IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 1277

REDACTED FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: TIMOTHY CASEY

Delivered On:	21 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	27 September 2010 to 8 October 2010 12 November 2010 20 June 2011 to 30 June 2011 1 July 2011 to 8 July 2011 12 July 2011
Findings of:	PETER WHITE, CORONER
Representation:	Mr D. Masel appeared on behalf of the Department of Justice Mr R. Shepherd appeared on behalf of G4S Custodial Mr R. Harper appeared on behalf of St Vincent's Health Mr D Bracken appeared on behalf of Forensicare Pty Ltd Mr J Halley appeared on behalf of Dr A W Mr R Stanley appeared on behalf of Dr S T Mr B McTaggart appeared for GEO Group Australia Pacific Shores Sergeant David Dimsey assisting the Coroner

I, PETER WHITE, Coroner having investigated the death of TIMOTHY DARRYL CASEY

AND having held an inquest in relation to this death on 27 September 2010 to 8 October 2010, 12 November 2010, 20 June 2011 to 30 June 2011, 1 July 2011 to 8 July 2011 and 12 July 2011

at MELBOURNE
find that the identity of the deceased was TIMOTHY DARRYL CASEY
born on 22 December 1978
and the death occurred between 3.00pm and 4.15pm on 28 March 2008
at Port Phillip Prison in cell 468, Scarborough South Placement Unit
from:

1 (a) HANGING

in the following circumstances:

Background

1. Timothy Casey was born on 22 December 1978.

2. During his school years, Mr Casey had trouble with his peers, often becoming involved in fights at school, these incidents were sometimes followed by short periods of suspension. Mr Casey further experienced ongoing difficulty as he grew older and found himself uncomfortable during those occasions, which called upon him to socialise.

3. He indicated low self-esteem and considerable anxiety when exposed in this way.[1]

4. Mr Casey left school in year 9 and commenced a painting apprenticeship, which he continued for approximately 12 months. Following this employment, he took on a number of unskilled jobs,

   'indicating that he was in and out of work for approximately equal periods from the mid 90's onward."[2]

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[1] See Office of Corrections Services Review (OCSR) Report, Exhibit 9 at page 10. Profile of the subject, Timothy Darryl Casey.

[2] Ibid page 10.

5. His Community Corrections Service (CCS) reports[3] further suggest that Mr Casey began using drugs by experimenting with petrol sniffing when he was 12 years old. This progressed to regular cannabis use and by the age of 15 years it is said that,

'he was drinking alcohol and injecting amphetamines, regularly and in substantial quantities.'[4]

6. It is known that he formed a long-term relationship with a Ms Julie Monaghan at aged 17 years, and was the father of her two children, a son and a daughter. The relationship broke down in early 2007 (after 11 years), although in Mr Casey's view he continued thereafter to maintain a civil relationship with her and a good relationship with his children.

7. During this period, it is also relevant that Mr Casey became a regular heroin user injecting himself up to four times a week. This continued until his mid 20's when he completed a residential drug withdrawal programme through South Eastern Alcohol and Drug Services, following which he maintained a period of abstinence for a period of approximately six months.[5]

8. It is also relevant that, despite his lengthy history of substance abuse and trouble with authorities, his family remained supportive of him.[6]

9. At the time of his death, he was a dual status prisoner at the Port Phillip Prison (PPP).

10. On 26 February 2008 he was remanded to Melbourne Assessment Prison (MAP), on a charge of having, on the 24 February 2008, murdered his girlfriend of some four months, Miss Angelica Rosa, at the home they shared in Roslyn Avenue, Rye.[7]

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[3] His Community Corrections Service (CCS) file which included comprehensive reports prepared by treating specialists and CCS staff were not available to Corrections staff during any of his remands, with most of his health information collected directly from Mr Casey during the various reception processes, undertaken at the (three) prisons in which he was placed in 2007-08.

[4] See OCSR Report Exhibit 9 at page 11.

[5] Ibid page 12.

[6] Ibid page 12. His family's affection was evident during their ongoing attendance and participation in these proceedings.

[7] Finding COR 2008 0793.

11. He assumed dual status on 13 March following the imposition of a previously suspended sentence of two months by the Frankston Magistrates' Court.

12. Mr Casey was due to appear in the Melbourne Magistrates' Court on 20 May 2008, in relation to the murder charge.

13. He had first appeared in the Children's Court in 1993, and came before the Court on five subsequent occasions.

14. From the Report of the Office of Correctional Services Review report, we also know that,

'Prison records indicate that during his three periods in custody, Mr Casey either self-harmed or made threats to self-harm on four occasions, each requiring medical, psychological and correctional officer support. These actions included the alleged swallowing of razor blades in October 2007[8] *and self-inflicted razor blade cuts to the neck, in the MAP on 29 of February 2008.'*[9]

15. Prior to his remand on 26 February 2008, it is known that he made some six earlier attempts on his own life, whilst not in prison.

Focus of the investigation

16. As set out above, Mr Casey was arrested on 25 February 2008, and held at MAP between 26 February and 17 March, 2008 when he was transferred to Port Phillip Prison.[10]

17. My investigation into the death of Mr Casey has focused on several main areas:

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[8] See exhibit 9 the Office of Correctional Services Review (OCSR), which includes detail of this incident which occurred in October 2007.

[9] These incidents, the last described as being carried out 'with lethal intent', each occurred at different points in time prior to his final transfer on remand to PPP, on 18 March, 2008. See Exhibit 9 at page 3.

[10] He remained in Port Phillip Prison from the 17 March until his death 12 days later on 28 March, 2008.

While held at MAP

18. On the processing of his admission to MAP (on 26 February) and the further suicidal event on 29 February, which led to his transfer from the general prison population into Unit 13. I note here that Unit 13, contained the prison's Muirhead cells, which were designed to allow for greater levels of protection to be provided to at risk prisoners.[11]

19. I further note that prisoners might also be sent to the Acute Assessment Unit (AAU) for the analysis of the medical conditions underlying such behaviour or other psychotic behaviour by the staff psychiatric consultant or psychiatric registrars.[12]

20. The conflicting evidence from the psychiatric consultant then in charge Dr A W, and psychiatric registrar, Dr S T, concerning the circumstances in which Mr Casey came to be transferred out of Unit 13 (without review for admission to the AAU), and back into section 1[13], within the general prison population, this on 5 March.

21. The further deterioration suggested by the P1 ratings recorded by the Health Risk Assessment Team (HRAT) on 7 March, and again on 9 March on the advice of Nurse Sheehan,[14] and the Nurse D T review on 16 March,[15] all of which occurred while he remained at MAP Unit 1, together with the response of prison and Forensicare staff, to those presentations.

