IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005748

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF RUBY-LEE GOLD

Findings of:	Coroner David Ryan
Delivered on:	5 October 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	14-16 August 2023
Counsel Assisting the Coroner:	Fiona Batten of counsel
Chief Commissioner of Police:	Rachel Ellyard of counsel
Melbourne Health:	Paul Halley of counsel
Forensicare:	Erin Gardner of counsel
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Keywords:	Death in care – release from custody – medical transfer

TABLE OF CONTENTS

INTRODUCTION 3
BACKGROUND 3
CORONIAL INVESTIGATION 4
CIRCUMSTANCES IN WHICH DEATH OCCURRED 6
SOURCES OF EVIDENCE 10
SCOPE OF THE INQUEST 11
IDENTITY OF THE DECEASED 11
MEDICAL CAUSE OF DEATH 11
TRANSFER TO SUNSHINE HOSPITAL RATHER THAN NORTHERN HOSPITAL 12
TRANSFER TO AN INPATIENT FACILITY FROM SUNSHINE HOSPITAL 14
CIRCUMSTANCES OF RUBY ABSCONDING FROM SUNSHINE HOSPITAL 15
STEPS TAKEN TO LOCATE RUBY AFTER SHE WAS REPORTED MISSING 15
THE SYSTEM NEEDS TO BE CHANGED 16
FINDINGS AND CONCLUSION 18
COMMENTS 18
RECOMMENDATIONS 19

INTRODUCTION

1. On 28 October 2021, Ruby-Lee Gold (**Ruby**) was 28 years old when she died from injuries she sustained after falling from an overpass on the Calder Freeway in Airport West.

2. Ruby is survived by her mother Debbie Gold, and her siblings Chloe Gold and Robbie Milne.

BACKGROUND

3. Ruby's medical history included schizoaffective disorder and polysubstance abuse. Her condition was complex, chronic and treatment resistant, and she had a history of interpersonal violence. Her treatment had required a number of hospital admissions and she was case managed by the North West Area Mental Health Service (**NWAMHS**).

4. On 31 May 2021, Ruby was remanded in custody at the Dame Phyllis Frost Centre (**DPFC**) after being charged with offences of unlawful assault, theft and offensive behaviour. During her time in custody, she spent periods receiving mental health treatment at the Marmak Unit at DPFC and also at Thomas Embling Hospital. She remained a high risk of interpersonal violence against staff and other residents.

5. Ruby was provided with mental health treatment by the Victorian Institute of Forensic Mental Health (**Forensicare**) while she was in custody at the Marmak Unit and Thomas Embling Hospital. Forensicare psychiatrist Dr Sandeep Kosaraju stated that "*Due to the acuity of her condition and the risk of harm to others throughout her time at DPFC, the view of the Forensicare treating team was that Ms Gold would require compulsory assessment and treatment in an inpatient setting upon release from prison*".[1]

6. Accordingly, it was agreed that when Ruby was released from custody, she would be subject to an Inpatient Assessment Order (**IAO**) under section 28 the *Mental Health Act 2014* (**the MHA**) and transferred to the NorthWestern Mental Health (**NWMH**)[2] inpatient unit at the Northern Hospital. In preparation for Ruby's release from custody, Forensicare staff liaised with her case worker at NWAMHS and the bed manager at the Northern Hospital.

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[1] CB257.
[2] At the time of Ruby's death, NWMH was part of Melbourne Health. It included NWAMHS.

7. Ruby was well known to the NWAMHS, it was her "*home*" designated mental health service, and she had a long history of receiving treatment from them. She was aware of and happy with the plan for her transfer to the Northern Hospital on her release.

CORONIAL INVESTIGATION

Jurisdiction

8. Ruby's death constitutes a "*reportable death*" under sections 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as her death occurred in Victoria and immediately before her death, she was a person placed in custody or care, being a patient detained in a designated mental health service within the meaning of the MHA. Pursuant to section 52(2)(b) of the Act, an inquest was also required to be held which occurred in August 2023.

