FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1449/09

Inquest into the Death of JEREMY EDWARD CHANDLER

Delivered On:	20th October, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria 3000
Hearing Dates:	16th February 2011, 21st and 22nd July, 2011
Findings of:	Coroner, Heather Spooner
Place of Death:	Melbourne Assessment Prison (MAP) Spencer Street, Melbourne, Victoria 3000
Representation:	Ms F A L Ryan, on behalf of Corrections Victoria Mr D Masel, on behalf of Justice Health Mr D J Bracken, on behalf of Forensicare
Police Coronial Support Unit PSCU:	Leading Senior Constable Remo Antolini

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Court reference: 1449/09

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname:	CHANDLER
First name:	JEREMY
Address:	Melbourne Assessment Prison, 317 Spencer Street, Melbourne, Victoria 3000

AND having held an inquest in relation to this death on 16th February, 2011, 21st and 22nd July, 2011 at Melbourne

find that the identity of the deceased was JEREMY EDWARD CHANDLER and death occurred on or about 8th March, 2009

at Melbourne Assessment Prison, 317 Spencer Street, Melbourne, Victoria 3000

from

1a. ACUTE BLOOD LOSS FROM A SINGLE INCISED INJURY TO LEFT FOREARM

In the following circumstances:

1. Mr Chandler was aged 49 when he died. He was born in the United Kingdom. When he was 14, he came to Australia with his family who settled here. He was twice married. Mr Chandler previously resided in a rented cabin at the Kilmore Caravan Park. He had a past medical history that included heart disease for which he had undergone stent surgery in 2003.

2. As Mr Chandler was in prison when he died, an Inquest was required to be convened. The **Coroners Act 2008** section 52(2)(b) states in part:

> "a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and -
> the deceased was, immediately before death, a person placed in care or custody;"

3. A police investigation was conducted into the circumstances surrounding the death. The Coroners Prevention Unit (CPU)[1] also reviewed the death.

Brief Background

4. On Friday 6 March 2009, Mr Chandler was found guilty by a jury in the County Court of Victoria of numerous charges. After the verdict was delivered, Mr Chandler instructed his barrister to lodge an appeal as he believed he was innocent. Mr Chandler was placed on remand at the Melbourne Assessment Prison (MAP), pending a sentencing hearing that was scheduled for 20 March 2009. It was his first time in custody.

5. Mr Chandler underwent three separate assessments:

> A Corrections Reception Assessment was performed when he entered into custody. Mr Chandler was identified as an at-risk prisoner due to the nature of his offences. Mr Chandler was offered and accepted, a protective placement in cell 8 of unit 10, located on level 5 of MAP.
>
> A Mental Health Assessment was completed following his reception and he was found not to be at risk of self-harm although six risk criteria were noted as "not known".
>
> A Medical Assessment was performed on Mr Chandler on Saturday, 7 March 2009. He received a Justice Health M2 rating, which apparently related to his cardiac condition and reflected a "medical condition requiring regular or ongoing treatment". These three assessments are referred to again further on in this Finding.

6. Later that Saturday, 7 March 2009, at about 4.30pm, Mr Chandler was locked in his cell, as was usual prison routine.

[1] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

7. On Sunday, 8 March 2009, at about 7.30am, a prison guard performing a cell check located Mr Chandler cold and unresponsive. There was a wound to his arm and he was lying on his back with a plastic bag covering his head. Resuscitation attempts in accordance with prison policy proved futile and Mr Chandler was declared deceased at the scene.

8. Hand written suicide notes were located nearby.

9. The parties who appeared at Inquest through their respective Counsel were Justice Health, Forensicare and Corrections Victoria, all of whom were involved in the care of Mr Chandler prior to his demise.

Family Concerns

10. Although the family of Mr Chandler were unable to attend the Inquest, they were understandably concerned about the circumstances surrounding the death of their son and brother. They were troubled at how his death could have occurred given that he was a prisoner at the time.

