IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3618

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the death of Joanne Finch

Delivered on:	7 May 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	7 May 2021
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Death in custody; mandatory inquest; family violence; suicide

HIS HONOUR:

BACKGROUND

1. Joanne Finch (**Ms Finch**) was a 42-year-old woman who died in custody whilst on remand at the Dame Phyllis Frost Centre pending criminal prosecution for her involvement in the death of her son, Brodie Moran (**Brodie**).

2. Ms Finch was born and raised in England and travelled to Australia in 2005. Whilst in Australia, Ms Finch met with a former acquaintance, Mr Moran, who was already living and working in Melbourne. Ms Finch and Mr Moran commenced a relationship shortly after and started living together.

3. Ms Finch fell pregnant around mid-2009 and was living with Mr Moran in a property they had purchased in Langwarrin, Victoria. On 5 February 2010, Ms Finch gave birth to Brodie at Frankston Hospital.

4. In 2014, Mr Moran was concerned about his employment in Australia and began looking for work overseas. He secured a job in Shanghai, China and was planning to travel first to settle in and have Ms Finch and Brodie join him the following six months. Mr Moran left Australia at the end of March 2014.

5. Ms Finch ended the relationship with Mr Moran whilst he was in China around July 2015 and decided to remain in Australia with Brodie.

6. In October 2016, Ms Finch met Stephane Lucas (Mr Lucas) whilst working at a local café and moved into Mr Lucas' rental unit at 97 Alma Street, Tootgarook, Victoria shortly after. Ms Finch started working at a local nursery called the Digger's Club.

7. In July 2017, Ms Finch's grandmother died in England and she was reported to have been deeply affected by her loss. She and Brodie went to her grandmother's funeral in August 2017 before and returning to Australia, work colleagues and Mr Lucas observed Ms Finch to be noticeably more depressed, socially isolated and anxious after her return.

8. On Thursday, 8 March 2018, Mr Lucas left the house at approximately 4.45am for work and a neighbour, heard a young boy scream that sounded like Brodie at approximately 5.30am. The neighbour did not hear anything further.

9. At 1.25pm on the same day, Ms Finch contacted emergency services over the telephone and confessed to suffocating Brodie and that she had done this around 5.00am. Ms Finch remained on the phone with the emergency service operator until Police and Ambulance paramedics arrived on scene at her residence on Alma Street, Tootgarook at approximately 1.38pm. Ambulance paramedics found brodie lying in the bottom bunk in a bedroom close to the front door. He was pronounced deceased upon inspection by paramedics and Police arrested Ms Finch and she was conveyed to the Rosebud Police Station. On 9 March 2018Ms Finch was remanded to the Dame Phyllis Frost Centre.

10. Whilst at Dame Phyllis Frost Centre, Ms Finch presented with signs and symptoms of acute grief and a depressive illness. She displayed chronic suicidal ideation with planning and intent, with periods of acute risk. Reviews by a psychiatrist, psychiatric registrar, psychologist and occupational therapist occurred throughout Ms Finch's period of remand. Ms Finch's psychiatric and suicide risk ratings, accommodation, access to personal items (including clothes) and medications were regularly changed based on mental health professional reviews. A safety plan had been developed which included early warning signs and ways that Ms Finch could manage her distress. At the time of her death she was prescribed the antipsychotic olanzapine and antidepressant fluoxetine.

11. The following events were notably recorded between the period that Ms Finch was remanded to Dame Phyllis Frost Centre and the fatal incident:[1]

- On 9 March 2018, Ms Finch was transferred to Dame Phyllis Frost Centre where she was housed in a Muirhead cell[2] on the Marrmak Unit. She was given S1[3] and P1[4] ratings. Ms Finch remained in the Marrmak Unit for the duration of her remand.

- After a review by the psychiatric registrar on 14 March 2018, Ms Finch was given a S2 rating and moved out of the Muirhead cell.

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[1] The following is a summary of the key events from a Death in Custody report dated 7 August 2018 and prepared by Justice Health.

[2] Muirhead cells are observation cells designed to be used when prisoners are showing signs of distress and immediate intention to self-harm. All clothing is removed and in most circumstances, the prisoner is strip-searched, placed into canvas clothing and issued with canvas bedding. The intent of a Muirhead cell is to minimise hanging points.

