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**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA  
**ACT** : CORONERS ACT 1996  
**CORONER** : MICHAEL ANDREW GLIDDON JENKIN, ACTING  
DEPUTY STATE CORONER  
**HEARD** : 31 MARCH 2026  
**DELIVERED** : 28 APRIL 2026  
**FILE NO/S** : CORC 278 of 2024  
**DECEASED** : DEVREE, COREY DESMOND

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*Legislation:*

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

**Counsel Appearing:**

Ms E Lynch appeared to assist the coroner.

Ms P Femia (State Solicitor's Office) appeared on behalf of Department of Justice.

**SUPPRESSION ORDER**

On the basis that it would be contrary to the public interest there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Bunbury Regional Prison on or about 14 October 2024. Any such prisoner is to be referred to as "Prisoner [Surname Initial]".

Order made by: MAG Jenkin, Acting Deputy State Coroner (31.03.26)

Coroners Act 1996  
(Section 26(1))

## RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Acting Deputy State Coroner, having investigated the death of **Corey Desmond DEVREE** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 31 March 2026, find that the identity of the deceased person was **Corey Desmond DEVREE** and that death occurred on 14 October 2024 at Bunbury Regional Prison, Centenary Road, Bunbury, from ligature compression of the neck (hanging) and penetrating sharp force injury (stab wound) to the chest in the following circumstances:*

### Table of Contents

<b>INTRODUCTION</b> .....	<b>3</b>
<b>COREY</b> .....	<b>4</b>
<i>Background and medical history</i> .....	4
<i>Criminal history</i> .....	6
<i>Circumstances of last incarceration</i> .....	6
<b>EVENTS LEADING TO COREY’S DEATH</b> .....	<b>10</b>
<i>Corey attends Paint Shop</i> .....	10
<i>Corey is found</i> .....	11
<b>CAUSE AND MANNER OF DEATH</b> .....	<b>14</b>
<b>LESSONS LEARNED WORKSHOP</b> .....	<b>15</b>
<i>Overview</i> .....	15
<i>Lessons learned</i> .....	16
<b>ISSUES ARISING FROM THE EVIDENCE</b> .....	<b>19</b>
<i>Overview</i> .....	19
<i>Delays in completing Corey’s treatment assessment</i> .....	19
<i>Response to hearing voices and request for an appointment</i> .....	25
<i>Supervision of prisoners in Paint Shop</i> .....	27
<b>QUALITY OF SUPERVISION, TREATMENT AND CARE</b> .....	<b>29</b>
<i>Overview</i> .....	29
<i>Quality of treatment and care</i> .....	29
<i>Quality of supervision</i> .....	30
<i>Was Corey’s Death Preventable?</i> .....	31
<b>RECOMMENDATIONS</b> .....	<b>32</b>
<i>Recommendation No. 1</i> .....	32
<i>Recommendation No. 2</i> .....	32
<i>Recommendation No. 3</i> .....	33
<i>Recommendation No. 4</i> .....	33
<i>Comments on recommendations</i> .....	34
<b>CONCLUSION</b> .....	<b>36</b>

## INTRODUCTION

1. Mr Corey Desmond Devree (Corey)<sup>1</sup> died at Bunbury Regional Prison (BRP) on 14 October 2024 from ligature compression of the neck and a self-inflicted stab wound to the chest.<sup>2,3,4,5,6,7,8,9</sup>
2. At the time of his death, Corey was a sentenced prisoner at BRP and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (the Department). As a result, immediately before his death Corey was a “*person held in care*” within the meaning of the *Coroners Act 1996* (WA) and his death was a “*reportable death*”.<sup>10</sup>
3. In such circumstances, a coronial inquest is mandatory and where (as here) the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.<sup>11</sup>
4. Members of Corey’s family attended the inquest I conducted into his death on 31 March 2026 in Perth. The documentary evidence comprised one volume, and the following witnesses gave evidence:
  - a. Mr M Rampin, Vocational Support Officer, BRP;<sup>12</sup>
  - b. Mr J George, Paramedic, St John Ambulance WA;<sup>13</sup>
  - c. Mr B Goff, Case Management Coordinator, BRP;<sup>14</sup>
  - d. Ms T Palmer, Senior Review Officer;<sup>15</sup>
  - e. Dr C Gunson, Deputy Director Medical Services;<sup>16</sup> and
  - f. Mr D Brampton, Deputy Commissioner, Operational Support.<sup>17</sup>

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<sup>1</sup> At the request of his family, the deceased was referred to as “Corey” during the inquest and in this finding.

