IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000975

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Brian Richard Pope

Delivered On:	14 May 2024
Delivered At:	Southbank
Hearing Date:	10 May 2024
Findings of:	Coroner Simon McGregor
Counsel Assisting the Coroner:	Leading Senior Constable Darren Cathie
Ms Debra Hansen, Senior Next of Kin:	Ms Lisa Papadinas of Counsel, instructed by Mr Barrie Woollacott of Slater and Gordon
Forensicare:	Ms Sophie Pennington of HWL Ebsworth Lawyers

Correct Care Australasia:	Mr Jeremy Smith of Meridian Lawyers, instructed by Mr Shane Dawson
Department of Justice and Community Safety:	Mr Ben Lloyd of Russell Kennedy Lawyers
Keywords:	Death in custody, Recent Reception, Mental and Physical Disability, Suicide, Hanging.

I, Coroner Simon McGregor, having investigated the death of Brian Richard Pope, and having held an inquest in relation to this death on 10 May 2024 at Southbank in the State of Victoria find that the identity of the deceased was Brian Richard Pope born on 26 November 1981, and that his death occurred on 21 February 2022 at Metropolitan Remand Centre, Victoria from: (a) compression of the neck; and (b) hanging.

INTRODUCTION

1. Brian Richard Pope was born in Sale on 26 November 1981 to Debra Hansen and David James Pope.

2. On 21 February 2022 whilst in custody at the Metropolitan Remand Centre (MRC), Brian took his own life. He was 40 years old.

CORONIAL INVESTIGATION

3. At the time of his death, Brian was a person placed "in custody or care" as defined in Section 3 of the *Coroners Act 2008* (the Act). Section 52(2)(b) of the Act stipulates that an inquest is mandatory in these circumstances.

4. Coronial investigations and inquests are not about finding fault or apportioning blame for a person's death. Parliament has tasked this court with identifying, as far as is practicable, the identity, causes and background circumstances of all deaths in custody, and where appropriate, identify any prevention opportunities which may reduce the likelihood of these circumstances recurring.

FINDINGS AS TO CIRCUMSTANCES[1]

Personal Background[2]

5. Brian is the second eldest of Debra's six children: Billie-Joe Pope, Warren Pope, Shauna Pope, Lareena Baird-Pope and Megan Baird-Pope.

6. Brian initially lived with his mother, father and siblings Billie-Joe and Warren on a dairy farm at Clydebank, just out of Sale. The family moved into a house in Sale living there for approximately 12 months or so.

7. At some point the three children Billie-Joe, Brian and Warren were placed in state care at Swan House in Traralgon. This was due to Debra not coping at the time, with three children under the age of five and the relationship with David was beginning to deteriorate.

8. Debra went to Wyong to stay with her father sometime mid to late 1984. David rang Debra one evening and told her that Warren had been taken to the Royal Children's Hospital (RCH) with a suspected fractured skull.

9. On arriving at RCH, Debra was informed by staff that Warren was brain dead. Life support was ceased and in October 1984, Debra's third child Warren died on his first birthday. The Coroners Court hearing at Sale determined that Warren died from pneumonia, not the fractured skull.

10. The death had a profound and lasting effect on Debra and her family. The relationship between Debra and David worsened. Debra packed her children up and moved. Brian was two or three years old at the time.

11. Debra and the children moved to Koonwarra and initially shared a house with another female, but it was too expensive so the family moved into the Thomson River Caravan Park, staying there until a ministry of housing place became available in Sale.

[1] Pursuant section 67(1)(c) of the *Coroners Act 2008*.
[2] Brian's early life is described in statements by his mother, Debra Hansen, CB v2 page 19 and his sister Shauna Pope, CB v2 page 38

12. Debra met another man, Wayne Loader and remained in a relationship with him for about four years. Debra had another child during this relationship – a daughter called Shauna, born in 1987.

13. Brian is described as being a bit of a loner as a young child. However when he made friends at school, he became very close to them, stuck by them and was very protective of them.

14. Brian went to the Tobruk Street Primary School in Morwell. In 1987 when Brian was in Grade 2 or 3, Debra and Wayne separated. Debra remained living in Morwell with her children until 1991.

15. In Grade 5 a teacher identified that Brian was struggling academically with his reading and writing. Brian was assessed and diagnosed with dyslexia and comprehension problems. Brian however was good at maths.

