IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 006365

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Heather Ida Simone CALGARET
Delivered on:	28 July 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	17 December 2021, 19 October 2023 and 26 February 2024 (Directions Hearings) 29 & 30 April; 1, 2, 3, 6, 7, 8, 9, 13, 14, 15, 17, 20, 21 & 22 May 2024 (Inquest Hearing) 17 & 18 September 2024 (Oral Submissions)
Findings of:	Coroner Sarah Gebert
Counsel Assisting the Coroner:	S. Lacy SC and M. McDonald Instructed by Samantha Brown, Coroners Court of Victoria
Counsel for Jenny Calgaret:	S. Gold and S. Schwartz

	Instructed by Victorian Aboriginal Legal Service
Counsel for Secretary for Department of Justice and Community Safety:	L. Brown SC and M. Isobel Instructed by Russell Kennedy Lawyers
Counsel for Forensicare:	P. Matthews SC Instructed by K + L Gates
Counsel for Dr Shalendra Nath:	A. Mukherjee Instructed by Wotton Kearney
Counsel for Correct Care Australasia:	N. Murdoch SC and E. Gardner Instructed by Meridian Lawyers
Counsel for Rochelle Betita:	J. Stoller Instructed by Gordon Legal
Counsel for Fiona Millson:	K. Popova Instructed by Kennedys
Counsel for Imelda Morgan:	B. House Instructed by JK Legal
Other Matters:	*Death in Custody, Provision of Health Care, Suboxone, Parole*

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person.
Readers are warned that there may be words and descriptions that may be culturally distressing.

Family Impact Statements

Read by Sister, Suzzane

Heather was a proud Yamatji, Noongar, Wongi and Pitjantjatjara woman. She was a kindred spirit, a caring and loving soul who was bubbly, funny, always laughing and cracking jokes.

Heather loved her culture and loved being around it. She loved reading, writing, painting and taking care of everyone's kids. She was like an old mother hen type person. She had a big heart and supported everyone around her.

Heather was born in Dandenong. She was a proud daughter of Jenny and Bill. She was a loving sister to Suzzane, Big James, Glenys, Chum and Rory as well as Dwayne, Cecilia, Michael, William, Colin and Michael. She was a mother to her four beautiful children. Heather's children meant the world to her. She was a cousin to Tarlina, Melissa and many others. And a proud aunty to many nieces and nephews. She was a partner to [redacted] *and a friend to many. She was loved by everyone who spent time with her including many of the women and people at the Dame Phyllis Frost Centre, and the officers who came to know her really well. The amount of people at Heather's funeral, showed the positive impact she had on all those around her.*

Heather brought so much love, joy and care to our family. When Heather was around, we were all together. She was the rock of our family. We are heartbroken by her death.

Life is precious. Heather's life was precious – it is a blessing and a gift to us and it shouldn't have been taken away from her. The pain of losing Heather has caused complete heartache for our whole family and Heather's community. Nothing is the same without Heather. Nothing will bring Heather back.

Heather was born in 1991, the same year, as the Royal Commission into Aboriginal deaths in custody's final report was handed down. Many of those recommendations have still not been implemented. Heather may still be here with us today, if those recommendations had been implemented properly.

I will leave you with Heather's words:

'The happiest people don't have the best of everything, they just make the best of everything'

'I never wanna come back to jail ever.'

'I want to do what's right for our 3 beautiful children. I don't want to lose them'

'It won't be easy but it will be worth it… it's time to be the mother... our kids need us to be'

'Being a family means you are part of something wonderful.'

'… It's woken us up so when we get out we will be as strong as ever, all that matters is... our kids. Think how they are suffering, their poor little hearts without us here.'

'This is the last chance we will have to make things the way they should be… Things are going to change.'

'I have been victimised, I was in a fight that was not a fair fight. I did not ask for the fight. I lost. There is no shame in losing such fights. I have reached the stage of survivor and am no longer a slave of victim status. I look back with sadness rather than hate, I look forward with hope rather than despair. I may never forget but I need not constantly remember. I was a victim. I am a survivor.'

Always remember we are under the same sky, looking at the same moon…. When it rains, look for rainbows. When its dark, look for stars'

WORDS ABOUT HEATHER

From Mum, Aunty Jenny

Heather is Yamatji, from my side from Murchinson and Gascoyne regions of Western Australia, and Pitjantjatjara from her Dad's Mum side, Noongar and Wongi, from her Dad's Dad side. Heather loved her culture and connected with her culture through the kids, that was her way.

Heather was born in Dandenong and she was the middle child. We used to call Heather 'Bubba' ever since she was a little baby. She was the youngest at the time and the name 'Bubba' stuck.….

Heather has five siblings on my side; three brothers, Rory, Big James and Little James (Chum) and two sisters, Glenys and Suzzane. Heather also has seven siblings on her dad's side – Dwayne, Ceceila, William, Michael, Colin and Michael. Heather was close to her siblings and family. We were all close. A few years before we lost Heather, Heather's brother William Calgaret Woods died due to a drug/heart attack in custody.

As a young child, Heather loved playing with dolls, and playing shop keeper and schools. Heather kept herself busy. She always had pens and papers with her. She loved books. Heather was always laughing and giggling and was a happy kid. Heather always wanted to be like her sister Suzzane and looked up to her. ….

Heather had a kind heart and a kind soul. She was very caring. During the holidays, we would sit and watch movies and cuddle and laugh and muck around and get in trouble. We were really close, and would do everything together.

Heather was the rock of our family. She was a mother hen type of person. As she got older, she was the one who helped me with looking after the kids and family. Heather had four beautiful children.…. Heather's four children meant the world to her. She was very much a Mummy. …

Heather would say 'My heart is dying' from having her children taken away from her. She was always thinking about them. …

I don't understand how Heather's health got worse in prison. She didn't have so many health issues before that. ….

Heather's passing affects the whole family and Heather's community. The amount of people at Heather's funeral showed she had that impact on people. People came from everywhere including jail.

It has been devastating for me. Some days I can't get up. I feel numb. Nothing is the same. Heather would be the one to cheer me up no matter what. But there's no Heather. There's certain songs I can't listen to because of her.

Heather's passing wrecked our family – Glenys, Suzzane, my sons. It's the worst feeling. There's no hope. It's like our life's dead. It's ruined us. It's affected all my kids in bad ways. They all have their ways of coping to ease the pain of losing Heather. It's caused complete heartache. It feels like nothing will help us.

Suzzane and me both can't sleep. When it's time to sleep thoughts about Heather and why she shouldn't have died come into our minds and we can't get to sleep….

Heather's last phone call to me was normal, she was her happy self. She spoke to Zulli and me and was off to bed. I never spoke to her again.

Life stops when your child dies, I don't know how mothers ever move on.[1]

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[1] Coronial Brief (**CB**) at p.4264-4269. Not reproduced in full.

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INTRODUCTION

1. Heather Ida Simone Calgaret (referred to in my finding as Heather) was a proud Yamatji, Pitjantjatjara, Noongar and Wongi woman.

2. Heather was born on 8 January 1991 and was 30 years old when she passed away whilst undergoing sentence at the Dame Phylis Frost Centre (**DPFC**).[2]

3. Heather had been found by her sister Suzzane unresponsive in her cell on the morning of 23 November 2021 when she tried to wake her in the morning. She was transported to Sunshine Hospital but tragically passed away on 27 November 2021.

4. Heather had been remanded in custody on 31 July 2019 to DPFC. She was six months pregnant at the time. On 29 October 2019, she gave birth to her fourth child, [redacted], at Sunshine Hospital.

5. Heather is survived by her four children: [redacted]; her mother, Jennifer (referred to as **Aunty Jenny** with her permission); her partner, [redacted] and her siblings Big James, Glennis, Suzzane, Little James and Rory. Her father, William, passed away in May 2023.

6. At the time of Heather's passing her sister, Suzzane was also incarcerated at DPFC. They were described as *peas in a pod… wherever the other one was, you knew the other was there*.

THE CORONIAL INVESTIGATION

7. Heather's passing was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). She was in custody at the time and

[2] The term "*passing*" is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available here). On the advice of the Yirramboi Murrup Unit (Coroners Aboriginal Engagement Unit), the term "*passing*" will be used instead of "*death*" in this Finding, save where required by the words of relevant statutes.

further, her passing may have been unexpected, unnatural or violent or to have resulted from accident or injury.

The coronial role

8. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death.[3] Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

9. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

10. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

11. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[4] The effect of this and similar authorities is that a coroner should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that the individual or entity caused or contributed to the death.

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[3] The exceptions being cases where an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances: section 67 of the Act.

[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".*

Mandatory inquest

12. As Heather was in the custody of the State when she passed away, an inquest into her passing is mandatory.

13. All prisoners held within prisons and correctional facilities are held under the legal custody of the Secretary to the Department of Justice and Community Safety (**DJCS**) pursuant to section 6A of the *Corrections Act 1986* (**the Corrections Act**).

Victorian Charter of Human Rights and Responsibilities

14. Section 9 of the *Charter of Human Rights and Responsibilities Act 2006* (**the Charter**) states that "[e]*very person has the right to life and has the right not to be arbitrarily deprived of life*". This obligation to protect life has been interpreted as a procedural requirement that authorities effectively investigate deaths that occur in certain circumstances, including where a person has died in custody.

15. Counsel Assisting, Sharon Lacy SC along with Mietta McDonald, are independent members of the Victorian Bar and were instructed by the Coroners Court to assist with Heather's coronial investigation and inquest. This, in combination with requirements of the Act, helps to ensure the independent scrutiny of the circumstances surrounding the death of a person for whom the State has assumed responsibility.

16. Other Charter rights may have been engaged or are relevant to Heather's passing and are documented throughout my finding.

OTHER INVESTIGATIONS

17. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

18. I have been provided with the review report prepared collaboratively between the Justice Assurance and Review Office (**JARO**) and Justice Health, which was included in the coronial

brief.[5] JARO is a business unit within DJCS that advises the Secretary, DJCS on the performance of the youth justice and corrections systems. Justice Health is a business unit within the DJCS with responsibility for the oversight of primary health, primary mental health and specialist forensic mental health services for people in Victorian prisons and young people in custodial centres.

19. The report is titled: *Review into the passing of Ms Heather Calgaret at Sunshine Hospital on 29 November 2021* (**The Justice Review**), dated 31 October 2023 and is referred to later.

Sources of evidence

20. As part of the coronial investigation, the Coroner's Investigator Detective Senior Constable Simone Peirce prepared a coronial brief in this matter. The brief includes statements from witnesses, including those present at the scene of Heather's collapse, the forensic pathologist who examined Heather, ambulance paramedics, investigating police officers, as well as other documentation such as plans, scene photographs, CCTV footage, Body Worn Camera (**BWC**) footage and a prison intercom recording. Also available was the audio of the Triple Zero call made following Heather's collapse and calls made by Heather and others whilst at DPFC proximate to her passing (these are referred to as **ARUNTA** calls).

21. The Court also obtained a range of statements and documents including from Heather's mother, health clinicians who saw Heather in prison, corrections staff and institutional statements on behalf of the Department of Family, Fairness and Housing (**DFFH**), Forensicare, Correct Care Australasia (**CCA**), DJCS, Corrections Victoria, Justice Health, Ambulance Victoria and the Adult Parole Board (**APB**). Heather's records from Western Health, Elizabeth Morgan House, WestCASA, Justice Health (JCare electronic medical record), Corrections Victoria,[6] Ambulance Victoria and the APB were obtained. Relevant

[5] *See* The Justice Review, CB at p.3310-3409.
[6] *See* CB at p.1355: "*For each prisoner there is a hard copy file, known as the Individual Management File (IMF) and electronic records made in the Prisoner Information Management System (PIMS). The IMF moves with the prisoner around the prison system and is held in the prisoner's unit. The prisoner's Prison Officer Case Manager, who has*

policy documents were also provided by agencies. As already noted, the Justice Review formed part of the material before the Court.

22. To further assist my investigation, the Court obtained reports (five) about a range of issues from experts in the fields of clinical toxicology, general medical practice, emergency medicine, psychiatry and epidemiology and Aboriginal health research. Interested parties also obtained reports (eight) including from two Addiction Medicine Specialists, Pharmacologist and Forensic Toxicologist, Forensic Pathologist, a General Practitioner, Consultant Cardiologist and experts in matters related to parole.

The Inquest

23. I determined the inquest scope which is outlined in Appendix 1.[7]

24. The inquest ran for sixteen days and heard evidence from forty-one witnesses which included six expert panels. The witnesses are listed in Appendix 2.

25. After the conclusion of the inquest, I received a written submission from Counsel Assisting followed by written submissions in response from all interested parties. Oral submissions were heard on 17 and 18 September 2024.

26. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents

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regular discussions with the prisoner, keeps a record of those discussions and meetings in the form of file notes in the local management plan notes section in the IMF. Other officers will also make notes about the prisoner in the IMF. Details of Local Plan Agreements are also recorded in the IMF. PIMS records personal details of prisoners, incidents, sentence management panel meetings and local Case Management Review Committee (CMRC) meetings. PIMS is accessible by all Prison Officers and other staff in prisons and Corrections Victoria head office staff who require access."

[7] I made a determination on 16 February 2024 regarding scope to include*: The appropriateness of the management of Ms Calgaret's parole application by Community Correctional Services and Corrections Victoria, including: delays in the progress of the parole application; the availability of offence specific treatment; facilitation of any necessary steps in the parole application process; support provided to obtain suitable accommodation; and support provided to navigate the parole process.*

tendered through them, any documents tendered through counsel (including Counsel Assisting), written and oral submissions of counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Heather Ida Simone Calgaret's passing. I do not purport to summarise all the material and evidence in this finding but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

BACKGROUND

Heather's Imprisonment

27. DPFC is managed and operated by Corrections Victoria and is a maximum-security rated women's prison. Heather was accommodated in Blackwood A at DPFC from 4 August 2021 until her passing.

28. Blackwood A forms part of the Reintegration and Transition Precinct, which is designed to prepare women for their release from prison or for their progression to the minimum security Tarrengower Prison. The unit employs less regimented processes and assimilates community living where possible. It consists of a communal kitchen and lounge area, single bedrooms and two bathrooms.

29. At the time of Heather's passing, also housed in the Blackwood A unit was her sister, Suzzane, Tammy Innes[8], Rose Talisa and Stacey Edwards[9] who were all of Aboriginal descent. Suzzane described them as a *jail family*[10] who ate dinner together every night.

30. Rose said that Heather *was a beautiful soul, she would always make you laugh, she's like a big teddy bear. Everyone loved Heather.*[11] Tammy said that everyone knew Heather *because*

[8] Tammy is a Yorta Yorta and Jeithi woman from, Jerilderie, New South Wales.
[9] Stacey identifies as a Taungurung Boonwurrung woman.
[10] T145 L13,Tammy said, *You've only got each other.*
[11] Statement of Rose Talisa, CB at p.52.

she's a lovable person that just cares for everyone. She's the mother hen.[12] Stacey said that she was *just a beautiful person.*[13]

Aboriginal Wellbeing Officer – Aunty Lynn

31. At the outset it is also important to mention Aunty Lynette Killeen (**Aunty Lynn**) who was the Aboriginal Wellbeing Officer employed by DPFC at the time of Heather's passing. She was also the only Aboriginal Wellbeing Officer located at DPFC at the time.

32. Aunty Lynn gave evidence at the inquest and it was noted that she had worked at DPFC for *going on 28* years.[14] Her role at the prison was broad and all encompassing. She described her main role was *to provide support, teach the officers how to deal with the Aboriginal ladies, making sure that they have things in place eg, Medical, families outside, issues in here, it really consists of everything*.[15] Aunty Lynn said that she was the spokesperson for each of the women and if they were not doing the right thing they were spoken to by her, and if the staff were not doing the right thing she would speak to them as well.

33. Aunty Lynn said that Heather and her sister *would always be together, wherever one went the other was there*[16] and that they adored their kids. She said that if anything was going wrong, the sisters would always come and see her. She said that they *were just two beautiful women that took care of each other, and they used to say to me if we need to we'll come and let you know*.[17] She said that they, *had the respect of a lot, a lot of people, a lot, a lot of women and everything, you know, not – not just mine, but from staff to the girls themselves and everything*.[18]

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[12] T143 L13-15.
[13] T251 L6-7.
[14] T32 L4.
[15] Statement of Aunty Lynette Killeen, CB at p.1218.
[16] Ibid.
[17] T51 L18-20.
[18] T42 L8-11.

Matters relevant to the provision of health care to Heather

34. Heather was in custody at DPFC from her reception on 31 July 2019 until her collapse on 23 November 2021. During that time, her Justice Health and other medical records document that she attended numerous medical appointments (over 100) which occurred primarily onsite. This included medical care and primary mental health care provided by CCA (weight loss clinic, diabetes clinic) and secondary health care by the Victorian Institute of Forensic Mental Health (**Forensicare**).[19] In addition, Heather had admissions to Sunshine Hospital (pregnancy related), presentations to St Vincent's Hospital (to treat her umbilical hernia and referrals for diabetes, weight management) as well as dental, physiotherapy, podiatry and optometry services.

35. Both CCA and Forensicare were contracted by DJCS through Justice Health to provide health services at DPFC.

36. As part of primary mental health care, CCA medical practitioners could prescribe medications used to treat mental health (nurses could not), however, specialised mental health treatments, such as medication for psychosis, complex mood disorders and some other conditions were and are generally only prescribed on an ongoing basis by Forensicare clinicians.

37. There were occasions when Heather did not attend scheduled appointments and sometimes, they were cancelled by the health service. In some instances, it is hard to determine from the records why a scheduled appointment did not take place as the reason for missed appointments are not always detailed. It is apparent that on occasion appointments clashed with Heather's other commitments .[20] It should also be noted that part of Heather's detention

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[19] Forensicare is a statutory agency established by the then-*Mental Health Act 2014* (Vic) (**MHA**) providing specialist forensic mental health services in Victoria. Forensicare provides a range of clinical services for people with a serious mental illness in the criminal justice and general mental health systems. I note that as of 1 September 2023, the Mental Health Act 2014 was superseded by the *Mental Health and Wellbeing Act 2022* (Vic).

[20] PO Berry commented at inquest, at T110 L21-T111 L12, *as well as having medical appointments the women will have programs appointments and these are not kept on one spreadsheet so often …. there'll be clashes and the women will need to either prioritise which thing that they think is more urgent or …. if they're capable of, I suppose you need*

occurred during the COVID-19 pandemic, which had well known impacts on health services and the operations of prisons.

Why examine Heather's health history outside a time proximate to her passing?

38. Not all details of Heather's medical management during her time custody are set out in my finding. I have endeavoured to document those matters which are or may be relevant to the scope of my investigation including those which may reveal systemic issues affecting the way health services were delivered. Individual clinicians' decision making over the course of more than a two-year period was not the focus of the investigation. It was apparent however that despite the broad range of services available to Heather at DPFC, over the course of her detention, there was a marked deterioration in her health. Some of Heather's indicators of poor health, such as WHO Class III obesity and diabetes, developed while she was in custody and feature in her cause of death.[21] This is why it was important to examine how Heather's health deteriorated over time and whether there were (are) any prevention opportunities.

CHRONOLOGY

39. At Heather's reception into DPFC on 31 July 2019, Heather weighed 94kg, was six and half months pregnant (22 to 26 weeks pregnant with her fourth child) and appeared *generally well*.[22] She reported no previous medical history, aside from cannabis[23] and methamphetamine[24] use.[25] She was not currently on an opioid substitution therapy program

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to understand not all, not all of the women that we have at the prison have the capability to not only prioritise but also to think if I go and I speak to Ms Berry about how my medical appointment and my family engagement worker appointment are at the same time maybe she can help me re-jig it. Not everybody has that capability so often they'll just prioritise one over the other without thinking that they can reschedule. So then if they don't show up to the medical appointment they're written down as a no show.

[21] The World Health Organisation (**WHO**) provides stratifies Body Mass Index (**BMI**) into categories of obesity. These categories range from underweight to Class I Obesity (with a BMI of 30.0–34.9 kg/m^2), Class II Obesity (with a BMI of 35.0–39.9 kg/m^2) and Class III obesity (with a BMI greater than 40 kg/m^2).

[22] JCare electronic medical records, CB at p.309.

[23] JCare electronic medical records, CB at p.546. 10gm daily, last smoked that day.

[24] JCare electronic medical records, CB at p.546. 10pts daily, last used the day before.

[25] JCare electronic medical records, CB at p.546.

(**OSTP**) and was not noted to be withdrawing from any substance. Heather's health plan at this time included scans and tests related to her pregnancy and to *review if needed.*[26] No concerns were identified and no other ongoing treatment or health need was established. [27] There was a note: *Assess eligibility for Chronic Health Care Plan.*[28]

40. At the time of her reception, Heather's status as an Aboriginal person was the only factor relevant and identified from a list of 20 possible Chronic Health Criteria/Conditions. A Chronic Healthcare Plan was therefore required.[29]

41. On 1 August 2019, Heather was reviewed at the Melbourne Magistrates' Court by Clinical Psychologist, Alice Crole (**Ms Crole**), who prepared a report.[30] Heather reported using cannabis daily, that prior to discovering her pregnancy she was a heavy methamphetamine user and that she had not used methamphetamine in the previous 6 months. No psychiatric diagnoses were disclosed but Heather reported that she suffered badly from depression and that her symptoms had gotten worse over the previous week. Heather's past mental health history included being placed on a temporary involuntary treatment order at Casey Adult Mental Health Service on 20 May 2017 where she was diagnosed with an adjustment disorder and depressive episode. Heather reported that she had never required psychological treatment and had never engaged in counselling.

42. Ms Crole described Heather as:

a young woman with several vulnerability factors that are likely to be compounded in the custody setting, including being Aboriginal, pregnant, suffering from depression with suicidal ideation, and being intermittently acopic in custody. [. . .] *She positively has family*

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[26] JCare electronic medical records, CB at p.309.
[27] JCare electronic medical records, CB at p.308-309.
[28] *See* JCare electronic medical records, CB at p.550. At Heather's previous reception assessment at DPFC on 17 October 2018 her weight was **88kg**. Her drug and alcohol use at that time documented cannabis (10mg daily, last smoked 5 months earlier) and amphetamine/ice (10pts daily, last smoked that day).
[29] JCare electronic medical records, CB at p.549.
[30] Mental Health Advice and Response Service (**MHARS**), *Confidential Psychological Report* CB at p.971.

supports and nil acute psychiatric diagnoses, including bipolar disorder, psychosis and personality disorder.[31]

43. Ms Crole indicated in her report that should Heather remain in custody, she would forward a copy of the report to DPFC and request mental health follow up for concerns regarding Heather's mental wellbeing, including depression, suicidal ideation, and anxiety and stress around her pregnancy.[32] Consistent with this advice, on 2 August 2019, Ms Crole sent an email attaching her report to 'Female Prison Reception; Marrmak Nursing Group' and said, *I assessed this woman yesterday at MMC. Please find attached the report in case you come across her*.[33]

44. On 2 August 2019, Heather was seen by a CCA medical practitioner, Dr Shalendra Nath (**Dr Nath**)[34], who gave evidence at the inquest. He completed the assessment for a Chronic Health Care Plan by noting her Aboriginal and Torres Strait Islander status indicating that she was Aboriginal and required a Chronic Health Care Plan.[35] Health planning focused on her pregnancy. No concerns for Heather's mental health were documented at this time.

45. Also on this day, Heather's initial mental health assessment was conducted by a CCA Registered Psychiatric Nurse (**RPN**).[36] Heather denied any *psych or SASH* [suicide and self-harm] *issues*[37] and *nil psych issues*[38] were evident, but a prior history of *depressive episode/adjustment disorder* was noted.[39]

46. Whilst Ms Crole's report was uploaded to Heather's JCare file, it appears unlikely that it would have been available to any clinician on 2 August 2019. More broadly however, there

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[31] MHARS, 'Confidential Psychological Report' CB at p.973.
[32] Ibid.
[33] Email from Alice Crole to 'Female Prison Reception', dated 2 August 2019, CB at p.4523.
[34] Unless indicated otherwise, medical practitioners/doctors referenced will be from CCA.
[35] JCare electronic medical records, CB at p.549.
[36] JCare electronic medical records, CB at p.310. Unless indicated otherwise Registered Psychiatric Nurses referenced will be from CCA.
[37] Ibid.
[38] Ibid.
[39] JCare electronic medical records, CB at p.574.

is no evidence to suggest that any clinician had regard to the report as part of their assessments moving forward.

47. From Heather's reception until the birth of her fourth child, Heather was seen at the Sunshine Hospital and at DPFC by a midwife from Western Health for matters associated with her pregnancy. Heather was also seen for a variety of medical issues by both nurses and doctors at DPFC on a needs basis during this time.

48. On 28 August 2019, Heather applied to the Living with Mum Program (**LWM Program**) .

49. On 3 September 2019, Heather disclosed to a medical staff member that she shared a 50mg tablet of Seroquel (quetiapine) with another prisoner.[40]

50. At approximately 3.05pm on 6 September 2019, a Referral for Health 'At Risk' Assessment was made by a prison officer. Heather had stated that she would take any pills she could get her hands on as she just did not care anymore. This followed being advised by her lawyer to expect a 3 to 4 year jail sentence.[41]

51. At approximately 3.47pm that day, Heather underwent a mental state examination by a RPN. The records document a diagnosis of *subjective depression, substance abuse.*[42] Heather reiterated that she was upset about advice from her lawyer regarding her likely sentence. She reported missing her partner and the father of her children and felt like punching someone although was able to deescalate during the course of the assessment. She reported poor sleep but no other mental health concerns were noted.[43]

Heather's LWM Program application is determined

52. On 24 October 2019, the Local Plan Notes (which are notes compiled by Corrections Victoria staff) reflect that Heather was informed that her application for her child to live with her at

[40] JCare electronic medical records, CB at p.300.
[41] JCare electronic medical records, CB at p.1003.
[42] JCare electronic medical records, CB at p.297.
[43] JCare electronic medical records, CB at p.297-298.

DPFC once born as part of the Corrections Victoria LWM Program had not been approved.[44]

Heather's baby is born

53. On 29 October 2019, Heather was transferred to Sunshine Hospital for an elective caesarean delivery and gave birth to a healthy baby girl. The discharge summary from Western Health noted amongst other things that, *patient may benefit from psychiatric nurse support at Dame Phyllis Frost.*[45]

54. On 1 November 2019, a referral was made to the Western Region Centre Against Sexual Assault (**WestCASA**) by Aunty Lynn which said that, *Heather has been in hospital giving birth to her child; Heather was not given custody of a child and DHHS were present at the birth and took custody of the child straight after birth; Heather has been extremely traumatised by this and is not coping; and Lynn would like WCASA to catch up with Heather ASAP.*[46]

55. Heather returned to DPFC on 2 November 2019 and was reviewed by a CCA Registered Nurse (**RN**).[47] Heather reported that *emotionally*[48] and *mentally*[49] she had distanced herself from not having her baby with her in prison. Heather was also reviewed by a medical practitioner who provided Panadeine (paracetamol and codeine) for pain from the c-section incision. He documented at that time *nil acute mental illness, not suicidal*.[50]

56. After the birth of her baby, Heather had a number of appointments with doctors and nurses at DPFC related to her recovery from the c-section and the development of an umbilical hernia as well as other medical issues such as headaches. She was also reviewed by a physiotherapist.

57. On 6 November 2019, Heather was reviewed by a midwife from Western Health at DPFC.

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[44] Local Plan File Notes, CB at p.1540
[45] Western Health, Obstetric Discharge Summary, CB at p.879.
[46] WestCASA records at CB p.3844-3898. *See* in particular at p. 3846.
[47] Unless indicated otherwise, Registered Nurses referenced will be from CCA.
[48] JCare electronic medical records, CB at p. 294.
[49] Ibid.
[50] JCare electronic medical records, CB at p.293.

The midwife discussed the signs and symptoms of post-natal depression and Heather disclosed that she was feeling *really flat*.[51] The importance of reaching out and speaking to someone if she was feeling flat or low was emphasised by the midwife as well as being in a good head space for her release date in December[52] and working towards getting her children back. There was a documented discussion with the psychiatric nurse who reported that Heather didn't feel like getting out of bed and would be seen later in the week.[53]

58. At approximately 1.00pm on 7 November 2019, Heather had a session with WestCASA but did not feel up to participating in the intake process. Therapeutic interventions were noted to have included, *listening, normalizing and validation; CBT/ACT* [cognitive behavioural therapy/acceptance and commitment therapy] – *grounding and mindfulness; psycho-ed around grief and loss; client centered/strengths focused*.[54] The session was followed by contact being made with prison officers to ensure Heather was being monitored. WestCASA was advised that Heather was attending a medical review to seek support for her depression.[55]

59. At 5.25pm on 7 November 2019, a review was conducted by a medical practitioner who documented that Heather's mood was *stable* and she was not suicidal.[56]

60. On 6 December 2019, Heather completed an Adult Medical Request Form which documented *Having Troulbe* [sic] *Sleeping Have Depression Bad Need to See a Doctor ASAP*.[57]

61. On 9 December 2019, Heather had her intake appointment with WestCASA. The worker documented: *Intrusive symptoms: nightmares and stressful dreams, ruminations, body responses to triggers - loud noises etc; hyperarousal symptoms: feeling on edge a lot, anxiety*

[51] JCare electronic medical records, CB at p. 291.
[52] CCA prepared a *Discharge Summary – Primary Health* with Heather's expected release being 8 December 2019. It is not clear what this was based on. *See* CB at p.1007-1009.
[53] JCare electronic medical records, CB at p.291-292.
[54] WestCASA records, CB at p.3852-3853.
[55] WestCASA records, CB at p.3854-3855.
[56] JCare electronic medical records, CB at p.291.
[57] JCare electronic medical records, CB at p.706.

- feels panicked a lot, stressed, difficulty sleeping; cognition symptoms: not retaining information as much, struggling to feel clear in her mind; depressive symptoms: feeling of depression, loneliness, sadness, grief and heartbreak, feeling shame and grief [sic] *the things that have happened, overwhelmed with current situation; Physical:* [. . .] *She was also very traumatised from the experience.*[58] During the WestCASA session Heather's hopes for counselling were documented as: *To have someone to talk through all that has happened to her and heal from the multiple traumas she has faced.*[59]

62. On 10 December 2019 Heather was reviewed by a RPN. The notes record, amongst other things, that Heather had an upcoming court date on 22 January 2020. Heather requested an appointment with a psychiatrist to commence an anti-depressant which she had not been prescribed before. Heather reported feeling *depressed*, was *isolating in her room*, wanted *to sleep all the time*, was *teary* with *reduced appetite*, *concentration* and *energy*.[60] Heather stated that she has had some thoughts to self-harm but with no intent or plan. An appointment was booked for a Forensicare Psychiatric Nurse Practitioner on 16 December 2019.[61]

63. On 14 December 2019, a referral for Health 'At Risk' assessment was made by a prison officer documenting that Heather was *thinking about self harm*.[62]

64. A Risk Review was performed by a RPN on that day. The notes record that Heather expressed some fleeting thoughts of self-harm but reacted well to one-to-one time. She indicated that she had not self-harmed for over a year. Hourly observations were put in place for temporary support. Her mood was noted to be *low* and her affect *flat*.[63] It was, however, noted that she displayed a good awareness of her mental health. Heather denied *SASH* and stated that she would advise prison staff if she developed suicidal ideation.[64] Her risk rating was increased

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[58] WestCASA records, CB at p.3857-3862, *see* p.3858.
[59] WestCASA records, CB at p.3857-3862, *see* p.3861.
[60] JCare electronic medical records, CB at p.289.
[61] Ibid.
[62] JCare electronic medical records, CB at p.1002.
[63] JCare electronic medical records, CB at p.288.
[64] Ibid.

from S4 to S3.[65]

65. On 15 December 2019. a RPN performed a Risk Review and reduced Heather's suicide risk rating back to S4 as well as ceasing the hourly observations. The records document that Heather continued to voice that she had *lowered mood* and an increase in *chronic self-harm thoughts*.[66] She denied any intent or plan and was keen to come off the observations as she found them very intrusive. Her children were noted to be a protective factor and Heather was keen for the Forensicare Psychiatric Nurse Practitioner review the following day.

66. However, the scheduled appointment on 16 December 2021, did not take place with the reason recorded as *clinician unavailable*. The reason for the appointment was noted as *Baby removed 5 weeks ago, depressed and would like to commence antidepressants.*[67]

67. On 21 December 2019, a RPN reviewed Heather and documented, amongst other things, that she was experiencing some self-talk but *no hallucinations - nil derogatory, nil persecutory or command*. Her mood was noted to be *low* and her affect *flat*. Heather denied *SASH* and said that she would reach out to prison officers if this was to occur. A follow up appointment with the Psychiatric Nurse Clinic was made.[68]

68. On 30 December 2019, a scheduled Psych Nurse Clinic appointment for a mental state examination was cancelled (Cancellation Reason noted as Clinician Unavailable).[69]

69. On 2 January 2020, a scheduled Psych Nurse Clinic appointment for a mental state review was cancelled, possibly due to COVID-19 lockdown.[70]

70. Also on this day, Heather spoke to her case manager who recorded, *Today Heather talked to*

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[65] Suicide and self-harm ratings are referred to as 'S' ratings; there are four categories that range from S1 to S4 (S1 being 'currently at risk' to S4 as 'not currently at risk'.) The ratings denote the level of observation indicated by clinical assessment.
[66] JCare electronic medical records, CB at p.288.
[67] JCare electronic medical records, CB at p.231.
[68] JCare electronic medical records, CB at p.287.
[69] JCare electronic medical records, CB at p.231.
[70] JCare electronic medical records, CB at p.226.

me about her heavy emotions regarding the death in custody overnight.[71] Heather was referring to the passing of Veronica Nelson.[72]

71. On 8 January 2020, Heather's birthday, she was reviewed by a RPN in the Psych Nurse Clinic[73] who documented that she reported *her mood had been up and down lately* which she attributed to spending her first Christmas and birthday away from her children. Heather had phone contact with them and visits on a Monday morning. Heather stated that she had no issues around *SASH* and agreed to attempt more pro-active coping techniques i.e. physical activity and continuing her art. The nurse noted that there was *unclear rational* [sic] *for anti-depressants at present*. Heather's mood was noted to be *euthymic* and her affect *flat*. A follow up appointment with the Psych Nurse Clinic was made.[74]

72. On 18 January 2020, Heather was reviewed by a RPN who documented amongst other things that Heather complained of depression, anxiety and poor sleep. She had not seen her children for several weeks and was saddened by this as there was a court order in place with child protection for this to occur. Heather stated that she didn't see a psychiatrist after the recent birth of her baby and feels sad about this. She also had a 13-year-old child who she hadn't seen for 12 years. Heather was experiencing sadness and loss around her children. She also missed her partner and was worried for him. She was also worried about getting a long sentence. Heather said that she preferred spending time in her unit rather than socialising with peers, usually due to feelings of anxiety and depression. She said she would seek out her sister or aunty when feeling challenged by her mental state. Heather reported having fleeting *SASH* thoughts to self-harm, and talking to her aunty helped resolve these thoughts. It was noted that she attended Koorie Art and other courses. Heather said that at times she felt she was stared at by others which added to her anxiety and made her want to withdraw.

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[71] Local Plan File Notes, CB at p.1546.
[72] *See* Finding into the Passing of Veronica Nelson (COR 2020 0021) dated 30 January 2023. Accessible at: COR 2020 0021 - Veronica Nelson Inquiry - Form 37 - Finding into Death with Inquest - 30 January 2023 - Amended 24 August 2023.pdf
[73] Unless otherwise stated Heather saw Registered Psychiatric Nurses in the Psychiatric Nurse Clinic.
[74] JCare electronic medical records, CB at p.287.

She also stated that she would get a pill from the *compound* sometimes to help her sleep so she can function the next day. Heather wanted to stop doing this and receive medication the correct way. During the assessment Heather was focused on her future, wanting to get out of prison, attend Odyssey House and work at getting her children back with a long-term plan of returning to Western Australia. On mental state examination, Heather had fleeting self-harm thoughts, but denied any current thoughts, plan or intent. Her children were noted as a protective factor. Her mood was noted as *a little low* with her affect as *reactive*. The plan was for a psychiatric nurse practitioner review for further investigation of her mental state and possible medication (booked for 21 January 2020). Also, a planned review by a RPN on 25 January 2020.[75]

73. On 21 January 2020, Heather did not attend a scheduled a Forensicare Psychiatric Nurse Practitioner appointment. The appointment records *Patient refused to attend*.[76]

74. Also, on this day Heather attended a Case Management Review Committee meeting. One of Heather's recorded goals was to look after her physical health and recover from her c-section following the birth of her child. It was noted that she had physically recovered and was now able to start to work but she was suffering from depression and had been placed on a modified risk management plan on 14 December 2019. Heather expected to be on medication soon. Heather reported attending the gym a few times a week and walking the compound most days. Heather had started Koorie Art (Mumbu Dhal), Aboriginal studies and computer certificates. She was waiting to commence WestCASA counselling and wanted to attend Caraniche for alcohol and drugs programs. It was noted that Heather had many challenges with her depression and a number of personal issues which were not helping her recovery, including that child protection had not brought the children to visit at DPFC for three weeks. Heather was discussing these matters with Jodie, Aboriginal Wellbeing Officer.[77]

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[75] JCare electronic medical records, CB at p.285-286.
[76] JCare electronic medical records, CB at p.226.
[77] PIMS records, CB at p.1149-1150.

75. On 25 January 2020, a nurse in the Psych Nurse Clinic documented that Heather wanted to be reviewed by a Nurse Practitioner for medication review and *that she kept being seen by psychiatric nurses* not a Nurse Practitioner. An appointment was made for the following week. There were no concerns recorded following a mental state examination.[78]

First review by a Forensicare Nurse Practitioner

76. On 29 January 2020, Heather was first reviewed by a Forensicare Psychiatric Nurse Practitioner (**the Forensicare Nurse Practitioner –** Heather referred to her as *Nushi*)[79] who documented that she was referred for an appointment due to increased anxiety, poor sleep and low mood and, that she was seeking medication. Her alcohol and drug history included daily methamphetamine and cannabis. A review was undertaken of Heather's JCare notes from 17 October 2019. During the assessment Heather reported poor sleep, low mood, increased anxiety, restlessness especially during the night. She also reported hearing voices. Heather reported that she had been using quetiapine and mirtazapine by hassling others in the compound. She hadn't seen her children for a few weeks. She was attending drug and alcohol programs and worked in horticulture. She reported that she was well supported by other prisoners and prison officers. There were no concerns regarding self-harm. She was aware of her substance use and risk of impulsive and risk-taking behaviour. On mental state examination, Heather reported that she was becoming depressed and unwell and requested medication. The clinician noted that Heather had a history of substance use and was currently experiencing mild to moderate depressive and anxiety symptoms. There were no self-harm risks and she was seeking help. Her children were considered a significant protective factor. The documented plan was to commence sertraline (50mg), psychiatric nurse review in accordance with her existing plan, and a nurse practitioner review in six weeks.

77. During February 2020, Heather attended several appointments related to umbilical area pain

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[78] JCare electronic medical records, CB at p.285.
[79] JCare electronic medical records, CB at p.283-285. Heather had four reviews by the same Forensicare Psychiatric Nurse Practitioner.

and hernia pain.

78. On 4 March 2020, a Medical Request Form was completed by Heather requesting, *Nushi at forensicare ASAP*.[80]

Second review by a Forensicare Nurse Practitioner

79. On 10 March 2020, Heather had her second review with the Forensicare Psychiatric Nurse Practitioner who documented that Heather reported feeling depressed *just the same* and experienced poor sleep. She was angry in the context of a visit with her children that day with the behaviour of the child protection worker and also felt angry and sad about leaving her children behind. On mental state examination her mood was reported to be depressed and noted to be *flat*. There were ongoing self-harm thoughts about being in prison but no clear plan or intent. The documented plan was to increase sertraline (100mg), psychiatric nurse review in accordance with her plan, and a nurse practitioner review in four weeks.[81]

80. The records note that there were several missed appointments for medical issues in March and early April 2020.

Third review by a Forensicare Nurse Practitioner

81. On 9 April 2020, Heather had her third review with the Forensicare Psychiatric Nurse Practitioner who documented that Heather was very angry and upset. She had not seen her children for six weeks; other inmates had been released, and her court date had been adjourned until 4 May 2020. She was becoming depressed and anxious and was not sleeping well. She said that she felt frustrated and let down by the system. On mental state examination Heather presented as dishevelled and upset. Her mood was noted to be *flat restricted* with poor sleep. There were no self-harm risks noted. The documented plan was to commence

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[80] JCare electronic medical records, CB at p.701.
[81] JCare electronic medical records, CB at p.281-282.
During a strip search on 11 March 2020, custodial officers located half a tablet of Seroquel (quetiapine) on Heather, which was seized. The related offence was found proven and she was given a fine. CB at p.1047.

quetiapine XR (extended release) (50mg), psychiatric nurse review in accordance with her plan, and no further nurse practitioner reviews were booked. Heather was to rebook if needed.[82]

82. The records document that there were several missed appointments in April and early May unrelated to appointments at the Psych Nurse Clinic.

83. On 14 April 2020, Heather had her first session with WestCASA after the intake appointment on 9 December 2019. COVID-19 had impacted the way in which sessions were conducted: they were now conducted by phone and were limited to half hour phone sessions about every 2-3 weeks.[83]

Heather raised difficulty with her weight management

84. This is the first reference in the records obtained by the Court to Heather's weight management being an issue.

85. On 27 April 2020, Heather had a phone session with WestCASA where she indicated that she was grateful for counselling. The file revealed a focus on navigating and advocating for contact with Heather's children.[84]

Heather is sentenced in the Koori Court

86. On 4 May 2020, at the County Court at Melbourne (Koori Court Division) Heather was sentenced to two years and three months imprisonment for Armed Robbery and six months imprisonment for make threat to inflict serious injury with a non-parole period of 14 months.

87. On 6 May 2020, a Medical Request Form was completed by Heather requesting, *Need to see*

[82] JCare electronic medical records, CB at p.280-281.
[83] WestCASA records, CB at p.3864-3865.
[84] WestCASA records, CB at p.3876.

Forensic Care asap.[85]

88. On 9 May 2020, a Medical Request Form is completed by Heather requesting, *I need to see Forensic Care regarding my Seroquel script which ran out yesterday*.[86]

89. On 10 May 2020, Heather was reviewed by a RPN who documented amongst other things that Heather had been sentenced and was angry about matters associated with the offending that led to her incarceration. Heather said that her three youngest children were with family and felt they were safe. She said that she found sufficient sleep helped with her depression and that she wanted to see the Forensicare Psychiatric Nurse Practitioner again for a medication review. She was aware that this required a referral from CCA. On mental state examination no issues were identified. Her mood was noted be *flat* and affect *blunted*. An appointment with the Forensicare Psychiatric Nurse Practitioner was booked for 20 May 2020.[87]

90. On 11 May 2020, Heather had a phone session with WestCASA. Fortnightly counselling sessions were proposed.

91. On 12 May 2020, Heather completed an application for parole.

Fourth and final review by a Forensicare Nurse Practitioner

92. On 20 May 2020, Heather was reviewed for the fourth and final time by the Forensicare Psychiatric Nurse Practitioner who documented the outcome of Heather's recent sentence. Heather expressed her anger and disappointment about matters associated with the outcome. She reported increased anxiety and crying periods and that she was not sleeping well. There were ongoing self-harm thoughts, but no active plan or intent. On mental state examination, her mood was noted to be *anxious restricted* with poor sleep. A long discussion was had regarding self-care/stress management/routine and structure. The documented plan was for

[85] JCare electronic medical records, CB at p.698.
[86] JCare electronic medical records, CB at p.697.
[87] JCare electronic medical records, CB at p.279.

her sertraline to be increased to 150mg and her quetiapine increased to 100mg with psychiatric nurse review in accordance with her plan, and no further nurse practitioner reviews were booked. Heather was to rebook if needed.[88]

93. No further review or ongoing management of Heather's mental health occurred between this appointment and 2 July 2020. The records note that there were several missed appointments in April and June 2020 unrelated to appointments at the Psych Nurse Clinic.

94. On 26 May 2020, there was a meeting of the Case Management Review Committee concerning Heather's parole application, where Heather confirmed that she would live with her mother on release. The Committee endorsed the content of Heather's parole application following which her application was received by the APB that day.[89]

95. Also on 26 May 2020, Heather had a phone session with WestCASA where she expressed sadness about the separation from kids and that she *cannot touch and hug them*.[90] This appears to be the last session Heather had with WestCASA.

96. On 2 July 2020, Heather was reviewed by a RPN who completed the Mental Health Chronic Health Care Plan Review and recorded under diagnosis – *psychosis*[91]. Heather's goals[92] under the plan were discussed and sent to her. Heather was noted to be future focused, aware of mindfulness with no issues identified. The documented plan was for a review after her appeal.[93]

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[88] JCare electronic medical records, CB at p.278.
[89] *See* PIMS record CB at p.1129-1132 *Based on the above information the CMRC Chair endorses the content of the parole application. Using the satisfaction behaviour guide, the CMRC considers the prisoners recent institutional behavior as of some concern overall, the CMRC considers the SVO prisoner has met the threshold for progression to parole planning towards their earliest eligible release date*.
[90] WestCASA records, CB at p.3888-3889.
[91] Statement of the nurse, CB at p.3442, the nurse said that he believed this is an error and that based upon the Mental Health Chronic Health Care Plan, the correct recorded diagnosis was depression. This related to chronic health care planning..
[92] These included matters around Daily Living, Home, Health and Wellbeing, Lifelong Learning, Work, Social and Community Participation, Relationships and, Choice and Control.
[93] JCare electronic medical records, CB at p.276-277.

97. On 7 July 2020, Heather was reviewed by a RPN who documented a diagnosis of depression with no *psych* issues identified (*Travelling well)* and compliant with medications with no side effects. The predominant issue was *pain with her abdominal hernia*. A medical appointment was booked for the following day. A Mental Health Care Plan was added and it was noted that *MH CHCP - initial consultation was completed*.[94]

98. On 8 July 2020, Heather was reviewed by a medical practitioner regarding her umbilical hernia. He performed an abdominal examination but noted it was difficult due to *body habitus*. He noted obvious protrusion and the documented plan was for an ultrasound and review to consider surgery.[95]

99. On 10 July 2020, there was a Local Plan Review. Heather reported that she was regularly attending the medical centre for medications and was awaiting an ultrasound appointment for her hernia. It was documented that *Heather is keeping on top of her mental health issues by taking medication daily and attending her WestCasa appointments on a weekly basis. She is getting on top of her hernia issue and is awaiting an ultrasound.* She had also successfully completed a parenting program. It was further noted that Heather was concentrating on being eligible for parole and to this end was to complete all programs and remain incident free to be eligible for parole. Other comments included;

    Heather has remained incident free and is very polite, respectful and compliant. Heather has good reviews from her place of employment being the Goulburn billet. Heather would like to complete any programmes required to prepare herself for parole and to be able to focus on developing a positive relationship with her children who are currently in DHS care.[96]

100. On 16 July 2020, Heather was reviewed by a RPN who documented a diagnosis of depression with no *psych issues* identified and that she was remaining positive, attending work and being future focused. She indicated she would now take her morning medication and she wanted to

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[94] JCare electronic medical records, CB at p.276.
[95] Ibid.
[96] Local Plan records, CB at p.1595-1596.

get up earlier. On mental state examination her mood was noted to be *euthymic* with nil issues around anxiety levels or depression and her affect was noted to be *reactive*. There was a plan for Heather to be reviewed following the outcome of her appeal and for her to self-refer as needed. A reference was noted for Heather to be rebooked for the psychiatric nurse (presumably the nurse practitioner) to check her mood *considering sporadic medication compliance* but this was not part of the plan made.[97]

101. On 17 July 2020, Heather attended a Case Management Review Committee meeting. The notes document that she was keeping on top of her mental health issues by taking medication daily and attending her WestCASA appointments on a weekly basis. She had decided against appealing her sentence. Heather had applied for parole but as a Serious Violent Offender, she would be assessed by Forensic Intervention Services for programme requirements. Heather had received a letter from the APB confirming receipt of her application for parole and advised her to proceed to parole planning. It was noted that Heather understood she needed to be incident free, engaged in programmes designed to address her offending and take advantage of all opportunities to improve herself whilst at DPFC.[98]

Heather is weighed for the first time following her reception

102. On 22 July 2020, Heather was reviewed by a medical practitioner (for pain in the belly preventing her from working) who documented amongst other things, that her hernia was *looking ok* and she was wearing a tubigrip. Her waist was measured at 140cm with height at 165 cm, weight at 145kg and a Body Mass Index (**BMI**) of 53.3 kg/m^2 (WHO class III obesity). Surgery for hernia repair was considered as well as metabolic work ups to check for diabetes and cholesterol levels. There was also a query around starting metformin for weight management.[99]

103. Of note, this was only the second time Heather had been weighed in prison, and it is apparent

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[97] JCare electronic medical records, CB at p.275-276.
[98] PIMS records, CB at p.1124-1128.
[99] JCare electronic medical records, CB at p.274-275.

that she had gone from 94kgs (although 6 months pregnant) to 145kg, in just under a year.

104. On 25 July 2020, Heather did not attend a scheduled Psych Nurse Clinic appointment. It is recorded that *Patient refused to attend*.[100] On 27 July 2020, the JCare records document an *Integrated Care Plan* was added.[101]

105. On 28 July 2020, Heather's Mental Health Chronic Health Care Plan was completed, where it was noted that there was no diagnosis in JCare. Heather reported that her mental state was settled and she was happy to continue her current medication regime.[102]

106. On 10 August 2020, Heather was reviewed by a medical practitioner following receipt of her blood test results. Early signs of deranged Liver Function Tests (**LFTs**) were documented. In relation to her large umbilical hernia, which was considered to be irreducible, she was to be referred to St Vincent's Hospital (**SVHM**) for surgery. Weight management was discussed, and Heather was to be reviewed in a month with her food diary.[103]

107. On 17 August 2020, Heather was reviewed by a medical practitioner who documented a discussion around weight loss including methods. She was to be reviewed in two weeks.[104] There is a handwritten food diary from 10 August 2020 to 17 August 2020 but no further.[105]

108. On 30 August 2020, there was a scheduled review of Heather's Chronic Health Care Plan and a medical review for 'weight management' on 31 August 2020. Heather did not attend either appointment (*Patient refused to attend*).[106] There were a number of other appointments in September and early October 2020, including physiotherapy and a review of Heather's Chronic Health Care Plan which did not proceed.[107]

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[100] JCare electronic medical records, CB at p.223.
[101] JCare electronic medical records, CB at p.274.
[102] Ibid.
[103] JCare electronic medical records, CB at p.272-273. She also saw a dentist on this date.
[104] JCare electronic medical records, CB at p.272
[105] JCare electronic medical records, CB at p.630-631.
[106] JCare electronic medical records, CB at p.224.
[107] JCare electronic medical records,, CB at p.224-225.

109. On 22 October 2020, Heather's Local Plan was reviewed. Heather reported continuing her studies and participating in the Koorie Art Program and participating in counselling sessions with WestCASA. Regarding physical/mental health issues it was reported *she [was] currently doing okay physically, but has a hernia and some dental issues (with no associated pain), and is waiting to receive treatment. She also said that her mental health is generally okay, but since she has post-natal depression, she sometimes feels down. Heather plans to see a Psych Nurse.* It was further documented that Heather was committed to do whatever she could to get parole as soon as possible so that she could be with her children.[108]

110. Of note, this is the first reference to Heather suffering post-natal depression, which was not documented as a diagnosis in her JCare records but appears to be self-reported.

111. On 27 October 2020, Heather attended a Case Management Review Committee Meeting she was commended for her engagement in education and Koorie Art.[109]

112. On 4 November 2020, Heather attended an appointment with the Surgery Clinic at SVHM. The surgical registrar canvassed in correspondence to the DPFC medical practitioner the risks and benefits of surgical management of the hernia including risks related to Heather's central obesity,

    I would appreciate your assistance while she is in the prison with attempts at weight reduction. This may include a discussion with her about diet and exercise and I am not sure whether there are any dietitians that could be utilised in the prison system. In addition, whether or not you would consider a discussion with her about weight loss medication.[110]

113. On 7 November 2020, Heather's Mental Health Chronic Health Care Plan was reviewed. A diagnosis of **post-natal depression** was documented for the first time. It was documented that Heather planned to live with her mother on release. She reported that her mental state

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[108] Review of Local Plan, CB at p.1597-1598.
[109] PIMS records, CB at p.1119-1123.
[110] JCare electronic medical records, CB at p.871-872.

was reasonably stable, and she was compliant with treatment. No significant concerns were reported. She was booked for a plan review in 3 months.[111] It was not clear from the records how a diagnosis of post-natal depression was reached and there does not appear to be any additional or changed treatment in response to the diagnosis.

114. On 10 December 2020, Heather had a Local Plan Review where it was noted that she was required to complete the See Change Program (over 12 weeks) which was due to commence in February 2021,to be considered for parole.[112]

115. On 21 December 2020, Heather lodged a Medical Request Form which stated that she wished *to join weight loss clinic please*. An appointment was scheduled for 10 February 2021.[113]

116. On 24 December 2020, Heather was reviewed by a RPN, Francis Loguli (**RPN Loguli**), who gave evidence at the inquest. He documented that Heather wanted to stop re-offending and find help to deal with the problems that led to her being in prison. Heather wanted to continue taking medication when released and would attend her GP for this purpose. On mental state examination her mood was reported to be *depressed* and *upset* and she was noted to be *anxious restricted* with poor sleep.[114]

117. After midnight on 28 December 2020, a RN attended Heather's cell as she was feeling unwell. The JCare records document, *I did not recognise* [Heather] *due to the increased weight gain; observed plate Dim Sim on table and concentrated lime cordial bottle with little water added.* Heather described general pain all over and she was observed to be *visibly tired*.[115]

118. On 3 February 2021, a RN reviewed Heather regarding her hernia (*growing bigger and*

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[111] JCare electronic medical records, CB at p.270-271. There were reviews of chronic health care plan scheduled but not attended on 15 and 29 November 2020.
[112] Local Plan File Notes, CB at p.1555.
[113] JCare electronic medical records, CB at p.681.
[114] JCare electronic medical records, CB at p.266.
[115] JCare electronic medical records, CB at p.265-266.

painful to manage).[116]

119. On 17 February 2021, Heather was reviewed by a medical practitioner who referred her to SVHM for surgical management of her hernia. The referral noted *the hernia is enlarged on the background of gaining weight and mental health issues after refused to be released.* Her weight was documented as **159kg** (a gain of 14kg).[117]

120. On 20 February 2021, it was recorded in the Review of Local Plan, that Heather was being treated for depression and was finding that the medication was *really helping*. She was scheduled to attend the weight loss clinic but was unable to make it due to a Koori program but was keen to attend. She recently refused a *psyche* appointment because she had been frustrated by the cancellation of numerous appointments and was not in the right mindset.[118]

121. On 3 March 2021, Heather attended her **first** appointment at the Weight Management Clinic. Her weight was recorded as **159kg** with a BMI 58.4 kg/m^2 (WHO Class III Obesity). The RN documented that Heather was *extremely concerned* about her weight. She said that she was *self medicating* with food to help with her depression. And further that she feels *extremely low in mood at night and often gets up in the middle of the night and eats whatever she can find in the fridge. Feels like her weight is affecting* [sic] *her quality of sleep, states she may have sleep apnea* [sic]. *Struggles to walk around the compound and is constantly tired.* Optifast was recommended which she was keen to start.[119] An appointment was made for routine blood tests *as she has not had any done for a long time*.[120] It was further documented that Heather's Optifast needed to be charted and she *needs a review with MO* [Medical Officer] *on the subject of metabolic syndrome/LADA*.[121]

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[116] JCare electronic medical records, CB at p.265.
[117] JCare electronic medical records, CB at p.264 and p.678-680.
[118] JCare electronic medical records, CB at p.1599-1600.
[119] I note that the JCare medical records use the terms, *Optifast* and *Optislim* interchangeably. *Optifast* and *Optislim* are brand names of meal replacement products intended for weight loss.
[120] JCare electronic medical records, CB at p.263-264.
[121] LADA (Latent Autoimmune Diabetes in Adults) is an autoimmune condition like type 1 diabetes, however the rate at which the cells of the pancreas are destroyed is slower.

122. Of note, this is the first reference to the possibility of *metabolic syndrome* - a group of conditions that increase the risk of heart disease, stroke and type 2 diabetes. These conditions include high blood pressure, high blood sugar, too much fat around the waist, and high cholesterol or triglyceride levels.

123. On 9 March 2021, Heather's Optifast order was ceased, *as per Nursing staff request*, during a non-contact appointment. The basis for the request or the decision to cease the order is not recorded.[122]

124. On 10 March 2021, Heather attended her second appointment at the Weight Management Clinic where her weight was recorded at **160kg**. She was booked for a medical review on 15 March 2021 and review with a dietician.[123]

125. On 13 March 2021, Heather was reviewed by RPN Loguli. Heather reported feeling depressed and that her medications were *not working effectively*, that she was sad, unmotivated, crying and missing her kids. The stressors documented were that she had lots of friends being released but she had 8 more months of her sentence. The plan was to book a medication review with a medical practitioner and to continue taking her medications until review.[124] The records did not disclose that a medication review took place or a change in treatment or plan was developed in response. RPN Loguli suggested at inquest that this may have been a function of the JCare system being down.

