Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 56/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Bret Lindsay CAPPER*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***8 - 10 October 2019*** *find that the identity of the deceased person was* ***Bret Lindsay CAPPER*** *and that death occurred on* ***14 January 2016*** *at* ***Fiona Stanley Hospital****, from* ***bronchopneumonia and brain swelling following ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner.

Ms N Eagling and Mr M McIlwaine (State Solicitor's Office) appeared on behalf of the Department of Justice (the Department).

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INTRODUCTION

1. Bret Lindsay Capper (the deceased) died on 14 January 2016 at Fiona Stanley Hospital (FSH) as a result of bronchopneumonia and brain swelling following ligature compression of the neck (hanging).

2. At the time of his death, the deceased was being held in custody on remand at Hakea Prison and was therefore in the custody of the Chief Executive Officer of the Department of Corrective Services, as the Department was known at the relevant time.[1]

3. Accordingly, immediately before his death, the deceased was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2]

4. In such circumstances, a coronial inquest is mandatory.[3] 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.[4]

5. I held an inquest into the deceased's death at Perth on 8 – 10 October 2019. The following witnesses gave oral evidence at the inquest:

i. Mr G Russell (prisoner);
ii. Mr G Rapley (former prisoner);
iii. Mr J Brown (reception officer);
iv. Mr A Meyer (PCS[5] psychologist)
v. Ms Gillian Forbes (custodial officer);
vi. Mr K Said (Senior custodial officer);
vii. Dr M Hall (consultant forensic psychiatrist)
viii. Mr T Curtis (Senior custodial officer, SOG[6]);
ix. Mr B Leadbeatter (Assistant Superintendent, SOG);
x. Mr G Hawthorn (custodial officer); and
xi. Mr S Blenkinsop (Superintendent, Hakea Prison).

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[1] Section 16, *Prisons Act 1981 (WA)*
[2] Sections 3 & 22(1)(a), *Coroners Act 1996 (WA)*
[3] Section 22(1)(a), *Coroners Act 1996 (WA)*
[4] Section 25(3) *Coroners Act 1996 (WA)*
[5] PCS stand for Prisoner Counselling Services, see ts 09.10.19, (Meyer), p49
[6] SOG stands for Special Operations Group, see ts 10.10.19, (Curtis), p106

6. The documentary evidence adduced at the inquest included independent reports concerning the deceased's death prepared by the Western Australia Police[7] and by the Department[8]. Together, the brief of evidence comprised three volumes.

7. The inquest focused on the care provided to the deceased while he was in custody, as well as on the circumstances of his death.

CONTEXTUAL ISSUES

Hakea Prison

8. In the year 2000, the Canning Vale Prison and the CW Campbell Centre were amalgamated to create Hakea Prison (Hakea), located in Canning Vale about 24 kilometres from Perth.[9]

9. Hakea is a maximum security adult male prison, and is the largest custodial facility in Western Australia. It houses a large number of remand prisoners and is the State's usual receival point for new prisoners. Hakea's current capacity is 1,200 prisoners and its average muster is about 1,160. At midnight on 12 January 2016, Hakea's capacity was 1,225 and its muster was 916.[10]

10. Some idea of the turnover at Hakea is revealed in the statistics for prisoner movements. In August 2019, Hakea had 1,800 prisoner movements with 905 prisoners leaving and 929 prisoners arriving. In January 2016, there were 1,577 movements with 773 arrivals and 804 departures.[11]

The E Wing dayroom

11. At the relevant time, the deceased was housed at Hakea in E wing of unit 7, which at the time was an "orientation" wing. All of the cells on the wing were doubled-up, meaning that two prisoners occupied each cell.[12]

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[7] Exhibit 1, Vol 1, Tab 2, Police Investigation Report
[8] Exhibit 1, Vol 3, Death in Custody Review
[9] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 7
[10] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, paras 8-9 & para 11
[11] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 10
[12] ts 09.10.19 (Forbes), pp75-76

12. Prisoners on E Wing have access to a communal area known as the "dayroom" (Dayroom) in which several metal framed picnic-type tables with attached bench seats were located. The Dayroom was also equipped with a fridge and a hot water urn. One wall of the Dayroom looked into the wing and had waist high windows. The opposite wall of the Dayroom had vented windows that looked into a courtyard behind the cells on the wing.[13]

13. At the time of the deceased's death, the heavy door between the Dayroom and the wing opened inwards, meaning it could be barricaded from the inside, as was done in the deceased's case.[14]

14. The tables in the Dayroom were sturdy and heavy. At the time of the deceased's death, a program was underway to bolt these tables, which were present in other communal areas at Hakea, to the floor. The program was initiated after safety concerns were raised by Prison Union delegates. In addition, it had also been recognised that unless they were secured, the tables could be used to barricade the doors of the rooms they were located in.[15,16]

15. At the time of the deceased's death, the tables in the Dayroom had not been bolted to the floor. This was attended to following the deceased's death.[17,18]

16. The method used by the deceased to barricade himself into the Dayroom had never been used before at Hakea. Nevertheless, following the deceased's death, the door of the Dayroom was modified so that it opened outwards.[19]

17. As was pointed out to me when I visited Hakea with counsel on 28 August 2019, a second door was added to the Dayroom on the courtyard side, to improve access.[20]

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[13] Exhibit 1, Vol 2, Tab 18, Scene photographs, photos 17, 22, 31-33, 116-117
[14] ts 10.10.19 (Hawthorn), p151
[15] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, para 54
[16] ts 10.10.19 (Hawthorn), p149, 150 & p151
[17] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 55-56
[18] ts 10.10.19 (Hawthorn), p151
[19] ts 10.10.19 (Hawthorn), p149
[20] Visit to Hakea Prison (28.08.19)

At Risk Management System (ARMS)

18. ARMS is the Department'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.[21]

19. 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.[22] Within 24 hours of arriving at a prison, the prisoner's physical health needs are assessed by a nurse.

20. When he was received at Hakea, the deceased was placed on moderate ARMS and allocated to the Crisis Care Unit following a recommendation by Officer Brown, who conducted the deceased's intake risk assessment. This recommendation was appropriate given the deceased antecedents and presenting issues.[23]

21. When a prisoner is placed on ARMS, an interim management plan is developed and the prisoner is managed with observations at either high, moderate or low levels.[24,25]

22. Previously, the ARMS observation levels were high (one or 2-hourly), moderate (6-hourly) and low (12-hourly). In mid-2016, the ARMS observation levels were changed and are now: high (one-hourly), moderate (2-hourly) and low (4-hourly).[26]

23. Within 24 hours of a prisoner being placed on ARMS, a meeting of the Prison at Risk Management Group (PRAG) is convened to determine the appropriate levels of support and monitoring required to manage the prisoner's identified risk.[27]

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[21] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), pp1-6
[22] Exhibit 1, Vol 1, Tab 42, Statement - Officer J Brown
[23] Exhibit 1, Vol 1, Tab 42, Statement - Officer J Brown, paras 57-59 and ts 08.10.19 (Brown), p34
[24] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), pp44-49
[25] See also: Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), pp50-55
[26] Exhibit 1, Vol 1, Tab 42, Statement - Officer J Brown, paras 60-61 and ts 08.10.19 (Brown), p35
[27] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), pp85-91

Support and Management System (SAMS)

24. SAMS is the Department's secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide. This includes first-time and/or younger prisoners, socially isolated or vulnerable prisoners and prisoners who have been identified as being at chronic risk[28] of self-harm or suicide.[29]

25. SAMS adopts a case management system to draw together a variety of staff with relevant expertise. SAMS is designed to provide support to prisoners who, whilst not at acute risk,[30] nevertheless require additional support, intervention or monitoring.[31]

26. The SAMS manual says that SAMS will extend to those prisoners who satisfy two or more of the following criteria:[32]

- has a mental disorder as defined in the *Mental Health Act 1996*[33]
- has an acquired brain injury
- has a physical or intellectual disability
- is experiencing sensitive spiritual or cultural issues
- is identified as at chronic risk of suicide
- requires intensive support, and/or would benefit from receiving coordinated services
- may experience or is demonstrating difficulty coping or adjusting to placement in custody

27. The SAMS manual acknowledges that all prisoners may be vulnerable at times. However, prisoners with minimal supports inside and/or outside the prison system are particularly vulnerable. Prisoners on SAMS are reviewed at regular case conferences, the frequency of which depends on the needs of the particular prisoner.[34]

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[28] Chronic here means "elevated lifetime risk"
[29] Exhibit 1, Vol 2, Tab 14, SAMS Manual (June 2009), pp1-5
[30] Acute in this context means "*elevated risk in this immediate period of time*"
[31] Exhibit 1, Vol 2, Tab 14, SAMS Manual (June 2009), p3
[32] Exhibit 1, Vol 2, Tab 14, SAMS Manual (June 2009), p6
[33] Note: the current legislation is the *Mental Health Act 2014* (WA). Further, the term "*mental disorder*" is not defined in either the 1996 Act or the 2014 Act, however, the term "mental illness" is.
[34] Exhibit 1, Vol 2, Tab 14, SAMS Manual (June 2009), p29 and see also: pp42-50

28. A table in the SAMS Manual[35] sets out the categories of prisoners who may experience particular difficulties in prison. Categories applicable to the deceased include:

i. adult males expecting or serving long sentences); and
ii. past suicide attempts, impulsive, unpredictable behaviour.

29. Although he was never placed on SAMS, the deceased satisfied at least two of the above criteria, namely he was at chronic risk of suicide and he was experiencing difficulty adjusting to placement in custody. As I will discuss later in this Finding, a review of the deceased's care conducted after his death, was critical of the fact that he was not placed on SAMS.[36,37]

The predictability of suicide

30. As Dr Hall (prison psychiatrist) and Mr Meyer (prison psychologist) pointed out, suicide is extremely unpredictable. It is a rare event and it is impossible to predict rare events with any certainty. A complicating factor is that a person's suicidality can fluctuate, sometimes on a relatively short time frame.[38,39]

31. In 2017, the Department of Health published a document called: *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document). 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.

32. The Document points out that clinicians (and here I would add reception officers) faced with the onerous task of assessing a person who may be suicidal 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 patient. As the Document points out, the use of risk assessment tools containing checklists of characteristics has been found to be ineffective.[40]

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[35] Exhibit 1, Vol 2, Tab 14, SAMS Manual (June 2009), p11
[36] Exhibit 1, Vol 3, Tab 12, CSG review, p4
[37] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, 8.1 (officer's summary)
[38] ts 10.10.19, (Hall), p101-102 & 105
[39] ts 09.10.19, (Meyer), p56 & pp57-58
[40] DOH: Principles and Best Practice for the Care of People Who May Be Suicidal (2017), pp2-3

33. The ARMS manual, current at the time of the deceased's death relevantly observes:

> There is a widely held assumption explicit in suicide prevention procedures that suicides can be predicted and action taken to avert them. The extent to which individual suicides are in fact predictable remains a complex and somewhat confused issue. It is likely that certain types of suicide are more predictable and preventable than others. There may be a number of factors which *may* mean a prisoner is more likely to be at risk. But these factors are poor predictors. There is no sure way of "diagnosing" suicidal intentions or predicting the degree of risk. Assessments can only be of temporary value because moods and situations change. Self-harm can be an impulsive reaction to bad news or a sudden increase in stress.[41]

34. Prison staff who conduct suicide and self-harm risk assessments use an online tool that asks the prisoner a series of questions to elicit information about factors tending to make it more likely the person will attempt suicide (risk factors) and factors which make this less likely (protective factors).[42]

35. In addition to a prisoner's self-reported history (including self-harm or suicidal attempts and/or ideation), reception officers conducting risk assessments look for signs that the prisoner is stressed or not coping.[43]

36. Further, the reception officer must consider whether the prisoner being assessed has any protective factors such as family support. The same factor may be given different weight depending on the particular prisoner.[44]

37. Risk factors might include young or old age, childhood trauma and mental health issues whereas protective factors might include a supportive family and a focus on the future.[45]

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[41] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), p9
[42] Exhibit 1, Vol 1, Tab 42, Statement - Officer J Brown, paras 25-26 and ts 08.10.19 (Brown), pp29-30
[43] ts 08.10.19 (Brown), pp28-29
[44] ts 08.10.19 (Brown), p30
[45] ts 08.10.19 (Brown), pp32-33 and see also: ts 09.10.19, (Meyer), p57-58

38. An important risk factor is a history of self-harm and/or suicide attempts. Self-harm has been described as: "*the practice of deliberately injuring oneself in order to relieve emotional distress with non-fatal consequences*. In contrast, suicide involves self-inflicted injury and the intent is to die.[46]

39. I accept it can be very difficult to conduct meaningful risk assessments where, for example, a prisoner is withdrawing from illicit substances (as in the deceased's case) or where the prisoner's initial distress at being in prison is overwhelming. Reception officers base their assessment of the risk of self-harm and/or suicide on the prisoner's presentation, the prisoner's responses to questions and any history about prisoner of which the Department has a record, by way of records on the Total Offender Management Solutions (TOMS)[47] or otherwise.[48]

