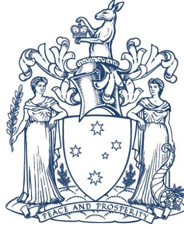

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5936

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Travis Lee FERNANDEZ
Delivered on:	15 January 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Directions Hearing: 12 July 2017 Inquest: 15 – 17 November 2017 Written Submissions: July 2019
Findings of:	Coroner Paresa Antoniadis SPANOS
Counsel assisting the Coroner:	Leading Senior Constable Kelly RAMSEY from the Police Coronial Support Unit
Representation:	Ms E. GARDNER, instructed by A. Galanti of Meridian Lawyers, appeared on behalf of Correct Care Australasia Mr H. KIRIMOF, instructed by A. Sheed-Finck of SMR Legal, appeared on behalf of Rumbalara Aboriginal Co-operative Limited Ms A. HABAN-BEER, instructed by D. Mazoori of Victorian Government Solicitors Office, appeared on behalf of Corrections Victoria and Justice Health
Catchwords:	Death in custody, Dhurringile, hanging, surgically repaired jaw fracture, failed bony union, pain, and medical management in custody

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I, PARESA ANTONIADIS SPANOS, Coroner, having investigated the death of TRAVIS LEE FERNANDEZ and having held an inquest in relation to this death at Melbourne on 15-17 November 2017:

find that the identity of the deceased was TRAVIS LEE FERNANDEZ

born on 4 June 1979, aged 35 years

and that the death occurred on or about 23 November 2014

at Dhugala Unit 1, Dhurringile Prison, Murchison-Tatura Road, Dhurringile, Victoria 3610

from:

I (a) HANGING

in the following circumstances:

INTRODUCTION[1]

1. Travis Lee Fernandez (Mr Fernandez), aged 35 years, was the second of three sons born to Sandra Hosking and was raised by her in Queensland. At the age of about ten years, Mr Fernandez exhibited aggressive behaviour and, despite psychological counselling, this persisted into adolescence. When he was about 13 years old, Mr Fernandez was placed in 'Boys' Town', a residential school for troubled youth.[2] According to Ms Hosking, the placement did not 'end up being a good idea' as it brought Mr Fernandez into contact with anti-social peers and illicit drug use.[3]

2. Mr Fernandez reportedly started using illicit substances in adolescence, commencing with cannabis at the age of 15 years and amphetamines the following year.[4] According to his mother, his drug use had an adverse influence on his behaviour and, consequently, on his relationships with family members from whom he eventually became estranged.[5]

3. Mr Fernandez moved to Victoria when aged in his early 20s.[6] Although he engaged in manual work periodically, his polysubstance use became habitual and his involvement in criminal activity more pronounced.[7] He formed a relationship with Naomi Dewhirst which

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[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.
[2] Inquest Brief (IB), page 55.
[3] Ibid.
[4] IB page 358.
[5] IB page 56.
[6] IB page 55.
[7] See generally IB pages 55-6, 58, 358, and 500-501.

was punctuated by Mr Fernandez's repeated incarceration.[8] Ms Dewhirst and Mr Fernandez share a son, Jack.

4. At the time of his death, Mr Fernandez was serving his seventh term of imprisonment. He had been remanded in custody on 15 July 2013 and was later sentenced to 26 months' prison for aggravated burglary and other offences.[9] He was due to complete that term of imprisonment on 31 August 2015 unless paroled on or after 28 February 2015.[10]

5. On arrival in custody and throughout any custodial term, prisoners are assessed to determine their appropriate security classification and prison placement. Classification codes used by the Sentence Management Unit of Corrections Victoria (CV) reflect its assessment of a prisoner's level of risk and his/her needs across six domains. Mr Fernandez was assigned the following alert ratings: S4, indicating a prior history of risk of self-harm or suicide; P3, reflecting a stable psychiatric condition (depression) requiring monitoring or treatment; M3, indicating a known or suspected medical condition (Hepatitis C); V2 in relation to the use of violence; and, T3 demonstrating vulnerability in the custodial environment.[11] Mr Fernandez was consistently accommodated as a mainstream (not a protection) prisoner and prior to 29 April 2014 was placed primarily at Port Phillip Prison (PPP), a maximum security prison.[12]

6. On the evening of 15 January 2014, a Code Black (medical emergency) was called after Mr Fernandez was found in his unit with a swollen jaw and deformed right forearm. He reported 'slipping in the kitchen' after an argument with another prisoner.[13] A medical officer (MO) attended to Mr Fernandez, administering first aid and requesting his transfer to hospital for management.[14]

Healthcare in the Custodial Setting

7. Legislation requires that prisoners are able to access reasonable medical care and treatment.[15] Custodial health service delivery is based on the principle of community equivalence whereby prisoners are provided health care of a quality and standard equivalent

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[8] IB page 58.
[9] IB page 498.
[10] There is conflicting information about whether Mr Fernandez intended to apply for parole: he appears to have informed Corrections Victoria that he would serve his full term of imprisonment while reportedly indicating to the Department of Health and Human Services that he intended to apply for parole (IB page 504).
[11] IB page 498; Mr Fernandez's T-rating was applied following his 'alleged' assault on 15 January 2014 at Port Phillip Prison. Note that for ratings, the higher the number, the higher the risk. The ratings range as follows: S1-S4, P1-P4, M1-M3, V1-V3 and T1-T3. There is also an alert/rating for the risk of escape: E1-E4.
[12] IB page 499.
[13] IB page 493.
[14] IB page 493.
[15] Section 47 of the *Corrections Act* 1986.

to that provided in the community through the public health system.[16] Justice Health (JH)[17] is responsible for custodial health care policy, management and monitoring in public and private Victorian prisons, and contracts delivery of health services to other providers.[18]

8. In addition to 24-hour access to emergency healthcare,[19] custodial health services comprise of three levels of healthcare: primary, secondary and tertiary healthcare.[20] Primary healthcare refers to general medical, mental health and nursing services that are delivered at (or near)[21] each prison location by the contracted healthcare provider; relevantly, at Melbourne Assessment Prison (MAP), Marngoneet Correctional Centre (Marngoneet) and Dhurringile Prison (Dhurringile) primary health services are provided by Correct Care Australasia (Correct Care).

9. Secondary healthcare involves diagnostic services and treatment requiring more complex and specialised skills and facilities than are available in the primary healthcare setting and usually follows a referral from a primary healthcare provider. Such services include specialist outpatient care, non-specialist and sub-acute inpatient care and voluntary acute and sub-acute inpatient care that are provided by St Vincent's Correctional Health (SVCH) at PPP's[22] St Thomas' (outpatient), St Paul's (inpatient psychosocial) and St John's (inpatient low acuity) Units.[23]

10. Tertiary healthcare is the most complex and specialist form of clinical care requiring sophisticated diagnostic services and forms of treatment. Tertiary healthcare, such as general specialist acute and sub-acute inpatient care and involuntary acute and sub-acute psychiatric care, is provided only by major hospitals and, in the custodial setting, is accessed through a purpose-built secure inpatient unit, St Augustine's Ward, at St Vincent's Hospital in Fitzroy with clinical care delivered by SVCH.[24]

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[16] Exhibit K.
[17] A business unit of the Department of Justice.
[18] Exhibit K.
[19] Prisoners requiring emergency healthcare are transferred to the nearest hospital emergency department by ambulance. For example, a prisoner at Dhurringile would be transferred to Goulburn Valley Health Service for assessment and management.
[20] Exhibit K.
[21] I note that dental services are classified as primary healthcare though, relevantly, a dentist was not available to Mr Fernandez onsite at Dhurringile; rather, dental services were provided, via contract, to Rumbalara Aboriginal Cooperative.
[22] Port Phillip Prison is a privately owned and operated Victorian prison managed and operated by G4S Australia Limited, which subcontracts health services to SVCH.
[23] Exhibit K.
[24] Exhibit K and IB pages 64-67.

11. In 2014, the effect of these arrangements was that if a male prisoner in Victoria required secondary or tertiary health care, he must either be accommodated at PPP or transition through there.

12. Prisoner movements, the transfer of prisoners between prisons, from police stations, to and from courts and for medical treatment, are facilitated by G4S Australia Limited under contract with CV and Victoria Police.[25] Although 'urgent' transfers (those occurring with less than seven days' notice) can be accommodated, prisoners are typically told that round-trip transfers via PPP for medical appointments may take between two and three weeks as there are set rosters for prison vans moving between prisons and there may be only one van each week travelling between a regional prison and PPP.[26] One of the consequences of these arrangement is that there is 'no guarantee' that a prisoner will return to the same cell or unit when returned to his classified prison.[27]

Treatment of Mr Fernandez's jaw injury between 15 January and 28 April 2014

13. After the MO's initial assessment of Mr Fernandez, he was transferred first to St Thomas' and then to St John's Unit for assessment. Opioid analgesia was administered, and his condition monitored while awaiting transfer to hospital for management of his suspected fractured jaw and forearm.[28]

14. An ambulance was called at about 7.15pm, dispatched to PPP at 9.20pm and arrived around 10.05pm. Mr Fernandez initially told paramedics that he sustained his injuries in a fall though later revised this account, reporting that he had been punched to the face repeatedly by several assailants.[29]

15. Mr Fernandez arrived at St Vincent's Hospital Emergency Department (ED) around 11pm. Upon examination, he was found to have difficulty speaking and closing his mouth due to pain and tenderness throughout his lower jaw (mandible). <u>Computerised tomography (CT) scans showed two mandibular fractures</u>: a minimally displaced oblique fracture through the right mandibular mental tubercle into the floor of the mouth; and a comminuted mildly displaced fracture through the left mandibular ramus, with extension through to the third molar, also fractured, and posteriorly through the ramus – thus, an open fracture with the left inferior alveolar nerve potentially at risk.[30]

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[25] Exhibit L.
[26] Exhibit L.
[27] Exhibit L.
[28] IB pages 341 and 340.
[29] IB page 252.
[30] IB page 218.

