JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	11 - 13 MARCH 2024
DELIVERED	:	3 JANUARY 2025
FILE NO/S	:	CORC 170 of 2021
DECEASED	:	HILLSTEAD, CHRISTOPHER JOHN

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Ms S Markham assisted the Coroner
Mr J Berson (State Solicitor's Office) appeared on behalf of the Department of Justice
Mr C Beetham (instructed by A Percy, Wotton Kearney) appeared on behalf of Serco Australia Pty Ltd

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Christopher John HILLSTEAD** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 11 - 13 March 2024, find that the identity of the deceased person was **Christopher John HILLSTEAD** and that death occurred on 18 January 2021 at Acacia Prison, Great Eastern Highway, Wooroloo, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

"Education is not a preparation for life; education is life itself."
John Dewey – educational reformer

1 Christopher John Hillstead (Mr Hillstead) died on 18 January 2021 at Acacia Prison (Acacia), Wooroloo, from ligature compression of the neck (hanging). At the time of his death Mr Hillstead was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1] He was 59 years old.

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

3 I held an inquest into Mr Hillstead's death in Perth from 11 to 13 March 2024. The following witnesses gave oral evidence:[4]

i. Helena Zielinski (Manager, Education and Vocational Training at Acacia);
ii. Sandra Lewry (Sentence Management Manager at Acacia);
iii. Dr Shona Hyde (Director at the WA Office of Crime Statistics Research);
iv. Ellen Itzstein (Senior Social Worker at Acacia);
v. Poonan Gulati (Acting Unit Manager at Acacia);
vi. Bradley Warburton (Intelligence Manager at Acacia);
vii. Marcus O'Leary (Unit Manager at Acacia);
viii. Christopher Calverley (Acting Assistant Director at Acacia);
ix. Stephen Dillon (Residential Operations Manager at Acacia);
x. Julian Middlemiss (Unit Manager at Acacia);
xi. Toni Palmer (Senior Review Officer at the Department);
xii. Alan Chaney (Security Manager at Acacia);
xiii. Craig Moody (Deputy Director at Acacia);
xiv. Aaron Baker (prisoner at Acacia);

[1] *Prisons Act 1981* (WA) s 16
[2] *Coroners Act 1996* (WA) s 3 and s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)
[4] The cited positions of these witnesses are the positions they held at the relevant time.

xv. Pansey Stewart (Health Services Manager at Acacia); and

xvi. Dr Joy Rowland (Director, Medical Services, at the Department).

4 The documentary evidence comprised of three volumes of the brief, which was tendered as exhibit 1 at the inquest's commencement. A further two exhibits were tendered during the inquest and they became exhibit 2 and exhibit 3.

5 During the inquest, I asked the Department to provide a response to questions concerning Mr Hillstead's prospects of participating in the Violent Offender Treatment Program (VOTP). The Department responded to these matters by an emailed letter dated 19 April 2024.[5]

6 In addition, I sought some further information from Serco Australia Pty Ltd (Serco) regarding the presence of negotiators on 18 January 2021 at Acacia and whether any photographs of information on whiteboards at the command suite were taken as of 18 January 2021. Serco provided that information via its solicitors in an email to the Court on 5 July 2024.[6]

7 The inquest focused on the treatment and care provided to Mr Hillstead in the final weeks of his life regarding his tertiary education and the actions taken by Acacia custodial staff on the day of his death.

8 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities.

9 I am also mindful not to insert hindsight bias into my assessment of the actions taken by Department staff in their treatment and care of Mr Hillstead in the weeks before his death, and by Acacia custodial staff on the day of his death. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[7]

MR HILLSTEAD [8]

10 Mr Hillstead was born in Invercargill, New Zealand, on 24 July 1961. After completing school, he worked as a truck driver. By 1983, he had moved to live in Western Australia.

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[5] Email from Mr Berson to Counsel Assisting dated 19 April 2024

[6] Letter from Wotton Kearney to Counsel Assisting dated 5 July 2024

[7] Dillion H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

[8] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021; Exhibit 1, Volume 1, Tab 40, History for Court – Criminal and Traffic, Christopher John Hillstead; Exhibit 1, Volume 1, Tab 41.1, Sentencing transcript of Blaxell J dated 9 August 2006

11 Mr Hillstead had served previous terms of imprisonment in Western Australia for convictions that included assaults, burglaries, armed robbery and serious sexual offending.

