IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 1758

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: COLIN DAVID JOHNSON

Delivered On:	27 March 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	18, 19, 20 August 2014
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Ms J M Forbes of Counsel, instructed by Mr Shane Dawson of Meridian Lawyers, appeared on behalf of the GEO Group Australia Pty Ltd
Police Coronial Support Unit	Sergeant Sharon Wade, assisting the Coroner.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of COLIN DAVID JOHNSON

AND having held an inquest in relation to this death on 18, 19 and 20 August 2014

at Melbourne

find that the identity of the deceased was Colin David Johnson

born on 4 September 1957

and the death occurred on 6 May 2011

at The Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004

from:

I (a) COMPLICATIONS ARISING FROM BLUNT FORCE TRAUMA TO THE HEAD

in the following circumstances:

Summary

1. On Saturday 23 April 2011 at 11.46pm, two correctional officers within the Fulham Correctional Centre responded to an activated smoke alarm near cells 5, 6, 7 and 8 within the Yeerung Unit of the Centre. Upon arrival at this location, the responding correctional officers conducted an inspection of these cells. Whilst inspecting cell 6, officers observed the occupant, Mr Colin Johnson (Mr Johnson), naked and bent over on his knees. After accessing the cell, officers found Mr Johnson breathing and unresponsive. Officers observed blood and vomit on the floor of the cell and blood covering the right side of Mr Johnson's face. He was treated at the scene by the duty nurse and ambulance officers who gave Mr Johnson's conscious state a Glasgow Coma Score of five.[1] It was further found that Mr Johnson had orbital swelling around his right eye and had sustained extensive head injuries.

2. Mr Johnson was transported via ambulance to the Central Gippsland Health Service, where a clinical examination revealed two independent right frontal-temporal lacerations. A CT scan revealed a large acute left sided subdural haematoma with midline shift to the right. The scan further revealed that Mr Johnson had sustained up to four individual facial

[1] Glasgow Coma Scale is a standardised system for assessing response to stimuli in a neurologically impaired patient; reactions are given a numerical value in three categories (eye opening, verbal responsiveness, and motor responsiveness), and the three scores are then added together. The lowest values are the worst clinical scores. (Source: *Dorland's Illustrated Medical Dictionary*, 30th Edition).

fractures. Due to these findings, Mr Johnson was transported to The Alfred Hospital, Melbourne, where he underwent craniotomy surgery to relieve the pressure on his brain.

3. Post surgery, Mr Johnson was admitted to the Intensive Care Unit, where he remained on life support until 10 May 2011, when it was determined that due to a poor prognosis, support should be withdrawn. Mr Johnson was moved to palliative care, and at 6.00am on 6 May 2011, he was confirmed deceased.

4. As a result of post mortem examinations, the cause of Mr Johnson's death was determined to be *complications arising from blunt force trauma to the head*. His injuries resulted from at least four blows to the head. The causes of Mr Johnson's injuries were determined to be the result of a serious assault, which occurred on Saturday 23 April 2011.

Personal history

5. Mr Johnson was born on 4 September 1957 at the Chelsea 'Bush Nursing' Hospital to Ms Patricia Johnson and Mr Laurence Johnson Snr (dec). After his birth, Mr Johnson lived with his parents and older brother, Laurence Johnson Jnr, aged two, at 96 Elsie Grove, Chelsea. Mr Johnson Snr and Ms Johnson went on to have five more children and adopted a child into the family. This made Mr Johnson a younger brother to Laurence Jnr and an older brother to Mark, Steven, Carl, Rachael and Rebekah, and a half brother to Linda.

6. Mr Johnson attended school at Edithvale Primary School, where he completed prep through to grade 6. He then attended Aspendale Technical College where he completed years 7 to 9. After completing year 9, Mr Johnson left school and began working with his father in a concreting business, and performed other labouring roles.

7. Mr Johnson had an active life and enjoyed interests and hobbies such as fishing, camping, horse riding and surfing. He also played football with a number of clubs including Edithvale, Chelsea and Aspendale and was a member of the Edithvale Lifesaving Club.

8. At 17 years old, Mr Johnson moved out of home and moved in with friends and his older brother. It was around this time that he was introduced to illicit drugs and came to the attention of police. He received his first criminal conviction in January 1975 for offensive behaviour, and was then regularly brought before the courts between 1975 and 2010 for offences including drug possession and use, burglaries, thefts, possessing housebreaking implements, driving offences, handling stolen goods and deceptions. Most of these charges originated in Victoria, but Mr Johnson had also been brought before courts in New South Wales and the Northern Territory for offences of a similar nature.

