IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 005235

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: MICHAEL SCOTT WYLY

Delivered On:	27 July 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	20 January 2012
Findings of:	JOHN OLLE, CORONER
Representation:	Ms Debra Coombs, Barrister, on behalf of Corrections Victoria; Mr Paul Halley, Barrister, on behalf of Dr Alexandra Welborn; Mr John Goetz, Barrister, on behalf of Forensicare. Ms Marnie O'Brien, Solicitor, on behalf of GEO/Pacific Shores Health;
Police Coronial Support Unit	Senior Sergeant David Dimsey

I, JOHN OLLE, Coroner having investigated the death of MICHAEL SCOTT WYLY

AND having held an inquest in relation to this death on 20 January 2012
at Melbourne
find that the identity of the deceased was MICHAEL SCOTT WYLY
born on 3 November 1966
and the death occurred between 22 November 2008 and 23 November 2008
at Melbourne Assessment Prison, Spencer Street, Melbourne, Victoria 3000

from:

1a. HANGING

in the following circumstances:

1. Michael Wyly was charged with the murder of his partner and remanded into custody on 24 September 2008. His arrest followed a lengthy siege involving police. Mr Wyly had self harmed during the siege, his injuries subsequently treated.

2. On the morning of 23 November 2008, Mr Wyly was found hanging in his cell at the Melbourne Assessment Prison (MAP).

3. Mr Wyly died in custody and accordingly a mandatory inquest has been conducted. My investigation has focused on the management of Mr Wyly, in particular his suicide and self harm risk whilst a prisoner at MAP.

4. I note the full cooperation of interested parties and the able assistance provided by Counsel. Further, I thank the Office of Correctional Service Review, for provision of the comprehensive report into the death of Mr Wyly, and the detailed report of Mr Rod Wise, Deputy Commissioner Operations, Corrections Victoria. Finally, the statements and evidence at inquest of Forensicare staff, has greatly assisted my task.

5. <u>Chronology</u>

21 September 2008 - Mr Wyly's defacto is killed and siege unfolds

23 September 2008 – Mr Wyly was arrested.

24 September 2008 – Mr Wyly reception into MAP and housed in the Acute Assessment Unit (AAU).

16 October 2008 – Mr Wyly discharged from the AAU into main stream unit at MAP.

17 October 2008 – Mr Wyly transferred to the St Augustine's Ward at St Vincent's Hospital.

22 October 2008 – Discharged from St Augustine's Ward to MAP. Admitted to the AAU.

12 November 2008 – Mr Wyly discharged from the AAU to mainstream unit MAP. Placed in double cell.

13 November 2008 – Prison staff downgrade 'V' rating to V2.[1]

15 November 2008 – Psychiatric review - at 10.30am SASH downgraded to S3; at 2.00pm SASH downgraded to S4.

19 November 2008 – Dr Welborn spoke briefly with Mr Wyly, who claimed he was *"doing well"*.

20 November 2008 - Moved to single cell.

22 November 2008 – Staff assess Mr Wyly appearing normal throughout the evening.

23 November 2008 – Mr Wyly found deceased at count at 7.38am.

At 10.11pm on 22 November 2008, Mr Wyly telephoned his brother Shane. The call lasted approximately 10 minutes. Shane later explained Mr Wyly gave no indication of suicidality.

6. Decision to discharge Mr Wyly from the AAU on 12 November 2008

I have heard evidence from Dr Welborn. I am satisfied that the decision to discharge Mr Wyly from the AAU was made following the comprehensive clinical review and assessment of Dr Welborn.

[1] OCSC review determines the decision appeared correct, however there were no notes in the IMP to explain the decision.

7. The 15 November 2008 Assessment by Todd Davies

Todd Davies was an impressive witness. Mr Davies would liked to have known that Mr Wyly was moved to a single cell on 20 November. His psychiatric assessment of 15 November had noted Mr Wyly considered the presence of a cell mate, beneficial. Mr Davies mental state assessments of Mr Wyly were comprehensive. Dr Welborn reviewed the clinical judgements of Mr Davies and fully endorsed his clinical decision of 15 November[2].

Mr Davies identified the following improvements, following the death of Mr Wyly:

a. There is now a Sentence Management Unit (SMU) panel member at every daily review (HRAT) meeting.

b. The views of psychiatric staff at daily meetings are now acknowledged by SMU and invariably followed. Prior to Mr Wyly s death clinical staff were unaware that they could request the shared cell for a prisoner.

c. Following Mr Wyly's death a clinical care coordinator attended HRAT meetings and would ensure that any change in rating 'S' for suicide rating of a prisoner is entered on the e-Justice system.

d. It is noted that at the time of Mr Wyly's incarceration, a prisoner could not be housed in main stream without a S3 or S4 rating. At his psychiatric review on 15 November, Mr Davies noted the rating was incorrectly nominated at S2. He corrected the rating accordingly to S3. Unfortunately, there were no documenting records. The participation of SMU and a clinical care coordinator at all HRAT meetings will address this previous oversight.

e. Subsequent to Wyly's death there is now a mandatory psychiatric review three days following discharge from Unit 13 or the AAU.

f. There is a further mandatory psychiatric review 7 days following discharge from Unit 13 or AAU. The prisoner will remain on hourly observations until seven days post discharge from Unit 13 or the AAU.