<sup>2</sup> Section 16, *Prisons Act 1981* (WA) & sections 3, 22(1)(a) and 25(3), *Coroners Act 1996* (WA)

<sup>3</sup> Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (22.10.24)

<sup>4</sup> Exhibit 1, Vol 1, Tab 3, P92 - Identification of Deceased Person by Other than Visual Means (19.10.24)

<sup>5</sup> Exhibit 1, Vol 1, Tab 3, P92 - Identification of Deceased Person by Visual Means (14.10.24)

<sup>6</sup> Exhibit 1, Vol 1, Tab 3, Affidavit - Sen. Const. B Honner (19.10.24)

<sup>7</sup> Exhibit 1, Vol 1, Tab 3, Affidavit - Sen. Const. R Meeks (17.10.24)

<sup>8</sup> Exhibit 1, Vol 1, Tab 4, Life Extinct Form (14.10.24)

<sup>9</sup> Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (31.01.25)

<sup>10</sup> s16, *Prisons Act 1981* (WA) & s3, *Coroners Act 1996* (WA)

<sup>11</sup> ss22(1)(a) & 25(3), *Coroners Act 1996* (WA)

<sup>12</sup> Exhibit 1, Vol 1, Tabs 9 & 37.7, Statements - Mr M Rampin (14.10.24 & 12.01.26) & ts 31.03.26 (Rampin), pp8-28

<sup>13</sup> Exhibit 1, Vol 1, Tab 17, Statement - Mr J George (14.10.24) & ts 31.03.26 (George), pp28-35

<sup>14</sup> Exhibit 1, Vol 1, Tabs 41 & 41.1, Statements - Mr B Goff (20.02.26 & 25.03.26) & ts 31.03.26 (Goff), pp36-48

<sup>15</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26) & ts 31.03.26 (Palmer), pp49-60

<sup>16</sup> Exhibit 1, Vol 1, Tab 42, Health Services Review (23.03.26) & ts 31.03.26 (Gunson), pp60-71

<sup>17</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26) & ts 31.03.26 (Brampton), pp71-87

COREY

*Background and medical history*<sup>18,19,20,21,22,23</sup>

5. Corey was born in Lake Grace on 6 March 1983 and was 41 years of age when he died. Corey was the eldest of four children, and left school during Year 11. Corey undertook an apprenticeship as an auto body technician, but he worked in the agricultural sector for most of his adult life. Corey had a son from a previous long-term relationship, and he maintained regular contact with members of his family.
6. Corey smoked tobacco cigarettes and had been a heavy drinker of alcohol, although he reported giving up drinking in 2015. Corey also had a history of using cannabis and methylamphetamine.
7. On 14 September 2022, Corey was admitted to Fiona Stanley Hospital (FSH) for just under one month following an incident in which he stabbed himself repeatedly with a “Stanley knife”. Corey sustained deep lacerations to both arms and his left thigh, chest, neck and cheek.
8. The history recorded in the FSH discharge summary states:

[R]ecent release from prison on parole. Today was due to undergo drug test and stated that he was likely to fail and therefore go back to prison. ?drugs on board and self-harmed with Stanley knife. Uncertain circumstances around injury and not known if this incident was witnessed by anyone. Seen at Lake Grace nursing post.<sup>24</sup>
9. Corey was diagnosed with “*drug-induced psychosis*” and “*polysubstance abuse*”, and he underwent numerous surgical procedures to repair damaged muscles and tendons and receive various skin grafts. Corey’s past psychiatric history was recorded by FSH as: “*Polysubstance use disorder and substance induced psychotic disorder*”.<sup>25,26</sup>

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<sup>18</sup> Exhibit 1, Vol 1, Tab 24, EcHO Medical Records (14.10.24), p2

<sup>19</sup> Exhibit 1, Vol 1, Tab 30, Fiona Stanley Hospital - Discharge Summary (11.10.22)

