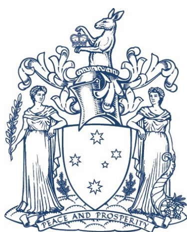

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 2134

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Barry Gray
Delivered on:	17 December 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	14, 15 & 21 April 2021
Counsel Assisting the Coroner:	Ms I Giles, instructed by Ms K Sonneveld
Representation:	Ms S Fitzgerald of counsel on behalf of the Secretary of the Department of Justice and Community Safety, instructed by the Victorian Government Solicitor's Office Mr P Halley of counsel on behalf of Peninsula Health, instructed by HWL Ebsworth Lawyers Ms N Hodgson of counsel on behalf of Forensicare, instructed by Meridian Lawyers

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INTRODUCTION

1. Barry Gray was 72 years old and living at his family's beach house in Rye at the time of his death.

2. On 17 May 2013 his body was found with multiple stab wounds to his chest and neck area in the living room of his house.

3. Mr Gray's 22-year-old neighbour, John Woodruff, was charged with Mr Gray's murder. It was not disputed Mr Woodruff committed this act.

4. On 14 July 2016 a jury found Mr Woodruff not guilty by reason of mental impairment. Mr Woodruff is currently subject to a custodial supervision order and was committed to remain at the Victorian Institute of Forensic Mental Health (**Forensicare**) at the Thomas Embling Hospital.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Gray's death was reported to the coroner as his death was unnatural and as a result of violence and therefore within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**).

6. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[1] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2]

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[4] or to determine disciplinary matters.

8. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. For coronial purposes, the phrase "*circumstances in which death occurred*,"[5] refers to the context or background and surrounding circumstances of the death. Rather than

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[1] Section 89(4) *Coroners Act 2008* (Vic).
[2] Preamble and section 67 *Coroners Act 2008* (Vic).
[3] *Keown v Khan* (1999) 1 VR 69.
[4] Section 69(1) *Coroners Act 2008* (Vic).

being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the investigation findings and the making of comments and recommendations.

11. Following the conclusion of the criminal proceedings against Mr Woodruff a coronial brief was forwarded to the court, and subsequently supplemented by further material. The coronial investigation in this case was undertaken by Detective Sergeant Robert Catania, who was appointed as the coroner's investigator.

12. This investigation was originally with the State Coroner Judge Ian Gray and on his retirement transferred to State Coroner Judge Sara Hinchey. As Acting State Coroner, Iain West then took over the investigation, and following his retirement in April 2019, I assumed carriage of the investigation.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[6] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[7] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

APPLICATION FOR INQUEST

14. On 30 April 2019, Mrs Sandra Gray (**Mrs Gray**) requested an inquest into the death of Mr Gray on the grounds of public health and safety. She stated:

There were two state funded systems who had involvement with the offender in the weeks leading up to his crime, namely Corrections Victoria and Peninsula Health (Mental Health Services) referred by Forensicare. It is the state's responsibility to ensure that the services it provides, looks at public safety as paramount and it is the

[5] Section 67(1)(c) *Coroners Act 2008* (Vic).
[6] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[7] (1938) 60 CLR 336.

public's right to know what system failures led to Barry's death and what changes have been made to ensure this doesn't happen again.[8]

SCOPE OF INQUEST

15. Section 71 of the Act provides that a coroner is not required to make any of the findings specified in section 67 in the circumstances where a person has been charged with an indictable offence in respect of the death, and the coroner considers the making of findings would be inappropriate in the circumstances.

16. In light of the matters raised by Mrs Gray in her Form 26, I decided to hold an inquest.

17. In Justice Hollingworth's Ruling,[9] when considering the effects of Mr Woodruff's offending, Her Honour noted:

    They [Mr Gray's family] also feel angry that Mr Woodruff was released from prison only a few weeks before these events, with what seems to have been inadequate supervision and monitoring of his mental health, after he had been diagnosed with schizophrenia whilst in custody.[10]

18. Between Corrections Victoria, Forensicare and Peninsula Health Mental Health Services, the following facts illustrating gaps in information sharing, were established:

(a) Whilst Mr Woodruff was remanded in custody, Forensicare prepared a pre-sentence psychiatric report for the Magistrates Court, and on 29 April 2013 made an urgent referral to Peninsula Health Mental Health Services for Mr Woodruff to receive post release mental health treatment;

(b) On 23 April 2013 Mr Woodruff was assessed for a pre-sentence report for a Community Correction Order (**CCO**). The Community Corrections case worker was not aware of Mr Woodruff's first episode psychosis in custody, the pre-sentence psychiatric report or the Forensicare referral to Peninsula Health Mental Health Services; and

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[8] Form 26 'Request for Inquest into Death', dated 30 April 2019 and received by the Coroners Court on 3 May 2019. This text is directly quoted and it is noted for completeness that, while the Form 26 refers to the 'crime' of the offender, Mr Woodruff was found not guilty by way of mental impairment on charges that included the murder of Mr Gray.
[9] *DPP V Woodruff* [2016] VSC 525 at [22].
[10] Coronial Brief (**CB**) 387.

(c) Neither Forensicare nor Peninsula Health Mental Health Services were aware that on 30 April 2013 Mr Woodruff was sentenced to a CCO for 18 months with conditions including, amongst others, community work, assessment and treatment (including testing) for drug and alcohol abuse or dependency as directed, and mental health assessment and treatment as directed.

19. Given the time that had passed since Mr Gray's death, I did not call Mr Woodruff's 2013 individual clinicians and case workers as witnesses at the inquest. Instead, I heard evidence from senior management at Corrections Victoria, Justice Health, Forensicare and Peninsula Health Mental Health Services to examine the systemic issues identified in this case regarding information sharing and communication.

20. Although some new programs have been developed since Mr Gray's death, the evidence suggests even today they would not have been appropriate in Mr Woodruff's circumstances, and that little has changed to improve information sharing between the relevant agencies since 2013.

21. The inquest scope considered:[11]

(a) What health information was available to Corrections Victoria when conducting the pre-sentencing assessment of Mr Woodruff? What health information is generally available to Corrections Victoria when conducting pre-sentence assessments of prisoners, and what are the impediments to being advised of health issues, such as a recent mental illness?

(b) What information-sharing arrangements exist between Justice Health and their contracted service providers, Corrections Victoria, and public mental health services, when a person is placed on a CCO after exiting custody, and requires mental health treatment in the community?

(c) What treatment is available in prisons for first episode psychosis, what services are available and how is transition managed into the community mental health services?

