noted that the GEO investigation identified one area for improvement, namely, one officer had to wait for the arrival of a breathing mask before commencing CPR. The GEO investigation recommended that all officers in a first response role be issued with, and be required to carry, disposal breathing masks.[38]

Pre-reception screening assessment

45. There are four reception (or 'front-end') prisons in Victoria – the MAP, the Metropolitan Remand Centre (**MRC**), RCC and Dame Phyllis Frost Centre (**DPFC**). RCC can receive prisoners directly from police cells on weekdays, and on weekends by prior arrangement, however they can only receive prisoners assigned a medium (or lower) security rating. The other three facilities can accept maximum security prisoners, with DFPC being the only facility that accepts female prisoners.

46. While in a police cell, a person can be assigned a nominal security rating via a PRSA, however the number of prisoners who are assigned a nominal security rating via this process is low.[39] If a PRSA is not conducted, the prisoner defaults to a maximum-security rating and therefore must be received by a maximum-security location.[40]

47. The JARO report explained that the PRSA process does not constitute the prisoner's formal classification. Once they are assigned a security classification via PRSA, they are interviewed in person within 14 days by the SMD. The SMD will either confirm or amend the classification given via the PRSA.[41] In Mr Mai's case, his PRSA was completed on 23 November 2018, and he was assigned a medium-security rating.

48. The SMD is required to communicate the outcome of a PRSA both electronically and in hard copy. The JARO report noted that these processes are manual and are therefore at high risk of human error.[42] The PRSA results are required to be recorded within the sentence management assessments

[37] Ibid.
[38] Ibid.
[39] This was determined via JARO's review into the death of another person in custody.
[40] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-14.
[41] Ibid.
[42] Ibid.

module of E*Justice within 48 hours of completion. The E*Justice system communicates with Corrections Victoria's Prisoner Information Management System (**PIMS**), and PIMS displays the PRSA security rating.[43] In Mr Mai's case, the SMD explained that it did not record his PRSA outcome onto E*Justice. Therefore, he incorrectly appeared as a maximum-security prisoner on PIMS.

Mr Mai's identification as a maximum-security rated prisoner

49. On 26 November 2018, SMD staff identified that Mr Mai was incorrectly recorded as a maximum-security prisoner. RCC staff also independently identified this issue on the morning of 27 November 2018, as they were not advised by SMD. The JARO report noted that despite both RCC staff and the SMD being aware of the error, Mr Mai was locked down in his cell for more than four hours.[44]

50. On 26 November 2018, SMD staff received an automated email which alerted them to Mr Mai's maximum-security rating. SMD staff explained that they tried to contact the person who completed the PRSA, however were unable to reach them. They did not amend the error and did not contact RCC staff to advise them of the issue.[45]

51. On 26 November 2018 when Mr Mai arrived at RCC, RCC staff did not identify that Mr Mai was incorrectly recorded as a maximum-security prisoner. This was identified by a RCC staff member at about 7.30am on 27 November 2018. This staff member notified Mr Mai's Unit Supervisor, who verified the issue via PIMS and subsequently attended cell 36 to advise Mr Mai and Prisoner 1 of the issue.[46] Mr Mai was locked down in his cell at 7.57am, after Prisoner 1 was removed.

52. From 8.00am to 8.30am, an SMD staff member spoke to the RCC Unit Supervisor and explained that Mr Mai should be a medium-security prisoner and that they were fixing the error with his classification. At 8.46am, the Unit Supervisor emailed an SMD Assistant Manager to advise that Mr Mai had "*reverted back [to] A2 [maximum-security]. Prisoner is currently locked and unit staff are awaiting further instruction*". The Unit Supervisor did not receive a response to this email.[47]

53. From 8.30am to 9.00am, a RCC Correctional Manager spoke to SMD staff who happened to be at the prison. The SMD staff explained that they were aware of the issue and that they would advise

[43] Ibid.
[44] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-15.
[45] Ibid.
[46] Ibid.
[47] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-16.

