321. 320 RT also testified about the case management system then in place at PPP. He stated that there was a whiteboard in each unit, which set out the cell number, inmate name and caseworker. He also stated that the Officers report form[182] dated 28 March, was written in part by an admissions officer A. The second part identifies the caseworker as officer Ms TC, but that another officer Ms R, had completed the form, in this instance.

322. He also stated that (unlike on the 28 March), normally each caseworker would be scheduled to work 3 x12 hour shifts each week, in his/her allocated unit and that it was,

'the responsibility of each caseworker to get to know his/her prisoner, at the first opportunity'.

323. RT further testified that when Mr Casey spoke to him about seeing a *'psych registrar'* and following his telephone inquiries he did not look to see who his caseworker was and that he didn't consider it unusual that he, Mr Casey, believed that he had but in fact did not have such an appointment. If he had known of Mr Casey's background,

'I may have asked him if he wanted me to contact the psych nurse to see where his appointment is at.'[183]

324. RT was also further asked about the S3 suicide rating and explained that such a rating indicated self-harm issues in the past. For such a rating there were no actual observations required, but that several notations had to be made on the watch sheet each day usually two, three or four, through the unlock period with

'meaningful conversations'

to be undertaken on each of these occasions.[184]

325. RT also testified about the making of a *'crisis call'* and of getting a prisoner reviewed by the RRT and of how he may have reacted to the situation at the officers desk with Mr Casey, if he knew that he had previously had an S3 rating.

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[182] See exhibit 6(e)

[183] See transcript page 301.

[184] 'It can – you know, you could be doing a tier walk and he could be sitting in his cell watching TV and you might just put your head in and there speak for a quarter of an hour. If he's watching football I'd watch the football with him for five minutes and just sort of, you know, talk about the football or anything like that.'. Transcript at page 305.

326. RT was also questioned about prisoner consults with the therapeutic team psychologists and informed that these meetings usually took place in the Scarborough south interview room and were preceded by a call to establish that the prisoner was in the unit and available at that time.[185]

Prison Officer GR.

327. Officer GR testified that he was on duty at Scarborough south on the 28 March, with Officer RT, '*who is also the CPS Union representative*' and fellow officer MT. He heard the code purple at 16.17 hours and ran up to cell 468 to assist Officer RT, who was doing CPR on Mr Casey. GR who has level 2 First Aid, was unable to find a pulse. He then testified as to his further involvement in the attempts to resuscitate Mr Casey and as to the presence at the scene of Officer MS.

328. Officer GR gave further evidence about his '*excellent*' colleagues and that neither would put themselves in a position to either swear at or threaten prisoners, and that they were '*respected*' by prisoners.[186] Officer GR was then further questioned about the crime scene log and about *'bringing a chair down,'* but was unable to assist with whether there had been a chair in the cell at the time of Mr Casey's death.[187]

329. Officer GR was also questioned about the allegation that Mr Casey had approached the officer's desk on at least three occasions prior to his death. His evidence was that he was not aware of that and had no recollection of being spoken to by Mr Casey about his wanting to see '*a psych*'.

330. Additionally, Officer GR stated that prison officers often were not aware of a relevant history, as there were 70 prisoners for just three staff to watch and that there was also a high turnover, with frequent transfers in and out of the unit and frequent intra prison visits for counselling and medical health care, all requiring officer supervision, (and paperwork).

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[185] According to officer RT subsequent inquiries established that Mr Casey did not have a (recorded) appointment with his therapeutic team psychologist, that afternoon, the 28 March. I note however that the absence of a formal record in the therapeutic services office would not necessarily exclude the possibility that case psychologist, Ms K M, intended to review him at that time, as she stated in her own evidence. See transcript at page 283

[186] See supplementary statement exhibit 7(b).This statement was prepared by GR following the evidence given by the (former) prisoners, which is referred to above.

[187] See exhibit 7(c).

331. His further opinion was that Scarborough south was the busiest unit in the prison.

332. GR further testified that officers typically relied upon medical *'assessors'* concerning the mental health of prisoners, and that the fact that he had once had an S3 rating and had been reduced to an S4 rating (with his name to be no longer entered on a watch sheet), would not be brought to the attention of prison officers.

Prison Officer MS.

333. Prison officer MS was the third officer scheduled on duty in Scarborough South on 28 March 2008. At the time, he had 4 years experience 'working in the Units'. He recalled Mr Casey's cellmate, former prisoner JS, calling out to the officers. He also recalled Mr Casey asking officer RT if he had a psych appointment that day, and a resulting phone call made by RT. He did not believe that Mr Casey was in distress and did not know what the result of RT's inquiry was.

334. He further denied that he spoke to Mr Casey suggesting that he might be sent to the *'slot'*, or that he would ever swear at or threaten prisoners. Officer MS also spoke of his involvement following the discovery of Mr Casey hanging in cell 468, of his arrival immediately following OIC RT, and of his running down stairs to get the *'ligature knife'*. [188]

Prison Officer TC.

335. Prison officer TC was appointed as case manager to Mr Casey (it seems while he was still at the MAP). She had been employed as a Corrections officer since November 2006, and had been at PPP from that time.

336. She stated that she had received Mr Casey into Scarborough south on the 17 March and undertaken a *'rules and regulations'* induction. Following induction she states that she worked on the 17, 19, 25, and 26 March, and that her independent recollection of Mr Casey at the time of making her statement (i.e. in November 2010), *'is vague'*.

337. Officer TC additionally stated that she was not the officer who conducted a one on one interview with Mr Casey on 17 March as fellow officer Ms R. undertook this interview. And that an induction was carried out by (billet) former prisoner HP, who took his role seriously

[188] See exhibit 17.

and who had, no problem talking to officers, all of which evidence (together with the evidence of HP), seemingly contradicted her earlier statement concerning Mr Casey's induction.

338. Officer TC further stated that case managers were expected to help prisoners set goals as part of their rehabilitation and help identify suitable programmes for the prisoner to participate in. She further stated that prisoners who like Mr Casey *'are not classified to PPP'* are not required to have a plan until they had remained at PPP for a period of 6 months unless otherwise directed by a supervisor, and that a case manager would normally have up to 7 prisoners to case manage at any one time.

339. She also informed that a prisoner was required to have a back up case manager when the primary caseworker is not rostered to work. In addition, that prisoners know who their caseworker and backup caseworker is, as they are told on admission. Her further evidence was that she had no recollection of receiving any requests from Mr Casey concerning medication, or indeed any other matter.[189]

340. In her courtroom testimony, I note that Officer MC, gave a somewhat different version of her understanding of the caseworker programme. In that evidence she stated that it was not unusual for an officer other than the caseworker (or back up caseworker), to have direct contact with a prisoner and follow up as required, with all officers at Scarborough South participating in each others casework. The underlining is mine. Her further evidence was that no officer in particular discussed or developed programmes for a prisoner who might approach any officer in connection with such matters.[190]

341. She also testified how three officers dealing with up to 71 prisoners and 20 to 30 movements each day during unlocked hours, created an enormously challenging work environment, which was a matter of ongoing concern for the officers.