[3] Suicide ratings are referred to as S ratings and denote the level of observation indicated by clinical assessment. S1 – immediate risk of suicide / self-harm; S2 – significant risk of suicide / self-harm; S3 – potential risk of suicide / self-harm; S4 – Previous history of risk of suicide / self-harm (these prisoners are not considered to be "at risk", their risks are historical only). Prisoners with an S1 rating require custodial observations every 15 minutes, an S2 rating every 30 minutes, and an S3 rating every 60 minutes

[4] Psychiatric ratings are referred to as P ratings and denote the severity of an existing psychiatric condition and required intensity of care and treatment. P1 – serious psychiatric condition requiring intensive and/or immediate care; P2 – significant psychiatric condition requiring psychiatric treatment; P3 – stable psychiatric condition requiring continued treatment or monitoring; PA – suspected psychiatric condition requiring assessment.

- On 18 March 2018, Ms Finch was reported to have attempted suicide by submerging a kettle in water and as a result. Her suicide risk rating was increased to an S1 rating and she was returned to a Muirhead cell.

- On 23 March 2018, a random cell search found a ligature made from ripped towels and plastic tweezers hidden in the collar of a shirt. Ms Finch reported to have made the ligature a week earlier while feeling suicidal and then forgot about it.

- On 28 March 2018, Ms Finch began spending four hours per day outside of the Muirhead cell in preparation for transitioning out of the Muirhead cell. She remained on P1 and S1 ratings.

- On 6 April 2018, Ms Finch was changed to an S2 rating and began spending the day outside the Muirhead cell, returning at night[5].

- On 11 April 2018, Ms Finch transitioned to a standard B side cell but was required to sleep in canvas clothing and was allowed only minimal personal items in her cell.

- On 18 April 2018, she was allowed her own clothing at night and standard bedding.

- On 20 April 2018, a mental health nurse noted that a towel and sheet in Ms Finch's cell were missing the seem/hemmed edge. Ms Finch denied ripping these on three occasions over the following three days and stated that they were torn when she got them.

- On 11 May 2018, a smell of burning plastic was detected outside Ms Finch's cell though the source was not found. Ms Finch was also observed on a chair and it was suspected that she may be looking for a hanging point. She denied lighting a fire and reported to be on the chair to attach a curtain to the Velcro, as she was having trouble keeping the curtain up.

- On 13 May 2018, (Mother's Day) a letter with concerning content was found in Ms Finch's cell and while the content was not documented in her records, it was noted that it did not include current suicidal intent. Ms Finch said that she was writing down her thoughts and did this a month earlier.

- On 1 June 2018, Ms Finch was noted to be asleep in an odd position with a pillow over her head. She was woken and stated that she was unaware of her sleeping position and denied that this was an attempt to harm herself.

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[5] She was allowed her own clothes when outside the Muirhead cell during the day and wore canvas clothing when returning to the Muirhead cell at night.

- On 8 June 2018, Ms Finch advised a psychiatrist that she might attempt suicide if she had access to means and was not under routine observation, but denied current plans.

- On 9 June 2018, Ms Finch was observed to tighten a ligature around her neck. She followed instructions to remove the ligature, was transferred to a Muirhead cell and increased to an S1 rating. Torn clothes and notes to family regarding the division of her assets were located in her cell. The next day she reported that she was just experimenting and had no real intent to suicide but acknowledged ongoing grief and feeling that her family would be better off without her.

- On 14 June 2018, Ms Finch was decreased to a S2 rating and began spending time outside the Muirhead cell during the day.

- On 29 June 2018, Ms Finch attended a court appearance which caused some distress but was relatively uneventful. She was relieved when it was over.

- On 12 July 2018, Ms Finch was moved out of a Muirhead cell to a standard B side cell with Muirhead conditions (including restrictions on clothing, personal items and movement).

- On 18 July 2018, Ms Finch allegedly attempted to place a seatbelt around her neck during transportation. Ms Finch denied this and asked health staff to review CCTV footage and remove this from her notes. Health staff were unable to verify the incident and documentary evidence could not be found. It was noted that if confirmed, such behaviour would automatically result in a Muirhead cell placement. Her management plan was altered to allow her to have clothes during the day and pyjamas during the night (but no bra during the night), have normal bedding and have a book, pen and pad in her cell but no TV, kettle or shower curtain.

