IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004889

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of Jessica Anne Thomas

Findings of:	Coroner Simon McGregor
Delivered at:	Coroners Court of Victoria
Delivered on:	16 October 2024
Hearing date:	16 October 2024
Keywords:	In custody, suicide, mental health, gender diversity
Police Coronial Support Unit:	Leading Senior Constable Premala Thevar
Instructing Solicitor:	Fiona Ransom
Counsel for the Secretary to the Department of Justice and Community Safety	Liam Brown SC with Rose Singleton Instructed by MinterEllison
Counsel for Forensicare	Morgan McLay Instructed by K & L Gates
Counsel for Western Health	Jessica Jones Instructed by HWL Ebsworth Lawyers
Counsel for WorkSafe Victoria	Georgina Rhodes Instructed by Alex Hillgrove

I, Coroner Simon McGregor, having investigated the death of Jessica Anne Thomas, and having held an inquest in relation to this death on 16 October 2024, make findings as follows.

INTRODUCTION

1. On 2 September 2023, Jessica Anne Thomas (Jezza) was 33 years old when they passed in custody at Dame Phyllis Frost Centre, 101-201 Riding Boundary Road, Ravenhall Victoria 3023.

2. Jezza was a gender-diverse person who used male, female and non-binary pronouns in different periods of their life.[1]

3. At the time of their death, Jezza was remanded in custody at the Dame Phyllis Frost Centre, Ravenhall. They were remanded into custody on 28 July 2023, following an incident where they set fire to their residential home unit in Dandenong.[2]

4. Jezza also had a significant prior criminal history, including the following prior convictions:

    a) On 13 September 2012, Jezza was sentenced to 42 days imprisonment for charges including assault with a weapon and making threats to kill;

    b) On 21 February 2013, they were sentenced to 2 months imprisonment for assaulting a police officer;

    c) On 6 May 2013, they were sentenced to 3 months imprisonment for the armed robbery of a service station in Strathdale;

    d) On 24 April 2019, they completed a 4 month good behaviour undertaking for a charge of assault which was subsequently dismissed; and

    e) On 21 October 2021, they were sentenced to 30 days imprisonment for affray and assaulting an emergency services officer.

5. Jezza had a number of complex diagnoses including schizoaffective disorder (with a differential diagnosis of bipolar disorder), borderline personality disorder, post-traumatic

[1] Statement of Dr Shakira Kumar, p 44.
[2] Ibid, p 52.

stress disorder, antisocial personality traits and substance use disorder.[3] Jezza had a chronic high risk of self-harm behaviour and suicide and had attempted suicide numerous times in the past.[4]

THE CORONIAL INVESTIGATION

6. Jezza's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is subject to both a mandatory initial report and subsequent inquest by the Coroner, even if the death appears to have been from natural causes.[5]

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jessica's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Jezza including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[3] Statement of Dr Shakira Kumar, p 49.
[4] Ibid, p 49.
[5] Section 52(2) of the Act.

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[6]

11. In considering the issues associated with this finding, I have been mindful of Jezza's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

12. At the time of their passing, Jezza was being held in the Marrmak Unit, a 20-bed inpatient Mental Health Unit, within the Dame Phyllis Frost Centre (**DPFC**). The Marrmak Unit cares for prisoners in the acute and sub-acute phases of serious mental illness, and those assessed as high risk for self-harm or suicide related to serious mental illness.[7]

13. While on the Marrmak Unit, Jezza had been involved in a number of incidents including self-harm, threats of self-harm, an assault on staff, and assaults against other prisoners.[8] Their psychiatric health and self-harm risk was continually monitored, re-assessed and calibrated during this time.

14. Between 28 July and 2 September 2023, Jessica had regular (almost daily) phone contact with their father, Mark Thomas. Their conversations were general in nature and often touched on the state of their house following the fire and the possibility of salvaging any property from the burnt unit. Their last call was on 1 September 2023 at 3:33 pm. Jezza asked Mark if they had managed to salvage anything from the clean-up of their house. Mark explained that "It was a mess" and they only managed to get a few items. The remainder of the call was about the cleaning of the house, with Jezza requesting that Mark thank the others that assisted with the clean-up.

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

[7] Statement of Dr Shakira Kumar, p 45.

[8] Ibid, p 50.