9. At age 20, Mr Johnson experienced his first period of incarceration. From that point onwards, he spent much of his adult life in prisons in Victoria. When not in prison, Mr Johnson was a heavy user of heroin and alcohol, and was financially supported via government payments.

10. In November 2009, Mr Johnson was convicted of a number of offences and sentenced to two years' imprisonment.

11. On 10 May 2010, Mr Johnson was transferred to the Fulham Correctional Centre in Sale, Victoria. On 20 September 2010, he was moved into the Yeerung Unit and was originally eligible for parole from 19 March 2011. On 25 February 2011, Mr Johnson provided a sample for urinalysis. On 26 March 2011, Mr Johnson attended an apparent favourable parole hearing. Whilst the decision whether parole be granted was pending, Mr Johnson's urine sample tested positive for the presence of buprenorphine. Mr Johnson was therefore denied parole and his order was varied for three months, making his next eligible parole date 26 May 2011. However, after receiving his injuries on 23 April, Mr Johnson was released on parole on 5 May 2011.

12. The Yeerung Unit within the Fulham Correctional Centre is a standalone building consisting of two 'pods'. The Unit is capable of housing 52 prisoners.

13. Each pod has its own day room, laundry and kitchen. The pods are separated by an officers' station, which has views of the day rooms of both pods and the foyer leading to the main entry/exit. Prisoners are free to walk from one pod to the other via a connecting corridor, which passes in front of the officers' station.

14. The Unit is equipped with 12 surveillance cameras, which are monitored from within the officers' station. Only eight of these cameras record live motion of the cell corridors. No cameras are installed to capture events within the day rooms.

15. Each cell is fitted with a sensor that sounds an alarm within the Fulham Control Room if it detects the presence of smoke. Each cell is also fitted with an intercom, which allows prisoners to request medical or other assistance from correctional staff.

The Inquest

16. An inquest into Mr Johnson's death was held between 18 and 20 August 2014. Time was given for final submissions to be made by legal representatives. Submissions were received by the GEO Group Australia Pty Ltd (GEO Group) on 5 December 2014, and by OCSR on 23 February 2015.

Inquest – Scope

18. The focus at inquest was on:

- Yeerung Unit at the Fulham Correctional Centre
  - security within the Centre
  - surveillance from within the officers' station
- Procedure at lockdown – observation of prisoners
- Measures taken by correctional services flowing from the incident in the Office of Correctional Services Review (OCSR) report.

20. WX also objected to giving evidence on the grounds that he may incriminate himself. I accepted the ground of his objection, granted a section 57 certificate and he then gave evidence.

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[2] The names of several witnesses were suppressed so that publication or broadcasting of any material tending to identify the witnesses is prohibited. I have therefore not referred to the witnesses in question by their names or by any titles that would identify them.

[3] A certificate under section 57 of the *Coroners Act 2008* may be given to a witness if a witness objects to giving evidence, or evidence on a particular matter, at an inquest on the ground that the evidence may tend to prove that the witness has committed an offence or is liable to a civil penalty under an Australian law or a law of a foreign country. The Coroner must determine whether there are reasonable grounds for the objection.

21. A number of suppression orders were made during the course of the inquest, prohibiting publication or broadcasting of various material or evidence, as I reasonably believe that publication would be contrary to the public interest.

22. At the conclusion of the inquest, I indicated that I would not conclude the matter before being informed of any decision making in respect of criminal charges arising from Mr Johnson's death. I have been informed by the CI that no individuals have been charged in respect of Mr Johnson's death at this stage.

23. The Director of Public Prosecutions advised the CI was that it was '*the Director's view that the matter should proceed by way of Coronial Inquest following which, the circumstances of the case and the findings of the coroner may be reviewed*'.[4]

Purpose of a Coronial Investigation

24. This finding is based on the totality of the material the product of the coronial investigation of Mr Johnson's death. That is, the brief of evidence compiled by Sgt Densley, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

25. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be guilty of an offence. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable may have been committed in connection with the death.[5]

Findings as to uncontentious matters

26. In relation to Mr Johnson's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Colin David Johnson, born on 4 September 1957, aged 53, died at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004, on 6 May 2011.

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[4] Inquest brief summary, page 48.

[5] *Coroners Act 2008* sections 69(2) and 49(1).