Circumstances of Mr Hillstead's final imprisonment

12 Following a trial before a jury in the Perth Supreme Court, Mr Hillstead was convicted of the wilful murder of a 66-year-old man. This offence had occurred on 23 July 2002 and as the sentencing judge described: [9]

> It was a premeditated and cold-blooded killing by way of bludgeoning your victim to death and was preceded by other acts of physical violence and torture. The ordeal that [the victim] must have gone through is simply horrifying to contemplate.

13 On 9 August 2006, Mr Hillstead was sentenced to strict security life imprisonment with a minimum prison term of 25 years before parole eligibility. The sentence was backdated to 1 September 2003, which meant Mr Hillstead's earliest eligible date for parole was 31 August 2028.

Prison history for Mr Hillstead's final imprisonment

14 During the 18½ years of Mr Hillstead's final imprisonment he was placed in the following facilities:

- Hakea Prison: 28 July 2002 to 28 February 2005 (945 days)
- Casuarina Prison: 28 February 2005 to 3 July 2018 (4,873 days)
- Acacia Prison: 3 July 2018 to 18 January 2021 (930 days)

15 On 8 October 2008, Mr Hillstead attempted suicide by an overdose of suspected opioid medication and was transferred from Casuarina Prison (Casuarina) to the ICU at Royal Perth Hospital. He was diagnosed with brain hypoxia. Upon his return to Casuarina, a psychiatric review found no evidence of a major mental disorder or a need for psychiatric medication. It was noted that Mr Hillstead's main issue was anger management. Although no mental health follow-up was organised, he did have follow-up with counselling services at Casuarina.

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[9] Exhibit 1, Volume 1, Tab 41.1, Sentencing transcript of Blaxell J dated 9 August 2006, p.781

OVERVIEW OF MR HILLSTEAD'S TERTIARY STUDIES DURING HIS FINAL IMPRISONMENT [10]

16 After recovering from his suicide attempt in 2008, Mr Hillstead began his educational pursuits in Casuarina. Studying gave Mr Hillstead a strong future focus and he was an intelligent man who achieved very good academic results.

17 After Mr Hillstead completed a degree in finance, the Department's Tertiary Studies Assessment Committee (TSAC) approved his research proposal for a master's thesis in April 2017. This thesis was about art and design, with a focus on the ability of prisoners to express themselves and how artwork enabled those viewing the art and those creating the art to experience prison life differently.

18 Mr Hillstead undertook this thesis whilst at Casuarina through the Justice and Equity Through Art (JETA) program at Curtin University. He was able to continue his thesis after moving to Acacia in July 2018.

19 For his master's thesis, Mr Hillstead was supervised by an educator at Acacia and a lecturer from Curtin University. All outgoing contact with the lecturer was made through the Acacia staff member, with the lecturer having monthly meetings with Mr Hillstead in prison.

20 Mr Hillstead was housed in November Block at Acacia. This was a self-care unit for prisoners serving life sentences and who were employed within the prison. As Mr Hillstead's engagement in full-time tertiary study was considered to be employment, he was permitted to reside in November Block. He was placed in an upstairs pod that had six cells with a communal kitchen and living area. Access to the pod's entrance was via a flight of external stairs.

Disagreements emerge regarding Mr Hillstead's education

21 In 2020, Mr Hillstead provided the Department with a copy of a conference paper titled "Limited Depth Perception and Restricted Movement within the Prisons". He wanted to deliver this paper remotely at the 4th International Conference of Carceral Geography. In correspondence dated November 2020, the Department advised Mr Hillstead it would not be approving his proposed conference presentation as his research proposal was subject to conditions that included the prohibition of any publication of his paper for "*public distribution*".[11] Mr Hillstead did not accept this decision.

[10] Exhibit 1, Volume 1, Tabs 48.1- 48.5, Various letters from Dr Shona Hyde; Exhibit 1, Volume 3, Tab 1.6, Statement of Helena Zielinski dated 19 September 2023
[11] Exhibit 1, Volume 1, Tab 48.1, Letter from Dr Shona Hyde to counsel assisting dated 3 March 2023, p.1

22 By the end of 2020, Mr Hillstead was nearing completion of his thesis. Once he had finished his thesis, his very clearly stated goal was to apply for a Doctor of Philosophy (PhD).

23 In December 2020, another contentious issue arose in relation to Mr Hillstead's studies. On 31 December 2020, he was advised that after completing his thesis, his employment in Education would come to an end. In addition, Mr Hillstead was told he would only be able to continue his studies after completing the VOTP. Mr Hillstead refused to accept this proposal and he remained fixated on starting his PhD without participating in the VOTP.

