IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005190

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Jayke Michael ALECKSON
Delivered on:	11 December 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	28 September, 2 & 3 October 2024
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	R. Ellyard Instructed by Coroners Court of Victoria
Counsel for Secretary for Department of Justice and Community Safety	L. Brown and M. Isobel Instructed by Victorian Government Solicitor's Office
Counsel for Forensicare:	R. Harper Instructed by Minter Ellison

Counsel for St Vincent's Hospital:	S. Reid Instructed by Lander & Rogers
Counsel for Correct Care Australasia:	P. Halley Instructed by Meridian Lawyers
Other Matters:	*Death in Custody, BDRP compliant cells, separation*

Family Impact Statement

My name is Jayne, and I am the mother of the young man you all know as "Jayke"
Jayke was just one of many names my son was known by.
He was also fondly known as "Blocka" or "Biggen" due to his less than weedy stature as a young junior league footballer in his home town .
Jayke was funny, Jayke was kind, and he had more friends than most.
He was charismatic, he could talk to anyone about anything.
He was a protector of anyone he cared about and would always be there if anyone needed a hand.
As he grew and was of age, he would become the unofficial bouncer with his friends on a night out.
It was a given that Jayke would look after everyone and ensure they were all safe.
Maybe this personality trait became a burden as he matured as he was so friendly and trusting and in real life and a long way from home, he should have been more wary of people.
He believed in the good of people. Always.
Jayke moved from his hometown and family at 21 years of age, looking for adventure and a good job. He found both.
He also found a beautiful girl who became the mother of his child, who is now 7. This little girl is the light in our lives and a constant reminder of the beautiful boy we lost too early who will not be here to see his daughter grow and shine.
When Jayke was arrested in 2018 the previous months had been messy, and as his mum I found a certain solace in the fact he had been placed on remand, and after a few moves found him to be reasonably settled in Marngoneet prison.
In my heart I felt he was "safe" away from the environment that had ultimately brought him down.
He was in a place where he was locked up in a cell, a safe place, a place where no harm should come, a place where "Duty of Care" should be number one on the agenda. But was It???
No parent or family member should ever have to endure the torture that comes with a phone call from the mother of Jayke's child saying:
"They have found Jayke today, unresponsive in his cell"
Hard to hear, even harder to live with as we spoke to the Geelong hospital on a twice daily basis for the next ten days and on day 8 we had to make the agonising decision to turn his life support off, he passed on day 10.
The questions are endless, the loss immense. The financial strain that was placed on us unexpectedly, that we still deal with as we pay off the cost of what has happened, has been emotionally draining as we deal with our grief daily.
We have lost our son.
His two brothers have lost their youngest brother.
His daughter has lost her daddy and our family as a whole will never be whole again.
We will forever miss what could have been, what should have been and what never will be.
The question, Why, is the one that rolls around in our minds every minute of every day ….
Hold your own children tight and I hope you never have to feel this way in your own lifetime.
Thank you for taking this time to listen …

JAYKE'S POEM

Sick of Crime

I'm sick of having mugshots taken all the time
I'm sick of everything to do with fucken crime
in and outta jail there's more than this to life
got a gorgeous daughter and should have had a wife

See started off just social n slowly worked its charms
before you could know it I'm sweating from the palms
stealing fucken cars just to get a hit
I lost the fucken lot for a dirty hit

Now i'm on the inside thinking of it all
Stood in this cell tryna climb the fucken wall
Knowing how I've hurt yous eatin me alive
Can't even shut my eyes I'm getting sleep deprived

I wish it was a nightmare and could just wake up
But that ain't reality so I gotta suck it up
Gotta be a man for my baby girl
Baby just know you are your daddy's world

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INTRODUCTION

1. Jayke Michael Aleckson, born 17 February 1994, was 24 years old when he died whilst on remand at the Marngoneet Correctional Centre (**Marngoneet**).

2. Jayke had been found by prison officers on 5 October 2018 unresponsive in a health ward cell where he was being accommodated whilst on separation. He was transported to the University Hospital Geelong but tragically passed away on 15 October 2018.

3. Jayke's health ward cell was not Building Design Review Project (**BDRP**)[1] compliant. BDRP cells have design elements such as no ligature points that make them safer areas for people at risk of self-harm.[2]

4. At the time of Jayke's death, he was the first suicide to have occurred at Marngoneet since its commissioning in 2006.

THE CORONIAL INVESTIGATION

5. Jayke's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**), He was in custody at the time and further, his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[3]

The coronial role

6. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death.[4] Cause of death in this context is

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[1] According to the JARO report*: Following coronial findings and recommendations in 2000, Corrections Victoria undertook a program of work, titled the 'Building Design Review Project'. The intent of the project was to minimise the risk and consequences of self-harm across the corrections system. This led to the development of the system's Cell and Fire Safety Guidelines and a program of removing hanging points from, and improving the fire safety of, cells across Victoria. Priority was given to management units, units which are used to hold mentally ill prisoners and prisoners who are at risk of suicide or self-harm.*

[2] Coronial Brief (**CB**) at p.2230.

[3] Deputy State Coroner Caitlin English, as she then was, initially had carriage of this investigation.

[4] The exceptions being cases where an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances: section 67 of the Act.

accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

7. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

8. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

9. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[5]

Mandatory inquest

10. As Jayke was in the custody of the State when he died, an inquest into his death is mandatory.

11. All prisoners held within prisons and correctional centres are held under the legal custody of the Secretary to the Department of Justice and Community Safety (**DJCS**) pursuant to section 6A of the *Corrections Act 1986*.

Victorian Charter of Human Rights and Responsibilities

12. Section 9 of the *Charter of Human Rights and Responsibilities Act 2006* states that "[e]*very person has the right to life and has the right not to be arbitrarily deprived of life*". This obligation to protect life has been interpreted as a procedural requirement that authorities effectively investigate deaths that occur in certain circumstances, including where a person has died in custody.

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[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".*

13. Counsel Assisting, Rachel Ellyard, is an independent member of the Victorian Bar and was instructed by the Coroners Court for Jayke's investigation and inquest. This, in combination with requirements of the Act, helps to ensure the independent scrutiny of the circumstances surrounding the death of a person for whom the State has assumed responsibility.

OTHER INVESTIGATIONS

14. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations. I have been provided with the Justice Health and Justice Assurance and Review Office (**JARO**)[6] review reports, both of which are included in the coronial brief.[7] Justice Health is a business unit within DJCS.

15. The reports noted are: *JARO Review into death of Mr Jayke Aleckson (CRN 214987) at Geelong Hospital on 15 October 2018,* dated 11 September 2019 and *Justice Health Death in Custody Report, Jayke Aleckson (CRN 214987),* signed 24 December 2018.

16. These reports are discussed later.

Sources of evidence

17. As part of the coronial investigation, the Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including those present at the scene of the incident, the forensic pathologist who examined Jayke, ambulance paramedics, investigating police officers, as well as other documentation such as plans and scene photographs. Also available were the audio of calls made by Jayke whilst at Marngoneet proximate to his passing (referred to as ARUNTA calls).

18. Subsequent to the provision of the brief, the Court obtained statements from a range of individuals including Jayke's mother, health clinicians who saw Jayke in prison, and corrections staff; institutional statements on behalf of Forensicare, Correct Care Australasia,

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[6] The Department of Justice and Community Safety's (**DJCS**) Justice Assurance Review Office (**JARO**) reviews deaths and other serious incidents in Victorian adult prisons and youth justice facilities. The purpose of JARO's work is to understand what happened, and to identify whether any changes can be made to prevent similar incidents from occurring in the future. JARO assists the DJCS Secretary to ensure that adult prisons and youth justice facilities are safe, secure and humane.

[7] CB 167, 185

Corrections Victoria and Justice Health, as well as Jayke's records from Justice Health (JCare record), Corrections Victoria (Individual Management File and Community Correctional Services File) and Ambulance Victoria. Relevant policy documents were also obtained from agencies. As already noted, the JARO and Justice Health reviews formed part of the material before the Court.

19. To further assist my investigation, the Court obtained an expert report about the provision of care to Jayke while he was in prison from consultant psychiatrist, Dr Jacqueline Rakov, who prepared a report dated 20 January 2023. She gave evidence as part of an expert panel on his care with other experts as noted below (paragraph 22(c)).

20. I also attended a view of Marngoneet in Lara, along with Counsel Assisting and all interested parties.

Scope of Inquest

21. The inquest scope was as follows:

Circumstances in which the death occurred

1. The immediate circumstances in which the incident on 5 October 2018 at Marngoneet Correctional Centre which led to Jayke's passing on 15 October 2018 occurred, including but not limited to,
   a. the role and responsibility of the correctional staff who were in contact with Jayke on 5 October 2018; and
   b. clarification of the manner in which Jayke was able to cause himself harm on 5 October 2018.

Provision of mental health care

2. Was the provision of mental health care to Jayke during the period of his incarceration from 6 June 2018[8] until his passing appropriate, having regard to the

[8] Jayke was incarcerated from 4 to 6 June 2018 at Melbourne Assessment Prison but the quality of the mental health care provided at this facility is not at issue.

assessments undertaken, medications prescribed (or not prescribed, treatment plans, monitoring and referrals, noting his placements at:

a. Port Phillip Prison from 6 June 2018 until 20 August 2018; and

b. Marngoneet Correctional Centre from 20 August 2018 until 5 October 2018.

3. If not, why not?

Compliance with the Justice Health Quality Framework.

4. Was the provision of mental health care to Jayke during his period of incarceration from 4 June 2018 until his passing consistent with the expectations of the Justice Health Quality Framework:

   a. across the period of his detention;

   b. at Port Phillip Prison from 6 June 2018 until 20 August 2018; and

   c. at Marngoneet Correctional Centre from 20 August 2018 until 5 October 2018.

5. If not, why not?

6. Were sufficient systems and resources in place to support health providers to deliver services to prisoners which were consistent with the expectations of the Justice Health Quality Framework and if not, what barriers existed at the time?

Prisoner Placement at the time of the incident which led to death

7. Who made the decision to place Jayke in Health Cell 2 on 3 October 2018 and what was the basis for that decision?

8. Was there an appropriate risk assessment process in place to enable a decision to be made that Jayke be moved from the Operational Management Centre (**OMC**) to Health Cell 2 on 3 October 2018?

9. Was an appropriate risk-assessment undertaken to support a decision that Jayke be moved from an OMC Cell to the Health Cell 2 on 3 October 2018? If not, what would an appropriate risk assessment have entailed?

10. Was it appropriate for a separated prisoner to be placed in a non-compliant cell?

11. Was the placement of Jayke in Health Cell 2 on 3 October 2018 consistent with applicable policies and procedures regarding prisoner placement at the time?

12. Was it appropriate for Jayke to be placed in Health Cell 2 on 3 October 2018, having regarding to:

a. his status as a separated prisoner;
b. his T3 rating;
c. his mental health management and presentation as reflected in his Justice Health records since his incarceration on 4 June 2018;
d. the further isolation Jayke would experience consequent from his move from an OMC Cell to the Health Cell; and
e. that his placement would be in a non-compliant cell.

13. Should further monitoring or measures have been put in place following Jayke being placed in Health Cell 2 on 3 October 2018?

Relevant changes subsequent to death and prevention opportunities

14. Any relevant changes within the corrections system which have been made subsequent to Jayke's passing.
15. Any prevention opportunities arising from the circumstances of Jayke's death.

22. The inquest ran for three days and heard evidence from ten witnesses, including the following:

a. Garth Studham, Prison Officer, Marngoneet;

b. Christine Fuller, Deputy Chief Executive Officer and Chief Nursing Officer, Correct Care Australasia and Francis Olopade, Chief Medical Officer, Correct Care Australasia (witnesses gave evidence concurrently);

c. Dr Jacqueline Rakov, Consultant Psychiatrist, Dr Scott Hall, Consultant Psychiatrist, and Kate Roberts, Director of Prison Clinical Services, Forensicare (witnesses gave evidence concurrently);

d. Kirsten Rodger, General Manager, Integrated Care Services, St Vincent's Hospital Melbourne;

e. Susannah Robinson, Acting Executive Director Operations, Justice Health;

f. Andrew Reaper, Acting Deputy Commissioner, Corrections Victoria; and

g. Dale Slater, Acting General Manager, Marngoneet Correctional Centre.

23. After the conclusion of the inquest, I received a written submission from Counsel Assisting[9] followed by written submissions in response from all interested parties.[10]

24. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, any documents tendered through counsel (including Counsel Assisting), written and oral submissions of counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Jayke Aleckson's death. I do not purport to summarise all the material and evidence in this finding but will refer to it only in such detail as is relevant to comply with my statutory obligations and necessary for narrative clarity.

BACKGROUND

25. Jayke was born in Warialda, NSW, to parents Jayne Kennedy and Steven Aleckson. He had two older brothers, Rhys and Jarryd.

26. Jayke worked in various areas including as a process worker, driver, tree removalist, butcher and was also a qualified welder. He had sustained a number of hand injuries through his work, which required surgery and caused him pain.

27. Jayke had a history of alcohol and drug use, including the consumption of large amounts of alcohol daily. Jayke's ACSO[11] assessment recorded that from ages 18 to 20 years, he would consume up to 20 cans of premixed spirits daily. He reported during the assessment a regular pattern of using recreational drugs each weekend from about the age of 17 when he began using speed and then progressed to methamphetamine when he was aged 18 years. His methamphetamine use appeared to have increased when he moved to Mildura in 2015. Jayke made unsuccessful attempts to manage his drug use once his daughter, [redacted] was born.

[9] Dated 24 June 2024.
[10] CCA dated 30 August 2024, Secretary of DJCS dated 28 August 2024, Forensicare dated 5 September 2024 and SVCHS dated 30 July 2024.
[11] Australian Community Support Organisation.

