Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 28/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Peter Philip HUMES*** *with an inquest held at the* ***Perth Coroner's Court, Court 52, CLC Building, 501 Hay Street, Perth****, on* ***30 - 31 July 2014****, find that the identity of the deceased person was* ***Peter Philip HUMES*** *and that death occurred on or about* ***24 November 2010*** *at* ***Hakea Prison*** *in circumstances consistent with* ***Ligature Compression of the Neck (Hanging)****:*

Counsel Appearing:

Ms I Burra-Robinson assisting the Coroner
Mr P Gazia (Aboriginal Legal Service WA Inc) appearing on behalf of the family
Mr N van Hattem (State Solicitors Office) appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. Peter Philip Humes[1] died on the evening of 23 November to 24 November 2010 at Hakea Prison (Hakea). Peter was found in an unresponsive state suspended by a ligature from a window in his cell at 4.50am on 24 November 2010 and could not be revived.

2. As Peter was a remand 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).

3. Pursuant to section 22(1)(a) of the *Coroners Act*, as Peter was a person held in care immediately before his death in Western Australia, an inquest was required to be held.

4. Accordingly, I held an inquest at the Perth Coroner's Court on 30 and 31 July 2014.

5. Under section 25(3) of the *Coroners Act*, 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.

6. The inquest focussed primarily on the admission of Peter into prison and the assessment of his risk of self-harm at that time, as well as the events of 23 - 24 November 2010. In addition, evidence was given about the steps taken by the Department of Corrective Services to minimise the risk of suicide by hanging in the prison environment since Peter's death.

7. The documentary evidence tendered comprised a total of three volumes of materials,[2] as well as some additional statements,[3] photographs,[4] a Management

[1] At the request of the deceased's family the deceased will be referred to as Peter during the course of this finding.
[2] Exhibits 1 - 3.
[3] Exhibits 4 – 6.
[4] Exhibit 8.

Review Report[5] and Medical Review Report[6] from the Department regarding the circumstances of the death of Peter, and the design guidelines for cells and some additional statistics on deaths in custody in ligature minimised cells.[7]

8. As part of the evidence before me, substantial material was provided from the Department relating to the Department's Ligature Minimisation Program and suicide prevention strategies, and two witnesses gave oral evidence expanding upon that information.

9. In addition, oral evidence was heard from a number of Departmental staff who had contact with Peter at key times during his incarceration, before his death, and a paralegal from Aboriginal Legal Service who saw the deceased shortly before his death.

BACKGROUND OF THE DECEASED

10. Peter was born on 13 September 1972 in Perth. He completed part of his secondary schooling at North Lakes Senior High School before commencing an apprenticeship in spray painting and panel beating. He did not complete his apprenticeship but did work intermittently in the spray painting industry.[8]

11. He had been in a long term relationship with his de-facto and they had five children together. At the time of his death he also had one grandchild.[9]

12. Peter's family life was troubled by domestic violence and he had been convicted as an adult of assaulting his partner, as well as one of his children.[10] He had served terms of imprisonment in the past for assault, as well as for driving and traffic offences.[11] His first term of

[5] Exhibit 7.
[6] Exhibit 10.
[7] Exhibits 9 and 11.
[8] Exhibit 2, Tab 31.3, 2.
[9] Exhibit 1, Tab 2, 11.
[10] Exhibit 2, Tab 31.3, 1 & Tab 4.
[11] Exhibit 2, Tab 31.3, 1 & Tab 4.

imprisonment as an adult was in 1998, followed by a further 14 admissions between 1999 and 2010, either as a remand or sentenced prisoner.[12]

13. Peter had no known medical conditions, including psychological or psychiatric illnesses.[13] He was known to abuse alcohol, which often contributed to his offending behaviour.[14]

14. The only clear report of Peter attempting self-harm or injury is a police record in 1998, which Peter explained involved him banging his head against the side door of a police car.[15]

15. There was also a record that Peter had apparently threatened self-harm whilst in custody as a juvenile, but he couldn't' remember what the threat was and confirmed that he did not actually self-harm.[16]

16. There were apparently no reported self-harming or suicidal behaviour exhibited by Peter during his previous prison terms as an adult.

ADMISSION TO HAKEA PRISON

17. On 27 October 2010 Peter appeared before the Midland Magistrates Court, following his arrest on an outstanding bench warrant, and was remanded in custody. He was taken to Hakea Prison pending his next court appearance.[17]

Officer Trevena's Interview

18. Peter was received at Hakea and underwent an admission interview at 3.40pm with VSO Reception

[12] Exhibit 2, 31, 5.
[13] Exhibit 2, Tab 31.3, 3.
[14] Exhibit 2, Tab 31.3, 1, 3.
[15] Transcript 12 – 14 (Trevena, S.L.); Exhibit 1, Tab 6 [3] – [4].
[16] Exhibit 2, Tab 7, 'At Risk' Assessment, 2.
[17] Exhibit 1, Tabs 7 (Admission Checklist) & 8 (Orientation Checklist); Exhibit 2, Tab 5.

