Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2020 2744

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: LX

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	15 April 2026
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006.
Hearing Dates:	18 February 2025 – 21 February 2025, 24 February 2025, 2 April 2025 – 4 April 2025, 7 April 2025 – 11 April 2025, 4 September 2025, 5 – 6 November 2025.

Appearances:	Ms Ffyona Livingston-Clark & Ms Amber Harris of Counsel on behalf the family (Victorian Bar Pro Bono Scheme). Ms Sally Flynn KC, leading Mr Nicholas Petrie of Counsel on behalf of the Secretary to the Department of Justice and Community Safety (Russell Kennedy).
Appearances in relation to Human Rights issues:	Ms Joanna M Davidson of Counsel on behalf of the Victorian Equal Opportunity & Human Rights Commission. Mr Emrys Nekvapil SC, leading Mr Nick Boyd-Caine of Counsel on behalf of the Victorian Aboriginal Legal Service. Ms Kylie Evans KC, leading Ms Amber Harris & Ms Ffyona Livingstone-Clark of Counsel on behalf of the family. Ms Sally Flynn KC and Mr Liam Brown SC (5 November 2025 only), leading Mr Nick Petrie of Counsel on behalf of the Department of Justice and Community Safety.
Counsel Assisting the Coroner:	Mr Michael Stanton SC, leading Ms Sally Buckley of Counsel.

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I, AUDREY JAMIESON, Coroner having investigated the death of LX

AND having held an Inquest in relation to this death on 18 February – 21 February 2025, 24 February 2025, 2 April – 4 April 2025, 7 April – 11 April 2025, 4 September 2025, 5 November – 6 November 2025

at Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was LX

born on a date known to the Court

died between 22 and 23 May 2020

at the COVID-19 Quarantine Unit of Corella Place at 228 Warrak Rd, Ararat

from:

1 (a) MIXED DRUG TOXICITY (METHADONE, DIAZEPAM, PREGABALIN, PROMETHAZINE, PIZOTIFEN).

In the following summary of circumstances:

LX was found unresponsive in the lounge room of his residential unit in the COVID-19 Quarantine Unit of Corella Place in Ararat at around 11.00 am on 23 May 2020. He was due to be transferred out of the Quarantine Unit that day, having returned to Corella Place on 8 May 2020 under a post-sentence order that required him to reside at the facility and subjected him to other restrictions on his liberty. He was not there voluntarily. He presented with a constellation of factors that made him a vulnerable person at Corella Place.

BACKGROUND

LX's background and personal circumstances

1. LX[1] was 31 years of age at the time of his death. Until the age of 10 years when his father left the family home, LX grew up with his mother EC, his father and his sister. From

[1] This finding has been deidentified for publication pursuant to a pseudonym order made 18 February 2025 and proceeding suppression order made on 24 February 2025. The names of LX, his family and current and former residents of Corella Place have been replaced with a pseudonym.

about the age of 12 years onwards, LX's family home consisted of his mother, sister, stepfather, stepbrother and stepsister. LX had a son who at the time of his death was nine years old and was in the care of EC.

2. At around the age of six years, LX was diagnosed with attention deficit hyperactivity disorder (**ADHD**). He had difficulty fitting in at school, following routines and applying himself to schoolwork. He had several changes of school but enjoyed outdoor activities including sport.

3. In his early teenage years LX's behaviours and his use of cannabis eventually led to his removal from the family home and into a range of supported accommodation for "troubled youth".[2] LX's drug use continued to escalate, impacting his relationship with his family and resulting in estrangement from them for some time. He made several attempts on his own life during his early twenties.

4. In 2009, LX was assaulted and subsequently diagnosed with an acquired brain injury (**ABI**) and post-traumatic stress disorder (**PTSD**). A neuropsychological assessment in 2010 found that LX's intellectual functioning fell into the upper end of the borderline range and he was considered to have a low-average premorbid intellectual ability. He was noted to be impulsive with limited ability to generate ideas and strategies, solve novel problems, plan ahead and organise material. He was black and white in his thinking.[3] EC found that LX's ABI amplified his ADHD symptoms; it affected his ability to plan and organise and his ability to emotionally regulate.[4] He did better when he had structure in his life.[5]

5. In June 2015, at the age of 26 years, LX was directed to reside at Corella Place through a supervision order made by the County Court of Victoria after he had served a four-month period of immediate imprisonment.

[2] Exhibit 1 - Statement of EC, dated 7 January 2021 [8].

[3] Detention and Supervision Order Assessment Report of Simon Candlish dated 5 November 2023, CB p2434 [48].

[4] T53.5-10.

[5] T53.27-29.

6. At around the time of his death, in addition to PTSD, LX suffered from other forms of impaired mental functioning, including depression and anxiety. He had a history of self-harm, including multiple episodes of self-harm at Corella Place in 2016 and 2017. LX also suffered from chronic pain.

7. LX had significant substance abuse issues that impacted on his life.

8. LX is remembered for his generous nature, loyalty and wicked sense of humour. He was loveable and a practical joker who often brought laughter to those around him. He loved shopping and fashion and took pride in his appearance. His loyalty and generosity towards his friends and family was unwavering and he always wanted to please them. He loved and adored his family and above all his son, who was the heart of his world.

Supervision orders

9. Under the *Serious Offenders Act 2018* (Vic) (***SO Act***),[6] if a person is in custody for a relevant serious offence, the Secretary to the Department of Justice and Community Safety (**DJCS**) can apply for a detention or supervision order. These orders apply after a person's sentence has expired. They can be renewed.

10. The primary purpose of the *SO Act* is to provide for enhanced protection of the community. The secondary purpose is to facilitate the treatment and rehabilitation of relevant offenders.[7]

11. In relation to supervision orders, if the person is found to be an unacceptable risk of committing a relevant offence, the court may make such an order.[8]

12. Before doing so, the court must be satisfied by acceptable, cogent evidence to a high degree of probability that the offender poses or will pose an unacceptable risk.[9] However,

[6] Formerly the *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic).

[7] *SO Act*, s 1.

[8] Ibid, s 14(1).

[9] Ibid, s 14(3).

an order can be made even if the likelihood that the offender will commit a relevant offence is less than more likely than not.[10]

13. The court retains the discretion to make, or not to make, a supervision order.[11]

14. A supervision order has mandatory and discretionary (additional) conditions. Those additional conditions can include, amongst other things, that the person:

- reside at a particular place (or that the Post Sentence Authority may direct the person to reside at a particular place);
- not be permitted to leave that place without supervision;
- must abide by a curfew; and
- must be subject to electronic monitoring.

15. Such additional conditions must constitute the minimum interference with the offender's liberty, privacy or freedom of movement that is necessary in the circumstances to ensure the purposes of the conditions, and they must be reasonably related to the gravity of the risk of the offender re-offending.[12]

16. Contravening the conditions of a supervision order is a criminal offence punishable by up to five years' imprisonment, and for some conditions (known as "restrictive" conditions) there is presumptive imprisonment of not less than 12 months, subject to narrow exceptions.[13]

[10] Ibid, s 14(4).

[11] Ibid, s 14(6).

[12] Ibid, s 27(4).

[13] Ibid, s 169.

LX placed on supervision order

17. LX was first placed on an interim supervision order on 18 December 2014, to commence on 11 January 2015 after having been sentenced by the County Court of Victoria to eight months' imprisonment, with four months suspended for 18 months.

18. A final supervision order was made on 30 June 2015 for a period of three years. This order was renewed on 31 January 2019 for a further three years.

19. LX first resided at Corella Place in 2015. With some limited exceptions, including leaving the residential facility and returning to his family in mid-2019, he continued to reside there until his death.

20. When the first final supervision order was made, there was expert evidence adduced by both the Secretary to the DJCS (as the applicant) and by LX (as the respondent). Psychologists Mr Simon Candlish (**Mr Candlish**) and Mr Jeffrey Cummins (**Mr Cummins**) agreed that LX required intensive drug treatment to address his substance abuse issues, and that if he did not, it would adversely impact on his risk of re-offending. Both experts recommended that LX would benefit from a residential drug rehabilitation program.

21. Ms Danielle Windley (**Ms Windley**), in her capacity as the Manager of Applications within the Sex Offender Management Branch for Corrections Victoria, gave evidence that Corella Place was the most appropriate accommodation for LX at that time to manage his risk, and that drug treatment would be a priority at Corella Place.[14] Various representations were made about the type and frequency of rehabilitative treatment that could be provided at Corella Place. Ms Windley envisaged that LX's placement at Corella Place would be temporary in order to enable him to transition back into the community.[15]

22. At subsequent hearings in relation to the supervision order in 2017, LX was found to have breached the order by drug use, failing to attend for drug testing, failing to report

[14] CB p411 [199]-[201] and p413 [216] (Her Honour Judge Pullen's reasons for making the supervision order, dated 30 June 2015).

[15] Ibid, CB p411 [203].

for supervision, failing to attend drug and alcohol treatment, and failing to attend specific treatment appointments.

23. Notwithstanding those compliance issues, concerns were raised by Mr Candlish that LX was being provided significantly less drug and alcohol treatment than had been recommended.

24. Having heard evidence from Ms Windley, her Honour Judge Pullen also expressed concern regarding the lack of suitable treatment, stating:

> I am concerned [LX] needs treatment and am concerned he is not receiving adequate/appropriate treatment at Corella Place, given the previous opinions of Mr Cummins and Mr Candlish. If a residential rehabilitation is not available, further consideration should be given to day rehabilitation. If this continues to be an issue on the supervision order, consideration should be given to returning this matter to the Court (me) in a timely manner.[16]

Corella Place

25. LX resided in a transitional residential facility known as Corella Place located in Ararat. This facility is managed by Corrections Victoria. The residents of the facility belong to a cohort who have been convicted of a "serious sex offence"[17] and, post-sentence, have been placed on a supervision order by the Supreme Court or the County Court pursuant to either the *Serious Sex Offender (Detention and Supervision) Act 2009* (Vic) or the *SO Act* (which replaced the former in September, 2018). Theoretically, the residents of the facility are residing in the community.

26. Corella Place has two locations in Ararat. These are 156B Warrak Road (referred to as **Corella Place Main**) and 228 Warrak Road (referred to as **Corella Place 228**). The main supervision and administration office is located at 156B Warrak Road and is staffed 24 hours per day.

[16] Reasons for Ruling of her Honour Judge Pullen on an Application for Review of Supervision Order, dated 7 December 2017, CB p438 [117].

[17] As defined in s 3 of the *SO Act*.

27. Corella Place 228 is staffed between the hours of 8.00 am and 7.00 pm each day by Specialist Case Workers (**SCWs**). Typically, there is a minimum of two staff members present at any given time between those hours. During the day, the number of staff on site fluctuates depending on the number of scheduled activities, outings, or supervision sessions. Corella Place 228 is considered a "step down" from Corella Place Main, with residents having less supervision.

28. A third residential facility, known as Emu Creek Homestead, was located in Trawalla on the grounds of the Langi Kal Kal Prison. It was staffed 24 hours a day and electronically monitored by Corrections Victoria staff at the Corella Place Main facility. The Emu Creek facility has since been decommissioned.

29. Located nearby Corella Place is the Rivergum Residential Treatment Centre, which houses serious sex and serious violent offenders subject to supervision orders. By contrast, Rivergum is a secure facility.

30. The legislative framework which overlays these facilities is the *Corrections Act 1986* (Vic) (***Corrections Act***). Notwithstanding the restrictive nature of supervision orders, because the residents are theoretically residing in the community, they are only subject to the provisions of the *Corrections Act* to the same extent as any community member who is a visitor or otherwise on prison property. However, Corrections Victoria staff at Corella Place are given conditional powers under the *SO Act* to conduct pat down searches of the residents, unit searches, and analysis of electronic devices.

31. Prior to the COVID-19 pandemic and the restrictions placed on people's movements, residents of Corella Place were able to go on regular outings in the community. These outings were however, supervised by SCWs and usually necessitated residents being electronically monitored via an ankle bracelet. From 21 March 2020 all community outings were suspended.

32. The Corella Place 228 facility in which LX resided comprises eight two-bedroom, self-contained units. At the time of LX's death, there were 12 residents at this facility. LX occupied Unit 2 which was, at the time, a designated COVID-19 quarantine unit where residents coming into the facility from the community or prison/custody had to self-

isolate for 14 days before being moved into a general residential unit. LX occupied Unit 2 on his own.

33. LX's quarantine period expired at approximately 4.00 pm on 22 May 2020. He was due to move out of the unit and into another unit, Unit 3, with another resident, Resident H, on the morning of 23 May 2020.

34. Each resident of Corella Place is directed to reside at that location by their respective supervision order and is subject to the conditions contained within their order.

35. Each resident of Corella Place is required by the supervision order to undergo specific treatment and rehabilitation programs as a means of protecting the community. The resident's progress through these programs assists in determining suitability for transitioning into the community. Most residents are monitored via electronic monitoring.

36. Notwithstanding the restrictions placed upon them by their respective supervision orders, residents of Corella Place are not in considered to be in “custody” (discussed below) and, as such, are considered to be members of the community. They are expected to take full responsibility of their day-to-day affairs such as shopping, banking, developing and maintaining social networks and hobbies, and arranging and attending to any medical appointments, to name a few.

37. The residents’ supervision orders also allow for Corrections Victoria staff to issue lawful instructions to the residents to address specific issues/concerns or incidents that are identified. In addition to the supervision order (and any lawful instructions that may have been issued), residents are governed by Corella Place House Rules and a Residential Contract. The House Rules are an overarching set of instructions for the residents to ensure the good order of the facilities, the safety and welfare of residents, staff and visitors, and to assist with compliance of supervision orders.

38. According to EC, LX never received the intensive drug rehabilitation that Corrections Victoria had submitted to the County Court would and could be provided to him at Corella Place. During his period at Corella Place between 2015 and 2017, EC contacted staff at Corella Place on several occasions to express her concerns over the lack of

treatment LX was receiving for his drug addiction. On one occasion, she was told by a staff member that it was not his job to find LX counselling.[18] EC also telephoned and wrote to Sarah Miles, the then-General Manager of the Supervision Order Management Branch at Corrections Victoria[19] (**Ms Miles**), with her concerns but received no return calls or response to her correspondence,[20] other than a brief acknowledgment from Ms Miles via email to confirm that she had received EC's letter of 5 May 2016. EC also contacted the Victorian Ombudsman with her concerns. In January 2016, she wrote a letter to the Ombudsman after discovering that LX was administering his own prescription medication at Corella Place, including Suboxone and anti-depressant medication.

CIRCUMSTANCES PRIOR TO DEATH

39. In May 2019, LX transitioned out of Corella Place and returned to live with his mother and stepfather. He was very happy to be back living with family; he *came alive*[21] following his return and had hope for the future.[22]

40. LX enrolled himself into the Salvation Army START Drug and Alcohol Recovery Program which, according to EC, was the first time that LX was able to access a substantive, intensive and regular drug rehabilitation program since being placed on a supervision order in 2015 when it was deemed essential that he receive such treatment. EC said that, as a result of LX's involvement in this program, he was the happiest and most content that she had seen him in years. EC said, *He was optimistic, determined, and finally supported in setting and achieving goals in turning his life around.*[23] During this time, LX was also re-engaging with his family including his son.

[18] T66.22-27.

[19] At the time of the Inquest Sarah Miles ACM was the Deputy Commissioner, Offender Services, DJCS.

[20] Exhibit 1 - Statement of EC, dated 7 January 2021 [21]-[22].

[21] T950.8.

[22] T978.3-6.

[23] Exhibit 1 - Statement of EC, dated 7 January 2021 [36].

41. In August 2019, LX was found to have breached his supervision order and he was returned to Corella Place in early-September 2019. The circumstances of his breach related to him having a girl under the age of 16 in his motor vehicle. This occurred because LX had agreed to give a friend from the START Program a lift and was later asked by the friend to also collect his daughter. Apparently, LX did not know beforehand that his friend had a daughter, and he had not disclosed to his friend that he was on a supervision order. There is no evidence that LX was ever alone with his friend's daughter or that he acted in any way inappropriately towards her.

42. LX's wellbeing declined on his return to Corella Place. He remained in frequent contact with his mother, often expressing distress and frustration about the *apparent lack of direction and transparency of Corrections Victoria's requirements* for what he needed to do to be able to return to the family home.[24] His substance abuse issues appeared to be escalating, particularly in relation to his own prescribed medication and medication not prescribed to him.

43. In January 2020, LX's urine test was positive for cannabinoids. In April 2020, amphetamines were detected in his urine, resulting in his arrest. He was interviewed and remanded in custody.

44. LX was subsequently released on bail to reside at Corella Place on 8 May 2020. At that time, he began the 14-day quarantine/COVID-19 isolation period. This was despite already having been in COVID-19 isolation whilst in prison. He was restricted to his unit, including a small deck/balcony, for 23 hours a day. He was allowed one hour of exercise provided he was wearing a mask and observed social distancing requirements.[25]

45. He was placed at Corella Place 228 as he was unable to be placed at Corella Place Main due to having previously been sexually assaulted by a resident there.[26]

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[24] Ibid, [42].

[25] T899.19-30.

[26] T1251.10.

Hours preceding LX's death

46. Following the end of his isolation period on 22 May 2020, LX attended Resident H's unit at around 4.00 pm. He was observed to consume medication, believed to be methadone tablets. Sometime before 8.00 pm, LX attended the unit of Resident F and Resident G before returning to his own unit at around the curfew time of 8.00 pm. Resident F later stated that LX was *as high as a kite*.[27]

47. Sometime that evening, possibly while he was still at Resident H's unit, LX spoke to EC on the telephone. According to EC, it was only a short call because LX was on another call, speaking with a friend. Nevertheless, EC said that LX *was in good spirits, sounded happy and alert*.[28] She said that they ended the call confirming that they would talk the following Sunday on a video call.

