JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	26-27 JULY 2022, 14-16 DECEMBER 2022
DELIVERED	**:**	21 AUGUST 2023
FILE NO/S	**:**	CORC 789 of 2019
DECEASED	**:**	BLANKET, JOMEN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Tyler assisted the Coroner
Ms K. Dias and Ms R. Hartley (State Solicitor's Office) appearing on behalf of the Department of Justice and the North Metropolitan Health Services
Mr C. Beetham instructed by Wotton & Kearney appearing on behalf of Serco Australia Pty Ltd
Mr S. Penglis SC and Mr S. Castan instructed by National Justice Project appearing on behalf of Karen Blanket and Alice Blanket
Mr M. Williams appearing on behalf of Dr Bilyk

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Jomen BLANKET*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 26 to 27 July 2022 and 14 to 16 December 2022, find that the identity of the deceased person was* ***Jomen BLANKET*** *and that death occurred on 12 June 2019 at Acacia Prison, Wooroloo, from ligature compression of the neck (hanging) in the following circumstances:*

Table of Contents

LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
Acacia	Acacia Prison
AOD	Alcohol and other Drugs
ARMS	At Risk Management System
AVS	Aboriginal Visitors Scheme
the Board	the Prisoners Review Board
the ***Briginshaw*** principle	the accepted standard of proof the Court is to apply when deciding if a matter has been proven on the balance of probabilities
Casuarina	Casuarina Prison
cm	centimetres
COPP	Commissioner's Operating Policy & Procedure
CPR	cardiac pulmonary resuscitation
the Department	the Department of Justice
the Document	the Department of Health's *Principles and Best Practice for the Care of People Who May Be Suicidal*
EcHO	the Department's Electronic Health Online
FDV	Family Domestic Violence
FVRO	Family Violence Restraining Order
Hakea	Hakea Prison
HALO	Hopes Aspirations Leadership Opportunity
IMP	Individual Management Plan
the MHT	the Mental Health Team
mm	millimetres
PCS	Prisoner Counselling Service (the previous title for PWS)
PiP	the Department's Parole-in-reach Program
PRAG	Prisoner Risk Assessment Group
PSC	Pre-Self Care
PTS	Prisoner Telephone Service
PWS	Psychological Wellbeing Service
SAMS	Support and Monitoring System
Serco	Serco Australia Pty Ltd
the SPGU	the Suicide Prevention Governance Unit
the steering committee	the Suicide Prevention Steering Committee
TOMS	Total Offender Management Solution
VRO	Violence Restraining Order
WAPF	Western Australian Police Force

INTRODUCTION

> We've gone from warehousing people in buildings that felt like prisons into warehousing them in actual prisons. In the past, so many people did not ask for help. Thankfully that's no longer the case, but now we're not in a position to give it to them. If we want to be a society that respects and values mental health, we have to respect and value mental health care. And that means supporting people who deliver it [in prisons].[1]

1 The deceased (Mr Blanket) died on 12 June 2019 at Acacia Prison (Acacia), from ligature compression of the neck (hanging). As I will outline in this finding, a critical situation created by a concurrence of factors[2] enabled Mr Blanket to tragically take his own life. He was 30 years old.

2 At the time of his death, Mr Blanket was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[3]

3 Accordingly, immediately before his death, Mr Blanket was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[4] In such circumstances, a coronial inquest is mandatory.[5]

4 Acacia opened in May 2001 and was the first privately managed jail in Western Australia, with the land and infrastructure publicly owned. As is still the case today, in 2019 Serco Australia Pty Ltd (Serco) privately operated Acacia under an agreement with the Department and was responsible for the prison's operational and maintenance services.[6]

5 I held a five-day inquest into Mr Blanket's death at Perth on 26-27 July 2022 and 14-16 December 2022. At the resumption of the inquest on 14 December 2022, I gave an Acknowledgement of Country to the Whadjuk people of the Noongar nation and, as Mr Blanket had ancestral links to the Torres Strait Islands, I also acknowledged the traditional custodians there. This was the first time an inquest held in Perth had given an Acknowledgement of Country.

6 The following witnesses gave oral evidence at the inquest:

(i) Senior Constable Nigel Foote (Coronial Investigation Squad at WAPF[7]);

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[1] John Oliver, political commentator, "Last Week Tonight" screened 31 July 2022 (season 9, episode 18)
[2] Also known as a "perfect storm"
[3] *Prisons Act 1991* (WA) s 16
[4] *Coroners Act 1996* (WA) s 3, s 22(1)(a)
[5] *Coroners Act 1996* (WA) s 25(3)
[6] Annual Report 2021/22 – Acacia Prison Services Agreement 2020
[7] Western Australian Police Force

(ii) Michael Saligari (Social Worker at Acacia);
(iii) Anna Francis (Safer Custody Coordinator at Acacia);
(iv) Dr Natalia Bilyk (Consultant Psychiatrist at the State Forensic Mental Health Service);
(v) Toni Palmer (Senior Review Officer at the Department);
(vi) Andrew Daniels (Assistant Director, Infrastructure Services at the Department);
(vii) Doug Benson (Rehabilitation and Reintegration Manger at Acacia);
(viii) Pansey Stewart (Health Services Manager at Acacia);
(ix) Dr Joy Rowland ACM (Director of Medical Services at the Department); and
(x) Andrew Beck (Deputy Commissioner, Offender Services at the Department).

7 The documentary evidence at the inquest comprised of three volumes of the brief, which were tendered as exhibit 1 at the commencement of the inquest. Counsel assisting and counsel appearing on behalf of the family tendered additional exhibits during the inquest, and they became exhibit 2 through to exhibit 7. At my request, further information was supplied to the Court in July and August 2023 by the Department and Serco through their legal representatives. This information mainly related to the installation of safe cells at Acacia's Foxtrot Block and the availability of treatment programs for prisoners sentenced to a term of 12 months imprisonment or less. In August 2023, the Department and Serco also responded to nine proposed recommendations that I was contemplating.

8 The inquest focused on the treatment and care provided to Mr Blanket, and primarily in regard to his mental health during his time as a prisoner at Acacia.

9 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proven on the balance of probabilities (the ***Briginshaw*** principle):[8]

> …reasonable satisfaction is not a state of mind that is obtained or established independently of the nature and consequences of the fact or facts to be proved. The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should

[8] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J)

> not be produced by inexact proofs, indefinite testimony, or indirect inferences.

10 I am also mindful not to insert hindsight bias into my assessment of the actions taken by those responsible for Mr Blanket's supervision, treatment and care when he was in prison. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[9]

MR BLANKET [10]

11 Mr Blanket was born on 26 April 1989 at King Edward Memorial Hospital in Subiaco. He was one of 10 children his mother, Karen Blanket, had. Sadly, Karen Blanket lost her youngest daughter at birth, and she then suffered the loss of Mr Blanket (her eldest son) from a death in custody. Mr Blanket was a proud and respectful First Nations and Torres Strait Islander man.

12 Mr Blanket attended Winterfold primary school in Beaconsfield, before completing Year 10 in high school. He then continued with media and acting studies. Mr Blanket later performed at Cirque du Soleil and appeared in television commercials. He was also part of an Aboriginal dancing troupe from the Hilton PCYC, and he performed in different places around Australia, including Alice Springs and Melbourne. In addition, Mr Blanket travelled to different towns in Western Australia performing Torres Strait Island dances.

13 Mr Blanket had also enrolled with HALO (Hopes Aspirations Leadership Opportunities). HALO is responsible for coaching young people to achieve success using positive psychology for personal leadership development. After completing the HALO course, Mr Blanket became a mentor to other younger men.

14 Mr Blanket had had a long-term relationship with his partner. They had three children together, with the eldest named after his father.

Circumstances of imprisonment [11]

15 Mr Blanket's relationship with the mother of his three children was on and off. On 22 December 2016, his partner obtained a Violence Restraining Order (VRO) against him for a duration of two years.

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[9] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

[10] Exhibit 1, Volume 1, Tab 2, Report of Senior Constable Nigel Foote dated 22 January 2020; Exhibit 1,Volume 1, Tab 10, File Note of Senior Constable Nigel Foote dated 15 July 2019; Exhibit 7, Family Statement

[11] Exhibit 1, Tab 48, Transcript of Sentencing Proceedings in Fremantle Magistrates Court dated 23 October 2018; Exhibit 1, Volume 1, Tab 49, Incident Report 200217 1115 12910; Exhibit 1, Tab 50, Court Outcomes – Criminal and Traffic for Mr Blanket.

16 On 17 February 2017, Mr Blanket seriously assaulted his partner. This assault included kicking her in the face when she was on the ground. He then applied pepper spray to her face.

17 Mr Blanket subsequently pleaded guilty to aggravated assault occasioning bodily harm, carrying a controlled weapon (the pepper spray), causing poison to be administered (his use of the pepper spray) and a breach of a VRO.

18 On 23 October 2018, Mr Blanket was sentenced in the Fremantle Magistrates Court to a total term of imprisonment of 12 months with eligibility for parole. The magistrate also imposed a Family Violence Restraining Order (FVRO) on behalf of Mr Blanket's partner for a period of 10 years commencing on the expiry date of the previous VRO that was obtained by Mr Blanket's partner in December 2016. During the sentencing remarks, the magistrate noted that for a number of days leading up to the offending, Mr Blanket was using methylamphetamine daily.

19 Mr Blanket's earliest eligible date for parole was 22 April 2019. This was to become a significant date for him.

Prison history [12]

20 After he was sentenced, Mr Blanket was taken to Hakea Prison (Hakea). During his reception at Hakea, Mr Blanket was asked if he had ever tried to take his own life or harm himself, and he replied that he had attempted to hurt himself 18 months ago. Mr Blanket also said that his mother's illness was a source of anxiety. He denied having any serious health issues and said he was not on any medication. He denied using illicit drugs and confirmed he occasionally consumed alcohol.

21 Mr Blanket's initial "maximum" security rating was reduced to "medium" after his risk factors were assessed, and he was approved for a transfer to Acacia to facilitate potential visitors. On 1 November 2018, Mr Blanket was transferred from Hakea to Casuarina Prison (Casuarina) due to a high muster count at Hakea. On 6 November 2018, he was transferred from Casuarina to Acacia where he remained until his death.

OVERVIEW OF THE TREATMENT AND CARE PROVIDED TO MR BLANKET IN ACACIA FOR HIS MENTAL HEALTH

22 Upon his arrival at Acacia, Mr Blanket was assessed by a prison nurse. It was recorded by the nurse that Mr Blanket was on no current medications, and he denied any current thoughts of self-harm or suicidal ideation.[13]

[12] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated June 2022.
[13] Exhibit 1, Volume 1, Tab 3, Health Services Report by Pansey Stewart dated 20 July 2022, p.9

There is no written note of Mr Blanket's previous episode of self-harm, which suggests he did not inform the nurse at Acacia of it.

23 On 11 December 2018, a mental health nurse considered a referral that had been made to the Mental Health Team at Acacia (the MHT). A file review was conducted by the nurse and it was noted that it was unclear why Mr Blanket had been referred. After reviewing the Department's Electronic Health Online (EcHO), the nurse recorded that Mr Blanket was not under any mental health plan, and nor were there any mental health concerns. It was therefore noted no further input by the MHT was required.[14]

24 On 8 January 2019, Mr Blanket requested a transfer to Roebourne Prison. The reason he gave was so that he could be closer to his mother. This request was refused.

25 On 26 January 2019, Mr Blanket was housed in Mike Block when he requested a "time out". In accordance with prison regulations, he was relocated to the detention unit for this time out.[15]

29 January 2019: Mr Blanket's first contact with Mr Saligari after being placed on ARMS

26 Mr Blanket had expressed thoughts of self-harm during welfare checks when in the detention unit. Consequently, Michael Saligari, a social worker with Acacia's Psychological Wellbeing Service (PWS),[16] met with Mr Blanket for an assessment. This assessment took place on 29 January 2019.

27 Mr Saligari's assessment was required for the purposes of the At Risk Management System (ARMS) as Mr Blanket had been placed on ARMS.

28 ARMS is the Department's primary suicide prevention strategy and is used by all prisons in Western Australia. It aims to provide prison staff with clear guidelines set out in the ARMS Manual to assist with the identification and management of prisoners at risk of self-harm and/or suicide. Any prisoner exhibiting warning signs or risk factors that may increase the likelihood of self-harming or suicide behaviour should be placed on ARMS and monitored according to the level of risk and care required. The ARMS Manual has guidelines for assessing the degree of risk for a prisoner who is then allocated one of three levels: "High", "Moderate" or "Low".[17] An important feature of ARMS is that custodial and non-custodial staff share responsibility for suicide prevention and a

[14] Exhibit 1, Volume 1, Tab 3, Health Services Report by Pansey Stewart dated 20 July 2022, p.11
[15] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.12
[16] This service was previously known as the Prisoner Counselling Service (PCS)
[17] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), pp.52-53

prisoner can be placed on ARMS by any prison staff member at any time.[18] On 29 January 2019, Mr Blanket had been placed on Moderate ARMS.

29 Mr Blanket told Mr Saligari that he was experiencing anxiety and depression and had sleep issues. He reported fighting with other prisoners and feeling tense. He also indicated he was concerned about his unwell mother and not having seen his children for two years. Mr Saligari noted that Mr Blanket was, "*in a highly distressed mood with incongruent calm/relaxed affect*" and presented as a "*vulnerable prisoner*". Mr Saligari also noted this presentation, "*may be a barrier for staff to identify risk*" as Mr Blanket, "*appears calm with a highly distressing narrative which makes his situation difficult to follow*".[19] Mr Saligari recommended that Mr Blanket remain on Moderate ARMS due to his recent self-harm by banging his head as a coping mechanism, and placement concerns.

30 Following Mr Saligari's assessment, the Prisoner Risk Assessment Group (PRAG) discussed Mr Blanket at its meeting on 29 January 2019.

31 As of 2019, Acacia's PRAG comprised of the Safer Custody Coordinator (who was the chairperson), representatives from the prison health service providers (including the MHT), PWS, prison unit managers or unit officers, social workers and Peer Support Officers.[20]

32 For a prisoner on ARMS, PRAG is required to:[21]

- Form a comprehensive risk assessment on the prisoner.
- Develop a risk management plan for the prisoner.
- Arrange for the support and interventions that have been identified in the risk management plan.
- Review the prisoner's progress.

33 Notwithstanding his account to Mr Saligari, Mr Blanket had given a conflicting account as to how he was feeling to two Peer Support Prisoners[22] on 29 January 2019. He disclosed to them that he had no thoughts of self-harm or harming others. PRAG therefore determined that more time was required to better assess Mr Blanket's risk. It was decided he should remain on Moderate ARMS and be moved to a safe cell (also known as an observation cell) at the medical centre.[23]

[18] Exhibit 1, Volume 1, Tab 3, Health Services Report by Pansey Stewart dated 20 July 2022, p.7
[19] Exhibit 1, Volume 1, Tab 36.41, Prison Counselling Session File Note dated 29 January 2019
[20] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.1
[21] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.85
[22] Peer Support Prisoners are prisoners who work with Prison Support Officers to provide support to newly arrived prisoners and prisoners who are having difficulties coping with imprisonment. They are given training to enable them to provide support and advice to other prisoners, with a focus of the role being able to assist vulnerable prisoners who are at risk of self-harm or suicide.
[23] Exhibit 1, Volume 2, Tab 7, PRAG Minutes dated 29 January 2019, p.2

34 PRAG reviewed Mr Blanket on 1 February 2019. It was reported that Mr Blanket had told prison staff that he did not want to be in an observation cell[24] at the medical centre and that he would like to return to Mike Block. A mental health nurse from the MHT supported Mr Blanket's removal from ARMS due to there being no "*acute risk.*" PRAG discussed the matter and determined that Mr Blanket would be removed from ARMS at this time given there was no acute risk factor identified.[25] However, given Mr Blanket's chronic risk and his continued use of self-harm to cope by head banging, it was agreed he should be placed on the Support And Monitoring System (SAMS). SAMS is the Department's secondary measure to manage prisoners deemed to be at long-term risk of self-harm and/or suicide.

6 February 2019: Mr Blanket self-harms

35 On 6 February 2019, shortly after being transferred to Mike Block, Mr Blanket self-harmed in his cell by cutting his forearm with a razor blade. A Code Blue[26] was called, and Mr Blanket was treated by a prison nurse in his cell before he was taken to the medical centre.[27] The wound was sutured, and Mr Blanket was kept in an observation cell at the medical centre and placed under High ARMS.[28]

36 Mr Blanket was discussed at the PRAG meeting on 6 February 2019. The decision was made that he would remain on High ARMS and in an observation cell at the medical centre or another approved safe cell. It was also determined that Mr Blanket would remain in rip-proof clothing and have "finger" food only. PRAG was of the view that a chronic risk of non-suicidal self-injury remained.[29]

37 At its meeting on 7 February 2019, PRAG noted that Mr Blanket's poor coping ability and multiple stresses were linked to cultural factors and offence-based shame. As Mr Blanket had appeared more settled on that day, it was decided he would be reduced to Low ARMS. However, he was to remain in an observation cell at the medical centre and if this cell was required for another prisoner, then Mr Blanket would be moved to the detention unit (which was the only other part of Acacia that had safe cells). Moving forward, the unit manager at Mike Block was to explore the placement of Mr Blanket in Kilo Block where his uncle was situated. The

[24] There are two observation cells in the medical centre, and they are regarded as safe cells as they are fully ligature-minimised with CCTV cameras
[25] Exhibit 1, Volume 2, Tab 7, PRAG Minutes dated 1 February 2019, p.2
[26] A Code Blue is called over the prison's radio to indicate there is a medical emergency
[27] Exhibit 1, Volume 2, Tab 8, Incident Report Minutes dated 6 February 2019
[28] Exhibit 1, Volume 3, Tab 1, Health Services Report by Pansey Stewart dated 20 July 2022, p.15
[29] Exhibit 1, Volume 2, Tab 9, PRAG Minutes dated 6 February 2019

decision was also made to allow Mr Blanket to wear prison-issued greens.[30]

38 At the PRAG meeting on 13 February 2019, it was noted that Mr Blanket appeared calm and settled following his move to Kilo Block, and that he was denying any thoughts of self-harm. It was determined that as there were no acute risk factors identified, Mr Blanket could be removed from ARMS. However, as a period of sustained stability had not been reached, it was agreed that Mr Blanket would be placed on SAMS for further monitoring. It was also noted that Mr Blanket was compliant with his antidepressant medication.[31]

7 March 2019: Mr Blanket self-harms again

39 On 7 March 2019, Mr Blanket was placed in the detention unit after he had argument and vandalised the television in the cell he was sharing with another prisoner in Kilo Block.[32] He was then moved to an observation cell in the medical centre after striking his head against the wall of his cell in the detention unit. As a result of this self-harming behaviour, Mr Blanket was placed on High ARMS.[33]

40 At a meeting with Mr Saligari on the morning of 7 March 2019, Mr Blanket disclosed that he had been striking his forehead against the wall in his cell. Mr Saligari observed red marks to Mr Blanket's forehead and noted that the head banging was in a response to, "*anxiety and interpersonal stress with his cell mate*." [34]

41 Mr Blanket was discussed at the PRAG meeting on the afternoon of 7 March 2019. It was decided that he would be lowered to Moderate ARMS as he was not considered to be in a suicidal crisis but was likely to continue to engage in non-suicidal self-injury. It was also determined that Mr Blanket should be returned to Kilo Block and that he be allocated a different cell.[35]

42 At an appointment with a prison doctor on 7 March 2019, Mr Blanket indicated that his current antidepressant medication was not helping any more. He told the doctor that although he was not presently suicidal, he had suicidal thoughts on occasions. The doctor's assessment was that Mr Blanket was suffering from depression/anxiety and he was prescribed the antidepressant, fluoxetine.[36]

[30] Exhibit 1, Volume 2, Tab 10, PRAG Minutes dated 7 February 2019
[31] Exhibit 1, Volume 2, Tab 11, PRAG Minutes dated 13 February 2019
[32] Exhibit 1, Volume 2, Tab 14, PRAG Minutes dated 7 March 2019
[33] Exhibit 1, Volume 2, Tab 13, Incident Report Minutes dated 7 March 2029
[34] Exhibit 1, Volume 1, Tab 36.35, Prison Counselling Session File Note dated 7 March 2019
[35] Exhibit 1, Volume 2, Tab 14, PRAG Minutes dated 7 March 2019
[36] Exhibit 1, Volume 3, Tab 3.1, Health Services Report by Pansey Stewart dated 20 July 2022, pp.19-20

43 On 8 March 2019, Mr Blanket's mother visited him. She noted the mark on her son's forehead from his head striking. She also noticed Mr Blanket had lost a lot of weight and his teeth were uncleaned, which was very unusual.[37]

44 On 11 March 2019, Mr Blanket requested a form which he signed to say he wanted to be denied parole. However, shortly after, he cancelled this self-denial.[38]

13 March 2019: Mr Blanket expresses suicidal thoughts.

45 On 13 March 2019, Mr Blanket told his cell mate in Kilo Block that he wanted to kill himself. After being advised of that, prison officers automatically placed Mr Blanket on High ARMS and he was taken to an observation cell at the medical centre. Prison staff were also told that Mr Blanket had begun giving away his possessions, had advised his cell mate that the television was talking to him, that he could see writing and instructions on inanimate objects and the radio was commanding him to commit certain acts. In addition, Mr Blanket had said that if he did not kill himself, someone else on the outside would die.[39]

46 At the request of Mr Saligari,[40] Mr Blanket had an assessment with a mental health nurse from the MHT on 14 March 2019. He disclosed having a very traumatic childhood and that he was having anxiety attacks for no apparent reasons. He said he had experienced audio hallucinations involving voices since he was a child, with the voices saying random things to him. He reported only sleeping for about four or five hours per night. He expressed reservations about the new medication for his depression as it "*makes me feel funny*". He also reported fleeting thoughts of self-harm and suicidal ideation; however, he had no current plan or intention to hurt himself.[41] He added that he was not keen to return to Kilo Block and requested a move to Foxtrot Block, which he thought would better suit him.

47 Following the completion of this assessment, the mental health nurse met with Dr Natalia Bilyk, the consultant psychiatrist at Acacia. Following those discussions, the MHT plan for Mr Blanket was summarised as follows:[42]

> No florid psychosis identified from today's review, appears to have extensive trauma-related perceptual disturbances and anxiety which are likely

[37] Exhibit 1, Volume 1, Tab 12, Statement of Karen Blanket dated 23 June 2019, p.1
[38] Exhibit 1, Volume 1, Tab 2, Report of Senior Constable Nigel Foote dated 22 January 2020, p.4
[39] Exhibit 1, Volume 1, Tab 36.32, Prison Counselling Information File Note dated 13 March 2019
[40] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.3
[41] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.18
[42] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, pp.18-19

> exacerbated by being in a highly stressful/anxiety provoking environment such as jail.
>
> Not for MH [Mental Health] input at this time, however, psychiatrist happy for GP [prison doctor] to liaise regarding medication if needed. Can be referred if any concerns arise.
>
> To be discussed at PRAG.

