JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	13 - 14 JUNE 2022
DELIVERED	**:**	22 JULY 2022
FILE NO/S	**:**	CORC 516 of 2019
DECEASED	**:**	MITCHELL, CALLUM

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Mr L. Geddes (State Solicitor's Office) appeared for the Department of Justice.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Callum MITCHELL*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 13 - 14 June 2022, find that the identity of the deceased person was* ***Callum MITCHELL*** *and that death occurred on 21 April 2019 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 on Unit 1. Any prisoner is to be referred to as "Prisoner [Initial]".

Order made by: MAG Jenkin, Coroner (13.06.22)

INTRODUCTION

1. Callum Mitchell (Callum)[1] died on 21 April 2019 from ligature compression of the neck. He was 26-years of age. At the time of his death, Callum was a sentenced prisoner at Hakea Prison (Hakea) and was therefore in the custody of the Chief Executive Officer (CEO) of the Department of Justice (DOJ).[2,3,4,5,6]

2. Accordingly, immediately before his death, Callum was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[7]

3. In such circumstances, a coronial inquest is mandatory.[8] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[9]

4. I held an inquest into Callum's death at Perth on 13 - 14 June 2022, at which the following witnesses gave evidence:

a. Mr Joshua Brown, Senior Prison Officer (Officer Brown);
b. Mr Neville Bell, Prison Officer (Officer Bell);
c. Mr Ian Gibson, Principal Prison Officer (Officer Gibson);
d. Mr Sean Devereux, Acting Superintendent, Hakea Prison (Officer Devereux);
e. Ms Peta Barry, Manager, Psychological Health Services (Ms Barry);
f. Dr Edward Petch, Prison Psychiatrist, Hakea Prison (Dr Petch);
g. Ms Toni Palmer, Senior Review Officer, DOJ (Ms Palmer); and
h. Dr Joy Rowland, Director, Medical Services, DOJ (Dr Rowland).

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

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[1] At the family's request, Mr Mitchell has been referred to as Callum. No disrespect is intended.
[2] Exhibit 1, Tab 1, P100 - Report of Death (22.04.19)
[3] Exhibit 1, Tab 4, P92 - Identification of deceased (21.04.19)
[4] Exhibit 1, Tab 5, Life Extinct Form (21.04.19)
[5] Exhibit 1, Tab 6, Confidential Report to the Coroner - Forensic Consultation (Post Mortem Report) (24.04.19)
[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]

6. In the year 2000, the Canning Vale Prison and the CW Campbell Centre were amalgamated to create 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. As Deputy Superintendent Sean Devereux (Officer Devereux) pointed out, Hakea "*has not really been designed for function and is a collection of old and new buildings*".[12]

7. Hakea is the main remand receival prison for the metropolitan area. It has a capacity of 1,170 prisoners, although its current muster hovers around 900 prisoners. In his statement, Officer Devereux referred to the kinds of prisoners admitted to Hakea, noting:

> 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.[13]

8. As I will explain, Callum was a prisoner with complex needs and a long-standing history of self-harm issues. When he was received into Hakea, he also disclosed was withdrawing from illicit substances.

9. Hakea predominantly holds remand prisoners and there is a high turnover of the muster as a result. However, at various times, as a result of warnings or alerts, Hakea may hold maximum security prisoners from other prisons. In 2019, Hakea held 200 sentenced prisoners, although in April 2022, that number was 250. In terms of custodial staff, Hakea has 173 prison officers on duty during the week, although this number drops to 116 on weekends.

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[10] Exhibit 1, Vol 2, Tab 17.6, Statement - Dep. Supt. S Devereux (26.04.22), paras 2-10
[11] See: www.wa.gov.au/organisation/department-of-justice/corrective-services/hakea-prison
[12] Exhibit 1, Vol 2, Tab 17.6, Statement - Dep. Supt. S Devereux (26.04.22), para 2
[13] Exhibit 1, Vol 2, Tab 17.6, Statement - Dep. Supt. S Devereux (26.04.22), paras 7-8

Unit 1

10. Cells at Hakea are arranged in groups known as units, which are divided into wings. Unit 1 at Hakea is a multi-purpose/management unit that can hold a maximum of 52 prisoners in the following four wings:

a. *A-Wing*: houses a mix of prisoners including those with placement issues, protection status and/or mental health issues. It also holds prisoners referred to as "*sleepovers*" who are waiting to be housed in mainstream units;

b. *B-Wing*: houses prisoners on various confinement regimes (including basic and close supervision) who have been found guilty of committing prison offences;

c. *C-Wing*: houses longer term prisoners and those being investigated for prison offences; and

d. *D-Wing*: has a restraint cell, punishment cells, glass-fronted observation cells and "*safe cells*" containing no furniture or ligature points that are used to manage prisoners deemed to be at high risk of suicide or self-harm.[14]

11. At the relevant time, Callum was housed in cell A-11 on A-Wing on Unit 1. At the inquest, Dr Petch (Hakea's psychiatrist) described A Wing as "*a modern day dungeon*",[15] and in his statement had this to say:

> Unit 1 itself is a noisy, dirty, cramped, smelly, dimly lit, austere, acoustically difficult, unpleasant and non-therapeutic environment. It is stark. There are many people in a very confined space. There tends to be distress and loud vocalisations of distress and anger by the other prisoners in their observation cells, and the noise of other activities: prisoners being attended to, officers talking, prisoners conversing, doors being opened and shut with a bang. It can be difficult to hear. This is a far from ideal location to conduct evaluations. It is often not private. If anything is revealed, it can be used by other prisoners who overhear to taunt or humiliate later. Many prisoners are confined in their cells and cannot be allowed out, so vision of the person is impaired: interviews occur through the hatch.[16]

[14] Exhibit 1, Vol 2, Tab 17.53, Statement - Sen. Officer J Brown (20.05.20), paras 8-12 and ts 13.06.22 (Gibson), pp60-61
[15] ts 14.06.22 (Petch), p141
[16] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p13 and ts 14.06.22 (Petch), pp140-141

12. As I will explain, staff at Hakea had limited options in terms of accommodating Callum, mainly because of his profoundly maladaptive behaviours, violent mood swings and propensity to self-harm. Later in this finding, I will examine a proposal for an alternative to accommodate prisoners with complex needs like Callum, but for now I simply note what Officer Devereux said on this issue in his statement, namely:

> I do not feel that Unit 1 is the best kind of environment for the management of prisoners with mental health impairments. The restrictive nature of the regime and the environment often contributes to the prisoner's behaviour regressing further.[17]

At Risk Management System (ARMS)[18,19]

13. 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 (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.[20]

14. 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).[21]

15. When Callum was received at Hakea, he was placed on high ARMS and placed in the Crisis Care Unit following a recommendation by the reception officer, who conducted Callum's intake risk assessment. This recommendation was appropriate given Callum's antecedents and presenting issues.[22]

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[17] Exhibit 1, Vol 2, Tab 17.6, Statement - Dep. Supt. S Devereux (26.04.22), para 18
[18] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer A Van Blerk (07.07.20), paras 5-18 and ts 13.06.22 (Brown), p21
[19] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer I Gibson (27.06.20), paras 5-13
[20] Exhibit 2, ARMS Manual (2019), pp2-13
[21] Exhibit 2, ARMS Manual (2019), pp21-24
[22] Exhibit 1, Vol 2, Tab 17.5, ARMS reception intake assessment (04.09.19), pp5 & 7

16. 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]

17. On weekends at Hakea, the arrangements are slightly different. 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.[24]

18. In his statement, Officer Van Blerk, who chaired several PRAG meetings at which Callum was discussed, described his role as follows:

> As the PRAG chairperson I have the authorisation to change a prisoner's ARMS level, however, I rely on the professionals when making that determination. In the event that the committee does not agree on the best course of action, I err on the side of caution and leave the prisoner at the existing (ARMS) level.[25]

19. It seems obvious that the quality of PRAG's decisions will be enhanced when attendees have access to the best available information about the prisoner's recent presentation. I was therefore surprised to learn that feedback from custodial staff (who interact closely with the prisoner being discussed by the PRAG) is not always obtained. It seems that the practice of the relevant PRAG chair determines whether this occurs or not.[26] Given that mental health and counselling staff may often have only fleeting contact with the relevant prisoner, I **strongly** suggest that PRAG chairs be encouraged to proactively seek feedback from those custodial staff who have been supervising the prisoners being discussed.

[23] Exhibit 2, ARMS Manual (2019), pp16-18
[24] ts 13.06.22 (Gibson), pp48-49
[25] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer A Van Blerk (07.07.20), para 13
[26] ts 13.06.22 (Brown), pp19 & 21-24 and ts 13.06.22 (Bell), p38

20. Where it is felt that a prisoner being removed from ARMS requires ongoing support and monitoring, the PRAG may decide to place the prisoner on the Support and Management System (SAMS). A prisoner can remain on SAMS for an indefinite period depending on their needs and is subject to periodic monitoring and review. A prisoner need not have been placed on ARMS before being paced on SAMS. Callum was never placed on SAMS.[27,28]

The predictability of suicide

21. Dr Petch and Ms Barry (prison psychologist) both pointed out that suicide is extremely difficult to predict. That is because suicide is a rare event, and it is impossible to predict rare events with any degree of certainty. A complicating factor is that a person's suicidality can fluctuate, sometimes on a relatively short time frame.[29]

22. In 2017, the Department of Health published a document called: *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document). Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable.

23. The Document points out that clinicians (and here I would add prison officers) faced with the onerous task of assessing a person who may be suicidal confront two issues. Firstly, as noted, suicide is a rare event. Secondly, 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.[30] Further, as DOJ's ARMS manual relevantly 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.[31]

[27] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer A Van Blerk (07.07.20), paras 14-15
[28] Exhibit 2, ARMS Manual (2019), pp3, 9 & 24
[29] ts 14.06.22, (Barry), p126 and ts 14.06.22, (Petch), pp139-140
[30] DOH: Principles and Best Practice for the Care of People Who May Be Suicidal (2017), pp2-3
[31] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)

24. 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.[32]

25. Prison staff conducting suicide and self-harm risk assessments ask prisoners a series of questions using an online tool, designed to elicit information about factors tending to make it more likely the person will attempt suicide or self-harm (risk factors) and factors which make this less likely (protective factors).

26. At the inquest, Ms Barry noted that efforts had been made to enhance the risk assessments performed by PHS staff and that a more comprehensive assessment tool (based on the so-called Columbia Protocol) has been introduced. In addition to a prisoner's self-reported history (including previous self-harm or suicide attempts and/or ideation), reception officers look for signs that the prisoner is stressed or not coping.[33,34,35]

27. The reception officer must also consider whether the prisoner has any protective factors such as family support. Similar factors may be given different weight depending on the prisoner. Risk factors might include young/old age, childhood trauma and mental health issues whereas protective factors might include a supportive family and a future focus. An important risk factor is a history of self-harm and/or suicide attempts.

28. 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*".[36]

[32] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)
[33] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp13-14
[34] Exhibit 1, Vol 2, Tab 20, Annexure 1, Psychological Health Service Standardised Risk Assessment
[35] ts 14.06.22 (Barry), pp125-126
[36] Exhibit 2, ARMS Manual (2019), p32 (para 6.1)

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

> It is natural for those concerned with a self-inflicted death to ask themselves whether more could have been done to predict and prevent it. The burden of anxiety and guilt is made worse if critical judgements are made with the benefit of hindsight. It is all too easy to assume that suicide is preventable if certain techniques and procedures are followed.[37]

30. The ARMS Manual makes a good point with respect to who can ultimately prevent death by suicide when it 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.[38]

Adverse Childhood Events[39,40]

31. An aspect of risk assessment that has been given more emphasis in recent times is the pervasive impact of adverse childhood events (ACE). Examples of ACE include: family and domestic violence, sexual, emotional and/or physical abuse, neglect, loss of parents and/or other loved ones (including by incarceration), parents or significant others with mental health issues, and early exposure to polysubstance use.