48. The other telephone call that EC refers to as having occurred at the same time as her call to LX was likely with co-resident Resident M. Resident M thought LX was *out of* it;[29] he was falling asleep on the phone and breathing heavily which Resident M later recognised as the same noise he had heard when his grandmother was dying.[30] When asked by Resident M what he had taken, LX said he had consumed his whole script of Lyrica, and methadone.[31] Resident M regretted not having contacted anyone to alert them of LX's condition and said *I should've rang Corella staff*.[32]

49. At some time before the 8.00 pm curfew while LX was in Resident H's unit, Resident H reportedly called the Corella Place office to request LX move into his unit that evening because LX was *off his face … to the point it was scaring [him]*. He said:

> I requested that he stay with me because he needed someone to watch him for the night because something was wrong. I tried to convey how important it was without

[27] Exhibit 12 – Recorded conversation of Resident F, dated 30 June 2020, CB p148.

[28] Exhibit 1 – Statement of EC dated 7 January 2021 [43].

[29] T235.25.

[30] T236.22-25.

[31] T217.12-14.

[32] T236.25.

getting him into trouble. But they didn't want a bar of it. They just basically, like, yeah nah, he's moving in tomorrow, you can deal with it then.[33]

50. Resident H was unable to name who he had spoken to, but said it was *whoever would have answered the phone at the office.*[34, 35]

51. At around 7.15 pm that evening, Daniel Guinane (**Mr Guinane**), Team Leader who was working in the Corella Place Main office, received a telephone call from LX requesting that he move in with Resident H that evening as his protective quarantine period had finished. Mr Guinane informed LX that his move into Resident H's unit would occur in the morning,[36] the reason for this being that there was not enough time for him to move before curfew began at 8.00 pm, and staff would have to make notifications regarding LX's electronic monitoring.[37]

52. At around 11.00 am on 23 May 2020, LX was located deceased in the lounge room of his unit by Specialist Case Workers, Danny Drake and Michael Jennings.

JURISDICTION

53. LX death was a reportable death under s 4 of the *Coroners Act 2008* (Vic) (***Coroners Act***), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

54. Section 52(2) of the *Coroners Act* provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

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[33] T300.30 – 301.5.

[34] T301.20-21.

[35] See paragraph 9 in my commentary regarding Resident H's evidence about this alleged call.

[36] No contemporaneous note of this conversation was made. Mr Guinane made a Contact Note (p 322 AM-5.) about this conversation with LX on 23 May 2020, after he was made aware of LX's passing; T330.

[37] T377.26-30.

55. An Inquest into the death of LX was not mandated because he did not fall within the purview of s 52(2) of the *Coroners Act*, in particular, his involuntary detention at Corella Place does not specifically fall within the definition of "a person placed in custody or care" as it is defined in ss 3 and 4.

56. Nevertheless, s 52(1) further provides that a Coroner may hold an Inquest into any death that the Coroner is investigating. Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must exercise the discretion in a manner consistent with the preamble and purposes of the *Coroners Act*. In deciding whether to conduct an Inquest, a Coroner should consider factors including (although not limited to) –

    a. whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process;

    b. whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about; and

    c. the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

57. It was appropriate, on several grounds, that an Inquest was held into the death of LX including that he was a person with a number of known vulnerabilities and subject to a post-sentence order that mandated him to reside at a state-run facility, Corella Place, and who was experiencing significant restrictions on his human rights and civil liberties.

Human rights under the Charter

58. I determined that LX's human rights were relevant to this Inquest, particularly when considering potential findings, comments and recommendations under the *Coroners Act*.

59. As Coroner McGregor observed in the Findings in the Inquest into the Passing of Veronica Nelson on 30 January 2023, the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**) is potentially relevant to this proceeding in at least three ways:

    (1) First, the application of the Charter to the Coroners Court;

(2) Secondly, the application of the Charter to public authorities (other than the Coroners Court); and

(3) Thirdly, the Charter rights engaged by the factual events within the scope of the Inquest.

60. When the Coroners Court is acting in an administrative capacity it is a public authority under the Charter and is bound by the obligations under s 38 of the Charter.

61. Further, irrespective of whether it is acting as a public authority, s 6(2)(b) of the Charter applies directly to the Coroners Court to the extent that it has functions under Part 2 (that is, relating to particular Charter rights), and Division 3 of Part 2 (interpretation of laws, including the *Coroners Act*).

62. The Coroners Court has clear functions under the right to life (s 9 of the Charter). In addition, the Coroners Court has functions relating to the way matters are conducted, including the rights to a fair hearing and to equality before the law (ss 24 and 8 of the Charter respectively).

63. Section 32(1) of the Charter provides that, so far as it is possible to do so consistently with their purpose, all statutory provision must be interpreted in a way that is compatible with human rights. This includes the interpretation of the powers to comment and make recommendations pursuant to ss 67(3) and 72 of the *Coroners Act*.

64. Corrections Victoria is a public authority and carries the obligations imposed by s 38 of the Charter, including when administering Corella Place. These obligations include acting compatibly with Charter rights and giving proper consideration to relevant human rights (unless it could not reasonably have acted differently or made a different decision). In addition, making a person subject to a supervision order under the *SO Act* will often engage their human rights, including the rights of liberty, privacy and freedom of movement.[38]

[38] See *SO Act*, s 27(4)(a).

Custody or care

65. As stated above, LX is not considered "a person placed in custody or care" within the meaning of s 4(2)(c) of the Act, thus the reportability of his death was not mandated by the fact that he was detained involuntarily in a state-run facility, such as would be the case for a person who dies in a prison, or is in the custody of the police or is an involuntary/compulsory patient in a psychiatric facility. Absent the umbrella of "in custody or care" this unique state-run facility potentially escapes the independent scrutiny of the Coroner as occurs and is mandated for the examples of other "in custody or care" related deaths. LX's death was captured as a "reportable death" only because it was unexpected.

66. In the Finding into Death with Inquest of Gregory Sedgman[39] dated 9 September 2022, a matter that also concerned a death of a resident at Corella Place, Deputy State Coroner Hawkins (**DSC Hawkins**), as she then was, concluded:

> This case has identified that there is a gap in the *Coroners Act* which means that deaths of people on Supervision Orders who are required to reside at a residential facility, such as Mr Sedgman, do not meet the definition of custody and care under the *Coroners Act*.[40]

67. Noting that DSC Hawkins identified this gap in the *Coroners Act*, she nevertheless accepted the explanation of Corrections Victoria as to why that is so. I however, determined it was appropriate to consider the issue again in light of the circumstances of LX's death.[41]

PURPOSE OF THE CORONIAL INVESTIGATION

68. The Coroners Court of Victoria is an inquisitorial jurisdiction.[42] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if

[39] COR 2018 4920.

[40] Ibid, [92].

[41] Also noting that there have been a number of other deaths reported to the Coroner involving the use of illicit drugs and/or prescription medication by residents of Corella Place, for example Gregory Sedgman and at least two other deaths still under investigation at the time of handing down this Finding.

[42] S 89(4) *Coroners Act 2008*.

possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[43] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[44]

69. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the "prevention" role.[45] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[46] These are effectively the vehicles by which the prevention role may be advanced.[47]

70. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

STANDARD OF PROOF

71. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give

[43] S 67(1) *Coroners Act 2008*.

[44] See, for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[45] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[46] See ss 72(1), 67(3) and 72(2) of the *Coroners Act* regarding reports, comments and recommendations respectively.

[47] See also ss 73(1) and 72(5) of the *Coroners Act* which require publication of Coronial Findings, comments and recommendations and responses respectively; and s 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

effect to the principles enunciated in *Briginshaw v Briginshaw*.[48] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

72. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

73. This Finding draws on the totality of the coronial investigation into the death of LX, including evidence contained in the Coronial Brief, *viva voce* evidence of the witnesses called during the Inquest and the submissions of Counsel. Whilst I have reviewed and have had regard to all the material, including divergent views, I will only refer to that which is directly relevant to my Findings or necessary for narrative clarity. The absence of reference to any part of the evidence should not be viewed as though I have not considered it.

[48] (1938) 60 CLR 336.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

74. On 23 May 2020, LX, born on a date known to the Court, was formally identified by Daniel William Guinane, an employee at Corella Place, 228 Warrak Road, Ararat, and a Statement of Identification was completed.

75. Identity is not in dispute and required no further investigation.

Medical cause of death

76. Dr Chong Zhou (**Dr Zhou**), a legally qualified medical practitioner and fellow in Anatomical Pathology practising at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy on the body of LX under the supervision of Forensic Pathologist, Dr Brian Beer. Dr Zhou completed a report of her findings on 2 December 2020. At the time of her examination of LX, Dr Zhou had available to her the following materials:

    - Victoria Police Report of Death Form No. 83;
    - Two scene photos from Victoria Police;
    - VIFM iCMS contact log;
    - VIFM preliminary examination form;
    - Urine drug screen report from Dorevitch Pathology;
    - Supervision order (the County Court of Victoria); and
    - Post-mortem radiology (CT scan).

77. Following the autopsy, Dr Zhou had additional materials available to her as follows:

    - Eight scene photos from Victoria Police;
    - VIFM toxicology report; and

- Melbourne Health Pathology vitreous biochemistry report.

Post-mortem examination

78. According to Dr Zhou, the autopsy identified:

    i. Atherosclerosis of the left anterior descending coronary artery with up to 50% luminal stenosis;

    ii. A small granuloma including foreign body-type multinucleated giant cells surrounding polarizable foreign material in the right upper lobe of the lung;

    iii. Patchy moderate portal-based chronic inflammatory infiltrate including numerous eosinophils within the liver, suggestive of a drug-related aetiology;

    iv. A focal region of tubular atrophy, interstitial fibrosis, globally sclerosed glomeruli, and interstitial chronic inflammatory cells extending from the deep cortex to the renal capsule in one kidney. The cause of these changes was not identified, however, this constellation of features can be seen in reflux nephropathy; and

    v. Cholelithiasis (gallstones).

Toxicology

79. Toxicological analysis of post-mortem samples identified that LX had consumed a significant number of prescribed and non-prescribed medications prior to his death, including methadone.[49] The report of the analysis stated that:

> There is considerable overlap between therapeutic concentrations of methadone and concentrations attributed to overdose. In addition, there is an additive CNS depressive effect with concurrent use of other CNS depressant drugs.[50]

[49] SafeScript records reflect that LX was last dispensed methadone in January 2019.

[50] Amended VIFM Toxicology Report, CB p49.

Forensic pathology opinion

80. Dr Zhou opined that the cause of LX's death was "unascertained" but a possible cause of death was the combined use of multiple drugs that can cause depression of the central nervous system (**CNS**), leading to respiratory depression and death. She said:

> A possible cause of death is due to the combined use of multiple drugs that can cause depression of the central nervous system (CNS), leading to respiratory depression and death. Toxicological analysis of post-mortem samples showed the presence of methadone (an opioid) and its metabolite EDDP, and non-toxic levels of diazepam (a benzodiazepine) and its metabolite nordiazepam, pregabalin (an anti-convulsant), and promethazine (an anti-histamine). Pizotifen (an anti-serotonergic) was detected and unable to be quantified. These drugs all have sedative properties and may have a synergistic CNS depressant effect when used together.[51]

81. Dr Zhou also stated that the autopsy showed no significant natural disease to account for sudden death and there was no evidence of any injuries which may have caused or contributed to death.

Conduct of my investigation

82. The investigation and the preparation of the Coronial Brief was initially undertaken by Detective Senior Constable Greg Mitchell (**DSC Mitchell**) from the Supervision Order Specialist Response Unit on my behalf.

83. In addition to the materials contained in the Coronial Brief, the Court engaged three independent experts:

    i. Associate Professor Rajan Darjee, Consultant Forensic Psychiatrist;

    ii. Professor Edward Ogden, Clinical Forensic Medicine and Addiction Medicine Consultant; and

[51] Autopsy Report, CB p36.

iii. Professor Patrick Keyzer, Professor of Law, Thomas More Law School, Australian Catholic University.[52]

84. Materials before the County Court from the time that the supervision order was made in 2015 were also obtained, including transcripts from the proceedings from 2015-2019, as well as the expert reports from both Mr Candlish and Mr Cummins.

85. On 7 February 2025, Forensic Pathologist, Dr Zhou issued an amended supplementary Medical Examiner's Report after having been provided with the expert opinion of Professor Edward Ogden. Dr Zhou indicated that she accepted the opinion of Professor Ogden, and amended her opinion as to cause of death to MIXED DRUG TOXICITY (METHADONE, DIAZEPAM, PREGABALIN, PROMETHAZINE, PIZOTIFEN).

INQUEST

Direction hearing/s

86. Direction hearings were held on 29 May 2024, 19 September 2024 and 12 December 2024.

87. At the directions hearing on 29 May 2024, I made an Interim Suppression Order pursuant to section 20(1) of the *Open Courts Act 2013* (Vic) that (without repeating all the particulars of the Order) the following, or information derived from the following, is prohibited for disclosure or broadcast in Victoria or elsewhere in Australia:

    i. The identity of the deceased; and

    ii. The identity of certain family members of the deceased.

88. On 3 December 2024 a draft proposed scope and prospective witness list was circulated to the interested parties in the following terms:

[52] DJCS made submissions that the court appointed expert opinion of Professor Patrick Keyzer, Professor of Law, Thomas More Law School, Australian Catholic University should not be called upon to give evidence. My ultimate decision was to not call him to give evidence but to take his opinion as a legal submission.

The proposed scope of Inquest into the death of LX is:

(1) LX's treatment as a resident at Corella Place, including:

(a) the policies and procedures relating to illicit and licit drug consumption, including prescription medications such as methadone;

(b) the access and engagement of residents to rehabilitative courses and programs, including those addressing illicit and licit drug consumption;

(c) LX's access to mental health support, supervision and treatment;

(d) the policies and procedures relating to the isolation of residents during the COVID-19 pandemic;

(e) the manner in which Corrections Victoria and others responded to concerns raised by LX's mother about LX's treatment and wellbeing;

(f) whether LX's treatment was compatible with the *Charter of Human Rights and Responsibilities Act 2006* (Vic), including having regard to the obligations of Corrections Victoria as a public authority, and also having regard to the treatment of people subject to post-sentence detention and/or supervision regimes in comparable jurisdictions; and

(g) whether there should be changes to policies and procedures of Corella Place as a preventative measure in order to reduce the risk of death to residents;

(2) LX's cause of death, including whether the combination of diazepam, pregabalin, promethazine, and methadone significantly contributed to LX's death; and

(3) Whether the death of LX, as a resident of Corella Place, should be regarded as a death of 'a person placed in custody or care' pursuant to s 52(2)(b) the *Coroners Act 2008* (Vic).

89. At the directions hearing on 12 December 2024, Mr Nick Petrie appeared on behalf of DJCS. The proposed scope and prospective witness list that were circulated on 3 December 2024 were the subject of discussion at the directions hearing, as was correspondence received from Ms Sarah Manly, solicitor acting on behalf of DJCS, dated 11 December 2024.[53] In short, DJCS sought to delay the commencement of the Inquest on a number of grounds. I allowed DJCS until 24 January 2025 to make submissions to support their position noting that Mr Petrie did not have full instructions to make submissions on the day.

90. In addition, Mr Stanton SC assisting me clearly stated for the record:

> It is not proposed that your Honour should consider the correctness or otherwise of LX being made subject to a supervision order. However, it may be the representations made at that time about the services and programs that will be made available at Corella Place are relevant to your Honour's findings and recommendations.[54]

91. The outcomes from this directions hearing were that the Inquest would commence on 17 February 2025 with the first phase of evidence, but that the first day would be utilised for legal representatives to attend Corella Place for a view.[55] The 18 February 2025 would be utilised for any outstanding submissions in relation to the scope of the Inquest and the order/extent of the witnesses , with the Inquest proper to commence on 19 February 2025.

92. On 24 January 2025, written submissions were received from DJCS. One issue addressed in their submissions is the operation and effect of the Charter on the coronial jurisdiction with emphasis on whether the Coroners Court has the power to make findings of Charter breach – DJCS' submission being that the Court does not have any such power.[56]

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[53] See Transcript of Directions Hearing, 12 December 2024.

[54] Ibid, p4.

[55] I had previously attended a view of Corella Place Main, Corella Place 228 and the Rivergum Residential Treatment Centre on 1 December 2022.

[56] Of note, DJCS had previously been an Interested Party to the Inquests into the death of Veronica Nelson (COR 2020 0021) and XY (COR 2021 3810) where the Coroner had made findings of Charter breach – no challenge to the Coroner's power was made at the time nor any appeals made to the Supreme Court in respect of same.

93. Consequentially, notice of these submissions was given to the Attorney-General of Victoria and the Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) to enquire as to whether they sought to be heard on matters raised in DJCS's submissions. VEHORC exercised its right to intervene pursuant to s 40(1) of the Charter.

94. This issue will be considered in more detail below. For ease of reference and readability, an outline of the procedural history and submissions of each of the interested parties with regard to the jurisdictional issue can be found at Appendix A to my Finding.

Scope of the Inquest

95. The scope of the Inquest was first ventilated by Counsel Assisting at the first directions hearing on 29 May 2024. At each subsequent directions hearing the expert opinions obtained by the Court were discussed, firstly in respect of the area of expertise of each expert, secondly and subsequently, the provision of each of the opinions as they came to hand to the interested parties and, thirdly, through my own enquiries with the legal representatives of DJCS about whether they were intending to obtain their own expert opinions.

96. No additional expert opinions were received.

ISSUES INVESTIGATED AT THE INQUEST

Related Applications

97. On the first day of the Inquest, 18 February 2025, Ms Joanna M Davidson (**Ms Davidson**) of Counsel appeared on behalf of VEOHRC. Ms Davidson indicated that VEOHRC only sought to intervene in relation to the Charter issues and did not seek to be involved in the obtaining of evidence in the Inquest. She sought permission to provide written submissions on the Charter issues, which I granted.

