Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 18/16

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Gerardus Gerritt HEIJNE****, with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 24 May 2016 find the identity of the deceased was* ***Gerardus Gerritt HEIJNE*** *and that death occurred on 26 March 2013 at Acacia Prison as the result of Ligature Compression of the Neck in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner

Ms D Van Nellestijn (Instructed by State Solicitors Office) appeared for the Department of Corrective Services

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INTRODUCTION

On the morning of 26 March 2013 Gerardus Gerritt Heijne (the deceased) was located by a fellow prison inmate, hanging from his locked cell door by a dog leash the deceased had secured to the outer door handle, following unlock earlier that morning.

The deceased was 49 years of age.

The deceased was a sentenced prisoner serving a substantial prison term of imprisonment for murder and was a person held in care (*Coroners Act 1996* (the Act) section 3) for the purposes of the Act. This mandates a public hearing by way of inquest, (section 22 (1) (a)), and the quality of the supervision, treatment and care of that person while in custody must be commented upon by the coroner conducting the inquest (section 25 (3)).

BACKGROUND

The deceased was born on 4 December 1963 in the Netherlands. The family comprised of the deceased, his parents and three sisters.

The deceased was raised in the Netherlands until he was 7 years of age when his family moved to Singapore as part of his father's employment. The deceased self-reported a positive childhood in a happy parental marriage and a good relationship with his three sisters. He did, however,

describe a strained relationship with his father due to his self-declared homosexuality at 14 years of age.

The deceased's mother confirmed the deceased's expression of his sexual preferences at that age distressed her, and that there was a difficult relationship between the deceased and his father, which appeared to improve shortly before his father's death due to the deceased's successful life as an adult.

It was her view the deceased struggled throughout school and his childhood and adolescence as a result of his stated sexual preference at a young age.

The deceased stated he had romantic liaisons or intimate relations with women from a young age and that his sexual preference was a matter of person rather than gender.

The deceased and his family moved to Australia when he was 15 years old and, due to the difficulties with his declared sexuality, he soon ran away from home. After being retrieved by his parents he was assisted into independent living by their provision of an apartment for his accommodation.

The deceased commenced his long term relationship with Frank Cianciosi shortly after arriving in Australia and Mr Cianciosi moved into the deceased's apartment when he was given accommodation by his parents. The deceased

and Mr Cianciosi had lived together ever since. There was a significant age difference between the two with Mr Cianciosi being approximately a decade older.

The deceased and Mr Cianciosi became a very successful business couple, ultimately developing the Lenard's Chicken franchise globally. It was this success which the deceased believed brought him and his father closer prior to his father's death.

As the deceased matured, while in a long term relationship with Mr Cianciosi, he also developed a strong physical profile which he believed assisted him in business. He had a number of affairs of which he alleged Mr Cianciosi was accepting. It was a feature of the deceased's personal relationships that he did not discuss emotional matters either with his family or, apparently, his partner.[1]

It was as a result of a deterioration in his relationship with Mr Cianciosi as the deceased became more mature that he committed the offence of murder with the victim being Mr Cianciosi.

The deceased alleged he had been subjected to some degree of domestic violence from Mr Cianciosi which he accepted as his status in the relationship, however, he did not accept the death of Mr Cianciosi as anything other than an

[1] Ex 2, tab 1

accident. Following the murder the deceased remained in contact with his mother, but lost contact with his sisters.

The deceased's mother agreed the family as a whole did not discuss problems and that the deceased had always kept his problems to himself. She felt this may have been because she found it stressful raising four children, mostly on her own due to her husband's work commitments. The deceased's mother indicated he had suffered more emotional trauma growing up than he would acknowledge and confirmed two previous suicide attempts due to difficulties in his adolescence. She noted the deceased refused to discuss any relationship problems he may be having.

IMPRISONMENT

The deceased committed the offence of murdering his partner on 3 January 2008 by strangling him after an argument at his apartment. The deceased maintained he had been acting in self-defence, although he had confessed his involvement in the offence to two other people. The forensic evidence disputed the injuries as being entirely accidental and would suggest the deceased minimised the force he had used and did not accept responsibility for his actions. This is consistent with his general denial of adverse reactions to personal crises.

