IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 0422

FINDING INTO DEATH AFTER HAVING HELD AN INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Deceased:	**Michelle Hughes**
Findings of:	**CORONER DARREN J. BRACKEN**
Delivered on:	11 February 2022.
Delivered at:	Coroners Court of Victoria Kavanagh Street, Southbank
Hearing date:	22 – 24 October 2019
Appearances:	Leading Senior Constable Ramsey appeared to assist the Coroner.

Ms M. Isobel, Counsel appeared for Department of Justice and Community Safety.

Mr R. Ajzensztat, Counsel appeared for Forensicare.

Ms E. Gardner, Counsel appeared for Correct Care Australia.

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HIS HONOUR:

CIRCUMSTANCES

1. On 26 January 2017, Ms Michelle Hughes was 53 years old when she was found apparently deceased on the bed of her single cell in the Swan Unit at the Dame Phyllis Frost Centre, Women's Prison ("the Prison").

2. At about 7.50am, having failed to rouse Ms Hughes for the 'morning count', Prison Officer Duyvestyn looked through the observation window of Ms Hughes' cell door, saw her lying on the bed and noticed a red ligature[1] around her neck. Prison Officers entered the cell, cut the ligature from Ms Hughes' neck and called a 'code black'.[2] Prison Officers then rendered first aid, medical staff arrived, and an ambulance was called. At approximately 8.22am, despite the efforts of prison staff and ambulance officers Ms Hughes was pronounced deceased.

3. On 27 January 2017 Dr Michael Burke a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine conducted an autopsy on Ms Hughes' body and drew an 'Autopsy Report' dated 1 February 2017.[3] In his report Dr Burke opined that the cause of Ms Hughes death was "*…ligature strangulation*." Dr Burke's report refers having seen "*…a group of transverse and longitudinal scars…to the left forearm and left wrist*" at autopsy. The toxicology report prepared from samples taken at the autopsy refers to no drugs or poisons having been detected.

4. I accept Dr Burke's opinion, the accuracy of his observations and whilst there is no controversy that Ms Hughes died by suicide there is some controversy in relation Ms Hughes' management in the Prison, including of her mental health, during the time leading up to her death.

THE PURPOSE OF A CORONIAL INVESTIGATION

[1] This ligature was later identified as a pair of lady's briefs. Ms Hughes had put one leg hole over her head and around her neck and, using a shoe in the other leg hole, twisted and tightened the leg-hole of underwear around her neck.

[2] A requirement for urgent medical assistance.

[3] Exhibit 1.

5. Ms Hughes' death constituted a '*reportable death*' pursuant to section 4 *Coroners Act* (2008) ("the Act") because her death occurred in Victoria, was unexpected, unnatural and occurred from an injury.[4] Further, because she was serving a sentence of imprisonment Ms Hughes was, at the time of her death in the custody of the Secretary to the Department of Justice[5].

6. The Act requires a coroner investigating reportable deaths such as Ms Hughes' to find, if possible:

- The identity of the deceased.
- The cause of the death; and
- The circumstances in which the death occurred.[6]

7. For coronial purposes, "*circumstances in which the death occurred*"[7] refers to the context and background of the death including the surrounding circumstances. Rather than being a consideration of all the circumstances which might form part of a narrative, culminating in the death. Required findings in relation to circumstances are limited to those which are proximate and relevant to the death.

8. The coroner's role is to establish facts,[8] rather than to attribute or apportion blame for the death; it is not the coroner's role to determine criminal or civil liability.[9]

9. One of the broader purposes of coronial investigations is to reduce the number of preventable deaths in the community and to that end coroners may:

- Report to the Attorney-General on a death,[10]
- Comment on any matter connected with the death including matters of public health or safety and the administration of justice,[11] and

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[4] *Coroners Act* (2008) s.52(2)(a).

[5] *Coroners Act* (2008) s.52(2)(e).

[6] *Coroners Act* (2008) preamble; s 67.

[7] *Coroners Act (*2008) s. 67(l)(c).

[8] *Coroners Act 2008* (Vic) s 69(1).

[9] *Keown v Khan* (1999) 1 VR 16. pp.75-76.

[10] *Coroners Act 2008* (Vic) s 72(1).

[11] *Coroners Act 2008* (Vic) s 67(3).

- Make recommendations to any minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[12]

10. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities applying the principles of such proof set out in *Briginshaw v Briginshaw*.[13] The strength of evidence required to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[14] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the finding, and effect.[15]

11. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[16] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[17] Such a description should be interpreted in the context of the coronial jurisdiction being inquisitorial and having nothing to do with guilt or innocence.

Conducting an Inquest

12. Section 52 of the Act provides that a Coroner may hold an inquest into any death that the Coroner is investigating and mandates that an inquest be held if the death or cause of death occurred in Victoria and "*…the deceased was, immediately before death, a person placed in custody or care*." Immediately before her death Ms Hughes had been in prison for a considerable period of time.[18]

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[12] *Coroners Act 2008* (Vic) s 72(2).

[13] (1938) 60 CLR 336, pp. 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte; Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 9, 95.

[14] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd. Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70- 171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[15] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams*(1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pl 70-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[18] *Coroners Act* (2008) s. 52(1).

13. I held an inquest into Ms Hughes' death over 3 days between 22 and 24 October 2017 at which 8 witnesses gave *viva voce* evidence and 16 exhibits were tendered including 'the balance of the Coronial Brief'.

THE INQUEST

14. At the time of her death Ms Hughes was serving her first term of imprisonment, eighteen-months imposed by the County Court of Victoria on 8 November 2016 but which she effectively started serving when she was remanded in custody in December 2015. In sentencing Ms Hughes her Honour Judge Hampel described the matter for which Ms Hughes was being sentenced as one of the saddest cases of violence within a family with which she had to deal. Her Honour found that Ms Hughes had committed the assault for which she was sentenced in a drug induced psychosis.[19]

15. Before going into prison in December of 2015 the Swanston Centre in Geelong and the Geelong West Community Mental Health Team treated Ms Hughes' mental health conditions. Ms Hughes,

    "*…had been involved with mental health services since 2000 and had attracted diagnoses of bipolar disorder, borderline personality disorder, and delusional disorder.*"[20]

16. After entering prison, physicians from Forensicare[21] treated Ms Hughes in the Marmack Unit of the Prison as an inpatient and then as an outpatient. In his statement Dr Jindal explained that:

    "*Whilst Ms Hughes was in custody at DPFC[22], Forensicare was responsible for her specialist mental health care*." [23]

    Primary mental health care in the Prison was provided by Correct Care Australia.[24]

Ms Hughes' Treatment in Prison - Forensicare and Correct Care Australia

[19] *DPP v Hughes* 2016 VCC 1762.

