JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	11-12 JULY 2023
DELIVERED	**:**	6 FEBRUARY 2024
FILE NO/S	**:**	CORC 32 of 2020
DECEASED	**:**	ALLEN, PHILLIP JOHN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms Sarah Tyler assisted the coroner

Ms Eloise Langoulant and with her Ms Giorgia Papalia (Aboriginal Legal Service) appeared on behalf of the family

Mr Michael McIlwaine and with him Ms Karess Dias (State Solicitors Office) appeared on behalf of the Department of Justice

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Phillip John ALLEN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 11-12 July 2023, find that the identity of the deceased person was* ***Phillip John ALLEN*** *and that death occurred on 29 July 2020 at Roebourne Regional Prison, Samson Road, Roebourne, from ligature comprresion of the neck (hanging) in the following circumstances:*

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LIST OF ABBREVIATIONS & ACRONYMS

Abbreviation/ Acronyms	Meaning
the Academy	the Corrective Services Academy based at Bentley
ARMS	At Risk Management System
CT scan	computerised tomography scan
the ***Briginshaw*** principle	the accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
the Department	the Department of Justice
the Module	the Academy Training Module titled "Accounting for Prisoners"
MRI scan	magnetic resonance imaging scan
PHS	Psychological Health Services
PRAG	Prisoner Risk Assessment Group
the PSO	the Prison Support Officer
RRP	Roebourne Regional Prison
SAMS	Support and Monitoring System

INTRODUCTION

"Every shortcut has a price usually greater than the reward."
Bryant McGill - author

1 The deceased (Mr Allen) died on 29 July 2020 in a cell at Roebourne Regional Prison (RRP), from ligature compression of the neck (hanging). At the time of his death, Mr Allen was a remand prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1]

2 Hence, immediately before his death, Mr Allen was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA), and his death was a "*reportable death"*.[2] In such circumstances, a coronial inquest is mandatory.[3]

3 On 11-12 July 2023, I held an inquest into Mr Allen's death at Perth. The following six witnesses gave oral evidence:

- Douglas Popp (prison officer at RRP)
- Tamara van Hengel (prison officer at RRP)
- Dr Adam Brett (independent consultant psychiatrist)
- Thomas Perrin (review officer at the Department)
- Dr Joy Rowland ACM[4] (Director of Medical Services at the Department)
- Tanya Woolgrove (Assistant Superintendent at RRP)

4 The documentary evidence at the inquest comprised of three volumes which were tendered as exhibit 1 at the commencement of the inquest. Ms Langoulant, counsel appearing on behalf of the family, tendered an article by Tracy Westerman, a clinical psychologist, titled "Culture bound syndromes in Aboriginal Australian population" dated 15 March 2021. This document became exhibit 2.

5 The inquest focused on (i) the treatment and care provided to Mr Allen, primarily in regard to his mental health, during his final time as a prisoner at RRP and (ii) the supervision of Mr Allen by prison officers on the night of his death.

6 When making my findings I must be mindful of the standard of proof set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, which requires a

[1] *Prisons Act 1981* (WA) s 16
[2] *Coroners Act 1996* (WA) s 3, s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)
[4] Australian Corrections Medal

consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).[5]

7 I am also mindful not to insert hindsight bias into my assessment of the actions taken by those responsible for Mr Allen's supervision, treatment and care when he was in prison. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[6]

8 In addition, I must also take into consideration that Mr Allen was imprisoned at the time of the COVID-19 outbreak which had resulted in significant restrictions being placed on who could access RRP for much of Mr Allen's time in custody.

MR ALLEN

Background [7]

9 Mr Allen was born on 9 November 1972 in Port Hedland. He was 47 years old when he died. His family was from Nyamal country.

10 Mr Allen completed his schooling in Port Hedland and South Hedland. After finishing school, he had various jobs including as a fencing contractor, working for a mining company and mustering.

11 Mr Allen was in a long-term relationship with his partner and they had three daughters together.

12 Mr Allen had an alcohol dependency. He had been imprisoned 16 times between 1996 and 2020. These imprisonments were all at RRP, except for one term of imprisonment which was served at Greenough Regional Prison.

Threats of self-harm by Mr Allen in 2019 [8]

13 On 13 May 2019, Mr Allen's partner reported to police that Mr Allen had left their house and said he was going to hang himself. Police located Mr Allen, who admitted saying he was going to hang himself because he was angry and that he did not mean it.

[5] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J)
[6] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[7] Exhibit 1, Volume 1, Tab 2.1, Coronial Investigation Squad Report dated 28 January 2022
[8] Exhibit 1, Volume 1, Tabs 48.1-5, Various WA Police Incident Reports

14 Nevertheless, he was taken by police to the emergency department at South Hedland Health Campus for a mental health assessment which found no welfare concerns for Mr Allen. He was subsequently discharged.

15 On 29 May 2019, Mr Allen's partner again contacted police stating that Mr Allen had tried to hang himself at the house, with a shoelace tied to a patio roof, which had been cut by family members. He was taken to South Hedland Health Campus for another mental health.

16 On 6 August 2019, Mr Allen threatened to hang himself to family members and left the house saying goodbye to his daughters. Police located Mr Allen at his sister's house drinking alcohol with family members. He appeared fine to police.

17 On 14 September 2019, Mr Allen told his partner he was going to hang himself and left the house and once again, he said goodbye to his children. His partner then contacted police who could not find Mr Allen.

18 On 26 December 2019, Mr Allen made another threat to hang himself. On this occasion, police located him hiding in a nearby garage and took him to Karratha Health Campus. A doctor who conducted a mental health assessment was of the view that Mr Allen was threatening self-harm to get his partner to listen to him. Mr Allen admitted that this was true and stated that he would never carry out his threats to suicide.

CIRCUMSTANCES OF FINAL IMPRISONMENT [9]

19 In February 2020, Mr Allen was charged with a number of offences which included aggravated sexual penetration without consent, making a threat with intent to prevent or hinder a person doing an act, and aggravated assault occasioning bodily harm. The complainant with respect to these charges was Mr Allen's partner. On 27 February 2020, he was remanded in custody at RRP. He remained there until his death five months later.

Prison history [10]

20 Mr Allen was the subject of several management issues during his final remand in prison. These included incidents when he was confined to a separate cell for three days on two separate occasions after assaulting

[9] Exhibit 1, Volume 1, Tab 2.1, Coronial Investigation Squad Report dated 28 January 2022
[10] Exhibit 1, Volume 3, Tab A, Review of Death in Custody Report dated May 2023

other prisoners. Following these incidents, Mr Allen was also placed in a "maxi yard" cell for 14 days on 28 April 2020.

21 Mr Allen had short periods of employment when at RRP, mainly as a general unit worker and cleaner.

22 He received a number of official visits, and one visit from his partner on 5 July 2020. During July 2020, Mr Allen made numerous telephone calls using the Prisoner Telephone System to his partner and various family members. During a number of these calls Mr Allen raised issues in which he alleged that one of his daughters was being abused, his partner was cheating on him and that she was a "black magic woman".

23 Although Mr Allen's partner had subsequently booked further visits for 12, 19 and 25 July 2020, she did not attend on those dates.

OVERVIEW OF THE SUPERVISION, TREATMENT AND CARE PROVIDED TO MR ALLEN REGARDING HIS MENTAL HEALTH [11]

Mr Allen's initial assessments

24 On 27 February 2020, a Reception Intake Assessment was completed for Mr Allen at RRP. He informed the reception officer that he did not have a history of self-harm or suicidal ideation. He disclosed he had lost close family members to suicide. Mr Allen denied having current thoughts of self-harm or suicidal ideation. He described himself as a heavy consumer of alcohol.