11. The family also raised concerns about the legal process and the nature of the particular charges and verdict that had seen Mr Chandler placed in custody. The investigating member, Senior Constable Wise, informed the inquest that after discussing this issue with the family, they were apparently accepting of the fact that the police prosecution and coronial investigation were quite separate matters.

Issues at Inquest

12. The issues considered at Inquest included the psychiatric assessment of Mr Chandler, the distribution of razors and the use and availability of plastic bags and bin liners in cells. The first two issues are discussed in some detail. The latter issue relating to the plastic bags had largely been managed by the date of the Inquest, with restrictions to access plastic bags and bin liners already in place.

13. There was a clear difference of opinion between Justice Health and Corrections Victoria on whether access to razor blades should also be restricted for new prisoners in the mainstream prison population.

14. Several changes and improvements have been introduced in response to Mr Chandler's death pursuant to the "Corrections Victoria Action Plan in Response to Recommendations' made by OCSR & Justice Health from the Review into the Death of Jeremy Chandler CRN 192146, at the Melbourne Assessment Prison."

Evidence at Inquest

15. Mr Logan told the inquest that he was an experienced Forensicare psychiatric nurse at MAP (Registered Nurse Division 1). He performed a brief mental status examination upon Mr Chandler that included his background, offending and social history. Mr Logan gave lengthy evidence about the process involved in the Mental Health Intake Screening Assessment form and his clinical impression. When asked about the "not known" risks referred to he stated in part:

> "In relation to "Not known", what does that stand for?---That the information is not available to us from another source. What if there were no concerns? What would you fill in then?---Low risk. So no concerns would be "Low risk"?---Yes, the fact that Mr Chandler was the first time in prison and that, you know, the information on his background was coming, essentially, from information we had from Corrections and from what he's telling us and how he's presenting, he was still, essentially, perhaps an unknown quantity. But if there was no concern whatsoever, "Low risk" would be the appropriate box to circle?---it could be, yes. Would it be beneficial if there was a "No concern", or that would not be a suitable answer? "Low risk" would be a more appropriate answer?---It would probably be a more appropriate answer, "No problem". If we could amend the form, would that be an amendment that you would think would be beneficial?---That would probably need some discussion. No, but if you were filling it out. I'm not saying we should do it or I'm asking you to do it. Would you as a person who fills these forms out be helped if there was a column, an extra column added there, 'No concern"?---Possibly. Now you'd mentioned in the next heading, in the blue, that Suicide, Self-harm alert, got "Nil". Do you recall how you came about that information?---That's to do with, you know, his presentation and (indistinct). So that's from you conducting the reception?---Reception, yes. Did you conduct the reception interview?---Yes. You've come up with that assessment from your clinical knowledge?---Yes."[2]

16. He was asked about his recollection of what occurred that Friday evening when he first met Mr Chandler. He told the Court in part:

> "He stated that he certainly had no intention of hurting himself or ending his life, and that was backed up by his comments that he was appealing an appeal against the conviction."(sic)[3]

[2] Transcript page 18 and 19.
[3] Transcript page 15.

17. Mr Logan also told the Inquest that in the course of performing a debrief, following Mr Chandler's death that he was told:

> "I had heard afterwards that he was quite sociable and was actually playing pool with people on the unit and was out in the courtyard socialising..."[4]

18. Mr Ambalawarner told the Inquest that he was a Senior Prison Officer on duty at MAP and the last person to see Mr Chandler alive. Mr Ambalawarner explained by way of background that there were several formal counts or musters during a routine prison day. He described what occurred at the final muster or lockdown:

> " we will make them stand inside and the door is locked and they keep their hand through a trapdoor, a small door, so we can see their faces through the Perspex. That's when we go past them and ask them "What's your name" ... He was standing by the door of the cell there and said, "Chandler". Didn't even say anything else or ..."[5]

19. Mr Ambalawarner told the Inquest that in the absence of a plan to the contrary, there was no further observation required of Mr Chandler until the following morning muster at 7.30am.