[11] Mrs Gray raised a number of concerns prior to the Directions Hearing on 16 October 2020 which are broadly reflected within the scope such as: the relationship or information sharing arrangements between Corrections Victoria and community health services post transition from prison into the community, what were the trigger points for Corrections to be alerted if Mr Woodruff presented as mentally deteriorating or disengaged with the services he had been referred to, and what supports were in place to assist him with engagement. Further, following Mr Gray's death, has there been any changes to the supports offered to promote engagement of recently released medium to high-risk prisoners with community health services.

22. The inquest heard from four witnesses from the following organisations and an expert witness:

(a) Corrections Victoria, a business unit of the Department of Justice and Community Safety. Jenny Roberts, Director of Community Operations, Corrections Victoria gave evidence.

(b) Justice Health, a business unit of the Department of Justice and Community Safety with the responsibility for the delivery of health services for prisoners across Victoria. Justice Health sets the policies and standards of health care in prisons and monitors performance. Scott Swanwick, Director of Health Service and Clinical Governance gave evidence.

(c) Forensicare, a contracted service provider for Justice Health, providing certain mental health services to prisoners. Dr Kate Roberts, Director of Clinical Services (Prisons) gave evidence.

(d) Peninsula Health Mental Health Services is an Area Mental Health Service under the responsibility of the Department of Health. It provides programs for the care, treatment and management of the seriously mentally ill, in both inpatient and community settings. Gracie Tan, Forensic Clinical Specialist gave evidence.

(e) Expert witness Dr Kimberley Dean, Chair of Forensic Mental Health at the University of New South Wales School of Psychiatry gave evidence about best practice care for first episode psychosis in custody and transition to the community.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

23. On 21 May 2013 Warren Gray visually identified his father, Barry Gray, born 8 May 1941.

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

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

25. On 18 May 2013, Dr Melissa Baker, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Dr Baker was unable to complete her written report and Professor David Ranson, Deputy Director at the VIFM, reviewed Dr Baker's findings and provided a written report, dated 28 August

2014. In that report, Professor Ranson concluded that a reasonable cause of death was "*Multiple stab and incised wounds to the chest and neck*".

26. I accept Professor Ranson's opinion as to cause of death.

BACKGROUND

27. On 20 December 2012, Mr Woodruff was sentenced to a CCO at the Frankston Magistrates' Court for 18 months with a number of conditions, including that he attend for mental health assessment and treatment as directed.

28. On 22 January 2013, after further offences were alleged against him, he was remanded in adult custody for the first time. During this period in custody, he was diagnosed with first episode psychosis with an indication this may develop into schizophrenia. He was medicated with olanzapine and his condition was reported to have stabilised.

29. On 13 February 2013, the Magistrates Court ordered a psychiatric report from Forensicare and, separately, a pre-sentence assessment for the purposes of assessing Mr Woodruff's suitability to be placed on a CCO, to be prepared by a Community Corrections officer.

30. On 8 March and 15 April 2013, Dr Bhattacharya from Forensicare assessed Mr Woodruff and prepared a psychiatric report, noting he required ongoing assertive monitoring of his mental health and that at the point of release, this could occur voluntarily, in the community or in a mainstream prison location.[12] On 29 April 2013, Dr Bhattacharya also made an urgent referral for Mr Woodruff via Peninsula Mental Health Triage Service.

31. On 15 April 2013, the Community Corrections officer assessed Mr Woodruff for the pre-sentence report. The Community Corrections officer had limited health information, and relied on Mr Woodruff to self-report his mental health issues. Although Mr Woodruff advised he had been diagnosed with ADHD as a child, he stated he was prescribed medication in custody to help him sleep, and did not advise the Community Corrections officer about his first episode psychosis or that he was recently prescribed olanzapine.

[12] CB 762.

32. On 30 April 2013, Mr Woodruff was sentenced to 98 days in custody, as time already served, and his CCO was varied and extended. The conditions included a mental health assessment and treatment condition. Mr Woodruff was released from custody that same day, and on 2 May 2013 he attended for his CCO induction as required. A question arose at inquest as to whether Mr Woodruff was released from Court with or without his psychiatric medication. The evidence on this point was equivocal, and as I did not hear from witnesses directly involved, I note this only.

33. On 4 May 2013, Mr Woodruff's father telephoned Peninsula Health Mental Health Services via the triage service to check whether Mr Woodruff had made contact and to express his concerns he had not had his medication for three days. He expressed concerns Mr Woodruff was using drugs, would not engage and would 'fall off the rails again'.

34. On 9 May 2013, his Community Corrections officer noted Mr Woodruff had been diagnosed with first episode psychosis as per the Forensicare report dated 23 April 2013, but was still at that stage unaware of the referral to Peninsula Health Mental Health Services. Mr Woodruff had not taken up the referral to Peninsula Health by Forensicare and he was not connected to any mental health service by Community Corrections.

35. On 16 May 2013, Mr Woodruff's father telephoned the Community Corrections officer and expressed his concerns about his son's mental health and that he had not linked in with mental health services. Mr Woodruff's Community Corrections officer contacted Peninsula Health Mental Health Services in Frankston to ascertain the status of Mr Woodruff's referral. She was referred to Bayside House Acute Mental Health team (part of Peninsula Health Mental Health Services) and was told as Mr Woodruff had not engaged with the service, and as his engagement was voluntary, the referral had been closed. She was advised any acute mental health concerns about Mr Woodruff should be referred to the psychiatric triage unit for intake.

36. On the same day, 16 May 2013, at a supervision appointment with Mr Woodruff, his Community Corrections officer questioned him about his lack of engagement with mental health services. He responded that he did not need mental health services. He was directed to make an appointment with a GP for a mental health care plan prior to his next supervision appointment which was scheduled for 22 May 2013.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

Custody 22 January – 30 April 2013

37. Following his being remanded in custody on 22 January 2013, Mr Woodruff was transferred from Frankston Police Station on 24 January 2013 to Melbourne Assessment Prison (**MAP**), and thereafter transferred to the Metropolitan Remand Centre on 1 February 2013. On 23 February 2013, Mr Woodruff was transferred back to MAP due to assist in managing his increasingly serious mental health issues. On 25 February 2013, he was certified by Dr McInerney for transfer to Thomas Embling Hospital under s16(3)(b) *Mental Health Act 1986*, as was then in force.

38. However, the transfer to Thomas Embling Hospital was not effected, and Mr Woodruff was transferred to the Acute Assessment Unit (**AAU**) on 28 February 2013.[13] The AAU is a unit within MAP which has 24-hour mental health nurses and visiting consultant psychiatrists. The AAU is the bridge between the Thomas Embling Hospital and prison. Mr Woodruff remained in the AAU for five weeks and returned to mainstream custody on 3 April 2013.

