IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 3868

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Matthew Aaron CONDIE

Delivered On:	30 January 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	Directions: 10 August 2009 Adjournment/Directions: 12 October 2009 Inquest: 21, 22, 23, 24 and 25 June, 6, 7, 8 and 9 September, 9 and 10 December 2010 Submissions: 9 September 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr D. F. HORE-LACY S.C with Ms N. KARAPANAGIOTIDIS and Mr B. KIELY, appeared on behalf of the relatives of the deceased. Mr D. MASEL with Ms N. HODGSON, appeared on behalf of the Department of Justice (Corrections and Justice Health). Mr R. D. SHEPHERD, appeared on behalf of G4S Pty. Ltd. (Port Phillip Prison). Mr J. E. GOETZ, appeared on behalf of St. Vincent's Correctional Health Service (St Vincent's Health) Mr D. J. BRACKEN, appeared on behalf of Forensicare (Victorian Institute of Forensic Health)
Police Coronial Support Unit	Sergeant David DIMSEY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of MATTHEW AARON CONDIE

and having held an inquest in relation to this death at Melbourne

on 21, 22, 23, 24 and 25 June 2010, 6, 7, 8, and 9 September 2010, 9 and 10 December 2010 and 9 September 2011:

find that the identity of the deceased was MATTHEW AARON CONDIE

born on 30 October 1985, aged 21

and that the death occurred between 27 and 28 September 2007

in Charlotte Unit, Port Phillip Prison, Doherty's Road, Truganina, Victoria 3029

from:

1 (a) UPPER AIRWAY OBSTRUCTION AND PLASTIC BAG ASPHYXIA

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Matthew Aaron Condie (Mr Condie) was a 21 year old man who died while serving a sentence of imprisonment at Port Phillip Prison. He is survived by his father, Ronald Condie, his mother, Sheryl Lakey, and a younger brother.

2. Mr Condie spent the first seven years of his life living with his family in Camperdown, before moving to King Island where he attended the local primary school and the first two years of secondary school. According to his father, Mr Condie had a happy childhood on King Island, was a good sportsman and an average student. When Mr Condie was about 12, his parents relationship broke down and, two years later, he and his brother returned to the Camperdown area with their mother. About one year later, Mr Condie left school and found it difficult to hold done a job.[1]

3. Mr Condie started abusing using illicit substances in his early teens and by the age of 15 used drugs regularly, cannabis and amphetamines in particular. Not surprisingly, Mr Condie started coming to the attention of the police, primarily for offences of dishonesty,

[1] Statement of Mr Ronald Condie dated June 2010 at pages 1572 and following of the inquest brief.

believed to arise from the need to fund his drug use. According to his father, he also offended under peer pressure. Mr Condie appeared before the Children's Court on several occasions and was sentenced, inter alia, to multiple periods of detention in Youth Training Centres. As he continued to offend after he turned 18, Mr Condie was prosecuted as an adult, with some ten sets of charges heard between 2003 and 2005, culminating with a significant sentence of imprisonment that he was serving at the time of his death [2]

4. At about the same time as he started using illicit substances, Mr Condie also started to experience psychiatric illness. Not surprisingly, Mr Condie's first involuntary admission to a psychiatric facility was at the age of 15 when he was diagnosed with drug-induced psychosis. As will be discussed below, Mr Condie's psychiatric illness proved a diagnostic quandary, and he was variously diagnosed with drug-induced psychosis, schizophrenia, anti-social personality disorder and other diagnoses.

5. Whatever the correct diagnosis or diagnoses, deliberate self-harm and suicidal thoughts or utterances were a feature of Mr Condie's psychiatric illness, as was a reluctance, and at times blanket refusal, to take psychoactive prescription medications, and a preparedness to use illicit substances or medications not prescribed for him, while in custody.

MR CONDIE'S LAST PERIOD OF INCARCERATION

6. On 8 July 2005, Mr Condie met up with three other young men in the Camperdown area and started drinking alcohol for some hours before deciding to "bash up" someone known to one of them (but apparently not Mr Condie). What ensued was described by the sentencing judge as an unrelenting, brutal and cowardly attack on the victim, involving sustained punching kicking and beating to the head and body and the administration of electric shocks. Towards the end of the attack, Mr Condie delivered two blows with a double-sided axe to the back of the victim's leg and his upper arm.

7. Ultimately, Mr Condie pleaded guilty, and received a total effective sentence of 12 years' imprisonment with a minimum of eight years to be served before eligibility for parole,

[2] "Office of Correctional Services Review Report" at pages 140-175 of the inquest brief, especially "Offending History" at page 150-151.

with recognition of 429 days pre-sentence detention.[3] It was part of Mr Condie's plea that he was affected by alcohol, amphetamines in the form of "ice" and "magic mushrooms," at the time of the offences. Mr Condie appealed against the severity of his sentence and a decision was still pending at the time of his death.[4]

8. Mr Condie's last period of incarceration commenced when he was taken into custody in respect of these offences on 20 July 2005. Apart from his initial reception into the Melbourne Assessment Prison (MAP), and periods spent in the Acute Assessment Unit (AAU) at MAP, Mr Condie served most of his pre-sentence detention and sentence at Port Phillip Prison (PPP).[5]

9. At 21, Mr Condie was still a relatively young man in the adult prison population, serving a significant sentence of imprisonment. He posed challenges in terms of his placement at PPP, as he could be vulnerable in some settings and a threat to other prisoners in others.[6] With little, if any, appreciable success, in this custodial setting, treating clinicians grappled with the nature and extent of Mr Condie's psychiatric illness, his substance abuse issues and behavioural issues.

CHARLOTTE UNIT, PORT PHILLIP PRISON, 26-28 SEPTEMBER 2007

10. For reasons that will be discussed in some detail below,[7] on 26 September 2007, Mr Condie was transferred from the Sirius East Unit (via St Paul's and St John's Units) to Charlotte Unit, a management unit at PPP. Although Mr Condie was not serving a period of loss of privileges, and was "separated" to the Charlotte Unit pending investigation of

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[3] Sentencing remarks of His Honour Judge Ross, County Court, 7 September 2006 at pages 777-797 of the inquest brief. The presentment contained five counts – aggravated burglary, threat to kill, false imprisonment and two counts intentionally cause serious injury relating to the two blows struck with the double-sided axe.

[4] There is evidence before me that Matthew was anxious about the outcome of the appeal, aware of a risk that the sentence could be increased an vacillating between being optimistic or concerned about the outcome. See evidence of Dr ET, Ms JB and Dr Lester.

[5] A convenient "Chronology of Movements" at page 798 of the inquest brief, shows Matthew's movements within the correctional system on a timeline. Some 17.5 months of a total of 26 months (from 20 July 2005) was served at PPP. See also "Placement History" in the OCSR report pages 11-20, appearing at pages 151-160 of the inquest brief.

[6] Ibid OCSR report citation.

[7] See paragraphs 61 and following below.

his expressed concerns for his safety, he was placed in a single occupant cell in the Exclusion Placement Area (EPA) of the unit, known as "the spine".[8]

11. At about 6.15am on 28 September 2007, Correctional Officers SK and GB were in the process of conducting a morning "trap muster"[9] of all prisoners in Charlotte Unit to ensure that they were safe and well. When Mr Condie failed to respond to their calls, they called control to open Mr Condie's cell door and entered to find him face down on his mattress with a bed-sheet, pillowcase and plastic bag over his head. CO SK called a Code Pink over the radio system, signifying that immediate medical assistance was required, before leaving to retrieve a knife in order to free Mr Condie from the ligature around his face.[10]

12. Nursing and medical staff attended a short time later. They made no attempts to resuscitate Mr Condie as it was apparent that he had been dead for some time.

INVESTIGATION – SOURCES OF EVIDENCE

13. This finding is based on the totality of the material the product of the coronial investigation of Matthew Condie's death. That is the brief of evidence compiled by Sergeant Mark Guthrie, from Werribee Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[11] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

14. Included in the inquest brief, and of particular note, were the outcomes of three previous reviews of Mr Condie's death – a "Report into a Death in Custody" conducted by the

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[8] See paragraphs 79 below for a description of the usual regime in the spine/Charlotte Unit at PPP.

