Department of Justice

Acting Secretary

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Our ref: BC/12/22847

Coroner John Olle
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Coroner Olle

Response to coronial recommendations arising from the coronial inquest into the death of Michael Wyly at the Melbourne Assessment Prison on 23 November 2008

On 27 July 2012, you issued findings following the inquest into the death of Michael Wyly. The inquest determined that Mr Wyly's death was the result of 'hanging' and produced two recommendations. Pursuant to section 72(3) of the *Coroners Act* 2008, the Department has considered the recommendations and provides the attached response, for your consideration.

If you have any queries regarding this matter, please contact Liana Buchanan, Director, Office of Correctional Services Review on telephone 9947 1748.

Yours sincerely

Dr Claire Noone
Acting Secretary

State Government Victoria

Response to coronial recommendations arising from the coronial inquest into the death of Michael Wyly at the Melbourne Assessment Prison on 23 November 2008	
	Department's response
Recommendation 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.*	**An alternative to a coroner's recommendation has or will be implemented.** The department considers that the establishment of a ward clerk would duplicate the mechanisms already in place at the location. The department is satisfied that the arrangements provided in the health services contract at MAP with GEO Care allow sufficient responsiveness to family enquiries by health professionals. Upon receipt of information indicating concerns for a prisoner's mental health from staff, other prisoners or family, the health service provider is required to arrange an 'at risk' assessment by trained staff within two hours. MAP's health service provider at the time of Mr Wyly's death, Pacific Shores Health, required the service to answer and respond to all contact by the family of prisoners accommodated outside of the AAU or Unit 13. The same requirements apply to MAP's new health service provider, GEO Care, who commenced their contract on 1 July 2012. MAP's Visitor Information Sheet, in place since 1999, is available at the prison's entry foyer includes the following text: *Prisoner in Distress – If you are concerned about the safety and welfare of a prisoner, please contact the prison immediately so the situation can be addressed by prison staff.* The Department of Justice' public website also advises families that 'If you are concerned about the safety and welfare of a prisoner, contact the prison's Operations Manager immediately so that the situation can be assessed.' During business hours, family members of MAP prisoners may contact the prison's reception by telephone or in person. The information is provided to staff in the prisoner's unit, who will refer urgent matters to the prison's medical service. Less urgent matters, such as general medical information, will be discussed with the prisoner and appropriate referrals will be made if required. After-hours telephone calls are answered by MAP's control room, who transfer the caller to a 24-hour team of medical/psychiatric nursing staff for appropriate action and record in the prisoner's medical file. Contact between the prison reception and unit staff is recorded in each prisoner's IMP file. Contact referred to GEO Care by prison staff is recorded in the prisoner's medical file by GEO Care medical staff.

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	Department's response
Recommendation 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.*	**An alternative to a coroner's recommendation has or will be implemented.** As the named party in the second recommendation, Forensicare has responded to the Coroners Court directly. Justice Health support Forensicare's submission.