IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001217

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be distressing.

INQUEST INTO THE PASSING OF MICHAEL GARRY SUCKLING

Findings of:	Coroner Leveasque Peterson
Delivered on:	13 December 2024[1]
Delivered at:	Melbourne
Inquest Hearing Dates:	24, 27, 28 February 2023 1, 2, 3, 6, 8, 9, 10, 20 March 2023 3, 4, 5, 6 April 2023
Counsel Assisting the Coroner	Sharon Lacy SC, with Ingrid Giles, Senior Legal Counsel, instructed by Kajhal McIntyre, Coroner's Solicitor, Coroners Court of Victoria
Counsel for Maree Brincat	Nikolas Barron, instructed by the Victorian Aboriginal Legal Service

[1] The Finding was amended on 12 February 2025 under section 76 of the *Coroners Court Act 2008* (Vic) following the Court receiving an application to correct errors arising from an "accidental slip or omission" as well as to correct a "material mistake in the description of a person".

Counsel for Department of Justice and Community Safety	Liam Brown SC with Marion Isobel, instructed by the Victorian Government Solicitor's Office
Counsel for GEO Group Australia	Paul Halley, instructed by Hall & Wilcox
Counsel for G4S Custodial Services	David Oldfield, instructed by Marsh & Maher
Counsel for Forensicare	Morgan McLay, instructed by Lander & Rogers
Counsel for Correct Care Australasia	Neill Murdoch KC with Erin Gardner, instructed by Meridian Lawyers
Counsel for St Vincent's Correctional Health Service	Robert Harper, instructed by K&L Gates
Counsel for Dr Charles Ekwebelam	Fiona Ellis, instructed by Sparke Helmore Lawyers
Counsel for Dr Daniel Clinton	Peter Hamilton, instructed by Avant Lawyers
Yirramboi Murrup Aboriginal Engagement Unit	Jessica Gobbo, Aboriginal Family Engagement Manager Joseph Yugumbari, Aboriginal Cultural Support Adviser
Keywords	Aboriginal passing, death in custody, custodial healthcare system, obesity, cardiomegaly, natural causes, Ravenhall Correctional Centre

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SUMMARY

1. On 7 March 2021, Michael Garry Suckling, (**Michael**), was 41 years old when he passed away unexpectedly in the Dunmore Unit at Ravenhall Correctional Centre (**Ravenhall**).

2. Michael was a proud Aboriginal man, the dearly loved eldest son of Maree Brincat (**Maree**). He was raised by Maree and his grandmother, and had a happy childhood in Wonthaggi, spending time in outdoor pursuits. His love of the outdoors continued into adulthood, and he enjoyed horse riding, fishing and going to the bush, as well as cooking. He shared two children with his childhood sweetheart and was a father-figure to his younger sister, Fern.

3. Michael was capable and hardworking, and operated a plastering business for many years. At times however, Michael struggled with drug dependency and he had periods of imprisonment. Michael was a popular member of the prison community, described variously as a "*beautiful man*" and "*like a big brother*" by other prisoners who came to know him. He was raised without ties to his wider Aboriginal family. However, while in custody, Michael strengthened his cultural connections and re-discovered a passion for creating art.

4. At the time of his passing, Michael was serving a sentence of imprisonment for culpable driving and other driving offences in connection with a single vehicle fatal collision.[2] He had been in the custody of the State since January 2018, initially on remand and then as a sentenced prisoner from 24 July 2020. He was eligible for parole from 1 November 2024.

5. When Michael entered prison, he was within the normal weight range, but his physical and mental health were precarious. He struggled with ongoing pain and drug dependency, as well as challenges in coming to terms with his role in the collision and loss of his uncle, associated criminal proceedings and conviction, and relationship difficulties. Despite periods of strong self-advocacy, his overall condition continued to deteriorate. He underwent significant weight gain in custody. By the time of his passing, three years after he entered prison, Michael was in the range of 'severe' or 'morbid' obesity.

6. The coronial investigation examined Michael's treatment and care in custody, with a view to establishing the cause of his passing and identifying opportunities for prevention and improvement in the care and management of people in prison – particularly those who, as was the case with Michael, present with complex health needs.

[2] *DPP v Suckling* [2022] VCC 1092 (**Sentencing Remarks**).

7. Michael's story demonstrates the pressing need for change to the medical care and treatment of First Nations people who enter the custodial system in this State.

THE CORONIAL JURISDICTION

Jurisdiction

8. Michael's passing constituted a *'reportable death'* under section 4 of the *Coroners Act 2008* (**Coroners Act**), because his passing occurred in Victoria and immediately before his passing, he was a person in custody, as defined in the Coroners Act.

Purpose of the Coronial System

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

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

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

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

13. Coroners are empowered to:

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

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

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

[3] *Coroners Act 2008* (Vic) (**Coroners Act**), s 89(4).
[4] Coroners Act, s 72(1).
[5] Coroners Act, s 67(2).
[6] Coroners Act, s 72(2).

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

15. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability.[7] By ascertaining the circumstances of a death, a coroner can identify opportunities to help reduce the likelihood of similar occurrences in the future and promote public health and safety.

Standard of Proof

16. All coronial findings must be made on proof of relevant facts on the balance of probabilities.[8] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[9]

17. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[10] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[11]

18. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person acted appropriately. I am conscious of the need to judge the actions of all involved in Michael's care having regard to the information known to them at the relevant time.

Inquest

19. The Coroners Act requires a coroner to hold an inquest into the death of a person in custody.[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

[7] *Keown v Khan* (1999) 1 VR 69.
[8] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[9] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that his Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[10] (1938) 60 CLR 336.
[11] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[12] Coroners Act, s 52(2)(b).

reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

20. The Coroner is not required to hold an inquest if the Coroner considers that the death is due to natural causes.[13] However, coroners retain discretion as to whether to hold an inquest into any death they are investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Act.

21. In deciding whether to conduct an inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about, and the likelihood that an inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

22. Further, Practice Direction 6 of 2020 'Aboriginal Passings in Custody', requires that when investigating the circumstances of the passing of an Aboriginal person in custody, the coroner must consider the quality of care, treatment and supervision of the deceased prior to passing, even where the passing is due to natural causes.[14] This requirement follows recommendations arising from the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), including that:

    a) all deaths in custody be required by law to be subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death (Recommendation 11).

    b) a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death (Recommendation 12).

23. Having regard to these matters, I determined that an inquest was warranted to examine the circumstances of Michael's passing, with a specific focus on the adequacy of his care and management while in custody, and whether there were any opportunities for system improvements.

[13] Coroners Act, s 52(3A).
[14] Coroners Court of Victoria, Practice Direction 6 of 2020, 'Aboriginal Passings in Custody' first issued 22 September 2020, and updated on 14 May 2024, [6].

Scope of inquest

24. The inquest examined:

    1. The adequacy of assessment, treatment, care and management of Michael from a clinical and cultural perspective during his most recent period in custody (from January 2018 until March 2021), including:

        a) Michael's access to culturally-appropriate care, treatment and activities as an Aboriginal man;

        b) The management, provision, accessibility and adequacy of health care by primary, secondary and tertiary health care providers, prison operators and Corrections Victoria in relation to Michael's (i) mental health, (ii) physical health, (iii) ability to access appointments, and (iv) weight management, exercise and nutrition;

        c) Michael's access to health care immediately prior to his passing, including the adequacy of Michael's treatment and management on and between 5 and 7 March 2021;

    2. The extent to which current policies and procedures in relation to health care and prison management were implemented in relation to Michael's most recent period in custody;

    3. Whether there have been system improvements aimed at preventing similar deaths implemented by health service providers and prison operators; and

    4. Identification of any further prevention opportunities.

Sources of evidence

Coronial brief of evidence

25. Victoria Police assigned Detective Leading Senior Constable Paul Barrow (**DLSC Barrow**) to be the coronial investigator for the investigation into Michael's passing. DLSC Barrow conducted inquiries on my behalf and compiled a Coronial Brief of Evidence (**the brief**).

26. The brief included Michael's custody records, and statements from the forensic pathologist, prisoners who interacted with Michael prior to his passing, prison and correctional officers, medical and allied health professionals, and representatives of relevant government agencies.

27. The brief underwent five iterations, to include additional materials gathered through the course of my investigation, including expert reports obtained by the Court and interested parties.

Other inquiries and investigations

28. The deaths of persons who are in the custody of correctional services are not only investigated by coroners but are also routinely reviewed by a business unit within government known as the Justice Assurance and Review Office (**JARO**). The JARO is 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.[15]

29. In preparing its report, JARO examined Ravenhall's management of, and response to Michael's passing, as well as his custodial management, security classification and engagement with cultural supports, and opportunities for improvement. It also had regard to a report prepared by Justice Health, a separate business unit of DJCS which has responsibility for the delivery of health services to Victoria's prisoners. Both reports formed part of the brief.

30. In summary, JARO found that[16]:

    a) Michael's security classifications and placements were appropriate and his custodial and case management met the prescribed standards.

    b) Ravenhall's management of, and response to, Michael's passing was appropriate.

    c) Michael was not seen by an Aboriginal Wellbeing Officer within 24 hours of reception into custody, contrary to policy requirements.

    d) The morning prisoner count and unlock had not been conducted in line with required policy on the morning of Michael's passing.

31. JARO made a recommendation to the General Manager (**GM**) of Ravenhall that they incorporate prisoner count processes into the annual internal audit schedule as part of GEO's Governance Risk and Compliance Framework.

32. Justice Health reviewed Michael's medical records with a view to identifying any systemic or emerging issues and opportunities for improvement in custodial health services. Justice Health concluded that:

    a) on multiple occasions Michael declined to attend healthcare appointments, which were rescheduled by health staff.

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[15] *Corrections Act 1986* (Vic), s 7.
[16] Justice Assurance and Review Office, Review into the death of Michael at Ravenhall Correctional Centre on 7 March 2021 dated 24 November 2021 (**JARO Report**), Coronial Brief (**CB**)-3186.

b) Michael had the right to refuse to attend medical and health care appointments.

c) it appeared Michael had registered to attend but failed to participate in programs on multiple occasions.

d) Michael's weight was closely monitored while at Port Phillip Prison, but his weight was not monitored as closely at Ravenhall.

e) Michael had been advised to reduce his sugar intake including soft drinks that he purchased through the prison canteen.

f) Michael was engaged with an Aboriginal Health Worker, but there was limited supporting documentation about this in the healthcare records.

33. Justice Health noted initiatives being implemented by DJCS to improve health outcomes for Aboriginal prisoners (described further below) and made eight recommendations for:[17]

a) referrals to be made to a dietitian for expert dietary advice or to the health promotion officer for weight loss management.

b) further work be undertaken to explore ways to educate people in custody about healthier options in food choices.

c) obesity management programs and monitoring to be embedded into clinical practice and health promotion activities.

d) prisoner weight and height be recorded on reception to prison and while in prison to accurately monitor prisoner weight gain or weight loss over time.

e) the contracted hours of the Aboriginal Health Worker be reviewed by the prison operator to ensure the role meets the needs of the Aboriginal population at Ravenhall for better health outcomes.

f) the health service provider to liaise with the Aboriginal Programs team at Ravenhall to ensure a culturally safe and holistic health service including the establishment of an outreach service to Aboriginal prisoners onsite.

g) all health staff including Aboriginal Health Workers to document all occasions of health service in JCare for a complete medical record. JCare is a platform used exclusively in the prison system for the recording of prisoner health information including clinical records.

[17] Justice Health, Death in Custody Report (**Justice Health Report**) dated 29 October 2021, CB-3225.

h) a formal policy to be developed and implemented for appointment management including a process for failure to attend appointments.

34. Whilst coroners are, as a matter of course, provided with JARO and Justice Health reports by DJCS, the coronial investigation is independent and I have formed my own view on the evidence before me. My investigation identified a number of systemic issues which were not captured in the JARO or Justice Health reports. Further, I have reached different conclusions in respect of certain matters relevant to the circumstances of Michael's death, including his weight on entering custody, as discussed further below.

35. In addition to the specific inquiries into Michael's passing undertaken by JARO and Justice Health, there have been a number of systemwide reviews into Victoria's mental health and custodial systems in recent years. This includes, most notably:

a) Royal Commission into Victoria's Mental Health System (**RCVMHS**)[18]

b) Cultural Review of the Adult Custodial Corrections System (**CRACCS**);[19] and

c) Victorian Ombudsman Report on Healthcare Provision for Aboriginals in Custody (**VO Report**).[20]

d) Yoorrook Justice Commission Report into Victoria's Child Protection and Criminal Justice Systems (**Yoorrook for Justice Report**).[21]

36. I have also had the benefit of the recommendations and responses arising from the inquest into the passing of Veronica Nelson.[22]

37. These reports and findings have assisted in shaping recent and ongoing implementation of reforms across mental health and custodial systems. Where relevant, I have referred to

[18] The RCVMHS final report was tabled on 2 March 2021. The full report is available on the Victorian Government website at: https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report
[19] The CRACCS final report, 'Safer Prisons, Safer People, Safer Communities', was published in December 2022 and is available on the Victorian Government website at: https://content.vic.gov.au/sites/default/files/2024-03/Final-Report-Cultural-Review-of-the-Adult-Custodial-Corrections-System.pdf
[20] The VO Report was published in March 2024 and is available on the VO's website at: https://assets.ombudsman.vic.gov.au/assets/FINAL_07.03.24_VO-PARLIAMENTARY-REPORT_Investigation-into-healthcare-provision-for-Aboriginal-people-in-Victorian-prisons_Mar-2024.pdf
[21] The Yoorrook for Justice report was delivered on 4 September 2023 and is available on the Yoorrook Justice Commission's website at: https://yoorrookjusticecommission.org.au/wp-content/uploads/2023/09/Yoorrook-for-justice-report.pdf
[22] Coroners Court of Victoria, *Finding with inquest into the passing of Veronica Nelson* of Coroner McGregor delivered on 30 January 2023 (**Nelson Inquest**).

recommendations arising from those inquiries in this finding. I have also been mindful of the need to avoid unnecessary duplication of inquiries or investigations.[23]

View of Ravenhall Correctional Centre

38. In December 2021, prior to inquest, I conducted a view at Ravenhall with Counsel Assisting and representatives of the interested parties.

39. The GM of Ravenhall, Colin Caskie, showed the Court relevant sites throughout the prison, including the Hildene Health Centre, the Dunmore Community and unit where Michael was housed at the time of his passing, the opioid substitution therapy program (**OSTP**) dispensary clinic, the gymnasium, and the cultural centre.

