IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1114

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ADAM SASHA OMEROVIC

Delivered On:	24 January 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	10 April to 7 May 2013
Findings of:	PETER WHITE, CORONER
Representation:	Mr S McGregor of Counsel appeared for the Department of Justice and Office of Corrections Mr J Goetz of Counsel appeared on behalf of Forensicare Mr J Fitzpatrick of Counsel appeared on behalf of Mr Tony Omerovic
Counsel Assisting the Coroner	Tony Burns of Counsel Jodie Burns Principal In house Solicitor of the Coroners Court of Victoria

I, PETER WHITE, Coroner having investigated the death of ADAM SASHA OMEROVIC

AND having held an inquest in relation to this death between 10 April and 7 May 2013

at Level 11, 222 Exhibition Street, Melbourne

find that the identity of the deceased was ADAM SASHA OMEROVIC

born on 12 September 1969

and the death occurred on 23 March 2010

at Melbourne Assessment Prison, 317 Spencer Street, West Melbourne 3003

from:

1 (a) LIGATURE COMPRESSION OF THE NECK IN CIRCUMSTANCES OF BEING HANGED

in the following circumstances:

1. The inquest brief in this matter identified that Melbourne Assessment Prison (MAP) detainee Adam Sasha Omerovic (Mr Omerovic) had a significant past history of mental illness and self-harm. The inquest into his death focused on how those responsible for mental health services within MAP, responded to his presentation and whether the systems in use reasonably identified the level of risk associated with that presentation.[1]

A Guiding Principle

2. *'The most compelling reasons for identifying incarcerated individuals who suffer from mental illness are:*

   to prevent harm to themselves and others,

   to provide expedient care,

   to prevent de-compensation, and

   to assist inmates in adjusting to the institution.

3. *Mental health screening can reduce the risk of exacerbating pre-existing mental health problems and the occurrence of mental health problems suffered because of incarceration.*

[1] The process by which our Courts are serviced by Corrections Victoria is under ever-increasing pressure with delays occurring across the system, this because of the increasing numbers of persons on remand and the pressure put on financial and gaol space resources, by that increase. Not withstanding, the need to improve standards of psychiatric health care within Victorian prisons remains of paramount importance. It is appropriate to record that the evidence given at this inquest has given no cause for concern that there is other than an across the board commitment to this objective.

4. *In addition to the humanitarian rationale for providing mental health services in jails, screening assists in the allocation of scarce resources and serves the best interests of the institution, suicide prevention and the prevention of violence to others'.*[2]

Background

5. Mr Omerovic was born in Melbourne on 12 September 1968 the younger of two children. His parents separated in 1978 after which he lived with his father in Australia and overseas. Following his return to Australia, he was educated at Preston Technical School and finished Year 9 before leaving school at the age of 16. Records indicate that thereafter he worked in turn as a plasterer and apprentice cabinetmaker. Records further reflect that Mr Omerovic had a long history of substance abuse dating back to his adolescence.

6. I also note that Mr Omerovic had a significant history of involvement with the criminal justice system commencing with an appearance before the Children's Court in 1984.

7. In 1999, Mr Omerovic was convicted and sentenced by the County Court in respect of six counts of armed robbery and in 2004, he was convicted and sentenced in the Cairns District Court, on one count of armed robbery. It is also relevant that on 2 December 2009 the Heidelberg Magistrates Court sentenced him to five months imprisonment wholly suspended, for a dishonesty offence.

8. A prison assessment undertaken by Port Phillip Prison (PPP) in August 2008 noted that Mr Omerovic had attempted suicide by overdose, '*a couple of times,*' with the last attempt being approximately two years prior.

9. In December 2009, his General Practitioner, Dr P Khanna of the Mill Park Super Clinic referred Mr Omerovic to a Psychologist, Mr David Younger.[3] Mr Younger only saw Mr Omerovic on one occasion, this on 1 February 2010, i.e. some seven weeks prior to his death. Mr Younger reported that Mr Omerovic stated that he had been in a defacto relationship with Ms Kim Cooper for some four years and that they had two children Tanika, through a previous relationship her mother had with another, and Stephanie who

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[2] Excerpt from the statement of Director of Psychological Services Forensicare, Professor Ogloff, at exhibit 16, page 2. See discussion of his evidence commencing below at page 38.

As discussed in the Courts finding in Timothy Casey, Case number 1277 of 2008, it is relevant to note here my view that psychiatric diagnosis including provisional diagnosis, and where appropriate the prescription of medication, are together equally important aspects of mental health care in a prison setting.

[3] See statement of David Younger at exhibit brief page 8.

was his biological daughter. He told Mr Younger that he considered himself to be and was accepted by both girls, as their father.

10. Mr Younger further described Mr Omerovic as having a lowered mood and being of flat general affect. Mr Omerovic also spoke of his ongoing heroin use of which he believed his partner and children were unaware, and of his feelings of guilt arising from this matter.

11. Mr Younger also offered that,

> *'At no stage did Mr Omerovic indicate suicidal ideation with an intention to act.'*[4]

12. Mr Younger discussed a plan for an ongoing series of consultations, which he made conditional upon Mr Omerovic undertaking specialist drug withdrawal counselling. They then discussed arrangements Mr Omerovic had earlier made to attend Odyssey House the following day and a further appointment was made for a second consult to occur on 19 February 2010. Mr Omerovic failed to attend this second consultation.

13. Between 3 February and 17 February, it is known that Mr Omerovic attended the Mill Park clinic on several occasions and that he was prescribed the anti-depressant anti-anxiety medication, Lexapro.

14. At or around this time, Mr Omerovic is believed to have been consuming heroin on a daily basis. It is also the case that he was estranged from long-term partner Ms Cooper and their children and that he was living from hand to mouth while couch surfing between the homes of different friends.[5]

15. On or about 21 February, Mr Omerovic was identified by VICPOL as a person of interest concerning the commission of up to six recent armed robberies in the Hawthorn and Richmond areas.[6]

16. On 24 February, he was taken by ambulance to the Emergency Department of the Royal Melbourne Hospital (RMH) following a motor vehicle accident. According to hospital admission notes a suicide note, unrecovered, was found with him in the vehicle he had been driving. Thereafter he was placed on an Involuntary Treatment Order (ITO) pursuant to

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[4] Ibid page 2. It is not suggested that either Mr Younger or Mr Omerovic raised or spoke of the matter of his history of self-harm, during this consultation.

[5] Kim Cooper was his former partner and the mother of Mr Omerovic's daughter, Stephanie. See statement of Kim Cooper at exhibit 36, brief page 1-6.

[6] It appears that Mr Omerovic was aware at the time that he was suspected of involvement in these matters (by the Vic Pol Embona task force), and was wanted for questioning through this period.

Section 12 of the *Mental Health Act 1986* (Vic) and admitted to the hospital's psychiatric inpatient unit, from where he later absconded while being returned under escort after undergoing x–ray imaging.[7]

17. On 2 March, Mr Omerovic was arrested and taken by police to the Psychiatric Unit of the Northern Area Mental Health Service (NAMHS), where he was admitted. He was not returned to the RMH and absconded from NAHMS the following afternoon.

Events following Mr Omerovic's arrest on 15 March 2010

18. On 15 March, he was arrested by Detective Senior Constable Reynolds in Abbotsford and was later assessed by Dr J Giannakakis who found that he was mentally unfit to be interviewed.[8]

19. On both 16 and 17 March, Mr Omerovic appeared at Melbourne Magistrates Court. On the 17 March he was assessed by Paula Verity a Forensic Psychologist employed at the Court by Forensicare, at the Mental Health Liaison Service. She consulted the RAPID database and noted the relevant entries. She then prepared a comprehensive summary of her review detailing recent suicide attempts and suicidal ideation, which she faxed to her Forensicare colleagues at the MAP.[9]

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[7] See exhibit 32 the statement of Dr A Vi

[7] Excerpt from the statement of Director of Psychological Services Forensicare, Professor Ogloff, at exhibit 16, page 2. See discussion of his evidence commencing below at page 37.

[8] See exhibit brief page 20, the statement of Dr Giannakakis, who recorded that Mr Omerovic was cooperative and did not display aggression but expressed strong suicidal ideation,

'*and had confided to police several suicidal attempts over the last few days.*'

[9] See exhibit 34, which was compiled after a review, which lasted some 3 hours. In exhibit 34, Ms Verity referred to Mr Omerovic's attempt to commit suicide in his recent '*deliberate motor accident,*' following his relationship breakup. Further reference is made to earlier attempts to kill himself, *'every second day while on the run from police and (he) expressed shame and disappointment at his failure to succeed.'*

Mr Omerovic also informed that he was concerned at the likelihood of a lengthy sentence and that,

'he would lose everything, e.g. his relationship with his family'.

In conclusion, Ms Verity observed that it appeared that Mr Omerovic demonstrated no evidence of psychotic symptoms, but reported having suffered from depression for a long time, and that he may benefit from an anti-depressant.

(See also the attachments to her faxed two-page report at exhibit 34(a), which included the RAPID download and her handwritten notes, which were submitted to Forensicare staffer Vasilevska, but not to the RPN's, who subsequently reviewed Mr Omerovic, and allowed for his transfer to the general prison population.

I note here that Ms Verity's report, (as distinct from the RAPID downloads), made no mention of the ITO. I also note that only the admitting Nurse Lawrie had access to Ms Verity's report. See finding below.

Remand at the MAP

20. Mr Omerovic was received into the MAP on 17 March 2010 having been remanded on two charges of armed robbery, two counts of common assault and 9 other charges. He was due to appear at the County Court in Melbourne on 8 June 2010.

21. He remained in custody at MAP until his death on 23 March.

22. Over the same period and in the changed environment of the MAP, the operation of the ITO appears to have been suspended.[10]

23. At MAP reception, Mr Omerovic underwent a routine psychiatric assessment by RPN Simone Lawrie who determined that he presented a significant risk of suicide self harm and recommended his placement in a Muirhead observation cell, within Unit 13.[11]

RPN Simone Lawrie[12]

24. In March 2010, RPN Lawrie was employed at MAP undertaking reception mental health assessments. On March 17, Mr Omerovic undertook a full screening process, which included a general assessment by Corrections Officer Mommonwald, a medical assessment by a Pacific Shores Healthcare employee, all such documentation then available to Ms

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[10] I am informed and accept that in such circumstances an ITO is effectively suspended by the subsequent Court remand order. See Professor Bell at transcript page 833-34, which advice is consistent with Section 14(e) of the Mental Health Act.

I further note however that the psychiatric analysis which had determined that Mr Omerovic was at risk and required longitudinal psychiatric review and support under an ITO, is broadly similar in effect to the P1 and P2 Direction as described in the Commissioners MAP protocol.

And seemingly, to the system response suggested by that direction, (with the notable exception that the provision of a psychiatric review by a psychiatrist under an ITO, must take place within 24 hours of the making of such an order), whereas there are no specific time stipulations in the Commissioners protocol. See also the similar criteria and direction provided by Forensicare's protocol at exhibit 18(d) and the Department of Justice risk history record at exhibit 19(f), together with the further discussion of MAP systems response, found at footnote 13.

I also observe that had Forensicare staffers at MAP been informed of the fact of the ITO that it is likely that they would then have also put themselves in a position to learn of important and relevant aspects of Mr Omerovic's immediate past mental health history, while in custody under that order.

[11] The Court together with the legal representatives of all interested parties undertook a view of MAP on April 11, 2013. See note of observations at transcript page 68.

The Muirhead unit 13 cells at the MAP were set up to permit a high degree of protection to be provided to prisoners considered to be at immediate risk of self-harm.

RPN Logan later described the Muirhead cells as, '*a rather unpleasant unit*' (transcript 495) and '*crude, sparse, concrete box basically like with a stainless steel toilet and that's about it*' ... and where each prisoner is, held naked under a canvass smock. (See transcript at page 482).

The AAU is situated within Unit 13 and was primarily employed for the analysis and accommodation of prisoners seen to be overtly or floridly psychotic, or those remanded for psychiatric analysis at the request of a Victorian Court. Each of the 16 units is prison cell size with a single bed, TV, kettle shower and toilet. Usually the only prisoners housed in Unit 13 were those waiting psychiatric assessment in respect of oncoming court appearances, that may often involve later referral and remand to the Thomas Embling Hospital, which I note is also a Forensicare administered, high security forensic mental health facility.

[12] RPN Lawrie testified that having worked as a psychiatric agency nurse following her admission some two years earlier, Forensicare had employed her as a registered psychiatric nurse from January 2007.

Lawrie, though not thereafter to her Forensicare colleagues, and a mental health intake screening assessment by Ms Lawrie.

> *'This screening assessment was not intended to be a comprehensive psychiatric assessment for treatment purposes, rather it is used to assess the prisoners mental state at the time of reception into the MAP and the immediate risk of suicide/self harm, posed by the prisoner as well as to determine any ongoing management needs such as admission to the Acute Assessment Unit (AAU), special accommodation issues or need for the further assessment by a psychiatric registrar in a an out patient clinic.'*[13]

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[13] See exhibit 13 at brief page 282(a).

(Query whether notwithstanding Nurse Lawrie's own assessment of her role, the assessment at intake form, exhibit 13(a), was in fact designed to invite both a provisional longitudinal assessment as well as a here and now mental state assessment.

In this regard it is relevant that the intake form invites a review of such matters as the prisoner's RAPID history, an assessment of the prisoner's mental health plan and of his suicide, self-harm and psychiatric alert status. The form also mandates inquiry concerning the prisoner's suicide and self-harm history, together with his psychiatric history. RPN Lawrie addressed each of these issues to a degree, during Mr Omerovic's admission. Significantly, the intake form also suggests reference to a psychiatric registrar or above for assessment and or medication, in respect of all P1 or P2 classified prisoners, which approach is also supported by the wording found within a second relevant form, the Risk Assessment Form. This second form, exhibit 13(b), was partly filled out by RPN Lawrie and then used by Senior Prison Officer Richardson in consultation with the prison Operations Manager, to ratify the initial recommendation made to place Mr Omerovic in Unit 13. Again it is relevant that the exhibit13(b) form, as well as Mr Omerovic's Justice Risk History record, exhibit 19(f), both suggest reference for psychiatric evaluation and or medication review of P1 and P2 rated prisoners, who are by definition from exhibit 19f, prisoners presenting with, *... 'a serious psychiatric condition requiring intensive and or immediate care'.*

I also note the wording employed in Exhibit 19(f), and the evidence that diagnostic evaluation and directions on medication were the exclusive responsibility of psychiatric registrars and above rather than to be left to be undertaken by RPNs. I further note the additional evidence that RPNs were responsible instead for here and now mental state assessments. See also the consistency between the above mentioned protocols and exhibit 13(g) the Commissioner for Corrections protocol and exhibit 16(a) chapter 2.16, the applicable Forensicare Operations Manual, both of which confirm the above criteria, of a P1 or P2 psychiatric health classification, and seek to give a monitoring role concerning psychiatric alerts to Forensicare RPNs.

It is also the case that the application of interpretation rules, which require the giving of a normal meaning to clear words employed, suggests that these references in such circumstances (in the above protocols and forms), presupposes an examination and initial assessment screening will be performed by the admitting RPN, of both the here and now mental state as well as the longitudinal aspects of any particular presentation, with a reference on to a psychiatrist or psychiatric registrar where the initial or provisional diagnosis suggests severe mental illness warranting a P1 rating (requiring psych assessment) or a P2 rating (requiring a psych assessment for review of medication).