27. Nor was the medical cause of death contentious. On 17 May 2011, an autopsy of Mr Johnson's body and post mortem CT scanning (PMCT) were performed by Senior Forensic Pathologist Dr Malcolm Dodd, which revealed the cause of his death to be *I (a) complications arising from blunt force trauma to the head.* Dr Dodd stated that the post mortem examination revealed evidence of at least four independent blows to the head.[6] Post mortem toxicological analysis revealed the presence of morphine, metoclopramide, gabapentin and paracetamol, consistent with therapeutic administration.

Fulham Correctional Centre – Yeerung Unit

28. The physical layout and position of cameras in the Unit were issues explored at inquest. A number of exhibits were tendered to aid an understanding of the layout of the Unit. Exhibits 2 and 3 provided this information – including the cell of each prisoner in Pods 1 and 2 in the Yeerung Unit. Mr Johnson was allocated cell 6 within Pod 1 of the Yeerung Unit, which was a one-prisoner cell. CCTV cameras 159 and 160 give a view of the corridor where cells 1 to 14 are positioned.

29. It is clear that Mr Johnson was assaulted and injured whilst in the Pod 1 day room between 5.06pm and 5.49pm. The attack was not captured on any CCTV camera or witnessed by any correctional officers. The attack occurred within the short timeframe of 5.06pm to 5.49pm, when he was sitting on a couch. This was one of a group of three couches facing a TV cabinet. At the time of the incident, there were no cameras operating in the areas identified as day room 1 and day room 2 (otherwise known as the common rooms). I was advised that day room 1 an day room 2 are not subject to camera coverage because they are '*adjacent to the officers' station from which correctional officers have a clear visual through its glass windows*'.[7] GEO Group also stated that '*the cameras are positioned so that there is CCTV coverage of the areas within the Yeerung Unit but are not in direct line of sight from the officer's station. The view from these cameras are displayed on monitors within the officers' station. Since the time of this incident there has been no change to the number of cameras or their position*'.[8]

[6] Report of Dr Malcolm Dodd dated 26 July 2011.

[7] Exhibit 17: Letter from Meridian Lawyers dated 11 August 2014.

[8] Ibid..

31. An issue at inquest was whether the camera coverage in the area was adequate and whether it should be improved. I will return to this issue.

32. Mr Johnson's death was exhaustively investigated by the Homicide Squad. A comprehensive coronial brief was provided and I thank the CI, Sgt Nick Densley, for his assistance. The coronial brief sets out a summary of the Homicide Squad investigation. It also sets out the details of an internal investigation conducted by GEO Group after Mr Johnson's death.

33. There was no direct evidence of an attack on Mr Johnson – no statements of eyewitness evidence and no camera evidence of any assault. Prisoners in the area and others in the pod were, however, thoroughly investigated for the purposes of the criminal investigation.

35. The medical response to the injuries was delayed. Injuries were not detected on Mr Johnson until just after midnight on 24 April 2011; a little over six hours after the injuries were

[9] Inquest brief summary, page 32.

inflicted. The reason for this is that the lockdown rules at the time did not require each prisoner to be viewed physically, and face on, to assess their welfare

37. The evidence covered in detail the lockdown arrangements at the Unit at the time. This was a significant issue.

38. The lockdown on 23 April 2011 took place at 6.00pm. The process involved Correctional Officer (CO) A conducting an identity and welfare check of the prisoner within the cell, followed by COs B and C who locked and double locked each cell door. Critically, it was revealed by the investigators at the time, and confirmed at inquest, that upon reaching Mr Johnson's cell (cell 6), CO A found the cell door closed. He opened the door and found that the light was off but the TV was on. There was some ambient light from the TV. He was able to identify Mr Johnson sitting on the bed alone watching television. CO A asked Mr Johnson '*are you alright*' to which Mr Johnson replied '*yep*'.[10] CO A closed the door and COs B and C locked and double locked the door. There was not a close up, face on physical viewing of Mr Johnson.

39. At about 7.13pm, two other officers responded to an alarm in the vicinity of cell 7. One of those officers (CO D) inspected Mr Johnson's cell and observed the TV was on and that he was sitting upright on his bed with his back to the south wall. She could see the entire left side of Mr Johnson, who appeared to be completely naked. She observed him turn his head and look at her and believed that he was responding to her presence. Again, there was not a close up, face on physical viewing of Mr Johnson. After considering the evidence, I am satisfied that there was inadequate observation of Mr Johnson at the point of lockdown. This was conceded by GEO Group and changes were subsequently made to the lockdown procedure.

