IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 4132

REDACTED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of PB

without holding an inquest:
find that the identity of the deceased was PB
born on 30 October 1968
and the death occurred on or about 24 August 2009
at Jetty Road Car Park, Sandringham, Victoria 3191
from:

1 (a) CARBON MONOXIDE POISONING

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr PB was 40 years of age at the time of his death. He lived in his own home at Carrum Downs with his brother and his friend MB. PB was employed by a fisheries company as a delivery driver.

2. PB had a criminal record that commenced in 1995. All crimes were of a sexual nature, in the main, involving children. PB was isolative, lonely and spent a lot of his time watching television.

3. At the time of his death, PB was on a Community Based Order (CBO) administered by the Office of Correctional Services. The CBO commenced from his release from custody on 23 March 2009, and was scheduled to end on 22 September 2010. The CBO required PB to attend regular[1] supervision, with a Community Corrections Officer, undergo assessment and

[1] Unspecified frequency

treatment for alcohol or drug addiction and undergo assessment and intervention as directed by the Sex Offender Program. The Victoria Police LEAP record for 23 March 2009 in the Victoria Police Brief states PB was to *Undergo Sex Offender Programme.*

4. On 10 August 2009, during his annual mandatory Sex Offenders Registry interview with Victoria Police Detective Senior Constable Morris, PB disclosed he had rented out a room in his house to MB, who had children who stayed over. Detective Senior Constable Morris informed PB that he was breaching the *Sex Offenders Register Act 2004* (Vic) by having unsupervised contact with children. Detective Senior Constable Morris then informed PB that Victoria Police would undertake further investigations.

5. On 14 August 2009, PB telephoned his brother from Southern Cross Station. He was distressed and crying and PB told his brother he was leaving Melbourne, he would not go back to prison and he had done nothing wrong. At the time, his brother did not know what had prompted the telephone call. His brother convinced PB to return home. He checked on his brother some hours later and PB told him he was okay.

6. On 16 August 2009 at 2335hrs, PB was escorted by Victoria Police under Section 10 *Mental Health Act 1986* (Vic) to Peninsula Health Frankston Hospital Emergency Department after being found in his car at the Mornington Snapper Point Drive car park, where he was attempting to kill himself by carbon monoxide poisoning using his car. He had started rigging the car and had enough equipment to complete the suicide attempt. PB told Senior Constable Melanie Brennan: "I'm not a nice man, I'm not a nice man, I'm not a nice man".

7. On 16 August 2009 at 2336hrs, in the Emergency Department (ED) at Frankston Hospital Ms Karen Gardner (Registered Nurse Division 2) triaged PB with immediate referral to the Peninsula Health Frankston Hospital Emergency Department Consultation Liaison Inpatient Service Psychiatric Service (CLIPS). Ms Karen Harris (Registered Nurse Division 1) commenced a psychiatric assessment of PB at 0010hrs. Ms Harris rated as medium, PB's risk of self-harm and discharged him home via a taxi with directions to go to work, contact his Private Psychologist for an earlier appointment and to ring the Southern Health Triage Service[2] if he needed to.

[2] The Southern Health Triage contact details card was in the possession of PB at the time of his death.

8. PB had supervision appointments regularly with his Community Corrections Officer (CCO), Ms Claire Rankin. His last two contacts with Ms Rankin were on 20 July 2009 and 17 August 2009, the day after his presentation to Frankston Hospital. At both appointments, PB reported he was depressed. The CCO completed the departmental Victorian Intervention Screening Assessment Tool (VISAT) and PB reported he had suicidal thoughts, but after discussion with Ms Rankin, he reportedly did not have plans to suicide. It was suggested to PB by Ms Rankin he contact his General Practitioner and his Private Psychologist, Mr Leslie Thornton.

Events proximate toPB's death

9. PB's friend and tenant had two children and two stepchildren, some of whom spent weekends with their father at the Carrum Downs home. On 21 August 2009, the Sexual Offences and Child Abuse Investigation Team (SOCIT) and Department of Human Services staff interviewed one of the children and his mother. The child alleged that PB committed indecent acts.

10. On 22 August 2009, PB's friend and PB went out to the local hotel and had a *good night* and PB was said to be *in good spirits*.

