IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4920

FINDING INTO DEATH WITH INQUEST OF GREGORY SEDGMAN

Form 37 Rule 63(1)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Delivered on:	9 September 2022
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest hearing date:	18 August 2022
Counsel Assisting the Coroner:	Leading Senior Constable Danielle Lord, instructed by Ms George Carrington, Coroner's Solicitor of the Coroners Court of Victoria
Secretary of the Department of Justice and Community Safety:	Mr Liam Brown, Crown Solicitor for the State of Victoria, instructed by Jacob Coppel, Managing Principal Solicitor, Victoria Government Solicitor
Catchwords:	POST SENTENCE SUPERVISION ORDER, CONDITIONS, CORELLA PLACE, NOT PERSON PLACED IN CARE OR CUSTODY, POLYPHARMACY TOXICITY, CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES ACT

BACKGROUND

1. Gregory Paul Sedgman was 42 years old when he passed away at Corella Place, 228 Warrak Road, Ararat (**228 Corella Place**) on 30 September 2018, following an overdose of prescription medication.

2. Mr Sedgman was a resident at this facility because he had been convicted of serious sex offences and post sentence had been placed a Supervision Order pursuant to the *Serious Sex Offender (Detention and Supervision) Act 2009* (Vic)[1] (**SSODS Act**). The facility is managed by Corrections Victoria.

CORONIAL INVESTIGATION

Jurisdiction

3. Mr Sedgman's death constituted a 'reportable death' pursuant to section 4(2)(a) of the *Coroners Act 2008* (Vic) (**Coroners Act**), because his death occurred in Victoria and was unexpected.

4. Whilst Mr Sedgman was on a post sentence Supervision Order and had restrictive conditions associated with that order, the circumstances of his death did not meet the definition of a "person placed in custody or care" pursuant to section 3 of the Coroners Act. Therefore, his death did not require a mandatory inquest pursuant to Section 52(2)(b) of the Coroners Act.

5. Due to the restrictive nature of his Supervision Order, I determined to use my discretion and conduct a summary inquest. Consequently, an Inquest was held on 18 August 2022.

Purpose of the Coronial Jurisdiction

6. The Coroners Court of Victoria (**Coroners Court**) is an inquisitorial court.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

7. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

---

[1] This Act was repealed by the *Serious Sex Offenders Act 2018* (Vic) on 3 September 2018.
[2] Section 89(4) *Coroners Act 2008.*

8. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

10. Coroners are empowered to:

    (a) report to the Attorney-General on a death;

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

11. These powers are the vehicles by which the prevention role may be advanced.

12. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[3] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[4]

Standard of Proof

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[5] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[6]

[3] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[4] *Keown v Khan* (1999) 1 VR 69.
[5] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[6] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference

14. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[7] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[8] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[9]

Sources of Evidence

16. This Finding draws on the totality of the coronial investigation into Mr Sedgman's death. That is, the court records maintained during the coronial investigation, the Coronial Brief and any further material sought and obtained by the Coroners Court, the evidence adduced during the Inquest, and any submissions.

17. In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence should not lead to the inference that it has not been considered.

CIRCUMSTANCES OF DEATH

Medical history

18. Mr Sedgman's medical history included a gastrointestinal stromal tumour, asthma, head injury, personality disorder, post traumatic stress disorder, depression and intravenous drug use. His medications included mirtazapine, venlafaxine, oxycodone, imatinib, sildenafil, diazepam and metoclopramide.[10]

19. Mr Sedgman was on a Supervision Order and required to reside at 228 Corella Place.

---

to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[7] (1938) 60 CLR 336.

[8] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

[10] Statement of Dr Linda Danvers dated 27 February 2019, Coronial Brief, p 188.

20. On 10 August 2018, staff at 228 Corella Place conducted a search of Mr Sedgman's unit due to information received alleging that Mr Sedgman had engaged in on selling both his prescription medication, and other prescription medication to other 228 Corella Place residents. This concern came to light after Mr Sedgman reported to Victoria Police, earlier in the week, that a substantial quantity of medication had been stolen from him. [11]

21. Staff discovered that Mr Sedgman appeared to have been stockpiling and storing excessive amounts of medication, including mirtazapine, endone, viagra, antenex, glivec, targin-10, venlafaxine and pramin, which were subsequently seized.