32. People who experience ACE (especially multi-factor ACE) are 30 - 40 times more likely to take their own lives. There is also a strong link between ACE and the development of personality disorders, and an increased risk of incarceration. As I will outline later in this finding, Callum was exposed to significant levels of ACE and was identified as displaying the criteria for two personality disorders as well as being at chronic risk of self-harm. As a result of the ACE he was exposed to, he was also at increased risk of health and social problems.[41]

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[37] Exhibit 2, ARMS Manual (2019), p35 (para 7.2)
[38] Exhibit 2, ARMS Manual (2019), p36 (para 7.2)
[39] See: www.psychologytoday.com/au/basics/adverse-childhood-experiences and See also: 14.06.22 (Petch), pp144-145
[40] See: www.cdc.gov/injury/priority/index.html
[41] See for example: www.qxmd.com/calculate/calculator_715/adverse-childhood-experience-ace

Personality Disorders[42]

33. An individual's personality is defined as: "*A characteristic way of thinking, feeling, and behaving*", with personality embracing moods, attitudes, and opinions and being most clearly expressed in interactions with other people.[43] A person's personality is considered "*disordered*" when it differs:

> [M]arkedly from that expected in their cultures. People with personality disorders show lifelong, maladaptive responses to their environment, often associated with recurrent or persistent distress for those with the personality disorder and/or for others suffering from the consequences of their aberrant behaviour.[44]

34. Personality disorders are classified into "clusters" designated by the letters A, B and C. Cluster B includes antisocial personality disorder (ASPD) and borderline personality disorder, which are the two personality disorders most commonly seen in prisons. ASPD is thought to affect about 1 - 2% of the general community, but studies have suggested that as many as 1 in 2 males and 1 in 5 females in custody may satisfy the diagnostic criteria for ASPD.[45]

35. The features of ASPD include: a pervasive pattern of disregard for, and violation of, the rights of others, deceitfulness, irritability, aggression (including repeated physical fights), a reckless disregard for the safety of others, lack of empathy, impulsivity, irresponsibility and lack of remorse. As I will outline, Callum was thought to display characteristics of both borderline personality disorder and ASPD.

36. Those with ASPD generally have difficulty regulating their emotions, coping with stress and "getting on" with people. For these reasons, ASPD affects how they experience and interpret what is going on around them, and they often struggle within the prison environment. Part of the reason for the prevalence of ASPD amongst male prisoners appears to be the link between impulsivity, polysubstance use and criminal behaviour.

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[42] Therapeutic guidelines: Psychotropic, (Ver 7, 2013), Melbourne, pp197-203
[43] www.britannica.com/topic/personality
[44] Therapeutic guidelines: Psychotropic, (Ver 7, 2013), Melbourne, p197
[45] Therapeutic guidelines: Psychotropic, (Ver 7, 2013), Melbourne, pp198

37. Although medication may be useful in treating symptoms of distress caused by ASPD, the recommended treatment is therapy. However, to be successful, the active participation of the patient is required and a significant challenge is convincing a person with ASPD that they require treatment. Therapy aims to help the individual develop an understanding of themselves and, through cognitive or dialectic behavioural therapy, to change the way they think.[46,47]

38. Whilst the precise cause of ASPD is unknown, environmental factors are known to play a part and as noted, there is a link between ACE and the development of ASPD.[48] There is also a strong link between personality disorders, including ASPD, and an increased suicide risk. One study estimated that personality disorders were present in more than 33% of individuals who die by suicide and about 77% of individuals who make suicide attempts.[49]

39. The findings in this study are consistent with the ARMS manual which relevantly states:

> Specific increases in suicide risk have been associated with prisoners with a personality disorder in particular Borderline and Antisocial personality disorders, as well as Avoidant and Schizoid (withdrawal into the self) personality disorders. Suicide risk is also increased for individuals in this category by factors like family disagreement, financial problems, and other interpersonal conflicts or loss. Impulsivity may also increase suicide risk.[50]

40. However, despite the prevalence of APSD amongst the prison population, the practical reality is that the number of PHS and mental health staff available at Hakea means there is no possibility of providing any level of therapy for those with ASPD.

[46] Therapeutic guidelines: Psychotropic, (Ver 7, 2013), Melbourne, pp199-202
[47] See: www.everydayhealth.com/antisocial-personality-disorder/treatment/
[48] ts 14.06.22 (Barry), p121 and ts 14.06.22 (Petch), p141-142
[49] Pompili, M & others, Suicidality in Cluster B personality disorders, Ann Ist Super Sanità 2004, 40(4):475-483 at 475-6
[50] Exhibit 2, ARMS Manual (2019), p10 (para 2.1.2.4.4)

Specialist Psychological Service[51]

41. At the relevant time, the DOJ's Specialist Psychological Service (SPS) was supposed to provide consultation and advice to custodial staff to:

> [A]ssist them to manage prisoners who present as a management issue. This includes prisoners with mental health concerns, **behavioural issues**, and intellectual and/or cognitive issues which impact on their functioning. SPS also provides treatment services to prisoners under several broad categories: to address offending behaviour; to address management concerns; to life/indeterminate prisoners participating in a Re-Socialisation Program; for prisoners who were unable to attend group programs; and to address issues related to treatment readiness.[52]
>
> [Emphasis added]

42. In April 2019, the SPS structure consisted of a manager, three senior psychologists and six psychologists. However of these 10 full-time equivalent positions (FTE), only 1.6 FTE were actually filled. For that reason, although custodial staff could request an assessment of a prisoner they were concerned about, SPS were unable to respond to these requests with any degree of urgency because of very limited resources and a large backlog of cases.

43. In theory, following an assessment, SPS staff would develop a behavioural management plan which outlined the triggers for a prisoner's problematic behaviour and which suggested strategies to "*de-escalate*" the prisoner's behaviour.

44. In circumstances where a behavioural management plan was actually prepared, it would then be disseminated to all staff having contact with the prisoner and in theory at least, SPS staff would be "*available to consult staff on specific issues*".[53] Given the prevalence of ACE and ASPD within the prison population, it is appalling that the specialist psychological services available to custodial staff in April 2019 were as limited as they were. Regrettably, the situation in 2022 is no better.

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[51] Exhibit 3, Letter - Mr L Geddes, State Solicitor's Office (07.07.22), paras 2-15 and ts 14.06.22 (Barry), pp110-112
[52] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp17-18
[53] Exhibit 1, Vol 2, Tab 17.33, Email - Ms E Michelic to Ms C Emmerson (27.04.22)

45. Following a restructure, the SPS was abolished and absorbed into the Forensic Consultant Team, which is divided into the Forensic Psychological Assessment Team and the Forensic Psychological Intervention Team (Intervention Team). The Intervention Team has 17.3 FTE of which only 11 FTE are currently filled. As woeful as these numbers may be, the situation with respect to services addressing behavioural management is, as I will now explain, even worse.

46. The Intervention Team has three primary roles:

a. Working with offenders (predominantly in the community) to reduce recidivism rates;

b. Providing intervention to offenders in custody to address unmet treatment needs; and

c. Accepting referrals for intervention, including for behavioural management plans "*like that requested by A/Superintendent Devereux in April 2019*".[54]

47. The services referred to in paragraphs 46(a) and (b) are primarily directed towards prisoners with indeterminate sentences, or "*high risk sexual offenders*".[55] Further, because of limited resources, the Intervention Team cannot provide services on an immediate basis and prioritises those directed at recidivism and unmet treatment needs over the behavioural management services referred to in paragraph 46(c).

48. In relation to requests for assistance to manage behavioural issues:

> The Manager of the Forensic Psychological Intervention Team currently receives all such referrals and assesses if they are suitable for the service. If found suitable, the case will be placed on a waitlist. Referrals are then prioritised according to a number of factors. **The waitlist and prioritisation is necessary in circumstances where all existing staff carry a high case load and cannot respond immediately to new referrals.**[56] [Emphasis added]

[54] Exhibit 3, Letter - Mr L Geddes, State Solicitor's Office (07.07.22), para 11
[55] See: s7 of the *High Risk Serious Offenders Act 2020* (WA)
[56] Exhibit 3, Letter - Mr L Geddes, State Solicitor's Office (07.07.22), para 14

49. The approach of the Intervention Team with respect to behavioural issues is set out in a document entitled "*Forensic Psychological Intervention Team (FPIT)*". Frankly, the document makes depressing reading. Although the behavioural management services it describes are clearly attractive, there is limited scope to provide them, as the document itself makes clear. Under a section entitled "*Offenders with significant behavioural issues that are difficult to manage in custod*y", the following appears:

> This cohort of offender presents a significant challenge to custodial staff and treatment providers. For these offenders, the Manager or someone from the Team will consult with relevant parties to assess whether the offender is suitable for individual intervention. Where the offender has been largely unresponsive to mainstream interventions or management options - this may also mean that they are **unsuitable for individual psychological intervention**. For example:
>
> - ➢ significant mental health issues that are unmanaged
> - ➢ intellectual disability / cognitive impairment
> - ➢ antisocial personality features that include significant aggressive behaviours that compromise ability to engage in a meaningful way.
>
> If assessed to be unsuitable for individual intervention, the psychologist or Manager will provide consultation and advice as required. Behaviour modification strategies can be provided that may assist in the management of the offender. This will be in the form of a **Behaviour Management Plan** (BMP) and will be developed in consultation with the offender, relevant staff and treatment providers.
> Behaviour modification techniques can be used to decrease problem behaviour and also to promote positive behaviour. Behaviour modification focuses on changing behaviour through techniques such as positive reinforcement and teaching emotion regulation skills. Where the offender is assessed to be **suitable for individual intervention**, the psychologist who has been involved in the initial consultation process will provide the psychological service to the offender.
>
> [Original emphasis]
>
> **Note there is a high demand for service and the referral will be prioritised along with other referrals across the FPIT service area.**
>
> [Emphasis added][57]

[57] Exhibit 3, Attachment, Forensic Psychological Intervention Team (FPIT) (17.02.22), pp3-4

50. Section 7(1) of the *Prisons Act 1981* (WA) relevantly provides:

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

51. As I have pointed out in other inquests, the term "*welfare*" in section 7 takes its ordinary English meaning, namely: "*the health, happiness, and fortunes of a person or group*".[58] In addition to being responsible for the "*welfare*" of prisoners, the CEO must also ensure their "*safe custody*" and in my view, this reinforces the CEO's obligations with respect to prisoner welfare, and relevantly in this context, the management of seriously maladaptive behaviours.

52. I am at a loss to understand how the CEO can properly discharge these onerous statutory responsibilities when custodial staff have such limited access to specialist advice about the management of prisoners like Callum, who display such serious and self-destructive behaviours. In the absence of specialist psychological support, it is regrettable that custodial staff were left to manage Callum's behaviour by themselves.

53. As I will demonstrate later in this finding, SPS comprehensively failed to provide an appropriate level of assistance when Officer Devereux contacted them about the management of Callum's maladaptive behaviours in March 2019 and again in April 2019.[59,60,61,62]

[58] Compact Oxford English Dictionary (3rd Ed, 2005), p1179
[59] Exhibit 1, Vol 2, Tab 17.35, Behaviour and Risk Management Plan (12.12.17)
[60] Exhibit 1, Vol 2, Tab 17.34, Email - Dep. Supt. S Devereux to A/Manager SPS (16.04.19)
[61] Exhibit 1, Vol 2, Tab 17.34, Email - A/Manager SPS to Dep. Supt. S Devereux (17.04.19)
[62] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p11

CALLUM

Background[63,64,65,66,67,68]

54. Callum was born on 20 August 1992 and had four older siblings. As a young person, Callum enjoyed soccer and he was a talented graffiti artist, whose lettering in drawings was described by his sister as "*beautiful*". The evidence establishes that Callum experienced a troubled childhood that was characterised by significant ACE that placed him at increased risk of health and social problems. As Dr Petch relevantly notes in his report:

> [Callum] had a traumatic upbringing…one sibling died from a heroin overdose and another was an addict. His father was described as violent and abusive, and there was domestic violence at home, and some directed towards him. There was harsh and inconsistent parenting. Foster care at (age) 12 didn't last, and nor did staying with either parent (who had separated by that stage). He had a number of relationships and fathered 5 children with 4 partners.[69]

55. Callum began using cannabis in his early teens and much later, started using methylamphetamine and heroin. According to Dr Petch, alcohol dependency was also reported although Callum's sister told police "*prohibited drugs were more his thing*". When Callum was about 14-years of age, he was sent to Kalgoorlie to live with friends of his mother to "*try to get him back on the right track*" but he returned to Perth after about eight months to live with his father.

56. Callum described himself as "*extremely violent*", "*fearless*" and as having "*little respect for authority*". He had reportedly "*worked*" as a debt collector for an outlaw motorcycle gang and as a drug dealer, and he claimed to have been the occasional victim of violence himself.

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[63] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p9
[64] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p2
[65] Exhibit 1, Vol 1, Tab 2, Report - FC Const. N Arnold (28.09.19), pp3-5
[66] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), pp3-4
[67] Exhibit 1, Vol 1, Tab 8, Memo - FC Const. N Arnold - Conversation with Callum's sister (23.05.19)
[68] See for example: www.qxmd.com/calculate/calculator_715/adverse-childhood-experience-ace
[69] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p2

Offending and prison history[70,71,72]

57. Callum's extensive criminal history began when he was a juvenile. By the time of his last incarceration, he had accumulated a total of 127 convictions for offences including burglary, stealing, assault, criminal damage, and motor vehicle and drug-related offences. Callum served various periods of juvenile detention and received fines and community orders.

