Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 07/19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Annabel NICOL*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***12 February 2019*** *find that the identity of the deceased person was* ***Annabel NICOL*** *and that death occurred on* ***15 June 2015*** *at* ***Bandyup Women's Prison*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms B Burke appearing on behalf of Ms Susan Park.
Ms N Eagling (State Solicitor's Office) appearing on behalf of the Department of Justice and the North Metropolitan Health Service.

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INTRODUCTION

1. Annabel Nicol was found hanging in a shower cubicle at Bandyup Women's Prison, where she was being held on remand, on 12 June 2015. She had been exhibiting symptoms of depression and self-harming behaviours in the months leading up to her death so her death by suicide cannot be said to have been entirely unexpected. However, her death does raise questions about the level of mental health care that Ms Nicol received while in custody, and whether something more could have been done to prevent her taking her life.

2. As Ms Nicol was a prisoner being held in a Western Australian prison at the time of her death, she was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 12 February 2019.

3. I am required in such an inquest to consider the standard of treatment, care and supervision provided by the authorities. As noted above, there were particular concerns raised about Ms Nicol's psychiatric care in the months leading up to her death, which were a focus of the inquest. In that regard, I heard evidence from a Psychiatrist, two Mental Health Nurses and a Psychologist who were involved in Ms Nicol's mental health care while in custody. I also heard expert evidence from Dr Adam Brett, a Consultant Psychiatrist who reviewed Ms Nicol's medical records and provided an opinion to the court as to her medical care while at Bandyup Prison.

BRIEF BACKGROUND

4. Unlike many prisoners, Ms Nicol had a relatively privileged upbringing, although I would not necessarily describe it as settled or easy. Sadly, like many female prisoners, Ms Nicol reported being the victim of various sexual and physical assaults and emotional abuse at different times in her life, and had also experienced personal tragedy.

5. Ms Nicol's parents separated when she was young and Ms Nicol generally lived with her mother and one of her brothers while her two other brothers resided with her father. Her father was a highly successful architect and Ms Nicol felt she was unable to meet his high expectations for herself. On the other hand, she shared a close relationship with her mother, who Ms Nicol admitted spoilt her.[2] When Ms Nicol was 16 years old her mother remarried and her father remarried when she was 20 years old. She reported a strained relationship with her step-father and step-mother.[3]

6. Ms Nicol attended a private girl's school and was an above average student who was popular with other students and teaching staff. Ms Nicol reported suffering from anorexia for a year when she was 15 years old, related to her

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibit 3, Tab 1.3.
[3] Exhibit 2, Tab 47.

perfectionist traits, but she did not seek professional assistance. After finishing school she chose not to attend university and worked for some time at her father's architectural firm in an administrative role.

7. Tragically, one of Ms Nicol's brothers died in a car crash when she was 16 years old. In later years, another brother was diagnosed with schizophrenia and he committed suicide by hanging when she was 33 years old. Both brothers were reported to have had issues with substance abuse.[4]

8. Ms Nicol met her future husband when travelling in Bali and she moved to Bali to live with him at the age of 20, despite her family's disapproval. They married and had three children together and by all accounts she was a devoted and caring mother who was immensely proud of her children. However, her relationship was said to be abusive and she turned to alcohol as a coping strategy during her marriage. She eventually left her husband in 2004 and returned to Western Australia with her sons. On her return she lived on her father's property in Yallingup and helped to run the family vineyard while her sons attended boarding school. Ms Nicol's father died of cancer in 2010.[5] Ms Nicol's mother had suffered dementia for many years and lived in a nursing home from 2007 onwards.

9. Ms Nicol had started using alcohol at the young age of 15 years, which developed into chronic alcoholism during her marriage.[6] Ms Nicol was said to have suffered with depression and alcohol addiction for many years. She was seen at Sir Charles Gairdner Hospital Emergency Department on 17 October 2006, 2 August 2010 and 5 November 2013 after being found collapsed in the street due to acute alcohol intoxication. She also had convictions in 2012 and 2013 for driving under the influence of alcohol.[7] On each occasion she was fined and her driver's licence was disqualified.

10. At the time of her hospital attendance in November 2013 she was noted to be under significant stress, with financial difficulties and difficulties associated with the loss of her driver's licence.[8] Ms Nicol reported that her alcohol use escalated in 2013, which led to her youngest son returning to Bali to live with his father, and then she spiralled down further, leading to the first offending mentioned below.[9]

11. There were conflicting reports as to whether Ms Nicol had been diagnosed with the neurological disorders multiple sclerosis or transverse myelitis, which can be an early sign of multiple sclerosis. In the months prior to her death Ms Nicol denied such a diagnosis and a medical review undertaken at the request of the Court in relation to her sentencing proceedings found no signs or symptoms of a neurological disorder. A psychologist who reviewed Ms Nicol for the same purpose did see signs of slurred speech, abnormally long pauses and swallowing difficulties that could have been evidence of an underlying disorder, together with some other reported symptoms, but it was

[4] Exhibit 2, Tab 47.
[5] Exhibit 2, Tab 47.
[6] Exhibit 2, Tab 47 and Exhibit 3, Tab 1.3.
[7] Exhibit 2, Tab 47.
[8] Exhibit 1, Tab 31; Exhibit 2, Tab 47.
[9] Exhibit 3, Tab 1.3.

also noted many of the symptoms could be associated with severe anxiety/chronic alcoholism.[10] There is insufficient evidence before me to find she had an undiagnosed neurological disorder at the time of her death.

FIRST TIME IN CUSTODY

12. Ms Nicol's alcohol dependency led her to commit increasingly serious offences. After she lost her driver's licence she admitted to walking to neighbouring properties to steal alcohol. She was charged with attempted burglary, stealing and trespassing. She spent a short period of four days in custody on remand from 12 to 16 February 2014. While in custody she was placed on six hourly observations on the At Risk Management System (ARMS) and then moved into the Crisis Care Unit (CCU) after disclosing thoughts of self-harm while in the police lock-up and prison van.[11]

13. Ms Nicol was noted to have alcohol withdrawal and was teary and distressed. She reported that she usually drank two bottles of whisky per day and had also been smoking heroin and using cocaine more recently. Her family history of suicide and deep sense of shame over her imprisonment were noted. She was continually monitored on ARMS until discharged.[12]

14. Ms Nicol was eventually sentenced to a 10 month Community Based Order (CBO) for the attempted burglary, which was due to expire in December 2014.

15. However, during the term of the order Ms Nicol committed a number of further offences of stealing and trespass that were alcohol-related, either done to obtain alcohol or while under the influence of alcohol. She was also warned for attending community corrections whilst under the influence of alcohol. Ms Nicol was directed to attend substance abuse counselling with the Community Drug Service Team before entering a detoxification program at Bridge House on 20 October 2014 and then the Harry Hunter Residential Rehabilitation on 20 November 2014.

16. On 18 February 2015 the court cancelled Ms Nicol's existing CBO and placed her on another 9 month CBO. However, within days she had relapsed into alcohol use and committed further offences over a five day period, including trespass, stealing, burglary, disorderly conduct and obstructing police.[13] At that stage she had achieved only minimal engagement with her new CBO.

17. On 10 March 2015 Ms Nicol was taken to the Bunbury Hospital Emergency Department by police. She complained of nausea and vomiting and was noted to be dehydrated. She was treated for alcohol withdrawal. She reported feeling better after two hours of treatment and was discharged back into police custody after treatment.[14] She was not released on bail by the

[10] Exhibit 1, Tab 1.3.
[11] Exhibit 3.
[12] Exhibit 2, Tab 47.
[13] Exhibit 3.
[14] Exhibit 1, Tab 32; Exhibit 2, Tab 47.

police as it was felt she was a danger to herself if released and she was likely to commit further offences and/or fail to appear in court if not kept in custody. She was also said to be a Schedule 2 offender under the *Bail Act 1982* (WA), allegedly having committed a serious offence whilst on bail for a serious offence. Ms Nicol's release on bail was opposed by police prosecutors at her first court appearance and it appears she was refused bail and remanded in custody.

RETURN TO CUSTODY

18. On 13 March 2015 Ms Nicol returned to Bandyup Women's Prison as a remand prisoner.[15] Ms Nicol was referred to the Prisoner Support Officer due to her limited prior time in custody.[16] She was older than a typical first time prisoner and had no established support network. From her initial ARMS Reception Intake Assessment answers it was felt by the interviewing prison officer that Ms Nicol was not at risk of suicide or self-harm.[17]

19. However, shortly after, on 15 March 2015, custodial staff raised an ARMS Alert as Ms Nicol was clearly not coping with her custodial placement. An officer recorded that Ms Nicol burst into tears when asked if she was okay and appeared to be very afraid of the legal system and the process she was embarking on.[18] She was referred to the Prison Counselling Service (PCS) and her case was addressed by the Prisoner Risk Assessment Group (PRAG) the following day.

20. A Registered Psychologist, Ms Jeanne Neville, was employed within the Prison Counselling Service, based at Bandyup Prison at the time. Ms Neville described her main role as self-harm and suicide prevention through crisis management and intervention, as well as individual counselling and therapy. Ms Neville was Ms Nicol's counsellor through the PCS throughout her time in Bandyup.[19]

21. Ms Neville's note of their first meeting on 16 March 2015 recorded that Ms Nicol was walking slowly and at times she appeared bewildered and had a vacant expression. Ms Nicol had earlier admitted in her entry interview to having been a binge drinker and drinking a bottle of vodka and three bottles of wine a day before being imprisoned.[20] Speaking to Ms Neville she denied she was suffering from alcohol withdrawals, although she admitted drinking heavily for 10 years. An odour was present that made it apparent she had opened her bowels during the interview. Her behaviour was so unusual in the counselling session that it was felt possible she had cognitive impairment in addition to alcohol withdrawal. Given her unusual behaviour it was recommended that she remain on ARMS and it was suggested she also required medical assessment.[21] She remained subject to ARMS

[15] Exhibit 2, Tab 47.
[16] Exhibit 3, Mudford Report.
[17] Exhibit 3, Tab 1.6.
[18] Exhibit 3, Tab 1.7.
[19] Exhibit 3, Tab 11.5 [1] – [13].
[20] Exhibit 2, Tab 47.
[21] Exhibit 2, Tab 2, Tab 30 ARMS PRAG Minutes 16.3.2015 and Tab 47.

thereafter. Ms Nicol was also referred for mental health, psychiatric and medication reviews and provided ongoing medication for withdrawals.[22]

22. The observations logs show there were issues with Ms Nicol's self-care in the unit and she had to be spoken to about her grooming and hygiene. She rarely mixed with other prisoners, appeared lost and confused and refused visits from her family. Her primary concern in the early days of her imprisonment was contacting her lawyer, which the prison officers tried to facilitate.[23]

23. On 23 March 2015 a PCS note documented that Ms Nicol had low mood and ongoing symptoms of withdrawal. She was tearful and stated she was not coping. She requested medication but was told by Ms Neville that she could not prescribe medication. Ms Nicol advised she had spoken to her lawyer that morning and had been told that her charges might be upgraded. She appeared to feel she could cope provided the charges weren't upgraded.[24]

24. On 26 March 2015 Ms Nicol cancelled a visit from her brother. She reportedly told the control officer that she did not want any further visits whilst she was in prison.[25] It would appear that her feelings of shame about her current situation influenced her decision.