20. Since Mr Chandler's death, Mr Ambalawarner told the court that the restrictions on access to razors had changed on level 5:

> "Up in level 5 the prisoners don't have access to razors, so all razors when they buy from canteen or even when it comes down from reception, it's taken off them and we have a dedicated box per cell. It's kept in a locked area and we have what we call a shaving register. So when they want to take a shave or anything like that, they come and ask the officers and then they literally take the shaving stick, give it to them. They sign out the register to them and we give them about 20 minutes for them to have their shaves ."[6]

21. Mr Ambalawarner told the Inquest that he thought it would be logistically impossible to extend the restrictions to other mainstream prisoners. Their area was too large with too many places to hide a razor and it would create "all sorts of dramas" as a "tradable commodity" if restricted.

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[4] Transcript page 15.
[5] Transcript page 78 and 79.
[6] Transcript page 84.

22. Mr Momandwall told the inquest that he was working as a Prison Officer at MAP on both the day before and after Mr Chandler was found deceased in his cell. He recalled that he had seen him eating his dinner that Saturday afternoon but there was;

> "..nothing that stood out to me. I just recalled him consuming his meal ..."[7]

23. He told the Inquest of the new routine regarding razors on level 5:

> "When we take prisoners up to level 5 all the happy pack items are emptied out of the plastic bags and emptied into paper bags. The razor is kept separate and stapled to the front of the prisoners IMP file ..."[8]

24. When asked about extending the restrictions to the mainstream population he could not "foresee" how it could work. He stated;

> "Level 5 would be a lot easier, because we only have a handful of prisoners; a maximum of 15 prisoners at a time. Mainstream unit can accommodate anywhere up to 30 to 40 prisoners per unit, with two officers trying to maintain only the security and good order of the prison, receiving incoming and outgoing prisoners, maintaining musters, meals, keeping the files up to date, and there's all situations, unforseen reasons, that could interrupt your day, whether it be codes - codes could entail physical or verbal altercations with prisoners, movements, there could be deaths, or whatever may occur throughout the day which aren't foreseen. But if you were to maintain that, it would be virtually impossible. From my point of view, you would have to even allocate an extra two to three staff per unit... "[9]

25. Mr Ambalawarner was asked about a briefing by the prison supervisor at the 7.30am "morning parade" before he went on duty on Saturday, 7 March 2009. Mr Ambalawarner could not recall that anything was mentioned about Mr Chandler at that time.

26. Mr Taylor told the Inquest that at the time of Mr Chandler's death his role was Prison General Manager of MAP. He gave considerable evidence around prison management and the Action Plan.

27. He conceded that beyond the initial Correction Assessment there were no notes made by any correctional staff involved in supervising Mr Chandler during the 36 hours he was in custody. In regard to the Action Plan relating to interim file notes and whether it might have made any difference to the outcome here, Mr Taylor told the inquest:

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[7] Transcript page 104.
[8] Transcript page 109.
[9] Transcript page 110.

"---Well, I can't say whether it would have or wouldn't have had an impact on Mr Chandler and what he did, but what it would have done is there would have been notation of his activity or his behaviours when he came into the unit, and that would have informed other staff."[10]

28. Mr Taylor was referred to a memorandum prepared by Prison Officer Ellison after Mr Chandler's death, in which she stated in part that he was " ....co-operative and polite throughout Saturday, 7 March, he played pool and interacted with other prisoners. He had not appeared withdrawn nor had he approached the prison officer with any concerns or issues... "

29. In regard to razors, Mr Taylor told the Inquest that he was " ...100% sure you would not be able to retain an oversight of the razors that you give out ..."

30. Behaviour like shaving, which improved their self-esteem. He told the inquest of the resource implications and requirements and the various impacts that would be involved in restricting access, all of which were difficult to ascertain.