25 The reception officer reviewed prison records that indicated a recent history of suicidal ideation. However, the reception officer did not consider Mr Allen to be at a present risk of suicide or self-harm and referred him to the Prison Support Officer (PSO) for additional support.

26 On 28 February 2020, Mr Allen was reviewed by a prison nurse for an initial health assessment. There were no acute health issues identified.

Mr Allen refers to "black magic" and spirits

27 On 13 March 2020, Mr Allen was observed to be upset. When questioned by custodial staff, he complained that "black magic" had told him one of his daughters had been raped.

[11] Exhibit 1, Tab 44, TOMS Offender Notes; Exhibit 1, Volume 1, Tab 45, Extracts from Mr Allen's RRP medical records; Exhibit 1, Volume 1, Tab 49, Report of Dr Kevin Smith dated 21 February 2023; Exhibit 1, Volume 2, Tab 10.1, Health Services Summary into the Death in Custody dated 6 July 2023; Exhibit 1, Volume 2, Tab 10.2, Mental Health Alcohol and Other Drugs (MHAOD) Summary into the Death of Custody dated April 2021; Exhibit 1, Volume 3, Tab A, Review of Death in Custody dated May 2023

28 On 18 March 2020, Mr Allen attended an appointment with a prison doctor for a comprehensive health assessment. He was treated for some eyesight issues and discharge in his left ear. No record was made of any report from Mr Allen that he was experiencing spiritual or cultural issues.

29 During March and April 2020, Mr Allen was regularly reviewed by health service providers at RRP in relation to his eye irritation and ear problem.

30 On 17 April 2020, prisoners in Mr Allen's cell advised custodial staff that he was behaving strangely and talking about spirits. There is no record of Mr Allen disclosing this behaviour at an appointment he had with the prison doctor on 21 April 2020, or any subsequent appointments with prison nurses.

6 May 2020: Mr Allen is placed on ARMS

31 On 6 May 2020, Mr Allen was moved to a management cell in Unit 1 by prison staff after information was received from another prisoner that indicated Mr Allen may be contemplating self-harm. At the time, Mr Allen was placed on "Low" ARMS (At Risk Management System) with four-hourly observations.

32 ARMS is the Department's primary suicide prevention strategy and used by all prisons in Western Australia. It aims to provide prison staff with clear guidelines set out in the ARMS Manual to assist with the identification and management of prisoners at risk of self-harm and/or suicide. Any prisoner exhibiting warning signs or risk factors which may increase the likelihood of self-harming or suicide behaviour is to be immediately placed on ARMS and monitored according to the level of risk and care required.

33 The ARMS Manual has guidelines for assessing the degree of risk for a prisoner. The prisoner is then allocated one of the three levels: "High" (acute risk of suicide or self-harm), "Moderate" (not functioning well, with an increased risk of self-harm), or "Low" (difficulty coping, with fleeting thoughts of self-harm or suicidal ideation).[12]

34 The Prisoner Risk Assessment Group (PRAG) comprises of a chairperson and includes representatives from the prisoner's health service providers, counsellors, custodial staff, prisoner support and

[12] At Risk Management System (ARMS) Manual 1998 updated October 2016, pp.52-53

Aboriginal support. PRAG is responsible for the management of prisoners who are on ARMS and meets daily to discuss those prisoners.

35 For a prisoner on ARMS, PRAG is required to:[13]

- Form a comprehensive risk assessment on the prisoner.
- Development a risk management plan for the prisoner.
- Arrange for the support and interventions that have been identified in the risk management plan.
- Review the prisoner's progress (which includes an assessment of the ARMS level and/or whether the prisoner can be removed from ARMS).

36 On 6 May 2020, Mr Allen advised prison staff that others were trying to "sung him" and that he had been cast with black magic. He believed that his daughter was calling out to him and that she had told him she was being abused by a spiritual man. Mr Allen denied he was intending to self-harm. He was referred to the prison's Psychological Health Services (PHS) and the prison chaplin.

37 On 7 May 2020, a member of PHS interviewed Mr Allen. Mr Allen's mood and demeanour were described as "flat". He again reported being sung and that black magic was involved. He agreed that he heard voices that were related to black magic and spirits. Mr Allen denied any current thoughts of self-harm or suicide, and no risk factors were identified at the time of interview.

38 Mr Allen also spoke to the PSO and he reported facing spiritual battles with supernatural powers against other prisoners, and with another man who had a supernatural power in the community.

39 Following his interview with PHS, a risk management plan was created which detailed a number of proposed interventions which included continued interaction with the prison chaplin, the PSO and peer support. A sourcing of a spiritual healer from Mr Allen's same language/cultural group was raised. However, it was noted by PRAG this may be limited to in-prison considerations due to COVID-19 restrictions. It was also recommended that a mental health assessment was required given Mr Allen's reports of hearing voices that were involved in black magic and spirits.

[13] At Risk Management System (ARMS) Manual 1998 updated October 2016, p.85

40 At the PRAG meeting on 7 May 2020, a recommendation was accepted from PHS that Mr Allen be removed from ARMS and be placed on the Support and Monitoring System (SAMS). This placement was deemed appropriate due to Mr Allen's current mental health issues and poor coping.

41 SAMS is a step down from ARMS. The SAMS Manual sets out that its focus is to provide additional support, monitoring and intervention to prisoners presenting as vulnerable within the prison environment. This vulnerability may be either short term or long term. Eligibility for a prisoner's management through SAMS is not restricted by precise adherence to any particular criteria.

42 As specified in the SAMS Manual, the advantages of the support and monitoring offered by SAMS is that prisoners are observed and monitored in their own units by unit prison staff, and any adverse issues or problems can be identified firsthand and addressed in a more timely manner.[14]

43 Although SAMS documentation indicated that Mr Allen was scheduled for a mental health review on 11 May 2020, there is no documentation before the Court that this appointment occurred.

44 Mr Allen was still on SAMS at the time of his death.

Mr Allen's behaviour escalates

45 On 19 May 2020, Mr Allen was moved to a six bed cell in Unit 2 at his request.

46 On 20 May 2020, after Mr Allen had spent one night in the six bed cell, the prisoners in his cell approached prison staff and requested that he be moved out of the cell due to his "weird behaviour". This behaviour involved the prisoners waking up during the night to find Mr Allen staring at them beside their beds. He was subsequently moved back to a one bed cell in Unit 1.

47 On 21 May 2020, Mr Allen was referred to the PSO in relation to being sung and a further referral was made to PHS due to his recent deterioration in behaviour.

48 On 28 May 2020, Mr Allen was moved to another six bed cell in Unit 2. Mr Allen remained in that cell until his death.

[14] Exhibit 1, Volume 2, Tab 3, SAMS Manual, Version 1.2, June 2009

49 On 13 June 2020, prisoners in Mr Allen's cell complained to prison staff that Mr Allen did not sleep at night and would walk around the cell with a water bottle and stand over them until they woke up. He would then squirt water into their faces. Prison officers spoke to Mr Allen about his behaviour and he told them he was watching bad spirits and trying to wash them away. He declined a move to a one bed cell. Mr Allen was told he could remain in the six bed cell provided he did not continue to disturb his cell mates at night.

50 On 19 June 2020, the prisoners in Mr Allen's cell continued to complain that he was still doing weird things at night, and they reported being uncomfortable with him remaining in their cell. However, there was no other cell to move Mr Allen into due to mustering issues.

51 On 7 July 2020, it was reported that Mr Allen was tense and not getting enough sleep at night. He also continued to express concern about his daughter's welfare and appeared to be still experiencing cultural and spiritual issues.

