IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 1114 17 & COR 3579 17

FINDING INTO DEATH AFTER HAVING HELD INQUESTS

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	**Wiki Raymond Lowe** **&** **Noel Thomas**
Findings of:	**CORONER DARREN J. BRACKEN**
Delivered on:	15 July 2022
Delivered at:	Coroners Court of Victoria Kavanagh Street, Southbank
Hearing date:	18 February 2021 – 23 February 2021

Appearances:	Ms M. Isobel - Counsel appeared on behalf of The Secretary to the Department of Justice and Community Safety. Ms E. Gardner – Counsel appeared on behalf of Correct Care Australia. Ms J. Greenham – Counsel appeared on Forensicare. Senior Constable McKenzie appeared to assist the Coroner.

TABLE OF CONTENTS

HIS HONOUR:

SECTION 1 - BACKGROUND

1. Because Mr Lowe and Mr Thomas[1] died, each having hanged himself, within some four months of each other and while they were serving sentences in Karreenga Correctional Centre (a part of Marngoneet Prison) only some 12 months after the prison opened it was thought that there may have been common issues in their deaths. Consequently I held inquests into their deaths consecutively between 18 and 23 February 2021 and have drawn one finding dealing with both deaths.

Karreenga Correctional Centre

2. Karreenga Correctional Centre ("Karreenga") is a medium security facility accommodating approximately 300 'protection prisoners' that opened on 16 September 2016. Karreenga consists of eight accommodation buildings and a separate management unit ("EMU").[2] Each accommodation building consists of six self-contained cottage style units ("Accommodation Units"). Each Accommodation Unit has common areas, a lounge, kitchen etc., and a bedroom for each prisoner. Each is somewhat autonomous in that each is provided with a budget and residents are required to cook for themselves within the confines of the budget.

Mr Lowe

3. Mr Lowe and his partner Ms Leger moved to Melbourne from New Zealand in 2013; they had nine children.[3]

4. At approximately 7.41pm, 7 March 2017, Mr Wiki Raymond Lowe was 35 years old when he was found in his bedroom in one of the Accommodation Units apparently hanged with a shoelace, using a knife secured between the top of his closed bedroom door and the door frame.

5. Prison officers provided CPR until paramedics arrived, but Mr Lowe was unable to be revived and he was declared to be deceased at 8.36pm.

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[1] Also known as Robert Marshall.

[2] The 'Eastern Management Unit'. Prisoners are transferred to the management unit for a number of reasons including if their conduct is considered to require stricter supervision than is in place in the Accommodation Units or there is a concern for their safety including concerns based on risks of suicide or self-harm.

[3] Of which Mr Lowe was the father of eight.

6. On 9 March 2017, Dr Khamis Almazrooei a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine conducted an autopsy on Mr Lowe's body and in a resultant report dated 20 June 2017 opined the cause of Mr Lowe's death was 'hanging'.

Mr Thomas

7. On 23 July 2017, Mr Noel Thomas was 42 years old and attended the 'morning muster' in the loungeroom of the Karreenga Accommodation Unit in which he lived and then returned to his bedroom. For reasons unrelated to his death, two prisoners knocked on Mr Thomas' bedroom door at about 12.30pm and, unusually found the door locked. These prisoners alerted prison officers and shortly afterward Prison Officers Deans and Singh, opened Mr Thomas' bedroom door with a 'master key' discovering Mr Thomas hanging by a sheet made into a noose attached to the bedframe which had been 'stood-up' on one of its ends. Prison officers Deans and Singh cut Mr Thomas down and commenced CPR. Paramedics arrived shortly afterward and took over CPR, to no avail. Mr Thomas was declared deceased at 1.27pm.

8. On 24 July 2017, Dr Bedford a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on Mr Thomas' body and in a resultant report dated 28 July 2017 opined that the cause of Mr Thomas' death was 'hanging'.

9. Many facts surrounding Messrs Lowe's and Thomas' deaths are uncontroversial including:

(i) Their respective medical histories.

(ii) That while in prison they had each sought and indeed had undergone some treatment for mental health issues.

(iii) In the weeks leading up to their deaths, they had both been assessed by a Risk Review Team and their respective 'S Ratings'[4] and regimes of observations, changed.

[4] The Victorian prison system employs a regime of 'ratings' when managing prisoners. A prisoner's M rating represents an assessment of a prisoner's medical conditions, a T rating deals with the level of threats posed to a prisoner by other prisoners, a P rating refer to an assessment of a prisoner's mental health and an S rating deals with a prisoner's risk of suicide or self-harm.

(iv) There was nothing suspicious about their deaths in the sense that there is no evidence of anyone, other than each of them being involved in their respective deaths.

10. There is some controversy about how Messrs Lowe and Thomas 'S Ratings' were assessed and changed and the treatment each of them received having exhibited signs of being at risk of self-harm.

11. Each of Messrs Lowe's and Thomas' deaths constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) ("the Act") because their deaths resulted from injury and occurred while they were each in custody in Victoria.

SECTION 2 - THE PURPOSE OF A CORONIAL INVESTIGATION

12. The Act requires a Coroner investigating reportable deaths to find, if possible:

- The identity of the deceased.
- The cause of the death; and
- The circumstances in which the death occurred.[5]

13. For coronial purposes, "*circumstances in which the death occurred*"[6] refers to the context and background of the death including the surrounding circumstances. Rather than being a consideration of all the circumstances which might form part of a narrative culminating in the death, required findings are limited to those circumstances which are proximate to the death.

14. The coroner's role is to establish facts, rather than to attribute or apportion blame for the death. It is not the coroner's role to determine criminal or civil liability[7] nor to determine disciplinary matters.[8]

[5] Coroners Act 2008 (Vic) preamble; s 67.

[6] *Coroners Act 2008* (Vic) s 67(l)(c).

[7] *Coroners Act 2008* (Vic) s 69(1).

[8] *Keown v Khan* [1999) 1 VR 16.

15. One of the broader purposes of coronial investigations is to reduce the number of preventable deaths in the community, and to that end coroners may report to the Attorney-General on a death,[9] comment on any matter connected with the death including matters of public health or safety and the administration of justice[10] and 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.[11]

16. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities applying the principles of such proof set out by his Honour Justice Dixon in *Briginshaw v Briginshaw*.[12]

17. The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[13] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the finding, and its effect.[14]

18. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[15] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16] Such a description should be interpreted in the context of the coronial jurisdiction being inquisitorial and having nothing to do with guilt or innocence.