[20] Statement of Dr Sachin Jindal dated 16 September 2019 Exhibit 6 [5].

[21] Forensicare is a statutory agency established under the *Mental Health Act* (2004) to provide forensic mental health services in Victoria including to prisoners at the Dame Phyllis Frost Women's Prison.

[22] Dame Phyllis Frost Centre

[23] Statement of Dr Sachin Jindal Exhibit 6 [5].

[24] Statement of Dr Sachin Jindal Exhibit 6 [5].

Forensicare

17. Ms Hughes was an inpatient in the Marmack Unit between 4 December 2015 and 1 February 2016 reporting systemised persecutory delusions (with the same themes as prior to her incarceration). Dr Jindal considered that prior to imprisonment Ms Hughes had been dependent on opioids and amphetamines. In his statement Dr Jindal recounts Ms Hughes' delusions improving during this stay in the Marmack Unit, which improvement he said continued thereafter when Ms Hughes was treated as an outpatient of the Marmack Unit. As an outpatient Ms Hughes saw a psychiatric registrar every fortnight and a psychiatric nurse each week.[25]
18. On 8 June 2016 Ms Hughes was re-admitted to the Marmack Unit (as an inpatient) reporting having been bullied in the 'mainstream prison' by inmates when she told some of them about the offences for which she had been imprisoned. In his statement Dr Jindal refers to this bullying having triggered an exacerbation of Ms Hughes' maladaptive personality behaviours including mood instability, intense anger, impulsivity, self-harm and suicidal behaviours.
19. On 12 June 2016 while an inpatient in the Marmack Unit Ms Hughes 'self-harmed' by lacerating the volar side (inside) of her left wrist with a knife. Photographs in the inquest brief show her wrist severely damaged by, apparently, a number of connected wounds.[26] This self-harm incident can only be described as very serious. Ms Hughes harmed herself again during August 2016 including by lacerating her left wrist with a "*…small sharp object…*". It is not clear, but at least likely that the "*…group of transverse and longitudinal scars…to the left forearm and left wrist*" noted by Dr Burke in the Autopsy Report were the healed volar lacerations.
20. During this second stay in the Marmack Unit, on 8 November 2016, Ms Hughes was sentenced in relation to the offences for which she was in custody. In his statement Dr Jindal refers to Ms Hughes being relieved that the criminal proceedings were finalised and to her looking forward to re-connecting with her family.

Dr Jindal explains that Ms Hughes was conscious of her release date and wanted to cease taking medication (other than as needed) so as to be 'medication free' when she was

[25]Statement of Dr Sachin Jindal Exhibit 6 [10]-[11].

[26] Inquest Brief pp. 134-135.

released; she made clear to him that she wanted to return to the mainstream prison. Dr Jindal last saw Ms Hughes on 30 November 2016, 10 days after she had ceased her medication. His statement refers to her presenting as appropriate in behaviour and to psychotic or mood symptoms being absent; her judgement was intact, and she showed insight and capacity.[27] Ms Hughes expressed a desire to continue to abstain from taking medication and wanting to transfer back to the prison mainstream and find work. She was discharged from the Marmack Unit on 8 December 2016, actually left the unit on 12 December 2016 and saw a psychiatric nurse every week and a psychiatric registrar as an outpatient.

21. Dr Jindal reports that post discharge Ms Hughes' progress was not without difficulty or incident. Her difficult personality did not aid her relationship with Safer Care Staff or other prisoners; the requirement for observation by staff was increased between 21 and 23 December 2016. Ms Hughes reported that she did not like the Marmack psychiatric registrar and medical notes record that on 6 January 2017 she expressed a desire to be discharged as an outpatient from Marmack. During reviews with the registrar on 11 and 18 January 2017 Ms Hughes was noted to be hostile and extremely angry and, against advice, continued to abstain from taking her medication. Ms Hughes' psychiatric care was transferred to Correct Care on 19 January 2017.

Correct Care Australia

22. Associate Professor Dr Turnbull, the Chief Medical Officer of Correct Care provided a statement for the Inquest Brief dated 20 June 2017.[28] In that statement Dr Turnbull outlined Correct Care's treatment of Ms Hughes between 3 December 2015 and 17 December 2017.

23. Dr Turnbull refers to Ms Hughes self-harm incident on 12 June 2016 when she mutilated her left wrist, and of her again lacerating that wrist on 23 August 2016 this time "…*after emotional distress.*"

The injury that Ms Hughes did to herself in August was treated at St.Vincent's Hospital and Dr Turnbull refers to planned plastic surgery and to Ms Hughes having been prescribed and continuing to take Methadone as at 24 October 2016 and as at 10

[27] Ibid. [14].

[28] Inquest Brief pp.43-47.

December 2016 not taking prescribed anti-coagulation medication and of her having ongoing problems with her left hand.

At Risk Assessments

24. Within the Victorian prison system, prisoners about whom concerns of self-harm or suicide are held are described as being 'at risk'. The Deputy Commissioner's Instructions and the Dame Phyllis Frost Centre Local Operating Procedures set-out the processes by which a prisoner's 'at risk' status is assessed and how such prisoners are managed. This process includes prisoners being allocated S (suicide) ratings 1 – 4 and P (Psychiatric) rating 1 – 4. In both protocols rating 1 is the most serious and 4 the least. For example, P1 means a serious psychiatric condition requiring intensive and/or immediate care and S1 an immediate risk of suicide while S4 refers to a history of suicide or self-harm and P4 a suspected psychiatric condition requiring assessment. These ratings are set and altered by Risk Review Team Meetings. Ms Hughes was allocated P and S ratings from when she first entered the prison system and which as a result of various assessments changed from time to time.

