NOTES *written on 23 October 2018, updated 22 May 2019*

Contacts:

[redacted]

Conclusion

We, [redacted] family, feel aggrieved by the lack of care and compassion shown by [redacted] in their 'treatment' of [redacted] over a long period of time. The family believe that [redacted] has been negligent given his mental health history and numerous attempts at self-harm. He had self-harmed and spoke of suicide on two recent admissions prior to his death. When he was admitted after being assaulted by the Victoria Police member we have been unable to ascertain if any mental health support was provided especially given the alleged self-harm attempts in the cell after the assault. His face and torso (body) was very swollen and bruised and it would have been evident that these were very recent injuries. He was accompanied by the Police integrity unit and we believe it would have been understood that the injuries that [redacted] were reviewing were the result of a terrible assault.

When he was admitted late August, ICU received an impassioned plea from [redacted] GP but this was ignored and there was a deep sense that the ICU team were trying to 'get rid of him'. The language and choice of words by [redacted] to the family lacked respect, care and compassion.

The family has lost confidence in [redacted]. When [redacted] son was admitted in January and March to the Children's Ward. [redacted] was unable to visit due to anxiety felt. [redacted] felt dizzy and disorientated when entering the hospital. [redacted] felt anxious and distressed. When [redacted] son fell ill in May, she attempted to drive him to [redacted] Hospital as she didn't want to call an ambulance and go to [redacted] Hospital. However her son was too unwell and an ambulance had to be called. She found the experience overwhelming and [redacted] came in for support.

The family believes that [redacted] treatment by **Victoria Police** caused him pain both mentally and physically and that he sought pain relief from his injuries. We believe that his treatment whilst in custody was inhumane, cruel and vicious and are especially disgusted by the officers who witnessed and did not render assistance to their colleague or [redacted] [redacted] told family and is heard on the court audio saying that he sustained head injuries as a result of police attack.

It should also be noted that [redacted] asked **Centrelink** to be recognised as having a disability for years and for additional assistance to complete day to day activities. This request was asked repeatedly for nine months leading up to his death. It was a constant source of frustration for him and caused him to feel anxious and depressed and he would often say 'they are not listening' and 'no one will help me'. [redacted] was accompanied by [redacted] and [redacted] to Centrelink to help him on many occasions. This disability pension was signed off by Centrelink a week or so after his death as they finally realised that he did have a disability. This was very distressing for the family especially as the family had notified Centrelink and then to receive the letter.

[redacted] **Police** were in contact at time of death and the information has been vague. [redacted] tried contacting [redacted] Police multiple times regarding [redacted] personal belongings to no

avail. Family were only offered an interview after repeated requests in May (8 months later). [redacted] was interviewed. [redacted] was asked to provide a written statement (see below).

All family members are receiving counselling due to the deep distress caused by what we feel has been multiple systematic failures.

Account:

13 August 2018

In the afternoon, [redacted] called an ambulance because she was concerned about [redacted] welfare. Ambulance and police both arrived. [redacted] was taken to [redacted] Hospital. Due to his condition family was promised by [redacted] staff that he would not be released until daylight as family had concerns for [redacted] welfare and wanted to pick him up. He was released from hospital at approximately 4am. Family were not notified of his release and only realised when he called his mother in the early hours asking to be picked up. Police and hospital were both aware of [redacted] mental health issues.

16 August 2018

[redacted] saw Dr [redacted] (and a student). [redacted] asked [redacted] to attend appointment with him as he felt that he wasn't getting anywhere and wasn't being 'heard'. During appointment Dr [redacted] did not take his eyes off the computer and appeared not to be concentrating. [redacted] begged him to provide additional assistance, possibly a case worker to assist with day to day life and was told he did not require one. [redacted] begged for help. [redacted] behaviour was erratic and he was taking clothes off. [redacted] asked for less methadone. Dr [redacted] prescribed him the usual amount. [redacted] was incredibly frustrated after this appointment as he didn't feel like Dr [redacted] was listening or offering meaningful assistance. [redacted] felt exasperated and feared for her son's wellbeing.