40. At about 11.46pm on the same evening, there were four further alarm calls from cells 5, 6, 7 and 8 within the Yeerung Unit. They were followed up. At 12.05am on 24 April 2011, Mr Johnson's cell door was opened and he was attended by Registered Nurse YZ and other COs. He was non-responsive and had extremely shallow breathing, and blood and vomit were observed on the floor near where he lay. RN YZ observed an extremely swollen right

[10] Inquest brief summary, page 21.

eye and an open wound leading from about the right eye on his forehead going back down his hairline. Mr Johnson was moved out of his cell and further treated.

Medical Evidence

41. At 12.32am on 24 April 2011, ambulance paramedics arrived. Mr Johnson was observed to be bleeding from the skull, which was being controlled by Registered Nurse YZ. Both paramedics formed the opinion that the separate injuries to Mr Johnson's frontal and parietal skull regions were caused by assault and unlikely to be self-inflicted. Injuries were quite deep at two different locations on the skull. Mr Johnson was transported from the prison and his cell was locked down.

42. Mr Johnson was conveyed to the Central Gippsland Health Service. A CT scan of his brain, face and cervical spine was conducted, which revealed '*an obvious large acute left sided subdural haematoma with midline shift to the right*'.[11] A further CT scan revealed the extent of his injuries including fractures to the right frontal sphenoid sinus. A third fracture was identified at the right zygomatic arch. There was a fourth fracture to the nasal bone.

43. Dr Rong, who assessed Mr Johnson at the Health Service, concluded that his prognosis was poor and his chance of survival remote. In his opinion, Mr Johnson had sustained the injuries from either a very violent fall or an assault. Mr Johnson was then conveyed to the Alfred Hospital, Melbourne. He underwent various procedures at the hospital, was ultimately referred to palliative care and died at 6.00am on 6 May 2011.

44. Dr Malcolm Dodd, who conducted the post mortem examination of Mr Johnson's body, found that '*[i]n aggregate*' the findings of fractures '*represents at least four (4) independent blows to the head*'. He stated that '*[d]ue to the prolonged inpatient survival time (admitted 24/4; died 6/5), any evidence of additional blows would have resolved by naturally occurring healing processes*'.[12]

45. In the supplementary report prepared by Dr Dodd, he was asked whether an earlier intervention may have led to a different outcome. He stated that:

> *...the simple and uncomplicated answer is yes.*
>
> *Blunt force trauma of this severity may readily lead to intracranial haemorrhage as was seen in this case.*

[11] Inquest brief summary, page 10.

[12] Report of Dr Malcolm Dodd dated 26 July 2011.

The decision for early intervention would be governed by the external appearances of the injuries and also, the perceived neurological alterations, if any, at the time of discovery.

If Colin Johnson had been transferred to hospital soon after the wounds had been inflicted, a CT scan may have shown an evolving subdural haemorrhage which could have been more readily evacuated and this may possibly have changed the outcome.

On the other hand, a prompt CT scan may have shown little in the way of subdural haemorrhage formation by once in a controlled environment, the patient would have been amenable to continual neurological observation over time to monitor for the possibility of evolving intracranial haemorrhage.[13]

I accept Dr Dodd's evidence on these matters.

46. GEO Group made a detailed submission on this topic. It refers to the opinion of Dr Dodd on whether earlier medical intervention may have led to a better outcome. It describes the pathologist's answer to that question as '*necessarily speculative.*'[14] The argument is, in essence, because '*the timing of any earlier CT investigations could not be pinpointed. ... because it cannot be known whether a CT scan at any particular earlier point in time would have shown anything by way of evolving subdural haemorrhage formation*'.[15]

47. I accept the validity of these submissions, and that any finding about whether earlier intervention may have saved Mr Johnson's life must be qualified. However, from the family's point of view, the key point is that earlier knowledge of and identification of the injuries, and therefore earlier medical intervention, should have been possible in the circumstances. I agree with this contention. The question is whether earlier medical intervention would have made any difference to the outcome; this necessarily involves a degree of speculation.