Again while the protocol allowed for alerts to be monitored by RPN's with suggested changes to ratings provided to inform senior clinicians of changes in an individuals present assessed mental state, that assisting role, carried out in this case by RPNs Logan and So, does not suggest a negation of the overriding duty of senior clinicians to meet with and review all P1 and P2 classified prisoners, of whom Mr Omerovic was one.

In other words the protocols did not suggest any delegation of duty in this area, especially so given that these critical tasks were professionally central to the psychiatrists duties and reserved for senior clinicians, as against rules concerning the RPN's, who themselves were not legally qualified to diagnose, or to alter a provisional diagnosis, or to prescribe.

Equally, the protocols did not suggest a system under which appropriate clinical care was to be maintained in respect of one category of P1 or P2 classified prisoner, while denied as a matter of routine in respect of others.

The underlining is mine.

I also note however that the uncontradicted evidence of a number of witnesses, establishes that the P ratings, which were required under both the (exhibit13a) and (exhibit 13b) forms, were at the relevant time, no longer used as a means of ascribing a preliminary level of assessed illness or provisional diagnosis, or indeed for the referring of prisoners for psychiatric Consultant or Registrar review, (and or for the prescription of appropriate medication). Rather that the P1 rating was employed, instead, as a means of

25. RPN Lawrie testified that she received and read the prisoners health file, as well as the facsimile prepared by colleague Paula Verity before her own assessment began. Her assessment was recorded on a Mental Health Screening Assessment form dated 17 March.[14]

26. RPN Lawrie noted the variety of methods and frequency of Mr Omerovic's earlier attempts at self-harm. She also recorded his assertions that:

> '*If I could end it I would*' (and upset at the unit 13 placement proposal), '*I wont be able to kill myself here.*'[15]

27. She also referred to the self-reporting information obtained from the prisoner together with information included by Forensicare staffer Ms Ivana Vasileveska, which she had obtained from the RAPID database.[16] (Unfortunately Ms Vasileveska had included only a very limited description of the information available, which matter is discussed below under Findings).

28. I also observe however, that RPN Lawrie did not refer to the existing ITO or to Mr Omerovic's claim, noted by Prison Officer Mommonwald in his own assessment, that

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preventing the immediate transfer of prisoners out of the MAP, to other Victorian prisons, with a P1 classification acting as a systems block to such a transfer.

The use of the P1, P2 classification in this manner together with the movement of prisoner traffic through MAP and the consequences for the system that later emerged, is considered below.

(It is also relevant that later evidence suggests that a P1 classification may now be altered by a Forensicare RPN leading to the immediate transfer of the prisoner out of MAP, without further reference to HRAT).

See also RPN Logan's and RPN So's evidence below, as to the verbal direction received by Forensicare RPN staff from a series of in-charge Consultant Psychiatrists, concerning how and in what unusual circumstances MAP prisoners, at admission, might be referred directly to the AAU list, or to the Psychiatric Registrar 'outpatient' clinic list, as distinct from a Muirhead cell admission, to be followed by the possibility of a later RPN review, (if the prisoner had not been transferred out, and still remained at MAP).

Consider whether any such limit imposed upon the review and recommendation duties of admitting RPN's, was consistent with the applicable protocols around admission and the implications of this approach for prisoners, who like Mr Omerovic had an immediate past history of depressive illness including bipolar disorder and suicidal ideation and conduct, but who were not overtly psychotic.

Consider whether the longitudinal inquiry needed to best understand a presentation was possible in the average 10 minutes set aside for each prisoner seen at an outpatients clinic, and whether (as a consequence of the direction provided by successive Consultant Psychiatrists and apparently condoned by Forensicare), it meant that prisoners like Mr Omerovic were effectively excluded from a mental illness diagnosis, and as a consequence, from appropriate medical treatment.

Consider also whether such an approach (to non floridly psychotic) prisoners resulted in at risk prisoners like Mr Omerovic being accommodated in non BDRP compliant cells in MAP and or at a receiving prison like Port Phillip Prison Scarborough unit, where suicide ideation might easily be played out with tragic consequence.

Further, consider RPN Logan's evidence as to the use of Muirhead cells to allow for withdrawal from drug and alcohol dependency, to permit a more accurate understanding of any particular psychiatric presentation.

These matters are discussed in the Courts review of the evidence of Professors Bell and Ogloff below, and within the Findings sections of this decision.

[14] See exhibit 13(a). RPN Lawrie received the two-page fax exhibit 34 and not the materials including the RAPID Dump and the handwritten notes, which had earlier been attached. (See transcript 682-84). Exhibit 34 did not specifically mention the fact of the ITO.

[15] See exhibit 13(a) at page 4.

[16] See evidence of Ms Vasilevska, discussed below.

depending upon Mr Omerovic's phone call to his former partner Kim Cooper, he would determine whether or not to proceed to commit suicide, '*as soon as he was able to.*'[17]

29. As a result, this threat coupled with the result of his earlier call to Kim Cooper (undertaken during Prison Officer Mommonwald's assessment) was not considered by members of the High Risk Assessment Team (HRAT) or others at the time of his transfer out of the Muirhead cells.[18]

30. Following her review of Mr Omerovic, RPN Lawrie determined to assign him a psychiatric rating of P1 and a suicide rating of S2, and nominated him for admission to the Unit 13, Muirhead Cells, recommending that he should be observed at hourly intervals.[19] In so doing, she was mindful of the fact that Forensicare policies about Muirhead cell admissions meant he would be reviewed by a colleague RPN within 24 hours.

Reception Senior Prison Officer G Richardson

31. Mr Richardson was the senior officer at MAP reception at the time of Mr Omerovics admission to MAP, on the afternoon of 17 March. At the time, Mr Omerovic was assessed by an Assessing Officer, Mr Mommonwald, as well as RPN Nigel Logan. Both officers recommended he be placed on observation in a Muirhead cell within Unit 13, and in consultation with the Operations Manager, Mr Richardson accepted this advice.

> '*My function is to sign off on the placement and put any other actions into place regarding Mr Omerovic.*'

32. Mr Richardson attended the HRAT meeting the afternoon of the following day, concerning Mr Omerovic. Prison Supervisor R Milne chaired the meeting. Exhibit 13(f) the HRAT Diary for 18 March, reflects that Mr Omerovic was discussed at HRAT on this day and RPN Logan's recommendation that he remain in Unit 13 was adopted.

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[17] See exhibit 13(c). Prison Officer Mommonwald's assessment was available to RPN Lawrie but was not available to subsequent reviewing RPN's. See further discussion in Comments section below.

[18] See exhibit 13(c). I note that on the following day 18 March, PRN Nurse Logan recorded as above, that Mr Omerovic had told him that he had spoken with his partner and the relationship was still on. It is also the case however that Nurse Logan was not aware of either Mr Omerovic's threatened suicide on the previous day depending upon the attitude of Ms Cooper, or of the truthfulness of Mr Omerovic's assertion that Ms Cooper's ongoing support was now assured.

[19] The documents relevant to how this classification decision should be made (as of March 2007) were the Directors Instruction 1.2 at risk procedures dated 11/05/09, exhibit 18(c); the MAP Local Operating Procedure 1.2 At Risk Procedure dated 27/08/07 exhibit 27(d), together with the then Forensicare Operating Manual found at exhibit16(a).

RPN Nigel Logan[20]

33. On the morning of 18 March 2010, Mr Omerovic was reviewed by RPN Nigel Logan, in a small outside space adjacent to Unit 13, which we know is commonly used by Forensicare staffers for such purpose. RPN Logan confirmed that it was his usual practise to read the prisoners health file prior to any consultation. Typically, that file would include the Forensicare record of the history following admission, though not other material.

34. His full note of that consultation was as follows:

> *Seen in Unit 13 this am.*
>
> *40 yr old man in 4yr relationship. No clear psychiatric history prior to recent psychiatric admission last 3/52.*
>
> *Long history of heroin abuse but has been able to hold down a full time job in a nursery.*
>
> *Recent financial problems with $140,000 mortgage and $30,000 in other loans struggling to meeting repayments. Feeling like he was a failure not being able to look after family – several O/D of heroin and pills. Ended up in Northern and RMH psychiatric unit discharged himself after 1/7.*
>
> *Did an armed robbery in a 'Cash Converter' Store "off my head on pills".*
>
> *Today states no plans/intent to suicide. Spoken to partner stated relationship still on and maybe able to work out their financial problems.*
>
> *Expecting a couple of years sentence. Affect not depressed – but depressive themes evident. Not psychotic. Broken sleep – withdrawing. Appetite okay. Advised Adam given recent events that he will stay in 13 today and be reassessed tomorrow – he was a little irritated re: this plan.*
>
> *Remain P1 S2.*[21]

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[20] RPN Logan testified that he was a qualified psychiatric nurse of 30 years experience and that he commenced his training in an apprentice like regime, at what was then the Royal Park Psychiatric Hospital.

[21] See exhibit 18 and 18(a). There was no assessment tool to inform as to how this review was to be carried out.

According to the witness, his purpose was to undertake a '*here and now mental state assessment*' and to determine whether to downgrade Mr Omerovic's P1 status allowing for his release from a Muirhead Cell, and return to the general prison population, (and eventual transfer out of MAP). See also his observations about Muirhead cells at transcript pages 482 and 495 discussed above, and the general concern underpinning what was arguably a collective Forensicare staff endeavour, to get prisoners through and out of what was widely seen as a harsh and uncomfortable environment, as soon as reasonably possible.

35. RPN Logan further stated that his decision to recommend the maintaining of the P1 S2 rating was based upon, *'the recency of Mr Omerovic's suicide attempts.'*

36. RPN Logan additionally testified that he believed the Mirtazepine found in blood at autopsy, reflected that Mr Omerovic had illicitly obtained this drug, a psychotropic drug with anti-depressant qualities, from a fellow prisoner.

37. He further offered that it was generally beneficial to allow a prisoner like Mr Omerovic to go through drug and alcohol withdrawal, before determining whether to refer to a psychiatrist.

> *'In fact there is a policy if I could add it from our psychiatrist that no one from reception is to be referred to her, ... (for) sort of further assessment-except in a few extreme cases where someone is clearly perhaps floridly psychotic, with a clear well established mental health history...*
>
> *(It is not a written policy.) It's a verbal policy and I've had it confirmed on a number of occasions from our last two (Consultant) psychiatrists ...Dr Roberts, Dr McInerney ... and before that Dr A W, (name redacted).'*
>
> The underlining is again mine.[22]

38. RPN Logan was further questioned about Mr Omerovic's P1 rating and the Commissioners requirements, which establish that a P1 rating is to be given to

> *'Someone with a serious psychiatric condition requiring intensive and or immediate care'*[23]

39. In response, he offered that P1 is a classification used to ensure that prisoners may be kept at MAP for further assessment or,

> *'such as people returning to the MAP for Court reports ... or requiring further diagnostic clarification...and if I can just throw some statistics at you, I think there's usually around 50-odd people at the MAP on a P1 rating at any given time. There is (only) 16 AAU beds, so that would indicate there are large numbers of P1 people in*

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[22] See transcript at page 490-92. The last mentioned (Dr A W), was a witness in an earlier related matter in which finding her name was ordered to be redacted. See Inquest into the death of Timothy Casey, Coroners finding 1277 of 2008, at the Coroners Court of Victoria website.

[23] See exhibit 13(g) at brief page 355.

both protection units and mainstream units, (as distinct from management units)...I don't know whether this helps to clear things up...' [24]

40. And later,

Q *'Are all of these Units now (Corrections Building Design Review) BDRP compliant?*

A *No...only the AAU and units 13 and down stairs it is. Units 1, 2 and 7'.* [25]

41. In further testimony and after agreeing with the application of the PI Commissioners requirement (criteria), RPN Logan testified,

Q *So he is seen as P1 and the fact is he didn't get intensive and/or immediate treatment?*

A *As I've just stated earlier...that that is a very brief explanation of the P1 rating which I think most people would agree would require perhaps a more lengthy description.*

Q *Just dealing with the Commissioner's requirement, do you agree that Mr Omerovic was P1?*

A *Yes.*

Q *And properly P1*

A *Yes.*

Q *And the definition at p.355 of the brief is that, "he had a serious psychiatric condition requiring intensive and/or immediate care?"*

A *Yes.*

Q *And would you agree in Unit 13 and spending two or three days in Unit 13 and then being moved out of it, at the point of time that he moved out of it he hadn't received intensive or immediate care?*

A *I couldn't actually agree with you on that and I think we need to look at the effects of the Unit 13 environment on people's mental health. I think it's - you know, it's*

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[24] See transcript page 492-93.

[25] See transcript 493-94 and the evidence of MAP General Manager Brett Ryan, at Exhibit 27 and 27(e), and from transcript page 1243 where Mr Ryan testified that MAP is a 285 bed multilevel prison, over 6 levels. Mainstream prisoners stay at the prison for an average of 10 days with protection prisoners like Mr Omerovic usually staying longer.

Up to 25 new prisoners are received by MAP each day with maximum or near maximum capacity, the norm.

not rocket science as far as I'm concerned, to lock someone in a concrete box for an extended period of time is going to have a beneficial effect on their mental health.

Q Sorry, locking up in Unit 13 is going to have a beneficial effect?

A It is not going to have a beneficial effect. And the reason we have a clear focus on moving people out of Unit 13 to a farm or a normalised state, in the case of Mr Omerovic, I believe he went to a shared cell in Unit 4 ...

Q That he was released after two days in Unit 13, which would be unhelpful to his health?

A Yes.

Q Without any assessment, or without any treatment being provided?

A I think if I could just reinforce the issue that Mr Omerovic's withdrawing from a cocktail of heroin and Xanax which, you know, is obviously not a terribly good combination of substances to be using and that's ... the reason I expect he actually ended up there and was responsible for some of this chaotic behaviour that was happening and ... and it would seem that there was some degree of settling, you know, over this period.

Q Would it not have made more sense, if he was to be moved from Unit 13, rather than put in him mainstream (into an unrenovated cell ... with a number of available hanging points), to have put him in the AAU?

A It's highly unlikely there would have been a bed in the AAU. It is always full. There's usually a waiting list of four, five, six people waiting for a bed.'[26]

42. In additional testimony, the witness agreed that the fact that Mr Omerovic had been placed on an involuntary treatment order, an ITO indicated that a consultant psychiatrist or psychiatric registrar had believed he had a serious mental illness, which needed to be treated. He further agreed that no one from Pacific Shore's or other, had contacted Mr Omerovic's GP at the Mill Park Super Clinic, to ascertain whether he had continued to prescribe Lexapro, over the three weeks following Mr Omerovic's last visit.[27]

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[26] See transcript page 496-97

[27] Mr Omerovic had been prescribed Lexapro by his GP some three weeks before his arrest. Lexapro is widely used to treat major depressive illnesses, and general anxiety.

43. RPN Logan further stated that Mr Omerovic might have been reviewed again following his release from the Muirhead cells on 19 March, but agreed that in this instance, he had hung himself in a non-BDRP compliant cell, in the early hours of 23 March, before any such review could occur.[28] He further stated that as of March 2010, he would see an RPN only in the first instance within 7 days of a Unit 13 release, and only then see a psychiatrist or registrar if it was determined by the RPN to be appropriate.[29]

44. Additionally RPN Logan testified that the P1 rating, upon which remand in a Muirhead cell was predicated, could be altered at any time by an RPN with the S ratings alone only able to be altered by decision of the HRAT.[30] His further testimony was that prisoners who had been on P1 while at MAP might be transferred out when designated as a P2, this occurring prior to any RPN or subsequent Psychiatric Registrar review, with the possibility of a later assessment and receipt of appropriate medication initiated at a receiving prison.[31]

45. RPN Logan was unable to say whether he had seen Paula Verity's earlier assessment of Mr Omerovic for Forensicare.[32] Specifically he was not aware of her opinion that he was likely to, '*under report*', but agreed that that assessment would have put himself and his colleagues on notice of his potential to so under report.[33]

46. RPN Logan felt unable to comment on the suggestion that Mr Omerovic was irritated by his proposal to recommend that he remain in the Muirhead cells for a further 24 hours because it hampered his plan to take his own life.[34] He further testified that his notation in the HRAT diary,[35] '*may clear tomorrow,*' was a reflection on his opinion that, '*his mental state was improving ... and that keeping people in unit 13 was not an ideal arrangement,*' and was not intended to put pressure on RPN Karen So, who was to review him the following day.[36]

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[28] See transcript page 500-501.