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[9] *Coroners Act 2008* (Vic) s 72(1).

[10] *Coroners Act 2008* (Vic) s 67(3).

[11] *Coroners Act 2008* (Vic) s 72(2).

[12] (1938) 60 CLR 336, per Dixon J. pp. 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte; Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 9, 95.

[13] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd. Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70- 171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams*(1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at per Dixon J. pp. 362-3.

[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at per Dixon J. pp. 362-3 ; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

19. Section 7 of the Act sets out the Parliament's intention that coroners liaise with other investigative authorities, official bodies and statutory officers and avoid unnecessary duplication of investigations. I note that the Justice Assurance and Review Office, a 'business unit' of Victorian Department of Justice and Community Safety[17] conducted a 'review' of each of Mr Lowe's and Mr Thomas' deaths and provided copies of resultant Reports to the court.[18] I also note that 'Justice Health', another 'business unit' of the Department of Justice and Community Safety reviewed the health care provided to Messrs Lowe and Thomas and provided the court with copies of resultant documents.[19] I have referred to the contents of these report when necessary.

20. When the Inquest commenced Senior Constable McKenzie read a summary of the material contained in the inquest briefs compiled in relation each of Messrs Lowe's and Thomas' death.[20] Those appearing in court accepted the accuracy of the facts contained in the summary although there were issues raised about the effect of releasing the summary to journalists.[21]

SECTION 3

CIRCUMSTANCES SURROUNDING MESSRS LOWE'S & THOMAS' DEATHS

21. Within the Victorian prison system, prisoners about whom concerns of self-harm or suicide are held are described as being 'at risk'. The process by which a prisoner's 'at risk' status is assessed, recorded and how such prisoners are managed includes prisoners being allocated S (suicide) ratings 1 – 4 and P (Psychiatric) rating 1 – 4.

[17] Now the Department of Justice and Community safety

[18] Lowe-Exhibit 11. Thomas-Exhibit 7

[19] Lowe-Exhibit 12, Thomas-Exhibit 8.

[20] Lowe-Exhibit 2.

[21] T.2-21.

22. In both protocols rating 1 is the most serious and 4 the least. For example, P1 means a serious psychiatric condition requiring intensive and/or immediate care and S1 an immediate risk of suicide while S4 refers to a history of suicide or self-harm and P4 a suspected psychiatric condition requiring assessment. These ratings are set and altered by Risk Review Team Meetings.

Circumstances of Mr Lowe's Death

23. In July 2016 Mr Lowe was interviewed by police, charged with a number of serious offences and remanded in custody.[22] This was Mr Lowe's first time in custody indeed he had no prior convictions in Victoria at all. Subsequently, Mr Lowe was transferred between prisons and on 3 November 2016, whilst in custody at the Hopkins Correctional Centre underwent his first 'at risk assessment'[23] after staff noticed apparent minor cuts on his forearms. When asked by prison officers about these cuts Mr Lowe said that he had written the names of his children on his arms. Mr Lowe was referred to the Health Centre and an 'at risk assessment was conducted' at the Psychiatric Outpatient Department. The assessment[24] refers to Mr Lowe's risk of suicidality, his risk of self-harm, a serious deterioration in his condition and to him being "Low". The assessment describes him as :

> "*Well-spoken and well-presented young man. Emotional due to situation. First time in jail and has not had contact with family. Denies SASH history. Guarantees own safety 100%."*[25]
>
> …..
>
> …"*he has no suicidal ideas nor plans – worried about children….not on medication…*
>
> *…not considered at Risk of SASH*."[26]

24. As a result of the assessment no S or P ratings were instigated.[27]

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[22] The nature of the charges was particularly, upsetting to Mr Lowe.

[23] See 'At Risk Assessment' document pp.339-340 Lowe Inquest Brief. Prior to this assessment Mr Lowe had no S or P rating other rating.

[24] Lowe-Inquest Brief pp.338-341

[25] Lowe-Inquest Brief p.339.

[26] Lowe-Inquest Brief p.341.

[27] Lowe-Inquest Brief p.341.

Evidence of Psychiatric Nurse F. Bronte

25. Subsequently, Mr Lowe went to the Mental Health Nurse Clinic on 4 December 2016 where he saw registered psychiatric nurse Bronte. Nurse Bronte made two statements for the inquest Brief.[28]

26. In her first statement Nurse Bronte refers to having seen Mr Lowe on 4 occasions:

(i) 1 March 2017, Karreenga Prison in a Muirhead Cell

(ii) 2 March 2017, Karreenga Prison.

(iii) 3 March 2017, Karreenga Prison at the Morning Risk Review

(iv) 'Months before at Hopkins Correctional Centre'.

27. In her second statement, Nurse Bronte also refers to having seen Mr Lowe at Hopkins Correctional Centre on 4 December 2016[29] after Mr Lowe referred himself for review '…on the basis of his lawyer's advice'. In her second statement, Nurse Bronte refers to noting during her assessment of Mr Lowe on 4 December that he exhibited signs and symptoms of mild depression and that he did not want to "…*discuss his incarceration per se*." She refers to Mr Lowe's condition warranting "…*a more comprehensive assessment by a psychiatrist*."[30] and notes that Mr Lowe's 'self-reporting' was confined to his low mood and increasing anxiety in relation to his impending sentencing. Nurse Bronte described Mr Lowe as guarded, withdrawn, awkward and warranting further investigation. She did not consider Mr Lowe to be at acute risk of suicide or self-harm and made an appointment for him to see a psychiatrist on 9 December 2016.

28. In her first statement[31] Nurse Bronte refers to being told on 1 March 2017 that she was to perform an 'at risk assessment' of a prisoner who had been placed on an S1 rating and was in a Muirhead Cell under a 15 minute observation regime. Nurse Bronte conducted that assessment at approximately 12.30pm and drew a 'Risk Review' document[32] which includes the results of a Mental State Examination and referred to Mr Lowe being;

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[28] First Statement dated 13 February 2018 (Lowe Inquest Brief pp.43-44.) Second Statement dated 31 October 2018 (Lowe Inquest Brief p.45.). Both Statements are Lowe-Inquest Exhibit 2.

[29] Lowe-Inquest Brief pp.43-45.

[30] Lowe-Inquest Brief pp.45.

