IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000740

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF DARREN RICKY CULLETON

Findings of:	Coroner David Ryan
Delivered on:	14 September 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	5-9 & 13-16 June 2023
Counsel Assisting the Coroner:	Carly Marcs of counsel
Family for Mr Culleton:	Andrew Woods and Sam Bird of counsel
Chief Commissioner of Police:	Marion Isobel of counsel
Senior Constable Frank Giannioglou Constable Hugh O'Donnell Constable Harley Bruem Constable Inosha Bethge Gedara Police Custody Officer Phillip Clement	Astrid Haban-Beer and Fiona Livingston-Clark of counsel
St Vincent's Hospital (Melbourne) Ltd:	Paul Halley of counsel
G4S Custodial Services Pty Ltd	Ingrid Nunnink, Gilchrist Connell

Keywords:	Death in custody – medical treatment – risk assessment – police custody - observation

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INTRODUCTION

1. On 8 February 2021, Darren Ricky Culleton (**Darren**) was 31 years old when he died at the Royal Melbourne Hospital in Parkville from a hypoxic brain injury after becoming unresponsive in the back of a police vehicle at Melbourne West Police Station (**Melbourne West**) on 5 February 2021.

2. Darren is survived by his two children, his parents Stephen and Mary, his twin brother Gary and three other siblings, Trevor, Kim and Tina. Darren is warmly remembered by his family as a troubled but generous and good-natured man. In a Coronial Impact Statement delivered on behalf of the family, Darren was described as *"an anchor to the family network"*.

BACKGROUND

3. Darren was born in Melton on 14 February 1990. He was initially raised in Melton and then the family moved to Perth when Darren was nine years old. Darren and the family returned to Melbourne when he was in Year 7 at school and the family lived in Altona before eventually settling in Keilor Downs.

4. Darren completed Year 9 at Footscray City College and then began a labouring job pouring concrete, which later led him to complete a concreting qualification.

5. Darren has two children. Darren had his daughter when he was very young, at around age 15 or 16. He did not maintain a long-term relationship with her mother. However, Darren's brother Gary reports that Darren was older, aged 20 or 21 when his son was born. Darren and his son's mother lived together in Melton before moving to Ballarat. He was around 24 years old when that relationship broke down and he returned to the family home.

6. Darren lived a fairly itinerant life without stable accommodation. He began using recreational drugs in his mid-twenties. Darren's drug use eventually became problematic and had a devastating impact upon his mental health. His family intervened at various points in his life in an attempt to assist him with rehabilitation. For example, on occasions, Gary would have Darren come and live with him so that Gary could keep an eye on him. Ultimately these efforts were not successful in the long term.

7. Between 2009 and January 2021, Darren was convicted of several offences involving dishonesty, property, drugs and violence. He was sentenced to a term of imprisonment on eight occasions.

8. Between 2015 and 2021, Darren presented at several hospitals in Victoria while experiencing mental health issues and was subject to compulsory inpatient and community treatment orders under the *Mental Health Act 2014* (**the MHA**). His psychiatric diagnoses included schizophrenia, schizoaffective disorder, personality disorder, and substance use disorder.

9. Darren's first documented presentation to mental health services was a psychiatric admission to the Alfred Hospital in October 2015, where he was diagnosed with substance-induced psychosis. He had a further psychiatric admission to the Alfred Hospital between 7 September and 3 October in 2016, after having been detained under section 351 of the MHA following attempts to hang himself while acutely intoxicated with illicit substances. He was diagnosed with schizoaffective disorder and referred for further community treatment in Sunshine.

10. Prior to 5 February 2021, Darren's most recent admission to hospital had been on 16 January 2021. He was transported to the Emergency Department (**ED**) of St Vincent's Hospital Melbourne (**SVHM**) after being detained pursuant to section 351 of the MHA. Darren had been found by police behaving erratically while standing on a ledge at the Melbourne Arts Centre. He was sedated due to his level of agitation and was discharged after a period of monitoring. It was determined that his behaviour had been due to substance misuse in the context of antisocial personality disorder and homelessness.

CORONIAL INVESTIGATION

Jurisdiction

11. Darren's death constitutes a "*reportable death*" under sections 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death, he was a person placed in custody or care. Pursuant to section 52(2)(b) of the Act, an inquest was also required to be held which occurred in June 2023.

12. The Coroners Court of Victoria is an inquisitorial court.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

13. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

16. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[2]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[3] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[4]

17. These powers are the vehicles by which the prevention role may be advanced.

18. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically

[1] Section 89(4) of the Act.
[2] Section 72(1) of the Act.
[3] Section 67(2) of the Act.
[4] Section 72(2) of the Act.

prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[5] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[6]

19. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[7]

20. A number of factual disputes arose from the evidence given at the inquest. Many of these disputes were exposed by the questioning of the parties in the reasonable pursuit of their interests. However, it has not been necessary to resolve all of those disputes in order to make the findings necessary under section 67 of the Act.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

21. On 5 February 2021, Darren gained access to the Acute Inpatient Service (**AIS**) at SVHM. He appeared agitated and drug affected and told staff that he needed help. He became increasingly agitated and erratic as staff tried to engage with him and he poured a bottle of kerosene over himself and attempted to set himself on fire with a lighter before he was physically restrained by security and medical staff. A Code Black[8] was called by staff which resulted in a request at around 12.10pm for Victoria Police to attend.

22. Senior Constable Daniel Eastwood, Constable Aaron Taylor and Constable Harley Bruem (**Transit 711**) arrived the AIS at around 12.17pm. Senior Constable Stephen Toth (now an Acting Sergeant) and Constable Deschepper (now a Senior Constable) (**Fitzroy 307**) arrived shortly afterwards. Darren said to them that he wanted to kill himself. He continued to be agitated and he was handcuffed by Constable Bruem.

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[5] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[6] *Keown v Khan* (1999) 1 VR 69.
[7] (1938) 60 CLR 336.
[8] Alarm in response to a personal threat by a member of the public.

23. S/C Eastwood apprehended Darren under section 351 of the MHA and he was escorted to the Behavioural Assessment Room (**BAR**) in the ED at around 12.29pm. Nursing staff stated that Darren's vital signs were not assessed as his "*combative nature made it unfeasible*".[9]

24. Emergency Physician, Dr Sarah Ward conducted a medical assessment of Darren after he arrived in the BAR. She had reviewed his medical records and noted his extensive psychiatric history. She observed him to be calm, compliant, orientated and alert and noted that he did not appear to be in respiratory distress. She was able to effectively communicate with Darren and did not consider that he appeared to be drug affected. Darren denied any injury and stated that he wanted to leave the ED. Dr Ward determined that there was no apparent medical illness or emergency and no injury.

25. After his medical assessment, Psychiatry Registrar Dr Alexandra Riddoch and Psychiatric Nurse Tara Lantry conducted a mental health assessment of Darren in the BAR. Darren remained handcuffed during the assessment with a number of police and security staff present. Prior to their assessment, Dr Riddoch and Ms Lantry reviewed Darren's medical records and noted that he had an established history of presenting to emergency services with homicidal and suicidal ideation while acutely intoxicated.