9. The Coroners Court of Victoria is an inquisitorial court.[3] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

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

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

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

[3] Section 89(4) of the Act.

13. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[4]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[5] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[6]

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

15. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[7] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[8]

16. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[9]

17. A number of factual disputes arose from the evidence given at the inquest. Many of these disputes were exposed by the questioning of the parties in the reasonable pursuit of their interests. However, it has not been necessary to resolve all of those disputes in order to make the findings necessary under section 67 of the Act.

[4] Section 72(1) of the Act.
[5] Section 67(2) of the Act.
[6] Section 72(2) of the Act.
[7] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[8] *Keown v Khan* (1999) 1 VR 69.
[9] (1938) 60 CLR 336.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

18. On 25 October 2021 at around 6.00pm, an IAO was made in relation to Ruby in anticipation of her potential release from custody the following day. A person subject to an IAO must be taken to a designated mental health service as soon as practicable but not later than 72 hours after the order is made. Further, an IAO expires 24 hours after the person is received at a designated mental health service unless it is extended or revoked.[10]

19. On 26 October 2021, Ruby was released on bail pursuant to an order of the Magistrates' Court of Victoria. One of the conditions of bail was that she be transported by ambulance to the Northern Hospital on an IAO.[11] The relevant bail paperwork was finalised at around 4.45pm.[12] In order to comply with the court order, Corrections Victoria were required to release Ruby from DPFC before 12.00am on 27 October 2021.[13]

20. At around 4.25pm, a Forensicare registered psychiatric nurse contacted Ambulance Victoria (**AV**) and requested a non-urgent ambulance transfer to the Northern Hospital with a police escort.[14] The request for the police escort was on the basis of Ruby's history including that she could be violent, impulsive and unpredictable. They also contacted Ruby's case manager at NWAMHS and the bed manager at the Northern Hospital to advise them of her imminent release.

21. At around 5.37pm, an ambulance arrived at DPFC. As it was a non-emergency patient transport, the ambulance was staffed by employees of St John Ambulance Australia. At 5.50pm, Forensicare facilitated a handover to ambulance staff and provided Ruby's discharge paperwork while they awaited the arrival of the police escort.

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[10] CB275-CB276.
[11] CB204.
[12] CB652.
[13] T238.
[14] CB340.

22. Sergeant Daniel Allen, the supervising sergeant (**Caroline Springs 251**) in the Melton Police Service Area, received the request for police to provide an escort for the transfer of Ruby from DPFC to the Northern Hospital. At the time, he only had available to him three police vans to cover the general policing requirements of 31 suburbs and he was not in a position to allocate resources at that stage for the transfer.[15] Accordingly, Sgt Allen advised that he had no units available and that any escort would need to be to the nearest hospital.[16] His understanding was that this was also consistent with the relevant protocol that existed between the Department of Health and Victoria Police. Sgt Allen then put the job on hold.[17]

23. At around 6.52pm, the AV Duty Manager contacted Forensicare and expressed concern that Victoria Police would be unlikely to provide an escort to the Northern Hospital due to resourcing issues. It was her experience that, as a general rule, Victoria Police would only provide an escort to the nearest hospital. She requested that they make inquires with Sunshine Hospital, which was the closest hospital to DPFC, as to whether they could accept Ruby as a patient under the IAO.

24. Forensicare staff subsequently contacted Sunshine Hospital to "*discuss the possibility of Ms Gold being transferred there in an IAO*" and emailed the discharge paperwork to them at 7.26pm.[18] At 7.38pm, the ambulance staff waiting at DPFC advised the AV Duty Manager that they had been notified that Sunshine Hospital was willing to accept Ruby and requested that further inquiries be made with Victoria Police as to whether they could provide an escort in the changed circumstances.[19]

25. At 7.43pm, AV advised Victoria Police that Ruby was now required to be transferred to Sunshine Hospital and the job was allocated to Constables Tea Stewart and Julia Freyne (**Keilor Downs 301**) at 7.46pm. They arrived at DPFC at 8.11pm.[20]

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[15] T75.
[16] It is not clear from the Victoria Police Event Report when this notification occurred but it is likely to have been around 7.00pm which is consistent with the Justice Health records; see CB97; CB263; T59.
[17] CB97; CB108; T52.
[18] CB263-CB264.
[19] CB341.
[20] CB84.