Officer Sarah Trevena.[18] At that time Officer Trevena had been working for the Department for approximately 4 years.[19] As well as her Academy training, Officer Trevena had completed the Gate Keeper course (suicide prevention training) and had also undertaken Mental Health First Aid training on her own initiative.[20]

19. As part of the interview process Officer Trevena completed an MR011 Reception 'At-Risk' Checklist, which was the form in use at that time.[21] It is relevant to note that since that time a new, more extensive, form, known as an 'ARMS RIA' form, has replaced the previous MR011.[22]

20. Officer Trevena asked Peter questions and recorded his answers on the form.[23] The answers recorded on the form were a summary of the broader conversation engaged in during the interview.[24]

21. Based upon the verbal answers given by Peter, Officer Trevena recorded that Peter did not have a current partner but had supportive family and children, from whom he was expecting visits.[25] He expressed no fears or anxieties about being in prison but did state that he was suffering from depression. [26] He denied any previous attempts at self-harm or suicide while in custody and explained the circumstances of the recorded incident in 1998 with the police, noting that it occurred years ago, when he 'was younger'.[27] He told Officer Trevena he would not self harm now and that he would be okay if sentenced to a new term of imprisonment.[28]

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[18] Note: Officer Trevena surname has since changed to Harbour, but I will refer to her as Trevena for the purposes of this finding – Transcript 7 (Trevena, S.L.).
[19] Exhibit 1, Tab 6 [1].
[20] Transcript 8 (Trevena, S.L.); Exhibit 1, Tab 6 [2].
[21] Exhibit 1, Tab 6, MR011 Form.
[22] Transcript 9 (Trevena, S.L.).
[23] Transcript 9, 19 (Trevena, S.L.).
[24] Transcript 9 (Trevena, S.L.).
[25] Exhibit 1, Tab 6, MR011 Form.
[26] Exhibit 1, Tab 6, MR011 Form.
[27] Transcript 25 (Trevena, S.L.); Exhibit 1, Tab 6 [4].
[28] Transcript 25 - 26 (Trevena, S.L.); Exhibit 1, Tab 6, MR011 Form.

22. Officer Trevena noted that the deceased appeared calm and cooperative during the interview.[29] She could not recall him displaying any other remarkable behaviours or mood during the interview process.[30]

23. On the basis of all of the information available to Officer Trevena she formed the opinion at the conclusion of the interview that a referral to the prison At Risk Management System (ARMS) was not required as she did not form the view that Peter was at risk of self-harming.[31]

24. Although the new form is more detailed and involves a longer, more extensive interview, on the basis of the deceased's presentation that day, Officer Trevena did not consider that use of the new form would have made a difference to her conclusion that day.[32]

25. At the inquest, Officer Trevena confirmed in oral evidence that, despite later events, she maintained her position that at the time she interviewed Peter he was not at risk of self-harm or suicide and her decision not to place him on ARMS was correct.[33] She believes that from everything he told her during the interview he did not show any signs of self-harm or risk of suicide, which is the trigger for an ARMS referral. Depression of itself does not automatically indicate that he was likely to hurt himself.[34]

Nurse Lee's Interview

26. The standard at-risk assessment process is a two-tier assessment involving both a custodial and health screen assessment.[35] Accordingly, after Officer Trevena interviewed Peter he participated in another interview with a clinical nurse, Sandra Lee.

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[29] Transcript 25 (Trevena, S.L.); Exhibit 1, Tab 6 [5].
[30] Exhibit 1, Tab 6 [7].
[31] Transcript 15 (Trevena, S.L.).
[32] Transcript 15 (Trevena, S.L.).
[33] Transcript 17, 20, 26 (Trevena, S.L.).
[34] Transcript 26 (Trevena, S.L.).
[35] Exhibit 2, Tab 31, Mudford Report, 3.

27. Nurse Lee has been a nurse for more than 40 years. At the time she assessed Peter she had been employed at Hakea on and off for approximately 15 years, and for the last 6 or 7 of those she had been based in Prison Reception. Her role involved conducting health and risk assessments of incoming prisoners, which is what she did with the deceased.[36]

28. Nurse Lee assessed Peter using a document called a Health Assessment AMR1012 as a guide.[37] She also had available to her Officer Trevena's completed MR011 form.

29. Nurse Lee conducted a general interview with Peter, noting his answers in the form and also making notes in the electronic medical notes known as the EcHO notes.[38] The usual duration of such an interview is approximately 30 minutes.[39] At the end of the interview Nurse Lee did not make a referral to the prison support services or place Peter on ARMS.[40]

30. This was despite the fact that the deceased mentioned feeling depressed.[41] Nurse Lee regarded his reference to depression as relating to situational depression, due to estrangement from his family, rather than clinical depression.[42]

31. According to Nurse Lee's usual practice, she believed she would have offered to refer Peter to the prison counselling service but the absence of a referral indicates he declined the offer.[43] In her experience it is not uncommon for Aboriginal men to decline a referral to the counselling service, as they often prefer to discuss it with their peers.[44]

[36] Exhibit 1, Tab 7 [2], [5].
[37] Exhibit 3, Tab 2; Exhibit 4 [9].
[38] Transcript 32 - 33 (Lee, S.L.); Exhibit 4 [8].
[39] Exhibit 4 [10].
[40] Transcript 33 (Lee, S.L.).
[41] Exhibit 4 [20].
[42] Transcript 34 - 35 (Lee, S.L.).
[43] Transcript 35 - 37 (Lee, S.L.).
[44] Transcript 37, 39 (Lee, S.L.).

32. As to the ARMS assessment, based on his presentation and answers during the interview Nurse Lee did not consider that he presented with any particular cause for alarm that would require an ARMS alert.[45]

33. Peter did request to see a doctor after his next court attendance to discuss how he was feeling, so Nurse Lee made an appointment for him to see the doctor in approximately one week's time.[46] She also noted that he needed to see a dentist.[47]

34. Asked at the inquest by counsel appearing on behalf of Peter's family whether, in hindsight, prudence suggests she should have placed Peter on ARMS, Nurse Lee disagreed. She observed that the ARMS system is not designed to cover people who are simply depressed but not showing indicators of being at risk of self-harm or suicide.[48] Nurse Lee maintained that her decision not to place Peter on the ARMS system at that time was correct based upon his presentation at the time.

