IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003446

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Jessica Anne Katgert
Date of birth:	2 June 1982
Date of death:	Between 26 and 27 June 2023
Cause of death:	1a: Cardiomegaly
Place of death:	Dame Phyllis Frost Centre, 101-201 Riding Boundary Road, Ravenhall, Victoria, 3023

INTRODUCTION

1. On 27 June 2023, Jessica Anne Katgert was 41 years old when she was found deceased in her cell at Dame Phyllis Frost Centre, where she was remanded into custody. At the time of her death, Jessica lived in Box Hill.

2. Jessica and her long-term partner Steven had twin boys, born in 2004. Jessica had a strong relationship with her sons and was incredibly proud of them.

3. Jessica had an extensive forensic history dating back to 2011. She had been in custody on six occasions, including three custodial sentences imposed by the court.

4. At the time of her death, Jessica was scheduled to appear before the court on 14 July 2023 for charges relating to failure to answer bail, driving, deception, property and drug related offences.

Medical history

5. Jessica's medical history included depression and anxiety, and hypothyroidism for which she was prescribed Thyroxine, though her compliance with this medication was reportedly patchy. She also had a significant history of illicit drug use.

6. Jessica was admitted to St Vincent's Hospital Melbourne (**SVHM**) between 25 September and 13 November 2021 for the management of MSSA infective endocarditis. An echocardiogram showed

    a) Normal right and left ventricular function;

    b) Large aortic valve vegetation;

    c) No significant valvular compromise;

    d) No aortic root abscess;

    e) Normal structure and function of the mitral and tricuspid valves; and

    f) Persistent thickening of aortic valve leaflet with moderate aortic regurgitation and dilated left ventricle and normal systolic function.

7. Jessica was commenced on IV antibiotics and showed clinical improvement. As such, an aortic valve replacement was not indicated at that time.

8. On 13 November 2021, Jessica was discharged home on oral antibiotics. She was referred to the SVHM Infectious Diseases outpatient clinic but was discharged after failing to attend six appointments.

THE CORONIAL INVESTIGATION

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

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

11. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jessica's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Jessica Anne Katgert including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the

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

Circumstances in which the death occurred

14. At 8:25am on 23 June 2023, Jessica was arrested in Doncaster for breaching her bail conditions and failing to appear at her scheduled court appearance. She was compliant at the time of her arrest and there were no issues with her demeanour or behaviour.

15. Jessica was conveyed to the Heidelberg Police Station. On attendance, she was recorded as having an M2 risk rating, denoting a medical condition requiring regular or ongoing treatment and a PA risk rating, denoting a suspected psychiatric condition requiring assessment.

16. Jessica was charged with fail to appear and presented to the Heidelberg Magistrates Court that afternoon for a remand hearing. She was remanded in custody and transported to the Dame Phyllis Frost Centre (**DPFC**).

17. At 6pm on 23 June 2023, Jessica was received into custody at DPFC. She was reviewed by custodial and health staff to whom she disclosed her medical history, including that she had cardiac valvular disease and was on a waitlist for valve replacement surgery at SVHM. It was noted that she held an M2 risk rating. Health staff ordered her medication, referred her for blood pathology testing and sent a request to SVHM and her general practitioner for her health information, though this was ultimately not received prior to her death.

18. Jessica was placed in the cell 49 of the Dawson Unit, single cell accommodation for new reception prisoners.

19. On 24 June 2023, a Registered Psychiatric Nurse conducted a psychiatric assessment. Jessica disclosed drug misuse and advised she had used in the past two-weeks and self-reported a history of anxiety and depression. She denied any history of self-harm or suicide. The nurse made a referral to the Mental Health Outpatient Clinic.

20. On 25 June 2023, health staff initiated an integrated care plan for Jessica in response to her cardiac issues and hypothyroidism, though this was not completed by the time of her death.[2]

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Integrated care plans are required to be established within 29 days of reception.

21. Jessica was last seen at 7:24pm on 26 June 2023, when the evening count was conducted. She did not make contact with anyone overnight.

22. The morning count commenced at 7:45am on 27 June 2023. At 7:50am, custodial staff arrived at Jessica's cell and attempted to rouse her. At 7:51am, they used the intercom to attempt to wake her.

