JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	16 - 17 APRIL 2024
DELIVERED	**:**	6 SEPTEMBER 2024
FILE NO/S	**:**	CORC 3395 of 2021
DECEASED	**:**	LEACH, MATTHEW FRANCIS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr Tiller assisted the Coroner.
Mr Stockton with Ms Inkster (SSO) appeared for the WA Police Force and the Department of Justice.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Matthew Francis LEACH*** *with an inquest held at Perth Coroners Court, Court 85, Central Law Courts, 501 Hay Street, Perth, on 16 April 2024 - 17 April 2024, find that the identity of the deceased person was* ***Matthew Francis LEACH*** *and that death occurred on 20 December 2021 at Hakea Prison, Nicholson Road, Canning Vale, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Matthew Francis Leach (Mr Leach)had a long history of problematic use of alcohol, along with mental health issues. He also had a history of antisocial behaviours and criminal offending that had escalated in seriousness and resulted in him serving a number of lengthy terms of imprisonment. Mr Leach's last admission to prison was on 21 September 2021, after he was charged with violent offences against his partner and refused bail. He was identified as a returning prisoner and held on remand at Hakea Prison.[1]

2. Mr Leach was initially identified as a 'prisoner at risk' and he was monitored by the Hakea Prison Psychological Services staff for a period, including being reviewed after 'dates of interest' such as court appearances. By late October 2021, Mr Leach seemed to have settled and the monitoring ceased.

3. On 20 December 2021, Mr Leach appeared before a magistrate in the Fremantle Magistrates Court by video link from Hakea Prison in relation to the charges. He was found guilty and was sentenced to a total term of 12 months' imprisonment and some fines were imposed. This date had not been recorded as a 'date of interest' so Mr Leach was not formally reviewed by prison staff, although the prison officers who escorted him back to his unit noticed nothing out of the ordinary. On his return to his cell, Mr Leach's cell mate noticed he seemed a little withdrawn over the lunch lockdown period, although he indicated he was okay.[2]

4. After lunch, Mr Leach made a phone call to his father and left a message on his father's answering service at 1.32 pm. The message indicated he was contemplating suicide. He then went into his cell.[3]

5. At 2.23 pm, prison officers conducting a routine cell audit of electric fans in preparation for summer, opened Mr Leach's cell door. Unknown to them, Mr Leach had hanged himself with a bed sheet over the cell door. He fell against the officers as they opened the door, and his head hit the ground as he landed. The prison officers took steps to provide first aid to Mr Leach, as they could see he was unresponsive, as well as notifying other staff. Mr Leach's ligature was removed with the help of another prisoner and prison officers commenced CPR. They were assisted by prison nursing staff who quickly attended the emergency call. When St John Ambulance (SJA) officers arrived, they took over resuscitation efforts and intubated Mr Leach before taking him on a stretcher to the ambulance.[4]

6. As Mr Leach was being loaded into the ambulance, SJA officers did a further full assessment of Mr Leach and determined he had died and that further resuscitation efforts were futile. His death was declared at 3.17 pm by a paramedic. Mr Leach's body was then moved to an enclosed area to await the attendance of police officers, who commenced a coronial investigation.[5]

[1] Exhibit 1, Tab 4.
[2] Exhibit 1, Tab 4.
[3] Exhibit 1, Tab 4.
[4] Exhibit 1, Tab 4.
[5] Exhibit 1, Tab 4.

7. As Mr Leach was a serving prisoner at the time of his death, he comes within the definition of a 'person held in care' under the *Coroners Act 1996* (WA) and a coronial inquest into his death was, therefore, mandatory. I held an inquest on 16 and 17 April 2024.

8. WA Police officers conducted an investigation into the circumstances of Mr Leach's death and ruled out any suspicious circumstances or the involvement of any other person in his death. A report was prepared for the coroner, which was tendered at the inquest.[6] The Department of Justice conducted its own internal investigation into Mr Leach's death in custody, which was also tendered at the inquest.[7]

9. At the inquest, I heard evidence from two of the police officers who investigated the circumstances of Mr Leach's death, as well as a number of Department of Justice (Department) staff who were directly involved with Mr Leach either prior to his death or at the time his body was discovered. In addition, witnesses from the Department attended to speak to the medical treatment Mr Leach received while in custody and his supervision, and care, as I am required to comment on the quality of Mr Leach's treatment, supervision and care while in custody prior to his death. I also heard from Dr Adam Brett, a Forensic Psychiatrist, who independently reviewed Mr Leach's case to assist me in considering whether the standard of care and supervision provided to Mr Leach was commensurate with community standards.[8]

BACKGROUND

10. Mr Leach was born in Perth on 3 May 1971. He grew up with his parents and two siblings, a brother and a sister. Mr Leach left school in Year 11 and worked as a successful car salesman and a fitness instructor at various times, although he had been unemployed leading up to his last term of imprisonment.[9]

11. As noted above, Mr Leach had a long history of substance abuse. He had used drugs when he was younger but his primary addiction in later life was alcohol He had in the past attended the Harry Hunter Rehabilitation Centre for treatment of his chronic alcohol dependence, but he always relapsed.[10]

12. Mr Leach was divorced and had two adult sons from the marriage. He had formed a new relationship with a lady, whom I will refer to only as Ms S, to respect her privacy as she was not directly involved in the inquest and a Family Violence Restraining Order was in place binding Mr Leach and protecting Ms S at the time of his death. Mr Leach and Ms S had been together for approximately three years before his death. This relationship was reported to be turbulent and marred by domestic

[6] Exhibit 1.
[7] Exhibit 2.
[8] Sections 22(1)(a) and 25(3) *Coroners Act 1996* (WA).
[9] Exhibit 1, Tab 2.
[10] Exhibit 3.

violence, which had led to criminal charges being laid against Mr Leach. As a result, he was remanded in custody in the weeks leading up to his death.[11]

13. In terms of family support, Mr Leach had generally had a supportive relationship with his parents, but Mr Leach's mother had died prior to his last incarceration and Mr Leach's elderly father had found Mr Leach's alcohol abuse and associated behaviours increasingly difficult to manage. Mr Leach's father advised that his son had been anxious and irrational in the months leading up to his arrest and had been struggling to maintain an appropriate relationship with his girlfriend. His son had low self-esteem and was frequently aggressive and was said to be terrified of serving more gaol time.[12]

14. Mr Leach's medical records indicate that Mr Leach had a long history of alcohol dependence and mental health issues. A private psychiatrist had suggested a possible diagnosis of bipolar affective disorder in 2006 and he had been prescribed the antidepressant venlafaxine and the mood stabiliser sodium valproate for a time. During periods of incarceration he was seen by a prison psychiatrist who questioned the diagnosis of bipolar disorder, as Mr Leach did not describe any symptoms suggestive of elevated mood (hypomania), although he showed clear symptoms of depression.[13]

15. Mr Leach had a history of self harm and/or suicide attempts dating back to 2007, including threatening to jump off a bridge, threatened to cut himself and an attempted hanging. The records generally indicate those acts occurred while he was in the community and not when in prison. During his last reception to prison in April 2020, Mr Leach had told the nurse on admission that he would never hurt himself in jail.[14] However, sometimes the acts were said to be committed in response to Mr Leach's fear that he was going to return to custody.

16. Mr Leach had been a patient at the Northlake Road GP Clinic since March 2019. He attended frequent GP consultations for issues related to his alcohol dependence, including alcohol related liver disease, peripheral neuropathy and severe ulcerative oesophagitis. He also had a significant number of hospital presentations for alcohol related issues, including falls and withdrawals. Mr Leach had also been diagnosed with high cholesterol, hypertension amongst other things. The diagnostic list noted that Mr Leach had presumed bipolar disorder, and he was prescribed the antidepressant venlafaxine but he had not been prescribed a mood stabiliser since around 2015. Notably, in March 2020, his regular GP Dr Clinton Stanton indicated in a letter to Corrective Services that he was unable to determine if Mr Leach had a pre-existing mental health disorder as his alcohol use clouded the clinical assessment.[15]

17. During his last period of incarceration commencing in April 2020, Mr Leach had regular gastroenterology review at Fiona Stanley Hospital for his alcohol related liver disease and oesophagitis. He was assessed as stable in April 2021 and his test results

[11] Exhibit 3.
[12] Exhibit 1, Tab 2.
[13] Exhibit 1, Tab 24; Exhibit 3.
[14] Exhibit 3, p. 7.
[15] Exhibit 1, Tab 27.

had showed marked improvement while he was abstaining from alcohol, so he was encouraged to remain sober on release and had appeared optimistic he could succeed. Sadly, it was not to be.[16]

18. Mr Leach was released from prison for the last time on 16 June 2021, after spending approximately 14 months in custody. On 21 June 2021, Mr Leach's father called the Mental Health Emergency Response Line (MHERL) due to concerns about his son's aggressive and threatening behaviour. Mr Leach had apparently been abusing alcohol since his release from prison. It was noted Mr Leach was in police custody and it was recommended that he go to his GP and re-engage with alcohol and drug services.[17]

19. Mr Leach's father wrote to Mr Leach's GP on 28 June 2021. His thoughtful and articulate letter explained that his son had "quickly dispelled [his] optimistic hopes that he will be able to cope outside gaol."[18] Mr Leach's father often found his son unconscious and naked downstairs and mentioned he had been forced to call the police twice because of "fear for the safety of his injured girlfriend and [his] own."[19] He noted that Mr Leach's girlfriend had tried very hard to cope with him, but it was beyond her. It was noted in the letter that Mr Leach's father had rung the MHERL and found them to be unhelpful, as they had told him only a GP could initiate any action or assistance with Mr Leach's alcohol abuse and his risk to himself and others. Mr Leach's father had suggested he make a GP appointment for him and seems to have been relieved that his son had agreed to the suggestion. The purpose of the letter was to provide background for the GP, Dr Stanton, when reviewing Mr Leach.[20]

20. On 2 July 2021, Mr Leach was admitted to Fiona Stanley Hospital for surgical management of a hand infection. He had sustained the injury to his hand four days earlier when he punched a wall while intoxicated. He was given a surgical wash out of his infected wound and was eventually discharged on 6 July 2021, and given his remaining course of antibiotics to complete.[21]

21. Mr Leach's GP, Dr Stanton, sent a referral to the Fremantle Hospital Alma Street Clinic on 19 July 2021, requesting an emergency psychiatric assessment with a view to an involuntary psychiatric admission. Mr Leach had been released from prison four weeks earlier and had been consuming considerable quantities of alcohol and engaged in substantial substance use on at least two occasions, leading to serious concerns about his mental wellbeing. Dr Stanton's opinion was that Mr Leach was not taking care of himself, including not taking the prescribed antibiotics for his hand infection, and this represented a risk to his life. The outcome of this referral was unclear at the time of the inquest, but later enquiries were unable to locate any record of receipt of the referral at Fremantle Hospital.[22]

[16] Exhibit 1, Tab 24; Exhibit 3.
[17] Exhibit 1, Tab 8; Exhibit 3.
[18] Exhibit 1, Tab 27.9.
[19] Exhibit 1, Tab 27.9.
[20] Exhibit 1, Tab 27.9.
[21] Exhibit 1, Tab 8 and Tab 27.7.
[22] Exhibit 1, Tab 27.6

22. Dr Stanton also called the MHERL on 19 July 2021 requesting a psychiatric assessment for Mr Leach, stating he believed he would likely require involuntary treatment. It was noted he had cut his hand and was at severe risk of losing the limb in the context of increased alcohol use. Dr Stanton was advised to refer Mr Leach to the local mental health service, which he had already done.[23] Mr Leach's last GP consultation was on 6 August 2021, a couple of weeks after the Alma St referral. He presented with an infected olecranon bursitis (elbow) after a fight several days prior and was prescribed more antibiotics.