39. Mr Woodruff was commenced on olanzapine and during his time in the AAU, his P (psychiatric) rating remained at P1 and his S (suicide and self-harm) rating varied between S3 and S2.[14] The highest code or risk rating is 1 meaning an immediate or serious risk, with the lowest risk being 3 or 4 (depending on the code) and denoting a history or suspected risk.[15]

40. In her assessment of Mr Woodruff based on interviews on 8 March and 15 April 2013, Dr Bhattacharya stated: '*All evidence points towards him having experienced a recent first episode psychosis, this may yet develop into a recurrent psychotic illness such as Schizophrenia.*' [16]

41. Between 27 and 29 April 2013, Mr Woodruff returned to the AAU due to further mental health issues. His P rating remained at P1 and his S rating fluctuated between S2 and S3.

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[13] CB 878. Dr Bhattacharya states in her pre-sentence psychiatric report that Mr Woodruff was commenced on olanzapine in March 2013 and his mental health was monitored on the unit. Accordingly, he was not transferred to Thomas Embling Hospital *'[a]s his mental state rapidly improved*' (CB 761).

[14] 'P' rating refers to Psychiatric rating and 'S' rating refers to Suicide and self-harm risk rating.

[15] CB 1646.

[16] CB 762.

42. On 30 April 2013, Mr Woodruff was released from custody on a CCO.

Information available to Corrections Victoria

43. As previously noted, the Magistrates' Court ordered a full pre-sentence assessment of Mr Woodruff whilst he was remanded in custody. The Corrections Victoria Deputy Commissioner's Instruction (**DCI**) 5.1 *Court Assessment and Advice* dated 17 July 2012 was included in the Coronial Brief. The full pre-sentence report is distinguished from the 'on the spot' assessment and requires an adjournment of a case for 4-6 weeks for an assessment. The DCI outlines '*the practices to be undertaken when the judiciary requests a Full Written Pre-sentence report (PSR*)…'

44. Point 10 states:

If the offender is in custody or remand, and it becomes evident during the course of completing the PSR, that they are experiencing significant issues for which they have no support eg homelessness/ poor mental health, this needs to be communicated to the prison program coordinator/ TAP coordinator. This will ensure prison program staff are aware of the issues and can initiate assistance from relevant support services prior to release.[17]

45. The process also refers to:

Upon gathering as much information about the offender as possible ... the assessing officer will also need to deem the offender as either suitable or unsuitable for the order itself.[18]

46. On 15 April 2013, the Community Corrections officer completed a video assessment with Mr Woodruff in order to complete a pre-sentence report.

47. In the pre-sentence report, under *Health History*, the Community Corrections officer noted Mr Woodruff reported he was diagnosed with ADHD as a child and prescribed Zyprexa (olanzapine) and Ritalin, which he stated that he no longer took.

48. She wrote:

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[17] CB 1679.
[18] CB 1696.

Since being placed in custody, Mr Woodruff reports that he has been prescribed sleeping medication in order to help him sleep. He reports that he is not currently linked with any psychologists or psychiatrists, nor has he received any treatment in the past… the writer notes in the police summary … it is mentioned that Mr Woodruff has a previous diagnosis of ADHD as well as bi-polar. The writer has yet to receive any documentation to confirm this diagnosis, nor was this self-reported by Mr Woodruff.[19]

49. The Community Corrections officer was not aware of the Forensicare report ordered by the Magistrates Court, nor did the Community Corrections officer have any collateral information about Mr Woodruff's mental health or psychiatric condition, or knowledge that he had been placed in the AAU whilst in custody and had been diagnosed with first episode psychosis.

50. Jenny Roberts, Director of Community Operations, Corrections Victoria gave evidence:

CCS [Community Correctional Services] does not have access to the health and medical records of prisoners which are restricted due to the confidential nature of the information, and is consistent with legislative requirements […]

CCS practitioners mainly rely on self-report to ascertain a prisoner's health and medical history during a pre-sentence interview. Unless these histories are provided by the court, consent must be obtained from the prisoner before any health information, including psychiatric reports, can be provided to CCS staff.

The limitation in accessing criminal health information is further exacerbated by the limited time CCS staff have available to them to conduct an assessment. Generally psychiatric material is obtained pre-sentence and the CCS is often provided with psychiatric reports as part of the assessment material in the higher courts due to the serious nature of their offending, and the client being legally represented.

Psychiatric material is not generally available in the Magistrates' Court where offenders are often unrepresented or represented by Victoria Legal Aid with little pre-sentence material other than verbal submission[s] provided to the court.[20]

[19] CB 421, Transcript (**T**) 23.
[20] CB 569, T 16-17.

51. Ms Roberts agreed there was no formal process for Community Corrections staff who are completing pre-sentence reports to have access to or be made aware of any presentencing psychiatric assessments prior to writing a report,[21] and options for Community Corrections staff to obtain collateral health information was '*very limited without the consent of the offender, or of the accused*.'[22]

52. Ms Roberts acknowledged it would have been of assistance to the Community Corrections officer preparing the presentence assessment to have had Mr Woodruff's health information, for example, that he had been made subject to the *Mental Health Act 1986*. This would have been a relevant consideration, particularly given Corrections policy which states that an offender may be assessed as unsuitable for a CCO if they have '*a permanent incapacity to comply, i.e., ongoing severe psychological/psychiatric problems*.'[23]

53. In statements to the Coroners Court, Corrections Victoria acknowledged that it is '*common for offenders to not disclose pertinent information relating to their mental health status, illicit substance use or general health or wellbeing,*'[24] and Ms Roberts confirmed that such minimisation may be motivated by a prisoner not wanting to disclose information which might preclude them as being considered suitable for a CCO or release.[25] Ms Roberts agreed that '*ideally we would want to have that information on hand to make an … appropriate assessment as to their suitability to be released into the community subject to […] a CCO*.'[26]

54. When Mr Woodruff was assessed for the CCO, Ms Roberts stated '*It was not the then CCS practice to await the Forensicare Report before the CCS report was written. So she [the Community Corrections officer] had no documented evidence of any mental health diagnosis.*' Ms Roberts advised it is now the practice to wait for the Forensicare report, '*where it would be known that there was a Forensicare report being prepared*.'[27]

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[21] T 20.
[22] T 23.
[23] CB 1696.
[24] CB 560 (Statement of A/Deputy Commissioner Brendan Money, Operations, Corrections Victoria).
[25] T 30.
[26] T 30.
[27] CB 1651; T 32.