16. Debra described Brian as really struggling and that he tried his best to overcome his learning difficulties. Brian excelled at sports or anything outdoors. He wore glasses and this caused undue attention from his peers and he was bullied at school.

17. With the help of a tutor, Brian passed Grades 5 and 6.

18. At age 12 Brian developed anxiety which meant he would not go out to unfamiliar places. He found it very hard to socialise and even kept to himself a lot when he was at home. He always preferred to stay home.

19. Debra then formed a relationship with Alan Baird. In 1991 Debra moved with her children to Newborough. Alan didn't live with Debra, but remained in Moe. Brian changed schools again, this time going to Newborough Primary School. Brian was said to have coped well with this change even though he was close to Alan.

20. Brian mentioned to his mother that Alan was the only one who ever taught him things. Alan took Brian camping, fishing and taught him about the bush.

21. In 1991 Debra had another child Lareena and then moved to Kilmany with her children.

22. In 1994 Debra moved to Rosedale. Whilst living in Rosedale, Brian met a local man, Kevin Patmore, who did a lot of work with the local youth. Brian became involved in a junior darts

team. During this time he appeared to enjoy himself and came out of his shell. He started spending time with other boys from the darts team and gained a new circle of friends.

23. The relationship Brian had with Kevin appeared to fill the void that Brian felt in relation to his own father. Brian felt like an afterthought to his father and that his father didn't want him. At age 12 Brian made up his own mind that he didn't want to go and stay with his father anymore as he had never felt welcome there.

24. Brian commenced Year 7 at Sale Technical School and in April of that year the family moved once again and Brian then went to Lowanna High School in Newborough. In Year 8 Brian's mother and Alan separated, and Debra moved the family back to Sale. Brian appeared to do well back at Sale Tech as he knew several children from his previous year there.

25. Brian left school at the end of Year 8. Around this time, he was living in a bungalow at the rear of Debra's home. One day she went out to the bungalow and caught Brian and one of his friends chroming. This caused a fight between them after Debra kicked the friend out of the bungalow.

26. Around the age of 15 or 16 Debra found Brian passed out on Shauna's bed as a result of chroming. Debra couldn't wake him up and had to call an ambulance. Brian was not working or going to school at this stage.

27. Brian was going through a rebellious period and one of his friends went to a local drug dealers house and stole $800. Brian and the friend fled to Melbourne where they were located by police some days later.

28. Brian returned home and appeared to change for the better. He found employment at a local bakery in Sale and stayed there for a few months.

29. After leaving the bakery Brian rekindled the relationship with his father and went to work and live at his farm. Debra didn't see much of Brian for a couple of years as he appeared to have found his independence.

30. In 2000, aged 18, Brian asked Debra if he could move back home with her in Rosedale – he lived in a bungalow in the backyard with a friend. Brian seemed to be doing well, apart from his anxiety.

31. The family moved to another address in Rosedale, where Brian lived in a caravan in the backyard. Brian turned 21 and they had his party at home with friends and relatives.

32. Not long after, Debra and her partner separated with the partner threatening to kill three-year-old Megan. Intervention Orders were put in place and Brian, having witnessed the domestic violence, became very protective of Megan and his other sisters.

33. In 2002 Debra moved to New South Wales and Brian stayed behind with his sister Billie-Joe and her husband. Brian was living in a caravan in the backyard of the address.

34. Brian met a girl shortly after his 21st birthday and they were together for around 12 months.

35. In his late 20's Brian met another girl and had a relationship lasting about five years. After this relationship ended, Brian started seeing another woman who had a young boy. The relationship was tense and there was a lot of fighting, mostly between the young boy and Brian.

36. After Brian broke up with this woman, he began to drink heavily. He moved back in with his father, but this did not last due to the pair arguing.

37. Brian then moved to the Stratford Caravan Park, staying there for about 18 months. In 2019 Brian moved back to his mother's home in Rosedale.

38. In 2020 Brian's anxiety became extreme, barely leaving the house. He would only go down the street to collect his pay and do a bit of shopping. Brian had appointments with an employment agency, however every time he had to go to an appointment, he would be physically sick, vomiting and having panic attacks at the thought of leaving the house.

