IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0657

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	Katherine Lorenz, Coroner
Deceased:	BCA
Delivered on:	21 October 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	20 October 2021
Police Assistant to the Coroner:	Senior Constable Jeff Dart, Police Coronial Support Unit

INTRODUCTION

1. BCA was 26 years old at the time of his death and was undergoing a sentence at Langi Kal Kal prison for child pornography offences.[1] BCA had been sentenced to five years and six months imprisonment with a three year and three-month non-parole period. At the time of his death, BCA had more than two years left on his non-parole period.

THE PURPOSE OF A CORONIAL INVESTIGATION

2. BCA's death was reported to the Coroner as he was person in care or custody immediately before his death, and so fell within the definition of a reportable death in the *Coroners Act 2008* ***(the Act)***.

3. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the deceased was, immediately before death, a person placed in custody or care. As BCA was a prisoner detained at Langi Kal Kal prison at the time of his death, he is deemed to be a person placed in custody or care.

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] 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.[3]

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[5] or to determine disciplinary matters.

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

7. For coronial purposes, the phrase '*circumstances in which death occurred*,'[6] 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

[1] Leap Criminal record, Coronial Brief (CB) 394.
[2] Section 89(4) *Coroners Act 2008* (Vic).
[3] Preamble and section 67 *Coroners Act 2008* (Vic).
[4] *Keown v Khan* (1999) 1 VR 69.
[5] Section 69(1) *Coroners Act 2008* (Vic).
[6] Section 67(1)(c) *Coroners Act 2008* (Vic).

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. 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.

9. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[7] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[8] 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.

10. Coroner Bracken originally had carriage of this investigation. It was transferred to me after my appointment as a coroner on 8 February 2021.

The position of persons in custody or care

11. All deaths of persons deemed to be in the care or custody of the State are reportable no matter what their cause. Further, whereas a coroner usually has a discretion as to whether to hold an inquest into a reportable death, a coroner is obliged to hold an inquest into the death of a person in custody or care unless the death was due to natural causes. BCA's death was clearly not from natural causes and so an inquest was mandatory.

12. The reason for this different treatment is to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

13. Prisoner deaths are not only investigated by coroners, but they are also routinely reviewed by an arm of government called the Justice Assurance and Review Office (**JARO)**. The JARO is a part of the Department of Justice and Community Safety (**DJCS**) and reports to the Secretary of that Department, as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders.[9]

[7] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[8] (1938) 60 CLR 336.
[9] Section 7 of the *Corrections Act 1986.*

14. In preparing its report for the Secretary, the JARO invariably has regard to a separate report prepared by Justice Health, another business unit of DJCS. Justice Health has responsibility for the delivery of health services (including drug and alcohol services) to Victoria's prisoners. It contracts out the delivery of primary health care in Victoria's 14 public prisons, including the Langi Kal Kal, to Correct Care Australasia Pty Ltd (**Correct Care**). Psychiatric services are provided by Forensicare.

15. Whilst coroners are, as a matter of course, provided with JARO and Justice Health reports, the coronial investigation is independent and I have formed my own view on the evidence provided.

Sources of evidence

16. As part of the coronial investigation, the Coroner's Investigator, Detective Senior Constable (**DSC**) Cummins prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

17. Additionally, the Court received reports from JARO and Justice Health regarding the circumstances leading to BCA's death.

18. This finding is based on the coronial brief and the additional material submitted or tendered to the Court. It is unnecessary to summarise all this material, which will remain on the Court file.[10] I will refer only to so much of it as is relevant or necessary for narrative clarity.

BACKGROUND

19. BCA was 26 years old and serving his first term in custody. He had previously served a twoyear community correction order from 25 July 2012 to 24 July 2014 for child sex offences.

20. During his prison term, he was housed in the Hakea unit for 'protection' of classified prisoners. The unit housed fourteen prisoners including BCA. It comprised single rooms accessible from common areas. Prisoners were locked inside the unit during the night but could move about within the unit during the day.

21. According to his Department of Justice and Community Safety Individual Management File (**IMF)** BCA was known to enjoy art and music, playing both the keyboard and harmonica and enjoyed a close relationship with his mother. He had a history of depression prior to his prison

[10] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

term and had self-reported smoking cannabis. Throughout his time in custody, he remained in regular contact with his parents and siblings. His records indicate he was polite, quiet and easy to manage. He was active in undertaking work at multiple locations in the prison and received excellent work reports.

