IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6064

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	Dylan James Charlton-Smith
Delivered on:	8 March 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	19 January 2022
Findings of:	Katherine Lorenz, Coroner
Counsel assisting the Coroner:	Daniel Nguyen of Counsel instructed by Dylan Rae White, Senior Coroners Solicitor
Representation	Mr Nick Boyd-Caine of Counsel, for the family Mr Shane Dawson, Meridien Lawyers, for the GEO Group Ms Julie Buxton of Counsel, for the Department of Justice and Community Safety (Corrections Victoria)

INTRODUCTION

1. Dylan James Charlton-Smith (**Mr Charlton-Smith**) was born on 7 July 1993 and was aged 25 years when he died by hanging on 3 December 2018 while in custody in the Nalu Unit at the Fulham Correctional Facility (**FCC**).

THE CORONIAL INVESTIGATION

2. Mr Charlton-Smith's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) both because he was in custody at the time and further, his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.

3. Deputy State Coroner English had carriage of this investigation until I took carriage of it in February 2021.

Explanation of coronial investigations

4. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and, with some exceptions, surrounding circumstances.[1] Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

5. Under the Act, coroners have another important function and that is, where possible, to help prevent deaths and promote public health and safety by making comments or recommendations about any matter connected to the death they are investigating.

6. When a coroner examines the circumstances in which a person died, this is not to lay blame or attribute legal or moral responsibility to any individual or institution. Rather, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

7. Coroners do not make determinations of guilt or negligence; they are the province of other jurisdictions. Indeed, the Act specifically prohibits coroners from making a finding or

[1] The exceptions being cases where an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances: section 67 of the Act.

comment that a person has, or may have, committed an offence. A coroner should set out relevant facts, leaving others to draw their own conclusions from the facts.

8. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities with the *Briginshaw* qualification.[2] A finding that a person has caused or contributed to a death should only be made after taking into account the possible damaging effect of such a finding upon the character and reputation of that person and only if the evidence provides a comfortable level of satisfaction as to the finding.

The position of persons in custody or care

9. All deaths of persons deemed to be in the care or custody of the State are reportable no matter what the cause. Further, whereas a coroner usually has a discretion as to whether to hold an inquest into a reportable death, a coroner is obliged to hold an inquest into the death of a person in custody or care unless the death was due to natural causes.[3] Mr Charlton-Smith's death was clearly not from natural causes and so an inquest was mandatory.

10. The reason for this different treatment is to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

Sources of evidence

11. As part of the coronial investigation, the Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, other prisoners and prison staff.

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[2] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".*

[3] In general terms the other situations in which inquests must be held are suspected homicides (unless charges have been laid) and where the identity of the deceased is unknown: section 52 of the Act.

12. Additionally, the Court received reports from JARO and Justice Health regarding the circumstances leading to Mr Charlton-Smith's death. The interested parties also submitted additional material to assist the investigation to which I will refer below where relevant.

13. This finding is based on the coronial brief and the additional material submitted or tendered to the Court. It is unnecessary to summarise all this material, which will remain on the Court file.[4] I will refer only to so much of it as is relevant or necessary for narrative clarity.

BACKGROUND

14. Prior to and during his imprisonment, Mr Charlton-Smith was in a relationship with his partner, Ms Stacey Smith (Ms Smith). Ms Smith and Mr Charlton-Smith met when they were 19 and 18 respectively and had three children together.[3] They also parented Ms Smith's child from an earlier relationship.

15. Mr Charlton-Smith had previously worked as a rural fencer and in about March 2017, he had difficulties when he lost this job and his grandfather passed away.[5] According to Ms Smith, Mr Charlton-Smith 'resumed' using drugs and as a result, their family unit broke down.[6]

16. A police 'LEAP warnings report' records that on or about 29 March 2016, Mr Charlton-Smith rang 000 and stated he was going to hang himself.[7] The police attended and searched his house to find no person at home.[8] Mr Charlton-Smith was eventually contacted by phone and it was noted that he had 'continued suicidal thoughts re hanging' and that he said he 'had not slept in 5 days due to [an] ICE bender' and he 'was suicidal due to impact of drug use on her [sic] relationship'.[9]

17. Mr Charlton-Smith had an extensive criminal record with approximately 560 criminal charges dating back to when he was 14 years old. Most charges related to theft, burglary and motor vehicle offences.

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[4] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[5] Statement: Stacey Smith, p1, CB 15.
[6] Statement: Stacey Smith, p1, CB 15.
[7] LEAP Warnings report dated 4/4/16, CB 331-2.
[8] LEAP Warnings report dated 4/4/16, CB 331-2.
[9] LEAP Warnings report dated 4/4/16, CB 331-2.

18. Prior to his most recent term of imprisonment, Mr Charlton-Smith was subject to a Community Correction Order which he breached with further offending. This resulted in the custodial sentence.