26. Darren told Dr Riddoch and Ms Lantry that he had wanted to see his son. Dr Riddoch stated that he denied any thoughts of self-harm. In relation to his attempt to harm himself that morning, she recalled that he said he had not been "*thinking straight*" and "*just wanted to get attention…and now I've got the attention I'm fine…I just want to go home*".[10]

27. Darren reported regular drug use but stated that his last use of methamphetamine was a week earlier. He denied experiencing any psychotic symptoms and Dr Riddoch did not observe any evidence of delusional or disordered thinking. Dr Riddoch noted that Darren was not seeking any mental health support and wanted to be discharged.

28. Dr Riddoch determined that Darren was not suffering from a major mental illness, although she believed that there was a strong likelihood that he was intoxicated with a stimulant. She

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[9] Statement of Rachel Truman dated 18 May 2021, CB130.
[10] CB126.

considered that his "*actions were consistent with a pattern of high lethality and reckless conduct to have his needs met*".[11]

29. Ms Lantry observed that Darren was verbally abusive and irritable towards police and security staff. Dr Riddoch noted that Darren was generally cooperative and settled during the examination but that he was "*quick to anger*" when advised that they had no influence over whether he would be taken into police custody. Darren also asked to speak to his mother to say "*goodbye*".[12]

30. Dr Riddoch and Ms Lantry concluded that Darren did not meet the criteria for involuntary treatment under the MHA, although Dr Riddoch considered that he remained "*a high dynamic risk of violence towards others and either deliberate or inadvertent self-harm if taken into custody*".[13] Dr Riddoch discussed her assessment with her supervisor, Associate Professor Peter Bosanac, who agreed with her conclusions. The assessment concluded at around 12.38pm.

31. Sergeant Tom Windlow (now a Senior Sergeant), who was coordinating the police response to Darren's crisis that day, recalled being told by Ms Lantry that Darren did not meet the criteria for involuntary admission under the MHA and that his actions were "*behavioural*" rather than consistent with having a "*psychiatric crisis*". He also became aware that Darren was the subject of two "*Whereabouts*"[14] for theft (shop steal) offences which occurred on 23 December 2020.[15]

32. Darren was discharged from the ED at around 12.55pm and was then arrested by S/C Eastwood who had become aware that he was the subject of the "*Whereabouts*". Darren wanted to know why he was being arrested but S/C Eastwood was not in a position at that stage to identify the precise basis for the arrest. This appeared to cause Darren distress. Sgt Windlow subsequently advised Darren that police needed to speak to him for some outstanding matters relating to theft, although he would not have specific detail about the

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[11] CB127.
[12] Statement of Senior Constable Darren Eastwood, CB187.
[13] CB127.
[14] Person Whereabouts Desired, VP Form L12. Darren was identified as having been suspected of being involved in theft offences which were sufficient to engage an arrest power under section 459 of the *Crimes Act 1958*; CB969.
[15] CB226;T366.

matter until the paperwork could be reviewed at the police station. Darren asked to speak with his solicitor which Sgt Windlow advised could be arranged at the police station.

33. Sgt Windlow arranged for Darren to be taken to Melbourne West as it had suitable custody facilities with dedicated Police Custody Officers (**PCOs**)[16]. Darren was placed in the rear of a brawler van, after some resistance by him, and transported by Transit 711 at around 1.10pm. His hands were handcuffed behind his back. Sgt Windlow considered that Darren presented an ongoing risk of harm to himself and others and would need "*some vigilance in monitoring*". He spoke with Sergeant Drew Laughlin, one of the Custody Supervisors at Melbourne West, and advised him of this assessment. Sgt Laughlin subsequently performed a search of the LEAP[17] system which identified Darren as a "*custody risk*".[18]

34. On the way to Melbourne West, Darren manoeuvred his hands to the front of his body, removed his clothes and defecated, wiping the faeces on himself and the inside walls of the back of the van.

35. At around 1.25pm, the brawler van arrived at Melbourne West and pulled into the sally port. The Custody Supervisors decided that Darren should remain in the back of the van until a plan was formulated as to how he could be safely extracted. While this was occurring, Constable Bruem observed that Darren was frothing at the mouth and Constable Taylor observed that he had his underwear tied around his neck. Constable Bruem advised custody staff and then Sgt Brendan Payne, the Custody Supervisor who was rostered on with Sgt Laughlin, directed that Darren be immediately removed from the van.

36. PCO Phillip Clement contacted the Custodial Health Advice Line (**CHAL**) at the Melbourne Custody Centre (**MCC**) and spoke with Registered Nurse Marcus Witt. He advised Mr Witt that Darren had "*bronzed up*" in the back of a police van and that they wanted to arrange for him to be transferred to a padded cell at MCC. Based on the information provided to him, Mr Witt considered that Darren's behaviour was "*behavioural not self harming*" and he told

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[16] PCOs are not sworn members of Victoria Police and they receive 8 weeks of training at the Victoria Police Academy. Their main role is to manage a person in holding cells in police custody, including providing food, blankets and clothing.
[17] Law Enforcement Assistance Program.
[18] T370-T371; T538-T389.

PCO Clement that he could be transferred to MCC if the shift manager was happy to accept him. The phone call was then disconnected.[19]

37. PCO Clement undertook a risk assessment and assigned Darren as requiring the highest level of observations (Level 1) which was every 15 minutes.[20] He did not communicate this assessment to the Custody Supervisors as he was satisfied that *"it was happening"* as *"he was with people all the time"* and *"never left alone"*.[21]

38. At around 1.43pm, Darren was removed from the brawler van by S/C Eastwood and Constable Bruem and his underwear was removed from his neck. He was then placed in the shower in the sally port and given a drink of water. Sgt Payne sought to develop a rapport with Darren, remembering that he had had previous dealings with him in custody, including an incident where he self-harmed, and he told the officers that *"we can't take our eyes off him"* or *"something similar"*.[22]

39. Acting Senior Sergeant Storti, who was the officer in charge of Melbourne West, consulted with the Custody Supervisors. He assessed that Darren was a high risk of suicide in custody and decided that Darren should be transferred to MCC.

40. PCO Inosha Bethge Gedara (now a Constable) conducted a LEAP check in relation to Darren, noting his warning flags, and then contacted MCC and was advised that they would not accept Darren without "*remand papers*".[23] A/S/Sgt Storti then spoke with the shift manager at MCC, Bill Petropoulos. It was agreed that MCC could accept Darren provided the appropriate paperwork was filed with the Magistrates' Court of Victoria beforehand to enable him to be directly presented at Court and remanded in custody.[24]

41. At around 1.54pm, after showering himself, Darren was placed in an observation cell and provided with "*coveralls*" for clothing. Coveralls are a disposable jumpsuit with an elasticised hood, which zip up at the front. They are made of a robust, non-woven synthetic fibre. Darren put the coveralls on back to front, so that the hood was near his throat. The

[19] CB172.
[20] CB606.
[21] T630.
[22] T854.
[23] CB571.
[24] CB305.

coveralls were zipped up at the back by Constable Frank Giannioglou (now a Senior Constable). Darren was then given a telephone and he spoke with his father.

42. At around 2.02pm, after speaking with his father, Darren was assisted to put a suicide-resistant gown over the top of the coveralls. The gown is made of heavy canvas. The neck hole lay a couple of inches below Darren's collarbones and the hem fell below his knees. Darren's hands were then handcuffed behind his back and he was placed in the rear pod of Fitzroy 307's divisional van. Sergeants Laughlin and Payne agreed that it was appropriate to put Darren in the van at that stage as he was being transferred to MCC once the relevant paperwork had been finalised and they considered that his departure was imminent.