55. Since Mr Gray's death, Ms Roberts indicated that a prison report is now available to CCS when a prisoner is released to undertake a CCO.[28] In evidence she explained this is prepared by Corrections Victoria, and the prisoner's case manager (not health staff) outlines issues relevant to the prisoner's time spent in custody and risk ratings.[29]

56. When asked what had changed regarding CCS not knowing about Mr Woodruff's first episode of psychosis in custody or the Forensicare report, Ms Roberts stated '*nothing substantially, it would be fair to say ... we would still be reliant on offenders disclosing mental health*.'[30]

57. Mr Scott Swanwick, Director of Health Services and Clinical Governance, Justice Health, confirmed Justice Health contracts out the delivery of health services in prison, sets the standards for service delivery and owns the health records which are an electronic medical record called 'JCare'. JCare includes a prisoner's medical records and is used by mental health services provider, Forensicare, to record the mental health service delivery of diagnoses, outcomes, treatment plans and discharge summaries.[31] He confirmed a prisoner's consent is otherwise required to access health information outside of clinical staff.

Mr Woodruff's compliance with the Community Correction Order

58. On 2 May 2013 Mr Woodruff attended his first appointment with his Community Corrections officer. The required risk assessment was completed with no referrals made and Mr Woodruff signed off on the CCO Rules and Regulations and the Community Work Rules.

59. On 6 May 2013 the Community Corrections officer referred Mr Woodruff to ACSO COATS for assessment and treatment for substance abuse.

60. On 9 May 2013 Mr Woodruff attended his supervision appointment with his Community Corrections officer. He appeared to be under the influence of drugs and was directed to attend urinalysis the next day. He admitted to cannabis use in the preceding days. There is reference in the Community Correction officer's supervision

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[28] CB 1649.

[29] The Department of Justice & Community Safety provided three redacted examples of prison reports from Barwon, Dhurringile and Ravenhall (Exhibit 14 at Inquest). None of these examples contain health information however the example from Ravenhall refers to the prisoner being placed in '*Erskine*', and '*employment ready programs will be liaised with Forensicare OT depending on [REDACTED] ongoing mental health presentation*.'

[30] T 63.

[31] T 71.

file note from 9 May 2013 that '*Mr Woodruff was diagnosed with psychosis as per the Forensicare report completed on 23/04/2013. The writer will monitor his mental health and make contact with relevant treatment providers, however at this time it is unclear who Mr Woodruff is linked with, and as such this will be investigated and clarified by the writer*'.[32] Therefore it would appear the Community Corrections officer had, at that stage, the Forensicare report and an awareness of Mr Woodruff's mental health diagnosis. I note there were no details of any treatment pathway post discharge in the Forensicare report.

61. On 10 May 2013 Mr Woodruff did not attend for urinalysis.

62. On 13 May 2013 Mr Woodruff attended his assessment appointment with ACSO COATS. He was referred to the Peninsula Drug and Alcohol Program with a scheduled appointment on 29 May 2013.

63. On 15 May 2013 Mr Woodruff did not attend his supervision appointment with his Community Corrections case manager, citing insufficient funds for transport. The appointment was rescheduled to the following day.

64. On 16 May 2013 Mr Woodruff's father telephoned Mr Woodruff's Community Corrections officer to express his concerns about Mr Woodruff's behaviour since his release from prison including that he was not taking his medication. Mr Woodruff's father also noted that he believed that a referral had been made to Mental Health Services in Frankston/Rosebud and that Mr Woodruff had not engaged. Mr Woodruff's Community Corrections officer called Frankston Mental Health Services and was transferred to Bayview House Acute Mental Health Team and was advised Mr Woodruff had never engaged or attended and had refused a medical review. Accordingly, noting that there were no acute concerns for him, the Team had closed the referral.

65. Later, on 16 May 2013 Mr Woodruff attended his supervision appointment with his Community Corrections officer. He appeared engaged and was referred to the Bridge Program. He reported cannabis and alcohol use since his release and to buprenorphine use in custody. He was directed to his GP for a new referral for a mental health plan.

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[32] CB 602.

66. The same day, or in the early hours of 17 May 2013, Mr Woodruff killed his neighbour, Mr Gray.

67. On 17 May 2013, Mr Woodruff did not attend for community work and on 19 May 2013 absconded to NSW in a vehicle stolen from Mr Gray.

Management of Community Correction Order conditions

68. If a CCO has a condition for drug and alcohol assessment, at induction the offender is referred to ACSO-COATS[33] for drug and alcohol assessment. This program undertakes the majority of intake and assessment services for forensic clients referred through Community Corrections and the Adult Parole Board.

69. There is no regulated system equivalent to ACSO-COATS for CCO mental health assessment and treatment conditions for CCS clients who have been diagnosed and treated with a serious mental illness while in custody and who are not subject to other legislation upon release.

70. If a CCO has a mental health assessment and treatment condition, the offender is often referred to their GP for a mental health assessment for a mental health plan and referral. If a mental health provider was already providing treatment, '*then a referral for appropriate intervention, in consultation with a CCS Senior Officer should be considered and completed within the first 6 weeks of the CCO commencing*.'[34] The focus of Corrections Victoria is, in the main, linking people on CCOs with GPs and private psychologists which is reflective of the high prevalence of disorders such as anxiety and depression. Ms Roberts agreed this is not an appropriate approach to take with a prisoner transitioning from custody who has been diagnosed with a serious psychotic mental illness.[35]

71. The current system for CCS and Area Mental Health Services to establish communication about a client on a CCO is reliant on the motivation of individual services and clinicians, to initiate and nurture channels of communication and to seek consent for information-sharing where required.

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[33] Australian Community Support Organisations' (ACSO) Community Offenders Advice and Treatment Services (COATS).
[34] CB 1652.
[35] CB 1652, T 40-41.

72. In this case, Peninsula Health Mental Health Services did not know Mr Woodruff was on a CCO. Although Community Corrections had the Forensicare report by 9 May 2013 they were not aware of the referral to Peninsula Health Mental Health Services, which was not referred to in the Forensicare report.

73. As Mr Woodruff was not subject to the *Mental Health Act 1986*, as was then in force, it was his choice as to whether he engaged with Peninsula Health Mental Health Services or took his medication. The mental health assessment and treatment condition of the CCO cannot itself be enforced, save for initiating breach proceedings, as engagement with mental health services is voluntary.