28. In June 2017 Jayke reported that he had been suffering depressive symptoms since the age of 12. He described his schooling as a difficult experience as "*he was bullied as a child"*. He said that he would cry and run away but later began retaliating. He described "*flying into fits of rage as an adolescent/adult and sometimes blacked out when enraged.* [Jayke] *reported a history of violence. He reported more recently being able to contain his anger, but noted it was exacerbated by substance abuse".*[12]

29. There is evidence that Jayke's [redacted] attempted suicide. In addition, an uncle and close friend had taken their own life.

30. At the time of Jayke's passing, [redacted] was 2 years old. Jayke's mother lived in NSW and his daughter lived in Canberra with his former partner.

31. Jayne said that her son *had a loving family and a child he adored.*

Medical history

32. From 2015 to 2018, Jayke frequently attended the Deakin Medical Centre in Mildura for depression and a range of physical issues. During that time, he was regularly prescribed antidepressants.

33. The medical records document that on 19 August 2015, Jayke consulted general practitioner, Dr Paige Thompson (**Dr Thompson**), for depression. The records describe ongoing low mood despite fluoxetine (Lovan) and the use of quetiapine for *"? bipolar disorder"*. Jayke told Dr Thompson that he had a bad temper and had charges for assault which he did not remember. He experienced severe headaches which resolved spontaneously following a seizure incident. He admitted using methamphetamines.

34. Jayke had further attendances with Dr Thompson on 23 September 2015 and 27 January 2016 for depression where fluoxetine was prescribed.

35. On 7 March 2016, Jayke consulted with Dr Thompson. He required a mental health care plan for Corrections Victoria. He had stopped his antidepressant medication but indicated that he felt better when on it. He told Dr Thompson that his "*head play*[s] *up when he is*

[12] CB at p.1554.

alone" and reported using methamphetamine a few times in the preceding month "*when feeling down*." Jayke was referred to counselling but did not attend a scheduled appointment.

36. On 30 January 2017, Jayke consulted with Dr Ruby Kumari for depression where it was documented that he did not want to see a counsellor as he was "*feeling much better*" but also requested to be re-prescribed fluoxetine as it "*was helping before*."

37. On 27 March 2017, Jayke consulted with Dr Thompson for depression and poor sleep and wanted to restart his medication. He was prescribed fluoxetine and mirtazapine.

38. On 17 August 2017, Jayke consulted with Dr Thompson with high levels of anxiety associated with his hand injury and worry about his Workcover claim. His prescription of fluoxetine was increased at that time.

39. On 5 September 2017, Jayke consulted with Dr Thompson presenting as stressed and anxious regarding a court case. Dr Thompson discussed psychology with him and increased his fluoxetine dose to 40mg. His mood was noted to be "*much better*" by 25 September 2017.

40. Jayke was assessed by a psychiatrist in December 2017 for the purposes of work capacity, and he found that Jayke was not impaired for any psychiatric reason.

41. On 12 January 2018, Jayke told his general practitioner that the assessment report had not been favourable and he was encouraged to have some counselling under a mental health care plan. Jayke referred to his mental health as "*shit"* and said he had self-ceased his medication and would start back on them again.

42. On 5 February 2018, staff from Xchanging (Workers Compensation) spoke to his general practitioner, concerned that Jayke sounded suicidal. He had told them he would rather be dead. He later assured Dr Thomspon that he was mostly frustrated about his payments being cut off.

43. Jayke underwent an independent medical examination on 9 February 2018 related to a thumb injury he sustained in July 2016. The doctor noted that Jayke had undergone an operation of his fifth finger in June 2017 and that Jayke had a "*long-standing history of depression/bipolar disorder*."

44. In April 2018, Jayke underwent open reduction and internal fixation for his thumb injury.

CHRONOLOGY

First period of detention

45. Jayke had a criminal history dating back to 2015 where he was subject to a number of Community Corrections Orders with conditions related to mental health and drug and alcohol use.

46. Jayke was remanded to the Melbourne Assessment Prison (**MAP**) for two weeks from 6 March 2018 for charges of burglary and theft.

47. MAP is one of the reception points for male prisoners entering the Victorian prison system. At the time of Jayke's death, MAP was the only prison at which Forensicare was contracted by Justice Health to provide both primary[13] and secondary[14] mental health services.

48. At reception, all prisoners go through a screening process that includes a general assessment by a prison officer, a medical assessment by the general health service and a reception psychiatric assessment by Forensicare. At this time, Forensicare clinicians allocate and assign 'S' and 'P' ratings, if indicated.

49. Risk ratings are assigned to prisoners where they have identified issues within a particular area. [15] Suicide and self-harm ratings are referred to as 'S' ratings; there are four categories that range from S1 to S4 (S1 being currently at risk to S4 as not currently at risk.) The ratings denote the level of observation indicated by clinical assessment.

50. Psychiatric ratings are referred to as 'P' ratings and refer to the assessed need for psychiatric treatment and follow-up and have four categories that range from P1 to P3 (P1 being a serious psychiatric condition requiring intensive and/or immediate care to P3 being a suspected psychiatric condition requiring assessment). The ratings denote the severity of an existing psychiatric condition and required intensity of care and treatment.

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[13] Primary mental health services, which comprise mental health nursing, triage and referral to specialist services.
[14] Secondary mental health services, which comprise specialist outpatient services and visiting clinics, voluntary acute and sub-acute inpatient care.
[15] Other areas are Medical, Security and Violence.

51. At Jayke's initial appointment with medical officer on 6 March 2018, a plan was documented to reinstate fluoxetine and review if needed, but the prescription appeared to be cancelled in that same entry.

52. A Forensicare psychiatric nurse saw Jayke shortly after he had been seen by the doctor. He was observed to be "*anxious and depressed… reports that he should have been admitted to a psychiatric unit because sometimes 'I lose my shit… spin out'*." The nurse noted risk factors for suicide including first-time remanded, high risk age group, substance use, family history of mental illness and suicide, mental health diagnosis (depression, anxiety) and previous suicidal ideation.[16] A plan was documented to obtain collateral health information from Jayke's general practitioner, for Jayke to be referred to a nurse practitioner for assessment, and for him to be referred to a Forensicare psychiatric nurse at MAP for further assessment in approximately 2 weeks' time.

53. Jayke was assigned risk ratings P3 and S4.

54. Jayke was also interviewed by a prison officer to assess his security risk and placement, and was rated as a medium security risk.

55. On 8 March 2018, Jayke was transferred to the Metropolitan Remand Centre (**MRC**) where a psychiatric nurse conducted an interprison transfer assessment. It was documented that he reported a history of depression and was stable on current medication.

56. On 22 March 2018, Jayke was granted bail.

Second period of detention

57. On 31 May 2018, Jayke was arrested in Mildura for offences including aggravated burglary, cause serious injury and possess firearm/offensive weapon. The alleged offences occurred on 25 May 2018. During the incident, Jayke told the victim that he would shoot him and then himself, and that he didn't care if he died. Jayke's former partner told him that the

[16] Notes records: "*First timer. Remanded 22/03/18 (sic). Presents with psychiatric conditions. On medication. History suicidal ideation – never acted on same. Family history suicide. Denies suicidal ideation. Has protective factors. Aware crisis call and self-referral*." CB at p.407.

victim had harmed her, and Jayke said his offending on this occasion was in response to this information.

Melbourne Assessment Prison

4 June 2018

58. On 4 June 2018, Jayke entered MAP and was classified as a medium security prisoner.

59. That day, Jayke underwent a routine medical assessment by a medical officer. He did not report any history of chronic medical conditions but self-reported a hand injury which had required surgery at St Vincent's Hospital. Collateral information from St Vincent's Hospital confirmed that Jayke had sustained a fracture to his left first metacarpal which required surgery on 20 April 2018. It was noted that he had not attended post-operative follow up while in the community.

60. Jayke was then assessed by a Forensicare psychiatric nurse who completed a Reception Psychiatric Assessment. During the mental state examination, she noted Jayke was co-operative and pleasant, with underlying irritability, hostile as well as "*self-entitled and difficult to engage"* but also "*engaging well at the time of"* review. She noted that he denied any risk to self or others, denied any psychotic symptoms and **requested to be recommenced on his antidepressants**[17] which he had ceased while in the community four months prior. Jayke's ice and cannabis withdrawal, and labile mood, were noted as risk factors.

61. The Forensicare psychiatric nurse assigned risk ratings P3 and S4 and formulated a plan for Jayke to be referred to a nurse practitioner for mental state assessment and recommencement of antidepressants, to a Forensicare psychiatric nurse at MAP for further assessment in approximately 3 weeks' time and to obtain collateral information from Jayke's general practitioner. A diagnosis of depression was recorded. The records further document that the self-referral process within the prison was discussed with Jayke and he agreed to self-seek help if required.

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[17] CB at p.210. This was his first *overt* request to be recommended on his antidepressant medication.

62. A Mental Health Screening Intake Assessment confirmed that Jayke was not registered in the Client Management Interface (**CMI**), the system used by public mental health services, as he had no previous contact with the Area Mental Health Services.

63. On 5 June 2018, Jayke was interviewed by a prison officer, where he was noted to be co-operative and polite and denied any suicidal and self-harm (**SASH**) concerns. Psychiatric evaluation was noted as being recommended.

Port Phillip Prison

6 June 2018

64. On 6 June 2018, Jayke was transferred to Port Phillip Prison (**PPP**). This prison is not a reception point and a person is only transferred to PPP via an interprison transfer which is completed by the service that is providing primary mental health services at that facility. St Vincent's Correctional Health (**SVCHS**) were contracted by Justice Health to provide such services.

65. Forensicare was contracted to provide secondary mental health services at PPP.

66. In addition to reviewing the prisoner, an interprison transfer involves reviewing any existing mental health assessments, treatment plans and risk management plans recorded on JCare, as well as verbal communication in exceptional circumstances.[18]

67. An interprison transfer assessment was conducted by a SVCHS psychiatric nurse[19]. She documented a diagnosis of bipolar and depression. He admitted to poor judgement and gross impulsivity. It was noted that no psychotropic medications had been prescribed in custody however he had previously been prescribed Lovan 20mg nocte (fluoxetine) and Axit 15mg nocte (mirtazapine). He was noted to be a methamphetamine user and smoker. No previous psychiatric admissions were disclosed.

68. Jayke described his mood as "*2/10 sad and anxious*." The nurse documented that his sleep was "*affected due to racy thoughts, anxiety and poor sleep*."

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[18] CB at p.468.
[19] CB at p.252.

69. On mental health assessment, Jayke did not express any signs of suicide or self-harm to himself or harm to others. There were no signs of paranoia or hallucinations present. He was cooperative, calm and polite and reported that he was eating and sleeping well.

70. The management plan included a psychiatric nursing review for mental state examination (no time frame proposed) and that he should "*self-refer to clinics as required*."

71. Jayke's risk ratings remained as P3 and S4.

7 June 2018

72. On 7 June 2018, Jayke underwent a review by a SVCHS psychiatric nurse (**RPN ST**) as part of a Chronic Health Care Plan (**CHCP**) review[20]. The nurse noted, "*relapse triggers and new stressors are identified, and patient understands how to access health care and resources*." In the same entry the nurse recorded "*no imminent concerns noted, identified or reported*" and "*spoke about struggling with emotions*."

73. Jayke self-reported depression since 2012 when his [redacted] attempted to kill himself. He stated that he had become a "*person who has no emotion, hard and it worries him. Stated that he does not cry or become emotional…. Pt seeking help to get his emotions back*." The nurse also noted, "*use medications as prescribed to avoid side effects and avoid missing doses to prevent relapse*." Jayke was aware of his mental health issues and had agreed to seek health care if needed. The management plan consisted of follow up with a psychiatric nurse on 26 July 2018 and for Jayke to self-refer if in crisis. His next CHCP was scheduled for 4 September 2018.

74. On 9 June 2018, Jayke presented to health staff as he had developed pain in his hand while lifting weights in the gym. It was noted that his thumb was swollen and bruised and he was not able to make a fist. His recent hand surgery was noted. A Tubigrip bandage and ice was applied and simple analgesia was prescribed. Jayke was advised to present to the Nurse Clinic for review the following day. Jayke presented on 11 June 2018 for pain killers.

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[20] CB at p.206-208.

13 June 2018

75. On 13 June 2018, Jayke was reviewed by a SVCHS psychiatric nurse.[21] The nurse noted that he was pleasant and polite, had good insight and judgement and he did not express any thoughts of suicide or self-harm. He presented in a stable mental state and self-reported depression and anxiety. Jayke reported that he was on antidepressants which he self-ceased and **expressed a wish to go back to Avanza**[22], noting difficulty coping in prison without medication or drugs. Jayke cited his family and friends as protective factors although they were not able to visit as they were interstate. He reported that he spoke by phone with his family and his mother sent money. The nurse's plan was for "*ongoing psych review*."

76. On the same day, Jayke was reviewed by a medical officer in relation to his hand injury. He was given three days of pain relief in the form of Tramadol.

77. On 16 June 2018, Jayke was reviewed by a medical officer in relation to his hand injury where it was noted that he appeared to be in pain. The plan was for an ultrasound of the left thumb and referral to the hand clinic at St Vincent's Hospital (**SVH**).

78. On 22 and 23 June 2018, Jayke was reviewed for cold-like symptoms. On 25 June 2018, he was seen for back pain from working in the kitchen packing boxes.

79. On 29 June 2018, the health staff responded to a Code Black, medical emergency as Jayke had reported back pain while working in the prison kitchen. He required transfer to the medical centre for assessment where he was issued with pain relief. Another doctor saw him later that day due to inadequate pain relief. The doctor referred him for physiotherapy and started naproxen for anti-inflammatory pain relief. A lower bunk was requested. Over the following days, Jayke presented for pain relief on a regular basis as well as for other physical ailments.