58. As an adult, Callum served several periods of imprisonment. In 2012 he was sentenced to a 2-year term; in 2013 he received a sentence of 6-months imprisonment and in 2017, he was imprisoned for 18-months. During these periods of incarceration, Callum was the subject of numerous alerts in the Total Offender Management System (TOMS), the computer system DOJ uses to manage prisoners in custody. These alerts related to self-harm risk, threatening behaviour towards prison staff and risks to and from other prisoners.

Overview of medical conditions[73,74,75]

59. Following Callum's death, a DOJ review of the health services he was provided in custody, summarised his medical conditions as follows:

> At the time of his most recent admission, his documented active medical history included polysubstance abuse and dependency, attention deficit disorder, drug induced psychosis in 2012, Cluster B personality disorder, Hepatitis C, left internal carotid artery dissection seen on MRI 2017, epilepsy/pseudo-seizures, and a history of deliberate self-harm.[76]

60. In 2017, Callum was being investigated for epilepsy at Sir Charles Gairdner Hospital (SCGH). He underwent an MRI scan that found a left internal carotid artery aneurysm/dissection, which was described in the DOJ health summary as "*an incidental finding of a minor vascular irregularity*".[77]

[70] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p9
[71] Exhibit 1, Vol 1, Tab 15, Criminal and traffic history (printed 04.02.22)
[72] Exhibit 1, Vol 2, Tab 17.45, Management and placement report (08.02.19), pp2-5
[73] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022)
[74] Exhibit 1, Vol 1, Tab 2, Report - FC Const. N Arnold (28.09.19), pp4-5
[75] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p2
[76] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p3
[77] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p21

61. Although repeat MRI scans were scheduled, Callum declined to attend an appointment on 18 January 2018 and thereafter, repeat scans were not performed. On 25 March 2019, arrangements were made for a MRI scan, but Callum died before this was performed. According to the DOJ health summary, "*There is no suggestion this* (i.e.: the lack of repeat MRI scans) *had any impact on his health or outcome*.[78]

62. Callum was regularly reviewed at prison medical centres by nurses and/or prison medical officers in relation to his seizure episodes, and on two occasions, he was transferred to hospital. During an admission to Fiona Stanley Hospital (FSH) in February 2018, Callum was prescribed topiramate, a medication used to manage epilepsy. However, although Callum was subsequently seen in the epilepsy clinic at SCGH, clinicians were unable to determine whether his seizures were due to epilepsy or had a psychogenic cause, meaning they originated in his mind.

63. In any event, Callum's topiramate was ceased following a visit to FSH, shortly after his admission to Hakea in September 2018. After a review by a neurologist on 13 February 2019, Callum's topiramate was restarted.

64. As the DOJ health summary points out, doubt around the true cause of Callum's seizures may have hindered a more aggressive pharmacological response. Further, although the fact that Callum's seizures co-occurred with a "*high frequency and severity*" of self-harming behaviour was suggestive of a psychogenic cause, the upshot was that:

> [T]he primary health care team were managing the physical consequences of his self-harm or seizures, the mental health nurses were assessing his immediate risk post each event and when in safe cells, the Prison Counselling Service were providing counselling…the hospital was addressing acute physical issues and the Neurologists were providing advice but it is unclear which clinician was taking responsibility for treating Callum's psychological/psychiatric distress or responding to the escalation of this.[79]

[78] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p22
[79] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p21

65. Dr Petch thought it was possible Callum's seizures may have had both a physical and a psychogenic component, and noted that Callum had a history of head trauma and skull fractures and on one occasion, had reportedly been hit in the head with an axe.

66. In terms of addressing his substance use issues, I note that Callum had participated in the methadone program between November 2012 and February 2015, but had declined to be involved during his incarceration in February 2016. Callum was started on the methadone program in July 2017, but his participation was suspended due to concerns he was over-sedated and his refusal to provide regular urine samples.

67. During his last period of imprisonment in 2018, Callum wrote a passionate letter asking for help in dealing with his polysubstance issues but was assessed as "*unsuitable*" for the methadone program at that time.[80]

68. In terms of the management of his physical health, the evidence establishes that although Callum often received a level of care that was commensurate with that offered in the general community, there were gaps in his care, such as the reassessment of his aortic aneurysm and a firm diagnosis in relation to his seizure episodes.

Overview of mental health conditions[81,82,83]

69. Although Callum was seen by numerous mental health practitioners, he was never diagnosed with a major mental illness and although he had been diagnosed with attention deficit hyperactivity disorder, the origin of that diagnosis is unclear.

70. Dr Petch explained that in psychiatry a distinction is often drawn between a "*mental illness*" and a "*mental disorder*". Whereas a mental illness describes a chemical imbalance caused by disease (e.g.: depression), a mental disorder refers to a set of problems that cause the person, or those around them, distress (e.g.: personality disorders).

[80] See also: Exhibit 1, Vol 1, Tab 12, Letter - Mr C Mitchell (17.12.18)
[81] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), pp3-4 and ts 14.06.22 (Petch), pp134-137
[82] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp4-9
[83] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), pp5-6 & 19-21

71. As a result of ACE, Callum was thought to have developed "*emotionally unstable personality disorder of the borderline type*" (BPD), characteristics of which include impulsivity, recurrent suicidal gestures, self-mutilating behaviour and mood disturbances. Callum displayed all of these characteristics, often on a daily basis, and as Dr Petch noted:

> In custody (Callum) continued to present with multiple episodes of mood instability, almost on a daily basis, with extremes of seemingly unregulated temper. His mood was out of his control: one minute he could talk quietly to staff and be free of suicidal ideation and ideas of self-harm, the next be completely different. His moods could change rapidly, and he appeared that he could become disengaged, hostile, aroused, abusive, threatening, resentful, very impulsive, violent, self-harming or suicidal very quickly, all without provocation. Any provocation also prompted these responses. Sometimes after these episodes he tried to explain his behaviour, for example: '*I was trying to get a single cell*'…. '*I did it for a laugh*'.[84]

72. Dr Petch did not consider that BPD explained some of Callum's more "*pro-criminal attitudes*" and said it was probable that Callum satisfied some criteria for anti-social personality disorder (ASPD) as well. Those criteria included: failing to obey laws/ norms, impulsive behaviour, irritability, aggression, blatant disregard for the safety of others, and a pattern of irresponsibility. Dr Petch said that Callum's personality disorders were severe and caused him significant impairment and distress. However, as the DOJ Health summary noted:

> Despite the frequent input from mental health nurses and the intensity, frequency and severity of Callum's behaviour, self-harm and suicide attempts he was not assessed in person by a psychiatrist during the 7 months of his last period in custody other than via the hatch of his cell on 8th November 2018, which did result in a one week script of olanzapine and diazepam. Multiple notes by mental health nurses and notes made from mental health team meetings indicate an assessment that Callum did not have a "major mental illness" and did not qualify for treatment under the mental health team.[85]

[84] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p3
[85] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p21 and ts 14.06.22 (Rowland), pp168-169

ISSUES RELATING TO CALLUM'S INCARCERATION

Self-harm incidents in custody[86,87,88,89,90,91,92,93,94,95]

73. Callum had a well-documented and long-standing history of self-harm, and many of his self-inflicted injuries were serious. On one occasion he was admitted to an intensive care unit after severing his femoral artery. He also developed a collapsed lung after stabbing himself in the chest and he had once lit a fire that caused burns to 8% of his body.

74. Callum's propensity for self-harm was well known to prison authorities and this behaviour continued during his final period of incarceration. Callum was seen at the prison medical centre on numerous occasions in relation to self-harm including banging his head against prison walls, jumping off a toilet bowl to deliberately smash his wrist against a light fitting, punching the walls and ceiling of his cell, and cutting himself with sharp objects such as broken glass.

75. Callum made repeated threats to staff and on multiple occasions he used his fingers and/or sharp objects to reopen self-inflicted wounds and/or remove stitches. Callum was also seen in the medical centre on 13 November 2018, 29 January 2019 and 21 March 2019, following attempts to hang or strangle himself.

76. Several officers who knew Callum expressed the opinion that he often attempted self-harm at times when he knew "*officers would be around to rescue him*" or that he used the emergency call button in his cell to make a cell call before self-harming. Further, on multiple occasions Callum was recorded to have threatened self-harm if he was not moved to the unit he wanted. At the inquest, I expressed concern that Callum's behaviour might be viewed as "*manipulative*", thereby diminishing its significance.

[86] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp12-18
[87] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), pp19-20
[88] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp7-9
[89] Exhibit 1, Vol 2, Tab 17.8-13, 17.15-21 & 17.24-31, PRAG Minutes and Incident Reports (various dates 2018-2019)
[90] Exhibit 1, Vol 1, Tab 10, Statement - Officer K Howley (21.04.19), paras 7-13
[91] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer R Kaye (28.12.20), para 14
[92] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer D Weston (28.02.22), para 8
[93] Exhibit 1, Vol 2, Tab 17.34, Email - Officer S Devereux to Specialist Psychological Services (16.04.19)
[94] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer I Gibson (27.06.20), para 15
[95] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer A Van Blerk (07.07.20), paras 21-24

77. Interestingly, the DOJ's Mental Health Alcohol and Other Drugs (MHAOD) Summary relevantly observed:

> Overall staff found that (Callum's) behaviour was unpredictable and impulsive and could only be managed according to current presentation, it was also documented that he used self-harm instrumentally, for example to achieve a specific move or placement, making his management highly complex.[96]

78. However, as the ARMS manual eloquently points out:

> Elsewhere it has been stressed that the terms "manipulative" and "attention-seeking" are not appropriate labels to apply to a prisoner threatening or at risk of suicide or self-harm. However, there remains a commonly held belief that there are some prisoners whose suicidal threats or even actions seem to be a deliberate attempt to force a change in circumstances (e.g.: to change a transfer allocation).[97]

79. It may be true that some prisoners use self-harm to obtain specific outcomes (such as transfer to a different unit) and in Callum's case, there is evidence he "*felt egged on by people to do certain things at certain times*".[98] In truth however, such behaviours are more often than not maladaptive ways of dealing with emotional distress. At the inquest, Ms Barry said it was important to try and identify the motivations behind the prisoner's behaviour[99] and as the ARMS Manual notes:

> In order to understand this sort of behaviour and respond professionally rather than dismissively, it is helpful to think of suicidal words or actions as having either or both of 2 motivations: to escape or to communicate…Those who find it difficult to communicate effectively, or who feel they are in a situation where no-one is prepared to listen to them, can end up using drastic and desperate means to get their message across. Our response to such people should not be to dismiss them as manipulative, but to encourage them to communicate in more appropriate ways and to reward a change in style on their part by ensuring we are listening.[100]

[96] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p4
[97] Exhibit 2, ARMS Manual 2019, p29, para 4.4.14
[98] ts 14.06.22 (Barry), pp131-132
[99] ts 14.06.22 (Barry), pp131-133
[100] Exhibit 2, ARMS Manual 2019, p29, para 4.4.14

80. Callum variously identified his mother, his children and/or his placement in Unit 1 as protective factors. However, at other times, Callum felt no one cared about him and would say he had no family supports. He was also noted to have been distressed on occasions when his phone calls to his family were not answered and/or when his letters were returned unopened.[101,102,103]

81. Callum's self-harming behaviour was managed by placing him on ARMS at various levels for various periods of time. Notably, between January 2019 and April 2019, Callum was involved in 55 self-harm and/or behavioural incidents, including:[104,105,106,107]

a. *10.01.19*: writing a suicide note and attempting to hang himself using torn clothing;[108]

b. *24.02.19*: "*hacking*" at an open leg wound in his cell;[109]

c. *02.03.19*: damaging his cell by setting fire to it;[110]

d. *09.03.19*: lacerating his chest with a broken piece of ceramic;[111]

e. *11.03.19*: tampering with a self-inflicted chest wound;[112]

f. *21.03.19*: attempted to strangle himself;[113]

g. *29.03.19*: cutting his left arm using broken pieces of ceramic;[114]

h. *08.04.19*: ingesting the contents of a gel ice pack;[115]

i. *11.04.19*: cutting his leg using broken glass;[116,117,118] and

j. *15.04.19*: using broken porcelain to re-open wounds on his leg.[119]

[101] See for example: Exhibit 1, Vol 2, Tab 17.58, PHS ARMS - File Note (15.04.19)
[102] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp24 & 27
[103] See also: Exhibit 1, Vol 2, Tab 17.54, Statement - Ms C Sorensen (28.04.22), paras 10 & 22
[104] Exhibit 1, Vol 1, Tab 9.1, Statement - Officer J Brown (21.04.19), paras 11-15
[105] Exhibit 1, Vol 1, Tab 10, Statement - Officer J Howley (21.04.19), paras 7-13
[106] Exhibit 1, Vol 2, Tab 17.34, Email - Officer S Devereux to Specialist Psychological Services (16.04.19)
[107] Exhibit 1, Vol 2, Tab 17.50, Alerts history - Offender
[108] Exhibit 1, Vol 2, Tab 17.18, Incident Report Minutes (10.01.19) & Tab 17.57, PHS Consultation - File Note (10.01.19)
[109] Exhibit 1, Vol 2, Tab 17.21, Incident Description Report (24.02.19)
[110] Exhibit 1, Vol 2, Tab 17.26, Incident Description Reports (02.03.19) & Tab 17.57, PHS Consultation - File Note (02.03.19)
[111] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p16
[112] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p16
[113] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p16
[114] Exhibit 1, Vol 2, Tab 17.30, Incident Description Reports (29.03.19)
[115] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p17
[116] Exhibit 1, Vol 2, Tab 17.31, PRAG Minutes (12.04.19)
[117] Exhibit 1, Vol 1, Tab 14. 2, Fiona Stanley Hospital - Discharge summary (12.04.19)
[118] Exhibit 1, Vol 2, Tab 17.51, Critical Incident Notification relating to an incident on 11.04.19 (12.04.19)
[119] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p17

Circumstances of Callum's last incarceration[120,121,122,123]

82. On 2 September 2018, Callum attempted to rob a supermarket in Como whilst armed with a multi-tool. He was arrested and subsequently remanded in custody. In the District Court at Perth on 1 February 2019, Callum was sentenced to 15 months' imprisonment with his sentence backdated to 2 September 2018. His earliest eligibility date for parole was calculated to be 17 April 2019.[124]

83. When Callum was received at Hakea on 3 September 2018, he underwent an intake risk assessment designed to identify prisoners at risk of self-harm or suicide and whether the prisoner should be placed on ARMS. Callum said he had no family support and did not expect to receive visits. He also disclosed a history of self-harm and suicide attempts and said that he was withdrawing from heroin.