40. The view also included a video presentation.

Inquest hearings

41. At inquest, the following witnesses were called:

    a) Michael's mother, Maree

    b) two persons who were incarcerated with Michael prior to his passing[24]

    c) six prison officers

    d) the GMs of Ravenhall and Port Phillip Prison

    e) four Aboriginal Health Workers and correctional staff

    f) four correctional health nurses and two correctional health medical officers

    g) Gabrielle Simmons, Manager, Naalamba Ganbu and Nerrlinggu Yilam (Cultural Integrity and Resilience Unit), Corrections Victoria (**CV**), DJCS

    h) Melissa Westin, Deputy Commissioner, Custodial Operations Division, CV, DJCS

    i) Susannah Robinson, Acting Executive Director, Justice Health

    j) Christine Fuller, Deputy Chief Executive Officer, Correct Care Australasia (**CCA**)

    k) Dr Francis Olopade, Chief Medical Officer (**CMO**), CCA

    l) David Grace, Director, Health Services, GEO

[23] Coroners Act, s 7.

[24] On 30 January 2023, I made an order pursuant to section 55(2)(e) of the Coroners Act that required a pseudonym to be applied, where it was necessary in the proceedings, to refer to the identity of these two individuals in published documents.

m) Dr Deep Joseph, CMO, St Vincents' Correctional Health Services (**SVCHS**)

n) Dr Kate Roberts, Director of Clinical Services, Prison Services, Forensicare.

42. The inquest also heard from expert witnesses in the fields of forensic pathology, Aboriginal health practice, general medical practice, cardiology and psychiatry as follows:

a) Dr Linda Iles, Forensic Pathologist, Victoria Institute of Forensic Medicine

b) Cultural Clinical Panel – Dr Mark Wenitong and Professor Dennis Pashen

c) General Practitioner Panel – Associate Professor Richard Matthews, Dr Neil Bartels and Dr Gary Nicholls

d) Cardiologist Panel – Dr Garry Helprin and Associate Professor Neil Strathmore

e) Psychiatrist – Professor Jackie Curtis.

43. I also received coronial impact statements from Michael's mother Maree, and sister Fern. I am very grateful to Maree and Fern for providing me with their statements which gave me a better insight into Michael. I acknowledge the great loss and pain they and their family have suffered since his passing.

44. Following the inquest, Counsel Assisting and Counsel for all interested parties provided written submissions. I gratefully acknowledge the comprehensive submissions provided by Counsel Assisting which summarised much of the tendered material and provided a detailed chronology of Michael's life and experiences in custody.

Finding into death with inquest

45. This Finding draws on the totality of the materials produced to the court throughout the coronial investigation and inquest into Michael's passing. That is, the court records, the brief of evidence, evidence adduced during the inquest, and submissions provided by Counsel Assisting and Counsel representing the interested parties.

46. As Counsel Assisting comprehensively addressed the evidence in her submissions, I have relied on extracts of Counsel Assisting's submissions where appropriate to set out a chronology of events and summarise aspects of the evidence.

47. I have considered all the material. However, in writing this Finding, I do not purport to summarise all the evidence. I have referred only to such information and in such detail as is warranted by the forensic significance and for narrative clarity. The absence of any reference to any aspect of the evidence does not mean that it has not been considered.

CIRCUMSTANCES OF DEATH

Arrest and detention in custody

48. On 6 January 2018, Michael was the driver of a car that was involved in a single-vehicle fatal collision in Castlemaine. As a result of the collision, one passenger was killed, and another was seriously injured. Michael, who was substance-affected at the time of the collision, also suffered serious injuries. He was arrested and transported to Bendigo Hospital where he was diagnosed with multiple broken ribs and a fracture in his vertebrae.

49. On 10 January 2018, Michael was remanded in custody at a bedside hearing on a charge of culpable driving causing death and other related charges. He received inpatient treatment for his injuries initially at Bendigo Hospital, and subsequently at St Vincent's Hospital for a period of approximately 10 days, before he was transferred to prison.

Overview of Michael's time in custody

50. The following provides a brief overview and summary of Michael's time in custody. For most of his time in custody, Michael was classified and housed as a protection prisoner.[25] Relevant aspects of Michael's care and treatment while in custody are discussed in further detail below under 'Issues Examined at Inquest'.

51. In the context of expert evidence which described the development of Michael's cardiomegaly as "*a progressive, … and - unending sort of health condition that was … I think leading to an event, because there was … no return from that increased weight gain*"[26], I consider the circumstances of Michael's last period of incarceration as sufficiently proximate and relevant to his passing for the purposes of making findings, comments and recommendations.

Port Phillip Prison – January 2018 to February 2018

52. On 19 January 2018, Michael was discharged from St Vincent's Hospital and transferred to Port Phillip Prison (**PPP**) where he was housed in St John's, the in-patient ward.

53. PPP is a privately operated prison, managed by G4S Custodial Services (**G4S**). St Vincent's Custodial Health Services (**SVCHS**) is the primary health provider for prisoners at PPP.

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[25] A prisoner may be classified as a 'protection prisoner' where they may be at risk of harm from members of the mainstream prison population whether because of reasons specific to that prisoner or because of the nature of the crimes committed by the prisoner. Statement of Melissa Westin, Deputy Commissioner, Custodial Operations Division, Corrections Victoria dated 3 September 2021, [12], CB- 910.
[26] Transcript of Proceedings (**T**)-1472, per Dr Gary Nicholls.

Metropolitan Remand Centre – February 2018 to November 2018

54. On 10 February 2018, Michael was transferred from PPP to the Metropolitan Remand Centre (**MRC**) via an inter-prison transfer. Michael remained at MRC for a period of nine months.

55. MRC is a publicly operated prison managed by Corrections Victoria (**CV**). Correct Care Australasia (**CCA**) is the primary healthcare provider at MRC, with Forensicare providing secondary care and specialist mental health services.

56. There are limited records available of Michael's weight while on remand at MRC. Only four entries in the clinical records refer to Michael's weight:

    a) On 10 February 2018, upon his arrival to MRC, Michael underwent an inter-prison transfer assessment conducted by a general nurse employed by CCA. In that assessment, Michael's weight was recorded at 82kg.[27] This was the first time Michael's weight had been recorded since he had entered custody four weeks prior. As Michael was 191 cm tall[28] this equated to a body mass index (**BMI**) in the region of 22.5 kg/m^2, well within the 'normal' weight range, as classified by the World Health Organisation (**WHO**).

    b) On 20 July 2018, six months after entering custody, Michael's weight was recorded at 121kg (a BMI of 33.2 kg/m^2), and it was identified that he would benefit from a diet change. [29] This weight placed Michael within WHO Class I obesity.

    c) On 24 July 2018, four days later, Michael's weight was again recorded at 121 kg.[30]

    d) On 8 October 2018, two and a half months later, Michael's weight was next recorded at 132kg (a BMI of 36.2 kg/m^2), a further increase of 11 kg.[31] It was noted that Michael had gained 4 kg in the space of four weeks,[32] a rate of approximately 1 kg a week. This weight placed Michael within WHO Class II obesity.

57. This represented a total increase of approximately 50 kg in the eight months since Michael had entered custody, an *"extraordinary"* amount of weight.[33]

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[27] Justice Health records (**JH**), Interprison Transfer Assessment dated 10 February 2018, 641.
[28] As measured on external examination by forensic pathologist Dr Michael Burke on 11 March 2021: Per Autopsy Report dated 18 May 2021 signed on behalf of Dr Burke by Forensic Pathologist Dr Linda Iles. CB- 22. I note that there are various measurements recorded of Michael's height within the records. However, Michael was consistently described as a tall man, with a stature of at least 188cm and up to 193cm (6"4').
[29] MRC Review on 20 July 2018, JH- 286.
[30] MRC Review on 24 July 2018, JH- 286.
[31] MRC Short term review on 8 October 2018, JH- 271.
[32] MRC Short term review on 8 October 2018, JH- 271.
[33] T 1007, per Dr Francis Olopade.

58. At inquest, and in submissions from interested parties, concerns were raised regarding the reliability or accuracy of the weight recorded in the inter-prison transfer assessment on 10 February 2018,[34] speculating that Michael's weight upon entering custody may have been *"significantly greater"* than the weight recorded and pointing to various anomalies or inaccuracies in the Justice Health records concerning Michael's weight during his time in custody.[35]

59. As noted above, CCA was responsible for provision of healthcare services at MRC, including the inter-prison transfer assessment conducted on 10 February 2018.[36] Standard clinical practice – both in custody and the community – is not to rely on self-reported weight measurements.[37] If it is accepted that the weight measurement recorded on the inter-prison transfer assessment is incorrect (or 'significantly' less than Michael's true weight upon transfer), this suggests a concerning deficit in CCA's record keeping practices. To the extent that my investigation identified deficiencies in the reliability of, or accuracy of record keeping management practices in custodial health records more generally, I have made a relevant recommendation to address this issue, as discussed further below.

60. As to Michael's true weight on entering MRC, I accept that, on its face, the inter-prison transfer assessment form does not allow me to conclude with any certainty whether the weight as recorded (82kg) was verified by the nurse through use of a calibrated weight scale or whether the nurse relied upon a self-report or estimate of weight. The form does not indicate either way. However, no direct evidence was produced at inquest, by CCA or any other party, to contradict this record or to indicate Michael's weight differed substantially or at all from the figure recorded.

61. Having considered the evidence, I am persuaded to the requisite standard that at the time he entered custody, Michael's weight was at or close to 'normal' weight range. I have reached this conclusion taking into account the following matters:

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[34] This was also reflected the conclusions drawn by Justice Health in their report, which noted that "It appears Mr Suckling's weight had not been correctly documented as his body mass index (BMI) would be within normal range – BMI 23.2. It is noted that Mr Suckling's weight was recorded as 121kg in July 2018". See Justice Health Death in Custody Report dated 29 October 2021, CB-3209.

[35] Submissions of Correct Care Australasia dated 10 August 2023, [76]. In support of this submission, pointed to a difference in rounding of weight as recorded in inter-prison transfer assessments between February 2018 and November 2018. I note, however, that these assessments were conducted at different prisons, by different nurses. Further, insofar as reference is given to records of Michael's weight as recorded in prior periods of incarceration, those records are of limited assistance as they occurred over two years prior to the subject events and no evidence was called to confirm the validity of those records.

[36] Statement of Dr Foti Blaher, Chief Medical Officer for Correct Care Australasia dated 3 September 2021, CB-1216.

[37] Statement of Suzannah Robinson, Acting Executive Director of Justice Health, dated 27 January 2023, CB- 4709.

a) For a man of Michael's stature, a healthy weight range is between 68 to 91 kg (a BMI of between 18.5 to 24.9 kg/m^2).

b) There is no indication that clinicians had any concern about Michael's weight during his hospital admission immediately prior to entering custody in January 2018. Although his weight was not recorded during this period, there is no mention in the clinical records of a past medical history of obesity or difficulty with weight management. Michael was not identified as a 'bariatric patient'.[38]

c) The uncontested evidence of Michael's mother Maree, who knew him best, was that at the time of his incarceration *"he would've been about 80 kilograms tops. He was very skinny but was about 6 foot four tall. He was quite fit and this was due to the work he was doing. He was always active, doing things*".[39] At inquest, Maree confirmed that Michael *"was 6 foot 4 and I doubt whether he would have ever got over 85 or maybe 90 kilos".* His weight had remained fairly stable during his life.[40]

d) The inter-prison transfer assessment on 10 February 2018 did not identify 'morbid obesity' as a condition present, nor any other weight related issues.[41] Rather, the mental state examination conducted at PPP on 19 January 2018 (four weeks earlier) documented that Michael *"Appears gaunt"*.[42]

e) On review by the Mobile Forensic Mental Health Service (**FMHS**) in early September 2018, eight months after entering custody, it was noted that *"it appears [Michael] has gained some weight…since his reception photo was taken."*[43] Michael's reception photo depicts a slender man.

f) Custodial records from Michael's penultimate period in custody from 14 January to 22 July 2016, two years earlier, document his weight between 96 to 115kg[44] (a BMI in the range of 26.3 to 31.5 kg/m^2). This weight is higher than the normal weight range for a man of Michael's stature, ranging from overweight, to mildly obese. Despite this, Michael was

[38] That is, a patient with a BMI of > 30. In Michael's case, this would have equated to a weight of approximately 109 kg or greater.
[39] Statement of Maree Brincat dated 2 July 2021, CB- 51.
[40] T-1270, 1273-4, per Maree Brincat. No interested party cross-examined Maree on her evidence on this issue.
[41] Interprison Transfer Assessment dated 10 February 2018, JH-640.
[42] JH-652.
[43] MRC Short term review on 3 September 2018, JH-278.
[44] JH-666, 657, 673, 680, 693, 700 and 708.

described in clinical notes as having a "*slender build*".[45] However, these records provide limited utility to me in determining Michael's weight as at January 2018 as:

i. they document Michael's weight while in custody over 18 months prior to the relevant events.

ii. they do not provide any insight into what Michael's weight was when in the community, or what his weight was between the time of his release in July 2016 and his incarceration in January 2018.

iii. further, the weight gain of 15kg during these six months, is perhaps indicative of a trend for Michael where – when in custody – he gained weight.

62. I am satisfied that Michael's weight increased significantly during his first nine months in custody between January 2018 to October 2018, from a normal weight range to Class II obesity. This is consistent with clinician notes from the St John's inpatient unit at PPP on 25 December 2018, which record: *"[Michael] has put on a huge amount of weight since last on the ward (about 10 months ago)*".[46]

63. That upward trajectory continued, with some periods of relative stability, throughout the remainder of Michael's time in custody at PPP and Ravenhall.

Return to Port Phillip Prison – November 2018 to July 2020

64. On 12 November 2018, Michael was transferred back to PPP through an inter-prison transfer. He remained at PPP for the next 20 months, awaiting sentencing.

65. An inter-prison transfer assessment was undertaken upon his return to PPP, in accordance with the usual practice. That assessment form records Michael's weight as 118kg.[47] However proximate entries indicate his weight to be in the region of 131 kg at this time.[48]

66. Michael suffered two significant medical events while in custody at PPP.

67. The first, on 25 May 2019, occurred when Michael took an overdose of diverted medications. He later disclosed to clinicians that he had intended to take his own life, in the context of *"upcoming court, possible long sentence, breakdown of relationship with wife, felt he had*

[45] JH-670.
[46] St John's Inpatient Unit review on 25 December 2018, JH-257.
[47] Inter-prison Transfer on 12 November 2018, JH-633.
[48] Relevantly, Michael's weight was previously recorded at 132kg on 8 October 2018 – JH 271, and at 131.2kg on 14 November 2018 – JH-263. Dr Olopade accepted at inquest that the record of 118kg was an error. T-1006-7.

nothing to live for".[49] Michael's deteriorating mental health is discussed further at 'Issues Examined at Inquest' below. He was admitted to Sunshine Hospital for respiratory failure secondary to aspiration in the setting of multiple drug overdose. He remained in hospital for 53 days, with almost half of this period spent in a coma.