22. The investigation of the HRAT process also focused on the reference to the MAP staff psychologist, in undertaking suicide risk and mental state assessments on 5 and 14 March, her qualifications to undertake such assessments and the circumstances in which these matters were referred to her.

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[11] See discussion regarding Unit 13 at footnote 36.

[12] The Acute Assessment Unit situated in close proximity to Unit 13, within the MAP, was described as a custodial ward intended for use to house prisoners presenting with significant psychiatric disturbance issues, who were remanded pending full review and assessment.

[13] See footnote 48.

[14] See exhibit 3(a).

[15] See transcript page 1351.

While held at PPP

23. The process undertaken on his admission, the professional conflict over his presentation at that time and the failure of that system to receive his full HRAT documentation within the Individual Management File, (IMP file), which included details of his history and care whilst at MAP.

24. The uncertainty surrounding whether he was seen by his PPP caseworker following admission and the implications of the evidence given by his caseworker and others concerning her approach and the caseworker's role, as they understood it.

25. Mr Casey's recognized mental state deterioration which took place whilst in the Scarborough South Unit, and the response of prison and St Vincent's Health staff to that presentation.

26. The failure of several of the arrangements made for Mr Casey to be seen by responsible clinicians over the 10 days he spent at PPP, the deceptive record taking in regard to one such failed appointment and the failure of the PPP's *'Risk Review Team'* (RRT) to monitor his progress during this period.[16]

27. The downgrading of his suicide rating by the RRT and the consequent removal of the need for prison staff to undertake *'meaningful observations'* of Mr Casey, this decision made on March 20. The involvement of a non-clinically certified psychologist in that decision, the making of that decision without reference to a psychiatric review, which was supposed to have occurred the day prior, or to the missing HRAT notes concerning his relevant medical history while at MAP.[17]

28. The conflicting evidence about the events which occurred within Scarborough South on the afternoon of 28 March, concerning Mr Casey's interaction with prison staff at that time, this shortly before his suicide behind his self-locked cell door.

And more generally,

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[16] See below commencing at page 48 where evidence concerning his apparent deterioration is set out, together with details of the efforts made by staff to secure an examination by a psychiatrist and the systematic failure of those arrangements.

[17] It is also relevant that this downgrading occurred in the context of the earlier differences in the reception reviews undertaken on March 17, concerning Mr Casey's mental state at that time.

29. The then existing policy of Correctional Services/Department of Justice/G4S of in effect taking from medical examiners the discretion of returning an appropriately presenting prisoner directly to a prison administered opiate substitute programme, in the circumstances of the prisoner having, prior to his remand, defaulted on his duty to comply with the attendance/medication requirements of that policy.[18]

30. The then existing policy of Correctional Services/Dept of Justice concerning the employment of psychologists, (who do not have registration with the Psychology Board of Australia as 'clinical' psychologists), to make recommendations concerning the suicide risk and mental state evaluation of prisoners, within a prison setting.[19]

31. The design/building issues within the Scarborough South unit and the response of the State to those issues.

Mr Casey at the Melbourne Assessment Prison (MAP)

Admission Process

32. MAP is the primary reception point for adult males entering prison in Victoria. It is tasked to undertake a range of reception and assessment procedures concerning each newly received prisoner. Under present arrangements, once assessments are completed prisoners are classified and transferred to longer-term accommodation within the prison system.

33. Decisions about transfer within the prison and to other prisons were, and remain, the sole province of the Department of Corrections, through its Prison Management Committee.

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[18] Under arrangements, in place in 2008 and now, a prisoner who has earlier defaulted on his/her duty to comply with the requirements of an opiate substitute programme, commenced before remand, cannot resume participation until he again applies and again satisfies the requirements for participation, through a prison drug and alcohol officer, which role I distinguish from the role of a prison medical officer, prison psychiatrist, or psychiatric nurse.

Significantly, such an applicant cannot then rejoin a programme until he can be included within the quota of places available in the programme, which place may or may not be available at any given time.

[19] Paragraphs 22 and 27 above, refer.

The Psychologists Board has set up a registration system for the registration of different areas of practise, including clinical practise.

I note here that the more generally trained psychologists employed by the Correctional Department, to carry out suicide risk evaluation at the relevant time at both the MAP and PPP were not specialist clinical psychologists and do not now qualify for APB registration as clinical practitioners.

34. The Department of Justice through its Justice Health section is also responsible for the provision of health services throughout Victorian prisons.

35. Forensicare staff were responsible for Mr Casey's psychiatric health care while he remained at MAP.[20] This included his psychiatric screening on admission and one later assessment conducted by psychiatric Nurse T D,[21] as well as one such review undertaken by psychiatric consultant, Dr ST.

36. Upon admission to MAP on 26 February 2008, Mr Casey was received by Prison Officer R who completed the admission form.[22]

37. The admission form recorded that Mr Casey was an Australian national of German descent, who had been charged with murder.

38. It also stated that Mr Casey had been, but was not currently, on methadone and bupranorphine[23] and, before his arrest, had been using ice, heroin and speed on a daily basis, depending on what was available to him on the street.

39. The form also recorded that Mr Casey advised that he was schizophrenic and suffered from a social phobia and paranoia and that he had been medicated for these conditions.

40. In these circumstances, Officer R recommended him for inclusion in a drug and alcohol programme, as well as a cognitive skills programme, and noted that a referral to 'Moreland Hall or Therapeutic Services,' had been made.[24]

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[20] Forensicare is a pseudonym for the Victorian Institute of Forensic Mental Health, which is a statutory agency responsible for the provision of forensic mental health services across Victoria.

These services are provided through inpatient care at the Thomas Embling Hospital, and through community-based as well as prison-based services.

See Forensicare submission outline to the inquest, undated.

[21] Nurse T D's statement was not made until November 2008, i.e. some 20 months after the events under investigation.

[22] See exhibit 6(e).

[23] We know that he had earlier been part of a community-based programme but had apparently given up attending same, approximately two weeks before his arrest.

[24] See exhibit 20 page 2.

41. Exhibit 6(e) also informs that Mr Casey stated that he was concerned about contact with prisoners 'G...' and 'H...' who were known to him as relations or associates of his now deceased girlfriend, Angelica Rosa, and who were believed to be then accommodated in the 'back units.'

42. It is also stipulated within the admission form that his caseworker (at PPP), was to be Prison Officer TC. It is not known when Officer TC was informed of this matter or, in Mr Casey's case, if he was informed of this matter at all.