98. Also on 18 February 2025, the family, through their legal Counsel, made an application for a pseudonym order requesting that the deceased and their family members be referred to by pseudonyms. I was persuaded that a pseudonym order was necessary to secure the proper administration of justice in the proceeding by avoiding undue distress to the

family and ensuring their safety and wellbeing in circumstances where de-identification using pseudonyms will not compromise my preventative role. The order was made pursuant to s 55(2) of the *Coroners Act*.

99. On 24 February 2025, following an application made by the family through their legal Counsel, I made a proceeding suppression order pursuant to s 18(2) of the *Open Courts Act 2013* (Vic) prohibiting the disclosure or broadcast in Victoria or elsewhere of the past or present residential locations of the deceased's family, and any information or material that has the potential to identify same. I determined that such an order was necessary for the same reasons as the pseudonym order, to secure the proper administration of justice in the proceeding by avoiding undue distress to the family and ensuring their safety and wellbeing.

100. Also on 24 February 2025, following an application made by Counsel Assisting, I made an proceeding suppression order pursuant to s 18(2) of the *Open Courts Act 2013* (Vic) prohibiting the disclosure or broadcast in Victoria or elsewhere of the identity of current or former residents at Corella Place and any information that would identify or tend to identify such persons. I determined that such order was necessary because disclosure by publication or otherwise would be contrary to the public interest.

101. Also on 24 February 2025, having received a Form 31 application[57] from the Victorian Aboriginal Legal Service (**VALS**), I heard submissions from Mr Nick Boyd-Caine of Counsel as to why VALS sought to be added as an interested party to the Inquest. Mr Boyd-Caine stated that VALS sought leave only in respect to the question of the Court's jurisdiction to consider matters and make findings and recommendations pertaining to the Charter that had been raised by DJCS in their submissions dated 24 January 2025. DJCS did not oppose the application by VALS.

102. Leave was granted to VALS in the requested limited capacity and a Form 45[58] for release of limited documents was also granted.

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[57] Application for Leave to Appear as an Interested Party, Form 31 Rule 56(2) *Coroners Act 2008*.

[58] Application for Access to Coronial Documents or Inquest Transcript, Form 45 Rule 78(3) *Coroners Act 2008.*

103. The VEOHRC, VALS and the family were given until 7 March 2025 to provide written submissions on the Charter issues raised by DJCS.

Viva voce evidence at the Inquest

104. Viva voce evidence was obtained from the following witnesses:

- EC[59] – LX's mother
- Resident F[60] – Former resident of Corella Place
- Resident G[61] – Current resident of Corella Place
- Resident B[62] – Former resident of Corella Place
- Resident W (via WebEx)[63] – Former resident of Corella Place
- Resident M[64] – Former resident of Corella Place[65]
- Professor Edward Ogden[66] – Medical practitioner (expert witness)
- Resident H[67] – Former resident of Corella Place
- Daniel Guinane[68] – Team Leader at Corella Place

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59 Exhibit 1 – Statement of EC dated 7 January 2020.

60 Exhibit 12 – Transcript of Recorded Conversation made on 30 June 2020.

61 Exhibit 14 – Statement of Resident G dated 26 June 2020.

62 Exhibit 15 – Transcript of Recorded Conversation made on 26 June 2020.

63 Exhibit 16 – Statement of Resident W dated 24 June 2020.

64 Exhibit 17 – Statement of Resident M dated 11 September 2020.

65 Sadly, Resident M passed away on 5 April 2025 after having given *viva voce* evidence.

66 Exhibit 18 – Expert Opinion Report of Professor Edward Ogden dated 20 September 2024.

67 Exhibit 20 – Transcript of Recorded Conversation made on 10 June 2020.

68 Exhibit 21 – Statement of Daniel Guinane dated 25 May 2020.

- Michael Jennings[69] – Specialist Case Worker (**SCW**) at Corella Place
- Yvonne Pohl[70] – Former Specialist Case Manager (**SCM**) at Corella Place
- Samantha Andrews[71] – Former SCM at Corella Place
- Alanta Blount[72] – Senior Clinician, Forensic Intervention Services
- Zina Krishna (via WebEx)[73] – Former SCM at Corella Place
- Danielle Windley[74] – Former manager, Sex Offender Management Branch
- Scott Turner[75] – Activities Coordinator at Corella Place
- James Bulger[76] – Former General Manager (**GM**) at Corella Place
- Julie Marchant[77] – Community SCM at Dandenong Community Correctional Services
- Associate Professor Rajan Darjee (via WebEx)[78] – Consultant Forensic Psychiatrist (expert witness)
- Sarah Miles ACM[79] – Deputy Commissioner, Offender Services, DJCS

[69] Exhibit 22 - Statement of Michael Jennings dated 29 May 2020.

[70] Exhibit 23 - Statement of Yvonne Pohl dated 2 March 2021.

[71] Exhibit 25 - Statement of Samantha Andrews dated 21 August 2023.

[72] Exhibit 26 - Statement of Atlanta Blout dated 19 February 2025.

[73] Exhibit 27 – Statement of Zina Krishna dated 2 April 2025.

[74] Exhibit 28 – Statement of Danielle Windley dated 29 January 2025.

[75] Exhibit 29 – Statement of Scott Turner dated 25 March 2025.

[76] Exhibit 30 – Statement of James Bulger dated 26 March 2025.

[77] Exhibit 33 – Statement of Julie Marchant dated 29 May 2023.

[78] Exhibit 36 – Expert Opinion Report of Associate Professor Rajan Darjee dated 13 August 2024.

[79] Exhibit 38 – Statement of Sarah Miles dated 28 March 2025; Exhibit 39 – Further Statement of Sarah Miles dated 11 April 2025; and Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025.

105. Resident D, a former resident of Corella Place, was included in the initial proposed witness list however the Court was advised by DJCS that he had passed away prior to the hearing. His recorded conversation with DSC Mitchell on 30 June 2020 was played to the Court and tendered into evidence.[80]

MATTERS ARISING FROM THE EVIDENCE

Support and treatment provided to LX

106. LX struggled at Corella Place, and this was recognised by his fellow residents and staff, including SCM Ms Andrews who said he *had never done well at Corella Place and seemed to struggle day by day.*[81] He missed his family, struggled with boredom and isolation and found the lack of structure and routine difficult.

107. LX's mental health appeared to be better when he was in prison; he was more *content, alert* and *could work and had activities to do,* including short courses. [82] Indeed, when he was returned to Corella Place in September 2019, he told his SCM Ms Marchant that he would have preferred a prison sentence with a beginning and end date.[83] He was devastated to return and cried going back.[84]

108. The evidence indicates that LX used drugs to cope with his environment and the separation from his family whom he deeply missed. According to resident and friend Resident M, he *had to be off his face to be happy while he was at Corella or 228*.[85]

109. Despite his challenges, the evidence is that LX was pleasant and easy to build rapport with. SCM Ms Andrews, who worked with LX for close to four years, described him as *quite charismatic, quite friendly and quite a likeable person to work with and to be*

[80] Exhibit 13 – Transcript of Recorded Conversation made on 30 June 2020.

[81] T736.13.

[82] T65.18-25.

[83] T959.13.

[84] T54.25; T950.28.

[85] T219.9-12.

honest, probably one of the more easy going residents that I've worked with in the facility.[86]

Psychological support

110. Despite struggling with the environment, LX had little mental health support while at Corella Place and the evidence of residents was that there was little available at Corella Place in terms of psychological support. They believed *there are no supports up there.*[87] When asked about what supports could be provided to residents following the death of a peer, Team Leader Mr Guinane said they would be provided with the phone contact for the Area Mental Health Service or Beyond Blue, *cause essentially that's all we've got as a facility.*[88]

111. In around 2019 LX engaged with private psychologists via the Silvan Lodge Clinic which he arranged and paid for himself. These psychologists used dialectical behavioural therapy, modified to take into account LX's cognitive capacity.[89] LX *felt safe* with the psychologists, who *understood the way he worked.*[90]

112. LX subsequently disengaged from these supports in April 2020 due to inconsistent attendance and concern from the psychologists that they *may not be the most appropriate service for [LX] to receive his mandated treatment*.[91] They had also queried the fact that LX was paying for his treatment himself despite it being 'court mandated', and as a consequence was in arrears.[92]

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[86] T735.18-21.

[87] T113.1.

[88] T395.21-27.

[89] T956.30.

[90] T957.12.

[91] Email from Astra King to Yvonne Pohl on 22 April 2020, CB p656; Letter from Astra King to Julie Marchant dated 12 July 2019, CB p1005.

[92] Letter from Astra King to Julie Marchant dated 12 July 2019, CB p1005.

113. On one occasion between February and April 2020, LX's SCM put him in contact with a mental health nurse from Ararat Hospital, though she could not recall what about his behaviour caused her to make that referral.[93]

Drug and alcohol treatment

114. Between July 2015 and May 2016, LX had weekly drug and alcohol counselling with one counsellor and from August 2015, 14 fortnightly sessions with another[94] – well below the three or four times a week envisaged by Ms Windley.

115. LX and his mother made their own attempts to arrange drug rehabilitation; EC said *I think we phoned every drug and rehabilitation centre in Victoria.*[95] Little eventuated from these efforts as each service required an assessment *which at the time couldn't be facilitated because he was still at Corella.*[96] LX's SCM Ms Andrews also gave evidence that she had made enquiries of rehabilitation services but was *unable to find a facility or service that would be willing to take someone like LX at that time.*[97]

116. The most intensive period of drug and alcohol rehabilitation appears to be between December 2017 and June 2018 when LX was engaged with Caraniche Services as part of their HiROADS program. He attended (almost) weekly sessions though his attendance was dependent upon Corrections Victoria – he was 20 minutes late to one session and 75 minutes late to another due to Corella Place having transport issues. Two other sessions were cancelled by Corella Place due to other factors.[98]

117. Nonetheless, LX attended 17 sessions. Caraniche reported that LX engaged appropriately and meaningfully and made considerable progress.[99] According to EC, LX was positive

[93] T514.8-12.

[94] County Court transcript of proceedings, 2 November 2017, CB p2838.

[95] T66.30-31.

[96] T69.7-11.

[97] T758.4-8.

[98] Exhibit 11 – Letter from Caraniche Services dated 16 July 2019.

[99] Ibid.

about the sessions, he enjoyed attending and opened up to his counsellor. She noticed a change in her son as a result of the sessions; *he had some hope. He wasn't as depressed as he had been in the past*.[100] Over that same period she observed him to be *more upbeat and more positive*.[101]

118. In March 2020, LX was re-referred to the Caraniche HiROADS program and attended five of eight online counselling sessions between 21 March and 19 May 2020.[102]

<u>Case management proximate to LX's death</u>

119. LX was supported by several SCMs during his time at Corella Place. This was likely to have been difficult for LX who was acknowledged to *[find] it really difficult to build trust with people*[103] and had additional vulnerabilities of an ABI and ADHD[104]. LX cried when told by Ms Marchant that she would no longer by his SCM – *he was scared he was going to be forgotten up there* (at Corella Place).[105]

120. LX's SCM from January or February 2020 was Ms Pohl. They had weekly supervision sessions, which increased to twice weekly as LX *was just so frustrated at being returned to Corella Place.*[106] Ms Pohl explained that supervision sessions involved *discussions to reduce re-offending and to address their risks, and motivational interviewing to help them develop awareness of their own cognitive distortions around their risks and help them to develop more insight into how they could develop strategies to reduce their risk of reoffending.*[107]

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[100] T71.6-18.

[101] T72.5.

[102] AM-21 – Letter from Caraniche HiROADS dated 2 May 2025.

[103] T636.10-11.

[104] These vulnerabilities were not unique to LX. At the time of the Inquest, 20 per cent of the residents at Corella Place had a registered intellectual disability or acquired brain injury (T1206.18-20.).

[105] T974.1.

[106] T507.12-21.

[107] T508.2-9.

121. In February 2020, he began working with Forensic Intervention Services (**FIS**) Senior Clinician and accredited mental health social worker Atlanta Blount. Ms Blount provided offence-specific treatment to LX but also had *a lot of conversations around coping.*[108] She observed that LX *presented as anxious and overwhelmed, and experienced feelings of being trapped, hopeless and powerless since his return to Corella Place.*[109]

122. On 7 April 2020, Ms Blount contacted Ms Pohl by email and suggested that a care team meeting be arranged for LX, which she described in her *viva voce* evidence as *getting together as a team to create … a collaborative plan to support someone to be able to progress and hearing from the different stakeholders involved.*[110] Ms Blount again, on 22 April 2020, emailed Ms Pohl suggesting a case conference be held so *we can all discuss [LX] in relation to his presentation, supervision, treatment and current challenges with substance use.*[111] No care team meeting or case conference occurred.[112]

123. On LX's return to Corella Place following his incarceration for a failed urine screen, his case management was transferred to SCM Ms Krishna. There was no formal handover between the two, but Ms Pohl and Ms Krishna sat beside each other *so had lots of informal discussions.*[113] These were not documented.[114] Ms Krishna accepted that this was a shortcoming in relation to her role and that without a documented handover, *things can fall through the cracks.*[115]

124. At the time Ms Krishna took over as LX's SCM she was not aware that he had been incarcerated after testing positive for amphetamines at urinalysis. She was, however, aware that he had a history of issues with urinalysis screens, and a history of drug

[108] T569.2.

[109] T580.14-18.

[110] T587.22-25.

[111] T590.1-5.

[112] T590.8-9.

[113] T504.29 – 505.1.

[114] T648.27.

[115] T651.26-31.

abuse.[116] Ms Krishna had not received training in relation to working with clients with an ABI and could not recall training in relation to ADHD.[117]

125. Ms Krishna's formal supervision sessions with LX, of which there were two, were held by telephone which she explained was due to LX residing in the quarantine unit without a computer and unable to attend the office.[118] She said her *instructions were to only have phone contact with LX while he was in that 14 day isolation.*[119]

126. On 13 May 2020, a 38-minute supervision session occurred between LX and Ms Krishna. LX answered the phone sounding sleepy with his words muddled which Ms Krishna acknowledged *was an alarm bell*.[120] Her case note stated *it is unknown if LX had taken any medication before the phone call, for his presentation*[121] but she did not ask him.[122] LX spoke at length of his need to return to the wider community and his goal of being a good father, and acknowledged breaching his order. Ms Krishna notified him that there were no plans in place for his transition [to the community] and the possibility of transition might not occur until restrictions were lifted.[123]

127. Despite LX's presentation and Ms Krishna clearly turning her mind to whether LX had taken medication before the phone call, she entered his Dynamic Risk Assessment for Offender Re-entry (**DRAOR**)[124] risk score for 'substance abuse' as '1' and his score for

[116] T648.2-9; T651.19-21.

[117] T646.22 – 647.9.

[118] T658.6-18.

[119] T658.22-24.

[120] T670.12-20.

[121] Exhibit 27 – Statement of Zina Krishna dated 2 April 2025, p7.

[122] T670.21-23.

[123] Exhibit 27 – Statement of Zina Krishna dated 2 April 2025, pp7-8.

[124] The DRAOR is a tool used by staff to assess stable, acute and protective factors. It provides a clear structure and assists practitioners in monitoring changes in a resident's dynamic risk. It assists case managers in identifying when a resident is becoming unstable or may require further intervention.

negative mood as '0'[125] LX's risk score for substance abuse had regularly been rated as '2' prior to this.[126]

128. Ms Blount observed LX presenting in a worrying way in their final session on 19 May 2020. He presented as lethargic and tired. He mumbled his words, slurred his speech, had a slow rate of speech and was closing his eyes for long periods of time throughout the session. He presented in a flat mood, appeared irritated and was dishevelled in appearance. He disclosed to Ms Blount that he had self-harmed while being held in the police cells. He denied current thoughts of self-harm or suicide but said he would not report these to staff.[127]

129. Ms Blount's concern about this difference in presentation from their other five treatment sessions was such that she immediately contacted the Principal Practitioner by telephone following the treatment session, and followed up with an email to Ms Krishna and her team leader.[128] The following day, she emailed a copy of her case note, copying in the Principal Practitioner and offered further discussion.[129] Ms Krishna responded by email advising that Corella Place staff would continue to monitor LX's presentation.[130]

130. Ms Krishna's final supervision session with LX was at 11.00 am on 20 May 2020. He answered the phone after around seven rings in a barely audible tone and his initial words were slurred. He told Ms Krishna he had just woken up and was still sleepy and it took him a few minutes to say how he was feeling *as he kept mixing up the words and slurring them.* LX expressed his strong displeasure at being required to isolate and *felt an exception should be made for him as it is affecting his mental health*. He spoke of sleeping all day since returning to Corella Place as there was nothing else to do.[131]

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[125] Exhibit 27 – Statement of Zina Krishna dated 2 April 2025, pp7-8.

[126] T659.24-27.

[127] AM-5 – Bundle of documents provided by DJCS, p91.

[128] T592.17-22.

[129] T593.31 – 594.5.

[130] AM-5 – Bundle of documents provided by DJCS, p78.

[131] Exhibit 27 – Statement of Zina Krishna dated 2 April 2025, pp9-10.

131. Ms Krishna noticed LX was slurring his words which he explained was *because he didn't have his teeth in, and he had just woken up.* He said he had taken a Valium that morning as he was restless and anxious and had taken his Tramadol for back pain.[132]

132. Ms Krishna ultimately terminated the call after LX became heightened speaking of his frustrations of not being able to speak to his lawyer. He called her back at 12.25 pm and apologised for that behaviour. At that time, LX was informed that he would be seen by another SCM for his next appointment.[133]

133. According to the JARO Review undertaken following LX's death, Ms Krishna elevated LX's DRAOR substance abuse score from '1' to '2' following their supervision session, however she was advised by a Principal Practitioner that a rationale for this increase needed to be provided in the file. Apparently, rather than include a rationale, Ms Krishna reverted the score to '1'.[134] Ms Krishna could not recall this having occurred but said *if that would've occurred there should have been a case note to mention why.*[135]

Drugs and prescription medication

<u>Medication management at Corella Place</u>

134. Residents were responsible for purchasing, managing and administering their prescribed medications which, according to the relevant LOP, was *in line with [Corella Place's] non-institutional philosophy.*[136] They could either keep their medication in their unit or request that Corella Place hold the medication in a medication safe until required.[137] They were encouraged (but not required) to disclose the details of these medications to their SCM.