[9] The process is described in the inquest brief in the following terms – Correctional officers go to each cell, open the trap door on the front of the cell door and get the prisoner to walk up to the trap, place their hands on the trap and give a verbal response so they can do a count and make sure all prisoners are safe and well.

[10] Exhibit A, statement of Mr SK dated 28 September 2007 at pages 15-18 of the inquest brief. Exhibit E, statement of Mr GB dated 28 September 2007.

[11] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

Office of Correctional Services Review (OCSR) dated 29 July 2009,[12] "The Justice Health Review into a Death in Custody", undated, conducted by Justice Health[13] and an "Internal Management Review-Death in Custody" conducted by Port Phillip Prison on 18 October 2007.[14] While the approaches taken, the conclusions reached and the recommendations made reflect the remit of the respective reviewers and are not on all fours with a coronial investigation, there is an area of overlap that should be acknowledged.[15]

15. Also of assistance is a document entitled "Chronology of Mr Condie's Management at Port Phillip Prison which was drafted by my assistant Sgt Dimsey, and settled after consultation with Counsel. That chronology is incorporated by reference and largely obviates the need to repeat its contents.

PURPOSE OF A CORONIAL INVESTIGATION

16. Generally, apart from a jurisdictional nexus with the State of Victoria,[16] reportable deaths are those that appear to have been *unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.*[17] However, some deaths are reportable, irrespective of the cause of death, based entirely on the status of the deceased. For example, the death of a person who immediately before death was *a person placed in custody or care*, which includes serving prisoners like Mr Condie.[18]

17. Moreoever, in such cases, the coronial investigation must include an inquest which is a court hearing generally held in open court, or "mandatory inquest". The evident intention of the legislation is to recognise the vulnerability of people placed in the care or custody of the State or its instruments, and to accord to prisoners in particular, the protection afforded

[12] See pages 140-175 of the inquest brief. Although dated 29 July 2009, the "version control" information at page 174 suggests that it was finalised 4 August 2009, with final input from Justice Health.

[13] See pages 176-193 of the inquest brief. Although undated, this report was an attachment to the OCSR report and was presumably in existence as at 29 July 2009/4 August 2009.

[14] See pages 877-890 of the inquest brief.

[15] I note that section 7 of the ***Coroners Act 2008*** indicates that *"It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officer – (a) to avoid unnecessary duplication of inquiries and investigations; and (b) to expedite the investigation of deaths and fires."* All references to legislation that follow pertain to this Act, unless otherwise stipulated.

[16] Section 4(1) of the ***Coroners Act 2008*** provides that a death is reportable if the body is in Victoria, the death occurred in Victoria, the cause of death occurred in Victoria or the person ordinarily resided in Victoria at the time of death.

[17] Section 4(2)(a).

[18] Section 4(2)(c) and section 3 definition of "a person placed in custody or care".

by independent scrutiny of the circumstances in which they died, and to promote accountability on the part of the State or its instruments.[19]

18. The purpose of any coronial investigation of a *reportable death*[20] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[21] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[22]

19. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[23]

20. Coroners are also empowered to report to the Attorney-General in relation to a death they have investigated; to comment on any matter connected with the death, including matters of public health or safety, and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death,

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[19] Whereas a coroner has a discretion to hold an inquest into any death they are investigating, (other than in circumstances that are irrelevant for present purposes), a coroner *must* hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased was immediately before death, a person placed in custody or care. See section 52

[20] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[21] Section 67(1).

[22] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[23] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

including public health or safety or the administration of justice.[24] These are, effectively, the vehicles by which the prevention role may be advanced.[25]

21. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[26]

FINDINGS AS TO UNCONTENTIOUS MATTERS

22. In relation to Matthew Condie's death, many of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Matthew Aaron Condie born on 30 October 1985, aged 21, died between 27-28 September 2007, in Charlotte Unit, Port Phillip Prison, Dohertys Road, Truganina, Victoria 3029.

23. Furthermore, the inquest proceeded on the basis that Mr Condie's death was an act of suicide in that Matthew was alone and no other party was involved in his death, at least directly. That is, it was accepted, and I find, that Mr Condie intentionally took his own life, and/or died as a result of an act of deliberate self-harm. While the evidence does not ultimately support a finding as to when and why he formed this intent, in my view the lethality of means speaks unambiguously to his intent. Again, while difficult to determine with any certainty, the possibility that Mr Condie was suffering from a psychotic illness or experiencing command hallucinations, at the time he took his own life, remains open.

THE MEDICAL CAUSE OF DEATH

24. Nor was the medical cause of death contentious. At about 9.00am on 28 September 2007, Senior Forensic Pathologist Dr Malcolm Dodd, from the Victorian Institute of Forensic Medicine (VIFM), attended the scene together with (then) State Coroner Graeme Johnston

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[24] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[25] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[26] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.* See sections 69(2) and 49 (1).

when Mr Condie's body was still in situ. Although Mr Condie was lying supine on a mattress on the floor, Dr Dodd was informed that he had been found in the prone position and had been rolled onto his back for initial examination. He found that rigor was established with diffuse and patterned lividity involving the entire anterior surface of the body, consistent with death having occurred in the prone position.[27]

25. Later that day, Dr Dodd performed a full post-mortem examination or autopsy on Mr Condie's body at VIFM and provided a written report of his findings.[28] Dr Dodd made incidental findings of histological evidence of asthma and hepatitis, but advised that there was no evidence of significant natural disease or traumatic injury, that is such as might have caused or contributed to death. He advised that the immediate cause of death is upper airway obstruction and plastic bag asphyxia.

26. In a subsequent supplementary report written in response to questions posed by Mr Condie's family, Dr Dodd explained that on attendance at the scene, the plastic bag and pillow-case were next to Mr Condie's body. However, the ligature fashioned from a torn length of green cloth and applied around his face, was knotted at one end, and remained in situ. It was applied across and into the mouth at a point above the lower teeth and under the tongue, causing inferior angulation of the corners of the mouth and upward displacement of the tongue such that the upper airway adhered occluded. Dr Dodd advised that while the ligature would have elevated the tongue to partially obscure the upper airway, the *most leading cause of death…is almost certainly one of plastic bag asphyxia.*[29]

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[27] Dr Dodd also noted *a clearly demarcated imprint of the right hand, represented as pallor, is located over the lower anterior chest/upper abdominal area.* See page 4 of the autopsy report at page 4 of the inquest brief. This is consistent with Mr Condie dying in the prone position (ie on his stomach) with his right hand underneath him across his lower chest/upper abdomen.

[28] Dr Dodd's eleven page autopsy report is at pages 1-11 of the coronial brief and includes his formal qualifications and experience.

[29] See pages 3 and 10 of the autopsy report at pages 3 and 10 of the inquest brief. In a supplementary report provided in response to a letter received from the family, Dr Dodd made the following additional comments – *Plastic bag asphyxia is a commonly identified event in usual forensic practice with each pathologist at the Institute [VIFM] probably encountering four or five cases in an average year. Death is often quite rapid with little or no signs of conventional asphyxia identified on external examination. Gagging, vomiting and noisy breathing may not necessarily be encountered in all cases. If irregular breathing, gasping or perhaps choking were caused by the plastic bag over the head and cloth under the tongue, these sounds may not necessarily heard by the attending guards."* See page 14.2 of the inquest brief.

27. Significantly, in light of Mr Condie's reluctance to take prescription medications and history of taking illicit substances even while incarcerated, routine toxicological analysis of post-mortem samples revealed no ethanol/alcohol or other common drugs or poisons.[30]

28. Based on the advice of Dr Dodd, I find that the cause of Matthew Condie's death is *upper airway obstruction and plastic bag asphyxia.*

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

29. In common with many coronial investigations, the focus of the coronial investigation of Mr Condie's death was on the circumstances in which he died. At its broadest, the focus was on the adequacy of the clinical management and care provided to him during his last period of incarceration. Also speaking broadly, there was no serious suggestion that, during his last period of incarceration, Mr Condie did not have access to timely and reasonable medical management, nursing care, psychiatric treatment and therapeutic services for a range of ailments on an as needs basis.[31]

30. The more specific focus of the coronial investigation was on the management of Mr Condie's psychiatric illness and the risk of self-harm and suicide, proximate to his death. Albeit somewhat arbitrary, my focus was on the three month period immediately preceding his death, with particular emphasis on events from the afternoon of 25 September 2007 until his death overnight on 27-28 September 2007.