Treatment at St Augustine's Ward

16. In the early hours of 16 January 2014, Mr Fernandez was admitted to St Augustine's Ward for ongoing management.[31] Intravenous antibiotics commenced in the ED were continued as was regular opioid analgesia.[32] Following specialist review, the treatment plan was for Mr Fernandez to undergo an orthopantomagram (OPG)[33] radiograph that day and surgical repair of the mandibular fractures on 17 January 2014.[34]

17. On 17 January 2014, Mr Fernandez underwent open reduction and rigid internal fixation (ORIF) of his mandible fractures under general anaesthetic, performed by Surgical Registrar Dr Merhnoosh Dastaran.[35] Two bone plates were inserted above and below the mental nerve to fix the right parasymphysis fracture while the left angle fracture was secured with an upper border plate and four screws after an impacted third molar (wisdom tooth) was extracted to accommodate it.[36] In keeping with contemporary management of mandibular fractures, Mr Fernandez's jaws were not wired post-operatively.[37]

18. Mr Fernandez remained at St Augustine's Ward where he was regularly reviewed by Dr Dastaran. Intravenous antibiotics were continued until Mr Fernandez was able to tolerate oral antibiotics and anticipated post-operative pain was managed with opioid analgesia. He was directed to manage oral hygiene through mouth rinses and was provided a pureed diet. Mr Fernandez remained vitally stable and afebrile, and independent and self-caring throughout his admission.[38]

Management at St John's Unit

19. On 23 January 2014, Mr Fernandez was discharged from St Augustine's Ward and admitted to St John's Unit at PPP for further management. Dr Dastaran's discharge plan included a pureed diet for six weeks, analgesia, an oral hygiene regime and a post-operative review by the Plastic Surgery Outpatient clinic at St Vincent's Hospital on 5 March 2014.[39]

20. Mr Fernandez was accommodated at St John's Unit at PPP between 23 January and 11 February 2014. He was regularly reviewed by medical and nursing staff who noted he was eating a 'normal diet' on 4-5 February 2014 and experiencing some numbness around his

[31] IB page 218.
[32] IB page 226.
[33] An OPG is a panoramic or wide view x-ray of the lower face, which displays all the teeth of the upper and lower jaw on a single film.
[34] Ibid.
[35] IB page 65.
[36] IB pages 65-66.
[37] IB page 66.
[38] IB pages 227-229.
[39] IB page 72.

chin and 'shooting pain when eating' on 5 February 2014.[40] Mr Fernandez was seen by the SVCH dentist twice, and when reviewed by the dentist on 11 February 2014, the left mandibular fracture site was noted to be infected.[41] Pus was drained, and Mr Fernandez was commenced on oral antibiotics[42] and antiseptic mouthwashes. There was a plan for further dental review on 17 February 2014, but this was cancelled due to Mr Fernandez's transfer to Marngoneet on 11 February 2014.[43]

Management at Margoneet

21. Upon his transfer to Marngoneet on 11 February 2014, Mr Fernandez underwent a routine health assessment by a registered nurse (RN). His recent jaw fracture and surgical site infection were noted, along with the prescription of antibiotics and mouthwash.[44] A dietary request form for a 'minced diet until 5/3/14' was sent to the kitchen.[45]

22. On 12 February 2014, MO Dr Chris Gore reviewed Mr Fernandez's medical history. He noted Mr Fernandez's current medications as 60mg of methadone daily for opioid replacement therapy, 10mg of MS Contin (opioid analgesia) nightly, Ensure (liquid nutrition) twice daily, and paracetamol as needed.[46]

23. That evening, Mr Fernandez presented to the medical clinic to report that he was 'meant to be on antibiotics',[47] but implicitly, none had been administered since his arrival at Marngoneet. The RN telephoned the on-call doctor for a prescription and booked an appointment for review by a MO.[48]

24. On 14 February 2014, MO Dr Gore reviewed Mr Fernandez, noting his recent medical history of ORIF and left-sided jaw infection and a plan to continue antibiotics.[49] Mr Fernandez complained of numbness of the left side of his face, which the MO considered would improve with time.[50] Dr Gore noted that Mr Fernandez's gums and mucosa looked 'ok' and that he had ceased MS Contin and did not want his methadone dose to be increased.[51] The MO noted 'acute PTSD', with Mr Fernandez reporting anxiety and poor

[40] IB page 332.
[41] IB page 446.
[42] IB page 446.
[43] IB page 73.
[44] IB page 328.
[45] IB page 426.
[46] IB page 328.
[47] IB page 327.
[48] IB page 327.
[49] IB page 327.
[50] Ibid.
[51] Ibid.

sleep since being assaulted at PPP.[52] Mr Fernandez requested psychiatric review and regular hypnotic medication. Dr Gore 'declined' to prescribe mirtazapine[53] but prescribed a three-day supply of a non-benzodiazepine hypnotic for insomnia noting the prescription would 'not be a regular occurrence'.[54]

25. On 18 February 2014, Mr Fernandez requested dental care because his teeth were 'very painful' since his jaw was fractured.[55] A dental appointment was scheduled for 6 March 2014.[56] He also confirmed his willingness to attend the Plastic Surgery Outpatient clinic at St Vincent's Hospital on 5 March 2014.[57]

26. On 22 February 2014, Mr Fernandez requested 'urgent' medical attention due to experiencing 'severe nerve pain' and 'general pain' in his jaw.[58] An appointment with the MO was scheduled for the following day but Mr Fernandez did not attend.[59]

27. On 25 February 2014, Mr Fernandez presented to the medical clinic complaining of jaw pain. On examination, the RN noted that he had no difficulty opening his mouth and that there were no signs of infection.[60] Mr Fernandez was reminded of the upcoming dental appointment on 6 March 2015 and remarked that it was 'not soon enough'.[61]

28. On 28 February 2014, Mr Fernandez presented to MO Dr Gore complaining of a painful jaw, particularly at night, and requesting an increase of analgesia.[62] Dr Gore noted increased sensitivity to touch in Mr Fernandez's jaw and gums.[63] Mr Fernandez refused an increase of his methadone dose and Dr Gore refused to prescribe codeine.[64] The MO prescribed Panadeine Forte (paracetamol and codeine analgesia), noting that Mr Fernandez 'can either accept it or not' and that he thought he was 'probably angling for pregabalin,'[65] an anticonvulsant medication used to treat neuropathic pain.[66]

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[52] IB page 326.
[53] Mirtazapine is an antidepressant.
[54] IB page 326.
[55] IB page 425.
[56] IB page 425.
[57] IB page 326.
[58] IB age 424.
[59] IB age 424.
[60] IB page 326.
[61] IB page 326.
[62] IB page 325.
[63] IB page 325.
[64] IB page 325.
[65] IB page 325.
[66] Pregabalin, marketed in Australia under the brand name Lyrica, is used to treat epilepsy and neuropathic pain as it slows impulses across the brain involved in seizures and affects chemicals involved in pain signals. Long term use (or misuse) of pregabalin can lead to dependence and/or symptoms of withdrawal upon cessation. I note that among the most common side effects of pregabalin are dizziness/drowsiness, blurred vision, weight gain and fatigue.