- On 23 July 2018, Ms Finch was advised that her request to change her partner's visitation day from Tuesdays to Sundays was denied. Ms Finch was advised that Sundays were family visitation day where children were present and that she was a restricted access prisoner and not allowed around children due to her charges involving a child. On the same day, Ms Finch was reviewed by Forensicare Psychiatrist, Dr Anthony Cidoni, in relation to the availability of a mental impairment defense and she was worried about this review. Dr Cidoni stated that he was cautious that the review would be distressing and discussed her state of mind rather than her offence and reassured Ms Finch that she did not need to explain her offending. Dr Cidoni stated that Ms Finch coped very well with the interview, was grateful, did not express suicidal

ideation and declined additional staff support. She was reviewed by a mental health nurse after these events and no concerns were raised. Ms Finch's solicitor noted no concerns when he phoned her after these events.

- Dame Phyllis Frost Centre is approved to lockdown twice a month for staff training. On 24 July 2018, Ms Finch was unable to be reviewed by a mental health nurse as the prison was in lockdown from 12.00pm to 3.24pm to facilitate staff training. Ms Finch was informally observed by health staff on the unit during the morning with no obvious concerns. The Risk Review Team (RRT)[6] reviewed her management plan and there were no indicators noted by clinical or custodial staff that would change her management plan.

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Ms Finch's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) **(the Act)**, because of her status as a person placed in custody, as she was a murder suspect held on remand at the time of her death and therefore a person in the legal custody of the Secretary to the Department of Justice.[7]

13. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death occurred whilst the deceased was, immediately before death, a person placed in custody or care.

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9]

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[10] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[11] or to determine disciplinary matters.

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[6] **Risk Review Team (RRT)** is a multidisciplinary team which coordinates the management of prisoners assessed as at risk of engaging in suicidal behaviour. The RRT ordinarily comprises of health and custodial staff. The RRT meets daily to review the management plans of at-risk prisoners and are responsible for raising or lowering a prisoner's S rating.

[7] Section 4(2)(a) *Coroners Act 2008*

[8] *Coroners Act 2008* (Vic) s 89(4),

[9] *Coroners Act 2008* (Vic) preamble and s 67.

[10] *Keown v Khan* (1999) 1 VR 69.

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

16. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

17. For coronial purposes, the phrase "*circumstances in which death occurred,*"[12] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

18. 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 Court's "*prevention*" role.

19. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[13]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[14] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15] These powers are the vehicles by which the prevention role may be advanced.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[16] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[17] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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12 *Coroners Act 2008* (Vic) s 67(1)(c).
13 *Coroners Act 2008* (Vic) s 72(1).
14 *Coroners Act 2008* (Vic) s 67(3).
15 *Coroners Act 2008* (Vic) s 72(2).
16 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
17 (1938) 60 CLR 336.

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

21. On 25 July 2018, Stephane Lucas visually identified the deceased to be his former partner Joanne Finch, born 10 March 1976.

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

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

23. Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Ms Finch and provided a written report of her findings dated 9 October 2018.

24. Dr Baber commented on the following:

    (a) that external examination of the body showed findings in keeping with the clinical history; and

    (b) that examination of post mortem CT scans showed that the hyoid and laryngeal skeleton were intact and nothing else of note was identified.

25. Dr Baber concluded that a reasonable cause of death was:

    I(a) Neck compression due to self-suspension

26. Toxicological analysis of post-mortem specimens revealed the presence of therapeutic concentrations of fluoxetine and olanzapine and no alcohol.

27. I accept the cause of death proposed by Dr Baber.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

28. On 24 July 2018, CCTV footage showed custodial staff unlocking and opening cell doors at 3.52pm.[18] At 3.55pm, CCTV footage showed Ms Finch collecting a meal, placing it in the fridge and returning to her cell at 3.57pm.[19]

29. Ms Finch was documented to be observed in the lounge area at 4.00pm. At 4.22pm, 4.23pm and 4.25pm, CCTV footage captured Ms Finch's cell door opening and closing but due to the camera placement, it could not be seen if anyone entered or left the cell.[20] Between 4.35 and4.36pm, CCTV captured prison officers opening Ms Finch's cell door and then closing the door.[21]

30. At 5.00pm two custodial staff noticed a sheet protruding from the door of Ms Finch's cell. Custodial staff lifted the observation curtain of the cell and saw the back of Ms Finch's head. The door was initially unable to be unlocked as it was locked with the privacy lock, however one minute later a senior prison officer attended and unlocked the door.[22]

31. When the cell door was unlocked, Ms Finch's body was reported to have fallen to the ground and a ligature was observed to be tied around Ms Finch's neck.[23] Custodial nurses attended the cell and commenced cardiopulmonary resuscitation whilst Ambulance paramedics were called to attend. Custodial staff in attendance noted that no breathing apparatus or defibrillator was immediately available.[24]

