Court Reference: 1575 / 04

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Wesley Robert Jennings

Delivered On:	12 February 2010
Delivered At:	Melbourne
Hearing Dates:	19 and 22 March 2007 and 17 March 2008
Findings of:	Paresa Antoniadis Spanos
Representation:	Mr R. Shepherd appeared on behalf of Corrections Victoria
	Mr J. Goetz appeared on behalf of St Vincents Correctional Health Service
	Mr A.Halse appreared on behalf of G.S.L. Custodial Services Pty Ltd
	Mr J. Olle appeared on behalf of Forensicare
	Mr D. McSteen on behalf of Mr Birtles
Place of death/Suspected death:	Port Phillip Prison, Laverton, Victoria
State Coroners Assistant Unit:	A/g Sgt J. Stewart

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

In the Coroners Court of Victoria at Melbourne

I, Paresa Antoniadis Spanos Coroner **having investigated** the death of:

Details of deceased:

Surname:	Jennings
First name:	Wesley Robert
Address:	Port Phillip Prison

AND having held an inquest in relation to this death on the 19th to 22nd March 2007 and the 17th March 2008

at the Coronial Services Centre, Southbank

find that the **identity** of the deceased was Wesley Robert Jennings

and the **death occurred** on 6th May 2004

at Port Phillip Prison, Dohertys Road, Laverton, Victoria 3028 from:

1 (a) INCISED WOUND TO THE NECK

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Mr Jennings was born on the 21st February 1962, adopted at nine days of age and raised by his adoptive parents Mr Robert and Mrs Jennings in Belmont, a suburb of Geelong. He had a relatively stable upbringing until the age of twelve when he became involved in a youth group and was allegedly sexually abused by one of the male leaders.

[1] This finding is based on all the material the product of the coronial investigation of Mr Jennings' death, that is the brief compiled by Detective Senior Constable Dale Senior Constable dale Smith from the Prison Squad, Victoria Police, the statements and testimony of those witnesses who testified and any documents tendered at inquest. That material and the inquest transcript will remain on the coronial file. I do not purport to summarise all the evidence in this finding, but will only refer to it in such detail as is required in the interests of narrative clarity and forensic significance. Under this section of the finding, I have summarised matters which I believe were uncontentious, at least by the conclusion of the inquest.

Mr Jennings was a bright child but he became increasingly disruptive at school, and abandoned formal schooling midway through Year 10. At about the time that he left school, Mr Jennings became involved in criminal offending and substance abuse, and subsequently spent time at both Turana and Beltara Youth Training Centres. By the time he was twenty he had a heroin addiction.

2. Mr Jennings medical history included asthma which he had since childhood and which was treated with various medications including "Ventolin" and "Seretide", Hepatitis C first diagnosed in 1996 and believed to have been contracted through intravenous drug use, and long-standing depression and anxiety, first diagnosed in 1986. He had also suffered a workplace injury to the right knee in 1989 and a right ankle injury in 1996 and had some chronic pain management issues. Mr Jennings had a variety of jobs over the years, generally in labouring or unskilled occupations, but had trouble staying in the one job for any significant period, often citing difficulties with co-workers or employers.

3. Ms Elizabeth Kelly was in a de facto relationship with Mr Jennings on and off for about five years ending with their final separation in October 1992. Their son Luke remained in her care and one of the stressors in Mr Jennings' life was his perception that Ms Kelly was unreasonably preventing or limiting his access with his son. His mother Mrs Joy Jennings continued to support her son and to provide him with a place to live, although their relationship was fraught, and at times she was at risk from his violence towards her.

4. Despite a lengthy adult criminal history, Mr Jennings only served two periods of incarceration. The first when he was sentenced in the County Court for a series of armed robberies and was incarcerated between August 1985 and November 1996 in Pentridge, Ararat and Morwell River Prisons. The second commencing with his arrest on 1st March 2007 and lodgement in the police cells at Geelong. He was subsequently remanded in custody from 5th March 2007, first at the Melbourne Assessment Prison, and then at Port Phillip Prison where he died on 6th May 2004.[2]

THE SIEGES - 29th FEBRUARY & 1st MARCH 2004

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2 See generally, the Summary provided by DSC Dale Smith and the statements of Mrs Joy Jennings, Ms Elizabeth Kelly, Ms Kerrie-Anne Peucker, and Dr Neil Sheahan - all in Exhibit "P", the balance of the coronial brief.

5. On Sunday 29th February 2004, a number of allegations were made to police about Mr Jennings, including that he was cultivating cannabis in the back yard of his home. By about 8.00pm police had verified the information, obtained a search warrant and attended at his home in Grovedale to execute the warrant.

6. Mr Jennings refused the police entry and refused to leave his premises. He became verbally abusive and threw various objects at the police. He poured a substance, believed to be inflammable over himself and threatened to burn the house down. The police had concerns for the safety of Mrs Jennings who was also at the premises, in part based on information from a neighbour that Mr Jennings may have had a hand gun in his possession.

7. After lengthy negotiations, the stand-off was resolved, the police seizing the drugs in the back yard, and Mr Jennings agreeing to attend Geelong Police Station on 1st March 2004 for interview.

8. The following day, police received information concerning recent threats made by Mr Jennings towards his mother and his sister. They re-attended at the Grovedale property and he again refused to come out. Police cordoned off the area immediately around the home and brought in "negotiators" to resolve the stand-off.

9. Eventually members of the Special Operations Group were deployed. They forced entry into the home and used "capsicum spray" to subdue and arrest Mr Jennings. Mr Jennings had self-inflicted injuries to his wrists/forearms and was taken to Geelong Hospital for medical treatment prior to lodgement in the police cells at Geelong Police Station.[3]

6th MAY 2004

10. In the period between lodgement in the police cells and his death, Mr Jennings was assessed by a number of health professionals from different disciplines, across five different custody settings. The details of these assessments will be discussed below. Suffice to say that as at 6th May 2004 Mr Jennings was a remand prisoner at Port Phillip Prison.

11. At the 8.00am morning "trap muster" he told Prison Officer Victor Jablonski that he was supposed to attend court that day. PO Jablonski told him that he would make enquiries after the muster and let him know. PO Jablonski contacted the prison's records section and ascertained that Mr Jennings was not due to attend court until the following day 7th May.

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3 See generally, the Summary provided by DSC Smith and the statements of LSC Stanley from the Force Response Unit and SC Wrigley from Geelong Police, all in Exhibit "P" .

