JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	9 - 10 MAY 2023
DELIVERED	**:**	19 JULY 2023
FILE NO/S	**:**	CORC 1420 of 2020
DECEASED	**:**	INMAN, STANLEY JOHN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Mr J. Tiller appeared to assist the coroner.

Mr E. Cade (State Solicitor's Office) appeared for the Department of Justice and the Western Australian Police Force.

Ms R. O'Brien and Ms N. Dubey (both of counsel, instructed by the National Justice Project) appeared for Mr Inman's family.

Mr C. Beetham (of counsel) and Mr D. Vijayakumar (Wotton+Kearney Perth) appeared for Serco Group Plc, the current operators of Acacia Prison.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Stanley John INMAN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 9 May 2023 - 10 May 2023, find that the identity of the deceased person was* ***Stanley John INMAN*** *and that death occurred on 13 July 2020 at St John Of God Midland Public Hospital, 1 Clayton Street, Midland, from complications of ligature compression of the neck (hanging) in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION

1. Stanley John Inman (Mr Inman) died at St John of God Hospital Midland (SJOG) on 13 July 2020, from complications of ligature compression of the neck. He was 19 years of age. At the time of his death, Mr Inman was a sentenced prisoner at Acacia Prison (Acacia) and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (DOJ).[1,2,3,4,5,6]

2. Accordingly, immediately before his death, Mr Inman was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[7] In such circumstances, a coronial inquest is mandatory.[8] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[9]

3. I held an inquest into Mr Inman's death at Perth on 9 - 10 May 2023, at which the following witnesses gave evidence:

a. Mr Nicholas Manifis, Prison Officer, Acacia (Officer Manifis);
b. Ms Kate Moore, Prison Officer, Acacia (Officer Moore);
c. Mr Michael Waine, Psychologist, Acacia (Mr Waine);
d. Ms Anna Calverley, Safer Custody Manager, Acacia (Ms Calverley);
e. Ms Toni Palmer, Senior Review Officer, DOJ (Ms Palmer); and
f. Ms Jacinta Miller, (Mr Inman's sister).

4. The documentary evidence adduced at the inquest comprised two volumes and the inquest focused on the supervision, treatment and care provided to Mr Inman while he was in custody, as well as the circumstances of his death.

[1] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p4-5
[2] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (13.07.20)
[3] Exhibit 1, Vol 1, Tab 3, P92 - Identification of deceased (13.07.20)
[4] Exhibit 1, Vol 1, Tab 4, Death in Hospital Form (13.07.20)
[5] Exhibit 1, Vol 1, Tab 5.1, Supplementary Post Mortem Report (26.08.20)
[6] Section 16, *Prisons Act 1981* (WA)
[7] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[8] Section 22(1)(a), *Coroners Act 1996* (WA)
[9] Section 25(3) *Coroners Act 1996* (WA)

MR INMAN

Background[10,11,12,13,14]

5. Mr Inman was born on 12 January 2001 and he lived with his mother and his partner at his mother's home in Hamilton Hill. He enjoyed playing football, basketball, and riding his bicycle. Mr Inman also enjoyed creative activities, including painting and completing scrapbooks, and he was described as a "*loving uncle*".

Offending and prison history[15,16,17,18]

6. Mr Inman's criminal history began when he was a juvenile. By the time of his last incarceration, he had accumulated over 40 convictions for offences including burglary, aggravated and attempted robbery, and stealing. Mr Inman served 10 periods of juvenile detention from 2015 to 2019, and also received fines and community orders.

7. Mr Inman had been in the community for only eight months when he was received into custody for the last time at Hakea Prison (Hakea) on 19 February 2020. On 1 May 2020, in the Fremantle Magistrates Court, Mr Inman was sentenced to two years' imprisonment in relation to four counts of aggravated home burglary. His sentence was backdated to reflect the time he had spent on remand, and his earliest eligibility date for release on parole was calculated as 16 February 2021.

Overview of medical conditions[19,20]

8. Mr Inman was diagnosed with rheumatic heart disease after being hospitalised for two weeks with rheumatic fever in 2012. To protect against the possibility of dangerous infections, he was prescribed a monthly injection of long-acting benzylpenicillin until he was 21 years of age.

---

[10] Exhibit 1, Vol 1, Tab 7, Statement - Ms C Moses (21.04.21), paras 3-15
[11] Exhibit 1, Vol 1, Tab 2, Report - Sen. Const. L Baker (22.06.21), pp2-3
[12] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records, pp2 & 22
[13] Exhibit 1, Vol 2, Tab 39, Statement - Ms J Miller (08.05.23) and ts 10.05.23 (Miller), pp153-155
[14] Exhibit 1, Vol 2, Tab 40, Statement - Ms T Austin (08.05.23)
[15] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp4-5 & 8
[16] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p3
[17] Exhibit 1, Vol 2, Tab 36.3, History for Court - Criminal and Traffic (complied 06.05.20)
[18] Exhibit 1, Vol 2, Tab 36.4, Sentence Summary - Offender (F2905349)
[19] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p3
[20] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20)

Overview of mental health issues[21,22,23]

9. In her statement to the Court, Mr Inman's mother said she believed he may have had attention-deficit/hyperactivity disorder as a child, but that: "*he did not visit any psychiatrist*" prior to entering juvenile detention.

10. On admission to Hakea, Mr Inman denied intravenous drug use, although he did disclose using methylamphetamine on two recent occasions, and his family were aware he sometimes used cannabis. During the reception process at Hakea, Mr Inman also denied any psychiatric history, although he did say he had "*stress issues*". Mr Inman was diagnosed with anxiety by his GP in October 2019,[24] and the available evidence identifies three instances of self-harm.

11. In October 2015, Mr Inman was taken to Fiona Stanley Hospital (FSH) by police after threatening to hurt himself with a knife. Mr Inman reportedly said the incident had occurred during an altercation with his mother, and that he had "*no real plans to injure himself*". Before being discharged, a psychiatric registrar assessed Mr Inman and found no acute psychiatric illness, or active suicidal or homicidal ideation.

12. On 13 December 2019, Mr Inman was taken to FSH, after an apparent attempt to take his life by hanging, following the death of a family member in late 2019.[25] FSH medical records reportedly noted: "*suicidal patient, situational crisis, tied a noose, no hanging or injury*", but it appears Mr Inman left the hospital before being assessed.[26]

13. On 3 January 2020, Mr Inman's family contacted emergency services after Mr Inman was apparently attempting to hurt himself. Mr Inman was located by police and taken to FSH by ambulance. It is reported he had been anxious about his forthcoming court appearance, and after an assessment, Mr Inman was discharged home.[27,28,29,30]

[21] Exhibit 1, Vol 1, Tab 7, Statement - Ms C Moses (21.04.21), paras 11-12 & 16
[22] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp4-5 & 8-9
[23] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), pp15-17
[24] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records (05.03.20), p18
[25] Exhibit 1, Vol 1, Tab 40, Statement - Ms T Austin (08.05.23), paras 11-15
[26] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records 05.03.20), p18
[27] Exhibit 1, Vol 1, Tab 2, Report - Sen. Const. L Baker (22.06.21), pp2-3
[28] Exhibit 1, Vol 2, Tab 40, Statement - Ms T Austin (08.05.23), paras 16-21
[29] Exhibit 1, Vol 1, Tab 16.1 - 16.4, WAPOL Incident Reports LWP20010300007059 (03.01.20)
[30] Exhibit 1, Vol 1, Tab 17.1 - 17.2, IMS Welfare Alerts (activated 03.01.20, expired 18.02.20)

Initial assessment at Hakea Prison[31,32,33]

14. Mr Inman was received at Hakea Prison (Hakea) as a remand prisoner on 19 February 2020,[34] and underwent various assessments, including an evaluation of his risk of self-harm and suicide (discussed below). On 20 February 2020, Mr Inman was reviewed by a prison medical officer (PMO) and his history of rheumatic heart disease and his required monthly injections of benzylpenicillin were noted.

15. During the assessment Mr Inman described an episode one month earlier where he said he had fainted while smoking methylamphetamine, and it was also noted he had been prescribed mirtazapine (an atypical antidepressant). It was noted that Mr Inman smoked cigarettes, and he also disclosed daily use of cannabis and occasional alcohol use.

16. Under the heading "*mental health history*" in his DOJ electronic medical record (EcHO), the PMO recorded "*stress*", and noted a suicide attempt about two months earlier, when Mr Inman had reportedly attempted to hang himself following his brother's death. Mr Inman denied any current self-harm or suicidal ideation, and his exercise tolerance was recorded as "*good*". Several days later, Mr Inman was assessed as suitable for an upper bunk, to which he had already been allocated, and an orientation checklist was completed.[35,36]

Initial At Risk Management System assessment[37,38,39]

17. The At Risk Management System (ARMS) is DOJ's primary suicide prevention strategy, and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. When a prisoner is received at a prison, an experienced prison officer (reception officer) conducts a formal assessment designed to identify any presenting risk factors.[40,41]

[31] Exhibit 1, Vol 1, Tab 19.3, Multiple Cell Occupancy - Risk Assessment (19.02.20)
[32] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records (20.02.20), pp 20-22
[33] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20)
[34] Exhibit 1, Vol 1, Tab 18.1 - 18.4, Custody Transfer Records (19.02.20)
[35] Exhibit 1, Vol 1, Tab 19.4, Upper Bunk Occupancy - Risk Management (25.02.20)
[36] Exhibit 1, Vol 1, Tab 19.5, Orientation Checklist (25.02.20)
[37] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp4-5 & 8-13
[38] Exhibit 1, Vol 1, Tab 19.1, At Risk Management System - Reception Intake Assessment (19.02.20)
[39] Exhibit 1, Vol 1, Tab 19.2, At Risk Management System - Risk Management Plan (20.02.20)
[40] DOJ ARMS Manual (2019), pp2-13
[41] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), p2