126. On 17 March 2021, Heather was reviewed by a medical practitioner who documented that she had gained 70kg in the last two years, there were no recent blood tests, and she was under the care of the Weight Management Clinic on meal replacement shakes. There was no family history of diabetes. Her older brother and sister had passed away of heart attacks at the age of 39 and 42 years respectively. It was noted that she snored at night and was sometimes

[122] JCare electronic medical records, CB at p.263.
[123] JCare electronic medical records, CB at p.263.
[124] JCare electronic medical records, CB at p.263 and p.623.

gasping for air.[125]

Diagnosis of diabetes

127. On 24 March 2021, after receipt of the results of blood tests, Heather was diagnosed with type 2 diabetes. The medical practitioner referred Heather to St Vincent's Specialist Clinics – Diabetes Educator. Her weight was noted to be increasing despite diet changes and Optifast shakes. She was commenced on diabetes and cholesterol management medication; booked for regular Blood Sugar Level (**BSL**) testing. It was noted from the records that Heather attended these sporadically. Her Cardiovascular Disease Risk Level was noted to be low but also that she was Aboriginal, young and taking antipsychotic medications. She was prescribed a low dose of simvastatin (a statin) with a plan to check her cholesterol in 6 months.[126]

128. On 28 March 2021, at her monthly meeting with her Case Manager Prison Officer (**PO**) Berry, Heather advised of her attendance at the Weight Loss Clinic and that she was undertaking a nutrition and wellbeing course as a result of the diagnosis of type 2 diabetes. She also reported walking two laps of the entire compound each morning. New goals were developed focusing on diabetes education , regular moderate exercise, increasing daily water intake and adopting healthy eating habits. Heather asked for help with healthy eating and exercise plans which PO Berry provided.[127]

129. On 30 and 31 March 2021, Heather attended medical reviews. Her weight was documented by a RN as **157.7kg**. An electrocardiogram (**ECG**) was performed and blood tests taken.[128]

Heather's first request for opiate replacement therapy

130. On 12 April 2021, Heather was reviewed by Dr Mahfuz Chowdhury (**Dr Chowdhury**) who

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[125] JCare electronic medical records, CB at p.262-263.
[126] JCare electronic medical records, CB at p.262 and p.674.
[127] Local Plan File Notes, CB at p.1561-1562.
[128] JCare electronic medical records, CB at p.261.

referred her to the SVHM Diabetes clinic. The referral noted that she needed education, a diabetic educator review and that she was struggling to reduce her weight. She was unable to be weighed as the scales only went up to 150kg. Heather requested *suboxone*.[129]

131. Of note, this is the first time that the JCare records document a request by Heather for opiate replacement therapy.

132. Appointments were scheduled for 2 and 9 May 2021 to prepare Heather's Aboriginal and Torres Strait Islander Chronic Health Care Plan, which she could not attend due to being in lockdown on the first occasion with no reason recorded on the second occasion. No further appointment was scheduled.[130]

133. On the 19 May 2021, Heather attended the Weight Loss Clinic where her weight was recorded as **162kg** (a gain of 4.3kg) in less than 3 weeks. A RN noted that this was having a big impact on her mental health and Heather remained worried about her newly diagnosed Type 2 diabetes. She said she had no luck with restricting her food intake and stated that she uses food as a comfort while in custody away from her children. Heather asked to be put on the "Weight loss injection" and an appointment was made with a medical practitioner to discuss its suitability.[131]

134. On 21 May 2021, a Medical Request Form was completed on Heather's behalf by an Aboriginal Wellbeing Officer stating, *Needs to see psych nurse* [sic]*soon as possible*.[132]

135. On 22 May 2021, Heather was reviewed by Dr Nath who advised that the prescription of injectable weight loss medication (in custody) was yet to be approved and so her request *has been put on hold* . Heather was counselled about calorie restriction and intense exercise.[133]

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[129] JCare electronic medical records, CB at p.260-261, p.671.
[130] JCare electronic medical records, CB at p.259, p.260.
[131] JCare electronic medical records, CB at p.258-259.
On 20 May 2021, a half a brown tablet, identified as Seroquel (quetiapine), was located in a desk draw in Heather's room. Heather admitted it was her medication. The related offence was found proven, and she received a fine. PIMS records, CB at p.1068.
[132] JCare electronic medical records, CB at p.665.
[133] JCare electronic medical records, CB at p.258.

136. On 24 May 2021, Heather was reviewed by RPN Loguli who documented that Heather had noticed that her quetiapine script had expired. She was feeling depressed and sad about the burial of her niece (who died from bone cancer), her grief following the passing of her uncle who died from a heroin overdose and the passing of her former boyfriend by hanging. She was encouraged to seek help if her sadness was prolonged. A medical practitioner was asked to a rechart her medication. There were no expressions of self-harm and there was a plan for review in two weeks.[134]

137. Heather did not receive any mental health care or treatment (save for her prescribed medications)[135] between this appointment and November 2021.

138. On 25 May 2021, Heather was reviewed by the Sentence Management Committee. Heather reported that she had not been herself lately due to deaths in her family and that she had run out of her medication. She was in contact with the Aboriginal Liaison Officer to help with her grief. She said that she had submitted multiple forms within the last few weeks to have her medication renewed but did not receive an appointment, before her caseworker (on 24 May 2021) communicated with a psychiatric nurse and it was reinstated. It was noted that she had been accepted into the See Change Program and was waiting for it to start. [136]

139. On 2 June 2021, Heather attended the Weight Management Clinic where it was documented that she weighed **161kg** and had been working very hard and was positive about her progress.[137]

140. On 9 June 2021, Heather was reviewed by a podiatrist. Heather reported that her diabetes was not very well controlled, as her diet was poor, and she struggled with her weight and having sugary treats. She was provided with orthotics to help relieve the aches in her feet.[138]

141. On 16 June 2021, Heather attended the Weight Management Clinic where her weight was

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[134] JCare electronic medical records, CB at p.257.
[135] See generally medication administration records for this period, JCare electronic medical records, CB at p.715-752.
[136] PIMS records, CB at p.1090-1095.
[137] JCare electronic medical records, CB at p.257.
[138] JCare electronic medical records, CB at p.256-257.

recorded as **161kg**.[139]

142. On 18 June 2021, Heather was reviewed by a medical practitioner as she wanted to discuss weight loss injections. Her weight was recorded as **163kg**. The clinical impression was documented as *clinically metabolic syndrome.* The plan was to repeat bloods and a referral to SVHM endocrinology and/or diabetes clinic, start Optifast trial with review in one month to monitor weight loss.[140] The referral reason noted amongst other things, *Given Ms Calgaret's situation and her heritage I think it would be worthwhile to be reviewed by your service for optimisation of her diabetes management and to familiarise her with services that are available to her on the outside once she finishes her sentence next year*.[141] Heather had not been seen by a diabetes educator to date.

143. On 20 June 2021, a Medical Request Form was completed by Heather requesting, *OSTP Doctor Please*.[142]

144. On 21 June 2021, Heather was given Optifast.[143] She also advised her Case Worker, PO Berry, that she had *fallen off the wagon a bit with her health* but she was determined to get back on track. Heather reported having not exercised as regularly and having lost her way with her healthy eating habits. She had also had some issues with child contact visits being suspended.[144]

145. On 23 June 2021, Heather attended the Weight Management Clinic where her weight was recorded as **159kg**. Heather was noted to be feeling very motivated and stated that she could already feel the difference.[145]

146. On 24 June 2021, Heather was reviewed in the OSTP Clinic by RN Nhung Duong (**RN**

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[139] JCare electronic medical records, CB at p.255. There is reference to Heather having been put in lockdown on 11 and 12 June 2021 due to being symptomatic and potentially covid positive.
[140] As previously noted, it is unclear why Optifast was ceased in March.
[141] JCare electronic medical records, CB at p.255 and p.663.
[142]JCare electronic medical records, CB at p.662.
[143] JCare electronic medical records, CB at p.255.
[144] Local Plan File Notes, CB at p.1567.
[145] JCare electronic medical records, CB at p.255.

Duong), who gave evidence at the inquest. This consultation is described in detail later, but in summary, RN Duong took a full history, identified relevant health information required for her application and the need for assessment following that material being obtained.[146]

147. On 13 July 2021, a medical practitioner conducted a file review before seeing Heather, who presented for wrist pain and eczema. Her weight was recorded as **165kg**. The clinical note referred to an impression that simvastatin use may have caused derangement (persistently mildly high) LFT (liver function test) results. Heather's cholesterol levels were noted to be borderline but she was also noted to be implementing lifestyle changes. Both her Aboriginal status and importance of weight loss were noted. Empagliflozin[147] was commenced and her simvastatin ceased. Further blood tests were ordered and collected on 22 July 2021.[148]

148. On 26 July 2021, Heather was reviewed by Dr Chowdhury who documented that Heather had coughed up blood twice following which an xray of her chest was ordered. She reported that her quetiapine needed to be recharted.[149]

149. On 31 July 2021, Heather had left work and appeared upset and distressed which prompted a request to follow up on her welfare. She reported to PO Berry that she was struggling in general, that her anti-depressant medication had a side effect that made her extremely tired during the day and, despite taking it religiously she was feeling really depressed. She struggled to find the motivation necessary to attend work because of tiredness and depression . Heather agreed to submit a medical request. It was documented that she *feels like she has hit a bit of a wall where the day-to-day repetitiveness of prison life is getting to her.* Heather reported that as a result of the See Change Program, it was bringing up a lot of emotions as she unpacked *her childhood traumas* and as a result PO Berry offered to seek further help

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[146] JCare electronic medical records, CB at p.253-254. On 12 July 2021 Heather attended for blood tests which had previously been missed. Tests for "*FBE, U & E, LFT, Fasting Chol, TG, HDL, LDL BI Glucose, LFT< TSH< HBA1C, Urine Micro- Albuminuria, Vit D*" taken.

[147] Empagliflozin is used by itself or in combination with other medicines to treat type 2 diabetes mellitus. It helps control the high blood sugar levels seen in diabetics. It reduces the chances of serious complications of diabetes and also helps prevent heart disease.

[148] JCare electronic medical records, CB at p.252-253.

[149] JCare electronic medical records, CB at p.250.

after sessions took place. Heather agreed for a referral to be made to the Forensic Service Distress Intervention. She also reported eating too much to *self soothe*. PO Berry made a referral and spoke with nursing staff to express concerns regarding the effectiveness of Heather's antidepressant medications given the side effects she was reporting. She noted that changes in Heather's behaviour included *crying, not socializing to the point of self isolation, spending significant periods of time sleeping and not leaving her cell (withdrawn), not going to work.* It was arranged for Heather to have a private space with her sister after each See Change Program session to *debrief* as needed.[150]

150. A number of appointments were scheduled in August but not attended, including a Nurse Clinic appointment scheduled for a Chronic Health Care Plan review on 1 August 2021, and Weight Management Clinic appointments on 4, 11, 18 and 25 August 2021.[151]

151. On 14 August 2021, Heather had a monthly update and review of local plan with her Case Worker, PO Berry, who documented that the See Change Program was on hold because of COVID-19 pandemic restrictions.[152]

152. On 17 August 2021, at a Sentence Management Committee Review, Heather reported that she had cut out all sugars and had increased her exercise a little bit. She said that she was trying to control her diabetes through diet and did not want to become insulin dependent. It was noted that Heather had applied for parole and was now over her *EED* (earliest eligibility date). She advised that she would be residing with her mother and youngest brother in Pakenham. She said that she had never lived in that area and that her mother moved there so Heather could be away from the area where her offending occurred and where her old criminal associates still lived.[153]

153. On 25 August 2021, a Medical Request Form was completed on behalf of Heather by an

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[150] Local Plan File Notes, CB at p.1569-1570.
[151] JCare electronic medical records, CB at p.210. As well as for the following month on 1, 8, 15, 22 and 29 September 2021.
[152] Local Plan File Notes, CB at p.1570.
[153] PIMS records, CB at p.1084-1089.

Aboriginal Wellbeing Officer requesting: *Wants to go on Suboxone*.[154]

154. On 27 August 2021, Heather attended RN Fiona Millson at the OSTP Clinic who recorded that Heather had been seen on 24 June 2021 for assessment and was still wanting to go on the program. The required information remained outstanding.[155]

155. On 27 September 2021, Heather was reviewed by a RN and then a medical practitioner. Heather reported feelings of hunger and thirst increasing in the previous two weeks and that her BSL monitoring had not been regular. Her weight was recorded as 153kg, her BSL was 13.1mmol/L. Her scripts for metformin and Optifast were renewed, she was referred to a dietician at SVMH, with a plan for review by a medical practitioner in 2 weeks.[156]

156. On 7 October 2021, Dr Liyasha Goonetilleke (**Dr Goonetilleke**), a CCA medical practitioner, reviewed Heather. She also gave evidence at the inquest. Heather reported that she had been experiencing occasional chest pain, which she described as *chest tightness*. She described it as a sharp pain, that was worse with inspiration and lasted only a few seconds, but she could not move while she experienced the pain. She reported that occasionally she experienced shortness of breath but no dizziness or radiating of the pain. Heather was not experiencing this pain at the time of her assessment and was advised to let the health staff know when she was experiencing chest pain so they could perform an ECG.[157]

157. Heather also reported poor BSL control and it was suggested that further blood and urine tests be conducted to monitor her progress. Dr Goonetilleke said Heather had *known metabolic syndrome* and had been taking Optifast. She was however supplementing this with foods that were high in carbohydrates such as rice and pasta. She was informed that this was detrimental to her BSL control. Dr Goonetilleke planned to refer her to an endocrinologist once blood results were known. Heather's chest was clear, but her blood pressure indicated

[154] JCare electronic medical records, CB at p.658.
[155] JCare electronic medical records, CB at p.248.
[156] JCare electronic medical records, CB at p.246-247, p.654.
[157] JCare electronic medical records, CB at p.245; Statement of Dr Gonnetilleke, CB at p.1235-1239.

she was hypertensive (high blood pressure). She was commenced on anti-hypertensive medication (ramapril 5 mg daily). Heather also said she had been self-medicating with Suboxone (illegally obtained whilst in prison) and wanted to go on the OSTP programme following which a referral was made.[158]

158. Dr Goonetilleke based her label of *metabolic syndrome* on Heather's poor BSL control, central weight gain, hypertension and high cholesterol.

159. Although there were two previous referrals to an endocrinologist at SVHM, it does not appear that Heather attended any appointments for assistance with her diabetes. This may have been the result of COVID-19 pandemic-related changes to healthcare staffing (in and out of prison) and prison operations.

Heather's application for parole is denied

160. By letter dated 13 October 2021, Heather was advised that her application for parole had been denied.[159]

161. On 20 October 2021,[160] Heather attended upon Dr Goonetilleke who had the results of her fasting blood tests. Heather reported that she was still maintaining a poor diet, but that she had put in a referral to see a dietitian. Her BSL was 7.1mmol/L.[161] Dr Goonetilleke suggested an increase in her medication to lower her BSL but that unless she improved her diet it may not have a significant impact. She was advised that if her BSL did not improve she would need to commence insulin. Repeat blood tests were ordered for three months' time. Heather asked about *Suboxone* and Dr Goonetilleke advised her that she had discussed the request with the OSTP nurse who said they were awaiting information from her community General

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[158] Ibid.
[159] Adult Parole Board File, CB at p.3794.
[160] JCare electronic medical records, CB at p.244. On 15 October 2021, Heather's weight is documented as 129kg but this appears to be incorrect given the other proximate weights records – including 159kg on 29 September 2021. She was seen in the pathology clinic.
[161] JCare electronic medical records, CB at p.244. At 9.43am, Heather's BSL was recorded as 12.7 mmol/L.

Practitioner (**GP**).

162. Dr Goonetilleke noted stable LFT derangement, and that despite ceasing her statin (cholesterol lowering medication), LFT derangement had persisted. As her cholesterol level was elevated, Dr Goonetilleke recommenced her statin medication, given her other risk factors for heart disease (such as obesity and poorly controlled diabetes). She considered that a possible cause of the LFT derangement was non-alcoholic steatohepatitis (NASH), so she also made an order for Heather to have a liver ultrasound to look for possible liver pathologies. Dr Goonetilleke wanted to assess the progress of the current changes before a referral to an endocrinologist but did refer her to the Nutrition Department at SVHM.[162]

163. On 30 October 2021, Heather's Case Worker, PO Berry, documented that Heather had submitted a referral to WestCASA and had struggled to exercise because of the lockdowns over the previous month. Heather reported that she had cut out sugar from her diet again over the previous two weeks and was being cooked for by one of the girls in her unit which was helping. In addition, her parole had been denied and after initially being disappointed she is now focused on completing her sentence and getting the most out of the See Change Program.[163]

November 2021 – Month of Heather's passing

164. On 4 November 2021, RN Duong reviewed Heather's file as part of the OSTP Clinic and concluded based on the collateral information (discussed in detail later) that she was not eligible for OSTP.[164]

165. On 5 November 2021, Heather had a Local Plan Review. She reported that she had not attempted to engage with WestCASA and had no motivation for anything now that her parole was denied. She reported not exercising regularly due to losing motivation for anything

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[162] JCare electronic medical records, CB at p.243, p.651, Statement of Dr Goonetilleke at p.1235-1239.
[163] Local Plan File Notes, CB at p.1573.
[164] JCare electronic medical records, CB at p.240-241.

healthy and positive and had not been regularly completing her food diary as required by her dietician, again due to lack of motivation. It was further documented,

..... Heather reports that she has 'hit a wall' with her sentence. She says that even though she only has a few months to go, being denied parole and knowing that her partner is out is making her feel like giving up. She is feeling strong desires to use drugs and not even thinking about her children is helping her control her thoughts.

..... Heather is participating in the See Change program and even though she has been denied parole is still determined to complete it. She has spoken positively about this program in previous months but this month was somewhat unenthusiastic about the benefits of the program. This matches her general mood at the moment.

..... Heather states she is struggling with her mood and temper at the moment and experiencing strong desires to use. Case worker suggested she make contact with Caraniche to help with this and also discuss these feelings with her See Change facilitators to which she was again unenthusiastic.

.... Heather reports as being very low in mood and tolerance at the moment. She says she has hit a wall and is struggling to cope with every day life at DPFC. She is having regular thoughts about drugs, is feeling on edge when dealing with other women in the compound and avoids going out of the R&T precinct as much as possible in order to avoid potential altercations. She feels like she has nothing left to motivate her to do the right thing now that her parole has been denied and her partner has been released ending her interprison calls, and does not even feel that thoughts of her children are enough to keep her from losing her temper. Heather reports additional frustrations from continued denial from the suboxone injection program, that she was previously being administered [sic] *to control her drug use when living in Perth and states she has tried to be accepted into at* [sic] *DPFC for the past 8 months. She has discussed this with AWO Phillips in the hope that they can assist getting her on the program so that when she*

is released in February so she will be best positioned not to use drugs as soon as she gets out.[165]

166. On 6 November 2021, Heather saw a doctor who re-charted her sertraline at a dose of 100mg and documented that she felt *depressed* and the medication had been helpful before, but this was no longer the case.[166]

167. On 6 November 2021, Heather was reviewed by a RPN after reporting she was feeling *down* to the ALO.[167] She documented a diagnosis of morbid obesity and that Heather was very flat, noting that she had not been herself lately due her partner being released the day before and she *wanted to go home and settle with him*. This had been giving her sleepless nights. Heather also related that she wanted to commence on Suboxone injections since she was to be released in February, in that way she will not get herself back to using drugs once released. Heather appeared stressed but otherwise no risks were identified.[168]

OSTP nurse determines that Heather is not eligible for opiate replacement therapy

168. On 9 November 2021, Heather attended an OSTP Clinic appointment with RN Duong who following assessment of collateral information assessed that Heather was not eligible for OSTP. RN Duong advised Heather that she would book her with an OSTP Medical Officer to further assess and to make recommendations for OSTP commencement. RN Duong's documented plan was for a medical practitioner's comprehensive assessment or, advice from an AOD (alcohol and other drug) specialist to rule out drug seeking behaviour and misuse prior to commencing OSTP.[169]

169. There were scheduled appointments at the Diabetes Clinic that were not attended or cancelled on 10, 11, 12, 13 and 14 November 2021. There was no record of attendance at a Weight

[165] Local Plan File Notes, CB at p.1591-1592.
[166] JCare electronic medical records, CB at p.240.
[167] JCare electronic medical records, CB at p.214.
[168] JCare electronic medical records, CB at p. 239-240.
[169] JCare electronic medical records, CB at p.238-239.

Management Clinic appointment on 10 November 2021.

170. On 15 November 2021, Heather attended the Nurse Clinic. RN Imelda Morgan (**RN Morgan**) documented her BSL as 8.4 mmol/L post breakfast. Heather expressed her desire to continue with a weight loss program and was concerned about her cholesterol levels. She was booked to the next available GP Clinic.[170]

171. On 17 November 2021, appointments at the Diabetes Clinic and Weight Management Clinic were scheduled but not attended.[171] There were Diabetes Clinic appointments scheduled for 18 and 19 November 2021 for *BSL*, which were cancelled.[172]

Dr Nath determines that Heather is eligible for opiate replacement therapy

172. On 19 November 2021, Heather was reviewed by Dr Nath in the OSTP Medical Officer Clinic and commenced on OSTP. She was prescribed 8mg/0.16mL Modified Release Solution of buprenorphine via injection (Buvidal brand) from 22 November 2021 to 21 March 2022; this formulation is sometimes referred to by the acronym LAIB meaning Long-Acting Injectable Buprenorphine (**LAIB**). Dr Nath's prescription meant that Heather would receive a weekly subcutaneous injection of 8 mg buprenorphine commencing on 22 November 2021. Heather did not complete the required consent form.

173. Of note, this was the first time a prisoner at DPFC had been commenced on OSTP via weekly injection without first being stabilised on a course of sublingual Suboxone (suboxone strips).

174. No monitoring of the OSTP injection was ordered by Dr Nath. As Heather would not be commenced on Suboxone strips, the system in place at the time did not provide for post injection monitoring.[173]

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[170] JCare electronic medical records, CB at p.238. On 16 November 2021, Heather did not attend a nurse clinic appointment.
[171] JCare electronic medical records, CB at p.215.
[172] Ibid.
[173] JCare electronic medical records, CB at p.238.

175. Also on 19 November 2021, RPN Loguli reviewed Heather's Mental Health Chronic Health Care Plan and documented in relation to her immediate needs that her mental state required stabilisation , referral to *psych reg/consultant* for ongoing care and support; and provision of safe environment (if at risk of *SASH*). A history of depression with anxiety was noted with her medications being sertraline and quetiapine. No plans were documented following this review.[174]

176. On 20 November 2021, Heather did not attend a scheduled BSL appointment[175] and on 21 November 2021, a scheduled Diabetes Clinic appointment did not proceed.[176]

177. During an Arunta call on 21 November 2021,[177] Heather had a conversation with her partner, where she is recorded to say, *I just can't wait to get stoned tomorrow, I'm hanging.* She also mentioned that another prisoner expressed a desire to be on OSTP and she advised them to see a doctor rather than the nurses, as they will just say no.

CIRCUMSTANCES OF DEATH

Monday, 22 November 2021 – Day before Heather's collapse

178. At 10.15am on 22 November 2021, RN Fiona Millson (**RN Millson**) saw Heather at the OSTP Clinic. The opiate replacement injection was administered in accordance with Dr Nath's prescription and RN Millson documented *buvidal weekly 8mg/0.16ml administered SC R) lower abdo* [subcutaneous right lower abdomen] *as per PMO* [Prison Medical Officer]*, next appointment made for 29/11/2020.*[178]

179. RN Millson said that Heather told her that she was keen to start opiate replacement therapy which she had wanted it for some time and was looking forward to her release and not

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[174] JCare electronic medical records, CB at p.237-238.
[175] JCare electronic medical records, CB at p.237.
[176] JCare electronic medical records, CB at p.215.
[177] CB, Ex. 18 External phone call recordings 21-23/11/2021 ([redacted]). Timestamp: 9.36.
[178] JCare electronic medical records, CB at p.237.

wanting to use when she got out.[179]

180. At 10.42am, Heather attended the Diabetes Clinic for her BSL which was recorded at 10mmol/L.[180]

181. At 10.56am, Heather consulted with Dr Chowdhury who documented that she wanted weight loss tablets and another referral to a weight loss clinic. A referral to SVHM's Weight Management Clinic was made which noted that diet, exercise and medication had been tried with no improvement.[181]

182. At 10.59am, Heather underwent a dental procedure for a planned extraction.[182]

183. Heather returned to her Unit at around 11.48am.[183]

184. Throughout the afternoon, Heather was observed experiencing nausea and drowsiness, was scratching and unsteady on her feet.

185. A co-resident in Blackwood A, Tammy Innes (**Tammy**), who gave evidence at the inquest, said that Heather was fine for the first hour following her return, but she then lay on the couch, felt sick and *kept scratching herself saying she felt stoned*.[184]

186. Tammy also observed Heather vomiting and groggy. She said that they kept checking on her and she *seemed ok, but you could tell she …, had too much suboxone.*[185] She observed pin point pupils.[186]

187. Heather's sister, Suzzane, said that Heather needed *to lay down in the unit, she threw up a couple of times, it looked like signs of overdosing*. *I have seen quite a few people overdose*

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[179] Statement of Fiona Millson, CB at p.78.
[180] JCare electronic medical records, CB at p.237.
[181] JCare electronic medical records, CB at p.236 and p.649.
[182] JCare electronic medical records, CB at p.236-237.
[183] CB, Ex 4. CCTV Medical movements 22/11/2021..
[184] Statement of Tammy Innes, CB at p.39.
[185] Statement of Tammy Innes, CB at p.39.
[186] T177 L27-T178 L11.

on Heroin, and that's what it reminded me of.[187]

188. Sometime between 1.00 and 3.00pm, Suzzane said that Heather took an ondansetron tablet (an antinausea tablet) which she had obtained from a friend in prison.

189. Another Blackwood A co-resident, Stacey Edwards (**Stacey**), who gave evidence at the Inquest, observed Heather lying on the couch in the afternoon, and thought that she looked affected by the injection but not sick.[188] She said that she saw Heather eating pancakes later that evening with Suzzane and thought she looked affected, *with her eyes droopy*, but that *she wasn't really sick yet*.[189]

190. About 10 minutes before the afternoon count, Suzzane said Heather was on the couch and was *half on the nod.*[190]

191. As part of prison protocol prisoners are counted four times per day: being at 7.45am (unlock count), 12.30pm (afternoon count), 4.00pm (evening count) and 7.15pm (lockdown count).

192. At approximately 4.00pm, the count was conducted by PO Berry. Heather was lying on the couch and complained of feeling unwell. PO Berry was told by Suzzane that Heather had had her tooth out and received her first Suboxone injection. Heather stood up for the count and said that she was okay but her mouth hurt and she felt a bit sick. PO Berry advised her to let them know if it got any worse, so the Medical Unit could be contacted. Heather agreed to do so. She said that Heather *just looked tired.* She said that she would not say that she looked normal because she did look unwell, but she was well enough to be counted but not sick enough to call a Code Black.[191]

193. At approximately 4.32pm, Heather left the Blackwood A for the Mitchell Unit, which is a short walk away, to be issued with her afternoon medication and did not leave the unit after

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[187] Statement of Suzzane Calgaret, CB at p.26.
[188] Statement of Stacey Edwards, CB at p.69.
[189] Ibid.
[190] Statement of Suzzane Calgaret, CB at p.27.
[191] Statement of Nicole Berry, CB at p.82.

that time.[192] Heather was observed to present at the Mitchell Unit no differently than usual.

194. Suzzane said that Heather continued to *throw up, laying down feeling sick* and that she kept a bin next to her in case she needed to throw up.[193] Suzzane said that they kept an eye on Heather throughout the day.

195. The lockdown count was conducted at 7.00pm count by PO Kemp, who gave evidence at the inquest, and two other POs. They were informed by Suzzane that Heather was asleep in bed because she had started the *suboxone* injection that day and was feeling unwell. PO Kemp observed Heather lying in bed, on her left side elevated on some pillows. She was breathing deep and regular and appeared to be asleep.[194] She did not notice anything unusual. PO Kemp said that Heather did not verbally respond when she spoke to her but appeared to physically stir in response (meaning *snuggle into her pillows a little bit more*).[195] Heather was counted from that location.

196. At approximately 8.21pm, Heather requested ibuprofen and paracetamol for her toothache via the intercom in her unit. This was the only intercom call made from the Blackwood Unit in relation to Heather that day.[196]

197. Heather shared pancakes with Suzzane at approximately 9.00pm, but vomited shortly afterwards.[197]

198. At 10.15pm, POs accompanied a RN to Blackwood A to provide Heather with requested pain relief. They called out three times before Heather attended the kitchen, took her medication which comprised of two 500mg paracetamol tablets with a cup of water she filled from a tap in the kitchen. Heather said that the medication was for a toothache. A mouth check was conducted to confirm the medication had been swallowed. Heather was noted to

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[192] CB, Ex 6. CCTV Blackwood Unit (front) PTZ 22-23/11/202.
[193] Statement of Suzzane Calgaret, CB at p.27.
[194] Statement of Sharon Kemp, CB at p.86-87.
[195] T739 L9-12.
[196] Ex. 15 Intercom recording 22/11/2021, T200 L13-20.
[197] Statement of Suzzane Calgaret, CB at p.28.

have walked out of her bedroom independently and nothing unusual was noticed.[198] The unit was locked down by staff before leaving.

199. Heather was then heard snoring throughout that evening, which was not unusual for her.

Tuesday, 23 November 2021 - Heather is located unresponsive

200. At approximately 5.00am, upon returning to bed from the bathroom, Tammy heard a *gasping moan*[199] coming from Heather's room[200]. She checked on Heather and described her as looking ok – *just normal*, sleeping on her back.[201] At inquest she said that she tried to wake her and Heather *just sort of, like shrugged it off.* She thought Heather was sleeping and didn't know if she had made the sound.[202] She said that Heather didn't respond and,

    She was a deep sleeper. I just thought she was, you know, as normal. But I knew she'd been sick, so I thought, you know, she's clammy, she doesn't look quite right, but she's okay.[203]

201. Later that morning, as POs arrived to conduct the morning count, Suzzane went into Heather's room. She shook Heather and tickled her, but Heather didn't move. Suzzane grabbed Heather's arm and told her that it was time for count, but Heather remained unresponsive. Suzzane saw foam coming out of her sister's mouth.[204]

202. Tammy entered Heather's room and saw her covered in sweat. She noticed that she *wasn't breathing, she would gasp a breath and nothing for ages*.[205]

203. After seeing Prison Officer 1 (**PO 1**)[206] at the door, Suzzane told her that Heather was not

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[198] Statement of Registered Nurse, CB at p.90.
[199] Statement of Tammy Innes, CB at p.40.
[200] Bedroom A3.
[201] Ibid.
[202] T159 L25-30.
[203] T160 L6-10.
[204] Statement of Suzzane Calgaret, CB at p.29.
[205] Statement of Tammy Innes, CB at p.40.
[206] The identity of PO 1 is subject to a Pseudonym order.

getting up and left the room for count, leaving Heather in the care of attending prison staff.

Emergency Response to Heather's collapse

204. At approximately 7.48am on 23 November 2021, PO 1 and Prison Officer Deans (**PO Deans**) attended for count at the Blackwood A unit and noticed that Heather was in bed, being shaken on her shoulder by Suzzane. After Suzzane left the room, PO 1 tried to rouse Heather who was lying on her right side with her face towards the door. Heather appeared to be snoring which she described as a *deep-throated sort of blocked nose snore*.[207] PO 1 then noticed that Heather had white foam coming out of the side of her mouth, had been incontinent and that her extremities were cold.[208] PO 1, who had previously worked as a paramedic, checked for a carotid pulse but could not find one.[209] When she was unable to find a pulse, she called a Code Black. She was however a short time later able to obtain a pulse in Heather's foot (pedal pulse).

205. PO 1 observed that Heather's breathing was intermittent and stopped approximately every 30 seconds to one minute and she required vigorous shaking to recommence breathing again.[210] PO 1 described the breaths as long breaths. PO Deans described Heather's breathing as *intermittent breathing which resembled snoring*.[211] The POs continued to attempt to rouse Heather by talking to her and shaking her.

206. At approximately 7.53am, members of the Emergency Response Group (**ERG)** arrived, and the POs commenced a handover. PO 1 communicated her initial observations which included that Heather was experiencing intermittent breathing, they could not get a proper pulse, Heather had been incontinent and was very cold to touch.[212] She indicated that her breathing remained consistent the whole time she was present.

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[207] T689 L16-19.
[208] Statement of PO 1, CB at p.97.
[209] Ibid.
[210] Ibid.
[211] Statement of PO Deans, CB at p.100.
[212] Ex 11, BWC PO Devic (002).

207. The ERG officers activated their body-worn cameras (**BWC**) which captured much of the activities at this time.

208. Prior to medical staff attending, PO 1 and PO Kemp discussed whether they needed to commence cardiopulmonary resuscitation (**CPR**) but decided that it was not yet necessary as Heather was still breathing, albeit intermittently.[213]

209. At approximately 7.56am, agency nurses employed by CCA, RN Morgan and RN Rochelle Betita (**RN Betita**) arrived at the Blackwood A unit. They observed Heather lying on her bed on her right side facing the wall with her head propped up by a pillow. RN Morgan noted that her breathing was *unusual* and she was making a sound which she recognized as *Kussmaul breathing*, being *deep, rapid, and laboured kind of breathing*.[214] Heather was completely unresponsive. RN Morgan used a torch to observe Heather's pupils and noted they were fixed and dilated. RN Morgan was unable to palpate a pulse.[215] An additional pillow was placed under Heather by a nurse.

210. At approximately 7.58am, PO Kemp advised that Heather had had her first LAIB injection the day before.[216] The POs had no training on opioid overdose, including the administration of naloxone.

211. Aware that Heather was diabetic, RN Morgan checked Heather's BSL and measured her blood pressure. Initially, the blood pressure cuff being used was too small, so measurement was delayed until a bigger cuff was located in the equipment bag. [217]

212. At times there were eight people (aside from Heather) in the small room including nurses and POs, as well as two staff at the doorway.

213. Approximately, three minutes later, at 7.59.27am, nursing staff were still assessing Heather

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[213] T695 L12-T696 L30.
[214] Statement of RN Morgan, CB at p.122.
[215] Ibid.
[216] Ex 11, BWC PO Devic (002).
[217] T776 L6-10, T 779.

when Supervisor Mustaq Ahmed (**Supervisor Ahmed**) asked for the first time – *who is calling the ambulance* - but there was no clear response, and it is not apparent that the nurses could hear. He was standing behind the nurses who were facing away from him attending to Heather.[218]

214. At about 8.00am, Supervisor Ahmed repeated his enquiry about an ambulance (*who's call the ambulance, who's calling the ambulance guys*), while they attempted to obtain Heather's blood pressure. He asked again about 45 seconds later, following which a nurse queried what he was saying. He reiterated his question and received a positive response. He asked *who* was calling the ambulance, but received no response.[219] Seconds later, PO Kemp advised Supervisor Ahmed that she did not think the nurses had time to make the call Supervisor Ahmed immediately requested that Prison Supervisor Joanne Goodchild (**PS Goodchild**) call 000.[220] Although PS Goodchild stated that at some point during the assessment RN Morgan asked her to call an ambulance.[221] Throughout this period, Heather's breathing remained intermittent and prison staff occasionally shook Heather to rouse her and stimulate her breathing.

215. The nursing staff continued to conduct assessments but had not yet initiated treatment. Nursing staff attempted to measure Heather's blood oxygen level but were unable to get a reading.[222] At 8.02am, PO 1 suggested placing the pulse oximeter on a different finger to try to get a blood oxygen reading. This was apparently successful, and nursing staff recall an initial (very low) reading of 40%. At 8.04am, prison staff noticed that the pulse oximeter machine indicated that Heather had a heart rate.[223]

216. At 8.05am, prison staff prepared the defibrillator pads to apply to Heather, however, nursing

[218] Ex 11, BWC PO Devic (002).
[219] Ex 11, BWC PO Devic (003).
[220] Ibid.
[221] Statement of Joanne Goodchild, CB at p.2370
[222] Ex 11, BWC PO Devic (003).
[223] Ex 11, BWC PO Devic (003), T708 L26 – 29.

staff declined the machine at this time and reiterated that Heather needed oxygen.[224]

217. One minute later, at 8.06am, PS Goodchild returned to the room while on the phone to the 000 operator and relayed the operator's advice that Heather needed to be placed on her back.[225] Heather was repositioned onto her back shortly thereafter. PS Goodchild enquired whether Heather was still breathing and was told that her breathing was intermittent.[226]

218. The 000 operator advised to remove any pillow and lay Heather flat, but this was not done until after a second request: *take the pillow away from the head, we need to open that airway*.[227] .

219. At 8.08am, the nurses are depicted on the BWC footage having issues using the oxygen machine.[228] The machine was not operating in a way that staff understood that it was supposed to, until PO 1 took steps to correct the valve and tubing.[229] It is unclear precisely when oxygen was supplied to Heather, however, it is clear that a Hudson mask was applied once the machine was fixed.[230] Although a bag valve mask was available, it was not applied to Heather.[231] RN Betita was not aware that one was available.[232]

220. PS Goodchild returned to the room, still on the phone to the 000 operator, and communicated advice to apply the defibrillator.[233] At 8.12am, Heather was moved to the floor so that CPR could commence at about 8.14am.[234] Oxygen continued to be supplied through a Hudson mask while CPR was performed rather than providing ventilation using the available bag

[224] Ex 11, BWC PO Devic (004).
[225] Ibid.
[226] Ibid.
[227] Transcript of Triple Zero Call (Goodchild), CB at p.2379.
[228] Ex 11, BWC PO Devic (004).
[229] T711.
[230] T713.
[231] T713-714.
[232] T840.
[233] Ex 11, BWC PO Devic (005).
[234] Ibid.

valve mask.[235] The defibrillator continued to state no shock advised and to continue CPR.

221. Nursing staff and prison staff continued to perform CPR until paramedics arrived eighteen minutes later, at 8.30am, following which Heather was moved to the lounge area of the unit at 8.39am. Paramedics took over Heather's care until she was sufficiently stable to be transported to hospital at 9.33am.

222. Heather was admitted into the intensive care unit at the Sunshine Hospital. The initial computed tomography (**CT**) scan showed *loss of grey-white matter differentiation affecting the basal ganglia as well as generalised loss of cortical grey-white matter differentiation and sulcal effacement in keeping with hypoxic ischaemic encephalopathy.*[236] Her initial management included ventilation and sedation, and the cardiology team were content with aspirin and prophylactic enoxaparin (an anti-coagulant medication) being prescribed. No other intervention was required for the management of Heather's heart.[237]

223. At 1.50pm, Thomas Jones, Alcohol and Drug Clinician (**Clinician Jones**), Sunshine Hospital spoke to DPFC's Associate Health Manager Troy McIntosh, who confirmed that Heather commenced weekly depot buprenorphine 8mg the previous day, with her first injection administered in her lower abdomen and that she had no known history of opioid use disorder only a history of methamphetamine and cannabis use. The notes document,

- patient was started on depot buprenorphine because she had a history of seeking Suboxone. She had previously "not been eligible" to commence the Suboxone program. Assessed on 9/11/21 as not suitable to start. Was commenced on Suboxone as a harm reduction measure as release from prison was approaching.

[235] T713-714.
[236] Statement of Dr James Douglas, CB at p.1352, Western Health medical records, CB at p.2653.
[237] Statement of Dr James Douglas, CB at p.1352.

- not previously prescribed opioid replacement therapy in prison or in the community. Nil Suboxone.[238]

224. Clinician Jones documented that SafeScript was checked with *nil opioids, nil ORT*. The impression recorded was:

Buvidal (weekly depot buprenorphine) commenced yesterday in a patient who does not have an opioid use disorder - no clear clinical indication.

?may have contributed to respiratory depression and arrest.[239]

225. On 25 November 2021, a further CT scan revealed *progression of global hypoxic ischaemic encephalopathy with development of innumerable bilateral cerebral infarcts* with *associated tonsillar herniation, left-sided midline shift with effacement of the ventricles and based cisterns*.[240]

226. Clinical brain death testing was conducted on 27 November 2021.[241] That day, doctors determined that Heather had passed. At the request of her family, Heather's life support machine remained on until 29 November 2021.

Examination of the Scene

227. Investigating police arrived at DPFC after Heather had been transported to the Sunshine Hospital and processed the scene.

228. A search was conducted of Heather's room and police seized a 4mg tablet of ondansetron which was believed to have been obtained from another prisoner who had already left the facility.

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[238] Western Health medical records, CB at p.2448-2449.
[239] Ibid.
[240] Statement of Dr James Douglas, CB at p.1352, Western Health medical records, CB at p.2614.
[241] Statement of Dr John Douglas, CB at p.1352, on 27 November 2021, Dr James Douglas and another intensivist performed clinical brain death testing following which Heather was determined as brain dead at 1.29pm.

IDENTITY OF THE DECEASED

229. On 29 November 2021, Heather Ida Simone Calgaret born 8 January 1991 was identified by her sister, Suzzane Calgaret.

230. Identity is not in issue and required no further investigation.

BACKGROUND CONTEXT

The Royal Commission into Aboriginal Deaths in Custody

231. In 1987, the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) was established to investigate the causes of death of 99 Aboriginal people held in custody across Australia between 1980 and 1989, *in response to a growing public concern that deaths of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them*. In its final report, delivered in 1991,[242] the RCIADIC made 339 recommendations aimed at addressing the over-representation of Aboriginal deaths in custody and the underlying contributory causes. It noted that the legacy of Australia's history went *far to explain the over-representation of Aboriginal people in custody.*

232. There were a number of RCIADIC recommendations which had particular relevance to this investigation, including:

    a. that governments which have not already done so should legislate to enforce the principle that imprisonment should be utilised only as a sanction of last resort;[243]

    b. that Corrective Services authorities ensure that Aboriginal offenders are not being denied opportunities for probation and parole by virtue of the lack of adequate numbers of trained support staff or of infrastructure to ensure monitoring of such orders;[244]

    c. that provision of health care to people in custody is equivalent to that available to the general public and adequately resourced;[245]

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[242] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991). Accessible at: AustLII - Indigenous Law Resources - Royal Commission into Aboriginal Deaths in Custody.
[243] Recommendation 92.
[244] Recommendation 119.
[245] Recommendation 150.

d. that health services in custodial settings are both accessible and appropriate to Aboriginal prisoners;[246]

e. that, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge of and experience with Aboriginal persons;[247]

f. that all health services staff are trained to ensure an understanding and appreciation of issues relating to Aboriginal health, history, culture and lifestyle, so as to assist them in their dealings with Aboriginal people;[248]

g. that upon initial reception at a prison all Aboriginal prisoners are subject to thorough medical assessment by a medical practitioner;[249]

h. Prison Medical Services consult with Aboriginal Health Services as to the information and training which would be appropriate for staff of Prison Medical Services in their dealings with Aboriginal people;[250]

i. those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services;[251] and

j. that Corrective services, in conjunction with Aboriginal Health Services, should review and report upon the provision of health services to Aboriginal prisoners in correctional institutions.[252]

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[246] Recommendation 150.
[247] Recommendation 151
[248] Recommendation 154(a).
[249] Recommendation 156
[250] Recommendation 154(b).
[251] Recommendation 154(c).
[252] Recommendation 152.

The Aboriginal Justice Agreement

233. Also arising from the RCIADIC was the development of the Aboriginal Justice Agreement (**AJA**) in 2000 in Victoria. A collaborative partnership between the Victorian government and the Aboriginal community which resulted in the development of a number of initiatives, including, relevant to Heather's passing, the establishment of the Koori Court.

234. The latest iteration of the AJA is Phase 4, Burra Lotjpa Dunguludja (literally translated as 'senior leaders talking strong') has been in place since 2018.

235. Consistent with the Victorian Government's stated commitment to self-determination as the guiding principle in Aboriginal affairs, Corrections Victoria advised the Court that they endeavour to embed Aboriginal self-determination into its programs, initiatives and projects by working in partnership with the Aboriginal community in all aspects of the work under the AJA.

Other relevant Reviews and Reports

236. There have been a number of other recent reviews and enquiries which are relevant to the issues raised in this investigation.

237. In December 2022, the *Final Report of the Cultural Review of the Adult Custodial Corrections System* (**Cultural Review**) was delivered.[253] This review relevantly reported:

    a. that the custodial system is having devastating, intergenerational impacts on Aboriginal people and communities;[254]

    b. concerns about the quality and cultural safety of health services available to

[253] *Final Report of the Cultural Review of the Adult Custodial Corrections System* (December 2022). Accessible at: Cultural Review of the Adult Custodial Corrections System final report - Safer Prisons, Safer People, Safer Communities.
[254] Cultural Review, at p.27.

Aboriginal people in custody;[255]

c. on the need to transition to a community-led model of health care in custody;[256]

d. a widespread lack of understanding of cultural safety and limited support to maintain connections to culture and family;[257] and

e. the importance of, and challenges faced by, Aboriginal staff working in prisons and Correctional centres.[258]

238. In March 2024, the Victorian Ombudsman released its report into the *Investigation into Healthcare Provision for Aboriginal People in Victorian Prisons* (**the Ombudsman's Report**).[259] The Ombudsman's Report made five recommendations to DJCS and other key departments aimed to:

a. involve Aboriginal Community-Controlled Organisations (**ACCOs**) in the design and delivery of holistic custodial services that are culturally safe and responsive to Aboriginal people, culture and rights;[260]

b. increase Justice Health's capacity to oversight the delivery of culturally responsive healthcare to Aboriginal people by developing and implementing a capability building plan;[261]

c. consider ways to vary the current custodial primary health contracts to provide oversight that is more culturally safe and responsive to Aboriginal people;[262]

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[255] Cultural Review, at p.29.
[256] Ibid.
[257] Cultural Review, at p.iii.
[258] Cultural Review, at p.466.
[259] Victorian Ombudsman, *Investigation into healthcare provision for Aboriginal people in Victorian prisons* (March 2024) Accessible at: Investigation into healthcare provision for Aboriginal people in Victorian prisons | Victorian Ombudsman.
[260] Victorian Ombudsman, *Investigation into healthcare provision for Aboriginal people in Victorian prisons,* at p.158.
[261] Victorian Ombudsman, *Investigation into healthcare provision for Aboriginal people in Victorian prisons,* at p.159.
[262] Victorian Ombudsman, *Investigation into healthcare provision for Aboriginal people in Victorian prisons,* at p.160.

d. develop an audit framework to regularly assess the clinical effectiveness and cultural responsiveness of healthcare delivery to Aboriginal people across all Victorian prisons;[263] and

e. invest in education and training to increase the number of Aboriginal health professionals in Victoria and better support their career development.[264]

239. The above recommendations were accepted by the Government, in full or in principle, subject to funding.

240. In 2021, the Victorian Government established the Yoorrook Justice Commission (**Yoorrook**) to investigate and report on Victorian First Peoples' past and ongoing experiences of systemic injustice. Important findings of particular relevance to this investigation addressed:[265]

a. the over-representation of First Nations women in prison and poorer health outcomes for them;

b. an acknowledgement of systemic failures in prison healthcare;

c. the poor access to rehabilitation programs of Aboriginal prisoners;

d. the lack of cultural connection and cultural programs available;

e. identification of flaws in the application of the parole system and particular disadvantages for Aboriginal applicants; and

f. acknowledgement of harm caused to First Nations people by incarceration.[266]

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[263] Ibid.
[264] Victorian Ombudsman, *Investigation into healthcare provision for Aboriginal people in Victorian prisons,* at p.161.
[265] Yoorrook Justice Commission, *Yoorrook for Justice* (4 September 2023). Accessible at: Yoorrook-for-justice-report.pdf.
[266] Yoorrook For Justice Report, p.14-22.

POLICES AND PROCEDURES RELEVANT TO HEATHER'S PASSING

Corrections Framework

241. At the time of Heather's passing the relevant Corrections Victoria framework (Offender Management Framework) encouraged self-responsibility as part of the rehabilitation process.[267]

242. Prisoner management policies and procedures within Victorian prisons are now designed according to the Correctional Practice Framework, which followed the Cultural Review.

243. The Correctional Practice Framework[268] appears to represent a shift in approach with key principles noted to include:

> *Where the sentence is considered the punishment for the perpetration of a crime, the remainder of the correctional journey must be seen as an opportunity to rehabilitate and reintegrate each individual, such that upon their unsupervised return to the Victorian community, they are functionally able to live a life that is both self-supporting and prosocial. To borrow from the Norwegian Correctional System* [emphasis added] *– "you go to Court to be punished, prison to become a better neighbour".*[269] *This is how all correctional systems best serve the rights of victims. This means, therefore, that our correctional services must contribute to the desistance from crime by holding an expectation of change for all individuals and providing both the space and opportunity for this development. A high-quality correctional system must work to both prevent* and *create outcomes* [emphasis original].[270]

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[267] Statement of Melissa Westin, Acting Commissioner, CB at p.1354-1370, particularly at [12].
[268] Department of Justice and Community Safety, *Correctional Practice Framework* (October 2024). Accessible at: Correctional-Practice-Framework.pdf.
[269] Norway's criminal justice system focuses on the principles of restorative justice and the rehabilitation of prisoners, noting that Norway's official policy is to produce a person who, *when the sentence has been served, is drug-free or in control of their drug use, has a suitable place to live, can read, write and do math, has a chance on the job market, can relate to family and friends and society at large, are able to seek help for problems that may arise after release and can live independently.*
[270] Correctional Practice Framework, at p.9.

Specific instructions/commitments related to the management of Aboriginal and Torres Strait Islander Prisoners

244. At the time of Heather's entry into custody in July 2019, Deputy Commissioner's Instruction (**DCI**) 2.07, *Aboriginal and Torres Strait Islander Prisoners,* created obligations in relation to public prisons regarding the management of Aboriginal and Torres Strait Islander Prisoners.[271] The instruction:

a. reflected an outcome that Aboriginal and Torres Strait Islander people in prison have access to an equitable justice system that is shaped by self-determination, and protects and upholds their human, civil, legal and cultural rights;

b. recognised that Aboriginal and Torres Strait Islander persons are over-represented in the criminal justice and corrections systems and Corrections Victoria will actively work in partnership with the Victorian Aboriginal community as appropriate, to improve justice outcomes for Aboriginal prisoners;

c. acknowledged the recommendations of the RCIADC and relevant Charter rights.

d. included a commitment that Corrections Victoria provide an environment which fosters the maintenance of cultural and community links for Aboriginal people in prisons; and

e. included a commitment that Corrections Victoria develop networks that improve justice related programs and services, making them more responsive, effective and accessible to Aboriginal.

245. Further obligations were that Aboriginal and Torres Strait Islander prisoners are given access to an appropriate contact person, ideally an Aboriginal Wellbeing Officer, within 24 hours of reception; the General Manager should endeavour to have Aboriginal and Torres Strait

[271] Accessible at: Deputy Commissioner's Instructions Part 2: Prisoner management | Corrections Victoria and CB at p.1425-1433.

Islander programs delivered by suitably qualified Aboriginal and Torres Strait Islander people; and custodial staff participate in cultural awareness training at recruitment and during refresher training.[272]

Offender Services and Reintegration

246. Anna Henry (**Ms Henry**), Director of Offender Services and Reintegration,[273]referred to the Aboriginal Social and Emotional Wellbeing Framework (**SEWB**)[274] which recommended holistic interventions for Aboriginal women that incorporate connections to family, Country and community.

247. Ms Henry noted that Aboriginal staff and Corrections Victoria staff are supported by the Naalamba Ganbu Nerrlinggu Yilam **(the Yilam**). The Yilam is Corrections Victoria's *Cultural Integrity and Resilience Unit* which is responsible for leading the design, development, implementation and monitoring of Corrections Victoria procedures, programs and services aimed at reducing the over-representation of Aboriginal people within the Victorian correctional system.[275]

Living with Mum Program

248. Heather's youngest child was subject to an unborn child report to Child Protection under the *Children, Youth and Families Act 2005.*[276] Her child subsequently became subject to a Care by Secretary Order (**CBSO**)[277] and resided in *kith* placement.

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[272] DCI 2.07, *Aboriginal and Torres Strait Islander Prisoners*, CB at p.1427.
[273] Statement of Anna Henry, CB p.2362 – 2368, dated 5 May 2023.
[274] Discussed in detail later.
[275] Statement of Anna Henry, CB at p.2362.
[276] Pursuant to section 29 of the *Children, Youth and Families Act*, a person who has significant concerns for the wellbeing of a child after their birth may make an unborn child report to the Department of Families, Fairness and Housing's Child Protection Intake Service.
[277] A CBSO gives parental responsibility for a child's care to the Secretary or delegate to the exclusion of all other persons. This order is made for a period of two years. A CBSO is appropriate when a child has been in an out-of-home care for a period of 24 months, or earlier where it has been determined that a child will not be able to safely return to the care of the parent and the appropriate permanency objective is adoption, or permanent care, long-term out-of-home care.

249. Corrections Victoria's LWM Program operates at DPFC and is available to both sentenced and remanded women. The overarching aim of the LWM Program is to diminish the impact of the mother's imprisonment on her dependent child/children. It is also recognised that the LWM Program supports the family ties that are essential to the effective rehabilitation of mothers and their successful reintegration into the community upon release.

250. In determining whether a mother can participate in the LWM Program the central determinants are what is in the best interests of the child and the management, good order or security of the prison.[278] The authorising Commissioner's Requirement (**CR**) 3.4.1 Mothers and Children Program, outlines the factors that will be considered to determine the best interests of the child and the management, good order or security of the prison.[279]

251. The Charter is also relevant to the operation of the LWM Program. In particular, the right to protection of families and children in section 17 of the Charter provides that:

    (1) *Families are the fundamental group unit of society and are entitled to be protected by society and the State; and,*

    (2) *Every child has the right, without discrimination, to such protection as in his or her best interests and is needed by him or her by reason of being a child.*

252. Mothers who wish to access the LWM Program are assisted by the LWM Program Support Worker and the Family Engagement Workers.

253. When a woman is found ineligible to participate in the LWM Program, the Court was advised that every effort is made by these workers to ensure that she gets the supports required. Steps must also be taken by the General Manager to ensure that the mother is provided with appropriate support (e.g. counselling) to help her adjust to the outcome of her application.

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[278] The LWM Program operates in accordance with section 31 of the *Corrections Act 1986* and regulations 34 to 38 of the *Corrections Regulations 2019*.
[279] Commissioner's Requirement 3.4.1, CB at p.1371-1374.

Access to nutrition/exercise/weight management

254. The Court was advised that there were a number of policies and procedures relevant to Heather's circumstances and her capacity to manage her weight. These ranged from policies for Aboriginal prisoners generally, to policies specifically focusing on health care, diet, exercise and recreation.

255. Under *Prisoners' Rights* detailed in the *Corrections Act 1986*, prisoners must be provided with food that is adequate to maintain their health and wellbeing.[280] It is recognised that what food is provided to prisoners is significant to them and is important in maintaining their welfare.

256. I note that the *DCI 4.03 - Food*[281] requires that meals provided to prisoners should be of sufficient quantity and nutritional value for the health and wellbeing of the prisoners. The policy sets out the operating principal that Corrections Victoria will provide nutritious, varied and palatable meals that cater for special diets and food allergens, and, wherever possible, at times acceptable by normal community standards.[282]

257. During the period of Heather's incarceration, she was housed in cottage-style accommodation for 690 of the 845 days she was in custody, including in the Blackwood Unit[283] which meant she could self-cater meals (individually or as part of a group). This initiative is designed to encourage prisoners to develop and maintain skills like working with others, ordering and preparing food.

258. In addition to catered meals and self-catered meals, prisoners may purchase food, confectionery and drinks from the prison canteen. These items are purchased with the prisoner's own funds. Food might also be shared between prisoners.

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[280] Section 47(b).
[281] Accessible at: Deputy Commissioner's Instructions Part 4: Prisoner services | Corrections Victoria.
[282] In developing menus catering staff are required to provide a variety of nutritional meals that meet cultural, religious and dietary requirements and include vegetarian and vegan meals.
[283] From 4 August 2021.

259. DPFC has a leisure centre including a gymnasium, a basketball and volleyball court, an outdoor swimming pool as well as open spaces for running or walking.

Data from DPFC regarding weight

260. According to data provided to the Court, on 25 November 2022 the population of DPFC was 313 prisoners. Of that cohort 55.9% were obese or overweight. This compares to the most recent figures from the Australian Bureau of Statistics (in 2018) that 67% of the general population (both genders) or women only (like the DPFC population) which was 60% in 2018.[284]

261. On that date, there were 42 prisoners who identify as Aboriginal or Torres Strait Islanders in DPFC. Of that number, the proportion that were overweight or obese was 73.8% compared with the proportion of the national female indigenous population of 75% in 2018-2019.[285]

262. The Court was advised by Corrections Victoria that health care staff will record the weight of prisoners when clinically indicated. The frequency of weight measurement recorded by health staff will depend on the degree to which weight was relevant to the health of the prisoner (either weight gain or weight loss).