24 A further area of contention involved letters that Mr Hillstead was attempting to send out from Acacia in late 2020. In those letters, which were intercepted by staff at Acacia, Mr Hillstead was seeking publication of his thesis.

25 On 21 December 2020, Helena Zielinski (Ms Zielinski), Manager, Education and Training at Acacia, and Stephen Dillon (Mr Dillon), Residential Operations Manager at Acacia, had a meeting with Mr Hillstead. He was advised his outgoing mail was being reviewed by Acacia staff. The following day, Mr Hillstead was provided with a letter from Mr Dillon detailing what mail would be placed in his property and not sent, and the reasons for that mail not being sent. As he believed he was being unfairly targeted, this decision caused further resentment from Mr Hillstead

26 On 6 January 2021, the Department's Research Application and Advisory Committee (RAAC) wrote to Mr Hillstead advising him that amendments would have to be made to his thesis. Mr Hillstead was opposed to making these changes.

EVENTS LEADING TO MR HILLSTEAD'S DEATH

27 At about 9.00 am on 14 January 2021, Ms Zielinski had a meeting with Mr Hillstead to advise him that his education period was coming to a close. Also at that meeting was Chelsea Rawlings (the Education Facilitator of Higher Education) and Tara Smallshaw (Ms Smallshaw), a custodial officer. Mr Hillstead was informed that his employment in Education as an external studies student would cease in three weeks' time. Mr Hillstead made it very clear that he had no intention of doing the VOTP and he did not accept the reasoning for him having to leave his employment position in Education.[12]

28 Ms Zielinski outlined what Mr Hillstead then did:[13]

[12] Exhibit 1, Volume 3, Tab 1.6, Statement of Helena Zielinski dated 19 September 2023, pp.6-7
[13] Exhibit 1, Volume 3, Tab 1.6, Statement of Helena Zielinski dated 19 September 2023, p.7

> As I was sitting in front of him, he stood up and towering over me, pointed at me aggressively and said: "*You need to get it through your fucking head that I'm not doing the fucking VOTP*".

29 Ms Smallshaw then asked Mr Hillstead to leave. In the corridor he swore again and went into the External Studies room, slamming the door.

30 Ms Zielinski submitted an incident report and Mr Hillstead was advised he had been internally charged for his abusive behaviour.[14]

31 Later that day, Mr Hillstead returned to November Block in an agitated state. As a result, Poonum Gulati (Ms Gulati), the acting Unit Manager at November Block, made a referral to Acacia's Psychological Wellbeing Service (PWS) which stated: "*Prisoner has requested support due to having ongoing issues with residing at Acacia due to his education classes.*"[15]

32 Following a discussion between Ms Gulati and Ellen Itzstein (Ms Itzstein), a Senior Social Worker at PWS, it was decided that Mr Hillstead was not a risk to himself or in need of an ARMS placement.[16] Instead, he was referred to the PWS and placed on a priority waitlist for an appointment with a counsellor.

33 On 15 January 2021, a PWS counsellor was assigned to Mr Hillstead. There was an expectation that Mr Hillstead would be seen by that counsellor in the week of his death;[17] however, that did not occur.[18]

34 At 10.32 am on 15 January 2021, Mr Hillstead had a telephone conversation with a friend. Such telephone conversations are routinely recorded by the prison. Mr Hillstead advised his friend that he would be charged for abusive behaviour which he hoped would have him moved back to Casuarina. He also threatened that if he was not transferred he intended to do something similar to what another prisoner (who he named) had done.[19] That prisoner had been recently charged for the attempted murder of another prisoner at Acacia.[20]

35 Over the weekend of 16 and 17 January 2021, Mr Hillstead's mood continued to deteriorate. An entry in his diary on 16 January 2021 stated: "*A weekend of sheer hell. I am feeling absolutely drowned and very concerned for my health and wellbeing.*"[21] On 17 January 2021, another diary entry read:[22]

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[14] Exhibit 1, Volume 3, Tab 1.6, Statement of Helena Zielinski dated 19 September 2023, p.8
[15] Exhibit 1, Volume 1, Tab 33, Email from Ellen Itzstein dated 19 January 2021, p.2
[16] ARMS is an acronym for At Risk Management System which is the Department's framework for suicide prevention that manages prisoners deemed to be at risk of self-harm or suicide.
[17] The week commencing Monday, 18 January 2021.
[18] Exhibit 1, Volume 1, Tab 33, Email from Ellen Itzstein dated 19 January 2021, p.2
[19] Exhibit 1, Volume 1, Tab 37, Transcripts of telephone conversations between Mr Hillstead and others, p.2
[20] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, p.6
[21] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, p.6

> I have never gone to where I am now. I am so content and at peace with myself yet full of anger and hatred for the system. I am very scared of what will happen next. This is not a good space. Thank fuck the screws have stayed away.