RCC staff when the issue was fixed. The Correctional Manager spoke to the relevant SMD staff member via phone who confirmed that they were fixing the error. RCC staff tried calling this SMD staff member again between 9.30am and 9.45am, however the call was not answered, nor returned.[48]

54. SMD staff made an entry on PIMS to confirm that Mr Mai was in fact a medium-security prisoner at 10.42am. The entry explained why Mr Mai incorrectly previously appeared as a maximum-security prisoner. SMD staff did not contact RCC staff to advise that the error had been resolved.[49]

55. Since Mr Mai's death, SMD advised that they have instructed all staff to respond to any automated email alerts regarding security ratings on the day that the email is received. JARO noted that this instruction was not contained within Corrections Victoria's Sentence Management Manual (**SMM**) and recommended (**Recommendation 1**):

That SMD update the SMM to include its processes for responding to discrepancies between a prisoner's security rating and the classification of the receiving location. This may include:

a) How SMD staff expediently rectify any classification issues in the event they cannot contact staff who were involved in completing the PRSA.
b) Who from the receiving location SMD should inform of the outcome of prisoner classification reviews and the timeframe in which this must occur.[50]

56. Corrections Victoria has since made the required amendments to the SMM. The SMD implemented a process whereby the Manager of the Prisoner Intake and System Flow became the primary contact point to resolve any discrepancies, in circumstances where the staff member who completed the PRSA is unavailable.[51]

RCC's new reception process regarding security classifications

57. Following Mr Mai's death, RCC management advised JARO that they have advised their reception staff to check the security rating of all new receptions on the day of their arrival. At the time of Mr Mai's death, there was no formal policy at RCC regarding how to manage prisoners who were

[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] CB, Statement of Deputy Commissioner Melissa Westin to CCoV, 14 March 2025, 10-1.

classified as maximum-security prisoners. Since then, a new policy has been drafted and implemented by RCC.

RCC induction process

58. The JARO report noted that RCC staff did not complete two components of the induction process with Mr Mai as required, namely, the 'Day of Arrival Checklist' and the 'First Night Program'. The JARO report noted that this was not Mr Mai's first time in custody and therefore he was likely aware of some of the procedures and processes in prison. However, the JARO report concluded that it was important that all induction processes are followed, regardless of whether it is a prisoner's first or subsequent time in custody.

59. JARO recommended that the RCC's General Manager incorporate its prisoner reception processes into its annual internal audit schedule, as part of GEO's Governance, Risk and Compliance Framework (**Recommendation 2**). This recommendation has since been acquitted by GEO.

Building Design Review Project

60. Following coronial findings and recommendations made in 2000, Corrections Victoria undertook a program of work entitled the 'Building Design Review Project' (**BDRP**). The BDRP aimed to improve fire safety and eliminate and/or reduce potential hanging points in prison cells. According to the most recent figures available to JARO in November 2014, 76.1% of prison beds are either BDRP-compliant, or are not required to be BDRP-compliant (for example, minimum security cottages).[52]

61. Certain prisoners with an active suicide or self-harm risk must be accommodated in a BDRP-compliant cell. Although a BDRP-compliant cell was not required for Mr Mai due to his lack of an active suicide/self-harm risk, his cell was nevertheless BDRP-compliant.[53] The JARO report found that Mr Mai's death exposed a potential ligature point in a BDRP-compliant cell (noting the need to modify/manipulate the smoke detector to expose the ligature point).[54]

Replacement of RCC' smoke detectors

[52] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-20, 18-21.
[53] Ibid.
[54] Ibid.

62. RCC management investigated how Mr Mai opened the smoke detector and used it as a ligature point to take his life. RCC found that Mr Mai used a prison-issued metal fork to remove the mesh vent covering the smoke detector. RCC postulated (although could not confirm) that Mr Mai was able to damage the spot-welds that held the mesh in place by persistently damaging it with the bent fork. Mr Mai subsequently manoeuvred a prison-issued bed sheet via an internal component in the smoke detector and used it as a ligature point to take his life.[55]

63. In response to Mr Mai's death, RCC replaced all in-cell smoke detectors with a new smoke detector, which was developed by RCC. The new in-cell smoke detector is comprised of one solid plate and has no mesh vent or other removable parts. It is secured to the ceiling using security screws which are tamper-proof.[56]

Review of smoke detectors at public and private prisons

64. Following the deficiencies identified in the RCC smoke detectors, Corrections Victoria's Security Standards Unit (**SSU**) undertook a review of all in-cell smoke detectors across public prisons. The SSU recommended that the smoke detectors in 1,751 prison cells should be replaced.[57] JARO recommended that Corrections Victoria provide JARO with quarterly updates on its progress against smoke detector replacement works across the public system (**Recommendation 3**). The replacement works were completed as of 10 August 2022.[58]

65. At the time of the JARO report, Victoria also had three private prisons – RCC, FCC and PPP. GEO operates both RCC and FCC and advised JARO that FCC's smoke detectors differ from RCC's smoke detectors and therefore remediation works were not required. At the time of the JARO report, PPP was operated by G4S Australia, however it is due to close by the end of 2025.[59]