<u>8 June 2016</u>	P3, S4.
Ms Hughes reported being upset By bullying by other prisoners. RRT meeting changed Ms Hughes' ratings and Ms Hughes re-admitted to Marmack Unit.	P1, S3.
<u>12 June 2016</u>	P1, S3.
Ms Hughes seriously lacerated volar aspect of left arm with a butter knife after which she called staff to her cell by intercom for assistance. A code black was called and Ms Hughes taken to hospital. RRT meeting changed Ms Hughes	

ratings.	P1, S1.
<u>16 July 2016</u>	P1, S4.
Ms Hughes told a mental health nurse	
That she could not guarantee her safety.	
A cache of drugs was found in Ms Hughes'	
Cell which she said that she had been	
'storing-up' to commit suicide.	
Ms Hughes was placed in a Muirhead	
Cell and on P1 observations.[29]	P1, S1.
<u>23 August 2016</u>	P1, S4.
Other prisoners reported Ms Hughes	
walking down a corridor in the prison	
with a bloodied left arm. It was	
thought that she had re-opened the	
wounds that she inflicted to herself	
on 12 June 2016. RRT meeting	
changed ratings and Ms Hughes was	
returned to a Muirhead Cell with a	
regime of observations every	
15 minutes.	P1, S1.
<u>21 December 2016</u>	P2, S4
Ms Hughes seen to be 'withdrawn'	
crying, unsteady on her feet and	

[29] A discrepancy in prison records resulted in Ms Hughes' S rating being 4 on one record and 1 on another. Any effect of this discrepancy is unknown.

refused to engage with staff. RRT meeting changed her rating and observations every 30 minutes instigated.	P2, S2.
<u>4 January 2016</u>	P2, S4.
Ms Hughes said by prison officers to be aggressive and nasty with staff and other prisoners.[30]	P2, S4.
<u>6 January 2017</u>	P2, S4.
Another prisoner alleged that Ms Hughes had threatened her and Told her of a prison officer who was trying to kill her. After review by mental health staff no change to ratings or observation regime.	P2, S4.
<u>25 January 2017</u>	P2, S4.
A prisoner reported seeing 'bruising' Around Ms Hughes' neck. An 'at risk' assessment was conducted by Registered Nurse Pare who concluded that Ms Hughes was not at risk and her ratings and observation regime were	

[30] The Inquest brief contains a number of references to the relationship between Ms Hughes and prison staff being strained and difficult.

not changed. P2, S4.

Evidence of Registered Nurse Pare

25. Nurse Pare provided a written statement for the Inquest Brief dated 15 February 2017 2017[31] and gave *viva voce* evidence.

26. In his statement Nurse Pare described his qualifications as a registered mental health nurse and of having been employed by Correct Care at the DPFC since August 2016. He recounted having conducted an 'At Risk Assessment' on Ms Hughes on 25 January 2017 in the Thompson 3 unit at DPFC and of having only seen Ms Hughes once before that date (on 8 November 2016), for the purposes of a 'return from court assessment'.

27. Dealing with 25 January 2017 Nurse Pare's statement refers to him having left a case conference and being en-route to 'the Management unit known as Swan 2' with Dr Barnes, a forensic psychiatric registrar, when at about 1.45pm staff from the Thompson 3 Unit approached him and asked him to 'assess Michelle's level of risk'. Nurse Pare's statement records Dr Barnes telling him that Ms Hughes was 'an angry woman, that she was hostile and anti-social and that her therapeutic relationship with Marmak Unit staff had broken down."

28. Nurse Pare's statement refers to him going to the Thompson 3 Unit and meeting 3 or 4 'correctional staff' who told him that:

- Ms Hughes;
  - Had bruising on her neck which had not been noticed the previous day.
  - They thought that such bruising was consistent with self-harm.
  - Told them that she was not at risk.
  - Was displaying 'odd behaviour that day – staring at other women and staring into space.'
  - Had recently been discharged from the Marmak Unit and that she had told them that her relationship with Marmak staff had broken down – that she wasn't happy with Marmak staff.
  - Presented safety issues and that he would have to assess her through the 'trap' in the cell door.[32]

[31] Exhibit 7.

- Other women in the unit had raised concerns with them about the bruising on Ms Hughes' neck.
- When staff had approached Ms Hughes about the bruising on her neck that she had become angry and confrontational and so had been 'locked-down' in her cell.

29. In his statement Nurse Pare refers to:

- Speaking to Ms Hughes through the 'trap' and of seeing her sitting on the side of the bed which he described as being toward the other end of the cell from the door.
- Ms Hughes as being initially angry but relaxing when he spoke to her, demonstrating a reactive affect and being influenced by her environment.
- Him not being able to see any bruising on Ms Hughes' neck through 'the trap'.
- Him asking her about the reported bruising on her neck and her replying that she,

  "*…hadn't noticed the bruising …. she sometimes, absentmindedly, rubs her neck when she is felling under stress* [as a] *self-soothing mechanism.*"

- Ms Hughes denying any thoughts or intention of self-harm or suicide.
- Ms Hughes having a reactive affect, being engaged and her responses being genuine.
- Ms Hughes telling him that she was embarrassed that others thought that she had made an attempt on her life.
- Discussing how she was going to deal with bullying including getting correctional staff "*…involved in the situation.*"
- Her response being appropriate and rational leading him to believe that she was future focussed and had appropriate future planning.
- Him always ending assessments asking if the person being assessed is 'OK' and if there is anything that he can do. His statement records Ms Hughes '…assuring him that she was fine.'
- Ms Hughes remaining reactive in affect, relaxed and open with good eye contact and a congruent smile.

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[32] The Trap is a small panel in the cell door that opens allowing those outside the cell to see something of the person in the cell and speak to them and vice-versa.

- Him telling staff that he was reassured that Ms Hughes was not exhibiting risk behaviours and of Ms Hughes' concerns in relation to being bullied.
- A prison officer telling him after he finished the assessment that he, the prison officer had seen the bruising going all the way around Ms Hughes' neck. That to him, Nurse Pare this was "…*new information…*" but that he remained "…*comfortable with his assessment of her risk.*"
- Him being told that Ms Hughes would be moved to another unit and observed hourly.
- Him telling staff that he would book an appointment for Ms Hughes the next day and someone would visit Ms Hughes in that management unit.

30. Nurse Pare's statement refers to him then returning to the 'Medical Centre', telling Dr Barnes of his assessment and of Dr Barnes telling him that Ms Hughes had previously carried out a number of significant acts of self-harm, made suicide attempts and had a history of minimising her suicide attempts and self-harm behaviour as well as of having denied carrying out previous acts off self-harm and attempting suicide. Nurse Pare's statement makes clear that when he assessed Ms Hughes that he was unaware of this history but his statement also makes clear that this information did not change his assessment or plan. Nurse Pare reviewed Ms Hughes medical notes garnering further 'new information' including that Ms Hughes had suffered from a delusional disorder.

31. Nurse Pare's statement refers to him forgetting to make the appointment for Ms Hughes the next day, although the statement asserts that he was working the next day and was sure that the appointment would have occurred.