68. He was discharged from Sunshine Hospital on 17 July 2019 and transferred back to PPP to continue his recovery in the St John's inpatient unit. His weight was recorded the following day on 18 July 2019 at 150.7 kg, using standing scales.[50] This equated to a BMI of around 40.9 kg/m^2, and placed him within the WHO Class III obesity range, also known as 'severe' or 'morbid' obesity.[51]

69. The second medical event occurred on 16 December 2019, when Michael suffered an injury to his right index finger during an altercation between other prisoners. The first phalangeal joint was crushed and amputated, causing further pain and trauma and requiring a further in-patient admission to St Vincent's Hospital for four nights.[52]

70. On 24 July 2020, Michael was sentenced by his Honour Judge Bourke to a total effective sentence of 10 years and 3 months, with a non-parole period of 7 years. He was eligible for parole from 1 November 2024 and arrangements were subsequently made for Michael to be transferred to Ravenhall as a sentenced prisoner.

71. At the time of his transfer to Ravenhall, Michael's weight was documented at 175.2 kg,[53] with a BMI of around 48 kg/m^2 (WHO Class III Obesity). This represented a weight increase of approximately 43kg during Michael's second period in custody at PPP, an overall increase in weight of over 90kg since he had first entered custody two and a half years earlier.

Ravenhall Correctional Centre

72. On 10 August 2020, Michael was transferred to Ravenhall, where he was housed in the Dunmore Protection Unit.

73. Ravenhall is a privately operated prison, managed by GEO Group Australia (**GEO**). CCA is the primary health provider for prisoners at Ravenhall, with Forensicare providing secondary care and specialist mental health services.

[49] PPP Short term review on 17 July 2019, JH-231.
[50] JH-230.
[51] St John's Inpatient Unit, JH-230.
[52] JH-1457.
[53] RAVENHALL Interprison Transfer Assessment on 10 August 2020, JH-626.

74. Michael remained at Ravenhall until his passing, seven months later. As mentioned earlier, his weight continued to increase during this period, and he gained a further 23.8kg, weighing 199 kg at the time of his passing on 7 March 2021 (a BMI of around 54.5 kg/m^2).

75. The evidence suggests Michael gained approximately 117 kg in the three years he was in custody. The response to, and management of Michael's weight gain in custody, is discussed further below in 'Issues Examined at Inquest'.

Events leading to Michael's passing

Code Black on 5 March 2021

76. On the morning of 5 March 2021, Michael approached correctional officers stationed at the Dunmore Unit Post B-Side.[54] The officers observed that he appeared unwell and lethargic, *"in some pain*" with swelling of his limbs, difficulty walking and was slow-talking.[55] Michael sought assistance from the officers with his in-cell device which wasn't working properly.[56] The in-cell device allows prisoners to watch TV, request clothing supplies and canteen, and to see and make program and health appointments.[57] Michael indicated that he would need to see a nurse due to his limbs swelling overnight. He returned to his cell shortly afterwards.

77. Due to concerns about Michael's welfare and a belief Michael had downplayed his health issues, the correctional officers and their supervisor attended Michael's cell shortly afterwards.[58]

78. The correctional supervisor observed that Michael had a droopy face on the right-hand side and was experiencing difficulty using his limbs and hands.[59] The supervisor directed that a Code Black be called to elicit an emergency medical response.[60]

79. Two CCA nurses attended in response to the Code Black and observed Michael was having difficulty breathing. His legs and feet were discoloured, and he had a droopy face on the right side. They were concerned he may have been suffering a stroke.[61] Vital signs observations were taken, which indicated Michael's blood pressure and pulse rate were slightly elevated, and his oxygen saturation was *"a bit low"*.[62] It was determined that Michael would be taken to the

[54] T-134, per S R Lee.
[55] T-134, per S R Lee
[56] T-135, per S R Lee.
[57] T-114, per P M Whitfield; T-139, per S R Lee.
[58] T-135; T-140, per S R Lee.
[59] T-105, per P M Whitfield
[60] T-105, per P M Whitfield
[61] T-306-7, per T M J Tosto; T-330, per L D Curran.
[62] T-309, per T M J Tosto; T-331, per L D Curran.

Hildene Medical Centre (**Hildene**) for assessment by a medical officer, to which he ultimately agreed.[63]

80. Michael was taken to Hildene via a medical buggy transport,[64] where he was examined by medical officer Dr Clinton. A handover summary of Michael's medical history and current vital signs was provided by the CCA nurses. This included concerns that Michael may have had a possible stroke and was complaining of a worsening headache, with tingling on the right side of the body and drooling.[65] They also relayed that Michael had a past history of Bell's palsy, a condition that causes sudden weakness or paralysis on one side of the face caused by inflammation or damage to the facial nerve.

81. Dr Clinton consulted Michael's JCare records, took a lengthy history from Michael and conducted an examination including a full neurological examination.[66] Dr Clinton gave evidence that on examination, Michael did not display shortness of breath: *"his lungs were clear and had no increased work of breathing"*.[67] The neurological examination revealed an abnormality of the seventh cranial nerve on the right side, but was otherwise normal.[68]

82. Dr Clinton also observed that Michael had pitting oedema to the knees. At inquest, he explained that this could have many different causes, some of which could be significant, such as cardiac failure, renal failure, side effects of medication or sedentary lifestyle.[69] While there was a possibility Michael may have had heart dysfunction, Dr Clinton did not consider any of the findings on examination were severe enough to require urgent investigation and management at the time in an acute setting.[70]

83. Based on his examination, Dr Clinton excluded the likelihood of stroke and formed a principal diagnosis of 'migraine'.[71] He did not identify any neurological signs or symptoms that required review by a specialist neurologist.[72]

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[63] T-307, per T M J Tosto; T-331, per L D Curran.
[64] T-109-20, per P M Whitfield
[65] T-156-7, per Dr Clinton.
[66] T-157-8, per Dr Clinton.
[67] T-160, per D J Clinton. Later in evidence, Dr Clinton confirmed that *"at the time he wasn't short of breath, um, and his chest was clear"*. T-161, per D J Clinton.
[68] T-158-9, per D J Clinton.
[69] T-160, per D J Clinton.
[70] T-160-1, per D J Clinton
[71] T-159, per D J Clinton.
[72] T-191, per D J Clinton.

84. Dr Clinton prescribed Michael 900mg aspirin in accordance with Australian therapeutic guidelines.[73] He also directed that Michael be reviewed the next morning in the general nurse clinic, with escalation to a medical officer if there were any signs of deterioration.[74] He did not deem it necessary to keep Michael at Hildene overnight for observation, or to send him to hospital.[75] An appointment was arranged for Michael to be reviewed in the general nursing clinic the following day at 1.30pm. This was the earliest available appointment for the protection prisoners.[76] Michael was informed of the upcoming appointment for the next day, and these details were also accessible to Michael via his in-cell device.[77]

85. In addition, Dr Clinton ordered an electrocardiogram (**ECG**) at Michael's request while he was at the clinic.[78] Michael had previously missed appointments for the ECG as they conflicted with the time that he received his methadone. The ECG was required prior to any adjustments being made to increase Michael's medications; it was not directed in response to any observed symptoms.[79]

86. Nursing staff conducted the ECG, which was reviewed and interpreted by medical officer Dr Ekwebelam, who had ordered the investigation.[80] Dr Ekwebelam reviewed the results to ascertain whether the QT interval[81] was prolonged, given the medications Michael was on, including methadone.[82] The results, according to Dr Ekwebelam were *"still in the safe range for a man"*[83], and did not provide any indication of potential heart enlargement.[84] While Michael's increasing weight could raise concerns for the function of his heart and put pressure on organs in the body, no specific concerns about Michael's heart function were indicated at this time.[85]

[73] T-163, 165, 194-5 per D J Clinton.
[74] T-163-4; 175 per D J Clinton.
[75] T-172; 174, per D J Clinton.
[76] T-340, per L D Curran.
[77] T-345-6, per L D Curran.
[78] T-166, per D J Clinton; T-336, per L D Curran.
[79] T-162-3, per D J Clinton; T-204, per C C Ekwebelam; T336, per L D Curran.
[80] T-166, per D J Clinton; T-200-1, per C C Ekwebelam.
[81] An elongation of the QT interval would indicate the risk of heart dysfunction, a risk which might be exacerbated if certain medications were increased.
[82] T-201-3, per C C Ekwebelam.
[83] T-205, per C C Ekwebelam.
[84] T-205, per C C Ekwebelam. Dr Ekwebelam explained that if a person has left ventricular hypertrophy or dilatation, there may be very high peaks in the leads called V4 and V5, which Michael did not have.
[85] T-207-8, per C C Ekwebelam.

Michael's return to Dunmore Unit on 5 March 2021

87. Following his assessment Michael walked back to the Dunmore Unit without assistance of the medical buggy transport. CCTV footage confirms that Michael arrived back at Dunmore at approximately 9.50am, half an hour after arriving at Hildene.

88. The correctional officers expressed surprise and concern at the swiftness of Michael's return to the unit. They had anticipated that it would take longer for clinical staff to address his health conditions.[86] The correctional supervisor asked the officers to monitor Michael's presentation and report any anomalies.[87]

89. Michael's movements, captured on CCTV over the following hours, do not indicate any obvious concerns regarding Michael's presentation, to the extent this can be detected audio-visually. The correctional officers did not identify, nor escalate, any concerns about Michael's presentation over the following day.[88]

90. At 11.43am, Michael left the unit to collect his methadone. At 2.01pm, Michael called his mother, Maree, using a fellow prisoner's telephone account. During that call, he referred to the medical episode that morning 'as a stroke'.

91. At 3.30pm, Michael collected his medication. He received a hot meal at 4.10pm and returned to his cell at around 5.10pm, carrying an in-cell device, and he was locked down at 6.16pm.

Movements on 6 March 2021

92. On the morning of 6 March 2021, Michael attended the officers' post where he spoke with correctional officers about his in-cell device not working. He was provided with a spare device to try, and when that was not operational, he was moved to another cell where there would be a working device.

93. At 10.30am, Michael was moved from his cell on Dunmore 'B' Side to Cell 5 on Dunmore 'A' Side, where he was to be housed in a double cell with Prisoner 1. He was assisted by two other prisoners to move cells. Prisoner 1 gave evidence that he was told by prison staff to *"look after Michael"*,[89] although the correctional officers did not recall saying this to Prisoner 1.

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[86] T-140, per S R Lee.
[87] T-111, per P M Whitfield. This direction was made on the supervisor's own initiative. No direction was given by CCA staff to perform those checks, and there are no general policies in place for correctional staff to monitor prisoners who have returned from a medical assessment. T-127-8, per P M Whitfield.
[88] T-111, per P M Whitfield; T-145, per S R Lee.
[89] T-462, 478, per Prisoner 1.

94. Prisoner 1 gave evidence that Michael had told him he had a stroke the day prior.[90] He observed Michael was droopy on one side of his face, his speech was funny, and he had issues with one of his hands.[91]

95. At 1.10pm, Michael received his methadone. He was released from the opioid substitution therapy program (**OSTP**) holding cell shortly afterwards and returned to the Dunmore unit.

96. Michael's follow up appointment with the general nursing clinic was scheduled for 1.30pm. However, he did not attend. In accordance with the usual processes, nursing staff marked that Michael had not attended in the JCare record. Michael was also noted to have a forthcoming appointment on 8 March 2021.[92]

97. It was not usual practice at the time for the clinic to contact patients who did not attend their appointment, unless a specific note was made in the booking.[93] Rather, evidence at inquest indicated that CCA nurses did not have capacity to contact all patients who did not attend to remind them to attend, notwithstanding that CCA policy required patients who failed to attend appointments to be actively followed up.[94] The resourcing issues are discussed further at 'Issues Examined at Inquest' below.

98. At 3.45pm Michael collected his medication. Later that afternoon, correctional officers provided Michael with cake and milk, as he had not received his meal due to his cell change from the 'B' side to the 'A' side. Nothing unusual was observed in Michael's presentation.

99. Prisoner 1 saw that Michael was having trouble eating. He stated that *"one minute he'd be talking to me next minute he'd be asleep"*. He helped Michael pick up things that he had dropped in the cell, including his food.[95]

100. Dunmore 'A' Side was locked down at approximately 6.10pm. Prisoner 1 listened to music for a while, and then Michael fell asleep and commenced snoring loudly.[96]

101. Overnight, at approximately 3am, Prisoner 1 awoke to find Michael on the toilet, asleep and snoring. He assisted Michael back to bed, steadying his balance, and covered him with his doona. Prisoner 1 returned to bed and fell asleep a short while later.[97]

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[90] T-478, per Prisoner 1.
[91] T-464, per Prisoner 1.
[92] T253-254; 258-259, per S Joseph.
[93] T-259, 263, per S Joseph; Evidence of G Komp; T-375, 379, per G Komp.
[94] T-266-7; 280-2, per S Joseph. See also CB-1242.
[95] T-465-6, per Prisoner 1.
[96] T-467, per Prisoner 1.
[97] T-467, per Prisoner 1.

Code Black on 7 March 2021

102. On 7 March 2021, at approximately 7.10am, the morning muster was called via the intercom. The correctional officers came around to conduct the count five minutes later, at which point they were required to open the trap and receive a response from each prisoner in each cell before moving to the next cell.

103. Prisoner 1 recalled moving around when the trap was open, but that *"Michael didn't give a response or move"*.[98] He believed Michael was still sleeping.[99]

104. The correctional officer gave evidence that he saw Michael on his bed through the trap but moved on from Cell 5 before getting a response from him.[100] This was contrary to the correctional officer's usual practice and established procedures to seek a response from each inhabitant.[101]

105. The correctional officer explained at inquest that, having just returned from leave, he *"got a bit complacent because I generally always get a movement from the prisoner to make sure that they are okay by either tapping on the door or kicking the door with my boot to get a response until they move, and then we carry on with the count. Unfortunately, on that day I failed at that"*.[102] This was a regrettable deviation from required practices. However, it was not contributory to Michael's passing, and I am satisfied that Ravenhall have taken appropriate remedial action to ensure compliance with prisoner count processes in the future.

106. At approximately 7.25am, the cells were unlocked after the count was completed. Prisoner 1 approached Michael's bed and tried to wake him up to let him know the cell had been unlocked. Michael was unresponsive, and he observed Michael's hands were bluey-red.[103] Prisoner 1 sought assistance from a prisoner in the neighbouring cell, and then attended the officers' post to report the situation.[104]

107. Correctional officers immediately attended Michael's cell.[105] They observed Michael lying on his bed, in the same position, but with a blanket now over him. They checked for signs of life, but there was nil present.[106] A Code Black was initiated at approximately 7.32am and emergency services were called to attend.