<sup>20</sup> Exhibit 1, Vol 1, Tab 32, Report - Dr W Oyewopo (16.09.18)

<sup>21</sup> Exhibit 1, Vol 1, Tab 33, Medical Records - Woodlake Village Medical Centre

<sup>22</sup> Exhibit 1, Vol 1, Tab 40, Report - Dr K Palmer (24.03.26)

<sup>23</sup> Exhibit 1, Vol 1, Tab 42, Health Services Review (23.03.26) & ts 31.03.26 (Gunson), pp60-71

<sup>24</sup> Exhibit 1, Vol 1, Tab 30, Fiona Stanley Hospital - Discharge Summary (11.10.22), p1

<sup>25</sup> Exhibit 1, Vol 1, Tab 30, Fiona Stanley Hospital - Discharge Summary (11.10.22)

<sup>26</sup> See also: Exhibit 1, Vol 1, Tab 28, Consultation Notes - Dr O Olumide (02-23.11.22)

10. Although Corey denied any significant psychiatric history or history of suicidal or self-harm ideation, in 2018 he was reviewed by a psychiatrist in relation to “anger management”. Corey described fleeting feelings of paranoia and was diagnosed with: “*Chronic Dysthymia on the background of Cluster B Personality structure and anger dyscontrol*”.<sup>27,28</sup>

11. A consultant psychiatrist (Dr K Palmer) assessed Corey on 18 October 2023 for the purposes of preparing a sentencing report for the District Court of Western Australia (District Court). Dr Palmer noted that at the time of her review, Corey was not under the care of a GP, psychiatrist, or mental health service and he had never been admitted to a psychiatric unit. Dr Palmer said this about Corey’s mental health history:

(Corey) had a history of polysubstance use, particularly methamphetamine and alcohol, past episodes of methamphetamine-induced psychosis, antisocial personality disorder, and possible untreated attention deficit hyperactivity disorder (ADHD). In my report I recorded that he had longstanding problems with impulsivity and attention dating back to childhood but had never undergone formal ADHD assessment.<sup>29</sup>

12. On examination, Dr Palmer found Corey was “*settled, pleasant and cooperative*”, and there was no evidence of thought disorder, psychotic symptoms, or self-harm ideation. On that basis, Dr Palmer considered that Corey did not require any psychotropic medications, and she listed his diagnoses as:

- Substance use disorder involving methamphetamine and alcohol
- Past episodes of drug-induced psychosis
- Antisocial personality disorder
- Possible untreated attention deficit hyperactivity disorder.<sup>30</sup>

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<sup>27</sup> Exhibit 1, Vol 1, Tab 28, Consultation Notes - Dr O Omoniyi (17.01.18 - 04.09.18)

<sup>28</sup> Exhibit 1, Vol 1, Tab 32, Report - Dr W Oyewopo (16.09.18), p2

<sup>29</sup> Exhibit 1, Vol 1, Tab 40, Report - Dr K Palmer (24.03.26), p2

<sup>30</sup> Exhibit 1, Vol 1, Tab 40, Report - Dr K Palmer (24.03.26), p2

***Criminal history***<sup>31,32,33,34</sup>

13. Corey had an extensive criminal history with 30 convictions for various offences including: burglary, criminal damage, aggravated assault, and traffic offences. Corey received fines and various community orders in relation to these offences.

***Circumstances of last incarceration***<sup>35,36,37,38</sup>

14. On 27 March 2023, On 1 December 2023, Corey appeared in the District Court and was sentenced to a term of 28 months' imprisonment in relation to the domestic violence offences of aggravated indecent assault, and strangulation. Corey's term was backdated to 27 March 2023 (to take account of the time he had spent on remand) and his earliest release date on parole was calculated as 25 May 2024. Corey's prison term expired on 26 July 2025.
15. After Corey had been sentenced, he was transferred to Hakea Prison where he underwent an At-Risk Management System (ARMS) Reception Intake Assessment.
16. From previous inquests I have conducted, I am aware that ARMS is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.
17. When a prisoner is received at a prison, an experienced prison officer (reception officer), conducts a formal assessment designed to identify any presenting risk factors. Within 24 hours of arriving at a prison, the prisoner's physical health needs are assessed by a nurse. When it is deemed necessary to manage a prisoner on ARMS, an interim management plan is developed and the prisoner is managed with observations at either high, moderate or low levels.<sup>39</sup>