31. From the family's perspective, during this period and the latter period in particular, there was a systemic failure to recognise or properly evaluate Mr Condie's risk of self-harm or suicide, and a failure to minimise this risk and keep him safe, given what was known or should have been known about him.[32]

CUSTODIAL SETTING & RELEVANT ENTITIES

32. In defining the focus of the inquest by reference to time and subject matter, I do not disregard the fundamental significance of the context or setting in which Mr Condie died.

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[30] Pages 12-13 of the inquest brief.

[31] Even a cursory perusal of the medical records supports a finding along these lines. See also the OCSR report and the Justice Health review at pages 140-175 and 176-193 of the inquest brief respectively.

[32] This is an over-simplification, sufficient for present purposes as the crux of the family's position.

To the extent that the setting is custodial or punitive, it gives rise to a tension between the need for orderly management of PPP and the needs of a vulnerable, complex and relatively young prisoner such as Mr Condie, irrespective of any diagnosed psychiatric illness or disorder.

33. It is also a setting in which a number of institutions or entities co-existed, where power over prisoners, and responsibility for their welfare is shared, to use a positive term, and/or fragmented, to imply a negative. Inherent in shared or fragmented service delivery is the potential for information to be lost or simply unavailable, and for decision-making, such as the assessment of a prisoner's risk of self-harm or suicide, to be commensurately impoverished.

34. At the material time, Corrections Victoria (Corrections) supervised the Victorian prison system, encompassing both publicly run and privately run prisons. Until July 2007, Corrections was also responsible for monitoring performance of and imposing standards on health care service providers, and where necessary, amending those standards. From July 2007 this role devolved to Justice Health, a newly established business unit of the Department of Justice.[33]

35. Then and now, Port Phillip Prison (PPP) was operated by G4S Australia Pty Ltd (G4S) under contract to the State of Victoria. As part of its Therapeutic Services, G4S employed psychologists to assist in the training of correctional officers about the suicide and self-harm risk of prisoners (SASH), and to provide psychological counselling to prisoners at PPP.

36. General medical and psychiatric services at PPP were provided by St Vincent's Correctional Health Service (St Vincent's, part of St Vincent's Health).[34] In relation to Mr Condie, health care was also provided at the MAP by Pacific Shores Health Care Pty Ltd, which provided medical services, other than psychiatric and psychological services,

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[33] According to "The Justice Health Review into a Death in Custody " at page 176 of the inquest brief "The business unit of Justice Health was established in July 2007 to consolidate the health functions previously provided in collaboration between Corrections Victoria and the Prisoner Healthcare Unit, Department of Human Services. The establishment of Justice Health will ensure the provision of quality and streamlined services with a centralised Governance Model."

[34] Conveniently summarised in the final submissions of Mr Masel and Ms Hodgson for the Department of Justice dated 4 August 2011.

Forensicare Pty Ltd which provided psychiatric services and the Clinical Services Unit of Corrections which provided psychologists.

ACUTE ASSESSMENT UNIT, MELBOURNE ASSESSMENT PRISON 3 JULY-11 SEPT 2007

37. In the early hours of 28 June 2007 Mr Condie was taken by ambulance from PPP to St Vincent's Hospital. He had initially complained of chest pain but later disclosed that he had cut his penis with a razor blade. After his wound was dressed, Mr Condie returned to PPP. When questioned, he maintained that he had not wished to die.

38. This self-harm incident prompted review of Mr Condie by Dr MC, a psychiatric registrar from St Vincent's at PPP. Dr MC considered Mr Condie's past diagnoses and documented his impression that he suffered from antisocial personality disorder, Cluster B/borderline adjustment disorder, poly-substance abuse disorder and previous drug-induced psychosis. Differential diagnoses noted were mild low-grade schizophrenia or current psychotic relapse. After a short period of observation and discussion with a consultant psychiatrist, Mr Condie was transferred to the AAU at the MAP for further assessment.[35]

39. Mr Condie was placed at the AAU from 3 July 2007 until 11 September 2007[36] to facilitate assessment by Forensicare staff with a view to clarifying his diagnosis or diagnoses and initiating treatment. During this two-month placement, clinical staff observed Mr Condie, assessed his mental state daily and made detailed notes in the medical records as appropriate. This is likely to have been the longest and most concerted effort ever made to assess Mr Condie's mental state and arrive at a definitive diagnosis.[37]

40. Dr Grant Lester is a Consultant Psychiatrist employed by Forensicare since 1999, and at the AAU from August 2006 until December 2007. Dr Lester reviewed Mr Condie personally during his admission, and also reviewed the medical records as a whole before

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[35] Exhibit K, statement of Dr ET at pages 38-50 of the inquest brief. See also OCSR report and Justice Health review at pages 158-159 and 181 of the inquest brief respectively.

[36] I note that Mr Condie was placed in a "Muirhead observation cell" at the MAP from 3-5 July 2007 when he was actually placed in the AAU. He remained in the AAU until his return to PPP on 11 September 2007, apart from about 12 days spent in a management unit at the MAP from mid-August due to his disclosure of a "shiv" and threats of violence to co-prisoners.

[37] The medical records/progress notes are summarised in the Justice Health review at pages 181-187 of the inquest brief. They are also summarised (and more accessible) in Exhibit AA, Dr Grant Lester's statement dated 20 August 2010.

compiling his statement for the inquest. At first review, Dr Lester provisionally diagnosed treatment resistant psychosis with a differential diagnosis of anti-social and borderline personality traits.[38]

41. According to Dr Lester, significant features of Mr Condie's admission to the AAU were a discordance between his reported experience of auditory hallucinations, especially at night, and his observed behaviour, a clinical suspicion that he was feigning and/or exaggerating psychotic symptoms and psychological testing suggesting that this was so, poor compliance with prescribed medication (Clozapine),[39] seeking drugs of his preference (sedatives/benzodiazpines), threats of violence toward co-prisoners, limited engagement with therapeutic interventions, and occasional inappropriate behaviour towards female staff.[40]

42. Also significant, given the circumstances in which he died, was the observation made at the AAU that Mr Condie responded badly to isolation becoming angry, surly, threatening and withdrawn when he was removed from the AAU temporarily and placed in an isolation cell at the MAP, after making threats of violence to co-prisoners.[41]

43. Conversely, although Mr Condie displayed some lability of mood, he was generally relaxed in the AAU and sociable with co-prisoners, maintained his cell in an exemplary manner, generally slept well overnight even without sedatives or hypnotics, displayed no evidence of disorganised behaviour or thought disorder, no evidence of sustained lowered mood and, on questioning, generally denied any self-harm or suicidal ideation.[42]

44. Towards the end of August 2007, Dr Lester reviewed Mr Condie's admission with the treating team and concluded that his diagnosis was most likely personality disorder of the borderline and anti-social type, and that his reported hallucinations were a combination of

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[38] Exhibit AA, Exhibit L medical records – note of Dr Lester dated 4 July 2007, transcript page 1060 and following regarding the process of diagnosis and preference for "longitudinal" assessment.

[39] See transcript pages 1063 and following Dr Lester's explanation of the Clozapine work-up and trial.

[40] Exhibit AA and Exhibit L medical records generally and transcript pages 1078,1085-1086. The psychological testing was conducted by Dr Lisa Forrester, Clinical Psychologist. Her notes dated 25, 27 July and 1 August 2007 are in the medical records Exhibit L.

[41] Exhibit AA. This occurred in mid August 2007.