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[98] Statement of Prisoner 1 dated 16 March 2021, CB-108.
[99] T-468, per Prisoner 1.
[100] T-391-2, per S Ransom.
[101] S Ransom T-119, per S Ransom; T-390-2, per P M Whitfield.
[102] T-392, per S Ransom.
[103] T-468-9, per Prisoner 1.
[104] T-469, Prisoner 1; T-392-3, per S Ransom.
[105] T-393, per S Ransom.
[106] T-393, per S Ransom.

108. Two CCA nurses arrived at 7.35am and received a brief handover from the officers.[107] The nurses sought assistance from the officers to get Michael onto his back, which required all four of the responders to assist. They then commenced cardiopulmonary resuscitation (**CPR**), with use of an external defibrillator, until the arrival of Ambulance Victoria (**AV**) and Country Fire Authority officers at 9.50am.[108]

109. Sadly, Michael was unable to be revived, and the AV paramedics confirmed on assessment that Michael had passed.[109]

IDENTITY OF THE DECEASED

110. On 12 March 2021, Michael Garry Suckling, born 25 May 1979, was formally identified by way of fingerprint comparison.

111. Michael's identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

112. A key issue in dispute at inquest was the formulation of the cause of Michael's passing. To assist me in determining the medical cause of death, I heard evidence at inquest from forensic pathologist Dr Iles, an expert cardiologist panel comprised of Dr Helprin and A/Prof Strathmore, and a panel of general practitioners comprised of A/Prof Matthews, Dr Bartels and Dr Nicholls.

Post-mortem examination

113. On 11 March 2021, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy on the body of Michael. Head of Forensic Pathology, Dr Linda Iles, undertook a histological examination and provided a written report of the autopsy findings on behalf of Dr Burke dated 18 May 2021.

114. The post-mortem examination revealed:

    a) Michael weighed 199kg, placing him within WHO class III obesity, with a body mass index of 54.5 kg/m^2. Class III obesity is a complex chronic disease in which a person has

[107] T-381, per S G Komp.
[108] T-381-2, per S G Komp. The investigation identified that there was a brief delay in the commencement of CPR, as the correctional officers waited for the arrival of CCA nurses. Ordinarily, it would be expected that correctional officers would commence CPR as first responders to an incident, where they are trained to do so. However, Michael's positioning meant it was not possible for the correctional officers to get Michael onto his back by themselves, and in the case of one of the correctional officers, they had never performed CPR before. Further, there is no evidence that earlier commencement of the CPR would have altered Michael's tragic outcome. In the circumstances, I make no adverse findings against any of the first responders, who responded to the best of their ability in stressful circumstances.
[109] JH-63; T-382, per S G Komp.

a body mass index of 40 kg/m^2 or higher. A BMI of over 50 kg/m^2 is associated with very significant morbidity and mortality.[110]

b) significant cardiac enlargement (cardiomegaly) and bilateral pleural effusions. Michael's heart weighed 675g, where a man of his height might be expected to have a heart weighing about 504g. Cardiac enlargement is a risk factor for cardiac dysfunction, cardiac dysrhythmias and, and is a well-known cause of sudden cardiac death.[111]

c) there was some evidence of subepicardial scarring of the myocardium, which can be seen following episodes of cardiac inflammation or arrhythmogenic cardiomyopathy. There was insufficient finding at evidence to make a diagnosis, but the possibility of arrhythmogenic cardiomyopathy could not be excluded.

d) no evidence of traumatic injury contributing to death. Further, while concerns had been raised that Michael may have suffered a stroke in the days prior to his death, neuropathological examination showed no evidence of acute, subacute or chronic ischaemic brain injury.

e) scattered necrotic calcified lung nodules indicative of a remote lung infection, as well as foreign body granulomatosis within the lungs. There was also liver cirrhosis and statosis.

115. Toxicology testing of post mortem blood detected methadone[112] (~1 mg/L) and its metabolite EDDP (~0.2 mg/L), amitriptyline[113] (~0.3 mg/L) and its metabolite nortriptyline (~0.2 mg/L), mirtazapine[114] (~0.4 mg/L), hydroxyrisperidone[115] (~ 8 ng/mL), olanzapine[116] (~0.5 mg/L), quetiapine[117] (~0.2 mg/L) and trace amount of paracetamol.

116. At the time of his passing, Michael was prescribed mirtazapine, amitriptyline and sodium valproate for treatment of his mental illness and methadone to treat chronic pain and opioid

[110] T-22, per Dr Linda Iles.
[111] Autopsy Report dated 18 May 2021, CB-21; Report of Dr Gary Nicholls dated 20 October 2022, CB-4330.
[112] Methadone is a Schedule 8 drug indicated for opioid dependence in former heroin addicts and severe pain. Persons prescribed methadone as a pharmacotherapy for drug addiction must have a permit issued from the Drugs and Poisons Regulation Group, Department of Health. Therapeutic postmortem femoral blood concentrations can be as high as ~ 1 mg/L. Adverse effects of methadone include anorexia, bradycardia, constipation, diaphoresis, dizziness, headache, insomnia, nausea, palpitations, sedation, respiratory depression, ventricular arrhythmias, visual disturbances and weakness. Overdose can cause cold and clammy skin, coma, circulatory collapse, hypotension, miosis, muscle flaccidity, respiratory depression and stupor.
[113] Amitriptyline is a tricyclic antidepressant that inhibits the reuptake of noradrenaline and serotonin, indicated in the treatment of major depression, panic disorder, neuropathic pain and enuresis.
[114] Mirtazapine is indicated for the treatment of depression.
[115] Hydroxyrisperidone is the metabolite of risperidone, an atypical antipsychotic drug effective against the positive and negative symptoms of schizophrenia.
[116] Olanzapine is an atypical antipsychotic drug indicated for mood stablisation.
[117] Quetipaine is an atypical antipsychotic agent.

dependence. He was also prescribed four medications to reduce the risk of a cardiovascular event: amlodipine, atorvastatin, fenofibrate and rivaroxaban. Three medications identified in the toxicology results – risperidone, olanzapine and quetiapine – were not prescribed to Michael, and were likely obtained through diversion from other prisoners.

117. Dr Iles commented that while the concentration of methadone identified was relatively high, in the absence of any documented recent increase in methadone dose or change in dispensation of his regular dose, given his body habitus, this could/may well reflect a normal therapeutic concentration of methadone. Tolerance to opiates and other CNS depressant drugs can vary markedly, however the setting of controlled dosage of regularly administered medications makes acute toxicity in the form of centrally mediated depression of cardiorespiratory function unlikely. Michael had received treatment for opioid dependence with methadone and/or buprenorphine since 11 October 2016.

118. Dr Iles commented that, whilst cardiomegaly is not a pathological diagnosis, based on histological examination and Michael's past medical history, it was likely multifactorial in nature. There was no evidence of valvular heart disease or significant coronary artery artherosclerosis. However, he had a history of persistent hypertension, was notably obese, and had a possibility of obstructive sleep apnoea (not formally diagnosed) which would place significant stress on the heart.

119. Dr Iles provided an opinion that the medical cause of death was *'1(a) Cardiomegaly in a man with WHO Class III obesity*'. There was no evidence to suggest that the death was due to anything other than natural causes.

What was the cause of Michael's death?

120. Examining Michael's cause of death and any possible contributing factors required me to consider several aspects of Michael's health, including obesity, medications, cardiac conditions, and obstructive sleep apnoea (**OSA**).

Obesity

121. Class III obesity is a complex chronic disease in which a person has a BMI of 40 or higher.[118] The WHO provides the scales in relation to BMI health.[119]

[118] T-21-22 per Dr Linda Iles.
[119] T-22 per Dr Linda Iles; See alsoWorld Health Organisation FactSheet, 'A healthy lifestyle – WHO recommendations', accessible at https://www.who.int/europe/news-room/fact-sheets/item/a-healthy-lifestyle---who-recommendations.

122. A BMI over 50 is associated with very significant morbidity and mortality.

123. Increasing weight can cause various metabolic changes and cardiometabolic abnormalities. As the degree of obesity increases, so too does the risk of cardiac disease. The main issue with obesity is the extra load that is put on the heart, requiring the heart to pump more strongly to pump blood around the larger body.

124. Some people can be obese but have normal cardiac function and a normal metabolic profile, but that is relatively unusual.

125. Generally, obesity is associated with conditions like hypertension (high blood pressure), OSA (periods of hypoventilation during sleep) and abnormal metabolic profile. In obese individuals, there is also increased blood volume requiring the heart to work harder. Each of these features can be deleterious to cardiac function, and in the context of obesity can be referred to as Obesity Cardiomyopathy.

Cardiomegaly

126. Cardiomegaly refers to an enlarged heart. It is a description of the heart as enlarged, rather than a pathological diagnosis. Heart enlargement caused by obesity can lead to serious heart problems, such as heart failure and cardiac arrhythmia. It is a well-known cause of sudden cardiac death.

127. Michael's heart weighed 675 grams. For a person of Michael's height, the upper 95% confidence interval for heart weight is 504 grams.

128. The main reason a heart becomes heavy is because it is doing extra work. This can cause remodelling of the heart muscle, such that it changes its morphology including fibrosis in the heart, both of which can cause increase to cardiac weight. Once those stressors are applied to the heart, it can cause the heart to fail, or cause an increased predisposition to cardiac arrhythmias, which can have fatal outcomes.

129. In a person who weighs 199kg, there is a likelihood that the heart is enlarged. And therefore, there is an associated increased risk of sudden death.

130. Michael gained a significant amount of weight over a relatively short period of time and in that context, enlargement of his heart is not unexpected.

131. In the autopsy report, the cardiac enlargement is described as both "*significant*" and later as "*moderately enlarged*".[120] A/Prof Strathmore asserted that in the context of Michael's BMI, it is

[120] Autopsy Report, CB-21, 24.

"*mildly enlarged*"[121], rather than moderately to severely enlarged. In Dr Helprin's view any extreme sized heart, whether it has enlarged with obesity or reduced through anorexia, is not a healthy heart[122].

132. Whilst there was some dispute about the most appropriate calculators with which to measure heart enlargement, ultimately, both cardiologists agreed with Dr Iles, that Michael had an enlarged heart, which was causally related to his death.[123]

133. Based on the evidence I accept it is likely that Michael's "*heart condition of Cardiomegaly was developing over a period of a few years, but it deteriorated in his final months*".[124]

Cardiac Arrythmia

134. There is a recognised association between an enlarged heart and electrical conduction abnormalities of that heart. Michael's heart stopped – he had a cardiac arrhythmia – in circumstances where his heart had grown enlarged.

135. Heart failure is a general clinical term where the heart is unable to produce a cardiac output sufficient to supply the body's needs. Usually, it occurs when the heart is weak. Symptoms can include shortness of breath (**SOB**) and fluid accumulation in the legs, known as peripheral oedema. There is insufficient evidence to conclude that Michael had heart failure as Michael suffered from co-morbidities that are also known to cause the same symptoms.

136. Michael had several ECGs during his time in custody. These were reviewed by the cardiology experts, who found that there were not any major changes to his heart function indicated.

137. Michael also had a transthoracic echocardiogram on 28 May 2019 which did not indicate abnormal heart function. Other tests that could have been conducted on Michael to determine his heart health include: MRI, which may not have been possible because of Michael's body habitus; angiography, which is more intrusive and involves certain risks; and transoesophageal echocardiogram, which is more invasive as the ultrasound probe is placed down the oesophagus.

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[121] T-1565-6, per A/Prof Strathmore

[122] T-1527, per Dr Helprin. Dr Helprin explained at T-1517 that: *it's a continuum and the larger you get, the more stress there is on the heart and then there's some very complex things happening bi-chemiccally with, with – with fatty tissue…the bottom line is that the heart can enlarge when people become morbidly obese, but it's not a healthy enlargement…it…can lead to pretty serious problems such as heart failure and a cardiac arrhythmia"*.

[123] T-1526-8, 1532, 1534 per Dr Strathmore; T-1528, 1532-3, per Dr Helprin. Dr Strathmore agreed with Dr Helprin that *"the most likely cause of death in the end was a ventricular arrhythmia, as he describes ventricular tachycardia or ventricular fibrillation, and that this is on the basis of an abnormal heart"*.

[124] Report of Dr Gary Nicholls dated 20 October 2022, CB-4330.

None of these testing procedures were indicated as appropriate referrals for Michael, and none were undertaken.

138. Dr Nicholls gave evidence that;

> *"Mr Suckling's later medical conditions were chronic and serious and most likely to be progressive and irreversible. I do not think that his eventual outcome would have been prevented even if he had gone to hospital for specialist cardiac treatment in the days or weeks (or months) prior to his death."*[125]

139. I accept Dr Nicholls' opinion and I make no criticism of the health professionals for not referring Michael for the investigative tests beyond the ECG.

Obstructive Sleep Apnoea

140. In December 2019, when Michael was admitted at St Vincent's Hospital, records indicated he "*has likely undiagnosed COPD [chronic obstructive pulmonary disorder] and OSA*" and a respiratory function test and sleep study was suggested. The recommendation was never followed up by primary care clinicians so no further diagnosis was made.

141. OSA can lead to a low oxygen level during sleep. Low oxygen level can trigger a ventricular arrythmia and then cause death.

142. Morbid obesity is the strongest risk factor for developing this condition. Michael reported symptoms of OSA, including snoring and suffering daytime somnolence (drowsiness). He made self-referrals for assessment of sleep apnoea, however he was never fully investigated for the condition. OSA can also cause cardiac enlargement.

Prescribed and unprescribed medications

143. In addition to Michael's physical conditions, Michael had a long association with prescribed and unprescribed, legal and illicit drug use.

144. At time of his passing, Michael was prescribed three medications for treatment of his mental illness:

    a) Mirtazapine 45mg nocte (atypical tetracyclic anti-depressant, prescribed for treatment of depression);

    b) Amitriptyline 25mg nocte (known as Endep, a psychotropic agent, prescribed for pain management and as an opioid sparing agent); and

[125] Report of Dr Gary Nicholls dated 20 October 2022, p 4316.

c) Sodium valproate 200mg BD (prescribed for emotional dysregulation).

145. Michael was also prescribed methadone 100mg daily to treat chronic pain and opioid dependence.

146. Mirtazapine, Amitriptyline, Sodium Valproate and Methadone are all capable of contributing to weight-gain. They are also all sedative in nature, which can be problematic in patients who are obese and suffer from OSA.