19. He entered Melbourne Assessment Prison on 14 October 2018. Routine medical assessments were completed by a medical practitioner who noted a past medical history of asthma for which salbutamol inhaler was routinely prescribed (but not requested or used), and leg pain associated with a previous gunshot injury treated with pregabalin.[10] A substance use history established he regularly used cannabis, amphetamines and benzodiazepines but had not used in the two weeks prior, smoked 20+ cigarettes daily and there were no indications of withdrawal from any substance. No concerns regarding his mental health were noted.

20. A routine mental health intake assessment was completed by psychiatric nurse Sophia Pantagnan, who noted he had a history of contact with public mental health service Maroondah from the state wide Client Management Interface (**CMI**) which consisted of an acute stress reaction in 2011. The JARO Report notes Dylan was registered on the CMI because he had a history of drug and alcohol or other substances.[11]

21. The intake assessment noted he denied any mental illness, psychosis or depression, did not express any hopelessness or helplessness, was eating and sleeping, denied suicidal thinking, plan or intent and his mental state examination was unremarkable. He identified partner Stacey Smith and their children as a protective factor. He was assigned an E Justice risk rating of nil – psychiatric and S4 – suicide/self-harm – which represented a previous history of risk of suicide or self-harm.[12] Mr Charlton-Smith was first assigned the S4 rating on 7

July 2015 while serving a Community Correction Order. At that time, following screening on 5 August 2015, no further action had been required to manage his self-harm risk.

22. Suicide/self-harm ratings are referred to as 'S' ratings; there are four categories that range from S1 to S4 (S1 being currently at risk to S4 as not currently at risk.) The ratings denote the level of observation indicated by clinical assessment. These ratings are assigned by Justice Health clinicians and prison staff complete the observations.[13]

23. Psychiatric ratings are referred to as 'P' ratings and have four categories that range from P1 to P3 (P1 being a serious psychiatric condition requiring intensive and/or immediate care) to PA (suspected psychiatric condition requiring assessment.) The ratings denote the severity of an existing psychiatric condition and required intensity of care and treatment.

24. On 18 October 2018, Mr Charlton-Smith was transferred to FCC in Sale, and near where he and his family lived.[14] FCC is a medium security prison. It has been privately operating since April 1997 under a public private partnership contract between the state and GEO Group. At FCC, Mr Charlton-Smith was assigned E Justice ratings of S4 and M2 – medical condition requiring regular or ongoing treatment.[15]

25. On 30 October 2018, following review of his medical record by registered nurse Sally Tatnell, Mr Charlton-Smith was transferred to the minimum-security young offender

residential facility Nalu, which is located outside of the prison walls and focuses on preparation for release.

CIRCUMSTANCES OF DEATH

26. On 2 December 2018 at approximately 10:30am, Ms Smith visited Mr Charlton-Smith at FCC.

27. According to Ms Smith she had tried to cancel the usual weekend visit because she wanted a break, but Mr Charlton-Smith had become angry with her over the phone. Then a friend had told Ms Smith that Mr Charlton-Smith had had an alleged affair prior to going into prison, which distressed her, and she wanted to speak with him about it and other relationship issues.

28. Ms Smith was a regular visitor and would usually bring the children on visits.[16] On this occasion, she did not bring them.[17] Mr Charlton-Smith was angry that Ms Smith had not brought the children and when she asked about the alleged affair he became angry, derogatory and told her it was over.[18] Ms Smith left the prison and returned home.

29. Correctional Supervisor KPG[19] observed the visit as he thought it was unusual that Ms Smith had attended without the children. KPG observed a 'heated' discussion between Mr Charlton-Smith and Ms Smith and after the visit, KPG observed that Ms Smith seemed to be upset and Mr Charlton-Smith appeared agitated. KPG enquired of both Ms Smith and Mr Charlton-Smith but neither would discuss the details of the visit.

30. After the visit KPG checked with Ms Smith whether Mr Charlton-Smith would be okay and she said that he would.

31. KPG conducted a strip search of Mr Charlton-Smith at 10:55am, and at that time asked if Mr Charlton-Smith was alright, to which he said 'yes'.[20] KPG also asked if Mr Charlton-Smith

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[16] Statement: Stacey Smith, p1, CB 15.
[17] Statement: Stacey Smith, p1, CB 16.
[18] Statement: Stacey Smith, p 2, CB 17.
[19] A pseudonym.
[20] Statement: KPG, p1, CB 28.

wanted to talk about it and Mr Charlton-Smith said he did not.[21] Mr Charlton-Smith then returned to his room.