22. Following the seizure of the medication, Mr Sedgman was issued with a written instruction pursuant to section 137 of the SSODS Act which required him to provide all medication (both prescription and non-prescription medication, including Panadol) to a supervision officer at 228 Corella Place for administration when required.

23. On 5 September 2018, the following medication was held by 228 Corella Place staff on behalf of Mr Sedgman as a result of the instruction issued on 10 August 2018: glivec, venlafaxine, endone, mirtazapine, targin-10, pramin, antenex, nurofen, panadol. This list of medication was recorded by staff on a handwritten note and kept in a box in a cupboard in the administration office.

24. Mr Sedgman appeared to comply with the written instruction and attended the administration building each day to collect his medication. Staff were not allowed to dispense the medication other than to hand over the container to Mr Sedgman with his medication and remain present whilst he administered it. A log sheet was usually signed to record the collection of medication.

Events preceding Mr Sedgman's death

25. On Sunday 23 September 2018 at approximately 7.13pm Mr Sedgman and a fellow resident attended the administration office so that Mr Sedgman could collect his evening medication. Mr Sedgman entered the interview room where residents are given their medications and Jay Moody, Specialist Case Worker, obtained his medication from a locked cabinet. His medication was kept in a shoebox. Mr Moody supervised Mr Sedgman whilst he accessed his medication.

[11] Coronial Brief, p 277.

26. Whilst this was occurring the other resident requested the second staff member to assist him with charging his phone. Unbeknownst to Mr Moody, Mr Sedgman collected more medication than his prescribed amount, which included an entire bottle of antenex (diazepam) and an unknown amount of endone. According to Mr Moody's statement there was nothing in Mr Sedgman or the other resident's behaviour, mannerisms, or conversations that made him suspicious that anything out of the ordinary had occurred.[12]

27. Mr Sedgman and the co-resident then returned to Mr Sedgman's unit in the presence of two other residents. At some stage during the evening, Mr Sedgman consumed an unknown quantity of the medications he had removed from the administration building. It is understood Mr Sedgman may have swapped medications with another resident who had access to Lyrica. The evidence reveals that Mr Sedgman also supplied medications to two other residents.

28. Curfew was 8pm and at some stage just prior, the other residents returned to their respective units, leaving Mr Sedgman with his housemate. During the evening, Mr Sedgman spoke with several residents on the phone and came outside his unit on three occasions where he met another resident and exchanged something.

29. 228 Corella Place staff were unaware of these interactions, despite the operation of electronic and video surveillance monitoring.

30. At approximately 2am, and again between 5 and 6am, Mr Sedgman's housemate awoke and heard Mr Sedgman snoring loudly, but did not attend his room because he thought he was sleeping.

31. At approximately 9.30am on 24 September 2018, Mr Sedgman's housemate found Mr Sedgman sitting cross-legged on an armchair in front of the tv with an x-box video game controller in his hands, and his head tilted back, snoring. The housemate removed the game controller and straightened his legs to make him more comfortable.

32. About an hour later, the housemate asked another resident to assist him to try and wake Mr Sedgman. The other resident shook and slapped Mr Sedgman in an attempt to wake him but was unable to.

[12] Statement of Jay Moody dated 16 November 2018, Coronial Brief, p 83.

33. At approximately 12.28pm Mr Sedgman's housemate became concerned for Mr Sedgman as he still had not moved, so he alerted two staff members on duty.

34. Staff members from 228 Corella Place attended Unit 4 and noted that Mr Sedgman was pale, clammy, snoring, and non-responsive. Mr Nathan Day contacted 228 Corella Place administration and requested emergency assistance. Staff obtained a defibrillator and commenced following the instructions.

35. Ambulance Victoria paramedics arrived at 12.48pm and police shortly thereafter. Mr Sedgman was transported to the Ballarat Base Hospital. He did not regain consciousness and a decision was made to turn the life support off. Mr Sedgman died on 30 September 2018 at 11.35am.

CORONIAL INVESTIGATION

36. Detectives from the Supervision Order Specialist Response Unit attended the scene and commenced a coronial investigation. Police located many empty prescription medication packets in his room, including an empty box of endone prescribed to Mr Sedgman, two empty trays of endone, and two empty mirtazapine blisters in a bin in the living area where Mr Sedgman was located. All prescriptions were in Mr Sedgman's name.

