IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002147

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of Zoran Alic

Delivered On:	6 December 2024
Delivered At:	Coroners Court at Melbourne
Hearing Date:	22 November 2024
Findings of:	Coroner Ingrid Giles

Representation

Counsel Assisting the Coroner	Lindsay Spence, In-House Legal Service instructed by Kajhal McIntyre, Senior Coroner's Solicitor Coroners Court of Victoria
Chief Commissioner of Police	Andrew Imrie of Counsel instructed by MinterEllison
Department of Justice and Community Safety (Corrections Victoria and Justice Health)	Sarala Fitzgerald of Counsel instructed by Victorian Government Solicitor's Office
Forensicare (Victorian Institute of Forensic Mental Health)	Morgan McLay of Counsel instructed by K&L Gates
Correct Care Australasia	Sarah Curran, Solicitor Meridian Lawyers

Table of Contents

BACKGROUND

1. Zoran Alic ('**Mr Alic**'), born on 19 March 1961, was 58 years old at the time of his death on 29 April 2019 whilst in custody at Marngoneet Correctional Centre ('**Marngoneet**'). Mr Alic was born in Serbia before migrating to Australia in 1970 with his family as a ten-year-old. He never obtained Australian citizenship which became a stressor for him during his time in custody.

2. On 30 December 2018, Victoria Police commenced an investigation into Mr Alic after receiving reports in respect of alleged family violence offending. Of relevance, during the taking of the complainant's statement that day, Leading Senior Constable NEWBERRY observed in respect of the complainant, that the tone in her voice was very panicked and she said '*I need help, he is going to kill me if he finds me, he has threatened to kill us and burn the house down if I ever went to the police. He has been hurting us for a long time and I need help to get away*'.

3. In response to the complaint and subsequent statement, Victoria Police members attended the residence of Mr Alic, where he was apprehended without incident and conveyed to the Northern Hospital for a mental health assessment, due to the threat he had made in respect of burning the house down. He was assessed by a Mental Health Clinician who determined he did not require involuntary treatment under the *Mental Health Act 2014* (as then applied), after which he was arrested, cautioned and conveyed to Broadmeadows Police Station for interview in respect of family violence offences. Following this interview, he was charged with 'intentionally cause injury' and was refused bail by the custody Sergeant and remanded to attend Broadmeadows Magistrates Court on 31 December 2018. This was Mr Alic's first time in custody.

4. At that time, Victoria Police members created a warning on the LEAP system that read:

   'Warning Type: Suicide/Self Injury

   – above male made numerous comments regarding the desire to harm himself and set the family home on fire. He stated that life is not worth living after 50. Male also stated that he will follow through with these actions if she repeats this and F/V matters to Police'.[1]

[1] LEAP Warnings Report, Inquest Brief, p996.

5. Following Mr Alic's reception into police custody, a welfare check was conducted on him prior to his placement in a cell and he raised no issues or concerns, and reported to be fine, other than feeling tired.

6. Mr Alic appeared before Broadmeadows Magistrates Court the following day where he was refused bail, remanded in custody and a final Family Violence Intervention Order was made in which he was named the respondent. At the same time, the Hume Family Violence Investigation Unit ('**FVIU**') continued its investigation into this alleged offending.

7. On the 2 January 2019, Mr Alic was transferred to the Melbourne Assessment Prison ('**MAP**') where a Reception Psychiatric Assessment was conducted including a full mental statement examination ('**MSE**'). He was described as having a relaxed, cooperative demeanour, denied any psychological complications or any suicidal or self-harm risks or ideation. Mental health staff also confirmed he was not registered on the Client Management Interface ('**CMI**'), the client management system used by public mental health services. He agreed to self-refer should he have any issues and cited certain family members as protective factors. At the time no risk was identified, and he was not assigned a P, S or M risk rating in E*Justice (an information management system in relation to prisoners accessible to Corrections Victoria and Victoria Police). A mainstream placement was recommended.

8. On the 8 January 2019 there were two relevant occurrences. Firstly, the Hume FVIU obtained an additional statement from the complainant disclosing further serious family violence offending. Mr Alic was also transferred from MAP to the Metropolitan Remand Centre ('**MRC**'). Upon reception at the MRC, an Inter-Prison Transfer Assessment was conducted where Mr Alic was described as presenting as easily engaged, reactive in conversation, settled and denied any risk. No medical, psychological or suicide/self-harm risks were identified, and he was not assigned a P, S or M risk rating in E*Justice.

9. On the 25 January 2019 a further additional statement was obtained from the complainant where further disclosures were made in respect of, *inter alia*, serious family violence offending.

10. On the 7 February 2019 Mr Alic was transferred from MRC to Marngoneet and again was not assigned a P, S or M risk rating in E*Justice due to the absence of identifiable medical, psychological or suicide/self-harm risks. Whilst Mr Alic described his mood as 'nervous', he denied any thoughts of suicide or self-harm. On arrival at Marngoneet, Mr Alic was placed in the Rothwell mainstream unit.

11. On the 15 February 2019 Mr Alic appeared before Broadmeadows Magistrates Court where his lawyer made a bail application on his behalf that was ultimately refused. Mr Alic was reportedly visibly upset during this hearing but declined the offer to speak with a mental health nurse and guaranteed his safety on the unit.

12. On the 26 February 2019 Mr Alic was interviewed at Marngoneet by Police members from Hume FVIU after which he was charged with a further eight (8) offences in respect of serious family violence offending including one count of rape. First Constable KATU applied to have the matter uplifted to a filing hearing at the Melbourne Magistrates Court on 6 March 2019 which was granted by the Magistrate, and copies of these additional charges were supplied to Mr Alic's legal representative.

13. On the 6 March 2019, Mr Alic changed legal representation and instructed a new firm. A filing hearing was held at the Melbourne Magistrates Court where a committal mention date was set down for 31 May 2019.

14. Six days later, on 12 March 2019, Mr Alic completed and signed a Medical Request Form with a handwritten notation '*Urgently need to see psych nurse. Severe anxiety and depression*'.[2] That form was receipted on the 14 March 2019, the urgency rated as High (that is to be seen within 1 week) and an appointment made on 16 March 2019 for Mr Alic to consult with the Psychiatric Nurse.

