JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	8 - 9 OCTOBER 2024
DELIVERED	**:**	15 NOVEMBER 2024
FILE NO/S	**:**	CORC 2080 of 2022
DECEASED	**:**	GARLETT, KINGSLEY DEAN

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Mr E. Heywood and Mr T. Boyle (State Solicitor's Office) appeared for the Department of Justice.

Ms C. Wood and Mr F. Crockett (Aboriginal Legal Service of WA Inc) appeared for Mr Garlett's family.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Kingsley Dean GARLETT*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 8 - 9 October 2024, find that the identity of the deceased person was* ***Kingsley Dean GARLETT*** *and that death occurred on 31 July 2022 at Casuarina Prison, 288 Orton Road, Casuarina, from ligature compression of the neck (hanging) in a man with methadone and methylamphetamine consumption in the following circumstances:*

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SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of:

a. the name of any prisoner (other than the deceased) housed at Casuarina Prison on or about 31 July 2022. Any such prisoner is to be referred to as "Prisoner [*Surname Initial*]"; and

b. any document or evidence that would reveal any information about the methods of detecting illicit drugs with respect to persons under the care and control of the Director-General of the Department of Justice.

Order made by: MAG Jenkin, Coroner (08.10.24)

INTRODUCTION

1. Kingsley Dean Garlett (Mr Garlett) died at Casuarina Prison (Casuarina) on 31 July 2022, from ligature compression of the neck. He was 32 years of age.[1,2,3,4,5,6]

2. At the time of his death, Mr Garlett was a sentenced prisoner at Casuarina and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (the Department).[7]

3. As a result of his incarceration, immediately before his death Mr Garlett was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory and where (as here) the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[8]

[1] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (01.08.22)
[2] Exhibit 1, Vol 1, Tab 2, Life Extinct Certification (31.07.22)
[3] Exhibit 1, Vol 1, Tab 3, P92 - Identification of Deceased Person by Visual Means (31.07.22)
[4] Exhibit 1, Vol 1, Tab 4, P98 - Mortuary Admission Form (31.07.22)
[5] Exhibit 1, Vol 1, Tab 5.1, Supplementary Post Mortem Report (16.08.23)
[6] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24)
[7] Section 16, *Prisons Act 1981* (WA)
[8] Sections 3, 22(1)(a) and 25(3), *Coroners Act 1996* (WA)

4. Members of Mr Garlett's family attended the inquest I conducted into his death in Perth on 8 - 9 October 2024, and the documentary evidence comprised two volumes. The inquest focused on the supervision, treatment and care Mr Garlett received in custody, as well as the circumstances of his death, and the following witnesses gave evidence:

a. Mr B Huntley, Psychologist, Casuarina (Mr Huntley);
b. Mr A Brick, Prison Officer, Casuarina (Officer Brick);
c. Mr L Brickland, Prison Officer, Casuarina (Officer Brickland);
d. Mr J Pittard, Acting Superintendent, Casuarina (Officer Pittard);
e. Mr J Rowbottom, Dep. Supt. Drug Detection Unit (Officer Rowbottom);
f. Dr C Gunson, Acting Director Medical Services, DOJ (Dr Gunson)
g. Ms T Palmer, Senior Review Officer, DOJ (Ms Palmer); and
g. Dr V Pascu, Independent Consultant Psychiatrist (Dr Pascu).

5. The documentary evidence adduced at the inquest comprised two volumes, and the inquest focused on the supervision, treatment and care Mr Garlett received in custody, as well as the circumstances of his death.

6. When assessing the evidence in this matter I have been mindful of two key principles. The first is the phenomenon known as "hindsight bias", which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[9] The other principle is "the Briginshaw test", derived from a High Court judgment of the same name in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[10]

7. Essentially, the Briginshaw test requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of that allegation.

[9] See for example: www.britannica.com/topic/hindsight-bias
[10] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362

MR GARLETT

Background[11,12,13]

8. Mr Garlett was born on 27 November 1989, and his parents separated when he was young. Information about Mr Garlett's social history is limited, but it is known that he had four sisters and two brothers. Although Mr Garlett completed Year 10, he was never in paid employment.

9. At the time of his death, Mr Garlett had a partner, with whom he had one child, and he also had another child from a previous relationship. The Death in Custody Review completed by the Department after Mr Garlett's death (the Review) states:

> Mr Garlett was raised by his extended family and not his biological parents. During his childhood he was exposed to violence and alcohol abuse and he was the victim of sexual abuse by a relative. Mr Garlett spent a significant portion of his juvenile years in detention.[14]

Offending and prison history[15,16,17,18]

10. Mr Garlett had an extensive criminal history. As an adult, he accumulated 46 convictions for offences including: stealing, assault, aggravated burglary, armed robbery, and unlawful wounding. From about 2009, Mr Garlett was imprisoned on 11 occasions and he therefore spent the majority of his adult life in custody.

11. On 14 February 2020 in the District Court at Perth, Mr Garlett was sentenced to seven years' imprisonment in relation to the offences of: aggravated armed robbery, assault occasioning bodily harm, steal motor vehicle, reckless driving, aggravated home burglary, aggravated assault, and threats to injure, endanger or harm a person. As I will explain, this was to be Mr Garlett's last period of incarceration.

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[11] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p8
[12] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), pp3-4
[13] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p6
[14] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p8
[15] Exhibit 1, Vol 2, Tab 1.2, History for Court - Criminal and Traffic (compiled 03.07.24)
[16] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p8
[17] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p3
[18] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), pp4-5

12. Mr Garlett was made eligible for parole, and his sentence was backdated to reflect the time he had spent on remand. Mr Garlett's earliest eligibility date for release on parole was calculated as 19 April 2024.

General management issues[19,20]

13. Mr Garlett was remanded in custody at Casuarina on 22 April 2019, after he was arrested in relation to the offences referred to earlier. He was identified as a returning prisoner, and spent 66 days at Casuarina before he was transferred to Hakea Prison (Hakea) due to "*placement issues*". On 8 February 2020, Mr Garlett was returned to Casuarina, apparently following conflict with a fellow prisoner.[21]

14. After Mr Garlett was sentenced in the District Court, a management and placement report noted that his security rating was "*maximum*" and that he was to remain at Casuarina. An educational and vocational assessment noted that Mr Garlett wanted to attend a literacy and numeracy course, and it was recommended he receive career guidance and complete various employment courses before his release.[22,23,24]

15. Mr Garlett completed a Violent Offending Treatment program on 25 January 2022, and was enrolled in the Addictions Offending course at the time of his death. Individual Management Plans completed prior to Mr Garlett's death note that he was housed in Unit 1 at Casuarina "*due to behavioural issues*".[25]

16. Between 1 December 2020 and 31 June 2021, Mr Garlett was subjected to 13 periods of "*administrative sanction*" when he was managed on confinement regimes, with seven of these involving loss of contact visits. These sanctions were imposed because: "*Mr Garlett was found to have been trafficking or (in) possession of Illegal Substances*".[26,27,28]

[19] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), pp8-14
[20] ts 09.10.24 (Palmer), pp192-209 & 229-232
[21] Exhibit 1, Vol 2, Tab 1.4, TOMS Decision slip (10.02.20)
[22] Exhibit 1, Vol 2, Tab 1.5, Management and Placement Report (30.03.20)
[23] Exhibit 1, Vol 2, Tab 1.6, Education and Vocational Training Checklist (17.04.20)
[24] Exhibit 1, Vol 2, Tab 1.8, Classification Review (15.04.21)
[25] Exhibit 1, Vol 2, Tabs 1.9 & 1.11, Individual Management Plans (15.04.21 & 21.05.20)
[26] Exhibit 1, Vol 2, Tabs 1.16-1.19, Prison charges documents
[27] Exhibit 1, Vol 2, Tab 1.38, Prison charges history
[28] Exhibit 1, Vol 2, Tab 5, Statement - Officer J Pittard (03.10.24), para 31

17. Mr Garlett maintained regular contact with family and friends using the Prisoner Telephone System (PTS). Prisoners are permitted to make an unlimited number of 10-minute phone calls daily using the PTS, and on any given day at Casuarina over 5,000 calls may be made.[29,30,31]

18. With limited exceptions calls made using the PTS are recorded, but not all calls are routinely monitored unless welfare or security issues have been identified. Mr Garlett's calls were routinely monitored because of his involvement in trafficking and/or possession of illicit substances. However, due to logistical and operational limitations, not all of his calls were listened to.[32,33]

19. Mr Garlett was noted to "*get on well*" with other prisoners, and his personal hygiene was of "*an acceptable level*". Mr Garlett was described as "*quite stoic and strong-willed*", and Officer Brickland said that although Mr Garlett could be "*a bit of a rogue*", he was well respected by his peers, and Officer Brickland also noted that "*to this day there are still pictures up in the blocks of (Mr Garlett)*".[34,35,36]

20. Mr Garlett was employed in various capacities whilst he was incarcerated, including as a cleaner, assistant cook, and dining room attendant.[37,38] Mr Garlett received 71 in-person and e-visits, all bar three of which were from loved ones, and he sent 18 pieces of mail.[39,40,41]