12. At about 8.20am and before he could convey this information to Mr Jennings, PO Jablonski responded to a duress alarm from the prisoner sharing a cell with Mr Jennings. This prisoner spoke mainly in Russian and was difficult to understand but sounded distressed. PO Jablonski went to the cell and looked in through the "trap". He saw Mr Jennings naked in the shower cubicle, kneeling and slumped forward with the water still running above him. He had a large bleeding wound to the neck.

13. PO Jablonski alerted his colleagues, one of whom called a "Code Pink", denoting a medical emergency. The Prison Officers entered the cell and immediately removed the other prisoner to the exercise yard. They used towels to attempt to staunch the bleeding while medical/nursing staff arrived in response to the Code Pink.

14. Despite timely medical attention, including the attendance of two M.I.C.A. Paramedics, Mr Jennings could not be revived. All resuscitation efforts were ceased at 8.55am and Mr Jennings was pronounced deceased at 9.00am.[4]

THE PURPOSE OF A CORONIAL INVESTIGATION

15. The primary purpose of a coronial investigation of a "reportable death"[5] is to ascertain, if possible, the identity of the deceased person, how death occurred, the cause of death and the particulars needed to register the death - effectively and date and place where the death occurred.[6] In order to distinguish 'how' death occurred from the 'cause' of death, the practice is to refer to the latter as the *medical* cause of death, incorporating where possible and *mode or mechanism* of death, and the former as the context or the background and surrounding circumstances. These circumstances must be sufficiently proximate and relevant to the death, not merely circumstances which might form part of a narrative culminating in death.

16. As Mr Jennings was on remand when he died, he was a "person held in care" and his death was reportable, irrespective of the cause of death or the circumstances in which death

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4 See generally, the Summary provided by DSC Smith and the statements of Prison Officers Jablonski, Koukmenides and Spearman, Dr Eugenie Tuck and M.I.C.A. Paramedic Scrofani, all in Exhibit "P".

5 "Reportable death" is defined in detail in section 3 of the Coroners Act 1985. Apart from a jurisdictional nexus with Victoria, the general definition captures a death "that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury". Although the Coroners Act 2008 commenced operation on 1 November 2009, the effect of the transitional provisions is that the 1985 Act continues to apply where an inquest commenced before that date. All references to legislative provisions are therefore to the provisions of the 1985 Act unless otherwise stated.

6 See section 19(1).

occurred.[7] The other consequence flowing from this status is that an inquest is mandated by the legislation, as part of the coronial investigation of his death.[8] To this extent, prisoners and others held in the care of the State, are accorded special status, reflecting a recognition of their vulnerability, and of the appropriateness of independent scrutiny afforded by the coronial process.

17. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including public health or safety; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety.[9] Whilst the current legislation does not explicitly refer to the purpose of any reports, comments or recommendations made by a Coroner, the implicit purpose, certainly the generally accepted purpose, is the prevention of similar deaths in the future.

18. In relation to Mr Jennings' death, a number of matters required to be ascertained are uncontentious, namely his identity, and the date and place of his death. I find as a matter of formality, that Mr Wesley Robert Jennings, born on the 21st February 1962, died at the Port Phillip Prison, Laverton, on the 6th May 2004.

CAUSE OF DEATH

19. Nor was there any controversy about the medical cause of death. Associate Professor David Ranson, Forensic Pathologist, Deputy Director, Victorian Institute of Forensic Medicine (VIFM), attended the scene and made his own observations. He also made an initial examination of Mr Jennings in a treatment room in the hospital block and subsequently performed a full post-mortem examination or autopsy at VIFM. He provided a detailed report of his investigations and findings, concluding that the cause of Mr Jennings' death was an "incised injury to neck".[10] Associate Professor Dr David Ranson described this as an extensive incised wound to the left side of the neck which had severed both arteries and veins and associated supporting musculature, the nature and severity of which would have required several passages of an incision object.[11]

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7 Section 3, definition of "reportable death" paragraph (i).
8 Section 17(1)(b).
9 Section 21(1), 19(2) and 21(2) re reports, comments and recommendations respectively.
10 Associate Professor/Dr David Ranson's 16 page autopsy report including his formal qualifications and experience was part of Exhibit "P" the balance of the coronial brief.
11 Ibid, see comment 2, page 16 of the autopsy report.

20. Dr Ranson confirmed that there was no evidence of significant natural disease of a type that might be expected to have contributed directly or indirectly to death, and no unequivocal physical evidence to suggest that a third party inflicted the injury to the neck or minor injuries to other parts of the body, that is the minor very superficial incised injuries to the left hand and abrasions over the knees and left forehead.[12]

21. Toxicological analysis of post-mortem blood samples, also undertaken at VIFM, revealed no alcohol or other commonly encountered drugs or poisons.[13] This has significance in both confirming Mr Jennings abstinence from illicit substances, at least in the period immediately preceding his death, and also confirming the absence of any prescription anti-depressants or other psycho-active medications.

22. I find that the cause of Mr Jennings' death was the incised injury/ies to the neck described by Associate Professor Dr David Ranson in the autopsy report.

HOW THE DEATH OCCURRED

23. One aspect of the circumstances surrounding Mr Jennings' death which was not contentious, certainly by the commencement of the inquest, was that the injury which resulted in his death was self-inflicted and intentional. A finding of suicide, that is that an act was performed with the intention of taking one's own life, is not made lightly, but I am satisfied that it is appropriate to do so in this instance.[14]

24. It is also appropriate to recognise that suicide can be an impulsive act and/or an act which is entirely unexpected, even by the most vigilant professional person or family member or friend, even when they are in close and regular contact with the deceased. Having said that, the main focus of the coronial investigation of Mr Jennings' death, including the inquest, was the psychiatric/psychological services provided to him during his last period of incarceration, with particular emphasis on the flow of clinical information between the various institutions and professionals involved and any impediments to that flow, whether real or perceived.[15]

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12 Ibid, see comments 3 and 4, page 16 of the autopsy report where Dr Ranson gives possible explanations as to how these minor injuries could have occurred consistent with self-infliction.

13 The toxicologist's report is also part of Exhibit "P", the balance of the coronial brief.

14 Apart from the nature of his injuries and the fact that they were self-inflicted, there is a body of evidence which supports this finding - see statements of Dr Neil Sheahan, Mr David Sullivan, Mrs Joy Jennings especially from page 7 onwards - in Exhibit "P ".