25. On 30 March 2015 Ms Neville had a counselling session with Ms Nicol and recorded that Ms Nicol denied any self-harm or suicidal ideation but it was noted that she was emotionally fragile and described herself as "emotionally exhausted."[26] A concern had been raised after she refused the visit from her brother and indicated that she did not want any further visits while she was in prison due to her guilt. She also said she did not want to engage with other prisoners, which meant she was very socially isolated. Ms Nicol was reluctant to engage with Ms Neville as she was aware she was unable to prescribe medication. Ms Nicol said it was medication that she needed and she did not think counselling would help.[27]

26. I note that at this time Ms Nicol spoke about seeing a lawyer that afternoon and her hope that she would get a better understanding of her legal situation prior to her court appearance the next day.[28] However, she also said she did not know if she would cope if she was remanded further,[29] which as it came to pass was exactly what did occur on more than one occasion.

[22] Exhibit 2, Tab 47.
[23] Exhibit 2, Tab 1.
[24] Exhibit 2, Tab 4 and Tab 47.
[25] Exhibit 2, Tab 47.
[26] Exhibit 2, Tab 5.
[27] Exhibit 2, Tab 5.
[28] Exhibit 2, Tab 47.
[29] Exhibit 2, Tab 47.

FIRST SELF-HARM ATTEMPT

27. On 2 April 2015 a prisoner alleged that Ms Nicol was drinking cleaning products. She was spoken to and initially denied doing so.[30] On 5 April 2015 Ms Nicol admitted that she had done so and she was taken by ambulance to the Swan Hospital Emergency Department. She gave a four day history of ingesting multiple cleaning products, as well as a metal paperclip two weeks previously. She reportedly told a prison officer she swallowed the chemical because she hates herself and wants to die.[31] It was recommended that she have a psychiatric assessment "once she goes back to prison as she's been having thoughts of self-harm for last couple of weeks."[32] She was returned to Bandyup that same day.

28. On her return she was seen by a clinical nurse due to poor sleep. It was suggested that she try valerian for three nights and, if it helped, she could get a regular prescription.[33]

29. On 7 April 2015 Ms Neville made a PCS note that Ms Nicol presented with passive aggressive traits and that she spoke in a childlike manner. She was not accepting of her incarceration and said of a prospective prison sentence, "I can't cope being here," "I won't be able to do it" and "it's too hard."[34] She denied that the ingestion of chemicals was a suicide attempt and said she could not actively take her life, but she did say she wanted to make herself sick and agreed that she did not want to live. Her main focus in the counselling session was on having a cigarette, as she said smoking helped calm her, and she complained of being unable to smoke in CCU. Ms Nicol expressed a desire to return to her unit as there she could mix with other people and smoke. Her other focus was on her next court appearance. It was recommended that she remain on ARMS and in CCU.[35]

30. On 8 April 2015 Ms Nicol underwent a medical officer review for new admission. She was said to be very unhappy and her history of alcoholism was noted. She was referred for psychiatric assessment.[36]

31. On 9 April 2015 was seen again by Ms Neville. The PCS note recorded that Ms Nicol engaged well during the counselling session and although tearful, her behaviour was appropriate. She spoke about her family, and how happy they had been about her attempts to do rehabilitation. She felt that she had let them down by reoffending and was concerned they would not forgive her. Her impulsivity was noted and she spoke of her fear that she was going "mad."[37] She expressed an interest in continuing counselling and a recommendation was made that she continue on ARMS but be considered for a return to mainstream placement.[38]

[30] Exhibit 3, Tab 1.
[31] Exhibit 2, Tab 44.
[32] Exhibit 2, Tab 47 [21].
[33] Exhibit 2, Tab 47.
[34] Exhibit 2, Tab 6.
[35] Exhibit 2, Tab 6.
[36] Exhibit 2, Tab 47.
[37] Exhibit 2, Tab 7.
[38] Exhibit 2, Tab 7.

32. On 10 April 2015 Ms Nicol was seen by a mental health nurse. The assessment noted that she did not appear to have any psychiatric history and the conclusion of the nurse was that she did not need to be seen by mental health. It was recommended that she see a general practitioner for 'sleepers' (presumably sleeping tablets).[39]

33. On 12 April 2015 it was noted on the medical file that Ms Nicol had been commenced on the antidepressant mirtazapine 15 mg the previous day.[40]

34. On 13 April 2015 Ms Nicol was noted to have been transferred to Unit 2. She had a PCS that day and reported she was low in mood and not coping with her incarceration. She spoke of her new medications and said she believed she needed more as she was feeling no better. The counsellor attempted to suggest other coping strategies but Ms Nicol's focus remained on her medication.[41]

35. On 16 April 2015 Ms Nicol asked for a trial of valerian whilst waiting for the mirtazapine to work.[42]

36. On 17 April 2015 Ms Nicol had another counselling session and she apparently reported that she was gradually becoming accustomed to being in prison. However, she remained focussed on wanting more medication. She denied any thoughts/plans of self-harm and it was recommended her ARMS reduce to 12 hourly.[43]

37. On 22 April 2015 a psychological assessment was performed by a Clinical and Forensic Psychologist, Ms Oliveri, in order to prepare a report for sentencing purposes. It was noted that Ms Nicol was initially mute and non-responsive but she eventually engaged in the process although she remained emotionally distressed throughout. Ms Oliveri concluded Ms Nicol was an emotionally immature woman with chronic alcoholism, severe depression and anxiety and feelings of failure and self-loathing. Her poor coping skills in prison were evident. She admitted previous suicidal ideation whilst in custody but denied any current suicide or self-harm plans. Ms Oliveri noted that if sentenced to a period of imprisonment, Ms Nicol's risk of suicide was likely to escalate. It was felt that Ms Nicol required highly intensive and structured long-term residential rehabilitation or an inpatient psychiatric program, as well as long-term psychological therapy.[44]

38. On the same day Ms Nicol engaged in a counselling session with Ms Neville and spoke of self-loathing in relation to her behaviour in the community before she was imprisoned. She also reported that she had experienced her first panic attacks a few days earlier. Ms Nicol was not felt to be an imminent risk to self but given her symptoms of depression and self-loathing and difficulty adjusting to incarceration it was recommended she stay on ARMS 12 hourly.[45]

[39] Exhibit 2, Tab 47.
[40] Exhibit 2, Tab 47.
[41] Exhibit 2, Tab 8.
[42] Exhibit 2, Tab 47.
[43] Exhibit 2, Tab 9.
[44] Exhibit 2, Tab 47.
[45] Exhibit 2, Tab 11 and Tab 47.

39. On 23 April 2015 Ms Nicol had a medical review and her dose of mirtazapine was increased to 30 mg at night.[46]

FIRST HANGING ATTEMPT

40. On 25 April 2015 Ms Nicol trashed her cell and attempted to hang herself on the hatch on her cell with a cord. The incident was reported by a prisoner and she was seen to have ligature marks around her neck by a prison officer. Ms Nicol was transferred to the CCU and her ARMS was increased to 2-hour monitoring.[47]

41. On 28 April 2015 Ms Nicol had her first psychiatric review with Dr Sophie Davison. Dr Davison works part-time as a Consultant Forensic Psychiatrist for the State Forensic Mental Health Service, North Metropolitan Health Service and also works part-time for the Office of the Chief Psychiatrist as the Deputy Chief Psychiatrist. Dr Davison has significant experience working as a Consultant Psychiatrist in a prison environment.[48] Dr Davison noted the day-to-day management of suicide risk is managed by the nurses, prison counsellors and custodial staff using the prison ARMS process. Her role is to assist and advise the prison-based mental health nurses in their assessment and day-to-day management of women with severe mental health problems. Dr Davison only attends Bandyup Prison on Tuesdays and alternate Fridays to perform that role.[49]

42. Dr Davison saw Ms Nicol in company with Clinical Nurse Specialist (CNS) Susan Park. This was also the first time CNS Park had met Ms Nicol. CNS Park is a very experienced mental health nurse who has been employed at Bandyup Women's Prison since 2012.[50] CNS Park did not have any independent recollection of Ms Nicol, apart from her notes.[51]

43. The psychiatric review took place at the CCU. Dr Davison was aware Ms Nicol had tried to hang herself three days prior, as well as her earlier ingestion of cleaning fluid. Ms Nicol reported difficulty coming to terms with being in prison and expressed feelings of shame and guilt. She said she had been in rehabilitation and had initially done well, but relapsed and was then arrested and remanded in custody. Ms Nicol described feeling low in mood all the time with no energy and poor sleep and concentration. She felt there was no relief from her feelings. In relation to the hanging attempt, Ms Nicol said she had not planned to hang herself but wanted to die at the time. She said she had never tried to kill herself before and actually undid the cord around her neck as she realised she had to sort out her problems and carry on. Ms Nicol told Dr Davison she no longer wanted to die but did have very

[46] Exhibit 2, Tab 47.
[47] Exhibit 2, Tab 11 and Tab 47.
[48] Exhibit 3, Tab 11.3.
[49] Exhibit 3, Tab 11.3 [4].
[50] Exhibit 3, Tab 11.7.
[51] T 36.

negative feelings about the future as she felt she could never go home as everyone would see her as a criminal.[52]

44. Ms Nicol was very reluctant to talk about her drug and alcohol history and refused to discuss her personal and family history. She said she had let her family down. Ms Nicol said she was finding it difficult being isolated on the CCU as she was not able to make phone calls when she needed to in order to sort out her court case and she also found it distressing not being able to smoke. She indicated she wanted to go back to her unit.[53]

45. Dr Davison concluded Ms Nicol was a 50 year old woman with a history of severe alcohol dependence who now presented with features of depression, including sustained low mood, loss of interest and pleasure, lack of energy, poor sleep and excessive guilt and self-blame. Her problems were compounded by the fact that she had traditionally used alcohol as a coping mechanism and she was having difficulty coping with her thoughts and feelings without access to alcohol. She was not considered to be acutely suicidal at the review but was considered to remain a risk to herself in her current state.[54] Dr Davison recommended that Ms Nicol remain on CCU and her ARMS observations were reduced to 6-hourly. A mental health nurse review was scheduled for two days' time, with a view to assessing her for return to her unit. Dr Davison recommended Ms Nicol's antidepressant medication dose be increased and a sedative medication, quetiapine 50mg, was added to Ms Nicol's medication regime to help calm her through this crisis. Dr Davison considered adding diazepam but felt Ms Nicol's risk of dependence was too great.[55]

46. Ms Nicol had a counselling session with Ms Neville on the morning of 30 April 2015 while she was still at the CCU. She was very focused in the interview on returning to her unit and kept returning to this subject. It was apparent she found the CCU environment very restrictive and said she wanted to go back to her unit to have a cigarette, make phone calls and recreate with others. Ms Neville spoke to CCU staff who confirmed that Ms Nicol was having great difficulty accepting the routine of the unit and was continually asking for phone calls and cigarettes.