[31] Lowe-Inquest Brief pp.45

[32] Lowe-Inquest Brief p.394.

"…*reasonably kempt, settled, subdued, easily engaged, good eye contact, mood:….now understands that refusing to eat would prolong his time in observation cells….strongly denies SASH* [suicide self-harm]…*After RRT, rating decreased S1 to S2 Visual Obs.30/60* [half hourly]….*change from canvass to prison greens…to be reviewed by psych nurse tomorrow and RRT to follow*."

29. Nurse Bronte then refers to reviewing Mr Lowe the next day, 2 March and drawing another 'Risk Review' document[33] in which she recommended that his rating be changed from S2 to S3 and his observation regime be changed to hourly. Nurse Bronte's first statement then refers to her having reviewed him on 3 March and to her having drawn a resultant 'Risk Review' document[34] which recommends his rating be further downgraded to S4. No recommendations for an observation regime are made.

30. Subsequent to Nurse Bronte's assessments on 1, 2 and 3 March, Risk Review Team meetings changed Mr Lowe's S rating, accommodation type and observation regime as recommended by Nurse Bronte.[35]

31. Nurse Bronte gave *viv-a-voce* evidence during which she described her assessment of Mr Lowe in December 2016 as him not being then 'at risk'. When she assessed him in March 2017, he had been allocated an S1 rating and was detained in a 'Muirhead Cell'. She gave evidence that before undertaking this assessment she did not review Mr Lowe's 'J Care notes' or any other 'mental health notes' because she was required to undertake other duties – effectively she was too busy and didn't have time.[36] Nurse Bronte gave evidence that when she saw Mr Lowe on 1 March 2017, she didn't immediately remember having seen him in December 2016 but that he reminded her that she had seen him then.[37]

32. Nurse Bronte gave evidence that she asked Mr Lowe about what had happened since and whether he had seen a psychiatrist because, she said, that she remembered that she had recommended that he do so.

[33] Lowe Inquest Brief pp. 394-398.

[34] Lowe Inquest Brief pp. 399-401.

[35] Modified Risk Management Plans pp. 307-307 Lowe Inquest Brief.

[36] T.65.

[37] T.72.

Nurse Bronte gave evidence that Mr Lowe told her that he had not seen a psychiatrist and that she thought to herself "…*Boy you've deteriorated*" because he looked so different.[38]

33. Nurse Bronte's statements don't deal with her assessments of Mr Lowe in great detail and her evidence of what she remembered of the assessment of 1 March was of what would have happened rather than what did happen, perhaps unsurprising given the time between events and the Inquest. She gave evidence that during the review of 1 March she and Mr Lowe discussed him, not eating while in the Muirhead Cell, his perception that this would lead to him being released from the Muirhead cell. She gave evidence of having told him,

> "…*you realise that if you do things that make us think you're depressed we have to keep this strict level of management…if you're refusing to eat food people think you're depressed you're going to stay in not be sent out.*".[39]

34. She gave evidence that Mr Lowe made very clear to her that he wanted to get out of the Muirhead Cell although she did not remember what he actually said to her that gave her this impression. Nurse Bronte gave evidence that prior to this assessment she was not aware of Nurse Sholakis's 'At Risk Assessment' dated 27 February 2017[40] referring to Mr Lowe having been trying to see a psychiatric nurse and a Psychiatrist since August 2016.

35. When asked whether Mr Lowe's telling her that he wanted to see a psychiatrist was a 'significant issue' Nurse Bronte said that it was not, because he made that request as a result of her asking him 'what can we do for you' (or words to that effect). She gave evidence that Mr Lowe said words to the effect of ' I want to see a psychiatrist – hoping for medication' (or words to that effect).[41] There is no reference to any such conversation in either of Nurse Bronte' statements or the 'Modified Risk Management Plan' dated 1 March 2017.

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[38] T.72.

[39] T.70.

[40] Inquest Brief P.342-343.

[41] T.73.

36. After Nurse Bronte assessed Mr Lowe on 1 March 2017, she, Ms Bluett and Mr Ford drew the Modified Risk Management Plant dated that day and considered it appropriate for Mr Lowe's S rating to be downgraded to S2.[42] Nurse Bronte gave evidence that the relaxation of Mr Lowe's S rating was appropriate because she saw no specific reason to continue with the more strict regime instigated on 28 February and that relaxing his regime was better for his mental health and that "…*absolutely*…" nothing suggested to her that the stricter regime should be maintained.[43] When asked whether, when Mr Lowe was moved to S2 from S1 on 1 March 2017 as a result of the risk assessment then conducted, she was aware that he had been seeking to see a psychiatrist she answered "*I'm aware that he had three months to ask for a psychiatrist and he hadn't, yes.*". Nurse Bronte said that when she saw Mr Lowe on 1 March that he posed no more suicide risk than the majority of prisoners.

37. I asked Nurse Bronte a number of questions about risk factors for suicide between pages 81 and 87 of the transcript. Many of her answers were not always clear. On page 87, I asked Nurse Bronte about her having booked Mr Lowe in on 4 December to see a psychiatrist, the transcript continues

> "…*And were you aware that – on 1 March you're aware that hadn't occurred - Yes, Your Honour*.
>
> *And was that significant, that that diagnostic clarification hadn't occurred on 1 March?--- I thought it reflected a lack of resources rather than a lack of reasonable care.*".

38. 'Reasonable care' is a term often used in civil litigation involving allegations of negligence. As I set-out earlier in this Finding the jurisdiction of this court is strictly limited to establishing facts and excludes consideration of civil liability and that the very nature of investigations undertaken by this court eschews consideration of attribution of blame or liability. It is essential that witnesses understand this, if for no other reason, that it frees them to provide frank and concise evidence.

[42] T77.

[43] T.75.

39. Modified risk management plans dated 2 and 3 March 2017 record Mr Lowe's S rating being reduced to S4 on 3 March 2017 when he was then to 'return to normal prison population.[44]

Mr Lowe's Last Court Appearance

40. Mr Lowe appeared at the County Court in Victoria on 6 March 2017 where he pleaded guilty to a number of serious criminal offences and his sentencing was adjourned to a date to be fixed. Before pleading guilty Mr Lowe obtained legal advice that as a result of pleading guilty, he would be sentenced to a term of imprisonment and how long that term of imprisonment was likely to be.