48 At the subsequent PRAG meeting on 14 March 2019, it was reported by the mental health nurse who had seen Mr Blanket that he was not assessed as being in a "*current suicidal crisis*", and he reported that he wanted to live. In those circumstances, it was decided Mr Blanket should be lowered to Moderate ARMS due to the current risk assessment.[43] It was also recommended that Foxtrot Block be a future placement for Mr Blanket and in the meantime, he should relocate to a safe cell. Mr Saligari was tasked with completing the application for Mr Blanket to be moved into Foxtrot Block.[44]

15 March 2019: Mr Blanket's telephone conversation with his mother

49 At the PRAG meeting on 15 March 2019, it was reported that Mr Blanket spent an hour sitting in the shower that day and that he refused to engage with any prison staff, including Mr Saligari. As he refusal to engage with anyone meant his risk to himself could not be assessed, PRAG decided to increase Mr Blanket to High ARMS and he was placed in an observation cell at the medical centre.[45]

50 At 2.14 pm on 15 March 2019, Mr Blanket telephoned his mother using the Prisoner Telephone Service (PTS).[46] All PTS calls are recorded. It is clear that Mr Blanket was very distressed during this conversation. At one point he states: "*I want to hang myself. That's what I want to do*."[47] When his mother implores him not to do that, Mr Blanket responded that his mother could not do anything about it, adding: "*I do not want to be around anymore*".[48] To hear her eldest son making these statements would have undoubtedly caused significant distress and anxiety for Mr Blanket's mother.

51 To her credit, Mr Blanket's mother spoke to a prison officer and said she was worried about her son as he had told her he was going to kill himself.[49]

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[43] Exhibit 1, Volume 2, Tab 17, PRAG Minutes dated 14 March 2019, p.2
[44] Exhibit 1, Volume 2, Tab 17, PRAG Minutes dated 14 March 2019, p.2
[45] Exhibit 1, Volume 2, Tab 18, PRAG Minutes dated 15 March 2019
[46] Mr Blanket's mother recalled that this telephone conversation occurred the day before on 14 Mach 2019: Exhibit 1, Volume 1, Tab 12, Statement of Karen Blanket dated 26 June 2019, p.1
[47] Exhibit 1, Volume 2, Tab 32, Serco - Post Incident Review dated 20 August 2019, p.41
[48] Exhibit 1, Volume 2, Tab 32, Serco - Post Incident Review dated 20 August 2019, p.41
[49] Exhibit 1. Volume 1, Tab 12, Statement of Karen Blanket dated 26 June 2019, p.2

17-18 March 2019: Mr Blanket's behaviour escalates

52 On 18 March 2019, a prison officer reported that Mr Blanket had been showing signs of stress and anxiety and was self-harming by banging his head against his cell's wall. Mr Blanket requested "*some time out*" in the detention unit and that was organised for the night of 17 March 2019. After returning to Kilo Block the next morning, prison staff heard loud screaming coming from Mr Blanket's cell. The decision was made to place him on High ARMS and into an observation cell at the medical centre for his own protection.[50] The prison officer's report concluded:[51]

> Reports are [Mr] Blanket has been having conversations with the devil, is having hallucinations, seeing writing on the wall telling him to act on certain things, the TV is sending his [sic-him] messages in order to hurt himself, has very slow speech, bangs his head against the wall, has been placing his own pubic hair into sandwiches and eating it and also taking lengthy showers that can last up to hours.
>
> I recommend [Mr] Blanket has a mental assessment ASAP as he seems to be deteriorating very quickly.

53 As a result of that report, Mr Saligari met with Mr Blanket for an ARMS assessment. Mr Blanket told Mr Saligari that it had been two days since he hit his head and he reported fleeting self-harm ideation. Although he said the voices he hears are non-intrusive, Mr Blanket did not wish to add anything more about that experience. He further disclosed that he has dreams that contain messages about his future; however, he refused to discuss whether the messages involved life or death. Mr Saligari noted that Mr Blanket may be experiencing trauma-based delusions which he believes are premonitions or messages about the future.[52]

54 Mr Saligari noted Mr Blanket's calm presentation and engagement in the risk assessment and recommended that as his self-harm ideation was fleeting rather than the intrusive, the automatic High ARMS could be lowered to Moderate ARMS.[53]

55 Mr Blanket was discussed at the PRAG meeting on 18 March 2019. The mental health nurse at the meeting confirmed that Mr Blanket was not under the MHT; however, he had been reviewed daily by a clinical nurse. It was noted that Mr Blanket was very adamant about not taking his antidepressant medication. Nevertheless, it was decided that Mr Blanket would be lowered to Moderate ARMS given his engagement with Mr Saligari earlier that day, his report of not having engaged in head banging for two days and his statement of having no current thoughts to

[50] Exhibit 1, Volume 1, Tab 36.28, Prison Counselling Session File Note dated 18 March 2019
[51] Exhibit 1, Volume 1, Tab 36.28, Prison Counselling Session File Note dated 18 March 2019, p.2
[52] Exhibit 1, Volume 1, Tab 36.27, Prison Counselling Session File Note dated 18 March 2019
[53] Exhibit 1, Volume 1, Tab 36.27, Prison Counselling Session File Note dated 18 March 2019

harm himself. PRAG also agreed that Mr Blanket's transition to Foxtrot Block should be gradual and that he should remain at the medical centre that night.[54]

27 March 2019: Mr Blanket's supervision level is reduced to SAMS

56 At the PRAG meeting on 20 March 2019, it was noted that Mr Blanket had been in Foxtrot Block for one day and was still settling in. Mr Saligari reported that Mr Blanket had not engaged in head banging for four days, and that despite low/fleeting urges for self-harm, there was no suicidal ideation. Mr Blanket had reported to a Prison Support Officer that since his move to the Foxtrot Block, he did not feel anxious or paranoid about his surroundings. Mr Saligari noted that Mr Blanket's presentation at his most recent assessment was the best he had seen. In light of those factors, PRAG recommended that Mr Blanket be reduced from Moderate to Low ARMS.

57 Mr Blanket was next reviewed by PRAG at its meeting on 27 March 2019. It was noted that Mr Blanket declined to speak to Mr Saligari during his ARMS assessment that morning and therefore no risk assessment was made. Nevertheless, Mr Saligari stated that Mr Blanket had smiled and presented with a calm and relaxed mood, and with consistent body language. Mr Saligari noted:[55]

> Whilst the policy suggests that refusing counselling may be a risk factor, it has been previously formulated for [Mr Blanket] that him doing this is not indicative of increased risk. Rather, he experiences different moods and fluctuations in anxiety which he copes with [by] isolation. I have reviewed previous notes /risk factors and the supervision log. No acute risk factors were noted.

58 PRAG concluded that Mr Blanket's current situation meant he could be removed from ARMS on that day, given there were no acute risk factors identified. Although it was noted that the ARMS Manual said if a prisoner was unwilling to engage in a risk assessment he should be upgraded to one-hourly High ARMS, it was agreed this was unnecessary in this instance. In making that decision, PRAG noted the following:[56]

> [Mr Blanket] has previously declined to talk or engage in an assessment and it has not been a pre-cursor for increased risk to self.
>
> [Mr Blanket] has settled into Foxtrot Block and has displayed a period of stability.
>
> [Mr Blanket] has not demonstrated any warning signs for increased risk to self, such as head banging, bizarre behaviour, intense presentation.

[54] Exhibit 1, Volume 3, Tab 20, PRAG Minutes dated 18 March 2019
[55] Exhibit 1, Volume 2, Tab 21, PRAG Minutes dated 27 March 2019
[56] Exhibit 1, Volume 2, Tab 21, PRAG Minutes dated 27 March 2019, p.2

> [Mr Blanket] was polite in his decline for an assessment today and was observed looking happy and content, with no changes to the presentation recorded in his supervision log.
>
> Staff who interact with [Mr Blanket] on a regular basis have raised no concerns or issues and are content with the recommendation of removal from ARMS and support being offered by SAMS.
>
> PRAG noted Foxtrot Block placement should remain, [Mr Blanket] appears to be coping well in his own space (single cell) and is slowly starting to become more sociable, notably sitting with others to eat.

59 Mr Banket was subsequently removed from ARMS and placed on SAMS.

60 At an appointment with the prison doctor on 17 April 2019, Mr Blanket advised he had not taken his antidepressant medication for two weeks. Nevertheless, he reported his mood had improved and that he did not want any further drugs. Consequently, the prison doctor discontinued the antidepressant medication that had been prescribed for Mr Blanket.[57]

22 April 2019: Mr Blanket is advised his parole has been denied.

61 What progress Mr Blanket had recently made with his improved mental health ended abruptly on 22 April 2019 when he was advised by Acacia custodial staff that his parole had been denied.

62 Later that day, at about 4.05 pm, a Code Red call was made after Mr Blanket had assaulted two other prisoners, with both requiring treatment for facial and head injuries.[58]

63 When prison officers responded to the assaults, Mr Blanket told them he had earlier tried to take his life by hanging himself. He then showed prison officers a noose he had made out of a bedsheet. When questioned as to the reason for attacking the two prisoners, Mr Blanket stated he had been stressed out about not being released on parole and that one of the prisoners made fun of him.[59]

64 The two prisoners subsequently made complaints to WAPF, and Mr Blanket was later charged with common assault and assault occasioning bodily harm.[60]

65 Due to Mr Blanket's statement that he had attempted suicide and his violence towards the two prisoners, he was taken to the medical centre in

[57] Exhibit 1, Volume 3, EcHO Medical Record, p.15
[58] Exhibit 1, Volume 2, Tab 22, Incident Report Minutes dated 22 April 2019
[59] Exhibit 1, Volume 2, Tab 22, Incident Report Minutes dated 22 April 2019
[60] These charges were only withdrawn following Mr Blanket's death: Exhibit 1, Volume 1, Tab 50, Court Outcomes – Criminal and Traffic for Mr Blanket

restraints and allocated an observation cell. He was placed on High ARMS.[61] The ARMS Alert read:[62]

> [Mr] Blanket was involved [in] an incident whereby he assaulted two prisoners. When interviewed by staff, he informed staff that he was frustrated and wanted to die. Prisoner proceeded to show the staff a noose that he had fashioned out of a bedsheet. Prisoner stated that he had tried to hang himself off the door but failed.

66 On 23 April 2019, Mr Blanket declined to be reviewed for an ARMS assessment.[63] At the PRAG meeting that day, it was decided that due to Mr Blanket's non-engagement, he was to remain on High ARMS in the observation cell at the medical centre. He was to remain in rip-proof clothing and have "finger" food only.[64]

67 On 24 April 2019, Mr Blanket agreed to meet with Mr Saligari for an ARMS assessment. On this occasion, Mr Blanket presented in a calm and stable mood. He answered all questions and shared his narrative openly. Mr Blanket gave an account of the incident involving the other two prisoners. After he stated his past trauma was a prophecy, Mr Saligari recorded Mr Blanket as saying:[65]

> He said that he knew this to be true, based on his ability to read people by seeing their thoughts and histories. He added that he is receiving messages that were "beyond this world" telling him this prisoner was trying to harm him. [Mr Blanket] explained that parts of him care and other parts are very uncaring. He went on to speak about how killing these prisoners would mean nothing to him and they would be a blood sacrifice. [Mr Blanket] added his future had already been determined that he would likely kill others and that his life would end in the next two months to two years.

68 Mr Saligari also noted that although Mr Blanket reported no current thoughts of suicide, the risk "*was difficult to determine due to complex spiritual/cultural/mental health profile*".[66] Mr Blanket also openly shared his reasons for making a noose, describing that the ending of his life was a way to stop and/or control his violent urges.[67]

69 At its meeting on 24 April 2019, PRAG decided that Mr Blanket could be lowered to Moderate ARMS, be returned to prison greens and a normal food regime, and be placed in a crisis care unit in the medical centre with an eventual return to Foxtrot Block as requested by Mr Blanket. A

[61] Exhibit 1, Volume 2, Tab 22, Incident Report Minutes dated 22 April 2019
[62] Exhibit 1, Volume 1, Tab 36.21, Prison Counselling Non-Contact File Note dated 23 April 2019
[63] Exhibit 1, Volume 1, Tab 36.21, Prison Counselling Non-Contact File Note dated 23 April 2019
[64] Exhibit 1, Volume 2, PRAG Minutes dated 23 April 2019
[65] Exhibit 1, Volume 1, Tab 36.20, Prison Counselling File Note dated 24 April 2019
[66] Exhibit 1, Volume 1, Tab 36.20, Prison Counselling File Note dated 24 April 2019
[67] Exhibit 1, Volume 2, Tab 24, PRAG Minutes dated 24 April 2019

recommendation was also made that Mr Blanket be provided with cultural support through Peer Support Prisoners.[68]

24 April 2019: Mr Saligari completes a mental health referral for Mr Blanket and he is seen by Dr Bilyk

70 After conducting his ARMS assessment of Mr Blanket on 24 April 2019, Mr Saligari completed a mental health referral as he believed there was sufficient evidence that Mr Blanket had experienced a major mental illness, namely psychosis.[69] In an email to the MHT on the same date, Mr Saligari detailed his reasons why another mental health assessment was warranted.[70]

71 An appointment was made by the MHT for Mr Blanket to see Dr Bilyk for a psychiatric review on 1 May 20219. However, Mr Blanket did not attend that day, or the following day when the appointment was rescheduled. Dr Bilyk only attended Acacia two days per week and engagement with the prison psychiatrist by a prisoner is not compulsory.

72 Mr Blanket did not attend the medical centre the following week for an appointment with Dr Bilyk on 9 May 2019. When he did not attend for his appointment rescheduled for 10 May 2019, Dr Bilyk spoke to the prison officer who was the unit manager at Foxtrot Block.[71] It was arranged that Dr Bilyk would attend Foxtrot Block in the afternoon of 10 May 2019 so that she could complete an initial assessment of Mr Blanket.

73 Although he was initially reluctant to see Dr Bilyk, Mr Blanket eventually spoke to her for about 20 minutes before Dr Bilyk had to leave Foxtrot Block due to prison operational matters.[72]

74 Mr Blanket said to Dr Bilyk that he had no thoughts of harming himself or anyone else. He maintained that he felt everyone was over-reacting.[73]

75 Although Dr Bilyk was unable to complete her assessment, she was able to form a view that Mr Blanket had an evident psychotic illness that was in the prodromal phase[74] which had been preceded by affected depressive symptoms.[75]

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[68] Exhibit 1, Volume 2, Tab 24, PRAG Minutes dated 24 April 2019, p.2
[69] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.4
[70] Exhibit 1, Volume 1, Tab 55.1, Email to Acacia Mental Health Team from Michael Saligari dated 24 April 2020
[71] Exhibit 1, Volume 1, Tab 56.1, Statement of Dr Natalia Bilyk dated 4 July 2022, p.2
[72] Exhibit 1, Volume 1, Tab 56.1, Statement of Dr Natalia Bilyk dated 4 July 2022, p.2
[73] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.10
[74] The prodromal phase is the period during which the person is experiencing changes in feelings, thoughts, perceptions and behaviour; although they had not started experiencing clear psychotic symptoms such as hallucinations, delusions or thought disorder: Exhibit 1, Volume 3, Tab 3.1, Health Services Report by Pansey Stewart dated 20 July 2022, p.8
[75] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.9

76 Dr Bilyk noted that her ongoing plan was to undertake further assessments with an aim to build a therapeutic rapport which she regarded as essential for the initiation of any treatment. Dr Bilyk also noted if there was any further episode of violence that was psychotic-driven then consideration would be given to referring Mr Blanket as an involuntary patient to the Frankland Centre at Graylands Hospital.[76]

14 May 2019: Mr Blanket is placed on High ARMS

77 During this period, Mr Blanket had regular ARMS assessments from PWS, including Mr Saligari.

78 On 14 May 2019, Mr Saligari met with Mr Blanket. Although Mr Blanket presented with a calm and relaxed mood, at times he laughed when discussing specific plans to end his life. He said during the previous night he had thoughts of ending his life by hanging himself to the back of his cell door. Mr Blanket then explained to Mr Saligari how he could tie a knot in his sheet and close the door to hang himself. Nevertheless, despite this disturbing thought, Mr Blanket made other statements that were inconsistent with suicidal ideation, including: "*I won't kill myself in prison*", "*I have visions of me being killed in a way other than suicide*" and "*If I was serious then I would have done it by now*".[77]

79 After his session with Mr Blanket, Mr Saligari spoke to Anna Francis, the Safer Custody Coordinator and PRAG chairperson. They agreed that Mr Blanket's suicide risk formulation would be upgraded to an assessment that he was in a suicidal crisis due to his well-developed plan to kill himself by using his bedsheets and cell door. He was therefore placed on High ARMS and taken to an observation cell at the medical centre where he was placed in rip-proof clothing.[78]

80 Mr Blanket was discussed at the next PRAG meeting on 15 May 2019. At his ARMS assessment conducted earlier that day by PWS, Mr Blanket stated he had no intention to act on the thoughts he had expressed to Mr Saligari the previous day. He denied having any plan to attempt suicide or engage in any self-harming behaviour. Mr Blanket also denied wanting to die when in prison and said that he was looking forward to being with his family when released. He requested a return to Foxtrot Block.[79]

81 After reviewing Mr Blanket's current situation, PRAG agreed he should be lowered to Moderate ARMS and returned to Foxtrot Block. It was noted:[80]

[76] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, pp.9-10
[77] Exhibit 1, Volume 1, Tab 36.14, Prison Counselling Session File Note dated 14 May 2019
[78] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.4
[79] Exhibit 1, Volume 2, Tab 26, PRAG Minutes dated 15 May 2019
[80] Exhibit 1, Volume 2, Tab 26, PRAG Minutes dated 15 May 2019, p.2

> PRAG agreed whilst [Mr Blanket] has previously been found in possession of a noose and has discussed hanging himself, he also maintains he does not want to die in prison, has "too much to live for", has a family who he is close to and has stated a number of times, "I would have done it by now if I was serious", which can be considered protective.
>
> …
>
> PRAG agreed periods of isolation are not helpful for [Mr Blanket] and that he should return to Foxtrot Block and have regular cell checks for items he could use to harm himself with.

30 May 2019: Mr Blanket's second appointment with Dr Bilyk

82 In contrast to their first meeting, Mr Blanket was more agreeable to meet with Dr Bilyk at his appointment on 30 May 2019. He attended the health centre and was prepared to wait 20 minutes before he saw Dr Bilyk. He "*remained guarded about the details concerning 'wakening', but consistently spoke of how he now understands everyone was connected spiritually.*"[81] He attributed his past experiences of depression, anxiety, and self-harm by cutting as "karma" and a type of payback for his offending and domestic violence. Mr Blanket interpreted a cloud he saw through a window at Acacia that looked like a caterpillar as confirmation of a "transformation" within himself, and he thought this was a positive development for him. Mr Blanket said he believed in angels that were "spiritual guides" and also believed he had special talent to write books and music.

83 Dr Bilyk explained to Mr Blanket that she was concerned he was displaying early changes to his mental health that were consistent with psychosis. Dr Bilyk also said that antipsychotic medication may help. Although Mr Blanket, as he was entitled to do, declined a trial of antipsychotic treatment, he agreed to see Dr Bilyk again. He maintained that he had no current thoughts of harming himself or any other persons.[82]

84 At the completion of this appointment, Dr Bilyk planned to continue her assessment and continue to develop a therapeutic relationship with Mr Blanket. Notwithstanding Mr Blanket's refusal to take any antipsychotic medication, Dr Bilyk's view remained that he did not meet the threshold for involuntary treatment in the Frankland Centre at Graylands Hospital.[83]

85 Mr Blanket was discussed at the next PRAG meeting on 31 May 2019. It was noted that his behaviour over the past two weeks, which included more socialising and less reclusive conduct, were positive and indicated

[81] Exhibit 1, Volume 3, Tab 4, EcHO Medical Notes, p.8
[82] Exhibit 1, Volume 1, Tab 56.1, Statement of Dr Natalia Bilyk dated 4 July 2022, pp.3-4; Exhibit 1, Volume 3, Tab 4, EcHO Medical Notes, p.8
[83] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.8

improved coping by him. It was also noted that previous isolation in a safe cell had negatively impacted Mr Blanket's mood and he should, therefore, remain in Foxtrot Block where he had his supports and comforts. Nevertheless, PRAG decided that the risk management plan was to include the following, "*should any signs of distress be observed,* [*Mr Blanket*] *should be relocated to a ligature-free cell at the earliest opportunity as this could be an indication of increased risk to self*."[84] It was also agreed Mr Blanket should be reduced to Low ARMS.

86 On 6 June 2019, Dr Bilyk met with Mr Saligari to discuss Mr Blanket. It was noted there was still a concern regarding the risk of Mr Blanket self-harming since his previous preparation for an attempted hanging using his bedsheets. It was identified that there were challenges in making a risk assessment for Mr Blanket, given his fluctuating mental state and indication of early psychosis. The agreed plan was for PWS to continue providing Mr Blanket with counselling and stress management options, and that his appointments with Dr Bilyk should be maintained.[85]

87 The next PRAG meeting that reviewed Mr Blanket took place on 7 June 2019. A Foxtrot Block prison officer who attended that meeting stated that Mr Blanket was displaying some unusual behaviour which included sitting in the dark inside his cell. The prison officer also noted that Mr Blanket does fluctuate in his behaviour and interaction with others. No thorough risk assessment had been completed by PWS since 29 May 2019 and it was agreed by PRAG that Mr Blanket should remain on Low ARMS. It was again noted that if any signs of distress were observed and Mr Blanket became paranoid or violent, he should be relocated to a ligature-free cell at the earliest opportunity as "*this could be an indication of increased risk to self*."[86]

10 June 2019: Mr Blanket's last case review by PRAG

88 Mr Blanket was reviewed by PRAG at its meeting on 10 June 2019. The prison officer who attended from Foxtrot Block reported that no issues had been raised over the past several days, although Mr Blanket still keeps to himself. Mr Saligari noted that no ARMS assessment had been conducted for Mr Blanket on 10 June 2019 as he did not want to engage. The attending Prison Support Officer saw Mr Blanket that morning and reported he "*seems happy, laughing.*" It was noted that Mr Blanket had Peer Support Prisoners and family for support.[87]

89 As PWS had not been able to properly access Mr Blanket's risks, it was decided he should remain on Low ARMS and be reviewed again at the

[84] Exhibit 1, Volume 2, Tab 28, PRAG Minutes dated 31 May 2019, p.2
[85] Exhibit 1, Volume 3, Tab 4, EcHO Medical Notes, p.7
[86] Exhibit 1, Volume 2, Tab 29, PRAG Minutes dated 7 June 2019
[87] Exhibit 1, Volume 2, Tab 31, PRAG Minutes dated 10 June 2019

PRAG meeting on 17 June 2019. It was also noted that Mr Blanket had an upcoming appointment with Dr Bilyk on 14 June 2019. Once again, PRAG's risk management plan for Mr Blanket was that, "*should any signs of distress be observed, and* [*Mr Blanket*] *become paranoid or violent, he should be relocated to a ligature-free cell at the earliest opportunity as this could be an indication of increased risk to self*."[88]

EVENTS LEADING TO MR BLANKET'S DEATH

11 June 2019 [89]

90 On 11 June 2019, as Mr Blanket was on still on ARMS, observations of him were to be recorded in the ARMS "Offender Supervision Log" on the Department's Total Offender Management Solution (TOMS) as required by his risk management plan. In this case, PRAG had specified that the frequency of the observations was to be recorded three-hourly.[90]

91 Observations on Mr Blanket were recorded at the following times on 11 June 2019: 12.55 am, 3.45 am, 6.42 am, 9.01 am, 11.23 am, 1.50 pm, 4.09 pm, 5.52 pm, 6.23 pm, 7.11 pm and 10.00 pm. When asked on a number of occasions during these observations whether everything was ok, Mr Blanket indicated in the affirmative. During a conversation with the prison officer conducting the observation at 5.52 pm, Mr Blanket said that he was spending so much time in his one-person cell as he liked to be alone to think. Although he was not able to clearly state what was on his mind, Mr Blanket denied he had any thoughts of self-harm.