15. On Saturday 2 September 2023, prison officers conducted a count of the prisoners on the Marrmak Unit. At 11:16 am that morning, Jezza was sighted and counted by staff who spoke to Jezza while they were in their cell. After being counted, Jezza then closed their cell door.[9] CCTV footage from the Marrmak Unit shows Jezza's cell door open slightly at 11:21 am before closing again.

16. At approximately 11:35 am prison staff noticed what appeared to be the end of a bed sheet protruding from the closed door of Jezza's cell. Prison Officers immediately attended. On opening the cell door, staff observed Jezza, unresponsive, drop to the ground from behind the door, with a ligature fashioned out of a ripped pillow slip around their neck.[10]

17. A Code Black was immediately called with prison officers and medical staff responding.[11] CPR was commenced by staff, with Ambulance Victoria Paramedics arriving a short time later, however Jezza could not be resuscitated and was declared deceased at 12:00 pm.[12]

18. At the time of their death, Jezza was subject to a S4 rating for risk of suicide and self-harm and was not on regular observations by staff, other than regular prisoner checks conducted of all prisoners on the unit.[13] This rating was reasonable and appropriate given the tone of their recent interactions with staff.

Identity of the deceased

19. On 2 September 2023, Jessica Anne Thomas, born 15 November 1989, was visually identified by their custodian, Ms Joy McDonald. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. Senior Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an external examination on 4 September 2023 and provided a written report of his findings dated 7 September 2023.

[9] Statement of Prison Officer Richard Detar, p 81.
[10] Statement of Prison Officer Jessica Byrnes, p 99.
[11] Statement of Prison Officer Jessica Byrnes, p 99.
[12] Statement of Dr Terry Runciman, p 58.
[13] Statement of Dr Shakira Kumar, p 56.

21. The examination showed a ligature abrasion around the neck. No unexpected signs of trauma were seen, although the post-mortem CT scan showed evidence of previous surgery to the gallbladder and right hip. Bilateral anterolateral rib fractures were also seen, consistent with the history of resuscitation attempts. No other significant pathology was identified.

22. Dr Young explained that hanging is a form of asphyxia due to compression of the neck structures by a ligature tightened by the weight of the body. Death may be due to reflex cardiac arrest, occlusion of the blood vessels of the neck or airway obstruction. In cases of hanging, unconsciousness can occur very rapidly, and death follows shortly after.

23. Toxicological analysis of post-mortem samples identified the presence of therapeutic doses of Aripiprazole,[14] Clonazepam,[15] Risperidone,[16] Valproic Acid,[17] Promethazine[18] and Olanzapine.[19] The samples did not identify the presence of any alcohol or other common drugs or poisons, apart from Cannabis, which Jezza acknowledged regularly consuming before their sentence began, and which would still have been gradually releasing back into their blood stream from storage in fatty tissue.

24. Dr Young provided an opinion that the medical cause of death was 1(a) neck compression secondary to 1(b) hanging, and I accept his opinion.

REVIEW OF CARE

25. The Justice Assurance and Review Office (**JARO**) provides advice to the Secretary of the Department of Justice and Community Safety (**DJCS**) on the performance of corrections and youth justice systems by reviewing deaths in custody, including any Justice Health component. Justice Health is responsible for the oversight of primary health services for people in Victorian prisons. JARO investigated Jezza's passing and prepared the *Review into the death of Jessica Thomas at Dame Phyllis Frost Centre on 2 September* 2023 dated 13 September 2024.

[14] An antipsychotic drug.
[15] A nitrobenzodiazepine, indicated for the treatment of seizures.
[16] An antipsychotic drug.
[17] Valproic acid (dipropylacetic acid, divalproex, sodium valproate) is indicated for epilepsy.
[18] An antihistamine.
[19] An antipsychotic drug.

26. The JARO report also helpfully appended the Office of the Chief Psychiatrist's (**OCP**) *Review of Death – JT* dated April 2024. The role of the Chief Psychiatrist is to promote the highest standards of clinical practices and care and promote the rights of persons receiving mental health and wellbeing services. With the introduction of the *Mental Health and Wellbeing Act 2022* on 1 September 2023, the Chief Psychiatrist's powers and responsibilities of oversight expanded to include custodial settings where forensic mental health and wellbeing services are provided.

27. Both these reviews made insightful recommendations from their differing institutional perspectives. In considering whether to adopt or endorse these recommendations, I have been assisted by submissions from the interested parties.