[2] Justice Health Medical Record, Inquest Brief, p774.

15. On 16 March 2019, Mr Alic was reviewed with the following notation made:

> '*He reports that up until now he felt able to manage with being in prison but he is finding it harder to deal with the ruminating thoughts. He describes dwelling on the complainant's "lying" and her attempts to paint him in the worst possible light. He also maintains that he has been wrongly accused … … … Zoran is a Serbian who came to Australia as a ten-year-old and never became an Australian citizen. This is causing him considerable concern as he has been told he might be extradited. He reports eating well and doing moderate exercise daily (walking laps) but poor sleep.*
>
> *Zoran presents with clear and logical thought processes and no perceptual disturbances. Thought content revolves around not accepting the complainant's description of his behaviours. He has plans for post release in that he expects to gain work and "pick up his life". He describes his mood as "sad", and this is reflected in his affect which remains reactive. He denies any suicide/self-harm thoughts or intent. Discussed techniques of distraction and the relationship between exercise and mood. He has agreed to increase his exercise regime and to practice using distraction to diminish his ruminating thoughts'*.[3]

16. Following this consultation Mr Alic was not assigned a P, S or M risk rating in E*Justice.

17. Twelve days later on 28 March 2019, Mr Alic attended a mental health follow-up with the Psychiatric Nurse. The notation of that consultation read '*Zoran attended for review today. Tells me his mood has been low for some time. He isolates and feels depressed. Denies any suicide/self-harm ideation. Plan: Refer to Psychiatrist*'.[4]

18. A referral was made for a psychiatry review and Mr Alic was placed on the waiting list for consultation. As he was not considered to be urgent, a psychiatry review was scheduled for 17 May 2019. He was not prescribed any medications as there were no indications for these to be commenced. Mr Alic was encouraged to self-refer should he continue to feel low and a follow up Mental Health Nurse Review was scheduled for 4 July 2019. He was not referred to the Mobile Forensic Mental Health Service as he was assessed as low risk and was not assigned a P, S or M risk rating in E*Justice.

[3] Justice Health Clinical Notes, Inquest Brief, p737.
[4] Justice Health Clinical Notes, Inquest Brief, p735.

19. Since Mr Alic's arrest, the Hume FVIU investigation had been ongoing whereby statements had been obtained from two further complainants. These statements detailed incidents of strangulation, being rendered unconscious, escalating violence and sexual offending. Consequently, on 18 April 2019 the Hume FVIU served on Mr Alic's lawyer a hand-up brief including notice of committal mention. This brief included additional charges that now totalled 55 charges involving three separate complainants.

20. On 21 April 2019, Mr Alic was transferred within Marngoneet from the Rothwell mainstream unit to Eagle Place.

CORONIAL INVESTIGATION

Jurisdiction

21. Mr Alic's death constituted a 'reportable death' pursuant to s 4(2)(c) of the *Coroners Act 2008* (Vic) ('**Coroners Act**'), as his death occurred in Victoria and immediately before his death, he was a person placed in custody or care (being a person in the legal custody of the Secretary to the Department of Justice). Accordingly, pursuant to s 52(2)(b) of the Coroners Act, an inquest into his death is mandatory.

Purpose of the Coronial jurisdiction

22. The jurisdiction of the Coroners Court of Victoria ('**Coroners Court**') is inquisitorial.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[6]

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

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

[5] Section 89(4) Coroners Act.
[6] Preamble and s 67 Coroners Act.

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

    a. reporting to the Attorney-General on a death;
    b. commenting on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and
    c. making recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[7]

26. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[8] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[9] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death.[10]

Standard of proof

27. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[11] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[12]

[7] Sections 67(3), 72(1) and (2) of the Coroners Act.
[8] Section 69(1) of the Coroners Act.
[9] *Keown v Khan* (1999) 1 VR 69.
[10] See ss 69(2) and 49(1) of the Coroners Act.
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[12] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

28. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[13] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

29. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[14] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[15]

30. Whilst an inquest was mandatory in respect of Mr Alic's passing, in the circumstances I considered it appropriate to hold a summary inquest which was held on 22 November 2024. The individual witnesses who provided statements in the inquest brief were not required to give evidence at inquest as, after carefully considering all the material within the brief, I was satisfied that there were no significant factual disputes which required the calling of viva-voce evidence. Accordingly, I was satisfied that I was able to discharge my statutory functions and make the findings required under section 67 of the Coroners Act. All interested parties who appeared at inquest were given an opportunity to make submissions in relation to the evidence, including the proposed comments and recommendations.

31. This finding draws on the totality of the material obtained in the coronial investigation of Mr Alic's death: the coronial brief prepared by Detective Senior Constable John McKinnon and Detective Sergeant Adam Radley of the Geelong Criminal Investigation Unit, which includes further material obtained by the Court; the transcript of the proceedings; exhibits tendered at the inquest (which in this case, was: (i) the inquest brief v2.0 [as at 7 Nov 24]; and (ii) correspondence to the Court dated 20 November 2024 sent on behalf of the Department of Justice and Community Safety) and the closing submissions of counsel.

[13] (1938) 60 CLR 336.
[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

32. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased: s 67(1)(a) of the Coroners Act

33. On 3 May 2019, Zoran Alic was visually identified by his wife as per the Statement of Identification, same dated. Mr Alic's identity was not in dispute and required no further investigation.

Cause of death: s 67(1)(b) of the Coroners Act

34. On 30 April 2019, Dr Malcolm Dodd ('**Dr Dodd'**), Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon Zoran's body and confirmed that a ligature had been fashioned with a section of bed sheeting.