147. Michael had also been prescribed medications to reduce the risk of a cardiovascular event including:

a) Amlodipine (prescribed to treat hypertension);

b) Atorvastatin (prescribed to lower cholesterol);

c) Fenofibrate (prescribed to lower fatty substances in blood); and

d) Rivaroxaban (anticoagulant, prescribed to treat pulmonary embolism in 2016).

148. Amitriptyline and Methadone are both capable of interfering with the electrical function of the heart, by prolongation of the QT interval.

Conclusion on cause of death

149. DJCS[126], CCA[127] (with whom GEO agreed[128]) and Dr Ekwebelam[129] all submitted the evidence did not allow me to make a finding as to the cause of Michael's passing. In support of this contention, reliance was placed on:

a) evidence from the cardiologist panel regarding the "combination of factors" that could result in an increased risk of sudden death[130], such that the exact cause of death could not be *"dissected"*.[131]

b) other potential causes which may have alone, or in combination, led to arrhythmia, included the postmortem findings of scarring in some sampled sections of the myocardium, prescribed and non-prescribed medications, and undiagnosed obstructive sleep apnoea.[132]

[126] Submissions of DJCS dated 11 August 2023, [9]-[14].
[127] Submissions of CCA dated 10 August 2023, [18]-[23].
[128] Reply Submissions of GEO Group dated 1 September 2023, [1].
[129] Submissions of Dr Ekwebelam dated 11 August 2023, [8]-[10].
[130] Submissions of DJCS dated 11 August 2023, [10].
[131] Submissions of DJCS dated 11 August 2023, [10].
[132] Submissions of DJCS dated 11 August 2023, [11]-[13].

c) toxicological evidence that Michael had taken a *"cocktail of anti-psychotic drugs that he was not prescribed"* prior to his death, and which the evidence was unable to determine whether any or all of these drugs alone or in combination caused Michael's passing.[133]

d) common law principles of causation, and specifically that an increased risk of an event occurring, does not on its own, establish causation.[134]

150. During evidence Dr Iles and the cardiologist panel were questioned extensively about the pathological findings and the cause of death.

151. The consensus view of the cardiologist panel was that Michael had an enlarged heart, although there were differing views on the degree of enlargement. Further, the panel agreed that cardiac enlargement is a risk factor for cardiac dysfunction, cardiac dysrhythmia and sudden death.

152. There was evidence concerning the multiple aetiologies for cardiac dysrhythmia, and I accept that Michael's cardiomegaly may have had multiple aetiologies including hypertension, OSA, increased blood volume, and additional strain on the lungs. Further, I accept the role of contributing factors is impossible to differentiate. However, as explained by Dr Iles, the cause that runs through all of the multi-factors is obesity[135], and the panel agreed as to the essentials, that Michael had an enlarged heart the primary cause of which was obesity[136].

153. Dr Iles was not challenged on her formulation of the cause of death in evidence.

154. The cause of death is ultimately a question of fact to be determined by the Coroner after weighing all the evidence.

155. I am satisfied on the balance of probabilities that the evidence supports a finding the pathological cause of death was cardiomegaly in a man with WHO class III obesity as formulated by Dr Iles.

ISSUES INVESTIGATED AT INQUEST

156. At inquest, extensive evidence was given about the circumstances of Michael's death and his experiences in custody, with a particular focus on:

a) the assessment and management of Michael's healthcare needs on entering custody.

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[133] Submissions of DJCS dated 11 August 2023, [11]-[13].

[134] Submissions of CCA dated 10 August 2023, [22], referring to *Powney v Kerang District Health* (2014) 43 VR 506 at [104] citing *Amaca Pty Ltd v Booth* (2011) 246 CLR 36 at [41], in which French CJ held that *"Causation in tort is not established merely because the allegedly tortious act or omission increased a risk of injury. The risk of an occurrence and the cause of the occurrence are quite different things. That proposition is obvious enough and not determinative of these appeals"*.

135 Evidence of Dr Iles T32

136 Evidence of Dr Heprin and Dr Strathmore T 1532

b) identification and management of Michael's weight gain.

c) barriers faced by Michael in accessing suitable medical and mental health treatment.

d) Michael's access to culturally appropriate care and treatment.

e) the adequacy of Michael's care and treatment in the days prior to his passing.

f) remedial measures implemented since Michael's passing to improve health outcomes for Aboriginal prisoners.

The Justice Health Quality Framework

157. The Justice Health Quality Framework (**JHQF**) includes foundational standards that should underpin prison healthcare. These standards are described in the JHQF as intrinsic to the delivery of quality healthcare and include safety, effectiveness and appropriateness, person-centredness, accessibility and continuity.

158. The JHQF aims to ensure that prisoners receive equivalency of care, which means prison health services provide a quality of care that is equivalent to that provided in the community.

159. An examination of Michael's healthcare experience requires an analysis of his care through this lens.

Assessment and management of Michael's healthcare needs on entering custody

160. Although Michael's assessment and management on entering custody was not causal or contributory to his passing, it was a relevant focus of the investigation.

161. Michael needed acute health care immediately after the accident for which he was subsequently sentenced. He was hospitalised, initially at Bendigo Health, St Augustine's, and subsequently transferred to a secure ward at St Vincents Hospital.

162. Because he came into custody through hospitalisation, Michael's reception procedure into MRC differed from that which normally occurred.

163. When Michael first entered custody his inter-prison transfer assessment form was not properly completed. There was no "M" rating recorded[137] and the form noted "CV data unavailable". It was a less detailed form than the standard comprehensive medical and psychiatric reception assessment that is undertaken when prisoners are entering custody for the first time.

[137] "Risk Assessment and Observations" dated December 2015, which contains the following definition: "M" status – The scale: M1, M2, M3 refers to any medical condition that requires immediate treatment, including and known or suspected conditions that have not been confirmed': Additional Materials (**AM**)-25-73.

164. It was also evident that the information gathered during the reception process was largely self-reported by Michael. No collateral information was collected[138].

165. Dr Joseph gave evidence that when a patient was transferred from St Augustine's, the medical records from Bendigo Health and St Augustine's would not have formed part of the JCare medical file available to prison doctors receiving Michael into their care. Rather, these files needed to be independently requested.

166. Dr Joseph also told the court when a discharge summary is not received, medical staff could download the discharge summary from a St Vincent's intranet[139], however there was no evidence that suggested staff accessed Michael's discharge summary in this way.

167. Records reveal a telephone handover took place and there was a file notation that Michael "may be considered drug seeking, was on methadone (35mg) and had rib fractures".

168. Although Michael was assessed by a nurse at his intake, there was no evidence of an assessment undertaken by a medical officer.

169. Michael also missed receiving a comprehensive Reception Psychiatric Assessment. There were no records to indicate that Michael had been assessed for primary mental health follow up, or that he required specialist mental health treatment. Had he been assessed as requiring specialist mental health attention Michael would have received a referral to Forensicare.

170. Dr Kate Roberts, Director of Clinical Services, Prison Services, agreed some of Michael's later psychiatric issues may have been detected earlier if he had received the standard Forensicare psychiatric assessment upon his entry into custody.

171. While I accept the evidence of Associate Professor Matthews that "*there is a limit to what can be accomplished in the health reception assessment*"[140], I consider that Michael's reception assessment fell short of what was required and could reasonably have been expected.

172. In circumstances where Michael was identified in the inter prison transfer assessment as Aboriginal, these failures elevate my concern about the deficiencies of the process that Michael experienced.

173. I consider that Michael's reception into prison constituted a lost opportunity to properly assess Michael's physical and mental state at the time of his entry into custody. A more detailed

[138] JH-329.
[139] The system is known as MRO: T-1053-4, per Dr Joseph.
[140] Report of A/Prof Matthews, CB-3816

assessment would have ensured Michael was provided with appropriate and targeted supports at the earliest opportunity to assist him in navigating his ongoing struggles with pain and trauma arising from the motor vehicle accident.

174. Although these failures did not cause Michael's death, there are gaps in the system that must be rectified to improve the healthcare experience for prisoners like Michael at the timeliest juncture of their incarceration.

Michael's weight gain and management in custody

175. Any consideration of Michael's care and treatment must also occur through the lens of patient autonomy. In a custodial setting, where so many aspects of day-to-day life do not involve freedom of choice, patient autonomy is important. I agree with the submission of Counsel for DJCS that people do not lose their right to make decisions about their diet, their level of exercise and their own medical treatment just because they are incarcerated and being forced or coerced to attend healthcare appointments would be a breach of prisoners' Charter rights[141].

176. The evidence about Michael's precise weight at his reception into custody was equivocal. The lack of certainty about Michael's entry weight was due to the circumstances of his reception (as he went straight into hospital). The available records suggest Michael self-reported his weight at that time.

177. From July 2018, however, Michael's weight gain trajectory was easier to track.

178. Records established that Michael's weight was recorded on at least 54 occasions during his imprisonment. The helpful table drawn by Counsel Assisting showed a steady trend of weight gain. At the time of his passing Michael weighed 199 kilograms.

179. Weight gain is not uncommon in a custodial setting due to a variety of reasons and not all of which are linked to poor health. However, for Michael, weight gain was rapid (taking place over 3 years), and it interacted with his comorbidities, physical and mental, in a manner that diminished his overall health and wellbeing significantly.

180. Michael regularly bought a significant amount of high-calorie canteen food at all three prisons, particularly Ravenhall. A witness reported Michael would buy junk food and meat packs intended for multiple meals: "*Mic was buying um like meat packs, so that's every week, which-*

[141] *Charter of Human Rights and Responsibilities Act 2006*, ss 10(c) and 22(1).

which allowed him to have two hamburgers, two steaks and two sausages in a - in the meat pack. And also, he was buying packs of chips and lollies and heaps of soft drinks from the canteen".[142]

181. I also heard evidence that Michael knew his weight gain was an issue, and he seemed to want to lose weight. However as is the case with a significant percentage of the community, he found it incredibly challenging despite his desire.

182. Nicole Watt, a registered nurse, saw Michael in 2019 at the Koori Health Clinic at PPP. The notes record Michael's concern with his weight gain. This was followed by a self-referral on 14 November 2019 where Michael recorded that he had put on 70 kgs and he had a discussion with Ms Watt about the merits of the "healthy options" provided for prisoners.

183. Michael and Ms Watt continued to pursue a referral to a dietician until December 2019. Despite these requests no one facilitated a referral to a dietician.

184. Dr Joseph initially attributed this failure to Michael, saying that he failed to re-raise his concerns at subsequent medical appointments. Later in evidence, Dr Joseph indicated that Michael would have had to demonstrate a commitment to losing weight and have commenced on this path prior to such a referral being made. "*If you have not made the right changes, a dietician is just going to write you off and say you…Don't need to see me again because there is no follow – there is no- you're not adhering to advice*."[143] I accept that Dr Joseph considered that a certain threshold has to be met by a prisoner before a GP is prepared to refer a prisoner, so as to "*not to set him up for failure."* [144] and this is a sensible perspective from a place of good intention. Nevertheless, I consider it sadly ironic.

185. Professor Jackie Curtis gave evidence that simply advising people to eat more healthily or to exercise more and leaving it to their choice, does not seem to work to motivate people sufficiently. Rather, programs built around holistic care, involving dieticians, exercise physiologists, gym training and other forms of social connectedness build much greater enthusiasm and motivation for participants.

186. Professor Curtis also observed once a person has more enduring mental health problems and has reached obesity, simply suggesting that someone goes away and loses weight is not likely to be effective, even in the general population. It can be even harder to motivate someone who has already developed obesity, and particularly so for a person suffering mental illness.

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[142] T-488, per David (a pseudonym).
[143] T-1073, per Dr Joseph.
[144] T-1073, per Dr Joseph.

187. Clinical strategies to address Michael's weight gain across the prisons were limited; most medical notes on the subject simply reported that Michael had either gained weight and/or needed to lose weight, and that he should reduce his calorie intake and increase his exercise.

188. With respect to the clinician's handling of Michael's weight gain I heard evidence that a number of healthcare personnel and custodial staff expressed their concern for Michael and encouraged him to change his habits. For example, Michael's case workers advocated for his weight loss to be supported through diet shakes and a healthy lifestyle course. However, no steps were taken by others to action these referrals. In any event, as observed by A/Prof Matthews; *"exhorting Mr Suckling to reduce his food intake from the canteen would be unlikely to succeed as a sole measure"*.[145]

189. While I have no criticism of specific health care providers across the different prisons, the best that can be said of the clinical response to Michael's weight gain was that it was ad hoc and perfunctory.

190. In the context of his consistent weight gain, the risk that obesity poses to health, Michael's obvious disengagement and missed appointments, it is clear he needed a different, more intensive approach to his weight management.

The intersection of Michael's physical and mental health issues

191. The impact of mental health on physical health can be profound. Poor mental health is known to have a diminishing impact on physical health, and in particular, depression and anxiety are both strongly associated with weight gain.

192. The Equally Well Consensus Statement[146] focuses on the intersection of mental and physical health. It provides guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to the health needs of people living with mental illness. It also contains strategic actions to improve physical health outcomes for people living with mental illness, including adopting a holistic, person centred approach.

193. Evidence suggested Michael's poor mental health was a key factor in his worsening physical condition. Although this was not limited to his time in custody, the fact and circumstances of Michael's imprisonment had a deleterious effect on Michael's already complex condition.

[145] Expert Report of Dr Richard Matthews dated 29 July 2022, CB- 3799
[146] National Health Commission: www.mentalhealthcommission.gov.au

194. Initially, Michael was an active self-advocate who vigorously agitated for some of his specific needs. But a pattern of non-attendance at medical, nursing and allied health appointments developed and increased in frequency over time and his advocacy diminished.

195. The non-attendance became particularly pronounced once Michael had moved to Ravenhall in August 2020. Michael is recorded as not attending nearly 60% of his scheduled appointments. Records show these are mostly denoted as a refusal to attend without any clarifying explanation. The evidence indicated that missed appointments were often recorded as a refusal even where there was an apparent scheduling conflict. The limited detail available in the records prevents any detailed scrutiny or analysis of the reasons behind Michael's failure to attend.

196. Between September and November 2020, Michael 'refused to attend' a number of specialist appointments with St Vincent's Health in relation to cardiac and respiratory consultations. Unfortunately, Michael's non-attendance leaves unanswered questions about his cardio health at that time and whether active measures could have been undertaken to improve his heart health, and little was done to interrogate the non-attendance.

197. Although there was evidence that clinicians identified Michael's cardiac and respiratory health concerns, and were responsive to them as they presented, Michael did not receive a comprehensive multidisciplinary team review.