32. After this interaction, KPG was worried Mr Charlton-Smith might try to and visit Ms Smith. This was possible because the Nalu Unit is outside of the main section of FCC and is contained by a courtesy fence and it would have been possible for Mr Charlton-Smith to leave. Because of this concern, KPG undertook a number of actions:

    a. KPG asked a prisoner, LNI,[22] to speak with Mr Charlton-Smith.[23] He told LNI that Mr Charlton-Smith had a bad visit with his girlfriend and that he was concerned that Mr Charlton-Smith, being a local boy, might break out and 'do a runner'. He asked him to keep an eye on Mr Charlton-Smith, and to explain how good Mr Charlton-Smith had it in Nalu Unit and not to risk it.[24]
    b. KPG also asked Prison Intelligence Unit for (**PIU**) for a review of Mr Charlton-Smith's recent phone calls.[25]
    c. KPG then advised the Shift Manager, RWI,[26] about the situation.[27]
    d. PIU called KPG and advised that Mr Charlton-Smith's phone calls appeared OK; there was a little arguing about frequency of visits and that Ms Smith was going to bring the children in; Mr Charlton-Smith was a little upset but he never lost it.[28]

33. At about 11:45am, the Shift Manager advised KPG that staff would be sent over to relocate Mr Charlton-Smith to the main prison.[29] Mr Charlton-Smith was not informed of the decision to move him from Nalu to the main prison.[30]

34. In between LNI's conversation with KPG and muster being conducted, LNI knocked on Mr Charlton-Smith's cell door, went in, saw Mr Charlton-Smith facing the wall crying and asked if he was OK. Mr Charlton-Smith said 'no'. LNI asked Mr Charlton-Smith if he

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[21] Statement: KPG, p1, CB 28.
[22] A pseudonym.
[23] Statement: KPG, p1, CB 28.
[24] Statement: LNI (prisoner) CB 18.
[25] Statement: KPG, p1, CB 28.
[26] A pseudonym.
[27] Statement: KPG, p1, CB 28; note that shift manager RWI's statement (CB 39) is silent on this.
[28] Statement: KPG, p1, CB 28.
[29] Statement: KPG (Nalu Unit Supervisor), p1, CB 28; note that shift manager RWI's statement (CB 39) is silent on this.
[30] Melissa Westin (Acting Deputy Commissioner, Custodial Operations) letter to Coroner's Court dated 21 May 2020, CB 222.

wanted to talk and Mr Charlton-Smith said he did not. LNI then left Mr Charlton-Smith's room to give him some space and planned to speak to Mr Charlton-Smith again during muster.[31]

35. At 11:56am a 'code black' was called in Nalu Unit after LNI found Mr Charlton-Smith hanging having used a sheet as a ligature and bunk as a suspension point. LNI noted that Mr Charlton-Smith was 'very white', and his lips were 'blue'.

36. LNI tried to lift Mr Charlton-Smith but he was too heavy so he went to get help from another prisoner, HRM.[32] [33] They weren't able to loosen the sheet from Mr Charlton-Smith's neck and were struggling to hold him.[34]

37. LNI then alerted KPG who attended the room with another corrections officer, NEH,[35] to find prisoners LNI and HRM supporting Mr Charlton-Smith.

38. At about 11:56am, KPG told NEH to go get help and a defibrillator. When NEH ran to get the defibrillator, he also called a CERT 1 Code Black (serious medical emergency) response on his radio. When he went to retrieve the defibrillator, NEH had forgotten that he was carrying a Hoffman knife which is carried for the purpose of cutting ligatures.

39. After attempting to free Mr Charlton-Smith, KPG told HRM to get a knife from the kitchen outside. Prisoner HRM returned with a knife and was able to cut the sheet and they lowered Mr Charlton-Smith to the floor lying on his back. KPG recalled that this occurred about 1-2 minutes from when he had entered Mr Charlton-Smith's room.

40. K9 handler, SJC[36] attended to see Mr Charlton-Smith being taken down and both he and KPG began cardiopulmonary resuscitation (CPR) on Mr Charlton-Smith, alternating between themselves.

Medical response

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[31] Statement: LNI (prisoner) CB 18.
[32] A pseudonym.
[33] Statement: LNI (prisoner) CB 19.
[34] Statement: LNI (prisoner) CB 19.
[35] A pseudonym.
[36] A pseudonym.

41. The nurses were in the lunch-room when they heard the Code Black.

42. Nurses DSK[37] and TJO[38] went to the medical room to retrieve a Centre Emergency Response Team (CERT) bag and automated external defibrillator (AED) while nurse EKT[39] was directed to and did run to the Nalu unit.

43. As nurse EKT was making her way, she heard on the radio that they needed a defibrillator, so she went to get the keys for Nalu medical room but when she left the office, she saw NEH with a defibrillator and she followed him to the scene.

44. At about 11:59am, nurse EKT and NEH, with the defibrillator, arrived at the scene.

45. Nurse EKT made the following observations of Mr Charlton-Smith:

    a. incontinent of urine;
    b. centrally cyanosed;
    c. unresponsive;
    d. extensive bruising around neck, with creases in skin;
    e. mucous emitting from both nostrils.