12 June 2019

92 On 12 June 2019, like the previous day, entries were recorded in the ARMS "Offender Supervision Log" on TOMS in accordance with Mr Blanket's risk management plan. The entries on this day were made at 12.45 am, 1.16 am, 4.02 am, 6.40 am, 7.09 am, 7.44 am and 8.20 am.[91]

93 Jeana Andrews (Ms Andrews) was the prison officer responsible for conducting the observations on Mr Blanket from 6.00 am when she began her shift.[92]

94 At 6.40 am, during the morning unlocking of cells, Ms Andrews saw Mr Blanket by the sink in his cell washing his hands. At 7.09 am,

[88] Exhibit 1, Volume 2, Tab 31, PRAG Minutes dated 10 June 2019, p.1
[89] Exhibit 1, Volume 2, Tab 30, Supervision Log Entries dated 11 June 2019 for Mr Blanket
[90] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.55
[91] Exhibit 1, Volume 2, Tab 34, Supervision Log Entries dated 12 June 2019 for Mr Blanket
[92] Ms Andrews was not called at the inquest as she was deceased. The Court, however, had a statement from her: Exhibit 1, Volume 1, Tab 13.1. Although that statement had not been signed by Ms Andrews, she had indicated to Senior Constable Nigel Foote that it was correct in an email dated 3 October 2019: Exhibit 1, Volume 1, Tab 13.2, Emails between Ms Andrews and Senior Constable Foote. I have therefore accepted the contents of the unsigned statement as true and correct to the best of Ms Andrews' knowledge and belief.

Mr Blanket left his cell and began walking around the common area. He acknowledged Ms Andrews by waving to her.[93]

95 At 7.44 am, Ms Andrews asked Mr Blanket to accompany her to the medical centre for a schedule blood test. Initially, Mr Blanket said that he would not go and then decided he would.[94]

96 At about 8.20 am, Ms Andrews escorted Mr Blanket and some other prisoners from the medical centre back to Foxtrot Block. She then observed Mr Blanket appear to be confused. He asked her if he could see someone from "PSC". As PSC was an abbreviation for "Pre-Self Care" (a description that was used to identify Foxtrot Block), Ms Andrews asked Mr Blanket if he would like to see somebody from PCS (i.e. Prisoner Counselling Service which had been the previous title for PWS). Mr Blanket answered, "*Nah, it's ok*" and walked away.[95] I am satisfied that Mr Blanket was making a request to speak to someone from PWS.

97 It would appear that Ms Andrews then tried to contact PWS; however, her telephone call was not answered.

98 Shortly after that, Ms Francis, the PRAG chairperson, saw Ms Andrews and observed that she appeared to be flustered and slightly agitated. When Ms Francis asked what was wrong, Ms Andrews said that she was unable to reach anyone from PWS.[96]

99 Ms Andrews then advised Ms Francis that Mr Blanket was not himself and that he appeared to be distressed and was pacing around.[97]

100 After confirming with Ms Andrews that it was her opinion that Mr Blanket was distressed, Ms Francis decided that further action needed to be taken in accordance with Mr Blanket's risk management plan; namely, if he appeared to be distressed, he should be relocated to a ligature-free cell and consideration be given for his ARMS supervision level to be increased.[98]

101 Ms Francis then spoke to the unit manager of Foxtrot Block. She advised that Mr Blanket should be placed in a safe cell and his ARMS supervision level needed to be increased. Ms Francis asked the unit manager to make the necessary arrangements for Mr Blanket's relocation to a safe cell, advising that in the meantime he needed to be observed when he was with the other prisoners.[99] A move from Foxtrot Block to a safe cell (either in

[93] Exhibit 1, Volume 2, Tab 34, Supervision Log Entries dated 12 June 2019
[94] Exhibit 1, Volume 2, Tab 34, Supervision Log Entries dated 12 June 2019
[95] Exhibit 1, Volume 1, Tab 13.1, Statement of Jeana Andrews (undated)
[96] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.19
[97] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.20
[98] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.20
[99] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.20

the detention unit or the medical centre) would normally only take ten to 15 minutes as they were all very close to each other.[100]

102 Ms Francis returned to her office (which was located in Foxtrot Block) and sent an email to the ARMS Notification Group (an internal email distribution list). This email was sent at 9.22 am and stated: "[*Mr*] *Blanket has been increased to hourly observations owing to increased risk to self. He will be relocated to a MEDS OBS Cell in accordance with his Risk Management Plan*".[101]

103 Ms Francis attempted to make telephone contact with PWS and was told they were offsite. At about this time, she was advised by the unit manager of Foxtrot Block that he had arranged for a prisoner to be moved from one of the observation cells in the medical centre to allow Mr Blanket to be placed there. However, before that could be done, a nurse placed another prisoner in the observation cell.[102]

104 On this day, Mr Saligari (and most of the PWS staff) had arrived at Acacia later than usual as they had been attending an offsite farewell function for a staff member. According to fingerprint movements data, Mr Saligari scanned in at Acacia at 9.30 am.[103]

105 After Mr Saligari moved through the prison to his desk and started up his computer, it was about 9.45 am to 10.00 am before he read the email from Ms Francis stating that Mr Blanket was going to be moved to a safe cell. Mr Blanket then had a telephone conversation with Ms Francis, who advised he would need to provide a risk assessment of Mr Blanket before the PRAG meeting at 1.00 pm.[104]

106 After this telephone conversation, Ms Francis left her office in Foxtrot Block to attend a meeting. The last time Ms Francis observed Mr Blanket he was in the common area of the unit, and she did not recall him having gone into his cell before she left.[105]

107 At 10.11 am, Ms Andrews decided to complete another ARMS check on Mr Blanket as she still had concerns regarding his earlier behaviour. Ms Andrews had seen Mr Blanket return to his cell some time earlier when she was sitting in the movement control section and saw him through the windows. Mr Blanket waved at her and gestured that he was going into his cell.[106]

[100] ts 14.12.22 (Ms Francis), pp. 257-258; Exhibit 6, Aerial photograph of Acacia
[101] Exhibit 1, Volume 2, Tab 52.1, Email from Anna Francis to the ARMS Notification Group date 12 June 2019
[102] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.21
[103] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.8
[104] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, pp.8-9
[105] ts 14.22 (Ms Francis), p.261
[106] Exhibit 1, Volume 1, Tab 13.1, Statement of Jeana Andrews undated, p.3

108 Ms Andrews approached Mr Blanket's cell and looked through the viewing window of the closed cell door. She could not see Mr Blanket on his bed or in the shower area of the cell. She continued to look for him and noticed something green coloured to the left side of the cell against the door. At this point, she noticed the cell door had been prisoner-locked from the inside. Ms Andrews used her keys to unlock the cell door and as she began opening it towards her, she noticed the cell door felt heavier than usual. As she looked through the small gap between the side edge of the door and the door jamb, she could see Mr Blanket against the left hand side of the door in a position that led her to believe his feet were not touching the floor. When she opened the door further, she saw something loosen from Mr Blanket's neck before he slid to the floor. Ms Andrews quickly called a Code Blue medical emergency on her radio.[107]

109 When she checked Mr Blanket, Ms Andrews noticed that he was unresponsive, his lips and tongue were blue, his tongue was protruding from his mouth and his face had lost all its colour. She immediately commenced cardiopulmonary resuscitation (CPR).[108]

110 Other prison officers and medical staff responded to Ms Andrews' radio broadcast, and at 10.17 am a telephone call was made to emergency services.[109] Resuscitation efforts continued for nearly 30 minutes; however, Mr Blanker could not be revived. Life extinct was confirmed by a prison doctor[110] ten minutes before the arrival of the ambulance.[111]

111 After hearing the Code Blue call over the radio, Ms Francis made her way to Foxtrot Block. Even before she had arrived at the unit she could hear Ms Andrews' screaming. When she saw Ms Francis, a distressed Ms Andrews said to her: "*It's* [*Mr Blanket*], *I told you!"*.[112]

CAUSE AND MANNER OF DEATH

Cause of death [113]

112 Dr Gerard Cadden, a forensic pathologist, conducted a post mortem examination on Mr Blanket's body on 17 June 2019.

113 Dr Cadden noted there was a mark around Mr Blanket's neck in keeping with the application of a ligature. There was an injury towards the back of Mr Blanket's head, which was consistent with the given history of

[107] Exhibit 1, Volume 1, Tab 13.1, Statement of Jeana Andrews undated, pp.4-5
[108] Exhibit 1, Volume 1, Tab 13.1, Statement of Jeana Andrews undated, p.4
[109] Exhibit 1, Volume 1, Tab 43, St John Ambulance Patient Care Record, p.1
[110] Exhibit 1, Volume 1, Tab 5, Life Extinct Form for Mr Blanket
[111] Exhibit 1, Volume 1, Tab 43, St John Ambulance Care Record, p.2
[112] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.22
[113] Exhibit 1, Volume 1, Tabs 6.1 & 6.2, Supplementary Post Mortem Report and Addendum Post Mortem Report; Exhibit 1, Volume 1, Tab 7, Toxicology Report; Exhibit 1, Volume 1, Tab 9, Neuropathology Report dated 24 June 2019

Mr Blanket's head striking the floor as the cell door was opened by Ms Andrews.

114 Dr Cadden later examined the ligature used by Mr Blanket and recorded that it was knotted at both ends and was about 50 mm in width and could be compressed to a width of about 10 mm. The furrow marking on Mr Blanket's neck was consistent with the sustained application of the ligature.

115 A specialist neuropathological examination of Mr Blanket's brain showed no features of a recent traumatic brain injury or significant abnormality.

116 Toxicological analysis detected no alcohol or common illicit drugs in Mr Blanket's system.

117 At the conclusion of his investigation, Dr Cadden expressed the opinion that the cause of death was a ligature compression of the neck (hanging).

118 I accept and adopt the conclusion expressed by Dr Cadden as to the cause of Mr Blanket's death.

Manner of death [114]

119 Police officers from the Coronial Investigation Squad attended Acacia on the afternoon of 12 June 2019.

120 They noted Foxtrot Block held a maximum of 12 prisoners and that Mr Blanket was housed in a cell for one prisoner only. Each prisoner had a key to their own cell door and although Mr Blanket could lock his cell door, it could not be key-locked from the inside. The door of Mr Blanket's cell was hinged on the left hand side and opened outwards.

121 An examination of the cell located a piece of material torn from a bedsheet on the floor under a doona. It had a knot tied at one end and was 140 cm in length. Footprint impressions were found on the bottom of an upside-down plastic bin. There was also a writing pad containing handwritten notes by Mr Blanket detailing his struggles with his mental health.

122 An examination of Mr Blanket's body at Acacia's medical centre showed a 102 cm piece of torn bedsheet with a knot tied at each end. This was lodged under Mr Blanket's right arm pit and continued around the back of his neck. A ligature mark was observed at the front of Mr Blanket's neck.

123 Based on all the information available, I find that Mr Blanket's death occurred by way of suicide when he used a torn bedsheet to create a ligature at one end and a knot at the other end. This knot was placed over

[114] Exhibit 1, Volume 1, Tab 2, Report of Senior Constable Nigel Foote dated 22 January 2020

the top of his cell door so that the bedsheet could be anchored when the door was closed. This was sufficient to support Mr Blanket's suspended body weight until such time as the cell door was unlocked and opened.

124 Furthermore, I am satisfied that Mr Blanket used the same method that he had described to prison officers on 22 April 2019, and to Mr Saligari on 14 May 2019.

125 I make that finding with some considerable disquiet.

126 It was also disquieting to read the following paragraph in Serco's Post Incident Review of Mr Blanket's death:[115]

> The mechanism of death apparently involved in the death of [Mr] Blanket, is available to any prisoner accommodated in a cell that they are capable of independently locking and who are not issued with rip-proof bedding/clothing. This applies to the majority of the prisoner population at Acacia Prison and most correctional facilities in Australia.

ISSUES RAISED BY THE EVIDENCE

Were adequate steps taken to diagnose Mr Blanket's mental health issues?

127 It is well-recognised that the diagnosis of a mental health disorder can be a complicated and lengthy process. There are any number of factors that can contribute to a mental health condition. These include a genetic predisposition, alcohol and drug use, stressful life events, family conflict or disorganisation, discrimination and trauma.[116] As Dr Bilyk said at the inquest regarding the diagnosis of a mental health disorder: "*It's not a science, unfortunately*".[117]

128 In Mr Blanket's case, the metal health service providers at Acacia lacked the benefit of any previous mental health assessments, and had no previous treatment plans for him. Essentially, they were faced with a blank canvas.

129 A further complication was that Mr Blanket, at times, was very reluctant to engage with those people who wanted to assist him overcome the challenging mental health issues that he had. To compound the matter further, Mr Blanket was reluctant to take the antidepressant medications prescribed by the prison doctor and refused to take any antipsychotic medication suggested by Dr Bilyk.

130 I must also take note that, at least within a prison setting, an attendance by a prisoner to an appointment with a health service provider is entirely

[115] Exhibit 1, Volume 2, Tab 32, Serco - Post Incident Review dated 20 August 2019, p.45
[116] https://www.mhc.wa.gov.au/your-health-and-wellbeing/about-mental-health-issues/
[117] ts 14.12.22 (Dr Bilyk) p.335

voluntary; as is the taking of medication prescribed by a prison doctor or psychiatrist.

131 Additional issues were the time constraints facing those providing mental health services to prisoners. Dr Bilyk only attended Acacia two days a week, usually Thursdays and Fridays.[118] In 2019, Acacia had the capacity to house 1525 prisoners.[119] It is a well-known fact that the proportion of the prison population with mental health issues is considerably greater than within the general community. About 10% of a prison population will have a major mental illness or psychotic disorder, compared to 1%-2% in the general population.[120] Dr Bilyk's average daily list of appointments at Acacia was between eight to 11 prisoners.[121]

132 In contrast to his initial health assessment at Hakea on 23 October 2018, Mr Blanket did not disclose any previous self-harm/suicide attempts when he was initially assessed by a nurse when he was transferred to Acacia on 6 November 2018.[122] It was nearly three months later that there was an indication Mr Blanket may need assistance for his mental health. This was when he expressed thoughts of self-harm for the first time to a health service provider at Acacia. As a result, on 29 January 2029, PRAG became involved with Mr Blanket's care .

133 As already outlined above, Mr Blanket was reviewed at several PRAG meetings before he was placed on SAMS on 13 February 2019. On 7 March 2019, he was placed on High ARMS when he disclosed to a prison officer that he had engaged again in head banging, stating it was due to anxiety and voices in his head.[123] At the PRAG meeting of 8 March 2019, it was agreed Mr Blanket would be removed from ARMS and returned to SAMS for daily monitoring.

134 Although Mr Blanket had participated in regular counselling sessions with Mr Saligari, no mental health assessment had been conducted by a mental health nurse or prison psychiatrist at this point in time. On 7 March 2019, the prison doctor had assessed Mr Blanket as having "*depression/anxiety*" and he was prescribed the antidepressant, fluoxetine.[124]

135 On 13 March 2019, prison officers became aware of an escalation in Mr Blanket's behaviour.[125] It was after hearing of this escalation that

[118] Exhibit 1, Volume 1, Tab 56.1, Statement of Dr Natalia Bilyk dated 4 July 2022, p.1
[119] Annual Report 2021/22 – Acacia Prison Services Agreement 2020
[120] ts 14.12.22 (Dr Bilyk) pp.310-311
[121] ts 14.12.22 (Dr Bilyk) p.312
[122] Exhibit 1, Tab 3, EcHO Medical Record, p.37
[123] Exhibit 1, Volume 2, Tab 13, Incident Description Report dated 7 March 2019
[124] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.21
[125] A prison officer was advised by a prisoner that Mr Blanket had been giving away his possessions, talking about suicide, stating the television was talking to him, that the radio was commanding him to commit certain acts and that he could see writing and instructions on inanimate objects. Mr Blanket also said that if he did not kill himself then

Mr Saligari requested a mental health assessment for Mr Blanket for the first time on 14 March 2019.[126] A nurse from the MHT conducted a mental health assessment on that day. After that assessment, the mental health nurse discussed Mr Blanket with Dr Bilyk and it was decided that the MHT would not be involved at this time.[127]

136 Unfortunately, the information that prison officers received on 13 March 2019 was not conveyed to Dr Bilyk during her discussions with the mental health nurse the following day.[128] I am satisfied that this information was critical for any mental health assessment. It was precisely the information that formed the basis for Mr Saligari's referral for a mental health assessment. When asked at the inquest whether this behaviour displayed by Mr Blanket indicated a potential major mental illness, Dr Bilyk answered: "*Yes. So, television talking to him, those symptoms that you described are consistent with psychosis*."[129]

137 When asked what steps she would have taken had she been aware of that information on 14 March 2019, Dr Bilyk answered: "*I think we would have organised an assessment by myself.*"[130]

138 I am satisfied, to the required standard, that this was a significant missed opportunity for an earlier timeframe in which Dr Bilyk could commence her assessment and potential diagnosis of Mr Blanket's mental health issues. Accordingly, I make that finding.

139 As it transpired, Dr Bilyk did not see Mr Blanket until eight weeks later on 10 May 2019. This missed opportunity assumes a greater significance when it is noted that on 17 April 2019 Mr Blanket had told the prison doctor that he did not want to take any medications for his depression and anxiety. On that date, the prison doctor ceased the prescribing of amitriptyline and fluoxetine for Mr Blanket.[131]

140 Appropriately, Mr Saligari made his second referral for a mental health assessment on 24 April 2019, after Mr Blanket had shown prison officers a noose he had fashioned out of a bedsheet and said that he had tried to hang himself with it from his cell door. Mr Saligari stated he made this referral as he believed there was sufficient evidence that Mr Blanket had

someone on the outside would die: Exhibit 1. Volume 1, Tab 36.32, Prison Counselling Information File Note dated 13 March 2019

[126] Exhibit 1, Volume 1, Tab 55, Statement of Mr Michael Saligari dated 18 August 2020, p.3
[127] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, pp.18-19
[128] ts 14.12.22 (Dr Bilyk), p.321
[129] ts 14.12.22 (Dr Bilyk), p.322
[130] ts 14.12.22 (Dr Bilyk), p.322
[131] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.15

experienced a major mental illness, namely psychosis, and that he met the criteria for intake into the MHT.[132]

141 It was this referral from Mr Saligari that eventually led to Mr Blanket being seen by Dr Bilyk on 10 May 2019. Mr Blanket had not attended three previous appointments with Dr Bilyk.[133] Nevertheless, Dr Bilyk took the unusual step of making arrangements to see Mr Blanket in his cell. At the end of her first session with Mr Blanket, Dr Bilyk indicated that ongoing assessment was required, noting it was essential that therapeutic rapport be built between herself and Mr Blanket for the initiation of treatment.[134]

142 Dr Bilyk did not see Mr Blanket again until 30 May 2019. I am satisfied there are reasonable explanations for that delay. As Dr Bilyk said at the inquest, she only attended Acacia two days a week and she was also at a conference for one week from 10 May to 30 May 2019.[135]

143 Dr Bilyk's assessment at the end of this second session with Mr Blanket was that he had prodrome/early psychosis with undifferentiated thought content. Despite her advice to Mr Blanket that antipsychotic medication may help, he declined to take any medication.[136]

144 Dr Bilyk noted that her plan was to continue to assess and develop a therapeutic relationship with Mr Blanket. She also noted that Mr Blanket did not meet the threshold for an involuntary admission to the Frankland Centre at Graylands Hospital under the *Mental Health Act 2014* (WA). Part of the ongoing plan was that she would continue to liaise with PWS, which was seeing Mr Blanket weekly whilst he was on ARMS, and that she would conduct another psychiatric review in two weeks.[137]

145 I accept the following explanation from Dr Bilyk at the inquest that it was too early to identify any precise mental health illness for Mr Blanket:[138]

> If someone is developing a psychotic illness it can evolve over months. It can fluctuate, disappear, and come back … in prodrome they will have fluctuating symptoms.
>
> … there's enormous challenges with early psychosis because it's such a fluctuating component of an established psychotic disorder. The early phases are – it's a very challenging time to make a diagnosis. They change often. The psychosis, like I said, can come and go and they can be very psychotic, then the psychotic symptoms will be very different the following week or the following month. And there's – it's a highly fluctuating time of someone's early mental

[132] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.4
[133] These appointments were scheduled for 1, 2 and 9 May 2019
[134] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.9
[135] ts 14.12.22 (Dr Bilyk), p.322
[136] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.8
[137] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.8
[138] ts 14.12.22 (Dr Bilyk), pp. 334-335

> illness if that's what is emerging at that time. And that's my suspicion, that he had an emerging mental illness, in terms of a psychotic illness.
>
> So that information [which I had] - it tells me he has been unwell for a while, and he has been in and out of acuity and risk, but also presentation. There are days where he can be quite well and be very organised; other days when he wasn't, based on what I collected from Amy Ford[139] When she assessed him he was well enough to give a very coherent summary that he chose to give then. But all this – all this information is important. On the basis of that, I can't make a diagnosis of, say, schizophrenia or anything, but I would take that into account as him being in early prodrome and into psychosis.
>
> …
>
> So my provisional diagnosis – I had a broad diagnosis of early episode or early psychosis, but hadn't had sufficient time, really, or information to narrow down a diagnosis. And that's not uncommon in someone in an emerging illness.

146 I also accept Dr Bilyk's reasoning as to why she was of the view there was no basis to refer Mr Blanket under the *Mental Health Act 2014* (WA) to the Frankland Centre:[140]

> Because the referral under the *Mental Health Act* requires not only clear symptoms of psychosis but the need for involuntary treatment – or further assessment and involuntary treatment. And at that stage his risk profile and his presentation, collectively, did not impress as someone who needed referral under the *Mental Health Act*.