    The statement also refers to him making a "…*mental note…*" about Ms Hughes having suffering from a delusional disorder.

32. Nurse Pare gave viva-voce evidence that:

    - As at 25 January 2017 he didn't recall having met Ms Hughes on the occasion when he conducted the 'return from Court assessment'.[33]
    - Whilst before he assessed Ms Hughes on 25 January he was aware that she had a history of self-harm he, he was unaware of some details and knew something of Ms Hughes from risk review team meetings.[34]

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[33] T.226.

[34] T.226.

- When he assessed Ms Hughes through the 'trap' in the cell door he did not see the reported bruising around her neck – he couldn't see her neck at all.[35]
- He didn't remember asking staff for clarification of why they considered the marks on Ms Hughes' neck to be consistent with self-harm.[36]
- He considered that Marmack Unit staff had previously assessed Ms Hughes' anger and believed it to be 'safe'.[37]
- He was used to carrying out assessments through 'traps in cell-doors'.
- Ms Hughes was initially hostile and didn't want to talk to him. That it didn't take very long, although he couldn't remember how long, for him to calm her down.[38]
- On his observations Ms Hughes was reacting appropriately to her environment.
- He didn't recall what Ms Hughes' mood was like.
- He believed Ms Hughes when she told him that the bruising seen on her neck (albeit not by him)[39] was a result of self-calming – she demonstrated to him how she did it and he found her explanation plausible.
- Ms Hughes' affect was neither heightened nor lowered, either of which would have caused him to consider her self-harm risk heightened even though he didn't know her.[40]
- He did not know how long he spoke to Ms Hughes through the trap door.[41]
- He felt that he had sufficient information to make his assessment after having seen her but that he needed to look at her 'file review' and speak to others about her.[42]
- After he spoke to Ms Hughes and was told for the first time that the bruising around her neck went all the way 'around' he didn't ask why it was a concern for the prison officers.[43]

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[35] T.227.

[36] T.227.

[37] T.227

[38] T.229.

[39] T.231.

[40] T.231.

[41] T.232

[42] T.232-233.

- After Dr Barnes told him that Ms Hughes had engaged in a number of significant acts of self-harm and had a history of minimising suicide attempts he remained comfortable with her reactions and interactions that he had with her.[44]
- After reviewing Ms Hughes' medical file he could have made changes to Ms Hughes' risk rating.
- After reading her file and speaking to Dr Barnes he saw "*…an improvement…*"in her risk status through the previous 'at risk' assessments. He saw "*…a general steady improvement…*"[45]
- He corrected himself explaining that as a part of his document review, he did not read the risk assessment documents but the J-care entries aligned to them.[46]

33. Nurse Pare gave evidence of considering static and dynamic risk factors when he assessed Ms Hughes including the bullying that she had reported and gave evidence that Ms Hughes didn't want to talk about the bullying and became upset when he raised it. He gave evidence that there was a heightened risk of Ms Hughes harming herself if the bullying wasn't addressed.[47]

34. Nurse Pare gave evidence that on 25 January 2017 he read Ms Hughes' medical record starting at 18 January 2017 going backwards. He gave evidence of the entry of 18 January 2017 having been made by Dr Barnes.

    Nurse Pare gave evidence that he considered the anger and hostility that Ms Hughes expressed towards Dr Barnes as set out in that entry was a risk factor having seen her calm down after he first saw her made him feel that there was a bit of improvement '*…in that area*."[48]

35. Nurse Pare gave evidence of having read the medical record entry of 11 January 2017 and it referring to Ms Hughes being able to calm herself down and a reduction in hostility gave him some comfort that she was not at risk of self-harm or suicide.[49]

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[43] T.233.

[44] T.234-235.

[45] T.237-238.

[46] T.241.

[47] T.250.

[48] T.253-255.

[49] T.255.

36. Nurse Pare was asked about the reference in Dr Barnes' entry of 23 December 2016 referring to;

> *"...Impression... Borderline antisocial paranoid personality style conveys chronic risks of SASH, IPV"*

and how that fed into his assessment of her risk of suicide / self-harm on 25 January. Nurse Pare explained that such chronic risks make an assessor more aware that the risk could escalate – that a chronic risk of suicide / self-harm could co-exist with an absence of then heightened present risk. Nurse Pare described assessment as a balancing exercise[50] and that he felt that when he compared Ms Hughes' presentation, as he saw her, with the documented presentations he saw a steady improvement in her mental state.[51]

37. Nurse Pare gave evidence that on 25 January at the medical centre when he told Dr Barnes of the outcome of his assessment and the plan that Ms Hughes was to go to the Management Unit Swan 2 and be on hourly observations that Dr Barnes said "OK".[52]

38. Nurse Pare gave evidence that after reading Ms Hughes' medical file and entries at least back to 21 December 2016 he didn't think it necessary to go to see Ms Hughes again and further assess her.[53]

39. When asked by Mr Ajzensztat whether as at 25 January 2017 he had a high degree of confidence in his assessment that Ms Hughes was not 'at risk' Nurse Pare gave evidence that he did and further that as he gave evidence, he was still of the view that when he assessed Ms Hughes that she was not at risk.[54]

40. When asked by Ms Gardner what S rating would have prevented Ms Hughes from taking her own life as she did, he nominated S1 because it required prisoners to be clothed in a thick canvass smock. Nurse Pare gave evidence that there was nothing about her presentation on 25 January 2017 that would have justified her being placed on an S1 rating.[55]

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[50] T.258-259.

[51] T.259.

[52] T.260 -270. T.291-292.

[53] T.262.

[54] T.269-270.

[55] T.282.

41. Nurse Pare gave evidence that as at 25 January 2017 he understood S4[56] to mean:

"Not currently at risk but, given history of suicide attempts or self-harm behaviour the potential for self- harm may escalate."[57]

42. When taken through the criteria for S3 Nurse Pare agreed that as at 25 January 2017 Ms Hughes was probably an S3[58] but not S2 or S1. Nurse Pare gave evidence that Ms Hughes was not S2 because as at 25 January her risk of suicide had not escalated – that what the prison staff had told him about bruising around Ms Hughes neck and her having had her jumper around her neck didn't cause him to consider that Ms Hughes risk of suicide had escalated. Having been taken through the elements of the various S criteria Nurse Pare gave evidence that it would have been appropriate to place Ms Hughes on an S3 rating albeit that under that rating she would still have had her own clothes but observations would have been more frequent but that even this may not have prevented her taking her own life in the manner she did.[59]

43. Nurse Pare was unable to say if inspecting the reported bruising around Ms Hughes' neck would have made any difference to his assessment.[60]

Evidence of Prison Officer Ms J. James

44. Ms James provided a statement for the Inquest brief dated 15 February 2017[61] and gave viva voce evidence.

45. In her statement Ms James recounted conducting hourly observations of Ms Hughes[62] overnight from about 11.15 pm 25 January until shortly before 7.00am on 26 January 2016 via a window in the cell door.

