IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004536

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

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

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

INQUEST INTO THE PASSING OF JOSHUA STEVEN KERR

Findings of:	Coroner David Ryan
Delivered on:	1 July 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	5-9, 12-16 & 22 February 2024
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Keywords:	Death in custody – medical treatment – drug toxicity – observation – communication between correctional and medical staff

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INTRODUCTION

1. On 10 August 2022, Joshua Steven Kerr **(Josh)** was 32 years old when he passed away at Port Phillip Prison (**PPP**). He had received treatment earlier in the day at St Vincent's Hospital in Melbourne (**SVHM**). PPP is operated by staff from G4S Custodial Services Pty Ltd (**G4S**) and medical services to prisoners at PPP are provided by St Vincent's Custodial Health Service (**SVCHS**).

BACKGROUND

2. Josh was born on 30 August 1989. He was a proud Yorta Yorta, Gunnai Kurnai man. He is deeply mourned by his loving family which includes his mother, Aunty Donis Kerr, his sisters Patricia and Maggie, his partner Chantell Osman and his five children. Josh is warmly remembered as a kind, charming and charismatic man who was also a talented artist.

3. In moving Coronial Impact Statements delivered to the Court, Josh's family conveyed with warmth and affection their experience and memory of Josh, and their grief, devastation and loss at his passing.

4. Josh's childhood was complicated. His mother's own difficult history as a survivor of the Stolen Generation affected her ability to care for Josh, and he was placed in foster care and then moved to live with family in Deniliquin. Josh experienced multiple foster and residential care placements during his childhood and was exposed to alcohol and sexual abuse.

5. Josh had an intellectual disability and had also experienced mental health issues throughout his life. He suffered from anxiety and depression, for which he was prescribed quetiapine, and also reported a history of self-harm.

6. Josh started using drugs at an early age and at the time of his passing was a longtime and regular user of ice.[1] By the age of 15 he was involved in the criminal justice system. He subsequently served multiple periods of imprisonment in New South Wales and Victoria. His offending was strongly linked to his drug habit.

CORONIAL INVESTIGATION

Jurisdiction

7. Josh's passing constitutes a "*reportable death*" under ss 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as it occurred in Victoria and immediately before his passing, he was a person placed in custody or care. Pursuant to s 52(2)(b) of the Act, an inquest was also required to be held which occurred on 5-9, 12-16 and 22 February 2024.

8. The Coroners Court of Victoria (**the Court**) is an inquisitorial court.[2] 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.

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

10. 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.

11. 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.

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[1] Methylamphetamine, also known as crystal meth.
[2] Section 89(4) of the Act.

12. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[3]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[4] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[5]

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

14. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[6] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[7]

15. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[8]

16. A number of factual disputes arose from the evidence given at the inquest. Many of these disputes were exposed by the questioning of counsel for the interested parties in the reasonable pursuit of their clients' interests. However, it has not been necessary to resolve all of those disputes in order to make the findings necessary under section 67 of the Act.

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[3] Section 72(1) of the Act.
[4] Section 67(2) of the Act.
[5] Section 72(2) of the Act.
[6] Section 69(1) of the Act. 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. See sections 69(2) and 49(1) of the Act.
[7] *Keown v Khan* (1999) 1 VR 69.
[8] (1938) 60 CLR 336.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

17. Josh was on remand at PPP awaiting trial for offences which included aggravated carjacking. He had been in custody since 29 May 2021.

18. The week before his passing, on 4 August 2022, Josh had been on a prison escort to attend Sorry Business for his uncle in Echuca. He interacted with family members at the funeral, including his mother and partner.

19. Covid protocols in place at PPP in August 2022 required that upon his return to PPP, Josh had to undertake a period of quarantine in the Matilda Unit for seven days.

20. On 10 August 2022 at around 9.16am, Josh lit a fire inside his cell. It appears he inserted a metal strip from a face mask into a power socket. Smoke from a burning mattress entered the Matilda Unit and alerted correctional officers to the fire. A Code Red[9] was called and Tactical Operations Group (**TOG**)[10] officers attended Josh's cell and negotiated with him to move the burning mattress so that his cell door could be opened and the fire extinguished. Josh's right hand was burned.

21. Josh was removed from his cell and he received medical treatment from SVCHS staff, initially in the yard at the Matilda Unit and then in an adjoining clinic. His vital signs were taken by Registered Nurse Arrieta Manuel, which were slightly elevated, and his hand was run under cold water. He was also provided some paracetamol. Josh did not appear to be experiencing any pain from his burns and he was observed to pull a significant amount of loose and blistered skin from his hand. His hand was then bandaged.

22. Josh received a psychiatric assessment from Registered Psychiatric Nurse Gordon Frost, and disclosed to him that he was paranoid from using ice. He told Mr Frost that he had not intended to take his life by lighting the fire but also said he wished he had died. Mr Frost decided to raise Josh's suicide and self-harm rating to S2 which identified that he was assessed as a significant risk of self-harm and that he was required to be observed by

[9] A Code Red is an alarm activated in the event of a fire.
[10] Specialist correctional officers with responsibilities for responding to prison incidents and escorting prisoners within and outside the prison.

correctional staff every 30 minutes.[11] He completed a referral form and an Interim Risk Management Plan which was also signed by the Supervisor of the Matilda Unit, Karen Gibson. She subsequently delivered the forms to the St John's Unit (**St John's**)[12] where Josh was admitted later in the day.

23. While he was receiving treatment at the medical clinic at the Matilda Unit, Josh also disclosed having taken ice to TOG Supervisor Darren Beckett, Registered Nurse Rhiannon Velden and Senior First Nations Cultural Advisor Roy McPherson. He stated that he had obtained the drugs from within the prison.

24. Mr Arrieta spoke with a SVCHS medical officer about the most appropriate place for Josh to be treated and it was decided that he required further medical assessment and treatment in hospital. An ambulance was called at 9.52am.

25. Ambulance Victoria arrived at PPP at 10.29am and paramedics were advised by SVCHS staff that Josh had disclosed taking ice. The paramedics recorded that Josh had ingested the ice intranasally. He was transported to SVHM in the ambulance and was escorted by TOG officers Robert McPherson and Zachary Miller-Crimmins. He was not strip-searched before leaving PPP.[13] Josh refused pain relief from paramedics as he stated that he *"didn't want to ruin the buzz"* from the ice.[14] He was observed to become paranoid in the ambulance and believed they were being followed by police vehicles but he was able to be settled by the paramedics.

26. Josh arrived at triage at SVHM at 12.20pm and Mr McPherson overheard Josh tell the triage nurse that he had been on ice for three days and had *"the last of the bag"* that day.[15] It is recorded in the triage notes that he had *"smoked and snorted"* ice that morning prior to setting fire to his cell.[16]

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[11] The "S" Risk Rating is the allocation of a rating that identifies the level of risk of suicide or self-harm of a prisoner used by Corrections Victoria for all Victorian prisons; CB1129; CB1142.
[12] An inpatient medical unit at PPP.
[13] CB782.
[14] CB383.
[15] CB383.
[16] CB830.

27. Josh was taken to a resuscitation bay in the Emergency Department (**ED**) and he was restrained and secured to the bed. Josh was initially assessed by Registered Nurse Emma Colvin and Emergency Physician, Dr Michael Khoury at around 12.24pm. They thought that Josh was clearly drug affected but he refused to take diazepam[17] which was offered by Dr Khoury. Dr Khoury decided to focus on the treatment of Josh's burned hand as, although he was agitated, Dr Khoury considered that he was capable of engagement and Dr Khoury was able to negotiate with him to generally accept treatment.

28. A blood sample was collected at 1.10pm.

29. Josh was reviewed by a plastics registrar at around 1.20pm. It was decided that he was not required to be admitted to hospital for the treatment of his burns but his hand would be bandaged in a special dressing and he required outpatient review the following week.

30. Josh became frustrated while waiting in the ED for his hand to be dressed and refused further treatment and stated that he wished to return to PPP. He pulled out a cannula which had been inserted in his arm, refused a Covid test and he became aggressive and abusive to Ms Colvin. Dr Khoury spoke with Josh again at around 2.00pm and was able to de-escalate Josh and convince him to remain in hospital and receive further treatment. However, it was decided that further nursing treatment should be provided by Registered Nurse Jack Daley given Josh's behaviour towards female staff.

31. At around 2.49pm, Josh stood up from the bed and again stated that he wanted to return to PPP. At that point, Mr McPherson and Mr Miller-Crimmins decided to cancel the escort as they were concerned about Josh's escalating behaviour and the risk he posed to medical staff. Josh left the ED without being formally discharged and without Dr Khoury's knowledge. He was placed in a holding cell in the basement of SVHM for about 17 minutes while transport was arranged.[18] He then spent about 25 minutes in the back of a

[17] A sedative used to treat anxiety, insomnia, seizures and spasms.
[18] The first eight minutes of this period were not recorded on CCTV; CB784.

transportation truck before departing SVHM at around 3.40pm. Mr McPherson drove the truck accompanied by Mr Miller-Crimmins and TOG Supervisor Steven Massa.[19]

32. At 4.43pm, after returning to PPP, Josh was escorted by TOG officers to an observation cell (920) in St John's. Medical staff had not been notified of the cancellation of the escort and that Josh was returning to St John's. Further, a discharge summary from SVHM was not available to them. He was strip searched and provided with clothing that did not contain cords or other features that might be used to self-harm. In addition to a bed, toilet, sink and intercom, Josh's cell contained a CCTV camera.