47. Ms Nicol denied any current self-harm suicidal ideation and said she had really frightened herself with her recent attempt. The trigger for that attempt appeared to have been phone calls that were not responded to, reinforcing her belief that people had not forgiven her. However, it was also noted that she appeared to be minimising the events of the previous week so that she could return to the unit. A recommendation was made that Ms Nicol remain on 6-hourly ARMS and her placement be discussed at the PRAG meeting, although Ms Neville and CNS Park both felt Ms Nicol needed to remain in the CCU as she had only recently commenced medication and there was an element of risk around her earlier self-harm attempt.[56] Contrary to her wishes, Ms Nicol remained in the CCU, which she was unhappy about.

[52] Exhibit 3, Tab 11.3 [11] – [14].
[53] Exhibit 3, Tab 11.3 [15] – [16].
[54] Exhibit 3, Tab 11.3 [17].
[55] Exhibit 3, Tab 11.3 [18] – [19]
[56] Exhibit 2, Tab 12.

48. On 4 May 2015 Ms Nicol had another counselling session with Ms Neville. She was still in the CCU. She commenced the session by saying, "I'm not gonna hurt myself so why are they keeping me here?"[57] She spoke of how being in the CCU was making her depressed and she wanted to return to the unit so she could feel less isolated, make phone calls if she chooses, have cigarettes and feel the sun on her skin. Ms Nicol again denied any active self-harm or suicidal ideation. Significantly, she was future focussed about her court appearance the following week and was hopeful of release, although she also expressed concern that her pre-sentence report had not yet been done, which might mean a further remand. She did not give the impression she was an imminent risk to self, but was felt to still remain a chronic impulsive and reactive risk to self. It was recommended she remain in CCU and on 6-hourly ARMS until her psychiatric appointment the following day.[58]

49. Ms Nicol was scheduled to see Dr Davison on 5 May 2015 but for some reason that review did not take place.[59] A PRAG meeting was held that day and Ms Nicol's request to return to the unit was considered. Her counselling session the previous day was noted and information was provided on behalf of Dr Davison that Ms Nicol presented as depressed but not actively suicidal and the psychiatrist recommended she be returned to the general population but remain on ARMS.[60] Ms Nicol was told on the morning of 5 May 2015 she would be returning to Unit 2 that day. Ms Nicol appeared happy with the news and appeared to settle back into the unit well that afternoon.[61]

50. On 6 May 2015 Ms Nicol was noted to be sitting by herself and not mixing with the other prisoners or officers. She was returned to the CCU that evening at about 6.00 pm following a telephone call to her son, during which she alluded to feeling suicidal.[62] She remained in CCU for some time thereafter.

51. Ms Nicol had a counselling session with Ms Neville on 7 May 2015. She presented with flat affect and low mood and had a rash on her face that she had been picking at and scratching. She exhibited passive aggressive traits at times during the interview. They discussed her telephone call to her son and her refusal to allow him to visit her. Ms Nicol spoke of how she felt it was "too hard,"[63] meaning being in Bandyup and seeing her family due to her shame. Ms Nicol indicated she wanted to go back to Unit 2 as she did not like being in CCU and felt she should not have been brought back there. Ms Nicol acknowledged having some suicidal thoughts but denied any intent or plan and minimised her previous conduct. She cited her children as protective factors, but also said she felt they would be better off without her. Ms Nicol was considered to remain an impulsive chronic risk to self and

[57] Exhibit 2, Tab 13.
[58] Exhibit 2, Tab 13.
[59] Exhibit 2, Tab 13.
[60] Exhibit 3, Tab 7, ARMS PRAG Minutes 5.5.2015.
[61] Exhibit 3, Tab 7, ARMS – Offender Supervision Log, p. 16.
[62] Exhibit 2, Tab 14; Exhibit 3, Tab 7, ARMS – Offender Supervision Log, p. 16.
[63] Exhibit 2, Tab 14.

chronically depressed. It was decided she should remain on 6-hourly ARMS in the CCU. She was given a cream to help heal the rash on her face.[64]

52. On 11 May 2015 Ms Nicol was seen again for an ARMS review. She walked slowly into the interview room and kept stopping and looking at her reflection, apparently due to concern about the rash on her face, although it had largely resolved. She behaved and spoke in a childlike manner and mentioned wanting to make phone calls to her community corrections officer and lawyer, which was being arranged by the prison officers. She mentioned her court appearance the following day and expressed concern she didn't know what was going to happen. She said she thought she was "going mad"[65] but eventually settled somewhat. Ms Nicol denied any suicidal intent but then added, "even if I wanted to there is no way I would be able to do it in this place."[66] It was recommended she remain on ARMS and in the CCU. It was also suggested she be further reviewed if she returned to prison from court.[67]

COURT APPEARANCE

53. Ms Nicol's case was considered at a PRAG meeting on 12 May 2015 while she was at court. It was agreed she should remain on ARMS in the CCU.[68]

54. On 12 May 2015 Ms Nicol charges came before the Busselton Magistrates Court via videolink. She pleaded guilty to all outstanding charges. It was noted that a pre-sentence report and psychological report raised significant concerns regarding Ms Nicol's psychological health and medical wellbeing, with a suggestion that she might be suffering from multiple sclerosis. It was recommended that a medical assessment and psychiatric report be completed before sentencing proceeded in order to ensure Ms Nicol's treatment needs could be met. Sentencing was adjourned until 9 June 2015 and she was remanded in custody pending sentencing.[69] As noted earlier, Ms Nicol had been very concerned about not being released on this date, and her fear had been realised. This clearly affected her mental state in the days that followed.

55. On 13 May 2015 Ms Nicol was still in CCU and she was noted to have been screaming and talking in a childlike manner after her sentencing was adjourned. She was refusing to eat and was vomiting. It was documented that she was hearing voices and yelling at nothing.[70] She had to be coaxed into seeing Ms Neville for her ARMS review and she appeared vague and disoriented during the interview. She appeared to believe the court had made a hospital order. Ms Nicol told Ms Neville she needed medication to help her. Ms Neville considered Ms Nicol's presentation appeared to be deteriorating and requested a medical and mental health review. She spoke to Mental

[64] Exhibit 2, Tab 14; Exhibit 2, Tab 7, ARMS PRAG Minutes 7.5.2015.
[65] Exhibit 2, Tab 15.
[66] Exhibit 2, Tab 15.
[67] Exhibit 2, Tab 15.
[68] Exhibit 3, ARMS PRAG Minutes 12.5.2015.
[69] Exhibit 3, Mudford Report.
[70] Exhibit 2, Tab 47.

Health Nurse (MHN) Gerald North that day, who indicated he would refer Ms Nicol to the psychiatrist Dr Davison when she came to the prison on 15 May 2015.[71]

56. MHN North has over 40 year's clinical experience as either a Registered Nurse or Mental Health Nurse and has worked continuously within the Department of Justice in numerous prison facilities since 2001. In 2015 he was jointly responsible with CNS Park for the mental health nursing of prisoners at Bandyup. Unfortunately, MHN North no longer works at Bandyup and had little personal recollection of events and Ms Nicol personally. Most of his recollection was prompted from reading his notes, although he did recall that Ms Nicol was quite ill.[72]

57. On 14 May 2015 Ms Nicol refused to see Ms Neville for her ARMS review but was seen by a MHN. The nurse noted Ms Nicol was walking very slowly and using her hand on the wall to support herself, but suspected her presentation was behavioural to some degree. The nurse did consider Ms Nicol was at risk of suicide, which took into account information she had secreted a plastic bag the night before. She was increased to 4-hourly ARMS and placed in a non-tear gown due to her perceived risk to self. She was noted to be displaying bizarre behaviour, including screaming in her cell while naked and hitting her head against the wall lightly. She was non-compliant with requests to attend the medical centre for blood tests.[73]

58. The following day a sharp steel item (metal skirting board) was also discovered in her bedding at CCU and she was increased to 1 hourly ARMS.[74] She refused to talk to Ms Neville and said "there's nothing you can do."[75]

59. When Dr Davison attended the prison that day she participated in a shared care meeting with the mental health team and members of the prison counselling service during which Ms Nicol's case was discussed. Her severe alcohol dependence and current depression was noted, as well as her shame about her offending behaviour and difficulties that created with her family. She was expressing her distress in a dysfunctional and histrionic way and had demonstrated repeated self-harm attempts that appeared to be escalating. It was agreed that there was still a risk Ms Nicol might succeed in harming herself.[76]

60. The agreed plan was to try get more information about Ms Nicol's time in rehabilitation prior to her incarceration, encourage her to have her blood tests to rule out any organic problems, review her medication, continue regular counselling and support and formulate a plan to monitor her for self-harm.[77]

[71] Exhibit 2, Tab 16.
[72] T 28.
[73] Exhibit 2, Tab 16, Tab 17 and Tab 47.
[74] Exhibit 2, Tab 17 and Tab 47; Exhibit 3, Tab 7, ARMS PRAG Minutes 15.5.2015.
[75] Exhibit 1, Tab 18.
[76] Exhibit 3, Tab 11.3 [21].
[77] Exhibit 3, Tab 11.3 [22].

61. Ms Nicol was reviewed by Dr Davison that day with MHN North. She was wearing a protective gown and walked very slowly into the room. Ms Nicol said she "was in agony and torture and pain because of all she had lost, with no let-up or relief."[78] She said she was going mad and her lawyer had told her she was going to hospital, which had prompted her to ask her lawyer if the hospital "could put her out of her misery."[79] She said she had no hope for the future after what she had done and after a prison sentence. She said she wanted to go to rehab but had been told they wouldn't have her because of her mental health issues, so she "wanted to be dead."[80]

62. Dr Davison concluded Ms Nicol appeared profoundly depressed and completely overwhelmed by her feelings as she did not know how to cope with them without alcohol. She was felt to be at very high risk of suicide in her current state. Her mirtazapine was increased to 45 mg per day (the recommended maximum dosage) and her quetiapine dose was also significantly increased. It was noted that she might need to be transferred to Frankland Centre if she remained so depressed. A further psychiatric review was arranged for 19 May 2015 when Dr Davison was next at Bandyup.[81]

63. Dr Davison's evidence was that after seeing Ms Nicol on 15 May 2015 she remembered agonising about whether to refer her for inpatient treatment at the Frankland Centre at that stage.[82] Her reasons for not doing so were:

    - The Frankland Centre is not a therapeutic environment for meeting the needs of distressed women, especially those with a history of trauma. It is an acute mental health unit with 30 beds and the overwhelming majority of patients are men with psychotic illnesses who have been violent;
    - There is no dedicated area on the unit for women and the few women who do get admitted end up very restricted for their own protection and many find it traumatic;
    - In addition, there are very few beds so there is often a long wait for a bed, during which time the patient still has to be managed in prison;
    - Because of the shortage of beds, prisoners are often only admitted for short periods of stabilisation when acutely unwell and returned to prison very swiftly to make room for other patients; and
    - Ms Nicol was accepting of medication for the treatment of depression was receiving psychological support from the prison counselling service and could be kept physically safe when acutely at risk at the CCU. Therefore, she did not need to be given involuntary treatment, which can only be given in an authorised hospital.[83]

64. Dr Davison also noted in her oral evidence that the nurses who were seeing Ms Nicol more frequently indicated that Ms Nicol's mood was generally improving.[84]

[78] Exhibit 3, Tab 11.3 [24].
[79] Exhibit 3, Tab 11.3 [24].
[80] Exhibit 3, Tab 11.3 [24].
[81] Exhibit 2, Tab 47; Exhibit 3, Tab 11.3 [26].
[82] T 53.
[83] Exhibit 3, Tab 11.3 [28].
[84] T 53.