80. Jayke also had physiotherapy and dental work over the next few weeks.

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[21] CB at p.204-205.
[22] CB at p. 205. This was his second *overt* request to be recommended on his antidepressant medication.

30 July 2018

81. On 30 July 2018, Jayke was reviewed by a SVCHS psychiatric nurse[23]. He reported that he had been feeling sad and more irritable over recent weeks and that he was not sleeping or eating well. He **requested to recommence antidepressant medication**,[24] citing that he was more stable when on medication and reported that he had days when it was hard to go to work. Jayke was counselled to exercise patience in the workplace to reduce his irritability. Jayke told the nurse his previous medications were ceased prior to police intervention. He self-reported depression and anxiety as well as a drug history of ice, cannabis and alcohol abuse daily. Jayke disclosed a family history of bipolar affective disorder. He reported the following since his last review on 13 June 2018,

> *his mood always low however identifies feeling sad and more irritable, angry, poor sleep and feels like a trigger waiting to go off (poor impulse control), denies manic episodes except when on drugs requesting to recommence his medications as felt generally stable when taking these Reports racing thoughts, everything, when not distracted*[25]

82. Jayke denied any perceptual disturbance or perceptual abnormalities and there was no sign of psychosis. He was keeping in regular contact with his family by phone and exercising to keep fit. Jayke was assessed as at low risk of suicide or self-harm and identified his family and friends as a protective factor.

83. The summary documented,

> *24 yo first time prison Established substance Hx, self reports Depression anxiety treated with Mirtazapine, Prozac was stable when taking these requesting to recommence antidepressants, fraternal Hx of Bi polar* [redacted]*, reports depressive symptoms for past few weeks*

[23] CB at p.199-200.
[24] CB at p.199. This was his third *overt* request to be recommended on his antidepressant medication.
[25] CB at p.199

poor sleep, increased irritability anger poor appetite and feeling sad, no evidence of psychotic phenomena or perceptual disturbance denies SASH intent[26]

84. In follow up, a referral was made for Jayke to be assessed by the Forensicare psychiatric registrar at the St Paul's Unit for a diagnosis and treatment review, where he was placed on the waiting list. The referral letter was completed on 30 July 2018 and sent the same day and accepted by Forensicare on 6 August 2018. An appointment was subsequently made for 22 August 2018. The nurse also noted another psychiatric nursing appointment was scheduled for two weeks' time.

85. Jayke's risk ratings remained as P3 and S4.

86. On 2 August 2018, at a review with a medical officer, Jayke requested Lyrica as pain relief for his hand. His back pain had resolved. He was offered an alternate anti-inflammatory medication (Celebrex) which he refused.

13 August 2018

87. On 13 August 2018, Jayke underwent a review by a SVCHS RPN ST.[27] As Jayke reported that he was enjoying his work but irritated by some other workers (he was *at the verge of punching them*), he was counselled to exercise patience in the workplace.

88. Jayke **again requested antidepressant medication**.[28] The nurse documented that he was "*seeking medication to take the edge off blaming stopping bipolar medication as a cause of his increased irritability*." His insight and judgement were described as fair and there were no signs of depression. He denied any thoughts of suicide or self-harm and there were no risks identified. The nurse's documented plan was "*self-refer in crisis*" and a psychiatric nurse booked to follow up for mental state examination on 3 September 2018.

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[26] CB at p. 200
[27] CB at p.197-198.
[28] CB at p.198. This was his fourth *overt* request to be recommended on his antidepressant medication.

Transfer of Appointments from PPP to Marngoneet

89. As Jayke was being transferred to Marngoneet, on 17 August 2018 the SVCHS Administration Support Worker created an entry in JCare that listed (in red text) the internal appointments which had been scheduled for Jayke which included the appointment at St Paul's Unit on 22 August 2018.[29]

90. At the time of Jayke's passing, the functionality of JCare did not allow for scheduled clinical appointments with a psychiatrist (or any other type of clinician) from one site to remain in place when a prisoner transferred to a new site due to there being a different clinic structure and waitlist. This resulted in the appointment on 22 August 2018 being cancelled on JCare.

Marngoneet

91. Marngoneet is a medium security prison that, at the time, housed remand and sentenced prisoners. It had four neighbourhoods and a number of other buildings including its Operational Management Centre (**OMC**) and Belin Belin Health Centre (**Health Centre**).[30]

92. The JARO report described the four neighbourhoods as Rothwell, Station Peak, Spring Hill and Flinders Peak, which functioned as independent therapeutic communities. Each neighbourhood included a combination of cellular and self-contained cottage accommodation, along with a neighbourhood centre and recreational facilities. Cottage accommodation aims to facilitate the rehabilitation of prisoners by emulating aspects of daily life in a non-custodial environment.

93. The OMC is a centrally located building, outside of its four neighbourhoods which is adjacent to, and connected with, the Health Centre.

94. According to the JARO report, the OMC had a number of functions including the management of prisoners who are separated. The cells used to separate prisoners at Marngoneet include four management cells located in the OMC; two observation cells and

[29] CB at p.197.
[30] At the time of Jayke's death, it accommodated approximately 517 prisoners with an operating capacity of 559 prisoners.

two health ward cells located in the Health Centre and twelve cells in the Stringybark separation unit located in the Flinders Peak neighbourhood.

20 August 2018

95. On 20 August 2018, Jayke was transferred to Marngoneet where he remained until the incident that led to his death. He was placed in the Springhill Mainstream Unit.

96. Marngoneet is not a reception point and, as noted above, a person is only transferred to Marngoneet via interprison transfer which is completed by the service that is providing primary mental health services at that facility. Justice Health contracted Correct Care Australasia (**CCA**) to deliver primary health care at Marngoneet. Forensicare was contracted to provide secondary mental health services.

97. On 20 August 2018, a CCA psychiatric nurse (**RPN B**) performed a face-to-face interprison transfer assessment with Jayke. Her mental state assessment described "*appropriate*" thought content. Jayke's inquired mood was documented as "*euthymic*." Much of the documentation was not completed including the page on Suicide and the Summary. There was no detailed documented plan for mental health care to follow up, but a box was checked for follow up action based on his 'P' rating by 27 August 2018.

98. Jayke underwent a urinalysis test on 20 August 2018, with a negative result.

99. On 23 August 2018, a Case Management Review Committee (**CMRC**) met with Jayke to induct him into Marngoneet and discuss any concerns he had. Jayke said that he was supposed to be taking medication for anxiety and depression, but he did not receive any medication at PPP. He said that he had already spoken to the Marngoneet medical staff about this medication. Jayke said that he was seeing a psychiatric nurse at PPP, because he was hearing voices telling him to hurt someone, however that these voices had stopped since his arrival at Marngoneet, as it was a more relaxed environment. He had asked to see a dentist, because he had been in a lot of pain. He had also fallen over and reported consequent issues with his left thumb. He expected to receive visits on an irregular basis, including from his former partner and their two-year-old daughter, who lived in Canberra. He planned to make telephone calls. He requested to be accommodated with friends in the Rothwell Mainstream Unit, saying that he had no family in Victoria. He said that he was a

qualified welder and had applied to work in the prison metal factory. The CMRC said that he could talk to prison officers about any issues that arose, as they were approachable and handled issues discreetly.

100. On 27 August 2018, Jayke did not attend a scheduled appointment with a psychiatric nurse who re-booked an appointment for 3 September 2018.

101. On 28 August 2018, the Local Plan File notes[31] documented that had Jayke attended his induction on 23 August and the neighbourhood rules and expectations were explained. Jayke stated that he had no issues or concerns at "*this location at this time"*. He also stated that he was "*hearing voices"* and suffered from depression and anxiety. Jayke "*guaranteed his personal safety"* and was taken through the process for booking a medical appointment.

102. On 3 September 2018, as Jayke had not attended a mental health review, the health staff contacted the unit staff to remind him to attend. The review was rebooked for 6 September 2018.

103. On 4 September 2018, Jayke attended a review with a medical officer for left-hand pain relating to his chronic injury. Jayke requested Lyrica and Oxycontin as pain relief but this was refused. The medical officer discussed duloxetine with him and it was commenced at 30mg with a view to auto-increase to 60mg on 12 September. Dr Syed Udman confirmed that the drug was prescribed for neuropathic pain and the plan was for a follow up appointment with a medical officer in approximately one months' time. Dr Udman advised Jayke to inform staff if he developed any allergy type reactions or if he had any other concerns.[32]

6 September 2018

104. On 6 September 2018, Jayke attended a review with CCA RPN B.[33] Jayke reported that he had settled in well at Marngoneet without any issues or concerns. He also reported that he had been diagnosed with bipolar disorder by his general practitioner and was prescribed mirtazapine and Lovan. The notes record that there were no signs of a depressive disorder

[31] CB at p.1186.
[32] CB at p.2125-2127. Statement dated 21 July 2023.
[33] CB at p.196.

present and no signs of suicide or self-harm. Jayke reported a low mood, said he felt *"up and down"* and conveyed a flat affect. The plan was documented as "*aware of self-referral process and crisis call procedure."* The nurse acknowledged that Jayke had commenced duloxetine "*for pain purposes*".

105. Jayke's risk rating remained P3 and S4.

106. On 9 September 2018, Jayke was moved to the Rothwell Unit. This cottage style accommodation is not BDRP compliant (and is not intended to be).

107. On 11 September 2018, Jayke did not attend a dental appointment.

108. On 12 September 2018, the duloxetine 30mg tablets were discontinued automatically and the dosing regimen changed to 60mg daily (for 12 September 2018 to 11 March 2019).[34] The evidence suggests that his duloxetine was not discontinued prior to his death.[35]

109. On 19 September 2018, Jayke met with his corrections case worker who advised him to stay busy and reminded him to attend his medical appointments, after "*forgetting"* to attend two previous appointments which had been scheduled in September.

110. On 20 September 2018, Jayke called his former partner and asked why she made a no comment interview rather than a formal report to Victoria Police about the incident that he said led to his offending. He asked her to bring their daughter in for a visit. In a later call with his mother, he was angry about the situation with his charges, and the prospect of a very lengthy sentence.

111. On 27 September 2018, Jayke was reviewed in the medical centre after sustaining welding flash burns to his eyes while working in the prison metal industries. He was issued with eye drops for symptomatic relief.

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[34] CB at p.296.

[35] Correct Care was unable to locate the MultiDose Profile's recording administration of a weekly pack between 18-28 September 2018. Christine Fuller, Deputy Chief Executive Officer and Chief Nursing Officer at Correct Care Australasia said that, *it is unlikely that Mr Aleckson did not receive his prescribed medication between 18-28 September 2018. Notably, there were two documented interactions between Mr Aleckson and Correct Care nursing staff on 26 and 27 September 2018, and there is no record in those interactions of any concern being raised regarding Mr Aleckson's medication not having been received*.

112. Correction's records reflect that during his detention Jayke was noted to be a professional, punctual worker with a good work ethic who enjoyed attending work and even worked through his breaks.

Jayke as a witness

113. Jayke was a witness in criminal proceedings related to an aggravated burglary and stabbing that occurred in Merbein, Victoria, on 3 December 2017. He had been subpoenaed to give evidence at the County Court in a trial which was commencing on 26 November 2018.

Week preceding Jayke's death

Jayke's separation

114. On 29 September 2018, Jayke was accused of assaulting another prisoner. He was separated and placed in a management cell (Cell 3) in the OMC.

115. If a prisoner is on a separation regime, they are isolated from the other prisoners. In the OMC, prisoners have access to an isolated run out yard behind their cell. In contrast, the health wards only have access to one large run out yard and prisoners must be taken out at a specific time. Prisoners on a separation regime cannot attend programs, education, or go to the gym. Aside from any court appearances, medical appointments or phone calls, separated prisoners are contained in their cell.

116. The medical unit is advised of a prisoner's movement following their separation to facilitate the provision of any existing medical or health regime, including dispensing medication.

117. Jayke advised the prison officer inducting him to the OMC that he had no intention of self-harming.

118. According to the JARO report, Marngoneet's *LOP 1.17-1 – Management of Separated Prisoners* which was in operation at the time of Jayke's death, prisoners "*placed into separation cells at Marngoneet* [were] *to be managed in the least restrictive way appropriate to their separation requirements and to minimise the risk of harm to themselves*

and others". It was however "*expected that such cells do not contain hanging points and are BDRP compliant"*.[36]

119. Deputy Commissioner Melissa Westin advised the Court with respect to whether separated prisoners are considered to be at increased risk,[37]

> *Separated prisoners are initially considered to be at an increased risk of suicide or self-harm due to their separation. Separated prisoners are generally placed under management observation for the first 24 hours of their separation. The frequency of observation may range from constant to hourly. The officer must physically observe the prisoner and take reasonable steps to ascertain that he is unharmed, whilst taking into consideration the potential for exacerbating the prisoner's distress by intrusive actions.*
>
> *A separated prisoner may also be at increased risk due to the circumstances surrounding their separation, or the anticipated length of their separation. These risks are managed considering the type of separation placement and the intended length of stay. Separated prisoners at Marngoneet are not normally placed under observation unless their behaviour and mental health assessment indicates it is necessary.*

120. On 30 September 2018, Jayke had a short call with his former partner who was with his daughter. He told her he was in "*the slot*". He made future plans for a visit with his daughter and told his former partner to give his daughter a kiss and cuddle and to tell her he loved her.

1 October 2018

121. On 1 October 2018, Jayke had a short phone call with his lawyer.

122. Jayke's corrections records document that a prison officer rostered to the OMC on 1 October did not report any issues with his presentation ("*Jayke displayed polite and compliant behaviour towards staff"*).[38]

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[36] CB at p.178.
[37] CB at p.608.
[38] CB at p.1189.