37. As part of the investigation, police obtained witness statements, photographs and CCTV footage.

38. Ashley McNeight, Specialist Case Manager said that there were no concerns about Mr Sedgman's mental health. He had never disclosed any suicidal ideations or previous incidents of self-harm or threats made to others about self-harm.

39. His sister, JW, stated that in the last year prior to his death, Mr Sedgman's mental health was as healthy as could be under the circumstances and his general outlook was quite positive.

40. Police found no evidence of violence, intended self-harm or suicide, foul play or direct physical involvement from any third party.

IDENTITY OF THE DECEASED

41. Gregory Paul Sedgman was formally identified by his sister, JW, on 30 September 2018.

MEDICAL CAUSE OF DEATH

42. On 5 October 2018, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on the body of Mr Sedgman and reviewed the Victoria Police Report of Death Form 83, e-Medical deposition from Ballarat Health Services, medical records from Ballarat Health and Tristar Medical Group Horsham and a post-mortem computed tomography (CT) scan.

43. Dr Bedford reported that the post mortem examination confirmed a lack of injuries and a lack of significant internal pathology, especially with reference to the heart. Terminally there were hypoxic ischaemic changes in the brain as well as areas of haemorrhagic infarcts. Areas of pneumonia have also been noted. There was deterioration of renal function and a rising creatinine kinase was documented.

44. Toxicological analysis of ante-mortem specimens showed the presence of multiple drugs including oxycodone, morphine, diazepam, nordiazepam, midazolam, venlafaxine, metoclopramide and ketamine.

45. Dr Bedford provided an opinion that the medical cause of death was 1(a) complications post polypharmacy toxicity. I accept this cause of death.

CORONIAL INQUEST

Witnesses

46. Two witnesses were called to give *viva voce* evidence at the Inquest, including Detective Acting Sergeant (DA/S) Greg Mitchell, the Coroner's investigator and Ms Franca Guglielmino, Acting Director of the Post Sentence Branch, Department of Justice and Community Safety.

Scope of Inquest

47. The following issues were examined at the Inquest:

    a) Post sentence Supervision Orders and condition to reside at 228 Corella Place.

    b) Mr Sedgman's Supervision Order and the conditions imposed.

    c) Mr Sedgman's access to and management of his medication.

    d) The Justice Assurance and Review Office Report.

e) Mr Sedgman's protection under the Charter of Human Rights and Responsibilities Act 2006.

Post sentence Supervision Orders and condition to reside at 228 Corella Place

48. Once a high risk offender has completed their sentence and been assessed by a forensic psychologist, the Secretary of the Department of Justice and Regulation[13] may apply to a Court for post-sentence orders.

49. Offenders are placed on a Supervision Order if a Court is satisfied that the offender poses an unacceptable risk of committing a serious sex offence or a serious violent offence, or both.[14] A Supervision Order is subject to a range of conditions imposed by the Court with the primary purpose being the protection of the community from a person who presents an unacceptable risk. The secondary purpose is to provide specific treatment and rehabilitation programs as a means of protecting the community.

50. Supervision Orders can impose conditions to reside at a particular location, such as 228 Corella Place. 228 Corella Place is an appointed residential facility under the SSODS Act. 228 Corella Place provides supervised and supported accommodation for men under Supervision Orders who have not been able to secure suitable accommodation elsewhere in the community or whose accommodation is no longer viable.[15] The philosophy of the residential facilities is to create independent living.[16] 228 Corella Place aims to provide a less restrictive environment in which offenders can live independent lives while working towards transitioning into living in the broader community over time.[17]

51. Each resident at 228 Corella Place is directed to reside at that location by their respective Supervision Order and are subjected to a number of other conditions contained within the order. Core conditions are generic and additional conditions are applied to each offender to meet their specific circumstances and support their rehabilitation.

[13] Now known as the Department of Justice and Community Safety
[14] Section 14, *Serious Offenders Act 2018* (Vic).
[15] Email to the Court from Andrew Wegener, Review Officer, Justice Assurance and Review Office, dated 13 December 2018.
[16] Transcript of evidence, p 42.
[17] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 29.