[42] Exhibit AA.

pseudo-hallucinations, common in this personality group, and fabrication or exaggeration.[43]

REPORTS OF AN ATTEMPTED ASPHYXIATION – 30/31 AUGUST 2007

45. In light of the means by which he died, it is important to note that Mr Condie made disclosures of an attempt to asphyxiate himself on 30 and 31 August 2007. Dr Lester placed these disclosures in a setting of anxiety about a delay with his appeal as evidenced by some sleep disturbance and need for medication to help him sleep.[44]

46. On 30 August 2007, psychiatric registrar Dr Tallents, documented a discussion with Mr Condie during which he described putting a gag over his mouth so he won't scream out, putting a plastic bag over his head after binding his legs and lying on his hand with torn sheet and tying it to his other wrist.[45] Dr Tallents also documented that Mr Condie was not distressed as he narrated, gave assurances that he would not attempt suicide and wanted to live. Dr Tallents concluded his entry with a documented plan for close oservations and a direction that Mr Condie was not to have plastic bags.[46]

47. As a result, it appears that Mr Condie's cell was searched and a plastic bag/s removed, and he was examined by one of the nursing staff who found no evidence of any trauma to the wrist, ankles or neck from the alleged incident. Although clearly documented in the medical records, there was no analogous notation in the files accessible to correctional staff, to the effect that Mr Condie should not have access to plastic bags.[47]

48. Similarly, on 31 August 2007, a correctional officer at the AAU made a notation in the correctional file that a search of Mr Condie's cell yielded shoe laces which were not

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[43] Exhibit AA. Dr DS and Dr Mullen also commented about this symptom of personality disorder/s.

[44] Exhibit AA. Also borne out by the medical records Exhibit L, progress note entries dated 27-29 August 2007

[45] Exhibit L, progress note entry dated 30 August 2007. Reproduced in the JH review at page 186 of the inquest brief. The entry goes on to note that he said his soul floated above him half an hour later and Grim [the Grim Reaper was the figure that came to Mr Condie in his hallucinations] appeared to him and looked like an octopus with thousands of tentacles. He was able to elaborate further saying the Grim's teeth were like vampire teeth. Grim told him that it wasn't his time to die and that he shouldn't die yet. He said he thought there might be a microchip in his right temple which the Grim reaper would set off to kill him.

[46] Ibid.

[47] This is one of the criticism made in the OCSR report at page 159 of the inquest brief. I note that there was no notation in the hard copy "IMP" file, as it was referred to during the inquest, nor in the electronic Prisoner Information Management System or "PIMS" file.

permitted and torn sheets, but this information appears not to have been conveyed to any of the clinical staff. If available to clinical staff, such information had the potential to transform the reported incident, whether involving an auditory/command hallucination or not, from an unconfirmed to a confirmed self-harm attempt by asphyxiation.[48]

49. As discussed at inquest, the date of the entries is somewhat problematic as the "attempt" reported to Dr Tallents was overnight on 29-30 August 2007 and the torn sheets were apparently found during a daily search on 31 August 2007.[49] However, Dr Lester agreed that the finding of such items in Mr Condie's cell would be concerning.[50]

PORT PHILLIP PRISON, SIRIUS EAST UNIT, 11 SEPTEMBER 2007

50. On 11 September 2007, Mr Condie was discharged from the AAU with a medical clearance and a P3 rating denoting a stable psychiatric condition requiring continuing treatment or monitoring,[51] and an S3 rating, referred to as "alert", denoting a potential risk of suicide or self-harm. Mr Condie returned to PPP which was not his stated preference and was placed in Sirius East, a protection unit used to accommodate protection prisoners who have a history of difficulties in placement in other protection units.[52]

51. Part of the reception processes at PPP was assessment of a prisoner's SASH risk by reference to a structured assessment tool entitled the Structured Interview Tool for Understanding Prisoner Safety (SITUPS). According to the SITUPS assessment, Mr Condie's score of 15/50 placed him in the S4 category indicating that there were risk factors present or a history of risk of suicide or self-harm, but no current risk. Nevertheless, the corrections officer undertaking the assessment, apparently erred on the side of caution and gave Mr Condie an S3 rating. Significantly, although Mr Condie does not appear to have been forthcoming during this assessment, he did disclose that he *tried*

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[48] See page Local Management Plan Progress Note dated 31 August 2007. I note that the entry is a little ambiguous but the most natural inference is that the torn sheets were found *"Matthew decided to tear up his sheets last night and was also found with shoe laces in his cell. Needs to be watched closely."*..Transcript pages 1095 and following.

[49] Transcript page 1096

[50] Transcript page 1097 and following.

[51] OCSR report at page 161 of the inquest brief.

[52] See the evidence of Mr Roach and Mr Money at transcript pages 1020 and 582 and following.

to suffocate himself with plastic bag in the past six months.[53] Thereafter, the SITUPS assessment formed part of Mr Condie's correctional file[54] and a copy was also filed in the medical records.[55]

52. Another routine part of the reception process was a medical and psychiatric assessment, conducted on 11 September 2007 by a registered psychiatric nurse from St Vincent's, RPN JB. Overall, Mr Condie was unco-operative with this assessment, presenting as slouched, defensive, with slowed movements and poor eye contact, blunted flat affect, lowered mood, rational thought content and hesitant monotonous slow and quiet speech. RPN JB also noted that Mr Condie brightened up and engaged well when talking to another prisoner, and concluded that the S3 rating was appropriate. It appears that RPN JB was aware of the plastic bag incident but Mr Condie refused to answer questions about it or to elaborate on any suicidal ideation.[56]

53. Consequent on his S3 rating, Mr Condie was reviewed by Psychologist Ms JB, from PPP Therapeutic Services on 12 September 2007. He told her that he tried to suffocate himself at the AAU six weeks earlier as a means of "escape". Ms JB sought confirmation of this incident from a staff member of St Vincent's who did not know anything more about it. Despite this disclosure and some concerns about his current placement in Sirius East, Mr Condie appeared to Ms JB to be coping well and he remained on an S3 rating.[57]

54. Ms JB reviewed Mr Condie the following day 13 September 2007 and became concerned that he was quite paranoid, reported auditory hallucinations and was not compliant with medication as he felt it was the wrong medication.[58] She arranged for him to be reviewed

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[53] The SITUPS assessment dated 11 September 2007 conducted by CO SN appears at pages 745-749 of the inquest brief. The disclosure followed an affirmative answer to the question "Have you ever deliberately harmed yourself, for example, cutting yourself or overdosing?

[54] The Individual Management File, referred to as the IMP file, is a hard copy file and is reproduced at pages 531 and following of the inquest brief.

[55] Exhibit L

[56] St Vincent's C.H.S. Patient Health Reception Assessment dated 11 September 2007 in Exhibit L.

[57] Exhibit I, statement of Ms JB dated 3 September 2009 at pages 37.1-37.3 of the inquest brief. Ms JB thought the staff member was RPN JB but could not recall precisely. I note the following notation in the minutes from the RRT meeting of 12 September 2007 *"Different presentation today, paranoid schizophrenic not compliant with medication, current thoughts but will not act, will see Fiona psyche nurse tomorrow, stays S3."*

[58] Exhibit I and her progress note dated 13 September 2007 at 13:10 at pages 37.24-37.25 of the inquest brief.

by RPN FR who conducted a psychiatric review in Ms JB's presence and then arranged a review by Consultant Psychiatrist Dr DS later that day.[59]

55. Dr DS gave a detailed account of his review of Mr Condie on 13 September 2007.[60] In summary, he noted Mr Condie's recent extended admission to the AAU, the investigation and treatment for schizophrenia there and the discharge diagnosis of personality disorder. Mr Condie told him he was not prepared to take the medication being offered and sought sleeping medication. On mental state examination Dr DS found Mr Condie to be passively aggressive, uncooperative, hostile and depressed, and at risk of self-harm to get his way. He prescribed Olanzapine[61] 10mgs and Avanza[62] 30mgs to be taken at night on the basis that both medications had sedative properties and would assist with sleep, without leading to addiction.[63]

56. Dr DS' advice to RPN FR and Ms JB was that Mr Condie should be observed, and, if considered at risk, managed accordingly.[64] Following discussion with Mr Condie, Dr DS and Ms JB, RPN FR decided to upgrade Mr Condie to an S2 risk rating as at 3.40pm on 13 September 2007.[65] Although Mr Condie was not happy with Dr DS' refusal to prescribe his drugs of choice, he denied the need for an increase in his SASH status telling RPN FR

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[59] Exhibit I and Ms JB's progress note dated 13 September 2007 at 15:30 at pages 37-21-37.22 of the inquest brief.

[60] Exhibit BB, statement of Dr DS dated 6 September 2010 and Curriculum Vitae, at pages 1587-1595 of the inquest brief, see especially 1592-1593.