84. The reception officer considered Callum was a self-harm risk and recommended he be placed in a safe cell on "*high*" ARMS, observing that:

> Prisoner has a history of (self-harm) over his time in prison. Police report states (self-harm) history. Prisoner has started to (self-harm) in holding cell 2 in reception by way of hitting his head on the back cell wall.[125]

85. During 2018 and 2019, Callum committed numerous prison offences including damaging his cell, assaulting other prisoners and threatening behaviour. He also assaulted prison officers by spitting, throwing hot water at an officer and trying to grab another officer by the throat. Sanctions for these offences included a loss of privileges and Callum also received 11 periods of close confinement including two periods of 14-days in both October 2018 and March 2019, for setting fire to his cell.[126]

[120] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p10
[121] Exhibit 1, Vol 2, Tab 17.5, ARMS reception intake assessment (04.09.19)
[122] Exhibit 1, Vol 1, Tab 15, Criminal and traffic history (printed 04.02.22)
[123] Exhibit 1, Vol 2, Tab 17.44, Close Confinement Regime Rules (various dates between 2018-2019)
[124] Exhibit 1, Vol 1, Tab 16, Transcript of proceedings before Bowden DCJ in the District Court of WA (01.02.19)
[125] Exhibit 1, Vol 2, Tab 17.5, ARMS reception intake assessment (04.09.19), p7
[126] Exhibit 1, Vol 2, Tab 17.44, Close Confinement Regime Rules (02.03.19 & 08.04.19)

86. Although Callum was eligible for parole on 17 April 2019, a parole review report dated 15 February 2019 recommended parole be denied due to his poor prison behaviour; the fact he had an outstanding criminal charge relating to criminal damage of his cell; his lack of a suitable plan in relation to employment and/or accommodation; and his entrenched offending behaviour.

87. During his last period of incarceration, Callum wrote 25 letters to family and friends and made 210 phone calls, although only 62 of these were "*successfully completed*". Callum received no social visits and except for two periods in September 2018 and April 2019 when he worked as a unit cleaner, he was not engaged in prison employment.[127,128]

88. Staff at Hakea were very well aware of Callum's challenging and difficult behaviour, and supported the idea of transferring him to Casuarina, with a possible placement in the Special Handling Unit (SHU). On 12 April 2019, a senior prison officer emailed Officer Devereux recommending Callum be transferred to Casuarina and then to the SHU, "*as a priority*".[129]

89. For his part, Officer Devereux actively pursued transfers to Casuarina and Albany Regional Prison, but encountered considerable resistance from the senior management teams at both facilities, ostensibly because Callum was the subject of numerous alerts on TOMS.[130]

90. In passing I note that the SHU at Casuarina is used to manage prisoners who pose a major threat to the prison system. Applications to place a prisoner in the SHU must address strict criteria and prisoners placed there are the subject of a management plan. Prisoners in the SHU are visited weekly by senior prison staff and placements are monitored by a committee. Although placing Callum in the SHU would have been a significant change to his usual placements, it was clear that Hakea did not have the resources to effectively and safely manage him.[131,132]

[127] Exhibit 1, Vol 2, Tab 17.47, Prisoner mail - Offender & Exhibit 1, Vol 2, Tab 17.48, Work history - Offender
[128] Exhibit 1, Vol 2, Tab 17.49, Prisoner Telephone records
[129] Exhibit 1, Vol 2, Tab 17.51, Email to Dep. Supt. S Devereux (12.04.19) and ts 13.06.22 (Devereux), pp73-75
[130] Exhibit 1, Vol 2, Tab 17.34, Email - Dep. Supt. S Devereux to A/Manager SPS (16.04.19)
[131] Inquest into five deaths at Casuarina Prison Ref: 14/19, (22.05.19), paras 28-32
[132] Office of the Inspector of Custodial Services - Inspection of Casuarina Prison (No. 129, March 2020), pp17-19

91. In addition to trying to transfer Callum to Casuarina, Officer Devereux contacted the SPS in early March 2019, seeking guidance on how to better manage Callum's challenging behaviours. After hearing nothing, Officer Devereux contacted SPS again in early April 2019, and finally, in desperation, he sent the following email to SPS on 16 April 2019:[133]

> Last week we spoke about (Callum). I note he is a sentenced prisoner with outstanding court following an incident at Hakea, where he has charges related to damage from a fire in his cell. He has 55 incidents reported in TOMS since January 2019 and a history of self-harm. This prisoner was referred to SPS by Hakea in early March 2019, we were seeking assistance in how to best manage him.
>
> It appears SPS is lacking resources.
>
> (Callum) is not progressing, he is in poor physical condition and has obvious Personality Disorder issues. I think we should look at preparing a (Special Handling Unit) application for consideration. He is sentenced and has been managed at Hakea since 4/09/18. He has a high level of needs and requires particular attention which is not available here at Hakea. He is currently on High ARMS and he was involved in another incident of self-harm last night.[134]

92. On 17 April 2019, the Acting Manager of SPS responded as follows:

> I do apologise, we are experiencing a bit of a backlog of ongoing interventions and statutory assessments at present which has limited our ability to respond in a timely manner to requests for behaviour management assessments. (Callum) has previously been assessed by SPS, in the context of behaviours that appear broadly similar to what you are experiencing at Hakea now (he was at Casuarina at the time).
>
> I have attached that assessment and the resulting behaviour management plan as I thought that may be of some assistance to you. If you would like us to go ahead with an updated assessment he can remain on the list and we (will) get to him as soon as we can.[135]

[133] ts 13.06.22 (Devereux), pp80-84
[134] Exhibit 1, Vol 2, Tab 17.34, Email - Dep. Supt. S Devereux to A/Manager SPS (16.04.19)
[135] Exhibit 1, Vol 2, Tab 17.34, Email - A/Manager SPS to Dep. Supt. S Devereux (17.04.19)

93. The behaviour management plan (the Plan) forwarded to Officer Devereux by SPS had been prepared when Callum was incarcerated at Casuarina in December 2017. The Plan's stated aim was to reduce the frequency of Callum's self-harming behaviours and it identified a number of "*triggers*" for his behaviour. Although the Plan may have seemed superficially pertinent, some of the identified triggers were not relevant to Callum's placement at Hakea.

94. For example, one of the identified triggers in the Plan was "*interpersonal conflicts with certain prisoners*" and included a reference to a prisoner in the Crisis Care Unit (CCU) at Casuarina who repeatedly made Callum feel uncomfortable by "*invading his personal space and touching his face with dirty hands*". Another identified trigger in the Plan was "*perceived mistreatment by staff*", although there is no evidence that Callum was experiencing any such concerns whilst he was incarcerated at Hakea.[136]

95. By way of an email dated 27 April 2022, Ms Toni Palmer (senor review officer with the DOJ) received the following response to concerns she had raised about the SPS response to Officer Devereux's plea for help:

> Due to resource constraints, SPS did not have the capacity to respond to the custodial referral with a second assessment. Given that the issues identified in the referral were broadly similar to the issues previously identified, SPS provided a previously completed Behaviour Management Report that contained triggers for Mr Mitchell's behaviour and some suggestions to manage these.[137]

96. Whilst the identified triggers and suggested management strategies outlined in the Plan may well have been appropriate in December 2017, in the absence of an updated assessment it was unreasonable and risky to assume that the same triggers were operative in April 2019 and/or that the strategies suggested in the Plan would necessarily be beneficial.[138]

[136] Exhibit 1, Vol 2, Tab 17.35, Behaviour and Risk Management Plan (12.12.17)
[137] Exhibit 1, Vol 2, Tab 17.33, Email - Ms E Michelic to Ms C Emmerson (27.04.22)
[138] See also: ts 14.06.22 (Barry), pp118-120

97. I accept that at the relevant time, SPS were experiencing severe staff shortages and were no doubt doing their best to respond to the various requests they were receiving for their services. Nevertheless, in my view, in the absence of any detailed appreciation of Callum's current behaviour it was completely unacceptable, and indeed potentially dangerous to respond to Officer Devereux's very genuine plea for assistance by simply forwarding a plan prepared in 2017.[139]

Observations of Callum in the days before his death[140,141,142]

98. I have already outlined Callum's self-harming behaviour in April 2019, which included ingesting gel from an ice pack, cutting his legs using broken glass and reopening sutured wounds. In addition to these incidents, on 3 April 2019, which was the day after Callum was advised his parole application had been denied, he reportedly had a seizure and sustained a cut to his left eyebrow.

99. During the period 4 - 17 April 2019, Callum remained on ARMS at various levels. When he was seen by a Prison Counselling Service (PCS) counsellor for the purposes of a PRAG review on 4 April 2019, Callum denied his recent injuries were due to self-harm and strongly denied any suicidal ideation. He expressed safety concerns with respect to his placement on Unit 4, said he was concerned about how other prisoners would view the fact that he was on ARMS.

100. On 9 April 2019, Callum presented to PHS. He denied his ingestion of gel from an ice pack the previous day was a self-harm attempt and said he had done it "*for a laugh*". By 11 April 2019, Callum was back in Unit 1 and after he used broken glass to cut his leg, he was taken to FSH where his wounds were cleaned and sutured. On his return to Hakea, Callum was placed in a safe cell on high ARMS. When seen by a mental health nurse on 12 April 2019, Callum was described as "*calm*" and was reduced to moderate ARMS and referred to the SPS.[143,144]

[139] Exhibit 1, Vol 2, Tab 17.35, Behaviour and Risk Management Plan (12.12.17), p2
[140] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp14-18
[141] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp9-10
[142] Exhibit 1, Vol 2, Tab 23, Health Summary (10.06.22), pp17-19
[143] Exhibit 1, Vol 1, Tab 14.2, Fiona Stanley Hospital - Discharge summary (12.04.19)
[144] Exhibit 1, Vol 2, Tab 17.51, Critical Incident Notification relating to an incident on 11.04.19 (12.04.19)

101. On 15 April 2019, after Callum had reopened the wounds on his leg, he was elevated to high ARMS and placed in a safe cell. The following day, he was reportedly in "*good spirits*" and denied further thoughts of self-harm. Callum was subsequently removed from the safe cell and placed back in Unit 1 and when seen by a mental health nurse on 16 April 2019, he Callum emphatically denied any intent to self-harm and said he was not suicidal. Callum was, however, unable to identify any trigger for his behaviour.[145,146]

Reduction in ARMS - 17 April 2019[147,148,149,150]

102. On 17 April 2019, the senior management team at Hakea asked Officer Gibson (who was rostered as principal officer) to chair the PRAG meeting in the safe cells that morning. At the time, Callum was on high ARMS and was housed in a safe cell on Unit 1. Prisoners on high ARMS were reviewed daily and as this PRAG meeting was being held on the weekend, it was attended by a mental health nurse, a PCS counsellor, and the unit manager (Officer Phillips). Callum was brought before the PRAG team and when asked, said he had no self-harm or suicidal ideation.