11. On 24 August 2009, PB had a Victoria Police scheduled arrest for 1000hrs with Detective Senior Constable Morris at the Frankston Police Station. The arrest related to PB's breach of the *Sex Offenders Register Act 2004* (Vic). PB also had an appointment with his CCO Claire Rankin, at Frankston for the same day at 0930hrs.

12. On 24 August 2009 at 0655hrs, Victoria Police attended the Jetty Road Car Park at Sandringham Victoria after a woman walking her dog came across PB in his car. He had rigged his car to enable exhaust fumes to enter the cabin of the car. Ambulance Paramedics attended and pronounced PB dead at the scene at 0700hrs.

Investigation

Medical Investigation

13. Victorian Institute of Forensic Medicine (VIFM) Forensic Pathologist, Associate Professor Dr David Ranson, conducted an external examination on the body of PB and reviewed the Police Report of Death for the Coroner, Form 83. No evidence was identified of any significant injuries to indicate the involvement of other parties and toxicological analysis identified the

presence of carboxyhaemoglobin at a level of 78% saturation, which is a level known to cause death. Associate Professor Dr Ranson attributed the cause of death to carbon monoxide poisoning.

Police Investigation

14. No suspicious circumstances were identified. No "suicide note" was located.

15. In a statement to Police, PB's brother said that he had found PB's completed tax return for the year and his room had been left clean and tidy with folded clothes all of which he stated, was unusual.

Coroners Prevention Unit

16. The Coroners Prevention Unit (CPU)[3] provided assistance to the investigation by reviewing the health care provided to PB in the lead up to his death and commenting on the provision of his care in light of current accepted practice. The review of the services involved with PB included:

- Community Correction Services;
- Peninsula Health Mental Health Service;
- Leslie Thornton, Private Psychologist; and
- Sex Offender Management Branch.

Service response to PB's mental health issues

17. PB presented to Community Correctional Service and the Peninsula Health Frankston Hospital Emergency Department in the week prior to his death on 24 August 2009 and to his Private Psychologist Leslie Thornton, one month prior on 27 July 2009. PB's last contact with his General Practitioner Dr Robert Jordan was 25 May 2009.

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

Community Correctional Officer

18. PB had supervision appointments regularly with his CCO, Ms Claire Rankin. His last two contacts with Ms Rankin were on 20 July 2009 and 17 August 2009. At both appointments, PB reported he was depressed. The CCO completed the departmental Victorian Intervention Screening Assessment Tool (VISAT) and PB reported he had suicidal thoughts, but after discussion with Ms Rankin, he reportedly did not have plans to suicide. It was suggested to PB by Ms Rankin that he contact his General Practitioner and his Private Psychologist Mr Leslie Thornton.

19. On 17 August 2009, the CCO Ms Rankin encouraged PB to involve himself in community-based services and discussed making a referral to Forensicare for support until he was commenced on the Sex Offenders Program. It is not clear in the *Office of Correctional Services Review Offender Death Report*[4] if this referral took place.

20. The *Office of Correctional Services Review Offender Death Report* listed dates for supervision by Community Correctional Services are monthly once initial assessment was completed. However, the report then states Ms Rankin was concerned enough about PB's mental state to increase the frequency of his supervision from fortnightly to weekly and the next follow-up appointment with Ms Rankin was for the 24 August 2009, the day of his death. The appointment card in PB's wallet at the time of his death supports this. The CPU did not have access to the Community Correctional Officer's notes to clarify what was the required supervision period. Ms Rankin also made contact with Mr Thornton but the details are not available.

Frankston Hospital Emergency Department

21. Victoria Police transported PB under Section 10 of *Mental Health Act 1986* to the ED and Karen Gardner (Registered Nurse Division 2) triaged PB at 2336hrs on 16 August 2009 with immediate referral to the Peninsula Health Frankston Hospital ED Consultation Liaison Inpatient Service (CLIPS) Psychiatric Service. Ms Harris commenced a psychiatric assessment of PB at 0010hrs. Ms Harris rated as medium PB's risk of self-harm. Ms Harris identified PB's issues as related to his self-disgust about his paedophilic thinking patterns and his guilt related to his recent re-offending.

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4 Victoria Police Brief of Evidence for the Coroner for PB, pages 28-34.