43. Darren was placed in the pod of the divisional van at around 2.05pm and the door was closed. There were two cameras inside the pod, one facing to the front and one to the rear. Footage from inside the pod may be viewed from a small screen above the console in the driver's cabin and may be recorded. There is also a microphone which enables a prisoner in the pod to be heard by officers in the cabin and for communication to occur. Constable Giannioglou recalled activating the recording function of the camera at this stage. He also recalled offering to the custody sergeants in the muster room to cut off the hood to the coveralls.

44. One of the custody sergeants, directed that Darren be monitored. Constable Bruem volunteered to monitor Darren from the screen in the cabin of the divisional van.[25]

45. Sgt Laughlin had directed S/C Toth and Constable Deschepper to prepare the paperwork necessary to have Darren transferred to MCC. They commenced this task soon after they arrived at Melbourne West. They subsequently finalised a "*Remand Pack*", consisting of charges relating to the shop thefts and a summary. The preparation of these documents had already been commenced by the informant relating to the shop thefts and S/C Toth arranged for her to sign the charges. The preparation of the paperwork took about 70 minutes and it was then emailed to the Magistrates' Court for filing at around 2.40pm.[26]

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[25] T941;T944.

[26] CB903;CB1465;T411.

46. Darren was in the pod of the van for around 48 minutes and footage was obtained as recorded by the camaras in the pod.[27] Constable Bruem monitored Darren from the cabin through the camera on the console. At around 2.12pm, Darren had manoeuvred his hands to the front of his body. At around 2.15pm, he appeared to place a ripped piece of the coveralls, later identified as the hood, in his mouth and choke and gasp. After a few minutes he spat out the hood and appeared to place it between his legs. Constable Bruem observed some of this behaviour and alerted custody staff. A number of officers attended the sally port and the door of the pod was opened at around 2.20pm for about 13 minutes while some of the officers engaged in conversation with Darren.

47. Constable Giannioglou, in the presence of Constable Bruem and Constable Hugh O'Donnell, engaged in most of the discussion with Darren. He observed that the hood to the coveralls was missing and looked at Darren's hands but could not see it and assumed Darren had swallowed it. Darren requested and was provided with a number of cups of water to drink.

48. Constable Giannioglou observed that Darren appeared paranoid and agitated and recalled trying to get Darren to focus on his family and reminded him that there were people who loved him. Sgt Laughlin also spoke with Darren in the presence of one of the afternoon shift Custody Supervisors, Sergeant Matthew Jerabek. Sgt Laughlin recalled directing the officers to keep the door open and continue engaging with Darren although they gave evidence at the inquest that they did not hear this direction.

49. The door to the pod was closed at around 2.33pm at Darren's request. About a minute later, the door was opened again as Constable O'Donnell had reported to Constable Giannioglou that he thought that Darren had vomited and Constable Bruem thought that he was lying strangely in an awkward position.[28] Constable Giannioglou observed that Darren had not vomited and gained a verbal response before again closing the door at Darren's request at around 2.35pm.[29] Constable Bruem remained to monitor Darren from the cabin of the van, accompanied by Constable O'Donnell.

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[27] The camera did not record the first 7 minutes of Darren's time in the pod.
[28] T812;T965;T995.
[29] T812.

50. Once the door to the pod was closed, Darren again appeared to shove the hood to the coveralls down his throat. At around 2.41pm, Darren called out, "*Boss, boss, boss*", and shortly afterwards, the cameras record him sweating, thrashing around and appearing to have difficulty breathing. At 2.46 pm, Darren then lay down on his back and became motionless. At this stage, Constable Bruem thought that Darren had been "*acting up*" and had calmed down and may have been sleeping.

51. At around 2.49pm, as Darren had not moved, Constables Bruem and O'Donnell got out of the van and looked into the pod through the side windows. Constable Bruem observed that Darren did not appear to be breathing so Constable O'Donnell alerted custody staff and then the door was opened at 2.52pm. Darren was observed to be unresponsive, removed from the van and Constable Bruem commenced cardiopulmonary resuscitation (**CPR**) and emergency services were called.

52. Fire Rescue Victoria and then Ambulance Victoria attended and continued CPR. Darren's circulation was eventually restored, and he was transferred by ambulance to the Royal Melbourne Hospital. Darren was admitted to the intensive care unit with no signs of neurological function or brain stem reflex. Brain scans revealed that Darren had sustained a non-survivable hypoxic brain injury. He was extubated on the evening of 8 February 2021 and passed away at 5.55 pm.

OTHER INVESTIGATIONS

53. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

54. Victoria Police conducted an Operational Safety Critical Incident Review (**OSCIR**) and prepared a report dated 24 September 2021.

55. In summary, the following relevant findings were contained in the OSCIR report:

    (a) The decision to transport Darren to the Melbourne West to be processed for outstanding *"Whereabouts"* (for thefts) was based on a risk assessment concerning the deceased's mental health issues and a need for more intensive care and supervision by police and PCOs;

(b) The deceased wore the coveralls backwards thereby placing the hood at the deceased's face;

(c) The suicide-resistant gown was worn over the top of the coveralls. Anecdotally, at other custody facilities, the practice is for a suicide-resistant gown to be worn only on the naked body;

(d) There is no criteria, information or instructions provided in any of the policies, guidelines, or Standard Operating Procedures at Melbourne West concerning the use of a suicide-resistant gown;

(e) Victoria Police provides for general distribution of four different types of coveralls to persons in custody. Each type is made of different material. A risk assessment is being conducted on all types being fit for purpose;

(f) Custody Supervisors and PCOs acted in accordance with guidelines by regular assessment of the deceased while in the care and custody of police;

(g) Police assessed and determined that Darren was alert, responsive, breathing with attendant members not assessing him to require any medical intervention or assessment as a result of swallowing material from the coveralls;

(h) After police closed the van door, Darren removed and reinserted an object from his mouth several times;

(i) Police monitored Darren's behaviour, before checking on him. At varying times throughout the footage, Darren makes sounds suggestive of airway obstruction but then starts moving around again. Earlier physical intervention during this time may have resulted in a different outcome;

(j) Clarification and confirmation of what administrative process was required to lodge the deceased at MCC. This led to a delay in timely transport of the deceased from Melbourne West to MCC;

(k) An opportunity existed for Darren to remain in the observation cell (Cell 1) rather than being placed into the pod of Fitzroy 307 van;

(l) Melbourne West police were provided contradictory advice from CHAL and MCC as to the administrative process to be implemented to lawfully lodge Darren at MCC. Ultimately, MCC advice was determined as being the authoritative advice and delayed Darren's transport from Melbourne West;

(m) MCC requires a Remand Warrant to lodge a detainee at MCC;

(n) Police did not consider an additional mental health assessment pursuant to s351 of the MHA based upon Darren's second suicide attempt. Police considered that Darren's transfer to MCC was a more practical and appropriate action. The need to apprehend to prevent serious and imminent harm was no longer applicable (as stated in section 351 criteria);

(o) An opportunity exists to include training to employees concerning the use of coveralls and suicide-resistant gowns for use in custody environments;

(p) Victoria Police policies, procedures and guidelines applicable to this incident are not fit for purpose;

(q) Members involved in this incident followed applicable Victoria Police policies, procedures and guidelines and training;

(r) Involved members undertook appropriate response, displayed appropriate behaviours and displayed sound operational decision making;

(s) The Review Team did not identify any area of deficiency associated with police practice or culture associated with the incident;

(t) The Operational Response Principles and Incident Command and Control Systems (**ICCS**) were understood and applied to the initial response to Darren and the subsequent investigation.