40. Obviously, where a prisoner is guarded about what they disclose, the risk assessment process may be compromised.

41. In the deceased's case, the fact that he was an "experienced" prisoner played a role. The reception officer, Officer Brown, said he did not ask the deceased for detailed responses to all of the questions on the ARMS reception risk assessment form, because in his view, to do so would have been disrespectful.[49]

42. The enormity of the task facing prison staff who conduct assessments aimed at predicting suicide risk is captured in the following extract from the ARMS manual:

> It is natural for those concerned with a self-inflicted death to ask themselves whether more could have been done to predict and prevent it. The burden of anxiety and guilt is made worse if critical judgements are made with the benefit of hindsight. It is all too easy to assume that suicide is preventable if certain techniques and procedures are followed.[50]

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[46] ts 08.10.19 (Brown), p28 and Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), p5
[47] TOMS is the Department's prisoner records management system
[48] ts 08.10.19 (Brown), pp32-34
[49] ts 08.09.19 (Brown), pp26-27
[50] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), p9

43. The ARMS Manual makes good point with respect to who can ultimately prevent death by suicide when it says:

> Suicide can be prevented, but ultimately only by the prisoner themselves. The responsibility of the Department of Justice is to provide care and support which reduces the risk of suicide and enables the prisoner to recover the will to live.[51]

Dealing with personality disorders

44. The personality of an individual refers to:

> [A] lifelong pattern…of a person's thinking, their way of feeling, their way of behaving, interpersonal interactions, concept of themselves and the way they respond to things that happen in their environment.[52]

45. Personalities are said to be "*disordered*" when they:

> [D]iffer markedly from that expected in their cultures. People with personality disorders show lifelong, maladaptive responses to their environment, often associated with recurrent of persistent distress for those with the personality disorder and/or for others suffering from the consequences of their aberrant behaviour. [53]

46. The Diagnostic and Statistical Manual organises personality disorders into clusters A, B and C. Relevantly, Cluster B includes antisocial personality disorder (ASPD) and borderline personality disorder, the two personality disorders most commonly seen in prisons.[54]

47. In 2004, the deceased was diagnosed with Cluster B personality disorder.[55] Dr Hall confirmed that the deceased exhibited traits commonly associated with ASPD.[56] APSD affects about 1 - 2% of the general community, but studies have suggested that perhaps as many as 1 in 2 males and 1 in 5 females in prison satisfy the diagnostic criteria for APSD.[57]

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[51] Exhibit 1, Vol 2, Tab 15, ARMS Manual (1998), p10
[52] ts 10.09.19 (Hall), p100
[53] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p197
[54] Diagnostic & Statistical Manual (5th Ed.)
[55] Interim discharge letter - Graylands Hospital (03.09.04)
[56] ts 10.09.19 (Hall), p101
[57] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p198

48. The features of APSD include: a pervasive pattern of disregard for and violation of the rights of others, deceitfulness, irritability, aggression (including repeated physical fights), a reckless disregard for the safety of others, lack of empathy, impulsivity, irresponsibility and lack of remorse.[58]

49. The recommended treatment for ASPD is long-term therapy, included cognitive behavioural therapy. However, as I will discuss later in this Finding, the number of Prison Counselling Service (PCS) staff at Hakea at the relevant time meant that there was no possibility of providing any level of therapy for those with APSD, including the deceased.[59,60]

50. A strong link has been demonstrated between personality disorders (including ASPD) and increased suicide risk. One study found that personality disorders were estimated to be present in more than 33% of individuals who die by suicide and about 77% of individuals who make suicide attempts.[61]

51. Apart from being at higher risk of suicide, prisoners with ASPD tend to be more difficult to manage. Dr Hall agreed that custodial staff would benefit from training dealing with the features of ASPD and how to more effectively manage people with this condition.[62]

PCS resources

52. The PCS is comprised of social workers and psychologists who are responsible for providing a counselling service to prisoners.

53. As I will describe, at Hakea, because of limited resources, PCS were not able to offer any ongoing therapeutic intervention or what might be referred to as proactive, preventative counselling.[63]

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[58] ts 10.09.19 (Hall), p103
[59] ts 10.09.19 (Hall), p103 & pp104-105
[60] ts 09.09.19 (Meyer), p50
[61] Pompili, M; Ruberto, A; Girardi, P And Tatarelli, R: Suicidality in DSM IV cluster B personality disorders - An Overview, Ann Ist Super Sanità 2004;40(4):475-483 at 475-6
[62] ts 10.09.19 (Hall), pp103-104
[63] ts 09.10.19 (Meyer), pp58-59 and ts 10.10.19 (Hall), pp104-105

54. Mr Meyer said that when he started work at Hakea as a psychologist with PCS in 2013, there were nine counsellors. When he left in May 2016, there were perhaps six or seven. During the same period, the muster at Hakea had increased and this had the effect of placing even greater pressure on PCS resources.[64]

55. During an inquest I conducted in March and April 2019, into the deaths of five prisoners at Casuarina Prison (Casuarina), I heard evidence from a PCS counsellor who was employed at Hakea between December 2009 and May 2017. During the time she was employed, PCS numbers dropped from 12 counsellors when she started, to four or five when she finished, again at a time when the muster at Hakea was steadily rising.[65]

56. Counsel for the Department, Ms Eagling, advised that in 2016, there were 10 full-time equivalent positions (FTE) for PCS at Hakea. However, only seven of those positions were actually filled because of a "freeze" on public sector recruitment at that time. Despite a 21% increase in the muster at Hakea from 2016 to 2019, the number of FTE for PCS staff at Hakea only increased to 7.2 in that period.[66]

57. Dwindling PCS numbers meant that clinical supervision of counsellors was no longer possible. I accept that the work carried out by PCS staff is difficult and stressful. The failure to offer regular supervision, in combination with ever increasing workloads is a recipe for staff burnout and subsequent turnover.

58. Mr Meyer and Dr Hall each confirmed that because of rising musters and dwindling staffing levels, PCS staff were almost exclusively engaged in managing prisoners on ARMS and SAMS and attending to acutely distressed prisoners. As a consequence, PCS staff had no capacity to provide the kinds of proactive, preventative counselling that could help lower the risk of suicide and self-harm.[67]

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[64] ts 09.10.19 (Meyer), pp49-50 and pp58-59
[65] Inquest into five deaths at Casuarina Prison (26-29.03.19) & ts 28.03.19 (Mandolene), pp224-225 & p254
[66] ts 10.10.19 (Eagling), p183
[67] ts 09.10.19 (Meyer), pp58-59 and ts 10.10.19 (Hall), pp104-105

59. This situation led to intolerable pressure being placed on PCS staff, as Mr Meyer confirmed when he outlined why he resigned from PCS:

> [T]here's too much pressure to perform only risk assessments and I didn't feel, professionally, I was being challenged and…able to provide what I was originally employed to do, which was to provide risk assessment but also, ongoing counselling for prisoners.[68]

60. As Mr Meyer pointed out, ongoing, proactive counselling can reduce a prisoner's risk of self-harm and help a prisoner develop coping strategies. He agreed that the deceased would have benefitted from this form of counselling had PCS resources allowed.[69]

61. Mr Meyer confirmed that:

> The intervention provided would be to assist him in building confidence…strengthening coping strategies to deal with stress, to deal with facing court and integrating back into the prison community…a safe place to be able to speak, I guess, with some limits on confidentiality being in the prison system but, essentially, it's about unpacking any deeper core issues for an individual with a therapeutic framework and that, in itself, can have amazing and fantastic benefits for someone's mental health long term if they are provided that opportunity.[70]

62. Apart from the deceased's case, another example of unmet need was powerfully articulated at the inquest by Mr Russell. He was a remand prisoner on E Wing at the time of the deceased's death and had known the deceased for about nine years.[71] Following the deceased's death, Mr Russell formed an irrational belief that he had somehow contributed to the deceased's decision to take his life. This led to profound depression and a suicide attempt.[72]

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[68] ts 09.10.19 (Meyer), p59
[69] ts 09.10.19 (Meyer), p60
[70] ts 09.10.19 (Meyer), p60
[71] ts 08.10.19 (Russell), p7
[72] ts 08.10.19 (Russell), p12

63. Mr Russell's account of his attempts to get help for his mental health condition describes the situation at Hakea at the time of the deceased's death in stark terms:

> I have literally begged…absolutely begged for help. I got to see the prison counselling service once and they agreed that I needed continued counselling, as in Bret's case. He needed continued counselling, but because…he and I, we weren't diagnosed as having a severe mental illness such as schizophrenia or something along those lines…we were only eligible for that one appointment. There was literally no care for mental health problems after that one appointment. I begged and begged and begged for help for at least 12 months and got absolutely nothing. It wasn't until the detectives that were investigating…Bret's death came and actually interviewed me. I think they actually sent an email to the prison saying that you need to look after this fellow and you need to – to have a look at this guy. It wasn't until that was actually sent to them that they actually got off their arse and actually approved some counselling which was over a year later. So the mental health care inside Hakea is non-existent.[73]

64. During the inquest, Ms Eagling advised that approval had been given for an additional nine PCS staff to be employed. Six of these positions will be based in metropolitan prisons, including Hakea, and three positions will be allocated to regional prisons.[74]

65. Whilst this is welcome news, it is now incumbent on the Department to take all necessary steps to expeditiously recruit suitably qualified staff to fill these positions and importantly, to put structures in place to properly supervise and support these new staff, in order to retain them.[75]

66. Apart from limited resources, the work of PCS counsellors was also significantly hampered by the fact that at the relevant time, PCS and mental health staff did not have access to each other's computer systems and notes.[76]

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[73] ts 08.10.19 (Russell), p12
[74] ts 10.10.19 (Eagling), pp183-184
[75] ts 10.10.19 (Eagling), pp183-184
[76] ts 09.10.19 (Meyer), p63 and ts 10.10.19 (Hall), p99

67. As Dr Hall pointed out, reciprocal access to these computer systems is essential if a multidisciplinary approach is to be truly embraced. Dr Hall also agreed that in some circumstances, the lack of reciprocal access had placed the lives of prisoners at risk.[77]

68. During the inquest, Ms Eagling advised that some progress has been made on this issue. PCS now distribute notes of prisoners who are at risk of self-harm or suicide to mental health and custodial staff.[78]

69. Ms Eagling said that the Department's ultimate aim is that:

> PCS notes will be linked to EcHO[79] but at the moment that is only partly one way…more EcHO licences have been purchased to allow PCS staff to access EcHO and that has already started to occur. But my understanding is that individual licences have to be purchased for that to occur…There is [also] more information sharing for co-managed cases in relation to PCS notes and the ultimate aim is that PCS notes will be linked to EcHO.[80]

70. Although these developments are pleasing, more needs to be done. The Department should redouble its efforts to achieve its "*ultimate aim*" of a linkage between a prisoner's PCS notes on TOMS and their health records on EcHO as soon as possible. Only then can a truly multidisciplinary approach be said to be in place. Reciprocal access will help to facilitate efforts to reduce self-harm risk amongst a vulnerable prison population.

Special Operations Group (SOG) and deployment issues

71. The SOG operates from a base near Hakea and is comprised of prison officers who have undergone a selection process and specialist training. The SOG offers a range of services including responses to major incidents. SOG officers also conduct training for the Prison Response Team and for prison officers in riot control.[81,82]

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[77] ts 10.10.19 (Hall), p99
[78] ts 10.10.19 (Eagling), p185
[79] EcHO is the electronic record system used by Prison Health Services
[80] ts 10.10.19 (Eagling), p185
[81] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 4
[82] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 3 and ts 10.10.19 (Curtis), p107

72. The SOG has been described as:

> [A] strategic resource that provides specialist emergency response and security support services for all correctional facilities (including the Youth Detention Centre) within the State.[83]

73. At one time, prison superintendents were able to contact SOG directly for help. I heard evidence that this system was efficient and worked well.[84]

74. In contrast, in his statement, Deputy Commissioner Elderfield said that when he commenced his duties as Director, Security and Response Services in October 2015, he became aware of "*issues*" with the deployment and tasking of the SOG.[85]

75. Deputy Commissioner Elderfield said that:

> It became evident that the various prisons were relying on SOG to manage incidents which, in the first instance, they should have been able to manage using their prison-based resources. This process was a reactive and ineffective way to manage a specialised and important strategic resource.[86]

76. Deputy Commissioner Elderfield also said that SOG resources becoming "*dislocated*" while responding to non-essential incidents. He said that in order to ensure SOG resources were prepared to deal with serious incidents across all prisons, it was decided that SOG resources would be deployed through a centralised system.[87]

77. The "*centralised*" deployment process that was introduced requires a formal request for SOG intervention. Under this system, the prison-based incident controller or officer in charge, is responsible for calling the Department's Operations Centre (the Centre) and providing various details about the incident.[88]

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[83] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 3
[84] ts 10.10.19 (Curtis), pp123-125; ts 10.10.19 (Leadbetter), pp131-132 and ts 10.10.19 (Blenkinsopp), pp169-171
[85] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 6
[86] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 6
[87] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 7
[88] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 10

78. In turn, the Centre seeks approval for SOG deployment from either the Director, Security and Response Services, the Deputy Commissioner, Operational Support, the "duty" Director or the Commissioner. Once approval is granted, the Centre contacts SOG which is then finally authorised to deploy.[89]

79. According to Deputy Commissioner Elderfield, there are "*very good reasons*" why a request for SOG deployment should go through the Centre, namely:

i. the Centre has up to date contact details and information about who holds delegations and their availability; and

ii. the Centre is able to provide a State-wide overview and provide a consistent response to incidents. Senior staff at the Centre are able to provide advice and guidance and liaise with emergency services personnel.[90]

80. In his statement, Deputy Commissioner Elderfield noted that notwithstanding this multi-layered deployment process, in "*certain exceptional circumstances*" the deployment process can be "*condensed*". An example of this occurred during the Greenough Prison riots, where deployment was initiated by the SOG Superintendent, and formal approval followed later.[91]

81. As it happens, the SOG deployment procedure was also "*condensed*" in the deceased's case. To his very great credit, Assistant Superintendent Leadbeatter deployed the SOG directly on a request from Hakea. Had he not done so, it is doubtful that the deceased would have been revived.