29. On 2 March 2014, Mr Fernandez requested urgent dental review due to 'very, very severe tooth pain.[67]

30. On 4 March 2014, the medical clinic received advice via PPP that Mr Fernandez's post-operative review on 5 March 2014 at St Vincent's Hospital's Plastic Surgery Outpatient clinic had been cancelled and rescheduled for 23 April 2014.[68] According to Correct Care's Chief Medical Officer, Dr Thomas Turnbull, unilateral cancellation of appointments by St Vincent's Hospital 'happens quite regularly'.[69] I note the evidence of Dr Charles Roth, Medical Director of SVCH that SVCH's 'usual policy' is to reschedule a cancelled or refused appointment once and that patients are 'removed from the waiting list if they fail to attend on two consecutive occasions without adequate reason or notif[ication]' in advance.[70]

31. On 6 March 2014, Mr Fernandez received some dental care. The dentist extracted Mr Fernandez's left maxillary (upper jaw) wisdom tooth noting 'pain at night time'.[71] The dentist also noted that the molar adjacent to that extracted was decayed and would be reviewed at a subsequent appointment to ascertain if it could be 'saved with a filling'.[72] A further dental appointment was scheduled for 17 April 2014 but did not take place.[73]

Transfer to the MAP

32. On 20 March 2014, Mr Fernandez was transferred to the MAP in anticipation of his rescheduled post-operative outpatient review at St Vincent's Hospital on 23 April 2014.[74]

33. On 23 April 2014, Mr Fernandez refused to attend his post-operative review.[75] He signed a "Release of Responsibility for Health Services" form stating that his 'jaw has healed properly[,] it doesn't need any more medical att[ention]'.[76]

34. On 28 April 2014, Mr Fernandez was deemed fit for transfer by a RN on the basis of a review of his medical file. The nurse noted, 'prisoner recently refused to attend plastics appointment. ? [query] needs re-schedule. Please fu [follow up]'.[77]

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[67] IB page 422.
[68] IB pages 86 and 324.
[69] Transcript page 154.
[70] IB page 73.
[71] IB page 446.
[72] IB page 446.
[73] IB page 323. The dental appointment scheduled for 17 April 2014 did not occur due to Mr Fernandez's transfer to MAP on 20 March 2014.
[74] IB page 86. Mr Fernandez was also due to attend court on 25 March 2014 (IB pages 493 and 500).
[75] IB page 415.
[76] IB page 416.
[77] IB page 316. There is no evidence before me that any follow-up occurred at Dhurringile, though I note the evidence of Dr Charles Roth, Medical Director of SVCH, that it is St Vincent's Hospital's policy to reschedule a cancelled appointment once and that patients are removed from the waiting list after failing to attend two consecutive

Transfer to Dhurringile

35. On 29 April 2014, Mr Fernandez was transferred to Dhurringile, a minimum-security prison located about 160 kilometres north of Melbourne. Dhurringile has capacity to accommodate around 300 male prisoners, predominantly in small, multi-occupant self-catering units. At the time of his death,[78] Mr Fernandez lived in Dhugala Unit 1 with five other prisoners, each man having a cell/room of his own and sharing the communal living areas.[79]

36. Mr Fernandez does not appear to have formed close bonds with any of his co-prisoners at Dhugala Unit 1. He had disclosed to two, however, that a friend of his had recently hanged himself while in custody at MAP.[80] Mr Fernandez was reportedly 'upset' about his friend's death but gave no impression that he was acutely distressed.[81] Indeed, the co-prisoner who perhaps knew Mr Fernandez best, observed that he was someone who 'always puts on a brave face, but seems sad inside' and 'never liked to talk about things'.[82]

37. While at Dhurringile, Mr Fernandez received no visitors until the day before his death and only infrequently had telephone contact with anyone. His last telephone call, on 16 October 2014,[83] was to Cheryl Dewhirst, Jack's maternal grandmother with whom the child had been placed by the Department of Human Services Child Protection. Mr Fernandez spoke to his son after speaking briefly to Cheryl Dewhirst, who recalled that Mr Fernandez 'sounded sad, like he had something on his mind' and expressed a wish to be reunited with Jack.[84] Indeed, Mr Fernandez participated in child protection proceedings in the Family Division of the Children's Court in Melbourne via video-link from Dhurringile on 27 October 2014.[85] Further hearing of the proceedings was adjourned to January 2015.[86]

38. Mr Fernandez's medical management while at Dhurringile will be considered in greater detail below. It is sufficient for present purposes to note that aside from daily administration of prescribed medications, Mr Fernandez presented to the medical centre 11 times[87] and that on 10 June 2015 'delayed or non-union'[88] of his left mandibular fracture was detected. He

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appointments 'without adequate reason or notification in advance', and that thereafter a new referral is required before a further outpatient appointment will be made (IB page 73).

[78] I note the Coronial Investigator DSC Kervin's advice that Mr Fernandez moved into Dhugala Unit 1 on 17 November 2014, though he did not indicate the source of that information.

[79] IB page 116.

[80] IB pages 27 and 35. This disclosure may have been made as recently as 21 November 2014.

[81] IB page 27.

[82] IB page 35.

[83] Exhibit 10.

[84] IB page 61.

[85] IB page 504.

[86] Ibid.

[87] IB pages 77-78.

[88] Exhibit F.

was also seen by a dentist at Rumbalara Aboriginal Co-operative Limited (Rumbalara) twice prior to his death, the last of appointments being on 20 November 2014.[89]

CIRCUMSTANCES PROXIMATE TO DEATH

39. On 22 November 2014, Naomi Dewhirst travelled with friends to Dhurringile to visit Mr Fernandez. Ms Dewhirst spent about three hours with Mr Fernandez in the visitors' centre, which was supervised by Correctional Officers (COs). Mr Fernandez appeared to be 'just his usual self', if a little embarrassed about gaining weight while in custody.[90] He reportedly told Ms Dewhirst that he had used 'ice' (methylamphetamine) that day.[91] Their conversation did not touch upon any 'upsetting' topics, and Mr Fernandez did not refer to anyone or anything 'causing him … grief' nor that he was finding his current custodial sentence any more difficult than others he had served.[92] At the end of the visit, there was 'no emotional goodbye'; indeed, they spoke of the possibility of Ms Dewhirst returning to visit the following day.[93]

40. Later the same day, Mr Fernandez underwent a targeted urine screen.[94] I note the evidence of Mr Roderick Wise, Deputy Commissioner of Operations at Corrections Victoria, that Mr Fernandez would have been aware that urinalysis positive for illicit drugs would result in his immediate transfer to a higher security prison and prohibition of contact visits for at least three months, pursuant to the Victorian Prisons Drug Strategy.[95]

41. At about 8.30pm on 22 November 2014, Mr Fernandez retired to bed.[96] However, around 10.30pm he rose again to ask a co-prisoner for a cigarette. He took the offered cigarette and said he would see the other man in the morning.[97]

42. At about 7.10am on 23 November 2014, COs conducted the morning 'let out count' of prisoners at Dhugala Unit 1. All prisoners except Mr Fernandez were in the common room

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[89] Exhibits C and D.
[90] IB pages 58-59.
[91] IB pages 58-59.
[92] IB pages 58-59.
[93] IB pages 58-59.
[94] IB page 501. 'Targeted' urinalysis is a non-random urine test used when there is a reasonable suspicion of illicit drug use by a prisoner. On 22 November 2014, police were called when a drug detection dog signalled the presence of drugs on two visitors at Dhurringile (IB Pages 95-96).
[95] Exhibit L and Transcript page 197-198. Although the results of urinalysis were not known at the time of Mr Fernandez's death, the sample provided on 22 November 2014 tested positive to amphetamines (IB page 166) and, given his disclosure to Mr Dewhirst about his use of ice, Mr Fernandez could have anticipated this result.
[96] IB page 35.
[97] IB page 40.

of the unit.[98] The COs were told that Mr Fernandez was still in his room, Cell 1, with the door locked.[99]

43. CO Steven Maskell unlocked Cell 1 and upon entering saw Mr Fernandez slumped in a sitting position in the wardrobe with a blue ligature around his neck and attached to the clothes rail.[100] Mr Fernandez appeared lifeless.[101] CO Maskell called for assistance and CO Michael Wheatley attended and used an intervention knife to sever the ligature before checking for a pulse.[102] CO Maskell initiated a Code Black and emergency services were called.[103]

44. Attending Ambulance Victoria paramedics confirmed that Mr Fernandez was deceased.[104]

45. Detective Senior Constable Shane Kervin of Shepparton Crime Investigation Unit arrived at Dhurringile at about 8.15am and commenced a coronial investigation. DSC Kervin photographed Mr Fernandez's room. He observed that the portion of the ligature around Mr Fernandez's neck appeared to have been made from lengths of blue fabric braided into a rope.[105] The fabric was consistent in appearance with an intact prison-issued douvet cover.[106] The portion of the ligature attached to the clothes rail comprised of a length of thin green rope, similar in appearance to drawstrings found on prison-issued tracksuit pants and broad-brimmed hats, tied to a length of blue braided fabric.[107] The ligature was removed from the clothes rail and seized.

46. During a search of Mr Fernandez's cell, DSC Kervin observed that the non-opening security screen on the window appeared intact.[108] He noted that although the cell had been locked, the mechanism was of a type that could be locked from either inside or out.[109] A sketchbook containing a single-paged note (the note) addressed to 'Dearest Jack' was located on Mr Fernandez's desk.[110] These items were seized for analysis.

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[98] The sixth prisoner at work at the dairy.
[99] IB Page 47.
[100] Ibid.
[101] IB page 47.
[102] IB page 49.
[103] Code Black is the emergency code alert applicable to serious medical incidents or deaths.
[104] IB Page 503.
[105] Exhibit A and Transcript page 6.
[106] Prison-issued bedding is not audited and so it was not possible to determine when or from where Mr Fernandez obtained the fabric used to create a ligature: Transcript page 6.
[107] Exhibit A.
[108] Ibid.
[109] Ibid.
[110] Ibid.