26. At around 8.15pm, the ambulance staff met Ruby at DPFC and they conducted an assessment of her behaviour and risk. Although her behaviour was noted to be bizarre, they did not consider that there was any risk or threat to safety. At around 8.37pm, Ruby was loaded into the ambulance and was noted to be "*cheerful during the transport*". Constable Freyne sat in the front passenger seat of the ambulance on the recommendation of the ambulance staff, while Constable Stewart drove the police vehicle. Constable Freyne observed that Ruby was calm, cooperative and pleasant to deal with and she wanted to avoid any escalation in her behaviour.[21]

27. The ambulance arrived at the Sunshine Hospital at 8.52pm and Ruby was handed over to the staff at the Emergency Department (**ED**) at 9.30pm. This was over four hours after the request for transfer had been made by Forensicare. Ruby was initially agitated and abusive after arriving at the ED but she became calmer and more cooperative after accepting oral medications.[22]

28. Ruby was allocated a space in the ED during her stay at Sunshine Hospital while she awaited transfer to an inpatient facility at a mental health service which could provide her treatment. The ED is managed by Western Health and at the time, mental health services to patients in the ED were provided by NWMH. Ruby was subject to observation by a "*psychiatric special*"[23] while in the ED.

29. Ruby attempted to leave the ED on four occasions throughout her stay.[24] On each occasion staff were able to direct her back to her designated space without incident. At around 12.00am on 27 October 2021, Ruby was moved to cubicle 8, which was near the nurses station and provided relatively good visibility.[25]

[21] CB342; T155; T164.
[22] CB834.
[23] A psychiatric special is a clinician who provides one-to-one observation of an at-risk mental health patient. They are not empowered to physically restrain a patient; T106.
[24] 9.27am on 26 October 2021; 3.30am, 1.44am & 7.47pm on 27 October 2021.
[25] CB66.

30. During her stay in ED, Ruby was relatively calm, voluntarily accepted medication[26] and was open to redirection when she wandered. The MHA required medical staff to use the least restrictive measures that were appropriate in the circumstances. They assessed that she did not require seclusion or physical restraint, which can only be authorised where there is an imminent risk of serious harm.[27]

31. Ruby was reviewed by clinical staff from NWMH at around 12.09pm on 27 October 2021 and a Temporary Treatment Order (**TTO**) was made under the MHA.[28] She was not assessed as a suicide risk. Ruby initially refused to have a Covid test, which was required before she could be transferred to an inpatient facility, but she eventually agreed to a test after 3.00pm on 27 October 2021. It was planned for Ruby to be transported when possible to a NWMH inpatient mental health facility, potentially at Broadmeadows Hospital.[29]

32. Ruby telephoned her sister Chloe on 27 October 2021 at 5.15am and 5.15pm. Chloe recalled that she "*seemed cheerful*" and in a "*positive mood*" but she also told her that "*she had been in a coma for months and months because she had jumped off a bridge*".[30]

33. At around 8.40pm, nearly 24 hours after her arrival at Sunshine Hospital, Ruby was able to leave cubicle 8 and run out of the ED. At that time, staff (including security staff) were attending to a Code Grey[31] incident related to another patient. Ruby was followed by the "*psychiatric special*" and another nurse, and security officers followed soon afterwards. They were unable to catch up with her to negotiate her return before she had left the perimeter of the hospital, heading towards Ginifer Station.[32]

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[26] Diazepam, olanzapine and lorazepam.
[27] CB71: T107
[28] The TTO replaced the IAO subsequent to a statutory review by a psychiatrist.
[29] CB835.
[30] CB34.
[31] A response to actual or potential violent, aggressive or threatening behaviour.
[32] CB66; CB81.