Mr Allen's appointments with mental health service providers in July 2020

52 On 7 July 2020, Mr Allen had a review by a prison mental health nurse. He presented with an underlining delusional/paranoid ideation in relation to black magic. Mr Allen also held the belief that he was "being watched". He stated that he felt his concerns for his daughter's alleged abuse were not being listened to, and that he was having auditory hallucinations of her voice. Mr Allen denied he posed a risk to himself or others.

53 Mr Allen also said he did not need medication and it was noted by the nurse that he was lacking insight. Consequently, he was scheduled for a review by the prison psychiatrist. That took place via a telehealth appointment on 17 July 2020.

54 The psychiatrist recorded that Mr Allen appeared to have been delusional for some time and noted that his family had tried to dissuade him from his beliefs and accusations. Nevertheless, it was apparent to the psychiatrist that Mr Allen was experiencing auditory hallucinations consistent with his beliefs. It was also noted Mr Allen was somewhat narcissistic and the aetiology (i.e. cause or origin) of his mental state appeared to be from his chronic alcohol dependency that had resulted in both his delusional disorder and frontal lobe impairment. The psychiatrist also noted that although Mr Allen refused to accept that he had a delusional disorder and would not take medication to treat that, he

was willing to talk about his beliefs. As he had stated to the mental health nurse, Mr Allen denied any thoughts of self-harm or suicidal ideation.

55 The psychiatrist recommended that a CT scan and MRI scan would be desirable, and that cultural counselling may benefit Mr Allen.

EVENTS LEADING TO MR ALLEN'S DEATH [15]

56 At about 5.40 pm on 27 July 2020, Mr Allen complained to a prison officer that another officer had ripped up a money order that his mother had sent him. Mr Allen appeared paranoid and fixated on this other prison officer and said that the same thing had happened before. The prison officer attempted to explain to Mr Allen that no staff would have access to, or the ability to alter or delete, a prisoner's funds.[16]

57 At about 9.30 am on 28 July 2020, the PSO spoke to Mr Allen. Although he remained stressed about the money order, Mr Allen self-reported that he had no thoughts of self-harm or suicidal ideation. He also said he was receiving support from his countrymen in Unit 2.

58 At 4.16 pm on 28 July 2020, Mr Allen was abusive towards prison officers who were conducting a cell and body check. However, he seemed to settle for the remainder of that day and no further incidents were recorded.

59 The lock-up of cells in Unit 2 commenced at about 6.50 pm on 28 July 2020. Prison officers Douglas Popp (Mr Popp) and Tamara van Hengel (Ms van Hengel) were on night shift that evening and conducted what has been described as night shift cell and body checks in Unit 2.

60 Mr Popp and Ms van Hengel conducted three such cell and body checks in Unit 2 at or about the following times: 9.30 pm, 11.10 pm on 28 July 2020, and 4.35 am on 29 July 2020. Mr Popp conducted the cell and body checks on the right wing of Unit 2 and Ms van Hengel was responsible for the cell and body checks on the left wing. The cell that housed Mr Allen was located on the left wing.

61 At the second cell and body check at about 11.10 pm, Ms van Hengel recalled observing Mr Allen standing next to a bunk bed on the

[15] Exhibit 1, Volume 3, Tab A, Review of Death in Custody dated May 2023

[16] A subsequent internal investigation of this incident established that Mr Allen's money order was returned to his mother by administrative staff at RRP due to it exceeding the permitted amount in his private cash account: Exhibit 1, Volume 3, Tab A, Review of Death in Custody Report dated May 2023, p.15

right-hand side of his cell. However, during the third cell and body check at about 4.35 am, she could not recall where Mr Allen was located within the cell.

62 Occurrence book entries dated 28 and 29 July 2020 completed by Mr Popp recorded that the three cell and body checks conducted by Ms van Hengel had been undertaken.

63 At about 6.35 am on 29 July 2020, two day shift prison officers conducted a pre-unlock check of Unit 2. This pre-unlock check required the prison officers to complete a muster sheet titled "Unit Count by Cell". When these prison officers checked Mr Allen's cell they observed there were only five men on their beds, with one empty mattress on the floor. The muster sheet indicated there should have been six prisoners in the cell. One of the officers used a torch to search the cell and observed that the toilet door was closed. The other officer observed through the gap between the floor and the toilet door two feet on the floor inside the toilet. One of the officers then called out "*Bloke in the toilet, are you right in there?*". A voice responded, "*Yeah miss, bloody hell*". Satisfied with that response, the prison officers continued their morning duties.[17]

64 At about 7.34 am, prison officers commenced a welfare check and the morning unlock in Unit 2. As a prison officer approached Mr Allen's cell, a prisoner said that Mr Allen was in the toilet. When the prison officer asked how long he had been there, the prisoner responded, "*about 30 minutes*". However, another prisoner inside the cell said Mr Allen had hanged himself.

65 This prison officer and another officer then unlocked and entered the cell. They found the toilet door was locked from the inside. When one of the officers called out to Mr Allen, he received no response.

66 From looking through the gap under the toilet door, one of the officers could see that Mr Allen had a green coloured fabric ligature around his neck. A Code Red emergency was immediately called over the radio at about 7.36 am. Three minutes later, the front gate was informed to call an ambulance.

67 Meanwhile, a prison officer had kicked the toilet door open and Mr Allen was observed in a standing position to one side of the toilet bowl. The fabric that was around his neck had been attached to a

[17] In later interviews with these two prison officers, both indicated that with hindsight, they could not be certain whether this response came from the toilet or from another prisoner within the cell.

diagonal metal window grille above the toilet. One of the officers took the weight of Mr Allen whilst the ligature was cut from his neck. Mr Allen was then placed on the cell floor.

68 After establishing that Mr Allen was not breathing, prison officers commenced CPR and an oxygen resuscitator was obtained from within the unit.

69 At about 7.39 am, a prison nurse attended and a short time later a defibrillator was applied to Mr Allen. Prison medical staff in attendance noted that Mr Allen was cold to the touch and although no shocks were delivered to Mr Allen by the defibrillator, prison officers rotated through continuance CPR cycles until the arrival of an ambulance. Ambulance officers attended at about 8.02 am and took over resuscitation efforts after Mr Allen had been moved from the cell to the outside verandah.

70 Despite maximal resuscitation efforts, Mr Allen could not be revived and his death was declared by an ambulance officer at 8.15 am.[18]

71 A search of Mr Allen's cell located two letters he had written to family members. One of those letters alleged that his daughter was being abused and that someone wanted to kill him. Mr Allen wrote that he could not think straight anymore and that he had to get out to receive tribal punishment as it was torturing him and he was always in pain.

CAUSE AND MANNER OF DEATH [19]

Cause of death

72 On 5 August 2020, two forensic pathologists, Dr Daniel Moss and Dr Joseph Ong, conducted a post mortem examination on Mr Allen's body.

73 It was noted by the forensic pathologists that there was a ligature mark to Mr Allen's neck which corresponded with the ligature that had been provided. There was no evident internal neck injury; however, Mr Allen's lungs were congested which may be seen with a compression of the neck. There was evidence of medical intervention, including CPR. There was no other significant injury or evidence of significant natural disease.

[18] Exhibit 1, Volume 1, Tab 4, Life Extinct Form dated 29 July 2020

[19] Exhibit 1, Volume 1, Tabs 6.1-6.4, Supplementary Post Mortem Report, Full Post Mortem Report, and Interim Post Mortem Report dated 5 August 2020, Email from Dr Dan Moss to the Court dated 8 June 2023; Exhibit 1, Volume 1, Tab 7, Toxicology Report dated 7 August 2020

74 Toxicological analysis found no evidence of alcohol or common illicit drugs in Mr Allen's system. Although ambulance officers recorded Mr Allen's body temperature upon their attendance (28.3^0 C), the forensic pathologists were unable to estimate the likely time of Mr Allen's death. The reason for that is that there are many variables that could affect the cooling of a body after death. These included the ambient temperature at the scene, the type of clothing being worn, initial body temperature at the time of death and air movement/humidity.