39. Brian was very reclusive and spent his time watching television, mowing the lawns and doing his washing.

Deteriorating mental health and precipitating incident

40. In 2021 Brian had made an application to access his superannuation. He had received a reply saying that he couldn't access his super because something wasn't matching up. He had

previously accessed his super at the start of the COVID-19 pandemic and could not understand why he was now being denied access to these funds.[3]

41. Brian said to his mother that he " ...might as well go hang himself because he didn't exist, and nobody would care." He was very angry at the time.[4]

42. On 6 January 2022, Debra arrived home from work and took Brian into town to get some money so he could pay his board and some bills. He went to the supermarket and bought a 10 pack of Jim Beam cans. Brian then went to his appointment at Sureway employment agency and appeared relaxed when he left the premises,[5] not displaying any of his usual signs of anxiety.

43. On arriving home Brian went to his room saying he was going to play some darts. Then at some later stage in the day, Brian came out of his room and attempted to sexually assault his mother.[6]

44. The police were called, but Brian left the house before they arrived. There were concerns for Brian's mental health as he had threatened to kill himself after the incident with his mother.

45. On 7 January police located Brian lying on the highway having rolled his ankle on a gutter.[7] An ambulance was called, and he was taken to Latrobe Regional Hospital (LRH) for treatment.

Medical and Mental Health assessment and treatment – January / February 2022

Latrobe Regional Hospital – 7 to 31 January 2022[8]

46. Brian was admitted onto Tanjil Ward where he received treatment for his fractured leg. He was also seen by a dietician, social worker and physiotherapist. Police had requested a mental health assessment. When Brian was first taken to hospital this was in a voluntary capacity as the injury to Brian's leg took precedence. A Mental Health transfer form was not completed.

[3] Hansen paragraph 91, CB v2 p. 33
[4] Ibid par. 91, CB v2 p. 33
[5] Ibid par. 96, CB v2 p. 34
[6] Ibid par. 98, CB v2 p. 34; Pope par. 16, CB v2 p. 41; DSC Jacinta Elliott statement par. 27, CB v2 p. 104
[7] Vijay Prajapati statement, CB v2 p. 43
[8] Ibid

47. The Emergency Department triage clinician noted that Brian had no money, nowhere to live and felt like giving up on life. Brian added he did not wish to make a suicide attempt whilst in hospital as the nurses already had too much to do.

48. On 10 January Brian was placed under an Inpatient Assessment Order under the *Mental Health Act 2014*, due to the intensity of suicidal thoughts and his temptations to leave hospital.

49. On 11 January Brian was assessed by the Consultation Liaison Psychiatrist Doctor Prem Chopra who diagnosed Brian with a Major Depressive Disorder, Alcohol Use Disorder and traits of personality disorders. Dr Chopra revoked Brian's Inpatient Assessment Order and decided to admit him to the Flynn Adult Mental Health Unit as a voluntary patient. Brian was prescribed an anti-depressant Mirtazapine when he first arrived on Tanjil Ward with a dose of 7.5 milligrams. This was increased to 15mg daily by Dr Chopra.[9]

50. Brian was next assessed by Dr Vijay Prajapati on 14 January.[10] The following information was provided by Brian:

    a. He had been having suicidal thoughts for the last three years;

    b. He attributed these thoughts to feelings of guilt for being disabled, useless and helpless, that he can't read properly and couldn't help his family when they needed him;

    c. Prior to admission to hospital, his thoughts of suicide occurred a few times a week;

    d. He reported attempting suicide three or four years prior when he tried to strangle himself and also took 10 unknown tablets;

    e. He reported telling his mother he was going to kill himself in the weeks prior to Christmas 2021;

    f. In relation to the incident with his mother, Brian stated he could not remember it as he was substance affected at the time; and

[9] Prajapati, CB v2 p. 44
[10] Ibid

g. Stated that he had been using marijuana, ICE and heroin up until a year ago. He stated he still drank regularly, and this escalated to binge drinking on Fridays after he lost his job.

51. Brian was diagnosed with a depressive disorder, mental and behavioural disorder due to a history of substance abuse and a learning disability after that assessment.

52. A review was conducted on 16 January and Brian reported that he felt down and anxious and that there was no change to his mood and thoughts of suicide. He agreed to continue taking the anti-depressant even though it made him feel "hungover".

53. On 19 January, Brian was again reviewed, it was noted that he was feeling a bit more hopeful with plans for his future including stopping substance abuse, finding employment and somewhere to live. Brian said the leg pain he was experiencing was becoming less of a burden. He complained that his heart had been racing but that was put down to his anxiety. The dosage of anti-depressant was increased from 15mg daily to 30 mg at night in the hope of further improving his symptoms.