29 August 2018

[redacted] was admitted to ICU at University Hospital [redacted] in early hours of morning (approximately 5am) after being found by a neighbour outside home in the gutter suffering from hypothermia. Family were notified mid-morning. [redacted] spent the night in hospital under sedation. Family asked to be present when being woken from sedation as they were worried about his mental state. [redacted] (ICU) committed to calling family before he was woken. Family repeatedly requested he not be woken up until family were present as family wanted a mental health assessment.

[redacted] provided ICU team [redacted] medication list.

30 August 2018

[redacted] arrived at hospital (approx. 9am) as she walked into his room, [redacted] (nurse) along with [redacted] were just about to inject the medication into [redacted] to wake him up. [redacted] reminded [redacted] of previous agreement Hospital then waited until his family being [redacted] and [redacted] arrived. Once they arrived [redacted] was woken up by the injections and spent the day in ICU. At request of family he was seen by a psychiatrist. Family requested that he be involuntarily committed.

Family doctor, Dr [redacted], called hospital and made an 'impassioned plea' for treatment (these were [redacted] – head of ICU words) not to release [redacted] and that he needed care. Dr [redacted] reported that he was out of

touch with reality, showed signs of paranoia, was a danger to himself and others, and that he needed a safe place.

During this day [redacted] repeated that he 'hadn't finished the job'. This was heard by attending nurse [redacted] Attending nurse tried to provide information to consulting team but was told 'nurse, go back to your station' in an exceptionally rude and condescending manner. This was heard by all four family members. Family were extremely concerned by the suicidal threats made by [redacted] and repeatedly spoke to ICU during the day.

[redacted] was seen by two psychiatrists. Before he was seen by psychiatrists he was administered medication by ICU (family not told what he was administered) which changed his disposition immensely and changed him down to a 'dopey' type state. Prior to this being administered be was quite irrational and aggressive. He was still restrained at this point. He threatened to self-harm and also made threats against other people and staff. He stated "That he had a razor blade 'in his crack' and that he was going to kill someone."

The first psychiatrist and a nurse then consulted the family and said that there was no help available for 'someone like [redacted] It was a fruitless and hopeless conversation where the family felt like they begged for help and were told that there was nothing that could be done and nowhere for him to go. The family was given advice to 'just let him go', [redacted] responded that she couldn't turn her back on him.

The family then asked for a second opinion. Dr [redacted] and a team arrived. After a five minute consult with [redacted] Dr [redacted] offered to see him in her practice (the following Tuesday – five days away) and was told by family that he has no ability to make or keep appointments.

Both psychiatrists were informed by family that he was:

- Out of touch with reality
- Showed signs of paranoia
- Was a danger to himself and others
- Made threats to kill himself often
- Could not administer his own medication

Dr [redacted] states in medical documents obtained by family from Freedom of Information that she reviewed [redacted] for 15-20 minutes. In fact Dr [redacted] was in the room less than five minutes. Dr [redacted] asked to see family privately along with first psychiatrist. Family expressed hesitation to leave ICU room as we believed that he would run or be released from hospital room as had happened previously (promises broken).

Staff then asked family to go to a separate room to discuss the situation with [redacted] further. Family continued to request that [redacted] not be released and they were worried about [redacted] and his welfare.

Dr [redacted] said that [redacted] did not meet the 'criteria' for mental health support as his primary concern was personality disorder and secondary concern was mental health issues.

During consult Dr [redacted] asked if he had committed any crimes that we could have him arrested for. [redacted] responded that 'I cannot believe you said that, is that really your solution?'

Dr [redacted] bedside manner was very poor. The manner in which she spoke to [redacted] was hostile and completely lacked compassion. [redacted] was told to 'face reality' and that [redacted] would end up 'dying from this'. [redacted] begged Dr [redacted] to help and said that [redacted] had been begging for help.

Dr [redacted] was asked whose clinical governance responsibility [redacted] was when he left the hospital as family did not have capacity to provide the level care he required.

Family asked for him to go to the [redacted] but were told that he was too dangerous and that they couldn't put their staff at risk. Family enquired about seclusion rooms. Were told that this was not an option.

[redacted] was so distressed and frustrated by the consultation that he left the hospital in tears.