[29] RPN Logan's further testimony was that following Mr Omerovic's death this (RPN) review period requirement had been reduced from 7 days down to 3 days. See also Nurse So's evidence at transcript page 591-92, concerning this issue.

[30] See transcript page 505.

[31] See transcript page 507. The witness had no personal knowledge of conditions at for instance the Scarborough reception unit at Port Phillip Prison, and was unable to comment on what may occur following transfer. See further discussion concerning those conditions at footnote 144, and Recommendation 3 below.

[32] See exhibit 34.

[33] See review of Paula Verity evidence set out below and RPN Logan's evidence at transcript page 513.

[34] See exhibit 18(a)

[35] See exhibit 13(f)

[36] See transcript page 517-18. See exhibit 18 at pages 2-3. The possibility that this advice, provided as it was to both Mr Omerovic and to the HRAT put additional pressure on RPN So to later recommend the downgrading on the 19th is discussed below in the findings section of this determination.

47. The witness further testified as to the condition of all general prison population cells at the relevant time, and why these arguably threatening environs, were not and could not be a primary consideration in determining when to recommend the transfer of a at risk prisoner, from a Muirhead cell.[37]

RPN Karen So[38]

48. During the morning of 19 March 2010, RPN Karen So reviewed Mr Omerovic in the Unit 13 courtyard used on the previous day for this purpose by RPN Logan.

49. Prior to seeing Mr Omerovic, RPN So had access to the Intake Screening Assessment and the separate Risk Assessment, made or contributed to by RPN Lawrie on 17 March, and the clinical note recorded the following day by RPN Logan,[39] which materials included the (incomplete) RAPID data base notes earlier recorded by Ms Vasilevska.

50. RPN So was however not able to say if she had seen psychologist Paula Verity's assessment, exhibit 18(b), prior to her own review.

'I don't recall now but I would probably have had a look at it.' [40]

51. She further agreed that the Paula Verity review contained important information most particularly in respect of the prisoner's underlying depressive illness and suicidal ideation and his earlier attempts to mask that presentation.

52. RPN So also stated that she did not have access to the prison officer review conducted on admission[41] and agreed with the suggestion put by Counsel assisting, that the information there obtained about a '*trigger*' issue concerning Ms Kim Cooper's attitude to Mr Omerovic, and the connected threat of a possible future attempt on his own life, was important and would have been useful to her.

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[37] See transcript 577-78, RPN Logan's point being that he and his colleagues had no other alternative.

[38] RPN So, (Bachelor of Nursing, Post Grad Diploma of Mental Health Nursing), was an apparently experienced and competent RPN and I further note that at the time of her giving her testimony, she was employed within Unit 13 as the acting in charge unit manager. Her recollection is that at the time of her review of Mr Omerovic only 3 of the 8 Muirhead cells were occupied. I further note that Nurse So did not make a statement in connection with this matter until some 18 months after the events under consideration.

[39] See exhibits 13(a), (b) and 18(a).

[40] See transcript page 637. (This evidence was later seemingly contradicted at transcript page 663). My understanding from earlier evidence given however, was that material such as Ms Verity' report would normally only be seen at admission and would not be seen by RPNs subsequently called upon to review a prisoner remanded in a Muirhead cell.

[41] See exhibit 13(c). She considered that the availability of this record would have been of assistance. See also footnote 152 below concerning new arrangements now put in place as informed by Professor Bell.

53. She also was not aware of the ITO dated 24 February and as a result was not informed of earlier psychiatric and medication reviews of Mr Omerovic under that order, undertaken on 2, 4, 9, 15 and 16 March, (i.e. before his MAP admission on 17 March). She further agreed that no one from MAP had contacted the clinicians involved and that she herself would have undertaken such an inquiry, had she been aware of this history.[42]

54. She spent approximately 30 minutes with Mr Omerovic. Her completed note of that consultation was as follows:

> *'Nursing U 13: Seen in Unit 13 courtyard, warm and reactive, open to engaging with writer. Spoke to writer re: the problems and reasons leading to overdose attempt stating that he was in a "bad place" at the time and it was his, "cry for help". Currently denying thoughts / intent of SASH and able to guarantee his safety. Nil depressive themes evident in this conversation. Requesting for counselling or psychology help for his problems if in mainstream. Adam has been in contact with his family and feels he is slowly working through his issues with him. Identifying them as protective factors. Cleared from U13 in HRAT. P1 S3.'*[43]

55. RPN So further explained that the above note was in fact not recorded until later in the day, this following the HRAT meeting which she had later attended and which approved her recommendation to downgrade Mr Omerovic and allow for his transfer to a general prison population cell.[44]

56. In this regard, she explained that she recorded her proposed recommendation for the afternoon HRAT meeting on the HRAT diary for 19 March in the HRAT diary, exhibit 19 (d). I note here that her diary note simply states:

> *78166 Adam Omerovic 1 (P Rating) 3 (S Rating) Cleared.*

(The rating change S2 to S3 allowed for his transfer out of a Muirhead cell).

[42] RPN So also agreed that material not included in the note by Ms Vasilevska, which also would have been relevant to her own review, included his history of ideation, his history of non compliance in respect of medication and his ongoing opiate abuse. See transcript 634-35.

[43] See exhibits 19 and19(c) and transcript page 590-91.

[44] See transcript page 648-50. RPN So further agreed that although Senior MAP Psychologist Maria Aggrides was present on the 19th (exhibit 19d), that she was the only person present who had assessed Mr Omerovic.

57. In addition, she further testified how she wrote an independent note of her clinical review at the time of her review and took both her note, no longer available, and the diary to the HRAT meeting.[45]

58. RPN So's further evidence was that the decision to recommend a downgrade and allow for transfer into the general prison population was a balancing exercise in which she was required to balance risk factors against protective factors.

59. Additionally she stated that the fact that transfer would include a subsequent RPN review within seven days, now three days,[46] was a factor in her consideration but agreed that such a review was dependent on the prisoner actually remaining within MAP, until that time.

60. Also relevant to her decision was the belief that Mr Omerovic would remain subject to hourly observations by prison staff following his transfer out of Unit 13.

61. Her further evidence was that the reference to half hour observations in his Modified Risk Management Plan, 19 March, was in error and related only to observations actually made in Unit 13 that is before his downgrade.[47]

62. In examination by Counsel Assisting, RPN So also agreed that Nurse Lawrie's note informed that the prisoner had spoken of, recent suicide attempts x 6, … '*I wish I was dead* …', and that he could not guarantee his own safety.[48] She was also aware of the At Risk Procedures Schedule[49], which suggests that,

> *'The first 72 hours after initial reception or reception into a new prison is one of the highest risk periods for suicide.'*

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[45] Her approach to the issue of the later recording of her clinical review and finding, only following the HRAT meeting, which approach I note was later not supported by Professor Bell in his evidence seen at transcript page 941-43, was made the subject of an observation by the court to Ms So at transcript page 747.

[46] See transcript page 591-92. Another change to practise from June 2010, involves a requirement that the updated Modified Risk Plan be signed by all present at the HRAT meeting and then attached to each prisoners medical and IMP files. See modified document at exhibit 19(e) and compare with exhibit 19(b), the risk plan documentation previously in use.

[47] See bottom half of exhibit 19(b). The error concerning length of time between observations noted on the exhibit, i.e. half hour, and the one hour observations systematically undertaken by prison officers in respect of at risk prisoners transferred to the general prison population, (which occurred in respect of Mr Omerovic), appears to be that of the prison officer co-ordinator responsible for Mr Omerovic. See transcript page 658.

[48] See transcript page 599.

[49] See exhibit 18(e).

63. As I understand her evidence, she further agreed that she was aware that her recommended down grading of Mr Omerovic would lead to his transfer to a non-BDRP compliant cell.[50] Additionally she affirmed that the purpose of her review was to undertake a mental state examination and agreed that the available note concerning the RAPID database, included by Ms Vasilevska, was incomplete in that it should have included the fact of and detail of the ITO order.[51]

64. She further stated however that the fact of the existence of the ITO, would not of itself have an influence on prisoner treatment within MAP, or whether a psychiatrist reviewed such a prisoner.

65. Her further testimony (in support of RPN Logan), was that there had been an, '*understanding*', to the effect that other than the most floridly psychotic prisoners should not be referred directly to a psychiatrist, rather than to a Unit 13 Muirhead cell or into the general prison population.[52]

66. RPN So was further questioned about PRISM, and the manner in which Mr Omerovic may have come to the attention of the MAP employed prison psychologists. She was able to confirm and it was not in dispute that Mr Omerovic was not seen or indeed scheduled for a later review by PRISM psychologists, during the four-day period between his transfer from Unit 13, and his death on 23 March.[53]

67. RPN So also agreed with Counsel assisting that exhibit 18(d) (The Forensicare Policy and Procedure Manual 2.1 version 3 at page 1033-35), set out the applicable policy and procedure in respect of admission to the AAU and that it was part of their training, and that all staff had access to it.

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[50] See transcript page 646. However see also transcript page 663 where RPN So stated, '*I am aware of BDRP compliant cells now, but at the time it was not a well known fact to me that all mainstream units were not BDRP. See also Recommendations 2 and 3 below.*

No one told you that?

No'

[51] See transcript 617-19.

[52] See transcript 624-26.

[53] PRIM refers to the provision of psychological services by MAP employed personnel. See discussion at transcript at page 658-59. I also record here that Mr Omerovic had separately requested to see a psychiatrist 22 March, and a psychologist during his review by RPN So on 19 March, but that the evidence establishes that no arrangements pertaining to scheduling to see either, took place before his death. In so noting, I accept that Nurse So might reasonably have expected MAP psychologists at PRIM to directly make contact with Mr Omerovic following his discharge from Unit 13, without direction on this matter from herself.

68. She also agreed that the P1 assessment by RPNs Lawrie, Logan and herself indicated that the prisoner,

> '*has a psychiatric illness which makes him vulnerable in the mainstream prison or protection units.*'[54]

69. RPN So also agreed with Counsel assisting that there had been a systemic failure in respect of the inability of those responsible to consider all available information concerning Mr Omerovic, which had then led to his placement in a non BDRP compliant cell, that made suicide more likely. [55]

70. Her further evidence in response to Counsel for Mr Omerovic's family was as earlier, that the information given to PO Mommonwald on admission concerning the contact with Kim Cooper, would have been helpful to her own assessment. Similarly, the fact and detail of the ITO would also have been helpful, had it been included in the RAPID summary prepared for RPN Lawrie, by Ivana Vasilevska.[56]

71. Her further advice was that the additional medical materials attached to Ms Verity's two-page fax, exhibit 34, which were then separated and not included in her file would also have been helpful to her. She further agreed that the six overdose attempts outlined by Ms Verity appeared to be serious attempts, and that her further record that he had being trying to kill himself, *'every second day,'* was also important.[57] His available history, which suggested that he might attempt to manipulate his presentation, was a further important matter for her to consider.

72. She additionally stated that his request to her to see a prison psychologist when he was in mainstream, was also a protective factor.

73. She further agreed that it was relevant to her assessment of protective factors that RPN Lawrie had noted on admission that Mr Omerovic had a 'girl friend', but was not expecting any visitors and had no supports. She also agreed that there was a difference between the information obtained by RPN Lawrie on this matter, and what he had said to her concerning his working through family problems.

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[54] See exhibit 16(a) and transcript page 662. See also discussion about Nurse Lawrie and Nurse Logan's evidence, on the issue of a P1 classification at respectively footnote12 from page 9 above.

[55] See transcript page 666-67.

[56] See transcript 674-75. On one view this material was alluded to by Ms Verity in her own assessment exhibit 34, although I note here that the witnesses understanding of that matter was equivocal.

[57] See transcript page 718.

74. She felt that this difference might have occurred because of additional family contact after admission, although I note here that the evidence does not suggest that any such contact actually occurred.[58]

75. She also considered his improved mood and engagement on the 19th, as opposed to his poor presentation on admission on 17 March was relevant, but agreed that his presentation to Ms Verity on the morning of 17 March appeared to be markedly different to his presentation later that day.

76. RPN So additionally agreed with Counsel for the families suggestion, *'that it was a very complex matter'* and that in the absence of an appropriate *'structure,'* that there was no *'clear way'* of working out and balancing the issues concerning his, *'pre-dispositional and situational factors at risk.'*[59]

77. RPN So also agreed with the evidence of RPN Logan that the Unit 13 (Muirhead cells) were considered to be an, *'unhealthy environment'*, with a focus by clinicians on clearing prisoners out, *'when the risk levels are suitable..'*

78. She also agreed with Counsel for the DOJ that it was for prison officers to determine whether a prisoner released from Unit 13 should go into a one man or two-man cell, in mainstream. She also agreed that Mr Omerovic's status on the E Justice Rating programme, had not been updated following his downgrading on 19 March.[60]

79. RPN So further agreed with Counsel for Forensicare, that when she assessed him on 19 March, Mr Omerovic demonstrated a number of factors mentioned in exhibit 18(e), the Directors Instruction (referred to by Counsel for the family), which were positive indicators and relevant to her determination of risk.[61] She further testified that she had conducted a mental state examination, observing his behaviour, his interaction, his affect and thought content, trying to identify and assess the risk signs.[62] Her further evidence was that her method of recording a clinical note of an earlier held interview, this only after the HRAT meeting, meant that she would not be distracted and could be concise. She also felt that the

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[58] See transcript page 708.

[59] See transcript 719-721.

[60] See exhibit 19(f).

[61] See transcript page 736.

[62] See transcript page 737.

use of a pro forma in undertaking a Unit 13 mental state assessment might *'de-skill'* clinicians.

80. Her further evidence was that …

> *'At times we would be asked by the Sentence Management Unit to review P ratings …in terms of whether they need to be staying at MAP at P1, or whether they can be transferred to Port Phillip, who have got the continuing kind of psychiatric care…*
>
> *Q Have you ever bowed to pressure…*
>
> *A No if it was inappropriate I would not have - I would not have changed it.* '[63]

81. In re-examination the witness was referred to her answers given concerning the positive aspects of Mr Omerovic's' presentation she observed on 19 March. She agreed that if, *'you compare it with what has been recorded by other clinicians,'* that there was a change in behaviour and an inconsistency, which she did not pick up (or view with concern).

82. She also testified that she had never been in a mainstream cell and at the time that she was also not familiar with the concept of BDRP compliance, and that it would be a good idea for all RPN's to familiarize themselves with such matters.[64]

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[63] See transcript 742-43.