33. Shortly after entering the observation cell, Registered Nurse Franklin Walde attempted to assess Josh's hand, obtain vital sign observations and perform a Covid test. Josh refused to allow his hand to be assessed or to take a Covid test. At this point, Mr Massa decided not to proceed with the medical assessment and it was agreed that the TOG would return to St John's later to assist medical staff to complete their assessment.

34. Josh's cell door was closed at around 5.00pm and correctional staff at St John's, including Paul Grimison and Alice Dowling, were of the understanding that Josh's cell could not be opened without the presence and assistance of the TOG (**the TOG direction**). This direction was in turn communicated to SVCHS staff.

35. Josh was observed by correctional staff at least every 30 minutes. He was also observed at least every 30 minutes by medical staff. The observations occurred either through the window or trap in his cell door or via CCTV from the monitor at the Officers' Station.

36. Soon after the cell door was closed, Josh's behaviour became increasingly bizarre and included pacing the cell, removing the bandage from his hand and taking off his clothes.

37. At around 5.20pm, medical officer Dr Jai Li attended Josh's cell with an intention to assess him. She was told by correctional staff that she was unable to enter the cell without TOG being present. She then returned to her desk and reviewed Josh's medical records (**J-Care**) with Registered Psychiatric Nurse Reynald Montalbo. She noted that he had disclosed

[19] Josh's period in the transportation truck was not recorded on CCTV but he was subject to intermittent observation by the TOG officers on the trip back to PPP; CB1260-CB1261.

taking ice earlier in the day and had been treated for burns at SVHM. Dr Li then contacted the ED at SVHM and she was told that Josh had been treated for burns but was not for admission and that he had been aggressive while in the ED. She was advised that the discharge summary would be sent to St John's by facsimile.

38. Dr Li consulted with Mr Montalbo and decided to prescribe an extra dose of quetiapine and to administer it together with his usual dose, in an attempt to reduce his agitation. Mr Montalbo attended Josh's cell at around 6.15pm but was told by correctional staff that he could not enter the cell or open the trap without TOG being present. He observed Josh's bizarre behaviour on CCTV and considered that he may be experiencing some form of psychosis. He then commenced the process of increasing Josh's psychiatric rating from P3 to P1 which involved a referral to Forensicare[20] and a potential transfer to Ravenhall Correctional Centre.[21]

39. At around 6.40pm, Mr Massa returned to Josh's cell with other TOG officers (including Luke Clark, Lawrence Bandera and Andrew Thomas) to discuss with medical staff how best to manage Josh's care. Dr Li and Mr Montalbo also attended together with G4S Duty Manager Dawn Gilbert. Dr Li stated that she wished to administer medication to Josh and TOG Officers attempted to engage with him through the trap. It was decided that it would not be possible to administer mediation to Josh through the trap and the medical plan was to wait for him to settle before administering the medication and dressing his burns. Dr Li left PPP at around 7.16pm and she advised Associate Nurse Unit Manger Brooke Metcalfe to arrange for Josh to be transported to hospital if his condition deteriorated.[22]

40. After the gathering outside Josh's cell, as a result for her concern for staff safety, Ms Gilbert made a *"directive that TOG staff needed to be present for any entry to the cell"*.[23] Ms Gilbert subsequently communicated to Accommodation Supervisor Samantha Colligan[24]

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[20] Forensicare, also known as the Victorian Institute of Forensic Mental Health, is the leading provider of forensic mental health services in Victoria.
[21] A P1 rating is allocated to prisoners who are assessed to have a significant ongoing psychiatric condition requiring intensive an/or psychiatric treatment. A P3 rating is allocated to prisoners who are assessed to have a stable psychiatric condition requiring continuing treatment or monitoring.
[22] T687.
[23] CB550.
[24] She was the supervisor in charge of a number of accommodation units which included the St John's Unit.

that staff *"should not enter the cell whilst [Josh] was behaving in this erratic manner without TOG presence"*.[25] Ms Colligan then passed the direction on to correctional officers David Goldsmith and Danielle Reid who were commencing the night shift at St John's at 7.45pm.

41. From around 7.40pm, Josh's movements became slower and he struggled to stand. He was recorded by correctional staff in the Observations Register as *"screaming, yelling, behaving strangely"*.[26]

42. A review of the CCTV of Josh's cell depicts that he fell to the floor at 7.43pm and his body movements started to slow down after 7.50pm. He was lying on his stomach next to the toilet with his left arm over the toilet seat. At around 7.55pm, Josh's movements became less pronounced and his right arm, head and legs appeared to wriggle slightly. The last movement seen on CCTV was at 8.01pm.

43. A couple of minutes later, Mr Goldsmith was concerned that Josh's movements had significantly decreased. He went to the door of Josh's cell and looked through the Perspex window. He thought that he could still see the rise and fall of Josh's chest as he breathed. From 8.04pm and for the following five minutes, Mr Goldsmith made several observations of Josh from outside the cell door and via the CCTV footage. The intercom was also used to rouse Josh but he remained unresponsive.

44. At about 8.09pm, Mr Goldsmith sought the assistance of Enrolled Nurse Zach Sanders and they both went to the cell door to observe Josh. Mr Walde and Ms Metcalfe also attended and tried unsuccessfully to rouse Josh through the trap. At around 8.10pm, a Code Black[27] was called by Mr Goldsmith, specifically requesting the attendance of the *"TOG and Management only"*.[28]

45. Ms Metcalfe requested that Josh's cell door be opened so that she and other medical staff could provide emergency treatment. Mr Goldsmith did not open the door as he considered

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[25] CB551.
[26] CB (Exhibit 15).
[27] A Code Black is a medical alarm which signifies a serious medical incident requiring urgent assistance.
[28] CB (Exhibit 19).

that he was required to await the arrival of TOG as a result of the TOG direction. Duty Supervisor Matthew Weate arrived a few minutes later but he also considered that it was appropriate to await the arrival of the TOG.

46. When the Code Black was called, TOG members Samuel Harawene and Paul Tomkinson had been stationed in the control room at the front of PPP. Their arrival at St John's was delayed as they were required to collect some items of equipment along the way. They arrived at Josh's cell at 8.18pm and Mr Weate then opened the cell door. Josh was removed from the cell and medical staff commenced their emergency response which included cardiopulmonary resuscitation (**CPR**) and calling an ambulance. Ambulance Victoria paramedics arrived at PPP at 8.27pm but Josh was unable to be revived and he was pronounced deceased at 8.41pm.

47. From CCTV footage it appears that Josh became unresponsive at approximately 8:02pm and the Code Black was called about 8 minutes later. A further 8 minutes elapsed before TOG officers opened the cell to allow medical treatment to be provided to Josh. There was a total of 16 minutes delay between Josh becoming unresponsive and being provided access to medical treatment.

OTHER INVESTIGATIONS

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

49. SVHM conducted an In Depth Case Review (**ICDR**)[29] in relation to Josh's passing which resulted in the following relevant findings:

    (a) Emergency staff were unclear what the process is, in circumstances where G4S officers decide to remove a patient, and whether this requires medical authorisation;

    (b) Due to the haste of Josh's discharge from the ED, the medical notes (including the discharge summary) were not immediately provided to PPP;

[29] See statement of Jonathan Prescott dated 30 January 2024.

(c) The visual observations performed by staff at St John's were not recorded on an observation chart or on the Sedation Assessment Tool;[30]

(d) Safety and security, in the context of the TOG only direction, was weighted more heavily than the provision of clinical care; and

(e) There were missed opportunities for communication of shared care between SVCHS, the ED at SVHM and G4S.

50. The ICDR made the following relevant recommendations:

(a) Staff understand the escalation process to advocate for access to patients whose health may be deteriorating;

(b) Improve the communication of shared care between SVCHS, the ED at SVHM and G4S;

(c) Emergency staff are aware of the process for escalating medical concerns, when G4S officers decide to terminate an emergency visit;

(d) Medical notes (such as a discharge summary) are provided to PPP on discharge or in a timely manner to facilitate ongoing care and management;

(e) Emergency staff are familiar with the process for referring Aboriginal prisoners to the Aboriginal Health Unit to support provision of care; and

(f) St John's nursing staff record all visual and physical observations in the appropriate charts, including the Sedation Assessment Tool.

51. Josh's passing was reviewed by the Justice Assurance and Review Office (**JARO**) which is part of the Department of Justice & Community Safety and reported to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[31]

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[30] A tool utilised in the *Acute Poisoning Management Guideline*.
[31] Section 7 of the *Corrections Act 1986*.

52. JARO took an intersectional approach when conducting its review which accounted for Josh's identity as a young Aboriginal man with an intellectual disability and substance use disorder. Further, it noted that systemic, structural, racial, and discriminatory barriers within the criminal justice systems, particularly the disproportionate impacts on Aboriginal people, are well documented, and the review into Josh's passing cannot be understood without recognition of these barriers.[32]

53. As part of its review, JARO engaged Safer Care Victoria and the Chief Paramedic Officer to review Josh's medical management by SVCHS and G4S staff. Further, advice was provided to JARO by an Aboriginal Expert Panel to promote the review's cultural safety and to ensure it was conducted appropriately through a cultural lens.