During this private consult with the family, [redacted] appeared to be released by staff that had been dressing him and in essence preparing him to leave. We did not feel that his consult with Dr [redacted] had concluded.

Family again did not realise that he had been released until after he had left the hospital (we heard a 'code grey' get called over the speaker system). Staff stated that he had run off when he was left alone which contradicts what he later informed [redacted] and [redacted] that staff had encouraged him to leave and return in about half an hour to get his medication as he wanted a smoke.

He returned half an hour later to the hospital to collect his medication. Family members where quite upset that he had been released from hospital and not even released into the care of family. Left to defend for himself with no phone therefore unable to contact him and vice versa.

We were quite distressed that he was released straight from ICU to the public. We do not understand why he wasn't put onto a ward after being in an induced coma for over 24 hours for further observation/care?

21 September [redacted] was arrested for shop lifting in morning. He was sprayed with capsicum spray at the scene by an officer and was not given any after care – no water was provided. He asked for water repeatedly and his girlfriend also requested water for him. He was told to 'stop being a smart ar**' by police. [redacted] (sister) was on phone to his girlfriend and could hear that [redacted] was clearly distressed and asking for help. [redacted] heard comment above when [redacted] was begging for water.

There is no footage available according to police ([redacted]). After care not administered and family told this was because there was no tap nearby (note: this is a residential area and many taps nearby, Also [redacted] eyecare and x-ray facility all in the vicinity). Where is duty of care?

He was taken to the police station approximately 15 minutes later without any after care. Whilst handcuffed he was sprayed with capsicum spray again and viciously and unlawfully assaulted by police officer [redacted] whilst handcuffed and pinned stomach first onto the ground by [redacted] (described by [redacted] as a captive hold). There is footage of this incident which [redacted] (integrity) and [redacted] Police) has. Family advised that actions were 'not justified' [redacted] and that it is being 'treated at highest level'. [redacted] said that the assault was 'deplorable' and 'one the worst that he has seen in custody'. He also said that there is 'no place for officers like him under my command'. Injuries sustained to his face and side which we believe we received during the assault. Family has repeatedly asked to be shown footage.

We also understand that [redacted] is known to have an extremely high rate of use of OC spray and that this was widely known by management and even minuted.

We understand that there were multiple Police officers who witnessed the assault. Namely [redacted], [redacted] and possibly [redacted]. It is also understood that [redacted] who was an acting sergeant witnessed the assault and laughed and returned to the station (within a month of this incident [redacted] had received a promotion we believe). There were possibly more officers who witness the assault. These officers had a duty of care and in talking to [redacted] and [redacted], no-one stepped in to stop the assault that went for approximately 2.5 minutes.

This behaviour contradicts Victoria Police values:

- Safety – healthy, safety & respectful workplaces
- Integrity – behave with honour and impartiality – the arresting officers knew he was a vulnerable person
- Leadership – fair process, values, a senior officer who assaulted him
- Respect – inspire confidence through ethical and fair treatment of others ensuring that actions are not unlawfully discrimatory
- Support – empathy not shown
- Professionalism – lead by example, accountable and personal standards – the officer who attacked [redacted] and the bystanders who did not try to protect or intervene

[redacted] and [redacted] called police station but were not given any information and were told not to bring clothes and that he could not have visitors etc. [redacted] warned of his self-harm tendencies and that he required his medication. [redacted] offered to send list of medication but police said that they would contact his doctor to get this medication. [redacted] said that it was a Saturday and his family GP would be closed and they responded that they

had a medically trained doctor who could 'work it out'. We later found out that no medical field officer was called and no medication was admitted to him.

We understand he was then moved to [redacted] Station.

We understand that a sergeant at [redacted] Station reported to Police Integrity. We also understand that over 20 officers were interviewed, and approximately 6-7 witnessed but only one officer elevated the complaint.

We have been informed that [redacted] has been stood down but we feel that other members involved require discipline. Family is extremely unhappy with witnesses who were complicit in supporting the assault of a vulnerable, handcuffed, OC-sprayed and helpless man.

The first we knew of his assault was upon his release.

22 September

Months later police advised [redacted] that [redacted] was self-harming in his cell which caused his facial injuries. Was he given any medical support in the 31 hours between the assault and [redacted] arriving? We understand that there is footage of this at [redacted] Police Station?