47. The note was forensically examined at the Victoria Police Forensic Services Centre. Only fingerprints belonging to Mr Fernandez were located on the note[111] and a handwriting comparison[112] indicated that the note had been written by him.[113] Although the note's content shows Mr Fernandez's clear intention to take his own life, it does not reveal his reasons for doing so.[114]

INVESTIGATION AND SOURCES OF EVIDENCE

48. This finding is based on the totality of the material obtained in the coronial investigation of Mr Fernandez's death. That is, the original coronial brief prepared by DSC Kervin, the inquest brief compiled by Leading Senior Constable Kelly Ramsay, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[115] In writing this finding, I do not purport to summarise all the material and evidence; rather, I will refer to the evidence only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

49. Included in the inquest brief, and of particular note, are the reports of two earlier reviews of Mr Fernandez's death. Namely, a "Report into Death in Custody of Mr Travis Fernandez …"[116] undertaken by Justice Health dated 23 February 2015 and a "Review into the death of Mr Travis Fernandez … at Dhurringile Prison on 23 November 2014"[117] prepared by the Office of Correctional Services Review dated 15 April 2015. While the approaches taken and the conclusion reached reflect the remit of the respective reviewers and are not on all fours with a coronial investigation, there is an area of overlap that should be acknowledged.[118]

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[111] IB page 160 and Transcript page 6.
[112] Forensic Scientist David Black compared the note with a letter written by Mr Fernandez to his friend Charmaine Camilleri: see Exhibit B and IB page 62 and the compared documents, which appear at IB pages 158 and 159.
[113] Exhibit B.
[114] IB page 158.
[115] From the commencement of the *Coroners Act* 2008 (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[116] IB Exhibit 20.
[117] IB Exhibit 21.
[118] I note that section 7 of the Act indicates that it is 'the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officer – (a) to avoid any unnecessary duplication of inquiries and investigations; and (b) to expedite the investigation of deaths …'.

PURPOSE OF A CORONIAL INVESTIGATION

50. The purpose of a coronial investigation of a *reportable death*[119] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[120] Mr Fernandez's death was reportable because of his status as a person placed in custody or care as he was a prisoner serving a sentence of imprisonment at the time of his death and therefore a person in the legal custody of the Secretary to the Department of Justice.[121]

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

52. For coronial purposes, the term *circumstances in which the death occurred* refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[122]

53. The broader purpose of any coronial investigations is to contribute to a reduction in the number of preventable deaths, through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role.'[123] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.[124] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[125]

54. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of

[119] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria (s 4(1)), reportable death includes "a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury" (section 4(2)(a)).
[120] Section 67(1) of the Act.
[121] See section 3 of the Act for the definition of a "person placed in custody of care" and section 4 for the definition of "reportable death", especially section 4(2)(c).
[122] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[123] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act* 1985 where this role was generally accepted as 'implicit'.
[124] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[125] See also sections 73(1) and 72(5) of the Act which require publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

an offence.[126] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions, if the coroner believes an indictable offence may have been committed in connection with the death.[127]

MEDICAL CAUSE OF DEATH

55. On 24 November 2014, forensic pathologist Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine (VIFM) reviewed the circumstances of Mr Fernandez's death as reported by police to the coroner,[128] post-mortem computerised tomography (PMCT) scanning of the whole body and performed an external examination. Having done so, Dr Bouwer provided a five-page written report, dated 12 December 2014.[129]

56. Among Dr Bouwer's anatomical findings were marked petechiae over the face and an abraded furrow around the neck measuring up to two centimetres in width associated with a ligature of approximately 1.5 cms diameter, which appeared to have been made by plaiting strips of teal cotton fabric to form a rope with a simple knot situated at the back of the head. An imprint of the plaited ligature was noted on the skin of the neck. Fractures of both superior cornu of the thyroid cartilage were evident on PMCT.

57. Routine toxicological analysis of post-mortem specimens detected methylamphetamine (~0.1mg/L), methadone[130] (~0.1mg/L), and antidepressants fluoxetine (~0.5mg/L) and mirtazapine (~0.1mg/L). The presence of methadone and fluoxetine (only) was consistent with Mr Fernandez's treatment regime at the time of his death. The provenance of the other drugs detected can only be the subject of speculation.

58. At my request, additional testing of post-mortem specimens occurred after the inquest because an anticonvulsant medication prescribed to Mr Fernandez for neuropathic/chronic back pain, pregabalin, was not among the drugs routinely screened for in 2014. An amended toxicology report indicated that pregabalin was not detected at the reporting level of <1mg/L.[131] This allows of the possibility that the pregabalin dispensed to Mr Fernandez was diverted or potentially traded for other substances. To take the matter any further would be to speculate.

[126] Section 69(1) of the Act.
[127] Sections 69(2) and 49(1) of the Act.
[128] Police Report of Death to the Coroner (Police Form 83) prepared by Detective Senior Constable Shane Kervin on 23 November 2014.
[129] Dr Bouwer's medical examination report is at IB pages 16-20 and includes his formal qualifications and experience.
[130] Methadone is a synthetic narcotic used in the treatment of opioid dependence and for the treatment of severe pain.
[131] Amended VIFM Toxicology Report dated 6 December 2017.

59. I was advised by VIFM's Chief Toxicologist, Dr Dimitri Gerostamoulos, that a failure to detect pregabalin (in circumstances where it had been regularly administered) may be due to the drug being present at a level below the reporting level specific to the drug or degradation of the specimen in the three years since it was retained.

60. Dr Bouwer observed that his examination was consistent with the reported circumstances and concluded that on the basis of the information available to him at the time, it was reasonable to attribute the cause of Mr Fernandez's death to hanging without the need for an autopsy.

61. I accept the cause of death proposed by Dr Bouwer and find that the cause of Mr Fernandez's death is hanging.

IDENTITY & NON-CONTENTIOUS FINDINGS AS TO CIRCUMSTANCES

62. Mr Fernandez's identity was not in issue. On 23 November 2014, Kevin Williams, Senior Prison Officer at Dhurringile Prison, visually identified the deceased's body as being that of prisoner Travis Lee Fernandez, born 4 June 1979, and completed a Statement of Identification.[132]

63. Nor was there any contention around the date and place where Mr Fernandez died. Accordingly, I find, as a matter of formality, that Mr Fernandez died in the Dhugala Unit 1, Dhurringile Prison, Murchison-Tatura Road, Dhurringile, Victoria on or about 23 November 2014.

FOCUS OF THE CORONIAL INVESTIGATION

64. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into Mr Fernandez's death was on aspects of the circumstances in which the death occurred.

65. The focus of the inquest was on the adequacy of Mr Fernandez's medical management at Dhurringile and, in particular, whether there is any evidence that he experienced jaw pain proximate to his death of a type likely to have contributed to his decision to end his own life.

ADEQUACY OF MR FERNANDEZ'S MEDICAL MANAGEMENT AT DHURRINGILE

66. On the day of his arrival at Dhurringile, 29 April 2014, Mr Fernandez was reviewed by a RN. His previous medical history of Hepatitis C, jaw fracture and suicide and self-harm (SASH) risk were noted, along with the absence of any current concerns about his mental health.[133] Mr Fernandez was oriented to the medical services at the prison and routine

[132] IB page 15.
[133] IB page 311.

pathology, medical and psychiatric review appointments were scheduled.[134] His prescribed medications upon reception to Dhurringile were methadone (40mg daily) and two Panadeine Forte tablets (twice daily).[135]

67. On 2 May 21014, Mr Fernandez presented to MO Dr Yousif Shamoun complaining of chronic back pain and stating that he had previously been prescribed pregabalin to manage it.[136] Mr Fernandez reported ‘shooting nerve [/] back pain’ particularly when active.[137] Dr Shamoun prescribed a 75mg dose of pregabalin to be administered twice each day.[138]

68. Mr Fernandez re-presented to Dr Shamoun on 6 May 2014, advising that pain persisted despite the administration of pregabalin.[139] The MO authorised a gradually increasing dose of pregabalin to 300mg twice each day, with a plan for review in four weeks’ time.[140] Mr Fernandez’s pregabalin dose was increased gradually to the prescribed maximum between 7 and 19 May 2014 and the maximum dose was administered consistently thereafter until his death.[141]

69. On 15 May 2014, Mr Fernandez underwent review by a psychiatric nurse during which his history of depression was noted.[142] Recommencement of an antidepressant was recommended, with escitalopram prescribed by Dr Shamoun the following day at a commencing dose of 10mg daily to be increased to 20mg per day over a fortnight.[143] A follow-up review with the MO in one month was planned.[144]

70. Mr Fernandez’s medical record suggests he failed to attend a review appointment with the MO on 3 June 2014 though it appears that MO Dr Shamoun did see him on that date.[145]

Football Injury

71. Around lunchtime on Friday, 6 June 2014, Mr Fernandez presented to the medical clinic complaining of left lower jaw pain after being struck on the jaw during a football match.[146]

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[134] Ibid.
[135] IB page 88g.
[136] IB page 311.
[137] Ibid.
[138] Ibid.
[139] IB page 311.
[140] IB page 311.
[141] IB page 88g.
[142] IB page 310.
[143] IB pages 310 and 88g.
[144] IB page 310.
[145] IB pages 310 (containing an entry recording the missed appointment) and 309 (containing a note by Dr Shamoun concerning ‘depression/anxiety/insomnia’ and confirming that escitalopram had been tolerated). Dr Shamoun testified that he saw Mr Fernandez on 3 June 2014: Transcript page 76.
[146] IB page 309 and Transcript page 76.