32. Paramedics arrived at 5.15pm and Ms Finch was pronounced deceased at 5.44pm.[25] The available evidence suggests that the door jamb was the ligature point and torn bedding was used as a ligature.[26]

FURTHER INVESTIGATIONS AND CPU REVIEW

33. In light of Ms Finch's death occurring in circumstances where she died whilst in custody and received proximate mental health care and emergency health care, I requested that specialists

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[18] *Coronial Brief*, Exhibit 13 – Discs containing CCTV footage
[19] Ibid
[20] Ibid
[21] Observation records documented custodial observations at 4.00pm and 4.30pm, consistent with CCTV footage.
[22] *Coronial Brief*, Statement of Eva Pasnin dated 24 July 2018, 34
[23] Ibid
[24] *Coronial Brief*, Statement of Dr Leah Caroline George dated 1 August 2018, 42
[25] Ibid
[26] Ibid

from the Mental Health Team and Health and Medical Team from the Coroners' Prevention Unit (CPU)[27] examine the circumstances of her death.

Mental health investigation and history

34. I directed mental health specialists within the CPU to review the mental health services that had proximate contact with Ms Finch including her mental health treatment while at Dame Phyllis Frost Centre.

35. Ms Finch was accommodated in the Marrmak Unit for the duration of her stay, either in a Muirhead cell or B side cell. She fluctuated between S1 (immediate risk of suicide) and S2 (significant risk of suicide) ratings.[28]

36. Ms Finch was discussed daily at the RRT meetings, as is required for all prisoners who are considered at risk of suicide (S1, S2 or S3 ratings). Her S rating, accommodation and management plan (including medication and restrictions on movement and items) were regularly reviewed and changed depending on her presentation and needs. Even when denying suicidal ideation, Ms Finch was still considered to be at risk of suicide based on the nature of her offending, her grief and potentially upsetting events (such as court dates and Mother's Day).

37. Custodial and health staff were suspicious that Ms Finch was considering or engaging in suicidal behaviours even when she denied this, and these suspicions were documented and considered in risk assessments.[29] When deemed suitable for less restrictions, this occurred in a graduated fashion by allowing her to have brief periods outside the Muirhead cell, transitioning to a B side cell but with Muirhead conditions, and gradually reintroducing personal items that may be used to harm herself (such as electrical items, a chair and shower curtain).

38. The negative impact of management in a Muirhead cell was noted; the environment was isolating and Ms Finch would be less likely to be honest about her thoughts and intentions if the response was to implement a more restrictive regime. Nevertheless, there was evidence

[27] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[28] Justice Health – Death in Custody Report dated 7 August 2018, 4
[29] Justice Assurance and Review Office Report – Review into the death of Ms Joanna Finch at Dame Phyllis Frost Centre on 24 July 2018 dated 29 July 2019, 17

that the RRT made attempts to balance Ms Finch's safety needs with the therapeutic impact of these restrictions when deciding to transition her in and out of a Muirhead cell.[30]

39. Ms Finch was also discussed at eight internal case conferences, which highlighted that she was acutely suicidal, would suicide if she had the means, that these feelings were worse at night, that she presented as "calculated" and continually tested processes.[31]

40. Ms Finch was regularly reviewed by a psychiatrist, psychiatric registrar, psychologist and psychiatric nurses. She chose to cease engaging with the psychologist after 4 July 2018 as the psychologist was leaving and Ms Finch preferred to await the new psychologist rather than sharing her thoughts with a psychologist who would be leaving. She also attended various groups facilitated by an occupational therapist, including therapeutic groups such as mindfulness, sensory modulation, and communication and interaction skills, as well as, recreational groups such as cooking, pamper sessions and crafts.

41. Ms Finch's S rating was most recently decreased from S1 to S2 on 14 June 2018, and over the following month she transitioned from a Muirhead cell to a standard B side cell. She had been in a B side cell with regular clothing and bedding for a week prior to her death. The available information indicated that her risks had reduced and therefore a reduction from S1 to S2 was reasonable.[32]