52. Conditions may restrict an offender's movements within and outside of 228 Corella Place including curfew, accompaniment, and forms of monitoring such as electronic monitoring.[18] Offenders' movements within 228 Corella are otherwise relatively unrestricted and unsupervised. Residents are able to move between units and access common areas within curfew hours.[19]

53. Notwithstanding the restrictions of the Supervision Orders, the residents are considered members of the community and are only subject to the provisions of the *Corrections Act* 1986 (Vic) to the same extent as any community member who is a visitor or otherwise on prison property.[20]

54. 228 Corella Place is staffed between the hours of 8am and 7pm each day by Specialist Case Workers. Usually there are a minimum of two staff members rostered on at any given time. The number of staff fluctuates depending on scheduled activities, outings, or supervision sessions.

55. 228 Corella Place is not institutional in appearance or operation and promotes a normalised environment that encourages the development of residents' independent pro-social living skills. Within the parameters of their orders, residents are encouraged to lead independent and normalised lives as far as it is possible and appropriate to do so.[21] Residents are expected to take full responsibility of their day-to-day affairs such as shopping, banking, developing and maintaining social networks and hobbies, and arranging/attending to any medical appointments. The Supervision Orders also allow Corrections Victoria staff to issue lawful instructions to the residents to address specific issues or concerns.

Mr Sedgman's Supervision Order and the conditions imposed

56. Mr Sedgman was placed on a Supervision Order on 25 July 2011 for a period of five years. The order was renewed on 5 December 2016 for a further four years.[22]

57. Mr Sedgman was not a prisoner, nor was he classified as being in custody.[23] The Supervision Order required Mr Sedgman to reside at 228 Corella Place. Corella Place

[18] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 30.
[19] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 29.
[20] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 32.
[21] Email to the Court from Andrew Wegener, Review Officer, Justice Assurance and Review Office, dated 13 December 2018.
[22] Coronial Brief, pp 211-7.

has eight two bedroom self-contained units. Mr Sedgman lived in unit 4 with another resident.

58. His Supervision Order included a number of conditions, including *inter alia*:

    a) Not to engage in conduct that poses a risk to the good order of the facility or the safety and welfare of offenders or staff at the facility.

    b) Not engage in conduct that threatens the safety of any person, including the offender.

    c) Obey all instructions given by a supervision order.

    d) Must reside at a residential facility.

    e) Must not leave or be absent from the residential facility except in the company and presence of a person approved by Corrections Victoria.

    f) Must not use prohibited drugs, obtain drugs unlawfully or abuse drugs of any kind.

    g) Must be present between 10pm and 7am during summer daylight savings hours and between 8pm and 7am at any other time.

59. Ms Guglielmino's evidence is that the conditions of a Supervision Order try to accommodate the resident's individual set of risks. These individual risks are determined by an assessment of a medical expert prior to being placed on the order.[24]

Mr Sedgman's access to and management of his medication

60. Whilst at 228 Corella Place, Mr Sedgman was encouraged to lead an independent and normalised life as far as it was possible and appropriate to do so, including self-managing his medication.[25]

61. 228 Corella Place does not directly employ medical professionals. Any treatment Mr Sedgman required was administered by relevant medical professionals in the community. Staff at 228 Corella Place are generally not aware of the residents' specific

[23] Email to the Court from Andrew Wegener, Review Officer, Justice Assurance and Review Office, dated 13 December 2018, Transcript of evidence, p 13.
[24] Transcript of evidence, p 36.

medications or the reasons for them. Their role is to monitor access to the medication so that residents don't access or retain excessive amounts.[26]

62. At 228 Corella Place, an offender may have their access to medication and/or drugs restricted by conditions of the Supervision Order.[27] There are policies and procedures that regulate residents' access to their own prescribed medication.

63. Mr Sedgman was reluctant to disclose details of his health to 228 Corella Place staff and had consistently refused to sign an Authority to Exchange Information (**ATEI**), to allow them to communicate with his GP.[28] Unless the resident has signed an ATEI, supervision staff are not permitted to dispense medication to residents.[29] Therefore, the facility is limited as to what they can do, other than supervising the task.[30] The evidence revealed that residents are often not comfortable completing an ATEI, because there is a history of mistrust by residents of Corrections.[31] This was confirmed when Mr Sedgman's sister noted that he "had a significant distrust of Corella Place staff. He did not feel that they were motivated to act in his interest and that any sharing of medical information would be used to further delay his progress towards returning to the community".

