JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : MICHAEL ANDREW GLIDDON JENKIN

HEARD : 18 - 20 OCTOBER 2022

DELIVERED : 28 NOVEMBER 2022

FILE NO/S : CORC 514 of 2021

DECEASED : LARDER, WAYNE THOMAS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms K. E. Ellson and Ms G. Gilbert (State Solicitor's Office) appeared for the Department of Justice.

Ms B. Burke (ANF Legal Services) appeared for Ms T. Deakin, Ms S. Kemp and Ms A. Whyte.

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Wayne Thomas LARDER*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 18 - 20 October 2022, find that the identity of the deceased person was* ***Wayne Thomas LARDER*** *and that death occurred on 22 February 2021 at Hakea Prison, from ligature compression of the neck (hanging) in the following circumstances:*

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SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Hakea Prison on 22 February 2021. Any such prisoner is to be referred to as "Prisoner [Initial]".

Order made by: MAG Jenkin, Coroner (18.10.22)

INTRODUCTION

1. Wayne Thomas Larder (Wayne)[1] was 42-years of age when he died on 22 February 2021 from ligature compression of the neck. At the time of his death, Wayne was a remand prisoner at Hakea Prison and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (the Department).[2,3,4,5,6] Accordingly, immediately before his death, Wayne was a "*person held in care*" and his death was a "*reportable death*".[7]

2. In such circumstances, a coronial inquest is mandatory.[8] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received.[9] Members of Wayne's family attended an inquest I held at Perth on 18 - 20 October 2022, at which the following witnesses gave evidence:

a. Ms Kellie Cunningham (Senior Supervisor, Regimes PRAG Chair);
b. Ms Angela Whyte (Mental health nurse and PRAG member);
c. Officer John Bohling (Principal officer and PRAG Chair);
d. Ms Samara Kemp (Mental health nurse and PRAG member);
e. Ms Trina Deakin (Mental health nurse and PRAG member);
f. Officer Bradley Galway (Video-link officer);
g. Officer Scott Gardner (Prison officer);
h. Officer Siobhan Black (Prison officer);
i. Officer Ian Gibson (Principal officer);
j. Ms Peta Barry (Prison psychologist);
k. Dr Edward Petch (Prison consultant psychiatrist);
l. Dr Adam Brett (Consultant forensic psychiatrist); and
m. Ms Toni Palmer (Senior Review Officer).

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

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[1] At the family's request, Mr Larder has been referred to as Wayne in this finding.
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (06.12.21)
[3] Exhibit 1, Vol. 1, Tab 3, Life Extinct Form (22.02.21)
[4] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of deceased (25.02.21)
[5] Exhibit 1, Vol. 1, Tab 6.1, Confidential Report to the Coroner - Supplementary (Post Mortem Report) (22.03.21)
[6] Section 16, *Prisons Act 1981 (WA)*
[7] Sections 3 & 22(1)(a), *Coroners Act 1996 (WA)*
[8] Section 22(1)(a), *Coroners Act 1996 (WA)*
[9] Section 25(3) *Coroners Act 1996 (WA)*

CONTEXTUAL ISSUES

Hakea Prison[10]

4. In 2000, Canning Vale Prison and the CW Campbell Centre were amalgamated to create Hakea Prison (Hakea), located in Canning Vale, about 24 kilometres from Perth.[11] Hakea is a maximum security adult male prison, and is the largest custodial facility in Western Australia. During the inquest I conducted into the death of Mr Callum Mitchell, Deputy Superintendent Devereux (Officer Devereux) noted that Hakea "*has not really been designed for function and is a collection of old and new buildings*".[12]

5. Hakea is the main remand receival prison for the metropolitan area and has a maximum capacity of 1,170 prisoners. Because Hakea predominantly holds remand prisoners, there is a high turnover of the muster. At various times, often because of warnings and/or alerts, Hakea may hold maximum security prisoners from other prisons.[13]

6. In February 2021, Hakea's daily muster was about 913, and its current muster hovers around 900 prisoners.[14] As to the kinds of prisoners admitted to Hakea, Officer Devereux made the following observation:

> Hakea is a complex prison in regards to the cohort of prisoners located there. Prisoners arriving at Hakea often come with complex needs and problems, including being under the influence of drugs and alcohol, along with the worries and stress of coming into prison, perhaps for the first time. They can also present as high risk in regards to self-harm issues. In comparison to sites where prisoners are more settled, Hakea has a high number of incidents, due to the high number of prisoners with multifaceted needs.[15]

7. At the inquest, Principal Officer Gibson (Officer Gibson) said he agreed with Officer Devereux's comments about Hakea and its muster.[16]

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[10] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p3
[11] See: www.wa.gov.au/organisation/department-of-justice/corrective-services/hakea-prison
[12] [2022] WACOR 34, (published 20.07.22), para 6
[13] [2022] WACOR 34, (published 20.07.22), paras 7 & 9
[14] Letter - Dr A Tomison, Director-General, DOJ (09.11.22), pp3-4
[15] [2022] WACOR 34, (published 20.07.22), para 7
[16] ts 19.10.22 (Gibson), pp150-152

8. On 22 February 2021, Hakea had about 115 prison officers on duty during the day, which represents a shortfall of 20 officers. As Hakea's Superintendent, Officer Hughes, noted in his statement to the Court:

> Daily staffing numbers at Hakea remain a challenge due to a number of factors including attraction, retention and a very strong employment market. I am aware that approximately 18 staff per month are leaving and the situation is gradually becoming worse.[17]

Unit 2[18]

9. Cells at Hakea are arranged in groups known as units, which are further divided into wings. At the time of his death, Wayne was accommodated in cell 2 of C-Wing in Unit 2. At the time, Unit 2 was used as the orientation unit for newly admitted prisoners. It has 63 cells and can hold a maximum of 126 prisoners. As of October 2022, the orientation wing at Hakea has been temporarily moved to Unit 7, which has 86 cells, 70 of which are three-point ligature minimised.[19]

10. At the time of Wayne's death, none of the cells in Unit 2 were fully ligature minimised. A-Wing of Unit 2 was being used as an "*enhanced wing*" for earned supervision and standard supervision prisoners, and housed the primary workers for the unit, and B, C and D-Wings held standard supervision prisoners. The current situation is that 47 of Unit 2's 63 cells have been three-point ligature minimised, and the wing by wing breakdown is as follows:

> A-Wing: 15 cells, 15 of which are three-point ligature-minimised;
>
> B-Wing: 16 cells, 10 of which are three-point ligature minimised and six of which are not ligature-minimised;
>
> C-Wing: 16 cells, 12 of which are three-point ligature minimised and four of which are not ligature-minimised; and
>
> D-Wing: 16 cells, 10 of which are three-point ligature minimised and six of which are not ligature-minimised.

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[17] Exhibit 1, Vol. 2, Tab 41, Statement - Superintendent A Hughes (17.10.22), para 15
[18] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p4
[19] Exhibit 1, Vol. 2, Tab 45, Letter - Mr C Williams (19.10.22)

At Risk Management System (ARMS)[20]

11. ARMS is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. When a prisoner is received at a prison, an experienced prison officer (known as the reception officer), conducts a formal assessment designed to identify any presenting risk factors. Within 24 hours of arriving at a prison, the prisoner's physical health needs are assessed by a nurse.[21]

12. When a prisoner is placed on ARMS, an interim management plan is developed and the prisoner is managed with observations at either high, moderate or low levels. In mid-2016, the ARMS observation levels were changed and are now: high (one-hourly), moderate (2-hourly) and low (4-hourly).[22]

13. Within 24-hours of a prisoner being placed on ARMS, a meeting of the Prisoner Risk Assessment Group (PRAG) is convened to determine the appropriate levels of support and monitoring required to manage the prisoner's identified risk. During the week at Hakea, PRAG meetings are chaired by the Senior Supervisor Regimes who is supported by mental health and counselling staff, and prison support officers. Each prisoner's case is discussed and the PRAG chair makes a determination about the prisoner's ARMS level.[23]

14. On weekends at Hakea the arrangements are different and PRAG meetings are chaired by the principal officer on-duty. Other attendees include the relevant prisoner's unit manager, a mental health nurse and a representative of Psychological Health Services (PHS). If the prisoner's unit manager is unavailable, they will provide the PRAG chair with notes about the prisoner. Where a prisoner being removed from ARMS requires ongoing support and monitoring, they may be placed on the Support and Management System (SAMS). Wayne was never placed on SAMS.[24,25,26]

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[20] ts 18.10.22 (Cunningham), pp12-15
[21] Exhibit 2, ARMS Manual (2019), pp2-13
[22] Exhibit 2, ARMS Manual (2019), pp21-24
[23] Exhibit 2, ARMS Manual (2019), pp16-18
[24] Exhibit 1, Vol. 2, Tab 30.17, Statement - Prin. Officer J Bohling (18.08.22), paras 4-7
[25] ts 18.10.22 (Bohling), pp50-51 & 65-66
[26] Exhibit 2, ARMS Manual (2019), pp3, 9 & 24

The predictability of suicide

15. Dr Petch, Dr Brett and Ms Barry all agreed that suicide cannot be predicted. That is primarily because suicide is a rare event and it is impossible to predict rare events with any certainty. A complicating factor is that a person's suicidality can fluctuate, sometimes over a relatively short time frame. The purpose of risk assessments is therefore not to predict suicide, but to manage the risk of self-harm.[27]

16. In 2017, the Department of Health published *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document). Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable. The Document points out that those who are faced with the onerous task of assessing a person who may be suicidal (and here I would include prison officers) confront two issues.

17. The first issue has already been noted, namely that suicide is a rare event. The second issue is that there is no set of risk factors that can accurately predict suicide in an individual patient. As the Document points out, the use of risk assessment tools containing checklists of characteristics has been found to be ineffective.[28] As the Department's ARMS Manual notes:

> There is a widely held assumption explicit in suicide prevention procedures that suicides can be predicted and action taken to avert them. The extent to which individual suicides are in fact predictable remains a complex and somewhat confused issue. It is likely that certain types of suicide are more predictable and preventable than others.[29]

18. As to the limitations of risk assessments, the ARMS Manual notes:

> There may be a number of factors which *may* mean a prisoner is more likely to be at risk. But these factors are poor predictors…There is no sure way of "diagnosing" suicidal intentions or predicting the degree of risk. Assessments can only be of temporary value because moods and situations change. Self-harm can be an impulsive reaction to bad news or a sudden increase in stress.[30]

[27] ts 19.10.22 (Barry), pp168-169; ts 20.10.22 (Petch), pp206-208; and ts 20.10.22 (Brett), pp225-226
[28] *Principles and Best Practice for the Care of People Who May Be Suicidal* (Department of Health, 2017), pp2-3
[29] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)
[30] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)

19. Reception officers conducting initial suicide and self-harm risk assessments ask prisoners a series of questions using an online tool. The aim is to elicit information about factors tending to make it more likely the prisoner will attempt suicide or self-harm (risk factors) and those factors which make this less likely (protective factors).

20. Self-harm has been described as: "*The practice of injuring oneself in order to relieve emotional distress with non-fatal consequences*". In contrast, suicide is "*Death from injury, poisoning or suffocation where there is evidence (implicit or explicit) that the injury was self-inflicted and the person intended to kill him/herself*".[31]

21. Similar factors may be given different weight depending on the prisoner. Risk factors might include young or old age, childhood trauma and mental health issues. An important risk factor is a history of self-harm and/or suicide attempts. On the other hand, protective factors might include family support and a focus on the future.

22. The enormity of the task facing prison staff tasked with identifying at-risk prisoners is captured in the following extract from the ARMS manual:

> It is natural for those concerned with a self-inflicted death to ask themselves whether more could have been done to predict and prevent it. The burden of anxiety and guilt is made worse if critical judgements are made with the benefit of hindsight. It is all too easy to assume that suicide is preventable if certain techniques and procedures are followed.[32]

23. As to who can ultimately prevent death by suicide, the ARMS Manual states:

> Suicides can be prevented, but ultimately only by the prisoner themselves. The responsibility of the Department of Justice is to provide care and support which reduces the risk of suicide and enables the prisoner to recover the will to live.[33]

[31] Exhibit 2, ARMS Manual (2019), p32 (para 6.1)
[32] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)
[33] Exhibit 2, ARMS Manual (2019), p36 (para 7.2)

WAYNE

Background[34,35,36,37,38]

24. Wayne was born on 2 April 1978 and had three siblings. He left school part way through Year 10 to work on a station in Dongara and was described as "*a hard worker*" who "*particularly loved farm work*". Wayne had two children from a previous relationship, and three children with his second partner, whom he met in 2011 and married in 2017. Wayne's interests included the outdoors, riding motorbikes, gardening, camping, and four-wheel driving.