Discharge planning and information sharing

Community Corrections

74. Ms Roberts indicated it would have been useful for the Community Corrections officer to know about Forensicare's referral to Peninsula Health Mental Health Services. When asked whose responsibility it was to provide that information, she stated:

In the absence that [of Mr Woodruff's or any offender's consent] it's difficult to know who's ultimately responsible for providing that information to CCS. What we don't know we don't know.[36]

75. Ms Roberts agreed that a snapshot of a prisoner's health record, such as a Justice Health discharge summary, would be a helpful summary for Community Corrections officers to determine whether there have been mental health issues of a serious nature experienced by a prisoner whilst in custody.[37]

Justice Health

76. With respect to information sharing when a person is placed on a CCO after exiting custody and requires mental health treatment in the community, a discharge summary/plan is prepared by Forensicare to ensure continuity of treatment in the community. Mr Swanwick stated that there would be no barriers to Justice Health

[36] T 40.
[37] T 43.

providing the discharge summary to a Community Corrections officer, where consent is obtained, and a CCO assessment has been ordered.[38]

77. Mr Swanwick agreed that in this case there had not been a continuum of care between Mr Woodruff leaving custody and being in the community.[39]

78. To address the communication problem evidenced by the fact that Forensicare made a referral for Mr Woodruff to attend Peninsula Health Mental Health Services but neither Forensicare nor Peninsula Health Mental Health Services were aware Mr Woodruff was placed on a CCO, Mr Swanwick advised he was reviewing the electronic medical record and '*one of the things that we could possibly consider - how the information from the […] justice system could actually possibly give us that information.*'

Forensicare

79. The Justice Health Quality Framework applies to Forensicare and continuity of care is a key principle of the 2011 Framework, as then applied. Dr Kate Roberts agreed that a component of continuity of care is adequate discharge planning.

80. However, Forensicare was not aware Mr Woodruff was placed on a CCO with a mental health assessment and treatment condition and neither was Peninsula Health Mental Health Services. Dr Roberts advised there is no formal system for notifying Forensicare of the outcome of a court hearing that includes assigning a mental health condition on a CCO as they are separate systems and processes.[40]

81. Moreover, Dr Roberts did not see the value in Forensicare having access to that information given it is the Community Corrections officer who manages the direction for mental health follow up. Dr Roberts was under the impression that the Community Corrections officer would be aware of the Forensicare referral to Peninsula Health Mental Health Services.[41] Dr Roberts also assumed that the client (Mr Woodruff) would be aware of the referral to Peninsula Health and would have informed the Community Corrections officer. She conceded that if that had not occurred, as in this case, there may be a basis for more formal method of sharing that information.

[38] T 75.
[39] T 85.
[40] T119.
[41] T 119.

82. When Dr Roberts was advised Peninsula Health Mental Health Services considered it important information to know that Mr Woodruff was on a CCO, Dr Roberts stated:

I would make the point that if a referral has been made from Forensicare to [an] Area Mental Health Service, that should initiate a process where they engage with Mr Woodruff, to continue his treatment in the community.

83. When asked to reflect on any issues Forensicare could have addressed differently, Dr Roberts stated whilst Forensicare was not aware of Mr Woodruff's CCO, it did follow usual practice in assessing whether Mr Woodruff fulfilled the criteria under the *Mental Health Act*, determined the sort of follow-up he required, made a referral to Peninsula Health Mental Health Services, which was accepted, and alerted them that Mr Woodruff had been released from custody, '*so, my view is then that the continuity of care was the responsibility of Peninsula*.[42]

Peninsula Health Mental Health Services

84. On 29 April 2013, Peninsula Health Mental Health Services received a referral seeking '*urgent follow up'* for Mr Woodruff who was expected to be released from custody on 30 April 2013.

85. Mr Woodruff was released from custody on 30 April 2013. On 1 May 2013 Forensicare telephoned Peninsula Health Mental Health Services to advise that Mr Woodruff had been released. Peninsula Health Mental Health Services made attempts on 1, 2 and 3 May to obtain Mr Woodruff's telephone number and to contact him. On 4 May 2013 a psychiatric nurse made telephone contact with him and conducted an assessment by telephone. Mr Woodruff was triaged at Code G, which means requiring '*information only/no further action*.'[43]

86. Ms Tan, Forensic Clinical Specialist at Peninsula Health Mental Health Services, explained that although the referral from Forensicare spoke in terms of Mr Woodruff being in need of an '*urgent*' referral, on 4 May 2013 there was nothing during his assessment that indicated his presentation was acute, as he was willing to engage and

[42] T 133.
[43] CB 1444.

‘*his mental state is reasonably settled*.’[44] Ms Tan explained that ‘*Code G is really looking at that moment in time*.’[45]

87. On 3 May 2013 Mr Woodruff’s father had contacted Peninsula Health Mental Health Services concerned his son had not had contact with his family, or his medication for three days and ‘*is worried that John will not engage with our services and “fall off the rails again”*.’[46] When asked about the extent to which these family concerns were taken into account, Ms Tan noted:

While information from family members is useful, it is not determinative of how a patient will be triaged, and it is apparent that [the registered psychiatric nurse assessing Mr Woodruff] formed the view that Mr Woodruff was prepared to engage and did not seem to present with acute concerns in his mental state.

88. Ms Tan did note, whilst not commenting on the triage nurse’s assessment, that she now encourages clinicians to go back to the carer or family and:

… collect more collateral information and get more specific details as to what their current concerns are and what their observation of the current behaviours and presentations are.[47]

In this instance Ms Tan was of the view Mr Woodruff’s father was voicing ‘*historical*’ concerns rather than commenting on Mr Woodruff’s current presentation.[48]

89. On 5 May 2013 Mr Woodruff was re-triaged by the Port Philip Acute Team as ‘Code E’ (‘*non-urgent mental health response*’).[49] He was scheduled to attend an appointment at Bayview House which was re-scheduled to 7 May 2013. When he did not attend the appointment, a message was left on his phone. On 8 May 2013 Mr Woodruff was discharged by the Port Phillip Acute Team. The conclusion was reached that ‘*he was unwilling to engage because of his failed attendance*.’[50] Ms Tan conceded that given the concerned call made by Mr Woodruff’s father, she would have expected contact with the family member to be made prior to the decision to

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[44] T 169.
[45] T 171.
[46] CB 1368.
[47] T 174.
[48] T 174.
[49] CB 1439.
[50] T 176.

discharge Mr Woodruff, or the referral being closed. She agreed this might have been a failure in these particular circumstances.[51]

90. As Mr Woodruff was a voluntary patient, Ms Tan stated, '*there is actually very little that an Area Mental Health Service can do to compel that person for a face to face to come and see us or engage with us.*'[52] Ms Tan was of the view that there was no indication from Mr Woodruff's assessments on 4 and 5 May 2013 that suggested he met the mental health criteria in section 8 of the *Mental Health Act 1986* as it applied at the time.[53]

91. Ms Tan confirmed there is no formal information sharing arrangements between Justice Health and their contracted service providers, Corrections Victoria and Area Mental Health services when a person is placed on a CCO requiring mental health treatment in the community after exiting custody. She stated:

The criminal justice system and the mental health system tend to run quite separately from one another and Forensicare, as the state-wide forensic mental health agency sitting across the two systems, is the only agency that has access to both.[54]

92. The referral from Forensicare was made prior to Mr Woodruff's release from custody and Peninsula Health Mental Health Services was not informed or aware that Mr Woodruff had been placed on a CCO.[55]

93. Ms Tan acknowledged:

Accordingly, there appears to have been gaps in communication and information sharing in the circumstances of Mr Woodruff's case in that key information was not provided to PHMHS.[56]

94. Ms Tan noted there were advantages of Peninsula Health Mental Health Services being aware that a person was on a CCO:

… there are several benefits ... if a patient/offender is not forthcoming with our attempts to engage them, we can also reach out to the Community Corrections Officer

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[51] T 176.
[52] T 192.
[53] T 192.
[54] CB 1363-1364.
[55] CB 1364.
[56] CB 1364.

... we can get more details about the current mental state from the officer ... which will add on to our assessment if we are unable to see to see the individual for a face to face assessment.[57]

The collateral information would assist to make a clinical assessment, '*as to what is the next course of action in relation to engaging the individual or treatment of the individual.*'[58]

95. An Area Mental Health Referral guide produced by the Department of Health (2020), and included in my brief as an attachment to Ms Tan's statement, states for remand clients the referral should be made to AMHS '*ASAP to enable AMHS to either come and assess the client or organise a collaborative discharge plan and that 'AMHS want (and NEED) to know information regarding charges, legal status on discharge, future court dates and risk*' and asks that the referral include '*any information regarding legal commitments and reporting requirements patients will have on discharge…Correctional orders, etc.*'[59] Ms Tan described this as 'welcome' as it serves '*to clarify the roles of both Forensicare and the AMHS when a patient is being referred for mental health services after a term of imprisonment'*.[60]

96. Ms Tan advised there is now a new service where remand clients can be assessed by the Area Mental Health Service whilst still in custody.

97. When asked about the benefits of information sharing Ms Tan stated:

… if we had known someone is coming on a community corrections order, and that information has come to us, of the things that quite immediately we will put in place ... is to find out who the community corrections officer is, and under which community corrections team office they're based, and reach out quickly to the community corrections officer, so that we can work together collaboratively to support that individual, and to mitigate the risk of reoffending, and to support the individual in their mental health issues.[61]

98. Ms Tan reflected that since Mr Gray's death, there is greater appreciation '*that people who are exiting from custody are at significant risk in terms of mental health issues, as*

[57] T 152-3.
[58] T 153.
[59] CB 1370.
[60] CB 1370.
[61] T 181-182.

well as at risk of reoffending…'.[62] Since 2017, her role as Forensic Clinical Specialist has been introduced and forms part of a new policy which established the Forensic Clinical Specialist Program, which is state-wide and locates Forensic Clinical Specialists within Area Mental Health Services with support and coordination from Forensicare. The aim of the program is to build the capacity of the AMHS and '*[m]y role as FCS has a specific focus on partnerships and networking as a key contact, liaison and referral point for mental health services, justice system and support agencies within local areas*.'[63]

99. In ascertaining how communication links may improve, Ms Tan agreed a link between an Area Mental Health Services and Community Corrections officers would assist. She explained part of her role is:

> *… being the bridge – or the liaison person for individuals who may be going through the different systems between the health system and the criminal justice system ... currently I would get notifications of active or recently active clients entering custody so that we can be involved in early discharge planning or handover of critical health information to manage their assessment and treatment in prison, as well as I'll get notification or I'll be involved in early discharge planning for people [who] are exiting custody and whom we are aware that will be coming back to or will be referred to our specific catchment.*[64]

100. Ms Tan noted that she relies on information provided by Forensicare or Corrections Victoria; she does not have access to a person's offending history and '*may not have adequate information to come to an accurate assessment of whether or not this person is at risk and what we can do to mitigate the risk*.'[65] She was of the view it was important information for her service to know if someone had a history of previous violence as part of their mental illness[66] and endorsed an improvement in sharing information between the criminal justice system and mental health system, '*There should be more timely sharing of such pertinent information*.'[67]

101. Ms Tan agreed that, as Forensicare did not know Mr Woodruff was on a CCO and Community Corrections was not aware of the Forensicare referral to Peninsula Health

[62] T 182.
[63] CB 1370.
[64] T 194.
[65] T 198.
[66] T 198-9.
[67] T 199.

Mental Health Services, '*if all that information somehow could be shared, that would be a much better system.*'[68] One suggested method of sharing information was the distribution of CCOs to various agencies involved.

102. Ms Tan was a very responsive witness and I gained valuable insights about the interaction between the agencies involved with Mr Woodruff from her evidence.

Treatment in prison for first episode psychosis and transition to the community

103. Psychosis is a term that encompasses a range of severe mental illnesses, and commonly means a person may experience hallucinations and delusions and misinterpret or confuse what is going on around them. A first episode of psychosis is most likely in late adolescence or in the early adult years. Mr Woodruff was aged 22 years with a diagnosis of first episode psychosis and he met the criteria for referral to 'early intervention for psychosis' services. As Mr Woodruff's diagnosis was made when he was in custody, he was treated with pharmacological therapy only, namely antipsychotic medication.

104. Dr Roberts from Forensicare conceded that although there was medical information about Mr Woodruff that Forensicare did not have (and referred to in Dr Bhattacharya's report), whether Mr Woodruff had either a first or second episode of psychosis:

> *… would not have changed the treatment given at the time ... I'm not sure that the knowledge of him having a previous episode would have changed that critically ... but I do accept the more information the better.*[69]

105. The expert engaged by the Coroners Court, Professor Kimberley Dean, Chair of Forensic Mental Health at the University of New South Wales School of Psychiatry gave evidence about first episode psychosis at the inquest. She indicated schizophrenia would be the most common cause of first episode psychosis, but other causes include bi-polar affective disorder, a drug induced episode or other brain disorder.[70] The Australian Clinical Guidelines for Early Psychosis indicate the first line of treatment is anti-psychotic medication, and treatment may include

[68] T 199.
[69] T 134.
[70] T 211.

psychological and social therapies.[71] Compliance with medication and a therapeutic alliance with the treating team are all very important in the first episode.