18. If a prisoner is deemed to be at risk they are placed on ARMS and an interim management plan is prepared. Prisoners on ARMS are subject to observations at either high (one-hourly), moderate (two-hourly) or low (four-hourly) levels. From previous inquests I have conducted I am aware that within 24-hours of a prisoner being placed on ARMS, the Prisoner Risk Assessment Group (PRAG) meets to determine the level of support required to manage the prisoner's identified risk(s). The PRAG attendees include custodial officers, peer support officers, and mental health and counselling staff. All prisoners on ARMS are discussed at regular meetings, with the frequency of those discussions being dependant on the prisoner's risk level.[42,43,44,45]

19. On 19 February 2020 at Hakea, Mr Inman underwent an initial ARMS assessment during which a reception officer asked him a series pre-prepared questions. It was noted Mr Inman "*has had no thoughts or ideations of (self-harm) or suicide since being arrested*", and was not withdrawing from drugs or alcohol. Mr Inman disclosed his attempt to hang himself after his brother's death, but the reception officer noted Mr Inman had "*hope for the future and is future focussed*" and concluded:

> No statements of ideation of Self Harm made at time of interview. Prisoner was cooperative and answered all questions, the prisoner had good eye contact at the time of interview and was very future focused. Nil recommendations.[46]

20. In accordance with *Local Order 74 - Management of Young Offenders*,[47] Mr Inman was placed in the crisis care unit for 24 hours, and he remained on "*low*" ARMS for seven days. On 20 February 2020, Mr Inman was reviewed by a Psychological Health Services (PHS) worker, who described him as "*calm and settled*" and "*friendly and cooperative at all times*".[48]

---

[42] DOJ ARMS Manual (2019), pp16-18 & pp21-24 and ts 09.05.23 (Calverley), pp90-95
[43] [2022] WACOR 34, Record of investigation to Death - Mr Callum Mitchell, para 16
[44] Exhibit 1, Vol 1, Tab 19.1, At Risk Management System - Reception Intake Assessment (19.02.20), pp1-6
[45] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p32
[46] Exhibit 1, Vol 1, Tab 19.1, At Risk Management System - Reception Intake Assessment (19.02.20), p6
[47] Exhibit 1, Vol 2, Tab 36.7, Local Order 74 - Management of Young Offenders (31.07.13)
[48] Exhibit 1, Vol 2, Tab 36.8, PHS ARMS - File Note (20.02.20)

21. Mr Inman said he was coping well, and "*firmly denied*" any suicidal or self-harm ideation. As he was a newly admitted young offender, the PHS worker recommended Mr Inman remain on low ARMS,[49] and later that day, his case was discussed by the PRAG. The support of his family and his partner was noted, and Mr Inman said he was expecting visits. He also said he was "*hoping to get out on bail at his next court appearance*". In accordance with Local Order 74, Mr Inman was kept on low ARMS and referred to the Peer Support Officer and PHS.[50]

22. Mr Inman remained on low ARMS, and was reviewed by a PHS worker on 25 February 2020. He was described as having a "*settled demeanour and relaxed affect*", and apart from saying he was bored, he reported no issues or concerns. Mr Inman denied any self-harm or suicidal ideation and identified his partner, art, and football as "*strategies to reduce his stress*". No overt risk factors were verbalised or displayed, and his removal from ARMS was recommended.[51]

23. On 27 February 2020, PRAG discussed Mr Inman's case and it was agreed he should be removed from ARMS because he was considered to be at low risk of self-harm. PRAG also agreed that Mr Inman did not need to be placed on DOJ's Support and Monitoring System (SAMS) because he did not require ongoing monitoring.[52]

24. On 6 May 2020, Mr Inman was transferred to Casuarina Prison (Casuarina) "*in view of muster pressures at Hakea Prison*". He remained at Casuarina until 18 May 2020 when, at his own request, he was transferred to Acacia Prison (Acacia) where he had family members.[53,54,55]

[49] Exhibit 1, Vol 2, Tab 36.8, PHS ARMS - File Note (20.02.20)
[50] Exhibit 1, Vol 2, Tab 36.9, PRAG Minutes (20.02.20)
[51] Exhibit 1, Vol 2, Tab 36.11, PHS ARMS - File Note (25.02.20)
[52] Exhibit 1, Vol 2, Tab 36.12, PRAG Minutes (27.02.20)
[53] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp12-13
[54] Exhibit 1, Vol 2, Tab 36.6, Cell Placement History - Offender
[55] Exhibit 1, Vol 2, Tab 36.13, Administrative Decision Slip (06.05.20)

25. Mr Inman was housed in Unit 3 of Uniform block, which was part of Acacia's "Young Offenders Unit" that aims to provide extra support to young prisoners. He was employed as a block worker, and he had successful Skype[56] and social visits with his family, and other than some trivial incidents of misconduct, Mr Inman was not the subject of any prison offences or disciplinary matters.[57,58,59,60,61,62]

Management of medical issues[63,64,65,66,67]

26. As noted, Mr Inman's history of rheumatic heart disease was noted on his admission to Hakea, and he underwent a routine electrocardiogram (ECG) on 25 February 2020. On 5 March 2020, Mr Inman presented to the health centre at Hakea complaining of sudden onset left-sided chest pain. He had been playing football and was "*hot and sweaty*" and an ECG was performed which was normal so he was reassured and given pain relief.

27. Although Mr Inman was scheduled to receive monthly injections of benzylpenicillin (in relation to his rheumatic heart disease), he refused the injection on 7 March 2020, and signed a "*release from medical responsibility form*". Mr Inman's medical records were reviewed on 23 March 2020, and he was placed on a cardiac chronic disease management plan.[68]

28. Mr Inman's reluctance to accept his monthly benzylpenicillin injection persisted, apparently on the basis that he had no symptoms and could not see the point. However on 26 March 2020, a PMO explained the rationale for the injections, and Mr Inman agreed to accept them until he turned 21 years of age. From that point onwards, Mr Inman accepted his benzylpenicillin injections in May and June 2020.[69]

---

[56] During the COVID-19 pandemic lockdowns, prison visits were conducted electronically using Skype
[57] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p25
[58] Exhibit 1, Vol 2, Tab 36.44, Work History - Offender and Exhibit 1, Vol 2, Tab 36.18, Visits history - Offender
[59] Exhibit 1, Vol 1, Tab 21.5, Incidences and Occurrences - Prisoner
[60] Exhibit 1, Vol 2, Tab 36.45, Charge History - Offender
[61] Exhibit 1, Vol 2, Tab 36.35, Statement - Officer B Leipold (17.09.20), paras 6-7
[62] Exhibit 1, Vol 2, Tab 36.31, Acacia Prison Floor plan - Unit 3
[63] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp4-5 & 8-13
[64] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23)
[65] Exhibit 1, Vol 2, Tab 37, Death in Custody Review (13.04.23), pp4-5 & 8-13
[66] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records
[67] Exhibit 1, Vol 1, Tab 30, Acacia Medical Timeline Summary (19.02.20 - 12.07.20)
[68] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records, p17
[69] Exhibit 1, Vol 1, Tab 35.1, EcHO Medical records, pp7, 9-10, 11-12 & 14-16

29. Later in this finding I will deal with the deficiencies in the management of Mr Inman's mental health, but in relation to the management of his physical health, I agree with the following observation in the Health Review prepared by DOJ after Mr Inman's death (Health Review):

> After a comprehensive review of [Mr Inman's] health management whilst in custody, it is our opinion that his general health care, including of chronic disease and preventative health, was commensurate with and possibly of a higher standard than community care.[70]

ISSUES RELATING TO MR INMAN'S INCARCERATION

Concerning phone calls: 4 - 8 July 2020[71]

30. Prisoners are permitted to make time-limited phone calls to family and friends using the Prisoner Telephone System (PTS). With limited exceptions, all calls made using the PTS are recorded, but at the time Mr Inman was at Acacia, they were not routinely listened to, even for prisoners considered to be at higher risk of self-harm and/or suicide.[72]

31. Between 4 and 8 July 2020, Mr Inman used the PTS to call his mother, and his partner on a number of occasions. During these calls, he repeatedly asked his partner to return to his mother's home, and the content of some of the calls clearly shows Mr Inman's mental state deteriorating.

32. The following examples of the content of these calls illustrates this point:[73,74]

a. 04 Jul 20: in a call to his mother Mr Inman says: "*I got no life, I got no life, I got fuck all…c'mon I will kill myself literally…don't fuck me around mum talking about that shit*";

[70] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p19
[71] Exhibit 1, Vol 2, Tab 36.48, Telephone Call Reports (01.02.20 - 11.07.20)
[72] Exhibit 1, Vol 2, Tab 44.1, Statement - Ms T Palmer (09.05.23), paras 2-5 and ts 09.05.23 (Palmer), pp135-136
[73] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp13-15
[74] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), pp2-3, 10-12 & 22-23

b. 05 Jul 20: in the first of several calls to his partner, Mr Inman says: "*All that other stuff I stress about. I got no help in here. I got nothing to look forward to…I'm gonna be gone soon… I'm gonna be gone soon…I swear on my (inaudible)…auntie I swear that I'm gone…its not your fault, I'm sick of thinking all the time*". When Mr Inman's partner tells him she is going to a funeral, he says: "*If you go to one you'll go to two*".

In a second call, Mr Inman wants his partner to stay at his mother's house and says: "*I'm thinking about ways to kill myself. I don't really care about my life at the moment…there's something seriously wrong with me. I'm not mentally stable*".

