JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	27 - 28 FEBRUARY 2024
DELIVERED	**:**	28 MARCH 2024
FILE NO/S	**:**	CORC 1720 of 2020
DECEASED	**:**	DAVIS, SUZZANNE DENISE

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms P. Femia (State Solicitor's Office) appeared for the Department of Justice.

Ms B. Kerr (Belinda Burke Legal) appeared for Mr G. Collins.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Melaleuca Prison on 13 August 2020. Any such prisoner is to be referred to as "Prisoner [*Initial*]".

Order made by: MAG Jenkin, Coroner (28.02.24)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Suzzanne Denise DAVIS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 27 - 28 February 2024, find that the identity of the deceased person was* ***Suzzanne Denise DAVIS*** *and that death occurred on 13 August 2020 at Melaleuca Women's Prison, Nicholson Road, Canning Vale, from ligature compression of the neck (hanging) in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION

1. Suzzanne Denise Davis (Ms Davis) was 47-years of age when she died on 13 August 2020 from ligature compression of the neck. At the time of her death, Ms Davis was a remand prisoner at Melaleuca Women's Prison (Melaleuca) and therefore in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1,2,3,4,5,6,7]

2. Accordingly, immediately before her death, Ms Davis was a "*person held in care*" and her death was a "*reportable death*".[8] In such circumstances, a coronial inquest is mandatory.[9]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received.[10] Members of Ms Davis' family attended an inquest I held at Perth on 27 - 28 February 2024, at which the following witnesses gave evidence:

a. Ms Maureen Kay (Chaplain, Melaleuca);
b. Mr Aaron Cusack, (Clinical nurse, Melaleuca);
c. Mr Gavin Collins, (Clinical nurse, Melaleuca);
d. Mr David Hunter (Acting Senior Prison Officer, Melaleuca);
e. Mr Kedar Jadhav (Prison Officer, Melaleuca);
f. Ms Toni Palmer (Senior Review Officer);
g. Dr Catherine Gunson (Acting Director of Medical Services); and
h. Dr Viki Pascu (Independent Consultant Forensic Psychiatrist).

4. The documentary evidence adduced at the inquest comprised one volume, and the inquest focused on the care, treatment and supervision provided to Ms Davis while she was in custody, as well as the circumstances of her death.

---

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (07.07.22)
[2] Exhibit 1, Vol. 1, Tab 2, P98 - Mortuary Admission Form (13.08.20)
[3] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of deceased (13.08.20)
[4] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (13.08.20)
[5] Exhibit 1, Vol. 1, Tab 5.2, Supplementary Toxicology Report (28.02.23)
[6] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (19.08.20)
[7] Section 16, *Prisons Act 1981* (WA)
[8] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[9] Section 22(1)(a), *Coroners Act 1996* (WA)
[10] Section 25(3) *Coroners Act 1996* (WA)

MS DAVIS

Background[11,12,13,14,15]

5. Ms Davis was born on 1 August 1973 and was 47-years of age when she died at Melaleuca on 13 August 2020. She was one of four children and left school in Year 9. She had reportedly started using illicit substances in her early teens and was said to have gone "*downhill from there*".[16]

6. Ms Davis had two children of her own, and for about two years prior to her death, she had been in an "*abusive and very toxic*" relationship. Ms Davis' partner had allegedly introduced her to methylamphetamine, and her mental health was said to have deteriorated as a result.[17]

Overview of criminal and prison history[18,19,20,21,22]

7. Ms Davis had an extensive criminal record and had accumulated "*295 criminal court outcomes*" between 21 January 1987 and her death. Ms Davis was incarcerated on 29 occasions, and spent a total of 4,414 days in custody. On 28 June 2020, Ms Davis was taken into custody after being charged with wilfully lighting a fire with intent to injure or damage. She was remanded in custody several times, the last occasion being on 13 August 2020, which as noted, was the day of her death.

Medical issues[23,24,25,26,27]

8. Ms Davis' medical history included back and arm pain (related to previous injuries), sciatica, skin infections, generalised anxiety disorder, depression, flashbacks related to post-traumatic stress disorder, and epilepsy, with her last reported seizure having occurred in October 2019.

---

[11] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), p4
[12] Exhibit 1, Vol. 1, Tab 10, Statement - Ms C Fisher (unsigned), paras 2-9
[13] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp3-5
[14] Exhibit 1, Vol. 1, Tab 31.1, Health Services Summary (27.12.23), p3
[15] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. N Dempsey (03.09.20) re information received from Ms Davis' father
[16] Exhibit 1, Vol. 1, Tab 11, Statement - Sen. Const. N Dempsey (03.09.20), para 9
[17] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p8
[18] Exhibit 1, Vol. 1, Tab 25.1, Statement of Facts (Brief No. 1973068-1)
[19] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p8
[20] Exhibit 1, Vol. 1, Tab 25.2, History for Court - Criminal and Traffic (21.08.20)
[21] Exhibit 1, Vol. 1, Tab 32.5, Remand Module Screenshot (13.08.20)
[22] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), p4
[23] Exhibit 1, Vol. 1, Tab 31.1, Health Services Summary (27.12.23), pp3-10
[24] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), pp4-5
[25] Exhibit 1, Vol. 1, Tab 22, Patient health summary - Sonic HealthPlus, West Perth
[26] Exhibit 1, Vol. 1, Tab 34, Summary into Death - MHAOD Branch (08.04.21), p3
[27] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp3-5 & 10

9. Ms Davis had been diagnosed with an episode of delusional parasitosis,[28] and she had a history of polysubstance use including heroin, cannabis, overuse of benzodiazepine medication, and more recently, methylamphetamine. From 2011 to 2012, Ms Davis was admitted to the mental health unit at Bentley Health Service on three occasions and variously diagnosed with drug induced psychosis, and delusional disorder with polysubstance dependence.[29]

10. According to the police investigation report into her death, Ms Davis reportedly attempted to take her life by hanging in 1999, and she had been treated for "*mental illness*" as an involuntary patient. The police report also notes that:

> On 23 November 2017, (Ms Davis) absconded from Royal Perth Hospital during treatment following suicide attempts, during which time (she) had a visible line on her neck from her suicide attempt.[30]

11. During six of her previous periods of incarceration Ms Davis had been managed on the At Risk Management System (ARMS). 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.[31,32]

12. 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. When a prisoner is placed on ARMS, an interim management plan is developed and the prisoner is managed with observations at either: high (one-hourly), moderate (2-hourly) or low (4-hourly) intervals. During her last admission at Melaleuca, Ms Davis was not managed on ARMS, and I will say more about this issue later in this finding.[33,34,35]

---

[28] An infrequent psychotic illness characterised by the unshaken belief that one has been infested with a parasite when one has not
[29] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp3-5
[30] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), p5
[31] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), p4
[32] Exhibit 1, Vol. 1, Tabs 20.1-20.5, Various ARMS Offender Referrals & Management Plans (07-13.12.19)
[33] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp4-5
[34] ARMS Manual (2019)
[35] Exhibit 1, Vol. 1, Tab 32.2, Statement - Officer S Corbett (28.03.23), paras 7-15 and ts 27.02.24 (Hunter), p41

13. Following her last admission to Melaleuca, Ms Davis was reviewed by a mental health nurse on 1 July 2020. Although it was noted that Ms Davis had been on the suboxone program in the community, there was an unfortunate delay of several days before she was given this medication in prison.[36]

14. At the inquest, Dr Gunson said this interruption in Ms Davis receiving suboxone may have caused symptoms of opioid withdrawal, which can include: "*hot and cold flushes, sweats, joint aches and pains, muscle aches and pains, nausea, vomiting, diarrhea, watery eyes, runny nose*". However, Dr Gunson also noted that suboxone "*does last quite a time in the system*", and as a result, Ms Davis may not have experienced "*severe withdrawal symptoms*".[37]

15. Dr Gunson also said that in her opinion, this interruption was unlikely to have had any impact on the events that led to Ms Davis' death. In any event, in accordance with departmental policy, Ms Davis was subsequently transferred onto the methadone program.[38,39,40,41,42]

16. Following Ms Davis' death, the Department conducted a review of the health services she received whilst incarcerated (the Health Review). The Health Review noted Ms Davis had "*presented with some psychotic symptoms and signs*" during her admission into custody in December 2019, but that "*these settled within a few days*". During her 2020 admission, Ms Davis did not "*show any signs or report any symptoms of psychosis or paranoid ideation*".[43]

17. The Health Review also noted that during periods of incarceration, Ms Davis was seen at the prison medical centre on several occasions in relation to issues including agitation, pain related to a previous fracture of the ankle, and knee pain. However, the Health Review also noted that some health issues were not followed up because Ms Davis was released from custody before this could occur.

---

[36] ts 28.02.24 (Gunson), pp78-79
[37] ts 28.02.24 (Gunson), p79
[38] ts 28.02.24 (Gunson), pp79-80
[39] See also: Exhibit 1, Vol. 1, Tab 37, Statement - Dr M Quadros (19.02.24), paras 14-17
[40] Exhibit 1, Vol. 1, Tab 37-MCQ1, MM08: Methadone and Suboxone (effective July 2008)
[41] Exhibit 1, Vol. 1, Tab 37-MCQ2, MM08: Opioid Substitution Treatment (effective 09.08.21)
[42] Methadone is preferred because suboxone is "*highly trafficable*": ts 27.02.24 (Cusack), p25 & ts 27.02.24 (Collins), pp32-33
[43] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p13 and ts 28.02.24 (Gunson), pp77-78

18. During her last admission to Melaleuca, Ms Davis had regular "*quick superficial interactions*" with members of the Mental Health Alcohol and Other Drugs team (MHAOD), who managed her "*opioid substitution pharmacotherapy*".[44] Ms Davis was also seen on two occasions by the Psychological Health Service (PHS) for "*ongoing counselling*", and disclosed concerns about her daughter's safety, and relationship issues with her partner.[45,46] Ms Davis was also referred to a mental health nurse, who conducted a mental health review on 31 July 2020. I will say more about that review later in this finding.