22. Upon arrival at the Melbourne Assessment Prison in December 2016, BCA was assessed by a medical officer who continued his ongoing prescription of Desvenlafaxine 50mg daily for depression. On this basis, BCA was ascribed a "P3", with a "stable psychiatric condition requiring continued treatment or monitoring". This classification was based on BCA self-reporting a history of depression and anxiety for which he was taking medication in the community. During the assessment, BCA denied any thoughts of suicide or self-harm although he admitted to having thoughts about it in the past, but never acted on them. BCA's records show that he was assessed regularly by medical officers during his prison term and continually denied any suicidal or self-harm ideation.[11]

23. The Victorian correctional system employs a series of risk ratings which are attached to prisoner offender records to ensure communication about significant issues experienced by that person. BCA was categorised as a prisoner who required protection and was assigned a "T2" rating on 2 February 2012 which was maintained until his death. The T2 rating is defined as "[S]ignificant risk of threat from others in protection cell/ unit". BCA's placement risk rating was based on the nature of his offending, being child sex offences, which may have placed him at risk in a mainstream custodial setting.

24. Following his remand, BCA was transferred to Hopkins Correctional Centre (**Hopkins**) where he spent the majority of his time in custody. Approximately three months prior to his death he expressed his desire to be accommodated at Langi Kal Kal. On 22 November 2017 a Sentence Management panel considered BCA's placement and found that a transfer to Langi Kal Kal was appropriate given his time left to serve and incident free behaviour. He was transferred there in November 2017. BCA's extended placement at Hopkins and Langi Kal Kal was commensurate with his risk rating, noting that both prisons accommodate large numbers of sex offenders and protection prisoners.[12]

25. During his time in prison, BCA was a prolific diary writer. Among other things he wrote about visiting other prisoners in their rooms to seek sexual encounters. These are graphically

[11] Statement Assoc Prof Turnbull, CB 50-52. See also medical records.
[12] JARO report.

described in the diary, the first of which took place on 18 January 2018.[13] A second encounter is described in the diary entry of 19 January 2018."[14]

26. Prison staff had become aware that BCA was visiting other prisoners' cells and that he was seeking sexual encounters with some. They became concerned that he was not complying with the rules related to entering other cells at night and because of this, he was at risk.

27. BCA's IMF contained Local Plan File Notes, which documented observations and file notes of interactions between BCA and prison staff. BCA's Local Plan File Notes records entries regarding staff concerns about BCA's behaviour. Those concerns are broadly that BCA may be at risk from predatory behaviour of other prisoners.

28. In his statement to the court, BCA's case worker, Mr Ashley Kelly set out his concerns about BCA visiting other rooms. Mr Kelly recalled his concerns about slight changes in BCA's behaviour from mid-January 2018 which coincided with the time he started going to other prisoners' rooms.[15] Mr Ashley's statement refers to the handwritten notes found in BCA's cell, purporting to seek "massages" with other prisoners and innuendo in a note stating "later".[16] These concerns are also reflected in the statement of Prison Officer Tony Geor.[17]

29. On 6 February 2018, BCA consulted with the registered nurse and Prison Medical Officer. He told them that he had had a recent 'dizzy spell'. Physical examination including vital signs were normal. BCA reported had not had breakfast nor lunch that day, nor any fluid intake. The Medical Officer advised BCA to eat his normal diet, drink water, and to return if he had further concerns.[18]

30. On 7 February 2018, Mr Kelly also had a conversation with BCA about visiting other prisoner's rooms. BCA was upset and the conversation got a little bit heated. Later that day, BCA apologised for his behaviour during the meeting and Mr Kelly asked him if he was okay and if he would like to speak to "a professional". BCA reassured Mr Kelly that he was ok. Mr Kelly noted he was in good spirits because he had received the harmonica he had requested.

[13] Diary, CB 88 – 92.
[14] Diary, CB 93 – 94.
[15] Ashley statement CB 48.
[16] Handwritten notes, CB 140.
[17] Geor statement, CB 37.
[18] Turnbull statement, CB 52.

31. The contemporaneous diary notes of BCA largely corroborate the conversations recorded in the Local Plan Notes, save for BCA expressing anger at prison guards he had spoken with him about entering other prisoners' rooms.[19]

32. In his last diary entry dated Wednesday 7 February 2018, BCA expressed that the last 48 hours had been some of the worst prison time that he had experienced.

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

33. On 9 February 2018, Ms Kirsty De Ruiter visually identified BCA, born on 8 June 1991.

34. Identity was not in dispute and required no further investigation.

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

35. On 9 February 2018, at approximately 0655 hours prison officers Simpson and Geor were conducting an 'unlock count' in the Hakea unit. When this occurs, prisoners are required to stand by their door to allow staff to account for the presence of each prisoner. When they commenced the count at the Hakea Unit, BCA was not present and his door was closed. Prison Officer Simpson opened the unlocked door, and upon entry observed BCA hanging with a cord wrapped around his neck which was tied to the top bunk.[20]

36. Prison Officer Geor checked BCA for signs of life, noting there was no pulse and his body was stiff. The officers then called for assistance and proceeded to cut BCA from the bedframe and onto the floor. They called a "Code Black" [21] over the portable radio. A Code Black triggers a chain of responses, including crime scene protocols, calling emergency services and emergency response.