25. In about January 2016, Wayne was seriously injured at work when a large bale of hay fell on him from the back of a truck, damaging his shoulder and neck. Wayne was prescribed pain medication including morphine and pregabalin, and he also took diazepam, and anti-depressants. According to his wife, Wayne became addicted to his pain medication.

26. Because of the severity of his injuries, Wayne received a substantial worker's compensation payout and was unable to work for a number of years. He used part of the payment he received to purchase a home in Woodridge, which he set about renovating. Whilst he was undertaking this work, Wayne's wife and children remained at the family home in Leeman, a small coastal town about 263 km north of Perth.

27. At around this time, Wayne's methylamphetamine use reportedly increased and, according to his wife, in 2018 his behaviour "*became worse*" and he became "*verbally abusive*". Wayne also began buying and selling cars and spare parts (apparently to support his methylamphetamine habit). As I will outline, in February 2021, Wayne allegedly assaulted his wife and following that point, his family relations became understandably strained.

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[34] Exhibit 1, Vol. 1, Tab 9, Statement - Ms M Larder (15.10.21), paras 2-36
[35] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p8
[36] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), p3
[37] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp2-4
[38] Exhibit 1, Vol. 1, Vol 1, Tab 2.1, Report - Det. Sen. Const. G Holt, pp3-4

Overview of medical conditions[39,40,41,42]

28. Wayne experienced an episode of depression in 2012 and was prescribed the antidepressant, desvenlafaxine, by his GP. As noted, in about January 2016, Wayne was involved in a workplace accident. As a result he sustained very serious injuries to his shoulder and the vertebrae in his neck (cervical spine) and subsequently underwent cervical spine fusion.

29. According to his GP, Wayne had been using injectable recreational drugs since 2012. The evidence before me suggests that Wayne's use of methylamphetamine increased following his workplace accident, and also in the period leading up to his incarceration.

30. When Wayne saw his GP in October 2016, he presented with a history of poor sleep, low self-esteem and irritability. He was referred to a clinical psychologist and "*engaged well*" in therapy sessions between October 2016 and November 2017.[43]

31. During 2017, Wayne was prescribed the antidepressants desvenlafaxine and escitalopram, although it appears Wayne may not have taken this medication. Nevertheless, he was also reportedly taking duloxetine, another antidepressant. The severity of Wayne's injuries was eventually assessed as 26% "*whole person permanent impairment*" which explains his substantial worker's compensation payout.

32. Wayne's depression was reported to have continued into 2018, and he started seeing a psychologist again. In 2019, he is said to have received cognitive behavioural therapy to treat his depression, anxiety and polysubstance use, and Wayne was noted to "*have severe depression with long-standing suicidal ideation*".[44]

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[39] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), pp3-7
[40] Exhibit 1, Vol. 1, Tab 2.1, Report - Det. Sen. Const. G Holt, p9
[41] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (02.07.22), pp4-9
[42] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp3-4
[43] Exhibit 1, Vol. 1, Tab 25, Letter Ms V Tobar, Clinical Psychologist (03.06.19)
[44] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), p3

33. On 26 June 2019, Wayne was admitted to Joondalup Health Campus (JHC) after threatening to slice his neck with a knife whilst he was intoxicated by methylamphetamine. Hospital notes identified emotional infidelity, financial issues and "*drug debts*" as compounding issues. He was diagnosed with methylamphetamine-use disorder, cluster B personality traits,[45] and methylamphetamine-induced disorder. Follow up was organised through his GP, and Wayne was discharged on 28 June 2019.

34. On 5 June 2020, Wayne saw his GP and reported that he had been seeing a psychologist. He also said he "*wanted to feel less angry*" and that he had abstained from using illicit drugs over the past 30-days.

35. Following his death, the Department conducted a review of the health services Wayne was provided in custody (Health Review), which summarised his medical care in these terms:

> Wayne received appropriate health care from health services staff on each occasion including appropriate admission processes, arrangement of continuity of care with community providers, assessment and referral for substance abuse, and appropriate responses to acute presentations.[46]

Events leading to Wayne's incarceration on 14 February 2021[47,48,49,50,51]

36. On 2 December 2020, officers from the Joondalup Detective's office executed a search warrant at Wayne's home and seized a small quantity of methylamphetamine, some ammunition, a hand gun, and an M1 carbine semi-automatic rifle.

37. Wayne was arrested and charged with unlawful possession of firearms, attempting to sell firearms, and possession of a prohibited drug. Although he was initially refused bail by police, Wayne was later released following an appearance in the Magistrates Court.

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[45] Cluster B traits include dramatic, overly emotional or unpredictable thinking and/or behaviour
[46] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), p10
[47] Exhibit 1, Vol. 1, Tab 9, Statement - Ms M Larder (15.10.21), paras 36-49
[48] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp4-5
[49] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp4-5
[50] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (02.07.22), p6
[51] Exhibit 1, Vol. 1, Tab 2.1, Report - Det. Sen. Const. G Holt, p5

38. On 12 December 2020, police served Wayne with a 72-hour protection order (PO) after he was involved in a violent incident relating to his wife. Wayne was taken to JHC for a mental health assessment and reportedly said he would kill himself. He also disclosed an attempt to take his life in 2018, apparently by shooting himself. After an assessment, Wayne was discharged home.

39. On 11 February 2021, Wayne allegedly assaulted his wife after she refused to have sex with him. She managed to escape and contacted the police who served Wayne with another PO. Wayne had reportedly smashed a window at his house by punching it and after his injuries had been treated at hospital, he called his wife repeatedly and sent her abusive text messages, thus breaching the PO he had just been served with.

40. Wayne subsequently managed to locate his wife and he went to her temporary accommodation at about 6.30 am on 13 February 2021. On arrival, Wayne made various threats including that he would: "*kill everyone, kill himself and slit his mother's throat*". Wayne's wife described his behaviour as being a "*rampage*",[52] and he was arrested and taken to the Perth Watch House (PWH). At PWH, Wayne had a "*pseudo-seizure*" and was injured after banging his head repeatedly on his cell floor.

41. Although he had full movement of his limbs, Wayne claimed to have "*broken his neck*", and because of his threats to kill himself, he was taken to JHC for assessment. Clinical staff noted Wayne had previously been seen at Royal Perth Hospital with chest pain in the context of an anxiety disorder and he was diagnosed with angina. Wayne was given glyceryl trinitrate spray (GTN) to alleviate his pain symptoms and discharged back into police custody.

42. On 14 February 2021, Wayne appeared in the Magistrates Court, where his application for bail was refused. Wayne was remanded in custody and transported to Hakea.

[52] Exhibit 1, Vol. 1, Tab 9, Statement - Ms M Larder (15.10.21), para 44

ISSUES RELATING TO WAYNE'S INCARCERATION

Initial ARMS assessment - 14 February 2021[53,54]

43. When Wayne arrived at Hakea on 14 February 2021, he underwent an initial risk assessment conducted by a reception officer, the aim of which was to determine whether he needed to be placed on ARMS. Wayne did not disclose his suicide attempt in 2018 to the reception officer, although he did mention his recent attempt to harm himself by banging his head in the police cell, which he said was due to "*frustration and anger*".[55]

44. Wayne told the reception officer he had depression and anxiety, but did not disclose his previous suicidal ideation, or that he had made recent threats to kill himself. Regrettably therefore, the reception officer was unaware of the full extent of Wayne's self-harming behaviour at the PWH and his recent suicidal ideation.[56]

45. On the basis of the information that was available, the reception officer concluded Wayne was not at risk of suicide or self-harm and he was not placed on ARMS. The reception officer noted:

> Prisoner stated he has no self-harm history, it is noted that prisoner hit his head to cell in police custody. Prisoner stated that this was due to anger and frustration as no one would listen to him and he wanted a phone call to let his family know where he was. Prisoner stated he had no current self-harm thoughts and could guarantee his safety.[57]

Initial health assessment - 14 February 2021[58]

46. On 14 February 2021, Wayne also underwent a routine health screen conducted by a prison nurse. His injury on his right hand (apparently from punching a window the previous day) was noted and during the assessment, Wayne became anxious and complained of chest pain. He was diagnosed with angina and given GTN.

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[53] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), pp4-5
[54] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), p4
[55] Exhibit 1, Vol. 1, Tab 10.1, ARMS reception intake assessment (14.0.21), pp3-5
[56] ts 20.10.22 (Petch), pp198-199
[57] Exhibit 1, Vol. 1, Tab 10.1, ARMS reception intake assessment (14.0.21), p7
[58] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), pp3-5

47. Wayne told the prison nurse he experienced fits, and had been diagnosed with anxiety and depression. He also disclosed that in the previous 24-hours he had threatened to kill himself and had self-harmed by banging his head on his cell floor at the PWH. Wayne also disclosed previous suicidal ideation and his attempt to shoot himself in 2018. Nevertheless, he told the prison nurse he did not feel at risk at Hakea and denied self-harm or suicidal ideation. After this assessment, the prison nurse did not consider Wayne was at risk of suicide or self-harm.

Code Red Medical Emergency - 15 February 2021[59,60,61]

48. At about 8.12 am on 15 February 2021, Wayne activated the emergency call bell in his cell, and told Officer Cole he was "*having chest pains and was struggling to breathe*". A Code Red Medical Emergency was activated and officers attended his cell. Wayne told one of the officers he was really stressed and his anxiety was "*really bad right now*".

49. Wayne was given oxygen and nursing staff attended and took him to the prison medical centre for further assessment. Wayne was subsequently taken to Fiona Stanley Hospital by ambulance, where his previous suicidal ideation, anxiety and methylamphetamine use were documented. No cause was identified for his chest pain and after he was given GTN spray, Wayne was returned to Hakea.

Release on bail and subsequent incarceration[62,63,64,65,66]

50. Wayne appeared in the Magistrates Court again on 16 February 2021. On this occasion his application for bail was granted, and Wayne was released from Hakea at about 5.30 pm.

51. Prior to his release, Wayne was served with a family violence restraining order (VRO) protecting his wife and children. Almost immediately after being released, Wayne breached the VRO by sending his wife some 200 text messages and calling her 37 times.

[59] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), p4
[60] Exhibit 1, Vol. 1, Tabs 16.1 & 16.2, Incident Report Minutes & Incident Report Summary (15.02.21)
[61] Exhibit 1, Vol. 1, Tabs 16.3.1 - 16.3.5, Incident Reports - Officers R Singh; G Benson; G Cole; P Faranda; and D Thorne (15.02.21)
[62] Exhibit 1, Vol. 1, Tab 9, Statement - Ms M Larder (15.10.21), paras 49-55
[63] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp8-9
[64] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp4-5
[65] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (02.07.22), pp6-7
[66] Exhibit 1, Vol. 1, Tab 2.1, Report - Det. Sen. Const. G Holt, p5

52. In these calls and text messages, Wayne made various threats. He also demanded that the VRO be withdrawn or he would take his life. In one of the text messages, Wayne attached a photograph of himself lying on train tracks. In another, he faked a car accident and in yet another, he threatened to jump off a bridge.

53. At about 3.30 am on 17 February 2021, Wayne went to his wife's temporary accommodation. Police were called and had to use a Taser to subdue him before he could be arrested for breaching the VRO. After his arrest, Wayne was taken to JHC by ambulance.[67] When he was seen at about 9.00 am, he was assessed as: "*at chronic elevated risk*" of self-harm and suicide because of his "*personality structure, previous attempts and polysubstance abuse*". Nevertheless, he was found to be "*organised, not psychotic, not clinically depressed,* (and) *not manic*". Wayne was diagnosed with adjustment disorder and polysubstance use, and after guaranteeing his safety, he was released back into police custody.[68]

54. Not surprisingly, bail was subsequently refused, and Wayne was remanded in custody. At about 2.40 pm, he was seen on closed circuit television (CCTV) to bang his head on the wall of his holding cell before lying face down on the floor. Custodial officers attended and tried speaking with Wayne through the cell door. Although Wayne was clearly breathing, he did not respond, although while officers were waiting for back-up, he stood up and bashed his head on the cell door again before falling to the floor.[69]

55. Other officers arrived and the cell was breached. Wayne was placed in the recovery position and was mumbling to himself and not responding to officers. However, when he subsequently complained of chest pains, he was taken to JHC by ambulance.[70] He arrived at JHC at about 3.30 pm and although MRI scans were normal, Wayne told clinical staff he was concerned he wouldn't "*be able to handle (his) day in court tomorrow*" and would be unable to manage the journey to court because of illness. Nevertheless, he was discharged and returned to Hakea.[71,72]

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[67] JHC Medical Records (URN 81844) - St John Ambulance Patient Care Record: WOO21NC (4.40 am, 17.02.21)
[68] JHC Medical Records (URN 81844) - Mental Health Triage form (9.00 am, 17.02.21)
[69] Exhibit 1, Vol. 1, Tab 17.1 & 17.2, Incident Summary Report & Incident Description Report - Officer J Tucker (17.02.21)
[70] JHC Medical Records (URN 81844) - St John Ambulance Patient Care Record: WNG27D2 (2.46 pm, 17.02.21)
[71] Exhibit 1, Vol. 1, Tab 17.1 & 17.2, Incident Summary Report & Incident Description Report - Officer J Tucker (17.02.21)
[72] JHC Medical Records (URN 81844) - Integrated Progress Notes (4.30 pm, 18.02.21)

ARMS assessment - 18 February 2021[73,74,75,76,77]

56. Wayne underwent a further risk assessment on his return to Hakea at 10.30 pm on 18 February 2021. On this occasion, Wayne was reportedly "*calm and cooperative*" and this time, he disclosed his recent history of self-harm including banging his head and jumping in front of a police car.