34. At around 9.15pm, Constable Freyne received a call from Sarah Quick at Sunshine Hospital who reported that Ruby had absconded from the ED at around 8.45pm. After getting off the phone with Ms Quick, Constable Freyne called through a KALOF[33] for surrounding police units and completed a missing person's report.[34] She allocated a risk rating of "*medium*".

35. At around 12.52am on 28 October 2021, Ruby attended the 7-Eleven store on the corner of Hoffmans and Keilor Roads in Niddrie. She then walked west along Keilor Road.

36. At around 1.15am, Ruby was observed by a number of motorists to be lying on the Calder Freeway underneath the Matthews Avenue overpass. Phillip Conway contacted emergency services and Rick Infantino commenced cardiopulmonary resuscitation (**CPR**) while they awaited the arrival of AV. Ruby was declared deceased by AV paramedics at 1.50am.

SOURCES OF EVIDENCE

37. Victoria Police assigned Detective Senior Constable Zachary Neale to be the Coroner's Investigator for the coronial investigation into Darren's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief.

38. The inquest ran over three days and evidence was given by the following witnesses:

    (a) Terry Runciman (Forensicare);

    (b) Sergeant Daniel Allen (Victoria Police);

    (c) Sergeant Neil Keltie (Victoria Police);

    (d) Professor Anne-Maree Kelly (Western Health);

    (e) Commander Mark Galliott (Victoria Police);

    (f) Constable Julia Freyne (Victoria Police);

    (g) David Shearer (Ambulance Victoria);

[33] Keep a lookout for.
[34] T167-T168.

(h) Peter Kelly (NorthWestern Mental Health); and

(i) Assistant Commissioner Jennifer Hosking (Corrections Victoria).

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

SCOPE OF THE INQUEST

40. The following issues[35] were investigated at inquest:

(a) The decision to transfer Ruby to Sunshine Hospital rather than the Northern Hospital;

(b) The steps taken at Sunshine Hospital to arrange for Ruby's transfer to an inpatient facility;

(c) The circumstances of Ruby absconding from the ED of Sunshine Hospital; and

(d) The steps taken by Victoria Police to locate Ruby after she was reported missing.

IDENTITY OF THE DECEASED

41. On 8 February 2021, Ruby-Lee Gold, born 21 December 1992, was identified via fingerprint comparison by Coroner Lorenz.

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

MEDICAL CAUSE OF DEATH

43. On 28 October 2021, Dr Chong Zhou, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination and reviewed the results of a

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[35] The scope of the inquest was identified at the directions hearing conducted on 8 March 2023.

post-mortem computed tomography (**CT**) scan. She prepared a report of her findings dated 1 November 2021.

44. Dr Zhou observed blunt force trauma to the head and neck which was consistent with having been sustained in a fall from height. She stated that there were no injuries to suggest secondary impact with a motor vehicle.

45. Toxicological analysis of post-mortem samples detected the presence in non-toxic levels of diazepam (and its metabolite nordiazepam),[36] lorazepam,[37] aripiprazole,[38] olanzapine,[39] haloperidol[40] and zuclopenthixol.[41]

46. Dr Zhou provided an opinion that the cause of death was "*1(a) Multiple injuries sustained in a fall from height*".

47. I accept Dr Zhou's opinion.

TRANSFER TO SUNSHINE HOSPITAL RATHER THAN NORTHERN HOSPITAL

48. It was reasonable and appropriate for Forensicare and NWMH to plan for Ruby to be discharged on an IAO to the inpatient mental health facility at the Northern Hospital upon her release from DPFC. As stated by Peter Kelly, NWAMHS was familiar with Ruby's treatment history and had established a rapport with her; an acute mental health bed was available at the facility and a direct transfer would avoid the busy, less secure and high stimulus environment of an ED; and the ED at Sunshine Hospital was already overwhelmed with a number of acutely unwell persons.[42]

49. Given Ruby's history of violent, impulsive and unpredictable behaviour, I am satisfied that it was appropriate for AV to require a police escort on the recommendation of Forensicare.