54. On 21 January a review was again conducted and it was noted that Brian was socializing with some of the other clients. Looking back on some of his past bad habits and not wanting to repeat them. He was pleased with himself as he had regained his appetite and his mood was improving although he still reported being a bit "up and down" at times.

55. A discharge review was conducted on 27 January, Brian interacted appropriately and engaged well with no thoughts of self-harm or suicide. He reported feeling anxious at times but did not present with hopelessness. He did not present any psychotic features. He was able to move around utilising a wheelchair. Brian was told that the Police Sexual Offences and Child Abuse Investigation Team (SOCIT) had to be notified when he was released. On the basis of his current physical limitations, a Supported Residential Care Facility place had also been secured for Brian, in case SOCIT released him after his interview.

Remanded in custody – 31 January until death

56. On 31 January Brian was discharged from the Flynn Unit and taken into custody by SOCIT detectives. Brian was interviewed at the Sale Police Station and remanded in custody.[11]

57. He was transferred to Morwell Police Station later that day. On 1 February 2022 Brian was transferred to the Dandenong Police Station cells and on 2 February he was transferred to MRC.[12]

58. On reception at MRC, Brian was interviewed and assessed – through his cell trap door due to the COVID-19 pandemic – for his requirements whilst in prison. Clinicians noted this was not ideal due to the small size of the trap door, and all parties were wearing face masks.[13]

59. It was noted on Criminal Justice Enhancement Program (CJEP) Risk History that Brian was classed as Psychiatric PA (suspected psychiatric condition requiring assessment) and a recommendation that he be referred to mental health providers.

60. The Correct Care Australasia (CCA) Medical Officer (MO) and Registered Nurse (RN) identified that he had a history of depression, and a Mental Health Chronic Health Care Plan (MHCHCP) was initiated by the RN. An appointment was scheduled for 23 February for a planned review, assessment and completion of the MHCHCP.[14]

61. Collateral information was requested from LRH at this time, but was still not available by 17 February. In this context, 'collateral information' means all information regarding a prisoner, whether it be from police, other mental health clinicians, prison records etc. This information can be used to assist in the assessment and management of a prisoner.[15]

62. Prisoner health information management form compiled on 2 February shows that no comments were made in relation to significant medical or psychiatric illnesses. Brian did not overtly express suicide or self-harm thoughts, plans or intentions.[16]

[11] Prajapati, CB v2 p.48; Elliott par.27, CB v2 p.104 – incorrect date of release; DSC R Basford statement par.8, CB v2 p.189 confirms date of being taken into custody and interviewed for sex offences was 31 January 2022
[12] Elliott par.29, CB v2 p.104
[13] Correct Care Australasia Initial Review into the death of Brian Pope, dated June 2022, CB v2 p.458
[14] Dr Francis Olopade statement par. 3, CB v2 p.460
[15] Dr Katherine Roberts statement dated 9 January 2023, CB v2, par. 3.11 p.426
[16] PIMS Report, Mental Health Professional prisoner summary, CB v2 p.187

63. Brian indicated he wished to contact a family member. In the contact comments it is noted, “Prisoner is in isolation due to COVID-19 protocols at time of reception. Therefore, welfare call could not be facilitated."

64. In the Local File plan notes, a day three welfare check was conducted on 4 February. The handwritten notes by Prison Officer Cookson states there are no medical or health concerns, however, Brian requested being put into protection because he is terrified of being in prison. Brian was also issued with a TV to help with his boredom levels.[17]

65. On 10 February a day eight welfare check was conducted by Prison Officer Diver – no concerns were voiced or noted on this day.

66. Brian spent fourteen days in COVID isolation in Bellbridge Unit as part of the Prison COVID response plan and was moved to the mainstream Ballan Unit on 17 February.

67. At this stage, Brian still had a cast on his leg and was using crutches to get around. Staff on the unit helped Brian fill out paperwork and he was encouraged to engage with his caseworker and attend education orientation. Brian was instructed on the use of the emergency call button in his single person cell at this time.