31. Mr Taylor spoke of his involvement in a local MAP Working Group, aimed at considering the "...risks factors in the prison and identifying remedial action to make the environment more safe." The ongoing task of removing hanging points was continuing and in regard to plastic bags, he told the inquest:

"Currently the working group at MAP have considered all areas that we use plastic bags in, and we're up to the stage now where there's - so plastic bags are used in the reception area to put prisoners' property in when they go into the units; the cell rubbish bins, the communal rubbish bins, the canteen items. So we're just looking at - we've got ideas about how we can take them away and change. So the wheelie bins that we've done on level 5, yes, we think we can do that on level 3-4."[11]

32. The Working Group had also discussed ways of minimising or restricting shavers. Some research had been considered. He went on in part:

"The risk itself - certainly we don't minimise the risk of shavers or razor blades, we're very clear. However, it's one risk amongst a whole host of risks that are posed in our prison that we consider how we can minimise."[12]

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[10] Transcript page 122.
[11] Transcript page 146.
[12] Transcript page 148.

33. It was the view of Mr Taylor that razor blades were "exceptionally easy to hide and exceptionally difficult to detect."

34. Ms Gardner, Director of Justice Health, elaborated on the different view that she took regarding access to razor blades. She was surprised at some of the evidence at Inquest about the impact of any implementation. Whilst acknowledging she was a health purist, Ms Gardner was concerned about the vulnerability of prisoners and she made some salient points. When questioned about the impact of implementation on safety and security and prison management Ms Gardner told the inquest:

> "... the prison and so forth?---Yes, but I would again say that the - when you minimise risk, you also increase the safety and security and good order of the prison by less access to items that can cause risk."[13]

35. The inability of Mr Logan to access the RAPID information system after-hours was highlighted, but Ms Gardner told the inquest that the issue had apparently been resolved so that all clinicians had "24/7" access to that service.

36. Investigating Member Detective Senior Constable Wise commented after hearing the evidence throughout the inquest that whilst the issuing of razor blades to prisoners was a concern, "...it's been made clear that there are logistical issues involved in that...".[14] Mr Wise also referred the Inquest to some hand written notes belonging to Mr Chandler, which his family had located. They went back to January 2007 and revealed suicidal tendencies.

The Three Prison Assessments

Corrections Reception Assessment

37. The Corrections Reception Assessment was completed with Mr Chandler on his arrival at MAP on Friday 6 March 2009. At the assessment, he was offered and accepted accommodation in a protection unit (Unit 10) because he was considered at risk. During the Corrections Reception Assessment, it was established that Mr Chandler should be referred to Forensicare for a psychiatric assessment because he was deemed to be at risk according to the Corrections Victoria Public Prisons Director's Instruction 1.2: At Risk Procedures. Schedule 1.2(4) of the Instruction lists 14 criteria that trigger automatic referral for mental health assessment, four of which were directly pertinent to Mr Chandler:

[13] Transcript page 205 and 206.
[14] Transcript page 181.

- if the prisoner has been charged with a serious offence which is likely to attract a very long sentence if convicted;
- if the prisoner is in prison for the first time;
- if the prisoner is charged with offences that are of a particular nature or have attracted a significant amount of media attention; and
- if the prisoner upon reception, appears distressed or was imprisoned contrary to expectation or received a significantly longer sentence than expected.

Psychiatric Assessment

38. Mr Chandler's psychiatric assessment was also completed on Friday, 6 March 2009 by Mr Logan. The assessment was guided by the Mental Health Intake Screening Assessment form, a four-page psychiatric assessment tool that is evidence based and comparable to any standard psychiatric intake assessment document with a forensic focus, though with the addition of the following specialist fields:

- suicide/self harm alert;
- psychiatric alert;
- prior imprisonment; and
- charges.

39. When Mr Logan filled out the Initial Plan section on page 1 of the form for Mr Chandler on 6 March 2009, he circled "not known" for all six risk criteria listed in this section (suicide/self-harm, violence, vulnerability, fire risk, substance misuse and non-compliance).

40. Overall, Mr Logan indicated on the Mental Health Intake Screening Assessment form that Mr Chandler presented with no overt symptoms of a mental illness, and volunteered no information suggesting an increased risk of self-harm or emerging mental health issues.

41. Not all sections of the Mental Health Intake Screening Assessment form appear to have been filled out in detail. However, based on the information recorded therein, it would be reasonable to conclude that Mr Logan did not believe Mr Chandler was at immediate risk in any of the six risk areas. It is also reasonable that the interview and assessment did not reveal Mr Chandler had any indicators that would have resulted in an increased observation category based on his risk of self-harm at the time of his assessment.