82. I am obliged to point out that the evidence I heard at the inquest, from the Superintendent of Hakea and two currently serving senior SOG officers, contradicts the Department's position on the efficacy and appropriateness of the current SOG deployment process.

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[89] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 10
[90] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 12
[91] Exhibit 1, Vol 1, Tab 54, Statement - Dep. Commr. R Elderfield, para 12

83. As the officer in charge of Hakea, Superintendent Blenkinsopp is responsible for the largest custodial facility in Western Australia. He is an experienced custodial officer and was Assistant Superintendent of the SOG from 1999 to 2007.[92] Thus, Superintendent Blenkinsopp has direct operational experience with deploying SOG resources and is uniquely qualified to express a view on the appropriateness of the current SOG deployment process.

84. At the inquest, Superintendent Blenkinsopp was asked how the current SOG deployment system works in practice. His reply was pithy and direct. He simply said: "*It doesn't*".[93]

85. When asked to explain what he meant, Superintendent Blenkinsopp said:

> [T]his has been raised with the Executive before… you need to have a much more streamlined process, the way that we used to.[94]

86. Superintendent Blenkinsopp said he was aware that in the past, there had been a concern that the SOG was being over utilised.[95] However, neither he nor Assistant Superintendent Leadbetter[96] were aware of there ever having been any inappropriate deployment of the SOG.[97,98]

87. As Superintendent Blenkinsopp pointed out, superintendents are very senior custodial officers who are given responsibility for the welfare and security of the prisoners in their respective facilities.[99] The point being made by Superintendent Blenkinsopp is that if the Department has enough trust in these experienced custodial officers to make them responsible for a prison, the Department should also trust them to deploy the SOG appropriately. On the basis of the evidence before me, it is difficult to disagree with that proposition.

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[92] ts 10.10.19 (Blenkinsopp), p169
[93] ts 10.10.19 (Blenkinsopp), p169
[94] ts 10.10.19 (Blenkinsopp), p169
[95] ts 10.10.19 (Blenkinsopp), p169
[96] He is currently Assistant Superintendent, Security, Support and Administration at the SOG and responsible for the Technical Support Unit that provides support to the SOG Superintendent.
[97] ts 10.10.19 (Blenkinsopp), p169
[98] ts 10.10.19 (Leadbetter), p131
[99] ts 10.10.19 (Blenkinsopp), p169

88. Superintendent Blenkinsopp agreed that any inappropriate deployments of the SOG in the past should have been dealt with by counselling the individual concerned, not by introducing a centralised deployment process.[100]

89. Tellingly, Superintendent Blenkinsopp confirmed that the current SOG deployment process is routinely bypassed in order to ensure that SOG is deployed in an efficient manner. Both he and Assistant Superintendent Leadbeatter expressed the view, with which I agree, that a superintendent who determines that SOG assistance is necessary should be able to contact the SOG direct.[101,102]

90. The fact that direct contact with the SOG is occurring routinely (and indeed occurred in the deceased's case) is evidence of the fact that the current centralised SOG deployment process requires urgent review.

91. Both Superintendent Blenkinsopp and Assistant Superintendent Leadbeatter said there were no operational impediments to the Department reverting to previous system of SOG deployment.[103,104]

92. In an email to the Court dated 15 October 2019 (the Email), counsel for the Department Ms Eagling set out her instructions on this issue in the following terms:

> A review of the decentralised model highlighted a number of increased risks for the Department namely; limited visibility regarding each deployment and a lack of transparency regarding the whereabouts of SOG resources. This in turn resulted in reduced availability of resources in the event of a major incident occurring, or multiple incidents occurring at the same time. Following discussion with the Corrective Services Executive Team, the Commissioner agreed with the centralised model as it provides for a better governance and accountability process, an efficient and effective use of the SOG resources and at the same time ensures the safety of staff, prisoners and the community…

[100] ts 10.10.19 (Blenkinsopp), p169
[101] ts 10.10.19 (Blenkinsopp), pp170-171
[102] ts 10.10.19 (Leadbetter), p132
[103] ts 10.10.19 (Blenkinsopp), p171
[104] ts 10.10.19 (Leadbetter), pp131-132

> Therefore there will be no reverting back to a decentralised deployment process whereby the Superintendent is able to approve SOG deployment. However, Corrective Services will review the current centralised model and adjust the deployment matrix to introduce process improvements to triage and streamline SOG deployment and provide for increased transparency and improved responsivity with appropriate controls in place.[105]

93. The contents of the Email suggest that the Department is either unaware of the lived experience of its senior operational and custodial officers, has failed to give sufficient weight to their views, or has chosen to ignore them. All of these possibilities are unfortunate. In the light of the evidence I heard at the inquest, the Department's stance on this issue, as set out in the Email, seems misguided.

94. Whilst it is heartening that the Department will "*review the current centralised model*" with a view to improving it, I suggest that in addition to consulting members of his Executive Team, the Commissioner should urgently consult with senior custodial and operational officers (such as Superintendent Blenkinsopp and Assistant Superintendent Leadbetter).

95. Broader consultation may help to ensure that legitimate concerns about the current SOG deployment process can be frankly and openly canvassed and then appropriately remediated.

[105] Email to the Court from Ms Eagling, State Solicitor's Office (15.10.19)

THE DECEASED

Background[106]

96. The deceased was born in Victoria on 28 December 1972. He was the youngest of five children and his parents separated when he was 5 years of age, reportedly because their relationship was characterised by alcohol abuse and domestic violence.

97. The deceased's mother was said to be a heavy drinker who often responded to the deceased's behavioural issues with physical violence. The deceased's education was disrupted because his mother's new partner (with whom the deceased was on good terms) worked in the horse racing industry and the family moved frequently.

98. The deceased first came into contact with the criminal justice system when he was 10 years of age. However, he completed Year 10 during subsequent periods of incarceration as a juvenile.

99. The deceased reportedly began using solvents, alcohol and illicit drugs when he was 11 years of age. After leaving the family home at the age of 13 years, he was made a Ward of the State. He began living on the streets when he was 14 years of age. Later, the deceased is reported to have begun using heroin on a daily basis.

100. At the time of his death, the deceased was in a defacto relationship with a woman he had known for 24 years. He was involved with the care of her son, who he reportedly planned to adopt.[107]

101. The deceased was described as a brilliant artist who enjoyed painting, matchstick work and woodwork, and who took pride in everything he did. He was passionate about music and enjoyed a wide variety of genres. He was said to have used music to cope with his incarceration.[108]

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[106] Exhibit 1, Vol 3, Death in Custody Review, p6
[107] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 42-43, 48
[108] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 42-43, 48

Offending History

102. The deceased had an extensive criminal history. As a juvenile, he accumulated 257 convictions, including numerous motor vehicle theft offences involving luxury vehicles.[109,110]

103. As an adult, the deceased accumulated 54 convictions for offences including: armed robbery, stealing and burglary. The deceased was sentenced to two years imprisonment in 1991, nine years imprisonment in 1997 and 8 years imprisonment in 2004.[111] According to his partner, the deceased was incarcerated for about 11 years between 2003 and 2014.[112]

104. Departmental reports describe the deceased as: "*an institutionalised individual entrenched in a lifestyle characterised by drug abuse and anti-social behaviours*".[113]

Overview of medical conditions

105. The deceased's medical history included: high cholesterol, severe central canal stenosis and displacement of the L5 nerve root and varicocele and hydrocele of the right testis. The deceased was also diagnosed with hepatitis C.[114]

106. When admitted to Hakea on 5 October 2015, the deceased stated that he had been using heroin and methylamphetamine and was taking prescribed pain relief medication (Tramadol).[115]

Overview of mental health conditions

107. During his incarceration in 2000, the deceased was reported to have suffered from depression and anxiety. He was also documented to have engaged in self-harm behaviour on a number of occasions.[116]

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[109] Exhibit 1, Vol 3, Death in Custody Review, p6 & p7
[110] Exhibit 1, Vol 2, Tab 12, Deceased's criminal history
[111] Exhibit 1, Vol 2, Tab 12, Deceased's criminal history
[112] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 42-43, 48
[113] Exhibit 1, Vol 3, Death in Custody Review, p6
[114] Exhibit 1, Vol 3, Tab 9, Report - Dr A Thillainathan, pp1-2
[115] Exhibit 1, Vol 3, Tab 9, Report - Dr A Thillainathan, pp1-2
[116] Deceased's departmental medical records, (90-16-41)

108. The deceased is noted to have been placed on ARMS at various times, including in 2000, 2003, 2004 and 2012.[117] On 11 July 2001, the deceased was found to have razor blades in his possession and admitted self-harm ideation. In 2004, he received treatment for substance abuse and he was admitted to Graylands Hospital between 30 August 2004 and 3 September 2004 with suicidal ideation.[118]

109. At that time, the deceased's diagnosis was cluster B personality disorder (i.e.: ASPD), polysubstance abuse and dysthymia (persistent mild depression). It was recommended that he be managed in CCU on his return to Hakea and that he: "*be seen by a psychologist on…*(a)*…regular basis*".[119]

110. With respect to the deceased's last incarceration, his partner said that he was not "*in a good head space*" and had admitted to attempting to overdose on three occasions before being arrested. She said that the deceased had embarked on a "*crime spree*" with the hope that the police would "*do the job for him*", which I take to mean, the deceased hoped that the police would kill him whilst attempting to apprehend him.[120]

111. The deceased's partner said that following his arrest, he felt his family had abandoned him and was angry and bitter as a result.[121] The deceased's partner remained concerned for his mental health whilst he was incarcerated and in addition to his concerns about a lengthy sentence, she says the deceased expressed a lack of faith in his lawyer.[122]

112. The deceased's partner also said that the deceased was having difficulty coping with the "*younger more disrespectful crowd*" he found in Hakea.[123] Shortly before taking his life, the deceased made a similar comment to Senior Officer Said.[124]

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[117] Deceased's departmental medical records, (90-16-41)
[118] Interim discharge letter - Graylands Hospital (03.09.04)
[119] Interim discharge letter - Graylands Hospital (03.09.04)
[120] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 7-9
[121] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 14-15 & 19
[122] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 14-15 & 19
[123] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 23
[124] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, para 20

Circumstances of the deceased's last incarceration

113. On 5 October 2015, the deceased appeared in the Perth Magistrates Court, charged with 17 serious offences, including two counts of armed robbery and four counts of stealing, as well as reckless driving and stealing a motor vehicle.[125] The deceased was arrested by police and while he was being transferred to court from the Perth Watch House, he reportedly struck his head on inside of the escort vehicle.[126,127]

114. After his court appearance, the deceased was remanded in custody and received at Hakea. In accordance with departmental procedures, the deceased underwent an intake risk assessment.[128] As the name suggests, the assessment is designed to identify prisoners at risk of self-harm or suicide and to help determine whether the prisoner should be placed on ARMS.[129]

115. During the reception risk assessment, the deceased was asked a number of questions aimed at gauging his current level of risk. One question related to whether the deceased's family were supportive. Although Officer Brown, the reception prison officer completing the form, ticked "*Yes*", the deceased's recorded response was:

> [P]risoner states not, I turned my back on all of them".[130,131]

116. This discrepancy was explained by Officer Brown, as a "*typo*".[132] Officer Brown noted that the deceased had a history of previous self-harm, had lost a brother to suicide and was withdrawing from heroin.[133]

117. The deceased was described as "*calm and cooperative*" with respect to his answers to questions[134] but in the summary section of the assessment, Officer Brown noted:

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[125] Exhibit 1, Vol 3, Death in Custody Review, pp7-8
[126] Exhibit 2, WA Police Custody handover summary, pp3-4
[127] Exhibit 1, Vol 3, Death in Custody Review, p8
[128] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment
[129] Exhibit 1, Vol 1, Tab 42, Statement – Officer J Brown, para 18 & para 25
[130] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, question 6.2.1
[131] Note: this document also appears at: Exhibit 1, Vol 2, Tab 9
[132] ts 08.10.19 (Brown), p39-40
[133] Exhibit 1, Vol 2, Tab 3, ARMS reception intake assessment, questions 6.3.1, 6.3.4 & 6.7.1
[134] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, question 6.2.1

> Prisoner has self harmed by banging his head at Court, appears very anxious at the moment about being back in prison. Prisoner states he needs time to re-adjust to the prison environment. Prisoner expects to be dealt with harshly by the Court and is adamant he is not guilty of all of his charges. Prisoner also appears paranoid and jumpy, possibly due to being on the run.
>
> I recommend placement on 6 hourly ARMS to give…[the deceased]…an opportunity to adjust back to prison life.[135]

118. After the deceased's death, the Department conducted a counselling and support governance review with respect to the care and support provided to the deceased during his incarceration (the CSG review). The CSG review identified the discrepancies in the deceased's ARMS reception risk assessment referred to above (i.e.: level of family support and mood/affect during the reception assessment) and stated:

> These inconsistencies raise concerns about the habitual completion of assessment items and the potential for critical risk information to be overlooked both at the time of completion and at later stages when reviewed by stakeholders making risk management decisions.[136]

119. Officer Brown said he had completed hundreds of reception risk assessments, and that as result of his experience, he used the form as a guide to assessing the prisoner sitting in front of him. He said that in his view, the reception risk assessment form was "*not fit for purpose*" and that a number of the questions reception officers are obliged to ask are quite intrusive.[137]

120. In light of these criticisms, it may be appropriate for the Department to consider whether the reception risk assessment form should be revisited to ensure that it is as useful and "user-friendly" as possible.