15 I include in this category Dr Sheahan and Mr David Sullivan, Psychologist, whose clinical

PRIOR TO INCARCERATION

25. Dr Neil Sheahan first met Mr Jennings in 1995 through his work at the Geelong Hospital methadone clinic. From this time onwards he became Mr Jennings' general practitioner, treating him regularly between September 1995 and September 2003 for drug rehabilitation, mental health issues and general health issues. Dr Sheahan described a good rapport and functional therapeutic relationship over a significant period.

26. According to his statement, it was obvious to Dr Sheahan from the outset, that Mr Jennings had "some specific problems with anxiety and depression" which were initially manageable but became more problematic in later years. He described Mr Jennings as a "person who was constantly struggling with depression on and off. Family issues and, in particular, court appearances seemed to get [him] into a state of excessive anxiety and compounded his pre-existing depression issues. The fear of incarceration was always at the forefront of his mind after receiving his suspended sentence. It was quite obvious to me he was not comfortable with returning to prison."[16]

27. At his last consultation with Mr Jennings on 17th September 2003, his medications were citalopram ("Cipramil" an anti-depressant), methadone (opiate replacement therapy), tramadol ("Tramal" an analgesic), and diazepam ("Valium" a benzodiazepine anxiolytic).[17]

28. Dr Sheahan also mentioned Mr David Sullivan in his statement, a Psychologist who had seen Mr Jennings sporadically between 1989 and 2003, mainly to help with his depression and anxiety, and one with whom he had been able to work with when required to ensure that Mr Jennings had the medications required to complement psychotherapy.[18]

29. Mr Sullivan had first seen Mr Jennings following his workplace injury and continued to see him occasionally on a pro bono basis after settlement of his claim. He expressed the opinion that he had "suffered a severe and chronic Major Depressive Disorder for many years, had used illicit dugs, then prescribed anti-depressant medication to manage his mood disorder and associated severe anxiety disorder, that ... [he] had suffered a life long threat

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information regarding Mr Jennings was, at least notionally, and probably optimally, "available" to the clinicians who saw him within a custody setting.

16 Interestingly, a similar assessment was made by the Mr David Lindros, Pharmacist, who had known Mr Jennings for some four years and was the pharmacist who regulary dispensed his methadone. His statement dated 13 May 2004 is part of Exhibit "P".

17 As well as "Seretide" and "Ventolin" for asthma and "Vioxx" for osteoarthritis which I have ommitted as irrelevant for present purposes. See Dr Sheahan's statement page 8 in Exhibit "P".

18 Ibid at page 2.

sensitivity, that he was suspicious, had difficulties with emotional intimacy, and became angry as a means of defence in the face of even relatively minor pressures."[19] Mr Sullivan also expressed considerable concern that Mr Jennings should have committed suicide "given the long-standing medical, pharmacological and psychological management which he had sought, and which was known at the time of his arrest". A concern not unrelated to the focus of the inquest.

DURING THE SIEGE: 1st MARCH 2004

30. Mr David Mayer[20], Clinical Coordinator of the Surfcoast Community Mental Health Team (SCMHT), and a Registered Psychiatric Nurse of twenty-five years' experience, attended the siege in response to a police request for assistance. Between receiving the request at 10.40am and arriving at the Grovedale scene at 11.00am, he conducted a "cursory background check" for Mr Jennings with no success. In evidence he explained that this involved searching Barwon Health's in-house Patient Information Management System (PIMS) and RAPID[21], a statewide database. He explained that the absence of information about Mr Jennings was not surprising, and reflected the limitations of both sources. He noted incidentally, that processes within Barwon Health had changed so that all contacts are now noted on the PIMS system.[22]

31. Mr Mayer saw his role at the scene as assisting the resolution of the stand-off by assessing whether Mr Jennings was grossly out of touch with reality, whether he was likely to leave the premises voluntarily and whether he would self-harm by "slashing-up" as he

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19 In his letter/statement, part of Exhibit "P", he also stated that "Mr Jennings was an intelligent man who had not achieved his academic potential, who suffered a life long sense of vulnerability, insecurity and social isolation ... [recently] he had again been concerned about his obsessive hoarding behaviours, which it is considered was associated with issues of his underlying difficulties with identity and belongingness."

20 Mr Mayer was employed by Barwon Health who ran the SCMHT. His statement dated 1 June 2004 was Exhibit "D". The two triage forms relating to each of his contacts with Mr Jennings were also included in the brief Exhibit "P" as annexure "Q".

21 Transcript pages 134-135, 137, 143. RAPID is an acronym for "Redevelopment of Acute & Psychiatric Information Directions", a statewide database containing all client information collected by public clinical mental health services. By definition, contacts with private mental health services (eg. Psychiatrists or Psychologists in private practice) and mental health-related contacts with general health services (eg. a General Practioner or the Emergency Department of a hospital where review by a Psychiatric Registrar is requested) are not captured.

22 Transcript page 135. The new process involves allocating all constacts a Geeling Hospital UR number, even where no follow-up is envisaged and it's a situation of "open/close".

was threatening to do. He concluded that Mr Jennings would not leave voluntarily and that the risk of self-harm was low, and advised police accordingly.[23]

32. A number of health professionals were contacted by Mr Mayer in the course of the afternoon. They provided information about their knowledge of Mr Jennings' issues and/or treatment, apparently without demurrer as to patient confidentiality or information privacy and the like, as the exigencies of the situation overrode any such considerations.[24] In so doing they enhanced Mr Mayer's ability to understand Mr Jennings' behaviour, by advising him as to their most recent assessments of him and by enabling his current behaviour to be seen within a broader context.[25]

33. Mr Mayer conceded that the mental state assessment he made on 1st March 2004 was an ephemera. He testified that although aspects of Mr Jennings' psycho-social functioning could be expected to have ongoing relevance, for example his experience of childhood sexual abuse and his feelings of entrapment, the assessment itself would be of little significance beyond the "then and there". Certainly, he would not have expected his assessment to have any value as a prognostication of his mental state, say, two months down the track.[26]

POLICE CUSTODY: 1st - 4th MARCH 2004

34. Dr Cameron Profitt responded to a police request to assess Mr Jennings fitness for interview. He saw him in the police cells at Geelong at about 9.35pm on 1st March 2004. Mr Jennings consented to and was co-operative with the assessment. Dr Profitt described him as being tearful and avoiding eye contact. He told him that he "felt like he'd had enough" but " couldn't bring himself to put a hole in himself". Dr Profitt concluded that he was significantly depressed and required psychiatric review which was arranged for the

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23 Exhibit "D" pages 2-3. In evidence Mr Mayer sought to explain the complexity of making these assessments and the subtle interplay between the factors he considered in arriving at his conclusions - transcript pages 129-132, 138-140, 146-148.