Nurse T D

43. On admission, Mr Casey was also seen by Forensicare employee, Psychiatric Nurse T D.[25]

44. Nurse T D completed two forms -

    a. 'MAP Reception/Review (SP and M) Risk Assessment Mental Health Professional (MHPS)

    b. Prisoner Summary' (the Reception Summary).[26]

    c. 'Victorian Institute of Forensic Mental Health Melbourne Assessment Prison Mental Health Intake Screening' (the Screening Assessment).[27]

45. Nurse T D testified that current practice (not in place in February 2008) was to have those who have had a serious suicide attempt,

    'tend to remain' (at the MAP) *'a bit longer than in the past'*,

    and then be considered for entry to Thomas Embling Hospital. He explained that previously (in February 2008), the immediate risk of suicide was dealt with at MAP and that at this time such prisoners would be placed elsewhere, with all such prisons able to deal with self-harm risk,

    '...because all prisons are supposed to be able to deal with self harm risks.'

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[25] Statement exhibit 20, (Brief 194) and evidence from transcript page 460.

[26] See Exhibit 9(d) at page 34.

[27] See Exhibit 20A and the submission of Forensicare.

47. Nurse T D further testified that the approach to assessing psychiatric illness (as opposed to suicide risk) had not changed significantly at MAP since February 2008 with some prisoners who have unresolved psychiatric issues, sent to a,

'city' (prison like), Port Phillip or Barwon, where we also have psychiatric treatment.'[28]

48. In addition Nurse T D informed that he had never visited PPP and was not familiar with the conditions there.

49. According to Nurse T D the objective of his assessment was to screen rather than comprehensively assess the prisoner's mental state, and to assess their immediate risk of suicide or self-harm and to assess any urgent ongoing management needs,

'such as admission to the Acute Assessment Unit (AAU), special accommodation issues or need for further assessment, by the psychiatric registrar in an outpatient clinic'. [29]

50. Nurse T D further informed that the risk of suicide/self-harm may or may not be connected to psychosis or psychiatric illness.[30] His further testimony was that as of March 2008, priority for places in the AAU was usually given to persons suffering from psychosis, above those whose presentation merely threatened suicide/self harm. A further priority was given to those awaiting assessment for court appearances and that in order to be admitted to the AAU or to go on the waiting list, a prisoner had to be given a P1 status.

51. This could mean either that he was assessed as suffering from a psychosis which needed treatment or that his presentation was such that he was believed to be in need of assessment.

52. Nurse T D also testified about how some prisoners may suffer from a drug-induced psychosis, which condition may self-correct while the prisoner waits for assessment.

53. Nurse T D made the following plan:

    a) To have Mr Casey reviewed by a registered psychiatric nurse in one week (RPN 1/52);

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[28] See transcript page 473.

[29] Statement at page 1.

[30] See transcript page 487.

b) To have his medication reviewed by a psychiatric registrar (Med R/V);[31] and

c) (RPN) – indicating that the prisoner himself may request to see a RPN prior to 1/52.

54. Nurse T D further testified that it was his practice, (and his strategy in this case) to refer to 'Med R/V', to help ensure that Mr Casey saw a Psychiatric Registrar, for a full assessment of his needs.

55. Nurse T D assessed Mr Casey at S4 and P3, for the likelihood of suicide self-harm.

56. According to Nurse T D the P3 rating was made on the basis that he had not previously been admitted to an inpatient psychiatric hospital and,

'therefore didn't have a history'

57. His further view was that giving him a P3 rating would allow for him to be reviewed for depression by a GP,

'in perhaps a country prison when he is moved',

58. Nurse T D recorded in his Reception Summary that Mr Casey,

'denied current P/SASH' (psychiatric illness, suicide and self-harm).'

59. Nurse T D also testified that his S4 rating was based on the fact that Mr Casey had told him that he had,

'slashed up in the past.'

60. The Intake Screening Assessment[32] further records that Mr Casey was assessed by Nurse T D as low risk for suicide, self-harm, vulnerability, fire risk, drug seeking and medication non-compliance.

61. Nurse T D also recorded Mr Casey's use of marijuana and (recent) use of heroin and his withdrawal symptoms and previous attendance on a Dr Korman of Frankston and that he had been on buprenorphine (18mg per day), but not over the previous three weeks.

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[31] See discussion concerning this method of referring Mr Casey for review, at footnote 38 below.

[32] See page 1 of Exhibit 20 (a)

62. Nurse T D did not fill out a response to queries concerning the use of other illicit substances, stating that this would indicate that Mr Casey denied use of these other substances.

63. Nurse T D further testified about his use of the RAPID programme to access details of Mr Casey's State health care background, both medical and psychiatric, while in both the general and prison community and how he employed this background information in preparing the Mental Health Screening and the Reception Summary documents.

64. I note that at this time Nurse T D also had access to information provided by Corrections Victoria, as to his various,

'PNS rating, violence rating and management rating,'[33]

from Mr Casey's previous occasions while in custody and that this information, if considered, would have informed him of a pattern of self-harming behaviour which had occurred during previous incarcerations.[34]

65. Nurse T D did not contact Dr Korman or Frankston Hospital about Mr Casey's past history. It is further relevant that the front page of Exhibit 20(a) also suggests that he did not seek collateral information and nor does it inform that he undertook a RAPID check or searched other documentation.

66. According to Nurse T D he had no immediate concerns for his self-harm or suicide.[35]

67. Nurse T D also spoke of how a patient with unresolved psychiatric issues might be transferred out of MAP, with the receiving prison advised of the outstanding issues, through an entry on the patients file[36].

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[33] Transcript page 493

[34] Ibid. Nurse T D was unable to recall what he saw of this material before assessing Mr Casey with a P3, S4 classification. The fact that he did not refer to the earlier incident where it was recorded that Mr Casey had swallowed razor blades while in custody at PPP during October 2007 (see exhibit 20(a) page 3) tends to establish that he relied heavily upon his own assessment and that he did not consider or paid little attention to the earlier collected history. See witnesses' discussion of his approach to this matter at transcript page 497.

[35] Transcript page 492

[36] See transcript page 474. Consider here the attitude of the reception officer at PPP to earlier assessments undertaken at the MAP, which was that it was not his practise to refer to same.

I further note that Mr Casey's HRAT record did not accompany his IMP file to PPP and was not later recovered and passed on by MAP authorities, or indeed sought at any later time by his caseworker, or other PPP staffer.

