

TRANSFER OF CUSTODY BETWEEN A PLACE OF DETENTION OR CORRECTIONAL CENTRE AND DMHU OR DMHU AND COURT

URN: _____

ACTCS PID: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

ACT Corrective Service/Bimberi Youth Justice Centre

This form is to be completed by ACT Heath and ACT Corrective Services (ACTCS)/Bimberi Youth Justice Centre (BYJC) staff whenever a detainee or young detainee is transferred:

- from a correctional centre or place of detention to Dhulwa Mental Health Unit (DMHU); or
- from DMHU to a correctional centre or place of detention; or
- from DMHU to the courts; or
- from the courts to DMHU

Surname: _____

Given names: _____

Gender: _____ Date of Birth: _____

Does the person identify as Aboriginal or Torres Strait Islander? Yes No

Consumer is being transferred from _____ to _____

Statement of Action Taken by ACTCS/BYJC staff

Did any of the following occur when, or in relation to, transferring the person to DMHU? (e.g. the person was subject to threat of violence from another person; a package of white powder fell out of the person's pocket; the person was in an agitated state and hit their head against the side of the transport vehicle)

(NOTE: The Escort Officer must provide a written statement if any of the following events occurred in the lead-up to the transfer or during the transfer, regardless of whether they were personally involved.)

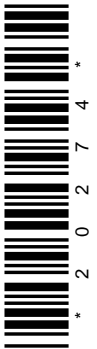
- Use of force
- Restraint
- Involuntary seclusion (including where a person was subject to a confinement order or segregation direction ACTCS/BYJC immediately prior to the transfer)

If any of the above occurred, please detail the nature and extent of the actions taken (Mental Health Act 2015):

Did anything else happen when, or in relation to, taking the person to DMHU, or between DMHU and court, that may affect the person's physical or mental health? Yes No

ACTCS/BYJC staff:

Signature _____ Print name _____ Designation _____ Date _____ Time _____



DO NOT WRITE IN THIS BINDING MARGIN

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Statement of Action Taken by JHS Clinicians

(NOTE: Justice Health clinicians must provide a written statement if any of the following events occurred in the lead-up to the transfer or during the transfer, regardless of whether they were personally involved.)

Did the person receive:

Forcible giving of medication on the day of transfer

If the above occurred, please detail the nature and extent of the actions taken (Mental Health Act 2015):

Did anything else happen when, or in relation to, taking the person to DMHU that may affect the person's physical or mental health? Yes No

If any of the above occurred, please detail the nature and extent of the actions taken (Mental Health Act 2015):

JHS Clinician:

Signature Print name Designation Date/time

Statement of Action Taken by DMHU Staff

Did any of the following occur prior to transferring the person from DMHU, i.e., on the day of transfer?

- Use of force
- Restraint
- Involuntary seclusion
- forcible giving of medication

If any of the above occurred, please detail the nature and extent of the actions taken (Mental Health Act 2015):

Did anything else happen that may affect the person's physical or mental health on the day of transfer from DMHU? Yes No

If any of the above occurred, please detail the nature and extent of the actions taken (Mental Health Act 2015):

DMHU Staff:

Signature Print name Designation Date Time

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URN: _____

ACTCS PID: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Transfer of custody completed

Custody of the consumer has been handed over (*tick relevant options*):

From

- ACTCS - Correctional Centre
- ACTCS - For Court Attendance
- BYJC
- DMHU

To

- ACTCS - Correctional Centre
- ACTCS - For Court Attendance
- BYJC
- DMHU

General Manager (or delegate) OR Clinical Director DMHU (or Consultant Psychiatrist):

Signature	Print name	Designation	Date	Time
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AND

ACTCS Escort Officer **OR** BYJC Youth Worker:

Signature	Print name	Designation	Date	Time
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AND

Nurse in charge DMHU:

Signature	Print name	Designation	Date	Time
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AND

Senior Security Team Member DMHU:

Signature	Print name	Designation	Date	Time
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Pursuant to s. 144A (3) *Mental Health Act 2015*, this form is to be photocopied after signature and a copy provided to both agencies involved in the transfer.

A copy of this form must be forwarded to the Tribunal Liaison Officer, Building 25, the Canberra Hospital and faxed to: 6244 4558

DO NOT WRITE IN THIS BINDING MARGIN

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