56. The following recommendations were contained in the OSCIR report:

(a) Custody Capability (SESC)[30] conduct a Custody Policy Review focused on prisoner coveralls and suicide resistant gowns and update/create policy covering purpose, training and use;

(b) Custody Capability (SESC) draft and issue a global communications email across Victoria Police warning on the danger of coveralls issued to prisoners/person in custody;

(c) Custody Management Division engage with MCC and the Custodial Health Service to review arrangements and requirements for when it is necessary to transfer a person with serious physical and mental illnesses;

(d) The police response and interaction/engagement with medical professionals in respect to the application of section 351 of the MHA regarding reassessment in Darren's circumstances be considered by the PRIME[31] Project Group; and

(e) People Development Command (Centre for Custody and Protective Services) review PCO Foundation training (inclusive of police officers to include the use of suicide-resistant gowns and persons in custody with mental health issues.

SOURCES OF EVIDENCE

57. Victoria Police assigned Detective Acting Sergeant Simon Florence to be the Coroner's Investigator for the coronial investigation into Darren's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief, including statements from the forensic pathologist, various police members and medical staff who attended to Darren on 5 February 2021, additional statements from the interested parties, CCTV and BWC[32] footage and the OSCIR report. It also includes two expert reports relating to Darren's mental health treatment at SVHM.

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[30] State Emergencies and Support Command.
[31] Police Responding in Mental Health Events.
[32] Closed Circuit television and Body Worn Camera.

58. The inquest ran over 10 days and evidence was given by the following witnesses:

(a) Dr Sarah Parsons (Forensic Pathologist);

(b) Dr Sarah Ward (SVHM Consultant Emergency Physician);

(c) Dr Alexandra Riddoch (SVHM Psychiatry Registrar);

(d) Tara Lantry (SVHM Psychiatric Nurse);

(e) Associate Professor Vinay Lakra (Expert Consultant Psychiatrist);

(f) Dr Scott Hall ((Expert Consultant Psychiatrist);

(g) Senior Constable Daniel Eastwood (Victoria Police);

(h) Senior Sergeant Tom Windlow (Victoria Police);

(i) Senior Constable Joshua Deschepper (Victoria Police);

(j) Acting Senior Sergeant Travis Storti (Victoria Police);

(k) Acting Sergeant Stephen Toth (Victoria Police);

(l) Sergeant Drew Laughlin (Victoria Police);

(m) PCO Phillip Clement (Victoria Police);

(n) Marcus Witt (CHAL Nurse);

(o) Constable Inosha Bethge Gedara (Victoria Police);

(p) Bill Petropoulos (MCC Shift manager);

(q) Senior Constable Frank Giannioglou (Victoria Police);

(r) Sergeant Brendan Payne (Victoria Police);

(s) Constable Harley Bruem (Victoria Police);

(t) Constable Hugh O'Donnell (Victoria Police)

(u) Sergeant Matthew Jerabek (Victoria Police); and

(v) Inspector Gerard Cartwright (Victoria Police)

59. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief (including material tendered during the inquest) and the submissions made by counsel assisting and the interested parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

SCOPE OF THE INQUEST

60. The following issues[33] were investigated at inquest:

(a) The health assessment, care and treatment provided to Darren at SVHM on 5 February 2021, including the assessment that he did not meet the criteria for involuntary treatment under the MHA. This topic included:

- Any risk assessment;
- The behaviour/mental illness distinction;
- Darren's treatment plan;
- The decision to discharge Darren "*into police custody*"; and
- Communication between Victoria Police and SVHM mental health staff.

(b) Darren's treatment and care while in the custody of Victoria Police after his arrival at Melbourne West later on 5 February 2021. This topic included:

[33] The scope of the inquest was identified at the directions hearing conducted on 17 February 2023 and refined in consultation with the parties.

- Darren's attempt to choke himself in the brawler van with his underwear and Victoria Police's awareness of this attempt;
- Any risk assessment conducted and how it informed decisions made relating to his placement and treatment in custody;
- The decision to clothe Darren in the coveralls and then allowing him to put them on backwards;
- The decision to place Darren in the divisional van and his monitoring by police; and
- The application of relevant policies and procedures to at-risk prisoners in the circumstances.

IDENTITY OF THE DECEASED

61. On 8 February 2021, Darren Ricky Culleton was visually identified by his brother, Gary Culleton.

62. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

63. On 9 February 2021, Dr Sarah Parsons, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy and prepared a report of her findings dated 30 June 2021. She was provided with some further material after she performed the autopsy but *before* she prepared her report, including relevant CCTV footage, photographs and medical records.[34]

64. Dr Parsons reviewed the CCTV footage from inside the pod of the divisional van and observed Darren ripping the hood from his coveralls and putting it in his mouth and at varying times making sounds suggestive of an upper airway obstruction. Dr Parsons

[34] CB86; T20.

commented that it was unclear if Darren had an upper airway obstruction or a cardiac event prior to collapsing for the final time.

65. Toxicological analysis of ante-mortem and post-mortem blood samples identified the presence of a number of drugs including methamphetamine,[35] diazepam[36] and midazolam.[37]

66. Dr Parsons observed that Darren was highly agitated in the back of the police van and noted that toxicity associated with amphetamine use includes agitation, hyperthermia, hallucinations leading to convulsions, unconsciousness, and respiratory and cardiac failure.

67. Dr Parsons expressed the opinion that the cause of death is likely to be a combination of upper airway obstruction and methamphetamine use.

68. Dr Parsons formulated the cause of death as hypoxic ischaemic encephalopathy following out of hospital cardiac arrest in a man using methamphetamine and with a probable airway obstruction by a foreign body.

69. Subject to a matter of clarification which came out in evidence (dealt with at [73]), I accept Dr Parson's opinion as expressed in her report.

70. During her examination, Dr Parsons was unable to determine whether Darren had a complete airway obstruction as the hood had been removed from his throat at that stage and he had been on a ventilator for three days prior to his death. She stated that if the hood had been found down deep in the trachea, as opposed to just above the voice box, and it had to be pulled out, then it would be more likely to be a complete obstruction.[38]

71. Dr Parsons further stated, in reference to the potential contribution of methamphetamine to Darren's cause of death, that "*if there's an upper airway obstruction that's causing complete obstruction of the airways, it doesn't matter whether you've got methamphetamine in your system or not*".[39]

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[35] A strong central nervous system stimulant, often known as speed or ice.
[36] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[37] Midazolam is an imidazobenzodiazepine derivative used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent. This drug was administered to Darren by Ambulance Victoria.
[38] T29.
[39] T28.