75 At the completion of their investigations, the forensic pathologists expressed the opinion that the cause of death was ligature compression of the neck (hanging).

76 I accept and adopt the conclusion expressed by the forensic pathologists as to the cause of Mr Allen's death.

Manner of death

77 I am satisfied that at about 11.10 pm on 28 July 2020, Mr Allen was seen by Ms van Hengel standing next to a bunk bed in his cell. This was the last known time he was seen alive.

78 Between that time and about 6.35 am the next morning, Mr Allen entered the cell's toilet cubicle. He had in his possession a length of green-coloured fabric. After locking the toilet door, Mr Allen knotted one end of this fabric to one of five diagonal metal grilles in front of the toilet's window and placed the other end of the fabric around his neck as a ligature.

79 I am also satisfied Mr Allen had already died before prison officers began their attempts to resuscitate him.

80 Based on the information available, I find that Mr Allen's death occurred by way of suicide.

ISSUES RAISED BY THE EVIDENCE

Were adequate steps taken to treat Mr Allen's mental health issues?

81 Dr Adam Brett (Dr Brett), a consultant psychiatrist, was engaged by the Court to prepare an independent report regarding this question.[20]

82 Dr Brett's report concluded:[21]

[20] Exhibit 1, Volume 1, Tab 8, Report of Dr Adam Brett dated 17 November 2022

> Mr Allen was flagged as being at risk and was appropriately monitored. There did not appear to have been any acute flags, but there were a number of chronic risk factors. He had a previous history of threatening self-harm in the community when under stress. He had poor coping mechanisms. He had a probable psychosis. He was under significant stress due to his legal issues, his family not visiting and his concerns about his family and the spiritual issues.
>
> I believe that Mr Allen's management was appropriate given the clinical resources at the prison.
>
> I believe that the mental health resources are insufficient in Roebourne prison, in line with other prisons. The model could be improved and the focus should include trauma, multidisciplinary teams, which would include aboriginal peer workers and traditional healers. This should not be something that needs to be brought in, it should be embedded.

83 The Department's Health Services also provided a report to the Court.[22] That report concluded:[23]

> Overall the presentations and interactions of Mr Allen with Health Services, including mental health services, were indicative of comprehensive, compassionate and patient-centric care. However, awareness of the delusions by the health services team appears to have been significantly delayed, which may reflect intentional silence by Mr Allen or acceptance (or assumption) by staff that these were more cultural than medical issues, and also likely reflect a lack of communication to health staff regarding what was being observed elsewhere.

84 It was noted in the report that recognition by prison health staff of Mr Allen's delusions and auditory hallucinations did not occur (or at least was not documented) until July 2020. In her evidence at the inquest, Dr Joy Rowland (Dr Rowland), the Department's Director of Medical Services, accepted that this was a missed opportunity.[24]

85 Notwithstanding that missed opportunity, I am satisfied that Mr Allen's mental health and emotional well-being was assessed on multiple occasions which included specific enquiry regarding social support, risks and stressors, and any thoughts of self-harm or suicide. These enquiries were undertaken by prison nurses, the prison doctor, PHS, the PSO and the prison psychiatrist. He was appropriately placed on ARMS for eight days in response to concerns raised by his cell mates. However, as he denied any risk of harm to himself, it was appropriate for him to be taken off ARMS after that period of time. I also note that he was then placed

[21] Exhibit 1, Volume 1, Tab 8, Report of Dr Adam Brett dated 17 November 2022, pp.8-9
[22] Exhibit 1, Volume 2, Tab 10.1, Health Services Summary into the Death in Custody dated 6 July 2023
[23] Exhibit 1, Volume 2, Tab 10.1, Health Services Summary into the Death in Custody dated 6 July 2023, p.14
[24] ts 12.7.2023 (Dr Rowland), pp.193-194

on SAMS and remained on that system until his death. I am satisfied that was an appropriate course of action taken by PRAG.

86 I also accept Dr Brett's evidence at the inquest after he was asked whether there was anything that suggested to him that Mr Allen's suicide should have been predicted: "*No. I think suicide is very difficult to predict and clinicians are taught not to try and predict who's going to suicide because statistically it's almost impossible*." [25]

87 That observation by Dr Brett is well-grounded. Even in a prison setting, suicide is rare and it is impossible to predict rare events with any certainty.

88 In 2017, the Department of Health published a document titled, "Principles and Best Practice for the Care of People Who May Be Suicidal"[26] (the Document).

89 The Document points out clinicians faced with the onerous task of assessing a person who may be suicidal will confront two issues. First, suicide is a rare event and second, there is no set of risk factors that can accurately predict suicide in an individual. The Document explains that the use of risk assessment tools that contain check lists of characteristics have not always been found to be very effective.[27]

90 Notwithstanding the identification by Dr Rowland of the missed opportunity outlined above, I accept Dr Brett's evidence at the inquest when he said: *"I think reviewing his case it seemed like everyone was doing their best to help him. It was a very difficult case. There was a lot of things going on and it was very difficult to predict"*.[28]

Were adequate steps taken for Mr Allen to access culturally appropriate support?

91 The Department's Health Services correctly identified the importance of culturally appropriate support in the provision of health services:[29]

> Multidisciplinary teams, inclusive of a range of health staff to provide a broad knowledge of culturally and religiously diverse worldviews and beliefs are

[25] ts 11.7.2023 (Dr Brett), p.101
[26] https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf
[27] https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf p.3
[28] ts 11.7.2023 (Dr Brett), p.103
[29] Exhibit 1, Volume 2, Tab 10.1, Health Services Summary into the Death in Custody dated 6 July 2023, p.14

> ideal but cross-cultural health care can still be effective, high quality and acceptable to patients. Repeat assessments, collateral history, involvement of family and religious or cultural leaders, and observation for distress and dysfunction are also useful. Diagnosis and formulation for individual patients often evolve over time as more information becomes available.

92 With respect to Mr Allen, Dr Brett was asked this question:[30]

> As a health practitioner or clinician, if you are presented with an Aboriginal client who is expressing distress and unusual behaviours linked to a cultural concept like being sung for example, how do you distinguish the cultural impact of what's happening as opposed to a mental health issue developing?
>
> - - - Well, the ideal way is to see the client with an Aboriginal clinician or have an Aboriginal consultant see the client and feedback to you. So if an Aboriginal consultant told me that the symptoms they were experiencing were cultural and that they would be able to manage them then obviously that's good. If they felt they weren't cultural but were mental health then we would get involved. But again the clear thing is the liaison between the two and the clarification is usually from the Aboriginal consultant.

93 Dr Brett explained that the Aboriginal consultant he was referring to was usually an elder from the patient's country.[31] For someone with the issues facing Mr Allen, Dr Brett agreed that it was desirable to have layers of support starting with peer and prison officer support, psychological support in the middle and psychiatric support at the top with cultural support imbedded in every layer.[32]

94 Culture-bound syndromes are prevalent in First Nation populations. Being "sung" is one such syndrome. As Tracy Westerman, an Aboriginal clinical psychologist, explained:[33]

> Participants spoke of non-psychical retribution for wrong-doing (payback) interchangeably referred to as "being sung" or "cursed" which involved conjuring (or calling/ceremonial singing for) spirits to inhabit the person's psyche and for bad mental physical, or spiritual health to result.