42. There were no confirmed suicidal behaviours or preparatory acts after being reduced from S1 to S2 and moved out of the Muirhead cell. There was suspected suicidal behaviour which Ms Finch denied and that was unable to be corroborated.[33] Continuing a S2 rating acknowledged that she remained at significant risk of suicide despite her denial of suicidal ideation and it was reasonable that she remained in a B side cell where a higher level of care was provided. In the absence of evidence that she was at immediate risk of suicide, there was no indication that Ms Finch required transfer to a Muirhead cell (where there are no ligature points) and, as previously indicated, the use of the two Muirhead cells at Dame Phyllis Frost Centre is for the purpose of monitoring immediate safety and does not have therapeutic value.[34]

43. On the day of her death, Ms Finch was observed by custodial staff at 3.52pm and 4.35pm and was found hanging at 5.00pm. This was in accordance with the 30-minute custodial

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[30] Ibid, 18
[31] Ibid, 15-17
[32] Justice Health – Death in Custody Report dated 7 August 2018, 8
[33] Ibid
[34] Justice Assurance and Review Office Report – Review into the death of Ms Joanna Finch at Dame Phyllis Frost Centre on 24 July 2018 dated 29 July 2019, 18

observations required for prisoners on an S2 rating. Ms Finch was not reviewed by mental health staff on the day of her death due to a lockdown. Any review by mental health staff on that day would have been as a routine part of her management plan, as custodial staff did not note any concerning behavioural that would warrant additional mental health review.

Health and Medical Investigations Team (HMIT) review

44. I directed medical specialists within HMIT as part of the CPU to also review the resuscitation attempt by custodial staff at Dame Phyliss Frost Centre prior to the arrival of Ambulance paramedics.

45. At approximately 5.00pm on 24 July 2018, staff members conducting routine observations found Ms Finch hanging from the door jamb of her cell. Ms Finch fell to the ground when the cell door was opened. A code black was called, and Cardiopulmonary Resuscitation **(CPR)** commenced by two psychiatric nurses and a psychiatric registrar. Issues were raised regarding availability of resuscitation equipment. Ambulance Victoria **(AV)** paramedics arrived at 5.15pm.[35]

46. The outcomes of Out of Hospital Cardiac Arrest **(OHCA)** are very poor with less than 10% of patients surviving.[36] In general terms a '*shockable rhythm*' means ventricular fibrillation which is usually the result of a heart attack. Cardiac arrest because of hanging would almost always result in a non-shockable rhythm. The chain of survival is an internationally recognised initiative which involves early access to help, early CPR, early defibrillation, and early access to advanced cardiac life support.

47. The CPU found that prison staff did a good job in the resuscitation attempts given this emergency would be an infrequent event. The stress and anxiety to staff in this situation should not be underestimated. There was an early call for help with emergency services called at 5.03pm, CPR was started immediately by the psychiatric nurses and registrar.[37]

48. In Basic Life Support training the emphasis is on cardiac compressions rather than ventilations. The Australian and New Zealand Committee on Resuscitation (ANZCOR)[38] guidelines state '*...all persons should perform chest compressions for all persons who are*

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[35] Statement of Dominique Madelaine Batten dated 5 August 2018, 1

[36] St John Victoria, *The latest cardiac arrest survival rates* (11 February 2019), available online at: https://www.stjohnvic.com.au/news/cardiac-arrest-survival-rates-victoria/

[37] Statement of Dominique Madelaine Batten dated 5 August 2018, 1; *Coronial Brief*, Statement of Dr Leah Caroline George dated 1 August 2018, 42

[38] The Australian and New Zealand Committee on Resuscitation guidelines (2016), available online at: anzcor-guideline-6-compressions-jan16.pdf

unresponsive and not breathing normally...those who are trained and willing to give rescue breaths do so...'

49. There was a short delay in the breathing apparatus arriving on scene which given the timeline of events would be estimated at two or three minutes. The CPU did not consider this would have affected the final outcome given that CPR was in progress and the prognosis of an OHCA in a non-shockable rhythm is very poor. The CPU notes a barrier mouthpiece was available and Ambulance Victoria paramedics arrived on scene very quickly.

50. I confirm that a formal debrief was conducted by the general manager of the Dame Phyliss Frost Centre on 6 August 2018, which included a review of the circumstances of this case and the response to a cardiac arrest. There was a recommendation to follow up and ensure appropriate equipment, such as a self-inflating bag mask for ventilation, was made available as soon as possible in the Mental Health precinct of the facility.