103. Officer Gibson said the PRAG team had no concerns about Callum and asked him where he wanted to be placed. Callum said he wanted to stay on Unit 1 for "*some time out*" and Officer Phillips told the meeting that Callum could be accommodated on A-Wing. The PRAG minutes state:

> No change to presentation, he continues to be tired and subdued. He denied any thoughts of DSH/SI (deliberate self-harm or suicidal ideation). Stated he does not want to go back to mainstream as he knows he will end up fighting. He cannot provide an explanation as to why he continues with the demonstrative behaviours other than saying he is sick of prison and surrounded by other prisoners.[151]

[145] Exhibit 1, Vol 1, Tab 14.2, Fiona Stanley Hospital - Discharge summary (12.04.19)
[146] Exhibit 1, Vol 2, Tab 17.51, Critical Incident Notification relating to an incident on 11.04.19 (12.04.19)
[147] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer I Gibson (27.06.20), paras14-25 and ts 13.06.22 (Gibson), pp50-57
[148] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p17
[149] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p9
[150] Exhibit 1, Vol 2, Tab 23, Health Services Summary (June 2022), p18
[151] Exhibit 1, Vol 2, Tab 17.31, PRAG Minutes (17.04.19)

104. Callum's request to be moved out of the safe cell and into A-Wing was seen as a positive development by the PRAG team, and as he did not present "*as being at chronic risk*" he was reduced to moderate ARMS. This meant that when he was moved out of the safe cell and placed on A-Wing, he would subject to two-hourly checks and reviewed again in three days. In his statement, Officer Gibson said that when considering a prisoner's ARMS status, the PRAG team considers the prisoner's history and a range of factors including:

> [A] strong focus on how (the prisoner) is presenting at the time of the meeting, officers, mental health/PCS reports, compliance with medication and other interventions.[152,153]

105. At the inquest, Dr Petch was asked about the appropriateness of the PRAG team's decision on 17 April 2019, to reduce Callum to moderate ARMS and his response was:

> I think it was a reasonable decision to have made…with the information they had available, and it didn't seem, from what I read anyway, that his actual risk on the day when he took his own life was any higher than it had been on any other day.[154]

106. In my view, it is difficult to impugn PRAG's decision to move Callum out of a safe cell and place him on moderate ARMS. Callum's mental state appeared settled and he denied self-harm or suicidal ideation. He had also asked to be moved out of the austere environment of the safe cell, which was properly considered as a positive development.

107. However, for reasons which I will now explain, it is my view that to the extent that the PRAG team was comforted by the fact that Callum would be checked every two hours once he had been moved to A-Wing, that comfort was misplaced. At its heart, the ARMS system relies on prison staff having regular interactions with prisoners and making observations of those prisoners under various ARMS observation regimes.

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[152] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer I Gibson (27.06.20), para 25
[153] See also: ts 13.06.22 (Gibson), pp56-57
[154] ts 14.06.22 (Petch), pp138, 139 & 144-145, see also: Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), pp13-16

108. In terms of what is expected from the staff making those 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.[155]

109. Prisoners on moderate ARMS are not considered to be actively suicidal but are still assessed as being 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*".[156]

110. At the time he was placed on moderate ARMS, Callum was housed on A-Wing. The two prison officers allocated to supervise prisoners on A - Wing and B-Wing were obliged to spend the majority of their time on B-Wing. That is because prisoners on B-Wing were subject to various confinement regimes and needed to be let in and out of their cells for various reasons.

111. For that reason, it was impossible for these officers to conduct any meaningful observations of prisoners on ARMS regimes on A-Wing, including Callum. In those circumstances, the ARMS observations were little more than a check that the relevant prisoner was physically present on the unit and were not in any sense "*supportive contacts*".[157,158]

112. At the inquest I asked Officer Bell (who was on duty in A and B-Wings at the relevant time) how realistic it was to expect him and his colleague to check on Callum when they had 15 prisoners in B-Wing that had to be let in and out of their cells. Officer Bell's unsurprising response was "*It wasn't very practical*". Officer Bell also agreed that additional staff would have been of enormous benefit in terms of managing his responsibilities on B-Wing whilst at same time trying to carry out meaningful ARMS checks on prisoners in A-Wing.[159]

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[155] Exhibit 2, ARMS Manual (2019), p25 (para 4.4.2)
[156] Exhibit 2, ARMS Manual (2019), p25 (Table 4)
[157] ts 13.06.22 (Bell), pp28-29 & 39 & 44-45 and ts 13.06.22 (Brown), pp15-17
[158] See also: ts 13.06.22 (Gibson), pp60-61 & 66-68 and ts 14.06.22 (Barry), pp124-126
[159] ts 13.06.22 (Bell), p39

113. As it happens, the two ARMS observations in the period immediately prior to Callum's death were incorrectly recorded. One of the observations that was entered into the supervision log is timed at 1.19 pm, when Callum was out of A-Wing at the medical centre getting his medication. The other entry is timed 3.15 pm, which was about 75 minutes after Callum had been secured in his cell.[160]

114. Clearly the integrity of the ARMS system relies on observations being conducted in accordance with the prescribed regime and being accurately entered into the supervision log. In this case, the officer responsible for making entries in respect to Callum was located in the control room on Unit 1. As such, he was not making the ARMS observations himself but was instead recording what he had been told by the officers in Unit 1 who had conducted the observations.

115. It appears that because of competing priorities, the control room officer entered Callum's last two ARMS observations some considerable time after they had actually been made. In his statement, the officer says with the benefit of hindsight, he should have either backdated the entries or made it clear in the supervision log that the entries were being made retrospectively.[161]

116. The current procedure now requires a note to be made in the supervision log whenever a late entry is made, and email broadcasts were sent to staff on 21 August 2020 and again on 2 August 2021, reminding them of the importance of making accurate entries about ARMS observations.[162]

[160] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer D Weston (28.02.22), paras 7-24
[161] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer D Weston (28.02.22), paras 19 & 21
[162] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p21 and ts 14.06.22 (Palmer), pp155-158

THE EVENTS OF 21 APRIL 2019

Medications and a strip search[163,164,165,166,167,168,169,170]

117. On the day of his death, Callum was housed in cell A11, a 3-point minimised cell on A-Wing in Unit 1. After the morning unlock, Callum was seen moving around A-Wing and interacting with other prisoners. As noted, at the time, he was on moderate ARMS, meaning he was supposedly subject to two-hourly observations.

118. At some point in the morning, two prisoners approached Officer Bell and told him that Callum had experienced "*a fit*" the night before and they had heard him "*bouncing around*" in his cell. Officer Bell went to Callum's cell and spoke with him. Callum said his leg was "*really sore*" and Officer Bell told Callum he would arrange for him to attend the medical centre.

119. At about 11.00 am, Callum was served lunch and whilst he was locked in his cell, he pressed the emergency call button in his cell and asked when he could go the medical centre to get his medication. Although Callum was told this would occur at 12.45 pm, he made a further cell call at 12.44 pm asking the same question. Moments later, Officer Brown gave Callum a pass authorising him to make his own way to the medical centre to obtain his medication and Callum left Unit 1 for that purpose.

120. When Callum finished at the medical centre, he was supposed to return directly to Unit 1. Instead of doing so, Callum went to an enclosed yard adjacent to the gate leading to Unit 1, where he spoke to a prisoner from Unit 3. Although this was a restricted area, Callum remained in the yard for about 20-minutes, apparently unnoticed. At about 2.00 pm, Officer Brown was alerted to the fact that Callum was "*milling around*" in the yard and he and another officer, Officer Brock, went to check.

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[163] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp18-19
[164] Exhibit 1, Vol 1, Tab 9.1, Statement - Officer J Brown (21.04.19), paras 16-48 and ts 13.06.22 (Brown), pp10-13 & 19-20
[165] Exhibit 1, Vol 1, Tab 9.2, Incident Description Report - Officer J Brown (21.04.19)
[166] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer J Brown (20.05.20), paras 14-26
[167] Exhibit 1, Vol 2, Tab 21, Statement - Officer N Bell (22.04.22), paras 12-23 and ts 13.06.22 (Bell), pp30-32 & 43-44
[168] Exhibit 1, Vol 1, Tab 10, Statement - Officer J Howley (21.04.19), paras 7 & 18-21
[169] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer R Kaye (28.12.20), paras 16-21
[170] Exhibit 1, Vol 2, Tab 18, Statement - Officer S Hildred (11.05.22), paras 11-26

121. When the officers got to the yard, they saw Callum speaking to a prisoner from Unit 3 through the yard fence. Officer Brown called out to Callum and told him to come over, but Callum seemed reluctant to do so and continued speaking with the prisoner. Officer Brown called out again before he and Officer Brock started moving towards Callum, who eventually went over to the officers.

122. Because Callum had been found in a restricted area and had seemed reluctant to come when called, Officer Brown became suspicious and decided to conduct a strip-search to ensure Callum was not in possession of contraband. As Callum was accompanied back to his cell, Officer Brown told him he would be strip-searched because of his behaviour. Officers Brock and Kaye accompanied Officer Brown to Callum's cell to assist with the search.

123. As Officer Brown entered his cell, Callum's radio and TV were blaring and Officer Brown turned both off at the wall so he would have Callum's full attention during the strip-search. Officer Brown says Callum smiled and jokingly remarked: "*I wish you didn't turn my radio off at the wall, it's going to take me ages to reset the time*".

124. Callum was permitted to sit on his bed as he removed his clothing for the search because the wounds on his legs were painful. Officer Brown says Callum was compliant during the search, which found nothing untoward. Officer Brown said he had no concerns for Callum's welfare noting: "*I had a bit of a laugh with (Callum) and thanked him for being compliant*".[171]

125. In passing, I note with concern the fact that Callum was able to remain in a restricted area for 20 minutes. In my view, this is a clear demonstration that A-Wing prisoners were not under effective supervision at the relevant time for the reasons I have outlined.

[171] Exhibit 1, Vol 1, Tab 9.1, Statement - Officer J Brown (21.04.19), paras 44 & 46

Code Red and CPR[172,173,174,175,176177,178,179,180,181]

126. At about 4.15 pm, Officers Howley and Bell started "*dish up*" on A-Wing, meaning they were serving dinner to prisoners in their cells. When they got to Callum's cell, Officer Bell asked his colleague if he had seen Callum and Officer Howley said he hadn't seen him since Callum's earlier medical centre appointment.

127. At 4.20 pm, Officer Bell unlocked Callum's cell and he and Officer Howley saw Callum slumped against the left-hand side wall of the cell, next to the sink. Callum was unresponsive and had white strips of material around his neck that were tied to the sink's single tap.

128. Officer Bell used his radio to call a Code Red Medical Emergency as Officer Howley entered the cell and used his Hoffman knife[182] to cut the ligature from around the tap. In response to the Code Red, other prison staff converged on A-Wing, including Officers Brown and Kaye and Nurse Cahill.

129. Officers Kaye and Bell started CPR under direction from Nurse Cahill and Callum was subsequently removed from his cell and placed in an adjacent hallway area where there was more room. Officer Brown ran to the control room and grabbed an Air Viva and on his return, helped apply defibrillator pads to Callum's chest.

130. As the officers waited for an ambulance to arrive, they took turns performing CPR. There is no evidence that their efforts in this regard were anything other than efficient and appropriate. The defibrillator attached to Callum's chest did not advise a shock should be administered and it appears that at all relevant times, Callum' heart was in asystole.[183]

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[172] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp18-20
[173] Exhibit 1, Vol 1, Tab 9.1, Statement - Officer J Brown (21.04.19), paras 50-60 and ts 13.06.22 (Brown), pp13-15
[174] Exhibit 1, Vol 1, Tab 9.2, Incident Description Report - Officer J Brown (21.04.19)
[175] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer J Brown (20.05.20), paras 27-42
[176] Exhibit 1, Vol 2, Tab 21, Statement - Officer N Bell (22.04.22), paras 24-34 and ts 13.06.22 (Bell), pp33-35
[177] Exhibit 1, Vol 1, Tab 10, Statement - Officer J Howley (21.04.19), paras 21-41
[178] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer R Kaye (28.12.20), paras 22-33
[179] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer K Howley (17.12.20), paras 22-41
[180] Exhibit 1, Vol 1, Tab 13, SJA Patient Care Records: Crew MEL21D2; Crew RIV21D2 & CSS01D2 (21.04.19)
[181] Exhibit 1, Vol 2, Tab 18, Statement - Sen. Officer S Hildred (11.05.22), paras 27-40
[182] A Hoffman knife has a curved blade with the cutting edge inside the curve and is used to cut ligatures
[183] Asystole is the total cessation of electrical activity in the heart and is the most serious form of cardiac arrest.

131. The first of three ambulance crews arrived on A-Wing at about 4.41 pm and took over resuscitation efforts. A clinical support paramedic (CSP) arrived after ambulance officers had been performing CPR for 17 minutes and Callum was attached to a LUCAS machine (a device that performs automated CPR) at about 4.58 pm.