64. On 10 August 2018, Mr Sedgman's unit was searched following a reasonable suspicion that he may be misusing prescription medication or supplying medication to others. The search was conducted pursuant to section 142 of the SSODS Act. Staff found a significant quantity of prescription medication which was subsequently seized.[32]

65. To mitigate any potential harm, Mr Sedgman was issued with a lawful instruction for his medication to be held at 228 Corella Place administration office.[33] Mr Sedgman was then required to attend the administration office to obtain his medication as needed. The purpose of the instruction is to allow the residents to safely access their medications in accordance with their prescriptions.[34]

---

[25] Email to the Court from Andrew Wegener, Review Officer, Justice Assurance and Review Office, dated 13 December 2018, Transcript of evidence, p 13, Transcript of evidence, p 17.
[26] Exhibit 2, Coronial Brief, p 82.
[27] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 34.
[28] Email to the Court from Andrew Wegener, Review Officer, Justice Assurance and Review Office, dated 13 December 2018,
[29] Transcript of evidence, p 21.
[30] Transcript of evidence, p 44.
[31] Transcript of evidence, p 44.
[32] Exhibit 2, Coronial Brief, p 37.
[33] Exhibit 2, Coronial Brief, p 37.
[34] Transcript of evidence, p 25.

66. Staff are not medically trained so are not able to dispense the medication, but they do supervise the resident who accesses the medication. This process is governed by Local Operating Procedure (**LOP**) - Resident Medication 13.5.22 which was in operation at the time of Mr Sedgman's death. This contains a procedure for Corella Place staff to follow regarding accessing and storing residents' medications. The LOP requires staff to monitor and record in a register each time a resident accesses their medication, and note the dosage of each medication that is retrieved by an offender.[35]

67. When residents attend under an order to get their medication, they have to sign the medication register which logs the date, time, name and supervising staff member who observed them obtaining their medication.[36] Without an AETI it is impossible for staff to know what is prescribed and how much.[37] Staff also reportedly experience difficulties when other residents' medications are not restricted.[38]

68. The day before Mr Sedgman died, he attended the administration office with another resident who managed to distract the supervising staff. Mr Sedgman was then able to opportunistically take more of his medication. The evidence reveals that there was no entry on the register for the last occasion he accessed his medication on 23 September 2018.[39]

69. Mr Sedgman's death was subject to an Internal Management Review which reported that the most significant challenge is the lack of power for supervision staff to conduct routine screen searches for medication and/or drugs when an offender returns from outings in the community. Further, in the absence of access to unlawful substances, offenders will often resort to abuse of prescription medication, usually obtained or purchased from another resident who may possess a legitimate prescription. The requirement of 'reasonable suspicion' to authorise a search makes it difficult to monitor the selling/trading of prescription medication between offenders at residential facilities, particularly those that cohabitate in the same unit.[40]

70. Since Mr Sedgman's death, Corrections Victoria have adopted a more restrictive approach to controlling medication from a harm reduction/duty of care perspective by prohibiting the possession of excessive quantities of over-the-counter medication.

[35] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 36.
[36] Exhibit 2, Coronial Brief, p 81, pp 272-5.
[37] Transcript of evidence, p 24.
[38] Transcript of evidence, p 27.
[39] Transcript of evidence, p 28.

Further where residents are suspected of abusing, trading or misusing prescription medications, a lawful instruction may be issued pursuant to section 183 of the *Serious Offenders Act 2018* (**the SO Act**) that the resident's medication must be given to the facility's administration office and stored in a secure electronic safe, for access under supervised circumstances, which includes logging the type and amount of medication retrieved.[41]

71. Ms Guglielmino explained that Corrections Victoria have improved their processes in relation to storage of medication at 228 Corella Place and the Resident Medication LOP has been updated. Each resident now has their own Webster-pack which is stored in a safe at the administration building.[42] The Medication Register is now reviewed on a daily and weekly basis by staff.[43] The updated LOP now explicitly states that staff are to report any suspected medication abuse by residents or excessive quantities of over-the-counter medication to the Officer in Charge as soon as possible. The Officer in Charge may issue a written lawful instruction in relation to resident medication where a resident is suspected of abusing, trading or misusing medication.[44]

Justice Assurance and Review Office Report

72. The Justice Assurance and Review Office (**JARO**) reviewed the circumstances of Mr Sedgman's death and made the following key findings:

    a) Mr Sedgman's initial and continued placement at 228 Corella Place was appropriate.

    b) Mr Sedgman's case management was inconsistent with the intent of Correction Victoria's guidelines and multiple opportunities were missed to identify and intervene in his apparent increased risk of medication misuse.

    c) If appropriate oversight of Mr Sedgman's case management occurred, the issues identified with his case management may not have eventuated, and his increased risk of substance abuse may have been dealt with more effectively.

    d) The oversights of Mr Sedgman's access to medications was inconsistent.