Delays in obtaining collateral information

19. At the inquest, Dr Gunson confirmed that although Ms Davis' GP had faxed information about her medical history to the Department in the first week of July 2020, this information was not entered into Ms Davis' prison medical file (and therefore available to prison medical officers) until 31 July 2020.[47]

20. The information from Ms Davis' GP included concerns that Ms Davis was exhibiting paranoia "*and also some psychotic features*", and referred to a plan to reduce Ms Davis' dose of the antidepressant mirtazapine. However, Dr Gunson noted that at the time of Ms Davis' death, the planned dose reduction had not occurred and Ms Davis was still on her original dose of mirtazapine.[48,49,50]

21. At the inquest, Dr Gunson conceded that had the information from Ms Davis' GP been available at an earlier time, prison clinical staff "*might have changed her antidepressant dose earlier* (and) *that may or may not have made a difference* (to Ms Davis' outcome)". However, Dr Gunson also noted that:

> A lot of those medications take two to six weeks to really show their full effect (but) she might well have been brought to the attention of the mental health team more strongly and sooner.[51]

[44] ts 27.02.24 (Cusack), pp21-22
[45] Exhibit 1, Vol. 1, Tab 32.3, Psychological Health Service File Note (07.07.20)
[46] Exhibit 1, Vol. 1, Tab 32.4, Psychological Health Service File Note (22.07.20)
[47] ts 28.02.24 (Gunson), pp81-83
[48] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (31.07.20), p8
[49] ts 28.02.24 (Gunson), p83
[50] See also: Exhibit 1, Vol. 1, Tab 37, Statement - Dr M Quadros (19.02.24), paras 11-13
[51] ts 28.02.24 (Gunson), pp83-84

22. Following Ms Davis' death, the MHAOD branch reviewed the mental health care provided to Ms Davis and concluded that:

> Ms Davis' principle presenting problem was long standing drug addiction. She also experienced intermittent mental health issues, involving at various times, psychotic and affective presentations which were primarily related to her drug use. This review finds that the mental health care provided to Ms Davis during her incarceration was appropriate and, although areas for improvement in documentation have been identified, these issues did not impact on the care provided to Ms Davis, or contribute to her death.[52]

23. The Health Review made the following comments about the health services provided to Ms Davis whilst she was in custody:

> Over her multiple periods in custody (Ms Davis) received holistic and high-quality care. This was within the limitations imposed by interruptions due to short periods of incarceration interspersed with short periods in the community, and also the logistical challenges presented by the custodial environment. Some issues pertaining to the delivery of care were identified during her periods of custody, and moving forward these continue to be addressed. However, it is highly unlikely that any of these affected Ms Davis' ultimate health outcome.
>
> Staff were proactive in ensuring Ms Davis was reviewed when she disclosed any health concerns, and also followed up when she missed appointments, by re-scheduling as needed and also by speaking directly with her to encourage her to attended. When custodial staff raised concerns these were also responded to appropriately. In conclusion, the health care provided to (Ms Davis) was overall of an excellent quality, and certainly equivalent or better than the standard she would have received in the community.[53]

24. I am satisfied that in relation to her physical health, Ms Davis received a level of care that was commensurate with that offered in the general community. However, as I will explain later in this finding, I have some concerns about the management of aspects of Ms Davis' mental health.

[52] Exhibit 1, Vol. 1, Tab 34, Summary into Death - MHAOD Branch (08.04.21), p6
[53] Exhibit 1, Vol. 1, Tab 31.1, Health Services Summary (27.12.23), pp15-16

ISSUES RELATING TO MS DAVIS' INCARCERATION

Admission - 28 June 2020[54]

25. During her last admission to Melaleuca, Ms Davis gave inconsistent answers to some of the questions she was asked during her ARMS reception intake assessment. Although no acute self-harm risks were identified, there was a concern that another inmate may represent a risk, and Ms Davis was transferred to the Crisis Care Unit for her own safety. Ms Davis was reportedly angry about this placement, and she was transferred into a mainstream cell after a few days.[55,56,57]

Mental health review - 31 July 2020[58,59]

26. On 31 July 2020, Ms Davis was assessed by Mr Cusack (a mental health nurse), having been referred for a mental state review. I note that Ms Davis had failed to attend scheduled appointments on 23 and 24 July 2020, and she variously claimed she had not been called, and/or that "*there was nobody there when she got there*".[60]

27. Mr Cusack's entry in the EcHO records state that Ms Davis was "*polite and appropriate*", and that she did not display any psychotic symptoms. Ms Davis said she was surprised she had been called to the Health Centre for a review of her mental health, and denied she had any significant mental health history. Ms Davis also denied any psychotic symptoms and/or "*thoughts or plans to harm self and others*".[61]

28. Ms Davis said she was eating and sleeping well, and although "*A little stressed due to outside issues*", she was described as "*fairly pragmatic regarding the same*", and said: "*Not much can be done about it in here*". Ms Davis said she was feeling "*reasonably well*" and had "*reasonable support*" in her unit. No mental health needs were identified and the recorded plan was "*No further MH* (mental health) *input required*".[62]

---

[54] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), pp8-10
[55] Exhibit 1, Vol. 1, Tab 19.1, ARMS Reception Intake Assessment (28.06.20)
[56] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp5-6
[57] Exhibit 1, Vol. 1, Tab 32.2, Statement - Officer S Corbett (28.03.23), paras 16-33
[58] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p11 and ts 27.02.24 (Cusack), pp23-25
[59] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), p6
[60] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (23 & 24.07.20), p9 and ts 27.02.24 (Collins), pp33-34
[61] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (31.07.20), p8 and ts 27.02.24 (Cusack), pp24-25
[62] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (31.07.20), p8

Concerns re mental state - 11 August 2020[63,64,65]

29. Officer Hunter knew Ms Davis reasonably well as a result of her previous periods of imprisonment. In his statement, Officer Hunter said he considered Ms Davis' long custodial history was a "*protective factor*" in relation to her risk of self-harm, and he did not recall any behavioural or other issues while Ms Davis was at Melaleuca.[66]

30. On 11 August 2020, Officer Hunter was an acting senior officer and in his statement, he says he noted Ms Davis' mental state "*appeared to have deteriorated*" and "*she seemed anxious and different to how she normally presented*". When he spoke with Ms Davis, Officer Hunter said he could not make sense of what she was saying, or what she was asking him for.[67]

31. In his statement, Officer Hunter says at some stage he asked Ms Davis "*Are you all good*", and she replied "*Yes, I am Dave*". He also asked her: "*Do I need to worry, do you need some help*", and she had replied: "*No Dave*". Officer Hunter said his interaction with Ms Davis:

> (D)id not give me cause to believe she was at an acute risk to herself - but I considered it appropriate at the time to raise it with the Mental Health Alcohol and Other Drugs Team (MHAOD).[68]

32. At 7.57 am on 11 August 2020, Officer Hunter sent the following email to Mr Collins[69] (who was an acting clinical nurse consultant, and in charge of the MHAOD team):

> I was wondering if mental health could review Ms Davis. I have known her for many years and her mental state seems to have deteriorated. She is not angry or disruptive. She is not making any sense and appears anxious about everything. She is approaching me every half an hour. I am concerned for her mental health. Could we possibly review her please?[70]

---

[63] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p12
[64] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp6 & 11
[65] ts 27.02.24 (Hunter), pp41-44
[66] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 12-15 and ts 27.-2.24 (Hunter), pp40-41
[67] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 16
[68] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 17
[69] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 18
[70] Exhibit 1, Vol. 1, Tab 38-DH1, Email - Officer D Hunter to Mr G Collins (7.57 am, 11.08.20)

33. Officer Hunter says he emailed Mr Collins because he was concerned about Ms Davis' mental health,[71] and at 7.58 am on 11 August 2020, he made the following entry in Ms Davis' "*Offender Notes*" module in TOMS:[72] "*Ms Davis presented anxious and incoherent this morning. She has been referred to (MHS)*[73] *this is a recurring theme*".[74]

34. Officer Hunter also said that after sending his email, he spoke with Mr Collins and explained that Ms Davis seemed anxious and he was trying "*to establish if there was anything from a Mental Health perspective of concern or follow up*". Officer Hunter says Mr Collins "*looked into the matter*" and told him that "*Mental Health would see her*". As a result of that conversation, Officer Hunter says he was satisfied that Ms Davis would be reviewed by the MHAOD team.[75,76]

35. In his statement, Officer Hunter said he was aware that Ms Davis had been managed on the ARMS at various times during previous periods of incarceration. Officer Hunter also said that if he believed there were any signs that Ms Davis was acutely at risk of suicide or self-harm, he would have placed her on ARMS.[77,78] As noted, Ms Davis was not on ARMS during her last admission to Melaleuca, and in his statement (and at the inquest), Officer Hunter confirmed that:

> There was nothing to indicate to me on 11th August 2020 during my assessment that Ms Davis should have been placed on ARMS. I could not identify any discernible risk to self when I engaged with her.[79]