In the third call, Mr Inman again tells his partner he wants her to stay at his mother's house and says: "*I'm gonna kill myself…I will, I will I will. What will you think when I'm dead and all you needed to do was to go to my mother's house. I'm gonna cut my face right up my neck everything my whole body, my whole body is gonna get slashed I don't give a fuck anymore, all night I'm gonna do stupid shit to myself whatever I do to myself it's ya Auntie's fault*".

c. 06 Jul 20: during the course of 11 calls to his partner, she and Mr Inman break up but then reconcile.

d. 07 Jul 20: Mr Inman called his partner and told her he was cutting himself and she told him to "*snap out of it*". He also said his body was covered in scars and: "*I can't talk to anyone, I've got no psych*".

e. 08 Jul 20: Mr Inman called his partner eight times, and repeatedly asked where she was. In one call he became emotional and started crying and he said: "*All I fucking do is cut myself everyday…all I do is cut myself everyday this is fucked man this is my routine…right after this I'm gonna show someone what I have been doing…I'm sick of this shit I'm gonna kill myself you dog…I'm ready to, I feel nothing the big sleep bro…I won't have to put up with nothing…(noise of Mr Inman apparently striking himself with the handset)…I'm gonna kill myself I'm spry…I just want ya to help me*".

33. The content of these calls is confronting and in my view provides clear evidence that Mr Inman's mental state was deteriorating. He expresses suicidal ideation, discloses his self-harming behaviour, and is clearly experiencing significant distress. As I will explain, none of the information in these calls was reviewed by PRAG at any of its meetings relating to Mr Inman. Although the information could have been accessed, at the relevant time it was not the practice to do so.

34. In his statement, Mr Waine said that since Mr Inman's death, he had attended a PRAG meeting where a transcript of a telephone call had been provided and that this had assisted the PRAG "*to make a more holistic determination of the prisoner's ARMS ranking*".[75]

35. Further, at the inquest, Ms Calverley (who was the PRAG Chair at all relevant times) was asked whether having access to the content of the phone calls Mr Inman was making in the period leading up to his death might have changed PRAG's assessment. Her response was:

> Yes. It certainly could have…and has affected the outcomes in PRAG. You know…that's a key piece of information and I…can speak from having done PRAG without that, you know, to this point and then having done PRAG since, that…it can be such vital information because often whilst prisoners know generally their phone calls are recorded and monitored, they also know that they're not all…monitored.
>
> But so often they will speak quite freely on the phone and we've found out some really key piece of information and been able to keep people safe having that information. So it absolutely could have changed things.[76]

[75] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(09.07.20), para 32
[76] ts 09.05.23 (Calverley), p105

Mr Inman discloses self-harm: 8 July 2020[77,78,79,80,81]

36. At about 5.55 pm on 8 July 2020, Mr Inman approached custodial staff and told them he had been cutting himself. He showed the officers superficial cuts and scratches to his chest and arm, and he was taken to the unit office. A short time later Officer Manifis, who had developed a good rapport with Mr Inman, took him to the medical centre.[82]

37. On the way to the medical centre, Officer Manifis asked Mr Inman "*what's going on*" and Mr Inman became emotional and teary and said: "*he had been cutting his chest for over a week now due to the passing of his brother before he came to Acacia Prison*". Notably, Mr Inman did not mention any of the issues he had discussed with his partner, and instead only referred to his brother's death.[83,84,85]

38. Officer Manifis said that when they arrived at the medical centre, he was shocked when Mr Inman's demeanour completely changed and he: "*was his normal bubbly self*" and replied "*I'm good*" when asked how he was. Officer Manifis reported Mr Inman's rapid change of demeanour to his Unit Manager, because in his view it was out of character for Mr Inman and assumed this would be passed on to the PRAG.[86]

39. Mr Inman's wounds were assessed as not requiring treatment, and he was placed in an observation cell in the detention centre on "*high ARMS*". As a result, Mr Inman was obliged to wear a rip proof gown and use rip poof bedding.[87,88]

40. When Mr Inman was reviewed by a nurse on 9 July 2020, "*no issues of concern*" were raised.[89]

---

[77] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp15-16
[78] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), paras 8-16
[79] ts 09.05.23 (Manifis), pp14-15 & 24-25
[80] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), pp3 &19
[81] Exhibit 1, Vol 1, Tabs 23.1-23.5, TOMS Records of self-harm incident (08.07.20)
[82] Exhibit 1, Vol 2, Tab 36.19, Incident Description Report - Officer D Walker (08.07.20)
[83] Exhibit 1, Vol 2, Tab 36.19, Incident Description Report - Officer N Manifis (08.07.20)
[84] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p16
[85] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), para 13 and ts 09.05.23 (Manifis), pp14-15
[86] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), paras 13-16 and ts 09.05.23 (Manifis), pp14-15 & 25
[87] Exhibit 1, Vol 2, Tab 36.19, Incident Description Report - Clinical Nurse J Jones (08.07.20)
[88] Mr Inman was not placed in the medical observation cell because it was already occupied
[89] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), p2

41. At 8.52 am on 9 July 2020, Mr Inman called his partner and told her he was "*down the back*" because he was stressed, and was waiting to see a psychologist. Mr Inman promised his partner he would not mention her when he saw the psychologist, and would instead say that his self-harm was related to other issues. Mr Inman's partner told him that she would not answer his calls again if he "*ran her down*".[90]

ARMS review: 9 July 2020[91,92,93,94,95]

42. Mr Inman was reviewed by a psychologist (Ms Alana Lindell) in the presence of a social work student in the detention centre on 9 July 2020. He presented as "*polite and engaged*" with "*no obvious signs of stress identified*". Mr Inman said his self-harm was due to increased "*distress and loneliness*" reportedly linked to "*unresolved grief and loss*" as a result of the deaths of his brother and more recently, his grandmother. Mr Inman reported no other concerns and displayed no signs of thought or perceptual disturbance.

43. Mr Inman also denied self-harm or suicidal ideation and expressed an interest in further counselling. He said he wanted to return to his unit to be with "*family support*" and because he enjoyed the "*strong daily routine*" there. He also said he would ask for "*time out*" if his distress became overwhelming. Ms Lindell identified several protective factors including Mr Inman's family, partner, his placement in Uniform block with "*family*", and his strong future focus demonstrated by his request for a temporary transfer to Albany Regional Prison to visit family.

44. Ms Lindell also referred to Mr Inman's willingness to seek help and request time-out, his strong daily routine of work, social activities, and interaction with his peers, and "*other adaptive coping strategies*". Ms Lindell recommended Mr Inman be reduced to "*moderate ARMS*" and considered for return to his unit. This recommendation was endorsed by PRAG at its meeting later the same day.

[90] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p16
[91] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p17
[92] Exhibit 1, Vol 2, Tab 36.22, PHS ARMS File Note (09.07.20)
[93] Exhibit 1, Vol 2, Tab 36.23, PRAG Minutes (09.07.20)
[94] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(09.07.20), paras 5-6
[95] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p3

45. The PRAG discussed Mr Inman's "*strong future focus*" despite his recent self-harm, and that his protective factors included his partner, his family and "*the community and family*" in his unit. It was noted Mr Inman had expressed remorse about his self-harm behaviour, and had a supportive cellmate and family. The PRAG reduced Mr Inman to moderate ARMS, and decided he should be returned to his unit "*at the earliest convenience*" and despite "*his ligature use history*" a standard cell was appropriate.[96,97]

ARMS review: 10 July 2020

46. On 10 July 2020, Mr Inman's ARMS status was reviewed by psychologist Mr Waine who was accompanied by the same social work student who had seen Mr Inman the day before. Prior to the review, Mr Waine reviewed previous PHS notes, and although he did not have access to any information about the phone calls Mr Inman had been making, Mr Waine said "*I am sure that if I asked the Acacia Intel Branch for phone calls I would receive them*".[98]

47. During the review, Mr Inman did not refer to any issues he was having with his partner, or that he was having any difficulty locating her. Initially he presented with "*flat affect*", but he became responsive as the session continued. Mr Inman did not refer to any specific issues, although he did refer to issues with the rip-proof gown he was required to wear while he was housed in the detention centre observation cell. He reported no current thoughts of suicide or self-harm, and was focussed on a brief transfer to Albany Regional Prison so he could speak to family members who were closest to his grandmother.[99]

48. Mr Inman repeated his regret at his self-harming behaviour, referred to his supportive family, and said he was willing to engage in further counselling. In his statement, Mr Waine noted: "*Given Mr Inman's protective factors, especially his future focus on* (a) *visit to Albany and his denial of self-harm ideation, I recommended he be reduced to four-hourly ARMS for a period of monitoring and stability in the block*".[100]

[96] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p17
[97] Exhibit 1, Vol 2, Tab 36.23, PRAG Minutes (09.07.20) and ts 09.05.23 (Calverley), pp95-102
[98] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(09.07.20), para 15 and ts 09.05.23 (Waine), pp54-64 & 65-79
[99] Exhibit 1, Vol 2, Tab 36.17, Temporary transfer for Visits application (09.07.20)
[100] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(09.07.20), para 27

49. The PRAG meeting held later on 10 July 2020 decided to accept Mr Waine's recommendation, and Mr Inman was reduced to low ARMS, meaning he was the subject of four-hourly observations. The PRAG found Mr Inman was no longer suicidal, had a strong future focus, and had access to strong supports, including his family and the young offender mentors. The PRAG decided Mr Inman should remain in his unit where he had support from family members and his cellmate, and because he had "*indicated a willingness to seek help*".[101,102]

50. The Death in Custody Review (the DIC Review) notes that when spoken to after Mr Inman's death, the PRAG Chair, Ms Calverley, noted that Mr Inman was "*very new in the risk assessment space*", and was unknown to the PRAG. Ms Calverley also said the PRAG was aware that Mr Inman had "*a lot of support around the prison*", including family members and the young adult mentors, and "*liked his call mate*".