46. At the commencement of her viva voce evidence Ms James changed the time at which she commenced observations of prisoners from 11.15pm 25 January to midnight. Ms James explained that she was the only prison officer on duty over-night in the Swan 2

[56] Ms Hughes then s rating.

[57] T.282. The criteria for each S rating are set out on page 254 of the Inquest Brief.

[58] T.283.

[59] T.294-295.

[60] T.296.

[61] Exhibit 8,

[62] As well as other prisoners.

Unit, as is the usual practise, and that it was also the usual practise for that person to not have a key to open any of the cell doors.

47. Ms James described her usual practise as lifting the curtain over the cell door window of each prisoner she was required to check and shining a torch into the cell. Ms James explained from this position she was able to see the rise and fall of the cell occupant's chest and stomach.[63] Ms James explained that she would look for an indication that the prisoner in the cell was alive which sometimes involved yelling at them or knocking on the cell door.[64] Ms. James would then record her observations in the Observations Register.[65]

48. In relation to Ms Hughes Ms James first observation was at midnight and the relevant entry in the Observation Register is *"**AAS**"* which Ms James explained is her short-hand for 'appears asleep' and that at this time Ms Hughes was lying on her back. Ms James refers to the records showing that at 3.00am she found Ms Hughes awake standing facing the back of the cell so that Ms James could see her back. Ms James explained that if prisoners were nominated as being 'at risk' she may ask if they are OK but that then Ms Hughes was not so nominated and so she didn't speak to her. [66]

49. Ms James gave evidence of her observations of Ms Hughes at 4.00am, 5.00am and at 6.00am of seeing Ms Hughes asleep on her back. Ms James gave evidence that the entry recorded in the Observation Log of Ms Hughes being asleep on her left side at 7.00am was not strictly accurate; those observation having been made at approximately 6.50am.[67] Ms James was unable to say what sign of life she saw of Ms Hughes when she conducted the observation at 6.50am other than to say:

> "*…Okay…I can't recall. I couldn't recall right now what I'd actually seen, but she appeared to be asleep to me. That's why I'd written that in the book. I obviously had seen something that made me think that she was asleep.*"[68]

50. When asked if she had received training in relation to what to look out for if a prisoner might be becoming slightly more at risk than others Ms James said that she had but was unable to recall what it was, that it was learn as you go.

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[63] T.307.

[64] T308.

[65] A hand-written document at page 78 of the Coronial Brief.

[66] T.309- 310.

[67] T.311.

[68] T.313.

51. Ms James was asked about 'Reception care or control of prisoners placement of prisoners on management observations – procedure 1.11.1 which Ms James agreed was the policy that regulated observation of 'management prisoners' as at January 2017. Ms James gave evidence that in relation to Ms Hughes as required by that policy that she:

- Appraised herself of any handover briefing material or documentation for management of prisoners at the commencement of her shift.[69]
- Consciously identified Ms Hughes and the required frequency of observations.[70]
- Referred to emails sent by Marmak SPO and referring to RRT meeting outcomes.
- Referred to the completed DCI schedule102(9) (reference to the Deputy Commissioner's Instructions) which was a list of the prisoners who require observations and of which cell they are each in and the observation regime required.
- But rather than recording the actual time of observations that she recorded an approximate time.
- During observations she took reasonable steps to ascertain that the prisoner is unharmed whilst considering the potential for exacerbating the prisoner's distress by being intrusive.

52. Ms Isobel asked Ms James about Footnote 8 to the Instructions referring to how observations ought to be conducted. The instructions and the footnote appear at page 245 of the Inquest Brief. The footnote refers to it being sufficient satisfaction of the requirement that a prison officer can establish that a prisoner is "…*breathing or* alive" if the prison officer can see movement of the prisoner's chest or reaction to the torchlight, The footnote goes on to explain that:

"…*However, if staff cannot do this they need to consider the element of risk in concluding that the prisoner is asleep. In doing this they should take into account what opportunities the prisoner may or may not have had to acquire something that could be used to cause harm and whether interruptions to sleep could impact negatively on the prisoner's mental state. If the prisoner has been under constant video surveillance and nothing untoward has been observed the waking of the prisoner may be overly intrusive.*

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[69] T.316-317.

[70] T.317.

53. Relevantly, this instruction, seems to require that a prison officer undertaking observations who is not able to establish that a prisoner is "…*breathing* [71]*or alive*…", (a choice which presents its own dilemma) should consider the prisoner's access to articles with which they may harm themselves before waking-up the prisoner to establish whether the prisoner is "…*breathing or alive*." Ms James readily agreed with Ms Isobel that the instruction accurately reflected how she understood her obligations to undertake observations of Ms Hughes.

54. Ms James last observation of Ms Hughes, at 6.50am and that she "…*appeared asleep on her left side*…". Ms Gardner asked if when she made that observation that Ms Hughes was:

> "…*lying sideways across the bed with her head against the wall and her feet of the ground*…

She, Ms James replied:

> "*Like…I said I can't recall now, but, no, because I would have written something different in the observation book….If I had seen that , yes, I would have called a code…. Code black, which, um, makes the compound aware that there's an issue, yeah, that it's a medical issue*."[72]

55. It is not clear that Ms James would have conducted observations of Ms Hughes differently had she known that Ms Hughes had been subject to an 'at risk assessment' during the afternoon of 25 January particularly if Ms James had been aware that that assessment did not result in any change of P or S rating.[73]

Evidence of Mr A. C. Carabot

56. Mr Carabot made two written statements for the Inquest Brief[74] and gave viva voce evidence.

57. Mr Carabot's statements and his viva voce evidence explained the operation of the video monitoring and recording system in place in Swan 2 as at January 2017. In short, the

[71] T.321

[72] T.323.