22. Ms Harris's formulation[5] was *Paedophilia*[6] and her discharge plan was to discharge PB home via a taxi with directions to go to work on 17 August 2009, contact his Private Psychologist for an earlier appointment and to ring the Southern Health Triage Service[7] if he needed to. Ms Harris had reportedly faxed a copy of her assessment to the Southern Health Triage service on 17 August 2009.

23. The review failed to locate any record of Peninsula Health Mental Health Services or the Frankston Hospital ED having forwarded information to the care providers listed in the discharge plan, or having provided follow-up contact directly to PB.

Mental health assessment

24. Ms Harris's assessment of PB's mental state and suicide risk took no longer than twenty minutes. This is significant in the context of PB having been transported under Section 10 *Mental Health Act 1986* by police following their interrupting what was a serious suicide attempt with a clear plan, in the process of being carried out with intent and means.

25. Sands[8] (2009) states suicide (risk) assessment, provided by specialist psychiatric staff as:

> *Refers to the establishment of a clinical judgement of risk in the very near future, based on the weighing of a very large mass of available clinical information.*
>
> *Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is reasoned, inductive process, and a necessary exercise in estimating probability over short periods.*

26. In other words, good psychiatric assessment expects the inclusion of all available information.

27. PB did not kill himself for another week and the assessment outcome by Ms Harris may have been unchanged had she spent more time completing the assessment, as PB may have continued to deny any current ideation.

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5 A formulation is conclusions about diagnosis and aetiology summarised with a list of outstanding problems, and a list of any further investigations required. A concise plan of treatment is outlined.

6 ICD-10 International Classification of Diseases. F65.4

7 The Southern Health Triage contact details card was in the possession of PB at the time of his death.

8 Sands, N (2009) *Mental Health Triage Education Program*. The University of Melbourne, Melbourne. pp 53-45

a. *Sometimes a person may deny their suicidality while waiting in the ED for an assessment. They may suddenly appear much calmer. The inherent risk in this situation is that the person may have decided to carry out a suicide plan and wants to avoid detection. In this case, it is important to look at the seriousness of the suicidal behaviour; if it was of moderate intent and with some degree of planning, it is best to assume the suicidal crisis is not over, despite the apparent resolution of distress. The fact that the person presented to an ED means that there is a risk of suicide, which continues for some time*[9].

28. The review identified that there was a lack of communication of the assessment of PB by Ms Harris to the GP and/or the Private Psychologist whom she was aware were involved in PB's care. Once an attempt of any lethality is made, the risk of future and more serious attempts and completion increases significantly. The significance of a prior suicide attempt is increased in importance to the current assessment if it is recent, relatively lethal and more death-intentioned and did not lead to a positive therapeutic experience for the patient[10]. The assessment of the acuity of suicide plans is difficult, and the patient's denial of a plan can be a sign of increased planning or more immediate risk as much as an honest reflection.

29. In addition, there appears to be a lack of any follow-up by the Peninsula Health Mental Health Services of PB, a person who had been transferred under Section 10 of *Mental Health Act 1986* (Vic) following a serious suicide attempt, albeit interrupted. Evidence suggests that follow-up care improves with timely contact with other involved providers. Providing a detailed record of contact with the person's provider, in this case his General Practitioner or Private Psychologist facilitates this.

30. It is not clear from the review if Ms Harris asked PB's permission or offered to notify his General Practitioner or Private Psychologist of his presentation to the ED.

Follow-up to CLIPS assessment

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9 Mental Health, Drugs & Regions branch, Victorian Government Department of Health 2010. *The suicidal person: Clinical practice guidelines for emergency departments and mental health services.* Accessed at www.health.vic.gov.au/mentalhealth on 14 December 2010.

10 Wasserman, D, & Wasserman, C. 2009. The Oxford Textbook of suicidology and suicide prevention: A global perspective. Oxford: Oxford University Press. pp.402

31. The Southern Health Triage Service was faxed the assessment by Ms Harris on 17 August 2009. Southern Health Triage did not react to the faxed information by contacting PB. It is good practice to contact all clients who have presented to an ED on the next working day, particularly patients who are currently under stress and who had presented in crisis following a serious suicide attempt, especially in the context of neither provider involved in his care being notified. The Department of Health 2010 document *Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services*[11] summary of recommendations cites the main principles for staff to consider in the assessment and management of people at risk of suicide. They are information gathering, thorough assessment, secondary consultation/debriefing/supervision, and decision making that is clear and communicated to those involved. The suggested outcomes to an assessment are:

- A follow-up plan documented and communicated to the person and significant others;
- Mental health team follow up all people within 48 hours of discharge, where possible.