46. Nurse EKT attached the defibrillator pads to Mr Charlton-Smith's chest. Shortly after, nurse DSK arrived and began to maintain Mr Charlton-Smith's airway. At that point, Mr Charlton-Smith's eyes were fixed and dilated.

47. The defibrillator showed, 'nil shock advised'. Nurse EKT ordered that an ambulance be called and assisted with CPR.

48. At about 12:02pm, Shift Manager RWI rang 000 and requested that an ambulance attend. FCC staff were deployed to meet with the ambulance and escort them to the scene.

49. Nurse TJO then arrived with the CERT bag and the air viva and oxygen bottle were taken out of the bag and applied to Mr Charlton-Smith with oxygen turned onto 10 litres per minute – it took two nurses to maintain his airway effectively.

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[37] A pseudonym.
[38] A pseudonym.
[39] A pseudonym.

50. At some point, the area was cleared by moving away all uninvolved persons and prisoners and the medical mule so that the ambulance could have better access on arrival.

51. At about 12:13pm, ambulance paramedics arrived and were escorted to Mr Charlton-Smith's room. The paramedics saw Mr Charlton-Smith lying supine on the floor with CPR in progress and a defibrillator 'insitu'. Paramedic Jenson observed that Mr Charlton-Smith had 'no palpable carotid pulse' and he 'was not spontaneously breathing'.

52. The paramedics did not have 360 degrees access to Mr Charlton-Smith, so he was moved from his room to the lounge area to provide for better access.

53. The paramedics removed the defibrillator pad applied by FCC staff as that one was not compatible with the paramedics' defibrillator and applied the Ambulance Victoria issued defibrillator. Rhythm analysis showed Mr Charlton-Smith had a 'non-shockable rhythm' and that it was 'asystole' (flat-lining).

54. At about 12:16pm, MICA paramedic Trevor Gibson arrived on scene and was directed to Mr Charlton-Smith's location. Paramedic Gibson observed Mr Charlton-Smith to be 'unconscious' and 'with no pulse or breathing'.

55. At about 12:20pm, paramedic Gibson inserted an intravenous cannula into Mr Charlton-Smith's right antecubital fossa and administered 1 mg of adrenaline.

56. At about 12:24pm, a second dose of 1 mg of adrenaline was administered and there was a change of heart electrical rhythm from asystole to ventricular fibrillation and Mr Charlton-Smith was then defibrillated at 200 joules. In other words, Mr Charlton-Smith was found to have a shockable rhythm once he had been administered with adrenaline and he was given a single shock via the paramedic's defibrillator.

57. An infusion of adrenaline was initiated at 100 micrograms a minute to maintain Mr Charlton-Smith's blood pressure.

58. At about 12:40pm, a second MICA officer arrived and took over airway control with the intubation of Mr Charlton-Smith.

59. A sedation infusion of morphine and midazolam was then initiated at 1 mg per hour.

60. At about 1:30pm, MICA flight paramedic Darren Hodge arrived, and he transported Mr Charlton-Smith by ambulance to the helicopter and at about 2:04pm, once Mr Charlton-Smith was stabilised, he was flown by helicopter to the Alfred Hospital.

61. On 3 December 2018 at about 4:20am, Mr Charlton-Smith was pronounced brain dead by medical staff.

INVESTIGATIVE REVIEWS

62. Prisoner deaths are not only investigated by coroners, but they are also routinely reviewed by an arm of government called the Justice Assurance and Review Office (**JARO)**. The JARO is a part of the Department of Justice and Community Safety (**DJCS**) and reports to the Secretary of that Department, as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders.[40]

63. In preparing its report for the Secretary, the JARO invariably has regard to a separate report prepared by another business unit of DJCS, namely Justice Health. Justice Health has responsibility for the delivery of health services (including drug and alcohol services) to Victoria's prisoners. At FCC, the primary health care provider is GEO Group.

64. Whilst coroners are, as a matter of course, provided with JARO and Justice Health reports, it is important to note that we remain independent investigators and form our own views of the matters in issue.

65. The Court received a confidential report from JARO dated 6 August 2019, which reviewed the circumstances leading to Mr Charlton-Smith's death. In summary, the JARO did not identify any failings and noted:

    a. He was a compliant and forward-looking prisoner. He did not present with behaviours that indicated suicidal ideations or express any self-harm thoughts during his last period in custody.
    b. His placement at FCC and the minimum security Nalu unit were suitable.
    c. His case management was appropriate.

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[40] Section 7 of the *Corrections Act 1986.*

d. On the morning of 2 December 2018, staff noted that Mr Charlton-Smith was unsettled after a contact visit with his partner and sought to put in place actions to reduce associated risks, including the risk of escape.
e. Medical staff were quick to respond once he was found.
f. Staff could not have anticipated his actions based on previous behaviour while in custody.