[73] T.327-335

[74] Exhibit 9 & 10.

views of a number of cameras installed in the Swan 2 Unit could all be monitored via screens in the officer's post, but the system did not record all of each camera's views; only the view of one camera at a time was recorded. Which camera's view was being recorded was able to be selected from, amongst other locations the 'officers' post. Ms James doing her rounds and making her observations of prisoners in their cells overnight was not recorded. Mr Carabot's evidence was to the effect that before the end of October 2018 the system changed, more cameras were installed, and the system altered so that all views of all cameras were recorded.[75]

CONCLUSIONS

58. 'At risk assessments' are ephemeral; a change in any of the circumstance extant when the assessment is made may undermine, if not invalidate its accuracy. Such changes include a person's mental and emotional state as influenced by internal personal factors or external factors, or indeed both. Such changes may not be noticeable.

    The accuracy and utility then of hourly assessment much beyond the time at which is was made may vary considerably. This inherent dynamic quality of assessments makes those having been assessed vulnerable to self-harm.

59. Those who have undergone assessments know the shibboleths, reference to which will result in an assessment conferring maximum liberty. Some have been known to manipulate this process to provide themselves with the time, space and privacy to carry-out a settled self-harm plan.

60. It would have been preferable if Nurse Pare was able to undertake his assessment of Ms Hughes with her out of the cell or him in it,[76] he may then have been able to see the marks on her neck which had caused the prison guards concern although on his evidence, which I accept, that may not have made any difference to his assessment.

61. Nurse Pare also gave evidence that after he had read Ms Hughes medical file and became aware of her mental health history including her history of denying having harmed herself, he could have changed her S and P ratings and her observation regime. His evidence was that even taking all that into account he saw no reason to alter her S or P ratings or to increase the frequency of observations. Nurse Pare did however concede that rather than Ms Hughes being assessed as S4 that given her history of risk of suicide

[75] T. 344-347.

[76] T.219. (Evidence of Dr Jindal).

or self-harm Ms Hughes probably should have been rated S3. Such a rating would have indicated that there was a potential risk that Ms Hughes would harm herself or suicide. Such a change is however unlikely to have made any difference to the manner and timing of Ms Hughes death. Nurse Pare gave evidence that he was comfortable with his assessment of Ms Hughes at the time of the assessment and remained so when he gave evidence – there is no evidence impeaching that assessment begging the question what moved Ms Hughes from being at potential risk of self-harm when he assessed her to taking her own life.

62. Nurse Pare commenced undertaking his assessment at approximately 3.05pm.[77] Prison Officer James observation sheets record her seeing Ms Hughes alive at just before 7.00am, 26 January although when giving evidence she was unable to be clear about what she saw through the cell door window at about 4.00am, 5.00am, 6.00am and 7.00am that led her to believe that Ms Hughes was then alive.[78] The Observation record clearly refers to Prison Officer James seeing Ms Hughes standing in her cell shortly before 3.00am. Given that if something changed, whatever changed in Ms Hughes circumstances between when Nurse Pare assessed her and her taking her own life could, and in these circumstances likely was, unobservable by Prison Officer James. How hourly observations by Prison Officer James through the window in the cell door could function to mitigate any changing risk of suicide of self-harm is unclear. The only function the observations seem to have is either to seek to discover Ms Hughes in the act of at least harming herself and to interrupt her or of discovering her shortly after she had harmed herself either injured or dead and so increases the effectiveness of any resuscitation attempts. Given the overt nature of observations and their regularity the former is at least likely to fail because Ms Hughes would know when she was going to be checked by the on-duty officer. The latter is simply not an effective mitigation strategy – it maybe an hour between a suicidal act and a prisoner effected by it being discovered.

63. Prison Officer James observing Ms Hughes "*APPs asleep*" is not an observation that could reasonably be considered to establish that Ms Hughes has not harmed herself. Waking-up prisoners on hourly overnight observations to ensure that they are alive and well is unreasonable. The dilemma is clear.

[77] T.332.

[78] T.309-313.

64. It is to be borne in mind of course that because Ms Hughes had been observed by prison officers to have bruises around her neck and had suggested to Prison Officer McDonald that she might harm herself an 'at risk' assessment was sought. Ms Hughes is said to have become aware of the pending assessment, became angry and "…*confrontational toward…*" prison officers and was locked in her cell in Thompson 3 pending the assessment.[79] After the assessment Ms Hughes was transferred to Swan 2 on hourly observations. These observations were not ordered by Nurse Pare as a result of his assessment although he was aware that they were to occur, but rather, as a part of the management of Ms Hughes' angry confrontational conduct.[80]

    It is to be recalled that Prison Officer James knew that the hourly observations were not instigated by Nurse Pare out of concern that Ms Hughes may harm herself but were a part of managing Ms Hughes. Prison Officer James gave evidence that overnight on 25 and 26 January that she did not know that Ms Hughes had been the subject of an 'at risk assessment' on 26 January and that if she had been she may have spoken to her when she saw her standing up in her cell at about 3.00am but that otherwise the manner in which she undertook the hourly observations "…*would have been the same*."[81] The utility of any discussion at about 3.00am is unknown and, frankly, unknowable.

65. Had Nurse Pare decided that Ms Hughes should be placed on hourly observations as a result of his 'at risk assessment' such observations would have been conducted in largely if not entirely the same way as Prison Officer James undertook her observations of Ms Hughes and would have been of very limited utility in preventing Ms Hughes suicide.

66. As a result of Ms Hughes Death 'Justice Health', a part of the (then) Department of Justice and Regulation of the Victorian Government and the 'Justice Assurance and Review Office' a part of the then Department of Justice and Community Safety of the Victorian government drew reports. 'Justice Health' commissioned an independent review of Nurse Pare's 'at risk assessment' of 25 January ("The Review").

67. The Review made 19 recommendations.

Counsel's Submissions

[79] Statement of Ms. M. McDonald – Exhibit 2. pp.2-4.

[80] Statement of Mr K. Pare - Exhibit 7.p4., T 327.

[81] T.329 – 335.

68. The Court has the benefit of written submissions from Counsel who appeared for Correct Care Australasia, the Secretary to the Department of Justice and Community Safety and Forensicare.

69. Mr Ajzensztat's submissions on behalf of Forensicare deal with some legislative issues, consideration of which provide a context on which to consider more substantive issues.

70. I accept Mr Ajzensztat's submission that the Act requires the Court to make the findings set-out in section 67(1) together with comments and recommendations without apportioning blame or civil or criminal liability.