[redacted] did not receive a formal interview. [redacted] said to [redacted] he was 'too uncontrollable'. [redacted] said that he was incoherent and drug affected (30 hours after arrested??). Was any consideration given that he had been sprayed with OC spray twice, assaulted, reportedly had seizures and had not been given medication.

He was taken to hospital for x-rays etc at 4.55pm.

Was he assessed by mental health team at hospital given he was deemed a self-harm risk? He had visual facial injuries and had clearly been assaulted.

Police did not inform family that he had been hospitalised and next of kin was not notified of his injuries.

Was transferred to Melbourne (unsure of day).

Did not call anyone in family (this is highly unusual and has never happened before). Was he offered a call?

[redacted] told multiple family members that he was stripped naked. [redacted] told us that had seizure(s) in his cell and was not attended to. We understand that this happened at [redacted] Police Station in the holding cell but may have been elsewhere. He told his mum 'how would you feel if you stripped naked and hog tied?' There was no medication treatment provided after his alleged seizure and he told family that police did not attend cell to check on his welfare.

Has the footage of the cell [redacted]) been obtained and reviewed? Did he have seizures? Was he given appropriate treatment?

24 September

[redacted] represented himself via telelink at court and was granted bail. Released by police in Melbourne with strict bail conditions which included a curfew to [redacted], and that he needed to be accompanied by [redacted] (this is [redacted] house and [redacted] was not informed, he was on holidays at this time). He was not given a phone call and had no money, no phone. He had to find his own way back from [redacted] in the evening.

The family has obtained the audio of the bail hearing. At the end of the interview [redacted] says 'and sir can I just add that the police integrity team come to see me over that <u>they jumped on my face three times'</u> (he was then cut off by magistrate'). Family has this audio.

[redacted] called sister [redacted] by reverse charges. She set up a phone for him and [redacted] organised a train ticket to get back to [redacted]

The family query whether four days imprisonment was justified given the nature of the offense (shoplifting)?

25 September

[redacted] presented to D [redacted] with family friend [redacted]. It was clear he had been assaulted as he had black eyes, bruised face/temple and bruised chest and arms.

[redacted] conversations with [redacted] all stated that he was not a good mental state after his ordeal (beating). [redacted] said he feared for his safety given treatment by police. He said that he was in extreme pain and was self-medicating to help with the pain and that he felt suicidal. He complained to sister [redacted] of have a headache from being kicked and in his words 'sore ribs and I have a punctured lung'.

He advised that he had a fit in his cell and was not attended to, nor did he receive any medical treatment after his seizures.

[redacted] arrived home from a holiday to find [redacted] at home with girlfriend [redacted] [redacted] noted that his face was swollen and bruised and he had a lump on his forehead. [redacted] told him that he had been 'belted by the coppers'. [redacted] complained about his ribs constantly through the day and said that he had been to doctors.

27 September

[redacted] presented at doctor (x2) in [redacted] complaining of chest and head pains. [redacted] spoke to [redacted] and girlfriend and complained of chest pain, said he thought it was a punctured lung and sore head.

He said that he was scared to stay at [redacted] as he feared that police would 'come after him' and went to stay with his partner in [redacted] where he said he felt safer. [redacted] spoke to [redacted] about skipping state as he didn't want to sign in at [redacted] Police Station after what had happened days prior. He wanted to move to Cairns to start fresh.

[redacted] spoke to [redacted] and [redacted] throughout the day. He continued to complain about how sore his head and chest was. He seemed to be in a lot of pain and [redacted] offered to call an ambulance for [redacted] as he said that he was having seizures.

[redacted] spoke to [redacted] in the early evening and said he sounded 'as good as gold' but was still complaining of being in pain.

Sister [redacted] spoke to [redacted] at around 11pm. She thought he sounded fine and didn't appear to be affected by drugs in his speech or conversation. He told [redacted] that he was still in pain and trying to relieve the pain of the injuries from his assault.