24 Transcript pages 122-123, 140. The health professionals he contacted were Dr Sheahan, Dr Kerr (another doctor in the same practice, Mr Sullivan and Mr Ian Joblin, a Forensic Psychologist. Although this was Mr Mayer's "take" on the relevance of privacy in such situations of urgency and not that of the health professionals contacted, he was not challenged on this issue by any party represented at inquest, and I did not understand that this was a controversial view of the relevant law.

25 Exhibit "D" pages 2-3. Transcript pages 120-123.

26 Transcript page 136.

following morning. In the meantime he organised for Mr Jennings to have Ventolin and Valium and to be closely observed overnight.[27]

35. The following morning, 2nd March 2004, Dr Profitt found Mr Jennings much the same, perhaps more animated and angry but not suicidal. He concluded that he was fit for interview in the presence of an independent third party but still required psychiatric review.[28]

36. The psychiatric review was conducted by Mr Mayer who saw Mr Jennings in the cells at about 10.15am. Again, Mr Jennings was co-operative with the process of assessment. He described a number of symptoms of depression, spoke in a monotone and, in terms of thought content, conveyed that he found life difficult due to the impact of sexual abuse and feeling alone and isolated. In terms of suicide risk, there were factors which indicated a moderate risk, but Mr Mayer's ultimate assessment was that the risk was low, primarily based on Mr Jennings indication that he 'just couldn't do it' and his articulation of future plans including reconciliation with his son, interpreted as futuristic projection inconsistent with an intention to take his own life.[29]

37. The third professional to assess Mr Jennings in the police cells was Mr Keith Singleton, a Registered Psychiatric Nurse with twenty-five years experience including eight years in a correctional setting.[30] Mr Singleton was aware of Mr Mayer's assessment on 2nd March[31] and took that into account in arriving at his own assessment. He also spent time with Mr Jennings in his cell and took into account the police register of prisoners which indicated no concerning behaviours when Mr Jennings had been regularly checked by police overnight. Mr Singleton concluded that Mr Jennings was extremely angry and frustrated when told his he would not be provided with methadone, that his behaviour throughout the day had been settled, and his risk of further self-harm was low.[32]

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27 Dr Profitt's statement dated 19 May 2004 includes his formal qualifications (M.B;B.S. 1985, part-time Forensic Medical Officer since 1991) and is part of Exhibit "P", as were his handwritten notes - see Annexure "O".

28 Ibid.

29 Exhibit "D", transcript page 150.

30 In his statement of 8 June 2004, Exhibit "C", he described his duties as a Custodial Nurse employed by Victoria Police as "offering health assessments to everyone in police custody, liaison with other health professionals and the police to ensure that appropriate arrangements are made for the health and welfare of people in custody."

31 He was present for at least part of, and perhaps throughout, that assessment - Exhibit "C".

32 Exhibit "C" and transcript pages 102, 108-10.

38. Mr Singleton obtained details from Mr Jennings as to his prescription medications immediately prior to incarceration, and then set about trying to verify this information with a view to ensuring continuity where possible. In the Confidential Treatment Record, Mr Singleton's notes were to the effect that he mentioned "Tramal", "Valium" and "Cipramil" which he was not currently taking, and methadone 25mg daily prescribed by Dr Sheehan and dispensed at Pardey's Pharmacy which he was currently taking, last dose taken "yesterday".[33]

39. Ultimately, Mr Jennings was not provided with Methadone whilst in the police cells, as Mr Singleton's investigations revealed that there was no current prescription.[34] In order to deal with the anticipated symptoms of withdrawal from methadone, arrangements were made for medical review and Mr Jennings was provided with diazepam, ibuprofen and tramadol.[35]

40. It was apparent from both the statements of Mr Mayer and Mr Singleton and their evidence at inquest that they perceived no problem with the flow of information between them about Mr Jennings, and one presumes about any other prisoner in custody in the police cells. The "handover" of information, was both verbal and document-based. Furthermore, it was the clear expectation of Mr Singleton that any information he gleaned about a prisoner in custody would and should follow him to his next place of incarceration, certainly to the Melbourne Assessment Prison (MAP).[36]

MELBOURNE CUSTODY CENTRE: 4th - 5th MARCH 2004

41. Mr Jennings was transferred to the Melbourne Custody Centre (MCC) on 4th March 2004, where he was assessed by Ms Carrie Brander, a Registered Psychiatric Nurse, as part of the routine reception process. Ms Brander found Mr Jennings cooperative with the interview/assessment process and not overtly depressed. Although he initially denied any psychiatric illness, he later acknowledged having taken citalopram ("Cipramil") for

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33 This document was Annexure "P" in Exhibit "P".

34 It appears an inadvertent dispensing error had occurred with the result that Mr Jennings had continued to receive Methadone for some three months without a current prescription. See Dr Sheehan's and Mr Lindros' statements in Exhibit "P", Mr Sigleton's statement Exhibit "C" and transcript pages 110-111.

35 These medications are, respectively, a benzodiazepine anxiolytic, a non-steroidal anti-inflammatory and an analgesic for moderate to severe pain. They were prescribed by Dr Ryan, another Forensic Medical Officer - transcript pages 111-112.

36 Transcript pages 103-106 and Exhibit "N" the Prisoner Information Record pro forma tendered later in the inquest, during Mr Birtles' evidence.

depression, but not recently, and was evasive or unclear about when he had last taken it. When questioned about current thoughts of suicide or self-harm, he denied ever having harmed himself in the past and attributed the superficial forearm lacerations self-inflicted during the siege to "anger". Mr Jennings gave a verbal guarantee that he would not attempt anything similar whilst in custody. Ms Brander concluded that Mr Jennings was settled, posed no risk of suicide and was suitable for mainstream housing at that time. She arranged for medical review so that the need for antidepressant medication could be considered, as well as analgesia for his chronic pain.[37]

42. Prior to the commencement of the inquest, no further statements were obtained by DSC Smith from MCC staff. In the course of the inquest, I became concerned that clinical information obtained while Mr Jennings was in custody in the police cells appeared not to have "followed" Mr Jennings to MCC as expected, or at least, not to have followed him out of MCC to MAP, so that it could inform clinical staff in their later assessments of his presentation and needs. The inquest was adjourned while further enquiries were made by my assistant, and almost twelve months to the day later, re-convened for the hearing of evidence on this issue.[38]