57. Wayne also told the reception officer he wanted to kill himself, and would do so if given the opportunity. Wayne said he had lost a family member to suicide, and that he had been seeing a drug and alcohol counsellor in the community.

58. Wayne disclosed he had been tasered by police and was aching all over. He also "*endorsed feelings of hopelessness, anger, guilt, impulsive behaviour and suicidal thoughts*". The reception officer noted Wayne was a heavy user of methylamphetamine, and that he had abstained for the previous six-days.

59. At the conclusion of the ARMS assessment, the reception officer concluded: "*Prisoner is at risk of self-harm and suicide*". An interim management plan was created, and Wayne was placed in a safe cell on high ARMS, meaning he was the subject of hourly observations.

Court appearance by video-link - 19 February 2021[78]

60. On 19 February 2021, Wayne appeared by video-link in the Magistrates Court and was remanded in custody at Hakea until 22 February 2021. At about 11.30 am, after he had been placed in a holding cell following his appearance, Wayne charged at the cell wall striking his head multiple times before falling to the floor. Wayne was subsequently assessed by a prison medical officer (PMO) and given medication for acute lower back pain.[79,80]

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[73] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp4-5 & 8-9
[74] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp5-6
[75] Exhibit 1, Vol. 1, Tab 26.1, Report - Dr A Brett (02.07.22), pp6-7
[76] Exhibit 1, Vol. 2, Tab 30.2, At Risk Management System - Reception Intake Assessment (18.02.21)
[77] Exhibit 1, Vol. 1, Tab 12.1, At Risk Management System - Interim Management Plan (18.02.21)
[78] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p10
[79] Exhibit 1, Vol. 1, Tabs 18.1 & 18.2, Incident Report Minutes & Incident Summary Report (19.02.21)
[80] Exhibit 1, Vol. 1, Tabs 18.3.1 - 18.3.4, Incident Description Reports - Officers M Khan; N Paul; K Carroll; and D Smith (19.02.21)

ARMS Assessment - 19 February 2021[81,82,83]

61. On 19 February 2021, Wayne was also seen by Ms Whyte, a mental health nurse, who undertook an ARMS review. Ms Whyte described Wayne as being "*angry and closed off*", and recalled him telling her that "*if he wasn't released from prison he would kill himself*". On the basis of her assessment, Ms Whyte considered that Wayne needed to remain in a safe cell on high ARMS.[84]

62. Ms Whyte did not have access to the statement of material facts (SOF) for Wayne's offences and it appears at that time, none of the mental health nurses at Hakea had access to SOF either. According to Ms Deakin, another of the mental health nurses at Hakea, access had been denied on the ludicrous basis that if mental health nurses were able to view SOF, "*it might influence their assessment of risk*".[85] With respect that is **precisely** why access to SOF by mental health staff is so important.

63. In Wayne's case, the SOF relating to his offences contained information that was **crucial** to any proper assessment of his risk of self-harm and/or suicide. At the inquest, Ms Whyte, Ms Deakin, Ms Barry, Dr Petch and Dr Brett, all agreed that with the benefit of hindsight, access to Wayne's SOF would have been helpful.[86,87]

64. Given that the SOF is read out in open court in the case of a plea of guilty and that mental health nurses, social workers, medical officers, psychiatrists and psychologists in the prison system, all owe obligations of confidentiality to their respective professional bodies (over and above their contractual obligations to the Department) it is difficult to understand the logic behind denying access to the SOF to some of these clinicians.

65. The critical importance to the assessment of Wayne's risk of self-harm and suicide of the information in his SOF would have been clear from the most cursory reading of the document.

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[81] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp9-10
[82] Exhibit 1, Vol. 2, Tab 43, Statement - Ms A Whyte (14.10.22), paras 11-14 and ts 18.10.22 (Whyte), pp37-44
[83] Exhibit 1, Vol. 2, Tab 30.8, ARMS Risk Management Plan (19.02.21)
[84] Exhibit 1, Vol. 2, Tab 30.9, PRAG Minutes (19.02.21)
[85] ts 18.10.22 (Whyte), p38 and ts 18.10.22 (Deakin), pp98-99
[86] ts 18.10.22 (Whyte), pp38 & 46 and ts 18.10.22 (Deakin), pp98-99
[87] ts 19.10.22 (Barry), pp162-163; ts 20.10.22 (Petch), pp202-203; and ts 20.10.22 (Brett), p229

66. As I will now demonstrate, the SOF for Wayne's offences outlines the fact that he was the subject of a VRO which he breached almost as soon as he was released from custody. The SOF shows he had also behaved in an aggressive and threatening manner towards his wife and police, and had made threats to kill himself. Access to this information would have negated Wayne's assertion of family support and have demonstrated that his prospects of being released on bail were minimal, despite his confident assertions to the contrary.

67. The following extract from Wayne's SOF is illustrative of the point, and contains crucial information about his recent suicidality and unstable behaviour:

> The accused was released from custody at approximately 5.30 pm on 16 February 2021, the afternoon after he had been served the Family Violence Restraining Order. Within one hour of his release the accused commenced breaching the Family Violence Restraining Order. For approximately 10 hours between 5.45 pm on Tuesday 16 February 2021 and 4.30 am the next morning the accused made approximately 37 calls to the victim. **Much of the phone call conversation was aggressive and involved the accused attempting to blackmail the victim into 'dropping the restraining order' and threatening to commit suicide if she didn't do so.** [Emphasis added] At approximately 3.30 am on Wednesday 17 February 2021, the accused attended…[his wife's address]…The accused was heard cutting up in his vehicle outside…[his wife's address]…The accused was also heard yelling and screaming at the victim from the locked gates outside the property stating: "*I'm coming for ya*" and "*open the gates*". The accused was eventually arrested by Police at 4.35 am outside…[his wife's address]….The accused was aggressive and threatening towards attending Police and the use of a taser was required to subdue and gain control of him.[88]

68. In my view it is a very dangerous practice for the Department to require its staff to conduct risk assessments whilst denying them access to key pieces of information, such as the SOF. In my view, all staff required to perform risk assessments should be provided with access to a prisoner's SOF.

[88] Exhibit 1, Vol. 2, Tab 40, Statement of Material Facts (Brief No.: 2078668-1), pp1-2

69. In addition to not having access to Wayne's SOF, Ms Whyte did not have access to the Psychiatric Services Online Information System (PSOLIS). PSOLIS is the responsibility of the Department of Health and is a state-wide data base that records a patient's mental health diagnoses, presentations at emergency departments and mental health facilities, specialist reports and other relevant information.[89,90] Astonishingly, neither Dr Petch nor Ms Kemp had access to PSOLIS either.[91]

70. Quite obviously, information of this nature is critically important to those mental health professionals making assessments of a prisoner's risk of self-harm and/or suicide for the purpose of advising the PRAG about a prisoner's ARMS status.

71. Notwithstanding the fact that access to PSOLIS had previously been denied to mental health staff in prisons (for a range of spurious reasons) at the inquest, I was heartened to learn that Ms Deakin had recently had her application for access to PSOLIS approved. She said she had been prompted to apply for access to PSOLIS by "*an email from head office*" and that the approval process had taken about two-months. She expected to have full access to PSOLIS once she had completed some training, which she expected to do shortly. Ms Deakin also noted that two colleagues at Casuarina Prison had recently been granted access to PSOLIS as well.[92]

72. The mental health nurses who gave evidence at the inquest, as well as Dr Petch and Dr Brett, all emphasised how important they believed access to PSOLIS was to any proper assessment of a person's risk of self-harm and/or suicide.[93,94] For that reason, I have recommended that the Department take immediate steps to request that all mental health professionals in the prison system be granted access to PSOLIS as soon as possible.

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[89] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p3 and ts 18.10.22 (Whyte), pp38 & 46-47
[90] See also: www.datalinkage-wa.org.au/wp-content/uploads/2021/09/Mental-Health-Data-Collection-Research-Data-Dictionary.pdf
[91] ts 18.10.22 (Kemp), p72 and ts 20.10.22 (Petch), p203
[92] ts 18.10.22 (Deakin), pp92-94
[93] ts 18.10.22 (Whyte), pp38 & 46-47; ts 18.10.22 (Kemp), pp82-83; and ts 18.10.22 (Deakin), pp93-94
[94] ts 20.10.22 (Petch), pp203-204; and ts 20.10.22 (Brett), p228

73. Following her assessment of Wayne, Ms Whyte wrote some notes in EcHO (the computer system that manages medical and psychological issues relating to prisoners) and emailed a copy to the PRAG chair. Ms Whyte attended a meeting of the PRAG at about 10.00 am, along with departmental staff, namely Ms Cunningham and Officer Lyons. After discussing his presentation, the PRAG decided to maintain Wayne on high ARMS, and he remained in a safe cell.

Reduction in ARMS - 20 February 2021[95,96]

74. Wayne was seen by Ms Kemp (a mental health and drug and alcohol nurse) on 20 February 2021, who undertook an ARMS review. Ms Kemp recalled Wayne was forthcoming during the assessment and that he did not present with any psychotic features. He was "*not self-harming at that time*" and "*presented reasonably*". Ms Kemp said she "*had no cause to believe he would that day kill himself*".[97]

75. Ms Kemp also did not have access to Wayne's SOF offences or PSOLIS, and was unaware of his mental health history or his recent suicidal ideation. Ms Kemp described Wayne as "*calm, cooperative and polite*" during the assessment. He told her he was keen to be moved out of the safe cell and into Unit 2, and wanted to transfer to Unit 8 to be with a relative.

76. Wayne "*firmly denied*" any current suicidal or self-harm ideation and/or plans, and Ms Kemp's assessment of his risk was as follows:

> I considered that Wayne did not need to remain in a safe cell on high ARMS and that he could be reduced to low ARMS with psychological health service follow up with a counsellor, and [he] was also referred to the prison support officer.[98]

77. Ms Kemp made an entry in EcHO and emailed some notes to the PRAG chair, Officer Bohling. At the PRAG meeting at about 10.00 am, Ms Kemp's assessment was endorsed and Wayne was reduced to low ARMS and transferred to Unit 2.[99]

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[95] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp10-11
[96] Exhibit 1, Vol. 2, Tab 35, Statement - Ms S Kemp (13.10.22), paras 9-21 and ts 18.10.22 (Kemp), pp73-79
[97] Exhibit 1, Vol. 2, Tab 35, Statement - Ms S Kemp (13.10.22), para 19
[98] Exhibit 1, Vol. 2, Tab 35, Statement - Ms S Kemp (13.10.22), para 22
[99] Exhibit 1, Vol. 2, Tab 30.12, PRAG Minutes (20.02.21) and ts 18.10.22 (Bohling), pp51-52

Elevation in ARMS - 20 February 2021[100,101]

78. At about 6.10 pm on 20 February 2021, Wayne activated the emergency cell call button in his cell, and told prison officers he had taken two Amoxicillin tablets he had found under the mattress in his cell. Wayne said he was allergic to penicillin and had been dry retching over the toilet in his cell since taking the tablets. I note that Wayne's allergy to penicillin had been documented during several of his admissions to JHC.[102]

79. Wayne handed the empty medication blister pack to the officers and when asked why he had taken the tablets, Wayne said he "*wanted something for his head*". Although he was taken to the medical centre, no signs of an anaphylactic reaction were noted. Wayne was placed back in a safe cell and elevated to high ARMS.