[132] Ibid.

[133] Ibid.

[134] JARO Review into the death of LX at Corella Place on 23 May 2020, CB p760.

[135] T663.13-22.

[136] Local Operating Procedure 13.5/22, Resident medication, CB p350.

[137] The relevant LOP stated that this *may be useful to prevent stand-over or threats from other residents where a resident has been prescribed tradeable or otherwise divertible medication.* CB p 351.

135. In some circumstances, such as for safety reasons or where a resident is suspected of abusing, trading or misusing medication, staff may issue a lawful instruction requiring the resident to store their medication centrally in the facility's medication safe, the keys to which were held by Team Leaders.[138] Corella Place House Rules explicitly stated that excessive quantities of medications were not permitted in the facility.[139]

136. Staff are not medically trained or authorised to dispense or supply medication and the LOP made explicit that staff are ***not*** *responsible for the dosages that a resident may self-administer, for monitoring compliance with any prescription requirements, or for observing residents when taking their medication.*[140]

137. In circumstances where a resident's medication was held centrally, they would attend at the office where they were provided with their plastic box of medication by staff, who are supposed to record each occasion a resident accesses their box and note the dosage of each medication retrieved.[141] This process appeared not to be foolproof – one resident gave evidence that staff had given his medication, likely Lyrica/pregabalin to another resident in error.[142] Another described residents secreting excess medication in the sides of their mouths.[143]

138. LX had previously been subject to several lawful instructions requiring his medication to be stored centrally, including on his return to Corella Place in 2019, though this was rescinded on 7 November 2019.[144] There was no lawful instruction in place at the time of his death, however on his return to Corella Place he requested that staff store his

[138] Statement of Franca Gugliemino, undated, CB p81 [45]; Exhibit 30 – Statement of James Bulger dated 26 March 2025, p2 [11].

[139] Corella Place House Rules and Resident Contract, CB p318.

[140] Local Operating Procedure 13.5/22, Resident medication, CB p352.

[141] Statement of Franca Gugliemino, undated, CB p83 [54].

[142] T164.

[143] T223.10-12.

[144] Statement of Franca Gugliemino, undated, CB p85 [69].

Tramadol for him. Concerningly, his SCM Ms Krishna was of the belief that LX was subject to a relevant lawful instruction and was not in possession of his medication.[145]

139. Ms Pohl gave evidence that during her time as his SCM, being February to April 2020, she raised concerns with the Principal Practitioner and Operations Manager that LX should be subject to lawful instruction that his medications be held centrally, *but that discussion was passed up above [her] rank and was outside of [her] control.*[146]

Trading and stockpiling of medication

140. There was clear and consistent evidence that the trading, exchange and stockpiling of prescription medication was a significant issue at Corella Place[147] – that it was commonplace and widely known[148] to be occurring.[149] According to Mr Guinane [150] there was a significant issue with residents sharing and trading, in particular, prescription medications. Mr Guinane was also aware of the stockpiling of medications.[151] This was also known by General Manager Mr Bulger[152] and other staff.[153] Corella Place attempted to stymie the trade, exchange and stockpiling of medications through methods such as

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[145] T657.13-19.

[146] T497.28 – 498.4.

[147] This included between Corella Place Main and Corella Place 228, when residents travelled between the two for activities or appointments (T226.6-7).

[148] According to Resident W, this included the staff:

> *So all the residents there, we pretty much know what's going on between each other ... most of the staff members knew what was going on. I'm sure countless of us had told them that, you know, people were doing all of these things because it had become quite a problem. People being, you know… off their tree basically on drugs, running around doing stupid things, and nothing was ever done about it.* (T198.16)

[149] Resident H, T307.7-8; Resident F, T87 and T115; Resident W, T198.12-24; Resident D – Exhibit 13, QA13 and 121.

[150] T333.13.

[151] T336.6.

[152] T862.23-29.

[153] T721; T654.2-4.

room searches, the issuing of lawful instructions and through the employment of intelligence analysists.[154]

141. The stockpiling of a Schedule 8 medication, namely methadone tablets, was occurring at the relevant time by another resident of Corella Place 228, Resident F.

142. Resident F was prescribed methadone tablets for chronic pain and stated that at one stage, he had seven boxes of methadone tablets in his unit – each box containing 20 tablets. He kept his methadone tablets under his wardrobe in his room. Resident F said that at one stage he suspected one of his "cards" of methadone was missing or had been taken but he was not completely sure about this as he was not keeping track of his medication – he neither counted them nor kept an eye on them.[155] He also said he generally kept the door to his room locked because of other resident's high-risk behaviours of trading drugs and medication but, that there were times where he was *slacking off a bit* with his security.[156]

143. At the relevant time, Resident F was not subject to a lawful instruction to surrender his medication to the Corella Place office despite being the only resident prescribed this Schedule 8 medication in this form.[157] and despite having accrued a stockpile of this medication in his room. He also said that LX had expressed an interest in the methadone tablets but did not offer to purchase any from him and Resident F denied having supplied LX with any.[158]

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[154] T890.21-27.

[155] T96-99.

[156] T98.

[157] Ms Miles gave evidence that, to the knowledge of DJCS, Resident F was the only resident prescribed methadone tablets at the relevant time – or indeed at any time (T1279). Resident F gave evidence that he believed he was the only resident who was prescribed methadone tablets (T99.11).

[158] T110.

LX and methadone

144. LX was first commenced on opioid substitution therapy with methadone around March 2015. He was prescribed a maximum dosage of 90 mg per day, which was gradually reduced to 50 mg per day in 2017.

145. By June 2018, LX's methadone dose had been reduced to 22 mg per day. By August 2018 it had been increased to a dose of 40 mg per day, and by January 2019, he was on a dose of 50 mg per day. There is no evidence that LX was prescribed methadone after January 2019.

146. Professor Ogden, a medical practitioner specialising in addiction medicine with over 45 years' clinical experience, gave extensive and compelling evidence about methadone and the likely effects of methadone on LX. In his expert opinion report to the Court, Professor Ogden explained that methadone is a powerful synthetic opioid used for the management of chronic pain and the long-term maintenance therapy of individuals with narcotic addiction, commonly referred to as opioid replacement therapy. It is available as syrup and in tablet form. The syrup is used for the treatment of opioid dependence and tablets are predominantly prescribed for severe chronic pain. The only tablet formulation available in Australia is 10 mg tablets. Methadone is a pure opiate and acts in the brain in the same way as morphine and other pure opiates with one significant side effect of all opiates, including methadone, being that they *can act on the centres of the brain responsible for breathing and …are capable of suppressing respiration and therefore, there's always the risk of death.*[159]

147. Professor Ogden provided extensive information about the effects of methadone, including that they are prolonged and that it has delayed onset and this is why care must be taken when commencing someone on methadone. The starting dose is low and is increased very slowly to enable the brain to become used to the effects and avoid depression of the respiratory centre.[160] After a few weeks of a stable dose of methadone, people develop a tolerance and have few side effects, but the tolerance is rapidly lost –

[159] T258.20.

[160] T259.

in just a matter of days. The Victorian Guidelines for the prescribing of methadone are quite clear, according to Professor Ogden – if someone has missed more than three or maybe four days, the dose must be dramatically reduced and retreated back up to the dose they were on because *they have just become sensitive again, and – and there is the risk…of overdose.*[161]

148. Given the lapse of time since LX had been prescribed methadone, Professor Ogden opined that he likely had no established tolerance for the drug, and that it was his lack of tolerance to methadone that was the *critical factor* in making him especially vulnerable to an overdose. He concluded that the combination of methadone, pregabalin, diazepam, and promethazine significantly contributed to LX's death by exerting a synergistic depressant effect on his central nervous and respiratory systems, greatly increasing the risk of sedation and respiratory failure. Methadone, in particular, caused profound sedation, likely leading to airway compromise and death by asphyxia.[162]

<u>Methadone – safety considerations for custodial settings</u>

149. Professor Ogden said that, from a risk management perspective, he would not prescribe methadone tablets in a situation where he thought there was a risk of stockpiling, misuse or where the tablets assumed some currency. He said that in that type of setting he would want to use syrup.[163]

150. In response to the amount of methadone tablets Resident F had accumulated and kept in his unit, being seven boxes, each containing 20 tablets, Professor Ogden said that this is a *staggering* quantity of methadone for someone in a custodial or similar environment to accumulate, as stockpiling such a large amount poses serious risks of misuse or diversion. In such a setting with these risks, methadone syrup is a safer alternative because:

> …if you swallow it in front of someone, you've swallowed it… it's very difficult to divert methadone syrup once you've swallowed it… if you have supervised dosing then you know it's not being diverted and the simplest, if you sort of allowed

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[161] T259.26 – 260.4.

[162] Exhibit 18 – Expert Opinion Report of Professor Edward Ogden dated 20 September 2024.

[163] T272.3-20.

> people seven takeaways a week, they have to bring back seven bottles… if they don't bring back, they have one dose in front of the pharmacist and they bring back the six takeaway bottles, if they don't bring back the six takeaway bottles, they don't get replaced.[164]

151. Professor Ogden said that the dispensing of methadone syrup to residents at Corella Place would be a risk management strategy he would be more comfortable with rather than allowing methadone tablets at the facility, which was *a strong no from [him] … the risks are unacceptable.*[165]

152. Professor Ogen did acknowledge that because methadone is a Schedule 8 drug, a lot of non-clinical people do not want to handle it. However, because it is a Schedule 8 drug, it is essential that these medications are secured in a safe or other form of locked storage. He explained how it was indeed possible for non-clinical people in a custodial setting to legally look after it. Professor Ogden said, in relation to persons in the custody of Corrections, that:

> … the methadone could be dispensed once a week and so they have one dose administered by the pharmacist and six bottles are taken away and put in a safe and anybody could pull a bottle out of the safe and say here you are, here's today's dose, with appropriate record keeping and so on … legally that's perfectly possible. In the rehabilitation unit which I look after, that's exactly what we do. They go to the pharmacy once a week. The client has a dose in front of the pharmacist and the client and staff take six bottles away which get put in the safe and each day the client can come and get their methadone and the staff who are all relatively untrained, Cert 4 in community services or something like that, all of whom have limited experience, allow the person access to their own medication and a record is kept, so it's signed for.[166]

153. According to Mr Bulger, who at the time of LX's death did not know methadone came in tablet form, Corella Place had a Memorandum of Understanding with Priceline Pharmacy in Ararat with respect to the administration of methadone and some other Schedule 8 medications. A pharmacist would attend on business days to dispense the methadone (in syrup form) and if the pharmacist was not present, the resident could

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164 T268.12-29.

165 T280.14.

166 T270.12-28.

access their 'take-away' dose of methadone from a lockbox for which only Priceline Pharmacy and that resident held the key.[167]

Other medications – safety consideration for custodial settings

154. Pregabalin (sold under the brand name Lyrica) was also identified on LX's post-mortem toxicological analysis and was identified by Professor Ogden as a drug of concern in the custodial setting. He said that this drug, which can be used as a sedative, has currency in the prison setting, particularly because of its rapid onset and potency.[168] He stated that it was highly addictive and, in his expert opinion to the Court, he set out that it can cause drowsiness, dizziness and reduced cognitive function particularly at higher doses or when it is used in combination with other central nervous system depressants. The association between pregabalin misuse and overdose deaths is significant, especially when it is combined with opioids (such as methadone) or benzodiazepines. Such a combination often leads to severe respiratory depression – the primary cause of death in such cases.

155. Professor Ogden said that, at the rehabilitation facility he provides advice to, the clients are taken off pregabalin and placed on an alternative drug which has less currency as a drug of addiction or drug of abuse.[169]

156. LX was prescribed pregabalin and it was included in the list of prescriptions filled on 25 March 2020 by Priceline Pharmacy. When LX was located deceased, a significant amount of medications were also found within his unit. LX was not subject to a lawful instruction at the time, of which I will say more of below.

157. Of note, pregabalin was added to SafeScript for real-time monitoring in February 2023 following a number of Coronial recommendations.

[167] T864.28-31; Exhibit 30 – Statement of James Bulger dated 26 March 2025, pp 9-13.

[168] T263.9-264.14.

[169] T263.28-31.

Corella Place

Corella Place as a rehabilitative environment

158. The secondary purpose of the *SO Act* is to facilitate the treatment and rehabilitation of offenders.[170] It follows that Corella Place should be a venue at which that purpose can be progressed. This appeared not to be the case for LX.

159. SCM Ms Andrews gave evidence that, in her experience, the maximum amount of drug and alcohol treatment that a resident at Corella Place could have was one session per week.[171] A/Prof Darjee opined that *Corrections Victoria, and other services they worked with, were not equipped to, and did not deliver, the necessary substance misuse intervention [to LX] at Corella Place*.[172]

160. A/Prof Darjee explained at inquest the difficulties in having meaningful rehabilitation occur at Corella Place, with almost all residents being *clinically complex* and with staff not necessarily having a background *where they have been trained or have clinical skills to work with such complex cases*.[173] He said:

> ...it's not set up as a treatment facility; it's set up as a residential facility. It's a place… that's meant to be for people to live when they haven't got anywhere to live in the – what I'll call the community, or it's not safe for them to live in the actual community. So it's – it's somewhere for people to live; it's not a treatment facility. It's not a rehabilitation facility, and so the staff role is mainly to – to run a facility in that way even though you've got a group of individuals who have very, very complex needs, very, very complex, difficult behaviours.[174]

[170] *Serious Offenders Act 2018* (Vic), s 1(b).

[171] T736.29.

[172] Exhibit 36 – Expert Report of A/Prof Rajan Darjee, p25 [104].

[173] T1002.

[174] T1003.5-18.

161. A/Prof Darjee said that Corella Place can be a *criminogenic* environment for some people and *there's good research evidence that the types of facilities we put offenders in increase the risk they pose in the longer term.*[175]

162. Corella Place houses a combination of "high tariff" and "low tariff" offenders, with LX falling into the latter category. A/Prof Darjee spoke of the spectrum of residents: *you've really got a whole range of individuals both in terms of their personality and their clinical profile but also in terms of their risk profile.* Some residents may have *committed multiple rapes over many years … sexual murders … multiple violent contact child sex offences,* and in contrast some *aren't like those individuals, who may have committed more minor sex offences, who don't necessarily pose the same risk of serious sexual harm.* The residents range from *highly dangerous, predatory, psychopathic offenders right through to people with – who are anxious, introverted, inadequate*.[176]

163. Ms Andrews, SCM and then acting Principal Practitioner at Corella Place did not consider LX a "high tariff offender" in terms of his risk in comparison to other residents at Corella Place.[177] Similarly, A/Prof Darjee did not regard LX as a "high-tariff offender",[178] nor was he callous or lacking in empathy.[179]

164. A/Prof Darjee also gave evidence as to the most effective delivery mode for treatment/therapy. He explained that whether a session occurs in person or via video conference *doesn't really make any difference*.[180] However, there could be significant disadvantages using telephone conferencing given the treatment provider cannot see the

[175] T1020.11-14.

[176] T1006.14-31.

[177] Exhibit 25 – Statement of Samantha Andrews dated 21 August 2023, [50].

[178] T1040.10.

[179] T1061.4.

[180] T1029.24.

person.[181] This sentiment was shared by Ms Blount who said *it can be really hard in therapy if someone's off the screen and you can't see what they're doing at the time.*[182]

165. The nature of Corella Place, and particularly Corella Place 228 with more limited facilities to conduct video conferencing, is such that appointments often had to occur over the phone, including LX's fortnightly drug and alcohol counselling with the Community Offender Advice and Treatment Service proximate to his death.[183] LX had also raised concerns about confidentiality and his worry that his sessions may be overheard by staff in the next room.[184]

<u>Activities at Corella Place</u>

166. One reason for the drug misuse that was rife at Corella Place appears to be the hopelessness, loneliness and sheer boredom experienced by residents.[185] As Resident F stated, *there's a real drug problem in this place because people can't cope with the boredom. So, they take drugs and end up drug addicts.*[186] The evidence was that LX certainly used drugs to cope at Corella Place. Ms Harris of Counsel put to Resident M that *it was your understanding that [LX], due to missing his family and the boredom …*

[181] T1031.7-14.

[182] T618.4-6.

[183] T556.11-26.

[184] T618.15-17.

[185] Examples of some of the remarks made by the residents, and former residents, of Corella Place include - *The system is letting people down. It's taking away people's hope* (Resident D, CB 202-239) and Resident F agreed (T93), saying *People are killing themselves with drugs, because there's no hope*. (T115.17). Resident B explained, *You are pretty much in limbo* (T155.28), and *You would feel that sense of hopelessness… you can see where the goalposts are but they kept on shifting… So, it sort of becomes daunting… and you just wanna like give up*. (T187.23–188.1). Resident W described Corella Place as *a cesspool of despair* (T195.6). Resident H said, *We have essentially zero input in our own lives and no-one knows when they're gonna get out. No-one knows anything so it's – it's very easy to just lose hope. It's like you're stuck in a – it's worse than jail. It's worse than jail.* (T308.2-6).