66. Justice Health commissioned a review of the health care provided to Mr Charlton-Smith in the lead up to his death and provided a report dated 6 August 2019. Justice Health concluded that there was nothing to suggest that the healthcare provided to Mr Charlton-Smith was not in accordance with the Justice Health Quality Framework 2014.

67. Following receipt of the Coronial Brief and the Health Justice Report and the JARO report, Deputy State Coroner English sought advice from the Coroner's Prevention Unit (**CPU**) about the mental health care provided to Mr Charlton-Smith while he was in custody. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised. Mr Charlton-Smith's case was reviewed by an experienced mental health investigator.

68. The CPU advised that the medical and psychiatric assessments for Mr Charlton-Smith at the Melbourne Assessment Prison and Fulham Correctional Centre were routine and appropriate. There were no indications of current psychiatric illness or suggestion of emerging pathology. He settled into the routine of Nalu Unit and had plans to complete further study, gain some local employment, and appears to have been well supported by his corrections case manager. He sought and received support from his partner and children, with stated goals to become a better father and more patient partner.

69. The CPU found that the findings in the JARO report were a reasonable assessment of the circumstances of Mr Charlton-Smith's death, which appeared to have been impulsive. The CPU did not identify any prevention opportunities.

70. I have noted the contents of the three investigative reviews, being the CPU review, the JARO review and the Health Justice Review and considered them in their context after reviewing all the evidence presented to the court and hearing the submissions of the interested parties. Whilst I have read and considered these reports, I have formed my own views about the circumstances of Mr Charlton-Smith's death based on all the evidence provided to the court.

INQUEST

71. The scope of this inquest was the subject of a directions hearing held on 29 July 2021. Following the directions hearing and carefully reviewing the available evidence provided as part of the original Coronial Brief and further material submitted by the interested parties, I made a ruling[41] that the following matters were causally related and proximate to Mr Charlton-Smith's death and fell within scope of this coronial investigation:

    a. Mr Charlton-Smith's placement at Nalu generally, his mental health history and any other significant risk factors relevant to his term of imprisonment.

    b. Mr Charlton-Smith's risk of self-harm or suicide following his partner's visit and the prison's response to that risk.

    c. The medical response, including:

        I. The adequacy of the mental health response.

        II. The adequacy of the resuscitation attempts including the availability of working equipment, particularly defibrillators.

        III. The adequacy of training of prison officers in recognising risks of self-harm and suicide and how to respond to such risks (together, the **Scope**).

72. Just prior to the inquest, I received written submissions from GEO Group on behalf of FCC and Mr Charlton-Smith's family. Representatives for the interested parties also made short oral submissions addressing the evidentiary issues set out in the Scope.

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[41] Ruling No 1, dated 27 October 2021.

Issue 1: Mr Charlton-Smith's placement at Nalu generally, his mental health history and any other significant risk factors relevant to his term of imprisonment.

73. Counsel for the family, Mr Boyd-Caine, submitted that during Mr Charlton-Smith's prison term, prison staff downplayed or ignored his psychiatric history and mental health. As a result, following Ms Smith's visit they 'were fundamentally unprepared to anticipate, engage with or respond to Mr Charlton-Smith's psychiatric needs resulting in Mr Charlton-Smith having the time and, crucially the freedom to successfully attempt suicide.'

74. Mr Boyd-Caine noted that evidence of self-harm and suicidal concerns was the reason Mr Charlton-Smith was assigned an 'S4' risk classification in the first place. As articulated in the Correctional Suicide Prevention Framework, such a rating does not only indicate a previous history of self-harming behaviour, but that given this history, the potential for suicide or self-harm or harming behaviour can escalate. The reason for Mr Smith's distress in 2016 were problems and breakdowns in his relationship caused by his drug taking.[42] Not only was this carried over in 2018, but the mode by which he threatened suicide, hanging, was also mentioned in prison documents in 2015 and 2016.

75. Mr Boyd-Caine further submitted that during his term at FCC, GEO Group staff failed to consider these risks and failed to put in a risk management plan for Mr Charlton-Smith despite his S4 rating and the instances of recorded suicidal behaviour in 2015 and in 2016. Had such a risk management policy been followed and had the required risk management plan been created, one of the key risk factors (and the protective factor) of his relationship with Ms Smith and their children would have provided prison staff with a greater understanding and capacity to respond to the risks following Ms Smith's visit.

76. Mr Boyd-Caine concluded that the failure to identify the mental health risk contributed directly to Mr Charlton-Smith's death in that it left FCC staff completely ill-equipped to respond to any incident that might place stress on Mr Charlton-Smith's relationship with his family. As such, Mr Boyd-Caine encouraged me to make a finding that staff failed to provide the correct level of care and engagement to Mr Charlton-Smith's psychological needs and a recommendation be made that all prisoners with a psychological rating be

[42] Mr Boyd-Caine cited that LEAP report at CB331 and 332.

provided appropriate care in line with the risk management self-harm and suicide management policy that GEO Group claims to have in place.