35. Dr Dodd noted that there was no evidence of offensive or defensive type injuries.

36. In a report dated 6 May 2019, Dr Dodd determined the cause of death to be I(a) HANGING.

37. Post-mortem toxicology did not detect any ethanol or other drugs.

38. I accept Dr Dodd's opinion.

Circumstances in which the death occurred: s 67(1)(c) of the Coroners Act

Sunday 28 April 2019

39. On Sunday 28 April 2019, the day either of or prior to Mr Alic's death, he had a professional visit with his lawyer that lasted approximately an hour and a half. His lawyer states in his evidence that '*at the conclusion of the visit I provided Mr Alic with a copy of his hand-up brief … … during the conference my impression was that Mr Alic was very concerned about the allegations against him. I don't recall him being overly emotional, crying for example, but he was generally apprehensive and downcast about his situation. I took Mr Alic through parts of the brief and it became apparent to me that he was not aware of some of the material in the brief, in particular that statements had been made against him by two further females*'.[16]

40. Mr Alic was seen returning to his section at approximately 12.45pm with no at-risk observations made. Prison Officer Raynor stated that '*Mr Alic didn't approach the officer's post for any reason once he was back at Eagle Place. He collected his dinner at approximately 15.45 hours and I didn't notice anything unusual with his behaviour. Alic normally had a quiet demeanour and would walk around the Rothwell Neighbourhood with fellow prisoners … … The lock-up count was called in progress at 17.20 hours … … Alic said 'good night' as we counted him and closed the cell door. He was polite and didn't appear to be upset about anything when we conducted the lockup count*'.[17] This was the last time that Mr Alic was seen alive.

Monday 29 April 2019

41. Approximately 7.25am the following morning, Monday 29 April 2019, Prison Officers Jackson and Partridge were unable to rouse Mr Alic during the trap count. Entry to the cell was gained and Mr Alic was observed to be hanging in a slumped position in the doorway of the bathroom with a cut-up sheet used as a ligature. A Code Black was called, and he was cut down however he was clearly deceased, and CPR was not commenced. Ambulance Victoria attended and verified death at 8.06am. A forensic crime scene examination was conducted and his death was notified to the Coroners Court.

[16] Statement of Mr Alic's lawyer, Inquest Brief, pp8-9.
[17] Statement of Prison Officer Raynor, Inquest Brief, p10.

COMMENTS

42. I make the following comments connected with the passing of Zoran Alic pursuant to section 67(3) *Coroners Act 2008*.

Examination of the absence of S (suicide/self-harm) and P (psychiatric) risk ratings in respect of Zoran Alic, and whether the absence of risk ratings (and associated cell placement) was appropriate and in accordance with policy

43. Mr Alic's death was reviewed by the Justice Assurance and Review Office ('**JARO**'), which is part of the Department of Justice and Community Safety. JARO found that Mr Alic's classification as a medium security prisoner and placement at Eagle Place in Marngoneet, was appropriate and consistent with Corrections Victoria's Sentence Management Manual ('**SMM**') and with his prisoner profile.

44. It should be noted that JARO identified that Mr Alic's charges in respect of his alleged sexual offending were not recorded within the Prisoner Information Management System ('**PIMS**'). Corrections Victoria clarified that PIMS picked up only the first four charges on the warrant, and the sexual offence charge was not within these first four charges and therefore had been allocated to the 'plus other' category.

45. Ultimately JARO concluded that '*a lack of awareness of Mr Alic's rape charge may have impacted, albeit very minimally, his custodial management as this information could not be used in relevant decision making about him … … while staff advised JARO that it would have been useful to have this information in order to consider it when placing Mr Alic, it did not necessarily mean that Mr Alic's placement would have been any different. Further, staff reported that it is not uncommon for prisoners with charges such as this to be in a mainstream environment*'.[18] This was also supported by the evidence of Deputy Commissioner Westin, Corrections Victoria, who stated, '*This information would not have necessarily impacted Mr*

[18] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p721.

Alic's classification, management or approach of Corrections Victoria to Mr Alic'.[19] I accept that evidence.

46. Corrections Victoria indicates that it has been liaising with the Magistrates' Court of Victoria to address this issue and that '*it is being considered as part of the new Court Management System under development for the Magistrates' Court of Victoria to replace the Courtlink system. Intended system improvements will ideally ensure that a prisoner's most serious charge is always listed first on relevant documentation or electronic records. However, there are limited funds available for such enhancements and so it is not clear at what time these enhancements will take place*'.[20]

47. JARO noted that at the time of his death, Mr Alic had not been ascribed any risk ratings. JARO considered that the absence of violence, security and placement risk ratings was appropriate as there were no documented concerns about Mr Alic. JARO was unable to comment on the absence of suicide/self-harm, medical or psychiatric risk ratings, as these were matters for clinical staff.[21]

48. A fundamental question for consideration is whether, on all the available evidence, a suicide/self-harm or psychiatric risk rating should have been ascribed to Mr Alic at any point throughout his period of incarceration.

49. One of the relevant matters that flows from this was the appropriateness of Mr Alic being housed within Eagle Place at Marngoneet Corrections Centre. Eagle Place was opened in September 2014 and consisted of nine shipping containers housing three single cells per container. The type of accommodation at Eagle Place was in the form of a small cottage-style accommodation with a bed, bathroom, air conditioner and refrigerator. Eagle Place was not cellular accommodation and therefore not required to be compliant with the Cell and Fire Safety Requirements, which operate, in part, to optimise cellular accommodation design to reduce the risk of hanging points.[22] Prisoners assessed as a significant to potential risk of

[19] Statement of Deputy Commissioner Westin, Corrections Victoria, Inquest Brief, p835.
[20] Statement of Deputy Commissioner Westin, Corrections Victoria, Inquest Brief, p836.
[21] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p716. I note that the current approach of JARO to its review of deaths in custody is to produce a report reviewing both prison management and clinical care, which is a very positive development since Mr Alic's death.
[22] Department of Justice 'Cell and Fire Safety Guidelines', Inquest Brief, p1390.

suicide and self-harm, that is S1 to S3, were not to be accommodated in accommodation that was not compliant with the Cell and Fire Safety Requirements, including at Eagle Place.[23]

50. As Mr Alic's death occurred eight days after his placement in Eagle Place, JARO considered the appropriateness of this placement in the context of his prisoner profile. During interviews with Marngoneet staff, JARO was informed that for a prisoner to be eligible for a placement in Eagle Place, they must not have an Identified Drug User status, be incident-free and be employed. JARO's review of various information systems identified that Mr Alic met these criteria and that his placement in Eagle Place was appropriate and commensurate with his prisoner profile.[24]

51. The assessment of risk in respect of suicide/self-harm operates on a four-tier assessment regime for risk of suicidal behaviour:[25]

    a. Rating S1–currently at risk–prisoner assessed as at immediate risk of suicide/self-harm;

    b. Rating S2–currently at risk–prisoner assessed as at significant risk of suicide/self-harm;

    c. Rating S3–not currently at risk–prisoner is assessed as at potential risk of suicide or self-harm. Means that the prisoner is identified as having a number of risk factors where, without intervention, there is the potential for escalation of his/her risk, but who is not at high/moderate risk of suicide or self-harm;

    d. Rating S4–not currently at risk–prisoner has previous history of self-harm behaviour.