68. He also stated that he was aware that MAP had more Forensicare employed psychiatric consultants (and support staff) available within the AAU and Unit 13[37], than either PPP or Barwon, which each having access to only one such psychiatrist. [38]

69. Nurse T D also explained that there was typically a list of prisoners (and their medical reviewers), waiting on an opportunity for prisoner admission to the assessment unit. Admission was usually made on the basis of perceived need with priority given to those most in need, as determined by the Psychiatric Consultant, generally in consultation with colleagues during an

'outpatient meeting, which was usually held once a week, with the list maintained... on top of a cupboard...within the AAU'.

70. Such transfers into the AAU, and indeed all transfers within MAP had to be made following application to Corrections Victoria, Sentence Management Office, (SMO).

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[37] The Unit 13 Muirhead cells within MAP were used to accommodate those believed to be at acute risk of immediate self-harm, or rarely, of causing harm to others. The cells were designed defensively, to attempt to limit the risk of self-harm. There are five such cells within Unit 13. There were television sets with screens protected by plexiglass, in each cell.

[38] Mr T D statement page 3.

I note that in the Reception Summary, Nurse T D did not tick off on 'refer to psychiatrist for Assessment/ Review of medication', although this option was available to him. (See Exhibit 9(d) at page 34).

This was evidently because the M/R referral within the Reception Summary form, was limited to patients designated as 'P1or 2', - i.e. with a high (risk of) psychiatric illness rating, which prisoners, (while classified as P1 at least), could not be transferred out of the MAP other than to the Thomas Embling Hospital.

I also observe that in the Screening Assessment document (also filled out by Nurse T D) Ibid page 6, that there is reference in his notes to a hand written 'M/V' only.

Nurse T D later stated at transcript page 582 that his reason for keeping his classification of Mr Casey at P3 was that he might get his anti-depressant medication faster if kept on P3, when he might see either a psychiatrist or a GP, than if he was a P2, when he would have to wait to see a psychiatrist.

Query whether it should be inferred that on Mr Casey's reception, Nurse T D was in fact concerned that Mr Casey was at a higher risk of suicide and/or lasting psychosis, than his P3, S4 rating found in the Screening Assessment might suggest. It is also relevant that a reading of the Screening Assessment discloses that Nurse T D appears to have been in some doubt as to how to rate Mr Casey. See his re-markings and cross outs on that Assessment, at Exhibit 9(d) page 1.

71. Further evidence about the use of the nearby Muirhead cells and of the different entry arrangements, concerning emergency admission to those cells, was also given. Nurse T D additionally testified about how some prisoners may be transferred from within the Unit 13 Muirhead cells, directly into the AAU and how some might be required to wait in the Muirhead cells until a bed in the AAU became available.[39]

72. Observations within Unit 13 and the AAU were required to be made every 30 minutes, unless a prisoner was designated S1 in which case the prisoner was to remain in Unit 13, and observations were required every 15 minutes.

73. Nurse T D was also further questioned about Exhibit 9d pages 14-19, which was an application to Frankston Hospital, for access to Mr Casey's health information initiated on the 29 February 2008 by Nurse D, i.e. three days following Mr Casey's admission to MAP. Nurse T D testified that he had not previously seen this document.[40]

74. Following the completion of the admission Mr Casey was placed in the mainstream Franklin Unit, on hourly observations[41], where he remained until 29 February when he attempted self-harm by cutting his neck with a number of razor blades. Thereafter, he was medically treated and placed in Unit 13.

75. Nurse T D was further questioned about the High Risk Assessment Team (HRAT), process within MAP. His evidence was that HRAT meetings took place daily with the Forensicare psychiatric nurse responsible for Unit 13 most usually in attendance, representing all (Forensicare employed) psychiatric nurses. To assist the process a nursing diary, setting out the names of the prisoners to be discussed, was kept. This would be supplemented by an oral input to the Unit 13 nurse from the psychiatric nurse most familiar with the prisoner, or with whoever was proposing the discussion concerning a particular prisoner.

76. Nurse T D attended the HRAT meeting on 29 February, which discussed the admission of Mr Casey into Unit 13, this following the razor blade neck cutting referred to above.[42]

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[39] See transcript 479-484. See photographs of a MAP Muirhead cell at Exhibit 20 (d).

[40] See transcript 499.

[41] This meant hourly observations during lock up i.e. from 5 pm to 8am the following day. He was also to be reviewed by HRAT within 5 days.

[42] See exhibit 19(b) at page 1.

77. The HRAT meeting in question was chaired by a Corrections Officer level 3, Officer P, with Officer A, taking notes and prison psychologist Z, also in attendance.

78. Nurse T D testified that he had no particular recollection of the discussion at this meeting. As above, I note that he had admitted Mr Casey to MAP three days earlier and that his in cell use of razor blades to inflict multiple cuts to his neck, with apparent '*lethal*' intent, had occurred shortly thereafter. It is also relevant that on admission he was somewhat hesitant in his documentation concerning Mr Casey's presentation. I infer that while Nurse T D had no memory of this particular HRAT meeting, it is highly likely that at the time he was an active participant in the discussion concerning Mr Casey.[43]

79. Nurse T D was also questioned about a document entitled HRAT Modified Risk Management Plan.[44] He further informed about HRAT's operation and by reference to exhibit 3(a), about its deliberations concerning Mr Casey.

80. Following this HRAT meeting (on the 29th), Mr Casey was transferred to Unit 13.[45]

81. On Saturday March 1, the HRAT meeting determined Mr Casey was to remain in Unit 13. That meeting was attended by four prison officers and Nurse T D. A similar meeting occurred the following day with the HRAT management plan for that day recording that he was to be reviewed by a psychologist before he was released from Unit 13.[46]

82. On the Monday 3 March, the nurse's diary note indicates that Mr Casey was seen by a psychiatric registrar.[47]

83. According to Mr T D the diary note 'appears' to have been made by Ms Sheehan a psychiatric nurse temp. Mr Casey had in fact been cleared to return to the mainstream on S3

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[43] See discussion at footnote 37 above.

[44] See exhibit 20 (a) at page 8.

[45] The HRAT management plan dated 29/3 states that Mr Casey was classified as an S4, although to be sent to Unit 13 required a classification of S2. See transcript page 532 and the management plan exhibit 3(a) at page 4. See also psychologist Dr A's opinion about this classification discussed below at paragraph 189.

[46] See HRAT plan 2/3 at Exhibit 3(a) at page 3.

[47] The psychiatric registrar in question was Dr S T, who in fact reviewed Mr Casey on March 3 (see exhibit 9 (d) 25-23) and alleges that he recommended to Psych consultant Dr A W, that she admit him to the AAU for a full psychiatric review. See discussion from page 68 below.

'observations', although it is later recorded that he was to remain in Unit 13, as he was *'unsettled'*.[48]

84. A similar diary note is recorded again on the following day. It suggests that the decision of the meeting was that,

'P2 S3 cleared to mainstream to remain in Unit 13 until psychologist cleared.'