36. Despite the concerns that Officer Hunter had raised about Ms Davis, she was not reviewed by a mental health clinician prior to her death. In his statement, Mr Collins said that after receiving Officer Hunter's email, he spoke with Officer Hunter to obtain further information, and made an entry in Ms Davis' prison medical record (EcHO) regarding the concerns that had been relayed to him.[80]

---

[71] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 18 & 20
[72] TOMS (Total Offender Management Solutions) is the electronic prisoner management system used by the Department
[73] In this context, MHS is the abbreviation for Mental Health Services
[74] Exhibit 1, Vol. 1, Tab 38-DH2, Offender Notes - Ms Davis (7.58 am, 11.08.20)
[75] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 19
[76] ts 27.02.24 (Collins), pp35-36 and ts 27.02.24 (Hunter), pp44-45
[77] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 21-24 & 29
[78] See also: Exhibit 1, Vol. 1, Tab 32.9, Statement - Officer K Calwell (08.03.21), paras 22-24
[79] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 26 and ts 27.02.24 (Hunter), pp43-44 & 51-52
[80] Exhibit 1, Vol. 1, Tab 36, Statement - Mr G Collins (17.02.24), paras 47-39

37. Mr Collins noted that Ms Davis was being seen by mental health nurses "*predominantly for opiate substitution with no identified risks to herself arising at any time*". Mr Collins also said that on checking EcHO, he established Ms Davis had been seen by a mental health nurse following a referral from Psychological Health Services (this is clearly a reference to Mr Cusack's review of Ms Davis' mental state on 31 July 2020).[81,82]

38. In his statement, Mr Collins also noted that:

> (Ms Davis) was reported three times to our department and was escalated to the psychiatrist on the third time for some finality regarding the mental health concerns made by (Officer Hunter). The next available appointment was 2 days later (13 August 2020) which I booked for her. At no time did we believe she was a risk to herself.[83]

39. I accept that at no stage was Ms Davis considered to be at acute risk of self-harm. However, her last mental health review was on 31 July 2020, and Officer Hunter (who knew Ms Davis well) was concerned enough about her mental state to both email and call Mr Collins. In that context, it is unfortunate that Ms Davis was not reviewed by a mental health nurse on 11 August 2020.

40. With the benefit of hindsight, the failure to review Ms Davis on 11 August 2020 can be viewed as a missed opportunity to have possibly enhanced the management of Ms Davis' mental health. That said, I accept it is impossible to know whether Ms Davis' clinical journey would have been any different had this occurred, especially given the impossibility of predicting suicide.

[81] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (31.07.20), p8
[82] Exhibit 1, Vol. 1, Tab 36, Statement - Mr G Collins (17.02.24), paras 28-39
[83] Exhibit 1, Vol. 1, Tab 36, Statement - Mr G Collins (17.02.24), para 40 and ts 27.02.24 (Collins), pp35-37

Concerns re mental state - 12 August 2020[84,85,86,87]

41. At the relevant time, Ms Kay was the prison chaplain at Melaleuca. Prior to becoming a chaplain, Ms Kay had been employed by Lifeline in various roles including telephone counsellor, crisis supporter and trainer for a suicide awareness program, and a program aimed at training professionals on the "*invitations*" people may make when contemplating suicide. Ms Kay had also been employed as a trainer and group facilitator with a mental health recovery agency.[88]

42. Ms Kay therefore had a high level of skill in the area of suicidality and risk management, and she saw Ms Davis on six occasions during her last incarceration at Melaleuca. Ms Kay says she noticed it took longer for Ms Davis to "*readjust to prison life*" on this admission, and that she did not appear to be her usual self and was "*distant and withdrawn*". In her statement, Ms Kay said she recalled a conversation with Mr Collins in which she expressed her concerns about Ms Davis' presentation, and that Mr Collins had advised that Ms Davis' medication had recently changed, and this might account for her presentation.[89]

43. Ms Kay last saw Ms Davis at about 4.40 pm on 12 August 2020, after Prisoner T approached her and asked to speak with her. Ms Davis had reportedly come into Prisoner T's cell and although Ms Davis was visibly upset, she "*struggled to voice her thoughts and feelings*".[90] Ms Kay says when she spoke to Ms Davis there was nothing about her appearance or presentation that caused concern, but Ms Davis seemed "*confused and worried*".[91]

44. Ms Davis also had a piece of paper in her hand that had a phone number written on it, and Ms Kay felt Ms Davis seemed "*conflicted about whether or not she wanted this number added to her phone system*".[92,93]

---

[84] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p12
[85] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), pp4-5
[86] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp7-8
[87] Exhibit 1, Vol. 1, Tab 16.2, Statement - Prisoner T (13.08.20)
[88] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), paras 1-5 and ts 27.02.24 (Kay), pp10-11
[89] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), paras 7-11 and ts 27.02.24 (Kay), pp11-12
[90] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 5-9
[91] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), paras 12-15 and ts 27.02.24 (Kay), pp11-12
[92] Prisoners may only call numbers registered on their profile within the Prison Telephone System
[93] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), para 15 and ts 27.02.24 (Kay), pp13-14

45. I note that in her statement, Ms Davis' eldest daughter says she last spoke with her mother two days before she died, and that Ms Davis "*sounded very happy because I had managed to get her the number of a lawyer*". It may therefore be that the number on the paper Ms Davis was holding was that of her lawyer, although this cannot be confirmed.[94]

46. Ms Kay says Ms Davis confirmed she felt pressure to add the number she was holding to her phone system, and although Ms Davis declined to disclose any further information, she did take the relevant application form needed to add the number. Ms Kay says she and Ms Davis spoke until about 5.50 pm when they had to vacate the office they were in. Before leaving, Ms Kay gave Ms Davis a prayer card, and Ms Davis "*smiled in gratitude*.[95]

47. As to Ms Davis' presentation and perceived risk level, Ms Kay made the following observation in her statement:

> Throughout the interaction Ms Davis did not do or say anything that caused me concern. In my experienced opinion, she did not make any indication she was having thoughts of suicide.[96]

48. Shortly after her interaction with Ms Davis, Ms Kay spoke with Senior Officer Calwell (Officer Calwell) who told Ms Kay: "*she also had concerns for Ms Davis and had already liaised with Mental Health*". Prior to leaving Melaleuca for the day, Ms Kay told Officer Calwell that she intended to follow up with "*Mental Health*" the following day.[97]

49. Ms Kay also noted that she did not discuss placing Ms Davis on ARMS with Officer Calwell, and "*it was not something that was considered needed at this time*". However, in her statement and at the inquest, Ms Kay said that with the benefit of hindsight she believed Ms Davis "*would have benefitted from the additional support that an ARMS referral attracts*".[98]

---

[94] Exhibit 1, Vol. 1, Tab 10, Statement - Ms C Fisher (undated), para 23
[95] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), paras 15-18 and ts 27.02.24 (Kay), p16
[96] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), para 19
[97] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), para 20 and ts 27.02.24 (Kay), pp14-15
[98] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), paras 21 & 24

50. Nevertheless, at the inquest Ms Kay confirmed that even if she had recommended that Ms Davis be placed on ARMS, it would have been on "*low ARMS*", meaning Ms Davis would have been subject to four-hourly observations. In her statement, Ms Kay makes the reasonable observation that she could not comment on whether "*an ARMS referral would have changed the outcome*".[99]

51. At the relevant time, chaplains were not permitted to place a prisoner on ARMS, and I agree with Ms Kay when she says in her statement that in her view, the ability to place a prisoner on ARMS was "*an essential component of chaplaincy*".[100]

52. In my view it is extraordinary that there was ever a time when chaplains were not able to place a prisoner on ARMS. In Ms Kay's case, this was a particularly egregious systems failure, given her extensive experience in the area of suicide awareness and intervention. However, I note with approval that this appalling situation has since been rectified and chaplains are now able to place prisoners on ARMS.[101]

53. In any case, by 12 August 2020, Prisoner T, Ms Kay, Officer Calwell, and Officer Hunter had all noticed a change in Ms Davis' mental state. With the benefit of hindsight, the failure to place Ms Davis on ARMS on 12 August 2020, whilst understandable in terms of her presentation at the time, can be viewed as a potential missed opportunity to have enhanced the management of Ms Davis' mental health.

54. However, having made that observation, I accept that it is impossible to know whether Ms Davis' outcome would have been any different had she been placed on ARMS, especially as it is likely that only "low ARMS" observations would have been recommended, meaning four hourly observations.

[99] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), para 24 and 27.02.24 (Kay), pp16-18
[100] Exhibit 1, Vol. 1, Tab 15, Statement - Ms M Kay (29.03.21), para 25 and ts 27.02.24 (Kay), pp16-17
[101] ts 27.02.24 (Kay), pp16-17 and ts 27.02.24 (Palmer), pp66-67

Psychiatrist appointment - 13 August 2020[102,103,104]

55. As noted, because of the repeated concerns that had been raised with him about Ms Davis' mental state, Mr Collins booked an appointment for her to see the psychiatrist who visited Melaleuca on 13 August 2020. Although the appointment was scheduled for 7.00 am, this was before the psychiatrist arrived at Melaleuca, and was merely an administrative placeholder, indicating that Ms Davis needed to be seen that day.[105]

56. At the inquest, I was very surprised to learn that it was very unlikely that Ms Davis would have had advance notice of the psychiatrist appointment that had been made for her. The reason Ms Davis was not told about her appointment was that the list is somewhat dynamic, and her appointment may have to be rescheduled if a more unwell prisoner was identified.[106] With great respect, this reasoning is unsatisfactory and illogical.