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[135] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, 8.1 (officer's summary)
[136] Exhibit 1, Vol 3, Tab 12, CSG review, p2
[137] ts 08.10.19 (Brown), p38

121. The CSG review also identified inconsistencies in the deceased's five previous reception risk assessments. These inconsistencies related to whether those assessments correctly recorded the deceased's self-harm risk. In some cases, known suicide attempts were not recorded, whereas in other cases, they were.[138]

122. The CSG review's findings with respect to the deceased's ARMS risk assessment on 5 October 2015, were referred to in the summary that followed the Department's "Lessons Learnt" workshop relating to the deceased's death. That workshop summary concluded that:

> Education and training is required for Reception staff in completing the initial risk assessments. More probing questions should be asked and additional dialogue to occur in order to accurately identify the risk level.[139]

123. Officer Brown said that although there was often significant pressure at Hakea, in terms of the number of admissions, he did not feel that this compromised his ability to conduct an accurate and appropriate risk assessment.[140]

124. It is pleasing that the Department has identified the need for additional training for reception officers, so as to ensure that these key staff were given further guidance in the critically important task of completing of risk assessments.

125. After Officer Brown completed his risk assessment, the deceased was placed on moderate ARMS (6-hourly observations) and transferred to the crisis care unit (CCU). The deceased was subsequently reviewed by a prison nurse and given diazepam to manage his agitation.[141,142]

126. As the deceased was in the CCU, he was assessed by a PCS counsellor, in this case, Mr Meyer, who had assessed the deceased in May 2014, during a previous incarceration.

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[138] Exhibit 1, Vol 3, Tab 12, CSG review, p2
[139] Exhibit 1, Vol 3, Tab 19, Lessons Learned workshop, p4
[140] ts 08.10.19 (Brown), p37
[141] At the time, the observation frequencies for prisoners on ARMS was: High: 2 hourly (now 1-hourly), Moderate: 6-hourly (now 2 –hourly) and Low: (12-hourly (now 4-hourly).
[142] Exhibit 1, Vol 3, Tab 9, Report - Dr A Thillainathan, p2

127. When he assessed the deceased in the CCU on 6 October 2015, Mr Meyer noted that the deceased was withdrawing from heroin, but that he appeared orientated as to time, person and place. The deceased told Mr Meyer that if he was suicidal, he wouldn't tell him (Mr Meyer) or anybody else, but went on to say: "*[T]o be honest I don't have the energy to do anything and I'm not going to do anything*".[143]

128. Mr Meyer's assessed the deceased as being a moderate risk of self-harm or suicide. The basis for that assessment was the deceased's inability to point to any protective factors, and his deteriorated emotional and physical presentation. Mr Meyers recommended that the deceased remain on moderate ARMS.[144,145]

129. The deceased was reviewed by PCS psychologist Mr Stopler on 9 October 2016. At that time, the deceased appeared physically weak and referred openly to three recent suicide attempts by overdose prior to his incarceration.[146]

130. The deceased said he felt too physically weak to take his life by suicide and expressed concern about being a burden on his family if a suicide attempt left him in a vegetative state. In view of the deceased's presentation, Mr Stopler recommended that he remain on moderate ARMS.[147]

131. Mr Meyers reviewed the deceased again on 13 October 2015. The deceased presented in a frail and vulnerable manner, but seemed to be in a reflective mood with respect to his offending behaviour. Although the deceased expressed some unspecified concerns for his safety, he maintained he was "*fine*". The deceased admitted to some fleeting and passive suicidality but denied any desire to act on those thoughts. He stated that he "*just couldn't be bothered*" self-harming when he "*felt so sore*". He seemed to have some hope for the future and referred to a supportive partner and stepson.[148,149]

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[143] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, para 12
[144] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, paras 13-14
[145] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Meyers (06.10.16)
[146] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Stopler (09.10.16)
[147] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Stopler (09.10.16)
[148] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, para 15
[149] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Meyers (13.10.16)

132. The deceased's case was discussed at the PRAG meeting on 13 October 2015.[150] As a result of the deceased's denial of any current suicidal intent or plan and his reference to protective factors, the deceased's ARMS observations were reduced to low (12-hourly).[151]

133. On 20 October 2015, the deceased was reviewed by Mr Meyers and presented in a reflective, but confused manner. He seemed fearful about his pending court appearance and said he had been "*fed*" conflicting information about his charges.[152,153]

134. The deceased denied any suicidal or self-harm ideation and said he was hoping to gain employment within Hakea, which he hoped would provide "*structure and functionality*" and help reduce the intensity of his ruminations about his charges. He seemed more accepting of his prison placement and agreed to self-refer to PCS as required. Mr Meyers assessed the deceased as not being a suicidal or self-harm risk, and he was taken off ARMS at the PRAG meeting on 20 October 2016.[154,155]

135. Once he was removed from ARMS, the deceased was not placed on SAMS. SAMS is designed to manage those prisoners who are at chronic, as opposed to acute risk. It appears that the deceased was not placed on SAMS because of a misunderstanding about the SAMS critera.[156]

136. That misunderstanding was to the effect that to be placed on SAMS, a prisoner had to be vulnerable as a result of intellectual or physical disability, or where there was an element of vulnerability to other prisoners.[157]

137. The CSG review was critical of the fact that the deceased was not placed on SAMS after he was removed from ARMS, noting:

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[150] The PRAG is a group within each prison that monitors all prisoners on ARMS and SAMS
[151] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, paras 16-17
[152] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, paras 18-20
[153] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Meyers (20.10.16)
[154] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, paras 18-20
[155] Exhibit 1, Vol 3, Tab 13, PCS counselling notes, Mr Meyers (20.10.16)
[156] ts 09.10.10 (Meyers), pp60-61
[157] ts 09.10.10 (Meyers), pp60-61

> In light of the available risk relevant information, including that outlined above[158] and his admissions that he had considered methods of suicide and would not tell staff if he was at risk, consideration for placement on SAMS was warranted. Chronic risk to self is an eligibility criterion for SAMS.[159]

138. The CSG review pointed out that the benefit to the deceased of being placed on SAMS would have been that this would have ensured:

> [T]hat observed improvements were maintained with sustained stability in his presentation and behaviour.[160]

139. With respect to SAMS, the Department's "Lessons Learnt" workshop relating to the deceased's death concluded that:

> SAMS is currently underutilised across prisons state-wide. A probable cause for this may be a lack of understanding by prison staff as to the eligibility criteria and application of SAMS.[161]

140. The workshop summary action item with respect to the SAMS issue was to promote the system in training that was planned for prison officers. The ARMS and SAMS manuals were also under review at that time.[162]

141. On 30 October 2015, the deceased was seen by a mental health nurse, Ms Whyte. She observed that the deceased's mood was low and that he was constantly ruminating on negative events. The deceased said he was open to counselling, and said he had asked to see PCS that day, but hadn't heard anything back. He said his main issue was that he is easily annoyed and that his "*fuse was short at the present*".[163]

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[158] That is: three recent overdoses, fleeting suicidal ideation, multiple stressors, including possible risk from others and limited protective factors.
[159] Exhibit 1, Vol 3, Tab 12, CSG review, p4
[160] Exhibit 1, Vol 3, Tab 12, CSG review, p5
[161] Exhibit 1, Vol 3, Tab 19, Lessons Learned workshop, p6
[162] Exhibit 1, Vol 3, Tab 19, Lessons Learned workshop, p6
[163] Exhibit 3, Extract from deceased's EcHO notes (1.51 pm, 30.10.16)

142. Although the deceased denied any plan to harm himself, he again reiterated that he would not tell anyone if he was intending to do so. Ms Whyte's impression was that the deceased:

> [I]s a very experienced prisoner **who requires long term counselling**. Presenting today with moderate depression and has complex personality structure - extremely critical of himself because of this, he is making his distress worse - in other words, not able to cope but feels he does not deserve any help at present. [emphasis added][164]

Contact with PCS - 30 October 2015

143. In my view, it is significant that the deceased asked to see PCS on 30 October 2015, and that he said his request was "*quite urgent*". Mr Meyer went to the deceased's wing and to the medical centre to see the deceased, but was unable to do so. As a result, the deceased was seen by another PCS counsellor, Mr Davey.[165]

144. In accordance with his usual practice, before he met with the deceased (who he had known from an incarceration in 1999), Mr Davey reviewed the deceased's PCS counselling notes and spoke to Ms Whyte.[166]

145. Ms Whyte told Mr Davey that the deceased "*presented as depressed but without any other serious mental health issues*". Ms Whyte had encouraged the deceased to consider antidepressants, but he had been resistant to the idea.[167]

146. Mr Davey noted the deceased's low mood and very flat affect. The deceased referred to his three suicide attempts in the community using heroin and said there "*must have been something wrong with the shots*" because they had not killed him as he expected they would.[168,169]

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[164] Exhibit 3, Extract from deceased's EcHO notes (1.51 pm, 30.10.15)
[165] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 14-15
[166] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 14-15
[167] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 14-15
[168] Exhibit 1, Vol 2, Tab 1, PCS counselling notes, Mr Davey (30.10.15)
[169] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 19 & 23

147. The deceased said he was worried he had a "*short fuse*" and did not want this to prompt him to engage in reactionary type behaviour. The deceased also said that some information he was given by WA Police had "*rattled him to his core*", although there is no mention of what that information was.[170,171]

148. In light of the deceased's depressed mood, Mr Davey strongly encouraged the deceased to consider taking an anti-depressant, especially as the deceased had disclosed he was experiencing chronic insomnia. Mr Davey concluded that the deceased did not present as being at current risk of self-harm or suicide. In coming to this assessment, Mr Davey was assisted by his previous contact with the deceased.[172,173]

149. Although the deceased presented with a low mood, Mr Davey said he was not overly concerned with the deceased's overall presentation at that point. Mr Davey did not think it was necessary to place the deceased on ARMS or SAMS and recommended follow-up PCS contact "*as needed*".[174,175]

150. As I have outlined, the number of PCS counsellors at Hakea in October 2015, meant that there was no capacity to offer the deceased any form of ongoing, proactive counselling, as had been recommended by Ms Whyte. Instead, PCS resources were directed towards providing at risk assessments and short-term counselling interventions.[176]

151. As Mr Davey confirmed:

> Due to the limited resources in PCS, it was very uncommon to make a follow-up appointment with a client who was not on ARMS or SAMS.[177]

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[170] Exhibit 1, Vol 2, Tab 1, PCS counselling notes, Mr Davey (30.10.15)
[171] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 16-17
[172] Exhibit 1, Vol 2, Tab 1, PCS counselling notes, Mr Davey (30.10.15)
[173] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 20-26
[174] Exhibit 1, Vol 2, Tab 1, PCS counselling notes, Mr Davey (30.10.15)
[175] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, paras 23-26
[176] ts 09.10.19 (Meyer), p59
[177] Exhibit 1, Vol 1, Tab 55, Statement - Mr J Davey, para 27

152. Mr Meyer and Dr Hall both agreed that the deceased would have benefitted from ongoing counselling, had it been possible to offer this to him. The benefits to the deceased, of this type of intervention would have included: equipping the deceased with skills to deal with his psychological pain and building his resilience and coping strategies. Both Mr Meyer and Dr Hall agreed that the inability of PCS to offer proactive and ongoing counselling to prisoners at Hakea who required it, placed the lives of those prisoners at risk.[178]

153. At around the time of the deceased's death, there were 955 prisoners at Hakea who were serviced by six or seven PCS staff. Between 1 January 2019 and 8 October 2019, the average number of prisoners at Hakea was 1157, and there were 7.2 PCS staff.[179,180] In other words, since the deceased's death, there was been a 21% increase in the muster at Hakea but no effective increase in PCS staff numbers.