72. Paramedic Steven Sault from Ambulance Victoria treated Darren in the sally port of Melbourne West after he was removed from the divisional van. He performed a laryngoscopy and observed a white object "*below the level of the patient's vocal cords*". He then utilised forceps to "*secure the object*" before removing it. He noted that it appeared to have "*occluded the patient's airway*".[40] I note that this evidence was not available to Dr Parsons when she prepared her report. The only evidence from Ambulance Victoria that she had available to her was the Ambulance Victoria records which did not record that the object had been removed from below the level of the vocal chords and that it appeared to have occluded the airway.[41]

73. In the circumstances, I am satisfied that Darren had an upper airway obstruction that caused a complete obstruction of his airways. It follows that I am satisfied that the cause of death is "*1(a) Hypoxic ischaemic encephalopathy following out of hospital cardiac arrest in a man using methamphetamine with an airway obstruction by a foreign body*".

HEALTH ASSESSMENT, CARE AND TREATMENT AT ST VINCENT'S HOSPITAL

Medical assessment

74. The first stage of Darren's treatment and care at SVHM involved his medical assessment by Dr Ward. Her medical assessment was brief but, in the circumstances, I am satisfied that it was reasonable and appropriate. Primarily based upon Darren's ability to effectively communicate and engage with her, Dr Ward assessed that he had no medical problem to be managed and should be referred for mental health assessment.[42] She conceded that Darren's vital signs should have been taken as part of his medical assessment but I accept her evidence that it would have been unlikely to have changed her assessment of him.

75. Further, I accept Dr Ward's evidence that it would not have been appropriate to sedate Darren given he was able to effectively communicate and engage with her.

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[40] CB148.
[41] T20;T26; CB325; Contrary to the submission of the Chief Commissioner of Police at [9].
[42] T77.

Mental health assessment

76. The second stage of Darren's treatment and care at SVHM involved his mental health assessment by Dr Riddoch and Ms Lantry. They conducted a mental health assessment to determine whether Darren satisfied the following criteria for an involuntary admission under an Assessment Order pursuant to section 29 of the MHA:

> *(a) The person appears to have mental illness; and*
>
> *(b) Because the person appears to have mental illness, the person appears to need immediate treatment to prevent:*
>
> > *(i) Serious deterioration in the person's mental or physical health; or*
> >
> > *(ii) Serious harm to the person or to another person; and*
>
> *(c) If the person is made subject to an Assessment Order, the person can be assessed; and*
>
> *(d) There is no less restrictive means reasonably available to enable the person to be assessed.*

Expert Reports

77. The Court obtained a report dated 16 November 2022 from an independent expert consultant psychiatrist, Associate Professor Vinay Lakra. In his report, A/Prof Lakra expressed the following opinions:

- The psychiatry assessment conducted by Dr Riddoch was adequate;

- There is a degree of ambiguity in the criteria for making an Assessment Order under section 29 of the MHA to allow for a degree of interpretation;

- The definition of "*mental illness*" in section 4 of the MHA[43] allows a range of conditions and presentations to be considered as mental illness rather than restricting it to major mental illnesses;

- Darren could have met criterion (a) in appearing to have a mental illness as Dr

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[43] "*A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.*"

Riddoch observed that he was substance affected with a "*strong likelihood of being intoxicated with a stimulant*". Being substance affected would be considered as a serious temporary effect of using drugs indicating that the person has a mental illness;

- There were indicators that Darren needed further assessment and would have met criterion (c);
- Darren met criterion (b) because of the "*high dynamic risk of violence to others and either deliberate or inadvertent self-harm*";
- With a degree of hindsight, A/Prof Lakra believed that Darren would have met the criteria for an Assessment Order or would have benefited from a voluntary admission;
- There was no discharge plan about Darren's health needs;
- Darren's further suicide attempt in the police van should have triggered further concerns about his safety and an ambulance called;
- A person could present with "*actions consistent with a pattern of high lethality and reckless conduct to have their needs met*" and meet the involuntary admission criteria under the MHA;
- Darren presented with contingent suicidality with a new pattern of high lethality and was substance affected. A further assessment when the effects of substance use had waned would have provided an opportunity for a detailed assessment; and
- Dr Riddoch was placed in a very difficult situation and quite rightly escalated to her supervisor. Timely availability of senior staff to provide guidance and support to junior staff is very important while they continue to upskill and learn.

78. SVHM obtained a report dated 4 May 2022 from an independent expert consultant psychiatrist, Dr Scott Hall. In his report, Dr Hall expressed the following opinions:

- No state-wide standards exist to guide the mental health assessment process of patients detained under section 351 of the MHA;

- It would have taken at least a week for Darren to be referred to a community mental health team had he been discharged into the community from SVHM;
- Dr Riddoch and Ms Lantry took reasonable steps to obtain a history of recent events and explore Darren's presenting complaint;
- Dr Riddoch and Ms Lantry took reasonable steps to obtain and review Darren's medical records;
- Dr Riddoch and Ms Lantry took reasonable steps to determine the nature and degree of Darren's current psychological symptoms via a Mental State Examination;
- Dr Riddoch and Ms Lantry took reasonable steps to undertake a focused risk assessment;
- There had been an opportunity for Dr Riddoch and Ms Lantry to obtain collateral information from family members;
- Based upon Dr Hall's review of footage, Darren was unlikely to have been experiencing gross disturbance of perception, mood and thinking at the time of the assessment, but there was a significant likelihood of impaired judgment due to acute intoxication;
- The clinical judgment that Darren was possibly feigning a suicide attempt was reasonable;
- It was reasonable to conclude that Darren did not require immediate health treatment;
- The limitations of Darren's assessment related to standards, training and poorly defined models of care that exist in emergency departments rather than incompetence or inadequacy of Dr Riddoch and Ms Lantry's clinical skills relative to their training and experience. An experienced psychiatrist may have been able to respond to some of these limitations;
- Although Darren did not appear to be experiencing a significant disturbance of thought, mood perception or memory, the nature of his presentation was of sufficient

gravity that he appeared to have a mental illness under criterion (a);

- Criterion (b) was not met given that Dr Riddoch and Ms Lantry concluded that Darren's transient disturbance in his mental state, due to intoxication, had resolved;
- He did not meet the criteria for an Assessment Order because, in summary, he appeared to have a mental illness but he did not appear to need immediate treatment to prevent further deterioration or further acts of self-harm in the short term. It was apparent that Darren posed a risk to himself in the longer-term but detaining him under an Assessment Order would not prevent it;
- The criteria and language used by Dr Riddoch was of a Temporary Treatment Order, not an Assessment Order;
- Direct assessment by a consultant psychiatrist may have provided a more nuanced approach with a longitudinal assessment;
- Darren repeatedly stated that he did not want to be admitted to hospital, up until the point that it became apparent that he would be placed in police custody. Accordingly, a voluntary admission would have been unreasonable;
- The absence of a referral to an urgent crisis or outreach service was reasonable;
- There was insufficient evidence to assert that Darren's self-harming behaviour was conduct "*to have his needs met*". The reckless nature of his conduct was likely related to a pattern of intoxication with stimulants and a pervasive disregard for life, safety and wellbeing. It is unlikely that his behaviour was premeditated to have his "*needs*" or "*agendas*" met. Such comments constitute an unhelpful value judgment.

Concurrent evidence of Associate Professor Lakra and Dr Hall

79. Both experts agreed that:

    (a) the assessment of Darren by Dr Riddoch and Ms Lantry was reasonable and that they both acted reasonably in the conduct of the mental health assessment;

(b) Reasonable minds can differ in relation to an assessment as to whether a person fulfils the criteria for compulsory admission which may be influenced by the level of the practitioner's training and experience;[44] and

(c) Darren's assessment would likely have been more effective if he had not been restrained and there had been fewer people in the BAR.