---

[40] Exhibit 2, Coronial Brief, p 280.
[41] Exhibit 2, Coronial Brief, p 38.
[42] Transcript of evidence, p 52.
[43] Transcript of evidence, p 52.
[44] Exhibit 2, Coronial Brief, p 349.

e) Opportunities were missed to direct Mr Sedgman to attend urinalysis testing to ensure his compliance with his Supervision Order.

f) Opportunities were missed to search of Mr Sedgman's unit in the lead up to the incident on 24 September 2018.[45]

73. The JARO report made the following recommendations:

a) That the General Manager of Corella Place ensures that staff placement procedures are developed or modified and appropriately applied, to ensure compliance with Resident Medication LOP, particularly that a member of the Corella Place management team is rostered on, and present, at 228 Corella Place during operating hours.

b) That the General Manager of Corella Place, reinforces the requirement and importance of Principal Practitioners engaging in fortnightly supervision with respective Specialist Case Managers and ensures that this supervision includes periodic auditing of randomly selected case files.

c) That the General Manager of Corella Place, on a periodic basis, reviews a random selection of medication registers, to ensure compliance with the Resident Medication LOP.[46]

74. All recommendations have been accepted by Corrections Victoria.

Mr Sedgman's protection under the Charter of Human Rights and Responsibilities Act 2006.

75. In considering the issues associated with this Finding, I was mindful of Mr Sedgman's human rights; to life, dignity and humane treatment as espoused in the *Charter of Human Rights and Responsibilities Act* 2006 (Vic) (**the Charter**), in particular, sections 8, 9, 10, 12, 21 and 22.

76. The Commissioner of Corrections Victoria (**Commissioner**) is responsible for the management and good order of a residential facility such as 228 Corella Place.[47] The Commissioner is a public authority under the Charter. Due consideration must be given

[45] Exhibit 2, Coronial Brief, p 314.
[46] Exhibit 2, Coronial Brief, p 318.
[47] Section 180, *Serious Offenders Act 2018* (Vic).

to the Charter when making decisions affecting the residents' privacy, physical and psychological wellbeing, restrictions of movement, and access to medication.

77. The Commissioner is charged with the responsibility of ensuring residents comply with their Supervision Orders, maintain the good order of the residential facilities, ensuring the safety and welfare of residents, staff and visitors, and adhere to the obligations of the Charter.

78. Section 27(4) of the SO Act states that conditions placed on the residents must constitute the minimum interference of liberty, privacy or freedom of movement to ensure the purposes of the conditions and be reasonably related to the gravity of the risk of reoffending.

79. It was conceded that "interfering with an offender's access to their medication impacts on their rights to privacy, both by interfering with their physical and psychological integrity as well as compelling the provision of health information without consent".[48] According to Deputy Commissioner, Offender Services, Corrections Victoria, Sarah Miles, under the Charter, "an offender's human rights may only be subject to reasonable limits as can be demonstrably justified, taking into account the nature of the right, the importance and extent of the limitation, and whether there are any less restrictive means reasonably available".[49] In regulating an offender's access to medication, "the Commissioner must strike a balance between upholding the human rights and autonomy of an offender and discharging her responsibilities to maintain good order and welfare within a residential facility".[50]

80. Significant measures are in place to ensure the protection of human rights of those on Supervision Orders, including that Parliament has enacted the SO Act in accordance with the Charter, and that the SO Act has significant oversight from the Supreme and County Courts to institute and oversee these orders. The Post Sentence Authority is responsible for independent, rigorous monitoring of serious sex offenders and serious violent offenders on post sentence orders, and oversight of the scheme is delivered by government agencies in Victoria. It also oversees the day-to-day operation of the orders,[51] ensuring minimum interference and less restrictive options.[52]

[48] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 33.
[49] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 33.
[50] Exhibit 1, Statement of Sarah Miles dated 1 April 2019, Coronial brief, p 33.
[51] Transcript of evidence, p 58-9.
[52] Transcript of evidence, p 60.

