IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 001694

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF MLADEN JOVANOSKI

Findings of:	Coroner David Ryan
Delivered on:	11 July 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria
Inquest Hearing dates:	4-5, 7-8 April, 1 & 10 June 2022
Counsel Assisting the Coroner:	Paul Lawrie of counsel
Secretary to the Department of Justice and Community Safety:	Marion Isobel of counsel
GEO Group Australia Pty Ltd:	Rachel Walsh of counsel

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BACKGROUND

1. On 11 April 2018, Mladen Jovanoski was 57 years old when he died at the Alfred Hospital from injuries he sustained after falling from an elevated walkway at Fulham Correctional Centre (**FCC**).

2. Mr Jovanoski was born in Macedonia in 1960. His parents both passed away in Macedonia in the late 1970s. He had four older sisters.

3. Mr Jovanoski first came to Australia in 1981, although he subsequently travelled back to Macedonia on a number of occasions. He had little contact with the rest of his family. His sister, Vassa Lopaticka, last saw him in 2014 or 2015 and recalled that he drank beer and whiskey and smoked tobacco. She did not know what employment he had or how he managed financially. Mr Jovanoski resided mostly in the Footscray and Yarraville areas. He was never married and had no children.

4. Mr Jovanoski had a history of hypertension, non-insulin dependent diabetes and dyslipidaemia (elevated blood cholesterol). He had no diagnosed mental health condition or known history of mental health issues.

5. Mr Jovanoski had several surgical procedures at the Footscray Hospital in late 2015, including a thyroidectomy for metastatic thyroid cancer on 18 November 2015.

6. On 20 November 2011, Victoria Police executed a search warrant at Mr Jovanoski's home in St Albans and located a hydroponic cannabis crop. Mr Jovanoski was not present at the time but he subsequently attended the Keilor Downs Police Station where he was arrested and interviewed. On 18 February 2012, he was charged with various offences including possession of a drug of dependence for trafficking and cultivation of a commercial quantity of cannabis. Mr Jovanoski was subsequently released on bail.

7. On 3 March 2016, Mr Jovanoski failed to appear at the County Court of Victoria in answer to his bail and a warrant was issued. He was arrested 18 months later on 23 September 2017 and remanded in custody at the Melbourne Custody Centre.

8. On 29 September 2017, Mr Jovanoski was transferred to the Melbourne Assessment Prison and on 5 October 2017, he was transferred to the Metropolitan Remand Centre (**MRC**). On 9 October 2017, he was transferred to FCC where he stayed in the Lima Block.

CORONIAL INVESTIGATION

Jurisdiction

9. Mr Jovanoski's death constitutes a '*reportable death*' under s4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death he was a person placed in custody or care. Pursuant to s52(2)(b) of the Act, an inquest was also required to be held which occurred on 4-5 April, 7-8 April and 1 and 10 June 2022.

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

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

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

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

14. Coroners are empowered to:

    a. report to the Attorney-General on a death;

[1] Section 89(4) *Coroners Act 2008.*

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

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

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

16. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[2] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[3]

17. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[4]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

18. On 29 October 2017, Mr Jovanoski completed a "Request for Medical Attention" form at FCC in which he identified his problem as *"neck pain, need an x-ray reason had an operation 3 years ago on my neck"*.[5]

19. On 20 November 2017, Mr Jovanoski presented to the medical centre (the triage window) at FCC requesting a thyroid ultrasound and reporting that he had not had any follow up in the community since his thyroid surgery in 2015. The clinical notes in his custody health records (**J-Care**) noted:

> *Prisoner attended triage requesting thyroid U/S*

[2] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[3] *Keown v Khan* (1999) 1 VR 69.
[4] (1938) 60 CLR 336.
[5] CB370.

States he had a thyroidectomy about 3 years ago and hasn't "had ok check up"

Had blood tests attended late October and hasn't been told the results

...

Prisoner needs Lots of reassurance [6]

20. On 29 November 2017, Mr Jovanoski attended the medical centre for a change of a dressing on a wound and the J-Care notes record:

... Prisoner more concerned about thyroid

thyroidectomy about 3 years ago and hasn't had follow up post.

States "worried because some was cancerous"[7]

21. On 30 November 2017, Mr Jovanoski requested to see the medical officer for a thyroid ultrasound.

22. On 1 December 2017, Mr Jovanoski attended the medical centre to obtain a consent form for the Disclosure of Health Information. The clinical notes record:

Prisoner thinks he may have "thyroid cancer"?? [8]

23. Dr Lana Anderson, a visiting medical officer at the FCC, first saw Mr Jovanoski on 12 December 2017 and assessed him in light of his past surgery for thyroid cancer. The same day Dr Anderson made a referral to the Endocrinology Unit at St Vincent's Hospital which noted:

D/w Endocrinology consultant over the phone for URGENT biopsy

Hx of Thyroid Ca. Thyroidectomy in Melbourne 2015.

[6] CB180.
[7] CB180.
[8] CB179.

Recent US results – new lump L side of the neck, requires biopsy. Ca?

Priority: Urgent [9]

24. On 3 January 2017, Dr Anderson reviewed Mr Jovanoski at which time he was waiting for his appointment with the endocrinologist at St Vincent's Hospital.