80. Both experts agreed from their assessment of the evidence that Darren satisfied criterion (a) of section 29 of the MHA in that he appeared to have a mental illness, although Dr Hall was of the view that Darren did not satisfy criterion (b) in that he did not need immediate treatment. A/Prof Lakra considered that Darren met the criteria for compulsory treatment while Dr Hall did not.

Was the Mental Health Assessment reasonable and appropriate?

81. I am satisfied that Darren needed mental health treatment on 5 February 2021, but did not receive it. I am satisfied that his attempt to light himself on fire in the AIS was a deliberate act of attempted self-harm. However, I am satisfied that the mental health assessment conducted by Dr Riddoch and Ms Lantry was reasonable and appropriate in the circumstances. Although, accepting that reasonable minds can differ in relation to an assessment as to whether a person fulfils the criteria for compulsory treatment, it may well have been that different practitioners would have been satisfied that Darren *did* meet the criteria. I accept the evidence of A/Prof Lakra that there needs to be an amount of flexibility inherent in the process so as to avoid undue restriction on clinical judgment.[45]

82. I accept the evidence of Dr Hall and A/Prof Lakra that it would have been helpful to have obtained collateral information from Darren's family as part of the assessment. However, I am not able to conclude that this step would have made any appreciable difference to the outcome of the assessment. It may have had an impact on a discharge plan for Darren had he not been arrested and placed in police custody.[46]

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[44] T273-T274.
[45] T272.
[46] T289-T290.

83. A reasonable mental health assessment performed by a competent clinician that identifies that a person does not satisfy the criteria for compulsory treatment can seem obviously inadequate where that person subsequently dies soon afterwards from self-harming behaviour. However, that tragic outcome does not automatically lead to the conclusion that the risk assessment performed by the clinician was inadequate. In many cases it is a function of the limitations of the process itself, the complex nature of self-harm and the difficulty in predicting its likelihood in any particular case.[47]

Behaviour/mental illness distinction

84. The proposition that Darren's self-harming behaviour was *"behavioural"* and motivated by a desire to get his needs met rather than as a result of mental illness created an unhelpful dichotomy which filtered down to police and informed their subsequent risk assessments.[48] I accept the evidence of A/Prof Lakra that the interplay between behavioural and mental illness justifications for self-harm is not mutually exclusive. As he stated in his expert report:

> "*these two issues are not an 'either and or' situation. One can present with 'actions consistent with a pattern of high lethality and reckless conduct to have their needs met' and meet criteria under the Act*".[49]

Treatment plan

85. There was no treatment plan formulated by SVHM staff for Darren although I do not consider that this was unreasonable given that they were aware that Darren was going into police custody after his discharge from hospital.

86. I am not satisfied that Dr Riddoch conveyed to Victoria Police her view that Darren remained "*a high dynamic risk of violence towards others and either deliberate or inadvertent self-harm if taken into custody*". Dr Riddoch does not recall conveying this information to any police officers and none of the police officers gave evidence that this information was conveyed to them.[50] Further, it is not recorded as having been conveyed in any medical

[47] T319-T321.
[48] T154-T155;T365;T601-T602;T923;T1024.
[49] CB1391-CB1392.
[50] T197.

documents. This was relevant information that should have been communicated to Victoria Police although I consider that Darren was nevertheless considered by Victoria Police to be a high risk of self-harm once he was removed from the brawler van in the sally port at Melbourne West.

TREATMENT AND CARE IN POLICE CUSTODY

At St Vincent's Hospital

87. I am satisfied that Darren remained in the custody of Victoria Police while he was being assessed at SVHM. Section 351(4) of the MHA provides that a person who is apprehended under that section is subject to the custody of Victoria Police until released from custody in accordance with that section. Subsection (6)(b) provides that a person is released from the custody of Victoria Police when they enter onto the care of the hospital.

88. Section 6 of Victoria Police Manual (**VPM**) – Procedures and Guidelines (**VPMG**) – *Apprehending persons under the Mental Health Act* provides that:

    - When a person is taken directly to hospital for an examination, members should liaise with the hospital staff/mental health team about when to formally release the person into the care of the hospital; and

    - Members do not need to wait until the end of the examination if safety is not a significant issue.[51]

89. Although the mental health assessment may have been more effective if Darren had not been restrained, I am satisfied that it was reasonable in the circumstances for Darren to remain handcuffed and in police custody given he had recently attempted to light himself on fire, his clothes were still saturated with kerosene, and his intermittent agitation and aggression.

90. Although the police witnesses did not have a consistent understanding on this issue, I am satisfied Darren had not yet entered into the care of the hospital and remained in police custody during the assessment. I note that this is consistent with the view of Sgt Windlow.[52]

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[51] CB1458.
[52] T385.

I do not consider that the mere signing by Ms Lantry of the Victoria Police Mental Disorder Transfer form (VP Form L42) was sufficient or effective to transfer custody to SVHM.[53]

91. Given that Darren was not going to be admitted to hospital under the MHA, I am satisfied that it was not inappropriate for him to be arrested under section 459 of the *Crimes Act 1958*, pursuant to the "*Whereabouts*" that had been issued in relation to alleged shop thefts.[54] Sgt Windlow gave evidence that the police were required in the circumstances to apprehend Darren and had no residual discretion.[55] Although, I consider that the failure to advise Darren of the precise reason for his arrest is likely to have contributed to his increased agitation and aggression at SVHM.

Arrival at Melbourne West

92. A person may be in care or custody of police whether they are on the street, in a police vehicle, or in police facilities. Regardless of the situation or location, when a person is taken into police care or custody, Victoria Police assumes a responsibility for their safety, security, health and welfare.[56]

93. I am satisfied that Darren's actions in tying his clothing around his neck in the back of the brawler van after its arrival in the sally port at Melbourne West was an act of self-harm. It may have been motivated in part by seeking to achieve an outcome, such as being removed from the van, but such a motivation does not exclude an intention to harm himself.

94. A/S/Sgt Storti and the custody supervisors, Sgt Payne and Sgt Laughlin, all assessed Darren as a high risk given his behaviour before being removed from the brawler van.[57] This assessment was reached notwithstanding that some of the members may have considered the source of the risk to be behavioural rather than mental illness.

95. I am satisfied that the decision by A/S/Sgt Storti to transfer Darren to MCC to provide an appropriate environment to manage his risk was reasonable in the circumstances. Another option available was to apprehend Darren again under section 351 of the MHA (on the basis

[53] CB1210.
[54] CB969.
[55] T367.
[56] Statement of Inspector Gerard Cartwright dated 4 December 2021; VPMG – Persons in police care or custody.
[57] T443 (Storti); T539 (Laughlin); T854 (Payne).

that he appeared to be mentally ill and was likely to harm himself) and transport him to hospital for a further assessment. However, I consider that it was not unreasonable to prefer a transfer to MCC over a further apprehension under section 351 given that Darren had only just been assessed at SVHM, and his earlier self-harming behaviour had not led to a determination that he required compulsory admission. Further, MCC had the facilities and the staff to manage Darren's risk.