28 September — [redacted] passed away in the early hours (time unknown)
Coroners report 'combined drug toxicity'.

2 November — Complaint letter sent to [redacted] (Clinical Director, Mental Health Drugs and Alcohol Services) and [redacted] (Director Intensive Care)

21 November — Unsatisfactory response received from [redacted] (note <u>no response</u> ever received from [redacted]

18 December — [redacted] met with [redacted] and colleague [redacted]
Told overuse of OC spray isn't an assault
Asked about footage and told there isn't footage of cells
Downplayed assault
Quite defensive and when challenged said 'ring my boss and have me taken off the case'

January — [redacted] engaged [redacted] Police Station as [redacted] said that he wasn't investigating the other officers, only [redacted].
[redacted] met with [redacted] and [redacted] regarding the inaction and discipline of the officers who witnessed the assault and the alleged seizures.
Informed that he was kicked three times whilst being held to the ground over period of 1.5 – 2.5 minutes and first kick was particularly brutal.
[redacted] raised the seizures in the cells that [redacted] had continually raised.
[redacted] promised to review footage.

29 April — [redacted] contacted by [redacted] Police. As [redacted] [redacted] and [redacted] were last three people to speak to [redacted] we have asked if or when we would be interviewed by [redacted] Police to officer [redacted].

[redacted] contacted [redacted] Police Station and was advised the [redacted] [redacted] had handed over the case to [redacted] (sp?). [redacted] called [redacted] and left a message.

We have repeatedly asked for [redacted] phone and wallet from [redacted] police (since 29/9/2018). We have mixed messages whether or not they have these items. Police initially said they did and were sent to Coroner with [redacted] On day of funeral [redacted] asked funeral home if they

had the items, they didn't. [redacted] rang Coroner and they said they never came to them. [redacted] called [redacted] Police who then said that they never had the items. [redacted] received text messages from [redacted] (girlfriend) saying that police 'bagged' wallet and phone.

[redacted] Police are now saying that they do have the phone and not the wallet (although wallet was in scene photographs)

We do not have an understanding of who attended the scene. We understood that [redacted] attended the scene but he has been taken off the case and now [redacted] is our contact and we have been advised that [redacted] never went to the scene.

There is an unexplainable gap in the security footage at the house where [redacted] was found. We were told camera was switched off days before but switched on as ambulance and police arrived. This doesn't make any sense at all… who turned it on/off, why was it turned off/on, the timing is suspicious. We believe there is a back up of all footage with the installer (through domestic violence).

We want to know time from the 000 call made by [redacted] to officers/ambulance arriving on scene. We understand that he had a pulse when girlfriend found him (based on her account to family). Girlfriend was told by 000 to do compressions.

[redacted] who is known to the family has been circulating an image of [redacted] in a deceased state via Messenger taken at the house in [redacted] [redacted] rang [redacted] on the night that [redacted] passed away and said that he had a photo because the police had asked him to identify [redacted] via Facetime as [redacted] hadn't known him for six months. [redacted] called [redacted] on Facetime so that he could identify him. He then sent the disturbing image to sister [redacted] to prove that he had done this. (further information in [redacted] statement below).

We believe that [redacted] may have been present when [redacted] died. [redacted] (sister) was talking to [redacted] sister [redacted] at the [redacted] Police Station when [redacted] made his statement. [redacted] said that [redacted] had called his dad [redacted] to call [redacted] and [redacted] and tell them about [redacted] passing. [redacted] stated in conversation that [redacted] was at [redacted] house when [redacted] passed away. [redacted] was very shocked to hear this.

[redacted] spoke to [redacted] about this photo in October and asked how the photo was obtained by [redacted] To date there has been not been any contact by the family with [redacted] to find out how he obtained the photo. We are concerned that this lead has not been followed up.