Medical Assessment

42. Mr Chandler underwent the required medical assessment on Saturday, 7 March 2009, which covered his medical history. The Pharmaceutical Benefits Scheme and Medicare report obtained by the CPU, reported Mr Chandler had only made a single claim on Medicare and PBS prescribed medication, that being on 12 February 2007. This did not however rule out Mr Chandler had sought medical assistance or medications privately.

43. The Mental Health and Risk Assessment section of the MAP Reception Health Assessment form consisted of three specific questions related to history of diagnosis of a mental illness, past self-harm or suicide attempts and current thoughts of self-harm, which Mr Chandler denied. Mr Chandler was classified as "M2 - regular and ongoing medical issues", and scheduled for a review in three months.

Discussion regarding Statement of Professor James Ogloff and the Mental Health Intake Screening Assessment Form

44. Professor Ogloff, Forensicare Director of Psychological Services provided a statement dated 24 August 2011. In that statement he explained the content and structure of the Assessment Form used at MAP. He stated that the process is:

> To identify prisoners who have psychiatric illnesses or other mental health needs for which they will require care while at MAP or in the broader prison system. The screening process culminates in a mental health formulation/summary that enables the nurse to determine whether risks exist across six areas: suicide/self-harm, violence, vulnerability, fire risk, substance misuse (drug seeking) and non-compliance with psychiatric treatment.
>
> He further explained that:
>
> Regardless of the approach to screening that is taken, or which measures are employed, one of the main purposes of the screening is to determine whether a follow-up assessment or consult with a psychiatric or other appropriate professional is warranted.
>
> He also stated that:
>
> In addition to placement recommendations and referrals, psychiatric nurses use the Screening Assessment Form to document mental health symptoms and to make global predictions of adjustment difficulties across a number of domains: suicide/self-harm risk, violence, vulnerability, fire risk, substance misuse and psychiatric non-compliance.

Assessment of immediate risk

The Mental Health Intake Screening Assessment form appears to be a satisfactory tool for guiding the assessment of a prisoners' immediate risk and needs.

Assessment of ongoing risk

The assessment of ongoing and emerging risk is very important in a corrections context. Schedule 1.2(1) of the Corrections Victoria Public Prisons Director's Instruction 1.2: At Risk Procedures explicitly recognises that:

The first 72 hours after initial reception or reception into a new prison is one of the highest risk period for suicide.

Schedule 1.2(1) also includes a more detailed explanation of the nature of suicide risk in prison, which is broken into two categories of factors:

> Pre-Dispositional Factors are those attributes of the person associated with the risk of suicide or self-harm. Examples include previous history of attempted suicide/self-harm, history of impulsive behaviour, history of drug use, age (young or elderly prisoners), history of mental illness, history of violent behaviour, history of traumatic incidents (such as victim of abuse), and being in prison for the first time.
>
> Situational Factors are the situations that individuals are placed in that contribute to their risk of suicide/self-harm. Examples include separation from family and friends (especially children), major disappointment, failure or rejection, any type of abuse, unexpected court outcomes, reception/transfer to a new prison, other major loss, current withdrawal from drugs of dependence (including alcohol), lack of family support or assistance and prison problems such as concerns regarding protection and bullying within the prison.[...]

It is the combination of pre-disposition, situation and elevated stress (which leads to distress) that can constrict an individual's perception of the options available to them to cope with their psychological pain and initiate an active suicidal scenario.

45. The Mental Health Intake Screening Assessment form did not appear to be an effective tool in identifying and assessing ongoing risk. Making global predictions about adjustment difficulties in the stated domains requires a longer-term approach to risk assessment rather than a single assessment.

46. A major issue is that a prisoner (such as Mr Chandler) who is admitted to the MAP and assessed as having no history or current evidence of risk in the six assessed areas (suicide/self-harm, violence, vulnerability, fire risk, substance misuse and non-compliance), would not attract a risk and observation category that would necessarily result in any formal follow-up. There were apparent shortcomings in the consideration of adjustment issues occurring after the initial assessment.