It would seem in reality the deceased was very stressed and frustrated at the time of the offence and under extreme

pressure which culminated in a build-up of anger and resentment towards his partner. Due to a lack of coping strategies he was unable to control his actions and this resulted in extreme violence. This may also have been exacerbated by the types of substances he was misusing.

Following the offence on 3 January the deceased was remanded in custody at Hakea Prison from 5 January 2008 and, because it was his first time in prison and for a serious offence, he underwent extensive prison assessment. When assessed for programs within the prison system the deceased confirmed he preferred to pretend everything was going well and tended to minimise adverse interactions. The deceased claimed his first and only serious homosexual relationship was with Mr Cianciosi, although he had a number of affairs during that relationship which he stated were physical only. He denied these played a part in his eventual offending against his partner.

The deceased denied having serious health problems, including asthma or attention deficit disorder as was apparent from his prison file. He only admitted to one previous suicide attempt at 13 years old as a response to loss of hair, which his mother said occurred due to trauma with his peers over his sexual orientation. He did not acknowledge another suicide attempt or his father's threat that if he was to do it again he better make sure he got it right.

The deceased accepted he had a history of abusing prescription medication duromine (amphetamine based), steroids and Ritalin. He indicated these were used to assist him with his physical image and to give him an *"edge"* in business. He acknowledged these caused some side effects which he used other medications to reduce. At the time of his offending he had been using both Ritalin and steroids and alleged they did not affect him adversely, although he did accept he had been feeling less emotional and anxious while in custody and allegedly abstaining from the misuse of substances.

The deceased remained at Hakea from 5 January 2008 until 26 August 2009 and was reviewed due to his alleged physical ailments and complaints of depression. He was prescribed a minimum dose of citalopram, despite repeat requests to various visiting medical practitioners for Ritalin. He was never placed on the At Risk Management System (ARMS) due to there being no identified risk issues during his time on remand. Despite ongoing requests for medication for his depression he denied suicidal ideation and kept himself fit in the gym. It was not considered necessary to increase his dosage or add additional medication.

Following the deceased's conviction and sentencing on 9 June 2009 he was reduced to a medium security prison placement on 20 August 2009 and transferred to Casuarina Prison on 26 August 2009. The deceased had appealed

against his conviction which was dismissed in July 2009. He then appealed against his sentence.

In July 2009 the deceased was treated for concussion as a result of a fall while exercising but there were otherwise no stated concerns with his psychiatric health during his remand period.

The deceased undertook further education in business and related studies while incarcerated but also applied for a number of short term courses useful for general living during his time at Casuarina.

Once incarcerated the deceased formed an emotional attachment with one of the Lenard's franchise employees, Thelma Gale, and they appeared to have a close emotionally dependent bond during the deceased's imprisonment.

The deceased's relationship with Ms Gale deepened due to her support and his loss of some support from his family. Ms Gale reported the deceased as being quite distressed about the disjunct with his siblings over his incarceration.[2]

The deceased became engaged to Ms Gale towards the end of 2009, while still at Casuarina, and she remained supportive of him throughout his prison time.

[2] Ex 1, tab 19

Acacia Prison

The deceased was transferred to Acacia Prison on 20 January 2010 where he remained until the time of his death. The deceased attained self-care status within three months of arriving at Acacia Prison and remained in self-care throughout his time in prison. He was considered a model prisoner and appeared to relate well to both prisoners and prison officers.

The deceased was employed in the prison system as an education and resettlement officer which he enjoyed and was in the position of being trusted by staff and able to live a relatively productive life considering his environment.

The deceased was assessed for his suitability to participate in cognitive skills and violent offending programs for which he received extensive assessment[3] in February 2011.

Overall, the deceased appears to have adapted to life as an inmate at Acacia Prison well. He lived in a self-care pod with other, mostly younger, prisoners with whom he had good rapport, enjoyed his freedom to exercise, self-educated himself, was employed and generally lived a productive life provided he had contact with the outside world and banking through Ms Gale, and occasionally his mother.