51. However, Ms Calverley confirmed that the PRAG was unaware of the content of Mr Inman's phone calls from 4 to 9 July 2020, and was unaware of the fact that Mr Inman was having issues with his partner. On 10 July 2020, Mr Inman tried to call his partner on 14 occasions, but the calls did not connect. He also called his mother and asked her to contact his partner and told his mother not to come to Acacia for a scheduled visit the following day.[103,104,105]

[101] Exhibit 1, Vol 2, Tab 36.26, PRAG Minutes (10.07.20)
[102] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(09.07.20), paras 28-29
[103] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p17
[104] See also: Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p41
[105] ts 09.05.23 (Calverley), pp103-106, 117 & 119

THE EVENTS OF 11 JULY 2020

Mr Inman is missing from muster check[106,107,108,109,110,111,112,113,114,115,116,117,118]

52. By 11 July 2020, Mr Inman was back in his unit in Uniform block and on low ARMS. He was observed by custodial staff on several occasions during the morning, and entries were made into the ARMS observation logbook. At about 9.00 am, Officer Manifis saw Mr Inman playing a computer game and thought he "*appeared fine*".[119,120,121]

53. Mr Inman's cellmate said that although they shared a cell, he and Mr Inman were not close. He described Mr Inman as a "*happy bloke*" and said that during lockups, they would talk and watch TV and Mr Inman would paint. The cellmate said Mr Inman did not talk about his partner, but the cellmate was aware from other prisoners in the unit, that Mr Inman suspected she was "*cheating on him*". The cellmate also said that in the days before his death, Mr Inman "*seemed to be fine*" and on the morning of 11 July 2020, he "*was pretty happy*" and "*was laughing*".[122]

54. Mr Inman was also seen moving around the unit and the basketball area and speaking with various prisoners, and at about 9.37 am, Officer Moore asked how he was going and Mr Inman replied: "*Yeh alright*". Officer Moore had also seen Mr Inman playing a computer game earlier, and when she asked if he needed a few days rest from his job as a unit worker, he said "*he was still doing it and doesn't mind it*".[123]

---

[106] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp19-23
[107] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), pp2-3
[108] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), paras 18-24 and ts 09.05.23 (Manifis), pp16-18
[109] Exhibit 1, Vol 1, Tab 10, Statement - Officer N Manifis (undated), paras 11-20
[110] Exhibit 1, Vol 1, Tab 11, Statement - Officer K Moore (10.08.20), paras 9-18 and ts 09.05.23 (Moore), pp36-37
[111] Exhibit 1, Vol 2, Tab 36.29, Statement - Officer K Moore (02.09.20), paras 7-17
[112] Exhibit 1, Vol 2, Tab 36.28, Statement - Officer D Boudville (09.10.20), paras 10-26
[113] Exhibit 1, Vol 2, Tab 36.35, Statement - Officer B Leipold (17.09.20), paras 8-14
[114] Exhibit 1, Vol 2, Tab 36.37, Incident Description Reports - Attending Officers (11.07.20)
[115] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), pp5-7 & 23
[116] Exhibit 1, Vol 1, Tab 25, CCTV Summary of Mr Inman's movements (11.07.20)
[117] Exhibit 1, Vol 1, Tabs 13.1 - 13.3, WAPOL Incident Reports 110720132015282 & LWP20071100567013
[118] Exhibit 1, Vol 1, Tab 28, Master Control Logs and related documents (11.07.20)
[119] Exhibit 1, Vol 2, Tab 36.27, ARMS Offender Supervision Log
[120] Exhibit 1, Vol 1, Tab 10, Statement - Officer N Manifis (undated), para 10
[121] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p21
[122] Exhibit 1, Vol 2, Tab 36.38, Statement - Prisoner HB (17.09.20), paras 4-8
[123] Exhibit 1, Vol 1, Tab 11, Statement - Officer K Moore (10.08.20), paras 9-15

55. Between 7.51 am and 10.36 am, Mr Inman used the PTS to call his partner four times, but his calls went unanswered. Police enquiries later determined that this was because Mr Inman's partner had been arrested at about 4.15 pm on 9 July 2020. On 10 July 2020, she was remanded in custody to Melaleuca Prison, and so would not have had access to her mobile phone when Mr Inman was trying to call her.[124]

56. In addition to calling his partner, Mr Inman also called a friend, and he called his mother three times. Although Mr Inman was due to receive a visit from his partner that morning, during a call with his mother at 10.36 am, his mother told him that his partner was not answering her (the mother's) messages and she would keep trying to reach her. Mr Inman told his mother not to worry and said he was "*going now*", and when his mother asked him if he was going to "*do anything stupid*", he replied: "*I'm not*", before he ended the call.

57. CCTV footage shows that after his call to his mother, Mr Inman collected a laundry bag and returned to his cell, before heading to the laundry which is located next to a storeroom. At the time, prisoners had unfettered access to this storeroom, with the door (which locked if closed) being propped open during the day.

58. It appears this free access was permitted for administrative convenience, and prisoners went into the storeroom to obtain items including food, toiletries and recreational equipment. One of the prisoners on the unit also said that some officers would close the door, whilst others were happy to leave it open and that at times, prisoners propped the storeroom door open using tissues.[125]

59. In any case, CCTV footage shows Mr Inman walking in the direction of the storeroom, before he moves out of view of the CCTV camera. At about 11.20 am, the muster conducted prior to lunch was underway, and it was realised that Mr Inman was not standing outside of his cell door as he was required to do.

[124] Exhibit 1, Vol 1, Tab 22.3, Summary of Incoming Calls (09.07.21 - 11.07.21)
[125] Exhibit 1, Vol 2, Tab 36.32, Statement - Prisoner BL (30.07.20), paras 18-20

60. Officer Moore, who was one of the custodial staff involved in conducting the muster, made a series of calls to various areas of Acacia, in an attempt to locate Mr Inman, but was unsuccessful.

Mr Inman is found[126,127,128,129,130,131132,133,134,135,136,137,138,139,140]

61. When Mr Inman could not be located, Officer Moore asked her colleagues to return to Unit 3 to help her search for him. When Officer Manifis arrived on the unit, he noticed that the unit's storeroom door was closed, and he thought this was unusual because the door was usually propped open.

62. Officer Moore asked Officer Manifis to check the storeroom, and when he entered, he found Mr Inman hanging, with a bedsheet around his neck that was tied to an air conditioning duct. Officer Manifis made a Code Red emergency call using his prison radio at about 11.22 am, and two prisoners helped to remove the bedsheet from around Mr Inman's neck and lower him to the floor.

63. The prisoners who assisted Officer Manifis are to be commended for their prompt and valuable efforts in very difficult circumstances. After helping Officer Manifis, the prisoners returned to their cells as they had been told to do. Meanwhile, Officer Moore and Officer Derek Boudville immediately started CPR, assisted by Officer Manifis, and the various custodial and medical staff who responded to the Code Red.

64. When Mr Inman's cellmate returned to their shared cell, he noticed that some extra sheets Mr Inman had obtained because he was feeling cold were now missing. The cellmate also noticed "*torn up photographs and bits of paper*" in the cell's bin and alerted custodial staff.

---

[126] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), pp19-23
[127] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), pp2-3 & 24-28
[128] Exhibit 1, Vol 1, Tab 10, Statement - Officer N Manifis (undated), paras 21-31
[129] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), paras 26-52 and ts 09.05.23 (Manifis), pp19-22
[130] Exhibit 1, Vol 1, Tab 10, Statement - Officer K Moore (10.08.20), paras 19-38 and ts 09.05.23 (Moore), pp37-39
[131] Exhibit 1, Vol 2, Tab 36.32, Statement - Prisoner BL (30.07.20), paras 4-26
[132] Exhibit 1, Vol 2, Tab 36.29, Statement - Officer K Moore (02.09.20), paras 18-28
[133] Exhibit 1, Vol 2, Tab 36.33, Statement - Officer A Ohrman (05.10.20), paras 4-21
[134] Exhibit 1, Vol 2, Tab 36.34, Statement - Officer P Whayman-Smith (15.09.20), paras 7-38
[135] Exhibit 1, Vol 2, Tab 36.35, Statement - Officer B Leipold (17.09.20), paras 15-34
[136] Exhibit 1, Vol 2, Tab 36.36, Statement - Officer S Hey (11.09.20), paras 8-15
[137] Exhibit 1, Vol 2, Tab 36.37, Incident Description Reports - Attending Officers (11.07.20)
[138] Exhibit 1, Vol 2, Tab 36.38, Command Suite Incident Log (11.07.20)
[139] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), pp5-7
[140] Exhibit 1, Vol 1, Tabs 32.1 - 32.5, Acacia Critical Incident Briefs (11.07.20 - 13.07.20)

65. Officer Manifis had realised the possible significance of the items found in the bin, and so he secured it to ensure that the items were not inadvertently disposed of. One of the pieces of paper in the bin had the words "*RIP Stanley*" written on it several times. This is significant because Stanley is Mr Inman's first name.[141]

66. In passing I note that Officer Manifis was not wearing a Hoffman knife, which has a curved blade that is designed to safely cut ligatures. Nevertheless, the evidence before me establishes there was no significant delay in freeing Mr Inman from the ligature and starting CPR.

67. Medical staff arrived on the unit at about 11.26 am, and an oxy-viva mask and defibrillator were attached to Mr Inman's body. The defibrillator advised that Mr Inman's heart was in a non-shockable rhythm, and so CPR was continued.