342. Officer MC spoke further of changes which had been instituted since the death of Mr Casey. These included advance warning of the arrival of a prisoner on S watch, and that staff from the therapeutic office were now more actively involved at an early stage. Protective changes regarding the supplying of razer blades, plastic bin liners and serrated edged eating utensils

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[189] See statement of Officer TC at exhibit 15.

[190] Transcript page 21 and 27.

had also been introduced, although razor blades might still be purchased and taken into the cells, and serrated utensils were still in use..

343. Additional evidence was given as to how duty officers would be informed as to whether a prisoner was on watch. This involved reference to the prisoners IMP file[191], which would be kept in the units office filing cabinet. There was also a security register, (a sash folder for each prisoner), kept at the officers desk with this material removed, when the S risk was reduced to S4, as we know occurred in Mr Casey's case on the 20 March, following an earlier review by Psychologist Ms K M.

344. Officer TC gave additional evidence on the

'*meaningful conversation,*'

345. requirement and how this requirement was implemented, depending upon the presentation of the prisoner.[192]

Corrections Department Acting GM, Offender Behaviour Programmes, Brenda Dolieslager.

346. At or near the conclusion of this inquest I considered that there was some level of confusion concerning the position taken by the Department of Justice as to the work undertaken by senior psychologist Dr M A (MAP) and psychologist K M, formerly at PPP. At my request, a statement was prepared by a Corrections Department manager to address this issue.[193] That statement became exhibit 36 and broadly details the history of the work undertaken by psychologists within the Corrections Department, and how the system has changed over the last three years with the development of the offending behaviour programme(s) (OBP), section within the department.

347. According to Ms Dolieslager, prison psychologists which include properly qualified and as I understood her, registered clinical psychologists, at least those within her section are mainly concerned with intervention programmes intended to reduce the risk of re offending. The

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[191] See Mr Casey's somewhat incomplete file, reference MAP originating material, at exhibit 3.

[192] Transcript page 31.

[193] The suggestion set out in paragraph 4 of exhibit 36 is an incorrect summary of the issue raised. The correct statement of the issue was whether psychologists called upon to assess and provide an opinion on a prisoner's mental state and or risk of suicide/self-harm, should now be required to be clinically qualified and registered as clinical psychologist(s), by the Psychology Board of Australia.

section is also involved with skills acquisition programs and individual interventions in the case of certain cases of prisoner distress.

348. I note with approval that if an OBP staffer is called upon to undertake an assessment of suicide or self-harm that person is now required to advise referral to a mental health specialist who are of course medically qualified to undertake that work and give that advice.

FINDINGS

1. Following his review on the 16 of March 2008, Psychiatric Nurse T D described Timothy Casey as,

   '*thought disordered and dissociated'.*

2. The noted psychiatric symptoms which were not present in the prior assessments were

   i) his poor concentration,

   ii) his limited recall of the detail of recent events,

   iii) the change in his perception of time,

   iv) his expressed feelings of detachment,

   v) his racing thoughts and poor sleep,

   vi) this combined with indicators of delusional thinking, such as God having a grander plan for him.

3. I find that these symptoms in a man with a known history of a major depressive disorder with continued treatment up until three weeks prior were suggestive of deterioration in his mental state.[194]

4. Also indicative of an earlier deterioration, were the HRAT P1 ratings given to Mr Casey on both 7 and 9 March.

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[194] See transcript at page 1403 where Dr A W testified that, 'this was the first time I can see (that) there's evidence of any evidence that could represent psychosis…'

5. I further find that I am satisfied to a comfortable satisfaction that the P1 rating found within the Department of Justice Enhancement Document at exhibit 35, is also relevant. That exhibit as explained by the statement of Ms Forrester, together with the evidence of Dr S T and inferences drawn from the rest of the evidence, establishes to my satisfaction that on 3 March, Dr S T concern about Mr Casey was, as he claimed, communicated to unknown colleagues and was reflected in the designation there given to Mr Casey. That designation indicating on the document itself, suspicion that Mr Casey was then suffering from a,

'serious psychiatric condition requiring intensive and or immediate care'.

6. In addition, I find that there was little or no response by MAP or Forensicare officials, throughout this period, to Mr Casey's presentation. This lack of response occurred, despite his earlier recorded history of suicidal behaviour, while in custody, the P1 ratings accorded to him referred to above and what I now find were the earlier effort(s) of Dr S T, to have him assessed for suitability for admission as an inpatient in the Acute Assessment Unit.[195]

7. Rather, (and instead of seeking to assess his situation and make plans for his treatment and placement having regard to that assessment), the fact is that Mr Casey was pushed through Melbourne Assessment Prison into the general prison population at Port Phillip Prison, with insufficient care taken to understand or address either his psychiatric condition or suicide risk profile.[196]

8. I further hold that this approach paid little or no regard to the requirements of exhibit 20(b), the then applicable MAP operating procedure for at risk prisoners.

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[195] See paragraphs 14-16 below.

[196] See the hearsay evidence of Dr M A at transcript page 767 to the effect that as late as March 14, Forensicare had told her of plans to have him reviewed (again) by a psychiatrist. See also Exhibit 21(a) at page 5 where Dr M A noted on March 14, a Friday, that she was informed that Mr Casey was on a list to see the 'psychiatric registrars for assessment,' but that this hadn't happened yet and 'it was discussed that he would be flagged for assessment over the weekend'. I further note that no evidence has been led, which establishes that this event was scheduled (at MAP), or that it occurred.

See also discussion between the Court and Nurse T D at transcript page 588, where Nurse T D did not seek to refute the proposition that Mr Casey had been 'pushed through' MAP. See also discussions with Counsel on this issue from transcript page 1452-56 and at 1965.

9. It is also the case that the processing of Mr Casey out of MAP was undertaken in circumstances in which it was highly probable that on being cleared for transfer, he would be moved to PPP and into its main reception unit, Scarborough south[197].

10. It is further relevant that Scarborough south, to which he was transferred the day after receiving his P2 rating on 16 March, was a busy and crowded facility which possessed and is still possessed of fundamentally flawed design features.[198]

11. I further find that the initial assessment on 26 February, by Nurse T D failed to identify earlier self-harm incidents while in custody. Perhaps recognizing this limitation and the time constraints, which contributed to it,[199] Nurse T D then sought to refer the matter to a psychiatric registrar/consultant, but without use of the specifically designed Reception Summary document and a P1 or P2 classification. Notwithstanding this backdoor approach, I find myself satisfied that Nurse T D, who I find was a responsible and hard working clinician, was sufficiently concerned about Mr Casey's initial presentation, which he described as,

'tearful, fearful.... dishevelled and pathetic'[200] ,

to conclude that there was a need to have Mr Casey assessed by a registrar/consultant.[201]

12. Thereafter, we know that Mr Casey was admitted to the general prison population and three days later on the 29th that he used several razor blades to cut in the region of his neck,

'with lethal intent'.