57. Clearly, Ms Davis should have been told about the psychiatrist appointment so she had time to prepare, and so that she was not surprised at hearing about it for the first time by way of an announcement on the PA system. If it had proved necessary to change Ms Davis' appointment time, then mental health staff could simply have explained why this was necessary.

58. At the relevant time, prisoners were called to appointments by means of announcements made by custodial officers using Melaleuca's public address system (PA system). In his statement, Mr Cusack confirmed that the medical centre kept a list of prisoners that were due to attend appointments each day. If a prisoner was called and did not attend their appointment the next prisoner on the list would be called, and the prisoner who did not attend would be called later the same day.[107]

59. Mr Cusack also said that mental health staff did not use the PA system to call prisoners up for appointments and instead, relied on custodial officers to "*source the prisoner and get them to the medical centre*".[108]

---

[102] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), pp13-14
[103] Exhibit 1, Vol. 1, Tab 32.8, Emails between Ms T Palmer and Ms G Owen (09-15.05.23)
[104] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), p8
[105] Exhibit 1, Vol. 1, Tab 32.8, Email - Ms G Owen to Ms T Palmer (15.05.23) and ts 27.02.24 (Palmer), p71
[106] ts 27.02.24 (Collins), pp37-38
[107] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), para 13
[108] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), paras 14-15

60. Further, Mr Cusack noted that: "*If a prisoner does not want to attend the appointment, medical staff are informed of this by the custodial officers*". In relation to Ms Davis, Mr Cusack said he made a retrospective entry in her EcHO notes at 3.15 pm: "*to capture that we had made attempts to get her to attend the medical centre prior to the critical incident*".[109]

61. Although there is no evidence about who made the PA system announcements calling Ms Davis to her appointment, or indeed when those announcements were made, Mr Cusack's entry states:

> DNA appointment. Called for scheduled psychiatrist appointment three times this AM and once this PM per custodial. Did not attend. Code Red called this afternoon for a medical emergency in her cell, was subsequently taken to hospital by ambulance.[110,111]

62. Despite her repeated failure to respond to the PA system announcements, there is no evidence that any member of the prison staff approached Ms Davis to encourage her to attend the appointment. In any case, as I have explained, at the relevant time this was not the procedure. It is also unclear why Ms Davis did not respond to any of the four PA system announcements which were reportedly made.

63. However, given that the psychiatrist appointment had been booked to review Ms Davis' mental state, it seems patently obvious that her non-attendance should have been followed up as a priority. In my view, the fact that this did not occur represents a missed opportunity to have potentially enhanced the management of Ms Davis' mental health.

64. Once again in making that observation, I accept that it is impossible to know whether Ms Davis' outcome would have been any different had she been reviewed by a psychiatrist as planned on 13 August 2020. All that can be said is that there is at least a chance that she may have benefitted from a comprehensive review of her mental state at that time.

---

[109] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), paras 14-15 and ts 27.02.24 (Cusack), pp25-27
[110] Exhibit 1, Vol. 1, Tab 21, EcHO medical records (31.07.20), p8
[111] See also: Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), paras 16-17

65. Since July 2021, an appointment card system has been used for prisoner appointments at Melaleuca,[112] and I note with approval that prisoners are now actively followed up when they do not attend scheduled appointments. In his statement, Mr Cusack said since Ms Davis' death, "*the mental health team have become more vigilant when calling a prisoner up and noting non-attendance*",[113] and he also said:

> I am aware of the current practice at (Melaleuca) to document EcHO when a prisoner does not attend a scheduled appointment. If Ms Davis had not taken her life on 13 August 2020, the mental health team would have attended the unit and engaged with Ms Davis to see how she was. Because there had been multiple calls to get her to attend the medical centre, mental health would have followed her up before the end of the business day.[114]

66. At the inquest, Ms Palmer confirmed that since Ms Davis' death:

> [T]here has been a superintendent change, and the (new) superintendent has been quite proactive in ensuring that: (a) people are making their appointments; and (b) if they don't make their appointments, it's properly and adequately noted as to why they're not making their appointments.[115,116]

67. In a Superintendent Bulletin issued on 10 February 2023 (the Bulletin), Superintendent Heslington (Officer Heslington) made the following comments about prisoners and appointments:

> I understand we give out appointment cards and the consensus is that the women need to be responsible for attending, however, this does not work for several reasons and the risk it creates to both myself and the Clinical Nurse Manager (CNM) is extreme. I am also aware that the previous death in custody here at (Melaleuca), when reviewed, found that the prisoner had been called up for an appointment of some kind and never turned up. It appears that we have not learned anything from this!

[112] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p13
[113] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), paras 20-21 and ts 27.02.24 (Cusack), p30
[114] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), paras 21-24
[115] ts 27.02.24 (Palmer), p68
[116] See also: ts 27.02.24 (Hunter), pp48-50 and ts 28.02.24 (Gunson), pp85-86

> My expectation, **with immediate effect**, is that every single prisoner who is listed for an appointment turns up at the Health Centre. If they decline the appointment, then there is paperwork that the nursing staff have which they sign to decline treatment, and this covers us as staff.
>
> If a prisoner is called and fails to attend, the units need to be contacted to find the prisoner and ensure that they make their way to the appointment. Under no circumstances is it acceptable, from both the Health Centre (Duty Officer), or the unit staff, to say that we have called and they have not shown up so there is nothing further that we can do.
>
> They **must** be found and sent down. Medical appointments are to be treated as a priority over everything apart from Court. Unless there is a non-health related critical incident, the CNM is in charge within the Health Centre and staff will take direction from them, if required.[117,118] [Original emphasis]

68. I commend Officer Heslington for the unequivocal terms he has used in the Bulletin, and for setting out his expectations in such a crystal clear manner. It seems to me that had this proactive approach been in place during Ms Davis' last admission to Melaleuca, it is almost certain she would have been followed up personally by a member of the prison staff in relation to her non-attendance at the psychiatrist appointment. Had this occurred, Ms Davis could have been encouraged to attend the appointment, which as I have noted, was booked following the expression of repeated concerns about her mental state.

Court appearance - 13 August 2020[119]

69. At 10.09 am on 13 August 2020, Ms Davis appeared in the Magistrates Court at Perth by way of a video link. Although Ms Davis was represented at that hearing, it appears she had not had the opportunity to speak with her lawyer before the hearing commenced. It was noted Ms Davis had been charged with four offences, and that she had received bail in relation to three of those charges.

---

[117] Exhibit 1, Vol. 1, Tab 32.7, Superintendent Bulletin 2/2023 - Melaleuca Women's Prison (10.02.23)
[118] See also: Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 38-40
[119] Exhibit 1, Vol. 1, Tab 30, Transcript of proceedings - Magistrates Court at Perth (13.08.20), pp1-4

70. Towards the end of the five-minute hearing, Ms Davis asked: "*Is it possible to get a surety bail on that charge or no*". However, her request was refused and she was remanded in custody until 27 August 2020.[120] After her video link appearance, Ms Davis was given her daily dose of methadone, and she had a brief conversation with Officer Jadhav. He noticed Ms Davis did not seem her usual self, and when he asked her about the outcome of her court appearance, Ms Davis said she did not want to discuss it.[121]

71. Officer Jadhav says he also asked Ms Davis if she wanted to speak with "*someone from mental health*" and recalls that she said: "*she would think about it*". Following his interaction with Ms Davis, Officer Jadhav says he contacted the mental health nurse to request an appointment for Ms Davis and was told that Ms Davis already had a scheduled appointment (with a psychiatrist) that day.[122]

72. In his statement, Mr Cusack makes the following comment about Ms Davis' mental state following her video link court appearance:

> On 13 August 2020, I was not responsible for giving out the Schedule 8 medications (i.e.: methadone). However, one of my colleagues noted Ms Davis seemed off and relayed that information to the mental health team and we tried to get her down to the medical centre in the morning, we tried again in the afternoon.[123]

73. It certainly appears that Ms Davis was expecting to be released from Melaleuca on bail, or at the very least was hoping that this would occur. Given that one of the reasons she was further remanded in custody was that some amendments were to be made to her charges with the possibility she would enter pleas, it was perhaps unrealistic for Ms Davis to think that she might be released on bail. In any case, during a phone conversation she had with a male friend at 12.54 pm on 13 August 2020, she expressed frustration about her situation and also said her day had been "*shit*".[124]

[120] Exhibit 1, Vol. 1, Tab 30, Transcript of proceedings - Magistrates Court at Perth (13.08.20), p4
[121] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), paras 11-12 and ts 27.04.24 (Jadhav), pp55-60
[122] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), para 12
[123] Exhibit 1, Vol. 1, Tab 32.6, Statement - Mr A Cusack (30.11.23), para 19 and ts 27.04.24 (Cusack), pp28-29
[124] Exhibit 1, Vol. 1, Tab 32.10, Recorded call report (12.54 pm, 13.08.20), p9

74. As mentioned earlier, because Ms Davis did not present as being at acute risk of self-harm at any time during her last incarceration at Melaleuca, she was not managed on ARMS. However, one of the consequences of this was that Ms Davis' court appearance on 13 August 2020 was not recorded as a date of interest (DOI) on her TOMS profile, as it would have been had she been on ARMS.