80. It appears that, contrary to Hakea's *Standing Order 11.2 - Searching*, Wayne's cell had not been searched for contraband prior to him being placed into it.[103] However, the situation is not entirely clear, as Assistant Superintendent Security at Hakea, (Officer MacNeill) pointed out:

> There is no record of this cell being searched that day in TOMS, however if it was a search for the purposes of cell allocation it would not always be recorded in TOMS due to the very high turnover of cell moves at a remand facility like Hakea. I note the cell was recorded in TOMS as searched at (1.25 pm on 10 February 2021) but there had been movement in and out of the cell between then and (20 February 2021).[104,105]

Reduction in ARMS - 21 February 2021[106,107]

81. Sometime after 8.30 am on 21 February 2021, a mental health nurse (Ms Deakin) conducted a risk assessment of Wayne prior to the PRAG meeting later that morning. Ms Deakin said she was required to review six patients and that ideally one hour was required for a mental health risk assessment, although "*this was not possible in the circumstances*".[108]

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100 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p11 and ts 18.10.22 (Bohling), pp63-64
101 Exhibit 1, Vol. 1, Tabs 19.3.1 - 19.3.3, Incident Description Reports (20.02.21), Officers S Gardner; K Happ; and R Singh
102 For example: JHC Medical Records (URN 81844), Mental Health Triage form (4.30 pm, 18.02.21)
103 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p11
104 Exhibit 1, Vol. 2, Tab 30.15, Email - Asst. Supt. C MacNeill (15.08.22)
105 TOMS stands for Total Offender Management Solutions, the Department's prisoner management database
106 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp11-12 and ts 18.10.22 (Deakin), pp86-91
107 Exhibit 1, Vol. 1, Tab 30.16, PRAG Minutes (21.02.21)
108 Exhibit 1, Vol. 1, Tab 36, Statement - Ms T Deakin (13.10.22), paras 9-36

82. Ms Deakin was required to undertake her assessments and document her findings prior to the PRAG meeting at 10.00 am. Wayne was described as "*alert, articulate, and showed no signs of psychosis or formal mood disorder*". He claimed he was not concerned about his upcoming court appearance and was more accepting of being in prison. He also said he felt physically better than when he was admitted and wanted to move to a mainstream cell so he could wear normal clothes and have access to phone calls and hot meals. He gave a "*credible and articulate explanation*" for why he had taken the tablets in his cell, namely that he recognised the brand name on the blister pack and had assumed the tablets were painkillers which might "*give him a buzz*".[109]

83. Wayne firmly denied any self-harm or suicidal ideation and said he felt able to guarantee his safety. He presented as "*calm and rational*" and had *"an amenable demeanour*". Ms Deakin said in her clinical judgement, Wayne did not disclose any concerning signs and had explained he found the restrictions in the safe call to be counter-therapeutic.[110] Notwithstanding these observations, Ms Deakin recalled "*completing my assessments swiftly*" so she could make entries into EcHO before the PRAG meeting. As to her assessment of Wayne, she noted:

> Seen by MHN (mental health nurse) with the PRAG team. Engaged well. Nil evidence of mental illness or withdrawal symptoms. ARMS observations increased to HIGH yesterday after he disclosed taking medications that were not prescribed to him. Firmly denies any thoughts of self-harm or suicide at this time. Gave firm reassurance that he would approach unit officers or medical staff should his mood or mental state alter in any way…
>
> Keen to return to a mainstream unit. Also gave reassurance that he would not take any medications that were not prescribed to him in the future. Recommend remove from the safe cell and reduce ARMS observations to LOW. PHS (Psychological Health Service) to follow up. Refer to PSO (Peer Support Officer). Medical follow up has been booked.[111]

[109] Exhibit 1, Vol. 1, Tab 36, Statement - Ms T Deakin (13.10.22), paras 18-23
[110] Exhibit 1, Vol. 1, Tab 36, Statement - Ms T Deakin (13.10.22), paras 26-27
[111] Exhibit 1, Vol. 1, Tab 30.16, PRAG Minutes (21.02.21)

84. Officer Bohling (the chair of the PRAG meeting) recalled that during the assessment, Wayne had been focussed on "*going to court and getting out*" and was confident he would be released on bail. Officer Bohling also said that Wayne was keen to be transferred to Unit 8 where he had a relative. Officer Bohling acknowledged that Wayne had not been asked what he would do if he was not released from custody, and that with the benefit of hindsight, this was clearly a question which he should have been put. In any event, Ms Deakin's recommendation was subsequently endorsed by those at the PRAG meeting, and Wayne was reduced to low ARMS.[112,113]

Placement in three-point ligature minimised cell - 22 February 2021[114]

85. Even if the decision to reduce Wayne's ARMS level to low and transfer him to Unit 2 is defensible, the same cannot be said for the decision to place him in a cell where he had access to ligatures and obvious ligature points. It is absolutely astonishing that despite Wayne's well-documented history of recent suicidal ideation and self-harming behaviours, he was not placed into a fully ligature minimised cell. Instead, he was placed into a cell in C-Wing that was supposedly "*three-point ligature minimised*".

86. I will deal with the issue of ligature minimisation later in this finding, but note that in addition to the hanging points clearly visible in photos of his cell taken after his death, Wayne had access to a TV, fan and power adaptor, all of which had power cords. Further, the type of stainless steel basin in Wayne's cell was designated as an "*approved ligature minimised fixture*" and is used in all "*fully ligature minimised*" cells.[115,116,117]

87. Mr Williams (the Department's Director of Procurement Infrastructure and Contract Services), advised that the term "*ligature approved*":

> [R]efers to a fixture or fitting that is approved as a ligature minimised fixture or fitting. The fixtures and fittings utilised are reviewed and assessed by an independent consultant for its suitability in a custodial environment for Western Australia and Victoria and subsequently approved if found suitable.[118]

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[112] Exhibit 1, Vol. 1, Tab 36, Statement - Ms T Deakin (13.10.22), paras 28-30 and ts 18.10.22 (Bohling), pp64-65
[113] Exhibit 1, Vol. 1, Tab 36, Statement - Ms T Deakin (13.10.22), paras 28-30 and ts 18.10.22 (Bohling), pp89-91
[114] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p11
[115] Exhibit 1, Vol. 2, Tab 45, Letter - Mr C Williams (19.10.22)
[116] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), paras 20-24
[117] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p4
[118] Exhibit 1, Vol. 2, Tab 45, Letter - Mr C Williams (19.10.22)

88. Despite the fact that the tap fittings and basin in Wayne's cell were "*ligature approved*", he was able to manipulate the stainless steel surround of one of the basin's taps in such a way as to secure the TV power cord that he used to take his life.[119] Mr Williams says that the basin in Wayne's cell was inspected by a member of his team on 16 March 2021 and: "*markings to the basin stainless steel face plate and push button tap were consistent with forcing the internal tap plumbing away from the face plate*".[120]

89. The fact that a so-called "*ligature approved*" fixture could be so easily modified in this way is clearly of very serious concern. The Department should conduct an urgent investigation to determine how Wayne was able to modify his tap fitting so it could support a ligature. The Department should also give urgent consideration to whether these types of basins can properly be said to be an approved "*ligature minimised fixture*" and whether they are actually fit for use in fully ligature minimised cells.

90. To the extent that the PRAG may have been comforted by the fact that Wayne would be checked every four hours once he was placed on low ARMS in Unit 2, that comfort was misplaced. The ARMS system relies on staff having regular interactions with prisoners and documenting those interactions. In terms of what is expected from the staff making such observations, the ARMS Manual provides:

> Supervision of the suicidal should be active, involving supportive contact rather than mere observation. This avoids stigmatisation and builds a positive relationship in which both prisoner and staff will feel more secure.[121]

91. Prisoners on low ARMS are not considered to be actively suicidal but are still at "*moderate risk of suicide*". In terms of the level of observation required, the ARMS Manual states: "*Intermittent checks per management plan: both visual and supportive contact*".[122] However, in the 18-hours before his death, Wayne was the subject of only **one** face-to-face ARMS observation.[123]

[119] Exhibit 1, Vol. 1, Tab 21, Photo showing basin in Cell C-2 with ligature attached to basin tap (22.02.21)
[120] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), para 24
[121] Exhibit 2, ARMS Manual (2019), p25 (para 4.4.2)
[122] Exhibit 2, ARMS Manual (2019), p25 (Table 4)
[123] Exhibit 1, Vol. 2, Tab 30.20, ARMS Supervision Log (21-22.02.21), pp3-4

92. Further, as the Health Review relevantly notes:

> His suicide risk and safety was considered multiple times by a range of clinicians with appropriate referral to the ARMS process and review by mental health nurses and the PRAG committee. The volatility of his emotional state and unreliability of self-reports complicated this process and created an opportunity for the patient to act whilst acutely distressed. **An incident of self-harming was predictable after court as this had occurred several times very recently and his court date was known.**
>
> Continuity of staff conducting assessments, therapeutic environments for reviews and adequate staffing to allow time to be spent with individuals are challenging to implement without structural change. The use of documentation tools for suicide risk to minimise repetition and facilitate accumulation of knowledge and understanding of individuals and include a focus on therapeutic intervention is possible and work on this has begun. Improvements to processes to triage patients requiring additional support on the day of court are required.[124] [Emphasis added]

Comment on reduction in ARMS - 21 February 2021[125]

93. One significant consequence of Wayne being reduced to low ARMS on 21 February 2021, was that because of time pressures, Officer Black had to prioritise ARMS observations for two prisoners in Unit 2 on Moderate ARMS on the morning of 22 February 2021. As a result, she did not have the opportunity to make any assessment of Wayne's risk of self-harm and/or suicide before he left Unit 2 to head to the video-link room.[126]

94. As a result, the last face-to-face ARMS observation Wayne was the subject of before his death occurred at 5.04 pm on 21 February 2021. The other ARMS observations during the 18-hour period that preceded Wayne's death occurred when he was asleep, and were therefore essentially "*body checks*".[127] However, had Wayne been on moderate ARMS at the time, it seems clear that Officer Black would have found time to speak with him before he left Unit 2 to head to the video-link room.[128,129]

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[124] Exhibit 1, Vol. 2, Tab 38, DOJ Health Services Summary (Sep 2022), p10
[125] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp11-12 and see also: ts 19.10.22 (Barry), pp172-174
[126] Exhibit 1, Vol. 2, Tab 34.1, Statement - Officer S Black (12.10.22), paras 19-21 and ts 19.10.22 (Black), pp132-142
[127] Exhibit 1, Vol. 2, Tab 30.20, ARMS Supervision Log (21-22.02.21), pp3-4
[128] ts 19.10.22 (Black), pp134 & 136
[129] See also: Exhibit 1, Vol. 2, Tab 30.37, Email re ARMS/SAMS Supervision Log recording practices (21.08.20)

95. The other consequence of Wayne not being placed on moderate ARMS was referred to by Officer Galway (the video-link officer dealing with Wayne on the morning of 22 February 2021). Officer Galway noted that had Wayne been on moderate ARMS, custodial staff would have escorted him back to Unit 2 after his court appearance.[130] Had this occurred, there is at least the possibility that Wayne may have said something to the escorting officers that raised concerns, and/or that the officers may have noticed something about Wayne's demeanour. The escorting officers would also have been aware of the long remand Wayne had received and would have been able to communicate this information directly to the officers on Unit 2.

96. In his report to the Court, Dr Petch noted when assessed by PRAG on 21 February 2021, Wayne was not professing "*intent, desire or plans to kill himself*". Dr Petch said that based on his assessed degree of risk of suicide and/or self-harm, "*the placement on low ARMS appears to have been understandable*".[131] However, the question of whether the ARMS assessment was reasonable is another matter entirely. At the inquest, Dr Petch was asked whether, on 21 February 2021, a more conservative approach to Wayne's ARMS assessment should have been taken because of his unpredictability, and his reply was as follows:

> Clearly, with hindsight, the answer to that has to be yes. The fluctuating nature means that…any risk assessment you undertake is going to be valid for a shorter period of time. In his case, it might have only been valid for 15, 20 minutes, because the situation was changing so rapidly. Now, you're obviously not going to be able to…undertake a risk assessment every 20 minutes. So…I suppose, the more conservative, more justified approach would be to say, "*Yes, well, we think, therefore, the risk assessment should reflect the highest risk that may prevail during that period*" (the) next 24-hour period, till we do it again. Therefore, he should be on a higher level, rather than a lower level…but when risk does change so rapidly, then, normally, one would think, yes,…this is a case that requires greater conservative approach, despite pressures there might be to lower the…the ARMS rating, because there's so many people needing these type of cells.[132]

[130] ts 19.10.22 (Galway), pp117-119
[131] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), p19
[132] ts 20.10.22 (Petch), p200

EVENTS LEADING TO WAYNE'S DEATH

Court appearance by video-link - 22 February 2021[133,134,135,136,137,138]

97. At about 8.30 am on 22 February 2021, Officer Black gave Wayne a pass authorising him to leave the unit and head to the video-link room, in readiness for his video-link appearance in the Magistrates Court that morning. Wayne reportedly thanked Officer Black and returned to his cell, before heading to the video-link room, arriving there just before 9.00 am.