71. The provision of the Act facilitating a Coroner making comments is broad but constrained to "*…any matter connected with the death including matters relating to public health and safety or the administration of justice*."[82] The power to make recommendations is similarly broad and constrained, "*…to any Minster, public statutory authority or entity on any matter connected with the death…including recommendations relation to public health and safety or the administration of justice*."[83]

72. Mr Ajzensztat submits that "*…under the Coroners Act 2008 (Vic) there is no occasion for a coroner to make findings as to the identity of any person who contributed to the death*".[84] and that a coroner's obligation as set-out in section 67(1)(b) "*…is generally taken to mean the medical cause of death including the mode or mechanism of death.*"[85] The second proposition was not supported by authority. What Mr Ajzensztat means by "*…there is no occasion for a coroner to make findings as to the identity of any person who contributed to the death…"* is unclear.

73. In *Keown v Khan* his Honour Justice of Appeal Callaway said that a coroner is not concerned with questions of law but rather the coroner is to find the facts from which others may, if necessary, draw legal conclusions. His Honour referred to 'the Norris Report', which amongst other things set-out the function of future inquests:

[82] Section 67(2)(iii)

[83] Section 72(2).

[84] Submissions on Behalf of Forensicare [2].

[85] Submissions on Behalf of Forensicare [4].

"*…In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest requires without deducing from those facts any determination of blame"*[86]

74. In *Keown v Khan* Callaway JA said that a requirement in the then current legislation that a coroner should, where possible, identify any person who contributed to the cause of death served no purpose because the issue of 'contribution' was contemplated by a consideration of whether a person's act or omission was a cause of the death.[87]

"*The findings by a coroner as to how death occurred and the cause of death should, where that is possible, identify any person who contributed to the cause of death. Section 19 (1)(e) serves no purpose other than to ensure that that is done. The reference to contribution to the cause of death reflects the commonplace truth that it is sufficient if a person's acts or omissions are a cause of a relevant event… The test of contribution is solely whether a person's conduct caused the death. It may have been the only cause or one of several causes... In determining whether an act or omission is a cause or merely one of the back-ground circumstances, that is to say a non-causal condition it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty but that is the only sense in which para (e)mandates an inquiry into culpability."*[88]

75. His Honour said that a coroner is required to set out the relevant facts in the course of a finding in relation to how death occurred and the cause of death. The facts will then speak for themselves. His Honour called for the repeal of section 19(1)(e) because he considered it otiose.

"*...the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest requires, without deducing from those facts any determination of blame. The findings of the coroner or jury should in terms be findings of fact only. The findings by a coroner as to how death occurred, and the cause of death should where that is possible identify any person who contributed to the cause of death. Section 19(1)(e) serves no purpose other than to ensure that this is done. The reference to a contribution to the cause of death reflects the commonplace*

[86] *Keown v Khan* (1999) 1 VR 16. p.75.

[87] *Keown v Khan* (1999) 1 VR 16.p.76.

[88] *Keown v Khan* (1999) 1 VR 16.p.76.

truth that it is sufficient if a person's acts of omissions are a cause of a relevant death.[89]

76. To the extent then that Mr Ajzensztat submits that a coroner's obligation only requires findings in relation to a medical cause of death, and separately the "*…mode or mechanism of death…*" and does not require a determination of whether any identified person's act or omission was a cause of the death it cannot be accepted. The identity of a person whose act or omission is determined to be a cause of the death is a relevant fact to be set-out by the coroner in findings.

77. A coroner's obligations include a requirement to set-out the facts constituting the cause, or indeed causes of death including, where another person's act or omission was such a cause, separately from findings in relation to "*…the mode or mechanism of death.*" and "*…background circumstances…non-causal conditions.".* These obligations extend to, in some cases, considering whether a person's act or omission departed from a norm or standard, or whether an omission was in breach of a recognised duty. A finding that a cause of death was conduct that departed from a norm or standard or that an omission was in breach of a recognised duty does not, *ipso facto*, attribute blame or liability. Consider the distinction drawn by his Honour Justice Callaway between 'self-defence' and 'lawful self-defence in *Keown.* I can see no reason, far less any compelling reason, for a person whose act or omission is found to have been a cause of the death for that person not to be identified in the coroner's findings. Indeed, if section 19(1)(e) is otiose as described by Justice Callaway such identification is required.

78. A finding that Nurse Pare or Forensicare breached a duty that either or both owed to Ms Hughes based on the way in which Nurse Pare conducted the 'at risk assessment' of her on 25 January 2016 would not, in and of itself, attribute blame or liability on Nurse Pare or his employer but may result in a finding that the manner in which the assessment was conducted was a cause of Ms Hughes' death. Such a finding would however be a significant one for Forensicare and Nurse Pare and should only be made on the basis of considerable cogent evidence, which is here absent. Indeed, as I earlier set-out 'at risk assessments' are based on dynamic, ephemeral and somewhat nebulous considerations. On the evidence before the Court Nurse Pare's assessment is properly characterised as a background circumstance to Ms Hughes' death.

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[89] *Keown v Khan* (1999) 1 VR 16. pp. 75-76.

79. Developing practices and protocols that are sensitive to the dynamic nature of 'at risk' assessments would help protect those who are subject to changes in mental state that give rise to self-harm. Continuously monitoring the vital signs of those at risk of self-harm and suicide may indicate a change in mental state and perhaps signal the need for immediate attention. Such monitoring may, at the very least, provide an early opportunity to commence resuscitation of a prisoner who has suicided.

    In the not-too-distant past, continuous monitoring of vital signs could only be achieved by connecting people to various 'machines' with wires. Relatively recent technology allows monitoring of at least some vital signs by devices resembling watches and wireless broadcasting of the monitored date may also be possible.

    I am conscious that a suggestion that prisoners considered to be at risk of self-harm or suicide be subjected to their vital signs being remotely monitored by prison officers might be considered at least novel, but I see no reason for the efficacy and effectiveness of such monitoring not to be properly researched and considered. Clearly this raises privacy and other issues but a reduction of the number of deaths of prisoners by their own hand demands broad, innovative and determined consideration.

80. I note the Justice Health Report into Ms Hughes' death makes no recommendations but that it refers to Justice Health commissioning an independent review of the "*…At Risk assessment and mental health (and where relevant primary health) care received by Ms Hughes on 25 January* 2017).[90] ("Independent Review") The Independent Review makes 19 recommendations.[91]

81. In her submissions made on behalf of the Secretary to the Department of Justice and Community Safety Ms Isobel refers to the 4 of those 19 recommendations dealing with the operations of Corrections Victoria[92] and provides a 'Justice Health Action Plan' for implementing those recommendations.

82. In her submissions made on behalf of Correct Care Australia Ms Gardner refers to an 'Action Plan', a part of Ms Fuller's[93] statement, dealing with the implementation of the relevant Independent Review recommendations as well as setting out innovations made

[90] Inquest Brief pp.351-352. "Independent Mental Health Review" Inquest Brief pp.348-379.