Conclusion

We have so many unanswered questions (per report above) but also below:

1. Who is doing the inquest brief – [redacted] Police or Ethical Standards (or both?)

2. Is this considered a death in custody? [redacted] died within seven days of being in custody (he was released on Monday evening and died Friday morning).
3. Will [redacted] be providing information/a statement?
4. Will Ethical Standards be supplying any statements to the [redacted] police which they have taken from other witnesses including police to be included on the Inquest brief?
5. Have any police alleged to have been involved in misconduct and/or criminal activity been formally interviewed by Ethical Standards, will the interviews be included on the Inquest Brief?
6. The family are terribly distressed that no medical assistance was offered nor given to [redacted] for over 30 hours by police after the assault and whilst in custody (until Integrity took him to hospital) – does this form part of the hearing?
7. Will the brief highlight the failure to comply with standard operating procedures and the Police Regulation Act by police regarding the care of persons in custody?
8. Will the Ethical Standards investigator ([redacted]) be supplying a statement to go on the Inquest Brief regarding his investigation?
9. Where was [redacted] mobile phone kept since his death, if in police custody was it entered on P.A.L.M. (electronic police property management system)? Do police have the phone or not? What forensic examinations have taken place with the phone, if none why not, has the phone's integrity been compromised? [redacted] was talking on the phone at 11pm to sister [redacted] and he was in bed… where is his phone? Why has the family received so many mixed messages about the phone from [redacted] police (we still do not have an answer on this).
10. Where is [redacted] wallet and contents if in police custody was it entered on P.A.L.M. (electronic police property management system)? Officers told [redacted] that it can be seen in the photographs taken at the scene. We still do not have an answer on this.
11. Is there a statement from [redacted] when he died?
12. Was anyone else at the house when [redacted] died?
13. How did [redacted] obtain an image of [redacted] in deceased state? It is not a Facetime photo.
14. Does [redacted] (girlfriend) statement include all the details of what happened to [redacted] prior to his arrest and after his arrest including when he returned from court, what did he say about his injuries, what did he say about being in custody, what did he say about court proceedings?
15. Will the brief highlight the fact that police have failed to comply with the Police Regulation Act and Bail Act in regard to setting bail conditions for [redacted] involving other persons without their consent? [redacted] was on holidays and completely unaware of these bail conditions. Why was [redacted] not contacted? If the conditions were for [redacted] to supervise [redacted] then why was he released in the early evening in the middle of Melbourne without his phone or any money, or why weren't arrangements made for family to collect him? It is irresponsible to release a vulnerable man [redacted] from home with no money, phone. If the bail conditions had been followed up, [redacted] would have told the police he was not home, he knew nothing of what had happened nor of [redacted] condition. If he was told of these things, he would be expected to attend the police station and pick up [redacted] from same and then take him home per a bail condition.
16. Ethical Standards say [redacted] was not completely coherent when they asked him for a statement, he certainly was when he was in court negotiating his bail conditions and speaking with the magistrate and telling the magistrate that he had been assaulted by police, why weren't Ethical Standards in court when [redacted] was released on bail ready to whisk him away and take a statement from him, they weren't even in court for the bail hearing. Listening to the bail hearing was very distressing. It was not organised at all… no

wonder a person would feel let down by the system given this treatment. We would like to share this audio with the Coroner.

17. Was [redacted] given a copy of the Bail / Remand brief prior to the court hearing as is required?
18. Was anyone else at the house when [redacted] died aside from [redacted]?
19. How did the security footage get switched off then back on? When it was turned off, why didn't this raise a red flag with security company?
20. How did [redacted] obtain the image? Was he there at the time?

[redacted] statement

Note: this was prepared for [redacted] Police however it was never followed up and therefore has not been provided to [redacted]

My full name is [redacted], I currently reside at an address known to police.

My brother [redacted] 36 years of age, had been using drugs at the age of 17 started off with marijuana, then lead to using other illicit drugs including speed, Heroin and Ice.

[redacted] and I had been close our whole lives, as my family would say growing up I was his shadow, we always spoke on the phone or hung out at times. If I thought [redacted] was taking medication or drugs, I would ask him straight away, he would tell me the truth.

Later on in life he was placed on methadone and he also started taking prescription medication. This lead to his criminal activities which lead to him being in prison. He was released in December 2017, he stated he wanted to stay off the drugs and never wanted to return to jail.

The next 6 months he didn't appear to be using any drugs, but did have episodes of paranoia and mental health issues.

Around June his mental health became worse with paranoia episodes.

Roughly 7 weeks before he passed away he meet [redacted]. On one occasion the family was concerned of [redacted] welfare I called 000 for an ambulance, [redacted] was taken to hospital sedated and released early hours of the morning.