147 In summary, I commend the steps taken by Dr Bilyk to diagnose Mr Blanket's mental health issues. I am of the view that she did everything she possibly could, given the constraints that she had. Those constraints were not merely confined to the time she had available to assess and treat Mr Blanket (which was clearly very limited). Unfortunately, the constraints also extended to the lack of information she was provided. This is dealt with later in my finding.[141]

Were adequate steps taken to treat Mr Blanket's mental health issues?

148 The services at Acacia that were primarily providing care and treatment for Mr Blanket's mental health were PWS, MHT and PRAG. I will address the adequacy of what each of these services did in that order.

149 Mr Saligari was the main point of contact for Mr Blanket with respect to PWS. It is clear from all the evidence before me that Mr Saligari was committed to assisting Mr Blanket. Although there were occasions when Mr Blanket did not want to engage with Mr Saligari or other PWS staff, the fact he wanted to speak to PWS shortly before his death demonstrated

[139] The mental health nurse who assessed Mr Blanket on 14 March 2019
[140] ts 14.12.22 (Dr Bilyk), p.329
[141] see: "*Was all relevant information concerning Mr Blanket's health and safety communicated to his mental health service providers?*"

the rapport and trust that had developed between him and Mr Saligari. This request also followed the risk management plan that Mr Saligari had recommended to Mr Blanket if he felt unsafe.[142]

150 I commend Mr Saligari for his requests that mental health assessments be conducted for Mr Blanket. These requests took place on 14 March 2019 and 14 May 2019. With respect to the health service providers at Acacia, it was Mr Saligari who first identified Mr Blanket's behaviours as potentially psychotic. Unsurprisingly, Mr Saligari testified that although the MHT concluded after the first assessment that the auditory and visual hallucinations of Mr Blanket were not considered psychotic, he had "*some scepticism*" and thought "*there might be a bit more to it*".[143] I accept that Mr Saligari's position as a social worker meant it was not his place to challenge this mental health assessment at the time.

151 I am satisfied that the care Mr Saligari provided to Mr Blanket was appropriate. His decision not to immediately see Mr Blanket on 12 June 2019 is dealt with separately in my finding.[144]

152 I am also satisfied of the care provided to Mr Blanket by the MHT, including Dr Bilyk. Although the MHT declined to intake Mr Blanket following his first mental health assessment on 14 March 2019, I am satisfied of the explanations for why that was not done. Unfortunately, as I will outline in more detail later in my finding,[145] all relevant information was not available to the MHT at the time that assessment was made. To now be critical of that decision not to intake Mr Blanket would be to insert impermissible hindsight bias.

153 As from 29 January 2019, PRAG had significant involvement in the care of Mr Blanket, and more precisely, with respect to the management of his mental health care. I am broadly satisfied with the decisions made by PRAG regarding its assessment of the need of ARMS for Mr Blanket and the level of ARMS that were given. I acknowledge the difficulties that PRAG can encounter in weighing up the lack of comforts available to a prisoner on High ARMS and the need to ensure the prisoner is at a low risk of self-harm or harming others. The complete absence of therapeutic safe cells at Acacia compounded the dilemma for PRAG when weighing up these factors.

154 The only error I have found with regard to its assessments of Mr Blanket was made by PRAG at its meeting on 31 May 2019. At the time of this meeting Mr Blanket was on Moderate ARMS. After discussing

[142] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari, dated 18 August 2022, p.7
[143] ts 27.12.22 (Mr Saligari), p.180
[144] see: "*Was it appropriate for Mr Saligari to not see Mr Blanket before his move to a safe cell on 12 June 2019?*"
[145] see: "*Was all relevant information concerning Mr Blanket's health and safety communicated to his mental health service providers?*"

Mr Blanket's current situation, PRAG agreed that he should be lowered to three-hourly Low ARMS. It is evident that a primary reason for that decision was the information provided by the mental health nurse at the meeting regarding Dr Bilyk's assessment on 30 May 2019. This assessment was taken to mean that Mr Blanket's risk of self-harm was "*considered low*".[146]

155 The notes made by Dr Bilyk following her meeting with Mr Blanket on 30 May 2019 was that her assessment of Mr Blanket's risk to himself and others were "*currently low*".[147] As Dr Bilyk testified at the inquest, what was recorded in the PRAG minutes for its meeting on 31 May 2019 did not properly capture her views; which were that Mr Blanket was at a lower risk in the context of someone who was "*at chronic high risk*".[148]

156 I accept Dr Bilyk's evidence that most prison psychiatrists do not attend PRAG meetings due to time constraints and the sheer volume of reviews psychiatrists are required to make.[149] Nevertheless, the following question asked by Mr Penglis SC to Dr Bilyk at the inquest was pertinent:[150]

> And I want to put to you that it really is quite undesirable for the psychiatrist's views to be expressed to PRAG by a mental health nurse who has done no more than look at the notes of the psychiatrist? - - - It's not ideal.

157 I find that it is most likely that had PRAG been aware of the full context of Dr Bilyk's assessment on 30 May 2019 then Mr Blanket would have remained on Moderate ARMS. However, I am satisfied that Mr Blanket's placement at Low ARMS by PRAG on 31 May 2019 did not contribute to his death 13 days later.

158 I commend PRAG's decision at its meeting on 31 May 2019 that, "*should any signs of distress be observed, [Mr Blanket] should be relocated to a ligature-free cell at the earliest opportunity as this could be an indication of increased risk to himself."*[151]

159 However, what I do not commend are the comments made by the acting unit manager at the first PRAG meeting which discussed Mr Blanket on 29 January 2019. The minutes from that meeting record that this prison officer said the following: "*[Mr Blanket] said he had thoughts of self-harm, however this is difficult to gage if this is genuine or manipulative. I feel somewhat confused and I'm not sure what to believe*."[152]

[146] Exhibit 1, Volume 2, Tab 27, PRAG Minutes dated 31 May 2019, p.1
[147] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.8
[148] ts 14.12.22 (Dr Bilyk), p.356
[149] ts 14.12.22 (Dr Bilyk), p.340
[150] ts 14.12.22 (Dr Bilyk), p.357
[151] Exhibit 1, Volume 2, Tab 27, PRAG Minutes dated 31 May 2019, p.2
[152] Exhibit 1, Volume 2, Tab 7, PRAG Minutes dated 29 January 2019, p.1

160 These comments were not appropriate and were at odds with the approach that the ARMS Manual recommends:[153]

> There is a tendency to dismiss acts of self-harm as manipulative, rather than as genuine cries for help and a sign of potential suicide risk. Most self-harmers are distressed and have some thoughts of suicide. A judgmental response to self-harm only increases their distress.

161 Thankfully, it is apparent these unwarranted doubts were not shared by other PRAG members at this meeting, as the decision was made that Mr Blanket was to remain on Moderate ARMS.

Was all relevant information concerning Mr Blanket's health and safety communicated to his mental health service providers?

162 The short answer to the above question is "no". It was disturbing to hear evidence at the inquest that important information was never communicated to the MHT, and particularly to Dr Bilyk. Indeed, some of this information did not come to Dr Bilyk's attention until the actual inquest.

163 With respect to her discussions with the mental health nurse on 14 March 2019, Dr Bilyk was unaware of the contents of the file note completed by Mr Saligari the previous day.[154]

164 This very important information was never brought to Dr Bilyk's attention during Mr Blanket's lifetime. Unsurprisingly, Dr Bilyk accepted that Mr Saligari's file note held relevant information for her assessment of Mr Blanket on 10 May 2019.[155]

165 Dr Bilyk was also unaware that on 22 April 2019 Mr Blanket had shown prison custodial staff the noose he had fashioned out of a bedsheet and said that he had tried to hang himself from his cell door.[156] Again, unsurprisingly, Dr Bilyk said this would have been very important information for her to have had prior to her meeting with Mr Blanket on 10 May 2019.[157] Dr Bilyk accepted she was unaware of this information until she heard it at the inquest.[158]

166 Dr Bilyk agreed there was a lot of information she did not have that would have enabled her to make a more informed decision regarding

[153] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.8
[154] Exhibit 1, Volume 1, Tab 36.32: This file note recorded that a prisoner had said Mr Blanket had been giving away his possessions, talking about suicide, stating the television was talking to him, that he could see writing and/or instructions on inanimate objects and that the radio was commanding him to commit suicide. It was also recorded that Mr Blanket said that if he did not kill himself someone on the outside would die.
[155] ts 14.12.22 (Dr Bilyk), p.349
[156] ts 14.12.22 (Dr Bilyk), p.351
[157] ts 14.12.22 (Dr Bilyk), p.351
[158] ts 14.12.22 (Dr Bilyk), p.351

Mr Blanket's treatment.[159] Critically, she did not see the ARMS file note prepared by Mr Saligari after he saw Mr Blanket on 14 May 2019.[160] Although, Dr Bilyk testified that she was aware of some information recorded in that file note regarding Mr Blanket's self-harm/suicide indicators at that time, she was not aware of the following:[161]

1. Mr Blanket had reported delusions and highly diverse spiritual ideals about life and death.
2. He reported having attempted to hang himself ten times historically.
3. He had stated the previous night he was thinking about a way to end his life by means of hanging himself on the back of his cell door.
4. He explained how he could tie a knot in his bedsheet and close the door to hang himself from the other side.
5. He casually mentioned that he could end his life by headbutting the wall or with a kitchen knife, although he appeared less motivated to use these means.[162]

167 Dr Bilyk agreed she would expect to have had this information communicated to her in May 2019, adding she did not have access to ARMS file notes such as this one completed by Mr Saligari.[163]

168 The failure of the system to provide relevant information to Dr Bilyk is not lessened by her evidence at the inquest that even if she had the full background of Mr Blanket's behaviour, she would not have considered a referral for involuntary hospital treatment under the *Mental Health Act 2014* (WA) as of 10 May 2019.[164] Dr Bilyk later provided these answers from questions asked by Mr Penglis SC:[165]

> But if you were more concerned about Mr Blanket's state of mind and mental position, being informed by all the information you now know that you didn't know at the time, is it fair to say that you could have been – I'm not going to ask you to guess what you would have done. But you probably would have been a little bit more concerned about him than you were? - - - Yes.
>
> That concern might have resulted in you being more definite about him being on medication? - - - Yes.
>
> And that would have also then resulted in – if he had refused his medication – that you may well have taken more drastic steps – well, recommended more drastic steps be taken in what you considered to be his best interests? - - - Yes.
>
> And those more drastic steps could have included referral under the Mental Health Act? - - - Yes.

[159] ts 14.12.22 (Dr Bilyk), p.322
[160] ts 14.12.22 (Dr Bilyk), p.354
[161] ts 14.12.22 (Dr Bilyk), pp. 351-352
[162] Exhibit 1, Volume 2, Tab 25, PHS ARMS File Note dated 14 May 2019
[163] ts 14.12.22 (Dr Bilyk), p.355
[164] ts 14.12.22 (Dr Bilyk), p.329
[165] ts 14.12.22 (Dr Bilyk), pp.357-358

169 Those answers reinforce my satisfaction, to the required standard, that there was a failure in the system that was in place at Acacia to provide Dr Bilyk with all relevant information regarding Mr Blanket's behaviour that would have enabled her to properly assess his mental health. Accordingly, I make that finding. This information had been acquired by PWS and had been shared, for the most part, to PRAG. However, it failed to reach Dr Bilyk.

170 Unfortunately, the above evidence provides an example of the silo effect; an all-too-common feature in inquests.[166] Dr Bilyk's evidence starkly exposed the outcomes of this failure. Had this evidence been available to her, Dr Bilyk testified that she would have likely diagnosed a schizophreniform, an early psychosis diagnosis, that would have probably warranted treatment and management.[167] As Mr Penglis SC put to Dr Bilyk in his customary succinct manner:[168]

> And you would agree that this appears to be a case where the non-sharing of information may well have had a substantially different outcome? - - -In terms of timeliness of assessment and treatment, yes.

171 On a more positive note regarding the timely sharing of relevant information, the concerns of Mr Blanket's mother regarding the distressing PTS call she had with her son on 15 March 2019 were passed onto health service providers at Acacia.

172 At 6.47 am on 16 March 2019, a prison nurse conducted a welfare check on Mr Blanket and her entry in EcHO recorded that Mr Blanket had, "*thoughts of suicide to his mother via a phone call*".[169] I am satisfied that this is a reference to the PTS call Mr Blanket had with his mother the previous day. The nurse also recorded that: "*No self-harm ideation expressed at this time and no other issues raised.*"[170]

Was it appropriate for Mr Saligari to not see Mr Blanket before his move to a safe cell on 12 June 2019?

173 It is not in dispute that Ms Francis and Mr Saligari had a telephone conversation on 12 June 2019. It is most likely it had taken place closer to 9.45 am than 10.00 am. Their recollections of what was said differ. Both agreed Ms Francis told Mr Saligari that Mr Blanket had requested to speak to him. Ms Francis recalls telling Mr Saligari that Mr Blanket was still in Foxtrot Block, and it would be easier to see him now. She also recalls

[166] "Silo effect" is a term used in the business field to describe how compartmentalisation creates inefficiencies and confusion between employees and departments: https://www.igi-global.com/dictionary
[167] ts 14.12.22 (Dr Bilyk), p.335
[168] ts 14.12.22 (Dr Bilyk), p.358
[169] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.17
[170] Exhibit 1, Volume 3, Tab 4, EcHO Medical Record, p.17

Mr Saligari saying it was not standard practice to see a prisoner outside of the ARMS process and that he would first look at his interview notes.[171]

174 In his evidence at the inquest, Mr Saligari recalled that Ms Francis did say to him Mr Blanket was in Foxtrot Block and that he would be able to see him now.[172] He did not recall saying the other matters mentioned above and added that this would not make sense to him as Mr Blanket was already on ARMS.[173]

175 It is not necessary for me to determine this conflict in the accounts given. It is common ground that Ms Francis did say that Mr Saligari could see Mr Blanket now. I also accept Mr Saligari's account that after this conversation, he called the officer responsible for prisoner movements to see if Mr Blanket was suitable to be assessed. Mr Saligari was advised that Mr Blanket was still waiting to be moved to the medical centre.[174] When he was advised of that, Mr Saligari decided to wait until 12.00 pm so that Mr Blanket could be settled in the safe cell at the medical centre.

176 Although Mr Saligari agreed that seeing Mr Blanket was "*something to be prioritised*",[175] I accept his explanation for not arranging to see Mr Blanket straightaway. I note that the purpose of the session was to undertake a risk assessment for the PRAG meeting scheduled for 1.00 pm that day. It was not simply a case of finding out why Mr Blanket wanted to speak to someone at PWS.

177 Mr Saligari also gave evidence that it was almost impossible to see someone during a cell move as it was clinically undesirable.[176] In addition, there is merit to Mr Saligari's observation that: "*I did not want to push for an assessment during the move to a safe cell as it may overwhelm him and interrupt the session mid-way due to 11.00 am prison muster*".[177] Furthermore, Mr Saligari had advised the officer responsible for prisoner movements that if Mr Blanket was able to be seen before 12.00 pm then he was to be contacted.[178]

178 Mr Saligari also made the point that he was aware from the email he had read earlier that Mr Blanket was being moved to a safe cell. In those circumstances he had assumed, "*there was no possible way in the information I had, that he would be at risk.*"[179]

[171] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.21
[172] ts 27.7.22 (Mr Saligari), p.118
[173] ts 27.7.22 (Mr Saligari), pp.118 & 120
[174] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.9
[175] ts 27.7.22 (Mr Saligari) p.125
[176] ts 27.7.22 (Mr Saligari) p.128
[177] Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.9
[178] Exhibit 1, Vol 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, p.9
[179] ts 27.7.22 (Mr Saligari), p.136

179 To now be critical of Mr Saligari's decision not to see Mr Blanket until 12.00 pm would be inserting impermissible hindsight bias. In finding that Mr Saligari's decision to delay seeing Mr Banket was appropriate, I also note what Mr Penglis SC said in his closing submissions at the inquest:[180]

> … Mr Blanket's family does not invite any finding adverse to Mr Saligari, and specifically does not invite any finding that it was in fact inappropriate or inadequate for Mr Saligari to choose not to meet with Mr Blanket until he had been moved to a safe cell.

180 I extend my appreciation to Mr Blanket's family for making that concession, which I regard as being properly made.

Was it appropriate for Mr Blanket to be in his cell by himself on 12 June 2019?

181 This question relates to Mr Blanket entering his cell after the decision had been made to place him on Moderate ARMS and transfer him to a safe cell. For the reasons I have outlined below, I am satisfied it was appropriate to allow Mr Blanket to return to his cell so he could be by himself as that was a well-entrenched coping mechanism that he had. However, what was clearly inappropriate was allowing him to close his cell door. For the reasons I have outlined below, I am satisfied, to the required standard, that this was a grave error and one that should not have been made given the information available to Acacia staff at the time.

182 On 12 June 2019, Mr Blanket was at Low ARMS. Accordingly, the PRAG meeting the day before was not scheduled to discuss him.[181] However, when Ms Andrews observed Mr Blanket in a distressed state, she raised her concerns with Ms Francis. Ms Andrews is to be commended for taking that action. It followed the risk management plan that was in place for Mr Blanket at the time.[182] Ms Francis immediately made an arrangement for Mr Blanket to be relocated to a safe cell and increased his supervision level to Moderate ARMS. She then sent an email to the ARMS Notification Group advising of Mr Blanket's updated status at 9.22 am.[183] Ms Francis is also to be commended for the prompt action that she took.

183 As I have outlined above, Ms Francis spoke to Mr Saligari after sending this email and advised him that Mr Blanket had asked to speak to him. She also said that Mr Saligari would need to undertake a risk assessment for Mr Blanket now that he was on Moderate ARMS. Ms Francis then left Foxtrot Block to attend a meeting. At that time, Mr Blanket was in a common area with other prisoners. I am satisfied that in this environment Mr Blanket was not at an imminent or acute risk of suicide or self-harm.

[180] ts 16.12.22 (Mr Penglis SC), p.573
[181] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.19
[182] Exhibit 1, Volume 2, Tab 29, ARMS Minutes dated 7 June 2019, p.2
[183] Exhibit 1, Volume 2, Tab 37, Email from Anna Francis to ARMS Notification Group dated 12 June 2019

However, the question arises as to whether there was an increase in that risk once Mr Blanket returned to his cell and then closed the door. I am satisfied the answer to that question must be "yes". The next question is whether that risk should have been identified, given the information Acacia staff had at the time.

184 In her evidence at the inquest, Ms Francis accepted, with the benefit of hindsight, that she would have made a different decision with respect to Mr Blanket returning to his cell on 12 June 2019.[184] However, she maintained at the inquest:[185]

> … at the time, given the circumstances, given the situation and the information we had, it didn't feel like the wrong decision at the time, because, returning to his cell to be alone, could be very protective for him.

185 Ms Francis was later asked this question by Mr Penglis SC:[186]

> Do you not, sitting here today, understand that there is a tension between a decision to put this man in the ligature-free cell at the earliest opportunity, because, to minimise the increased risk to self, but in the meantime allowing him to go back unsupervised into his cell and shut the door? - - - The risk at the time was not only he might harm himself. It was that he might harm others. So, by removing himself from potential antagonists, that was seen as protected.

186 I do not accept the decision to elevate Mr Blanket's ARMS status and move him to a safe cell was due to a risk he might harm another prisoner or prisoners.

187 In drawing that conclusion, I rely on the contents of the email Ms Francis sent to the ARMS Notification Group which specified that Mr Blanket's increase to Moderate ARMS and relocation to a safe cell was "*owing to increased risk to self*."[187] Similarly, the risk management plan referred to Mr Blanket exhibiting signs of distress as potentially being "*an indication of increased risk to self*", and not an increased risk of harming others.[188]

188 Based on his prior behaviour, the risk of Mr Blanket harming others was clearly less than the risk of harming himself. On all the evidence before me, there was only one previous occasion at Acacia where Mr Blanket was violent towards other prisoners which led to disciplinary action being taken.[189] That occurred on 22 April 2019, and there were extenuating

[184] ts 14.12.22 (Ms Francis), p.273
[185] ts 14.12.22 (Ms Francis), p.273
[186] ts 14.12.22 (Ms Francis), p.274
[187] Exhibit 1, Volume 2, Tab 37, Email from Anna Francis to ARMS Notification Group dated 12 June 2019
[188] Exhibit 1, Volume 2, Tab 28, PRAG Minutes dated 31 May 2019, p.2
[189] In February 2019, Mr Blanket had reported to Mr Saligari of being involved in a fight in the laundry at Mike Block and that he was mobbed. However, it does not appear there was any punitive action taken or that Acacia custodial staff were even aware the incident had occurred: Exhibit 1, Volume 1, Tab 36.37, Prison Counselling Consultation File Note dated 13 February 2019

circumstances particular to that incident; namely, it was on this day that Mr Blanket had first become aware his parole had been denied.

189 I am therefore satisfied that, if not the sole reason, then certainly the primary reason for Mr Blanket's relocation to a safe cell was the increased risk of self-harm or suicide that had been identified. Accordingly, I make that finding. The monitoring of Mr Blanket's movements should have been performed with that squarely in mind until his relocation to a safe cell had been completed.

190 The question was also raised at the inquest as to whether Mr Blanket should have been elevated to High rather than Moderate ARMS on 12 June 2019. In accordance with the ARMS Manual at the time, this would have required continuous observations being made until Mr Blanket had been placed in a safe cell.[190] I am therefore satisfied that had Mr Blanket been placed on High ARMS, and had there been compliance with the ARMS Manual, he would not have been permitted to close his cell door.

191 At the inquest, Ms Francis maintained that Mr Blanket did not have the identified factors as set out in the ARMS Manual to place him on High ARMS.[191] Specifically, Ms Francis said that as Mr Blanket was not "*extremely*" agitated on 12 June 2019, he did not satisfy Criterion B in the ARMS Manual for the identifying factors of "High Risk".[192]

192 Strictly speaking this is correct. Although Mr Blanket was distressed on 12 June 2019 (which may also be considered as "agitated"), it could equally be regarded that he was not "*extremely*" agitated as specified in the ARMS Manual under Criterion B.