36 At 10.15 am on 18 January 2021, Mr Hillstead was called to report to the office of the Unit Manager for November Block (the Unit Manager's office). Unbeknown to Mr Hillstead, Christopher Calverley (Mr Calverley), Assistant Director at Acacia, had decided that Mr Hillstead was to be relocated immediately to the Detention Unit due to the threats he had made during his telephone conversation with his friend (as outlined above). Mr Calverley had arranged for three security officers to attend November Block with him to assist with Mr Hillstead's escort to the Detention Unit.

37 As Mr Hillstead approached the Unit Manager's office, he stopped when he saw the security officers and Mr Calverley. Mr Hillstead said words to the effect of "*No, fuck this*", and began walking back towards his pod. He refused to engage with custodial staff and walked up the stairway to his pod.[23]

38 When custodial staff followed Mr Hillstead, he responded by throwing items (including tins of food) from the landing to his pod and making threats. He refused to come out of the pod, instead challenging staff to come and get him. Mr Hillstead began to erect makeshift barricades to the stairway and entrance to his pod with furniture from inside the pod, which included refrigerators, a table and a couch. He also lubricated the steps of the stairway with soapy water.[24]

39 At 10.28 am, Mr Calverley called a Code Red.[25] A short time later, with no signs of Mr Hillstead willingly coming out of the pod, the Correctional Emergency Response Team (CERT) were called to attend with the task of extracting Mr Hillstead from the pod.

40 At about 11.10 am, Mr Hillstead shouted challenges and verbal abuse to Mr Dillon and Mr Calverley, at one point saying they would, "*get what's coming*".[26] This was the last time anything was heard from inside the pod. Thereafter, Mr Hillstead was not sighted and he did not respond to calls from custodial staff to communicate with them.[27]

41 After turning off the gas and water facilities to the pod, and having confirmed that Mr Hillstead was the only prisoner inside, CERT officers removed the

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[22] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, p.6
[23] Exhibit 1, Volume 3, Tab 1.31, Statement of Christopher Calverley dated 1 May 2023, p.4
[24] Exhibit 1, Volume 3, Tab 1.31, Statement of Christopher Calverley dated 1 May 2023, pp.5-6
[25] A call over the prison radio following a disruption to the prison's routine operation that requires additional staff.
[26] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, p.7
[27] Exhibit 1, Volume 3, Tab 1.27, Serco Post Incident Review dated 26 March 2021, p.11

barricades from the stairway and made their way into the pod at 11.35 am. Although the door to the pod was open, it was obstructed by a table and a couch. Once those obstacles were removed, CERT officers found Mr Hillstead hanging from the door of a cell inside the pod by a ligature made from a prison bed sheet.[28] He was unresponsive.

42 A Code Blue was called[29] and the ligature was removed with CPR immediately started by two CERT officers. Prison health staff attended within minutes of the Code Blue and provided further medical attention to Mr Hillstead, including the application of an automatic external defibrillator and intravenous adrenalin. Despite continuous resuscitation efforts, Mr Hillstead could not be revived.[30] He was certified life extinct at 12.01 pm on 18 January 2021 by the prison doctor.[31]

CAUSE AND MANNER OF DEATH [32]

43 Dr Clive Cooke and Dr Joe Ong, two forensic pathologists, conducted a post mortem examination upon Mr Hillstead's body on 1 February 2021.

44 The examination found a ligature-type marking to Mr Hillstead's neck. There was also fracturing on the throat (larynx) involving the bone (right superior horn of hyoid bone) and cartilage (right superior horn of thyroid cartilage) at the front of his neck. Several superficial cuts were present to the left side of Mr Hillstead's neck and his right wrist. There was evidence of medical intervention, including the use of CPR.