[61] Olanzapine (marketed as "Zyprexa") is an atypical antipsychotic prescribed for the treatment of schizophrenia and mania and for long term treatment of bipolar disorder. Also used as a mood stabiliser. The Royal College of General Practitioners New Guide to Medicines & Drugs, Australian Edition, 2008 at page 353.

[62] Mirtazepine (marketed as "Avanza" among others) is an antidepressant that works by increasing the naturally occurring chemicals in the brain, serotonin and noradrenaline. It is used in the treatment of major depression. One of its common *side-effects* is drowsiness/sedation/fatigue. Ibid at page 340.

[63] Questions were raised by Professor Mullens about the suitability of these drugs, in all the circumstances. Prof Mullens subsequently withdrew this criticism. As there was no evidence of these or any drugs in post-mortem toxicological analysis, I have not pursued the merits of Dr DS' prescribing practice. Lest silence be interpreted as validation, I simply note that, based on my own experience in this jurisdiction, there remains a question mark in my mind over this aspect of Dr DS' clinical management of Mr Condie, notwithstanding footnotes 59 and 60 above.

[64] Somewhat counter-intuitively, psychiatrists such as Dr DS, were not directly involved in the day to day assessment of prisoners' SASH risk. This was the remit of other clinical staff including the psychologist's employed in by PPP in Therapeutic Services and the Risk Review Team. Exhibit BB, and paragraphs 61 and following below.

[65] Exhibit I. It is not entirely clear whether this occurred after RPN FR's review of Mr Condie, in the presence of Ms JB, or after Dr DS' review. See Ms JB's progress notes.

and Ms JB that he was not having any thoughts of self-harm or suicidal ideation and said he simply wanted to go back to his unit.[66]

57. Mr Condie remained on an S2 rating until 17 September 2007 when the Risk Review Meeting reduced him to and S4 rating, skipping the intermediate S3 rating.[67] The reason for this departure from the norm of reduction through all S ratings, is not apparent.[68]

58. Mr Condie consulted Dr ET from St Vincent's on 18 September 2007 when he told her that he expected to attend court regarding his appeal on 4 October 2007 and that, while he understood that his sentence might be increased, he was hoping for some reduction. As regards medication, he reported taking Clozapine when in the AAU and that he had chosen to stop taking it three weeks earlier, and that he had not taken the medications prescribed by Dr DS as he as he could not sleep when taking anti-psychotics.[69]

59. Dr DS saw Mr Condie again on 20 September 2007. Mr Condie reported feeling settled in Sirius East. As he also reported not taking the medication previously prescribed, Dr DS prescribed Haloperidol[70] 5mgs to be taken at night and Imovane[71] 15mgs for three nights only to assist with sleep.[72] In his statement and at inquest he explained that he prescribed Haloperidol for its sedative and tranquilizing properties, and not as an antipsychotic. His rationale was that prescribing medications that were acceptable to Mr Condie might

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[66] Mr Condie was in St Thomas' unit and was asking to return to Sirius East. See Progress Notes at pages 37.20-37.21 in the inquest brief.

[67] The RRT minutes of 17 September 2007 note the following in relation to Mr Condie – *""[Ms] JB and Doctor DS saw him, doctor upgraded him to S2 no suicidal ideation, classified to Barwon, but has court in 2 weeks, guarantees own safety, reduced to S4 (off watch)."* This is not an entirely accurate account and may reflect a misunderstanding on behalf of the minute taker or more fundamental shortcomings with the RRT process. See Exhibit T, annexure DR3 at pages 1299-1303 of the inquest brief and discuss at paragraphs 65 and following below.

[68] See the relevant Operational Instruction as in force at the time at page 1285 of the inquest brief.

[69]Exhibit K, statement of Dr ET at pages 38-550 of the inquest brief. Mr Condie also complained of a headache he had suffered for one month and of testicular soreness for three months. On this day, Mr Condie also had a short telephone conversation with his lawyer.

[70] Haloperidol is a butyrophenone antipsychotic used to reduce violent, aggressive manifestations of mental illnesses such as schizophrenia, mania, dementia and other disorders in which hallucinations are experienced. Drowsiness/lethargy is a common side effect. See reference cited at footnote 59 at page 291.

[71] Imovane (a brand name for "Zopiclone") a non-benzodiazepine sleeping drug that works in a similar way to benzodiazepines. They are not intended for long term use and withdrawal symptoms have been reported. Ibid page 68.

[72] Exhibit BB and transcript page 1253

promote a calmer presentation and this might in turn lead to a longer lasting effective therapeutic relationship.[73]

60. On 25 September 2007, Mr Condie consulted Dr ET again and asked for medication to relax him, nominating the benzodiazepine Oxazepam. When asked about the medication prescribed for him by Dr DS, he said he didn't take psychiatric medication. They discussed anxiety around his pending appeal and Dr ET encouraged him to take the medication prescribed for him. He told Dr ET once again that he would take buprenorphine if it came into PPP.[74]

"SEPARATION" & TRANSFER TO CHARLOTTE UNIT 2

61. At about 6.00pm on 25 September 2007, after seeing the triage nurse at St Thomas', the outpatient medical unit at PPP, Mr Condie refused to return to Sirius East saying that he feared for his safety as he had made a "shiv" and other prisoners had told prisoner CS that he was the intended recipient of the shiv. Mr Condie threatened to slash himself from head to foot if he was returned to Sirius East, and stated that he wanted to be transferred to the Charlotte Unit for his own safety.[75]

62. As a result, from 6.20pm, Mr Condie was deemed at immediate risk of suicide or self-harm and given an "S1" rating (referred to as "intensive watch") which required staff to make observations of him every four minutes. This regime commenced in an observation cell in Sirius East, pending arrival of a "separation order" from Corrections Victoria at about 6.45pm, when Mr Condie was transferred first to St Paul's, the psychosocial unit, then to an observation cell in St John's, the inpatient medical unit. Mr Condie remained in an observation cell in St John's overnight on 25-26 September 2007 under the S1 regime of four minutely observations.[76]

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[73] Exhibit BB where Dr DS stated, inter alia, that *"Apart from helping him to relax and become calmer and less aggressive, there was very little by way of medication that could assist in alleviating the anti-social personality traits.* Transcript page 1253.

[74] I note that in the interim, Mr Condie was visited by his mother on 22 September 2007 between 1344-1404 hours.

[75] This is a compilation of a series of exchanges documented most accessibly in the Justice Health review at pages 176-193 of the inquest brief, especially at pages 188-189.

[76] See pages 1048-1050 of the inquest brief, S1 Observation Register/s dated 25 and 26 September 2007.

63. As a consequence of his S1 rating, on the morning of 26 September 2007, while still in St John's, Mr Condie underwent a "suicide and self-harm" or SASH assessment by Ms JB, an intern psychologist employed within PPP's Therapeutic Services.[77] During her assessment, Mr Condie repeated his concerns for his safety if returned to Sirius East and told Ms JB that he was more than happy to go to Charlotte Unit and had no SASH concerns if he was placed there.[78]

64. At the daily meeting of the Risk Review Team (RRT), Mr Condie's situation was discussed and he was assessed as suitable for reduction to an S2 risk rating, denoting a significant (as opposed to immediate) risk of suicide or self-harm. At PPP, the S2 rating was referred to as "random watch" and mandated observations at a frequency of six times per hour, around the clock, at random intervals but no more than 15 minutes apart. This regime of observations commenced at 3.15pm, while Mr Condie was still in St John's and continued after his move to Charlotte Unit at 4.17pm, including overnight on 26-27 September 2007.[79]

65. Ms JB saw Mr Condie in Charlotte Unit on 27 September 2007, again by way of SASH review. Earlier that day, Mr Condie was interviewed by the Sentence Management Unit (SMU) and told Ms JB that they told him he was classified to Barwon Prison and would be transferred once his appeal was determined, and that in the meantime, he would be transferred out of Charlotte to Alexander North Unit at PPP once a bed was available.[80] Without naming him, Mr Condie told Ms JB that the prisoner who he feared had been moved to Charlotte Unit and they discussed coping strategies, including Mr Condie not taking his daily run out so as to minimise the risk of contact. Mr Condie denied any thoughts of self-harm or suicide and promised Ms JB that he would ask to speak to someone from Therapeutic Services if he had such thoughts.