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<sup>31</sup> Exhibit 1, Vol 1, Tab 2.1, Report - Det. FC Const. A Wroe (20.06.25), p12

<sup>32</sup> Exhibit 1, Vol 1, Tab 32, Report - Dr W Oyewopo (16.09.18), p2

<sup>33</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), p9

<sup>34</sup> Exhibit 1, Vol 1, Tab 37.3, History for Court - Criminal & Traffic (compiled on 07.10.25)

<sup>35</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), pp9-10

<sup>36</sup> Exhibit 1, Vol 1, Tab 37.3, History for Court - Criminal & Traffic (compiled on 07.10.25)

<sup>37</sup> Exhibit 1, Vol 1, Tab 37.4, Sentence Summary (06.12.23)

<sup>38</sup> Exhibit 1, Vol 1, Tab 37.5, Management & Placement Report - Sentenced (11.12.234)

<sup>39</sup> ARMS Manual 2019

18. ARMS observation levels were previously: high (one or 2-hourly), moderate (6-hourly) and low (12-hourly), but in mid-2016, ARMS observation levels were changed to: high (one-hourly), moderate (2-hourly) and low (4-hourly).<sup>40</sup>
19. During his ARMS assessment, Corey was asked a series of questions to determine his risk level. Although Corey disclosed attempting self-harm “*over one year ago*”, he denied any current suicidal ideation. At the conclusion of the assessment, the reception officer made the following entry in Corey’s ARMS Reception Intake Assessment form:
- (Corey) did not present as a risk of self-harm or suicide in my interview. There were no statements or any ideation made referring to self-harm at the time of interview. (Corey) was cooperative and answered all questions during my interview. (Corey) had made good eye contact and was very focused and had clear plans for his future. Nil recommendations or concern relating to self-harm.<sup>41</sup>
20. Despite the fact that Corey disclosed a previous self-harm event to a reception officer during his ARMS intake assessment and to medical staff (likely a reference to the 14 September 2022 incident) no one requested a copy of his FSH discharge summary or any other medical records. This is regrettable as these documents would have provided relevant information about Corey’s previous mental health history.
21. During Corey’s incarceration at BRP, he was employed as a unit worker, and then as a Paint Shop worker, and he was the subject of various alerts related to his domestic violence offences. Corey did not commit any prison offences and he was not the subject of any random substance use testing. Whilst at BRP, Corey received a number of visits, and he maintained regular contact with his family using the Prisoner Telephone System.<sup>42,43,44,45,46,47</sup>

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<sup>40</sup> ARMS Manual 1998 & ARMS Manual 2019

<sup>41</sup> Exhibit 1, Vol 1, Tab 37.2, ARMS Reception Intake Assessment (01.12.23), pp3 & 5-6

<sup>42</sup> Exhibit 1, Vol 1, Tab 37.39, Work History - Offender (01.12.23 - 14.10.24)

<sup>43</sup> Exhibit 1, Vol 1, Tab 37.34, Alert History - Offender (01.12.23-14.10.24)

<sup>44</sup> Exhibit 1, Vol 1, Tab 37.35, Loss of Privileges - Prisoner Report (01.12.23-14.10.24)

<sup>45</sup> Exhibit 1, Vol 1, Tab 37.36, Substance Use Tests Results - Prisoner Report (01.12.23-14.10.24)

<sup>46</sup> Exhibit 1, Vol 1, Tab 37.37, Visit History - Offender (01.12.23-14.10.24)

<sup>47</sup> Exhibit 1, Vol 1, Tab 37.38, Prisoner Telephone Call Report (01.12.23-14.10.24)