68. Ambulance officers arrived at the unit at about 11.41 am, and took over resuscitation attempts. This included giving him adrenalin, and at about 11.56 am, a spontaneous return of circulation was achieved and a pulse was detected. Mr Inman was placed in an ambulance and left Acacia for SJOG at about 12.18 pm.[142]

69. On arrival at SJOG, Mr Inman was initially treated in the emergency department. A CT scan of his head showed evidence of a hypoxic brain injury, with swelling of the brain as well as "*loss of grey/white matter differentiation and early cerebral peduncle herniation*".[143,144]

70. When Mr Inman was admitted to SJOG, his custodial supervision was taken over by staff from Broadspectrum, the company contracted by DOJ to supply this service. As Mr Inman had been placed in an induced coma, authorisation was given for him to be unrestrained and he was permitted unlimited visits from his family.[145,146,147,148149]

[141] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p21
[142] Exhibit 1, Vol 1, Tab 14, SJA Patient Care Record Crew WUN21DC (11.07.20)
[143] Exhibit 1, Vol 1, Tab 15.1, SJOG Discharge Summary (13.07.20)
[144] Exhibit 1, Vol 1, Tab 15.2, SJOG Progress Notes (11-13.07.20)
[145] Exhibit 1, Vol 2, Tab 36.41, Broadspectrum Death In Custody documents and ts 09.05.23 (Palmer), pp132-133
[146] Exhibit 1, Vol 2, Tab 36.41, Email Dep. Director C Moody (11.07.20)
[147] Exhibit 1, Vol 2, Tab 36.39, Command Suite Incident Log (Mr Inman's mother contacted at 1.25 pm, 11.07.20)
[148] Exhibit 1, Vol 2, Tab 36.40, Offender Notes, Ms M Turvey contacts Mr Inman's mother (3.27 pnm 11.07.20)
[149] Letter from Wotton + Kearney Perth to Mr J Tiller (16.06.23), paras 11-12

Restraints issue[150]

71. In a statement to the Court, one of Mr Inman's sisters says her mother received a text message from Acacia advising her that Mr Inman was in hospital. When family members arrived at SJOG, Mr Inman's sister says a doctor told them Mr Inman had gone missing at Acacia and been found in a storeroom. Family members were told Mr Inman was on life-support, and Mr Inman's sister says that her brother was "cuffed to the bed" and being supervised by staff. She says the family asked: "*Why does he need the cuffs*".[151]

72. At the inquest, the family's counsel Ms O'Brien stated that her instructions about the matter were as follows:

> I do have some information about the restraints issue, your Honour, which is not dealt with in the statements, and we can confirm by providing a further statement if that's needed, but my understanding is that the family's recollection is that when they went to the hospital on 11 July (2020), Stanley's right arm was handcuffed to the bed. There were no other restraints. He did not have, for example, shackles on his legs and so on…The right hand was handcuffed and that day, an advocate on behalf of the family, and that is a person who is in the room today, telephoned the Commissioner of Corrective Services to request that the restraints be removed, and when the family came in the next day, on 12 July (2020), the restraints had been removed.[152]

73. Other evidence before me suggests Mr Inman was not restrained at SJOG. For example, Acacia's Control Room Log which contains contemporaneous entries about Mr Inman's emergency care at Acacia and his transfer to SJOG, states in part:

> 1221: CPR continued by paramedics. No restraints applied.
>
> 1307: Master Control contacted - no restraints applied due to emergency medical care.
>
> 1347: Master Control called with updates. No restraints applied.

[150] ts 09.05.23 (Palmer), pp139-145
[151] Exhibit 1, Vol 2, Tab 40, Statement - Ms T Austin (08.05.23), paras 27-28
[152] ts 10.05.23 (O'Brien), p193

1550: Prisoner unresponsive. No restraints applied.

1600: Handover to (Broadspectrum).

1625: Visitors arrive (i.e.: family members).

1645: Handover to (Broadspectrum) completed.[153]

74. An incident report prepared by one of the two prison officers who supervised Mr Inman at SJOG until Broadspectrum took over refers to the arrival of ambulance officers at Acacia and states: "*Due to* (Mr Inman's) *medical status and the life preserving work that was being conducted it should be noted that no mechanical restraints were applied*".[154]

75. The other prison officer supervising Mr Inman at SJOG prior to Broadspectrum assuming this duty is consistent with the extracts of entries from the Control Room Log. That officer arrived at SJOG at 12.55 pm and their incident report states: "*We maintained constant supervision of Prisoner Inman, SJ as he was not in restraints due to his state at the time*".[155]

76. An email from Mr Craig Moody, Deputy Director Serco Asia Pacific at 4.13 pm on 11 July 2020, states that based on Mr Inman's condition no restraints are to be placed on him, until "*any change in condition*" when a further assessment would be undertaken.[156]

77. A Broadspectrum "PIC Record of Events" document states: "*standard restraints not applied - security check done. Nil restraints applied*",[157] and the directive in Mr Moody's email is reflected in Broadspectrum's "Restraints Risk Assessment" dated 11 July 2020, which states: "*Amended version due to induced coma. Nil restraints have been approved by Craig Moody - Deputy Director Serco Asia Pacific. Should PIC Inman health position change Control to be notified to review the situation with Acacia and Department of Justice*".[158]

[153] Exhibit 1, Vol 1, Tab 29.3, Control Room Log (11.07.20), pp238547 - 238547
[154] Exhibit 1, Vol 1, Tab 27.1, Incident Description Report - Officer A Anderson(11.07.20)
[155] Exhibit 1, Vol 1, Tab 27.16, Incident Description Report - Officer A Hindi (11.07.20)
[156] Exhibit 1, Vol 2, Tab 36.41, Email Dep. Director C Moody (4.13 pm, 11.07.20)
[157] Exhibit 1, Vol 2, Tab 36.41, Broadspectrum PIC Record of Events 262745 (4.45 pm, 11.07.20)
[158] Exhibit 1, Vol 2, Tab 36.41, Broadspectrum Restraints Risk Assessment (11.07.20)

78. At the relevant time, under the heading "*Medical conditions/injuries prohibiting the use of restraints*", DOJ's restraints policy provided that:

> If, in the opinion of the escorting officer, a prisoner is seriously ill to the extent that it is apparent that security will not be breached, the officer may remove the restraints. If this occurs, the superintendent is to be advised immediately.[159]

79. Under DOJ's current restraints policy, subject only to an adverse risk assessment, Mr Inman would not have been restrained when he left Acacia because he was unconscious.[160] However, contrary to the entries in the Control Room Log, to which I referred earlier, documents relating to Mr Inman's movement to SJOG state that handcuffs and leg irons are required.[161,162] This discrepancy is clearly confusing, and it does seem unlikely that Mr Inman's sister would be mistaken about him being restrained when she first saw him at SJOG.[163,164]

80. I have not been able to determine why most of the available evidence appears to indicate that restraints were not applied to Mr Inman, when his family say they were. It is possible that Mr Inman may have been restrained at some point, but that after Mr Moody's email, any restraints which had been applied to Mr Inman were removed.[165,166,167] It is also possible (however unlikely) that in the appalling circumstances of visiting her unconscious brother, his sister may perhaps be mistaken.

81. All I can say is that if Mr Inman was restrained at any stage after he left Acacia, this would have been contrary to the policy at the time, and wholly inappropriate. Although the preponderance of documentary evidence is to the contrary, the evidence of Mr Inman's sister as to what she and the family saw when they first saw him at SJOG is that he was restrained. Even though her statement was not signed until 8 May 2023, as I have noted it would be surprising if she is mistaken on this point.[168]

---

[159] Exhibit 1, Vol 2, Tab 45.1, Policy Directive 82 - Appendix 1: Prisoner Movements Procedures, para 30.4.4
[160] Exhibit 1, Vol 2, Tab 45.2, COPP 12.3 Conducting Escorts, para 5.3.1 (effective from 04.01.21)
[161] Exhibit 1, Vol 1, Tab 31.1, Acacia Prison - Offender Movement Information (11.07.20)
[162] Exhibit 1, Vol 1, Tab 31.2, Acacia Prison - Medical Appointment Form (11.07.20)
[163] Exhibit 1, Vol 1, Tab 31.1, Acacia Prison - Offender Movement Information (11.07.20)
[164] Exhibit 1, Vol 1, Tab 31.2, Acacia Prison - Medical Appointment Form (11.07.20)
[165] ts 09.05.23 (Palmer), p144
[166] Exhibit 1, Vol 2, Tab 45.2, COPP 12.3 Conducting Escorts, para 5.3.1
[167] See also: Exhibit 1, Vol 2, Tab 45.1, Policy Directive 82 - Appendix 1: Prisoner Movements Procedures
[168] Exhibit 1, Vol 2, Tab 40, Statement - Ms T Austin (08.05.23), paras 27-28

82. In any case, at the inquest, Mr Cade confirmed DOJ's position in relation to the need to restrain Mr Inman was as follows:

> Regardless of which policy is considered, it's the position of the department that Stanley's condition at the time of transport to [SJOG] was not such as to require restraint either during the period of transport or whilst he was at [SJOG].[169]

Mr Inman's death[170,171]

83. Mr Inman was admitted to SJOG and intubated. His treating team discussed his poor prognosis with his family, and over the next two days Mr Inman's condition continued to slowly decline.

84. In the early hours of 13 July 2020, his blood pressure dropped markedly and he experienced an "*acute vasopressor requirement*", consistent with the progression of his hypoxic brain injury.