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[77] Transcript page 163. Ms JB was a member of the clinical staff of Therapeutic Services PPP from May 2005 to June 2008. She described herself as an intern psychologist working under supervision until her registration in June 2007. After that, she continued to be supervised although the nature of the supervision changed, it was less structured and less prescriptive. Transcript pages 204-205.

[78] Exhibit I, statement of Ms JB dated 3 September 2009 at pages 36-37.4 of the inquest brief.

[79] See pages 1051-1053 of the inquest brief, S2 Observation Register/s dated 26 September 2007.

[80] This early intervention by the SMU was, at least in part, fortuitous, as Thursday was the day of the week that the SMU usually attended at the Charlotte Unit.

66. Ms JB foreshadowed to Mr Condie that he might be reduced to an S3 rating denoting a potential (as opposed to immediate or significant) risk of suicide or self-harm at that day's RRT meeting and why she thought he should remain on that rating until he acclimatised to Alexander North. The RRT met and, after discussing Mr Condie's situation, indeed reduced him from S2 to S3 status, referred to as "alert".[81]

67. Although there was some scope for tailoring of observations and other requirements for prisoners at risk and on an S3 status,[82] Ms JB stipulated that Mr Condie should have a minimum of two meaningful conversations per day with correctional staff,[83] in keeping with the prescribed "minimum" for those on an S3 rating. This regime commenced at 3.15pm when correctional officers at Charlotte Unit were made aware of Mr Condie's change of status.

68. Thereafter there are three documented "contacts" between Correctional Officer NK and Mr Condie at 3.22pm, 5.00pm and 7.35pm.[84] It is not so much the brevity of the notations made that are concerning, as they could conceivably reflect a practice of noting that a more fulsome exchange has taken place, but the explanation given in evidence. I allow that the witness may have been unable to recall precisely and may have been unable to articulate his usual practice. But, taken at face value, his evidence cannot support a finding that "meaningful" conversation took place, such as would might enhance the safety of an at risk prisoner.[85]

69. Significantly, there was no requirement for correctional staff to monitor or observe Mr Condie overnight on 27-28 September 2007.[86] While the possibility that Mr Condie could have taken his own life in the way that he did, while subject to an S2 observation regime,

[81] Exhibit I, statement of Ms JB dated 3 September 2009 at pages 37.3 of the inquest brief.

[82] This is the "minimum" requirement for at risk prisoners on an S3 rating but further observations or requirements aimed at enhancing their safety may be stipulated on the Modified or Interim Risk Management Plans. See evidence of Mr Brendan Money and Ms JB's evidence at transcript page 172.

[83] See pages 1048-1050 of the inquest brief, S1 Observation Register/s dated 25 and 26 September 2007.

[84] See page 1061 of the inquest brief, Modified Risk Management Plan dated 27 September 2007. I simply note here and do not resolve the debate that played out at inquest about whether or not the contacts as described by correctional staff in evidence satisfied the requirement for "meaningful conversation."

[85] Of course there was scope for further meaningful interaction when the morning shift staff arrived. How realistic is this in the face of already documented compliance with the risk management plan for the prisoner? Exhibit G, page 95 of the inquest brief and transcript pages 127 and 139 and following.

[86] See pages 1053-1054 of the inquest brief, S3 and S4 Observation Register/s dated 27 September 2007.

cannot be entirely excluded, it is likely that the correctional officers would have noticed something untoward and the tragic outcome could have been averted.

PSYCHOLOGIST'S ACCESS TO MEDICAL RECORDS

70. A salient feature of Ms JB's evidence at inquest was her evidence that, while she did have access to the Therapeutic Services file and information from Mr Condie himself, she did not have access to his medical records. If Ms JB felt the need to access information that she knew was or might be in the medical records she would approach one of the psychiatric nurses or other clinical staff from St Vincent's and they would generally oblige. Ms JB felt she had a good relationship with St Vincent's staff and had no qualms about asking for information.[87] However, how could she possibly know whether the medical records contained information relevant to her needs?[88] At inquest, she indicated that a number of pieces of information would have been nice to know at the time that she was assessing Mr Condie.[89]

71. It appears that the justification for denying Ms JB and other Therapeutic Services staff was the confidentiality of medical or health information. The notion that a verbal disclosure of information that is otherwise confidential is acceptable, only has to be stated to be exposed as flawed. I note that the legal status of the medical records was not addressed in any of the parties' legal submissions, other than the family, and I do not propose to address the legalities of the situation as it pertained at the time.

72. In her capacity as Director of Justice Health, Ms Michelle Gardner's testified at inquest and took a strong stance in relation to this issue, asserting by analogy with the practice of community mental health services, that psychologists should be given access as of right.[90] Furthermore, Ms Gardner's evidence was that access would be available to psychologists, once the electronic health record project was successfully implemented across the Victorian prison system.

[87] Transcript pages 187, 211-216.

[88] See transcript page 267-277.

[89] Transcript pages 208 and following.

[90] Transcript of Ms Gardner's evidence and the final submissions of the Department of Justice.686

73. I am unable to determine whether and to what extent, the denial of the access to medical records arises from Ms JB's employment by PPP Therapeutic Services and the medical records being, at least in an immediate sense, held by St Vincent's medical, psychiatric and nursing staff. Counsel's final submissions were unhelpful in this regard. In any event, as at the date of the inquest, there was evidence that this situation had been remedied, and psychologists from Therapeutic Services had access to the medical records held by St Vincent's at PPP.[91]

74. Moreover, the issue of Ms JB's access to the medical records, needs to be seen in the broader context of access to SASH sensitive information across the PPP campus and the prison system as a whole, including correctional files, whether in hard copy (the IMP file) or electronic (PIMS). For example, I have already mentioned the notation about torn sheets being found by correctional officers proximate to Mr Condie's reported visitation by the Grim and his reported attempted asphyxiation to Forensicare clinical staff. Conversely, the clinical direction that plastic bags be removed from Mr Condie, though documented in the medical records, did not make it across the great divide to his correctional file.[92]

S.A.S.H. RISK & RISK REVIEW MEETINGS

75. Mr Dennis Roach, Director of PPP, with extensive prior experience in correctional management provided two detailed statements with several annexures and testified at inquest.[93] For present purposes, suffice to say that, whilst any correctional officer or clinician could impose or raise a prisoner's S rating,[94] once imposed an S rating could only be reduced by a consensus of the Risk Review Team (RRT). At PPP, the RRT met daily and comprised clinical staff from Therapeutic Services, clinical staff from St Vincent's

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[91] Transcript page 1018.

[92] See paragraphs 42, 45-49 above.

[93] Exhibits T and U and transcript at pages 686 and 987. While a number of witnesses testified about the operation of the RRT, including Ms JB and Dr ET, Exhibit T contains a convenient summary of its operations.

[94] In the case of correctional officers, the mechanism for doing so was to make a "crisis" call to Therapeutic Services who would respond within two hours and arrange to review the prisoner.

(generally a psychiatric nurse), correctional staff at supervisor level and correctional managers.[95]

76. Following the RRT meetings, information about prisoners' S ratings is communicated to correctional staff who are tasked with the responsibility of complying with the appropriate observations or watch regime. This occurs against the background of the general confidentiality of prisoner's medical information and is consistent with the recognised exception that information about prisoners' risk of SASH can and should be communicated to correctional staff.[96]

77. According to Ms JB, full and frank discussion was encouraged at the RRT meeting and the "culture" of the meeting was such that they tended to err on the side of caution when determining the appropriate rating or risk status for a particular prisoner.[97] That said, the RRT meeting relied on a presentation of each prisoner's current situation by one of the clinical staff attending the meeting, and absent dissent, the endorsement of the presenter's recommendation.

