Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 28/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Jayden Stafford BENNELL*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***29 August 2016 – 1 September 2016*** *find that the identity of the deceased person was* ***Jayden Stafford BENNELL*** *and that death occurred on* ***6 March 2013*** *at* ***Casuarina Prison*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Mr D Leigh (State Solicitor's Office) appearing on behalf of the Department of Corrective Services.
Mr S Castan (instructed by Shine Lawyers) appearing on behalf of the family of the deceased.

TABLE OF CONTENTS

INTRODUCTION

1. Jayden Stafford Bennell (referred to hereafter as Jayden, at the family's request) died on 6 March 2013 at Casuarina Prison. As Jayden was a sentenced prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1]

2. Prior to the inquest a directions hearing was held on 4 March 2016 to define the issues in the inquest and clarify some evidentiary matters, following submissions being filed by counsel representing Jayden's family. In particular, I indicated at the hearing that there was no cogent evidence obtained during the police investigation, including from further investigations based on information provided by Jayden's family, to support the conclusion that there was any involvement of a third party in the death of Jayden. Accordingly, I ruled that questioning of witnesses, other than the lead police investigators, was generally to be limited to other relevant issues. I also ruled that questioning directed towards any potential systemic issues and preventative comments/recommendations must relate to the particular circumstances of Jayden's death rather than extending into a broad-reaching inquiry into prison systems as a whole.[2]

3. I held an inquest at the Perth Coroner's Court, which commenced on 29 August 2016 and concluded on 1 September 2016.

4. The inquest focussed primarily on the psychiatric care provided to Jayden while a prisoner within the custodial environment and issues relating to his ability to freely access the cupboard where he died, which had not been subject to the Department's ligature minimisation program. Counsel on behalf of Jayden's family also raised the issue of the adequacy of his supervision that afternoon, as well as the adequacy of the investigation into Jayden's death.

5. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department), together comprising four volumes.[3] The authors of both reports were also called as witnesses at the inquest. In addition, a number of other documents were tendered and oral evidence was heard from a number of witnesses who had contact with Jayden prior to his death or were involved in events surrounding his death. Some additional fingerprint and DNA testing was also undertaken by the WA Police investigators at my direction.[4]

---

[1] Section 22(1) (a) *Coroners Act*.
[2] Directions Hearing 4.3.2016, T 4.
[3] Exhibits 1 – 4.
[4] The results of which were provided to the court on 16.1.2017 and 3.2.2017.

6. Following the inquest submissions were filed on behalf of Jayden's family[5] and the Department.[6] I have taken those submissions into account in drafting this finding.

GENERAL BACKGROUND

7. Jayden was born on 13 May 1992. His family are Noongar people of the Bibbulum Tribe and are recognised as traditional owners and custodians of the land around Brookton in Perth.[7] Jayden's maternal grandfather was an artist and activist, playing many roles as a leader in the Noongar community, including serving as the inaugural chairman of the National Aboriginal Commission in Canberra and writing books and plays on Noongar history.[8] Other family members also played significant roles in advancing Noongar culture. Jayden's mother also had ambitions to follow her father into the performing arts but following his death, not long before Jayden's birth, she lost her path and her life spiralled downwards.[9]

8. Jayden was raised by his mother, in the absence of his father, as the eldest of seven children. Together with his younger brother, Jayden was exposed to severe domestic violence inflicted on his mother by her partner during his childhood. This had a profound impact upon him. Substance abuse was an ongoing problem in the household.[10] He also witnessed wider family feuding.[11]

9. Jayden experienced further trauma at about 11 years of age when he discovered that he was a twin, but his twin brother, Keegan, had been stillborn. He was shown a photo of his stillborn twin by a relative. This event had a profound impact upon him and apparently marked a turning point in Jayden's behaviour.[12] From that time he began to act out and participate in anti-social behaviour. He began smoking and moved on to alcohol and cannabis at a relatively young age.[13] As he grew older he began intravenously injecting amphetamines. His drug and alcohol use led to criminal behaviour and interactions with the juvenile justice system, including periods of juvenile detention.[14] He eventually amassed a significant criminal record, including offences involving violence and the use of weapons.[15]

10. Jayden ceased schooling in Year 8 and while he had developed good oral skills, he struggled with his literacy and numeracy skills.[16] After

[5] Outline of Written Submissions on behalf of Ms Maxine Bennell filed 22.11.2016.
[6] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[7] Exhibit 3, Tab 34, p. 1.
[8] Exhibit 3, Tab 34, p. 1 – 2.
[9] Exhibit 3, Tab 34, p. 3.
[10] Exhibit 1, Tab 2, p.11; Exhibit 3, Tab 34, p. 5.
[11] Exhibit 2, Tab 2, p. 11; Exhibit 3, Tab 29.
[12] Exhibit 3, Tab 34, p. 7.
[13] Exhibit 1, Tab 2, p. 8.
[14] Exhibit 1, Tab 2, pp. 8 and 11; Exhibit 2, Tab 29.
[15] Exhibit 2, Tab 2, p. 11; Exhibit 3, Tab 29.
[16] Exhibit 3, Tab 11, p. 6.

leaving school he did not manage to obtain employment whilst in the community, although he had expressed some desire to do so.[17] His accommodation was unstable and he was highly transient, with Jayden at times living on the streets.[18]

11. Jayden loved his family and was very protective of his brothers, particularly his eldest brother, who was next in age to Jayden.[19] On the occasions when he went into prison as an adult he spoke to Community Corrections staff about his desire to be a good role model for his brothers.[20] When in prison he had regular contact with his family through visits and telephone calls.

MENTAL HEALTH HISTORY

12. Despite Jayden being regularly medically assessed while in juvenile detention, the first reference to any mental health issues appears to have been in early February 2009 when Jayden was nearly 17 years old. On 12 February 2009, while serving a period of detention, Jayden was seen by a doctor and diagnosed with a depressive disorder. He also admitted to abusing alcohol, cannabis, solvents and amphetamines.[21] He denied any suicidal thoughts or hallucinations at that time. Jayden was referred to a psychologist. By 19 February 2009 his depression was noted to be improving.

13. On 2 October 2009, while still in detention, Jayden was reviewed by a psychiatrist, Dr Gosia Wojnarowska, and reported experiencing agitation, insomnia, auditory and visual pseudo-hallucinations and paranoid thoughts. He denied any thoughts of self-harm. The psychiatrist noted a long history of cannabis abuse and a family history of schizophrenia. The psychiatrist noted that the symptoms Jayden described could be related to cannabis withdrawals, but she also could not rule out psychosis. Jayden was commenced on the antipsychotic medication Seroquel (quetiapine) at a low dose of 50mg at night.[22]

14. Jayden was reviewed by the same psychiatrist on 16 October 2009 and reported feeling much better. He was noted by the psychiatrist to be bright and reactive. Jayden was diagnosed with drug-induced psychosis and advised to continue with the Seroquel for the next couple of weeks and then to stop. On 30 October 2009 Jayden was seen again by Dr Wojnarowska and he reported feeling well, so the Seroquel was ceased and Jayden was discharged from mental health follow up.[23]

15. However, on 29 January 2010 Dr Wojnarowska had cause to review Jayden again. At that time Jayden complained of hearing people

[17] Exhibit 3, Tab 29.
[18] Exhibit 2, Review Report, p. 6.
[19] Exhibit 1, Tab 2, p.11; Exhibit 3, Tab 29.
[20] Exhibit 3, Tab 29.
[21] Exhibit 1, Tab 2, p. 9.
[22] Exhibit 1, Tab 2, p. 9 and Tab 32, p. 1.
[23] Exhibit 1, Tab 32, p. 1.

whispering at night and feeling paranoid, but he had no other psychotic symptoms and no anxiety or depression was identified. He reported that he had had similar symptoms in the community after smoking cannabis. Jayden was diagnosed with an adjustment disorder but Dr Wojnarowska noted the need to consider whether Jayden was 'prodromal' (showing early symptoms) for a psychotic illness (such as schizophrenia). He was started on a different antipsychotic medication, risperidone, at a low dose of 1mg at night.[24]

16. When Jayden was next reviewed on 19 February 2010 he complained of experiencing flashes and blackouts, which had reportedly begun earlier back in 2009. He was referred for a head CT scan and EEG, which were reportedly normal. On 5 March 2010 Jayden told Dr Wojnarowska he was hearing voices during the day and it seemed as though people around him were playing tricks on him. He also described experiencing some anxiety but his mood was stable. The risperidone was ceased and his medication was changed back to Seroquel, 50 mg twice daily.[25]

17. When reviewed two weeks later on 19 March 2010 Jayden reported feeling better, the voices had stopped and his mood had improved. He was asymptomatic, other than occasional visual 'flashes'. It was Dr Wojnarowska's plan at that time to gradually reduce and cease the antipsychotic medication ahead of Jayden's planned release the following month.[26]

18. When reviewed again on 30 March 2010 Jayden showed no evidence of any psychiatric problem and reported the visual 'flashes' had resolved. The plan was for him to cease Seroquel and no further review was arranged. However, despite this plan, Jayden reportedly continued to receive Seroquel in the prison and he apparently continued to take it for a few weeks after his release into the community on 25 April 2010. He then lost his medication, after which his symptoms started to re-emerge.[27] This occurred within the context that after being released from detention Jayden continued his previous pattern of abusing alcohol and drugs, including amphetamines. He also committed more offences.

19. After being returned to prison on 20 July 2010 Jayden was convicted and sentenced on 6 August 2010 to a term of imprisonment as an adult for the first time. Once in prison he was assessed by a new psychiatrist, Dr Mark Hall, on 2 September 2010. Dr Hall is a consultant forensic psychiatrist with extensive experience working in Western Australian prisons.[28] Dr Hall consulted with Jayden on 15 occasions at both Acacia and Hakea prisons, so he came to know Jayden well.[29]

[24] Exhibit 1, Tab 32, p. 2.
[25] Exhibit 1, Tab 32, p. 2.
[26] Exhibit 1, Tab 32, p. 2.
[27] Exhibit 1, Tab 31, p. 3 and Tab 32, p. 2.
[28] T 335 – 336.
[29] Exhibit 1, Tab 32, p. 2.

20. At the inquest Dr Hall observed that Jayden's case was unusual, as despite the length of time he saw Jayden the exact nature of his condition was never established, which is rare.[30]

21. During the first assessment, Dr Hall noted that Jayden's psychotic symptoms had re-emerged after he had stopped using Seroquel and been using marijuana. He described low mood and a tendency to 'catastrophise' about the future. Jayden told Dr Hall he fought back thoughts of suicide but denied any plans or intent to suicide due to the distress it would cause his family. He also described symptoms of claustrophobia consistent with panic attacks, hearing whispers and feeling at times like he was going 'crazy'. On further enquiry he described seeing "little people" run quickly across his field of vision. It was unclear if this was to do with traditional aboriginal matters. Jayden also reported often misinterpreting what people said to him. Dr Hall noted Jayden's mood was depressed and he seemed to be on the verge of tears on a couple of occasions. Dr Hall formed an impression of mixed disturbance of mood, thinking and perception, in addition to anxiety and poorly formed psychotic symptoms. He diagnosed a depressive disorder with 'attenuated' psychotic symptoms.[31] Dr Hall noted that, once released, Jayden would need referral to a community mental health team and he "should be considered in the ultra-high risk group for development of psychotic disorder."[32]

22. Jayden expressed a willingness to engage in treatment at that time. Dr Hall commenced Jayden on the antidepressant citalopram at a dose of 10mg daily and recommenced him on his antispsychotic medication Seroquel at a dose of 100mg at night. The management plan also involved ongoing monitoring of his mental state for any evidence of risk to himself. Dr Hall hoped to continue establishing rapport with Jayden with the intention of providing him with education around his symptoms and supportive counselling. Dr Hall encouraged Jayden to get involved in education, work or training skills development.[33]

23. Jayden did not attend his follow up appointment with Dr Hall on 1 October 2010. Another appointment was scheduled for 4 October 2010, which he did attend. Dr Hall noted at that review that Jayden's symptoms had persisted, albeit in an attenuated form, so his doses of citalopram and Seroquel were increased. However, during the weeks that followed Jayden became non-compliant with his medication and was also found secreting it at medication rounds. At a review with a mental health nurse on 27 October 2010 Jayden admitted he had been non-compliant with his medication. He described feeling paranoid about other prisoners and his surroundings but denied any thoughts of

[30] T 336 – 337.
[31] Exhibit 1, Tab 32, p. 3.
[32] Exhibit 1, Tab 2, p. 9 and Tab 32, p. 3.
[33] Exhibit 1, Tab 32, p. 3.

self-harm or suicide. The importance of medication compliance was discussed and he agreed to attend for medication.[34]

24. On 4 November 2010 Jayden told Dr Hall that he felt that the medication was not helping. Although he said his experiences of hearing voices and seeing things had abated, he continued to feel as if there was a 'presence' behind him, which he found disconcerting, and his mind felt blank. He agreed to comply with treatment and Dr Hall increased Jayden's Seroquel dose further to 400mg at night.[35]

25. By 23 December 2010 Jayden reported to Dr Hall that he was feeling somewhat better, less paranoid, less psychotic and his mood was improving. However, he described further symptoms of a visual nature and he also described feeling angry and edgy at times. During this consultation he talked about his childhood and acknowledged being deeply affected by witnessing the domestic violence against his mother, which had left him hypervigilant and with a distrust of others. He was also concerned about his intermittent, intense feelings of anger. Jayden indicated he was open to the idea that he may have post-traumatic stress disorder and he agreed to be referred to the prison counselling services for trauma counselling.[36]

26. Jayden's next psychiatric review was with Dr Edward Petch on 24 February 2011, during which it was noted that Jayden had again been secreting his medication. He said it was because it made him feel sleepy, so he preferred to take it later in the evening rather than when it was dispensed (rather than not wanting to take it at all). Jayden's mental state at that time appeared stable and he had no suicidal ideation and no psychosis. A six month review was arranged.[37] However, Dr Hall saw him sooner on 14 April 2011 as Jayden felt he had deteriorated. During that interview Jayden appeared irritable with underlying hostility towards Dr Hall as he had been kept waiting. Dr Hall increased his Seroquel dose to 800mg at night and made a follow up appointment for three weeks' time.[38]

27. At the next review on 5 May 2011 Jayden reported considerable improvement with his paranoid ideation. However, he described ongoing (daily) problematic visual 'flashes' and a bad taste in his mouth.

28. An EEG was performed on 29 June 2011, which did not reveal any specific abnormality or explanation for Jayden's symptoms, although Dr Hall noted that a normal EEG cannot exclude intermittent seizure activity within the brain.[39]

[34] Exhibit 1, Tab 32, p. 3.
[35] Exhibit 1, Tab 32, p. 3.
[36] Exhibit 1, Tab 32, p. 4.
[37] Exhibit 1, Tab 32, p. 4.
[38] Exhibit 1, Tab 32, p. 4.
[39] Exhibit 1, Tab 32, p. 9.

29. On 14 July 2011 Jayden reported to Dr Hall that he was still experiencing the 'flashes'. He was prescribed a trial of sodium valproate (an antiepileptic medication), which he started taking on 25 July 2011 twice daily. He later reported feeling much better after starting the sodium valproate. It eventually reduced to a single evening dose.[40]

30. In early 2012 Jayden was reviewed by a mental health nurse. He reported that he had been clean of drugs for 22 months while in custody and was planning to remain drug-free when released from prison.

31. Jayden was reviewed by Dr Hall on 22 March 2012 and was noted to be due for release on 7 April 2012. Jayden told Dr Hall that since the cessation of the morning sodium valproate dose the flashing symptoms had returned, which he was attempting to ignore. There was no evidence of any delusional or paranoid ideation. Dr Hall felt the symptoms were most likely neurological (seizure activity) in origin. His nightly dose of sodium valproate was increased and his Seroquel dose was concurrently reduced.

32. Jayden was reviewed again on 5 April 2012, two days before his release, and he reported tolerating the new doses although in his view it had made no difference to his symptoms. He expressed a desire to cease the medications altogether although he agreed to continue his medications in the community under the care of a general practitioner and to follow his GP's advice as to continuation or cessation of the medications in due course. Jayden was also advised to attend Alma Street Centre after release, should the need arise for urgent psychiatric assessment.[41]

MENTAL HEALTH DURING LAST PERIOD OF IMPRISONMENT

33. Jayden was released from prison, as planned, on 7 April 2012. Unfortunately, upon release he recommenced intravenous use of amphetamines, later admitting that he used amphetamines intravenously on the day he was released. The drugs were allegedly provided to him by family members.[42] He also stopped taking his prescribed medications. Having immediately relapsed back into illicit drug use, Jayden quickly became engaged in criminal offending and committed new offences only a few weeks after being released back into the community. He was arrested on 30 April 2012 and returned to prison.[43] He was disappointed in himself that his genuine intentions to remain drug free and out of prison had so quickly failed.[44]

[40] Exhibit 1, Tab 32, p. 5.
[41] Exhibit 1, Tab 32, p. 6.
[42] Exhibit 1, Tab 11, p. 5.
[43] Exhibit 3, Tab 11, p. 5.
[44] Exhibit 3, Tab 34 [111].