65. A summary of her situation on 15 May 2015 by Ms Neville noted that whilst in CCU Ms Nicol had been found with plastic bags and a cord from a window blind under her mattress, been seen vomiting after possibly ingesting soap/toothpaste, been found with a plastic bag and the top of a toothpaste tube during a strip search and then most recently the steel piece of skirting. She was classed as a high risk of suicide, exhibited no future focus and did not cite any protective factors. A multidisciplinary approach between the psychiatrist, the mental health nurses and the prison counselling service was being implemented.[85]

66. On 18 May 2015 Ms Neville and MHN North discussed Ms Nicol's case and it was agreed that the mental health nurse would review Ms Nicol that day due to her continuing escalation of behaviour over the weekend despite the significant increase in her quetiapine, which had been expected by Dr Davison to help settle her behaviour.

67. Ms Nicol had a review with MHN North that day. His impression was that Ms Nicol was becoming very bored and feeling isolated in CCU and therefore was wanting to return to her unit.[86] However, it was still felt that her presentation was much improved. She said her lawyer had requested that she be placed in a hospital down south and she was told the only forensic beds were at Graylands Hospital (which would presumably have been a reference to the Frankland Centre, which is the State's only maximum security forensic inpatient service, based at Graylands Hospital).[87] It was noted in the PRAG minutes that day that Ms Nicol had then told staff she wanted to go to Graylands Hospital and had even asked cleaning staff, "What do I need to do to get to Graylands."[88] She was seen eating toilet paper and then throwing it up so the toilet paper was removed.[89]

68. On 19 May 2015 Ms Nicol was seen by Dr Davison, as planned, in the company of CNS Park. She was assessed as being brighter and more alert than the previous week but she remained depressed and a potential risk to herself. She pleaded to go back to the ordinary unit as she felt the CCU was a punishment and made her worse. She was very preoccupied with the fact that she had been told that she would be going to hospital from court on a hospital order. She said she had not noticed any change since her medication was increased. Dr Davison planned to review her again in one week.[90] Within the unit, she agreed to stop wetting herself if given normal clothing, which was done and she complied with that agreement.[91]

69. On 20 May 2015 Ms Nicol was said to be behaving like a lost child and she commenced some mild tantrum-like behaviour when her request for a cigarette was declined.[92]

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[85] Exhibit 2, Tab 18.
[86] Echo Notes 18.5.2019 9.08 am.
[87] Exhibit 2, Tab 18 and Tab 47; Echo Notes 18.5.2019 9.08 am; Exhibit 3, Tab 11.6 [42] – [43].
[88] Exhibit 3, Tab 7, ARMS PRAG Minutes 18.5.2015.
[89] Exhibit 3, Tab 7, ARMS PRAG Minutes 18.5.2015.
[90] Exhibit 1, Tab 47; Exhibit 3, Tab 11.3 [29].
[91] Exhibit 3, Tab 7, ARMS PRAG Minutes 19.5.2015.
[92] Exhibit 3, Tab 7, ARMS PRAG Minutes 20.5.2015.

70. On 21 May 2015 Ms Nicol was seen for an ARMS review and it was noted she was said to be continually yelling and screaming as an expression of her emotional distress.[93] She asked if she could go back to her unit and was told she would have to remain in the CCU until she was reviewed by the psychiatrist on Tuesday. She appeared not to comprehend this information and persisted in asking if Ms Neville could send her back to the unit. She was asked about phone calls and visits and said she was not ready to talk to her family.[94]

71. Ms Nicol was reviewed by CNS Park the same day. She repeatedly asked when she was leaving CCU and going back to the unit. She spoke a little of her history during the interview and claimed to have drunk cleaning fluids before going to prison as she did not like herself. They discussed her habit of secreting things in her room and said she felt better and more hopeful she would not hurt herself, noting "you can't hurt yourself in here in CCU."[95] She admitted to auditory hallucinations but showed no evidence of thought disorder. Her mood was felt to be brighter but she remained depressed and a risk to herself.[96]

72. On 22 May 2015 Ms Nicol was reviewed by Dr Davison and CNS Park. Dr Davison noted Ms Nicol seemed a bit brighter and was less hopeless as she was able to see a future where she might go to rehabilitation again. Ms Nicol was noted to be very focussed on telling them how pointless being in CCU was for her and how it was making her worse as she needed human company. Dr Davison recalled how persuasive Ms Nicol was on this point.[97] Ms Nicol was unable to explain why she had secreted string and plastic bags in her room on CCU and was noted to be somewhat guarded and dismissive of discussing her current thoughts and feelings. Dr Davison felt it was difficult to assess and monitor Ms Nicol's risk accurately due to her variable presentation and her apparently contradictory tendency to sometimes minimise things and at other times to dramatise. There was no doubt she was depressed and had poor self-esteem. She had previously coped by drinking to excess, so abstinence was taxing her coping skills. There was felt to be a risk that she might try to self-harm again but it was also acknowledged that keeping her in CCU was likely to cause a deterioration in her mental state.[98]

73. The reasons for this were that the CCU was quite isolating and there was no general freedom as there was in a mainstream unit. Ms Nicol was similar to most other prisoners in the CCU who find it restrictive as they're not able to smoke freely and they can't sit and chat. There are also a lot of difficult and very rowdy people to manage in CCU, so it is "not the best therapeutic environment."[99] The treatment Ms Nicol required at that time was ongoing monitoring, it was felt that going to a unit and being monitored in the unit might be a lot more stabilising for her. The unit she was sent to was general

[93] Exhibit 1, Tab 47.
[94] Exhibit 2, Tab 20.
[95] Echo Notes 21.5.2015 10.26 am.
[96] Exhibit 1, Tab 47.
[97] T 56.
[98] Exhibit 2, Tab 47; Exhibit 3, Tab 11.3; Echo Notes 22.5.2015 11.24 am.
[99] T 94.

population but the smallest unit at the prison, which meant she could be monitored a lot more closely by the prison officers.[100]

74. Ms Nicol, in particular, found the CCU to be a punitive environment,[101] as if she was being punished for bad behaviour rather than being taken there to keep her safe. Certainly, when she was placed in the management unit, this might be the case as the management unit is used as a punishment block for prisoners who have committed infractions, but it is also where prisoners are placed who are acutely suicidal and there is overflow from the CCU.[102]

75. Dr Davison recommended that Ms Nicol have a phased transition back to the unit, by spending the day on the unit and returning to CCU at night where she could be more closely monitored.[103] If this went well, she could then be moved back to the unit full-time, but remain on ARMS. This proposal was approved at the PRAG meeting held on the afternoon of 22 May 2015.[104]

76. It does not seem that Ms Nicol was allowed back to her unit on 23 and 24 May 2015, which I gather was the weekend. She was noted on the supervision log to be often screaming and yelling and pacing in her cell and her behaviour meant she was not permitted to go to the unit. She was told if her behaviour improved she might be permitted to go to the unit, but it does not seem this eventuated.[105]

77. Ms Nicol was reviewed by CNS Park on 25 May 2015 and she avoided questions about her behaviour over the weekend and asked in a childlike way if she could go back to unit as she was 'being good'. She denied any current thoughts of self-harm or suicidal intent. Given her inconsistent behaviour and the fact she was difficult to assess, the mental health nurse recommended she remain in CCU until she was seen by the psychiatrist the following day.[106]

78. On 26 May 2015 Ms Nicol had another psychiatric review. Ms Nicol said she was bored in her cell and paced a lot. She denied any thoughts of suicide or self-harm. Dr Davison felt that Ms Nicol's behaviour fitted the picture of histrionic and borderline personality traits. She was said to have little tolerance of frustration and expressed her distress in a rather dramatic way. It was felt that remaining in CCU was counterproductive for her and Dr Davison recommended that Ms Nicol return to her unit on 12-hourly ARMS. Another psychiatric review was scheduled for three weeks' time (being 16 June 2015, the day after Ms Nicol died).[107]

79. The following day Ms Nicol was placed on the management unit and increased to 6-hourly ARMS after she had been seen behaving strangely on CCTV and investigations found she had hidden under the blankets on her bed and put a plastic bread bag over her head. Ms Nicol was reviewed by

[100] T 94 - 95.
[101] T 56.
[102] T 64.
[103] Exhibit 2, Tab 47; Exhibit 3, Tab 11.3; Echo Notes 22.5.2015 11.24 am.
[104] Exhibit 3, Tab 7, ARMS PRAG Minutes 22.5.2015.
[105] Exhibit 3, Tab 7, ARMS Offender Supervision Log, p. 25.
[106] Exhibit 1, Tab 47; Echo Notes 25.5.2015 9.00 am.
[107] Exhibit 1, Tab 47; Exhibit 3, Tab 11.3 [36] – [40].

CNS Park. Ms Nicol told the nurse she did it for attention as she was bored and denied she wanted to die.[108] She remained in the management unit over the next few days, although it was still planned to eventually transfer her to mainstream. She was spoken to by Ms Neville on 28 May 2015 and confirmed what she had said to CNS Park. She still denied any plans to self-harm or commit suicide but was felt to remain at chronic impulsive risk to herself.[109]

80. Ms Nicol spent the afternoon of 28 May 2015 on the unit recreating and spent time in the smokers hut and no issues were noted.

81. On 29 May 2015 Ms Nicol had a review by a GP and nurse to investigate her claims that she had transverse myelitis or multiple sclerosis. No significant findings were made in the physical examination and a letter to that effect was prepared for the court.[110]

82. Ms Nicol was noted to be pleased about going to the unit again on the afternoon of 29 May 2015. On 30 May 2015 Ms Nicol was recorded as pacing around Unit 1 and when spoken to she said she didn't want to mingle with anyone at the moment. She was seen pacing in the unit again on 31 May 2015 and she was told to stay away from another inmate who was volatile and was finding Ms Nicol's conduct irritating, yet she continued to approach the inmate. Ms Nicol returned to CCU that night and said she'd had a good day in the unit and made a friend.[111]

83. On 1 June 2015 Ms Nicol was recorded in the CCU as being keen to spend her day on the unit and stated she had a couple of nice friends in there. She was recorded by unit prison staff as pacing around the unit asking other prisoners for cigarettes. She was also said to be attention seeking with staff and prisoners and when she did not get attention she wanted to return to the CCU. Nevertheless, she was said to be anxious to return to the unit the next day and expressed a desire to remain in the unit full-time.[112]

84. On 2 June 2015 Ms Nicol told a MHN North she was concerned about being sent to hospital by the Court when she appeared the next week. She presented with depressed mood and affect despite being compliant with her medication.[113]

85. That afternoon Ms Nicol was brought back from recreating on the unit and placed into the management unit after ripped sheets were found hidden in her cell that were thought to have been intended for a ligature. She was increased to 4-hourly ARMS and put into a protective gown.[114]

86. Ms Nicol was seen by CNS Park on the morning of 3 June 2015. She was asked about the ripped sheet and said she'd ripped it a few days before and said she did it for attention and was surprised it had taken them so long to

[108] Exhibit 1, Tab 47.
[109] Exhibit 2, Tab 22.
[110] Exhibit 2, Tab 23; Echo Notes 29.5.2015 1.19 pm.
[111] Exhibit 3, Tab 7, Offender Supervision Log, pp. 27 - 28.
[112] Exhibit 3, Tab 7, Offender Supervision Log, p. 28.
[113] Exhibit 1, Tab 47.
[114] Exhibit 3, Tab 7, Offender Supervision Log, p. 28.

find it. She wanted to know how long until she could go back to the unit as she had friends there now. She was quite oppositional during the review and a risk assessment was unable to be completed. When the nurse terminated the interview Ms Nicol wouldn't leave the interview room and had to be escorted by prison officers back to her cell.[115] MHN North visited her again that afternoon. She seemed quiet and flat but was still described as the best he had seen her. She was clear and coherent and there was less negativity to her statements. Ms Nicol spoke of her desire to go back to the unit and to go to rehabilitation in the future, although she was concerned they wouldn't have her back. It was recommended she be allowed back into prison clothing and to recommence transitioning back to her unit.[116] This was approved by PRAG the next day.[117]

87. Ms Nicol was moved from an observation cell to another cell in the MMU and reduced from high to low ARMS. Over the next four days her ARMS supervision log recorded no significant concerns although it was noted that she became distressed and declined a booked visit as she did not want her visitors "to see her like this."[118]

RETURN TO THE UNIT

88. On 8 June 2015 Ms Nicol was transferred to Unit 1 and placed into a single cell. She was still subject to low ARMS. An entry in her ARMS supervision log at 5.07 pm recorded that Ms Nicol "seemed to be in her own little world"[119] and she appeared "miserable and to have the weight of the world on her shoulders"[120] although she was polite and compliant.