43. On 17th March 2008, Mr Kevin Birtles, Centre Manger of MCC as at May 2004, gave evidence about the procedures in place for prisoner reception, including the transfer of the Victoria Police Form 450 or Prisoner Information Record (PIR) with the prisoner into MCC and out again to the next remand or prison facility. Upon reception, the prisoner's PIR would be separated into two parts, the medical records reports or documents being provided to medical staff at MCC and the remainder remaining within the cardboard covered PIR which was filed alphabetically at MCC. When the prisoner left MCC, the PIR containing any additional documents, notably a current remand warrant, would be handed to those officers transporting the prisoner, together with the prisoner's medical records which would be sealed to ensure that confidentiality was maintained. Mr Birtles was unaware of

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37 Ms Brander's statement of 31 May 2004 is part of Exhibit "P". Her statement refers to "chronic back pain" whereas other evidence, particularly Dr Sheahan's statement, also part of Exhibit "P", refers to knee & ankle injuries and associated chronic pain management issues. In contrast with the history outlined in Dr Eugenie Tuck's statement which refers to both 'back injury and back pain', and a 'fracture and laceration of the right knee' - Exhibit "F" pages 4-5.

38 It was DSC Smith's evidence which gave rise to this concern - transcript pages 323-331. Unfortunately the full discussion involving Counsel was not transcribed.

any departure from this practice as regards Mr Jennings reception on 4th March 2004 and transfer to MAP twenty-four hours later.[39]

44. In evidence, Mr Birtles expanded on the processes outlined in his statement, insisting that the PIR should follow the prisoner out of MCC to their next remand/prison facility, and that the medical records although separated out and secured, should also follow the prisoner on transfer. The only PIRs which would remain at MCC and be filed there for a time before archiving, were those pertaining to prisoners who were released MCC.[40] Apart from the possibility of human error which could be implied, Mr Birtles was unable to give an explanation consistent with these processes[41], which sat comfortably with DSC Smith's evidence. He testified that in the course of his investigation, he attended at the MCC and "retrieved the original PIR, and in it contained all the reports that were created by Keith Singleton and also by David Mayer. They were still intact in the folder."[42]

MELBOURNE ASSESSMENT PRISON: 5th MARCH - 8th APRIL 2004

45. On the morning of 5th March 2004, Mr Jennings was taken from the MCC to the County Court for a hearing before Judge Anderson regarding the alleged breach of his suspended sentence. Judge Anderson requested a report from Forensicare and Mr Jennings was remanded in custody until 7th May 2004 when he was to return to the County Court. He was not returned to the MCC but was taken to MAP arriving late that night.

46. On arrival at MAP, Mr Jennings was assessed by Ms Alma Kristensen, a Registered Psychiatric Nurse Level 3, in the context of a somewhat contracted reception assessment due to his arrival outside normal reception hours.[43] Her evidence as to the expectation that the prisoner's medical records/information would follow the prisoner was at odds with the evidence of other witnesses. In the first place, none were available to her on that occasion, and although she acknowledged an ability to request information from various repositories,

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39 Mr Birtles' statement of 15 December 2007 was Exhibit "M"and transcript pages 340-342.

40 Transcript pages 341-344, 348-349.

41 Transcript pages 345-346, 349 and following.

42 Transcript page 323 where he also testifed that he couldn't say for sure if they were original or photocopied documents but thought they were actually carbonated copies, and the cross-examination of Counsel following esp 329-330.

43 Ms Kristensen was an employee of "Forensicare" (the Victorian Institute of Forensic Mental Health). Her statement, Exhibit "E" contains details of her years of experience in the corrections setting. "Normal reception" processes involve assessment by a number of health professionals - transcript pages 158-9, 167, 173-4.

she agreed that the flow of information was "a bit hit and miss".[44] Based on his presentation and the limited information Mr Jennings gave her, and in the absence of any other medical records/information, Ms Kristensen found him suitable for placement in a mainstream prison unit, with no particular concerns regarding the need for psychiatric or psychological intervention at that time.[45]

47. Ms Kristensen gave cogent evidence as to how useful she might have found some of the information which was "known" but not available to her at the time of her first assessment, in particular the long-term use of citalopram (or any other antidepressant) and its relatively recent cessation, and the nature and extent of drug use which might represent self-medicating and exacerbate withdrawal.[46] While this information may not have changed her ultimate assessment of suicidality, it might well have informed the choice of interventions of referral to other clinicians.

48. When next seen by Ms Kristensen on the evening of 8th March 2004, Mr Jennings was complaining of methadone withdrawal symptoms, muscle twitching and restlessness causing him sleep problems. She found him agitated but not suicidal, with no depression or other psychiatric features. She provided paracetamol for pain relief and noted that he had made a booking to see a Psychiatric Nurse through the Outpatients Clinic.[47]

ALCOHOL & OTHER DRUGS SERVICE @ M.A.P. (15th - 30th MARCH 2004)

49. Apart from general medical services[48], in March 2004, there were three entities at MAP providing clinical services to prisoners. The Alcohol & Other Drugs Service (AODS), the Psychological Referral & Intervention Service (PRISM) and Forensicare which provided psychiatric services proper.[49] Prisoners could be referred to these services upon reception by any of the initial assessing officers - the doctor, general nurse, psychiatric nurse or custodial officers. Thereafter they could be referred by the same range of people or could

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44 Transcript page 161.
45 Exhibit "E" and transcript page 161,
46 Transcript pages 162-165, 172.
47 Exhibit "E" and transcript pages 166-167.
48 General medical services were provided by Pacific Shores Healthcare which was not represented at the inquest. See Ms Kristensen's statement Exhibit "#E" page 1 which outlines their role upon reception, and Dr Tucks' statement Exhibit "F" pages 4-7 which details their contacts with Mr Jennings, based presumabley on his medical records.
49 Exhibits "A" & "B" page 1, transcript page 1, 56. AODS and PRISM were part of Corrections Victoria, under the Manager of Clinical Services who was responsbile for all clinical Services Units at all State run prisons. "Forensicare" is a service run by the Victorian Institute of Forensic Mental Health.