48. Dr Dodd does put it in a qualified way by saying '*a CT may have shown an evolving subdural haemorrhage which could have been more readily evacuated and this may possibly have changed the outcome*'.[16] He allowed for the fact that a prompt CT scan may have shown '*little in the way of subdural haemorrhage formation*',[17] but makes the point about the advantages of the patient being able to have '*continual neurological observation over time*'.[18] On balance, any medical opinion such as this must have a degree of speculation

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[13] Exhibit 26: Supplementary Report of Dr Malcolm Dodd dated 12 August 2014.

[14] Submissions of GEO Group dated 5 December 2014, page 11.

[15] Ibid.

[16] Exhibit 26: Supplementary Report of Dr Malcolm Dodd dated 12 August 2014

[17] Ibid.

[18] Exhibit 26: Supplementary Report of Dr Malcolm Dodd dated 12 August 2014.

about it. However, in my view and on the balance of probabilities, earlier identification of the injury, earlier medical intervention and earlier transportation to hospital would have increased Mr Johnson's prospects of surviving the attack. He did after all live for some time after the attack.

49. I accept GEO Group's submission about the nature and importance in this case of the *Briginshaw*[19] standard,[20] and accept that it is not open to find that earlier medical intervention would have necessarily changed the outcome. However, in my view it is open to find on balance that it is more likely than not, that early intervention would have led to at least an improved medical prospect for Mr Johnson, and I so find.

Circumstances of the assault

The evidence

51. AB was asked if he recalled what the correctional officers were doing at the time. He stated that he believed they were doing '*just normal things. Just kicking back, I guess.... Just sometimes like it's - they have their feet up on the desk and just head in - and they're reading in the newspaper, stuff like that.*'[25] He could not recall if that was exactly what they

[19] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp 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...'

[20] Submissions of GEO Group dated 5 December 2014, page 11.

[21] Inquest transcript, pages 66-7.

[22] Ibid page 68.

[23] Ibid pages 69-70.

[24] Ibid page 72.

[25] Ibid, page 73.

were doing at the time of Mr Johnson's death,[26] but described the officers as appearing '*pretty relaxed*' at the time.[27]

52. AB gave evidence about his observations of the general demeanour of the prison officers. He stated:

> *I've had concerns for myself, what happens if I had a heart attack or something, you know, look at them, they're just kicking back. How easy their job - feet on the chair, reading the paper and some are on the computer perhaps doing their work and - you know, you do see them sometimes snoring asleep and there's been incidents where they've had to wake them up because the governor's coming down. I've seen that happen.*[28]

53. This is disturbing evidence of one aspect of the culture within the prison at the time.

54. AB was also asked, about the placement of CCTV cameras in the area, whether he understood that the common area did not contain cameras and whether he would have had any objection to their placement. AB stated that the presence of CCTV cameras was '*sort of reassuring in a way, like, for safety*' and that '*you want all the protection you can get I guess*'.[29] AB noted the difference in the lockdown procedure following Mr Johnson's death, and stated that the previous practice was '*just a quick look in, then shut the door. Like, "Goodnight," shut the door, and that was it*'.[30]

56. Witness CD gave evidence at inquest via videolink. He agreed that he was moving around the Unit and going in and out of Pod 1 at the time Mr Johnson was believed to have been injured. He recalled seeing Mr Johnson holding his head.[33] CD did not see any blood on the common room floor, but believed that it had been cleaned as he saw another prisoner

[26] Inquest transcript pages 76-7 and 80-1.

[27] Ibid pages 76-7.

[28] Ibid page 77.

[29] Ibid page 75.

[30] Ibid.

[31] Ibid page 19.

[32] Ibid page 20.

[33] Ibid page 154.

cleaning up.[34] He recalled being told shortly before lockdown that Mr Johnson had been injured.[35]

57. CD was shown CCTV footage of himself walking towards the Pod 1 day room, before turning abruptly and returning to his cell at 5.45.50pm. He could not recall why he turned so abruptly away and walked away from the day room, but stated that he probably forgot something. He did not agree with the proposition that he saw something that made him turn around to return to his cell.[36] CD was asked about the absence of CCTV cameras in the Pod 1 day room and stated that he believed that cameras should have been present in the area because it was otherwise a '*blind spot*'.[37]

58. CD agreed that he told GEO Group investigators following the assault that he found it difficult to accept that the correctional officers on the day had not seen Mr Johnson injured, either before or during lockdown as the injury appeared to be serious.[38]

59. I am satisfied on the evidence that Mr Johnson was assaulted in Pod 1 day room, four to five metres outside the prison guards' office in the Yeerung Unit, and that the assault caused his death. Video footage of the office shows a large window looking out to the common area, and shows an apparently unobstructed view. It is unacceptable that the correctional officers on duty did not observe the assault on Mr Johnson, the subsequent cleaning up of the area by another prisoner, Mr Johnson walking, injured, back through the common area to the cells, or his injuries at lockdown.