2 October 2018

123. On 2 October 2018, Jayke attended Court via Tele Court where he was remanded to 31 January 2019.

124. The JARO report noted that *Deputy Commissioner's Instruction (DCI) 1.02 – At Risk Procedures,* which was in place at the time of Jayke's death, required prisons to maximise the safety of prisoners through the prompt identification of any '**At Risk**' issues that arise after transfer from another location, return to Court (including Tele Court) or at any other time during a prisoner's time in custody. Prison officers were therefore required to be aware of signs, factors and triggers that may indicate a risk of suicide or self-harm, noting that an active suicidal scenario may arise from a "*combination of pre-disposition, situational factors and elevated stress"*.

125. In accordance with this instruction, a follow up was conducted in relation to Jayke's welfare after his Tele Court attendance, where he indicated that he "*was fine and did not need to attend medical"*.[39]

126. At 3.00pm, a Sentence Management Panel (**SMP**) was convened to discuss the complaint against Jayke for assault and his separation. Jayke admitted the assault, saying he was frustrated because his personal items had been stolen. The SMP advised Jayke that the victim had not stolen the items, but was given them by another prisoner, and that he had assaulted the wrong person. The SMP noted that Jayke appeared to understand that his actions were inappropriate and he was remorseful and apologetic. Jayke reported stress associated with his court proceedings and his family living in NSW.

127. The SMP determined that Jayke would be transferred to MRC (Attwood Intermediate Regime Unit) for one month and he was advised that he could return to Marngoneet if he remained incident free during that time. The SMP also decided that his security rating would be increased to maximum upon his arrival at MRC.

128. The SMP reviewed Jayke's risk ratings and updated his placement rating to T3, noting that he presented "*as vulnerable in the custodial environment"*.[40]

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[39] CB at p.1189.

129. In an undated letter left by Jayke, he wrote that *"Marngoneet was the bomb im filthy im getting tipped*".

130. Jayke's corrections records document that a prison officer rostered to the OMC on 2 October did not report any issues with his presentation ("*He was polite and friendly towards staff and followed instructions as requested without any issues. He has nil issues or concerns at this point in time"*).[41]

3 October 2018 – Move to Health Centre

131. On 3 October 2018, Jayke was moved from a management cell in the OMC to Health Ward Cell 2 in the Health Centre while he waited for his transfer to MRC. The cell transfer was due to a shortage of management cells.

132. Acting General Manager of Marngoneet, Dale Slater (**Mr Slater**) explained in relation to the cell shortage[42],

> *At the time of* [Jayke's] *separation, Marngoneet was experiencing a shortage of available separation cells due to delays in transfers of prisoners to other prisons. Prisoners were spending longer times in separation cells awaiting transfer to other prisons because the receiving prisons had limited vacancies.*
>
> *Although single cell BDRP compliant accommodation was generally available for overflow, this was not preferred as it exposed or placed separated prisoners within the mainstream prison population, which would mean restrictions imposed on those mainstream prisoners to allow a separated prisoner to be moved within the unit. As a result, health ward cells were used as overflow separation cells.*

133. With the exception of some individual cells, the health wards are not BDRP compliant. It was noted that while every effort was made to reduce ligature points in the wards, it was not possible to eliminate completely all hanging points. For example, adjustable beds are required in the health wards and these cannot meet the applicable standards.

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[40] The JARO report noted this rating assignment occurred on 1 October 2018. CB at p.173.
[41] CB at p.1189.
[42] CB at p.507. in

134. The level of monitoring that Jayke underwent in the Health Ward cell was the same as that in the OMC. This consisted of visual checks undertaken at counts, when attending to requests, escorting him to exercise and telephone calls, responding to cell intercom calls and issuing meals. Interactions and observations of him were documented in the daily file notes. The level of monitoring was consistent with the relevant operating procedure at the time.

135. The 'At Risk' procedures[43] also always applied in addition to this monitoring regime. That meant that if a prison officer is concerned about a prisoner's suicide or self-harm risk, an 'At Risk' referral must be made immediately. All Custodial staff at Marngoneet received SASH training to enable them to recognise and respond to the behavioural indicators of an 'At Risk' prisoner. A Prisoner is deemed to be 'At Risk' if, in the opinion of the staff member, he is considered to be at immediate or significant risk of suicide or self-harm.

136. No formal risk assessment was however performed while Jayke was in the Health Centre.

137. At approximately 5.31pm on 3 October 2018, Jayke had a call with his mother (lasting 12 minutes) where he said he got kicked from Marngoneet as he had a fight after he found things he bought were taken whilst he was at work, and he was going to MRC. He said that with all his court and other things he just "*lost it"* and "*spun out"*. He assured his mother that he was "*alright"* and "*fine"*. He explained that all his cases had been consolidated and he wanted nothing outstanding. He referred to jail as his "*rehab for his daughter"*. He said he could return to Marngoneet if he was incident free and whilst he had restrictions at MRC he could still train and it would be okay. Jayke said that jail needed to happen, because otherwise "*he was going to end up six foot under"*. He said he was training and working again, missing seeing his daughter, but would be ready when it was time to leave. His mother reiterated to keep being strong, that she loved him very much and was thinking of him every minute.

138. Jayke's records document that corrections officer [redacted] (**PO 1**) rostered to the OMC on 3 October did not report any issues with his presentation ("*Jayke is in good spirits*

[43] Those prisoners within Marngoneet who display, or are assessed as having suicidal and self-harm (**SASH**) tendencies are managed in a safe, secure and humane environment that addresses their needs promptly and provides the necessary support and protection. Marngoneet Correctional Centre Local Operating Procedure - At Risk Procedures, LOP 1.02-1, 4 May 2017

and is glad he is on the bus tomorrow and is looking forward to that. Jayke has been respectful to staff and in good spirits").[44]

4 October 2018

139. At 9.45am on 4 October 2018, Jayke had a run out in the yard and was noted to be polite and friendly to prison officers.

140. At 10.42am, Jayke had a 12-minute phone call with his lawyer. In a letter to the Court, his lawyer said,

> [Jayke] *needed to speak with us prior to the sentencing for his summary matters listed at the Mildura Magistrates' Court on 13 November 2018. He indicated that he was due to be moved from Marngoneet Correctional Centre to Metropolitan Remand Centre shortly. He expressed some concern about this because there was an indication that he had received a subpoena to give evidence in the matter of a case of DPP v* [another] *on 28 November 2018*.
>
> [Jayke] *was hoping to get out of giving evidence in the [*other*] matter and he indicated that when he gave his statement he was drug affected at the time and can't really remember. He believed that* [the Defendant] *was remanded at the Melbourne Remand Centre as well*. [Jayke] *wanted to know if he could retract his statement as if people found out at the MRC about the matter it could cause him a lot of trouble*.[45]

141. Jayke's records document that prison officer [redacted] (**PO 2**) was rostered to the OMC on 4 October and did not report any issues with his presentation ("*He was polite and friendly towards staff and followed instructions as requested without any issues. He has nil issues or concerns at this point in time"*).[46]

142. PO 2 further stated[47],

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[44] CB at p.1189.
[45] CB at p. 436.
[46] CB at p.1189.
[47] CB at p.777-778.

I distinctly remember him as being in the medical cell and on separation. He was polite and friendly at all times. I had a chat with him at morning request, because I thought it was hard being stuck in his cell with only an hour out of the cell each day due to him being separated. I would try and do what he asked for whilst he was separated, to help him in his separation.

143. Prison officer Garth Studham (**PO Studham**) said that he thought Jayke had been in the Health Centre for a couple of days and knew him to be a separated prisoner but did not know the reason for his separation. He said that he presumed he would have been assessed prior to separation. PO Studham said he interacted with Jayke a number of times over those couple of days and Jayke,

seemed fine and never gave any impression that he was not coping or needed any medical or psychological assistance.[48]

144. At inquest he clarified that a prisoner would be asked how they were feeling and whether they needed to see someone from the health service, rather than undergoing a formal assessment prior to separation.

145. It was further noted that information provided by a prisoner to a health worker is not generally known to a prison officer. As a general rule, the personal health care information about a prisoner is kept private, and prison officers do not have access to JCare.

146. The JARO report noted that Jayke appeared to be *"calm and cooperative",* a quiet prisoner who worked well and appreciated keeping in contact with his family who kept him *"grounded".* His case worker met with him at the required frequency and he was encouraged to engage in work, maintain contact with his family, and avoid incidents.

CIRCUMSTANCES OF DEATH

147. At approximately 7.00am on Friday 5 October 2018, Jayke was served breakfast in his cell in the Belin Belin Health Centre (the cell is referred to as Day Ward 2 or Medical Ward 2). The cell had a single hospital bed on wheels and a separate bathroom. There was a glass

[48] CB at p.32.

window within the door to the cell. There was no closed-circuit television (**CCTV**) in the room.

148. During the morning Jayke requested fresh clothes, canteen items (via a Canteen Form), a run out in the yard and a phone call at 5.00pm.

149. Prison officer [redacted] (**PO 3**) said that his,

> *impression of* [Jayke] *was that he was conversational and polite. He was a good prisoner to work with. He did not raise any concerns, other than asking about the bus. He was in generally good spirits and did not appear in any way agitated. Often separated prisoners become closed off and demanding, however he was conversational and engaging.*[49]

150. At around 12.30pm, PO 1 brought Jayke in from the run out yard and said, "*we were talking to one another and laughing and joking. The interaction with* [Jayke] *lasted about 10 to 15 minutes".* About 10 minutes before the count[50] Jayke asked him whether he was on the bus for MRC. PO 1 checked the PIMS system and advised Jayke that he was not on the bus and he "*did not seem bothered by the response".*

151. At 1.05pm, PO 1 conducted the count and Jayke was observed to *"smile and wave"* acknowledging him for the count. He said that he viewed Jayke through the window in the health ward cell door where he observed him to be fully clothed. He said that he could see the furniture in the cell was in the position that it was meant to be.

152. At approximately 1.38pm, PO Studham and prison officer [redacted] (**PO 4**) attended Jayke's health ward cell to issue him with his canteen order. It was at this time they observed Jayke to be hanging from a makeshift rope from torn bed sheeting attached to his upturned bedframe utilising his metal cup as an anchor. The upturned bed was up against the bathroom door. A Code Black was immediately called. They were unable to get a response from Jayke who was lifted to support his body weight.

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[49] CB at p.488.
[50] The count is to ensure that all prisoners are accounted for and they are awake and without injury or harm.

153. Medical staff within the Health Centre immediately responded to the Code Black and an intervention knife was retrieved after which Jayke was cut down from his ligature. At approximately 1.40pm, the automatic external defibrillator (**AED**) was applied, cardiopulmonary resuscitation (**CPR**) was commenced and an Ambulance Victoria emergency response was requested. No shock was delivered as no heart rhythm could be detected.

154. At 1.54pm an ambulance arrived following which paramedics continued CPR. Country Fire Authority members were also in attendance.

155. Jayke was transported by ambulance to University Hospital Geelong where he was transferred to the Intensive Care Unit (**ICU**). Despite maximal care, a decision was made in consultation with Jayke's family that life support should be ceased, following which he was transferred to palliative care. At 8.53am on 15 October 2018, Jayke was declared deceased.

156. Police attended the health ward cell at 2.10pm on 5 October 2018 and seized relevant items. A notepad was located on which several handwritten notes had been made by Jayke including a note to his daughter which said, "*You are my world i'm so sorry I love you so much my little princess, do daddy proud. look after mommy"*. And a note to his mother which said, "*I'm sorry for all the pain I've caused you over the past few years, I truly am. Its all become too much for me and I'm so afraid. I love you so much Im so sorry for any pain I cause but im in a better place."*

157. In a number of other letters clearly written before Jayke's decision to take his own life, he said that no matter the outcome of his court hearing, he needed to use the time in prison as positively as he could including education as well as rehabilitation from the drugs and life he was living. He also mentioned being upset with himself for getting in trouble again ("*I'm in the slot at Marngoneet I'm being tipped to MRC because I had an incident"*). His letters include expressions of apology and that he felt he had made selfish decisions which he deeply regretted.

158. On 5 October 2018, Jayke's medical conditions were recorded as lactose intolerant, and depression, with his medications being: Celecoxib 200 mg Capsules, Dose: 1 capsule Midday; Paracetamol 665 mg Modified release caplets, Dose: 1 tablet bd Oral; Duloxetine

60 mg Capsules, Dose: 1 capsule daily Oral; and Diclofenac dimethylamine 1.16 % Emulgel, Dose: 1 Application bd Topical.

IDENTITY OF THE DECEASED

159. On 17 October 2018, Jayke Aleckson born 17 February 1994 was identified via fingerprint comparison.

160. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

161. On 23 October 2018, Dr Melanie Archer, medical practitioner and registrar in forensic pathology at the Victorian Institute of Forensic Medicine, conducted an autopsy and prepared a report of her findings dated 6 February 2019.[51]

162. Dr Archer noted that Jayke had a cardiac arrest secondary to hanging. Although circulation was restored, he sustained irreversible brain damage and died 10 days later. The autopsy confirmed severe brain damage due to lack of blood flow to the brain.

163. The autopsy and postmortem CT scan revealed no evidence of skeletal trauma, and there was no significant soft tissue injury.

164. Postmortem toxicology showed the benzodiazepine sedative midazolam, the analgesics morphine, codeine and paracetamol, the anti-vomiting drug metoclopramide, the anti-seizure drug levetiracetam and the antidepressant duloxetine. The results are largely consistent with therapeutic use in a hospital setting.

165. There was no evidence of any significant natural disease that could have caused or contributed to death.

166. Dr Archer formulated the cause of death as "*1(a) Hypoxic Ischaemic Encephalopathy; 1(b) Hanging"*.

167. I accept Dr Archer's opinion.

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[51] With supervising pathologist, Dr Joanna Glengarry.