The RN noted Mr Fernandez's vital observations and his recent bilateral ORIF.[147] When reviewed the same day by MO Dr Phillip Lu, the absence of tenderness over the jaw and no loose teeth were noted.[148] The MO requested an OPG x-ray be performed on Monday.[149]

72. On 7 June 2014, Mr Fernandez re-presented to the medical clinic with a swollen jaw and 'pain ++'.[150] The RN noted that Mr Fernandez was aware that an OPG x-ray should occur on Monday and that he was resistant to advice that he should attend the local hospital, Goulbourn Valley Base Hospital, earlier for review.[151] Mr Fernandez reported that he was 'managing pain ok' and was reminded that he could re-present to the clinic if pain increased or if he observed signs of infection.[152]

73. On Tuesday, 10 June 2014, an OPG x-ray was performed. MO Dr Shamoun contacted the radiographer by telephone as he had not received her report when Mr Fernandez attended the clinic for review.[153] At inquest, Dr Shamoun testified that he recalled the consultation with Mr Fernandez because is 'wasn't a usual case': he had sustained trauma to his jaw in circumstances where he had had recent jaw surgery and Dr Lu had been 'concerned that it might be fractured'.[154]

74. Dr Shamoun gave evidence that he was told by the radiologist that Mr Fernandez had sustained 'no acute injury'.[155] However, the radiologist advised him that 'there is a gap, maybe it's [non]union'[156] – noted by Dr Shamoun in Mr Fernandez's medical record as 'delayed healing'[157] – of the left mandibular fracture. The MO recalled that the radiologist had opined that the gap – described in her subsequent report as a 'fairly wide gap'[158] – was 'unlikely to cause any problem … in the short term'.[159]

75. Dr Shamoun testified that when he discussed the x-ray findings with Mr Fernandez, he told him that 'because there's no union, at some stage, [he would] need surgery … [so that the fracture could be] fixed again'.[160] Although there is no contemporaneous note of this conversation in Mr Fernandez's medical record, the MO testified that Mr Fernandez did not

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[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Ibid.
[151] Ibid.
[152] Ibid.
[153] Transcript page 60.
[154] Transcript pages 59 and 77.
[155] Transcript page 60.
[156] Transcript page 60.
[157] IB page 308.
[158] IB page 178.
[159] Transcript page 60. I note that on 18 June 2014, Dr Shamoun signed as sighted the radiologist's report, which remains in Mr Fernandez's JH Medical record: IB page 381.
[160] Transcript page 60.

want treatment to proceed because 'he doesn't [sic] want to go to Port Phillip' and he 'refused to go.'[161] Moreover, he would not agree to undergo a magnetic resonance imaging (MRI) scan either because 'we have to send them to St Vincent's [Hospital] and he might go to Port Phillip' and remain there 'he doesn't want to lose his spot at Dhurringile because it's better'.[162] Dr Shamoun testified that like other prisoner patients, Mr Fernandez 'insisted he wouldn't go' for treatment via PPP.[163]

76. Dr Shamoun stated that during the 10 June 2014 consultation, Mr Fernandez did not complain of any jaw pain.[164] The MO prescribed Panadol Osteo (paracetamol) and Neurofen (ibubrofen) as required, stating that if Mr Fernandez had presented with pain, his dosing instructions would instead have indicated regular administration of these medications.[165] Mr Fernandez's medical records show that paracetamol was administered once a day on most days between 12 June and 13 July 2014 (and on three days, administered twice) and that ibuprofen was concurrently administered once per day on 23, 26 and 29 June 2014.[166]

77. Mr Fernandez next presented to medical staff on 24 June 2014 in relation to low mood, racing thoughts, increased anxiety and poor sleep.[167] When reviewed by a psychiatric nurse, he denied any thoughts of suicide or self-harm and reported that he had felt better when prescribed fluoxetine.[168] He asked to be excused from work on medical grounds (and was),[169] and was advised to see the MO the following day for a medication review and to return for psychiatric review in one month.[170]

78. On 25 June 2014, Mr Fernandez's antidepressant was changed to fluoxetine by Dr Shamoun, who commenced him on a daily 20mg dose increasing to 40mg per day over the following fortnight.[171]

79. During the same consultation, Mr Fernandez reported that he thought the surgical plates in his mandible were loose.[172] I note that neither the MO's notes nor his subsequent statement[173] reveal the nature or findings of any examination he may have conducted, nor

[161] Transcript page 60.
[162] Transcript page 60.
[163] Transcript page 61.
[164] Transcript page 79.
[165] Transcript page 79.
[166] IB page 408: paracetamol was administered on 12, 13, 16, 22, 23 (twice), 26 and 29 June and 4 (twice), 5-7, 8 (twice), 9-13 July 2014;
[167] IB page 307.
[168] IB page 307.
[169] IB page 412.
[170] IB page 307.
[171] IB pages 307 and 88g.
[172] IB page 307.
[173] Exhibit F.

whether Mr Fernandez's experience of pain or difficulty eating – if any – were canvassed during the consultation. However, at inquest, the MO stated that he 'couldn't feel anything loose when [he] examined him.'[174] Dr Shamoun did note that he had reiterated his advice for review at St Vincent's Hospital[175] and that Mr Fernandez was content to adopt a 'watch and wait' approach.[176]

80. At inquest, the MO testified that he did not demur from Mr Fernandez's decision to "watch and wait" for a number of reasons. Dr Shamoun stated that the '[June] x-ray was normal' … [and] showed that the [non-union] was stable';[177] Mr Fernandez 'didn't have any symptoms' such as difficulty moving his mouth or difficulty eating a normal diet,[178] and he reported 'no pain, except immediately after the trauma … and that was the upper jaw,'[179] not the mandible. The MO 'thought it was a tooth issue'[180] and, given that a patient's consent is necessary before adopting any referral or treatment course in the custodial as well as the community healthcare setting, Dr Shamoun considered "watch and wait" 'best for the patient'[181] after balancing symptoms, findings and Mr Fernandez's wishes.[182] I note that, despite his impression that this was a "tooth issue", Dr Shamoun does not appear to have suggested that Mr Fernandez undergo a dental review.

81. Similarly, Dr Shamoun does not appear to have considered seeking 'special circumstances'[183] approval for Mr Fernandez to access secondary or tertiary health care via a prison other than PPP, presumably because of Mr Fernandez's stated refusal to travel there for review or treatment of his jaw.

82. Between 25 June 2014 and 8 October 2014, Mr Fernandez presented to the medical clinic on seven occasions for a variety of complaints unrelated to his oral health. During this period, he was excused from work twice due to back pain August 2014,[184] and twice for ill health in October 2014;[185] he experienced an adverse reaction to a reduction of his methadone dose in

[174] Transcript page 62.
[175] Exhibit F and IB page 307.
[176] IB page 307 and Exhibit F.
[177] Transcript page 62. Dr Shamoun's characterisation of the June 2014 x-ray as 'normal' is unexpected and it seems unlikely that anyone could definitively assess the "gap" in Mr Fernandez's mandible as 'stable' on the basis of an x-ray; here I am mindful of the evidence of Drs Richard Bassed (Transcript page 104 and 119) and Kevin Spencer (IB 111a-111b)
[178] Transcript pages 62-63.
[179] Transcript page 65. Dr Shamoun's recollection of the location of the pain Mr Fernandez experienced appears to be inaccurate.
[180] Transcript page 63.
[181] Transcript page 61.
[182] Transcript pages 61, 63 and 71.
[183] Exhibits K and L.
[184] IB page 306.
[185] IB page 306.