23. On 1 September 2021, Mr Leach attended the Fiona Stanley Hospital Gastroenterology Outpatient Clinic with his father. It was noted he had been drinking again since leaving prison and was estimated to be drinking up to two litres of vodka or four litres of wine a day. He had tried to stop drinking a few days before and was now in withdrawal. He was given a short prescription for diazepam to manage his withdrawal symptoms and a flyer for Next Step and he was also encouraged to be assessed for a mental health plan if he felt his anxiety and depression were driving his excessive alcohol consumption.[24]

24. On 5 September 2021, Mr Leach was taken to Fiona Stanley Hospital by police officers following a violent incident where Mr Leach was allegedly seen with his hands around his partner's throat at a shopping centre. He was found by police swimming in a lake, heavily intoxicated, and there were reports he had a seizure. His blood alcohol on admission was found to be very high at 0.38%. After about four hours of supportive treatment for alcohol withdrawal in the ED, he was then discharged into police custody.[25]

25. Mr Leach was held initially at the Perth Watch House and his history of alcoholism and self-harm was noted, along with a possible diagnosis of bipolar disorder. The Watch House staff were informed he remained a high risk to himself. After he had sobered up, Mr Leach was charged with intimate partner violence related charges against his partner Ms S, namely: impeding another person's normal breathing or blood circulations by applying pressure to the neck, breach of a violence restraining order, breach of protective bail condition and breach of a police order.[26] After appearing in court, he was remanded in custody.[27]

LAST ADMISSION TO HAKEA PRISON

26. Mr Leach was admitted to Hakea Prison on 21 September 2021. Most of Mr Leach's personal and medical history was available in the Department of Justice's records due to his various previous terms of incarceration, the last ending only a few months before. It was noted he had a documented history of chronic alcohol abuse and dependence, with a number of alcohol-related health issues, including liver disease and peripheral neuropathy. He was known to have seizures secondary to acute

[23] Exhibit 1, Tab 8.
[24] Exhibit 1, Tab 27.5.
[25] Exhibit 1, Tab 27.4.
[26] Exhibit 2, Tab 1.
[27] Exhibit 1, Tab 8.

alcohol withdrawal. Mr Leach had also been diagnosed with hypertension, hypercholesterolaemia, obesity, gastro-oesophageal reflux disease and anaemia.[28]

27. On the last two previous occasions he had come into custody, in April 2020 and June 2021, he presented in severe alcohol withdrawal and required symptomatic treatment for several days. Mr Leach's history of mental health admissions to hospital was also noted.[29]

28. Mr Leach told reception staff (a prison officer and a nurse) that he suffered from depression and anxiety, for which he was taking medication, although not consistently. He provided information that he had tried to take his life and attempted self-harm a couple of years prior while in the community. He denied any current thoughts of self-harm or suicidal plans and told the reception officer he had family support, although it should be noted that his girlfriend unsurprisingly ended their relationship after these charges were laid. Mr Leach was noted to be an alcoholic and he appeared to be withdrawing from alcohol, with an obvious visible tremor, which was consistent with previous admissions. He had also recently had hand surgery.[30]

29. Mr Leach was placed on the prison's At Risk Management System (ARMS) at a moderate rating, with two hourly observations following his reception intake. He was initially placed in the Crisis Care Unit (CCU) for alcohol withdrawal monitoring, and he was referred to support services.[31]

30. A prison doctor reviewed Mr Leach the next day. His mood was noted as low but with no suicidal thoughts and good insight. He was at high cardiovascular risk along with his alcohol-related issues. A plan was made to obtain his records from Fiona Stanley Hospital and to monitor him in the Crisis Care Unit for a couple of nights due to his risk of alcohol withdrawal related seizures. Blood testing and other investigations were ordered and a letter was to be sent to his GP requesting an up to date health summary. As the requested documents and investigation results came in, they were then reviewed by prison medical officers and nurses and requests were made for Mr Leach to see an optometrist and to have an ultrasound on his abdomen and liver, which occurred on 14 and 19 October 2021 respectively. Mr Leach was also started on a COVID vaccination regime.[32]

MENTAL HEALTH MANAGEMENT

31. Mr Leach had a counselling session at 8.00 am on 22 September 2021, in the CCU. He met with a Prison Counsellor, Registered Psychologist Andrea Naumoska, who worked in the Psychological Health Service (PHS) at Hakea Prison. Ms Naumoska saw Mr Leach in order to perform an ARMS assessment on him.[33]

[28] Exhibit 3.
[29] Exhibit 3.
[30] Exhibit 2, Tab 1, Tab 1.4 and Tab 1.5; Exhibit 3.
[31] Exhibit 1, Tab 17.2; Exhibit 2, Tab 1.
[32] Exhibit 3.
[33] Exhibit 1, Tab 30; Exhibit 2, Tab 1.6.

32. Mr Leach presented as very shaky and worried about being back in prison. He said he felt unwell while withdrawing from alcohol and that was his main current concern, but he also mentioned past issues with other prisoners, including being threatened with a knife and bullying. He said he felt frightened in the prison environment and wanted protection. The prison health records show Mr Leach had reported being assaulted on 23 May 2021, not long before he was released from custody. He was reviewed by a nurse at that time and explained the assault occurred when he wouldn't let a prisoner push ahead of him to use the phone. He was hit and threatened with a knife and reported he had feared for his life. This incident had significantly impacted on Mr Leach and his ability to feel safe in the prison environment.[34]

33. Mr Leach also told Ms Naumoska he had spoken to his elderly father and was worried about him, noting his mother had only passed away a few months ago. Mr Leach admitted previous suicidal plans in the community but said he had no history of suicide attempts in custody and firmly denied any current intent or plan to harm himself. He had a history of depression, but hadn't been taking his antidepressant medication in the community, and admitted current feelings of hopelessness, particularly around his recent relationship breakdown (noting his partner was the victim of the current alleged offences).[35]

34. After reviewing Mr Leach that morning, Ms Naumoska recommended that Mr Leach's ARMS level be reduced to low, and he remain in the CCU while he was still withdrawing from alcohol. Her recommendation was based on the fact that Mr Leach had engaged well during the ARMS assessment, he denied any current suicidal intent or plan or risk to himself, but he still presented as vulnerable and was experiencing multiple stressors, in particular the effect of withdrawing from alcohol. On low ARMS, he would receive regular observation at least every four hours and be required to see a prison counsellor once a week, but in the short term in the CCU he would be monitored. Ms Naumoska hoped if he remained in CCU for a further period he would stabilise and feel more settled. Mr Leach indicated he was happy to remain in the CCU for health monitoring and said he felt safer there.[36]

35. Later that morning, Ms Naumoska participated in the morning Prisoner Risk Assessment Group (PRAG) meeting, during which Mr Leach was discussed. There was input from a number of sources and a number of protective factors were noted, including his willingness to engage and his future focus (although I note support from his father and partner was also considered a protective factor at that time, which was not necessarily the case). After considering all of the information, his risk rating was reduced to low ARMS. He was to remain in CCU for medical monitoring and referred to the Prison Support Officer (PSO).[37]

36. There is a nursing entry the following day that Mr Leach presented for a scheduled appointment. He was still very shaky but had not experienced any withdrawal seizures. He was noted to be very upset as his father had informed him he didn't

[34] Exhibit 1, Tab 30; Exhibit 2, Tab 1.6; Exhibit 3.
[35] Exhibit 1, Tab 30; Exhibit 2, Tab 1.6; Exhibit 3.
[36] Exhibit 1, Tab 17, Tab 19.1 and Tab 30; Exhibit 3.
[37] Exhibit 1, Tab 8.

want him back in his home. Mr Leach queried some aspects of his scripted medications and asked to see the optometrist, which was arranged.[38]

37. After leaving CCU, Mr Leach was allocated a double up cell with another prisoner in Unit 7 in F Wing. This wing was a security or protection wing that housed prisoners who were at risk from other prisoners. Mr Leach was placed there given his expressed concerns about being harmed by other prisoners.[39]

38. Mr Leach was seen by a prison counsellor for his low ARMS review on 29 September 2021. He seemed stable but flat and deflated. He reported that he felt safe in protection and had no unit based issues or concerns. He was very disappointed in himself for only lasting three months in the community after his latest release from prison and acknowledged he had been an alcoholic for around 27 years, which had contributed to his offending. Mr Leach strongly denied any current thoughts of suicidal and, in particular, said he would not do anything to harm himself in custody. It was noted he was still vulnerable and experiencing multiple stressors, with little hope for the future, so it was recommended that he remain on low ARMS until prison supports had been established and he was feeling more settled. He was also referred for a psychiatric/medical review as he was felt he might benefit from some treatment for his alcohol use disorder.[40]

39. The next PRAG review for Mr Leach was conducted the following day and the information from the previous day's counselling session was noted. Based on his presentation, the PRAG determined that he would remain on low four hourly ARMS so he could receive further support and monitoring.[41]

40. Mr Leach travelled to Fiona Stanley Hospital for gastroenterology review and investigations in October 2021. His diagnoses of alcohol-related liver disease and severe ulcerative oesophagitis were confirmed, and his history of anxiety and depression was noted. It was recorded he had been experiencing alcohol withdrawal symptoms, including delirium and tremors but no seizures. An ongoing management plan for his liver and stomach disease was formulated, noting he would likely succeed in remaining alcohol abstinent while in custody. Testing found no malignancy, but he was warned cancer could develop if he continued to abuse alcohol.[42]

41. Mr Leach had a discussion with unit staff on 4 October 2021, as part of his ARMS management. He had a court appearance scheduled the next day and he stated that if he got sentenced to 7 years imprisonment or more then he would kill himself. He also said he had formulated a plan as to how he would do it. He was asked what an acceptable sentence would be, to stop him from self-harming, and he stated 5 years. Mr Leach was also served with a Family Violence Restraining Order in respect of his father that day. There was obviously elevated concern about Mr Leach's welfare as a