[186] T89.5-7.

he resorted to drug use? to which he responded in the affirmative.[187] LX himself had blamed boredom as a trigger for his substance abuse.[188]

167. Professor Ogden described the situation and environment at Corella Place – including the boredom, isolation and hopelessness – as *almost a perfect storm for increased drug use.*[189] In his experience treating patients, particularly those on court orders or who had been incarcerated, drug use was often a way to pass the time, and to make life more tolerable.[190]

168. Boredom, isolation and loneliness were experienced both across Corella Place Main and 228 but were certainly more pronounced in the latter. Not only were there more residents at Corella Place Main but there were significantly more facilities, including an indoor gym, an activities building/living skills room utilised for activities such as cook ups and bingo, a woodshed, welding shed and sporting facilities.[191]

169. By contrast, Corella Place 228 had a small men's shed/woodworking shed, some basic gym equipment and a walking track. Access to these activities was not guaranteed, either – tools for the woodworking shed were locked away and only accessible if staff were available to grant access,[192] the gym equipment was outdoors and thus its use weather dependent, and use of the walking track was restricted during COVID-19. The COVID-19 period was described as *hard* by Activities Coordinator Mr Turner due to restrictions in terms of activities; residents were restricted from going outside which they enjoyed.[193] Residents of Corella Place 228 were also restricted from participating in activities at Corella Place Main.

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[187] T231.2-4.

[188] Exhibit 25 – Statement of Samantha Andrews dated 21 August 2023, [17].

[189] T266.10.

[190] T266.25.

[191] T358; T817.

[192] The evidence was that *when 228 is manned by two staff … and if there's not an emergency or other work duties that override the request, they'll be given access.* (T464.30 – 465.2)

[193] T807.26.

Family visits/contact

170. Isolation, including separation from ones' family, was a theme arising out of the evidence, particularly from the residents. Family was a clear protective factor for LX. He spoke to his mother almost daily.

171. Residents were encouraged to have family visits in the community. Several rationales for this approach were given, including that it was a more conducive and prosocial environment,[194] that Corella Place was not suitable for family visits,[195] and that there were no toilet facilities for family visitors.[196]

172. In contrast to the situation at Corella Place, Rivergum has appropriately equipped visiting facilities. Counsel attending the view on 17 February 2025 were told that a Rivergum resident had recently held a barbeque at the facility with their family. Ms Miles sought to distinguish Rivergum from Corella Place, telling the Court that Rivergum was a secure facility where residents were not accessing the community or going on regular outings as they would at Corella Place.[197]

173. However, the evidence was that those family visits – in the community – were often cancelled due to operational and staffing constraints, often at late notice, and this had happened to LX. Resident M recalled being with LX when he was told that a family visit he had been excited about had been cancelled. LX *lost it… he started crying and he'd say he was missing his mum and son and his family… and he's not coping [living at Corella Place]*.[198]

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[194] T1183.21-31.

[195] T1190.1-7.

[196] T920.10-24; T1190.13-21.

[197] T1184.13-27.

[198] T323.25-233.4.

174. An additional factor complicating family visits was Corella Place's regional location. Resident M gave evidence that he had fortnightly visits with his mother which involved eight hours of travel time for a two-hour visit.[199]

175. The residents, and many staff, believed that family visits could not occur at Corella Place for the reason that they were not permitted. This was in fact not the case – *technically incorrect* as put by Mr Bulger.[200]

176. Corella Place has (and had) a Local Operating Procedure (**LOP**) 'Visitors to Corella Place' which allows for visits where *special circumstances* exist, and *preferred options have been exhausted*.[201] The resident must discuss the proposed visit with their SCM and make an application in writing to the General Manager. The LOP notes that *regard is also to be had to the fact that there are no public toilet facilities at Corella Place*, *no refreshment stations, and no children may be brought into the facility or car park.*[202]

177. However, the resident cannot begin the process of arranging a visit if neither they, nor their SCM, are aware that it is possible. Eloquently stated by Counsel Assisting in their submissions: *In reality, the theoretical possibility of having family visits at Corella Place is illusory.*[203]

Missed opportunities and failings

178. Despite the long lead time from the date of LX's death and the commencement of the Inquest, there had been no acknowledgement from DJCS that there were any failures on their part, or opportunities missed, that may have changed the outcome for LX. Despite several directions hearings and the opportunity given to provide submissions prior to the commencement of the Inquest, no concessions were made by DJCS.

[199] T222.10-21.

[200] T883.26-28.

[201] AM-13 – Local Operating Procedure 13.5.8, Visitors to Corella Place, p,17.

[202] Ibid, p5.

[203] Counsel Assisting's Outline of Submissions, dated 30 September 2025, p64 [273].

179. During the course of the Inquest, a number of missed opportunities and failings were identified. During proceedings, the Court made a request to DJCS for further information about a number of issues including what was known about methadone at Corella Place. When Ms Miles, Deputy Commissioner, Offender Services, DJCS[204] returned to the witness box on 4 September 2025, having previously given *viva voce* evidence on 10 and 11 April 2025, she accepted missed opportunities and failings related to:

Methadone at Corella Place

180. Despite the evidence of Mr Bulger, former General Manager of Corella Place, that he was unaware that methadone was available in tablet form, Ms Miles revised her evidence from 10 April 2025 and stated that she accepted that all staff should be aware of the different forms of methadone – syrup and tablets. She also accepted that the management at Corella Place should have been aware at the relevant time that Resident F was prescribed methadone tablets and was, not only bringing this Schedule 8 medication into Corella Place but storing it in his unit. For a residential facility to be bereft of knowledge about a prescription medication, that it is a Schedule 8 medication, and for that resident to be left to "manage" it himself reflects a very concerning culture in the administration of Corella Place.

The need for lawful instructions

181. Ms Miles accepted that Resident F should have been subject to a lawful instruction[205] directing him to surrender his methadone so that it could be centrally controlled. This would have gone a long way to preventing Resident F from stockpiling his methadone which, by his own evidence, had reached breathtakingly large quantities by the relevant time. Some staff were aware of Resident F's access to methadone tablets and if not

[204] In the interim a further statement had also been received from Ms Miles dated 16 May 2025 – Exhibit 40.

[205] A core condition of a supervision order is that the person subject to the order must obey all instructions given by a community corrections officer or other specified officer under s 209 of the *SO Act.* The provision empowers the relevant officer to give any reasonable instruction that is necessary to ensure matters related to the safety and welfare of the offender or other person, compliance with any conditions of the supervision order, compliance with any rehabilitation or treatment plan or compliance with any directions given by the Authority.

before, at a Multi-Disciplinary Assessment Team (**MDAT**)[206] meeting on 2 August 2019 this issue and the concern about stockpiling were discussed, as was the need for a lawful instruction. No lawful instruction eventuated, despite another MDAT meeting being held on 27 February 2020. Resident F was issued with a lawful instruction regarding his medication after LX passed.

182. Similarly, there was no lawful instruction in place for LX, despite there having previously been one due to concerns about his own medication management. On 7 November 2019, this lawful instruction was revoked by MDAT based on information that LX had been managing his own medications in the community. But this was incorrect information and could have easily been checked by Corella Place. EC and LX's stepfather had been supervising LX's medication during his period in the community that immediately preceded his return to Corella Place. The decision to revoke the lawful instruction came a mere two weeks after a case-noted discussion had occurred between two of LX's SCMs and his Team Leader about how his medication should not be provided to him to manage and should remain centrally stored.[207] There was no case management representation at the MDAT meeting.[208]

183. The retention of a lawful instruction for LX, who was in COVID-19 isolation for a fortnight, had known issues with boredom, poor impulse control due to his ABI (also known) and who was openly aggrieved by the perceived unfairness of his situation, would have provided the protective mechanism that is intended from a lawful instruction. But it is apparent no one turned their mind to LX's particular heightened risks, including his SCM at the relevant time, Ms Krishna, who incorrectly thought that LX *was* subject to a lawful instruction to keep his medication at the office because of his failed urinalysis screen.[209]

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[206] The primary purpose of MDAT is to provide assurance to the GM, Corella Place and the PSB that an individual's risk, needs and complexities are being considered. The MDAT also ensures that cases are being reviewed in accordance with the Corrections and Justice Services Case Management Framework.

[207] T965.22 – 966.18.

[208] T1132.15-23.

[209] T657.13-23; T694.26.

Senior Case Managers and case management and risk assessment

184. There were several identified shortcomings in the case management of LX and, of particular attention in the Inquest, was the immediate period proximate to his death when he had returned to Corella Place and was placed in isolation due to the COVID-19 quarantine requirements. Counsel Assisting extensively reviewed and summarised the evidence of the examples of these shortcomings in their Outline of Submissions[210] and included:

   a. a lack of documentation reflecting the handover between LX's SCM's, Ms Pohl and Ms Krishna;

   b. breach of a commitment made by DJCS to hold fortnightly supervision meetings[211] between SCMs and the Principal Practitioner (**PP**) by holding only monthly meetings;

   c. a failure to escalate the concerns and warnings of Ms Blount, Forensic Intervention Services (**FIS**) senior forensic clinician, that a care team meeting or case conference in relation to LX's care was needed as a matter of urgency; and

   d. the lack of factual information that LX's SCM was working with him on, including the belief that LX was subject to a lawful instruction, that a resident prescribed methadone had that stored at the office, and an apparent lack of understanding of the DRAOR risk scores,[212] reflected in the entries made in the case notes following supervision meetings with LX on 13 and 20 May 2020 – both of which were held on the telephone and did not include any facial vision.

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[210] See pp 49-54.

[211] This commitment was made by DCJS during the Inquest into the Death of Gregory Sedgman COR 2018 4920.

[212] T660.

Urinalysis

185. Condition 3.8 of LX's supervision order required him to submit for urinalysis testing at the direction of an officer who has reasonable grounds to suspect that he may have been using drugs. LX had indeed been subject to urinalysis testing while a resident at Corella Place and, in January 2020, had tested positive to cannabinoids. In April 2020, he tested positive to amphetamines, resulting in a period of imprisonment. His risk of abusing prescription medication and illicit substances was known. His presentation on the telephone to his SCM on 13 May 2020, including sounding sleepy, his tone being low and his words sounding muffled should have been matters of concern or "red flags" about his possible drug use. Similarly, in his second conversation and telephone meeting with his SCM, LX was noted to be slurring and mixing up his words, sounding sleepy despite the conversation occurring at mid-afternoon, not being in a good state of mind, having taken Valium at around 5.00-6.00 am, and even the reasons he provided for sleeping so late being due to having nothing else to do were all details that should have raised "red flags" of concern that he may be using drugs. Invoking Condition 3.8 at that time would have been appropriate – it was a tool readily available to his SCM, and this was an opportunity lost to halt LX's abuse/misuse of drugs.

186. The evidence that LX was at a heightened risk of harm from abuse and misuse of prescription medications and illicit drugs was observed and reported on by Ms Blount on 19 May 2020. She communicated her concerns onto SCM, Ms Krishna, and to her Team Leader, Ms Marshall, in an email after she had observed LX closing his eyes while talking, rubbing his eyes, appearing lethargic and mumbling and slurring his words. Significantly, this information was available to the SCM the day before her own meeting with LX on 20 May 2020, where he was exhibiting similar, concerning features and without the benefit of being able to visualise LX.

187. The Justice Assurance and Review Office (**JARO**) Review finding that "[t]here is no record of meaningful discussions with LX about substance abuse and possible misuse of medications or strategies to counteract any issues he might be experiencing", was accepted by Ms Krishna. The JARO Review also found that it was a missed opportunity for LX to have not been directed for urinalysis testing noting, "…his presentation

indicates that this would have been an appropriate intervention and should have occurred”.[213]

188. Mr Bulger agreed that LX should have been subject to Condition 3.8 relating to urinalysis testing during his period of protective quarantine.[214] However, Ms Miles was of an opposing position to the JARO Review and Mr Bulger – she maintained that LX should not have been sent for urinalysis testing whilst in protective quarantine because this would have required him to commence a new 14-day period of quarantine which would have been detrimental to his mental health, given he was already expressing significant frustration and concern about being placed into quarantine at Corella Place. The Practice Guideline in place at the time also stated, according to Ms Miles, that people in protective quarantine did not have to undergo urinalysis testing, which Ms Miles appears to have interpreted as a blanket prohibition against urinalysis being undertaken on any resident in protective quarantine. The wording of the practice guideline states: *Residents in protective quarantine are not required to participate in urinalysis testing.*

189. Mr Bulger did not accept that this equated to a blanket prohibition on urinalysis testing for people in protective quarantine. Similarly, I do not accept Ms Miles’ interpretation of the policy in this regard and I cannot reconcile her evidence that it would have been detrimental to LX’s mental health to have been sent for, or arrangements made for him to have a urine sample taken, when the cogency and consistency of the evidence amounts to a lack of identification and concern for LX’s wellbeing and mental health. In addition, even in the understandable position of applying hindsight bias, a “guideline” is just that – some assistance at guiding employees – and should not be interpreted as a mandatory practice. Indeed, it would be concerning if a “Practice Guideline” purported to render null and void Condition 3.8 of LX’s supervision order.

[213] JARO Review into the death of LX at Corella Place on 23 May 2020, CB p 750.

[214] T932.8.

Drug and alcohol treatment

190. Ms Miles agreed that more could have been done to advance LX's drug and alcohol treatment and rehabilitation at Corella Place.

191. Mr Candlish, who assessed LX in 2013, considered *[f]or any treatment or case management interventions to be effective, he will need to remain abstinent from drug use. This is likely to require intensive drug and alcohol rehabilitation.*[215] Ms Windley made assurances to Judge Pullen that this could be provided at Corella Place.

192. This did not occur, despite LX's need for intensive rehabilitation being well identified and DJCS being on notice – it was raised repeatedly by EC in her communications with DJCS and it was raised when LX's matter returned to the County Court in 2017.

193. When LX was receiving that intensive drug and alcohol treatment, such as when he engaged with the Salvation Army START Program while living with his family, he made clear, good progress. A/Prof Darjee opined that it was during that period that *he received the most appropriate and effective drug treatment services.*[216] EC noted that it was *incredibly detrimental to his rehabilitation and mental health* to lose that intensive treatment when he was returned to Corella Place.[217]

194. In the period proximate to his death, and following his return to Corella Place, LX received fortnightly drug and alcohol counselling via phone with the Community Offender Advice and Treatment Service.[218] He was additionally referred to the Caraniche HiROADS program that he had previously engaged with, attending five out of eight scheduled online appointments between 31 March and 19 May 2020.[219] This clearly fell short of what he needed.

[215] Detention and Supervision Order Assessment Report of Simon Candlish, dated 5 November 2013, p 29 [133], CB 2453.

[216] Exhibit 36 – Expert Report of Dr Rajan Darjee, p 23 [99].

[217] T43.27-30.

[218] T556.

[219] AM-21 – Caraniche attendance summary.

195. DJCS appear to have, to a degree, considered the shortcomings in drug and alcohol treatment –since 2023, FIS have expanded their service delivery to include rehabilitation of individuals with an identified link between their alcohol and other drug use and offending.[220] Ms Blount explained that this would not be intensive treatment perhaps akin to a residential alcohol and other drug treatment service, but where there was a link between alcohol and drugs and the offending, that could form part of treatment sessions.[221]

<u>Family contact</u>

196. Family was such a protective factor for LX as acknowledged throughout the Inquest – A/Prof Darjee thought that having increased contact with family *could have been very helpful for LX.*[222]

197. Ms Miles accepted that there should have been more contact facilitated between LX and his family,[223] and conceded that it would have been possible, stating: *We could have facilitated [a visit] in one of the meeting rooms at Corella Place. That could have been managed. We could have managed that safely, I think.*[224] She did however maintain that it was her strong preference that family visits occur in the community.

198. I accept that preference and agree that the community is likely to be a more "conducive and prosocial" environment than Corella Place. It is certainly likely that residents would prefer visits to occur in the community. However, given the evidence that these visits in the community were often interrupted, rescheduled or cancelled and the *crushing*[225] effect that could have on the residents so looking forward to seeing their loved ones, it is

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[220] T566.14-21.

[221] T568.21-569.15.

[222] T1040.6-7.

[223] T1254.10-12.

[224] T1183.

[225] T116.20-27.

certainly, as stated by Counsel Assisting, *extraordinary* that there is functionally no way for family to visit Corella Place.[226]

Charter training

199. Corella Place staff are required to complete Charter training comprising six online modules developed by VEOHRC – three of which are mandatory for all staff and three mandatory for managers only.[227]

200. Mr Bulger, in his role as General Manager, agreed that he wanted to have a human rights culture at Corella Place and the SCWs and SCMs had a good working understanding of the Charter.[228] The evidence is that this was not the case. Corella Place staff giving evidence at the Inquest could not recall having done training on the Charter[229] or could not recall what it entailed.[230] Some were unable to describe how their obligations as a public authority impacted on their day-to-day work[231] or how the Charter impacted their duties,[232] or were unable to identify a right under the Charter.[233] In those circumstances, it follows that those staff cannot give appropriate consideration to the human rights of residents when making decisions that impacted upon them.

201. Ms Miles advised that as of 2025, staff must re-complete the VEOHRC program on a biennial basis *to ensure staff remain cognisant of their obligations under the Charter as public authorities.*[234] This is an improvement, but I do not consider it sufficient for staff working in such a unique environment as Corella Place. This is training delivered to all

[226] Counsel Assisting's Outline of Submissions, dated 30 September 2025, p63 [271].

[227] Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025, [45].

[228] T888.24-30.

[229] T536.31 – 537.1.

[230] T365.6-7.

[231] T366.1-3.

[232] T439.24-25.

[233] T408.21-24.

[234] Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025, [45].

Corrections Victoria staff – it is not facility-based training and it does not specifically cover how human rights would apply to a resident at Corella Place.[235]

Restorative/preventative measures

Reforms following LX's death

202. Some, though limited, reforms were made at Corella Place in the immediate aftermath of death, as a result of a formal debrief into LX's death held on 1 June 2020.[236] These were:

   a. Staff being reminded of confidentiality and the DJCS social media policy and relevant conduct and ethics policies being circulated to staff;[237]

   b. A list made of staff who were trained in defibrillator use in case of emergency;[238]

   c. An emergency code system introduced mirroring the prison code system;[239] and

   d. Radios being the preferred method of communication between staff during an incident was emphasised in the emergency management framework.[240]

203. In addition to the reforms spoken to by Mr Bulger, Franca Guglielmino, then the Acting Assistant Director, Post Sentence Branch at Corrections Victoria made a statement for the coronial brief in which she outlined the "recommendations/changes" made following LX's death. She said that Corrections Victoria had taken a more restrictive approach to controlling medication by prohibiting the possession of excessive quantities of over-the-counter medication, and by issuing lawful instructions where a resident is suspected of

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[235] T1256.2.