78. The brevity of the minutes of the relevant RRT meetings is such that it is difficult scrutinize the quality of its decision-making process and its decisions.[98] Inherent challenges arise from the practice of attendees generally relying on memory without reference to files, the lack of continuity of participants and the number of prisoners to be discussed within a relatively short time frame.[99]

79. At the RRT meetings proximate to Mr Condie's death, it was Ms JB who presented his circumstances to the meeting, and whose recommendation was endorsed or adopted by the RRT.[100] Although it is clear that significant SASH sensitive information that was not available to inform Ms JB's recommendation, was available, at least notionally, to others at the RRT meeting, only serendipity would have yielded up that information so that it

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[95] Exhibit T from paragraph 35 and following, transcript page 238.

[96] Exhibits T and P, statement of Mr Brendan Francis Money, Assistant Commissioner, Offender Management Services of Corrections Victoria at page 1525-1526 of the inquest brief.

[97] Transcript pages 257 and following.

[98] Annexure DR3 at pages 1294-1310, especially at pages 1307-1310.

[99] Transcript page 231.

[100] The psychologist's/Ms JB's role in assessing risk within the overall SASH system was clearly pivotal. See discussion and evidence from transcript page 992 and following.

could inform the RRT meeting's determination of Mr Condie's risk. It seems by necessary inference that nothing of that nature was forthcoming.[101]

80. As a consequence of the above, Ms JB's clinical judgement was repeatedly challenged at inquest on the basis that she attached too little weight to chronic or longitudinal factors, and too much to Mr Condie's self-report and guarantees of his own safety. The weight of the evidence supports a finding that Ms JB was ill-equipped to properly assess Mr Condie's risk of suicide or self-harm, not as a result incompetence but because she had little to go by other than what she could glean from Mr Condie himself, her own progress notes, the Therapeutic Services file, and any other information offered ad hoc by correctional officers or other clinicians. This speaks to systemic rather than individual failures.

SEPARATION, ISOLATION & "AT RISK" PRISONERS

81. PPP is a maximum security prison that holds male prisoners from diverse backgrounds, most of whom have been convicted of serious crimes including murder, other acts of violence such as armed robbery and sexual assaults, drug offences and dishonesty offences. It is accordingly a highly regulated environment, with some prisoners on management regimes. As at the date of the inquest, PPP accommodated about 820 prisoners segregated into 14 accommodation units for a range of prison populations including management, protection, mainstream, medical, intellectually disabled and youth.[102]

82. Charlotte Unit is a management unit with single cell accommodation for up to 38 prisoners, including 13 cells in the Exclusion Placement Area (EPA), commonly referred to as the spine. Prisoners are transferred to the spine for a range of reasons, including security, management, protection and loss of privileges. The prevailing regime is a management regime and is austere with prisoners being locked down in their cells for 23 hours a day. Prisoners are allowed a one hour "run-out" in an exercise yard, generally taken on their own if they are in the spine. Prisoners such as Mr Condie who are not

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[101] It also seems that there was substantial but not complete compliance with the requirement that S ratings be reduced no more than one level per day unless there are exceptional circumstances but Mr Condie went from S1 at ~6.20pm on 25 September 2007 to S2 from ~3.15pm on 26 September 2007 and to S3 from ~3.15pm on 27 September 2007.

[102] Exhibit T. Transcript page 695.

serving loss of privileges can make telephone calls and accept visits, can see a psychologist from Therapeutic Services, can seek medical attention but cannot work or participate in any other activities.[103]

83. Consistent with the austerity of Charlotte Unit, PPP must obtain the approval of Corrections Victoria for the "separation" of any prisoner from their usual unit and their placement in Charlotte. This occurred in the case of Mr Condie's placement there on 26 September 2007, and in the case of prisoner CS on 27 September 2007 with consequential arrangement made to ensure their separation from each other. Another requirement that arises from the nature of Charlotte is the operational instruction that mandates that every prisoner admitted to Charlotte be accorded an S2 status initially.[104]

84. As regards the need to separate Mr Condie to the spine, Mr Roach stated that a balance needs to be maintained between removing a prisoner from an area where he has access to greater privileges but his welfare may be directly at risk and moving that prisoner to an area where his privileges are marginalised but his safety is secured.[105] The evidence before me indicates that the decision to separate Mr Condie was made quickly, as it needed to be in the circumstances, to afford an opportunity to the Sentence Management Unit to assess the risk.[106] Mr Condie's placement was problematic as although he feared for his own safety, he was also a threat to others.[107]

85. Professor Paul Edward Mullen, is a well-known Consultant Forensic Psychiatrist[108] who provided a pro bono expert opinion for Mr Condie's family.[109] He based his opinion on the medical and psychiatric records of St Vincent's and the AAU,[110] and other documents including the statement of Dr ET and progress notes of Ms JB's contact with Mr Condie. From this material, Prof Mullen identified two issues of concern. The first, the manner in which his psychiatric state and suicidal risk were evaluated and managed by the various

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[103] Exhibit T.

[104] Exhibit T, Exhibit U and DR5 Operational Instruction 107 at page 1320 and following, especially at page 1328.

[105] Exhibit U at page 1313 of the inquest brief.

[106] Transcript page 585, 594, 609.

[107] Transcript page 606.

[108] Prof Mullen's formal qualifications and vast experience are outlined in his curriculum vitae, part of Exhibit X.

[109] Exhibit X, expert opinion of Prof Mullen dated 17 June 2010.

[110] He was Clinical Director of Forensicare at the time of Mr Condie's admission in July – September 2007 – and declared a "conflict of interest" to that extent but had never treated Mr Condie.

mental health professionals. The second, and in his opinion more important, the system by which those known to be at risk of suicidal and self-damaging behaviour are managed at PPP.[111]

86. He expressed the opinion that the medical records he reviewed presented a picture of uncertain and fluctuating diagnostic formulations combined with a disorganised and often tentative approach to management. He conceded that there were inherent diagnostic difficulties compounded by Mr Condie's unwillingness to provide even vaguely consistent accounts of his symptoms or to comply with treatment. Prof Mullen noted that there was a vacillation between the diagnoses of schizophrenic illness and severe personality disorder, in apparent disregard of the clinical reality that the two often co-exist, in the prison population in particular, where it was *common to see a combination of schizophrenia and what looks like antisocial and/or borderline personality disorders.*[112]

87. Prof Mullen conceded that the medical records suggest a real difficulty in distinguishing between genuine reports of psychotic symptoms and self-serving exaggerations and inventions. While confusion over diagnosis and inconsistent treatment approaches may have played a role in Mr Condie's death, *this reflected the inherent difficulties presented by Mr Condie as much, or more than, any failures* by individual clinicians.[113]

88. Irrespective of diagnosis, Prof Mullen expressed the opinion that Mr Condie was an unstable, intermittently self-damaging and potentially suicidal individual, and this was recognised by the risk ratings he attracted in the three days prior to his death. Prof Mullen was critical of extraordinary rate of improvement inferred in the rapid downgrade of Mr Condie's risk between 25 September 2007 and his death, particularly absent any changes in his external circumstances, ongoing pharmacotherapy or psychotherapeutic interventions.

89. Prof Mullen was most critical of the placement of Mr Condie in the spine in Charlotte Unit, which he characterised as a regime of isolation, singularly inappropriate for a prisoner at risk.[114] While this was resisted by Mr Roach and others at inquest, it is

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[111] Exhibit X.

[112] Exhibit X at paragraphs 9-10.

[113] Transcript page 1060 and following.

[114] Both of the other psychiatrists who testified at inquest agreed that isolation is inappropriate for at risk prisoners.

unarguable that the regime imposed on Mr Condie in the spine was the opposite of what was needed to enhance his safety – *having social contact, having social supports, being integrated into activities which give some structure, some point and purpose to your life, and also feeling safe…the presence of human beings who can listen and attend and communicate…people around them who can recognise when their state is getting worse.*[115]

90. At inquest, Prof Mullen testified over several sessions, and there was an appreciable change in his criticisms of the management of Mr Condie. Ultimately, he stressed that he was directing his criticisms, not at individuals but at processes, and finding fault with them.[116] He maintained his criticism of isolation for at risk prisoners, and did not accept that the dictates of prison management and good order might warrant isolation even for a short period of time.

91. The crux of Prof Mullen's evidence was that he commended a patient focused approach to at risk prisoners, preferencing their safety over the safety of others within the prison and over the needs of prison management. However, in the custodial setting, Mr Condie was also a prisoner, some would argue foremost a prisoner, and a balance needed to be struck between ensuring his physical safety from others, investigating his complaint and the orderly management of the prison.