28. I accept the submission made on behalf of Forensicare that the recommendations made by the OCP effectively identify areas that warrant further consideration by Forensicare and other service providers within the justice system, rather than specific prevention opportunities arising out of Jezza's circumstances.

29. I accept also that work has already begun in implementing necessary practice and service provision improvements identified by the JARO review since Jezza's passing. Rather than repeat those, I shall restrict my sole recommendation to the 'unfinished business'. I shall, however, record here my commendation of the interested parties for their prompt acceptance of, and action taken to date in relation to a number of recommendations made by JARO and the OCP, including, notably, recommendations that:

    a) Health Service Providers undertake an audit to determine if reception health assessments are being conducted in line with current Health Services Quality Framework and health service provider policy and provide Justice Health with an action plan to address non-adherence;[20]

    b) Corrections Victoria amend existing policy to include governance and assurance measures to support the development and implementation of Intensive Case Management Plans;[21]

[20] *Review into the death of Jessica Thomas at Dame Phyllis Frost Centre on 2 September 2023* (13 September 2024), Recommendation 1. ('JARO report')
[21] Ibid, recommendation 2.

c) DPFC develop a process for a formalised handover between custodial and Forensicare staff in the Marrmak unit of any information relating to priorities and activities relevant to the operation continuity of care for people accommodated in of Marrmak[22]; and

d) DPFC consider options for delivering specialised training for custodial staff within Marrmak to equip them with skills to manage complex people in custody.[23]

30. The unresolved remaining issue identified during the JARO review is whether Corrections Victoria ought develop a process that requires custodial staff to record a person's gender identity on the Prisoner Profile Screen within the Prisoner Information Management System (PIMS) once custodial staff have identified or become aware that a person in custody is transgender, gender diverse or intersex.

31. I make no finding that the absence of this functionality contributed to Jezza's passing, but echo the comments of JARO that gender diverse people face unique vulnerabilities in the correctional environment and failure to affirm and support gender identity can be particularly harmful. In recognition of these vulnerabilities, use of preferred names and preferred pronouns can and should be facilitated by making that information more easily accessible to clinical and custodial staff where possible.

32. The Secretary observed that information in PIMS is available to all custodial staff, and that some individuals in custody do not wish to disclose their gender identity to all custodial staff. They further submitted that gender identity, if self-disclosed by persons in custody, can currently recorded in the person's Individual Management File, JCare file, and Corrections Victoria Intervention Management System (for clinical support). Accordingly, it is information that is already recorded in a number of accessible locations. Finally, they submitted that since gender can be fluid, and the gender identity of a person in custody may change, this would create difficulty with the accuracy of the information in PIMS.

33. Many other aspects of the information which is central to the safe management and rehabilitation of prisoners is also subject to change, so that difficulty appears to be surmountable given the expertise already at the Secretary's disposal.

[22] Ibid, recommendation 3.
[23] Ibid, recommendation 5.

34. Insofar as the gender identity information is already recorded elsewhere within the system, it seems to invite inconsistency or incoherence not to give prisoners the opportunity, without it being a requirement, to further share that information on PIMS so their custodial management can take it into account at all times, and I shall adjust the wording of the recommendation accordingly.

FINDINGS AND CONCLUSION

35. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jessica Anne Thomas, born 15 November 1989;

    b) the death occurred on 2 September 2023 at Dame Phyllis Frost Centre 101-201 Riding Boundary Road Ravenhall Victoria 3023, from neck compression secondary to hanging; and

    c) the death occurred in the circumstances described above.

36. Having considered all of the circumstances, I am satisfied that Jezza intentionally took their own life.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

> That Corrections Victoria give consideration to developing a process that gives prisoners the option of allowing custodial staff to record a person's gender identity on the Prisoner Profile Screen within the Prisoner Information Management System.

I convey my sincere condolences to Jezza's family for their loss.

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

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

Mark Thomas, Senior Next of Kin

Debbie Thomas, Senior Next of Kin

Secretary to the Department of Justice and Community Safety, C/- MinterEllison

Forensicare, C/- K & L Gates

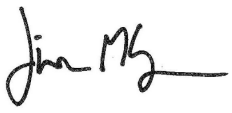
Western Health, C/- HWL Ebsworth Lawyers

Alex Hillgrove, WorkSafe Victoria

Mark Boscaglia, The Justice Assurance and Review Office

Senior Constable Sean Armstrong, Coroner's Investigator

Signature:



Coroner Simon McGregorDate : 16 October 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 investigation. 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.