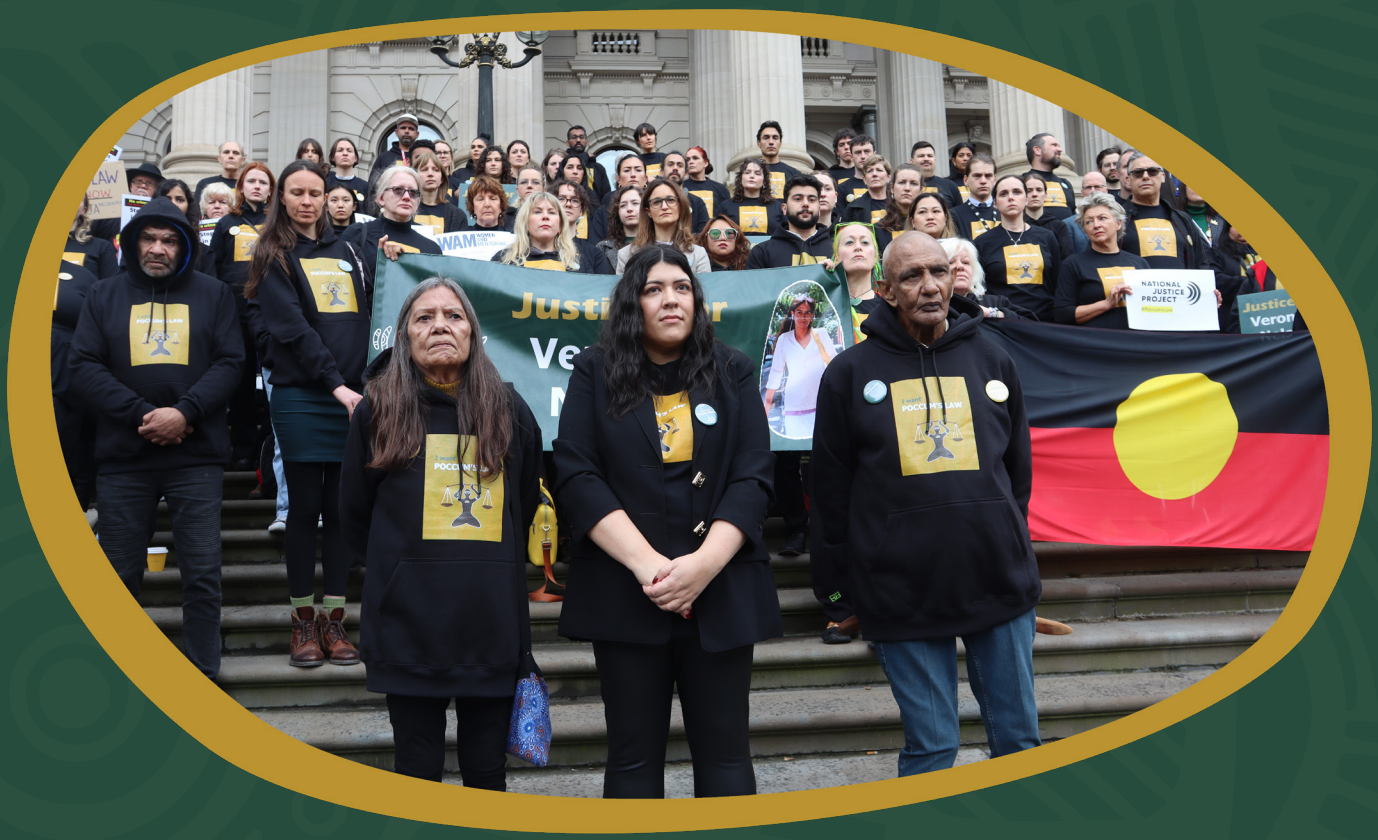
Community Factsheet




# *Inquest into the passing of* Veronica Nelson

VALS

YEAR 50 ANNIVERSARY

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# Veronica Nelson

Veronica Marie Nelson ('Veronica') on was born on 3 March 1982 in Dandenong. She is a Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman.

Veronica was a deeply spiritual woman, whose connection to her culture was incredibly important to her. It was a gift that she would regularly share with those around her. Veronica was well-known as a helper, and she would give whatever she could to those who needed it – she was someone to talk to, someone who'd listen, someone who'd give you food and a place to rest. She was a well-respected member of the Fitzroy Aboriginal community.

Veronica Nelson

## Veronica's passing

Veronica passed away at the Dame Phyllis Frost Centre Prison (**DPFC**), Victoria's main women's prison, on 2 January 2020 after days of crying out for help. She had been arrested three days earlier, on 30 December 2019, for shoplifting-related offences. She died of complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition.

The Coronial Inquest into Veronica's passing found that **Veronica's death was preventable.** She could have been saved by any one of the people in charge who she asked to help her. She needed to go to hospital and could have been saved by something as simple as an intravenous drip.

According to the Coroner, "[t]he conditions under which Veronica lived out her final days are harrowing…[th]at Veronica was separated from her family, community, culture, and Country at the time of her passing is a devastating and demoralising circumstance."

## The Coronial Inquest into Veronica's passing

The Coronial Inquest into Veronica's passing ran for five weeks from 26 April to 27 May 2022.

Aunty Donna Nelson and Uncle Percy Lovett were joint senior next of kin in the inquest. Aunty Donna was represented by Robinson Gill and Uncle Percy was represented by the Victorian Aboriginal Legal Service (**VALS**). VALS would like to acknowledge the incredible advocacy and leadership of Aunty Donna and Uncle Percy, who continue to fight for **#JusticeforVeronicaNelson.**

The Coronial Inquest heard from 59 witnesses, including medical experts, prison health stakeholders, and experts on the administration of justice.

On 30 January 2023, Coroner McGregor handed down 51 findings and 39 recommendations relating to accountability for Veronica's death, the bail system, prison healthcare, reviews and investigations into deaths in custody, and the recommendations from the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**).

Aunty Donna and Uncle Percy's statements in response to the Coronial findings are available here.

The Government's and other State bodies responses to the Coronial recommendations are available here.