25. On 9 January 2018, Mr Jovanoski had an ultrasound on his neck (performed by Central Gippsland Health Service – Medical Imaging). The radiologist noted a suspect 2.8cm mass at the base of his neck and recommended a computed tomography (**CT**) scan of the neck and chest and a possible biopsy.[10] The same day Dr Anderson reviewed Mr Jovanoski's ultrasound report and made a second referral to St Vincent's Hospital which noted.

PHx thyroidectomy due to Thyroid cancer.

US report ? metastatic lesion on the neck? For biopsy

Priority: Urgent [11]

26. On 19 January 2018, Mr Jovanoski had a CT scan (again performed by Central Gippsland Health Service – Medical Imaging) and the report concluded that the lesion in the left side of his neck was "*highly suspicious for nodal metastasis"*.[12]

First appointment – February 2018

27. An appointment was made for Mr Jovanoski to attend the Thyroid Surgery Clinic at St Vincent's Hospital on 7 February 2018. This appointment was cancelled by staff at MRC on 1 February 2018.

[9] CB112.
[10] CB280.
[11] CB105.
[12] CB109.

Second appointment – March 2018

28. A second appointment was made for Mr Jovanoski to attend St Vincent's Hospital on 14 March 2018 at 2.00pm. In preparation for this appointment he was transferred to the MRC on 12 March 2018.

29. Mr Jovanoski was not taken to this appointment. The J-Care records note (at 2.31pm on 14 March 2018):

> *Patient had an appointment with Thyroid Surgery Clinic today at SVHM however it was cancelled due to corrections Victoria advising they had no transport to take him. Appointment has been rescheduled for 9/5/18 at 2.30pm.*[13]

30. Mr Jovanoski returned to FCC on the afternoon of 15 March 2018. He presented at reception with signs of agitation and anxiety and was reviewed in the medical centre. Mr Jovanoski was informed of the reason for cancellation of his appointment at St Vincent's Hospital and eventually left the medical centre apparently calm and composed.[14]

Mental Health Intervention – 15 March 2018

31. At about 5.30pm on 15 March 2018, Mr Jovanoski was overheard by Corrections Officer Travis Masterson saying, *"I might as well jump off the top tier"* and was seen to throw his hands up in the air.[15] Mr Masterson immediately notified his supervisor who arranged for Mr Jovanoski to be assessed by Colin Young, a psychiatric nurse, at the medical centre. Mr Young concluded that there was no evident psychopathology and that Mr Jovanoski was a low risk of suicide or self-harm. Accordingly, he was released back to his unit that evening.

[13] CB170.
[14] CB618.
[15] CB52; T254-5.

32. Mr Jovanoski was reviewed again by a mental health nurse at FCC on 16, 20 and 23 March 2018.[16]

33. The missed appointment at St Vincent's Hospital on 14 March 2018 had initially been rescheduled for 9 May 2018 but, after efforts were made by health staff at FCC, on about 16 March 2018 an earlier appointment was arranged for 11 April 2018.[17]

34. The J-Care notes for the mental health review on 16 March 2018 record:

> *Established that* [the] *major stressor apart from not being medically reviewed at St Vincents on 14/3/18 is that he hasn't been able to talk with his solicitor and further, establish whether he has all his medical records to present to the court on 26/4/18.*[18]

35. On 24 March 2018, at a regular medical review, Mr Jovanoski was noted to be very frustrated about the cancellation of his surgery and observed to be *"emotional and teary"*.[19]

36. On 26 March 2018, Mr Jovanoski complained of not being able to swallow due to swelling in his neck. The swelling was visible to the attending nurse.[20]

37. Mr Jovanoski continued to raise his concerns with medical staff and on 7 April 2018 the attending nurse recorded:

> *Also concerned about why they cancelled his operation.*
> *Stated that he went down to PPP but they did nothing and sent him back*
> *Has great concerns as to what is going to happen to him* [21]

[16] CB619.
[17] CB162.
[18] CB169.
[19] CB167.
[20] CB166.
[21] CB163.

Third appointment – April 2018

38. The appointment arranged for 11 April 2018 was cancelled before Mr Jovanoski was transferred to MRC. The J-Care records note that the medical staff at FCC became aware of the cancellation on 9 April 2018 and also provide as follows in relation to this cancellation:

> *14/3/2018 Prisoner was transferred to MRC for neck surgery at SVH, but appointment was cancelled because MRC couldn't organise transport. therefore MRC rebooked for 9/5/18. We then pushed for appointment on 11/4/18.*
>
> *Appointment on 11/04/2018 was cancelled by PPP due to operational issues, then was rebooked for 6/6/18. …*
>
> *This matter has been escalated to* [Justice Health] *by Fulham nurse manager (Julie Bond) – to see if we can bring this prisoner's operation appointment forward given its urgency and prisoner's ongoing symptoms.*[22]

11 April 2018

39. Shortly before 9.30am on 11 April 2018, Mr Jovanoski had a telephone conversation with his criminal lawyer, Simon English. His next court appearance in his criminal matter was listed on 26 April 2018.