68. After the entry on 17 February there were no further recorded interactions between prison staff and Brian in either the Prison Information Management System or on his Individual Management File, but the JARO review summarises the various interactions that occurred.[18]

69. On 21 February at around 7.55am staff in the Ballan Unit were conducting the morning count. On checking Cell 1, prison officers looked through the cell window and saw Brian suspended from a ligature, which was tied to his crutches which had in turn been tied together to form the hanging anchor point.

70. Prison staff opened the cell trap and attempted to get a verbal response. After receiving no response officers opened the cell door and a Code Black (urgent medical assistance required) was called.

71. On entering the cell, staff cut the ligature from Brian’s neck. Prison staff positioned Brian on the cell floor and checks were conducted for any vital signs. At this stage Brian had no

[17] Elliott, CB v2 par.37 p.104
[18] CB 320-1.

pulse, was not breathing and was cold to the touch. Cardiopulmonary Resuscitation was commenced.

72. Correct Care nursing staff attended and placed a defibrillator onto Brian.[19] The defibrillator indicated that there was no shockable rhythm at this time. Fire Rescue Victoria staff arrived on scene and assisted with chest compressions until 8.16am.

73. Ambulance Victoria staff arrived at around this time and declared Brian deceased at around 8.16am.[20]

Medical Cause of Death[21]

74. Specialist forensic pathologist Dr Matthew Lynch made the following observations as part of his post-mortem external examination:

    a. Mr Brian Pope was a 40-year-old man found hanging in his cell at the Metropolitan Remand Centre in circumstances that were not considered suspicious.

    b. He apparently had used crutches and a shower curtain to effect neck compression.

    c. A suicide note was located at the scene.

    d. There is an ill-defined ligature mark about the neck.

    e. Cause of death:

        1 (a) Compression of the neck

        1 (b) Hanging

Investigation

75. Detective Senior Constable Jacinta Elliott, acting as Coronial investigator, investigated Brian's death and prepared a coronial brief at my direction.

[19] Aliza Bonilla statement, CB v2 p.50
[20] Ibid
[21] Pursuant to section 67(1)(b) of the Act; Medical Examiner's Report, CB v2 p.91

76. The brief contains statements from family members, prison staff, prison medical staff and mental health clinicians.

77. Correct Care Australasia, the medical health agency in charge of prisoner health care at MRC at that time, prepared an internal review report in relation to Brian's death.[22]

78. At MRC, Forensicare, the specialist mental health agency tasked with assessment, treatment and management of prisoner's mental health in collaboration with CCA, also prepared a report in relation to Brian's death. [23]

79. The Justice Assurance and Review Office (JARO) review deaths and other serious incidents in Victorian prisons to understand what happened and to identify opportunities to prevent similar incidents occurring again. JARO completed a review of the circumstances surrounding Brian's death.

80. After reviewing the brief submitted to the court, I requested further material from Forensicare and Correct Care Australasia.

81. On behalf of Forensicare, an overarching statement and supplementary statement were provided by Dr Katherine Roberts, Forensicare's Consultant Psychiatrist and Director of Clinical Services (Prisons).[24]

82. Dr Roberts describes the interactions between Brian and Forensicare staff, and remedial actions undertaken arising from Brian's death.

83. Upon Brian's reception at MRC, a structured psychiatric assessment was conducted by Forensicare Nurse Bibbin to determine:[25]

    a. Current mental state;

    b. Any immediate needs for psychiatric care;

    c. Current risk of suicide, self-harm and harm to others; and

    d. Any appropriate recommendations for placement within the facility.

[22] CCA Initial Review, CB v2 p.458
[23] Dr Roberts, CB v2, par.2.2 p.424
[24] Ibid and supplementary statement dated 16 June 2023, CB v2, p.450
[25] Ibid, par.3.6 – 3.8, CB v2 p.233, 425

84. The reception assessment is intended as a screening tool to ascertain imminent risk, rather than a comprehensive psychiatric assessment.[26] As noted earlier, this assessment was affected by the protocols required due to the COVID-19 pandemic.[27]

85. Brian indicated to the assessor a psychiatric history and recent admission to Latrobe Regional Hospital for treatment post suicidal thoughts and plan, but that he was taking medications and denied any self-harm or suicidal thoughts or intent.[28]

86. Brian was given a psychiatric rating of P3 meaning he had a stable psychiatric condition requiring continuing treatment or monitoring. In the four tiers of this rating system, P1 is the highest. S ratings broadly describe the level of risk for suicide or self-harm a person displays. S1 requires the highest level of observations, and S4 the lowest. Brian was rated S4.[29]

87. Pursuant to his reception assessment, welfare checks were conducted on Brian on 3, 4, 6 and 8 February. He did not indicate distress at these times.[30] [31] As a result, the need for further welfare checks was cancelled, and Brian was advised of the self-referral process.[32]

88. Dr Roberts notes that after Brian's death some collateral information was received at MRC from LRH which had been requested earlier to inform relevant assessments about his mental health. The request for this information had not been followed up by Forensicare staff.