198. I accept that I should not engage in "hypercritical assessments coloured by hindsight or *ex post facto* reasoning"[147], however there was evidence that Michael's disengagement and increasing isolation did not go unnoticed. I consider there is scope for improvements to the coordination of treatment and care for prisoners including broadening the criteria for inclusion in a case management approach. The GP expert panel consensus was that Michael warranted multi-disciplinary review and a multi-faceted approach.

199. Dr Nicholls agreed with A/Prof Matthews, that multi-disciplinary team reviews, early on in Michael's incarceration, may have supported his care. As did Dr Wenitong, who said:

> "*A GP treating a patient for something, not talking to the psychiatrist, not talking to the health worker, not talking to someone else, is actually designed to fail. Unless you've got a situation where communication can occur between all of the people caring for that patient, you miss vital bits and that's true both in the community and…within the prison system."*[148]

[147] CCA submissions p 2
[148] T-1321, per Dr Wenitong.

Fragmentation of healthcare and treatment

200. It is clear to me that Michael had access to a plethora of services and programmes, however, what emerged from the evidence was a sense of the fragmentation of his medical care and treatment.

201. Michael endured a range of interconnected health problems, from chronic pain and weight gain to mobility issues, mental health decline, and social withdrawal. Clinicians generally responded to each issue as it arose, however multiple transfers to different prisons diminished clinicians' ability to integrate his care and treatment.

202. By way of example, Michael saw a number of Forensicare psychiatrists across the prisons where he was housed. Records indicate there was a variation amongst the practitioners in relation to diagnostic impressions of Michael, and a range of plans for him. When asked about the lack of continuity in Michael's treatment Dr Roberts stated that "[i]*n an ideal world, you would have one practitioner… if a patient moves or a prisoner moves between sites, as happened in Michael's case, then you will get different psychiatrists*".[149] Dr Roberts also considered that a lack of continuity would be mitigated by the shared medical record. While I accept that the delivery of healthcare in prisons is necessarily constrained, and continuity of care is undermined by factors such as prisoner transfers, the mitigatory effect of a shared medical record relies upon consistently accurate and clear records that are readily available.

203. In addition, Michael was said to have benefited greatly from his time with Ms Patterson of the Mobile FMHS at MRC, however, he did not receive any one-on-one counselling or support from a psychologist at PPP ort Ravenhall. Dr Roberts indicated it was not available. The lack of access to counselling at PPP and RCC (outside an offender behaviour or crisis context) demonstrates a deficiency in continuity of care.

The need for a holistic approach

204. While doctors cannot compel the treatment of patients against their will, I am satisfied there was more that could have been done to engage Michael if his healthcare was approached from a trauma-informed, holistic and person-centred perspective.

205. The court heard compelling evidence from Dr Wenitong and Dr Pashen concerning this approach.

[149] T-1139, per K J Roberts.

206. Dr Wenitong remarked, for example, that the ACCHO services model showed higher compliance rates and better outcomes for participants, and he attributed the success to the holistic and relational trauma-informed practice method.

207. Dr Pashen observed that a holistic approach "*requires a communication strategy that should exist between all treating health professionals. This works best with a Case Management Model with support structures implementing a strategic implementation of the plan".*[150] Holistic, multi-disciplinary care *"is not just a whole lot of different providers under one roof, it's how they work together for – with the client in the centre of that."*[151]

208. Ravenhall did have a complex cases review process; however Michael did not satisfy the threshold of seriousness for intervention. Entry to a case review process was discretionary, and there were no clear or established criteria for multidisciplinary review.

Barriers to accessing suitable medical and mental health treatment

209. This section summarises the barriers to accessing suitable medical and mental health treatment that emerged from the evidence. My investigation initially focussed on Michael's health and presentation, however I also considered it necessary to examine the administrative, systemic and logistical barriers that affected his ability to access medical and mental health services.

210. In examining Michael's experience, several barriers emerged that prevented Michael taking full advantage of the health services available to him. These barriers to treatment included:

    a) Mental illness;

    b) Limited mobility; and

    c) Cultural factors.

211. The court heard evidence that "*Michael was substantially depressed, and he was substantially in pain*"[152], and video evidence was available that demonstrated Michael's lack of mobility.

[150] Joint expert report of Professor Pashen and Dr Wenitong, CB-3860.
[151] T-1322, per Prof Pashen.
[152] T-1294, per Prof Pashen.

212. When Michael took the near fatal overdose on his 40th birthday in May 2019, "*he wanted to die that day*"[153]. Maree said:

> *"He told me, and I know he did. He – he took 'em all. He took 'em all in. He was shattered that he had to be there for 10 years, and he'd lost everything so*."[154]

213. On 15 October 2019 a nurse noted: "*Feels amotivated, hopeless, helpless "All I do is sitting and eating …I have no life*"".[155]

214. Michael's case worker, PO Fisher also noticed that Michael seemed more depressed after he returned from Sunshine Hospital in 2019. Michael became frustrated due to his debilitating back pain. PO Fisher observed: "..*his tone of voice…just his attitude towards things since he came back. He seemed to be getting real depressed about things*."[156]

215. In relation to his mobility, Michael's injuries from the car accident caused him chronic pain, which continued throughout his imprisonment. Michael's friend, David, noticed Michael's behaviour changing after he moved to Ravenhall. He complained of pain frequently, and his only regular movement was limited to attending to obtain his methadone and medications. He stopped coming out of his cell to meet up for coffee or walk around the yard, particularly after he experienced injuries to the soles of his feet. He started shutting himself off from people, even the people that were trying to help him.

216. Some of the other obvious barriers to health care in the custodial setting include security considerations, resourcing, staffing and continuity of care. All these issues have previously been identified in coronial cases and some are the subject of further discussion in this finding.

Staffing and Covid-19

217. The pandemic decimated staffing levels and resourcing in healthcare and other sectors across the Victorian community. It impacted the prison system particularly hard. The need to take previously unimagined precautions meant that support services for prisoners, even those as important as cultural programmes, became logistically too burdensome.

218. Although I did not hear detailed evidence about the staffing levels of the healthcare service at Ravenhall, nurses gave evidence about their experiences at that time. Many of the witnesses reported they worked double shifts, and one witness felt the nurses were "run ragged". Nurse

[153] T-1276, per Maree Brincat.
[154] T-595, per Maree Brincat.
[155] JH-160
156 T-74, per S Fisher.

Joseph explained that at the General Nursing Clinic (**GNC**), there were often more bookings made than stated capacity of 50-55 appointments and that this was the result of a KPI that requires prisoners to be seen within three days by a nurse and within ten days by a doctor.

219. Records establish this happening on 6 March 2021, for example, when there were 4 simultaneous scheduled appointments at the GNC, one of them being a Management Clinic appointment, and thus subject to the 20-minute roundtrip from Hildene. At 1:15pm there were 3 simultaneously-listed appointments, and at 1:30pm – the time of Michael's appointment – there were also 3 simultaneously-listed appointments. Nurse Komp gave evidence that a number of these patients in this period did not attend; however, if all the patients had shown up *"I would've tried my hardest to see them all*."[157]

220. The court also heard that on the day of Michael's passing none of the four medical officers rostered on that day had worked their shift.

221. Ms Fuller gave evidence that staffing was a challenge during the pandemic due to staff being furloughed and identified as close contacts, however CCA had a system for replacing staff wherever possible and doing catch up clinics if replacements could not be found. She also told the Court that CCA endeavoured to set a culture which valued and rewarded staff.

222. I accept that the impacts of the pandemic on staffing were significant and unlikely to be repeated, however I was concerned about the unintended impact that quantitative KPIs has on the staff and the prisoners, and I have dealt with the issue of quantitative KPIs in my recommendations.

The rationale for a relational, holistic and trauma-informed approach to healthcare

223. Victorian Government policy in relation to assessment, treatment and care of Aboriginal prisoners is intended to achieve a relational, holistic, and trauma-informed approach.

224. The latest iteration of the Aboriginal Justice Agreement, *Burra Lotjpa Dunguludja* (**AJA4**), which was in place at the time of Michael's incarceration, identifies its principles as including:

    a) Be trauma-informed;

    b) Be restorative;

    c) Use therapeutic approaches;

    d) Respond to context;

157 T-264-5, per Nurse Joseph.

e) Be holistic; and

f) Address unconscious bias.

225. A holistic approach involves understanding the patient's whole environment – their family, where they fit, how they live - the whole picture. Holistic, multi-disciplinary care "*is not just a whole lot of different providers under one roof, it's how they work together for – with the client in the centre of that*."[158] It is an approach that "*requires a communication strategy that should exist between all treating health professionals. This works best with a Case Management Model with support structures implementing a strategic implementation of the plan*".[159]

226. Dr Wenitong said that 'trauma-informed' practice is critical in managing Aboriginal and Torres Strait Islander patients with chronic disease; and applying a 'relational approach' is essential to trauma-informed care.

227. Dr Wenitong outlined the physiological process of transgenerational trauma and how it related to Michael's health profile. He explained that epigenetic changes are genetic changes made by the environment we live in. They can leave a mark on genetic expression, and those marks can be passed down generationally, even though descendants may live in very different environments to their forebears. There can be a relationship between trauma-based phenotype changes and particular hardship in prison for Aboriginal people; lower average life-span; and other health conditions.

228. Dr Wenitong continued;

> " *While it may appear the cultural self-knowledge and identity may have been minimal, the effects of epigenetic changes are generational, that is phenotype changes based on trauma can be passed across generations including risk factors for disease from Aboriginal grandparents….*".[160]

229. He said that a relational approach:

> "*is really about learning more about the patient, but it's also sometimes telling them a bit about yourself…I think that's completely professional and in these situations like working with our mob, it's the only way to be effective, is to develop relationships…*"[161]

[158] T-1322, per Dr Wenitong.
[159] Joint Expert Report of Professor Pashen and Dr Wenitong dated 21 November 2022, per Professor Pashen, CB-3860.
[160] Joint Expert Report of Professor Pashen and Dr Wenitong dated 21 November 2022, per Dr Wenitong, CB-3846.
[161] T-1358, per Dr Wenitong.

230. Having heard Maree give evidence about her son, Dr Wenitong considered many of Michael's health and wellbeing issues flowed from his unresolved trauma. He noted that there is a strong evidence base for dealing with trauma in a different way in Aboriginal patients; "*dealing with trauma does require different kinds of approaches than just your standard kind of mental health treatment plans, et cetera, and there's a large movement in both psychology and psychiatry around trauma informed practice and that's at an institutional level*".[162]

231. Professor Pashen said that Michael's care was "*moderately adequate but complicated in part by failure to attend on many occasions*"[163]. There was a lack of coordinated, multidisciplinary approach, which was exacerbated by COVID and staff shortages. He said that repeated failures to attend appointments should have been a "red flag" for his worsening mental and physical deterioration.

232. While doctors cannot compel the treatment of patients against their will, there was more that could be done to engage Michael in better healthcare had a trauma-informed, holistic and person-centered approach been applied.

Culturally appropriate care and treatment

233. In the context of the overrepresentation of Aboriginal deaths in custody, it is imperative that prisons and adjacent prison services continuously reflect on the adequacy of the level of cultural appropriate care and treatment that is available in our health services.

234. A strong sense of cultural identity has been shown to be a protective factor for Aboriginal people in relation to both mental and physical health. Those who more deeply understand their cultural identity report better psychological outcomes and higher levels of well-being.

235. It is therefore critical that Victoria's prison system and allied services provide the highest level of culturally appropriate care and treatment and accommodate holistic and culturally responsive approaches, including the use of traditional healers, as a means by which to engage in care. Traditional healers can also be effectively used to engage and motivate withdrawn disengaged patients. Dr Wenitong said he had worked with traditional healers inside prisons and witnessed "really great success", particularly with patients with social and emotional wellbeing problems.

[162] T-1289, per Dr Wenitong.
[163] Joint Expert Report of Professor Pashen and Dr Wenitong dated 21 November 2022, per Prof Pashen, CB-3853.

236. A key initiative that has been implemented to improve to provide culturally appropriate care for First Nations prisoners was the funding and staffing of specifically designed and staffed positions at our prisons that catered to the needs of First Nations prisoners.

237. Due to the mixture of public and private prison arrangements there is no consistency to the number, and designated duties of these positions across the state.

238. Although Michael had a history of failing to attend appointments scheduled with mainstream health care providers in prison, particularly towards the end of his life, he was noted at various points to have attended diligently to his health issues when supported by the Aboriginal Health Worker (**AHW**).

239. The AHW constitutes an intermediary between the Aboriginal patients and mainstream medical staff, providing support in attending health appointments, improving the social and emotional wellbeing of Aboriginal men in the correctional environment, and conducting education with the view of improving health literacy.

240. There was no AHW at MRC and thus no opportunity for any culturally-specific health interventions in the first nine months of Michael's incarceration.

241. The court heard evidence that organisations face staffing and retention challenges in relation to these positions so they are often vacant.

242. Michael never saw an Aboriginal Wellbeing Officer (**AWO**) while he was at PPP, however, he did receive ad hoc support at PPP from Derek Kickett, a proud Noongar man from Ballardong country, in Mr Kickett's role as Aboriginal Cultural Liaison Worker (**ACLW**), and later, as Senior Aboriginal Cultural Liaison (**SACL**). Mr Kickett gave evidence that he would usually visit Michael's unit every Tuesday and facilitate Michael's requests for art packs for his painting.

243. When Michael entered Ravenhall, the AWO position was vacant and he was not seen within 24 hours of his reception there (despite this being 'best practice' as per the Correctional Management Standards for Men's Prisons in Victoria and a perceived requirement at Ravenhall). Michael was in fact seen three days after arriving at Ravenhall by Allison O'Leary, an Aboriginal Key Worker (**AKW**), and proud Wurundjeri woman. Ms O'Leary connected Michael with AHW Richelle Jackson for urgent healthcare needs and proceeded to see Michael monthly. Her formal sessions with Michael are documented.

244. Richelle Jackson, a proud Gunditjmara and Wiradjuri woman, was employed by CCA as the AHW at Ravenhall from October 2017 until March 2021. She provided useful commentary and insights.

245. Ms Jackson explained the importance of this culturally-specific approach:

> "*So we have a lot of men that have either heart problems, diabetes, they actually turn off, they don't listen to the professional people. So I try and explain to them in our own way, what's wrong with them and also I try to get culturally appropriate booklets and stuff to help with the men*".[164]

246. Ms Jackson worked with AKWs to provide support to over 100 Aboriginal prisoners at Ravenhall at any given time. Ms Jackson saw Michael within a week of him entering Ravenhall. She also saw him on 14 September 2020, 19 October 2020, and 13 January 2021, as well as via informal contacts that were not recorded in J-Care notes.