[91] Inquest Brief pp.376-377.

[92] Submissions of Secretary to the Department of Justice and Community Safety [50].

[93] Statement of Ms C Fuller, Deputy Chief Executive Officer Correct Care Australia, dated 18 October 2019 Inquest Brief p. 48.3.

by Correct Care Australia, some of which were implemented in conjunction with Forensicare. Ms Gardner refers to:

- Changes to protocols in relation to the conduct of 'at risk' reviews including that such reviews are undertaken by Forensicare staff rather than Correct Care Staff.
- Sharing of 'discharge summaries' from Forensicare with Correct Care Australia
- Changes to documentation to be completed as a part of at-risk assessments.
- Changes to documentation detailing material, including that available on JCare to be considered by mental health nurses undertaking at risk assessments.
- Re-enforcing that conducting an at-risk assessment is a significant process that potentially involves life and death issues.
- Review and 'improvement of documentation utilised by prison officers when undertaking observations of those who had recently been subject to at risk assessment.

83. In his submissions made on behalf of Forensicare Mr Ajzensztat canvasses Ms Hughes' treatment by Forensicare concludes:

    "*…It follows therefore that there is no evidence that links in any way Ms Hughes' suicide on 26 January with any suicidal thoughts, ideation or intent from her time as a Marmak outpatient.*"[94]

84. This submission seems to treat incidents of suicidal thought as being siloed. Dr Jindal's and Dr Barnes' evidence considers the condition of Ms Hughes' mental health a continuum along which, from time-to-time thoughts of self-harm are stronger and weaker including to the extent that they may become absent. Post Ms Hughes having been sentenced, 8 November 2016, and on her own instigation she ceased some of her medication. Her condition was monitored by Dr's Jindal and Barnes until she was discharged from Marmak outpatients on 18 January2016. Dr Jindal and Dr Barnes were conscious of Ms Hughes' change in medication regime and the effects. Mr Ajzensztat's submissions contain a number of references to evidence of Ms Hughes denying thoughts of suicide or self-harm.[95] Part of the difficulty of assessing potential for self-harm is that there are few if any objective measures of state of mind. All these matters, variation in thoughts of self-harm and reliance of self- reporting of state of mind demonstrate the

[94] Submissions on Behalf of Forensicare [27]

[95] Submissions on Behalf of Forensicare [16-[25].

difficulty of assessing the potential for suicide and self-harm and highlight its ephemeral nature.

85. Constant monitoring of vital signs (after assessment) is one way of trying to come to grips with an assessment of the potential for suicide or self-harm only being, at best, accurate at the time when it is made. It may be considered the braces for the belt; both of which are desirable for prisoner safety.

86. I endorse the manner in which Forensicare, Correct Care Australasia and The Department of Justice and Community Safety have dealt with the recommendations set-out in the Independent report and the other steps they have each taken to augment the safety of prisoners at the Prison.

87. Below I have recommended that the Secretary of the Department of Justice and Community Safety investigate the viability of the vital signs of prisoners rated S1-S3 be recorded and monitored and that prisoner officers be immediately notified of any aberrant variation. This recommendation may be considered *avant-garde* if not controversial and so I shall flesh it out.

88. I am conscious that currently, many small devices including narrow wrist bands, devices resembling watches and even rings are capable of monitoring and recording a person's vital signs[96] as well as 'wirelessly transmitting' the monitored data. Such information could considerably support the safety of relevant prisoners who may be locked alone in a cell for a great majority of each day as well as relieving prison officers of the need to look through the windows in cell doors to check occupants for signs of life.[97] Monitoring such information would also be far less intrusive on prisoners than a prison officer regularly looking into the prisoner's cell. Medical advice would inform a decision about which vital signs would be usefully monitored. Rather than prison officers being required to make assessments about what readings are aberrant, medical advice might be sought to effectively 'set alarms' when an 'aberrant reading', one outside what is considered normal parameters is recorded. For example, if data from a prisoner indicates that at 3.00am their pulse and respiration has stopped, a prison officer who is immediately notified could immediately go to the prisoner's cell and perhaps

[96] Vital Signs are conventionally considered to be 1. Body Temperature, 2. Pulse Rate and 3 Respiration Rate, 4.Blood Pressure.

[97] The effectiveness of which, according to the evidence in this matter, may be unreliable.

commence resuscitation. That resuscitation is considerably more likely to be effective vis-à-vis resuscitation commenced an hour or more after cessation of pulse and respiration.

Implementation of any such strategy may face considerable opposition but anticipation of resistance ought not bar consideration of the viability of a process that may considerably support prisoners in crisis and potentially reduce the number of deaths in prisons.

MATTERS IN RELATION TO WHICH FINDINGS MUST, IF POSSIBLE, BE MADE

89. Having investigated Ms Hughes' death and held an inquest pursuant to 67(1) of the *Coroners Act* (2008), I find that:

- The identity of the deceased was Michelle Hughes born 6 July 1963.
- Ms Hughes' death occurred:
  - On 26 January 2017 at the Dame Phyllis Frost Centre, 101 Riding Road Ravenhall, Victoria;
  - as a result of '*Ligature Strangulation'* and
  - in the circumstances set out in paragraphs 58-67 above.

RECOMMENDATIONS

90. Pursuant to section 72 of the Act I recommend that:

> The Secretary of the Department of Justice and Community Safety investigate the viability, utility and implementation of a process by which vital signs of prisoners at the Dame Phyllis Frost Centre who are assessed as S1 – S3 can be continually remotely electronically monitored and recorded 'in real time' and in such a manner that prison guards are immediately alerted to aberrant fluctuation.

PUBLICATION

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

DISTRIBUTION

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

Ms Rebecca Falkingham - Secretary to the Department of Justice and Community Safety

Dr Emma Cassar - Commissioner of Corrections

Ms Tania Scally - Executive Director Justice Health

Ms Allison Will - Director Justice Health

Ms Donnacha Keniry - Registered Nurse, Clinical Nurse Consultant, Mental Health and Specialised Services – The Park-Centre for Mental Health, West Moreton Hospital Health Service

Ms Tracey Jones - General Manager Dame Phyllis Frost Centre

Mr John Hoogeveen - Managing Director Correct Care Australasia

Dr Margaret Grigg- Chief Executive Officer Forensicare.

Detective Senior Constable Jurilj - Coronial Investigator

Signature:

DARREN J BRACKEN

CORONER

Date: 22 February 2022.