[64] On April 19 at transcript 747-48 following the evidence of RPN So, and having heard evidence on the subject of lack of cell familiarity from a number of Forensicare staff, I made an interim recommendation in the following terms,

'Mr McGregor, I would also, I note that Mr Ryan is here. I would also…having regard to what has been said now by three Forensicare witnesses,

***I recommend** that arrangements be made for Forensicare staff from Dr Roberts (now Dr Claire McKiernany) down, to have a look at the recent renovation of cells at the Melbourne Assessment Prison, so that they are fully aware of the changes that have been made, and the conditions in the cells that have been renovated, as opposed to the conditions in cells, which have not.*

***I further recommend** that arrangements be made for the same staff to go to Port Phillip Prison and to actually inspect the Scarborough Reception Unit in that place and thereby be made aware of the actual conditions there, so that we can be confident that MAP Forensicare staff are fully informed about the (unrenovated) conditions that at risk prisoners maybe sent to, dependent upon decisions and the recommendations that they may make, concerning a prisoners mental health and his readiness for downgrading and transfer.*

'Certainly, I would not expect that to happen overnight. Nevertheless, I (recommend) that Corrections investigate the possibility with Forensicare, and make that arrangement with Port Phillip Prison.

And, I recommend that Corrections, and I'm sure Mr Ryan would fully assist, arrange with Forensicare, for that visit to be undertaken by all Forensicare clinical staff presently serving at the Melbourne Assessment Prison.'

Mr Ryan informed during testimony that this recommendation had been accepted and followed to the extent that all MAP based Forensicare staff had visited or would soon visit both BDRP and non BDRP compliant cells at the MAP, with arrangements for a future visit to the Scarborough South Unit Port Phillip Prison, still pending.

March 23, 2010

Inmate Leon Cook

83. Mr Leon Cook shared cell 16 in Unit 4 with Mr Omerovic, following the latter's transfer to the general prison population on 19 March, after his release from a Muirhead Cell. He was not a part of any peer support programme in respect of his new cellmate. Following his transfer, a prison officer came and identified Mr Omerovic as the prisoner on the upper bunk, upon whom he was required to conduct observations and *'shine a torch at'* this following lockdown which occurred between 4.30pm and 7.30am, the following morning.

84. Over the next few days the two communicated frequently and in a reasonably open manner and with humour. During this period however conversation often came back to discussions initiated by Mr Omerovic, many of which appear to have related to Mr Omerovic's interest in the possibilities for suicide, within the cell. Mr Omerovic also spoke extensively and lucidly about the breakdown of his relationship with his wife and how he had assigned to her his interest in their home, and told her, *'not to wait'*.

85. It is also relevant that he told Mr Cook that he had done a lot of gaol time and that he,

> *'had done stick-ups at 7-eleven and servo type stuff. He said he was getting gear and hoping for the best. I took this to mean that he was trying to overdose but he said the heroin was too weak in strength. During the day, I saw him look at the towel holder. He also looked at the shower bar.'*

86. Mr Omerovic also reportedly told Mr Cook that he had used syringes or knives at these robberies and was expecting to be sentenced to a 10-year term. According to Mr Cook these conversations were spread out over a three-day period and so, it was not obvious to him what Mr Omerovic was, *'planning to do.'*

87. He was also observed to put his hand on the shower rail and test its weight.[65] It is also relevant however that during this period Mr Omerovic asked Mr Cook for financial assistance to get some deodorant and shampoo, which request was granted and that Mr Cook saw this as a positive indication of Omerovic's will to live. He was unable to recall if Mr Omerovic received pharmacy drugs while they shared cell 16, but had some recollection that they both went *'to the truck'* to get meds.

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[65] Transcript page 183

88. On his last day Mr Cook recalled that his cellmate was somewhat withdrawn spending more time in the cell than out in the yard.

89. During the night prior to his death Mr Cook states that Mr Omerovic was up and down from his bed, *'maybe three times,'* And on one occasion, that he awoke to find Mr Omerovic with his face very close to his, *'checking if I was asleep or not.'* Later they had a cigarette and Mr Cook fell back into sleep. At some later point, this I find at approximately 4.10am, Mr Cook woke again and saw Adam near the toilet. He called out to him with no response and then discovered that he was in fact hanging from a twisted pillowcase, which had been attatched to a section of the shower screen. Mr Cook immediately activated the intercom and attempted to lift Mr Omerovic from his waist, thereby taking the weight off the ligature.

90. Soon after Mr Omerovic dropped from his ligature and Mr Cook observed that his tongue had swollen extensively. He held him on the floor with his arms across his chest and tried to do chest compressions.

> *'I just knew he was dead and it wouldn't help.'*

91. His arms were, *'very stiff. As I was doing this, prison officers came in and told me to get away from him, this about 15 minutes later, after pressing the button.'*

92. Mr Cook further stated that he asked PO Fitzgerald[66] where he had been as no one had carried out observations since 8pm. His later assessment was that he had not seen observations after 9pm, until he pressed the intercom the following morning and that,

'they do obs now very well after Adams death.'[67]

93. Mr Cook was questioned about what he would have done had he realized that Mr Omerovic was intending to take his life. He stated that he would have sought out known friends of Mr Omerovic and would only have spoken to prison staff as a very last resort.

94. At the conclusion of his evidence, the contents of which were not in dispute, I commended Mr Cook on his efforts to assist Mr Omerovic, as set out in his evidence above.

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[66] See PO Fitzgerald's statement (exhibit 1), who confirmed that he was the first PO to arrive at the scene, soon after 4.15am after being notified to attend by Senior Prison Officer Ferguson, (statement at exhibit 1(a), who was on duty in the control room.

[67] See exhibit 9 page 3-4. I also note here that later evidence from transcript page 190 suggests that Mr Cook may have slept for all but approximately 40 minutes, between switching the TV off (following a movie) at 10.30pm, and when he awoke to find Mr Omerovic hanging, shortly after 4am.

Prison Officer Bernie Whittingham

95. Prison Officer Whittingham attended outside cell 16 Unit 4, soon after receiving a direction to from the Control Room Duty Officer to take the emergency keys to the cell. Soon afterwards, at 4.20am in the presence of PO Fitzgerald, Supervisor Sullivan and PSN Patrick Dam, he opened the cell door. The ligature was removed and Mr Omerovic was examined, following which he was found to be deceased, with Mr Cook then removed to another cell. Attempts at resuscitation commenced soon after 4.15 am, were unsuccessful.

Overview by Forensicare and the Department of Justice

Dr Roberts[68]

96. *'The role of Forensicare in reviewing prisoners in Unit 13 is narrow and focussed on the assessment of a person's risk of self harm and suicide.'*

Professor Bell [69]

97. Professor Bell had no direct involvement with Mr Omerovic's care.

98. Professor Bell's evidence was that MAP was the entry point for all prisoners entering the Victorian Prison System. 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 (GEO Healthcare), and a mental health assessment undertaken by a Forensicare RPN. The focus of the Forensicare assessment is to determine the person's current mental state and any immediate needs for care, their current risk of suicide and self-harm and any appropriate recommendations for their placement. The processes for management for at risk prisoners are set out in Corrections Victoria Policies and Procedures: Directors Instruction 1.2/1, At Risk Procedures.[70]

99. Professor Bell's duty was to provide, '*clinical governance...across the prison system.. as well as quality control.*'

[68] At the relevant time, Dr Roberts was the Consultant Psychiatrist in charge at the MAP. See exhibit 29 at paragraph 20.

[69] Professor Bell, a senior Consultant Psychiatrist, testified that he has been with Forensicare since 1994, when he commenced employment as a psychiatric registrar. Thereafter he undertook full time continuous employment within the organisation. At the time of Mr Omerovic's death Professor Bell was (and is now) the Acting Clinical Director for Forensicare.

[70] See exhibit 18(e).

See also exhibit 16(a) the Forensicare Operational Manual, applicable at MAP and the Dame Phyllis Frost Centre, introduced during the evidence of Professor Ogloff.

100. His further evidence was that a new Screening Assessment Form was now being piloted by Forensicare at MAP, which document I note seeks to create a distinction between a prisoners P rating, and his need for inclusion on the AAU Waitlist.[71]

101. Professor Bell testified in favour of RPN Lawrie's decision on admission, to recommend an S2 rather than an S1 rating, as he felt that Mr Omerovic was at a significant rather than any immediate risk of suicide, and that he would remain on15 minute observations while in the Muirhead cell.

102. He also observed (consistently with earlier evidence), that the placing of a patient in a Muirhead cell, meant high levels of intrusion into a prisoners privacy and, '*is not without its potential for a detrimental impact upon a suicidal prisoner's mental state.*'[72]

103. In answer to questions from Counsel assisting, Professor Bell stated that he was familiar with the Forensicare Operations Manual, see exhibit 16(a) the version applicable in March 2010. He further agreed that under the 'Process Standards' therein, that a P1 designation signifies, '*a serious psychiatric condition requiring intensive and or immediate care, and that a persons health needs determine that he stay at the MAP.*'[73]

104. His further evidence was that the P1 classification system was intended to indicate to correctional and clinical staff both a certain level of psychiatric illness and the need for a certain level of intensity of psychiatric treatment as well as the kind of cell in which the prisoner needs to be located.[74]

105. Professor Bell further testified that the applicable Commissioner's direction, exhibit 13(g) was adopted by Forensicare in its own manual and that P1 is the level deemed to require the most intensive and or immediate care.

106. In addition, the question of whether a P1 rated prisoner actually needed to see a psychiatrist for either psychiatric review or the provision of medication, was for the judgement of a RPN each of whom, were well qualified to make such an assessment.

107. He further noted that:

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[71] See exhibit 23(b).

[72] See exhibit 23 at page 3.

[73] See exhibit 16 (a) and transcript page 824. See also references to the P1 classification and the indication for review indicated by exhibits 13(a) the Screening Assessment document prepared by Nurse Lawrie and the discussion at footnote 13 above.

[74] See transcript page 684.

'It is very common for people to come into the prison in a state of high arousal, distress, feelings of being overwhelmed, and for that to include a significant risk of suicide, where those features that I've just mentioned may not necessarily be present. Where a person comes in with what might be called an acute crisis reaction, and where the risk for a relatively brief period, is elevated, but where with appropriate monitoring and emotional and psychological support, emotional containment, physical containment, if that's appropriate – that risk will diminish as the person adjusts to the rigours of prison life.'[75]

108. Professor Bell informed that Forensicare did not have sufficient resources in regard to the number of psychiatrists or psychiatric registrars at MAP to review everyone who had been classified P1/2.

109. Professor Bell stated that he was aware of current admission practise and allowed that it would be *'highly unusual'* for a reception RPN to refer a prisoner directly to a psychiatrist for review in the first instance, as opposed to review on the recommendation of an RPN following an out patients clinic. He was not however able to say what the practise was in December 2010.[76]

110. Further, prisoners at immediate risk might be sent to the Muirhead cells, directly from reception, and that over and above that, RPN'S could always consult with a Forensicare staff psychiatrist if they wished to discuss a particular case.

111. Professor Bell further testified of the suspension effect of a subsequent incarceration, on an existing ITO.

112. He further agreed with the approach taken to provide RPN's with a summary only of the RAPID data at exhibit 13(d), and observed that the pro-forma in question did not suggest to Ward Clerk, Vasilevska that she was required to indicate whether a prisoner was serving either a CTO[77] or an ITO.

113. He agreed with the proposition that information from an ITO file about a recent psychiatric history, together with details of medication prescribed by a psychiatrist or psychiatric

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[75] See transcript page 828.

[76] See discussion of RPN nurses evidence on this issue, as set out above.

[77] CommunityTreatment Order.

registrar, would have been helpful but he felt, that this was not a critical omission in the case of Mr Omerovic.

114. In this respect he stated that the material reported by Ms Verity together with that found in the RAPID data base, was sufficient to make a,

> *'reasonable judgement about salient issues…and not knowing about the ITO …was not critical (because)… it was known that he had been treated recently for depression…*

(Instead),

> *'Where they have been subject to involuntary treatment, where they have been receiving treatment through an area mental health service, including antidepressants, and where it is known that the person is continuing to express a strong (suicidal) desire, it will not make any difference to the initial reception assessment… Later down the track after the prisoner has settled in … and adjusted to being in prison … it may be relevant for staff to contact the previous treating psychiatrist…'*[78]

115. Professor Bell further stated that information about the prisoner's provisional diagnosis and any medication prescribed on 9 March by Dr Coding, was important,

> *'As part of the more longitudinal assessment of ongoing needs but not critical for the decision that needed to be made at reception assessment time.'*

116. Additionally Professor Bell testified that it was also not critical to have this level of background history before down grading a prisoner like Mr Omerovic from S2 to S3 and that while continuity of treatment was important, '*it all depended upon the individual circumstances of each presentation.'*

117. His further evidence was that although there was no specific reference in the RAPID summary or Ms Verity's report to the fact of the ITO, or reference to the fact he was an involuntary prisoner, that matter should have been inferred.

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[78] See transcript pages 839 and 841. I note here that Professor Bells consistent evidence was that there was no need for a great deal of the information that had been collected by Mr Omerovic's earlier treating specialists, to be made available during MAP admission, because the issue at admission had simply to do with initial placement and not to do with his,

'*ongoing needs for psychiatric care and treatment*.' (856).

118. Professor Bell was then asked about the material filled in concerning his history by the ward clerk, and agreed that it did not disclose any unusual presentation or *'red flags'* concerning Mr Omerovic. He further agreed that someone with a P1 rating was required to stay in a *'Prison Treatment Facility'* under the Commissioners Requirement, which is found in exhibit 13 (g). He was not able to say whether the whole of the Melbourne Assessment Prison was a *'treatment facility'* within the meaning of exhibit 13(g).[79] His view was however that as a P1 classified prisoner, that MAP was the only suitable place for him and that such a placement may be relatively short term while he remains acutely overwhelmed by a psychological reaction to his changed circumstances, but that resulting symptoms can be overcome after a relatively brief term.[80]

119. The witness was then questioned about Mr Omerovic's request on the day prior to his death, to see a psychiatrist.[81] He agreed that a prisoner, who like Mr Omerovic had recently prior to arrest, been prescribed Lexapro for a depressive illness, would at some stage have seen a psychiatrist.

120. Professor Bell further informed that he was aware of the concept of BDRP compliant cells and had been so aware in March 2010. He was also aware of the risks associated with putting someone who was vulnerable to suicidal behaviour into a non-BDRP compliant cell if, *'according to clinical judgement he could not safely be placed in that environment.'* [82]

121. And that Forensicare RPN staffers had to do this each day and were clinically trained to make such a finding.

122. He also confirmed that there was always a waiting list for admission to the Acute Assessment Unit (AAU). In addition, that Senior Prison Officer Sullivan was correct in stating that HRAT prison officer members might from time to time challenge a Forensicare staffer at their meeting(s), about the need for a classification downgrade and delay in transfer from unit 13 of any particular prisoner.

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[79] See transcript page 851-2.

[80] See transcript at page 861.

[81] See Mr Omerovic's request made in exhibit 9(a), to see, *'a psych please, regarding anti-depressant meds +A,'* which was not actioned before his death. The request was not unearthed during the initial stages of my inquiry, and was only later provided, after it was forwarded by Pacific Shores Healthcare, to Justice Health.

[82] See transcript page 869-75.