40. In a letter to the Court dated 18 October 2021, Mr English indirectly confirmed the fact of the telephone conversation that morning. Mr English also raised a claim of legal professional privilege in respect of the contents of the phone call. Unfortunately, there was no viable means for waiver of the privilege in the circumstances and so, after giving the interested parties an opportunity to be heard on the matter, the Court determined not to call Mr English.

41. At approximately 9.33am, Mr Masterson and Corrections Officer Dean Cheshire were walking near Mr Jovanoski's cell when they heard another prisoner yelling *"no, no, no"*.[23] Prisoner Matthew Moore was playing snooker when he saw Mr Jovanoski climb up on the

[22] CB162-3.
[23] CB59.

rail of the second level walkway. Mr Jovanoski sat on the rail, leaned forward and fell headfirst approximately four metres to the ground below.[24]

42. An emergency response was immediately initiated by FCC staff with multiple persons involved in the first aid effort. Mr Jovanoski was unresponsive and had suffered significant head injuries with a visible depressed fracture of the skull. Cardiopulmonary resuscitation (**CPR**) was commenced and an ambulance team arrived at 9.55am. Shortly afterwards Mr Jovanoski was transported to the West Sale aerodrome and airlifted to the Alfred Hospital. Despite the best efforts of medical staff, Mr Jovanoski could not be saved and he was pronounced deceased at 3.57pm.[25]

OTHER INVESTIGATIONS

43. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations. I have been provided with the Justice Health and Justice Assurance and Review Office (**JARO**) reports, both of which are included in the Coronial Brief.

Justice Health Review

44. Justice Health is a part of the Department of Justice and Community Safety (**DJCS**) and has responsibility for the delivery of health services to Victoria's prisoners. It commissioned an independent review of the health care provided to Mr Jovanoski in the lead up to his death and prepared a report dated 8 October 2018.

45. Justice Health found that the surgery that was scheduled at St Vincent's Hospital for Mr Jovanoski to undergo a biopsy in relation to possible metastases of thyroid cancer was cancelled on three separate occasions. The first appointment, scheduled on 7 February 2018, was cancelled on 1 February 2018 by the MRC as no transport was available. Justice Health noted that there was no indication in J-Care that the health staff at either the MRC or FCC were informed of the cancellation. The second appointment, scheduled for 14 March 2018, was cancelled as Corrections Victoria was unable to transport Mr Jovanoski to St Vincent's

[24] CB50.
[25] CB412.

Hospital from MRC as another medical escort had taken precedence. Justice Health noted that there was no indication that the cancellation was discussed with health staff including the medical officer at MRC. The third appointment, scheduled on 11 April 2018, was cancelled by Corrections Victoria due to a lack of transport and escort staff.

46. Justice Health made the following recommendations:

    a. That transport escorts to tertiary medical appointments are not cancelled without appropriate review by the health service to confirm the urgency based on clinical need.

    b. That transport escorts to tertiary medical appointments are not cancelled without consultation with the prisoners' home prison – to confirm the urgency of the appointment and to advise the prisoners' home prison health service of the cancellation.

Justice Assurance and Review Office

47. Deaths of prisoners in custody are also reviewed by JARO. JARO is a part of DJCS and reports to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[26]

48. JARO conducted a review into Mr Jovanoski's death and prepared a report dated 6 May 2019. In preparing its report, JARO had regard to the report prepared by Justice Health.

49. In summary, JARO made the following findings:

    a. In particularly confronting and difficult circumstances, correctional and medical staff immediately responded to the incident, providing urgent medical assistance and should be commended for their actions.

    b. Mr Jovanoski consistently displayed a high level of anxiety while in custody; his anxiety was known to be associated with his unresolved legal and medical

[26] Section 7 of the *Corrections Act 1986*.

issues. JARO found that these matters were managed appropriately by custodial and medical staff.

c. Mr Jovanoski's case management met the standards prescribed by Corrections Victoria.

d. JARO was unable to ascertain the specific motive for Mr Jovanoski jumping from the top tier of the unit. However, given previous threats made on 15 March 2018 it is considered likely that Mr Jovanoski's ongoing health and legal issues were a contributing factor.

e. Emergency responders who attended the incident advised FCC that they were very satisfied with the emergency response of staff at the location.

f. There is a lack of defined responsibility and clarity for health and custodial staff in prioritising and organising medical transfers, which may impact prisoners' access to medical and specialist appointments.

50. JARO made the following recommendation:

a. That Corrections Victoria and Justice Health work together to develop a policy on the management and coordination of medical escorts which addresses issues such as:

i. Assigning responsibility for booking medical appointments; and

ii. Who has responsibility for determining medical escort priority.

51. In response to its report, Corrections Victoria advised JARO that it accepted the recommendation in-principle and that a statewide policy would be developed in consultation with Justice Health to provide health and custodial staff with guidance on how to manage the facilitation of escorts and appointments.

SOURCES OF EVIDENCE

52. Victoria Police assigned Sergeant Benjamin Tobias to be the Coroner's Investigator for the investigation into Mr Jovanoski's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from witnesses, family members, the forensic pathologist, treating clinicians and corrections officers.