96. I am unable to conclude with any degree of certainty exactly when PCO Clement contacted Mr Witt at CHAL. His notes indicate that the call occurred at 1.36pm, while the chronological structure of his statement suggests that it occurred after Darren was removed from the brawler van at around 1.43pm.[58]

97. I am satisfied that it is likely that PCO Clement contacted Mr Witt before Darren had been removed from the brawler van. This is consistent with Mr Witt's evidence, which I accept, that he was not told by PCO Clement that Darren had been engaging in self-harming behaviour by tying his clothing around his neck.

98. Mr Witt gave evidence that if he had been aware that Darren had recently engaged in self-harm by tying his clothing around his neck, then he would have advised police to call an ambulance. However, I accept the police evidence that Darren recovered quite quickly after being removed from the van, was no longer actively engaged in self-harm and did not require urgent medical assessment.[59] I consider that it was reasonable in the circumstances to have Darren transferred to MCC either on the basis that the facilities at Melbourne West were inadequate or potentially because it was necessary to ensure that Darren obtained the health services available at MCC (ie nurse on site, padded cells). The extent of the health services provided at MCC would be determined by the nurse from the Custodial Health Service who would assess Darren on arrival.[60]

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[58] CB157; CB1417.
[59] T887.
[60] T660;T672;T676.

Provision of clothing

99. It was appropriate for police to use a suicide-resistant gown given Darren's risk of self-harm. However, it should not have been used over the top of the coveralls which provided Darren with an opportunity to engage in self-harm by choking himself. This opportunity became more obvious to Darren with the coveralls being put on backwards. I am not satisfied that Constable Giannoglou's offer to cut off the hood to the coveralls was conveyed with sufficient clarity to be heard by the custody sergeants in the muster room. He acknowledged that "*there were heaps of people in the custody area*" and he had "*kind of butted in*" to convey the offer.[61]

100. I am satisfied that Victoria Police members were not aware of the risk associated with the use of coveralls together with a suicide-resistant gown and that they had not received sufficient training to alert them of this risk. Victoria Police had no previous recorded instances where a person in custody had self-harmed by ingesting the hood attached to coveralls.[62]

101. There is no relevant provision in the VPM which specifically addresses the situation, although email alerts, flyers and online learning modules have since been provided to members to alert them to the risk.[63] However, the flyer refers to "*detainees*" which assumes that the person requiring the garment has been "*lodged*" in custody.[64] This was not the case with Darren who was never officially lodged in custody at Melbourne West.

102. PCOs Clement and Bethge Gedara were aware of the risk associated with the use of coveralls with a suicide-resistant gown but I am not satisfied that they advised any members of Victoria Police. I note in particular that PCO Clement stated in evidence that he did not raise any objection because of the "*hierarchical*" nature of the organisation and that he assumed that "*somebody higher above me made that decision*".[65]

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[61] CB249.
[62] CB576.
[63] CB1514;T1135.
[64] VPM – Persons in police care or custody; CB593.
[65] T643.

Preparation for transfer to MCC

103. There was clear confusion between the staff at MCC and Melbourne West as to the paperwork that was required to be completed before Darren could be transferred to MCC.[66] The VPMG provides that detainees at a police station can be transferred to MCC if:

- the facilities are inadequate and they have been charged before transfer; or
- it is necessary because the detainee requires the health services available at MCC (ie nurse on site, padded cells).[67]

104. The staff at Melbourne West or MCC did not consider the second option identified above. There is some doubt about whether the technical conditions for such a transfer were satisfied in that Darren had not yet formally "*lodged*" but it would have avoided the delay associated with preparing the paperwork necessary to have Darren remanded in custody.[68]

105. The staff at Melbourne West and MCC proceeded on the basis that relevant paperwork was required to be prepared before Darren could be transferred to provide a legal basis for his ongoing custody at MCC. There was some confusion about whether a "*remand warrant*" was required to be obtained before Darren could be transferred to MCC.[69] The documents that were actually required to be prepared and filed with the Magistrates' Court prior to transfer consisted of a "*Remand Pack*". These documents were charges for the shop thefts (signed by the informant) and a summary.

106. Once filed with the Court by email, Darren could then be transported to MCC and directly presented to Court with an order obtained remanding him in custody at MCC. An alternative process developed during the Covid-19 pandemic was for the court hearing to occur online with the person in custody appearing from Melbourne West prior to their transport to MCC. It appears that Mr Petropoulos considered that the order of the Magistrates' Court remanding

[66] CB222;T455;T734.
[67] CB611.
[68] T1156-T1167.
[69] T412;T455;T749.

a person in custody was a *"remand warrant"* which was required before Darren could be transferred to MCC.[70]

107. The preparation of the paperwork by S/Cs Deschepper and Toth took about 70 minutes between 1.30pm and 2.40pm. The evidence from police witnesses was that the preparation of such paperwork could take anywhere between 20 minutes to two and a half hours. The evidence from the police witnesses was that after Darren had been moved from the observation cell at Melbourne West to the rear of the divisional van in the sally port, his transfer to MCC was imminent. Unfortunately, this was not the case.

Transfer to divisional van

108. Darren should not have been moved from the observation cell at Melbourne West to the rear of the divisional van until the relevant paperwork had been completed and filed with the Magistrates' Court, and there was sufficient certainty that his transfer was indeed imminent. The VPMG provides that police vehicles should not be used for the purpose of holding persons for extended periods.[71] A/S/Sgt Storti stated in evidence that people, particularly those assessed as high-risk, should not be kept in a van for an extended period of time because of the limitations with visibility and circulation, and if it needs to be done then the rear door should remain open.[72] Sgts Laughlin and Payne gave similar evidence.[73] Persons in custody, particularly those assessed to be a high risk, should not be held in police vehicles at a police station if there are observation cells available.

109. The time that it took police to complete the paperwork for Darren to be transferred to MCC was longer than expected, which increased the amount of time Darren remained in the rear of the van. There was an element of "*mission creep*"[74] in this process whereby despite knowledge of the continuing delay, there was a collective view that Darren's departure remained imminent. Once it became clear that Darren's transfer to MCC was not imminent (after about 30 minutes), Darren should have been transferred to an observation cell.

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[70] T735.
[71] CB599.
[72] T459.
[73] T604; T911.
[74] T1165.

110. Accepting that police had made a decision to place Darren in the rear of the van while awaiting his transfer to MCC, given his level of risk, the door should have remained open to provide a better opportunity for him to be monitored. The size and configuration of the screen in the cabin of the van did not enable Darren's behaviour and movements to be closely monitored and accurately interpreted. The ability to adequately observe Darren in the particular van was compromised by the poor quality of the camara (ie scratched surface, screen obstructed by gear stick and radio and the camera footage on the already small screen was split into quadrants).[75]

111. I am not satisfied that any direction by Sgt Laughlin to Constables Giannioglou, Bruem and O'Donnell to keep the van door open was conveyed with sufficient clarity, acknowledging that the circumstances were chaotic and hearing may have been compromised by officers wearing masks. Sgt Jerabek, who was also present at this time, did not recall hearing any such direction.[76] I am satisfied that Constables Giannioglou, Bruem and O'Donnell would have complied with such a direction if they had heard it.