123. Professor Bell also agreed with Counsel assisting, that Mr Omerovic had been referred to Forensicare MAP by the Custodial Nursing Service, and that he was a, '*high suicide risk, or has made a recent suicide attempt.*'

124. As I understood him, Professor Bell also agreed that four of the five criteria established by the Forensicare Operations Manual, for admission to the AAU (rather than to a cell in mainstream), were satisfied by Mr Omerovic's presentation. However, according to Professor Bell that admission was not required in this instance because it was the assessment of a qualified and experienced RPN, that Mr Omerovic was not at immediate risk of suicide.[83]

125. There were also resource considerations, '*but if people could be managed without there being a more intensive residential mental health setting...then that is how it should be.*' [84]

126. Professor Bell was further questioned about Ms Verity's two page fax to MAP, exhibit 34, and particularly about the comment that:

> '*Given his relationship break up and pervasive suicidal ideation, Adam requires ongoing monitoring re: mood and risk and level. Although superficially polite and cooperative, it is likely that Adam will under report and minimise his depressive symptoms. He is unlikely to seek support or counselling of his own violation.*'[85]

127. Professor Bell agreed that this was important information, which was available to RPN Lawrie and he believed to the following reviewing RPN's, Logan and So. He also agreed that RPN Lawrie's screening assessment exhibit 13(a), informed that he had,

> '*planned to gas himself in the car and had made a noose to end his life*...and that he was...*upset at unit 13 placement stating I won't be able to kill myself here.*'[86]

128. Professor Bell also agreed that Nurse Logan had identified that Mr Omerovic was (again) '*irritated*' at staying in Unit 13.

129. He was also aware of RPN Logan's HRAT diary note on March 18 that '*he may clear tomorrow*' and felt that this did not put additional pressure on RPN So, whose job it became to review the prisoner and present a status report to HRAT the following day. Nor did he

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[83] See transcript page 874. These were four of five criteria established by the Forensicare Operational Manual (exhibit 16(b).See brief at page 1034.), for admission to the AAU.

[84] See transcript page 875.

[85] See transcript page 921.

[86] See transcript page 921-22.

consider that giving this information to Mr Omerovic as RPN Logan did, might have conveyed to the prisoner that if he behaved himself, he would be released to mainstream the following day.[87]

130. Professor Bell was also referred to the prison officer preliminary assessment exhibit 13(c) prepared on admission by PO Mommonwald, concerning Mr Omerovic's threat of suicide in connection with a phone call to be made to his partner, Kim Cooper.

131. Professor Bell accepted that RPN's Logan and So were not aware of the threat earlier made to the admission Prison Officer, and were therefore not able to pursue the matter directly with Mr Omerovic, who simply told RPN So that he was working through issues with his family. Professor Bell agreed that all of the information contained in the Prison Officer reception assessment should in future be put on the prisoners health file so that it would then be available to reviewing Forensicare RPN staff.

> *'A I don't believe that it is of a critical nature but it certainly would be helpful...*
>
> *Q Ms So's duty was to conduct her assessment of his mental state on the 19th...*
>
> *A That's correct.'* [88]

132. In further response on this issue Professor Bell raised the hypothetical of what should be done with adverse information received from a collateral source about the future prospects of a family relationship, and whether such information should be passed to an at risk prisoner like Mr Omerovic, pointing out that such information could be very destructive. He also agreed that remand prisoners would inevitably be in a position to make contact with family members during remand and inform themselves of ongoing relationship issues.

133. Professor Bell did not agree that such a scenario should call for an early psychiatrist consultation and if appropriate, the prescription of medication and placement review by HRAT, as there was no urgency about this presentation that necessitated such a referral.

> *'He clearly needed to see a psychiatrist, that is true.'* [89]

134. However, not at this time.

[87] See transcript page 925.

[88] See transcript page 930-32.

[89] See transcript page 937.

135. Additionally Professor Bell stated that he did not believe that the process by which a mental state assessment was undertaken at MAP would be assisted by the introduction of a pro forma or, '*structured tool,*' that would dictate to staff which issues or questions were to be covered within the assessment. The intake screening assessment tool like that currently used in the reception process, took a long time to develop as did its predecessor the form, which was used by Nurse Lawrie at the time of Mr Omerovic's admission.[90] Professor Bell was further questioned about the criticisms of the intake assessment contained at pages 19 and 20 of the OCSR Report exhibit 26(a) and the observation that, '*there was no consistent means by which a patients mental state or risk of suicide or self harm was documented.*'

136. In response, he agreed with the proposition but again doubted that the introduction of a risk analysis tool would be helpful.

137. Further failures alleged by the OCSR Report were put to Professor Bell. These alleged failures included non-documentation in connection with the notification of a psychiatrist of the recommendation for a downgrading of his risk rating and the nil involvement of a psychiatrist in assessing his possible medication needs.

138. Professor Bell had evidently not previously considered these criticisms, and felt unable to offer an opinion about them.[91]

139. Professor Bell further stated that he would welcome a recommendation, which suggested an increase in the number of psychiatrists to be made available to undertake work within MAP.[92]

140. Under examination by Mr Fitzpatrick Counsel for Mr Omerovic's family, Professor Bell stated that an S1 rating on admission was unusual and indicated that the prisoner was at imminent risk and required a minimum of 15-minute observations. He was also aware of the potential for such patients to engage in violent incidents of self-harm and to hide weapons on their person as part of the planning of such behaviour. He was also familiar with exhibit 27(a), the MAP Local Operating Procedure, and schedule 1.2 the Risk Level Framework, found at brief page 210.

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[90] See exhibit 23(b), and its predecessor exhibit 13(a).

[91] See transcript page 960. Consider also the suggested amendments to OCSR report in evidence of Mr Arnol at exhibit 26.

[92] See recommendation 1 below.

141. Mr Fitzpatrick further referred the witness to protective factors that included effective clinical care, restricted access to highly lethal means of suicide, strong connections with family, skills in problem solving, cultural and religious beliefs and Professor Bell agreed that these factors among others might be relevant protective factors in any particular case. Professor Bell did not believe that a checklist approach to measuring protective factors and his further evidence was that a skilled RPN would be aware of the kind of things that may be relevant.

142. As against protective factor's it was also necessary to have regard to risk factors, which in this case included a history of depressive illness, substance and alcohol abuse, and withdrawal from such abuse.[93] Further possible risk factors accepted by the witness included a prisoner's recent arrest and incarceration, as well as his recent relationship breakdown.

143. The witness was then referred to Directors instruction at 1.2, which I note is headed Signs and Factors that may indicate a risk of suicide or self-harm.[94] He agreed that the signs referred to could be properly equated with current risk, which are beyond the prisoners, '*inner mental and emotional world and are pertaining to circumstances in which they find them selves.*'[95]

144. Such risks were referred to as *'dynamic risks'* which change according to a whole range of factors which include changes in a persons mental state and changes in financial and in relationship circumstances. Changes in behaviour are also reflective of dynamic risk and this includes talk of death or suicide, as occurred on March 17 when Mr Omerovic spoke of these matters in terms set out above, to both RPN Laurie and PO Mommonwald. Professor Bell further agreed with Counsel that in such a situation it would be important for subsequent reviewers to evaluate the ongoing risks by attempting to tease out details of a prisoner's immediate past suicidal ideation and behaviour and of the consequences of such behaviour. His further testimony was that RPN So did make mention of the fact of this earlier behaviour, but not in a manner which indicated that she knew of the repeated nature of these attempts.[96]

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[93] On a standard opiate withdrawal package but not on methadone or bupramophine, as discussed at transcript page 976

[94] See exhibit 18(e) at brief page 519.

[95] See transcript page 590.

[96] See transcript page 985-87.

145. Professor Bell was then asked about the protective factors identified by RPN So and her record of the statement that he was working through those issues with his family, and further about the fact that Ms Verity had recorded that he was likely to *'under report.'*

146. He agreed that by the time of RPN So's evaluation on March 19, these matters were still fresh and relevant issues. He further agreed that the nursing note did not disclose whether or how these dynamic features had been considered and resolved by the reviewer. [97]

147. In response to further questioning by the Court, Professor Bell agreed that the inquiry undertaken on the 17th by RPN Lawrie was more longitudinal than the inquiries undertaken on subsequent days by RPN's Logan and So. He also agreed that the focus of RPN's Logan and So was to look to establish in a here and now Mental State Assessment when Mr Omerovic might be safely transferred out of the Muirhead cells which was an approach which had been introduced by Consultant Psychiatrist(s) years earlier and maintained to the present day.[98]

148. Professor Bell further agreed that the Forensicare Policy and Procedure Manual 21 version 3 suggested that appropriate persons may be directed to the AAU or to the AAU waitlist, this either by an admission RPN or from an AAU out patients clinic.[99] He also agreed that while the policy was written in this way that it was not the practise.

> *'I agree Your Honour that there is a certain level of apparent contradiction between that, and the reading of the policy.'*[100] The underlining is mine

149. Professor Bell was further queried about the Justice Health contribution to the OCSR at exhibit 25(a) which suggested that every P1 or P2 classified prisoner should be reviewed by either a psychiatric registrar or consultant before release to the general prison population, (and the later statement of Larissa Strong from Justice Health).[101]

150. In response, he agreed that the provision of treatment for prisoners suffering from mental illness was as important as diagnosis of the condition, but could not agree that review of P1

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[97] See transcript page 994.

[98] See transcript page 995-97.

[99] See exhibit 16(a) from brief page 933, at page 1033.

[100] See transcript at page 1000.

[101] See Larissa Strong statement at exhibit 25(b) and her review of the Justice Health Mental Health Care Standard at paragraph 10 of that statement, and discussion at transcript page 1001-3.

and P2 classified prisoners by a Psychiatric Consultant or Registrar in the circumstances described above was a requirement of Justice Health.

151. Professor Bell further testified concerning the research into a series of six similar deaths, which occurred at the MAP between November 2008 and August 2010.[102]

152. He was, as he stated, well aware of the difficulty of the work undertaken by reviewing RPN's who are called upon to consider down grading.

153. Professor Bell was mindful of the *'unhealthy'* aspects of an extended stay in a Muirhead cell. He was also aware of the tension that arose for clinicians between that focus and the dangers of releasing a mentally ill prisoner to a (then) non-BDRP compliant cell in the general prison population at MAP, or the Scarborough South reception unit at Port Phillip Prison, where cells were then and remain now, BDRP non compliant.

154. He was also conscious of a '*fundamental conflict of interest within the process*,' which was concerned with the work of the clinicians who are involved in a therapeutic process that invites a collaboration with prisoners, and the requirement that they pass clinical judgement which:

'*may involve coercive placement of the person in a toxic environment...I suggest your honour that there is virtually nowhere else in the community where clinicians are faced with a similar problem.*'[103]

155. Professor Bell testified as to the history of suicide in Victorian prisons and the fact that the majority were by hanging at night.[104] He also spoke of the improvement in prevention statistics since the introduction of BDRP compliant cells and the restriction of '*sharps*' at MAP, and (from Mr Ryan the general manager of the MAP) the new arrangements allowing for the removal of all plastic bags from cells in units 1-5 and unit 7.[105]

156. In response to further questioning by Counsel for the Department of Justice, Professor Bell agreed that at some point it was desirable that a psychiatrist review Mr Omerovic before his transfer out of MAP, and at that time that he would have been reviewed automatically by an RPN within 7 days of his release from the Muirhead detention, in any event.

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[102] See exhibit 26(b).

[103] See transcript page 1008. See also discussion on this subject in respect of Corrections employed psychologists at MAP, found in finding 1277 of 2008.

[104] See exhibit 26(b).

[105] See transcript page 1010.

157. Professor Bell was then asked about exhibit 10, the Forensicare - Department of Justice, Mental Health Care Services Agreement. He agreed that the Directors instructions as well as the MAP local operating procedures exhibit 27(d) were incorporated into the agreement. He further offered that these manuals together, with Forensicare's own operations manual exhibits 16(a) previously in place and now 16(b), were also a part of ...'*the qualified framework ... in which we work.*' [106]

158. According to the witness such policy statements were always part of an '*evolving beast,*' and that there was now recognition that Forensicare's own operations manual needed to be developed and upgraded which would now be undertaken in collaboration with Justice Health.

159. In response to further questioning from Forensicare's Counsel, Professor Bell confirmed that the screening assessment tool now in use by RPN Admission staff had been upgraded and was being trialled, and Professor Ogloff's involvement in that process.[107] The witness further detailed the changes incorporated in the new document and the reasons for same. He also detailed how the admitting RPN now has direct access to the RAPID data base, and not just to a summary of the RAPID entry as was the arrangement at the time of Mr Omerovic's admission.[108]

160. The witness was further questioned about the fact that the old form did not invite a review of particular risk factors and informed that the new form (exhibit 23(b)), similarly excluded such a reference as this because of his view that such a checklist was inappropriate and would encourage staff to think in a '*rote or mechanical way.*'

161. Similarly, the witness considered that ongoing reviews by RPN's concerning release and transfer out of the Muirhead cells and indeed out of MAP would not be aided by a *mechanical* tool.[109] Professor Bell felt instead that the RPN clinical reviews at an outpatient's clinic, which now took place within 3 days following release from a Muirhead

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[106] See transcript page 1020.

[107] See exhibit 23(b), which is the 'upgraded' version of the screening assessment documented used at the admission of Mr Omerovic, found at exhibit 13(a).

[108] See transcript page 1031.

[109] See transcript 1032-35 and the pro risk tool position adopted by Counsel for the Department of Justice in the earlier relevant matter, Case number 1277 of 2008. Inquest into the death of Timothy Casey, referred to at footnote 21 above. See also exhibit 24(e), the Forensicare response to the Courts earlier recommendations concerning the use of risk tools handed down in the Timothy Casey finding. See also the 'pro risk tool view' set out in the writings of Professor Ogloff discussed by the witness at transcript page 1064-65 and found at exhibit 24(f).

cell, *'required, a more meticulous attention to documentation and directs the attention of staff ... to address these kind of concerns.'*

162. He was then questioned about the time available at such out patient clinic reviews, to see each recently downgraded P1, P2 prisoner, (an average of 10 minutes according to RPN Logan). Further, about the difficulty involved in undertaking any reasonable longitudinal review over such a limited period and if indeed these assessments were again simply, here and now mental state assessments. Professor Bell responded that while 10 minutes might be an average, more time might be taken if required, and that 10 minutes was approximately the time taken for each consultation in a community setting by a GP.[110]

163. Professor Bell gave further evidence about the support offered by MAP employed forensic psychologists around offence related issues, and their limited function in respect of distress support service.[111]

164. Counsel for Forensicare then questioned Professor Bell about Forensicare's response to recommendations earlier made by the Court in Timothy Casey (1277 of 2008), specifically in regard to the preparation of a psychiatrist authored discharge note for prisoners classified for release from a Muirhead cell.

165. He was then asked whether the new screening assessment tool[112] sufficiently encouraged review by a psychiatrist of prisoners who on release from a Muirhead cell, were believed to be suffering from mental illness other than '*a florid*' schizophrenia.

166. In reply, Professor Bell stated that the ability of the admission screen RPN to place a prisoner on the AAU waitlist, or to refer directly to a psychiatrist, or through an out patient clinic to a psychiatrist, allowed by the new form sufficiently met the problem.[113] I note here that the limited period available for each such review carried out in an out-patients clinic, as well as the focus of such reviews on a 'here and now' mental state assessment, was inconsistent with the likelihood that such a reference would occur. See also paragraph 168 below.

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[110] See transcript page 1038-40

[111] See transcript page 1040-44. It was common ground that Mr Omerovic did not see a MAP psychologist prior to his death.

[112] See exhibit 23(b) and 24(e), the Forensicare response.

[113] See evidence of the reviewing RPN's set out above, as to the Consultants direction about the route to be taken concerning admission to the AAU. See discussion at transcript 1046-50 and also at 1071 where the witness spoke of the discouragement at intake screening, to refer a prisoner directly to a psychiatrist.