98. Although the interaction between Wayne and Officer Black took place at a time when Wayne's next four-hourly ARMS observation was due, as noted, due to time pressures, Officer Black did not record any observation in the ARMS module of TOMS.

99. Wayne appeared in the Magistrates Court by video-link at about 9.30 am. It appears he had previously entered pleas of guilty to the firearms and drug charges he faced, and during this court appearance he also entered pleas of guilty to a further charge of receiving stolen property and three charges of breaching the VRO protecting his wife and children.

100. The following excerpt transcript of that morning's court proceedings shows that Wayne's lawyer raised serious concerns about Wayne's mental health:

> Now, his wife is extremely supportive through all this and she is worried that he is very suicidal and should be on medication. And the situation at Hakea Prison is just not the place for him. **Everyone is scared he** (Wayne) **will commit suicide and he should be on 24-hour watch"**.[139]
> [Emphasis added]

101. Regrettably, it appears that these concerns were not raised with anyone at Hakea because court proceedings are not continuously monitored.

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[133] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), paras 12-13
[134] Exhibit 1, Vol. 2, Tab 30.24, Statement - Officer B Galway (16.08.22), pp2-19 and ts 19.10.22 (Galway), pp104-120
[135] Exhibit 1, Vol. 2, Tab 33, Statement - Officer B Galway (12.10.22), paras 4-17
[136] Exhibit 1, Vol. 2, Tab 34.4, Employee OSH Incident Report - Officer S Black (22.02.21)
[137] Exhibit 1, Vol. 2, Tab 30.19, Statement - Officer S Black (18.08.22), paras 8-19 and ts 19.10.22 (Black), pp132-142
[138] Exhibit 1, Vol. 2, Tab 34.1, Statement - Officer S Black (12.10.22), paras 6-19
[139] Exhibit 1, Vol. 2, Tab 30.4, Transcript of proceedings, Perth Magistrates Court (22.02.21), p4

102. Officer Galway explained that there are usually three video-link officers rostered on at Hakea's facility, and they deal with between 60 - 90 prisoners. One officer is responsible for processing prisoners and speaking with any lawyers, whilst another handles phone calls and bookings. A third officer monitors court proceedings, essentially to ensure that the next prisoner on the list is available to the court when required. As multiple court appearances take place simultaneously, this officer is unable to listen to any one hearing in its entirety.[140]

103. At the inquest, Officer Galway said that if he had been made aware of the concerns raised by Wayne's lawyer, he would have raised them with his senior officer and consideration would have been given to whether Wayne needed to be placed into a safe cell. Officer Galway also said that he had been unaware that Wayne had previously threatened to kill himself if he was not released on bail. Officer Galway said had he been aware of that information, he would have placed Wayne in a safe cell.[141]

104. In any event, at the request of Officer Black, Officer Galway made an entry in the ARMS Supervision Log of TOMS at 10.46 am, that Wayne was "*attending court*". This ARMS observation was essentially a "*body check*" because Officer Galway had no opportunity to speak with Wayne for the obvious reason that he (Wayne) was appearing in court at the time.[142]

105. Not surprisingly, Wayne's further application for bail that morning was refused and he was remanded in custody until 28 April 2021. The long remand was to enable pre-sentence and psychiatric reports to be prepared prior to Wayne being sentenced.[143] After his court appearance, Wayne made his way from the video-link room to the control desk, where he was heard to mutter the word "*fuck*" under his breath. Officer Galway said Wayne appeared to have made the remark out of frustration and that despite Wayne's placid demeanour, he (Officer Galway) was concerned about him because he was aware that Wayne had self-harmed after his previous court appearance on 19 February 2021.[144]

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[140] Exhibit 1, Vol. 2, Tab 33, Statement - Officer B Galway (12.10.22), paras 4-11 and ts 19.10.22 (Galway), pp112-114
[141] ts 19.10.22 (Galway), pp116-119
[142] Exhibit 1, Vol. 2, Tab 30.20, ARMS Supervision Log (22.02.21), p4 and ts 19.10.22 (Galway), pp108-109
[143] Exhibit 1, Vol. 2, Tab 30.4, Transcript of proceedings, Perth Magistrates Court (22.02.21), p13
[144] Exhibit 1, Vol. 2, Tab 33, Statement - Officer B Galway (12.10.22), para 17 and ts 19.10.22 (Galway), pp109-111

106. Officer Galway returned Wayne's identification card and Wayne made his way back to Unit 2 alone. In an incident description report written after Wayne's death, Officer Galway made the following observations:

> (Wayne) appeared mildly frustrated and softly muttered under his breath upon leaving. It is to be noted that I completed an ARMS supervision log on (Wayne) approximately 1045 while he was in court. **Given the incident that occurred on Friday, the 19th of February in the Video Link concerning the same prisoner, and the long remand that he was subject to, I informed Unit 2 of his situation and to keep an eye on him as he was returning to the unit.**[145] [Emphasis added]

107. CCTV footage shows Wayne talking to another inmate (Prisoner A) as he made his way to the video-link room.[146] At the time, Wayne was aware that his wife had cancelled her surety and that a further surety would be required if he was to be released on bail. According to the Homicide Squad running sheet in relation to the police investigation of Wayne's death, Prisoner A told police Wayne had said: "*If no-one is there for me I'll commit suicide*", to which Prisoner A responded: "*Don't be silly*".[147]

108. Prisoner A also told police investigators he had not spoken to Wayne before and wished "*he had told the guards*" about what Wayne had told him. In passing, I note that the Coronial Investigation Squad report states that Wayne had told Prisoner A "*he wanted to end his life and thought about eating plastic utensils to choke on*", although the source of this piece of information is unclear.[148,149]

109. In any case, it is clearly unfortunate that the conversation Wayne reportedly had with Prisoner A (in which he had said he intended to take his life) was not immediately brought to the attention of custodial staff. However, I accept that there is an understandable degree of reticence on the part of prisoners in raising matters of this nature with custodial staff. Prisoners may feel they are "*snitching*" on their fellow inmates and/or that they are obliged to maintain confidences disclosed to them by other prisoners.

[145] Exhibit 1, Vol. 1, Tab 13.3.1, Officer B Galway - Incident description report (22.02.21)
[146] Exhibit 1, Vol. 2, Tab 30.21, CCTV - Walking from Unit 2 to Video-link (22.02.21)
[147] Exhibit 1, Vol. 1, Tab 39, Homicide Squad Running Sheet, (7.45 pm, 22.02.21), p11
[148] Exhibit 1, Vol. 1, Tab 2.1, Report - Det. Sen. Const. G Holt, pp6-7
[149] Exhibit 1, Vol. 1, nTab 39, Homicide Squad Running Sheet, (7.45 pm, 22.02.21), p11

110. Nevertheless, if Wayne's comments were as reported by Prisoner A, and if they had been raised with custodial staff, it seems almost inevitable that Wayne would have been placed in a safe cell and elevated to high ARMS. From previous inquests I have presided over, I am aware that there are still only six safe cells at Hakea, and I will have more to say on this issue later.

111. Officer Galway's call to Unit 2 (which occurred at about 11.15 am) was answered by Officer Gardner. According to Officer Black, Officer Galway passed on to her that Wayne had received a "*bad/unexpected outcome from his court hearing*" and had been "*quite stunned by the outcome*". In his statement, Officer Gardner says he passed on that Wayne had received bad news and that "*his demeanour had dropped quite dramatically*" and that Wayne "*needed a welfare check*". Officer Black said that when she became aware that a prisoner had received "*bad news in court*" it was her general practice to follow this up with the prisoner "*as soon as I can*".[150,151]

112. Officer Black says that at about 11.10 am, she started the lunchtime muster on C Wing, which she completed at about 11.20 am. During the muster, prisoners stand by their cell doors and show officers their identification cards so that all prisoners on the wing can be accounted for. Officers do not engage with prisoners during the muster and instead, "*just tick them off the muster list*". Once the muster is complete, prisoners serve themselves lunch in a process known as "*dish up*", before being locked in their cells.[152]

113. Officer Black says that it was during the muster period that she last saw Wayne alive. He was standing by his cell door but that she:

> [S]imply did not have an opportunity to discuss (the outcome of Wayne's court appearance) with him between the time he returned from video-link and the time that the incident was discovered.[153]

114. At about 11.30 am, officers announced the lunchtime lockdown on Unit 2, and began moving through the wings locking prisoners in their cells. A short time later, Wayne was discovered in his cell.[154]

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[150] Exhibit 1, Vol. 2, Tab 30.19, Statement - Officer S Black (18.08.22), paras 17-19 and ts 19.10.22 (Black), pp132-142
[151] Exhibit 1, Vol. 2, Tab 30.25, Statement - Officer S Gardner (26.08.22), paras 4-11 and ts 19.10.22 (Gardner), pp121-123
[152] Exhibit 1, Vol. 2, Tab 30.19, Statement - Officer S Black (18.08.22), paras 14-16 and ts 19.10.22 (Black), pp132-142
[153] Exhibit 1, Vol. 2, Tab 30.19, Statement - Officer S Black (18.08.22), para 18
[154] Exhibit 1, Vol. 2, Tab 30.27, Incident description report - Officer E Lloyd-Cresswell (22.02.21)

Code Red and CPR - 22 February 2021[155,156,157,158,159,160,161,162,163,164,165,166]

115. When Officer Bourke approached Wayne's cell, he noticed the door was closed. Officer Bourke then looked through the observation hatch and saw Wayne lying face down on the cell floor, apparently hanging. Wayne had a black cord around his neck that was tied to the tap surround of the cell's metal handbasin.[167] Officer Bourke made a Code Red Medical Emergency radio call after motioning to Officer Lloyd-Cresswell, who entered the cell and lifted Wayne up to reduce pressure from the ligature.

116. Seconds later, Officer Lange entered the cell and used his Hoffman knife[168] to cut the cord from around Wayne's neck. Officers Lloyd-Cresswell and Bourke then removed Wayne from his cell and started CPR, whilst Officer Lange ran to fetch a defibrillator. Meanwhile, Nurses Chalkley and Moloney arrived at about 11.40 am and were joined by Nurse Scanlan at about 11.46 am.

117. Prison staff took turns performing CPR as they waited for an ambulance to arrive. Their efforts in this regard appear to have been efficient and appropriate. The defibrillator attached to Wayne's chest did not advise a shock and it appears that at all relevant times Wayne' heart was in asystole.[169,170] The first of three ambulance crews arrived on C-Wing at about 11.55 am. Ambulance officers took over resuscitation efforts, assisted by prison staff, and were subsequently joined by officers from two other ambulance units. Despite the combined efforts of prison staff and ambulance officers, Wayne could not be revived and he was declared deceased at 12.22 pm on 22 February 2021.[171,172]

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155 Exhibit 1, Vol. 1, Tab 2.1, Report - Det. Sen. Const. G Holt, pp6-9
156 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp12-17
157 Exhibit 1, Vol. 1, Tab 13.3.2, Officer S Black - Incident description report (22.02.21)
158 Exhibit 1, Vol. 1, Tab 13.3.2, Officer S Black - Incident description report (22.02.21)
159 Exhibit 1, Vol. 1, Tab 13, Nurse N Scanlan - Incident description report (22.02.21)
160 Exhibit 1, Vol. 2, Tab 30.27, Incident description report - Officer E Lloyd-Cresswell (22.02.21)
161 Exhibit 1, Vol. 2, Tab 30.28, Incident description report - Officer D Bourke (22.02.21)
162 Exhibit 1, Vol. 2, Tab 30.29, Incident description report - Senior Officer S Cassidy (22.02.21)
163 Exhibit 1, Vol. 2, Tab 30.30, Incident description report - Officer R Lange (22.02.21)
164 Exhibit 1, Vol. 2, Tab 30.32, Incident description report - Senior Officer S Choudhary (22.02.21)
165 Exhibit 1, Vol. 2, Tab 30.35, Incident Events Log (22.02.21)
166 Exhibit 1, Vol. 2, Tab 30.36, Critical Incident Brief Part 2 (26.02.21)
167 Exhibit 1, Vol. 1, Tab 21, Scene photo - showing metal hand basin with ligature attached to tap
168 A Hoffman knife has a curved blade with the cutting edge inside the curve and is used to cut ligatures
169 Asystole is the total cessation of electrical activity in the heart and is the most serious form of cardiac arrest.
170 ts 19.10.22 (Gibson), pp156-157
171 Exhibit 1, Vol. 1, Tab 23, SJA Patient Care Records - KLM21D2 (22.02.21)
172 Exhibit 1, Vol. 1, Tab 3, Life Extinct Form (22.02.21)

CAUSE AND MANNER OF DEATH[173,174,175,176,177]

118. Two forensic pathologists (Dr Cooke and Dr Ong) conducted a post mortem examination of Wayne's body on 2 March 2021. Their most significant finding was a faint ligature mark around Wayne's neck along with fracturing of the left superior horn of his thyroid cartilage.