Mr Mai's language barrier and use of interpreters

66. During Mr Mai's first term of imprisonment, prison authorities identified that he needed a Mandarin interpreter. This was re-confirmed during his RCC reception assessment. RCC policy requires staff to use an adequate interpreting service for Chinese or Vietnamese foreign nationals. Based on JARO's review of Mr Mai's records, it was satisfied that officers and medical staff regularly used

[55] Ibid.
[56] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-22.
[57] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-16.
[58] CB, Statement of Deputy Commissioner Melissa Westin to CCoV, 14 March 2025, 10-2.
[59] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-23.

interpreters to communicate with Mr Mai during his most recent term of imprisonment. Staff usually used a formal interpreting service; however, they also used Prisoner 2, who spoke Cantonese and minimal Mandarin.[60]

Justice Health review

67. Justice Health reviewed the medical and mental health treatment provided to Mr Mai during his two periods of incarceration (28 September to 29 October; 26 to 27 November 2018). Justice Health did not identify any issues with the healthcare provided to Mr Mai during these periods on remand. Justice Health made no recommendations for systemic improvements arising from Mr Mai's death.[61]

GEO internal review

68. GEO conducted an internal review following Mr Mai's death and made six recommendations for improvements to their systems to prevent similar deaths in the future, as follows:

    a) That the two Correctional Officers who first discovered Mr Mai unresponsive be required to complete refresher training in the actions of a first responder at the scene of a suicide attempt by a prisoner.

    b) That disposable breathing masks be issued to all personnel in a first response role and that carriage of the item at all times whilst on duty is mandated by policy.

    c) That the Correctional Supervisor and the other first responding correctional employees are commended for their performance and that is recorded on their employment records.

    d) Consideration is given to not issuing metal cutlery to maximum-security prisoners at RCC.

    e) Consideration of a draft procedure[62] referenced by one of the Correctional Officers be expedited and introduced to RCC's doctrine.

    f) The practice engaged in by the Correctional Supervisor wherein he also reviews for compliance and quality) assessments conducted by him is ceased and a root cause analysis

[60] CB, JARO Review into the death of Mr Chaoliang Mai, Exhibit 18, 18-20.
[61] CB, Justice Health, Death in Custody Report, Exhibit 19, 19-6.
[62] A draft procedure developed by RCC staff to handle situations in which a prisoner is found to have an incorrect classification. While it was used locally by RCC staff at the time of Mr Mai's death, the Correctional Officer told the GEO internal review that it was sent to Corrections Victoria to approve.

is undertaken by RCC to determine any causal factors and recommend and necessary remedial action.

69. In May 2025, GEO advised that the following actions have been taken to acquit the above six recommendations:

a) The two Correctional Officers completed the requisite training. Both staff members have since ceased working for GEO.

b) All staff are issued first aid kits that include face masks and staff are reminded that they must always wear these kits while on duty.

c) The first responding staff were formally recognised for their exemplary efforts during a special luncheon and were presented with a Certificate of Commendation.

d) Maximum security prisoners are now issued bamboo cutlery and are not permitted to use metal cutlery.

e) The draft procedure in place at RCC at the time of Mr Mai's death has since been incorporated into GEO's 'Classification and Placement' operating instruction.

f) The practice engaged in by the Correctional Supervisor has since ceased.[63]

GEO's response to recommendation 2 of the JARO report

70. GEO noted that it has an annual internal audit schedule as part of its Governance, Risk and Compliance Framework (as noted above). The audit schedule specifically addresses the processes involved in prisoner reception. As of May 2025, the last internal audit of the prisoner reception process was conducted in March 2024.[64]

Changes to classification and placement policy; communication with SMD

71. GEO explained that RCC's Classification and Placement policy has been reviewed and amended since Mr Mai's death. The changes made to this policy include:

[63] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-4, 9-5.
[64] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-2.

a) When a prisoner's security rating is elevated to maximum security, Corrections Victoria automatically sends an email notification to several designated staff at the RCC to inform them of the updated security rating.

b) Each day, the RCC Contract Compliance Coordinator and RCC Reception & Discharge Records staff review PIMS to identify whether any maximum-security rated prisoners are located within RCC.

c) When a maximum-security prisoner is identified, the relevant manager and supervisors are promptly contacted and informed.

d) RCC staff will secure the person in custody in their cell while awaiting confirmation of the prisoner's updated security classification from Corrections Victoria. While the person is locked down in their cell, staff perform hourly welfare observations.[65]

72. GEO further noted that it is common practice at RCC for staff to conduct daily checks of PIMS to identify any maximum-security prisoners that are accommodated outside of their Forensic Mental Health Units.[66]

73. GEO explained that RCC is automatically emailed and notified by the SMD if a prisoner's security rating changes, as noted above.