21. Mr Garlett was searched 55 times, but nothing of interest was ever found. Mr Garlett was also the subject of a number of drug and alcohol tests, and other than tests on 20 November 2020 and 5 February 2021 (both of which detected buprenorphine), these tests returned negative results.[42,43,44]

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[29] Exhibit 1, Vol 2, Tab 1.36, Recorded calls report
[30] Exhibit 1, Vol 2, Tab 5, Statement - Officer J Pittard (03.10.24), para 31 and ts 08.10.24 (Pittard), pp102-103
[31] Exhibit 1, Vol 2, Tab 2.1 & 2.2, Versions of COPP 7.1, Prisoner Communications
[32] Exhibit 1, Vol 2, Tab 5, Statement - Officer J Pittard (03.10.24), para 31 and ts 08.10.24 (Pittard), p135
[33] Exhibit 1, Vol 2, Tab 8, SMF-PRO-00 - Prisoner telephone system monitoring
[34] Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), paras 17-18
[35] Exhibit 1, Vol 2, Tab 1.24, Statement - Officer L Brickland (07.08.24) and ts 08.10.24 (Brickland), pp84-86
[36] See also: ts 08.10.24 (Pittard), pp101-102
[37] See for example: Exhibit 1, Vol 2, Tab 1.9, Individual management Plan (15.04.21)
[38] Exhibit 1, Vol 2, Tab 1.33, Offender work history
[39] Exhibit 1, Vol 2, Tabs 1.9 & 1.11, Individual Management Plans (15.04.21 & 21.05.20)
[40] Exhibit 1, Vol 2, Tab 1.34, Prison visits history
[41] Exhibit 1, Vol 2, Tab 1.35, Prison mail history
[42] Exhibit 1, Vol 2, Tab 1.39, Search person history
[43] Exhibit 1, Vol 2, Tab 1.41, Substance use tests results
[44] Exhibit 1, Vol 2, Tab 5.2, Substance use tests results

22. Notably, on five occasions between 23 March 2021 and 20 March 2022, Mr Garlett declined to provide samples for drug and alcohol testing. At the inquest, Officer Pittard confirmed that although prisoners are entitled to refuse to provide samples for testing, when they do so they receive similar penalties to what they would have been given if they had actually tested positive to an illicit substance.[45,46,47]

23. At the inquest, Ms Wood (counsel for Mr Garlett's family) asked Officer Rowbottom whether Mr Garlett's refusals to provide samples for testing suggested he "*merited closer monitoring or supervision*". Officer Rowbottom's response was:

> To a degree. If he has refused, what it would suggest to me, and again, I base this information that I used to be a prison prosecutor was that potentially he was using more than one drug. Simply because if a prisoner is charged with multiple drug offences…they can be charged with a separate charge for each drug class. So if they're using cannabis, methamphetamine, buprenorphine, and it's found in their system, they can get a charge for each of those. And then, hence, the penalties will apply for each of those. So, typically, if a prisoner knows that he's going to get charged three times for drug offences because he's using it, and he knows he's going to come up positive…they'll say, "I'm refusing" because it's one offence…So they're only going to get pinged for, you know, one penalty rather than three penalties, if that makes sense.[48]

24. Mr Garlett was known to be involved in "gang" activity at Casuarina, and was the leader of a group known as the "*Scrubs and Thugs Outlaw Gang*".[49,50] Officer Brick said Mr Garlett could be "*very outspoken and aggressive*", and he did not recall ever seeing Mr Garlett have a normal conversation, especially on the phone. Officer Brick also said Mr Garlett "*often raised his voice and would swear*" but that "*everyone wanted to speak to him or be acknowledged by him*".[51,52]

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[45] Exhibit 1, Vol 2, Tab 1.41, Substance use tests results
[46] Exhibit 1, Vol 2, Tab 5.2, Substance use tests results
[47] ts 08.10.24 (Pittard), pp102, 107-108 & 117-118
[48] ts 09.10.24 (Rowbottom), p157
[49] Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), paras 17-18
[50] ts 08.10.24 (Brick), p80
[51] Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), paras 17-18
[52] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer A Brick (10.07.24), para 7 and ts 08.10.24 (Brick), pp61-62 & 80-81

Medical history and management[53,54,55,56]

25. Mr Garlett's medical history included: gastro-oesophageal reflux disease, cellulitis, tachycardia (increased heart rate), depression, thoracic/lumbar pain, and acute renal impairment following an accident in 2019. Mr Garlett had received treatment for various fractures, and he also had a history of polysubstance use including methylamphetamine (from 13 years), heroin (from 15 years), and cannabis dependence since 2011.

26. When he was 16 years of age Mr Garlett was diagnosed with psychotic symptoms in the context of amphetamine use. In 2011, when he was admitted to the Frankland Centre, Mr Garlett was diagnosed with paranoid psychosis and started on antipsychotic medication.

27. The Health Services Summary completed by the Department after Mr Garlett's death (Health Summary) makes the following comments about his mental health:

> It is also likely that in the longer term, medication would not be the most appropriate way to manage a patient like Mr Garlett, who fairly clearly demonstrated that he preferred not to take prescribed medications, for the most part. Additionally, while he was at some risk of depressive or dysthymic episodes, as per the independent psychiatric report, (Mr Garlett's) diagnosis was most likely that of emotionally unstable personality disorder, in a chronically institutionalised person whose history of trauma would have made his engagement with supports more difficult.[57]

28. Mr Garlett had a history of self-harm and was managed on the At Risk Management System (ARMS) on occasions when he expressed suicidal ideation.[58,59] 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.[60]

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[53] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), pp4-5
[54] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), pp4-14
[55] ts 08.10.24 (Huntley), pp11-55 and ts 09.10.24 (Gunson), pp163-191
[56] Exhibit 1, Vol 1, Tabs 25 & 25.1, PHS File Notes
[57] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p15
[58] Exhibit 1, Vol 2, Tab 1.20, ARMS Interim Management Plan (19.03.21)
[59] Exhibit 1, Vol 2, Tabs 1.21 & 1.22, Prisoner Risk Assessment Group Minutes (22.03.21 & 30.03.21)
[60] ARMS Manual (2019)

29. From 1 June 2021 to 27 July 2022, Mr Garlett was seen on seven occasions by Mr Huntley, an experienced prison psychologist with whom Mr Garlett had developed a rapport. During each of these counselling sessions, Mr Garlett consistently denied any self-harm or suicidal ideation, and at times he referenced his children as protective factors.[61,62] Although he had requested them, I note that Mr Garlett declined the counselling sessions he was offered on 20 and 27 July 2022.[63]

30. From 3 March 2021, Mr Garlett regularly complained of chest pain, and he underwent a number of electrocardiograms, all of which returned normal results. Mr Garlett often declined to attend external medical appointments, and despite being counselled and agreeing to attend a subsequent appointment, he would often decline to do so.

31. During a hospital admission in May 2021, Mr Garlett was prescribed metoprolol, a medication used to treat high blood pressure. Despite counselling from medical staff about the importance of taking this medication regularly, Mr Garlett periodically declined to do so. During this admission, fresh "*track marks*" were noted in Mr Garlett's left elbow crease, a finding which is consistent with intravenous drug use.

32. According to Mr Huntley, Mr Garlett took his role as father seriously and this was a strong motivator for him to address his history of substance use.[64] On 31 July 2021, Mr Garlett asked to speak with clinical staff about entering the methadone program. Mr Garlett said he wanted to enter the methadone program to help him stop injecting illicitly obtained buprenorphine, which he had tested positive for on three occasions in August 2021, "*suggesting ongoing regular use*".[65]

33. Methadone is a synthetic opioid, which is used to "*treat people who were addicted to opiate drugs by producing similar effects and preventing withdrawal symptoms in people who have stopped using these drugs*".[66]

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[61] Exhibit 1, Vol 1, Tab 25.1, PHS Counselling - File Notes (01.06.21 - 27.07.22)
[62] ts 08.10.24 (Huntley), pp14-44 and see also: ts 09.10.24 (Pascu), pp223-224
[63] Exhibit 1, Vol 1, Tab 25.1, PHS File Notes (20.07.22 & 27.07.22) and ts 08.10.24 (Huntley), pp37-40
[64] ts 08.10.24 (Huntley), p48
[65] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p10
[66] See: https://medlineplus.gov/druginfo/meds

34. In October 2021, Mr Garlett was assessed by a prison medical officer and found to be suitable to commence depot injections of buprenorphine. However, he was not started on the methadone program until January 2022. It appears that high demand for places, and limited clinical staff to administer the medication caused the delay in Mr Garlett starting the methadone program.[67]

35. At the inquest, Mr Huntley said in 2022, a delay of five months in a prisoner starting on the methadone program was "*not uncommon*", and that "*it's gotten worse since then*".[68] Mr Huntley also said this about Mr Garlett's reaction to the delayed start to the methadone program:

> I think he was frustrated because he…was highly motivated to address his drug…addiction issues, and yes, and that was a delay. He was, sort of, actively wanting to do it right then and there, and it was just that frustration of having to wait.[69]

36. Despite the delay in starting the methadone program, Mr Huntley says Mr Garlett was not deterred and "*he remained pretty firm*", about his desire to address his polysubstance use.[70] Nevertheless, the delay is very unfortunate and it would obviously have been better if Mr Garlett had been started on the methadone program soon after being assessed as suitable.