106. Professor Dean noted:

> *… it's very well known that overall the prevalence of any type of mental disorder, that particularly severe mental illness like the psychotic illnesses, are much more common in people in the prison than in the community…there have also been a few studies that have indicated that the early stages of psychosis may be particularly common amongst people in prison or in contact with the justice system.*[72]

107. Professor Dean noted that the challenge of treating first episode psychosis in a prison setting is that the first priority is security, rather than the mental health care of prisoners. Professor Dean described it as a '*very long way from an ideal mental health clinical setting*' and that conditions in prison will themselves affect a person's mental health, either as a result of conditions such as seclusion or segregation, and there may be an unwillingness to provide details that would allow clinicians to obtain collateral information on mental health conditions. This is further compounded by the fact that there are 'separated services' whereby the service providing mental health care in prisons is not directly linked or part of the mental health service providing care in the community, which also impacts access to information.

108. Professor Dean identified a gap in the equivalency of care between treatment for first episode psychosis between the community and prison settings with early interventionist services that specialise in assessing and treating people in their first episode psychosis:

> *To my knowledge there are few if any models of that sort that operate either in prisons or with any reach into prisons. And given the high level of psychosis and first episode psychosis I would argue, and many have argued that this is a real gap that we don't have that service model extended into custody.*[73]

109. However even with the benefit of specialised early intervention service Professor Dean noted there is a significant chance of relapse following first episode psychosis, and there may be no reduction in the risk of violent offending.

[71] T 213-214.
[72] T 216.
[73] T 222.

110. Further, she noted, community transition from custody '*represents a high-risk period and difficulties persist within existing mental health and other service frameworks for maintaining continuity of care and support*.'[74] Professor Dean was asked how those risks should be managed and what should be the focus of the referring service. Professor Dean noted this was a high-risk time and in most jurisdictions was not well managed. One of the reasons for this was that '*health services in the prison and health services for community are typically separated ... and there are [...] communication barriers*.'[75] Treatment is a challenge for community services and the prisoner may have lost contacts as a result of incarceration, such as housing stability, employment, education, and family. These are potential contributors to risk. Critical time interventions include '*ensuring that a mental health worker is engaged with the prisoner well before release and follows that prisoner up into the community*.' Professor Dean mentioned trials where the relevant community team comes into custody and engages with the prisoner prior to release. She stated both models have been tested with some benefit shown, so there exists a need '*for coordination, management and support to ensure there's engagement because the rate of engagement ... post release is so poor otherwise*.'[76]

111. Professor Dean noted in relation to information-sharing, and the role of the clinician in effective post release management that *'communication was key and ... it's often raised in circumstances in which there are adverse outcomes ... repeatedly raised.*'[77] Professor Dean cited reasons why communication and information-sharing is so difficult in practice, such as different services and clinicians using incompatible electronic medical record systems. '*So that is definitely a major area of focus that would make a difference to outcomes*.'[78]

Conclusions

Community Corrections and Mr Woodruff's health information

112. The Community Corrections pre-sentencing assessment was based on incomplete information as the assessor was unaware of Mr Woodruff's recent mental illness and his referral to Peninsula Health Mental Health Services on release.

[74] CB 1087.
[75] T 227.
[76] T 228.
[77] T 232.
[78] T 233.

113. This case is an example of the importance of reliable collateral information when conducting a pre-sentence assessment to verify self-reporting by a prisoner. In this case Mr Woodruff did not provide accurate information to the assessor about his mental health. Ms Roberts' evidence confirmed that obtaining collateral health information requires a prisoner's consent, that information about Mr Woodruff's mental health would have assisted the assessment, this was information relevant to whether he was suitable or unsuitable for a CCO and that it is common for prisoners to withhold or not disclose information.

114. It is axiomatic that, aside from narrow legislative exceptions, a prisoner's health or mental health information can and should only be accessed with their consent.

115. The importance of a prisoner's health information when conducting a pre-sentence assessment for the court is reflected in the DCI's reference to '*gathering as much information about the offender as possible'.* While otherwise noting that reports are prepared in about an hour, Ms Roberts agreed that the benefit of the Full Written Pre-sentence report, which was ordered in relation to Mr Woodruff, is that there is time to obtain such information, as opposed to the 'on-the-spot' assessments done at court.

116. In explanation of why the assessor did not have information about Mr Woodruff's mental health, Corrections Victoria relied on the fact that a prisoner's consent is required to access health information. I note the DCI in place at the time of Mr Woodruff's assessment makes no specific reference to obtaining consent for health information in its '*outline of practices to be undertaken when taking steps to prepare a Full Written Pre-Sentence report*' and provides no advice or guidance to Community Corrections officers about how to or when it might be important to obtain this consent. There was, however, a requirement to '*validate and verify information contained in the report, and where this is not possible identify this as such*'.[79]

Communication between Forensicare, Peninsula Health Mental Health Services and Corrections Victoria

117. Dr Roberts from Forensicare noted there was no formal way for Forensicare to be notified about a prisoner's court outcome. She did not see the value in Forensicare having that information as Community Corrections is responsible for managing the

[79] CB 1686.

CCO. She conceded if a client had not told Community Corrections about the referral then there may be a basis for a formal method of sharing information.

118. I find the referral from Forensicare to Peninsula Health Mental Health Services was incomplete in that it did not contain the important piece of information that Mr Woodruff had been placed on a CCO with a mental health assessment and treatment condition. Ms Tan from Peninsula Health Mental Health Services agreed that there were gaps in communication and information sharing in the circumstances of Mr Woodruff's care, and key information was not provided to Peninsula Health Mental Health Services.

119. Respecting the privacy and confidentiality of a person whilst in custody and upon release may create issues for informed decision making. Community Corrections manages offenders on CCOs and is required to make timely referrals and monitor engagement. This case illustrates the need for an information pathway so that relevant health information is included in a pre-sentence assessment. In addition, it would have been very useful for the Magistrate and Community Corrections officer to have known that Forensicare had referred Mr Woodruff to Peninsula Health Mental Health Services for treatment.

120. Access (with consent) to a prisoner's detailed medical record is not necessary for the purposes of a Community Corrections pre-sentence assessment and would be problematic given the potential complexity and size of health records versus the information necessary for a pre-sentence assessment. However, a current 'in custody' health summary should be available. This may require Justice Health mental health service providers to have up to date information in a database from which they can generate a health summary document, similar to the Patient Summary electronically generated by GPs through their medical record. A usable health summary document should include current diagnoses, medications, treatment plans for quick access, and should be restricted to health information needed for the purpose of an informed pre-sentencing assessment.

121. The expert evidence from Professor Dean confirmed transition from custody to the community is a high-risk period for prisoners who have suffered a first episode psychosis in custody. The evidence at inquest confirmed that health services in prison and the community are separated, and communication and information sharing is problematic. These factors contributed to a limited mental health treatment outcome

once in the community for Mr Woodruff. Ms Tan indicated that had Peninsula Health Mental Health Services been aware of the CCO they could have followed up with his Community Corrections officer and had another means by which to contact and engage Mr Woodruff.