45 A toxicological analysis of blood and urine samples from Mr Hillstead detected no alcohol or common illicit drugs.

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

47 I accept and adopt the opinion expressed by the forensic pathologists as to the cause of Mr Hillstead's death.

48 I am satisfied that Mr Hillstead encountered a major upheaval in his life when he was told he would not be able to continue with his education until such time as he completed the VOTP. His diary entries and telephone

[28] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, p.7
[29] A call over the prison radio to indicate a medical emergency.
[30] Exhibit 1, Volume 1, Tab 2, Coronial Investigation Squad Report dated 13 June 2021, pp.7-8
[31] Exhibit 1, Volume 1, Tab 3, Life Extinct Certification
[32] Exhibit 1, Volume 1, Tabs 5.1-5.3, Supplementary Post Mortem Report dated 1 February 2021, Full Post Mortem Report dated 1 February 2021, Interim Post Mortem Report dated 1 February 2021; Exhibit 1, Volume 1, Tabs 7.1 and 7.2, Supplementary Toxicology Report dated 21 May 2021 and Toxicology Report dated 10 February 2021

conversations with friends in the days before his death demonstrated he was extremely frustrated with what was occurring and that his life was "*sheer hell*". I also note the observation expressed by Dr Adam Brett (Dr Brett), an independent consultant psychiatrist engaged by the Court, that although Mr Hillstead's hypoxic brain injury in 2008 did not impact his academic functioning, it "*may have made him more impulsive and have impaired executive functioning.*"[33]

49 Based on all the information available, I find that Mr Hillstead's death occurred by way of suicide when he used a bed sheet to create a ligature by which he hanged himself using a cell door as a ligature point.

ISSUES RAISED BY THE EVIDENCE

Was the Department's response to Mr Hillstead's plan to undertake a PhD reasonable?

50 I am satisfied that the position taken by the Department regarding Mr Hillstead's refusal to complete the VOTP was appropriate.

51 I accept that since 2017, Mr Hillstead had been saying he would complete the VOTP once he had completed his education. I am satisfied the Department was justified to understand this to be a reference to Mr Hillstead completing his master's degree, as distinct from any future intention he had to undertake a PhD.[34] There are documented entries to that effect, which included the following.

52 On 7 July 2017, a Treatment Assessment Report for Mr Hillstead recommended that his participation in the VOTP be deferred until he had completed his studies at that time (i.e. his thesis).[35]

53 On 2 July 2018, Mr Hillstead, in the course of making a complaint, was noted as saying:[36]

> … he wants to defer the [VOTP] program until 2019 in order to finish his Master of Philosophy degree. He says that over the last few years he has been allowed to defer his program to continue studying for his degree, but this transfer was organised without his knowledge.[37] He advised that he does not want to refuse the program, just defer it.

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[33] Exhibit 1, Volume 1, Tab 11.1, Report from Dr Adam Brett dated 27 June 2023, p.9
[34] Ts 13.3.24 (closing submissions of Mr Berson), p.298
[35] Exhibit 1, Volume 1, Tab 54.4, Individual Management Plan dated 6 April 2020, p.2
[36] Exhibit 1, Volume 1, Tab 55.3, Email from Complaints Access dated 2 July 2018, p.4
[37] Mr Hillstead's transfer from Casuarina to Acacia.

54 As late as 6 April 2020, Mr Hillstead had stated he was prepared to participate in the VOTP at the completion of his education.[38]

55 I also note that a compromise was offered by the Department to Mr Hillstead. This was outlined by Sandra Lewry, Sentence Management Manager at Acacia:[39]

> I remember discussing with the external studies coordinator and education manager at Acacia and people at the Department, I think Christine Laird and Brian Ellis, the possibility of Mr Hillstead continuing to do research for his PhD while he undertook the VOTP and before he enrolled in the PhD program. I also remember having this discussion with Mr Hillstead.
>
> However, I believe Mr Hillstead instead wanted to enrol.

56 As at the end of 2020, Mr Hillstead still had some way to go in his preparation to undertake a PhD. He had not completed his thesis, he had not been advised by the RAAC that it required him to amend the thesis, he had not settled on a topic for his PhD, and he had not submitted an application to do the PhD. Consequently, a particular topic had not even been endorsed, as required by the RAAC and TSAC, and accepted by Curtin University.[40]

57 At the inquest, I had expressed a view that the reasonableness of the compromise offered by the Department ought to be measured by when it would have been possible for Mr Hillstead to enrol and then complete the VOTP. At the conclusion of the inquest, I sought the following information from the Department: (i) after November 2020, the earliest date that Mr Hillstead would have been able to commence the VOTP and (ii) what did the Department consider to be the completion of the VOTP for the purposes of Mr Hillstead being able to commence his PhD?

58 The Department advised that: [41]

> First, the next available VOTP that Mr Hillstead could have participated in commenced on 2 March 2021 and concluded on 5 August 2021. There was an earlier course that commenced in November 2020, but that course was fully booked.
>
> Second, the Department considered the completion of the VOTP for the purposes of Mr Hillstead being able to move on to his PhD as completion of the course requirements. That is, if Mr Hillstead had participated in the March VOTP course, he would have completed that course on 5 August 2021. It would not have included any subsequent assessment by a forensic pathologist.