54. JARO prepared a report containing its findings and recommendations dated 1 December 2023. The review was conducted in collaboration with Justice Health.[33]

55. In summary, JARO made the following relevant findings:

    (a) Josh's perceived security risk was prioritised above his safety and wellbeing;

        (i) The cancellation of Josh's hospital escort had a significant flow on effect on his treatment;

        (ii) The TOG directive was based on inaccurate assumptions and had a negative impact on Josh's care; and

        (iii) Health and custodial staff failed to use effective professional judgment when observing Josh;

    (b) The incident response was delayed and ineffective;

[32] These issues have been thoroughly explored by the Yoorrook Commission and have been set out in its *Report into Victoria's Child Protection and Criminal Justice Systems* dated August 2023; See also *Safer Prisons, Safer People Safer Communities*, Final report of the Cultural Review of the Adult Custodial Corrections System dated December 2022.
[33] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

(c) Lack of observations in the SVHM holding cells and during return to PPP created opportunities for Josh to consume methylamphetamine undetected;

(d) Josh's arrival at St John's was unexpected and lacked hospital discharge paperwork;

(e) The health assessment at St John's was terminated prematurely;

(f) Health assessments were inadequate and lacked follow through;

(g) Josh's treatment in the observation cell was hindered due to a direction from TOG officers;

(h) Limited information was provided at shift handover;

(i) Observations conducted by health and custodial staff were inconsistent and not effectively documented or escalated, and failed to adequately monitor and escalate Josh's deterioration;

(j) Health staff failed to recognise and respond appropriately to Josh's Acute Behavioural Disturbance (**ABD**); and

(k) Initial response to the incident by custodial staff was delayed and ineffective;

  (i) The Code Black was not communicated with sufficient detail;

  (ii) Perception of staff safety overrode the decision to enter Josh's cell;

  (iii) Hierarchical culture inhibited staff ability to exercise professional judgment;

  (iv) TOG officers were delayed by over seven minutes;

  (v) The health response to the Code Black was significantly delayed due to the TOG directive;

  (vi) The TOG directive was based on inaccurate assumptions and had a negative impact on Josh's care; and

(vii) Health and custodial staff failed to use effective professional judgment when observing Josh.

56. JARO made the following relevant recommendations:

(a) That Corrections Victoria (**CV**) amend relevant escort policies to provide clear guidance to custodial staff on:

(i) Their roles and responsibilities for the provision, management and documentation of transfer and discharge information when a prisoner is transferred to and from hospital; and

(ii) The requirement for escort staff to seek health staff input prior to terminating an escort, wherever possible, to determine the health implications for consideration that may inform the decision and influence outcome;

(b) That the Health Service Provider:

(i) Undertake interviews with health staff at PPP to ascertain if there are any thematic or cultural issues surrounding escalation of clinical deterioration and awareness of Alcohol and other Drug services at the location and provide a report and subsequent action plan to address if required; and

(ii) Review policy related to the management of deterioration in a prisoner to ensure adequate direction in response to a prisoner that is under the influence or suspected of being under the influence of a substance;

(c) That PPP:

(i) Update its ABD training package to include reference to Operational Instruction 45 *Known or Suspected Drug Ingestion* and SVCHS *Acute Poisoning Management Guideline*, specifically that 000 should be called for prisoners presenting with an ABD; and

(ii) Require ABD training be undertaken by all PPP custodial staff on an annual basis;

(d) That PPP amend its "Management of refractory/disruptive/non-compliance" template to extend across the prison to record all prisoners on modified instructions;

(e) That PPP amend its "Management of refractory/disruptive/non-compliance" template to:

(i) Include the time and date the direction was issued, the name of who authorised the direction, a review timeframe and the time and date the direction ceases to be in force;

(ii) Require the completion of the template is to be conducted in collaboration between the Health Service provider and TOG to ensure health considerations and directives are adequately reflected alongside operational considerations;

(iii) Require that the template be incorporated into shift handover processes for custodial and health staff and communicate agreed actions from the template to relevant staff; and

(iv) Note that a copy of the template must be saved onto the prisoner's Individual Management File and J-Care;

(f) That the Health Service provider update policy and processes to include the escalation of concerns where any modified instruction (such as a TOG directive) is in place that limits comprehensive assessments;

(g) That CV update Deputy Commissioner's Instruction 1.02 – *At Risk Procedures* to require that staff commencing their shift where there are prisoners At Risk observations in their unit:

(i) Populate a new Observation Register entry at the start of their shift or as soon as practicable for each prisoner on At Risk observations in the unit.

A new entry must be recorded irrespective of the time of the last observation was completed by the outgoing staff member responsible for the At Risk observations; and

(ii) Conduct the observation in consultation with health staff wherever possible and in line with policy (direct observation at the cell door confirming the prisoner is unharmed);

(h) That CV require prisons to update local Operating Procedures to align with the changes to Deputy Commissioner's Instruction 1.01 – Safety and Security outlining guidance around opening cell doors after hours, including (but not limited to) that "preserving life should be your first priority, which includes the safety of staff" and require private prisons to update their Operational Instructions in accordance with this recommendation;

(i) That Health Service Providers in consultation with Justice Health update relevant mental health policies and procedures to ensure there is clear guidance of primary and mental health staff regarding:

(i) Adequate and accurate documentation of clinical observations regimes; and

(ii) Complete and holistic documentation of clinical management plans; and escalation of health concerns; and

(j) That Justice Health review existing acute overdose assessment tools to determine suitability for use by prison Health Service providers and implement as required.

57. G4S made the following relevant concessions in relation to the findings in the JARO report prior to the inquest:

(a) There is a need for a formal process for communication between G4S and SVHM for the management of prisoners who display escalating behaviour of concerns in the ED;

(b) Formal SASH[34] observations were not documented while Josh was in the holding cells at SVHM or awaiting departure in the transport vehicle;

(c) With the benefit of hindsight, it is open to conclude that at-risk observations by custodial staff, and clinical observations by health staff failed to adequately monitor and escalate Josh's deterioration;

(d) The Code Black should have been called earlier in St John's at around 8.02pm;

(e) G4S is aware that a practice has developed where a Code Black may be called for cases involving a medical matter that may not in fact have a high level of urgency. A policy is being developed which deals with the key information which must be conveyed when a Code Black is called;

(f) The Duty Supervisor should have performed a risk assessment when he arrived at Josh's observation cell at around 8.15pm which resulted in medical staff being given access to the cell. Further, the other correctional staff already present outside the cell had the capacity to conduct their own risk assessment. G4S has recently communicated to staff that where there is a clear threat to life, the cell door is to be opened immediately by a sufficient number of staff members based on the dynamic risk assessment performed. Staff have been reminded that preservation of life is the first priority;

(g) An adequately performed risk assessment at around 8.11pm would have warranted correctional staff giving medical staff access to Josh's cell without awaiting the arrival of TOG; and

(h) G4S accepts that Josh's apparent reference to *"half a ball"* ought to have been communicated directly to medical staff. [35]

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[34] Suicide and self-harm.
[35] CB1352-CB1358.

58. In response to the JARO report G4S have implemented a number of changes including the following:

   (a) Approval must be sought from the G4S Duty Manager or Duty Supervisor before a TOG direction is made and arrangements will then be made for a TOG Officer to be stationed within the relevant unit;

   (b) G4S has updated *OI45 – Known or Suspected Drug Ingestion* to provide a non-exhaustive list of the signs and symptoms of drug overdose and the procedure which ought to be followed in circumstances where ingestion or secretion of an illicit substance is suspected; and

   (c) G4S has updated *OI11 – Chain of Command in Medical Incidents* to provide that detailed instructions are to be provided to G4S and SVCHS staff by the Duty Manager which confirms the expectations regarding management of medical observations and intervention in the event of a medical emergency. Further, in a life-threatening situation for a prisoner, until the arrival of medical staff, the G4S Supervisor and responding correctional officers at the scene must ensure first aid and resuscitation (including CPR) are provided, and an ambulance is called.[36]

59. SVHM made the following relevant concessions in relation to the findings in the JARO report prior to the inquest:

   (a) Health staff did not recognise the emergent nature of Josh's ABD and did not intervene effectively to manage his clinical risk;

   (b) In assuming that Josh's condition would settle, SVCHS staff did not recognise the need to apply the *Acute Poisoning Management Guideline* and, therefore, there was a lack of intervention in relation to possible drug toxicity;

   (c) It would have been appropriate for staff to use the Sedation Assessment Tool set out in the *Acute Poisoning Management Guideline*;

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[36] CB1359-CB1360.

(d) There should have been active consideration by SVCHS staff to transfer Josh back to the ED at SVHM;

(e) Josh's behaviour was not identified as ABD in the context of the *Acute Poisoning Management Guideline*;

(f) Josh's treatment plan did not include a management plan for drug ingestion, as further drug ingestion (since the morning) was not known or expected by SVCHS staff; and

(g) Clinical decision making was influenced by Josh's discharge from SVHM.[37]

60. In response to the JARO report and the submissions made at the inquest, SVHM have agreed to implement a number of relevant changes including the following:

(a) They are supportive of the recommendation suggested by Josh's family that all prison staff (medical and correctional) receive regular training recognising and managing drug affected prisoners, including those who may be experiencing ABD and drug toxicity, and intend to develop a package for SVCHS staff at PPP;

(b) SVHM has developed a flowchart to guide medical staff in the ED in dealing with decisions to terminate hospital escorts to ensure that there is clear communication with the treating medical officer and escalation processes are in place;

(c) A review of the escalation of care process for SVCHS was conducted to enhance staff understanding of their role in accessing patients and to set out escalation points for staff if and when access is not provided;

(d) SVCHS has developed the *St John's Observation Cells Clinical Deterioration & Escalation Flowchart* which provides clear guidance for escalation of care and to access a person for assessment;

[37] CB1344-CB1347.