22. Corey was described as a polite person who maintained a low profile on his unit, and interacted appropriately with other prisoners. Departmental records also noted that Corey maintained his personal and cell hygiene to an acceptable standard.<sup>48,49</sup>
23. Corey's management during his incarceration as a sentenced prisoner may be summarised as follows:
- a. **9 January 2024:** Corey was transferred to BRP.<sup>50</sup>
  - b. **18 January 2024:** during an orientation checklist process, Corey advised that his family were aware he was at BRP and he would receive visits from them.<sup>51</sup>
  - c. **5 February 2024:** during an education and vocational training assessment, Corey reported that he was a qualified auto body technician (panel beater and spray painter).<sup>52</sup>
  - d. **22 April 2024:** the Prisoner Review Board advised Corey that his application for parole (which had not been supported during a review on 3 April 2024) was refused due to unmet family violence treatment needs.<sup>53,54</sup>
  - e. **25 April 2024:** a management and placement assessment concluded that Corey's security rating should remain at medium and that he would remain at BRP. A further security classification review was scheduled for 5 June 2024.<sup>55</sup>
  - f. **29 April 2024:** Corey completed a referral to Communicare's "Breathing Space" program.<sup>56</sup>
  - g. **12 June 2024:** Corey was advised that his application for the Breathing Space program was unsuccessful.<sup>57</sup>

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<sup>48</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), p12

<sup>49</sup> Exhibit 1, Vol 1, Tabs 37.40-37.42, Individual management Plans (08.10.24, 19.06.24 & 15.02.24)

<sup>50</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), p11

<sup>51</sup> Exhibit 1, Vol 1, Tab 37.6, Orientation Checklist (18.01.24)

<sup>52</sup> Exhibit 1, Vol 1, Tab 37.1, Education and Vocational Training Checklist (05.02.24)

<sup>53</sup> Exhibit 1, Vol 1, Tabs 26 & 37.7, Parole Review Report (03.04.24)

<sup>54</sup> Exhibit 1, Vol 1, Tab 37.8, Decision Slip - Parole Review (22.04.24)

<sup>55</sup> Exhibit 1, Vol 1, Tab 37.9, Management and Placement - Sentenced Report (25.04.24)

<sup>56</sup> Exhibit 1, Vol 1, Tab 37.10, Offender Note (29.04.24)

<sup>57</sup> Exhibit 1, Vol 1, Tab 37.10, Amendment to Offender Note (12.06.24)

- h. **25 September 2024:** Corey finally underwent a treatment assessment review at BRP, although the review was conducted remotely by video-link. Corey's responses to questions were short and he appeared "*unhappy*". During the assessment Corey became "*belligerent*" and talked over the assessor "*multiple times*". He also told the assessor that her questions were irrelevant and "*vehemently refused*" to answer questions related to domestic violence.

Corey was advised on five occasions that the assessment was voluntary, and he could withdraw at any time, but in order to complete the assessment he needed to answer relevant questions. Corey's uncooperative behaviour continued and the assessment was terminated when he said: "*these are personal questions- when was the first time you had sex?*";<sup>58</sup> and

- i. **14 October 2024:** a classification review noted that Corey was "*an average worker who was enthusiastic and diligent in his work*" and he interacted appropriately with prison staff and other prisoners. It was noted that Corey had refused to participate in programs, or to transfer to another prison to do so.<sup>59</sup>
- j. **14 October 2024:** Corey was found hanging in the Paint Shop after he had stabbed himself in the chest with a kitchen knife he had removed from its steel wire tether. Despite resuscitation efforts, Corey could not be revived and he was declared deceased.<sup>60</sup>

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<sup>58</sup> Exhibit 1, Vol 1, Tabs 27 & 37.11, Treatment Assessment Report (24.09.24), p1

<sup>59</sup> Exhibit 1, Vol 1, Tab 37.12, Classification Review (08.10.24), pp4-5

<sup>60</sup> Exhibit 1, Vol 1, Tab 4, Life Extinct Form (14.10.24)