85. Mr T D was further referred to the clinical record continuation sheet Exhibit 9(d) at page 22, which records Psychiatric Nurse M H's review of Mr Casey, while still in Unit 13 on 4 March.[49]

86. Nurse T D observed that the note records that Mr Casey was psychiatrically cleared on the day previous, i.e. on the 3 March, though not by whom.

87. Relevantly, Nurse T D pointed out that he would have expected RN M H to have discussed the matter with Registrar Dr S T, before clearing him on 4 March, given that Dr S T had on the previous day, 3 March, directed in his review[50] that,

'he remain in Unit 13', although ...

'it wasn't mandatory that Nurse M H should do so'.

88. Nurse T D also testified that the record indicates that Mr Casey was prescribed Zoloft on 3 March (for his depressed mood), by Dr S T.[51]

89. Nurse T D further acknowledged that the diary note (exhibit 19b) for 4 March, was written by himself, which HRAT meeting he attended with four prison officers and prison psychologist, Dr M A, and that it was finally determined that Mr Casey would continue to remain in Unit 13.

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[48] See discussion at transcript page 543. See also the statement of MAP Psychologist, Dr M A, where she states that having reviewed Mr Casey's file on the 4 March, she saw him on the 5/3, this because of a difference of opinion between un-named Forensicare staff, who wanted to transfer him back to the general prison, and the Prison Operations Manager, who felt that it remained unsafe to do so.

[49] Attempts to locate Nurse M H, who was known to have left Australia and believed to have returned to the Netherland's, were unsuccessful and accordingly she did not testify during this inquest.

[50] See exhibit 9 (d), pages 25-23.

[51] See transcript page 585.

90. Nurse T D further stated that the diary notes, however, suggest that the initial plan (on 4 March), was to clear him to main stream at classification P2 S3 '2 outer', which meant that he would have shared a cell with one other and been subject to observations.

91. When further queried on who had '*cleared*' Mr Casey, Nurse T D was unable to say, this after reference to both the diary note and the HRAT plan for that day.[52]

92. Nurse T D further offered that he would have looked at the HRAT management plan for 3 March only, and understood that Mr Casey was cleared by a psychiatric registrar and would not have felt the need to further check the materials in the file.

'That's how it's done ....we have very little time.'[53]

93. When further pressed on why, as the Forensicare representative at the HRAT meeting, he would not have reviewed the prisoner's case file before attending the meeting. He stated that it was not his role to preview those notes, but rather that of the person who had been allocated the prisoner on that particular day.

94. Mr Casey was released from Unit 13 to mainstream on the 5th, after a stay of five days, with plans for him to be reviewed by Psychiatric Nurse Sheehan four days later. According to Nurse T D, this occurred after he was

'cleared' by psychologist, Dr M A.[54]

95. He was sent to a two-person cell within Unit 1, which was a mainstream cell but for prisoners who are considered vulnerable,

'usually from a mental side of things.'[55]

96. While in Unit 1 he was made subject to hourly observations, during lockdown.

97. Nurse T D was then further questioned by the Court about the HRAT plans dated 4 March and 5 March, and the S3 P2 rating, and the absence of a psychiatric diagnosis or any

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[52] See page 2 Exhibit 3 (a).

[53] See transcript page 561.

[54] See transcript page 635-36.

[55] See transcript page 575.

treatment/medication plan, during the period from his admission to Unit 13, i.e. on 29 February, until at least his planned psychiatric review on 9 March.

98. In response, Nurse T D confirmed these arrangements and that Mr Casey was to be psychiatrically reviewed on 9 March.

99. On 9 March, the diary note exhibit 19(b) and the continuation sheet exhibit 9(d) (page 21), indicated that Mr Casey was seen by a Nurse Sheehan, as previously arranged. The result of that review was that he was designated 'S3, P1', with observations to continue and with a further review in one week.

100. I note here that it remains unexplained as to why the P1 rating given to Mr Casey on both 7 and 9 March at the HRAT meetings, did not result in Mr Casey's transfer back to Unit 13 or into the Acute Assessment Unit and, given his history, the further involvement of a psychiatric registrar or consultant.[56]

101. Nurse T D further testified how he saw the prisoner one week later on 16 March, and changed Mr Casey to P2, which reduced rating, I note, permitted his transfer out of MAP.

102. Nurse T D was unable to say whether he had or had not read the history or specifically had read Dr S T's review, 3 March, before he conducted his own assessment.[57]

103. His record of his assessment 16 March, was as follows:

'Sixteenth of the 3rd of the 8th, outpatient clinic, review of obs. History noted, antisocial personality issues with impulsive behaviour. Denies current self-harm and suicide/self-harm,

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[56] The giving of a P1 rating at intake, suggests that he was to be reviewed by a Psychiatric Registrar, as set out on page 1 of the Mental Health Screening Assessment, see exhibit 9(d), and that he remain at the MAP. We also know from the evidence of Nurse T D that a P1 rating was a pre-requisite for admission to the AAU, or to that Unit's waiting list.

I note here that the then guidelines and new guidelines exhibits 20(b) and (c), both give some direction in regard to the consequences of the giving of a changed P rating at a point in time after admission, but do not specifically direct that a (later) P1 rating should also attract the involvement of a psychiatric registrar or above. It is also relevant that exhibit 35, the Criminal Justice Enhancement Programme Risk History, stipulated that a P1 rating ascribed to Mr Casey on March 3, is for a prisoner, who is suffering from a serious psychiatric condition requiring intensive and immediate care. The underlining is mine.

I further note that on 16 March when ascribing a P2 rating and effectively clearing him for transfer, Nurse T D described Timothy Casey as *'thought disordered and dissociated.'* See discussion in findings section below.

[57] See responses to leading questions put by Counsel for the Department of Justice to Nurse T D, at transcript pages 598-604. The fact that he would have expected Dr A W *'to see the prisoner'* if he had read the Dr S Ts' March 3 referral, and that he himself would have therefore been *'exonerated from making a decision'* on Mr Casey's P classification, is consistent with the notion that he had not read Dr S T's note of March 3, before he saw Mr Casey on the 16th.

but presents as though disordered. Reports to feeling 'nothing', says he feels 'empty', unable to concentrate. Poor sleep due to racing thoughts, is paranoid re: co-prisoners.

Denies thoughts of interpersonal violence, reports to poor perception of time. Unable to relay the outcome of court as he thought the judge was talking gibberish. Has no contact with children for months and believes God has a greater plan for him as he has been unable to suicide.