247. Ms Jackson gave evidence that Michael: "*knew that himself that since he's been incarcerated that he'd put on a lot of weight and that had to do with the diet in there. So I tried to help him with that."*[165] She advocated for Aboriginal men to have access to their cultural foods, although this only occurred during NAIDOC week.[166]

248. Ms Jackson reminded Michael of his health appointments via post-it notes, as staying up to date with appointments could be overwhelming for him or affected by computer issues. Relevantly also, Ms Jackson told the court Michael preferred it when she visited him in his cell, rather than attending at the health centre.

249. Although Ms Jackson was the only AHW who gave evidence, the supports she offered Michael at Ravenhall mirrored the supports offered to Michael by Ms Watt at the Koori Health Unit at PPP. Ms Watt saw Michael on several occasions, including making referrals for him to see allied health services.

250. Helena Gonebale was also a considered and impressive witness. She described the current structure of Aboriginal programs at Ravenhall as including "*a team leader or coordinator position that has daily oversight of the team; three Aboriginal Key Worker roles - so the case management positions and the Aboriginal Well-being Officer position*".[167]

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[164] T-607, per Richelle Jackson.
[165] T-617, per Richelle Jackson.
[166] T-620, per Richelle Jackson.
[167] T-530, per Helen Gonebale.

251. The new structure was responsive to COVID-19 to best meet the needs of prisoners, but also aimed to make the roles attractive to applicants and have a structure in which workers can thrive and progress.

252. Ms Gonebale said that Michael was "*engaged, but not overly engaged*" at Ravenhall, a sentiment with which Ms O'Leary agreed. Ms O'Leary said: "*I don't know if he enjoyed time to himself or it was more so the pain that kept him from, you know, getting out and about but, yeah, he was always - often in his cell*".[168]

253. Ms Gonebale said that working in a prison for Aboriginal people is also difficult because

> "*Corrections [is] a beast of its own and it's attitudinally and behaviourally 20 years behind the rest of the community and the things that you see and you're exposed to can be challenging morally and ethically and as an Aboriginal person working in an environment that has oppressed our community for - you know, as long as we can think of, it's a burden to carry*". [169]

254. It follows that cultural awareness training of non-Aboriginal workers could make the prison environment more culturally safe for Aboriginal prisoners, but also for Aboriginal workers who may also experience a lack of cultural safety in the workplace.

255. Christine Fuller agreed that the AHW role was an important position and noted that CCA would support a full-time AHW "*if it is approved*" in terms of resourcing.

256. Susannah Robinson of Justice Health also agreed it was an important role and one that she would like to see expanded across prisons. Although she indicated that at present this would only be contractually required through public prisons where healthcare will be run by GEO.

257. Much evidence was heard in relation to staffing issues for Aboriginal workers in prison, in both program and healthcare contexts. Gabrielle Simmons, Manager of Corrections Victoria's Naalamba Ganbu and Nerrlinggu Yilam (Cultural Integrity and Resilience Unit) (**the Yilam**)[170] and proud Gunditjmara woman, spoke eloquently about certain of the sources of staffing issues for AWOs, including 'cultural overload', whereby Aboriginal workers in prisons are "*having to meet the role's expectations but also the view of community, which could be very different and trying to balance and walk in both those worlds can be very difficult as an Aboriginal person*".[171]

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[168] T-510, per Alison O'Leary.
[169] T-550, per Helen Gonebale.
170 The Yilam is a business unit in Corrections Victoria that leads Corrections Victoria's policies, programs and services aimed at reducing the overrepresentation of Aboriginal people in prison and provides support to Aboriginal programs staff in prisons.
171 T-582-3, per G Simmons.

258. This was acknowledged to be one of the causes of understaffing. Ms Simmons said that the AWO role can be difficult to fill because: it is a VPS3 role and thus lower-paid; there is stigma for Aboriginal people associated with working for Corrections Victoria; AWOs are frequently managed by non-Aboriginal managers; and the overrepresentation of Aboriginal people in the prison system means that a potential AWO will often have family or a kinship connection within the recruiting prison.

259. Some of these issues are intractable. However, some can be mitigated by provision of support to Aboriginal prison workers, including via the Yilam which provides recruitment support to Corrections Victoria. While the Yilam can provide support to Aboriginal workers across public and private prisons, the take-up is more pronounced at public prisons. Ms O'Leary, who now works at Loddon Prison, said: "*I can't praise [Yilam] enough since being [at] a Corrections location. The support that I've received is beyond belief*".[172] Richelle Jackson also identified that she would have benefited from support from the Yilam as an AHW otherwise working solo at Ravenhall.

260. It is unfortunate that there are resourcing and staff retention challenges to these positions, as the evidence indicates they are an invaluable support for First Nations prisoners. I have made recommendations with a view to improving both the number of staff and the retention rate.

261. In addition to further work being undertaken to support the AWO or its equivalent position in prisons throughout Victoria, it was useful to consider alternative models to current health serves for Aboriginal and Torres Strait Islander prisoners.

ACCHO Model of Primary Healthcare

262. Both Dr Wenitong and Prof Pashen advocate for the Aboriginal community-controlled health care organisation (**ACCHO**) model of Primary healthcare as "a successful model of care for First Nations peoples. A lack of this model in correctional services can contribute to the increased morbidity and mortality rate of Indigenous inmates."

263. There is evidence that the ACCHO services model has shown better compliance rates and better outcomes due to its holistic approach and relational trauma-informed practice.

264. ACCHOs are holistic, culturally resonant, and deal with whole person related issues including family support, with staff that are very experienced with ATSI health and cultural issues.

[172] T-517, per Alison O'Leary.

265. Aboriginal and Torres Strait Islander health professionals approach engagement issues from an Aboriginal male health perspective that builds relationships as well as progresses health management.

266. Traditional healers can also be effectively used to engage and motivate withdrawn disengaged patients. Dr Wenitong said he had worked with traditional healers inside prisons and witnessed "really great success", particularly with patients with social and emotional well- being problems. He said that in South Australia and the Northern Territory there are formalised traditional healer programs as part of mainstream hospital services. He reflected:

> *"… I've worked with really difficult indigenous prisoners before, very, very difficult and I've used a traditional healer and it's like magic, really awesome difference, you know. I guess I've got five years of medical experience, medical school experience, he's got 60,000 years, so I guess he does know his – his client base a lot better, but the issue here is that traditional healers really know how – what people's world view of health is so they're able to get a treatment regime that people really understand and really fits with them, you know, and that's what I notice because when I'm working with traditional healers they get 100 per cent compliance. I'm not sure whether people are scared or –, but I think a lot of that is just both cultural authority and the fact that the Indigenous inmates really understand what they're talking about when they have a treatment regime that makes a lot of sense to them."*[173]

267. Dr Wenitong considered that ACCHO programs in prisons would make a significant difference to outcomes.

268. The spiritual dimension of Aboriginal health and wellbeing is not a concept that sits easily within an understaffed and overbooked prison health system. However, the overrepresentation of Aboriginal and Torres Strait Islander deaths in custody is the only impetus needed to persuade me to echo recommendations made by Coroner McGregor in this regard.

269. In the Nelson Inquest, Coroner McGregor recommended that DJCS and/or Justice Health, in partnership with Victorian ACCHO (**VACCHO**), take steps to build the capacity of VACCHO to provide in-reach health services in prisons.

270. DJCS has since confirmed that implementation of part of this recommendation has commenced (via the Continuity of Aboriginal Health Care Program at Fulham Correctional Centre and Dame Phyllis Frost Centre) but the recommendation is otherwise under consideration. However, DJCS has stated it will partner with the ACCHO sector to develop an Aboriginal-led model of

[173] T-1333-4, per Dr Wenitong

healthcare and identify additional measures to support capacity- building of ACCHOs to provide in-reach prison health services.

271. In circumstances where a full integration of ACCHO services is not able to be completed under current contractual arrangements I have made a recommendation for an alternative, shorter term solution.

Adequacy of Michael's care and treatment in days prior to passing

272. The details of Michael's medical care and treatment have already been set out in detail in this finding.

273. The experts considered all aspects of Michael's clinical interactions in the days immediately prior to his passing.

274. The consensus of evidence was that the clinical findings and the ECG supported Dr Clinton's decision that Michael be returned to his cell on 5 March 2021, and reassessed the following day.

275. The autopsy findings also supported Dr Clinton's assessment, revealing no evidence of a stroke.

276. Expert clinicians considered that Dr Clinton's judgement was appropriate in the circumstances.

277. Dr Wenitong gave evidence that, with the benefit of hindsight, he would have approached Michael's presentation even more conservatively and sent him to hospital. However, I accept that this approach was not clinically indicated.

278. Having examined the medical care and treatment Michael received between 5 March 2021 and 7 March 2021, I find that it was reasonable and appropriate, and I make no adverse findings about the staff who cared for Michael during this time.

279. However from a systems perspective, there are aspects of Michael's experience I consider could have been improved including a clear system for follow up appointments, particularly in relation to Code Black events, and a more conservative approach to risk assessment where an Aboriginal man presents with symptoms similar to those Michael reported.

Governance and management of prison healthcare

280. Good prison governance is largely dependent on the existence of a sound enabling policy framework, necessary resources and the extent to which management has the ability to implement these policies on a day-to-day basis in a transparent and accountable way.

281. The JHQF provides overarching governance for prison healthcare and implements custodial healthcare standards.

282. Over recent years the have been several reviews and inquiries into the prison healthcare system. The aim of these reviews has been to drive a focus on identifying and understanding the challenges to healthcare in custodial settings. Numerous recommendations have resulted from this scrutiny, and a plethora of changes have been recommended. Largely those recommendations have received the support of the State.[174]

283. CCA submitted that these reviews obviate the need for me to make some of the recommendations urged upon me by Counsel Assisting, and reliance in support of the submission is placed on section 7 of the Coroners Act.[175]

284. While this submission has merit there are two issues that arose during the inquest which provoked my hesitation in fully accepting the CCA submission.

285. Firstly, the Justice Health Report which examined Michael's healthcare provision in custody from January 2018 until his passing, purported to identify any systemic and/or emerging issues and whether systemic health service delivery improvements could be made. While a set of recommendations were made following the review, these failed to capture some systemic issues that emerged at inquest. Specifically, the need for a coordinated approach between primary, secondary and tertiary health care providers; and the need to have robust processes for following up secondary and tertiary health appointments.

286. I note that at the time of compiling its report, Justice Health did not have the benefit of the comprehensive evidence that emerged at inquest including the evidence of relevant clinicians, medical and cultural experts.

287. Secondly the inquest brought to light some confusion about the requirement to conduct a root cause analysis (**RCA**) into Michael's passing. This appeared at first glance to be a requirement of the JHQF 2014. However, neither Dr Clinton nor Dr Ekwebelam were requested to participate in a root cause analysis or debriefing following Michael's passing.

288. Noting that an RCA is only required where there is a serious adverse incident, Susannah Robinson said (about the obligations of contracted health care providers to undertake an RCA):

[174] Victorian Government Response to the recommendations of Coroner McGregor arising from the Inquest into the passing of Veronica Nelson dated 28 April 2023.
[175] Section 7 of the Coroners Act requires the coroner to liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations.

> "*it's something that obviously we've reflected on the findings in Veronica's inquest and continuing to work with our healthcare providers to make sure that they meet the contractual arrangements".*[176]

289. To ensure that there is no ambiguity in those contractual arrangements I have dealt with this question in a recommendation.

Remedial measures since 2021

290. Since Michael's passing there have been a multitude of system improvements across prisons and the healthcare services.

291. JARO and Justice Health made recommendations as set out at paragraphs 29-33 of this finding.

292. GEO conducted an in-depth review following Michael's passing, led by Mr Allan Borg, Manager, Office of Professional Integrity (the Borg Report). The Borg Report was conducted in accordance with requirements of relevant policies, including Commissioner's Requirement 1.3.3 – Reporting and Review of Prisoner Deaths and GEO Group Australia Pty Ltd – Investigation of Incidents and Allegations. The review process was concluded on 21 April 2021, proximate to Michael's passing, and the interviews, CCTV summary and conclusions were included in the initial brief provided by the Coroner's Investigator and were of assistance to my investigation.

293. G4S accepted the significant role that First Nations Cultural Support workers play within the custodial environment. Despite the challenges in recruiting in this space, G4S has increased engagement with Aboriginal recruitment agencies and has had more success in accessing suitable candidates to fill these roles.

294. G4S has also recently added four people to work in PPP's First Nations team. Although one of these roles was only funded until June 2023, G4S has retained the position and funded it internally.

295. Further, G4S has been 'over-recruiting' in this space so that when there is a turnover of staff, the role can be filled as efficiently as possible.

296. In addition to access to personal support, PPP has commenced art, maths and English courses and classes that have been specifically designed for First Nations prisoners.

297. PPP also reported several cultural programs will be implemented:

    a) Rehabilitation Assistance Program – cultural rehabilitation program that aims to

[176] T-909, per Susannah Robinson.

prepare men for release into their communities;

b) Warrior Fitness Program – physical health program for Aboriginal men facilitated for G4S recreational staff;

c) Yawal Mugadjina and the Cultural Journey – a Corrections Victoria Reintegration Pathway program supporting cultural planning for Aboriginal men; and

d) 12-hour Koori Health AOD Program – health related AOD program.

298. Forensicare is presently considering how to implement the cultural safety principle enshrined in the new Mental Health and Wellbeing Act 2022, which includes, that "*treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers*"[177].

299. In relation to the staffing of Aboriginal Health Workers, GEO accepted that the contracted hours of the role should be expanded beyond two days per week and Ms Fuller, on behalf of CCA, indicated support for creating a full-time role subject to Justice Health funding and ability to recruit to such an expanded role.

300. GEO also accepted that the cultural awareness training developed by Ms Gonebale at Ravenhall had not been fully taken up, and this will be rectified. The training will be implemented at all levels of the organization.

301. GEO has also commissioned Professor Jackie Curtis to deliver training to staff about the links between mental health and physical health.

302. Following Michael's passing there has also been commitments across correctional and health services to implement significant improvements to their approach to weight management of prisoners with the introduction of obesity working groups and the inclusion of elevated BMI as a criteria for inclusion in complex case management.

303. It is encouraging to hear about the extensive work the interested parties have undertaken in response to Michael's passing and I commend these efforts. It is a reflection of the candour that was evident throughout the inquest.

[177] *Mental Health and Wellbeing Act 2022* (Vic), s 27(3).

FINDINGS AND CONCLUSIONS

304. Having investigated the passing of Michael, and having held an inquest in relation to Michael's passing between 24 February 2023 and 6 April 2023, I make the following findings pursuant to s 67(1) of the Coroners Act:

a) the identity of the deceased was Michael Garry Suckling, born 25 May 1979;

b) Michael died in the Dunmore Unit of the Ravenhall Correctional Centre on 7 March 2021 from cardiomegaly in a man with WHO Class III obesity;

c) Michael died in the circumstances described in this finding at paragraphs 48 to 109 above.