## What did the Coroner say about accountability for Veronica's death?

At the Inquest, Uncle Percy submitted that relevant individuals and organisations must be held accountable. He argued that Correct Care Australasia (**CCA**), Corrections Victoria (**CV**) and the individual doctors, nurses and prison officers who were responsible for Veronica's passing, should be criminally prosecuted, either for negligent manslaughter or a breach of the *Occupational Health and Safety Act 2004.*

The Coroner referred CCA to the Director of Public Prosecutions (**DPP**), in relation to a possible breach of section 23 of the *Occupational Health and Safety Act 2004.* Uncle Percy and VALS strongly support this referral.

The Coroner did not make any referrals to the DPP in respect of CV or individual doctors, nurses or prison officers. However, the Coroner shared a copy of his findings with the Australian Health Practitioners Regulation Agency (**APRHA**), in relation to Dr Sean Runacres (the doctor who did Veronica's medical reception assessment) and Registered Nurse Atheana George (the nurse who was on duty the night that Veronica passed away). Additionally, the Coroner shared his findings with the Victorian Legal Services Board and the Victorian Legal Services Commissioner, who investigated Mr. Tass Antos.

# What did the Coroner say about the Royal Commission into Aboriginal Deaths in Custody?

In 1991, after investigating the Deaths in Custody of 99 Aboriginal people across Australia, the RCIADIC made 339 recommendations, including in relation to the criminal legal system and investigations into deaths in custody.

In particular, the Commission recommended:

- Arrest and imprisonment should be a last resort
- Any discriminatory or restrictive criteria in bail laws should be amended.
- Prison health care should be equivalent to that available outside of prison and Aboriginal people should have access to culturally appropriate healthcare.
- Coronial investigators should provide information that is sought by families regarding the progress of the investigation and the preparation of the coronial brief of evidence.

In the Inquest into Veronica's passing, the Coroner found that had the RCADIC recommendations been successfully implemented by the Government and its agencies, **Veronica would likely not have died.**

He also noted that although RCIADIC implementation reviews and strategic and policy initiatives suggest progress towards improved criminal justice outcomes for Aboriginal people, statistical evidence demonstrates the opposite. Aboriginal people now die in custody at a greater rate than before RCIADIC, with an average of 16.6 deaths per year since 1991, compared to 11 deaths per year between 1980-89.

The Coroner recommended that the Victorian Government, in consultation with Victoria Police, the Department of Justice and Community Safety (**DJCS**), the Department of Health (**DH**) and peak Aboriginal organisations, **urgently develop a review and implementation strategy for the State's implementation of the 339 RCIADIC recommendations.** The Coroner stated that previous implementation efforts had resulted in 'too much policy, not enough change.'

VALS strongly supports urgent implementation of all RCIADIC recommendations in a way that achieves the full intention of these recommendations.

# What did the Coroner say about Veronica's arrest?

On 30 December 2019, Veronica was walking with her brother in Melbourne city, minding her own business. She was arrested by an off-duty police officer, Sergeant Brendan Payne, for shoplifting offences and failing to appear on bail without reasonable excuse. Sergeant Payne stated he recognised her on the street. He had never met her.

In Victoria, studies have found that Aboriginal women are more likely to be apprehended by police than non-Aboriginal women. This policing is most likely to focus on theft and breach of justice offences.

The Coroner found that Veronica's arrest was lawful, but that the use of handcuffs by Victoria Police was unjustified and disproportionate in the circumstances**.** He did not make any findings about racism.

Veronica and her life partner, Uncle Percy Lovett

# What did the Coroner say about Veronica's detention by police?

The offences that Veronica was charged with meant that she fell into the highest 'exceptional circumstances' threshold under the *Bail Act 1977* (Vic).

Even though Victoria Police had the power to grant her bail, and were legally required to consider her individual circumstances, police automatically refused bail because Veronica fell under the highest threshold under the *Bail Act*. During the Inquest, Victoria Police officers gave evidence of an "unwritten internal policy" to always refuse bail when someone fell under this threshold.

The Coroner found that a number of police officers were empowered to grant Veronica bail but failed to give proper consideration to their discretion do to so under the *Bail Act*. He found that this failure infringed Veronica's rights under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**), in particular, the right not to be automatically detained (s. 21(6)) and the right not to be subjected to arbitrary arrest or detention (s. 21(2)). Further, the Coroner found that Victoria Police failed to adequately consider Veronica's vulnerability in custody as an Aboriginal woman.

The Coroner also noted that the "informal policy" of automatically refusing bail to people like Veronica, who were subject to the exceptional circumstances test, amounted to arbitrary and automatic detention, and was in breach of s. 21 of the *Charter*. The Coroner recommended that Victoria Police urgently correct this unlawful "informal policy".

Uncle Percy and Sarah Schwartz, Principal Managing Lawyer, Wirraway, VALS

The Coroner recommended changes to the Victorian Police Manual to clarify the legal requirements for police bail decision makers (particularly s. 13A) and to require that police properly record all bail decisions. The Coroner also recommended that police bail decision makers be required to undertake periodic and mandatory training on s. 3A of the *Bail Act*, relating to considering Aboriginality in bail decisions, and that the Chief Commissioner of Police collect and publish data on people charged with offences to which the 'exceptional circumstances' and the 'compelling reasons' tests apply.

VALS strongly supports the urgent correction of Victoria Police's 'informal policy' regarding bail refusal, and mandatory and periodic training for all bail decision makers on the *Bail Act* (particularly s. 3A), systemic racism, unconscious bias and cultural awareness. This requirement should apply to police bail decision makers, as well as judges, magistrates and bail justices. Training should be developed jointly with Aboriginal communities and ACCOs. There should be data collection and independent oversight to ensure that this training is implemented.

# What did the Coroner say about Veronica's bail application?

After bail was refused by the police, Veronica was taken to the Melbourne Magistrates Court (**MMC**) and spent the night alone in the cells of Melbourne Custody Centre (**MCC**).

## Legal assistance and representation

On 31 December, Mr Tass Antos - a barrister who was a member of Victoria Legal Aid's criminal law panel - was briefed to represent Veronica in her bail application. However, Veronica represented herself in her bail application.

The Coroner found that Veronica should not have appeared unrepresented in her bail application, and that the legal services provided by Tass Antos were inadequate. The Coroner has shared his findings with the Victorian Legal Services Board and the Victorian Legal Services Commissioner, who investigated Mr Antos.

After investigating Mr Antos, the Victorian Legal Services Board stated they had "decided to close the complaint without taking disciplinary action against Mr Antos."