[38] Exhibit 1, Volume 1, Tab 54.1, CM 5 - Regular Contact Report created 18 October 2020
[39] Exhibit 1, Volume 2, Tab 5, Statement of Sandra Lewry dated March 2024 (unsigned), p.4
[40] Ts 13.3.24 (Ms Palmer), p.221
[41] Letter from Mr Berson to counsel assisting dated 19 April 2024

59 In those circumstances, I am satisfied that the compromise offered by the Department to Mr Hillstead was reasonable. There was a VOTP available within several months, which took five months to complete. Had he accepted the compromise, Mr Hillstead would have been able to use this five-month period to take the necessary preparatory steps, including the completion of his thesis, before he was even in a position to commence his PhD.

60 I also note that Mr Hillstead's prospects for parole eligibility would have been enhanced had he completed the VOTP. He therefore should have had an incentive to do it. It was also in the community's interest that he complete the VOTP before consideration be given to his release from prison.

61 The manner in which Mr Hillstead murdered his victim in 2002 was particularly abhorrent and gratuitously violent.[42] He also had other convictions that were violent in nature.[43] The sentencing judge for the wilful murder conviction addressed Mr Hillstead during the sentencing remarks in this way: "*This background, combined with the particular circumstances of the present offence, indicate to me that you do represent a serious future risk to the community.*"[44] In those circumstances, I am satisfied it was an entirely reasonable requirement from the Department that Mr Hillstead complete the VOTP before he was permitted to undertake any further studies.

Was the response by PWS on 14 January 2021 appropriate?

62 At the inquest, Ms Gulati described Mr Hillstead's demeanour after his meeting with Ms Zielinski on 14 January 2021 as angry and very frustrated, and that she had not seen him behaving like this before.[45] Ms Gulati also clarified that despite the written reference to Mr Hillstead requesting support from PWS on 14 January 2021,[46] he had actually declined assistance from PWS and it was her decision to do the referral to PWS, "*as a safety precaution to assist him in getting counselling to, you know, work through those anger and frustration - those issues that he was facing at the time*."[47]

63 When Ms Gulati was asked why she initially regarded the situation as "*urgent*", she stated:[48]

> I think it was more-yes, at the time I did think it was urgent because of the level of anger he was expressing at that time, and that is why I thought - not

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[42] Exhibit 1, Volume 1, Tab 41.1, Sentencing transcript of Blaxell J dated 9 August 2006
[43] Exhibit 1, Volume 1, Tab 40, History for Court – Criminal and Traffic, Christopher John Hillstead
[44] Exhibit 1, Volume 1, Tab 41.1, Sentencing transcript of Blaxell J dated 9 August 2006, p.781
[45] Ts 11.3.24 (Ms Gulati), p.89
[46] Exhibit 1, Volume 1, Tab 33, Email from Ellen Itzstein dated 19 January 2021, p.2
[47] Ts 11.3.24 (Ms Gulati), p.90
[48] Ts 11.3.24 (Ms Gulati), pp.90-91

> purely if he was going to harm himself, but more would he do anything to, you know, anyone else or to education or anything like that. It was more around that, not directly to himself.
>
> …
>
> It was more around damaging property, more so, because of the level of anger that he was expressing initially.

64 Ms Gulati also confirmed that she had directly asked Mr Hillstead if he was considering self-harm, which he denied.[49]

65 At the inquest, Ms Itzstein explained the reason why Mr Hillstead was not given an urgent appointment and seen on 14 January 2021:[50]

> We get quite a few requests for urgent appointments, and that's part of my role as the senior to, I guess, triage that and figure out if that urgency was required. And the way that PWS works as a service is our urgent response is a suicide risk assessment.
>
> …
>
> So, it's more a question around that acute risk. And when I was talking to Poonum [Gulati] about Mr Hillstead it was would he benefit from a suicide risk assessment or would he benefit from a counselling appointment in which he can vent his frustration, discuss strategies to deal with his anger and work through those types of things. So that was part of the discussion between Poonum and myself around what is best suited for Mr Hillstead at the time. And we came to that conclusion together that it seemed more appropriate for us to offer him the counselling intervention as opposed to a suicide risk assessment.

66 In all the circumstances, particularly Mr Hillstead's denial he had any thoughts of self-harm and the evidence from Ms Gulati that he had not requested an urgent appointment with a counsellor, I am satisfied that the arrangements for Mr Hillstead to see a counsellor in the following week (rather than immediately) was appropriate.