85. At about 3.10 am, the treating team advised Mr Inman's family that his condition had deteriorated significantly. Active treatment was withdrawn later that morning and Mr Inman was kept comfortable, until he died, in the presence of his family, at 10.54 am.[172,173,174]

[169] ts 10.05.23 (Cade), p159
[170] Exhibit 1, Vol 1, Tab 15.1, SJOG Discharge Summary (13.07.20)
[171] Exhibit 1, Vol 1, Tab 15.2, SJOG Progress Notes (11-13.07.20)
[172] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (13.07.20)
[173] Exhibit 1, Vol 1, Tab 3, P92 - Identification of deceased (13.07.20)
[174] Exhibit 1, Vol 1, Tab 4, Death in Hospital Form (13.07.20)

CAUSE AND MANNER OF DEATH[175,176]

86. A forensic pathologist (Dr Victoria Kueppers) conducted an external post mortem examination of Mr Inman's body at the State Mortuary on 16 July 2020 and reviewed post mortem CT scans. Dr Kueppers' most significant finding was an apparent ligature mark around Mr Inman's neck which was "*in keeping with the circumstances provided surrounding the death*".[177]

87. Dr Kueppers also noted healing superficial linear defects to the left forearm and chest "*possibly in keeping with intentional self-harm*". A post mortem CT scan showed pharyngeal oedema, but no other internal neck injury, and other than swelling of the brain, there were no other significant findings.[178]

88. Toxicological analysis of samples taken prior to Mr Inman's death found nortriptyline (an anti-depressant medication) in his system. Alcohol and other common drugs were not detected, and samples taken after death found medications consistent with Mr Inman's medical care.[179,180]

89. At the conclusion of the external post mortem examination, Dr Kueppers expressed the opinion that the cause of death was complications of ligature compression of the neck.

90. I accept and respectfully adopt Dr Kueppers' opinion and find Mr Inman died from complications of ligature compression of the neck.

91. Further, on the basis of the available evidence as to the circumstances of Mr Inman's death, I find death occurred by way of suicide.

[175] Exhibit 1, Vol 1, Tab 5.1, Supplementary Post Mortem Report (26.08.20)
[176] Exhibit 1, Vol 1, Tab 5.2, Post Mortem Report (16.07.20)
[177] Exhibit 1, Vol 1, Tab 5.1, Supplementary Post Mortem Report (26.08.20), p1
[178] Exhibit 1, Vol 1, Tab 5.1, Supplementary Post Mortem Report (26.08.20), p1
[179] Exhibit 1, Vol 1, Tab 6.1, Supplementary Toxicological Report - ChemCentre WA (17.08.20)
[180] Exhibit 1, Vol 1, Tab 6.2, Final Toxicological Report - ChemCentre WA (23.07.20)

ISSUES RELATING TO MR INMAN'S CARE

Failure to record history of self-harm

92. Although information about Mr Inman's December 2019 presentation to FSH was entered into his DOJ medical record (EcHO) on 5 March 2020, it was not added to Mr Inman's "*Active Problem List*" in EcHO. According to the DOJ Health Review, had this been done it would have "*raised visibility of this for all staff accessing his file and ensure awareness of this elevated vulnerability*".[181,182]

93. Nevertheless, the minutes of the PRAG meeting on 9 July 2020 refer to Mr Inman's placement on ARMS when he was initially admitted to Hakea and that: "*it was reported during that placement* (February 2020) *that Mr Inman had attempted to take his life by hanging two months prior to his imprisonment due to increased stress and substance use*".[183]

94. The question of whether sufficient weight was placed on this previous history is of course another matter. Information about Mr Inman's self-harm history was obviously relevant to any proper assessment of his current risk level. Further, as the DOJ Health review notes, data from the Australian Institute of Health and Welfare (AIHW) establishes that the suicide rate for Aboriginal people is twice that for non-Indigenous people, and the rates for young Aboriginal men are "*more than double that of females*".[184]

95. The Health Review also noted:

> **All this information from AIHW would suggest that in a young male Aboriginal person, any history at all of self-harm or suicidal ideation should be flagged as they are at high risk compared to the general population.** Another significant statistic from AIHW is that people who died by suicide accessed fewer health services in their last year of life than those who died from other causes…

[181] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p16
[182] See also: ts 09.05.23 (Calverley), p115
[183] Exhibit 1, Vol 2, Tab 36.23, PRAG Minutes (09.07.20)
[184] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p16

> …It may be that indirectly, Mr Inman's increasing lack of compliance with his [Rheumatic Heart Disease] prevention regime, was a subtle symptom that might have pointed to an increasing vulnerability. Whether that was so is conjecture; however, raising the visibility of his recent suicidal ideation in response to a stressful family loss (his brother's death) could have enabled more awareness in his treating team of this vulnerability and risk of repetition in the setting of other stressors.[185] [Emphasis added]

96. In terms of access to information about health issues affecting the prisoners they are assessing, I note that PWS staff[186] now have read and write access to EcHO and have received relevant training.[187] Read access to EcHO was granted in June 2020 with training delivered in about July 2020, whereas write access to EcHO was made available in about 2021.[188] This should mean that all health and psychological services staff have better access to relevant information about the prisoners they are jointly managing.

97. Access to EcHO is not restricted by "*user type*" and instead operates on a first on basis. In terms of the licences necessary to access EcHO, as of 29 May 2023, DOJ purchased a further 25, meaning there are now 225 licences which can be used across the prison estate.[189] All prison health staff have access to EcHO, including mental health nurses, Aboriginal Health Workers, allied mental health workers, psychologists and psychiatrists.[190,191]

Access to prisoner calls[192]

98. Following Mr Inman's death, Acacia prepared a post incident report (the Report) which made three recommendations. The first was that prison procedure be changed so that PTS calls and prisoner mail would be routinely checked for all prisoners "*being considered for a four-hourly low ARMS observation level*".

[185] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), pp16-17
[186] Now known as Prison Health Services - Counselling staff
[187] ts 09.05.23 (Waine), p80 and ts 09.05.23 (Calverley), p93
[188] Letter from Wotton + Kearney Perth to Mr J Tiller (16.06.23), para 4
[189] Email Mr J Tiller (30.06.23), conveying information received from State Solicitor's Office
[190] ts 09.05.23 (Palmer), pp144-145
[191] Letter from State Solicitors Office to Mr J Tiller (25.05.23), Response 1
[192] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p24

99. As I have noted, the PRAG was unaware of the content of any of the calls Mr Inman made from 4 to 8 July 2020,[193] and I agree with the following observation in Serco's Post Incident Review Report that:

> Had that occurred it would have been clearly obvious (Mr Inman) may actually have been under significant stress due to his obviously failing relationship with his 17-year old girlfriend together with his inability to control her life.[194]

100. In my view the importance of PRAG having access to information from the calls Mr Inman was making to his loved ones cannot be underestimated. Although Mr Inman routinely denied any self-harm or suicidal ideation during his ARMS reviews, he was clearly expressing his intention to harm himself to his family and his partner. In a very real sense, the matters he discussed during these calls clearly indicated that Mr Inman's mental state was deteriorating.

101. Had the PRAG been aware of the content of Mr Inman's phone calls at the time it was making assessments as to his appropriate ARMS level, it may have realised that Mr Inman's recent self-harm was not an isolated event, but rather a further indication of his acute and ongoing distress. This may have meant the PRAG would have arrived at a different assessment of Mr Inman's risk level and provided an increased level of monitoring and support.

102. I am aware that the PTS is heavily used by prisoners and that numerous calls are made every day. However, the monitoring of calls made by at-risk prisoners is clearly an important component of ensuring the PRAG has all relevant and available information at its disposal when it makes critical decisions about the welfare of at-risk prisoners.

103. The Director General's responsibilities for prisoner welfare are set out in section 7(1) of the *Prison Act 1991* (WA) (the Prisons Act), which provides:

[193] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p17
[194] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p41

> Subject to this Act and to the control of the Minister, the chief executive officer is responsible for the management, control, and security of all prisons and **the welfare and safe custody of all prisoners**. [Emphasis added]

104. When interpreting this provision, the term "*welfare*" takes its ordinary English meaning, namely: "*the health, happiness, and fortunes of a person or group*".[195] It is significant that in addition to being responsible for the welfare of prisoners, the Director General must ensure their "*safe custody*" and in my view this includes the proper management of at-risk prisoners who are the subject of ARMS observations.

105. I therefore note with approval, the contents of a briefing note dated 31 July 2020, which states that on days when the PRAG was meeting, the Acacia Prison Intelligence Unit (APIU) will monitor the most recent calls of prisoners at risk that are being assessed. The briefing note says that APIU would listen to "*as many calls as operationally feasible*" and put additional resources into monitoring "*more calls of prisoners on higher levels of observation*", where this was "*operationally feasible*".