"self-refer" by completing a "Programs Referral Form" and leaving it in one of two places within the facility.[50]

50. On 15th March, Ms Amanda Leeper, AODS Coordinator at MAP, collected a referral regarding Mr Jennings. As the referral mentioned he was withdrawing from methadone, she gave him priority and made initial contact with him the same day. He told her he had been on 5ml/25mg methadone in the community, that he was anxious with minor muscle cramps and some diarrhoea. He also admitted using amphetamines and withdrawing from those as well. Ms Leeper provided him with some written information about AODS programs. Due to his anxiety and emotional state, she considered that he should not be placed on a waiting list, and arranged for AODS to see him the next day.[51]

51. Ms Leeper saw Mr Jennings again on 16th March and obtained a fuller history from him. He told her he was not travelling well generally, not coping with withdrawal and anxious about his court case. On a positive note, he wanted to re-establish contact with his son and had been writing to him when Ms Leeper came. Although not purporting to make a formal psychological assessment, Ms Leeper considered he was not at risk of suicide or self-harm. His disclosures of such conduct in the past were in the context of amphetamine use six months earlier, although Ms Leeper also noted that he slashed himself shortly before his arrest on 1st March.[52]

52. Mr Jennings told Ms Leeper that he was keen to pursue drug treatment through AODS but did not want to see a Psychologist. Despite his stated preference, Ms Leeper consulted with PRISM Psychologist, Ms Tarmala Capel, who said she would speak to Mr Jennings. This process of consultation between AODS and PRISM was a way of avoiding duplication of services and ensuring that prisoners on waiting lists were eventually seen by the service best able to address their predominant presenting problem.[53]

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50 Exhibit "B" page 2, transcript page 56.

51 Exhibit "B" page 2. Ms Leeper made no clinical notes of this contact which she considered a "support and advice process" and not "contact counselling".

52 Exhibit "B" page 3, transcript pages 59-60, 78-9.

53 Exhibit "B" page 3, transcript pages 61-62. Ms Leeper agreed with Ms Moulday's evidence that both Ms Capel and Ms Zuliani, another PRISM Psychologist were consulted - see transcript pages 8-10. The sequence of contacts/attempted contacts from a PRISM perspective are outlined in Ms Moulday's statement Exhibit "A" page 1.

53. It follows that Ms Leeper did not feel constrained by confidentiality or privacy concerns in initiating this "secondary consultation process", nor do I suggest that she should. Her concern that Mr Jennings may have benefited by at least initial contact with PRISM was understandable enough. Nevertheless, although AODS and PRISM shared office space, institutionally, they were separate entities. They did not share files, but did share information about prisoners verbally. Ms Leeper testified that she did not believe this was in the best interests of prisoners, and that the exchange of clinical information between the different clinical disciplines at MAP was often debated between AODS, PRISM, Forensicare and Pacific Shores Health.[54]

54. Mr Jennings had contact with AODS and/or Ms Leeper on 17th, 26th and 30th March. He appeared to be well-engaged and motivated. As she was to be absent from MAP after that date for about one week, Ms Leeper briefed a co-worker in case any of her clients had any issues, but there is no further record of contact between Mr Jennings and AODS after 30th March.[55]

PSYCHOLOGICAL REFERRAL & INTERVENTION SERVICE @ M.A.P (19th MARCH-6th APRIL 2004)

55. In the meantime, despite his earlier indication to the contrary, a second Programs Referral Form dated 19th March was submitted by Mr Jennings in which he requested to speak to a Psychologist about problems with sleeplessness, slight paranoia and also about problems which head to his arrest and incarceration. Ms Nicole Moulday, a Psychologist employed within PRISM, collected the referral on 24th March, completed a Supplementary Information Form from information she was able to obtain from prison records and then, effectively, placed Mr Jennings on the PRISM waiting list.[56]

56. Ms Moulday did not see Mr Jennings until 6th April, not because he had progressed up the PRISM waiting list, but in response to a request from a Prison Officer who advised that Mr Jennings had returned from court in a distressed state and needed to talk to someone

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54 Transcript pages 62-64, 76-77.

55 Exhibit "B". I note also the evidence from Mr Jennings' solicitor and friends that he seemed more supported and settled whilst at MAP and less so at PPP, in particular the statement of Mr Kumnick who visited him on 3rd May 2004 and found him changed for the worse - Exhibit "P".

56 Exhibit "A" page 3, transcript pages 16-18. I note that it Mr Jennings "P1" rating pertained to Judge Anderson's request for a court report and not to any "need for immediate psychiatric care and continued placement in MAP for assessment" - transcript pages 22-24.

immediately. This urgent consultation took about one hour. Ms Moulday described Mr Jennings at the commencement of the consultation as agitated, nervous and stressed, but by the end he had relaxed considerably. Ms Moulday did not feel that he needed a psychiatric referral and assessed him as posing no suicide or self-harm risk at that time.[57]

57. At inquest, Ms Moulday testified about a number of matters relevant to the flow of clinical information with a prisoner, as they moved within a corrections setting. She agreed with Ms Leeper that the sharing of clinical information about a prisoner would enhance her work and that ideally, there should be one single file containing all clinical information, irrespective of source which should be accessible to all clinicians. My understanding of her professional interaction with Forensicare, was that she was denied access to their files on the basis of constraints around medical records, but felt she could seek and would obtain a fulsome verbal briefing about a prisoner if required.[58] Problems of proof and sanctions aside, it was not clear, how legislative protection of medical information, if it precluded disclosure, could be avoided by simply making a verbal disclosure, but not providing a copy of the medical record or document. None of the parties represented at the inquest took issue with the practice, either by questioning Ms Moulday (or Ms Leeper for that matter), or Mr Baldacchino who testified to similar practices at Port Phillip Prison as will be seen below.[59]

58. Finally, Ms Moulday explained that at the relevant time, that is early 2004, Clinical Services records from both AODS and PRISM, remained at MAP after a prisoner was transferred, unless requested by a clinician at the receiving prison. She went on to explain that innovations were made at a later time, which went some way towards ensuring that clinical information did follow prisoners leaving MAP, although she had an imperfect understanding of those new processes.[60]

FORENSICARE REPORT

59. As a result of His Honour Judge Anderson's request for a psychiatric evaluation of Mr Jennings, Consultant Psychiatrist, Mr Adam Deacon interviewed him for one and a half

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57 Exhibit "A" page 3, transcript pages 24-25.

58 Transcript pages 12-15. I note that Ms Moulday also agreed that clinical informaiton held by health professionals outside corrections could be useful and was occasionally sought if considered relevant. Transcript pages 19-20.