53. The inquest ran over 6 days and evidence was given by the following witnesses:

    a. Dr Lana Anderson;
    b. Dr Herris Xiao;
    c. Colin Young;
    d. Julie Bond;
    e. Thomas Masterton;
    f. Scott Swanwick (Director of Health Services and Clinical Governance, Justice Health);
    g. Jenny Hosking (Assistant Commissioner, Corrections Victoria); and
    h. Melissa Westin (Deputy Commissioner, Corrections Victoria).

54. This investigation was initially allocated to Coroner Lorenz. On 14 April 2022, her Honour recused herself from further involvement in the investigation after having commenced the inquest and hearing four days of evidence. I was then allocated the investigation.

55. This finding is based on the evidence heard at the inquest,[27] as well as the material in the Coronial Brief, material tendered during the inquest and the submissions made by the parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

[27] I have reviewed the transcript of the evidence given before Coroner Lorenz and, at the request of counsel for GEO, watched video recordings of the evidence given by Dr Xiao, Ms Bond and Mr Masterton.

SCOPE OF THE INQUEST

56. The following issues[28] were investigated at inquest:

a. The adequacy of Mr Jovanovski's medical management at FCC, including:

i. What medical care was provided to Mr Jovanovski proximate to his death in respect of his physical health and mental health?

ii. What (if any) threats were made by Mr Jovanovski in respect of self-harm?

iii. How were these threats assessed?

iv. What effect if any did these threats have on treatment provided to Mr Jovanovski?

b. The cancellation of Mr Jovanovski's medical appointments scheduled on 7 February 2018, 14 March 2018 and 11 April 2018, including:

i. Why and by whom were the appointments cancelled?

ii. What was the process, decision-making responsibility and criteria for booking, cancellation, re-booking and prioritization of Mr Jovanovski's prisoner medical transfers?

iii. How, when and what information was communicated to Mr Jovanovski regarding the scheduling, cancellation and re-scheduling of the appointments?

iv. What was the effect, if any, on Mr Jovanovski of the cancellation of the appointments?

[28] These issues were drawn from the written scope of the inquest which was circulated to the parties by the Court in August 2021 and has been condensed where appropriate.

c. Governance

i. What were the governance arrangements in place for the transport of prisoners to medical appointments?

ii. What criteria was used to determine whether an appointment is cancelled?

iii. Did these arrangements conform to the Health Justice Quality Framework?

d. To what extent, if any, did anxiety about his medical condition, the cancellations of his medical appointments or his telephone conversation with his legal practitioner proximate to death, contribute to his decision to end his life?

IDENTITY OF THE DECEASED

57. On 18 April 2018, Mr Jovanoski's body was identified by a fingerprint report pursuant to an order of Coroner Byrne.

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

MEDICAL CAUSE OF DEATH

59. On 16 April 2018, Dr Khamis Almazrooei, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy upon Mr Jovanoski's body. In a report dated 14 August 2018, Dr Almazrooei noted that Mr Jovanoski suffered a significant head injury and cardiac arrest and died as a consequence of this injury.

60. Dr Almazrooei formulated the cause of death as:

1(a) Consequences of multiple injuries.

61. I accept Dr Almazrooei's opinion.

MEDICAL MANAGEMENT OF MR JOVANOSKI AT FULHAM

Medical care provided to Mr Jovanovski

62. The provision of primary medical care to prisoners at FCC is managed by GEO Group Australia Pty Ltd (**GEO**). Mr Jovanoski was a "*complex case*"[29] and attended the medical centre at FCC on a daily basis. The two main reasons for Mr Jovanoski's attendance at the medical clinic were to seek and follow-up on treatment for the suspected return of his thyroid cancer and for the management of his diabetes.[30]

63. In relation to the suspected return of his thyroid cancer, Dr Anderson made an urgent referral to an endocrinologist at St Vincent's Hospital in Melbourne, and on 12 December 2017 arranged for an ultrasound and a CT scan to be conducted of his neck at the Central Gippsland Health Service on 9 January and 19 January 2018 respectively. Dr Anderson made a further urgent referral to St Vincent's Hospital for a biopsy on 9 January 2018. Dr Anderson was expecting an appointment in the next two to four weeks.[31] After Dr Anderson left FCC in February 2018, Dr Xiao continued to manage Mr Jovanoski's thyroid investigation and provided reassurance to him in relation to the arrangement for treatment at St Vincent's Hospital.[32]

Threats made by Mr Jovanovski in respect of self-harm

64. Mr Jovanoski made one threat of self-harm after his return to FCC from MRC on 15 March 2018. In the evening, after he had returned to his unit, Mr Jovanoski asked Mr Masterson if he could see the Unit Manager. Mr Masterson explained that the Unit Manager had left for the day but would be returning the next morning. When Mr Masterson asked whether the matter was urgent, Mr Jovanoski "*threw his hands up in the air*" and said "*I might as well jump off the top tier*".[33] Mr Masterson discussed the matter with his manager and a decision was made to refer Mr Jovanoski for a risk assessment.

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[29] T181.
[30] CB69-72; T177-8.
[31] T47.
[32] T75.
[33] T254-5.