193 Nevertheless, Ms Francis agreed that the ARMS Manual is only a guide.[193] As with any documents detailing guidelines, deviations from those guidelines are acceptable if the circumstances warrant it. Such a deviation actually occurred regarding a decision whether Mr Blanket should be on ARMS at the PRAG meeting on 27 March 2019.[194]

194 The ARMS Manual stated that prisoners should be considered at an acute risk of suicide or self-harm if they are, "*likely to have, or be suspected of having, a well-developed suicide plan which includes method, time, place*

[190] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.53
[191] ts 14.12.22 (Ms Francis), p.259 & pp 278-281; Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), pp. 52-53
[192] ts 14.12.22 (Ms Francis), p.281; At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.53
[193] ts 14.12.22 (Ms Francis), p.273
[194] This meeting was held after Mr Blanket had refused to engage in a risk assessment with Mr Saligari earlier that day. PRAG determined that Mr Blanket could be removed from ARMS as there were no acute risk factors identified. It was noted in the meeting's minutes: "*PRAG discussed how if a prisoner is unwilling to engage in an assessment, the ARMS Manual states he should be upgraded to one-hourly High observations. However, the PRAG agreed this was unnecessary in this instance*": Exhibit 1, Volume 2, Tab 21, PRAG Minutes dated 27 March 2019, p.2

and a high degree of lethal intent."[195] If such a plan exists then Criterion A or Criterion B must be satisfied before a prisoner is placed on High ARMS.[196]

195 In Mr Blanket's case, he had a "*well-developed suicide plan*" that was not simply one he was "*likely to have or be suspected of having*". That suicide plan involved closing his cell door and using it as a ligature point with a torn bed sheet. Since 22 April 2019, Acacia staff had not only been aware of this plan but knew that Mr Blanket had actually tried, and failed, to implement that precise plan in his cell. He even showed Acacia custodial officers the torn bed sheet he had used.

196 In these circumstances, and even if Mr Blanket did not strictly fall within Criterion A or Criterion B in the ARMS Manual, he should not have been permitted to close his cell door once he had returned to his cell. Given the very specific suicide plan and a recent previous attempt by Mr Blanket to implement it, the ARMS Manual should not have been strictly applied in this instance. A deviation from its guidelines was clearly warranted, and it was a deviation that was very simple to enforce: Mr Blanket should not have been permitted to close his cell door. Accordingly, I make that finding.

197 Being mindful not to insert hindsight bias, I am satisfied, to the required standard, that there was an error made in allowing Mr Blanket to close the door to his cell when by himself, with the means to implement his known suicide plan and when he was considered to be at an elevated risk of self-harm and/or suicide. Applying the ***Briginshaw*** principle, I am also satisfied that this error was a contributing factor in Mr Blanket's death.

198 I do not attribute this error to any particular Acacia staff member, and I do not single out Ms Francis. I note that she was not an operational officer in her capacity as the Safer Custody Coordinator and was therefore only a non-custodial staff member.[197] As she said at the inquest:[198]

> I didn't make a decision to allow him to go back into his cell. As I left, he was in the unit. I didn't make any instructions that he should be kept in line of sight, I didn't say he should not be allowed to go back into his cell. But I didn't give explicit permission for him to go back into his cell. So, it wasn't my decision I made. It was just about the action I took.

199 I agree with Deputy Commissioner Andrew Beck's comment at the inquest that prison staff are, "*very good at following rules and as a consequence, the response to a person who was at risk sometimes was very rule-based as opposed to being centred around the needs of the*

[195] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.52
[196] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), pp.52-53
[197] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.22
[198] ts 14.12.22 (Ms Francis), p.274

individual."[199] This provides the most likely explanation for the error made which allowed Mr Blanket to close his cell door.

Were Mr Blanket's treatment needs adequately met for the purpose of parole eligibility?

200 The Prisoners Review Board (the Board) denied Mr Blanket's release on parole. The Board determined that his release, "*would present an unacceptable risk and safety to the community and there is a likelihood of* [*Mr Blanket*] *committing an offence whilst subject to a Parole Order.*"[200] One of the reasons cited by the Board was Mr Blanket's "*unmet treatment needs*" and that Mr Blanket had, "*not been assessed for any intensive treatment programmes whilst in custody due to the short duration of the current sentence.*"[201]

201 The issue raised by Mr Blanket's family, which is one that has caused me some concern, is that Mr Blanket was never assessed for treatment intervention and was therefore never given the opportunity to engage in any treatment programs, "*that will support the prisoner's reintegration back into the community and reduce their likelihood of re-offending*".[202] It was not the case that Mr Blanket did not wish to participate in, or had refused, an invitation to complete any treatment programs. It appears he had actually applied for several voluntary programs that, from their descriptions, would have provided him with appropriate treatment to address at least some of his "unmet" needs.[203] However, Mr Blanket had not been accepted into any of them.

202 At the time of Mr Blanket's imprisonment, Serco was responsible for funding treatment programs for prisoners at Acacia. This was in accordance with the Annual Schedule issued by the Department, and was consistent with the provisions of the Acacia Prison Services Agreement 2006. This arrangement has continued under the replacement 2020 Acacia Prison Services Agreement.[204]

203 Currently, a prisoner's ability to participate in prison treatment programs is governed by "*Commissioner's Operating Policy and Procedure: Assessments and Sentence Management*" (COPP 2.3) which came into operation on 1 September 2020. Included in the aims of sentence management in COPP 2.3 are:[205]

[199] ts 16.12.11 (Deputy Commissioner Beck), p.546
[200] Exhibit 1, Volume 1, Tab 46.2, Letter from the Prisoners Review Board to Mr Blanket dated 18 April 2019
[201] Exhibit 1, Volume 1, Tab 46.2, Letter from the Prisoners Review Board to Mr Blanket dated 18 April 2019
[202] COPP 2.3 Assessment Sentence Management v 7.0, p.13
[203] Exhibit 1, Volume 1, Tab 46.2, Letter from Mr Blanket to the Prisoners Review Board dated 14 February 2019, p.3; Exhibit 1, Volume 2, Tab 12, Parole Review Report dated 8 February 2019, p.5
[204] Email from Ms Robyn Hartley to counsel assisting dated 13 July 2023; Email from Diviij Vijayakumar to counsel assisting dated 14 July 2023
[205] COPP 2.3 Assessment Sentence Management v 7.0, p.5

> To reduce risk of re-offending by prisoners by identifying areas of risk and providing Individual Management Plans (IMPs) during imprisonment aimed at reducing that risk.
>
> To enable prisoners to make constructive use of their time in prison through structured IMPs by providing strategies to avoid further offending and re-imprisonment through the provision of appropriate interventions, working towards the possibility of the earliest release of prisoners from custody.
>
> Program inclusion based on prisoner risks/needs and available resources.

204 An Individual Management Plan (IMP) is a document that outlines the management of a sentenced prisoner and provides information regarding, amongst other matters, rehabilitation and reintegration that identifies the prisoner's main intervention needs, including any treatment programs and specific parole issues.[206]

205 On the face of it, an IMP has noble aspirations. However, there is a major obstacle for a prisoner who has been sentenced to imprisonment for 12 months or less of having an IMP developed for them. That is because of clause 5.4.1 of COPP 2.3 which states: "*An initial IMP shall be developed generally within six weeks of sentencing, for all prisoners serving an effective sentence of greater than six months*."[207] A prisoner serving an effective sentence of six months or less can only have an initial IMP completed at the discretion of the relevant Assistant Superintendent (or delegate). However, this discretion can only be exercised if information gathered during the completion of a Management and Placement checklist identifies significant risks that should be further assessed.[208]

206 Mr Blanket was not serving an effective sentence of greater than six months as he was eligible for parole at the completion of six months and, hence, had an effective sentence of six months or less.[209]

207 I am troubled by these provisions of COPP 2.3 which largely excludes prisoners serving an imprisonment term of 12 months or less from having a mandatory initial IMP. The subsequent outcome is that the opportunity for these prisoners to complete programs that will enhance their prospects of parole eligibility are significantly diminished.

208 I am of the view that this situation prejudices a prisoner like Mr Blanket who wanted to participate in courses designed to assist his rehabilitation. As the Office of the Inspector of Custodial Services noted in its report following an inspection of Acacia in 2018:[210]

[206] COPP 2.3 Assessment Sentence Management v 7.0, p.10
[207] COPP 2.3 Assessment Sentence Management v 7.0, p.12
[208] COPP 2.3 Assessment Sentence Management v 7.0, p.12
[209] Email from Ms Robyn Hartley to counsel assisting dated 13 July 2023
[210] Exhibit 1, Volume 3, Tab 2, 2018 Inspection of Acacia Prison, p.6

> Failure to complete treatment assessments, or significant delays, means prisoners cannot be booked into offender programs they need as part of their rehabilitation. The Prisoners Review Board (PRB) are aware of the situations the prisoners are in. However, the fact that offending behaviour has not been addressed is a negative factor in decisions whether to grant parole. Prisoners are less equipped to manage their issues on release and more likely to reoffend and return to prison. Further offending comes at a considerable cost to the victims, society at large, the offenders and their families.
>
> Fewer parole releases and increased imprisonment means that prison populations are high and services, including rehabilitation, are stretched thin.

209 It is hardly surprising Mr Blanket reacted in the manner that he did when he was told that his release on parole had been denied. One of the reasons given by the Board was: "*Your release plan does not include any way to adequately address your unmet intensive treatment needs*."[211]

210 It was not the fault of Mr Blanket that his "*unmet intensive treatment needs*" existed. It was because he had, "*not been assessed for treatment interventions and therefore has not had the opportunity to address his offending behaviour*."[212]

211 As I found this state of affairs very troubling, I invited the Department and Serco to address the fact that the vast majority of prisoners who are sentenced to 12 months imprisonment or less are not having an initial IMP prepared for them. I feared the outcome for these prisoners, like it was for Mr Blanket, was that they are regularly not being granted parole by the Board and that a commonly cited reason is due to "*unmet treatment needs*". I received further information and submissions from the Department and Serco in July and August 2023. They were also invited to address why it was that Mr Blanket was not able to participate in any voluntary courses.

212 Serco submitted that its records indicated that Mr Blanket had applied to participate in three voluntary programs. One was titled "*Positive Communication in Relationships*" which Mr Blanket applied for on 12 November 2018 and was placed on a waitlist. There was no record of him being invited to attend that program. Another one he applied for was "*The Green Lighthouse*" which was a program that addressed drug use. This was done on 12 November 2018 and he was placed on the waitlist. Mr Blanket was removed from the waitlist when he failed to attend an appointment to meet the course facilitator. The third program was "*Control of Violence for Angry Impulsive Drinkers*", which Mr Blanket

[211] Exhibit 1, Volume 1, Tab 46.2, Letter from the Prisoners Review Board to Mr Blanket dated 18 April 2019
[212] Exhibit 1, Volume 2, Tab 12, Parole Review Report dated 8 February 2019, p.7

applied for on 8 November 2018. However, he was advised on 12 November 2018 that this program was no longer available.[213]

213 Mr Blanket had also reported that he had applied for "*Alternative to Violence Project*". Serco stated Mr Blanket had enquired about this program on 8 November 2018 but there was no record that he had actually applied for it. Serco also noted that this program and "*Positive Communication in Relationships*" were in high demand at the time Mr Blanket was imprisoned.[214]

214 In its response, the Department accepted the predicament that prisoners such as Mr Blanket faced, stating it "*recognises the difficulties prisoners with short sentences experience in accessing treatment programs which has the potential to impact their parole prospects*".[215] That concession was properly made. The Department outlined what progress has been made in tackling this problem since Mr Blanket's death and I address that later in my finding.[216]

215 I have carefully considered the material provided by Serco and the Department, and reviewed the documentary evidence regarding Mr Blanket's parole eligibility. I am of the view that the Board, in accordance with section 5A of the *Sentence Administration Act 2003* (WA) and the legislation requiring the Board to apply the defined "*release considerations*", had no option other than to deny Mr Blanket's release on parole.

216 However, I am satisfied, to the required standard, that Mr Blanket was denied a reasonable opportunity before the date he was eligible for parole to participate in some rehabilitative programs that would have addressed his treatment needs. I therefore make that finding. This situation was predominantly due to the high demand for these programs and the waitlists that this demand had generated. The outcome was that the system affected Mr Blanket's prospects of being granted parole.

Were adequate steps taken to ensure Mr Blanket's supervision, treatment and care was culturally appropriate?

217 Regrettably, the beginning of Mr Blanket's supervision, treatment and care was anything but "*culturally appropriate*". That was because the document prepared for Mr Blanket's Reception Intake Assessment at Hakea on 23 October 2018 described his ethnicity as "*Australian - Non-Aboriginal*".[217] This incorrect description was then repeated in later

[213] Attachment to email from Diviij Vijayakumar to counsel assisting dated 16 August 2023
[214] Attachment to email from Diviij Vijayakumar to counsel assisting dated 16 August 2023
[215] Email from Karess Dias to counsel assisting dated 11 August 2023
[216] see: "*Comments Relating to the Proposed Recommendations*"
[217] Exhibit 1, Volume 2, Tab 2, ARMS - Reception Intake Assessment dated 23 October 2018

documentation generated at Hakea, Casuarina and Acacia.[218] The same mistake continued with the Parole Review Report prepared for Mr Blanket dated 8 February 2019 which still incorrectly described his ethnicity as "*Australian - Non-Aboriginal*".[219]

218 This mistake had not been rectified for more than six months after Mr Blanket had been imprisoned. In her preparation to assess Mr Blanket in May 2019, Dr Bilyk had noted that neither the EcHO or the TOMS records indicated he was First Nations.[220] This was an embarrassing error and one that should have been corrected promptly.

219 Notwithstanding this mistake, I am satisfied that the treatment and care given to Mr Blanket by his health service providers at Acacia was culturally appropriate, given what was available to them. That is not to say what was available to these providers was adequate; rather, they used what they had available as effectively as they could.

220 I am satisfied with Mr Saligari's efforts to arrange culturally appropriate treatment for Mr Blanket. However, this was difficult for Mr Saligari to navigate. As he testified at the inquest:[221]

> I proceeded with caution because he [Mr Blanket] denied me arranging cultural support for him. So, I proceeded with caution and further, I was aware that it may not be suitable for me to know what was being done. So, I respected that. So, it was a difficult sort of dance but there was significant contact to try and arrange cultural support.

221 Mr Saligari also said that Mr Blanket, "*was never open about any cultural issues with me*" and that, "*he never requested that I ever elicit cultural support for him*."[222]

222 Notwithstanding these obstacles, Mr Saligari spoke to several people who had experience with First Nations culture. He had various discussions with Ms Kay Buck, the Aboriginal Services Manager at Acacia, about the cultural support that could be offered to Mr Blanket.[223] As he stated at the inquest:[224]

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[218] At Hakea, the error was repeated in the Multiple Cell Occupancy-Risk Assessment dated 23 October 2018, the Orientation Checklist dated 24 October 2018, and the Management and Placement – Sentenced dated 29 October 2018: Exhibit 1, Volume 2, Tabs 3 & 4.
At Casuarina, the error was repeated in the Orientation Checklist dated 2 November 2018: Exhibit 1, Volume 2, Tab 5;
At Acacia, the error was repeated in the Multiple Cell Occupancy – Risk Assessment dated 7 November 2018: Exhibit 1, Volume 2, Tab 6

[219] Exhibit 1, Volume 2, Tab 12, Parole Review Report dated 8 February 2019

[220] Exhibit 1, Volume 1, Tab 56.1, Statement of Dr Natalia Bilyk dated 4 July 2022, p.3; ts 14.12.22 (Dr Bilyk), pp.342-353

[221] ts 27.7.22 (Mr Saligari), p.193

[222] ts 27.7.22 (Mr Saligari), p.75, p.76

[223] ts 27.7.22 (Mr Saligari), p.191

[224] ts 27.7.22 (Mr Saligari), p.192

> There were many consultations with Kay Buck; some which I've recorded. Kay was looking at the history of Mr Blanket and trying to use her cultural knowledge to arrange a prisoner from a similar area or background to provide cultural support. I have used Ms Kay Buck, in this way before, in consultation on this. [In Mr Blanket's case] it never really went anywhere.

223 Although, Ms Buck was not a First Nations person, Mr Saligari was of the view that, "*she does have a good reputation within the First Nations community of Acacia*".[225]

224 In March 2019, Larsen Burgoyne, a First Nations man employed by Serco as a Prison Support Officer, forwarded an email to Mr Saligari regarding Mr Elvis Yarran.[226] Mr Yarran was a case worker from ReSet (an organisation run by the Wungning Aboriginal Corporation that provides support to First Nations prisoners).

225 On 20 March 2019, Mr Saligari received an email from Mr Yarran which set out his belief that Mr Blanket may have been suffering spiritually from a fallout by not fulfilling his initiation through tribal lore. Mr Yarran advised Mr Saligari that Mr Blanket had fled because he was scared and may now believe he was being punished spiritually by Elders. Mr Yarran suggested he could follow up with Mr Blanket if he needed any spiritual healing at Acacia.[227]

226 On 27 March 2019, Mr Saligari met with Ms Buck to discuss potential spiritual issues regarding Mr Blanket. It was agreed that some of Mr Blanket's behaviours may be spiritual/trauma-based experiences rather than psychiatric. Ms Buck agreed to follow up with Mr Yarran, who by this stage was Mr Blanket's ReSet case officer, to provide cultural support/healing.[228]

227 Mr Saligari also recalled following up with Mr Yarran regarding spiritual healing for Mr Blanket. He rang Mr Yarran; however, it went to his voice mail. Mr Saligari left a message on the voice mail stating that he very much encouraged cultural support taking place for Mr Blanket.[229]

228 There is no evidence before me as to whether Mr Yarran did provide any cultural support to Mr Blanket. Although Mr Saligari said that any such support would have been recorded in the minutes of PRAG meetings,[230] I

[225] ts 27.7.22 (Mr Saligari), p.173
[226] ts 27.7.22 (Mr Saligari), p.152
[227] Exhibit 1, Volume 1, Tab 36.25, Prison Counselling Consultation File Note dated 20 March 2019
[228] Exhibit 1, Volume 1, Tab 36.23, Prison Counselling Consultation File Note dated 27 March 2019: Exhibit 1, Volume 1, Tab 55, Statement of Michael Saligari dated 18 August 2020, pp. 3-4
[229] ts 27.7.22 (Mr Saligari), p.191
[230] ts 27.7.22 (Mr Saligari), p.174

have been unable to find in the PRAG minutes in exhibit 1 any reference to Mr Yarran having seen, or being scheduled to see, Mr Blanket.

229 What is evident in the PRAG minutes was the frequent contact that Mr Blanket had with Prison Support Officers, particularly Mr Burgoyne, who also provided cultural expertise at PRAG meetings.[231] Mr Blanket also received visits from fellow First Nations prisoners in their role as Peer Support Prisoners. Unfortunately, there were periods when Mr Blanket declined support from these men. For example, at the PRAG meeting on 18 March 2019, the attending Prison Support Officer advised that Mr Blanket, "*continues to decline peer support, this is the third time in doing so.* [*Mr Blanket*] *will continue to be offered*".[232] He would also decline, on occasions, assistance from Prison Support Officers, such as Mr Burgoyne, who were well-acquainted with cultural needs.

230 The ARMS Manual noted that when creating a Support Plan for First Nations prisoners: "*PRAG should be cognisant of the impact of the cultural issues and should seek clarification from relevant staff where necessary*."[233] When Ms Francis was asked at the inquest whether that happened for Mr Blanket, she stated:[234]

> [Mr Saligari] had liaised with Ms Kay Buck, Larsen Burgoyne, and we also had Mr Blanket's uncle … interacting with him. We wouldn't tend to do that but, from a cultural sensitivity point of view, we understand the importance of relationships and family, so we made arrangements for Mr Blanket to have a visitation with his uncle, even whilst he was in a safe cell.
>
> …
>
> I do have a memory of, as I said, Michael Saligari trying to co-ordinate some support to him and there had been talk about a smoking ceremony. There had been talk about all sorts of things but, from my recollection, Mr Blanket wasn't particularly interested in it at the time.

231 Deputy Commissioner Andrew Beck, the officer responsible for Offender Services at the Department, accepted that the Support Plan for First Nations prisoners as set out in the ARMS Manual that existed in 2019 was "*wholly insufficient*" from "*a cultural perspective*".[235]

232 As to Dr Bilyk's efforts to ensure her treatment was culturally appropriate, she takes a very different approach when treating a First Nations patient. When asked at the inquest what she does, Dr Bilyk replied:[236]

> Some of my best teachers have been Elders, who have taught me how to help them, First Nations Elders. They have certainly told me the importance of

[231] ts 27.7.22 (Mr Saligari), p.192
[232] Exhibit 1, Volume 2, Tab 20, PRAG Minutes dated 18 July 2019, p.1
[233] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.58
[234] ts 12.02.22 (Ms Francis), p.295
[235] ts 16.12.22 (Deputy Commissioner Beck), p.561
[236] ts 14.12.22 (Dr Bilyk), pp.344-345

> yarning and listening. So, where I might be little bit more direct and ask lots of questions, it's really important to allow space and time … for a First Nations person to tell their story, and that takes time. And so where I might normally go through the list and ask lots and lots of questions, I have to respectfully sometimes hold back and wait and listen to the story as it's ready to unfold, because I think that is really important. … I don't always have the luxury of a long time to yarn or to listen, but I make every effort, certainly the situation insists on that. And where I might not normally involve other prisoners, but if there is family and they really want to have some input, or there is peer support if it's available or if there is some other involvement – cultural involvement, that would be part of that process.
>
> Ideally you would have cultural Aboriginal health support for that person, ideally, because the stigma of mental illness is a challenge, and just facilitating that engagement. They're the two key issues that are difficult to overcome sometimes on my own, you know, and that is where cultural support is important. So, I am aware of those things. I'm also aware of cultural history and intergenerational trauma. That's an important part of the assessment. That's – trauma is always important in prison. It is important for every prisoner for their trauma history. But I'm aware of the broader intergenerational histories. So, yes, I guess time and building trust and rapport become – they're always important in any mental health assessments, but I can't get very far without that at all if I don't have any other cultural supports for a First Nations person.

233 In conclusion, I am satisfied that every effort was made, with the resources that were available, to offer Mr Blanket culturally appropriate treatment and care. It would appear on the evidence before me that what was offered to Mr Blanket was sometimes not accepted by him.

234 Thankfully, there have been changes made by the Department and Serco in the area of culturally appropriate treatment and care for prisoners who are First Nations. As Ms Francis said at the inquest regarding cultural support for these prisoners, what is available now is what could and should have been available back then.[237] These changes are considered later in my finding.[238]

The number of safe cells and fully ligature-minimised cells in Acacia.

235 There are three descriptions given to cells with respect to the capacity for them to be used for ligature points. A three-point ligature-minimised cell means that the most obvious points (lights, windows and shelving) have been removed. Cells classified as being fully ligature-minimised are cells where all obvious ligature points including furniture, fixtures within the cell and plumbing are removed.[239] A safe cell is an operational term used to describe a fully ligature-minimised cell with CCTV cameras

[237] ts 14.12.22 (Ms Francis), p.266
[238] see: "*Culturally appropriate treatments*"
[239] Exhibit 1, Volume 3, Tab 1.1, Report of Jason Parker dated July 2022, p.2

installed.[240] At the time of Mr Blanket's death, Acacia had six safe cells (two in the medical centre and four in the detention unit).[241]

236 It was grossly inadequate that there were only six safe cells out of 1059 cells at Acacia. I am not alone in expressing that view as Ms Francis agreed it was "*woefully inadequate*".[242] When it is noted that four of those cells are in the detention unit, this inadequacy is simply magnified. A detention unit is designed to house misbehaving prisoners. By its very purpose and description, it is not the therapeutic environment needed for a prisoner with mental health issues and who is at a high risk of self-harm or suicide. I can fully understand why Mr Blanket did not like being housed in the detention unit when he was on ARMS. That just leaves two cells at Acacia (the observation cells at the medical centre) which I regard as appropriate cells to house prisoners deemed to be at high risk of self-harm or suicide.