13. This led in due course to his transfer to the Muirhead cells in Unit 13 and review by Dr S T on 3 March,[202] and to the conflicting evidence referred to above, as to the arrangements made for Mr Casey's care by psychiatric registrar Dr S T, at that time.

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[197] See evidence of Acting Assistant Commissioner B M. A transfer to PPP was also suggested earlier by the SMU, See exhibit 9(d) at top of page 25, a fit for transfer to PPP note written on the 3 March by a MAP Dr 'Ryan', or like.

[198] See discussion below at

[199] See transcript at page 506 where the witness offered that he would be required to conduct one such reception assessment every 10 minutes.

[200] See transcript page 501

[201] In my view this result should have been achieved through Nurse T D use of the appropriate rating contained within the Reception Summary document, (and without the misinformation which may have resulted), from his initial P3 S4 rating. See my discussion of the approach taken with witness at transcript page 504-05 and at 507.

Query whether the Reception Summary document, (Ibid at page 34), should henceforward be amended to exclude reference to 'P1 or P2 prisoners only'.

14. In regard to that controversy, I have now reviewed all of the evidence and counsels submissions and note that Dr A W's testimony was that she had no recollection of discussing Mr Casey with Dr S T or anyone else, and that she would not have acted, in the manner suggested by the evidence of Dr S T, (if such a conversation had occurred). I also note that Dr S T did not after his (alleged), brief conversation with Dr A W near the AAU station on or about March 4, raise the matter of Mr Casey directly with her or seek to otherwise establish what had happened to his recommendation, that Mr Casey be reviewed for entry to the AAU, although he had the opportunity to do so.[203]

15. On all of the evidence, however, I find myself satisfied that on or about 4 March, Dr A W was in fact made aware of Dr S T's referral of Mr Casey to her care, but for unknown reason that she or unknown others, later took a course which ultimately resulted in Mr Casey not receiving the assessment that Dr S T had recommended.[204] (I also find that she acknowledged the reference to her care in the brief conversation with Dr S T, referred to above, which provided him with a level of relief concerning Mr Casey).

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[202] See his clinical notes at exhibit 9(d) at page 25.

[203] Dr S T testified that he later became aware of Mr Casey's transfer to PPP through Corrections and that 'he could not be returned'. He was also then under the impression that Dr A W had seen him and cleared him from the Muirhead cells. Transcript page 123.

[204] At the time under consideration Dr A W was six weeks into her role as a consultant psychiatrist at the MAP. It was a three day a week appointment in what was both a busy and stressful environment.

It is also relevant that Dr A W's evidence suggested that she did not have a great deal of confidence in the clinical abilities of Dr S T, and that she did not consider that the AAU should be employed to undertake an analysis of prisoners who were suicidal, but with 'no known psychosis', (evidence as to the policy within the AAU which was broadly supported by the commentary of Nurse T D).

I do not know to what extent her approach to these matters might have influenced her decision concerning Dr S T's referral and recommendation, that she review Mr Casey for admission to the AAU.

I also note here my finding that Dr A W demonstrated an assertive personality in evidence, while Dr S T's did not so present.

Dr S T reference to Dr A W's leadership style in the context of answering a question from the Court concerning his actions, suggests that he avoided a further confrontation with Dr A W, in part because of his reaction to that leadership style. I note that is not inconsistent with their manner of presentation as witnesses before this inquest.

I also observe that when he discovered that Mr Casey had been transferred out of MAP the evidence establishes that focus was on how and what psychiatric support he might then receive at PPP, rather than on the approach to the issue, which may have been taken earlier by his boss, Dr A W.

Following a consideration of the evidence both direct and circumstantial, I find myself satisfied that Dr S T testified truthfully about his recollection of these matters, before this inquest and that his recollection is broadly accurate and can be relied upon. In so finding,

I indicate my further view that the evidence before me establishes only that Dr A W now has an imperfect memory of the event(s) under consideration.

16. I observe in conclusion, that it appears from the evidence of Dr A W concerning AAU use at that time and the general commentary on that matter by Nurse T D, that the decision to return Mr Casey to the prison population without review for admission to the AAU was consistent with the policy of the day in regard to the use of the AAU. However, I also note that had that review occurred and had Mr Casey then been admitted to the AAU, it is much more likely that management at both MAP and PPP, would have been provided with an improved understanding of the challenges, psychiatric or other, that he then faced and that, if appropriate at that time, Mr Casey himself, would have received treatment.

17. I further find that there were process failures, which occurred while Mr Casey remained at MAP. These include the failures of the Forensicare Nurse M H, and psychologist Dr M A,[205] to confer directly with Dr S T prior to recommending the return of Mr Casey to the general prison population from Unit 13 on 5 March. It is relevant that these errors occurred despite Dr S T's direction on 3 March that Mr Casey was *'to remain in unit 13,'* and despite the P1, classification on 3 March referred to in exhibit 35, as discussed above. Also relevant was the HRAT failure to respond directly to the 3 March P1 classification as well as the later HRAT recorded P1 classifications on both 7 and 9 March.

18. Further, (unexplained) error occurred in regard to the transfer of Mr Casey with an S3 P2 rating, rather than S2 P2, which matter I discuss above at footnote 129.

19. Questionable practice also occurred in regard to the directive of the Corrections Victoria, Prison Management Office, that he be transferred to the PPP, without HRAT being consulted or made aware of the matter, and the,

    'fit for transfer based on file review',

    rubber-stamping of that Prison Management Office decision by a Pacific Shores employed medical nurse who I find was not medically qualified to assess either Mr Casey's mental health, or his clinical record.[206]

Port Phillip Prison

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[205] The evidence does not suggest that either Nurse M H or psychologist Dr M A conferred with Dr S T, before reviewing Mr Casey on the 4th and 5th, respectively.

[206] See her statement at exhibit 12. This was then and remains the practise in respect of prisoner transfer, out of MAP.

20. It is apparent that by the time of Mr Casey's transfer to PPP an extensive work up of his earlier presentation had been prepared by psychiatrist Dr Ong among others. Evidence concerning this workup established that when earlier seen (at PPP), by Dr Ong in October 2007, i.e. some five months before his remand for murder, that he was believed by Dr Ong, (a Forensicare psychiatrist), to be in need of support concerning both his depressive illness and his drug and alcohol withdrawal.

21. Dr Ong's opinion, in particular, is important in that it provides support for the claim that Mr Casey continued to require a medical/psychiatric review to consider a timely re-introduction of medication and that this need persisted until the time of his death.

22. I note there is no evidence that these opinions were seen or considered by St Vincent's staff who dealt with Mr Casey following his transfer to PPP on 17 March. I further note that the evidence does not suggest that Dr Ong's opinion was referred to at all by PPP staff in March 2008, this evidently because of the protocol which required staff at both MAP and PPP to reassess Mr Casey, through a drug and alcohol councillor, given his earlier withdrawal programme, non compliance.