August 2014[186] and requested a further dose reduction despite MO advice to the contrary;[187] and a dressing was applied to a finger injury in September 2014.[188] As at 8 October 2014, Mr Fernandez was prescribed 12mg methadone and 40mg fluoxetine daily and 300mg pregabalin twice daily.[189]

Loose Plate Screws

83. On Sunday, 12 October 2014, Mr Fernandez presented to the medical clinic 'very concerned' because one of the retention screws for the plate fixing his mandibular fracture had come loose the previous night.[190] He reported tightening the screw himself but that morning 'another screw had fallen out' and Mr Fernandez had rinsed his mouth with mouthwash before replacing the screw.[191] He was concerned about why the screws were falling out and that an infection could develop. His jaw was 'beginning to ache' but he declined analgesia.[192] The RN entered Mr Fernandez on the doctor's list for that Tuesday and advised him to re-present if he noticed increased pain, swelling occurred or an elevated temperature.[193]

84. Mr Fernandez attended an appointment with Dr Shamoun on 14 October 2014. The MO's notes are sparse, referring only to 'left jaw screws falling off and [Mr Fernandez] trying to push them back' and documenting his treatment plan for Mr Fernandez to see a dentist that week.[194]

85. Both in his statement prepared some 18 months later, and at inquest, Dr Shamoun elaborated on the content of the consultation and his diagnostic impression. He stated that he was conscious that the June 2014 OPG x-ray showed no evidence of 'rod protrusion' and so Mr Fernandez's perception that there was a foreign body in his mouth may be caused by a 'dental issue'.[195] This was why he urgently referred Mr Fernandez to a dentist, considering that if any further x-ray was required to assess changes in Mr Fernandez's mouth, the 'dentist would be able to perform them that same week'.[196] Dr Shamoun also discussed the need for review by an oral surgeon with Mr Fernandez again.[197] However, the ultimate plan

[186] IB page 306.
[187] IB page 311.
[188] IB page 306.
[189] IB page 88g.
[190] IB page 305.
[191] Ibid.
[192] Ibid.
[193] Ibid.
[194] IB page 305.
[195] Exhibit F and Transcript page 82.
[196] Exhibit F and Transcript page 82.
[197] Exhibit F and Transcript page 82.

was for Mr Fernandez to see a dentist first and consider a specialist referral when the outcome of the dental appointment was known.

86. Dr Shamoun did not see Mr Fernandez again after the 14 October 2014 consultation. He stated at inquest, 'yeah, I didn't know what happened to him after that' and had assumed Mr Fernandez would have re-presented to the clinic if there was an ongoing issue with his oral health.[198]

87. A RN actioned Dr Shamoun's plan for 'emergency dental care,' with an appointment made for Mr Fernandez to see a dentist at Rumbalara on 16 October 2014.[199] The RN assisted Mr Fernandez to complete a Medical History Questionnaire,[200] a document generated by Rumbalara to assist its clinicians. I mention in passing that neither form is particularly helpful in contextualising Mr Fernandez's need for dental care.

Dental Care

88. Mr Fernandez was transported to Rumbalara for his appointment with Senior Dentist Dr Prashanth Tatagari under guard by COs, who waited in reception during the appointment.[201]

89. Dr Tatagari testified at inquest that he started seeing prisoner patients in about June or July 2014 and that he was provided no instructions from CV or Dhurringile about how to manage them or how to manage any referrals for further investigations or treatment.[202] He also testified that he had no knowledge of logistical arrangements for transporting prisoners to medical appointments outside the prison.[203]

90. Dr Tatagari stated that he had no independent recollection of treating Mr Fernandez[204] and so the content of his statements, and his evidence at inquest, were informed by the contemporaneous notes he made of the 16 October and 20 November 2014 consultations on Rumbalara's electronic patient records (dental record), and his usual practice.[205]

91. It does not appear as though any referral materials or information, save that included in Mr Fernandez's Medical History Questionnaire, accompanied him to the dental appointment. Dr Tatagari testified that he elicited an account of Mr Fernandez's attendance from him and noted this in the dental record.[206] The dentist noted that Mr Fernandez had presented for a

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[198] Transcript page 83.
[199] IB page 443.
[200] Exhibit E.
[201] Transcript page 27.
[202] Transcript page 18; Ms Fuller's evidence did not contradict Dr Tatagari's evidence: Transcript page 226.
[203] Transcript page 19.
[204] Transcript page 19.
[205] Transcript page 20-21.
[206] Transcript page 26.

'check up' and complained of a 'lost screw in the plate'[207] that was placed 'in the left side of his jaw' the previous year.[208] Indeed, Dr Tatagari noted, 'plate present with 3 screws distal to 37'[209] (left mandibular second molar). Apparently, Mr Fernandez did not report that he had undergone an OPG x-ray in June 2014.[210]

92. Dr Tatagari stated that he would have noted it if Mr Fernandez had reported experiencing pain because this is the 'highest priority'.[211] Given that no notes were made about pain, the dentist testified that Mr Fernandez did not mention experiencing pain[212] or loss of feeling,[213] nor had he noted any difficulty eating.[214]

93. Although Dr Tatagari considered that the report of a lost screw was the 'primary reason' for Mr Fernandez's presentation, he was unable to advance the assessment and treatment of this as, in his view, an OPG x-ray was required.[215] As Rumbalara does not have an OPG x-ray facility,[216] a referral for this to occur elsewhere was necessary.

94. Dr Tatagari testified that he did not take intraoral periapical radiograph[217] of Mr Fernandez's left jaw because it would not have been an adequate diagnostic tool,[218] and placement of the instrument would be 'uncomfortable' for the patient.[219] I note that Dr Bassed, registered Dentist and Senior Forensic Odontologist at VIFM, considered it 'feasible' though 'somewhat limited' diagnostically to undertake periapical x-rays of Mr Fernandez's left jaw to investigate the presenting complaint and that he would have done so in the circumstances.[220] However, at inquest, he noted his 'differing clinical judgement' and conceded Dr Tatagari's decision not to take periapical x-rays was 'reasonable'.[221]

95. During his examination of Mr Fernandez's teeth, Dr Tatagari observed that his right maxillary and mandibular wisdom teeth and right maxillary second molar were carious.[222] The dentist did not note any signs of infection,[223] swelling or oral discharge.[224]

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[207] IB page 82.
[208] Exhibit D.
[209] IB page 82.
[210] Transcript page 35.
[211] Transcript page 27.
[212] Transcript page 27.
[213] Transcript page 37.
[214] Transcript page 35.
[215] Transcript page 33.
[216] Transcript page 23.
[217] An intra-oral radiograph is one where the x-ray film is placed inside the mouth. A periapical x-ray is one that produces a small image of the length of the tooth and at least 2 mm of the periapical bone. The purpose of the intraoral periapical examination is to obtain a view of the entire tooth and its surrounding structures.
[218] Transcript pages 44-45.
[219] Transcript page 49.
[220] Exhibit H.
[221] Transcript page 115.
[222] Exhibit D.

96. Dr Tatagari took intra-oral periapical x-rays of the decayed teeth and recommended extraction of both wisdom teeth and that the second molar be filled. With Mr Fernandez's consent, the dentist performed one of the recommended extractions under local anaesthetic.[225] Dr Tatagari noted that Mr Fernandez had no difficulty opening his mouth while his posterior tooth was extracted[226] and that if Mr Fernandez had complained of pain to his left jaw he would not have treated teeth in the right side of his jaw.[227]

97. I note that Dr Bassed was somewhat critical of Dr Tatagari's decision to proceed with 'substantial work' on the right side without first investigating the 'significant issue with the left side of [Mr Fernandez's] jaw' (Exhibit H). However, he moderated his criticism when giving evidence at inquest given Dr Tatagari's account that Mr Fernandez had not complained of pain nor were there indications of inflamed gums or inadequate mouth opening.[228] Dr Bassed stated that the treatment was 'perfectly reasonable' given the severe tooth decay and risk of infection.[229]

98. Dr Tatagari gave evidence that he handwrote a referral for an OPG x-ray and that it was his usual practice to hand the referral directly to prisoner patients and to inform the CO escort of the referral.[230] Rumbalara does not retain a copy of referrals provided to prisoner patients.[231] It was put to Dr Tatagari during the inquest that there was no means of verifying that he had, in fact, completed an OPG x-ray referral for Mr Fernandez.[232] The dentist denied that he could not be sure a referral was made because he had made relevant entries in the dental record.[233] Dr Tatagari highlighted the entry 'OPG' made in the Treatment Plan and Investigations[234] sections of the dental record, and the instruction to 'review OPG' in a section labelled 'Clinical Handover For Next Visit'.[235]

99. Dr Tatagari observed that the process through which referrals are actioned is different for prisoner and non-prisoner patients. Referrals made by Rumbalara's dentists for non-prisoner patients are actioned by Rumbalara via the Dental Health Service Victoria, a process which

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[223] Transcript page 35.
[224] Transcript page 36.
[225] Exhibit D.
[226] Transcript page 35 and 38.
[227] Transcript page 33.
[228] Transcript pages 112-113.
[229] Transcript page 113.
[230] Transcript page 20. Dr Tatagari testified that since October-November 2014, the process for handling referrals, and clinician communications more generally, had changed with the introduction of a 'communication folder' transferred with prisoner patients via escorting COs: Transcript pages 20 and 23.
[231] Transcript page 39.
[232] Transcript page 40.
[233] Transcript pages 41-42.
[234] Dr Tatagari observed that the heading, 'Investigations' is visible on his computer terminal, but not documents printed from it: Transcript page 40.
[235] Transcript page 23.

enables dentists to track and monitor their progress.[236] In contrast, Rumbalara had, and has, no role in giving effect to referrals made for its prisoner patients;[237] rather, Dhurringile's medical service attend to referrals for prisoners.[238]

100. Christine Fuller, Chief Nursing Officer at Correct Care, gave evidence that it was her expectation that any communications from an off-site clinician, including referrals, would come to the Dhurringile medical clinic via a CO.[239] She would not expect any correspondence to be given directly to the prisoner.[240] An extensive search of Mr Fernandez's medical records was conducted by Correct Care after his death during which no OPG x-ray referral from Dr Tatagari was found.[241] Ms Fuller observed that there was 'no record of anything coming back' from Rumbalara but that she believed that 'there must have been some communication … to say they wanted to see Mr Fernandez again' because a second dental appointment was made on his behalf.[242]