34. Following his return to prison, Jayden's case was discussed at a mental health team meeting on 7 May 2012. At that meeting Dr Hall explained to the team his impression that Jayden had a longstanding history of perceptual disturbances, with possible causes including partial seizures and/or PTSD from childhood trauma. A psychiatric appointment was arranged for 23 May 2012. A request for an EEG was also made and it was recommended that Jayden remain medication free until the EEG, or at least until his next psychiatric review. Jayden was unable to attend the appointment scheduled for 23 May 2012, as he was on close supervision at the time for security reasons relating to the alleged assault and intimidation of another prisoner,[45] so the appointment was rescheduled.[46]

35. Jayden saw Dr Hall on 18 June 2012 and indicated his symptoms of 'flashes' and accompanying paranoia had intensified since he was released in April 2012, when he stopped taking medication. However, he denied any specific persecutory beliefs or suicidal ideation. He said that he was coping well and was adjusting to the idea of receiving a long sentence. The lack of progression in resolving Jayden's symptoms and his inconsistent response to medications (no doubt influenced by his intermitted non-compliance with such medications) resulted in diagnostic uncertainty, but on balance Dr Hall decided to re-trial Jayden on risperidone in view of his ongoing, possibly psychotic, symptoms.[47]

36. When Dr Hall reviewed Jayden on 3 July 2012, Jayden voiced distress over his worsening symptoms. He was unable to sleep and admitted to depressed mood and some preoccupation with a family matter affecting his mother. However, he adamantly denied any suicidal thoughts. He felt that the risperidone had made his symptoms worse, so his medication was changed to the antipsychotic olanzapine and he was started on the antidepressant fluoxetine, to be taken at night given his stated aversion to attending the morning medication round.[48]

37. On 26 July 2012 Jayden engaged in a counselling session with a prison counsellor, after being advised of the death of a close family friend. He was emotional and upset, but indicated he did not have any current thoughts of self-harm or suicide. He was followed up a few days later and indicated he did not need any further support from the prison counselling service and was managing himself positively.[49]

38. On 3 August 2012 Jayden stopped taking his medications and told staff he intended to remain off medication. He was reviewed again on 6 August 2012 by Dr Hall and indicated he had stopped taking his medications as he felt they were not helping. He said he was now sleeping well and was able to talk and laugh with friends, which was

[45] Exhibit 2, Review Report, p. 8.
[46] Exhibit 1, Tab 32, p. 6.
[47] Exhibit 1, Tab 32, p. 7.
[48] Exhibit 1, Tab 32, p. 7.
[49] Exhibit 3, Tab 4.

also evident in his presentation at the interview (in contrast to the preceding interview). Dr Hall was able to convince Jayden that his symptoms had partially responded to the medications, and he eventually agreed to continue the medications for at least three more months. However, he soon again became non-compliant.[50]

39. Jayden was reviewed by the mental health nurse on 17 August 2012 and denied any thoughts of self-harm but admitted being non-compliant with his medications. His non-compliance was noted at the mental health team meeting on 21 August 2012 and a review with Dr Hall was planned for that day but was unable to be kept, apparently due to competing clinical demands.[51] However, I also note that the prison records indicate that Jayden was convicted of an assault against another prisoner on 5 July 2012 and confined to a punishment cell for 5 days from 20 August 2012, which might have also impeded his ability to attend a psychiatric review.[52]

40. On 2 September 2012 Jayden was overdue for a psychiatric review and the reason was noted as "staff shortage." He was reviewed by mental health nursing staff instead and a psychiatric appointment was rescheduled for the following day but it does not appear to have occurred. A nursing entry for that day indicated that he had been taking his medications again for the last week.[53]

41. On 28 September 2012 Jayden was again seen by the mental health nurse but was unwilling to enter the room and was seen pacing up and down outside. He appeared slightly agitated and stated that he did not need medication. An appointment was arranged for psychiatric review the following week, but again this does not appear to have occurred.

42. Jayden saw a GP on 12 October 2012. A psychiatric appointment was made for 22 October 2012 but Jayden did not attend the appointment, possibly due to a court listing that day. On 24 October 2012 Jayden also failed to attend an appointment. He presented to the health centre a few days later due to a gum abscess, which was dealt with by a doctor by way of an e-consult.[54]

43. On 30 October 2012 Jayden was reviewed by the mental health nurse and was noted to be easy to engage, with good rapport. He denied psychotic symptoms but rated his mood as 6/10 as he was under stress due to his impending court proceedings and a likely lengthy sentence. He denied any suicidal intent and remained resistant to taking medication.

44. Jayden was due to see Dr Hall on 19 November 2012 but when he attended the health centre Dr Hall was occupied with an unscheduled

[50] Exhibit 1, Tab 32, p. 7.
[51] Exhibit 1, Tab 32, p. 7.
[52] Exhibit 2, Tab 12.
[53] Exhibit 1, Tab 31, p. 4.
[54] Exhibit 2, Review report, p. 9.

patient in the Crisis Care Unit and Jayden elected not to wait to be seen. The appointment was rescheduled but in the interim Jayden was transferred to Casuarina on 26 November 2012.[55] Dr Hall was not providing clinical sessions to Casuarina at that time, so that transfer ended his contact with Jayden.[56]

45. Before his transfer to Casuarina Prison, a detailed analysis of Jayden's personal circumstances had been undertaken. It was noted that he had had issues with bullying, stand over and graffiti (Jayden being the alleged perpetrator of all three), which had led to his regression to basic supervision and placement in punishment at times. Apart from these issues, Jayden generally interacted appropriately with staff and was not viewed as a management problem.[57] Recommendations were made for various courses that might benefit Jayden. The recommendations included participation in the high intensity Pathways Program to assist Jayden to manage his substance abuse and reduce his risk of reoffending.[58] He was also assessed for the cognitive skills program and noted to have "cognitive shortfalls in the areas of consequential thinking, problem solving, self-management and victim empathy." Accordingly, he was recommended for the 'Think First' program.[59] Jayden apparently indicated strong motivation to participate in these programs, which was a positive sign.[60]

46. On 11 December 2012 Jayden was reviewed by the mental health nurse at Casuarina. He maintained his position that he did not want to take his medications anymore. He admitted that he still experienced hallucinations but felt that he coped with them. The benefits of the medications were explained to him but this did not change his view. Jayden declined the offer to speak with a psychiatrist but agreed to stay on the Mental Health Register. Jayden denied any past or present thoughts of self-harm and agreed to alert staff if he felt unable to cope.

47. On 13 December 2012 Jayden was noted to still be refusing his medication and a medical review was requested.

48. On 17 January 2013 a mental health nurse recorded that Jayden remained adamant that he wouldn't take antipsychotic medication, despite admitting to ongoing auditory and visual hallucinations and hearing mocking voices laughing or calling his name and acknowledging the medication reduced his symptoms. He referred to his experience seeing other family members on such medications as the basis for his refusal. He recognised that his use of drugs had triggered deterioration in the past but claimed to be abstinent from illicit substances. He denied thoughts of self-harm or suicide and his insight appeared intact. Early intervention triggers and warning signs were

[55] Exhibit 1, Tab 32, p. 8.
[56] Exhibit 1, Tab 32, p. 8.
[57] Exhibit 3, Tab 11, p. 3.
[58] Exhibit 3, Tab 11, pp. 8 – 9.
[59] Exhibit 1, Tab 31, p. 2.
[60] Exhibit 3, Tab 11, p. 5.

discussed and he indicated he was also happy to speak to the psychiatrist about his decision to cease taking medication.

49. Jayden continued to be non-compliant with his medications. When he was seen again by the same mental health nurse on 25 February 2013 there was little change in his presentation. He was attending education full time and claimed he was benefitting greatly from it. He was not accepting of taking any medication, claiming he managed his symptoms well. It was noted that his overall presentation was settled and stable but that he appeared intermittently guarded, with "early signs of deterioration."[61] The mental health nurse later explained that by this, she meant that he displayed some cues suggesting there may be something going on for him. She booked him in for follow-up in six weeks' time and told him he could be seen earlier if required. Even after learning of Jayden's suicide, the nurse maintained that, based upon Jayden's presentation on that day, she would not have done anything differently.[62]

50. Dr Hall was asked in his evidence whether he agreed that was an appropriate response to what the nurse had observed that day. Dr Hall indicated that in his expert opinion he would have expected that in those circumstances Jayden would have been booked in to see the psychiatrist within two to three weeks at the outside, and follow-up with the mental health nurse to occur in the interim.[63] Dr Hall maintained that opinion even in the face of Jayden's expressed reluctance to see a psychiatrist, as he believed it was important to at least make the appointment and hope that he would attend it.[64] It is relevant to note, however, that Dr Hall did not suggest there needed to be an urgent appointment made at that time.

51. On 6 March 2013 there was an entry in the medical record stating that Jayden had continued to refuse his medications and another task was sent to the mental health nurse to see if his medications could be ceased. His non-compliance was discussed with a psychiatrist that afternoon and the plan was for Jayden to be listed for the next available appointment with the psychiatrist. Sadly, Jayden's body had been discovered shortly before this discussion.[65]

52. From the time that Jayden transferred to Casuarina on 26 November 2012, he did not see a psychiatrist. Jayden's last psychiatric assessment was on 6 August 2012, so he had not seen a psychiatrist for seven months at the time of his death on 6 March 2013.

[61] Exhibit 1, Tab 31, p. 5.
[62] Exhibit 2, Review report, p. 17 and Tab 27.
[63] T 385.
[64] T 388.
[65] Exhibit 4, Tab 1, 6.3.2013, 4.27 pm.

OTHER RELEVANT EVENTS LEADING UP TO THE DEATH

53. On 9 January 2013 Jayden was appointed as an Education Centre cleaner/gardener. He later received compliments and encouragement from staff about his excellent work.[66]

54. Also on 9 January 2013 Jayden made an application for rental housing to Homeswest and also applied for a Medicare card.[67]

55. On 11 January 2013 Jayden was waitlisted for drug and alcohol counselling at Holyoake. He attended visits with Outcare on two occasions in February to discuss pre- and post-release support and on 27 February 2013 he submitted an application for a birth certificate.[68] All of these actions support the inference that, at least at this time, Jayden was feeling positive about the future and making plans for his eventual release from prison.

56. Jayden was due to be brought to the Supreme Court on 10 April 2013 to be sentenced in relation to serious charges of aggravated armed robbery, armed robbery, wounding and stealing a motor vehicle, for which he was very likely to receive further terms of imprisonment.[69] Jayden had indicated to prison staff that he understood his total prison sentence was likely to change significantly as he was expecting to receive a lengthy sentence.[70]

57. Jayden's phone calls for the two months prior to his death were reviewed by Det Sgt West. He found no indicators of suicidal ideation in the calls.[71] Jayden's mother was also given an opportunity to listen to those calls and did not draw any of them to the attention of the court.

58. Approximately two weeks prior to his death Jayden was allegedly given a small package of cannabis by a family member, who had smuggled it in and supplied it to him during a visit at his request. Jayden also apparently indicated that he needed three more similar packages, but it does not seem they were provided prior to his death.[72] It is unclear whether or not Jayden actually consumed the cannabis, as police intelligence also indicated that he had some minor drug debts and he might have been using the drugs to pay off some of the debt.[73] If he had used the cannabis himself, his psychotic symptoms would have been aggravated by it.[74]

59. There was no police intelligence to indicate that Jayden had serious drug debts or was actually dealing in drugs.[75] The evidence of Jayden's

[66] Exhibit 2, Review report, p. 12.
[67] Exhibit 2, Review report, p. 12.
[68] Exhibit 2, Review report, p. 12.
[69] Exhibit 1, Tab 28; Exhibit 3, Tab 9.
[70] Exhibit 1, Tab 2, p. 9; Exhibit 3, Tab 11, p. 4.
[71] Exhibit 1, Tab 2, p. 10.
[72] Exhibit 1, Tab 2, p. 16 and Exhibit 3, Tab 34.
[73] Exhibit 1, Tab 2, p. 16.
[74] T 341.
[75] Exhibit 1, Tab 2, p. 16.

cellmate supported the fact that his debts were minor, estimated to be in total only about $300 and had reduced to only about $100 at the time Jayden died.[76] This is consistent with Jayden's mother's recollection of being asked by him to pay $300 into an account, into which she deposited $195 as that was all she could manage.[77] She did not know who the account belonged to, but was given the details by Jayden.[78]

60. Jayden's mother also informed police that Jayden told her he had gambling debts that he owed to other prisoners, although their identity and the extent of the debts were not disclosed.[79] There was no evidence obtained from other prisoners or prison staff to support this claim.[80]

61. During the last month prior to his death Jayden had been sharing a cell with Craig Scortaioli. Mr Scortaioli had known Jayden since they were both very young, having grown up in the same area. He also knew Jayden's family well.[81] As far as Mr Scortaioli was aware, Jayden had never tried to harm himself before the day of his death.[82]

62. Jayden also had another good friend in Unit 5, Zachary Anderson. Mr Anderson had been Jayden's cellmate immediately before Mr Scortaioli.[83] Mr Anderson was aware that Jayden was an amphetamine user by the time he was sent to Casuarina, as were Mr Scortaioli and himself. Mr Anderson reported that all three of them were "getting into a lot of trouble"[84] with their drug use at Casuarina, and they all ended up owing a lot of money to other prisoners. Mr Anderson was aware that one of the other prisoners tried to "stand over" Jayden for his drugs, although it didn't seem to have troubled him greatly. Indeed, according to Mr Anderson none of them cared that they owed money.[85] Mr Anderson believed that Jayden was getting drugs brought in to the prison by his girlfriend and that he had then got more drugs on credit in the expectation that more would be brought in, although there is no other evidence that this occurred.[86] Jayden had also rented out a syringe he owned to get more drugs but he lost the syringe in early February 2013, which made him upset.[87]

63. Mr Scortaioli maintained in his oral evidence at the inquest that Jayden had been asking repeatedly prior to his death to move units and share a cell with his cousin, as he wanted to get away from some prisoners in his unit who were giving him a hard time about his drug debts.[88] While

[76] T 111 – 112.
[77] Exhibit 3, Tab 34, p. 10.
[78] Exhibit 3, Tab 34 [128].
[79] Exhibit 1, Tab 2, Filenote 16.4.2013.
[80] Exhibit 1, Tab 2, p. 17 and Exhibit 1, Tab 2, Filenote 16.4.2013.
[81] T 94 – 95; Exhibit 1, Tab 5 [48].
[82] Exhibit 1, Tab 5 [50].
[83] Exhibit 1, Tab 5 [5] and Tab 34.
[84] Exhibit 1, Tab 34 [21].
[85] Exhibit 1, Tab 34 [25], [32].
[86] Exhibit 1, Tab 34 [30] –[32].
[87] Exhibit 1, Tab 34 [36] – [41].
[88] T 97, 111.

Mr Scortaioli suggested that the harassment about repaying the debt was "starting to get to him," he did not think Jayden was particularly worried about the debts and he was not fearful of the other prisoners.[89]

64. Mr Scortaioli was asked at the inquest why he hadn't previously mentioned Jayden wanting to move units. Mr Scortaioli suggested that he had mentioned this in his statement,[90] although there is no mention of it in the handwritten notes taken in an interview with him on 6 March 2013, nor in the typed revised version signed by Mr Scortaioli on 22 August 2014. He then said he "mustn't have thought about it at the time"[91] due to his distress. Mr Scortaioli did explain in his oral evidence that he spoke to Jayden's cousin about the fact that he was coming to give evidence at this inquest, and Jayden's cousin reminded him that Jayden had been asking to move about three weeks before his death.[92]

65. Jayden's mother also indicated in her statement that Jayden had told her that he had been requesting to move units to be with his uncle.[93] She believed he had filed paperwork requesting a unit transfer.[94] However, a search by the Department of its records found no such paperwork existed. It therefore seems Jayden had not made a formal request for a transfer from that wing.[95] The prison officers from Unit 5 who were called to give evidence also had no recollection of Jayden making an informal request to move.[96] Indeed, Officer Mills expressed surprise that Jayden would do so, as his cell was located in what was generally considered to be "the best landing in the jail outside of self-care."[97] Given Jayden had been in prison before, and would have had some understanding of the formal processes involved to initiate a cell transfer, it would seem that if he had expressed some interest in moving at some stage, he had not communicated that interest to prison staff prior to his death. In any event, the evidence indicates he was housed with two good friends as his cellmates in the months prior to his death, so he still had good social support even without being housed with a family member.