37. The Health Summary made the following observations about the benefits of opioid substitution therapy (OST):

> The availability of OST in prison has been linked to a reduction in drug injection and thus lower associated harms such as needle sharing and infections. OST also reduces cravings and withdrawals, and improves overall physical and mental health. In the community, OST reduces the rates of drug-related crime and the demand for illicit drugs. Additionally, within the prison system, OST reduces the rates of medication diversion and trafficking, and the harms associated with these.[71]

[67] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), pp14-15 and ts 09.10.4 (Gunson), pp164-166 & 185-186
[68] ts 08.10.4 (Huntley), p48
[69] ts 08.10.4 (Huntley), p48
[70] ts 08.10.4 (Huntley), p48
[71] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p16

38. I have made a recommendation that the Department consider expanding its methadone and buprenorphine programs to reduce the wait time for prisoners seeking to enter these programs. The prevalence of polysubstance use in the general community, and in the prison population in particular, highlights the importance of taking all possible steps to reduce the scourge of prisoners using illicit drugs.

39. In March 2022, Mr Garlett's dose of methadone was increased as he was reporting "*mild withdrawal symptoms and thoughts of wanting to use*". On 19 March 2022, Mr Garlett was placed in an observation cell after he was seen ingesting a foreign substance during a contact visit. This was considered to be a serious breach of the "contract" Mr Garlett had signed when he entered the methadone program, and he was formally warned that any further breaches of his contract would result in him being removed from the program.[72]

40. On 6 January 2022, Mr Huntley and Assistant Superintendent Pickering attended Unit 1 and spoke with Mr Garlett about his application for a place in the Mallee Rehabilitation Centre (Mallee) at Casuarina.[73,74] In a file note about this meeting, Mr Huntley states:

> Attended U1 with A/Super Kate Pickering, who advised (Mr Garlett) his application for Mallee Rehab Unit has not been approved for this round of intakes. He will remain on the waiting list for consideration at a later date. (Mr Garlett expressed an interest in doing Pathways course in the meantime.[75]

41. At the inquest, Mr Huntley was asked whether he was aware of the reason why Mr Garlett's application to be transferred to Mallee was refused and he responded: "*I think I was just told it was security issues*". Despite his application being refused, Mr Garlett commenced the Pathways Program (a treatment assessment program) in June 2022.[76]

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[72] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p11 and ts 09.10.4 (Gunson), pp167
[73] Mallee is the first alcohol and other drug treatment facility for male prisoners in Western Australia
[74] See also: www.wa.gov.au/government/announcements/mallee-rehabilitation-centre-opens
[75] Exhibit 1, Vol 1, Tab 25.1, PHS File Note (06.01.22)
[76] ts 08.10.4 (Huntley), pp32-33 & 51

EVENTS LEADING TO MR GARLETT'S DEATH

Phone calls: 30 - 31 July 2022[77]

42. On 30 July 2022, Mr Garlett used the PTS to call his partner on 15 occasions. In a number of these calls, Mr Garlett accused his partner of being unfaithful and she responded by saying she was "*sick of him*" and "*wanted to have a life and to have a break*". Their conversations often devolved into "*shouting arguments*".[78]

43. In a call at 3.28 pm, Mr Garlett told his partner he "*thinks about killing himself every day*" but did not think he could do so and "*leave her behind*". Mr Garlett used the PTS account of one of his partner's relatives to call her on five occasions between 4.18 pm and 5.47 pm. In a call at 5.47 pm, Mr Garlett's partner asked if he intended to kill himself, and Mr Garlett responded: "*Yeah I am*".[79]

44. On 31 July 2022, Mr Garlett used the PTS account of one of his partner's relatives to call her on two occasions. In a call at 10.33 am, they each said they were missing the other, and Mr Garlett told his partner that if she needed to have sex with another man, then she could. In Mr Garlett's final call at 10.54 am, they spoke about sex, and the partner said she loved Mr Garlett but that she hated their arguments.[80,81]

45. Mr Garlett then accused his partner of having someone with her, which she denied. He then said: "*Someone's on top of you fucking maggot*", and his partner replied: "*You're sick. I…*", to which Mr Garlett says: "*No. Serious. Look how you just went. Look how you just went*." The partner then says: "*I just laid down Kingsley*" before the call terminates.[82,83]

46. Mr Garlett clearly believed his partner was being unfaithful to him, despite her repeated denials. His comments during their calls (especially on 30 July 2022) appear to show his mental state was deteriorating.

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[77] Exhibit 1, Vol 2, Tab 1.36, Recorded calls report
[78] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p14
[79] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p14
[80] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), pp14-15
[81] See also: Exhibit 1, Vol 1, Tab 23, Transcript of call between Mr Garlett and his partner (10.54 am, 31.07.22)
[82] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), pp14-15
[83] See also: Exhibit 1, Vol 1, Tab 23, Transcript of call between Mr Garlett and his partner (10.54 am, 31.07.22)

47. It is obviously unfortunate that the content of the calls between Mr Garlett and his partner was not brought to the attention of prison staff prior to his death. At all relevant times, there was no basis for prison security staff to be monitoring Mr Garlett's calls, and he was not being managed on ARMS. Thus, the only way prison staff would have known what Mr Garlett had been saying to his partner would be if she advised them, and there is no evidence before me that she did so.

48. In making that observation, I do not wish to be seen to be criticising Mr Garlett's partner. She was not called to give evidence at the inquest, and I accept that there are many reasons why she may not have wished to tell prison staff about what Mr Garlett had been saying. For example, she may not have considered Mr Garlett's threats were serious, and/or she may have been concerned that Mr Garlett would be angry with her if she contacted prison staff without his permission.

49. At the inquest Officer Brick and Officer Brickland both said that if they had been aware of a prisoner threatening suicide, they would have taken action to have them assessed and provided with support.[84,8586] There is no way of knowing whether any such intervention would have made any difference, and as I will explain, it appears Mr Garlett's actions were an impulsive response to the conversations he and his partner were having.[87]

50. As noted, prisoners are not restricted in the number of calls they can make using the PTS system, providing they have credit. The telephones used by prisoners are located in "public" areas on the wings, and it is not uncommon for prisoners to shout and yell during these calls.[88,89]

51. Given that prisoners' calls are not routinely monitored in real time, unless a prison officer happened to walk past at exactly the moment a prisoner was expressing suicidal ideation during a phone call (or such remarks were reported to custodial staff by another prisoner), comments of this nature would not become known.

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[84] ts 08.10.24 (Brick), pp64-65 and ts 08.10.24 (Brickland), pp97-98
[85] See also: ts 08.10.24 (Huntley), pp42-44
[86] See also: Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), paras 11-15
[87] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), p12
[88] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer Brick (10.07.24), para 7 and ts 08.10.24 (Brick), pp63 & 75-77
[89] ts 08.10.24 (Brickland), pp96-97

Lunchtime lockup[90,91,92,93,94,95,96]

52. At about 11.45 am on 31 July 2022, Officers Brick and Brickland conducted a muster check on Unit 1, prior to locking prisoners up for lunch. At the time, Mr Garlett was accommodated in D Wing, and he was the sole occupant of a double occupancy cell (D06).[97]

53. Once all prisoners had been accounted for, they were locked in their cells. This enabled custodial staff to have their designated lunch break between 12.00 pm and 1.00 pm.

54. At the inquest both Officer Brick and Officer Brickland said they did not notice anything unusual about Mr Garlett's behaviour in the period leading up to 31 July 2022. Officer Brick also said he did not see anything of concern when he locked Mr Garlett in his cell, and that Mr Garlett did not make any requests for support. Officer Brickland said no one raised any concerns with him about Mr Garlett during that time.[98]

55. In his police statement, Officer Pearse says he was the control officer on Unit 1 on 31 July 2022, and that he observed the lunchtime lock up muster.[99] Officer Pearse said:

> I do not have a specific recollection of Mr Garlett's presentation or behaviour on 31 July 2022. However, if I had noticed anything unusual I would have recorded that information in my TOMS incident report that I completed later that day.[100]

56. During the lunchtime lock down, custodial staff do not check on prisoners unless a prisoner makes a call using the emergency call button in their cell. There is no record of Mr Garlett making any emergency cell calls from his cell during the lunchtime lock up.[101]

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[90] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), pp15-17
[91] Exhibit 1, Vol 1, Tab 18, Statement - Officer Brick (27.03.23) and ts 08.10.24 (Brick), pp65-67
[92] Exhibit 1, Vol 2, Tab 1.24, Statement - Officer Brickland (07.08.24)
[93] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer Brick (10.07.24)
[94] Exhibit 1, Vol 2, Tab 1.25, Incident Summary Reports - Attending Officers (31.07.22)
[95] Exhibit 1, Vol 2, Tab 1.26, Statement - Officer G Grace (09.07.24)
[96] Exhibit 1, Vol 2, Tab 1.27, Statement - Officer W Neve (03.07.24)
[97] ts 08.0.24 (Brick), pp59-60
[98] ts 08.10.24 (Brick), pp65-67 & 71-72 and ts 08.10.24 (Brickland), pp86-87 & 92-93
[99] Exhibit 1, Vol 1, Tab 19, Statement - Officer J Pearse (14.04.23), para 22
[100] Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), para 24
[101] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p21

Mr Garlett is found[102,103,104,105,106,107,108]

57. After lunch, Officer Brick and Officer Brickland began unlocking cells on D wing. Shortly before 1.35 pm, Officer Brickland approached Mr Garlett's cell (D06) and raised the observation hatch to conduct a "*body check*" before unlocking the cell door.