Presents as disassociated. P2, S3, continue observations, psych nurse follow up in one week. Psych review of meds.'[58]

104. The P2 designation suggested that Mr Casey was to remain on hourly observations, these to continue until 21 March. Nurse T D knew that a P2 classification allowed for his transfer out of the MAP, and that this may occur without Forensicare staff or HRAT being so notified.[59] His mention of '*Psych review of meds'* was a (repeated) indication that he should again be reviewed by a psychiatrist, wherever he may be placed.[60]

105. Nurse T D later attended the HRAT meeting on that day, the 16 March, which meeting apparently altered the above designation by increasing the S risk to '*S2*', with Mr Casey to remain in mainstream.[61]

106. The following day, the 17th, Mr Casey was transferred to the PPP, with his Clinical Record stamped by Registered Nurse Heather Whitworth[62] as,

'Fit for transfer based on file Review'.[63]

107. Nurse T D was then asked by Mr Bracken, Counsel for Nurse T D's employer Forensicare, about the changed arrangements for HRAT meetings, which are now in place.

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[58] See transcript page 569.

[59] See transcript page 583 and 87.

[60] See transcript at page 624. Nurse T D's belief that his notes on the subject would be received and reviewed wherever Mr Casey was sent, proved to be misplaced and appear to be overly optimistic given his own stated approach to Mr Casey's medical history and given his further testimony on his lack of understanding of the prevailing circumstances at PPP.

[61] See exhibit 3(a).

[62] Registered Nurse Whitworth was a medically but not psychiatrically qualified nurse, employed by MAP. She did not see or review Mr Casey.

[63] See Exhibit 9(d) at page 20.

108. Nurse T D was also called upon to contrast any changes in approach now adopted by Forensicare staff working at MAP. In summary, Nurse T D's further evidence was that there were now a greater number of senior prison officers, including the Chief of the prison, in attendance with sometimes the Forensicare psychologist and sometimes also a prison psychologist. Additionally, there was now Forensicare representation from both a Unit 13/AAU Nurse as well as a mainstream prison based psychiatric nurse.

109. In answer to the Courts further question about whether (psychiatrically trained) Forensicare staff might exercise a greater degree of authority over the transfer back to mainstream of ex Unit 13/AAU prison remandees, Nurse T D informed that HRAT decisions were now reached by a majority vote, with prison staff retaining that majority.[64]

110. Nurse T D further elaborated and confirmed that finally transfer, within the prison and transfer out, remained the province of the Department of Corrections Sentencing Management Office.[65]

111. His further testimony was that the decision of HRAT, as in the case of Mr Casey on the 5 March, may also be to remain in Unit 13 until cleared by the prison psychologist, where Corrections Victoria were disagreeing with Forensicare -

'it looks to me as though they had made a decision for Corrections psychologist Dr M A, to interview the person, and then make a decision on clearing.'[66]

112. Following this consult Nurse T D stated that he would have expected that the findings of such a review would have been referred back to HRAT.[67] Nurse T D was later questioned about Unit 1 where Mr Casey was sent on 5 March.

'Unit (1) is a mainstream unit which has a tendency to have vulnerable people housed in it or overflow from the AAU....vulnerability may include ..a diagnosis of intellectual disability or a

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[64] See further at transcript page 619, about all persons signing in agreement with the majority decision, sometimes reluctantly.

[65] See transcript at page 576 and also at 608 where the witness further stated in answer to my questions,

'We just raise and lower the P and S ratings. Sentence people, move people on, Your Honour. There is a big difference.

Q Effectively, that decision does move people on.

No, it does not. It allows them to be moved on, but it doesn't move them on...'

[66] See transcript at page 620.

[67] See transcript page 650.

first timer, young first timer, its 23 hour lock down like Unit 13 but you have your own cell with your own linen... with access to razor blades as opposed toUnit 13, which is a smock and a blanket made out of canvass.'[68]

113. When further questioned about the suitability of MAP to accommodate longer stays, Nurse T D stated that it depended on the presentation of particular prisoner.

114. Nurse T D further offered that he considered Dr S T to be an (able)... 'a cautious practitioner.'

'He had a reputation for being overly cautious.'[69]

115. His further opinion was that when Dr S T referred to Mr Casey's failure to acknowledge earlier self-harm attempts that he was indicating that Mr Casey was,

'not (being) fully forthcoming about his self-harm history',

and that he lacked insight.[70]

116. Nurse T D later testified that his own direction on 16 March, that Mr Casey should be reviewed by a psychiatrist for medication, could be expected to trigger psychiatric nurse intervention by the 23 March in regard to that matter, if his recommendation had not for whatever reason, been achieved.[71]

117. His further testimony was that in March 2008, the AAU was more focused on prisoners with psychiatric illnesses, than people who, like Mr Casey, had suicidal tendencies,

'which could be adequately treated elsewhere.'[72]

118. In answer to questions from Counsel for G4S the operator of PPP, Nurse T D testified that he would have expected all HRAT notes to be placed on the prisoner's IMP file, which we know did not occur in this instance.[73]

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[68] When transferred to Unit 1 on 5 March, Mr Casey again had access to razor blades, transcript 618.

[69] See transcript page 640.

[70] See transcript page 643.

[71] Nurse T D's belief that his notes on the subject would be received and reviewed wherever Mr Casey was sent, proved to be misplaced and was overly optimistic given his own approach to Mr Casey's earlier medical history, and given his later testimony on his lack of understanding of the prevailing circumstances at PPP.

[72] See transcript page 653.

119. In further testimony in answer to questioning by the Court, Nurse T D defended his strategic approach to the use of P and S ratings and stated that his approach had the support of

'the doctors.'

120. He also pointed out that his ratings were used to help ensure that the prisoner is

'reviewed by the right people.'[74]

Nurse D[75]

121. Nurse D testified that he admitted Mr Casey in to Unit 13 on 29 February following an earlier self-harming incident on that day, when Mr Casey had slashed his throat with a razor. Prior to reviewing Mr Casey, he read his most recent psychiatric assessments, which included reference to 'his history of multiple self-harm incidents (including an incident immediately prior to entering the MAP when he injected bleach into his arm)'.[76] Nurse D also noted that Mr Casey had previously swallowed razor blades at PPP in October of 2007 ie 4 months earlier. He further '*believed*' that he had reviewed material received from Peninsula Health Psychiatric Services.[77]

122. Mr Casey presented as downcast, teary and mildly depressed, with constant flashbacks of seeing the victim in a pool of blood.

123. Nurse D felt that he did not appear to need psychotropic medication but held what he described as,

' Serious concerns for his safety at that time'.