263. In addition, patients, generally with a BMI of greater than 30kg/m^2, are monitored by the prison Medical Officer during regular, scheduled clinical consultations where their weight will be recorded to monitor progress. Lifestyle changes are recommended including healthy eating and exercise for weight loss. Support is provided by the nursing staff who are able to provide advice at any time. Referrals are made to a consultant dietitian for additional monitoring and support, as clinically required.

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[284] Statement of Scott Swanwick, CB at p.1608 citing Australian Bureau of Statistics, *Overweight and obesity*. Accessible at: https://www.abs.gov.au/statistics/health/healthconditions-and-risks/overweight-and-obesity/latest-release.

[285] Statement of Scott Swanwick, CB at p.1608 citing National Aboriginal and Torres Strait Islanders Survey 2018-19 (ABS Table 18/3).

264. With respect to weight loss medications: several medications are now available in Australia to assist with weight loss, and these are available in DPFC in the same way they would be to members of the community. These medications are prescription only and taken under strict medical supervision (where clinically indicated) and are available to patients while in prison consistent with community best practice guidelines. Lifestyle changes (diet and exercise) are recommended in conjunction with the medication for the medication to be effective.

265. Corrections Victoria also advised that maintaining a healthy body weight is challenging for the broader community and these challenges are reflected within the prison community. Although the correctional environment necessarily limits prisoners in a number of ways, prisoners are encouraged to take responsibility for their health and wellbeing and make their own decisions, what medical treatment they receive and take their own actions regarding maintenance of their health and wellbeing.

Health Framework and policies

Justice Health

266. Justice Health has responsibility for overseeing the delivery of health services (including mental health and alcohol and other drug services) to persons in Victoria's adult and youth justice facilities by contracted health service providers.

267. Justice Health sets the policy and standards for health care in prisons, monitors the delivery of health care programs, and contract manages the health service providers in the public prisons. Justice Health works in partnership with the Aboriginal community, under the AJA (Burra Lotjpa Dunguludja) to improve outcomes for Aboriginal people and communities through active participation in the Aboriginal Justice Forum and associated Collaborative Working Groups. [286]

268. At the time of Heather's passing, the Justice Health Quality Framework 2014 (**2014 Quality Framework**) was in place with custodial healthcare standards, including that:

    a. prisoners have the right to receive health services equivalent to those available in the general community through the public health system;

    b. health services are responsive to the needs of Aboriginal and Torres Strait Islander prisoners;

    c. prisoners receive a comprehensive health assessment by a medical practitioner within 24 hours of their initial reception to prison; and

    d. prisoners with chronic health conditions have a Chronic Healthcare Plan, which is implemented and reviewed with the aim of decreasing symptoms and improving

[286] Statement of Scott Swanwick, Director, Health Services and Clinical Governance, Justice Health, CB at p.1603-1615..

function and quality of life.[287]

Cultural safety standards

269. The Cultural Safety Standards for Prison Health Service Providers, Information Booklet, Clinical Governance (July 2018), established Cultural Safety Standards for Victorian prison health service providers (**Cultural Safety Standards**). These standards were in place at the time of Heather's incarceration and set out eleven cultural safety standards.[288]

270. The Cultural Safety Standards noted that, cultural safety is defined as an *environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening*.[289]

271. Culturally safe health services were noted to adopt a SEWB approach to healthcare where SEWB for Aboriginal and Torres Strait Islander people is defined *by many as a concept that reflects a holistic understanding of health, mental health and wellbeing* and that *this view recognises that achieving optimal conditions for health and wellbeing requires a whole- of-life view of health encompassing the social, emotional, spiritual and cultural wellbeing of the individual and their community*.[290]

272. Further, that connection to land, culture and community are central to Aboriginal and Torres Strait Islander wellbeing and as all aspects of SEWB are interrelated, ill health is likely to persist in Aboriginal and Torres Strait Islander people if any aspect of their social and emotional wellbeing is left untreated.

273. The Cultural Safety Standards noted that being able to access culturally safe and competent

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[287] *See* Justice Health Quality Framework, CB at p.1618-1747.
[288] *See* The Cultural Safety Standards for Prison Health Service Providers Information Booklet (**Cultural Safety Standards**), dated July 2018, CB at p.1794-1896.
[289] Cultural Safety Standards 2018, CB at p.1831.
[290] Cultural Safety Standards 2018, CB at p.1797.

health care for many Aboriginal people is key to the accessibility and effectiveness of health services they receive. Culturally safe services are welcoming and otherwise unthreatening environments that acknowledge the socioeconomic and cultural factors influencing the health and wellbeing of Aboriginal people. Culturally safe services place clients at the centre of care utilising a *wrap around approach to address health and wellbeing needs in a holistic manner*.[291] The presence of Aboriginal staff members (i.e. Aboriginal health workers) has been demonstrated to help manage the risk of services unintentionally alienating indigenous clients.

274. It further noted that prison offers an opportunity from a clinical perspective for Aboriginal prisoners to make gains that are not available in the community due to a number of reasons. It is the responsibility of all health service providers to consider their role in helping close the gap in the health disparity.

CCA as the Primary Service Provider - Health Policies

275. CCA provided primary healthcare for both medical and mental health needs in DPFC. If a patient required healthcare, they would see the appropriate practitioner from CCA in first instance. If further care was required, the CCA practitioner would refer to secondary health care or external services, as appropriate.

276. When a patient required mental health care, CCA would provide the primary mental health services and identify, assess and manage mental health needs. CCA did not make formal mental health diagnoses or provide psychological services. CCA would refer more complex mental health cases to Forensicare, which provides specialised psychiatric evaluation and treatment in response to increased acuity or exacerbation of existing diagnosis and symptoms. Forensicare undertakes diagnosis, diagnostic clarification, commencement of treatment with anti- depressant or anti -psychotic medications, psychological services.

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[291] Ibid.

277. A number of relevant CCA policies were made available to the Court, which were consistent with the polices and commitments contained in Corrections Victoria policy.

278. For example, the CCA – Aboriginal and/or Torres Strait Islander Health CS 1.6 provided the following under *Patient's Rights*,

> *Correct Care Australasia Pty Ltd (Correct Care) will ensure that the health needs of Aboriginal and Torres Strait Islander patients are met in a culturally respectful and responsive manner, which addresses all aspects of health, including prevention, treatment, health education and promotion.*[292]

279. CCA policy also recognised amongst other things that,

    a. The Aboriginal and/or Torres Strait Island status of patients is identified and documented on reception in order that health care can be provided in a culturally informed manner;

    b. Aboriginal patients are able to express their views and have those views understood through a consultative and supported process to identify their health needs and improve their health and wellbeing;

    c. The provision of health care to Aboriginal patients includes the recognition of the holistic Aboriginal or Torres Strait Islander origins of personal health, which encompass social, emotional and spiritual wellbeing, and an awareness of the historical and cultural factors that affect the health of Aboriginal and/or Torres Strait Islander people;

    d. Aboriginal patients are involved in decisions about their health care. Involvement in decision-making improves the identification of the health problems that are being experienced by Aboriginal patients, as it brings with it improved health outcomes and health benefits due to strengthening the identity and self-determination of the patient;

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[292] CCA Policy 1.6, *Aboriginal and/or Torres Strait Islander Health,* CB at p.1977, dated February 2019.

e. Health staff are aware of the high-risk factors such as Post Traumatic Stress Disorder, intergenerational trauma, suicide and special health needs associated with Aboriginal people. These issues are to be considered in relation to the development of the patient's Chronic Health Care Plan and referral made for psychiatric evaluation when issues are identified during the initial health assessment and mental health assessment.[293]

280. CCA policy stated that it would develop, implement and review Chronic Health Care Plans for all prisoners with chronic health care needs to meet outcomes of:[294] proactive detection and management of disease; reducing disease progression and complications; and maximising wellbeing of prisoners.

281. A Chronic Health Care Plan was noted to be a documented record of a disease affecting a patient that lists planned interventions discussed with the prisoner and agreed upon, states the intended outcome wherever possible, and is reviewed periodically overtime to ensure that the planned treatment remains relevant.

282. All prisoners with a diagnosed Chronic Health Condition including mental illness will have a Chronic Health Care Plan or Mental Health Recovery Plan established within 29 days of reception into the prison system or from time of diagnosis to assist in providing immediate and ongoing health care.[295]

283. The CCA policy noted that case conferencing provides an opportunity for the multidisciplinary team (Correct Care, Allied Health, Forensicare, Aboriginal Health Worker, other providers involved in the care) for continuity of care, to share information and plan treatment options. Where possible, the prisoner is involved in this process to ensure that their health needs are met through a planned and co-ordinated approach.

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[293] CCA Policy 1.6, *Aboriginal and/or Torres Strait Islander Health,* CB at p.1983.
[294] CCA Policy 10.1, *Chronic Health Care Planning,* dated February 2017, CB at p.2033.
[295] CCA Policy 10.1, *Chronic Health Care Planning,* dated February 2017, CB at p.2034.

CCA provision of care in practice

284. As already detailed, Heather had more than 100 consultations with CCA health service providers during her incarceration, including at the nurse clinic which operated every day of the week. In addition, she was noted to have attended clinics related to diabetes, weight loss and OSTP. Heather also frequently attended with medical practitioners at the Doctor's Clinic which operated six days a week. Dr Goonetilleke said that the allocated appointments in the medical clinic were usually 15 to 20 minutes.

285. In addition, Heather also consulted with CCA mental health nurses at the Psychiatric Clinic.

286. Mark Bulger (**Mr Bulger**), previously the Manager of Performance Review and a member of the Senior Clinical Team at CCA,[296] gave evidence at the inquest.

287. In a statement to the Court, Mr Bulger said that commensurate with their level of training and scope of practice, CCA mental health nurses utilise diverse therapeutic approaches which may include cognitive-behavioural therapy, trauma-informed care, motivational interviewing, assisting with development of coping strategies, mindfulness-based activities, interpersonal therapy, and monitoring patients' medication compliance.[297]

288. Mr Bulger stated that referrals from primary to secondary mental health care providers (Forensicare) at DPFC were ordinarily made in circumstances where:

    a. a patient's presentation, diagnosis or needs were sufficiently complex or high-risk that specialist mental health care from a PNP or Psychiatrist was required for diagnosis and/or ongoing management of the patient (including, for example, the provision of specialist therapy or prescribing certain medications such as anti-psychotics or anti-depressants); and,

    b. for an At-Risk Assessment, which could be triggered by CCA staff receiving an At- Risk

[296] Statement of Mark Bulger, CB at p.3457-3469.
[297] Statement of Mark Bulger, CB at p.3458.

referral from another concerned individual (such as a prison officer or another prisoner) or where CCA staff observed concerning symptoms or behaviour.[298]

289. Mr Bulger stated that integration of primary mental health care management with physical health management was achieved through collaboration between mental health nurses and primary care nurses in addition to medical staff where necessary. Importantly, all clinicians had access to the same electronic medical records, ensuring that comprehensive information was available to each team member.[299]

The management of Health Care Plans

290. Mr Bulger stated that Justice Health directed all Health Service Providers to transition to an Integrated Care Plan (**ICP**) system, effective from 1st August 2019, which was just after Heather entered DPFC. The ICP was designed to consolidate the management of most conditions under one plan.[300] These health care plans are a nurse led process.

291. It was apparent from the JCare records that Heather had a number of plans, including a Chronic Health Care Plan. Mr Bulger advised that a plan is developed using a pro-forma document in JCare, addressing key components of chronic disease management, including assessment, care planning, development of individual and treatment goals, regular review, appropriate multidisciplinary referrals, health promotion and support for self-management. The document includes prompts and questions, which guide the clinician completing it. It is documented on the prisoner's health record, scheduled for review every 12 months or more frequently if clinically indicated.[301]

292. Mr Bulger said that management by case conferencing or a multidisciplinary team would be indicated where the level of complexity or difficulty in managing a patient's mental and/or

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[298] Statement of Mark Bulger, CB at p.3460.
[299] Statement of Mark Bulger, CB at p.3461.
[300] Statement of Mark Bulger, CB at p.3463. As directed by Justice Health, the Aboriginal and Torres Strait Islander Care Plan, Over 60's+, Opioid Substitution Care plans, Mental Health Chronic Health Care Plans, and State-wide Hepatitis Care Plans were excluded from roll up into ICP and were to remain as individual plans.
[301] Statement of Mark Bulger, CB at p.3464.

physical health conditions was significant and it was determined that a multidisciplinary approach was required.[302]

Forensicare appointments with Heather

293. As already outlined, Heather was seen four times by RNP Manzoor, previously referred to as the Forensicare Nurse Practitioner.

294. In 2019, scheduling of appointments for prisoners referred to Forensicare was the responsibility of CCA. From June 2021, the Forensicare Clinical Coordinator managed the process of triaging referrals and scheduling appointments. Heather's ongoing mental health care was however managed by CCA with re-referral to Forensicare if needed.

295. RNP Manzoor advised the Court that the outpatient clinic appointments with Forensicare were 5 to 10 minutes duration, so the clinician was reliant on the detailed and comprehensive assessments already performed by CCA. She said that the purpose of her appointments with Heather were medication reviews, although they may also involve short mental state examinations. If she disagreed with the assessment, provisional/diagnosis of CCA she would note that and make another appointment with the patient to conduct a more detailed assessment.[303]

296. Dr Katherine (Kate) Roberts (**Dr Roberts**), Director of Clinical Services (Prison Services), Forensicare, said that the constraints of operating in a prison mean that there isn't much time or ability to provide much more than assessment, diagnosis and then treatment with medication.[304]

297. She said with respect to the use of diagnosis/differential diagnosis and the use or otherwise of standardized tools, that it would be unlikely during those brief reviews to conduct a full

[302] Statement of Mark Bulger, CB at p.3466.
[303] Statement of Naushaba Manzoor, CB at p.3416- 3421.
[304] T1535 L26-T1536

diagnosis assessment.

298. RNP Manzoor indicated that a standardised tool is employed to supplement clinical assessment and in this case, she did not feel that a tool was warranted or would enhance her assessment of Heather.[305]

299. RNP Manzoor indicated that longitudinal monitoring and management is the responsibility of the primary mental health team being CCA at that time and not the secondary mental health team. She noted that resources to deliver non-pharmacological therapies are not available within the constraints of the correctional environment, and Forensicare was unable to provide them.[306]

300. RNP Manzoor said that she was aware of the possible side effects of quetiapine, and it was part of her usual practise to warn and educate patients about the risk of metabolic syndrome. She noted that Heather had ongoing anxiety and difficulty with sleep. She had previously been prescribed mirtazapine, but she reported better response to quetiapine, and she was also aware at the time that mirtazapine was a high-risk trafficking drug within the corrections environment.[307]

301. RNP Manzoor prescribed Heather a low dose of quetiapine. She knew she would be monitored by her primary mental health team and they could refer her to a dietitian and weight loss clinic.

302. She said it was the primary mental health team's role to monitor and address any concerns about her medications, or medication side effects and re-refer Heather to secondary mental health as necessary.[308]

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[305] Statement of Naushaba Manzoor, CB at p.3419.
[306] Statement of Naushaba Manzoor, CB at p.3419-3420.
[307] Statement of Naushaba Manzoor, CB at p.3420.
[308] Ibid.

HEATHER'S HEALTH TRAJECTORY DURING HER INCARCERATION

303. When Heather entered DPFC in July 2019, she was a 28-year-old woman who was pregnant and overweight, but otherwise with no ongoing treatment needs identified or planned for. Within two years, she had poorly controlled type 2 diabetes, WHO Class III obesity, sustained liver function derangement and likely obstructive sleep apnoea.

304. As it was clear that at least the first two of these conditions developed whilst Heather was in custody and, as they featured in her cause of death, it was important to interrogate her care history for prevention opportunities.

305. Having said that, I undertook a broad review of the medical information, statements and was assisted by an expert panel (**the expert health panel**) comprising Dr Denver Jansen,[309] Professor Louise Newman,[310] Dr Neil Bartels,[311] and Dr Jocelyn Jones.[312] I did not examine individual decision making over a 2 year period, but endeavoured to examine systemic issues.

306. All the experts agreed that there was a *significant* decline in Heather's health while she was in custody.

307. At reception, the only indicators that a Chronic Health Care Plan was required was that Heather was an Aboriginal woman and had a mental illness (although the latter was not identified by reception assessment staff). By the date of her collapse, two years later, Heather

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[309] *See* Expert Report of Dr Denver Jansen, CB at p.2984-3002. Dr Jansen is a medical practitioner with a fellowship in General Practice. He has worked in general practice for over twenty-five years, including with Aboriginal health services.

[310] *See* Expert Report of Professor Louise Newman, CB at p.3009-3021. Professor Newman is a consultant psychiatrist and professor of psychiatry at the University of Melbourne. She also has qualifications in psychology, is a director women's mental health and is undertaking research into the development of trauma focused interventions for women.

[311] *See* Expert Report of Dr Niel Bartels, CB at p.3599-3661. Dr Bartels specialises in general practice. He has experience providing medical care to rural and remote communities, including Aboriginal communities and remains a fellow of the College of Rural and Remote Medicine.

[312] *See* Expert Report of Dr Jocelyn Jones, CB at p.3908-3953. Dr Jones is an epidemiologist with over thirty years' experience in Aboriginal primary health care, Aboriginal health research and research into improving the health and wellbeing of Aboriginal people in the criminal justice system.

had seven indicators of chronic health issues, which included:

a. she was an Aboriginal woman;

b. she was prescribed seven or more medications;

c. she had diabetes;

d. she had an unstable long term medical condition;

e. she had WHO Class III obesity;

f. she had a mental illness; and,

g. she was prescribed psychotropic medication for longer than one month.

308. What is confounding about the downward progression of Heather's health is that the policies and procedures in place at the time all contained commitments to broadly improve health, as well as cultural health safety standards and a recognition of the need for culturally safe and competent health care.

General issues related to the delivery of health care in prison

309. Dr Roberts observed that in addition to general resourcing issues, there are other constraints with the delivery of health services to people in custody and the fact that any health service provided is secondary to the safety and security of the prison. She said,

So certain things have to – have to occur for the prison to operate safely and often we're trying to kind of squeeze our services in whether it'd be in a certain environment that's not really appropriate for that care or with time constraints acknowledging that individuals are, you know, locked in cells,…[313]

[313] T1566 L25-30.

Impact of COVID-19

310. COVID-19 also had an effect on services and the way things were managed in prison. In March 2020, the State of Victoria went into lockdown due to directions issued by the Chief Health Officer. Across 2020 and 2021 there were six lockdowns of varying intensity. The pandemic had significant implications for the delivery of healthcare to prisoners and it resulted in long periods where the women were confined to their cells. Heather spent 23 days in COVID quarantine. The women were unable to exercise. Visitations were also cancelled. Referrals to outside health providers, such as the St Vincent's weight loss clinic for weight and diabetes management, were not able to be actioned. WestCASA moved to counselling sessions by telephone.

311. Aunty Lynn said that like any business, COVID-19 had an impact and that *[e]verything sort of came to a standstill and everything but [they] tried to keep as much of it going* as they could.[314]

313.Dr Roberts said that it did come to bear until March 2020,

> *and the reality of working in prisons at that time was fairly confronting, lots and lots of lockdowns, really difficult to access patients. So I think there's probably an access issue, patients definitely struggled to access care more in prison I believe, whether that be external specialist appointments and I'm talking more broadly than just mental health care here but it can be very challenging to access everything you would in the community just by virtue of the fact that they're in custody*.[315]

Reception Medical Assessment Process

314. The reception assessment process was designed to identify a person's health risks and ensure that appropriate health management was provided while a person was in custody. At the time

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[314] T64 L5-8.
[315] T1567 L1-11.

Heather entered into custody, CCA was undertaking the reception assessments (this changed in January 2020).

315. The Court's expert, Dr Jansen described the initial medical assessment as *absolutely paramount* to understand each person and improve continuity of care.[316] At inquest, Mr Bulger on behalf of CCA agreed, and said that it allowed a reference point for each treating clinician and is the first point of call in the prevention and early intervention of medical issues.[317]

316. Dr Jansen identified three primary health features that should have been identified for Heather and responded to upon entry to prison, being her mental health condition, her state of WHO Class I obesity and the fact that she was pregnant. Mr Bulger agreed with Dr Jansen's assessment.[318]

317. Heather's initial medical assessment did not identify that, at the time of reception, she had WHO Class I obesity which Dr Jansen said had a number of consequences. Firstly, that there was no assessment of any underlying causes of her weight gain. Secondly, it meant that she was not screened for potential consequences of her obesity such as obstructive sleep apnoea and finally, there was no treatment plan commenced for her weight gain. Dr Jansen said this denied Heather and her clinicians the opportunity to prevent her deterioration from WHO Class I obesity to WHO Class III obesity.[319]

318. In addition, as Heather was an Aboriginal woman, with a history of smoking and reported a family history of heart disease, these factors increased the need to minimise the additional risk factor of obesity and prevent its progression. Dr Jansen said,

Given the chronic, progressive nature of obesity, it is imperative to establish a diagnosis as early as possible and develop and implement a management plan. Review of anthropometry

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[316] T1048 L30-T1049 L7.
[317] T1463 L6-12.
[318] T1464 L13-17.
[319] Expert Report of Dr Denver Jansen, CB at p.2985-2988.

and obesity related complications should be repeated at regular intervals (National Health and Medical Research Council, 2013). In Ms. Calgaret's case, basic weight measurements could have prompted further assessment and, I expect they would have informed pharmacological choices when initiating treatment for her mental health condition. This would have offered the opportunity to delay her progression to Class III obesity, metabolic associated fatty liver disease and the development of diabetes.[320]

Reception Mental Health Assessment

319. Heather's initial mental health assessment was conducted by a CCA mental health nurse on 2 August 2019. The assessment documented that "nil psych issues" were evident but a prior history of depressive episode/adjustment disorder was noted.

320. It is apparent that the report of Clinical Psychologist Ms Crole was not considered by reception staff at DPFC as it was not available. There is also no reference in the JCare records to it being referred to at any later assessments.

321. Mr Bulger said that if the report had been available to the CCA clinician, he would have expected that Heather would have been referred to Forensicare, but not necessarily a psychiatrist.[321]

322. Dr Roberts said that these reports are prepared by Forensicare clinicians to provide advice and support to the court and to the magistrates. The report would be treated as collateral information, and she *would hope that* a clinician reviewing the case or seeing the patient would access all available information, including information filed under 'collateral information' on J-Care.[322]

323. Dr Roberts said that she did not expect that the contents of the report of Ms Crole alone would be sufficient for a referral to Forensicare. She said it would always depend on an initial

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[320] Expert Report of Dr Denver Jansen, CB at p.2987-2988.
[321] T1476 L13-27.
[322] T1539 L5-11.

assessment by the primary healthcare provider and that information, along with how the patient presented on that assessment, would determine whether a referral was made to specialist mental health services.[323]

The removal of Heather's Baby

324. On 29 October 2021, Heather gave birth to her fourth child, a daughter, who was removed from her care shortly after the birth. Aunty Lynn said, *Heather was not given custody of a child and DHHS were present at the birth and took custody of the child straight after birth; Heather has been extremely traumatised by this and is not coping*.[324]

325. The 2014 Quality Framework provided health service providers were to ensure that, *assessment and treatment is provided for women at risk of postnatal depression.*[325]

326. Court experts, Epidemiologist and Aboriginal Health Researcher Dr Jones and Consultant Psychiatrist Professor Newman, identified the removal of Heather's daughter as a pivotal moment in the overall decline of Heather's health while in custody. Dr Jones said that it had *very serious and detrimental effects to her social, emotional wellbeing*[326] and Professor Newman considered it to be a *major contributing factor to her mental health, high levels of distress, depression*.[327]

327. Dr Newman stated,

> *The syndrome of loss and grief following removal of infants can be a profound state. Typically, what is known as post-natal depression refers to a specific condition which is very much thought to be influenced by post-delivery hormonal changes and other vulnerability factors. It tends to respond to a combination of anti-depressant treatment if indicated and psychosocial support. It typically presents as a Major Depression and without treatment*

[323] T1544 L20-28.
[324] WestCASA records at CB p.3844-3898. *See* in particular at p.3846.
[325] Justice Health Quality Framework, CB at p.1651.
[326] T1009 L7-11.
[327] T1013 L10-12.

may last for 12 months. Underlying factors such as trauma or loss of a previous infant may contribute to ongoing distress and mood changes.

....

Lack of [I]ndigenous, safe and responsive clinical services [f]or a woman in this position would contribute to her mental deterioration over time and also to her difficulty in self-organisation and motivation particularly around her health needs.[328]

328. The context in which Heather's baby was removed is significant and likely complicated her experience of it. Heather had her other children removed, including another baby removed at birth while she was in custody, and her family had been affected by the Stolen Generation experience. Each of these factors would be expected to produce a range of both trauma-related symptoms and feelings of despair. Professor Newman said that it did not appear that there was any trauma-focused counselling for Heather and there was a lack of Indigenous-safe and responsive clinical services that could assist to arrest her decline over time and to help her deal with her feelings of loss, depression and anxiety.[329]

329. Whilst Heather had some sessions with WestCASA, they were limited and impacted by COVID-19. I note that it was during these sessions that Heather mentioned the *shame* she was experiencing.[330]

330. It is apparent from the JCare records that there was no formal recognition or assessment of whether Heather was suffering post-natal depression, and therefore whether she needed specific treatment or services to assist her. Heather said she was suffering from post-natal depression on 22 October 2020, and a diagnosis was documented on 7 November 2020, apparently without a formal tool being used (more than a year after the birth).

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[328] Expert Report of Professor Louise Newman, CB at p.3017.
[329] Ibid.
[330] WestCASA records, CB at p.3857-3862, *see* p.3858.

331. Professor Newman stated,

> *…. if the diagnosis of a post-natal depression was to be considered, it would be important to use a standardised tool for the examination and rating of the experiences of post-natal depressions such as the Edinburgh Depression Scale which is routinely used in health and mental health services to screen for significant post-natal depression along with associated suicidal ideation.*[331]

332. Dr Jones agreed and said there are two postnatal depression scales that could have been used to screen Heather for postnatal depression being the Edinburgh Postnatal Depression Scale and Kimberley Mums Mood Scale (**KMMS**) which is a perinatal mental health assessment tool designed and validated for use with Aboriginal women from the Kimberley region, the Pilbara and Far North Queensland.[332]

333. Susannah Robinson (**Ms Robinson**), Executive Director of Justice Health, considered that anyone who is giving birth and having their child removed and then coming back into a custodial environment, *should have a lot of supports around them.*[333] She said that the expectation would have been that Heather be supported, but it was clear, *there were some significant opportunities to improve that* and there were *definitely opportunities for additional intervention to support* her.[334]

334. Mr Bulger accepted that there wasn't any trauma-focused counselling or support offered to Heather during that period.[335]

335. Dr Roberts said that as soon as Heather gave birth, this would have been an ideal place to intervene and to unpack what presumably was repeated trauma in her case.[336]

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[331] Expert Report of Professor Louise Newman, CB at p.3017.
[332] Expert Report of Dr Jocelyn Jones, CB at p.3930.
[333] T1872 L27-30.
[334] T1872 L10-13, 19-22.
[335] T1473 L19-21.
[336] T1565 L19-26.

Mental health

336. As already noted, Clinical Psychologist, Ms Crole, indicated that should Heather be remanded in custody, she would request follow up for concerns around her mental wellbeing, including depression, suicidal ideation and anxiety and stress around her pregnancy. This followed a report she prepared.[337]

337. In another report prepared by Forensic Psychologist, Jeffrey Cummins, Jeffrey Cummins,[338] he indicated that Heather suffered from *an Adjustment Disorder with mixed Disturbance and Emotions and Conduct*[339] and that she suffered a mental illness which required urgent mental health treatment.

338. Both these assessments reports were prepared for Heather's court hearings.

339. The JCare records suggest that following her reception to prison, Heather was not provided with any mental health treatment or support until she self-referred for medication on 6 December 2019 at which time she reported experiencing *bad depression* and difficulty sleeping.[340]

340. As noted in the health chronology, there were cancellations of appointments and occasions when appointments were not rescheduled from late 2019 to early 2020, which Mr Bulger agreed was a *failure in the system*.[341]

341. During this time Heather was isolating in her room, suffering depression, teary, with thoughts of suicide, lowered mood, she was the subject of a Risk Review, and Heather commented that she hadn't seen a psychiatrist after the recent birth of her baby and feels *sad* about this.[342]

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[337] MHARS, *Confidential Psychological Report,* CB at p.971.
[338] Dated 12 February 2020 and prepared for sentencing in May 2020.
[339] Adult Parole Board File, CB at p.3695.
[340] JCare electronic medical records, CB at p.706.
[341] T1478 L17-24.
[342] JCare electronic medical records, CB at p.285-286.

342. WestCASA documented as part of her presentation during that time,

Intrusive symptoms: nightmares and stressful dreams, ruminations, body responses to triggers - loud noises etc;

hyperarousal symptoms: feeling on edge a lot, anxiety - feels panicked a lot, stressed, difficulty sleeping;

cognition symptoms: not retaining information as much, struggling to feel clear in her mind; depressive symptoms: feeling of depression, loneliness, sadness, grief and heartbreak, feeling shame and grief the things that have happened, overwhelmed with current situation;

Physical: …She was also very traumatised from the experience.[343]

343. Heather's first Forensicare appointment was on 29 January 2020, which represented a significant delay of about six months from reception, 3 months since the birth and 2 months since her specific request for assistance. It appears that during this time, Heather did not have access to a clinician who was sufficiently qualified to make decisions regarding pharmacotherapy or psychotherapy, she did not have any management plan and no pharmacotherapy was commenced. This all occurred in the context of Heather being post-partum; her child being removed from her care; voicing symptoms of ongoing depression and thoughts of self-harm; and history of depressive episodes.

344. Mr Bulger thought that the delay was caused by a failing of the individual clinicians rather than a system failure and he would have expected referrals to have been made earlier given the passage of time and Heather's interactions with various CCA clinicians. He considered that the systems that had been put in place by CCA, in policy and procedure at the time, should have been sufficient for nurses or medical practitioners following those procedures to have identified Heather's vulnerabilities of Heather.[344]

345. Dr Jansen observed that there were no further consultations with the Forensicare psychiatric team following the consultation on 20 May 2020, despite ongoing recognition of Heather's

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[343] WestCASA records, CB at p.3857-3862, *see* p.3858.
[344] T1749 L7-29.

mood being low, and there being a strong connection between her mood and eating habits (as documented in the Weight Management Clinic on 3 March 2021 and again on 19 May 2021).[345]

346. Dr Jansen considered that the overall management including coordination of care for Heather's mental health conditions appeared inadequate.[346]

347. Professor Newman commented that,

> *…. the traumatic experiences of an [I]ndigenous mother in terms of separation from children and having had very early removal of two infants, both in prison situations would seem to be a major component of a complex trauma situation.*
>
> *…. that a comprehensive program of ongoing mental health care and support requires in this situation, culturally, safe and appropriate recognition of trauma and the complexity of Post-Traumatic Stress Disorder in a woman with significant psychological and social vulnerability*.[347]

348. Professor Newman further commented that Heather's circumstances of *very, very complicated loss and trauma*,[348] was better described as complex post-traumatic stress disorder. In her view, the only professionals qualified to diagnose that condition were a clinical psychologist or psychiatrist and that Heather was never reviewed by someone at the right level for diagnosing her mental state or formulating appropriate treatment was a *major issue* in her care.[349] She further commented that medications alone were unlikely to be effective. [350]

349. Heather had no access to a psychologist while at DPFC and it was apparent that these services

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[345] Expert Report of Dr Denver Jansen, CB at p.2991.
[346] Expert Report of Dr Denver Jansen, CB at p.2992.
[347] Expert Report of Professor Louise Newman, CB at p.3018.
[348] T1095 L17-24.
[349] T999-1000, T1096 L2-30.
[350] T1002 L29-T1003 L10.

are rarely available to women at DPFC.

350. Dr Jansen noted that the *2020 Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders* recommended that for management of mood disorders (depression), there should be a component of psychological therapy with or without medication.[351]

351. Professor Newman commented that *psychological treatment aimed at improving her own self-understanding and capacity to be an active participant in her own treatment and recovery* would have benefited Heather.[352]

352. Mr Bulger accepted that psychological assessment and care should have been provided to Heather. Significantly, Mr Bulger said that there is a *body of people* who present with mental illness, mental health vulnerabilities, mental health distress, that don't need a psychiatrist, or psychiatric care but do need mental health support and *it's been a failure that's been identified in the system for many years, that those services don't exist.*[353] Mr Bulger agreed that that there did not appear to be room for more comprehensive services for those cases that *fell in the middle*.[354]

353. Dr Roberts advised that given the limited psychology resources available at DPFC (which are stretched across the inpatient unit, mainstream outpatients and an outreach service to management and protection units), Forensicare is not able to provide psychological services to all women at DPFC (where there is a waitlist). Clients with comorbid, complex or high-risk presentations are generally considered the priority treatment group. Less complex presentations are often picked up by other services (e.g. Centre Against Sexual Assault, Forensic Intervention Services and primary health) or other members of the outpatient team.[355]

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[351] Expert Report of Dr Denver Jansen, CB at p.2993.
[352] Expert Report of Dr Louise Newman, CB at p.3021.
[353] T1483 L23-T1489 L5.
[354] T1496 L27-T1540 L2.
[355] Supplementary statement of Dr Kate Roberts, dated 17 January 2024, CB at p.3421.

354. Dr Roberts said that in order to best use Forensicare resources, they aim to provide time limited periods of treatment, and as such do not routinely provide cognitive behavioural therapy (or other evidence-based treatment) on an ongoing basis throughout the length of a person's incarceration. Dr Roberts said that members of the psychology team regularly liaise with the AWO and Aboriginal Liaison Officers (**ALO**s)[356] at DPFC and that this is an important conduit for identifying Aboriginal women who may benefit from psychology services and for the psychology team to receive support as to how best to approach individuals in a culturally sensitive/informed way.[357]

355. Dr Roberts said that the option of psychiatric opinion was available at the time but in her view, Heather's case would not have necessarily *demanded the input from a psychiatrist*. She noted that Heather had treatment by a PNP and this is a model used in prisons and more broadly in the community. Dr Roberts said that Heather presented with anxiety and depression, so it was reasonable that a PNP would see her in the first instance, and then her care was handed back to the primary service who had an opportunity to re-refer within the subsequent 18 months, but didn't apparently have concerns at that time.[358]

356. Dr Roberts also stated that the constraints of operating in a prison mean that there is not much time or ability to provide much more than an assessment, diagnosis and then treatment with medication, when referring to the services of a PNP.

357. Dr Roberts accepted that throughout Heather's assessments, there was no use of any formalised tools for screening or identification of mental health conditions. She noted that whilst the expert panel commented that there were no standardised instruments or tools used to formally diagnose Heather or accurately measure her levels of depression or anxiety, she viewed the tools as a supplement or an additive to clinical assessment. She said that clinical

[357] Supplementary statement of Dr Kate Roberts, dated 17 January 2024, CB at p.3422.
[358] T1560 L29-T1561 L7.

assessment is the gold standard depending on people's location of practice, and standardised tools were used at the discretionary of the treating clinician.[359]

358. Dr Roberts said that it was not her expectation that the assessments of Heather by Forensicare staff would include the use of any formalised tools or instruments. She said the *richer information* is obtained from a clinical interview which can be supplemented by various tools.[360]

359. In relation to whether there was a clear comprehensive plan for Heather's care, Dr Roberts' evidence was to the effect that the comprehensiveness and planning were constrained by the reality of an operating model involving a primary and a specialist secondary mental health care provider. This meant that the usual practice is for a referral to Forensicare, followed by an assessment, recommendations, and prescription of medication as appropriate, and then referral back to the primary health care provider with an open invitation to re-refer if there are concerns.[361]

360. Members of the expert health panel all agreed that the mental health care provided to Heather did not meet minimum standards prescribed by Justice Health. Specifically, Heather was entitled to receive care from a multidisciplinary team whose care consisted of: assessments; a mental health recovery plan; treatment (including a range of relevant therapies and interventions); and the conduct of regular reviews. It was their unanimous opinion that Heather did not receive this kind of care.

361. Further, Heather was entitled to receive holistic care for her mental illness by way of a coordinated and integrated care plan between primary and secondary mental health services, including, but not limited to, structured processes and meetings. It was the expert health panel's unanimous view that this minimum requirement was not met.

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[359] T1547 L8-28.
[360] T1548 L4-12.
[361] T1549 L26-T1550 L27.

362. Ms Robinson said on behalf of Justice Health that she accepted that there were opportunities to provide Heather with better support from a mental health care perspective.[362]

Management of Diabetes/Blood Sugar Levels

363. Heather was diagnosed with diabetes on 24 March 2021. Dr Jansen noted that at this time, she had a fasting blood sugar of 11mmol/L (less than 7.8 is normal) and a glycated haemoglobin (HbA1c) of 7.9% (over 6.5% confirms a diagnosis of diabetes). She also had significantly deranged liver function tests supporting a likely diagnosis of metabolic associated fatty liver disease (**MAFLD**). On 10 March 2021, she had a recorded weight of 160kg (Class III obesity) and on 17 March 2021, was noted to have an elevated blood pressure of 147/100mmHg. Heather had a strong family history of ischemic heart disease and her JCare records indicated that she was a snorer, strongly suggesting the presence of obstructive sleep apnoea .[363]

364. Dr Jansen stated that Heather was an Indigenous woman with newly diagnosed diabetes, multiple comorbidities, and an intermediate risk of developing cardiovascular disease. That risk of at least 5 to 10% of developing cardiovascular disease in the next 5 years was highly significant for a 30-year-old female.[364]

365. Dr Jansen said the most appropriate management for Heather at this time and over the ensuing weeks would include a referral to a dietitian, podiatrist, optometrist, and a specialist weight management clinic which included an endocrinologist. He suggested that it appeared that there were some deficiencies with her management, specifically in relation to the absence of an early referral to a specialist weight management team. While waiting for the assessments he referred to, Heather should have had regular, scheduled visits with a medical practitioner to,

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[362] T1858 L7-10.
[363] Expert Report of Dr Denver Jansen, CB at p.2988.
[364] Ibid.

a. Immediately commence metformin to facilitate blood sugar control and facilitate weight control;

b. immediately commence treatment for high blood pressure and regular follow up of blood pressure for titration of medication dose; and,

c. undertake a full medication review in combination with a pharmacist to consider options for management and drug interactions, as well as with Heather's treating psychiatric team, as to the choice of anti-depressant and anti-psychotic medication.[365]

Weight Management – development of other conditions

366. Excessive weight gain appeared to be a central factor in the deterioration of Heather's health. It was apparent that there was an absence of any routine recording of Heather's weight, BMI or waist circumference.

367. Heather progressed from WHO Class I obesity (between 84 and 88 kg taking into account her pregnancy) at reception on 31 July 2019, to WHO Class III obesity (145kg) on 22 July 2020 (approximately 12 months following her initial reception to DPFC), *seemingly without recognition.*[366] At the time of her passing, Heather weighed 162kg.

368. Dr Jansen observed that Heather's obesity was present from the time of admission and *obvious to every doctor, to every nurse, to every psychiatric nurse, to every nurse practitioner and every other member of the Allied Health Team that treated her*.[367] Despite this, it was not diagnosed until Heather had gained 57kg in twelve months and had become morbidly obese.

369. Dr Goonetilleke said that there was no system in place at DPFC to monitor weight gain and that it was, instead, incumbent upon each individual practitioner to detect it and decide to

[365] Expert Report of Dr Denver Jansen, CB at p.2988-2989.
[366] Expert Report of Dr Denver Jansen, CB at p.2987.
[367] T988 L7-10.

weigh a patient.[368]

370. It was Mr Bulger's expectation that a patient would be weighed at reception and during each subsequent consultation with a doctor, particularly for a patient prescribed quetiapine.[369]

371. Dr Jansen considered that the management of Heather's weight during her imprisonment, was not at an acceptable standard. The primary failures he identified were:

    a. An absence of routine recording or her weight and BMI;

    b. Failure to adequately document and manage her condition of WHO Class I obesity upon reception to DPFC; and,

    c. Failure to adequately manage her weight when she was diagnosed with WHO Class III obesity.[370]

372. Dr Jansen noted that a referral to a specialist weight management clinic could have facilitated a discussion about the full suite of options available for her weight management and this would have been particularly important for Heather, given her depression, the medication that she was prescribed, and her probable obstructive sleep apnoea.[371]

373. Dr Jansen further advised that once Heather's WHO Class III obesity was recognised, a referral for specialist management was important given her co-existing depression, prescribed medication, probable obstructive sleep apnoea and anthropometry (body proportions). A specialist team could have had a more comprehensive discussion regarding all modalities of weight management, including pharmacotherapy or bariatric surgery, to better assist her weight management in the context of her other risk factors.[372]

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[368] T213 L7-14.
[369] T1497 L3-14.
[370] Expert Report of Dr Denver Jansen, CB at p.2985.
[371] T986 L16-24.
[372] Expert Report of Dr Denver Jansen, CB at p.2987.

374. Mr Bulger clarified that there was no policy from CCA (or Justice Health) that a weight loss injection couldn't be prescribed, but at that time the Therapeutic Goods Administration (**TGA**) recommended that it was for diabetes, not for weight loss. He said that the first line medication was metformin which Heather was prescribed, and if that did not work, clinicians could look for an alternative.[373]

375. Dr Jansen considered that the failure to appropriately identify and then manage Heather's weight meant that she was deprived the opportunity to prevent the progression not only of her obesity, but also the progression to diabetes, to metabolic fatty liver disease and probable obstructive sleep apnoea.[374]

Weight monitoring – quetiapine

376. The JCare records disclose that there were no baseline assessments conducted when Heather was commenced on quetiapine, such as blood pressure and weight measurements, which would have allowed for monitoring of the effects of this medication on her physical health.

377. Given Heather had WHO Class I obesity and was prescribed quetiapine - a medication known to have an association with weight gain and diabetes - it would have been reasonable to have conducted these assessments.

377. Dr Roberts said when prescribing medications with potential side effects of weight gain, Forensicare considers the views and preferences of a patient. The usual practice is to inform the patient of all the risks and benefits of treatment, including possible weight gain, so they can make an informed decision regarding their care.[375] She observed that because medication will not necessarily be the only cause of weight-gain, it is appropriate for that aspect of a patient's physical health to be managed by their primary health care team, so there can be a

[373] T1515 L6-19.
[374] Expert Report of Dr Denver Jansen, CB at p.2987-2988.
[375] Supplementary statement of Dr Kate Roberts, dated 17 January 2024, CB at p.3425.

holistic approach.[376]

378. Specifically in relation to the commencement of quetiapine, Dr Roberts expected that a mental health nurse should know the potential effects of the drug and that primary health should be across metabolic monitoring.[377]

379. The evidence is that assessment and monitoring of physical effects of medications such as quetiapine, strictly falls to primary health clinicians.[378]

380. Mr Bulger said that once a prisoner has been referred to Forensicare, a diagnosis is made, and a prescription provided, CCA is responsible for their medication needs including monitoring the medication's effects on the prisoner.[379] He said that it is *simply good clinical practice to* undertake metabolic monitoring if quetiapine is prescribed.

381. Professor Newman said that the central clinical question was of-

the ongoing use of medication that appears to be, in this case, associated with severe and rapid weight gain in an individual who may well have specific sensitivity to this [and] *who already has multiple risk factors for cardiovascular disease including pre-existent obesity and poorly controlled Type 2 diabetes. This should be considered a high-risk clinical situation for ongoing use of anti-psychotic medication.*[380]

382. Dr Roberts observed that identification of weight gain was complicated by limitations of the JCare records shared by primary and secondary health service providers. She said it would be helpful if JCare had-

the ability to set up alerts when things were due or when they were recommended for re-taking, I think that would aid both services enormously. […] *Also having a clear place within*

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[376] Ibid.
[377] T1568 L15-27.
[378] T1568 L15-20.
[379] T1468 L21 – T1469 L4.
[380] Expert Report of Professor Louise Newman, CB at p.3019.

J-Care that all of these weights, and girths could be entered […]*it was really dependent on clinicians kind of noticing that there might have been weight gain whereas if it's very clearly documented and comes up as an alert, 'This has increased by 20 kgs', or whatever, it would be much more helpful, and clinicians would be supported then to be aware of the risks more so than they are now*.[381]

383. In the context of discussing Heather's diagnosis of *metabolic syndrome* and the importance of exploring the causes of weight gain (including the potential of medications initiated by mental health clinicians to do so),[382] Dr Goonetilleke identified an additional systemic barrier to weight management at DPFC. She observed that while discussions with other clinicians involved in a patient's care did occur, these usually occurred in connection with acute issues rather than chronic health-related issues like obesity and diabetes.[383] She said at inquest, *I feel that there probably should have been more of a role* [for the primary health medical practitioner]. *We should have had something like a multidisciplinary team meeting regularly to discuss issues like this. It wasn't there at the time. I feel like it probably operated within silos*.[384]

384. Mr Bulger agreed that Heather's medications regime should have been subject to multi-disciplinary review,[385] and Dr Roberts acknowledged that a multi-disciplinary discussion would have been useful.[386]

385. And Dr Jansen noted-

We didn't have a group of clinicians looking at what medication she should've been on, what medication she was on. Did she need to be on the medication she was on? Were there other

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[381] T1559 L2-18.
[382] T221 L24-30.
[383] T214 L16-20.
[384] T214 L10-14.
[385] T1493 L24 – T1494 L7.
[386] T1555 L30 – T1556 L20.

choices?[387]

386. It appears that in Heather's case there was no one professional or team responsible for the ongoing management and review of her medication, its efficacy and effects.[388]

387. Dr Jansen said that in reviewing this aspect of her Heather's care, he considered there to be a disconnect between the primary and secondary health services, and that it also raises questions regarding implementation of the *holistic model of care* which is referenced in the 2014 Quality Framework.[389]

388. In particular, he noted Standard 5.3.9 - Primary Mental Health services.[390] Minimum Requirement number 7, which stated:

the provision of a holistic model of care for Prisoners with a mental health issue or mental illness by ensuring the coordination and integration of care between primary mental health services and FMH [Forensic Mental Health] *services. This will include, but is not limited to, the establishment of structured processes and meetings:*

a. *for the assessment of Prisoners initially received into prison custody and Prisoners transferred to the Prison;*

b. *to discuss the care and ongoing management of Prisoners;*

c. *for case management activities; and,*

d. *for case conferencing.*[391]

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[387] T989 L3-6.
[388] RPN Loguli's identification of the psychiatrist or the nurse practitioner*, or even the GP* as each potentially reviewing the effects of mental health medication is illustrative: T295 L31-T296 L4.
[389] Expert Report of Dr Denver Jansen, CB at p. 2995, *see also* the Justice Health Quality Framework 2014, CB at p.1671.
[390] A coordinated system is in place to provide contemporary mental healthcare for Prisoners with mental health issues and/or mental illness, including referral to specialist services when required.
[391] Justice Health Quality Framework 2014, CB at p.1671-1672.

389. Dr Jansen explained that, with respect to *Treatment,* the 2014 Quality Framework set a minimum requirement that;

Health services providers will ensure that,

….

prescription of medications known to have potential for dependency or abuse is avoided wherever possible and only prescribed when clinically indicated. Safe use and potential side effects are considered and monitored when prescribing psychotropic drugs (emphasis added).[392]

Health Plans

390. As required by CCA policy, a Chronic Health Care Plan (later referred to as an Integrated Care Plan) should have been developed for Heather at reception to assist in providing ongoing health care on the basis that she was an Aboriginal. A Mental Health Chronic Health Care Plan was created on 2 July 2020.

391. Under the 2014 Framework, Standard 5.3.7 – Chronic Disease Management, minimum requirements include that health service providers are to ensure that systems are in place to address the key components of chronic disease management, including assessment, care planning, regular review and support for self-management. The aim of this requirement was *decreasing symptoms and improving function and quality of life.* [393]

392. Mr Bulger said that Heather should have had a Chronic Health Care Plan which included a number of conditions, a mental health care plan and an Aboriginal and Torres Strait Islander care plan. He conceded that none of the care plans were initiated and implemented, other

[392] Expert Report of Dr Denver Jansen, CB at p.2995-2996, *see also* Justice Health Quality Framework 2014, CB at p.1672.
[393] Justice Health Quality Framework 2014, CB at p.1668. *See also* CCA Policy Number 10.1, *Adult Chronic Health Care Planning Procedure,* dated June 2021: *Prisoners with chronic health conditions have a Chronic Health Care Plan, which is implemented and reviewed with the aim of decreasing symptoms and improving function and quality of life.* CB at p.2053.

than the mental health care plan but his expectation would be that Heather would have had each of those plans in place.[394] Mr Bulger said that some of the steps were there, but the plan wasn't documented; documentation of a plan is important for communication between clinicians so that people are aware of what's going on.[395]

393. Mr Bulger agreed that beyond identifying at reception that Heather was Aboriginal (a box was ticked) no further action occurred. In effect, there was nothing more than a note in the system and that the need for a Chronic Health Care Plan was identified but the plan was never developed.[396]

394. Ms Robinson, on behalf of Justice Health, said that there was always a requirement for a care plan to be prepared for Aboriginal prisoners, and that was to ensure that services are *looking holistically at how their care needs were met*. She said that Heather had a range of criteria that meant that she should have had a coordinated care plan in place. [397]

395. Ms Robinson also said that in relation to the manner in which Heather's chronic health care conditions were supported and the relevant plan was instigated and managed, she acknowledged that it did not meet the requirements or minimum standards of the 2014 Quality Framework.[398]

396. It is apparent that the way in which the Heather's plans (however described) were instituted and managed in some respects appeared to be contrary to both CCA policy requirements and the 2014 Quality Framework.

397. Given what they are intended to achieve, non-compliance with health care planning requirements may have undermined the ongoing effective monitoring of Heather's health and the care she required throughout her imprisonment, and therefore, opportunities to

[394] T1478 L24-T1479 L5.
[395] T1488 L23 – T1489 L1.
[396] T1489 L16-21.
[397] T1849 L12-21.
[398] T1873 L10-26.

intervene as her health deteriorated.

Comprehensive Care

398. Standard 5.3.1 of the 2014 Quality Framework provides that health service providers will ensure *the development of evidence-based clinical guidelines and protocols for the delivery of care to ensure a consistent multidisciplinary approach to the identification, assessment, diagnosis, treatment planning review and management of health conditions*.[399]

399. Ms Robinson on behalf of Justice Health said that it was always the expectation that prisoners should have a co-ordinated approach where they have complex care needs. She further indicated that the healthcare framework is premised on a multidisciplinary approach, and in practice, Justice Health also expect the health service providers to work closely together.[400]

400. It is apparent that at the time of Heather's collapse her health had significantly declined with the development of significant health issues, both physical and mental, in addition to seeking opiate replacement therapy.

401. Professor Newman said that there did not appear to have been a comprehensive review of Heather's situation and her multiple and escalating risk factors. She observed the connection between her mental and physical health noting that-,

Given Heather's very significant health problems in conjunction with her experiences of recent loss of her infant born in prison and the recapitulation of her previous loss of an infant, it is likely that these factors contribute[d] to her sense of lack of engagement and motivation and overall poor level of functioning.[401]

402. Professor Newman noted that opportunities were not taken for a broad review of her overall situation with the aim of developing a comprehensive management approach. For example,

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[399] Justice Health Quality Framework 2014, CB at p.1657.
[400] T1883 L27-T1884 L5.
[401] Expert Report of Professor Louise Newman, CB at p.3020.

the proper facilitation of a chronic health care plan with a level of coordination may have helped prevent the deterioration in Heather's health. There appeared to be no comprehensive plan to consider any interaction between her mental and physical health needs. Professor Newman said that it was not apparent who, if anyone, had responsibility or oversight for a long-term plan.[402]

403. Dr Goonetilleke said that ideally the care required would be a multidisciplinary course of action - *I feel like it probably operated within silos.*[403]

404. Mr Bulger said with respect to whether there was a process in place for a multidisciplinary team to oversee the care of someone like Heather, with complex health presentation, that it didn't happen in Heather's case and possibly it should have happened.[404]

405. Although Mr Bulger didn't work at DPFC, he said from his reading of the notes it appears that the care operated in silos and theoretically collaboration should have been easier as primary and secondary services are collocated.[405]

406. Mr Bulger noted that the emphasis of CCA policy and procedure is on prevention, early intervention and personalised care, but said the notes didn't indicate to him that there was a great deal of attention paid to Heather, as an individual.[406]

407. Dr Roberts said the system in place at the time was *not particularly workable* and was *probably not a gold standard approach* to manage vulnerable individuals with complex health needs. She said that it was challenging, they work with it as best as they could and try to collaborate. Dr Roberts said that there is a shared electronic medical record (JCare) with a referral back and forth process between primary and secondary carers, and this is the system

[402] T1040 L11-28.
[403] T214 L14.
[404] T1493 L24 – T1494 L2.
[405] T1494 L11 – T1495 L5.
[406] T1482 L23-28.

that they work in across prisons.[407]

Equivalency of Care

408. The United Nations Standard Minimum Rules for the Treatment of Prisoners (**the Mandela Rules**) provide international standards for treatment of prisoners. They require that prisoners enjoy the same standards of health care that are available in the community and have access to necessary healthcare services free of charge.[408] As Counsel Assisting noted in submissions, greater entrenchment of this principle was recommended in the Cultural Review[409] and Yoorrook for Justice Report:

The Cultural Review recommended that the Victorian Government include the right to equivalent healthcare and health outcomes as a minimum standard in the Corrections Act. The review further recommended that a model of care for Aboriginal people in custody be developed that supports equivalent healthcare outcomes and continuity of care for Aboriginal people. Yoorrook agrees.[410]

409. The 2014 Quality Framework also references a commitment that *persons in custody have the right to receive health services equivalent to those available in the general community through the public health system*.[411]

410. The Court's experts identified a number of ways in which Heather's treatment in custody did not match the type of care that she would have had available in the community. The most significant of these is the absence of psychological treatment which has already been discussed.

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[407] T1563 L23 – T1564 L9.
[408] United Nations Standard Minimum Rules for the Treatment of Prisoners, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016,adopted 17 December 2015) Rule 24(1) ('Mandela Rules'). Accessible at: The United Nations Standard Minimum Rules for the Treatment of Prisoners
[409] The Cultural Review at p.67.
[410] Yoorrook Justice Commission, *Yoorrook for Justice* (4 September 2023), p.371. Accessible at: Yoorrook-for-justice-report.pdf.
[411] Justice Health Quality Framework, CB at p.1656.

411. In addition, Heather did not have access to the same ongoing general practitioner who could be a central point of management of her overall care. Dr Jansen considered this was another indicator that equivalency of care was not met, because in the community, one general practitioner can operate as the coordinator of a patient's holistic health care.

412. Ms Robinson on behalf of Justice Health, accepted that patients have reduced capacity to choose their healthcare providers in custody but added that there were challenges in accessing an individual practitioner in the community as well.[412]

413. Further, during Heather's time in DPFC, she did not have access to any Aboriginal Health Worker or any Aboriginal Community Controlled Health Organisation.[413]

414. Dr Jones identified this as a further breach of the equivalency of care principle. She said that the lack of availability of these services was also recognised in the Cultural Review and Victorian Ombudsman's report.[414]

415. Ms Robinson gave evidence that Justice Health, was at that time (in 2024), exploring ways to develop **in-reach models** for Aboriginal Community Controlled Health Organisation to treat Aboriginal people in custody.[415]

Cultural Care

416. The inquest considered Heather's physical and mental health trajectory over her two years in DPFC from a cultural perspective. Significantly, it addressed Heather's circumstances as an Aboriginal woman in custody, separated from her children.

417. All the appliable policies – those of Corrections Victoria, Justice Health and CCA –

[412] T1867 L22-26.
[413] T318 L13-21.
[414] T980 L19-T981 L6.
[415] T1867 L15-22.

demonstrated a commitment to cultural needs being respected. [416]

418. In particular, Standard 5.2.1 of the 2014 Quality Framework, *Aboriginal and Torres Strait Islander, Cultural and Specific Needs*, provided, amongst other things, that;[417]

    a. health service provider staff are aware of vulnerabilities such as past trauma and specific health needs that may affect the planning and delivery of care for Prisoners;

    b. Aboriginal and Torres Strait Islander Prisoners' physical, social, spiritual and emotional wellbeing is addressed in a manner that is consistent with their cultural needs;

    c. access to traditional healing is available and facilitated where necessary; and,

    d. consultation with Aboriginal Community Controlled Health Organisations is undertaken to enhance and further develop Health Service delivery for Aboriginal and Torres Strait Islander Prisoners and to support connection and engagement upon transition to the community.[418]

419. Yoorrook reported that:

    Many Aboriginal women in prison are also victim survivors of physical, sexual and family violence. Self-medication with legal and illegal drugs in response to their trauma is also common. Yoorrook heard that Aboriginal women in prison have higher rates of mental ill-health, substance use disorders and homelessness compared to other groups. In line with this, Yoorrook was consistently told that Aboriginal women have vastly different

[416] For example, the Victorian Standards for the Management of Women Prisoners provide that women should be managed and treated in a manner that is sensitive to their cultural needs. Department of Justice, Corrections Victoria, Standards for the Management of Women Prisoners in Victoria (Report, 2014) 14.
[417] Justice Health Quality Framework 2014, Standard 5.2.1: *Aboriginal and Torres Strait Islander, Cultural and Specific Needs*, CB at p.1650.
[418] Ibid.

rehabilitative needs.[419]

420. Dr Jones described cultural safety in health care in the following terms,

> *In summary, culturally safe care emphasises creating an environment where patients feel safe, respected, and empowered, while culturally competent care focuses on healthcare providers' ability to understand and respond effectively to the cultural needs of patients. [C]ultural competence focuses on cultural diversity and not specifically Aboriginal and Torres Strait Islander peoples.*[420]

421. Dr Jones considered that, while at DPFC, Heather did not have access to culturally safe healthcare that aligned with the definition of Aboriginal health.