52. The P rating refers to the assessed need for psychiatric treatment and follow-up:[26]

    a. P1 – where the prisoner has a serious psychiatric condition requiring intensive and/or immediate psychiatric care;

    b. P2 – where the prisoner has a significant ongoing psychiatric condition requiring psychiatric treatment;

    c. P3 – where the prisoner had a stable psychiatric condition requiring continuing treatment or monitoring.

[23] Statement of Deputy Commissioner Westin, Corrections Victoria, Inquest Brief, pp851-852.
[24] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p721.
[25] Justice Health Correctional Suicide Prevention Framework, Inquest Brief, pp1653-1654.
[26] Statement of Terry Runciman, Forensicare, Inquest Brief, p1620.

53. At no time, either prior to Mr Alic's entry into custody, or at any time whilst he was in custody, was he diagnosed with a psychiatric condition. A 'P' rating of prisoners at regional prisons is based on a clinical assessment conducted by either Forensicare or the primary mental health service provider (at the time that Mr Alic was detained at Marngoneet, the primary health care provider was Correct Care Australasia). Whilst Mr Alic consulted the Psychiatric Nurse on 16 March 2019, and was followed up twelve days later, these consultations resulted in the referral for a formal review by a psychiatrist, in the absence of any formal diagnosis of a psychiatric condition.

54. There were numerous points at which Mr Alic's mental state and/or welfare were assessed:

    a. On 30 December 2018 he was apprehended pursuant to s 351 *Mental Health Act 2014* and conveyed to the Northern Hospital for examination where it was determined there were no grounds to place Mr Alic under an Assessment Order.

    b. On 30 December 2018 following Mr Alic's admission into police custody, a welfare check was conducted on him prior to his placement in a cell and he presented with no issues or concerns and reported to be fine other than feeling tired.

    c. On 2 January 2019 upon Mr Alic's transfer to MAP a full mental state examination was conducted and he was described as having a relaxed, cooperative demeanour, denied any psychological complications or any suicidal or self-harm risks or ideation.[27] It should be noted that Mr Alic's LEAP warning regarding his threat, amongst other things, to burn down his house was visible in Centurion (Corrections Victoria's intelligence database) on the day of his reception to MAP and was available to be factored into Mr Alic's risk assessment.[28] When viewed in its proper context, the content of that LEAP warning was a matter to be considered, not in isolation, but in totality alongside the full mental state examination conducted. As was submitted in the statement of Deputy Commissioner Westin, Corrections Victoria, and which I accept, '*the LEAP warning provides static risks which are considered in the assessment, but the information is not relied on by itself as incidents listed can date back years. Mental health staff form their decision using a dynamic comprehensive assessment*'.[29]

[27] Justice Health Clinical Notes, Inquest Brief, p741.
[28] LEAP Warnings Report, Inquest Brief, p996. It is for this reason that I do not consider it to be of concern that Victoria Police did not ascribe a risk rating to Mr Alic on the E*Justice system at the time he was still in the custody of Victoria Police.
[29] Statement of Deputy Commissioner Westin, Corrections Victoria, Inquest Brief, p832.

d. On 8 January 2019 upon reception at the MRC an Inter-Prison Transfer Assessment was conducted where Mr Alic presented as easily engaged, reactive in conversation, settled and denied any risk.[30]

e. On 7 February 2019 upon his final transfer to Marngoneet Correctional Centre where Mr Alic described his mood as 'nervous' but denied any thoughts of suicide/self-harm.[31]

f. On 16 March 2019 during the review by the Psychiatric Nurse where it was noted '*Zoran presents with clear and logical thought processes and no perceptual disturbances. Thought content revolves around not accepting his partner's description of his behaviours. He has plans for post release in that he expects to gain work and "pick up his life". He describes his mood as "sad", and this is reflected in his affect which remains reactive. He denies any suicide/self-harm thoughts or intent'*.[32]

g. During the follow-up twelve days later on 28 March 2019 with the Psychiatric Nurse with the corresponding notation '*Tells me his mood has been low for some time. He isolates and feels depressed. Denies any suicide/self-harm ideation*'.[33] This consultation resulted in the referral for a formal review by a psychiatrist.

55. Mr Alic was not ascribed an 'S' risk rating as, at no time during any of these assessments or welfare checks, were any risk factors identified that would have caused a risk rating to be generated.

56. As part of the coronial investigation the policy document, *Correctional Suicide Prevention Framework | Working to prevent prisoner and offender suicides in Victorian correctional settings*, was obtained. Referencing this document specifically in respect of Mr Alic:

a. There were a number of general risk factors present in respect of Mr Alic, including that he was in custody for the first time, and immediately separated from his partner and daughter upon being arrested and charged and a final FVIO granted;[34] *however*

[30] Justice Health Clinical Notes, Inquest Brief, p739.
[31] Interprison Transfer Assessment, Inquest Brief, p748.
[32] Justice Health Clinical Notes, Inquest Brief, p737.
[33] Justice Health Clinical Notes, Inquest Brief, p735.
[34] Justice Health Correctional Suicide Prevention Framework, Inquest Brief, p1669.

b. Mr Alic had no past psychiatric history, no history of mental illness and no demonstrated history of any form of suicidal behaviour; and

c. Throughout his time in custody Mr Alic exhibited no at-risk behaviours, he never expressed suicidal ideation or exhibited acute distress.