59 Paragraph 61 below and following.

60 Transcript pages 26 and following where she described the File Information Management System (FIMS).

hours on 24th March.[61] He emphasized, both in his statement and in evidence, that he was not "treating" Mr Jennings but preparing a court report. Nevertheless, it was routine for him to conduct a suicide risk assessment, whenever the prisoner he was interviewing for court reported purposes, disclosed a history of depression and/or self-harming behaviours, in order to assess whether the risk was current or not.[62] Mr Deacon had no concerns for Mr Jennings welfare. On the contrary, he assessed him as having improved since ceasing drug use, on reception into prison, with happy and jovial presentation, and with no symptoms of depression.[63] He echoed the sentiments of Ms Moulday and Ms Leeper, that in the "ideal" treatment situation, there would be continuity of shared information across custody settings.[64]

PORT PHILLIP PRISON: 8th APRIL - 5th MAY 2004

60. Following his transfer to Port Phillip Prison (PPP) on 8th April, and as part of the reception process at that prison, Mr Jennings was assessed by reference to a "Structured Interview Tool for Understanding Prisoner Safety" (a SITUPS assessment). This is an actuarial risk assessment measure designed to elicit responses in relation to topics that are indicators of suicidality, or a tendency to self-harm. As the resultant score of 20/50 fell within the category "S3 - potential risk of suicide or self-harm", Mr Jennings was placed "on alert".[65]

61. Mr David Baldacchino, a Psychologist within the Psychological Services Team at PPP, saw Mr Jennings on 13th April, by way of routine review of his "on alert" status. At this initial interview he conducted a "Suicide and Self Harm Risk Assessment" (SASH Risk Assessment), which was a structured interview developed by GLS Custodial Service Pty Ltd, the private operators of PPP. As the reviewing Psychologist, it was within Mr Baldacchino's remit to recommend that the prisoner remain on alert, or be downgraded or

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61 Mr Deacon explained that his dual role at MAP - to provide court reports and a clinical role within the prison's Acute Assessment Unit and as ut-Patient Registrar - transcript page 208.

62 Exhibit "G", transcript pages 208, 238, 246.

63 Exhibit "G" page 3, transcript pages 212, 232-233.

64 Transcript pages 218-224, 227. Mr Deacon's evidence here is also instructive about the inter-play between depression proper, poly-substance abuse and the cessation of anti-depressant medication. No doubt the aim of psychiatric/psycholgoical engagement with Mr Jennings in the longer term would have been aimed at unravelling this conundrum.

65 Supplementary statement of Mr David Baldacchino dated 21st March 2007, Exhibit "I", page 2. For more detailon the reception process at PPP see Dr Tuck's evidence ranscipt 195 and following.

upgraded as appropriate. He was not bound by the outcome of the SITUPS assessment, but was required to exercise clinical judgement about the prisoners level of risk and how best to ensure their safety. He noted that Mr Jennings' "on alert" status was the lowest SASH risk rating, the next highest being "random watch" and the highest "intensive watch" involving continual monitoring in an isolation cell.[66]

62. Following this initial assessment, Mr Baldacchino's recommendation was that Mr Jennings remain on alert, that he be referred for psychiatric review, and that he be moved from the Scarborough (induction) Unit to Alexander North Unit where he should be more settled and comfortable.[67] The recommended move was actioned by prison management the following day, and the referral for psychiatric review made.

63. In evidence at the inquest, Mr Baldacchino expanded on the processes underpinning the ongoing psychological review of prisoners' SASH risk ratings, namely the regular multidisciplinary SASH Meeting and Clinicians Meeting where more confidential aspects of a prisoner's treatment would be discussed.[68] He testified that he experienced no difficulty accessing medical/psychiatric information from within the records of St Vincent's health, which provided those services at PPP.[69]

64. The thrust of Mr Baldacchino's evidence was that, over his next three contacts with Mr Jennings, he saw noticeable and sustained improvement in his mood and functioning, so that by 19th April he considered that his SASH risk no longer warranted an on alert status. He was aware Mr Jennings had seen the Psychiatric Nurse and was scheduled for follow-up. In his formal contacts with Mr Jennings on 14th and 19th April, he saw nothing to raise concerns about his SASH risk, nor in his last, albeit informal, contact on 3rd May, did he see anything to raise concerns about his welfare.[70]

65. Dr Eugenie Tuck, a Medical Practitioner with sixteen years experience within a correctional setting, was the Director of Medical Services at St Vincent's Correctional Health Service at PPP. Dr Tuck provided a helpful clinical overview regarding Mr Jennings, including his contacts with the various healthcare providers at PPP between his

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66 Ibid, page 3 and transcript page 283.
67 Ibid.
68 Exhibit "H" & Exhibit "I" page 3. Dr Tuck's evidence about these meetings, transcript page 191.
69 Transcript pages 281-282, not unlike Ms Moulday's evidence - see paragraph 57 above.
70 Transcript pages 286-287. One limitation on the investigation of the change in alert status was the poor documentation of SASH Meetings in terms of minutes or rationale of decision-making. This was addressed in the Internal Review. See footnote 77 below and 55 above.

reception on 8th April and his death on 6th May.[71] Without detailing all those contacts, I note that after he was taken off alert on 19th April, he had no contact with any healthcare professionals at PPP. Mr Jennings had an appointment to see a doctor on the 21st April which had been scheduled upon his reception into the prison. For reasons which are not entirely clear, it appears he failed to keep that appointment. The outcome of his review with a Psychiatric Nurse on 19th April was a schedule review by a Psychiatrist on 12th May, and the extant appointment with a Psychiatric Nurse for follow-up on 17th May, also made upon reception.

66. In evidence, Dr Tuck explained the reception process at PPP, and the expectation that medical records would follow the prisoner and be secured in a red bag, including any assessments made while the prisoner was in the police cells, MCC and MAP. Regardless of this expectation, Dr Tuck testified that Mr Jennings medical record did not contain any information obtained whilst he was in police custody or at MCC. Nothing before his assessment by Ms Kristensen at MAP.[72] My understanding of her evidence was that it related to the processes in place when she was giving evidence and not necessarily when Mr Jennings was at PPP. In any event, in common with the other healthcare professionals who testified, she agreed that such information could usefully enhance any assessment of the prisoner and commented that the electronic medical file seemed the "only answer".[73]

INTERNAL MANAGEMENT REVIEW

67. It would be remiss of me not to acknowledge the Internal Management Review conducted into Mr Jennings' death. It is in the nature of such reviews that they bring together people across a range of disciplines to review the circumstances in a timely way, without the jurisdictional limitations of a coronial investigation. I was appraised of progress with the three recommendations most pertinent to the coronial investigation.[74] I heard

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71 Exhibit "F".

72 Transcript page 194.

73 Transcript page 199. I note Dr Tuck's suggestion that contact be made routinely with a prisoner's general practitioner upon reception into the prison and acknowledgement that some prisoners may not provide accurate details of even their general practitioner. She also thought that some aspects of court reports might be useful. Transcript pages 201-202.