106. The briefing note also says that a brief summary of the information obtained would then be provided to the PRAG Chair no later than one hour prior to the PRAG meeting.[196,197] In an email dated 13 March 2023, the Safer Custody Manager confirmed that the current practice at Acacia is that the Safer Custody Unit now monitors calls made by at-risk prisoners.[198]

107. At the inquest, Ms Calverley confirmed that following Mr Inman's death, when she was in the role of the PRAG Chair, she had access to the recordings of calls made by at-risk prisoners. She explained her process in these terms: "*I had access to all the phone calls and then I could listen to whoever we were reviewing that day, could listen to all their phone calls that had been made in between reviews and then I could give a summary to the rest of the PRAG as to the content*".[199]

---

[195] Compact Oxford English Dictionary (3rd Ed, 2005), p1179
[196] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p24
[197] Exhibit 1, Vol 2, Tab 36.42, Acacia Prison Briefing Note - PRAG and APIU (31.07.20)
[198] Exhibit 1, Vol 2, Tab 36.42, Email - Ms K Gazzola (13.03.23)
[199] ts 09.05.23 (Calverley), p105

108. In his statement to the Court, Mr Waine said he was surprised to hear of Mr Inman's death and that there had been no indication in the ARMS review he conducted on 10 July 2020 that Mr Inman was at risk. Mr Waine says he would have asked Mr Inman about his concerns at not being able to contact his partner, had he (Mr Waine) been aware of the issue. Mr Waine said that Mr Inman's response would have provided more information to assist him in arriving at an appropriate ARMS recommendation, and it was likely Mr Waine would "*have taken a cautious approach to [Mr Inman's] ARMS supervision levels*".[200]

109. As I have noted, since Mr Inman's death, PRAG has had access to information from telephone calls made by at-risk prisoners being managed on ARMS.[201] Further, at the inquest, Ms Calverley was asked whether access to Mr Inman's calls might have changed PRAG's assessment and her response was:

> Yes. It certainly could have…and has affected the outcomes in PRAG. You know…that's a key piece of information and I…can speak from having done PRAG without that, you know, to this point and then having done PRAG since, that…it can be such vital information because often whilst prisoners know generally their phone calls are recorded and monitored, they also know that they're not all…monitored.
>
> But so often they will speak quite freely on the phone and we've found out some really key piece of information and been able to keep people safe having that information. So it absolutely could have changed things.[202]

110. In passing I note that another source of information about prisoner's welfare is the prisoner's family and loved ones. Although there is no obligation for a prisoner's family to report any concerns they may have, many do so. Although this did not occur in Mr Inman's case, in the Report Ms Calverley emphasised the value of receiving such information, noting:

[200] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(02.10.20), paras 30-31
[201] Exhibit 1, Vol 2, Tab 36.16, Statement - Mr M Waine(02.10.20), para 32
[202] ts 09.05.23 (Calverley), p105

> If we get third party information, it's like gold, so we can kind of use that to show the inconsistency, to show that he's saying one thing to us who can make the changes and give him what he wants, but he's saying something very different to his mum, his girlfriend, whoever, so we take that really seriously.[203]

111. In her statement to the Court, Mr Inman's sister says that she became concerned for her brother's welfare in the days before his death, and called Acacia's reception number several times. She says she eventually spoke to a staff member who told her someone would call her back, but that nobody did.[204]

Access to Hoffman knives[205,206]

112. The second recommendation made by the Report relates to ensuring that all officers are equipped with "*rescue tools*". Although the officer who located Mr Inman was not carrying a Hoffman knife, there is no evidence before me that there was any significant delay in removing the ligature from around Mr Inman's neck, lowering him to the ground, and starting CPR.[207,208,209]

113. In a statement to the Court, one of the officers who responded to the Code Red suggested that response officers should "*carry a Hoffman knife to counteract any delay in assisting prisoners who may be found hanging*".[210] It appears that this very sensible suggestion was acted on, and the DIC Review notes that in an email dated 13 March 2023, Acacia confirmed that all "*response officers*" now have immediate access to Hoffman knives.[211,212]

---

[203] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p5
[204] Exhibit 1, Vol 2, Tab 39, Statement - Ms J Miller (08.05.23 undated), paras 31-37
[205] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p24
[206] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p44
[207] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p45, para 12.1.2
[208] Exhibit 1, Vol 1, Tab 10, Statement - Officer N Manifis (undated), paras 21-31
[209] Exhibit 1, Vol 2, Tab 36.20, Statement - Officer N Manifis (17.10.20), paras 26-52
[210] Exhibit 1, Vol 2, Tab 36.33, Statement - Officer A Ohrman (05.10.20), para 22
[211] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p24
[212] ts 09.05.23 (Manifis), pp22 & 29-30 and ts 09.05.23 (Moore), p40

Access to Unit storerooms[213]

114. The third recommendation was that access by prisoners to the storerooms on their respective units be controlled by custodial staff.[214] In other words, since Mr Inman's death, all storeroom doors are locked, and prisoners needing to access the storeroom must seek the assistance of a prison officer, and are supervised while in the storeroom.[215]

115. Acacia confirmed that storerooms in all units are locked at all times, and are unlocked by custodial staff when a prisoner makes this request. Custodial staff supervise prisoners accessing storerooms, and the door is locked after the prisoner leaves. Further, in an effort to reduce the need for prisoners to access storerooms in their units, various items have been relocated to other areas.[216]

Acacia ARMS review[217]

116. In a review of Mr Inman's health file conducted by Serco, it was noted that following Mr Inman's death, Dr Andrew Mead (psychiatrist at Acacia) had conducted a review of the ARMS manual and reviewed the approach of other jurisdictions to managing at-risk prisoners. Although the Western Australian approach was found to be "*the most comprehensive*", Acacia said it would look to "*augment*" the ARMS process by having Indigenous Support Officers link with all placements and reviews of prisoners on ARMS or SAMS.

117. Acacia had also provided "*greater operational oversight*" to PRAG meetings by the attendance of senior management staff, so that PRAG decisions also incorporated "*operational placement and operation risk*" as well as clinical factors when making decisions about a prisoner's level of risk.

118. Following an inquest I conducted into the death of Mr Wayne Larder in October 2022 (the Larder Inquest), I recommended DOJ:

[213] Exhibit 1, Vol 2, Tab 36.1, Death in Custody Review (13.04.23), p24 and ts 09.05.23 (Manifis), pp40-41
[214] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p45, para 12.1.3
[215] ts 09.05.23 (Manifis), pp11-12 and 19 and ts 09.05.23 (Moore), pp35-35
[216] Exhibit 1, Vol 2, Tab 38.2, Email - Mr N McRaith, Asst. Director (22.07.20)
[217] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), pp3-4

> Establish a Suicide Prevention Governance Unit (the Unit) in order to (amongst other things) provide a system of formal quality assurance, oversight, and auditing of PRAG decisions. The Unit would promote consistency and best practice in the application of the At Risk Management System (ARMS) and provide advice and training to PRAG members.[218]

119. At the inquest, Ms Palmer advised that DOJ's Suicide Prevention Governance Unit (SPGU) was established on 1 February 2023. In a response to the recommendations I made in the Larder Inquest, DOJ advised that SPGU would be fully operational from 1 July 2023. In my view this is a welcome development and should enhance and support the important work that the PRAGs undertake on a daily basis.[219,220]

Cultural support of Indigenous prisoners[221]

120. In a detailed report provided to the Court, Professor Pat Dudgeon AM (with assistance from Dr Ee Pin Chang) outlined her views on culturally safe prison care for Aboriginal people. The report referred to the importance of culturally safe programs in prisons, and "*the visible representation of Aboriginal and Torres Strait Islander staff*".[222]

121. After reviewing the materials in the Brief, Professor Dudgeon expressed the opinion that the care provided to Mr Inman was not culturally safe, noting that Mr Inman should have had access to (and have been supported by) Aboriginal clinical and peer support staff.[223]

122. Professor Dudgeon also noted that the disparity between Mr Inman's self-reporting when asked about his mental health, and what he was telling his family and partner:

> May suggest that Mr Inman did not feel supported by the prison staff to enable him to share his concerns with the staff who provided him care.[224]

---

[218] [2022] WACOR 48, para 88, Recommendation 1
[219] Exhibit 1, Vol 2, Tab 42, Statement - Ms T Palmer (08.05.23) and ts 09.05.23 (Palmer), pp133-134
[220] Attachment 1 to Letter to Court from Minister for Corrective Services (02.05.23)
[221] Exhibit 1, Vol 2, Tab 37, Serco Health File Review (26.10.20), pp3-4
[222] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23), pp2-4
[223] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23), pp5-6
[224] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23), p5

123. According to Acacia, in July 2020, there were seven Aboriginal and Torres Strait Islander (ATSI) staff at Acacia, two of whom "*were employed in health and mentoring positions*". In July 2020, Acacia says it did not have an Aboriginal Liaison Officer, but that the following staff "*would have been able to give support to Mr Inman's family in July 2020*": an Indigenous Initiatives Coordinator, an Education facilitator, and a Young Adult Support Worker.[225]

124. Although the number of ATSI health workers and peer support prisoners has increased, the total current number of ATSI staff and support prisoners at Acacia (20 staff out of a total of 325 staff) remains discouragingly low. DOJ provided additional information regarding the number of ATSI staff at Acacia in July 2020 compared with May 2023.

125. After the inquest, Counsel Assisting (Mr Jon Tiller) provided me with a table, setting out the data provided by DOJ and his analysis of changes in staff numbers over the relevant period. I have reproduced this table at the end of this finding (see Attachment 1: Table showing ATSI staff and support prisoners at Acacia).

126. Despite my concerns about the total number of ATSI staff available at Acacia, Ms Calverley commented favourably about the support provided to young offenders by the Young Adult Mentor, Ms Michelle Turvey, (known as "*Auntie*") who was available at Acacia during Mr Inman's incarceration.[226,227] I also note that an Aboriginal Peer Support Officer attended the PRAG meeting on 10 July 2020.[228,229]

127. In terms of cultural support for Aboriginal prisoners, it is disappointing that the Aboriginal Visitors Scheme (AVS) ceased at Acacia in April 2022, when the AVS visitor resigned. According to Ms Palmer, the AVS: "*promotes a culture of resilience and healing and assists prisoners in connecting with their culture and community*",[230] and is clearly an important support mechanism.