422. Dr Jones identified that there was insufficient facilitation of family visits and community engagement which is essential for maintaining cultural ties, support systems and spirituality for Heather's social and emotional wellbeing.[421]

423. Although Heather was suffering various types of trauma, Dr Jones identified that she did not receive 'trauma-informed care' which understood her trauma in its cultural context of intergenerational trauma and child removal, nor she did have access to traditional healing to promote social and emotional wellbeing to address the trauma and loss.[422]

424. Dr Jones noted that Heather did not have access to an Aboriginal health practitioner or any kind of Aboriginal Health Worker. She advised that Aboriginal Health Workers are specialists as they provide culturally safe and competent health services to Aboriginal people.[423] Heather was not linked with any Aboriginal Community Controlled Health Organisations, despite policy which noted a commitment to consultation with such services,

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[419] Yoorrook Justice Commission, *Yoorrook for Justice* (4 September 2023), p.365. Accessible at: Yoorrook-for-justice-report.pdf (footnotes omitted).
[420] Expert Report of Dr Jocelyn Jones, CB at p.3913.
[421] Expert Report of Dr Jocelyn Jones, CB at p.3928.
[422] T982 L21-28.
[423] Expert Report of Dr Jocelyn Jones, CB at p.3917.

where possible.

425. Dr Jones considered that it was not possible for Heather to receive healthcare in custody *equivalent* to what she would have received in the community public health system because in order to receive an equivalence of health care, she needed to have access to health services from an Aboriginal Community Controlled Health Organisation.[424]

426. Dr Jones noted that the only contact Heather had with an Aboriginal worker was Aunty Lynn and a referral to AWO Phillip.[425]

427. Dr Jones considered there to be an over reliance on the AWO to address all of Heather's psychological needs, which overlooked the complex nature of her needs and the necessity for an approach that included a culturally appropriate specialised assessment and a care plan.[426]

428. Dr Jones said that Heather did not have access to any culturally safe care at DPFC that aligns with the definition of Aboriginal health care as provided for in CCA policy regarding Aboriginal Torres Strait Islander Health.[427] Specifically, Dr Jones raised:

    a. the lack of any direct contact with Aboriginal Community Controlled Health Organisations;

    b. the absence of any Aboriginal Health Worker;

    c. the lack of culturally safe antenatal or postnatal care;

    d. the lack of culturally safe counselling or support following the removal of Heather's child or after Heather reported grief following the death of her niece, uncle and former

[424] Expert Report of Dr Jocelyn Jones, CB at p.3928.
[425] Expert Report of Dr Jocelyn Jones, CB at p.3920.
[426] Expert Report of Dr Jocelyn Jones, CB at p.3939.
[427] Expert Report of Dr Jocelyn Jones, at p.3928.

partner.

429. Dr Jones also identified that the lack of a trauma-informed or culturally safe health assessment meant that Heather did not receive an initial health assessment which could have provided *crucial insight into her needs*.[428]

430. Dr Jones considered that Heather did not receive or have access to culturally safe antenatal and postnatal care, noting that she was not supported by an Aboriginal health worker during clinical appointments at DPFC or during her appointments at Sunshine Hospital.[429]

431. Mr Bulger agreed that Heather was not provided assistance from an Aboriginal Health Worker but said that the services she described, did not exist at that time within DPFC.[430] He also said that in reviewing the notes there was nothing specifically written about Heather's cultural needs but that this did not mean that she was denied *culturally aware care*.[431]

432. Dr Roberts agreed that Heather received no ongoing trauma informed or culturally specific counselling. She endorsed that services should be more culturally sensitive and should endeavour to aspire to the highest standards with respect to that and ideally, she considered that every clinician should practice in a trauma-informed way, but there isn't the resourcing for formal trauma services within our prisons.[432]

Lack of access to Medicare for Prisoners

433. It was suggested that a barrier to the delivery of health care in prisons was the lack of access to Medicare (the Commonwealth does not provide access to Medicare for people in custody).[433]

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[428] Expert Report of Dr Jocelyn Jones, CB at p. 3933.
[429] Expert Report of Dr Jocelyn Jones, CB at p.3930.
[430] T1464 L23-26.
[431] T1504 L22-23.
[432] T1561 L26-T1562 L1.
[433] T1041 L27-T1042 L10.

434. However, Ms Robinson on behalf of Justice Health stated at inquest, that she did not see it as a barrier to providing psychological services. She said that a much broader range of mental health services, that go well beyond what is provided through Medicare, are provided based on need and don't require payment from individuals. She said that there is constant evaluation of what community equivalence is in relation to care and the needs of men and women in custody.[434]

Heather's application to the LWM Program

435. I have included a discussion about Heather's application to the LWM Program in the Health Care section, as the removal of her child appears to have been a pivotal moment in her wellbeing trajectory.

436. On 28 August 2019, Heather applied to the LWM Program. She was supported by a Mother and Child Support Worker (**MCSW**)[435] who recommended that Heather submit an application to the LWM Program upon her entry into custody. On 30 August 2019, the MSCW sent an information request to Child Protection. On 10 September 2019, Child Protection advised that it was not supportive of Heather's application on the basis she had not addressed a range of protective concerns that had led to her three older children being placed on Children's Court orders and out of her care.

437. On 8 October 2019,[436] Heather's application was considered by the Mother and Children Program Steering Committee (**MCPSC**). The application was not supported by the MCPSC or the Deputy Commissioner of Operations,[437] who cited the concerns raised by Child Protection.[438] Whilst the Corrections Victoria policy did not require a representative from an Aboriginal Controlled Community Organisation be a member of the MCPSC at the time

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[434] T1866 L15-27.
[435] MCSWs have since been replaced with LWM Support Workers.
[436] Annexures to statement of Jennifer Hosking, CB at p. 4069-4073, the letter to Heather is dated 2 October 2022, at p.4073, the letter states that the Steering Committee considered the application (including the view of Child Protection) on 8 October 2022.
[437] Previous title for Deputy Commissioner, Custodial Operations.
[438] Annexures to statement of Jennifer Hosking, CB at p.4069-4074.

Heather's application was considered,[439] it is noted that a representative from the Bendigo and Districts Aboriginal Co-Operative was involved which the Court was advised ensured an appropriate level of cultural consideration.[440]

438. Dr Jones said she did not understand why Heather's application was not assessed based on her current environment, and that the application process was looking at it from a deficit rather than strength-based approach.[441]

439. At the time of her application, there were seven children residing with their mothers at DPFC and three pregnant women.[442]

440. Aunty Lynn said of the children residing at DPFC that,

it didn't matter what colour that baby was or who the mother was; that baby would be the most protected thing in the prison because the women adored them no matter who they were and everything. So you could - you could always know that the babies would be safe no matter where they go.[443]

441. In her 28-year history, Aunty Lynn thought there had been three or four Aboriginal children living with their mums at DPFC.[444] She also said that she was present with nine out of 10 of the Aboriginal women who had their babies in custody[445] and there had been 14 or 15 births during her time at DPFC.[446]

442. Aunty Lynn spoke of the trauma of having a baby removed,

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[439] Two representatives from Aboriginal organisations are now required to be on the Committee.
[440] T1916 L17-27.
[441] T1012 L13-27.
[442] Annexures to statement of Jennifer Hosking, CB at p.4073.
[443] T39 L8-13.
[444] T39 L31-T40 L3.
[445] T53 L25-28.
[446] T54 L12-14.

That's like any woman that gives birth to a baby and you have that baby taken away, you're devastated you know what else can you be? You've just given birth to the most beautiful thing in the world, and someone walks in and takes it away, what do you want them you know, they're not going to be happy. They're going to be disappointed; they're going to be depressed, they're going to be everything and that's natural for any woman whether you're black, white, green, yellow, purple, that's a normal process of it and everything.

You know, you're going to go through that grieving stage. You don't have to do that just because you're Aboriginal, it's for any woman. You get your baby taken away from you from birth or something like that, that's the most cruellest thing on earth and everything and she's got to learn to live with that. You know we can only do so much, we're not God but we can only be there to support the person themselves and everything and yes. And it's hard for us too to be there to, because sometimes mum will hand you that baby and say I can't do it, you do it and that's the worst thing in the world. No mum wants to see some person walk in and say I'm taking your baby. So that's got to be the worst thing in the world for a woman.[447]

443. At inquest, Tammy said of Aboriginal women having their child taken away in prison,

[T]he system's not designed to give you your kids back when you're on the outside, let alone on the inside.[448]

444. The LWM Program, Commissioner's Requirement provides that the overarching aim of the program is to *diminish the impact of the mother's imprisonment on her dependent child/children*.[449] The opinion of Child Protection is sought but is said not to be determinative. However, Acting Deputy Commissioner (**A/DC**) Jennifer Hosking said at inquest that she was not aware of any decision to allow a child to reside with a mother at either DPFC or Tarrengower, where Child Protection did not support that occurring.[450] The Commissioner's

[447] T62 L9-31 – T63 L1-2.
[448] T169 L6-8.
[449] Statement of Jennifer Hosking, CB at p.3958.
[450] Statement of Jennifer Hosking, CB at p.3961.

Requirement established that: the contracted prison health service provider is responsible for providing ante and post-natal care to a community standard; and, the provider is responsible for monitoring and support for women assessed as being at risk of post-natal depression and providing timely access to professional counselling for pregnant and post-natal women.[451] This is largely consistent with the 2014 Framework already noted.

445. There was however no evidence of any specific support offered to Heather after the refusal of her application.

446. A/DC Hosking gave evidence that Heather met with her case worker and Aunty Lynne on a regular basis, however, was unable to identify any other supports provided to Heather.[452] She accepted that there may have been a *gap* in the services provided to Heather following the refusal of her application.[453]

447. She said that there is not a system whereby somebody would automatically be referred for assistance – to avoid a one-size-fits-all process[454] – but that a referral to somebody for an individual assessment certainly would be a process that would be useful to stop people falling through the cracks.[455]

448. Regarding LWM Program statistics, she said that there had been 571 applications since 1991 (noting that the program had been going since the early 1980s but the earlier data is not of the best quality) and of those applications, 62 were made by Aboriginal women. Of those 571 applications, 299 were approved, which included 34 Aboriginal women in both women's prisons.[456]

449. A/DC Hosking agreed that the LWM Program can be seen as a valuable opportunity to support Aboriginal women moving forward as suggested by Dr Jones. Specifically, it provides an

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[451] Annexures to statement of Jennifer Hosking, CB at p.4009.
[452] T1925-1926.
[453] T1926 L17-19.
[454] T1949 L22.
[455] T1949 L17-26.
[456] T1929 L22-26.

opportunity for women to live with their babies and learn parenting skills in a safe environment with a number of supports around them. This, in turn, can improve a mother's prospects of reunifying with her children upon her release and therefore assist in breaking the cycle of the disproportionate numbers of Aboriginal children being removed from their families.[457]

Summary of Conclusions

450. Heather was six months pregnant with her fourth child, when she was remanded in custody on 31 July 2019. At this time a clinical psychologist conducted an assessment at the Melbourne Magistrates' Court and requested mental health follow up for concerns regarding Heather's mental wellbeing, including depression, suicidal ideation, and anxiety and stress around her pregnancy. However, the report was not available for the reception assessment.

451. Heather soon applied under the Living with Mum Program for her newborn to be with her in prison, but her application was declined following advice from Child Protection. Her daughter, born on 29 October 2019, was therefore removed from Heather's care shortly after her birth.

452. Heather was 28 years old and relatively healthy when she entered into custody being pregnant and overweight, but otherwise had no ongoing treatment needs identified or planned for. Within two years, she was classified as WHO class III obese also known as severe or morbid obesity (first identified on 22 July 2020), had poorly controlled type 2 diabetes (first diagnosed on 24 March 2021), sustained liver function derangement and likely obstructive sleep apnoea. At the time of her passing, she was also taking a range of medications which included empagliflozin, metformin, ramipril, sertraline, atorvastatin, and quetiapine. She had most recently been prescribed weekly Buvidal injections, as part of opiate replacement therapy.

[457] T1931 L7 – T1932 L3.

453. A review of more than 2 years of medical records reflect that Heather consulted regularly with CCA doctors and nursing staff as well as allied health professionals (such as physiotherapists, optometrists and podiatrists) for physical issues, and also predominantly CCA mental health nurses, for mental health support. She attended numerous appointments, with more than 100 being documented during this time. Heather had limited involvement with Forensicare such that she was only seen by the psychiatric nurse practitioner four times during her time in custody.

454. Heather's incarceration occurred during Covid-19 which impacted the delivery of services, including allied health providers (such dietitians) who were not considered to be essential services. Prisoners were also required to be locked down in their cells for periods of time.

455. It was agreed however that Heather suffered a "significant" decline in her health while in custody, and a number of areas were identified in the course of the inquest, representing opportunities for intervention with the potential to have altered her health outcomes.

456. It was important that the examination of these issues acknowledged the Aboriginal Social and Emotional Wellbeing Framework which *recognises that achieving optimal conditions for health and wellbeing requires a whole- of-life view of health encompassing the social, emotional, spiritual and cultural wellbeing of the individual and their community*.

457. In this context, the Court experts, Dr Jones and Professor Newman identified that the removal of Heather's daughter was a pivotal moment in the overall decline of Heather's health while in custody.

458. After the birth, in early December 2019 Heather was isolating in her room, she was noted to be teary, with thoughts of suicide and lowered mood and was later the subject of a Risk Review requested by corrections staff on 14 December as she was *thinking about self-harm*. She had asked to see a psychiatrist for anti-depressant medication on 10 December and by 18 January the following year being 2020, Heather commented that she felt *sad* that she had not seen a psychiatrist after the birth of her baby. It was not until 29 January that she was seen by a Forensicare Nurse Practitioner who was able to prescribe an anti-depressant medication.

459. Heather did have access to CCA mental health nurses and doctors, a midwife (one session) and WestCASA (one consultation) during this time, but did not see anyone who would prescribe anti-depressant medication.

460. A requirement to respond to Heather's situation was recognised in a Commissioner's Requirement which required monitoring and support for women assessed as being at risk of post-natal depression and, the provision of timely access to professional counselling for pregnant and post-natal women.

461. The 2014 Quality Framework, which was in place at the time, also set out that health service providers were to ensure that, *assessment and treatment is provided for women at risk of postnatal depression*.

462. DJCS accepted that there may have been a "gap" in the services provided to Heather following the refusal of her application for her newborn to stay with her. In addition, that there is not a system whereby somebody would automatically be referred for assistance, but this could be useful to stop new mothers falling through the cracks.

463. Justice Health accepted that there was an expectation that Heather would have been supported, but it was clear, *there were some significant opportunities to improve* and, there were *definitely opportunities for additional intervention to support* her.

464. Mr Bulger, formally employed by CCA, accepted that there wasn't any trauma-focused counselling or support offered to Heather during that period.

465. It was apparent from the records that the profound grief and trauma Heather was experiencing was not fully appreciated and responded to, following the birth and removal of her newborn from her care. The response in these circumstances appears inconsistent with both the Commissioner's Requirement and the 2014 Justice Quality Framework.

466. There was clearly a potential opportunity to have intervened in response to the trauma Heather was experiencing and her decline in mental health at this juncture, to have improved Heather's health trajectory.

467. Professor Newman also noted that a lack of indigenous, safe and responsive clinical services for a woman in Heather's position would contribute to her mental deterioration over time and also to her difficulty in self-organisation and motivation particularly around her health needs. These observations are important as they demonstrate the connection between the mental health issues that Heather experienced and its impact on her physical health, particularly her ability to manage her weight. I note that it was later documented that she was *self-medicating* with food to help with her depression and low mood, and used food as a comfort while away from her children.

468. There was much evidence about Heather's significant weight progression, described as *severe and rapid weight gain*. Court expert Dr Jansen provided an opinion that there was no treatment plan commenced for her weight gain following her reception, which denied an opportunity to prevent her deterioration from WHO class I to class III obesity, noting that she was first weighed almost a year after her reception on 22 July 2020. In addition he noted that as an Aboriginal woman, with a history of smoking and, a family history of heart disease, these factors increased the need to minimise the additional risk factor of obesity and prevent its progression.

469. It was also note that the possibility of *metabolic syndrome*, a group of conditions that increase the risk of heart disease, stroke and type 2 diabetes was first recognised when Heather attended her first appointment with the weight loss clinic on 3 March 2021. She was subsequently diagnosed with diabetes later that month.

470. Heather was also commenced on Quetiapine (10 March 2020) which is a drug known to be associated with weight gain. The JCare records disclose that there was no baseline assessments conducted when Heather was commenced on the drug, such as blood pressure or weight measurements, which would have allowed monitoring of the effects of this medication on her physical health. There was no communication between Heather's CCA clinicians and Forensicare clinicians about its possible side-effects or any plan to review the medication in this context.

471. Metabolic monitoring is crucial for individuals taking antipsychotic medications due to the risk of developing metabolic syndrome and related health problems. Guidelines recommend regular monitoring of weight, blood pressure, fasting blood sugar, and lipid levels. Early detection and intervention are essential to mitigate the risks of cardiovascular disease and other complications.

472. The evidence is that assessment and monitoring in relation to a medication prescribed such as quetiapine, strictly falls to primary mental health but it was agreed amongst the witnesses at inquest that a multidisciplinary discussion would have been useful.

473. It appears however, that in Heather's case there was no one professional or team responsible for the ongoing management and review of her medication, its efficacy and effects.

474. This appears inconsistent with the 2014 Quality Framework, which includes a requirement that the *safe use and potential side effects are considered and monitored when prescribing psychotropic drugs*.

475. Dr Roberts on behalf of Forensicare considered that it would be helpful for there to be a clear place on JCare where *all of weights could be entered, with an alert at certain increases to assist clinicians* with monitoring weight.

476. In any event it remains unknown if Heather had a *specific sensitivity* to quetiapine and whether it contributed to her weight gain following its commencement.

477. It appears therefore that there were several opportunities missed and not captured which could have afforded an opportunity to prevent the progression of her obesity and subsequent diabetes diagnoses.

478. Heather also experienced ongoing depression which continued until her passing. Dr Jansen noted that the *2020 Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders* recommended that for management of mood disorders (depression), there should be a component of psychological therapy with or without medication.

479. It was apparent however that Heather had no access to a psychologist while at DPFC and that these services are rarely available to women at DPFC.

480. The Yoorrook Justice Report reported a lack of mental health support and care for prisoners, including a lack of "*access to well-trained psychologists in trauma and cultural awareness*".

481. Mr Bulger agreed that Heather should have received such services but said that it had been a *failure* identified in the system for many years. He identified that there is a category of prisoner who *fell in the middle* of the mental health continuum, who required such services but they were generally unavailable.

482. The lack of psychological care also appeared inconsistent with the equality of services requirement in the 2104 Quality Framework.

483. The expert health panel all agreed that the mental health care provided to Heather did not meet minimum standards prescribed by 2014 Justice Framework. Specifically, Heather was entitled to receive care from a multidisciplinary team whose care provided assessments; a mental health recovery plan; treatment (including a range of relevant therapies and interventions); and the conduct of regular reviews. It was their joint opinion that Heather did not receive this kind of care. I agree with the health panel's assessment.

484. Further, Heather was entitled to receive *holistic care* for her mental illness by way of a coordinated and integrated care plan between primary and secondary mental health services, including, but not limited to, structured processes and meetings. It was the panel's unanimous view that this minimum requirement was not met. I agree with the health panel's assessment.

485. In terms of Heather's overall care, Professor Newman commented that there did not appear to have been a comprehensive review of Heather's situation and her multiple and escalating risk factors, which again appeared contrary to the minimum requirement in the 2014 Quality Framework regarding service delivery for service providers to *ensure a consistent multidisciplinary approach to the identification, assessment, diagnosis, treatment planning review and management of health conditions.*

486. This was consistent with Counsel Assisting who commented that,

A holistic picture of her health decline was not captured and addressed in a coordinated and culturally-responsive way.

487. The 2014 Quality Framework also provided for a minimum standard regarding chronic disease management, which included that health service providers are to ensure that systems are in place to address the key components of chronic disease management, including assessment, care planning, regular review and support for self-management with the aim of *decreasing symptoms and improving function and quality of life.*

488. CCA policy reflected this requirement with the development of chronic health care plans. However, the inquest heard that the manner in which Heather's health care plans were instituted and managed in some respects were contrary to both CCA policy requirements and the 2014 Quality Framework.

489. The stated outcome of the CCA chronic health care plans was proactive detection and management of disease; reducing disease progression and complications; and maximising wellbeing of prisoners.

490. Given these objectives, appropriately developed plans formulated for Heather may have provided an opportunity to intervene and improve Heather's health trajectory.

491. The 2014 Quality Framework also reflects a commitment that persons in custody have the right to receive health services equivalent to those a community through the public health system. The absence of psychological treatment for Heather appears inconsistent with this commitment.

492. Court expert, Dr Jones considered that Heather did not at any time whilst at DPFC have access to culturally safe healthcare that aligned with the definition of Aboriginal health. She further identified that whilst Heather was suffering various types of trauma, she did not receive 'trauma-informed care' which understood her trauma in its cultural context of intergenerational trauma and child removal, nor she did get access to traditional healing to

promote social and emotional wellbeing to address the trauma and loss.

493. She further highlighted that this extended to her initial health assessment, which could have provided "*crucial insight into her needs*".

494. Dr Jones also highlighted that during Heather's time in DPFC, she did not have access to any Aboriginal Health Worker or any Aboriginal Community Controlled Health Organisation. Dr Jones identified this as a further breach of the equivalency of care principle.

495. The inquest learnt that there were no Aboriginal Health Workers engaged at DPFC at the time, which made the commitment to cultural care (and the cultural safety standards) difficult to achieve in Heather's care.

496. On behalf of CCA it was submitted that from reception there was insufficient intervention into the deterioration of Heather's physical health and systems were not set up to respond to the need of an Aboriginal pregnant woman in her position. And further, to the extent that particular deficits in the cultural aspect of healthcare existed, they were the product of systemic and funding limitations. That is, the system designed and funded by Justice Health at the time did not provide for a designated Aboriginal Health Worker, the utilisation of ACCHO's or trauma based therapy of any type, including culturally safe counselling. CCA noted that these matters were regularly found in various reviews.

497. What is confounding about the downward progression of Heather's health was that the policy settings in place at the time which have been detailed in my finding, all contained appropriate commitments to improve health as well as a recognition of the need for culturally safe and competent health care. This included Justice Health policy Standard 5.2.1 in the 2014 Quality Framework, *Aboriginal and Torres Strait Islander, Cultural and Specific Needs*, CCA policy and Corrections Victoria policy.

498. In particular CCA policy recognised that the holistic Aboriginal or Torres Strait Islander origins of personal health, encompasses social, emotional and spiritual wellbeing, and an awareness of the historical and cultural factors that affect the health of Aboriginal people.

499. I can only conclude therefore, that whilst there were robust health policies and commitments in place, it was apparent that the delivery of health services to Heather, did not meet those aspirations in the crucial areas which have been highlighted.

Changes to Healthcare Services

Changes to the Justice Health Quality Framework

500. Justice Health reviewed and updated the 2014 Quality Framework. The *Healthcare Services Quality Framework for Victorian Prisons 2023* (**2023 Quality Framework**) came into effect on 1 July 2023 and applies to all primary healthcare providers operating in public prisons.[458]

501. The 2023 Quality Framework contains mandatory Aboriginal Cultural Safety Standards, endorsed by the Aboriginal Justice Caucus. The framework sets stronger expectations around cultural awareness and cultural safety in custodial health services, and includes (but is not limited to) requirements;

    a. for health providers to have an ongoing process to build the cultural capability of health staff;

    b. to employ, retain and develop Aboriginal staff;

    c. to provide cultural wraparound support for Aboriginal staff; and,

    d. to foster an organisational culture that is culturally safe, inclusive and responsive to the needs of Aboriginal people in prison.[459]

502. Additional requirements under the new Primary Health Service Specifications, which enhance Health Service Provider supports for Aboriginal people in custody, include:

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[458] Justice Health, Healthcare Services Quality Framework for Victorian Prisons 2023, dated July 2023. *See* exhibit 1, *2023 Framework,* to the statement of Susannah Robinson, CB at p.4006-4456.
[459] 2023 Quality Framework, CB at p.4434-4437.

a. an Aboriginal-specific health check on reception to custody (which is equivalent to the standard of an Aboriginal and Torres Strait Islander check (Medicare 715)) ;

b. the requirement for enhanced integrated care plans for all Aboriginal people in custody that includes involvement from family members or a nominated support person, to better support Aboriginal people's health care journey;

c. added role of post release support coordinators to strengthen health-related release planning and continuity of care for Aboriginal people in prison and facilitate handover to community health services;

d. AOD health programs specifically tailored for Aboriginal men and women; and,

e. an enhanced Aboriginal workforce including Aboriginal Health Workers and Aboriginal Health Practitioners.[460]

503. In addition, Amanda Allen-Toland (**Ms Allen-Toland**), Director of Aboriginal Health of the Department of Justice and Community Safety, further indicated that in alignment with principles of self-determination, Justice Health's Aboriginal Health Unit is working with the Victorian Aboriginal Community Controlled Health Organisation, Aboriginal Community Controlled Health Services and the Aboriginal Justice Caucus. Together they will establish an Aboriginal-led governance structure which will have particular focus on the development and design of new Aboriginal models of custodial healthcare and will be a mechanism to provide Aboriginal leadership and voice to Justice Health, and its contracted custodial Health Service Providers, on the design, implementation and evaluation of new health service arrangements.[461]

[460] Statement of Amanda Allen-Tolland, CB at p.2359.
[461] Statement of Amanda Allen-Tolland, CB at p.2360.

504. The 2023 Justice Framework articulates the standard of care expected from primary health service providers and the unique requirements of delivering healthcare within the prison system. Underpinning the 2023 Framework are:

a. the duty of care that Justice Heath (and DJCS) has to men and women in custody; and

b. the dual aims of:

i. improving prisoner health outcomes generally; and,

ii. recognising that the way health services are delivered can improve the rehabilitation prospects of men and women in custody and reduce the overrepresentation of Aboriginal people in custody.[462]

505. The 2023 Quality Framework has also been designed to closely align with the National Safety and Quality Health Service Standards (**NSQHS Standards**), developed by the Australian Commission on Safety and Quality in Health Care.

506. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision, with eight standards comprising a nationally consistent statement about the level of care consumers can expect from health services in the community.

507. The 2023 Quality Framework also requires providers to be independently accredited to the NSQHS Standards.[463]

508. Ms Robinson on behalf of Justice Health said that in addition to new monthly data reporting requirements and audits of the plans, the most significant change is the introduction of an Aboriginal health check which would proceed the development of the care plan.[464]

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[462] Statement of Susannah Robinson, CB at p.4397.
[463] Statement of Susannah Robinson, CB at p.4397-4398.
[464] Statement of Susannah Robinson, CB at p.4398.

509. In addition, at DPFC, Western Health - which replaced CCA, have a clinical governance structure that also sits above and would review the quality of the plans. She advised that Western Health brought their clinical governance structures from the hospital and the ways in which they oversee their health services through their hospital is being equally used at DPFC to monitor the quality of the services.[465]

510. The Aboriginal Healing Unit (**AHU**) opened in September 2023 at DPFC and offers programs, group sessions and workshops and includes art, yarning circles and mindfulness sessions.[466] Ms Henry, Director of Offender Services and Reintegration, described this as an intensive therapeutic and cultural setting for Aboriginal women at DPFC.[467]

511. This appears to be consistent with Dr Jones' view that it is appropriate for there to be access to traditional healing methods to promote social and emotional wellbeing for prisoners, access to Elders, and access to cultural ceremonies.[468]

512. Ms Robinson said that there was better recognition across all their contracted health service providers about the risks associated with metabolic syndrome and several providers had been working on a range of strategies to better track and monitor that issue which required a holistic approach.[469]

513. Ms Robinson also highlighted a greater emphasis in their new requirements for a multidisciplinary approach to care but also considered that this had been driven by their new health service providers. In addition, there is a desire to work more collaboratively, both with

[465] Statement of Susannah Robinson, CB at 4399-4401.
[466] The AHU has been developed with the input of the Victorian Aboriginal community, including the Aboriginal Justice Caucus, community members, Aboriginal organisations, Aboriginal women with lived experience and Aboriginal staff working in prisons to ensure delivery of the project objectives. The principle of self-determination has driven the design and delivery of the AHU.
[467] Statement of Anna Henry, CB at p.2363-2364.
[468] T1964 L12-30.
[469] T1865 L22 – T1862 L2.

other health practitioners but also with the custodial staff, to ensure that there is greater coordination and integration of the supports provided to patients.[470]

Forensicare

514. Forensicare, rather than the primary health care provider, now conducts the initial mental health screens at reception of a new prisoner at DPFC. This means, for instance, that a document such as the Crole report would now be available and accessed on reception (via Forensicare's PMI system) and the information would be considered as part of the initial mental health screen.

515. Since June 2021, referrals from CCA to Forensicare at DPFC are received by Forensicare's Clinical Coordinator who triages referrals and books appointments between the patient and a Forensicare clinician. Prior to June 2021, when Heather was primarily receiving services, CCA was responsible for making appointments for patients referred to Forensicare.

516. The Clinical Coordinator manages the waiting list, triages the referrals and can be the contact for the primary mental health service if queries or urgent issues/cases need discussion. The Clinical Coordinator position is a RPN4 level (registered psychiatric nurse).[471]

517. In addition, Forensicare now have weekly out-patient meetings, which are multidisciplinary in nature, with the primary health care provider. Western Health representatives (nurse practitioners, managers, coordinators and mental health nurses and service manager) and Forensicare, including its psychiatry service attend the meetings. They involve discussion of patients, like Heather at the point of referral back to primary care and the referral was entered on JCare.

518. Forensicare advised that there is a commitment, as part of the Aboriginal Mental Health Traineeship model, to the continuous employment of Trainees, who undertake degree-level

[470] T1884 L8-15.
[471] Supplementary statement of Kate Roberts, dated 17 January 2024, CB at p.3425.

study and supported work placements. Forensicare have also established the role of *Mental Health Clinician – Transition Support*. This position is specifically designed to enable the ongoing employment of an Aboriginal Mental Health Trainee, who has successfully completed the traineeship, including work placements and academic study.[472]

519. It was noted that Forensicare also remains committed to its Aboriginal Social, Emotional and Wellbeing Approach (including Board commitment) to the delivery of services.[473]

PAROLE

Parole Process

520. The APB is an independent statutory authority established under section 61(1) of the *Corrections Act 1986* (Vic). Pursuant to section 74, the APB may order that a prisoner, serving a prison sentence in respect of which a non-parole period was fixed, be released on parole.

521. While on parole, a prisoner is still serving their sentence and may be returned to custody to complete their sentence if they fail to comply or present an unacceptable risk to the community.

522. Section 73A of the *Corrections Act 1986* requires the APB to give paramount consideration to the safety and protection of the community in determining whether to make or vary a parole order, cancel a prisoner's parole or revoke the cancellation of parole.

523. Prisoners become eligible for release on parole on their Earliest Eligibility Date (**EED**), this is the end of the non-parole period determined by the sentencing court. An EED marks the minimum period of time a prisoner must spend in custody before they are eligible for release.

524. Prisoners are eligible to apply for parole 12 months prior to their EED.

525. Following consideration of a parole application, if the APB decides to progress to a Parole

[472] Supplementary statement of Kate Roberts, dated 17 January 2024, CB at p.3422.
[473] Ibid.

Suitability Assessment (**PSA**), the Community Correctional Services (**CCS**) must prepare and submit a PSA to the APB. The PSA must be submitted no later than five months before the expiry of the prisoner's sentence to allow the APB to make a decision about the prisoner's parole application.

526. A PSA is described as a comprehensive report designed to assess an eligible prisoner's suitability for release on parole. The PSA provides information about a prisoner's program participation, previous compliance and community-based dispositions, criminal history, their assessed level of risk of general re-offending and/or risk of violent or sexual re-offending, attitude towards their offending, behaviour in custody, proposed accommodation plan, identification of any protective factors and plans for transition. Based on all information available, the PSA will also include a recommendation on the prisoner's suitability for parole and recommend conditions to manage their risks whilst on parole.

527. Prisoners who are defined as serious violent offenders or sex offenders (**SVoSO**), and who have applied for parole, are also considered by a second parole division, and are generally required to demonstrate satisfactory prison behaviour for at least the second half of their custodial sentence and, to have satisfactorily completed offence-specific treatment, if assessed as suitable for such treatment.[474]

528. In addition to the PSA, the APB also considers information provided by other sources such as, the reasons for sentence; material obtained from the courts about the offences for which a custodial sentence was imposed the structure of the sentence, reports available to the sentencing court; a Victorian criminal history; information about a prisoner that is recorded in the PIMS which is generally used by prison staff to record information about prisoners such as incidents that occur in prison and the testing of a prisoners for drug and alcohol use;

[474] In July 2013, Ian Callinan AC prepared a Review of the Parole System in Victoria in response to serious re-offending by parolees in the community, Mr Callinan made wide-ranging recommendations which led to significant changes to the Victorian parole system and the APB, which included (among other things): Higher thresholds were introduced to determine parole suitability for prisoners classified under legislation as SVoSO. These thresholds included mandatory completion of recommended offence specific programs and satisfactory prison behaviour (**SVoSO threshold**). All prisoners must have a suitable accommodation plan post release.

submissions by victims, and assessment from Corrections Victoria Intelligence Unit.

Parole supports provided to prisoners

529. Jenny Roberts (**Ms Roberts**), Executive Director, Community Operations and Parole (**COP**)[475] advised the Court that the work done to progress an application for parole is coordinated by dedicated staff within each prison whose role it is to administer the Parole Coordination Functions (**PC Functions**). PC Functions includes providing correct information and advice to ensure all prisoners are well informed and have the relevant information about applying for parole.[476]

530. According to Ms Roberts, it is an expectation that prisoners are kept informed and are supported by the staff involved in the PC Functions throughout the entire parole application process up to the determination of their application.. Additionally, information and advice should be provided to prisoners in relation to what step they are up to in their parole application process. Whilst there is no set frequency for when that occurs, prisoners are kept informed at each step of their parole application process.[477]

531. In addition, the Court was advised that there were Assessment and Transition Coordinators (**ATCs**) whose roles included facilitating prisoner risk of re-offending and transition needs assessments, providing information, advice and support to prisoners and prison staff (particularly prison Case Workers) throughout the parole application and the parole assessment process.[478]

532. Ms Roberts further advised that Case Management Review Committee meetings are also a key mechanism to proactively engage prisoners throughout their sentence via a structured review process that allows for effective monitoring, pro-social role modelling, clearly

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[475] Justice Service Division with the Corrections and Justice Services (**CJS**) business unit at DJCS CB at p.3295 – 3305, statement dated 15 December 2023.
[476] Statement of Jenny Roberts, CB at p.3296.
[477] Ibid.
[478] Statement of Jenny Roberts, CB at p.3297-3298.

articulated expectations and encouragement or support for prisoners to address their criminogenic needs while in custody.[479]

533. Ms Roberts said that staff administering the PC Functions do not assess the suitability of an address proposed by a prisoner for parole, but confirm that the address exists to enable CCS to assess the suitability of that address.[480]

534. Referrals are available for housing assistance and prison-based housing workers are funded by DFFH and are employed by community housing organisations.[481]

535. Once a prisoner progresses to the PSA stage, the prisoner is allocated to the CCS office closest to the proposed address and is assigned a CCS practitioner to undertake the assessment.[482]

536. Ms Roberts advised that the PSA processes and expectations are reiterated during the introductory meeting between the assigned CCS practitioner and the prisoner, to provide full transparency regarding the process. Specific due dates are not provided to the prisoner or their family and other support networks - this is because the parole process is dynamic and dependent on ensuring CCS has all the information necessary for the APB to be able to make a decision. She said that whilst CCS will work towards ensuring a PSA report is submitted prior to a prisoner's EED, this is an indicative date only.[483]

537. In terms of timeframes, Ms Roberts said that on the basis that a prisoner has applied for parole 12 months before their EED, the recommended timeframes at the time of Heather's incarceration were that between six and 10 months before the EED, an initial introduction meeting with the prisoner is recommended to provide information about the PSA process and expectations. It was noted that, CCS officers are encouraged to explore at this stage accommodation options to ascertain if there are any early indications of concerns about the

[479] Ibid.
[480] Statement of Jenny Roberts, dated 15 December 2023, CB at p. 3300.
[481] Ibid.
[482] Statement of Jenny Roberts, dated 15 December 2023, CB at p.3304.
[483] Ibid.

proposed accommodation that may contribute to its unsuitability.[484]

538. At four to six months before EED, interview(s) with the prisoner occur. During this stage, the prisoner is informed of the process following the completion of the parole assessment interview.[485]

Heather's sentence and parole

539. On 4 May 2020, His Honour Judge Sexton delivered his sentence in the County Court (after a sitting of the Koori Court Division).[486] Heather pleaded guilty to one charge of armed robbery and one charge of making a threat to inflict serious injury.

540. Judge Sexton observed that Heather had *genuinely* participated in the '*shaming' aspect* of the sentencing conversation, that she had been *fully and emotionally invested* in that process and took responsibility for her actions.[487]

541. The Reasons for Sentence noted that Heather told police that she was very high on *'Ice'* at the time of the offending.[488] With respect to her drug use history, she provided information that she commenced using heroin at approximately 21 years of age and after some four years switched to amphetamines.[489] Previously her longest sentence of imprisonment was 53 days, imposed at the Dandenong Magistrates' Court on 9 July 2018.[490]

542. Judge Sexton noted that each of Heather's children had been removed from her care, with the youngest only a few days after she gave birth and commented,

in what I imagine to be most traumatic circumstances for you.

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[484] Ibid.
[485] Ibid.
[486] *DPP* v *Calgaret* [2020] VCC 673, heard on 24 February 2020 and date of sentence on 4 May 2020, CB at p. 3687-3706.
[487] *DPP* v *Calgaret* at [39], CB at p. 3698.
[488] *DPP* v *Calgaret* at [10], CB at p.3679.
[489] *DPP* v *Calgaret* at [22], CB at p.3692.
[490] *DPP* v *Calgaret* at [24], CB at p.3694.

You have reported some suicidal thoughts following the removal of [your youngest child] *from your care*.[491]

543. Forensic psychologist, Jeffrey Cummins, provided an opinion to the sentencing court that Heather suffered from a Trauma and Stressor Related Disorder in the form of an Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, likely triggered as a result of her *dysfunctional upbringing, subsequently exacerbated by the removal of* [her] *children* and in his opinion, her condition required urgent mental health treatment.[492] Mr Cummins considered that *it is improbable* [she would] *be provided with appropriate mental health treatment whilst incarcerated*.[493]

544. Judge Sexton recorded in the Reasons for Sentence,

Given the particular circumstances of your case, and in particular given your hardship in custody due to the reasons I have outlined, and notwithstanding some concerns arising out of the pre-sentence report regarding your recent behaviour in prison, I will impose a sentence that facilitates your rehabilitation through a structured transition to the community, and allows for a substantial period of supervision once you are back in the community, should you be granted parole. For these reasons, I am imposing a more substantial than usual parole eligibility component in the sentence I am about to impose. There will be a considerable gap between the head sentence and the non-parole. Whilst ultimately it is not a matter for me, I recommend that whilst in custody, you be given access to culturally appropriate programs that will best assist your reintegration into the community, and that preparing for a supported return to the community on parole be considered an important part of planning for your release.

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[491] *DPP* v *Calgaret,* at [25], CB at p.3694.
[492] *DPP* v *Calgaret*, at [34], CB at p.3696 referencing the pre-sentencing psychological report of Jeremy Cummins, dated 12 February 2020.
[493] *DPP* v *Calgaret*, at [37], CB at p.3697 referencing the pre-sentencing psychological report of Jeremy Cummins, dated 12 February 2020.

I make it clear that in sentencing you a term of imprisonment with a non-parole, I am not making a prediction in relation to parole. I am simply sentencing you on the basis that a term of imprisonment with a parole eligibility component is, in my view, the most effective means of achieving the sentencing purposes I have earlier described.[494]

545. Heather received a total effective sentence of two years and four months' imprisonment in respect of which a non-parole period of 14 months was fixed. A period of 188 days was declared as served by way of pre-sentence detention.[495]

Heather's Parole Journey

546. Following the sentence imposed on 4 May 2020, Heather's EED was 27 December 2020. Her sentence was expected to expire on 27 February 2022 - her Earliest Discharge Date (**EDD**).[496].

547. On 12 May 2020, Heather completed a parole application which was received by the APB on 26 May 2020. The APB referred the parole application to CCS for the preparation of a PSA on 4 June 2020.[497]

548. The timeframe between the sentence date (4 May 2020) and Heather's EED (27 December 2020), gave a limited timeframe for the completion of a PSA by the CCS..

549. In addition, as Heather was classified as a SVoSO she was required to be screened and/or assessed by Forensic Intervention Services (**FIS**). The FIS assessment report, dated 11 November 2020, indicated that Heather posed a high risk of violent re-offending. It set out a number of recommendations, including that she undertake the Talking Change and See Change programs.[498]

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[494] *DPP* v *Calgaret,* at [48]-[49], CB at p. 3704-3705.
[495] *DPP* v *Calgaret,* at [51], CB at p.3705.
[496] As of 12 October 2021, Heather would have become eligible to be released on parole on 27 December 2020, and the sentence of imprisonment she was serving would expire on 16 February 2022, due to the granting of Emergency Management Days by the Secretary.
[497] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4493-4494.
[498] T1824 L21-24, *see also* Supplementary statement of Jenny Roberts, CB at p.4494.

550. In November 2020, Heather's case was transferred from Dandenong to Pakenham/Cranbourne CCS after her mother moved house and consequently, Heather's proposed parole address changed.[499]

551. Given Heather experienced delays accessing the treatment programs she was required to undertake, she wrote a letter outlining her wish to be released to seek custody of her children from Child Protection and requested that she complete the required programs in the community. The letter was addressed: *To Parole* and was dated 11 April 2021:[500]

To whom it may concern

My name is Heather Calgaret and I am a prisoner at Dame Phyllis Frost Centre. My CNR is 212994. I was sentenced to a total of 2 years and 4 months imprisonment. I currently have 10 months of my sentence remaining. I was given a non parole period of 14 months.

My earliest was December 27th 2020.

Have been told in order to get my parole I need to complete the 'sea change' program. As Dame Phyllis Frost Centre are not running any sessions for this I don't believe I should suffer when I can complete the programme out in the community. I have 4 children that need me. I believe I have suffered enough. Can you please give me the opportunity to complete the "Sea Change" program in the community. I have been complying with all my programs. I have completed my 24 hour caraniche program also. I have been incident free for approximately 9 months and I have never returned a positive urinalysis test. I guess what I'm trying to say is if DPFC is not running the "Sea Change" program is there any possibility of completing this on the outside (in the community) or is there any other alternative for me in order to get my parole sooner than rather than later?

I also need to be released as Department of child protection are trying to order my children to Ward of the state, I need to fight to get my kids back. But by doing that I need to be released from prison. I believe I shouldn't be doing more of a sentence when it's the prison system that is holding me back from getting Parole.

Very recently I have been diagnosed with type 2 diabetes. In order to get my diabetes under control I need to see the correct medical professionals being in Prison makes this very difficult as wait times are longer. Unless an escort is pre organised there is a high chance of appointments not being attended to which then raises my stress and anxiety levels also. Is

[499] Supplementary statement of Jenny Roberts, CB at p.4494-4495.
[500] WestCASA records, CB at p.3899-3901.

there any chance of getting my parole earlier if there is no sea change program that seems to be the only thing holding me back?

..someone can please read and answer my letter

I would be very grateful.

552. Heather's request was not forwarded to the APB or otherwise considered by FIS.[501]

553. On 9 July 2021, the APB received an intelligence assessment from the Corrections Victoria Intelligence Unit.[502]

554. On 21 September 2021, an Environmental Scan was completed which indicated that the accommodation proposed by Heather was deemed unsuitable, and the concerns identified could not be appropriately mitigated through parole conditions. In addition, that Heather *report*ed that she had no alternative accommodation options in the community.[503]

555. The PSA was also completed on 21 September 2021 which indicated that Heather was not considered to be a suitable candidate for parole as she had not proposed suitable accommodation and she had not completed her required treatment program.[504] At that time Heather was engaged in the See Change Program, which was due to be completed on 5 November 2021.[505]

556. On 23 September 2021, the APB received the PSA.[506]

557. On 5 October 2021, the Tier 1 division of the APB considered Heather's application. It recommended that parole be granted subject to conditions, including a period of intensive

[501] Heather's letter *To Parole* is not in the Adult Parole Board file provided to the Court.
[502] Supplementary statement of Jenny Roberts, CB at p.4496.
[503] Adult Parole Board File, CB at p.3764 and p.3768.
[504] Adult Parole Board File, CB at p.3758..
[505] Heather completed the recommended treatment programs six days before she passed.
[506] Supplementary statement of Jenny Roberts, CB at p.4496.

parole beginning on 1 December 2021, following the completion of the See Change Program.[507]

558. On 12 October 2021, the SVoSO Tier 2 division of the APB considered Heather's application and determined not to grant parole because there was no suitable accommodation and, in those circumstances, Heather's identified risks were not able to be managed on parole. They also determined there was insufficient time remaining on Heather's sentence to address the issue of suitable accommodation and to provide for *a meaningful period of parole*.[508]

559. At the time, Heather had approximately 4 months remaining on her sentence..

560. By letter dated 13 October 2021, Heather was advised that her application for parole had been denied.[509]

Parole documentation

561. Heather's Adult Parole Board File formed part of the documentation before the Court, which included the Reasons for Sentence from Judge Sexton.

562. Documentation reflected that Heather experienced intergenerational trauma, which was exacerbated by all her children being removed from her care. It noted that when Heather's child was being removed from her care at two days old, the clinician observed this to be distressing for Heather, with Heather describing it as *hell*[510] and that *she experienced debilitating sadness ….* [was] *suffering from nightmares of hearing her children crying*.[511]

563. Heather's long history of substance abuse including alcohol, cannabis and methamphetamine was also documented.

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[507] Statement of Fatima Ebrahim, Acting Secretary and Acting Chief Administration Officer of the APB, CB at p.3414.
[508] Ibid, *see also* Adult Parole Board File, CB at p.3709 and p.3794.
[509] Adult Parole Board File, CB at p.3794.
[510] Adult Parole Board File, Corrections Victoria, Forensic Intervention Services, Assessment Report, November 2020, CB at p.3726.
[511] Adult Parole Board File, Corrections Victoria, Forensic Intervention Services, Assessment Report, November 2020, CB at p.3727.

564. Heather reported at an early stage of the parole process, in 2020, that her partner would be residing at the same address upon his release from prison. Upon raising the prospect of the ABP not approving the couple to reside together, she reported that he was her *shadow* and that they would continue to see each other daily.[512].

565. From 21 July 2021, Heather undertook the Talking Change Program and completed it on 4 August 2021.[513]

Parole Suitability Assessment Guidance at the time of Heather's incarceration

566. The guidance document *Preparing for a Parole Suitability Assessment, Parole Case Management,*[514] provided that *Aboriginal Serious Violent Offenders* should be prioritised for allocation to Aboriginal Parole Officers with Aboriginal generalist parolees to follow.[515]

567. The guidance document *Interviewing for Parole Suitability Assessment, Parole Case Management*,[516] noted that during the interview with the parole applicant, it is likely that they will discuss their post release plans, including accommodation and co-residents and that being proactive in these discussions with a prisoner may assist in minimising the requirement for additional reports should accommodation options fall through during the process or they are overtly unsuitable.[517] The guidance document advised that practitioners should encourage the prisoner to consider if there are *additional addresses that could be assessed alongside the first proposed address* to reduce the possibility of delays in the PSA process.[518]

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[512] Adult Parole Board File, Corrections Victoria, Forensic Intervention Services, Assessment Report, November 2020, CB at p.3728 and p.3732.
[513] Adult Parole Board File, Corrections Victoria, Forensic Intervention Services, Assessment Report, November 2020, CB at p.3728 and p.3739.
[514] CCS PG 6.2.1 - Preparing for a Parole Suitability Assessment, v.1, dated December 2018, CB at p.4159-4172.
[515] CCS PG 6.2.1 - Preparing for a Parole Suitability Assessment, v.1, dated December 2018, CB at p.4164.
[516] CCS PG 6.2.2 - Interviewing for a Parole Suitability Assessment, v.1, 3, dated December 2018, CB at 4173-4183.
[517] CCS PG 6.2.2 - Interviewing for a Parole Suitability Assessment, v.1, 3, dated December 2018, CB at p.4178.
[518] CCS PG 6.2.2 - Interviewing for a Parole Suitability Assessment, v.1, 3, dated December 2018, CB at p.4178.

568. It was further noted that if the prisoner is a SVoSO, the practitioner can contact Corrections Victoria Intelligence Unit and request that two addresses are assessed.[519]

569. According to the guidance document *Writing Comprehensive Parole Suitability Assessment Reports, Parole Case Management,*[520] PSA reports must be submitted to the APB no later than five months prior to the EDD, regardless of whether all of the information has been obtained.[521]

570. It further noted that if the accommodation is deemed unsuitable, the report provides space for practitioners to outline:

a. Steps the prisoner has taken to find suitable accommodation,

b. What options, if any, remain,

c. What future planning is required for the prisoner to secure accommodation.[522]

571. In addition, as a Practice Point, it noted,

Throughout the assessment process, practitioners are encouraged to discuss accommodation options with prisoners.[523]

[519] *See above* n 515, CB at p.-4179.
[520] CCS PG 6.2.3 - Writing Comprehensive Parole Suitability Assessment, Reports, v.2. 11 March 2020, CB at 4184-4209.
[521] CCS PG 6.2.3 - Writing Comprehensive Parole Suitability Assessment, Reports, v.2. 11 March 2020, CB at p.4187.
[522] CCS PG 6.2.3 - Writing Comprehensive Parole Suitability Assessment, Reports, v.2. 11 March 2020, CB at p.4192.
[523] Ibid.

Other reviews of Heather's parole application

Justice Review parole assessment

572. The Justice Review[524] identified that there were *multiple compounding issues*[525] which delayed Heather's parole application, including,

a. Heather was only able to complete her recommended treatment programs six days before she passed, despite a requirement that treatment programs start within six months of a positive eligibility assessment. By this stage, her EED for parole had been surpassed by approximately 11 months and her EDD was less than three months away; [526]

b. in total, CCS sought eight extensions to complete Heather's PSA and when the APB refused to grant the eighth extension in September 2021, CCS completed and submitted the PSA prior to Heather completing her required treatment program; [527]

c. from the beginning of Heather's parole application, she was clear that her intended parole address would be with her mother and brother. This was also discussed with FIS during her assessment in October 2020 where she reported that both she and her partner would reside at her mother's house following their release from custody. Heather's proposed address to reside while on parole was ultimately deemed unsuitable, however, CCS did not sufficiently support her to identify a suitable alternative; [528]

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[524] Justice Assurance and Review Office, Department of Justice and Community Safety, *Review into the passing of Ms Heather Calgaret at Sunshine Hospital on 29 November 2021* (**The Justice Review**), dated 1 November 2023, CB at p.3310-3409.
[525] The Justice Review, CB at p.3319
[526] The Justice Review, CB at p.3370.
[527] The Justice Review, CB at p.3320.
[528] The Justice Review, CB at p.3378-3379.

d. despite being reviewed by FIS staff in July 2020, Heather was not assessed and deemed eligible to participate in the required programs until October 2020, with her assessment report completed in November 2020; [529]

e. Heather's participation in programs was delayed by the COVID-19 pandemic, challenges associated with transitioning programs online and insufficient demand to run the courses. Her recommended treatment program, See Change for Women, was rescheduled on two occasions and she was required to complete the prerequisite program, Talking Change, which further pushed back her commencement. The programs ultimately started in July 2021 and August 2021, eight and nine months, respectively, after Heather was deemed eligible. This was 12 months after her case was first reviewed by FIS staff. At the time, the FIS metrics required that treatment programs start within six months of a positive eligibility assessment;

f. despite Heather being allocated a Senior Parole Officer in June 2020, they did not engage with her until November 2020 and this contact was poorly documented. Given the process typically takes around six months to complete, the Senior Parole Officer should have engaged with Heather sooner to build rapport and better prepare her PSA; [530]

g. a new Senior Parole Officer was assigned to her in December 2020 following her mother moving house and Heather's parole address changing, but they did not contact Heather until March 2021 and this contact was also poorly documented. It was also the only contact Heather had with this Senior Parole Officer until her PSA was completed in September 2021; [531]

h. in April 2021, Heather sent a letter to CCS asking that she be allowed to complete her treatment programs in the community. The Justice Review identified several

[529] The Justice Review, CB at p.3319.
[530] The Justice Review, CB at p.3320.
[531] The Justice Review, CB at p.3320.

opportunities for better engagement, including not responding to her request and not referring her request to the APB. This meant she was not informed of the decision to not progress her request to the APB or given the opportunity to decide on any further actions she might take based on this information. In addition, CCS did not ask FIS about the feasibility of Heather completing her treatment programs in the community. The Senior Parole Officer believed that there were no suitable treatment programs available to women in the community. FIS has confirmed that Heather's recommended treatment programs were in fact available in the community via Zoom, however, there may have been delays in accessing them; [532] and,

i. with respect to not progressing Heather's request to undertake the required programs in the community to the APB, that while the Senior Parole Officer held legitimate concerns about meeting the SVoSO PSA threshold, decisions about granting parole or not and where treatment is completed, are ultimately a matter for the APB. [533]

573. The Justice Review further noted with respect to DJCS's commitment to Aboriginal self-determination, that it is evident that more could have been done to better engage Heather in decision making about her parole and that better engagement would have allowed Heather to be more informed and ultimately exercise self-determination. [534]

574. It was also noted that the availability of the required FIS treatment programs was better for men than for women have less availability of FIS programs in custody. [535]

575. In addition, as there had never been a funded Aboriginal Parole Officer role within the broader Southeast Metropolitan Region, Heather could not be allocated to one. However, the Justice Review noted that at the Dandenong CCS, Heather's first Senior Parole Officer did work collaboratively with an Aboriginal Case Manager but that at no other point in Heather's parole

[532] The Justice Review, CB at p.3320.
[533] The Justice Review, CB at p.3220.
[534] The Justice Review, CB at p.3381.
[535] The Justice Review, CB at p.3220.

application process, was comparable cultural expertise engaged to support either Heather or her Senior Parole Officer. [536]

576. The Justice Review further noted that it was very difficult for any prisoner to move through the required treatment pathway if their sentencing occurred with less than 12 months before their EED and it was not possible for CCS to submit Heather's PSA three months before the EED as required by policy. [537]

577. According to the Justice Review, the most significant delay occurred within the intervention phase. As already noted, Heather's recommended treatment programs were rescheduled and the earliest did not start until eight months after her assessment for suitability was endorsed. [538]

578. To respond to FIS program delivery problems, the *CCS PSA Practice Guideline* provides actions to be taken where there is no capacity for a program to be delivered. However, in Heather's case, FIS was never advised by CCS that there was no capacity for Heather's programs to be delivered and CCS could not write to the APB without this advice. As already noted, FIS confirmed that Heather's recommended treatment programs were available in the community from the end of 2020 via Zoom, however, there may have been delays in accessing these programs. [539]

579. The Justice Review further noted that whilst offence specific programs for SVoSOs are expected to be completed in custody, the APB can consider a parole application for an offender who has not completed their mandated programs in circumstances where they were unable to (and not because they refused to). The APB considers each parole application on its own merits and relies on information contained in PSAs, which include information on completion of programs, and if any programs can be completed in the community. FIS may

[536] The Justice Review, CB at p.3377 and p.3381.
[537] The Justice Review, CB at p.3370.
[538] The Justice Review, CB at p.3374.
[539] The Justice Review, CB at p.3374 and p.3320.

also provide supporting advice on the availability of offence-specific programs in the community.[540]

580. I am grateful for the analysis contained in the Justice Review regarding these matters.

Expert advice

581. To further consider the appropriateness of the management of Heather's parole application, I was assisted by an expert panel comprising Associate Professor Amanda Porter,[541] Associate Professor Crystal McKinnon,[542] and Karen Fletcher, Executive Officer, Flat Out Inc.[543]

582. In their joint report, Associate Professors Porter and McKinnon[544] (**Porter-McKinnon Report**) and separately, Ms Fletcher identified similar issues with the management of Heather's parole as those identified in the Justice Review.