74 See Exhibits "J", "Q" and "R", the latter relating to changes at PPP in response to the two recommendationw which concern them directly.

Recommendation 2: That the Correctinal Health Board ensure there is a 'joined-up' system in place to provide better integration of, and communicaiton between, health and allied health-related disciplines in the provision of medical and medical related services to prisoners.

evidence from Mr David Ware, Deputy Commissioner Strategic and Financial Services, Corrections Victoria, about progress with Recommendation 2, in particular with the Department of Justice's agreement in principle with the concept of an electronic medical record and the complexities involved in bringing this to fruition.[75]

68. I also heard evidence from Ms Carolyne Thompson, Principal Program Advisor, Corrections Victoria, about progress with Recommendation 5.4. She advised that although the SITUPS assessment tool had been piloted and evaluated prior to roll-out to Victorian prisons, the findings of an external review occurring after Mr Jennings' death found that it did not accurately discriminate between risk levels, and returned too many false negatives (so that prisoners at risk were not detected) and too many false positives (less of a concern but still a drain on resources). Consistent with Dr Tuck's evidence that an actuarial tool such as SITUPS was valuable in a correctional setting, Ms Thompson testified that in the absence of a validated tool, all prisoners were being subjected to a full assessment by psychiatric staff at reception.[76]

COUNSELS' SUBMISSIONS

69. In considering my findings in relation to Mr Jennings death, I have considered the detailed and considered written submission provided by Counsel and their oral submissions. I do not propose to summarise those submissions, save to note the concern evinced by all Counsel that I should not make adverse findings against their respective clients, either on the basis that there had been no demonstrable lack of appropriate care and/or no evidence of a causative link between any possible lack of appropriate care and Mr Jennings' death.

70. As Counsel have stressed, the standard of proof which applies to coronial findings is the civil standard of proof on the balance of probabilities with the Briginshaw gloss or explication.[77] Specific reference is made in the authorities to the requirement that adverse findings or comments should not be made lightly, and should only be made against a

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Recommendation 3: The PPP take immediate action to review the conduct of SASH meetings, to ensure that meanignful records of meetigns are documented and that there is a follow-through of any issues raised in relation to SASH prisoners at these meetings.

Recommendation 5.4: That the correctional Services Commissioner undertakes a state-wide review of SASH procedures to ensure tha the SASH shortcomings revealed at PPP are not repeated at other prisons."

75 Exhibit "J", transcript pages 306-317.

76 Transcript pages 318-320.

77 *Briginshaw v Briginshaw (1938) 60 C.L.R. 336, esp 362*

professional person in their professional capacity where there is a comfortable level of satisfaction that negligence or unprofessional conduct has been established as contributing to the death.[78]

71. Having applied the standard of proof to the evidence before me, I find insufficient evidence to support any adverse comment against any of the individual health professionals or institutions involved, either on the basis that there is no demonstrable connection between the care provided and his death, or on the basis that his presentation and the limited clinical history known to them at the relevant time, justified their assessments and treatment.

COMMENTS PURSUANT TO SECTION 19(2) OF THE CORONERS ACT 1985

72. I am also mindful of the authorities which constrain the making of coronial recommendations or comments by reference to the need for subject matter to have a connection with the death.[79] In my view, the evidence before me overwhelmingly supports a comment on a matter of public health, namely the need for improvements to be made in the gathering of clinical information about prisoners, and the transfer of such information with the prisoner while they remain incarcerated. Other than archival value and in the event of recidivism, such information is of no use to anyone once the prisoner has left the particular facility. All healthcare professionals who testified conceded that some or all of the evidence which had been gleaned by others before them might have coloured their assessment of Mr Jennings, had they been privy to it at the relevant time, that is when he was in contact with them. This must, as a matter of logic, carry with it the potential to have changed the outcome for him.

73. At the risk of being simplistic, I can see no good reason why greater efforts cannot also be made to obtain clinical information from the prisoners' general practitioners or other treating healthcare professionals upon reception into custody. The fact that significant numbers of prisoners don't have a regular general practitioner, or don't provide accurate

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[78] *Anderson v Blashki [1993]* 2 V.R. 89, at 95 per Gobbo, J; Secretary to the *Department of Health and Community Services and Ors v Gurvich (1995) 2 V.R. 69 per Southwell,* J; *Chief Commissioner of Police* v *Hallenstein [1996] 2 V.R.I.* Of course the legislative requirement to find 'contribution' as such has been removed, but I proceed on the basis that some causal connection is nevertheless required to found any adverse comment or finding.

[79] *Clancy v West [1996] 2 V.R. 647; Harmsworth v The State Coroner [1989] V.R. 989; Matthews v Hunter [1993] 2 N.Z.L.R. 683;*

contact details, is beside the point. For those like Mr Jennings who can competently access health care in the community, it is surely worth the effort to strive for richer clinical information so that clinical judgements are better informed and not merely episodic, relying too heavily on the prisoner's presentation "then and there" and scant histories whether due to poor recall, lack of co-operation or otherwise. The fact that there is fragmentation of health services in the community, is no reason to mirror or condone that fragmentation within the correctional setting.

74. Moreover, if prisoners routinely "consent" to the provision of medical information to those custodial officers who may be involved in transporting them from one place to another, by signing a blanket written consent upon reception, then surely they could be asked to give "informed consent" to the exchange of information between community healthcare providers and those within a correctional setting, and between custodial providers, irrespective of their particular discipline. I do not disregard the expressed concern that clinical information is sensitive and may be dangerous in the hands of the uninitiated. Training and upgrading of skills may be called for. Legislative amendment may be required. The starting point in looking for the solution, whether electronic or otherwise, should be the value of the clinical information to the clinician and therefore to the quality of care provided, and not the potential obstacles or maintenance of the status quo for its own sake.

75. It follows that I would commend the concept of an electronic medical record for all Victorian prisoners, for its potential to yield better clinical management and care, and better outcomes, particularly for prisoners with a known history of self-harm or suicidality.

Dated at Melbourne, the 12th February 2010

Paresa Antoniadis Spanos

Coroner

Appearances:

A/g Sgt J. Stewart, State Coroners Assistants Unit, to assist the Coroner.
Mr R. Shepherd appeared on behalf of Corrections Victoria.
Mr J. Goetz appeared on behalf of St Vincent's Correctional Health Service.
Mr A. Halse appeared on behalf of G.S.L. Custodial Services Pty Ltd.
Mr J. Olle appeared on behalf of Forensicare.
Mr D. McSteen on behalf of Mr Birtles.