95 The evidence before the Court was that Mr Allen held the view that none of his fellow countrymen in RRP could culturally assist him as they were also subject to "black magic".[34] Consequently, Mr Allen's cultural group within RRP did not understand or know what he needed as he was not

[30] ts 11.7.2023 (Dr Brett), p.93
[31] ts 11.7.2023 (Dr Brett), p.94
[32] ts 11.7.2023 (Dr Brett), p.102
[33] Exhibit 2, Tracey Westerman, "Culture-bound Syndromes in Aboriginal Australian Populations" dated 15 March 2021, p.6
[34] ts 12.7.2023 (Ms Woolgrove), p.214

articulating to them what he required.[35] They were also not certain that Mr Allen had actually been sung as he was not asking for things to happen that a person who had been sung would ordinarily request.[36]

96 This problem was further compounded by the COVID-19 restrictions that were in place for a significant period of Mr Allen's imprisonment regarding outside visitors.[37]

97 Tanya Woolgrove (Ms Woolgrove), Assistant Superintendent at RRP, accepted that, with the benefit of hindsight, she would have sought cultural guidance from her contacts in the local community as to who may be best placed to assist Mr Allen.[38]

98 I am not convinced that Ms Woolgrove is able to qualify her evidence by "the benefit of hindsight". That is because the SAMS Manual specifically identifies this course of action. The provisions of the SAMS Manual applied to Mr Allen when he was on SAMS from 7 May 2020 until his death.

99 The SAMS Manual has a section that deals with a prisoner experiencing spiritual or culturally related issues and sets out what can be done, including making contact with an appropriate community or family member:[39]

> Coordinating the resolutions of a prisoner's sensitive and cultural issues may in many instances involve a telephone call to the appropriate community or family member and identifying and arranging a suitable placement for the prisoner. However, it may involve liaising with appropriate community and/or family members, cultural consultants or community elders to resolve the prisoner's sensitive spiritual and cultural issues. (underlining added)

100 Dr Kevin Smith (Dr Smith), the psychiatrist who had the telehealth appointment with Mr Allen on 15 July 2020, suggested to Mr Allen that cultural counselling might be beneficial. However, he did not personally make any further arrangements for that to take place.[40]

101 I am satisfied that attempts were made by RRP's health service providers and other staff to address the cultural and spiritual issues that Mr Allen believed he had. I also accept that these issues were complicated and unlikely to be easily resolved. Nevertheless, I find that there was a

[35] ts 12.7.2023 (Ms Woolgrove), p.229
[36] ts 12.7.2023 (Ms Woolgrove), p.214
[37] This period was from 27 February 2020 to 27 June 2020.
[38] ts 12.7.2023 (Ms Woolgrove), pp.231-232
[39] Exhibit 1, Volume 2, Tab 3, SAMS Manual, Version 1.2, June 2009, pp.8-9
[40] Exhibit 1, Volume 1, Tab 49, Report of Dr Kevin Smith dated 21 February 2023, p.2

missed opportunity in not contacting relevant community and/or family members as recommended in the SAMS Manual.

Was there adequate supervision of Mr Allen on the night of 28 and 29 July 2020?

102 For the reasons I have outlined below, I am satisfied to the required standard that one aspect of the supervision of Mr Allen by prison officers on the night of his death was inadequate.

103 The Court was provided with various Local Orders for RRP relating to night shift cell and body checks that applied at the time of Mr Allen's death. As can be seen from the extracts cited below, these were often repetitive in nature.

104 RRP's "Local Order S6 - Muster Management" dated 15 February 2016 (Local Order S6) was "*applicable to all musters and prisoner body checks/counts*" at RRP.[41] A "count" was defined as "*accounting numerically for prisoners checked*".[42]

105 Local Order S6 specified that for night counts:[43]

> Night shift staff will account for prisoners by conducting body and integrity checks at the scheduled times. Officers are to satisfy themselves that the prisoner is present and there are no obvious indications of an attempt to self-harm when they conduct a body check.
>
> These checks and the associated count are to be recorded in the occurrence books in the following or similar format 'Body and integrity checks complete Count xx, all appears correct.'

106 RRP's "Local Order 02 - General Security" dated April 2012 (Local Order 02) specified that for night musters/checks: "*Night shift staff will conduct body and welfare checks at the appropriate times. These checks are to be recorded in the occurrence books. The Senior Officer will sign each unit occurrence book during his/her rounds acknowledging the muster as being correct*".[44]

107 Local Order 02 specifies that the first cell and body check is to be conducted before midnight but no earlier than 9.30 pm, and that a minimum of two further cell and body checks are to be conducted

[41] Exhibit 1, Volume 2, Tab 8.1, Local Order - S6, Muster Management dated 15 February 2016, p.1
[42] Exhibit 1, Volume 2, Tab 8.1, Local Order - S6, Muster Management dated 15 February 2016, p.2
[43] Exhibit 1, Volume 2, Tab 8.1, Local Order - S6, Muster Management dated 15 February 2016, p.5
[44] Exhibit 1, Volume 3, Tab 26.1, Local Order 02 - General Security, p.10

randomly by prison officers and before the unlocking of cells take place.[45] Identical provisions appear in Local Order S6.[46]

108 RRP's "Local Order S12 - Night Shift" (Local Order S12) which was in place at the time of Mr Allen's death repeats the provisions of Local Order 02 outlined above and also states during the cell and body check that: "*Officers are to satisfy themselves that the prisoner is present and there are no obvious indications of an attempt to self-harm when they conduct body checks.*"[47]

109 The Department's Review of Mr Allen's death identified that Local Order 02 and Local Order S12 were not complied with as Ms van Hengel *"did not satisfy herself that Mr Allen was present in his cell and failed to satisfy herself that there were no obvious indications of an attempt to self-harm"*.[48]

110 Following a Professional Standards Directorate investigation, Ms van Hengel was subsequently disciplined[49] and was required to undergo retraining with respect to her night shift duties at RRP.[50]

111 At the inquest, Ms van Hengel agreed that she failed to satisfy herself that Mr Allen was present during the final cell and body check at about 4.35 am on 29 July 2020. She also confirmed that she accepted the disciplinary findings made against her.[51]

112 Ms van Hengel's explanation for not counting the prisoners in each cell was that she had not been taught at RRP to count the prisoners during night shift cell and body checks.[52] At the inquest, Ms van Hengel explained that during her night shift orientation at RRP, she was told the following by the prison officer conducting the orientation:[53]

> He said you put the light up to the ceiling and you let it flow down and you just check the prisoners. His advice was to be more careful of the two ups than the six ups[54] because the six ups are generally countrymen and look after themselves.

[45] Exhibit 1, Volume 3, Tab 26.1, Local Order 02 - General Security, p.11
[46] Exhibit 1, Volume 2, Tab 8.1, Local Order – S6, Muster Management dated 15 February 2016, p.6
[47] Exhibit 1, Volume 3, Tab 26.1, Local Order S12 - Night Shift (revoked 31 August 2020), p.2
[48] Exhibit 1, Volume 3, Tab A, Review of Death in Custody dated May 2023, p.7
[49] Exhibit 1, Volume 3, Tab A, Review of Death in Custody dated May 2023, p.7
[50] ts 11.7.2023 (Ms van Hengel) p.135
[51] ts 11.7.2023 (Ms van Hengel) p.135
[52] Exhibit 1, Volume 1, Tab 25.1, Transcript of interview by Professional Standards Division with Ms van Hengel dated 12 August 2020, p.15
[53] ts 11.7.2023 (Ms van Hengel) p.113
[54] "Two ups" refers to two bed cells and "six ups" are six bed cells.