[38] Exhibit 3.
[39] Exhibit 1,Tab 4.
[40] Exhibit 1, Tab 8 and Tab 20.1.
[41] Exhibit 1, Tab 31.
[42] Exhibit 3.

result of these events and after a senior officer was informed, Mr Leach was moved back to a safe cell in CCU for closer monitoring.[43]

42. While still on High ARMS, Mr Leach was interviewed by a prison counsellor in the CCU the next day. He presented as calm and engaged well. He described his current mood as 'okay', although he reported feeling slightly anxious due to his scheduled court hearing. Overall, he said he was 'coping'. His current concerns were his legal issues and likely sentence, other psychosocial stressors. He denied any current thoughts of suicide or any intent or plan to self-harm and was able to provide assurances about his personal safety. However, he did confirm his history of suicide attempts in the past and described symptoms of anxiety and depression, but said he was on medication to manage these symptoms. He remained open to engaging with PHS staff to learn additional coping mechanisms and identified internal and external supports if he needed them. Overall, it was felt he appeared future focussed. It was recommended that he be removed from the safe cell and his ARMS rating be reduced to low.[44]

43. Prior to moving out of CCU and returning to his unit, Mr Leach was interviewed a second time on 5 October 2021. He stated he had anxiety issues generally but had previously been in the same unit and was happy in his allocated wing as he got along with the majority of prisoners in the wing. He said he was feeling better. He was trying to get Legal Aid to assist him in court, which he was happy about, and he had spoken to the chaplain and PHS, which he had found helpful. He also felt his medication was helping. Mr Leach said he would seek staff assistance when required and denied any active thoughts of self-harm.[45]

44. He was spoken to again the next morning and said he was 'travelling okay' except for the fact he had no outside contacts due to VRO's being placed on him. He was still a little shaky but was managing and was happy with his new cell mate, whom I will refer to as Mr P. Mr P remained Mr Leach's cell mate until his death. Mr P was later spoken to by police and he indicated that they got on well and, as far as he was aware, Mr Leach had no enemies in prison, never got into any fights and kept to a small group of approximately five friends.[46]

45. Mr Leach was interviewed again by a prison counsellor for the purpose of an ARMS review on 12 October 2021. He freely discussed his situation, although he came across as anxious and displayed minimal eye contact at first. Mr Leach said that while he had regularly had thoughts of suicide and made plans over the last 20 years, he maintained he had never had an intention to carry them out and they were always just passive thoughts. He was taking his medications and said he felt he had made a mistake before when he stopped taking them. Mr Leach again mentioned that his partner and father had VRO's against him, which meant he had no external support and he found this difficult. He said his current cellmate was his only support and he was quite concerned when prison staff wanted to relocate his cellmate to another wing that day. Mr Leach mentioned he had court coming up again on 2 November

[43] Exhibit 1, Tab 31.
[44] Exhibit 2, Tab 16
[45] Exhibit 1, Tab 31.
[46] Exhibit 1, Tab 4.

2021, and he was unsure of what the outcome might be. Mr Leach said he was hopeful to gain some employment and apply to education and also intended to see the chaplain. Due to his overall presentation, ongoing legal issues, lack of family support and mental health history, it was recommended he remain on low ARMS. The recommendation was accepted and he remained on low ARMS.[47]

46. Mr Leach had mentioned in the session that he wanted to get into the Alcohol Other Drug (AOD) program to help him with his drinking, so he was referred to the program.[48] Mr Leach was also referred to an optometrist on 12 October 2021.

47. A PHS ARMS counselling note on 18 October 2021 indicated Mr Leach was feeling deflated and sad, which he felt had been made worse as he had slept in and missed the medication round. He was still worried about his legal situation and lack of external support, noting he had ceased contact with his siblings and children a long time ago, and now he had lost the support of his partner and father. He was still finding his cell mate to be a good support and indicated he was hopeful of restoring his relationship with his father and was contemplating trying to reach out to his children. Mr Leach acknowledged fleeting suicidal ideation but said he would not do anything in prison. It was recommended he remain on low ARMS with a future consideration of a transfer to the Support and Monitoring System (SAMS).[49]

48. On 19 October 2021, it was noted in ARMS-PRAG minutes that Mr Leach's father had sought a VRO against him and his partner had taken the number off his phone list, so he now had no outside contacts or safety net. It was documented that while he said he would not kill himself in prison, he had said he knew how he could do so by hanging, should he decide to try. It was agreed he would remain on ARMS for a further period of monitoring.[50]

49. Mr Leach was seen again on 25 October 2021, for an ARMS counselling session. He continued to express concern about his upcoming court appearances and lack of external supports. He presented as quietly spoken but forthcoming about his situation. His main current concern seemed to be the fact his father had a VRO in place. He was due in court on 4 November 2021 to discuss the conditions of the VRO and he was quite concerned about the outcome as he believed it would impact on his future and lead to possible homelessness post release from prison. He was also due in court for his pending criminal charges on 2 November 2021. He was reported as accepting that he would receive more imprisonment, although his comments about being homeless on release seem to suggest he wasn't expecting to receive a lengthy term. Mr Leach admitted an occasional fleeting passive death wish and feelings of worthlessness but denied any current thoughts or plan to end his life. He reported a willingness to engage with staff if required and continued to receive good internal support from his cell mate. He agreed to a further Date of Interest (DOI) review to monitor his ability to cope after the VRO court proceedings involving his father on 4 November 2021, but otherwise seemed agreeable to being removed from ARMS.[51]

[47] Exhibit 2, Tab 18.
[48] Exhibit 1, Tab 31.
[49] Exhibit 1, Tab 8; Exhibit 2, Tab 20.
[50] Exhibit 1, Tab 8 and Tab 31; Exhibit 2, Tab 21.
[51] Exhibit 2, Tab 22.

50. A DOI review is a tool that Hakea Prison has implemented as an additional layer of monitoring and support for prisoners on ARMS/SAMS, as well as those who have recently been removed from monitoring but may be identified as still vulnerable. Usually, a DOI will relate to a court date, as that is often the most significant concern for a prisoner,[52] but it can also be some other significant date that might require a follow up welfare check with the prisoner, such as the anniversary of the death of a loved one. It was brought into Hakea Prison as Hakea Prison is the remand prison, where many prisoners are attending court every day and receiving new outcomes, so there was seen to be an additional level of risk from court outcomes.[53]

51. Mr Leach had his last PRAG ARMS review on 26 October 2021. It was noted he now seemed to be presenting in good spirits and was able to discuss his current concerns with ease, and although still worried about his father's FVRO proceedings, he seemed hopeful they could have a positive outcome. Mr Leach still had no lawyer as he was awaiting a grant from Legal Aid, but he appeared future focussed and was talking about what he would do when he got out of jail. It was noted that the PRAG team had discussed Mr Leach's management and behaviour at length and no current risk was identified, so he was removed from ARMS on 26 October 2021. SAMS placement was not endorsed as he did not meet the criteria (it is reserved for prisoners with a disability or an acute mental illness but not a self-harm risk)[54] but it was noted he had DOI scheduled.[55]

52. Mr Leach had a brief DOI review on 2 May 2021, prior to his videolink court appearance related to his pending charges. He didn't seem worried about the upcoming appearance as he was expecting to simply be remanded again. His greater focus was on the VRO application in a couple of days' time.[56]

53. As recommended, Mr Leach had a brief DOI review with a prison officer after his court appearance on 4 November 2021. It was noted his father had requested that the VRO application be dropped and Mr Leach appeared very happy with the outcome.[57]

54. Mr Leach had another counselling session on 12 November 2021, as a formal DOI review in relation not his VRO matter. He presented as settled, happy and talkative. He had received good support from his lawyer and now that his father had dropped the VRO application, he was hopeful that he would be able to return home and receive support from his father on his eventual release from prison. He expressed some sadness about his former partner, who still had a FVRO against him, but seemed otherwise positive about the future. He mentioned he had been offered a job in prison and he planned to start saving some money so that he would have some money available on his release from prison. At the end of the session, it was concluded that no further clinical intervention was indicated and his referral to the

[52] T 53.
[53] T 54; Exhibit 1, Tab 31.
[54] T 49.
[55] Exhibit 1, Tab 8 and Tab 31; Exhibit 2, Tab 23.
[56] Exhibit 2, Tab 25 and Tab 27.
[57] Exhibit 1, Tab 8 and Tab 31; Exhibit 2, Tab 24 and Tab 26.

counselling service was closed. It was noted that Mr Leach indicated he would self refer to the service if required in the future.[58]

EVENTS ON 20 DECEMBER 2021

55. Mr Leach had a medical review on 16 November 2021, to discuss the results of his gastroscopy on 19 October 2021. He was told that his symptoms were alcohol related and not malignant (cancer). However, he was told that it could turn cancerous if he continued to drink. He seemed enthusiastic about engaging in alcohol rehabilitation.[59]

56. Mr Leach did not see a doctor after that time, but continued to see nursing staff to receive his medications. It is significant that Mr Leach was recorded as having told nurses on 12 and 17 December 2021 that he needed a list of his medications and a blister pack to be prepared, as he believed he would be released on 20 December 2021, at his court appearance.[60] When considered along with his statements about saving his income for his release and hoping he could live with his father again, it suggests that Mr Leach had begun to hope that he might be released at his next appearance. This was contrary to his earlier statements that he would be happy so long as his sentence was no more than 5 years' imprisonment. In hindsight, when considered together, this information would have warranted Mr Leach having his sentencing date marked down as another DOI. Unfortunately, that did not occur.

57. The night before Mr Leach's final court appearance, Mr Leach and his cell mate, Mr P, watched a movie together on their shared television. They did this every night and Mr Leach appeared to be his usual self during the evening, with no noticeable change in his demeanour. Mr Leach fell asleep a short time after the movie started, which was also normal for him.[61]

58. On the morning of his court appearance, Mr P recalled Mr Leach started getting ready for his court hearing at around 8.00 am. He seemed his usual self when he left the unit for the video link appearance.[62]

59. Mr Leach went to the prison's video link facility and appeared by video link before Fremantle Magistrates Court. The court session was stood down at 10.15 am and then resumed at 10.45 am. Mr Leach was then found guilty of the charges against him and he was sentenced to 9 months and 3 months imprisonment, to be served cumulatively, resulting in a total of 12 months' imprisonment. In addition, some fines were imposed. His sentence was backdated to commence from 20 September 2021, when he was first taken into custody, so he only had around three months more time to serve before he would be eligible for release on 20 March 2022.[63] It doesn't appear, on its face, to have been a significantly negative sentencing outcome for Mr Leach, given what he had previously speculated might be the outcome. However,

[58] Exhibit 2, Tab 28.
[59] Exhibit 1, Tab 8.
[60] Exhibit 1, Tab 8; Exhibit 3.
[61] Exhibit 1, Tab 4.
[62] Exhibit 1, Tab 4.
[63] Exhibit 1, Tab 4; Exhibit 2, Tab 30.

it's clear that something about these proceedings led him to feel acutely suicidal. However, he did not share those thoughts with anyone.