(e) SVHM has implemented a flowchart entitled *Management of custodial patients in the Emergency Department with escalating Behaviours of Concern* which provides a set of decision making pathways for staff in relation to matters which include behaviours of concern, de-escalation strategies, consent and competency assessments of custodial patients and the provision of discharge summaries; and

(f) They are broadly supportive of the findings and recommendations in the JARO report insofar as they apply to them and have developed an Action Plan to chart their response to the recommendations.[38]

SOURCES OF EVIDENCE

61. Victoria Police assigned Detective Senior Constable Antarpreet Bajwa to be the Coronial Investigator for the investigation into Josh's passing. The Coronial Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from the forensic pathologist, various correctional officers and medical staff who attended to Josh on 10 August 2022, additional statements from the interested parties, CCTV and BWC footage and the JARO report. It also includes reports from a number of independent experts obtained by the Court and the interested parties regarding the cause of Josh's passing and his medical management while at SVHM and PPP.

62. The inquest ran over 11 days and evidence was given by the following witnesses:

(a) Karen Gibson (G4S Correctional Supervisor);

(b) Darren Beckett (G4S TOG Intelligence Supervisor);

(c) Rhiannon Velden (SVCHS Registered Nurse);

(d) Manuel Paulo Arrieta (SVCHS Registered Nurse);

(e) Gordon Frost (SVCHS Registered Psychiatric Nurse);

[38] Reply Submissions on behalf of SVHM dated 19 June 2024.

(f) Roy McPherson (Senior First Nations Cultural Advisor);

(g) Emma Colvin (SVHM Registered Nurse);

(h) Dr Michael Khoury (SVHM Emergency Physician);

(i) Jack Daly (SVHM Registered Nurse);

(j) Robert McPherson (G4S TOG member);

(k) Zachary Miller-Crimmins (G4S TOG member);

(l) Paul Grimison (G4S Correctional Officer);

(m) Alice Dowling (G4S Correctional Officer);

(n) Luke Clark (G4S TOG member);

(o) Lawrence Bandera (G4S TOG member);

(p) Franklin Walde (SVCHS Registered Nurse);

(q) Brooke Metcalfe (SVCHS Registered Nurse);

(r) Dr Jia Li (SVCHS Medical Officer);

(s) Reynald Montalbo (SVCHS Registered Psychiatric Nurse);

(t) Zachary Sanders (SVCHS Enrolled Nurse);

(u) Samantha Colligan (G4S Correctional Supervisor);

(v) Danielle Reid (Correctional Officer);

(w) David Goldsmith (G4S Correctional Officer);

(x) Paul Tomkinson ((G4S TOG member);

(y) Samuel Harawene (G4S TOG member);

(z) Matthew Weate (G4S Correctional Supervisor);

(aa) Steven Massa (G4S TOG supervisor);

(bb) Dawn Gilbert (G4S Duty Manager);

(cc) Dr Jo Glengarry (Forensic Pathologist, Victorian Institute of Forensic Medicine);

(dd) Dr Nicola Reid (Emergency Physician);

(ee) Professor Johan Duflou (Consulting Forensic Pathologist); and

(ff) Associate Professor Nicolas Clark (Addiction Medicine Physician).

63. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief (including material tendered during the inquest) and the submissions made by counsel assisting and the interested parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

SCOPE OF THE INQUEST

64. The following issues[39] were investigated at inquest:

The medical cause of Josh's passing

(a) What was the cause/s of Josh's behaviour at St Vincent's Hospital and the St John's Unit?

(b) What impact did Josh's apparent ice use have on his behaviour on the day of his passing?

(c) What was Josh's medical cause of death?

[39] These issues were drawn from the scope of the inquest which was identified at the directions hearing held on 14 July 2023.

(d) Was Josh's passing preventable?

Josh's treatment at St Vincent's Hospital

(e) What assessment and treatment did Josh receive?

(f) What assessment and treatment did Josh require?

(g) Who was responsible for decision making regarding Josh's assessment and treatment, including as to his capacity to consent to or refuse treatment?

(h) Who in fact made decisions regarding whether Josh would receive or refuse treatment?

(i) What was the reason/s for Josh leaving without being treated?

Josh's treatment in the St John's Unit

(j) What policies and procedures governed Josh's treatment in the St John's Unit, including as to the hierarchy of decision-making regarding access to Josh's cell?

(k) Were those policies and procedures complied with?

(l) How was Josh's treatment at St John's impacted by the circumstances of his departure from St Vincent's Hospital?

(m) What information was available to medical staff at the St John's Unit about Josh's presentation, including any drug use?

(n) Who was responsible for ensuring that Josh was properly assessed, treated and monitored in the St John's Unit?

(o) Was Josh properly and adequately assessed by medical staff? If not, why not?

(p) Was Josh properly and adequately treated by medical staff? If not, why not?

(q) Was Josh properly and adequately monitored by correctional and medical staff? If not, why not?

(r) Was the medical care and monitoring provided to Josh influenced or delayed by security concerns? If so, was that influence or delay preventable?

IDENTITY OF THE DECEASED

65. On 15 August 2022, Josh was visually identified by his mother, Aunty Donis Kerr.

66. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF JOSH'S PASSING

What was the cause/s of Josh's behaviour at St Vincent's Hospital and the St John's Unit

67. I am satisfied that the primary cause for Josh's agitated and escalating behaviour at SVHM and his increasingly bizarre behaviour at St John's was his ingestion of ice on 10 August 2022 and its effect on his system. I also accept that some of his behaviour at SVHM was influenced by frustration at wanting to return to PPP.

What impact did Josh's apparent ice use have on his behaviour on the day of his passing?

68. The impact of Josh's ice use on his behaviour on 10 August 2023 was significant and manifested in an ABD. I am satisfied that it influenced his decision to light the fire in his cell and throughout the day it increasingly compromised his judgment and capacity to act in his own interest. It also increasingly affected his coherence and control over his movements and his ability to effectively engage with staff.

69. When Josh was being treated at the Matilda Unit directly after the fire, he was agitated and restless and did not appear to be experiencing pain from the effects of the burns to his hand.[40] At that stage, although he was heightened and easily distracted, he was generally cooperative, lucid and capable of engagement and redirection.[41]

[40] T33-T35.
[41] T113.

70. At SVHM, Josh's behaviour became more paranoid, frustrated and at times abusive and aggressive.[42] He was still capable of engagement with Dr Khoury who was able to persuade Josh during their discussions to remain in hospital and accept treatment but overall, his pattern of behaviour appeared to be escalating.[43]

71. Soon after his return to PPP at 4.45pm, and his placement in the observation cell at St John's, Josh's behaviour deteriorated rapidly and became increasingly bizarre over the following hours before his movements slowed and he became unresponsive. I am satisfied that he was not consciously deciding to act in this way, rather it was a feature of ABD caused by the ice in his system.[44]

What was Josh's medical cause of death?

72. On 12 August 2022, Dr Joanne Ho, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy. She prepared a report of her findings dated 12 January 2023.

73. Toxicological analysis of ante-mortem and post-mortem samples identified the presence of a number of drugs and substances including methylamphetamine[45], and carboxyhaemoglobin. The ante-mortem sample showed a methylamphetamine level of 0.6mg/L and the post-mortem sample showed a level of 8.1mg/L. Further, methylamphetamine was also detected in the stomach contents (27mg), liver (50mg) and in the hair. Dr Ho stated that the level of methylamphetamine detected in Josh's system suggested that he may have ingested a further amount of the drug between the time when his ante-mortem sample was taken at 1.10pm and his passing.

[42] T362; T369.
[43] CB599; T196; T206; T268
[44] T1550-1551.
[45] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methylamphetamine, is often known as "speed" or "ice". Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.

74. The autopsy also showed multiple bruises and abrasions to Josh's face, elbows, forearms, knees and ankles. Those injuries are consistent with his movements in and on the floor of the observation cell at St John's in the hours prior to the Code Black being called.

75. Dr Ho stated that death from acute use of amphetamines is uncommon, but at high levels cardiac arrhythmias may occur. She also considered that the level of carboxyhemoglobin detected was not significant in relation to his cause of death and was likely secondary to smoke inhalation experienced during the fire in his cell at the Matilda Unit.

76. Dr Ho formulated the cause of death as *"unascertained"*.

77. A medical panel of experts gave evidence concurrently at the inquest in relation to Josh's cause of death. The panel was constituted by Dr Glengarry, Professor Duflou and Dr Reid. Dr Ho was not available to give evidence but she had been able to consult with Dr Glengarry.

78. Dr Glengarry noted that more information had become available since Dr Ho had prepared her autopsy report and it was appropriate for this to be taken into account and the cause of death revised.

79. Dr Glengarry stated that the methylamphetamine detected in Josh's hair was consistent with the use of the drug over a period of time.[46]

80. Professor Duflou stated that the level of methylamphetamine detected in Josh's system post-mortem was *"exceptionally high"* although there is not necessarily a proportionate relationship between the level of the drug in a person's system and their likelihood of dying from toxicity.[47] The panel considered that the unusual and erratic behaviours displayed by Josh on 10 August 2022 were likely caused by the methylamphetamine in his system.[48]

[46] T1452.
[47] CB1303; T1448.
[48] T1446; T1465-T1466.

81. The evidence of the panel by consensus was that the cause of Josh's passing was methylamphetamine toxicity.[49] They considered that the likely mechanism of death was either a cardiac arrhythmia or seizure activity.[50]

82. The panel confirmed that neither Josh's physical injuries nor the level of carboxyhemoglobin in his system contributed to his passing. Further, they agreed that the level of natural disease found at autopsy was not sufficient to be contributory to his passing.