583. The Porter-McKinnon Report identified the following concerns,

a. Heather's nominated housing should have been discussed much earlier;

b. There was no investigation into alternative housing;

c. Concerns raised in Heather's letter dated 11 April 2021 were not taken seriously, or escalated;

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[540] The Justice Review, CB at p.3380.
[541] *See* Porter-McKinnon Report, CB at p.4076. A/Prof McKinnon is an associate professor of criminal law and criminology with over fifteen years experience in research and teaching racial discrimination law, with a specialisation in Indigenous deaths in custody.
[542] *See* Porter-McKinnon Report, CB at p.4076. A/Prof Crystal McKinnon is an Amangu Yamatji historian and associate professor in history, law and justice. A/Prof McKinnon has experience in Aboriginal community sector organisation ;and is currently serving on the board of the Victorian Aboriginal Legal Service and steering committees for the Law and Advocacy Centre for Women and the Dhadjowa Foundation.
[543] *See* Expert Report of Ms Karen Fletcher, Ms Fletcher is an Australian legal practitioner with twenty-seven years experience in administrative, human rights and public health law, particularly in a prison context.
[544] *See* Porter-McKinnon Report, CB at p.4076.

d. There was a failure to investigate alternative options to undertake the required treatment programs in the community;

e. There was a failure to seek cultural expertise of Aboriginal Case Managers;

f. There was a failure to take steps to engage Heather and to encourage her participation in the process;

g. Heather met infrequently, and belatedly, with her first Senior Parole Officer;

h. Heather met infrequently with her second Senior Parole Officer;

i. There was a failure to proactively engage with Heather's mother;

j. There was a failure to provide support following the outcome of Heather's parole application; and

k. Generally, the issue of timeliness and adherence to the required timeframes regarding Heather's parole application**.**

584. The Porter-McKinnon Report noted that in the thirty years since the RCIADIC, Indigenous incarceration rates have *increased* and at the time of their reports, Indigenous peoples in Australia were incarcerated at the highest rate of any people in the world.[545] In addition, they noted that in Victoria over the past decade the number of Aboriginal women in prison had grown by over 400%.[546]

585. Associate Professors Porter and McKinnon referred to Yoorrook's report which observed that large numbers of Aboriginal and Torres Strait Islander prisoners did not receive parole:[547]

[545] Porter-McKinnon Report, CB at p.4081.
[546] Porter-McKinnon Report, CB p.4080.
[547] Porter-McKinnon Report CB at p.4085.

Yet, Aboriginal people are less likely to be granted parole than non-Aboriginal prisoners. This outcome suggests that First Peoples experience indirect discrimination in the operation of the parole system. This is contrary to the right to equality before the law and to be protected from and against discrimination in the Charter. Over the last five years, while the proportion of eligible Aboriginal people applying for parole has been higher than that of the overall eligible population, the proportion of decisions to grant parole (of the total of all decisions) remains consistently lower for Aboriginal people. In 2021–22, the rate was 50.5 per cent compared to 65 per cent of decisions overall. This denies Aboriginal people the benefits of parole, increases the risk of reoffending and contributes to over-imprisonment, as more Aboriginal people will be in prison for longer.

As a result of reforms in 2013 which made it harder to get parole, the number of people accessing parole has fallen significantly. The Legal and Social Issues Committee Inquiry reported that between 2009–10 and 2019–20 the proportion of people released from prison on parole declined from 30 per cent to six per cent of all discharges from custody. It recommended that the Victorian Government evaluate the impacts of parole reforms on community safety outcomes. It also recommended that the Victorian Government ensure the Adult Parole Board can appropriately determine applications for parole from people who have been unable to complete prerelease programs due to limited availability. The Victorian Government has not yet formally responded to the inquiry's recommendations.

Submissions to Yoorrook identified many barriers to gaining parole. These include lack of timely access to offence-specific programs while in prison, as well as lack of adequate and secure accommodation in the community. These challenges are even more acute for Aboriginal women, because they experience greater difficulty accessing pre-release programs deemed necessary to be considered for parole.[548]

[548] Porter-McKinnon Report, CB at p.4085 citing Yoorrook Justice Commission, *Yoorrook For Justice: Report into Child Protection and Criminal Justice Systems,* dated August 2023,: at p372-374 (citations omitted).

586. The Porter-McKinnon Report also detailed that the issue of timely access to offence-specific programs had been identified consistently within the academic and policy literature as representing a major obstacle to parole, and it also recognised that there is a shortage of offence-specific programs.[549] Further, they noted that a similar and related issue is the long waiting lists for screening and assessment *to determine program suitability and treatment needs*[550] which they indicated disproportionately affects Aboriginal people, for reasons which include that since incarcerated Aboriginal people are more likely to serve shorter sentences which makes it harder to access pre-release programs because of the long wait times.[551]

587. The Porter-McKinnon Report stated that the failure to seek out the cultural expertise of Aboriginal case managers and personnel in Heather's case represented a *significant missed opportunity*. This was in addition to Heather not being referred for immediate support following the denial of her parole application.[552]

588. Reference was also made to the management of Heather's parole in the context of the stated commitment of relevant government agencies to AJA4 including Aboriginal self-determination; as well as Recommendation 119 of the RCIADIC (replicated above).[553]

589. It was Associate Professors Porter and McKinnon's opinion that,

> *….Parole Officers need to ensure they are seeing the people assigned to them in* [a] *timely fashion in order for them to meet the requirements for parole, and that this work is being monitored and they are accountable when they are not meeting their duties. They hold the liberty of people they are seeing in their hands; the management and outcome of Ms. Calgaret's parole has been a lethal failure.*[554]

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[549] Porter-McKinnon Report, CB at p.4087.
[550] Porter-McKinnon Report, CB at p.4088.
[551] Ibid.
[552] Porter-McKinnon Report, CB at p.4091-4092.
[553] Porter-McKinnon Report, CB at p.4090-4091.
[554] Porter-McKinnon Report, CB at p.4101.

590. Ms Fletcher noted in her report, that Heather's sentence created a shorter than usual period for the necessary steps in the parole application process to take place – just under 8 months. Whereas Correction Victoria's policies, procedures, guidelines and metrics for the process, particularly on the SVoSO pathway, are based on a 12-month period.[555]

591. Ms Fletcher referenced the Commissioner's Requirement 2.6.1 - *Parole Application Process* (November 2020) which states, at paragraph 3.3:

> *Section 21 of the Charter of Human Rights and Responsibilities Act 2006 protects a person's right to liberty and security of person and prescribes that a person must not be subjected to arbitrary detention. As such, the parole application process must occur in a timely manner and not prevent or delay the APB's consideration of a prisoner for parole.* [Emphasis in Ms Fletcher's report][556]

592. She commented that, seemingly no one, of the many Corrections Victoria officers involved, was responsible for co-ordinating the steps of the highly complex Serious Violent Offender Pathway to ensure they were timetabled and carried out in a timely way.[557]

593. Ms Fletcher noted that Heather's sentence was intended to *facilitate* [her] *rehabilitation through a structured transition to the community, and allow for a substantial period of supervision once* [she was] *back in the community, should* [she] *be granted parole* and in her opinion, that intention was defeated by Corrections Victoria, and particularly CCS', failure to appropriately manage the parole application process.[558]

594. She noted that a key purpose of the PSA introductory meeting is *to explore accommodation options … and if there are any early indications of concerns with the property that may*

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[555] Expert Report of Karen Fletcher, CB at p.4121.
[556] Expert report of Karen Fletcher, CB at p.4122 citing Corrections Victoria, *Commissioner's Requirement 2.6.1 'Parole Application Process'*, dated November 2023 and accessible at: Commissioner's Requirements - Part 2 | Corrections Victoria.
[557] Expert report of Karen Fletcher, CB at p.4121.
[558] Expert report of Karen Fletcher, CB at p.4121 quoting *DPP* v *Calgaret*, Judge Sexton's Reasons for Sentence delivered on 4 May 2020 at [48].

contribute to its unsuitability with respect to the delay in alerting Heather to the serious concerns about the suitability and considered that the delay in alerting Heather to the concerns about the suitability of her mother's address seriously reduced the time available to address those concerns or secure an alternative accommodation option.[559]

595. Ms Fletcher further noted that the PSA interview is central to the preparation of the PSA by CCS and is often the only opportunity for an applicant to speak to their application in person and as such, in her opinion. the failure by CSS to conduct, or to adequately conduct or document a PSA interview with Heather, or perhaps even to communicate with her at all after that first introductory interview with the Dandenong CSS Senior Parole Officer, was not merely a failure to follow a *practice tip* but was a serious breach of CCS responsibility in the parole system and arguably a breach of Heather's human rights under the Victorian Charter.[560]

596. Ms Fletcher reiterated that problems with the availability of treatment programs in the Victorian corrections system are longstanding. She also stated that the problem has been the subject of many reviews, investigations and attempts at reform over the last decade but it persisted.[561]

597. Consistent with the Justice Review, Ms Fletcher noted that there is a more serious lack of available programs for women in prison in Victoria because of the much smaller numbers of women in the system compared to men, there are far fewer clinicians are employed to run women's programs, and facilities are sparse. In her experience, programs at DPFC are routinely cancelled or delayed because there are either insufficient numbers of participants for them to go ahead or no rooms or clinicians available.[562]

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[559] Expert report of Karen Fletcher, CB at p.4117 quoting statement of Jenny Roberts, CB at p.613.
[560] Expert report of Karen Fletcher, CB at p.4117.
[561] Expert report of Karen Fletcher, CB at p.4120.
[562] Expert report of Karen Fletcher, CB at p.4121.

598. Ms Fletcher noted that in 2020/21 the problems were significantly exacerbated by COVID-19 because many programs, facilities and activities at all prisons closed down and it took some time for programs to be made available online.[563]

599. Ms Fletcher noted that Heather was subject to many risk assessment processes using a range of actuarial tools and that there is a significant body of academic literature on race and gender bias affecting the risk assessment tools used in corrections environments.[564]

600. In her opinion many of the factors that led to Heather being scored at a *high risk of serious violent offending* (family violence, intergenerational trauma, child removal, financial hardship, healthcare discrimination, housing instability and homelessness) stemmed from her Aboriginality and gender.[565]

601. Further, Ms Flecther advised that it was her opinion that Heather's fears about the permanent removal of her children were well founded and likely based on legal advice about the *permanency* provisions introduced to Child Protection legislation in 2015/16 which provide that a parent whose child is removed by Child Protection has 12 months to meet protection concerns in order to be reunified with their child. In exceptional circumstances, this may be extended to 24 months (sometimes referred to as the *12/24-month reunification rule*).[566]

602. Given that Heather's daughter was born in October 2019, Ms Fletcher considered that Heather would have been aware that under the *12/24-month reunification rule* there was an escalating risk she would be permanently removed from her care if was she not released to parole on or soon after her EED.[567]

603. Ms Fletcher considered that,

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[563] Expert report of Karen Fletcher, CB at p.4121.
[564] Expert report of Karen Fletcher, CB at p.4127 and p.4129.
[565] Expert report of Karen Fletcher, CB at p.4129.
[566] Expert report of Karen Fletcher, CB at p.4132.
[567] Ibid.

... it is striking that Heather's separation from her children - particularly her newborn daughter - and [Judge Sexton's] *reasons for sentence relevant to that separation, were not properly considered, or indeed considered at all, by CCS officers managing her application. Heather raised the issue at every available opportunity but those opportunities were few, and were also frustrated by mismanagement, for example by the failure to pass on her letter of 11 November 2021 to the APB and to conduct an adequate Parole Suitability Assessment interview.*[568]

604. Ms Fletcher considered that Heather's status as an Aboriginal mother with a history of intergenerational child removal (her mother was also removed from her family) and family trauma, and the real risk of permanent removal of her newborn daughter and young sons, should have been considered in the management of her parole application process.[569]

605. She noted that when the APB was finally provided with the information they needed to make a decision on Heather's application for parole, their reason for refusal included that she did not have suitable accommodation.[570]

606. In their 2021-22 Annual Report, the APB reported that *lack of suitable accommodation* was the most common reason for refusal of parole, contributing to 54% of all decisions to refuse parole that year. They also observed that 26% of applicants who withdrew their parole applications did so because they did not have suitable accommodation.[571]

607. Ms Fletcher stated that Heather should have been able to access independent legal information, advocacy and support to navigate the SVoSO parole application process. She suggested that workshops, template letters and documents and individual advice and assistance, for example to request access to alternative programs or programs in the

[568] Expert report of Karen Fletcher, CB at p.4132.
[569] Expert report of Karen Fletcher, CB at p.4133.
[570] Expert report of Karen Fletcher, CB at p.4134.
[571] Expert report of Karen Fletcher, CB at p.4134 citing the Adult Parole Board, *Annual Report 2021-22*, dated September 2022 and accessible at: adultparoleboard.vic.gov.au/system/files/inline-files/Adult_Parole_Board_Annual_Report_2021-22.pdf.

community where required programs are not available in the prison or to request to appear before the APB, may assist future applicants in a similar position.[572]

608. Ms Fletcher also referred to the *precipitous* decline in grants of parole overall over the last 20 years, particularly to women, and especially to Aboriginal women, In 2006-2007, 26% of women leaving prison were released on parole. By 2020-2022, grants of parole had fell to just 4% of discharges.[573]

Aunty Lynn's view on accommodation on release

609. Aunty Lynn said that housing on release from prison was difficult for women, and she advocated for a halfway house where the women could go, where they could see their family and gradually *learn how to interact with each other again* to avoid the cycle of fights (which she referred to as the *merry go round*) starting over again. She said that there were places for men to go on release but *nothing for the women to go to.* She said that motel accommodation was not *good enough*.[574]

Responses from FIS, CCS and CV

610. According to its Director, Alfie Oliva (**Mr Oliva**), FIS is a specialist program area of CV that provides individuals in custody and in the community with offence-specific, evidence-based screening, assessment and intervention services to support their rehabilitation.[575].

611. For a woman assessed as a high risk of violence such as Heather, the See Change program is the offence specific program offered by FIS which targets violence. It is typically delivered in two 2.5-hour sessions a week over a three-month period. The Talking Change Program is

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[572] Expert report of Karen Fletcher, CB at p.4123.
[573] Expert report of Karen Fletcher, CB at p.4124 referencing Corrections Victoria, *Annual Prisoner Statistical Profile 2006-7 to 2018-19*, table 3.10 – All Prisoner Discharges, by Sex and Discharge Type, *and* Corrections Victoria *Annual Prisons Statistical Profile 2012-13 to 2021-22*, table 3.10 – All Prisoner Discharges by Sex and Discharge Type.
[574] T36 L10-29, T37 L19-20.
[575] At the time of his statement ne was the Acting Assistant Commissioner, Custodial Operations, CV, DJCS, CB at p.4464- 4471

an introductory group-based program designed to prepare people for participation in more intensive treatment programs.

612. The purpose of FIS programs and in particular, the See Change Program is to reduce risk which provides for the safety and protection of the community.

613. The See Change Program is available to female prisoners and can be delivered in the community, however eligibility is determined by factors including sentence length and sentence status, amongst other things. The See Change Program is the only violence specific program available for women.[576]

614. Mr Oliva advised that participant numbers impact on when a program commences but does not otherwise impact eligibility.[577].

615. Regarding Heather's experience during her parole application, Mr Olivia said that the use of FIS staff for additional duties related to COVID-19[578] reduced the capacity of FIS to deliver its full suite of programs as quickly and efficiently as was the case prior to the imposition of the additional COVID-19 adaptations and, that the issues and constraints were widely experienced across the prison population during the pandemic.[579].

616. He said that prior to COVID-19, every program delivered by FIS was done face-to-face and treatment had never before been delivered remotely.[580]

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[576] Statement of Alfie Oliva, CB at p.4468.
[577] Ibid.
[578] In March 2020, the State of Victoria went into lockdown due to directions issued by the Chief Health Officer in response to the COVID-19 pandemic. In total across 2020 and 2021 there were six lockdowns of varying intensity: 30 March 2020 to 12 May 2020, 8 July 2020 to 27 October 2020, 12 February 2021 to 17 February 2021, 27 May 2021 to 10 June 2021, 17 July 2021 to 27 July 2021 and 5 August 2021 to 26 October 2021.
[579] Statement of Alfie Oliva, CB at p.4468-4469.
[580] Statement of Alfie Oliva, CB at p.4469.

617. Mr Olivia said he recognised that there was a long period of time between the completion of Heather's assessment on 11 November 2020 and her recommended treatment programs commencing but could not specifically say what contributed to the length of that period,

save for it being an unprecedented time and there being unprecedented demand for services with the priority and directive being the safety and wellbeing of the prison population who were throughout 2020 and 2021 subject to extreme lockdowns.[581]

618. He further accepted that the performance metrics in force at the time were not met and the periods of delays were as stated in the Justice Review.[582]

619. Mr Olivia also indicated that there are specific and unique issues faced by the female prison population in relation to eligibility for programs, because many serve sentences of less than 18 months (which is the minimum sentence requirement to be able to complete treatment with FIS). In addition, the relatively small number of participants in the female prison population can make the scheduling of the treatment programs more difficult (for example, there being insufficient women to reach the minimum participant quota).[583]

620. Ms Roberts, on behalf of CCS, also added that the progression of parole applications may have been delayed due to the unavailability of video conferences for CCS staff to interview prisoners in custody (due to lockdowns), and complicated further by needing to remotely assess accommodation.[584]

621. She confirmed that the ATC Coordinator at DPFC emailed Heather's letter requesting that she complete the See Change Program in the community to her Senior Parole Officer on 12 April 2021.[585]

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[581] Statement of Alfie Oliva, CB at p.4470.
[582] Statement of Alfie Oliva, CB at p.4470-4471.
[583] Statement of Alfie Oliva, CB at p.4471.
[584] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4493.
[585] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4495.

622. In relation to the management of Heather's parole application, Ms Roberts accepted that CCS should have taken a more proactive role in engaging with Heather throughout the PSA process and that in *hindsight,* there were missed opportunities and delays by both of [Heather's] parole officers.[586]

623. Ms Roberts further accepted that CCS had the opportunity to engage with Heather on more than the two occasions between June 2020 and March 2021, and that such contact should have occurred at the point of her case being allocated to the initial Senior Parole Officer, upon the reallocation of her case to the second Senior Parole Officer, and, in response to Heather's letter in April 2021.[587]

624. With respect to accommodation, Ms Roberts advised that the women's prison population has far more limited options for post release accommodation on parole than the men's prison population, consistent with the evidence of Aunty Lynn.[588]

625. Ms Roberts disagreed with the suggestion that CCS should have told Heather earlier that her mother's accommodation would be considered unsuitable, saying that *a critical part of the parole process is the need to objectively consider all information and to then weigh up whether the proposed property would assist in mitigating risk* and further that the assessment as to the suitability of any property needs to be contemporaneous.[589]

626. Ms Roberts said however that *best practice* would suggest that discussions with Heather regarding why properties may be found unsuitable generally (such as evidence of drug use or violence amongst co-residents is likely to deem a property unsuitable, etc) could have been held earlier and Heather could have been encouraged to consider alternative accommodation options.[590]

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[586] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4496
[587] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4497
[588] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4498.
[589] Supplementary statement of Jenny Roberts, dated May 2024, CB at p.4499.
[590] Ibid.

627. Ms Roberts said that there was nothing CCS could have done to progress parole for Heather as she was waiting for required programs to be completed (the intervention phase). It was noted that the only time at which CCS would go to the APB to consider alternatives is when a program could not be delivered before the end of the sentence.[591]

628. Mr Oliva accepted that it is probably not adequate if something outside of the control of a prisoner impacts on their ability to apply for parole or be granted parole, or if there is a delay in the process.

629. It was noted that for SVoSO, it takes about 18 months to get through the whole pathway, which means there is a mismatch, with shorter non-parole periods.[592]

630. A/DC Hosking, on behalf of Corrections Victoria, when asked whether she would accept that there is a significant problem if people cannot have their applications for parole considered at the time a sentencing judge determined that they should be eligible for consideration, responded in the affirmative and stated,

…. I think it is a problem and I think there is a number of people for whom some of those restrictions won't apply. That is, those people who are assessed as eligible to do their treatment programs in the community. So where the risk that they pose, there's not the requirement to mitigate that risk by treatment in order for them to be in the community. They can get their treatment in the community essentially.[593]

631. A/DC Hosking further stated that she accepted that the mismatch had the potential to undermine the integrity of a sentence imposed and stated,

I think the courts have an expectation that people will - when they set a non-parole period will have a period of supervised release into the community and the - the functions and the structures and the decisions of the board and the expectations of the [Adult Parole] board

[591] T1832 L17-22.
[592] T1819, L13-24.
[593] T1935 L25-T1936 L6.

sometimes make that difficult to achieve. –There is - and some of the - the expectations are difficult to be met when there is a short period between the sentencing and the end of the non-parole period.[594]

Conclusions regarding Heather's parole application

Limits of Inquiry

632. It is important to note at the outset that a review of the parole system was beyond the scope of my coronial investigation. This investigation was limited to the matters outlined in the scope, following consideration of the Justice Review.

633. I noted as part of my determination to include these issues that Heather's parole decision in and of itself did not *directly* cause Heather's passing. Ultimately, whether parole is granted in a matter for the APB, and a sentencing judge clearly has no power regarding whether a person is paroled.

634. However, it was apparent on the material provided prior to the commencement of the inquest, that CCS and Corrections Victoria have a significant role in the management and course of an individual's parole application. Whether and how a parole application progresses has the potential to impact on a person's continuing incarceration and all that flows from being in the custody of the State. I further noted that the continuing over-representation of Aboriginal people in custody, also heightens the need for and significance of examining the issues that were included.

635. There was also further evidence that during Heather's last case management session on 5 November 2021, she stated she had lost motivation for anything positive. She had low tolerance, was concerned with behaviour regulation and was having regular thoughts about using drugs and attributed her lack of motivation to being denied parole.[595]

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[594] T1936 L15-23, T1934 L5-8.
[595] Local Plan File Notes, CB at p.1547.

Conclusions regarding Heather's parole application

636. I have considered the analysis of the Justice Review, which was endorsed by the expert panel of Associate Professors Porter and McKinnon and Ms Fletcher, and I agree and adopt the conclusions reached which are already outlined in detail.

637. In summary, numerous issues of concern were identified with the management of Heather's parole application. There was a lack of adherence to relevant metrics; poor and limited engagement by CCS parole officers; poor documentation kept by CCS parole officers; a lack of cultural engagement in the process; significant delays in the FIS component of parole preparedness - in particular the lack of availability of required treatment programs; and Heather did not receive sufficient support to identify suitable accommodation on her release.

638. Particularly concerning was the lack of appropriate action in response to Heather's letter requesting that she undertake the required treatment program in the community, given its continued unavailability. The letter disclosed Heather's desire to be reunited with her children, noting in particular her concern about the Child Protection rule (*12/24-month reunification rule*) in relation to her youngest child, as well as her recent diagnosis of diabetes and difficulty obtaining appropriate treatment. Her communication was particularly relevant given the required program was in fact available in the community via Zoom from the end of 2020 (noting however that there may have been delays in accessing the programs).

639. In addition, as the Justice Review and experts identified, this was also inconsistent with commitments made to the self-determination of Aboriginal people in the justice system by DJCS, noting that Heather did not receive a response to her letter.

640. There is also no evidence before the Court to suggest that the matters set out in the Reasons for Sentence of Judge Sexton about Heather's history and circumstances, nor the matters raised in her correspondence, were actively considered in the management of her parole application. Proactive engagement with Heather as well as appropriate cultural engagement, may have allowed for this to have occurred.

641. Heather was denied parole because her housing was deemed unsuitable and there was insufficient time for her to find suitable housing. Despite having placed her mother's address on her parole application on 12 May 2020, there is no evidence that CCS raised concerns about this address or discussed alternatives with Heather prior to her housing being found unsuitable on 21 September 2021.

Management of parole and the sentencing process

642. As noted by Counsel Assisting and Ms Fletcher, the sentence imposed by Judge Sexton was designed to facilitate Heather's rehabilitation through a structured transition to the community and allowed for a substantial period of supervision once she was back in the community, should she be granted parole. His Honour determined that, in light of Heather's particular circumstances, including the hardship she faced in custody, he would impose a *more substantial than usual parole eligibility component in the sentence*.[596]

643. Counsel Assisting further noted,

> *In formulating a sentence, Judges draw together a large body of evidence, subject it to application of complex sentencing law, apply an instinctive synthesis and impose a sentence that is just in all the circumstances. The sentencing judge in Heather's case also had the benefit of the Koori Court process and input from judicial [E]lders. In his Honour's judgment, Judge D. Sexton applied a particularly short non-parole period so that Heather would have the opportunity of facing the APB for consideration of parole which, if approved, would give her supervised re-integration into the community and a chance at reunification with her children.*[597]

644. In Heather's case it appears that the delays in the preparation of her PSA spanned 16 months because the relevant treatment programs were not available.

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[596] *DPP* v *Calgaret*, at [48], CB at p.3704.
[597] Closing Submission Behalf of Counsel Assisting, dated 14 July 2024, at p.72 [421].

645. The evidence suggests that if a person is required to complete treatment programs to be considered for parole, the application process will take approximately 18 months. If a person is not required to complete treatment programs in order to be considered for parole, but is in the SVoSO stream, the application process will take approximately 12 months.

646. Heather was eligible to be considered for parole seven months after her sentence was imposed. Under these timelines, her application was never going to be considered by the APB before her EED.

647. The inquest heard that it is not uncommon for a person to be sentenced to a term of imprisonment with a parole period and become eligible to be considered for parole much sooner than the applicable 12 or 18 month timeframe to achieve paroles readiness, particularly after the deduction of pre-sentence detention. Counsel Assisting made submissions that, in these circumstances it appears that the operation of the PSA and the availability of treatment programs in particular, may make it impossible to give effect to some sentences imposed by judicial officers which is significant for the operation of the criminal justice system. That is, it risks undermining the integrity of sentences imposed, which as noted above, was accepted by A/DC Hosking.[598] In addition, it may reduce the availability of a period of supervision while on parole which is an essential component to the management of community safety and the rehabilitation of an offender.[599]

648. I note however that relevant legislation provides that in sentencing an offender, a court must not have regard to,

> *any possibility or likelihood that the length of time actually spent in custody by the offender will be affected by executive action of any kind.*[600]

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[598] Closing Submission Behalf of Counsel Assisting, dated 14 July 2024, at p.71 [413] citing T1936.
[599] Closing Submission Behalf of Counsel Assisting, dated 14 July 2024, at p.71 [413] citing T1810–1811.
[600] *Sentencing Act 1991* (Vic), section 5(2AA)(a).

649. Submissions on behalf of DJCS, in response to a proposed recommendation *designed to improve judicial understanding of administrative timelines which are capable of impacting the implementation of judicial sentences*, including *notification of any delays in treatment programs which an offender might be required to complete before being considered for parole*, advised the Court that, *senior departmental staff have regular meetings with key court stakeholders to discuss a range of issues, including the parole process*.[601]

Availability of required treatment programs and accommodation

650. Issues related to the availability of treatment programs and accommodation were also reflected in evidence before Yoorrook, which reported:

> *Submissions to Yoorrook identified many barriers to gaining parole. These include lack of timely access to offence-specific programs while in prison, as well as lack of adequate and secure accommodation in the community. These challenges are even more acute for Aboriginal women, because they experience greater difficulty accessing pre-release programs deemed necessary to be considered for parole.*
>
> *In evidence to Yoorrook, DJCS acknowledged the 'disparity between parole applications for Aboriginal prisoners compared to non-Aboriginal prisoners and that more could be done to support Aboriginal people to apply for parole'.*
>
> *Corrections Victoria also admitted there is unmet demand for post-release programs, and that in particular 'finding safe, sustainable housing for people getting out of prison is one of the biggest challenges'.*[602]

651. In addition, it appeared broadly reported, that the unavailability of required treatment programs is commonly known to affect women more acutely than men. This was regardless of the impact of COVID-19. The evidence was that treatment programs run by FIS are less

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[601] Submissions of The Secretary to the Department of Justice and Community Safety, dated 30 August 2024, at [19].
[602] Yoorrook Justice Commission, *Yoorrook for Justice* (4 September 2023), p.374. Accessible at: Yoorrook-for-justice-report.pdf.

frequent for women because there are fewer women required to complete them, compared to their male counterparts, and men may complete FIS programs at one of 13 locations, female offenders have only two options - DPFC and Tarrengower.[603] A prisoner's security ratings, placement classifications and program availability are all factored into decisions on when and where programs are completed.

652. The Justice Review also noted that in the context of the availability of the required treatment programs, women have less availability of FIS programs in custody than male prisoners.[604]

653. Questions regarding how DJSC consider section 8 of the Charter, *Recognition and equality before the law*, in the context of the availability of required treatment programs based on the sex of a prisoner were not canvassed at inquest, although I raised this matter during oral submissions.

654. Clearly, equality in this context, is particularly important in circumstances where the programs are 'required', and access (or lack of it) has the potential to impact a person's liberty.

655. Heather's letter is insightful regarding the issue of program availability. She says that she shouldn't *suffer* because the required programs were not being run, and that she should not be further incarcerated when the prison system was not supporting her to do the programs.

656. Counsel Assisting noted that for Heather,

> *There was a cruel Kafkian circularity in the requirement that Heather complete a particular program before facing a parole decision, where no such program was in fact available*.[605]

[603] The Justice Review, CB at p.3380.
[604] The Justice Review, CB at p.3320.
[605] Closing Submission Behalf of Counsel Assisting, dated 14 July 2024, at p.73 [425].

657. Ms Fletcher commented that seemingly no one at Corrections Victoria, of the many officers involved, was responsible for coordinating the steps to ensure they were timetabled and carried out in a timely manner.[606]

658. The Court was advised that specific due dates were not provided to the prisoner, their family and other support network and that whilst CCS will work towards ensuring a PSA report is submitted prior to a prisoner's EED, the timeframes are only indicative.[607]

659. In these circumstances, there is potential to create a divergence of expectations between the sentenced prisoner who has an EED, and the CCS who are managing the parole process.

660. In any event, there is relevant guidance for the *parole application process* in the Commissioner's Requirement 2.6.1 - *Parole Application Process* which includes a statement that,

> *Section 21 of the Charter of Human Rights and Responsibilities Act 2006 protects a person's right to liberty and security of person and prescribes that a person must not be subjected to arbitrary detention. As such, the parole application process must occur in a timely manner and not prevent or delay the APB's consideration of a prisoner for parole.*[608]

661. In addition, there is recognition by DJCS that Aboriginal and Torres Strait Islander people are over-represented in the corrections system and a commitment by DJCS to reduce such over-representation. And further, recommendation 199 of the RCIADIC provides that Aboriginal prisoners should not be denied opportunities for parole based on staff or infrastructure availability, which in my view invites a commitment for appropriate resourcing to support opportunities for parole. Given the stated commitments by DJCS and acknowledgement of

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[606] Expert report of Karen Fletcher, CB at p.4121.
[607] Statement of Jenny Roberts, dated 15 December 2023, CB at p.3304.
[608] Expert report of Karen Fletcher, CB at p.4122 citing Corrections Victoria, *Commissioner's Requirement 2.6.1 'Parole Application Process'*, dated November 2023 and accessible at: Commissioner's Requirements - Part 2 | Corrections Victoria.

the recommendations of the RCIADC, a reasonable inference would be that these matters would also be relevant to the *parole application process*.

662. Clearly, parole is not a right and is not guaranteed. However, a reasonable expectation would be that treatment programs that are required to be undertaken, are in fact available – and, that their availability is not unreasonably dependant on the sex of the applicant.

Changes to Parole process

663. Since Heather's passing, a new Women's Intervention Team has been formed at FIS which focuses on offence-specific service delivery. The Team's remit has been expanded to include the delivery of offence-related, trauma-informed programs to women (both sentenced and on remand) at DPFC and Tarrengower.[609]

664. The Court was also advised that a two-year pilot would be conducted across CCS locations in the 2023-24 financial year which would involve four Aboriginal Professional Practice Advisors being deployed across four CCS regions.

665. In addition, the Court was advised that the Parole Central Unit was undertaking a review of PSAs to identify system blockages impacting the progression of reports to the APB and at the time of the advice, it identified key themes contributing to delays, with the most significant factors being a lack of suitable housing and completion of treatment. As a result of the findings, further work was occurring to strengthen guidance around CCS' submission of PSAs in these key areas and to establish a Parole Practice Committee to support parole practice oversight and continuous improvement.

666. In addition, planned updates to practice guidance will reiterate the benefit of timely engagement with prisoners who have applied for parole and introducing further guidance relating to the extension of PSA.

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[609] Statement of Alfie Oliva, CB at p.4471.

OPIATE REPLACEMENT THERAPY

Introduction and relevant terms

667. Opioid Replacement Therapy is a form of pharmacotherapy where drugs are used in the treatment of opioid dependence – such as heroin.

668. Opioid Agonist Therapy (**OAT**) is the contemporary name for Opioid Substitution Therapy Program (**OSTP**) and/or Medicated Assisted Treatment for Opioid Dependence (**MATOD**).

669. Buprenorphine is a prescription opioid used to treat opioid dependence and chronic pain.

670. Authorised prescribers (such as a medical practitioner) may prescribe buprenorphine (brand name **Suboxone**) in sublingual form (under the tongue)[610] sometimes referred to as *strips*, or buprenorphine in a long-acting injectable form referred to as **LAIB** (brand name **Buvidal**).

671. The Victorian Drug and Alcohol Clinical Advisory Service (**DACAS**) is a 24-hour specialist telephone consultancy service operated by Turning Point. DACAS is designed to assist health and welfare professionals with the clinical management of drug and alcohol problems. The service helps these professionals to respond to a variety of clinical scenarios involving drug and alcohol issues, within generalist settings, in a supportive and appropriate way.

Heather's Opioid Replacement Therapy

672. Heather's JCare records document that Heather first requested Suboxone on 12 April 2021, whilst being reviewed by Dr Chowdhury.[611]

673. On 20 June 2021, a Medical Request Form was completed by Heather requesting, *OSTP Doctor Please*.[612]

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[610] Sublingual is a commonly used in pharmacology to describe a route of administration where substances dissolve and are absorbed into the bloodstream through the tissues beneath the tongue.
[611] JCare electronic medical records, CB at p.260-261.
[612] JCare electronic medical records, CB at p.662.

674. On 24 June 2021, Heather was reviewed in the OSTP Clinic by RN Duong.[613] Patients are first assessed by a RN to see if they satisfy the eligibility criteria, and if so, are referred for an assessment by a OSTP prescriber such as a medical practitioner.

675. RN Duong indicated in her evidence that the criteria used for assessment was the CCA Policy Number 12.3, entitled *Opioid Substitution Therapy Program* dated May 2021.[614] She was, however, also familiar with The Victorian Prison Opioid Substitution Therapy Program dated 2015, and the Justice Health policies in relation to OSTP.[615] She further indicated that there were training sessions provided by CCA when the long-acting injectable form of buprenorphine (**LAIB**) was introduced into DPFC. RN Duong had obtained a certificate in Alcohol and Other Drugs Skill Set by completing a short course run by Odyssey House to be an OSTP Nurse.[616]

676. At the appointment with Heather on 24 June 2021, RN Duong recorded in the JCare records that Heather requested Suboxone to enable her to be *stabilised* and *to prevent her from using unprescribed Suboxone in prison*. She reported a drug history of heroin addiction since the age of 13 and stated that she had been using Suboxone in prison, with her last use one month earlier (*1/12 ago*).[617]

677. Heather also told RN Duong that she had been on community pharmacotherapy comprising Suboxone in 2017, but was unable to recall the name of the prescriber and dispensing pharmacy. She advised that the clinic where the prescribing clinician was located was at the Dandenong & District Aborigines Co-Operative Limited (**Dandenong Co-op**).[618]

678. RN Duong noted that based on her review of Heather's JCare file, there was no history of opioid addiction documented and that her primary drug of use was amphetamine. She

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[613] JCare electronic medical records, CB at p.254.
[614] T331 L28-29; T339 L5-16; *see CS12.3 Opioid Substitution Therapy Program (May 2021-2023),* CB at p.2087.
[615] T331 L24-T332 L6.
[616] T333 L4-7; Statement of Nhung Duong, CB at p.1227.
[617] JCare electronic medical records, CB at p.254.
[618] Ibid.

documented that Heather was not appropriate for OSTP eligible assessment at that time. She documented a plan which included to obtain collateral information from the Dandenong Co-op to substantiate that Suboxone had been prescribed for opioid replacement therapy, and to obtain drug urinalysis results from Correction Victoria to establish the existence of any positive results for unprescribed Suboxone. Heather's application would be assessed when the further information was available.[619]

679. RN Duong understood during this appointment that Heather was seeking Suboxone strips. At inquest she said that she explained to Heather that as part of the OSTP it was not recommended to prescribe an opioid to someone who did not have a history of opioid dependence, as it could create another drug dependence.[620]

680. On 25 August 2021, Aunty Lynn filed a Medical Request Form on Heather's behalf indicating that Heather *wants to go on Suboxone*.[621]

681. On 27 August 2021, Heather attended with RN Millson at the OSTP Clinic. Heather was still unable to provide further details of the prescribing clinician and pharmacy as had been requested and was advised that information was still required to ascertain opiate use in the community. Heather said she would try to get the information and put in a request when she had it.[622]

682. On 20 October 2021, during a medical review with Dr Goonetilleke about unrelated matters, Heather asked about Suboxone and Dr Goonetilleke advised her that she had discussed the request with the OSTP Nurse who said they were awaiting the details of her community GP.[623]

683. On 4 November 2021, RN Duong reviewed Heather's file as part of her role in the OSTP

[619] Ibid.
[620] T338 L4-9.
[621] JCare electronic medical records, CB at p.658.
[622] JCare electronic medical records, CB at p.248.
[623] JCare electronic medical records, CB at p.243.

Clinic. Heather had stated at her earlier appointment that she had been prescribed OSTP community pharmacotherapy Suboxone in 2017 by a clinician at the Dandenong Co-Op. However, the response from the Dandenong Co-Op was that there was no pharmacotherapy prescribed for opioid addiction. In addition, Heather had no positive urine results recorded by Correction Victoria while in custody. RN Duong concluded that there were no indicators of her using non-prescribed drugs in prison and she was not eligible for OSTP. [624]

Registered Nurse Duong's Assessment of Heather for OSTP

684. On 9 November 2021, RN Duong saw Heather at an OSTP Clinic appointment where she noted that Heather had lodged a medical request to commence OSTP via LAIB prior to her release in February 2022. RN Duong documented that Heather had reported a history of heroin use, and mostly self-access to non-prescribed Suboxone in the community. RN Duong informed Heather that she did not meet the criteria for OSTP as she had no diagnosis of heroin dependence recorded - only of amphetamine - and no opioid withdrawal pack was prescribed upon reception.[625]

685. In addition, collateral health information received from the community disclosed that no OSTP was prescribed nor was there a diagnosis of opioid dependence. No urinalysis undertaken by Correction Victoria detected drugs and no intravenous *track marks* were noted on her arms or legs. Heather reported she had used by shared intravenous equipment twice in prison and *occasionally* accessed unprescribed Suboxone or illicit substances in prison. Heather was adamant that she would immediately return to drug use post release if she was not given a chance to commence on OSTP and stated she had not reported her opioid use on reception to prison, because of embarrassment and fear of judgement.[626]

686. Heather also said she was prescribed OSTP in Western Australia, but RN Duong noted that this was not mentioned in her previous OSTP assessment in June 2021. RN Duong suggested

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[624] JCare electronic medical records, CB at p.240-241 and at p.1230-1231.
[625] JCare electronic medical records, CB at p.238-239.
[626] Ibid.

a referral to community Alcohol and Other Drug (**AOD**) services post release, but Heather declined and insisted that she be placed on OSTP prior to her release to prevent her from drug relapse. RN Duong advised Heather she would make an appointment for her with an OSTP medical practitioner to further assess and to make recommendations for OSTP commencement. RN Duong observed that based on her drugs history, there was very limited validity to Heather's self-reported use of opiates and opiate dependence. RN Duong's documented plan was for a medical practitioner's comprehensive assessment or, advice from an AOD specialist to rule out drug seeking behaviour and misuse prior to commencing on the OSTP.[627]

687. RN Duong said that she did not use or complete the Assessment Form included in the Victorian Prison Opioid Substitution Therapy Program Guidelines 2015 as Heather did not meet the criteria to commence the program.[628]

688. RN Duong indicated at inquest that as a result of her assessment Heather required a *thorough* assessment by a medical practitioner. She said that whilst a patient may report what they are using, you need objective health information including a history to make a *prescribing decision*, and that decision is for a medical practitioner to make. RN Duong agreed that *you must critically analyse what people are telling you* to support *safe practice*.[629]

689. RN Duong further indicated that after a physical examination she formed the opinion that what Heather was saying was likely to be inaccurate. She confirmed that any health professional can call DACAS, and that her reference to this service in her JCare documentation (*AOD specialist*) was to rule out drug seeking behaviour which would inform an assessment of whether OTSP was clinically indicated.[630]

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[627] Ibid.
[628] T375 L24-29, *See* Victorian Prison Opioid Substitution Therapy Program Guidelines 2015, 7.2 Appendix 2 Assessment Form, CB at p.1895.
[629] T349 L16-20, T368 L28-30.
[630] JCare electronic medical records, CB at p.238-239.

Dr Nath's Assessment of Heather for OSTP

690. On 19 November 2021 (10 days after RN Duong's assessment), Heather was reviewed by Dr Nath who documented the following in the JCare records:

OSTP - Considered
given that the Pt is in custody since mid 2019.
There isnt any physical signs of dependance
Seems Pt is comtemplating that she " might" start using
When having the consult with the Patient she tells that she is using every 3 -4 days ever since being in prison ? how
says is due for release in Feb 2022
Partner is on LAIB
says her crimes were related/ influenced to Drugs
Mx
> *Considered for Low dose OSTP*
> *based on the soical and community iompact of her using illict drugs -- decision is reached to consider her for the LAIB*
> *Pt understands the risks and the benefit of LAIB and is happy to proceed*
> *TOGETHER what she needs is Intensive psychological intervention from a psychologist specialing in Substance Use disorder or a psychiatrist*
> *Advised to have good control over her DM and other CVD risks*
- *MedChart: New Buprenorphine 8 mg/0.16mL Modified Release Solution for injection; 8 mg weekly Subcutaneous. 22/11/2021 - 21/03/2022.*

Regular - Short Term. Opiate/Opioid Substitution Therapy Program (OSTP)[631]

691. Dr Nath prescribed buprenorphine as OST in the injectable form, LAIB, and did not prescribe a period of stabilisation on sublingual Suboxone (strips).

692. Heather was the <u>first person</u> at DPFC to be prescribed the injectable form of buprenorphine without a period of stabilisation and the available evidence suggests that there have been no other patients prescribed LAIB without a period of stabilisation since.[632]

693. At 10.15am on 22 November 2021, RN Millson administered the LAIB in accordance with

[631] JCare electronic medical records, CB at p.238.
[632] T352 L19-27, T422 L5-11.

Dr Nath's prescription.[633]

694. At the time RN Millson administered the LAIB, she was unaware that Heather had not been stabilised on sublingual Suboxone (strips).[634] Dr Nath had not noted this in Heather's JCare records, nor was it communicated verbally or otherwise to the OSTP Clinic nursing staff.[635]

695. RN Duong confirmed at inquest that in November 2021 nursing staff would have assumed that when presenting for LAIB, Heather had already been inducted on Suboxone (strips), and therefore already had an appointment slip to return for observations later that day.[636]

696. RN Duong also said that if during the post dose monitoring a patient was scratching and vomiting, swaying as if intoxicated or sedated, or had restricted pupils, this would be reported to a medical practitioner.[637]

697. In addition, whilst Dr Nath's documented in JCare that Heather required *intensive psychological intervention*[638] from a psychologist specialising in substance use disorder or a psychiatrist, that note alone would not have triggered any sort of referral to the mental health care team. Dr Nath would have had to make a referral, noting that CCA did not provide psychology or psychiatry services.[639]

BUVIDAL PRODUCTION INFORMATION

698. The LAIB product prescribed by Dr Nath was *Buvidal*. The Product Information for Buvidal,[640] published by the TGA (**the Product Information**) notes the following amongst its boxed warnings:

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[633] JCare electronic medical records, CB at p.237.
[634] T654 L1-4.
[635] T658 L9-16.
[636] T408 L14-22.
[637] T382 L6-20.
[638] T654 L1-4.
[639] T1515 L26-T1516 L4.
[640] Therapeutic Goods Administration, Product Information, Buvidal® Weekly (buprenorphine) Solution for Injection, published 28 November 2018 and revised 17 January 2023 , CB at p.1297-1322.

Hazardous and harmful use

Although Buvidal Weekly is indicated for the treatment of opioid dependence it still poses risks of hazardous and harmful use which can lead to overdose and death. Monitor the patient's ongoing risk of hazardous and harmful use regularly during opioid substitution therapy with Buvidal Weekly.[641]

Life threatening respiratory depression

Serious, life-threatening or fatal respiratory depression may occur with the use of Buvidal Weekly. Be aware of situations which increase the risk of respiratory depression, and monitor patients closely, especially on initiation or following a dose increase.[642]

Concomitant use of benzodiazepines and other central nervous system (CNS) depressants, including alcohol

*Concomitant use of opioids with benzodiazepines, gabapentinoids, antihistamines, tricyclic antidepressants, antipsychotics, cannabis or other central nervous system (**CNS**) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Patients and their caregivers should be made aware of the symptoms of respiratory depression. Patients and their caregivers should also be informed of the potential harms of consuming alcohol while taking Buvidal Weekly.*[643]

699. Section 4.1 of the Product Information under *Therapeutic Indications* notes the following, *Buvidal Weekly is indicated for initiation and maintenance treatment of opioid dependence, with or without prior stabilisation on sublingual buprenorphine or buprenorphine/naloxone, within a framework of medical, social and psychological support.*[644]

700. Section 4.2 of the Product Information further notes the following with respect to *Dose and*

[641] The Product Information, CB at p.1297.
[642] Ibid.
[643] Ibid.
[644] The Product Information, CB at p.1298.

Method of Administration,

Administration of Buvidal Weekly is restricted to healthcare professionals. Buvidal Weekly is given by subcutaneous injection. Buvidal Weekly is indicated for initiation and maintenance treatment of patients with opioid dependence in patients who have been stabilised on treatment.[645]

701. A table is provided in the Product Information in a section entitled *Transitioning of patients from sublingual buprenorphine to Buvidal Weekly.* It indicates that patients *stabilised on sublingual buprenorphine or buprenorphine/naloxone* may be transitioned directly to Buvidal Weekly, starting on the day after the last daily sublingual treatment dose. The following table is provided for transition recommendations.

Table 1. Sublingual buprenorphine daily treatment doses and recommended corresponding doses of Buvidal Weekly and Buvidal Monthly[646]

Dose of daily sublingual buprenorphine	Dose of Buvidal Weekly	Dose of Buvidal Monthly
2-6 mg	8 mg	
8-10 mg	16 mg	64 mg

702. The Product Information includes a *Dependence* warning which notes that it can produce opioid dependence,
Buprenorphine is a partial agonist at the μ (mu)-opioid receptor and chronic administration can produce opioid dependence. Studies in animals, as well as clinical experience, have demonstrated that buprenorphine may cause dependence, albeit at a lower level than a full agonist (eg morphine).[647]

703. Section 4.9 of the Product Information concerns the potential for *overdose*, noting under the

[645] Ibid.
[646] The Product Information, CB at p.1299. Table reproduced in part only.
[647] The Product Information, CB at p.1303.

symptoms,

Respiratory depression, as a result of central nervous system depression, is the primary symptom requiring intervention in the case of buprenorphine overdose because it may lead to respiratory arrest and death. Preliminary symptoms of overdose may also include excessive sweating, somnolence,[648] *amblyopia, miosis, hypotension, nausea, vomiting and/or speech disorders.*[649]

704. With respect to *Pharmacokinetic Properties – absorption,* the following is noted,
*Buvidal Weekly is a modified release formulation of buprenorphine designed for administration by subcutaneous injection once a week. After injection, the buprenorphine plasma concentration increases with a median time to maximum plasma concentration (tmax) of about **24 hours.*** [emphasis added][650]

Department of Justice & Regulation Policies and Guidelines for Opioid Replacement Therapy

Victorian Prison Opioid Substitution Therapy Program Guidelines 2015, Department of Justice & Regulation

705. The *Victorian Prison Opioid Substitution Therapy Program Guidelines 2015, Department of Justice & Regulation* (**the 2015 Guidelines**),[651] provide that eligible prisoners, at high risk of opioid-related harm in prison or upon release to the community, may have an opportunity to begin treatment while in prison.
706. Prisoners who wish to commence OST while in prison will undergo an assessment to check eligibility.[652]

707. According to the Eligibility Checklist. Prisoners must:

- be diagnosed by correctional health service staff and the prison medical practitioner with

[648] Drowsiness
[649] The Product Information, CB at p.1311.
[650] The Product Information, CB atp.1315.
[651] Victorian Prison Opioid Substitution Therapy Program Guidelines 2015 (**the 2015 Guidelines**), CB at p.1858-1915
[652] *See* Eligibility Checklist at Appendix 1,the 2015 Guidelines, CB at p.1894.

an opioid use disorder according to the *American Psychiatric Association's Diagnostic Statistical Manual, Fifth Edition (DSM-V);* or continue to use illicit opioids in prison in a manner which constitutes a significant risk of harm; or be at significant risk of using opioids in prison or post-release;

- give voluntary informed consent to begin treatment in prison;
- have no outstanding court matters or release date for at least six weeks to ensure there is sufficient time to complete the assessment and stabilisation period before being released;
- have no unstable medical or psychiatric conditions; and,
- agree to abide by the rules of the program and have signed the Program Consent and Agreement Contract.[653]

708. Section 3.2 of the 2015 Guidelines, which is expressed in slightly different terms to the Eligibility Criteria, notes in relation to the eligibility of prisoners for the induction phase that induction is indicated for prisoners who:

    a. are opioid dependent at the time of imprisonment and not receiving treatment;

    b. continue to use opioids (licit or illicit) in prison in a manner which constitutes a significant risk of harm;

    c. are at significant risk of using opioids in prison or post-release.[654]

Low levels of neuroadaptation for OST

709. The 2015 Guidelines note that neuroadaptation (physical dependence) to opioids, shown by the development of tolerance and features of a withdrawal syndrome, does not have to exist for the diagnosis of opioid use disorder. However, caution must be taken when considering

[653] Ibid.
[654] The 2015 Guidelines, CB at p.1880.

prisoners with low levels of neuroadaptation for OST.[655]

710. The 2015 Guidelines further note that, given that most prisoners being assessed for the induction phase will have low levels of neuroadaptation, the treatment team (prison medical practitioner and OST nurse) must:

a. establish a history of prior opioid dependence.

b. identify how the potential benefits outweigh the potential disadvantages of OST.

c. consider alternative treatment options.

d. use caution when initiating treatment in prisoners with low levels of neuroadaptation.[656]

711. With respect to assessment principles and considerations, section 3.4 notes that the initial assessment of a person using opioid drugs should follow standard practice for assessment of a complex clinical condition and incorporate collateral information where appropriate.[657]

712. The section further notes that due to concerns about prisoners starting the induction phase without a history of opioid dependence, and the difficulties of assessing prisoners who have little or no neuroadaptation, the following assessment principles are recommended:

a. use collateral history to confirm previous episodes of opioid dependence;

b. potential risks and benefits of commencing methadone treatment should be identified and documented for each prisoner; and,

c. if there is doubt regarding the suitability of a prisoner for OST, consultation with an addiction medicine specialist or DACAS may be indicated.[658]

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[655] Ibid.
[656] Ibid.
[657] The 2015 Guidelines, CB at p.1881.
[658] Ibid.

713. The 2015 Guidelines provide that evidence of previous episodes of opioid dependence must be documented before a prisoner becomes eligible to start OST.[659]

714. The 2015 Guidelines further note however that whilst in general, the inability to confirm prior episodes of dependence would make a prisoner ineligible to start OST, in some circumstances where prior opioid dependence cannot be clearly established, and the prisoner is at risk due to opioid use, the decision regarding suitability for OST may need to be made in consultation with an addiction medicine specialist or DACAS. This includes cases where the prisoner:

    a. repeatedly uses opioids while in prison (as identified by clinical presentation and pathology results).

    b. is deemed to be at significant risk from their opioid use in prison.

715. The 2015 Guidelines emphasise that the primary indication for OST is opioid dependence but also that while neuroadaptation does not have to exist for a diagnosis of dependence, in practice, features of neuroadaptation can be assessed clinically, through:

    a. history – both from the prisoner and collateral history;

    b. examination – looking for:

        i. Appearance of withdrawal or intoxication;

        ii. Evidence of recent opioid or other drug use, e.g. injection sites;

        iii. Features of complications associated with heroin or injecting drug use, e.g. venous or systemic infections or hepatitis; and,

    c. investigations – in particular, the use of urine drug screens to identify recent drug

[659] Ibid.

use.[660]

716. The 2015 Guidelines further notes that a prisoner's history may not be reliable, either due to difficulties with memory, or the prisoner deliberately falsifying information to be accepted on to the Program.[661]

Justice Health Guidelines for LAIB

717. The *Practice Guidance for Long Acting Injectable Buprenorphine For health service providers – Justice Health*, dated 15 December 2020 (**Justice Health LAIB Practice Guidance**)[662] is said to complement the 2015 Guidelines but does not supersede the guidelines.

718. The Justice Health LAIB Practice Guidance indicates that in accordance with the 2015 Guidelines assessing risk remains pertinent. A review of history, conducting a current examination and analysis of collateral information *must* be conducted.[663]

719. The Justice Health LAIB Practice Guidance outlines that prisoners must be stabilised on sublingual buprenorphine or buprenorphine/naloxone for up to seven days prior to commencement to LAIB and, that they may be transitioned directly to Buvidal Weekly or Buvidal Monthly, starting on the day after the last daily sublingual treatment dose. Consistent with the Product Information noted above, transition recommendations are provided for in a table reproduced below.[664]

Table 1 Dosing Variations Sublingual film and LAIB

Dose of daily sublingual buprenorphine; suboxone	Dose of Buvidal weekly	Dose of Buvidal Monthly
< or equal to 6 mg	8 mg	No monthly equivalent

[660] The 2015 Guidelines, CB at p.1882.
[661] Ibid.
[662] Practice Guidance for Health Service Providers ‐ Long-Acting Injectable Buprenorphine, dated 15 December 2020, CB at p.1916 – 1940.
[663] Justice Health LAIB Practice Guidance, CB at p.1920.
[664] Justice Health LAIB Practice Guidance, CB at p.1922. Table not reproduced in full.

8-10 mg	16 mg	64 mg

720. The *Justice Health LAIB Practice Guidance* outlines that it is recommended that prisoners are placed on the sublingual film for up to seven days but notes that clinical trials have demonstrated that this timeframe can be reduced for those who are treatment familiar or who report recent use of illicit, diverted or unprescribed buprenorphine. This decision is up to the clinical discretion of the prescriber.[665]

721. Consistent with the product information, the *Justice Health LAIB Practice Guidance* notes that after subcutaneous injection, buprenorphine peak concentrations are observed approximately 24 hours after the Buvidal Weekly injection and that after the initial buprenorphine peak, the plasma buprenorphine concentrations decrease slowly to a plateau.[666]

722. The *Justice Health LAIB Practice Guidance* further provides that during the first week of initiation (whilst on sublingual buprenorphine), staff should ensure that prisoners return to the prison health service daily to be monitored by health staff for signs of intoxication (e.g. sedation, constricted pupils) or withdrawal symptoms, side effects, and other substance use.[667]

CCA POLICIES AND GUIDELINES FOR OPIOID REPLACEMENT THERAPY

723. CCA provided a suite of policies and guidelines around OST at DPFC, some of which are discussed below.

CCA - OPIOID SUBSTITUTION THERAPY PROGRAM, Section 12: Addiction and Dependency (OSTP)

724. The stated purpose of the CCA policy, entitled *Opioid Substitution Therapy Program* (**CCA**

[665] Ibid.
[666] Justice Health LAIB Practice Guidance, CB at p.1928.
[667] Ibid.

OSTP Policy),[668] is to provide clinical guidance and support for CCA health staff when a prisoner asks to be considered for OSTP in custodial facilities. It notes that the policy aligns with national directions and recommendations in accordance with the 2015 Guidelines.[669]

725. Relevant to this investigation, the CCA OSTP Policy provides that OST treatment with buprenorphine is appropriate for prisoners who:

    a. are receiving opioid substitution treatment at the time of coming into custody;

    b. are opioid dependent at the time of coming into custody and not receiving treatment;

    c. continue unsanctioned use of opioids in prison facilities in a manner which constitutes a significant risk of harm; and,

    d. are pre-release from prison facilities, due to high overdose risk for opioid users due to reduced tolerance.[670]

726. The CCA OSTP Policy notes that opioid substitution treatment is provided for prisoners to:

    a. reduce opioid-related harm;

    b. reduce withdrawal effects during transition from addictive drugs used prior to imprisonment;

    c. reduce the medical and mental health consequences of illicit use in a custodial facility including transmission of blood borne viruses among prisoners;

    d. prevent/reduce deaths associated with illicit opioid use in a custodial facility, and upon

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[668] Correct Care Australasia, Section 12: Addiction and Dependency (OSTP), Policy Number 12.3, *Opioid Substitution Therapy Program,* dated May 2021, CB at p. 2088-2095. References to Youth Justice have been removed.
[669] As well as the National Guidelines for Medication-Assisted Treatment of Opioid Dependence (2014); and *The Drugs, Poisons and Controlled Substances Act (1981)* and *Drugs, Poisons and Controlled Substances Regulations (2017)*.
[670] CCA OSTP Policy, CB at p.2090.

release to the community; and,

e. reduce the social consequences including drug related criminal activity after release from a custodial facility.[671]

CCA - Induction Program Opioid Substitution Therapy

727. The *CCA - Induction Program Opioid Substitution Therapy* guidance policy[672] (**CCA OSTP Clinical Guidance**) provides clinical guidance to CCA staff to assess and monitor patients who require or request to begin the OSTP while in a custodial facility.