[236] See AM-8 – Formal debrief minutes, death of resident, LX, 1 June 2020.

[237] T857.1-6. This occurred because staff and residents became aware of LX's death prior to his family being informed.

[238] T185.19-22.

[239] T857.29 – 858.5.

[240] T858.18-23.

abusing, trading or misusing medications. Residents were to be supervised when retrieving their medication from the office and identified by photo ID.[241]

204. Ms Guglielmino also said that LOPs were issued setting out *a comprehensive procedure for identifying and managing offenders at risk of substance abuse*, and training was provided to staff which included information on assisting residents with their own medication.[242]

205. Concerningly, many of the staff who gave *viva voce* evidence were unable to describe any reforms that occurred in the aftermath of LX's death.[243]

Reforms made as a result of the Inquest

206. In a further statement provided prior to Ms Miles' return to the witness box, she acknowledged that reforms were made as a result of this Inquest:

> From hearing evidence at LX's inquest and also from a review of Resident F's file, we identified that changes needed to be made to the MDAT. The PSB has reviewed the MDAT and significantly overhauled its operating model … The key changes outlined below aim to increase accountability on staff to make sound, evidence based and robust decisions.[244]

Multi-Disciplinary Assessment Team (MDAT)

207. Ms Miles explained that MDAT is now chaired by the General Manager or Manager of Professional Practice, who must also endorse the minutes of the meeting which are shared with all members. Previously, the Chair had been the Operations Manager.[245] MDAT meetings are to be scheduled weekly and if a resident is being case managed by another CCS region, their allocated SCM or Principal Practitioner must be present.[246]

[241] Statement of France Guglielmino, undated, CB p 87 [82].

[242] Ibid [83]-[84].

[243] See for example T347.17-24; T402.4-7.

[244] Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025, [18].

[245] Ms Miles explained that this change came about so that the GM has greater oversight and to ensure the Chair is neutral in their role.

[246] Ms Miles acknowledged this change came as a *direct result* of the Inquest. Exhibit 40, [23].

208. MDAT meetings now canvass new referrals, including referrals due to risk escalation, responsivity impacting case management and posing a risk to the good order of the facility/staff. The MDAT also contained regular resident reviews, and all new and returning residents must be considered by the MDAT within seven days prior to their arrival, and four weeks thereafter. Several topics are set out in the new MDAT agenda template for discussion including medication, which must be expressly considered as part of resident reviews.

209. The MDAT LOP has been updated and encourages information sharing at Corella Place and across Corrections Victoria – documents related to MDAT are stored on both the Corrections Victoria electronic information management system and in the resident's CCS file. The LOP has also been updated to include medication and outlines the process with regard to lawful instructions – they must now be reviewed on a six-monthly basis and cannot be rescinded until formally considered at MDAT.

Management of residents' medication

210. Ms Miles also acknowledged that changes were made to the management of resident medication as a result of hearing evidence at Inquest, and the relevant LOP has been updated.

211. Where a staff member suspects medication abuse or has concerns around a resident's medication, this must be escalated to a management team member who then must make a referral to MDAT for consideration. Where a staff member becomes aware that a resident is using a medication used to treat opioid dependence, they must escalate the matter to a Team Leader who must make a referral to MDAT.

212. However, there remains no obligation for residents to disclose to staff at Corella Place the medication they are prescribed, including Schedule 8 medications,[247] but they may consent to information being shared between Corella Place and their prescriber by

[247] T1225.19-28.

signing an Authority to Exchange Information. SCWs are expected to make observations during outings about what medications are being collected by residents.[248]

213. DJCS has sought legal advice in relation to the process of managing residents' medication at Corella Place, and that advice, I was informed during the Inquest, remains outstanding.[249]

214. Ms Miles agreed that this was an issue in relation to the balancing of rights[250] – namely privacy and the safety of the residents. She agreed at Inquest that it would *in some ways … be more straightforward* to have a rule that Schedule 8 medications are disclosed and centrally administered at Corella Place and that this may be less corrosive of trust between workers (who are expected to note their observations made during outings regarding medication) and the residents. But, she said, the balance of that would be *all of the other residents who are not engaging in problematic behaviour, perhaps would see that as – that they're not being trusted* and *its also about upskilling people to manage their medication and lead independent lives and have the right to not disclose their medical information.* She was unsure that such a policy *would be legally permissible because of the civil nature of the scheme* and said that that was the point of the legal advice being sought.

Alcohol and other drug training

215. Ms Miles also advised that during 2025, Caraniche was engaged to run harm minimisation sessions to residents incorporating risks around medication use, and a staff training session incorporating risks around medication use and to educate staff on assessing drug affected presentations. Those sessions will now be delivered to both staff and residents on a quarterly basis, and Caraniche will provide information sheets which will incorporate medication risks.[251]

[248] T122917-20.

[249] T1226.6.

[250] T1131.8-10.

[251] Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025, [46].

COMMENTS

Pursuant to s 67(3) of the *Coroners Act*, I make the following comments connected with the death:

1. From the perspective of the residents of Corella Place, the post sentencing system is a system of prolonging the punitive aspect of sentencing which does not apply to all offenders – it is a distorted system which stands outside our legal justice system where incarceration for serious criminal offences is accepted by our society in part because it is anticipated that the offender will be provided with rehabilitative support and reintegration strategies to assist them at the end of their sentence – "commit the crime, serve the time". But the unpalatable nature of the offences that invokes the post sentencing system/regime has led to the creation of this facility, Corella Place, to be filled with people with ongoing restrictions on their liberty as if they were still serving their original sentence but with the difference that they have no certainty about when they will conclude their post sentence period, when they will be released to reintegrate back into society, and what is required of them to get to that point. This is not an equitable application of the criminal law – this is a distortion of the principles our society has formulated to address offending behaviours.

2. Corella Place imposes a number of conditions on the residents. Yet, I am asked to accept that they are not in custody. The conditions that I have identified include the restrictive conditions that are imposed through supervision orders, a breach of which can lead to a mandatory minimum 12-month prison sentence – a not insignificant potential punishment. In addition, Corella Place House Rules and the Residential Contract require every resident to sign that they agree to the rules in place and failing to comply with those rules may constitute a breach of the supervision order. In relation to "suspicion" of excessive drugs/medication, staff have powers to search inside of a resident's premises on the grounds of reasonable suspicion, they can do a pat down search and direct for urinalysis. And there is of course a curfew at night starting at 8.00 pm, thus confining the residents to their units. Having regard to all of these imposed conditions it is difficult to give Corella Place anything but a title of a custodial facility. The conditions and limitations on the liberties of the residents at Corella Place depict the vulnerability of this

cohort. This should be acknowledged by ensuring all their deaths are subject to mandatory reporting under the *Coroners Act* and subject to a mandatory inquest.

3. I was informed during the Inquest that DJCS is seeking legal advice in relation to managing residents' medication. However, DJCS' deference to the "right to privacy" in response to issues that arose about residents managing their own medications, is anathema to the remainder of the restrictive practices imposed on the residents of Corella Place. The policies and procedures that allowed LX to access methadone are so at odds with other conditions and restrictions imposed on residents – they must abide by a curfew, they cannot possess dumbbells or offensive material and cannot have an additional heater without permission, they are accompanied to appointments and to family visits and ankle monitoring bracelets are the norm. It is also difficult to reconcile LX's easy access to methadone with the duty of Corella Place staff – a *paramount duty* according to Mr Bulger[252] – to try and ensure his compliance with his supervision order conditions which included, very relevantly, *must not use/possess prohibited drugs* and *must not abuse drugs of any kind*. But the laissez faire attitude to residents' medication in the restrictive and isolated environment of Corella Place is not conducive with the expectation placed on them to successfully rehabilitate and transition back to the community – it equates more into setting them up for failure. Ms Miles held contrary views – she said that a mandate requiring medications to be administered centrally would interrupt a resident's ability to practice skills towards their rehabilitation, *ultimately interrupting their rehabilitation and reintegration into the community.*[253]

4. EC attempted to advocate for her son and raise concerns regarding the lack of drug treatment and did so by phoning Sarah Miles on several occasions and writing to her.[254] She did not receive a response other than a brief email acknowledgment that Ms Miles had received her letter of 5 May 2016. Ms Miles, in her statement, said that she had made enquiries but had not been able to locate receipt of EC's correspondence.[255] However,

[252] T917.21 – 918.6.

[253] Exhibit 40 – Further Statement of Sarah Miles dated 16 May 2025, [39].

[254] Exhibit 1 – Statement of EC dated 7 January 2020.

[255] Exhibit 38 – Statement of Sarah Miles dated 28 March 2025, [94].

she corrected her statement in her *viva voce* evidence and advised that she had that morning located the correspondence and accepted that there should have been a response and that it was *unacceptable* none was provided.[256] She explained that she had handed over EC's correspondence to a colleague for follow up though could not locate any written evidence of doing so.[257] She had since spoken to that colleague who recalled that he had spoken to Corella Place about the concerns raised by EC, attempted to call her and had then forgotten to follow up.[258] I do not suggest that this oversight contributed to LX's death – I am unconvinced that had EC's concerns been considered, increased drug treatment would have been provided in any case. But, this oversight, the failure to acknowledge or communicate with a mother expressing her concerns and fears for her son's wellbeing and safety, goes strongly to the culture at Corella Place and those involved in its administration, and the sentiment that these men are being warehoused and put out of sight/out of mind. EC said *in my opinion LX was constantly treated like a caged animal, a second-class citizen, and was knocked down at every opportunity. His soul was destroyed from this extended experience long before he passed away.*[259]

5. The structure in place for scheduling appointments, including with family was dependant on staff availability as they were required to escort the residents – and this was frequently changed/cancelled as late as the night before the scheduled appointment if there were insufficient staff available. This led to frustration and uncertainty amongst the residents. The only time EC had visited Corella Place was after her son's death, where she collected his belongings from *outside the office on the footpath.*[260]

6. LX's ability to engage with drug rehabilitation was hampered because he was not permitted to do residential drug rehabilitation and he was required to find his own programs while at Corella Place. Having read the transcripts of the County Court proceedings where the orders were made, it is abundantly clear that DJCS were aware of

[256] T1130.

[257] T1130.6.

[258] T1130.13.

[259] Exhibit 1 – Statement of EC dated 7 January 2020; T46.21-25.

[260] T52.15.

the importance of LX receiving intensive treatment. Ms Windley told Judge Pullen she would *do everything [she] could to make it happen.*[261] None of this happened.

7. The identified shortcomings relating to Senior Case Managers, case management and risk assessment were manifold and cannot be excused by the turmoil of the pandemic – the residents of Corella Place were still under the control and care of DJCS. The impact of the restrictions imposed by the COVID-19 pandemic were widespread and I acknowledge that this included impacts on staff members. However, the impact on the residents of Corella Place cannot be understated, something acknowledged by Ms Miles who said that *no doubt, being in a residential facility is more difficult than it would have been in the broader community.*[262] Their experiences of hopelessness, isolation and boredom would certainly have been amplified by the pandemic and this would have increased their risk, as is depicted in the circumstances surrounding LX's death.

8. LX and his family's commitment to his rehabilitation during his period in the community in 2019 must be acknowledged. This was the first time LX was fully engaged in his rehabilitation and by all accounts his efforts represented a commitment to being re-engaged with his family, including his son. On his return to Corella Place, there was an incredibly stark contrast noted, even by staff: *he'd actually changed I think. He was on a better path than I previously knew him.*[263]

9. In relation to the alleged telephone call that Resident H made on the evening of 22 May 2020, he explained having not told DSC Mitchell about this call in their recorded conversation as a consequence of his ADD and ADHD which caused him memory issues at times of high stress.[264] In cross-examination by Counsel for the Secretary, Resident H said that he had *told the police, whether it was on the recorded interview or*

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[261] County Court transcript of proceedings, 26 May 2015, CB p2336.

[262] T1179.2.

[263] T390.17-18.

[264] T302.10-12.

not. [265, 266] Counsel for the Secretary have pressed for me to make a finding that this did not happen and that I should reject his evidence *per se*. While I acknowledge the implications for DJCS if Resident H had in fact made that call, I do not consider it necessary to incorporate this issue into my findings as I have attached no weight to Resident H's evidence in this regard.

10. The restorative and preventative measures implemented by DJCS following LX's death and as a result of the Inquest are an implicit acknowledgement of the Department's failings in various respects. The fact that restorative and preventative measures were implemented as a result of the evidence heard at Inquest underscores the importance of the coronial jurisdiction and specifically an Inquest in affecting change and reinforces my conviction that the deaths of this vulnerable cohort should be subject to a mandatory Inquest.

11. I have allocated a separate section within the Finding to deal with the issue of the Charter. This includes commentary.

RECOMMENDATIONS

Pursuant to s 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

To the Secretary of the Department of Justice and Community Safety:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that Corella Place institute a policy whereby residents are required to disclose if they are prescribed any Schedule 8 medications (including methadone) and all

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[265] T322.15-16.

[266] In lieu of *viva voce* evidence on this point, DSC Mitchell provided a statement dated 5 November 2025 advising that he had no recollection of being told by Resident H about the phone call and he had reviewed his contemporaneous notes which did not contain any references to such a phone call. He said that had he become aware of such a phone call he would have discussed this at length during the recorded conversation and followed up with relevant staff. He stated *it is my belief that Resident H is factually incorrect in asserting that he informed me of the call he stated he made.*

Schedule 8 medications should be centrally controlled and administered at Corella Place, subject to limited exceptions overseen by the Multi-Disciplinary Assessment Team.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that serious consideration be given as to whether controls are placed in relation to pregabalin so that it is centrally controlled and administered at Corella Place, given its potential for abuse, its dangerousness in combination with other medications and its prevalence in trading and exchange.

3. With the aim of promoting public health and safety and preventing like deaths within the correctional facility of Corella Place, I recommend the Department of Justice and Community Safety review the medication management policies at Corella Place with a view to giving consideration to adopting a system of dispensing medication that replicates the system or systems in place in other correctional facilities known as prisons.

4. With the aim of supporting mental health and wellbeing within the vulnerable population of Corella Place residents, I recommend that serious consideration be given to making improvements to Corella Place so that appropriate family visits can occur at the facility. In the interim, serious consideration should be given to allowing residents at Corella Place to access the purpose-built facilities at Rivergum for appropriate family visits. I further recommend that all staff and residents are informed that family visits can occur at Corella Place in accordance with the relevant Local Operating Procedure.

5. With the aim of best supporting and meeting the individual needs of the vulnerable population of Corella Place residents, I recommend that Specialist Case Managers and Specialist Case Workers receive mandatory, regular and specific training in relation to working with people with acquired brain injury, intellectual disability and attention deficit hyperactivity disorder (ADHD).

6. With the aim of best supporting the vulnerable population of Corella Place residents, I recommend that supervision meetings between Specialist Case Managers and residents be held in person or if necessary, by video. Supervision meetings should not be held by telephone only.

7. With the aim of best supporting the residents and staff at Corella Place, I recommend that the Department of Justice and Community Safety recommit to and emphasise the importance of Principal Practitioners engaging in at a minimum, fortnightly supervision with Specialist Case Managers, a recommendation from the Justice Assurance and Review Office accepted by Corrections Victoria following the death of Gregory Sedgman. I further recommend that all handover meetings are properly documented and that all staff at Corella Place are made aware of these requirements.

8. With the aim of promoting public health and safety and preventing like deaths at Corella Place, I recommend that steps are taken to improve general awareness of the signs and symptoms of drug overdose/misuse including but not necessarily limited to providing information to all residents on how to respond.

9. With the aim of promoting public health and safety and preventing like deaths at Corella Place, I recommend that regular and specific training is provided to staff at Corella Place on the signs and symptoms of drug misuse and overdose and what to do in case of an emergency.

10. With the aim of best supporting and meeting the individual needs of the vulnerable population of Corella Place residents, I recommend that Specialist Case Managers and Specialist Case Workers receive regular, updated training in relation to their obligations under the *Charter of Human rights and Responsibilities Act 2006* (Vic), including with regard to the rights of residents to equality and freedom from discrimination. This training should be specific to Corella Place and include practical scenarios in which staff are required to consider human rights and to identify lawful and unlawful limitations on human rights.

11. With the aim of best supporting and meeting the individual needs of the vulnerable population of Corella Place residents, I recommend that the Department of Justice and Community Safety request the Victorian Equal Opportunity and Human Rights Commission review its training in relation human rights and the *Charter of Human Rights and Responsibilities Act 2006* (Vic) to assess its adequacy in relation to its specific application in the unique environment of Corella Place.

12. With the aim of promoting public health and safety and preventing like deaths at Corella Place, I recommend that Corella Place guidelines are updated to make clear whether, and in what circumstances, a resident in quarantine may be required to undertake urinalysis.

13. With the aim of supporting mental health and wellbeing within the vulnerable population of Corella Place residents, I recommend that improvements are made to Corella Place 228 so that residents have access to activities and facilities that are commensurate with those provided at Corella Place Main.

14. With the aim of promoting public health and safety and preventing like deaths at Corella Place, I recommend that the Department of Justice and Community Safety take steps to ensure that all correspondence and concerns from family members of Corella Place residents is properly logged and responded to in a timely and appropriate manner.

15. With the aim of engaging residents of Corella Place in their own rehabilitation and transition to the community, I recommend that the Department of Justice and Community Safety give serious consideration to providing a clearer articulation within the supervision framework of what is required by each individual resident to achieve their transition to the community.