60. The standard of proof for coronial findings of fact is the civil standard of proof, on the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[34] Inquest transcript, page 155.

[35] Ibid page 156.

[36] Ibid page 159.

[37] Ibid page 161.

[38] Ibid page 165.

62. It is unreasonable to expect prisoners who may have witnessed an attack to come forward and provide a fulsome statement, for their very real fear for their personal safety. This is, unfortunately, particularly so in light of the fact that prisoners observed that an attack of this nature went unnoticed by correctional officers. This would have, understandably, further increased any reluctance to provide a statement.

Submissions

63. The family asked, and the GEO submissions responded to, the following questions:

- Why was it possible for the injuries to be inflicted without being observed or being seen by any correctional officers?
- Why was the scene able to be mopped up and cleaned by other prisoners without this being detected?
- Why were Mr Johnson's injuries not observed earlier – at least at the 6.00pm lockdown point?
- What procedures relating to lockdown applied then, what procedures now apply and have the changes been effective?

64. I note the submissions of Mr Johnson's family, made by way of Ms Patricia Johnson's statement and the victim impact statement of Ms Linda Oeser, Mr Johnson's sister. Both statements were read aloud in open court by the family members. The statements evidence the family's grief for the loss of their loved one, as well as their understandable frustration and dissatisfaction with the circumstances surrounding Mr Johnson's death.

GEO Group submissions

65. In the submissions made on behalf of GEO Group, the following topics were covered:[39]

(i) circumstances of the assault

(ii) supervision of prisoners

(iii) lockdown procedures

(iv) presence and accessibility of surveillance television footage

(v) emergency response by the Centre and the effect of any delay in receiving medical treatment

[39] Submissions of GEO Group dated 5 December 2014, page 2.

(vi) changes implemented at the Centre following the death of Mr Johnson.

66. The evidence is summarised accurately and succinctly in that submission. It is accepted by GEO Group that Mr Johnson must have been assaulted in the Pod 1 day room. No one informed correctional staff that they saw the assault and no correctional staff observed the event.

67. In relation to the supervision of prisoners, the submission notes (and the evidence confirms) that the supervision of prisoners was maintained by direct observation from the officers' station and by conducting patrols of the Unit, including monitoring the CCTV screens displaying corridor areas of the Unit not within the line of sight of the officers' station. But no officer saw Mr Johnson being attacked. Put another way, the officers on duty failed to see the attack or the associated mopping up of blood from the floor. This was a highly significant failure and one that required correction. The submission made by GEO Group pointed out that '*The requirement was that at least one officer be present in the officers' station at all times*'.[40] It referred to the '*conflicting prisoner evidence as to whether two or three of the officers on duty were in the station at around the time of the assault...*'[41] On any view, the station should be manned and those manning it should be maintaining careful observation of prisoners and an observation of the screens covered by the cameras.

68. The submission referred to the findings of the OCSR report. That report concluded that the officers were all '*likely to be collecting their belongings in preparation for lock-in*'[42] as an explanation for them not witnessing the assault, nor the subsequent CCTV footage of Mr Johnson in his injured state in the corridors prior to him entering his cell. GEO Group also submitted that this was the explanation for the failure to witness the assault. The submission noted that all three correctional services officers faced disciplinary proceedings in relation to their actions on the day. This was entirely appropriate, as there were clear performance failures by these officers. The submission informed me that the disciplinary charges related to the failure to perform their supervision duties on the day as well as matters relating to the reporting and recording functions.[43]

69. In terms of improvement and change of system, the submission notes that the OCSR review identified two ways in which correctional staff visual supervision were inadequate: '*firstly*

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[40] Submissions of GEO Group dated 5 December 2014, page 4.

[41] Ibid page 5.

[42] Ibid.

[43] Ibid.

that patrols through the unit were insufficient to maintain a dynamic presence in the unit, and secondly, the particular practice of all officers collecting their belongings, leaving the unit unsupervised for a short but predictable time'.[44] The submission noted that GEO Group has taken action to remedy both shortcomings. These actions were necessary and appropriate. The submission noted the changes and the fact that the number of patrols is now regulated and must be entered in the logbook, and that '*[t]he requirement for officers in the station to fulfil their supervision obligations was reminded to officers in a memorandum issued by a correctional manager...*'[45]

70. Ultimately, GEO Group submitted that, in light of the action already taken with regard to failings in supervision, no further recommendation be made by the coroner for further action.[46] I accept that submission; there is no need for a further recommendation on this point.