47. For most prisoners this may not be so much of an issue. However, where a prisoner is at risk of developing suicidality because of known pre-dispositional and situational factors that are documented in the Corrections Victoria Public Prisons Director's Instruction 1.2: At Risk Procedures, this may not be adequate. In the case of Mr Chandler, he was (1) convicted of a serious offence that was likely to attract a long sentence, (2) a first time prisoner, (3) charged with an offence of a particular nature, and (4) imprisoned contrary to expectation. The Mental Health Intake Screening Assessment form does not appear to give weight to these pieces of information in making a professional clinical judgement about the likelihood of adjustment difficulties over the 72 hours of high risk in a prisoner whose initial risk was assessed as "not known".

Razor Blade Access at MAP

48. In response to Mr Chandler's death, Corrections Victoria to its credit, have implemented a policy restricting razor access for prisoners housed in high-risk units and prisoners who are assessed at risk level S1 or S2. Justice Health wanted to extend the razor access restrictions to all new prisoners at MAP, regardless of their risk level or where they were housed. Competing submissions were made by Corrections Victoria and Justice Health on this issue.

Initial Justice Health recommendation on razor blade access

49. Justice Health conducted a review of Mr Chandler's death in conjunction with the Office of Correctional Services Review (OCSR). In an undated report endorsed by Justice Health Director Ms Gardner, the following recommendation regarding Victorian prisoner access to razors was made:

> "That a review of prisoner access to razor blades be undertaken by Corrections Victoria in collaboration with Justice Health, including strategies to limit access for new receptions and prisoners with an S1 and S2 rating. [The "S1" rating is that the prisoner is at immediate risk of suicide or self harm. The "S2" rating is that the prisoner is at significant risk of suicide or self harm.]"

50. The reasons underpinning this recommendation were that any prisoner new to custody is vulnerable, and it is not an onerous task for prisoner officers to supervise razor use.

51. In a statement to the Coroners Court of Victoria dated 21 July 2011, Ms Gardner described several meetings between Justice Health and Corrections Victoria that occurred in the period March 2009 - March 2010, regarding prisoners' access to razors. As a result of these meetings, Corrections Victoria provided Justice Health with a draft Commissioner's Requirement addressing access to razor blades, and invited feedback before finalising the Requirement. Ms Gardner annexed to her statement a memorandum dated 10 May 2010 that Justice Health sent to Corrections Victoria Commissioner, in response to the draft Requirement. In this memorandum, Justice Health set out its position that in addition to limiting razor access for prisoners at risk across Victoria, no prisoners at MAP should be permitted to retain razors, because a blanket ban at MAP is easier to implement than a selective ban.

OCSR recommendation on razors

52. The OCSR's final report into the death of Mr Chandler was dated 16 August 2010. In the report, the OCSR noted that MAP had introduced Operating Procedure 1.24/1, and that Corrections Victoria had produced a draft Commissioner's Requirement to standardise razor access policies for prisoners at risk and prisoners held in management accommodation units such as protection units.

53. The OCSR reviewed the draft Commissioner's Requirement and noted that it did not address the issue of newly arrived prisoners' access to razor blades. This was a concern because newly arrived and first-time prisoners are generally at higher risk of self-harm than the general prisoner population. Consequently, the OCSR made the following recommendation:

> "Recommendation 4: That Corrections Victoria, in consultation with Justice Health, should consider whether there are any circumstances in which newly received prisoners' access to razor blades should be restricted."

Corrections Victoria Commissioner's Requirement on razor blades

54. In August 2010, at around the same time that the OCSR released its final report, Corrections Victoria issued the final version of its Commissioner's Requirement titled Access to Plastic Bags, Plastic Wrap and Shavers. The Requirement included the following directions on razors:

- Prisoners in "high risk" areas or who are classified with an "at risk" rating of S1 or S2, are not to retain shaving equipment. [...]