Assessment of the threat and effect on treatment

65. Psychiatric nurse Mr Colin Young conducted a risk assessment on Mr Jovanoski which lasted approximately 50 minutes. Mr Jovanoski denied that his comment was a true statement of his intention and Mr Young established a number of protective factors including his family and a friend on the unit. At the conclusion of the assessment, Mr Young was satisfied that Mr Jovanoski was a low risk of self-harm and he was released back to the unit.[34] The mental health team of the medical centre followed up with Mr Jovanoski through psychiatric nurse Arch Gardner on 16, 20 and 23 March 2018. He was not assessed on any of these occasions as presenting a risk of self-harm.

66. When he was reviewed by the medical team on 16 March 2018, Mr Gardner noted that one of the stressors operating on Mr Jovanoski was the failure to be medically reviewed at St Vincent's Hospital.[35] Mr Jovanoski was subject to an appropriate mental health assessment in response to his threat of self-harm but I do not consider that it altered the medical team's view of the care and treatment that he required for the suspected return of his thyroid cancer. The consistent view of the medical team was that the treatment was urgent as any returning cancer could be spread rapidly and be life-threatening.[36]

67. I am satisfied that the medical care provided to Mr Jovanoski by the staff at GEO while he was at FCC was reasonable and appropriate. He was able to access medical services at the medical centre easily and regularly. The staff acted promptly to arrange urgent treatment for the suspected return of his thyroid cancer. Further, his threat of self-harm was treated seriously and cautiously and a thorough risk assessment was conducted with appropriate follow-up. The staff displayed diligence, compassion and empathetic care in their dealings with Mr Jovanoski.

[34] T168.
[35] CB169.
[36] T88.

CANCELLATION OF MR JOVANOSKI'S MEDICAL APPOINTMENTS

68. Transfer of prisoners for medical treatment generally involves movement from their "*home*" prison to an intermediate location from which transport to the appointment can arranged. Mr Jovanoski's intermediate location was designated by Sentence Management Division (**SMD**) of Corrections Victoria as MRC. Mr Jovanoski was on remand and prisoners on remand are usually designated to MRC as their intermediate location, although this is not always the case.

69. Cancellation of transports that occur before a prisoner has been transferred to an intermediate location is overseen by Sentence Management Operations (**SMO**) of Corrections Victoria. When the SMO cancels a transfer, contact is usually made (by email) with the medical administrative team (rather than the clinical team) at the intermediate location, as they are responsible for booking and rescheduling medical appointments. Once SMO has coordinated and finalised the transfer of a prisoner from their home prison to an intermediate location, it becomes the responsibility of the intermediate location to oversee the transfer to the medical appointment.

70. Cancellation of transports from a prisoner's intermediate location to the location of a medical appointment which occurs on the day of that appointment is usually made by a senior custodial staff member of that prison, such as the Security Supervisor or Operations Manager.[37]

7 February 2018 appointment

71. Mr Jovanoski's appointment at St Vincent's Hospital on 7 February 2018 was cancelled after SMD were advised by an administration services officer employed by Correct Care Australasia (**CCA**)[38] at MRC that all the available transports for that day were already booked. The appointment was cancelled on 1 February 2018.[39] It was noted by SMO that Mr Jovanoski was *"not suitable for a PPP placement"*.[40] There is no evidence of any

[37] Affidavit Of Melissa Westin affirmed 31 May 2022.
[38] CCA are responsible for the medical care of prisoners at MRC.
[39] Affidavit of Melissa Westin affirmed 31 May 2022.
[40] MSW-1 to the Affidavit of Melissa Westin affirmed 31 May 2022, p 2.

involvement of clinical staff in this cancellation. Mr Jovanoski's appointment was rescheduled for 14 March 2018.

14 March 2018 appointment

72. Mr Jovanoski's appointment at St Vincent's Hospital on 14 March 2018 was cancelled on that day because another prisoner at MRC had dislocated his shoulder and it was determined that his escort to hospital should take precedence over Mr Jovanoski's escort. There is no record of who made the decision to cancel this transport and after exhausting its inquiries, the Corrections Victoria has been unable to identify that person. However, Ms Westin has given evidence, which I accept, that it is likely that the transport was cancelled when Emergency Response Group staff at MRC discovered there was no vehicle available to transport Mr Jovanoski at the scheduled time for his escort as it had already been used to transport the prisoner who had dislocated his shoulder.[41] There is no evidence of any involvement of clinical staff in this cancellation and the Secretary has conceded that this did not in fact occur.[42] Mr Jovanoski's appointment was rescheduled for 9 May 2018 but medical staff at FCC arranged for this appointment to be brought forward to 11 April 2018.

73. On 16 March 2018, Ms Bond, Health Services Manager (**HSM**) at FCC, emailed Mr Swanwick, the Director of Health Services and Clinical Governance for Justice Health, to escalate consideration of the urgency of Mr Jovanoski's treatment given the seriousness of his condition. Ms Bond's concerns were referred to the Operations Manager and the General Manager of MRC. They were also referred to CCA who noted that the issue would be discussed with the administration team at MRC to ensure that the process of rescheduling urgent referrals is being followed and escalated to the HSM when necessary. On 19 March 2018, the Operations Manager directed that no scheduled medical escorts were to be cancelled by Corrections Victoria staff without an Operations Manager's approval.[43] The urgency of Mr Jovanoski's treatment was also the subject of discussion at the GEO Group - Fulham – Clinical Governance Meeting on 20 March 2018.[44]

[41] Affidavit of Melissa Westin affirmed 31 May 2022.
[42] Outline of Closing Submissions for the Secretary dated 8 June 2022, para 17.
[43] MSW-1 to the Affidavit of Melissa Westin affirmed 31 May 2022, p 13.
[44] T188.