119. Dr Cooke and Dr Ong also noted minor skin injuries involving the forehead and knees. Microscopic examination of tissues showed chronic inflammatory changes in the left elbow crease (antecubital fossa) and possible scarring was also observed.

120. Dr Cooke and Dr Ong found that Wayne's major body tissues appeared normal and that a nose and throat swab tested negative for the SARS-CoV2 RNA (COVID-19) virus. Evidence of medical intervention, including changes relating to cardiopulmonary resuscitation, was noted and specialist examination of Wayne's brain showed no evidence of any significant abnormality or recent traumatic injury.

121. Toxicological analysis of samples taken after Wayne's death found low levels of methylamphetamine and amphetamine in his system, along with citalopram (an antidepressant), naproxen (non-steroidal anti-inflammatory) and paracetamol in his system. The analysis did not detect alcohol or other common drugs.

122. At the conclusion of their post mortem examination, Dr Cooke and Dr Ong expressed the opinion that the cause of Wayne's death was ligature compression of the neck. I accept and adopt the conclusion expressed by Dr Cooke and Dr Ong as to the cause of Wayne's death.

123. Further, on the basis of the available evidence, I find that Wayne's death occurred by way of suicide.

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[173] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (22.04.21)
[174] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (02.03.21)
[175] Exhibit 1, Vol. 1, Tab 7, Toxicology report (16.03.21)
[176] Exhibit 1, Vol. 1, Tab 8.1, Neuropathology report (09.04.21)
[177] Exhibit 1, Vol. 1, Tab 8.2, Microbiology PCR / Nucleic acid amplification test report (23.02.21)

ISSUES RAISED IN THE DEATH IN CUSTODY REPORT

Overview[178]

124. Following Wayne's death, Mr Perrin (a Review Officer) conducted a "Death in Custody" review (DIC Review) that identified three issues which I will now briefly canvass. The issues were: that Wayne's risk management plan was inadequate, that Wayne's cell on Unit 2 wasn't searched before he was placed into it, and that Wayne was permitted to make a phone call that breached the VRO he was subject to at the time.

Inadequate risk management plan[179]

125. The DIC Review noted that PRAG conducts an initial assessment of prisoners assessed as being at risk of self-harm and/or suicide and develops a risk management plan "*once the underlying problems have been identified*". The prisoner is then managed in accordance with that plan, until the point at which they are deemed to no longer be at risk.

126. The DIC Review found that Wayne's risk management plan was not sufficiently comprehensive to ensure his safety, because:

> [A]s it did not evidence consideration of:
>
> Protective factors relating to his self-harm and suicidal ideation;
>
> Mr Larder's risk of a relapse considering the repeated recent incidents of self-harm;
>
> Information relating to ongoing treatment and intervention;
>
> Mr Larder's support systems (including social, spiritual and religious supports); and
>
> Reference to consideration of a Crisis Care Unit placement.[180]

127. To this list, I would add the fact that Wayne's risk management plan also failed to take account of the significant risks associated with his various court appearances. This is particularly relevant because Wayne had made it clear that if he was not released on bail (and he clearly expected he would be), then he would take his life.

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[178] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp18-22 and ts 20.10.22 (Palmer), pp181-184
[179] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p18
[180] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p18

128. Having determined that Wayne's risk management plan was "*not sufficiently comprehensive*", the DIC Review recommended that the requirement to develop and implement comprehensive risk management plans that document PRAG's integrated approach to prisoner self-harm and suicide be reinforced. The following specific action (with a target completion date of 31 December 2022) was also recommended:

> Further work will be undertaken to improve a prisoner's risk management plan so that greater attention is given to the risk of relapse based on recent history of a prisoner's self-harm incidents. Completed Risk Management Plans will include commentary, where applicable, around ongoing treatment and interventions, protective factors, support systems and placement options, including into the CCU, or ligature minimised cells and consideration of actions related to the management of risk in line with the ARMS Manual.[181]

Failure to search cell

129. Departmental standing orders require that as a matter of routine, cells are to be searched "*when a cell clearance is conducted*".[182] In this case, there is no record that Wayne's cell (C-2) was searched before he was placed in it on 20 February 2021. As I have already discussed, Wayne told officers he had taken tablets he said he had found under the mattress in his cell. There is no corroborating evidence as to where Wayne found the tablets and/or whether he actually took the medication, as opposed to merely producing the empty medication blister pack.[183,184]

130. Wayne did not appear to experience any anaphylactic symptoms, but nevertheless, the failure to search his cell was clearly problematic.[185,186] Such failures can result in "*unauthorised items being dispersed amongst prisoners*" and for that reason, cell searches should be conducted and documented in accordance with departmental policy.

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181 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p19
182 Exhibit 1, Vol. 2, Tab 30.14, Standing Order 11.2 Searching (06.05.20), para 10.2, p13
183 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p20
184 Exhibit 1, Vol. 2, Tab 30.15, Email - Asst. Supt. C MacNeill to Mr T Perrin (15.08.22)
185 Exhibit 1, Vol. 2, Tab 30.13, Incident Description Report (20.02.20)
186 Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p11

131. In this case, the DIC Review recommended the following action (with a target completion date of 31 October 2022):

> A Superintendent's Notice will be generated and forwarded to all staff reminding them of the importance of recording all relevant information related to any cell searches conducted prior to a prisoner being moved from one cell to another in line with Standing Order 11.2.[187]

Facilitating a breach of the VRO

132. The third issue identified by the DIC Review was that Wayne made an "*officer initiated*" phone call to his wife on 18 February 2021, contrary to the terms of a VRO which was then in force to protect her. This occurred despite the fact that on 15 February 2021, an alert relating to the VRO had been placed on TOMS and the DIC Review recommended that a Superintendent's Notice be issued reminding prison officers to be vigilant when initiating calls for prisoners subject to a VRO to "*ensure that contact is not facilitated with a protected person*".[188]

OTHER ISSUES RAISED BY THE EVIDENCE

Overview

133. In addition to the issues identified in the DIC Review, the evidence before me raises additional concerns about Wayne's care and supervision whilst he was incarcerated. I will now briefly canvass the additional concerns I have identified.

Placement in a ligature minimised cell[189,190]

134. A significant percentage of prisoners (including Wayne) have personality disorders that are characterised by an inability to regulate emotions and a tendency to act impulsively. The risk of self-harm and suicide in this cohort is therefore much greater. It is also the case that hanging is a method commonly used by prisoners to take their lives and these facts highlight the critical importance of strategies to deal with opportunistic self-harm by removing obvious ligature points.

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[187] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), p20
[188] Exhibit 1, Vol. 2, Tab 30, Death in Custody Review (31.08.22), pp21-22
[189] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), paras 12-24 and see also: ts 19.10.22 (Gibson), pp153-154
[190] Exhibit 1, Vol. 2, Tab 45, Letter - Mr C Williams (19.10.22)

135. At Hakea, cells are categorised as either:

a. *Non-ligature minimised*: cells that contain obvious ligature points, such as window bars, shelving brackets, etc;

b. *Three-point ligature minimised*: cells in which the three most obvious ligature points have been removed, namely: window bars, light fittings, and shelving; and

c. *Fully-ligature minimised*: cells in which all identified ligature points have been "*addressed*".

136. Since at least 2006, the Department has been slowly adapting cells at Hakea so they are either fully-ligature minimised, or three-point ligature minimised. However, the work is far from complete and progress has been painfully slow. As of September 2022, only 3.9% of cells at Hakea have been fully-ligature minimised, and a staggering 39.1% of cells are not ligature minimised at all. This is truly lamentable, given the vulnerable prison population housed at Hakea.

137. Funding for the Department's ligature minimisation project (the Project) is provided by Treasury for successive three-year periods. The aim of the Project is "*to undertake ligature minimisation to secure cells (medium & maximum facilities) state-wide*". Funding is allocated on a priority basis, determined by assessing the number of ligature minimised cells in each prison and the average number of prisoners in each facility who are on ARMS or SAMS.[191,192]

138. For the 2020-2021 financial year, Mr Williams had recommended that all available funding be directed to Hakea, which would have allowed for 16 cells to be fully-ligature minimised. The work was due to be completed by April 2021, but the COVID-19 pandemic interrupted this plan and the works are now expected to be finished by December 2022. By that time, 42 cells at Hakea will be fully-ligature minimised, which represents 6.4% of all cells at Hakea, up from the previous figure of 3.9%.

[191] Letter - Dr A Tomison, Director-General, DOJ (09.11.22), p4
[192] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), paras 13-14 & 17

139. Although these works are a welcome step in the right direction, progress is painfully slow and so much more needs to be done. I fully accept that ligature minimisation is costly. I also accept that the Department has a finite budget, and must make difficult decisions as to the prioritisation of its allocated funding. Nevertheless, the issue of ligature minimisation is not new and for over 25-years this Court has repeatedly recommended that the Department increase the number of ligature minimised cells.

140. Following an inquest into a hanging death at Casuarina in 2008, the then State Coroner recommended that the number of ligature minimised cells be increased, and that a capital works program be established for this purpose.[193] In 2019, I made recommendations about ligature minimisation following an inquest into five deaths by suicide at Casuarina, four of which occurred by way of hanging.[194] Further, in 2020, Coroner Urquhart made similar recommendations following an inquest into a hanging death at Hakea in 2017.[195]

141. This Court cannot continue to make these types of recommendations in the face of ongoing prisoner deaths by hanging. The Department must now take urgent action to address this appalling situation.

142. Whilst the ligature minimisation work that has been undertaken at Hakea is welcome, it is completely unacceptable that in 2022, 39.1% of cells at the prison are still non-ligature minimised. The Director General's statutory responsibilities under section 7 of *Prisons Act 1981* (WA) with respect to the welfare and safe custody of all prisoners, apply to the issue of ligature minimisation.

143. I accept that prisoners can and have taken their lives in three-point and fully-ligature minimised cells. Nevertheless, there is obvious merit in making this more difficult by ensuring that as many cells as possible have been fully-ligature minimised. The ever increasing prison population means a commensurate rise in the number of prisoners with mental health illnesses, mental health conditions and/or severely maladaptive behaviours.

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193 Annual Report, Office of the State Coroner (2008-2009), p63 re: Inquest into the death of Mr Mark Briggs
194 Inquest into five deaths at Casuarina Prison Ref: 14/19, (22.05.19)
195 [2020] WACOR 44, (published 22.12.20), Recommendation 1, p46

144. Prisoners in these categories have demonstrably higher rates of self-harm and suicide, and as a class, are particularly at risk. It is my sincere hope that the Department will now make the completion of the ligature minimisation work to cells at Hakea an **absolute priority** and will take **urgent** steps to ensure that all obvious ligature points in those cells are removed.

Access to safe cells

145. At the time of Wayne's death, there were six safe cells at Hakea and there has been no increase in that number since. In terms of what a safe cell actually contains, Mr Williams confirmed that:

> A safe cell is a special purpose cell. It is fully ligature minimised and includes a bed which is an in-situ poured, ribbed concrete plinth. It has an enclosed corner mounted closed circuit TV camera which is monitored from both the unit office and Central Control Room…The fittings within safe cells include a ligature minimised toilet pan, an inwall (recessed) water bubbler, a ligature minimised cell call, ligature minimised cell lights, (and) a ligature minimised air conditioning vent.[196]

146. It is unclear how many of the six safe cells at Hakea were occupied at the time Wayne reportedly told Prisoner A that he (Wayne) intended to take his life. Nevertheless, at the inquest, several prison officers said that they were aware that many prison officers felt under pressure to "*clear*" safe cells in order to house even more vulnerable prisoners.[197,198]

147. The evidence before me establishes that there is a clear and present need for more safe cells at Hakea. I therefore wholeheartedly concur with the view expressed by Coroner Urquhart in his finding in relation to the death of Mr Jordan Anderson that, "*the number of safe cells at Hakea is inadequate*".[199] In my view, this is demonstrably so given that Hakea's muster hovers around 900 and, as I shall point out, Hakea does not have a mental health unit to support staff trying to manage an ever-increasing number of disturbed and vulnerable prisoners.