23. Based upon the evidence of Dr Blaher, the Department of Justice submission that a waiting period to join a relevant prison programme is desirable (because it allows for an enforced detoxification) is accepted. However, I find that this submission masks the reality that, if indeed they reach a medical assessment, prisoners who might then satisfy all medical requirements and who demonstrate an existing medical need, can be left without access to a medically supported drug substitute programme.

24. Turning now to the admission process, I find that there was a difference of opinion at the RRT 17 March meeting, (not recorded in the meeting notes), as to how Mr Casey should be classified, with significant difference between the positions taken in the documentation from Mr B C who was present and Psychiatric Nurse N, who was not.[207] Given the mental state review undertaken at MAP on 16 March, ie the previous day, by Psychiatric Nurse T D, referred to above and having regard to all of the rest of the evidence I am satisfied that Mr B

[207] See the debriefing summary within the OCSR Report Exhibit 9 (attachment 51 to PPP Internal Management Review where Mr B C commented concerning the failure of the RRT to give Mr Casey a higher risk alert on admission to PPP.) See also the discussion by the Chairperson concerning the manner of note taking, (by another) at transcript page 1758 and 1765.

C's recommendation was justified, and should have been accepted, pending a full psychiatric review by Dr W, or other available registrar.

25. In such circumstances, I further find that (certainly following the rejection of the SASH officers recommendation), a prudent management of this prisoner should have resulted in efforts being made by the RRT to secure an early appointment for review of Mr Casey by a psychiatric registrar, with appropriate follow up (by the RRT). This also did not occur, instead with an appointment to see Dr W failing to eventuate on March 19, with the fact of this scheduled appointment apparently unknown to the RRT, and the record concerning that matter (later falsified) also flying below RRT scrutiny.[208]

26. It is also relevant that there was no (known) attempt by PPP staff to chase up (MAP) HRAT notes absent from his IMP, before taking decisions on March 17 and 20, concerning his further care and safety.[209] I also find that the 20 March RRT reliance placed on the suicide/self harm assessment of non clinically qualified psychologist K M, was inappropriate.[210]

27. It is also relevant that, the note taking at PPP concerning the mental state reviews, which were conducted by psychiatric nursing staff, were also inappropriately truncated with some times little or no reference made to Mr Casey's relevant history.[211]

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[208] The failure of the RRT to monitor the progress of Mr Casey through its St Vincent's Health attendees, is reflected in the fact that the appointment for him to see Dr W was for March 19, but was not discovered to have been unsuccessful until Nurse D inadvertently came across the matter 8 days later, (which was quite properly followed by his attempt to rectify, as set out above).

The falsity of the records concerning that appointment does not excuse the RRT's failure to be informed of these matters as the RRT' St Vincent's Health staff support, should have been aware of and seeking the results of Dr Ws review on March 19, in preparation for the meeting to decide Mr Casey's S rating future, the following day.

[209] See discussion at footnote 129 above.

[210] See the RRT record directing psychologist Ms K M's involvement of March 19, at exhibit 40 page 275.

Psychologists Ms K M, (and Dr M A at MAP), both showed themselves to be hard working and diligent employees. However, it is relevant that both were recruited to the Corrections Department, early in their professional careers and over time were required to provide opinions on suicide risk (and at times in Dr M A's case), mental state evaluation, which assessments I find they were not clinically qualified to make and should not have undertaken.

Furthermore, their involvement in clinical work was understood to be such by their colleagues. See Nurse T D at transcript page 620 and Dr A W at transcript page 1406-7 reference psychologist Dr M A, and Nurse D at transcript page 1012-13, reference Ms K M, and again I find that this level of involvement orchestrated or condoned as it was at that time by the Department of Justice, was not in the public interest.

[211] See medical notes prepared by Nurse D in respect of assessments on the 19th (and 24th) of March as discussed at transcript page 851.

28. It is also the case that the March 20 downgrade occurred in the absence of a clinical diagnosis or provisional diagnosis, and without reference to Nurse N earlier recommendation concerning the reintroduction of psycho-tropic medication.

29. These omissions were further complicated by a management system which appears to have only paid lip service to the caseworker system in place at the time, and which condoned the non-involvement of any particular case officer in a prisoner support role, in this instance officer TC.

30. I further record here that the clerical administration of medical care by staff at the St Thomas psychiatric outpatient unit to Mr Casey concerning the March 19 and other appointments was poor, and in that particular instance deceptive.

31. Turning now to the events, which occurred on March 28, I find myself satisfied that over the period of his incarceration, Mr Casey continued to receive mixed messages from PPP staff, the therapeutic unit staff and St Vincent's psychiatric staff about whether it was planned that he would see a psychiatrist, psychiatric nurse or psychologist. It is also relevant that he had received negligible medication, in relation to drug withdrawal following his first few days at the MAP, and in regard to his depressed state, since his arrest.

32. These issues came to a head when he confronted prison staff or a staff member, within Scarborough South at around 3.00pm, on 28 March. This occurred while he was in a withdrawn mental state of undiagnosed origin, which remained untreated.

33. I have now reviewed the conflicting evidence of both the prison officers and the prisoners, concerning the exchange, which took place, and that of the psychiatric nursing staff, as well as psychologist Ms K M and Consultant Dr W, concerning the ongoing failure of St Vincent's Health in particular, to supply Mr Casey with the several consultations for which he had been recommended, and was seeking. I have also directed myself as to how, and in what circumstances, I may draw inferences from proven facts.

34. Having so directed myself, I find that at that final meeting, Mr Casey's frustration is likely to have flowed over as he again sought psychiatric assistance through the officer(s), stationed at the ground floor desk within Scarborough south.

35. It was in these circumstances that without reference to Mr Casey's IMP file, a telephone inquiry was made, or had earlier been made, which reasonably established a cause for belief that Mr Casey did not have a psychiatric appointment scheduled for that afternoon.

36. It is also relevant that at this time Scarborough south was operating at full or near full capacity and, particularly during unlock periods, was an extremely busy place where officers were forced to be constantly alert to threats to their own security as well as to similar threats, in regard to the outbreak of violence between prisoners.

37. I further find that unaware of his underlying illness and informed by the belief that an appointment had not been made, that an unknown officer or officer(s) then spoke to Mr Casey in a manner, which was intended to make him leave the area. [212]

38. Following that confrontation I find that a bewildered and compromised Mr Casey, left the desk area believing that his long awaited and promised appointment with a psychiatrist would not take place.[213]

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[212] All officers denied knowledge of a heated verbal exchange with Mr Casey as alleged by prisoner CV.

I note that the three officers scheduled to work at Scarborough South on March 28, were usually deployed elsewhere and were not caseworkers or backup caseworkers to any of the prisoners within that unit. It is also relevant that during their shift they did not always remain at or around the unit desk.