## Section 3A Bail Act

**During her bail hearing, Veronica's Aboriginality was not mentioned by either the Prosecutor or the Magistrate**. At the Inquest, Uncle Percy and VALS argued that the magistrate hearing Veronica's application, Magistrate Bolger, did not ask relevant questions about Veronica's circumstances or her Aboriginality, despite the requirement to do so under ss. 3AAA and 3A of the *Bail Act*. Veronica was again refused bail because she failed to show 'exceptional circumstances' and was transported to DPFC.

The Coroner found that by not alerting the Magistrate to Veronica's Aboriginality, the Prosecutor failed to properly consider Veronica's human rights under the Charter. He noted that proper weight should have been given to Veronica's kinship ties, the significance of her mother and brother's ill health, her cultural connection to Country and community, and the unique disadvantages she experienced as an Aboriginal woman in the criminal justice system. He recommended changes to the Victorian Police Manual and training for police prosecutors to address this issue.

The Coroner did not make any findings or recommendations in relation to Magistrate Bolger, as this was not part of the scope of the Inquest.

## Cultural safety and treatment at the Melbourne Magistrates Court and the Melbourne Custody Centre

The Coroner found that Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest to her passing. This included her time at the MMC and the MCC.

Although there was a Koori Court Officer at the MMC on 30-31 December 2019, Veronica did not see them as the Officer was not notified that Veronica was in the cells and applying for bail. The Coroner found that the restrictions on the role of the Koori Court Officer and processes at the MCV failed to give proper consideration to Veronica's right to equality (s. 8) and right to culture (s. 19) under the Charter. The Coroner recommended that the MCV employ sufficient Aboriginal people at the court, who can provide assistance to and advocate on behalf of Aboriginal court users.

The Coroner also stated that Veronica's discomfort during her bail application was "palpable". Important health information was not obtained or disclosed during her bail application. Expert witnesses provided evidence about why Veronica may have been uncomfortable during the hearing, including: the lack of cultural safety; the stigma she would have experienced given that she had been described by police as "a recidivist shop thief who stole to support her drug habit", and the lack of information provided to Veronica about why certain questions were being asked. There were no orders made about Veronica's management in custody.

The Coroner stated that it is important for the wellbeing of people in custody that "judicial officers understand and can manage the barriers to disclosure of health information".

## What did the Coroner say about the *Bail Act*?

The Coroner found that the amendments to the *Bail Act* introducing the 'exceptional circumstances' test have been a "**complete and unmitigated disaster**" which have had a discriminatory impact on Aboriginal people resulting in grossly disproportionate rates of remand in custody, particularly for Aboriginal women.

**The Coroner recommended urgent review of the *Bail Act 1977* with a view to repeal any provision that has a disproportionate adverse effect on Aboriginal people.**

VALS strongly supports the Coroner's recommendations regarding urgent changes to the *Bail Act*. We also support the Coroner's recommendation to review and repeal any provision that has a disproportionate adverse effect on Aboriginal people.

In October 2023, the Victorian Parliament passed the *Bail Amendment Bill 2023*. The Bill does not fulfill the recommendations of Veronica's family or the Coroner. The Bill does require a statutory review in 2026, and VALS urges the Parliament to use this as an opportunity to finish the job of bail reform that is in line with Poccum's Law.

## Reverse onus provisions

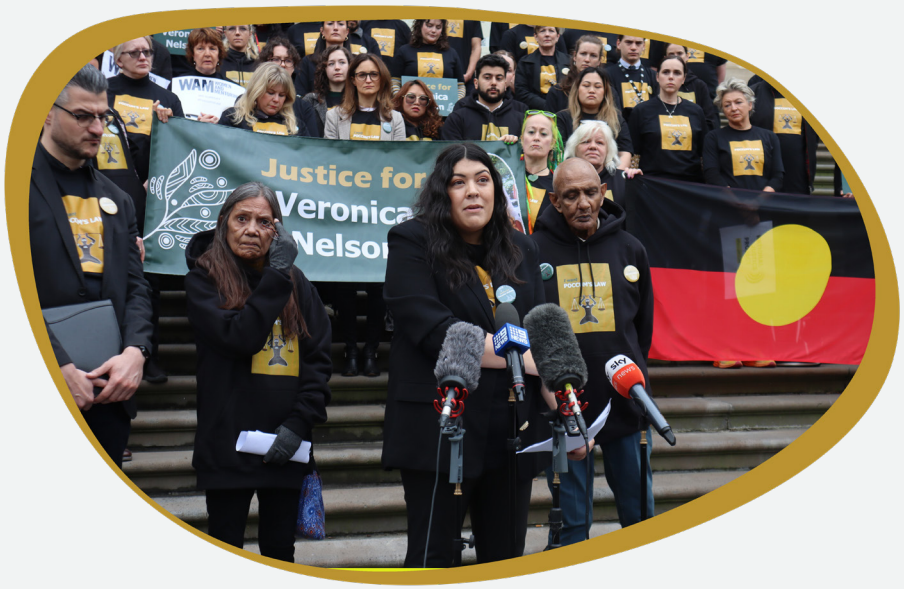
The Coroner also found that the reverse onus provisions in the *Bail Act* (ss. 4A, 4C, 4AA(2)(c) and clauses 1 and 30 of Schedule 2) are incompatible with the right to liberty, particularly the right not to be automatically detained in custody (s. 21(6) of the Charter).

Accordingly, he recommended urgent amendment of the *Bail Act* to:

- Repeal the double uplift provision (s. 4AA(2)(c))
- Repeal clause 1 of Schedule 2 (including any indictable offence in certain circumstances within the reverse onus regime)
- Repeal clause 30 of Schedule 2 (including bail offences within the reverse onus regime)

Although the Coroner did not make any recommendations about ss. 4A and 4C of the *Bail Act*, he explicitly endorsed proposals from expert witnesses who gave evidence in the Inquest, **including that the presumption against bail and the reverse onus regime must be repealed.**

The *Bail Amendment Act 2023*, which commences on 25 March 2024, implements several bail reforms including to repeal clauses 1 and 30 of Schedule 2 of the Act.




Nerita Waight, CEO of VALS, Aunty Donna Nelson, Veronica's mother, Uncle Percy and Ali Besiroglu, Principal Lawyer, Robinson Gill Lawyers, with supporters on the steps of Victorian Parliament.