[3] Ex 2, tab 1

There were difficulties for the deceased within the prison system due to the perception he was financially secure in his external life. Prisoners do not have access to bank accounts, other than the prison spends while incarcerated and this caused the deceased difficulties as a result of pressure within the system with requests for *"loans"*.[4] While initially referring pressure to the prison authorities the deceased desisted because it made life complicated for him within the prison environment.[5]

International Transfer

The deceased made an application for international transfer to the Netherlands in September 2011. This was ultimately rejected in March 2013 shortly prior to the deceased's death. At the time the deceased appeared to accept the news philosophically, however, it is possible this related to his later suicide.

Medication

Due to the prison doctors' refusal to provide the deceased with Ritalin he remained on citalopram for most of his prison life. In early 2013 he started the ADHD drug, Strattera, because he believed ADHD medication enabled him to focus and he was continuing with his business studies. While there are some concerns with the use of Strattera in children, there has been no proven association between Strattera and increased risk of suicidal ideation in

[4] t 24.05.16, p27
[5] Ex 1, tab 19

adults and there are no contra indicators to using it with citalopram.

The prison doctor, while not prepared to prescribe the deceased Ritalin, was prepared to prescribe Strattera and he was prescribed Strattera for a trial period pending psychiatric review. While the gap between the addition of Strattera to his medications and psychiatric review was considerable, the deceased did not report any difficulties with Strattera and he did not attend for the ECG recommended as a base line indicator. The dispensing medication charts indicate the deceased was compliant with his medications in the period January through to March 2013.

Some concerns with respect to the deceased's external financial holdings were canvased with him again in February 2013, however, he denied there was an issue. There was no indication there was a cause for concern with his welfare which would affect prison security.

Dog Training Program

Acacia Prison was also involved in a prison dog rescue and training program with an external agency from July 2011 through to September 2013. The deceased was heavily involved in the program and one of the prisoners who cared for the dogs in the prison environment. Prisoners involved in the project were issued with a dog leash as part of the program. All the dogs except one were returned to kennels

outside the prison each evening and were cared for during the day on prison premises on a rotational basis. To participate in the program prisoners had to reside in the assisted self-care sections of the prison, and only five were involved at any one time. The dog that remained on prison premises over night was cared for by different prisoners during the days and evenings.

On his last visit with Ms Gale on 24 March 2013 the deceased had taken the prison rescue dog, Queenie, with him and is clear from some of the later telephone conversations he appreciated his time with Queenie.

Telephone Records

The deceased was in regular contact with his fiancé using the prison telephone access to specified numbers. Ms Gale reported it was her impression the deceased was quieter than usual immediately prior to his death when she visited, however, noted he had a tendency to deny problems and it was difficult to read his mood. In hindsight, she believed he was contemplating suicide in her last contacts with him. Ms Gale had visited him in prison on the Sunday before his death and last spoke with him on the afternoon of Monday 25 March 2013.[6]

Telephone calls between the deceased and Ms Gale were accessed following the deceased's death and indicate the

[6] Ex 1, Tab 19

deceased was concerned about a financial transaction external to the prison, but connected to the fact of his incarceration, in the days before his death. He was discussing ways of dealing with complications which had arisen immediately prior to his death. In hindsight, it is clear the deceased was suffering stress with respect to the manner in which he intended to deal with those complications.

On the evening of 25 March 2013 the deceased discussed on the telephone his planned management of his financial complications with Ms Gale in a context which could be seen as an attempt to avoid any further conflict. He reassured her she had nothing to fear for her safety.

Cell Safety

The self-care pods at Acacia Prison are constructed with the concept of the minimisation of hanging points in mind. However, realistically a reasonable living environment will always provide some hanging points for ligatures suitable for use, if there is a real will to utilise that as a form of suicide. Living environments completely devoid of any opportunities for hanging points can be extremely sterile and difficult to live in. Prisoners in self-care units are generally not considered to be at risk, and are trusted with an environment which is more compatible with that in the community.