154. Mr Meyer said he left the Department in May 2016, because he found the inability to offer any form of longer term counselling, professionally unsatisfying and because he could no longer bear the unrelenting pressure of exclusively conducting risk assessments on vulnerable prisoners.[181,182]

155. Given that the evidence before me was that the level of PCS resources number in 2016 was incapable of providing ongoing counselling support, the increasing muster at Hakea means that in 2019, the situation is now worse.

156. In a letter to the Court dated 4 October 2019, the Director General of the Department, advised that in response to recommendations I made on 29 May 2019, following an inquest into the death of five prisoners at Casuarina Prison (Casuarina), interim approval had been given to increase the number of PCS staff at Hakea and at Casuarina.[183]

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[178] ts 09.10.19 (Meyer), pp59-60 and ts 10.10.19 (Hall), p103
[179] ts 10.10.19 (Eagling), p183
[180] Exhibit 4, Average daily population by facility
[181] Exhibit 1, Vol 1, Tab 45, Statement - Mr A Meyer, para 3
[182] ts 09.10.19 (Meyer), p59
[183] Attachment to Letter to the Court, Dr A Tomison (04.10.19), p1

157. In closing submissions, Ms Eagling, counsel for the Department, advised the Court that funding for a total of nine PCS positions had been approved to date and that the recruitment process to fill those vacancies was underway. Three of these new positions will be based in regional Western Australia with the remaining six allocated to the metropolitan area.[184] This is very heartening news, and it is to be hoped that the Department will use its best endeavours to ensure that these positions are filled as quickly as possible.

Mental health team meeting – 23 November 2015

158. In June 2013, Dr Hall introduced a system of weekly, local level mental health team meetings at Casuarina and at Hakea. The meetings had three main functions:

i. to enhance the multidisciplinary approach to the triage, assessment and management of prisoners with established or suspected mental health needs;

ii. to provide supervision and guidance to mental health nursing staff; and

iii. to "*cast a wide net*" so as to discuss as many prisoners who may have a mental health problem as possible.[185]

159. PCS staff at Casuarina attended these mental health team meetings and their contributions were valuable. In contrast, PCS staff at Hakea did not attend these meetings and told Dr Hall that their line managers had told them that "*it was not an effective use of their time*".[186]

160. It appears that at least part of the reason for their non-attendance was the fact that PCS staff resources at Hakea at the time were already overstretched.[187] As it happens, in the deceased's case, the fact that PCS staff did not attend the mental health meetings at Hakea was to have negative consequences.

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[184] ts 10.10.19 (Eagling), p183-184
[185] Exhibit 1, Vol 1, Tab 44, Statement - Dr M Hall, paras 9-14 (16.01.19)
[186] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, paras 14-15 (12.09.19) and ts 10.10.19 (Hall), pp98-99
[187] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, paras 14-15 (12.09.19) and ts 10.10.19 (Hall), pp98-99

161. On 23 November 2016, Dr Hall attended a mental health tam meeting at Hakea at which the deceased's case was raised (the Meeting).[188] The deceased was discussed at the Meeting because he had been reviewed by mental health nurse Ms Whyte, and she had expressed concerns about possible risk.[189]

162. The Meeting decided that the deceased did not need specific intervention from the mental health team. This decision was based, at least in part, on the false assumption that the deceased was engaged with PCS at that time.[190]

163. In turn, the false assumption that the deceased was engaged with PCS was based on the fact that when the deceased was seen by Ms Whyte on 30 October 2016, he told her he had asked to see PCS. Further, Ms Whyte recorded that she had spoken to PCS counsellor, Mr Davey about providing the deceased with ongoing support.[191]

164. At the time, health staff did not have access to PCS notes and vice-versa, so Dr Hall was unaware that the deceased was not in fact regularly being seen by PCS. Dr Hall agreed that this lack of reciprocal access to notes could, in some circumstances, put the lives of prisoners at risk.[192] He expressed the view, with which I agree that:

> In relation to information sharing between PCS and health services, I am of the opinion that medical records and PCS records should be accessible by PCS and mental health staff respectively.[193,194]

165. The fact that PCS did not attend the mental health team meetings at Hakea meant that there was no possibility that the mental health team's false assumption about PCS involvement with the deceased could be corrected.[195]

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[188] Exhibit 1, Vol 1, Tab 44, Statement - Dr M Hall, para 19 (16.01.19)
[189] See also: Exhibit 3, Extract from deceased's EcHO notes (1.51 pm, 30.10.15)
[190] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, paras 9-10 (12.09.19)
[191] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, para 10 (12.09.19)
[192] ts 10.10.19 (Hall), p99
[193] ts 10.10.19 (Hall), p100
[194] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, para 17 (12.09.19)
[195] Exhibit 1, Vol 1, Tab 44A, Statement - Dr M Hall, paras 12-13 (12.09.19)

166. In his evidence at the inquest, Dr Hall said that had he been aware that the deceased was not receiving regular counselling support, he would have referred the deceased to PCS.[196]

167. The mental health team meetings that Dr Hall instituted at Casuarina and Hakea were a proactive initiative aimed at enhancing a multidisciplinary approach to the care of prisoners with mental health issues. Dr Hall is to be commended for implementing this system.

168. Unfortunately, the effectiveness of these meetings at Hakea was hampered by the failure of PCS staff to attend them and the fact that reciprocal access to PCS and medical records was not available.

EVENTS LEADING TO DEATH

169. The evidence about the deceased's mental state in the days prior to 12 January 2016 comes from his partner, (who visited him on 11 and 12 January 2016) and from prisoners housed on his wing.

Visits by the deceased's partner: 11-12 January 2016

170. The deceased's partner visited him at Hakea on 11 January 2016. She described the visit as a "*very sombre one*". She said the deceased spoke about some childhood trauma and was very emotional and upset. The deceased's partner said that he had made the decision to "*wipe his family from his life*" and she could see the emotional turmoil that this decision was causing him.[197]

171. In contrast, when the deceased's partner visited him on 12 January 2016, he seemed happy and there was no mention of the previous day. The deceased and his partner discussed their plans to move interstate when he was released from prison and they spent "*a real quality hour together*". The deceased's stepson sat on his lap and they joked and had play-fights together.[198]

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[196] ts 10.10.19 (Hall), p97
[197] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 32-33
[198] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, para 34

172. The deceased referred to his court appearance the following day and told his partner he was going to tell the judge he had no confidence in his lawyer and would be representing himself. The deceased's partner said she and the deceased spoke about him seeking a lengthy adjournment so he could properly prepare. Although she knew the deceased was worried about his upcoming court appearance, she thought he had "*turned a corner*". With respect to him taking his life, the deceased's partner said:

> I know I was worried about the state of mind he would be in after this appearance; I had no reason to believe that anything like what happened was even in the equation for him at this point.[199]

The deceased's demeanour in the days before his death

173. Following the deceased's death, police interviewed 23 prisoners housed on E wing at the relevant time. The purpose of these interviews was to investigate the deceased's demeanour in the lead up to his death.

174. I have assessed those accounts and although it seems that the deceased was "*preoccupied*" or "*different*" on the day of his death, with one exception (i.e.: Prisoner JI), none of the prisoners interviewed said the deceased gave any indication that he intended to take his life. I note that several of the prisoners the police approached either did not know the deceased or declined to be interviewed.

Summary of observations by prisoners

175. The following observations were made by prisoners about the deceased's manner in the lead up to his death:

i. Prisoner LB: last spoke to the deceased at 11.30 am on 12 January 2016. Prisoner LB didn't notice anything unusual about the deceased.[200]

ii. Prisoner DC: spoke with the deceased briefly on 12 January 2016. The deceased didn't seem himself, but did not say what was bothering him.[201]

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[199] Exhibit 1, Vol 1, Tab 10, Statement - Ms C Heron, paras 35-38
[200] Exhibit 1, Vol 1, Tab 19, File note - Interview with Prisoner LB (04.10.16)
[201] Exhibit 1, Vol 1, Tab 20, File note - Interview with Prisoner DC (06.10.16)

iii. Prisoner SH: had known the deceased for 13 years. After dinner on 12 January 2016, he spoke with him about some paintings SH was doing for the deceased's son. The deceased gave no indication that he was intending to take his life.[202]

iv. Prisoner JI: met the deceased in December 2015. The deceased seemed depressed in the days leading up to his death and had confided in JI that he intended to barricade himself in the E wing dayroom. He had also disclosed an intention to self-harm, but JI didn't think he was serious.[203]

v. Prisoner TJ: had known the deceased since 2012. He could tell that the deceased was going to do something because he was angry, but didn't know what. The deceased gave no indication he was intending to take his life.[204]

vi. Prisoner MJ: had known the deceased for three years. The deceased gave no indication he was intending to take his life.[205]

vii. Prisoner JM: spoke to the deceased near the showers opposite the Dayroom about five minutes before the incident. The deceased gave no indication he was intending to take his life but had mentioned he had previously "*starved himself*" to get what he wanted from prison staff.[206]

viii. Prisoner CM: spoke to the deceased briefly on the morning 12 January 2016. The deceased seemed "*OK*" and gave no indication that he was intending to take his life.[207]

ix. Prisoner LM: had known the deceased since 2012. On 12 January 2016, the deceased seemed a bit quiet, and angry about how long he would have to stay in prison. The deceased gave no indication that he was intending to take his life. LM thought he heard one of the female prison officers call the deceased a: "*junkie*".[208]

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[202] Exhibit 1, Vol 1, Tab 23, File note - Interview with Prisoner SH (04.10.16)
[203] Exhibit 1, Vol 1, Tab 24, File note - Interview with Prisoner JI (04.10.16)
[204] Exhibit 1, Vol 1, Tab 25, File note - Interview with Prisoner TJ (13.10.16)
[205] Exhibit 1, Vol 1, Tab 26, File note - Interview with Prisoner MJ (24.10.16)
[206] Exhibit 1, Vol 1, Tab 28, File note - Interview with Prisoner JM (06.10.16)
[207] Exhibit 1, Vol 1, Tab 29, File note - Interview with Prisoner CM (06.10.16)
[208] Exhibit 1, Vol 1, Tab 30, File note - Interview with Prisoner LM (03.10.16)

x. Prisoner BM: grew up with the deceased. On 11 January 2016, the deceased seemed to be having problems and was not getting on with prison officers. He gave no indication of self-harm or depression. After lunch on 12 January 2016, the deceased looked stressed. BM asked if he was alright and the deceased said "*Yes*". When the deceased had barricaded himself in the Dayroom, BM tried to talk to him but the deceased shook his head.[209]

xi. Prisoner TO: met the deceased in December 2015. The deceased gave no indication he intended to take his life. TO believes he heard two female prison officers laughing and joking about the incident.[210]

xii. Prisoner JP: spoke to the deceased about one hour before the incident. The deceased gave no indication he intended to take his life.[211]

xiii. Prisoner NT: when the deceased had barricaded himself in the E wing dayroom, NT spoke to him through the door and asked if he was alright. The deceased replied: "*No NT, no one can help me this time*". NT said the quality of care at Hakea was substandard and the prison officers would not take you seriously if you asked for help.[212]

xiv. Prisoner AW: had known the deceased since 2000 and thought he was "*acting strange*" in the days before his death. He spoke to the deceased about 20 minutes before the incident. The deceased was walking in and out of the bathroom and seemed to have his mind set on something.[213]

xv. Prisoner KB: had known the deceased since childhood. Says the deceased was struggling and was getting a "*hard time*" from some prison officers who treated him like a "*low life*" and were unfairly targeting him. He spoke to the deceased five minutes before the incident and he seemed "*alright*" with no issues.[214]

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[209] Exhibit 1, Vol 1, Tab 31, File note - Interview with Prisoner BM (13.10.16)
[210] Exhibit 1, Vol 1, Tab 32, File note - Interview with Prisoner TO (05.09.16)
[211] Exhibit 1, Vol 1, Tab 33, File note - Interview with Prisoner JP (13.10.16)
[212] Exhibit 1, Vol 1, Tab 37, File note - Interview with Prisoner NT (23.10.16)
[213] Exhibit 1, Vol 1, Tab 38, File note - Interview with Prisoner AW (13.10.16)
[214] Exhibit 1, Vol 1, Tab 41, File note - Interview with Prisoner KB (04.10.16)

Mr Rapley's observations

176. At the time of the deceased's death, Mr Rapley's was a remand prisoner at Hakea. He had known the deceased since they were young children and considered the deceased a very close friend.[215]

177. Mr Rapley noticed that the deceased was "*a bit more agitated*" during his last admission to Hakea and put this down to the deceased's recent drug use. Mr Rapley said that prior to the incident, he would not have thought that the deceased would take his life.[216]

Mr Russell's observations

178. At the time of the deceased's death, Mr Russell was a remand prisoner at Hakea. He had known the deceased for about nine years and considered him a friend. About one week before his death, the deceased told Mr Russell: "*Shit is going to go down*".[217]