71. Dealing with the lock up muster, the submission makes the clear point, again strongly supported by the evidence, that: '*[h]ad Mr Johnson been required to stand at his cell door, it is probable that his injuries would have been identified by corrections staff prior to lock up. Lock up muster procedure was changed as a result of this incident and prisoners are now required to stand in front of their cell doors for this purpose*'.[47] There was a substantial body of evidence about the change and it is undoubtedly a necessary corrective measure.

72. The submission again is to the effect that given the changes already implemented, no further recommendations on this point are now necessary. Again, I agree with the submission and will make no further recommendations for change.

73. The next topic dealt with in the submission was the CCTV footage. The submission deals at some length with the reasoning behind the placement of the cameras, and argues that the GEO Group does not have the power or authority to alter the locations of the cameras at the Centre, and that even if did: '*[i]t is the submission of GEO that, although footage of the assault would most likely have produced evidence that may have identified the perpetrator of this crime, the evidence has not disclosed any broader rationale to justify a camera in this particular position*'.[48] I do not accept this submission. Identification of the

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[44] Submissions of GEO Group dated 5 December 2014, page 5.

[45] Ibid pages 5-6. This memorandum was Exhibit 18 at inquest.

[46] Submissions of GEO Group dated 5 December 2014, page 6.

[47] Ibid.

[48] Ibid page 9.

perpetrator/perpetrators of this assault by CCTV cameras would of itself have justified having them there. However I accept, in this context, that it was expected that the guards would be watching the relevant area themselves. In addition the evidence of prisoners and former prisoners on the point was that they would consider the area safer, and themselves safer, if there were CCTV cameras covering these areas. These witnesses did not believe that they would feel intruded upon, or that their privacy would be unreasonably invaded by cameras covering the day rooms in both pods. This is cogent evidence.

74. I agree with the submission that the '*[b]est practice in terms of visual supervision is actual supervision rather than monitoring a screen*'.[49] All measures rely on active, alert and conscientious staff. I also agree that the purpose of cameras in any prison is primarily to assist with supervision to ensure the welfare of prisoners. However, noting the evidence of the prisoners, I can see no compelling reasons why both pods should not be subject to CCTV cameras coverage. Significantly, who gave evidence on behalf of GEO Group accepted that a recommendation for additional cameras applicable to both pods would be appropriate and that he would in fact support it. I intend to recommend accordingly.

The changes since the death

75. The OCSR review, and the evidence of are important in this context. In relation to the supervision of prisoners by correctional officers on the Yeerung Unit, gave evidence that a memorandum that was issued to all Yeerung Unit staff on 18 May 2012 regarding the OCSR recommendation following Mr Johnson's death.[50] The memorandum required correctional officers to ensure the appropriate supervision of prisoners at all times, and noting that it was apparent that some work habits adopted by staff had at times resulted in less than appropriate supervision. Staff were reminded to comply with all relevant policies when undertaking their duties, and to be mindful of not congregating in one location, resulting in less than acceptable or no supervision. The relevant staff signed the memorandum acknowledging that they had read and understood it.[51]

76. In relation the lockdown procedure at the facility, detailed the change following Mr Johnson's death. The procedure now involves the prisoner having to stand at their cell door and state their name and Corrections Reference Number (CRN), in order for

[49] Submissions of GEO Group dated 5 December 2014, page 7.

[50] Exhibit 18, Memo addressed to all Yeerung staff dated 18 May 2012.

[51] Inquest transcript, page 193.

the correctional officer to physically observe the prisoner to confirm that they are in a safe and fit state.[52] The wooden rolling pins which had been made by the prisoners, were removed from the units, and prisoners no longer make these utensils.[53] There were also changes to strengthen the ability to report incidents to appropriate senior staff in a timely manner, at any time.[54]

77. In relation to security checks, I note that log book entries from some two years after Mr Johnson's death, were tendered at inquest as evidence of compliance with the security checking policy, but actually demonstrated a failure to comply with GEO Group's requirements governing the minimum number of daily checks to be conducted. This was despite GEO Group submitting that it has taken appropriate steps to ensure that correctional officers understand their duties and responsibilities. I would hope that this revelation at inquest has led to a tightening up and to fully compliant practices.