## Bail offences

The *Bail Act* contains three bail offences: failure to answer bail (s. 30); breaching certain conduct conditions (s. 30A); and committing an indictable offence whilst on bail (s. 30B). Veronica was charged with one count of failing to appear on bail without reasonable excuse.

When ss. 30A and 30B were adopted in 2013, bail offences became the most common secondary offence charged and sentenced in Victoria. The Coroner noted that there is an increased risk of non-compliance of bail conditions for vulnerable individuals.

The Coroner recommended that **all three bail offences (ss. 30, 30A and 30B) be urgently repealed.**

From 25 March 2024, sections 30A and 30B of the *Bail Act* will be repealed.

## Sections 3A and 3AAA of the Bail Act

In 2010, the *Bail Act* was amended to include a requirement that bail decision makers take into account any issues that arise due to the person's Aboriginality, including the person's cultural background, including the person's ties to extended family or place; as well as any other relevant cultural issue or obligation (s. 3A).

Section 3A was introduced as a "special measure" under the Charter, with the aim of reducing the overrepresentation of Aboriginal people remanded in custody.

As noted above, Veronica's Aboriginality was not mentioned during her bail hearing at the MMC, despite ss. 3A and 3AAA.

The Coroner recommended that the *Bail Act* be urgently amended to provide:

- Legislative guidance about the procedural and substantive matters to be considered by bail decision makers in relation to bail applications by Aboriginal people (s. 3A).
- A legislative requirement for bail decision makers to articulate (and record) what enquiries they make in relation to the surrounding circumstances of the person applying for bail (s. 3AAA), and any issues that arise due to the person's Aboriginality (s. 3A).
- A legislative requirement that bail decision makers who intend to refuse bail must make all necessary enquiries about, and where necessary note on any remand warrant, any potential custody management issues, including for example, health conditions.

The *Bail Amendment Act 2023*, which commences on 25 March 2024, introduces a new s. 3A which partly implements the Coroners

recommendations on s. 3A.

### New facts and circumstances test

Under s. 18AA of the *Bail Act*, if a person is legally represented and makes a bail application that is refused, they are not able to apply for bail again unless there are 'new facts and circumstances.' The Coroner recommended that s. 18AA of the *Bail Act* be amended so that someone applying for bail does not have to establish 'new facts and circumstances' before they make a second application for bail. He also recommended legislative changes so that Aboriginal people do not need to establish 'new facts and circumstances' before making any subsequent bail application.

The *Bail Amendment Act 2023* implements one of the coronial recommendations on s. 18AA. From 25 March 2024, someone applying for bail will not have to establish 'new facts and circumstances' before making a second bail application.

## What did the Coroner say about Veronica's medical care at DPFC?

After Veronica was refused bail, she was transferred to DPFC, where she was detained for approximately 36 hours before her passing on 2 January 2020. During this time, Veronica consistently told CV staff and medical staff that she was unwell. She pressed the intercom buzzer in her cell at least 49 times to ask for help and tell staff about her symptoms.

The Coroner also found that Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest to her passing. This included a lack of culturally safe medical care.

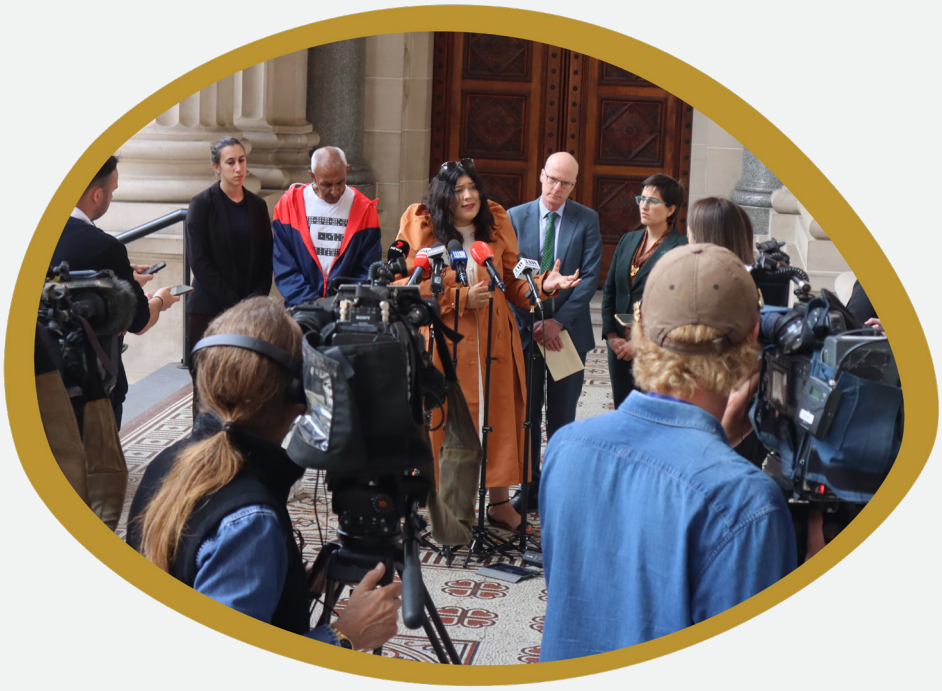
### Correct Care Australasia

The medical care that Veronica received whilst she was at DPFC was provided by a for-profit private company called Correct Care Australasia (**CCA**). CCA provided healthcare at all of Victoria's public prisons (adult and youth), although this changed in 2023 as healthcare in women's prisons was taken over by local public health services and GEO group took over responsibility for healthcare in the remaining facilities. CCA is a subsidiary company of Wellpath, the largest private prison healthcare provider in the United States. CCA's contracts with the Victorian Government were worth approximately $700 million. The contracts for healthcare delivery at Victoria's adult prisons are managed by Justice Health, which is a business unit of DJCS.

At the Inquest, the Coroner found that CCA failed to provide Veronica with medical care equivalent to the care she would have received from the public health system in the community, and that this failing causally contributed to her passing.

The Coroner found that Veronica should have been transferred to hospital at the time of her reception to DPFC, and that CCA staff continually failed to transfer her to hospital thereafter, which causally contributed to her passing. The Coroner also found that Veronica's care and treatment by CCA staff was influenced by drug-use stigma, and that this causally contributed to her passing.

The Coroner referred CCA to the DPP for criminal investigation in relation to an indictable offence. VALS strongly supports this referral.



Nerita Waight, Uncle Percy and Sarah Schwartz advocating for reform at Victorian Parliament to media.