179. The deceased did not elaborate and Mr Russell assumed the deceased was going to cause trouble in the prison. Mr Russell promised the deceased he wouldn't get involved.[218]

180. Mr Russell didn't consider that the deceased was the type of person to self-harm or take his own life. In the days leading up to the incident, Mr Russell noticed a change in the deceased's mood, but the deceased did not share his plans with Mr Russell.[219]

181. A few days before the deceased's death, he spoke to Mr Russell and said: "*Big fella, it's going to happen this weekend*". Again, the deceased did not elaborate on what he was going to do. Mr Russell reiterated his promise that he wouldn't get involved.[220]

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[215] Exhibit 1, Vol 1, Tab 18, Statement - Mr G Rapley, para 4
[216] Exhibit 1, Vol 1, Tab 18, Statement - Mr G Rapley, paras 13 & 16 and ts 08.10.19 (Rapley), p16 & pp 19-20
[217] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 4-9 and ts 08.10.19 (Russell), p7
[218] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 4-9 and ts 08.10.19 (Russell), p7
[219] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 10 & 29 and ts 08.10.19 (Russell), pp7-8
[220] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 11-12 and ts 08.10.19 (Russell), p7-8

The deceased barricades himself into Dayroom

182. After dinner on 12 January 2016, Mr Russell was cleaning the Dayroom. He stopped work to make a phone call to his family and as he returned to the Dayroom, the deceased asked to be advised when Mr Russell had finished cleaning it. The deceased didn't say what he wanted the Dayroom for, and Mr Russell assumed that he (the deceased) was intending to cause trouble so that he would be moved to a prison closer to his family.[221]

183. SG was a prisoner on E wing at the time and had known the deceased since December 2015. Prisoner SG says that after dinner on 12 January 2016, the deceased came into the Dayroom carrying brown paper bags, which I take to be wet bags (i.e.: brown paper bags used for kitchen waste). SG says the deceased asked prisoners to leave the Dayroom, and they did so.[222]

184. Mr Russell says that the deceased gave him some wet bags, a white bedsheet, a roll of masking tape and a pair of scissors, and asked him to put the items in the Dayroom. Mr Russell did so, but had no idea what the items were for. Mr Russell said if he'd known the deceased was intending to use the items to take his life, he would never have agreed to put them into the Dayroom.[223]

185. Once he had finished cleaning the Dayroom, Mr Russell gave the deceased a "*thumbs up*" to let him know it was free. A short time later, Mr Russell returned to collect a water bottle he'd left behind, but the deceased would not let Mr Russell back inside.[224]

186. When Mr Russell saw the deceased, he was sticking wet bags onto the inside of the Dayroom windows with masking tape.[225] Mr Russell saw the deceased tearing up the bedsheet and says it was at that point he realised that the deceased intended to harm himself.[226,227]

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[221] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 11-16 and ts 08.10.19 (Russell), p8-9
[222] Exhibit 1, Vol 1, Tab 19, File note - Interview with Prisoner LB (04.10.16)
[223] ts 08.10.19 (Russell), pp9-10
[224] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 18-22 and ts 08.10.19 (Russell), pp9-10
[225] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, paras 18-22 and ts 08.10.19 (Russell), pp9-10
[226] Exhibit 1, Vol 1, Tab 17, Supplementary Statement - Mr G Russell, paras 4-5
[227] ts 08.10.19 (Russell), p10

187. At about this time (5.35 pm), Mr Rapley walked past the Dayroom and could see the deceased through the window. Mr Rapley motioned to the deceased who made a hand gesture indicating he intended to hang himself. Mr Rapley immediately alerted prison officers.[228]

188. As soon as prison officers were made aware that the deceased had barricaded himself in the Dayroom and was threatening self-harm, an emergency call known as a "code red" was made on the prison two-way radio network.[229] A "code red" means that all available staff attend the scene immediately.[230]

189. Prison officers began securing the prisoners on the wing in their cells, as other officers arrived to assist. Meanwhile, other officers attempted to open the door to the Dayroom but were unsuccessful.[231] The door could only be opened a few centimetres because the deceased had wedged the frame of a table behind a steel post supporting a bench near the door. The weight and position of the table frame had jammed the door closed and made it impossible to open the door fully.[232]

190. Meanwhile, the most senior prison officer on duty in Hakea at the time, Senior Officer Hawthorn, who had heard the code red being called, arrived on the wing. He instructed staff to stop trying to gain entry to the Dayroom whilst a muster check was conducted. The muster check confirmed that all prisoners on the wing had been accounted for and that the deceased was the only person in the Dayroom.[233,234]

191. Senior Officer Hawthorn established a security cordon on the wing, designed to keep non-essential staff out of the area. He also directed that a prison wide emergency muster be conducted and that all prisoners be locked in their cells.[235,236]

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[228] Exhibit 1, Vol 1, Tab 18, Statement - Mr G Rapley, paras 5-10 and ts 08.10.19 (Rapley), pp16-17
[229] Exhibit 1, Vol 3, Death in Custody Review, p11
[230] Exhibit 1, Vol 1, Tab 13B, Statement - Officer G Forbes, para 7 (28.08.19) and ts 09.10.19 (Forbes), p66
[231] Exhibit 1, Vol 3, Death in Custody Review, p11
[232] See: Exhibit 1, Vol 2, Tab 18, Scene photographs, photos 116-118
[233] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 8-14
[234] ts 10.10.19 (Hawthorn), pp143-144
[235] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 13-14 & 26
[236] ts 10.10.19 (Hawthorn), p144

192. While this was going on, custodial staff began breaching the security cordon and Senior Officer Hawthorn was obliged to put out a radio call instructing all non-essential staff to leave the area.[237,238] The scene on the wing at the time has been described as "*chaos*" with a number of prison officers "*milling about*".[239,240,241]

193. At the time of the incident, Senior Officer Said was the senior officer on unit 6. He was a trained negotiator and had known the deceased for 20 years. Senior Officer Said attended unit 7 in response to the code red. He tried to open the Dayroom door and he spoke to the deceased for 4 or 5 minutes. Because other officers were also talking to the deceased, Senior Officer Said decided to return to unit 6.[242,243]

194. About 10 minutes later, Senior Officer Said was called back to unit 7 because the deceased wanted to speak to him. Initially, he spoke to the deceased through the Dayroom door. The deceased was pacing up and down and appeared agitated. The deceased asked Senior Officer Said to go around to the courtyard side of the Dayroom, which was not obscured by wet bags, and Senior Officer Said did so.[244,245]

195. The deceased told Senior Officer Said to move all custodial staff behind a metal grille some distance from the Dayroom. The deceased held up a noose he'd prepared and told Senior Officer Said that if anyone tried to enter the Dayroom, he would hang himself.[246,247]

196. It took about 5 minutes to clear staff out of the wing and while this was happening, the deceased continued to pace up and down. Once staff had been removed, the deceased began talking to Senior Officer Said.[248,249,250]

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[237] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 18-19
[238] ts 10.10.19 (Hawthorn), p144
[239] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 13
[240] ts 10.10.19 (Hawthorn), p119
[241] See also: ts 10.10.19 (Leadbetter), p130
[242] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, paras 9-13 (26.08.19)
[243] ts 09.10.19 (Said), pp78-79
[244] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, paras 14-16 (26.08.19)
[245] ts 09.10.19 (Said), p79
[246] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, paras 16-18 (26.08.19)
[247] ts 09.10.19 (Said), p80-81
[248] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, paras 16-18 (26.08.19)
[249] ts 09.10.19 (Said), p80-81
[250] See also: Exhibit 1, Vol 2, Tab 18, Scene photographs, photos 95-112

197. Senior Officer Said asked the deceased what was going on and why he was doing what he was doing. The deceased replied that he had had enough of prison and that he could not handle the long prison term he expected to receive with respect to his most recent charges). He also said that the newer prison officers did not show him the respect that "*old school*" officers did. Senior Officer Said tried talking to the deceased about his family and his son but the deceased said he had said "*his goodbyes*" to his family.[251,252]

198. At about 6.10 pm, the deceased removed some of the bags covering the wing side windows of the Dayroom and looked through. He said: "*They have opened the grille, I told you what I would do*", then placed his head through the noose he had fashioned, and hanged himself. Senior Officer Said called out "*no, no, no, don't*"[253] and used his radio to advise: "*The prisoner is hanging, we need to get in there now*". Senior Officer Said kept talking to the deceased, but there was no reply.[254,255]

199. Officer Heggs tried to smash the courtyard side windows using an extendable baton, but was unsuccessful because the windows were made of reinforced glass. Meanwhile, other staff tried to smash the wing side windows of the Dayroom, but were similarly unsuccessful. A short time later, Senior Officer Hawthorn directed all staff to stop trying to smash the Dayroom windows.[256,257,258]

Deployment of the SOG

200. At about the same time, Senior Officer Hawthorn contacted SOG for assistance and spoke to Senior Officer Wilson. It was 5.45 pm. Senior Officer Wilson, (the emergency response unit officer) was advised that the incident involved a single prisoner who had barricaded himself in the Dayroom and was "*kicking off*".[259,260]

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[251] Exhibit 1, Vol 1, Tab 15A, Statement - Senior Officer K Said, paras 26-34 (21.10.16)
[252] ts 09.10.19 (Said), pp80-82
[253] ts 09.10.19 (Forbes), p71
[254] Exhibit 1, Vol 1, Tab 15A, Statement - Senior Officer K Said, paras 36-40 & 43 (21.10.16)
[255] ts 09.10.19 (Said), p82
[256] Exhibit 1, Vol 1, Tab 15B, Statement - Senior Officer K Said, paras 25-28 (26.0819)
[257] See also: Exhibit 1, Vol 2, Tab 18, Scene photographs, photos 17-19
[258] Exhibit 1, Vol 1, Tab 16A, Statement – Prison Officer W Heggs, para 25
[259] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 6
[260] ts 10.10.19 (Curtis), p107

201. SOG staff member, Senior Officer Curtis was tasked by Assistant Superintendent Leadbeatter to attend Hakea with another SOG officer and carry out an initial assessment and to determine what resources were required. A second call from Hakea a short time later advised that there were 27 prisoners in the Dayroom. Senior Officer Curtis was sceptical of this information and correctly surmised that the figure referred to the wing muster.[261,262]

Gaining entry to the day room

202. Senior Officer Curtis arrived at the Hakea front gate at 6.05 pm. After entering Hakea, he and another SOG officer made their way to unit 7. On arrival at E wing, he was given a briefing by Senior Officer Hawthorn. As he couldn't see into the Dayroom from the wing side, Senior Officer Curtis walked around to the courtyard side. His view into the Dayroom was obscured by the deceased's body and as a result, he couldn't tell if the deceased was supporting his own weight and/or had any weapons.[263,264]

203. Senior Officer Curtis realised that the grilles over the windows on the courtyard side of the Dayroom could not be easily breached and he decided to attempt access from the wing side. Although he had been told that the Dayroom door was barricaded, he was not able to see that the deceased had used a table leg to secure the door in such a way as to make access through the door impossible.[265,266]

204. I accept that despite being given information by those at the scene of an incident, SOG officers must make an independent assessment of the situation they are confronted with. They are the ones with specialist skills and equipment and they need to ensure that the information they are being given is accurate.[267]

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[261] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 7-8 & 10
[262] ts 10.10.19 (Curtis), pp107-108
[263] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 12-20
[264] ts 10.10.19 (Curtis), pp108-109
[265] ts 10.10.19 (Curtis), pp108-109
[266] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 14-20
[267] ts 10.10.19 (Curtis), pp108-109

205. Meanwhile, on their way to the wing, the main SOG team experienced a short delay at the sally port double doors at the front entrance to Hakea. Senior Officer Curtis briefed them on his plan when they arrived at the wing at about 6.15 pm. Senior Officer Curtis took the role of team leader whilst Assistant Superintendent Leadbetter became the incident controller.[268,269]

206. The initial plan was to enter the Dayroom by opening the door. When this plan failed, SOG officers tried to force the door open using a "*hooligan bar*" but this was also unsuccessful.[270]

207. The SOG team then enacted their alternative plan which was to cut a hole in one of the Dayroom windows on the wing side using a special circular saw. Once the window had been breached, a distraction device was thrown into the Dayroom. When deployed, this device makes loud noises and flashes and, as the name suggests, creates a distraction. The device was necessary because although it is now known that the deceased was in fact hanging and did not have any weapons, this was not clear at the time.[271,272,273]

208. The alternative plan was executed flawlessly, and the Dayroom was breached at 6.27 pm. SOG officers cut the deceased down, placed him on one of the tables and began CPR. Prison medical staff assisted and a spontaneous return of circulation was achieved. [274,275,276]

209. Meanwhile, ambulance officers arrived at Hakea and the deceased was taken to FSH. Despite treatment, the deceased did not regain consciousness and was declared deceased at 12.27 pm on 14 January 2016.[277,278,279,280]

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[268] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 26-29
[269] ts 10.10.19 (Curtis), pp111-112
[270] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 32-34
[271] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 35-38
[272] ts 10.10.19 (Curtis), p112-113
[273] See also: Exhibit 1, Vol 2, Tab 18, Scene photographs, photos 13-16
[274] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 39-43 & ts 09.10.19 (Forbes), pp73-74
[275] Exhibit 1, Vol 1, Tab 46, Incident description report - Clinical Nurse K Breen
[276] Exhibit 1, Vol 3, Death in Custody Review, p13
[277] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 39-43 & ts 09.10.19 (Forbes), pp73-74
[278] Exhibit 1, Vol 1, Tab 46, Incident description report - Clinical Nurse K Breen
[279] Exhibit 1, Vol 3, Death in Custody Review, p13
[280] Exhibit 1, Vol 1, Tab 7, FSH Death in hospital form

Criticisms of SOG response

210. After the incident, several general service prison officers were critical of what they perceived as delays by SOG in accessing the Dayroom.[281,282]

211. Further, in his statement, Senior Officer Hawthorn said he was surprised that SOG officers tried to access the Dayroom via the door because he had told Senior Officer Curtis that the door was barricaded.[283] However, at the inquest, he conceded given the fluidity of the situation, it was quite likely that Senior Officer Curtis had not appreciated that access through the Dayroom door was impossible.[284]

212. For obvious reasons, prison staff wanted to get into the Dayroom as quickly as possible to help the deceased.[285] This explains the earlier frantic, but futile efforts to smash through the Dayroom's reinforced glass windows. In that context, it is perfectly understandable that any delay in the SOG accessing the Dayroom, no matter how reasonable, must have seemed interminable.