Evidence of Nurse A. Anthony

41. Mr Anthony, a registered nurse assessed Mr Lowe when he returned from Court on 6 March 2017. Mr Anthony's statement[45] and his evidence set-out his assessment of Mr Lowe as ;

- Bright and cheerful
- Easily engaged
- Responsive and maintaining eye contact,
- Stating that he was OK but tired from a long day at court and wanted to go to sleep.
- Answering that he had no current self-harm or suicidal thoughts , plans or ideas and that he didn't want to see a mental health nurse.
- Not identifying any self-harm thoughts.

42. Mr Antony concluded that Mr Lowe was not at risk of self-harm or suicide.

Events of 7 March 2017

43. On 7 March, Mr Lowe spoke to his sister over the telephone between about 5.34pm and 6.08pm.[46] During those telephone calls Mr Lowe learned that he may be sentenced to a longer term of imprisonment than his legal advice had led him to expect.

[44] Modified Risk Management Plan Wiki Low dated 3 March 2017 p.307 Lowe Inquest Brief.

[45] Mr Anthony provided 1 written statement for the Inquest Brief which was tendered as exhibit 3.

[46] There were actually three calls all of which were recorded by prison resources.

The transcript of the telephone calls makes clear that he is very angry and distressed that he may spend more time in gaol than he expected to. [47] Mr Lowe says

"*There's no f***[48]ing way I'm going to do that f***ing time. It's f***ing bull***...*"…

"*Yeah but f***ing to do 9 years, she's hoping for 9, I thought she was hoping for 7 before. F***ing hell man, it just keeps getting worse and worse eh? I f***ing can't do f***ing 9 years, you have to be f***out of your goddamn mind! So 9 years of my life wasted. I'll be a f***ing old man by the time I get out. F***ing hell."...*

"*You know if this is going to be f***ing its going to be the end of it, then I don't wanna f***ing be living without knowing, huh.*".

44. Mr Lowe asked his sister to speak to another person there present with her. His sister told him that this person didn't want to speak to him. Mr Lowe is angry and concludes the call with:

"*F*** that does it man, I'm not even gonna bother ringing up. Don't f***ing worry about it.*"

45. Mr Lowe was found deceased later that day.

46. Any 'at risk assessment' is ephemeral; a change in any of the circumstances extant when it is made, can undermine, if not invalidate the assessments integrity. Such changes include a person's mental and emotional state as influenced by internal personal factors or external factors, or indeed both. Such changes may not be noticeable. This inherent dynamic quality of assessments makes those having been assessed vulnerable to self-harm post assessment. Some of those who have undergone assessments know the shibboleths, reference to which will result in an assessment conferring maximum liberty. Some have been known to manipulate this process to provide themselves with the time, space and privacy to carry-out a settled self-harm plan.

47. Mr Lowe clearly did not welcome the news that his sister provided over the telephone on 7 March 2017; it clearly greatly upset him.

[47] Lowe Inquest Brief pp.127-140. 'She' in the transcript is a reference to the person who provided advice about sentencing.

[48] The transcript of the telephone calls contains asterixis as set-out here.

He was disgruntled at the prospect of having to spend considerably longer in prison that he had originally thought that he would have to. The transcript reveals that when he was told about the prospect of a longer prison sentence, followed by deportation and further incarceration in New Zealand, he was surprised, angry, distressed, disheartened and distraught. It is likely that resulting impetuousness directed his closely following suicide.

48. Such an experience is likely to have affected the relative equanimity that nurse Anthony saw on 6 March and upon which nurse Anthony based his view.

49. There is no evidence that prison staff knew anything of the contents of Mr Lowe's telephone conversation with his wife or that they should have.

50. I cannot say what, if any difference Mr Lowe having seen a psychiatrist in December 2016 or even early in March 2017 would have made to his actions of 7 March 2017.

Circumstances of Mr Thomas' Death

51. In December 2016, Mr Thomas was interviewed by police and charged with a number of offences. He subsequently pleaded guilty and was sentenced to 12 months imprisonment; he expected to be released on 22 December 2017. This term of imprisonment was the first that Mr Thomas had served in Victoria although not the first time that he had served a custodial term; he had served a considerable period of time in custody in South Australia. After release in or about 22 December 2017 Mr Thomas expected to be arrested and extradited to South Australia to face further charges. As at 23 July 2017, the day of his death, Mr Thomas was about half way through his 12 months sentence.

52. After having been taken into custody by police on 23 December 2016, Mr Thomas was transferred to the Melbourne Custody Centre then the Melbourne Assessment Prison where he presented as distressed, disclosed past suicide and self-harm and a psychiatric history.

53. On 30 December 2016 at the Melbourne Assessment Prison Mr Thomas underwent assessment by a Sentence Management Panel and it was noted that he had;

"…*a significant ongoing psychiatric condition requiring regular monitored psychiatric treatment…downgrades or upgrades only in consultation with mental health professional.*[49]

He was noted to then have S3 and P2 ratings.

54. Mr Thomas underwent a risk assessment on 31 December 2016; a resultant Risk Management Plan noted that he was,

"…*a drug user, able to follow direction…irritable & hostile…unable to asse??...partner unable to visit.*".[50]

55. On 1 January 2017 'Local Plan File Notes' completed at the Melbourne Assessment Prison record Mr Thomas telling prison staff that he was '…discontented with Corrections Victoria and HM Prison Service.' He also expressed his frustration at not being able to access 'bi-polar medication'. He said that he was frustrated that Victorian Prisons could not Adelaide prisons to discuss his medical conditions. Mr Thomas also explained that he was upset because his children had just been taken from him and his partner which, he said, made things worse because his daughter had "…*just been raped.*". Mr Thomas made reference to having tried to hang himself prior to going into prison and his partner having 'cut him down.'. Mr Thomas' ratings of S3 P2 were maintained.

56. On 3 January 2017 Mr Thomas was transferred to Port Phillip Prison where an Interim Risk Management Plan[51] maintained his S3 rating and on 4 January he underwent further assessment as a result of which his S rating was 'reduced' to S4. The Modified Risk Management Plan evidencing this assessment[52] refers to him being,

"…*Well versed in prison life. Happy with court outcome. Making plans for future. Settled well on unit.".*

57. I note that the Interim Risk Management Plan from only the day before refers to him having an extensive prison history in South Australia, his wife and daughter being a protective factor, his partner being unable to visit him and that he was,

[49] Roberts Inquest Brief p.670-674.