## Reception Medical Assessment

When Veronica first arrived at DPFC, she was assessed by Dr Sean Runacres and Registered Nurse (**RN**) Stephanie Hills. At the Inquest, the Coroner found that Dr Runacres' medical assessment and treatment of Veronica was inadequate.

RN Hills provided evidence that Dr Runacres did not conduct any physical examination of Veronica and remained in his chair for the entirety of the medical assessment. She said that Veronica was extremely unwell during the assessment, including being unable to sit upright, walk to the scale and was fading in and out of consciousness. RN Hills stated that she told Dr Runacres that Veronica needed to go to hospital, but that Dr Runacres dismissed this. Dr Runacres' notes contained a number of serious inaccuracies, including that Veronica's weight was 40.7kg, rather than 33kg. The Coroner preferred RN

Hills' evidence over Dr Runacres and found that Dr Runacres' failure to physically examine Veronica, plan her ongoing care and maintain accurate records were significant departures from reasonable standards of care and diligence expected in medical practice.

The Coroner did not refer Dr Runacres to the DPP for investigation. However, he has shared his findings with AHPRA for its consideration. Dr Runacres has appealed certain findings. VALS is representing Uncle Percy in the appeal, which is currently being determined by the Supreme Court.

## Opioid Substitution Therapy

During Veronica's reception medical assessment, she disclosed that she was withdrawing from an opioid dependence. Veronica requested methadone, which is a form of opioid substitution therapy that is available to people in the community.

The medical expert panel provided evidence that "opioid substitution therapy, or pharmacotherapy, is the safest and most effective method to treat opiate withdrawal". However, at the time of Veronica's passing, the Justice Health guidelines for people in prison only allowed for people in prison to obtain opioid substitution therapy if they are going to be in custody for over six weeks.

During Veronica's bail application, after she was denied bail, she asked for a six-week adjournment. According to the Coroner, it could be inferred that Veronica requested this adjournment so that she could have access to opioid substitution therapy (**OST**). This was supported by Veronica's request for methadone.

The result of the Justice Health policy was that Veronica did not have access to OST, but was instead forced to undergo rapid withdrawal. Veronica was given a rapid withdrawal pack and was told that if she wanted OST, she would need to make an appointment with the relevant clinic.

The Inquest heard evidence from people who had been in prison about the pain and suffering involved in forced rapid withdrawal. The Coroner found that Veronica's cause of death was complications of withdrawal from chronic opiate use and Wilkie Syndrome (a gastrointestinal disorder), in the setting of malnutrition. Opioid withdrawal can cause severe vomiting that is capable of leading to fatal electrolyte imbalances.

The Coroner found that Justice Health's OST Program Guidelines deny people who are incarcerated equivalent care to that available in the community, and infringe their right to life (s. 9) and right to be treated humanely while deprived of liberty (s. 22) under the Charter.

He also found that Veronica's treatment by CCA - pursuant to CCA's

Guidelines and the Justice Health Guidelines - **constituted cruel and inhumane treatment** contrary to the Charter (s. 10).

The Coroner recommended that Justice Health immediately amend the OST Guidelines so that opioid substitution therapy can be prescribed to women whose health may be at significant risk by being required to undergo forced opiate withdrawal.

In late 2023, Justice Health issued an Interim Practice Instruction directing all Health Service Providers that the duration of time in custody and court matters no longer affect OST eligibility. Justice Health is also undertaking a broader review of the OST Guidelines.

## Care and treatment at the Medical Centre

Veronica initially stayed in the Medical Centre at DPFC, because she was too unwell to be transferred to the mainstream prison. Although there was a RN on duty at the Medical Centre, the intercom in her cell was attended by a prison officer. She was told by the prison officer that the intercom was "for emergencies only," and when she asked to see a doctor, she was told that, "it's not an emergency, stop asking." Veronica was left to lie in her own vomit for hours.

## Medical care and treatment in the Yarra Unit

On 1 January 2020, Veronica was moved from the Medical Centre to the mainstream prison. Veronica continued to use the intercom in her prison cell to ask for help and complain about severe pain, vomiting and cramping.

The prison officer (**PO**) who was on duty the night that Veronica passed away, on 1-2 January 2020, Tracy Brown, responded to Veronica's intercom calls. PO Brown referred Veronica to RN Athaena George, the nurse on duty. RN George did not conduct any medical assessment of Veronica and only looked at Veronica through the trap, gave her pain medication and did not open Veronica's cell door. Other prison officers gave evidence that Veronica could not even open her hand to take the medication and that RN George needed to pry open her hand.

At the Inquest, the Coroner found that RN George failed to provide Veronica with adequate assessment, treatment or care. He found that RN George's conduct was lazy, unprofessional, and not in keeping with the standards of care one would reasonably expect from a health care professional while on shift. The Coroner did not refer RN George to the DPP for investigation, but he has shared his findings with AHPRA for its consideration.

# What did the Coroner say about prison healthcare?

In addition to Veronica's medical care and treatment by individual doctors and nurses, the Coroner also made findings about the systems, policies and processes for medical care at DPFC and in other Victorian prisons.

In particular, he made findings about:

- Equivalency of medical care at DPFC
- Culturally safe and/or appropriate medical care
- Opioid Substitution Therapy Programs in Victorian prisons
- Information sharing between CCA and Corrections Victoria (CV) at DPFC
- Handover of critical patient information between CCA medical staff at DPFC
- Medical clearance of a person from the Medical Centre to a mainstream unit at DPFC
- Escalation of medical care by CCA staff

The Coroner made the following recommendations about prison healthcare in Victoria:

1. DJCS and DH should consult to determine which department should have oversight of prison healthcare.
2. DJCS and DH should consult with stakeholders, including Aboriginal community representatives to determine what model of healthcare will achieve the best health outcomes for people in Victorian prisons.
3. DJCS and/or Justice Health, in partnership with VACCHO, must take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.
4. The Victorian Government should revise the system for auditing and scrutiny of custodial healthcare services.
5. Justice Health should require custodial Health Service Providers to engage with Victoria's Aboriginal communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to people who are incarcerated.
6. Justice Health should require custodial Health Service Providers to: ensure that their medical practitioners and Registered Nurses have completed training in Alcohol and Other Drugs (AOD); and employ a full-time specialist in Addition Medicine and doctors and nurses who are qualified to practice opioid substitution therapy.