A few weeks into their relationship [redacted] was found by a neighbour in the gutter outside his address [redacted] suffering from hypothermia. When [redacted] woke he told me both he "hadn't done the job good enough" and was having seizures outside the house. He was in ICU at University Hospital in an induced coma we tried to have him involuntary admitted for mental health issues and paranoia he was refused treatment, as a family we begged for help. [redacted] started to abuse his own medication.

[redacted] regularly travelled to [redacted] with [redacted] and would stay for a few days at a time. I last saw [redacted] on the Thursday 13th at night he seemed to be affected by either drugs or his own medication he was acting paranoid.

I had regular contact with [redacted] for the next week, I spoke to [redacted] on Friday 21st September the morning of him being arrested he wanted a lift, I called approximately 30 minutes later while he was being arrested, [redacted] Answered the call I could hear he was distressed and asking for water, [redacted] also asked police for water for [redacted] as he had been sprayed with OC they were refused.

Late morning I called the [redacted] police station [redacted] (formally [redacted] answered the call she stated he seemed drug affected I was surprised as I had only spoke to him 30 minutes prior and he seemed lucid. I informed [redacted] about [redacted] having mental health issues and was concerned about his Welfare he had previously told me if he was to be locked up he'd commit suicide. [redacted] also mentioned he'd stripped himself

off in the cell. I also told [redacted] he may not have had his medication and will need it. I stated he had mental health issues and a personality disorder.

She told me he had been moved to [redacted] and to call the custody office. I called the custody office left a message and had no return call, at this stage I was feeling concerned as [redacted] would make a call to family to say he was in custody and ok.

Later on that day approximately 7pm I spoke to [redacted] the custody supervisor and asked about dropping of spare clothes and having a visit on the Saturday morning I was told no to both. I had also mentioned he would need medication and we could send a current medication list they said they have a DR who will be able to get his medication from his dr. I told them his DRS would be closed. Our family and [redacted] still hadn't received a phone call from [redacted] this was out of character.

Monday night I had a reverse charge call from [redacted] stating he'd been released in Melbourne with no money or way to get home, he stated some of his bail conditions and had been assaulted by police and was in pain. I organized his SIM card to be set up so we could contact him. My mum [redacted] organized a train fair for [redacted] to get back to [redacted] My mum then picked him up and dropped him and [redacted] at my dad's [redacted] house my dad was away at the time.

Mum spoke to me stating he had been sprayed, stripped, hog tied and assaulted by police, mum had asked [redacted] to take photos of his injuries.

Over the next few days I continued having conversations with him over the phone. He continuously complained about his head having a headache from being kicked and in his words "my ribs are sore and I have a punctured lung my chest is so sore".

[redacted] went to the family doctor in regards to these issues he continued to talk about his pain and injuries he refused to sign in at [redacted] police station due to being assaulted and it gave him anxiety going there to sign in. [redacted] had told me he wasn't going to sign in at [redacted] where he'd been assaulted he was going to skip states and move to Cairns and live with a family friend. [redacted] we going to [redacted] to sell [redacted] furniture and we're moving. I didn't blame him from not signing in and wanting to go back to the [redacted] police station.

I believe he attended to 2x doctors in [redacted] for the same reason trying to get more of his prescription medication for his pain. He got more but don't know where from and I last spoke to [redacted] on the Thursday night around 11pm he sounded fine and didn't appear to be affected by drugs in his speech and conversation. He was telling me how [redacted] and he were going to move and start fresh. During our last conversation he had told me he was having fits earlier on that night while [redacted] was in the shower he had wet himself during one of them, he kept saying to me "I have a punctured lung you have no idea how sore I am" he insisted he was ok and had his med with him and was going to sleep.

I used to talk to [redacted] 15-20 times a day/night sometimes for an hour at a time since he was released in December 2017.

During this time on occasion he's been affected by medication/drugs and sometimes normal in his speech as

a result I believe I would know if he was affected by drugs at the time on this last occasion I believe he was not severely affected by drugs. He told me he was self-medicating to relieve the pain of his injuries from the assault.

September 28th [redacted] passed away early morning.