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196 Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), paras 9-10
197 ts 18.10.22 (Bohling), pp57-59 and ts 19.10.22 (Gibson), pp152-153
198 See also: ts 19.10.22 (Barry), pp171-172
199 [2020] WACOR 44, (published 22.12.20), para 141

148. The situation is compounded by the fact that Hakea is the main receival prison for the metropolitan area. As a consequence, the number of vulnerable and/or volatile prisoners it houses is always high. Added to that is the fact that Hakea is required to manage anywhere from 100 - 150 prisoners with mental health illnesses, using a level of mental health staff that can only be described as woefully inadequate.[200]

149. I therefore endorse Coroner Urquhart's recommendation in the Anderson matter (published on 22 December 2020) that:

> In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should increase the number of safe cells from six to 12.[201]

150. In terms of progress towards increasing the number of safe cells at Hakea, Mr Williams advised that:

> The Department is increasing the number of fully ligature minimised cells and seeking quotations to increase the number of Safe Cells at the direction of Hakea Prison to meet their operational needs.[202]

151. It is certainly regrettable that Coroner Urquhart's carefully considered and commendably sensible recommendation has not already been acted upon by the Department. Nevertheless, I note with considerable approval that the Department is finally taking action to remedy the situation.

152. In a letter to the Court dated 10 November 2022, the Director General advised:

> The Department is increasing the number of fully ligature minimised safe cells within Hakea Prison, bringing the total number of safe cells to twelve. Infrastructure Services is currently in the process of working with Hakea Prison to determine where the additional 6 safe cells should be situated within the Prison to best meet their operational needs.[203]

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[200] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp20-23
[201] [2020] WACOR 44, (published 22.12.20), para 141
[202] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), para 11
[203] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p5

Mental health unit

153. At the inquest, there was abundant evidence that Hakea lacks the facilities and expertise to manage prisoners with complex mental health and behavioural needs, such as Wayne.[204] In June 2020, there were about 6,771 prisoners in adult custodial facilities, of whom about 10% (i.e.: about 700 prisoners) had psychiatric conditions, with a significant number requiring intensive or ongoing mental health care.[205] As noted, Hakea usually has more than 100 prisoners who require mental health treatment, although this number can be as high as 150.[206]

154. The need for a mental health unit at Hakea was eloquently addressed in the Department's Mental Health Alcohol and Other Drugs Summary in this case (the MHAOD Summary), which noted:

> **There is a lack of infrastructure to support prisoners with mental health issues - there is no dedicated mental health unit which provides an environment which is conducive to providing mental health or psychological health care.** The number of services requiring contact with prisoners, including Department staff and external providers, exceeds the availability of interview rooms on site. A lack of dedicated rooms for PHS staff at Hakea has been documented in numerous OICS reports over time. Availability of officers to assist with escorting and supervising prisoners for contacts with PHS staff are also factors which impact on response times, and capacity to be able to conduct a comprehensive assessment. This is particularly the case for specialist units, including the management unit. **While various strategies have been used to try and assist with access to rooms, there is unlikely to be any improvement without a commitment to new buildings**.[207] [Emphasis added]

155. In my view the Department should conduct an **urgent** review to determine if the resources and facilities available to staff at Hakea to manage prisoners with complex mental health issues and/or behavioural issues are adequate. That review should consider the feasibility of establishing a mental health unit at Hakea to appropriately manage prisoners with complex mental health issues and/or behavioural issues.

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[204] ts 19.10.22 (Gibson), pp154-155; ts 19.10.22 (Barry), pp166-170; and ts 20.10.22 (Petch), pp209-212
[205] Office of the Inspector of Custodial Services, Annual Report 2020/2021, pp 11 & 16-17
[206] Exhibit 1, Vol. 1, Tab 27, Report - Dr E Petch (13.09.22), pp21-23
[207] Exhibit 1, Vol. 1, Tab 28.1, MHAOD Summary (Sep 2022), p9

Training for PRAG Chairs

156. The MHAOD Summary identified that as part of the Department's suicide prevention project, the online training course for PRAG Chairs had been "*updated*". At the inquest, Officers Bohling and Gibson were each scathing of the online course content, and Ms Kemp, Ms Barry, Dr Petch and Dr Brett all agreed that online training for PRAG Chairs was problematic and that face-to-face training would be preferable.[208,209]

157. As for training in relation to risk management, including training specifically directed at PRAG Chairs, it seems obvious that face-to-face training is superior. For a start, face-to-face training allows attendees to interact with each other and the facilitator, and share ideas and perspectives. After noting that training for PRAG Chairs is currently delivered online, the Superintendent of Hakea (Officer Hughes) noted:

> To improve the quality of training the Department must provide in person mandatory training in a face-to-face classroom environment to effectively educate, assess and support the role of the PRAG Chairperson including the Principal Officers who perform this role on the weekends. This entails the development of a PRAG Chairperson training module to be delivered through the Department's Training Academy. The current at-risk self-paced training module should complement this training not be a substitute for it.[210,211]

158. At the inquest, Officer Bohling (an experienced PRAG Chair) said that when he was assessing a prisoner's risk of suicide/self-harm, he focussed on "*what was in front of him*" and treated "*each day as a new day*".[212] I am not critical of Officer Bohling's approach, especially as he has never received any formal training and acts as PRAG Chair on weekends at Hakea "*to allow the wheel to keep rolling*" willing and able to do so.[213] I merely mention Officer Bohling's approach to risk assessment as a compelling reason why formal training for PRAG Chairs is desirable.

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208 ts 18.10.22 (Bohling), pp65-66 and ts 19.10.22 (Gibson), pp148-150
209 ts 18.10.22 (Kemp), pp82-83; ts 19.10.22 (Barry), p164; ts 20.10.22 (Petch), p221; and ts 20.10.22 (Brett), pp231-232
210 Exhibit 1, Vol. 2, Tab 44, Letter - Supt. A Hughes (19.10.22)
211 See also: Exhibit 1, Vol. 2, Tab 41, Statement - Superintendent A Hughes (17.10.22), paras 7-10
212 ts 18.10.22 (Bohling), pp56-58
213 ts 18.10.22 (Bohling), pp50-51 & 65-66

159. Although the "*here and now*" is no doubt important, risk assessments do not occur in a vacuum. Ms Barry and Dr Brett confirmed that the best predictor of future behaviour is past behaviour.[214] It follows that risk assessments will be more accurate when all relevant factors are considered, including a prisoner's antecedents and their recent self-harm history.

160. At the inquest, both Officer Bohling and Ms Deakin said that since Wayne's death, they were now more cautious about reducing a prisoner who was on high ARMS directly to low ARMS, except in circumstances where the prisoner had been inappropriately placed on high ARMS in the first place.[215] Officer Bohling said:

> [I]n those incidences…where there has been self-harm threatened, I don't believe you should go from high to low. You should go high, medium, low and that way. I think that is where I'm getting at.[216]

161. Face-to-face learning would enable individual approaches to risk assessment to be challenged in a supportive manner. Roleplays could be designed to help participants practice chairing PRAG meetings and be given constructive feedback as they do so. Facilitators would also be able to model a broader context for risk management and thereby emphasise the importance of considering all relevant factors. I was therefore pleased to note the Director General advised that:

> The need for face-to-face training has been identified and an outline of the required scope will be included as a deliverable as part of the Suicide Prevention Project. Work has commenced with the project team working in partnership with the Training Academy to update and develop training packages for all staff including PRAG Chairpersons.[217]

162. The number of vulnerable prisoners routinely housed by the Department makes it absolutely essential that its risk management processes are fit for purpose. Clearly, the training of PRAG Chairs is an important part of the risk management process and it is my sincere hope that a face-to-face training package for PRAG Chairs will be developed as soon as possible.

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[214] ts 19.10.22 (Barry), p166 and ts 20.10.22 (Brett), p227
[215] ts 18.10.22 (Bohling), p69 and ts 18.10.22 (Deakin), pp97-98 and see also: ts 19.10.22 (Barry), p172
[216] ts 18.10.22 (Bohling), p69
[217] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p1

Suicide Prevention Governance Unit

163. Another critical aspect of ensuring quality risk management is the need for a governance unit to oversee the process. The Director General advised that suicide prevention and clinical governance within the Department was previously undertaken by the Clinical Governance Unit (CGU). Astonishingly, the CGU was abolished as part of the "*machinery of government restructure*" which occurred between 2017 - 2018.[218,219]

164. Notwithstanding this short-sighted decision, there are promising signs that the situation is being remedied. The Director General advised that Mr Morgan, a former Inspector of Custodial Services who was engaged to review the ARMS and SAMS processes, delivered his findings in May 2021. In June 2021, the Department established the Suicide Prevention Project (the Project) to oversee the implementation of those findings, and pleasingly the Director General advised that:

> A key deliverable in this project is to develop a proposal to reinstate the clinical governance and oversight function for suicide prevention, through the establishment of the Suicide Prevention Governance Unit.[220]

165. In my view, the Suicide Prevention Governance Unit (the Unit) should be reinstated immediately. The Unit will fulfill critically important functions including: the establishment of a system of formal quality assurance as well as oversight, and auditing of PRAG decisions. The Unit will also be able to promote consistency and best practice in the application of ARMS assessments, and provide advice, training, and guidance to PRAG members and chairs.

[218] Letter - Dr A Tomison, Director-General, DOJ (09.11.22), pp2-3
[219] See also: ts 19.10.22 (Barry), pp163-164 and ts 20.10.22 (Petch), pp219-220
[220] Letter - Dr A Tomison, Director-General, DOJ (09.11.22), p3

OPPORTUNITIES FOR IMPROVEMENT

Standard risk management tool[221]

166. The MHAOD Summary noted that following Wayne's death, PHS had further developed its standardised risk assessment tool. The document is more comprehensive than previous assessment forms, and is based on the Columbia Protocol, an approach which supports suicide risk assessment through a series of simple, plain-language questions.

167. I acknowledge Dr Petch's concerns about the utility of risk assessment tools generally. Nevertheless, it seems sensible to conclude that a standardised risk management tool, that takes account of international developments, is at least of some help to those with the onerous task of assessing self-harm and/or suicide risk.[222]

168. At the inquest, Ms Barry confirmed that a standardised risk assessment tool is being added to EcHO for use by PHS counsellors.[223] In a letter to the Court dated 9 November 2022, the Director General provided additional information, and advised that:

> A standardised risk assessment (inclusive of the Columbia protocol) will be available for counsellors to use in EcHO from November 2022. A 'Risk Screener' (a briefer version) is also being developed for use in EcHO. This will be similar to what is being explored for use by nursing staff, as they generally undertake brief contacts (whether via hatch or in a room on the unit).[224]

Suicide prevention project[225]

169. In addition to enhancing ARMS, and clarifying the roles and responsibilities of PRAG members, the Project also includes additional suicide identification training for key staff including those who regularly chair/attend PRAG meetings, as well as enhancements to existing programs to refine course content and explore flexible delivery methods.

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[221] Exhibit 1, Vol. 1, Tab 28.1, MHAOD Summary (Sep 2022), p10
[222] ts 20.10.22 (Petch), pp205-208
[223] ts 19.10.22 (Barry), pp159-160
[224] Letter - Dr A Tomison, Director-General, DOJ (09.11.22), p2
[225] Exhibit 1, Vol. 1, Tab 28.1, MHAOD Summary (Sep 2022), p109

Gatekeeper refresher training

170. In previous inquests, I have noted that during their entry level training, prison officers undergo a suicide prevention course authored by the Mental Health Commission (MHC) known as the "Gatekeeper Program" (the Program). The Program involves two days of face-to-face learning, delivered by a qualified mental health clinician and a skilled facilitator.

171. I have previously expressed my surprise that no refresher training is currently offered in relation to the Program, despite the crucial importance of suicide prevention. The Department's response to criticism on this account has been to point to the fact that the Program "*is not owned by the Department*" but rather is "*a product provided by the Mental Health Commission*" which doesn't presently offer refresher training.[226]

172. Be that as it may, all skills have the potential to degrade over time, and attitudes to prisoner behaviour may vary between officers. Some officers appear to regard self-harming behaviour (especially frequent, non-life threatening behaviours) as "*manipulative*", and therefore potentially less serious.[227]

173. This is of grave concern because of the potential that officers may miss warning signs of suicidal risk by downplaying clearly maladaptive behaviours. The Department cannot expect prison officers to identify at risk prisoners, without providing them with regular training in how to do so. It is therefore pleasing to note the Director General's advice that:

> [A]s part of the Suicide Prevention Project, the Department is working with the Mental Health Commission to improve Gatekeeper training, including the development of a tailored program. The Department is considering the feasibility of a refresher training program as part of this process. The development and implementation is dependent on support from the Mental Health Commissioner. Delivery of the training will also require a full needs and impact assessment, including cost, undertaken by the Corrective Services Training Academy.[228]

[226] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p5
[227] Exhibit 2, ARMS Manual (2019), p29 and see also: ts 19.10.22 (Gibson), pp155-156 and ts 19.10.22 (Barry), pp165-166
[228] Letter - Dr A Tomison, Director-General, DOJ (10.11.22), p5

174. Clearly any costs associated with introducing refresher training in relation to the Program, are expenses the Department must accept as the cost of it "*doing business*". It is not acceptable to continue to rely on the "*gut instincts*" of custodial staff, and to some extent good luck, in order to avoid the prospect of prisoners harming themselves or worse.