66. The prison records show that Jayden's girlfriend, Gwen Michael, occasionally visited him in prison and they kept in regular phone contact. However, according to Mr Scortaioli and Mr Anderson, Jayden was having problems with his girlfriend shortly prior to his death.[98] She was hanging up when he called her and not turning up for booked visits. Jayden told Mr Scortaioli he believed she had a new boyfriend.[99]

[89] T 99.
[90] T 98.
[91] T 127.
[92] T 98.
[93] Exhibit 3, Tab 34 [118] – [119].
[94] Exhibit 3, Tab 34 [121].
[95] T 561.
[96] T 211, 256.
[97] T 256.
[98] T 99.
[99] Exhibit 1, Tab 5 [52] and Tab 34 [43].

Jayden had also mentioned to his Pathways facilitators that he was having issues with his partner.[100]

67. The last time Ms Michael visited Jayden was on 28 February 2013. She was due to visit him again on 2 March 2013 but the records indicate that she failed to attend. She had also missed some earlier scheduled visits[101] Their regular phone calls also decreased prior to Jayden's death, with Jayden only making one phone call to her between 19 February 2013 and 6 March 2013. Ms Michael was interviewed by a police officer after Jayden's death and she maintained that she had been loyal to Jayden and had been prepared to wait for him. She indicated Jayden had seemed normal during her last visit on 28 February 2013 and she did not get the impression he was in any particular trouble or danger, or was likely to harm himself. Ms Michael did acknowledge that during her last visit Jayden had told her to make sure that she came for her next visit but, as noted above, she did not turn up for that visit.[102] It is possible her failure to attend was interpreted by Jayden as indicating she was not committed to their relationship.

68. Mr Anderson also reported that Jayden felt that other things were going wrong for him around this time. He wasn't doing exercise or looking after himself and was unhappy that he had started balding. Mr Anderson also reported that Jayden "was also feeling bad about how he had behaved on the outside"[103] and he knew he was in for a "big stint"[104] in prison in relation to his upcoming charges and used to mention often that he was worried about the extra prison time he was going to receive.[105]

69. The drugs issue was also reaching a crisis point, as the three of them (Jayden, Mr Anderson and Mr Scortaioli) had spent months being high on drugs, but now it was all falling apart and they had burnt all their connections to get drugs. They were struggling to get drugs, and were even finding it difficult to get cigarettes.[106]

70. In mid-February 2013 Mr Anderson stole some print fluid from the print shop and he shared it with Jayden, Mr Scortaioli and another prisoner. They all sniffed some of the fluid. Jayden then left to have a shower. When he returned he said, "It's all going downhill from here. I am never doing drugs again and I'm never doing crime again."[107] He then said, "I have just had a vision, I have seen myself hanging."[108] Jayden's friends didn't take him seriously and made fun of him as they

[100] T 413.
[101] Exhibit 2, Tab 15.
[102] Exhibit 1, Tab 29.
[103] Exhibit 1, Tab 34 [48].
[104] Exhibit 1, Tab 34 [49].
[105] T 96.
[106] Exhibit 1, Tab 34 [50], [59].
[107] Exhibit 1, Tab 34 [54].
[108] Exhibit 1, Tab 34 [55].

thought he was being funny.[109] Mr Scortaioli agreed in evidence that this incident had occurred.[110]

71. During the first week of March 2013, in the days leading up to Jayden's death, Mr Scortaioli and Mr Anderson noticed that Jayden had spent a lot of time sitting in his cell and not coming out. Mr Scortaioli asked him why he was just sitting there, and Jayden replied that "there was nothing else to do."[111] Mr Anderson thought it was Jayden's way of dealing with the lack of drugs.[112]

72. Mr Anderson was removed from Unit 5 and sent to isolation for two month on about 25 February 2013, so he was not with Jayden during the week prior to his death. In the last few days before his death Mr Scortaioli, who was Jayden's new cellmate, thought Jayden appeared to be "a bit depressed."[113]

EARLY EVENTS ON 6 MARCH 2013

73. On the morning of 6 March 2013 Jayden was in his cell, which was Cell C3 in Unit 5, C Wing. Unit 5 consists of four wings, with 13 cells in each wing.[114] Jayden's cell was diagonally opposite a cleaning storeroom.

74. Jayden's cell-mate, Mr Scortaioli went outside for a cigarette when the cell was unlocked at 7.00 am, at which time Jayden was still asleep.[115] When he returned to the cell Jayden was awake and watching television. Jayden appeared his usual self and according to Mr Scortaioli everything seemed fine.[116] The only thing that, in hindsight, was unusual was that when Mr Scortaioli left for work Jayden shook his hand and hugged him and said, "I love you, my brother. I will see you later."[117] This was unusual behaviour for Jayden, who would usually just say goodbye.[118]

75. Sometime between 7.10 and 7.50 am Jayden was retrieved from his cell by a prison officer and brought to the medical officer for the morning medication round, but he refused to take his medication.[119]

76. One of the prison officers, Officer Sibongile Ncube, gave evidence she had received specific training as a prison officer about Aboriginal health and wellbeing in the prison and particularly the acute vulnerability of young Aboriginal people. She understood that this is because of their

[109] Exhibit 1, Tab 34 [56] – [58].
[110] T 113 – 114.
[111] Exhibit 1, Tab 5 [
[112] Exhibit 1, Tab 34 [60] – [61].
[113] T 97 – 98.
[114] Exhibit 1, Tab 2, p. 3.
[115] Exhibit 1, Tab 5 [8] – [9].
[116] Exhibit 1, Tab 5 [9].
[117] T 100.
[118] T 100.
[119] T 265, 273, 281 – 282.

high rate of suicide. As a result, she gave evidence that she was more vigilant in her care of young Aboriginal prisoners. She had seen Jayden in the unit from time to time and thought he appeared young, motivated and generally happy. This included on the morning of his death.[120]

77. After showering and having breakfast Jayden was escorted to the ODP building to attend the Pathways Program (High Intensity Addictions Course) at 9.00 am. Before he left he was warned by a prison officer about being late for the morning escort. A note was made that he was told this was his final warning as he was regularly late and gave poor excuses.[121]

78. The morning session of the Pathways Program concluded at 11.20 am. It is not clear exactly when Jayden returned to his unit, but it was sometime after then and prior to the lunchtime muster.[122]

79. A prisoner who was working as the unit 5 cleaner, Adrian Edwards, recalls seeing Jayden prior to the lunch lockdown. He had noticed at the beginning of March 2013 that Jayden had become quiet and self-absorbed, staying in his cell a lot (consistent with the evidence of Mr Scortaioli and Mr Anderson). However, on this day Mr Edwards noticed that Jayden was showered and clean shaven and seemed really happy, which was a complete change to how he had appeared in the previous few days. Mr Edwards, who also had peer support training, remembered thinking it was interesting that his behaviour was so different.[123]

80. There is a lunchtime lockdown every day from approximately 12.00 pm to approximately 1.15 pm. On this day it was recorded the lunchtime lockdown commenced at 11.45 am and concluded at 1.15 pm.[124] Jayden was recorded at the lunchtime muster at his unit, which was conducted shortly before the lunchtime lockdown.[125] Jayden was then locked alone in his cell for the lunchtime period, as his cellmate was still at work.

81. After the lunchtime lockdown another prisoner, Michael Barry, who was a peer support inmate, saw Jayden outside his cell during the muster head count. At that time Jayden appeared normal to Mr Barry. He did not see Jayden have any negative interactions with staff or other inmates at that time. Mr Barry had participated in the Gate Keeper Suicide Prevention course and he did not see any indicators that Jayden was at risk of committing suicide at that time.[126]

---

[120] T 209 – 211.
[121] Exhibit 2, Tab 16.
[122] Exhibit 1, Tab 2, pp. 3, 17.
[123] Exhibit 1, Tab 22.
[124] T 316.
[125] Exhibit 1, Tab 2, p. 3.
[126] Exhibit 1, Tab 36.

82. The afternoon session of the Pathways program runs from 1.30 pm to 3.30 pm, so Jayden should have left the unit before 1.30 pm. However, Jayden did not leave the unit and did not attend the session.

83. Instead, at 1.26 pm Jayden's telephone records show that he attempted to call his brother from a telephone located in Unit 5, C Wing. The call was made at 1.26 pm but Jayden's brother did not answer so the call did not connect. This is the last time that Jayden is known to have been alive.[127]

DISCOVERY OF JAYDEN'S BODY

84. Jayden's cell-mate, Mr Scortaioli, finished work early that day and was back in Unit 5 at around 1.30 – 1.40 pm, just after the cells had been reopened after the lunchtime lockdown. He went up the stairs and looked towards his cell and noticed the cell door was open. However, he decided not to go to the cell. Instead, he went and made a phone call, at the same spot where Jayden had made a call only minutes earlier.[128] Call records show the telephone call was made at 1.39 pm. Mr Scortaioli gave evidence he was sitting on a chair facing towards his cell the entire time,[129] so there was no possibility that Jayden came out of the cell during the duration of the call.[130]

85. After the telephone call, which lasted about ten minutes,[131] Mr Scortaioli returned immediately to his cell and noticed that the cell was disordered. This was unusual as Jayden was generally tidy.[132] Mr Scortaioli noticed bedding from Jayden's bed was missing, including some doonas and a sheet. Mr Scortaioli assumed Jayden was changing his sheets. Mr Scortaioli also noted there were empty cigarette butts on a bench in the room and some pens had been smashed. Although he noticed these things, and described it at the inquest as looking "like someone had a fight in there, pretty much"[133] Mr Scortaioli also said that at the time he "really didn't think much of it,"[134] indicating that what he saw didn't cause him to be alarmed for Jayden's safety. Mr Scortaioli had earlier said in his statement that he thought perhaps the cell had been searched.[135]

86. When Mr Scortaioli had walked into the cell a song had been playing on repeat on Jayden's Xbox, the significance of which I will refer to later.[136] Mr Scortaioli changed the music and then noticed an exercise book was sitting on top of Mr Scortaioli's stereo. He hadn't seen the book before. He picked it up and opened it. There was a letter written

[127] Exhibit 2, Review report, p. 13.
[128] T 100 – 101; Exhibit 1, Tab 5 [14] – [17].
[129] T 122.
[130] T 122.
[131] T 102.
[132] T 101.
[133] T 101.
[134] T 102.
[135] Exhibit 1, Tab 5 [18] – [26].
[136] T 96.

inside the exercise book, which Mr Scortaioli started to read. He quickly realised from reading the first line that it was a personal letter to Jayden's mum, so he closed the book and put it back on the stereo.[137]

87. Mr Scortaioli looked around further and noticed a sheet tucked in the cupboard on the right hand side of the cell. He picked up the sheet and saw it was in two pieces, with the appearance that the middle had been removed. Mr Scortaioli thought that perhaps Jayden had done it to use during lockdown to put out the window like a fishing line to get things, such as cigarettes. Mr Scortaioli thought no more about it. He left the cell to make another telephone call, using a telephone on a different wing,[138] then returned to his cell and listened to some music on Jayden's 'Xbox'. At no stage did Mr Scortaioli see Jayden that afternoon. He thought perhaps Jayden was at his course, although he had also noticed Jayden's prison ID in the cell, which he was supposed to wear if he left the unit, so that made him think perhaps Jayden was possibly around the unit.[139]

88. One of the inmates, Mr Barry, thinks he recalls Jayden's name being called over the PA system approximately 20 minutes after the cells were unlocked after lunch, which he assumed was because Jayden had missed a session or appointment. Mr Barry recalls that Jayden's name was called a few more times until they were called to muster.[140] This is consistent with the Pathways coordinators' evidence (which I will discuss later) that they asked for Jayden to be called. However, Mr Scortaioli denied that any announcements were made. He believed Mr Barry must have been mistaken that he heard any such announcements as he was positive he would have noted any announcements about Jayden if they had been made.[141] In addition, none of the prison officers in the unit recall making, or hearing, such calls. I note that calls were made over the PA system for Jayden following the next muster,[142] so it is possible Mr Barry has confused himself as to the timing of the calls.

89. At approximately 3.15 pm prison officers started to perform the afternoon muster for Unit 5, which involves a headcount of all the prisoners in the unit.[143] The initial muster identified that Jayden was missing from the unit, as well as a number of other prisoners.[144] It was explained at the inquest that there can be a number of reasons why a prisoner is not present for a muster, so at that stage there was no significant concern about Jayden's whereabouts.[145]

[137] T 102 – 103, 119; Exhibit 1, Tab 5 [18] – [26].
[138] T 123.
[139] T 103 – 104; Exhibit 1, Tab 5 [29] – [30].
[140] Exhibit 1, Tab 36 [21] – [24].
[141] T 105, 130 – 131.
[142] T 306.
[143] Exhibit 1, Tab 14 [13] – [16].
[144] Exhibit 1, Tab 10 [6] and Tab 14 [26].
[145] T 236.

90. Prison officers made telephone calls to other areas of the prison to see if they could locate the missing prisoners. They located all of them except for Jayden.[146] Prison officers made calls to the control officer at Offender Development Programs to see if Jayden was there, but it was confirmed that he was not. He was called on the unit's PA system and they also looked in the unit's yard and the yard in the outer perimeter. Two of the prison officers even looked on the roof, as there had a spate of roof ascensions recently that made them think it was possible Jayden had climbed on the roof. [147] At some stage Mr Scortaioli was called to the control box and asked if he knew where Jayden was. He indicated that he didn't know Jayden's whereabouts.[148]

91. At 3.45 pm a prisoner recount was called over the radio and the Unit 5 officers began a second muster.

92. Officer Ncube, accompanied by Officers Mills, O'Byrne, Taylor and Hughes, attended the prisoner recount in C wing. Officer Ncube marked off the prisoners from cells C1 and C2 and then entered a cell to make sure there were no other prisoners in the cell. As she looked back out of the cell Officer Ncube glanced towards the cleaning storeroom. She saw the door was open and the light was off. She then saw what she thought were some white shoes in the cleaning room and thought that was odd.[149] Officer Ncube then moved to have a closer look and noticed a figure that appeared to be standing behind a pillar of grey metal ducting in the darkened room. She thought the person was hiding from the prison officers.[150] Officer Ncube then recognised the figure as Jayden although he was partially obscured by the ducting.[151]

93. Officer Ncube spoke to Jayden and asked him, "What are you doing in there?" Why are you hiding from us?"[152] Officer Mills had joined Officer Ncube by this stage to investigate what was happening and had walked inside the cleaning storeroom, followed by Officer Ncube. Officer Mills saw someone standing in the corner, apparently hiding, then realised as he took a step closer that the person was actually hanging. Officer Ncube also looked more closely and noticed a white ligature around Jayden's neck and realised that he was hanging.[153]

94. Officer Mills grabbed Jayden around the lower bottom area from behind and tried to support his weight while Officer Ncube climbed onto the sink in the room in order to untie the ligature, which was tied around a pipe near the ceiling and knotted two or three times. Officer Taylor came in to help hold Jayden's weight. After Officer Ncube untied the knots Officer Mills and Officer Taylor lowered Jayden to the floor inside the storeroom. After briefly commencing resuscitation attempts the two

---

[146] T 305.
[147] T 194 – 195, 238, 236, 306; Exhibit 1, Tab 9 [4] and Tab 14 [27] – [29].
[148] T 306 – 307.
[149] T 197 – 198; Exhibit 1, Tab 6A [17].
[150] T 200.
[151] T 180, 189; Exhibit 1, Tab 5 [32], [65] – [68].
[152] Exhibit 1, Tab 6A [23].
[153] T 200 – 201, 238 – 239; Exhibit 1, Tab 6 [18] – [33] and Tab 6A [21] – [25].

men then stopped and moved Jayden out of the storeroom onto the hallway landing, as there was insufficient room in the storeroom to properly attempt resuscitation.[154] While this was occurring Officer Ncube fainted, so other prison officers attended to her.[155]

95. Officer Mills was handed a Hoffman knife by another member of staff, which he used to cut the ligature that was still around Jayden's neck and he then removed the ligature and continued performing cardiopulmonary resuscitation with Officer Taylor.[156]

96. A Code Red had been called at 3.44 pm when Jayden's body was discovered. After hearing the Code Red a number of nurses from the health centre attended Unit 5. They arrived at 3.47 pm and found Jayden lying on the floor outside the cleaning storeroom with the prison officers performing CPR. The nurses took over CPR and did an assessment of Jayden, which showed he was white, cold, unresponsive and his pupils were fixed and dilated. As a result of that assessment it appeared that Jayden had died, but the nurses continued with resuscitation efforts nevertheless.[157] A defibrillator was applied, which showed that he was asystole (flatline) the whole time and no shock was advised. Dr Wee arrived at approximately 4.00 pm and gave Jayden two doses of adrenaline at 4.06 and 4.08 pm.[158]

97. St John Ambulance had received a call to attend the prison as a Priority 1 at 3.57 pm. Paramedics arrived at the unit and took over resuscitation efforts from prison staff at about 4.14 pm. Jayden was still asystole at that time. They administered further adrenaline and continued CPR for a further twenty minutes but still could detect no signs of life. Accordingly, Jayden was declared life extinct at 4.32 pm by a paramedic.[159]

98. Jayden's body was examined by police officers from the Forensic Field Operations – Crime Scene Investigations unit at Casuarina prior to him being taken to the State Mortuary.[160]

99. I should add that during his evidence at the inquest Mr Scortaioli asserted that when Officer Ncube first went into the cleaning storeroom and told Jayden to 'come out', she then turned and looked at Mr Scortaioli before walking away with another male officer. Mr Scortaioli alleged that it was only when he then went into the storeroom and shouted that the prison officers returned and started to attend to Jayden while other officers locked Mr Scortaioli in his cell.[161] Officer Ncube disagreed with Mr Scortaioli's version of events.[162]

---

[154] Exhibit 1, Tab 6 [34] – [49] and Tab 7 [6] – [15].
[155] Exhibit 1, Tab 6 [49] – [54] and Tab 7 [15] – [19].
[156] T 242 – 243.
[157] Exhibit 1, Tab 18 [10].
[158] Exhibit 1, Tab 18 [14].
[159] Exhibit 1, Tab 2, p. 8.
[160] Exhibit 1, Tab 2, p. 5.
[161] T 108 – 109, 131 – 133.
[162] T 201.