305. Taking into account all available evidence, I further find that:

a) Michael gained in excess of 100 kgs between the time of his incarceration in January 2018 until the time of his death on 7 March 2021.

b) Although Michael's weight gain was not the cause of his passing, it did contribute to his passing.

c) Throughout his incarceration Michael had access to wide array of medical and allied health services.

d) However, Michael's weight gain during his time in custody was not managed optimally. This was due to a combination of factors including

i. Michael's lack of motivation to attend appointments; and

ii. systemic issues identified regarding the lack of follow up and holistic management of Michael's medical care and management.

306. There is no doubt that the outbreak of Covid-19 impacted on the availability of some cultural supports, services and programs. However even taking into account the vicissitudes of the pandemic, I found that culturally appropriate care and treatment was not fully available to Michael. Had Michael's health been treated more holistically, some of the barriers to his engagement may have been diminished.

307. While patient autonomy must continue to be respected I encourage correctional and health services to focus on supplementing the information and support mechanisms available to prisoners who are noted to be disengaging, to provide them with every opportunity to recalibrate their health and wellbeing whilst in prison.

308. The investigation and the candid approach of the interested parties in this matter assisted the court to identify a number of opportunities for improvement in systems concerned with Michael's assessment, treatment and care as follows:

a) The importance of a culturally specific approach to the health and wellbeing of Aboriginal prisoners that addresses particular vulnerabilities they may face in custody;

b) The importance of Aboriginal Health Care Workers and similar in the engagement of Aboriginal and Torres Strait Islander prisoners in their own health and well-being;

c) Early identification and intervention of cardio-metabolic health issues, including weight gain;

d) The significance of multi-disciplinary case management for prisoners with complex health issues;

e) The need for more intensive and targeted wrap around services to engage with prisoners who appear to be losing motivation;

f) Adequate staffing of prison health services;

g) Improvements to continuity of care;

h) Accurate and detailed record keeping; and

i) The need for more comprehensive reception assessment processes when prisoners are received from hospital or other clinical settings

309. Based on the evidence I am unable to say whether the implementation of these initiatives in whole or in part would have altered Michael's trajectory, or that his death was preventable. However, they would have fostered an environment that would have provided the best opportunity to engage, motivate and support Michael's health and wellbeing in custody.

COMMENTS

310. This inquest was not about finding any person or entity upon whom to attribute blame for Michael's passing. It was about understanding the cause and circumstances of his passing, and considering how Michael might have been assisted to improve his engagement with his complex healthcare needs. This and similar investigations identify how systems and services can be improved, with a view to reducing the prospect of further deaths in custody, in particular for Aboriginal and Torres Strait Islander prisoners

311. Health care in the Victorian prison system has already been the subject of significant examination and change, however the provision of optimal health care in a custodial setting is a continuum rather than a point-in-time achievement.

312. Staffing in healthcare services was under extraordinary pressure, particularly during the latter period of Michael's incarceration. Although I did not undertake a comprehensive examination of staffing levels, I heard sufficient evidence from the healthcare personnel to appreciate that the system is overstretched.

313. It is the State's responsibility to ensure that prison systems it oversees, both public and private, provide Aboriginal people in prison with culturally appropriate and responsive healthcare.

314. The principles enunciated in AJA4 were developed through extensive consultation with members of the Aboriginal community and represent a proactive and evidence-based approach. Largely they were not applied in assessment, treatment and care of Michael, and there was overwhelming agreement from the GP panel that a "whole of person" approach and "relational connection" would have improved his treatment.

315. The court heard about the challenges facing prisons in their efforts to provide better cultural awareness and a more culturally safe environment for First Nations prisoners. While the explanations are understandable, they are not justifiable as a status quo. The court heard from DJCS about the desperate state of affairs in terms of adequately resourcing prison health system and key Aboriginal positions and received evidence about the stigma of working in custodial setting. I accept that despite using its best endeavours, DJCS was unable to keep positions staffed.

316. The importance of Aboriginal Liaison Officers, Aboriginal Key Workers and Aboriginal Health Workers cannot be overstated. Further work is required to make these positions more prevalent and more attractive. Unfortunately staffing and retaining staff in these positions is proving difficult despite the commitment and efforts of government, custodial service providers and the Aboriginal community. The candid evidence I heard from Aboriginal workers, about the challenges of working in a custodial setting, requires government and Aboriginal community leaders redouble efforts to address these issues and support the work of the Aboriginal Justice Forum (**AJF**) and the Aboriginal Justice Caucus (**AJC**) in promoting increased positive participation of the Aboriginal community in the justice system.

317. The expert panel convened to consider cultural issues provided thoughtful and useful evidence. The consensus was the optimal service model in Victorian prisons for Aboriginal prisoners would be constituted by ACCHOs.

318. The VACCHO recommendation endorsed moving to this model of care, but also urged undertaking a baseline survey in order to qualitatively assess the response of prisoners as to how this model has enhanced or amplified their experience.

319. I note that several experts including those who gave evidence at this inquest have echoed a call to end the use of private healthcare providers in the prison system in favour of the Government contracting to ACCHO directly (rather than through sub-contracts) to deliver prison healthcare services for Aboriginal people.

320. Whilst I am supportive of this in principle, I recognise there are current contractual arrangements in place that mean this cannot occur at the moment. Additionally, the VO Report noted that ACCHOs have multiple reasons why they do not want to enter into sub-contracting arrangements, particularly with multinational private organisations, including that subcontracts place ACCHOs under other providers, diminishing their authority and compromising the way they work.

321. Given the current challenges faced by Aboriginal prisoners, I would urge all parties including the private operators, the State and the ACCHOs to look at ways that ACCHOs can be assimilated into practise now in Victoria's prison system within current commercial arrangements.

322. As previously noted, at the core of the Victorian prison healthcare system is the notion that prisoners are entitled to receive equivalency of care. I agree with Dr Wenitong's view, that equivalency for Aboriginal prisoners should be measured against best practice equivalence of ACCHO; and quite simply the services documented were not equivalent to these standards. He regarded it is a "*false equivalency*" to compare the treatment Michael received to mainstream community standards, which have failed Aboriginal people outside the corrections system.

Access to culturally appropriate care and treatment

323. For Aboriginal people in prison to receive culturally safe, continuous and equivalent healthcare, more work needs to be done. Aboriginal organisations and community legal centres have raised concerns about the access to and provision of healthcare to Aboriginal people in prisons.

324. The issues identified in this inquest are sadly not uncommon. Deputy State Coroner of New South Wales, Magistrate Harriet Graeme recently handed down a finding in similarly tragic circumstances to those of Michael[178], and GEO identified four additional similar cases in New South Wales.[179] A common thread through these cases was fragmentation of care and the lack of a holistic approach. It is therefore critical that prisons, prison health care providers and allied health services are open to developing an effective means of implementing multidisciplinary healthcare.

325. The recommendations I have made below are intended to assist with improving healthcare in the custodial setting and enhancing awareness of the particular needs of First Nations prisoners. I am hopeful that through the implementation of these recommendations future deaths in similar circumstances may be prevented.

RECOMMENDATIONS

326. Pursuant to s 72(2) of the Coroners Act, and in addition to the remedial measures outlined by the respective parties:

To Department of Justice and Community Safety

1. That the Department of Justice and Community Safety update the Justice Health Quality Framework 2023 to reflect that the principle of equivalency of care should be:

    a) Measured in terms of health outcomes in addition to accessibility and availability of health services; and

    b) For Aboriginal prisoners, measured against the types of services provided by Aboriginal Community Controlled Health Organisations (**ACCHOs**) rather than those of mainstream health providers.

2. That the Department of Justice and Community Safety update the Justice Health Quality Framework 2023 to reflect the recommendations of the Equally Well Consensus Statement.

3. That the Department of Justice and Community Safety ensure that the standard comprehensive medical and psychiatric reception assessment processes are structured to apply to all newly-received prisoners, regardless of entry points. Where a prisoner is received via a non-reception prison, Corrections Victoria will ensure that notice is provided

[178] Coroners Court of New South Wales, *Finding with Inquest into the death of Reuben Button* dated 21 July 2023.
[179] Further Statement of David Grace dated 30 January 2023, CB-5099.

to: (i) the contracted prison manager (if applicable); (ii) the primary health service provider; and (iii) Forensicare, that comprehensive medical and psychiatric assessments are required to be arranged within 24 hours for a particular prisoner.

To Justice Health

4. That Justice Health work with Forensicare, Correct Care Australasia (**CCA**), GEO and St Vincents Correctional Health Services (**SVCHS**) to ensure access to therapeutic counselling / psychologists is provided at all prisons in Victoria without being tethered to offender management programs.

5. That Justice Health prepare and circulate a guideline or bulletin to all Health Service Providers for people in Victorian prisoners to remind prison-based clinicians that:

    a) weight measurements should be confirmed via scales as far as reasonably practicable and witnessed by clinicians, unless reasons otherwise exist which should be documented.

    b) records should clearly indicate whether a weight measurement has been recorded using standing scales, or has been self-reported.

6. That Justice Health, in conjunction with all Health Service Providers, ensure there is a policy or operating instruction addressing multidisciplinary case management for prisoners with complex health issues, including:

    a) clear referral criteria for identification of complex cases and inclusion in complex case management meetings;

    b) that one of the criteria for multidisciplinary referral is obesity, where the prisoner has a BMI is above 35 (Class II obesity), or where girth measurement places a patient in a high risk category, and where there patient has at least one comorbidity, unless otherwise clinically indicated;

    c) when the above criteria at (b) are met but the prisoner is not referred to multidisciplinary case management, the clinical rationale should be documented.

7. That Justice Health mandates a requirement for primary health service providers in prisons that:

    a) a prisoner who is prescribed psychotropic medication should be screened for cardiometabolic risks; and

b) where significant or rapid weight gain occurs which, in the opinion of the clinician, increases the individual prisoner's cardiometabolic risk profile this triggers reassessment.

8. That Justice Health makes modifications necessary in J-Care to allow for the following:

   a) Inclusion of details in J-Care that indicate the full name, role, discipline and employer of clinicians;
   b) Add in fields or drop-down options to accurately record reasons for non-attendance;
   c) Development of fields to record height, weight, waist circumference and calculation of BMI;

9. That Justice Health explore the feasibility of developing the following:

   a) a prompt for cardiometabolic monitoring in relation to patients on psychotropic and other weight-gaining medications; and
   b) a system to ensure that Gateway and J-Care can interact to capture patient referrals and follow-up.

10. That Justice Health ensure all Aboriginal passings in custody give rise to a Root Cause Analysis coordinated by the primary health care provider in conjunction with any secondary or tertiary health services involved in the patient's care.

To Providers of Health Services in Victorian Prisons - Forensicare, St Vincent Correctional Health Services, Correct Care Australasia, GEO

11. That Health Service Providers proactively consult with ACCHOs to explore further opportunities for ACCHOs to provide in-reach services for Aboriginal prisoners.

12. That Health Service Providers, in circumstances where an Aboriginal Health Worker position remains vacant for more than 3 months, ensure an ACCHO is contacted to determine if it is possible for the ACCHO to provide in-reach services until the vacancy is filled.

13. That Justice Health, SCVHS, CCA and GEO work with the Yilam and the Aboriginal community to identify opportunities to increase the pool of potential Aboriginal Health Workers, with the view of having a minimum of one full-time equivalent AHW at every prison in Victoria.

14. That Health Service Providers, with support from DJCS as required, explore opportunities to provide the services of traditional healers for Aboriginal and Torres Strait Islander prisoners.

15. That Health Service Providers ensure there is a policy or operating instruction addressing multidisciplinary case management for prisoners with complex health needs, including referral criteria.

16. That Health Service Providers develop a policy or operating instruction that identifies that a Senior Clinician in the relevant prison health service is appointed responsible for organising a multidisciplinary meeting at regular intervals to ensure that complex cases are reviewed and discussed holistically, including specifically mental health and medication reviews, and a process for obtaining patient consent.

17. That Health Service Providers consider developing additional KPI measurements that are outcome focussed rather than quantitative measurements.

18. That Health Service Providers review current KPI measurements and assess them for unintended consequences that impact on quality of delivery as has previously been covered in recommendations in the CRACCS.

To GEO

19. That GEO educates its correctional staff about appropriate referral pathways for prisoners facing mental health or medical issues, including clarifying the role and function of the key clinician.

20. That GEO continue work on addressing the issue of weight gain amongst prisoners and ensure that an iteration of the Obesity Management Work Group becomes a permanent feature of the healthcare system at Ravenhall.

21. That GEO undertakes a feasibility study in relation to obesity, comorbidities and complex case management interventions with a focus on determining the most appropriate level of obesity and the level and type of co morbidity for referral criteria.

ACKNOWLEDGEMENTS

327. I convey my deepest sympathy to Michael's family – in particular Maree and Fern. I acknowledge the dignity and fortitude with which you approached and participated in the inquest, and the thoughtful submissions you provided to me.

328. With an investigation of this magnitude, it is appropriate that I acknowledge the significant work of all who were involved in assisting me.

329. I thank the witnesses and experts who gave their time, evidence and insights at inquest. My investigation has benefited profoundly from your participation and frank and candid accounts, and I acknowledge the emotional toll of your engagement in the coronial process.

330. I thank the coronial investigator, DLSC Barrow, who worked tirelessly to collate the evidence that formed the coronial brief and for his capable assistance during my investigation. I would also like to thank *Yirramboi Murrup*, the Court's Aboriginal Engagement Unit for supporting Michael's family with dedication over the past few years. I also thank the Coroners Prevention Unit for their assistance in reviewing the medical care provided to Michael and identifying appropriate cultural and medical experts.

331. Finally, I would like to thank and acknowledge the unflagging work of Counsel Assisting, all other Counsel and instructing solicitors for their work and comprehensive submissions. I also acknowledge and thank Ms Kajhal McIntyre, who worked diligently and provided me with invaluable assistance through the entirety of this investigation.

ORDERS AND DIRECTIONS

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

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

Michael's family
Department of Justice and Community Safety
GEO Group Australia
G4S Custodial Services
Forensicare
Correct Care Australasia
St Vincent's Correctional Health Service
Dr Charles Ekwebelam

Dr Daniel Clinton

Victorian Aboriginal Community Controlled Health Organisation

Prisoner 1, c/ Arnold Thomas & Becker

Detective Leading Senior Constable Paul Barrow, Coronial Investigator

Signature:

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Date: 12 February 2025

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