37. A nurse attended and assessed BCA and confirmed that he was deceased. Following this, the remaining prisoners in the unit were moved to the Lexton unit. A crime scene was established, and a crime log commenced. Paramedics arrived and pronounced BCA deceased at 0745 hours.

[19] Diary, CB 125 – 126.
[20] Incident Report, CB, 144.
[21] A Code Black is an emergency response code used for a serious medical issue or death.

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

38. On 13 February 2018, Dr Melanie Archer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report, dated 15 May 2018.

39. Dr Archer concluded that a reasonable cause of death was *'neck compression in the circumstances of hanging*.'

40. Toxicological analysis identified the antidepressant medication desmethylvenlafaxine in keeping with BCA's prescription medication.

41. I accept Dr Archer's opinion as to cause of death.

INITIAL INVESTIGATION

42. DSC Cummins attended the scene of the death on 9 February 2018 and conducted an initial investigation comprising:

    a. attendance, examination and photographing of the scene;

    b. seizure and analysis of relevant exhibits including BCA's diary, letters, a booklet containing personal writings and pieces of paper stating, "Do you want massage later".[22]

    c. Interviewing prison staff relating to the circumstances surrounding the death of BCA and the background to it;

    d. Interviewing BCA's mother regarding BCA's history and mental state in the lead up to his death;

    e. Interviewing all prisoners present in the Hakea unit throughout the night prior to the discovery of BCA's body.

43. Following the initial investigation, DSC Cummins prepared a brief of evidence which was submitted to the Coroners Court of Victoria.

44. In late 2019, DSC Cummins received fresh information regarding the death of BCA and passed it to the Homicide Squad.[23] The allegations, made by an anonymous source (the **Source**) were

[22] Cummins statement, CB 65.
[23] See letter from Cummins to Homicide Squad dated 24 January 2020.

that other prisoners, identified as TH[24] and DN,[25] had strangled BCA. The Source alleged that TH had confessed after the fact while both were housed at another prison. The Source refused to provide his full details or provide other assistance but was identified through other means.

45. The Source provided the names of a number of other prisoners who he suspected to have knowledge about TH's involvement in BCA's death but the report does not detail why he had this belief. The Source, when asked, refused to make a sworn statement.

46. Detective Acting Sergeant Luke Farrell (**DAS Farrell**) from the Homicide squad commenced an investigation into the anonymous allegations.

47. Pursuant to the investigation, on 9 January 2020, DAS Farrell conducted a telephone conference with Dr Melanie Archer and detailed the nature of the fresh information received by Sergeant Cummins, namely that another person may have had involvement in the deceased's death either through sexual activity or an intentional assault.

48. Doctor Archer advised DAS Farrell of the following:

    f. Photographs had been taken at VIFM of BCA's body, clothing, personal effects and throughout the autopsy which were not in possession of the investigating police;

    g. No genital, anal or oral swabs had been taken because no injuries consistent with sexual assault were identified;

    h. No injuries consistent with physical assault were identified;

    i. No injuries aside from the ligature marks were present;

    j. Features consistent with hanging as opposed to manual or ligature strangulation were identified, namely the particular configuration of the ligature marks, the absence of bruising to the strap muscles or structural damage to the hyoid bone / thyroid cartilage, the absence of other injuries to the body and the presence of the end of the ligature in BCA's left hand;

    k. Hanging in the context of "sex play" could not be eliminated by the autopsy alone, but there were no positive indicators to suggest this;

[24] A pseudonym.
[25] A pseudonym.

l. She had reviewed scene photographs of the deceased in situ, prying to making her reporting conclusions; and

m. she remained comfortable with her finding that the death was a result of BCA hanging himself.

49. Following this, DAS Farrell identified a number of avenues of inquiry to ensure that the allegations were thoroughly investigated.

50. Victoria Police completed the enquiries recommended by DAS Farrell and the steps taken to complete them are set out in the statement of DSC Cummins in the coronial brief.

51. On the basis of the inquiries, police formed a view that the allegations were not substantiated, or even credible. Among other reasons for concluding that the information provided by the Source was not credible or reliable, was that prisoner DN, who the Source alleged to have been involved in BCA's death was not, and never had been in custody at Langi Kal Kal Prison. Further, the Source had been housed at Hopkins Correctional Centre at the time of BCA's death and could not have had any first-hand knowledge of BCA's death.

52. However, to satisfy himself that all avenues of enquiry had been investigated and to exclude the possibility that any other person had been involved in BCA's death, Coroner Bracken made a direction for forensic testing to be undertaken by the Victoria Police Forensic Services Department of the ligature cord which was found at the scene. DNA samples were collected from the prison guards present and prisoner TH.