FURTHER INVESTIGATIONS

Justice Health Quality Framework

168. The Justice Health Quality Framework April 2014 (**Quality Framework**), relevant at the time of Jayke's death, incorporated the principles of care delivery as expressed in the Justice Health, Health Policy (2011); the standards to which care must be delivered; and the structures, systems and measures by which the quality of care is monitored and improved.[52]

169. All contracted health services are required to comply with the Quality Framework.

170. The Quality Framework establishes minimum requirements for healthcare delivery. These minimum requirements include standards for the provision of health information and healthcare services that aim to address the particular needs of prisoners.

171. Advice was provided by Susannah Robinson (**Ms Robinson**), Acting Executive Director of Justice Health, that the Quality Framework is predicated on a coordinated, multidisciplinary approach to healthcare. Justice Health expects that health service providers will engage across disciplines to support management of individual prisoners' care needs and that staff involved will be appropriately trained in quality improvement methodologies to ensure evidence-based, best practice care is recommended and implemented.

172. According to the Quality Framework, prisoners are entitled to receive care that is coordinated across the care continuum to ensure a comprehensive and streamlined treatment journey. All health-related information about a prisoner is documented in the electronic medical record, JCare, which is managed by Justice Health, and is used by all prison health service providers across all prison sites. This means a prisoner's health record travels with them electronically; it can be accessed and added to in the same way by health providers across the Victorian prison system.

173. On entry into prison, all prisoners undergo a comprehensive assessment with a medical officer within 24 hours of entry into prison. A mental health screening is also conducted by

[52] The Quality Framework is designed to assist the Health Service Provider to implement a comprehensive approach to the provision of consistent clinical services across service and Prisoner types to achieve the best possible health outcomes. It also provides a means to demonstrate evidence of the quality of healthcare provided.

a mental health professional. This includes an 'At Risk' assessment which is an assessment of the risk of suicide or self-harm.

174. When prisoners are transferred within custodial settings, health service providers are required to provide relevant information to custodial staff to enable prisoners to be safely transferred to a different custodial facility, but also to ensure the choice of a facility is informed by the prisoner's healthcare needs. Providers are required to assess prisoners prior to transfer to determine that they are fit to transfer. Any prescribed medication accompanies prisoners upon transfer to, and from, custodial settings.

175. Ms Robinson advised that in order to ensure the continuity of healthcare, all prisoners transferred from another prison location undergo an interprison health assessment conducted by a registered nurse, medical officer, or nurse practitioner within 24 hours of transfer to the new prison site. This assessment builds on information obtained in previous health assessments and includes a review of any immediate health needs and current health status.

176. The Court's expert, Dr Rakov noted in her report that the dimensions of quality addressed in the Quality Framework are Safety; Effectiveness & Appropriateness; Person-centredness; Access and Continuity:

- Safety relates to "*prisoners* [having] *the right to expect healthcare that does them no harm*".

- Effectiveness and appropriateness relate to the "*extent to which a treatment, intervention or service is the right one for the prisoner and the extent to which it avoids unnecessary variation in the practice and standard of care*."

- Person-centredness related to "*opportunities for those receiving care to become active participants in their treatment*." This involves "*care that is planned and focused on achieving the greatest benefit to the prisoner in a way that is acceptable to the values, beliefs and cultures of that prisoner*." Healthcare staff "*have professional obligation to ensure that they understand their patients' healthcare problems and the prisoners understand the information provided to them*."

- Accessibility identifies an "*aim to minimise the anxiety and stress for prisoners accessing healthcare. Accessibility includes timely and appropriate access…*"

- Continuity describes a prisoner's entitlement to receive "*care that is co-ordinated across the care continuum to ensure a comprehensive and streamlined treatment journey*." This requires not only determining what care is needed but also requires clarifying roles and tasks to ensure the prisoner received the care they need. Continuity "*also requires that follow-up becomes a part of standard procedure*."

177. Dr Rakov noted that Health Service Providers are accountable for the quality and safety of clinical services. Staff "*must be selected, trained and managed so that their capacity and capability are optimal*" because "*Ensuring quality of care requires close attention to recruitment, credentialing, scope of practice, peer review, skills assessment, clinical supervision, skill mix and continuing education*."

178. Primary Mental Health Services[53] have minimum requirements. They are provided by a multidisciplinary team that provides a Mental Health Recovery Plan. They should provide treatment including a "*range of relevant therapies and interventions*." Prisoners should have timely access to primary mental health services that are non-urgent. Prisoners who decline participation in an assessment are followed up to ensure their mental healthcare needs are addressed.

179. Forensic Mental Health[54] denotes prisoners with a mental illness or mental health issue have access to co-ordinated, flexible levels of stepped-care services in Victoria. A minimum requirement is early intervention to prevent deterioration of the prisoner's mental health and management of risk of harm to self and others.

Findings from other reviews

Justice Health review

180. As already noted, Justice Health prepared a report summarising its review of the health care afforded to Jayke which was attached to the JARO report.

181. The review made the following findings,

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[53] Standard 5.3.9
[54] Standard 5.4.1

Based on a file review of Mr Aleckson's medical record, there is nothing to suggest that the healthcare provided to Mr Aleckson was not in keeping with the Justice Health Quality Framework 2014. As such Justice Health makes no recommendations for systemic improvements arising from the death of Mr Aleckson on 15 October 2018.

Justice Assurance and Review Office

182. As already noted, prisoner deaths are also reviewed by the JARO. In preparing its report for the Secretary, JARO had regard to the report prepared by Justice Health.

183. According to the JARO report, it was expected that the cells holding separated prisoners do not contain hanging points and are BDRP compliant.

184. JARO was advised that system pressures resulted in prisoners spending longer times in separation cells awaiting transfer to other locations resulting in an increasing number of separated prisoners being accommodated at Marngoneet and a shortage of available separation cells to place them in and that,

> *While single cell BDRP compliant accommodation is generally available for any overflow, Marngoneet management advised JARO that this option is not preferred as it exposes 'separated' prisoners to the mainstream prison population. Instead, JARO was informed that health ward cells, which are not BDRP compliant, have been, and continue to be used as overflow 'separation' cells*.

185. At the time of Jayke's death, BDRP compliant management cells were at capacity due to newly separated prisoners and as a result he was moved from a management cell in the OMC to a health ward cell. In addition, that to manage the risk of separated prisoners being placed in non-BDRP complaint cells,

> *Marngoneet staff had an informal and undocumented risk assessment process in place. This involved Marngoneet staff conducting a risk assessment by considering* [Jayke's] *low suicide risk rating and noting the absence of 'at risk' behaviours while he was separated, as well as the reasons for his separation. JARO notes that on this occasion, the factors considered in the risk assessment conducted by Marngoneet staff did not indicate or reveal* [Jayke's] *risk of self-harm or suicide*.

186. In summary, the JARO made the following findings:

a. Jayke's demeanour prior to the incident that led to his death was overall calm, forward looking and friendly. He did not present to prison officers with signs that indicated a risk of suicide or self-harm.

b. Jayke's case management complied with the standards prescribed by Corrections Victoria.

c. The management of the incident that led to Jayke's death was appropriate.

d. Marngoneet's continued use of not BDRP compliant health ward cells to separate prisoners, even those who are 'low risk', presents an increased risk of harm to those persons.

187. The report made the following recommendation, the second of which was accepted by the General Manager, Marngoneet at the time,

1. *That the General Manager, Marngoneet:*

a) in consultation with the Commissioner, Corrections Victoria (or delegate) consider ceasing to use cells that are not BDRP compliant (including health ward cells) as 'separation' cells; or alternatively

b) update its Local Operating Procedures and corresponding practices to ensure that separated prisoners are only placed in cells that are not BDRP compliant as a last resort, for the shortest time necessary and after a documented risk assessment process has been undertaken. The risk assessment process should consider an 'at risk' assessment by a mental health professional highlighting any factors that contraindicate the placement of the prisoner.

188. As subsequent evidence established, in February 2020, Marngoneet implemented a new version of *Local Operating Procedure 1.17-1 - Management of Separated Prisoners*, which stated that "[p]*risoners under separation will never be placed into the Health Ward Cells*."

189. In a further change, CCTV cameras were installed in July 2019 with vision of the interior of the health ward cells.

Use of restraints

190. Jayke had leg restraints fitted when he passed away whilst in palliative care. The JARO report made a recommendation,

> *That consideration is given to developing a process where leg restraints are removed from a prisoner when entering an end-of life (palliative) situation at hospital.*

191. That recommendation was accepted, noting "*A decision will be made by the GM on a case by case based on medical advice".*[55]

192. I consider that the removal of leg restraints for prisoners who are transferred to end-of-life care, is an appropriately humane response to those circumstances.

Expert Advice regarding mental health services

Dr Rakov

193. Of the experts who provided advice to the Court about Jayke's care, Dr Rakov was the only expert who had worked in a prison environment for a significant period.[56]

194. Dr Rakov noted that structured clinical handover is known to improve patient safety and points of transition are known to be highest risk for communication errors leading to poor patient outcomes.

195. At the point of the transfer from MAP to PPP, Dr Rakov said there was no documentation to suggest an active decision was made by PPP staff not to pursue an appointment with a prescriber, that is, that it was not indicated or inappropriate. She noted that the internal appointment on 25 June 2018 was noted at the time of the transfer request on 5 June 2018 but it appeared the previous plan formulated at MAP was merely overlooked. Dr Rakov considered that this was not clinically appropriate and did not support continuity of care as required by the Quality Framework.

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[55] CB at p.184.
[56] Report of Dr Rakov, CB at p.1860

196. Dr Rakov further noted that despite the SVCHS psychiatric nurse on 6 June 2018 identifying multiple symptoms of a depressive illness (despite no concluding impression) and recording that no psychotropic medications were prescribed in custody with two medications having been previously prescribed, the only plan was for nursing reviews to be made with the option to "*self-refer to clinics as required*." Dr Rakov commented that while no documentation of Jayke making a request to obtain medications is evident, the recognition of prior treatment of depression as well as numerous symptoms of major depressive disorder would have also warranted a referral to a prescriber (whether nurse practitioner, medical officer, or psychiatric registrar).

197. Dr Rakov noted in relation to the clinician's view that she *"did not have collateral health information"*, that Jayke had described symptoms of depression and a previous prescription of medications for this illness to the clinician and, in Dr Rakov's view, she did not require any more *"collateral information"* than the assessment and plan made on 4 June 2018, together with her contemporaneous mental state examination, to make such a referral. Dr Rakov said that in her view the nurse's assessment alone (complains of depressive symptoms and used to take antidepressants) would have been sufficient in isolation to escalate to a prescriber, whether nurse practitioner or medical officer.

198. Dr Rakov noted that Jayke again reported to a SVCHS psychiatric nurse on 13 June 2018 that he wished to return to taking antidepressant mirtazapine, stating that it had been *"difficult to cope"* without it (and drugs) in prison. Dr Rakov noted that in the clinical entry there was mention of Jayke's request to return to his medication, however this information was omitted as part of the nurse's clinical reasoning in her statement. The nurse said that "*based on my usual practice, if I had felt that a prisoner required psychiatric medications, I would refer to a psychiatric registrar*." Dr Rakov considered that ignoring his request to return to his previous treatment for depression by not escalating to a prescriber breaches compliance with Patient-Centredness and Accessibility as required by the Justice Framework.

199. Dr Rakov noted that SVCHS RPN ST saw Jayke on 13 August 2018 (she had also seen Jayke on 7 June 2018) and in her statement she said that he had been referred to a psychiatric registrar, but this was not reflected in her clinical entry. Her clinical entry documented that he was "*seeking medication*" and that he "*was on medication in the*

community." RPN ST stated she had reviewed him not to be at "*imminent risk*" which is why she pursued a nursing review. Dr Rakov said that people do not warrant mental health treatment (via prescription) only if they are at imminent risk.

200. Once transferred to Marngoneet, Dr Rakov examined the clinical appropriateness of the decision by staff at Marngoneet not to reschedule Jayke's appointment for a psychiatric review. She considered from the documentation that the interprison transfer conducted by RPN B on 20 August 2018 to be "*woefully inadequate"*, noting that the form was completed in two minutes, there were large blank sections, and most of the information available was copied and pasted from the 6 June 2018 review. Dr Rakov commented that there is a "*difference between not determining something to be clinically indicated and determining something to be not clinically indicated"* and there was nothing to suggest an active and considered process was undertaken to establish or dismiss the clinical indication for a medical review and that it appeared this was an omission that came as a result of inadequate assessment of the information available and longitudinally from the clinical file.

201. Dr Rakov did however note,

> *that while observations can be made from each individual attendance, what is most prominent is the cumulative decision-making burden regarding risk and medical management placed upon subsequent clinicians, due at least in part to the absence of a Mental Health Recovery Plan developed by health staff*.

202. She considered that failing to obtain a psychiatric doctor's assessment in the face of multiple points of acknowledgement of a mood disorder, in the context of the multiple requests to return to antidepressant treatment, was a departure from the reasonable standard of care.

203. Dr Rakov noted that during a follow-up appointment on 6 September 2018 with RPN B, the nurse observed that Jayke was low, flat, feeling *"up and down",* and had recently been commenced on duloxetine (for pain). She commented that as a prisoner with a P3 rating, follow up should have been arranged rather than merely "*aware of self-referral process and crisis call procedure*" and this was an inadequate plan.

204. With respect to the appropriateness of duloxetine to address mental health symptoms, Dr Rakov noted that it is a second-generation antidepressant (specifically, serotonin and

noradrenaline reuptake inhibitor) and it has strong evidence for efficacy as an antidepressant although with higher dropout rates regarding acceptability. Further, that it is specifically indicated for pain with depression.

205. Dr Rakov commented that while duloxetine was not an unreasonable choice for mental health care, it is considered a second-line agent of choice as per RANZCP guidelines for mood disorders and a therapeutic dose is considered to be 60-120mg. She noted that a dose of 60mg was initiated on 12 September 2018 but this medication was not likely to restore Jayke's disturbed sleep.

206. Dr Rakov further noted that initiation of all antidepressants can produce worsening of depressive symptoms and/or the emergence of suicidal ideation and that no matter the indication for its use, this should have been monitored by a follow up appointment from the prescriber or other clinical staff.