[50] Roberts Inquest Brief p.669.

[51] Roberts Inquest Brief p.652.

[52] Roberts Inquest Brief p.660.

"…*easily distressed / emotional while talking about his family guarantees his safety and future focussed.*"[53]

58. On 15 January 2017 Mr Thomas was transferred to Loddon Prison and after only a little more than two months, on 3 March, he was transferred back to Port Phillip Prison. Only two days after that he was transferred to Hopkins Prison and one month later, on 5 June 2017, to Karreenga where he remained until his death. Mr Thomas was transferred between five prisons in seven months.

59. Shortly after arriving at Karreenga, on 17 June 2017, Mr Thomas was found with a bedsheet fashioned into a noose. Other prisoners provided the noose to prison staff and told them that Mr Thomas had had it. An 'at risk assessment' was conducted during which Mr Thomas history of attempting suicide was noted.

The assessment refers to him reporting feeling increasingly depressed over then recent month and he said that the noose wasn't to hang himself with. but was for 'resistance training'. Mr Thomas was allocated an S3 rating.

60. On 18 June 2017 another 'at risk assessment' was conducted and Mr Thomas rating was downgraded to S4.[54] Mr Thomas medical treatment immediately post 18 June 2017 is summarised in the Justice Health Report drawn as a result of Mr Thomas' death.[55]

61. On 16 July 2017 Mr Thomas underwent another 'at risk assessment' and was ultimately allocated an S1 rating, confined to a Muirhead Cell and subject to observation every 15 minutes. His clothes were taken from him and he was provided with a canvass smock, as is usual when an S1 rating is allocated. The Justice health report refers to Mr Thomas having,

"…*expressed vague suicidal ideation but no intent to suicide , with his mood was assessed as labile. Mr Marshall appeared to have longstanding, unresolved personal issues that were exacerbated under stress.*

*It was initially thought that he would be assigned an E*Justice risk rating S2 however as Mr Marshall's mood rapidly changed a decision was made to increase the rating to S1 – at immediate risk of suicide or self-harm – due to signs of impulsivity*.".[56]

[53] Roberts Inquest Brief p.813.

[54] Modified Risk Management Plan Roberts Inquest Brief p.771.

[55] The Report is Roberts Inquest Brief pp.1239-1265. Medical treatment is summarised on p.1246.

62. On 17 July Mr Thomas underwent another 'at risk assessment' during which he reported being more settled but occasionally having fleeting thoughts about wanting to die.

He said explicitly that if he intended to kill himself he would not tell anyone and that if he were to suicide he would hang himself. Mr Thomas also made reference to three previous suicide attempts in the community. A 'Modified Risk Management Plan' dated 17 July at 9.20am nominates Mr Thomas as holding an S1 rating, being resident in an observation cell and requiring half-hourly observations.[57] The treatment plan section of the Plan refers to an S2 rating and half hourly observations.

63. The 'Modified Risk Management Plan' dated 18 July 2017 at 1.00pm nominates Mr Thomas as holding an S2 rating and requires that he be detained in an observation cell. The treatment plan anticipates an S3 rating and hourly observations.

64. The 'Modified Risk Management Plan' dated 19 July 2017 nominates Mr Thomas as being allocated a S4 rating and being returned to 'normal cells'.[58] That Plan also refers to him being;

> "*Warm bright and reactive. Denies SASH. Wants to return to cottages. States he will report if risk escalates.*"

65. It may be difficult to see how anyone could have confidence in what Mr Thomas said given that two days prior he told prison officers that he wouldn't tell anyone if he intended to kill himself and that if he were to kill himself he would hang himself – a task more easily undertaken in 'the cottages' than in a Muirhead Cell. As I have said 'at risk assessments' are dynamic and ephemeral.

66. Mr Thomas was reviewed by consultant psychiatrist Dr Magner on 21 July 2017. During the review Dr Magner denied Mr Thomas' request for a prescription for an antidepressant medication.[59] Further, Dr Magner assessed Mr Thomas for suicide self-harm risk and found him not to be suicidal.

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[56] Roberts Inquest Brief p.1246.

[57] The Requirement for a canvass smock and ¼hrly observations has apparently been removed.

[58] Roberts Inquest Brief p.812.

[59] Forensicare Submissions [35].

67. During his *viva-voce* evidence, Dr Magner said that he probably would have read the comment in Mr Thomas' medical file of 17 July 2007 in which Mr Thomas was recorded as having said that if he intended to kill himself he would not tell anyone. Acting on the results of Dr Magner's review of Mr Thomas, on 22 July 2017 a Correct Care Australasia psychiatric nurse made a referral for Mr Thomas to see a psychiatric nurse one week hence and a follow-up was planned in a week.[60]

68. Mr Thomas hanged himself in his bedroom in his accommodation unit two days later on 23 July 2017.

69. Mr Thomas was known by prison authorities to have attempted suicide in the past and to have at least made reference to intending to do so again during his then current period of incarceration. He had been found in possession of a noose that he had made form a bedsheet but still went from an S1 rating and being resident in a Muirhead Cell clothed in a canvass gown to being back in 'the cottages' with no observations in 3 days.

70. Mr Thomas's letters[61] make it abundantly clear that he could have used the support that could be provided by his wife visiting him.[62] For a period of time at least his wife was in Victoria and her letter to him makes clear that not only was she very keen to visit him but that she tried only to be turned away.[63] Constant transfers between prisons making visits more difficult do not support the protective factors that such visits potentially provide.

The Justice Health Report

71. Justice Health a division of the Victorian Government Department of Justice and Community Safety compiled a report dated 15 September 2017 and concluded that;

[60] Roberts Inquest Brief pp.1246 -1247.

[61] Found after his death.

[62] Thomas Inquest Brief pp.587-596.

[63] Thomas Inquest Brief pp.597.

"*There is nothing to suggest that the healthcare provided to Mr Marshall was not in accordance with the Justice Health Quality Framework 2014. As such Justice Health makes no recommendations for systemic improvements arising from the death of Mr Marshall on 23 July 2017*."[64]

Justice Assurance and Review Office Report

72. The Justice Assurance and Review Office report ("the JARO Report"). The JARO Report canvasses Mr Thomas' incarceration including his transfer between prisons, assessments of his mental and physical states and his medical treatment whilst he was in custody.[65] The JARO report refers to Mr Thomas having been transferred between prisons as being "…*largely unavoidable given his self-reported safety concerns*[66]it does not however deal with the reasons for so many transfers in such a short period of time other than by this brief assertion.