EVENTS IN THE WEEK FOLLOWING ADMISSION

35. After his admission interviews and health screen Peter was taken to a single cell in the Orientation Unit to be assessed as to the most suitable cell placement.[49] His orientation checklist was completed by a prison officer the next day and it was noted that he had family within the prison and was expecting to receive visits from his grandmother.[50]

36. On the afternoon of 28 October 2010 he was moved to a shared cell in Unit 10.[51] Peter was also charged that day with additional offences including aggravated assault occasioning bodily harm and other serious

[45] Exhibit 1, Tab 7 [7].
[46] Transcript 36 (Lee, S.L.); Exhibit 1, Tab 7 [10].
[47] Exhibit 1, Tab 7.
[48] Transcript 39 (Lee, S.L.).
[49] Exhibit 2, Tab 31, Mudford Report, 6.
[50] Exhibit 1, Tab 8.
[51] Exhibit 2, Tab 31, Mudford Report, 6.

offences relating to his ex-partner and also a number of breaches of violence restraining orders relating to his children.[52]

37. The following day Peter's cellmate was replaced with another prisoner, with whom he shared a cell until two days prior to his death.[53]

38. Peter re-appeared in the Midland Magistrates Court on 2 November 2010 and was remanded in custody without bail pending his next court appearance. He was received at Hakea Prison again later that day and returned to the same cell.[54]

APPOINTMENT WITH DR HAMES – 5.11.10

39. Dr Phillip Hames is a qualified medical practitioner and currently holds the position of Senior Prison Medical Officer within the Department. He has held that position since February 1992.[55] His role involves general practice management of the adult male prison population.[56]

40. Dr Hames saw Peter on 5 November 2010, 13 days after he had been admitted to prison and assessed by Officer Trevena and Nurse Lee.[57]

41. According to Dr Hames' notes,[58] the main focus of the appointment was that Peter was experiencing difficulty settling in prison after a period of continuous arousal/vigilance while he was on the run for a prolonged period of time before his arrest on the bench warrant. He described being agitated and having difficulty getting to sleep at night. He also reported concern that he might get involved in a dispute with

[52] Exhibit 1, Tab 2, Report of Det S/C Bennison, 1 – 2.
[53] Exhibit 2, Tab 31, Mudford Report, 6.
[54] Exhibit 1, Tab 2, Report of Det S/C Bennison, 2; Exhibit 1, Tab 5.
[55] Transcript 42 – 43 (Hames, P.R. (Dr)); Exhibit 1, Tab 9 [2] – [3].
[56] Transcript 42 (Hames, P.R. (Dr)).
[57] Exhibit 1, Tab 9 [8].
[58] Exhibit 3, EcHO notes entry 05/11/2010 14:11, Phillip Hames MD.

someone in the prison due to his agitated state and asked for some help to get himself settled.[59]

42. They also discussed his general health. He reported having taken steps to improve his health by ceasing intravenous drug use and cigarettes and he requested that he be tested for medical matters such as diabetes and heart disease, for which he had a known family history.[60]

43. His conversation with Peter indicated to Dr Hames that the deceased was not feeling hopelessness about his future. Rather, he was taking control of his health and welfare, with an eye to the future. Accordingly, Dr Hames concluded Peter was not suicidal at the time Dr Hames saw him.[61]

44. Similarly, although he considered the possibility as the word depression had been used by Nurse Lee, Dr Hames did not diagnose Peter with depression.[62] Dr Hames explained in oral evidence that the medical diagnosis of depression is very different to the general feeling of sadness often described by a person as 'depression'.[63] Dr Hames described the medical definition of depression as, "A blackness. A hopelessness about yourself; what you've done; about your future; about your ability to control anything."[64] Peter's forward-looking thinking did not support such a diagnosis.[65]

45. Based on Peter's request for something to settle him, Dr Hames prescribed Peter 15 mg daily of Avanza (mirtazapine) for 30 days.[66] Whilst in higher doses Avanza can be used to treat depression, in lower doses and for a short period, it has a relaxing effect and works

[59] Transcript 43 (Hames, P.R. (Dr)).
[60] Exhibit 1, Tab 9 [10].
[61] Exhibit 1, Tab 9 [11].
[62] Transcript 48, 51, 55 (Hames, P.R.(Dr)).
[63] Transcript 59 (Hames, P.R.(Dr)).
[64] Transcript 47 (Hames, P.R.(Dr)).
[65] Transcript 47 (Hames, P.R.(Dr)).
[66] Exhibit 1, Tab 9 [13].

as a sedative. Dr Hames prescribed the Avanza to treat Peter's agitation rather than for depression.[67]

46. Dr Hames also arranged for blood and urine tests to be completed in line with Peter's requests to investigate the possibility of diabetes and heart disease, and a review date was set for a couple of months later.[68]

47. Although Dr Hames, like the other custodial staff, is in a position to refer a prisoner to ARMS or the Prison Counselling Service when appropriate, Dr Hames saw nothing to prompt him to do so in Peter's case.[69]

48. It was put to Dr Hames during the inquest by counsel appearing on behalf of Peter's family that he might have got Peter's diagnosis wrong on this occasion. Dr Hames accepted the possibility,[70] although did later indicate in response to questioning by me that his review of the matter didn't lead him to that conclusion and Peter's presentation to him on that day was not like someone who was depressed.[71]

49. If Dr Hames was wrong (although I don't find that he was) and the deceased did have depression, it would have resulted in him not being medicated appropriately, as the low dose of Avanza would not have materially assisted his depression.[72]

50. However, Dr Hames testified that even if he had diagnosed Peter with depression and prescribed him a higher dose of Avanza, it would not necessarily have led Dr Hames to make a referral to ARMS at that time. Bearing in mind Dr Hames' primary role as Peter's treating general practitioner, in Dr Hames' view, as long as he had not considered Peter to be at high risk of killing himself at that time, he still would not have made a referral.[73]

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[67] Exhibit 1, Tab 9 [12].
[68] Exhibit 1, Tab 9 [17].
[69] Transcript 48, 59 - 60 (Hames, P.R.(Dr)).
[70] Transcript 58 (Hames, P.R.(Dr)).
[71] Transcript 62 (Hames, P.R.(Dr)).
[72] Transcript 61 (Hames, P.R.(Dr)).
[73] Transcript 61 (Hames, P.R.(Dr)).