VALS strongly supports the Coroner's recommendations on prison healthcare. To ensure that Aboriginal people who are incarcerated are able to access healthcare that is equivalent to that available in the community, Aboriginal Community Controlled Health Organisations (**ACCHOs**) must be adequately funded to provide in-reach primary healthcare.

Uncle Percy with family and supporters outside the Coroners Court of Victoria

## What did the Coroner say about Veronica's treatment and care by Corrections Victoria?

Throughout her time at DPFC, both in the Medical Centre and the Yarra Unit, Veronica relied on CV staff to facilitate her access to medical care. When she was in her cell, her only way of asking for help was to communicate with a CV prison officer through the intercom.

On the night before she passed, PO Tracy Brown dismissed Veronica's cries for help and lied to her. PO Brown told Veronica to try and have water, keep moving around, to have a shower, and to stop making noise as she was "keeping the other prisoners awake." When Veronica requested salt, PO Brown told her that she had contacted Operational Support, but she never made the call.

Between 3:58am - when Veronica last used the intercom to call for help - and 7:30am, no one properly checked on Veronica. When Veronica was found in the morning, the shower was running in her cell and her cell was flooded with water.

The Coroner made the following findings regarding Veronica's treatment by CV:

- CV staff continually and collectively obstructed the provision of 'equivalent care' to Veronica and failed to protect her welfare.

- Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest to her passing. This included her care by CV staff.
- Veronica's treatment by some prison officers in the morning of 1 January 2020 **amounted to inhumane and degrading treatment** contrary to the *Charter* (s. 10).
- Veronica's care and treatment by CV staff was influenced by drug-use stigma, and this causally contributed to Veronica's passing.
- PO Brown failed to escalate Veronica's care on at least three occasions.
- PO Brown's failure to physically check on Veronica at any point overnight, but particularly after Veronica became unresponsive during the final intercom call, was a failure to provide appropriate care for Veronica.

The Coroner did not make any recommendations in relation to PO Brown, but made several recommendations relating to CV, including:

- CV should review its practice whereby only two POs have access to cell keys during the Second Watch overnight at DPFC and address any impediment to the timely entry to cells to ensure prisoner health, welfare and safety.
- DJCS should develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review which is applicable to CV.
- DJCS should develop and implement a policy to ensure that cultural considerations are incorporated into management of a deceased Aboriginal person in custody and, to the extent possible, the scene of that person's passing.

## What did the Coroner say about Drug and Alcohol Services?

The Coroner noted that there is a "severe service gap" for culturally specific and gender-specific supports and services for Aboriginal women on bail, including rehabilitation facilities.

He recommended that DH, in collaboration with relevant ACCHOs and other stakeholders, must prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal women with drug and/or alcohol dependence.

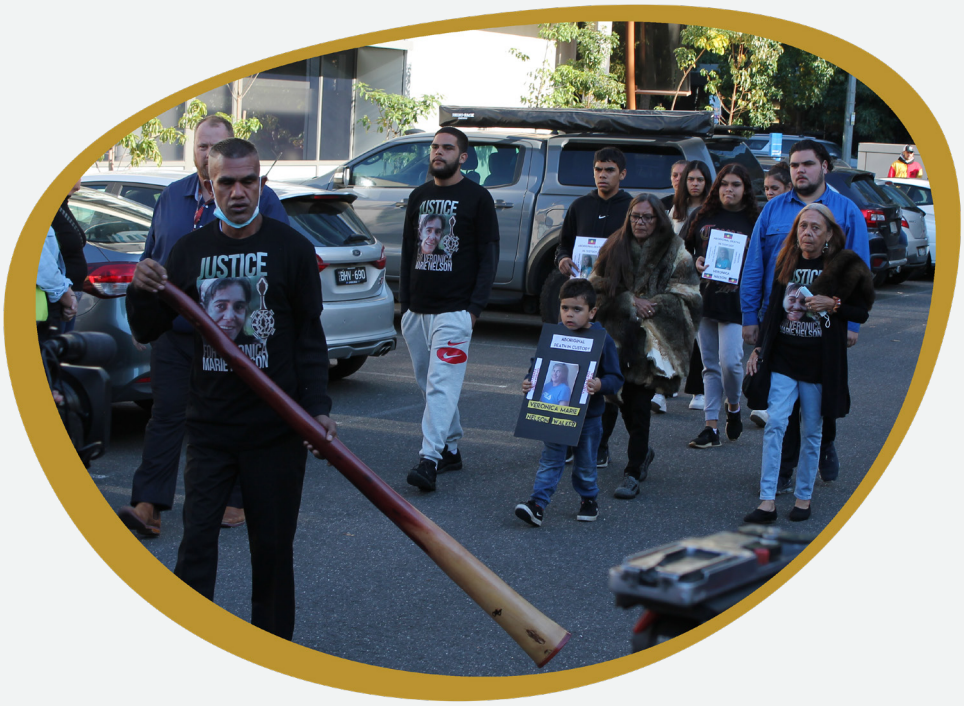
# What did the Coroner say about the investigation into Veronica's passing?

After Veronica's passing, DPFC, CCA, Justice Health and the Justice Assurance and Review Office (**JARO**), each caried out debriefs and reviews regarding Veronica's death.

The DPFC conducted a formal briefing which involved staff from CCA, CV, Justice Health and JARO, which is a business unit of DJCS. The Governor of DPFC concluded that he couldn't see much that could have been improved. The Coroner found that the formal DPFC debrief did not critically examine the incident, and that the minutes of the debrief were grossly inadequate and misleading.

The Coroner also found that there was an "appalling lack of disclosure" by CCA, who failed to provide critical information to Justice Health following Veronica's passing. At the Inquest, CCA witnesses provided evidence about the "don't ask / don't tell" arrangement, which the Corner noted was a "matter of grave public interest."

The JARO conducted a review of Veronica's death and Justice Health conducted a Death in Custody Report. The Coroner found that both the JARO Review and the Justice Health Death in Custody Report were grossly inadequate and misleading.




Aunty Donna and family after smoking ceremony outside the Coroners Court of Victoria

The Coroner recommended that the DJCS urgently redesign the JARO and Justice Health processes to ensure they are independent, timely, comprehensive, and identify opportunities for improved practice. Additionally, if the deceased person is an Aboriginal person, the adequacy of their cultural care whilst in custody should be assessed by a suitable member of the Aboriginal community.