167. In re-examination, Professor Bell was further examined by Counsel assisting, on how a prisoner might be downgraded and taken from the AAU waitlist, before having an opportunity to be reviewed by a psychiatrist, about which matter the witness felt unable to comment. He was also questioned about the alleged imperative to move prisoners through the MAP (and the removal of any P1 rating, which is a prerequisite to transfer out of the prison) which question he answered by reference to the completion of relevant MAP functions.[114]

168. Finally, Professor Bell testified that he was himself unaware of any instance where an ex-Muirhead cell prisoner, had been referred from an outpatient clinic by an RPN, to the Acute Assistance Unit for a review by a psychiatrist.[115]

Larissa Strong[116]

169. Ms Larissa Strong, the recently appointed Director of Justice Health made two statements, exhibits 25 and 25(b). The witness was asked by Counsel assisting to address an uncertainty within the Justice Mental Health Care Standards exhibit 25(c), previously put to Professor Bell.

170. Question in paragraph 5 says,

> *"In the case of psychiatric medical and suicide self-harm ratings the risk rating system is not a clinical diagnosis" and this is the part, "and is not intended to guide health care decisions or treatment pathways."*
>
> *And yet in paragraph 17, for example, "Health staff are to apply a P1 rating where they assess the prisoner has a severe psychiatric condition requiring intensive and/or immediate care."*
>
> *'Q Surely that P rating against that criteria, guides health care decisions and treatment pathways?*
>
> *A I think the fact that they were displaying symptoms that were presenting as psychiatric illness requiring immediate and/or intensive action; it is the fact that they had those symptoms which would guide the treatment pathway. The P1 is a*

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[114] See transcript 1075-76.

[115] See transcript 1077-78 See also paragraph 166 above.

[116] Ms Strong was employed to lead Justice Health following the departure of Ms Gardiner, who was the in charge at the time of Mr Omerovic's death. Ms Strong told the Court that she was an administrator, experienced in policy issues with no clinical background and was not a medical professional.

code used primarily for the management of the patient within the prison system.' [117]

171. Her further evidence was that while a P1 classification is appropriate for a severe condition requiring intensive immediate care, that the subsequent presentation to an RPN would guide that care and that you would expect subsequent review by a mental health professional.[118]

172. Ms Strong further agreed that the review undertaken by Justice Health tended to establish that Mr Omerovic should have been given a suicide risk evaluation of S1, rather than S2.[119]

173. Ms Strong also agreed that the records indicated that his recent history included multiple suicide attempts, coupled with depression, bipolar disorder and psychosis.

Professor Ogloff[120]

174. In his written statement to the Court Professor Ogloff spoke of Victoria's record in respect of the care of mentally ill prisoners in Victoria prisons, which he states was considered in 2006 to have (included) the most comprehensive mental health screening process in Australia.

175. Professor Ogloff further pointed out that, '*consistent with elsewhere in the world and elsewhere in Australia, a disproportionally high proportion of men admitted to MAP, have been found to have a major mental illness.'*

176. His further opinion was that it is not practicable to review all such prisoners, *'because of the growing numbers involved and given that most do not require psychiatric care and do not present acute risks to themselves or others…As such, best practise in prison mental health suggests that a two step-process be employed, which is similar to other public health screening programs (e.g. breast cancer screening).*

The most compelling reasons for identifying incarcerated individuals who suffer from mental illnesses is to prevent harm to themselves and others, to provide expedient care, to prevent decompensation, and to assist inmates in adjusting to the institution. Mental health*

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[117] See transcript page 1096.

[118] See transcript page 1099.

[119] See transcript page 1100.

[120] Professor Ogloff is a clinical psychologist and the Director of Psychological Services at Forensicare, having been with the institute since its inception. He was, a primary author of the Forensicare system for the delivery of mental health services in Victorian prisons, and the protocols around that system.

Prior to coming to Australia, he had an extensive career in British Columbia, Canada with overall responsibility for the delivery of mental health services in some 20 prisons and community correctional centres. See exhibit 16, at page1.

screening can reduce the risk of exacerbating pre-existing mental health problems and the occurrence of mental health problems suffered because of incarceration. In addition to the humanitarian rationale for providing mental health services in jails, screening assists in the allocation of scarce resources and also serves the best interests of the institution; suicide prevention and the prevention of violence to others'[121]

177. The intake screening assessment is based upon a Canadian tool, the Jail Screening Assessment Tool (JSAT). The primary purpose for undertaking a psychiatric screening on arrival at MAP is to determine whether a follow up assessment with a psychiatrist or other appropriate professional is necessary.[122] This approach is undertaken to permit the identification of prisoners who have psychiatric illness for which they require (immediate) mental health care while at MAP, or in the broader prison system. The further purpose of the form is to assist MAP by identifying and documenting mental health problems and risk for suicide, self-harm, violence and victimization among new admissions to gaols and pre-trial remand facilities.

178. It is important to note that the form is not a psychometric test but rather a semi-structured tool, which allows professional judgement to make institutional referrals and recommendations following the admission interview.

179. Further, RPN screeners (are intended to) have considerable discretion in how the data is used to make referral decisions and do so having tried to collect all relevant information.[123]

180. The information collected includes both protective factors, which reduce the risk of the presence of mental illness or adverse outcome, and risk features, which factors increase such risk.

181. For most prisoners such things as a good education, job history and supportive family life are seen as protective factors, although Professor Ogloff noted that the humiliation and a sense of loss arising from the arrest of such an individual, may contribute to an increased level of post incarceration depressive illness.[124]

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[121] Ibid page 1. Decompensation means becoming unwell or becoming more unwell.

[122] Professor Ogloff was seeking to identify psychiatric registrars, consultants or RPN's, as 'appropriate professionals' in this statement, prepared as I understand from Mr Goetz of Counsel, in respect of an earlier unrelated inquest. See transcript page 1552.

[123] Ibid page 3.

[124] Ibid page 5.

182. In his further oral testimony provided in support, Professor Ogloff made the following observations:

1) That the structured tool system at use under JSAT, and in Victoria, is flexible and allows the RPN to make a recommendation based upon the interview, but is not tied to a particular conclusion based on a points score result.

2) That the time taken to complete the screen in each case was on average between 15 and 20 minutes, with the larger proportion of prisoners who don't suffer from mental illness taking only around 5 minutes each.

3) The admitting RPN in each case has access to the Public Psychiatric Data Base, so they can immediately access if anyone has previously had contact with public Psychiatric Services. It is helpful for the admitting nurse to seek collateral information. This is often related to the fact that approximately 50% of those coming into the MAP who suffers from mental illness do not admit that fact to the admissions RPN and the illness is identified only after reference to the RAPID database, or to the Public Mental Health Data Base.

4) The screening form requires the reviewing RPN to write basic notes like those in a triage form. Reviewing RPN's Lawrie, Logan and So did not have access to the RAPID database and only Lawrie had access to the summary of RAPID, prepared by staffer Ivana Vasilovska.

5) The admission triage notes should be read in conjunction with the clinical notes written following each days review, while the prisoner remained in Unit 13.

6) Reference to Ms Paula Verity's advice, which did not occur in this case, would have been important as only the admissions RPN (as distinct from the RPN's who saw her subsequently), had access to her faxed memo. That memo included reference to Mr Omerovic's immediate history of suicideality, together with her warning about his propensity for under reporting.

7) Similarly the notes from PO Mommonwald concerning the uncertain nature of the prisoners relationship with Kim Cooper, and his threatened suicide if that relationship broke down, did not reach PRN'S other than admissions RPN Lawrie, as this material went directly on to his prison file management rather than to his medical file.

8) The fact that the screening assessment form is not ticked, next to collateral information indicates that in this case RPN Lawrie did not think that further collateral information such as information about the relationship with Ms Cooper, was required.

9) There are problems for health staff, who are governed by health privacy principals, (as distinct from prison staff), in making calls to family without a prisoner's permission.

10) It is an improvement in the system that all properly interested RPN's may now access the RAPID database.

11) Exhibit 16(a) the Forensicare Training Manual current at the time of Mr Omerovic's death, was the subject of training provided to Forensicare staff at MAP during 2001-02 only, with training replaced by 'mentoring' by senior staff since that time.

12) It is now the predominant view that formal ongoing training is desirable.[125]

13) The mental state assessment set out in Appendix C to exhibit 16(c) authored by the witness, set out 'Mental State Assessors Indicators.' These indicators were primarily designed for the use of general nurses who deal with general health issues and who may be called upon to psychiatrically review certain prisoners, held on remand at Victorian police station cells, that is, while they await transfer to the MAP.[126]

14) There was no need for a tool to assist in assessment as the numbers of persons committing suicide in Victorian prisons was too small statistically to believe that such a tool could assist in identifying that group.[127]

15) P1 classified prisoners may be so classified for a number of reasons and may not necessarily need to be reviewed by a psychiatrist or psychiatric registrar. The RPN's are clinically equipped to review prisoners classified as P1 or P2, and determine whether they should be referred on to a psychiatric registrars out patient list. [128]

16) Prisoners held in Muirhead cells were reviewed by way of a here and now mental state assessment, to seek to establish whether they were fit to transfer out of such a setting, and finally,

17) Court.

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[125] See transcript page 1546.

[126] See transcript pages 1550-2.

[127] See witnesses discussion of pros and cons at transcript page 1555-56.

[128] See transcript pages 1559-60.

'Well the question I am asking is somewhat – or slightly different to the one you have answered. The question I am asking is this. Is there not a difficulty, based upon the fact that the focus of the people who are seeing him after he's admitted to the Muirhead cells is upon whether he should be removed from the Muirhead cells, based upon a Mental State Assessment at that time, as distinct from the longitudinal exercise that... that takes place on intake? And if that is the case, is there not a danger that people who have a complex presentation which involves depression and various kinds of depression and the risk of suicide arising from their condition, may be missed?

Answer. *I think there is a possibility, and certainly one of the realities, which we have to face is the huge pressure on resources, because as I mentioned, you know, in a typical year about 33 or 35 to 40 percent of people have some mental health problem as the-so the difficulty for this gentleman is two fold. One is, he is in a highly restrictive environment, which is, you know, terribly unpleasant for him.*

Draconian?---Sorry?

Quite Draconian?---Very Draconian. I mean, shameful, really. And then, the... so that's one option.

Yes?---And then also there'll be somebody waiting to get into that bed that he vacates. So these units are typically full. Unit 13 and certainly the AAU operate at, you know, 96 plus percent cent.

We've heard that the AAU was virtually-well it was only used by reception staff to refer people who were floridly psychotic, and was not used for someone with Mr Omerovic's presentation?---Correct.

Who could be perfectly rational?---That's right. In his presentation?--- Yes. And again, I think my own view is---and his behaviour?---My own view is that's tragic because as we could see, he is someone who is acutely unwell, suicidal. Any rational person would think that (he is) someone who, in a prison, needs special-you know, special care.

OK..---The problem, you know, he has... it's something Corrections Victoria is trying to work on, is the 16 bed Acute Assessment Unit was set up at the time Melbourne Assessment Prison opened. I don't think there's been, certainly my time here, since 2001, there have been no additional beds. And since 2001 the prison population has close to doubled. So we have huge pressure on very few beds. If you think about 16

beds, acute beds, for in the order of 5000 prisoners (state wide?), when we know we have high rates of mental illness. So that's the difficulty, is you're really trying to balance three things: one is mental state, because some people deteriorate in a unit like Unit 13. It's.. you know, you've locked down, it's Draconian.

Particularly someone who suffers from depression, I would think?--- Absolutely. I mean, when your stuck with your own thoughts and ruminating and feeling dreadful. So you've got that. That's one consideration. The second consideration, you're trying to balance the person's other risks, in this case suicide. And then the third problem is the pressure to vacate beds so that there's additional space available for the next person.

<u>*So it's very difficult and – but just going back to your question, I do think there's a risk, because of the nature of these pressures, that when you do have a fairly complex presentation in an individual who's not psychotic, it doesn't get the level of attention as say (if he) was hearing voices or irrational, he would have almost doubtless have been either kept in Unit 13, or put into the Acute Assessment Unit, if they were (un)safe. So it really is a shortcoming.*</u>'[129]

The underlining is again mine.

<u>Unnatural deaths at MAP-Common themes and issues [130]</u>

183. The following material referred to in the evidence of Professor Bell, is adopted from the OCSR report on some distinctly similar deaths, which occurred at MAP in the relevant period, and significantly before the commencement of a cell renovation programme, which saw the introduction of a numerically significant number of BDRP cells at that prison. Comment as to the relevance of this information is included in the findings section below.

<u>*'Introduction*</u>

Between November 2008 and August 2010, seven apparently unnatural deaths occurred in the Victorian prison system.

[129] See evidence of Professor Ogloff at pages 1562-1564.

I note here information recently received from the Deputy Director of the Department of Corrections Mr Wise, informs that a new male Corrections facility, Ravenhall, now being built in Melbourne's west will accommodate up to 1000 prisoners and provide specialist forensic mental health services for approximately 175 prisoners, including 75 mental health service places, and approximately 100 outpatient places.

[130] See OCSR Report at exhibit 26(b)

One of these was the result of an apparent fatal assault at Barwon Prison on 19 April 2010, and remains the subject of ongoing investigations by Victoria Police and the Office of Correctional Services Review (OCSR).

The remaining six deaths occurred at the Melbourne Assessment Prison (MAP), four apparently by means of hanging, one involving the use of a plastic bag, and the last involving both a plastic bag and razor blade.' Exhibit 26(b) at page 1.

<u>'Risk Status</u>

Four of the six prisoners held a current S3 rating, indicating they had been assessed as being a potential risk of suicide or self-harm and one - Mr W - had recently de-escalated from an extended period with an S2 rating, indicating he was considered to be at significant risk of suicide or self- harm.

Mr W... and Mr Omerovic held a P1 psychiatric risk alert indicating 'serious psychiatric condition requiring intensive and/or immediate care', while Mr H..., Mr P... and Mr D... held a P2 risk alert, indicating a 'significant ongoing psychiatric condition requiring regular monitored psychiatric treatment'.

Four of the five had a provisional diagnosis of depression.

	M W	*J H*	*Adam Omerovic*	*R P*	*D D*
CRN	*48330*	*65674*	*78166*	*147400*	*184739*
Day/date of self harm	*23/11/2008*	*24/12/2009*	*23/03/2010*	*18/05/2010*	*10/08/2010*
Day/date of death	*23/11/2008*	*27/12/2009*	*23/03/2010*	*21/05/2010*	*10/08/2010*
S rating	*S4*	*S3*	*S3*	*S3*	*S3*
P rating	*P1*	*P2*	*P1*	*P2*	*P2*
Provisional diagnosis	*Depression*	*Anxiety Disorder*	*Depression*	*Depression*	*Depression*
Observations	*None*	*Hourly*	*Hourly*	*Hourly*	*Hourly*
Days since last HRAT/RPN review	*8*	*2*	*3*	*7*	*Same day*
Days between risk rating reduction and self-harm	*8 days (S3 to S4)*	*2 days (S2 to S3)*	*6 days (S2 to S3)*	*13 days (S2 to S3)*	*5 days (S2 to S3)*
Drug & Alcohol History	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*

See exhibit 26(b) at page 6.

'<u>Summary of affected prisons and relevant circumstances</u>

Four of the six deaths occurred by way of (or following) a hanging incident. In each case, the prisoner was accommodated in a cell that had not been renovated to remove hanging points.