113 When she was asked at the inquest what she was looking for when conducting a night time cell and body check, Ms van Hengel replied: "*Just looking that everybody is calm, everyone is ok, … nothing is going wrong … nobody is self-harming, that there's peace throughout the cell so that there's no maybe people getting angry with each other*."[55]

114 In response to Ms van Hengel's statement that she relied on her orientation at RRP when conducting night shift cell and body checks, the Department provided to the Court the Academy Training Module titled "Accounting for Prisoners" (the Module). This material is distributed to all prisoner officers during initial training at the Academy. Under the heading "Night Counts", the following passage appeared in the Module:[56]

> Night counts are carried out at either nominated times or within nominated periods. On every "Night count" you must make absolutely sure, beyond any doubt, that you are counting an actual body. If there is any doubt in your mind, you must gain an audible or movement response from the prisoner.

115 Ms van Hengel could not recall being told this at the Academy.[57] I am not surprised by that answer. As Ms van Hengel explained at the inquest: "*There was so much taught at the Academy that apparently I had two 55 minute courses on night shift on a 12 week course. So I was more guided by my orientation by another officer*."[58]

116 Ms van Hengel had initially been a prison officer at Hakea Prison for four years. I note there are no six bed cells at that prison. She was then transferred to RRP where she had worked for about two years before the death of Mr Allen. She was therefore a relatively experienced prison officer. I asked Ms van Hengel this question at the inquest:[59]

> So in the two years you were at Roebourne, it never crossed your mind that it was important for the prison to know how many prisoners were in cells at night-time? - - - I thought that basically I could see everybody. I thought that what I was looking at was making sure that nothing was amiss. It just never occurred to me that somebody could actually in a multicell take their own life.
>
> …
>
> But if you regarded it as a cell and body check, I'm having trouble just understanding why the attitude was taken that it was really only a cell check and not a body check? - - - It's just how my orientation was presented to me. And you call it a cell and body check but it's – that's just what's it called. Like,

[55] ts 11.7.2023 (Ms van Hengel), p.123
[56] Exhibit 1, Volume 2, Tab 11.1, Department of Corrective Services, Accounting for Prisoners Training, p.7
[57] ts 11.7.2023 (Ms van Hengel), p.118
[58] ts 11.7.2023 (Ms van Hengel), p.129
[59] ts 11.7.2023 (Ms van Hengel), pp.129-130

> I literally thought I was doing ok. I literally did not know. And I wish to this very day that I did know because I am not the sort of officer that takes shortcuts.

117 As to her check at about 4.35 am on 29 July 2020, Ms van Hengel was asked these questions by counsel assisting after she said she had shone her torch on the roof of the cell:[60]

> Do you recall actually seeing each of the beds when you did that? - - - Now I can't. No.
>
> Your evidence is that you didn't at any point realise there was an empty bed. Is that right? - - - I might have realised there was an empty bed, but I thought there was nothing wrong with that because other beds had been empty in the past.
>
> So you didn't know what the capacity of that cell was - - - ? - - - No.
>
> - - - and how many prisoners to expect in there? - - - No.

118 At the inquest, Ms van Hengel acknowledged that looking back now she "*can see where I was very much mistaken*".[61]

119 Although it was naïve of Ms van Hengel to have never considered a prisoner could take their life in a six bed cell, I accept her evidence that her failure to properly undertake a night shift cell and body check was not because she was "*lazy or lackadaisical*".[62] I also accept her evidence that the mistaken manner in which she conducted night shift cell and body checks was due to the instructions she had been given by another prison officer during her orientation when she commenced work at RRP. In those circumstances, Ms van Hengel's culpability in her inadequate supervision of Mr Allen on the night in question is reduced as I am satisfied the "shortcut" method she used for her night shift cell and body checks was the one that she was shown during her orientation at RRP.

120 Based on the evidence before me, I am not able to find that had there been adequate supervision of Mr Allen during the final cell and body check, his death could have been prevented. That is because an estimated time of his death cannot be calculated.[63]

Ligature points in cells at RRP

121 RRP opened in March 1984, one month shy of 40 years ago. It is almost trite to say that a prison built today would not have the extraordinarily

[60] ts 11.7.2023 (Ms van Hengel), p.126
[61] ts 11.l7.2023 (Ms van Hengel), p.128
[62] ts 11.l7.2023 (Ms van Hengel), p.128
[63] Exhibit 1, Volume 1, Tab 6.4, Email from Dr Dan Moss to the Court dated 8 June 2023

high number of ligature points in cells that RRP had as at the time of Mr Allen's death. The diagonal metal grilles across the toilet window of the six bed cells in RRP were also in place across the windows in the common areas of these cells. Any number of these grilles can be effectively and easily used as ligature points for a suicide by hanging. I was astounded to discover this when I viewed the photographs of the cell that Mr Allen was in.[64]

122 Following Mr Allen's death, mesh screening was installed in 2021 to every six bed cell toilet cubicle. This screening was placed in front of the diagonal metal grilles, thereby reducing the use of these grilles as ligature points.[65] However, a large number of cells at RRP still have these grilles to cell windows in their common areas that can be easily accessed.

123 At the inquest, Ms Woolgrove gave evidence that fly wire had been installed on these windows; however, it would easily break.[66] Following a recommendation from the Office of the Inspector of Custodial Services, a harder-wearing mesh began to be installed. However, that was not completed after the decision was made to install air-conditioning in all cells.[67] As Ms Woolgrove explained, the cell windows will need to be completely enclosed for the air-conditioning to be effective. Although the final plans for the installation of the air-conditioning had not been submitted at the time of the inquest, I had stressed it was imperative the enclosure of the windows be done internally to prevent access to the diagonal metal grilles by prisoners when they were in their cells.[68]

QUALITY OF THE DEPARTMENT'S SUPERVISION, TREATMENT AND CARE OF MR ALLEN

124 Having considered the documents tendered into evidence, and the oral evidence of the witnesses at the inquest, I am satisfied that Mr Allen's mental health issues were appropriately managed by the health service providers at RRP, given the resources that were available to them at the time. Although there were two missed opportunities that I have outlined above, I am satisfied that the standard of supervision, treatment and care provided to Mr Allen for his mental health issues whilst he was in custody was adequate.

[64] Exhibit 1, Volume 1, Tab 32.1, Photographs 1 - 6 of Cell 5.13 in Unit 2
[65] Exhibit 1, Volume 2, Tab 8, Report of Superintendent Tanya Woolgrove dated 29 June 2023, p.5, attachment 12
[66] ts 12.7.2023 (Ms Woolgrove), p.254
[67] ts 12.7.2023 (Ms Woolgrove), pp.254-255
[68] ts 12.7.2023, p.256

125 Accordingly, I agree with the assessment by Dr Rowland that: "*Overall, the presentations and interactions of Mr Allen with Health Services, including mental health services, were indicative of comprehensive, compassionate and patient-centric care.*"[69]

126 However, applying the ***Briginshaw*** principle and having considered the evidence from Ms van Hengel and Mr Popp, I am satisfied that the supervision of Mr Allen on the night of his death was inadequate. Specifically, I am referring to the cell and body check at about 4.35 am on 29 July 2020 by Ms van Hengel which failed to account for the whereabouts of Mr Allen inside his cell. That was a failure to comply with the policies and procedures for night shift duties that were applicable at the time.[70]

127 I am also satisfied to the required standard that the handwritten entry by Mr Popp in the occurrence book with respect to the final night shift cell and body check that read: "*0435 cell plus body check*"[71] was an incorrect entry insofar as it related to the cell and body checks undertaken by Ms van Hengel, which he well knew at the time.