101. For completeness, I note that between 13 and 28 October 2014, Mr Fernandez's methadone dose was further and gradually reduced to 6mg daily.[243] Dr Shamoun testified that methadone dose reduction ordinarily occurred in the absence of a consultation between a prisoner and doctor, with the prisoner making a written request for the reduction and the MO modifying the prescription accordingly.[244] Further, there is no record of Mr Fernandez presenting to the medical clinic for "as needed" analgesia after 1 September 2014, despite attending twice each day for his regular medications.[245]

102. On 20 November 2014, Mr Fernandez attended an appointment with Dr Tatagari at Rumbalara but brought no OPG x-ray with him.[246] Dr Tatagari told Mr Fernandez that he could not assess the loose screw issue without an OPG x-ray.[247] Unable to advance that issue, with Mr Fernandez's consent, the dentist extracted the right maxillary wisdom tooth and placed a temporary filling in the adjacent molar under local anaesthetic in accordance

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[236] Transcript page 24.
[237] Transcript pages 24 and 26.
[238] Transcript page 39.
[239] Transcript page 222.
[240] Transcript page 222.
[241] Transcript pages 223 and 158 (Dr Turnbull).
[242] Transcript pace 222.
[243] IB page 88g.
[244] Transcript page 69.
[245] See generally Exhibit 14 and the evidence of Ms Fuller at Transcript pages 230-232.
[246] Exhibit D. The dentist had anticipated that Mr Fernandez would bring the OPG x-ray with him because x-rays were not sent directly to Rumbalara.
[247] Exhibit D.

with his previously documented treatment plan.[248] Mr Fernandez's dental record contains no note of any report of pain or difficulty accessing posterior teeth at this consultation.[249]

103. Dr Tatagari testified at inquest that he told Mr Fernandez to follow up the outstanding OPG x-ray himself.[250] However, under cross-examination he conceded that he perhaps should have informed the COs accompanying Mr Fernandez that he had referred Mr Fernandez for an OPG x-ray and that he had returned without one.[251] He also agreed that he could have telephoned the Dhurringile medical clinic to follow up himself.[252]

104. At inquest, Dr Tatagari was shown photocopies of Mr Fernandez's pre- and post-operative OPG x-rays (taken on 16 January and 10 February 2014 respectively), and a PMCT image of his posterior left mandible (taken 23 November 2014).[253] In his report, Dr Bassed described the left mandibular surgical repair as 'unhealed', with one of the four screws used to secure the plate 'missing' and two 'not attached to bone but "floating" in soft tissue' along with the anterior portion of the plate; there is a 'gap of at least two millimetres' between the fractured portions of the mandible.[254]

105. When asked to comment on the PMCT image, Dr Tatagari remarked that he was 'shocked', having never seen 'such a huge gap'.[255] He testified that had he had access to such an x-ray, he would have 'immediately' called 'whoever's in charge at Dhurringile' to request the contact details of the surgeon, and then speak directly to the surgeon, 'because this needs immediate attention by a specialist'.[256] I note that the gap was evident in the June 2014 OPG x-ray and the radiologist's report – if not the x-ray itself – formed part of Mr Fernandez's JH medical record.

106. At inquest, I also had the benefit of an expert report, commissioned on behalf of Correct Care, prepared by Oral and Maxillofacial Surgeon, Mr Kevin Spencer and aspects of the report were put to Drs Bassed and Tatagari during cross-examination. Mr Spencer opined that although there was 'clear radiographic evidence of a non-united left mandibular angle fracture' post-ORIF this did not necessarily mean that fibrous union – invisible on CT scan –

[248] Exhibit D and IB pages 83-84.
[249] IB pages 83-84 and Transcript page 34.
[250] Transcript page 42.
[251] Transcript page 42.
[252] Transcript page 43.
[253] Transcript page 30.
[254] Exhibit G.
[255] Transcript page 32.
[256] Transcript page 30.

had not occurred.[257] Dr Bassed agreed that fibrous union would not be visible on PMCT scans and so whether it had occurred in Mr Fernandez's case was 'unknowable'.[258]

107. The Forensic Odontologist also agreed that Mr Spencer's account of the sequelae of non-union of fractures was accurate.[259] That is, that non-union may be altogether asymptomatic or may result in symptoms ranging from pain, pain on chewing or mouth opening, reduced mouth opening, malocclusion, mobility across the fracture site, facial swelling and wound dehiscence (reopening) with oral discharge.[260] Mandibular fracture or its surgical treatment may also traumatise the nerve running through the mandible resulting in complete loss of sensation, pins and needles or painful pins and needles of the lip and chin on the affected side.[261]

108. Mr Spencer opined that if Mr Fernandez experienced severe ongoing pain he would have expected him to have difficulty chewing solid food/tolerate only a pureed diet and so lose weight. He would have reduced or guarded mouth opening prohibitive of dental treatment. Mr Fernandez would require ongoing opioid analgesia (though he noted Mr Fernandez was prescribed methadone) and that he would have sought surgical review rather than adopt a "watch and wait" approach.[262] There is no evidence before me that proximate to his death Mr Fernandez experienced any of the indices of severe ongoing pain enumerated by Mr Spencer.

109. That said, at inquest, Dr Bassed stressed how 'rare'[263] it was for a post-ORIF patient to present to a clinician reporting 'screws coming out of a plate that's supposed to be screwed into [one's] jawbone: it's not a trivial thing.'[264] Loss of a screw 'alerts someone to the fact that there is a breach of gum tissue'[265] and indicated to him that 'there is no fibrous union'[266] because the fracture is 'still mobile'.[267] Both Drs Bassed and Tatagari agreed that they would have expected Mr Fernandez to have experienced some pain – described by the latter clinician as 'mild to moderate' – due to the movement caused by the non-healing left

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[257] IB page 111a.
[258] Transcript page 104.
[259] Transcript page 104.
[260] IB page 111b.
[261] Ibid.
[262] IB page 111b.
[263] Transcript page 112.
[264] Transcript page 107.
[265] Transcript page 133. Dr Bassed also noted that breach of the gum may be accompanied by inflammation – in a difficult to observe location in Mr Fernandez's case – and that gum tissue heals very quickly: Transcript page 139.
[266] Transcript page 119.
[267] Transcript page 104.

fracture.[268] It was conceded that pain is experienced subjectively but Dr Bassed testified that he could not imagine Mr Fernandez being completely symptom-free.[269]

FINDINGS/CONCLUSIONS

110. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[270] The effect of the authorities is that Coroners should not make adverse comments or findings against individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death and in the case of individuals acting in their professional capacity, only where there was a material departure from the standards of their profession.

111. <u>Having applied the applicable standard of proof to the available evidence, I find</u> that:

a) Although Mr Fernandez had an extant diagnosis of depression and was prescribed medication to manage it, there is no evidence before me that he disclosed to anyone a risk of self-harm, nor that he presented as acutely distressed, proximate to his death.

b) Given the lethality of means chosen, and the note addressed to his son, Mr Fernandez intended to take his own life on or about 23 November 2014.

c) That said, neither the note nor the available evidence enable me to determine to the requisite standard the stressors that caused or contributed to his decision to take his own life.

d) Mr Fernandez sustained a fractured jaw whilst in custody at PPP in January 2014. It appears likely that his post-ORIF recovery was complicated by infection of the surgical site and that delayed healing of his left mandible fracture was not detected until June 2014 due to cancellation of two appointments for outpatient review, the first by SVCH and the second following Mr Fernandez's refusal to attend.

e) Although Mr Fernandez signed a "Release of Responsibility for Health Services" form, it is not clear that he did so on an informed basis, in the sense that he understood the potential consequences of his decision.

f) The initial clinical management and care provided to Mr Fernandez for his jaw injury on 6-7 June 2014 was reasonable and appropriate.

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[268] Transcript pages 118 (Dr Bassed) and 31 (Dr Tatagari).
[269] Transcript page 105.
[270] <u>Briginshaw</u> v <u>Briginshaw</u> (1938) 60 C.L.R. 336, especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…*"

g) There is no evidentiary basis for a finding that, proximate to his death, Mr Fernandez experienced severe ongoing pain associated with his jaw of a type likely to have contributed to his decision to end his life.

h) The available evidence suggests that episodes of acute/unmanageable jaw pain – when analgesia was sought and/or prescribed – correlate with the immediate post-operative period (January 2014), post-operative infection (February 2014), and subsequent football injury (June-September 2014).

i) Nonetheless, it seems counterintuitive and contrary to the evidence of Drs Tatagari and Bassed, and *not inconsistent* with Mr Spencer's opinion, to conclude that bony non-union of the left mandibular fracture, displacement of a surgical plate and loss of a retention screw left Mr Fernandez wholly symptom-free.

j) There is no causal connection between Mr Fernandez's medical management by Correct Care clinicians and his death.