I also find that the Scarborough South shift schedules at the time, were not accurate (or reliable), as in the case of Officer 'S' and her unscheduled helping out within Scarborough South on 27 March, and the three rostered Scarborough South officers who were also called out to assist in an unscheduled search in another unit (pre-unlock), on the morning of 28 March.

It follows that the possibility of the unscheduled involvement of unidentified officers in the management of Scarborough South on the 28th , during the occasional absence of one or more of officers RT, GR and MS, cannot be excluded.

[213] Ms K M's hearsay evidence concerning the separate allegation made to her by Mr Casey on the 25th that an earlier appointment for him to see a psychiatrist had also been cancelled, may relate to his appointment to see Dr W on 19 March. However, on the available evidence I find the fact that that alleged failed appointment related to Dr W, has not been established. See the evidence of Nurse D at transcript page 972.

However having regard to the observations of Psychiatric Nurse D, supported by Ms K M, and fellow prisoners, concerning his declining mental state, and the multiple (proven) failed attempts to obtain a psychiatric/ psychologist consult,

[see the evidence of Ms K M telling Mr Casey that appointments for the 28/3 had been made for him to see a PRN and later herself, (transcript page 1123), and the evidence of Nurse D concerning the also failed attempts to have Mr Casey assessed by Dr W (19/3) and later Dr Rumsberg, (28/3)],

I am satisfied that by 3.15pm on the afternoon of the 28 March, Mr Casey may well have felt quite powerless concerning his wish to seek medical assistance.

Given that we know that the last made appointment had earlier been (correctly) communicated to Mr Casey only the previous day by a Prison Officer, officer 'S' then situated at the units same office desk, the subsequent failure of this last arrangement in particular, is likely to have considerably heightened Mr Casey's level of frustration and anguish.

39. Frustrated, and in a depressed mental state of undiagnosed cause, (and untreated), Mr Casey returned to his cell and, following the departure of former prisoner JS and in a manner consistent with earlier patterns of behaviour, he then began preparations to take his own life.

40. These preparations involved him in locking his cell door and using either a previously torn sheet or in tearing material from a fully intact sheet, and attaching one end of same securely to a horizontal drainage or heating pipe (which was easily accessible to him) on the rear wall.[214]

41. He then looped the remainder of the material length over the shower wall and tied it around his neck, while he remained standing. He then sat down, thereby intentionally causing his own death, this not long after 3.15pm.

COMMENTS AND RECOMMENDATION

Comment 1

The movement of Mr Casey through two prisons over a 35-day period with one significant incident of self-harm and the Unit 13 placement apart, without any particular protective response to his declining presentation, is troubling.

It is relevant that this took place during a period when Mr Casey was seeking to come to terms with his own earlier brutal conduct towards his partner, together with the perceived loss of the social privilege of family life with his children aged 5 and 7, and his withdrawal from a deep-rooted drug and alcohol dependence, and its consequences.

It is also the case that the different presentations recorded at MAP[215], as well as the deterioration later observed at PPP, reflected a deterioration in Mr Casey's mental state, which the authorities at both institutions failed to address.

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[214] See scene photographs at page 115 below. See also Exhibit 6 (c).

[215] See notes of Psychiatric Registrar Dr S T, Psychiatric Nurse T D, and the P1 rating recorded on the 7th and again on the 9th, by HRAT.

As above, I find that these errors occurred in MAP as a result of the overall failure of Forensicare staff to respond to the referral of Mr Casey, coupled with the failure of HRAT to sufficiently re-visit the matter of his condition, despite P1 indicators suggesting that his presentation was poor, and remained unresolved.

Over-riding these findings and of particular importance to Mr Casey, was the arrangement under which the DOC Sentencing Management Office, was able to effect his transfer out of MAP, this occurring with apparent little regard to his existing psychiatric presentation[216] and the design conditions at the Scarborough South reception unit, which the placement decision ultimately forced him to confront.

Later error also occurred within the PPP (because of the RRT's initial failure to respond adequately to conflicting reports about Mr Casey's presentation on admission, and because of administrative errors and cover-up, concerning his appointment schedule). Also relevant was a general failure by the RRT to monitor his progress and to ensure that Mr Casey was appropriately supported by staff employed for that purpose. Further the evidence does not suggest that he received other than negligible sleeping medication, after his arrival at MAP and anti depressant medication on March 3 following his consult with Dr S T, (who believed he would soon be reviewed by Dr A W).

In dealing with the prevention of suicide, treatment is as important as diagnosis.[217] If it was inappropriate to consider a restart of psycho-tropic medication as recommended in the plan prepared by Nurse N, I would have expected a comprehensive review from a member of St Vincent's health staff, setting out the reasons why the reintroduction of that medication was not appropriate.

I further observe that additional contributing difficulties (at PPP), were the weight of prisoner numbers within the reception unit over the relevant time, a badly flawed cell design and a non-application of the caseworker support system then supposedly in place.[218]

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[216] I refer here to the inadequacies in the care provided to that point and the rubber-stamping of his file as 'fit for transfer on file review', by an RN who was not qualified to make that assessment.

[217] Kerkhof and Blaaw Suicide in prisons and remand centres, Suicide Prevention, Oxford University press at 267.

[218] I do not know and make no findings as to whether under staffing or inadequate training also contributed to the seemingly difficult work place conditions, which confronted officers deployed within that unit on the day of Mr Casey's death. Recommendations 5 and 6 below refer.

Mr Casey deliberately ended his own life in the circumstances described above. In so finding I reject the notion that his final acts were in any way inevitable and I urge the State of Victoria and its agents to move towards, and to support and maintain adherence to best prison practice, concerning the provision of independent medical care and related services.

Melbourne Assessment Prison – Assessment Process

Recommendation 1

I recommend that a written discharge note be prepared in respect of all MAP prisoners earlier housed in either Unit 13 or the Acute Assessment Unit, for reasons connected to psychosis or suicide/self-harm. Such discharge note to be prepared by a Consultant Psychiatrist or a Psychiatric Registrar or a Psychiatric nurse as deemed appropriate by the Senior Consultant. Further, any psychiatric nurse prepared discharge notes should be reviewed and counter signed by the duty Psychiatric Registrar or above.[219]

Recommendation 2

In conjunction with recommendation 1) above I further recommend that discharge notes for prisoners released from the MAP who have during their present incarceration previously been held in either Unit 13 or the Acute Assessment Unit,

- are to be received and acknowledged as read prior to a MAP general prison population admission by,

  a) SASH Officers by reference to same in an amended SITUPS or like document.

  b) The Risk Review Committee, or equivalent at any other such receiving prison, with the documentation employed to record such deliberations, to be amended to include reference to the receipt and reading of, such a discharge summary.

Comment 2

[219] I have considered the responses of the various interested parties to the potential for use of discharge notices in this way. See also Dr A W's evidence at transcript page 1342;

I also note here that I consider it to be inappropriate for MAP psychiatric nursing staff to draft S and P mental health classifications for 'strategic reasons,' as I find Nurse T D did upon both Mr Casey's entry and discharge from MAP.