Observation in van

112. Constable Bruem, with assistance from Constable O'Donnell, provided constant monitoring of Darren in the divisional van once the doors were closed at 2.33pm. This was appropriate given Darren's risk of self-harm. I am satisfied that Constables Bruem and O'Donnell did not interpret Darren's movements and behaviour in the back of the van between 2.35pm and 2.46pm as distress or self-harm. It is unsurprising that Constable Bruem and Constable O'Donnell's perception of Darren's behaviour in the back of the divisional van on 5 February 2021 is different to the way they interpreted it in evidence at the inquest, after viewing an enhanced copy of the footage well after the event with the knowledge of what had occurred. At the time, noting the limitations with the size and configuration of the camera monitoring screen, they thought that he had been acting up to get attention. When Constable Bruem had previously observed behaviour from Darren that he considered required intervention (eg eating the hood or lying in a strange position), he had acted to alert custody staff.

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[75] T1028; T1032.
[76] T1118.

113. When Darren had banged the roof, shaking the van, Constable Bruem thought that he was acting up and he did not open the door at this stage to avoid the risk of a confrontation. I accept that Constable Bruem assumed that Darren would calm down quickly as he had observed on occasions earlier in the day.[77] It was not appreciated at the time that "*acting up*" behaviour could also be self-harming behaviour that required intervention.

114. I am satisfied that Constables Bruem and O'Donnell did not foresee the risk that Darren would choke himself by swallowing the hood to the coveralls. Constable Bruem received some assurance from the fact that Darren was wearing a suicide-resistant gown.[78] With the benefit of hindsight, they should have sought an earlier verbal response from Darren once he lay down and became motionless after 2.46pm, and then opened the door. However, I accept that they thought that he was sleeping or resting and did not realise until later that he may have in fact lost consciousness in some other way.

COMPLIANCE WITH RELEVANT POLICIES AND PROCESSES

115. Inspector Cartwright stated in evidence that the SESC is "*currently rewriting every custody policy sitting under Victoria Police*".[79]

Clothing

116. Part 8.6 of the VPMG – *Safe Management of Persons in Police Care or Custody*, relevantly provides that:

- clothing may be taken from detainees during their time in police custody, for evidentiary, safety or hygiene purposes and custody staff should ensure that detainees have access to replacement clothing;

- if a detainee is at risk of self-harm or harming others, and the clothing that is provided could enable them to harm themselves or others (cords, drawstrings, zips etc), consider not using the clothing or removing the items that could cause harm;

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[77] T988.
[78] T986.
[79] T1124.

- all police cells must maintain suicide-resistant gowns; and
- the issuing of "*disposable paper suits*" are to be added into the Observations of the Custody Module.[80]

117. There is no current Victoria Police policy or guideline which provides guidance to members about the use of coveralls and suicide-resistant gowns. Specifically, the risks presented by coveralls to persons in custody who are assessed to be a risk of self-harm, and that they should not be used in conjunction with a suicide-resistant gown. As found by the OSCIR Report, the Victoria Police policies, procedures and guidelines on this issue are "*not fit for purpose*".

118. Since Darren's death, Victoria Police have circulated targeted emails to staff and posters for display at police stations which warn of the risks presented by coveralls to persons in custody who are assessed to be a risk of self-harm, and that they should not be used in conjunction with a suicide-resistant gown.[81]

Use of police vehicles to hold persons in custody

119. Part 3.3 of VPMG – *Persons in Police Care or Custody*, provides that:

> *As a general rule, police vehicles must not be used for the purpose of holding persons for an extended period. If a person does need to be held in a vehicle, they must only be placed in a secure vehicle and must be transferred or released as soon as suitable holding arrangements are made*.[82]

120. Part 3.1 of the VPMG – *Safe Management of Persons in Police Care or Custody*, provides that police vehicles should not be used for the purpose of holding persons for an extended period.[83]

121. These Victoria Police policies and guidelines were clearly not followed in Darren's case. He was held in the pod of a divisional van when a suitable cell was available at Melbourne West

[80] CB620.
[81] CB638-CB642;CB1514
[82] CB584.
[83] CB599.

for a period of approximately 47 minutes, which I am satisfied is an extended period in the circumstances.

FINDINGS AND CONCLUSION

122. I am satisfied that Darren's behaviour in placing the hood of the coveralls down his throat and choking himself was a reckless act of self-harm which led to his death. However, the evidence does not enable me to be comfortably satisfied that he intended to take his own life.

123. Having held an inquest into Darren's' death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Darren Ricky Culleton, born on 14 February 1990;

    (b) the death occurred on 8 February 2021 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria;

    (c) from hypoxic ischaemic encephalopathy following out of hospital cardiac arrest in a man using methamphetamine and with an airway obstruction by a foreign body; and

    (d) that the death occurred in the circumstances set out above.

COMMENTS

124. Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

    (a) Darren's death in custody was a preventable tragedy. It has devasted his family but also affected those who were responsible for his welfare. The inquest was a challenging and distressing process for both family and the witnesses.

    (b) Darren required care and treatment which may well have been better provided in a hospital environment, but once he went into police custody, Victoria Police was responsible for his safety, security, health and welfare.

    (c) The circumstances leading to Darren's death were unusual and occurred while restrictions were in force as a result of the Covid-19 pandemic. Darren's evolving

presentation, his distress and agitation, created challenges for those charged with the responsibility to provide for his care in a way that balanced his welfare and dignity with the management of risks of self-harm and safety of staff.

(d) The hospital staff and police officers who came into contact with Darren on 5 February 2021 were motivated to assist and look after him and they did not foresee that he would harm himself in the way that he did. Nevertheless, a number of risks crystalised while Darren was in police custody which, combined with communication problems, lack of training and an absence of policy, led to an unfortunate confluence of circumstances that ultimately led to Darren's death.

RECOMMENDATIONS

125. Pursuant to section 72(2) of the Act, I make the following recommendations:

(a) Victoria Police create a policy and guideline in relation to the appropriate use in custody facilities of coveralls and suicide-resistant gowns.

(b) Custody Management Division of Victoria Police engage with MCC and the Custodial Health Service to review the arrangements and requirements for transfer of prisoners from a police station to MCC:

(i) To clarify with specificity the documents that are required to be prepared by Victoria Police when the basis of the transfer is that the facilities at the police station are inadequate; and

(ii) To clarify the circumstances in which a transfer may occur on medical grounds (ie the health services available at MCC are required) and what documents, if any, are required to be prepared by Victoria Police.

(c) Victoria Police review the training provided to police members and Police Custody Officers to guard against perceived hierarchical barriers which may inhibit the communication of relevant and valuable information concerning the welfare of people in custody.

(d) Victoria Police review the training provided to police members and Police Custody Officers to ensure that relevant information recorded on the LEAP system relating to the risks attaching to a person brought into custody is efficiently shared with all the officers necessary to appropriately manage that person's welfare and safety.

I convey my sincerest sympathy to Darren's family.

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

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "*1(a) Hypoxic ischaemic encephalopathy following out of hospital cardiac arrest in a man using methamphetamine with an airway obstruction by a foreign body*".

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

Mary & Steven Culleton, Senior Next of Kin

Detective Acting Sergeant Simon Florence, Coroner's Investigator

Chief Commissioner of Victoria Police

Victorian Government Solicitor's Office

St Vincent's Hospital (Melbourne) Ltd

G4S Custodial Services Pty Ltd

Signature:

Coroner David Ryan

Date: 13 September 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.