237 The risk management plan in place for Mr Blanket on the day of his death was effective as his elevated risk of suicide was actually identified. However, there was a significant failing with respect to the infrastructure at Acacia as it did not have a safe cell available for him to be promptly moved into. That delay proved critical as it gave Mr Blanket the opportunity to implement the plan he had made eight weeks earlier to end his life. I am therefore satisfied, to the required standard, that the lack of an appropriate number of suitable safe cells at Acacia was a contributing factor in Mr Blanket's death. I therefore make that finding.

238 It was alarming to discover that Foxtrot Block, a unit to house vulnerable prisoners, had no safe cells. As Mr Saligari testified, it is almost like a medical unit with a lower number of prisoners than other cell blocks, who require a lot more time and care, and access to more support than the general prisoner cohort.[243]

239 I am firmly of the view that there was considerable merit in the following recommendation made by Serco's Post Incident Review:[244]

> It is recommended that consideration is given to converting (minimum of two) cells in F Block (PSC) to (ligature-free) observation cells, thereby significantly increasing the Centre's capacity and minimising the use of the detention unit for that purpose.

240 However, the Court was advised that there had been no changes to Foxtrot Block's infrastructure.[245] This was despite an apparent submission having

[240] ts 15.12.22 (Mr Daniels), p.403
[241] ts 27.7.22 (Ms Francis), p.216
[242] ts 27.7.22 (Ms Francis), p.216
[243] ts 27.7.22 (Mr Saligari), p.65
[244] Exhibit 1, Volume 2, Tab 32, Serco-Post Incident Review dated 24 August 2019, p.65
[245] ts 15.12.22 (Mr Benson) p.419

been made to the Department by Serco on or about 31 July 2020 regarding the above recommendation.[246] I say "apparent" as the Department has not been able to find any information received from Serco on or about 31 July 2020 regarding this submission.[247] Nor, for that matter, has Serco; although it supplied an Acacia Action List that indicated the safe cell recommendation from the Post Incident Review was discussed with the Department on 27 August 2020.[248] Notwithstanding the passage of nearly three years since that discussion, as of 14 July 2023, "*the safe cell review is ongoing*".[249]

241 The lack of priority given to the very sensible recommendation for the installation of a minimum of two safe cells in Foxtrot Block (a recommendation which was made four years ago) is extremely disappointing.

242 Just as alarming is the statistic provided at the inquest that of the 1059 cells at Acacia, only 290 (27.4%) are fully ligature-minimised.[250] The Court was informed that there could be as many as 30 possible ligature points in a cell at Acacia.[251] With that concerning figure in mind, I asked Andrew Daniels, the Director of Infrastructure Services at the Department, these questions at the inquest:[252]

> So, if a 1059 cell prison was built today, how many of cells would be fully ligature-minimised? - - - We would do all of them.
>
> Yes, you see, so there's the problem. We've got antiquated prisons that are not up to the standards that would be expected regarding ligature-minimised cells if a prison was built today? - - - Yes, I agree.
>
> And it's just a matter of costs as to why prisons today are not fully ligature-minimised? - - - Yes, so if you gave us a number – X number of million dollars, we would do as many as you like.
>
> It's not very satisfactory, is it? - - - I can only answer to what we are funded to do.
>
> Yes, I appreciate that, but with those sorts of statistics,[253] it's not very satisfactory, is it? - - - Not from that perspective, no.
>
> And unfortunately, Mr Daniels, a good part of the Coroners Court work is examining deaths in custody that are by suicide, and in my personal experience, it has all been by hanging? - - - Yes.

[246] Exhibit 1, Volume 3, Tab 6.2, Serco Justice (PIR) Tracker - Recommendations;
[247] Email from Karess Dias to counsel assisting dated 9 March 2023
[248] Email from Diviij Vijayakumar to counsel assisting dated 14 July 2023 and attachment, p.4
[249] Email from Diviij Vijayakumar to counsel assisting dated 14 July 2023
[250] ts 15.12.22 (Mr Daniels), p.407
[251] Exhibit 1, Volume 3, Tab 1.1, Report from Jason Parker dated July 2022, p.2
[252] ts 15.12.22 (Mr Daniels), p.407
[253] That only 290 of the 1059 cells at Acacia are fully ligature-minimised.

243 With respect to Mr Blanket's use of his cell door, Mr Daniels explained, that whilst parts of a cell door such as the hatch and the locks can be ligature-minimised, there is no way to prevent the use of the door as a ligature point in the manner Mr Blanket did.[254] As Jason Parker, a Project Manager at the Department, explained in his report to the Court:[255]

> However, door frames are not ligature-minimised as you cannot ligature minimise how a door closes on a frame. Doors are designed to function and allow a secure entry and exit to a cell or space. Currently, there are no known options to ligature minimise the opening and closing of a door without compromising functionality and cell security.

244 Mr Blanket was just one of a significant number of prisoners with mental health conditions that are characterised by an inability to regulate emotions and a tendency to act impulsively. The risk of self-harm and suicide in this cohort is therefore increased. It is a well-reported fact that hanging is a method frequently used by prisoners to end their lives. This highlights the critical importance of strategies to deal with opportunistic suicide by hanging.

245 With only 27.4% of its cells fully ligature-minimised, the situation at Acacia should be a matter of grave concern. However, as of September 2022, a mere 3.9% of cells at Hakea had been fully ligature-minimised.[256]

246 I suspect that the far higher percentage at Acacia is due to the building of two units in 2015 to accommodate 387 new beds as all the cells in these units were built to be fully ligature-minimised.[257] Nevertheless, the percentage of fully ligature-minimised cells at Acacia remains far too low.

247 The words used by Coroner Jenkin in last year's ***Inquest into the death of Wayne Thomas Larder*** [2022] WACOR 48 to describe the parlous state of affairs at Hakea regarding ligature-minimised cells should still be ringing in the Department's ears. I accept that the anchor point for the ligature used by Mr Blanket cannot be eliminated. Nevertheless, I will add my own views regarding the large number of cells in medium and maximum security prisons in Western Australia that remain replete with ligature points that can be removed with relatively minor modifications:

The situation regarding the unacceptable proportion of prison cells with a high number of ligature points remains an acute crisis; a crisis that this Court has now been pointing out for over 20 years. The Court will undoubtedly continue to encounter deaths in prisons from hangings in cells that use these ligature points. All too frequently, these deaths involve First Nations young men and leave behind

[254] ts 15.12.22 (Mr Daniels), pp.404-405
[255] Exhibit 1, Volume 3, Tab 1.1, Report of Mr Jason Parker dated July 2022, p.3
[256] ***Inquest into the death of Wayne Thomas Larder*** [2022] WACOR 48, p.37
[257] Exhibit 1, Volume 3, Tab 1, Report of Jason Parker dated July 2022

devastated mothers, fathers, partners, children and extended family members asking: "*How was this allowed to happen?*"

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MR BLANKET AT ACACIA

248 After careful consideration of the documentary evidence and closing submissions from the interested parties at the inquest, and having heard the oral evidence of the inquest's witnesses, I am satisfied that the standard of the supervision, treatment, and care of Mr Blanket at Acacia with respect to his mental health issues was appropriate, with two exceptions. Regrettably, one of those exceptions was a significant one that contributed to Mr Blanket to taking his life.

249 The other shortcoming that I identified did not have such a significant outcome. That was the failure to provide all relevant information relating to Mr Blanket's health and safety to his mental health service providers at Acacia. The outcome of that failure was that the assessment and treatment of Mr Blanket's mental health conditions by Dr Bilyk and the MHT were not undertaken in a more timely manner.

250 As to the more serious shortcoming, I make the following general observations. Suicide is extremely unpredictable. It is rare and it is impossible to predict rare events with any certainty. In 2017, the Department of Health published a document titled *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document).[258] Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable.

251 The Document points out that clinicians faced with the onerous task of assessing a person who may be suicidal will confront two issues. First, suicide is a rare event and second, there is no set of risk factors that can accurately predict suicide in an individual. The Document explains that the use of risk assessment tools which contain checklists of characteristics have not always been found to be very effective:[259]

> The widespread belief within the community that suicide is able to be accurately predicted, has led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However, the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicides.

[258] https://www.health.wa.gov.au/~/media/Files/Corporate/general%20health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf
[259] https://www.health.wa.gov.au/~/media/Files/Corporate/general%20health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf , p.3

252 Notwithstanding the above, the risk management plans in place for Mr Blanket at Acacia were very effective and he was appropriately placed in safe cells on several occasions. His risk management plan in place on 12 June 2029 was, at least to begin with, "*rigorously applied*". One risk factor that had been identified in this risk management plan was any observation of Mr Blanket in a distressed state. When Mr Blanket's distressed appearance was noted by a prison officer on the morning of 12 June 2019, the risk management plan was implemented in a prompt manner, with measures taken to move him to a safe cell. However, this commendable foresight was then seriously undermined by the failure to properly monitor Mr Blanket when there was an unexpected delay in transferring him to a safe cell.

253 I have found that this delay was caused by the inadequate number of safe cells at Acacia. This inadequacy and the failure to properly monitor Mr Blanket when he was alone in his cell were contributory factors in his death. These factors blighted what was otherwise an appropriate, and at times very high, standard of supervision, treatment and care that had been provided to Mr Blanket.

CHANGES AND IMPROVEMENTS SINCE MR BLANKET'S DEATH

254 As would be expected of all organisations and governmental departments, Serco and the Department are always on pathways of continual improvement with respect to the operations of prisons.

255 There is frequently a gap of some duration between the date of the death requiring a mandatory inquest and the date of the inquest. In those circumstances, the entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

256 In this case, there have already been changes made by Serco and the Department since Mr Blanket's death that are designed to reduce the risk of the missed opportunities that were identified at the inquest from occurring again.

Changes at PRAG

257 It is now customary to have unit managers attending PRAG meetings at Acacia rather than a prison officer attached to the unit.[260]

258 Another beneficial change has been the attendance at PRAG meetings of members of the senior management team at Acacia. One of these members acts as a cultural adviser for PRAG.[261] The other benefits from this

[260] ts 15.12.22 (Mr Benson), p.426
[261] ts 27.7.22 (Ms Francis), p.223

involvement of senior management are that it provides oversight, and it can be a means of resolving any conflict between individuals regarding recommendations to be made by PRAG.[262]

259 Another improvement made at Acacia involved the manner in which PRAG operates within the prison system. This was achieved by making the Safer Custody Coordinator an operational officer. As explained by Ms Francis:[263]

> Difficulties experienced at the time of the incident [involving Mr Blanket on 12 June 2019] was centred around my role not being an operational role. As a non-custodial staff member, I did not have the authority to arrange for a prisoner to be moved and had to convey the need and urgency to custodial staff members. In turn, they expected a justification of my recommendation which took time. This has since been changed with the role becoming operational a year also after this incident.

260 This change now means that the Safer Custody Coordinator can arrange for a prisoner on ARMS to be moved without making a request of a unit manager and leaving it to that person to arrange the move.

261 PRAG members at Acacia are now also able to listen to telephone conversations that prisoners on ARMS are having on the PTS.[264] This option was not available in 2019 which meant the PTS call that Mr Blanket had with his mother on 15 March 2019 was not discussed at any PRAG meeting.[265]

262 There has also been an improvement in the way minutes from PRAG meetings at Acacia are recorded. In 2019, there were handwritten notes taken by someone at the meeting which were typed up about an hour after the meeting. After Mr Blanket's death, a change to introduce "live minutes" were made. This meant that:[266]

> … all attendees could see and agree to what was been recorded prior to the meeting ending and prior to the chair accepting the minutes on the system. This way, there could be no doubt as to what actions should be taken and by whom as recorded in the recommendations.

Culturally appropriate treatments

263 In Western Australia, First Nations people are imprisoned at a very high rate. In 2018, they comprised of 39% of the adult prisoner population, and their rate of imprisonment was more than 16 times the non-Indigenous rate.[267] I expect these disturbing statistics have not markedly changed

[262] ts 15.12.22 (Mr Daniels), pp. 426 - 427
[263] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.22
[264] ts 27.7.22 (Ms Francis), p. 232
[265] ts 27.7.22 (Ms Francis), pp.231-232
[266] Exhibit 1, Volume 2, Tab 49.1, Statement of Anna Francis dated 2 June 2022, p.23
[267] Exhibit 1, Volume 3, Tab 7.2, Review of Mental Health Service Provision, p.7

since then. Although First Nations prisoners have a similarly high rate of mental disorders as non-Indigenous prisoners, they are less likely to have been previously assessed by mental health services.[268] It is almost trite to say the following:[269]

> The over-representation of Aboriginal people in custody necessitates that the design and delivery of services must include approaches that are culturally safe, competent, and respectful and acknowledge the importance of the relationship to family, community and Country.

264 Unfortunately, what existed in 2019 at Acacia regarding culturally appropriate treatment for First Nations prisoners at high risk of self-harm and suicide fell well short of an acceptable standard. As Ms Francis conceded at the inquest, "*it was definitely an area that required work to get it up to the level it should have been at*".[270] She added that the options for PRAG, "*were quite limited as to what we could do about those cultural concerns*".[271]

265 The inquest heard that some changes have been made at Acacia in this important area since Mr Blanket's death.

266 Serco now employs Indigenous Liaison Officers at Acacia who provide cultural advice and support for PRAG.[272] These officers are required to respect First Nations cultural connections and contemporary beliefs, and have a cultural association and/or knowledge and understanding of First Nations people and communities in Western Australia.[273]

267 More external service providers are now invited to provide information to PRAG about a prisoner who is on ARMS, including the identification of any cultural issues that the prisoner might be facing.[274]

268 Another development since 2019 has been the creation of the Aboriginal Visitors Scheme (AVS). AVS staff are Department employees who work solely with the First Nations prison population. AVS provides supports and counselling for First Nations prisoners throughout Western Australia. The relevant website from the Department states:[275]

> AVS provides culturally appropriate support and works as part of a multidisciplinary team to prevent instances of suicides and self-harm amongst Aboriginal people in adult prisons and the youth detention facility. AVS

[268] Exhibit 1, Volume 3, Tab 7.2, Review of Mental Health Service Provision, p.7
[269] Exhibit 1, Volume 3, Tab 7.2, Review of Mental Health Service Provision, p.7
[270] ts 27.7.22 (Ms Francis), p.221
[271] ts 27.7.22 (Ms Francis), p.221
[272] ts 27.7.22 (Ms Francis), pp.222-223
[273] https://careers.serco.com/ASPAC/jobs/Indigenous-Liaison-Officer-Acacia-Prison/772576902/
[274] ts 27.7.22 (Ms Francis), p.223
[275] https://www.wa.gov.au/organisation/department-justice/corrective-services-aboriginal-visitors

promotes a culture of resilience and healing and helps prisoners and detainees connect with their culture and community.

269 AVS also assists the families of First Nations prisoners to visit their relatives who are in custody.[276] Ms Francis described the support offered by the AVS to PRAG as "*really valuable*".[277]

270 Unfortunately, the AVS ceased at Acacia in April 2022, when the AVS visitor resigned. As at May 2023, there was only an after-hours AVS service available to First Nations prisoners at Acacia. The Department has maintained that the filling of AVS positions across all prisons in Western Australia remains a priority.[278]

271 Derbarl Yerrigan Health Service is a First Nations operated community health organisation that provides culturally secure primary health and mental health care to First Nations people living in the Perth metropolitan region. It was established in 1974 and has gained an excellent reputation for the services it provides.[279]

272 At the time of the inquest, Derbarl Yerrigan Health Services had an agreement with Acacia which involves one of their health service providers attending Acacia once a month to engage with First Nations prisoners who are about to be released. The aim is to have First Nations prisoners continue their involvement with a health service provider after their release from prison.[280]

273 The next step for Acacia is to have a First Nations healthcare worker from the community working in the medical centre twice a week. As outlined by Ms Stewart at the inquest, it is hoped that this will provide a type of "walk-in clinic" so that prisoners will be willing to speak to the healthcare worker, who will then be able to relay relevant information to the health service providers at Acacia (including the MHT) so that any issues that are raised can be addressed.[281] At the time she gave evidence, Ms Stewart indicated that a First Nations healthcare worker had indicated an interest in performing this role.[282]

274 It is my fervent hope that this plan has come to fruition. The presence of a First Nations healthcare worker at Acacia's medical centre would go a long way to breaking down the barriers that can exist between non-Indigenous health service providers and First Nations prisoners.

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[276] https://www.wa.gov.au/organisation/department-justice/corrective-services-aboriginal-visitors
[277] ts 14.12.22 (Ms Francis), p.266
[278] ***Inquest into the death of Stanley John Inman*** [2023] WACOR 21, pp.34-35
[279] https://www.dyhs.org.au
[280] ts 15.12.22 (Ms Stewart), p.456
[281] ts 15.12.22 (Ms Stewart), p.472
[282] ts 15.12.22 (Ms Stewart), p.472

275 Although Acacia has been able to employ more First Nations prison officers since 2019, there has not been a successful recruitment of a psychologist or social worker who identifies as First Nations.[283] I am aware that there have been, and no doubt will continue to be, concerted efforts across all prisons in Western Australia to recruit health services providers who identify as First Nations. The sad fact is that it has been a difficult exercise to fill many of these positions from the general population, let alone from the much smaller number of those who are First Nations.

Mental health service providers

276 As has been outlined above, there was a lack of information that was passed from PWS and PRAG to Dr Bilyk regarding Mr Blanket's health and safety. Ms Stewart acknowledged at the inquest that this created "*gaps in what we're trying to deliver*".[284] She then went on to explain that from 2023, as a result of what happened in Mr Blanket's case, "*we are now going to align the two services together where PWS now sits under our mental health services*".[285] Ms Stewart anticipated that this would lead to a better standard of care for prisoners as it is expected communications will improve.

277 This alignment had already been introduced in 2018 at prisons operated by the Department.[286]

278 Another improvement outlined by Ms Stewart at Acacia is that the MHT will document all patient care within the EcHO medical records. As the PWS now also has access to EcHO, this will mean there is, "*once source of truth, all documentation will be in the one medical, I suppose, file and not two separate documents*."[287]

279 I hope these changes will see a reduction in the silo effect which had undermined the timeliness of the mental health assessment and care that was provided to Mr Blanket.

280 Dr Joy Rowland, Director of Medical Services at the Department, described a new innovation by the Department's Psychological Health Service that involved the introduction of a comprehensive suicide risk assessment form in EcHO.[288] In her outline of what is contained in the several pages of the form, Dr Rowland stated:[289]

[283] ts 27.7.22 (Ms Stewart), p. 233
[284] ts 15.12.22 (Ms Stewart), p.443
[285] ts 15.12.22 (Ms Stewart), p.443
[286] Exbibit 1, Volume 3, Tab 7.2, Review of Mental Health Service Provision 2019, p.7; ts 16.12.22 (Dr Rowland), p.501
[287] ts 15.12.22 (Ms Stewart), p.443
[288] ts 16.12.22 (Dr Rowland), p.499
[289] ts 16.12.22 (Dr Rowland), p.500

> It includes information-gathering regarding past background history and risk, so underlying risk, and it includes history regarding previous thoughts of self-harm, previous attempts, how serious those attempts have been, how persistent those thoughts have been, how detailed their plans have become, if they've tried [suicide], … how bad was that attempt in terms of how close to success have they been in the past, etcetera, and some of the details.
>
> And it includes their current status, so their current level of stress and how that compares to the past and includes protective factors and what would be required or what works for them in terms of managing that level of stress and what are the flags for them that they're deteriorating. So, it is fairly comprehensive. It is not a five-minute assessment. Depending on experience and your background knowledge of a person, that may take quite some time to do thoroughly, or it might be quite quick to review. So, the form will pre-populate with prior information.

281 As at the time Dr Rowland gave her evidence,[290] this suicide risk assessment form had been used for about a month and that it, "*will continue to improve as feedback comes from staff*".[291]

282 I commend the Department for this initiative. With a wider cohort of prison health service providers having access to EcHO, this suicide risk assessment form will provide important information to those providers.

Creation of the Suicide Prevention Taskforce and re-establishing of the Suicide Prevention Governance Unit

283 It was disturbing to find out that the unit responsible for suicide prevention governance in prisons had been abolished in 2017. This meant that no entity had been leading suicide prevention governance in the Department since 2017 until the end of 2022.[292]

284 On 18 August 2020, a media statement by the then Minister for Corrective Services stated that the Department had been instructed, "*to establish a suicide prevention task force to examine the management of at-risk prisoners.*"[293]

285 On 3 September 2020, the Suicide Prevention Taskforce was established to examine the management of at-risk prisoners. On 20 January 2021, its role became strategic, and it was renamed the Suicide Prevention Steering Committee (the steering committee).[294]

286 Professor Neil Morgan (an ex-Inspector of the Office of Custodial Services) was contracted by the steering committee to undertake a review

[290] 16 December 2022
[291] ts 16.12.22 (Dr Rowland), p. 499
[292] Exhibit 1, Volume 3, Tab 8, Letter from Deputy Commissioner Andrew Beck dated 8 October 2022
[293] Exhibit 1, Volume 3, Tab 7.1, Letter from Deputy Commissioner David Brampton dated 26 July 2022, p.2
[294] Exhibit 1, Volume 3, Tab 7.1, Letter from Deputy Commissioner David Brampton dated 26 July 2022, p.2

and analysis of the ARMS, SAMS and PRAG processes undertaken at all prisons.[295]

287 A project working group was then established in June 2021 which was to provide oversight of the suicide prevention project and corresponding initiatives, including the implementation of Professor Morgan's findings.[296]

288 In 2022, Deputy Commissioner Beck had recognised that the Office of the Inspector of Custodial Services and the Coroners Court had indicated the need for overarching oversight and support in relation to suicide prevention governance and had advocated the re-establishing of a suicide prevention and governance unit.[297] At Deputy Commissioner Beck's recommendation, a decision was made to re-establish the Suicide Prevention Governance Unit (SPGU). Temporary vacancies and funding were made available as an interim measure to facilitate the establishment of the SPGU over the first six months of 2023.[298] The function of the SPGU is to ensure that the integration of the three essential components of suicide prevention in prisons takes place, namely: [299]

1. clinical insight into risk behaviours and thereby effective strategies to mitigate risk;
2. operational knowledge of implementing any suicide prevention policy; and
3. First Nations cultural understanding of risk so as to benefit the largest vulnerable prisoner cohort.