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[2] T41

g. Finally Mr Davies, a clinician who I consider vastly experienced and diligent was firm that the views of mental health clinicians are now being heard by SMU and further documentation since Wyly's death is much improved.

8. I am heartened to acknowledge the above lessons have been implemented, and according to Mr Davies represent significant improvement. The improvements were the direct result of a robust internal review of the circumstances of Mr Wyly's death.

9. It is important to note that the work undertaken by clinicians in the custodial system is often thankless. They perform a valued and vital role in our custodial system. It is crucially important that systems operate in a manner, which assists mental health clinicians carry out their important, onerous responsibilities.

Appointment of a Ward Clerk

10. The appointment of a Ward clerk following discharge from the AAU or Unit 13, would be a significant enhancement to information flow. Any person, in particular family members, may have valuable information to convey to mental health clinicians. Someone to call to convey the information has obvious benefits. I note the submission of Corrections Victoria dated 29 March 2012, is opposed to the appointment of a Ward clerk:

> *"Should family have concerns about prisoners who have been discharged from AAU, they would contact prison staff, who will refer the call to the appropriate contact. Once prisoners have left Forensicare's treatment, it is not practical for it to have contact with a prisoner, when it has no more connection with that prisoner."*[3]

12. Despite the difficulties identified above, I consider the appointment of a Ward clerk for a prisoner upon discharge from Unit 13 or the AAU a necessary initiative, to best ensure that information, which could be relevant to the exercise of clinical judgement of mental health clinicians is conveyed in a timely manner. The safety and welfare of the discharged prisoner is paramount.

13. The submission of Corrections Victoria highlights the need to consider the range of operational issues, which impact on prisoner placement decisions. For example double or single cell. I accept this reality. If a request of a mental health clinician that a prisoner reside

[3] Submission Corrections Victoria 29 March 2012.

in a double cell is rejected for other operational considerations, the mental health clinician may re-assess the appropriateness of mainstream placement.

14. I was assisted by the further submission of Forensicare dated 13 February 2012. All matters raised in the communication are appropriate and have fully and satisfactory addressed the issues raised in the course of the inquest.

Cell Design

Mr Wise provided a cell design update:

> *"I believe it is important to provide an overview of the prisoner accommodation at the Melbourne Assessment Prison (MAP), and the recent cell safety upgrade works."*[4]

15. Mr Wise explained that initial cell safety upgrade works at the MAP focussed on small specialist units on level 5, which accommodate prisoners with increased psychiatric, self harm and protection needs. Mr Wyly was housed in main stream accommodation on levels 3 and 4, which were not upgraded under the Building Development and Review Project (BDRP) at the time of Mr Wyly's death.

16. Mr Wise explained however:

> *"However, in response to the increased number of unnatural deaths at the location, in December 2010, significant funding was reprioritised to complete cell safety works on three of the six mainstream units. This work is due for completion on 20 October 2011 and the department is currently considering further funding opportunities to complete the works at the prison. Until all cells have been upgraded, the prison has implemented policy to ensure that the prisoners with an identified suicide and self risk rating (S1, S2 and S3) are accommodated in BDRP-Compliance cells at the MAP."*[5]

17. 23 November 2008

At 7.38am on the pre-letout count of prisoners, Mr Wyly was found by custodial staff to be hanging from a bed sheet in his cell.

18. The sheet had been threaded through small air vent holes high in the corner of his cell. It appeared he had removed the mattress from his bed and raised its wire mesh base onto its side, creating sufficient height to enable him to stand on the bed and reach the holes in the air vent.

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[4] Report Corrections Victoria 17 October 2011.

[5] Report Mr Wise.

19. I am satisfied that all staff response endeavours were appropriate but sadly Mr Wyly was unable to be revived.

20. I endorse all endeavours to ensure that the BDRP upgrade is undertaken as swiftly as possible.

21. A suicide note written by Mr Wyly was located in his cell. He expressed concern about his access to funds. I note a number of recommendations set out in the report of the Office of Correctional Service Review. I endorse the recommendations as appropriate and urge their implementation.

Post Mortem Medical Examination

22. On 23 November 2008, Dr Sarah Parsons, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Michael Scott Wyly.

23. Dr Parsons found the cause of death to be hanging. Dr Parsons commented:

> *"There is no evidence of natural disease contributing to death. The findings at post-mortem are consistent with the reported circumstances."*[6]

RECOMMENDATIONS

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

1. The safety and welfare of a prisoner is paramount. A Ward clerk would be a readily identified conduit for potentially vital information to be conveyed to mental health clinicians.

   I recommend that the Office of Corrections appoint a Ward clerk for all prisoners discharged from either Unit 13 or the AAU.

2. I consider a discharge sheet should be provided to mental health clinical staff upon transition of prisoners into mainstream prison. The discharge sheet should contain a summary of the prisoners AAU history and include relevant information.

   I recommend that Forensicare provide a discharge sheet to mental health clinical staff upon discharge from Unit 13 or the AAU.

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[6] Comment section Dr Parsons report.

Finding

I find the cause of death of Michael Scott Wyly is hanging in circumstances in which he intentionally ended his own life.

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

The family of Michael Scott Wyly,

Corrections Victoria.

Signature:

JOHN OLLE
CORONER
27 July 2012