Further, Officer Hughes gave evidence that he stopped Mr Scortaioli going to the cleaning storeroom and placed Mr Scortaioli into his cell.[163]

100. I do not accept Mr Scortaioli's version of events. I prefer the evidence of the prison officers, all of whom gave evidence that they immediately took steps to cut Jayden down and attempted to resuscitate him once they realised he was hanging in the storeroom. I accept that this is what occurred.

CAUSE OF DEATH

101. On 11 March 2013 the Chief Forensic Pathologist, Dr Clive Cooke, performed a post mortem examination on Jayden at the State Mortuary.[164] Dr Cooke is a very experienced forensic pathologist, having been practising as a forensic pathologist since 1986 and held the role of Chief Forensic Pathologist at the State Mortuary since 1991.[165] In that role he has seen many hanging deaths.[166]

102. Three police officers were present during the post mortem examination to assist with full forensic recording of the procedure.[167]

103. The examination commenced with an external examination, during which Dr Cooke looked for any suspicious findings on the body such as injuries that might be associated with "restraint, or struggle, self-defence injuries or even offence type injuries."[168] Dr Cooke explained in his evidence that generally speaking it takes just 10 seconds of examination to find suspicious injuries if they exist.[169]

104. Dr Cooke then elaborated on what he looked for in that 10 second examination. He looks closely at various parts of the body for well-known signs of injury that can arise following a struggle, restraint or in self-defence. One of the particular regions that receives attention is the throat area, looking for any marks around the neck from strangulation attempts. Dr Cooke also examines the face, particularly the nose and mouth, looking for marks from punches to the face or compression marks from smothering. He also looks at the eyes for blood spots/petechiae, which are typical of asphyxiation. Dr Cooke advised that for deaths in custody, such as Jayden's, particular attention is paid in the examination looking for any of those types of suspicious injuries that form part of his '10 second rule.'[170]

105. Jayden's mother claimed that Jayden was seriously assaulted around the time of his death and alleged he had sustained injuries including a

[163] T 282.
[164] Exhibit 1, Tab 21.
[165] T 162.
[166] T 166.
[167] Exhibit 1, Tab 2, pp. 5 – 6.
[168] T 163 – 164.
[169] T 164.
[170] T 164 – 165.

broken nose, broken jaw and rope marks on his wrist. These concerns were not borne out by the findings of the post mortem examination. Dr Cooke found no evidence consistent with Jayden having been involved in a struggle or that another person was involved in his death in any way.[171] Dr Cooke found no evidence of recent injury to the soft tissues or bones of the limbs and specifically found no bruises or other marks on the fronts or backs of Jayden's wrists. His nasal bone was palpably intact and his nostrils were noted as normal, which made it highly unlikely that he had a broken nose. There was also no fracture to his skull, and specifically no broken jaw.[172]

106. Dr Cooke explained at the inquest that a person who is not an expert can commonly mistake post mortem lividity for bruising, making it appear that they have been in a fight when it is really just a post mortem event.[173] Dr Cooke indicated that in this case, there was intensive lividity around Jayden's ears on both sides and on both sides of his neck, that might be mistaken for bruising by someone who was not an expert, such as Ms Bennell.[174]

107. The primary injury that was observed by Dr Cooke was a typical type of ligature mark to the skin of the neck.[175] Dr Cooke was provided with the bed sheet that had formed the ligature around Jayden's neck, sealed in an evidence bag, and accepted that the mark on Jayden's neck "could easily have been caused by a bed sheet,"[176] in the sense that it was consistent with a broad sort of folded fabric of any type, rather than a rope or electrical cord.[177]

108. Dr Cooke was asked during the inquest about the length of time it would have taken for Jayden to die, once the ligature was in place. Dr Cooke explained that it "depends very much on the degree of effective neck compression, first of all, and if there's total occlusion of the arteries of the neck."[178] Where there is total occlusion, it is thought that a person will generally fall unconscious within 10 to 15 seconds, or even less, and once unconscious the person is in a helpless state and death is inevitable unless someone or something else intervenes. Dr Cooke indicated that it is commonly said in forensic texts irreversible brain damage will occur within three minutes, and can occur much sooner.[179]

109. In Jayden's case, although unable to state a definite timeframe for death, Dr Cooke did point to the absence of petechiae (blood spots around the eyes) to support the conclusion that the neck compression

[171] T 165, 168.
[172] T 168 – 169; Exhibit 1, Tab 21.
[173] T 169 – 170.
[174] T 176.
[175] T 165.
[176] T 165 – 166.
[177] T 166, 174.
[178] T 167.
[179] T 167, 175.

was probably quite effective, which would shorten the opportunity for Jayden to be saved if he had been discovered earlier.[180]

110. At the conclusion of the examination and all investigations Dr Cooke formed the opinion that the cause of death was ligature compression of the neck (hanging). I accept and adopt the conclusion of Dr Cooke as to the cause of death.

111. In terms of whether that hanging was due to an act of suicide, Dr Cooke was obviously unable to comment, but he did give expert evidence that "[h]omicidal hanging is very, very unusual, but suicidal hanging is extremely common."[181]

THE INVESTIGATION

112. As per standard prison procedures, when Jayden's body was discovered prison officers initiated 'lock-down' on the unit, securing all prisoners in their cells. They then initiated the Departmental standard operating procedures for dealing with a death in custody. Police were notified and the Major Crime Squad sent a team of five detectives to co-ordinate the investigation.[182] The investigation was approached on the basis that Jayden's death might have been a homicide. Suicide was not presumed, despite the known circumstances.[183]

113. As noted above, Jayden was examined at the prison by a number of police officers from the Forensic Field Operations – Crime Scene Investigation unit. The officers obtained video and photographs of Jayden and the scene generally. Several items were seized, including Jayden's clothing and medical intervention items used in the resuscitation attempts.[184]

114. The ligature found around Jayden's neck appeared to be torn from a bedsheet located in Jayden's cell.[185] The ligature was seized and retained by forensic police.

115. At 11.15 pm Sergeant McCulloch and Senior Constable Owen from the Forensic Fingerprint Bureau conducted an assessment of the scene and made the following observations/decisions:

i. Fingerprint examination was confined to an area in the storeroom;
ii. The surfaces of the room (ducting, pipes and walls) were mainly painted flat white;
iii. No blood was evident on any surfaces;
iv. No damage or moved items indicated a scuffle of any sort;
v. Chemical processes were not required for the scene; and

[180] T 167 – 168, 175.
[181] T 177.
[182] Exhibit 1, Tab 2, p. 4.
[183] T 56, 65, 78.
[184] Exhibit 1, Tab 2, p. 5.
[185] Exhibit 1, Tab 2, p. 5.

vi. Oblique lighting and black powder only were to be utilised.[186]

116. At 11.20 pm Senior Constable Owen commenced fingerprint examination of the designated area. He noted that the pipe that had been wrapped with the sheet was very dusty behind (between the pipe and the wall). No fingerprints were developed showing fingerprint ridge detail on any surfaces. No other physical material was recovered from the storeroom.[187]

117. A spot of what appeared to be dried blood was identified next to Jayden's head after he had been moved to the corridor for resuscitation. The spot was in a common traffic area and located where the resuscitation of Jayden was attempted, not in the vicinity of where his death occurred. The blood was not analysed given where it was located, which pointed to the conclusion that it occurred during medical intervention attempts.[188]

118. As well as the storeroom, crime scene investigators also examined Jayden's cell, which he shared with Mr Scortaioli. Mr Scortaioli had earlier brought to the attention of prison officers the exercise book belonging to Jayden.[189] He had re-opened the book when he returned to his cell after Jayden was found hanging and read the letter inside. After reading the letter he banged on his cell door and told the prison officers who attended that he needed to talk to them. He told Officer O'Byrne that he had been laughing and joking with Jayden the night before but that Jayden "was expecting to receive a longer sentence and was worried."[190] Mr Scortaioli then showed Officer O'Byrne the torn bedsheet in the cell cupboard and pointed out the note in the exercise book. In the note Jayden apologised to his mother and expressed his love for her and his brothers, but also indicated an intention to take his life. He also mentioned that he was going to be with someone named Keegan, who Mr Scortaioli explained to Officer O'Byrne was Jayden's deceased brother.[191]

119. The exercise book was placed back on the stereo and then seized by another prisoner officer before later being given to police investigators.[192]

120. Another two crumpled pieces of paper were later located in a red bucket on the floor of Jayden's cell, which appeared to be two halves of one page, that had been torn from the same notebook. One half was blank and the other half appears to have been an unfinished attempt at writing the suicide note.[193] Also located in Jayden's cell was a white bed

[186] Exhibit 1, Tab 2, p. 7.
[187] Exhibit 1, Tab 2, p. 7.
[188] Exhibit 1, Tab 2, p. 5.
[189] T 123.
[190] Exhibit 1, Tab 13 [41].
[191] Exhibit 1, Tab 5 [40], [43] – [44] and Tab 13 [42] – [46] and Tab 23.
[192] Exhibit 1, Tab 2, p. 7 and Tab 11 [14] – [18] and Tab 23.
[193] Exhibit 1, Tab 2, p. 7 and Tab 27, Photo 5.

sheet with a torn edge, which appeared to match, and be the source of, the ligature found around Jayden's neck.[194]

121. The police made enquiries as to what closed circuit television recordings might be available from Unit 5 that would shed light on events. The Casuarina Security Manager advised that Unit 5 (as part of Units 1 to 10 inclusive) are part of the original prison construction and, as such, have somewhat dated technology available. The CCTV cameras on the unit only record if officers in the Unit Control Booth became aware of an incident occurring and physically activate the recording. A single CCTV camera points in the direction of the storeroom where Jayden was found. However, as in the rest of the unit, it is closed circuit only and does not automatically record, but must be manually started.[195]More recently constructed units in the prison have much better CCTV and general technological capability. Upgrading the older Units has been acknowledged by the Department to be desirable, but there are significant costs, staffing and IT integration units that make it a more complex project.[196]

122. Major Crime Squad detectives noted there was no evidence of a struggle in the cleaning storeroom where Jayden was found, the post mortem examination found he had no defensive wounds or injuries and he had left what appeared to be a suicide note. After considering the available evidence the detectives from Major Crime Squad determined there was no criminality involved in Jayden's death. On 13 March 2013 the investigation was transferred to the Coronial Investigation Unit to complete the coronial investigation into Jayden's death.[197] Det Sgt West took charge of the investigation.[198]

123. Det Sgt West met with Jayden's mother, Maxine Bennell, on 21 March 2013 to discuss her concerns in relation to Jayden's death. Ms Bennell indicated in the meeting that she did not believe that Jayden's death was a suicide. Ms Bennell told Detective Sergeant West that she had received information that another prisoner, named Darryl Drage, was involved in Jayden's death and had allegedly paid some members of an Outlaw Motor Cycle Group (OMCG) to 'murder' Jayden.[199] Ms Bennell claimed that the prisoner Drage had then been released from prison the weekend after Jayden's death. However, during the same meeting Ms Bennell also stated that she was told by other prisoners that a prison officer locked Jayden in the cleaning cupboard and the prisoner Drage then killed him.[200] Ms Bennell also claimed that Jayden had made a number of requests to be transferred from his unit, had been assaulted once in the Education Block and was involved with fights with up to three other prisoners every day.[201]

---

[194] Exhibit 1, Tab 2, p. 7.
[195] Exhibit 1, Tab 2, pp. 6, 8.
[196] Exhibit 1, Tab 2, p. 8.
[197] Exhibit 1, Tab 2, p. 11.
[198] T 11.
[199] Exhibit 1, Tab 2, Filenote 16.4.2013.
[200] Exhibit 1, Tab 2, Filenote 16.4.2013.
[201] Exhibit 1, Tab 2, Filenote 16.4.2013.

124. Det Sgt West investigated these allegations and confirmed in his report that there was no police intelligence or any evidence found to indicate that Jayden had any contact or dealings with any member of any OMCG, drug related or otherwise. As noted earlier, although there was some police intelligence that he had some drug debts, they were believed to be of a minor nature. Det Sgt West spoke to Jayden's cell mate, Mr Scortaioli, who confirmed that he didn't think Jayden had any significant issues with drug debts or OMCG members, or any other prisoners.[202]

125. No physical evidence to support another person being involved in Jayden's death was found in the police investigation and Det Sgt West's investigation did not find evidence of a Darryl Drage in Casuarina prison at the time of Jayden's death. The only Darryl Drage on the Department's records had been released from Acacia Prison in 2009.[203] It was put to Det Sgt West by counsel on behalf of the family that a prisoner named Graham Drage was housed in the unit at the time and he should have investigated whether that person knew anything about Darryl Drage. Det Sgt West did not agree that this was an appropriate line of enquiry in the circumstances.[204] Given the lack of any other objective evidence to support the involvement of another person, and the fact that Ms Bennell gave a specific name, not just 'Drage', I accept that this was sufficient.

126. Detective Sergeant Keith Williams, who was working in the Major Crime Squad at the time of Jayden's death, also gave evidence at the inquest about the investigation. Det Sgt Williams gave evidence that he was part of the attending team at Casuarina on the day of Jayden's death.[205] Det Sgt Williams explained that in this investigation the scene was probably of the most significance, and there was nothing at the scene to suggest that Jayden's death was a potential homicide.[206] The police officers at the scene concluded it was well within the realms of possibility that Jayden had hanged himself in the cleaning storage room and no witnesses spoken to at the scene nor police or Departmental intelligence raised any suspicion to the contrary.[207]'

127. Counsel on behalf of Ms Bennell submitted that there were significant failing in the post death investigation by police. I do not accept that submission and I am satisfied that the level of investigation was appropriate and provided sufficient evidence to allow me to perform my functions under s 25(1) and (3) of the *Coroners Act*.

128. Counsel on behalf of Ms Bennell also submitted that Dr Cooke failed to take crucial steps, including failing to visit and examine the scene himself. I am aware that there is an arrangement in Perth whereby the forensic pathologist on duty will attend the scene at the request of

[202] T 12 – 14; Exhibit 1, Tab 2, Filenote 16.4.2013.
[203] T 14 – 15; Exhibit 1, Tab 2, p. 17.
[204] T 41 – 42.
[205] T 47.
[206] T 48 – 49.
[207] T 50 – 51.

police investigators, where it is considered appropriate. In this case, that request was not made. In the circumstances, given what evidence was available to the investigators at the scene, I accept that it was not necessary for such a request to be made. I also do not accept the other criticism of Dr Cooke, a very experienced forensic pathologist, as valid. Most of the propositions were not put to Dr Cooke when he gave his evidence, and in any event I am satisfied that he performed a thorough and appropriate post mortem examination of Jayden, given the known circumstances of his death.