60. Prison Officer Andrew Powell (Officer Powell) was working in the Video Link area at Hakea Prison on this date. Officer Powell worked in that area regularly at that time and gave evidence it was generally a hectic day liaising with the court staff and ensuring all prisoners were ready for appearances at the appropriate time. Nevertheless, Officer Powell gave evidence that at times he would be requested by PHS to have a chat with a particular prisoner if there were any concerns, and alternatively, he would communicate with PHS staff if he identified anyone displaying concerning behaviour while in the videolink area. In particular, he would be informed of any prisoners with a DOI recorded, by way of an email at the start of the day, so he could ensure that they were appropriately monitored. Officer Powell explained that this would not necessarily mean that he would interview the prisoner after their court appearance, but the officers in the area will usually ensure they have "a polite chat when they come out"[64] just to ensure they are properly monitored for any concerning behaviour. Any concerns will then be escalated to the appropriate area.

61. The information on this particular day identified Mr Leach as a segregated prisoner given he was housed in the protection area, but there were no other alerts. Officer Powell did not have an independent recollection of Mr Leach from that day, given the length of time that had elapsed, but he had completed an incident report after being informed of Mr Leach's death, in which he noted that there was nothing he could recall that was out of the ordinary in Mr Leach's behaviour on that date. Officer Powell explained that he had become aware of Mr Leach's death early in the afternoon as Mr Leach's cell mate, Mr P, was in the video link area making his phone call to family overseas. Accordingly, the video link staff were informed so that they could manage Mr P's welfare given they were apparently close.[65]

62. After his sentencing, Mr Leach was returned to a holding cell that was separated from most of the other prisoners, given he was a protection prisoner. He was observed by prison staff to be eating lunch and interacting with other prisoners and they did not notice anything of concern. The prison staff he interacted with thought Mr Leach seemed in good spirits and he appeared to be taking the news of his sentence very well.[66]

63. Officer Powell gave evidence that he will regularly make referrals to PHS, prisoner support, the chaplain and ARMS for prisoners who appear distressed or are exhibiting concerning behaviour in the videolink area, but he did not make any such report for Mr Leach.[67]

64. Mr Leach was escorted back to his unit from the videolink holding cell at 11.27 am. Mr Leach saw his cell mate, Mr P, when he returned from the hearing. He told Mr P he had received an additional sentence. The cell mate recalled Mr Leach appeared

[64] T 26.
[65] T 18 – 20; Exhibit 1, Tab 32.
[66] T 17; Exhibit 1, Tab 4; Exhibit 2, Tab 30.
[67] T 21.

"distant and off"[68] following his return from court. The unit was locked down for the staff meal break shortly after at 11.30 am. Mr Leach went to bed and had a sleep, which his cell mate said was normal behaviour for him. Unit 7 was released from the staff lunchtime lockdown at 12.45 pm. Mr Leach's presence was noted by prison staff during the standard muster process at this time.[69]

65. At about 1.00 pm, shortly after their cells were unlocked, Mr Leach left the cell to have a shower. He returned at around 1.15 pm. Mr Leach still seemed quiet and Mr P asked him if he was okay. Mr Leach responded only by nodding his head. Mr P had a scheduled video call with his family, so he left the cell soon after. Mr Leach asked him before he left how long the call would take and when he would return to the cell. Mr P told Mr Leach that he would be back in the cell after 2.30 pm. He then departed, leaving Mr Leach alone in the cell. Mr P did not see Mr Leach again.[70]

66. At 1.31 pm it appears that Mr Leach tried to call his father on his mobile number. Then, at 1.32 pm, Mr Leach made a telephone call to his father's landline at home The calls were made using the Prison Telephone Service (PTS). All PTS calls are recorded. It was not known to anyone at the time, but a recording of the second call indicates that Mr Leach was unable to get through to his father, so he left a voice message. In the message to his father, Mr Leach appeared upset about things that had been said during the hearing and indicated that he intended to demonstrate to Ms S just how much she had meant to him. He also said he didn't want a funeral and any items left in his estate he wanted to go to Ms S. He also bid his father farewell. It is very clear from listening to the call that Mr Leach had formed an intention to end his life when he made the call and he then went to put a plan into action.[71]

67. Unfortunately, the calls are not usually monitored in real time, so no one was aware of the nature of the call until it was too late. There was evidence that prisoners on ARMS will have their phone calls monitored more closely, but Mr Leach was not on ARMS at that time and, in any event, the calls are not usually listened to contemporaneously, so it is unlikely the call would have been listened to in time, even if he was still on ARMS.[72]

68. After making the call, Mr Leach returned to his cell. As well as the main lock on the door, the cells in the unit have an internal locking system with a personal lock, so they are able to be locked from the inside by the prisoners. Only the occupiers of the cell and prison officers have keys to enter when it is locked. Mr Leach's cell mate had left the unit for the afternoon so the only people who had access to the cell at that time were Mr Leach and any prison officers in the unit. Mr Leach was in his cell on his own for at least half an hour before he was then discovered. During that time, he fashioned a ligature and hanged himself from the door frame in some way. How exactly he manufactured a hanging point is not entirely clear, given no one saw it in situ.[73]

[68] Exhibit 1, Tab 4, p. 5.
[69] Exhibit 1, Tab 2.
[70] Exhibit 1, Tab 4.
[71] Exhibit 2, Tab 36.
[72] T 55 - 56.
[73] T 45 – 46.

DISCOVERY OF MR LEACH HANGING

69. That afternoon, two prison officers, Senior Officer Wayne Bourke (SO Bourke) and Prison Officer Nicholas Butler (Officer Butler) were conducting a routine audit of the prison cell fans in preparation for the approaching summer weather. They arrived at Mr Leach's cell, Cell 20, at around 2.23 pm and found the cell door was closed and locked. This was not unusual, as the cell is designed so that when a prisoner closes the door, it locks automatically. As noted above, the cell can only then be opened from the outside with a key. Mr Leach and his cell mate both had a key to the cell, and prison officers all have access to a master key that opens all cells. The two prison officers used their master key to unlock the door and open it.[74]

70. As the door swung open, Mr Leach, who unbeknownst to them had been hanging from the door, fell backwards towards the two prison officers. The two prison officers were caught by surprise. Mr Leach's body fell against SO Wayne Bourke and then fell to the ground. SO Bourke recalled trying to try to lower him down, but it seems Mr Leach struck the back of his head on the floor before the officers could properly catch hold of him. SO Bourke gave evidence that he didn't initially see that Mr Leach had a ligature around his neck, but it was clear he had suffered some kind of medical episode, so he called a code red medical emergency. It then became apparent that Mr Leach had a bedsheet knotted around his neck as a ligature and it had apparently been wedged between the top of the cell door and the door frame when the door was closed. The cell was noted to be empty except for Mr Leach.[75]

71. Two prisoners were in the cell opposite and one of them, whom I will refer to as Mr N, had seen the two prison officers opening the cell door and saw Mr Leach fall backwards and strike the back of his head with some force on the ground. It appeared to this prisoner that the two prison officers were in shock. Mr N came over to try to help and he could see the torn bed sheet that had been used as a ligature was still around Mr Leach's neck, so he attempted to untie the knot, which was double knotted. It was difficult to untie, so Mr N eventually used his teeth to pry the knot apart. Mr N's cell mate had not seen Mr Leach fall but he did hear the impact of Mr Leach hitting the ground and observed his cell mate trying to loosen the knot while prison officers began to perform CPR.[76]

72. After SO Bourke had called a code red over the radio, he instructed all of the other prisoners to return to their cells, noting there were more than 50 prisoners out of their cells at the time, so for safety reasons it was important they were secured in order for the prison staff to then focus on giving first aid to Mr Leach. The prison officers called for a Hoffman safety knife to be brought to them, which they intended to use to remove the ligature, but by the time the knife arrived, the other prisoner had succeeded in untying the knot. SO Bourke did use the Hoffmann knife to cut open

[74] Exhibit 1, Tab 2 – 4, Tab 33 and Tab 40.1.
[75] T 31 - 33; Exhibit 1, Tab 3.
[76] Exhibit 1, Tab 3 and Tab 4.

Mr Leach's shirt instead, in order to allow the defibrillator pad to be applied. They also commenced CPR with help from other prison officers who had arrived.[77]

73. Two nurses on duty had heard the code red medical emergency call over the radio and they immediately attended Mr Leach's cell. They observed the prison officers performing CPR and it was apparent a defibrillator had been applied. The nursing staff attended to Mr Leach's airway and commenced ventilation, but their attempts to insert an intravenous canula were unsuccessful.[78]

74. A prison medical officer also attended the medical emergency call and arrived on the scene a few minutes after the nursing staff. The doctor noted the prison officers and nursing staff were performing adequate CPR but Mr Leach remained unresponsive. Dr Luna managed to insert the intravenous canula and administered a dose of adrenaline. Dr Luna requested a second dose of adrenaline, but none was available. Dr Luna managed the airway and noted Mr Leach remained in asystole throughout the resuscitation efforts until SJA staff arrived.[79]

75. The call for an ambulance to attend was received by SJA at 2.29 pm. The first ambulance team arrived on the scene at 2.47 pm, and a total of three units attended. When the SJA officers arrived at Mr Leach's cell, CPR was still in progress. After observing the efforts being made, the SJA officers advised the prison officers to slow down the rate of compressions. The SJA staff tried to insert an endotracheal tube without success due to the state of Mr Leach's airways. Mr Leach was taken by stretcher to where the ambulance was parked. Resuscitation efforts were continued as he was moved, and it was noted they had continued for more than 20 minutes without any response, so before Mr Leach was put into the ambulance, he was assessed again and then CPR was eventually ceased. A SJA paramedic declared Mr Leach life extinct, while still in the prison, at 3.17 pm.[80]

POLICE ATTENDANCE AND REVIEW

76. WA Police were notified of the death at 3.01 pm and Detective Sergeant Stuart Fairlie (Det Sgt Fairlie) and Detective Senior Constable Christopher Pople from the Homicide Squad attended, as per protocol for a prison death in custody, along with Forensic Field Operations staff and Coronial Investigation Squad officers. They seized the ligature that had been taken from around Mr Leach's neck and noted it appeared the ligature had been thrown over the door with a knot at one end to form a hanging point. They examined Mr Leach, who was observed to have ligature marks to his neck and a large gash with some blood around it at the rear of his head, consistent with the described fall to the ground. No defensive wounds were observed. There was no evidence to suggest another person was involved in Mr Leach's death. Mr Leach's cell mate had been in another unit during the day, and he was the only other prisoner who would have access to Mr Leach's cell once the door was shut.[81]

[77] T 32 - 35; Exhibit 1, Tab 3.
[78] Exhibit 3.
[79] Exhibit 3.
[80] Exhibit 1, Tab 4, Tab 5 and Tab 11.
[81] T 9 - 10; Exhibit 1, Tabs 2 to 4 and Tabs 9 to 10.