Private Psychologist Leslie Thornton

32. Mr Leslie Thornton, a clinical Private Psychologist had been providing psychology services to PB from 18 March 2009 after referral from his General Practitioner Dr Robert Jordan. Mr Thornton completed face-to-face consultations with PB on 18 March 2009, 6 April 2009, 15 June 2009 and 27 July 2009. Mr Thornton's statement is not clear about what therapies were undertaken in these sessions but it does suggest he only became aware of PB's current depressive symptoms after his conversations with CCO Claire Rankin. PB had disclosed previous suicidal thinking during a previous stressful event in his life.

33. The *Office of Correctional Services Review Offender Death Report* indicates Mr Thornton had discussed stress management, vulnerabilities and avoidance in relation to PB's offences. Mr Thornton's response to contact from Ms Rankin was to discuss these symptoms with PB at the next appointment in August 2009.

34. It is not clear from the review when in August this appointment was scheduled.

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[11] Victorian Government, Department of Health, Mental Health, Drugs & Regions Branch, 2010 Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services Melbourne, Victoria.

General Practitioner Dr Robert Jordon

35. Dr Robert Jordon's last appointment with PB was on 24 May 2008, for post-surgical wound infection after PB's inguinal hernia repair at Frankston Hospital in May 2008. PB's last recorded consultation at the Carrum Downs Medical Centre was on 24 May 2009. Dr Jordan reports there was no indication of PB having any mental health disease in his clinical file.

36. The absence of this information makes it unclear why Dr Jordon made the referral for PB for psychology services.

State Government of Victoria activities

37. The 2008 State Government of Victoria Protocol between Department of Health Mental Health, Drugs and Regions Division[12] and Community Correctional Services[13] [14]outlines the responsibilities of both departments when working with a patient on any order[15] imposed by a court. The protocol covers direct service delivery of mental health services to patients in combination with Corrections Services. It provides details on who should refer to the mental health service, how to make contact, which will result in telephone advice and referral, crisis intervention or arrangement of a more detailed assessment later. It lists suicidal thoughts or acts of self-harm and significant changes of mood, such as pronounced depression, pronounced anxiety[16], as indicators of mental illness, which should result in a Community Correctional Officer considering a mental health service assessment.

38. The protocol[17] is clear in recognising the vulnerability of Community Correctional Service clients to mental health problems especially at transition points. The transition points listed are movement between prison and Community Correctional Services, movement between area mental health services and Community Correctional Services, completion of court orders and other relevant changes in treatment circumstances.

> *It is expected that clinical case managers working in Area Mental Health Service (AMHS) routinely ask clients whether they are involved with other*

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[12] Department of Human Services
[13] Department of Justice
[14] State Government of Victoria 2008 *Protocol between Mental Health Branch and Community Correctional Services.* www.health.vic.gov.au/mentalhealth accessed 12 April 2011.
[15] Community based order; intensive correction order; combined custody and treatment orders; parole orders and interstate orders.
[16] Section 4.1 Who should be referred.
[17] Section 4.9 Transition Points

services, including Community Corrections Service (CCS). Similarly, CCS staff should routinely seek information from clients regarding whether they are in receipt of treatment by health services (including mental health services), regardless of whether it is a requirement of their orders[18].

39. Neither Ms Rankin nor Ms Harris communicated the experience of PB to the other service, or to the GP, although Ms Rankin was proactive in contacting the private psychologist involved and the Sex Offenders Program when she became aware of PB's suicidal thinking. On 17 August 2009, PB claimed to Ms Rankin to have no plan to kill himself. It is possible Ms Rankin would have had a different interpretation if she had been aware of the suicide attempt some ten hours prior, although it is not clear in the protocol if Ms Harris would have been expected to notify Community Correctional Services of PB's presentation and discharge plan.

Privacy and exchange of information

40. Usual confidentiality issues apply including those of Community Corrections Services and Mental Health, Drugs and Regions Division. No evidence was identified of an attempt by Ms Harris to gather collateral information from PB's family. His records indicate that PB had no family to contact but this was incorrect.

41. The disclosure of personal information should be in the best interests of the patient, and the treating clinician must balance the need for disclosure with the right to privacy.