58. As he raised the observation hatch Officer Brickland realised Mr Garlett was hanging and had a ligature around his neck that was tied to the metal slats of the cell's upper bunk bed. Officer Brickland made a Code Red emergency call (to alert other custodial staff) using his prison radio, and as he unlocked Mr Garlett's cell, he told Officer Brick to fetch the Oxy-Viva.[109,110]

59. Officer Brickland then lifted Mr Garlett's body up, and untied the ligature around his neck before lowering him to the ground and removing the ligature. As Officer Brickland was checking Mr Garlett for injuries, two prisoners came into the cell. One of them (Prisoner K) cradled Mr Garlett's head, before Officer Brickland opened Mr Garlett's mouth and started CPR.[111,112]

60. After Officer Brickland had given Mr Garlett's chest 30 compressions, he asked Prisoner K to give Mr Garlett two breaths, which Prisoner K then did.[113,114] Moments later a senior officer arrived and applied the Oxy-Viva mask to Mr Garlett's face, and the two prisoners returned to their cells. CPR was continued until the attendance of ambulance officers, who had been requested after the Code Red emergency call was made.

61. Despite concerted resuscitation efforts, Mr Garlett could not be revived and he was declared deceased at 2.04 pm.[115,116]

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[102] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), pp15-17
[103] Exhibit 1, Vol 1, Tab 18, Statement - Officer Brick (27.03.23)
[104] Exhibit 1, Vol 2, Tab 1.24, Statement - Officer Brickland (07.08.24)
[105] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer Brick (10.07.24)
[106] Exhibit 1, Vol 2, Tab 1.25, Incident Summary Reports - Attending Officers (31.07.22)
[107] Exhibit 1, Vol 2, Tab 1.26, Statement - Officer G Grace (09.07.24)
[108] Exhibit 1, Vol 2, Tab 1.27, Statement - Officer W Neve (03.07.24)
[109] An Oxy-Viva is a portable oxygen powered resuscitator unit
[110] ts 08.10.24 (Brickland), pp87-88
[111] Exhibit 1, Vol 2, Tab 1.24, Statement - Officer Brickland (07.08.24), paras 24-26
[112] ts 08.10.24 (Brickland), pp89-92
[113] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer Brick (10.07.24), para 17
[114] Exhibit 1, Vol 2, Tab 1.24, Statement - Officer Brickland (07.08.24), paras 27-28
[115] Exhibit 1, Vol 1, Tab 39.1, St John Ambulance Patient Care Records 22043607, 22043608 & 22043610 (31.07.22)
[116] Exhibit 1, Vol 1, Tab 2, Life Extinct Certification (31.07.22)

CAUSE AND MANNER OF DEATH

62. Two forensic pathologists (Dr J White and Dr K Patton) conducted a post mortem examination of Mr Garlett's body at the State Mortuary on 3 August 2022 and reviewed post mortem CT scans. The examination noted a ligature mark to Mr Garlett's neck, and a fracture of the cartilage on the right side of his neck (right superior horn of the thyroid cartilage).[117,118]

63. Biochemical testing showed normal kidney function, and specialist examination of Mr Garlett's brain showed "*no significant abnormality*". Changes consistent with intravenous drug use were noted in Mr Garlett's left elbow crease (antecubital fossa), and the blood vessels supplying Mr Garlett's heart were found to be narrowed (coronary artery atherosclerosis).[119,120,121]

64. In view of their finding of coronary artery atherosclerosis (which was confirmed by microscopic examination of tissues), Dr White and Dr Patton made the following recommendation:

> Given the presence of significant coronary artery atherosclerosis in this relatively young man, we recommend that the deceased's immediate family consult their General Practitioner with regards to risk factors for early cardiovascular disease.[122]

65. Toxicological analysis detected therapeutic levels of the antidepressant medication, amitriptyline, in Mr Garlett's system along with non-toxic levels of quetiapine (an antipsychotic medication), and the benzodiazepine medication, diazepam. Metoprolol (used to treat tachycardia) and methadone (used to treat opioid dependence) were also detected, along with tetrahydrocannabinol (confirming Mr Garlett's recent cannabis use) and methylamphetamine.[123,124]

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[117] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (16.08.23)
[118] Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (03.08.22)
[119] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (16.08. 23), p1
[120] Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (03.08.22)
[121] Exhibit 1, Vol 1, Tab 6, Neuropathology Report (08.08.22)
[122] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (16.08. 23), p1
[123] Exhibit 1, Vol 1, Tab 7, Final Toxicological Report - ChemCentre WA (18.08.22)
[124] Exhibit 1, Vol 1, Tab 7.1, Interim Toxicological Report - ChemCentre WA (17.08.22)

66. Although Mr Garlett was prescribed metoprolol and methadone, he was not prescribed amitriptyline, quetiapine or diazepam.[125] This means that he must have obtained these three medications illicitly, along with the cannabis and methylamphetamine that were also detected in his system.

67. At the conclusion of their post mortem examination, Dr White and Dr Patton expressed the opinion that the cause of Mr Garlett's death was:

> [L]igature compression of the neck (hanging) in a man with methadone and methylamphetamine consumption.[126]

68. I accept and respectfully adopt Dr White's and Dr Patton's opinion and find Mr Garlett died from ligature compression of the neck.

69. Further, on the basis of the available evidence as to the circumstances of Mr Garlett's death (including the handwritten note found in his cell),[127] I find that death occurred by way of suicide.

[125] ts 09.10.24 (Gunson), pp171-172 and ts 09.10.24 (Pascu), pp212-213
[126] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (16.08. 23), p1
[127] Exhibit 1, Vol 1, Tab 20, Mr Garlett's handwritten note

ISSUES RELATING TO MR GARLETT'S CARE

Access to drugs in prison[128,129,130]

70. The evidence before me demonstrates that the Department has made, and continues to make, concerted efforts to address the scourge of illicit substances in the prison system.

71. Those efforts include, but are not limited to, targeted and inter-agency operations; routine and specific searches of prisoners, cells and other areas within the prison estate; the use of drug detection dogs, and the use of specialist resources and emergent technologies in relation to drug testing and detection.

72. Information about the methods, technologies and resources used by the Department to minimise illicit drugs in prisons is obviously highly sensitive from a security perspective. If information about these matters were to become widely known, the effectiveness of current and future strategies would be severely compromised.

73. In light of those concerns, I made a suppression order at the start of the inquest with respect to evidence about these matters. Therefore, I do not intend to traverse that evidence in this finding. However, having carefully reviewed the available materials, I am satisfied that the Department is trying to reduce the prevalence of illicit substances in the prison system, within the limits of its resources and currently available technology.

74. According to Officer Rowbottom from the Department's Drug Detection Unit, "*[M]ost drugs that come into the prison get in through contact visits. A small amount of drugs may also come through over the fence or through staff*". This helps explain why, when contact visits were ceased as a result of lockdowns imposed during the height of the COVID-19 pandemic, positive drug test results dropped markedly.[131,132,133]

[128] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24)
[129] Exhibit 1, Vol 2, Tab 3, Statement - Officer J Rowbottom (02.10.24) and ts 09.10.24(Rowbottom), pp140-163
[130] Exhibit 1, Vol 2, Tab 5, Statement - Officer J Pittard (03.10.24) and ts 08.10.24(Pittard), pp100-136
[131] Exhibit 1, Vol 2, Tab 3, Statement - Officer J Rowbottom (02.10.24), paras 26-27
[132] ts 08.10.24(Pittard), pp104-105 & 113-114
[133] See also: ts 09.10.24 (Rowbottom), pp154-155

75. It follows that one effective way to reduce the flow of illicit drugs into the prison estate would be to dispense with contact visits. However, this would be a draconian solution, and would adversely affect the majority of prisoners who are not involved in drug trafficking activities. Nevertheless, an additional focus on the security of contact visits would clearly be appropriate.[134]