132. Despite the fact that Callum was given three doses of adrenaline by means of a "*bone gun*" inserted into his left upper arm bone (humerus), his heart remained in asystole and he could not be revived. Resuscitation efforts ceased at 5.04 pm and Callum was declared deceased.[184,185,186]

[184] Exhibit 1, Tab 1, P100 - Report of Death (22.04.19)
[185] Exhibit 1, Tab 4, P92 - Identification of deceased (21.04.19)
[186] Exhibit 1, Tab 5, Life Extinct Form (21.04.19)

ISSUES RAISED IN THE DEATH IN CUSTODY REPORT

Lessons Learnt process[187,188]

133. On 23 October 2019, senior management at Hakea conducted a "*lessons learnt*" session to identify areas for improvement. Five issues were identified during the process, namely:

a. *Identify strategies to raise the awareness of signs of suicide amongst vulnerable prisoners and the importance of investigation and referral to appropriate services.*

The review identified that members of Callum's family had expressed disappointment at his latest convictions and had removed themselves from the prison telephone system, thereby reducing Callum's already limited external support network.[189] In addition, Callum's self-harming behaviour (which had escalated in the period prior to his death) showed his emotional distress and poor coping skills.

b. *Establish a specialised group comprising senior level staff to oversee the management of prisoners with ongoing high level service needs.*

The review identified the fact that the large number of prisoners on ARMS can actually impede the ability of the PRAG to provide a high level of service and address a prisoner's volatile and/or destructive behaviours and "*There may be benefits in establishing a specialised group, external to the PRAG, to manage a small cohort of prisoners with ongoing high level service needs*".

c. *Provide more training and support for officers chairing the PRAG and ongoing oversight of the PRAG's decisions*.

The review identified the need for consistency across various prisons and that the ARMS process was often seen as administrative rather than clinical oversight. The impact on the PRAG process of heavy workloads was also recognised.

[187] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp20-21
[188] Exhibit 1, Vol 2, Tab 17.39, Lessons Learnt Review (28.04.22)
[189] See also: Exhibit 1, Vol 2, Tab 17.53, Statement - Officer A Van Blerk (07.07.20), paras 25-26

d. *Assess ligature minimisations strategies on Unit 1, namely the feasibility of replacing taps and porcelain basins in Unit 1.*

The review identified that although Unit 1 was three-point ligature minimised after Mr Anderson's death in 2017, the taps remained. All tap hardware was subsequently retro-fitted.

e. *Review the prisoner referral and management processes adopted by SPS.*

A review of SPS in March 2020, noted that there were "*resource limitations which impact on timelines for responding to referrals*" which could be compounded by the high risk sex offender legislation, which was then about to be introduced. The review suggested that if a "*complex prisoner's management meeting was established, SPS could engage in a consultative role*".

134. As of June 2022, the first four of these "lessons learnt" actions were said to have been completed with the fifth, relating to the involvement of the SPS in the management of complex prisoners described as "*remaining in progress*". Amendments to the ARMS Manual are scheduled to be completed by August 2022, and include placing prisoners no longer at acute risk on the SAMS for ongoing management by the PRAG.[190]

135. Other changes include providing staff with more risk management options and providing suicide prevention governance to "*oversee operational and clinical practices to ensure a comprehensive approach to managing prisoners at risk*".[191]

136. As I have outlined, the resources currently available to the Forensic Consultant Team in general and the Intervention Team in particular, are woefully inadequate. I have made a recommendation calling on DOJ to consider establishing a specialised facility at Hakea to manage prisoners with complex behavioural needs.

[190] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p21
[191] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p21

Risk Management plan not sufficiently comprehensive[192]

137. Following Callum's death, Ms Palmer conducted a "death in custody" review to identify relevant issues. The review found that when Callum was initially received and identified as being at risk, an interim management plan was created and he was appropriately placed on ARMS. However, a comprehensive risk assessment and risk management plan was not subsequently completed.

138. The review therefore concluded that Callum's risk management plan "*was not sufficiently comprehensive to ensure his safety*" because it contained inconsistent references to his placement in CCU and/or ligature minimised cells and did not show evidence of:

a. The access Callum had to support systems, including spiritual, social, religious and/or mental health supports (if any);

b. Callum's "*risk of relapse*", given the frequency of his repeated self-harming behaviour;

c. The proposed intervention strategies and/or treatment to be applied in Callum's case and the roles of key staff were not listed; and

d. The scheduling of reviews to coincide with the dates of Callum's court appearances, when it could be expected that his risk of self-harm might reasonably be expected to be elevated.

139. The review made the following sensible recommendation:

> Reinforce the requirement to develop and implement comprehensive Risk Management Plans that document PRAG's integrated approach to prisoner self-harm and suicide prevention.[193]

140. The action statement for this recommendation stated that this recommendation "*needs to be explored further in the lessons learnt process*".[194]

[192] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp7-8 & 29-30
[193] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p30
[194] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p30

CONCERNS RAISED BY FAMILY

Overview[195]

141. Following Callum's death, members of his family raised several concerns relating to his supervision whilst he was incarcerated. These concerns were considered during Ms Palmer's death in custody review and were canvassed at the inquest. For the family's benefit, I will now briefly address each of the concerns they raised.

Theft of medication[196]

142. The family's first issue related to a concern that Callum was not receiving his prescribed medication because it was being taken from him by other prisoners. At the time of his death, Callum was prescribed: tramadol, aspirin and paracetamol for pain relief; topiramate to control his seizures; and the antidepressants amitriptyline and paroxetine.

143. Following Callum's death, an analysis of the security reporting module on TOMS failed to identify any reports by Callum that his medication was being taken from him. Similarly, a review of his telephone calls found no references to any concerns on his part that this was occurring. Callum's last successful call was to his sister on 9 April 2019. During that call, they discussed his upcoming charges and the fact that his application for parole had been denied.

144. At the inquest, Officer Devereux confirmed that for security reasons prisoners are not permitted to retain boxes of prescribed medication in their cells. Instead, prisoners receive their medication from prison officers on their units, or attend the medical centre and receive it from nursing staff. Either way, staff are required to watch the prisoner swallow their medication and then check the prisoner's mouth to ensure this has occurred. Officer Devereux said that although prisoners have sometimes been known to secrete medications, when this is detected formal charges are laid.[197]

[195] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp23-24
[196] Exhibit 1, Vol. 2, Tab 17.6, Statement - Officer S Devereux (26.04.22), paras 61-62
[197] ts 13.06.22 (Devereux), pp87-88

145. In this case, there is simply no evidence that Callum had ever complained about his medication being taken from him by another prisoner or anyone else and as Officer Devereux noted, on 21 April 2019:

> Callum…was given a pass and he walked down to the Health Centre to receive his medication for that day. When he came back, he never reported to staff that he had been under any pressure for his medications.[198]

146. Finally, I note that toxicological analysis of samples taken from Callum after his death found he had tramadol, amitriptyline, aspirin, paracetamol, paroxetine and topiramate in his system. These findings mitigate strongly against any suggestion that Callum was not receiving his prescribed medications and/or that someone was taking his tablets from him.[199]

Transfer to Casuarina[200]

147. The family's second concern was why Callum was not transferred to Casuarina, especially as DOJ records show Callum made a request to be transferred there on 5 September 2018. The evidence shows that senior management at Hakea had been actively trying to transfer Callum, either to Casuarina or Albany Regional Prison, but that these attempts had been blocked primarily because Callum was the subject of numerous "alerts".

148. A management and placement assessment to review Callum's security rating and his prison placement was conducted on 13 February 2019. That assessment confirmed Callum's security rating as maximum and with respect to his placement, noted:

> (Callum) is aware that as a maximum security prisoner he will be placed at Casuarina Prison upon completion of the assessments process and he has no issues with this placement. Considering his lack of visits, writer asked about the option of Albany Regional Prison placement and the active alert against (an) Albany prisoner. (Callum) stated he still has issues and prefers to be at metro area to sort his parole plan.[201]

[198] ts 13.06.22 (Devereux), p87
[199] Exhibit 1, Tab 7, Toxicological Report - ChemCentre WA (08.05.19)
[200] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p23
[201] Exhibit 1, Vol. 2, Tab 17.45, Management and Placement Report (13.02.19), p7

149. According to the death in custody review:

> The Superintendent (at Hakea) highlighted that (Callum) was not progressing in his current placement in Unit 1 and suggested that he be given a Special Handling Unit (SHU) placement at Casuarina. In a subsequent email on 12 April 2019 from the Assistant Commissioner Custodial Operations, it was suggested that the Superintendents of Hakea and Casuarina could make arrangements to transfer (Callum), (but he) died before the transfer could occur.[202]

150. It is certainly true that Callum was the subject of 16 active TOMS alerts relating to threats to staff, risks to/from other prisoners and his extensive self-harm history. Although it seems that this alert history may have been the primary reason Casuarina gave for refusing Callum's transfer, it also seems probable that his difficult and challenging behaviours made his transfer there unpalatable. This is unfortunate, especially given the fact that Callum had actually asked to be placed at Casuarina and had been managed there in the past.

151. Notwithstanding Callum's alert history and his challenging history of self-harm and behavioural issues, it is difficult to see why Callum could not have been successfully managed at Casuarina, whether in the SHU or in a mainstream unit. However, whilst a transfer to Casuarina may have been beneficial, even if Callum had been successfully transferred there, it is impossible to know whether he would ultimately have taken his life.

152. As I have pointed out, Callum's personality disorders and his childhood trauma meant that his risk of suicide was many times greater than the general population. Added to this was the fact that Callum's repeated self-harm incidents, which included making deep cuts to his body and attempting to hang himself, were incredibly risky actions and some were potentially fatal. All of this elevated the risk that Callum would eventually die at his own hand.

[202] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), pp23~24

Placement in a ligature minimised cell[203,204,205]

153. The third concern raised by Callum's family was why was he "*put in a cell where he could hang himself*". Given Callum's extensive self-harm history, it is clearly unfortunate he was not placed in a fully-ligature minimised cell, especially following the serious self-harm incident that occurred on 11 April 2019. However, Callum had specifically asked to be housed on Unit 1 and, as I will now explain, Hakea staff had limited options because not all of the cells in Unit 1 were fully-ligature minimised.

154. As I have pointed out, a significant percentage of prisoners (including Callum) experienced ACE and have personality disorders, making their risk of self-harm and suicide much greater. It is also the case that hanging is a method commonly chosen by prisoners wishing to take their lives.

155. This highlights the critical importance of strategies to deal with opportunistic self-harm by removing obvious ligature points. At Hakea, cells are categorised as either:

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

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

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

156. Since 2004, DOJ has been "*incrementally adapting*" the 650 cells at Hakea so they are either fully-ligature minimised or three-point ligature minimised. However, the work is far from complete and as of 9 June 2022, a staggering 40% of cells at Hakea were still non-ligature minimised. Of the remainder, only 56% were three-point ligature minimised whilst only 3.8% were fully-ligature minimised.

[203] Exhibit 1, Vol 2, Tab 17.1, Death in Custody Review (April 2022), p24
[204] Exhibit 1, Vol. 2, Tab 17.6.1, Statement - Officer S Devereux (10.06.22) 10.06.22), paras 5-23
[205] ts 13.06.22 (Devereux), p88-91

157. On 15 July 2022, the Court received updated information about ligature minimisation. In Unit 1 there are 59 cells and the situation is as follows:

a. A-Wing: 16 cells, all of which are three-point ligature minimised;

b. B-Wing: 15 cells, all of which are fully ligature minimised;

c. C-Wing: 16 cells, all of which are three-point ligature minimised; and

d. D-Wing: 12 cells, all of which are fully-ligature minimised.[206]

158. It is pleasing that following Callum's death, all cells in Unit 1 had their tap fittings replaced with fixtures of the same design as found in fully-ligature minimised cells. In addition, doors, beds, pin-up boards, plumbing fixtures and smoke alarms in A-Wing and B-Wing have been replaced. Although the 16 cells in C-Wing were to have been fully-ligature minimised in January 2022, this work was postponed because of increases in the prison population and a COVID-19 outbreak.[207] DOJ advised that it "*[E]nvisages that the work will be undertaken during the 2022-23 financial year and as soon as practicable*".[208]

159. The issue of ligature minimisation is not new and this Court has **repeatedly** recommended that DOJ increase the number of ligature minimised cells across the prison estate. 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, following an inquest into a hanging death at Casuarina.[209]

160. In 2019, I made recommendations about ligature minimisation following an inquest into five deaths by suicide at Casuarina, four of which had occurred by hanging.[210] In 2020, Coroner Urquhart made similar recommendations following an inquest into a hanging death at Hakea in 2017.[211] These types of recommendations cannot continue to be made. **Urgent** action to address the situation must now be taken.