The Event

On the evening of 25 March 2013 the deceased asked another prisoner in his unit, Dylan Wiese, to collect Queenie's leash for him in preparation for him collecting Queenie in the morning to take her with him when he went to work.[7] Mr Wiese collected the lead from a different block and when he returned to their unit N4C he left it on the floor of the deceased's cell because he was not there.[8]

The deceased prepared dinner for that evening and Mr Wiese reported they all sat down together to have their meals. The people in their pod interacted well and there did not seem to be any difficulty surrounding the deceased that evening. Mr Wiese reported the individual cells were locked at approximately 9pm after which the prisoners could not access their common room. He had last seen the deceased at approximately 8:30pm when the deceased asked him if he would turn down his television.

Prisoner Lance Collard said he had last seen the deceased at approximately 8:40pm when he came out of his room into the day room before going back to his room and shutting the door.[9]

All prisoners can lock their cells from inside, and none of the prisoners' cell keys will access another prisoner's cell. When the prisoners are locked inside at 9pm, another

[7] Ex 1, tab 2
[8] Ex 1, tab 9
[9] Ex 1, tab 8

prisoner cannot access that prisoner's door nor can the prisoner unlock their door from the inside.

The individual cells were unlocked between 4:30-5am after which prisoners can access their common room. Mr Wiese saw the deceased come out of his cell at about 5am on 26 March 2013 and they nodded to one another before Mr Wiese went back into his cell to go back to sleep.

At about 6:30am Mr Collard realised the deceased had not been into his room to wake him as he usually did at 6am. Mr Collard had instead slept though until his alarm went off at 6:30am. Mr Collard got up to see why the deceased hadn't woken him and noticed his door was shut. He noticed Queenie's leash, it was a long lead, and the handle had been looped over the outside handle of the deceased's cell. The lead then travelled up the door and over the top of the door.

Mr Collard looked through the window and could see the deceased hanging from the lead suspended over the top of the door.[10]

Mr Collard woke Mr Wiese and between them they alerted the prison officers who sent all prisoners back into their cells and retrieved the deceased from his cell. It had been locked from the inside after the dog lead had been attached to the outer handle and suspended over the top of the door.

[10] Ex 1, tab 8

The two prison officers who responded and issued a code blue were Glen Danks and Mark Evans. They opened the deceased's cell and found the deceased on the floor, having fallen to the floor when the other prisoners were trying to release the dog leash from outside to assist the deceased.

The code blue had been issued in response to the call from Wiese and Collard that there was a medical emergency in Unit C4. The code blue was issued at approximately 6:35am and prison officers Christopher Sharratt and Scott Martin were rostered as response officers. Mr Sharratt estimated it took him between 30-40 seconds to reach the pod from reception followed closely by Mr Martin. At the same time prison officer Natasha O'Donnell ran towards Pod C with an Oxy-viva machine.

The prison officers realised the deceased had wrapped the leash around his neck and unwound it while attempting to ease pressure on his throat as they unravelled it. The prison officers were trying to get a response from the deceased and having released him from the ligature, cleared his airways and commenced CPR. They continued with CPR until about 7:20am when the paramedics arrived and dragged the deceased out of the cell into the common room for more space.

CPR continued for a short while until the paramedics declared there was no point in further attempts at

resuscitation because the deceased had died. The cell was locked and kept secure according to normal prison procedures pending further investigation by the police.[11]

POST MORTEM REPORT

The post mortem examination of the deceased was undertaken on 28 March 2013 by Forensic Pathologist, Dr Jodi White.[12]

On examination Dr White reported the deceased showed an evident ligature mark to the neck which she was not able to compare to the ligature because it had not been provided. Dr White noted scattered soft tissue injuries to the head and limbs consistent with the history of hanging and retrieval and, pending the provision of additional investigations, gave a preliminary cause of death as consistent with ligature compression of the neck (hanging).

Once the additional investigations had been carried out and Dr White had been provided with the dog lead for comparison, as well as neuropathology and toxicology, Dr White was satisfied the cause of death for the deceased was ligature compression of the neck (hanging).