MANNER OF DEATH

129. Jayden had a traumatic childhood and a long history of drug and alcohol abuse. He eventually developed psychiatric problems, including diagnoses of drug-induced psychosis, atypical psychosis, depression and anxiety. He had been trialled on various antipsychotics, anti-epileptics and antidepressants in the past but prior to his death he had been continually non-compliant with his medications. He reported to medical staff that he did not think the medications helped and preferred to deal with the symptoms without medication.

130. Jayden had told his cellmate and another friend he was having issues with his girlfriend in the time leading up to his death. It was also accepted that he had some debts. He was also very concerned that he was about to receive a lengthy sentence in addition to the sentence he was already serving. He was expecting it to be much longer than any sentence he had previously served. These stressors, along with non-compliance with his medication, may have been factors that would make Jayden consider taking his life.

131. Jayden had no prior history of self-harming or suicidal behaviour but had told Dr Hall in the past that he had experienced such thoughts but had been deterred due to concern about the negative effect it would have on his family.

132. Jayden's cellmate, Mr Scortaioli, indicated in this statement that about three weeks prior to his death Jayden had continually played the same song on his Xbox. He couldn't recall the name of the song but knew that it was something like "all good things come to an end."[208] At the time Jayden told Mr Scortaioli that he wanted this song played at his funeral if he died. Mr Scortaioli didn't think too much about this conversation at the time but it gained added significance following Jayden's death.[209] According to Officer Licastro, who spoke to Mr Scortaioli that afternoon while escorting him to the Crisis Care unit, Mr Scortaioli "was upset that he didn't recognise that these may have been warning signs,"[210] in the sense that Jayden's death might have

[208] Exhibit 1 Tab 5 [53].
[209] Exhibit 1 Tab 5 [54] and Tab 11 [31] – [32].
[210] T 292 – 293; Exhibit 1, Tab 11 [34].

been prevented.[211] At the inquest Mr Scortaioli said that, "I sort of, blame myself in a way."[212]

133. When he provided a statement to police, Jayden's friend Zachary Anderson also recalled Jayden playing the same song prior to his death, which he recognised as Nellie Furtado's song, 'All good things (come to an end).' He stated that Jayden said, "I want this played at my funeral," but they didn't pay much attention as they all used to say similar things.[213]

134. A Prison Support Officer spoke to Mr Anderson on 7 March 2013 to tell him about Jayden's death and again the following day, in the company of Mr Scortaioli. Mr Anderson spoke about Jayden's drug debts and concern that he might get as much as a further 8 year sentence, and he was not sure how he could cope with this, as well as his concerns that his girlfriend was cheating on him. Mr Anderson also indicated he had seen Jayden appearing upset at times and when they had deep and meaningful conversations Jayden would say that he was "sick and tired of hurting people," which Mr Scortaioli acknowledged was something Jayden had written in his letter.[214]

135. The day after Jayden's death Mr Scortaioli made a telephone call to Jayden's relatives. Mr Scortaioli knew Jayden's family and it is understandable that he wished to make contact with them to discuss Jayden's sudden death. Mr Scortaioli first spoke to Jayden's brother, Rhys Bennell, and told him that Jayden had owed some people for 'gunja" (cannabis) and that he believed Jayden had hanged himself in the storeroom before Mr Scortaioli returned from work at 1.30 pm. Jayden's brother then told Mr Scortaioli the family believed Jayden had some injuries, including a broken jaw. Mr Scortaioli expressed surprise. Mr Scortaioli then told Jayden's brother that Jayden had left a note for his mother and proceeded to tell Jayden's brother what was in the letter. Jayden's mother, Maxine Bennell, came on to the phone and was informed by Mr Scortaioli that Jayden had left a note for her. He told her the letter was in Jayden's own handwriting and described what Jayden had written to her. Jayden's mother asks a number of times whether someone assaulted Jayden and for him to find out what happened.[215]

136. Surprisingly given all of the above, at the inquest Mr Scortaioli indicated that he believed that the note he found in the cell was **not** written by Jayden. He gave this opinion towards the end of giving evidence at the inquest, after he had already answered questions from counsel assisting and counsel on behalf of the family, and in response to questioning by Mr Leigh, who appeared on behalf of the Department. It was at that stage that for the first time Mr Scortaioli said he did not

[211] T 296.
[212] T 96.
[213] Exhibit 1, Tab 34 [62] – [63].
[214] Exhibit 2, Tab 1, p. 2.
[215] Exhibit 2, Tab 1.

think Jayden had written the suicide note in the exercise book.[216] He said he could say "100 per cent"[217] that it was not written by Jayden, as he knew Jayden's handwriting from when he did graffiti with Jayden.[218]

137. Mr Scortaioli agreed that he had gone back into his cell after Jayden's body was discovered and properly read the note. He then immediately banged on the door to bring the note to the attention of the prison officers. However, when asked whether at that time he thought the note had been written by Jayden, he said, "No. I just give it to them."[219] Mr Scortaioli was asked why he did not tell the prison officers and Mr Scortaioli answered that he was "still like freaking out" [220] at that stage. However, Mr Scortaioli suggested that he did tell Det Sgt West later that he thought Jayden's death was suspicious and that he also indicated that the note was not written by Jayden on the second occasion he spoke to police.[221]

138. Det Sgt West was recalled as a witness to have that evidence put to him. Det Sgt West categorically denied that Mr Scortaioli had told him that he did not believe Jayden wrote the note. Det Sgt West gave evidence that if Mr Scortaioli had done so, he would have included that information in the statement and also discussed it with other people.[222]

139. Mr Scortaioli also agreed in further questioning that the day after Jayden's body was discovered he spoke to Jayden's mother and brother on the telephone. When asked at the inquest why he would have said that the letter was in Jayden's handwriting at the time, he indicated that he must have been wrong.[223]

140. I indicated at the conclusion of the inquest that I did not find Mr Scortaioli's evidence that Jayden did not write the letter convincing.[224] However, because of the doubt it raised in the minds of Jayden's mother, I was prepared to order further testing on the letter to hopefully allay some of her concerns.

141. At my direction, following the inquest Sgt Broekmeulen arranged for the exercise book and the exercise book pages found in the cell bin to be fingerprint tested by officers from the Fingerprint Bureau.[225] The results of that testing were provided to the court in January 2017. The officers also undertook DNA testing, as there were concerns that the fingerprint testing would prohibit any such testing to be performed at a later date. The results of the DNA examination were inconclusive.[226]

---

[216] T 124.
[217] T 124 and 125.
[218] T 124 – 125.
[219] T 125.
[220] T 125.
[221] T 113; 126 – 127.
[222] T 570 – 573.
[223] Exhibit 2, Tab 1.
[224] T 586.
[225] T 589.
[226] Exhibit 6.

The fingerprint testing was of greater assistance. The testing found Jayden's fingerprints on various parts of the exercise book, but most significantly on the first page that contained the note. Mr Scortaioli's fingerprints were also identified on the front cover of the exercise book and the first page, which might be expected given his evidence of opening the book and reading the note.[227] These findings, together with the other evidence already referred to, support the conclusion that Jayden wrote the note.

142. Taking into account all of the evidence, including the personal nature of the information contained in the note, the consistency between the issues raised in it with the concerns Jayden had expressed to others in the past[228] and the forensic testing, I am satisfied that Jayden wrote the note in anticipation that it would be given to his mother after his death.

143. I am also satisfied, on the basis of all of the evidence before me, that Jayden committed suicide by hanging himself in the cleaning storeroom with a ligature fashioned from his bedsheet.

144. As to why Jayden would do this, some of the reasons are revealed in his note to his mother. It shows he was deeply remorseful about the hurt he had caused his mother and brothers and he was still traumatised by the knowledge of the death of his twin.[229]

145. Emeritus Professor Kamien, who conducted a review of Jayden's medical records on behalf of the Department, suggested Jayden may have committed the act because Jayden's psychosis had progressed (perhaps acutely) to a state where he could not tell his real voice from his psychotic voice that was telling him to "do stuff" (ie kill himself).[230] It is relevant that Dr Kamien was not given access to information such as the post mortem report and the suicide note and witness statements. He formed his opinion based entirely upon the information contained in the medical records. Dr Hall and Dr Brett were asked their response to this opinion, and they thought it was only one of a number of possibilities.

146. Dr Hall had discussed suicide with Jayden in the past. He noted Jayden "was not in favour of suicide. It was not something that he felt he ought to do or should do. It was something that he had contemplated as a mechanism of escape from life."[231]

147. Dr Brett noted that there are a lot of things we don't know about how Jayden was feeling at that time, although we are aware he had a lot of things going on. Jayden had an upcoming sentencing hearing he was

[227] Exhibit 6.
[228] For example, Jayden had told the Pathways facilitators he was having issues with his partner, and talked a bit of shame and grief around his actions and behaviour in the past and the impact that had had on his family and he wanted to make amends to his family: T 413 – 414 (Moodie).
[229] Exhibit 1, Tab 23.
[230] Exhibit 3, Tab 35, p. 7.
[231] T 362 – 363.

worried about and he had issues with shame. Dr Brett suggested that in those circumstances the cause may have been a relapse in psychosis but it may also have been a relapse in mood. It may also have been an impulsive act because of news he had received.[232]

148. I also note that Jayden's family submit that I should disregard Professor Kamien's conclusion. I agree with their submission and I am not persuaded from the evidence available to me (which is significantly greater than was available to Professor Kamien) that the only explanation for Jayden's death was because he was acutely psychotic.

149. I note that there was evidence to suggest that Jayden was preparing for his future by applying for a Medicare card, birth certificate, liaising with Outcare and attending drug counselling. The evidence of all of those who saw him the morning of his death, including his cellmate, other prisoners, prison officers and the Pathways coordinator, was that Jayden did not show signs that he was down and experiencing suicidal thoughts that day. However, the evidence is strong that once he was locked in his cell after the lunchtime muster at 12.00 pm he went about preparing to commit suicide by fashioning a ligature, writing a letter to his mother, putting the song he wanted played at his funeral on the Xbox on loop and leaving the exercise book containing the letter on the Xbox where it was likely to be found. I find that this done as part of an impulsive decision to commit suicide, rather than a premeditated plan over many days.

150. After being unlocked after lunch at approximately 1.15 pm, Jayden unsuccessfully tried to call a family member at 1.26 pm.[233] The evidence supports the conclusion that almost immediately afterwards, within a time period of less than 13 minutes, Jayden took the ligature and went into the cleaning storeroom. I reach this conclusion as when Jayden's cellmate returned from work he made a phone call at 1.39 pm, during which he looked into the corridor facing his cell and the storeroom doors so Jayden could not have passed without being seen. The phone call concluded after about 10 minutes and Mr Scortaioli then went directly into his cell. Jayden was not in his cell and the torn pieces of sheet were present, the song was playing on the Xbox and the exercise book was there.[234] Dr Cooke's evidence was that Jayden was likely to have been beyond recovery within minutes of the ligature compressing his neck. Therefore, it is highly likely that Jayden was deceased by the time Mr Scortaioli had finished his telephone call.

151. As noted previously, Jayden's mother, Ms Bennell, spoke to Detective Sergeant West in April 2013 and indicated her belief that Jayden did not commit suicide and provided information as to who she thought might have been involved in Jayden's death. Her information, while vague, was investigated by Det Sgt West and no evidence has arisen to support that conclusion. Whilst I appreciate that the thought of Jayden

[232] T 393.
[233] Exhibit 3, Tab 7.
[234] T 100 – 102, 118.

taking that action is very difficult for his mother to accept, given they had both discussed suicide in the past and noted it was against their Aboriginal law and spirituality. Jayden had also been opposed to it because of its impact on others.[235]

152. Nevertheless, all of the evidence points to Jayden taking his own life that afternoon. He said sorry in his note for his decision and asked his mother's forgiveness, knowing as he did how devastated she would be by his decision.

153. Based upon all of the evidence before me, I find that the manner of death was by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

154. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. Three main areas arose in this regard during the inquest. The first related to Jayden's unrestricted access to the cleaning storeroom. The second related to Jayden's psychiatric treatment and mental health care. The third related to his supervision during the afternoon of his death.

The Cleaning Storeroom and Ligature Minimisation

155. The cleaning storeroom where Jayden was found contains cleaning implements and a sink.[236] The particular storeroom was originally constructed as a service duct with the primary purpose of housing the duct work for the prison utilities, which is why it was full of pipe work and boilers. The unit was built in 2000 and since that time the Department has moved away from that type of construction and in newly built units have service ducts that are closed up as a matter of practicality.[237]

156. Mr Andrew Daniels, who is employed by the Department as the Assistant Director of Infrastructure Services, is involved in implementing the Department's cell ligature minimisation program in WA prisons. Mr Daniels confirmed that the storeroom does not come within the Department's ligature minimisation program, given it is a communal area and not a prison cell.[238] Mr Daniels indicated that the program focusses on cells only, which is where the majority of deaths in custody occur. He explained it is not practical to extend the ligature minimisation program out to communal areas, because of the volume of possible ligature points in communal areas. He indicated the volume makes it somewhere between impractical and impossible to actually

[235] Exhibit 3, Tab 34 [84].
[236] Exhibit 1, Tab 2, p. 6.
[237] T 456 – 457.
[238] T 455 – 456; Exhibit 1, Tab 33, p. 1.

ligature minimise those areas.[239] To minimise such areas would also render them non-functional, as anything from a door, table or chair can act as a hanging point.[240] The focus on cells also takes into account that the general literature suggests the risk is greatest when prisoners are alone in a cell, as opposed to in communal areas where there are other people around.[241]

157. Mr Daniels noted at the inquest that ligature minimisation, even in cells, is about "optimised risk,"[242] with a focus on reducing the opportunity for hanging. It is not a ligature *eradication* program, because it is nigh on impossible to achieve that goal and have the area habitable, although there are apparently some fully ligature minimised cells in the Crisis Care Unit.[243] Mr Daniels spoke of the need in cell minimisation to finding a balance between ligature minimising the cell and still making it liveable and habitable for the individual.[244] Mr Daniels gave the example of a door that opens and shuts as being a perfect ligature point, but you can't ligature minimise by removing all doors as that would be impractical.[245] He explained that the program ties in with ARMS and the ability to place people into fully minimised cells for periods of crisis care.[246]

158. Mr Daniels attended the cleaning storeroom where Jayden died a couple of weeks after Jayden's death and concluded that it would be impractical to ligature minimise the room. He noted that the actual bulk of the walls are covered in very large duct work and pipe work and there is a boiler unit at the back. These items could not be moved to any other area and could not be sheeted off as they need to be accessible to contractors performing maintenance works. Mr Daniels acknowledged that there were a significant number of potential ligature points in the room. In his opinion, the only way to make sure, from a 'ligature minimisation' perspective, that the risk was reduced would be to have the room locked at all times. Mr Daniels acknowledged that there might be operational reasons to allow prisoners access to the room that were separate from the factors that he would consider from the ligature minimisation program perspective,[247] but from his perspective it was a room that probably shouldn't have been opened.[248]

159. When the storerooms are locked, they can only be accessed by prison staff, who have the keys. However, the evidence was that at the time of the deceased's death and until shortly before the inquest hearing, the storerooms were routinely left unlocked during the day. They were usually unlocked at around 7.00 am and locked up at the evening muster, which is at about 6.15 pm. When unlocked prisoners can

[239] T 456.
[240] Exhibit 3, Tab 39, Proofing Note – Daniels - 12.8.2016.
[241] T 458.
[242] T 459
[243] Exhibit 3, Tab 39, Proofing Note – Daniels - 12.8.2016.
[244] T 473.
[245] T 459.
[246] T 459.
[247] T 457 – 458.
[248] T 463.

access the storerooms at any time to obtain mops, brooms, buckets and water to use to clean their cells. Every prisoner is responsible for cleaning their own cell and they have access to the storerooms for that purpose, other than in particular units such as crisis care and special handling unit.[249] There are also prisoners who work as unit cleaners throughout the day.