728. The CCA OSTP Clinical Guidance provides that any patient requesting to commence on treatment while in a custodial facility must undergo a comprehensive assessment process to confirm suitability and that the clinical assessment process must include:

a. reason for seeking treatment;

b. drug use history (past and current);

c. physical and mental state examination;

d. investigations (e.g. ECG, pathology tests, urine drug tests, etc.);

e. diagnosis of substance use disorder; and,

f. assessment of other health and social issues.[673]

729. The assessment process comprises of three phases that health staff should conduct in a timely manner.[674]

730. Consistent with other policies already discussed, the CCA OSTP Clinical Guidance refers to

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[671] CCA OSTP Policy, CB at p.2091-2092.
[672] Section 12: Addiction and Dependency (OSTP), May 2021, CB at p.2114–2117.
[673] CCA OSTP Clinical Guidance, p.2114-2115.
[674] CCA OSTP Clinical Guidance, CB at p.2115.

an initial screening of a patient by nursing staff using the Eligibility Checklist[675] and that if the patient satisfies the eligibility criteria, an Authority for Release of Information form (available via the electronic health record) must be signed by the patient for CCA to request collateral health information from any external or community health providers to determine the patient's opioid dependence status and confirm the patient's alcohol and drug dependence history. It notes that nursing staff should identify and discuss the risks and benefits of commencing OST with the patient and document all assessment information in the patient's medical record.[676]

731. The CCA OSTP Clinical Guidance provides that an appointment for a comprehensive assessment with the medical practitioner will be made, and they will consider all information compiled by staff before completing the medical assessment of the patient. All information and assessments should be clearly documented in the patient's medical record.[677]

CCA Induction Monitoring

732. Initial clinical induction monitoring and review contained in the CCA OSTP Clinical Guidance is set out as follows:

    a. immediately pre-dose from Day 1 to Day 10; and,

    b. 3-4 hours post-dose from Day 1 to Day 5.[678]

733. The CCA OSTP Clinical Guidance notes that the patient must be monitored for signs of behavioural and physiological parameters of intoxication: sedation; slurred speech; impaired gait; drowsiness; constricted pupils <2mm; tachycardia >100 beats per minute; respiratory depression <12 breaths per minute; and hypotension <90/60mmHg.[679]

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[675] *See* Eligibility Checklist at Appendix 1,the 2015 Guidelines, CB at p.1894.
[676] Ibid.
[677] Ibid.
[678] CCA OSTP Clinical Guidance, p.2115-2116.
[679] CCA OSTP Clinical Guidance, p.2116.

734. If the patient exhibits any features of intoxication or toxicity, nursing staff should withhold OST and other medication, and contact the medical practitioner for urgent review.[680]

CCA - FACTSHEET 12.3H LONG ACTING INJECTABLE BUPRENORPHINE

735. The CCA document entitled, *Factsheet 12.3H Long Acting Injectable Buprenorphine* (**CCA LAIB Factsheet**),[681] states it aligns with national directions and recommendations in accordance with the 2015 Guidelines and Justice Health Practice Guidelines.[682]

736. Also consistent with the Justice Health LAIB Practice Guidance, the CCA LAIB Factsheet provides that a short period (e.g. up to 7 days) of sublingual treatment with buprenorphine is generally recommended prior to transitioning to LAIB treatment. Longer periods of sublingual buprenorphine may be required prior to initiating LAIB treatment, such as if the prisoner reports buprenorphine related adverse events, has existing severe liver disease or is finding it difficult to stabilise on a dose of sublingual buprenorphine.[683]

737. Reference is again made to clinical trials which have demonstrated that the timeframe (generally of or greater than 7 days) can be reduced for those who are treatment familiar or report recent use of illicit, diverted or unprescribed buprenorphine and that this decision is up to the clinical discretion of the prescriber.[684]

738. With respect to clinical monitoring and review, the CCA LAIB Factsheet sets out that during the first week of initiation onto LAIB, CCA staff should ensure that prisoners return to the medical centre daily to be monitored for signs of behavioural and physiological parameters of intoxication. A clinical alert must be created in JCare stating *Currently on Depot Buprenorphine*.[685]

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[680] Ibid.
[681] Fact Sheet 12.3H Long Acting Injectable Buprenorphine, dated May 2021, CB at p.2351- 2357.
[682] As well as The Drugs, Poisons and Controlled Substances Act (1981) and Drugs, Poisons and Controlled Substances Regulations (2017).
[683] CCA LAIB Factsheet, CB at p.2353.
[684] Ibid.
[685] CCA LAIB Factsheet, CB at p.2354.

THE EVIDENCE OF DR NATH

739. Dr Nath provided two statements to the Court, and also gave evidence at the inquest.[686]

740. Dr Nath is a registered medical practitioner and became a fellow of the Royal Australian College of General Practitioners in 2022 (post Heather's passing). He worked as a locum GP/Medical Officer for CCA from April 2017 to April 2022 working at various prison sites.

741. Relevant to this investigation, Dr Nath completed the Medication Assisted Treatment for Opioid Dependence (**MATOD**) modules 1 and 2 by April 2017. He completed the LAIB training and was a registered prescriber in the DHHS (as it then was) system on 9 September 2020.[687]

742. For a few years leading to Heather's passing, Dr Nath was the head of the OSTP Clinic at DPFC, attending every Friday. He said that he had been managing patients with opioid dependence issues in both the community setting and in prison since 2017 and had inducted approximately 80 to 100 custodial patients onto the OSTP.[688]

743. With respect to his knowledge of the applicable CCA policy documents I have detailed, Dr Nath said that whilst they may have been attached to an email he received in February 2021, he did not open and read the attachments, as he thought the email was the same as an earlier one he had received.[689]

744. Dr Nath said in his first statement that Heather told him during the assessment on 19 November 2021 that she had been using two to three films of 2mg or one film of 8mg Suboxone strips every three to four days, depending on what she could acquire. She did not disclose to him how she acquired them. The reference to Heather taking two to three films of 2mg or one film of 8mg Suboxone strips was not documented in his consultation notes of 19

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[686] Statement of Shalendra Nath, dated 31 March 2022, CB at p.80-81, Supplementary statement of Shalendra Nath, dated 27 January 2023, CB at p.1240-1245.
[687] Ibid.
[688] T415 L8-10, T416 L5-9, L25-30.
[689] T419 L15-T420 L23.

November 2021.[690]

745. In addition to reviewing her blood work and ECG results as well as her medication chart, Dr Nath said that he was satisfied that there were no major contraindications to commencing Heather on OSTP. He said that he noted she was diabetic and obese, so her results were mildly outside normal ranges, but he was still of the opinion that they were not a contraindication for OSTP.[691]

746. Dr Nath said that based on Heather's reported opioid use and the concern she expressed regarding not being placed on the program he decided the treatment was medically appropriate.[692]

747. Dr Nath said he considered the lowest weekly dose of 8mg LAIB was appropriate given the fact she was not Suboxone naive. He said he explained to Heather that direct initiation of Buvidal as 'per the TGA guideline' for someone who was not Suboxone naive was 16mg. Although she reported use of Suboxone strips every three to four days and past heroin use without any ill effects, given her current medication and health status, he decided to prescribe the lowest possible weekly dose of Buvidal, being 8mg per week.[693]

748. Dr Nath said that he warned Heather of the common side effects when initiating LAIB (e.g. pain at the injection site and infection), the risk of mixed drug toxicity, and not to take any other opioid substances at the same time as that can cause serious side effects including death.[694] He said he recommended that she seek assistance from either a psychologist or psychiatrist who specialised in Substance Use Disorder.[695]

749. Dr Nath said he believed and trusted Heather when she reported her current opioid use and

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[690] JCare electronic medical record, CB at p.238.
[691] Statement of Shalendra Nath, CB at p.81; Supplementary Statement of Shalendra Nath, CB at p.1241.
[692] Supplementary statement of Shalendra Nath, CB at p.1242.
[693] Ibid.
[694] Supplementary statement of Shalendra Nath, CB at p.1242.
[695] Ibid.

her honest desire to begin LAIB.[696]

750. Dr Nath indicated that OSTP is a *risk reduction therapy for opioid/heroin dependence*, and if Heather did not reveal her past current use of opioid she would not have been considered for the programme, rather she would have been advised to seek psychological assistance.[697]

Why direct Initiation (Buvidal Weekly)/without prior stabilisation (sublingual Suboxone)

751. Dr Nath initiated Heather directly onto a weekly dose of injectable Buvidal rather than with stabilisation on Suboxone strips first which, as already noted, had never been done at DPFC before.[698]

752. Dr Nath says that support for this decision could be found in section 4.1 of the Product Information (referred to above).[699] He did not refer to section 4.2 of the Product Information (also referred to above).[700]

753. Dr Nath referred to a non-randomised trial that showed direct initiation of 16mg Buvidal was indicated for opioid dependent patients in a custodial setting.[701] The trial details noted at the outset,

Opioid agonist treatment is effective but resource intensive to administer safely in custodial settings, leading to significant under-treatment of opioid dependence in these settings world-wide. This study assessed the safety of subcutaneous slow-release depot buprenorphine in custody.[702]

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[696] Ibid.
[697] Supplementary statement of Shalendra Nath, CB at p.1243.
[698] T352 L19-27, T422 L5-11.
[699] Supplementary statement of Shalendra Nath, CB at p.1243. 4.1 of the Product Information is discussed in this finding under the heading, *Buvidal Product Information.*
[700] Discussed in this finding under the heading, *Buvidal Product Information.*
[701] Supplementary statement of Shalendra Nath, CB at p.1243 referencing A Dunlop et. Al. *Addiction*, Treatment of opioid dependence with depot buprenorphine (CAM2038) in custodial settings (**The CAM2038 Study** for the purposes of footnoting), Issue number 117 appearing at pages 382-391 and is contained in the CB at p.1341-1350.
[702] The CAM2038 Study, CB at p.1341.

754. The trial involved participants who were diagnosed with moderate to severe DSM-5 opioid use disorder and were provided with an initial 4-mg test dose of sublingual buprenorphine–naloxone, following which participants commenced depot buprenorphine with four once-weekly injections followed by three once-monthly injections administered.[703]

755. In addition, Dr Nath referred to comments from the Pharmaceutical Benefits Advisory (**PBA**) Committee meeting from November 2021, which recommended changes to the PBS restriction to remove the requirement for stabilisation on sublingual buprenorphine/naloxone prior to commencing treatment with weekly prolonged release buprenorphine.[704]

Calculation of the dose of Buvidal Dr Nath prescribed

756. Dr Nath said he referred to the Victoria Health *Brief clinical guidelines for use of depot buprenorphine (Buvidal and Sublocade) in the treatment of opioid dependence* (**Victoria Health clinical guidelines**) to calculate Heather's Buvidal dose.[705]

757. The Victoria Health clinical guidelines provide the following with respect to dosing recommendations for Buvidal,

> *Transferring from SL BPN* [sublingual buprenorphine] *Patient should usually be treated with seven or more days of SL BPN prior to transferring to Buvidal, with either Buvidal Weekly or Buvidal Monthly starting on the day after the last daily SL dose. Buvidal doses are 'matched' to SL BPN doses as shown in Table 1*.[706]

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[703] Lintzeris N., Dunlop A., Masters D. *Clinical Guidelines for Use of Depot Buprenorphine (Buvidal® and Sublocade®) in the Treatment of Opioid Dependence*. Sydney, Australia: NSW Ministry of Health; 2019. https://www.health.nsw.gov.au/aod/Publications/ full-depot-bupe-interim-gl.pdf (accessed 5 January 2020). Where it was noted that, *Direct induction to Buvidal is most appropriate for patients with previous evidence of BPN use without adverse effect before exposure to long acting depot BPN products. Patients who have not previously been prescribed BPN would benefit from induction to depot BPN via a brief period on Suboxone and should have at least one or two test doses of SL BPN prior to initiation of Buvidal to ensure tolerance and no adverse effects.*

[704] Supplementary statement of Shalendra Nath, CB at p.1243.

[705] Department of Health and Human Services, *Brief clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence,*. dated February 2020, CB 1323-1340.

[706] Victoria Health clinical guidelines, CB at p.1330.

Table 1: Dose conversions between SL BPN, depot Buvidal Weekly and Buvidal Monthly doses

Daily SL BPN dose	Buvidal Weekly depot dose	Buvidal Monthly depot dose
≤ 6mg	8 mg	No monthly equivalent
8-10mg	16mg	64mg

758. This table is the almost identical to the tables replicated above, extracted from the Product Information and the Justice Health LAIB Practice Guidance.

759. Similar to other guidance information, the *Victoria Health clinical guidelines* state that regarding the commencement of buprenorphine treatment with Buvidal,

> *While not recommended as routine practice, Buvidal Weekly can be initiated directly from short-acting opioids (such as heroin) or after fewer than seven days of SL BPN treatment (for example, the patient unable to access dosing sites for daily SL dosing)*[707]

760. Dr Nath said that as Heather informed him that she was a regular user of two-three Suboxone films of 2mg or one film of 8mg (depending on what she could acquire) every 3-4 days since entering the DPFC, he chose the dose from the table which he considered was closest to her past use, as he understood from her history that *she could tolerate it*.[708]

761. Dr Nath said that as Heather had reported use of Suboxone sublingual films while taking sertraline and quetiapine without adverse effects, and remained at approximately the same weight, he considered this indicated sufficient tolerance for the LAIB dose he prescribed.[709]

762. Dr Nath said that DPFC had designated OSTP Nurses who would follow the *usual procedure* regarding the administration of the LAIB and the monitoring of the patient including blood

[707] Victoria Health clinical guidelines, CB atp.1330. Figure 1: Overview dosing with Buvidal, refers to heroin only, if initiated directly to Buvidal Weekly without sublingual strips.
[708] Supplementary statement of Shalendra Nath, CB at p.1244.
[709] Ibid.

pressure, pulse rate, baseline ECGs and regular observations.[710]

763. Dr Nath gave evidence at the inquest which further clarified the explanations he provided in his statements.[711]

Use of applicable guidelines

764. Dr Nath said he relied on the Victorian Health clinical guidelines and the NSW guidelines for LAIB which he said medical practitioners in the community rely on and apply.[712] Dr Nath did however agree that Heather was not taking heroin at the time he prescribed Buvidal Weekly.[713]

765. Dr Nath also agreed that, when considering which guidelines to apply when prescribing in prison setting, you would best be served by those tailored for a correctional environment.[714]

766. Dr Nath further agreed that he did not apply the guidelines from Justice Health or CCA policy to guide his prescription of LAIB to Heather but said that he was not aware of them. He did not dispute the appropriateness of the underlying principles of the applicable CCA policy.[715]

767. When asked at inquest whether he was obliged to comply with, or adhere to, the applicable CCA's guidelines or policy which contained criteria specific to prison, as a locum engaged by CCA, he stated that,

If I'm not aware of and if - if nobody has told me about that there is a certain policy about a certain issue, then I'm sorry, I - if I'm not aware, then I - I can't oblige to what I'm not aware of.[716]

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[710] Supplementary statement of Shalendra Nath, CB at p.1245.
[711] *See* Evidence of Shalendra Nath, T411 L16-T625 L15.
[712] T426 L16-21, T427 L24-26.
[713] T536 L26-27.
[714] T551 L17-21.
[715] T543 L18-23, T546 L19, T552 L2.
[716] T429 L6-10.

Significance of Heather being the first patient inducted without stabilisation on Suboxone (strips)

768. Dr Nath agreed that Heather was the first person prescribed LAIB without induction on Suboxone (strips) at DPFC.[717]

769. He also said that he had never prescribed Buvidal to a patient directly without induction through Suboxone, other than Heather.[718]

770. Dr Nath said that he was aware of the significant changes to OST delivery at DPFC which commenced in 2021, and was aware at the time of prescribing, that a comprehensive assessment process to confirm suitability was required where a patient requested OST.[719]

Monitoring after dosing

771. Dr Nath said he understood that patients initiated on OST would be monitored for signs of intoxication but said that it was the nurses who would arrange monitoring and the nurses were aware of what is required when someone is started on the program.[720]

772. Dr Nath did not think there was a need to advise the nursing staff about his expectations of observations for Heather, despite it being the first time that a patient at DPFC was placed in LAIB without stabilisation on Suboxone (strips), as he expected the nurses would do it.[721]

773. With the added information that there was no objective evidence as to Heather's dependence, Dr Nath said in response to whether it was incumbent upon him to ensure that there were observations of her,

Yes, I would - I would have liked to have more observations, yes. That would have been

[717] T422 L5-8.
[718] T446 L16-20.
[719] T434 L31-T435 L3.
[720] T440 L9-14.
[721] T514 L13-26.

good.[722]

774. And further Dr Nath said,

It is a team approach. I'm not saying it is just the patient. It is every – every – as time progresses after the introduction of the treatment it is the role of each and every member to play their part, especially after the injection.[723]

...I believe - my understanding was that there is such monitoring practice that's happening in – in the prison.[724]

Contra indications to LAIB

775. Dr Nath agreed that contraindications for LAIB include concomitant use of buprenorphine with other central nervous system sedatives including antipsychotic medications like quetiapine, have compounding effects that increase the risk of adverse reactions, including overdose, respiratory depression and death.[725]

776. Dr Nath agreed that *OST should be used with caution in prisoners prescribed other sedating drugs, particularly benzodiazepines, antidepressants and some antipsychotic medications* as noted in the 2015 Guidelines.[726]

777. Dr Nath did not however agree that the prudent course of action in this case was to consult with the specialist who was prescribing the other medication that contributed to the risk of respiratory depression (here, quetiapine). He said that, as Heather was already tolerating concurrent use of quetiapine and unprescribed Suboxone (strips), with no ill effects, he

[722] T515 L11-12.
[723] T539 L12-16.
[724] T540 L17-18.
[725] T448 L8-14.
[726] T455 L29 – T456 L3 referencing the Victorian Prison Opioid Substitution Therapy Program Guidelines, dated July 2015, CB at p.1876.

considered that she could tolerate the amount and manner of buprenorphine he prescribed.[727]

778. Dr Nath was referred to the 2015 Guidelines which noted that, *Prisoners prescribed such medications should have a comprehensive review of their medication before beginning OST, with referral to a relevant specialist, e.g. addiction medical specialist or psychiatrist if required*. He said that knowing the outcome now, he accepted that Heather should have been referred to a relevant specialist such as an addiction medicine specialist or a psychiatrist because of the other medication that she was taking, but at the time disagreed, as he thought she was tolerating the medications.[728]

779. Dr Nath agreed that he did not consult an addiction medicine specialist despite Heather's more challenging presentation and comorbidities contrary to the Justice Health OSTP policy but said that he was not aware of the policy.[729]

780. Dr Nath said that he was aware of Heather's medications, her diabetes, depression, cholesterol and risk of heart disease but did not think Heather appeared morbidly obese but referred to her as *fit.* He stated,

she was a fit person so I was - I was aware but I couldn't be seeing that as someone is having any sort of breathing difficulties with the body physique.[730]

781. He did however agree that based on her obesity, Heather presented with risks to her heart function and risks to her respiratory function. He also agreed that obesity predisposes a person to obstructive sleep apnoea.[731]

782. Dr Nath acknowledged that part of the NSW Health guidelines[732] which he said he relied on noted key drug interactions and identified drugs that may interact with the Buvidal in a way

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[727] T448 L15-T450 L2.
[728] T456 L5-T457 L8, referencing the Victorian Prison Opioid Substitution Therapy Program Guidelines, dated July 2015, CB at p.1876.
[729] T546 L15-20.
[730] T465 L13-16.
[731] T446 L9-29.
[732] NSW Brief Depot Buprenorphine Interim Guideline, dated August 2019, CB at. 4380.

that creates further risks such as sedation, respiratory depression and overdose and stated that if concerned about potential drug interactions (**DDIs**):

initiate treatment with short-acting SL BPN for one to four weeks, monitor DDI and adjust medications accordingly prior to transfer to depot injection.[733]

Significance of drug tolerance

783. Dr Nath accepted that it was important to take care to assess a patient's level of opiate tolerance before prescribing LAIB.[734]

784. Dr Nath also accepted that at the time Heather entered prison she did not present with an opiate dependence.[735]

785. Dr Nath disagreed with the Court's expert, Clinical Toxicologist, Professor Joe Rotella, who gave an opinion that Suboxone use every three to four days was insufficient to achieve the steady concentration in blood necessary to promote the development of tolerance to a drug. Professor Rotella included in his report,

I disagree with the assumption made that [Heather] *was not opioid naïve on an individual account of using illicitly obtained buprenorphine 'every 3-4 days' as this is not in keeping with the dosing necessary to achieve steady state concentrations in the blood and therefore promote the development of tolerance to a drug (thereby losing naivety to said substance).*[736]

Evidence relied on for prescribing to Heather

786. Dr Nath said that he reviewed the records of the OSTP Nurse documenting that Heather had no recorded diagnosis of heroin dependence; had not been provided a withdrawal pack upon entering custody; had no physical indications of intravenous drug use; and that collateral

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[733] T529 L6-9 referencing NSW Brief Depot Buprenorphine Interim Guideline, CB at p.4388.
[734] T451 L7-12.
[735] T461 L6-8.
[736] T486 L21-T487 L1 referring to Expert Report of Joe Rotella, CB at p.2980.

information confirmed that Heather had no diagnosis of opioid dependence nor any previous prescription of OSTP in the community.[737]

787. Dr Nath was not concerned that the reliability of Heather's account of her unprescribed Suboxone use was undermined by her providing two apparently different versions in the space of 10 days . That is, he did not consider, *occasional* use, reported to RN Duong and, *every three to four days* use, reported to him, to be very much different.[738] However, accepted that there might be some unpredictability as to frequency and amount as well as her exaggerating.[739]

788. In forming the decision to prescribe OST, Dr Nath agreed that he relied entirely on Heather's self-report as to her assessment of her level of opiate dependence and opiate tolerance.[740] While he agreed that the OSTP Nurse's decision that Heather was not eligible for OSTP *can be* [an] *appropriate one*,[741] he reached a different decision taking all of the information together.[742]

789. Dr Nath disagreed with the proposition that *it is well known that prisoners sometimes overstate their drug use, in order to access methadone or buprenorphine in prison*[743] and did not think was relevant to Heather. Dr Nath had not heard that a patient might seek OST to get stoned or high.[744]

790. Dr Nath agreed that in order to consider Heather to be opioid dependent he would want to be satisfied of both the psychological addiction and a physiological addiction.[745]

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[737] T477 – T478.
[738] T481 L15-19.
[739] T501 L2-4, T502 L8-15.
[740] T496 L21-22.
[741] T479 L13-15..
[742] T444.
[743] T577 L26-T578 L14 referencing the Expert report of Associate Professor Nicolas Clarke, CB at p.3538.
[744] T581 L1-22.
[745] 488 L7-9.

Exercising caution when prescribing

791. Dr Nath agreed that the assessment process which included screening for previous drug use and collecting objective evidence of drug use before prescribing OST was for *patient safety reasons*.[746]

792. Dr Nath generally agreed that if relying solely on self-reported information, a medical practitioner should *err on the side of caution* when deciding the dose and means of administration.[747]

793. Dr Nath said that the whole OSTP is based on *trust*. He said,

> *you have to be nonjudgmental, you have to be respectful of what they are saying and show respect to what you hear*.[748]

794. Dr Nath accepted that *special caution* should be exercised when considering prisoners for whom you do not have any objective evidence regarding their tolerance levels but said it was too late to get objective evidence of Heather's drug use noting that urine tests are not reliable and take too long.[749] This was not mentioned in either of Dr Nath's statements or the JCare records.

795. Dr Nath agreed that if a patient is appropriately stabilised on Suboxone strips prior to LAIB, overdose is less of a concern.[750]

796. Dr Nath also agreed that the safest course when prescribing for Heather would have been 2mg Suboxone (strips), but said there were time limitations given her release date.[751] This was not mentioned in either of Dr Nath's statements or the JCare records.

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[746] T444 L15-22.
[747] T502 L24-27.
[748] T531 L10-12.
[749] T540 L23-T451 L6, T457 L28-31.
[750] T454 L6-8.
[751] T504 L25-T505 L4.

Other matters raised by Heather

797. Dr Nath said that indirectly Heather suggested to him that he would be responsible if she overdosed if he did not prescribe her with LAIB. He said that Heather said something similar to:

'You know, Doctor, if you don't give me this opportunity I will continue to use this and I will be using as I'm using and if something happens to me, like either here or outside, then – then you - it would be on you', something like that.[752]

Assessing whether Heather was more at risk on or off Opiate Replacement Therapy

798. The Court's expert, Dr Jansen, provided advice to the Court that on balance he considered Heather more at risk on ORT than off it based on a number of factors,[753] each of which Dr Nath agreed with. Those factors were,

a. There was no collateral evidence to support Heather's claims of opiate use and dependence in the community;

b. Heather had no physical evidence which suggested opiate dependence or withdrawal;

c. Heather had numerous comorbidities which increased the risks associated with the ORT including deranged liver function, depression, obesity and diabetes;

d. Heather was on quetiapine and sertraline both of which pose additional risks and warrant additional cautions when used with buprenorphine; and

e. There was no collateral evidence to support her claimed opiate use in prison.[754]

799. Despite agreeing to each of these propositions, Dr Nath did not agree with Dr Jansen's

[752] T611 L8-12.
[753] Expert report of Dr Denver Jansen, CB at p. 3000.
[754] T530 L3-L9.

conclusion and said of her risks,

> *she is using illicit buprenorphine so there was more risk for her to be overdosing and contracting blood-borne viruses, infections, and also on top of that, that risk-taking behaviour could have – could have resulted in death, ... and that's what I interpreted, that she was at more risk of such on the balance of what she – she could get through – through the therapy.*[755]

Documentation in the clinical records

800. Dr Nath agreed that he did not document a rationale in the clinical records for not prescribing a stabilising dose of buprenorphine. Nor did he document which eligibility criteria Heather met to commence OSTP but he did note that her offences were related to drug use, that she might use when she was released and the social and community impact of her using illicit drugs.[756]

801. Dr Nath further clarified that in accordance with the 2015 Guidelines, Heather was eligible for the OSTP as she, would continue to use opioids (licit or illicit) in prison in a manner which constitutes a significant risk of harm, and was at significant risk of using opioids in prison or post-release.

802. Dr Nath agreed that the time constraint rationale for not stabilising Heather on Suboxone (strips) was not mentioned in either statement or the JCare records.

Comments from family members and other prisoners about Heather's opiate use and their responses

803. Suzzane made two calls to her mother on 23 November 2021 (Arunta call) after Heather's collapse. During one call, Suzzane described Heather on discovery that morning as *breathing, snoring, her heart rate was irregular, she was stopping in between the breaths, still breathing*

[755] T531 L16-24.
[756] T613 L28-T614 L3.

on and off.[757] This was consistent with the observations of the POs and RNs who attended.

804. In the second call, after discovering that Heather had been prescribed *bup*, Aunty Jenny questioned why, as she wasn't a heroin addict. Suzzane said that Heather had *lied and said that she had used on the outside*. Aunty Jenny responded by saying that this should not matter because doctors *have to check that*. She said that you just cannot take the word of *a prisoner* in this context. She expressed her concern that it did not make sense to have prescribed the drug in Heather's circumstances.[758]

805. In a phone call to her mother on 24 November 2021, Suzzane said that on the afternoon of 23 November, Heather was experiencing nausea, *she was throwing up, she was still feeling sick and so she was laying down and having naps and rests and everything, and vomiting from then onwards*.[759] This is consistent with the observations made by the other women who shared their accommodation at the Blackwood Unit.

806. In Suzzane's statement to the Court she said,

> *...I am not sure how she got approved for it as she wasn't a Heroin user. She was happy she was getting it. She had used in the past but only dabbled in it. The last time she used would have been 18yrs old. Our poison was never 'Harry' (street name for Heroin) it was cannabis.*
>
> *Us girls in the unit were really concerned about the fact that Heather was getting the injection. It didn't make sense, Tammy was mostly concerned, she is on the 'done' program, so it didn't make any sense to her. Tammy was like the prison pharmacist; she was clever like that. She knows what all the medications are for. I remember her saying to Heather she should be having the strips not the injections*.[760]
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> …..

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[757] 005, Exhibit 19, Arunta call.
[758] 011, Exhibit 19. Arunta call.
[759] 007, Exhibit 19, Arunta call.
[760] Statement of Suzzane Calgaret, CB at p.25.

Heather had asked lots of times before for Suboxone, for the last 2 and half years she wanted to get high so that's why she kept asking.[761]

…. 8mg is a lot to have in one go for a non-opioid user. They are meant to start them on the suboxone strips first.[762]

807. Tammy said of Heather's drug use,

I don't know why she went to see the nurse as she was not a heavy drug user of opiates. I had seen Heather taking miniscule amounts of suboxone in the last month. A piece the size of a little fingernail would put her on the couch feeling sick, couldn't open her eyes and so on.

I think she liked the effects of it. She was also due to get out in February and wanted suboxone, so she wasn't tempted to use once she got out.[763]

808. Tammy confirmed at inquest that she had seen Heather take Suboxone strips a couple of times in the month before her death, being the size of a little fingernail coming from an 8mg strip – maybe 0.5 to 1.0mg (*a very minor amount of the total dose*)[764] and that it made her sick. That is, lethargic, *unable to hold a conversation* because she was falling asleep and *occasionally vomiting* and scratching.[765] She did not think it helped getting a person to stay off Ice, but it introduced another habit. Tammy said that she would have known if she was taking more, as you can see the *visible effects once someone is drug affected – You can't hide it*.[766]

809. Tammy further stated that it was *just a way of getting high if you're inside*, and it was *accessible*.[767] She said that it helps with psychological pain as it helps you block everything

[761] Statement of Suzzane Calgaret, CB at p.26.
[762] Statement of Suzzane Calgaret, CB at p.26.
[763] Statement of Tammy Innes, CB at p.38.
[764] T150 L14-17.
[765] T150 L27-T151 L4.
[766] T191 L1-3.
[767] T152 L6-7.

out and *numb* yourself. She said it was hard to get Suboxone in jail – *it's doable but hard*.[768]

810. Stacey said, *I never knew Heather to be a Heroin user, I believe her motives to be to get high and lose weight. Heather told me she used to be a heavy ice user and she also mentioned weed but never Heroin*.[769] She said that even though she was aware that Heather was using Suboxone occasionally in prison, she did not think it warranted getting on opioid replacement. At inquest she stated,

I didn't think that her habit was worth another addiction of drug replacement.[770]

It's very common for women in prison that don't have heroin backgrounds to get on a drug replacement program when they get in prison, it makes their time easier.[771]

Analysis of opioid prescribing

811. To inform the issue of OST prescribing to Heather, I was assisted by an expert panel comprising Addiction Medicine Specialists Associate Professor Nicolas Clark[772] and Dr Matthew Frei;[773] as well as Associate Professor Joe-Anthony Rotella[774] who was part of a different panel.

Opiate Tolerance

812. Tolerance is the degree to which the body has become adapted to regular opioids. Tolerance is what enables people who regularly use opioids to take doses that would be fatal to people

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[768] T191 L18-19.
[769] Statement of Stacey Edwards, CB at p.68.
[770] T266 L9-10.
[771] T268 L8-11.
[772] *See* First expert report of A/Prof Nicolas Clark, CB at p.3533, Second expert report of A/Prof Nicolas Clark, CB at 4270. Head of addiction medicine at Royal Melbourne Hospital. He has a research doctorate in the treatment of opioid dependence.
[773] *See* Expert Report of Dr Matthew Frei, CB at p.3549, Amended expert report of Dr Matthew Frei, CB at p.4472. Addiction medicine specialist with over twenty years of experience. He works as the clinical director of Turning Point at Eastern Health and as a sessional addiction medicine specialist for Alfred Health.
[774] *See* Expert Report of A/Prof Joe Rotella, CB at p.2974. Consultant emergency medicine physician and clinical toxicologist. His experience includes care for patients with problems pertaining to toxicology, alcohol and other drugs, addiction and mental health, and he is the current lead toxicologist at Northern Hospital.

without tolerance. Regular use (typically daily use) of opioids over months leads to tolerance.

813. A person is opioid naive when they have no tolerance to opioids and have experienced either very limited sporadic exposure or no exposure to an opiate.[775] A person is opiate tolerant where they are having regular (usually daily) exposure to opioids, , whether that is prescribed or non-prescribed.[776] Tolerance is not binary, it is a gradual progression from naivety to tolerance.[777]

814. Associate Professor Rotella said that a person taking opiates every three to four days in changeable doses (as Heather said she was at her consultation with Dr Nath) is not in keeping with the dosing necessary to achieve steady state concentration in the blood and therefore promote the development of tolerance to a drug (thereby losing naivety).[778] Other factors effecting tolerance would include whether the opiate was long or short-acting, the person's physical health, any other comorbid conditions, and metabolic features.[779]

815. There were different versions of Heather's exposure to opiates. This includes before she was in prison as noted in the Reasons for Sentence and Suzzane's knowledge of her use. On either version, it was many years ago. In prison, there were Heather's various reports of opioid use to RN Nuong and Dr Nath as well as the knowledge of those who shared her unit.

816. Based on the available evidence, I prefer the accounts given to RN Nuong and the knowledge of those who shared her unit, which are more closely aligned, as likely to more accurately reflect Heather's opiate use. The account given to Dr Nath, appears somewhat implausible, simply as a matter of accessibility (as noted by Tammy), in addition to being unsupported by any other evidence. Even Dr Nath appeared to question this in his notes when he recorded *?How* with reference to her reported drug use.[780]

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[775] T 859.
[776] T 859; T 1147 – 1148.
[777] T 1148 – 1149.
[778] Expert report of A/Prof Rotella, CB at p.2980.
[779] T 860.
[780] JCare electronic medical records, CB at p.238.

817. Forensic Toxicologist Dr Robertson and Associate Professor Rotella both agreed that a person's tolerance can not necessarily be predicted, particularly in circumstances of occasional use.[781] Dr Robertson stated,

the ability to quantify whether tolerance, well determine whether tolerance exists or not and then quantify the level of tolerance if it does exist really can't be done with any precision.[782]

818. Heather's tolerance level was described by the OSTP panel as either opioid naïve or not known[783] or *low or uncertain.*[784]

819. In terms of assessing Heather's opioid tolerance at the time she was administered Buvidal, the experts broadly considered that her tolerance was likely equivalent to someone naïve or with very low or low or uncertain tolerance.[785] There was no suggestion that Heather was opioid tolerant.

820. Support for Heather being of naïve or with very low or low tolerance is also consistent with the lack of buprenorphine in her hair sample[786] as well as clear drug screening results noted by RN Duong.

821. I agree with the expert analysis and note the difficulty with assessing a person's level of tolerance but consider Heather's opioid tolerance was likely to have been equivalent to someone naïve or with very low or low or uncertain tolerance but on any assessment, she was not opioid tolerant.

Admission to OSTP

822. As already noted, Dr Jansen considered that Heather should not have been prescribed

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[781] T860 – 861.
[782] T916 L10-13
[783] Evidence of Dr Frei, T1149. Amended expert report of Dr Matthew Frei, CB at p.4488.
[784] Evidence of A/Prof, T1149.
[785] Evidence of Dr Frei and A/Prof Clark, T1151; Evidence of A/Prof Rotella, T860-861; Evidence of Dr Robertson T862.
[786] VIFM Toxicology Report, CB at p.162.

buprenorphine because she was more at risk on the OSTP than off it.[787]

823. Associate Professor Clark noted that only people who are opioid dependent should be admitted for ORT and that this should be assessed with a detailed history, a corroborating history, physical assessment and urine screens.[788] He said that collateral information was important because it was *well-known* that patients overstate their drug use in order to access buprenorphine and methadone in custody.[789]

824. Ultimately, while Associate Professor Clark provided an opinion that there was little evidence that Heather had ever been opioid dependent and was unlikely to benefit from buprenorphine treatment,[790] it was his view that the decision lay with Dr Nath and that it was arguable that offering ORT was *reasonable*.[791]

825. Dr Frei considered that the decision to prescribe ORT was reasonable and consistent with good practice.[792]

826. General Practitioner Dr Bartels said that he did not believe that Heather was more at risk on the program than off it.[793]

827. Whilst there were differing opinions as to whether Heather should have been commenced on ORT, Counsel Assisting noted that there was no consensus that the decision was outside reasonable practice.

828. Dr Jansen, Associate Professor Clark and Associate Professor Rotella would not have initiated Heather on the program, whereas Dr Frei and Dr Bartels said they would.

829. Broadly, the policy documents in a custodial setting provide that a person would be eligible

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[787] Expert report of Dr Denver Jansen, CB at p. 3000.
[788] First expert opinion of A/Prof Clark, CB at p.3538.
[789] Ibid.
[790] First expert opinion of A/Prof Clark, CB at p. 3540.
[791] T1139.
[792] Original expert report of Dr Matthew Frei, CB at p. 3558.
[793] T1072.

for the OSTP if any of the following circumstances arise:

a. they are receiving pharmacotherapy in the community at the time they enter custody;

b. they are opioid dependent at the time they enter custody but are not receiving treatment;

c. they continue unsanctioned use of opioids in custody in a manner which constitutes a significant risk of harm; or,

d. are at significant risk of using opioids post release.

830. Dr Nath considered Heather was eligible based on the criteria in paragraphs (c) and (d).

831. It appeared arguable therefore that admission to the OSTP was open to a prescribing doctor in Dr Nath's position.

832. In these circumstances, the focus of my considerations was on Dr Nath's decision to induct Heather directly onto the LAIB, without an initial period of stabilisation on Suboxone (strips).

Decision to Prescribe the LAIB without Stabilisation

833. LAIB was introduced into DPFC in the middle of 2021.

834. The CCA policy recommended a short period (up to 7 days) of sublingual treatment with buprenorphine before transitioning to LAIB treatment. While longer periods of stabilisation could be required if the patient experienced adverse effects, the policy also stated that the seven-day timeline could be reduced for those who were treatment familiar or reported *recent use of illicit, diverted or unprescribed buprenorphine*. The decision about increasing or reducing the period of stabilisation was up to the clinical discretion of the prescriber.[794]

835. Similarly, the Justice Health policy also required a period of stabilisation on sublingual

[794] CCA LAIB Factsheet, CB at p.2353.

buprenorphine for up to seven days before commencing LAIB. This policy provided that the period of stabilisation could be reduced, at the discretion of the prescriber, for those who were treatment familiar or reported recent use of illicit, diverted or unprescribed buprenorphine.[795]

836. Neither policy *expressly* allowed the induction of a patient directly onto LAIB and it had never been done at DPFC before nor in Dr Nath's history of practice.

837. Dr Nath accepted that it was possible for a person who was opioid naïve to overdose on an 8mg weekly injection of the LAIB.[796]

838. Dr Nath's evidence was that he considered that it was appropriate to commence Heather directly onto the LAIB without a period of stabilisation because of her self-reported history of use which he considered meant that she was not opiate naïve and was consuming the equivalent of a daily dose of Suboxone of 16 mg. He then relied on the dose of LAIB as set out in the Justice Health Guidance and exercised caution by prescribing a lower dose of 8mg (rather than 16mg).

839. Dr Nath also gave evidence that he was concerned that he would not have enough time to stabilise Heather on Suboxone and then transition her to LAIB weekly and then monthly injections before she was released from custody.[797] This was not documented in the JCare records.

840. Heather had ten weeks before she would be released from custody and both Associate Professor Clark and Dr Frei gave evidence that ten weeks was *plenty of time* to safely induct Heather.[798]

841. As noted already , in support of his decision to commence Heather's ORT with LAIB, Dr

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[795] Justice Health LAIB Practice Guidance, CB at p.4243.
[796] T497 L10-13.
[797] T504-505.
[798] T1191-1192.

Nath referred to comments made by the Pharmaceutical Benefits Advisory Committee in November 2021; and the Product Information which allowed for induction onto LAIB with or without stabilisation.

842. Dr Frei agreed that it would probably have been safer to commence Heather on the sublingual film, but he did not think there was much to it.[799] He sympathised that Dr Nath was not an addiction specialist and lacked support in his treating environment. He concluded that the decision to prescribe directly onto LAIB was not reckless, but rather, it was *naïve* and reflective of *insufficient support or guidance*.[800] Dr Nath however did not appear to agree with this observation and maintained at inquest that he had made the correct decision. Dr Frei maintained his view that the decision was reasonable.[801]

843. Similarly, Dr Bartels emphasised that the lowest dose of LAIB was used and that the clinical judgement of a doctor allows for deviation from policy and guidelines.[802]

844. Dr Jansen maintained his position and rationale that inducting Heather into the OSTP at all carried more risk than benefit in the circumstances of her case. In his view, the policy materials provided a strong framework to guide treating practitioners to commence with a period of stabilisation and that strong and compelling evidence would be needed to deviate from them.[803] He concluded that there was no such basis in this case and that the decision to commence Heather directly onto the LAIB was inappropriate.[804]

845. Associate Professor Clark stated that the buprenorphine dose administered in Heather's case was too high and the dose formulation was wrong.[805] He said that a prescriber needs to carefully assess a patient's degree of tolerance to ensure that the dose is safe and then prescribe according to the degree of opioid tolerance. When the degree of opioid tolerance is

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[799] T1191.
[800] T1214 L17-22
[801] T1214.
[802] T1071; T 1073.
[803] Expert report of Dr Denver Jansen, CB at p.3001-3002.
[804] Ibid.
[805] First expert report of A/Prof Clark, CB 3540.

low or uncertain based on the history and examination, it is expected a doctor will give a dose that is safe and observe the effect of that dose.[806] In his view, it is preferable to use the lowest dose available when initiating a patient onto buprenorphine prior to their release and that – particularly in a prison setting where there is no benefit to rushing – that called for a dose much smaller than 8mg weekly.[807] That is, the *best course of action is to use a dose that will be clearly safe*.[808] He further noted that it is possible to simultaneously build trust with a patient and prescribe safely. Associate Professor Clark considered that the decision to prescribe an 8mg weekly injection without a period of stabilisation was *reckless*.[809]

846. Associate Professor Rotella said that it is widely recognised that sedative agents should be used with caution in patients diagnosed with obesity. Given Heather's documented BMI of 54 kg/m^2, administration of any opioid would come with significant risk and the more cautious approach of *start low, go slow*[810] may have been more prudent given her body habitus (physique). He said that this would be in line with current published guidelines regarding the use of LAIB where it is recommended that patients with no prior history of exposure to buprenorphine (which was unsubstantiated for Heather) should be trialled on sub-lingual buprenorphine prior to transitioning over to a LAIB.[811]

847. He said that he was cognisant of the PBAC recommendation and subsequent TGA approval to remove the PBS restriction regarding use of sublingual buprenorphine prior to introduction of a LAIB referred to by Dr Nath. However the cautious approach above would be in keeping with the principle of *primum non nocere* (first do no harm) in a patient with a condition that would predispose to respiratory failure in the presence of central nervous system depression. Furthermore, there was sufficient time to trial sublingual buprenorphine and identify

[806] First expert report of A/Prof Clark, CB 3538.
[807] First expert report of A/Prof Clark, CB 3539.
[808] Ibid.
[809] T1139.
[810] T969.
[811] Expert report of A/Prof Rotella, CB at p.2977.

potential adverse effects prior to their planned release in February 2022.[812]

848. Associate Professor Rotella further noted that the published evidence regarding LAIB does not specifically account for patients with elevated BMIs and that there is insufficient safety data for LAIB in patients who are obese (let alone morbidly obese) and that in the absence of published safety data, a cautious approach when initiating any form of opioid substitution therapy is strongly recommended.[813]

Lack of monitoring

849. Heather did not have any appointments scheduled for afternoon observations following the administration of the LAIB on 22 November 2021. As already set out, Justice Health and CCA policy prescribed careful monitoring of patients following induction onto the OSTP.

850. When patients returned for monitoring, their vital signs would be taken and nursing staff would monitor for symptoms including drowsiness, vomiting, nausea, lowered blood pressure and an unsteady gait. If staff had concerns or noted any of these symptoms, they would alert a medical practitioner as these could be a sign of overdose.[814]

851. RN Millson advised the Court that in accordance with usual practice, during the first five days of Suboxone strips, observations were booked for the morning before dosing and, for the afternoon. After day five on Suboxone strips, patients usually shifted to once-a-day observations, which occurred in the morning straight after *unlock*. The usual process was that the patient had observations the morning after they had their last Suboxone strip. Generally, by the time a patient was transitioned to LAIB there was no afternoon monitoring.[815]

852. RN Millson indicated that Suboxone strips were considered the induction phase and LAIB was the maintenance phase for OSTP.[816] By day 7 of ORT, there were no afternoon

[812] Ibid.
[813] Expert report of A/Prof Rotella, CB at p.2978.
[814] T382 L6-20.
[815] T647 L15-T648 L2.
[816] T660 L13-20.

observations.[817]

853. RN Millson indicated that in general, a nurse would be present with the doctor for an OSTP assessment and the doctor would tell the nurse if they had decided to start a patient on ORT.[818] RN Millson advised that the prescribing doctor would ask the nurse present to book the observations, following which the nurse would book 10 days of observations.[819]

854. If there was no nurse sitting with the doctor at the OSTP assessment appointment, the doctor would usually take the relevant documentation to the Associate Health Services Manager and they would either book the appointments or direct someone else to do it.[820]

855. Bookings were documented on J-Care on an appointment screen but not on a patient's file.

856. The evidence of both RN Duong and RN Millson was that it was not general practice prior to administering a LAIB injection to see if a patient had been prescribed the seven day's stabilisation doses of buprenorphine as it was a presumption based on general practice at the time, that the patient had already been stabilised on Suboxone strips. The LAIB injection would always start within a week or so of the strips.[821]

857. There is no evidence that a nurse was present during Heather's appointment with Dr Nath on 19 November 2021.

858. Dr Nath's said that it was his expectation that monitoring would occur according to usual procedure.[822]

859. Dr Nath accepted that he made no plan for Heather's monitoring[823] but relied on a system of monitoring which he expected to have taken place and therefore, Heather was not scheduled

[817] T648 L24-31.
[818] T643 L8-13.
[819] T646 L15-24.
[820] T 647.
[821] T670 L28-T671 L4.
[822] T441 L19-25.
[823] T518 L30- T519 L7.

for any afternoon observations.

860. Professor Fitzgerald provided an opinion that Heather's outcome may have been different if three-to-four hourly, post-dose monitoring had occurred[824] and that this was a missed opportunity. Dr Frei similarly said that there was a *missed opportunity* to act on the symptoms she displayed in the afternoon.[825]

861. Heather complained that she was unwell to POs at the 4.00pm count on 22 November 2021.

862. Professor Fitzgerald provided an opinion that there was no clear indication to escalate her care until she found unconscious at 7.48am the following morning.[826]

Conclusions regarding LAIB prescribing

863. In accordance with CCA guidelines and policy applicable to the OSTP, RN Duong conducted a thorough assessment of Heather's eligibility over a five-month period and determined on 9 November 2021 that she did not meet the relevant criteria. She referred Heather for a medical practitioner's comprehensive assessment or, advice from an AOD specialist to rule out drugs seeking behaviour and misuse prior to commencing OSTP.[827]

864. RN Duong was employed by CCA and was familiar with the relevant CCA guidelines for OSTP as well as other custodial OSTP guidelines more broadly and applied them in the work she performed at DPFC.

865. LAIB was introduced at DPFC around mid-2021. In November 2021, the practice was for patients to be stabilised on sublingual Suboxone for five days prior to moving to LAIB treatment. This was supported by CCA policy which provided that a short period (e.g. up to 7-days) of sublingual treatment with buprenorphine was generally recommended prior to

[824] Expert Report of Professor Fitzgerald, CB at p.3007.
[825] T1167 L14-15
[826] Expert report of Professor Fitzgerald, CB at p.3005.
[827] JCare electronic medical records, CB at p.238-239.

transitioning to LAIB treatment.

866. On 19 November 2021 (10 days after RN Duong's assessment), based on his own assessment, Dr Nath decided to commence Heather on ORT. He did not prescribe a period of stabilisation on sublingual buprenorphine (Suboxone). Rather, Dr Nath prescribed buprenorphine in its long-acting injectable form – LAIB.

867. Dr Nath did not document in Heather's JCare record that he had prescribed LAIB without a period of stabilisation on Suboxone.

868. Nor did Dr Nath record the rationale for this prescribing decisions.

869. Dr Nath was employed by CCA but said he was not aware of the relevant CCA guidelines which applied to OSTP at DPFC at the time, generally, nor that specifically relating to LAIB.

870. Whilst Dr Nath said he was not aware of the relevant policies, as the head of the OSTP Clinic at DPFC for some years, he was aware that the general practice at the time was that a patient would initially be stabilised on Suboxone prior to LAIB treatment.

871. In fact, Heather was the first person at DPFC to be prescribed the injectable form of buprenorphine without a period of stabilisation.

872. Dr Nath had never commenced a patient directly on to LAIB without induction by sublingual buprenorphine, other than Heather.[828]

873. Dr Nath said he relied on the (Buvidal) Product Information and the *Victoria Health clinical guidelines* to guide his prescribing decision on 19 November 2021. The latter relates to OST prescribing in the community.

874. In particular, he referred to section 4.1 of the Product Information under *Therapeutic Indications*, relying on the reference to initiation on LAIB *without prior stabilisation* on

[828] T422 L5-8; T446 L16-20.

sublingual buprenorphine. Dr Nath did not refer to section 4.2 of the same document under *Dose and Method of Administration*, which referred to the initiation of LAIB *in patients who have been stabilised on treatment*.[829]

875. In relation to the dose prescribed to Heather, Dr Nath said he used the dose conversion table in the *Victoria Health clinical guidelines*. I note that this table refers to transferring from Suboxone to LAIB and says, *Patients should usually be treated with seven or more days of SL BPN prior to transferring to Buvidal, with either Buvidal Weekly or Buvidal Monthly starting on the day after the last daily SL dose. Buvidal doses are 'matched' to SL BPN doses as shown in the table*.[830]

876. He also relied on that part of the *Victoria Health clinical guidelines* which said, *While not recommended as routine practice, Buvidal Weekly can be initiated directly from short-acting opioids (such as heroin) or after fewer than seven days of SL BPN treatment (for example, the patient unable to access dosing sites for daily SL dosing)*.[831]

877. There are a number of OSTP prescribing guidelines documented in this finding, and I agree with Dr Jansen's view that the policy materials provide a strong framework to guide treating practitioners to commence with a period of stabilisation and that strong and compelling evidence would be needed to deviate from this framework.

878. Dr Nath was aware that there was a practice of stabilisation and why this was the case, and that, prior to Heather, every other patient had received sublingual buprenorphine before having LAIB administered.

879. This practice is also consistent with the policy documents relied on by Dr Nath. Sections 4.1 and 4.2 of the Buvidal Product Information appear to contemplate Buvidal Weekly being commenced with or without prior stabilisation on sublingual buprenorphine, but, only where

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[829] Discussed in this finding under the heading, *Buvidal Product Information.*
[830] Victoria Health clinical guidelines, CB at p.1330, *see* the table replicated (in part) earlier in this finding.
[831] Victoria health clinical guidelines, CB at p.1330.

the patient is *stabilised* on some form of *treatment*. Further, the *Victoria Health clinical guidelines* which he relies upon, also says that direct initiation of LAIB is not *recommended as routine practice* and says that patients should *usually* be treated with seven or more days of Suboxone.

880. Dr Nath gave evidence that he was satisfied that Heather had been using illicit Suboxone in custody without any ill effects. He was aware that there was a compounding risk of sedation and respiratory depression from the prescription of Buvidal, Heather's obesity and her current medications including sertraline and quetiapine. However, he considered that because she had been taking Suboxone in custody with these comorbidities and medications without any adverse effects it would be safe to prescribe LAIB to her.[832]

881. Dr Nath agreed that he based his assessment of Heather's opioid tolerance entirely on her reported use with the knowledge that the nurses had found no objective evidence.[833]

882. One reason he relied on to not commence Heather on opiate replacement therapy via Suboxone was that there was insufficient time left on her sentence to then allow for transition to LAIB. This rationale was not recorded in either his JCare note or the two statements he made to the Court; it was only mentioned at inquest. There was clear expert evidence that there was sufficient time for Heather to be stabilised on the Suboxone before LAIB. This claim appears to have no merit.

883. Dr Nath accepted that *special caution* should be exercised when considering prisoners for whom you do not have any objective evidence regarding their tolerance levels but said it was too late to get objective evidence of Heather's drug use claiming that urine tests are not reliable and take too long.[834] This rationale was not mentioned in the JCare records or either of Dr Nath's statements. In addition, it appears to ignore the thorough assessment conducted

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[832] T448 L8-14; T455 L29 – T456 L3 referencing the Victorian Prison Opioid Substitution Therapy Program Guidelines, dated July 2015, CB at p.1876.
[833] T479 L19-T420 L3; T481 L28-T482 L3.
[834] T540 L23-T451 L6, T457 L28-31.

by RN Duong over a five-month period, which included consideration of any available objective evidence, such as urine tests.

884. There was a divergence of opinion about the appropriateness of Dr Nath's direct initiation of Heather onto LAIB. Associate Professor Clark, Dr Jansen and Associate Professor Rotella did not consider it appropriate prescribing, with Associate Professor Clark describing it as *reckless*. Dr Frei said the prescribing was reasonable but naïve being reflective of *insufficient support or guidance* (this was however not asserted by Dr Nath). Dr Bartels said it was reasonable noting it was a matter for the prescribing doctor and that Heather was given the lowest dose. Having considered the evidence of all the experts in detail, I prefer the opinions of Associate Professor Clark, Dr Jansen and Associate Professor Rotella which are extensively reasoned, and supported by policy guidance.[835]

885. Dr Nath spent much time in an effort to establish via various documents and guidance that Heather *could* have been commenced directly to LAIB (or that it was allowed or permissible). However, I consider the relevant question is whether she should have been directly commenced onto LAIB in the circumstances as they were known on 19 November 2021.

886. I consider that direct initiation to LAIB in Heather's case would have been appropriate, if the prescribing doctor could be reasonably satisfied that she had been stabilised on some form of treatment – in this case, illicit Suboxone.

887. There may be exceptional circumstances which impact on such an analysis, but none appear relevant in Heather's case. There was plenty of time left on her sentence, she had access to prescribed Suboxone at DPFC, and no other viable reason was presented by Dr Nath for consideration.

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[835] I note at [102], in *Runacres* v *The Coroners Court of Victoria* [2024] VSC 304 101, Justice Quigley said, *I am satisfied that the Coroner well understood the task of weighing the evidence that he was required to undertake. This does not mean that he must be satisfied that all the evidence be one way. In any contest of evidence there will be evidence of greater or lesser relevance, objectivity and persuasion. The Coroner had the benefit of observing all of the key witnesses, reference to the relevant documents and extensive submissions on behalf of the interested parties on the cogency and reliability of the evidence.*

888. Consistent with this approach, Dr Nath's said that Heather informed him that she used two or three 2mg Suboxone strips or one 8mg strip , depending on what she could acquire, every three to four days since entering DPFC. Dr Nath apparently considered Heather's reported Suboxone use equivalent to toleration of a daily sublingual buprenorphine dose of 8-10mg (as he appears to have been contemplating commencing Heather on 16mg weekly LAIB).[836] However, using the table in the *Victoria Health clinical guidelines*, *he prescribed a lower dose* - half the dose he considered Heather could tolerate based on her report[837] - not because he was concerned about the accuracy of her report but to account for her comorbidities and medications.[838] When making his decision about dosage, Dr Nath relied entirely on Heather's self-reported use of illicit Suboxone as if she had been prescribed 8mg daily (and was thereby stabilised) notwithstanding that he accepted that *special caution* should be exercised when prescribing ORT to prisoners for whom there is not any objective evidence regarding their tolerance levels.[839]

889. This approach was confirmed by Dr Nath in his submissions to the Court,

> *His reason for commencing on LAIB rather than a preceding sublingual dose is because he considered she had developed tolerance through her illicit use of Suboxone.'*[840]
>
> *In reaching this decision about the dosage at 8 mgs, Dr Nath formed the view that because Heather had already accessed illicit Suboxone that she had developed a tolerance.*[841]
>
> *Dr Nath relied upon the table regarding the equivalence of dosage in an injectable mode compared to a sublingual dose. .... In this table, an 8mg dose is comparable to a sublingual*

[836] T569 L28-T571 L3 and T613 L6-8.
[837] T614 L9-19.
[838] T570 L12-17.
[839] T457 L28-31.
[840] Paragraph 23, Submission dated 29 August 2024.
[841] Paragraph 46, Submission dated 29 August 2024.

dose of 6mgs or less. Dr Nath concluded that the lowest dose of LAIB, being the same as 6mgs or less of sublingual Suboxone was a safe dose to commence Heather with.[842]

890. I acknowledge that Dr Nath had discretion in his decision making, and that he chose the lowest dose of injectable buprenorphine.