75. Had her court date been entered as a DOI, Ms Davis would have been followed up by a mental health nurse or counsellor before and after her court appearance. In my view, the fact that Ms Davis' court appearance on 13 August 2020 was not recorded as a DOI on her TOMS profile was a missed opportunity for a clinician to have reviewed her mental state. I will have more to say about this issue later in this finding, but for now I merely observe again that it is impossible to know whether Ms Davis' outcome would have been any different had a DOI been logged.

76. In relation to other management issues, a multiple cell occupancy assessment determined that there was no impediment to Ms Davis sharing a cell, and during her last period of incarceration, Ms Davis was employed as a cleaner and received "*level three gratuities*".[125,126,127,128]

77. Ms Davis was not the subject of any prison charges and "*was not considered a management problem*". She was not the subject of any substance use tests, but she was the subject of three alerts on TOMS, namely "*risk to and from, escape and self-harm history*".[129,130,131,132]

78. Departmental records show that although Ms Davis did not receive any visits during her last period of custody at Melaleuca, she kept in touch with her family and loved ones by means of telephone calls and letters.[133,134,135,136,137]

[125] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p18
[126] Exhibit 1, Vol. 1, Tab 32.13, Orientation Checklist (29.06.20)
[127] Exhibit 1, Vol. 1, Tab 32.14, Multiple Cell Occupancy Checklist (28.06.20)
[128] Exhibit 1, Vol. 1, Tab 32.15, Work History - Offender
[129] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p18
[130] Exhibit 1, Vol. 1, Tab 32.16, Charge History, Loss Of Privileges - Prisoner
[131] Exhibit 1, Vol. 1, Tab 32.17, Substance Use Test Results - Offender
[132] Exhibit 1, Vol. 1, Tab 32.18, Alert History - Offender
[133] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p18
[134] Exhibit 1, Vol. 1, Tab 32.19, Prisoner Mail, Visits History - Offender
[135] Exhibit 1, Vol. 1, Tab 32.15, Work history - Offender
[136] Exhibit 1, Vol. 1, Tab 32.10, Recorded Call Report
[137] Exhibit 1, Vol. 1, Tab 26, Call Log

EVENTS LEADING TO MS DAVIS' DEATH

Ms Davis is found and CPR[138,139,140,141,142,143,144,145]

79. At about 1.47 pm on 13 August 2020, Prisoner T (who had known Ms Davis "*for over 30 years*" and regarded her as a close friend), went to Ms Davis' cell to drop off a bag containing some laundry. When Prisoner T opened the observation hatch in the cell door and called out for Ms Davis, she saw what she believed was Ms Davis' foot and assumed she was praying. Prisoner T hung the laundry bag over Ms Davis' cell door before returning to her cell.[146]

80. About five minutes later, Prisoner T went back to Ms Davis' cell, but there was no response to her knocks and shouts. Prisoner T looked through the observation hatch again and when she saw water on the cell floor she became concerned for Ms Davis' welfare. At about 1.50 pm, Prisoner T alerted Officer Kelly to what she had seen and shortly afterwards, Officers Kelly, Jadhav and Kelissa went to Ms Davis' cell and unlocked her cell door[147,148] after looking through the observation hatch.[149]

81. As soon as Officer Jadhav had unlocked the cell door, Prisoner T ran inside Ms Davis' cell, followed closely by the officers. Ms Davis was hanging in a kneeling position with her knees off the ground. She was facing her bed in the far left-hand corner of the cell with a ripped bed sheet around her neck that was attached to the frame of the wooden bunk bed. Officer Jadhav made a "*Code Red*" emergency call using his prison radio.[150,151,152,153,154]

---

[138] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), pp14-17
[139] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), pp1-6
[140] Exhibit 1, Vol. 1, Tab 8, Memorandum - Sen. Const. P Smith (13.08.20)
[141] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), pp8-9
[142] Exhibit 1, Vol. 1, Tab 32.9, Statement - Ms R Payne (21.11.23)
[143] Exhibit 1, Vol. 1, Tab 16.2, Statement - Prisoner T (13.08.20)
[144] Exhibit 1, Vol. 1, Tab 14, Statement - Mr K Stevens (22.03.21)
[145] Exhibit 1, Vol. 1, Tab 32.9, Statement - Officer K Calwell (08.03.21), paras 5-19
[146] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 15-16
[147] Departmental policy requires at least two officers are present when a cell door is unlocked in these circumstances
[148] Exhibit 1, Vol. 1, Tab 32.12, Statement - Officer M Kelissa (unsigned), para 17
[149] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 15-19 and ts 27.02.24 (Jadhav), pp60-61
[150] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), paras 15-22 and ts 27.02.24 (Jadhav), p61
[151] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 20-24
[152] Exhibit 1, Vol. 1, Tab 18, Incident Description Report - Officer A Kelly (13.08.20)
[153] Exhibit 1, Vol. 1, Tab 32.11, Statement - Officer A Kelly (unsigned), paras 13-22
[154] Exhibit 1, Vol. 1, Tab 32.12, Statement - Officer M Kelissa (unsigned), paras 16-23

82. In his statement, Officer Kelissa says he then told Prisoner T to return to her cell, but she did not do so. He says that at the time, officers were solely focused on assisting Ms Davis, and that Prisoner T's presence was "*not a priority*". Officer Kelissa says he does not recall asking Prisoner T to leave the cell again, and in any case, as Prisoner T assisted Officer Kelissa to lift Ms Davis up, Officer Kelly cut the bed sheet from around Ms Davis' neck using a Hoffman knife.[155] Ms Davis was lowered to the cell floor, and Officer Kelissa placed her into the recovery position before rolling Ms Davis onto her back and delivering 30 chest compressions.[156,157,158,159,160]

83. It appears Ms Davis vomited, and Officer Kelly asked Prisoner T to assist by providing three breaths, which she did. Although Prisoner T was offered a face shield by Officer Jadhav, she refused saying: "*she's like my sister, I don't mind*". After Prisoner T delivered three breaths into Ms Davis' mouth, the officers recommenced chest compressions.[161,162,163,164,165]

84. At this point, Officer Jadhav left the cell and ordered prisoners to return to their cells, which they did. A senior officer arrived and ordered Prisoner T to return to her cell and Officer Jadhav assisted with the lockdown process. Meanwhile, the "recovery team" (consisting of a senior officer, two officers, and two nurses) arrived on the scene at 1.53 pm and took over resuscitation efforts.[166,167,168] Emergency services were called, and the first of two ambulance units arrived at about 2.12 pm.[169,170,171,172,173]

---

[155] A Hoffman knife has a curved, hooked blade and is used by prison officers to safely cut through ligatures
[156] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 25-27
[157] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), paras 24-25 and ts 27.02.24 (Jadhav), p60
[158] Exhibit 1, Vol. 1, Tab 18, Incident Description Report - Officer A Kelly (13.08.20)
[159] Exhibit 1, Vol. 1, Tab 32.11, Statement - Officer A Kelly (unsigned), paras 23-28
[160] Exhibit 1, Vol. 1, Tab 32.12, Statement - Officer M Kelissa (unsigned), paras 24-27
[161] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 27-28
[162] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), para 25 and ts 27.02.24 (Jadhav), pp61-62
[163] Exhibit 1, Vol. 1, Tab 18, Incident Description Report - Officer A Kelly (13.08.20)
[164] Exhibit 1, Vol. 1, Tab 32.11, Statement - Officer A Kelly (unsigned), paras 29-32
[165] Exhibit 1, Vol. 1, Tab 32.12, Statement - Officer M Kelissa (unsigned), paras 28-30
[166] Exhibit 1, Vol. 1, Tab 18, Incident Description Report - Officer A Kelly (13.08.20)
[167] Exhibit 1, Vol. 1, Tab 32.11, Statement - Officer A Kelly (unsigned), paras 33-39
[168] Exhibit 1, Vol. 1, Tab 32.12, Statement - Officer M Kelissa (unsigned), paras 31-34
[169] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), para 29
[170] Exhibit 1, Vol. 1, Tab 14, Statement - Mr K Stevens (22.03.21), paras 25-38
[171] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), paras 26-30 and ts 27.02.24 (Jadhav), p62
[172] Exhibit 1, Vol. 1, Tabs 24.1 & 24.2, SJA Patient Care Record: Teams JKT41DD & MEL22D2 (13.08.20)
[173] Exhibit 1, Vol. 1, Tab 32.9, Statement - Ms R Payne (21.11.23), para 14

85. Ambulance officers took over CPR and noted that Ms Davis' heart was in asystole,[174] and an automated external defibrillator attached to Ms Davis' chest did not advise a shock should be administered.[175]

86. Despite the combined efforts of Prisoner T, prison staff, and ambulance officers, Ms Davis could not be revived and she was declared deceased at 2.27 pm on 13 August 2020.[176,177]

Use of Prisoner T during resuscitation efforts

87. Before dealing with Prisoner T's involvement in efforts to resuscitate Ms Davis, I note that after Ms Davis' death Prisoner T was placed on ARMS and in her statement, Prisoner T said: "*I believe I received adequate support after the incident*". Prisoner T also stated: "*I believe that all staff involved in this incident acted very well and did everything possible to assist* (Ms Davis)".[178,179]

88. Officer Jadhav said that in his opinion, "*all staff involved in this incident acted very well and did everything possible to assist Ms Davis*". He also said he "*did not believe that* [Prisoner T's] *presence hindered or affected the care or the level of care that Ms Davis received*".[180,181] Officer Kelly went further, and in his unsigned statement, he said:

> I believe that (Prisoner T) played a crucial role in assisting officers with Miss Davis. It is my opinion that (Prisoner T) did not hinder or affect the level of care that Miss Davis received but rather, assisted by administering mouth to mouth resuscitation to Miss Davis.[182]

89. In her statement, Principal Officer Payne (Officer Payne) said she was advised about Prisoner T's involvement in CPR "*after the fact*", and that although it is not standard practice for prisoners to assist officers in this way "*officers will use resources and help when and if needed*".[183]

---

[174] Asystole means that Ms Davis' heart had stopped
[175] Exhibit 1, Vol. 1, Tabs 24.1 & 24.2, SJA Patient Care Record: Teams JKT41DD & MEL22D2 (13.08.20)
[176] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (13.08.20)
[177] Exhibit 1, Vol. 1, Tabs 24.1 & 24.2, SJA Patient Care Record: Teams JKT41DD & MEL22D2 (13.08.20)
[178] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), paras 29-31
[179] See also: Exhibit 1, Vol. 1, Tab 32.9, Statement - Ms R Payne (21.11.23), paras 34-35
[180] Exhibit 1, Vol. 1, Tab 17, Statement - Officer K Jadhav (04.09.21), paras 34-35
[181] See also: Exhibit 1, Vol. 1, Tab 32.9, Statement - Officer K Calwell (08.03.21), paras 20-21
[182] Exhibit 1, Vol. 1, Tab 32.11, Statement - Officer A Kelly (unsigned), para 44
[183] Exhibit 1, Vol. 1, Tab 32.9, Statement - Ms R Payne (21.11.23), para 33

90. Having carefully assessed the available evidence, it is my view that the resuscitation efforts made by prison staff, ambulance officers and Prisoner T were of an appropriate standard. I also accept that there is no evidence that Prisoner T's involvement in efforts to revive Ms Davis had any impact on Ms Davis' outcome. Nevertheless, in my view the decision to allow Prisoner T to assist with attempts to resuscitate Ms Davis was wrong and highly inappropriate for the following reasons:

a. *Level of training*: I am aware that custodial staff are required to maintain their first aid competencies. However, this is clearly not the case for prisoners and there is no evidence before me as to what level of first aid training (if any) Prisoner T had at the relevant time. It is therefore possible that if Prisoner T had no first aid skills and was simply motivated to assist her close friend, she may in fact have done more harm than good;

b. *Risk of physical trauma*: although custodial staff have access to personal protective equipment, this is obviously not the case for prisoners. In this case, Prisoner T was offered a face mask, which she declined, but it is still possible that a prisoner assisting with CPR may be exposed to communicable diseases or physical trauma;

c. *Risk of mental trauma*: there is an obvious and very real risk that a prisoner assisting with CPR may experience mental trauma. In this case, Prisoner T's risk of experiencing mental trauma was exacerbated by the fact that she was a very close friend of Ms Davis.[184] Presumably this accounts for the fact that Prisoner T was managed on ARMS after Ms Davis' death;[185] and

d. *Risk of injury to custodial staff*: as resuscitation incidents are highly charged and emotional events, the behaviour of persons who have not undergone crisis scenario training (such as prisoners) cannot be accurately predicted. There is therefore a significant risk that a prisoner permitted to assist with resuscitation efforts might behave in an unpredictable way, and thereby pose a risk to the safety of custodial staff. This is presumably one of the reasons prisoners are "*locked down*" following a serious incident, as happened in this case.

[184] See also: ts 27.02.24 (Jadhav), pp62-63
[185] Exhibit 1, Vol. 1, Tab 16.1, Statement - Prisoner T (03.12.20), para 30

91. At the inquest, Officer Jadhav agreed that with the benefit of hindsight, there were medical and mental health reasons why it was inappropriate for prisoners to be involved in resuscitation efforts.[186] Whilst this was a pleasing concession, in my view it should be obvious that except in **exceptional** circumstances, prisoners should not be permitted to assist with providing first aid (CPR), and I have made a recommendation to this effect later in the finding.

92. One example of an exceptional circumstance where it would be appropriate for a prisoner to assist another prisoner by providing first aid would be where two prisoners are working in a prison kitchen, and one of them cuts themselves with a knife and sustains a serious injury that bleeds profusely. In those circumstances, it would obviously be appropriate for a nearby person (in this case another prisoner) to do their best to help by applying pressure to the wound and raising the injured limb. In the scenario I have outlined, it may be that if the nearby prisoner did not assist by providing first aid, then the injured prisoner might die from blood loss.

93. However, the situation in the present case was quite different. Three prison officers with first aid skills were in Ms Davis' cell and were willing and able to perform CPR. Further, a short time after Ms Davis was found, a recovery team (which included two nurses) arrived to assist. It is therefore impossible to argue that the assistance of Prisoner T was essential.

94. With great respect, as soon as Ms Davis' cell door had been opened and she had been placed on the floor, Prisoner T should have been required to return to her cell along with all other prisoners. Specifically in the circumstances of the present case, Prisoner T should not have been permitted to assist with resuscitation efforts, notwithstanding her close personal friendship with Ms Davis. It appears that the Department does not currently have a policy dealing with this issue,[187] and I have made a recommendation that this situation be rectified.

[186] ts 27.02.24 (Jadhav), p62-65
[187] ts 27.02.24 (Palmer), p69

CAUSE AND MANNER OF DEATH[188]

95. A forensic pathologist (Dr V Kueppers) conducted a post mortem examination of Ms Davis' body on 19 August 2020. Dr Kueppers noted Ms Davis "*showed features consistent with hanging*" including a mark around her neck which "*was consistent with the provided ligature*".[189]

96. Ms Davis had pinpoint blood spots to her eyes (petechial haemorrhages), and her lungs were congested, which is considered a non-specific finding "*that may be seen with compression of the neck due to hanging*". Dr Kueppers also noted "*old bilateral fractures of the superior thyroid horns*" but no evidence of recent neck injury.[190]

97. Toxicological analysis of samples taken after Ms Davis' death detected non-toxic levels of amitriptyline, methadone, mirtazapine, ibuprofen, paracetamol, valproic acid, and olanzapine. The analysis did not detect alcohol or other common drugs.[191]

98. Dr Kueppers found "*no evidence of significant underlying disease*" and at the conclusion of her post mortem examination, Dr Kueppers expressed the opinion that the cause of Ms Davis' death was ligature compression of the neck (hanging).[192]

99. I accept and adopt the conclusion expressed by Dr Kueppers as to the cause of Ms Davis' death.

100. Further, on the basis of the available evidence, I find that Ms Davis' death occurred by way of suicide.

[188] Exhibit 1, Vol. 1, Tab 7, Report - Det. FC Const. J Wapple (14.06.22), p6
[189] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (19.08.20)
[190] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (19.08.20)
[191] Exhibit 1, Vol. 1, Tab 5.2, Toxicology report (28.02.23)
[192] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (19.08.20)

ISSUES RAISED BY THE EVIDENCE

Overview

101. Following Ms Davis' death, the Department conducted a death in custody review and prepared a report (DIC Review) that identified one issue relating to the failure to flag Ms Davis' court appearance on 13 August 2020 as a DOI.[193]

102. In addition to the DOI issue identified in the DIC Review, the evidence raises one other issue relating to Ms Davis' care and supervision whilst she was incarcerated, namely her placement in a cell that was not fully ligature minimised. I will now briefly address both issues.

Date of interest not flagged

103. The DIC Review noted that currently, DOI only applies to those prisoners being managed on ARMS. When a DOI is added to a prisoner's TOMS profile, an automatic referral is sent to Psychological Health Services seven days prior to the DOI. As the DIC Review notes, examples of DOI include court dates, and the anniversary of the death of a loved one, or the offence leading to incarceration. Further, a DOI is seen as a "*future stressor that may potentially adversely affect the prisoner*".[194]

104. The DIC Review notes that both Prisoner T and Officer Jadhav were concerned about Ms Davis' welfare on 13 August 2020, as she "*was not herself*". After Officer Jadhav had spoken to Ms Davis when she had received her methadone dose in the Health Centre, he spoke to a mental health nurse and was advised that Ms Davis had an appointment to see a psychiatrist that day.[195]

105. However, as the DIC Review noted, "*Not having DOIs with managed guidelines for prisoners who are not on ARMS may result in prisoners with welfare concerns being overlooked*".[196]

---

[193] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), pp19-20 and ts 27.02.24 (Palmer), pp67-68
[194] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p19
[195] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p19
[196] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p19 and see also: ts 28.02.24 (Gunson), pp87-88

106. The DIC Review recommended defining a DOI procedure for prisoners not on ARMS, with guidelines on how to manage and support these prisoners in relation to their DOI. The following response to the recommendation is recorded in the DIC Review, with the "*target date*" for completion shown as 31 March 2024:

> Corrective Services acknowledge the finding and the relevant business areas are working collectively to address the matter. In the interim, a Deputy Commissioner's Notice will be issued to all staff ensuring that once a prisoner's court appearance has concluded, that the prisoner's welfare will be checked and offers of additional support are made, should the prisoner require, and that the engagement is noted appropriately.[197]

Ligature minimisation

107. In an internal memorandum to the Commissioner Corrective Services, the Executive Director Procurement explained the background to the Department's ligature minimisation program in these terms:

> The Department has undertaken a program to reduce ligature points in the State's prisons since 2005/6. The intent is to address the issue of opportunistic self-harm through an ongoing program of ligature removal complimented by the implementation of comprehensive suicide prevention strategies.
>
> **Due to funding constraints, the Department is unable to ligature minimise all secure cells but aims to ensure that there are sufficient cells available to effectively manage the number of prisoners deemed to be at risk (measured by the number of prisoners with ARMS or SAMS[198] alerts on TOMS).**
>
> The Department monitors the number of prisoners at risk on a quarterly basis and has received additional funding to expand the program to further increase the number of fully ligature minimised cells across the estate to provide additional flexibility for the management of prisoners.[199] [Emphasis added]

[197] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p20
[198] SAMS is the abbreviation for Support and Management System, the Department's step down system from ARMS
[199] Exhibit 1, Vol. 1, Tab 38.1, Internal Memorandum - Mr M Street to Mr M Reynolds (05.04.23), p2

108. On 15 September 2020, in answer to a Parliamentary Question directed to the Minister for Environment representing the Minister for Corrective Services, it was confirmed that in 2019 - 2020, $430,401 was spent on ligature minimisation, and that Melaleuca was one of six prisons which had been identified as being a priority for ligature minimisation work. It was also confirmed that the estimated cost for a fully ligature minimised cell was $30,000 - $50,000, and that approximately $500,000 had been allocated to perform this work each financial year.[200,201]

109. However, **no** ligature minimisation work has been conducted at Melaleuca since Ms Davis' death.

110. In his statement, Mr Jason Parker (Mr Parker), Principal Project Officer in the Department's infrastructure branch, advised that in 2023 - 2024, a mere $1.645 million was allocated for ligature minimisation work "*across the entire adult prison estate*". According to Mr Parker, this is on average "*only sufficient to refit approximately 8 cells to be fully ligature minimised*". In 2024 - 2025, the allocation is even more parsimonious, namely $1.137 million, enough for only 3.4 cells using Mr Parker's figures![202,203,204]

111. In his statement, Officer Hunter confirmed that on 18 October 2023, Officer Heslington received an email from Mr Parker seeking permission for a contractor to attend Melaleuca to conduct a ligature minimisation audit (the Audit). The Audit, which was part of a state-wide audit being undertaken in accordance with the "*Commissioners 2023/24 Ligature Minimisation Program*", was conducted on 23 - 24 October 2023, and consisted of a brief visual inspection of each cell at Melaleuca.[205,206,207] In his statement, Mr Parker said that the Audit had confirmed that with the exception of floor wastes/drain fixtures, all of the cells at Melaleuca were "*fully three-point ligature minimisation standard compliant*".[208,209]

---

[200] Question on Notice No. 3023 asked in the Legislative Council on 11 August 2020
[201] See: www.parliament.wa.gov.au/parliament/pquest.nsf/viewLCPQuestByDate/6BC502C87807E990482585C10023AF3E?opendocument
[202] Exhibit 1, Vol. 1, Tab 38.1, Internal Memorandum - Mr M Street to Mr M Reynolds (05.04.23), p2-3
[203] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), paras 20-22
[204] See also: Exhibit 1, Vol. 1, Tab 38.1, Internal Memorandum - Mr M Street to Mr M Reynolds (05.04.23), p2
[205] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 34-37 and ts 27.02.24 (Hunter), pp45-46
[206] Exhibit 1, Vol. 1, Tab 38-DH3, Email - Mr J Parker to Mr M Heslington (18.10.23)
[207] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), paras 9-12
[208] Exhibit 1, Vol. 1, Tab 39-JP2, Images of existing and proposed cell floor drain fixtures
[209] See for example: Exhibit 1, Vol. 1, Tab 39-JP1, Ligature Audit of Cell 2, Unit 1 (Ms Davis' cell)

112. However, I am aware from previous inquests I have conducted that referring to a cell as "*three-point ligature minimised*" simply means that the cell's three most obvious ligature points (i.e.: window bars, light fittings, and shelving) have been removed.[210] Thus, although Melaleuca may be ahead of some other prisons in that all of its cells are three-point ligature minimised, this is hardly satisfactory.

113. In my view, in 2024 (and given the vulnerable nature of the prison population in general) it is an entirely reasonable expectation that **all** cells in the prison estate are fully ligature minimised. That expectation is consistent with section 7 of the *Prisons Act 1981* which imposes statutory responsibilities on the chief executive officer of the Department with respect to "*the welfare and safe custody of all prisoners*". Those responsibilities are clear, and in my view, they clearly extend to the issue of ligature minimisation.[211]

114. I fully accept that ligature minimisation is costly and that the Department has a finite budget. In his statement, Mr Parker noted that "*where*" ligature minimisation funding is spent is determined by the Department's Adult Male Prisons branch (the AMP), and that at the start of each financial year, the Department's infrastructure branch prepares a list of options for the AMP to consider.[212]

115. In his statement, Mr Parker said it was his understanding that the AMP is currently prioritising special purpose/safe cells at Hakea Prison in response to recommendations made by this Court in recent inquests. Mr Parker also confirmed that: "*The Department has in recent years only been allocated a limited budget for ligature minimisation work across the entire adult prison estate*."[213]

116. In my view, Mr Parker's use of the term "*limited budget*" is a gross understatement. The total amount allocated by the Department to this crucial area of its operations for the period 2023 - 2025 is only $2.782 million, which is a truly pitiful sum.[214]

[210] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), paras 7-8
[211] Section 7, Prisons Act 1981 (WA)
[212] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), paras 17-18
[213] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), paras 19-20
[214] Exhibit 1, Vol. 1, Tab 38.1, Internal Memorandum - Mr M Street to Mr M Reynolds (05.04.23), p2

117. With respect, the issue of ligature minimisation is not new and for over 25 years this Court has repeatedly recommended that the Department increase the number of ligature minimised cells. Following an inquest into a hanging death at Casuarina in 2008, the then State Coroner recommended that the number of ligature minimised cells be increased and that a capital works program be established for this purpose.[215]

118. In 2019, I made recommendations about ligature minimisation following an inquest into five deaths by suicide at Casuarina, four of which occurred by way of hanging.[216] Further, in 2020, Coroner Urquhart made similar recommendations following an inquest into a hanging death at Hakea.[217]

119. In 2022, I made similar recommendations in my finding following an inquest into a death by hanging at Hakea Prison, and I also made the following comments, which I would apply to the present case:

> **This Court cannot continue to make these types of recommendations in the face of ongoing prisoner deaths by hanging. The Department must now take <u>urgent</u> action to address this appalling situation.** [Original emphasis]

120. In his statement, Officer Hunter said that following the Audit (in October 2023), senior management at Melaleuca "*have not received any material or reports yet in respect to that escorted audit*". In other words, nothing has been said about if, much less when, any ligature minimisation work may commence.[218]

121. I accept that prisoners can and have taken their lives in fully-ligature minimised cells. Nevertheless, there is obvious merit in making this more difficult by ensuring that as many cells as possible have been fully-ligature minimised, given that hanging is the method commonly used by prisoners to take their lives.

---

[215] Annual Report, Office of the State Coroner (2008-2009), p63 re: Inquest into the death of Mr Mark Briggs
[216] Inquest into five deaths at Casuarina Prison Ref: 14/19, (22.05.19)
[217] Inquest into the death of Wayne Larder, [2020] WACOR 44, (published 22.12.20), Recommendation 1, p46
[218] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 37

122. In the case of Melaleuca, photographs of Ms Davis' cell show old-fashioned wooden bunk bed frames, which in my view should be immediately re-inspected to determine their suitability.[219]

123. In more general terms, the ever increasing prison population means a commensurate rise in the number of prisoners with mental health illnesses, mental health conditions and/or maladaptive behaviours. Prisoners in these categories have demonstrably higher rates of self-harm and suicide, and as a class, are therefore particularly at risk.

124. It is therefore my sincere hope that the Department will make the completion of the ligature minimisation work to cells at Melaleuca an **absolute priority** and will take **urgent** steps to ensure that all cells are fully-ligature minimised as soon as possible.[220]

Safe cells

125. In his statement, Officer Hunter noted that at Melaleuca it was necessary to "*balance risk within the existing infrastructure limitations*", noting that the prison operated in what were two units at Hakea Prison that were repurposed in 2016. Officer Hunter also notes the "*heavily transient nature*" of the population at Melaleuca and the constant need to "*assess and review prisoners at risk*".[221]

126. There are only four Crisis Care cells (also known as safe cells) at Melaleuca, which are primarily used to manage prisoners at acute risk of self-harm, and/or those under "*medical observation*". Officer Hunter said that the transient population at Melaleuca, and the high levels of prisoners with mental health issues and/or self-harm and suicidal ideation, means that "*it is commonplace*" for the safe cells to "*routinely be at capacity*".[222]

127. Although this issue was not directly related to Ms Davis' death, it does seem clear that additional safe cells are required at Melaleuca.