16. With the aim of engaging residents in, and improving residents' access to, rehabilitation services, I recommend that the Department of Justice and Community Safety undertake a review of the current rehabilitation services offered at Corella Place, with a view to providing a suite of services that are tailored to the specific needs and requirements of the Corella Place cohort.

<u>To the Therapeutic Goods Administration:</u>

17. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Therapeutic Goods Administration give serious consideration to re-scheduling pregabalin as a Schedule 8 medication, given its potential for abuse, its dangerousness in combination with other medications, and its prevalence in trading and exchange.

To the Attorney-General:

18. With the aim of promoting public health and safety and the administration of justice, I recommend that the Attorney-General review the provisions of the *Coroners Act 2008* (Vic) that relate to the definition of "in custody or care" in s 3(1) and the mandatory requirement to hold an Inquest associated with that definition, with a view to expanding the definition and ensuring consistency to Coronial oversight of this vulnerable cohort to include deaths of people *required to live* in a residential facility, such as Corella Place.

FINDINGS

Having investigated the death of LX, and having held an Inquest in relation to his death, I make the following Findings pursuant to s 67(1) of the *Coroners Act 2008*:

1. I find that LX, born on a date known to the Court, died between 22 May 2020 and 23 May 2020 at Corella Place, 228 Warrak Road Ararat in the State of Victoria. At the time of his passing, LX was subject to a supervision order made pursuant to the *Serious Offenders Act 2018* (Vic) – a condition of his order authorised the Post Sentence Authority to direct him to reside at a residential facility – Corella Place.

2. I find that the cause of death of LX as originally ascribed by Dr Chong Zhou as "Unascertained" cause(s), did not reflect the weight of the evidence that he was known to be abusing prescription medication and that significant amounts of medication were identified on post-mortem toxicological analysis; medications that have central nervous system depressant effects. Furthermore, no natural cause was identified at autopsy that could be said to have caused his death and similarly, no injuries were identified that could have caused or contributed to the death of LX. Based on clear and cogent evidence, including the opinion of Professor Edward Ogden and the amended supplementary report of Dr Chong Zhou, I find that LX died from mixed drug toxicity (methadone, diazepam, pregabalin, promethazine, pizotifen) in circumstances where I also find, in the absence of clear and cogent evidence to the contrary, that his death was the unintended consequence of his abuse of his own, and diverted prescription medication.

3. I find that a significant contributing factor to LX's death was his access to and ingestion of methadone and that there is clear and cogent evidence that he had access to, or in some other way obtained methadone tablets at Corella Place 228.

4. I find that there was a direct link between the failure of Corella Place to properly monitor and control methadone tablets entering the residential facility; to manage the access to, distribution of, methadone tablets; and to undertake, in any way, risk minimisation strategies for residents' access to diverted methadone tablets and the cause of LX's death.

5. Accordingly, having accepted the evidence that a more accurate cause of death has been identified, I have notified the Registrar of Birth Deaths and Marriages to amend the cause of death to mixed drug toxicity (methadone, diazepam, pregabalin, promethazine, pizotifen).

6. I find that LX's death was not an intentional act of self-harm but the unintended consequence of his intentional use and abuse of illicit and prescription drugs, in circumstances where he felt trapped, hopeless and powerless on his return to Corella Place and was experiencing boredom and isolation.

7. AND I find that Corrections Victoria failed to support LX in his rehabilitation. This failure of Corrections Victoria was multi-faceted and demonstrated through –

   a. its failure to adhere to the recommendations of its own expert psychologist;

   b. its failure to provide the mental health supports that he needed; and

   c. through the assurances it gave to her Honour Judge Pullen, namely that LX was to receive intensive drug rehabilitation and treatment, rehabilitation and support during his enforced residency at Corella Place.

8. I find the case management, supervision and treatment of LX after he returned to Corella Place in September 2019 was inadequate.

9. AND, I find that in combination, the plethora of missed opportunities and failings (identified above), contributed to the death of LX.

10. AND, in conclusion, there is clear and cogent evidence to support a finding that the death of LX was preventable.

Findings in relation to the *Charter of Human Rights and Responsibilities Act 2006* (Vic)

11. As the Secretary accepted, there were significant missed opportunities and failings in this matter. I have made findings that LX's death was preventable, and identified missed opportunities and failings that contributed to his death.

12. Ultimately, I have determined it is not necessary to make findings of Charter breach in the Inquest into LX's death, suffice that I have made findings that his death was preventable, a statutory role depicted in the Preamble and Purposes of the *Coroners Act 2008* (Vic).

13. I do however find that the Coroners Court of Victoria is empowered to make such findings. The approach previously taken by Coroner Simon McGregor appears to be correct when one has regard to the text, history and purpose of the *Coroners Act* and the Charter, including for the reasons given by VEOHRC, VALS and the Family. Given the position adopted by DJCS in the Inquest into the death of LX that the Coroners Court does not have the jurisdictional power to make findings of breach of the Charter, it is no less than bewildering to me that no appeal on a question of law or judicial review proceeding was commenced in relation to Charter issues in the matters of *Nelson* and *XY*, where there were specific findings of breach of the Charter – both matters involving the passings of Aboriginal people. I also made findings of breach of the Charter in the matter of Mathew Luttrell,[267] the passing of an Aboriginal person, albeit involving a health service and not DJCS. No appeal arose out of that matter.

14. The *Coroners Act* was enacted relatively soon after the Charter, which itself was modelled (with some important differences) on the *Human Rights Act 1998* (UK).

[267] COR 2018 005721.

15. In *Regina (Amin) v Secretary of State for the Home Department* (***Amin***),[268] Lord Bingham considered the obligation to respect human rights (Article 1) and the right to life (Article 2) in the *European Convention on Human Rights* and stated:

> 30. A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence under articles 1 and 2 of the Convention. This means that a state must not unlawfully take life and must take appropriate legislative and administrative steps to protect it. But the duty does not stop there. The state owes a particular duty to those involuntarily in its custody. As Anand J succinctly put it in Nilabati Behera v State of Orissa (1993) 2 SCC 746 at 767:
>
> > "There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life".
>
> Such persons must be protected against violence or abuse at the hands of state agents. They must be protected against self-harm: Reeves v Commissioner of Police of the Metropolis [2000] 1 AC 360. Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm.
>
> 31. The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred: Menson v United Kingdom, page 13. It can fairly be described as procedural. But in any case where a death has occurred in custody it is not a minor or unimportant duty. In this country, as noted in paragraph 16 above, effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.[269]

16. The *Coroners Act*, and the powers to make findings, comments and recommendations, are underpinned by Parliament giving effect to the right to life. This was clearly the intention of Parliament.[270]

17. Whether the right to life imposes a positive or only a negative duty, I find that the duty of the Department of Justice and Community Safety to protect that right was not

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[268] [2003] UKHL 51; [2004] 1 AC 653.

[269] At [30]-[31] (emphasis added).

[270] Parliament of Victoria, Legislative Assembly, Second Reading Speech to the Coroners Bill 2008 (Vic), Attorney-General Hulls, 9 October 2008, 4030. The Coroners Act was also intended to implement the recommendations of the final report of RCIADIC; Ibid, 4034-5.

adequately discharged in LX's case.[271] He was not adequately protected against a foreseeable risk of avoidable harm. LX was a vulnerable and isolated person, and he should have been better protected against the clear dangers caused by the stockpiling of a "staggering" quantity of methadone tablets, as well as the trade and exchange of prescription and non-prescription medication, at Corella Place.

18. I find that LX was not treated with dignity and due respect given his acquired brain injury and attention deficit hyperactivity disorder as required by s 8 of the Charter. The interactions between Ms Krishna and LX were not only a missed opportunity given how he presented at the time, but also reflected the danger of having a person with a duty to care for LX not adequately trained in respect of a person with those particular vulnerabilities, a responsibility that rests on the shoulders of the Department of Justice and Community Safety.

19. Further, I find that as a person who was effectively detained for the protection of the community, LX had rights under s 21 and s 22 of the Charter to be provided by the Department of Justice and Community Safety with reasonable opportunities to engage in treatment and rehabilitation programs to address and reduce his risk. Despite assurances to the County Court that the drug and alcohol treatment programs he required would be available to him at Corella Place, they were not.

20. In failing to respond to a mother who was expressing serious and justified concerns about her son, I find that the treatment of EC by Ms Miles was unacceptable and fell short of what should have been done to protect the rights of families.

21. In addition, I find that the current situation with regard to family visitation at Corella Place also fails to adequately discharge the right to families as required by s 17(1) of the Charter.

ACKNOWLEDGMENTS

I convey my sincerest sympathies to LX's family. I acknowledge the grief and devastation they have endured as a result of their loss; the impact of LX's death on his loved ones was clear in

[271] See, eg, *Nelson* at [767].

the moving coronial impact statement read out by his stepfather at the conclusion of the Inquest. I acknowledge their tireless advocacy for LX throughout his life and in death and their hope that no other family has to endure the same loss. I thank them for participating in LX's Inquest with such grace, dignity and patience.

I thank Detective Senior Constable Greg Mitchell for his sensitive and considered approach to the role of Coronial Investigator in LX's matter, for the time and effort put into compiling the coronial brief and for his decision to participate in recorded conversations with the Corella Place residents, an approach which proved to be most helpful at Inquest. I also thank him for his ongoing help and responsiveness during the proceedings.

I thank Counsel Assisting Mr Stanton and Ms Buckley, my solicitor Anna Pejnovic and registrar Niels Gabriels, and all Counsel and solicitors representing the interested parties, including VALS and VEOHRC, for their assistance throughout the Inquest and comprehensive and considered submissions, and for their collegial approach throughout proceedings.

I also wish to specifically acknowledge the representation that Ms Livingstone-Clark and Ms Harris, through the Victorian Bar Pro Bono Scheme, provided to LX's family.

ORDERS AND DIRECTIONS

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I order that a copy of this finding be published on the Coroners Court of Victoria website.

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

EC, Senior Next of Kin

Victorian Bar Pro Bono Scheme – Ms Ffyona Livingstone-Clark & Ms Amber Harris of Counsel

The Honourable Sonya Kilkenny, Attorney-General

Russell Kennedy on behalf of the Secretary of the Department of Justice and Community Safety

Victorian Equal Opportunity & Human Rights Commission

Victorian Aboriginal Legal Service

Therapeutic Goods Administration

Detective Senior Constable Greg Mitchell

Signature:

Coroners Court of Victoria

AUDREY JAMIESON

CORONER

Date: 15 April 2026

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

APPENDIX A

Charter of Human Rights and Responsibilities Act 2006 (Vic): Jurisdictional limits of the Coroners Court

Outline of submissions made in the Inquest into the death of LX

1. A significant issue emerged during the inquest about the operation and effect of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**) on the jurisdiction of the Coroners' Court.

2. During Counsel Assisting's opening at the directions hearing on 29 May 2024, it was submitted:

> LX's human rights are likely to be relevant to this inquest when… Your Honour considers potential findings, comments and recommendations under the Coroners Act 2008. As his Honour Coroner McGregor observed when making findings in the inquest into the passing of Veronica Nelson on 30 January 2023, the Charter of Human Rights and Responsibilities Act 2006 (the Charter) is potentially relevant to this proceeding in at least three ways.
>
> First, the application of the Charter to the Coroners Court. Secondly, the application of the Charter to public authorities other than the Coroner's Court. And thirdly, the Charter rights engaged by the factual events in the scope of this inquest. When the Coroners Court is acting in an administrative capacity it is a public authority under the Charter and bound by the obligations under s 38 of the Charter. Further, irrespective of whether it is acting in an administrative capacity, s 6(2)(b) of the Charter applies directly to the Coroners Court to the extent that it has function under Part 2 of the Charter, that is, relating to particular Charter rights and Division 3 of Part 2 interpretation laws including the Coroners Act.
>
> The Coroners Court has clear functions under the right to life, s 9 of the Charter. In addition, the Coroners Court has functions relating to the way matters are conducted including the rights to a fair hearing and equality before the law, ss 24 and 8 of the Charter respectively.
>
> Further, s 32(1) of the Charter provides that so far as it is possible to do consistently with their purpose all statutory provisions must be interpreted in a way that is compatible with human rights. This includes the interpretation of the coronial powers to comment and make recommendations pursuant to ss 67(3) and 72 of the Coroners Act.
>
> It is clear that Corrections Victoria is a public authority and carries the obligations imposed by s 38 of the Charter including when administering Corella Place. These obligations include both acting compatibly with Charter rights and also giving proper

> consideration to relevant human rights unless it could not reasonably [have] acted differently or made a different decision… [I]t is also clear that making a person subject to a supervision order under the Serious Offenders Act will often engage their human rights including the rights of liberty, privacy and freedom of movement.[272]

3. These submissions were grounded in the approach taken by Coroner McGregor in the Inquest into the Passing of Veronica Nelson[273] (**Nelson**) and the Inquest into the Passing of XY[274] (**XY**). It was also reflected in the findings of Coroner English in the Inquest into the Passing of Tanya Day[275] (**Day**). All these inquests concerned the passing of First Nations people.

4. Accordingly, it had been understood in those matters that the Coroners Court may, when the issue properly arises on the evidence and was found to be within scope, make a finding that a person's human rights as protected by the Charter had been breached.[276] This has been regarded as part of the Coroner's preventative role.

5. In the Nelson and XY inquests, there were clear findings of breach.[277]

6. While this Court is not bound to follow the approach in those matters, no appeal on a question of law or judicial review proceeding was commenced in relation to Charter issues by institutional parties, including with regard to the powers of the Coroners Court having regard to the Charter.

7. In the Day inquest, the language of "breach" was not used, but Coroner English found that, amongst other things, "Ms Day was not treated with humanity and respect for the inherent dignity of a human person as required by the Charter".[278]

[272] 29 May 2024, T7.9 – 8.24.

[273] COR 2020 0021. See in particular Appendix A.

[274] COR 2021 003810.

[275] COR 2017 6424.

[276] See, eg, *Nelson* at [39] (referring to *Day*), [78].

[277] See, eg, *Nelson* at p 23 [56]-[60], Findings p 5 [32], [34] ; *XY* at [752]-[753].

[278] At [533].

8. As will be explained below, it was ultimately not in issue from any party in this inquest that the above approach in the Day inquest was within the powers of the Coroners Court.

9. On 3 December 2024, the Court provided the parties with the proposed scope for the inquest, including at (1)(f):

> [W]hether LX's treatment was compatible with the Charter of Human Rights and Responsibilities Act 2006 (Vic), including having regard to the obligations of Corrections Victoria as a public authority, and also having regard to the treatment of people subject to post-sentence detention and/or supervision regimes in comparable jurisdictions…

10. There was a directions hearing on 12 December 2024 where issues of timetabling and scope were discussed.

11. On 24 January 2025, the Secretary to DJCS (**Secretary**) provided written submissions which, in part, addressed Charter issues. In summary, those submissions included:

    (1) The Coroners Court is a public authority and will be acting in an administrative capacity when it determines the scope of an inquest; conducts an inquest; and makes findings, comments and recommendations under the Coroners Act;[279]

    (2) When making findings, comments and recommendations, the Court can consider whether a person's rights were engaged, to the extent that this might be relevant to the Coroner's statutory task.[280] The Coroner may consider whether such rights were relevant to the circumstances in which the death occurred, or assist in understanding the cause of the death.[281]

    (3) Some rights will be relevant to most inquests, including the right to a fair hearing (s 24), the right to life (s 9) and the right to equality before the law (s 8(3));[282]

[279] At [19].

[280] At [24].

[281] At [22].

[282] At [23].

(4) However, the Coroner does not have the power to make a finding, comment or recommendation which states that a public authority has or has not acted unlawfully under the Charter.[283] This is because:

   (i) A legal conclusion made pursuant to s 38(1) of the Charter that a human right has been limited in a manner which is not reasonable and demonstrably justified as set out by s 7(2) of the Charter is a legal test involving questions of proportionality and justification. The Coroners Court does not have the power to make such findings of civil liability, as it is not part of its fact-finding function;[284]

   (ii) Such a power would be contrary to the clear intention of ss 38 and 39 of the Charter;[285]

   (iii) When making findings, comments or recommendations, the Coroners Court is not making a "decision" for the purpose of the Charter (and therefore bound by s 38(1) of the Charter), because there is no decision being made which has a substantive legal effect on a person's, or class of persons', human rights and interests. Accordingly, the procedural obligation under s 38(1) of the Charter does not apply to the Court. Even if it did apply, it would not provide a relevant separate source of power;

(5) Further, the Coroners Court cannot find or make comments that legislation is inconsistent with Charter rights.[286] This is because:

   (i) Only the Supreme Court is empowered to make a declaration of inconsistent interpretation pursuant to s 36 of the Charter;

[283] At [25].

[284] [25](a).

[285] [25](b).

[286] At [26].

(ii) Because of the procedural requirements in light of s 36 of the Charter, if the Coroners Court were to make a declaration, finding or comment that a statutory provision is incompatible with a Charter right, it would subvert the process which the legislature has established; and

(iii) It is not within the Coroner's fact finding role and powers to make a declaration that a legislative provision is incompatible with a Charter right. Rather, it is a legal determination which is the domain of the Supreme Court while exercising judicial power; and

(6) Section 6(2)(b) of the Charter does not impose any additional obligations on the Coroners Court. To the extent that it has an impact on the Court, it would require the Coroners Court to adopt a process that is compatible with the right to a fair hearing in s 24(1) of the Charter, but not directly apply and enforce substantive rights such as the right to life (s 9) or the right to protection of families and children (s 17).[287]

12. Notwithstanding those submissions, the Secretary did not object to item (1)(f) remaining in the inquest scope and did not seek for the wording to be amended.[288]

13. Because of the potential importance of this issue to the coronial jurisdiction, notice was given to the Attorney-General for the State of Victoria and to the Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**). VEOHRC then exercised its right to intervene in the proceeding pursuant to s 40(1) of the Charter.