160. Information provided by Commissioner James McMahon indicates that Unit 5 is the prison's receival and orientation unit. As a result, it has a high rate of prisoner cell changes within the unit, which necessitate a high standard of cell cleanliness and prisoner personal hygiene, for health and operational reasons. Prisoners may be required to clean cells or common living areas at any time between unlock and lockup. Commissioner McMahon advised in February 2016 that it would be impractical to restrict prisoner access to the cleaning products in the utility room.[250]

161. However, at the time of the inquest hearing, the Department had implemented temporary restriction on access to the cleaning storeroom, other than during a three hour period in the morning from 7.30 am to 10.30 am.[251] Assistant Commissioner Steven Southgate explained at the inquest that the Superintendent of Casuarina made the direction (on 26 August 2016) as there was considered to be a risk that media coverage of this inquest might impact upon the risk presented by the storeroom. The Superintendent also decided it was an appropriate time to undertake a wider and broader risk assessment of ligature minimisation throughout Casuarina at that time, and it was decided to limit access to the storeroom while that risk assessment was being done.[252]

162. Assistant Commissioner Southgate noted that the temporary closure of the storeroom in the afternoon did impact upon staff and prisoners, which was why the closure was only intended to be temporary at that stage, until the risk assessment had been carried out.[253]

163. Assistant Commissioner Southgate noted that there are other places in the prison, apart from the storerooms, that had similar issues of ligature points and lack of supervision.[254] He noted that prisoners are given access to lighters, they work in kitchens with access to knives, they have access to lawnmowers and fuel, and unless they are on ARMS they can have access to razors. They also have access to electricity, cables, etc in most places. However, Assistant Commissioner Southgate expressed his view that it is necessary for this to be so, for the sake of "decency, humanity"[255] and to provide a reasonable living environment. Assistant Commissioner Southgate expressed the opinion

[249] Exhibit 1, Tab 2, p. 6.
[250] Exhibit 1, Tab 33, p. 1.
[251] Exhibit 3, Tab 46.
[252] T 533 – 534, 557.
[253] T 534.
[254] T 536.
[255] T 537.

that it is necessary to leave some choice for prisoners, when their liberty has already been completely removed, and to give them some responsibility back, in order to be humane. He also expressed the view that this trust and responsibility "in itself assists to reduce the anxiety and risk."[256]

164. Commissioner McMahon explained in his report to the court that the Department's ligature minimisation program represents one component of the Department's broader suicide prevention strategy, which includes primary prevention strategies to create prison environments that limit stress on prisoners, secondary prevention strategies to assist staff to identify 'at-risk' prisoners and to support prisoners at statistically higher risk of self-harm, and tertiary prevention strategies, including intervention for prisoners identified as at high risk of self-harm or suicide. Commissioner McMahon advised that all front-line staff receive suicide prevention awareness training. Assistant Commissioner Southgate also referred to ARMS, staff training, prisoner orientation and support as part of a bigger picture aimed at reducing the risk of self-harm.[257]

165. The evidence at the inquest was that there had not been another recorded self-harm incident involving a cleaning storeroom in any prison in Western Australia other than Jayden's. This was despite prisoner's continuing to have unrestricted access to the storerooms until recently. As noted above, most deaths occur in cells.[258] The Department provided statistical information on apparent self-harming incidents that have resulted in deaths in Casuarina in the period 2000 to 2016. Information was provided in relation to 18 deaths in that period. The majority involved hanging and, other than Jayden's death, occurred in cells, usually during lockdown.[259] Two deaths in common areas, not in cleaning storerooms and not in Casuarina, have occurred in recent years, and presumably they will be the subject of their own inquests in due course.[260]

166. It is relevant to note in this case that prior to Jayden going into the storeroom, he was locked in his cell on his own for the lunchtime muster. Mr Daniels confirmed at the inquest that the cell Jayden was housed in was not ligature minimised in any way.[261] It had very obvious ligature points, including exposed bars on the window and numerous others pointed out by Mr Daniels, that he estimated to be in the range of 20 to 24 different ligature points.[262] Jayden was locked in that cell, with its numerous ligature points and the sheet that was

[256] T 538.
[257] T 537, 564.
[258] T 471, 558; Exhibit 3, Tab 37.
[259] Exhibit 3, Tab 37.
[260] Exhibit 3, Tab 41 [50].
[261] Since 2002 all new prisoner accommodation must meet the minimum three point ligature standard and since 2005/2006 the Department has undertaken a retrofitting program in existing medium and maximum security cells, which is still in progress, with money allocated in the current State budget to continue the program for four more years. It is presumed the cell will eventually be subject to 'three point' ligature minimisation at some stage. See Exhibit 1, Tab 33, pp. 2 – 3.
[262] T 474 – 476.

eventually used as a ligature, alone and unsupervised for at least an hour prior to the time when he went into the storeroom. It appears that Jayden used that time to write a letter to his mother and tear the sheet into a ligature, but there is no evidence to suggest he attempted to hang himself in the cell, despite the means and opportunity.

167. Following the inquest, submissions were provided to the court on behalf of the Department. In those submissions, information was provided as to the Department's position on cleaning storeroom access in Casuaraina following the completion of the risk assessment. The Department advised that as a result of the risk assessment:

i. an adjustment will be made to the storeroom doors to enable the doors to be locked open, to assist with visibility;
ii. the doors will be locked open during the hours of 7.30 am and 10.30 am;
iii. the cleaning storerooms will be locked at all other times, requiring prison staff to provide access to prisoners under their direct supervision outside the opening times.[263]

168. It was noted during the inquest that the storeroom's walls, which had been described as very dark, had been repainted a lighter colour after Jayden's death but prior to the inquest. The Department advised that the risk assessment found that the ambient lighting in the C wing at the present time is sufficient to provide good visibility inside the storeroom even when the light to the storeroom is not turned on.[264] In my view, given the storeroom is only open for three hours a day, having the light on as a standard practice during that limited time would still be a better practice, but I don't take it further.

169. As to the cleaning storerooms being open for three hours each morning, I accept that the decision has been made as part of a balancing exercise between reducing the risk of impulsive acts of self-harm and the practicality of allowing prisoners to access cleaning products for their cells. Obviously the option of least risk would be to have the storerooms locked at all times, but I accept that from the evidence put before me that would be burdensome on both prisoners and prison officers. I also consider the balancing of the risk and the practicalities within the context that, even when much more extensive access was allowed for many years, Jayden's death was the only such incident to occur in that area.

170. I also note that Officer Mills gave evidence that he now pays much more attention to checking the storeroom, given his experience of what occurred with Jayden,[265] and I have no doubt that the same could be said of most prison officers who have become aware of this incident.

[263] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[264] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[265] T 261.

Mental Health Care

Report of Dr Hall

171. Dr Hall, who is now employed as the Consultant Forensic Psychiatrist of Co-Morbidity Services for the Department. He provided a detailed report about his care of Jayden, as well as giving evidence at the inquest, much of which has been set out above in the chronology of events.

172. Despite seeing Jayden regularly for a reasonably prolonged period of time, Dr Hall commented that it was not possible to be confident of a psychiatric diagnosis in Jayden's case. He explained that although Jayden was, at times, mentally unwell, the atypical nature of both his symptoms and the way in which they responded to treatment meant that it was not possible to be sure of the precise nature of his ailment. Both his non-compliance with medication and the influence of 'outside issues' further complicated the assessment.[266] Dr Hall noted that it was rare for his treatment to have gone on so long but for the exact nature of his condition to still be unclear.[267] Dr Hall did not appear to consider that the reason for the lack of diagnosis was due to an inability to see Jayden with sufficient regularity, as Dr Hall concluded that the number of visits over that period was roughly equivalent to what would have occurred if Jayden was a patient at a community clinic.[268]

173. Dr Hall was clear that Jayden suffered from psychosis as a symptom cluster, but was unable to determine whether the symptoms were occurring as part of a developing schizophrenic illness or as part of a depressive disorder or post-traumatic stress disorder, or even an organic disorder such as undiagnosed epilepsy.[269] Jayden's varying response to treatment also confused the picture. Further, Jayden's preference to keep private his personal issues and reluctance to describe his symptoms in detail also made diagnosis difficult.[270]

174. In the time he was seeing Jayden, Dr Hall did not form the opinion that Jayden's subjective experience of prison was notably more distressing than for anyone else in prison. However, Dr Hall noted that prison is a "very challenging environment"[271] for most people.

175. Dr Hall noted that Jayden's transfer between prisons resulted in a break in the continuity of his treatment. Further, around that time there was very limited availability of visiting psychiatric sessions to Casuarina, which compounded the problem.[272] Dr Hall acknowledged that the mental health nursing staff documented their intention to have Jayden seen by a psychiatrist, and they reviewed him regularly in the

[266] Exhibit 1, Tab 32, p. 9.
[267] T 336.
[268] T 344.
[269] T 337.
[270] T 338, 340.
[271] T 342.
[272] Exhibit 1, Tab 32, p. 9.

interim, but from the time he was transferred to Casuarina, he did not see another psychiatrist.[273]

176. Dr Hall acknowledged that Jayden's willingness to engage in psychiatric care was not robust and he was not an enthusiastic participant in mental health care. Accordingly, a lot of Dr Hall's therapeutic work had been focussed on keeping Jayden engaged in treatment.[274] The difficulty with the prison transfer, and the shortage of psychiatrists at Casuarina, is that it allowed Jayden to disengage from treatment in a way that would have been more difficult if he had stayed under the same psychiatric care. However, Dr Hall acknowledged in his evidence that he was not sure that even if Jayden had seen a psychiatrist at Casuarina it would have changed his compliance with treatment.[275] Even with the level of continuity of care provided by Dr Hall, Dr Hall estimated Jayden's compliance with medication was less than half the time.[276] Dr Hall was concerned about the consequences if Jayden was not taking his medication, so he spent quite a bit of time convincing Jayden to do so, although his success was somewhat limited.[277]

177. Despite his concern to try to keep Jayden compliant with his medications, Dr Hall also accepted that Jayden could sometimes be non-compliant for some time and feel okay, and at other times he could be taking medication then deteriorate, so the effect on him not taking his medication at Casuarina was difficult to estimate with confidence.[278] However, knowing Jayden as he did, if he had been aware that Jayden had not been taking his medication for 3 or 4 weeks then Dr Hall would have been concerned to check in and see his level of symptoms.[279]

178. In his evidence at the inquest Dr Hall described the practical implications of Jayden not seeing a psychiatrist for the last seven months of his life as a 'lost opportunity' for someone to get a good assessment of what his mental state was like and any associated risk.[280]

179. However, it was also put to Dr Hall that a consequence of Jayden seeing a psychiatrist at Casuarina might have been that his medication would have been officially ceased (as suggested by Dr Brett in his report). Dr Hall agreed that it was a likely possibility, although he indicated that he personally would resist the pressure to cease the medication, despite the repeated non-compliance. Nevertheless, he acknowledged that a different psychiatrist could very well have ceased the medication in those circumstances, noting that there was no

[273] Exhibit 1, Tab 32, p. 9.
[274] T 344 – 345.
[275] T 348.
[276] T 346, 368.
[277] T 368.
[278] T 369.
[279] T 369.
[280] T 378.

indication that Jayden was so unwell that he might have needed to be treated involuntarily.[281]

180. Dr Hall indicated that if he had been told that Jayden was having visions of seeing himself hanging, as he told his cellmate and friends prior to his death, he would have been quite alarmed by that and probably taken an over-cautious response. The discussion about the song being played at his funeral would have also been of great concern to Dr Hall.[282] However, it is not certain that Jayden would have disclosed that sort of information to a psychiatrist, rather than his friends. As Dr Hall noted in his report, Jayden "was known to struggle with 'outside issues' about which he was very private"[283] and he also accepted that Jayden might be less likely to disclose information to him if it involved illicit drug use within the prison.[284]

181. Overall, Dr Hall described Jayden's psychiatric treatment in prison from a medical point of view as adequate in terms of access to a psychiatrist.[285] Dr Hall noted that different psychiatrists might consider that a different frequency of contact is appropriate, although operational issues had played a part in Jayden not seeing a psychiatrist at Casuarina.[286] Dr Hall considered the therapeutic contact that Jayden had with the mental health nurses at Casuarina was appropriate and fulfilling many of the functions that Dr Hall's therapeutic contact with him fulfilled, including the monitoring of his symptoms. Dr Hall commented that he would have liked to have seen Jayden see at psychiatrist at Casuarina, but acknowledged that he wasn't sure it would have changed his compliance with treatment.[287]

182. Given his problems, Dr Hall considered Jayden to be at a chronic level of risk of suicide to some degree.[288] In the time he was treating Jayden, Dr Hall had not seen any occasions where he felt that Jayden's risk had escalated beyond that chronic level of risk. Similarly, Dr Hall acknowledged that health staff at Casuarina routinely asked Jayden as to whether he had any thoughts of suicide or self-harm when he was reviewed, but he did not acknowledge any such ideation and did not exhibit other strong warning signs of suicide in 2013.[289]

183. Nevertheless, Dr Hall noted that suicide attempts may be impulsive and/or a reaction to an external stressor or event or social pressures, such as those Jayden had been experiencing. Dr Hall commented that "people in Jayden's demographic, young men, can be impulsive and can react dramatically and intensely to troubling events or circumstances."[290] He agreed that sometimes their decision to commit

[281] T 382 – 383.
[282] T 379 – 380.
[283] Exhibit 1, Tab 32, p. 9.
[284] T 379 – 380.
[285] T 346.
[286] T 348.
[287] T 348 – 349.
[288] T 351.
[289] Exhibit 1, Tab 32, p. 9.
[290] T 351.

suicide might occur spontaneously without necessarily having exhibited behaviour that would alert people.[291]

184. Dr Hall also speculated that Jayden might have been concerned at the prospect of developing a serious mental illness, which might prompt suicidal behaviours.[292]

185. Dr Hall also acknowledged that Professor Kamien's theory (after he reviewed the medical care on behalf of the Department) that Jayden's psychosis might have progressed to a state where he could not tell his real voice from his psychotic voice, leading to a suicidal act, was one of a number of possibilities, although he did not think it was possible to make that link explicitly.[293] Dr Hall expressed the view that it was also possible that Jayden was not acutely psychotic and chose to take his life based on other reasons.[294]

Report of Dr Brett

186. Dr Adam Brett, who is also a consultant psychiatrist with significant experience in the prison system, was requested by the Coroner's Court to review the management of Jayden's mental health while in prison and provide an opinion as to whether the management was appropriate in all the circumstances.[295] Unlike Dr Hall, Dr Brett was not involved in any of Jayden's psychiatric care, but simply reviewed the available records and relevant material.

187. Dr Brett noted Jayden's history of trauma in his childhood and pattern of substance abuse, "consistent with an effort to self-medicate against his mental health issues."[296] As a result of his childhood trauma Jayden entered adulthood with significant problems; developmentally he "appeared to struggle with the transition from adolescence to adulthood" and it appeared he felt guilt about his twin brother and being a burden to his family.[297] Dr Brett noted that Jayden went on to have a depressive disorder and a psychotic disorder, with an impact from substances. Dr Brett observed that this combination of mental health issues, personal history and his imprisonment "produced a complex clinical presentation."[298]

188. Dr Brett noted that Jayden had poorly defined mental health issues. Nevertheless, in Dr Brett's opinion, while Jayden was in Hakea the mental health team "fully investigated his issues and appeared to have a good handle on his mental health issues."[299] However, when he was transferred to Casuarina the mental health team did not have this

[291] T 357.
[292] T 351; Exhibit 1, Tab 32, p. 9.
[293] T 357 – 358.
[294] T 358.
[295] Exhibit 1, Tab 31.
[296] Exhibit 1, Tab 31, p. 7.
[297] Exhibit 1, Tab 31, p. 7.
[298] Exhibit 1, Tab 31, p. 7.
[299] Exhibit 1, Tab 31, p. 8.

knowledge of him and there was no psychiatric review. He was recommended to have psychiatric reviews but these did not eventuate. Dr Brett observes that ideally Jayden would have been managed in a mental health unit to clarify his issues, but this was not available at that time.[300] At the least, Dr Brett considered Jayden should have had ongoing review by the Casuarina mental health team to try and ascertain exactly what his mental health issues were.[301] Dr Brett noted Jayden's contact with the mental health team at Casuarina was less than at Hakea and described his care at Hakea as "excellent"[302] and his care at Casuarina as "suboptimal" but "adequate."[303]

189. Dr Brett observed that Jayden did not appear to have been identified as a high risk person and he did not have significant acute risk factors associated with suicide. However, he had a number of chronic risk factors, such as being a young male with mental health issues, who was a sentenced prisoner and was awaiting further sentencing.[304] I would add to that list that he was a young indigenous man.