57. Even the day of or prior to his suicide, there was no evidence of Mr Alic's impending decision. During the professional visit that lasted an hour and a half, his lawyer states '*during the conference my impression was that Mr Alic was very concerned about the allegations against him. I don't recall him being overly emotional, crying for example, but he was generally apprehensive and downcast about his situation. I took Mr Alic through parts of the brief and it became apparent to me that he was not aware of some of the material in the brief, in particular that statements had been made against him by two further females*'.[35]

58. Upon returning from the visitation, no at-risk observations were made. Prison Officer Raynor stated that '*Mr Alic didn't approach the officer's post for any reason once he was back at Eagle Place. He collected his dinner at approximately 15.45 hours and I didn't notice anything unusual with his behaviour. Alic normally had a quiet demeanour and would walk around the Rothwell Neighbourhood with fellow prisoners … … The lock-up count was called in progress at 17.20 hours … … Alic said 'good night' as we counted him and closed the cell door. He was polite and didn't appear to be upset about anything when we conducted the lockup count*'.[36]

59. Based on the available evidence, I find that it was appropriate and in accordance with policy, that no risk rating in respect of either a psychiatric condition or suicide/self-harming behaviour was ascribed to Mr Alic. At its highest, during his consultations with the Psychiatric Nurse on 16 and 28 March 2019, Mr Alic's presentations were appropriately triaged with a plan made for him to see a psychiatrist, which was also appropriate. The timing of that consultation, however, is a matter of concern that I will now address.

[35] Statement of Mr Alic's lawyer, Inquest Brief, pp8-9.
[36] Statement of Prison Officer Raynor, Inquest Brief, p10.

On 28 March 2019 Zoran Alic was referred for a psychiatric consultation that was scheduled on 17 May 2019. Examination of the timeframe between referral and scheduled consultation and whether this was in accordance with policy.

60. The first evidence of any psychological distress in respect of Mr Alic in custody became apparent on 12 March 2019 when he self-referred to consult with the Psychiatric Nurse. That consultation occurred on 16 March 2019 where no immediate risk was identified, with the case notation reading '*Zoran presents with clear and logical thought processes and no perceptual disturbances. Thought content revolves around not accepting the complainant's description of his behaviours. He has plans for post release in that he expects to gain work and "pick up his life". He describes his mood as "sad", and this is reflected in his affect which remains reactive. He denies any suicide/self-harm thoughts or intent'*.[37]

61. In a follow-up review on 28 March 2019, Mr Alic disclosed that his mood had been low for some time, he isolated and felt depressed but denied any suicide/self-harm ideation.[38] Following this a referral was made for a psychiatry review and Mr Alic was placed on the waiting list for consultation. As he was not considered to be urgent, a psychiatry review was scheduled in 7 weeks on 17 May 2019. He was not prescribed any medications as there were no indications for these to be commenced. Mr Alic was encouraged to self-refer should he continue to feel low, and he was not referred to the Mobile Forensic Mental Health Service as he was considered to be at low risk and was not assigned a P, S or M risk rating in E*Justice.

62. Within the Justice Health Death in Custody Report the following conclusion was reached:[39]

> *Justice Health is of the opinion that although Mr Alic's mental health was non-acute and low risk, a six week wait for follow up care by a psychiatrist is not in keeping with care standards at other prisons. Justice Health considers a reasonable time frame for a prisoner to be seen by a Forensic Mental Health service to be 4 weeks. This time frame is set out in Key Performance Indicator (KPI) 17 of the Corrections Victoria Private Prison Service Indicator, 30 June 2016.*

[37] Justice Health Clinical Notes, Inquest Brief, p737.
[38] Justice Health Clinical Notes, Inquest Brief, p735.
[39] Justice Health Death in Custody Report Zoran Alic, Inquest Brief, p729.

Therefore, as outlined above Mr Alic's referral follow up did not meet this time frame. Justice Health is of the opinion that both the Primary Mental Health provider could have arranged for a follow up appointment with either the Primary Mental Health Nurse or Medical Officer to monitor Mr Alic's mental state rather than relying on him making a self-referral. Justice Health is also of the opinion that the Forensic Mental Health Services provider should review their current practices to ensure prisoners are seen in a timely manner. However, it is noted that considering the nature of suicidality such a review may not have prevented Mr Alic's death.

63. Justice Health subsequently made the following recommendations:[40]

    a. *The Forensic Mental Health Service review its processes to ensure prisoners are reviewed within four weeks of a referral being made by the Primary Health and Mental Health Service; and*

    b. *Prisoners waiting to see a psychiatrist for a period greater than four weeks must be reviewed by the Primary Health and Mental Health team in the interim period.*

64. It is accepted by the relevant interested parties that this Justice Health Death in Custody Report erroneously referenced KPI 17 (which applies to private prisons only), and that the relevant standard that should have been referenced was the Justice Health Quality Framework 2014. This Quality Framework establishes a performance target for 100% of psychiatric specialist consultations to be provided within 30 days for non-urgent referrals across all public prisons where forensic mental health services are delivered (Key Result Area ('**KRA**') 4.4).[41] KRA 4.4 was in place at the time of Mr Alic's death and remains in place today.[42]

65. The Court was recently advised in correspondence on behalf of the Department, that Justice Health and Forensicare are currently in the process of recommissioning their contract for Forensic Mental Health services across public prisons. The new contract is expected to commence from 1 July 2025 and whilst it is anticipated that KRA 4.4 may be replaced, it is currently not known what performance target will exist in respect of timeframes for non-urgent referrals.[43]

[40] Justice Health Death in Custody Report Zoran Alic, Inquest Brief, p730.
[41] Justice Health Quality Framework April 2014, Inquest Brief, p1597.
[42] Statement of Ashlea Shaune, Justice Health, Inquest Brief, p1486.
[43] Additional Material #1, Correspondence from VGSO Principal Solicitor Kate Wright to Court dated 20-11-2024.