Sex Offender Program

42. A review of the access to the Sex Offender Program was undertaken because a review of the information available suggested that PB's re-offending, his associated guilt and the probability of a return to prison may have triggered his decision to take his own life.

Sex Offender Program details

43. Sex Offender Programs target all convicted sex offenders in Victoria, whether sentenced to prison or a community disposition. The programs also target offenders who have a sexual

[18] Section 4.10 Working together and collaboration.

element to their crime. The main aim of these programs is to protect the community by reducing the likelihood of sexual re-offending.

44. Corrections Victoria's sex offender programs staff are primarily located at the Carlton Community Correctional Services, the Ararat Prison and Marngoneet Correctional Centre. They provide a range of services including assessment, intervention, staff training, consulting, research and evaluation.

45. Corrections Victoria's Sex Offender Management Branch, which incorporates Sex Offender Programs, was established to ensure a streamlined, whole-of-system approach to the management of sexual offenders in Victoria. The Sex Offender Management Branch, coordinates specialist service delivery, has implemented a quality system of targeted case management and ensures the identification and effective supervision of high-risk sexual offenders. In line with the revised service delivery model[19], the Sex Offender Program has implemented structural changes to improve its capacity to meet demands and ensure high quality assessments and interventions.[20]

Available Sex Offender Programs

46. It is not clear what programs were available to PB or which programs, if any, he was assessed as eligible to attend. The most recent evaluation of the Sex Offender Program completed in 2008 by Deakin University[21]lists three program types:

- Skills Based Intervention Program specific to men with special needs[22].
- Modular Management and Intervention Program, which is tailored to medium to high-risk sex offenders with a conviction of child molestation or rape. In the community, the

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19 2002-2006

20 http://www.justice.vic.gov.au/wps/wcm/connect/justlib/DOJ+Internet/Home/Prisons/Prisoners/Prisoner+Programs/JUSTICE+-+Treatment+Programs
EVALUATION OF CORRECTIONS VICTORIA SEX OFFENDER PROGRAM RFT 049/ http://www.deakin.edu.au/hmnbs/psychology/pdf-docs/colloquia/reading-for-1-aug-graffam.pdf

21 Graffam, J, Bartholomew T, Carvalho, T, Shinkfield A, & Edwards, D. 2008. Promoting Psychological and Behaviour Change through Structured Intervention. Executive Summary. The Corrections Victoria Sex Offender Program. Deakin University, School of Psychology. Pp 2.

22 It is unclear in the report what the 'special needs' are.

Sex Offender Program is delivered to men in groups of 10-12, in three-hour session once a week[23].

- Maintaining Change Program, available to offenders who are released from custody. The program reinforces what was learned in the Modular Management and Intervention Program, with relapse prevention, so is only available to offenders who have completed that program.

47. In a statement obtained from Ms Melissa Braden, Department of Corrections Victoria Manager of Sex Offender Programs, she said that offenders on community-based orders have priority access based on their order end date, but there are caveats:

> *This depends on factors, including the availability of a treatment place, the appropriate program start date, responsivity factors such as unmanaged mental health issues or general health impediments that may affect the offender's ability in group treatment and the order end date*[24].

48. PB had been assessed as appropriate for the Sex Offender Program but his actual commencement date was impacted on by these caveats.

Sex Offender Program Community Targets

49. The Sex Offender Program has targets for participation. Data available to the CPU on these targets was restricted to 2001-2007[25] with the specific target for community based program involvement being 96 participants.

> *The program had difficulty achieving its annual target for both number of commencements and percentage of completions. Specifically, the annual target of 60 commencements for prison located participants and 96 commencements for community located participants was achieved in one of the four years in the period 2001-2002 through to 2005-2006. The completion target was achieved two of those four years for prison located participants and one of those four years for community located participants*[26].

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23 Ibid, pp 2
24 Statement of Melissa Braden, Manager of Sex Offender Program, Corrections Victoria. 3 August 2011. pp2
25 Graffam et al pp 8
26 Ibid pp 8

50. However, the Sex Offender Program evaluation completed in 2008 by Deakin University found that once in the program there was a *very low and highly satisfactory* withdrawal rate of 9.0% for community participants.