Procedural fairness responses

74. The Court wrote to the Department of Justice and Community Safety (**DJCS**), as the department with overarching responsibility for Corrections Victoria, including the Sentence Management Division, and offered DJCS an opportunity to respond to the proposed adverse comments (as above). The Court also wrote to GEO Group and provided an opportunity to respond.

DJCS

75. In response to proposed adverse comments, counsel for DJCS acknowledged that there was an error with the recording of Mr Mai's security classification, which was caused by the outcome of his

[65] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-2, 9-3.
[66] CB, Statement of Colin Caskie, Annexure 10, GEO Group Investigation Report, 9-3.

PRSA not being entered into E*Justice. DJCS also acknowledged that there were issues with the communication of Mr Mai's correct medium security rating to Ravenhall.

76. DJCS further explained that the PRSA process was implemented to facilitate prisoners being received into the least restrictive environment possible. Prior to the opening of Ravenhall and the introduction of PRSAs, male prisoners were always received into a maximum-security prison, pending an assessment of their security rating. At the time of Mr Mai's PRSA, this process had been in place for eleven months and was still in a trial and evaluation phase. Mr Mai's PRSA was conducted in November 2018, which saw an unusually high number of PRSAs undertaken, following additional beds becoming available at Ravenhall.

77. Finally, DJCS acknowledged the proximity of the PRSA issue to Mr Mai's passing, with the suggestion that it may have influenced his actions. However, DJCS noted that it is not possible to know why he decided to take his life.

GEO Group

78. Meridian Lawyers, on behalf of GEO Group, provided submissions in response to the proposed adverse comments, after the deadline to file same. They were nevertheless received prior to the hearing on 18 December 2025 and they have been considered in full.

79. Meridian submitted that according to information in the JARO Report, at the stage when Mr Mai was informed of his classification, he did not appear to be disappointed, was not overly upset and appeared to accept the information. Furthermore, no concerns were raised at the point of interaction with Mr Mai at 9.14am, which was after he was informed of the reclassification. There were further interactions with him after that time, and nothing of concern was noted.

80. GEO Group acknowledged that Mr Mai's reclassification was proximate to his death, however submitted that it would be speculative to make a finding that the communication of this advice was a key precipitating factor in his decision to take his life. GEO Group noted the other recent and stressful events for Mr Mai including being arrested on 22 November, being held in police custody until 26 November and entering prison on 27 November. GEO Group submitted that the fact of him having been arrested, held in police custody and then moved to prison are matters that could have also informed his decision to take his life. GEO Group submitted that I not make any finding in relation to what precipitated Mr Mai's death.

FINDINGS AND CONCLUSION

81. Having held an inquest on 18 December 2025 and pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased is Chao Liang Mai, born 14 December 1961;

    b) his death occurred on 27 November 2018 at Ravenhall Prison, 97 Riding Boundary Road Ravenhall Victoria 3023, from hanging; and

    c) his death occurred in the circumstances described above.

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

83. Although we will never know the precise reasons why Mr Mai made the decision to end his life, I consider that the information about Mr Mai's classification played a role and was a relevant factor in his decision given the proximity to his tragic death.

84. I note the reason that Mr Mai was given this erroneous information was due to a lack of timely identification and remediation of the classification error, and lack of communication by the SMD to RCC to notify them that the error had been resolved.

85. Notwithstanding the classification error, Mr Mai was able to take his own life by accessing a ligature point in a smoke detector in his cell. I am satisfied that Mr Mai's death was likely preventable, if not for the ligature point within his cell. I cannot determine that Mr Mai would not have found some other means to take his life, however, it is highly unlikely that he would have died in these circumstances if this ligature point did not exist.

86. I am satisfied that the issues with communication between SMD and RCC have since been resolved, and that there are now appropriate processes in place to efficiently identify and rectify security classification errors. Furthermore, the ligature point identified via manipulation of the smoke detector in Mr Mai's cell has also been resolved, by way of a new design that is impervious to modification. Other public prison cells across the state have been similarly remediated, so that a similar death cannot occur in the future. In those circumstances, I am satisfied that I do not need to make any further recommendations.

I convey my sincere condolences to Mr Mai's family and loved ones for their loss.

Pursuant to section 73(1) 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:

Cheuk Kin Mak, Senior Next of Kin

Department of Justice and Community Safety

GEO Group Australia Pty Ltd (C/- Meridian Lawyers)

Justice Assurance and Review Office

Justice Health

Leading Senior Constable Christopher Egan, Coronial Investigator

Signature:

_____

Coroner Kate Despot

Date: 18 December 2025

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.