51. Dr Hames did accept that one other possibility was that Peter developed depression *after* he was seen by Dr Hames, although he appeared to think it was unlikely given the biological changes that are required to occur.[74] In that regard, it is relevant to note that Peter did not appear to have any prior history of clinical depression, which might suggest that he was susceptible to developing it on this occasion. The only related record in Peter's medical file is on 15 January 1999 when he was prescribed the antidepressant Prothiaden daily for 8 days, apparently as he had reported experiencing insomnia and feeling "stressed out" at the time due to personal events. The information available does not suggest he was suffering from a depressive disorder at that time either and was medicated effectively for sedation, in a similar way to what Dr Hames has described.[75]

Avanza (mirtazapine)

52. Dr Hames acknowledged that Avanza is known to have some side effects when prescribed at doses high enough to treat depression (starting at a 30 mg dose and increasing to a maximum of 60 mg),[76] including sometimes an increase in suicidal ideation when a person suffering from a major depressive initially starts the medication. According to Dr Hames the relationship is stronger in teenagers but significantly reduces in adults, to the point of insignificance.[77]

53. At the level of dose he prescribed Peter, Dr Hames was of the opinion the only likely side effects of the Avanza were an initial excess of sedation and the possibility of some strange dreams in the first few days of taking it. Although Dr Hames had no independent recollection of what he told Peter at the appointment, it is his usual practice to warn people of the possibility of strange

[74] Transcript 60 – 61 (Hames, P.R.(Dr)).
[75] Exhibit 3, Progress Notes 8.1.1999 & 15.1.1999.
[76] Transcript 50 (Hames, P.R.(Dr)).
[77] Transcript 45 (Hames, P.R.(Dr)).

dreams and that they should stop taking it and let him know if any other problems occur. He has no reason to believe he departed from his usual practice in this instance.[78]

54. When asked his opinion as to whether he thought it was likely that Peter's use of mirtazapine had any impact on Peter's decision to suicide, Dr Hames stated "No, it was irrelevant".[79]

55. The Department's Health policy requires that where a death in custody occurs, a Health Review Report addressing the medical management of the deceased will be undertaken by an independent medical practitioner.[80] At the time Mr Mudford prepared his report he was informed that the required Health Review Report had not been compiled, apparently due to the Department experiencing difficulties recruiting medical officers to undertake such reviews.[81] It seems that that information provided to Mr Mudford was incorrect, as an Independent Medical Review Report prepared by a Dr Todd was provided by counsel appearing on behalf of the Department towards the end of the inquest, and that report is dated some four months prior to the date of Mr Mudford's report.[82]

56. It appears from Dr Todd's report that it was prepared solely from Peter's medical record, without the benefit of the statements of Nurse Lee and Dr Hames.[83] As a result, Dr Todd has mistakenly concluded that Dr Hames diagnosed Peter with clinical depression and prescribed him with mirtazapine as antidepressant therapy. He then comments upon the known side effects of prescribing mirtazapine to treat depression, including an uncommon but possible risk of suicide.[84]

[78] Exhibit 1, Tab 9 [14] - [15].
[79] Transcript 46 (Hames, P.R.(Dr)).
[80] Exhibit 2, Tab 31, Mudford Report, 5.
[81] Exhibit 2, Tab 31, Mudford Report, 5.
[82] Exhibit 10.
[83] Exhibit 10.
[84] Exhibit 10.

57. I am unable to place any reliance upon Dr Todd's report, given he did not have available to him all the relevant information at the time he prepared his report. The contents of that report were also not put to Dr Hames as it was not made available to the court and the parties until after Dr Hames had given evidence. However, Dr Hames did address the issue of the increased risk of suicide when prescribing mirtazapine in his evidence to some degree, as noted above, and his evidence was not challenged by counsel for any of the parties.

58. I made some observations during the inquest hearing about the inadequacy of Dr Todd's report[85] and counsel appearing on behalf of the family also made a submission in that regard.[86] I recognise that the reports are prepared for the Department's own purposes, but they are also helpful for the mandatory inquest hearing, and I suggest that such reports will be most useful for all parties if the Department provides the report writer with **all** the relevant materials for that purpose (such as statements from the medical staff) rather than only providing them with the medical records.

DAYS LEADING UP TO THE DEATH

59. There is only limited information available as to Peter's activities and behaviour over the 18 days between when he saw Dr Hames and when he died.

60. For most of this time Peter had a cell mate, but the cell mate moved by choice to another unit two days prior to Peter's death. The cell mate was later interviewed and identified no issues with respect to Peter's behaviour or mood for the period they shared a cell.[87]

[85] Transcript 123.
[86] Transcript 126 – 127 (Gazia, Mr).
[87] Exhibit 2, Tab 31, Mudford Report, 6 - 7.