83. The panel considered that it was likely that Josh had orally ingested the ice in his system given the level of methylamphetamine found in his stomach contents. They stated that the significant increase in the level of the drug detected post-mortem may be explained either by the process of absorption of the drug from the stomach to the blood or by a further ingestion after 1.10pm. They stated that the toxicological evidence did not enable them to conclude which of these two possibilities had occurred in Josh's case.[51]

84. It is possible that Josh ingested a further amount of ice after leaving the ED. He was not strip searched before leaving the Matilda Unit and he had the opportunity while in the cell at SVHM and then while in the transportation truck. At around 6.40pm, Josh also appeared to disclose that he had taken *"half a ball"* in response to questioning by Mr Thomas as to whether he had *"taken more drugs"* and *"how much have you had?"*.[52] However, given Josh's behaviour and his level of coherence at this stage, I am not satisfied that it is possible to conclude from this exchange whether Josh may have been referring to the amount of ice that he had taken that morning or whether he was referring to a second ingestion.

85. I accept the opinion of the expert medical panel in relation to the cause of Josh's passing and find that it was due to methylamphetamine toxicity. I am satisfied that it is likely that Josh orally ingested the drug, but in the circumstances it is not possible for me to determine if Josh ingested it in a single dose in the morning, or whether he ingested a further amount

[49] T1470.
[50] T1469-T1471.
[51] T1454-T1459.
[52] CB(Exhibit 12).

after he left the ED at SVHM and before he arrived at St John's. This is consistent with the evidence of Dr Reid, Dr Glengarry and Professor Duflou.[53]

Was Josh's passing preventable?

86. I am satisfied that Josh's passing could have been prevented if his emerging drug-induced ABD had been recognised and appropriately treated. There were a number of opportunities for this treatment to have been provided throughout the day on 10 August 2022.

87. Firstly, Josh should not have been removed from SVHM by TOG staff without properly consulting with medical staff and obtaining a formal discharge with the appropriate paperwork. If the escort had not been cancelled prematurely, Josh would have had an opportunity to receive further assessment and treatment for his emerging ABD. I am satisfied that Josh would have very likely survived had he remained in hospital.[54] However, in circumstances where Josh's behaviour did not become bizarre until after about 5pm, and he may have consumed a further dose of ice after he left the ED that affected the trajectory of his emerging ABD, it is by no means certain that he would have remained in hospital. It is possible that Josh would have been discharged at some point on 10 August 2022 by Dr Khoury (or another doctor) after his hand had been dressed with the specialist bandage and perhaps after a period of further observation.

88. Secondly, once Josh returned to PPP and his behaviour was observed by medical staff to be erratic and bizarre in the context of their awareness of his disclosure of having used ice earlier in the day, an ambulance should have been called to return him to SVHM. The clearest opportunity for this to have occurred was at around 6.40pm when all the relevant staff who were required to make the decision were gathered around Josh's cell.

89. Thirdly, the Code Black should have been called earlier by correctional and medical staff once Josh became unresponsive at around 8.02pm.

90. Fourthly, once the Code Black had been called, medical staff should have been provided access to Josh's cell by correctional staff notwithstanding the TOG direction. However,

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[53] T1456-T1459.

[54] Report of Associate Professor Sally McCarthy dated 6 February 2024, CB1414.

Josh's prospects of survival at this stage were *"dramatically reduced"* given the likely impact of his deterioration on his heart and brain and the limitations of the emergency response outside a hospital environment.[55]

JOSH'S TREATMENT AT ST VINCENT'S HOSPITAL

What assessment and treatment did Josh receive?

91. The focus of Josh's treatment in the ED at SVHM was his burned hand. Staff were aware of his disclosed use of ice that day and noted that he appeared to be drug affected but Dr Khoury was able to effectively engage with Josh and persuade him to accept treatment for his hand. Josh's vital signs were taken by Ms Colvin and noted to be slightly elevated and his Glasgow Coma Scale was 15.[56] The medical staff considered that Josh had decision-making capacity.[57]

92. Dr Khoury first assessed Josh at around 12.24pm. Josh refused Dr Khoury's offer of some oral diazepam to address his elevated and fidgety behaviour. He assessed that Josh was showing signs of a *"mild behavioural disturbance"* and did not consider that he required sedation against his wishes. I am satisfied that this was a reasonable assessment at this stage given that Dr Khoury was able to effectively engage with Josh and negotiate with him to generally cooperate to receive treatment.[58]

93. Dr Khoury did not observe that Josh was in respiratory distress and did not consider that he required treatment for smoke inhalation. The results of the blood test taken at 1.10pm showed mildly elevated carboxyhemoglobin but confirmed Dr Khoury's view that there was no clinical evidence that Josh was suffering from smoke inhalation.

94. Dr Khoury photographed Josh's injured hand and washed it with saline before applying cling film and a crepe bandage. Dr Khoury then referred Josh to the plastics registrar who assessed Josh at around 1.20pm. The plastics team decided that Josh did not require

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[55] T1556.
[56] The Glasgow Coma Scale is used to measure the state of a person's consciousness.
[57] T192; T249
[58] T274.

admission to hospital for treatment of his burns but would be reviewed as an outpatient the following week.

95. A cannula was inserted into Josh's arm for the purpose of administering intravenous fluids and antibiotics. Josh repeatedly stated that he wanted to return to PPP and he refused to receive intravenous fluids and antibiotics and a Covid swab. He became increasingly frustrated and pulled out the cannula from his arm.

96. At around 2.00pm, Dr Khoury returned and was able to negotiate with Josh to take a Covid swab and to stay in hospital for further treatment.

97. At around 2.45pm, Mr Daley took a partial set of vital sign observations from Josh and then made some phone calls to try to source an appropriate dressing for his hand which would be consistent with the plan formulated by the plastics team. Once Josh's hand had been dressed, he had planned to take final observations and arrange for Dr Khoury to review Josh before he was discharged.[59] Josh left the ED with the TOG officers while Mr Daley was on the phone. He stated in evidence that he did not have an opportunity to negotiate with the TOG officers about Josh's departure. He considered that Josh's behaviour could have been effectively managed in the ED.[60]

98. Dr Khoury was not aware that Josh had left the ED and in fact thought that he was likely to be admitted by the plastics team for treatment in relation to his burns.[61]

What assessment and treatment did Josh require?

99. Josh required further assessment and treatment in the ED at SVHM for his ABD in the context of his disclosure of having used ice earlier in the day.[62] The medical staff in the ED lost the opportunity to provide this further assessment and treatment as a result of the escort being cancelled by the TOG officers without meaningful consultation.

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[59] T317-T318; T333
[60] T327; T329; T335.
[61] T265.
[62] The median length of stay in an Emergency Department of patients with methylamphetamine toxicity is 14 hours; see report of Associate Professor Sally McCarthy, p 8; T1535.

100. Dr Reid considered that once Josh's burns had been treated, the priority of his ongoing management shifted to observation in the context of his ABD. She noted that Josh's escort was terminated before the ED staff had a chance to observe the *"trajectory"* of his ABD and to *"determine that he was safe"*.[63]

101. If Josh's escort had not been cancelled, Dr Khoury or another emergency physician would have had an opportunity to attempt to convince Josh to stay in the ED through verbal de-escalation and further assess him and observe the trajectory of his ABD. This may have led to him remaining in the ED for further observation with involuntary sedation if necessary. Further, a discharge plan could have been completed contemporaneously with his discharge.[64]

102. However, as previously stated, I consider that it is possible that Josh may have been reasonably discharged by Dr Khoury (or another doctor) once his hand had been dressed with the specialist bandage and after a further period of observation.[65] Particularly in circumstances where Josh may have consumed a further dose of ice after he left the ED which may have affected the trajectory of his emerging ABD. The CCTV evidence discloses that Josh's behaviour only became bizarre once he had been placed in the observation cell at St John's after his return to PPP.

103. Josh left the ED without a discharge summary which would have communicated to the receiving medical staff at St John's the assessment and treatment he had received while at SVHM as well as his management plan. The discharge summary was completed by Dr Jack Bergman to whom Dr Khoury had likely verbally handed over before he completed his shift.[66] It was not sent to St John's until after Dr Li had left for the day.

104. I consider that Josh's discharge summary should have been completed by medical staff and sent to PPP as soon as possible after he had left the ED. Ideally, this would have alerted

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[63] T1535-6.
[64] T267-268.
[65] T270; T274.
[66] T310; T330.

medical staff at St John's to Josh's disclosed ice use and his ABD and a plan for close monitoring with a return to the ED in the event of any deterioration.

105. The discharge summary completed for Josh was incomplete and its delivery to St John's was delayed. Dr Reid stated in evidence that the discharge summary failed to identify a plan to manage Josh's ABD and that it should have encouraged a return to the ED given that he had left prior to discharge. Further, Dr Khoury stated in evidence that the discharge summary ought to have included a plan for the management of Josh's ABD, including that he would need to be closely monitored and returned to hospital if his condition deteriorated.[67]

Who was responsible for decision making regarding Josh's assessment and treatment, including as to his capacity to consent to or refuse treatment?

106. Dr Khoury was primarily responsible for Josh's assessment and treatment while in the ED. However, the ongoing medical management of his burn was supervised by the plastics team.[68]

107. Dr Khoury was also primarily responsible for decision making as to Josh's capacity to consent to or refuse treatment until he handed over to another Emergency Physician at the end of his shift. Josh was also responsible for decisions regarding his treatment while he had that capacity.

108. The escorting TOG officers also had the authority to cancel Josh's escort and remove him from SVHM in the event that they considered that his behaviour represented a threat to himself or staff that could not be safely managed in the ED.[69] This authority gave the TOG officers the power to decide whether Josh continued to receive medical treatment at SVHM.