207. With reference to the Quality Framework, Dr Rakov noted that Jayke asked on multiple occasions to return to his antidepressant medication and this was not followed up and there were multiple entries denoting Jayke's awareness of crisis calls and self-referral. She observed that repeated denial of requests for his medication to be reinstated could serve as a deterrent to ongoing self-referral. Dr Rakov said that Jayke was not granted access to or continuity of appropriate care and this departs from all dimensions of the Quality Framework.

208. Regarding assessments, Dr Rakov observed that adequately performing a mental status examination requires an understanding of psychiatric phenomenology and some general awareness of the diagnostic criteria associated with individual conditions. She said there was very little evidence provided about the determination of the presence of depression apart from enquiries about mood and suicidality and noted that there are multiple other symptoms of depression which need to be explored in determining or excluding the presence of mental illness. 'Thought content' is one of the most significant domains in mental status examination and it was not sufficiently explored by any means throughout his incarceration. She noted brief mention about Jayke's concerns around "*access to 2-year-old daughter*" and his "*stressed partner*" but said that the only means of hoping to assess risk with any semblance of accuracy, and in turn guide clinical management, is by taking an accurate and

relevant assessment in the current context circumstances, monitoring any longitudinal change, and engaging meaningfully with the patient.

209. Dr Rakov said that relevant negatives become irrelevant (e.g., documenting '*no psychosis*') in someone who never presented with psychosis and tells us far less than simply discussing whether he felt stressed or anxious due to inadequacy as a partner/father/person or unexplored frustration with another matter such as having been made a witness in another prisoner's case. And that without asking a patient what is going on for them, clinicians can simply not accurately know.

210. With respect to the documentation in Jayke's clinical record, Dr Rakov observed that there was a distinct paucity in the quality and congruence in many of the entries. It was her view that the mental state documentation provided in Jayke's Justice Health file was a significant departure from an adequate standard.

Dr Scott Hall

211. Dr Scott Hall, consultant psychiatrist, advised that he was not a specialist in Forensic Psychiatry, nor did he routinely work in prison settings. His specific focus was on events following Jayke's transfer to Marngoneet.[57]

212. Dr Hall provided an opinion that he would expect the following standard of care from a psychiatrist should they have assessed Jayke at Marngoneet:

    a. On receiving the referral, they would identify that Jayke had been transferred to a new prison setting and that the assessment (based on the content of Jayke's JCare notes) was thus far incomplete and inadequate.

    b. He suspected that a psychiatrist working for Forensicare would have been aware of a fragmented governance system underpinning the provision of psychiatric assessment and treatment of transfer patients. Furthermore, on reviewing the notes, a psychiatrist would have identified that a range of assessors at different sites had seen Jayke. A psychiatrist aware of such imperfect systems would have been able to pick up on

[57] Report of Dr Hall, CB at p.2148

omissions in assessment and identify that Jayke could be at risk of falling through the mental health care gaps.

c. They could conclude that Jayke's mental health would have benefitted from further assessment and obtaining collateral information from a range of sources. They would have developed an interim plan to ensure these systems issues were tended to.

d. They would draw together the relevant existing data and obtain information from Jayke by taking a history, developing a rapport, and identifying the salient aspects of his presentation to arrive at a diagnosis, formulation, and treatment plan.

e. They would identify that a full psychiatric assessment may not be achieved in a single appointment and ensure arrangements were made to see the patient again and develop an interim plan for nursing or allied health staff to follow.

f. The integrative tasks above are those expected of a psychiatrist but would not be expected of registered psychiatric nurses, whose role would focus on specific tasks such as obtaining data, following protocols, monitoring treatment, and executing defined care plans.

213. In terms of risk assessments, Dr Hall commented that,

a. A psychiatrist would move beyond the usual 'tick boxes' of a risk assessment – as noted in prior nursing assessments and develop a risk formulation based on the following factors.

b. They would have noted that this was Jayke's first prolonged stay in prison and that there was marked uncertainty regarding when he would move through the legal system, that he was presenting with depressive symptoms, and that he likely suffered from a range of comorbid psychiatric conditions. He was a young man with limited educational achievement, with a clear and consistent history of poor impulse control. He had consistently exhibited externalising behaviours, and he would likely be vulnerable to abuse and exploitation from others in prison. They would likely also have noted that his [redacted] made a severe suicide attempt, and he had friends who committed suicide, he appeared to have very low self-esteem and did not appear to

value his life, that he was likely struggling to manage his distress and had no access to illicit substances.

c. He was separated from his family, his child and ex-partner for the foreseeable future with no prospect of seeing them, and he seemingly held a belief that something untoward had happened to his ex-partner and that she was not willing or able to communicate this to the police. They would also have noted his continued experience of persistent pain despite trialling a range of treatments.

d. In view of the multiple factors described above, Dr Hall concluded that had he been assessed by a psychiatrist they would likely have identified that he was at elevated risk of suicide. However, there would have been nothing to suggest Jayke was at imminent risk of suicide.

214. It was Dr Hall's opinion that based on a review of the evidence it is likely that Jayke suffered from a chronic mood disorder (persistent depressive disorder) which predated his incarceration in June 2018, and worsened while he was a prisoner. He also likely suffered from comorbid psychiatric conditions of a severe substance use disorder and a persistent pain syndrome, which were likely to have had a reciprocal relationship with his mood disorder (i.e. one exacerbated the other).

215. He considered that a reasonable treatment plan may have consisted of:

a. Antidepressant medication – commencement and titration.

b. Ensuring psychological therapy provided regularly (at least weekly).

c. Contact with family to obtain collateral information.

d. Psychoeducation and encouragement to verbalise his distress.

e. Development of a treatment plan for substance use disorder focusing on relapse prevention.

f. Further evaluation of comorbid conditions.

g. A reasonable follow-up period with a psychiatrist and fixed monitoring with nursing staff or psychologist – weekly.

h. Follow up with a psychiatrist in at least a month and provision of secondary consultation to clinicians in the prison staff in the interim.

216. He commented that Jayke would have unlikely benefited from medication treatment in isolation i.e. without other treatment modalities such as intensive psychological therapy. In his experience, antidepressants tend to have a therapeutic effect on those presenting with the most severe forms of depressive illness, the features of which were not consistently evident leading up to Jayke's suicide attempt on 5 October 2018. He observed that if anything, his activity and physical fitness levels had improved during his time in prison. He reported having gained weight and was sleeping relatively well.

217. Dr Hall commented that suicidal thoughts are related to negative emotional states such as despair, guilt, abandonment, humiliation, shame, perceived burdensomeness, thwarted belongingness, hopelessness, and entrapment and that Jayke,

> *was likely experiencing these and the mental states above in the hours prior to his suicide attempt, as evidenced by his (undated) writings. However, nothing in the material suggests they existed at such intensity, nature and degree in the previous weeks or months. It is unclear exactly when his mental health deteriorated to the extent that he opted to end his life. Although he was distraught during his conversation with his mother on 3rd October 2018, he still referenced future plans*.

218. Dr Hall said he could find no evidence that he was actively suicidal or very severely depressed at any point in time, outside of the undated note he wrote to his mother, which he understood was found in the cell in which Jayke was located unresponsive, suggesting that it was temporally proximate to the act.

219. He further commented that it was his belief that Jayke's mental state deteriorated very rapidly, and that the suicide attempt appears to have been an impulsive act with little prior planning. He noted that he had been transferred to a single cell on 3 October 2018, and hence likely the isolation meant he had no choice but to reflect on his situation and that the accumulating stressors including the prospect of being transferred to the MRC, combined with the acute and chronic stressors he experienced, triggered an impulsive suicide attempt in a highly impulsive individual.

220. Dr Hall said that the evidence for antidepressant treatment causing suicidal ideation is equivocal. Consequently, antidepressants generally carry a warning of suicidal thinking, and there are recommendations in most guidelines for increased monitoring by the prescribing physician during the initiation, titration, and discontinuation of these drugs.

221. He noted that Jayke was commenced on an antidepressant on 4 September 2018 and that following up within one week to assess for side effects would have been prudent but in his opinion would not have changed the outcome, although there is a possibility that had a follow-up review been arranged for the morning of the 5 October 2018 a deteriorating mental state may have been identified.

222. Dr Hall further commented that had the reports of Jayke *"hearing voices"* as noted on 24 and 28 August 2018, been escalated to clinicians, a more comprehensive psychiatric assessment would have been undertaken on transfer to Marngoneet, or the commencement of antidepressant treatment had been flagged as an additional risk factor for suicide, a review by a psychiatrist may have been expedited. However, there were no indicators of a severe deterioration in his mental health (of the kind that could culminate in a suicide attempt) at any stage during Jayke's time at Marngoneet. Dr Hall considered that a psychiatrist would not have been privy to the accumulating stressors and deteriorating mental state affecting Jayke immediately before his suicide attempt on 5 October 2018, regardless of whether or how often he was seen before then. Given these matters, even if things had been done, they would not have identified him as at risk of an imminent attempt on his life.

Associate Professor Doherty

223. Associate Professor Doherty, consultant psychiatrist,[58] noted that Jayke had a history of downturn in mood, depression, and complained of irritability and being sadder when not on antidepressant medication, and of being more stable when on antidepressant medication. He said that in those circumstances, there were reasons justifiable clinically for the recommencement of antidepressant medication.

[58] Report of Associate Professor Doherty, CB at p.2191

224. Associate Professor Doherty noted that Jayke was never seen by a psychiatry registrar or a psychiatrist in prison before his death, despite the initial appointment having been made.

225. He didn't however consider that an assessment by a psychiatrist in its own right would have prevented Jayke's death, noting that the reason for the suicide remains unknown and Jayke previously indicated he was fine and optimistic about rehabilitation. It was his assessment that the decision to suicide was not the culminating event of a depressive downturn in mood. Further, that the mini assessments by psychiatric nurses did not identify a clinically severe oppressive presentation and that the use of antidepressant medication or a session with a psychiatric registrar or psychiatrist would not have been expected to lessen Jayke's frustration and anger about his circumstances.

Expert Panel

226. The expert panel consisted of Dr Rakov, Dr Hall and Dr Katherine (Kate) Roberts who is also a consultant psychiatrist with Forensicare and the Director of Clinical Services (Prisons).

227. It was agreed that Jayke would have been prescribed antidepressant medication by a general practitioner in the community. There may also have been a referral for psychological therapy and an associated wait time in the community.

228. In the prison setting, a primary mental healthcare provider, such as a general practitioner, could have prescribed antidepressants to Jayke. There is however a reluctance to prescribe mirtazapine in prison, as it can be traded.

229. Dr Rakov noted in relation to not getting medication after repeated requests, "*you present with symptoms, or complain of some distress, and ask for what you believe to be a solution, and you are repeatedly denied that solution, you are likely to be deterred from asking again for assistance with that same distress"*.[59] Dr Hall highlighted the issue of *patient experience* in this context.

[59] T104 L24-28

230. Dr Rakov further commented as reflected in her expert report that, given the paucity of documentation in the clinical records, "*we've only been able to find that they didn't determine it was indicated, rather than actively weighing up the pros and cons of escalating this, getting a prescriber involved, doing an assessment of the spectrum of symptoms"*.[60]

231. Commenting on the Forensicare appointment not being remade on transfer to another prison, Dr Rakov noted that if there is an indication for a psychiatric assessment by a doctor, that doesn't change merely because your geography does.

232. Dr Hall advised that in terms of Jayke's overall presentation there was a significant history of depressive illness in the community associated with a severe dependency on methamphetamine. There were significant developmental traumas and potential developmental delay in childhood. There were a range of stressors impacting on Jayke prior to coming into prison as well as during his detention (including his separation and imminent transfer), and some information is only now known with the benefit of hindsight.

233. In summary, Dr Hall considered there were depressive symptoms of probably moderate severity, there was the potential for relapse to illicit substance use, that a severe substance use disorder impacted his presentation and there was a chronic pain problem comorbid which had been persistent throughout his episode of care in the prison setting. Accordingly, from a diagnostic perspective the treatment would have focused on his substance use disorder primarily and a depressive illness.

234. Dr Rakov agreed with Dr Hall's formulation.

235. In terms of the ability to have intervened Dr Rakov stated,

> *...I think because of the rapid deterioration, and the longitudinal failure to capture his mental state or the essence of it truly, I think by the time we get to those days, to put the burden of responsibility purely on those officers who may have only known him for*

[60] T106 L18-22

those couple of days he was under their supervision, is, ..., unrealistic and misguided….. [61]

236. Dr Roberts commented with respect to the movement of prisoners to different locations, which is seen all the time, that it has,

a major impact on continuity of healthcare, both physical and mental. ..., ... it does make it very difficult to conduct adequate longitudinal assessment when you're seeing a person for the first time often - and I think it also makes it very difficult for the patients who feel like they have to start again, to tell their story again, ..., and you can't then have a series of objective assessments, it's really a series of de novo assessments. ..., so I see that as a major problem in our system, that moves happen so frequently, and ...., ..., as we've seen no regard for healthcare or what may have been planned in the previous location.

237. Dr Hall commented that what really struck him was that there was marked differences in the "*sort of ethos of care"* in a prison setting, in that there didn't appear to be "*an emphasis on building rapport or instilling hope which is a key element of all mental health practice".*

238. In terms of changes, Dr Roberts advised that a regional coordinator has been funded across all of their regional sites where Forensicare have psychiatrists and nurse practitioners in place and whenever a P rated prisoner is moved, Forensicare would review transfer lists and identify the needs of those people, and ensure that the follow-up was rebooked.

St Vincent's Hospital Melbourne

239. Kirsten Rodger, General Manager within Integrated Care Services and Director of Nursing of Caritas Christi, reviewed the nursing care provided at PPP on behalf of SVCHS.