JARO and Justice Health reviews

51. Following Ms Finch's death, a Death in Custody report was produced by Justice Health[39] and a formal review was conducted by the Justice Assurance and Review Office (JARO).[40]

52. The JARO and Justice Health reviews into Ms Finch's death did not identify any prevention opportunities. The JARO review identified areas requiring closer examination (use of body worn cameras, prisoner exposure to the incident and staff debriefing), however these were not directly related to Ms Finch's management or her death.[41] The process of strip-searching was also examined by JARO, as Ms Finch's frequent changes in accommodation and clothing requirements meant that she was subject to regular strip searches.

53. While a review of strip-searching procedures would likely be beneficial, it cannot be concluded that changes to strip-searching procedures would have prevented Ms Finch's death. Given Ms Finch was suspected of engaging in suicidal behaviours which she later denied, regular strip-searches likely reduced her access to means. Ms Finch identified that suicidal thoughts and behaviours were precipitated by auditory hallucinations and grief over the loss

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[39] Justice Health is a business unit of the Department of Justice and Regulation with responsibility for the delivery of health and alcohol and other drug (AOD) services for prisoners across Victoria's prison system. Justice Health sets the policy and standards for health care and AOD services and programs in prisons, monitors the delivery of health care and AOD programs and contract manages the health service providers in public prisons.

[40] The Justice Assurance and Review Office (JARO) is a business unit within the Department of Justice and Community Safety (DJCS). It operates as an internal review and assurance function to advise the Secretary, DJCS on the performance of the youth justice and corrections systems.

[41] Justice Assurance and Review Office Report – Review into the death of Ms Joanna Finch at Dame Phyllis Frost Centre on 24 July 2018 dated 29 July 2019, 12-13 and 19-20

of her son and there was insufficient evidence that regular strip-searches contributed to her suicide.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

54. Ms Finch was treated for mental illness by her GP prior to the fatal incident and did not have contact with public mental health services. After allegedly murdering her son, she was accommodated at the Marrmak (mental health) unit of Dame Phyllis Frost Centre whilst awaiting trial. She was treated with olanzapine and fluoxetine during the period of her remand.[42]

55. The mental health treatment provided at Dame Phyllis Frost Centre appears to have been reasonable. Regular risk assessments were completed which were comprehensive and recognised Ms Finch's chronic suicide risk given the nature of her offending, regardless of whether she actively voiced suicidal ideation or engaged in suicidal behaviours. Her management plan was regularly reviewed and altered to reflect her level of risk. In the weeks before her death, Ms Finch's mental state and risks appeared to slightly improve. Ms Finch consistently denied suicidal ideation, there had been no confirmed suicidal behaviours and she was happy and excited about her progress and reducing restrictions. She also participated in the group programs available to her, both therapeutic and recreational.

56. As there was no evidence that Ms Finch was at immediate risk of suicide, it was reasonable that she had standard clothing and bedding and it was also reasonable that she was accommodated in a standard B cell where some ligature points would be present, such as the door jamb, but where a high level of support and observation was available. Custodial observations occurred as required and this was confirmed with CCTV footage. While a mental health review did not occur that day, this was reasonable in the circumstances and is unlikely to have contributed to her death.

57. The circumstances surrounding the resuscitation attempt were reviewed by medical specialists from the HMIT in CPU and there were no identifiable issues with the resuscitation attempts prior to Ambulance paramedics arriving and taking over the resuscitation attempt.

58. I find that the circumstances of Ms Finch's death and a thorough review of all the available evidence did not identify any prevention opportunities. I am satisfied that no further investigation is required in this case.

[42] Justice Health – Death in Custody Report dated 7 August 2018, 3

FINDINGS AND CONCLUSION:

59. Having held an inquest into the death of Ms Finch, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased was Joanne Finch, born on 10 March 1976;

    b) That the death occurred on 24 July 2018 at the Dame Phyllis Frost Centre, 106-162 Riding-Boundary Road, Deer Park, Victoria from I(a) Neck compression due to self-suspension; and

    c) That the death occurred in the circumstances set out above.

60. I convey my sincerest sympathy to Ms Finch's family.

61. Pursuant to section 73(1) of the Coroners Act 2008, I order that this finding be published on the internet.

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

Mr Stephane Lucas, Senior Next of Kin

Dr Neil Coventry, Office of the Chief Psychiatrist

Ms Kellie Dell'Oro, Meridian Lawyers

Ms Hannah Jankiewicz, K&L Gate Lawyers

Ms Nadia Bailie, Forensicare Victoria

Ms Lisa Homatopoulos, Manager, Operations Directorate – Custodial Division, Corrections Victoria

Detective Acting Sergeant Nathan Johnstone, Coroner's Investigator

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date: 7 May 2021

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.