89. CNS Park spoke to Ms Neville that day to ask if the PCS could do a follow up with Ms Nicol as she was now settled and would no longer be followed up by mental health.[121] It was explained at the inquest that once a person is stabilised via medication and there is no further concern for their safety from a mental health perspective, the prison counselling service would maintain the role as the prisoner's primary support, as occurred here.[122]

90. Ms Nicol had some issues with a prisoner who was apparently coming into her cell and messing it up. She was told to request assistance from staff at any time if the prisoner caused further issues. The prisoner was apparently moved to a different unit shortly after.[123]

[115] Exhibit 1, Tab 47; Exhibit 2, Tab 25; Echo Notes, 3.6.2015 10.21 am.
[116] Exhibit
[117] Exhibit 1, Tab 47; Exhibit 2, Tab 7, ARMS PRAG Minutes 4.6.2015.
[118] Exhibit 2, Tab 1, p. 30.
[119] Exhibit 2, Tab 1, p. 30.
[120] Exhibit 2, Tab 1, p. 30.
[121] Exhibit 2, Tab 27.
[122] Exhibit 3, Tab 11.4 [34].
[123] Exhibit 2, Tab 1, p. 31; Exhibit 3, Mudford Report.

COURT APPEARANCE ON 9 JUNE 2015

91. Ms Nicol had a court appearance on the morning of 9 June 2015. The sentencing could not proceed as a psychiatric report was still outstanding, so the proceedings were adjourned and Ms Nicol was remanded in custody until 28 July 2015.[124] Ms Nicol had already spent almost three months in custody by this time.

92. Ms Nicol was seen by Ms Neville later that day. She was tearful during the meeting and spoke in a childlike voice. Ms Neville recalled Ms Nicol had hoped to be released and couldn't understand why her case had been remanded again.[125] She could not recall the date she had been remanded to and presented as "morbidly depressed with no future focus"[126]. She spoke of having back and neck pain and emotional pain due to being in Bandyup. When asked what she needed Ms Nicol said "medication for the pain,"[127] referring to both her physical and emotional pain, but also said she didn't want to go and see the GP. She denied any self-harm or suicidal ideation but could not cite any protective factors against such behaviour. She was assessed as being an unpredictable risk to self and it was recommended that she remain on 12 hourly ARMS.[128]

93. Interestingly, in terms of whether Ms Nicol's risk of suicide increased after she was remanded again, Ms Neville felt that Ms Nicol may have wanted to get out of prison so that she could successfully commit suicide (as it was harder to do in prison where she was being monitored). Therefore, she did not necessarily see release from prison as being a way to have reduced Ms Nicol's risk to herself.[129]

94. Ms Neville described Ms Nicol's presentation as very different to any other prisoner she had dealt with. Ms Nicol presented as extremely depressed but also as if there was something physically wrong with her, which was why Ms Neville tried at various stages to get her medically assessed by the GP.[130] Ms Neville was aware of the suggestion Ms Nicol had a neurological disorder, and she also felt it possible her physical symptoms may have related to her alcohol withdrawal, but she felt strongly there was something wrong with Ms Nicol and was concerned to ensure there was nothing she was missing with her physical presentation.[131] After the session on 9 June 2015 Ms Neville emailed the Acting Nurse Manager to ascertain whether Ms Nicol had been seen about her back and neck as she seemed to be struggling physically.[132]

95. Ms Nicol was seen again by Ms Neville on 10 June 2015 at her request. No acute risk issues were noted but there were concerns about the possibility of covert self-harm and a suggestion Ms Nicol may have been concealing some

[124] Exhibit 3, Mudford Report.
[125] T 95.
[126] Exhibit 2, Tab 1, p. 30; Tab 28.
[127] Exhibit 2, Tab 28.
[128] Exhibit 2, Tab 28.
[129] T 96.
[130] T 96.
[131] T 96.
[132] Exhibit 3, Tab 11.5 [173] – [174].

of her symptoms as she did not want to return to CCU or MMU. Ms Nicol spoke of being accepting of being in Bandyup Prison and her hope she would be released after her next court appearance.[133]

96. Ms Nicol was noted at the PRAG meeting on 10 June 2015 to remain at impulsive, ongoing chronic risk to self and as she had recently returned to the mainstream unit it was recommended she remain on ARMS 12 hourly.[134]

97. Observations by custodial staff indicated Ms Nicol appeared more settled over the next few days and she was spending more time out of her cell and engaging with staff. She seemed to generally be sleeping well and exhibited no challenging behaviours. Her calmer demeanour appears to have reassured the prison officers that she was finally settling into the unit.[135]

98. Ms Nicol was not due to be reviewed again by the PRAG until 18 June 2015 and she had her next psychiatric appointment scheduled for 16 June 2015.

99. Ms Nicol made telephone calls to a friend and to two of her sons on 11 and 12 June 2015. She expressed her belief that during her court appearance it was mentioned that she had probably already served enough time for her offending but she was kept in custody as the court was concerned for her mental health and she now had to wait two more months for her next court date. Ms Nicol also seemed concerned that her behaviour in prison might require her to stay in prison longer. Some of Ms Nicol's comments in the conversations could be interpreted as indicating the possibility she was intending to take her life and wished to say goodbye.[136]

100. Entries on 13 June 2015 and 14 June 2015 in the observation logs indicate Ms Nicol seemed to generally be content in the unit.

101. On the day of her death Ms Nicol had been observed by custodial staff on three occasions. On the first two occasions she appeared to be asleep and on the last occasion, approximately three hours before her death, she was recorded as talking and mixing with other prisoners and appeared to have settled into the unit.[137]

102. Information was provided that forms had been completed by this stage for Ms Nicol to attend Bridge House for residential alcohol dependence treatment, although it was unclear how far this had progressed at the time of her death.[138]

[133] Exhibit 2, Tab 29,
[134] Exhibit 2, Tab 30, ARMS PRAG Minutes 10.6.2015.
[135] Exhibit 2, Tab 1, pp. 31 – 32.
[136] Exhibit 2, Tab 41.
[137] Exhibit 3, Mudford Report.
[138] Exhibit 3, 11.4 [36].

EVENTS SURROUNDING THE DEATH

103. On the afternoon of 15 June 2016 Ms Nicol approached a prisoner at about 2.30 pm and asked for some cleaning product. The prisoner thought Ms Nicol looked lost and out of sorts. She was given some cleaning products and then left the prisoner's cell.[139]

104. Shortly after, Ms Nicol entered the shower block of Unit 1, A Wing. The same prisoner who had just spoken to Ms Nicol went to the shower block around that time and became concerned for Ms Nicol's welfare. At a time estimated to be between 2.43 pm and 2.53 pm the prisoner went to the A Wing office and told Officer Karen Wood and Officer Boyd Switch that they were concerned about the another prisoner's welfare in the shower block.[140]

105. Officers Wood and Switch immediately went to the A wing shower block. They approached the first cubicle and saw the door was shut and a towel and dressing gown were draped over the door. The officers called out, "anyone in the shower, are you all right? They did not receive a response. The shower cubicle was locked from the inside, so Officer Wood looked under the door and saw a shoe. She ran and grabbed a chair and stood on the chair to look over the shower door. She could see Ms Nicol inside the cubicle hanging with a cloth ligature around her neck. The ligature appeared to be made out of a green sheet and a dressing gown.[141]

106. Another officer, Senior Officer Julie Dyson, attended and used the same chair to lean over the shower wall and cut the ligature with a Hoffman knife, which released Ms Nicol to the ground. Officer Dyson then climbed over the door into the cubicle and used the Hoffmann knife again to cut the ligature from Ms Nicol's neck before unlocking the door. A Code Red medical emergency had been initiated by this stage. The prison officers began resuscitation attempts until nursing and medical staff responding to the Code Red arrived and took over. All resuscitation attempts were unsuccessful and Ms Nicol was declared life extinct at 3.08 pm. [142]

107. A search of Ms Nicol's cell after her death found letters she addressed to her sons and a friend that spoke of her loss of dignity and self-respect and touched on how best to finalise her affairs and ended with her goodbyes. They were indicative of Ms Nicol having formed an intention to take her life.[143]

[139] Exhibit 1, Tab 3, p. 4.
[140] Exhibit 1, Tab 3, p. 4.
[141] Exhibit 3, Tab 30.2.
[142] Exhibit 3, Mudford Report.
[143] Exhibit 1, Tab 3.

CAUSE AND MANNER OF DEATH

108. A Forensic Pathologist, Dr Cadden, performed a post mortem examination on the body of Ms Nicol. Dr Cadden noted the circumstantial history was indicative of death by hanging and markings were present about the neck in keeping with the sustained application of the accompanying ligature.[144]

109. Toxicology analysis found the presence of Ms Nicol's anti-depressant medication. No other significant finding was made.[145]

110. Dr Cadden formed the opinion Ms Nicol died from ligature compression of the neck (hanging). I accept and adopt the conclusion of Dr Cadden as to the cause of death.

111. The evidence supports the conclusion Ms Nicol hanged herself with an intention to take her life. I find that the manner of death was by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

112. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

113. In this case, the issues that arise relate to the management of Ms Nicol's obvious mental health issues and her risk of suicide.

114. The ARMS Offender Supervision Log paints a picture of a woman who was deeply distressed at being incarcerated, with no familiarity with the custodial setting and no real personal support network inside prison. She felt humiliated at being in prison and shame about her conduct that had led her to prison, which made her unwilling to access her support network outside of prison. By the end of reading the log it is clear she was feeling very lost in the justice system and with very little hope for the future. She was profoundly depressed and at chronic risk of suicide. Ms Nicol's distress at her situation manifested itself in outwardly challenging behaviours.