240. She noted that none of the nurses had an ability to prescribe Jayke medication and if medication were to be provided, this would be determined by a prison medical officer, psychiatric registrar or a nurse with prescribing authority (**Prescriber**).

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[61] T127 L18-25

241. SVCHS accepted that the description of symptoms by Jayke to the RPN on 6 June 2018 could have warranted a referral by her to a Prescriber and that collateral information was not necessary to make the referral, although it was noted that a management plan was place which consisted of review with a psychiatric nurse for mental state examination and for Jayke to self-report to the clinic as required. However, SVCHS did consider that it would have been beneficial for the RPN to have documented that she attempted to review collateral health information and that this was not available at the time. Similarly, it would have also been prudent for the RPN to have noted that she had reviewed the plan where it was recommended that Jayke be reviewed by a nurse practitioner.

242. It was also observed that to the extent it is suggested by Dr Rakov that there was a failure by the RPN in not making a referral to a Prescriber, that this was addressed when the SVCHS nurse later made a referral of Jayke to the St Paul's Unit on 30 July 2018.

243. It was accepted by SVCHS that there was no escalation by the RPN on 13 June 2018 to a Prescriber and this could have occurred given the contents of the clinical notes. It was noted however that it was a single appointment where there was an ongoing management plan for ongoing psychiatric review which showed adherence more broadly to the concepts of person-centredness and accessibility.

244. With respect to RPN ST interaction on 13 August 2018, SVCHS agreed with the general proposition that treatment, via prescription, is not limited to a person being at *imminent risk*, but that the nurse's comment should be read in light of a referral having been made to the St Paul's Unit for Jayke to undergo review with a psychiatric registrar on 30 July 2018. That is, there was an appropriate referral and time frame to progress Jayke's treatment via the existing referral to the psychiatric registrar for review.

245. Ultimately with the benefit of hindsight, SVCHS agreed that earlier referral and escalation for consideration of medication for Jayke could have been made.

246. Ms Rodger noted that there had been significant changes to the process of information exchange and referrals from RPN to prescribers in recent times at SVCHS operated services. As such, if Jayke was reviewed on arrival to PPP today, it would be expected that a referral to a Forensic Mental Health nurse practitioner or psychiatrist would be made for diagnostic clarification. In addition, it would be expected that a referral to a SVCHS medical officer

would be made for medication review while awaiting the outcome of the review by a Forensic Mental Health Nurse or psychiatrist.

247. In addition, SVCHS has developed a template for the admission nurse to complete when a prisoner is transferred to PPP and this template guides the clinician to ensure that all areas of the inter-prison transfer assessment are completed thoroughly. The admissions template would be scanned into JCare.

248. In 2020, SVCHS also created a position for a Professional Practice Nurse dedicated to the primary mental health team. The role is aimed to support the ongoing development of clinicians and includes participation in service improvements by creating resources for clinicians and patients, auditing, clinical reviews and clinical oversight of the primary mental health team.

Correct Care Australasia

249. In her statement to the Court regarding the interprison transfer on 20 August 2018, RPN B stated that her usual practise when undertaking such transfers was to review the appointment list for each prisoner who is being transferred and to write the list of internal and external appointments that needed to be re booked on post it notes. Due to the functionality of JCare it was not possible to rebook the appointments before the prisoner had arrived at Marngoneet. She acknowledged that rebooking the appointment with a psychiatrist was an *oversight* on her behalf but with the passage of time cannot explain how it occurred.

250. RPN B maintained the view that Jayke did not require the appointment despite having been referred previously, however with the benefit of hindsight said, "*if faced with the same situation again, I would have made a referral to Forensicare or booked Mr Aleckson in the next available appointment with a psychiatrist."*

251. It was noted on behalf of CCA that mental health nurses cannot prescribe medication. If a prisoner wanted medication for anxiety and depression, a mental health nurse would undertake an assessment and make a referral to either the general practitioner or a referral to Forensicare for a specialist opinion, if clinically indicated.

252. It was also noted with respect to JCare, that as all appointments booked at the previous site were cancelled, it was very difficult at the time to go back and work out what appointments

had been made. However, this has been changed with the compilation of a list for the interprison transfer process.

Justice Health

253. At inquest Ms Robinson, Acting Executive Director Operations at Justice Health, advised that there is now a specific tab in JCare that you can click on for referrals to see all of the current opened and closed referrals that were made for a prisoner, which was not the case in 2018.

254. She also advised that the new Quality Framework that came into effect on 1 July 2023 was intentionally created so it could be a public document and is now on the DJCS website.

255. In addition, the revised Quality Framework is structured around the national standards for delivery of healthcare and is intended to enable it to continue to evolve as those standards evolve. Health service providers must meet the national standards in relation to clinical governance standards, policies, and procedures, so rather than Justice Health setting different standards for the prison system around clinical governance, there is an expectation that they align to the community standards. The Quality Framework is more robust and clearer that providers need to engage regularly with their patients to gather feedback on the way in which services were delivered.

256. Justice Health reviews are no longer desktop reviews when there is an apparent suicide. An external expert is engaged in those cases.

257. Ms Robinson advised that in terms of the quality of the health service provided to Jayke, she would defer to the experts and that based on the further information available, Justice Health would not maintain the finding made in the Justice Health review.

CORONERS PREVENTION UNIT RESEARCH

258. The Coroners Prevention Unit (**CPU**) identified 47 deaths by suicide between 1 January 2000 and 25 November 2024 in Victorian prisons. Of the 47 suicides, 27.7% (n=13) occurred at MAP of which 7 deaths were by hanging.

259. The majority of deceased were male (n=42, 89.4%), which likely reflects at least in part the fact that males make up more than 90% of the Victorian prison population. The most

prevalent age group for both males and females was those aged 25 to 44 (32 of 47, 68.1%). Hanging was by far the most prevalent method, used in 32 (68.1%) of the 47 suicides.

260. Among the 32 suicides by hanging, bed sheets were the most commonly used ligatures, having featured in 21 deaths.

261. Among the 32 suicides by hanging, the ligature points included:

- Bathroom or shower fixtures in seven deaths; and
- A bed frame in six deaths.

262. The CPU review noted that the 1991 *Royal Commission into Aboriginal Deaths in Custody* recommended that steps be taken to screen hanging points in police and prison cells. Following this, on 27 April 2000 then State Coroner Graeme Johnstone delivered findings into five suicide deaths at PPP. Four of the deceased died by hanging and the fifth died of a drug overdose. State Coroner Johnstone was critical of the cell design, which allowed obvious hanging points to remain.

263. In response to the recommendations in these deaths, Corrections Victoria undertook a program of work to develop cell safety standards titled the BDRP, to remove hanging points from maximum and medium security cells and improve fire safety in prisons. The design principles were finalised in 2001 and were applied when building new cells and refurbishing old cells from that point. In 2013 the Cell and Fire Safety Guidelines were published as part of the BDRP; and in 2022 these became the Cell and Fire Safety Requirements. All newly built and refurbished units must comply with these requirements.

264. Subsequently, questions about BDRP compliance have been explored by Victorian coroners in several hanging suicide investigations. Among the 32 Victorian prison hanging suicides since 2000, coroners have finalised their investigations in 23 deaths (as at 26 November 2024), and in nine of these cases the coroner considered BDRP compliance.

265. A review noted that in eight of those nine cases, the coroner found the cell where the suicide occurred was found not to be BDRP compliant.

266. Consistent with some of the common features of the CPU research, Jayke's death involved bed sheets as ligatures, use of a bed frame and a non BDRP compliant cell.

JAYKE'S PLACEMENT IN THE HEALTH CENTRE

267. A key aspect of the investigation was the decision making around Jayke's placement in the Health Ward Cell 2 in the Health Centre. That is, who made the decision, the basis upon which it was made, and any documentation around the decision. This was particularly relevant given the cell was not BDRP compliant.

268. It was apparent that as a separated prisoner Jayke was moved from a cell in the OMC to a cell in the Health Centre on 3 October 2018 but the time this occurred remains unknown.[62]

269. Mr Slater, General Manager at Marngoneet, advised that despite his own investigations (noting some staff were no longer employed by Corrections Victoria) he was unable to locate any information or documentation on the decision maker, or "*that a decision was made"* to move Jayke to the Health Centre. He said that at the time, there was no policy in place requiring staff to record a decision or movement of this nature.

270. He said however that based on his knowledge of Marngoneet policies and operational practices, and enquiries he had made with its staff, the following steps would ordinarily have occurred in a case like this:

    a. Once a decision was made to formally separate the prisoner, a decision about which cell to allocate to the prisoner would have been made by operational staff (for example a prison officer or senior prison officer).

    b. If there were risks to Jayke's health and wellbeing that were known by operational staff, then approval about cell allocation to the Health Centre would have been sought from the Duty Manager. The Duty Manager is a role allocated to an Operations Manager on a rotating basis, for the purpose of being an escalation point for operational staff.

    c. Prior to any transfer, prison officers perform an informal risk assessment which, in this case, involved consideration of Jayke's low suicide risk rating, the absence of 'At

[62] However, it must have occurred sometime before 18:17:35. CB at p. 1189.

Risk' behaviour whilst he was separated, and the reason for his separation. It was on this basis that it would have been determined appropriate to move Jayke to Ward 2.

d. At the time applicable Corrections Victoria and Marngoneet policies did not require operational staff to document such a risk assessment. That is, if no risks were identified, there was no requirement to capture this information, save for an entry into the prisoner's Individual Management File as a record of their presentation. If risks were identified, this would have been formally captured via any necessary referrals.

e. Any operational staff who were involved in the decision would have received SASH training by Forensicare to enable them to recognise and respond to the behavioural indicators of an 'At Risk' prisoner. SASH training is compulsory for all operational staff, and has been for many years.

f. If SASH concerns were identified (which was not the case with Jayke), then Corrections Victoria and Marngoneet policy required a written referral to a mental health nurse to be made. The subsequent assessment by the mental health nurse would be documented in the prisoner's Justice Health file and this would feed into the decision about where the prisoner would be appropriately accommodated, such as in a Muirhead (observation) cell if appropriate.

271. Mr Slater noted that changes have been made including that Health Cells are no longer used for separated prisoners as well as the introduction of formal assessments and decision-making processes (including documentation) in relation to separated prisoners.

272. The risk assessment process for separated prisoners requires that any officer making decisions about the placement of separated prisoners must now work through a clear set of steps in relation to the person being moved, which includes:

a. Considering whether the person has a relevant psychiatric history and/or suicide and self-harm history.

b. Considering how the person is presenting — whether they are displaying behaviours that suggest any emotional, physical or mental health concerns. If so, relevant health services should be contacted to provide support.

c. Reviewing the person's Individual Management File and/or speaking to the person's Case Manager to see if there has been any lead up to the incident behaviour decline/safety concerns that led to the separation.

d. Referring the person to Corrections Victoria's Forensic Intervention Services if the person is presenting as distressed or displaying behaviour that may suggest a mental health concern. If there is any immediate concern for a person's wellbeing, an 'At Risk' referral to the onsite health service provider should be completed.

273. Mr Slater said that if a separated prisoner required treatment in a Health Centre cell during a period of separation, this can be achieved using a BDRP compliant cell at OMC due to its close geographical proximity to the Health Centre.

Department of Justice and Community Safety

274. In correspondence to the Court dated 22 September 2023, Andrew Reaper, Acting Deputy Commissioner, Custodial Services on behalf of DJCS accepted that Corrections Victoria should be able to identify who made the decision to transfer Jayke to a Health Cell and what the basis for the decision was. He stated that accurate and comprehensive record keeping is an important part of enabling proper scrutiny of events within the prison.

275. Mr Reaper advised that changes have now been made to ensure that these kinds of decisions about placement and the risk assessment process that informed those decisions are always recorded.

276. Mr Reaper further accepted that there was not an appropriate risk assessment process specific to separated prisoners in place on 3 October 2018 at Marngoneet.

277. Mr Reaper noted that the risk assessment process described by Mr Slater (as noted above) was an application of the general SASH training that all prison officers receive and it was not tailored to the separation process, and the staff engaging with it were not required to document it anywhere. Mr Reaper accepted that this was not an adequate process.

278. Mr Reaper stated that changes have now been made to formalise the risk assessment process, so that anyone making decisions about the placement of separated prisoners is

aware of, and required to work through, a clear set of steps and criteria in relation to the person being moved.

279. Mr Reaper further accepted that, because Corrections Victoria do not know who made the decision to move Jayke to the Health Centre, they also do not know *for certain* whether an appropriate risk assessment was undertaken to support that decision. He noted that while there is no reason to think that the ordinary steps set out by Mr Slater were not taken in Jayke's case, they "*just do not know for certain"*. Mr Reaper accepted that this was an inadequate process.

280. Mr Reaper stated that while Jayke's placement was consistent with applicable policies and procedures at the time at Marngoneet, he accepted that those policies and procedures could have been improved. Since that time, in recognition of what occurred, those improvements have been made.

281. Mr Reaper accepted that, knowing what we know now, it was not appropriate for Jayke to be put into a non-compliant cell and, that this was *one of our most important learnings from his tragic passing* and why the changes to policy outlined had been made.

282. Mr Reaper also accepted that further monitoring would have been beneficial in this case. That is, if staff had seen what Jayke was doing, they would have stopped him. However, if Jayke had not been placed in a non-compliant cell, further monitoring would not have been necessary.

283. Mr Reaper noted with respect to the changes made that,

> *I am hopeful that these changes will ensure that what occurred in relation to Jayke's passing is never repeated*.

284. Reference was also made at inquest to the Separation Reform Project, which is designed to ensure that Corrections Victoria only separate prisoners as a *last resort*, after a fulsome assessment within a 24-hour period and make every attempt to place an individual in the most least restrictive regime or potentially not even to proceed to separation. The Project examined considerable research and learnings from other jurisdictions globally about the impact that separation can have on an individual as well as custodial staff and other staff within a prison environment.