81. In evidence, Ms Guglielmino explained that the Charter is carefully considered and assessed against all policies and procedures at Corrections Victoria, including LOPs.[53]

82. Having heard all of the evidence, I accept there is rigorous oversight by the courts, and the Post Sentence Authority when an offender is placed on a Supervision Order and the policies and procedures are in accordance with the Charter.

CORONIAL IMPACT STATEMENT

83. Mr Sedgman's sister, JW provided a coronial impact statement and considers that Mr Sedgman was in the 'custody' of Corella Place at the time of his death. She noted that it seems incongruous that people who are under a Supervision Order for certain types of criminal behaviours are all placed together in one facility, when if there were released, they would not be permitted to associate with these same people at all.

84. She commented:

> I believe the entire concept of placing like offenders in a semi supervised facility to be an extremely flawed construct ... placing these individuals together promotes risk taking behaviour that would be less acceptable than when placed in the care of law-abiding family and friends.

85. I have considered JW's comments when writing this finding and acknowledge her concerns. However, issues associated with philosophy of Supervision Orders and their effectiveness are beyond the scope of this investigation.

FINDINGS

86. Having investigated the death of Gregory Paul Sedgman, I make the following findings and conclusions, pursuant to section 67(1) of the *Coroners Act 2008*:

    a) that the identity of the deceased was Gregory Paul Sedgman, born 17 May 1976; and

    b) that Mr Sedgman died on 30 September 2018, at the Ballarat Base Hospital, 1 Drummond Street North, Ballarat, 3350 from 1(a) *complications post polypharmacy toxicity;*

    c) the death occurred in the circumstances set out above.

[53] Transcript of evidence, p 62.

87. Having considered all of the evidence, I find that Mr Sedgman's death was due to the unintended consequences of his deliberate consumption of excessive amounts of prescription medication.

88. I am satisfied that it was appropriate that Mr Sedgman's medication had been seized and a written instruction had been instituted by 228 Corella Place staff in the month prior to his death, to assist with his safe use of prescription medication. I am further satisfied that Corrections Victoria has made changes to policies and procedures at 228 Corella Place to prevent future harm to its other residents who may be at risk of misusing prescription medication.

COMMENTS

89. Pursuant to section 67(3) of the Coroners Act, I make the following comments connected with the death.

90. Mr Sedgman's death highlights that there are a small number of people in our community who are placed on Post Sentence Supervision Orders, after being assessed as suitable by a forensic medical psychologist or psychiatrist and Corrections Victoria.

91. Post Sentence Supervision Orders are unique in that they require certain terms and conditions be placed on a serious sex offender or serious violent offender. Some Supervision Orders place restrictions on a person's civil liberties such as requiring a person like Mr Sedgman to reside in a residential facility, wear electronic monitoring devices and require supervision when out in the community. Many people, including Ms JW, consider that these restrictions mean a person is essentially in the custody of Corrections Victoria. This Inquest has examined some of these issues.

92. This case has identified that there is a gap in the Coroners Act which means that deaths of people on Supervision Orders who are required to reside at a residential facility, such as Mr Sedgman, do not meet the definition of custody and care under the Coroners Act. I accept Correction Victoria's explanation of this.

93. Whilst the circumstances of Mr Sedgman's death did not require a mandatory Inquest, I used my discretion to examine the circumstances of his death because he resided in a state-run facility, with restrictions on his civil liberties. Having examined all of the evidence, I am satisfied that significant measures are in place to ensure the human rights of people on Supervision Orders are protected.

94. Supervision Orders strike an important balance between protecting the safety of the community from harm on the one hand, and providing rehabilitation to an offender on the other. This inquest was not the place for me to challenge the philosophy underpinning the making of these orders or their operational requirements. This Inquest served as an important opportunity to independently examine the circumstances of a person whose liberties had been restricted prior to death, to ensure the system is accountable and that Mr Sedgman was treated humanely and with respect.

95. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

The Family of Mr Sedgman;

Ms Renee Carman, Corrections Victoria

Ms Michelle Gavin, Director, Justice Assurance and Review Office

Mr Huynh Trieu, Victoria Legal Aid

Ms Rebecca Falkingham, Secretary of the Department of Justice and Community Safety;

Dr Linda Danvers, Ballarat Health Services

Detective Senior Constable Greg Mitchell, Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
CORONER
Date: 9 September 2022