128 Accordingly, I make those findings.

SECTION 50 OF THE CORONERS ACT 1996 (WA)

129 Section 50(1) of the *Coroners Act 1996* (WA) provides:

> A coroner may refer any evidence, information or matter which comes to the coroner's notice in carrying out the coroner's duties to a body having jurisdiction over a person carrying on a trade or profession if the evidence, information or matter —
>
> (a) touches on the conduct of that person in relation to that trade or profession; and
>
> (b) is, in the opinion of the coroner, of such a nature as might lead the body to inquire into or take any other step in respect of the conduct apparently disclosed by the evidence, information or matter so referred.

Ms van Hengel

130 The Court is already aware that the Department is undertaking an investigation as to whether a disciplinary process under Part 5 of the *Public Sector Management Act 1994* (WA) or a loss of confidence process under Part 10 of the *Prisons Act 1981* (WA) should occur with

[69] Exhibit 1, Volume 2, Tab 10.1, Health Services Summary into the Death of Custody dated 6 July 2023
[70] Exhibit 1, Volume 3, Tab 26.2, Roebourne Regional Prison Local Order - S12
[71] Exhibit 1, Volume 3, Tab 25, Occurrence Book dated 28 and 29 July 2020, p.3

respect to Ms van Hengel.[72] In those circumstances, I do not consider it is necessary for a reference to be made under section 50(1) of the *Coroners Act 1996* (WA) with respect to Ms van Hengel's final cell and body check of Mr Allen's cell at about 4.35 am on 29 July 2020.

131 However, I will simply note that I have found Ms van Hengel to be a credible and honest witness with respect to her actions on the night of Mr Allen's death. As I have outlined above, I have found that Ms van Hengel's conduct when performing her night shift cell and body checks which, whilst inadequate, was simply following the instructions provided to her during her orientation at RRP. In my view, that is a mitigating factor of some significance.

Mr Popp

132 In his statement to the Court dated 6 July 2023, Mr Popp recounted the following conversation he had with Ms van Hengel after the final cell and body checks at about 4.35 am on 29 July 2020:[73]

> In that interaction, I said to her, "…all mine [prisoners] are good, I checked and they are all there. How did yours go?" or words to that effect.
>
> Officer van Hengel then replied to me, "do you count them?" or words to that effect.
>
> I responded to her, "yes, I always count them."
>
> Officer van Hengel then said, "I didn't count them" or "I don't count them" or words to that effect.
>
> Officer van Hengel then said, "I am not happy with the check".
>
> She indicated that she was unhappy with the visibility within the cells. I agreed with her that it was difficult to see into the cells.
>
> I said to her, "if you are not happy, then we can go back and do it again. It's your call – if you are not happy then we can go back and do it again."
>
> She said, "No, all good. No problem" or words to that effect.
>
> After the interaction, we returned to the Unit 2 Office.

133 At the inquest, Mr Popp confirmed that this conversation was correct,[74] and that he was absolutely certain that it had taken place after the final

[72] Letter from Assistant State Counsel at the State Solicitor's Office to the Principal Registrar of the Coroner's Court dated 19 October 2023
[73] Exhibit 1, Volume 1, Tab 26.2, Statement of Douglas Popp dated 6 July 2023, pp.1-2
[74] ts 11.7.2023 (Mr Popp), pp.56-58

cell and body check.[75] Ms van Hengel could not recall any conversation she had with Mr Popp after this cell and body check.[76]

134 In contrast to Ms van Hengel's evidence on this point, Mr Popp stated that his body and cell checks always involved counting the number of prisoners and matching that number to the names that appear on the door of each cell.[77] He also confirmed that he completed the occurrence book entries for all the three cell and body checks completed in Unit 2 on the night of Mr Allen's death.[78]

135 At the inquest, I asked Mr Popp the following questions about his conduct following his conversation with Ms van Hengel:[79]

> … I want to know why didn't you take the responsible approach to this and say, "No, I'm signing the occurrence book. I'm going to sign that everyone has been counted and checked, so therefore we need to do it"? --- Because when I said we will go back and check, and she said – I said, "It's up to you". [She said] "No, all good. No problem".
>
> But you knew it wasn't all good because she had told you she hadn't counted the prisoners that she was required to count. So it wasn't all good, was it?--- Well, from my point of view it was. Yes.
>
> How can you possibly say that, Mr Popp? --- Well, because she said it was fine. Maybe she rethought her count – her check.
>
> She had told you, "I didn't count them"? --- Well, she – but then she told me it was fine.
>
> But how can you be satisfied it was fine if she was saying to you she hadn't counted them? --- Because I just took her word for it. It's – it was fine.
>
> No. But it wasn't fine, was it? --- Obviously not, and looking back on it all, no, it wasn't fine.

136 After stating as far as he was concerned, his entry in the occurrence book for the 4.35 am cell and body check *"was correct"*, I asked Mr Popp the following questions:[80]

> How could it be correct if she had not counted the prisoners? --- Well, she said, "All fine. All good".
>
> How could it be correct if she has not counted her prisoners? --- I don't know.
>
> Well, it's not correct, is it? --- Obviously not.

[75] ts 11.7.2023 (Mr Popp), p.64
[76] ts 11.l7.2023 (Ms van Hengel), p.138
[77] ts 11.7.2023 (Mr Popp), p.24
[78] ts 11.7.2023 (Mr Popp), p.53
[79] ts 11.7.2023 (Mr Popp), pp.59-60
[80] ts 11.7.2023 (Mr Popp), p.61

137 Counsel assisting later put this proposition to Mr Popp:[81]

> There's a level of responsibility there when you're given information by your colleague that they haven't done their job properly that you should make sure it's done correctly. Is that fair? - - - I suppose, yes, when you put it that way.

138 After Mr Popp gave that answer, I asked him whether he now sees that he had made an error that night. Mr Popp answered: "*Yes. I do now that you point that out, yes. Should have done it differently, I guess*".[82]

139 Mr Popp had been a prisoner officer with the Department since 1986. He therefore had 34 years' experience as at the time of Mr Allen's death. In contrast, Ms van Hengel had been a prison officer for about six years as of July 2020.[83] Unlike Ms van Hengel, Mr Popp was well aware that a cell and body check during a night shift required a confirmation that the number of prisoners housed in a cell were all accounted for during the check. As he was aware that a body count had not been undertaken by Ms van Hengel during the final cell and body check, I am satisfied that Mr Popp knowingly made an inaccurate entry in the occurrence book.

140 I am satisfied to the required standard that in the circumstances as recounted by Mr Popp, it was incumbent upon him to ensure a proper cell and body check for each of the cells allocated to Ms van Hengel be undertaken after she had told him that no count had been done. This was also the view of Ms Woolgrove.[84] I was therefore not surprised to hear Ms Woolgrove concede that she "*felt quite ashamed*" that Mr Popp did not think he had done anything wrong until it was pointed out to him at the inquest.[85] She also accepted that this example reflected, at least in July 2020, a concerning attitude towards cell and body checks at RRP.[86]

141 At the conclusion of the inquest, I indicated to counsel appearing on behalf of the Department that I was considering making an adverse finding against Mr Popp regarding his failure to ensure a proper cell and body check was undertaken for the cells allocated to Ms van Hengel after their conversation. Through counsel, I provided Mr Popp with the opportunity of providing a further statement or written submissions to address that potential adverse finding.[87]

[81] ts 11.7.2023 (Mr Popp), p.62
[82] ts 11.7.2023 (Mr Popp), p.64
[83] ts 11.7.2023 (Ms van Hengel), p.77
[84] ts 12.7.2023 (Ms Woolgrove) p.243
[85] ts 12.7.2023 (Ms Woolgrove) p.244
[86] ts 12.7.2023 (Ms Woolgrove) p.244
[87] ts 12.7.2023, p.270

142 By email dated 28 August 2023, counsel for the Department advised the Court that Mr Popp had elected not to make another statement or provide further submissions.[88]

143 In accordance with section 50(1) of the *Coroners Act 1996* (WA), I refer to the Department for any disciplinary process it deems appropriate in regard to Mr Popp's actions after Ms van Hengel had told him she had not counted the prisoners during the cell and body check she conducted at about 4.35 am on 29 July 2020.