66. At the time of Mr Alic's death, primary mental health services at Marngoneet were provided by Correct Care Australasia which was responsible for initiating the referral, triaging, scheduling consultations and monitoring and managing waitlists. Forensicare had no oversight of the triaging process and did not manage, triage or reorder clinic lists. By way of relevant side note, in July 2023, responsibility for primary mental health services at Marngoneet transferred from Correct Care Australasia to GEO Healthcare.

67. On 1 May 2021, a dedicated position commenced within Forensicare, the Regional Clinical Coordinator role ('**RCC**') that assumed coordination of clinic lists in regional prisons and was responsible for receiving, triaging and scheduling all referrals to Forensicare from primary mental health service providers. The RCC position as of October 2023 was funded on an ongoing basis. The anecdotal or qualitative evidence suggests that the RCC role has had a positive impact on service delivery and risk mitigation.[44] Forensicare is funded for a single RCC position that manages waiting lists for outpatient clinic services at regional prisons where Forensicare is contracted to provide specialist forensic mental health services.

68. To understand the impact that implementation of the RCC role had on the performance target established by KRA 4.4, the Court requested quantitative data from Forensicare in respect of KRA 4.4 in both 2019 (the year of Mr Alic's death) and 2024 (current day). This requisition was also raised partly based on the evidence of Justice Health Acting Clinical Director, Ashlea Shaune dated 22 October 2024 that '*Forensicare, as the Forensic Mental Health ('**FMH**') service provider, is required to report to Justice Health on this measure monthly. It is open to Justice Health to take action under the Agreement where there are service failures*'.[45]

69. Forensicare, within the statement of Executive Director of Prison Services, Terry Runciman dated 1 November 2024 submitted in response:[46]

    a. KRA 4.4 is not a performance assessment or reporting criterion that Forensicare has been assessed against or reported to Justice Health on since the implementation of the Quality Framework in 2014; and

[44] Forensicare Telepsychiatry & Regional Clinic Coordination 'Request for Ongoing Funding', Inquest Brief, pp1625-34.
[45] Statement of Ashlea Shaune, Justice Health, Inquest Brief, p1486.
[46] Statement of Terry Runciman, Forensicare, Inquest Brief, pp1617-1623.

b. Forensicare is not currently submitting monthly reports to Justice Health which capture the time between referral and appointment with the view of ensuring all prisoners can be seen within 30 days. In relation to the delivery of FMH psychiatry clinics at regional prisons, Forensicare has reported to Justice Health on the number of psychiatric consultations undertaken at each prison location on a monthly basis; and

c. Operationally KRA 4.4 is not reflective of how FMH services are able to be delivered at regional prisons under current funding arrangements between Justice Health and Forensicare. A 30-day time period between referral and psychiatric consultation is not a metric on which Forensicare assess or schedule patient appointments for psychiatric review across regional prisons. The time frames for psychiatric review of patients in regional prisons are determined by the RCC following review, clinical assessment and prioritisation of referral information received from the primary health service to ensure that the scheduling of appointments reflects the acuity and clinical needs of the patient cohort; and

d. Forensicare submits that it is not funded by Justice Health to resource regional locations to deliver all psychiatric consultations within 30 days of referral. If Forensicare was required by Justice Health to meet KRA 4.4, additional funding would be required to increase the number of available clinics at regional locations; and

e. The current electronic medical record system, JCare, utilised in prison services does not support the collection of data relevant to KRA 4.4, that is JCare does not currently have functionality to track or report on aging of referrals for psychiatric review. The RCC position currently utilises a spreadsheet to monitor waitlists for psychiatric consultations that is reliant on manual data input and does not capture data on the actual time between referral and a patient undergoing a psychiatric consultation.

70. The Court was recently advised in correspondence on behalf of the Department that functionality to support the collection and reporting of timeframe data between referral and appointment does in fact exist in JCare.

71. Both the Department and Forensicare acknowledge that the timeframe between referral and psychiatric consultation is an important consideration. Terry Runciman within his evidence stated, '*while the timeframe between referral and psychiatric consultation is an important consideration, it does not override clinical triage assessment of the Regional Clinical Coordinator*'.[47] Likewise the Department in recent correspondence acknowledged '*it is accepted that knowing how long a prisoner has been waiting for a non-urgent psychiatric appointment is useful in the clinical triage of appointments*'.[48]

72. I accept that this timeframe is not the sole consideration, and that the scheduling of psychiatric reviews is also required to consider the clinical assessment of acuity and urgency for review. Nonetheless, I consider that this timeframe remains an important consideration, and it is a timeframe that was *not* being measured back in 2019 at the time of Mr Alic's death, and which today remains routinely inaccessible by the Regional Clinical Coordinator, who has responsibility for receiving, triaging and scheduling all referrals to Forensicare from primary mental health service providers.

73. Consequently, there remains a real risk that a regional prisoner whose mental health is non-acute and low risk, may not be receiving a psychiatric consultation in a timely manner (namely within the stipulated 30 days) in accordance with the performance requirements established within the Quality Framework.

74. The overview to the Quality Framework April 2014 states:[49]

> *'The Quality Framework is designed to assist the Health Service Provider to implement a comprehensive approach to the provision of consistent clinical services across service and Prisoner types to achieve the best possible health outcomes. It also provides a means to demonstrate evidence of the quality of healthcare provided. It clearly defines the obligations for Reporting Requirements regarding the quality of care delivered in Victorian prisons. The Quality Framework aligns closely with contemporary health service quality and clinical governance frameworks, including the Victorian Safety and Quality Framework and the Victorian Department of Health Clinical Governance Policy. The definition of 'clinical governance' is derived from the Victorian Department of Health Clinical Governance Policy (2009): 'the system by which clinicians and staff share responsibility and are held accountable for the quality of care, continuously improving, minimising risks and fostering an environment of excellence*'.

[47] Statement of Terry Runciman, Forensicare, Inquest Brief, p1621.
[48] Additional Material #1, Correspondence from VGSO Principal Solicitor Kate Wright to Court dated 20-11-2024.
[49] Justice Health Quality Framework April 2014, Inquest Brief, p1489.