89. During a review of Forensicare practices, changes were made to encourage more assertive follow up by administrative staff to obtain all relevant collateral information. The reception procedure now requires staff to request collateral within 24 hours of reception into a prison, and follow up within 48 hours of non-receipt of such material. Records are to be kept to track, monitor and update these requests.[33]

[26] Dr Roberts, par.3.10, CB v2 p.426
[27] Ibid, par.3.12, CB v2 p.426
[28] Ibid, par.3.15, CB v2 p.426
[29] Ibid, par.3.18, CB v2 p.427
[30] Ibid, CB v2, par.4.1, 4.2, p.427
[31] Dr Roberts supplementary statement, CB v2, par.3.2, p.451
[32] Dr Olopade, CB v2, par. 6, p.461
[33] Dr Roberts, par.5.6, CB v2 p.428

90. On behalf of Correct Care Australasia, an overarching statement was provided by Dr Francis Olopade, Chief Medical Officer.[34]

91. The P3 and S4 ratings resulted in a Mental Health Chronic Health Care Plan (MHCHCP) being initiated by CCA. Collateral was required to complete the plan, and as described earlier, this was requested from LRH. A further appointment was made for Brian to attend on 23 February 2022 to complete the MHCHCP. During this appointment, a further mental state examination would have been performed.[35]

92. At the time of Brian's reception into custody and assessments, there were no CCA policies, procedures, protocols or guidelines related to COVID-19 protective quarantine welfare checks.[36] Improvement opportunities are dealt with later in this summary.

Correct Care Australasia review[37]

93. Correct Care Australasia provides health care to prisoners within nine Victorian prison settings.

94. CCA conducted an initial review of Brian's death and identified two opportunities for improvement:

    a. CCA to reach agreement with Justice Health for face-to-face reception assessments for quarantine patients

    b. CCA, Forensicare and Justice Health develop a policy and processes for requesting and tracking collateral information

95. The court has acknowledged that these identified areas for improvement are appropriate. Given that CCA no longer operate the MRC, I shall recommend that the implementation of these identified opportunities is pursued by the secretary, in collaboration with the new provider, Forensicare and Justice Health.

[34] Dr Olopade, CB v2, p.459
[35] Ibid, par.7
[36] Ibid, par.8
[37] CCA Initial Review, CB v2 p.458

Forensicare review[38]

96. Forensicare provides mental health services at prisons within Victoria including at MRC.

97. Forensicare's subsequent internal review identified that better collateral information collection may have offered more information to enhance the clinical risk assessment and psychiatric follow-up whilst in custody. The review identified that there was no procedure for Forensicare staff to chase collateral information when they were conducting secondary assessments, rather than initial reception assessments.

98. Two recommendations were made to address this issue, and both have now been completed. These recommendations will:

    a. Reduce the likelihood of future delays in obtaining collateral information, and

    b. Ensure prisoners in contact with external Area Mental Health services within the three months prior to their custodial reception receive additional follow-ups whilst in prison.

99. The implementation of these recommendations is appropriate, and I commend Forensicare for the expeditious conduct of their internal review and their acquittal of those recommendations.

Justice Assurance and Review Office (JARO) review[39]

100. JARO also noted the disadvantage to clinicians, and therefore Brian, resulting from the lack of collateral to inform assessments.

101. In its review the following recommendations were made:

    1. That Health Service Providers develop a detailed procedure for the collection and storage of collateral information during reception health assessments. The procedure must:

        a. set out staff roles and responsibilities;

[38] Forensicare Serious Incident Review dated 28 March 2022, CB v2 p.413
[39] Justice Assurance and Review Office (JARO) review into the death of Mr Brian Pope at the Metropolitan Remand Centre on 21 February 2022, 22 March 2023, CB v2 p.301

b. include a requirement to verify substance use (type and quantity) in a consistent manner (e.g, standard measure of alcohol units) with prisoners at the time of assessment;

c. require staff to make appropriate efforts to collect information from family members to inform mental health assessments, recognising that this requires consent and acknowledging that this can be challenging where a family member is an alleged victim;

d. set out an approach for gathering and using information about prisoners' offences and the impact on their relationships and future planning to inform assessments and decisions made;

e. provide guidance on the actions that must be taken following the review of collateral information, including a review of the prisoner's risk rating and mental health care plan; and

f. ensure that any actions taken following a review of collateral information are recorded in JCare.