Toxicology showed therapeutic amounts of citalopram only, and neuropathology indicated cerebral congestion

[11] Ex 1, tab 14-18
[12] Ex 1, tab 6

consistent with the history of ligature compression of the neck.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a sentenced prisoner in a self-care unit at Acacia Prison. He had been sentenced to a term of 13 ½ years for the murder of his partner and had a psychological profile which indicated he tended to minimise negative experiences and emotions by the use of denial and humour.[13] To enable him to do this he used a number of inappropriate coping strategies, including the misuse of substances.

While these ways of avoiding negative emotions may be a useful strategy for survival in the prison environment, they may also hide a real inability to cope with events outside an individual's control. I note from the Acacia Prison Director's rule 2.21 Annexure D indicators of self-harm or suicide,[14] one of the indicators of self-harm or suicide is noted to be *"stress plus lack of coping and problem solving skills"*. In that section there is a reference to suicides in custody often being the result of stress beyond the prisoner's capacity to cope and not necessarily related to a depressive illness. If a person can see no way out of a problematic situation, then self-harm or suicide may become a real option.

[13] Ex 2, tab 1
[14] Ex 3, tab 4

Accepting the above, in conjunction with the deceased's normal coping strategies with emotional stressors, it seems likely the deceased's response to the financial and safety stressors discussed in his telephone conversations immediately prior to his death, and the denial of international transfer to a prison in the Netherlands, may have pushed the deceased into feeling he was not in a position to solve the issues confronting him. He was not in a position to control life outside as well as inside prison.

In hindsight, the deceased's strategy of laughing over concerns becomes quite apparent in his telephone conversations.

It does not appear his decision to end his life was impulsive, and indeed was probably premeditated for at least the preceding 24 hours, and considered as an option for some time prior.

I am satisfied the deceased had reached a state of mind where he believed he had an unresolvable issue with his vulnerabilities in the prison environment which could not be overcome, due to prison culture generally, and the fact he now would not be transferred to another country.

I am of the view the deceased did not consider any ligatures and hanging points available within his cell would be a certainty for a successful hanging, and that the length and quality of Queenie's lead, once attached to his outer cell

door, would be of an appropriate length to provide him with a quick (narrow), effective ligature if he could devise a suitable fulcrum to take his weight. It was for this reason he requested Mr Weise obtain Queenie's lead.

During the deceased's regular telephone conversation with Ms Gale about the current state of his financial portfolio he concluded the pressures on his external life were insurmountable. They were not going to improve while he was incarcerated and not in a position to protect himself or those for whom he felt some responsibility.

Once his cell had been unlocked I am satisfied he used the opportunity, when no other prisoners were in the common room, to slide the dog leash handle over the outside cell door handle and suspend the lead over the top of the door. He then shut the door and locked it from inside. He could then suspend himself from the remaining part of the lead, inside his cell, knowing he would die very quickly and certainly before anybody was able to release the pressure on the ligature and so prevent his death.

I am satisfied the deceased hanged himself with the dog lead once he had suspended it over the cell door, with an intention to take his life.

I find death occurred by way of Suicide.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE A PRISONER

While I have formed the view, on the whole of the evidence, the deceased's suicide was reasonably premeditated and not impulsive, and that risk factors were present which would account for his decision, I do not believe the fact he would suicide, or when, were reasonably apparent to Acacia prison authorities. Certainly the prisoners in his pod did not appear to detect a problem in his behaviour, and that would have been consistent with his normal strategy of always appearing to be in control.

I accept that following his rejection for transfer, apparently despite the Netherlands accepting the proposition, he was assessed with respect to his response. Consistent with the deceased's normal strategies of coping with emotional negatives he appeared to accept the refusal philosophically. However, putting that rejection together with the evidence of stressors relating to his financial circumstances and prison culture, his death is not inexplicable or unpredictable in real terms.