190. Dr Brett expressed the view in his report that the mental health services within the prison service are inadequate – both "underfunded and under resourced."[305] In his report and when giving evidence at the inquest, Dr Brett explained that there is a very high prevalence of mental disorder and substance use problems in prisoners in Western Australia, with a recent survey indicating that many more male prisoners reported experiencing suicidal ideation than in the general male population.[306]

191. The survey to which Dr Brett referred is a report by Dr S Davison et al published in April 2015, which was based on the results of the *Health and Emotional wellbeing Survey of Western Australian Reception Prisoners, 2013*.[307] As noted by Dr Brett, the survey found that the prevalence of mental disorders and substance use disorders in WA reception prisoners is much higher than in the general population.[308]

192. Further, as noted in the Executive Summary of the Report, the "mental health of prisoners is not just the concern of prisons – it is a community concern. Each year many prisoners are released back into the community, and their mental health problems impact not only on them, but on their families and their communities. Prisoners' treatment needs are often not well met, either in the health system or the prison

[300] Exhibit 1, Tab 31, p. 8.
[301] T 390.
[302] T 392.
[303] T 391, 393.
[304] Exhibit 1, Tab 31, p. 8.
[305] Exhibit 1, Tab 31, p. 8.
[306] Exhibit 1, Tab 31, p. 9.
[307] S Davison et al (2015), *Mental health and substance use problems in Western Australian prisons. Report from the Health and Emotional Wellbeing Survey of Western Australian Reception Prisoners, 2013.* WA Department of Health, 2015.
[308] Ibid, 10.

system, and prisoners may frequently move back and forth between the two."[309]

193. In Dr Brett's experience, due to the limited resources and large number of potential clients, mental health services in prison prioritise people who are acutely unwell and people with lower acuity issues (such as Jayden) can be under managed.[310] Dr Hall acknowledged something similar in his evidence, and noted that following Jayden's death he instituted a mechanism for following up mental health clients who are not acutely unwell and haven't been seen for approximately three months, to avoid them 'slipping through the net'.[311]

194. Dr Brett expressed his opinion that Jayden should have been seen more frequently by a psychiatrist before his death. However, he also formed the view that it was unlikely that this would have had an effect on the final outcome. Dr Brett explained that he formed this view as he believed if Jayden had been seen by a psychiatrist more regularly, it is likely that his medication would have been officially ceased.[312] Dr Brett explained that this was because given the very, very high level of acuity of mental health problem in prisons, people who aren't displaying acute symptoms are more likely to be dropped off the system due to resourcing issues. Therefore, if Jayden was repeatedly non-compliant and stated he could control his symptoms without medication, he would be likely to have his medication ceased.[313]

195. Interestingly, Dr Brett comments that this would probably have been the case in the community too. Dr Brett indicated in his report that it,

> is often stated that prisoners should have equivalent mental health care to those in the community. It is likely that if [Jayden] had been managed by a community mental health team, his level of non-compliance would probably have resulted in his discharge. He had also declined an offer to see a psychiatrist, which may have resulted in discharge unless there were other acute concerns. He did not appear to fulfil the criteria of the *Mental Health Act 1996*, although this was not specifically stated.[314]

196. Dr Brett recommended in his report that, where a prisoner is being non-compliant with mental health medication, it be explicitly stated what the risks of this are. Further, Dr Brett also recommended that it be explicitly stated by the practitioner whether or not the prisoner fulfils the criteria for involuntary treatment.[315]

197. In summary, Dr Brett suggested that ultimately what was needed was for the Department to consider investing more resources in mental

[309] Ibid, Executive Summary.
[310] Exhibit 1, Tab 31, p. 8.
[311] T 382.
[312] Exhibit 1, Tab 31, p. 9.
[313] T 392.
[314] Exhibit 1, Tab 31, p. 9.
[315] Exhibit 1, Tab 31, p. 9.

health to provide a more holistic approach to mental health given the acuity of mental health issues amongst the WA prison population.[316] Dr Brett noted that, as an approximation, in the United Kingdom approximately 10 per cent of the mental health budget is put into forensic mental health, whereas in Western Australia it is more like 1 per cent.[317]

198. At the time he prepared his report in November 2015, Dr Brett was aware that prison mental health services in WA were being reviewed.[318]

Casuarina Prison Mental Health Services

199. At the time of Jayden's death the Department had a service level agreement with State-wide Forensic Mental Health Service to provide a psychiatrist from the Graylands Frankland Centre to metropolitan prisons. The psychiatrist was supposed to attend twice weekly at Casuarina. However, the Graylands Frankland Centre staff were frequently unable to meet the contractual requirements, primarily due to staffing issues at that time. When the psychiatrist failed to attend, prisoners were rescheduled to the next available appointment and mental health nursing staff provided intervention and follow up in the interim.[319] Limited access to a visiting psychiatrist resulted in a flow on effect for all prisoners with non-urgent mental health issues.[320]

200. Following Jayden's death, in early June 2013, Health services at Casuarina contracted their own psychiatrist from the Mental Health Commission which, according to the mental health staff in late 2013, had made a marginal improvement to the psychiatric services at Casuarina.[321] At the time, the difficulty was identified as a "drought of psychiatrists" in Western Australia, which meant there were simply not enough clinicians to meet the growing need within the community, and similarly within WA prisons.[322]

201. At the inquest evidence was given by Dr Hall that the psychiatric input at Casuarina has now essentially doubled since the time of Jayden's death. There are now two full days of psychiatric appointments available.[323]

202. Dr Brett was asked his opinion about what that doubling of resources would have on what he had described as a chronically under resourced service? His response was that "they're just managing the tip of the iceberg at the moment and so it's not holistic, comprehensive mental health care in the prisons, and psychiatry input is only one part of mental health care….it's an important part, but it's not the only part.

[316] T 395.
[317] T 396.
[318] Exhibit 1, Tab 31, p. 9.
[319] Exhibit 2, Review report, p. 15.
[320] Exhibit 2, Review report, p. 20.
[321] Exhibit 2, Review report, p. 15.
[322] Exhibit 2, Review report, pp. 15 – 16.
[323] T 389.

So mental health nursing, social work, psychology … a multi-disciplinary team approach to … care is essential."[324] Dr Hall seemed to agree that access to a suite of professional disciplines, such as was usually available in mental health care in the community, would be ideal.[325] Dr Brett also said that indigenous mental health workers would be helpful.[326]

203. It is relevant, in this regard, to note that in July 2012, Professor Bryant Stokes delivered a report to the Western Australian Government into admission, transfer and discharge practices in public mental health services within Western Australia. The review is known as the 'Stokes Review' and it included consideration of mental health services in the criminal justice system, which of course includes WA prisons. Professor Stokes noted in his review that "service provision to mentally ill defendants and offenders has lagged behind the provision of services to the general population and has led to the observation that mentally ill people who come in contact with the criminal justice system are among the most disadvantaged in our society."[327]

204. The review included a recommendation that, as a matter of urgency, the Department of Health, the Mental Health Commission and the Department of Corrective Services undertake a collaborative planning process to develop a 10-year plan for forensic mental health in WA. The recommendation specified that the planning, business cases and funding for provision of a full range of mental health services in WA prisons and detention centres, should include dedicated units and services in prison for mentally ill women, youth, Aboriginal and people with acquired brain injury/intellectual disability.[328]

205. Information was provided by the Department at the inquest that a recommendation was made following the internal business review for the Department to finalise the Memorandum of Understanding with the Department of Health in relation to the provision of health services, in particular mental health services, and to continue to contribute to responses of the Stokes Review.[329]

206. In the submissions provided on behalf of the Department after the inquest, no further information was provided about how the Department is reviewing its mental health services in line with the Stokes Review. Dr Brett's criticism that the mental health services are inadequate, underfunded and under resourced was also not addressed, although it was mentioned in the submissions of counsel assisting as an issue raised in the inquest. The submissions did provide some information about mental health services currently provided at Casuarina, such as the ARMS Manual and the Support and Monitoring

[324] T 395.
[325] T 344.
[326] T 395.
[327] *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Professor Bryant Stokes AM, July 2012, 110.
[328] Ibid, Recommendation 9.
[329] Exhibit 2, Review Report, p. 20.

System (SAMS) Manual and submitted that the Department provides a multidisciplinary approach to the mental health care of prisoners.[330]

207. The Department also advised that in addition to the current prison officer training in the Gatekeeper Suicide Training program it has recently introduced a new compulsory online mental health training course for frontline staff, known as Mental Health Online.[331] The course covers various modules, including one specifically on Aboriginal people. The course is currently being rolled out, starting from December 2016.[332] Cultural awareness training is also already provided at the initial prison officer training,[333] and some prison officers such as Officer Ncube gave evidence about what that training had taught them.[334]

208. Further, the Department also indicated it is proposing to develop a program whereby each prisoner is assigned a personal officer to help build a level of rapport with a prisoner and find out their individual needs.[335]

209. However, as to what are the Department's long-term plans, in conjunction with the Department of Health and Mental Health Commission, I have not been provided with any detailed information.

210. Without making too much independent inquiry, I am aware that the final report on the progress of implementing the Stokes Review recommendations was released by the Mental Health Commission and Department of Mental Health – Office of Mental Health in April 2016.[336] That report noted that, on the basis of the report, a clinical services plan has been developed and released by the Government to provide a blueprint for the investment in mental health, alcohol and other drug services to meet the needs of Western Australian across the State by the end of 2025. The actions in the plan, amongst other things, include the recommendations relating to prisons found in Recommendation 9. The report notes that a business case is currently being prepared for consideration, which will include expansion of the currently inadequate number and location of secure forensic mental health inpatient beds.[337]

Conclusion on quality of mental health care

211. I am satisfied, based on all of the evidence that has been put before me (and particularly noting the comparison with the care provided by Dr Hall to Jayden at Hakea, which was acknowledged by all involved in the inquest to be excellent) that the mental health care given to Jayden

[330] T 591.
[331] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[332] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[333] T 554.
[334] For example see T 209 – 211.
[335] Outline of Submissions by the Department of Corrective Services filed 15.12.2016.
[336] MHC & DoH, *Final Report on Progress of Implementing Stokes Review Recommendations*, (April 2016).
[337] MHC & DoH, *Final Report on Progress of Implementing Stokes Review Recommendations*, (April 2016), 30.

in Casuarina prior to his death was inadequate. While I accept that he was not always an enthusiastic participant in psychiatric treatment, the evidence was that he had generally cooperated in attending appointments with Dr Hall. Given Jayden's known history of ongoing psychotic symptoms and lack of a clear diagnosis despite a reasonable period of treatment, and his ongoing refusal to take his medication, it was important for Jayden to have been seen by a psychiatrist within a reasonable period of time after his transfer to Casuarina, and out of Dr Hall's ongoing care. I do not consider seven months to be a reasonable period of time for Jayden not to have seen a psychiatrist, given his history, and it would have been known at Casuarina that at the time of transfer it had already been a few months since he had last had psychiatric review and an appointment had been scheduled for a few days after his transfer.

212. I accept the evidence of Dr Hall and Dr Brett that it cannot be said that if Jayden had seen a psychiatrist it would necessarily have altered the path of events, as a different psychiatrist might well have consented to Jayden's medication being ceased. In addition, even if he had been convinced to restart his medication, it is known that his medication was not always effective in treating his symptoms and it is also not clear that his actions were a result of psychosis.

213. What can be said is that the failure to give Jayden access to a psychiatrist at Casuarina was a 'lost opportunity' (as described by Dr Hall) for a psychiatrist to assess his mental state and associated risk of self-harm. Jayden had many features known to indicate higher risk of self-harm (a young Aboriginal male with a history of mental health and substance abuse problems awaiting a likely lengthy sentence) and it was important for him to have an opportunity to be assessed and given an opportunity to establish rapport with a new psychiatrist. Whether or not he chose to continue with that care once he had seen a new psychiatrist was then a matter for him.

214. I accept that the availability of psychiatrists at Casuarina has improved since Jayden's death. However, I also accept the evidence of Dr Brett that on the whole, mental health treatment in WA prisons remains under resourced and underfunded. It is to be hoped that the implementation of the Stokes Review recommendation will go some way to solving those problems. However, given I am not aware of the details of what is proposed, I am unable to be satisfied that that is the case. Accordingly, I make a recommendation in the hope that the failings that are evident in this case are taken into account in the plans that are made by the Department for the future.

RECOMMENDATION

I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should

invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care. Efforts should also be made where possible to hire some Aboriginal mental health workers to form part of the mental health team.

Supervision and the Pathways Program

215. The last main area of concern was how Jayden was able to go into the storeroom and not be found for several hours, despite the fact he was supposed to attend the afternoon session of the Pathways program that day and despite the fact there was a muster check prior to him being found during the repeat of that muster check?

CCTV

216. One issue raised was why there was not CCTV footage to capture what occurred. Information was provided at the inquest that there are CCTV cameras throughout Casuarina, including in the units. Although they do play some role in the collection of evidence, they are primarily to enable officers to monitor the perimeter of the prison and to respond as quickly as possible in the event of a perimeter breach (that is, to prevent intruders and escapees). The majority of the cameras feed back to the Master Control Room. The images are displayed intermittently on monitors but not all images from all cameras are on display at any one time. It is up to the prison officer monitoring the screens in the Master Control Room as to which ones they are viewing at any given time. The images transmitted back are not automatically recorded other than in certain specified areas, such as in the Crisis Care Unit and the Infirmary. Some other cameras automatically record when an alarm is activated, but not all. In order for the images captured by the other cameras to be recorded, they must be up on one of certain monitors, and those are usually limited to perimeter cameras rather than those within accommodation units.[338]

217. The outcome of all of this information is that the CCTV cameras sited within unit 5, which were fixed wing cameras, did not automatically record the images they captured and may or may not have been being viewed by a prison officer that afternoon.[339]

218. Commissioner McMahon advised that, from the Department's perspective, the purpose of the fixed CCTV wing cameras is to provide security coverage of the unit wings to facilitate a response to any after-hours security breach or incident within the common areas. The

[338] Exhibit 3, Tab 33.
[339] Exhibit 3, Tab 33.

cameras record when a cell door reed switch alarm is generated and acknowledged by the Department's Special Operations Group, feeding up to the recording monitors in the Master Control Room. According to Commissioner McMahon the cameras are in good working order and there are no current plans to replace them.[340]

219. At the inquest Mr Daniels was asked about the Department's plans for CCTV in the future. He indicated there is an upgrading program for cameras at Casuarina.[341] However, Mr Daniels also stated that there were no plans to record the images captured by all the cameras, even after the upgrade. Instead, there will be a risk assessment to decide which of those cameras will record.[342] The reason for this is there are more than 200 cameras and the sheer volume of footage that would be captured is immense, so it would be impractical and costly to capture and store them all.[343]

Pathways Program

220. The Pathways Program is a drug and alcohol program. Its aim is to reduce relapse and recidivism into substance related offending and substance abuse. It also provides guidance on emotional management, emotional regulation, control skills and personal hygiene. It is not a compulsory program but is elective for a prisoner to attend. Although primarily aimed at Aboriginal participants, other prisoners are able to take part.[344]

221. As noted above, Jayden was recommended for participation in the course just prior to transferring to Casuarina. He was interviewed and found to be a suitable participant, and he then started the course in February 2013.

222. Jayden's good friend, Mr Anderson, reports that Jayden attended the Pathways program "to mix with other prisoners, from other units, to be able to purchase drugs"[345] and it also enabled him to go to the education block, which gave him something to do.[346] However, the facilitators felt that Jayden was genuine in his commitment to the program and his intention to take steps to manage his addictions and change his future.[347]

223. Mr Benjamin Moodie, who is currently employed as an Aboriginal Programs Facilitator with the Department, was employed as a Counsellor Educator with the Aboriginal Alcohol and Drug Service in 2013. The agency was contracted by the Department to deliver the Pathways Program in Casuarina. Mr Moodie met Jayden in Casuarina

[340] Exhibit 1, Tab 33, p. 3.
[341] T 470.
[342] T 471.
[343] T 470.
[344] T 400, 408 – 409, 411 – 412s.
[345] Exhibit 1, Tab 33 [67].
[346] Exhibit 1, Tab 33 [68].
[347] T 415.

in early 2013. He first met Jayden on 13 February 2013, in company with his then co-facilitator, Mr Russell Butler. They interviewed Jayden, who talked predominantly about his alcohol use and how it had affected his criminal behaviour. Mr Moodie did not recall Jayden showing signs of depression or self-harm during the interview.[348]

224. After that time Jayden began to participate in the group programme, which generally had 12 participants. Jayden missed the first session after his interview, which it appears from the records most of the participants were unable to attend for some reason. He attended two sessions on 18 February 2013 with Mr Moodie and Mr Butler, and he attended twice daily to all of his scheduled sessions for the remainder of February. As far as Mr Moodie could recall there was nothing unusual in Jayden's behaviour during those meetings. Mr Moodie formed the impression that Jayden was a 'happy guy' who was very forthcoming and open in what he was discussing.[349] Mr Moodie felt that Jayden was making progress and thinking about how to address his problems.[350]

225. Mr Butler knew Jayden as a young Aboriginal man who was proud of his culture and showed respect to Mr Butler as an older Aboriginal man. They had talked often and Mr Butler formed the view Jayden was an excellent young man who had become caught up in the wrong world. They talked about the issues of being caught up in institutions and the need to break away from that, and the importance of family in helping him move beyond imprisonment.[351]

226. The evidence establishes that Jayden attended a further Pathways group morning session on 6 March 2013 and Mr Moodie was one of the co-facilitators. However, some questions arose as to who was his co-facilitator on the day?