While appreciating his good intentions, I would instead advocate for nursing staff to at all times proceed to provide an accurate present P and S assessment, which is intended by all concerned to be relied upon by those seeking to best understand any particular prisoner's mental health history.[220]

Such assessments should be made based entirely upon clinical presentation and with only a secondary regard to the Department's stated goal, of moving prisoners on from the MAP within a set period following arrival.

Recommendation 3.

Having regard to this same issue, I further recommend a withdrawal of the stipulation presently found in the Reception Summary form[221], which suggests that a reference to a psychiatrist for psychiatric assessment or medication review should only be ordered in respect of prisoners classified as P1 or P2.[222]

Recommendation 4

I also recommend that the training of Forensicare psychiatric nursing staff should better instruct on this matter, and better emphasize the need to seek advice upwards concerning the position of a prisoner, who like Mr Casey, has a documented history of suicidal behaviour and who demonstrates a fluctuating mental state presentation.

Port Phillip Prison and Cell design

Comment 3

Appropriately, it has not been put in dispute that conditions at the Scarborough South Unit were at the time of Mr Casey's death, dangerous to prisoners undergoing serious ongoing suicidal ideation.

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[220] Such an appraisal should not be limited to 'here and now,' but should involve a reading and understanding of a prisoners history, insofar as same is relevant to a 'here and now' assessment.

[221] See Exhibit 9(d).

[222] See discussion above at footnote 38.

Following my view of the scene, I regret having to record that these same challenging conditions remain in place today and are properly reflected by the photographs taken by police investigators on the day of Mr Casey's death. For information, I include the relevant self-explanatory photographs below.[223]

(** All redacted from publication on the internet and not to be published in the media or like, under section 73(1) and (2) of the *Coroners Act 2008*, as directed by the Court on 21 September 2012).

It is of course the case and it is not in dispute, that the State and its agents have an ongoing responsibility to offer appropriate levels of protection to all persons incarcerated within Victoria, and that this duty applied equally to Mr Casey, this without any regard to his earlier demonstrated brutality.

Having reviewed the conditions as they continue to exist and having heard from Acting Assistant Commissioner, Corrections Victoria, Mr B M, of the Units design history and the similarity of other cells within the Unit, I note my view that there is clear evidence of what might be described as a serious lapse of judgement.

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[223] These photographs have been removed in the redacted version.

The lapse to which I refer stems from the decision of the Unit's architects, building managers and those who supervised them, to create a series of prison cells with piping intended to supply heating, placed within the cells and extending out from the rear wall and secured to the rear wall, all within easy reach of the inmates accommodated therein.[224]

This arrangement within a high security prison, providing at risk prisoners like Mr Casey with an ample number of suitable points from which a hanging material (also readily available), might be secured, is highly unsatisfactory and in my view is warranting of immediate and decisive action by the State of Victoria.

It is clear however that the task now facing correctional authorities is not straightforward.

Scarborough South was and remains now the primary reception unit at the PPP. Given the unsatisfactory design conditions and short of a substantial and no doubt costly renovation, which would necessitate the temporary closing of the unit to the reception/management of all prisoners, I can conceive of no way in which lethal attempts at suicide by at risk prisoners housed in Scarborough south, might now be prevented.

It is also relevant that most at risk prisoners are likely to face the greatest difficulty in adjustment during the early stages of any period of incarceration.

The underlining is mine.

Recommendation 5

In the circumstances, I therefore recommend,

a) That the Office of Correctional Services Review undertakes a comprehensive review of conditions at Scarborough south and other similarly designed units at the PPP, and advises the State of its findings and recommendations.

[224] See footnote 107.

b) That unless or until the State is able to introduce appropriate structural changes at Scarborough South,[225] that the Commissioner of Corrections directs that the housing of 'at risk prisoners' in all unrenovated cells at the PPP, be suspended indefinitely.

At risk prisoners, should include any prisoner who has previously been placed on and remained on, a P or S3 rating (or suicide watch) at MAP, or any other Victorian prison within the previous 21 days.[226]

If implemented this recommendation would help ensure as a minimum, that such prisoners would not be forced to face the challenges of residence at Scarborough South until they are at least three weeks past any period of a P or S3 rating, or above, during which, a time for adjustment to prison life would also have been served.[227]

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[225] I am informed and accept that necessary structural alterations were introduced to the Charlotte and St Pauls Units, following a 2000 recommendation by the then State Coroner, Graeme Johnstone.

To repair this existing condition all piping internal to cells would need to be removed and made non accessible by being either encased or made fully external to the units outside wall.

[226]. I have reviewed relevant studies, which deal with suicide committed in prisons. These studies have broadly supported the following conclusions.

- 'One of the consistent findings is a disproportionate number of suicides occur among remand prisoners and/or early in custody' and 'Just as outside, almost half of all prison suicides are found to have a history of self-injury or previous suicide attempts. A quarter, have injured themselves in custody before.'

Liebling, A 1993, Suicides in young prisoners: A summary, Death studies, 17:5, 381-407.

- 'The near-lethal suicide attempts often followed adverse life events, especially broken relationships or bereavement, criminal justice/prison-related factors e.g. anxieties about sentencing, and psychiatric or psychological factors e.g. drug/alcohol withdrawal, depression/anxiety and hearing voices'.

Rivlin A, Fazel S, Marzano L, & Hawton K, 2011. The suicidal process in male prisoners making near-lethal suicide attempts, Psychology, Crime & Law.

- 'The strongest risk factors were environmental, being in a single cell, psychiatric, a history of attempted suicide, recent suicidal ideation, and a current psychiatric diagnosis, and criminal history, being on remand, having received a life sentence, and having a violent index offence'

Fazel S, Grann M, Kling B, & Hawton K, 2011. Prison suicide in 12 countries: an ecological study of 861 suicides during 2003–2007Soc Psychiatry Psychiatric Epidemiol 46:191–195.

- 'Prisoners come into prison with major social disadvantages, which would in any event predispose to increased rates of mental illness and suicidal behaviour. These social disadvantages are exacerbated by the prison environment, which leads to an even higher level of problems.'

Jenkins R, Bhugra D, Meltzer, H et al, 2005. Psychiatric and social aspects of suicidal behaviour in prisons Psychological Medicine, 35, 257–269.

I am satisfied that at risk prisoners are likely to face the most difficulty in adjustment during the first three weeks of any incarceration

[227] (Where called for), the prescription of medication and the settling upon an appropriate level of any particular medication to achieve improved stability, will invariably take a longer period than three weeks.

Port Phillip Prison - Staffing and training at Scarborough South

Comment 4

The evidence of prison officers and prisoners concerning the events as they unfolded in Scarborough South on the day of Mr Casey's death and the evidence, as a whole, has raised the issue of staffing levels and the quality and regularity of staff training within PPP, at this time. These matters have been addressed to some extent at least by the evidence led by various interested parties, and have also been addressed in some of the evidentiary materials and submissions provided to me.