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[206] Letter to Mr W Stops from Mr L Geddes, State Solicitor's Office (15.07.22), paras 2-10
[207] Exhibit 1, Vol 2, Tab 17.52, Email to Ms T Palmer confirming the work was completed between 15-19.07.19 (26.04.22)
[208] Letter to Mr W Stops from Mr L Geddes, State Solicitor's Office (15.07.22), paras 7-8
[209] Annual Report, Office of the State Coroner (2008-2009), p63 re: Inquest into the death of Mr Mark Briggs
[210] Inquest into five deaths at Casuarina Prison Ref: 14/19, (22.05.19)
[211] [2020] WACOR 44, Inquest into the death of Jordan Robert Anderson, Recommendation 1, p46, (Coroner PJ Urquhart)

161. Whilst the ligature minimisation work that has been undertaken at Hakea is welcome, it is totally unacceptable that in 2022, 40% of cells at the prison are still non-ligature minimised. It is a matter of even greater concern that in Unit 1, the management unit at Hakea that regularly houses very vulnerable prisoners, 54% of cells are not fully-ligature minimised.

162. I have already outlined the CEO's statutory obligations under the Prisons Act with respect to the welfare and safe custody of prisoners in the context of managing severely maladaptive behaviour. I would apply those observations to the issue of ligature minimisation. I accept that prisoners have taken their lives by suicide in three-point and fully-minimised cells. Nevertheless, there is obvious merit in making it more difficult for this to occur by ensuring that as many cells as possible have been fully ligature minimised. The situation is serious and action must be taken.

163. With an increased prison population, the number of prisoners with mental health illnesses, mental health conditions and/or severely maladaptive behaviours has also risen. Prisoners in these categories have demonstrably higher rates of self-harm and suicide and as a class are therefore particularly at risk. It is my sincere hope that DOJ will now make the completion of the ligature minimisation work to cells at Hakea generally, and in Unit 1 in particular, an **absolute priority** and will take **urgent** steps to ensure that all obvious ligature points in those cells are removed.

Callum's plan to take his life

164. At the inquest, Officer Devereux was asked about a further concern, namely that Callum may have mentioned a plan to take his life to other prisoners and that this information may have been passed on to prison officers.

165. Officer Devereux confirmed that there was no record of any prisoner having come forward with such information and that had this occurred, Callum would have been immediately placed on high ARMS, as had been done on numerous other occasions when Callum had self-harmed.[212]

[212] ts 13.06.22 (Devereux), p84

OTHER ISSUES RAISED BY THE EVIDENCE

Behaviour management unit[213]

166. At the inquest, there was abundant evidence that Hakea lacks the facilities and expertise to manage prisoners like Callum who have complex behavioural needs.[214] On 30 June 2019, there were 6,940 prisoners in adult custodial facilities, of whom about 10% had psychiatric conditions. Of those, about half (i.e. 350 prisoners) were acutely unwell at any one time.[215,216]

167. At Hakea, there are usually about 100 prisoners on the mental health register requiring treatment, although this number can be as high as 150 and as Dr Petch pointed out, prison mental health services are "*chronically under resourced and cannot deliver all the care that is needed*". Further, prisons do not cater for people who have been traumatised and prison regimes are "*by definition punitive and untherapeutic and not conducive to good mental health*".[217]

168. Despite the number of prisoners who require acute mental health treatment, very few are able to access the State's only forensic mental health facility (Frankland Centre), because only 10 of its 30 beds are available at any one time. As a result, prisoners with mental illnesses must be managed in mainstream prisons and this impacts on the management of prisoners like Callum, as Dr Petch pointed out:

> Whilst the mental health team necessarily focuses on the more acute cases coming in, there is a risk that the sub-acute cases won't get quite as much focus as previously (inevitable without more resources), so the risks are that the mental health of these people will deteriorate and become acute, and the risks they pose to themselves and others will escalate. Although (Callum) would have been unlikely to get into hospital, these are important considerations because the increased burden of care placed on prison mental health services has not been met by a corresponding increase in resources.[218]

[213] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), pp17-19 and ts 14.06.22 (Petch), pp145-152
[214] ts 13.06.22 (Gibson), pp62-63 & 68; ts 13.06.22 (Devereux), p92-97 and ts 14.06.22 (Barry), pp121-123
[215] Office of the Inspector of Custodial Services, Annual Report 2018/2019, p9
[216] Office of the Inspector of Custodial Services, Annual Report 2020/2021, pp 11 & 16-17
[217] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p17
[218] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), pp17-18

169. As the MHAOD summary makes clear, there is a lack of infrastructure to deal with prisoners who have mental health issues and there is no dedicated unit for male prisoners which offers an environment conducive to providing mental health and/or psychological care. There are also serious problems with regard to a lack of suitable therapeutic spaces with prisons and logistical issues in terms of mental health practitioners gaining access to prisoners.[219]

170. Western Australia's first dedicated mental health unit is now open at Bandyup Women's Prison and a 34-bed mental health unit is planned for Casuarina, although it will not open until sometime in 2024. Whilst these facilities are a welcome addition to the prison estate, they would have been of no use in Callum's case, because under DOJ's current arrangements, he would not have qualified for a transfer there because he was not diagnosed with a mental illness.

171. In any event, the question of facilities designed to cater for prisoners with mental illnesses is not one "*connected with*" the death in Callum's case because, as I just identified, Callum was not diagnosed with a mental illness. However, Callum's death squarely raises the urgent need for a specialised behaviour management unit within the prison estate. That is because at present, the Western Australia prison system has no capacity to safely manage prisoners like Callum, who display grossly maladaptive behaviours, including multiple instances of self-harm.

172. Officer Devereux identified a decommissioned unit at Hakea (Unit 8) which could be readily converted into a facility to manage prisoners with serious behavioural issues.[220] This proposal has obvious merit and warrants serious consideration. Apart from the cost of refurbishing the decommissioned unit so that it is fit for purpose, the proposed facility will would need to be staffed with appropriately skilled custodial officers and mental health practitioners. Although working in the proposed facility will no doubt be very challenging, it offers an extraordinary opportunity to have a really positive impact on the lives of troubled and vulnerable prisoners.

[219] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp11-12
[220] ts 14,06.22 (Devereux), pp93-94

173. Despite the resource implications, I urge DOJ to investigate the feasibility of establishing a specialised behaviour unit at Hakea to deal with prisoners like Callum, who "*fall between the cracks*" of the currently available resources. As Dr Petch noted:

> Many recommendations arising from deaths in custody have been made. The level of mental health service in prison is what successive governments have been willing to provide, yet it remains well below the level that prisoners require. The government is well aware of these issues, as they have been raised in numerous reports and forums, but it has not been prioritised. Until the appropriate service is provided to properly cater for the needs of prisoners such as (Callum), despite the best efforts of MHAOD and prison staff, the risk of further suicides in prison remains grave.[221]

Tiered care[222]

174. The concept of "*tiered care*", which has particular relevance to Callum's case, was raised at the inquest by Dr Rowland. As I have explained, under current protocols access to mental health care is contingent on a prisoner being diagnosed with a major mental illness. However, as Dr Rowland pointed out, a far more appropriate system would be to provide care on the basis of a prisoner's identified need, rather than their diagnosis.

175. Dr Rowland said that meetings are currently underway with key staff to clarify the referral process to mental health practitioners. As to the referral process, Dr Rowland had this to say:

> [T]he words "major mental illness" are one of the things that we want completely struck out of this whole referral process. One of the other things in the referral process that we're aiming for and that we have some agreement towards - but we will see what comes out of the next meetings - is that any assessment regarding access to care and decisions about tiers of care that someone has access to, are based on distress and need and functional impairment rather than diagnostic labels.[223]

[221] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), pp18-19
[222] ts 14.06.22 (Rowland), pp170-172
[223] ts 14.06.22 (Rowland), p170

176. As to how this change in access to mental health care might have impacted a prisoner like Callum, Dr Rowland said:

> So if…(the)…assessment regarding access to tiers of care were based on need and functional impairment, then patients like Callum, whose dysfunction and distress related to the impacts of a personality disorder, which most likely were from childhood - adverse childhood events and cumulative trauma, he would…get a high level of tier of care commensurate with his need versus this labelling, which put a ceiling in…essence. So when you're talking about mental health units, they often exclude people with personality disorders because they don't have (a) major mental illness.[224]

177. The tiered model of care aims to match the person being treated with the right level of care at the right time and Dr Rowland emphasised that the effectiveness of this approach is supported by research studies from around the world. The discussions currently underway seek to create a coordinated approach with "*the whole mental health team*" in an effort to collaboratively use the limited resources available.[225]

178. The importance of enhanced primary mental health care in relation to the treatment of personality disorders was highlighted in a recent paper published by the Mental Health Commission. The model of care set out in the paper was developed in a "*highly collaborative process*" involving clinicians and those with a lived experience of personality disorder (PD) and their families. One of the paper's key findings was that "*people with PD can and do recover*" and that developing a system wide competency framework for PD will help to address treatment needs.[226]

179. I sincerely hope that the discussions Dr Rowland referred to will culminate in a collaborative approach to dealing with prisoners who have mental health issues. The aim will be to develop a model of tiered care where access to services will be based on a prisoner's functional impairment rather than their diagnostic label.[227]

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[224] ts 14.06.22 (Rowland), p171
[225] ts 14.06.22 (Rowland), pp171-172
[226] State-wide Model of Care for Personality Disorders, Mental Health Commission, (November 2020), see pp8-9
[227] ts 14.06.22 (Rowland), p172

OPPORTUNITIES FOR IMPROVEMENT

Standard risk management tool[228,229]

180. Following Callum's death, a standardised risk assessment tool was developed for use by PHS staff. 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 that anyone can ask*".[230]

181. All PHS staff have been trained in the use of the new risk assessment tool which was trialled at several sites before being adopted State-wide. Other tools such as an abbreviated risk screening tool (developed in response to the COVID-19 restrictions) and a depression, anxiety and stress scale have also been developed for use by PHS staff.

182. Regardless of the risk tool being used, a significant challenge faced by clinical staff is the lack of available therapeutic spaces at Hakea to conduct assessments and logistical issues relating to gaining access to prisoners in the first place. As the MHAOD report notes:

> Given the access issues to the prisoner due to his unit location and restrictions, these standardised processes may have been of use with (Callum) to provide consistent risk assessment and risk screening processes, and more clarity regarding changes to his thinking, moods and behaviour. Time for a thorough assessment would be of more value also in developing rapport, eliciting more in-depth information and providing sufficient time for clinical interventions to mitigate any identified risk.[231]

183. At the inquest, Ms Barry noted that the lack of therapeutic spaces at Hakea meant that prisoners often had to be interviewed in the official visits area, the prison medical centre and/or education areas. This adds to the difficulties with establishing rapport noted by the MHAOD review and further supports the need for a specialised behaviour management unit to manage prisoners like Callum.

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[228] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp13-15 and ts 14.06.22 (Barry), pp125-126
[229] Exhibit 1, Vol 2, Tab 20, Annexure 1, Psychological health Service Standardised Risk Assessment
[230] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p13
[231] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p15

Suicide prevention project[232]

184. A suicide prevention project that is currently underway in the prison system aims to address issues identified in a review of DOJ's risk management processes. 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, and enhancements to existing programs to refine course content and explore flexible delivery methods.

185. Whilst online training may be superficially attractive in terms of cost savings and efficiency, in my view it would be a mistake to deliver risk identification and management training via this means. As Officer Gibson pointed out at the inquest, online training is a poor substitute for face-to-face training, especially in this context.[233] I would have thought that interaction with a trained clinician in a group setting was a far more appropriate way to deliver risk management training and offers obvious opportunities to address inherent biases, such as the common perspective that self-harming behaviour is often manipulative.

Gatekeeper refresher training[234,235]

186. During their entry level training, prison officers undergo a suicide prevention course authored by the Mental Health Commission (MHC) known as the Gatekeeper program. However, despite the crucial importance of suicide prevention in the effective management of prisoners, the program currently offers no refresher training.

187. Attitudes to prisoner behaviour can vary between officers, and in this case there was evidence that several officers regarded Callum's self-harming behaviour as "*manipulative*", and therefore potentially less serious than it actually was. It is concerning that despite the Gatekeeper program and the ARMS Manual, these attitudes appear to have persisted. This is of grave concern because of the potential that officers might miss warning signs of suicidal risk by downplaying maladaptive behaviours.

[232] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp15-16 and ts 14.06.22 (Barry), pp126-127
[233] ts 13.06.22 (Gibson), p65
[234] Exhibit 3, Letter - Mr L Geddes, State Solicitor's Office (07.07.22), p3 (Table) and paras 24-26
[235] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), pp15-16 and ts 14.06.22 (Barry), pp131-133

188. DOJ is reportedly working with the MHC to "*contextualise the Gatekeeper training to suicide prevention in the Corrective Services settings and to the various staff roles*", but this project could take up to 12-months to complete and appears to be aimed at refining the Gatekeeper program, rather than developing a refresher component.