61. On 10 November 2010 Peter was interviewed by Hakea security staff in relation to his monitored telephone calls. It was put to Peter that he spoke to his ex-partner during a telephone call, which would be a possible breach of a current Violence Restraining Order. Peter denied doing so and informed the officers that he already had six breaches against him and didn't want another. He was told the matter would be referred to police for investigation.[88]

62. He appeared in court on 16 November 2010 in relation to his charges and was again remanded in custody to a further date in December 2010.[89]

63. On the morning of Tuesday 23 November 2010 Ms Katrina Lane, a paralegal at the Aboriginal Legal Service, attended Hakea to speak with Peter about his court matters. Prison records record the visit as a half hour visit from 8.30am to 9.00am.[90]

64. Ms Lane is an experienced paralegal who does regular prison visits to Hakea to provide early advice to prisoners, and that is the service she performed for Peter.[91] She spoke with Peter about his pending charges, both new and old. Ms Lane noted that they were missing the Statement of Material Facts for a number of the charges, which limited their ability to discuss them. Accordingly, Ms Lane made arrangements to see Peter the following Tuesday and reassured him that they would have time to get all the missing materials and discuss the matters before his next court date on 2 December 2010.[92] They did not discuss bail or the probable outcome in relation to the charges.[93]

65. Ms Lane did not observe anything about Peter in the interview to cause her concern. He did not say anything

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[88] Exhibit 2, Tab 31.30, Incident Report of D.Johnson, 10.11.2010.
[89] Exhibit 1, Tab 2, 4.
[90] Exhibit 1, Tab 2, 4.
[91] Transcript 63 (Lane, K.D.); Exhibit 1, Tab 10.
[92] Exhibit 1, Tab 10 [11] – [13].
[93] Transcript 64 (Lane, K.D.); Exhibit 1, Tab 10 [14].

to her about feeling like he wanted to hurt himself.[94] If he had, she would have made a note of it and spoken to someone at her office about her concerns.[95] Ms Lane described herself as "very surprised and quite shocked" when she was informed of his death the following day.[96]

66. The prison records also show a recorded appointment with the Health Centre for Peter and some other prisoners on 22 November 2010 for a blood clinic.[97] Peter missed the appointment and he saw Prison Officer Symington at about 11.00am on 23 November 2010 to arrange for the appointment to be rescheduled.[98] Officer Symington indicated Peter seemed happy at the time and told Officer Symington that he did not believe he needed his medication anymore and was thinking of stopping it.[99]

67. After the deceased's death police interviewed 83 prisoners that might have come into contact with Peter in the time shortly before his death. The general response of most who had spoken to Peter was that he had seemed fine.[100]

68. One prisoner told police he spoke with Peter during the day on 23 November 2010 and he seemed a bit concerned about possibly receiving an official visit from the police.[101] This is likely to have related to the possible breach of a VRO by telephone mentioned above.

69. A couple of prisoners in his unit thought Peter had seemed a bit down and upset on the day before he died, apparently attributed to 'women problems', and he didn't participate in his usual joking banter at lockdown that night.[102] However, none of the prisoners reported

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[94] Exhibit 1, Tab 10 [16].
[95] Transcript 66 - 67 (Lane, K.D.)
[96] Exhibit 1, Tab 10 [15].
[97] Exhibit 2, Tab 31, Mudford Report, 7.
[98] Major Crime Running Sheet.
[99] Exhibit 1, Tab 2, 4.
[100] Exhibit 1, Tab 2, 6.
[101] Exhibit 1, Tab 2, 5 read with Major Crime Running Sheet.
[102] Exhibit 1, Tab 2, 6 read with Major Crime Running Sheet.

that Peter had spoken to them of hurting himself or given them cause to be concerned that he might do so.

70. Peter made a number of telephone calls to his family that day.[103] In the last call with his father, at 4.56pm, he appears jovial and is laughing. In his last telephone conversation with his mother at 6.18pm, shortly before lockdown, he also does not sound distressed. In that call Peter's mother indicated she was coming up to see him the following day and she agreed she would bring him some money. Peter did not make any mention of feeling down or having any thoughts of harming himself.[104] It appears that if Peter was having thoughts of taking his own life at that time, he did not want to share those thoughts with his loved ones.

EVENTS ON THE EVENING OF 23 – 24 NOVEMBER 2010

71. Peter received his dinner and Avanza medication just before lockdown at 6.30pm.[105] He was then locked in his cell, Cell A02, on his own at approximately 6.30pm.[106]

72. No cell calls were made from Peter's cell over the evening of 23 – 24 November 2010.[107] A cell check conducted by Prison Officer Michael Rushworth at 10.50pm on 23 November 2010 recorded everything as being correct and Peter was not displaying any signs that would cause concern.[108]

73. The next muster check was around 4.50am on 24 November 2010. While Prison Officer Smith was conducting the check in A Wing he approached Peter's cell. He looked through the inspection hatch and saw Peter, who appeared to be standing near the rear of the

[103] Exhibit 1, Tab 13.
[104] Exhibit 1, Tab 2, 5 and Tab 13.
[105] Exhibit 1, Tab 2, 5.
[106] Exhibit 1, Tab 2, 6.
[107] Exhibit 1, Tab 2, 6.
[108] Exhibit 1, Tab 2, 6 and Tabs 11, 14 [6] – [7].

cell. Officer Smith instructed Peter to show movement and then shone his torch into the cell, but received no response. Officer Smith then raised the alarm and sought assistance from other officers.[109]

74. He was joined by Officers Wilson and Rushworth. They went to Peter's cell and again asked him to show movement. When they did not get a response Office Rushworth breached the cell door and the three officers entered the cell.[110]

75. They found Peter hanging from the window grille from a ligature made of white fabric that was tied around Peter's neck and to a bar outside of the cell window.[111]

76. Officer Rushworth supported Peter's weight while Officer Smith cut the ligature using a knife, before placing Peter on the floor and removed the ligature from his neck.[112]

77. Officer Wilson had brought to the cell the Oxy-Viva resuscitation equipment from the control room and he called a Code Red for medical assistance. At approximately 4.55am Officers Rushworth and Smith commenced cardiopulmonary resuscitation (CPR).[113]

78. They were joined by a medical officer, Nurse Maas, approximately 5 minutes later, who brought additional resuscitation equipment, including a defibrillator.[114] Nurse Maas observed that Peter's skin was clammy, his pupils were fixed and dilated and he had no pulse, but there were no signs of rigor mortis.[115] The defibrillator was used but Peter did not respond so Officers Rushworth, Smith and Nurse Maas took turns continuing to perform CPR until ambulance officers arrived at 5.26am.[116]

[109] Exhibit 1, Tab 15.
[110] Exhibit 1, Tab 15.
[111] Exhibit 1, Tab 15.
[112] Exhibit 1, Tab 15.
[113] Exhibit 1, Tab 15.
[114] Exhibit 1, Tabs 15 and 24; Exhibit 3, EcHO notes. 24.11.2010.
[115] Exhibit 1, Tab 24.
[116] Exhibit 1, Tab 15.