I find, however, that this material is insufficient to permit any useful conclusion. In the circumstances and having regard to my duties under Sections 7 and 72 (2) of the *Coroners Act 2008,* I recommend that the issue be picked up by the Office of Corrections Service Review (OCSR), which I consider is better equipped to fact find in this area.

Recommendation 6

I recommend therefore that the OCSR consider staffing arrangements at the Scarborough South Unit, with a view to determining whether staffing levels permit prison officers the opportunity to undertake their duty of care to prisoners, to an appropriate level. I make this recommendation despite the fact that current staffing levels have received the approval of the APOA.

Recommendation 7

I further recommend that the OCSR undertake a review of Exhibits 14(c), 32(d) and (e), and other G4S materials relevant to training reference 'at risk' prisoners, as required, (to include training and update training records), to seek to ensure that both training and training updates are being carried out in a timely way with appropriate course content, having particular regard to the need for all PPP Prison Officers and RRT Staff to fully comprehend,

a) The role of the caseworker and backup caseworker;

Notwithstanding adjustment across these several areas following the last P or S3 rating, (and prior to admission to a Scarborough south like cell), should result in a greatly improved level of protection being afforded to those previously at risk.

It is also likely to lead to an overall improvement in the ability of prison officers to undertake their management task, and the quality of the results they are able to achieve.

b) The purpose and ambit of 'meaningful conversations', in regard to a prisoner on observation watch and the recording of that matter;

c) First principle identification of SASH risk issues, as set out in training manual Exhibit ; and

d) The importance of proper minute taking in all RRT meetings, which minutes should fully reflect any division in views, which may occur at any such review meeting.[228]

Port Phillip Prison - St Vincent's Corrections Health Service, and the existing process, undertaken by the RRT, before downgrading S and P Assessments .

Comment 5

I note here that under newly introduced arrangements St Vincent's Health continues to provide clinical health care to prisoners held at PPP. This work now includes clinical input into the grading of patients suicide ratings within the PPP. The present arrangements are broadly the same as those they replace except that St Vincent's Health personnel are now engaged in psychiatric and suicide risk evaluation, and as clinically trained psychiatric nurses are therefore better equipped to undertake what is a critically important clinical assessment.[229]

Broadly, these arrangements are set out in exhibit 32 C and 32 (e). and G4S Operational Instruction No 107, "At Risk Prisoners" which instruction was in place in March 2008 and remains so today.

Instruction 107. 12 .1 provides,

- that the RRT will coordinate the management of 'at risk' prisoners and review the plan at regular intervals and make changes to the plan where required;
- that the RRT will determine any change in a prisoners risk status;
- that 'at risk' patients managed by the RRT will typically need to step down through all lower levels of suicide risk status, before removing a prisoner's at risk status.

[228] See page 71 finding 24 above.

[229] See further discussion from page 86 below.

The Department of Justice[230] submission to the Court submits that there is a need to amend these practises, in the following manner,

'When a downgrade of a suicide rating is being contemplated, there is to be,

a) a period of at least 24 hours between each downgrade,

And in addition,

b) that each downgrade is supported by a formal risk assessment by an appropriately qualified mental health professional

c) that each downgrade is supported by the RRT prior to the S rating being changed and;

d) that upon reception at another prison location where a prisoner is on an active S rating (S1, S2 or S3) the prisoner must not be down graded without a formal risk assessment as in b) above with the decision to reduce the rating later endorsed by the RRT.'

I have now had the opportunity to consider the arguments made by both parties with the DOJ submission opposed by St Vincent's Health, which remains in favour of no change to the existing policy. I note here that that policy as it applied in Mr Casey's case (and now), is premised on the principle that ultimate responsibility for assessment and downgrading should remain with the RRT.

As suggested above in my consideration of the relevant risk review process at the MAP and the PPP, it is in my view very important that the responsible authorities at all levels recognize that the analysis and treatment planning for prisoners in Victoria who suffer from mental illness which is connected to a history of drug abuse, indicates a medical rather than an administrative problem.[231]

Allowing for this premise, I suggest that the recent decision by the Department of Justice, through Corrections Victoria and Justice Health, to effect change in regard to the downgrading of the involvement of non clinically accredited psychologists, in suicide risk assessment, is a significant step in the right direction.

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[230] See DOJ, Justice Health, OCSR and Corrections Victoria submission, undated.

[231] The same conceptual view may be seen to equally apply to the discussion above concerning the appropriateness of generally trained rather than clinically trained psychologists, undertaking any role in the area of suicide risk review and mental state analysis.

I am also mindful of the likelihood that the involvement of non clinically accredited psychologists and prison officers in risk analysis review on the RRT, has over many years, given those officers (as well as those who work around the RRT), a confidence in their own collective clinical skill and experience.

I would respectfully offer my view that such a confidence, if it does exist, is misplaced.

Instead, it remains the case that these officers (and psychologists) have an important and continuing role to play in reflecting a collective impression of their prison officer/counselling colleague's observations of any particular individual prisoner, and through that knowledge a role to play, in auditing decisions which are made by properly qualified and certified clinicians. That role being to support or oppose the downgrade of a particular risk assessment (recommended by a St Vincent's Health clinician).

In short, that is where their expertise lie and that is how that expertise should be utilized.

Recommendation 8

Having regard then to Counsels submissions and to the above discussion, and to help best ensure that these roles are understood especially by those who will continue to work on the RRT, I recommend that the suggestions made in the DOJ submission outlined above, be formally adopted by the Governor of Corrections Victoria and be included within an amended G4S Operational instruction 107.

Recommendation 9

To avoid doubt on the matter of ordering, I further recommend that a full clinical review, the observations and findings of which are recorded on a properly developed risk assessment tool, should be sought prior to presentation of the particular matter to the RRT or like, and that any recommendation should not go before the RRT unless or until the analysis document tool, recommends with cause, a downgrade of the relevant classification.

Recommendation 10

Instruction 107 should also be amended to reflect this ordering.

Port Phillip Prison – 'At Risk' Prisoner medication

Comment 6

Under existing arrangements, (also in place at the time of Mr Casey's admission), a prisoner is not permitted access to ongoing drug substitution medication, unless it can be established that he was using the programme in the community in the 14-day period immediately prior to his admission.

Failing this pre-condition, it is then necessary for the prisoner to join the rest of the prison community who may be waiting for admission to a programme at any point in time.

However, when dependence and the need for a programme to support is medically established, further delay in admission to that programme is problematic.

In my view this approach can result in long-term abusers, who like Mr Casey have previously participated in a community based programme, but who have then relapsed into the abuse of illicit substances (in Mr Casey's case some three weeks before his arrest), having to face an unnecessarily lengthy delay in their access to needed prescribed medication support.

It is also the case as suggested by Dr Ong and others, that this is most likely to occur during periods when a prisoner's efforts to deal with personal and emotional crises, are likely to be their most challenging.

A poor result for the prisoner's emotional wellbeing serves no good purpose and in fact can only work against the interests of the prisoner, and his effective management.