891. Turning to the circumstances on 19 November 2021, the following was known,

    a. There was no collateral evidence to support Heather's claims of opiate use and dependence in the community;

    b. Heather had no physical evidence which suggested opiate dependence or withdrawal (including no physical indications of intravenous drug use);

    c. There was no collateral evidence to support her claim of opiate use in prison and she had not been provided a withdrawal pack upon entering custody;

    d. RN Duong had conducted a thorough assessment over five months and determined that Heather did not meet the OSTP guidelines – the details of which were all available to a prescribing doctor.

892. In addition, there were two apparently different versions of her unprescribed drug use in the space of 10 days, being 9 and 19 November 2021. Dr Nath said that he did not consider, *occasional* use, as reported to RN Duong and, *every three to four days use*, as reported to him, to be very much different.[843] This observation is not compelling.

893. And further, Heather's report of illicit Suboxone use since entering DPFC appeared somewhat implausible, and was unsupported by any other evidence. Dr Nath seemed unaware that a prisoner may overstate their drug use to gain access to the OSTP and said it was

[842] Paragraph 47, Submission dated 29 August 2024.
[843] T480 L30-T481 L3.

important to trust what a person is saying.[844]

894. In contrast, RN Duong indicated that Heather required a thorough medical assessment in order to make a prescribing decision and there must be critical analysis of what people are telling you to support *safe practice*.[845] RN Duong's approach is commendable.

895. Her approach is also consistent with the principle of *primum non nocere* (first do no harm).

896. Having considered all of the above matters, I do not consider a prescribing doctor could have been reasonably satisfied based on the information available that Heather had been stabilised on a treatment – in this case, illicit Suboxone, such that direct initiation to LAIB was appropriate, without a period of induction on sublingual strips.

897. Heather's opioid tolerance was likely to have been equivalent to someone naïve or with very low or low or uncertain tolerance. On any assessment, she was not opioid tolerant.

898. I agree with Associate Professors Clark and Rotella that the buprenorphine dose administered to Heather was too high for her tolerance level and the best course of action in this case was to use a dose that would clearly be safe for Heather.

899. RN Millson administered the LAIB to Heather on 22 November 2021. There is no evidence to suggest that Dr Nath alerted the OSTP Nurses that he had departed from the general practice of stabilising the patient on Suboxone strips before LAIB treatment. As such, RN Millson, was not aware that Heather had been inducted directly to LAIB.

900. Given that every other patient had been stabilised on Suboxone prior to the administration of LAIB and that she had not received any information that Heather's case was different, RN Millson's assumption was reasonable.

901. Having made that assumption, RN Millson also assumed Heather had started her observations

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[844] T531 L10-12, T578 L10-14, Supplementary statement of Shalendra Nath, CB at p.1242.
[845] T368 L28-30.

on the first day of having Suboxone strips, had observations already completed in the morning, and that she was on day seven of the OSTP program. Again a reasonable assumption to have made.

902. Heather should have been monitored in accordance with CCA OSTP and LAIB guidelines following administration of the LAIB on 22 November 2021.

903. It was Dr Nath's expectation that Heather would be monitored by way of observations after the administration of the LAIB and relied on the OSTP Nurses to do so.

904. However, as the general practice of commencing on Suboxone strips had not been followed by Dr Nath, a plan for observations was not initiated.

905. Dr Nath referred to every member of the *team*[846] being responsible to play their part, in the context of monitoring and the 2015 Guidelines refers to a treatment team comprising the prison medical practitioner and OSTP Nurse. I note that both RN Duong and RN Millson were aware of the applicable OSTP guidelines and, applied them to the work they undertook at DPFC. Dr Nath was the only *team member* not similarly informed.[847]

906. In my view, the obligation to ensure that Heather was appropriately monitored rested with Dr Nath. He had departed from standard practice by prescribing LAIB without a period of stabilisation. He therefore had an obligation to explicitly communicate this to the appropriate staff members and arrange for monitoring.

907. The absence of monitoring was contrary to applicable policy including that of CCA and Justice Health.

908. In making these findings I am aware that I must be so satisfied in accordance with the *Briginshaw* standard.

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[846] T439 L5.
[847] T991 L15.

EMERGENCY RESPONSE

Expectations of qualification for CCA agency nurses to a medical emergencies

909. At the time of Heather's collapse, CCA engaged labour hire agencies to provide registered nurse services. CCA expected that the agency staff, being registered nurses, would be compliant with appropriate credentials and have adequate skills to undertake the role of a registered nurse which would include Basic Life Support competency.

Equipment available to CCA clinical staff responding to a medical emergency

910. As of November 2021, CCA clinical staff at DPFC had access to essential emergency equipment for responding to medical emergencies, including situations requiring cardiac pulmonary resuscitation. The available equipment included a First Line Assessment and Treatment Backpack containing necessary resources for initial assessment and response, a Life Line Resus Kit featuring oxygen and a Twin-O-Vac suction kit, and an Automated External Defibrillator (**AED**). Emergency guidelines would have been available in the response bag for staff responding to the emergency.[848]

Orientation/training provided to CCA clinical staff about using the equipment when responding to a medical emergency

911. Orientation/training in the use of emergency equipment is part of Basic Life Support competency. It would be the usual practice for employed clinical staff to undertake an orientation to the site and area and for any health practitioners engaged via agencies to undertake a local site overview at DPFC upon commencement. This would generally involve being shown where the emergency response equipment was located and the requirement to regularly check the emergency equipment.[849]

912. All emergency bags are checked daily by nursing staff against standardised checklists to record that tamper evident seals remain intact and items unable to be sealed are present, in

[848] Statement of Mark Bulger, CB at p.3468.
[849] Statement of Mark Bulger, CB at p.3468-3469.

date and in working order. A full checklist of the bag is completed after use, when a seal is broken and/or at least monthly.[850]

Code Black on 23 November 2021

913. RN Rochelle Betita and RN Imelda Morgan attended the Code Black on the morning of 23 November 2021. Both nurses gave evidence at the inquest.

914. RN Betita was an agency nurse with CCA and had worked at DPFC since October 2021. She had never worked in a prison before and had never attended a Code Black. She was rostered to work in the Nurse Clinic when the Code Black was called on 23 November 2021.[851]

915. RN Morgan had been an RN for over 20 years and was also an agency nurse with CCA and had worked at DPFC since October 2021. She had never worked in a prison before and had attended seven or eight Code Blacks.[852] She was rostered on the *floater shift*, which meant that she was not rostered to any particular clinic on 23 November 2021.[853]

916. Both nurses were registered with Australian Health Practitioner Regulation Agency (**AHPRA**).

917. Two nurses are required to attend a Code Black and the responding nursing staff assume a coordinating role when attending to a patient in an incident response.

918. Two emergency bags were collected, being the emergency backpack and the AED. The nurses were transported by an electric buggy with a PO to the Blackwood Unit. The PO had collected the oxygen cylinder which is also taken to a Code Black site.[854]

919. Neither nurse had any information about the nature of the Code Black. Neither were

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[850] Statement of Mark Bulger, CB at p.3469.
[851] Statement of Rochelle Betita, CB at p.119; T830 L31-T831 L1.
[852] T776 L27.
[853] Statement of Imelda Morgan, CB at p.120.
[854] Statement of Rochele Betita, CB at p.119; Statement of Imelda Morgan, CB at p.120.

permitted to carry phones with them at the time.[855]

920. RN Morgan said that she had no knowledge of the patient, their history or the medical emergency and there was no ability to gain that information at the time independently.[856]

921. It was apparent when the nurses arrived at the Blackwood Unit that the scene was crowded and there were numerous POs occupying the small space - being Heather's room. The BWC footage captured up to 7 people in the room (including the nurses but excluding Heather) at times with further POs at the doorway.

922. RN Morgan described the environment as noisy. She said, *There was so much noise … – it was unbelievable….* She said that everyone was talking and there was *so much movement*.[857] She said that *it was so chaotic that day it was hard to hear anything, the prison officers were just everywhere and it was confusing*.[858]

923. It was also apparent from the BWC footage that some POs knew Heather very well, that they were anxious that she received the best care and were worried about her presentation. Medical information was also being provided verbally during the nurses' assessment, including whether Heather had experienced a seizure and that she had been given her first ORT injection the previous day.

924. Once they were on scene, the nurses were in charge of Heather's medical management, and therefore they were required to exercise leadership at the scene, which included the decision to call an ambulance.[859]

925. RN Morgan said when they first entered Heather's room that someone behind her asked whether an ambulance was required and that she did not respond as she had not yet assessed

[855] T771 L6-8.
[856] T770.
[857] T775 L20-22, L25-27.
[858] T787 L7-9.
[859] T843 L19-21.

Heather.[860] She also said that she remembered that Heather was at the Diabetes Clinic (just from her name) so that is why she proceeded to check her blood sugar levels during the assessment.[861]

926. When showed BWC footage at inquest, RN Betita said she could see from the footage that a PO put his head close to her asking about an ambulance being called, but said that she was conducting a blood pressure reading with the stethoscope in her ear and, with the noise in the room, she could not hear him at the time.[862]

927. There were issues identified with the equipment, and its operation.

928. Neither nurse could open the emergency bag, one of the ERGs opened it.[863] RN Morgan could not find the scissors in the emergency bag, so she asked a PO for assistance.[864]

929. RN Morgan said the Hudson mask was connected to the oxygen cylinder rather than the valve mask and it was not changed. She agreed it would have been better to apply the bag valve mask, but never had a chance because she was stuck in the room and never had a chance to ask someone to do it as she was concentrating on a task.[865]

930. RN Betita said she had no training with a dual function oxygen machine. She attached the Hudson mask as this was the first mask she saw and thought that it was the only one available. She said that she was not familiar with the content of the equipment bag.

931. RN Betita could not operate the portable oxygen machine. RN Morgan said it was unusual, and she had not worked with it before. It had both oxygen and sanction functions; they had not been trained in its use but managed to get it to operate.[866]

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[860] Statement of Imelda Morgan, CB at p.121.
[861] T776 L6-9.
[862] T843 L5-14.
[863] Statement of Imelda Morgan, CB at p.122.
[864] Statement of Imelda Morgan, CB at p.123.
[865] T810 L26-T812 L31.
[866] T809 L10-T810 L6.

932. RN Morgan said that she did not feel confident to communicate with the prison officers and it would have been more comfortable if she had met them beforehand - *Maybe knowing them and knowing who's in charge so we can ask them you know if we require anything. ... It was a very difficult situation*.[867]

933. She said that they were both agency nurses,

we're both in unfamiliar environment and most of the nurses who were there during that day were all, they were all permanent and we're only agency nurses.[868]

934. RN Morgan said that in relation to Code Black training, they do buddy shifts, where they join another team who is attending the Code Blacks and there is also hardcopy information.[869]

CCA Adult, Emergency Guidelines For Registered Nurses

935. The CCA Adult, Emergency Guidelines For Registered Nurses[870] provides as follows,

- *Nurses must call an ambulance without delay if assessment reveals any acute deterioration in the patient's condition as directed in these guidelines or if the nurse is concerned about a patient*.[871]

- *The emergency patient assessment commences with a rapid assessment to recognise if the patient is seriously ill or injured and needs immediate management or is less acutely unwell allowing time to conduct a more thorough assessment. Send for help and call an ambulance as soon as it is identified that the patient condition requires a higher level of care that can be provided on site, or the patient is deteriorating*.[872]

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[867] T813 L18-28.
[868] T814 L10-13.
[869] T816 L14-17.
[870] Correct Care Australasia, Adult Emergency Guidelines for Registered Nurses 2021-2023, CB at p.2177.
[871] Correct Care Australasia, Adult Emergency Guidelines for Registered Nurses 2021-2023, CB at p.2181.
[872] Correct Care Australasia, Adult Emergency Guidelines for Registered Nurses 2021-2023, CB at p.2185.

- *If not breathing normally, commence basic life support measures*.[873]

- *If unable to palpate carotid pulse in less than 10 seconds, commence CPR.*[874]

936. RN Morgan advised that an ambulance was called once the assessment was complete but agreed that Heather required a higher level of care than they could provide and that in hindsight, basic life support should have been commenced as soon as it could be seen that Heather was not breathing normally.[875] She also agreed that given they were unable to palpate a carotid pulse, CPR should have been commenced a lot earlier.[876]

937. RN Morgan also considered that her ability to provide basic life support and good clinical care was compromised by the environment being chaotic including being too noisy.[877]

938. RN Morgan agreed however that as part of her basic training, when she first qualified as a nurse, she received instruction, training and education about provision of basic life support to patients. In addition, that to maintain nursing registration annually, further educational or a refresher of basic life support training is undertaken.[878]

939. RN Betita said that she had never received any training (including online training) about what was expected of a nurse in a Code Black and was not familiar with the protocols of DPFC as they apply to responding to an emergency.[879]

940. RN Betita agreed that as soon as she became aware that Heather's breathing was abnormal in the way it was, her care should have been escalated and an ambulance called earlier.[880]

941. RN Betita accepted that there were some things that were not done in accordance with ideal

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[873] Correct Care Australasia, Adult Emergency Guidelines for Registered Nurses 2021-2023, CB at p.2185.
[874] Correct Care Australasia, Adult Emergency Guidelines for Registered Nurses 2021-2023, CB at p.2185.
[875] T818 L22-24.
[876] T181 L25-29.
[877] T819 L8-12.
[878] T822 L31-T823 L6.
[879] T8T832 L1-6.
[880] T835 L9-12.

emergency nursing practice and that recognising those red flags at the beginning, an ambulance should have been called straight away, given the limitations on the care they could provide, and that CPR should have been commenced sooner.[881]

942. RN Betita said that her lack of familiarity with the emergency kit made it difficult to open it and find things, noting there was neither training with the bag or the Code Black itself.[882]

943. She also agreed that as part of her basic training, when she first qualified as a nurse, she received instruction training and education about provision of basic life support to patients. In addition, that to maintain nursing registration annually, further educational or a refresher of basic life support training is undertaken. RN Betita said that she did not have time to read the CCA manual but agreed it is consistent with basic training and refreshers she had received.[883]

Justice Health Review, CCA's response and Expert evidence

944. The Justice Review noted the following with respect to the medical equipment:

- the tamper-proof seals that secured the emergency bags were the wrong ones and impeded access to the bags by nursing staff.
- the pulse oximeter battery was low.
- nursing staff were unable to operate the oxygen equipment effectively and were not trained in its use.[884]

945. The Justice Review further noted that tamper-proof seals are used to seal emergency bags once the contents have been restocked. They indicate that the contents of the bag have been checked and are ready for use and are not intended to prevent the bag from being opened.

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[881] T843 L22-31.
[882] T844 L2-16.
[883] T844 27-28; T846 L13-22.
[884] The Justice Review, CB at p.3343.

The seals snap under light pressure to allow quick access to the content of the bag in an emergency situation.[885]

946. The Justice Review noted with respect to the relationship between CCA staff and POs,

Custodial staff described the Post Incident Briefing as an 'us vs medical' between custodial staff and CCA staff, reflective of the poor working culture between the two teams at the time.[886]

At interview, both health and custodial staff indicated a strained working relationship, with low levels of trust between the two areas. This review considers that these cultural issues impacted Heather's management in custody.[887]

947. On behalf of CCA, Mr Bulger said that the nurses should have been given an orientation to the prison and to the roles that they were going to undertake in the prison.[888]

948. He noted in relation to the scene that, *it seemed to me that it was a very intimidating environment to be in.*[889] He also noted the uniqueness of the prison environment, including there being no phones and small spaces.

949. Mr Bulger accepted that the nurses did not, at the time of this incident, receive specific prison training that employed CCA staff received which aims to equip the staff to respond effectively to an emergency situation specific to the prison setting.[890]

950. He agreed that to respond adequately to a critical incident, specific prison training would be needed which would include a Code Black, and opioid overdose.[891]

951. Mr Bulger further agreed there was a significant difference between having basic

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[885] Ibid.
[886] The Justice Review, CB at p.3354
[887] The Justice Review, CB at p.3356
[888] T1506 L15-21.
[889] T1507 L18-20.
[890] T1520 L18-20.
[891] T1521 L15-21.

competencies and being able to respond to a situation.[892]

952. He did however note that none of the equipment is anything that would not normally be used in a resuscitation attempt or providing basic life support.[893]

953. Ultimately, Mr Bulger agreed that the agency staff had inadequate training to respond to this incident.[894]

954. In addition, it would have been his expectation that a staff nurse should always be present, responding to a Code Black.[895]

955. It was clear from the evidence of Court's expert, Professor Fitzgerald, that there was nothing that could have been done during the emergency response that would likely have made a difference to Heather's outcome. Heather was never going to recover from the hypoxic brain injury incurred over an extended period of inadequate oxygen and blood flow to the brain. Nor would the administration of naloxone at 8am have altered Heather's outcome.[896]

956. Professor Fitzgerald said that prison and nursing staff who find an unconscious patient with abnormal breathing, should respond by applying the relevant protocol of the prison.897 He said that you need clear guidelines for the staff to follow in order to then judge their efficacy and compliance against those guidelines and their training.[898]

957. Both RN Morgan and RN Betita accepted that, in hindsight, CPR should have commenced sooner, if not immediately.

958. RN Betita also accepted that she should have escalated Heather's care and called an

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[892] T1521 L27-30.
[893] T1527 L28-T1528 L7.
[894] T1526 L9-19.
[895] T1528, L8-13.
[896] Expert opinion of Professor Fitzgerald, CB at p.3007.
[897] T1404 L21-23.
[898] T1407 L5-16.

ambulance as soon as they attended and observed that Heather was unresponsive.

959. Not calling an ambulance and commencing CPR upon recognising Heather's irregular breathing, and when unable to obtain a pulse, was in contravention of CCA Emergency Guidelines and policy in respect of Vital Signs and Clinical Deterioration which stipulates that ambulance should be called if, a patient's oxygen saturation is measured below 90%; a patient's heart rate is below 40 beats per minute; or if there is any concern about the patient, regardless of observations.[899]

960. However, Professor Fitzgerald emphasised that the emergency response should not be compared to an in-hospital resuscitation response and that he did not believe that the response, viewed objectively, should be considered inadequate.[900] He emphasised that the cause of Heather's collapse was uncertain and unexpected, that staff were not in an environment with monitoring equipment and they did not have the experience or background to quickly appreciate the gravity of Heather's situation.

961. On the contrary, he observed that staff *did show a lot of concern and kindness to her. They were reassuring her, and I thought it was quite empathetic their treatment, I just think they were out of their depth*.[901]

Assessment of Emergency Response

962. It is relevant that both RN Morgan and RN Betita were agency nurses who had not been provided with adequate training on the response to a Code Black in DPFC and the equipment that they would be required to use.

963. RN Morgan had not received any specific training in relation to emergency situations in prisons. The training provided was through buddy shifts in which she would attend other Code Blacks with staff, however, those she attended were very minor and non-critical

[899] Correct Care Australasia, Policy 7.2, Vital Signs & Clinical Deterioration, CB at p.2147.
[900] Supplementary expert report of Professor Fitzgerald, CB at p.3955;T1412 L18-28.
[901] T1406 L20-25.

incidents. The training that RN Morgan received on the emergency equipment supplied was conducted online.

964. RN Betita had never attended a Code Black and had never received any training in relation to it. While she was hired with basic first aid training, it was not specific to a prison environment. Indeed, RN Betita had no prior familiarity with the emergency kit and had not been given information as to what was inside it.

965. In contrast clinical staff employed by CCA at DPFC received comprehensive training delivered by the Clinical Education team and onsite instructors which had been specifically tailored for the unique challenges of the prison environment.

966. Mr Bulger accepted that the training provided to the agency staff in relation to incidents such as Heather's was inadequate. He also said that there should always be a staff nurse attending.[902]

967. Professor Fitzgerald recommended an emergency card, with significant crisis information imprinted on it, be contained within the lanyard of nursing staff and other responders. Mr Bulger indicated that CCA were in the process of implementing a similar system in the twelve months prior to CCA ceasing service provision at DPFC.[903]

968. Professor Fitzgerald said with his over 40 years' experience in resuscitation and in reviewing resuscitation, he was uncertain as to how the response to Heather's collapse can be objectively measured, to then be considered inadequate. He said that the incident cannot be compared to an in-hospital resuscitation response, within a purpose-built, well-lit environment populated by trained, experienced expert staff who have immediate access to resuscitation equipment and monitoring.[904]

969. Professor Fitzgerald was clear in his evidence that not every failure to comply with a policy

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[902] T1528 L14-17.
[903] T1413 L28-T1414 L1, T1508 L14-29.
[904] Supplementary expert report of Mark Fitzgerald, CB at p.3955.

or procedure during an emergency response will be an indication of inadequacy in that response.

970. As noted in submissions on behalf of RN Betita, Professor Fitzgerald provided advice that,

a. this a very complex resuscitation,

b. the "criticism of the nursing staff... was quite unreasonable because it would be very difficult to set up protocols for this sort of circumstances";

c. the nurses "initial assessment was reasonable and then things changed dramatically";

d. "the initial response was that [the nurses] were applying basic life support guidelines".[905]

971. I agree with the opinion of Professor Fitzgerald, and while acknowledging the concessions made by the attending nurses, I do not intend to make findings against them which would be considered adverse.

972. I also agree with Mr Bulger that there is a significant difference between having basic competencies and being able to adequately respond to a situation.

973. Neither nurse had a great deal of familiarity with working in a prison environment, particularly a situation where they were required to assume responsibility and leadership of a significant event, which on this occasion was also chaotic and challenging. Mr Bulger expected that a permanent RN should have been in attendance.

974. In addition, I am mindful of the state of the relationship between POs and CCA staff which was alluded to in the Justice Review.

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[905] Paragraph 10 of Submission dated 30 August 2024 (footnotes removed).

975. I consider that the nurses who attended the Code Black were insufficiently prepared to have attended such an event and to criticise them in those circumstances is unjustified.

976. I further note that the key issue identified by Professor Fitzgerald was the failure to recognise an *at risk* person and then to provide better informed and more intensive observation, referring to the administration of Buvidal to Heather the day before.[906]

CAUSE OF DEATH

977. A number of expert panels were convened to assist with matters relating to the cause of death and associated issues.

978. These panels included,

a. A 'pathology panel' comprising Dr Joanne Ho,[907] Dr Yeliena Baber,[908] and Professor Johan Duflou;[909]

b. A 'toxicology panel' comprising Associate Professor Joe-Anthony Rotella[910], Dr Michael Robertson[911] and Associate Professor Dimitri Gerostamoulos;[912]

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[906] Statement of Professor Mark Fitzgerald, CB at p.3007.
[907] *See* Autopsy Report of Dr Joanne Ho and Dr Yeliena Baber, CB at p.145.Forensic pathologist at the VIFM with a fellowship with the Royal College of Pathologists Australia and Bachelor of Surgery and Medicine.
[908] *See* Autopsy Report of Dr Joanne Ho and Dr Yeliena Baber, CB at p.145.Forensic pathologist at the VIFM and member of the Royal College of Surgeons of Edinburgh, the Royal College of Pathologists of the UK and Australasia and a Fellow the Faculty of Post-mortem Imaging.
[909] Forensic pathologist with over thirty years' experience. He has a Master of Medicine in Forensic Pathology and is a Fellow of the Royal College of Pathologists of Australasia. Report of Professor Duflou, CB at p.3582.
[910] *See* Expert Report of Associate Professor Rotella, CB at p. 2975.Consultant emergency medicine physician and clinical toxicologist. His experience includes care for patients with problems pertaining to toxicology, alcohol and other drugs, addiction and mental health, and he is the current lead toxicologist at Northern Hospital.
[911] *See* Expert Report of Dr Michael Robertson, CB at p.3566.Pharmacologist and forensic toxicologist. Dr Robertson has a PHD in medicine, specialising in toxicology.
[912] Head of Forensic Sciences and Chief Toxicologist at the VIFM. He has a Doctor of Philosophy in Forensic Toxicology and a Bachelor of Science with Honours in Pharmacology and Chemistry.

c. A ‘cardiac and emergency medicine panel’ comprising Dr Garry Helprin,[913] Professor Richard Harper[914] and Professor Mark Fitzgerald.[915]

979. In addition, the ‘OSTP panel’ comprising Associate Professor Clark and Dr Frei, also assisted with further analysis.

Initial findings and cause of death

980. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 10 December 2021 and provided a written report of her findings dated 8 August 2022.[916] At the time, Dr Ho was a registrar and, pursuant to VIFM guidelines, required supervision by a senior pathologist. Senior VIFM pathologist, Dr Yeliena Baber, supervised the autopsy and co-signed the medical examination report.

981. Autopsy findings included,

a. Features of hypoxic ischaemic encephalopathy.

b. Cardiac hypertrophy (heart weight 528 g).

c. Moderate atherosclerosis of the left anterior descending coronary artery and mild atherosclerosis of the right coronary artery and left circumflex coronary artery.

d. Moderate hepatic steatosis (‘fatty liver’).

e. WHO Class III obesity (body mass index 54 kg/m$^{2)}$.[917]

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[913] *See* Expert Report of Dr Garry Helprin, CB at p.3023.Cardiologist with over thirty years of clinical experience in full time private practice, including two university teaching hospitals.
[914] *See* Expert Report of Professor Richard Harper, CB at p.3662.Consultant and interventional cardiologist. He is currently Emeritus Director of MonashHeart, Monash Health and holds an honorary position as Adjunct Professor of Medicine at Monash University.
[915] *See* Expert Report of Professor Mark Fitzgerald, CB at p.3004 and Supplementary expert report of Mark Fitzgerald, CB at p.3954. Fellow of the Australasian College for Emergency Medicine, with a Doctorate of Medicine, who performs clinical work at the Trauma Clinic at the Alfred Hospital.
[916] Autopsy Report of Dr Joanne Ho and Dr Yeliena Baber, CB at p.144.
[917] Autopsy Report of Dr Joanne Ho and Dr Yeliena Baber, CB at p.144-160.

982. In her report, Dr Ho provided advice that, despite a full post-mortem examination, including ancillary testing, the cause of Heather's initial cardiac arrest remains unclear. She noted several factors to be considered which included the following,

- There were concerns raised by the treating clinical team in Sunshine Hospital surrounding the use of long-acting buprenorphine, commenced on 22 November 2021, having contributed to her respiratory depression and arrest. It is a central nervous system (**CNS**) and respiratory depressant. Norbuprenorphine (metabolite of buprenorphine) was detected in the postmortem urine. No buprenorphine or norbuprenorphine was detected in antemortem or postmortem blood. As such, while it is possible that the buprenorphine has caused or contributed to death, it cannot be unequivocally proven due to the effects of drug metabolism in the antemortem period.

- The autopsy showed an enlargement of the heart (cardiac hypertrophy) with a heart weight of 528 grams. The expected heart weight for a woman of this age, weight and height should be 449 grams. Increased heart mass is correlated with increased cardiac mortality and morbidity, and is an independent risk factor for sudden death due to a cardiac arrhythmia ("heart attack"). The cause of her enlarged heart is unknown. The main causes of cardiac hypertrophy are hypertension, valve disease, inherited cardiomyopathies and obesity. While it is possible that her enlarged heart has contributed to her death, it is unlikely to be the sole cause for the initial collapse.

- Furthermore, there is an association between sudden cardiac death and obesity as they share common traditional cardiovascular risk factors such as hypertension, diabetes, obstructive sleep apnoea and metabolic syndrome. As such, structural, functional and metabolic factors modulate and influence the risk of sudden cardiac death in the obese population. Other risk factors such as left ventricular hypertrophy, increased number of premature ventricular complexes, altered QT interval and reduced heart rate variability are all documented in both obese and sudden cardiac death populations.

- Antemortem testing showed prolonged hyperglycaemia (with the highest glucose level documented at 36.0 mmol/L on an arterial blood gas (**ABG**) on the 23 November 2021 at 11.24am) in the setting of poorly controlled diabetes mellitus, which raises the possibility of diabetic ketoacidosis as the cause of the initial collapse. This can be a serious complication of diabetes mellitus that can lead to dehydration, diuresis, retention of ketones and eventual metabolic derangements which may be fatal. While this level of glucose was markedly elevated, at the same time, she had a documented ketone level of 0.2 mmol/L which is within the normal range of < 0.6 mmol/L. The prolonged hyperglycaemia cannot be entirely excluded as a contributing factor; however, the lack of ketosis makes a diabetic ketoacidosis less likely as a cause for her initial collapse. Beta-hydroxybutyrate, a ketone that can be elevated in instances of diabetic ketoacidosis could not be performed on antemortem samples due to sampling artefact. Hyperglycaemia can also be seen in instances of physiological stress as an adaptive immune-neurohormonal response in an attempt to increase metabolite substrates to struggling organs which may explain the ongoing hyperglycaemia in the clinical setting.

- The autopsy also showed features of hypoxic ischaemic encephalopathy, moderate atherosclerosis of the left anterior descending coronary artery and mild atherosclerosis of the right and left circumflex coronary arteries, moderate hepatic steatosis, bilateral parietal subgaleal haematomas and increased body mass index (BMI 54 kg/m^2). The lungs were congested and heavy but there was no evidence of aspiration pneumonia.

- Atherosclerosis is a build-up of cholesterol in the artery wall which narrows the artery meaning less blood carrying oxygen and nutrients flows to the heart muscle. This causes a condition known as ischaemia which predisposes to the development of cardiac arrhythmias and sudden death. Risk factors for the development of atherosclerosis include smoking, hypertension, hypercholesterolaemia, diabetes mellitus, obesity, and genetic factors. There is also an association of accelerated coronary artery disease in long term methamphetamine use. While Heather has

multiple risk factors, the amount of atherosclerosis identified is not in keeping with her age and raises the possibility of a genetic predisposition.

- Deranged liver functions were identified clinically and the possibility of non-alcoholic hepatosteatosis (**NASH**) was raised. Histology was limited by postmortem autolysis and only demonstrated possible moderate steatosis.

- Toxicological analysis of antemortem (collected 23 November 2021 at 11.06am) and postmortem blood showed no ethanol (alcohol). Levetiracetam (anticonvulsant) was detected in postmortem blood and urine but not antemortem blood. Sertraline (antidepressant) was detected in antemortem blood, postmortem blood and urine. Paracetamol was detected within antemortem blood but not postmortem blood. Amlodipine (antihypertensive), lignocaine (local anaesthetic) and metoclopramide (antiemetic) were detected in the urine. It is not clear how these may have interacted with the buprenorphine administered on 22 November 2021.

- During the consult on the 19 November 2021, Heather mentioned she had been *using* every three to four days since being in prison. Hair analysis (analysed hair mass ~ 23 cm of ~ 26 cm; approximate time frame 27 September 2021 to 27 November 2021) showed methylamphetamine (including metabolite amphetamine). No opioids were detected.

- Heather was also documented to have mixed acidosis then queried lactic then later respiratory acidosis. Given the clinical circumstances and findings, this has likely occurred as a result of her original precipitating event, in particular the prolonged lack of oxygen, rather than a cause of her original precipitating event.

- An antemortem c-reactive protein (**CRP**) was detected a concentration of 18 mg/L. CRP is a marker of inflammation or infection. There was no evidence of infection at autopsy or on histology. This level is only mildly elevated and may reflect a mild inflammation, which could be secondary to her recent tooth extraction or secondary to her cardiopulmonary resuscitation.

- Heather also had a tooth extraction the day prior to her death (tooth 23 socket identified on the PMCT). There was no overlying infection. This has had no effect on the cause of death.

- There were anterolateral right 3rd to 5th and left 2nd to 6th rib fractures, likely from cardiopulmonary resuscitation which may possibly explain the right apical pneumothorax identified clinically.

- There were bilateral parietal subgaleal haematomas and congestion, without underlying skull fracture or intracranial pathology; this was likely secondary to her terminal collapse. There was no other post-mortem evidence of any injuries which may have caused or contributed to death.[918]

983. Dr Ho provided an opinion that the cause of death was,

Hypoxic Ischaemic Encephalopathy complicating cardiac arrest of unclear aetiology in a woman with Type 2 Diabetes Mellitus and WHO Class III obesity.

984. Professor Duflou documented that he agreed with Dr Ho's formulation in his report. He said that there is without doubt hypoxic ischaemic encephalopathy (brain damage due to a period of lack of blood flow and oxygen to the brain).[919]

Absence of buprenorphine

985. No buprenorphine was detected in Heather's antemortem blood specimen (collected at 11.06am on 23 November 2021), and the drug was also not detected in the postmortem blood specimen. Norbuprenorphine, the drug's metabolite, was detected in a specimen of postmortem urine only.[920]

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[918] Ibid.
[919] Expert report of Dr Johan Duflou, CB at p.3592.
[920] VIFM Toxicology Report, CB at p.161-175.

986. Professor Duflou said that *these results are difficult to interpret with certainty*.[921] He further stated that, if it is accepted that buprenorphine was administered in the morning of 22 November 2021, some 25 hours prior to the antemortem blood specimen being collected, it would be expected that buprenorphine would be readily detectable in the blood specimen, given an expected peak blood level of around 1.5ng/mL (median 1.57ng/mL, range 0.95-2.54ng/mL) on administration of 7.5mg, at around 1 to 2 days post-administration, and a minimum detection limit of 0.5mg/mL by the toxicology laboratory.[922]

987. Dr Duflou said that the reason for an absence of detectable buprenorphine (or norbuprenorphine) in Heather's antemortem specimen is not clear.[923]

Information not available to the pathologists at the time of the original report

988. The absence of detectable buprenorphine (or norbuprenorphine) was extensively considered at inquest, as there appeared to be no doubt that Heather had in fact received the buprenorphine injection on 22 November 2021 and also displayed numerous signs consistent with its effects after it administration.

989. It was important therefore that the VIFM pathologists had an opportunity to further consider the cause of death given that there was information not available to them at the time of the original report. This included,

- witness statements (before and after Heather's collapse);
- specific expertise around opiate replacement therapy (which considered the evidence contained in the coronial brief);

[921] Expert report of Dr Johan Duflou, CB at p.3594.
[922] Ibid.
[923] Ibid.

- expert analysis of the features observed after Heather collapsed (which considered the evidence contained in the coronial brief and specifically the BWC footage); and,
- expert advice regarding toxicology, including how specific drugs interact.

990. I note that it is not the practice of a forensic pathologist to wait for a completed coronial brief and, evidence at inquest before a cause of death is given - this would be both impractical and unworkable.

Further toxicology information

991. Further enquiries with Associate Professor Gerostamoulos, Chief Toxicologist of the VIFM, revealed that buprenorphine and norbuprenorphine were in fact present in the antemortem sample, and therefore in Heather's blood stream, but at below reportable levels. The buprenorphine result was 0.17 ng/mL, with the reportable level at the VIFM being 0.5 ng/mL. The norbuprenorphine result was 0.9 ng/mL, with the reportable level being 1.0 ng/mL.[924]

992. Heather was noted to have consumed a range of drugs on 22 November 2021 which included,

a. at 8.30am: 25mg of empagliflozin; 1000mg of metformin; 5mg of ramipril and 100mg sertraline;

b. at 10.15am: first dose of buprenorphine 8mg weekly subcutaneous injection (Buvidal);

c. at 11.00am: local anaesthetic before tooth extraction;

d. at approximately 1.00pm – 3.00pm: 4mg of ondansetron;

e. at 4.30pm: 20mg of atorvastatin; 1000mg of metformin; 100mg of quetiapine; and

f. at 10.15pm: two paracetamol tablets.

[924] Email between the Coroners Court of Victoria and Associate Professor Dimitri Gerostamoulos of the VIFM, dated 15 February 2024, CB at p.3902.

993. Analysis of the antemortem blood sample found sertraline at a concentration of ~0.08mg/L which is consistent with therapeutic use. In addition, paracetamol at a concentration of less than 5mg/L which also consistent with Heather having consumed paracetamol in the evening.

994. Of the medications administered on 22 November 2021, all were excluded by the expert toxicology panel from having a role in Heather's collapse or death, except the buprenorphine and the quetiapine.[925]

How buprenorphine operates

995. Buprenorphine operates on the opioid receptors in the brain. Associate Professor Rotella explained,

> *Buprenorphine is a partial opioid agonist that demonstrates both high potency and high avidity for the endogenous opioid receptors (the most clinically important of which is the u (mu) receptor. In other words, buprenorphine can stimulate a measurable response at opioid receptors in the body at lower concentrations than other opioids such as morphine (the former is 80 times more potent in relation to morphine) and binds more strongly to the opioid receptor than any other opioid.*[926]

996. Buprenorphine is typically metabolised to norbuprenorphine by the liver. But when administered subcutaneously, the patient demonstrates slightly less metabolism because the drug bypasses the gastrointestinal tract. Buprenorphine is then excreted primarily in faeces, with some excretion through urine, together with norbuprenorphine.[927]

Interpreting the toxicological results

997. The concentrations of buprenorphine and norbuprenorphine were lower than would be expected following the administration of the Buvidal the previous day.

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[925] T953–T955.
[926] Expert report of A/Prof Rotella, CB at p.2976.
[927] T873 L26-T874 L7.

998. Dr Robertson said that generally reported therapeutic range is between 0.5ng/mL and 5ng/mL. Toxicity is reported between 10ng/mL to 100 ng/mL and concentrations in fatal cases have been reported between 8ng/mL and 29ng/mL although some have been as low as 1.1 ng/mL.[928]

999. The presence of norbuprenorphine in toxicological samples, does, however, confirm that there was sufficient exposure to buprenorphine for norbuprenorphine to be produced.[929] In the antemortem blood sample, the detected level of 0.9ng/mL contains a variance of +/- 0.5ng/mL. This means that the level may be as low as 0.4ng/mL or as high as 1.4ng/mL.

1000. At inquest, Associate Professor Gerostamoulos said that it is not possible to draw conclusions about toxicity from opioid toxicology results alone. He stated,

It's not possible just simply from a numerical value to imply that the drug is potentially toxic. It may be but there may be other factors as well that need to be considered. The presence of other drugs, the presence of any comorbidities, the time of administration of the drug, that's also something that needs to be considered, whether that person can actually metabolise that drug. There are a number of factors. It's not just simply based on a number.[930]

1001. He further stated that opioid concentrations in particular *are inherently difficult to interpret on their own and that be it for buprenorphine, be it for morphine, be it for a whole range of other opioids. There are a number of considerations,….the formulation of the drug, people's tolerance to the drug, individual variation. … So based on simply just the toxicology numbers or the lack of, it is really difficult to predict toxicity based on those numbers. ….So just based on simply toxicology numbers, it's really difficult to come to a conclusion about the toxicity of or the potential toxicity of that drug in isolation*.[931]

1002. In addition, buprenorphine levels can be particularly hard to detect because of the interaction

[928] Expert report of Dr Michael Robertson, CB at p.3579.
[929] T873 – T874.
[930] T877 L5-13.
[931] T883 L14-T884 L2.

it has with the body in the slow-release formulation of Buvidal.[932] It requires specialised instrumentation to be able to detect the low concentrations that are typical with slow-release formulations.[933]

1003. Associate Professor Gerostamoulos noted the limitation of what information toxicology can provide in relation to cause of death saying there simply *isn't a great correlation between concentration and clinical effect*.[934]

1004. Professor Duflou agreed that there was a difficult correlation between *toxicology numbers* and how a substance might be affecting someone.[935]

1005. This view appeared to be supported by advice regarding the slow dissociation from opioid receptors. Associate Professor Clark stated that buprenorphine has a slow dissociation from opioid receptors, which in other words means that the buprenorphine appears to stick to opioid receptors in the brain even when the concentration of buprenorphine in the blood drops. He stated that,

the slow dissociation from opioid receptors means that following a bolus of buprenorphine such as a sublingual dose or initial release of buprenorphine following a Buvidal injection, the initial higher doses will lead to a corresponding degree of receptor occupancy which will persist even after the plasma buprenorphine levels fall.[936]

1006. Dr Helprin agreed and stated that to focus on blood levels was the wrong paradigm, because the real inquiry is the biological effect of the drug on the brain, which we are unable to measure.[937]

1007. Associate Professor Rotella added that blood concentrations are not typically used clinically

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[932] T868-869.
[933] Evidence of A/Prof Rotella, Dr Robertson and A/Prof Gerostamoulos; T868 – T869.
[934] T925 L2-3.
[935] T1648 L8-10.
[936] Expert Report of A/Prof Clark, CB at p.4273; agreed to by Dr Robertson and Expert report of A/Prof Rotella at T926.
[937] Evidence of Dr Helprin at T1398, Evidence of Dr Robertson at T949 – T950, *see also* T1418-1419

for drug intoxication overdoses and have little relevance to treatment considerations in clinical practice.[938]

1008. Associate Professor Clark also indicated that based,

> *on one study conducted in Sydney, approximately one third of plasma samples taken in the hours after a sublingual dose of Suboxone (mean 20mg) did not contain buprenorphine, and 49% did not contain nor-buprenorphine (Jamshidi, 2023). This was thought to be due to the variability in the metabolism of buprenorphine.*

1009. In addition, that,

> *26% of the 277 post-mortem plasma samples in the series of suspected buprenorphine toxicity deaths referred to by Prof Duflou (Darke, 2021) also did not contain buprenorphine, and 47% did not contain norbuprenorphine, figures that are consistent with the findings of the Jamshidi et al. paper.*[939]

1010. Dr Helprin also referred to several articles which contained the following comments,[940]

> *Interpreting BUP* [buprenorphine] *involvement in a death is complex, and instances may be underestimated in epidemiological data because of the lack of a defined toxic or lethal range in postmortem blood along with its good safety profile.*[941]

> *Forensic pathologists and toxicologists may want to consider the possibility that cardiovascular and respiratory issues pose a risk in deaths related to BUP. BUP-related drug overdose cases are often complex, and it is imperative that all detailed toxicological, autopsy and investigatory information be considered when determining the COD [cause of*

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[938] T880 – T881.
[939] Second expert report of A/Prof Clark, CB at p.4273.
[940] Buprenorphine-Related Deaths in North Carolina from 2010 to 2018Journal of Analytical Toxicology, 2021;45:780–791, Sandra C. Bishop-Freeman, Laura W. Friederich1, Marc S. Feaste and Jason S. Hudson
[941] Sandra Bishop-Freeman et. al. *Journal of Analytical Toxicology* 2021 (45) at p 780-791, 'Buprenorphine-Related Deaths in North Caroline From 2010 to 2018', CB at p.3058..

death].[942]

1011. Ultimately, the toxicology panel agreed that, despite the low blood levels of buprenorphine in Heather's antemortem blood sample, it remained possible that the buprenorphine injection contributed to her collapse.[943]

1012. Importantly however, when asked about whether there are limits to what toxicology can provide in terms of contributing information to a coroner as to cause of death, Associate Professor Gerostamoulos stated at inquest,

As to cause of death, yes So toxicology is one part of the process where drugs are routinely looked for and then assessed in terms of their - either their cause or their contribution to death. But that's usually considered as, you know, along with a range of other findings from the pathologist.[944]

Buprenorphine's effects on people and relevant factors

1013. It was agreed that buprenorphine would have had minimal effects on Heather's cardiac function but can cause respiratory depression.

1014. Associate Professor Clark advised that whether or not buprenorphine induces respiratory depression depends on the dose of buprenorphine, the degree of opioid tolerance, the presence of any other sedative medication (in this case quetiapine), and the presence of any other medical conditions such as recent head injury, lung disease, heart disease, severe liver disease and obstructive sleep apnoea.[945]

1015. Associate Professor Clark said that of these, the most important is the degree of opioid tolerance and the least important is the buprenorphine dose. In people with significant

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[942] Sandra Bishop-Freeman et. al. *Journal of Analytical Toxicology* 2021 (45) at p 780-791, 'Buprenorphine-Related Deaths in North Caroline From 2010 to 2018', CB at p.3067.
[943] T956 – T959.
[944] T 873.
[945] First expert report of A/Prof Clark, CB at p.3535.

tolerance to opioids, buprenorphine is unlikely to cause sedation, even at high doses. In people with little or no tolerance to opioids, even low doses such as taken by Heather can cause significant sedation.[946]

Opiate Tolerance

1016. I have discussed opiate tolerance when considering the appropriateness of the ORT prescribing to Heather by Dr Nath.

1017. I consider that Heather's tolerance was likely to have been equivalent to someone naïve or with very low or low, or uncertain tolerance and, she was not opioid tolerant.

Effects of Buprenorphine and those observed in Heather

1018. It was agreed that the peak blood concentration of Buvidal weekly, known as the 'Tmax', occurs at about twenty hours post administration.[947] That is, upon release of the buprenorphine, buprenorphine concentrations increase for the first 24 hours, and then are intended to remain the same or similar over the dosing interval (here, over the week). Due to the controlled rate of release of buprenorphine from Buvidal Weekly the dose has a terminal half-life of between three and five days.

1019. Dr Robertson said that, with respect to the likelihood of adverse effects, these are most likely when first using the medication; when adjusting the dose and when using the drug in combination with other central nervous system depressants such as alcohol, other opiates and/or benzodiazepines etc.[948]

1020. Associate Professor Rotella provided advice that, individual factors related to metabolism, tolerance, previous exposure, and how the drug interacts with the particular individual means that people may develop toxicity before the drug has reached its Tmax; and some people

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[946] First expert report of A/Prof Clark, CB at p.3534-3535.
[947] First expert report of A/Prof Clark, CB at p.3535; T870.
[948] Expert report of Dr Michael Robertson, CB at p.3579.

experience greater clinical effects on lower concentrations.[949]

1021. He further noted that the hallmarks of opioid toxicity include nausea, vomiting, somnolence, sedation, coma, respiratory depression and loss of airway reflexes.[950]

1022. Observations of Heather in the afternoon and evening hours following administration include drowsiness, nausea, vomiting, scratching, and being unsteady on her feet. These observations suggest that Heather was experiencing the effects of buprenorphine on the opioid receptors in her brain.

1023. Drowsiness, pupil constriction, vomiting and severe pruritus (itchy skin) are symptoms of opioid intoxication or opioid toxicity. These are important signs that the person's life is at risk, and they should be hospitalised for continuous monitoring, naloxone infusion and potentially intubation.[951]

1024. Dr Frei said that there was a *missed opportunity* to act on the symptoms at this point.[952]

1025. Associate Professor Clark stated that the vomiting experienced by Heather was most likely the vomiting of opioid intoxication.[953] This provides additional support to the view that she was not regularly using opioids, as vomiting typically occurs in people who are not tolerant to the effects of opioid.

1026. It was noted that there appeared to be a *mismatch* between the dose given and the effects noted to be experienced by Heather (i.e. not expected for someone opioid tolerant) such that the symptoms indicated an incompatibility between her degree of tolerance and the dose and formulation that was administered. She was in a *high-risk scenario…that's not a degree of opiate effect which ... which it's ok to ignore*.[954]

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[949] T870 – T873.
[950] Expert report of A/Prof Rotella, CB at p.2977.
[951] Evidence of A/Prof Clark and Dr Frei, T 1166 – 1167.
[952] T1167 L14-15
[953] First expert report of A/Prof Clark, CB at p.3535.
[954] T1353, L16-18; T1167 L1-5.

Dose given to Heather

1027. In relation to the 8mg dose of buprenorphine Heather received Associate Professor Clark observed,

> *While Buvidal weekly is the lowest dose of the injectable formulation, the amount of buprenorphine absorbed into the blood following an 8mg injection of Buvidal weekly is sufficient to cause significant effects in some circumstances, including respiratory depression*.[955]

1028. Associate Professor Rotella further observed in relation to the dose given that an opioid naïve individual receiving an injection of 8mg of buprenorphine would be more susceptible to the effects of an opioid, including but not limited to sedation and respiratory depression. He said,

> *In an opioid naïve patient, this is a significant dose (a typical dose given in an Emergency Department setting would be 2.5-5mg intravenously for strong pain). Whilst an 8mg* [LAIB] *does not administer 8mg immediately, even a quarter of this amount would be considered an overdose in an opioid naïve patient.*[956]

Buprenorphine effect during sleep

1029. The evidence is that Heather was found in her bed in the early hours of 23 November 2021 having initially been asleep at the lock down count and later returned to bed after taking pain relief (paracetamol) at 10.15pm.

1030. Associate Professor Rotella noted that when asleep our respiratory function reduces in terms of rate and depth. So, when something affects respiratory function, that effect can be more pronounced when asleep or sedated.[957]

1031. Buprenorphine causes centrally mediated respiratory depression of which the effects

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[955] First expert report of A/Prof Clark, CB p.3534.
[956] Expert report of A/Prof Rotella, CB at p.2976.
[957] T934.

manifest as a reduction in respiratory drive when asleep. It operates differently to the mechanically mediated respiratory depression caused by Obstructive Sleep Apnoea where a person may snore and obstruct their airway, with a drop in oxygen levels. Professor Fitzgerald explained that when you have someone, like Heather, who already snores at night, and there may be a pause in their breathing and then recommencing breathing,

if you've already got a diminished respiratory drive because of the narcotic, then those pauses are going to be longer and rather than dropping your oxygen levels to, for instance, 70% saturation, they can drop even further. And once they do drop further, you can start getting end organ damage because of the lack of oxygen. And the organ that's most susceptible is the brain.[958]

1032. Professor Fitzgerald referred to an article titled, *Sleep disordered breathing in patients receiving therapy with buprenorphine/naloxone* which he indicated demonstrated that most people had some form of centrally reacting respiratory compromise when they were given buprenorphine. The article noted,

Despite the putative protective ceiling effect regarding ventilatory suppression observed during wakefulness, buprenorphine may induce significant alterations of breathing during sleep at routine therapeutic doses.[959]

1033. And that the research stated, *observations should raise concern about the potential for adverse and possibly lethal respiratory consequences during sleep using ordinary doses of buprenorphine*.[960]

1034. Associate Professor Clark said that is not uncommon for people experiencing a degree of sedation to be easily rousable,[961] but who can become hypoxic when they drift off to sleep in

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[958] T1444 L26-T1445 L3
[959] T1443 L29-T1444 L1 referencing Robert Farney et. al. *European Respiratory Journal* 2013 (42) at p.394-403, 'Sleep disordered breathing in patients receiving therapy with buprenorphine/naloxone', CB at p.4503.
[960] Robert Farney et. al. *European Respiratory Journal* 2013 (42) at p.394-403, 'Sleep disordered breathing in patients receiving therapy with buprenorphine/naloxone', CB at p.4510.
[961] Second expert report of A/Prof Clark, CB at p.4274.

a low stimulus environment. He was of the opinion that Heather was experiencing a degree of sedation when she went to sleep. He stated at inquest,

I think the most likely scenario is that there was a degree of sedation, either from the buprenorphine or from the combination and given that there was quetiapine, that's likely to be the combination, and that has resulted in, combined with the falling asleep, reduction in muscle tone around the neck, and progressively worsening sleep apnoea overnight.[962]

1035. Associate Professor Clark considered that a person can have quite prolonged periods where they become increasingly sedated, but are rousable, they might be able to talk and stand up for periods of time, but are still experiencing the effect of opioid intoxication. He stated the following at inquest, and Dr Frei agreed,

and that the danger of going to - to bed, as you refer, overnight, ..., the unnatural kind of tiredness kicks in and that - that overlays with the .... drug effect and that gives us a more profound sedation and often is manifested by our inability to kind of open our airways enough for the air to come in and out properly and then .... this leads to snoring, sometimes very loud snoring and - and sleep apnoea. So, you might have the same urge to breathe that, commensurate with that degree of intoxication, but then you're getting less oxygen with each breath, because of this obstruction in your airway from the, you know, relaxed muscle tone as you're sleeping.[963]

1036. And further,

it's been observed repeated times that people put themselves to bed. You know they're walking; they're talking, they get into bed but then they don't wake up in the morning and [Heather] *fits into that pattern.*[964]

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[962] T1349 L1-7.
[963] T1244 L1-14
[964] T1287 L5-7.

The Vulnerability of Heather's Respiratory System

1037. There were factors additional to buprenorphine that may have compromised Heather's respiratory system, including: obesity, obstructive sleep apnoea, and use of an antipsychotic medication. These factors therefore had the potential to have placed Heather at greater risk of respiratory depression.

Obesity

1038. Associate Professor Rotella said that obesity, and in particular morbid obesity (BMI > 40 kg/m^2) is an independent risk factor for respiratory disorders, both centrally and peripherally. Increased weight affects lung function and efficacy of respiration as well as predisposing individuals to conditions that affect respiratory such as Obstructive Sleep Apnoea. He also noted that the published evidence regarding LAIB does not specifically account for patients with elevated BMIs.[965] He stated,

> *... there is insufficient safety data for* [LAIB] *in patients who are obese (let alone morbidly obese)* and in the absence of that, a cautious approach should be applied to the initiation of any form of OST.[966]

1039. Associate Professor Rotella also referred to a syndrome known as obesity hypoventilation which recognises that obese people can have their respiration impeded both physically and centrally.[967]

1040. The additional weight of fatty tissue on the chest wall can affect the physical movement of

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[965] Expert report of A/Prof Rotella, CB at p.2977-2978. He noted that in, *three Australian studies all quote BMIs well under that of the passed. One study of 67 individuals in custody administered LAI BPN had a mean BMI of 29 with a standard deviation of 5.66. Another study examined 60 patients receiving LAI BPN where the mean BMI was 26 with a standard deviation of 6.57. The third examined 227 individuals receiving LAI BPN with a mean BMI of 26 and a standard deviation of 5.68. A targeted search of the available peer-reviewed scientific literature on LAI BPN with particular emphasis on obesity and/or elevated BMI did not yield any results.*
[966] Expert report of A/Prof Rotella, CB 2978.
[967] T894 L1-14.

the lungs in inspiration and expiration and typically renders breathing inefficient.[968]

Obstructive Sleep Apnoea

1041. Although not specifically tested, Heather *almost certainly had obstructive sleep apnoea and was noted to snore in her sleep*.[969] All of the experts agreed.

1042. Dr Jansen explained that Obstructive Sleep Apnoea is where the quality of sleep is not meeting a particular standard. Someone with Obstructive Sleep Apnoea is obstructing overnight, they're dropping their oxygen concentration, which has the effect of waking them up, in order to breathe. He said:

Often when you're listening to someone with sleep apnoea, you'll hear them stop and then you'll hear them startle so that's their drive to breathe kicking in and this'll go on all night[970]

1043. Obstructive Sleep Apnoea is a form of physical respiratory obstruction.[971] It is also an independent risk factor for cardiovascular disease.[972]

1044. Also potentially relevant is the article *Characteristics and circumstances of death related to buprenorphine toxicity in Australia* which notes that buprenorphine toxicity group appeared to have been in poorer cardiovascular health and were four times more likely to have been obese and one in seven had cardiovascular disease. The authors state:

The existence of cardiovascular disease is likely to substantially increase the risk of cardiac arrhythmias and death in the presence of reduced myocardial oxygenation due to drug-induced respiratory depression.[973]

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[968] Expert report of A/Prof Rotella, CB 2977lT893 – T894.
[969] Expert report of Professor Harper, CB 3662.
[970] T1088.
[971] T1088.L9-10.
[972] T1088 L25-30.
[973] Annexure to the Second Expert Report of A/Prof Nicolas Clark, CB at p.4270, Shane Darke et. al. *Drug and Alcohol Dependence* 2021 (218), 'Characteristics and circumstances of death related to buprenorphine toxicity in Australia', CB at p.4282.

Quetiapine and compounding effect

1045. Quetiapine was not detected at reportable levels in antemortem blood. On further enquiry, Associate Professor Gerostamoulos confirmed that it was in fact detected at 0.038mg/L, where the reportable threshold was 0.05mg/L.[974]

1046. Given Heather was vomiting after the administration of 100mg of oral quetiapine, this could explain the lower-than-expected blood results. A slow metabolism could also provide an explanation.[975]

1047. There was also some evidence that Heather's quetiapine dose was a mild dose and unlikely to affect respiration.[976]

1048. Associate Professor Rotella said that whilst opioids can cause CNS depression in isolation, concomitant use with other drugs known to depress CNS function such as alcohol, anti-depressants and anti-psychotics increases the risk of clinically significant sedation. Sedation can lead to loss of airway reflexes and the ability to protect one's own airway and therefore there is also an increased risk of aspiration.[977]

1049. Dr Robertson stated that quetiapine at low doses can be a sedative and is prescribed off-label as a sedative. At high doses it predominantly acts as an anti-psychotic. As a patient becomes tolerant to the drug, sedation decreases. But there are a number of variables that influence the sedating effect, including features of the particular individual.[978]

1050. Associate Professor Clark said that in the ordinary course of Heather's day-to-day activities, the quetiapine would not cause any sedation, but it does seem to provide some kind of additive risk of sedation when buprenorphine is taken.[979] He said that,

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[974] T885 L7-17.
[975] T886 – 888.
[976] T1576.1-10.
[977] Expert report of A/Prof Rotella, CB at p.2976.
[978] T892 – 893.
[979] T1177.

The combination of buprenorphine and quetiapine in the doses consumed by Ms Calgaret, in someone with little or no opioid tolerance, and in someone with morbid obesity (who is therefore likely to experience obstructive sleep apnoea) is capable of producing a prolonged period of hypoxia that could lead to a cardiac arrest. I believe this is what happened in this case.[980]

1051. Both Associate Professor Clark and Dr Frei agreed that these factors are *greater than the sum of their parts*. They *synergistically cooperate* to create a higher level of respiratory depression.[981]

1052. It was noted that quetiapine operates on histamine receptors, whereas buprenorphine interacts with opioid receptors.