Was Mr Hillstead's intended transfer to the Detention Unit on 18 January 2021 adequately planned?

67 After his outburst on 14 January 2021, Mr Hillstead would have been aware his placement within November Block was under review as Ms Gulati had conveyed that to him later that day.[51] Early on the day of his death, Mr Hillstead had told a friend in a telephone conversation that he anticipated

[49] Ts 11.3.24 (Ms Gulati), p.91
[50] Ts 11.3.24 (Ms Itzstein), p.82
[51] Exhibit 1, Volume 1, Tab 57, Incident Report Minutes dated 14 January 2021

being moved to the Detention Unit, stating: "*I'm going to go and pack my cell up because I don't think I'm going to be here much longer, mate*."[52]

68 The transfer of a prisoner to the Detention Unit is a standard operating practice at Acacia whilst an alleged threat by the prisoner is investigated.[53] Unfortunately, the three security officers who were to assist with the escort of Mr Hillstead to the Detention Unit on 18 January 2021 were visible to him as he was walking to the Unit Manager's office. This sighting occurred when Mr Hillstead was still outside of an area that could have been securely contained. The presence of the security officers undoubtedly alerted Mr Hillstead to the likely purpose of the meeting, and gave him the opportunity to retreat back into his pod that was only a short distance away.

69 Mr Calverley accepted that in regard to Mr Hillstead's transfer to the Detention Unit, "*there are things that perhaps could have been done better*".[54] At the inquest, he outlined that those things included Mr Hillstead being called to attend the meeting in a different manner, the security officers standing in a different location and the gates locked once Mr Hillstead had entered the building where the Unit Manager's office was located.[55]

70 I am satisfied it would not have been foreseeable to custodial staff that Mr Hillstead's reluctance to attend the meeting would lead to him barricading himself within his pod or, more significantly, making the decision to end his life.

71 Nevertheless, I am satisfied there was a missed opportunity to ensure that the presence of three security officers was not known to Mr Hillstead until after he had entered the Unit Manager's office or at the very least, the building where this office was located. I therefore agree with the observation from the Post Incident Review performed by Serco (the Post Incident Review) that: "*This was not a failing by staff but an opportunity for learning*."[56]

CHANGES AND IMPROVEMENTS SINCE MR HILLSTEAD'S DEATH

72 The Court recognises that prisons are always on the pathway of continual improvements following the death of a prisoner in their care. Given there is ordinarily a gap of some duration between the date of the prisoner's death and the inquest's date, a prison connected to the death will often implement

[52] Exhibit 1, Volume 1, Tab 37, Transcripts of telephone conversations between Mr Hillstead and others, p.3
[53] Serco Post Incident Review dated 26 March 2021, p.8
[54] Exhibit 1, Volume 3, Tab 1.31, Statement of Christoper Calverley dated 1 May 2023
[55] Ts 12.3.24 (Mr Calverley), p.154
[56] Exhibit 1, Volume 3, Tab 1.27, Serco Post Incident Review dated 26 March 2021, p.14

changes that are designed to improve practices and procedures before the inquest is heard. Acacia had done that with respect to Mr Hillstead's death.

73 The Post Incident Review made six recommendations arising from the matter in which Acacia custodial staff dealt with Mr Hillstead after he had barricaded himself in his pod.[57] The most significant recommendation was the creation of a dedicated command suite which would provide an "all systems" access when a Code Blue is activated in similar circumstances to Mr Hillstead's incident on 18 January 2021.[58]

74 I am advised that there is now a dedicated command suite at Acacia that not only has an all systems access but also access to live-stream body camera footage worn by CERT officers involved in the incident.[59] In addition, the CERT training schedule now includes training to deal with barricades.[60]

75 I commend Serco for implementing the recommendations made in the Post Incident Review.

76 I had considered several recommendations during the course of the inquest. However, upon further reflection and a review of the information available, I have decided not to make any of those recommendations.