11 April 2018 appointment

74. Mr Jovanoski's appointment at St Vincent's Hospital on 11 April 2018 was cancelled after SMD was advised by an administration services officer employed by CCA at MRC that all the available transports for that day were already booked. The appointment was cancelled on 4 April 2018. Again, it was noted by SMO that Mr Jovanoski was *"not suitable for a PPP for his upcoming medical appointment".* There is no evidence of any involvement of clinical staff in this cancellation. Mr Jovanoski's appointment was rescheduled for 6 June 2018.

75. SMO was not aware of the urgency of Mr Jovanoski's appointment or of the escalation which occurred after the cancellation of the 14 March 2018 appointment.[45]

76. I am satisfied that there was no consultation with any clinical staff in relation to the cancellation of any of Mr Jovanoski's three appointments. There is no evidence of any such involvement and if there had been, it is very likely that there would be evidence of the clinical staff seeking to ensure the appointments were not cancelled given their obvious urgency and the seriousness of Mr Jovanoski's medical condition. It is clear that administrative staff employed by CCA at MRC were aware of the cancellations on 11 February and 11 April 2018 but there is no evidence that they had any clinical expertise to enable them to assess the competing priorities of medical appointments. Nor is there any evidence of medical administrative staff conducting inquires, such as examining the relevant J-Care notes, for that purpose.

Communication with Mr Jovanovski regarding medical appointments?

77. I am satisfied that Mr Jovanoski was not aware of the specific dates of his appointments on 7 February or 11 April 2018 or their cancellations. This is consistent with Corrections Victoria security policy. However, he was obviously aware of the appointment on 15 March 2018, or thereabouts, as he would have reasonably deduced that he had been transferred to MRC for the purpose of receiving his urgent treatment. Further, an explanation for the cancellation was provided to him by Mr Young during his mental health assessment.[46]

[45] Affidavit Of Melissa Westin affirmed 31 May 2022.
[46] T123.

78. Although medical staff at FCC did not communicate specific dates to Mr Jovanoski in relation to his medical appointments, they did provide regular assurance to him that his appointment had been arranged and should occur *"soon"* and in the *"next few weeks"*.[47]

What was the effect, if any, on Mr Jovanovski of the cancellation of the appointments?

79. Although Mr Jovanoski was not aware of the specific appointments on 7 February and 11 April 2018, he clearly knew from his regular discussions with medical staff at FCC that his condition was serious and that he required urgent treatment.[48] It would have also been clear to him that despite the assurances of the medical staff, there had been a significant and ongoing delay in arranging for him to be transferred to St Vincent's Hospital to receive that treatment. At the time of his death, it had been over five and a half months' since he had first sought medical attention at FCC in relation to the suspected re-emergence of his thyroid cancer.

80. It is clear from the notations in the J-Care records and the evidence of the medical staff at FCC, that Mr Jovanoski was experiencing increased pain in his neck, was anxious to receive his treatment and was frustrated at the delay. I consider that his anxiety and frustration was only increased as a result of his awareness of the seriousness of his condition and the urgency of his treatment on the one hand and, despite general assurances to the contrary, the failure of his treatment to eventuate on the other hand.

GOVERNANCE

81. The Secretary has made a number of concessions about the cancellation of Mr Jovanoski's appointments and conceded that clinical input into the decision to cancel medical transfers is essential. It has also been conceded that there could be more flexibility in determining a prisoner's designated intermediate location for the purpose of increasing the chances of a successful transfer for medical treatment. Ms Westin has welcomed a number of

[47] T79; CB174.
[48] T75.

recommendations. However, there has been a delay in confronting and addressing some of the prevention opportunities presented by Mr Jovanoski's death.

82. The Secretary advised the Court that the recommendations of Justice Health and JARO made in 2018 and 2019 respectively have only partially been implemented and there is still no written policy which sets out the process for cancelling and rescheduling external medical appointments. It is understandable that there has been disruption as a result of the Covid-19 pandemic but nevertheless, this delay is clearly unsatisfactory. Ms Westin stated in evidence that there had been an *"absolute breakdown"*[49] of the regular monitoring and acquittal of recommendations to Corrections Victoria and the Secretary concedes that more work remains to be done to ensure that policies are robust, user friendly, and that appointments with external medical providers are not cancelled without appropriate input, escalation and communication.[50]

83. Justice Health conducted a review of the Centralised Hospital Pathway in 2019 which was designed to, among other things, reduce the volume and impact of refusals (by prisoners) to attend, and cancellations of, external medical appointments. As a result of the review, the reasons for a cancelled appointment are now required to be entered on J-Care and an Escalation and Risk Protocol was developed.