75. It is a key concern that Forensicare currently relies upon manual data input to manage waitlists in the absence of key metrics such as the time elapsed between referral and scheduled psychiatric consultation. In the circumstances it is difficult to reconcile how the absence of this key metric contributes towards accountability, risk minimisation and service delivery.

76. Pursuant to s 72(2) *Coroners Act* 2008 I intend to make pertinent recommendations that are detailed at the conclusion of this Finding and that will address the systems issues that persist some five-and-a-half years since Mr Alic's death, despite other positive improvements such as the advent of the role of the Regional Clinical Coordinator.

Examination of the provision of welfare and support services to Zoran Alic following the professional visit by his lawyer on 28 April 2019, and whether this was in accordance with policy

77. On 28 April 2019, Mr Alic had a professional visit from his lawyer of an approximate one-and-a-half-hour's duration. During this visit Mr Alic was provided with a copy of the hand-up brief that had now increased to a total of 55 charges and as his lawyer states in evidence '*I took Mr Alic through parts of the brief and it became apparent to me that he was not aware of some of the material in the brief, in particular that statements had been made against him by two further females*'.[50]

78. However, Mr Alic displayed no overt at-risk behaviours to either his lawyer during the visit, or to Prison Officers after the visit. At its highest, his lawyer described Mr Alic as '*very concerned about the allegations against him … … generally apprehensive and downcast about his situation*'.[51] The Prison Officers who conducted the lock-up count described Mr Alic as '*polite and didn't appear to be upset about anything*'.[52] It should also be noted that during the JARO review of this incident that they '*reviewed a phone call made by Mr Alic on the evening prior to the incident, and did not identify anything in Mr Alic's demeanour to indicate he was at risk of suicide or self-harm or was worried*'.[53]

[50] Statement of Mr Alic's lawyer, Inquest Brief, pp8-9.
[51] Statement of Mr Alic's lawyer, Inquest Brief, pp8-9.
[52] Statement of Prison Officer Raynor, Inquest Brief, p10.
[53] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p719.

79. Mr Alic suicided sometime that evening or the following early morning and it would be remiss not to recognise the proximity of this legal professional visit as a potential trigger point. However, JARO concluded '*based on available information, JARO has not identified anything in Mr Alic's demeanour that should have prompted staff to harbour concerns about his welfare*'.[54]

80. As part of the JARO Report, custodial staff were interviewed who confirmed that Mr Alic's disclosures to the mental health nurse in March 2019 were not shared with them. Those disclosures included that Mr Alic disclosed that he never became an Australian citizen and that '*this is causing him considerable concern as he has been told he might be extradited'* and that further '*his mood has been low for some time. He isolates and feels depressed*'.

81. JARO explored the information sharing practices with Justice Health who advised that Mr Alic's comments were not considered by health staff to be alarming, and if they were, an 'at risk' review would have been undertaken. This is consistent with the new primary healthcare model *Health Services Quality Framework for Victorian Prisons 2023*. One of the requirements within this Framework is '*2.23 health service providers must have a process to communicate critical information and risks to prison staff when there is a change to a person's health that places the person in prison, other prisoners or staff at risk of harm*'.

82. JARO ultimately concluded '*though JARO does not suggest that it would have prevented Mr Alic's death, greater sharing of information by health staff may have given custodial staff the opportunity to consider whether to monitor him more closely*'.[55] While this conclusion is supportable, I don't consider any adverse finding is warranted in circumstances in which Mr Alic continued to deny suicidal ideation to clinical staff, and in which a plan had been made by health services for him to consult a Forensicare psychiatrist.

83. At the time of Mr Alic's death, custodial staff were required to assess the risk status of a prisoner following a videolinks or Telecourt hearing, however it was identified that there was no defined process for a 'check-in' following a prisoner's interaction with their lawyer. It should be noted these welfare check-in processes had been previously engaged with.

[54] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p719.
[55] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p719.

84. On 15 February 2019 Mr Alic had a bail application via a Telecourt video link conference. Bail was denied and the next court date set for 28 February 2019. Prison Officer Smith noted that Mr Alic was visibly upset during the hearing. She asked if he wanted to talk to a mental health nurse, which he declined. She then confirmed that if Mr Alic needed to speak to anyone regarding his welfare, that he should speak to staff. Mr Alic said that he would be safe and was allowed to return to his unit.

85. Likewise on 9 March 2019 after attending Court, Mr Alic again said that he did not want to speak to a mental health nurse.

86. JARO considered whether a 'check-in' process was required for prisoners following any professional call or visit however ultimately concluded:[56]

> '*Due to the confidentiality associated with prisoner discussions with their legal representatives, JARO acknowledges that the ability of staff to monitor these interactions is limited. Further, given that remand prisoners at Marngoneet are free to call their lawyers an unlimited number of times during the day, JARO does not consider it viable for a check-in process to exist following every single professional phone call that would occur on a daily basis. In addition to the above, JARO has not identified a similar situation to that of Mr Alic, namely whereby a suicide has occurred so shortly after a prisoner has received a professional visit from their lawyer. Given the above, JARO considers the incident involving Mr Alic to be an isolated event, as opposed to one that is indicative of a broader or systemic issue*'.

87. Returning to a point previously made, Mr Alic displayed no overt at-risk behaviours to either his lawyer during the visit, or to the Prison Officers after the visit. At its highest his lawyer described Mr Alic as '*very concerned about the allegations against him ... ... generally apprehensive and downcast about his situation*'. The Prison Officers who conducted the lock-up count described Mr Alic as '*polite and didn't appear to be upset about anything*'.

88. The lawyer-client relationship is bound by a duty of confidentiality as set out in Rule 9 of the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015.* Whilst Rule 9.2.5 permits a lawyer to disclose confidential information for the purpose of preventing imminent serious physical harm to their client, or to another person, this exception carries with it numerous pre-conditions, including imminence and seriousness, neither of which appeared to be present in Mr Alic's circumstances.

[56] JARO Review into the death of Mr Zoran Alic at Marngoneet Correctional Centre on 29 April 2019, Inquest Brief, p720.