112. Though not causally connected to his death, the coronial investigation identified several suboptimal practices or procedures that affected the quality of the healthcare Mr Fernandez received while at Dhurringile. In the interests of promoting public health and safety, I note with concern:

a) The absence of any follow-up by clinical staff to reschedule Mr Fernandez's post-operative review despite there being a note in his medical record to this effect;

b) Dr Shamoun's reliance on the radiologist's opinion that the 'fairly wide gap' would present 'no problem in the short term', which appears to have coloured his management of Mr Fernandez throughout June 2014;

c) Dr Shamoun's failure to refer Mr Fernandez to a dentist on 25 June 2014 when Mr Fernandez was concerned about a 'loose plate' and the MO attributed this to a 'tooth issue' despite the same diagnostic impression leading to a dental referral in October 2014;

d) Dr Shamoun's apparent unawareness that alternative arrangements could be made in 'special circumstances' to facilitate a prisoner's access to secondary or tertiary healthcare where there is repeated refusal to transfer via PPP;

e) Mr Fernandez's relevant medical history – ORIF in January 2014, jaw injury and OPG x-ray in June 2014 and methadone prescription – was not recorded by the RN assisting him to complete Rumbalara's Medical History Questionnaire, nor was the

dentist otherwise alerted to the MO's view that 'emergency dental treatment' was required;

f) The absence of any field on the first page of Rumbalara's Medical History Questionnaire requesting details of any (recent/relevant) dental treatment;

g) Dr Shamoun's failure to provide referral materials (such as the St Vincent's Hospital ORIF discharge summary and the June 2014 OPG x-ray report) to Rumbalara to contextualise Mr Fernandez's attendance for 'emergency' dental care;

h) Dr Tatagari's failure to request any of the above-mentioned information in October 2014, and particularly after Mr Fernandez attended his second appointment without any OPG x-ray in November 2014;

i) The apparent lack of instruction provided to community clinicians working with prisoners about how the correctional setting may require alteration of their usual practices;

j) Dr Tatagari's failure to follow-up with Dhurringile/Correct Care about his OPG x-ray referral in November 2014;

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on matters with the death including matters relating to public health and safety or the administration of justice:

1. The coronial investigation of Mr Fernandez's death highlights, once again,[271] the obstacle posed to access to health care in a custodial health care system heavily reliant on using Port Phillip Prison as a conduit for outpatient specialist appointments and access to tertiary care at St Vincent's Hospital. Justice Health,[272] Corrections Victoria[273] and custodial healthcare providers[274] are well-aware of the 'in-built disincentive'[275] posed by transition through Port Phillip Prison presents to prisoners not classified, or reluctant to transfer, to Port Phillip Prison.

2. At inquest, several witnesses gave evidence that at the time of Mr Fernandez's death prisoners could access secondary and tertiary healthcare other than via Port Phillip Prison in

[271] See Findings into the Death of Joseph Mallia COR 2013 635; and Kevin John CARR 2010 3295; accessible at www.coronerscourt.vic.gov.au and the Victorian Ombudsman Investigation into Prisoner Access to Health Care, August 2011, accessible at www.ombudsman.vic.gov.au at paragraph 110, page 25.
[272] Transcript pages 171-172.
[273] Transcript page 192.
[274] Transcript pages 63 (Dr Shamoun) and 234 (Ms Fuller).
[275] Transcript page 153.

'special circumstances and with approval'.[276] According to Mr Wise of Corrections Victoria, special circumstances consideration is not a prescriptive system.[277]

3. Notably, representatives of Justice Health and Corrections Victoria appeared to have different views about what may constitute special circumstances in this context. Ms Redpath of Justice Health emphasised the need to identify a medical reason[278] such as clinical urgency[279] or potentially a prisoner's consistent refusal to access treatment via Port Phillip Prison[280] to establish special circumstances. In contrast, Mr Wise suggested that a broader range of factors could give rise to special circumstances consideration.[281]

4. Howsoever defined, special circumstances considerations appear to require concerted advocacy by a prisoner or his primary healthcare clinician which presupposes that both are aware of the availability of alternative transfer arrangements to access secondary and tertiary healthcare.

5. If special circumstances are raised – for instance, by a primary healthcare clinician – and then endorsed by Justice Health, ultimate approval for alternative transfer arrangements is determined by the Sentencing Management Unit of Corrections Victoria.[282]

6. Alternative arrangements to facilitate a prisoner's attendance at a secondary or tertiary healthcare appointment include transition through a prison in Melbourne other than Port Phillip Prison, or direct transfer to and from the appointment from his classified prison. Such arrangements are much more expensive than transit through Port Phillip Prison and, according to Mr Wise, come with no guarantee that the prisoner will be returned to his classified prison immediately after an appointment.[283]

7. In 2014, Justice Health initiated the Prisoner Health Service Planning Project through which alternative pathways for prisoners to access planned public hospital services were identified with the aims of alleviating pressure on Port Phillip Prison, improving prisoner attendance rates for specialist services and achieving better health outcomes for prisoners.[284]

8. In November 2015, Telehealth – a video-conferencing facility for clinicians to provide outpatient medical consultation to geographically dispersed patients – was introduced to

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[276] Exhibits K and L and Transcript pages 169, 183-184, 170 (Ms Redpath), 190 (Mr Wise) and 235 (Ms Fuller).
[277] Transcript page 190.
[278] Transcript page 183.
[279] Transcript page 169.
[280] Transcript page 170.
[281] Transcript page 190. Examples provided included a protection/safety concerns, the need for a single cell placement (not available at all prison locations), to facilitate return for a scheduled family visit, or if the prisoner patient was, for instance, the chief cook.
[282] Transcript page 183-184.
[283] Transcript page 185.
[284] Exhibit K.

Victorian prisons. Use of Telehealth for an outpatient appointment is a clinical decision made by the treating specialist.[285] Although a large proportion of St Vincent's Hospital's specialist clinics use Telehealth, surgical specialities that require physical examination of a patient are not suitable for Telehealth.[286]

9. Face-to-face appointments remain preferred for initial consultations, but Telehealth is frequently used to monitor health conditions.[287] Prisoners are accompanied to Telehealth appointments by a nurse to ensure that clinically relevant information is communicated to the specialist.[288] Ms Redpath testified that between April and June 2017, 109 of 160 Telehealth appointments proceeded as planned with a very low rate of refusal to attend by prisoners. Most cancellations were the result of prisoners being released from custody or due to unilateral cancellation or rescheduling by St Vincent's Hospital.[289] In September 2017, 55 per cent of all specialist appointments were conducted via Telehealth.[290]

10. In November 2016, a Regional Access Pilot, through which prisoners could access specialist clinics and elective surgery at the closest appropriate hospital to their classified prison, was commenced in the Grampians. As at 31 August 2017, 169 prisoners from Langi Kal Kal Prison and the Hopkins Correctional Centre had been referred to East Grampians Health Service for specialist assessment, with 78 specialist appointments completed, 24 procedures undertaken and a further five scheduled.[291]

11. At the date of the inquest, in November 2017, Justice Health was awaiting endorsement of a Direct Access Pilot through which prisoners in the Barwon prison precinct would directly access specialist clinics and elective surgery at a single metropolitan hospital without transfer through Port Phillip Prison.[292]

12. The findings from the both these pilot(s) will inform development of the custodial health service in the future.[293]

13. I commend Justice Health and its partners' commitment to innovation in, and improvement of, the custodial healthcare system.

[285] Transcript page 175.
[286] Exhibit K.
[287] Transcript page 176.
[288] Transcript page 176.
[289] Transcript page 180.
[290] Transcript page 175.
[291] Exhibit K.
[292] Exhibit K.
[293] Exhibit K.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations on any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety and the administration of justice:

1. That Justice Health collaborate with custodial health care providers to collect data on the reason(s) prisoners refuse medical treatment or refuse to attend specialist appointments to better inform further improvements to the custodial healthcare system.
2. That Corrections Victoria collaborate with Justice Health and custodial health care providers to establish a common approach to what may constitute 'special circumstances' warranting transfer for secondary and tertiary healthcare other than via Port Phillip Prison, and ensure that primary healthcare providers (in particular) are aware that this facility exists and when it may be recommended.
3. That St Vincent's Correctional Health consult with Justice Health and consider revising the policy of removing prisoner patients from the outpatient waiting lists after two consecutive appointment cancellations since, at present, information about why an appointment was cancelled or by whom does not appear to be meaningfully collated.
4. That Rumbalara Aboriginal Co-operative Limited consider revising its Medical History Questionnaire to include a field, preferably on the first page of the document, to ensure that information relating to 'previous/recent dental surgery' (or similar) is captured.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act*,* unless otherwise ordered by a coroner, the findings, comments and recommendation made following an investigation must be published on the Internet and I make no such order.

DISTRIBUTION OF FINDING

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

Ms Sandra Hosking

Correct Care Australasia

Rumbalara Aboriginal Co-operative Limited

St Vincent's Correctional Health

Justice Health

Corrections Victoria

DSC Shane Kervin, Coroner's Investigator, Victoria Police

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 14 January 2020