[67] T298-T296; T309.
[68] T242-T243.
[69] T367; T381. Josh was issued with a permit under the *Corrections Act 1986* which authorised Josh's transport to SVHM to receive treatment. It was subject to conditions, including the requirement of good behaviour, and could be cancelled or revoked by the escorting TOG members; CB1418.

Who in fact made decisions regarding whether Josh would receive or refuse treatment?

109. The medical staff at SVHM made the majority of the decisions as to whether Josh would receive or refuse treatment up until the point at which the escort was cancelled. These decisions were made in consultation with Josh who refused to receive some of the treatment that was offered to him. The medical staff at SVHM were not consulted in relation to the decision to remove Josh from the ED.

110. Ultimately, the TOG officers made the decision which prevented Josh from receiving any further treatment at SVHM when they cancelled his escort and removed him from the ED at around 2.49pm. They made this decision after having earlier consulted with Mr Massa about Josh's refusal of treatment and their concerns about his escalating behaviour.

111. After leaving the ED, Josh was placed in a holding cell at SVHM for about 17 minutes before being moved to the rear of a transportation truck. The truck then left SVHM about 25 minutes later.[70] In this period, there was a missed opportunity for TOG officers to consult with the medical staff in ED about their cancellation of the escort and obtain a copy of the discharge summary before they departed for PPP.

What was the reason/s for Josh leaving without being treated?

112. Josh left the ED because his escort was cancelled by the TOG officers. The TOG officers cancelled the escort because of their concern about Josh's abusive behaviour and escalating aggression. They were also aware that Josh had refused some treatment and was consistently asking to be returned to PPP. They thought that he only required treatment for the burns to his hand and were not aware that he may have required further assessment in relation to his ABD and ice use.[71] Mr McPherson and Mr Miller-Crimmins stated in evidence that had they been aware that Josh required further assessment for his drug ingestion, then they may not have cancelled the escort and rather encouraged Josh to receive further treatment.[72]

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[70] T784.
[71] T369.
[72] T409; T449.

113. Throughout his time in the ED, the TOG officers had used de-escalation techniques to address Josh's heightened and at times aggressive and abusive behaviour and encouraged him to stay in hospital to receive treatment.[73]

114. The TOG officers considered that Josh's increasing agitation and aggression was being primarily driven by his frustration at waiting in hospital for treatment that he did not want to receive. This view was confirmed when Josh's behaviour settled after they decided to leave the ED.[74] Mr Miller-Crimmins stated in evidence that he assumed Josh would be discharged as soon as his hand had been dressed with the specialist bandage.[75] They were not aware that his behaviour was likely driven by the effects of the ice in his system which could be compromising his judgment and his ability to act in his own interests.

115. In light of Josh's behaviour, including his abuse and aggression directed towards Ms Colvin, the TOG officers had discussed the option to cancel the escort if the behaviour got any worse. They spoke on the phone to Mr Massa about their concerns who supported any decision they thought was necessary to ensure everybody's safety. Mr Massa also discussed the possibility with Ms Gilbert. It was a rare occurrence for a medical escort to be cancelled.[76]

116. The trigger for the TOG officers to cancel the escort was at around 2.49pm when Josh stood up from the bed and again stated that he wanted to return to PPP. Mr McPherson stated in evidence that he considered that Josh was a high risk of violence and he was not following directions and posed an unacceptable risk to staff. The decision to cancel the escort was not discussed with medical staff.[77]

117. I consider that the TOG officers cancelled the escort prematurely and that they should not have done so without sharing their concerns and discussing their proposed plans with medical staff in a collaborative way. It would also have been appropriate for Dr Khoury to have advised the TOG staff that Josh required further assessment for his ABD and ice

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[73] T365; T374.
[74] T404; T431; T375.
[75] T433.
[76] T384; T348; T1262.
[77] T367; T380; T388.

ingestion before his discharge. Further, TOG staff should have been advised of the medical plan in the event that Josh's behaviour continued to escalate, for example that he may be required to be sedated against his wishes. This is consistent with the evidence of Dr Reid.[78]

118. It was Mr Daley's understanding that Josh needed to be reviewed by Dr Khoury before he was discharged. However, Mr Daley did not get an opportunity to negotiate with the TOG officers about Josh's departure from the ED as he was on the phone at the time.[79]

119. The TOG officers were overly security focussed and had not been trained about the impacts of ice use, its potential to affect behaviour and decision-making capacity and the need for it to be treated. There is an obvious problem with cancelling a prisoner's escort for not being of *"good behaviour"*[80] or not complying with a lawful direction when the cause of that behaviour or non-compliance is the very thing that requires medical treatment.

120. It is not surprising or unreasonable that the TOG officers were concerned about security given their primary role and Mr McPherson's previous experience of medical staff being assaulted during an escort.[81] However, staff should be sensitively and appropriately debriefed after such incidents to ensure that their past experiences do not disproportionately affect or distort their judgment in future circumstances.

121. During their evidence, the TOG officers reflected that with the benefit of hindsight they would have consulted with medical staff before cancelling the escort and made further attempts to de-escalate Josh's behaviour and encouraged him to remain in the ED to complete his assessment and treatment. Further, they would have obtained a discharge summary before leaving.[82]

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[78] T1513-T1514.
[79] T333-T335.
[80] Escort permit; CB1418.
[81] T381.
[82] T373; T379; T453

JOSH'S TREATMENT AT THE ST JOHN'S UNIT

What policies and procedures governed Josh's treatment in the St John's Unit, including as to the hierarchy of decision-making regarding access to Josh's cell? Were they complied with?

The TOG direction

122. At the time of Josh's passing, there was a procedure at PPP where a direction could be made which required TOG staff to be present before a cell door was opened. This direction could be made by correctional staff supervisors and was made in circumstances where TOG officers were required to manage the security risk presented by the prisoner. A TOG direction does not prevent correctional staff from entering a cell without TOG assistance in the event of an emergency, such as to provide a life-saving emergency response.[83] This procedure, including the exception, is not contained in any written policy.

123. Mr Grimison gave evidence that he was told by Mr Massa that Josh was *"TOG only"* soon after Josh's cell door had been closed after his arrival at St John's.[84] Mr Walde and Mr Sanders also heard a TOG officer advise a correctional officer of the TOG direction after Josh's initial medical assessment had been cancelled and he had left the observation cell.[85] Further, Ms Dowling recalled being advised of the TOG direction soon after Josh's arrival at St John's.[86]

124. In his statement, Mr Massa stated that he did not recall whether he gave a TOG direction to correctional staff after Josh's arrival at St John's and after his cell door was closed. He did however recall telling correctional staff to call him straight away if there were any issues so that TOG officers could provide assistance where necessary.[87] In evidence, Mr Massa stated that he did not give a TOG direction at this time and that Mr Grimison's recollection was incorrect.[88]

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[83] CB1355; CB551.
[84] T468.
[85] T732; CB632.
[86] T523.
[87] CB453.
[88] T1276.

125. I accept that Mr Massa may not have clearly articulated a formal TOG direction after Josh's arrival at St John's and his cell door was closed, but I am satisfied that his communication to correctional staff gave them the clear impression that no staff were to enter Josh's cell without TOG being present.

126. When staff gathered around Josh's cell at around 6.40pm and after a plan was made to wait until he settled down, Ms Gibson stated that she advised medical staff that she would ensure that TOG officers were present if they needed the cell door to be opened. She stated in evidence that she did not consider that this constituted a formal TOG direction, which she subsequently made later at around 7.30pm.[89] Further, CCTV footage appears to disclose the direction being written above Josh's cell door at around that time. However, notwithstanding Ms Gibson's intention in relation to when her TOG direction may have come into effect, I am satisfied that correctional and medical staff continued to have the clear impression that no staff were to enter Josh's cell without TOG being present.

127. I consider that Ms Gibson's TOG direction ought to have been conveyed to the TOG officers on the night shift so that they could have situated themselves in St John's and minimised any delays in getting to Josh's cell in the event that they were needed.

128. It is arguable that the TOG direction was not necessary in Josh's case given his evolving presentation throughout the day which demonstrated more erratic and chaotic behaviour rather than a risk of violence to staff. However, I consider that it is reasonable for correctional staff to take a conservative approach in addressing security concerns and erring on the side of caution when assessing risks to staff safety. But a TOG direction should not prevent a prisoner from receiving prompt medical treatment if required. In Josh's case, the failure to provide him treatment was not so much the existence of any TOG direction, but rather a reluctance of TOG officers to facilitate entry to the cell and a failure of SVCHS staff to insist upon it.

129. I consider that the TOG direction was too strictly and inflexibly interpreted by correctional staff and should have been reviewed over time given the deterioration of Josh's condition.

[89] T1380; T1394.

Further, regardless of whether the TOG direction was still in place or not, once the Code Black was called, correctional staff should have applied the exception and enabled medical staff into the cell to treat Josh given that he was unresponsive. It is understandable that some staff may have concerns about prisoners foxing[90] given their past experiences, but care must be taken to ensure that past experiences do not disproportionately effect and distort judgment in the future.

Observations

130. As Josh had been allocated an S2 rating, being a significant risk of suicide or self-harm, he was required to be observed by correctional staff at least every 30 minutes. This process is recorded in G4S's *Operational Instruction 0I.0107 - At Risk Prisoners*. The purpose of the observations is for staff to look for self-harming behaviour.[91] Observation must be direct observation of a prisoner which may be supplemented, but not replaced, by observation by CCTV.[92]

131. It is clear that some correctional staff who gave evidence had considered, incorrectly, that S2 observations could be conducted by CCTV only.