Some changes were made to the review process in August 2022. Despite this, VALS strongly supports an urgent and comprehensive overhaul of the review process. All investigations into deaths in custody, including for the purposes of a coronial inquest, must be completely independent from government and Victoria Police.

During the Inquest, VALS repeatedly requested crucial information and statements, and these requests were repeatedly dismissed, objected to, or ignored by CCA and DJCS lawyers. Withholding crucial information from family members is cruel and adds to their grief and trauma. Families must be given the opportunity to be fully involved in any review process following the death of a loved one in custody.

Under the *Coroners Act 2008* (Vic), inquests are not mandatory following a death in custody, despite RCIADIC recommending over 30 years ago that all deaths in custody should be followed by a formal inquest. If there had not been an Inquest into Veronica's passing, the JARO and Justice Health Reviews would have been the only information available. The circumstances of Veronica's passing would not have made public, and no one would have been held accountable.

## What did the Coroner say about racism?

At the Inquest, Uncle Percy submitted that there was ample and uncontested evidence that Victoria Police, including the officer who arrested Veronica, the MCV, prison officers, and prison medical staff, treated Veronica without humanity and dignity due to interpersonal racism and systemic racism.

**Interpersonal racism**, is when "interactions between people serve to maintain or exacerbate the unequal distribution of opportunity across ethnoracial groups."[1]

**Systemic racism** describes how laws, policies and practices across agencies work together to produce a discriminatory outcome for racial or cultural groups. It can be measured in the uneven or unfair manner in which certain apparently 'neutral' laws impact Aboriginal people. Systemic racism operates because agents of institutions hold racial bias, including values or assumptions that exclude and inferiorise Aboriginal people.

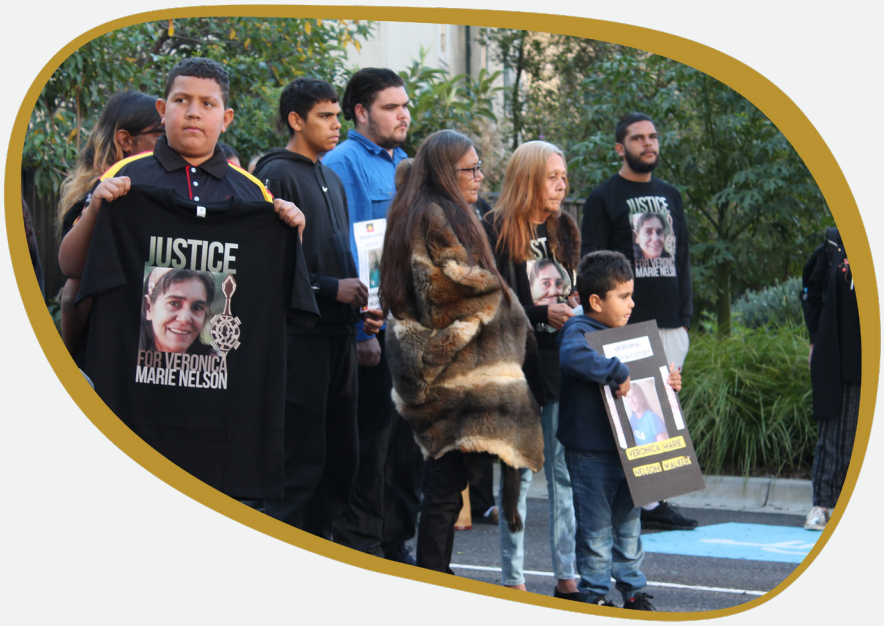
The Coroner found that the *Bail Act* had a discriminatory impact on Aboriginal people. However, he did not make any additional findings on interpersonal or systemic racism.

1 G. Berman and Y Paradies, "Racism, disadvantage and multiculturalism: Toward effective anti-racist praxis," Ethnic and Racial Studies (2008) 1-19, p. 4.

## What did the coroner say about torture, cruel, inhuman or degrading treatment?

The Coroner made three findings in relation to the right to humane treatment when deprived of liberty (s. 22) and the protection from torture, cruel, inhuman or degrading treatment (s. 10) which are both protected under the *Charter*:

- Justice Health's OST Program Guidelines **infringe the right to humane treatment when deprived of liberty** (s. 22)
- Veronica's treatment for her opioid dependence constituted **cruel and inhumane treatment** (s. 10).
- Veronica's treatment by some POs in the morning on 1 January 2020 amounted to **inhumane and degrading treatment** (s. 10).




Aunty Donna and family at smoking ceremony outside the Coroners Court of Victoria

## What did the Coroner say about Veronica's other human rights?

In addition to his findings in relation to ss. 10 and 22 of the *Charter*, the Coroner made a number of other findings about other *Charter* rights:

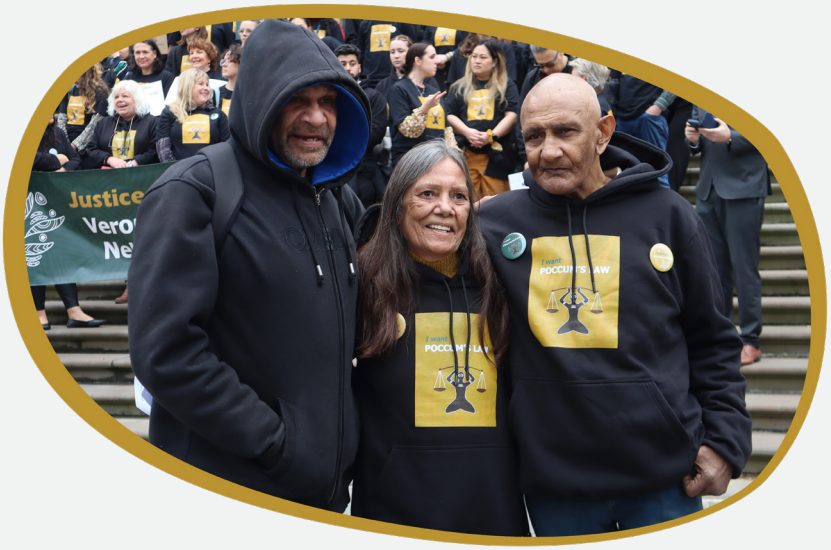
- Sections 4AA(2)(c), 4A, 4C and Clauses 1 and 30 of Schedule 2 of the *Bail Act* are incompatible with the Charter, in particular, the right not to be automatically detained in custody (s. 21(6)).
- The Police BDM was empowered to grant bail and failed to give proper consideration to the discretion to do so, which infringed Veronica's rights under the Charter, particularly the right not to be automatically detained (s. 21(6)) and the right not to be subjected

to arbitrary arrest or detention (s. 21(2)).