Other support from Sex Offender Program

51. Ms Braden, also stated that additional support is offered to offenders who are awaiting commencement of the program and they benefit from the Specialist Case Management Model utilized by Community Corrections. The model is *Good Lives Model* (GLM); a strengths based approach to sex offender rehabilitation.

52. It is unknown if PB's Case Manager, Ms Rankin had completed the required GLM training or what percentage of the Community Corrections Case Managers have completed it. PB undertook to arrange a referral to a community based Private Psychologist, Mr Thornton and to remain engaged in sessions.

53. The 2008, Corrections Victoria Sex Offender Program[27] evaluation involved participant feedback on all aspects of the program. The wait list and delay on accessing the program is one of the issues raised. All participants stated they had waited at least six month to commence the program once assessed as suitable and they *were not provided with any information regarding when they would be commencing the program, and this had caused a great deal of anxiety and frustration*[28].

PB's referral to Sex Offender Program

54. Community Correctional Services referred PB to the Sex Offender Program (SOP) on 24 March 2009, within the 5-day target period, for clinical assessment. The Sex Offender Program staff notified the Community Correctional Services on 7 April 2009 that PB was suitable for group programs and placed on a waiting list.

55. CCO Ms Rankin contacted the Sex Offenders Program following her appointments with PB on both 20 July 2009 and 17 August 2009. Ms Rankin enquired about the waiting list for PB and a commencement date to start the program. She did so because of concern about PB's

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27 Graffam, J, Bartholomew T, Carvalho, T, Shinkfield A, & Edwards, D. 2008. Promoting Psychological and Behaviour Change through Structured Intervention. The Corrections Victoria Sex Offender Program. Deakin University, School of Psychology. Pp 58.

28 ibid pp60

suicidal ideation and feelings of disgust and guilt. The *Office of Correctional Services Review Offender Death Report* does not provide any information on the details of what was the prospective commencement date for PB to commence the Sex Offender Program.

Commencement of Sex Offender Program

56. PB was released to the community on 23 March 2009 and his CBO commenced. PB was referred to the Sex Offender Program on 24 March 2009 and assessed as eligible by the Sex Offender Program group programs on 7 April 2009. PB's CBO ended on 22 September 2010. Nevertheless, it remains unclear if PB would have been able to commence the program he had been assessed as eligible for and which his participation in was part of his parole conditions.

57. The Sex Offender Program has an average duration of nine months and access is either prioritized or restricted based on the CBO end date. Once assessed as eligible, PB had seventeen months left on his CBO and at the time of his death, 13 months. There has been no information provided by the Sex Offender Program regarding a possible or probable start date for PB in the group program.

Victorian Auditor General's Report November 2009

58. The *Victorian Auditor General's Report Managing Offenders on Community Corrections Orders*[29] reviewed the effectiveness of the current system for managing offenders on orders in the community, including sex offenders. Of relevance, is the finding that Community Correctional Service's ability to monitor the effectiveness of community based treatment programs. This included the appropriateness and timeliness of offenders being able to access the treatment programs. The report recommends Community Correctional Services develop performance measures to assess the timeliness of offender access to programs and services. In addition, it should clarify the accountabilities and responsibilities of Community Correctional Services and assessment and treatment providers, in particular regarding timeliness for reporting on offender management processes, to provide assurance over offender management after referral to treatment services.

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[29] Victorian Auditor General's Report Managing Offenders on Community Corrections Orders. Accessed 2 May 2011. pp17.
http://www.audit.vic.gov.au/reports__publications/reports_by_year/2009-10/20092511_community_corrections.aspx

59. It is reported that the Secretary, Department of Justice, accepted the recommendations of the Auditor-General's Report.

60. Dr Karen Gelb[30] from the Sentencing Advisory Council, 2007 *Recidivism of Sex Offenders* research paper, states:

> *Although costly, successful treatment programs can reduce recidivism and help offenders return to the community*[31].
>
> *The timing of the provision of programs is another challenge facing sex offender treatment programs in Australia. Many offenders only participate in treatment programs towards the end of their sentence as parole approaches or even after parole has commenced. Starting therapy as early as possible after incarceration is crucial as offenders often fail to realise the severity of their crimes, and this aspect of treatment may be hampered by an antagonistic prison environment. Consistent with the principles of therapeutic jurisprudence, early assessment by a sex offender treatment team would help to ensure that an appropriate treatment regime is put in place as soon as possible during an offender's prison sentence (McSherry, 2006, cited by Gelb 2007 p.40).*

COMMENTS

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

1. PB's death occurred on a background of a probability of a return to a custodial sentence following his re-offending with the child of his housemate. He admitted the offence to Victoria Police during the annual mandatory Sex Offenders Registry interview.