1053. Associate Professor Rotella stated that the d*ownstream clinical effect you see with either receptor…is sedation*, and there can be a *cumulative* sedative effect when combining drugs that sedate via different pathways.[982] And further, *we know in instances where someone's been exposed to multiple sedating agents that will affect not only your level of conscious state but the efficacy of your respiratory effort*.[983]

The Vulnerability of Heather's heart

1054. Obesity and the concomitant health risks of metabolic syndrome were central to Heather's deteriorating health during her incarceration.

1055. Heather suffered cardiac hypertrophy, meaning that the muscle of her heart was thickened. It increased the weight of her heart, which was found at autopsy to be enlarged and weighing 528g. Hypertrophy, in association with obesity is a risk factor for sudden, fatal ventricular arrhythmias.

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[980] First expert report of A/Prof Clark, CB at p.3536.
[981] T 1177 – 1178.
[982] T891-892.
[983] T 892.

1056. Heather was also found to suffer coronary artery disease. Moderate atherosclerosis of the left anterior descending coronary artery and mild atherosclerosis of the right coronary and circumflex coronary arteries were noted in the autopsy report.

1057. Although coronary artery disease is a common cause of sudden unexpected death, in Heather's case, both cardiologists agreed, it was not severe; ECG showed no evidence of myocardial ischeamia and it is unlikely to have caused cardiac arrest but may have been a contributing factor.

Observations following Heather's collapse

1058. Heather was found unresponsive by her sister at about 7.48am. From the BWC footage following Heather's collapse, intermittent respirations can be heard, referred to as *agonal* or *Cheynes Stokes* breathing.[984] This usually means that the respirations are being driven by the part of the brain near the brain stem.[985] Associate Professor Fitzgerald described this as,

> *It's this cyclical obstructed breathing, Cheynes Stokes breathing, which is a breathing of ... usually a dying person because they're only running on the lower parts of their brain-stem at that stage*.[986]

1059. Similarly, Professor Harper described agonal breathing as *a reflex brain stem activity and it indicates that at least part of the brain is still alive*.[987]

1060. At 8.08am, Heather was reported be breathing albeit intermittently.

1061. At 8.09.54am, the ambulance instructions over the phone were to remove the pillow from under her head. From this point, no respiratory effort can be heard on the BWC footage and there is no discernible breathing heard when the CPR is paused.

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[984] T1356 L1-2.
[985] T 1355 – T1356.
[986] T 1362 – T1363.
[987] CB 3664.

1062. Professor Fitzgerald was of the view that Heather was unconscious but breathing when initially on her side and once rolled to her back and the pillow removed, her airway became completely obstructed.[988]

1063. Both Professor Harper and Dr Helprin agreed with this account and timeline of Heather's breathing, which was observable on the BWC footage for at least 15 minutes.[989]

1064. Agonal breathing typically only lasts four minutes or so if after cardiac arrest but has been known to last up to seven minutes in child drowning cases.

1065. Professor Harper said that *typically, agonal breathing lasts for about four minutes or so after cardiac arrest but can be longer*.[990]

1066. Professor Fitzgerald said that if a person's heart is stopped, *they don't keep breathing for fifteen minutes. I think the longest you see in the literature, unless it's a hypothermic arrest…. Is maybe a maximum six to seven minutes*.[991]

1067. There was no scientific support provided for breathing being possible 15 to 20 minutes post cardiac arrest, as appeared in this case.

1068. Professor Fitzgerald concluded that, on the basis of the identifiable breathing for 15 to 20 minutes, Heather must have had some circulation for most of that period.[992]

1069. Professor Fitzgerald said that the fact that Heather had an oxygen saturation, and that the oximeter recorded that she had circulation, suggests that she had a low flow rate and that she was hypoxic at that time.[993]

1070. Professor Harper initially rejected this conclusion on the basis of a lack of palpable carotid

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[988] T1356 L20-24.
[989] T1357.
[990] Expert report of Professor Harper, CB at p.3664.
[991] T1360.
[992] T1358 L6-10.
[993] T1392.

pulse and cold extremities, which is a feature of cardiac arrest.[994] However, he later accepted that it was a *strong possibility* that she had the cardiac arrest during the period she was being assisted, as seen on the BWC footage.[995]

1071. Dr Helprin said, that if Heather was cold, with an oxygen saturation of 40%, that the breathing and circulation could not have been effective.[996] Professor Fitzgerald explained that body temperature is controlled by the brain. He said:

[If] your brain's not working you can lose body temperature quite rapidly…and so clearly she has had some problem with her circulation, and I think she's already had anoxic brain injury which has affected her ability to maintain adequate body temperature.[997]

1072. Professor Fitzgerald was certain that Heather lost circulation and became asystolic[998] following the removal of the pillow from under her head. He stated at inquest,

Yeah, I'm absolutely sure of it. I mean it's Occam's razor. You know she's got an obstructed airway, she's unconscious, she's got intermittent breathing, she gets laid on her back, pillows removed, she stops breathing. Now – you know – and I think she was hypoxic and I think she had already had some circuitry collapse because of her hypoxia and I think the complete obstruction of her breathing was what precipitated, what we call a brady-asystolic arrest, where the heart was probably already oxygen depleted, she had a large heart. She already had some premature cardiac disease and I think she lost complete circulation when her airway became obstructed.[999]

1073. It was noted that given the poor state of Heather's health generally, her breathing was likely to stop almost immediately once she lost circulation unlike a healthy individual.

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[994] T1358.
[995] T1368.
[996] T1358.
[997] T1362.
[998] 'Asystolic' (in asystole) is medical term describing a complete absence of electrical and mechanical activity in the heart, effectively indicating cardiac arrest.
[999] T1369.

1074. Dr Helprin accepted that *when she was put on her back she probably obstructed her airway* but felt there was *not enough data to be exact* about when circulation stopped.[1000]

1075. There was no disagreement that the hypoxic brain injury suffered by Heather was irreversible by the time she was found in the morning on 23 November 2021.

Mechanism of Death

1076. Dr Ho's medical examination report primarily noted two possible central mechanisms related to Heather's death, being;

a. that the cardiac arrest was primarily due to a cardiac problem and unrelated to respiratory depression; or

b. that respiratory depression preceded and played a causal role in the cardiac arrest.

1077. Professor Harper said in his report: *I feel certain that Ms Calgaret was in cardiac arrest from 7:50am onwards and her breathing was agonal in nature, rather than a pattern of respiratory depression*.[1001] He provided two reasons for this conclusion at inquest.

1078. Professor Harper's first reason relied on Stacey's observation that at about 7.30am, while she was making coffee in the kitchen, she heard *Heather snoring*. Professor Harper accepted that this observation was a *tenuous basis* upon which to decide the cause of her ultimate cardiac arrest; and that it said little more than that *she was alive* at that point.[1002]

1079. Professor Harper's second reason was that the antemortem blood sample showed no evidence of buprenorphine or norbuprenorphine, which suggests that only *minute levels of buprenorphine were achieved from the 8mg subcutaneous injection. That being the case, such levels would not be sufficient to cause respiratory depression profound enough to result*

[1000] T1372.
[1001] Expert report of Professor Harper, CB at p.3665.
[1002] T1376.

in cardiac arrest.[1003] Whilst acknowledging he was not a toxicologist, Professor Harper maintained that it was difficult to concede that a subtherapeutic level of a drug was capable of causing a severe toxic effect, by itself.[1004]

1080. Professor Harper accepted the pathologists' finding that Heather had incurred a hypoxic brain injury, but contended that this could have occurred, on his hypothesis, after she was found and in cardiac arrest, because her circulation was not restored until about 8.30am by paramedics.[1005]

1081. Ultimately, Professor Harper said he found both explanations for the mechanism of death plausible on the available evidence,[1006] but maintained his opinion that the more likely cause of Heather's cardiac arrest was *a fatal cardiac arrhythmia secondary to her cardiomegaly and Class III obesity*.[1007]

1082. In contrast, Dr Helprin considered that the buprenorphine administered to Heather caused respiratory depression which preceded the cardiac arrest. He stated in his report,

> *Respiratory depression from Buvidal and hypoxia most likely set off a cardiac arrest and most likely with a significant ventricular arrhythmia such as ventricular tachycardia or ventricular fibrillation, and thus respiratory depression led to cardiac arrest. Because of the cardiorespiratory impairment, there is a lack of blood flow and oxygen to the brain which causes a hypoxic ischemic encephalopathy*.[1008]

1083. In Professor Fitzgerald's opinion, unequivocally, the hypoxic brain injury was caused by respiratory depression over an extended period prior to being found. He did not assert that the primary cause was the administration of buprenorphine at inquest, but he was absolute in

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[1003] Expert report of Professor Harper, CB at p.3665.
[1004] T1379 L30-T1380 L1.
[1005] T1402.
[1006] T1439.
[1007] Expert report of Professor Harper, CB at p.3666.
[1008] Expert report of Dr Helprin, CB at p.3028.

his finding that the primary event was respiratory collapse. He said,

She probably kept breathing for an hour or two while she was on her side but once she rolled onto her back she stopped breathing and the heart was already compromised, there was low circulation because of this prolonged episode of hypoxia.

The heart is a little more resilient than the brain to low levels of oxygen but I think that final insult is when she lost circulation and she went into a classic bradycardic asystolic arrest which is a non-shockable rhythm that occurs in people who have hypoxic cardiac arrest…they just brady down, the heart stops and then commonly these are the people that we can resuscitate even though they might not have a long-term outcome because of the hypoxic injury.

And it is quite interesting isn't it that the paramedics arrive and then some significant time after she's been seen to have this loss of circulation they're still able to effect cardiac output and they're still able to transport her to hospital and there doesn't appear to be too many problems with the heart afterwards and while it's found that she's got this hypoxic injury and all of the things that happened to her are absolutely characteristic of that occurring including her final loss of circulation and the reason why she didn't require defibrillation.[1009]

1084. Regarding the role the buprenorphine, Professor Fitzgerald stated in his report,

It appears that Ms Calgaret developed a degree of airway obstruction overnight, due to the combination of her obesity and associated airway obstruction, which were compounded by the Suboxone injection which caused respiratory depression.[1010]

1085. Dr Helprin agreed that this explanation for the mechanism of Heather's death made sense. He agreed with Professor Fitzgerald that Heather experienced a secondary, not a primary

[1009] T1394 – 1395.
[1010] Original expert report of Professor Fitzgerald, CB at p.3007.

cardiac event.[1011]

1086. In Dr Helprin's view, the timing is inescapable. He said:

> *…just to bring it back to the clinical level, you just cannot ignore the fact that there's a smoking gun you know one day before having a fatal cardiorespiratory arrest Heather was given buprenorphine.*[1012]

1087. Professor Harper also agreed that Professor Fitzgerald's account *makes sense* but he maintained that *it doesn't exclude the possibility that it was also a primary cardiac event*, perhaps made more likely by respiratory issues. But he remained *dubious* as to whether the buprenorphine had any effect.[1013]

1088. Professor Fitzgerald disagreed with Professor Harper's alternate explanation for the hypoxic brain injury, despite there being a lengthy period from when she was found collapsed to when she had circulation and oxygenation appropriately restored.

1089. Professor Fitzgerald accepted that *no doubt, there was a hypoxic brain injury occurring at that time as well*.[1014] But the fact that Heather's pupils were fixed and dilated when she was found, indicates that she already had a brain injury – that the midbrain, at that time, was not working properly.[1015] He stated,

> *If you don't have enough oxygen flow to the midbrain, your pupils will dilate. If you don't have enough flow to the area below the midbrain which is sort of getting down towards where the spinal cord starts, you'll end up with low respiratory rate and low ventilation and as you move further down that pons, you'll end up with Cheyne-Stoke respiration so the fixed dilated pupils in conjunction with the Cheyne-Stoke respiration, I believe was because she'd had significant hypoxia affecting the majority of the brain for a significant period of time, and I*

[1011] T1396.
[1012] T1384.20-23.
[1013] T1396 L12-17.
[1014] T1402 – T1403.
[1015] T1446.

can't quantify what significant means, but irreversible – significant – and with the brain, that can only be eight or 10 minutes, because the brain's very sensitive to hypoxic injury.[1016]

1090. Professor Fitzgerald explained that, while usually reluctant to provide a strong opinion, his opinion in this matter was not a personal opinion, it was an opinion based on facts, years of experience and objective evidence that was determined at the time. He said that *it is not plausible* that a primary cardiac event at about 7.50am is the cause of her collapse. He said: *I don't think there is any evidence to support…what Dr Harper is saying*.[1017]

Other expert views expressed

1091. Associate Professor Rotella said that the footage from the BWCs provided clear and identifiable evidence of a person with obstructed (and therefore ineffective) breathing and the additional statements from the staff present such as *intermittent breathing*, *snoring*, *now she's stopped again* provided strong arguments for opioid toxicity to be considered in this setting.[1018] He further stated that the timeline of events is such the buprenorphine injection administered to Heather contributed to her respiratory depression, collapse, and resultant death from complications secondary to these events.[1019]

1092. In Associate Professor Clark's view, it is highly likely that Heather did not have significant tolerance to opioids and that she experienced a degree of respiratory depression from the buprenorphine, in combination with the quetiapine and her physical characteristics, such that she had periods of hypoxia which ultimately led to cardiac arrest.[1020]

1093. Dr Frei also accepted that *one is unable to exclude buprenorphine making some contribution to a state of critically compromised breathing and oxygenation of vital organs*.[1021]

[1016] T1400.
[1017] T1438 – T1439.
[1018] Expert report of A/Prof Rotella, CB at p.2979.
[1019] Expert report of A/Prof Rotella, CB at p.2980.
[1020] T1138.9-19.
[1021] Expert report of Dr Matthew Frei, CB at p.4485 [71].

1094. Dr Robertson said that while he could not exclude that buprenorphine contributed to Heather's cause of death, he could not conclude *that it was more probable than not that the buprenorphine caused the death*.[1022]. He could not provide any explanation for the coincidence of timing between the first administration of LAIB and Heather's collapse.

1095. Ultimately, no expert provided an opinion that precluded a finding that the administration of buprenorphine contributed to Heather's collapse and ultimate death.

Amended Cause of Death

1096. As part of an expert panel discussion and following the provision of further information provided during inquest, much of which is outlined above, VIFM pathologists Dr Ho and Dr Baber, determined that it was appropriate to reformulate the cause of death.

1097. The cause of death was amended as follows:

1(a) Hypoxic ischemic encephalopathy complicating cardiac arrest of unknown aetiology in a woman with type 2 diabetes, WHO class III obesity, obstructive sleep apnoea and recent administration initiating dose of slow-release buprenorphine.

1098. Professor Duflou accepted this reformulation.[1023]

1099. The VIFM pathologists stated that this new formulation acknowledges the following factors that likely contributed to Heather's passing:

a. Type 2 diabetes mellitus;

b. WHO Class III obesity;

c. Obstructive sleep apnoea; and

[1022] T856; T901.
[1023] T1639 L2-6; T1647L4-7.

d. Buprenorphine depot injection (recent administration and initiating dose).

1100. However, they could not determine to what extent each of these factors contributed.[1024]

1101. Professor Duflou later qualified his agreement with the reformulation by querying whether it was *potentially possible* that the drug played no relevance in Heather's death because of her other underlying conditions[1025] and emphasising that he struggled to accept that buprenorphine caused Heather's death from a toxicological perspective.[1026]

1102. The pathologists did not consider that there was sufficient basis for quetiapine to be included in the formulation of the cause of death. Professor Duflou said that it was unlikely to have had a significant effect on respiratory depression.[1027]

1103. Heather had been taking a stable and modest dose of quetiapine for well over a year, without consequence. However, in the opinion of Associate Professors Clark and Rotella, and Dr Frei, there is a cumulative effect and additional risk of sedation when quetiapine is taken in conjunction with buprenorphine. People who are taking stable doses of other sedatives, including antipsychotics, are much more highly represented in buprenorphine overdose deaths. Professor Duflou also said,

there appears to be a synergistic effect when buprenorphine and quetiapine are taken together. In other words, the sum is greater than the additional [sic] - *of the individual parts, in terms of their potential contribution to death*.[1028]

AMENDED CAUSE OF DEATH

1104. I set out below propositions and various findings I have made, in order to reach a conclusion about the cause of death based on all the available evidence. This task was undertaken with

[1024] T1665 – T1667.
[1025] T1669.
[1026] T1669 – T1670L18.
[1027] T1616
[1028] T1618 L3-7.

the benefit of numerous expert opinions, which I note were largely in agreement.

1105. There was an absence of detectable buprenorphine (or norbuprenorphine) in Heather's antemortem blood specimen at 11.06am on 23 November 2021, which Dr Ho indicated was due to the effects of drug metabolism in the antemortem period. Norbuprenorphine, the drug's metabolite, was detected in a specimen of postmortem urine. Further evidence revealed that both substances were present in the antemortem sample, and therefore in Heather's blood stream, but at below the laboratory's reportable levels.

1106. Whilst the amounts were lower than expected following the administration of buprenorphine on 22 November 2021, I am satisfied that Heather was administered a first dose of buprenorphine 8mg weekly subcutaneous injection (Buvidal) at 10.15am on 22 November 2021.

1107. Expert toxicology advice indicates that it is not possible to draw conclusions about toxicity of a drug from toxicology results alone, noting that there is not a great correlation between concentration and clinical effect, that opioid concentrations in particular are inherently difficult to interpret on their own, and there may be difficulty detecting the slow-release formulation of Buvidal.

1108. There were a range of reasons to explain the lower-than-expected concentration including, individual metabolism, presence of comorbidities and other drug interactions.

1109. In addition, that buprenorphine has a slow dissociation from opioid receptors, which means the buprenorphine appears to stick to opioid receptors even when the concentration of buprenorphine in the blood drops, leading a number experts to consider that focussing on the blood levels was the wrong paradigm, as the real analysis was the biological effect of the drug on Heather's brain.

1110. The consensus of the toxicology panel did not exclude the possibility that the buprenorphine contributed to Heather's collapse.

1111. It was apparent therefore from the available evidence that toxicology results alone cannot

predict toxicity; the whole clinical picture and surrounding circumstances needed to be considered. In addition, that a determination of the cause of death must consider toxicology along with a range of other findings and is not generally the domain of a toxicologist.

1112. According to the Product Information, serious, life-threatening or fatal respiratory depression may occur with the use of Buvidal Weekly. And further, one should be aware of situations which increase the risk of respiratory depression, and monitor patients closely, especially on initiation or following a dose increase.

1113. Whether or not buprenorphine induces respiratory depression depends on the dose of buprenorphine, the degree of opioid tolerance, the presence of any other sedative medication (in this case, quetiapine), and the presence of any other medical conditions.

1114. The most important risk factor is the degree of opioid tolerance and the least important is the buprenorphine dose.

1115. I consider that Heather's opioid tolerance was likely to have been equivalent to someone naïve or with very low or low or uncertain tolerance. In any event, she was not opioid tolerant.

1116. In people with little or no tolerance to opioids, even low doses such as that administered to Heather can cause significant sedation.

1117. The likelihood of adverse effects associated with the administration of buprenorphine are most likely to occur when first using the medication; when adjusting the dose and when using the drug in combination with other central nervous system depressants.

1118. The signs of opioid toxicity include nausea, vomiting, somnolence, sedation, coma, respiratory depression and loss of airway reflexes.

1119. Observations of Heather in the afternoon and evening hours of 22 November 2021, following administration of Buvidal included drowsiness, nausea, vomiting, scratching, and being unsteady on her feet.

1120. Observations indicate that Heather was experiencing the effects of buprenorphine on the

opioid receptors in her brain.

1121. Vomiting experienced by Heather could be considered the vomiting of opioid intoxication and vomiting typically occurs in people who are not tolerant to opioid effects.

1122. I am satisfied following consideration of all the available evidence, including witness statements and oral evidence from those who interacted with Heather, that she was unwell from the early afternoon, and her presentation was likely the result of the buprenorphine administered that morning. Some of the observations made about Heather's presentation that day were recorded by police on the day of her collapse (23 November), prior to her passing (*symptoms of overdose*, *lethargic didn't want to get up, vomiting*). I note that Suzzane advised her mother in a private conversation (ARUNTA call), also before Heather's passing, that her sister was vomiting and napping.

1123. Heather's observed response in the afternoon is consistent with Heather being not opioid tolerant. Her lack of or low opioid tolerance is also consistent with clear drug screening results while at DPFC and the absence of buprenorphine in her postmortem hair sample .

1124. Heather was found in the morning, having slept in her bed overnight. When asleep, respiratory function reduces in terms of rate and depth, making something that affects respiratory function become more pronounced when asleep or sedated.

1125. It is not an uncommon scenario for people given a long acting opioid who are observed walking and talking during the daytime, while not suffering an overdose in the short term, becoming profoundly hypoxic when they drift off to sleep in a low stimulus environment.

1126. Factors additional to buprenorphine that had the potential to compromise Heather's respiratory system, include her obesity, suspected obstructive sleep apnoea, and possibly the use of an antipsychotic medication (quetiapine).

1127. These factors, in addition to Heather's lack of opioid tolerance, are greater than the sum of their parts and create a higher level of respiratory depression.

1128. Heather also had a *vulnerable heart* due to an enlargement of the heart (obesity cardiomyopathy), and mild to moderate coronary artery disease.

1129. The BWC footage and the observations of those who interacted with Heather when she was discovered on the morning of 23 November 2021, provide evidence that she was breathing albeit intermittently, and for at least 15 minutes. That is, until the pillow was removed from under her head and she was placed on her back.

1130. The Court received evidence that agonal breathing typically lasts for a significantly shorter period, particularly for someone of poorer health.

1131. In order to be breathing over that period, Heather must have had some circulation, and accordingly was not in medical cardiac arrest.

1132. This is also supported by the reading on the oximeter, and to a lesser degree of reliability, the finding of a pulse in her foot, acknowledging the reservations of some of the experts about the reliability of these observations.

1133. I further note the observations of Professor Rotella, a clinical toxicologist, that the BWC footage provides clear and identifiable evidence of a person with obstructed (and therefore, ineffective) breathing.

1134. Two primary causes of Heather's collapse were proposed, one being that cardiac arrest was primarily due to a cardiac problem and unrelated to respiratory depression; and the other being respiratory depression preceded and played a causal role in the cardiac arrest.

1135. The unequivocal expert advice of Professor Fitzgerald, which was supported by Dr Helprin, and which Professor Harper accepted made sense, was that the primary event was respiratory depression over an extended period which caused a hypoxic brain injury. I accept this as the likely occurrence, based on the analysis provided, and there being no persuasive evidence to support the alternative proposition. I note in this context, that I had the benefit of viewing the BWC footage.

1136. I accept that the hypoxic brain injury suffered by Heather was irreversible by the time she was found in the morning. That is, the first hypoxic injury occurred over the hours before she was discovered; and the second occurred once she was moved onto her back, the pillow was removed, and her heart stopped.

1137. The VIFM pathologists provided the following amended cause of death following consideration of the additional evidence which was not available to them at the time of the original report. That being,

1(a) Hypoxic ischemic encephalopathy complicating cardiac arrest of unknown aetiology in a woman with type 2 diabetes, WHO class III obesity, obstructive sleep apnoea and recent administration initiating dose of slow-release buprenorphine.

1138. I accept the advice of the VIFM pathologists, and the amended cause of death provided.

1139. The pathologists did not consider that the quetiapine Heather consumed in the afternoon of 22 November 2021, should be included in the formulation of the cause of death.

1140. I consider, based a range of expert advice, that the quetiapine may have played a role in Heather's collapse, but I am unable to say to what extent.

1141. I note that the reference to *unclear aetiology* in the cause of death refers to the mechanism of death and that is a matter for me to determine based on all the evidence, and I must be so satisfied in accordance with the *Briginshaw* standard.

1142. Having considered all the evidence in this matter, I consider it likely that the administration of Buvidal on the morning of 22 November 2021 contributed to Heather's respiratory depression, collapse and resultant death, and its administration was likely the initiating event.

1143. This finding is supported by the temporal link between the commencement of the opioid replacement therapy, Heather's presentation in the afternoon following administration and her subsequent collapse and its timing. In the circumstances therefore, I consider that *but for* the administration of Buvidal, Heather would not have passed.

1144. I acknowledge that Heather had other risks which may have eventuated at a future time, but my determination relates to Heather's collapse on 23 November 2021, and subsequent passing on 27 November 2021.

1145. I do not accept the proposition that, if it can't be said that something contributed to a particular extent or that other comorbidities contributed to a particular extent, it can't be concluded that it was a necessary condition of the collapse.

CONCLUSIONS

1146. Heather was Yamatji, from her mother's side, Pitjantjatjara from her paternal grandmother's side and Noongar and Wongi from her paternal grandfather's side. She was born on 8 January 1991.

1147. Heather passed away on 27 November 2021 whilst serving a sentence of imprisonment at DPFC, and as such, was a person in the custody of the State of Victoria.

1148. Veronica Nelson also passed away at DPFC whilst Heather was in custody.

1149. There were five primary areas of focus during the inquest, which included the provision of health care, the management of Heather's parole application, the prescription of opiate replacement therapy, the emergency care following Heather's collapse and the cause of her death. Each of which is analysed in the course of my finding and only aspects of the investigation are detailed in these concluding comments.

1150. Heather was six months pregnant with her fourth child, when she was remanded in custody on 31 July 2019. Heather soon applied under the Living with Mum Program for her newborn to be with her in prison, but her application was declined following advice from Child Protection. Her daughter, born on 29 October 2019, was therefore removed from Heather's care shortly after her birth.

1151. Heather was 28 years old and relatively healthy when she entered custody. She was pregnant and overweight, and while antenatal care was planned no other ongoing treatment needs were

identified nor management planned. Within two years, she was severely or morbidly obese (classified as WHO Class III obesity), had poorly controlled type 2 diabetes, sustained liver function derangement and likely obstructive sleep apnoea. At the time of her passing she was also prescribed seven regular medications.

1152. Both her obesity and diagnosis of diabetes developed whilst Heather was in custody and also featured in her cause of death. It was important therefore to understand, if possible, how her deterioration occurred and consider how systems and processes could be improved.

1153. A review of more than 2 years of medical records reflect that Heather consulted regularly with CCA doctors and nursing staff as well as allied health professionals (such as physiotherapists, optometrists and podiatrists) for physical issues, and also predominantly CCA mental health nurses, for mental health support. Heather had limited involvement with Forensicare such that she was only seen by the psychiatric nurse practitioner four times during her time in custody.

1154. It is important to note that Heather's incarceration occurred during the Covid-19 pandemic which impacted the delivery of services and prisoners were also required to be locked down in their cells for periods of time.

1155. It was agreed however that Heather suffered a "significant" decline in her health while in custody, and a number of areas were identified in the course of the inquest which represented opportunities for intervention with the potential to have altered her downward health trajectory.

1156. Any comments made about these matters are not intended to represent broad criticism of the many skilled health clinicians from CCA and elsewhere who Heather consulted, across more than 100 consultations. In this context I note that Aunty Jenny does not criticise individuals nor the good intentions of the healthcare providers.

1157. The investigation of the provision of health care was far more subtle, and concerned the obvious deterioration of a person in the care of the State, who had limited choice about the services that were available to them, in response to their health needs.

1158. At the outset I note that Court experts, Dr Jones and Professor Newman identified that the removal of Heather's daughter was a pivotal moment in the overall decline of Heather's health while in custody. Dr Jones said that it had *very serious and detrimental effects to her social, emotional wellbeing* and Professor Newman considered it to be a *major contributing factor to her mental health, high levels of distress,* [and] *depression*.

1159. Descriptions of Heather documented amongst the many responses to the removal of her baby included *feelings of depression, loneliness, grief and heartbreak, feeling shame, overwhelmed, debilitating sadness,* feeling *extremely traumatised, ... suffering from nightmares of hearing her children crying* and Heather describing it as *hell.*

1160. I further note that during an earlier incarceration, Heather stated that she had a 9 week old baby also removed from her care and that her forehead was *sore from punching herself* at that time.

1161. Aunty Lynn spoke of the trauma of having a baby removed, regardless of the colour of a mother's skin, *You've just given birth to the most beautiful thing in the world, and someone walks in and takes it away, ... that's the most cruellest thing on earth and everything and she's got to learn to live with that.*

1162. Tammy Innes, a Yorta Yorta and Jeithi woman, who shared the Blackwood Unit with Heather commented that, *the system's not designed to give you your kids back when you're on the outside, let alone on the inside*.

1163. Whilst the decision to remove Heather's newborn baby was beyond the scope of the inquest, I note that Dr Jones considered that allowing Heather to have had her baby in custody was a lost opportunity to have supported an Aboriginal woman move forward and potentially break the cycle of children being removed from her care. She considered that Heather's application was not assessed on the basis of her current environment and that the application process focussed on a deficit rather than strength-based approach.

1164. Included therefore in the areas identified as opportunities for intervention, was a lack of Indigenous, safe and responsive clinical services to respond to the trauma Heather was experiencing and her decline in mental health after the removal of her baby. This was not only identified as likely to have had an ongoing and long term impact on Heather's mental health, but there was also a connection to her ability to manage her physical health, particularly her ability to manage her weight noting that it was later documented that she was *self-medicating* with food.

1165. There was no treatment plan commenced in relation to Heather's weight at reception, which denied an opportunity to prevent her *severe and rapid weight gain*, and while not unnoticed by health clinicians did not prompt any documented intervention. After reception, Heather was next weighed about a year later, on 22 July 2020. Expert advice noted that as an Aboriginal woman, with a history of smoking and, a family history of heart disease, these factors increased the need to minimise the additional risk factor of obesity and prevent its progression.

1166. No baseline assessments were conducted when Heather was commenced on quetiapine on 10 March 2020, a drug associated with weight gain. Metabolic monitoring is crucial for individuals taking antipsychotic medications due to the risk of developing metabolic syndrome which increases the risks of cardiovascular disease and other complications including type 2 diabetes, with which Heather was ultimately diagnosed in 2021.

1167. Heather also experienced ongoing depression which continued until her passing. It was apparent that Heather had no access to a psychologist, and that psychologists are rarely available to women at DPFC. Mr Bulger, formerly of CCA said that it had been a *failure* identified in the system for many years. He identified that there is a category of prisoner who *fell in the middle* of the mental health continuum of acuity, who required such services but they were generally unavailable.

1168. It is noteworthy that Forensic psychologist Jeffrey Cummins who prepared a report for Heather's criminal hearing, considered that her condition required *urgent* mental health

treatment and it was his view that it was *improbable* she would be provided with appropriate mental health treatment whilst in custody.

1169. The 2014 Quality Framework and relevant CCA health policies referred to holistic and multidisciplinary care and culturally safe care as well as the development of care plans to capture more complex cases, and it was apparent that in some aspects of Heather's care these expectations were not met.

1170. Dr Jones considered that Heather did not at any time whilst at DPFC have access to culturally safe healthcare that aligned with the definition of Aboriginal health and she did not have access to any Aboriginal Health Worker or any Aboriginal Community Controlled Health Organisation. She identified this as a breach of the equivalency of care principle.

1171. There was, however, no Aboriginal Health Worker engaged at DPFC at the time, which made the commitment to cultural care (and the cultural safety standards) difficult to achieve in Heather's care.

1172. The investigation revealed that Heather's decline occurred despite there being policy settings in place that all contained appropriate commitments to improve health as well as a recognition of the need for culturally safe and competent health care.

1173. As Counsel Assisting noted,

> *The deterioration of Heather's health between 2019 and 2021 sits against a backdrop of Justice Health and Correct Care policy which was designed to enhance and preserve her health while in custody. That objective was quite clearly not achieved. In particular, a holistic picture of her health decline was not captured and addressed in either a coordinated or culturally responsive way and there were many missed opportunities throughout that time to intervene into Heather's health decline and improve her quality of life*.[1029]

[1029] T1975 L2-11

1174. On behalf of CCA, it was submitted that if any deficits in the delivery of culturally appropriate care existed, they were the product of systemic and funding limitations. That is, the system designed and funded by Justice Health at the time did not provide for a designated Aboriginal Health Worker, the utilisation of Aboriginal Community Controlled Health Organisations or trauma based therapy of any type, including culturally safe counselling.

1175. And further, if deficits were identified in relation to Heather's primary healthcare, they were the product of a system which was not, and possibly still is not, designed or resourced to respond optimally to the needs of women at DPFC, particularly Indigenous women, in a holistic and culturally sensitive way.

1176. On behalf of the Secretary to the DJCS, it was agreed that any gaps in services identified were not because of a lack of policy or procedure.

1177. It is important therefore in these circumstances that Justice Health reflect on how the stated aspirations for service delivery did not meet those goals in some crucial areas and what might be done differently in future.

1178. Counsel Assisting identified the following areas for improvement to services and systems in prisons as a result of the investigation:

a. a culturally-specific approach to the health and well-being of Aboriginal prisoners that addresses the particular vulnerabilities they may face in custody;

b. early identification and intervention of cardio-metabolic health issues, including weight gain;

c. multi-disciplinary case management for prisoners with complex health issues;

d. more comprehensive and co-ordinated mental health care, including psychological treatment; and

e. holistic trauma informed cultural care.

1179. A number of positive changes subsequent to Heather's passing have been put in place in relation to the delivery of health services in Victoria.

1180. I note that Forensicare, rather than the primary healthcare provider, now conducts the initial mental health screening of a new prisoner at reception at DPFC. This means, for instance, that a document such as the Crole report would now be available to inform the reception mental health assessment.

1181. In addition, an Aboriginal-specific health check is conducted on reception to custody (which is equivalent to the standard of an Aboriginal and Torres Strait Islander check (Medicare 715)).

1182. Forensicare now have a weekly out-patient meeting, which is multidisciplinary in nature, with the primary health care provider.

1183. The introduction of the 2023 Quality Framework brings with it a requirement for providers to be independently accredited to the NSQHS Standards and, there are mandatory Aboriginal Cultural Safety Standards, endorsed by the Aboriginal Justice Caucus.

1184. I also note that under the new Primary Health Service Specifications there is a requirement for enhanced integrated care plans for all Aboriginal people in custody that includes involvement from family members or a nominated support person, said to better support Aboriginal people's health care journey.

1185. Perhaps most importantly, the inquest learnt that Justice Health is exploring ways to develop in-reach models for Aboriginal Community Controlled Health Organisations to treat Aboriginal people in custody. This appears consistent with the longstanding call in various reviews including the Cultural Review and the Ombudsman's Report, for transition to a community-led model of health care in custody.

1186. The inquest also considered the supports that were provided to Heather to assist with her parole application, which was ultimately denied.

1187. There were numerous issues identified in the management of her parole application and experts raised particular concern about the lack of transparency of the process; and that Aboriginal people were disproportionately affected by factors which included the availability of treatment programs and suitable accommodation upon release.

1188. It was apparent that under the applicable timelines, Heather's application for parole was never going to be considered by the APB before her earliest eligibility date, noting her longer than usual parole period fixed by the sentencing judge. This raised concern about the risk of the parole process undermining the integrity of sentences, and potentially reducing the availability of a period of supervision while on parole, which is an essential component to the management of community safety and the rehabilitation of an offender.

1189. These concerns were not based on a premise that prisoners have an entitlement to be released at the expiration of the non-parole period. Rather, they were based on the premise that judges should know if it is *systematically impossible* for the purposes of a sentence to be met and that prisoners have a right to have their application for parole put before the APB without *systemic impediments* preventing that occurring.

1190. Whilst a recommendation was suggested by Counsel Assisting to improve the knowledge of sentencing judges about these matters, it was not considered viable by DJCS. I also noted in this context, the sentencing restrictions on judges under relevant legislation.

1191. Having thought about a resolution to this apparent impasse, I propose to suggest that, consideration be given for this matter to be raised at the Aboriginal Justice Forum, given the relevant participants, including courts.

1192. Continued efforts to address over-representation are critical noting the Yoorrook Justice Commission's advice that First Nations people *continue to be dramatically over-represented in Victorian prisons. ..... Aboriginal men are 13.6 times as likely as non-Aboriginal men to be*

in prison and Aboriginal women are 13.2 times as likely to be in prison as non-Aboriginal women.[1030]

1193. Also under investigation was the provision of opiate replacement therapy which Heather had requested from April 2021. Her desire to be placed on the therapy increased after her parole application was refused. She was assessed as ineligible by RN Duong on 9 November 2021, but 10 days later she was prescribed weekly injectable buprenorphine (Buvidal) by Dr Nath on 19 November 2021. This was the first time a prisoner at DPFC had been prescribed Buvidal without stabilisation on sublingual Suboxone, which was the practice at the time and consistent with the guiding Justice Health and CCA policies.

1194. RN Millson administered the Buvidal on 22 November 2021, unaware that Heather had not been stabilised on Suboxone. Dr Nath had not noted his departure from the usual practice in Heather's medical records, nor had he informed OSTP nursing staff verbally or otherwise.

1195. As a result of Dr Nath's decision to prescribe in this manner, there were no post monitoring arrangements in place following the administration of Buvidal that morning.

1196. There was evidence that Heather did experience symptoms consistent with buprenorphine intoxication which suggested that the dose given was too much for her tolerance level.

1197. Heather did interact with prison staff presenting as unwell during the day but I accept that there was no clear indication to escalate her care until she was found unconscious the following morning, being 23 November 2021.

1198. The prescribing of buprenorphine was thoroughly canvassed during the inquest. I have detailed my conclusions regarding this matter in paragraphs 863 to 908.

1199. Ultimately, I do not consider a prescribing doctor could have been reasonably satisfied based on the information available that Heather had been stabilised on a treatment, such that direct

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[1030] Yoorrook for Justice, Report into Victoria's Child protection and Criminal Justice Systems, Yoorrook Justice Commission at p.361.

initiation to injectable buprenorphine was appropriate, without induction and a period of stabilisation on sublingual Suboxone.

1200. I consider Dr Nath's prescribing on this occasion to have been inappropriate in the circumstances, and it lacked the careful consideration required for the safe prescribing of opiate replacement therapy.

1201. There was general agreement however that Dr Nath was genuinely motivated by a concern for Heather's wellbeing, and Aunty Jenny graciously accepted that this was the case.

1202. One expert observed; *it has been shown repeatedly that doctors who ignore the advice of nurses and junior colleagues are more likely to make mistakes*.

1203. Dr Nath expected Heather to be monitored by the OSTP Nurses for symptoms of intoxication, but as he had departed from standard practice without alerting the OSTP team, monitoring did not occur. It was his responsibility in these circumstances to have ensured monitoring occurred.

1204. The cause of Heather's passing was informed by four expert panels and how I arrived at my conclusion is detailed in paragraphs 1104 to 1145.

1205. I have accepted the amended cause of death as determined by the VIFM's pathologists which acknowledged that the following factors likely contributed to Heather's passing: Type 2 diabetes mellitus; WHO Class III obesity; Obstructive sleep apnoea; and Buprenorphine depot injection (recent administration and initiating dose).

1206. I further considered it likely that the administration of Buvidal on the morning of 22 November 2021 contributed to Heather's respiratory depression, collapse and resultant death, and its administration was likely the initiating event.

1207. In the circumstances therefore, I consider that *but for* the administration of Buvidal, Heather would not have passed on 27 November 2021.

1208. In addition, had Heather been subject to afternoon observations, it is likely that her symptoms of intoxication would have been identified such that she could have been treated appropriately before going to sleep that night. In this way, her passing may have been prevented.

1209. Heather's death in this context is not surprising. The Buvidal Product Information warns that serious, life-threatening or fatal respiratory depression may occur with the use of Buvidal Weekly. Policies (detailed in my finding) have been carefully developed over many years to provide clinicians with a framework for the safe prescribing of opiate replacement therapy, and consistent policies were in place at DPFC at the time. They established a regime of eligibility assessment; induction, post-dosage monitoring leading to stabilisation; and maintenance of opiate replacement therapy.

1210. Heather did not receive a stabilising dose or doses of sublingual Suboxone and was not monitored following commencement on the injectable Buvidal. Heather also had additional known risk factors.

1211. As such, the risks which have already been identified in relation to the prescribing of opiate replacement therapy, were realised in this case. That is, known risks of harm eventuated.

1212. I considered that, not only was Heather's passing preventable, she should never have passed in manner she did.

1213. At the time of her passing Heather was housed with her sister and three other Aboriginal women. She had less than 10 weeks left on her sentenced.

1214. I acknowledge those women who supported each other and were each other's family during their incarceration. They were unfortunately witness to the unspeakable which occurred in their small unit - the passing of a loved one and another death in custody.

1215. I particularly acknowledge, and can only imagine the ongoing trauma to Heather's sister Suzzane, who found her beloved sister barely breathing on the morning 23 November 2021. I agree with Suzzanne, when she said, *Heather's life was precious. She didn't have to die for lessons to be learnt*.

1216. I acknowledge the devastating loss for her family including her mother, Aunty Jenny – a parent should never have to lay their child to rest – as well as her siblings, and her children who now have the misfortune of being without their mother.

1217. On behalf of the Secretary of DJCS it was said that, *while losing a loved one is painful for all involved, the context of an Aboriginal passing in custody brings its own unique trauma given the history of colonisation in this country and the fact that Aboriginal and Torres Strait Islander people continue to be over-represented in Victoria's criminal justice system*.

1218. I also acknowledge the prison officers and nurses who attended on the morning of Heather's collapse who desperately tried to care for her.

1219. As part of a coronial investigation there is a window through which we learn something about a person's life.

1220. Heather had limited formal education but took every opportunity to educate herself in prison. This included maths, retail, parenting, Arts program, Koori programs, family violence, horticulture, cultural arts and many others. She painted, and her paintings were sold through Torch via the Indigenous Arts in Prison Program.

1221. She was noted to be a great student, who was very respectful towards teachers and enjoyed learning and participated with great enthusiasm.

1222. Heather's room was filled with photos of family most particularly her children - it was all about her kids and her family.

1223. She was well respected in the prison and was described as: a big personality, a very caring person, a person who would advocate on behalf of others, a mother hen, always cracking a joke, always having a laugh, very artistic, a delight to be around and she'd always put a smile on your face.

1224. It is my hope that the manner in which Heather passed, does not overshadow her spirit or her tremendous life of value.

FINDINGS

1225. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Heather Ida Simone Calgaret born 8 January 1991;

(b) Heather Ida Simone Calgaret born 8 January 1991 passed away on 27 November 2021 at Sunshine Hospital, Victoria, from *1(a) Hypoxic ischemic encephalopathy complicating cardiac arrest of unknown aetiology in a woman with type 2 diabetes, WHO Class III obesity, obstructive sleep apnoea and recent administration initiating dose of slow-release buprenorphine*; and

(c) Her passing occurred in the circumstances described in paragraphs 178-226,

1226. I consider that Dr Nath's prescription of Buvidal Weekly to Heather on 19 November 2021 was inappropriate in the circumstances, and lacked the careful consideration required for the safe prescribing of opiate replacement therapy.

1227. I further consider it likely that the administration of Buvidal on the morning of 22 November 2021 contributed to Heather's respiratory depression, collapse and resultant death, and its administration was likely the initiating event. In the circumstances therefore, I consider that *but for* the administration of Buvidal on the morning of 22 November 2021, Heather would not have passed on 27 November 2021.

1228. I consider that the obligation to ensure that Heather was appropriately monitored was the responsibility of Dr Nath. He had departed from standard practice by prescribing LAIB without a period of stabilisation and therefore had an obligation to explicitly communicate this to the appropriate staff members and arrange for monitoring.

1229. I further consider that had Heather been subject to afternoon observations on 22 November 2021, it is likely that her symptoms of intoxication would have been identified such that she could have been treated appropriately before going to sleep that night. In this way, her passing may have been prevented.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Pursuant to section 72(2) of the Act, I make the following recommendations:

Provision of healthcare in custody

Recommendation 1

I recommend that Justice Health investigate and establish appropriate measures to ensure that,

a. women who give birth in custody, or proximate to their remand into custody, are adequately screened and monitored for post-natal mental health symptoms and treated with appropriate post-natal care; and
b. consider establishing an automatic referral to Forensicare for assessment.

Recommendation 2

I recommend that Justice Health investigate and establish appropriate measures to ensure that,

a. women who are refused access to the Living with Mum Program, are adequately supported following the removal of their newborn, and
b. consider establishing an automatic referral to Forensicare for assessment.

Recommendation 3

I recommend that Justice Health make modifications necessary for JCare to allow for the following:

a. weights and girths of prisoners to be entered as a specific entry on JCare; and
b. an alert for significant weight increases be highlighted on JCare for clinicians.

Recommendation 4

I recommend that Justice Health engage with government and stakeholders to improve access to psychological services for women at DPFC.

Recommendation 5

I recommend that Justice Health collaborate with health service providers to ensure that commitments under the 2023 Quality framework and other applicable health standards are consistent with the following outcomes,

a. the scheduling of multi-disciplinary reviews for patients with complex health needs in order to treat and monitor their care holistically;

b. the scheduling of regular pharmacological reviews for patients who are prescribed multiple medications and/or have complex health presentations;

c. that health service providers conduct baseline testing of patients, including weight and BMI measurements, before commencing psychotropic medication;

d. that chronic health care plans are properly documented upon recognition of a patient's eligibility for a chronic health care plan. Proper documentation includes identification of treatment plans, reporting on progress of treatment plans and regular oversight and review of plans; and

f. identification and intervention to address ongoing deterioration of a patient's physical and/or mental health.

Recommendation 6

I recommend that Justice Health,

a. continue to explore ways to develop an in-reach model for Aboriginal Community Controlled Health Organisations to provide primary healthcare services to Aboriginal people in custody;
b. engage with Aboriginal Community Controlled Health Organisations to co-design auditing tools and processes to develop an independent and robust oversight and accountability system for all providers of prison healthcare (both public and private).

Recommendation 7

I endorse the following recommendations made to DJCS and other key departments in the Ombudsman's Report made aimed to:

a. involve Aboriginal Community-Controlled Organisations in the design and delivery of holistic custodial services that are culturally safe and responsive to Aboriginal people, culture and rights;

b. increase Justice Health's capacity to oversight the delivery of culturally responsive healthcare to Aboriginal people by developing and implementing a capability building plan;

c. consider ways to vary the current custodial primary health contracts to provide oversight that is more culturally safe and responsive to Aboriginal people;

d. develop an audit framework to regularly assess the clinical effectiveness and cultural responsiveness of healthcare delivery to Aboriginal people across all Victorian prisons; and

e. invest in education and training to increase the number of Aboriginal health professionals in Victoria and better support their career development.

Parole Application Process

Recommendation 8

I recommend that DJCS investigate ways to ensure that the parole application process, including the availability of required treatment programs, is consistent with,

a. the Commissioner's Requirement 2.6.1 – Parol Application Process, which requires that *the parole application process must occur in a timely manner and not prevent or delay the APB's consideration of a prisoner for parole;*

b. the commitment to reduce over-representation of Aboriginal and Torres Strait Islander people in Victorian custodial settings;
c. the principles of Aboriginal self-determination in the custodial setting ;
d. Recommendation 244 of the RCIADC; and
e. The right to equality under the Charter of Human Rights of Responsibilities, particularly with respect to access to required treatment programs for women.

Recommendation 9

I recommend that DJCS explores ways to ensure that Aboriginal and Torres Strait Islander parole applicants are assigned an Aboriginal Case Manager.

Recommendation 10

I recommend that DJCS, in consultation with the Naalamba Ganbu Nerrlinggu Yilam **(the Yilam**), explore ways to improve support for Aboriginal and Torres Strait Islander parole applicants to help navigate the parole application process, and improve justice outcomes for those prisoners.

Recommendation 11

I recommend that DJCS, in consultation with the Yilam, give consideration to raising through the Aboriginal Justice Forum, concerns about the potential for the parole application process to undermine the integrity of sentences, and potentially reduce the availability of a period of supervision while on parole, which is an essential component to the management of community safety and the rehabilitation of a prisoner.

Recommendation 12

I endorse the Justice Review recommendations that Corrections and Justice Services update relevant Practice Guidelines to:

a. Require Parole Officers to engage with Forensic Intervention Services to ensure they have up to date information about program availability both in custody and the community prior to the prisoners Earliest Discharge Date.

b. Clarify that, in circumstances where a prisoner has requested to complete treatment programs in the community and Forensic Intervention Services has advised that the treatment is available, a Parole Officer can progress the Parole Suitability Assessment to the Adult Parole Board for consideration.

c. Require Parole Officers to engage with their Principal Practitioner on prisoner requests relating to a parole application (including an application for a Parole Suitability Assessment) and document the rationale and outcome of such requests within the Offender Management File.

d. Require Parole Officers to promptly respond to prisoner requests made in relation to a parole application (including an application for a Parole Suitability Assessment) and explain the outcome to the prisoner.

Emergency Response

Recommendation 13

I recommend that Justice Health continue to work with health service providers to ensure that all staff, including all agency staff, are adequately trained in all relevant prison processes, including responses to a Code Black and the use of emergency equipment on site, prior to the commencement of employment and that regular.

Recommendation 14

I recommend that Justice Health audit all health service providers to identify that emergency medical equipment is regularly checked and maintained in good working order to ensure functionality and reliability during incident responses.

Recommendation 15

I recommend that Justice Health work with health service providers to ensure that all staff, including all agency staff, and officers receive training in drug overdoses and the administration of naloxone.

Recommendation 16

I recommend that Justice Health work with health service providers to provide and reinforce clear practical training to all staff on basic life support processes, escalating care and emergency management in the prison environment. Practical resources, such as lanyards, and posters, should be developed and disseminated throughout prisons.

ORDERS

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

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

Jenny Calgaret, Senior Next of Kin

Victorian Aboriginal Legal Service on behalf of Jenny Calgaret

Russell Kennedy Lawyers on behalf of Department of Justice and Community Safety

K + L Gates on behalf of Forensicare

Wotton Kearney on behalf of Dr Shalendra Nath

Meridian Lawyers on behalf of Correct Care Australasia

Gordon Legal on behalf of Rochelle Betita

Kennedys on behalf of Fiona Millson

JK Legal on behalf of Imelda Morgan

Detective Senior Constable Simone Peirce, Coroner's Investigator, Victoria Police

Signature:

SARAH GEBERT

CORONER

Date: 28 July 2025

APPENDIX 1 – Scope of Inquest

Circumstances in which Ms Calgaret's passing occurred

1. The immediate circumstances in which Heather Calgaret (**Ms Calgaret**) was found unresponsive on the morning of 23 November 2021 at Dame Phyllis Frost Centre (**DPFC**) preceding her passing on 27 November 2021, including but not limited to,
   a. Ms Calgaret's movements and activities following the provision of Buvidal buprenorphine (**Buvidal**) at around 10.15am on 22 November 2021;
   b. the manner in which Ms Calgaret was monitored following the provision of Buvidal on 22 November 2021;
   c. whether Ms Calgaret's presentation prior to being found unresponsive on the morning of 23 November 2021 warranted further intervention by either corrections officers or Correct Care Australasia staff; and
   d. the role and responsibility of correction officers and Correct Care Australasia staff regarding any monitoring undertaken following the provision of Buvidal on 22 November 2021;

Circumstances following Ms Calgaret's being found unresponsive on the morning of 23 November 2021

2. The appropriateness of the emergency response to Ms Calgaret being found unresponsive on the morning of 23 November 2021 at DPFC, including but not limited to, the actions of,
   a. Corrections staff;
   b. Correct Care Australasia staff; and
   c. Ambulance Victoria; With respect to,
      a. the provision of Basic Life Support and any resuscitation efforts;
      b. the timing of the call to Ambulance Victoria;
      c. the manner in which Ms Calgaret was moved to administer emergency care;
      d. the availability of medical equipment; and
      e. whether naloxone should have been administered;

Medical Cause of Death

3. Clarification, where possible, of Ms Calgaret's medical cause of death; Medical Management of Ms Calgaret at DPFC.
4. Whether the medical management of Ms Calgaret at DPFC was appropriate and met a reasonable standard of care, including but not limited to consideration of the following,
   a. the prescription of opioid replacement therapy (Buvidal) on 19 November 2021 and any treatment and/or monitoring plan initiated as a result;

b. the management of Ms Calgaret's weight;

c. the management of Ms Calgaret's diabetes/BSL;

d. the prescription of any other drugs to Ms Calgaret;

e. the manner of any assessments undertaken, treatment plans developed and the documentation of any assessments and treatment plans;

f. the coordination of Ms Calgaret's case management including the management of her multiple and escalating risk factors; and

g. the coordination of Ms Calgaret's care between Correct Care Australasia and Forensicare, including consideration of a comprehensive management approach and/or a multidisciplinary approach;

Provision of mental health care to Ms Calgaret at DPFC

5. Whether the provision of mental health care to Ms Calgaret at DPFC was appropriate and met a reasonable standard of care, including but not limited to consideration of the following,

   a. any assessment(s) following the birth of Ms Calgaret's baby whilst in custody and the baby's subsequent removal from her care, including whether trauma-focussed counselling or other response was required;

   b. the provision of pharmacotherapy/psychotherapy;

   c. the prescription of anti-psychotic and anti-depressant drugs to Ms Calgaret and any reviews undertaken of the drugs prescribed with particular reference to Ms Calgaret's increasing BMI and other known health risks;

   d. access to a psychologist;

   e. the manner of any assessments undertaken including with respect to post-natal depression, anxiety and depression, treatment plans developed and the documentation of any such assessments and treatment plans;

   f. regularity of psychiatric reviews;

   g. the coordination of Ms Calgaret's case management including the management of her multiple and escalating risk factors; and

   h. the coordination of Ms Calgaret's care between Forensicare and Correct Care Australasia including consideration of a comprehensive management and/or a multidisciplinary approach.

Assessment of the effects of the drugs prescribed to Ms Calgaret

6. The likely effects of the drugs prescribed to Ms Calgaret, including but not limited to consideration of the following;

   a. the effects of Buvidal;

   b. the effects of the combination of any drugs prescribed including sertraline and quetiapine, noting in particular any respiratory effects;

c. whether she was opioid naïve;

d. where she had WHO Class III obesity; and

e. Ms Calgaret's other known health risks;

Compliance with the Justice Health Quality Framework

7. Whether the provision of health care to Ms Calgaret during the period of her incarceration until her passing was consistent with the expectations of the Justice Health Quality Framework;

8. Were sufficient systems and resources in place to support health providers deliver services to Ms Calgaret which were consistent with the expectations of the Justice Health Quality Framework and if not, what barriers existed at the time.

Cultural appropriateness of Ms Calgaret's care

9. Whether the provision of care to Ms Calgaret during the period of her incarceration until her passing was culturally sensitive, safe and appropriate, including but not limited to any trauma experienced;

   a. in response to the potential loss and grief following the removal of a child from Ms Calgaret's care; and

   b. due to her continued separation from her children;

Appropriateness of the management of Ms Calgaret's parole application

10. The appropriateness of the management of Ms Calgaret's parole application by Community Correctional Services and Corrections Victoria, including:

    a. delays in the progress of the parole application;

    b. the availability of offence specific treatment;

    c. facilitation of any necessary steps in the parole application process;

    d. support provided to obtain suitable accommodation; and

    e. support provided to navigate the parole process.

Relevant changes subsequent to death and prevention opportunities

11. Any prevention opportunities arising from the circumstances of Ms Calgaret's passing;

12. Any relevant changes which have been made subsequent to Ms Calgaret's passing.

APPENDIX 2 – Witnesses at Inquest

- Aunty Lynne Killeen, Aboriginal Wellbeing Officer, DPFC;
- Corrections Officer Nicole Berry;
- Tammy Innes;
- Stacey Edwards;
- Dr Liyasha Goontilleke;
- RPN Francis Loguli;
- RN Nhung Duong;
- Dr Shalendra Nath;
- RN Fiona Millson;
- Corrections Officer PO 1;
- Corrections Officer Sharon Kemp;
- Corrections Officer Bobby Devic;
- Acting Supervisor Mustaq Ahmed;
- RN Imelda Morgan;
- RN Rochelle Bettita;
- Expert Panel comprising A/Prof Joe-Anthony Rotella, Dr Michael Robertson and Associate Professor Dimitri Gerostamoulos;
- Expert Panel comprising Dr Denver Jansen, Dr Neil Bartels, Prof Louise Newman and Dr Jocelyn Jones;
- Expert Panel comprising A/Prof Nicolas Clark and Dr Matthew Frei;
- Expert Panel comprising Dr Garry Helprin, Prof Richard Harper and Prof Mark Fitzgerald;
- Dr Kate Roberts, Director of Clinical Services (Prison Services), Forensicare;
- Mark Bulger, Manager of Performance, CCA;
- Expert Panel comprising Dr Joanne Ho, Dr Yeliena Baber, and Professor Johan Duflou;
- Jenny Roberts, Executive Director (Offender Services and Parole), Corrections Victoria;
- Alfie Oliva, Director of Forensic Intervention Services, DJCS;
- Expert Panel comprising A/Prof Amanda Porter, A/Prof Crystal McKinnon and Karen Fletcher, Executive Officer, Flat Out Inc.;
- Jenny Hosking, Acting Deputy Commissioner, Corrections Victoria;
- Anna Henry, Director, Offender Services and Reintegration, Corrections Victoria;

- Amanda Allen-Toland, Director (Aboriginal Health), Aboriginal Health Unit, Justice Health; and
- Susannah Robinson, Acting Executive Director Operations, Justice Health.