77 However, I will draw attention, as I and other coroners have done in many previous inquests, to the fact that the number of staff in mental health and psychological services in the prison setting remains woefully inadequate in this State. I was most concerned to hear Ms Itzstein's evidence that as at the time of the inquest, a prisoner waiting for priority counselling, which was not a suicide risk assessment, would need to wait two months for an appointment at Acacia.[61]

SUPERVISION, TREATMENT AND CARE OF MR HILLSTEAD

78 As Dr Brett noted: "*There are significant therapeutic benefits to prisoners having access to ongoing education, particularly higher education. This gives prisoners meaning and structure.*" [62] That observation was particularly relevant to Mr Hillstead. Nevertheless, he was a difficult prisoner to manage with respect to his educational expectations. As Mr Dillon noted at the inquest: "*When everything was going swimmingly for Chris, he was easy to*

[57] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody Report dated February 2024, p.25
[58] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody Report dated February 2024, p.25
[59] Ts 13.3.24 (Mr Moody), p.252
[60] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody Report dated February 2024, p.26
[61] Ts 11.3.24 (Ms Itzstein), p.82
[62] Exhibit 1, Volume 1, Tab 11.1, Report of Dr Adam Brett dated 27 June 2023, p.10

get along with ... the moment he hit a blockage of some sort, it was a different Chris turned up, or maybe the real Chris turned up."[63]

79 I am satisfied that the Department's treatment of Mr Hillstead with respect to his educational pursuits was appropriate. I am also satisfied that he had made a commitment that he would participate in the VOTP once he had completed his thesis. However, by the end of 2020, he had resiled from that commitment. In addition, I am satisfied with the efforts made by the Department to reach a reasonable compromise with Mr Hillstead, a compromise which he rejected.

80 I also accept Dr Brett's conclusion that Mr Hillstead's suicide was not predictable[64] and his observations that:[65]

> Suicide is a rare event and extremely difficult to predict. Risk management in suicide does not focus on prediction but in management of risk factors due to this reason. This includes screening for depression or managing stress. It also focuses on protective factors that reduce the risk of suicide. It was documented that education and meaningful activity would reduce his risk of suicide. It was also documented that in his particular case, it was very difficult to assess his level of risk.

81 In addition, I am satisfied, with the exception of one missed opportunity, that the actions taken by Acacia custodial staff on the day of Mr Hillstead's death was appropriate. I am also satisfied that the resuscitation efforts on Mr Hillstead by, initially CERT officers, and then Acacia medical staff were appropriate. Unfortunately, despite these maximal efforts, Mr Hillstead could not be revived.

CONCLUSION

82 The Post Incident Review into Mr Hillstead's death included the following passages:[66]

> Prisoner Hillstead was resolved to being in custody for the rest of his life. In reviewing his offender notes relating to past behaviour, the prisoner presents as what could be descried as "high maintenance".
>
> These styles of prisoners create dynamic challenges for prison management. This prisoner presented with consistent complaints about his involvement in his educational progress, a belief that being at a different prison (Casuarina) would solve his issues, his mail being intercepted based on his reluctance to

[63] Ts 12.3.24 (Mr Dillon), p.160
[64] Exhibit 1, Volume 1, Tab 11.1, Report of Dr Adam Brett dated 27 June 2023, p.10
[65] Exhibit 1, Volume 1, Tab 11.1, Report of Dr Adam Brett dated 27 June 2023, p.9
[66] Exhibit 1, Volume 3, Tab 1.27, Acacia Prison Post Incident Review Report dated 26 March 2021, pp.16-17

> accept his thesis material will not be published, all lead to how prisons manage prisoners with perceived greater needs.
>
> Education was not denied to this prisoner but his progression was prevented by his own actions. This impasse exacerbated the conflict between the prisoner and the staff.

83 That is an accurate summary of the issues facing staff at the Department and Acacia with respect to the management of Mr Hillstead.

84 I accept Mr Dillon's account at the inquest that his impression was that in the period before his death, Mr Hillstead felt he was being "*held back*" regarding his education. This caused increased anxiety and resulted in the unanticipated escalation in Mr Hillstead's behaviour on 18 January 2021.[67]

85 With the information available to them at the time, I am satisfied it would not have been possible for staff involved in overseeing Mr Hillstead's education and for Acacia custodial staff to predict the outcome of the events on 18 January 2021. Even Mr Hillstead himself could not, describing to a friend several hours before his death, how he would "*try and keep a cap on the volcano.*" [68]

86 I have found that the Department's treatment of Mr Hillstead with respect to his educational pursuits was appropriate. I am also satisfied that save and except for one missed opportunity, the manner in which Mr Hillstead was handled by Acacia custodial staff on the day of his death was appropriate.

87 I extend my sympathies to Mr Hillstead's family for their loss.

PJ Urquhart
Coroner
3 January 2025

[67] Ts 12.3.24 (Mr Dillon), p.163
[68] Exhibit 1, Volume 1, Tab 37, Transcripts of telephone conversations between Mr Hillstead and others, p.4