76. In 2021, I published a finding dealing with the death of Mr Ohm Sathitpittayayudh, who died at Karnet Prison Farm after using Kronic (a synthetic cannabinoid). In that finding I noted that in 2016, the Office of the Auditor General (OAG) undertook a performance audit to assess the effectiveness of the Department's strategies to minimise drugs and alcohol in prisons.[135]

77. The OAG acknowledged it was unrealistic to expect prisons to be completely free of these substances and made a number of recommendations aimed at "*practical and achievable actions*". The OAG also suggested that the Department build on existing strategies.[136,137]

78. In 2018, the Department launched the Western Australian Prisons Drug Strategy 2018-2021 (the Strategy), which provided strategic guidance to the Department's efforts to disrupt the trafficking of illicit drugs within the prison estate. Although the Strategy's lifespan was extended, it has now expired, and to date no replacement plan has been implemented.[138]

79. At the inquest, Mr Rowbottom confirmed that the Strategy had been a useful document, and as to whether it should be updated, he said:

> I would certainly hope so. Indeed, it's expired too long, but I'm not going to sit here and tell you that we shouldn't have had (indistinct) as we should have, but it certainly doesn't mean that the efforts have stopped.[139]

[134] ts 08.10.24 (Pittard), pp111-112
[135] Inquest into the death of Mr Ohm Sathitpittayayudh, [2021] WACOR 44 (published 15.12.21), para 50
[136] See also: ts 08.10.24 (Pittard), pp109-110
[137] Inquest into the death of Mr Ohm Sathitpittayayudh, [2021] WACOR 44 (published 15.12.21), para 50
[138] Exhibit 1, Vol 1, Tab 41, Western Australian Prisons Drug Strategy 2018-2021
[139] ts 09.10.24 (Rowbottom), pp149-150, and see also: ts 09.10.24 (Rowbottom), pp150-151

80. At the inquest Mr Rowbottom said that a great deal of work had been done in a short amount of time to achieve the goals in the Strategy. He also said: "*Just because, I guess, a document is out of date it doesn't mean that our efforts have waned by any means*".[140]

81. Nevertheless, there are clear benefits to the Department going through the process of updating the Strategy, and I have made a recommendation to that effect. In this case, Mr Garlett was able to access five substances that he should not have. This included three medications he was not prescribed (i.e.: amitriptyline, quetiapine and diazepam), as well as two illicit drugs, namely cannabis and methylamphetamine.[141,142]

82. On any view, the fact that Mr Garlett was able to do so is clearly unacceptable, and it demonstrates the crucial need for the Department to redouble its efforts in stemming the flow of illicit drugs into the prison estate. A good first step would be to update the Strategy.

83. That process would require input from a range of experts, and could include an analysis of evidence-based strategies from around the world. An updated drugs strategy would, once again, provide strategic direction to the Department as it continues its drug detection and elimination efforts.

84. At the Court's request, Dr Pascu (an experienced forensic psychiatrist) conducted a review of Mr Garlett's case and the care and treatment he received. In her report, Dr Pascu expressed the view that Mr Garlett's actions on 31 July 2022 were impulsive, and most likely a response to the conversations he had with his partner during their phone calls.[143]

85. At the inquest, Dr Pascu also said that in her opinion the illicit substances found in Mr Garlett's system were likely to have affected his behaviour and could have increased the likelihood that he would act impulsively.[144]

[140] ts 09.10.24 (Rowbottom), pp150 & 159-161
[141] Exhibit 1, Vol 1, Tab 7, Final Toxicological Report - ChemCentre WA (18.08.22)
[142] Exhibit 1, Vol 1, Tab 7.1, Interim Toxicological Report - ChemCentre WA (17.08.22)
[143] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), p12
[144] ts 09.10.24 (Pascu), pp213-214

Ligature minimisation[145]

86. Mr Garlett hanged himself using a prison issued windcheater, which he placed around his neck and tied to the metal slats of the top bunk in his cell.[146] These metal slats are sturdy and can clearly hold a person's weight. At the inquest Ms Palmer (a senior review officer) confirmed that this type of bunk bed is used in approximately 260 of the cells at Casuarina.[147]

87. The Review noted that Mr Garlett had been allocated a "*non-ligature minimised*" cell on Unit 1 at Casuarina. Although all cells in A wing (the management unit of Unit 1) are "*fully ligature minimised*" at the relevant time **none** of the cells in B, C or D wing (where Mr Garlett was housed) were.[148]

88. As the Review pointed out, at the relevant time Mr Garlett was not on ARMS, and as such there was no requirement for him to undergo additional checks. Further, as I have noted prisoners who are not being managed on ARMS are not checked during the lunchtime lockdown.

89. The Review made the following observation with which I **strongly** agree:

> Having easily accessible ligature points on the bunk beds gives prisoners the opportunity to spontaneously act on any self-harm or suicidal thoughts or ideation.[149]

90. In light of that observation, the Review made the following recommendations:

> **R1.1** Conduct an assessment of all the bunk beds at Casuarina with a view to establishing what would be required to ensure they are ligature minimised; and
>
> **R1.2** Unless there is no other option available consideration should be given to not putting a single person in a double occupancy cell.[150]

[145] ts 09.10.24 (Palmer), pp192-197
[146] Exhibit 1, Vol 2, Tab 1.30, Photographs of Cell D06
[147] ts 09.10.24 (Palmer), p194
[148] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p21 and ts 09.10.24 (Palmer), pp192-193
[149] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p21
[150] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p22

91. According to the Review, the response to recommendation R1.1 was:

> R1.1 Adult Male Prisons will have all bunk beds in Unit 1 D Wing at Casuarina Prison assessed to determine what steps are required to ensure they are fully ligature minimised. Preliminary findings will be presented by 31 October 2024.[151]

92. At the inquest, Ms Palmer confirmed that in fact, all cells at Casuarina had already been assessed and that by 31 October 2024 a preliminary determination would be finalised as to "*the steps required to ensure they are fully ligature minimised*".[152] As to the timeframe for the completion of remediation work to bunk beds identified as not ligature minimised, Ms Palmer said:

> [T]his is a little bit outside of my expertise I'm afraid. But I don't think it's as simple as removing a bed and putting a bed in. I think it's a lot more difficult than what you or I would possibly expect it to be. So I know that they've made the first step, they've done the assessment, they've identified the amount of beds, and now they're moving into the next phase of how we're going to fix this.[153]

93. As to the response to recommendation R1.2, the Review noted that: "*All general living unit cells are double bunked cells, therefore this recommendation is unachievable*".[154] Although recommendation 1.2 seems to be a sensible suggestion, I accept that it would be impossible to implement especially given the current muster at Casuarina, and the fact that all cells are double bunked.

94. In relation to the issue of ligature minimisation more generally, it is an appalling statistic that in 2024, of the 930 cells at Casuarina (excluding those in Unit 18), only 400 of those cells (i.e.: 43%) are "*fully ligature minimised*", with a further 191 cells (i.e.: 20.5%) being "*three point ligature minimised*".[155] To put it another way, well over one third of the cells at Casuarina (i.e.: 339 cells, or 36.4%) have **no** ligature minimisation in them at all.[156]

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[151] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p22
[152] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p22 and ts 09.10.24 (Palmer), pp193-194
[153] ts 09.10.24 (Palmer), p194
[154] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p22
[155] In three point ligature minimised cells, the light fittings, window bars and shelving brackets are addressed
[156] Exhibit 1, Vol 2, Tab 1.42, Emails to Ms T Palmer (02.10.24 & 03.10.24)

95. In its 2023 review of the Department's performance in responding to recommendations arising from inquests into deaths in custody, the Office of the Inspector of Custodial Services states:

> [T]o a large extent the Casuarina 512-bed expansion project accounts for a large proportion of the recent increase in ligature minimisation. Progress in retrofitting existing cells to reduce ligature points has been much slower. In March 2022, the Department advised us that the ligature minimisation program was suspended due to access issues as a result of COVID-19 restrictions. The Department expected the program to recommence as soon as practicable.[157]

96. In the finding I published in March 2024 concerning the death by hanging of Ms Suzzanne Davis (a prisoner at Melaleuca Prison), I noted the following about the Department's approach to ligature minimisation:

> 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 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.*
>
> 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.[158]

[157] Exhibit 1, Vol 2, Tab 6, Office of the Inspector of Custodial Services Directed Review (March 2023), p20
[158] [2024] WACOR 13, Investigation of the death of Ms Suzzanne Davis (published 28.03.24), paras 107-108

97. During the Davis inquest, the Department advised that in the 2023 - 2024 financial year, it had allocated $1.645 million for ligature minimisation work across the entire adult prison estate. That sum was said to be only enough to retrospectively make about eight cells "*fully ligature minimised*". The Department also advised that in the 2024 - 2025 financial year, its ligature minimisation allocation was only $1.137 million. On the Department's own figures this is only enough for about 3.5 cells, and is a sum which I described as "*even more parsimonious*" than its allocation in the preceding financial year.[159]