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[36] Diazepam is a benzodiazepine indicated for anxiety, muscle relaxation and seizures.
[37] Lorazepam is a benzodiazepine used for the treatment of insomnia and anxiety associated with depressive symptoms.
[38] Aripiprazole is an antipsychotic drug.
[39] Olanzapine is an antipsychotic drug.
[40] Haloperidol is an antipsychotic drug.
[41] Zuclopenthixol is used for the treatment of schizophrenia.
[42] CB224-CB335.

50. It is clear from the evidence of Sgt Allen that he was not in a position on 26 October 2021 to allocate police resources to provide an escort for AV's transport of Ruby from DPFC to the Northern Hospital. He had three vans to cover the general policing requirements of 31 suburbs and he could not justify having one of those vans unavailable for the extended time it would take for a transfer to the Northern Hospital as opposed to the nearby Sunshine Hospital.[43]

51. Sgt Allen stated in evidence that it is Victoria Police practice and policy to transfer a person released from prison on an IAO to the nearest ED. He gave evidence that police would only facilitate an escort to an alternative hospital in a "*one in a thousand*" or "*blue-moon scenario*".

52. Part 4.2.1 of the *Department of Health and Human Services – Victoria Police protocol for mental health (2016)* provides that the transport of a person with an apparent mental illness in a police vehicle, at the request of a mental health clinician, will be to the nearest hospital ED or designated mental health service. This part of the protocol, which is still in force, did not apply to Ruby's transfer on 26 October 2021 because she was not being transported in a police vehicle.

53. Victoria Police has conceded that, while there is no specific policy or other guidance directed to the circumstances of Ruby's transfer from DPFC, the general practice is to provide an escort to the nearest ED or designated mental health service.[44] Commander Galliott stated in evidence that the rationale for this general practice was that the provision of a police escort, as opposed to transport inside a police vehicle, still resulted in the deployment of a police vehicle that would remain unavailable for general policing duties in the relevant police service area.[45]

54. I am not critical of Victoria Police for their general practice of transporting people released from prison on an IAO to the nearest ED or designated mental health facility. It is justified

[43] T54.
[44] CB294.
[45] T142-T143.

given the limited resources available which must be managed and prioritised to provide general policing cover to the community.

55. Given the position of Victoria Police in relation to the allocation of its resources, it was not unreasonable for AV and Forensicare to investigate alternative options (specifically, Sunshine Hospital) for Ruby's admission to hospital upon her release from DPFC in the evening on 26 October 2021. It was unlikely that resources would become available for a police escort to the Northern Hospital prior to 12.00am on 27 October 2021.

56. Nevertheless, it is clear that the ED at Sunshine Hospital was not a therapeutic environment for Ruby while she waited for transfer to an inpatient facility for treatment. As stated in evidence by Professor Kelly, it is noisy, distracting, chaotic, uncomfortable and distressing and that it "*is about the worst place I think you could be with a mental illness*".[46]

57. It is noted that the Victorian Government has funded a number of specifically designed hubs co-located in the EDs of various hospitals for the treatment of patients with issues associated with mental health, alcohol and other drugs. Since Ruby's death, such a hub has been installed at Sunshine Hospital together with a Behavioural Assessment Unit.[47]

TRANSFER TO AN INPATIENT FACILITY FROM SUNSHINE HOSPITAL

58. Once Ruby was transferred to Sunshine Hospital in the evening on 26 October 2021, she effectively lost the bed that was arranged for her at the Northern Hospital inpatient unit. This is because NWMH "*was in extremis*" at the time with around 20 people being cared for in EDs at the Northern Hospital, Sunshine Hospital and the Royal Melbourne Hospital who were also awaiting transfer to an acute mental health bed and who were then ahead of Ruby in the queue.[48]

59. Further, before being transferred to a mental health inpatient facility, Ruby needed to undergo a statutory review of her IAO by a psychiatrist and it was best practice that it