124. At this point, Nurse D felt that he was in a state which had multiple causes but,

'there were no symptoms of what we call a major psychiatric disorder.'

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[73] See discussion at footnote 129 below.

[74] See transcript page 662 -63.

[75] Nurse D was the Forensicare psychiatric nurse who admitted Mr Casey into Unit 13 on 29 February 2008.

[76] See exhibit 19. The evidence establishes that such a review did not occur on his admission to MAP, by Nurse T D 3 days earlier.

[77] See exhibit 9(d) at pages 14-19, which reflects that Nurse D had initiated the seeking of this discharge assessment from the Frankston Hospital.

125. Accordingly, he kept him in Unit 13 overnight and planned for him to be reviewed by a psychiatric registrar.

126. Nurse D gave further evidence about the deployment of Unit 13 within MAP explaining that it was used for psychiatric isolation and, very rarely, to house a prisoner who was being highly aggressive. He also informed that the Nurse assigned Unit 13 duties would work from the AAU, with Unit 13 nursing assessments carried out in the morning and a return to AAU duties thereafter. Prison officers (otherwise), carried out the continuing observation and care responsibilities within Unit 13.

127. More generally, Nurse D believed that transactions with the prisoners within Unit 13 were

'pretty honest,'

and that most of the interface involved nursing, rather than more senior Forensicare staff.

128. He further confirmed that prisoners may be admitted to the AAU from Unit 13 or from the mainstream. He had no particular recollection of knowing about or discussing Dr S T's plan (that Mr Casey was to be reviewed by Dr A W before he was released from Unit 13), stating that he was only on duty a couple of days out of the,

'entire week'.

Psychiatric Registrar, Dr S T

129. Dr S T testified that at the time of Mr Casey's admission he was a psychiatric registrar undertaking specialist training. He had been working for Forensicare for three years at this time and left the employ of Forensicare in February 2011. He was at the time undertaking the second of two six-month rotations at MAP.

130. He had not been aware of Mr Casey's death until contacted by the police informant in early 2011.

131. Dr S T examined Mr Casey in Unit 13 on 3 March, following the review of Nurse D, which admitted him there following the neck slashing on 29 February.

132. The purpose of his examination was to assess his mental state and risk of self-harm and to determine whether ongoing placement in Unit 13 was appropriate. He was aware that on the

same day Mr Casey had already been earmarked for transfer to the mainstream prison and on to PPP, by a medical doctor, Dr Ryan or like, so marking his file. It is relevant to record here that this occurred despite Dr Ryan not having seen Mr Casey and, despite Nurse D's earlier recorded plan, to have him seen by a psychiatric registrar at MAP.[78]

133. Prior to examining Mr Casey, Dr S T had informed himself concerning his relevant history which included his previous suicidal behaviour and use of illicit substances. He was also aware of his personal circumstances and the reason for his incarceration and of his earlier engagement with Peninsula Health Psychiatric Services. His presentation was such that Dr S T recommended that he remain in Unit 13, due to his continuing risk of suicide.[79]

134. According to Dr S T his differential diagnosis at the time was of an adjustment disorder,

'resolving substance disorder and mood disorder,'

as he was minimizing his past history and was also believed to be suffering from an acquired brain injury.

135. Dr S T further testified that his plan was to have Mr Casey reviewed by the consultant psychiatrist, Dr A W,

'who could assess his suitability for admission to the AAU (when he was considered able to be removed from Unit 13), due to his continuing risk of suicide.'[80]

136. Dr S T further stated,

'11 After I assessed Mr Casey I went to the AAU and asked for the consultant (Dr W....). She was not on the unit, and had not yet been seen by AAU or administrative staff.[81] *My recollection is she worked part time (3 days a week). I told the nursing staff to ask Dr W... to see Mr Casey urgently and said my plan was for him to remain on Unit 13. I then proceeded to place a continuation sheet with a note in Dr W....'s pigeon hole. In this note I requested she urgently review Mr Casey in Unit 13. Doctors were not permitted to carry either pagers or mobile phones in MAP. As Dr W..... was not in the AAU, she would not have been at her*

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[78] See exhibit 9(d) at page 25 and 26.

[79] See Dr S T's statement at exhibit 17 and transcript from page 1.

[80] Exhibit 17 at page 2.

[81] I note that this evidence was consistent with her own diary record. See exhibit 29(c.

computer to receive an email. I searched for Dr W..... again in the afternoon without success. Later that day I was told by nursing staff they had not seen Dr W.... that day and that Mr Casey had not been reviewed by a consultant. I understand he was not seen by a consultant the following day either.

12 I next saw Dr W.... two days later on 5 March, after midday, as she was writing notes on the long workbench in the AAU staff station. I told her that I had left urgent messages asking for her to see Mr Casey in Unit 13. She said she had received the messages. I then said that I was very concerned about him and she said "I know". She then terminated the conversation. I was pleased that I had been able to confirm that she was aware of Mr Casey's presence in Unit 13 and knew of my request for a consultant review. I presumed that she would see him that day.

13 I had no further contact with Mr Casey following my interview with him on 3 March 2008. I was subsequently informed that Mr Casey had been transferred to another prison."[82]

137. This evidence was broadly supported by Dr S T in his testimony.

138. In that testimony Dr S T spoke of his pre-examination file review, which I note was full and apparently careful.

139. His record of the examination was also comprehensive to a point, with his stated plan being that Mr Casey remain in Unit 13. I note that relevantly he did not record that it was also part of his plan that Mr Casey was to remain until reviewed by Dr A W for placement in the AAU.

Psychiatric Consultant Dr A W[83]

140. Dr A W testified in response that she had no recollection of receiving Dr S T's request via her pigeonhole, or of any conversation with Dr S T or other Forensicare staff at all, regarding Mr Casey.

141. She further testified that even if she had received Dr S Ts' request to review Mr Casey for possible admission to the AAU, she would not have done so, given the note made by Nurse M

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[82] Ibid at page 3

[83] Dr A W was a Consultant Psychiatrist based at the MAP, at the time under consideration. She is now a Consultant Psychiatrist employed in another position.

H on 4 March, and her reference that he was '*psych cleared*'[84] and the HRAT meeting discussion to keep him in Unit 13.

142. According to Dr A W's interpretation of 4 March clinical note, Nurse M H was saying that he was psych cleared, which was her own assessment of Mr Casey,

'*and she feels he was psych cleared from Unit 13 – given what Dr S T..... has written there'.* [85]

143. It is relevant that Dr A W similarly testified about Nurse Sheehan's clinical note of 9 March and the statement that he was to be reviewed by a psychiatric nurse in one week.