98. Like Mr Garlett, a significant number of prisoners have personality disorders that are characterised by an inability to regulate emotions and a tendency to act impulsively.[160] The risk of self-harm and suicide in this cohort is therefore much greater, and hanging is a method commonly used by prisoners to take their lives. These factors have been repeated in numerous hanging deaths in custody and clearly highlight the critical importance of strategies to deal with opportunistic self-harm by removing obvious ligature points.[161,162,163]

99. I accept that prisoners can and have taken their lives in fully ligature minimised cells. Nevertheless, there are clear and obvious benefits to removing obvious ligature points, such as the style of bunk bed in Mr Garlett's cell.[164]

100. As I acknowledged in 2022 in my finding relating to the death by hanging of Mr Wayne Larder (a prisoner at Hakea Prison):

> I fully accept that ligature minimisation is costly. I also accept that the Department has a finite budget, and must make difficult decisions as to the prioritisation of its allocated funding. Nevertheless, the issue of ligature minimisation is not new and for over 25-years this Court has repeatedly recommended that the Department increase the number of ligature minimised cells.[165,]

[159] See: [2024] WACOR 13, Investigation of the death of Ms Suzzanne Davis (published 28.03.24), para 110
[160] See also: Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), p12
[161] See: Annual Report, Office of the State Coroner (2008-2009), p63 re: Inquest into the death of Mr Mark Briggs
[162] See: Inquest into five deaths at Casuarina Prison Ref: 14/19, (22.05.19)
[163] [2020] WACOR 44, Investigation of the death of Mr Jordan Anderson (published 22.12.20), Recommendation 1, p46
[164] Exhibit 1, Vol 2, Tab 1.30, Photographs of Cell D06
[165] [2022] WACOR 48, Investigation of the death of Mr Wayne Larder, (published 28.11.22), para 139

101. In my view the Department's painfully slow progress in remediating existing cells so they are fully ligature minimised continues to be a serious and unacceptable blight on its efforts to properly manage the security of its prisons, and the safety and welfare of prisoners and staff.

102. As I pointed out in my finding relating to the death of Ms Davis:

> [I]n 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.[166,167]

103. At the inquest, Mr Huntley, Officer Pittard, and Dr Gunson all agreed with the proposition that in 2024, all cells in the prison estate should be fully ligature minimised.[168]

104. In my view the importance of urgently addressing obvious ligature points in cells at Casuarina cannot be overstated. I have therefore recommended that **as a matter of the utmost urgency**, the Department take immediate steps to ensure that all cells at Casuarina are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Casuarina are fully ligature minimised over time.

105. Having made similar recommendations in the past which have not prompted any apparent sense of urgency on the Department's part, I can only repeat what I said in the finding I published following the inquest I conducted into Mr Larder's death:

> **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.**[169] (Original emphasis)

[166] Section 7, *Prisons Act 1981* (WA)
[167] [2024] WACOR 13, Investigation of the death of Ms Suzzanne Davis (published 28.03.24), para 113
[168] ts 08.10.24 (Huntley), pp53-54, ts 08.10.24 (Pittard), p131 and ts 09.10.24 (Gunson), pp189-190
[169] [2022] WACOR 48, Investigation of the death of Mr Wayne Larder, (published 28.11.22), para 141

ISSUES RAISED BY MR GARLETT'S FAMILY

106. Although a coroner's jurisdiction in relation to a death is not unlimited, a coroner may comment on "*any matter connected with the death including public health, or safety or the administration of justice*". Further, in relation to a death in custody, a coroner is required to comment on the "*supervision, treatment and care*" the deceased person received while incarcerated.[170,171]

107. During her submissions at the inquest, Ms Wood raised several issues on behalf of Mr Garlett's family.[172] After careful consideration, I have concluded that some of those issues were not sufficiently connected to Mr Garlett's death so as to enable me to make any relevant recommendation. In summary, the issues raised on behalf of Mr Garlett's family were:

a. *Frequency of counselling sessions*: it was submitted that Mr Garlett would have benefitted from more frequent counselling sessions, and in his evidence Mr Huntley agreed that this may have been of benefit. In previous inquests I have presided over I have recommended that the Department recruit additional counselling staff, especially given the ever increasing prison muster and the numbers of prisoners with mental health issues.[173]

In this case, there is no evidence before me that Mr Garlett's death was related to the number of counselling sessions he did or did not receive, and as I noted although he requested them, Mr Garlett declined the counselling sessions he was offered on 20 and 27 July 2022.[174]

Nevertheless, at Casuarina there are only eight prison counsellors for a muster of about 1,500 prisoners. Prisoners currently wait up to 12 months to see a counsellor, and there are about 150 prisoners on the waiting list.[175] In my view these figures establish that the number of counsellors at Casuarina is **woefully** inadequate. Despite the difficulties involved in recruiting additional counselling staff, I **strongly** urge the Department to do so **urgently**.[176]

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[170] Sections 25(2) & (3), *Coroners Act 1996* (WA)
[171] ts 09.10.24 (Heywood), pp104-108
[172] ts 09.10.24 (Woods), pp99-103
[173] See for example: Record of Investigation into Five Deaths at Casuarina Prison 14/19 (22.05.19), Recommendation 1
[174] Exhibit 1, Vol 1, Tab 25.1, PHS File Notes (20.07.22 & 27.07.22)
[175] ts 09.10.24 (Huntley), pp35 & 55
[176] See also: ts 09.10.24 (Pascu), p218 where Dr Pascu describes 8 counsellors for that number of prisoners as "*a joke*"

b. *Mental health training for prison officers:* it was submitted that custodial staff should receive regular face-to-face refresher training in relation to the Gatekeeper program (which deals with identifying prisoners at risk of self-harm), and receive training in relation to the management of prisoners with personality disorders and mental health conditions.

Although the Department offers some online mental health training, in previous inquests I have conducted, the efficacy of this training has been questioned by some custodial staff.[177] I have previously recommended that face-to-face refresher training on the Gatekeeper program should be provided to custodial staff.[178] I have also suggested that custodial staff be given training in how to better manage prisoners with personality disorders and mental health conditions, which Dr Gunson said: "*sounds very reasonable*".[179]

In this case, although it is possible that Mr Garlett's management may have been enhanced if custodial staff had received such training, there is no evidence this issue is connected to his death.

c. *Aboriginal workers:* it was submitted that there should be additional Aboriginal workers, including health workers in the prison system. As a general proposition, I agree that this is a sensible suggestion, especially given the large numbers of Aboriginal people in custody. I also accept that positive benefits have been demonstrated where Aboriginal health workers are used, however there is no evidence this issue is connected to Mr Garlett's death.

d. *Cultural awareness training:* it was submitted that in addition to the training custodial officers receive during their initial appointment course, officers should have regular refresher training, to enable them to better manage Aboriginal prisoners. Although I agree this is a sensible suggestion, there is no evidence this issue was connected to Mr Garlett's death.[180]

e. *Access to illicit drugs in prison:* amongst other matters, it was submitted that services aimed at assisting prisoners to deal with their addiction to illicit substances should be enhanced. I dealt with this issue of access to drugs in prison, and rehabilitation services earlier in this finding, and I have made two recommendations dealing with these issues.[181]

[177] See also: ts 08.10.24 (Brick), p59
[178] See for example: Record of Investigation into Five Deaths at Casuarina Prison 14/19 (22.05.19), Recommendation 6
[179] See also: ts 09.10.24 (Gunson), pp188-189
[180] See also: ts 08.10.24 (Brick), pp73-74 and ts 08.10.24 (Pittard), pp133-134
[181] Exhibit 1, Vol 1, Tab 41, Western Australian Prisons Drug Strategy 2018-2021

f. *Confinement regime:* as noted, departmental records show that during his last incarceration, Mr Garlett was the subject of confinement regimes on a number of occasions for various breaches of discipline.[182,183] At the inquest, Ms Wood asked Dr Pascu about the impact of such regimes on a prisoner's mental health, and Dr Pascu said "*certainly it's not a good one. Definitely that would be an additional stressor to anybody*". Dr Pascu also said that for prisoners like Mr Garlett (who have emotionally unstable personality disorder), "*it won't help their emotional regulation*".[184]

I accept that in general terms confinement regimes should be avoided and wherever possible positive management strategies should be used instead. However, there is no evidence that Mr Garlett's management on confinement regimes was connected to his death.

g. *Feedback on lessons learnt process:* the Review notes that on 5 December 2022, the senior management team at Casuarina conducted a "*lessons learnt process*" (the Process), and identified two areas for improvement. The first related to a requirement for staff to clearly identify the nature of the critical incident during a Code Red emergency call. The second identified "*further opportunities for the Department to assist in the promotion and development of staff resiliency*".[185] The Review noted that recommendations arising from the Process "*have been completed and closed*", but at the inquest both Officers Brick and Brickland confirmed they had not been involved in the Process, nor had they been briefed about its outcomes.[186]

In my view, there seems to be very little point in conducting such sessions unless custodial staff are advised about the "*lessons learnt*", whether by way of a meeting, an email or otherwise. It is possible that for whatever reason Officer Brick and Officer Brickland missed any such advice, or if they had received information about the recommendations, they had not associated it with the Process.