23. At 7:52am, staff unsuccessfully attempted to unlock her door and called for assistance from a Senior Prison Officer. Her door was unlocked and a Code Black activated one minute later. Staff removed Jessica from her bed and placed her in the recovery position on the floor.

24. At 7:56am, Emergency Response Group members arrived and were informed by custodial staff that there were no signs of life. At 7:57am, health staff arrived at the scene and directed the commencement of CPR and the application of a defibrillator. CPR was commenced and an ambulance was called at 7:58am.

25. At 8:10am, paramedics arrived at the scene. CPR was ceased and Jessica was declared deceased.

Identity of the deceased

26. On 29 June 2023, Jessica Anne Katgert, born 2 June 1982, was visually identified by her father, Cornelius Katgert, who completed a Statement of Identification.

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

Medical cause of death

28. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Jessica Katgert on 29 June 2023. Dr Burke considered the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 4 September 2023.

29. The autopsy showed significant heart disease and a heart weight of 565 grams. There was focal fibrosis indicating a prior ischaemic insult. The aortic valve showed fusion of two cusps with calcification resulting in a functionally bicuspid valve.

30. Dr Burke commented that individuals with significant myocardial fibrosis may die suddenly as a result of sudden cardiac arrhythmia.

31. The autopsy showed no evidence of any injury which would have contributed to or led to death, and there was no evidence to suggest that the death was due to anything other than natural causes.

32. Toxicological analysis of post mortem blood samples identified the presence of buprenorphine (~ 2 ng/mL), nordiazepam (~ 0.04 mg/L) and delta-9-tetrahydrocannabinol (~ 67 ng/mL).

33. Dr Burke provided an opinion that the medical cause of death was 1(a) CARDIOMEGALY.

JARO REVIEW

34. The Justice Assurance and Review Office (JARO) conducted a review into Jessica's death.

35. JARO's functions include advising the Secretary to the Department of Justice and Community Safety on the performance of corrections systems, and providing the Secretary with current, objective information on areas of risk, the adequacy of existing controls, and opportunities for improvement by reviewing certain cases, including deaths in custody.

36. JARO noted that Jessica's interaction with medical services at DPFC was minimal due to her only being in custody for four days prior to her death. The engagement of health staff was focussed on risk assessment and canvassing her medical history and medications to ensure continuity of care.

37. JARO concluded that the healthcare and custodial management afforded to Jessica at DPFC was in line with policy expectations and requirements.

38. JARO identified two shortcomings in the incident response, being

    a) The custodial staff who identified that Jessica was unresponsive did not have the keys to open her cell door, causing a small but avoidable delay in entering and calling a code Black. However, this would not have changed the outcome as she was already deceased.

    b) Nursing staff instructed custodial staff to commence CPR even though custodial staff had identified there was no signs of life and there was evidence of rigor mortis. The decision to start CPR was not in line with policy.

39. Corrections Victoria have since updated their policy with the requirement for at least one cell member present during all formal counts to be carrying a cell key.

40. I accept the findings of the JARO review.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jessica Anne Katgert, born 2 June 1982;

    b) the death occurred between 26 and 27 June 2023 at Dame Phyllis Frost Centre, 101-201 Riding Boundary Road, Ravenhall, Victoria, 3023;

    c) I accept and adopt the medical cause of death ascribed by Dr Michael Burke and I find that Jessica Anne Katgert died from cardiomegaly;

2. AND, having considered the available evidence, I am satisfied that there is no causal connection between Jessica Anne Katgert being placed in custody immediately before her death, and her death from natural causes.

3. AND FURTHER, having found that Jessica Anne Katgert died from natural causes, I have determined that section 52(3A) of the Act applies to this matter and it is not necessary for me to hold an inquest into the death.

I convey my sincere condolences to Jessica's family for their loss.

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

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

Ayden & Josh Koo, Senior Next of Kin

Corrections Victoria

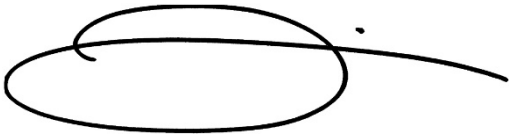
Justice Health

Justice Assurance and Review Office

Meridian Lawyers on behalf of Correct Care Australasia Pty Ltd

Leading Senior Constable Simone Peirce, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 20 May 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an 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.