79. The ambulance officers moved Peter out of the cell and provided further medical treatment in an attempt to resuscitate Peter. Unfortunately, despite their efforts he could not be revived and CPR was ceased by ambulance officers at approximately 5.50am.[117] Dr Hames later certified the death.[118]

80. Police detectives and officers attended Hakea that morning and commenced an investigation into the death. Peter's cell was searched and no suspicious circumstances were identified, although the exact origin of the material used by Peter to form the ligature was not identified.[119] The design of the cell, with the obvious ligature point of the window, was later identified as an area for consideration and review by the investigating officer.[120]

CAUSE OF DEATH

81. On 26 November 2010 Dr McCreath, a Forensic Pathologist, conducted a post mortem examination of the deceased. The examination revealed a ligature mark around the neck with minor bruising in the underlying tissues. Neuropathological examination of the brain showed cerebral congestion.[121] Toxicological analysis showed a therapeutic level of mirtazapine.[122]

82. Dr McCreath formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[123]

83. I accept and adopt Dr McCreath's conclusion as to the cause of death.

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[117] Exhibit 1, Tab 18; Exhibit 3, EcHO notes. 24.11.2010.
[118] Exhibit 1, Tab 3.
[119] Exhibit 1, Tab 2, 15.
[120] Exhibit 1, Tab 2, 17.
[121] Exhibit 1, Tab 28.
[122] Exhibit 1, Tabs 28 and 29.
[123] Exhibit 1, Tab 28.

MANNER OF DEATH

84. Until the events of November 2010 the evidence suggests that Peter had never given any indication that he was likely to take his own life.

85. All of the prison officers at Hakea have been trained in compulsory Gatekeeper Suicide Prevention training[124] and some medical staff, although it is not compulsory for them.[125] All of the witnesses at the inquest who had participated in the training agreed that it assisted them in looking for whether a prisoner is displaying concerning behaviours and assessing suicide risk.[126]

86. During his last period of incarceration Peter was generally reported to be behaving normally and, other than a suggestion he might have been feeling a bit down on the day before he died, there was no outward signs observed by prison officers or other prisoners that Peter had reached the stage where he might now be at risk of suicide.

87. However, it is relevant that Peter was reported by other prisoners to be a private person who generally kept his thoughts to himself.[127]

88. This would appear to be borne out by Peter's telephone conversations with his parents, shortly before he died, where he seemed to avoid answering a question from his father about his wellbeing[128] and generally seemed to keep the conversations light-hearted.

89. Although there is no known catalyst or significant event that occurred before 23 November 2010 that might have affected Peter and made him think of taking his own life, it is relevant to note that until two days before his death Peter had been sharing a cell. Having a cell mate is one suicide prevention strategy used within the

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[124] Exhibit 5 [25] – [41].
[125] Transcript 101 (Keller, M.).
[126] Transcript 8 (Trevena, S.L.), 30 (Lee, S.L.), 69 (Rushworth, M.A.).
[127] Major Crime Running Sheet.
[128] Exhibit 1, Tab 13, Call 8572855.

prisons.[129] As well as potentially providing a prisoner with support, in a practical sense it might be seen to make a suicide attempt more difficult to carry out undetected.

90. What is known is that sometime between 10.50pm on 23 November 2010 and 4.50am on 24 November 2010, Peter fashioned a ligature from a piece of white material and hanged himself from an external bar outside the open cell window, with the intention of taking his life.

91. The fact that witnesses described him as warm and clammy to the touch[130] and there were no signs of rigor suggests that it must have occurred closer in time to when he was found than the first muster.

92. Unfortunately, by the time Officer Smith conducted his second cell check at 5.50 am and discovered Peter hanging, too much time had elapsed to allow the Peter to be successfully resuscitated, although I am satisfied that everything that could be done to try to resuscitate him was done by prison staff and ambulance officers.

93. I find that death occurred by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

94. The deceased was interviewed by two staff members upon his admission to Hakea prison, Officer Trevena and Nurse Lee.

95. Nurse Lee is very experienced in assessing the physical and mental health of prisoners having completed more than four thousand such assessments.[131] She indicated that she uses the ARMS referrals a lot when

[129] Transcript 107 (Keller, M.).
[130] Exhibit 1, Tabs 18 and 24.
[131] Transcript 30 (Lee, S.L.).

conducting those assessments but in Peter's case he did not present as needing an ARMS referral.[132]

96. While less experienced than Nurse Lee in admitting and assessing prisoners, Officer Trevena had completed both Gatekeeper training and Mental Health First Aid training[133] and she impressed me in her evidence as being a thoughtful and diligent prison employee who had completed her assessment thoroughly.

97. It was submitted by Mr Gazia on behalf of the family that both Nurse Lee and Officer Trevena had demonstrated in their responses about the regularity of prisoners reporting depression a certain desensitisation or scepticism about such reports.[134] I did not take their evidence that way. Rather, what the witnesses were explaining was that the fact that a prisoner refers to themselves as 'depressed' (which occurs often) does not necessarily mean they have clinical depression, nor that they are at risk of suicide. That accorded with Dr Hames' evidence.