73. The JARO Report sought to analyse:

- The events leading up to Mr Thomas' death including the management of his self-harm risk.
- The incident response and impact of his placement at five different prisons in seven months particularly in relation to the continuity of his case management, information sharing and his access to therapeutic services and
- ongoing challenges faced by the prison, which appear to have manifested as a result of this unique infrastructure and complex cohort.[67]

74. The JARO Report found that:

- The response to, and management of the incident (Mr Thomas' death) met the required standards,

[64] Roberts Inquest Brief p.1247.

[65] Roberts Inquest Brief pp.1575-1610.

[66] JARO Report - Roberts Inquest Brief p.1588.

[67] Roberts Inquest Brief - JARO Report p.1577.

- The decisions around Mr Thomas' placement appear reasonable and appropriate the cumulative impact of these transfers significantly disrupted Mr Thomas' progress through the Victorian prison system and
- Some information about Mr Thomas was not appropriately recorded, accessed or shared meaning that decisions about his management were not always informed by the totality of information held by Corrections Victoria.[68]

75. The JARO Report does not precisely detail what 'the required standards' were or how they were said to be met.

76. The JARO report refers to Mr Thomas having an extensive criminal history in South Australia and of him telling authorities in Victoria when he was arrested that he had breached parole in South Australia for which he expected to be extradited to South Australia when he completed his sentence in Victoria. It refers to Mr Thomas reporting a history of mental health issues including of bipolar affective disorder and substance abuse issues. It refers to Mr Thomas being involved in three …'*self-harm related incidents*…' after being taken into custody in Victoria on 28 December 2016, 17 June 2017 and 16 July 2017.[69]

77. The first of these incidents occurred when Mr Thomas' was received into custody and was noticed to be distressed, he disclosed past suicide and self-harm and his psychiatric history.[70] The second incident, on 17 June 2017 occurred when other prisoners gave prison staff torn bedsheets that had been fashioned into a noose and told prison staff that they were worried about Mr Thomas welfare because he had been acting suspiciously.[71] The third incident, 16 July 2017 occurred when Mr Thomas approached prison staff and told them that he was upset and wanted someone to talk to. During this exchange Mr Thomas told staff that he had self-harmed many times in the past seven years.[72] The JARO Report refers to JARO having obtained Mr Thomas' South Australian Parole Report which provides more information about his mental health and substance abuse than he told prison authorities about.

[68] Roberts Inquest Brief p.1577.

[69] Roberts Inquest Brief p1577. The dates nominated were 28 December 2016, 17 June 2017 and 16 July 2017.

[70] Roberts Inquest Brief p.1590.

[71] Roberts Inquest Brief pp.1590-1591.

[72] Roberts Inquest Brief p.1591.

78. As at July 2017 prison management was aware of Mr Thomas's self-harm history.

79. The JARO Report made six recommendations and raised four matters for consideration.[73]

80. Recommendation five recommends a 'case management handover process to promote a more seamless transition through the system prioritised for prisoners whose placement across the system is transient or complex'. To the extent that this recommendation implicitly asserts that such a process was not in place in 2017, that is surprising. I endorse the establishment of such a process; it is clearly necessary. I note that there is, however, no reference to, for example, explicitly minimising transfers between prisons to circumstances where there is no reasonable alternative.

81. The JARO Report refers to

> "…*In conducting this review, JARO considered Mr Thomas classification and placement across the system, noting his multiple movements between locations contrasted against his relatively short sentence.*"[74]

The meaning and utility of this 'consideration' is not clear nor is the reference to

> "…*Mr Marshall's transient accommodation was largely unavoidable given his self-reported safety concerns.*[75]

82. The JARO Report concedes that Victorian Prisons obtaining prisoners' interstate prison histories and parole reports would assist the sentence management division in achieving its objectives especially in relation to prisoners who present to prison authorities as vulnerable.[76] The JARO Report canvasses Corrections Victoria continuing to

> "…*progress work in relation to obtaining access to interstate criminal histories as a matter of priority.*"[77]

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[73] These Recommendations are numbered 1 – 6 and the Matters for Consideration 1 – 4 in the JARO Report on pages 1578-1579 in the Roberts Inquest Brief. The Recommendations and Matters for Consideration are dealt with in some detail in the JARO Report between pages 1584-1602.

[74] Roberts Inquest Brief p.1586.

[75] Roberts Inquest Brief p.1588.

[76] JARO Report Roberts Inquest Brief p.1588.

[77] This 'work' was said to be as a recommendation made by 'Fulham escapes review'. Precisely what 'Fulham escapes review' is, is not clear form its terms. If the work is only in relation to 'Fulham Prison' or in relation to escapes or something similar it might usefully be extended to circumstances such as Mr Roberts' i.e. where a prisoner has extensive interstate records, a psychiatric history including of suicide attempts and self-harm.

and that progress on the recommendation having been made, although the endorsement of all state and territory jurisdiction may take a year or longer.

83. The JARO Report also refers Karreenga 'enacting' a 'step-down' process when prisoners are moved from the EMU to cottage accommodation, their S rating goes from S3 to S4 and observations are no longer regimented.

84. To the extent that such a process was not in place in 2017; that is surprising particularly in relation to prisoners who have a history of suicide attempts and self-harm and in particular when they have explicitly told prison staff that if they decide to harm themselves or take their own lives they will not tell anyone, as Mr Thomas did.

85. Karreenga has also adopted a process of providing prisoners "…*struggling with issues*…" with referral to Offending Behaviour Programs. The process allows immediate telephone referral and with prisoner consent notes to be made by prison staff.[78] The JARO Report contains reference to the number of such referrals made as at 26 March 2018. Analysis of the utility of these referrals since the process was implemented would allow for its refinement.

SECTION – 4 WRITTEN SUBMSSIONS

86. Forensicare, The Secretary to the Department of Justice and Community Safety and Correct Care Australasia provided written submissions to the court.

Forensicare Submissions

87. The Forensicare submissions deal with the cancellation of the appointment made on 4 December 2016 for Mr Lowe to see a Forensicare psychiatrist on the 9th of December 2016. The submissions assert that the appointment was made by Correct Care nurse Bronte and cancelled by Correct Care psychiatric nurse Skrabl on 9 December 2016 because, according to records, the psychiatrist was not visiting the prison that day. Nurse Skrabl's evidence was that he had no specific recollection of having cancelled the appointment or of having re-booked it. Forensicare submissions assert that that re-booking the cancelled appointment was nurse Skrabl's responsibility.