77. GEO Group submitted that Mr Charlton-Smith's placement in the Nalu Unit was appropriate and a number of reviews did not identify any concerns about Mr Charlton-Smith's mental health or any suicide or self-harm risks during his prison term.

78. The GEO Group referred to its At Risk/Self Harm/Suicide Management Policy dated 8 April 2015, which did not require any observation regime or ongoing monitoring of prisoners with S4 rating and did not make him ineligible for placement at Nalu. Further, GEO Group submitted that following Mr Charlton-Smith's screening in August 2015, no further actions had been required to manage his self-harm risk. All prisoners with a history of self-harm or suicidality were assigned an S4 rating, even if they are no longer considered to be a risk. The GEO Group concluded that the staff at FCC could not have anticipated Mr Charlton-Smith's suicide based on his behaviour in prison.

79. I accept that there was no evidence that prison staff, other prisoners, Mr Charlton-Smith or his family raised any concerns about his mental health, the risk of self-harm or suicide or his placement in the Nalu Unit before his death. With the benefit of hindsight, the sudden breakdown of his relationship with Ms Smith during the visit influenced his decision to commit suicide, but this decision appears to have been impulsive and prior to the visit, staff at FCC could not have anticipated that Mr Charlton-Smith would take his own life and reasonably believed that Mr Charlton-Smith was coping with prison at Nalu and looking forward to his release.

Issue 2: Mr Charlton-Smith's risk of self-harm or suicide following his partner's visit and the prison's response to that risk.

80. In his opening, Counsel Assisting, Mr Nguyen referred to a number of relevant factual issues, being that:

a. Following the visit, KPG made inquiries of both Ms Smith and Mr Charlton-Smith as to Mr Charlton-Smith's welfare and no significant concerns were raised by either of them.

b. There was a time lapse of approximately 50 minutes, from about 10.55am[43] (when Mr Chartlon-Smith was strip searched and asked about his welfare) to 11.45am (when Mr Charlton-Smith was found in his room) – for the prison to respond to any potential risk.
c. LNI saw Mr Charlton-Smith crying in his room, but it does not appear that this information was passed onto KPG or any prison staff.
d. After checking on Mr Charlton-Smith's welfare and satisfying himself that there was no risk, KPG perceived a 'flight risk' and he acted in accordance with that perceived risk.

81. The central premise of the family's submission was that in his behaviour immediately during and after Mr Charlton-Smith's visit from Ms Smith, KPG correctly identified a significant risk to Mr Charlton-Smith's psychological wellbeing, however in deciding that that risk was likely to manifest as an escape attempt by Mr Charlton-Smith rather than a risk of psychological or psychiatric ill health, KPG embarked upon a fundamentally flawed series of actions and decision-making that ultimately and directly contributed to Mr Charlton-Smith's death.

82. The arrival of Ms Smith at the prison without their children prompted KPG to enquire as to what was going on and why Ms Smith was there. Despite an assurance from Ms Smith that the visit with Mr Charlton-Smith would not cause any issues, KPG then informed relevant staff of the visit and observed the visit personally. KPG observed a heated conversation following which Ms Smith left in tears and Mr Charlton-Smith appeared to be 'agitated'.

83. Prompted by these observations, after the visit KPG enquired of both Ms Smith and Mr Charlton-Smith. According to Mr Boyd-Caine, each of these actions clearly indicate that KPG had correctly identified mental health concerns and he continued to have these concerns despite being assured by Ms Smith and Mr Charlton-Smith that no issues had arisen, and so KPG continued to act upon these concerns by enquiring of Mr Charlton-Smith's wellbeing again during the strip search.

84. Following this, having observed the distress of both Mr Charlton-Smith and Ms Smith, KPG sought assistance from fellow prisoner, LNI to 'keep an eye' on Mr Charlton-Smith,[44] whilst also initiating a process by which Mr Charlton-Smith was to be returned to the main FCC

[43] ECC incident log of 'prisoner [stripped]' at 10.55am, CB 538.
[44] Statement of LNI, CB 19.

prison. Each of these decisions was motivated by a concern that Mr Charlton-Smith may attempt to escape the Nalu Unit, as a result of his visit from Ms Smith. However, according to the family's submissions, each of these decisions failed to engage with Mr Charlton-Smith's psychological wellbeing. This was an administrative and security-focused response to the mental health concern, rather than a health-based response. As such, the suicide or self-harm risk was not considered or responded to.

85. The GEO Group submitted that there was no evidence to suggest that FCC knew or should have known that Mr Charlton-Smith was at risk of self-harm or suicide following Ms Smith's visit. In its written submissions, GEO Group restated that the visit was observed by KPG who witnessed a heated discussion. He then followed up with both parties to ensure that they were okay.