Coroner *"Does the fact that above that (in the clinical notes), is a nursing note which discloses medical attempts to deal with two earlier attempts at suicide give you any reason for pause?*

Dr A W ... *self harm is common in the prison setting, for all sorts of reasons and so the mental state examination... is critical in these events. The presentation of this prisoner is relatively common as well. I'm talking about his overall presentation as having unfortunately been alleged to be involved in a murder of a partner and so this does not give me 'pause', the fact that he had cut himself."*[86]

144. Her further view was that Mr Casey received appropriate care while in Unit 13 and later in Unit 1, until his transfer out of the prison on 17 March, which included 9 March when Nurse Sheehan saw him and classified him as S3 and P1.

145. Dr A W also testified about the importance of the AAU as,

'the pinnacle of psychiatric care in the Victorian prison system,'

and as a unit (intended) for pre-sentencing assessments and also for the assessment of psychosis of a seriousness, which may result in admission of an offender to the Thomas Embling Hospital, under the *Mental Health Act.*[87]

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[84] Dr A W transcript at page 1335

[85] Transcript page 1335

[86] Transcript page 1338.

[87] Transcript pages 1388-89.

"Coroner ..(Dr S T..... said this was complex, and that given the different presentations and the gaps that existed in the information, and given the history of (some) six suicide attempts – coupled with a further suicide attempt while he was taking drugs and using alcohol in a 'wild' way, coupled with the suicide attempt while he was at the MAP, that all of these things pointed to an underlying condition, which needed to be better understood, and that this was the reason this should be dealt with in the AAU. Do you agree.....or could that as easily have occurred in the prison section... not within the AAU?

Dr A W....its my opinion that Mr Casey could be appropriately diagnosed, assessed and treated in the mainstream prison. Taking into account every single factor you have outlined, all of which I absolutely accept, it's very sad but true that many of the young prisoners within the Melbourne Assessment Prison will present as it appears Mr Casey did.

As I said again, I am sorry I never met him."[88]

146. In cross-examination by Mr Stanley for Dr S T, Dr A W testified that, as the consultant psychiatrist she had ultimate care duties in regard to all psychiatric *'patients, prisoners'*, at the MAP albeit that they were held at various locations.

147. Dr A W agreed that most of her attention was devoted to the prisoners in the AAU and in Unit 13, with her priority being the consultation with and assessment of prisoners in the AAU.

148. She further agreed that the documentary evidence,[89] established that there were 2 prisoners in Unit 13 on 13 March and 14 in the AAU, with 15 in the AAU on 4 March. There were 16 cells in the AAU (Units 11 and 12) and 6 in Unit 13, the Muirhead cells.

149. Dr A W further spoke of her use of weekly team meetings and staff consults to inform herself about the condition of particular prisoners. She further testified that staff referrals were often verbal, but that a note in her pigeonhole was not a normal method of achieving an urgent patient referral.

150. She was then questioned about her workload and the time spent on preparing pre-sentence and parole board reports though evidently not reports concerned with

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[88] See transcript at page 1431.

[89] See transcript at page 1346 and exhibit .

'fitness to plead.'[90]

151. Her further evidence was that on 3 March, the day of Dr S Ts' review of Mr Casey, her diary indicated she was working at Thomas Embling, and that she had no independent recollection of working at the MAP on that day.[91]

'I have (no independent recollection).. but I wouldn't be surprised if it turned out that I was there, (that day)'.

152. She further agreed with Counsel's summation that there would be no independent way for Dr S T to find out that she wasn't at MAP on the 3 March 2008 (i.e. the day of his examination of Mr Casey, when he stated that he had tried unsuccessfully to locate Dr A W).[92]

153. She further agreed with Counsel for Dr S T that it was likely that she was working at the AAU *'long workbench'* during the afternoon on 4 March, where Dr S T says that they spoke about Mr Casey. (His later evidence was that he now believes it may have been on March 5).

154. She also confirmed that she was not at the HRAT meeting on 4 March, which considered the position of Mr Casey, who was still in Unit 13.

155. She was further asked about the evidence suggesting that the original Forensicare position on 4 March was that he should be cleared to mainstream and how that was changed to result in him remaining in Unit 13, until he was cleared by the psychologist.[93] She had no recollection of any involvement in that matter.

156. Dr A W was then questioned about the manner in which she would seek clarification of Dr S T's, concerns about a particular patient. She was of the view that he was,

'extremely cautious', 'overprotective' and, in this case, had difficulty 'reaching a diagnosis.'[94]

157. She was further questioned about her opinion that Dr S T's note,

'plan to remain in Unit 13,'

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[90] See transcript at page 1350.

[91] See discussion concerning Dr A W's diary and her movements on the 4/3 at transcript 1354-55.

[92] See transcript at pages 1352-53.

[93] See exhibit 19(b) for 4 March.

[94] See transcript page 1371.

158. (which she testified, was not referred to her), did not indicate that he felt Mr Casey was a high risk of suicide.

159. In response, she stated that,

'this didn't convey very much to me.'

160. Her further testimony was, in the circumstances of his review on 3 March, (as I note here Nurse T D also opined), that she would have expected Nurse M H to go back to Dr S T and discuss Mr Casey's presentation, before psychiatrically clearing him just one day later, i.e. on 4 March.[95]

161. She further stated that she had no recollection of any of the people who dealt with Mr Casey, ever referring his presentation to her and expressed confidence in the clinical skills of both Nurses T D and M H.

162. In response to additional questioning by Counsel for the Department of Justice, Dr A W confirmed that she would have been difficult to contact once away from MAP. She further stated that she would have expected any referral of a prisoner to herself to be recorded on the clinical fie.[96] Her further testimony was that an oral referral of a patient by a junior colleague (when it did occur) passed to her a duty of care concerning that patient.

163. Dr A W was then questioned by Counsel for the Department of Justice on the practice of having generally registered psychologists as distinct from clinically registered psychologists, undertake mental health examinations.

164. Her view was that she felt that Dr M A, a generally registered psychologist (and the senior psychologist at MAP) *was competent .... but in a team situation.. it would be good practice to have a psychologists diagnosis on (a psychiatric illness), confirmed by 'medical' staff.*[97]

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[95] See transcript page 1379. Subsequently at page 1381 she further testified that, 'It could be a proper thing for her to do.'

[96] See transcript page 1393. I note here that Dr S T's explanation for not making a clinical note of this matter was, that he did not wish to place the specific recommendation that the consultant review Mr Casey on record, as that might become an embarrassment to both, or either, Dr A W or himself, (in front of junior staff) should she decide to not so review.

[97] See transcript page 1406-7.