[78] Roberts Inquest Brief pp.1585-1586.

88. I note that submissions on behalf Correct Care Australasia that Mr Lowe's appointment with the psychiatrist ought to have been rebooked by Correct Care staff when it was cancelled and that human error likely frustrated the appointment being remade. I note too that Correct Care put in place a process aimed at ensuring that the same human error doesn't recur and sought support form Forensicare and Justice Health in this endeavour.[79]

89. I note that Forensicare was provided with funding to employ a mental health nurse to coordinate rescheduling of cancelled appointments and that as at March 2021 Forensicare intended to instigate a pilot programme so far as regional clinical referrals triage and waiting lists were concerned and work with correct care Australasia and Justice health survey as other than regional services were concerned to better coordinate consultant psychiatrist psychiatric registrar and mental health nurse practitioner clinics. The expectation, at least held by Forensicare was that forensic care's clinical coordinator would assume some functions then performed in such coordination.[80]

90. Forensicare submissions deal with Mr Thomas 'at risk' assessments during June-July 2017.

91. Mr Thomas was allocated S3 rating on 17 June 2017 which was reduced to S4 on 18 June 2017[81] and S1 rating on 16 July 2017, accommodated in a Muirhead observation cell and provided canvas smock as clothing.[82] On 17 July 2017 examination by Correct Care Australasia Psychiatric Nurse West reduced Mr Thomas's S rating to S2.[83]

Nurse West again examined Mr Thomas on 18 July and reduced his rating to S3. On 19 July 2017 after another examination by Correct Care Australaisa's Ms Leadbetter, Mr Thomas' S rating was further reduced to S4, he was returned to 'general population' without a nominated observation regime.

92. Forensicare submissions are a little unclear about when Mr Thomas started methadone.

[79] Correct Care Australasia Submissions [22] – [24]. Forensicare Submissions [12].

[80] Submissions on Behalf of Forensicare [12]-[15].

[81] Forensicare Submissions [16]-[18].

[82] Forensicare Submissions [19].

[83] Forensicare Submissions [20].

It's at least possible that he began the process for starting on the methadone program on or about 20 July and was told that because he was then housed in a management unit he couldn't start until the following Monday, 24 July 2017.

93. In any case Mr Thomas was reviewed by Forensicare forensic consultant psychiatrist Dr Magner on 21 July 2017. During the review Mr Thomas asked Dr Magner for a prescription for an antidepressant medication. Dr Magner declined the request and his reasons are set out in the forensic care submissions.[84] Further, Dr Magner assessed Mr Thomas for suicide self-harm risk and found him not to be suicidal. Dr Magner said that he probably would have read the comment in Mr Thomas' medical file of 17 July 2007 in which he was recorded as having said that if he intended to kill himself he would not tell anyone. Acting on the results of Dr Magner's review of Mr Thomas, on 22 July 2017 a correct care Australasia psychiatric nurse made a referral for Mr Thomas to see a psychiatric nurse one week hence.

94. According to Forensicare's submissions, there was no evidence to question Mr Thomas having been categorised as S1 on 16 July 2017 and then reduced to S4 on 19 July 2017 and given the evidence of the various underlying reviews there was nothing improper about the reductions of S ratings.

The Secretary to the Department of Justice and Community Safety - Submissions

95. Submissions made on behalf of the Secretary referred to the Secretary making no criticism of Correct Care's or Forensicare's conduct insofar as Mr Lowe's and Mr Thomas' treatment was concerned.[85]

96. The submissions addressed the pace at which Mr Thomas' S rating was changed during July 2017 asserting that it was not uncommon to see changes occur as quickly as they did in July because 'we' try to make sure that we keep people in the least restrictive regime possible that the approach is to;

> "*…if possible to move them down and out into more normalised accommodation, then of course we'll do that as quickly as we can but it's generally case-by-case.*

[84] Forensicare Submissions [35].

[85] Secretary's Submissions [6].

…it's no secret that the observation cells are actually counterproductive to good mental health.".

At the highest level of at-risk status, confinement, restrictions and monitoring that goes along with that highest level is not therapeutic.[86]

97. The submissions refer to 'Corrections' accepting a recommendation made in the JARO Report that the general manager of Karreenga consider inclusion of any and all relevant staffing incident debriefing activities, especially where the incident involves an area within their remit (for example, where the prisoner has recently been deemed at risk inclusion of staff should be considered). Further, that 'Corrections' communicate to all prisons that where practicable, best practice RRT meetings should include a diverse range of staff, including those directly involved with the business management. The submissions referred to 'Corrections' accepting the recommendation but not acting, other than issuing a reminder of the policy to general managers, senior operations managers and operations managers, on it because it was said that the referred to requirements were in place before the death.[87]

SECTION 5 - CONCLUSIONS

98. The competing imperatives of risk assessment including, on one hand minimising prisoners' exposure to Muirhead cells and onerous monitoring and, on the other, protecting them from the dangers that risks of suicide and self-harm pose, make striking a functional balance a very difficult exercise. The ephemeral nature of risk assessments, to which I have already referred makes such all the difficult. I note the Secretary's assertion in submissions made on her behalf that:

"*…it's no secret that the observation cells are actually counterproductive to good mental health.´*.

Such a recognition speaks loudly to the need to minimise isolating prisoners in Muirhead cells and to find safe alternative methods of dealing with the prisoners who are identified as at risk of suicide or self-harm.

[86] Secretary's Submissions [11].

[87] Secretary's Submissions [17]-[23].

That 'safest' level of protection is apparently broadly considered to be 'counter-productive of good mental' health makes abundantly clear that an alternative is highly desirable.[88]

99. Striking a balance between a prisoner's history including a prisoner having said, as Mr Thomas did, that if he were to take his own life that he would not tell anyone prior and at the same time recognising the ephemeral nature of 'at risk assessments' is obviously fraught and difficult. That a prisoner said to prison staff that if he formulated a plan to take his own life that he would not tell anyone should obviously be taken into account at any subsequent 'at risk assessment'. The very complex balancing exercise at the heart of 'at risk assessments' is made all the more difficult taking into account the essentially ephemeral nature of 'at risk assessment'.