98. What is required in the assessment is for the admitting officer to use their knowledge, experience and training to identify risk factors that might signal that they are at heightened or acute risk of self harm or suicide. Mr Keller, the Suicide Prevention and Clinical Governance Manager for the Department, described some of those factors, such as prior suicide attempts, gender, ethnicity, age, drug and alcohol issues and mental health issues.[135] Based on the background information provided to them, and Peter's recorded answers, I am satisfied it was reasonable for Officer Trevena and Nurse Lee to concluded that Peter was not suffering from clinical depression and was not at acute risk of self harm or suicide at the time they saw him. Accordingly, an ARMS referral was not appropriate.

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[132] Transcript 37 (Lee, S.L.).
[133] Exhibit 1, Tab 6.
[134] Transcript 126 (Gazia, Mr).
[135] Transcript 112 – 113 (Keller, M).

99. I am similarly satisfied, on the basis of Dr Hames' evidence, that there were reasonable grounds for Dr Hames' forming the medical opinion that Peter did not have clinical depression at the time he saw him on 5 November 2010 and did not require an ARMS referral at that time.

100. A submission was made by counsel on behalf of Peter's family that Dr Hames' notes were inadequate, given he was required to rely upon them as he had no independent recollection of events. Without commenting specifically on the adequacy of Dr Hames' notes on this occasion, as it was not put to him in evidence that they were inadequate, I do make the observation that comprehensive medical notes by medical staff is certainly to be encouraged, particularly given that doctors cannot reasonably be expected to have an independent recollection of every consultation with their patients.

101. The conclusion that the admitting officers and Dr Hames did not err in their conclusion that an ARMS referral was not indicated, is supported by the fact that no other prison officer who had dealings with Peter after that time saw fit to refer Peter to ARMS, despite the fact that they are all Gatekeeper trained and all have the capacity, and are expected, to do so if they see a prisoner displaying concerning behaviours.[136]

102. However, for the sake of completeness, I note that if the admitting staff or Dr Hames had formed a different conclusion at the time they saw Peter and placed him on ARMS, there is no certainty that Peter would still have been on ARMS and/or housed in a different cell, by 23 November 2010.[137]

103. Studies have shown that, at least in US prison populations, the highest risk for prison inmate suicides is within the first 48 hours of confinement and after two

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[136] Transcript 102, 105 – 106, 108, 113 (Keller, M.).
[137] Trasncript 116 – 118 (Keller, M.).

weeks of confinement the risk drops significantly.[138] Situational and personal factors that increase risk of suicide are also subject to change.[139]

104. The ARMS procedures take the dynamic and changing nature of suicide risk into account, with the prisoner's risk being subject to ongoing assessment by the Prisoner Risk Assessment Group (PRAG) once they have been referred to ARMS and risk prevention strategies have been put into place to ameliorate the risk.[140] According to Mr Keller, prisoners are generally managed on ARMS for a relatively brief period, whether it is a few days or a week, before they are assessed by PRAG as no longer at acute or imminent risk of suicide and either taken off ARMS entirely or transitioned to another process known as SAMS, which is a secondary prevention strategy to manage chronic ongoing risk.[141] Referral to the prison counselling service is also available on an ongoing basis.[142]

105. Accordingly, even if Peter had been placed on ARMS at the time of his intake to Hakea on 27 October 2010, it is likely, given the general evidence about his behaviour after that time, that he would have been transitioned off ARMS nearly a month later. Alternatively, he might have remained on ARMS but still have been housed in cell A02 on his own that evening. Therefore, the decisions of Officer Trevena, Nurse Lee and Dr Hames not to refer Peter to ARMS should not be treated as the pivotal moment that would have prevented Peter's death.

106. Dr Hames was asked by Mr Gazia, on behalf of the deceased's family, in his experience what percentage of people who commit suicide suffer from depression. Dr Hames indicated he might put it at roughly 50 per cent.[143] That leaves approximately half the deaths not

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[138] Transcript 110 - 111 (Keller, M.); Exhibit 5 [16].
[139] Transcript 116 (Keller, M.).
[140] Transcript 117 (Keller, M.); Exhibit 5 [13].
[141] Transcript 111, 115 – 116 (Keller, M.); Exhibit 5 [14].
[142] Trasncript 119 (Keller, M).
[143] Transcript 56 (Hames, P.R.(Dr)).

being related to clinical depression but for other reasons. If Peter was not clinically depressed, there was apparently some other reason that prompted him to think of taking his own life that night.

107. Peter did not communicate those thoughts to any other person in the time leading up to the night of 23 November 2010, despite being in contact with prison staff, other prisoners and his own family by telephone. He had also shown during his reception interview with Nurse Lee that he understood that he could ask to see a doctor if he wanted help, and indeed he did see Dr Hames and get some medication for his agitation early in his stay, but he did not choose to do so this time.

108. It was submitted to me that the Department should employ Aboriginal staff members in the prison system as an Aboriginal person is more likely to engage with other Aboriginal people. While I accept that this is probably true, given Peter's demonstrated unwillingness to disclose his thoughts to anyone else in the lead up to the night of his death, including his family, I find it difficult to connect such a proposition with this particular death.[144] In any event, counsel appearing for the Department, Mr van Hattem, indicated that the Department recognises the benefits to be obtained from having more Aboriginal people on its staff and does try to increase Aboriginal participation rates in its employment.[145]

109. Similarly, although it is relevant to note that there is now a new and more comprehensive admission form, the ARMS-RIA, which seems to be generally accepted as a significant improvement on the old form,[146] there is no evidentiary basis to conclude that Peter would have disclosed suicidal thoughts if interviewed with the new form. Although she obviously could not say conclusively, Officer Trevena certainly did not think it

[144] Transcript 130 – 131.
[145] Transcript 136 (van Hattem, Mr).
[146] Exhibit 5, Tab [21] – [24], [43] – [45].

was likely based upon her interview with Peter and her experience with the old and new form.[147] Therefore, it does not appear that this alteration to procedure might have affected the outcome in this particular case, although it is obviously a positive step generally for the Department.