- Shavers are to be safely secured into a clearly marked container identifying the prisoner's name and CRN. [...]
- Prisons are to implement procedures that provide prisoners in "high risk" areas, or with an S1 or S2 rating, the opportunity to shave on a daily basis. Issuing and collection of intact razors must be recorded in a shaver register.

55. There was no mention in the Commissioner's Requirement about restricting razor access for new prisoners.

Corrections Victoria response to recommendations on razors

56. Corrections Victoria issued an Action Plan dated 11 February 2011, in response to the OCSR and Justice Health recommendations. The response to OCSR Recommendation 4 was framed in the following terms:

> "Justice Health and the OCSR had been provided copies of the Commissioner's Requirement when in draft, and Justice Health provided feedback. Under this policy, restriction on shavers applies to S1 and S2 rated prisoners, in addition to prisoners in other higher risk areas (psychiatric, management and high security units). Corrections Victoria does not share Justice Health's view that shavers should be restricted for newly received prisoners. Such a restriction would be difficult to manage in the mainstream population, where many prisoners mix.
>
> Corrections Victoria has therefore considered Justice Health's recommendation and will not restrict access to new receptions unless of course these prisoners are accommodated in those high risk areas."

Justice Health submission at inquest regarding razors

57. In a statement to the Coroners Court of Victoria dated 21 July 2011, Ms Gardner acknowledged the Corrections Victoria concern that restricting razor access for new prisoners housed in a mainstream prison population would be difficult to manage. However, she maintained that restricting razor access for new prisoners at MAP was still appropriate because:

> "[...] whilst this would not take away the possibility of new prisoners using a fellow prisoners' razor blade, it would reduce the possibility of self-harm by this means, including minimising impulsivity of self-harm while shaving. The literature refers to a high incidence of impulsive acts of self-harm while having access to sharp instruments (such as a shaver with a razor blade) as opposed to a premeditated act."

Conclusions

Psychiatric assessment

58. Mr Chandler spent Saturday 7 March 2009 attending his medical assessment, playing pool, and being in the company of other offenders in protective custody. There was nothing in Mr Chandler's behaviour to alert either the medical practitioner or the Custodial Officers to his prospective suicide; however, there was no impetus for them to focus on how he was adjusting.

59. Over the 36 hours between arrival at the MAP and his death, Mr Chandler had time to reflect on his situation, which may have led to elevated stress. Mr Chandler was going to be in prison and in protective custody for the near future. The MAP assessment process focused on self-reported risk and not an assessment of either risk or adjustment issues. Once the Corrections Reception Assessment and psychiatric assessment were completed, a change in risk or category of observation relied on the prisoner self-identifying and asking for assistance. For most prisoners this may be appropriate, however, there may be scope for a different approach for prisoners who are at risk of having adjustment issues based on the Corrections Victoria's existing policies. Providing a routine follow-up appointment within 72 hours may not have captured Mr Chandler because he died within 36 hours, but there are options such as a Custodial Officer Interaction with Prisoner and those referred to in part of Mr Taylor's evidence. The process is already part of the Schedule 1.2(2) S1, S2 and S3 Risk Level Framework and described as follows:

> "Custodial Officer Interaction with Prisoner refers to a meaningful discussion in an appropriate environment with the prisoner regarding their current concerns and situation with a brief file note regarding the discussion."

60. An additional issue is the translation of the "not known" self-harm risk on the Mental Health Intake Screening Assessment form, into a "nil" suicide and self-harm rating on the MAP Reception/Review (SP&M) Risk Assessment Mental Health Professional Prisoner Summary form. A conclusion of "nil" self-harm risk should be the result of informed professional judgment using all available information and represent a positive assertion that the person is not at risk of self-harm. A conclusion of "not known" self-harm risk is very different; it indicates that the risk may or may not exist but the assessor is not in a position to offer a concluded view.

61. The psychiatric assessment completed for Mr Chandler following his admission to the MAP on 6 March 2009, resulted in his risk of suicide/self-harm, violence, vulnerability, fire risk, substance misuse and non-compliance being noted as "not known" on the MAP's Mental Health Intake Screening Assessment form.