115. The TOMS database records six incidents where Ms Nicol either concealed items for the purpose of self-harm or threatened self-harm, plus three incidents of actual self-harm. It has been said by some that past suicide attempts are the single best predictor of future death by suicide. It is suggested that suicide attempts may be part of a broader process of acquiring the capability to die by suicide by losing the fear associated with suicidal behaviour and developing a tolerance for expected and/or experienced pain.[146]

[144] Exhibit 1, Tab 8.
[145] Exhibit 1, Tab 8 and Tab 9.
[146] Exhibit 3, Mudford Report, p. 16 and Tab 10.

116. However, in Ms Nicol's case she would often try to minimise her conduct after the event, and suggest when questioned that she was doing it for attention rather than in a genuine desire to take her life. This, coupled with her often difficult and irritating behaviour, perhaps made her appear manipulative at times, rather than genuinely suicidal. Nevertheless, when any self-harming or potentially suicidal behaviour was identified, the matter was appropriately escalated. However, her desire to be returned to the mainstream unit was also taken into account when the risk was felt to have lessened. That was how Ms Nicol came to be in a mainstream unit at the time of her death.

117. Dr Davison had reflected on her decision after being informed of Ms Nicol's death. On reflection, although in hindsight she of course wished Ms Nicol had remained in the CCU as it would have been harder for her to take her life, Dr Davison still maintained that based on what was known at the time the decision to allow Ms Nicol back into the mainstream prison population was an appropriate decision.[147] Dr Davison noted that Ms Nicol was an intelligent woman from a good educational background and she had been very persuasive about wanting to return to her unit, and all the staff felt her mood was improving, so it seemed the right decision at the time as she would have more activities to keep her busy and protect her from being alone with her thoughts.[148]

The CCU and MMU

118. Within a prison, the primary method used to reduce the risk of a prisoner committing suicide is to limit the opportunity. As a result of her suicidal behaviour, Ms Nicol was housed in either the CCU or Management Unit (MMU) for most of her custodial term due to concerns about the risk she presented to herself.[149] The problem with this relocation was that, although it removed the possibility that Ms Nicol would take her life, it increased her distress.

119. Dr Davison noted that the CCU is indicative of the usual way prisons manage risk, which is from a physical safety approach. However, by removing the means by which people can harm themselves, it can result in a very sparse environment without anything else that might be protective or help someone's mental state.[150] The CCU serves its purpose with camera monitoring, safe cells and safe keeping of offenders assessed as being at high risk of suicide or self-harm but it is not a therapeutic environment. There can be relentless noise from the management unit prisoners and some prisoners in CCU can feel unsafe or scared by the noise. Even when prisoners are out of their cells, there is little to do in the CCU to occupy them, apart from a small television and some books.[151] The common area outside the CCU cells doesn't get used very often at all because of staff demands as they must manage the flow of people coming and going and

[147] T 61.
[148] T 62 – 63.
[149] Exhibit 3, Mudford Report.
[150] T 56.
[151] Exhibit 3, Tab 11.5 [184] – [191].

having access to clients, which limited the time clients could be out of their cells.[152]

120. The evidence indicates Ms Nicol was very unhappy in the CCU and MMU and actively campaigned to be returned to her unit. Ms Nicol gave a number of reasons for wanting to return to the unit, including being able to smoke, make phone calls when she wanted to, be able to go outside and to socialise with other prisoners. It might seem surprising that she couldn't do these things in the CCU, but the evidence at the CCU had become increasingly restrictive over time for a number of reasons, which meant that prisoners housed in the CCU could spend up to 23 hours a day in their cell.[153]

121. There was evidence that in the past, there was a designated smoking area at CCU but when the no smoking ban came and due to the construction of new buildings close to this area in the five metre exclusion zone, smoking was no longer permitted in the CCU designated smoking area. As a smoker, Ms Nicol's access to cigarettes was significantly limited each time she was placed in the CCU, and the evidence demonstrated this caused her a great deal of distress and anxiety, which given her already agitated mental state, was undesirable. Ms Nicol made regular demands for cigarettes but the ability to facilitate her smoking was very limited, as it required staff to take her outside and this was rarely practicable given the low staff numbers in the CCU and the demands on their time.[154]

122. An internal review conducted within the prison after Ms Nicol's death identified a number of opportunities for improvement in the management of 'at risk' prisoners and several remedial actions were initiated.[155] One that would appear to be significant in relation to Ms Nicol was the provision of nicotine replacement therapy at no cost to prisoners placed in the CCU, which followed a suggestion by Dr Davison.[156] This is a step forward.

123. However, it was generally agreed by the witnesses that nicotine replacement therapy does not replace the ritual of having a cigarette. Being able to be outside, to go through the physical act of lighting and smoking a cigarette, and the camaraderie of having it while having a conversation with another person, was all part of the ritual.[157] By removing the ability to have a cigarette, and only providing nicotine patches in its stead, the prisoner going to CCU is effectively being punished for having a mental health issue. That is certainly how Ms Nicol viewed it.

124. It was very clear from the evidence that the difficulty in being able to have a cigarette was a major factor in Ms Nicol not wanting to remain in the CCU. An entry on 3 May 2015 records Ms Nicol "had a tantrum and started crying"[158] after she was told that she would not be getting any more cigarettes that day due to her belligerent behaviour. She had been asked to return inside after having one cigarette due to staff needing to go elsewhere

[152] T 98.
[153] T 37.
[154] T 28 – 29; Exhibit 3, Mudford Report, p. 17.
[155] Exhibit 3, Mudford Report.
[156] Exhibit 3, Mudford Report.
[157] T 29 – 30, 37.
[158] Exhibit 3, Tab 7, ARMS Offender Supervision Log, p. 15.

and Ms Nicol had ignored the request and started smoking her second cigarette. She became upset for the rest of the day as she was not allowed to go outside to smoke.[159] Wanting to smoke was, therefore a great incentive for Ms Nicol to try to get released from the CCU and sent back to the mainstream prison.[160]

125. The evidence of the witnesses at the inquest was that this desire to get out of the CCU led patients like Ms Nicol to minimise their symptoms and hold back information.[161] CNS Park felt if they had been allowed to smoke, the prisoners may have been a little bit more honest with staff.[162]

126. As well as the desire to smoke, Ms Nicol spoke of the desire to just be outside in the sunshine, particularly as she had a rash on her face for a time that bothered her and she felt would be benefitted by sunshine. CNS Park noted there is a beautiful little garden at the side of the CCU and within the CCU's confines, but she understood prisoners were not able to use it as it was considered there was a security issue that someone might go on the roof if unsupervised. Therefore, it required a prison officer to supervise them, and there were insufficient staff rostered in the CCU to permit that to occur.[163] Both CNS Park and MHN North supported better access for prisoners in the CCU to the outdoors, not just for smoking, but just to be able to be outside and to sit and walk around in the fresh air.[164]

127. CNS Park still works at Bandyup, and at the time she gave evidence in February 2019 it was still the case that CCU prisoners could not smoke on the unit and there was very limited opportunity to go outside to smoke. She noted the prisoners were also locked in their cells for a long time with a lot more restrictions than on the general units. CNS Park described the situation as "very frustrating."[165]

128. Dr Davison also agreed that being allowed into an outdoor area for fresh air is very therapeutic and she had raised the problem with access to the garden as part of her concerns after Ms Nicol's death.[166] At the time of the inquest Dr Davison indicated her understanding that access to the garden off the CCU was still very limited.[167]

129. Mr Shayne Maines, the Deputy Commissioner for Adult and Youth Justice Services, Corrective Services, gave evidence at the inquest and indicated that the CCU garden area "has proved somewhat complex"[168] due to some security issues in relation to roof access. Mr Maines explained that he had visited the area on a number of occasions prior to the inquest and he had been assured that there were plans in place to try and ensure that people from CCU could get access to the garden, at least under supervision. As to

[159] Exhibit 3, Tab 7, ARMS Offender Supervision Log, p. 15.
[160] T 28.
[161] Exhibit 3, Tab 11.5 [191] – [195].
[162] T 36 – 37, 42 - 43.
[163] T 40.
[164] T 30.
[165] T 38.
[166] T 58; Exhibit 3, Tab 11.3A.
[167] T 58.
[168] T 78.

the issue of smoking, Mr Maines also noted that this was a complex issue, from an occupational health and safety view as much as anything, and would likely prove more problematic than simply arranging access to the garden. Mr Maines did, however, give an undertaking to the Court that he would raise the issue with the Deputy Commissioner to see whether access to smoking under supervision could be built into a prisoner's management plan.[169]

130. At the conclusion of the inquest I discussed with counsel the need to try to implement some immediate changes to the problems affecting prisoners in the CCU, as well as trying to move forward with longer-term solutions. On 29 March 2019, the Department advised that Bandyup reviewed its policies and procedures and a decision was made that prisoners in the CCU should be given an opportunity to smoke. This decision was to be progressed by way of a three step process, namely:

- Phase 1: From 1 March 2019 prisoners in the CCU were provided the opportunity to smoke tobacco at the front of the CCU under staff supervision.
- Phase 2: On 6 March 2019 a temporary hut was constructed at the rear of the CCU yard which has been designated as the smoking area for prisoners in the CCU. The CCU yard, which was spoken of positively by CNS Park as a lovely outdoor area, is also now able to be used for recreation.
- Phase 3: The Department recognised that the rear of the CCU requires a more permanent construction that will satisfy the security, safety and therapeutic needs of the area. It is anticipated that construction of this structure will commence on 23 April 2019 and that it will be completed by 27 June 2019.[170]

131. It is pleasing to see the Department taking a practical approach to implementing immediate changes to resolve some of the issues that were raised in the inquest about access to smoking and fresh air. While smoking and access to a garden may not sound like huge things to some people, in an environment such as this, they can take on enormous significance, as was apparent in Ms Nicol's case. I accept the larger infrastructure changes necessarily involve a more long-term plan, but it is important that simple alterations such as these made are made quickly, to improve the conditions for vulnerable and disturbed prisoners now.

132. In addition, the Department acknowledged that access to therapeutic needs and stimulation is a vital component to the effective care and management of prisoners at risk of self-harm and suicide. Evidence was heard at the inquest that there was very little for prisoners in the CCU to do to occupy themselves, and they spent a lot of time locked in their cells. The Department advised after the inquest that prisoners are not ordinarily locked away when PCS or mental health staff attend the CCU and that a range of stimulation is now being offered through games, colouring, painting and musical instruments. In addition, the prison is considering given CCU

[169] T 78 -80.
[170] Letter to Counsel Assisting from Counsel for the Department, dated 29 March 2019.

prisoner the opportunity to be included in the multiple recreation programs on offer such as Pilates, yoga, painting and the choir.[171] Again, these are simple changes, that can be put into effect now, and it is a positive step that the management of Bandyup Women's Prison is open to taking action now to improve the living conditions of these vulnerable prisoners.

Subacute Unit and Female Forensic Mental Health Unit

133. Dr Adam Brett is a Consultant Forensic Psychiatrist with extensive experience in the custodial setting. Dr Brett previously worked as a psychiatrist at Bandyup Prison, though not for a number of years, and he still visits Bandyup fairly frequently, so he is familiar with the workings of the particular prison.[172]

134. Dr Brett was requested by the Court to review Ms Nicol's psychiatric care prior to her death and provide an opinion as to the standard of care, as well as an opinion as to whether she should have been transferred to the Frankland Centre for more intensive psychiatric assessment and treatment.