100. Biometric monitoring of prisoners who have recently been allocated an S1 rating and indeed during the time afterward when they are progressing through the ratings to S4 may provide an objective, real time and ongoing check of health and welfare. Such biometric monitoring by currently available devices that people wear, bracelets, rings etc. is now unobtrusive, effective and economical. The details of how such monitoring may be implemented would not be straightforward and may be the subject of objections from various quarters including prisoners themselves.

101. Any such a program would need considerable input from prison medical staff including nomination of which vital signs would be most usefully monitored, how that monitoring would be undertaken, how data would be transmitted to a central monitoring point in each prison, what 'alarms' would need to be incorporated into the process and what ought to occur when an alarm is triggered. For example at the very least a precipitous drop respiration may allow first aid to be provided to a prisoner much more quickly than waiting for happenstance to find the prisoner has attempted to take their own life.

102. Mr Lowe's death was the result of an impetuous decision made after he became aware that he may have to spend a longer time in custody than he first thought and that after he served his term of imprisonment may be extradited. His mental health history and 'at risk assessments' at least indicated that he was at some risk of suicide or self-harm.

[88] Secretary's Submissions [11].

His last 'at risk assessment', or at least the last time his mental state was checked, when he returned from court after having pleaded guilty, was before the telephone calls during which he became aware of the likelihood of a longer custodial term and possible extradition. There is no evidence that between that telephone call and him taking his own life that he acted in any way that should have prompted an 'at risk assessment'. I am unable to say whether if Mr Lowe had seen a psychiatrist as the result of the appoint made by nurse on 4 December 2016 or indeed afterward would have made any difference to Mr Lowe's decision to take his own life.

103. Mr Thomas' death occurred in different circumstances. Mr Thomas had a history of suicide and self-harm. His change in S rating from S1 to S4 and transfer to cottages occurred over four days, on one view quite quickly although not necessarily too quickly. The primary basis upon which changes to S ratings occur is 'at risk assessment' taking into account of course a prisoner's history, particularly history of suicide and self-harm ideation and manifestation. As I set out earlier in this Finding, such assessments are ephemeral. Mr Thomas was assessed by Dr Magner, a psychiatrist after his rating moved down from S1 to S4. Whether Mr Thomas' state of mind changed after this assessment or whether he harboured an intention to harm himself and wanted the 'liberty' of the cottages to affect his intention is now unknowable. There is no evidence that Dr Magner's assessment of 21 July 2017was flawed or inadequate. That said, one way of dealing with the competing interests of prisoner protection and minimising onerous accommodation may be not to slow down the change of S ratings but to increase the monitoring of prisoners as their S ratings are reduced. With this in mind the management plan post S4 allocation canvassed in the JARO Report incorporating the 'Post-observation regime step-down routine'[89] adumbrated in Recommendation 3 and Matter for Consideration 1 commend themselves as indeed does biometric monitoring to which I have referred.

SECTION 6 –

MATTERS IN RELATION TO WHICH FINDINGS MUST, IF POSSIBLE, BE MADE

[89] Appendix 6 to the JARO Report.

104. Having investigated Mr Lowe's death and having held an inquest pursuant to 67(1) of the *Coroners Act* (2008), I find:

(i) The identity of the deceased was Raymond Wiki Lowe born 27 June 1956;

(ii) Mr Lowe's death occurred on 7 March 2017 at Karreenga Prison 1200 Bacchus Marsh Road Lara, Victoria.

(iii) As a result of hanging and in the circumstances set out above.

105. I am satisfied the Mr Lowe acted intentionally taking his own life

106. Having investigated Mr Thomas's death and having held an inquest pursuant to 67(1) of the *Coroners Act* (2008), I find:

(i) The identity of the deceased was Noel Thomas born 27 June 1956.

(ii) Mr Brown's death occurred on 23 July 2017 at Karreenga Correctional Centre, Bacchus Marsh Road, Lara, Victoria.

(iii) As a result of hanging and in the circumstances set out above.

107. I am satisfied the Mr Thomas acted intentionally taking his own life

SECTION 7 - RECOMMENDATIONS

Pursuant to section 72 of the Act I recommend that:

(i) That the Secretary to the Department of Justice and Community Safety investigate the viability and utility of prisons in Victoria each centrally and remotely monitoring the vital signs of prisoners who have undergone risk assessment for suicide or self-harm including the extent to which any such monitoring may reduce the need for prisoners allocated S1 ratings being held in 'Muirhead type' cells.

(ii) That when prison authorities consider transferring a prisoner from one prison to another, that such authorities explicitly consider whether there is any reasonable alternative for dealing with the perceived need for such transfer.

(iii) The Secretary to the Department of Justice and Community Safety ensure that Victorian prisons have timely access to 'interstate' medical records of prisoners in custody in Victoria.

(iv) The Secretary to the Department of Justice and Community Safety facilitate the 'step-down' management plan for prisoners whose S rating is reduced from S3 to S4 as foreshadowed in the JRO Repot into Mr Thomas's death including the use of annexure six to that Report.

(v) The Secretary instigate auditing of the utility and effectiveness of the referral process set out in the JARO Report into Mr Thomas's death for prisoners thought to be struggling with issues to 'Offending Behaviour Programs'.

(vi) The Secretary ensure that a clear line of responsibility is in place for rescheduling cancelled medical appointments in Victorian Prisons taking into account respective prison authorities and all relevant medical services providers. Further that the operation of that 'line of responsibility' is audited for efficient, effective operation.

PUBLICATION

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.

DISTRIBUTION

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

In relation to Mr Lowe

Ms Kirsty Lodger Senior Next of Kin

Correct Care Austral Asia

Sergeant J Johnston Coroners' Investigator

In relation to Mr Thomas

Ms N Borrett	Mr Thomas's partner and senior next of kin.
Mr J King	Robertson Gill Lawyers
Ms E Catford	Victorian Department of Justice and Community Safety
Sergeant A Reyntjes	Coroner's Investigator

Common to Both Deaths

Ms D Coombs	Victorian Department of Justice and Community Safety
Mr E Smith	Landers and Rogers Lawyers
Ms K Dell'Orro	Meridian Lawyers
Ms Nadia Baillie,	Forensicare
Ms Emma Catford	Victoria Department of Justice & Community Safety

Signature:

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DARREN J BRACKEN

CORONER

Date: 15 July 2020.