213. However, the reality is that before they could breach the Dayroom, SOG officers had first to assess the situation, formulate a plan and brief the team. They then had to don protective gear and gather specialist equipment. Only then could they enact the plan. Clearly in this situation, optimal results can be only be achieved by proceeding methodically. Rushing the preparation stage, however tempting, is surely a recipe for disaster.

214. In my view, concerns about the delay in getting into the Dayroom, whilst understandable are unfair. Given the information available to SOG officers at the time, the SOG response was appropriate. Even if the SOG had managed to breach the Dayroom earlier than they did, given the time the deceased had already been hanging, it seems unlikely that the outcome in this tragic case would have been any different.

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[281] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 35 & 52
[282] Exhibit 1, Vol 1, Tab 13, Statement - Prison Officer G Forbes, paras 46-47
[283] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 35 & 52
[284] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, para 38
[285] See for example: ts 09.10.19 (Forbes), p67

215. Some general service prison officers expressed concerns about the methods used by SOG to breach the Dayroom.[286] For example, Senior Officer Hawthorn said he was not expecting the Dayroom window to be cut with a circular saw. As a result, he and two other officers were taken to hospital to have glass fragments removed from their eyes.[287]

216. Officer Forbes said there was no warning before the distraction device was deployed and it gave her and her colleagues a fright.[288] Senior Officer Hawthorn was also concerned that the distraction device had caused some prisoners on the wing to become agitated.[289]

217. Given the nature of the SOG's practices and procedures and the specialist equipment deployed by SOG officers, it is my view that general service prison officers would benefit from being given basic information about what to expect when SOG deploy and how to best assist SOG officers. This was a suggestion with which, a number of departmental witnesses agreed.[290]

218. Assistant Superintendent Leadbeatter advised that information sessions covering this sort of material are currently being delivered to prison medical staff. He agreed that general service prison officers would also benefit from these sessions and confirmed that the SOG had the capacity to deliver this training.[291]

Conclusions regarding the deployment of SOG

219. Senior Officer Hawthorn's decision to request SOG assistance was clearly appropriate. The deceased had barricaded himself into the Dayroom, his threat to take his life was patent and custodial officers could not get access to him.

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[286] Exhibit 1, Vol 1, Tab 13, Statement - Prison Officer G Forbes, paras 46-47
[287] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, para 40
[288] Exhibit 1, Vol 1, Tab 13, Statement - Prison Officer G Forbes, paras 44
[289] Exhibit 1, Vol 1, Tab 53, Statement - Senior Officer G Hawthorn, paras 40 & 43
[290] ts 10.10.19 (Curtis), pp118-119; ts 10.10.19 (Hawthorn), p153-154 and ts 10.10.19 (Blenkinsopp), p162
[291] ts 10.10.19 (Leadbetter), p135 & pp137-138

220. Senior Officer Hawthorn's decision to contact SOG directly and Assistant Superintendent Leadbetter's decision to deploy the SOG immediately circumvented the multi-layered deployment process I have described.

221. However, the fact that these senior officers took the decisions they did meant that SOG officers were able to deploy to Hakea without delay.

222. Assistant Superintendent Leadbeatter agreed that with the benefit of hindsight, SOG officers would have attempted entry to the Dayroom through the wing side windows straight away.[292] Whilst this is a reasonable concession, on the basis of the information available at the time, it is my view that the decision to attempt entry through the Dayroom door was reasonable.

223. In this case, general prison officers did not appear to appreciate the importance of not breaching the security cordon on the wing, or the dangers inherent with encroaching on the SOG's area of operation. Further these staff were unfamiliar with SOG procedures and method of entry techniques.

224. Information sessions designed to educate prison health staff about these matters are currently being delivered. These sessions, appropriately modified, could also be delivered to general prison officers.

[292] ts 10.10.19 (Leadbetter), p141

OTHER ISSUES RAISED BY THE EVIDENCE

Incident management training

225. Senior departmental officers confirmed that their training in managing critical incidents is rudimentary. For example, Senior Officer Hawthorn said:

> I have had very little training in managing incidents like this, most of my training has come with experience. I have not had any training on what to do when a prisoner barricades themselves into a room.[293]

226. Superintendent Blenkinsopp pointed out that although prison officers are trained to respond to self-harm incidents, officers are not trained to manage critical incidents. He thought that senior officers would benefit from this training.[294,295] In my view, the correctness of this assertion is borne out by the evidence in this case, of what happened as the critical incident unfolded.

227. The security cordon that was established on the wing was repeatedly breached, even after the Dayroom had been accessed and SOG officers and prison nursing staff were attempting to resuscitate the deceased.[296]

228. Despite the fact that he was the SOG team leader, and therefore had a critically important job to do, Senior Officer Curtis was obliged to disperse general prison officers who were encroaching into the SOG's area of operation.[297,298]

229. When he arrived at unit 7, Senior Officer Curtis described the scene as "*chaos*". A lot of prison officers were milling about, there was a lot of noise and nobody appeared to be in charge.[299,300]

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[293] Exhibit 1, Vol 1, Tab 53, Statement - Snr Officer G Hawthorn, paras 34 & 36
[294] Exhibit 1, Vol 1, Tab 53, Statement - Supt S Blenkinsopp, paras 43-44
[295] ts 10.10.19 (Blenkinsopp), p162
[296] ts 10.10.19 (Curtis), p119 and ts 10.10.19 (Hawthorn), p152-153
[297] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, paras 27 & 30
[298] ts 10.10.19 (Curtis), p119
[299] Exhibit 1, Vol 1, Tab 52, Statement - Snr Officer T Curtis, para 9
[300] ts 10.10.19 (Curtis), pp108-109

230. Officer Forbes, (an orientation officer on unit 7 at the relevant time), said it was not clear to her "*who was doing what*" and:

> There seemed to be a lot of people waiting for something to happen and we were all waiting for direction.[301]

231. As Mr Mudford, (who prepared the Department's Death in Custody review) interviewed a number of prison officers following the deceased's death, and observed that:

> The 'line of command' was considered unclear, resulting in communication issues and too many non-essential staff remaining at the scene…Situationally there appeared to be a disconnect between the incident Controller, SOG and non-essential staff on the E-wing side of the dayroom and the Negotiating officer on the other.[302]

232. The issues I have just identified demonstrate that there was a need for a senior officer to exert control over general prison officers and to coordinate support to the SOG team. Whilst I do not mean to be critical of any of the general service officers, there was clearly a lack of understanding about the importance of not breaching the security cordon and the need to stay clear of the SOG's area of operations.

233. The benefit of ensuring that senior officers can competently manage critical incidents seems obvious. These senior managers need to be given skills to enable them to effectively deal with situations where the SOG are not deployed. Even where the SOG are deployed, the critical minutes before the SOG arrive must be capably and appropriately managed.

234. Senior officers in prisons are expected to provide leadership and management. There appears to be a skill deficit with respect to the management of critical incidents which I urge the Department to urgent take steps to address.

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[301] Exhibit 1, Vol 1, Tab 13B, Statement - Officer G Forbes, paras 34 & 36
[302] Exhibit 1, Vol 3, Death in Custody Review, p13

Did female officers make inappropriate comments?

235. Mr Russell says that after prisoners in E Wing had been locked down and he was in his cell, he heard two female prison officers say words to the effect that they: "*did not care if the deceased died because it was only some additional paperwork*" (the Words).[303] Prisoner JI who also was on the wing at the relevant time, says he heard something similar to the Words being said by female prison officers.

236. Prisoner TO says he heard female prison officers laughing and joking about the deceased and Prisoner LM says he heard a female prison officer call the deceased a "*junkie*".[304,305,306]

237. Mr Rapley said that he did not hear the Words or anything similar. He said that after the deceased's death, there were rumours that inappropriate comments had been made, but that he did not think this had actually happened.[307]

238. Neither Senior Officer Hawthorn nor Senior Officer Said heard the Words said. However, both officers said they would have reported what they considered would have been a serious breach of discipline.[308,309]

239. Officer Forbes said that she had not heard the Words nor had she used them.[310]

240. If the Words were said, it would be an appalling departure from the standards expected of prison officers. Further, if the Words were said in the hearing of the deceased, they would have inflamed an already critical situation.

241. Mr Russell and Prisoner JI appear to be the only two witnesses to have heard the Words, although Prisoners TO and LM heard female officers making inappropriate comments about the deceased.

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[303] Exhibit 1, Vol 1, Tab 17, Statement - Mr G Russell, para 26 and ts 08.10.19 (Russell), p11
[304] Exhibit 1, Vol 1, Tab 24, File note - Interview with Prisoner JI (04.10.16)
[305] Exhibit 1, Vol 1, Tab 32, File note - Interview with Prisoner TO (04.10.16)
[306] Exhibit 1, Vol 1, Tab 30, File note - Interview with Prisoner LM (03.10.16)
[307] Exhibit 1, Vol 1, Tab 18, Statement - Mr G Rapley, paras 18-20 and ts 08.10.19 (Rapley), p20
[308] ts 09.10.19 (Said), p86
[309] ts 10.10.19 (Hawthorn), p152
[310] ts 09.10.19 (Forbes), p75

242. The scene at the time was noisy and chaotic and it is therefore possible that the Words were said, notwithstanding the fact that only Mr Russell and Prisoner JI seem to have heard them. Although I have been unable to come to a final conclusion as to whether the Words were said, it is heartening that if either Senior Officer Said Senior Officer Hawthorn had heard them, they would have taken decisive action.

Notification of a prisoner's death

243. The death of a prisoner, particularly by way of suicide, is obviously a traumatic event. In the absence of cogent information about the death, misinformation may spread. In the deceased's case, some of the prisoners on his wing thought they heard grenades or gunshots during the incident. In fact what they had heard was the distraction device the SOG deployed - but this is an example of how misinformation can arise.[311]

244. It appears that at present there is no formal procedure for advising prison officers at a prison, much less prisoners on the relevant wing, that a death has occurred. In my view this is a mistake.

245. A traumatic event like the death of a prisoner by suicide is bound to have an effect on the custodial officers and prisoners on that person's wing. In order to maintain the security and good order of a prison, custodial staff should be given information about matters which may affect the mood and behaviour of the prisoners under their care, including information about the death of a prisoner by suicide.

246. Superintendent Blenkinsopp and Senior Officer Said agreed that information about deaths in a prison should be given to staff on the relevant wing in order to assist them to better manage prisoners on that wing.[312,313] I would add that in my view, prisoners on a wing where a death has occurred, should also be provided with basic information about the death and offered support and counselling.