89. In the absence of any mandated welfare check following any professional visit or call with their lawyer, it becomes of greater significance that lawyers providing briefs involving allegations of serious sexual offending to their clients when in custody, be cognisant of the potential impacts on their client and subsequent access to welfare support services. For the avoidance of doubt, it is not suggested that Mr Alic's conduct and demeanour during the consultation with his lawyer should have prompted any alternative response.

90. Accordingly, I shall not make any recommendation connected with this issue but will notify the Law Institute of Victoria ('**LIV**') of my Finding, in the event that it is viewed by the LIV as appropriate to remind or ensure that practitioners are aware of avenues to address their client's welfare issues in custody (outside of nominating custody management issues to the judicial officer at a hearing) where such issues are apparent within the meaning of Rule 9.2.5.

RECOMMENDATIONS

91. Pursuant to section 72(2) of the Coroners Act I make the following recommendations:

Recommendation No. 1

(a) That Justice Health collaborates with Forensicare to ensure that the timeframe measuring how long a prisoner has been waiting for a non-urgent psychiatric appointment, is: (i) measured in respect of every referral; and (ii) routinely available to the Regional Clinical Coordinator role that triages and schedules all referrals from primary mental health service providers; and

(b) That Justice Health collaborates with Forensicare and provides the appropriate training, knowledge transfer and support in respect of the functionality within JCare software that generates timeframe data between referral and psychiatric consultation for individual prisoners.

Recommendation No. 2

(a) That Justice Health reviews resourcing of forensic mental health services at regional prisons to enable Forensicare to achieve compliance with a prescribed timeframe within which non-urgent referrals for psychiatric consultations are to occur (whether that be according to the current KRA 4.4 or any newly negotiated performance target); and

(b) That Justice Health, in consultation with primary health service providers and Forensicare, develops a clear process to ensure that:

a. A prisoner waiting for a non-urgent psychiatric consultation with the forensic mental health service, continues to be monitored and reviewed by the primary mental health service provider, to ensure care is escalated to the forensic mental health service when clinically indicated; and

b. The above process should include that where a non-urgent referral for a psychiatric consultation does not occur within a prescribed timeframe *or* within a timely manner, that the prisoner be re-reviewed by the primary health service provider.

STATUTORY FINDINGS AND CONCLUSION

92. Pursuant to section 67(1) of the Coroners Act I make the following findings:

a. the identity of the deceased was Zoran Alic, born 19 March 1961;

b. the death occurred on 29 April 2019 at Marngoneet Correctional Centre, Lara, Victoria from HANGING;

c. in the circumstances described above at paragraphs [39] to [41].

93. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Malcolm Dodd, and I find that Zoran Alic died from hanging in circumstances where I find that he intended to take his own life. In having made such finding, I note the absence of identified suspicious circumstances, the lethality of the means chosen, and the evidence pointing to Zoran Alic's recent stressors, including the numerous criminal charges he was facing and concomitant fears of deportation, in the context of his isolative behaviours and deteriorating mental health.

94. I find that Zoran Alic's interactions with and management by Victoria Police, Corrections Victoria and his lawyers to have been reasonable and appropriate and in line with applicable policies.

95. I find that the plan devised by the prison health service at Marngoneet Correctional Centre on 28 March 2019 for Zoran Alic to have non-urgent psychiatric follow-up by Forensicare was reasonable and appropriate. However, the wait time of 6-7 weeks was not in keeping with the required standards of the Justice Health Quality Framework that existed then and still exist today, which require non-urgent psychiatric referrals to be seen within 30 days.

96. Notwithstanding, I do not find that Zoran Alic's death was preventable on that basis. Were Mr Alic to have attended a psychiatric consultation within 30 days of his referral, his subsequent diagnosis, treatment and clinical course are speculative on the available evidence.

97. However, I consider there to have been a lost opportunity for timely care to have been provided to Mr Alic in the context of his reportedly deteriorating mental health, and for him to have been comprehensively assessed in a specialist psychiatric setting in a timely manner, as required by Justice Health policy.

98. Having so found, I note that a considerable amount of time has elapsed since Mr Alic's death, and that a number of systems improvements have occurred in respect of health service provision in public prisons in Victoria since 2019, including, critically, the development of Forensicare's Regional Clinical Coordinator role, which provides an avenue for more nuanced triaging of the needs of prisoners awaiting psychiatric review beyond simple timeframe considerations.

99. However, the evidence before me clearly demonstrates that the timeframe between referral and psychiatric consultation remains an important consideration, albeit not the only consideration, in triaging and managing patients awaiting psychiatric review. Accordingly, I am satisfied that, with the two coronial recommendations made as a result of this Inquest, which have had the benefit of considered input from Interested Parties, and which keep these timeframe considerations in view in a flexible way, the relevant systems improvements have been appropriately identified.

100. It remains for Justice Health to consider my recommendations, in consultation with and through providing support to Forensicare, to ensure the delivery of timely and appropriate care to prisoners requiring psychiatric consultation.

I convey my sincerest sympathy to the family of Zoran Alic. I note that the coronial investigation into his death has been a lengthy one, and I am grateful for his family's patience in this regard.

I also wish to thank all counsel who attended the inquest and provided helpful and considered submissions to assist in the understanding of the issues at hand. In particular, I thank Mr Lindsay Spence, Counsel Assisting, for his excellent assistance.

DIRECTIONS

101. I order that this finding be published on the internet in accordance with section 73(1B) Coroners Act and the Rules.

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

a. The Family of Zoran Alic;
b. Kate Houghton, Secretary to the Department of Justice and Community Safety;
c. Adjunct Professor Colman O'Driscoll, Chief Executive Officer, Forensicare (Victorian Institute of Forensic Mental Health);
d. Correct Care Australasia, c/- Meridian Lawyers;
e. Shane Patton APM, Chief Commissioner of Police;
f. Matthew Hibbens, President, Law Institute of Victoria;
g. Detective Sergeant Adam Radley, Coroner's Investigator.

Signature:

Ingrid Giles

CORONER

Date: 6 December 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.