189. DOJ advised that within the next month it will "*roll out*" suicide prevention training to 640 regional custodial and non-custodial staff. The first aspect of this training is a 20 session program called SafeTalk, designed to help participants recognise a person who is suicidal. The other component of the training deals with talking about suicide and runs over two sessions. DOJ advised that this training is "*intended to start to address the refresher training need*".

190. With respect, whilst this may be a good start, it only appears to apply to regional staff and does not appear to address the concern I have about the fact that the Gatekeeper program does not currently include refresher training. I strongly urge DOJ to approach the MHC with a view to developing a refresher module for the Gatekeeper program. In my view, this would be an appropriate training enhancement and would assist in keeping officers up to date with current strategies to manage maladaptive behaviours and the identification of prisoners at risk of self-harm and/or suicide.

191. In passing, I note that 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.

192. Whilst it may not be logistically possible to have all prison officers undertake such a course, I 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*".[236]

[236] ts 13.06.22 (Gibson), pp64-65

Scenario-based training[237]

193. This Court has previously made recommendations relating to the conduct of scenario-based training exercises designed to assist staff to respond to medical emergencies, including hangings.[238,239] Coroner Urquhart's recommendation about training involving hanging scenarios was made following an inquest into the death of Mr Anderson. In a letter dated 4 August 2021, the relevant Minister expressed support for this recommendation in these terms:

> The Department has directed all prisons to undertake a simulated attempted hanging scenario at least annually. Presently, new custodial staff participate in a simulated hanging scenario as part of the Entry Level Training Program. To build on this, the Department is developing a new Suicide and Self harm module. This training will include the theory and practice of responding to an attempted suicide or suicide in varied circumstances, including seated and prone hangings.[240]

194. Nevertheless, at the inquest Officer Bell said he had not been involved in scenario-based training at all, and Officer Gibson thought this would be a useful addition to the training calendar at Hakea.[241] DOJ advised that Hakea currently undertakes scenario-based training on a quarterly basis and is due to conduct a hanging scenario in July 2022.

195. In my view, it would be more appropriate for Hakea to conduct scenario-based training on a bi-monthly basis, meaning six exercises would be conducted every year rather than four. This would take account of staff leave, duty rosters and other obligations and would help to ensure that as many prison officers as possible were able to attend this training. I therefore urge the senior management team at Hakea to consider adopting this suggestion.

[237] Exhibit 3, Letter - Mr L Geddes, Counsel for DOJ (07.07.22), p4, paras 16-21
[238] [2020] WACOR 44, Inquest into the death of Jordan Robert Anderson, p47, Rec. 4 (Coroner PJ Urquhart)
[239] [2022] WACOR 30, Inquest into the death of Ashley Adrian Lane, p64, Rec. 7 (Coroner MAG Jenkin)
[240] Exhibit 3, Letter - Mr L Geddes, Counsel for DOJ (07.07.22), p4, para 17
[241] ts 13.06.22 (Bell), pp36-37 and ts 13.06.22 (Gibson), pp63-64

TOMS Alarms

196. As I described, two of Callum's ARMS observations were incorrectly entered into the supervision log, apparently because the responsible officer was faced with numerous competing tasks.[242] Clearly the integrity of the ARMS system relies on meaningful observations that are conducted in accordance with the prisoner's ARMS regime. Further, these observations must be accurately recorded in the supervision log. If these things are not done the whole point of the ARMS system, with its regime of observations conducted at prescribed intervals, falls away.

197. At the inquest, I asked whether an alarm could be created within TOMS to alert the responsible officer of upcoming ARMS observations for the prisoners on that officer's unit. In Unit 1, my suggestion was that the control officer, who has responsibility for making such entries, would receive these notifications and where an observation had not been performed and/or entered by the relevant time, an alert would prompt the control room officer to take steps to address the issue.

198. DOJ advised that it would be possible to adapt TOMS in the manner I described so as to provide alerts when ARMS observations had not been performed and/or entered into the supervision log and that: "*the Department is willing to give consideration to such a change, and the staff and circumstances in which the change might be applied*".[243]

Additional counselling staff[244]

199. At the inquest, Ms Barry confirmed that because of the prison population and the acuity of prisoners being received, counselling staff (including psychologists and social workers) are able to do little more than conduct assessments in relation to self-harm and suicide risk and/or intervene briefly with acute crisis presentations. It follows that the ability of counselling staff to do any proactive work is minimal and this leads to frustration and professional burn-out. Clearly DOJ must make the recruitment of additional counselling staff an **absolute** priority.

[242] Exhibit 1, Vol 2, Tab 17.53, Statement - Officer D Weston (28.02.22), paras 7-24
[243] Exhibit 3, Letter - Mr L Geddes, State Solicitor's Office (07.07.22), paras 22-23
[244] ts 14.06.22 (Barry), pp114-117 & 128-129

CAUSE AND MANNER OF DEATH

200. A forensic pathologist (Dr Moss) conducted an external post mortem examination of Callum's body on 24 April 2019. Dr Moss' most significant finding was a ligature mark around Callum's neck which was about 10 cm in width.[245]

201. Dr Moss also noted multiple old scars on Callum's upper and lower limbs and shoulders, along with needle puncture marks to his left elbow. Superficial scratches were noted on Callum's left calf and there were four recent, superficial incised wounds to Callum's lower right leg, two of which had been closed with stitches.[246]

202. Toxicological analysis of samples taken from Callum after his death found therapeutic levels of tramadol (opioid pain medication) and amitriptyline (antidepressant medication) in his system. The analysis also detected the antidepressant, paroxetine; the anticonvulsant, topiramate; and the pain medications aspirin and paracetamol.[247]

203. Alcohol was not detected in Callum's blood but a low level of alcohol (0.01%) was detected in his urine. Based on the available research literature, it seems likely that this small amount of alcohol was caused by post mortem changes that occur naturally after death.[248,249]

204. At the conclusion of the post mortem examination, Dr Moss expressed the opinion that the cause of death was ligature compression of the neck (hanging).

205. I accept and adopt the conclusion expressed by Dr Moss as to the cause of Callum's death.

206. Further, on the basis of the available evidence, I find Callum's death occurred by way of suicide.

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[245] Exhibit 1, Vol 1, Tab 6, Confidential Report to the Coroner - Forensic Consultation (Post Mortem Report) (24.04.19)
[246] Exhibit 1, Vol 1, Tab 6, Confidential Report to the Coroner - Forensic Consultation (Post Mortem Report) (24.04.19)
[247] Exhibit 1, Vol 1, Tab 7, Toxicological Report - ChemCentre WA (08.05.19)
[248] Exhibit 1, Vol 1, Tab 7, Toxicological Report - ChemCentre WA (08.05.19)
[249] See for example: www.sciencedirect.com/science/article/pii/S0379073821004722

QUALITY OF SUPERVISION, TREATMENT AND CARE

207. After carefully reviewing the evidence, I have concluded that the supervision, treatment and care provided to Callum was of a lower standard than it might have been, because in the period leading up to Callum's death, custodial staff were unable to access specialised psychological support to help them to manage his extremely challenging and confronting self-harming behaviours.

208. Although Callum was regularly seen by doctors, mental health nurses and counsellors, it appears that the severity of Callum's distress in the period leading up to his death was not properly appreciated. Each separate incident of self-harm was managed appropriately by placing Callum on ARMS and at times in safe cells, but his management was far from consistent or holistic.[250,251,252]

209. The fact that Callum was not diagnosed with a major mental illness operated as a barrier to treatment, and during his incarceration at Hakea he was never formally assessed by a psychiatrist. When Hakea sought specialised psychological input into how to better manage Callum's behaviour, instead of a plan based on a recent comprehensive assessment, what they got (after some delay) was a plan from 2017 when Callum had been housed at Casuarina. This is clearly unacceptable and meant that Callum's management was suboptimal because custodial staff did not receive the specialised support they so obviously required.

210. Further, had custodial staff been able to transfer Callum to a specialised behaviour unit, he would have been managed by appropriately skilled custodial and clinical staff. It is impossible to know if the outcome for Callum would have been any different had this occurred, but it seems likely that his significant distress would have been better addressed. Finally, had the tiered care model outlined by Dr Rowland been available, the fact that Callum had not been diagnosed with a mental illness would have been irrelevant. Under the tiered care model Callum would have received care commensurate with his obvious emotional distress.

[250] Exhibit 1, Vol 2, Tab 20, MHAOD Summary (June 2022), p16
[251] See also: Exhibit 1, Vol 2, Tab 17.54, Statement - Ms R Smith (23.02.22)
[252] See also: Exhibit 1, Vol 2, Tab 17.54, Statement - Ms C Sorensen (28.04.22)

RECOMMENDATIONS

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

Recommendation No. 1
The Department of Justice (DOJ) should conduct a review to determine whether the resources and facilities currently available to staff at Hakea Prison (Hakea) to manage prisoners with complex behavioural needs are adequate. The review should consider the feasibility of establishing a behaviour management unit at Hakea, staffed by specialist mental health practitioners and custodial staff, to enable prisoners with complex behavioural needs to be appropriately managed.

Recommendation No. 2
As a matter of **urgency** DOJ should undertake remedial work at Hakea Prison to ensure that all cells on Unit 1 are fully ligature minimised.

Recommendation No. 3
DOJ should create an alert within the Total Offender Management System to prompt prison officers whenever a prisoner's scheduled observations under the At Risk Management System are not entered into the supervision log, and should consider the circumstances in which it would be appropriate to activate such alerts.

Recommendation No. 4
DOJ should explore the feasibility of introducing regular refresher training for the Gatekeeper program for all prison officers, and should also investigate the feasibility of providing senior prison officers with additional training in the effective management of prisoners with personality disorders and common mental health conditions.

Comments on recommendations

212. A draft of the first two of my proposed recommendations was forwarded to Mr Geddes (counsel for DOJ) on 5 July 2022. A draft of recommendations 3 and 4 was forwarded to Mr Geddes on 13 July 2022.[253,254]

213. By letter dated 15 July 2022, Mr Geddes advised that DOJ's response to the recommendations was as follows:[255]

a. *Recommendation 1*: DOJ supported this recommendation subject to approval being received from Treasury and the Government in terms of funding;

b. *Recommendation 2*: DOJ advised that some of the earlier information provided to the Court about ligature minimisation was out of date, and in fact all cells in Unit 1 were now at least three-point ligature minimised and that "*further works are contemplated during the current financial year, following which all but 16 cells will be fully ligature minimised*". In light of this update, I amended the proposed recommendation accordingly;

c. *Recommendation 3*: DOJ advised it was technically possible to include the recommended alert within TOMS, but that "*It may be counter-productive to impose such a change on the Total Offender Management System interface of all prison officers at all times*". DOJ supported a recommendation that it consider the circumstances in which such alerts could be "*effectively and efficiently*" incorporated within TOMS and I amended the recommendation accordingly; and

d. *Recommendation 4*: DOJ advised that it is willing to consider the training recommended for senior officers. As for the Gatekeeper program, DOJ reiterated that it does not own this training product and that no refresher training is currently available. However, DOJ was willing to explore the feasibility of a "*refresher training variant*" to the Gatekeeper program, providing the product's author (the MHC) was supportive.

[253] Email - Ms K Christie to Mr L Geddes, State Solicitor's Office (05.07.22)
[254] Email - Mr W Stops to Mr L Geddes, State Solicitor's Office (13.07.22)
[255] Letter to Mr W Stops from Mr L Geddes, State Solicitor's Office (15.07.22)

CONCLUSION

214. Callum was a deeply troubled young man who had spent a considerable part of his adult life in custody. As a result of his repeated self-harming behaviours he was regularly managed on ARMS, but his significant needs and his maladaptive behaviours were not comprehensively addressed.

215. Part of the problem was that because Callum was not diagnosed with a major mental health issue, he did not meet the threshold for specialist psychiatric health care. However, discussions currently underway aim to introduce a collaborative approach to mental health issues, where the level of care provided is determined by a prisoner's functional impairment rather than their diagnostic label.

216. The evidence before me clearly established that a specialised behaviour management unit is desperately required at Hakea to address the complex needs of prisoners like Callum. The unit, which could be established in a decommissioned unit at Hakea should be staffed with appropriately skilled custodial officers and mental health practitioners.

217. I have made four recommendations aimed at addressing the issues I identified during the inquest. I sincerely hope these recommendations will be implemented and as I did at the end of the inquest, I wish to again extend my sincere condolences to Callum's family and friends for their loss. In conclusion, I wish to wholeheartedly support the final comment in Dr Petch's report, namely:

Prisons should no longer serve as defacto mental health hospitals.[256]

MAG Jenkin
Coroner
22 July 2022

[256] Exhibit 1, Vol 2, Tab 19, Report - Dr E Petch (07.06.22), p19