CHANGES AND IMPROVEMENTS SINCE MR ALLEN'S DEATH

144 There is frequently a gap of some duration between the date of the death requiring a mandatory inquest and the date of the inquest. In those circumstances, the entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

145 In this case, there have already been changes made by the Department at RRP since Mr Allen's death that are designed to reduce the risk of (i) a prisoner self-harming during the night and (ii) unnecessary delays by custodial staff finding out about such an event.

Changes to night shift cell and body checks

146 Local Order S12 was revoked on 31 August 2020 and replaced by Local Order - S6 titled "Muster Control and Recording".[89]

147 Pursuant to this replacement Local Order - S6, the three night shift cell and prisoner welfare checks must be completed by two officers attending each cell. Previously, only one prison officer was required to attend each cell. Now, one prison officer is to record the check and count on the "Unit Count by Cell" sheet and the other prison officer is to complete a visual check of the number of cell occupants, and also conduct a visual welfare check of the cell occupants. As the replacement Local Order - S6 makes clear:[90]

> Officers are counting that the required number of prisoners are in each cell as per the Unit Count by Cell sheet. As the night officers present during the lockup, these officers are to satisfy themselves that the prisoner is present and that there are no indications of an attempt to self-harm when they conduct the night count check

[88] Email from Mr McIlwaine to counsel assisting dated 28 August 2023
[89] Exhibit 1, Volume 2, Tab 8.3, Local Order - S6, Muster Control and Recording
[90] Exhibit 1, Volume 2, Tab 8.3, Local Order - S6, Muster Control and Recording, p.7

Changes to cell toilet doors

148 Following Mr Allen's death, all cell toilet doors were removed and shortened in length to allow improved visibility for staff whilst ensuring dignity was maintained for those using the toilet. In addition, toilet door locks were moved to the top of the door, so that they can be easily accessible to prison staff if they are locked from the inside. The locks were changed to sliding bolt locks to assist with this accessibility.[91]

Installation of mesh screening to toilet cubicle windows

149 In 2021, mesh screens were installed to the toilet cubicle window of every multi bed cell. This mesh screen was placed internally so that the diagonal metal grilles could not be accessed by an occupant of the toilet. I am satisfied that these installations will effectively prevent prisoners from accessing these grilles for use as ligature points.[92]

Further ligature minimisation of cells

150 Although mesh screening had been installed in front of the diagonal metal grilles in every toilet cubicle in the multi bed cells at RRP, no such screening had been installed across the same diagonal metal grilles in the other windows of those cells. That was a matter that caused me some considerable concern at the inquest.

151 Thankfully, I have been advised that this issue will be addressed when air-conditioning is installed in all cells at RRP which is scheduled for mid-2024. Counsel for the Department confirmed that by email to the Court dated 15 January 2024, which read: "*Roebourne Regional Prison Temperature Management Project will incorporate fitting, glazing and ligature minimised mesh internal to the cell, which will remove the ability to have access to the existing blue steel grill.*"[93] (underlining in original)

152 In those circumstances, I have considered it is not necessary for me to make a recommendation that access to these ligature points in cells be eliminated.

Mental health first aid training

153 In her evidence at the inquest, Ms Woolgrove outlined a training program that was introduced to prisoners at RRP in October 2020. This

[91] Exhibit 1, Volume 2, Tab 8, Report of Superintendent Tanya Woolgrove dated 29 June 2023, p.5
[92] Exhibit 1, Volume 2, Tab 8, Report of Superintendent Tanya Woolgrove dated 29 June 2023, p.5
[93] Email from Mr McIlwaine to the Court dated 15 January 2024

training was specifically directed at mental health first aid for Aboriginal and Torres Strait Islanders. Nineteen prisoners completed the course, including female prisoners and those with the peer support team. This training had been organised by the PSO and was very well received.[94]

154 In addition, the Department is undertaking a pilot program designed as a refresher course for the Gatekeeper training that prison officers receive at the Academy. Gatekeeper training identifies risk factors for suicidality and identifying risk factors.[95]

155 RRP has also introduced the services of an external agency to run staff and peer support prisoner training in suicidal awareness and Aboriginal mental health.[96] I commend Ms Woolgrove for the introduction of this program.

CONCLUSION

156 Mr Allen was a 47 year old Nyamal man who was found hanging in the toilet of his cell by prison officers early in the morning of 29 July 2020.

157 Mr Allen had repeatedly denied suicidal thoughts when questioned during his time in prison and had no history of self-harming when imprisoned on previous occasions. Although Mr Allen had talked about hanging himself in the community in 2019, this appeared to be in the context of attention seeking behaviour, rather than a demonstrated true intent.

158 Mr Allen displayed some paranoid and possibly psychotic behaviour in the weeks leading up to his death. He was also experiencing cultural/spiritual issues regarding being sung. On 15 July 2020, Mr Allen was reviewed by a psychiatrist and it was considered he was having delusions and auditory hallucinations and/or psycho-hallucinations consistent with his cultural beliefs. The psychiatrist recommended brain scans and blood tests in order to determine if Mr Allen's delusions were due to alcohol-related frontal lobe damage. However, Mr Allen died before these tests were completed. The psychiatrist also suggested that cultural counselling might be of benefit. That was also not progressed any further before Mr Allen's death.

[94] ts. 12.7.2023 (Ms Woolgrove), p.259; Exhibit 1, Volume 2, Tab 9.3, Aboriginal and Torres Strait Islander Mental Health First Aid – Building Strong Minds
[95] ts. 12.7.2023 (Ms Woolgrove), p.258
[96] ts. 12.7.2023 (Ms Woolgrove), p.258

159 I have found that the mental health care Mr Allen received in RRP was appropriate given the resources available to mental health service providers and the COVID-19 restrictions that were in place for much of Mr Allen's imprisonment. He was identified as experiencing possible psychotic symptoms and was reviewed by a mental health nurse and then a prison psychiatrist. His diagnosis was in the process of being clarified at the time of his death and his refusal to take medications was a complicating factor. I am satisfied Mr Allen's suicide was unexpected and would have been difficult to predict.

160 I am also satisfied that once Mr Allen was discovered, the efforts to resuscitate him were appropriate and conducted in a timely manner by prison custodial and medical staff. However, I was not satisfied that the supervision of Mr Allen during the final night shift cell and body check was adequate as the prison officer assigned that task did not satisfy herself that she had sighted all prisoners, including Mr Allen, in his cell. I was also not satisfied with the other prison officer's response when he had become aware of this, including his inaccurate entry in the occurrence book that misleadingly indicated a body count had been done in all cells at Unit 2 during the final cell and body check.

161 I am satisfied that the changes made by RRP to its night shift cell and body checks will reduce the risk of a self-harming incident being undetected for an unnecessary length of time. In addition, I am satisfied that the changes to the infrastructure of cells that have already been undertaken, and scheduled to be undertaken in the middle of this year, will reduce the access to the numerous ligature points in cell windows that existed at the time of Mr Allen's death.

162 As Mr Allen's family and loved ones were unable to attend the inquest, I must note that at the inquest Ms van Hengel expressed her deep sorrow for what had happened on 29 July 2020.[97] It was evident to me from the manner in which Ms van Hengel gave her evidence that Mr Allen's death has weighed heavily on her mind since that date.

163 I extend my condolences to the family and loved ones of Mr Allen for their sad loss.

[97] ts 11.l7.2023 (Ms van Hengel), p.141

P J URQUHART
Coroner
6 February 2024