77. There were no CCTV cameras in the relevant area, so no footage was available to show the exact time Mr Leach entered his cell and closed the door. However, the detectives spoke to some of the other prisoners in the unit, including the two opposite who had heard/seen Mr Leach fall when the door was opened, and Mr Leach's cell mate. All of the prisoners who had spoken to Mr Leach earlier in the day indicated he had appeared to be in good spirits and his usual self and there was no suggestion anyone else had been involved in his death in any way.[82]

78. At 7.39 pm, Det Sgt Fairlie made the critical decision that the death appeared to be non-suspicious, given:[83]

- Mr Leach had been sentenced earlier that day and then left a telephone message with his father indicating apparent suicidal intent;
- No other people were reported to be in the cell when Mr Leach was discovered;
- The evidence indicated Mr Leach had secured himself against the cell door, with the ligature placed between the door and frame in such a way that it would have made it almost impossible for anyone else to have been involved and then left the cell;
- No defensive wounds were identified and all injuries appeared to be consistent with witness accounts; and
- No suspicious circumstances were identified.

79. Responsibility for the continued investigation into Mr Leach's death was formally handed over to the attending officers from the Coronial Investigation Squad (CIS) and the two detectives left the scene. The CIS confirmed the cell emergency call button was working in Mr Leach's cell and spoke to other prisoners, including Mr Leach's cell mate. They did not identify any further information to contradict the initial assessment that Mr Leach appeared to have committed suicide by hanging himself on the back of his cell door.[84]

CAUSE AND MANNER OF DEATH

80. On 22 December 2021, Forensic Pathologists Dr Downs and Dr White performed a post mortem examination on Mr Leach. The examination showed a ligature mark to the neck, including underlying bruising of the neck muscles and fracture of one of the small bones of the neck (hyoid bone). The ligature had been removed from his body, so it was received separately. A few lacerations, scrapes and bruises to the head, torso and limbs were observed, as well as changes due to CPR. The heat was enlarged with thickening of the heart wall and there was fatty enlargement of the liver.[85]

81. Toxicology analysis showed amounts of paracetamol and the prescribed antidepressant venlafaxine. Other common drugs and alcohol were not detected.

[82] Exhibit 1, Tab 3.
[83] T 9; Exhibit 1, Tab 2 and Tab 3.
[84] T 85 - 89; Exhibit 1, Tabs 2 to 3 and Tabs 9 to 10.
[85] Exhibit 1, Tab 7.

Gross neuropathology of the brain showed an old traumatic brain injury but no recent traumatic brain injury was apparent.[86]

82. At the conclusion of the examination, Dr Downs and Dr White formed the opinion the cause of death was ligature compression of the neck (hanging). I accept and adopt their opinion as to the cause of death.[87]

83. Based upon the conclusion of the WA Police that there were no suspicious circumstances in relation to Mr Leach's death, and noting his statements in the message he left for his father indicated an intention to end his life along with his cause of death, I find that Mr Leach died by way of suicide.

EXPERT REVIEW BY DR BRETT

84. Mr Leach's history of depression and suicidal ideation and associated risk to himself were well known prior to his sudden death. He had also made statements in the past to indicate that he might harm himself if he was required to serve more prison time. He had previously been monitored on the Department's ARMS but was not being regularly monitored for the last period of his incarceration as his risk had been assessed as low. Even after he had been removed from ARMS, he had still been monitored after some court appearances as they had been identified as DOI. However, his sentencing date had not been identified as such a date, so there was no formalised review on that date.

85. Noting these circumstances, an expert psychiatric opinion was sought from Consultant Psychiatrist Dr Adam Brett (Dr Brett) to consider the standard of psychiatric treatment provided to Mr Leach prior to his death in order to assist me in considering the standard of his treatment, supervision and care, and to consider whether Mr Leach's death may have been prevented.[88]

86. Dr Brett reviewed Mr Leach's relevant medical history and noted that Mr Leach "had poorly defined mental health issues."[89] The only psychiatric assessment available was when Mr Leach had seen in prison by a consultant psychiatrist in June 2012. At that time, the psychiatrist had thought there was little evidence for bipolar disorder, and his problems seemed primarily alcohol related. He had not had a comprehensive mental health assessment by a psychiatrist since that time, although there was mention in the records that he had been referred for potential psychiatric review in late 2021 as it was thought he might benefit from some kind of pharmacological therapy for his long-term alcohol disorder.[90]

87. After reviewing the records, Dr Brett considered that the quality of Mr Leach's mental health care was adequate, *within the limitations of the resources available in prison.* However, if the resources had allowed, Dr Brett believed ideally Mr Leach

[86] Exhibit 1, Tab 7.
[87] Exhibit 1, Tab 7.
[88] Exhibit 1, Tab 8.
[89] Exhibit 1, Tab 8, p. 8 [1].
[90] T 154; Exhibit 1, Tab 20.1.

should have had a comprehensive mental health assessment, including input from a psychiatrist as part of a multidisciplinary approach, which would have then laid out a plan for his care while in prison.[91]

88. In Dr Brett's opinion, Mr Leach had significant mental health issues, with a history of alcohol dependence and depression, and he was clearly in despair at his situation at the time of his death after being sentenced to a further period of imprisonment. Dr Brett suggested that Mr Leach's key issue at the time of his death was despair and hopelessness of his situation and probably feelings of guilt regarding his offending. His previous coping mechanism had involved alcohol intoxication, and when this was not available to him, his coping mechanisms were overwhelmed and he acted on his chronic suicidal thoughts.[92]

89. Dr Brett noted that Mr Leach's substance use disorder had no clear clinical pathway to mental health services while he was in prison. Dr Brett commented that people "with substance abuse problems and mental health issues often fall in the cracks of services."[93] This is the case both within prisons and within the community. Dr Brett noted that Mr Leach's father had tried to get him help before he was incarcerated, with the support of his GP, but they had been unsuccessful. Therefore, Dr Brett felt that Mr Leach's care in prison was probably equivalent to what he had previously received in the community.[94]

90. Dr Brett reviewed Mr Leach's interactions with the medical/nursing staff and PHS staff during his last period of incarceration. He noted that the rationale for taking Mr Leach off ARMS on 26 October 2021, was well documented and appeared reasoned and rational based on the information available. He was still on antidepressant medication at the time of his death, which was appropriate, and his acute issues were properly dealt with by way of counselling. Mr Leach was put in a shared cell, and his cell mate had become a protective factor. [95]

91. Dr Brett's only criticism of Mr Leach's risk management and care was that, "given his unstable initial presentations, he would have benefitted from a review before his final sentencing and following his final sentencing. These are clearly risk times."[96] Dr Brett acknowledged that from the documentation there was little evidence to support a greatly increased risk for Mr Leach, but in his opinion "pro-active reviews would have been helpful"[97] and a review after his sentencing by someone who already had a relationship with him would have been the most beneficial. This coincides with other evidence about the potential for Mr Leach to have had his sentencing date marked as a DOI.[98]

[91] T 91; Exhibit 1, Tab 8, p. 8.
[92] Exhibit 1, Tab 8, p. 8.
[93] Exhibit 1, Tab 8, p. 9 [12].
[94] T 92.
[95] Exhibit 1, Tab 8.
[96] Exhibit 1, Tab 8, p. 9 [7].
[97] Exhibit 1, Tab 8, p. 9 [7].
[98] T 93 – 94.

92. Ultimately, Dr Brett suggested there was not much that prison authorities should have done differently in terms of Mr Leach's management in prison.[99] Instead, Dr Brett suggested that Mr Leach would have benefitted from diversion away from custody, as he would have been an ideal candidate for the Start Mental Health Court (Start Court) and residential rehabilitation, which is what he really needed. Dr Brett also considered that Mr Leach would have benefitted from a comprehensive mental health assessment before he committed the offences that led to this last period of incarceration. Dr Brett commented that "people usually drink for a reason,"[100] but there was not a good formulation as to why Mr Leach was using alcohol, which impacted on how his addiction could be managed. Dr Brett believes that a holistic approach to his medical care, physically and mentally, prior to his incarceration, may have impacted on Mr Leach's trajectory.[101] Unfortunately, Mr Leach's father and his GP had both struggled to the get the mental health assessment that Mr Leach needed in the months prior to his being remanded in custody.

93. Once in custody, Dr Brett noted that the prison's mental health services are not resourced to allow prompt psychiatric review and there is no pathway to inpatient mental health care. Dr Brett commented that the facilities in prison "are not conducive to managing people with suicidal ideation or plans" and it is "urgent that these things are resolved as soon as possible."[102] Dr Brett noted that due to the huge numbers of prisoners with substance abuse problems, mood disorder problems and recent suicidal ideas, inevitably services are swamped.[103] In his report, Dr Brett provided some information about the percentages of prisoners who present with issues similar to Mr Leach. Data from a reported Western Australian study referred to as the Davison Report at the inquest showed that in 2013 around 77% of prisoners on reception report historic substance abuse disorders, 23% had a history of mood disorder and 16% had experienced suicidal ideation in the month before reception. There has not been any more recent study conducted, but Dr Brett indicated that anecdotally people believe those statistics have, if anything, increased since that time, and that would particularly apply to Hakea Prison as the remand prison.[104]

94. In conclusion, Dr Brett made no criticism of any individual health practitioner involved in Mr Leach's care, but rather pointed to failures in the system. Dr Brett expressed the opinion that the current system is not properly structured and resourced to care for someone like Mr Leach. Mr Leach's longstanding substance abuse issues were only able to be addressed in the acute stage as he withdrew from alcohol medically. His ongoing care plan did not address his psychological issues underlying his substance abuse in a comprehensive way, as there is no clinical pathway to provide that kind of care in prison. With limited resources and high demand, the prison psychiatry services focus on the higher risk offenders who with serious mental illnesses such as schizophrenia and are experiencing psychosis, so even if he was assessed as needing acute mental health care, someone like Mr Leach with a mood

[99] Exhibit 1, Tab 8.
[100] T 93.
[101] T 92; Exhibit 1, Tab 8.
[102] Exhibit 1, Tab 8, p. 10 [14].
[103] T 93, 102.
[104] T 93, 104 - 105; Exhibit 1, Tab 8, p. 8 [6].

disorder and substance abuse disorder would not have had any realistic hope of getting one of the limited forensic beds available at the Frankland Centre.[105]

95. However, Dr Brett also noted that if Mr Leach had been in the community, it is also "very unlikely that he would have got care by a specialist public mental health service."[106] His mental health issues would usually be managed by primary care, namely a GP, with medication and referral to substance abuse services. This was roughly equivalent to what was provided to Mr Leach in prison, other than the absence of a pathway to residential rehabilitation.