14. On 24 February 2025, the Victorian Aboriginal Legal Service (**VALS**) was granted leave to intervene in the proceeding and to make limited submissions on this issue given, as outlined above, that previous findings of breach (or findings that a person was not treated in accordance with the Charter) had been made in cases involving the deaths of First

[287] At [30].

[288] At [1].

Nations people in custody, and given the particular relevance of this issue to First Nations peoples.

15. On 7 March 2025, VEOHRC provided written submissions. In summary, VEOHRC submitted:

(1) The Coroners Court is acting "administratively" and is therefore a public authority when conducting an inquest, and bound by the obligations in s 38 of the Charter (agreeing with the Secretary);

(2) However, the consequence of being a public authority is that the Coroners Court is required to act compatibly with human rights and to give proper consideration to relevant human rights when making a decision. Contrary to the Secretary, the Coroners Court is making a "decision" when determining the scope of an inquest and when making findings, comments and recommendations;

(3) The Coroners Court is also a "court" for the purposes of the Charter. Accordingly, pursuant to s 6(2)(b), the Charter applies to the Coroners Court to the extent it has functions under the human rights in Part 2 of the Charter. The Coroners Court plays a critical role in conducting effective investigations into reportable deaths and identifying ways in which preventable deaths can be avoided in the future;

(4) Section 32 of the Charter (**the interpretive provision**) applies to the construction of provisions of the Coroners Act, including with respect to the construction of the powers of the Coroners Court;

(5) Unlike a number of other Australian and overseas jurisdictions, the Coroners Act does not preclude findings that appear to amount to a determination of "civil liability" and there is no basis for reading such a constraint into the Act. A finding, comment or recommendation in the form identified by the Secretary is within the Coroner's powers, subject to the usual requirements that a finding to this effect is sufficiently relevant in a causative sense, and that any such comment or recommendation is sufficiently "connected with" the death; and

(6) The Coroners Court has always had powers to make findings, comments and recommendations as to the adequacy and appropriateness of legislative provisions, subject to the usual requirements that the issue be sufficiently causative of or connected with the death in issue. The Coroner's powers include conducting such an assessment by reference to human rights in the Charter. The fact that the Supreme Court is given an express power to make a formal declaration of inconsistency does not operate to constrain the Coroner's powers to make findings, comments and recommendations in accordance with the provisions of the Coroners Act.

16. By written submissions dated 7 March 2025, VALS took a similar position to VEOHRC on the Charter issues. VALS emphasised the importance of the Coronial jurisdiction after the recommendations of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**). At the time that the Coroners Act was enacted, Parliament plainly intended to give effect to some of the RCIADIC recommendations.[289] In a series of inquests involving the deaths of First Nations people in custody, the Court had made important findings, comments and/or recommendations that included that the conduct of public authorities and/or legislative provisions were inconsistent with the Charter.

17. By submissions dated 11 March 2025, the Family in essence supported the submissions of VEOHRC and VALS.

18. While the Secretary initially sought a preliminary ruling on the Charter issues, I indicated I would not do so. Because of the history of the matter, and in respect to the wishes of the family, the Secretary did not press for a preliminary ruling before evidence was called. Instead, the issue was addressed by legal submissions after the close of the evidence.[290]

19. In part, that approach was taken because, until the evidence had been heard, it was unclear whether there would be any proposed findings of Charter breach (or any findings that a

[289] Parliament of Victoria, Legislative Assembly, Second Reading Speech to the Coroners Bill 2008 (Vic), Attorney-General Hulls, 9 October 2008, 4034-5.

[290] See 12 March 2025, T2.13-21.

person was not treated in accordance with the Charter), and so the issue had not crystalised and any ruling could have been premature.

20. As outlined above, the Secretary had not taken issue with the Charter being potentially relevant in the inquest. During the inquest, issues related to the Charter were regularly raised with witnesses.[291] This included issues such as the obligations of Corella Place staff as public authorities, the adequacy of Charter training, the rights of family members with regard to visitation of residents at Corella Place, and the need to balance the right to privacy of residents with the monitoring and control of dangerous medications such as methadone.

21. After the close of the evidence, the Court received detailed written and oral submissions from Counsel Assisting and the parties on Charter issues.

<u>Summary of Final Charter Submissions</u>

Counsel Assisting

22. By submissions dated 30 September 2025, Counsel Assisting adopted the submissions of VEOHRC, VALS and the Family on the powers of the Coroners Court to make a finding, comment or recommendation which states that a public authority has breached, or that legislation is inconsistent, with Charter rights.[292]

23. Counsel Assisting emphasised that the statement of compatibility and the second reading speech to the *Coroners Bill 2008* (Vic) demonstrated that, amongst other things, it was

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[291] See, eg:

- Michael Jennings, T406.25-409.7; T439.24-440.15; T442.3; and T462.9-464.14
- Daniel Guinane, T364.30-367.7
- Yvonne Pohl, T536.27-537.1
- Scott Turner, T804.10-24
- Zina Krishna, T646.11-21; T695.7-16; T698.5-20
- James Bulger, T887.25-889.30
- Sarah Miles, T1196.26-1200.14

[292] At [327].

intended by Parliament that: (1) the coronial system give effect to the right to life as protected by s 9 of the Charter; and (2) the Act would strengthen the Coroner's prevention role.[293]

24. It was submitted:

> Section 9 of the Charter provides that "every person has the right to life and has the right not to be arbitrarily deprived of life".
>
> The operation and effect of the Charter on the coronial jurisdiction was considered by this Court in the Inquest into the Passing of Veronica Nelson. In short, s 32(1) of the Charter affects the interpretation of the Coroners Act at the outset, including the powers of the Coroner to make findings, comments and recommendations pursuant to ss 67 and 72(2) of that Act.
>
> Further, s 6(2)(b) of the Charter results in it having direct application to the Coroners Court when exercising its functions under Part 2 and Division 3 of Part 3.
>
> Consistently with this approach, and with the clear intention of Parliament, the term "circumstances" in s 67(1)(c) of the Coroners Act and the expression "connected with a death" in s 72(2) of the Coroners Act, while having boundaries, should be construed broadly in order for the Coroners Court to fulfil its vital preventative role when making findings, comments and recommendations.[294]

25. However, it was submitted that it may not be necessary to resolve the issue of whether, and to what extent, the Court was acting in an administrative capacity given then operation of s 6(2)(b) of the Charter.[295]

26. It was submitted that, in LX's matter, many human rights had been engaged. This included his rights to life (s 9), equality and freedom from discrimination (s 8), protection from cruel, inhumane or degrading treatment (s 10), humane treatment when deprived of liberty (s 22), freedom of movement (s 12), privacy including the right to family life (s

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[293] At [33].

[294] At [34]-[37]. Citations omitted.

[295] See n 399. However, to the extent it was necessary to determine, it was submitted that the reasons of Coroner McGregor in the findings into the Passing of Veronica Nelson are correct: see [73]-[74] and Appendix A. See also the findings into the Passing of XY, [55]-[59] and the authorities there cited.

13), and the protection of the family (s 17).[296] However, that did not mean that those rights had been breached.[297]

27. Counsel Assisting submitted:

> DJCS has accepted that there were significant missed opportunities and failings in LX's case. If the Court concludes that LX's death was preventable, and that there are important recommendations that can be made as part of the Coroner's preventative role, then it may not be necessary to go further and determine whether human rights that were engaged in his case were breached (which DJCS submits is beyond power). This will of course depend on considering the submissions of the other interested parties.[298]

28. In light of the evidence, Counsel Assisting raised particular concerns about whether LX's treatment at Corella Place was consistent with the equality right and freedom from discrimination (s 8), especially given his treatment by Ms Krishna who had no training in relation to ABIs and ADHD.[299] It was submitted that this issue should be subject to a recommendation in relation to training, especially given the relatively common occurrence of residents at Corella Place having ABIs and/or intellectual disability. While such a recommendation would be informed by the importance of the Charter right, it was not necessary to make a finding of breach.

29. Further, Counsel Assisting submitted that the current situation with regard to family visits at Corella Place is highly problematic and does engage, and may breach, the rights of residents and their family members to family life and the protection of the family. However, it was noted that whether steps are taken to address that issue depends, in part, on the availability and prioritisation of resources and is a matter for the executive.[300]

30. Having regard to the very unusual circumstances during the COVID-19 pandemic, Counsel Assisting did not advance a submission that LX's rights to protection from cruel,

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[296] At [326].

[297] At [327].

[298] At [331].

[299] At [333].

[300] At [330].

inhuman and degrading treatment, and to humane treatment when deprived of liberty, were breached.[301]

Family Submissions

31. In written submissions, the Family submitted that:

> LX's family maintains the position detailed in the written submissions filed on 11 March 2025, specifically that the Coroner has the power to make a finding that a public authority acted incompatibly with the Charter. This position is consistent with the position taken by Coroner McGregor in the Inquest into the death of Veronica Nelson where his Honour determined that that 'a compatible interpretation of the power conferred by s 67(1) of the Coroners Act 2008 is one that includes investigating breaches of human rights that might have caused or contributed to [the death]'. The approach is also consistent with the preventative role of the Coroner, as was submitted by CA.[302]

32. Further, the Family submitted:

> LX's family submit that at least s 9, s 17, and s 22 of the Charter were breached. However, it is submitted that it is unnecessary for the Coroner to make any finding that a Charter right was breached in this Inquest because the recommendations that are sought do not depend on such findings being made. Consequently, LX's family agrees with Counsel Assisting submission at [331]:
>
> > If the Court concludes that LX's death was preventable, and that there are important recommendations that can be made as part of the Coroner's preventative role, then it may not be necessary to go further and determine whether human rights that were engaged in his case were breached.

Secretary of the DJCS

33. In written submissions, the Secretary maintained her position on the power of the Coroner to making such findings, as detailed in the submissions dated 24 January 2025. It was submitted that, to the extent that any interested party, or the Coroner, proposes such findings should be made, the Secretary would seek to make further submissions on this issue.

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[301] At [332]. In submissions the Family at [193] took issue that a "high threshold" was required to make such a finding, which was addressed by Counsel Assisting in oral submissions.

[302] At [166] (citations omitted).

34. The Secretary also took issue with a submission of Counsel Assisting that "[o]n one view, a coronial finding that a person's death is preventable and that missed opportunities and failings have contributed to that death inheres within it a finding that the right to life has been breached".[303]

Submissions in reply

35. In written reply submissions, and having had regard to the submissions of all parties, Counsel Assisting submitted:

> In relation to the right to life, which is foundational to the Court's purpose, jurisdiction and functions, CA submit that the Court should take an approach consistent with the approach of Coroner McGregor in the Inquest into the passing of Veronica Nelson (who did not make an express finding of breach of the right to life).
>
> Corrections Victoria has a positive duty to protect the right to life of the residents at Corella Place who are in its care. On the facts of this case, LX's right to life was engaged and limited due to several missed opportunities and failings. In those circumstances, it is open to find that this positive duty was not adequately discharged.[304]

36. In her reply, the Secretary maintained her primary submissions and added:

> It being an agreed position that the Coroner should not find in this inquest that there was a Charter breach or Charter unlawfulness, the Coroner should also not make comments that Charter rights have been "breached" , "infringed", subject to "unreasonable limitations"; or that circumstances were "incompatible" with Charter rights. To do so would be tantamount to a finding of a Charter breach or unlawfulness. Such an approach would be apt to mislead a reader of the coronial findings, who would likely interpret the comment of Charter breach as if it were a finding of the Court.[305]

37. Further, the Secretary argued that the right to life does not impose positive obligations,[306] and disputed that any of the rights pressed by the family had been breached.[307]

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303 At [329].

304 Page 3. Citations omitted.

305 At [11].

306 At [13](b). It was submitted that the Family's submission was contrary to the analysis of s 10(b) of the Charter in *Bare v Independent Broad- based Anti- corruption Commission* (2015) 48 VR 129 (*Bare*), [197], [208], [214] (Warren CJ), [457] (Tate JA), [665]-[668] (Santamaria JA).

307 At [12].

Oral submissions

38. The Court was assisted by extensive oral submissions on these issues on 5 and 6 November 2025. What follows does not seek to summarise every submission made. In most part CA and the interested parties maintained the positions in their written submissions.

39. In short compass, the parties made the following submissions.

40. The Secretary submitted that, while the Court could find that human rights were limited by the conduct of a public authority,[308] to make a finding of breach in light of the proportionality analysis required by s 7(2) of the Charter, that was a matter for an adversarial rather than inquisitorial proceeding. This is because the person who is said to have breached the Charter bears the onus of establishing that the limitation was justified. As with a finding involving a doctor who might have been negligent, the Court can make a finding that the authority has "fallen short" of the standard set by s 38, but cannot make a finding of breach. There was no real distinction between making a finding or a comment when it came to these kinds of issues. In that way, a finding about Charter rights could be "a long way down the path", but "short of the destination" of a finding of breach, unlawfulness or infringement.[309] Preferring the language of "relevance" rather than "engagement", the Secretary accepted that the rights protected by ss 9, 13, 17 and 22 were relevant in this matter. However, it was submitted that those rights were not breached.

41. VEOHRC focussed on three issues:

    (1) First, it was pressed that the Coroner has power to make a finding of breach under s 38, and there is no constraint in the Coroners Act, and s 39 of the Charter does not preclude it. Indeed, the only express constraint in the Coroners Act is s 69 (findings of criminal liability). Parliament did not impose a similar constraint in relation to civil findings. There is no reason why the

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[308] Preferring this to the language of "engagement".

[309] T84.2-4.

Court, as has traditionally been the case, cannot consider mixed questions of fact and law. The powers to make findings, comments and recommendations (ss 67(2) and 72 of the Coroners Act) was intended to strengthen the preventative role of the Court and can include the Court considering mixed questions of fact and law. Section 39 of the Charter is relevant when seeking civil remedies in the Supreme Court, but it does not mean that questions of Charter unlawfulness can only be considered in adversarial proceedings. Commonly the Court must consider issues relating to the reasonableness or otherwise in relation to the conduct of public authorities;

(2) Secondly, as a public authority in all respects (noting this was different to what was found to be the case by Coroner McGregor in the Nelson Inquest), the Coroner must give proper consideration to relevant human rights when making decisions (including when making findings, comments and recommendations). When determining whether to make a finding, comment or recommendation, the Court is making a decision, and there is no proper reason to interpret "decision" narrowly;[310] and

(3) Thirdly, the right to life clearly imposes a positive obligation, and this is well understood under international law.[311] There is a positive aspect of the right to protect life, and includes a systems duty and a duty to protect people in the State's care. The case relied on by the Secretary, Bare[312], did not expressly consider the right to life. In any event, in reality, LX was detained and the State had a duty to protect him from harm. Further, Corrections Victoria had an obligation to provide rehabilitation for detainees and a right to family visits under ss 13, 17 and 22 of the Charter.

[310] See, eg, *Castles v Secretary to the Department of Justice* [2010] VSC 310; (2010) 29 VR 141, 184 [185] (Emerton J).

[311] See, eg, *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; United Nations Human Rights Committee, General Comment No 36 on the ICCPR, [25].

[312] *Bare v Independent Broad- based Anti- corruption Commission* (2015) 48 VR 129.

42. VALS focussed on the importance of RCIADIC and its recommendations as relevant to the coronial jurisdiction, and responded to the Secretary's submissions. In short, it was submitted that s 39 of the Charter was irrelevant to this Court's functions, because it cannot grant remedies. It was pressed that the Court was acting in an administrative capacity in all respects and bound by the Charter.[313] Responding to the Secretary's position, it was submitted that Coroner's must regularly consider whether particular standards have been breached when conducting investigations. There are also matters where the Court must consider the adequacy or otherwise of laws when fulfilling its preventative role. With regard to the right to life, whether obligations reside in s 9 or s 38 of the Charter, the Charter defines an "act" as including "a failure to act",[314] and those responsible for LX's care had a duty to act to protect him from harm. Further, it would be strange for this Court, which embodies the obligation of effective investigation into a death under international law, to have to close its eyes to the Victorian Parliament's enactment of those very obligations.

43. The Family maintained that the Court has the power to make findings of breach but did not press for them. The Family sought findings modelled on Coroner English's language in Day. The Family pressed for the Court to find that: (1) LX's right to life was engaged and particularly important for Corella Place residents; (2) his family unit was not protected as required by s 17; and (3) he was deprived of liberty and not treated with humanity/dignity as required by the Charter (ss 21/22), and this included because of the failure to provide him with sufficient access to rehabilitation and treatment services.

44. Counsel Assisting clarified a reference in their written submissions about there needing to be a "high threshold" before the Court could make a finding of Charter breach, and that this was not intended to be different from Briginshaw considerations. It was repeated that it might not be necessary to resolve whether the Court is exercising administrative or judicial power when making findings, comments and recommendations given the operation of s 6(2)(b) of the Charter. With regard to the right to life, it was submitted that this was central to the Court's purpose and functions, and whether the right to life

[313] Citing *Waratah Coal Pty Ltd v Youth Verdict Ltd & Ors (No 6)* [2022] QLC 21 (25 November 2022).

[314] Charter, s 3.

imposed a positive or only a negative duty, it was clearly engaged on the facts of the case in circumstances where LX's death was preventable and there was not enough done by those at Corella Place to protect him from foreseeable harm. Further, it would be open to find that there was a significant "falling short" in relation to the rights of the family given the situation with visitation.

45. In reply, the Secretary submitted that the relevant finding the Day inquest could properly be characterised as a finding of limitation rather than breach, because no s 7(2) analysis was conducted. It was repeated that the Court should be careful about using language that could be regarded as constituting breach, but it was not in issue that the language used in Day was within power. It was submitted that care needs to be taken when considering comparative jurisdictions when there is different statutory language.

46. It should be noted that s 32(2) of the Charter makes it clear that international law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting a statutory provision.