227. Unlike with other witnesses, Mr Moodie and Mr Butler did not have the benefit of statements taken in a timely manner close to the events. A statement was not taken by the police from Mr Moodie until 18 February 2016. No statement was taken from Mr Butler. The lack of statements recording their recollection of events at the time of Jayden's death put Mr Moodie and Mr Butler in an extremely difficult position. I am satisfied that they both recalled Jayden personally, and did their very best to recall the exact chronology of events leading up to Jayden's death. However, it is apparent from other objective evidence that some of their evidence was unreliable. I do not say that as a criticism of either witness, as I formed a very favourable impression of both men as honest and genuine witnesses who had been deeply affected by Jayden's death and wished only to assist the court with their evidence. Nevertheless, the lengthy delay had an impact on their ability to give

[348] Exhibit 1, Tab 35 [9] – [17].
[349] T 399 – 401.
[350] Exhibit 1, Tab 35 [25] – [29].
[351] Filenote of telephone call between Russell Butler and Charandev Singh – 19.8.2016.

accurate and detailed evidence about events. It is regrettable that more was not done to take their statements earlier in the investigation.

228. As I have stated above, the evidence establishes that Jayden attended the Pathways group morning session on the day of his death. There is clear objective evidence that Mr Moodie was one of the co-facilitators that day. Mr Moodie and Mr Butler both believe that Mr Butler was the other co-facilitator that day. Mr Butler's recollection was that he was still there on 6 March 2013 and finished his employment that day after he returned to the Aboriginal Alcohol and Drug Service Office.[352] Mr Moodie had a similar belief.[353] However, there is some objective evidence obtained that indicates conclusively that Mr Butler had finished that role shortly before that date and been replaced by Mr Patrick Smith from 25 February 2013.[354]

229. Mr Moodie's case notes for 6 March 2013 reveal that Jayden had stated during the morning session that he thought it was impossible to change, although his thinking was challenged by the facilitators.[355]

230. Mr Moodie recalls that Jayden appeared normal that day and was being open about his drug use, saying it had caused problems in his life. Jayden expressed a commitment to changing his offending behaviour by changing his drug and alcohol use, although he acknowledged it seemed to be harder than he expected it to be. Jayden talked during the session about his remorse for his actions and behaviour and the effect they had on his family. He also spoke of his hope to spend time with his mum and family when he got out of prison.[356] According to Mr Moodie, Jayden seemed future focussed at that time, and did not present in any way as someone who was contemplating suicide.[357] The morning group session finished at 12.00 pm and Jayden returned to his unit. Jayden was due to return with the group at 1.00 pm for the afternoon session.

231. As is now clear, Jayden did not return for the afternoon session. Mr Moodie's evidence was that Jayden had never been late or missed a session before (although the records actually indicate that he did miss a session on 14 February 2013)[358], so when he did not arrive for the afternoon session that day he noticed it immediately. However, he was not immediately concerned as he thought Jayden may have been late for unlock, and he was aware that Unit 5 prisoners often came in late.[359] Mr Moodie indicated that the program session would have started at 1.35 pm and around that time he went to the ODP control, which is the movement section of prison guards in the programme section, and asked Officer Anthony Licastro (who he saw at the inquest

[352] T 427, 439.
[353] T 580 – 581.
[354] Exhibit 3, Tabs 28, 47 and 50.
[355] Exhibit 3, Tab 48.
[356] T 420; Exhibit 1, Tab 35 [31] – [36].
[357] T 415, 419 – 420; Exhibit 1, Tab 35 [38] – [40].
[358] Exhibit 3, Tab 49.
[359] T 401.

and remembered being the person he spoke to) to call Jayden.[360] Mr Moodie recalled that after 15 to 20 minutes had elapsed he asked the same prison officer again, who said Jayden was being sent down.[361] They then resumed the program. He followed up again with the same officer at about 2.30 pm, after another half an hour or so had elapsed without Jayden arriving. Mr Moodie then recalls that a few minutes later Officer Licastro came to the door and said that they did not know where he was.[362] The session finished at around 3.30 pm, without Jayden ever attending. After Mr Moodie left the prison he made a note of Jayden's absence from the afternoon session. Mr Moodie found out about Jayden's death when he returned to Casuarina the following day.[363]

232. Although Mr Moodie recalled Officer Licastro being the ODP control officer on the day of Jayden's death, and making his enquiries about Jayden's absence with that officer, the evidence of Officer Licastro was that he was not performing that role that day and he would not have had reason to go to the ODP that day.[364] Another prison officer, Andrew Hall, gave evidence that he was working in the control room of the ODP that afternoon, rather than Officer Licastro.[365] Officer Hall did not normally work in that area, so Mr Moodie would not have been familiar with him.[366] Officer Hall did not recall anyone making enquiries with him about Jayden's absence from the program that afternoon and he was fairly certain that if three such requests had been made (as was the evidence of Mr Moodie) he would recall that occurring as by the third time he would have put out an all points radio call to locate Jayden and the matter would continue to escalate until Jayden was found.[367] However, Officer Hall accepted that it was possible he might not realise that more than one request had been made for Jayden, if someone else in the control room took a second or third request.[368]

233. Officer Barrie Seldon was the control officer in unit 5 on the relevant day. He couldn't recall specifically any requests to find Jayden prior to the afternoon muster but his evidence was that if he had been asked to find him by someone from the ODP at 1.30 pm then he would have escalated the matter well before 3.00 pm.[369] As I have noted earlier none of the prison officers remembered announcements being made in unit 5 for Jayden, prior to the afternoon muster and their general evidence was that they would have done something to look for him if they had.[370] It is to be expected that they would have remembered any calls about Jayden, given its significance in relation to the later events of the afternoon. Although one prisoner thought he had heard such

[360] T 402 - 404.
[361] T 405.
[362] T 406 – 407.
[363] Exhibit 1, Tab 35 [42] – [52].
[364] T 561.
[365] T 444.
[366] T 449.
[367] T 445.
[368] T 449 – 450.
[369] T 311.
[370] T 189, 219, 230, 236, 282, 310 – 311, 314, 446, 449.

announcements, Mr Scortaioli was adamant they were not made. Interestingly, Mr Scortaioli also believed that prisoners were not routinely followed up if they failed to attend the Pathways program, but were just ticked off as having not attended, based upon his own participation in the program.[371]

234. In the end, I have found it impossible to reconcile the accounts of the various witnesses. I accept that Mr Moodie was an honest witness, but given the length of time that had elapsed and that his evidence did not match up with objective evidence in significant areas (such as the identity of his co-facilitator that day and the ODP control person he spoke to) I am unable to find him to be a reliable witness. As I said earlier, this is in no way intended as a criticism of Mr Moodie, who was extremely patient in attending and waiting to be called on more than one occasion, as well as agreeing to be recalled as a witness. The distress that the news of Jayden's death obviously caused to Mr Moodie, coupled with some angst about events surrounding Mr Butler leaving and the passage of time, simply meant that he did not have a good recall of events.

235. Counsel on behalf of the Department suggested that Mr Moodie and Mr Butler may have confused their dates, given Jayden had missed a previous session on 14 February 2013 when Mr Butler was the co-facilitator. This is a possibility. It is also possible that Mr Moodie did make some requests on the day that Jayden died, as was his usual practice, but perhaps not as many as he now recalls. It does not seem to me to be realistically possible, on the evidence, that Mr Moodie made the number of requests that he now recalls, as this would have escalated the matter with the prison officers in such a way that it would have been significant to the recollection of more than one of them.

236. It was also relevant that even on Mr Moodie's account, there was nothing in his request to suggest any particular urgency to finding Jayden, particularly at the start. He was not concerned about Jayden's welfare, he just wanted him to attend the program. There was no indication from what he had seen in the morning to make him think that Jayden was at risk of harming himself if not at the program.

237. In any event, in the context of the known events, I do not find that the failure of the prison officers to follow up Jayden when he did not attend the program (as Mr Moodie evidence suggests occurs) would have contributed to Jayden's death, in the sense that his death might have been prevented if Jayden had been found soon after Mr Moodie's first request.

238. Mr Moodie's evidence is that he would not have made the request until shortly after 1.35 pm. The evidence of the relevant prison officers was that the ODP control officer would have then telephoned the Unit 5 control officer and asked them to locate Jayden to find out why he

[371] T 115, 134.

hadn't attended. Mr Seldon, who was the Unit 5 control officer on the relevant day, gave evidence his first step would have been to call the person's name over the PA and ask them to come to the control and get a pass to go to ODP. He indicated he would do that two or three times, waiting a couple of minutes between calls. If that was unsuccessful, he would then get one of the wing officers to go and find them.[372] They would presumably start at his cell and then go from there to other areas. The cleaning storeroom would not necessarily have been the next place after his cell, although it may have been.

239. Based upon my earlier conclusion that Jayden must have been in the cleaning storeroom prior to Mr Scortaioli making his telephone call at 1.39 pm, and most likely having gone in not long after his failed telephone call at 1.26 pm, there is every chance that Jayden could have been hanging in the storeroom and gone beyond any chance of recovery, at the time Mr Seldon would have been making his PA calls, and before he sent anyone to start looking for Jayden.

240. What is of great concern is that, working from the position that Jayden had hanged himself by the time of 1.40 pm, his body was not found until around 3.44 pm, despite Jayden's body being in a commonly used area and officers actively searching for him from around 3.15 pm. It must be very distressing for Jayden's family to know that his body took so long to be discovered. The explanation appears to be that the room was dark and his body was largely concealed by the duct. I have made comments about the cleaning storeroom above. I note that now that it is only freely open for three hours a day, it is likely to be accessed much more often in that time period than before, making the likelihood of a similar event much less likely. Given it is locked the rest of the time unless access is supervised, it could not occur in the afternoon in the same way.

241. The other aspect of Jayden's supervision raised by counsel on behalf of Ms Bennell related to what prison staff should have known about Jayden's whereabouts after he didn't attend the Pathways program. It was submitted that the prison staff have a duty to know the location of every prisoner during the day, not only in terms of being in a unit but also where in the unit.

242. The response from the Department was that this is neither practical, nor desirable. It is not practical given the sheer volume of prisoners who are transferred throughout the prison each day. It is not desirable, given the emphasis placed upon prisoner autonomy.

243. As to the prisoner movements, they can involve hundreds of prisoners moving from place to place throughout the day. Prisoners are moved in groups or given a pass if moving individually. The prison musters are done periodically throughout the day and perform the role of ensuring that there have been no escapes from custody. So the aim is to ensure

[372] T 308 – 309.

that the right number of heads have been counted, so that the prison has the right number of prisoners inside its confines.[373] Assistant Commissioner Southgate gave evidence that if the muster is correct, there is no urgency around the location of an individual.[374]

244. Prisoners cannot be forced to go to work or programs, it is their choice, and those that did choose to work or participate in programs still have free time outside those periods.[375] The evidence was that it was usual for prisoners who were not at work or programs to be allowed some free time in the unit when not locked in their cells. They were allowed to use the shower, visit other people's cells, sit in their own cells and watch television or play games or recreate in the yard.[376] It was suggested that the aim is to make the environment as natural as possible, within the context of being a secure prison environment.[377] Prisoners are encouraged to be social.[378]

245. The Department targets to have zero deaths in custody and the environment is one part of the plan to achieve that. Assistance Commissioner Southgate explained that primary prevention strategies are aimed to create a physical and social environment in the prison that limits stress on prisoners. The Department recognises that a person is sentenced to imprisonment *as* punishment not *for* punishment.[379] Assistant Commissioner Southgate stated that "prison is very good at making prisoners, but we also need to be very good at making citizens again"[380] and giving prisoners choices and some limited personal freedom and responsibility is part of that. Assistant Commissioner Southgate stated "I'm proud to be part of that system because I think that in itself assists to reduce the anxiety and risk."[381]

246. This position is consistent with the evidence of Dr Hall. Dr Hall referred to the need for particular people not to be placed under too much scrutiny or to feel too confined, as it may backfire. Dr Hall went on to say that "you see that a lot with young indigenous men as well" noting that you "need to be very careful about…putting them in areas where there's a bit too much scrutiny because that can be quite … distressing for them."[382] Jayden would have been likely to have fallen into this category.

247. I accept that it would be impossible for prison officers (who are apparently outnumbered ten to one by prisoners) to keep track of the whereabouts of every prisoner within a unit without either having them all viewed on surveillance at all times or being made to move about in groups. I accept that there must be some balancing between monitoring

[373] T 527.
[374] T 532.
[375] 539, 544.
[376] T 249 – 250, 525, 532.
[377] T 525.
[378] T 532.
[379] Exhibit 3, Tab 41, [8] – [9], [30].
[380] T 537.
[381] T 538.
[382] T 353.

prisoners to reduce the risk and opportunity for self-harm and the need to give them some privacy and autonomy. Constant scrutiny is likely to increase anxiety, which will increase the risk of prisoners wanting to harm themselves.

Law Reform Commission Review

248. In January 2012 the Law Reform Commission of Western Australia (LRCWA) released their final report on their Review of Coronial Practice in Western Australia.[383] Recommendation 39 of the report recommended that the State Coroner review and update the guidelines for the investigation of deaths in custody. This recommendation took into account issues raised by the Aboriginal Legal Service which observed that deaths in custody investigations by police often tended to have a narrow focus on criminality rather than addressing all the issues that a coronial investigation should address, including policy and procedures issues raise by the circumstances surrounding the death.[384]

249. The LRCWA also made recommendations in relation to coronial training for Major Crime Squad detectives and the joint attendance of Major Crime Squad and Coronial Investigation Unit at the scene of a death in prison custody,[385] the latter apparently having already been implemented by the WA Police.[386] Further, the LRCWA recommendation that the State Coroner develop a collaborative information sharing relationship with the Office of the Inspector of Custodial Services with a view to receiving independent information about Western Australian prisons and better informing coronial recommendations that impact systematically across the prison system.[387]

250. I am aware that steps are underway by the State Coroner in conjunction with the Department of the Attorney General to consider if and how these recommendations should be actioned, in conjunction with the other LRCWA recommendations arising from that review.

251. Given the scope of this project, in my view it is appropriate for the submissions raised on behalf of Ms Bennell that relate to death in custody investigations generally, as well as the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody, to be referred to the State Coroner to be given such consideration as is thought appropriate as part of that wider process.

252. In those circumstances, I do not propose to make any recommendations in relation to those broader issues relating to deaths

---

[383] LRCWA, *Review of Coronial Practice in Western Australia: Final Repor*t, Project No 100, (January 2012).
[384] LRCWA, *Review of Coronial Practice in Western Australia: Final Repor*t, Project No 100, (January 2012), 59.
[385] LRCWA, *Review of Coronial Practice in Western Australia: Final Repor*t, Project No 100, (January 2012), Recommendations 40 and 41.
[386] T 25.
[387] LRCWA, *Review of Coronial Practice in Western Australia: Final Repor*t, Project No 100, (January 2012), Recommendation 42.

in custody and the treatment, care and supervision of Aboriginal prisoners, that do not relate to the specific circumstances of Jayden's death.

CONCLUSION

253. Jayden was a young Aboriginal man who hanged himself while serving a sentence at Casuarina Prison. His death is a tragedy and has caused immense grief to his mother and extended family, with whom he was very close. The lack of warning that he was experiencing any suicidal thoughts appears to have made his death that much harder for them to bear.

254. This inquest has explored some of the issues that were affecting Jayden leading up to his death, as well as some systemic issues surrounding his treatment, supervision and care.

255. Jayden's family have emphasised that Jayden's death was an Aboriginal death in custody and they place central reliance on the need for the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody to be implemented to prevent further Aboriginal deaths in custody. It is difficult, within the context of an isolated death, for me to consider many of these findings and recommendations and to make any assessment of what is necessary and practical.

256. However, as indicated above, I am aware the government has embarked on a widespread review of the coronial process in Western Australia, which will include specific consideration of procedures for death in custody investigations. Accordingly, I propose to refer both this finding and the submissions filed on behalf of Jayden's family to the State Coroner, who can consider them as part of all the overall process. By doing so, I do not intend to imply that I endorse what is contained within those submissions, but I believe it is appropriate to refer them on so that they can be given due consideration.

S H Linton
Coroner
28 February 2017