84. However, it was conceded by Mr Swanwick that the application of the protocol to the circumstances of the cancellation of Mr Jovanoski's appointments would not have resulted in a different outcome.[51] This is because the protocol does not explicitly require that there be consultation with clinical staff at a prisoner's home prison as part of the escalation process. It is also noted that the protocol is reactive to an appointment that has already been cancelled and does not provide for a process to consider clinical priority and urgency of a transport *before* it is cancelled.

[49] T11(MW)
[50] MSW-1 to the Affidavit of Melissa Westin affirmed 31 May 2022; Outline of Submissions of the Secretary dated 8 June 2022, para 18.
[51] T323-4.

85. Understandably, the protocol is a high-level document designed to apply across the prison system in Victoria and its practical application would be enhanced by Local Operating Procedures which provide practical and step-by-step guidance to staff as to exactly who to contact and when and how to contact them. Ms Westin has advised the Court that Justice Health is continuing to work with relevant service providers (including at PPP and MRC) to develop Local Operating procedures:

a. To outline the triage process, based on clinical acuity needs;

b. To guide the confirmation or cancellation of medical escorts; and

c. Provide the escalation pathway to mitigate risk.

86. Ms Westin also instructed her team to implement amendments to the Deputy Commissioner's Requirement regarding external escorts and that clinical input is required in all cases where an external medical appointment is to be cancelled, with corresponding updates to the Sentence Management Manual.[52]

87. After the inquest, the solicitors acting for the Secretary forwarded to the Court a copy of the updated *Deputy Commissioner's Instruction 1.12 – External Escorts and Transfer of Prisoners* and *Commissioner's Requirement 1.1.1 – External Prisoner Escort Arrangements*. These documents recognise the importance of clinical input in determining priority or urgency in the facilitation of medical transfers in Victoria's prison system and provide as follows:

a. If staff cannot facilitate a health permit, they must immediately escalate to the Operations Manager (**OM**). The OM must liaise with the prison's health service provider **(HSP**) for a clinical assessment, to determine priority.

b. Custodial staff must not make a decision about priority without a clinical assessment by the HSP.

[52] Affidavit Of Melissa Westin affirmed 31 May 2022.

c. The HSP must refer the decision to the HSM or medical officer to determine priority or urgency.

d. Where all transfers are urgent, alternative arrangements are to be made.

e. The HSP should inform custodial staff in writing if the appointment is urgent.

f. It is incumbent on the HSP to upload all relevant documentation to the prisoner's electronic medical record.

CONTRIBUTING FACTORS TO MR JOVANOSKI'S DECISION TO END HIS LIFE

88. I am satisfied in the circumstances that Mr Jovanoski intended to take his life when he fell from the second level of the walkway at FCC on 11 April 2018.

89. The evidence clearly demonstrates that Mr Jovanoski was anxious about the suspected return of his thyroid cancer and that the delay in receiving medical treatment was causing him further anxiety and frustration.[53] However, I accept that there were other circumstances in Mr Jovanoski's life which were likely causing him stress, such as the fact that he was incarcerated and the environment of living in prison, the management of his diabetes, and anxiety about the criminal proceedings against him and concern about his likely sentence.

90. I am also satisfied that Mr Jovanoski's telephone call with his legal practitioner on the morning of 11 April 2018 in which he was heard to be *"arguing loudly"* and after which he became very emotional and *"went straight upstairs to jump"*[54] was likely to have acted as a trigger in relation to his decision to end his life. Notwithstanding that we do not know the content of this discussion given that it is subject to legal professional privilege which has not been waived, I consider that this inference is available and appropriate in the circumstances given the proximity of the phone call to Mr Jovanoski's decision to jump.

[53] T94;T145;T189;T206-7;T229-230;T266;CB167-8;CB722-3.
[54] CB637; T169.

91. The Secretary has submitted that the Court is not in a position to speculate about which stressors causally contributed to Mr Jovanoski's death and it follows that I am not authorised under the Act to make any comment or recommendations in relation to the process, responsibility and reasons for the cancellation of Mr Jovanoski's medical appointments.

92. While the evidence reveals that there were likely multiple stressors impacting upon Mr Jovanoski at the time he decided to take his own life, it is not necessary to discover the entire matrix or measure the proportional impact of each stressor before I may make a comment or recommendation in respect of any one of those stressors. It is sufficient if I am satisfied that a particular stressor had a material adverse impact upon his state of mind so that it, more likely than not, contributed to his decision to take his life. I am so satisfied in respect of the persistent concern Mr Jovanoski had about the likely return of his cancer in combination with the ongoing delay to his treatment, which would have been evident to him. Accordingly, the submission that there is no sufficient causal connection between the failures to get Mr Jovanoski to his medical treatment in Melbourne and his decision to end his own life is rejected.

93. I accept that the staff at FCC responded reasonably and appropriately to Mr Jovanoski's threat of self-harm on 15 March 2018. His suicide was clearly an unexpected shock which was very distressing to them given their investment in his wellbeing and the relationship that they had developed with him. However, the unpredictability of Mr Jovanoski's suicide does not lead to the conclusion that it is not possible to identify factors which may have contributed to his decision. This is necessarily an exercise in hindsight but it is an exercise that is undertaken to establish the circumstances of Mr Jovanoski's death and not to cast blame or establish liability.