In any case, although I strongly urge the Department to ensure that after a "*lessons learnt*" process, custodial staff are briefed on its outcomes, there is no evidence that either of the areas for improvement identified by the Process were connected to Mr Garlett's death.

[182] Exhibit 1, Vol 2, Tabs 1.16-1.19, Prison charges documents
[183] Exhibit 1, Vol 2, Tabs 1.38, Prison charges history
[184] ts 09.10.24 (Pascu), pp225-225
[185] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (16.08.24), p17
[186] ts 08.10.24 (Brick), p77 and ts 08.10.24 (Brickland), pp95-96 & 97-98

QUALITY OF SUPERVISION, TREATMENT AND CARE

108. Between March 2022 and his death, Mr Garlett attended various medical appointments and he received treatment from a podiatrist, and a dentist (tooth extraction). Mr Garlett also underwent regular ECGs, and was reviewed in relation to stomach pain.

109. The Health Summary expressed the following conclusion about Mr Garlett's treatment and care during his incarceration:

> [D]uring his time in custody, (Mr Garlett) received appropriate health care. Regular medical, nursing, and allied health assessments and reviews were completed, and interventions were placed to ensure follow-up and continuity. Although some small areas for improvement were identified, it is highly unlikely that these affected the ultimate outcome for Mr Garlett. Staff provided patient-centred care and always responded quickly to issues when (Mr Garlett) requested assistance. In conclusion, the health care provided to (Mr Garlett) was overall of an excellent standard, and equivalent to or better than the standard he would have received in the community.[187]

110. At the inquest, Mr Stops asked Dr Pascu to comment on the quality of Mr Garlett's mental health care, and her response was:

> Having considered all the information that was made available to me which focused on whether Mr Garlett had a major mental illness that required psychiatric treatment and whether Mr Garlett had a substance use disorder which required treatment, I formed the opinion that as he did not have a treatable major psychiatric disorder requiring treatment he did not require ongoing psychiatric input. So as far as psychiatric treatment, I believe that the care that was provided to Mr Garlett, which included mental health input when he was on the ARMS, at risk management system, program was adequate. As far as the care that was provided regarding his substance use disorder, [it] was adequate, and it was in line with what would be available and adequate in the community.[188]

[187] Exhibit 1, Vol 2, Tab 7, Health Services Review (04.10.24), p17 and see also: 09.10.24 (Gunson), pp172-178
[188] 09.10.24 (Pascu), pp210

111. At various times, Mr Garlett was appropriately managed on ARMS, and he was regularly seen by clinical staff whilst he was on the methadone program. Mr Garlett was also seen by a prison counsellor with whom he appears to have developed a good rapport, on what might be described as an infrequent, though arguably regular, basis.[189]

112. Dr Pascu said that when reviewing Mr Garlett's psychiatric history, she had noted that Mr Garlett spent a number of years in custody and that he "*was aware of how he could seek help in prison*".[190] Dr Pascu also noted:

> [T]here is documentation that when (Mr Garlett) felt more distressed he would actually go and ask for help. It seems that…his engagement was brief and only related to crisis. So from what I saw, he disengaged quickly whenever he believed that the crisis was resolved.[191]

113. Mr Garlett's tendency to engage briefly with mental health services may explain why he subsequently declined the counselling sessions he was offered on 20 and 27 July 2022, despite the fact that he had previously requested them.[192]

114. In the report she prepared for the Court, Dr Pascu said that in her opinion there was no indication Mr Garlett needed to be managed on ARMS in the period leading up to his death. Dr Pascu also stated:

> In my opinion, from the information available to me, there was no indication for ongoing regular psychiatric or mental health follow up. Monitoring by the custodial staff, GP / primary health care service and the drug and alcohol staff was appropriate and in line with what is provided in the community, with clear pathways of referral to mental health service should this be required.[193,194]

[189] ts 08.10.24 (Huntley), pp14-15
[190] ts 09.10.24 (Pascu), p211
[191] ts 09.10.24 (Pascu), pp211-212
[192] Exhibit 1, Vol 1, Tab 25.1, PHS File Notes (20.07.22 & 27.07.22)
[193] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), pp10 & 12
[194] See also: ts 09.10.24 (Gunson), pp172-176 and ts 09.10.24 (Pascu), pp214-215 & 227-228

115. Having carefully considered the available evidence, I am satisfied that the management of Mr Garlett's physical and mental health was appropriate, and that the treatment and care he received while he was in custody was of a good standard.

116. At the inquest, Ms Palmer was asked to comment on the quality of Mr Garlett's supervision, treatment, and care, and her response was:

> I thought that the supervision, treatment and care was…pretty good for the most part. I mean, obviously the…incident has occurred and an unfortunate event that it…has turned out to be, but everybody that I spoke to commented on how likeable Mr Garlett was, how everybody said he was well respected by both staff and…prisoners alike. It seemed to me like everybody…(on)…the day of the incident…did absolutely everything that they could to try and assist him. So for the most part I thought that the supervision, treatment and care was…in accordance with policies and procedures.[195]

117. Having carefully considered the available evidence, I am satisfied that Mr Garlett's general management whilst he was in custody was appropriate. However, I repeat my observation that it would have been preferable for Mr Garlett's behavioural issues to have been managed in more positive ways, rather than by way of confinement regimes.

118. Although I am satisfied that Mr Garlett's care and treatment were of an appropriate standard, I take a different view with respect to the quality of the supervision he received whilst incarcerated.

119. I acknowledge that the Department has made, and continues to make, concerted efforts to stem the flow of illicit drugs into the prison estate. However, despite these efforts it is undeniable that a level of trafficking persists, and that illicit drugs continue to make their way into prisons. As I mentioned, the evidence suggests that this mainly occurs during contact visits between prisoners and their loved ones.

[195] ts 09.10.24 (Palmer), p197

120. In my view it is **appalling** that post mortem analysis detected three medications (diazepam, amitriptyline, and quetiapine) in Mr Garlett's system which he had not been prescribed, as well as methylamphetamine, and tetrahydrocannabinol (indicating cannabis use).[196]

121. As Mr Garlett had not been prescribed any of the three medications mentioned, he must have obtained them illicitly, along with the cannabis and methylamphetamine that was detected.

122. At the inquest, Mr Stops asked Dr Pascu whether the substances found in Mr Garlett's system after his death would have impacted his decision making ability on 31 July 2022. Dr Pascu's response was:

> So I think…Mr Garlett having had in his system methamphetamine…diazepam…a small dose of cannabis, quetiapine, they all would have some impact on his ability to make decisions…I cannot remember exactly the amount that he had in his system and, of course, the higher the amount, the more potential impact on his judgment at the time.[197]

123. Dr Pascu said she had formed the opinion that Mr Garlett had emotionally unstable personality disorder, a feature of which is impulsivity. Dr Pascu also said that: "*Definitely adding substances into that mix of symptoms will increase the risk of them becoming more impulsive and affecting their judgment*".[198]

124. Having due regard to the Briginshaw principle, I have concluded that the fact that Mr Garlett was able to access illicit drugs and medications he was not prescribed whilst he was in custody, means that the standard of supervision he received at Casuarina was inadequate. With great respect, the fact that the Department considers it has taken all reasonable steps to stem the flow of drugs into the prison system is irrelevant.[199]

[196] Exhibit 1, Vol 1, Tab 7, Final Toxicological Report - ChemCentre WA (18.08.22)
[197] ts 09.10.24 (Palmer), pp213-214
[198] ts 09.10.24 (Palmer), pp210-211 & 214
[199] ts 09.10.24 (Pittard), pp111-112 and see also: ts 09.10.24 (Palmer), pp230-231

RECOMMENDATIONS

125. In light 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 Casuarina Prison (Casuarina), the Department should, **as a matter of the utmost urgency,** take immediate steps to ensure all cells at Casuarina are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Casuarina are fully ligature minimised over time. Further, the Department of Justice should finalise its review of all bunk beds in cells at Casuarina, and as soon as practicable should ensure that all bunk beds at Casuarina are fit for purpose and in particular, can properly be described as "*ligature approved*".

Recommendation No. 2

In order to provide strategic guidance to its efforts to reduce the flow of illicit substances into prisons, the Department of Justice should implement a replacement strategy for the now expired Western Australian Prisons Drug Strategy 2018 - 2021.

Recommendation No. 3

In order to improve the support provided to prisoners, the Department of Justice should take urgent steps to recruit additional prison counsellors and Aboriginal Support Workers for Casuarina Prison. More broadly, the Department of Justice should review staffing levels of prison counselling staff and mental health staff at prisons across the State to determine if these levels are appropriate.

Recommendation No. 4

In order to better manage prisoners at Casuarina Prison who have polysubstance use issues, the Department of Justice should consider expanding its methadone and buprenorphine programs so that the wait time for prisoners to enter these programs is reduced.

126. At my request, Mr Will Stops (Counsel Assisting) forwarded a draft of my recommendations to all counsel by way of an email on 14 October 2024.[200] Feedback (if any) was requested no later than the close of business on 11 November 2024.