96. Looking to the future and noting the high levels of mental illness in reception prisoners, Dr Brett suggested that forensic mental health principles do not support building a mental health unit within Hakea Prison. Rather, Dr Brett supported a model of care adopted in Queensland, where people who are lower risk offenders but requiring mental health care, like Mr Leach, access mental health care through the general mental health system rather than prison specific mental health services, with a single specific service that can be escalated to provide more input or less input, depending on the person's fluctuating mental state. Dr Brett suggested this model would be appropriate even if there are plans to build new forensic mental health units, as those units will inevitably take the higher risk offenders with severe mental illnesses, leaving out the majority of prisoners with a less severe mental illness, like Mr Leach.

97. The position that "Health should be managing health in prisons"[107] is in line with the position of the RANZCP (Royal Australian & New Zealand College of Psychiatrists) and the National Statement of Principles for Forensic Mental Health[108] and has apparently been raised continuously within the Department of Corrective Services in this State and others. Dr Brett indicate that the RANZCP's position is that "mental health units should be run by Mental Health and they should be geographically remote from prisons."[109] The Frankland Centre is an example of this principle in practice, but due to bed blockage there is no prospect of any prisoners like Mr Leach being transferred there.

98. The National Statement was described as an 'aspirational' document with principle support, but it is quite clear that many of those principles have not yet been implemented in Western Australia. The National Statement acknowledges that "the relationship between the treatment and rehabilitation culture of forensic mental health services and the custodial culture of correctional agencies is often problematic,"[110] with a different focus, and there are safety needs for the community that must be weighed against the best therapeutic environment for providing safe and secure treatment to forensic patients. However, the National Statement also emphasises that the provision of mental health care for offenders remains a joint responsibility between Justice and Correctional Systems and Health and the third

[105] T 93 – 94.
[106] T 92.
[107] T 96.
[108] Exhibit 1, Tab 8.3.
[109] T 98.
[110] Exhibit 1, Tab 8.3, p. 5.

principle identifies that mental health services are preferably staffed by mental health personnel employed by a health service and mentally ill persons in prison need access to quality general medical services.[111]

99. Dr Brett gave evidence that while he understands the 'Queensland Model' has some 'in principle' support in WA, it has huge resource implications as the number of prisoners who would likely require that kind of public mental health care is "terrifyingly large."[112] That is a demand that would be placed on an ordinarily stretched public mental health care system. However, Dr Brett also observed that many of these prisoners have chronic mental health concerns and are known to public mental health before they come in to prison, so they are already within the system. The closure of long-term mental health beds in the community has then led many of these people to be transferred from the health system, where they were previously cared for, into the prison setting. Dr Brett observed that as a remand prison, Hakea "bears the brunt"[113] of that "transinstitutionalisation"[114] process. Therefore, it is not unreasonable to consider that the one system should remain caring for them, irrespective of whether or not they are incarcerated.[115]

100. Dr Brett also suggested that a service designed more like the Start Court Service (with allied health, peers support workers and mental health nurses and psychiatrists all working together)[116] would benefit the less severely mentally ill prisoners.[117] The various layers of support currently operating within Hakea Prison are already there, but they are fractured into different parts, with the mental health service run separately to the psychological health service. Dr Brett advocates for a more cohesive system of mental health care, with all those parts working together and run by Health. It would also, of course, have to be properly resources.

101. Through his long history of working within the WA prison system, along with his more recent involvement with the Start Court, Dr Brett has been able to see the benefits of providing more holistic mental health care to offenders with a mental illness. Accordingly, he is well placed to offer up an opinion on a better alternative to a system that he, like the other witnesses, described as currently "in crisis."[118] Dr Brett gave evidence that there is good data to demonstrate that this kind of holistic mental health care "improves people's mental health, it reduces substance use, it reduces risk of reoffending and it helps people."[119] However, Dr Brett noted that this requires cultural change, which is much harder to achieve than structural change.[120]

[111] Exhibit 1, Tab 8.3.
[112] T 96.
[113] T 97.
[114] T 96.
[115] T 96.
[116] That operates within the Magistrates Court dealing with certain offenders who have mental health issues.
[117] T 94, 106 - 107.
[118] T 98.
[119] T 98.
[120] T 106.

COMMENTS ON TREATMENT, SUPERVISION AND CARE

102. In terms of his general medical care, the Department's internal medical review formed the view that Mr Leach had received excellent and holistic health care for his chronic health problems, with good continuity and communication between prison health staff and external specialists. His diagnoses of alcohol dependence, hypertension and depression had been documented and he was treated appropriately with medication and referred to the Psychological Health Service for ongoing counselling. It was noted that he had been placed on ARMS in initially, which was appropriate.[121]

103. However, the medical review also noted some areas for improvement in Mr Leach's physical medical care. His hypertension was not regularly monitored as it should have been. In addition, his history of seizures secondary to alcohol withdrawal was not properly recognised. Both of these aspects of care have been reinforced with prison health staff since Mr Leach's death, although it is noted that they were not relevant to his actual cause of death.[122]

104. The medical review also identified the more significant failing in the supervision, treatment and care was that after he was removed from ARMS, and despite two court appearances being flagged as DOI's, the court date of 20 December 2021, was not flagged as a date of interest. Dr Catherine Gunson (Dr Gunson), the Deputy Director of Medical Services at the Department at the time of the inquest, gave evidence that the information to health staff that Mr Leach was seeking medications for his discharge was an indicator that he "might have had a really fixed opinion about what was going to happen,"[123] and in the context of his past history of self-harm, there were some indicators he might respond badly to a different outcome. Dr Gunson suggested some early questioning as to how he would feel if his expectations were not met, might have helped with risk planning for that sentencing date. However, the limited knowledge of the nurses as to the likelihood that he would be released would have hindered that understanding of risk.[124]

105. The Department's internal medical review acknowledged that Mr Leach's new stressors of an upcoming court date where he anticipated release, as well as the news that he would not be able to live with his father, were documented but not identified by staff as possible risks of self-harm. This was despite his history of self-harm being documented. As a result, Mr Leach did not receive pro-active support on the day of his court hearing. The internal review identified impediments to this occurring as: a lack of staff to monitor these dates and ensure follow-up is in place and a need for improved communication between custodial staff and prison health staff. It was acknowledged in the medical review that this same issue has been flagged recently a number of times. It was noted in the written medical review that there were ongoing discussions between custodial staff and Mental Health Services to determine how best these risks might be identified and addressed.[125]

[121] T 132; Exhibit 3.
[122] Exhibit 3.
[123] T 137.
[124] T 137 – 138; Exhibit 3.
[125] Exhibit 3.

106. In the covering letter for the Death in Custody Review Report directed to the State Coroner, dated 13 February 2024, then Acting Director General Kylie Maj[126] acknowledged that the omission of a date of interest for Mr Leach's sentencing on 20 December 2021 "was a missed opportunity to provide him with support before and after his appearance."[127] The Acting Director General advised the Department's ARMS and SAMS manuals are scheduled to be updated in 2024/2025 and this will include a review, which will potentially increase the scope of individuals captured within SAMS, including prisoners who have expressed that particular dates or events are a stressor for them. In the interim, mandatory online training for the prevention of suicide and non-suicidal self-injury was rolled out to all prison-based staff in September 2023 to empower staff to identify and respond to prisoners who may be at risk.[128]

107. Dr Brett had also noted, in his expert review, that the sentencing date was an important date that would ideally have been flagged as a DOI for Mr Leach, with monitoring. Dr Brett observed that it is "almost mathematically impossible to predict who's going to predict suicide" and he emphasised that the individuals involved in Mr Leach's care overall did good risk formulations and tried their best. However, Dr Brett's view was consistent with the internal reviews, that in hindsight an additional DOI for Mr Leach on that date would have been appropriate and was an opportunity for someone to speak to him and perhaps elicit information, without suggesting it required a formal mental health review.[129]

108. Following an inquest held in February 2024 into the suicide by hanging of a female remand prisoner, Ms Davis, at Melaleuca Women's Prison, the presiding Coroner made a recommendation on 28 March 2024 that:

> The Department should consider ways in which dates of interest (DOI) for prisoners who are not being managed on [ARMS] (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.[130]

109. Mr Leach's death pre-dated this recommendation, but it is helpful to know how the Department responded to this recommendation, given its relevance to Mr Leach's death, although it related to a different prison facility. The Department had been given notice of the proposed recommendation, prior to the Finding being delivered, and the Department had indicated in response that while a DOI could be flagged through PHS but there are resourcing impediments which hinder the ability to conduct follow ups with prisoners before and after a DOI, given the volume of prisoners attending court appearances daily. Similarly, the Department advised ARMS and SAMS "are currently strained and cannot meet service demand."[131] The Department indicated it was utilising resources currently available to support

[126] Who now holds the substantive position of Director General.
[127] Exhibit 2, Tab 0.
[128] T 126, 128; Exhibit 2, Tab 0.
[129] T 99, 102.
[130] *Inquest into the Death of Suzzanne Denise DAVIS* [2024] WACOR 13, Jenkin C.
[131] *Ibid*, [137d].

prisoners not on ARMS and SAMS, but who require additional support, such as Chaplaincy, the Aboriginal Visitors Scheme and Peer Support Services. The Department suggested that a recommendation might have a beneficial effect if it was framed with a focus on advocating for commensurate resourcing to provide additional supports to those prisoners not on ARMS and SAMS. The presiding Coroner indicated that the proposed recommendation was entirely consistent with the suggestion of the Department and the Department was encouraged to continue to do its utmost to find ways to "grapple with the complex issues that attach to the safe and appropriate management of vulnerable prisoners in its care."[132]

110. Information provided by the Department following this current inquest indicated that prisoners can be flagged for a DOI by PHS staff, as was done with Mr Leach prior to the earlier court appearances. One witness explained that PRAG now has access to the statement of material facts, which can also assist in identifying potential candidates for a DOI.[133] However, the Department advised there are currently "resourcing impediments which hinder the ability to conduct follow ups with prisoners both before and after a DOI."[134] Existing systems such as ARMS and SAMS are currently strained and cannot meet the service demand. Accordingly, the Department has struggled to implement the above recommendation. The Department advised that it is, however, exploring the possibility of all prisoners receiving a post-court welfare check in the first instance. This check will be conducted by custodial officers and referrals to PHS and Mental Health will be made, as required, based upon the outcome of this check.[135]

111. Assistant Superintendent Paul Senter (A/Supt Senter),[136] had also given evidence at the inquest about changes to DOI's at Hakea Prison and also about Peer Support Prisoners (PSP's) and Prison Support Officers (PSO's). PSP's are prisoners who have applied, or been nominated and agreed, to take on a support role in their unit. If approved, they can either perform the role in a voluntary capacity or as part of paid employment within the prison if they do not already have a paid position. They receive training and meet monthly to assist them in providing peer support to fellow prisoners. The recent training has been facilitated by an external provider with a focus on 'Suicide Awareness and Prevention'. A/Supt Senter noted that as Hakea Prison is the State's main remand facility, there can be a high turnover of PSP's at times, which can affect the roles that can be filled at any given time, as well as the level of training they have received, but they are always considered a valuable resource.[137]