[redacted] had told me [redacted] couldn't identify [redacted] as she hadn't known him for 6 months, he had told me the police got [redacted] to identify [redacted] over face time video, I thought that was strange but didn't look into it. Then the coroner's office had requested a family member to come up to identify [redacted] I said I would and was going to go on the Thursday 4th October, the Wednesday before(3rd) in the afternoon I was told it was no longer necessary.

On the evening of the 28th I spoke to [redacted], [redacted] was staying at [redacted] house, [redacted] and [redacted] had not meet prior to this day [redacted] had said.

Approximately October 1st I spoke to [redacted] he had told me he had a face time picture of [redacted] when he passed away, I didn't believe [redacted] and asked him to send it to me which he did.

I then asked [redacted] about the picture of [redacted] that [redacted] had she told me he screenshotted the picture on FaceTime. I don't believe screenshots are in the same format of the way the picture was sent to me. FaceTime usually has a large image of a person with a small image inside that image of the other caller, also there's no icons in the screen shot, where this picture is side by side.

I'm unsure of who took the picture. I have now found out this picture has reached other members of the community.

I had been in contact with [redacted] from [redacted] police around 23rd of April and explained what had happed. [redacted] said that facetime didn't happen while he was [redacted] house. I was under the impression [redacted] [redacted] attended not [redacted]

On Monday 15th May I was at [redacted] police station while my dad [redacted] was completing his statement I bumped into [redacted] ([redacted] sister) [redacted] is a member in the Victorian Police force. [redacted] apologized to myself about the loss of [redacted] in conversation [redacted] said [redacted] had called his Parents early hours of the morning to ask his dad to call both [redacted] and [redacted] as [redacted] was at the address of [redacted] house when [redacted] passed away. I was completely unaware of this. I was in complete shock and told [redacted] I had no idea he was there I thought he was on a facetime call to [redacted] that morning.

[redacted]

2019 Submission - Royal Commission into Victoria's Mental Health System

Submission: 0002.0030.0299

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
Listen to their family and find ways to better support the family. Better understanding of MH in the justice system. Better understanding of MH by Victoria Police.

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
n/a

What is already working well and what can be done better to prevent suicide?
n/a

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"Need a more nimble system. When a person with MH issues puts their hands up for help, it is not practical to wait for weeks for an appointment. it is disheartening for the person and their family."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
'She'll be right attitude'. Lack of resources in public health system. No referral system for those with personality disorders.

What are the needs of family members and carers and what can be done better to support them?
Listen and help them help their loved one. It is a lonely road and families are mostly treated with disdain.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
Education and knowledge of referral pathways.

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
Getting the right help at the right time.

Thinking about what Victorias mental health system should ideally look like, tell us what

areas and reform ideas you would like the Royal Commission to prioritise for change?
"Assistance for people who are in the justice system. The lack of help contributes to the cycle of reoffending. More MH education for police. Clear referral pathways. Assistance for families. They are there 24/7. Doctors need to listen to the families. Advice such as 'just kick them out' is not practical nor helpful. These are people... these are their children. Also being told by a hospital clinician that 'your son is going to die' and 'you need to face facts' is not helpful and deeply distressing. My poor mum hasn't been able to drive past the hospital, nor step foot in the hospital due to trauma suffered when asking for help. When my 3yo son became ill I was reluctant to call an ambulance as I did not want him to be in the care of the hospital as the last time I had been there had been such a negative experience. I suffered a mini panic attack whilst there."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
Build MH into classroom curriculum. Make it mandatory for all workplaces to have a MH action plan.

Is there anything else you would like to share with the Royal Commission?
"I will never forgive the public health system for their treatment of my brother. It was disgusting. He was treated with disdain, as were we. There was a genuine lack of care, empathy and respect shown. I will never forgive Victoria Police for the assault that took place in September 2018 (officer has been charged) and for Victoria Police not seeking medical assistance for him for 30 hours. My brother was violently kicked three times. He died a week later. Cause overdose. The family believes that he was self medicating as he was in pain and he was also scared of Victoria Police. I am also terribly disappointed that upon presentation the hospital were quick to x-ray but he was not asked about his mental health after a hideous assault. Care for body, not mind/soul."