289 The SPGU has oversight of the project working group, "*to ensure that the objectives which they have got to deliver against are being tracked and monitored appropriately*".[300]

290 At the inquest, Deputy Commissioner Beck outlined a number of improvements in the Department's endeavours to prevent self-harm and suicide in prisons.

291 One improvement had been with respect to the Gatekeeper training for prison officers. This training is a two-day workshop designed by the Mental Health Commission for workers in the human services whose roles bring them into regular contact with people at risk of suicide. The training aims to increase knowledge and understanding of suicidal behaviour in order to increase a worker's capacity to respond effectively.[301] This

[295] Exhibit 1, Volume 3, Tab 7.3 Briefing on Reviews of At-Risk Management in WA Custodial Facilities dated 20 May 2021
[296] Exhibit 1, Volume 3, Tab 7.1, Letter from Deputy Commissioner David Brampton dated 26 July 2022, p.3
[297] Exhibit 1, Volume 3, Tab 8, Letter from Deputy Commissioner Andrew Beck dated 8 October 2022, p.3
[298] Email form Karess Dias to counsel assisting dated 9 March 2023 with attachment
[299] Exhibit 1, Volume 3, Tab 8, Letter from Deputy Commissioner Andrew Beck dated 8 October 2022, p.4
[300] ts 16.12.22 (Deputy Commissioner Beck), p.556
[301] https://www.mhc.wa.gov.au/training--events/gatekeeper-suicide-prevention-training/

training was only being delivered to new entry prison officers when they went through their initial training and there was no refresher training element to it.[302] Previously, Gatekeeper training had not been specific for a custodial environment.

292 The Department has now worked with the Mental Health Commission to adapt the Gatekeeper training to make it more appropriate for a custodial environment. It is also intended that it be given as a refresher training for prison officers on a regular basis.[303]

293 Whilst the above redesign of the Gatekeeper training was taking place, the Department worked with Lifeline to develop specific training regarding the risk of self-harm and suicide for implementation in the custodial environment. At the time of the inquest, this had been delivered to about 300 people across the prison system which included prison officers, Peer Support Officers and Peer Support Prisoners.[304]

294 Arising from Professor Morgan's recommendations from his review in 2021, changes have been made to the ARMS Manual which has led to the development of a system with four levels of risk rather than three. The benefit of having four levels is that there is more flexibility in how an individual prisoner is managed, and it allows for more tailored responses.[305] At the time he gave his evidence, Deputy Commissioner Beck said a trial of this system had been successful in two prisons and the "*aim now is to role that out into the mainstream of all prisons*".[306]

295 In his evidence at the inquest, Deputy Commissioner Beck said that he agreed with all the observations made by Professor Morgan in his review regarding the revising of ARMS and SAMS.[307] Amongst a number of observations, Professor Morgan noted that the ARMS and SAMS Manuals were "*outdated and not user-friendly*".[308] Deputy Commissioner Beck envisaged that there would be a chapter within the revised ARMS Manual that will articulate the cultural aspect of risk management and he expects it will have far more detail than what existed in the ARMS Manual when Mr Blanket was imprisoned.[309]

296 Deputy Commissioner Beck was also aware of a draft Aboriginal Suicide Prevention Framework that has been developed. He explained that there will be a broader consultation and engagement with more First Nations

[302] ts 16.12.22 (Deputy Commissioner Beck), p.543
[303] ts 16.12.22 (Deputy Commissioner Beck), p.544
[304] ts 16.12.22 (Deputy Commissioner Beck), p.545
[305] ts 16.12.22 (Deputy Commissioner Beck), p.546
[306] ts 16.12.22 (Deputy Commissioner Beck), p.546
[307] ts 16.12.22 (Deputy Commissioner Beck), p.557
[308] Exhibit 1, Volume 3, Tab 7.3, Briefing on Reviews of At-Risk Management in WA Custodial Facilities dated 20 May 2021
[309] ts 16.12.22 (Deputy Commissioner Beck), p.561

people with respect to that document. He stressed that First Nations people need to be the authors of the document and that it "*needs to be owned*" by those people.[310] I note that these sentiments follow ex-Social Justice Commissioner Mick Gooda's sage advice that with respect to First Nations people, decision makers ought, "*work with us, not for us*".

297 I was impressed by what I heard from Deputy Commissioner Beck. He struck me as a person who is passionate about reducing the number of suicides by prisoners, especially those who are First Nations. Through their counsel at the inquest, Mr Blanket's family also expressed their appreciation of Deputy Commissioner Beck's efforts.[311] I share the same views as the family of Mr Blanket, and I am grateful that there are people like Deputy Commissioner Beck who are dedicated in their endeavours to reduce the risk of suicide amongst prisoners.

298 I am satisfied that there have been improvements to the treatment and care of prisoners with mental health issues in Acacia and the wider prison system in the four years since Mr Blanket's death. With respect to the care and treatment of First Nations prisoners, there is now a greater recognition of the important role that culturally appropriate care and treatment plays. Although what is presently in place is far from perfect, I expect that through the oversight of the SPGU, measures will continue to be introduced that addresses a number of the problems that Professor Pat Dudgeon identified in her report to the Court.[312]

PROPOSED RECOMMENDATIONS

Suggested recommendations provided by the family's legal representatives

299 I express my thanks to the suggested recommendations provided on behalf of Mr Blanket's family. A number of those recommendation have formed the basis for recommendations I have made in this finding. Others I have not adopted as I am satisfied with the progress that has already been made by the Department and Serco in those areas. There are also some that I know are wholeheartedly supported by the Department and Serco yet cannot be implemented despite their best endeavours.[313]

1: Installation of a therapeutic care unit at Acacia to treat mentally unwell and high risk prisoners

300 Having heard the evidence at the inquest, I have reached a firm view that a prison the size of Acacia requires a therapeutic care unit that can be used

[310] ts 16.12.22 (Deputy Commissioner Beck), p.553
[311] ts 16.12.22 (Mr Penglis SC), p.554
[312] Exhibit 3.1, Report of Professor Pat Dudgeon dated 13 December 2022
[313] For example: (i) all prison medical, health and social welfare service providers should employ First Nations staff in proportion to the First Nations population of the relevant prison and (ii) First Nations prisoners must have access to an First Nations health or support worker

to treat mentally unwell prisoners (including those who are deemed to be at high risk of self-harm or suicide) who do not meet the criteria for an involuntary admission to an authorised hospital under the *Mental Health Act 2014* (WA). At the inquest, such a facility was referred to as a crisis care unit which was the description given to the very first unit of this type in Western Australia that was opened at Casuarina in April 1999. However, I will use the more generic description of "therapeutic care unit".

301 At its highest, the situation facing Acacia staff trying to keep Mr Blanket safe and in a conducive environment when he was at an elevated risk of self-harm was dire. Sadly, Acacia does not stand alone amongst prisons facing the predicament of attempting to provide care for mentally unwell prisoners who are housed in non-therapeutic cells that are contained within an inappropriate setting. Following his suicide attempt on 22 April 2019, even Mr Blanket pleaded with Acacia staff to be placed in a "*mental ward*".[314]

302 Unsurprisingly, there was universal agreement from witnesses at the inquest that the present set-up at Acacia was inadequate and that a therapeutic care unit was desperately needed.

303 After pointing out the insufficient number of safe cells at Acacia, Dr Bilyk stated:[315]

> I've been open about this at various forums. A larger area or a critical care unit that allows people who aren't travelling well, who need a lot more focused mental health input or observations, who could actually stay in that environment and even receive active treatment and improve and get better in that environment. I have had that experience at other prisons.
>
> …
>
> I'm specifically referring to Casuarina Prison that has a critical care unit, where in the past when I have work there I have acutely floridly psychotic people who have been housed there, managed by the custodial [staff], seen by mental health staff, and seen by myself and treated and got better without needing referral under the *Mental Health Act*, if they are agree. If they didn't, they would be referred to the Frankland Centre.

304 Dr Bilyk outlined the difficulties with treating a mentally unwell prisoner in one of the safe cells at Acacia:[316]

> … if we have prisoners who go into acute psychosis, it's very challenging managing them in a segregation cell where they have no ability to also go out and have some free space. If they're really, really unwell, then they may not be able to anyway, and they would likely be waiting for a bed at the Frankland

[314] Exhibit 1, Volume 1, Tab 37.3, ARMS – Offender Referral
[315] ts 14.12.22 (Dr Bilyk), p.342
[316] ts 14.12.22 (Dr Bilyk), p.343

> Centre. But sometimes that can be a very long wait, weeks to months. But there's a middle group where if they're unwell but we're able to engage them, they have got some space to roam and have a cigarette, make a phone call, have a cup of tea. Even if they're considered higher risk, they can be … separated … from the other prisoners [in the general population] and have access to an open area while been safely held also in that cell.
>
> Segregation in itself in a cell with no access to space in itself is a highly stressful situation, and it's not ideal for someone with an acute mental illness. I mean, ideally if someone is unwell, we could get them into a hospital, but the hospital scenario is so dire at the moment. That's well recognised.
>
> …
>
> And I would have to say in my experience I have most of the time been able to treat people, even in a prison setting, and they can improve and get better. But to do it in a detention unit where they're in that cell, for instance down in Acacia or even in the medical unit, it's a single cell and there's occasionally a little bit of outside space but it's not therapeutic at all. Prison will always struggle to be therapeutic, but [it] can be more therapeutic than that. And the reality is we can't treat them all in hospital.

305 Dr Rowland stated that a vast majority of prisoners have a high-trauma history.[317] The prison health system now operates under what Dr Rowland described as a "*trauma-informed banner*".[318] And an integral part of that concept within a prison setting involves buildings or spaces that are therapeutic and less traumatising. However, as Dr Rowland pointed out, "*that's not how prisons were originally built*".[319]

306 Professor Morgan, a person highly qualified to provide input into custodial services, has also stated that "*additional therapeutic infrastructure*" is required at Acacia.[320]

307 At the inquest, Mr Daniels said that there were 16 prisons in Western Australia.[321] However, only two prisons housing male prisoners (Casuarina and Hakea) have crisis care units.[322] These units are staffed seven days a week by mental health service providers.[323] This means that Acacia is the largest prison in Western Australia (by prisoner population) without a dedicated unit for crisis mental health care.

308 The unit at Casuarina is nearly 25 years old and having visited that facility in 2023, I can attest to the fact it is showing its age.[324] The unit at Hakea

[317] ts 16.12.22 (Dr Rowland), p.504
[318] ts 16.12.22 (Dr Rowland), p.503
[319] ts 16.12.22 (Dr Rowland), p.503
[320] Exhibit 1, Volume 3, Tab 7.3, Briefing on Reviews of At-Risk Management WA Custodial Facilities
[321] ts 15.12.22 (Mr Daniels), p.406
[322] At the time of the inquest, the Department was building a crisis care unit at the Banksia Hill Juvenile Detention Facility: ts 15.12.22 (Mr Daniels), p.398
[323] https://www.corectiveservices.wa.gov.au/rehabilitation-services/health-care
[324] However, there is currently funding to build a new mental health unit at Casuarina

has hardly had a ringing endorsement from the Office of the Inspector of Custodial Services. A report in 2022 stated:[325]

> Our expert's assessment of the Hakea Crisis Care Unit (CCU) was that it does not provide a therapeutic setting for mental health care, nor does it compare favourably to modern community standards for inpatient units. Accordingly, the CCU cannot be considered a therapeutic setting for prisoners with mental illness or those in significant distress.

309 Nevertheless, the facilities designed specifically for treating mentally unwell and high risk prisoners at Casuarina and Hakea far outweigh the non-existent facilities at Acacia. As Deputy Commissioner Beck acknowledged, the crisis care unit at Hakea created a much better environment to manage people who are at risk compared to what was available at Acacia.[326] He went on to add:[327]

> I would love to have a crisis care unit in every single prison with the relevant services, because it's not just about the infrastructure, it's about the services that you provide in the prison as well to put around those people. So absolutely, we would love to do that, at the end of the day we're constrained by resources that we're given by government.

310 From the evidence given at the inquest, it was apparent to me that Foxtrot Block is presently being used as a unit for vulnerable/mentally unwell prisoners. I am of the view that this setup does not meet the requirements of a purpose-built unit to house this cohort of prisoners. It may, however, provide a useful means for the transitioning of prisoners from a therapeutic care unit back into the mainstream prisoner population.

311 Mr Daniels stated the timeline for the building of a therapeutic care unit within a prison setting would be 18 months to two years.[328] He also said that the size of the prisoner population at Acacia would require a unit with 12-14 beds.[329] That was an answer to a question "without notice", and I suspect the unit would have to be larger than that.

312 At the inquest, Deputy Commissioner Beck made the point that mental health was not only a custodial issue but a community issue as well and there are services in the community to treat people with mental health issues.[330] That is undeniably true. However, it is also undeniably true that there are a disproportionate number of prisoners with mental health issues compared to the general community. The following statistics from 2015 and 2018 are telling:[331]

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[325] oic.wa.gov.au/wp-content/uploads/2022/05/Hakea-Overview-Final.pdf
[326] ts 16.12.22 (Deputy Commissioner Beck), p.548
[327] ts 16.12.22 (Deputy Commissioner Beck), pp.548-549
[328] ts 15.12.22 (Mr Daniels), p.399
[329] ts 15.12.22 (Mr Daniels), p.400
[330] ts 16.12.22 (Deputy Commissioner Beck), p550
[331] Exhibit 1, Volume 3, Tab 7.2, Review of Mental Health Service Provision, pp.5-6

- Two in five prisoners fulfilled the criteria of a diagnosis of mood disorder, anxiety disorder, PTSD and/or eating disorder.
- 24% of prisoners had attempted suicide sometime in their lives.
- 13% of prisoners had a lifetime diagnosis of a psychotic disorder such as schizophrenia, schizoaffective disorder, or organic psychotic disorder.
- 18% of prisoners had previously been inpatients in a psychiatric unit.
- 22% of prisoners have high or very high levels of psychological distress.
- 10% of prisoners reported their mental health had deteriorated during their time in prison.

313 I would expect these statistics would be very similar today. With those disturbing numbers in mind, I asked Deputy Commissioner Beck the following questions:[332]

> If there is a mentally ill prisoner inside a prison, it becomes the responsibility of the Department of Justice. That's obvious, isn't it? We've reached a crisis point, haven't we, with respect to being able to appropriately house mentally ill prisoners in a prison setting? --- Prisons are not designed to be mental health facilities.
>
> I know they hadn't been designed [that way] in the past, but now we've got to look to the future, and they need to be designed to enable that to happen. Would you agree with that? --- I would agree with that, yes.
>
> And you're right, it's not just a question of building the infrastructure. There has to be the staff to be present within that infrastructure to provide those services. And that's another issue in itself. It's a huge problem, but it's one that's going to have to be addressed, because otherwise we're just going to see more suicides in prison settings. Would I be right there? --- I think at the end of the day the issue around how mental health is managed within the community and within forensic services and prisons is a matter for government, and they need to understand what the issues are which we clearly articulate to government. They are the deciders in terms of how they allocate the resources, but absolutely, I agree it is a significant issue in terms of prisons' ability to manage people who are often acutely unwell.

314 The quote from John Oliver that I provided at the very beginning of this finding was referring to the poor state of mental health care in prisons in the United States. In my view, it has equal application to the state of affairs in prisons in Western Australia. If Deputy Commissioner Beck is correct (and I have no reason to doubt him) when he says that the problems providing effective mental health care within prisons have already been clearly articulated to government, that is deeply troubling as systemic problems still remain.

[332] ts 16.12.22 (Deputy Commissioner Beck), p.550

315 It would appear there is a lack of understanding regarding the value, to not only prisoners but also to the community, of providing well-resourced mental health care in prisons. Many crimes are committed that are linked to the mental health of offenders. Those mental health issues are often either undiagnosed or have been left untreated in the community. A prison environment may actually be better than the community for the treatment of a prisoner's undiagnosed or untreated mental health issues. That is because there is the time, opportunity and potential incentive for the prisoner to have them treated. The present situation was perfectly articulated by Dr Rowland, in another example of her typically perceptive observations that she so often provides at inquests:[333]

> I consider prison to be our social hospital, in a sense, only we don't resource it or manage it like a social hospital. So if we're trying to provide therapy to help someone's trajectory turn around and help them to reconnect to family, society, meaningful activity, occupation, etcetera, then we need to heal the trauma. And that's not the primary reason the prisons were built, but that would be a key, core aim, if we're able to heal the trauma. So trying to imbed trauma-informed principles in the way we deal with every individual is something we're quite strong to push in the health system because it underlies health, so critical to health.

316 Well-funded and properly resourced treatment and care of a prisoner's mental health should be recognised as an essential part of a prisoner's rehabilitation. If a mental health condition cannot be effectively treated because of insufficient resourcing when the prisoner is incarcerated, it is likely to remain untreated when that prisoner is eventually released into the community. And with that comes all the dangers of re-offending that existed before imprisonment began. And so the circle of a life of crime will continue.

317 It may be time for those responsible for the allocation of resources to prisons to pay heed to what Dr Bilyk, Dr Rowland and Deputy Commissioner Beck are saying. Otherwise, the present situation is only going to get much, much worse from the perspective of not only individual prisoners but the community at large.

2: Addressing the unfairness to prisoners who are not assessed for an IMP

318 As I have already noted above, a prisoner who is sentenced to a 12-month term of imprisonment or less, and is made eligible for parole, does not automatically have an assessment completed for an IMP. The outcome for a majority of these prisoners, at least when Mr Blanket was imprisoned, was that the prospect of being able to complete any treatment programs before the date they became eligible for parole was considerably diminished.

[333] ts 16.12.22 (Dr Rowland), p.504

319 This has particular ramifications for those prisoners who are imprisoned for offences that are considered to require rehabilitative treatment. Such offending includes those involving violence and/or those caused by alcohol or drug dependency. The successful completion of treatment programs that address these issues could be a critical factor in the Board's determination whether or not to grant parole. I note that Mr Blanket's offending fell into both of these categories.

320 I am firmly of the view that this issue must be addressed by the Department and Serco. A situation should not arise where a prisoner who is genuinely committed to rehabilitating themselves by completing treatment programs, is denied the opportunity of participating in those programs in a timely manner due to the length of the waitlists for those programs.

321 The situation that Mr Blanket faced did not measure up to the commitment made on Department's website page under the heading, ***Rehabilitation and Services: Corrective Services***: "*While the Department provides offenders the opportunity to take part in programs and interventions, it is ultimately up to the individual to change*".[334] What actually also needs to change is the length of the waitlists for many of the programs that are available for short-term prisoners.

3: Installation of additional safe cells at Acacia

322 I have already expressed my disappointment regarding the lack of action taken by the Department and Serco in response to the recommendation from Serco's Post Incident Review regarding this matter. Had there been additional safe cells already installed in Foxtrot Block when Mr Blanket was imprisoned, there was every prospect he could have been quickly placed in one of them on 12 June 2019.

4: Access to ARMS records by prison health service providers

323 I was concerned to hear Dr Bilyk's evidence at the inquest that she did not have access to ARMS file notes, such as those that were completed by Mr Saligari.[335] At the time of the inquest, I was of the view that if this situation still existed then it had to be addressed.

5: Support for prisoners receiving an adverse decision from the Prisoner Review Board

324 When Mr Blanket was advised of the Board's decision not to grant him parole, he reacted impulsively and drastically. He assaulted two other

[334] https://www.wa.gov.au/organisation/department-of-justice/corrective-services/rehabilitation-and-services-corrective-services
[335] ts 14.12.22 (Dr Bilyk), p.355

prisoners and attempted to hang himself. The benefit of hindsight is not required to have anticipated that Mr Blanket was likely to react in this manner, given his previous episodes of depression and self-harm, and his suspected emerging psychosis.

325 I accept that not all prisoners would react in this way upon being informed of such a decision from the Board. However, there will always be a cohort of prisoners (who are most likely to also have mental health concerns) for whom such a reaction is highly possible.

326 It is those prisoners that I believe would benefit from having psychological and/or counselling support arranged to be on standby when they are informed of an adverse decision from the Board. Preferably, this support should be from someone who has had previous dealings with the prisoner and who has established a rapport with them.

327 The inquest heard that the current practice is for the prisoner's unit manger to deliver the news to the prisoner that they have been denied parole. It is then up to the unit manager to perform a risk assessment if it is deemed necessary.[336] I have no issue with this procedure, provided the added safeguard is in place for the group of vulnerable prisoners that I have identified. As Toni Palmer, Senior Review Officer at the Department, stated at the inquest:[337]

> … this is just my personal opinion, I think that it's probably appropriate that the unit manager who has the most interaction with the person delivers the news but have somebody on, I guess, standby, should there be a requirement for some additional support.

6: Training for prison officers with respect to cultural and spiritual issues for First Nations prisoners

328 At the inquest, Ms Francis identified that prison officers had cultural awareness training, mental health training and suicide prevention training. However, she added that there was no First Nations specific training: [338]

> … to identify what is a cultural or spiritual crisis versus whatever mental health symptoms [exist] and I think the two can be confused. And I think the two can be quite closely linked and I think that would be really helpful for staff to get a better understanding of that.

329 If that is the present situation regarding the training of prison officers, then I am of the view that changes need to be made that incorporates further training in this important area.

[336] ts 27.7.22 (Ms Francis), p.234
[337] ts 16.12.22 (Mr Palmer), p.373
[338] ts 27.07.22 (Ms Francis), pp. 223-224

7: Prisoners attending PRAG meetings

330 At the inquest, Ms Francis referred to when she was a prison officer in the United Kingdom. She indicated that at the equivalent to PRAG meetings at prisons where she worked, prisoners were able to attend the meeting and "*speak for themselves*" at their case review.[339] They could also have a support person attending, if that was their preference.[340]

331 Ms Francis said that this concept worked well and that she had "*recommended so many times*" that it be introduced at Acacia.[341] One of the reasons given by Ms Francis as to why this concept had not been adopted was: [342]

> Some of it is around … quite an old-fashioned view, I think, that we as staff members are the decision-makers and we tell them. They won't tell us how to manage them. That's not really my viewpoint. I think the more valuable information would come from them to tell us, you know, what would help you.

332 Ms Francis is not alone in her support of this concept. In his review, Professor Morgan raised the question as to whether prisoners should be present for PRAG meetings, either in person or via video.[343]

333 On the condition that it was safe to do so, I saw the merit in a prisoner being invited to attend their case review at PRAG meetings, and also having the option of choosing a suitable support person to accompany them.

8: Access to mental health service providers when urgent contact is required

334 As outlined above, the situation arose on 12 June 2019 when no contact could be made with the PWS by Ms Andrews or Ms Francis. This was because the majority of the PWS staff were attending an off-site function.

335 That situation could have been avoided if Ms Francis, in her position as chairperson of PRAG, had access to the mobile telephone numbers of staff at PWS. Although I accept that neither the PWS (or any other section providing mental health services) operates as an emergency or crisis service, there may be occasions when an individual mental health service provider needs to be urgently contacted due to concerns regarding a prisoner's mental health.