112. As a consequence of an internal review to identify whether lessons could be learned from Mr Leach's death, there is now a dedicated PSP in the Hakea Prison's Video-link area who has a specific space set where he can talk to prisoners. The PSP wears a bright yellow t-shirt with the PSP emblems on it, so he is highly identifiable for other prisoners, and they are able to seek him out if they need someone to confide in

[132] *Ibid.*
[133] T 81.
[134] Letter to CA from SSO counsel dated 15 May 2024, [34] – [37].
[135] Letter to CA from SSO counsel dated 15 May 2024, [33].
[136] Who was acting as Deputy Superintendent of Operations of Hakea Prison at the time of the inquest.
[137] T 111 – 112, 115; Exhibit 1, Tab 34.

or to help them process bad news. A/Supt Senter described the PSP as someone who is "plugging a gap"[138] that is not currently filled by the uniformed officers in the area, who are busy with trying to get prisoners to and from their court appearances and who also may not, due to their role, be someone that a prisoner may choose as their confidant.[139] Dr Gunson noted that a conversation at the right time by a supportive person can be just enough to distract someone like Mr Leach "from his purpose for long enough for that to recede in his mind,"[140] so it doesn't necessarily require a long conversation or someone who has particular training, for the intervention to be effective. If the PSP identifies a prisoner who requires additional support or interventions, the PSP will raise their concerns with the unit manager and/or other staff who will then determine what additional supports are required.[141]

113. The Video-link area PSP was implemented on paper in January 2023, and since that time they have slowly worked towards finding the right person for the role and putting them in the right space. A/Supt Senter gave evidence that at least at the time of the inquest in April 2024, they had placed a consistent person in the PSP role there, but it had taken some time since its introduction to find the right fit. A/Supt Senter indicated the individual in the role had been well received by prisoners and prison staff as a helpful, additional 'go-to point' for prisoners who need extra support.[142]

114. I was also provided with updated information on the Department's response to recommendations made in other recent inquests that might be pertinent to the issues arising in this matter.

115. One issue relates to the recruitment and retention of health professionals within the prison system. I was advised that currently there are more FTE's funded for prison medical officers than are filled, although at the time of the inquest it was anticipated more would be joining the team, so they would be close to reaching the full FTE complement. The Department is also in discussion to improve the salaries and conditions for prison medical officers to make them equivalent with other government positions for medical officers, in particular the Department of Health, which should hopefully go some way to improve recruitment and retention, although Dr Gunson, who described the Department's previous approach to contracts for medical officers as somewhat primitive and backward"[143] was not certain that small changes to the pay scale and on-call payments will improve recruitment, although it is obviously an improvement.[144]

116. Pay is only one aspect of employment and Dr Gunson commented that many doctors still work within prisons as "it is an opportunity to do something for people who do not get care anywhere most of the time"[145] but workload and other supports are also important. The Department acknowledged that in order to optimise workload and to

[138] T 113,
[139] T 112 – 113; Exhibit 1, Tab 34.
[140] T 151.
[141] Exhibit 1, Tab 34.
[142] T 113 – 119.
[143] T 144.
[144] Letter to CA from SSO counsel dated 15 May 2024, [11] – [22].
[145] T 146.

provide the best care to prisoners requiring medical care, ideally the Department should employ four or five more full-time prison medical officers. Expenditure Review Committee (ERC) submissions for additional funding for additional prison medical officers were submitted in 2020, 2021, 2022 and 2023, but all were unsuccessful.[146]

117. In a similar vein, the Department has increased efforts to fill vacant PHS positions within Hakea Prison, with the hope that a recent recruitment drive would see all but 0.6 of the 11 FTE positions within Hakea Prison's PHS team filled and all Mental Health Nursing positions filled. In 2023, the Department also made an ERC submission for six prison support officers, one clinical supervisor and four prison counsellors for recurrent funding for 2024-25 onwards, but this submission was rejected by Treasury.[147]

118. In submissions filed on behalf of the Department following this current inquest, I was informed that "the Department acknowledges that the increased prisoner population and the volume of prisoners needing counselling and psychological health services has created a greater need to expand the health care facilities at Hakea Prison."[148] However, like everything, expansion is dependent on the allocation of additional funding. The Department advised that it is currently developing a submission to Treasury seeking funding to enable the development of a project definition plan for expanding the facilities at Hakea Prison as part of the next infrastructure capital budget process.[149]

119. A specific issue that arose during this inquest into Mr Leach's death was the question of availability of psychiatrists, as opposed to prison medical officers. I was provided with information on behalf of the Department that there were 3 FTE psychiatrist positions allocated for all adult prisons, not just Hakea Prison, and at the time of the inquest 2.2 FTE were unfilled. That meant there was only one psychiatrist, at 0.8 FTE available, and they were apparently based at Hakea Prison. However, that sole psychiatrist was on long service leave at the time of the inquest. Accordingly, doing the maths, it means that at least as at the time of the inquest hearing in April 2024, there were *no* psychiatrists working in Hakea Prison, or in fact in any prison at that time. In fairness to the Department, I was advised that the Department had tried to recruit for those positions, without success and they did have some psychiatric support coming in other ways, but no formal clinical psychiatrist in that role.[150]

120. It hardly needs stating that this is very concerning given the generally acknowledged high level of mental health conditions within the prison population.[151] In Dr Brett's experience, "psychiatry is important to be a clinical lead in clinical services, and without that clinical leadership, … it's going to be a struggle."[152] In Dr Brett's opinion, the Mental Health team are overwhelmed as well as the PHS team and there

[146] Letter to CA from SSO counsel dated 15 May 2024, [11] – [22].
[147] Letter to CA from SSO counsel dated 15 May 2024, [24] – [27].
[148] Letter to CA from SSO counsel dated 15 May 2024, [29].
[149] Letter to CA from SSO counsel dated 15 May 2024, [29] – [31].
[150] T 98, 146 - 147; Email from SSO to CA dated 17 April 2024.
[151] As has been raised in previous inquests before me.
[152] T 98.

is "ongoing dissonance between the psychological services and the mental health services."[153]

121. Dr Brett also observed that there is a particular problem with recruiting psychiatrists within Corrective Services, which he believes is not necessarily due to pay, but more to do with having to working "within a system which isn't a functional system."[154] Dr Brett commented that while many psychiatrists find the work rewarding, as they have an opportunity to work see a lot of interesting psychiatric disorders, when you can't manage patients as you would like to manage them, there are no clinical pathways to help the people you are seeing and there is a tsunami of mental health clients, then "it's very difficult to sell people to want to do that job."[155]

122. Dr Brett had also suggested there would be significant benefits in having doctors within the prison who specialise in substance abuse. Given the above, while the Department indicated after the inquest that it is open to the recruitment of a doctor to an existing vacant position who specialises in addressing substance abuse, the challenge will be finding a suitably qualified practitioner who wants to work there. Currently, the Department does have doctors who are trained in the Prescribing Community Program for Opioid Pharmacotherapy (often referred to as POP), which is of some benefit, but does not go as far as Dr Brett has recommended.

123. Dr Gunson agreed that alcohol and drug dependence are common in the prison population at Hakea Prison, with many experiencing issues with withdrawal in the early stages of their prison admission. She identified gamma-hydroxybutyrate (often known as GHB or fantasy) withdrawal and alcohol withdrawal as two with potentially life threatening consequences in the withdrawal stage. Dr Gunson's previous role was in a specialist drug and alcohol service, so drawing on her personal experience, Dr Gunson was planning to hold some training for prison medical officers on this issue after the inquest. Dr Gunson also gave evidence that before the former Director of Medical Services, Dr Joy Rowland, resigned, there had been talk of recruiting a GP that would primarily do mental health, alcohol and other drugs works and serve as a kind of connection point for other staff. That does not appear to have progressed since Dr Rowland's resignation. In Dr Gunson's opinion, a GP in that role "would be incredibly helpful" within the Department's medical service, although she believes it would probably need a lot more than one GP to perform that role, given the number of prisoners with substance abuse issues.[156]

124. In terms of the issue of the failure to recruit psychiatrists, Dr Brett suggested that the Department (and realistically this is more directed at the WA Government as a whole as it involves both the Department of Justice and Department of Health) should consider implementing what was referred to during the inquest as the "Queensland Model."[157] The Department advised that it agrees with the premise of the Queensland Model and "acknowledges that prisoners who have a mental health illness requiring involuntary treatment under the *Mental Health Act 2014* (WA) should be sent to an

[153] T 98.
[154] T 108.
[155] T 108.
[156] T 135 – 136, 148 - 149.
[157] T 103.

appropriate facility for treatment."[158] However, the Department also noted that implementation of this model is dependent on additional mental health beds being made available within the public health system. The Department has met with Senior Representatives of the Health Service Providers to advocate access to civil authorised beds to ameliorate the bed block experienced at the Frankland Centre, which is currently the only place where such prisoners can be sent. The Department indicated it will now raise the Queensland Model as part of further discussions.[159]

125. The other issue that arose during the inquest was information that another reportable death occurred at Hakea Prison on 18 April 2024 and preliminary information suggests it may have occurred in similar circumstances to the death of Mr Leach, at least in terms of the ligature point. The Department has noted that it faces ongoing challenges in trying to minimise ligature points within the custodial environment as prisoners continue to identify new anchor points, even in ligature minimised cells. When Mr Leach's death was reviewed as part of a 'Lessons Learned Workshop' in September 2022, consideration was given to having a larger/smaller gap in the doors, as well as the possibility of a collapsible door, which might reduce the risk of a similar event. However, it was felt that any such change would pose a security risk. It was therefore determined that the current doors would remain unchanged at this stage.[160]

126. There will, of course, be another investigation into this new death, including a mandatory inquest. Noting that there are now two deaths in similar circumstances, I strongly recommend the Department try to think laterally about other ways to reduce the risk of further deaths using the same mechanism, as part of the Department's ongoing ligature minimisation program. However, I acknowledge that changing or altering the cell doors would be a very significant change, so it will need proper consideration of all the risks, and removing one type of ligature point does not mean that other mechanisms will be identified in the future.[161]

127. One final area that was raised in the inquest in relation to resourcing came from prison officers involved in finding Mr Leach. SO Bourke, who was the senior officers in the unit that day, noted that in the past, prison officers would be able to assist in monitoring prisoners mood and assessing risk through their day to day interactions with the prisoners in their unit. However, due to increased workload, prison officers now often find themselves being reactive, rather than proactive, in relation to managing risk with prisoners. Mr Leach is a case in point, as he had been in unit 4 for some time, but SO Bourke did not know him personally and could not recall any interactions with him prior to that day. Officer Bourke noted that in the past, he would try to be proactive and gauge the mood of prisoners informally. Where he was concerned someone was not travelling well, he would then take the prisoner aside and try to talk with them. He gave an example of a prisoner a few years before in the same unit who had appeared to be down, and SO Bourke had taken the time to talk to him and found out that he was feeling suicidal and had planned to hang himself in his cell that night. He had gone as far as making a noose,

[158] Letter to CA from SSO counsel dated 15 May 2024, [42].
[159] Letter to CA from SSO counsel dated 15 May 2024, [41] – [46].
[160] Exhibit 1, Tab 29.2; Letter to CA from SSO counsel dated 15 May 2024, [49] – [51].
[161] Letter to CA from SSO counsel dated 15 May 2024, [49] – [51].

that was hidden under his bed. He was moved to a safe cell and his death was prevented on that day. SO Bourke noted that now prison officers are "in crisis"[162] due to a lack of staffing and overcrowding with prisoners being doubled up in cells that were designed for one person, which makes that sort of casual interaction impossible.[163]

128. Dr Brett observed that you can "underestimate the power of human contact and just a listening, caring ear"[164] and you don't have to be an expert in mental health to be able to provide that. However, prison officers do need to have the time to get to know the prisoners in their care for that to occur. That won't happen when the units are overcrowded and understaffed.