122. Mr Swanwick conceded there had not been continuum of care between Mr Woodruff's transition from custody to the community.

123. In their final reflection, the Gray family contend Mr Gray's death was preventable.

124. Mr Woodruff was diagnosed in custody with first episode psychosis and the historic medical reports suggest Mr Woodruff's mental health and behavioural difficulties were complex and of long-standing duration. He also had a substance abuse history over many years. He was vulnerable to relapse in the community: he continued to use illicit substances, he had a history of impulsive violent behaviour and was in the high-risk period of release from custody with a lack of information sharing between agencies impeding the effective transition of his mental health treatment.

125. In his engagement with Community Corrections Mr Woodruff was cognisant enough to be able to minimise the information about his current and previous mental health issues he provided during his pre-sentence assessment to his Community Corrections officer. Further, he did not disclose in his conversations with two psychiatric nurses post release any indication his mental health condition was or had recently been acute, presenting as 'reasonably settled.' On 16 May 2013 he had an appointment with his Community Corrections officer, and she described that '*he presented well*.'[80]

126. I find the coordination of his post release care was less than optimal which meant that potential opportunities to provide effective mental health care were missed. However, given both Mr Woodruff's variable presentations on assessment, and the speed and severity at which his illness deteriorated post release, I am not satisfied his act of killing Mr Gray on late 16 or early 17 May 2013 could have been predicted and prevented.

[80] CB 201.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

I have considered the thoughtful reflection provided by the Gray family following the conclusion of the inquest. I note their disappointment '*in the lack of any recognition of responsibility where there have clearly been gaps*.' Although there were concessions made in the course of the inquest, particularly by Ms Roberts, Mr Swanwick and Ms Tan, this case illustrates the practical difficulties in addressing those gaps, summed up neatly in Ms Tan's evidence when she stated: '*The criminal justice system and the mental health system tend to run quite separately from one another…*'

Further, the evidence in this case and the expert evidence from Professor Dean confirmed the service providing mental health care in prisons is not directly linked or part of the mental health service providing care in the community

I note the recent Royal Commission into Victoria's Mental Health System (**Royal Commission**) has made two recommendations which are particularly relevant to this investigation, namely Recommendation 37: 'Supporting the mental health and wellbeing of people in contact with or at risk of coming into contact with the criminal and youth justice systems,' and Recommendation 61: 'Sharing mental health and wellbeing information.' Recommendation 62, 'Contemporary information architecture', also has relevance to the way in which technology and information-sharing are to be addressed in the context of mental health service provision.

I endorse those recommendations and will provide a copy of this finding to the Mental Health and Wellbeing Division in the Department of Health, which is charged with implementing the recommendations of the Royal Commission, as the facts of this case and the recommendations are highly relevant.

I will also provide a copy of this finding to Victoria Legal Aid (**VLA**) given the recommendations below in relation to the sharing of psychological/psychiatric material and health information, in light of the role of VLA in representing accused persons in criminal matters.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

To the **Department of Justice and Community Safety**, I recommend:

That Justice Health give consideration to the creation of a concise discharge summary, to include diagnoses, medications and treatment plans, which can be generated from a prisoner's

health records, similar to a patient summary electronically generated by GPs from a patient's medical record (**discharge summary**);

To the **Department of Justice and Community Safety**, I recommend:

A formal process should be considered to give an offender the opportunity to consent to provision of the above-mentioned discharge summary, or similar, to Community Correctional Services staff who are conducting an assessment for a Community Correction Order and case managing an offender, and who is being released from prison onto a Community Corrections Order (through their lawyer or as appropriate).

To the **Department of Justice and Community Safety**, I recommend:

A formal process should be considered to give an offender the opportunity to consent to provision of the above-mentioned discharge summary to an Area Mental Health Service to which a person has been referred upon their release from prison (through their lawyer or as appropriate).

To the **Department of Justice and Community Safety**, I recommend:

A formal process should be established whereby the consent of an offender should be sought (through their lawyer or as appropriate), to provide any previous psychiatric or psychological reports on the Court file to Community Correctional Services and Forensicare where the Court requests a pre-sentence psychiatric report (and any refusal recorded).

To the **Department of Health**, I recommend:

The Department of Health should consider increasing its allocation of funding for Forensic Clinical Specialist roles attached to Area Mental Health Services, and training packages available to Area Mental Health Service clinicians to promote expertise in working with patients transitioning out of a forensic setting, including optimal ways to engage such patients in voluntary treatment.

To the **Office of the Chief Psychiatrist**, I recommend:

The Office of the Chief Psychiatrist should coordinate a forum with Corrections Victoria, Justice Health and Forensicare to review current discharge processes to ensure the timely communication of critical information about discharge plans for a prisoner with a serious mental illness who is being released to the community and includes:

(a) For the receiving Area Mental Health Service, details of any Community Corrections Orders entailing assessment for treatment of mental health; and

(b) For Community Correctional Services and its case managers, a system for notifying the Community Correctional Services of a mental health service or practitioner to whom the prisoner has been referred as part of any Forensicare Discharge Plan.

I note for the benefit of Mr Gray's family that, pursuant to the requirements in section 72 of the Act, a written response is to be provided to the Coroners Court within 3 months of the date of this Finding by the Secretaries of the Department of Justice and Community Safety and the Department of Health, respectively, and the Office of the Chief Psychiatrist, specifying the action (if any) that has or will be taken in response to these recommendations. These responses will be published on the Coroners Court website.

FINDINGS AND CONCLUSION

127. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Barry Gray, born 8 May 1941, died on 17 May 2013 at 37 Parson Street, Rye, Victoria, from multiple stab and incised wounds to the chest and neck in the circumstances described above.

128. Pursuant to section 73(1) of the *Coroners Act 2008* I direct this finding be published on the Internet.

I convey my sincere condolences to Mr Gray's family for their loss and my gratitude for their active participation in these proceedings, including provision of their thoughtful reflections statement and comments in relation to the scope of inquest and potential issues to be considered in the course of these proceedings.

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

Mr Warren Gray, Senior Next of Kin
Mrs Sandra Gray
Department of Justice and Community Safety, incl. Justice Health and Corrections Victoria
Forensicare
Peninsula Health Mental Health Services
The Department of Health (including specifically the Mental Health and Wellbeing Division charged with implementing the recommendations of the Royal Commission)

The Office of the Chief Psychiatrist

Victoria Legal Aid

Detective Sergeant Robert Catania, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 17 December 2021