[339] ts 27.12.22 (Ms Francis), p.224
[340] ts 27.12.22 (Ms Francis), p.225
[341] ts 27.12.22 (Ms Francis), p.224
[342] ts 27.12.22 (Ms Francis), p.224
[343] Exhibit 1, Volume 3, Tab 7.3, Briefing on Reviews of At-Risk Management in WA Custodial Facilities

9: The reviews by the Department of deaths in custody

336 Ms Palmer prepared the Department's Review for Mr Blanket's death. During her evidence at the inquest, Ms Palmer stated that she had accepted the conclusions that had been made in Serco's Post Incident Review.[344]

337 However, Ms Palmer agreed that her review did not make any reference to the Post Incident Review prepared by Serco. She further agreed that, upon reflection, a reader of her review would have been assisted by the inclusion of a paragraph or sentence that stated the Department agreed with the various observations and recommendations made by Serco in its Post Incident Review.[345] I agree with this reflection by Ms Palmer.

COMMENTS RELATING TO THE PROPOSED RECOMMENDATIONS

338 Nine draft recommendations were forwarded to the Department, Serco and Mr Blanket's family via their legal representative on 28 July 2023. Each recommendation related to the nine topics that appear above. The Department and Serco were invited to make submissions regarding the draft recommendations by 11 August 2023. The Department's response addressed all the draft recommendations. The response from Serco dealt with three of them.[346]

Therapeutic care unit

339 As to the installation of a therapeutic care unit at Acacia, the Department indicated it was "supported in principle"; making the obvious point that such a unit would require significant funding from Treasury.

340 The Department then noted the following:[347]

> Serco, however, is exploring plans for the development of an Enhanced Support Unit to provide targeted service delivery to the growing number of prisoners at Acacia requiring a specialised and ongoing mental health care. It is envisaged this unit would operate similar to a therapeutic community being coordinated by clinical staff and supported by custodial officers.

341 Curiously, Serco elected not to make any submissions with respect to this proposed recommendation. I certainly would have appreciated how far the plans for this unit had progressed. Instead, I simply make the observation the unit sounds very similar to how the current Foxtrot Block operates. If that is correct, then it would fall well short of what I have envisaged is

[344] ts 15.12.22 (Ms Palmer), p.369
[345] ts 15.12.22 (Ms Palmer), p.383
[346] Those three draft recommendations concerned prisoners attending PRAG meetings, access to the mobile telephone numbers of the prison's mental health service providers if urgent contact is required and psychological and counselling support to be on standby should a prisoner receive news that parole eligibility has been denied.
[347] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.2

necessary for Acacia to provide proper care and treatment to vulnerable prisoners.

342 I have therefore maintained my view that a purpose-built therapeutic care unit at Acacia is desperately required. Accordingly, I have made a recommendation that will hopefully set the wheels in motion for that to happen.

Prisoners who are not assessed for an IMP

343 As to the unfairness for prisoners who are not assessed for an IMP, thereby reducing their prospects for parole eligibility, the Department indicated support and said that it has already begun to address this anomaly.

344 The Department pointed out that there are several rehabilitation and reintegration services available for prisoners who are ineligible for IMPs. I have always known that is the case. However, the problem is the waitlists that have existed for such programs which effectively means that short-term prisoners often cannot access them before their date for parole eligibility.

345 The Department also submitted:[348]

> In addition, to enhance a short-term prisoner's eligibility for parole, the Department's Parole in-reach Program (PiP) has commenced piloting AOD[349] and FDV[350] criminogenic programs at Acacia and Wooroloo for short-term prisoners who are ineligible for IMPs. The PiP programs are currently under evaluation to determine further rollout.

346 I was heartened to hear of this pilot project. It was precisely these types of programs that would have addressed the potential causes of Mr Blanket's offending and would have improved his prospects of being released on parole had he had the opportunity of completing them.

347 Serco also submitted that the introduction of the Real Support Network saw additional voluntary programs being implemented at Acacia.[351] However, I note that this service appears to be confined to the delivery of employment and training services to young First Nations prisoners.

348 I have made a recommendation in this area which I hope will reduce the number of short-term prisoners like Mr Blanket who want treatment to address their offending yet cannot readily access it due their ineligibility for IMPs. I also sincerely hope the Department and Serco continues to address the unfairness to prisoners who want to complete treatment

[348] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, pp. 2-3
[349] Abbreviation for "Alcohol and other Drugs"
[350] Abbreviation for "Family Domestic Violence"
[351] Email from Diviij Vijayakumar to counsel assisting dated 4 August 2023

programs, yet are unable to do so due to lengthy waitlists for these programs.

Additional safe cells at Acacia

349 As to the installation of additional safe cells at Acacia, the Department indicated its support and said that it was now a "*current project*". The Department advised:[352]

> The Department and Serco are presently upgrading six cells to safe cell configurations to achieve this outcome. The Department, in conjunction with Acacia's operator Serco, determined the most beneficial location for the additional safe cell upgrade were two in the medical centre (Echo Block) and four in the detention unit (Golf Block). This would provide optimal supervision and care for prisoners requiring these cells. The upgrades are planned to commence late September 2023 and be completed by November 2023.

350 That is welcomed news. Although it does not explain the delay that suggests there was a significant degree of apathy from the Department and Serco to rectify what I regarded as a pressing issue. It is my firm view that the installation of these safe cells should have been performed as a matter of urgency and been completed prior to the commencement of the inquest in July 2022. Instead, it will be nearly four and a half years since Mr Blanket's death before these upgrades are scheduled to be completed.

351 I also maintain my view that the location of safe cells in a detention unit for prisoners who are at a high risk of self-harm or suicide is not appropriate. Nevertheless, a decision has been made and I can only hope that the upgrade will provide a more therapeutic environment than the one which existed for Mr Blanket when he was placed in a safe cell at the detention unit.

352 As the plans for this upgrade appear to have been finalised, it is not necessary to make a further recommendation regarding the installation of additional safe cells at Acacia.

Access to ARMS records

353 After the inquest, I sought clarification from the Department as to the question of prison mental health service providers having access to ARMS records on TOMS. The Department responded:[353]

> In public prisons, all clinical staff have access to ARMS/ PRAG records via TOMS. This includes psychiatrists (including in-reach psychiatrists employed by the

[352] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.3
[353] Email from Robyn Hartley to counsel assisting dated 2 August 2023

> State Forensic Mental Health Service), mental health and AOD nurses,[354] medical practitioners, primary care nursers, and prison counsellors.
>
> Information sourced from the Knowledge Information and Technology (KIT) team confirms that all medical professionals have the same Medical Role in TOMS including Acacia Prison and therefore provided the same level of access.

354 The Department also confirmed that Dr Bilyk had this level of access in 2019.[355]

355 In light of the above, and as I am of the view that Dr Bilyk may have been mistaken with her recollection regarding her access in 2019, I am satisfied there is no need for me to make a recommendation with respect to prison mental health service providers being allowed access to relevant information on TOMS.

Support after an adverse decision from the Prisoner Review Board

356 Serco and the Department both responded to my proposed recommendation regarding additional support for prisoners receiving an adverse decision from the Board.

357 Serco was supportive of the recommendation, adding that Acacia's senior management team meets each morning to discuss those prisoners who may require extra support if they are expecting adverse Board decisions.[356]

358 The Department said that it supported the proposed recommendation; however, it stated that this was already the current practice and referred to the procedure that was outlined at the inquest.[357]

359 I remain of the view that the current procedure can be improved. By having a person from the prison's mental health service on a pre-arranged standby will mean that professional support is immediately available for the prisoner should it be required. It is a proactive measure rather than the reactive process currently in place. It is therefore an additional step beyond what currently exists and avoids the potential for no one from the prison's mental health service being available to immediately see the prisoner. I have therefore made a recommendation with this in mind.

Training for prison officers

360 A question that arose at the inquest was the adequacy of training that prison officers receive with the respect to the interplay between cultural and mental health issues for First Nations prisoners. The Department's response to this matter was that it provides, "*a range of online and face to*

[354] Nurses who specialise in alcohol and other drugs
[355] Email from Robyn Hartley to counsel assisting dated 2 August 2023
[356] Email from Diviij Vijayakumar to counsel assisting date 11 August 2023
[357] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.2

face training for staff designed to build organisational capacity with respect to cultural and spiritual understanding for First Nations prisoners".[358]

361 The Department outlined a number of aspects to this training, including the requirement that all prison officers must complete online modules regarding mental health awareness. Module 4 concerned First Nations peoples and is:[359]

> …designed to build an awareness of our history and the impacts on Aboriginal peoples and their collective mental health and outline some cultural considerations and practical advice for managing Aboriginal Peoples in custody. Section 1.7 of the training focuses on the need to consider beliefs, traditions and spirituality when assessing mental health.

362 In light of the Department's response, I am satisfied that prison officers are receiving adequate training with respect to this specific area and, more generally, regarding the management of at-risk prisoners, including First Nations prisoners.

363 I have therefore determined not to make a recommendation with respect to this matter.

Prisoners attending PRAG meetings

364 I had agreed with Ms Francis' evidence at the inquest and Professor Morgan's observation[360] of the need for a prisoner on ARMS to be offered the opportunity to attend their case review at PRAG meetings.

365 I saw merit for this as it would provide PRAG members with the opportunity of hearing directly from the prisoner regarding their views as to what measures should be taken to ensure their safety. One exception I had identified was if it is deemed not safe to do, then the prisoner should not be invited. Otherwise, an invitation should always be made.

366 I had also anticipated that some prisoners who are First Nations may be reluctant to attend. In those circumstances, the invitation should extend to an appropriate support person who could be a Peer Support Prisoner, a prisoner who is an Elder or a relative, or someone from AVS.

367 The Department and Serco responded to my proposed recommendation that a prisoner who is on ARMS should be given the opportunity to attend that part of a PRAG meeting where their case is reviewed.[361]

[358] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.3
[359] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.2
[360] Exhibit 1, Volume 3, Tab 7.3, Briefing on Reviews of At-Risk Management in WA Custodial Facilities
[361] This proposed recommendation did not extend to the prisoner being permitted to have a suitable support person accompanying them to their case review at the PRAG meeting

368 Serco supported such a recommendation and added:[362]

> Serco suggests this recommendation be referred to Department of Justice for consideration and psychiatric advice, as this will require state-wide implementation and change to the current At-Risk Management System (ARMS), the Department of Corrective Service's suicide prevention strategy developed by the Rehabilitation and Reintegration Directorate, alongside Commissioner's Operating Policy and Procedure (COPP) 4.9 At-Risk Prisoners which support the ARMS.

369 Having read that submission, I was somewhat surprised when I read the response from the Department which pointed out that section 7.5 of the ARMS Manual states that prisoners can attend PRAG meetings to provide input into their individual circumstances.[363] My surprise increased further when I discovered this provision in the ARMS Manual was already in existence at the time of Mr Blanket's imprisonment. Under the heading "PRAG Conference Review", one part of section 7.5 reads:[364]

> Each case review should involve the prisoner unless it is felt to be in their best interests to be excluded (for example, if the meeting is a cause of extreme anxiety). All staff working supportively with the prisoner should be present. It is not appropriate for staff who are not involved in the prisoner's management to attend the review. The presence of strangers can make a case review meeting an intimidating experience and be counter-productive.

370 I am very concerned that Serco is seemingly unaware of this provision in the ARMS Manual. That concern is heightened by the fact that Ms Francis, the PRAG chairperson from September 2017 to January 2022 at Acacia, was also not aware of this provision.

371 From all the evidence before me, and for whatever reason (either because of ignorance of the relevant provision in the ARMS Manual or because it is easier not to implement it), it seems prisoners at Acacia are not being offered the opportunity to attend PRAG meetings when their case is being reviewed. That state of affairs must immediately end. Accordingly, I have made a recommendation to that affect. This recommendation is to have general application to all prisons in Western Australia should it be the case that Acacia is not the only prison failing to comply with this part of section 7.5 of the ARMS Manual.

372 The paragraph cited above from section 7.5 of the ARMS Manual makes the very pertinent observation that a prisoner attending their case review at a PRAG meeting may find it "*an intimidating experience*". Even if he had been invited, I doubt very much whether Mr Blanket would have attended any of his case reviews as he would have found them too

[362] Email from Diviij Vijayakumar to counsel assisting dated 11 August 2023
[363] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.1
[364] Exhibit 4, At Risk Management System (ARMS) Manual 1998 (updated October 2016), p.88

intimidating. He may well have been more inclined to attend had he been offered the opportunity of having a trusted support person attend with him.

373 It is my view that the prospect of prisoners finding the experience too intimidating could be further reduced if they were permitted to have a suitable support person accompany them to their PRAG case review. Accordingly, I have made a recommendation to have this included in the ARMS Manual.

Access to mental health service providers

374 Serco and the Department responded to my proposed recommendation that the mobile telephone numbers of a prison's mental health service providers be available for use if urgent contact is required concerning the welfare of a prisoner. Both entities expressed support, with additional comments.

375 Serco pointed out that Acacia offers prisoners a 24-hour medical service with mental health service providers on site during business hours. If after-hours assistance is required, a prisoner can be taken to the medical centre where staff have access to an e-consult service staffed by medical practitioners.[365] It is my understanding these medical practitioners do not specialise in psychiatric or psychological care.

376 The Department noted that mobile telephones are not permitted into a prison for security reasons unless approved by the prison's superintendent on a case-by-case basis. It also pointed out that for after-hours assistance, custodial staff are trained in suicide prevention programs which enables them to identify at-risk prisoners who require placement on ARMS and the implementation of an interim risk management plan. These prisoners are then seen by clinical staff at the earliest opportunity and PRAG becomes involved.[366]

377 The question still remains as to why there should not be after-hours contact numbers for a prison's mental health service providers so that advice can be given over the telephone if a prisoner is in urgent need of psychiatric or psychological assistance.

378 With the high number of prisoners with serious mental health issues, there is every likelihood urgent after-hours advice on care and treatment is required for a prisoner from this cohort, just as much as it may be required for a prisoner experiencing a serious physical health issue. Those health service providers looking after a prisoner in the latter category also have

[365] Email from Diviij Vijayakumar to counsel assisting dated 11 August 2023
[366] Attachment to the email from Robyn Hartley to counsel assisting dated 10 August 2023, p.1

the additional option of calling an ambulance to transport the prisoner to a hospital.

379 In those circumstances, I see merit in a strictly limited number of prison staff having access to the mobile telephone numbers of the prison's mental health service providers. I have in mind that this group of prison staff be restricted to the chairperson of PRAG and prison health service providers who work after-hours. Use of these telephone numbers should be made rarely, and only if urgent and immediate contact is required regarding the welfare of a prisoner with respect to their mental health. The consent of each individual mental health service provider will need to be obtained before their mobile telephone number is provided for this purpose.

380 I have therefore made a recommendation with respect to this matter.

The reviews by the Department of deaths in custody

381 I am of the view that any review by the Department of a death in custody should clearly refer to any review carried out by the private management of the prison where the death occurred. The Department ought to also clearly specify in its review whether it accepts and/or rejects the observations and recommendations that have been made in the prison's review.

382 Currently, such a recommendation would only apply to deaths in Acacia and any Post-Incident Reviews conducted by Serco.

383 The Department responded to this proposal and expressed its support. Accordingly, I have made this recommendation.

RECOMMENDATIONS

384 In light of the observations I have made, and after a careful consideration of the responses from the Department and Serco, I make the following recommendations:

Recommendation No. 1

In order to provide appropriate care and treatment for prisoners in Acacia, funding be provided as a matter of urgency for a project definition plan regarding the creation of a therapeutic care unit to treat mentally unwell prisoners (including prisoners who are deemed to be at a high risk of self-harm) who do not meet the criteria for an involuntary admission to an authorised hospital under the *Mental Health Act 2014* (WA).

Recommendation No. 2

To address the previous inequality for access to treatment programs between prisoners who have been assessed for an IMP and those who have not, the Department's pilot Parole-in-reach Program (PiP) involving AOD and FDV criminogenic programs for short-term prisoners who are ineligible for IMPs be fully implemented and made available to the general prison population.

Recommendation No. 3

To enhance the care of vulnerable prisoners, a person from the prison's health service that provides psychological and counselling support be on standby should it be suspected that a prisoner may require such support after being informed of a decision from the Prisoner Review Board regarding the prisoner's parole eligibility. Preferably, this person should be one who is known to the prisoner.

Recommendation No. 4

So that there is compliance with section 7.5 of the ARMS Manual, Serco is to ensure that the chairperson of PRAG at Acacia is aware that a prisoner on ARMS must be invited to attend their case review, unless it is not in the prisoner's interests to do so.

The Department is to also take appropriate measures to ensure that case reviews at PRAG meetings in other prisons are complying with this part of section 7.5 of the ARMS Manual relating to the attendance of prisoners at their case reviews.

Recommendation No. 5

To overcome reluctance from a prisoner to attend their PRAG case review, a provision is added to section 7.5 of the ARMS Manual entitling a prisoner who is attending their case review to have a suitable support person accompany them.

Recommendation No. 6

To assist with the timely care and treatment of mentally unwell prisoners, a prison's after-hours health service providers and chairperson of PRAG have access to the mobile telephone numbers of the prison's mental health service providers if urgent and immediate contact is required regarding the mental welfare of a prisoner.

Recommendation No. 7

If the Department's Review of a Death in Custody at Acacia accepts any of the findings and/or recommendations made in Serco's Post Incident Review of the death, then the Department's Review should clearly identify that acceptance.

CONCLUSION

385 Mr Blanket was a relatively young man when he died at Acacia on 12 June 2019. He was a much loved family member and a proud father of three young children.

386 Mr Blanket's first term of imprisonment placed a terrible burden on his mental health and, it appears, his cultural beliefs. He began self-harming and experiencing episodes of suspected psychosis. Mr Blanket was placed on ARMS (and occasionally SAMS) at regular intervals throughout the eight months he was imprisoned. He was also housed in a safe cell on a number of occasions due to his high risk of self-harm and/or suicide.

387 With a handful of exceptions, I was satisfied with the supervision, treatment and care Acacia's mental health service providers and PRAG provided to Mr Blanket. However, one exception that involved Acacia staff concerned a short but nonetheless serious oversight with respect to a lack of appropriate supervision of Mr Blanket. Tragically, this oversight contributed to his death.

388 On the morning of Mr Blanket's death, a custodial staff member correctly identified an elevated risk of self-harm for Mr Blanket and the PRAG

chairperson promptly implemented his risk management plan. These were commendable actions.

389 However, there was an unanticipated delay in Mr Blanket's move to a safe cell. I have found that this delay was due to the chronic shortage of safe cells at Acacia (a shortage that still presently exists). This delay, together with a failure to properly monitor Mr Blanket, provided the opportunity for him to take his life. He was allowed to move from a common area in his unit and enter his one-person cell and, at some point, close the cell door. Mr Blanket was then able to implement his suicide plan by using a torn bedsheet as a ligature and the closed cell door as an anchor point.

390 As this precise suicide plan of Mr Blanket's was known to Acacia staff (including PRAG) for about eight weeks, I have found that Mr Blanket should not have been allowed to close his cell door at a time when he was thought to be at an elevated risk of self-harm. To have earlier predicted Mr Blanket's elevated risk of self-harm simply from his appearance is deserving of high praise. Yet Acacia staff then failed to identify the further raising of that risk level once Mr Blanket had closed his cell door. He was by himself in his cell, and with the means to implement his known suicide plan without any supervision or monitoring.

391 I am satisfied that some improvements and changes have been made by the Department and Serco in the four years since Mr Blanket's death. However, a lot more still needs to be done to lower the risk of suicide amongst prisoners, particularly those who are First Nations.

392 I have made seven recommendations, a number of which I believe will further reduce the risk of suicide amongst those vulnerable prisoners with mental health conditions. Of critical importance is the establishing of a therapeutic care unit at Acacia to house prisoners with mental health issues and who are at high risk of self-harm or suicide. Currently, when neither of the two safe cells in the medical centre are available, these prisoners are being housed in a unit designed to punish prisoners. I regard that situation as unfair, inappropriate and counter-productive.

393 Another important issue I have addressed in my recommendations regards the difficulty short-term prisoners have[367] in being able to participate in treatment programs that they need to complete to enhance their prospects of being released on parole. I have considerable empathy for Mr Blanket when he was given the letter from the Board on 22 April 2019. This letter stated his application for parole had been denied and cited twice that one reason was his unmet treatment needs.[368] The injustice Mr Blanket would have felt when he read that is easy to understand. He actually wanted his

[367] That is, those who are sentenced to a term of imprisonment of 12 months or less with eligibility for parole
[368] Exhibit 1, Volume 1, Tab 46.2, Letter from the Prisoners Review Board to Mr Blanket dated 18 April 2019

treatment needs to be met, yet he was denied that opportunity. That was because the system prevented him from having an IMP prepared and the programs that he applied to often had lengthy waitlists.

394 I have also drawn attention to the longstanding and perilous situation regarding the high number of cells in prisons in Western Australia that still have numerous ligature points that can be used by prisoners to hang themselves. The modification of cells to reduce or eliminate those ligature points is an expensive process. Nevertheless, the speed of progress in this area in recent years can be best described as "glacial". In the meantime, I have no doubt that prisoners will continue to use ligature points that remain in place within cells to end their lives.

395 I am also left in no doubt that Acacia's mental health service providers did their very best to look after vulnerable prisoners like Mr Blanket with the limited time and resources they had. I have highlighted the need to make changes that will improve the capability of prison mental health services to provide effective care and treatment to prisoners with mental health conditions. These changes come with a not insignificant financial cost as they will include additional infrastructure and an increase in staffing levels. However, if these changes are not made then more families like Mr Blanket's will bear the heartbreaking loss of a loved one to suicide in prison. And the community will also ultimately bear the cost of released prisoners who have not had effective treatment in prison for their mental health issues because of resourcing issues.

396 Finally, I commend the family of Mr Blanket for the dignified manner in which they have conducted themselves, not only at the inquest but since Mr Blanket's death. In doing so, they have honoured his memory. I also thank them for their patience in the wait for my finding to be delivered.

397 I want to also add my appreciation for the written statement from Mr Blanket's mother that was read out on the last day of the inquest by her daughter, Alice Blanket. Included in that statement was:[369]

> My son was a beautiful, kind soul and we miss him. Nothing can replace him.
>
> I am a grieving mother.
>
> Life will never be the same without [Mr Blanket].
>
> I and my children are suffering with a lot of trauma, struggling to sleep, and in deep grief.
>
> I ask the Coroner to bring justice to my family and to make recommendations so that no mother has to grieve like me again.

[369] Exhibit 7, Family Statement

398 As I did at the conclusion of the inquest, and on behalf of the Court, I extend my sincere condolences to Mr Blanket's family and loved ones, particularly his mother and his three children, for their sad loss.

PJ Urquhart
Coroner
21 August 2023