2. PB appears to have undertaken a degree of planning of his death after the interruption of a prior attempt 16 August 2009. After he was assessed at the Frankston Hospital ED and attended an appointment with Community Corrections on 17 August 2009, he appears to have organised his tax return, cleaned his room, washed his clothes, finished organising family

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[30] Senior Criminologist Sentencing Advisory Council 2007

[31] Ibid. pp39

photographs, and went out with his best friend. He also ensured he had access to his car. This planning and reconciliation with taking his own life is supported by his brother and housemate's recollections of him in the days leading up to his death who stated that he was *different, nice and more polite and attentive than usual* and *in good spirits*. It is also noteworthy that PB took his life on the day of his scheduled arrest for sex re-offending.

3. PB had sought help from Community Correction Services and Ms Rankin had attempted to gain more support for him in response. On the 17 August 2009, Ms Rankin's last appointment with PB, she was unaware of the serious suicide attempt the night before and subsequent assessment at Frankston Hospital. Ms Harris met the minimum requirements for assessing PB and satisfying herself of his risk before discharging him, however, the apparent lack of referral is disappointing and appears to be of a lesser standard outlined by the current *Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services*.

4. If Community Correctional Services, the Psychologist or GP had been made aware, there may have been a more proactive approach to engaging PB with either his GP and/or Forensicare. There is an apparent lack of communication between the mental health service and the Community Correctional Services. Nevertheless, when regard is given to the lapse of time between Ms Harris' engagement with PB and his death, along with the evidence of significant planning on his part, I am unable to find a direct causal connection between the lack of follow-up/referral and PB's death.

5. PB breached parole conditions that required him to stay away from areas where he had access to children. However, he was also required to participate in the Sex Offender Program and he did make every effort to comply, as did Ms Rankin to enable him to commence, with a timely referral and follow-up contact. It is outside the scope of my investigation to comment on the effectiveness of the Sex Offender Program but the funding of it assumes an evidence base in achieving the Sex Offender Program primary objectives of community protection and reducing the likelihood of sex re-offending. In the case of PB, the program offered a source of support and opportunity for improvement. However, the opportunity to benefit from the program did not occur in a timely way because of complex criteria and an extensive waiting list, resulting in further community impact and in PB's eventual actions.

RECOMMENDATIONS

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

1. To increase the safety of patients who are also registered sex offenders, the Department of Health Mental Health, Drugs and Regions Division and Department of Justice Community Correctional Services, review their application of the *2008 Protocol between Mental Health, Drugs and Regions Division and Community Correctional Services*. Particular emphasis should be given to addressing any perceived barriers to communication between services and a patient's right to privacy.

2. To increase community safety and reduce the risk of sex re-offending, the Sex Offender Management Branch review the process of criteria, assessment, wait listing and commencement of a Sex Offender Program to enable sex offenders who are required to complete the program as part of their parole to participate in the program in a timely manner.

FINDING

I accept and adopt the medical cause of death as identified by Associate Professor Dr David Ranson and find that PB died from carbon monoxide poisoning.

AND I further find that the circumstances surrounding PB's death support a finding that he intentionally took his own life.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that a redacted Finding with Recommendations be published on the internet.

I acknowledge the assistance of the Coroner's Prevention Unit in this matter.

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

PB's brother

Corrections Victoria
22/121 Exhibition St
GPO Box 123
Melbourne Vic 3001

Corrections Victoria Community Corrections Branch
22/121 Exhibition St
GPO Box 123
Melbourne Vic 3001

Corrections Victoria Sex Offender Management Branch
22/121 Exhibition St
GPO Box 123
Melbourne Vic 3001

Adult Parole Board of Victoria
4/444 Swanston St
Carlton Vic 3053

Office of the Chief Psychiatrist
Level 17, 50 Lonsdale Street
Melbourne Vic 3000

Peninsula Health
15-17 Davey Street
Frankston Vic 3199

Signature:

AUDREY JAMIESON
CORONER
Date: 6 September 2012