2. That compliance and effectiveness of the procedure for the collection and storage of collateral information must be audited by Health Service Providers within six months of endorsement by Justice Health and must be included in the Health Service Providers ongoing audit schedule.

3. That Health Service Providers develop a procedure to support staff to escalate concerns about assessments being conducted via the cell trap to ensure that face-to-face assessments occur wherever possible.

4. That Health Service Providers develop and provide Justice Health with an action plan outlining strategies to implement the recommendations to improve the quality of information collected and documented regarding substance use history.

5. That the Department of Justice and Community Safety (DJCS), in consultation with Health Service Providers, undertake a review of the current mental health assessment tool to ensure it meets contemporary practice.

CONCLUSION

102. Brian's diagnosis of dyslexia at an early age, and the problems associated with this condition including low self-esteem, possibly contributed to early undiagnosed mental health problems.

103. Brian had a long history of substance abuse beginning when he was in his early teens with chroming, alcohol and marijuana use, graduating to methylamphetamine and heroin abuse in his adult life. Alcohol use remained a constant in Brian's life up until the time he was admitted to the Flynn Unit.

104. Whilst in LRH prior to Brian's prison reception, there are well documented indicators that he was suffering from a psychiatric condition that was being treated by medication and required close monitoring.

105. Whilst Brian was a person who had at times suffered limited periods of involuntary mental health detention in which he did not have the capacity to safely make decisions about his own wellbeing, in the circumstances leading up to his death, he made a conscious choice to not make custodial and medical staff within the prison system aware of his mental health challenges.

106. If further or better collateral material had been obtained about Brian in a timely manner, there is a possibility (that does not rise as high as a probability) that his P and S ratings would have been escalated. In turn, whilst this may have led to an increased possibility of the prevention of his suicide arising from consequential changes to his observation regime or treatment programme, this does not rise as high as to be a probability, [40] and accordingly I make no adverse comment about the health or custodial decisions made in connection with Brian's time in custody.

107. I wish to express my condolences to his family at this difficult time, and thank them for nonetheless assisting with my investigation.

COMMENT

[40] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

108. I make the following comment connected with the death under section 67(3) of the Act:

A. I commend Forensicare for the expeditious conduct of their internal review and their acquittal of those recommendations.

RECOMMENDATIONS

109. I make the following recommendations connected with the death, under section 72(2) of the Act:

A. The DJCS Secretary, in conjunction with Justice Health, Corrections Victoria and any new Health Service Provider at the MRC:

i. Arrange for face-to-face reception assessments for quarantine patients; and

ii. Develop a policy and processes for the timely acquisition of collateral information to assist in the risk assessment and formulation of care plans for patients.

B. That Justice Health oversee Health Service Providers in Victorian prisons developing a detailed procedure for the collection and storage of collateral information during reception health assessments. The procedure must:

i. set out staff roles and responsibilities;

ii. include a requirement to verify substance use (type and quantity) in a consistent manner (e.g, standard measure of alcohol units) with prisoners at the time of assessment;

iii. require staff to make appropriate efforts to collect information from family members to inform mental health assessments, recognising that this requires consent and acknowledging that this can be challenging where a family member is an alleged victim;

iv. set out an approach for gathering and using information about prisoners' offences and the impact on their relationships and future planning to inform assessments and decisions made;

v. provide guidance on the actions that must be taken following the review of collateral information, including a review of the prisoner's risk rating and mental health care plan; and

vi. ensure that any actions taken following a review of collateral information are recorded in JCare.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Debra Hansen, Senior Next of Kin

Justice Assurance and Review Office

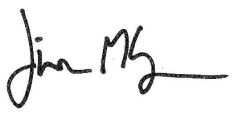
Department of Justice and Community Safety

Correct Care Australasia

Forensicare

Sergeant Jacinta Elliott, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date: 15 May 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.