CONCLUSIONS

285. Jayke was 24 years old when he died on 15 October 2018 at the University Hospital Geelong whilst on remand at Marngoneet. He had been found hanging and unresponsive in a cell in the Belin Belin Health Centre 10 days earlier. Jayke was a separated prisoner after an incident involving an assault on 29 September, and had been held in a non-compliant BDRP cell since 3 October.

286. It was Jayke's second time in custody, having entered MAP on 4 June 2018, been transferred to PPP on 6 June and subsequently transferred to Marngoneet on 20 August, where he was detained until the fatal incident. Jayke's Suicide Rating was S4 and his Psychiatric Rating was P3. These ratings remained unchanged throughout his incarceration.

287. While in custody Jayke self-reported regular use of Ice and a history of depression. He reported that he had previously been prescribed antidepressant medication that he had ceased while in the community prior to his arrest. The accuracy of the medical information he provided to health staff over his time in custody is evident in his general practitioner's medical records which document a history of Jayke experiencing depression in the community and having been prescribed antidepressant medication on numerous occasions from at least 2015. His records also document a history of self-ceasing his antidepressant medication while in the community and at times using Ice in response to a deterioration in his mental health. He was noted to regularly report to his general practitioner that he felt better on his medication.

288. There were different service providers at each prison, who were contracted by Justice Health to provide primary health services. Each service was obliged to deliver health services in accordance with the Quality Framework in place at the time.

289. Benchmarks for the delivery of health services in custody according to the Quality Framework included services that were safe, effective and appropriate, person-centred, accessible, and care that was co-ordinated across the care continuum to ensure a comprehensive and streamlined treatment journey. In addition, the expectation was that there would be equivalent levels of care for prisoners compared to those in the community.

290. Jayke had access to numerous medical appointments for *physical* issues (both nurses and general practitioners) as well as access to dentistry, physiotherapy and other health related services. There appeared to be relatively no limitations in responding to these needs and the services appeared to be accessible, responsive and of a high standard.

291. It was apparent however that a number of symptoms and complaints of distress experienced by Jayke in a mental health context were not as effectively responded to during his incarceration.

292. Jayke requested to be recommenced on antidepressant medication *overtly* on four occasions (4 June, 13 June, 30 July and 13 August 2018). He was commenced on duloxetine on 4 September 2018, but this was prescribed to manage his pain. The provision of services in these circumstances does not appear to represent equivalency of care as required by the Quality Framework. The evidence strongly suggests that Jayke would have received antidepressant medication if he was in the community, as had occurred on numerous occasions in the past.

293. Jayke was conscious that his requests for antidepressant medication had not been facilitated and raised it as a concern with correction's staff when inducted to Marngoneet. It is unclear what the effect of his repeated requests not being facilitated would have had on Jayke who had limited experience of being in custody and had already been in three facilities over a four-month period. There is no doubt it would have been frustrating and distressing for him and I agree with Dr Rakov that he may have thought it was pointless to continue asking and it may have been a deterrent to ongoing self-referral. From a health care perspective, it does appear to represent a significant departure from good care for a vulnerable young man in a custody environment, who had a known history of depression in the community. I agree with Counsel Assisting that this was a lost opportunity for Jayke to receive support in coping with the stressors he was facing.

294. I also note in this context Standard 5.2 – *Rights and Needs of Prisoners*, the rights of prisoners to be informed of and involved in decisions about their healthcare must not be compromised in custody.

295. Further, a Forensicare psychiatric registrar appointment which was made on 30 July 2018 and scheduled for 22 August was cancelled on his transfer from PPP to Marngoneet and was

not subsequently remade. From a health care perspective, this does not appear to reflect the continuity of care or co-ordinated care required by the Quality Framework. I also note that at the time this appointment was made, Jayke had already been in custody for almost two months.

296. When considering the responses to Jayke's mental health concerns and distress during his detention, it is important to reflect on the documentation in his JCare records which included references to: "*mood 2/10*, *sad and anxious*, *poor energy due to low mood*, *sleep affected due to anxiety*, *anger issues*, *struggling with emotions*, *depression*, *no longer experiencing emotion*, *mood always low*, *sad*, *more irritable*, *angry*, *poor sleep and appetite*, *felt like a trigger waiting to go off*, *variable mood*, *irritability with co-workers*, *up and down*, *flat affect"*. In addition to these reports there were references in his correction's records on 24 August 2018 to Jayke "*hearing voices"* to hurt someone and on 28 August that he was "*hearing voices"* and suffers from "*depression and anxiety"*.

297. The records as a whole clearly suggest that Jayke was struggling with his mental health, and was consistently seeking medication to address his concerns. I do however note that this was not the way he presented to prison officers, his mother or his lawyer.

298. It is apparent that the functionality of JCare at the time, played a significant role in the shortcomings experienced in his care. Firstly, the records were difficult to read and did not lend themselves to be able to view information easily or in a chronological manner, nor did they promote an ability to access relevant and important information such as existing treatment plans or scheduled appointments. In addition, the functionality of JCare did not allow for scheduled clinical appointments with a psychiatrist (or any other type of clinician) from one site to remain in place when a prisoner transferred to a new site due to there being a different clinic structure and waitlist. This meant that assessments being made at one location were not always able to build on information obtained in previous health assessments. This did not promote continuity of care or co-ordinated care and also had the potential to impact the quality of care provided.

299. JCare, which is managed by Justice Health, has now been altered to address these concerns.

300. The Court's expert, Dr Rakov also identified incidences where better clinical decisions could have been made, particularly regarding Jayke being referred for assessment to resume

his medication or the rebooking of appointments, and she further reflected on the quality of clinical documentation impacting on an ability to evaluate the decision making that had occurred.

301. Dr Rakov considered that failing to obtain a psychiatric assessment in the face of multiple points of acknowledgement of a mood disorder with the addition of multiple requests to return to antidepressant treatment, was a departure from the reasonable standard of care. I accept Dr Rakov's advice on this matter but do so without criticism of any individual clinician or their decision making, noting the impact on the ability of clinicians to provide co-ordinated care with the multiple movement of prisoners and the cumulative effect on decision making created by the health system in place at the time.

302. Systems must be sufficiently robust to reduce the impact on the continuity of healthcare, both physical and mental, upon the movement of prisoners particularly given its well-recognised impact on the conduct of adequate longitudinal assessments. In addition, points of patient transition are known to be the highest risk for communication errors leading to poor patient outcomes, and as noted by Dr Rakov, structured clinical handover is known to improve patient safety.

303. I disagree with the outcome of the Justice Health Review which concluded that "*there is nothing to suggest that the healthcare provided to Mr Aleckson was not in keeping with the Justice Health Quality Framework 2014".* I note that subsequently, and with the benefit of further information, Justice Health would now not agree with the outcome of the review.

304. The manner in which reviews are conducted by Justice Health has been significantly changed, noting that deaths in custody will no longer be the subject of a desktop review only. I do however struggle to understand how even a desktop review could have arrived at the outcome it did in this case.

305. I note that the expert panel concluded that had Jayke been assessed, a psychiatrist would have likely concluded that there were depressive symptoms of probably moderate severity, there was the potential for relapse to illicit substance use, that a severe substance use disorder impacted his presentation and there was a chronic pain problem comorbid which had been persistent throughout his episode of care, in the prison setting. Accordingly, from a

diagnostic perspective the treatment would have focused on his substance use disorder primarily and a depressive illness. I accept the expert panel's analysis on these matters.

306. Having noted concerns about aspects of Jayke's care, I did not receive advice that the provision of an earlier referral for assessment for recommencement of his medication would necessarily have change the outcome. It is apparent that Jayke had a rapid deterioration following his separation, and in particular his movement to the Health Centre, which on the basis of his documented history, was difficult to have predicted.

307. Jayke was initially accommodated in a management cell in the OMC but was finally transferred to a cell on 3 October 2018 which was not BDRP compliant due to "*system pressures"* at the time. The JARO report noted an expectation that a separated prisoner would be held in a BDRP compliant cell.

308. Regarding the placement decision, the JARO report referred to *"an informal and undocumented risk assessment process"* being "*in place".* Such an arrangement would rarely be considered reasonable or appropriate in the context of such an important decision, and ultimately one that provided the opportunity for a hanging point in Jayke's cell.

309. Fortunately, the same decision would not be made today noting a change in policy which stated that "[p]*risoners under separation will never be placed into the Health Ward Cells*."

310. I do however agree with JARO's conclusion that Jayke's demeanour prior to the incident was "*overall calm, forward looking and friendly"* and that he "*did not present to prison officers with signs that may indicate a risk of suicide or self-harm"*. In this context, there was nothing to alert the prison officers who interacted with Jayke in his final days of the tragedy that was to come nor could I form a view that those officers carried out their duties in anything other than a diligent and kind manner.

311. This investigation clearly emphasised the need for continued vigilance around BDRP compliant cells in Victoria's prisons. This was also highlighted by the CPU research which noted that in 8 of the 9 finalised investigations involving suicides by hanging where BDRP compliance was examined, coroners found the cell where the suicide occurred was not BDRP compliant.

312. The effect of Jayke's separation meant that he moved from cottage style accommodation where he lived with a number of other prisoners, shared cooking with relative freedoms to work and engage in social activities within the prison environment, to a cell locked down for approximately 23 hours per day with limited access to outdoor areas. His contact with others was extremely limited and he had much time to be with his own thoughts. This was a very significant change for Jayke.

313. In addition to his separation and relative youth, Jayke's further stressors included the prospect of movement to a fourth prison location, his status as a witness in another case and his concern that he might be in some danger when he was transferred to MRC, as well as his underlying vulnerabilities such as a family history of attempted and completed suicide. Jayke was also suffering depression for which he had sought medication to ease the distress he was experiencing.

314. Jayke was also father to a two-year-old daughter who he missed terribly and faced the prospect of not being with for many years. As evidence later revealed, during his isolation in his cell in the Health Centre, Jayke was writing and reflecting on the circumstances he found himself in, with strong feelings of guilt, sorrow and remorse, but also fear.

315. It took some time for this investigation to reveal the particular circumstances surrounding Jayke's placement, including who made the decision to place him in the Health Centre and what if any assessments were undertaken to facilitate that decision making.

316. The Court was ultimately advised by DJSC that no decision maker could be identified, there was no documentation of the decision making and that, as such, precisely how the decision was made could not be further clarified, although general practice could be referenced.

317. It was acknowledged by DJSC that Corrections Victoria should have been able to identify who made the decision to transfer Jayke to a Health Cell and what the basis for the decision was. In addition, that accurate and comprehensive record keeping is an important part of enabling proper scrutiny of events within a prison environment.

318. It was acknowledged that there was not an appropriate risk assessment process specific to separated prisoners in place on 3 October 2018 at Marngoneet.

319. Finally, it was accepted on behalf of DJSC that, "*knowing what we know now"*, it was not appropriate for Jayke to be placed in a BDRP compliant cell.

320. Jayke was in the care of the Secretary of DJSC at the time of his death, and the concessions made by DJSC are accepted regarding the circumstances of his placement.

321. Accordingly, the evidence supports a finding that there is no record of who made the decision to place Jayke in a health cell and as such, what if any risk assessment was conducted before the decision was made. Further, that there was no appropriate risk assessment process specific to separated prisoners in place on 3 October 2018 at Marngoneet and there should have been a documented process.

322. Jayke was a separated prisoner who had been assigned a T3 rating in recognition of him being a vulnerable prisoner. I note that whilst placement in the Health Centre of a separated prisoner was consistent with the practice at the time, it was not consistent with expectations of Corrections Victoria as identified by JARO.

323. I consider that there is insufficient evidence in this case to find that an appropriate risk assessment was undertaken to support Jayke's placement in a non BDRP compliant cell.

324. I find therefore that Jayke should not have been placed in a non BDRP compliant cell on 3 October 2018. The tragic significance of his placement was that the room had a moveable hospital bed rather than a fixed bed which provided a hanging point and an opportunity for self-harm.

325. Further monitoring was warranted with Jayke's placement in the Health Centre; however this was not part of the process at the time.

326. I am unable to say whether the outcome would have been different if Jayke had not been placed in a non-compliant BDRP cell, but it appears that his opportunity to access a hanging point would have been reduced.

327. Given the passage of time and the significant changes that have already been made to address many of the issues which were highlighted during the course of the investigation into Jayke's death, I am satisfied that there are no further recommendations are justified at this time.

FINDINGS

328. Pursuant to section 67(1) of the Act I find as follows:

(a) the identity of the deceased was Jayke Michael Aleckson, born 17 February 1994;

(b) Jayke Michael Aleckson A died on 15 October 2018 at University Hospital Geelong, 272-322 Ryrie Street, Geelong, Victoria, from *1(a) Hypoxic Ischaemic Encephalopathy; 1(b) Hanging*; and

(c) the death occurred in the circumstances described above.

329. Having considered all of the circumstances, I am satisfied that Jayke intentionally took his own life.

ORDERS

Pursuant to section 73(1) of the Act, I order that this finding (in redacted form) be published on the internet.

I again convey my sincere condolences to Jayke's family for their loss and acknowledge the traumatic circumstances in which his passing occurred.

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

Jayne Kennedy, Senior Next of Kin

Steven Aleckson, Senior Next of Kin

Secretary for Department of Justice and Community Safety (on behalf of Justice Health and Corrections Victoria) (care of Victorian Government Solicitor's Office)

Correct Care Australasia Pty Ltd (care of Meridian Lawyers)

Victorian Institute of Forensic Mental Health (Forensicare) (care of Minter Ellison)

St Vincent's Hospital (care of Lander & Rogers)

Office of the Chief Psychiatrist

Barwon Health

Detective Senior Constable Damian McKeegan, Coroner's Investigator, Victoria Police

Signature:

SARAH GEBERT
CORONER
Date: 11 December 2024