Acute Poisoning Management Guideline

132. The SVCHS *Acute Poisoning Management Guideline* recommends that patients presenting with an ABD are transferred to the ED at SVHM via ambulance for further medical assessment and monitoring. It states that *"all cases of the identification and treatment of an ABD that requires the administration of sedation or antidote, prisoner transfer to an ED for further medical assessment and monitoring is required"*.[93]

[90] "Foxing" is a term used to describe when a prisoner is pretending to be unconscious. It is noted that Mr Massa and Ms Gibson both gave evidence that they did not have a concern that Josh was foxing.
[91] CB1375.
[92] CB1142.
[93] CB1249-CB1253.

133. As Josh was unlikely to accept an oral medication, it is likely that any sedative would have been required to be administered by an intramuscular injection. This would have required the assistance of the TOG with the likely use of force.[94]

134. I am satisfied that Josh was clearly exhibiting the signs of an ABD soon after his cell door was closed at around 5.00pm. Further, SVCHS staff were aware that Josh had disclosed having consumed ice earlier in the day. SVCHS staff should have applied the *Acute Poisoning Management Guideline* and called an ambulance at around 6.40pm to return Josh to the ED at SVHM. In order to prepare Josh for transfer, it is likely that an intramuscular sedative would have been required to be administered with the assistance of the TOG. A decision could have been made to call an ambulance after Dr Li first observed Josh in his cell at around 5.20pm, but I consider that it would have been reasonable at this stage for a plan to be put in place to closely monitor Josh for a period so a better understanding of the trajectory of his ABD could be obtained. An assessment could then have been made an hour or so later to decide whether an ambulance was required. This plan is also consistent with the evidence of Dr Reid and Associate Professor Clark.[95]

How was Josh's treatment at St John's impacted by the circumstances of his departure from St Vincent's Hospital?

135. Josh was returned to PPP after his departure from SVHM without a discharge summary which identified the assessment and treatment he had received together with his proposed management plan. It was the usual practice on a returning medical escort for the discharge summary to have been placed in a red bag and provided by TOG officers to the medical staff at St John's. The discharge summary was not in fact sent to St John's by staff at SVHM until after Dr Li had finished her shift. She stated in evidence that her treatment plan for Josh would have likely been different had she had access to a discharge summary which advised that he required close monitoring and should be returned to hospital if he deteriorated.[96]

[94] T1553.
[95] T1543; T1533-T1534.
[96] T841.

136. The medical staff at St John's were not notified that Josh's medical escort had been cancelled and that he was being returned to PPP. Further, Dr Li stated that she had not been aware that Josh had been removed from hospital by TOG officers prior to his formal discharge.[97] This information should have been communicated by correctional staff to medical staff at St John's so that they could have better prepared for Josh's arrival.

137. Josh's premature departure from SVHM also prevented him from having his hand dressed with the specialist bandage that was being sourced by the ED staff. It also deprived the ED staff of the opportunity to further assess and monitor Josh in relation to his ABD.

What information was available to medical staff at the St John's Unit about Josh's presentation, including any drug use?

138. The medical staff at St John's were able to consider any information handed over to them about Josh's presentation by TOG officers when he arrived at the unit. Mr Sanders was told that Josh had taken ice and Ms Metcalfe was told that he was *"high as a kite"*.[98] In the absence of a discharge summary, the information handed over to medical staff appeared to be vague and lacking in detail.[99]

139. The medical staff were able to access Josh's medical records on J-Care which included information about Josh's presentation and treatment in the Matilda Unit after the Code Red was called earlier that morning. This included information about the burn to Josh's hand, his disclosure of ice use that day and that he appeared drug affected, his assessment by Mr Frost and his S2 rating. J-Care also disclosed that Josh was being prescribed quetiapine.

140. Dr Li contacted the ED at SVHM at around 5.45pm and spoke with Dr Rory Whelan. She recalled being told that that Josh had been treated for the burns to his hand but that he was *"not for admission or transfer to another hospital and was aggressive in the ED"*.[100] Dr Li interpreted this information as meaning SVHM did not want Josh to be returned to the ED. Dr Li did not know that Josh had left ED without a final review by an emergency

[97] T840.
[98] CB621; CB632.
[99] CB628.
[100] CB618.

physician.[101] Further, Dr Li did not have access to a discharge summary for Josh which should have clearly documented his medical plan, including the management of his ABD.

141. Importantly, medical staff were able to observe Josh closely both through his cell window and via CCTV to assess his evolving presentation. They were also able to receive information from correctional staff about their observations. TOG officers did not disclose to medical staff the *"conversation"* they had with Josh through the trap at around 6.40pm in which he may have stated that he had had *"half a ball"* of ice. G4S has conceded that this information ought to have communicated to medical staff.[102] However, even in the absence of this information, which I accept would have assisted medical staff in their ongoing assessment, I am satisfied that Josh was clearly exhibiting the signs of ABD which required a transfer to hospital. Further, the transfer was required even if medical staff had considered that the source of the ABD may have been behavioural and/or psychiatric rather than drug-induced. This is consistent with the evidence of Dr Reid and Associate Professor Clark.[103]

Who was responsible for ensuring that Josh was properly assessed, treated and monitored in the St John's Unit?

142. Ensuring that Josh was properly assessed, treated and monitored at St John's was a collective responsibility that was shared by all of the staff who came in contact with him while he was within the unit. As stated in evidence by Mr Massa, *"Everyone had a part to play"*.[104]

143. SVCHS medical staff had the primary responsibility for providing assessment and treatment to Josh while G4S correctional staff (including TOG officers) had the responsibility for providing medical staff with the access required in a manner which was consistent with competing security considerations.

[101] T840; T843; T891.
[102] CB357.
[103] T1550; T1557.
[104] T1340; See also evidence of Ms Gibson at T1420-T1421.

144. Both medical and correctional staff had a responsibility for ensuring that Josh was properly monitored while at St John's. The focus of medical staff was Josh's medical condition while the main focus of correctional staff was general welfare and the prevention of self-harm.

Was Josh adequately assessed and treated by medical staff? If not, why not?

145. Josh's initial assessment at St John's by Mr Walde was ceased prematurely by Mr Massa as he was concerned that Josh was demonstrating *"conflict indicators"* which presented a risk to staff and was consistent with his view that he was refusing treatment. He considered that the TOG would return *"in an hour or so"* to complete the process once Josh had calmed down.[105]

146. A completed assessment by Mr Walde would have provided a baseline for Josh's vital signs at St John's which would have assisted staff in assessing and interpreting his subsequent behaviour in the observation cell. This was particularly important as Josh had left SVHM without being discharged.[106]

147. There was no discussion or negotiation with medical staff before Josh's assessment was cancelled. Mr Massa stated in evidence that he would have sought to further negotiate with Josh if medical staff had told him they had wanted to continue with the assessment.[107] However the abrupt manner in which the assessment was cancelled did not suggest that medical staff could challenge the decision and Mr Walde stated in evidence that *"we are not allowed to challenge"* the TOG.[108]

148. Mr Walde stated in evidence that he considered that he would have continued to negotiate with Josh to complete his assessment.[109] When a prisoner appears to be refusing treatment, medical staff should be given an opportunity to negotiate its provision with the prisoner through discussion. Subject to imminent security concerns, the process ought not be

[105] T1269-T1276.
[106] T730.
[107] T1274-1275.
[108] T731.
[109] T732.

unilaterally abandoned by correctional staff without genuine consultation with medical staff.

149. Dr Li observed Josh through the observation cell window at around 5.20pm. The CCTV discloses that his behaviour was becoming increasingly bizarre at this stage. Dr Li then reviewed Josh's J-Care records and became aware that he had disclosed taking ice earlier in the day. At this point, it would have been appropriate for Dr Li to apply the *Acute Poisoning Management Guideline* and arrange for Josh to be returned to the ED at SVHM. Alternatively, as stated above, I consider that it would have been appropriate to make a plan to closely monitor Josh for a period of an hour or so and arrange for him to be transported to hospital if his condition did not improve or if he deteriorated. This is consistent with the opinion of Dr Reid.[110]

150. After consulting with Mr Montalbo, Dr Li decided to administer some oral quetiapine to Josh to reduce his agitation. This was not able to be given to Josh as he was not in a condition where he would accept oral medication.

151. At 6.40pm, Dr Li should have applied the *Acute Poisoning Management Guideline* and made a decision to call an ambulance and have Josh transported to the ED at SVHM. This should have been done regardless of whether Dr Li was given access to Josh in his cell by TOG officers. Josh's disclosure of drug use was known and his ABD was clear from observation at the cell door or through the CCTV. Further, his behaviour had deteriorated since she first observed Josh at 5.20pm. All the relevant decision makers from a medical and correctional perspective were present at this time for this plan to be facilitated. With the benefit of hindsight, this has been conceded by medical and correctional staff.[111]

152. Josh was not transported to hospital at around 6.40pm because the medical plan decided upon was to allow time for Josh's condition to settle so as to enable observations to be taken and medication to be administered safely.[112] Medical staff did not appreciate Josh's behaviour as ABD requiring discrete medical treatment and the plan was influenced by Dr

[110] T1543.
[111] T836; T1312.
[112] T864-T865.

Li's discussion with the staff at the ED, her perception that they did not want him to be returned to hospital and the lack of a discharge summary.[113] However, it was appropriate for an independent assessment to be made by Dr Li based upon Josh's current presentation at St John's as to whether he required treatment in hospital.

153. Further, there was a reluctance on the part of TOG staff to facilitate access to Josh's cell and a corresponding failure on the part of medical staff to insist upon it. This was influenced by a lack of understanding by medical and correctional staff of each other's authority and roles and how they can be informed by each other to promote effective cooperation and collaboration.[114]

Was Josh properly and adequately monitored by correctional and medical staff? If not, why not?