Recommendation 11.

This is a complex matter and it is relevant to report that all Australian states and territories maintain a similar approach to the one described above. It is also the case that mental illness and drug dependency and dependency withdrawal treatment are in many presentations, inter related conditions, with the symptoms of each difficult to differentiate, (and difficult to address). I am satisfied however that there is potential for a great improvement in both prisoner care and prison management, if hard and fast rules can be made more flexible allowing in appropriate cases, for the need for an early intervention to be identified.

Accordingly, I recommend that Pacific Shores Pty Ltd and St Vincent's Corrections Health Service, in consultation with the Commissioner of Corrections and G4S, develop protocols, which recognize that the provision of appropriate drug substitution medication within PPP, is a medical rather than

an administrative issue. Further, such protocols should be developed with a firm steadfastness to the ideals concerning a healer's duty to a patient, to be the driver of decision making in this area.

Under such an approach, I would expect that with the assistance of nursing staff, the duty medical officer would henceforward seek to corroborate any prisoner claims about his relevant drug history.

A medical review, such as that recommended in this instance by Dr Ong, should then be undertaken with a view to making an informed medical decision about the need to prescribe and the timing of commencement of delivery, to meet any particular presentation. [232]

Further such a review should (where a best practise medical need is so indicated) result in the prisoner being given timely access to the appropriate medication as a response to his presentation, and without regard to a waiting list which may or may not exist, for any particular 'programme', at that time.

General -Clinical Psychologists in MAP and PPP.

Comment 9

This investigation has also detailed the widespread practise of allowing psychologists, who are qualified and entitled to registration to practise generally, to undertake the task of suicide risk and sometimes mental state evaluation and then provide advice on appropriate S and sometimes P ratings, based upon those evaluations. [233]

I note that this practice occurred in respect of interviews with Mr Casey, undertaken by psychologists at MAP and PPP (reference S ratings only) and, in each instance, that the clinical

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[232] The introduction of anti-depressant or anti-psychotic medication is of course also a medical psychiatric issue.

General practitioners contemplating the re-introduction of for instance methadone, would need to first establish that there was no underlying mental illness, or related medication use, which might be compromised by the re- introduction of a methadone or like medication. It is self evident that this should not occur absent consultation and the receipt of an opinion from the appropriate specialist, treating staff.

Dr Blaher testified that the use of liquid methadone is easier to manage in a prison setting, than the use of buprenorphine, because of the difficulty in controlling the diversion of the latter, which comes in powder form as opposed to liquid in a methadone bottle, all of which must be consumed in the presence of a prison officer. See transcript page 875.

[233] See earlier reference to this matter under MAP and PPP headings above.

assessments then made were critical to subsequent HRAT and RRT decisions to downgrade the ratings then applicable to him.

In her testimony psychologist Dr M A acknowledged the perceived existence of training and qualification issues, as well as the potential tension between the clinical branch of psychology and the other branches of that discipline (counselling being one such possibility) with which she with her colleagues, had engaged with Mr Casey in the course of their general practice.[234]

Notwithstanding, Dr M A also sought to justify the clinical aspects of that multi-faceted involvement with Mr Casey, this based upon her training in clinical psychology and her wide prison experience obtained over a career employed within the prison system.

Having now reviewed all of that evidence, together with relevant submissions from the DOJ and the witnesses concerned, I find myself in disagreement with the positions taken by Dr M A (and Ms K M) on this matter, which approach was of course previously established and maintained by those authorities (Government and non-Government) responsible for the administration of both MAP and PPP.

Recommendation 12

In the circumstances, I recommend that henceforward only those psychologists, who obtain endorsement as clinical psychologists from the Psychology Board of Australia, be permitted to undertake such suicide risk assessment evaluations in MAP and PPP.[235] I note with approval that both MAP and PPP, with the support of Corrections Victoria and Justice Health have, in fact, recently downgraded the risk assessment role being undertaken by staff, who are not appropriately endorsed. This, in favour of clinically trained staff employed by Forensicare and St Vincent's Health, respectively.[236]

Recommendation 13

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[234] See Courts discussion with MAP psychologist Dr M A at transcript page 703.

[235] That is not to say that the contribution of non clinically psychologists to HRAT/RRT meetings should cease. Rather the work undertaken by psychologists in the counselling of prisoners at MAP and PPP would continue to assist HRAT/RRT meetings in the 'auditing' of risk review recommendations prepared and presented to such meetings by legally qualified clinical staff.

[236] See the evidence of Brenda Dolieslanger referred to above.

To further support this Department of Justice initiative, I recommend that the Commissioner of Corrections Victoria amend the existing Directive, to reflect this change of approach.

Recommendation 14

I also recommend that both Corrections Victoria and Justice Health henceforward seek to ensure that only those persons who have applied for and received clinical psychologist Board endorsement, are contracted to undertake this specific aspect of the work of psychologists, within Victorian prisons.

General – The Office of the Chief Psychiatrist

Recommendation 15

Finally, I note that the Office of the Chief Psychiatrist has a clinical review programme which is part of its Quality Assurance Committee, and that its jurisdiction extends to Victorian prisons.[237]

In the circumstances, I recommend that medically qualified specialist staff, under the auspices of the Chief Psychiatrist, be invited by the Corrections Commissioner to undertake periodic prison visits to both MAP and PPP. Such a course to be undertaken to further support the State's objective that at risk prisoners accommodated within both MAP and PPP, are being provided with appropriate ongoing mental health support.

CONCLUSION

I take this opportunity to thank the witnesses who appeared at inquest including Mrs Patricia Casey, the Informant Detective Senior Constable David Wolfe, as well as those interested parties who made submissions.

I also wish to thank Counsel, the Coroners assistant Senior Sergeant David Dimsey, and those engaged in instructing.

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[237] Mental health services provided within Victorian prisons are 'approved mental health services' under the *Mental Health Act 1986.*

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

Mrs Patricia Casey

The Office of the Premier

The Office of the Attorney-General

The Minister for Police and Corrections

The Secretary of the Department of Justice

The Commissioner for Corrections Victoria

The Chief Commissioner for Police

The Chief Executive Justice Health

The Chief Executive of the Prison Sentencing Management Unit

The Chief Psychiatrist, Dr R Vines

The Chief Executive of the Melbourne Assessment Prison

The Chief Executive of Forensicare

Mr D Roach, the Chief Executive of G4

The Chief Executive of the Port Phillip Prison

The Chief Executive of St Vincent's Health

The Chief Executive of Southern Shores Pty Ltd

The Chief Executive of the Australian Psychology Society

The Chief Executive Australian Prison Officers Association

Dr S T

Dr A W

Dr M A

Psychiatric Nurse Mr T D

Mrs M

Dr W

Mr B C

Psychiatric Nurse Mr N

Psychologist Ms K M

Psychiatric Nurse Mr D D

Ms M Gardiner

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

Signature:

PETER WHITE
CORONER
Date: 21 September 2012