129. I note a recent article in *The West Australian* newspaper reported that the WA Prison Officer's Union secretary, Mr Andy Smith, had expressed concerns that some prisoners are being forced to triple bunk now, so the overcrowding issue has not resolved and rather has worsened, and staffing levels are still said to be at "crisis point."[165] SO Bourke also expressed concerns about the lack of resourcing for PHS and other mental health and support services in Hakea Prison, noting that in his view, "their workloads are insane."[166]

130. Another witness, Acting Senior Supervisor Sarah Harbour (A/SS Harbour), who has been a prison officer for over 17 years and is the current chair of the PRAG at Hakea Prison, agreed with SO Bourke's comments about the stretched staff resources and pressures that come with the doubling up of prisoners in cells. She commented that she had "never seen it so bad," with hundreds of people on ARMS at Hakea and approximately half the prisoners mentally unwell. A/SS Harbour commented that the counsellors aren't currently able to counsel prisoners and are restricted to risk assessment due to the stretched resources of PHS. A/SS Harbour also noted that the limited safe cells are under pressure from prisoners seeking refuge for many reasons that do not relate to their crisis care role due to overcrowding. Officer Harbour noted that due to a lack of staffing most of the programs and education have been closed, so prisoners spend more time locked in their cells, which has a negative effect on their mental health, particularly when there is overcrowding.[167]

131. A/SS Harbour agreed with Dr Brett that there are serious issues with prisoners managing substance abuse issues along with their mental health issues and she agrees there needs to be a separate facility for mental health prisoners, given the limited beds at Frankland Centre, such as the facility at Wandoo, which is currently only for female prisoners, or moving the remand aspect of Hakea Prison to a larger prison like Casuarina Prison.[168]

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[162] T 41.
[163] T 40 – 42.
[164] T 100.
[165] https://thewest.com.au/news/wa/hakea-prison-triple-bunking-practice-at-canning-vale-prompts-major-concerns-from-prison-union-c-15764395.
[166] T 43.
[167] T 77 - 78.
[168] T 58 - 61.

132. As to the issue of Mr Leach's phone message to his father, it remains the case that most phone calls will not be monitored in real time unless there are known acute welfare concerns for a prisoner, which was not the case for Mr Leach. However, I was advised that if Mr Leach's father had been in a position to hear the message in time, then there is now a dedicated phone number available for concerned family members to call if they want someone to check on a prisoner's welfare following such a call. It would not have been likely to make a difference in this case, as it does not seem that Mr Leach's father heard the message before Mr Leach's death was discovered, but it is positive to hear that this is available in a case where the family might have some warning that a prisoner is feeling suicidal and can alert prison authorities in time.[169]

RECOMMENDATIONS

133. I propose to limit my recommendations to new issues that have been raised at this inquest that might prompt new ways of thinking. That does not mean that I do not consider the other issues raised to also be important, but the existing recommendations are already in place and it is for the relevant Ministers and heads of Departments to find a way to resource.

134. I note that an article that was provided by Dr Brett following the inquest notes that the adult prison population in Australia continues to rise disproportionately to the general population[170] and Western Australia prisons reflect that national change. "As a population cohort, persons detained in prisons have a disproportionate burden of mental illness compared to population cohorts in the general community," and are at increased risk of self-harm and suicide as a result.[171] What that means for the Department is that they are required to manage more and more prisoners with significant mental health issues and who are at high risk of harming themselves. Hakea Prison as a remand prison is particularly pressured, yet I was told at the time of the inquest that there were no psychiatrists working at Hakea Prison, due primarily to an inability to recruit and backfill when a staff member goes on leave, but also overall to issues with pay, conditions, workload pressures and a lack of suitable treatment options. When one considers the National Statement as an aspirational goal for the prisons in this State, we are falling very, very short of that goal.

135. I have noted the many comments about the lack of resourcing for prison officers and prison health staff, along with the pressures of overcrowding. Most of this information has come from the staff themselves and is undeniable. It paints a fairly bleak picture. Many recommendations to fix these concerns have already been made in other inquests and I am sympathetic to the Department of Corrective Services, as the Department has generally indicated it is receptive to implementing these recommendations, but very little can be done without proper funding and resourcing. When the Department asks for appropriate funding, those requests are routinely rejected.

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[169] T 70, 80.
[170] Exhibit 4 – "*No involuntary treatment of mental illness in Australian and New Zealand prisons*," The Journal of Forensic Psychiatry & Psychology (2021) 32(1), 1 – 28, Caroll *et al*.
[171] Exhibit 4, p. 3.

136. The study provided by Dr Brett observed that "Isolation, overcrowding, victimization and the poor physical environment of prisons are likely to contribute to a deterioration in the mental health of prison entrant."[172] Hakea Prison is full to bursting, prison officers and health staff feel unable to treat, care and supervise prisoners in the way they would like, and triple bunking prisoners as summer approaches can only make a terrible situation worse. I am concerned for the future of Hakea Prison in terms of the level of risk that it presents for prisoners and prison staff in the coming months.

137. Ultimately, it is an issue for the State Government to decide how it is going to deal with this problem. The answers are multi-faceted and go well beyond the simplistic suggestion that we might build more, and bigger, prisons, but instead require focus on sentencing practices, rehabilitation and support services for prisoners being released and early intervention with young offenders to break offending patterns before they reach an adult prison, amongst other things. These are not new issues. However, it is clear that there also needs to be new ways of thinking about these issues as the continual stretching of the resources of the Department of Justice without any proper mental health support for prisoners is only going to lead to more deaths in custody, irrespective of the best intentions of the individual Departmental staff.

138. Options such as changing Hakea Prison from the remand prison to a different facility or spreading the remand prisoners load between facilities, and the Queensland model of forensic mental health care all need to be considered as long-term solutions. In the short term, the Department's requests for allocation of funding to improve the level of health care and treatment for prisoners in Hakea Prison needs to be given urgent priority. I note the Honourable Paul Papalia, Minister for Corrective Services, wrote to the State Coroner in February 2024 in response to recommendations by another Coroner on this same issue and indicated that the Department supported in principle recruiting additional PHS and mental health staff for Hakea Prison and extended facilities to provide that health care, but it is all dependent on the allocation of additional funding by Treasury. Information provided to me by the Department at the conclusion of this inquest indicated there had been no progress in obtaining that necessary funding. Accordingly, I make recommendations as follows:[173]

Recommendation 1

I recommend that, as a matter of urgency, the State Government give strong consideration to approving fundings requests by the Honourable Minister for Corrective Services to recruit suitably qualified staff and extend existing facilities to provide appropriate mental health care (including counselling) to prisoners at Hakea Prison, starting with funding to enable the Department to develop a project definition plan.

[172] Exhibit 4, pp. 3 – 4.
[173] https://www.coronerscourt.wa.gov.au/_files/inquest_2024/recommendation%20roberts.pdf.

Recommendation 2

I recommend that, looking towards future planning, the Department of Health and the Department of Justice consult to consider whether an alternative model of mental health care for prisoners, such as the Queensland Model, should be implemented in Western Australia, in order to put into action some of the principles of the National Statement and reduce the pressure on the limited mental health resources of Hakea Prison.

CONCLUSION

139. Mr Leach hanged himself on 20 December 2021, shortly after he was sentenced for offences of violence involving his partner. It is clear that the outcome of his court proceedings had been weighing heavily on his mind leading up to that date, although his mood had fluctuated. He had made statements that suggested he thought it likely he would be released after the sentencing. In the end, he was sentenced to a further period of imprisonment. Either due to matters that were mentioned during the sentencing proceedings, or the knowledge he would have to spend some more time in custody, or both, he experienced suicidal thoughts immediately after he was sentenced.

140. In the past, Mr Leach had been spoken to by staff to check how he was feeling after a court appearance. However, on this particular date, he was no longer on ARMS monitoring and the sentencing date had not been flagged as a DOI, so he had no formal monitoring. Prison officers who spoke to him did not observe anything to raise their level of concern and his cell mate, with whom he was close, thought he seemed a little bit quiet but not so upset as to make him worried for his safety. The only person Mr Leach told about how he was feeling was his father, but he did so in a telephone voice message, so no one knew he was feeling suicidal until it was too late.

141. The Department's own internal reviews have identified and acknowledged that, in hindsight, it would have been appropriate for Mr Leach's sentencing date to have been marked as a DOI, given his history of being on ARMS and remaining vulnerable. However, the Department's resources to provide that kind of monitoring is limited. It is also not clear if Mr Leach would have shared how he was feeling, even if he had been identified as 'at risk' on that date. It was, however, a missed opportunity to potentially divert Mr Leach from his planned course.

142. There is no criticism of any individual person involved in Mr Leach's treatment, supervision and care. Any adverse comments I have made relate to the significantly stretched resources of the Department when faced with the huge burden of an ever-increasing prison population with a disproportionately high percentage of people with substance abuse disorders and/or mental health disorders. There is no simple solution, but any effective solution is going to require a new way of thinking and significant financial support to put it into effect.

143. In conclusion, I emphasise that all of the information before me at this inquest supports the conclusion that Hakea Prison has reached "crisis point" (a direct quote from a number of witnesses). As the overcrowding continues unabated with reduced prison staff to manage the prison population and no ability to provide the kind of general mental health supports (including education and exercise) and specific psychiatric treatment that is needed for such a psychiatrically vulnerable group of people, there are likely to be more deaths like Mr Leach.

S H Linton
Deputy State Coroner
6 September 2024