	M W	*Adam Omerovic*	*R P*	*D D*
CRN	*48330*	*78166*	*147400*	*184739*
Location of death/ self-harm	*Cell 24, Unit 1 (Level 4)*	*Cell 16, Unit 4 (Level 4)*	*Cell 28, Unit 7 (Level 4)*	*Cell 27, Unit 2 (Level 4)*
BDRP status of cell	*Non-compliant*	*Non-compliant*	*Non-compliant*	*Non-compliant*
Apparent mechanism of death	*Hanging (bed linen)*	*Hanging (bed linen)*	*Hanging (bed linen)*	*Hanging (bed linen)*
Suicide / self-harm risk rating	*S4*	*S3*	*S3*	*S3*

See exhibit 26(b) at page 7.

Part One

	M W	*J C*	*J H*
CRN	*48330*	*192146*	*65674*
General Documentation	*Time of entry and assessments not recorded*	*No clinical notes post reception*	*Time of entry and assessments not recorded*
At Risk documentation	*No 'at risk' paperwork in medical record (MAP)*	*N/A – no risk Status ascribed*	*No 'at risk' paperwork in medical record (MAP)*
Case Management	*No documented health case management plan*	*No documented health case management plan*	*No documented health case management plan*
Collateral Information	*No documented evidence of MHP seeking collateral information*	*No documented evidence of MHP seeking collateral information*	*No documented evidence of MHP seeking collateral information*
Decision Making	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*
Therapeutic Intervention	*No documented evidence of therapeutic intervention*	*No documented evidence of therapeutic intervention*	*No documented evidence of therapeutic intervention*

Part Two

	Adam Omerovic	***R P***	***D D***
CRN	*78166*	*147400*	*184739*
General Documentation	*Time of entry and assessments not recorded*	*Time of entry and assessments not recorded*	*Time of entry and assessments not recorded*
At Risk documentation	*No 'at risk' paperwork in medical record (MAP)*	*No 'at risk' paperwork in medical record (MAP)*	*No 'at risk' paperwork in medical record (MAP)*
Case Management	*No documented health case management plan*	*No documented health case management plan*	*No documented health case management plan*
Collateral Information	*No documented evidence of MHP seeking collateral information*	*Limited collateral information collected*	*No documented evidence of MHP seeking collateral information*
Decision Making	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*	*No documented evidence that psychiatrist was aware of recommendation to reduce risk rating*
Therapeutic Intervention	*No documented evidence of therapeutic intervention*	*No documented evidence of therapeutic intervention*	*No documented evidence of therapeutic intervention*

Parts 1 and 2. See exhibit 26(b) at page 19.

The bold printing of sections from Exhibit 26(b) above, is mine.

Findings

1. It is beyond doubt that Mr Omerovic deliberately ended his own life by hanging on the early morning of 23 March 2010 while held in cell 16, unit 4, at the MAP. This occurred in a setting of ongoing support offered by cellmate Mr Leon Cook, over the four-day period of Mr Omerovic's remand, in the cell they shared.[131]

2. Following an investigation into the issue of MAP staffing at the time, and having regard to the evidence of prison officers, together with the allegations of Mr Cook and to the fact that Mr Cook was sleeping through much of the time under consideration, I find that I am satisfied that hourly observations were in fact undertaken by MAP staff in unit 4, as required.

3. The question of whether an hourly observation regime, and the minimal degree of intrusion actually employed by MAP officers when undertaking observations of at risk prisoners, is appropriate in respect of a P1 recently S2 designated prisoner, has not been examined in this inquest and will not be a subject of comment.

4. I further find that at the time of his death, Mr Omerovic had an immediate past history suggestive of a severe and complex mental illness, thought on admission to be of a depressive nature,- the nature of which remained undiagnosed and untreated.

5. During his remand at the MAP and notwithstanding his P1 classification, Mr Omerovic was not reviewed or, diarised to be reviewed, by either a psychiatrist or a psychiatric registrar. This occurred in a setting of a series of protocols and forms, which I hold mandated the close involvement of psychiatric registrars and above, to provide diagnostic and medication assessment, in all cases where a prisoner was classified P1 or 2. See also discussion at footnote 13 above.

6. Failure to comply with these protocols occurred as a result of an informal process change, itself almost certainly because of staff shortage, and was supported by Forensicare introduced arrangements, requiring a here and now mental state assessment by an RPN, before a prisoner could be transferred out of a Unit 13 Muirhead cell, and a similar here and now assessment at a later RPN outpatient clinic to be held within 7 days,- should it remain

[131] Mr Omerovic's written request, but failed attempt, to see a psychiatrist or other psychiatric professional, on the afternoon before his death, (during which afternoon he was observed by his cellmate to have what I now characterize as a depressed demeanour), suggests that at the relevant time he recognised that he was in trouble, and that he was in need of professional assistance.

the case that the earlier downgrading of the prisoners P status, had not already led to the prisoners transfer out of the prison.

7. While waiting for such clinics, at risk prisoners like Mr Omerovic were accommodated in non-BDPR compliant cells similar to Cell 16, where multiple available hanging points had not been removed.

8. Subsequent to the intake screening assessment, these later RPN reviews again focused on 10-20 minute 'here and now' mental state and not the longitudinal aspects of any particular presentation, which necessarily required more time and the collection and consideration of additional background data. It is also the case that such reviews, which were undertaken in this instance by separate RPN's, were not designed or intended to allow for a provisional diagnosis of for example, a depressive illness such as bipolar disorder, and/or for the provision of an appropriate course of medication, (or other protective initiative).

9. Significantly and properly, diagnosis and prescription remained, at least at the time of inquest, within the exclusive province of the several part time psychiatric registrars and the responsible consultant, then employed at the MAP.

10. Accordingly, Mr Omerovic, although P1 and variously S2 and S3,[132] was not reviewed for a provisional diagnosis or the possibility of medication support, this because, although he was identified as suffering from:

> '*a serious psychiatric condition requiring immediate and or intensive care*',[133] <u>he was also seemingly rational, and not displaying overt signs of psychosis</u>.

11. The underlining is mine.

12. Mr Omerovic had been serving an ITO order prior to his remand and had been reviewed by a number of psychiatric registrars or above, and other professionals in connection with this order. Additionally I note that he was anticipating a sentence for a series of armed robberies of around 10 years, and that he felt guilty and ashamed about this matter in respect of Ms Cooper, and their children, and also similarly ashamed about his ongoing use of various illicit drugs including heroin, about which he believed that she was unaware.

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[132] A firm case has been established in favour of the proposition that on admission Mr Omerovic was an <u>imminent risk of suicide</u> or self-harm, rather than a significant risk, and accordingly that he should have been classified as an S1 rather than as an S2.

[133] *see for instance the E Justice Health Form, exhibit 19(f),*

13. On his arrival at the MAP on 17 March 2010, Mr Omerovic was reviewed by both Prison Officer Mommonwald and RPN Lawrie and provided with a psychiatric classification of P1 and a suicide risk classification of S2. At this time he told PO Mommonwald of his intention to commit suicide if his relationship with his former partner Kim Cooper, could not be re-established.[134]

14. He was recommended for detention in the Unit 13 Muirhead cells, this because of his presumed serious level of a depressive illness, and because of his immediate past history, which included attempts to commit suicide.[135]

15. There is no indication that his further threat to PO Mommonwald to take his own life, pending the outcome of the approach to Ms Cooper, was a factor in Nurse Lawrie's recommendation or indeed that she took the opportunity to inform herself concerning this matter, although she did note that he stated that he would kill himself if he could. There was also no evidence suggesting that she discussed his presentation or risk issues with other more senior Forensicare staff, before determining how to proceed.

16. There was also evidence of a lack of structure in the balancing of risk and protective factors and in her decision not to classify Mr Omerovic as an S1, this particularly so given the frequency and determination of his attempts, and the intensity of his on going ideation.

17. Given Mr Omerovic's presentation however, and the limited options available to her, which under the arrangements in place effectively did not include reference to the AAU or to a BDRP compliant cell, to await such review, the option of a Muirhead cell placement in unit 13, must have loomed as her only real alternative.[136]

18. After his admission to the Muirhead cell Mr Omerovic, was reviewed separately on the two days following, by RPN's Logan and So, following which he was released from the

[134] See exhibit 13 (c).

[135] A preliminary diagnosis of depressive disorder was made by RPN Lawrie and recorded on page 1 of Exhibit 13(a). See also the evidence of Dr Giannakakis discussed at paragraph 18 above.

[136] From the evidence of MAP Chief Executive Mr Brett Ryan, at transcript page 1248, coupled with our view of the prison, we know that this situation has now been greatly alleviated by the efforts of Government, and most particularly those of the former Secretary of Justice, Ms Penny Armytage, who pushed efforts to obtain funds to initiate a significant renovation of cells at MAP. This work was completed in November 2011, 'giving MAP 116 BDRP beds'... 'that is a little more than 50% of the total (beds) now available'.

Relevantly RPN Logan also testified that there were on average approximately 50, P1 classified prisoners at MAP at any given time.

constraints of that cell environment, on the advice of the latter.[137] As above, this all occurred without him being referred to, or discussed with, a psychiatric registrar or above.

19. I also find that because of a failure to fully document his history in materials prepared for inclusion in the Forensicare file, neither RPNs Logan or So, had access to his RAPID history, or had become aware that he was serving an ITO, and had been reviewed by psychiatric registrars or above in the period immediately before his arrest. As a result, neither nurse was aware of the results of those earlier inquiries and deliberations. Similarly both were not made aware of Mr Omerovic's threat to again attempt suicide in connection with his then failing relationship with Ms Cooper and their children, or of the findings of Ms Verity following her extensive review at the Melbourne Magistrates Court.

20. It is relevant that this earlier review by Ms Verity also sought to caution future carers in respect of Mr Omerovic's likelihood of under reporting the extent of his illness, about which caution they also remained unaware.

21. However it is also the case that both RPNs should have been aware of Mr Omerovic's impatience concerning his desire to leave Unit 13 as from exhibit 13(a) Ms Lawrie's record, he is reported as saying,

'I can't kill myself here.'

22. There was also a similar tell-tale exchange with RPN Logan when the prisoner again expressed his irritation when told that he was to remain for one more night in a Muirhead cell and be reviewed the following day, this while he continued to suffer from a serious mental illness, with no registrar or above, work up yet attempted.

23. I further find that Mr Omerovic was by the 19th, quite capable of rational thought, and desperate to get out of the Muirhead cell and back into the general prison population.

24. I am additionally satisfied that at this time neither the reviewing nurse, or indeed any one else connected with the HRAT decision to downgrade, allowing for his transfer into the general prison environment, had cause to be confident that his departure from the unit would lead to a successful outcome.

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[137] I find that RPN Logan's recorded assessment passed on to both Mr Omerovic and HRAT, that Mr Omerovic may be 'fit for transfer tomorrow,' was unhelpful and put additional pressure on RPN So in particular, to agree to downgrade Mr Omerovic, which occurred the following day.

25. I also find that the here and now mental state assessment inquiry supported as it was by the informal oral directives from a succession of senior Forensicare staff, advocated the approach taken by both nurses.

26. In complying as required with these directives, referred to in the evidence by both RPNs Logan and So, the process effectively removed psychiatrists and psychiatric registrars from direct responsibility for diagnostic and prescription work, in respect of a numerically significant grouping of non floridly psychotic P1 classified prisoners. I further find that this operations driven practise, created a significant service gap in the Forensicare clinical work undertaken at MAP, in respect of those prisoners who, like Mr Omerovic, suffered from other forms of mental illness. The underlining is again mine.

27. The result of this was that Mr Omerovic was pushed out into the general prison population, before that course was safe.

28. I additionally find this service gap effectively denied Mr Omerovic the in depth longitudinal examination by a psychiatrist or psychiatric registrar, which may have been expected to lead in time to a provisional or differential diagnosis together with the prescription of any appropriate medication, and the possibility of allocation to a safe-cell environment, then potentially available only in a Unit 8 management unit or the AAU, both also situated on the 5th floor.

29. And further, that the gap in service so described, took from Mr Omerovic an important opportunity to re-establish his own reasonable mental health regime, and in this way to protect himself in a manner which may have saved his life.

30. In so finding, I am mindful of the difficulties faced by Forensicare together with Corrections Victoria around the administration of psychiatric health care duties at MAP, at the time of Mr Omerovic's death.

31. I note particularly the limited human resources available to Forensicare and the need to execute psychiatric health care duties in an often pressured and stressful environment, at a time when a significant grouping of BDRP compliant cells, were broadly unavailable within the prison. Importantly, I also record that such work necessarily took place (and continues to take place), while the professionals concerned were seeking to provide a level of mental health care and support, to some of the most desperate and needing mentally ill patients in the State.

32. Faced with this level of difficulty I find however that those responsible, addressed the problem of shortage, by putting to one side what I hold were a series of consistent protocol directions and forms, which required that all P1 and 2 designated prisoners should be reviewed for mental illness and appropriate medication needs, by a psychiatric registrar or above.[138] The available evidence does not inform how these changes came to pass or whether any particular consideration was given to that particular group of P1 and 2 prisoners to come, who were not overtly psychotic of whom Mr Omerovic was one.

33. It is also the case that the evidence does not suggest that by 19 March, the date of transfer out of the Muirhead cell, Mr Omerovic continued to show the effects of his earlier misuse of drugs and alcohol. Rather I find that the evidence of his cell-mate Mr Leon Cook in particular, tends to establish that such was not the case.[139]

34. In such circumstances and with his P1 S3 classification then in situ, I consider that there was an immediate need to place him in a safe cell environment and to seek his early review by a psychiatric registrar, or above.[140]

35. As above I find that the absence at that time of a numerically significant number of BDRP compliant safe cells at MAP, coupled with the directions put in place by successive psychiatrists and apparently condoned by the Forensicare organisation, meant however that neither of these imperatives were effectively available.

36. Having regard to these matters I find then that Mr Omerovic's death at MAP was avoidable and that the systems failure, caused by a shortage of available resources and a perhaps a failure to fully comprehend the implications of the introduction of the arrangements referred to, contributed to his death.

37. Additionally I find that responsibility for the level of care needed to reasonably protect prisoners such as Mr Omerovic, should never have been delegated to RPNs who by their use

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[138] I have reviewed and reject the argument that the protocols may mean that a P1 classified prisoner (with a provisional assessment of severe mental illness requiring treatment), required other than early review by a consultant psychiatrist or psychiatric registrar.

I note that the evidence does not suggest that the alternative approach, advocated before me by Forensicare, was supported by legal opinion. See also additional discussion at footnote 13 above.

[139] See transcript pages 185-205. I further note however that the OCSR report into his death, records that at this time Mr Omerovic was believed to be participating in a drug detoxification programme,-elements of which may be expected to have contributed to any improvement in his demeanour and affect.

[140] Although no evidence was led on this matter, I accept that it may not have been appropriate to commence another medication regime until at or near the conclusion of any period of drug assisted detoxification, if that in fact occurred.

Mr Omerovic was never reviewed by a psychiatrist or relevant other, as a result of which the evidence does not establish whether in his case, (and if so when), such a medication regime might have been expected to commence.

of the P1 classification had under the protocols at least, already signified the identification of a serious level problem that required on going assistance from a more senior and more qualified specialist group. Again, the need to protect such prisoners necessitated the involvement of those more senior clinicians able to *diagnose and prescribe*, and such a scenario and the need to deliver this sort of response, was always recognised within the protocols.

38. This same approach was and remains particularly important in the case of severe and untreated mental illness, during the early stages of a prison sentence.

39. I find that this is even more so the case when such a prisoner may be youthful, in custody for the first time, and be detained in lockdown in an un-renovated cell and sometimes alone, for periods of up to 14 hours.