154. Josh was regularly monitored by correctional and medical staff both through the window at his cell door and via CCTV. All of the staff who observed Josh considered that his behaviour was erratic and bizarre. However, critically, staff did not appreciate that Josh was suffering from an ABD in the context of recent drug use which required active treatment.

155. Correctional and medical staff were alarmed and concerned about Josh's behaviour. However, they relied for too long upon a plan to observe Josh and allow him time to calm down and settle so that medical observations could be taken and medication administered. It was not appreciated and understood that Josh required sedation in order to calm down and settle and that his care and recovery required the specialist resources of a hospital ED.

156. The focus of the observations of correctional staff was to generally ensure that Josh did not harm himself, given his S2 rating. Their observations were recorded but the entries did not accurately reflect the severity of his behaviour or provide sufficient distinguishing language to alert oncoming staff to his deterioration.

[113] T839.
[114] T822-T823.

157. The observations of Josh's behaviour by medical staff together with their awareness of his disclosed drug use earlier in the day ought to have activated the *Acute Poisoning Management Guideline* which required Josh to be sedated (with the use of force if necessary) and transported to hospital. There was a misdirected focus on a potentially psychiatric basis for Josh's behaviour with his rating being upgraded to P1 and a referral made to Ravenhall for treatment. As previously stated, Josh required a transfer to hospital regardless of whether the source of the ABD may have been behavioural and/or psychiatric rather than drug-induced.

158. There is evidence that Josh used the intercom at around 6.27pm and stated, *"I'm dying"* and that he could be heard through the trap at around 6.40pm to be stating "*I need some help, please"*. Although these words can be heard on careful listening of the relevant recordings in a calm and controlled environment, I accept the evidence of the correctional and medical staff that they heard Josh making regular incoherent and incomprehensible sounds and that they did not hear those words at the time.

159. There was a delay in correctional staff calling the Code Black. It should have been called at the latest at around 8.02pm when Josh became unresponsive. This has properly been conceded by G4S.[115] Mr Goldsmith had only recently commenced his shift and did not have an appreciation of how Josh's behaviour had evolved throughout the day.

Was the medical care and monitoring provided to Josh influenced or delayed by security concerns? If so, was that influence or delay preventable?

160. The medical care and monitoring provided to Josh was influenced by security concerns which were reflected in the making of a TOG direction by Ms Gibson. Further, medical staff and some correctional staff were of the understanding that this direction had been in place since Josh's cell door was closed at around 5.00pm.

161. The TOG direction created a perceived barrier to Josh receiving treatment and staff had difficulty in marshalling the impetus and authority to overcome it. Medical and correctional staff clearly had a perception that it was difficult to challenge TOG officers in relation to

[115] CB1356.

security assessments. In fact, Dr Li stated in evidence that it was her understanding that the TOG could override a decision by medical staff to send a prisoner to hospital.[116]

162. As stated above, it is understandable that security is a significant consideration in providing medical treatment in prison. Staff do get assaulted in prison and their past experiences may influence their future judgment. However, a TOG direction should not prevent a prisoner from receiving medical treatment. Medical staff needed to be more forceful in advocating for Josh and seeking access to his cell and correctional staff needed to be more willing to facilitate that access.

163. The emergency response to Josh becoming unresponsive was delayed after the Code Black was called as a result of security concerns and an inflexible understanding of the effect of a TOG direction. Correctional staff did not allow medical staff into Josh's cell to provide him treatment as they had a rigid view of the effect of the TOG direction and in some cases had a distorted view of the risk he continued to present to staff informed by previous experience (ie foxing). I also accept that they had only recently commenced their shift and had a limited amount of time to assess Josh's security risk and medical needs and were not informed by an understanding of how his behaviour had evolved throughout the day.

164. Some TOG officers suggested in evidence that the transmission of the Code Black did not contain sufficient information and was not delivered in a tone which was sufficient to convey its urgency. A Code Black signifies a serious medical emergency or death requiring an immediate response.[117] All Code Blacks should be responded to with urgency. The transmission clearly requested the attendance of the TOG and management. Staff should not interpret the tone of the transmission to determine its urgency as it can be variable and subjective.

165. Medical staff ought to have been given access to Josh's cell by correctional staff after the Code Black was called given the emergency circumstances. Further, medical staff could have called an ambulance while they waited for access to be provided. Also, TOG officers should have been advised of the TOG direction which would have enabled them to be

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[116] T823.
[117] CB1356.

situated in St John's which would have avoided the delay in their arrival. This has been properly conceded by G4S.[118]

FINDINGS AND CONCLUSION

166. Having held an inquest into Josh's passing, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Joshua Steven Kerr, born on 30 August 1989;

(b) his passing occurred on 10 August 2022 at Port Philip Prison, Victoria;

(c) from methylamphetamine toxicity; and

(d) that his passing occurred in the circumstances set out above.

COMMENTS

167. Pursuant to section 67(3) of the Act, I make the following comments connected with Josh's passing:

(a) Josh's passing was a preventable tragedy which has devastated his family and community.

(b) The events of 10 August 2022 were triggered by Josh consuming ice and lighting a fire in his cell.

(c) There were a number of periods of time on 10 August 2022 where more decisive, considered and effective action by staff would have altered the care and treatment received by Josh in a way that most likely would have prevented his passing. I am satisfied that correctional and health staff were concerned about Josh but there was a clearly inadequate response to his evolving ABD (which was manifesting as a result of methylamphetamine toxicity) and a failure to provide him the positive treatment which he needed.

[118] CB1356.

(d) Josh should not have been removed from SVHM by TOG officers before he was formally discharged by medical staff. This prevented Josh's medical treatment being finalised and deprived the medical staff of a further opportunity to assess Josh and properly document a plan for his future treatment. The TOG officers assumed he was only receiving treatment for burns and did not consider that his ice use may have needed to also be medically addressed. They were also not advised by medical staff of any plan to treat his ABD.

(e) In particular, at 6.40pm outside of Josh's cell, there was an opportunity for medical staff to apply the *Acute Poisoning Management Guideline* and make the decision to call an ambulance. There was a lack of awareness of ABD in the context of drug use as a presentation which potentially required discrete medical treatment as opposed to only requiring monitoring and behaviour management.

(f) Further, there needed to be a more proactive response by staff to observations of Josh in the context of his bizarre behaviour over an extended period of time followed by his deterioration and collapse, including an earlier call of the Code Black and a readiness to enter his cell without the TOG.

(g) There needed to be greater and more robust advocacy for Josh's needs by medical staff and greater accountability by correctional staff to share in the responsibility to foster an environment where staff feel they can speak up and be heard.

(h) There can be a tension between the obligation of staff to ensure the security and good management of a prison and the obligation to provide appropriate medical care and treatment to prisoners. In Josh's case, there was a disproportionate focus on security concerns which obscured and hindered a clear and decisive assessment and management of his medical needs. It is understandable that past experiences of violence will inform the way staff respond to their assessment of risk. Effective debriefing should be designed to ensure that past traumatic experiences of staff do not disproportionately influence their future judgment.

(i) All correctional and medical staff who came into contact with Josh on 10 August 2022 were responsible for his safety. It is a collective responsibility and the circumstances of Josh's passing clearly demonstrate that there needs to be more communication, cooperation and collaboration between correctional and medical staff which recognises the shared responsibility to ensure the wellbeing of prisoners. This has been an ongoing issue at PPP and was identified in the earlier inquest into the death of Billy Bazouni in 2022 (3108/16).

RECOMMENDATIONS

168. I have noted the relevant recommendations made in the JARO Report. I do not propose to repeat them but I have formulated a number of recommendations which I consider are appropriate and clearly arise from the evidence given at the inquest.

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

1. G4S and SVCHS staff receive training to assist them in recognising and managing drug affected prisoners, including those who may be experiencing ABD and drug toxicity, and its effect on their decision making capacity;

2. SVCHS receive training about the practical application of the *Acute Poisoning Management Guideline*;

3. SVCHS staff receive training to reinforce their authority and responsibility to advocate for the treatment of prisoners in their care and to escalate where appropriate;

4. G4S TOG staff receive training about the importance of consulting with medical staff prior to cancellation of a medical escort;

5. SVHM ED staff receive training about the limitations of providing medical treatment in prison; the benefit of communication of a prisoner's treatment plan with escorting correctional staff; and the importance of prompt preparation of a discharge summary including the treatment plan;

6. G4S staff receive training about the circumstances in which they can exercise individual discretion to allow medical staff to enter a cell to provide a prisoner with medical treatment; and

7. Corrections Victoria develop and implement a training program, to be undertaken by correctional staff and medical staff together:

    (a) to enhance their mutual understanding of each other's respective roles in Victoria's prison system; and

    (b) to encourage a co-ordinated and cooperative relationship which recognises the respective roles and their corresponding authority in a way which reduces hierarchical barriers.

I am grateful for the valuable assistance provided to me in this investigation by Counsel Assisting Rachel Ellyard and Principal In-House solicitor Samantha Brown.

I convey my sincerest sympathy to Josh's family.

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.

Pursuant to section 49(2) of the Act, I direct the Registrar of births, Deaths and Marriages to amend the cause of death to the following *"1(a) Methylamphetamine toxicity"*.

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

Aunty Donis Kerr

Chantelle Osman

Lisa Thorpe

Secretary to the Department of Justice and Community Safety

G4S Custodial Services Pty Ltd

St Vincent's Hospital (Melbourne) Ltd

Detective Senior Constable Antarpreet, Coroner's Investigator

Signature:

Coroner David Ryan

Date: 01 July 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.