135. Dr Brett reviewed Ms Nicol's prison records and medical records and also applied his knowledge of the forensic mental health service in Western Australia in forming his opinion. Dr Brett considered Ms Nicol's management at Bandyup to be very good, within the constraints of what could be offered within the available resources. He felt the clinical decisions were made with what was thought to be Ms Nicol's best interests in mind. Dr Brett agreed with the diagnosis of Ms Nicol as having profound depression and felt her depression may have been so severe that she had developed psychotic features.[173] Based upon his review of the materials, Dr Brett felt it was highly likely that Ms Nicol would have been sent to a female mental health unit if one had existed. However, the only option available was the Frankland Centre, which was unsuitable.[174]

136. Dr Brett observed that the Frankland Centre is the only facility that will accept female prisoners with mental health problems. It has an acute mental health unit with 30 beds in total. These 30 beds are supposed to accommodate prisoners from all the prisons in the State, both male and female, as well as hospital orders made by a court. Dr Brett noted that the number of beds has not increased since the Frankland Centre was built more than two decades ago, when the total prison population was in the vicinity of 2000 to 2500 people. That population has now trebled, and the rates of mental health issues amongst prisoners has increased, and yet the number of beds remains the same. It is clearly inadequate.

137. Further, as I have already noted from the evidence of Dr Davison, the vast majority of patients at the Frankland Centre are male and have a history of violent and sexual offending. Consistent with Dr Davison's opinion, in Dr Brett's opinion it is not a suitable place to manage acutely unwell,

[171] Letter to Counsel Assisting from Counsel for the Department, dated 29 March 2019.
[172] T 6.
[173] T 18.
[174] Exhibit 1, Tab 47.

vulnerable females. He therefore considers it understandable that clinicians are reluctant to transfer female prisoners from Bandyup Women's Prison to the Frankland Centre, as Dr Davison expressed in the case of Ms Nicol. As I've noted above, Dr Davison's evidence was that she agonised about the decision whether or not to send Ms Nicol to Frankland Centre, but decided against it as she felt it would not be a therapeutic environment, she was unlikely to get a bed and if she did, they would not keep Ms Nicol for long given the pressure on forensic beds at the facility.[175]

138. Based upon his intimate knowledge of the system, Dr Brett suggested that ideally there should be a specialist 'female only' forensic mental health unit in this State. He noted there is clearly a need for such a unit, given the high prevalence of mental disorder in Bandyup and the unsuitability of the Frankland Centre for this purpose. Dr Davison concurred with this view.

139. In support of this proposal, Dr Brett observed that substance abuse and mental health problems are highly prevalent in women in prison. He referred to a WA study, conducted by Dr Davison along with a number of other researchers, that found that of the women assessed on reception into prison:

- 53% had an anxiety disorder,
- 36% had a mood disorder,
- 74% had a substance use disorder,
- 20% had schizophrenia, and
- 27% reported suicidal ideation in the previous month.[176]

140. In addition, a majority of female prisoners reported at least one physical health condition and 38% reported being the victim of sexual/physical violence.[177]

141. The study concluded that a major challenge for services is to address the high rate of co-occurring mental disorders and alcohol and other drug disorders in the context of multiple social problems. It was found that neither mental illness nor alcohol and drug use can be treated in isolation in this group, although this is in effect what often occurs.[178] Although there is a drug and alcohol nurse at Bandyup, the evidence at the inquest was that they were not in a position to work closely with the mental health staff, although that would be ideal.

142. The study also noted there is a high prevalence of suicidal thoughts in prisoners and it is not clear what factors might help to predict those who will go on to attempt suicide. There is a need to manage the risk in ways that do not overwhelm prison services or restrict prisoners so much that it increases the long term risk. Particularly relevant to this inquest is the study's conclusion that women prisoners are a minority group in a system designed

[175] Exhibit 1, Tab 47.
[176] Exhibit 2, Tab 47; S Davison, S et al, *Mental health and substance use problems in Western Australian prisons. Report from the health and emotional wellbeing survey of Western Australian reception prisoners,* (2015) WA Dept of Health.
[177] Ibid.
[178] Ibid.

primarily for men and there is a need for services to address the specific needs of women.[179]

143. The other witnesses all were in general agreement with Dr Brett about the difficulties with the Frankland Centre and the need for a designated 'female only' forensic mental health unit. CNS Park gave evidence she has used her position as an authorised mental health practitioner under the *Mental Health Act* to send prisoners to the Frankland Centre from Bandyup, but her evidence was that it was, "very, very hard; very, very difficult,"[180] to get a bed. CNS Park agreed with Dr Brett that the Frankland Centre is an inappropriate place to send female patients, given there are predominantly aggressive, psychotic male offenders housed there.[181]

144. Mr North threw his support behind Dr Brett's comments about the lack of forensic beds in Western Australia. Mr North noted that ever since he has been involved in working for corrective services in WA, which was more than 40 years, there have only ever been 30 forensic beds for the whole of Western Australia, which he described as "totally inadequate."[182] Mr North commented that it would "be great if some kind of more intense mental health supports could be incorporated within the major facilities at least in West Australia."[183]

145. Dr Davison indicated the mental health team at Bandyup, together with the prison counselling service, try to provide the equivalent level of treatment as might be provided by a community mental health team. This will include medication to treat symptoms and a degree of monitoring or risk and general support, including psychological support and assistance with developing coping skills.[184] Despite their good intentions, At the time of Ms Nicol's incarceration in 2015, Dr Davison expressed the view that they were struggling to provide the quality of care they wished to as Bandyup housed all the remand and sentenced prisoners, which led to a very high turnover of prisoners, with a very high proportion of them very distressed and very high risk with lots of mental health problems.

146. This accords with other information before me that indicates that at the time of Ms Nicol's death women's imprisonment in Western Australia was in crisis and Bandyup bore the brunt of that crisis due to high levels of overcrowding.[185]

147. Dr Davison indicated the mental health team did their best and prioritised the prisoners who were particularly acute and worrying, but for the first half of 2015 they had only one mental health nurse on shift and one drug and alcohol nurse.[186] Dr Davison commented that the rate of mental health concerns in the Bandyup prisoner population meant that they could have done with more nurses and a proper, full multi-disciplinary team, although

[179] Ibid.
[180] T 39 – 40.
[181] T 39 – 40.
[182] T 33.
[183] T 33.
[184] T 47.
[185] Inspector of Custodial Services Report 114, *2017 Inspection of Bandyup Women's Prison*, December 2017.
[186] T 47.

acknowledging that the mental health staff and prison counselling service worked well together, although separate services.[187] I understand that in January 2018 steps were taken to integrate the prison counselling service and mental health services to create a centralised service,[188] which should improve that working relationship further.

148. Since Ms Nicol's death Melaleuca Remand and Reintegration Facility opened in December 2016. Dr Davison indicated the opening of Melaleuca has made a difference to the number of acutely unwell prisoners coming into the prison on remand, particularly those who are simply disturbed in their first few days of prison due to alcohol/drug withdrawal and poor coping skills. However, Dr Davison indicated that Bandyup still manages any acutely unwell prisoners who are too difficult to manage at Melaleuca or who are waiting for a bed at Frankland Centre, so Bandyup still deals with the more acute and the chronic mental health patients.[189]

149. An inspection of Bandyup Women's Prison by the Inspector of Custodial Services in 2017 found that despite improvements to the general prison population, the mental health care at Bandyup was still crisis driven and the health care staff were not able to deliver mental health care in a holistic manner, so women suffering from depression or other psychological problems were missing out on support services. It noted, at a time two years on from Ms Nicol's death, the CCU was adequate in relation to keeping women safe but still did not provide a dedicated therapeutic environment for women in psychological distress. It was noted that some staff were reluctant to refer placement to the CCU as it was at odds with their commitment and dedication to caring for their patients. Management had apparently acknowledged this and recommended that the CCU be upgraded, including specific mention of the need for a therapeutic open air area[190] yet at the time of this inquest in February 2019, it appeared that still nothing had changed.

150. Dr Davison agreed with Dr Brett that a hospital environment can make a huge difference in terms of providing a more therapeutic and multi-disciplinary environment that is run by clinicians, but also agreed that there are very few beds at the Frankland Centre so it is very difficult to get a bed and, even if they get a bed, they are generally returned very quickly, even though they are not necessarily stabilised.[191] Dr Davison noted it is a simple decision to refer a prisoner who is acutely psychotic and doesn't have the capacity to make treatment decisions as there is really no other choice where they require involuntary treatment. However, where a woman is distressed and depressed but compliant with treatment, Dr Davison indicated it is difficult to weigh up the theoretical therapeutic benefits of a hospital environment with the reality that they will be housed in a ward full of psychotic and acutely disturbed men.[192] For their own physical safety from other patients, female patients at Frankland Centre often require one on one supervision by a nurse, which can also be quite intrusive. Therefore, it is a

[187] T 48.
[188] Exhibit 3, Tab 11.6 [49].
[189] T 65.
[190] Inspector of Custodial Services Report 114, *2017 Inspection of Bandyup Women's Prison*, December 2017.
[191] T49.
[192] T 48 – 50.

much more difficult balance to work out whether to refer such a patient and Dr Davison accepted she had a higher threshold for referring than she might have if there was a dedicated women's unit, as well as more beds available generally.[193]

151. Dr Davison agreed with Dr Brett that it would make a difference if there was a similar facility to Frankland Centre concentrating on women only, not only to avoid re-traumatising them by placing them in a ward full of aggressive males, but also to meet female patient's clinical needs more, which can present differently from the needs of psychotic men.[194]

152. In September 2018 the Office of the Inspector of Custodial Services released a report, 'Prisoner access to secure mental health treatment'.[195] The report was based on a review commenced in mid-2017 because of concerns raised by the circumstances of two women with acute mental health needs who were moved from Bandyup to the Frankland Centre. The report is very comprehensive and covers a great deal of the same areas as were canvassed in this inquest, arising directly out of the death of Ms Nicol.

153. The review identified a fundamental problem with the lack of forensic mental health beds in WA, noting that the "problem has reached such alarming levels that a solution is needed."[196] The review found 61% of all referrals lapsed without a hospital placement and noted that true demand is even higher, as psychiatrists working within the prison system are so aware of the shortage of forensic beds that they only make referrals in the most urgent of cases. The findings in the report echo the anecdotal evidence I heard in this inquest.

154. The review also found general agreement with a recommendation for a subacute unit in Bandyup Women's Prison, but different views on where the responsibility for funding lies. The Inspector noted that, to date, applications for funding have failed.[197] Relevantly to this inquest, the Inspector made a recommendation that the Government commit funding to increase the number of secure forensic mental health beds and support the establishment of the subacute unit in Bandyup Women's Prison.[198]

155. The Inspector recommended a double-pronged approach, with more hospital beds and improved mental health services. This again accords with the recommendations of the expert witnesses in this inquest.