175. I accept that the identification of at risk prisoners is an inexact process, but the Department places itself in potential jeopardy by failing to ensure its key staff are adequately skilled to undertake this important identification task. It follows that not only must custodial staff receive the Program during their initial training, but that the Department must ensure they receive regular refresher training as well.

Additional counselling staff

176. In other inquests I have presided over, Ms Barry has confirmed that a rising prison population and the increasing acuity of prisoners means that the PHS has no ability to do any proactive work and can only conduct risk assessments and intervene briefly in acute crises - which leads to frustration and burn-out of PHS staff. It remains my view, that the Department should make recruiting extra PHS and mental health staff an absolute priority.[229]

Behavioural management training for senior officers

177. At the inquest, Officer Gibson referred to a five-day course he attended when he was a prison officer in the United Kingdom. The course dealt with personality disorders and common mental health conditions, and provided strategies to manage prisoners with these conditions.[230]

178. I accept that it may not be logistically possible to have all prison officers undertake such a course, but I would urge DOJ to consider the feasibility of providing this training to senior prison officers. Officer Gibson said the course he attended was "*absolutely fantastic*" and had changed his perspective on prisoner management. Officer Gibson also said he refers back to the course content "*to this day*".[231,232]

[229] [2022] WACOR 34, (published 20.07.22), para 199
[230] ts 19.10.22 (Gibson), pp150
[231] ts 19.10.22 (Gibson), pp150
[232] See also: ts 18.10.22 (Kemp), p84; ts 18.10.22 (Deakin), pp94-95 and ts 20.10.22 (Brett), pp232-233

QUALITY OF SUPERVISION, TREATMENT AND CARE

179. After carefully considering the available evidence, I am satisfied that in relation to his physical health, Wayne received a level of care that was commensurate with that offered in the general community. However, for the reasons I have outlined, I find that the management of his mental health was demonstrably suboptimal, and further that his risk of suicide and/or self-harm was not properly appreciated.

180. In my view, the MHAOD Summary hits the nail on the head when it makes the following pertinent observation:

> A number of significant risk factors for suicide are identified in the EcHO record and/or TOMS between 14 and 21 February by different members of the Hakea Primary Care and Mental Health teams who assessed Mr Larder. **These are not drawn together into a structured assessment of his suicide risk. Had this been done, a different assessment of his level of suicide risk may have been made delaying his transition from High to Low ARMS.**[233] [Emphasis added]

181. Wayne was clearly a deeply troubled person who had a history of suicidal ideation. In custody, he engaged in self-harming behaviours, including banging his head on walls and floors and he had made threats to kill himself and others. Wayne clearly indicated his intention to take his life if he was not released from custody. On 19 February 2021, when bail was refused, he ran at his cell wall until he fell to the ground. He was also clearly in an agitated state after his court appearance on 22 February 2021, when he expected to be released on bail but wasn't.

182. Wayne carried out the previous threats he had made to take his life using a TV cord as a ligature, which he tied to a tap on the stainless steel basin in his cell - a fixture that was supposedly "*ligature approved*". Given the apparent ease with which Wayne was able to manipulate the tap fitting so that it could hold a ligature, the basin is demonstrably no such thing.[234,235]

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[233] Exhibit 1, Vol. 1, Tab 28.1, MHAOD Summary (Sep 2022), p7 and ts 19.10.22 (Barry), pp170-171
[234] Exhibit 1, Vol. 2, Tab 42, Statement - Mr C Williams (17.10.22), paras 20-24
[235] Exhibit 1, Vol. 2, Tab 45, Letter - Mr C Williams (19.10.22)

183. For the reasons I set out earlier in this finding, I am troubled by the decision to reduce Wayne from high ARMS to low ARMS on both 20 February 2021 and on 21 February 2021. In any event, regardless of the appropriateness of those decisions, the Department's failure to take any proactive steps to provide Wayne with support on 22 February 2021, following his lengthy remand in custody was reprehensible.[236]

184. It is clearly regrettable that the concerns about Wayne's mental health that his lawyer raised in court less than one hour before Wayne took his life were not relayed to custodial staff at Hakea. Had that occurred, it seems inevitable that Wayne would have been placed into a safe cell and elevated to high ARMS. As it happens, Wayne was placed into a three-point ligature minimised cell on Unit 2 where, astonishingly, he was given access to the TV power cord he used to hang himself.

185. Whilst it seems highly likely that Wayne's ARMS assessments would have been different had the various concerns identified about him (both by direct observation and in the available documents) been properly appreciated, I accept that it is impossible to know whether the outcome in this case would necessarily have been any different. I make that comment in the context that suicide is a rare event and is impossible to predict. Nevertheless, there is at least the prospect that had Wayne's ARMS level been reduced from high to moderate on 21 February 2021, he may have been the subject of closer scrutiny which may have made it less likely that he would take his life at the time that he did.

186. In my view, the recommendations I have set out below properly arise from the evidence. Whilst recommendations are only words on a page, they offer the Department a further opportunity to grapple with the complex issues that attach to the safe and appropriate management of the vulnerable prisoners in its care.

187. As I will shortly explain, the Department's response to the recommendations I have made has been encouraging. As ever though, the Department's actions will speak louder than its words.

[236] See also: ts 20.11.22 (Brett), pp226-227

RECOMMENDATIONS

188. In view of the observations I have made in this finding, I make the following recommendations:

Recommendation No. 1

In order to enhance the effectiveness and integrity of the deliberations of the Prisoner At Risk Assessment Group (PRAG), the Department should:

a. introduce face-to-face training for PRAG Chairs incorporating scenario-based training, roleplays and other appropriate delivery methods to educate, assess and support staff fulfilling the important role of PRAG Chair;

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

c. reinforce the importance of the PRAG carefully considering static and dynamic risk factors when assessing a prisoner's risk of self-harm and/or suicide and in particular, that the PRAG should carefully consider a prisoner's recent presentation and conduct including any suicidal and/or self-harm ideation and behaviour; and

d. require the PRAG to carefully document any decision to reduce a prisoner from High ARMS to Low ARMS and to set out the rationale for that decision, including all relevant factors that prompted that decision - including the important issue of exactly what has changed in the prisoner's presentation.

Recommendation No. 2

In order to enhance the effectiveness and integrity of the ARMS, the Department should:

a. explore the feasibility of providing all staff required to conduct ARMS assessments with access to the Statement of Material Facts in relation to the offences for which the prisoner has been taken into custody;

b. should, as a matter of **urgency,** improve the way that information obtained by the Department's senior mental health staff from the Psychiatric Services Online Information Service (PSOLIS) is shared amongst staff who are required to conduct ARMS assessments; and

c. give urgent consideration to providing prison mental health nurses with access to the Standardised Risk Management Tool currently being used by Psychological Health Services.

Recommendation No. 3

In order to better manage vulnerable prisoners and thereby enhance security at Hakea Prison (Hakea), the Department should, as a matter of the **utmost urgency undertake immediate remedial work at Hakea to ensure that all cells used to house newly admitted prisoners are fully ligature minimised**. The Department should also take immediate steps to ensure all cells at Hakea are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Hakea are fully ligature minimised over time. Further, the Department should conduct an urgent review of all three-point and fully-ligature minimised cells at Hakea to ensure those cells are fit for purpose and in particular, that the fittings in those cells (e.g.: taps, basins etc) can properly be described as "*ligature approved*".

Recommendation No. 4
As has previously been recommended by this Court, and in order to better manage vulnerable prisoners and thereby enhance security at Hakea, the Department should, as a matter of the **utmost urgency** increase the number of safe cells at Hakea from six to 12.

Recommendation No. 5
The Department should explore the feasibility of introducing regular refresher training for the Gatekeeper program for all prison officers **and** should include training in the effective management of prisoners with personality disorders and common mental health conditions.

Recommendation No. 6
The Department should conduct a review to determine whether the resources and facilities currently available to staff at Hakea to manage prisoners with complex mental health issues and/or behavioural issues are adequate. The review should consider the feasibility of establishing a unit at Hakea, staffed by mental health practitioners and custodial staff, to enable prisoners with complex mental health issues and/or behavioural issues to be appropriately managed.

Comments on recommendations

189. In accordance with my usual practice, drafts of my proposed recommendations were forwarded to Ms Ellson and Ms Gilbert (counsel for the Department) and Ms Burke (counsel for three of the nurses who appeared at the inquest) on 21 October 2022. Feedback was requested by close of business on 4 November 2022.[237] On 7 November 2022, Ms Burke advised her clients had no comments in relation to any of the proposed recommendations.[238]

[237] Email from Ms K Christie to Ms K Ellson, Ms G Gilbert & Ms B Burke (21.10.22)
[238] Email from Ms B Burke to Mr W Stops (07.11.22)

190. With respect to the Department, I granted two requests by Ms Ellson for extensions to the timeframe for its response to the proposed recommendations. In a letter dated 10 November 2022, the Director General made several sensible amendments to the wording of three of my recommendations which I have adopted and advised that the Department's position was as follows:[239]

a. *Recommendation 1a*: Supported. A project team is developing face-to-face training for PRAG Chairs;

b. *Recommendation 1b*: Supported in principle. Re-establishment of the Suicide Prevention Governance Unit was identified as a "*key deliverable*" by the Suicide Prevention Project;

c. *Recommendations 1c & 1d*: Supported. A Deputy Commissioner's Broadcast will be issued reminding PRAG members to consider all relevant factors when conducting ARMS assessments, and to adequately document all decisions;

d. *Recommendation 2a*: Supported in principle. The Department will explore this issue with the Western Australian Police Force;

e. *Recommendation 2b*: Supported in part. The Director General advised PSOLIS is available to "*senior mental health staff*" and I amended this recommendation accordingly;

f. *Recommendation 2c*: Supported. The identification and use of an appropriate standardised risk tool for mental health nurses is being considered by the relevant departmental committee;

g. *Recommendation 3*: Supported in principle. The Department "*continues to focus on increasing the number of ligature minimised cells throughout the prison estate*". Further, the Director General advised that a business case has been prepared for Treasury and seeks to extend funding for the current ligature minimisation program for a further four financial years;

[239] Letter - Dr A Tomison, Director-General, DOJ (10.11.22)

h. *Recommendation 4*: Supported. The number of safe cells at Hakea is being increased to 12, with work underway to determine where these additional cells should be located "*to best meet their operational needs*";

i. *Recommendation 5*: Supported in principle. The Department is considering the feasibility of refresher training for the Gatekeeper program; and

j. *Recommendation 6*: Not supported. In addition to the Bindi Bindi Mental Health Unit now operational at Bandyup Women's Prison, a 30-bed Mental health Unit (MHU) being developed for Casuarina is expected to be operational in 2024 - 2025. The MHU will receive male prisoners with complex mental health and/or behavioural issues from across the prison estate and it is "*anticipated that this will alleviate pressures that Hakea Prison is currently experiencing relating to the provision of health/mental health services*". Once the MHU is operational, the Department will consider whether the MHU's allocated resources are adequate.

191. With great respect, I do not accept the basis for the Director General's rejection of Recommendation 6. The recommendation is in two parts and suggests both a review of the adequacy of existing resources and a consideration of the feasibility of establishing an MHU at Hakea. The Director General's response to Recommendation 6 appears to "*throw the baby out with the bath water*".

192. The need for additional mental health resources at Hakea is patently obvious, especially because this prison houses the State's most vulnerable prisoners. For that reason, it remains my view that the review of the adequacy of the resources and facilities currently available at Hakea to manage prisoners with complex mental health issues and/or behavioural issues I have recommended, should proceed.

193. The outcome of the suggested review will surely help the Department to determine whether its current refusal to establish a mental health unit at Hakea can be justified and if so, on what basis/bases.

CONCLUSION

194. As I have explained, it is my considered opinion that the supervision and care provided to Wayne in relation to the management of his mental health was suboptimal. I have made six recommendations aimed at addressing the issues I identified during the inquest and it is my sincere hope these recommendations will be implemented. As I did at the end of the inquest, I wish to again extend my sincere condolences to Wayne's family and friends for their terrible loss.

MAG Jenkin
Coroner
28 November 2022