[46] T95.
[47] T232-T233.
[48] CB338; T209; T215; T218.

occurred at Sunshine Hospital and given that Victoria was in the midst of the Covid pandemic, Ruby needed to have a Covid test.[49]

60. There is no evidence that a bed was secured for Ruby at an inpatient facility by the time she absconded from the ED on 27 October 2021. However, after her statutory review, it was planned for Ruby to be transported when possible to a NWMH inpatient mental health facility, potentially at Broadmeadows Hospital. This would have required transport in an ambulance, possibly with a police escort, and would have involved further delay.

CIRCUMSTANCES OF RUBY ABSCONDING FROM SUNSHINE HOSPITAL

61. Ruby left her allocated cubicle in ED while staff (including security staff) were attending to a Code Grey relating to another patient. She was followed out of the hospital by the "*psychiatric special*" and another nurse but they did not have the power to restrain Ruby. The security staff arrived shortly afterwards but Ruby had left the perimeter of the hospital before they could catch up with her. They were not authorised to restrain Ruby once she had left the hospital grounds.[50]

62. I am satisfied on the evidence of Professor Kelly that seclusion and restraint were not justified given Ruby's level of risk while in the ED. She was relatively calm, voluntarily accepted medication[51] and was open to redirection when she wandered. Further, use of such restrictive measures in the circumstances would have been contrary to the objectives of the MHA.[52]

STEPS TAKEN TO LOCATE RUBY AFTER SHE WAS REPORTED MISSING

63. Constable Freyne acted diligently in her response to Ruby being reported as missing from Sunshine Hospital. She called through a KALOF and completed a missing person's report. She had been a police officer for six weeks at the time.

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[49] T231.
[50] T113.
[51] Diazepam, olanzapine and lorazepam.
[52] CB71.

64. With the benefit of hindsight and with her further experience, Constable Freyne conceded that she would have done some things differently. For example, she would have sent a police vehicle to the hospital to attempt to identify next of kin and sought to obtain CCTV from Ginifer Station. Further, identification of Ruby on the missing person's report as an involuntary patient would have increased her risk level to "*high*" which could have authorised the deployment of search and rescue.[53] However, I am unable to conclude that any of these further steps would have resulted in Ruby being located prior to her death.

THE SYSTEM NEEDS TO BE CHANGED

65. The current system for transferring persons released from prison on an IAO to a designated mental health service is by ambulance with Victoria Police providing an escort where required. While not all persons requiring transfer will require an escort, when they do, as clearly illustrated in Ruby's case, this system is not an effective mechanism for timely transfer to the appropriate facility for care and treatment of their mental illness. This has been a systemic issue for over a decade.[54]

66. Victoria Police do not have the resources to provide a timely escort beyond the nearest ED to the relevant prison in the circumstances given its general role to police the community. Victoria Police prioritises the use of its resources according to risk[55] which is a reasonable approach.

67. An alternative approach is for Corrections Victoria (or a suitable contractor, such as G4S) to perform the transport role with clinical support from Forensicare. This would maintain continuity of care and avoid delays associated with reliance on Victoria Police whose resources are subject to competing and draining demands elsewhere in the community. It is accepted that Corrections Victoria also has competing demands on its resources but having managed the person in custody, I consider that they would be better placed to plan in advance for the allocation of resources and to control their effective and timely deployment.

[53] T159-T160.
[54] T32.
[55] T55; T75.

68. One of the alternative options that has been identified is for custodial officers to be prescribed as "*authorised persons*" under the *Mental Health and Wellbeing Act 2022* (**MHWA**) for the limited purpose of transporting persons released from custody on an IAO to a designated mental health facility. This would require legislative reform.