---

[225] Letter Wotton + Kearney Perth to Mr J Tiller (16.06.23), paras 6-9
[226] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p42 and ts 09.05.23 (Calverley), pp107-108
[227] See also: ts 09.05.23 (Waine), pp63-64
[228] Exhibit 1, Vol 2, Tab 36.26, PRAG Minutes (10.07.20)
[229] ts 10.05.20 (Beetham), p168
[230] Exhibit 1, Vol 2, Tab 44.2, Statement - Ms T Palmer (09.05.23), para 7

128. Although AVS is not currently operating at Acacia, DOJ advised that an after-hours AVS service is available to Aboriginal prisoners at Acacia, and "*Reset and Outcare provide Aboriginal specific services at Acacia, contracted by the Department*". DOJ also noted that:

> The filling of AVS positions across the prison estate remains a priority for the Department. However, the challenges associated with attracting and retaining suitable staff continues to prevent filling these vacancies. Work continues on a revised service delivery model for the AVS and is expected to address the current staffing issues and improve conditions and outcomes for Aboriginal people in custody. In the meantime, efforts to fill vacancies continue with a recruitment process underway to ensure AVS positions are filled across the prison estate.[231]

129. In a statement to the Court, Ms Palmer advised that although DOJ does not have "*an overarching cultural support policy*", DOJ has "*progressively introduced policies and programs to protect and improve the health of Aboriginal prisoners, including the prevention of suicide and self-harm*".[232] In support of that assertion, Ms Palmer outlined a range of language, art, cultural, and leadership programs which are conducted at various prisons throughout Western Australia in partnership with a range of Aboriginal organisations.[233]

130. Ms Palmer also pointed to the establishment of Prison Support Services (PSS), which she said: "*has a role in providing support and cultural expertise to people in custody identified to be at higher risk of self-harm and/or suicide*". PSS is comprised of Prison Support Officers, the AVS, and the Peer Support Program. Ms Palmer noted that all PSS positions are filled by "*Aboriginal staff and Elders*".[234]

131. Professor Dudgoen's report canvasses a broad range of issues, and makes very sensible recommendations about systemic reforms of the justice system, with a view to developing and enhancing culturally safe practices.

---

[231] Letter State Solicitor's Office to Mr J Tiller (25.05.23), Response 2
[232] Exhibit 1, Vol 2, Tab 44.2, Statement - Ms T Palmer (09.05.23), paras 4-5
[233] Exhibit 1, Vol 2, Tab 44.2, Statement - Ms T Palmer (09.05.23), para 11
[234] Exhibit 1, Vol 2, Tab 44.2, Statement - Ms T Palmer (09.05.23), para 6

132. I strongly encourage both Acacia and DOJ to carefully review the recommendations outlined in Professor Dudgeon's report.[235] At the inquest, Mr Cade confirmed that the report had been provided to the SPGU, and that their general response was:

> The department acknowledges the impacts of historical factors on Aboriginal and Torres Strait Islander people and notes Professor Dudgeon's recognition of culturally safe approaches for (ATSI) people in our care. The department has drafted an (ATSI) suicide prevention strategy based on the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013, which is undergoing internal review by (ATSI) business areas.
>
> The department will continue to develop this strategy, taking into consideration coronial recommendations provided in response to Mr Inman's inquest to support a culturally responsive approach to suicide prevention for ATSI people in our prisons.[236]

QUALITY OF SUPERVISION, TREATMENT AND CARE

133. After carefully reviewing the evidence, I have concluded that the management of Mr Inman's general health was appropriate and that he was appropriately counselled when he declined his benzylpenicillin injections. However, the overall quality of Mr Inman's supervision, treatment and care was of a lower standard than it should have been because his level of risk was not properly understood.

134. In my view, this occurred because Mr Inman's background risk level was not properly appreciated when he was first admitted to Hakea. Notably he did not see a psychologist or counsellor from that time until 9 July 2020.

[235] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23), pp11-15
[236] ts 10.05.23 (Cade), pp156-157

135. The Health Review prepared by DOJ after Mr Inman's death notes that a mental health assessment on 20 February 2020 was unremarkable, but that:

> Ideally a standardised assessment such as a MADRAS score,[237] would have improved the quality of this assessment, and involvement or availability of Indigenous health workers to contribute to the accuracy of the assessment could also have assisted (with) accuracy and details.[238]

136. The Health Review also noted that:

> Identifying (Mr Inman) as having a higher background risk of suicide in the context of acute family stresses or losses would have been helpful and pro-active in managing his mental state, but at his time of death he had already been under observation following a very recent episode of self-harm and timely awareness of stressors impacting individuals that would enable proactive prevention and intervention is also a challenge.[239]

137. However, what is missing from this assessment is the fact that the content of the calls Mr Inman was making in the days before his death was not assessed at the PRAG meetings discussing his level of risk. On the basis of the evidence of Ms Calverley and Mr Waine, it is my view that had the content of Mr Inman's phone calls been assessed by the PRAG at its meetings on 9 July 2020 and 10 July 2020, it is almost inevitable that he would have been the subject of a greater level of scrutiny for a longer period.

138. Further, instead of viewing Mr Inman's self-harming behaviour (which he disclosed on 8 July 2020) as a discrete incident, the content of his calls to his mother and partner would have identified that his distress in the period leading up to his death was far more acute than was appreciated.

[237] MADRAS is the abbreviation for Montgomery and Asberg Depression Rating Scale, which assesses levels of depression
[238] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), p15
[239] Exhibit 1, Vol 2, Tab 41, Health Services Review (08.05.23), pp18-19

139. It is also possible that had the culturally safe care referred to in Professor Dudgeon's report been available at Acacia, Mr Inman's life journey may well have been different.[240]

140. It is notable that Mr Inman had spent most of his adolescence in juvenile detention, and his admission to Hakea and later transfers to Casuarina and Acacia were his first detentions in an adult prison. Mr Inman also had a history of self-harm, and the deaths of his brother and grandmother were clearly relevant to any assessment of his risk of self-harm and/or suicide. In the period leading up to his death, Mr Inman had engaged in self-harm but the issues he was having with his partner were not disclosed by him and were not known by Acacia staff.[241]

141. As the Report notes, the ARMS Manual already provides (amongst other things) that when considering lowering a prisoner's ARMS observation level:[242]

> Incoming and outgoing mail and phone conversations have been checked (where feasible) for evidence of suicidal ideation and none has been detected".[243]

142. However, this requirement was not satisfied when Mr Inman's ARMS observation levels were lowered.[244]

143. At the inquest, Mr Waine confirmed that suicide cannot be predicted in any meaningful way.[245] Instead efforts are made to manage a prisoner's risk of self-harm.

144. Whilst there is no guarantee that Mr Inman's life journey would have been different if he had been the subject of greater scrutiny for longer, it seems obvious that had the PRAG had access to the content of his phone calls, Mr Inman would have been provided with a greater level of support.

---

[240] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23)
[241] Exhibit 1, Vol 2, Tab 43, Report - Prof. P Dudgeon (04.05.23), p13
[242] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p44
[243] ARMS Manual (2019), p23, para 4.3.3.1.5
[244] Exhibit 1, Vol 2, Tab 36.21, Serco Post Incident Report (26.10.20), p44
[245] ts 09.05.23 (Waine), pp52-53

145. However, it is worth noting that in terms of psychological support, as Mr Waine noted at the inquest, the role of counselling staff is risk assessment and crisis management, and: "*long-term intervention work was not part of our remit*".[246]

146. It is also possible that had the PRAG sought input from his family, they may have been able to shed light on the various issues he was telling them about. Of course, there is no guarantee that Mr Inman would have given his consent for his family to be contacted.

147. Nevertheless, given Mr Inman's youth, and the fact that he was experiencing his first admission to the adult prison system, input from his family, if freely given, may have been very useful in properly assessing his actual level of risk of self-harm.

CONCLUSION

148. Mr Inman was a dearly loved family member, who was only 19 years of age when he died at SJOG on 13 July 2020. His level of risk of self-harm was not properly appreciated at the time of his death, largely because phone calls in which he made statements about taking his life were not available to PRAG at the relevant time.

149. Since Mr Inman's death, the phone calls and mail of those prisoners who are on ARMS is now the subject of some level of scrutiny. Given the obvious potential importance of the information that may be gleaned in this analysis, it is my **strong** suggestion that every effort be made to ensure that scrutiny is as fulsome as humanly possible.

150. In this way, when PRAG makes important decisions about at-risk prisoners, it may do so with a greater understanding of the prisoner's mental state.

[246] ts 09.05.23 (Waine), p50

151. As I have outlined, since Mr Inman's death, Acacia has made changes to its scrutiny of prisoner phone calls and mail, the availability of Hoffman knives to response officers, and the previously unfettered access by prisoners to storerooms on their units. I have therefore decided that it is not necessary for me to make any recommendations in this matter.

152. In conclusion, as I did at the conclusion of the inquest, I wish to again convey to Mr Inman's family and loved ones, on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin
Coroner
19 July 2023

Attachment 1: Table showing ATSI staff and support prisoners at Acacia

	July 2020			May 2023			Change		
Position	**Total**	**ATSI staff**		**Total**	**ATSI staff**		**Total**	**ATSI staff**	
		#	**%**		**#**	**%**		**#**	**%**
Prison Officers	264	5	2%	254	4	2%	**-10**	**-1**	Unchanged
Health workers (Derbal Yerrigan, Serco, and Serco contractors)	14	0	0%	9	3	33%	**-5**	+3	+33%
Nurses & medical officers	24	1	4%	21	0	0%	**-3**	**-1**	-4%
Aboriginal Support Services (Real Support Network, Serco, and Serco contractors)	N/A	N/A	N/A	11	2	18%	+11	+2	+18%
Psychologists & social workers	12	0	0%	7	0	0%	**-5**	0	Unchanged
Peer support prisoners	27	7	26%	23	11	48%	**-4**	+4	+22%
Youth mentors (prisoners)	1	1	100%	N/A	N/A	N/A	**-1**	**-1**	-100%
Aboriginal Visitors Scheme (AVS)	0	0	0%	0	0	0%	0	0	Unchanged
TOTALS:	**342**	**14**	**4%**	**325**	**20**	**6%**	**-17**	**+6**	**+2%**