110. On behalf of Peter's family, Mr Gazia also submitted that some thought might be given to close circuit television cameras being installed in cells so prisoners could be filmed at night and also additional muster checks at night. My preliminary response to those submissions is that whilst they might have some practical preventative effect on suicide attempts, they might have a significant detrimental effect on the mental health of prisoners. Without any evidence before me on the positive and negative aspects of the proposals, I am not minded to make a comment on their viability or advisability.[148]

111. In my view, the most concerning aspect of Peter's care and supervision was his placement in a cell with an obvious ligature point, namely the window bars. This was identified by the investigating police officers as a matter of concern and I agree.[149] The photographs comprising Exhibit 8 show the window bars to be an obvious hanging point.[150] It has been identified as such in at least one previous inquest dating back to February 2004, which involved a similarly configured cell and the use of the same hanging point, at Hakea.[151] At that time the State Coroner recommended that the Department take immediate action to review cells in the various prisons throughout the State to identify such obvious hanging points and take action to minimise such hanging points. In a response to the Finding the

[147] Transcript 15.
[148] Transcript 127 – 128.
[149] Exhibit 1, Tab 2.
[150] Exhibit 8.
[151] See Record of Investigation – Inquest 03 of 2004 – Finding of State Coroner into the death of DTG delivered 10 February 2004.

Department indicated it supported this recommendation and that it proposed to take steps to do so.[152]

112. Surprisingly, some six years later, those steps were still at such an early stage that they allowed prisoners to be housed in cells with the same window bars, such as Cell A02 in which Peter was housed.

113. The only positive matter to note is that since the time of Peter's death and the hearing of this inquest, the Department has given considerable attention to reducing hanging points in prison cells. At the inquest, evidence was heard from the Department's Acting Director of Infrastructure Services, Mr Andrew Daniels. Mr Daniels provided a detailed statement and annexures,[153] and also gave oral evidence,[154] in relation to the Department's Ligature Minimisation Program.

114. The funding for the program was first approved by Treasury in 2009.[155] It is apparent from Mr Daniel's evidence that since that time the Department has taken steps to reduce the number of ligature points in cells as far as possible, within the limits of available funding.

115. A '3 point' ligature minimisation involves removing the three most obvious hanging points in a cell associated with access to window bars (relevant to this inquest), ceiling lights and shelves and cupboards.[156] A '15 point' ligature minimisation involves removing a larger number of possible hanging points in a cell.[157]

116. In relation to ligature minimisation for access to bars from windows, if a window allows access to external grill bars, mesh louvres are placed over them in both the "3 point" and "15 point" program.[158] Examples are shown

[152] Department of Justice Response to the Findign of the Coroner into the manner and cause of death of DTF dated 2 July 2004.
[153] Exhibit 6.
[154] Transcript 86 - 94 (Daniels, A.).
[155] Exhibit 6 [6].
[156] Exhibit 6, [15].
[157] Exhibit 4, Tab 1 [19].
[158] Exhibit 6 [17].

as attachments to Mr Daniel's statement.[159] The particular cell in which Peter was housed, A02 at Hakea, has now been minimised in such a way.[160] Following the inquest hearing, I have also been provided with information from the Department that all cell windows across Hakea have been inspected and the review confirmed that only one cell window in one Unit allowed access to grille bars outside a window and a work order has now been issued to install mesh to the bars. It is anticipated that the work will be completed by 4 September 2014.[161]

117. Interestingly, the Department has also recently provided information that there have been three apparent suicides in prison since Peter's death, of which one occurred in a "3 point" minimised cell at Hakea.[162] In addition, in the three years prior to Peter's death, there were eight apparent suicides and six of those occurred in "3 point" minimised cells. That information does point towards people being adaptable to finding ligature points when the most obvious ones are not available, but does not detract from the fact that obvious hanging points, such as the one available in Peter's case, should not be present. Mr Daniels has provided information about the status of the implementation of the full "15 point" minimisation program in all prison in this State, which is hindered by a lack of ongoing funding.[163]

118. I have noted previously after another inquest the desirability of reducing all opportunities for prisoners to create and site ligatures, given the high personal costs to both the deceased, their family and friends and prisoners and prison staff from suicides in custody. In that regard, I reiterate that it is to be hoped that priority will be given by Treasury to funding the Department to continue this project's implementation into unsecured cells in other prisons in the future. More can be done to

[159] Exhibit 6, Attachments 2 - 5.
[160] Exhibit 6 [27].
[161] Email from Mr van Hattem dated 26 August 2014.
[162] Email from Mr van Hattem dated 26 August 2014.
[163] Exhibit 6 [37] and Attachments 6 and 7.

prevent further deaths of this kind in the future and that is the hope expressed by Peter's family.[164]

CONCLUSION

119. Peter was a 38 year old Aboriginal man who, although he had experienced some troubles in his life, was loved by his parents and other family members and had been showing some determination to improve his lifestyle and health for the future.

120. Sadly, while in custody on remand for some serious charges, his thoughts turned to suicide but he did not communicate those thoughts to anyone else who might have been able to help him.

121. Sometime in the early hours of 24 November 2010 while locked in a cell on his own and having decided to take his own life, Peter fashioned a ligature with some material and hanged himself from the accessible cell window bars. He died as a result.

122. Nearly four years later, his family are still learning to cope with Peter's loss. Their hope is that lessons can be learnt from his death to save other Aboriginal families experiencing the same grief.

123. I share their hope and encourage the Department to continue to endeavour to improve their suicide prevention strategies, including continuing to make its best efforts to complete the implementation of the full ligature minimisation program in all prisons throughout Western Australia.

S H Linton
Coroner
12 September 2014

[164] Transcript 130 (Gazia, Mr).