[219] Exhibit 1, Vol. 1, Tab 33, Photographs of Ms Davis' cell
[220] ts 27.02.24 (Hunter), p47
[221] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), paras 31-32 and ts 27.02.24 (Hunter), pp46-47
[222] Exhibit 1, Vol. 1, Tab 38, Statement - Officer D Hunter (23.02.24), para 33 and ts 27.02.24 (Hunter), pp46-47

QUALITY OF SUPERVISION, TREATMENT AND CARE

128. Dr Pascu (an experienced consultant forensic psychiatrist) reviewed the mental health care provided to Ms Davis, and provided the Court with a detailed report. Dr Pascu also gave evidence at the inquest and in summary, her observations about Ms Davis' care are as follows:[223,224]

> a. There is no clear information to confirm that in the period before her death, Ms Davis was experiencing psychotic symptoms. However, her withdrawal, isolation and concerns about her daughter being "*kidnapped*" might indicate an increase in Ms Davis' persecutory beliefs "*in the context of the stress of being in custody and her remand being extended by two weeks*";[225]
>
> b. Ms Davis was most likely experiencing "*residual psychotic symptoms and likely an adjustment disorder*", with a disturbance of emotions and conduct on a background of emotionally unstable personality disorder and a history of significant polysubstance use;[226]
>
> c. Ms Davis' risk factors including: past trauma, polysubstance use, unstable relationship with her partner, emotional dysregulation, and history of self-harm suggest she was "*a chronic and fluctuating risk to herself*" and any acute stressors (real or perceived) "*would have contributed to an increased risk*";[227]
>
> e. Although Ms Davis' presentation may not have warranted her being placed on ARMS on 11 August 2020, discussions between custodial and mental health staff "*regarding some degree of monitoring*" would have been appropriate. Further, Ms Davis' further period of remand (imposed shortly before her death) was "*a likely contributor*" to her distress and emotional dysregulation;[228]; and
>
> f. From the information available, there was "*no indication for ongoing regular psychiatric or mental health follow up after the review on 31 July 2020*".[229]

[223] Exhibit 1, Vol. 1, Tab 28.1, Letter Mr W Stops to Dr V Pascu (12.12.22)
[224] ts 28.02.24 (Pascu), pp94-99
[225] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 66, p11
[226] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 67, p11
[227] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 70, p12
[228] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), paras 71 & 73, p12
[229] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 1, p13

129. Dr Pascu noted that during Ms Davis' last incarceration, she had a number of risk factors, including: a history of polysubstance use and self-harm, paranoia (likely secondary to illicit drug use), relationship issues with her partner, an extended period of remand in custody, and emotionally unstable personality with borderline and antisocial traits, leading to emotional dysregulation when dealing with stress.[230]

130. As to whether Ms Davis' suicide was predictable or preventable, Dr Pascu expressed the following opinion:

> As far as being able to predict suicide in Ms Davis, as I pointed out above, suicide is extremely difficult to predict and that is because it is a rare event and it is impossible to predict rare events with any degree of certainty. As highlighted above a complicating factor is that a person's suicidality fluctuates, sometimes in a relatively short timeframe.[231]

131. Having carefully considered the available evidence, I am satisfied that in relation to her physical health, whilst incarcerated Ms Davis received a level of care that was commensurate with that available in the general community. I am also satisfied that with the exception of the fact that she was placed in a cell that was not fully ligature-minimised, Ms Davis received an adequate level of care and supervision whilst in custody.

132. However, with the benefit of hindsight (and for the reasons I have outlined in this finding) it is my view that there were a number of missed opportunities where the management of Ms Davis' mental health could have been improved.[232]

133. I have therefore concluded that the mental health care Ms Davis received whilst she was incarcerated was inadequate.

[230] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 3, p15
[231] Exhibit 1, Vol. 1, Tab 28.2, Report - Dr V Pascu (05.07.23), para 3, p15
[232] See: and ts 28.02.24 (Gunson), pp90-92

RECOMMENDATIONS

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

Recommendation No. 1
In order to better manage prisoners and thereby enhance security at Melaleuca Women's Prison (Melaleuca) the Department should, **as a matter of the utmost urgency**, undertake remedial work at Melaleuca to ensure that all cells are fully ligature minimised.

Recommendation No. 2
The Department should undertake an **immediate** audit of bunkbeds in all cells at Melaleuca Prison to ensure that these structures are fully ligature minimised.

Recommendation No. 3
The Department should remind custodial staff (by way of a Commissioner's Notice or other appropriate method) that prisoners are not to be asked or permitted to assist with an emergency response to another prisoner, except in **exceptional** circumstances.

Recommendation No. 4
The Department should consider ways in which dates of interest (DOI) for prisoners who are not being managed on the At Risk Management System (but who have nevertheless been identified as requiring additional support) can be flagged, so as to ensure that these prisoners can be followed up by staff before and after the DOI.

Comments on recommendations

135. In accordance with my usual practice, a draft of my proposed recommendations was forwarded to Ms Femia (counsel for the Department) and Ms Kerr (counsel for Mr Collins) by way of an email on 29 February 2024. Any feedback on the draft recommendations was requested by close of business on 28 March 2024.[233]

136. By way of an email dated 7 March 2024, Ms Kerr advised that Mr Collins was "*happy with those draft recommendations*".[234]

137. In an email dated 27 March 2024, Ms Femia advised that the Department's response to the recommendations was as follows:[235]

a. *Recommendation 1*: the Department says: "*action against this recommendation has been taken*" and the audit of cells conducted at Melaleuca in October 2023 found that "*all cell furniture/fixtures were within ligature minimisation standards, with the exception of the floor water waste drains*".

With respect, this response misses the point of Recommendation 1. The audit merely confirmed that cells at Melaleuca were "*three-point ligature minimised*". By contrast, Recommendation 1 strongly urges the Department to "*undertake remedial work at Melaleuca to ensure that all cells are **fully** ligature minimised*". For that reason, Recommendation 1 remains pertinent and appropriate.

b. *Recommendation 2*: the Department says: "*action against this proposed recommendation has been taken*", and that "*in October 2023 an audit of bunkbeds within Melaleuca Women's prison was conducted*" which *"confirmed that all bunk beds at Melaleuca Prison were fully ligature minimised compliant*".

With respect, the evidence before me is to the contrary. In his statement, Mr Parker says that all cells at Melaleuca "*are currently listed as Three-Point Ligature Minimised - which means the most obvious points in the cell (lights, windows and shelving have been ligature minimised)*".[236]

[233] Email from Ms K Christie to Ms P Femia & Ms B Kerr (29.02.24)
[234] Email from Ms B Kerr to Ms K Christie (07.03.24)
[235] Email from Ms P Femia to Mr W Stops (27.03.24)
[236] Exhibit 1, Vol. 1, Tab 39, Statement - Mr J Parker (26.02.24), para 8

There is **no** evidence before me that confirms that bunkbeds at Melaleuca are "*fully ligature minimised compliant*". Further, there is the obvious point that Ms Davis was somehow able to secure a bedsheet to the bunkbed in her cell in order to take her life.

In those circumstances, it is my view that Recommendation 2 remains appropriate, and that there should be "*an immediate audit of bunkbeds in all cells at Melaleuca Prison to ensure that these structures are fully ligature minimised*".

c. *Recommendation 3*: the Department advises it supports this recommendation "*as written*".

d. *Recommendation 4*: the Department's response is as follows:

"*Another way in which prisoners can be flagged for a DOI is through Psychological Health Services (PHS) staff. Currently there are resourcing impediments which hinder the ability to conduct follow ups with prisoners both before and after a DOI. This is illustrated through data which demonstrates the volume of individuals attending Court whereby their court appearance could be a potential DOI requiring follow up: 12/2/23: 241 appearances* (compared with) *1/2/24-1/3/24: 6,121 appearances.*

In addition, existing systems such as ARMS and SAMS which provide support for individuals are currently strained and cannot meet the service demand. Imposing the recommendation as written will put further strain on current systems, this recommendation would therefore be better framed with a focus on advocating for commensurate resourcing to provide additional supports to those prisoners not on ARMS and SAMS.

In the interim the Department continues to utilise resources currently available to support prisoners who are not on ARMS and SAMS but require additional support. These services include Chaplaincy, the Aboriginal Visitors Scheme and Peer Support Services. The Department is also exploring the possibility of all prisoners receiving a post video-link court welfare check by custodial staff in the first instance. This check will be documented in the Total Offender Management Solution and will allow for custodial staff to make referrals to PHS and Mental Health as required."

> I accept that the Department has a limited budget, and that the demands on PHS who manage prisoners on ARMS and SAMS is ever increasing. However, Recommendation 4 is framed in terms of the Department considering ways in which DOI for prisoners who are not being managed on ARMS and SAMS (such as Ms Davis) can be flagged so that these prisoners can be followed up "*by staff*".
>
> Recommendation 4 does not mandate that prisoners with a DOI who are not on ARMS or SAMS be followed up by PHS or mental health staff. Instead, the term "*staff*" is used. The point of the recommendation is that after the Department has given consideration to how such prisoners with DOI can be followed up, the Department will determine which staff can (and should) follow them up.
>
> Thus, when properly understood, Recommendation 4 is entirely consistent with the recommendation about DOI made in the DIC Review,[237] and the Department's response - which refers to custodial staff conducting the follow-up in the first instance, and referring to PHS or mental health staff as required.
>
> It therefore remains my view that Recommendation 4 is appropriate in its present form.

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

139. I have outlined the Department's response to the recommendations. However, as ever, it remains the case that the Department's actions will speak louder than its words.

[237] Exhibit 1, Vol. 1, Tab 32, Death in Custody Review (29.11.23), p20

CONCLUSION

140. This is a tragic case, dealing as it does with the death of a much loved 47-year-old woman, who took her life on 13 August 2020. Once again, this case highlights the difficulties involved with managing a person who is at chronic, long-term risk of self-harm, as Ms Davis appears to have been.

141. After careful consideration, I decided it was appropriate for me to make four recommendations aimed at addressing issues I identified during the inquest. It is my sincere hope that these recommendations will be embraced by the Department and fully implemented.

142. In conclusion, as I did at the conclusion of the inquest, I wish to again extend my sincere condolences to Ms Davis' family, friends, and loved ones for their terrible loss.

MAG Jenkin
Coroner
28 March 2024