[311] See for example: Exhibit 1, Vol 1, Tab 38, File note - Interview with Prisoner AW (13.10.16)
[312] ts 10.10.19 (Blenkinsopp), p174
[313] ts 09.10.19 (Said), p85

Negotiator training

247. Senior Officer Said's attempts to negotiate with the deceased were valiant and timely. He is a trained negotiator and has completed three negotiator training courses.[314]

248. The value of having trained negotiators available in a prison seems obvious. The ability to defuse and deescalate situations before they become more serious is clearly of benefit to the good order and security of a prison. However, Hakea does not have any "in date" trained negotiators.[315]

249. In the past, negotiator training was delivered to custodial staff by WA Police. The course they delivered was described as "*rigorous*" and a "*very good course*". In his statement, Superintendent Blenkinsopp noted that negotiator training is now delivered by a different facilitator and the course is less rigorous.[316]

250. Superintendent Blenkinsopp expressed the following view about the importance of trained negotiators:

> I believe trained negotiators are an integral component of any situation and there should be fully trained negotiators in each facility. There is no opportunity to facilitate refresher training as the Department does not facilitate the negotiator course.[317]

251. Superintendent Blenkinsopp noted that the follow-up or refresher training for negotiators, that was once provided, is no longer offered. He favoured a return to the previous training provider, namely WA Police, who in his view delivered a superior product.[318]

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[314] ts 09.10.19 (Said), p79
[315] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 46
[316] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 46 and ts 10.10.19 (Blenkinsopp), p163
[317] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 46
[318] ts 10.10.10 (Blenkinsopp), p163

Ligature minimisation

252. In his statement, Superintendent Blenkinsopp said that communal areas in prison are not ligature minimised because it is assumed that when prisoners use these areas, they are always under supervision. In his statement he also said there is no practicable way of ligature minimising communal areas or identifying possible ligature points.[319]

253. However, during his evidence at the inquest, Superintendent Blenkinsopp properly conceded that the current departmental view about ligature minimisation in communal areas is based on a false assumption, namely that prisoners are always be supervised when using these areas.[320]

254. As the deceased's case tragically demonstrates, prisoners are not always under supervision when using communal areas. Further, the Dayroom is some distance from the wing control room and is not fitted with CCTV cameras. The time chosen by the deceased to barricade himself into the Dayroom (just before evening muster), is a busy time in the prison day, when custodial officers are attending to a wide range of tasks.

255. During his evidence at the inquest, Superintendent Blenkinsopp agreed that it is always possible to make an assessment of communal areas and that where obvious ligature points are identified and can be removed, this should be done.[321] Indeed, following the deceased's death, the ligature point he used to hang himself from was removed. This demonstrates that, not only is it practicable to identify ligature points in communal areas, it is possible to remove some of them.[322]

256. I accept that it may not be possible to remove every ligature point in communal areas within prisons. However, in my view, the Department should carefully assess all communal areas in the prison estate and any obvious ligature points should, where practicable, be removed.

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[319] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 30 and ts 10.10.19 (Blenkinsopp), pp159-160
[320] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 30 and ts 10.10.19 (Blenkinsopp), pp159-160
[321] ts 10.10.19 (Blenkinsopp), pp159-160
[322] Exhibit 1, Vol 1, Tab 57, Statement - Supt S Blenkinsopp, para 38

Advice to next-of-kin

257. At the inquest, the deceased's brother-in-law, Mr Bretcher expressed significant concern that his wife (the deceased's sister), who had been the deceased's next-of-kin for over 20 years) was not immediately advised of the deceased's attempt to take his life. Mr Bretcher said that the only contact he and his wife received was from FSH.[323] Mr Bretcher said that it was disturbing and upsetting that even though his wife was the deceased's next-of-kin, she had been ignored.[324]

258. In an email to the Court dated 10 October 2019, counsel for the Department, Ms Eagling advised that her instructions were that the deceased's offender summary on TOMS recorded Ms Debra Bretcher as the deceased's next-of-kin, but that only an address was listed and not a contact phone number. Contact phone numbers were listed for the deceased's mother and his partner Ms Heron.[325]

259. Ms Eagling's email also notes that Ms Heron had visited the deceased on the day he attempted to take his life and that during his reception interview on 5 October 2016, the deceased had stated that his family were not supportive and that he had said: "I turned my back on all of them".[326,327]

260. The Department's position is that as Ms Bretcher was listed as next-of-kin, she would ordinarily have been contacted, but that because her phone number was not listed on TOMS, this did not occur.[328]

261. With respect, this explanation is unsatisfactory. It is patently obvious that next-of-kin details are recorded for use in an emergency. In my view, the Department should ensure that offender summaries on TOMS that list a next-of-kin, record a current mobile or landline telephone number for that person, so that emergency contact can occur.

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[323] ts 10.10.19 (Bretcher), p176
[324] ts 10.10.19 (Bretcher), p176
[325] Email to the Court from Ms N Eagling (10.10.19)
[326] Email to the Court from Ms N Eagling (10.10.19)
[327] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, question 6.2.1
[328] Exhibit 1, Vol 3, Tab 3, ARMS reception intake assessment, question 6.2.1

CAUSE AND MANNER OF DEATH[329]

262. Two forensic pathologists (Dr Cooke and Dr Kueppers) conducted a post mortem on the deceased's body on 20 January 2016.

263. The deceased was found to have a faint marking to the skin of his neck and there were fractures to both superior horns of his thyroid cartilage and his hyoid bone.

264. The deceased's lungs were found to be congested, a non-specific finding which can be seen with asphyxiation. Microscopic examination of lung tissue confirmed the congestion and also showed bronchopneumonia. Microbiological testing of lung tissue showed the presence of *Staphylococcus aureus* and *Streptococcus anginosus* which can cause pneumonia.

265. An incidental finding was that there was early thickening and narrowing of the arteries (early arteriosclerosis). Neuropathological examination of the deceased's brain found it was swollen, consistent with hypoxic/ischaemic brain injury.

266. Toxicological analysis found a number of medications in the deceased's system consistent with his hospital medical care.

267. At the conclusion of their investigation, Dr Cooke and Dr Kueppers expressed the opinion that the cause of death was bronchopneumonia and brain swelling following ligature compression of the neck (hanging).

268. I accept and adopt the conclusion expressed by Dr Cooke and Dr Kueppers.

269. I find the deceased's death occurred by way of suicide.

[329] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report, p1

QUALITY OF SUPERVISION, TREATMENT AND CARE

270. Although the deceased's risk assessment on his admission to Hakea contained some minor errors, the decision to place him on moderate ARMS in CCU was appropriate. However, in my view, the deceased should have been placed on SAMS when he was removed from ARMS on 20 October 2015. The fact this did not occur appears to have been due to a misunderstanding about the SAMS criteria.

271. Had the deceased been placed on SAMS, he would have been more regularly monitored by the PRAG and his case would have been discussed at weekly mental health team meetings. Further, the deceased would have been more likely to have received ongoing counselling from PCS.

272. At the relevant time, inadequate staffing levels meant that PCS follow-up for prisoners not on ARMS or SAMS was essentially unavailable. The parlous state of PCS resources at that time is further illustrated by Mr Russell's evidence.

273. On account of the imponderables in this matter, there is no way of knowing whether the outcome in this case would have been different had the deceased been placed on SAMS and/or had been provided with ongoing counselling. However, that is hardly the point. The deceased had a recognised need for ongoing therapeutic counselling which could not be met because the PCS only had the capacity to conduct risk assessments.

274. Although it appears that the deceased's physical health needs were addressed, his mental health needs were not. At the inquest, I was told that the Department has approved the employment of a further nine PCS counsellors. This is welcome news, and I hope this extra capacity will go some way to meeting the enormous need for therapeutic counselling that currently exists in Western Australia's prisons.

275. The Department must now expedite the recruitment process for these new PCS staff, and ensure that appropriate support and supervision structures are in place to ensure theses new staff are retained.

COMMENT ON RECOMMENDATIONS

276. At the conclusion of the inquest, I indicated that it was likely that I would make several recommendations to deal with issues that I had identified. I advised Ms Eagling that I intended to forward to the Department, any recommendations I intended to make in draft form, and ask for comment.

277. Six draft recommendations were forwarded to the Department on 31 October 2019. The Department was asked to provide any comments on those draft recommendations by 14 November 2019. By letter dated 13 November 2019 (the Letter),[330] the Director General of the Department advised as follows:

i. Draft recommendation 1 (SOG deployment): not supported. The Director General reiterated the Department's position on the SOG deployment procedure, namely that it intends to maintain the current centralised model. However, the Director General advised that:

> Corrective Services will review the current centralised model and adjust the deployment matrix to introduce process improvements to triage and streamline SOG deployment and provide for increased transparency and improved responsivity with appropriate controls in place.[331]

ii. Draft recommendation 2 (increased PCS numbers): supported. The Director General advised that there had been strong interest in the nine advertised vacancies and that interviews had been conducted. Three of the new positions will be allocated to Hakea, three will be allocated to other metropolitan prisons and that one the remaining three positions will be allocated to each of the prisons located in Albany, Bunbury and the Eastern Goldfields respectively.[332]

[330] Letter to the Court from the Director General, Department of Justice (13.11.19)
[331] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p1
[332] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p2

iii. Draft recommendation 3 (reciprocal access to information): supported. The Director General noted that all PCS staff now have access to EcHO. Further, the Director General advised that:

> Copies of all relevant PCS notes are now available to health staff…[and]…It is expected that all training and full implementation of the use of EcHO by PCS staff will be completed by the end of March 2020.[333]

iv. Draft recommendation 4 (information sessions for custodial officers on the role of the SOG): supported. The Director General advised that:

> Response procedures will be reviewed in light of the above, after which broader awareness sessions on prison-response, the role of medics and the role of specialist response groups will be delivered to prison-based staff.[334]

v. Draft recommendation 5 (critical incident management training for senior staff): supported. The Director General advised that incident management team training has been identified as a key deliverable as part of the enhancement of Security and Response Services across the State.[335]

vi. Draft recommendation 6 (mental health training for custodial officers): supported. The Director General advised that:

> The Department is developing the Staff Mental Health Training Framework and will take into the recommendation provided.[336]

278. Notwithstanding the fact that the Department did not support draft recommendation 1 which relates to the SOG deployment procedure, for the reasons I have set out above, it is my view that this recommendation is appropriate and arises from the evidence I heard at the inquest.

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[333] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p2
[334] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p3
[335] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p3
[336] Attachment to Letter to the Court from the Director General, Department of Justice (13.11.19), p4

RECOMMENDATIONS

279. In light of the observations I have made, I make the following recommendations:

Recommendation No. 1

The Department should review the deployment procedure for the Special Operations Group (SOG) and in doing so, should consider the views of experienced custodial and operational officers, that the current system is inefficient. The Department should give consideration to reverting to the previous deployment system where officers in charge of prisons could contact SOG directly when seeking assistance.

Recommendation No. 2

Now that funding for nine additional Prison Counselling Service (PCS) staff has been approved, the Department should take urgent steps to recruit these staff and more broadly, should consider the appropriate level of PCS and mental health staff for prisons across the State.

Recommendation No. 3

In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should, without delay, take all necessary steps to remove any remaining impediments so as to ensure that PCS and Prison Health Service staff have reciprocal access to prisoner information stored in the EcHO computer system and the PCS module of the Total Offender Management Solutions system respectively.

Recommendation No. 4

The Department should consider expanding the delivery of information sessions about the SOG (currently being presented to prison health staff) to custodial officers.

Recommendation No. 5

In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should consider providing critical incident management training to its senior custodial officers (i.e.: senior officers and above).

Recommendation No. 6

The Department should consult with an expert in the field of mental health with a view to providing training to custodial staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.

CONCLUSION

280. The deceased was a 43-year old man who at the time of his death was being held in custody on remand at Hakea, with respect to a number of serious charges.

281. On 12 January 2016, the deceased barricaded himself into a communal area on the wing he was being housed in, placed an improvised ligature around his neck and hanged himself. He had told other prisoners and custodial staff that he could not face the long prison sentence he anticipated he would receive. He died at FSH on 14 January 2016.

282. The deceased had sought counselling for his mental state on 30 October 2015, but because there were not enough counsellors at Hakea at the time, he was seen on only one occasion. The deceased had previously been diagnosed with antisocial personality disorder and the evidence is that he would have benefitted from long-term counselling, had this been available. One of the benefits of long-term counselling for prisoners like the deceased is that it may help reduce the risk of self-harm.

283. The deceased was not placed on SAMS after being removed from ARMS on 20 October 2015. Had this occurred, he would have been monitored more regularly by the PRAG and may have been more likely to have received ongoing counselling.

284. This was the first occasion at Hakea that a prisoner had barricaded themselves into a communal area in the way that the deceased did. The fact that the deceased entered the Dayroom with wet bags, masking tape and a bedsheet, suggests an element of pre-planning. Nevertheless, with one exception, the evidence is that the deceased gave no prior indication of his intention to take his life.

285. Since the deceased's death, steps have been taken to prevent a similar incident. The Dayroom door now opens outwards and the heavy tables the deceased used to barricade the door have now been bolted to the floor. Ligature points around the window vents in the Dayroom have also been removed.

286. These changes are pleasing, but more needs to be done. The number of PCS staff needs to be increased so that there is at least some capacity to provide therapeutic counselling to vulnerable prisoners in need. Custodial staff would benefit from additional training with respect to common mental health conditions including anti-social personality disorder and how to better manage prisoners with these conditions.

287. With respect to responding appropriately to critical incidents, senior staff would benefit from critical incident management training and the current deployment process for the SOG requires urgent review.

288. From the perspective of physical needs, I am satisfied that the supervision, treatment and care provided to the deceased was reasonable. However, the deceased was not provided with the ongoing counselling it had been identified he required.

289. I have made six recommendations aimed at addressing the issues I identified during the inquest. It is my hope that these recommendations, and the changes already made by the Department, will provide some solace to the deceased's family for their terrible loss.

MAG Jenkin
Coroner
13 November 2019