There does appear to be an issue with respect to prisoner welfare and prison security, but taking into account prison culture there is some difficulty in understanding how tension between security and welfare can be avoided. Where prisoners are not prepared to complain, or have not been assisted as the result of a complaint and fear reprisal

if they are suspected to have made complaint, it is extremely difficult for the gap between security and welfare to be crossed.

In this case it is hindsight, and some speculation, which raises a concern as to the vulnerability of financially independent prisoners in the prison system, and how that may have been exacerbated by a denial of international transfer. Certainly, the deceased said or did nothing which could imply there was a relationship between the two facts about which the prison authorities could take action.

The reality is financially independent prisoners, such as the deceased, are vulnerable to being preyed upon by the environment in which they are trapped. Unlike other vulnerable prisoners in the system, the fact of their vulnerability and the means by which they can be exploited, may not be evident without positive information which may further jeopardise their position. Having listened to the deceased's external telephone conversations I have considerable concerns he felt his death would be the only means by which he could control the situation in which he found himself. This is not something he verbalised, but rather, in view of his prior ways of dealing with adversity, was the obvious option when all other solutions he considered viable were no longer available. It was his ultimate control over his life.

I appreciate the deceased had, or believed he had, sought assistance from prison authorities in his earlier incarceration and concerns had been notified to the police. Unfortunately, these could not be substituted on the information available.

This leaves me with a difficulty in determining the adequacy of the deceased's supervision, treatment and care.

All those aspects of his incarceration at the time of his death appear appropriate. He was apparently healthy, fit and well, made no complaints and appeared to enjoy his work and living arrangements in view of the severity of his offending. How to achieve appropriate supervision, treatment and care with respect to the effect of incarceration on a vulnerable prisoner's out of prison circumstances in a case such as this is something I am unable to determine.

Hanging Points

I accept there are ongoing strategies for the reduction of hanging points within Acacia Prison and the prison system generally. Overall, Acacia has been constructed with fewer utilisable hanging points than many new prison buildings.

The lengths to which the deceased needed to go in order to secure the dog lead to the outside of his cell door would indicate there was not an issue with hanging points in the cell. It was not an impulsive suicide and consequently availability of incidental hanging points are not an issue in

this case. I do not consider the fact of the dog lead and its use by the deceased on this occasion to be an indicator training dogs should be banned from the prison environment where they are properly cared for.

Medication

Similarly, I am not of the view the deceased's change in medication, with the addition of Strattera, to be relevant to his suicide in the circumstances of this case. The deceased did not attend for his base line ECG and there is no indication his medication was related to feelings of suicidality. While earlier review by a psychiatrist would be desirable, there was no indication in this case a change in medication was relevant to his suicide.

I would hope improvements in the prison system with psychiatric access would, in future, minimise this type of delay in review, where medications have been altered, but that is a general comment on prison mental health rather than specifically relevant to the facts of this case.

To the deceased this was a rational suicide as a means of avoiding a problem related to his finances and the physical welfare of those he felt responsible for.

RECOMMENDATION

I RECOMMEND TELEPHONE CALLS RECORDED PRIOR TO THE DEATH OF A PRISONER IN CUSTODY BE PROVIDED TO THE CORONERS COURT AS THEY WERE IN THE PAST. ALL PRISON DEATHS ARE MANDATED TO BE INQUESTED, AND WHILE I APPRECIATE NOT ALL TELEPHONE CALLS, ALTHOUGH RECORDED ARE LISTENED TO WITHIN THE PRISON SYSTEM, NOR IS IT FEASIBLE, THEY MAY PROVIDE SOME INSIGHT, POST THE EVENT, AS TO WHAT MAY HAVE BEEN IN OPERATION IN THE PRISONER'S MIND AT THE TIME. THIS MAY INDICATE STRATEGIES WHICH MAY BE OF USE IN THE FUTURE IN PREVENTING SOME SUICIDES.

In the case of this deceased it has only been with the provision of his telephone calls, and review of the very competent assessments of the deceased by the prison system, one has been able to understand his denial strategies for coping with stressors he experienced. These are also relevant to his original offending.

E F Vicker
Deputy State Coroner
7 October 2016