62. The "not known" assessments on the Mental Health Intake Screening Assessment form became translated into "nil" suicide and self harm rating on the MAP Reception/Review (SP&M) Risk Assessment Mental Health Professional Prisoner Summary. Although this was not desirable because "not known" and "nil" are not equivalent categories, it is likely that the "nil" reflected an accurate assessment of Mr Chandler's position.

63. The major issue that exists was the lack of any planned or required follow-up activity by either Corrections Victoria or Forensicare to better assess and clarify Mr Chandler's unknown risk of self-harm, particularly given that his circumstances included a number of documented factors for developing a self-harm risk. In particular, the Mental Health Intake Screening Assessment form encourages examination of first-time prisoner's adjustment issues only on intake. However, it is logical that the prisoner would need to spend some time in the system before the adjustment issues manifest and can be accurately identified and managed.

Razor blade access

64. Justice Health submitted that razor blade access should be restricted for all new prisoners at MAP, to reduce the risk of self-harm among this recognised vulnerable prisoner sub-population. Corrections Victoria, however, maintained that such restrictions are not needed unless the prisoner is otherwise assessed to be at risk of self-harm, because they would be difficult to manage in an environment where new prisoners freely mix with prisoners who have been incarcerated for some time.

65. The CPU were requested to make inquiries of other Australian states regarding their policies on razor access for new and high risk prisoners. The results were limited but did tend to support the current practice of Corrections Victoria around razor access in that new and first time prisoners were not automatically regarded as at risk prisoners.

Razor blades and access to means

66. It was noted that in the death of Mr Chandler, restrictions on razor blades would not necessarily have prevented his suicide. A review of the photographs of the scene revealed other, equally lethal means available to him.

Post Mortem Examination

67. An autopsy was performed by Dr Malcolm Dodd, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. He formulated the cause of death and his report contained the following comments:

> "The immediate cause of death in this case is one of acute external blood loss.

The blood loss has occurred as a consequence of severing the median vein of the left forearm.

External examination disclosed a solitary oblique oriented 80mm incised defect over the proximal one-third of the left forearm. Dissection of this area disclosed densely haemorrhagic subcutaneous fatty tissues. Hesitation marks were not identified.

The cutting implement in this case would appear to be a disposable razor.
The internal examination disclosed moderate cardiac enlargement and the presence of a fine metallic stent within the circumflex branch of the left coronary artery.

No other significant naturally occurring disease was disclosed.
Toxicological analysis of body fluids was non-contributory."

Findings

It is impossible to know exactly what Mr Chandler was thinking on the eve of his death after being locked in his cell, however the reality of his predicament probably manifested in elevated stress over the 36 hours or so since his initial reception into prison and psychiatric assessment. The personal notes that were found reveal his suicidality and intention to take his own life. There are expressions of hopelessness and despair and he mentions in one note that "prison is not for me."

At some stage that evening he apparently removed a razor from the plastic shaver he received upon entering prison and inflicted an injury to his arm causing significant loss of blood. He also placed a plastic bin liner over his head.

Corrections Victoria clearly have an awareness of the risks to vulnerable prisoners in the prison environment. Appropriate steps regarding restricted access to plastic bags and razors for some prisoners have been implemented. Whilst I was not persuaded to recommend an extension of that restriction to razors to the mainstream MAP prison population, the views and concerns expressed by Justice Health for all new prisoners are valid.

The Mental Health Intake Screening Assessment Form and associated risk assessment processes at MAP should be improved however it cannot be known whether extra monitoring or assessment would have prevented Mr Chandler's ultimate unfortunate demise.

COMMENTS:

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment connected to the death:

1. To mitigate the risk of razors to all new prisoners, Corrections Victoria should conduct further research and consultation in an effort to achieve best practice.

RECOMMENDATIONS:

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

1. To improve the safety of first time prisoners with additional known self-harm risk factors who are initially assessed with either an unknown or low risk self-harm rating, a follow-up formal and recorded session with either a Forensicare or Correction Victoria staff member must take place after the first 24 hours of imprisonment to further assess risk and adjustment issues.

Signature:

Heather Spooner
Coroner

20th October, 2011