127. By way of an email dated 11 November 2024, counsel for Mr Garlett's family (i.e.: Ms Wood and Mr Crockett) suggested amendments to Recommendations 1, 2 and 4, which may be summarised as follows:[201]

a. *Recommendation 1:* it was suggested that Recommendation 1 be split, with separate recommendations in relation to ligature minimisation, and remediation work to bunk beds, respectively. After careful consideration, I have decided that this change is unnecessary, and that Recommendation 1 is appropriate as drafted.

The other suggested change was that the first part of Recommendation 1 be to require that all cells at Casuarina be "*fully ligature minimised as quickly as possible*". Although I fully understand why this amendment was suggested, after careful consideration, I have decided that Recommendation 1 is appropriate in its current terms.

b. *Recommendation 2:* it was suggested the words "*and to provide harm and demand reduction support to prisoners*" be added to Recommendation 2 to reflect all three "*pillars*" of the Strategy. In my view this is a sensible suggestion which is consistent with Mr Rowbottom's evidence.[202] I have therefore adopted the suggested amendment.

[200] Email - Mr W Stops to Mr E Heywood and Ms C Wood (14.10.24)
[201] Email - Ms C Wood & Mr F Crockett to Mr W Stops (11.11.24)
[202] See: Exhibit 1, Vol 2, Tab 3, Statement - Officer J Rowbottom (02.10.24), paras 8 & 14

c. *Recommendation 4:* Ms Wood suggested that the following words be added to this recommendation:

> More broadly, the Department should consider expanding other services available to prisoners who have polysubstance use issues, such as the Mallee Rehabilitation Centre and alcohol and other drug counselling, to ensure that the wait time for prisoners to access these services is reasonable.

After careful consideration of the available evidence relating to Mr Garlett's incarceration, I have decided it would not be appropriate for me to make the suggested amendment to this recommendation.

128. By way of an email dated 11 November 2024, Mr Boyle (one of the counsel for the Department) advised that the Department suggested amendments to each of the recommendations I proposed. Those suggestions may be summarised as follows:[203]

a. *Recommendation 1:* the Department confirmed that it had completed a review of bunk beds at Casuarina and identified 260 that need to be removed and replaced. Mr Boyle advised that the Department will now need to seek funding to ensure that the bunkbeds are replaced and that "*all cells are three-point ligature minimised*". Mr Boyle also advised that:

> Whilst the Department supports the original proposed recommendation in principle, we are instructed that as any proposed works on ligature minimisation are dependent on the allocation of funding, such funding being out of the control of the Department, the original recommendation is unable to be supported in its entirety at this stage.[204]

It was suggested that Recommendation 1 be amended as follows:

> *In order to better manage prisoners and thereby enhance security at Casuarina Prison (Casuarina), the Department should,* ***as a matter of the utmost urgency*** *consult with infrastructure services on the findings from the recent completed review of cells and bunkbeds within Casuarina with a view to identify funds and establish a plan to ensure that as soon as practical:*

[203] Email - Mr T Boyle to Mr W Stops (11.11.24)
[204] Email - Mr T Boyle to Mr W Stops (11.11.24)

a. all cells at Casuarina are three-point ligature minimised where possible;

b. fixtures including bunk-beds can be properly described as 'ligature minimised'; and

c. all cells are upgraded to a three-point ligature minimised standard.

In my view the suggested amendment inappropriately dilutes the thrust of the original wording of the recommendation. As I have pointed out in this finding, and in a number of other findings dealing with hanging deaths in the Department's prisons, ligature minimisation is an **urgent** issue, which the Department must address. Therefore, after careful consideration, I have decided that Recommendation 1 is appropriate as drafted.

b. Recommendation 2: the Department notes that as the Strategy has "*previously been in place with aspects of that strategy ongoing, consideration should be given as to whether this needs to be reinvigorated*". On that basis the Department suggests Recommendation 2 should be amended as follows:

> *In order to provide strategic guidance to its efforts to reduce the flow of illicit substances into prisons, the Department of Justice should consider implementing a replacement strategy for the now expired Western Australian Prisons Drug Strategy 2018 - 2021 or otherwise amend the strategy so that it reflects what is still current practice*.

In my view the suggested amendment is unnecessary, and is contrary to the evidence of Mr Rowbottom who heads the Department's Drug Detection Unit who agreed that a replacement strategy should be implemented.[205] Therefore, other than adopting the suggestion proposed by Ms Wood, I do not intend to further amend this recommendation.

c. Recommendation 3: Mr Boyle advised that the Department had already undertaken a review of "*Aboriginal support workers, counselling staff and mental health staff and submitted business submissions to Treasury to obtain additional funding*". Unfortunately, it appears that to date the Department's submissions have not been successful, and the Department therefore suggests Recommendation 3 be amended as follows:

[205] ts 09.10.24 (Rowbottom), pp149-150, and see also: ts 09.10.24 (Rowbottom), pp150-151

> *The Government should reconsider the Department of Justice's submission for funding for additional Aboriginal support workers, counsellors and mental health professionals noting the critical need for such positions across the WA custodial estate*.

In my view the proposed change is sensible, and I have amended Recommendation 3 accordingly.

d. Recommendation 4: Mr Boyle advised that although the Department supported the premise of Recommendation 4, because: "*the expansion of the programs are dependent on the allocation of additional human and financial resources consideration*" this recommendation should be amended as follows:

> *In order to better manage prisoners at Casuarina Prison who have polysubstance use issues, the Department of Justice should advocate for funding to expand its methadone and buprenorphine programs so that the wait time for prisoners deemed suitable to enter these programs is reduced.*

In my view the suggested amendment inappropriately dilutes the thrust of the original wording of the recommendation. The evidence at the inquest about the current delay in prisoners being able to access the methadone and the buprenorphine programs was stark. In my view that delay is inappropriate, and for that reason, after careful consideration, I have decided that Recommendation 4 is appropriate as drafted.

CONCLUSION

129. Mr Garlett was a dearly loved family member, who was 32 years of age when he hanged himself at Casuarina on 31 July 2022. Mr Garlett was described as "*a gregarious man*" who Officer Brick said was difficult not to like.[206]

130. In the period leading up to his death, neither custodial staff nor fellow prisoners reported any concerns about Mr Garlett's mental state,[207,208] and although he left a handwritten note in his cell indicating his intention to take his life, the evidence suggests Mr Garlett acted impulsively when he hanged himself, following an argument with his partner.[209,210]

131. Mr Garlett attached the ligature he used to take his life to metal slats on the top bunk bed in his cell. I am deeply concerned that the bunk bed in Mr Garlett's cell was clearly not ligature minimised, and that this type of bunk bed is used in about 260 other cells at Casuarina.[211,212]

132. I have made a recommendation that the Department **urgently** address the issue of ligature minimisation at Casuarina, and that the review it has completed as to whether bunk beds at Casuarina are fit for purpose be acted on promptly so that all identified remediation work can be completed as soon as possible.

133. As I have pointed out in a number of inquests I have presided over, the issue of ligature minimisation is not new, and this Court has repeatedly made recommendations that the situation be **urgently** addressed. In my view, it is **high time** the Department makes a serious and concerted effort to address the state of some of the cells prisoners are housed in.

[206] Exhibit 1, Vol 2, Tab 1.24.1, Statement - Officer A Brick (10.07.24), para 7
[207] Exhibit 1, Vol 2, Tab 4, Statement - Officer J Pearse (03.10.24), paras 22-24
[208] ts 08.10.24 (Brick), pp65-67 & 71-72 and ts 08.10.24 (Brickland), pp86-87 & 92-93
[209] Exhibit 1, Vol 1, Tab 20, Mr Garlett's handwritten note
[210] Exhibit 1, Vol 1, Tab 24.1, Report - Dr V Pascu (07.06.24), p12 and see also: ts 09.10.24 (Pascu), pp pp213-214
[211] Exhibit 1, Vol 2, Tab 1.30, Photographs of Cell D06
[212] ts 09.10.24 (Palmer), p194

134. Despite the fact Mr Garlett was incarcerated in a maximum security prison in the period leading up to his death, he was able to access and use methylamphetamine and cannabis, and three medications he was not prescribed.[213,214] I concluded this meant that the level of supervision Mr Garlett received at Casuarina was inadequate.

135. Although the Department considers it is taking reasonable steps to remove the scourge of illicit drugs (and the misuse of prescription drugs) from the prison estate, more needs to be done. I **strongly** urge the Department to redouble its efforts, and I have recommended that the now expired "*Western Australian Prisons Drug Strategy*" be updated.

136. It is my sincere hope that the Department will embrace all of the recommendations I have made.

137. In conclusion, as I did at the inquest, I wish to again convey to Mr Garlett's family and loved ones, on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin
Coroner
15 November 2024

[213] Exhibit 1, Vol 1, Tab 7, Final Toxicological Report - ChemCentre WA (18.08.22)
[214] Exhibit 1, Vol 1, Tab 7.1, Interim Toxicological Report - ChemCentre WA (17.08.22)