94. The Secretary has noted in her submission that, save for being in custody, Mr Jovanoski had none of the factors identified by the World Health Organisation (**WHO**) to identify prisoners at high risk of suicide. However, the WHO has noted that:

> *Whatever individual stressors and vulnerabilities may be operating, a final common pathway leading an inmate to suicide seems to be feelings of hopelessness, a narrowing of future prospects and a loss of options for coping. Suicide comes to be viewed as the only way out of a desperate and hopeless situation.*[55]

95. As noted above, it is not possible to know exactly what combination of factors and stressors led to Mr Jovanoski deciding to take his life on 11 April 2018. However, I am comfortably satisfied that the failure to facilitate timely medical treatment for the suspected return of his throat cancer likely contributed to Mr Jovanoski feeling a sense of hopelessness and desperation in relation to his situation, which in turn, was a motivating factor in his decision to take his life. I consider that this inference is available and appropriate given that his anxiety about his condition and the delay in treatment was a matter that he regularly raised with the staff at FCC and with more frequency than any other stressor. Further, it is clear from his assessment by Mr Young on 15 March 2018 that the principal reason for his threat to jump from the *"top tier"* of the unit earlier that day was his frustration and exasperation at the cancellation of his medical appointment at St Vincent's the previous day.[56]

96. It follows that I am also comfortably satisfied that the delay in providing medical treatment to Mr Jovanoski is a circumstance sufficiently connected with his death under s67 of the Act to justify consideration by the Court in this inquest and to form the basis of comment and recommendations.

[55] World Health Organisation Department of Mental Health and Substance Abuse, *Preventing Suicide in Jails and Prisons*, 2005, p 7.
[56] T127; T145.

FINDINGS AND CONCLUSION

97. Having held an inquest into the death of Mladen Jovanoski, I make the following findings, pursuant to section 67(1) of the Act:

    a. the identity of the deceased was Mladen Jovanoski, born on 12 May 1960;

    b. the death occurred on 11 April 2018 at the Alfred Hospital, 55 Commerical Road, Melbourne;

    c. from the consequences of multiple injuries; and

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

COMMENTS

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

98. Prisoners in Victoria are entitled to receive medical treatment of an equivalent standard to that received by people in the community. The medical treatment provided to Mr Jovanoski by the employees of GEO was of a high standard and reflected an admirable level of professional competence and empathy. It is clear they were invested in his wellbeing and were distressed by the circumstances of his death.

99. Mr Jovanoski required urgent medical treatment for the suspected return of his thyroid cancer. At the time of his death, he had been waiting for this treatment for 4 months. Despite the consistent efforts of the medical staff at FCC to facilitate this treatment, Mr Jovanoski was not able to be transported by Corrections Victoria to St Vincent's Hospital to receive it prior to his death. The delay in providing Mr Jovanoski with his urgent medical treatment was significant and not consistent with the standard of medical care available in the community.

100. Appointments to receive treatment for his thyroid cancer had been made for Mr Jovanoski on three occasions prior to his death, but they were all cancelled. In this case, the seriousness of Mr Jovanoski's condition and the urgency of his treatment was not communicated to the right people at the time of the cancellation of his appointments. It is essential that there be clinical

input into a decision to cancel the transport of a prisoner to obtain medical treatment at a tertiary hospital so that an informed assessment can be made of any competing priorities and whether the cancellation is appropriate in the circumstances. Corrections Victoria have recognised the importance of this issue and updated relevant procedures to ensure that it is addressed. However, the updates do not specifically require the HSM of a prisoner's home prison, where relevant, to be included in the clinical consultation.

RECOMMENDATIONS

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

i. That Corrections Victoria consider further updating its procedures to require that any decision to cancel a medical transfer must, where relevant, first involve referral to the Health Services Manager at the prisoner's home prison or a clinician who is best placed to advise on the priority to be given to the case.

ii. That Corrections Victoria implement a policy to require all persons involved in a decision to cancel a medical transfer to record: the circumstances; the reasons; and the persons involved, and implement a system for doing so.

iii. That Corrections Victoria and Justice Health develop a tool to guide persons in an operational setting so that an anticipated cancellation of a transfer may be properly escalated in advance of the potential loss of the scheduled medical appointment.

iv. That Corrections Victoria investigate the feasibility of adding a warning flag (not containing any medical information itself) in the Prisoner Information Management System (**PIMS**) or other system to highlight the need for priority of a medical transfer where clinically indicated.

v. That Corrections Victoria investigate the feasibility of adding an alternate intermediate location in the PIMS where the circumstances relating to the individual prisoner allow.

vi. That Corrections Victoria re-establish its quarterly governance forum or comparable process capable of monitoring its response to issues identified, and recommendations made, by JARO, Justice Health or similar entities.

I convey my sincerest sympathy to Mr Jovanoski's family.

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

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

Vasa and Sash Lopaticka, Senior Next of Kin

Sergeant Benjamin Tobias, Coroner's Investigator

Secretary to the Department of Justice and Community Safety

GEO Group Australia Pty Ltd

Signature:

Coroner David Ryan

Date: 11 July 2022

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