92. The weight of the evidence supports a finding that Mr Condie's placement in the spine was for the short term only and that the SMU interviewed him and advised him that he would be transferred to Alexander North as soon as possible, and that his ultimate classification pending the outcome of his appeal was to Barwon Prison.

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[115] Transcript page 921. Prof Mullen's objections to isolation for at risk prisoners was reiterated (more strongly) at transcript page 925 – *"Putting someone in a situation of almost total sensory deprivation and almost total social deprivation for 23 hours a day. Now suicide when it comes to it, is in large part about despair and hopelessness…The justification [for isolation] is that you put people in a totally empty environment and they can't go anywhere else and they can't interact with anyone, then they can't kill themselves…and therefore you stop, you use a mechanical solution to what is a profound psychological and sometimes psychiatric problem."*

[116] Transcript page 917, 1160-1161 and following.

STANDARD OF PROOF and CONCLUSIONS

93. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[117] As regards the making of adverse findings against or adverse comments about individuals or institutions, the effect of the authorities is that Coroners should not make them unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their respective profession/s and in so doing, caused or contributed to the death.

94. It is axiomatic that the assessment of any departure from norms or standards must be judged strictly without the benefit of hindsight. The trajectory of a suicide may well be obvious after the event. Patterns or causal connections that can be traced from the privileged position of knowing the tragic outcome, may not have been obvious or even appreciable before that outcome. This is particularly so with people at chronic, ongoing or intermittent risk of suicide, and/or whose impulsivity puts them at risk.

95. Having applied the applicable standard to the available evidence, I find that –

    a. Mr Condie suffered from a severe personality disorder, and was at chronic or intermittent risk of suicide and self-harm due to his emotional lability and impulsivity.

    b. The clinical management and care provide by Forensicare at the AAU between 3 July and 11 September 2007, was reasonable and appropriate.

    c. There was no want of clinical management and care, on the part of the staff of St Vincent's Correctional Health, that caused or contributed to Mr Condie's death.

    d. The separation order in respect of Mr Condie and his placement in the Exclusion Placement Are or spine of Charlotte Unit was an appropriate response by Port Phillip Prison and Corrections Victoria to the situation that pertained at the time, and the S2

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

rating and the associated observation regime were justified and adequate to ensure his safety.

e. The downgrading of Mr Condie's risk status from S2 to S3 on the afternoon of 27 September 2007 was precipitous and failed to take into account the particular strictures of the spine of Charlotte Unit.

f. Mr Condie's continued placement in the spine area of Charlotte Unit on an S3 rating, contributed to his death by providing him with the wherewithal to take his own life – a plastic bag, sheeting and a long period of time without disruption or observation.

g. Mr Condie's placement was in accordance with S.A.S.H. processes as they operated at Port Phillip Prison at the time, and that these were in turn in accordance with the relevant Corrections Victoria requirements.

h. While I accept that the S3 rating recommendation by Ms JB and its endorsement by the Risk Review Meeting on 27 September 2007 were made in good faith, systemic failures undermined the quality of the decision-making and the decision in each case.

i. Sub-optimal communication of information across the Port Phillip campus, poor documentation practices and information flow between Therapeutic Services, correctional staff and the staff of St Vincent's Correctional Health and the ad hoc composition of the Risk Review Team were all systemic failures.

j. Mr Condie's death was potentially preventable in the sense that a person or entity determining his S.A.S.H. risk, with access to all repositories of information at Port Phillip Prison, having fully informed themselves about his history of self-harm, suicidal ideation and threats to self-harm (whether for secondary gain or not), and the observed detrimental effect of isolation on his mental state, would likely have concluded that he should remain on S2 rating while placed in the spine of the Charlotte Unit.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecution under section 69(2) of that Act):

1. Mr Condie's death was the subject of review by the Office of Correctional Services Review, Justice Health and Port Phillip Prison. These reviews occurred much closer to his death and resulted in a number of recommendations. I was advised at inquest about a number of initiatives and improvements that had already been made as a result of those reviews, and I do not propose to reiterate those recommendations here.

2. Significantly, shortly after and in direct response to Mr Condie's death, Mr Roach issued a directive that all plastic bags be removed from all at risk prisoners with an S1, S2 or S3 risk status.[118]

3. Of particular interest, given my findings above, are the Justice Health requirement for complex care plans and an improved template for the Risk Review Team meeting minutes.

4. I also note that Port Phillip Prison has provided additional resourcing by way of a psychologist dedicated to prisoners in the Charlotte Unit each week day and has improved the S.I.T.U.P.S. assessment form. Both initiatives are commended as potentially enhancing S.A.S.H. processes at Port Phillip Prison and thereby prisoner safety.

5. To the extent that Professor Mullen's evidence and the family's final submissions invite a broad comment or recommendation proscribing the isolation of at risk prisoners entirely, as indicated repeatedly at inquest, to accept the invite would be to exceed the reasonable scope of a coronial enquiry of Mr Condie's death. That said, Prof Mullen, Dr Lester and even Dr DS gave cogent evidence of the singular unsuitability of isolation for at risk prisoners, and it behoves Corrections Victoria and Port Phillip Prison to heed their advice by ensuring that isolation of at risk prisoners is a last resort option for the shortest possible duration with appropriate safeguards in place.

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[118] Exhibit U and transcript page 988 and following.

RECOMMENDATIONS

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

1. While I have addressed the issue of access to medical records and the flow of information across the Port Phillip campus above, I am conscious that records can be voluminous, and therefore their contents may be inaccessible, even when they are physically available. At inquest, Ms Gardner testified at length about the development of an electronic health record, and how it might assist access to prisoners' health information, even potentially allowing remote access. I am conscious that with the regrettable effluxion of time, her evidence may have been superseded, or overtaken by events.

2. If the electronic health record has not been implemented, and/or voluminous electronic records still pose challenges to accessibility, I recommend that Corrections Victoria and/or Justice Health develop a comprehensive yet pithy summary of prisoners' health information, in consultation with all relevant stake-holders, that contains prescribed types of information, including S.A.S.H. sensitive information, and is regularly updated, and readily available to all clinicians involved in the prisoner's clinical management and care, including psychologists.

3. I recommend that Corrections Victoria and/or Justice Health take whatever steps necessary to mandate the use of such a document by any person or entity providing health care in any Victorian prison, whether privately or publicly operated.

4. Further, and/or in the alternative, I recommend that Corrections Victoria, Justice Health and Port Phillip Prison collaborate in the development, implementation and resourcing of a case management scheme for all prisoners with complex medical, psychiatric, behavioural issues, irrespective of any diagnosis. Such a case management plan should summarise in an accessible way the known chronic and acute SASH risks of the prisoner, including situational triggers, the clearest and most recent diagnosis available, particular symptoms, signs of relapse or deterioration, and characteristic behaviours and how to manage them.

4. I recommend that Corrections Victoria and Port Phillip Prison review S.A.S.H. processes and/or practice to further discouraging the rapid or precipitous downgrading of a prisoner's at risk status. Specifically, as regards prisoners placed in the spine of Charlotte Unit, consideration should be given to a requirement that any assessment of their risk by clinicians and/or the RRT should explicitly address the relative isolation and deprivation of their placement, and a requirement for an individually tailored, rather than homogenous observation regime.

5. I recommend that Corrections Victoria and Port Phillip Prison enhance S.A.S.H. risk training for correctional officers about compliance with the need for meaningful interaction with at risk prisoners rated S3, emphasising the need for the interaction to be meaningful by reference to the prisoner's risk and aimed at enhancing their safety.

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

Mr Ronald Condie

Ms Sheryl Lakey

G4S Pty Ltd/Port Phillip Prison c/o Ms Ingrid Nunnink, Marsh & Maher

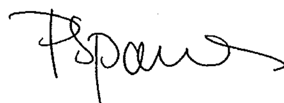
St Vincent's Correctional Health Services c/o St Vincent's Health

Forensicare c/o Victorian Institute of Forensic Health

Corrections Victoria }
Office of Correctional Services Review }Department of Health and Human Services
Justice Health }

Detective Senior Constable Mark Guthrie c/o Werribee Police

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: 30 January 2015