86. During the follow up discussions, Mr Charlton-Smith did not present to KPG as someone who was at risk of suicide and after having made inquiries about his mental health, KPG became concerned that Mr Charlton-Smith may attempt to escape. At the inquest, counsel for GEO Group, Mr Dawson conceded that with the benefit of hindsight, it is apparent that the visit was a precipitated event for suicide but that during the period of incarceration and prior to the suicide, there was nothing to suggest that Mr Charlton-Smith was at risk of suicide or self-harm or otherwise in need of mental health intervention. He was assessed on multiple occasions and found to not pose any risk and denied any thoughts or ideation of self-harm or suicide.

87. Secondly, the policy at the time required all correctional staff to immediately refer any prisoner who was thought to be potentially at risk of suicide or self-harm for a medical assessment. KPG was trained and experienced in assessing when a prisoner was at risk and he knew that if he identified those signs that the prisoner needed to be referred for assessment.

88. Further, KPG was well placed to assess first-hand Mr Charlton-Smith's reaction to the visit because he was familiar with Mr Charlton-Smith - familiar enough with him to know, for example, that when he visited without his family that was unusual. He had observed the visit and he spoke to both parties afterwards and was able to observe their demeanour firsthand.

89. Mr Dawson said for these reasons it should be inferred that if Mr Charlton-Smith had exhibited any signs suggesting he may be at risk of self-harm or suicide following the visit, this would have been identified by KPG and would have prompted referral for further assessment.

90. Further, Mr Dawson also said it was incorrect that Mr Charlton-Smith should have been referred for further assessment simply because he was agitated or distressed following the visit. There are many reasons why he may be agitated or distressed. That did not mean that he was at risk of suicide or self-harm. These include that Mr Charlton-Smith may have been considering an escape to his partner in order to continue the discussion, for example, as was the concern of KPG.

91. Mr Dawson concluded that KPG acted appropriately in the circumstances and that it would be unfair to 'second guess the assessment made by an experienced correctional officer based on what occurred subsequently'. KPG observed Mr Charlton-Smith and he spoke to him following the visit. He was the person best placed to assess whether Mr Charlton-Smith might be at risk of suicide or self-harm. His assessment was that he was at risk of escape. He did not identify any signs of suicide or self-harm.

92. The family submitted that KPG had no evidence before him that Mr Charlton-Smith posed any kind of escape risk. Mr Charlton-Smith had twice previously been assessed as to whether he constituted an escape risk in 2014 and in 2018, respectively and in each instance, he was given a 'zero' escape risk rating.[45] Further, the information received from Prison Intelligence about the phone calls did not reveal any evidence which would elicit a plan or intention to escape. Rather, the information available to KPG strongly suggested there was a mental health risk with evidence of suicidal behaviours associated with Mr Charlton-Smith's relationship with Ms Smith, and evidence of distress from the observations undertaken at the visitation of Ms Smith and Mr Charlton-Smith.

93. At the inquest, Mr Boyd-Caine submitted that the most concerning action undertaken by KPG was the charging of a fellow prisoner to engage with Mr Charlton-Smith rather than healthcare professionals employed by FCC. Mr Boyd-Caine considered this constituted a

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[45] CB 271 and 326.

significant failing in two ways: 1) that where there is a significant concern over the potential actions of a prisoner, staff, not fellow prisoners, are the ones who are trained, equipped and obligated to engage with the relevant prisoner to attempt to resolve those concerns; 2) in that charging LNI with the care of Mr Charlton-Smith, prison staff were denied the opportunity observe Mr Charlton-Smith's distress and 'intervene to prevent that distress from becoming a fully-fledged psychological emergency'. The failure to engage trained staff to speak with Mr Charlton-Smith, according to the family's submissions, contributed to his death.

94. I agree with Mr Charlton-Smith's family that there was no evidence that Mr Charlton-Smith posed a risk of escape. He did not exhibit any signs of wanting to escape nor did he express any intention to do so. The mere fact that his family lived nearby did not heighten any escape risk. Mr Charlton-Smith had been assessed as suitable for the Nalu Unit even though his family already lived nearby and any escape risk was factored into the decision for him to stay there.

95. I accept that KPG was mistaken about the risk of escape but I find that his belief genuinely held and does not reflect any lack of skill, diligence or good faith on his part. I accept that KPG made reasonable and repeated enquiries about Mr Charlton-Smith's mental state and that outwardly, Mr Charlton-Smith did not present as a suicide or self-harm risk. I make no adverse comments about KPG's conduct in this regard.