53. The Case Results Summary from analysed ligature cord obtained from the examination of items performed by the Biological Sciences Group excluded probability that TH or any other person had contact with the ligature around BCA's neck.

FAMILY CONCERNS

54. On 11 February 2018, TDS, wrote to the Coroner expressing concerns about the circumstances leading up to BCA's death in custody. In particular, TDS raised a concern that her son was the subject of homophobia in prison and that he had ceased his antidepressant medication just prior to his death.

REVIEW BY JARO

55. On 29 March 2019, JARO provided a copy of its review into the death of BCA. The review provides an overview of BCA's management in custody and the circumstances of his death. A

report provided by Justice Health, outlining BCA's health management while in custody is also attached to the JARO review.

56. The JARO report refers to BCA ceasing his medication on 5 February 2018.

57. The report explains that at minimum security locations, such as Langi Kal Kal, it is the prisoners' responsibility to manage their medication which they receive in weekly doses. This is in accordance with the philosophy of assisting prisoners to prepare for re-entry into the community, where they will similarly be responsible for managing their own health care.

58. While in custody, BCA self-reported a history of depression. Consequently, he was prescribed and took anti-depressant medication, which he collected weekly, including attending visits with the psychiatric nurse.

59. In a recorded telephone call on 5 February 2018, BCA advised a family member that he had stopped taking his anti-depressant medication. He advised that the reason he had not taken his medication was because had forgotten to pick it up and when he attended the medical centre at 1800 hours, it was closed. During this telephone call, he was asked how many days he had not taken his antidepressant medication for and responded, "just today".

60. This is consistent with the statement of Mr Kelly, who identified a change in BCA's mood and spoke with him about how he was feeling. BCA disclosed that he had stopped taking his medication for "a couple of days".

61. Accordingly, Mr Kelly recorded this on BCA's IMF and notified his case manager, prompting a follow up conversation with BCA. In interviews with JARO, Mr Kelly reflected on their conversation. He advised that BCA was feeling a bit anxious however this was not an uncommon event as he tended to "go up and down". At that time, Mr Kelly did not believe BCA was at risk of suicide or self-harm, but was instead displaying common and familiar expressions of anxiety.

62. Prison records indicate that BCA collected his medication on 6 February 2018. It is unknown whether he recommenced taking his medication on that same date. JARO noted that upon becoming aware that he may have been skipping his medication, Langi Kal Kal staff facilitated contact with BCA's case manager. His case manager was prompt in discussing these matters with BCA, at which time he did not identify any significant cause for concern.

63. The JARO report also refers to the prison staff concerns about BCA's movements and behaviours, in particular instigating sexual encounters with other prisoners in a manner which caused a risk to his own health and safety. Those concerns were well founded, based on the diary entries BCA made before his death. There is no evidence that the concerns arose from any homophobic views, but rather, well intentioned and genuine efforts to support and protect a vulnerable young prisoner.

64. JARO found that BCA's custodial management met the standards prescribed by Corrections Victoria. BCA was thoughtfully case managed with fittingly tailored local plan goals and supports. His case manager interacted with him regularly and consistently to address and allay his concerns. The review identified that Langi Kal Kal staff responded to the incident sensitively and appropriately. JARO also identified two opportunities for improvement, namely that greater consistency and transparency exist in addressing movement control at Langi Kal Kal and that Corrections Victoria consider the broader application of the Pride Officer portfolio.

65. I accept the conclusions of the JARO report.

FINDINGS AND CONCLUSION

66. Having investigated the death, and holding an inquest, I find pursuant to section 67(1) of the Act that BCA, born 8 June 1991, died on 9 February 2018 at Langi Kal Kal Prison, Victoria, from *neck compression in the circumstances of hanging* in the circumstances described above.

67. The coronial investigation has not yielded any evidence that any other person was involved in BCA's death or that he otherwise died in suspicious circumstances. I am satisfied that Victoria Police thoroughly investigated the anonymous allegations and find that those allegations were without substance.

68. The requests by prison staff that BCA cease visits to other prisoners' rooms were reasonable and necessary to protect BCA and other prisoners.

69. The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of Langi Kal Kal, or any want of supervision or care on the part of correctional staff that caused or contributed to BCA's death.

70. The clinical management and care provided to BCA during his last period of incarceration was appropriate by current standards. He was administered medication as prescribed, had regular mental health reviews and did not indicate any suicidal thoughts.

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

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

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

TDS, joint Senior Next of Kin
OPT, joint Senior Next of Kin
Mr Scott Swanwick, Justice Health
Correct Care Australasia, c/- Kellie Dell'Oro, Meridien Lawyers
Detective Senior Constable Cummins, Victoria Police, Coroner's Investigator.

Signature:

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KATHERINE LORENZ
CORONER
Date: 21 October 2021