78. gave evidence that a review was conducted by the Fulham Correctional Centre in relation to the placement of cameras, and that the review recommended the addition of certain external cameras, but none internally.[55] During cross examination, it was put to that the reason for cameras not being installed in the communal area is that the guard office is in that location, and that the guards can view the area through the window. agreed with the proposition.[56] Ultimately, agreed that cameras should be placed in the common areas of the Yeerung Unit.[57]

79. stated that it was '*disappointing and regrettable*' that the assault of Mr Johnson was not observed at the officers' station or the injuries at lock in muster. However, stated that he was most disappointed that other prisoners did not discreetly ask that Mr Johnson's cell be checked by using the intercom.[58] Whether this is a reasonable expectation in a prison environment is questionable. Ultimately, the principal way that the

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[52] Inquest transcript pages 216 and 236, and Exhibit 22: GEO Fulham Correctional Centre Operating Manual: "Musters" dated 30 July 2012.

[53] Inquest transcript, page 217.

[54] Ibid pages 225-6 and 239. Mr Johnson's death occurred during a public holiday period and the unavailability of certain staff was identified as an issue.

[55] Ibid page 227. It appears that the recommendation for the installation of these external cameras was due to another matter unrelated to Mr Johnson's death.

[56] Ibid pages 229-30.

[57] Ibid page 235.

[58] Ibid pages 230-1.

protection of the prisoners is assured is the action of the guards, and agreed with this proposition at inquest.[59]

Was the death preventable?

80. In my opinion, Mr Johnson's death *was* preventable. With the right camera coverage and/or attentive observations by the guards in the office of the day room where Mr Johnson was attacked, it is less likely that the attack would have occurred but once it did, it is highly likely it would have been seen. Mr Johnson would have been attended to immediately, medical intervention and treatment would have occurred far earlier, and there was a possibility that he would not have died from his injuries.

Referral to the Director of Public Prosecutions

Suppression Orders

83. I will suppress publication or distribution of those parts of this finding, pursuant to section 18(2) of the **Open Courts Act 2013**, that refer to and the references to the referral to the Director on the basis that publication would be likely to prejudice the fair trial of a person. Consistent with that order, I order that a redacted version of this finding be published on the Court website. Other suppression orders have been made in relation to various witnesses and material in this investigation, pursuant to the Open Courts Act, as I reasonably believe that publication would be contrary to the public interest.

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[59] Inquest transcript page 232.

[60] Section 49(1) of the Coroners Act provides that '*The principal registrar must notify the Director of Public Prosecutions if the coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire.*' The established practice in this jurisdiction, with rare exceptions, is to do so at the conclusion of the coronial investigation and at or after delivery of the finding.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I recommend that Corrections Victoria install and operate CCTV cameras in the areas identified as day room one and day room two of the Yeerung Unit of the Fulham Correctional Centre.[61]

I extend my sincere condolences to the family and friends of Mr Johnson.

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

Ms Patricia Johnson

Ms Linda Oeser

Mr Laurence Johnson

Office of Correctional Services Review c/o Mr Antonio Mazzone, VGSO

GEO Group c/o Ms Kellie Dell'Oro, Meridian Lawyers

Mr John Champion SC, Director of Public Prosecutions

Ms Jan Shuard, Commissioner, Corrections Victoria

Ms Larissa Strong, Director, Justice Health c/o Ms Jennifer Butler, VGSO

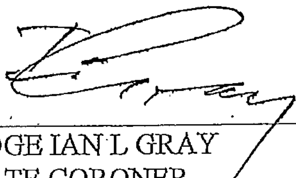
Ms Margaret Angliss, Alfred Health

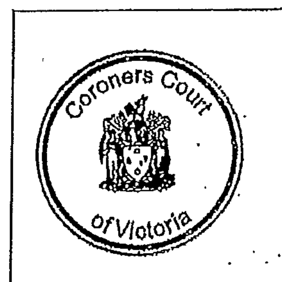
Ms Diana Battaglia, Alfred Health

Sergeant Nick Densley, Victoria Police, Coroner's Investigator

Sergeant Sharon Wade, Police Coronial Support Unit.

Signature:





JUDGE IAN L GRAY
STATE CORONER
Date: **27 March 2015**

[61] Exhibit 2: Site plan of the Yeerung Unit.