96. Further, there is no evidence that KPG's actions following his identification of the mistaken 'escape risk' contributed to Mr Charlton-Smith's death. Having satisfied himself that Mr Charlton-Smith was not at risk of self-harm or suicide, KPG then took steps to ensure that Mr Charlton-Smith did not take any action to leave the prison, as it would have had severe consequences for him. I also do not make any adverse findings about KPG asking LNI to keep an eye on Mr Charlton-Smith. There was no evidence that he abrogated his duty in any way, but rather, in the interests of Mr Charlton-Smith's overall welfare, took extra steps to ensure Mr Charlton-Smith did not act against his own interests.

97. There was no evidence presented to the court indicating that Mr Charlton-Smith's suicide was planned. On the contrary, the decision appears to have been somewhat impulsive. As Mr Nguyen pointed out, it was approximately 50 minutes from the time that Mr Charlton-Smith was strip searched and asked about his welfare to the time he was found hanging.

During that time, the evidence shows that KPG was vigilant in his attempts to identify indicators of distress and took steps to eliminate the risks as he perceived them.

Issue 3: The medical response, including:

IV. The adequacy of the mental health response.

V. The adequacy of the resuscitation attempts including the availability of working equipment devices available, particularly defibrillators; and

98. Mr Charlton-Smith's family submitted that there were "major flaws" in the medical response, particularly the failure to respond to Mr Charlton-Smith's increased risk of self-harm or suicide and the corresponding focus on the unsupported concern of escape. Given this, the mental health response was entirely inadequate, in that it did not exist. As a result, Mr Charlton-Smith was denied professional mental health support, contributing to his death.

99. The second issue raised by the family involved the adequacy of the resuscitation attempts. Whilst acknowledging that staff from the Nalu Unit and Ambulance Victoria engaged in significant resuscitation attempts over an extended period seeking to save Mr Charlton-Smith's life, their efforts were hampered by the failure of prison staff to use the available Hoffman knife to cut away the ligature that Mr Charlton-Smith had made, and the failure of the available defibrillator to administer a charge.

100. On the relevant day, Correctional Officer NEH was assigned the task of carrying the Hoffman knife around the unit for muster. A Hoffman knife is widely used in correction contexts and is intended to assist with the cutting and removal of ligatures. NEH was with KPG when LNI first alerted prison staff to Mr Charlton-Smith's hanging. NEH attended the cell with KPG. Upon attending Mr Charlton-Smith's cell and seeing him hanging, KPG sent NEH to get a defibrillator, which NEH did. As a result, prisoners LNI and HRM had to cut the ligature with a kitchen knife.

101. The unavailability of the Hoffman knife to cut the ligature was unfortunate. However, I am unable to say whether the temporary absence of the Hoffman knife caused or contributed to Mr Charlton-Smith's death. An alternative knife was obtained quickly and the ligature was cut a short time later.

102. The use of the defibrillator on Mr Charlton-Smith was the cause of some dispute during the coronial proceeding and arose from a comment made in the JARO report. I sought further evidence from JARO about the basis of the comment in the report and additional evidence was provided to the court by the DJCS. In short, I am satisfied that the balance of evidence is consistent with a finding that the defibrillator was working and the reading of 'nil shock advised' occurred because no cardiac rhythm was identified. For the machine to have had this reading, the defibrillator had to have battery.[46]

IDENTITY OF THE DECEASED

103. Mr Charlton-Smith was visually identified by his mother, Sally-Anne Charlton-Smith on 3 December 2018. Identity was not in issue and required no further investigation.

CAUSE OF DEATH

104. On 6 December 2018, Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Charlton-Smith and reviewed a post-mortem computed tomography (CT) scan.

105. The CT scan showed a swollen brain and changes consistent with pneumonia.

106. Dr Burke completed a report, dated 7 December 2018, in which he formulated the cause of death as "1(a) hypoxic ischaemic brain injury 1b) Hanging".

107. I accept Dr Burke's opinion as to the medical cause of death.

FINDINGS

108. Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Dylan James Charlton-Smith, born 7 July 1993;

(b) Mr Charlton-Smith died on 3 December 2018 at Fulham Correctional Facility, 110 Hopkins Road, Fulham, Victoria, from 1a) hypoxic ischaemic brain injury and 1b) hanging; and

[46] See statements of Nurse Tailor and DSK, CB.

(c) the death occurred in the circumstances described above.

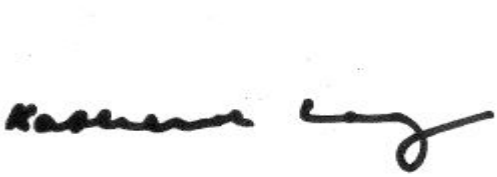
Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I convey my sincere condolences to Mr Charlton-Smith's family.

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

Sally-Anne Smith (senior next of kin)
Stacey Smith
GEO Group (care of Meridian Lawyers)
Corrections Victoria
Office of the Chief Psychiatrist
Detective Senior Constable Benjamin Tobias, Coroner's Investigator, Victoria Police

Signature:



KATHERINE LORENZ
CORONER
Date: 9 March 2022