40. I further find that as a consequence of what was an ongoing systems failure, the provision of an appropriate level of care among P1 and P2 classified prisoners was effectively limited to the 'floridly' psychotic only, with prisoners like Mr Omerovic and quite possibly those others named in the OCSR report, left to fend for themselves in the general prison population in a non BDRP compliant cell environment.[141] Moreover, some such prisoners, again prisoners with an RPN provided differential diagnosis of severe mental illness, and with suicidal ideation, who were not at the time demonstrating a florid psychosis, were passed through the MAP to equally hostile environments such as the Scarborough South Reception Unit at Port Phillip, again with lethal result made much more probable than would otherwise have been the case.[142]

41. At the time of writing my understanding is that this same gap in service remains in place in respect of both Muirhead cell prisoners, seeking transfer out, as well as those P1 prisoners who seek or are otherwise provided with review at the RPN administered out-patient clinics, where non longitudinal assessments (allowing for downgrading and transfer), also remain the norm.[143]

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[141] See exhibit 27(c), the report by the Office of Corrections Review into a series of related deaths at MAP relevant excerpts of which are set out in this finding from page 43, with parts bolded, as indicated.

[142] See the Courts finding in the Inquest into the death of Timothy Casey, Coroners case 1277 of 2008.

[143] See transcript page 1549 where Professor Ogloff confirms the here and now mental state examination nature of the post intake RPN interviews, conducted while Mr Omerovic remained in the Muirhead cell, and the similar objective of these interviews to those that might be subsequently conducted in an RPN psychiatric out patient's clinic.

42. Again, the result of this system failure has been that Corrections Victoria has been effectively running a gauntlet, with the transfer out of sometime P1 classified prisoners, non psychotic at a given point in time, with no meaningful time having gone into a consideration of the nature of the prisoners underlying mental illness and whether he requires ongoing management involving medication or other.[144]

43. I further find then that in these most difficult conditions, the system still in place remains flawed as overworked RPN's are required to undertake mental state reviews of P1 classified prisoners and similar comparatively superficial Muirhead cell release reviews, without systematically receiving game changing input from busy senior clinicians, and without sufficient time, structure (or training) to permit any real understanding of the levels and depth of the mental illness presented.[145]

44. Having so found on issues of fact then, I conclude then that I can not accept Professor Bell's suggested recommendation that the protocols in question should now be amended to reflect what has become the present approach to P1 classified prisoners at MAP, as set out above.

45. Rather I find that the possibility that those mentally ill prisoners, not picked up for review under such criteria in use, may still attempt self harm, remains a constant threat concerning which all Corrections, MAP (and G4S) personnel should be aware, and this continues to be the case notwithstanding the substantial increase in BDRP cells now available at MAP.

46. Instead and having regard to the evidence provided by various witnesses, I find myself satisfied that the protocols reviewed together with the scanning and placement forms in place at the time of Mr Omerovic's admission, were and remain reasonable and appropriate tools for the evaluation of psychiatric illness and suicide risk at admission, the tasks they were designed to assist.[146]

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[144] The notion expressed in oral testimony by some witnesses, that P1 and P2 prisoners, who leave the MAP without having seen a psychiatrist or registrar and without receiving appropriate diagnosis/treatment/medication, will inevitably be picked up and treated by psychiatric health services at receiving prisons, belies an understanding of those prisons and the condition of their mostly non-BDRP compliant cells. Despite the impressive efforts made in this respect at MAP, non-BDRP compliance remains the norm throughout the States maximum, high and medium security facilities, which presently house both our male and female detainees.

[145] The potential complexity involved in coming to a reasonable differential diagnosis concerning mental illness is such that the protocols and forms require that such an examination be carried out by a psychiatric registrar, or above. See for example exhibit 13(a) at page 1 and footnote 13 above.

The impact upon this situation made by the recent recruitment of two nurse practitioners, offers scope for reducing this threat, with the results of this initiative outside the parameters of this inquest.

However the fact that not all P1 classified prisoners are longitudinally reviewed, and may still be reviewed by RPNs not qualified to diagnose and prescribe (and not seen by more senior clinicians), leaves open the possibility that a situation like that which occurred in the case of Mr Omerovic may reoccur. See also footnote 149 below.

[146] See exhibits 13(a) and (b) and the discussion at footnote 13 above.

47. Again, I consider that the essence of providing effective mental health care screening within a prison system requires an attempt by a clinically trained professional to reach a reasonable provisional diagnosis on admission.

48. When then seen as appropriate, as in the case of a P1 or P2 designated prisoner, a suitably and legally qualified senior professional, not an RPN, should further review that prisoner seeking a provisional diagnosis. That professional should then prescribe or continue such course of medication, as may be needed and appropriate to help alleviate suffering.

49. Ideally, intervention should occur at an early point and certainly while the prisoner remains at MAP in a safe cell, or BDRP compliant cell environment.[147]

50. This in my respectful view is the minimum reasonable standard that civilised behaviour demands.

51. I appreciate that meeting such objectives at MAP can take time and that inmates coming down from substance and alcohol issues may not be able to be assessed within a short period. I also understand that such an approach needs to have regard to the operational objective of admitting up to 25 incoming prisoners per day. None the less I find that the focus concerning P1 and P2 designated mental illness at MAP should be longitudinal with the time needed taken, and that the objectives of mental health screening can not be safely met by the sort of here and now mental state assessment employed under direction by both concerned RPN's, which approach failed to assist either Mr Omerovic, or his ongoing management.

52. It is also relevant that the available evidence establishes that there are now sufficient BDRP compliant cells within MAP, to allow for the process directed by existing protocols to occur in relative safety in respect of all P1 and P2 classified prisoners.[148] The need to properly protect such prisoners is not in dispute, but what is clearly needed however are more psychiatric consultant hours performed within the prison, this to allow for the proper evaluation of such prisoners before transfer, for the supervision of more junior Forensicare

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[147] There is nothing about my reading of the similarities between the factors discussed in the Exhibit 27(c) Report on similar deaths at MAP, and my findings in the matter of Timothy Casey, 1277 of 2008, which causes me to doubt the importance of early intervention by a supervising psychiatrist or psychiatric registrar, and the provision of safe cell environments, at MAP in respect of all P1/ P2 classified prisoners.

[148] See evidence of CEO Ryan from transcript page 1248 and RPN Logan's evidence set out above, in regard to the numbers of P1 classified prisoners held at MAP at any one time.

staff, and also to better contribute to a stronger training culture to the advantage of all staff at MAP.[149]

53. Professor Bell while supporting the view that more consultant staff were required felt unable to assist with the number of hours, which may be needed to support the above objectives.

[149] It was suggested during evidence from Professor Bell, that funding for two Practioner nurses to work at MAP, was being sought at that time.

I understand that this has now occurred and that each is qualified to both diagnose and prescribe under supervision of a consultant psychiatrist, which involvement is expected to greatly assist the work of Forensicare at MAP.

In this regard I attach to this finding, a recent Forensicare publication describing the work undertaken by Practitioner nurses. employed at MAP. See Attachment 1

RECOMMENDATIONS

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

I note that Forensicare has recently moved to improve the quality of mental health screening and care at MAP by the addition of two permanent practitioner nurse positions on staff. This is a welcome development.

1) Having regard to the greater pressure placed upon the system by the number of persons being held on remand and the numbers awaiting remand, while held in VICPOL cells, and having particular regard to the possible consequences of transferring prisoners through this system and out of MAP, who are suffering from severe mental illness (untreated) into non BDRP compliant cells at Port Phillip prison or elsewhere, and to the need for ongoing consultant supervision of the two nursing practitioners and others, I recommend that Forensicare seek the necessary additional funding to place one further full time equivalent psychiatric consultant, on part time duties at MAP. Up to two consultants might share this work on a part time basis.[150]

   Further, that these newly appointed psychiatrist(s) and both Nurse practitioners be specifically tasked under the direction of Consultant Dr McKinerney, to review and medically manage all prisoners who are designated P1 or 2, floridly psychotic or not, this to occur and continue until such time as each such prisoner maybe be safely transferred out of Unit 13 and or BDRP compliant cells at MAP, into what remain as non BDRP compliant cells at MAP, and the reception unit at Port Phillip Prison, and elsewhere.

...

I also adopt the two interim recommendations made during the inquest, discussed at footnote 64 above. These with minor rewording were as follows:

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[150] The work of the recently appointed nursing practitioners will involve efforts to reach a working diagnosis in respect of prisoners classified as P1, including prisoners suffering from severe mental illness, where evidence of psychosis is not apparent. This work may involve a consideration of issues concerning serious and threatening depressive illness, and the prescription of anti-anxiety and other medication, in appropriate cases.

If the initiative involving nursing practitioners in this task is to be employed successfully, it is important that such work is adequately supervised by consultant psychiatrists. It should also be further supported by both MAP and colleague RPN staff, this latter involvement to include the collection of adequate and reliable medical histories and other relevant collateral information on admission, as well as by providing assistance to ensure appropriate disciplines, in respect of medication consumption.

2) I recommend that arrangements be made for MAP Forensicare staff from the Director down, to visit and review the recent renovation of cells at the MAP, so that they are fully aware of the changes that have been made and the conditions in the cells, which have been made BDRP compliant, as opposed to conditions in cells which have not.

3) I further recommend that arrangements also be made for the same staff to visit the Port Phillip Prison to inspect the Scarborough South Reception Unit and thereby be made aware of the conditions in that place, so that they are fully informed about the unrenovated cells into which at risk prisoners maybe placed, dependent upon decisions that they are now called upon to recommend, about P and S classification downgrading and transfer.

...

The use of P1 as a classification for preliminary psychiatric illness, has effectively fallen into disuse at the MAP. This I find has led to the above described service gap and to a failure to meet the reasonable needs of a numerically significant grouping of mentally ill prisoners, which included Mr Omerovic.

To more closely reflect the needs of a contemporary psychiatric illness classification system and to allow for its use in the manner originally intended, as well its continued use as a stop signal concerning the transfer of at risk prisoners out of the MAP, I further recommend as follows:

4 (a) The current P1 prisoner classification criteria be extended to specifically include those prisoners to be maintained at the AAU, for pre-sentence or pre-trial psychiatric reports.

b) The approach of remanding such prisoners referred to in a) above exclusively to the AAU, be reviewed by the Unit 13 Director and the prison CEO, to determine whether such prisoners might be safely and conveniently detained in a BDRP compliant cell unit near to or adjacent to, but not necessarily within Unit 13 as currently defined.

c) All P1 classified prisoners not covered by category a) above, suffering from what is believed at admission screening, or release from a Muirhead cell to be, *'a serious psychiatric condition, requiring immediate and or intensive care,'* be referred directly to the AAU for review, or in consultation with the CEO of MAP, to an adjacent BDRP compliant unit, to await detoxification and or available AAU cell space, in anticipation of a later review and provisional psychiatric diagnosis, by a nurse practitioner under a consultants supervision, or by a psychiatric registrar or above.

d) That all P2 classified prisoners be referred as in c) above, for medication review.

e) That all Forensicare staff receives ongoing instruction from the Unit 13 Director and such others as she may invite, on all matters pertinent to admission screening and Muirhead cell prisoner review.

This instruction should be ongoing and planned with a view to ensuring that all mentally ill prisoners including those believed on admission to suffer from a serious mental illness (including a serious depressive illness), are classified appropriately, and if P1 or P2 are then seen and reviewed in a time efficient manner as set out in c) above.

This instruction should also specifically include guidelines concerning the relevance of collateral information and its collection, and in consultation with the prison CEO, may also include advice given to admission prison and or SASH officers, concerning the collection of such information.

...

Conclusion

In the matter of an inquest into the death of Timothy Casey, Coroners Case number 1277 of 2008 handed down in September 2012, I made certain recommendations concerning the provision of mental health services by Forensicare at the MAP. These recommendations had primarily to do with issues around improved documentation at hand over, both internally within MAP, and when an at risk prisoner is transferred out of MAP, to another prison.

Such recommendations were also concerned with the timing of the presentation of cases to HRAT and the transfer out of MAP, following any particular classification down grade, and with the then HRAT practise of seeking the input of non-clinically certified psychologists, in the determination of suicide risk classification and psychiatric illness classification downgrades.

A further recommendation made in that finding called for the ongoing involvement of the State's Chief Psychiatrist in providing oversight, over mental health service quality control at the MAP.

It is relevant to record that in that earlier inquest, the duties of Forensicare under the same protocols examined above and the application of those protocols was not put in issue before me. [151]

[151] See discussion at transcript page 156-57.

I have considered the further recommendations now proposed by the various interested parties and the evidence that relates to these proposals.[152]

I have also given consideration to Professor Bells suggestion that the P classification system should be rewritten to embrace the approach now adopted by Forensicare, with a P1 classification on admission screening simply employed to block transfer, and not to be used to suggest a need for psychiatric registrar or above review, or to invite any particular psychiatric response.

As a result of this consideration I conclude however that save for the above four recommendations, (in which I have broadly supported and recommended compliance with existing written protocols), that an attempt to identify further issues to be made the subject of additional recommendation would not be helpful, at this time.

Rather I consider that the P classification system as written is broadly strong and allows for an appropriate and reasonable level of medical management in an extremely difficult environment. It is also consistent with what I have described as 'A Guiding Principal', referred to at page 1 of this finding, and in my opinion the importance of this message should not be diminished.

In summary then I recommend the introduction of one additional psychiatrist position as referred to in Recommendation 1) above, together with a minor rewrite of the P1 classification, and a renewed commitment to apply the existing admission screening and the backing mental health support protocols, in the manner discussed.

This should be undertaken, with an appropriate level of consultant support to be put in place and ongoing staff training provided, and for the reasons set out above, should be pursued in a manner, which is broadly consistent with existing protocols and in the way it was intended. There is nothing to add.

[152] These proposed recommendations were primarily concerned with the need or other, for reviewing RPN's considering prisoner transfer out of the Muirhead cells, to record their interviews within a structured tool document, and to allow their access both to the RAPID data base, as well as to the MAP officer intake assessment and other collected collateral information. (I understand from the evidence of Professor Bell that the proposal, in so far as it relates to the latter categories of information, has either already been adopted, or will be adopted shortly).

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

The family of Adam Omerovic

The Office of the Minister for Corrections, in the State of Victoria

The Secretary of the Department of Justice, in the State of Victoria

Commissioner for Corrections, in the State of Victoria

The Chief Psychiatrist, in the State of Victoria

The Chairperson of Forensicare

Professor Bell

Professor Ogloff

Dr McKinerney

Dr A W, (name redacted as in finding in the matter of Timothy Casey, at 1277 of 2008)

Dr Roberts

RPN Lawrie

RPN Logan

RPN So

Mr Ryan, Chief Executive, MAP

PO Mommonwald

The CEO OCSR, Attention Mr Arnol

The CEO Justice Health, Ms Strong

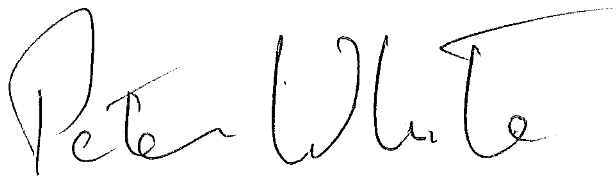
Mr Cook (Pages 20-22, and page 47 refers)

The CEO Port Phillip Prison (Pages 47-62 refer)

Ms Penny Armytage (Pages 47-62, and footnote 136 refers)

The family of Timothy Casey

The Manager, Coroners Prevention Unit, Attention Dr Jeremy Dwyer PhD and Mary Hyland.



PETER WHITE
CORONER
Date: 24 January 2014

Attachment 1: Recently published Forensicare Nurse Practitioner Model of Care.