156. Dr Davison was asked about the Inspector of Custodial Services report and she agreed that his comments that patients referred often don't get a bed at the time they require treatment. Dr Davison indicated those comments were absolutely consistent with her experience.[199] Dr Davison gave evidence that a week prior to Ms Nicol's death she had a very acutely psychotic female prisoner who she referred to the Frankland Centre. After a week had elapsed

[193] T 50.
[194] T 50 - 51.
[195] Inspector of Custodial Services Report, *Prisoner access to secure mental health treatment*, 21 September 2018.
[196] Ibid.
[197] Ibid.
[198] Ibid.
[199] T 51.

the woman still had not been given a bed, which indicated that there were no beds available at that time.[200] Dr Davison also noted that the Frankland Centre is unable to provide any sort of long-term therapeutic treatment for prison transfers.[201]

157. Dr Davison agreed that a subacute therapeutic unit would be "very helpful, really very helpful,"[202] although Dr Davison also noted it would never replace having some dedicated authorised hospital beds in a secure health service as sometimes people who are acutely unwell need 24/7 treatment in hospital.[203]

158. Dr Davison suggested a sub-acute unit in the prison would allow an opportunity to observe people away from the hurly burly on the wing but out of the sparse environment of the CCU. Dr Davison understood the idea would be that the unit would still be staffed by custodial staff, but it would be a smallish unit with enhanced input from mental health staff working quite closely with custodial staff. In addition, there would be allied health staff such as occupational therapists and psychologists to form part of the team and try to understand people's behaviour and develop some plans to assist them to develop coping skills while in prison.[204]

159. Ms Neville was aware of discussion about introducing a subacute unit at Bandyup for many years but for various reasons nothing ever happened to progress its implementation before she retired.[205] In Ms Neville's opinion, Bandyup is in much need of some sort of subacute unit and it would be an excellent addition to allow someone like Ms Nicol, who is disturbed and vulnerable, to be monitored a lot more closely without putting in the overly restrictive environment of the CCU.[206]

160. Like Ms Neville, CNS Park felt it would be "fantastic"[207] to have a subacute unit functioning at Bandyup. It would relieve the issues that many prisoners currently face on the CCU being locked up all the time, as it could house prisoners who are really quite unwell or depressed but still allow them to walk around and interact with nurses and not be locked up all the time.

161. The Chief Psychiatrist does not have oversight of the mental health services provided in prisons, but does have oversight of the standards of treatment and care provided at the Frankland Centre.[208] The Chief Psychiatrist, Dr Nathan Gibson, advised the court in January 2019 that Dr Davison was, under his direction, in the process of drafting specific guidelines for sexual safety in mental health inpatient units in Western Australia, which would include the Frankland Centre. The guidelines intend to make it clear that all mental health services need to be places where people feel, and are, sexually

[200] T 51.
[201] T 51.
[202] T 63.
[203] T 63.
[204] T 64.
[205] T 99 - 100.
[206] T 99 – 100.
[207] T 40.
[208] T 60; Exhibit 3, Tab 11.8.

safe.[209] The evidence before this court makes it clear that it would be difficult to anticipate the Frankland Centre might meet those guidelines, at least for female patients. The Chief Psychiatrist confirmed that the significant majority of patients at the Frankland Centre at any one time are male and this presents significant difficulties in providing adequate treatment to female patients at the Frankland Centre.[210]

162. The Chief Psychiatrist also advised that he has previously written to the Mental Health Commissioner and the Director General of Health highlighting his concern that forensic mental health services are significantly under-resourced in Western Australia compared with essentially all other Australian jurisdictions, specifically highlighting the urgent need for female and youth forensic inpatient facilities and services. The Chief Psychiatrist indicated it is his understanding there is clear planning intent for a female only forensic mental health unit to be developed, but at this stage he is unaware of any formal, funded plan for the same.[211]

163. A copy of the Department of Justices' response to the Inspector's review into prisoners' access to secure mental health treatment was provided to the Court. The Department agreed that there are not enough secure mental health beds to effectively manage the identified needs of Western Australian prisoners and indicated it would support an increase to the number of these beds.[212]

164. Mr Maines, giving evidence on behalf of the Department, also indicated that the Department of Justice supports in principle the recommendation of having a subacute mental health unit and more acute patient beds in a hospital. However, he noted it is an issue that must be done in conjunction with the Department of Health. Mr Maines' understanding is that, across government, there is support for greater capacity to house forensic mental health patients from prisons, but as in all things, it comes down to a question of prioritisation and funding.[213]

165. For the subacute unit at Bandyup, Mr Maines pointed to the information in the Department's response to the Inspector's review, where the Department indicated it has submitted a proposal and model of care for a 29 bed[214] sub-acute service at Bandyup Women's Prison to the Mental Health Commission for consideration, although any progress would depend upon funding. Mr Maines was unable to provide any further information on how this had progressed at the time of the inquest in February 2019.[215] One of the difficulties is that it is very difficult to construct any new infrastructure at Bandyup, due to its very small footprint, so Mr Maines indicated it would require conversion of existing infrastructure.[216]

[209] T 66; Exhibit 3, Tab 11.8.
[210] Exhibit 3, Tab 11.8.
[211] Exhibit 3, Tab 11.8.
[212] Exhibit 3, Tab 11.6C.
[213] T 82 – 84.
[214] A significant increase on the 6 safe cells currently available in the CCU, although there is potential overflow to the MMU – T 76.
[215] T 84 -85; Exhibit 3, Tab 11.6C.
[216] T 85.

166. The Department advised at the end of March 2019 that the proposal for funding of the subacute unit at Bandyup was in a budget submission to Government that was to be considered for inclusion in the State Government Budget released in May 2019.[217]

167. I have been advised by the Commissioner for Corrective Services, Mr Tony Hassall, that the budget submission for a subacute unit at Bandyup in the current financial year was presented to the Government.[218] However, it was not supported. The Department intends to resubmit the budget submission later this year for consideration in next year's budget estimates. It is to be hoped that the Government can find a way to support the submission next time, given the length of time that has passed since it was first recommended.

RECOMMENDATION 1

I recommend that the Government commit funding to the establishment of a subacute mental health unit in Bandyup Women's Prison, properly staffed with a multidisciplinary mental health team, as a matter of priority.

168. As noted above, a subacute unit at Bandyup is expected to be an important tool for managing the many female prisoners at risk of self-harm or suicide, but the experts were united in their opinion that it cannot replace a hospital environment, separate to the prison, for the seriously disturbed and vulnerable female prisoners who required access to safe and secure psychiatric treatment. I have not been provided with any information to suggest that anything is being actively done by the Government to progress this urgently needed facility, even though it is supported by the Chief Psychiatrist and the Inspector of Custodial Services.

RECOMMENDATION 2

I recommend that the Government commit funding to establish a 'female only' secure forensic mental health unit as a matter of priority.

[217] Letter to Counsel Assisting from Counsel for the Department, dated 29 March 2019.
[218] Letter to Counsel Assisting from Commissioner of Corrective Services dated 5 July 2019.

Access to PSR and Psychological Reports

169. An issue that arose in the evidence of Dr Davison was the lack of access for the mental health staff to court-ordered Pre Sentence, Psychological and Psychiatric Reports that relate to the sentencing of a prisoner. Dr Davison noted it would be incredibly helpful to have access to these documents as the treating physicians in prison currently don't get access to these rich sources of information, which can assist in really understanding a prisoner's problems and putting them in a context. It takes time to establish a rapport, and it is potentially even harder when the person is being held against their will. In the case of Ms Nicol, she was often reluctant to discuss her past, including her obvious alcohol dependency, which made it difficult for the treating mental health practitioners to obtain a meaningful history that might have helped them deal with their problem.[219]

170. Dr Brett also referred to the courts reports relating to Ms Nicol, and noted that they were excellent and comprehensive reports that would have been extremely useful for the clinicians if they had been made available. It also has the benefit of saving the person from having to repeatedly retell their story. Similarly to Dr Davison, Dr Brett's understanding is that for some reason they don't follow the client, so prison medical services don't have access to them.[220]

171. I note that these reports are court-ordered under the *Sentencing Act 1995* (WA), and the Act puts limits on the access to the reports, given their confidential nature. However, if the reports are used as a tool for sentencing, and by that sentencing process the offender becomes a sentenced prisoner, it seems foolish for such a valuable clinical tool to be withheld from the health practitioners who are then treating the offender who is serving that prison sentence. It was not entirely clear from the evidence why the reports are withheld from the medical staff; that is, whether it is simply a bureaucratic decision or a decision made due to the perceived constraints of the legislation and the fact that the health staff are not employees of the Department of Justice.

172. Mr Maines accepted that if there is an impediment to sharing this information with the mental health staff, that impediment shouldn't exist but there are some complexities given it is a court-ordered report, and his understanding was that it might require legislative change.[221]

[219] T 46.
[220] T 16 – 17.
[221] T 89 – 90.

RECOMMENDATION 3

I recommend that the Honourable Attorney General give consideration to amending the *Sentencing Act 1995* (WA) to permit the release of court ordered medical reports to the medical and nursing staff who are treating remand and sentenced prisoners in Western Australia to ensure that this valuable source of information is able to be accessed to improve the level of care and treatment that can be provided to prisoners.

CONCLUSION

173. Ms Nicol was an intelligent, well-educated woman and loving mother in her forties, who due to her alcohol addiction issues lost her path in life and ended up on remand in Bandyup Women's Prison. Although she retained the support of her family, she felt the loss of her reputation and freedom keenly, describing herself to a friend as "a woman who has lost all dignity, trust, love."[222]

174. Once in prison, Ms Nicol became profoundly depressed and suicidal. At the time of her incarceration, Bandyup Prison was in crisis due to significant overcrowding issues. Then, as now, the prison lacked a comprehensive mental health facility within the prison, as well as the the ability to easily send female prisoners to a safe forensic mental health facility for intensive mental health treatment. The dedicated health professionals managed Ms Nicol's mental health issues as best they could, within what was described as "the very difficult environment of Bandyup Prison."[223] The evidence indicates Ms Nicol's monitoring and mental health treatment was to a high standard, despite the pressures on the staff and the limited facilities available to treat her needs.

175. When Ms Nicol's risk to herself escalated, the need to prioritise her safety necessitated housing her in either the CCU or MMU of the prison, the design of which kept her safe, but increased her distress. She had limited ability to smoke or access fresh air and spent a lot of time locked in her cell with little to occupy her. Therefore, she actively campaigned to be returned to the general prison population. When it was felt that Ms Nicol's risk to herself had diminished, she was returned at her request to a mainstream prison unit where she had more freedom. Sadly, while housed in the general population, Ms Nicol took her life.

176. I am satisfied from the evidence before me that if other options had been available to the mental health staff to treat Ms Nicol in a less restrictive environment than the CCU, such as a subacute mental health unit, or a

[222] Exhibit 2, Tab 33.
[223] T 23.

more therapeutic environment, such as a 'female only' forensic mental health unit at a hospital, those options would probably have been utilised in the treatment of Ms Nicol, and may have increased the opportunity to keep her safe until she was released.

177. Others before me have recommended the development of a subacute mental health unit at Bandyup Women's Prison and a 'female only' forensic mental health unit to replace the current (limited) option of sending female prisoners to the male dominated Frankland Centre. I am convinced these recommendations are appropriate and the need for them is urgent. I add my own voice to those that have come before me, in the hope that the Government will take action.

S H Linton
Coroner
11 July 2019