69. The Department of Health considers that this option is not supported under the MHWA as "*prescribing the use of correctional staff in place of health professionals for such a purpose is not in keeping with the Act's principles that require powers to be exercised or informed by health professionals as far as is reasonably practicable in the circumstances*". Further, the Department considers that it may limit relevant rights under the *Charter of Human Rights and Responsibilities Act 2006* (**the Charter**) as the person would remain in custody after their lawful detention had expired for the purpose of transporting them to a designated mental health service. These concerns were also shared by the Department of Justice and Community Safety (**DJCS**).

70. I do not accept that this option would not be supported under the MWHA as the proposed transport by custodial officers could still be informed and supported by Forensicare clinical staff, which was suggested in evidence by Mr Runciman.[56] Further, I consider that any limitation of rights under the Charter would be justified in circumstances where it is to facilitate timely access to involuntary mental health treatment.

71. Another option discussed in evidence by Assistant Commissioner Hosking is for the person requiring transport under an IAO to remain in custody until they arrive at the designated mental health service.[57] The person would legally remain in custody, despite leaving the prison premises, until released from custody by the Secretary to the DJCS under Part 1A of the *Corrections Act 1986*.

72. This may well be the most practical option in the circumstances and it would avoid the issues associated with the Charter which were raised by the Department of Health. DJCS submit that this option may have other potential human rights implications given that it "*would fundamentally require CV to keep the person in custody for longer than they would otherwise*

[56] T39.
[57] T242-T244.

be, for the sole purpose of transporting them".[58] However, I am satisfied that any limitation of rights under the Charter would be justified in circumstances where it is to facilitate timely access to involuntary mental health treatment.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Ruby-Lee Gold, born on 21 December 1992;

    (b) the death occurred on 28 October 2021 on the Calder Freeway in Airport West, Victoria;

    (c) from multiple injuries sustained in a fall from height; and

74. In the circumstances, I am satisfied that Ruby intended to step off the overpass on the Calder Freeway which resulted her falling to the road below. However, given her history of impulsive and unpredictable behaviour, the evidence does not enable me to be comfortably satisfied that she intended to take her life.

COMMENTS

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

75. Ruby needed to be transported upon her release from custody to the Northern Hospital, which was the most suitable place for her to receive effective treatment for her mental illness. The current process in place in Victoria did not enable this to occur in a timely manner and resulted in Ruby being transferred to a busy ED (where she remained for nearly 24 hours before absconding). This was not a therapeutic environment for the treatment of her mental illness and contributed to the systemic problem of overcrowding in emergency departments.

76. The issue of transporting persons released from custody on an assessment order under the MHA to a designated mental health service has been a systemic problem for many years.

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[58] Submissions of DJCS dated 15 September 2023.

The solution to the problem requires the balancing of limited resources and the cooperation and agreement between various agencies within the Victorian Government. There have been recent inter-agency meetings to discuss possible options but as yet there has been no agreed solution.

77. Forensicare has proposed that a further working group be convened with the relevant stakeholders, led by the Department of Health and DJCS, to identify the optimum model to resolve the issue. I consider that the most practical option that emerged from the evidence in this inquest is for Corrections Victoria (or a suitable contractor, such as G4S) to perform the transport role with clinical support from Forensicare. Implementing a practical solution will require cooperation and coordination between the relevant stakeholders which may well be achieved through an inter-agency working group.

78. Whatever option is ultimately agreed upon, Ruby's death provides a clear illustration of the importance of a continued and focussed commitment to identifying and implementing a practical solution as soon as possible.

RECOMMENDATIONS

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

(i) The Department of Justice and Community Safety and the Department Health implement a system to enable Corrections Victoria (or a suitable contractor) to undertake the role of transporting persons released from custody on an assessment order under the *Mental Health and Wellbeing Act 2022* to a designated mental health service.

I convey my sincerest sympathy to Ruby's family.

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

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

Debbie Gold, Senior Next of Kin

Detective Senior Constable Zachary Neale, Coroner's Investigator

Chief Commissioner of Victoria Police

Melbourne Health

Western Health

Forensicare

Ambulance Victoria

Department of Justice and Community Safety

Department of Health

Signature:

Coroner David Ryan

Date: 05 October 2023

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