- By failing to alert the magistrate to the relevance of Veronica's Aboriginality during the bail hearing, the police prosecutor failed to properly consider Veronica's Charter rights.
- The MCV failed to give proper consideration to Veronica's right to equality (s. 8) and right to culture (s. 19) and those of other Aboriginal court users.
- The Justice Health OST Program Guidelines infringe the right to life (s. 9) of people who are incarcerated, given the greater risk of fatal overdose upon release.
- The absence of bed-based care at DPFC infringed Veronica's right to life (s. 9) and right to equality (s. 8).

## Where can I learn more about the Coronial Inquest into Veronica's passing, prison healthcare, bail reform and investigations into Aboriginal deaths in custody?

- Inquest into the Passing of Veronica Nelson – Coronial Findings and Recommendations
- Statement from Veronica Nelson's family (January 2023)
- Submissions to the Inquest on behalf of Uncle Percy Lovett (July 2022)
- VALS Policy Brief, Fixing Victoria's Broken Bail Laws (May 2022)
- VALS Factsheet, Ending Aboriginal Deaths in Custody (January 2022)



Aunty Donna, Uncle Percy and friend on steps of Parliament

# Summary of Coroner's Key Recommendations

## RCIADIC

- The Victorian Government in consultation with Victoria Police, the DJCS, the DH and peak Aboriginal organisations must urgently develop a review and implementation strategy for the State's implementation of the 339 recommendations from the RCIADIC.

## Bail Act reform

- Urgently review the Bail Act with a view to repeal any provision having a disproportionate adverse effect on Aboriginal people.
- Urgently repeal s. 4AA(2)(c) (double uplift), Schedule 2 Clause 1 and Schedule 2 Clause 30.
- Urgently repeal all bail offences (ss. 30, 30A and 30B).
- Urgently amend the requirement to consider a person's Aboriginality (s. 3A).
- Urgently amend the 'new facts and circumstances' test (s. 18AA).
- Prison healthcare
- DH and DJCS should consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services.
- DH and DJCS should consult with stakeholders to determine what model of healthcare delivery will achieve the best health outcomes for people in Victorian prisons.
- DJCS and/or Justice Health, in partnership with VACCHO, should take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.
- Justice Health must immediately amend the Justice Health Opioid Substitution Therapy Guidelines to ensure that all women with opioid dependencies are given access to opioid substitution pharmacotherapy upon reception to prison, including the option of methadone or suboxone and their long-acting injectable buprenorphine formulations, irrespective of the length of incarceration.

- Justice Health and the Health Service Provider at DPFC should ensure that all Aboriginal people have the option during the reception medical assessment of consulting with an Aboriginal Health Practitioner or Aboriginal Health Worker, either in person or by telehealth, within 48 hours.
- The Victorian Government should establish a subacute unit at the Medical Centre at DPFC available to all people who require it, and that includes oversight by a specialist who has completed Advanced Training in Addiction Medicine.
- CCA and/or the Health Service Provider at DPFC should develop and implement procedures for clearance of a person from the Medical Centre, and clinical deterioration.
- The Victorian Government should revise the system for auditing and scrutiny of custodial healthcare services.
- Justice Health should require custodial Health Service Providers to engage with Victoria's Aboriginal communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to people who are incarcerated. This process should be ongoing, guided by Victoria's Aboriginal communities and be conducted in the manner determined by these communities.
- Justice Health require custodial Health Service Providers to: ensure that their medical practitioners and Registered Nurses have completed relevant AOD training; employ a full-time specialist in Addition Medicine and doctors and nurses who are qualified to practise opioid pharmacotherapy.
- The Coroner referred CCA to the DPP for investigation for an indictable offence under s. 23 Occupational Health and Safety Act 2004.

## Drug and Alcohol Services

- DH, in collaboration with relevant ACCHOs and other stakeholders, must prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence.

## Magistrates Court of Victoria

- The MCV should employ sufficient Aboriginal or Torres Strait Islander staff in roles (however described) within the court to provide assistance to and, where necessary, advocacy for, Aboriginal and Torres Strait Islander court users including people remanded in custody.
- The MCV should ensure that the Court Integrated Services Program (CISP) is staffed whenever the court is open, including throughout Bail and Remand Court sessions.

## Corrections Victoria

- DJCS should develop and implement a policy and deliver training to CV staff about the operation of that policy, to ensure that cultural considerations are incorporated into management of a deceased Aboriginal or Torres Strait Islander person in custody and, to the extent possible, the scene of that person's passing.
- CV should review its practice whereby only two Prison Officers have access to cell keys during the Second Watch overnight at DPFC and address any impediment to the timely entry to cells that might arise so to ensure prisoner health, welfare and safety.

## Cultural awareness training

- The Victoria Police should partner with appropriate ACCOS to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review for all members.
- The Chief Commissioner of Victoria Police must require police BDMs to undertake periodic training to address the interpretation and application of section 3A of the Bail Act.
- DJCS should partner with appropriate ACCOs to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review, which is applicable to: (1) Corrections Victoria; and (2) Correct Care and/or the Health Service Provider at DPFC.
- The Victorian Legal Admissions Board, the Legal Services Board and the Victorian Bar should consider including cultural awareness training as a mandatory requirement for admission and continuing professional development.

## Deaths in Custody Investigations

- DJCS must urgently redesign the JARO and Justice Health Death In Custody reviews.

## Data

- The Chief Commissioner of Police and the MCV should collect and make available statistics relating to people charged with offences to which the 'exceptional circumstances' and 'compelling reasons' tests apply.

# Acknowledgement of Traditional Owners

The Victorian Aboriginal Legal Services acknowledges all of the traditional owners in Australia

and pay our respects to their Elders, past and present. Soveriegnty was never ceded.

Always was, always will be, Aboriginal land.

## Artwork

Aboriginal artwork by Dixon Patten, a proud Gunnai, Yorta Yorta, Gunditjmara, Dhudhuroa man.


Uncle Percy, Sarah Schwartz and Barristers Andrew Woods and Stephanie Wallace outside the Coroners Court of Victoria

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