## EVENTS LEADING TO COREY'S DEATH<sup>61</sup>

### *Corey attends Paint Shop*<sup>62,63,64,65,66,67,68,69,70,71</sup>

24. At about 9.00 am on 14 October 2024, Corey and another prisoner (Prisoner C) went to work in the Paint Shop at BRP. As the Paint Shop Vocational Support Officer (VSO)<sup>72</sup> was on annual leave, Mr Rampin (the Metal Shop VSO) was granted permission to open the Paint Shop which had recently been closed for several weeks.<sup>73</sup>
25. The Paint Shop was located in the Industries area of BRP and was one of several workshops where prisoners were able to carry out different types of manual work. Other workshops included the Metal Shop (where Mr Rampin usually worked) and the Cabinet Shop. The Paint Shop was directly opposite the Metal Shop and separated from it by a courtyard. Someone in the Metal Shop could look across the courtyard and see into the Paint Shop through large double doors.<sup>74,75</sup>
26. At the relevant time, Mr Rampin was supervising eight or nine prisoners in the Metal Shop, although he would sometimes be responsible for up to 18 prisoners. Although Mr Rampin and several Recovery Officers checked on Corey and Prisoner C at various times during the day, Corey and Prisoner C were left unsupervised for long periods of time.
27. Prisoner C later said he had no concerns for Corey's welfare that morning, and when Prisoner C had finished work at about 10.20 am he left the Paint Shop and went back to his unit. This left Corey alone in the Paint Shop.

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<sup>61</sup> Exhibit 1, Vol 1, Tabs 2.1 & 2.2, Report - Det. FC Const. A Wroe (20.06.25) & Memo - Det. FC Const. A Wroe (18.10.24)

<sup>62</sup> Exhibit 1, Vol 1, Tab 18, Statement - Prisoner G (14.10.24)

<sup>63</sup> Exhibit 1, Vol 1, Tabs 22 & 37.25, Incident Description Reports (14.10.24)

<sup>64</sup> Exhibit 1, Vol 1, Tab 21, Notes of discussions with prisoners - Sgt. I Jansen (14-15.10.24)

<sup>65</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), pp14-17 & ts 31.03.26 (Palmer), pp49-60

<sup>66</sup> Exhibit 1, Vol 1, Tab 37.16, Industries Occurrence Book (14.10.24)

<sup>67</sup> Exhibit 1, Vol 1, Tabs 9 & 37.17, Statements - VSO M Rampin (14.10.24 & 12.01.26) & ts 31.03.26 (Rampin), pp8-28

<sup>68</sup> Exhibit 1, Vol 1, Tab 37.22, Statement - Prisoner C (04.12.25)

<sup>69</sup> Exhibit 1, Vol 1, Tabs 14 & 37.23, Statements - Prison Officer N Beattie (14.10.24 & 08.01.26)

<sup>70</sup> Exhibit 1, Vol 1, Tab 37.23, Statement - Prison Officer J McIlraith (08.01.26)

<sup>71</sup> Exhibit 1, Vol 1, Tabs 37.18-37.20 & 37.24, Photographs: aerial view of Paint Shop & interior, fittings & barricaded door

<sup>72</sup> VSOs provide supervision and training to prisoners in areas such as metal work, spray painting, and cabinetry.

<sup>73</sup> Exhibit 1, Vol 1, Tab 37.16, Email - VSO M Rampin (14.10.24)

<sup>74</sup> See for example: ts 31.03.26 (Rampin), p15

<sup>75</sup> Exhibit 1, Vol 1, Tabs 37.18 & 37.19, Photographs: aerial view of Paint Shop location & Paint Shop double doors

28. At about 11.15 am Mr Rampin was doing a walk-through of the Paint Shop. Corey was in one of the spray booths and he gave Mr Rampin a “thumbs up signal” before carrying on with his work. As Mr Rampin was leaving the Paint Shop at about 11.30 am there was a heavy downpour of rain, and he closed the large double doors to the Paint Shop. Whilst this was an obvious and reasonable thing for Mr Rampin to have done, it meant that it was now impossible to see into the Paint Shop from the Metal Shop across the courtyard.<sup>76</sup>
29. At about 11.55 am, Mr Rampin fetched Corey from the Paint Shop for lunch. Mr Rampin last saw Corey in the Paint Shop during a walk-through check between 1.15 pm and 1.30 pm. Corey had acknowledged Mr Rampin’s knock on the window of the spray booth he was working in by nodding his head.

**Corey is found**<sup>77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99</sup>

30. Between about 2.20 pm and 2.30 pm, Mr Rampin escorted two prisoners to the Multi-Function office located about 40 metres from the Metal Shop. On his way back the Metal Shop at about 2.30 pm, Mr Rampin went to check on Corey in the Paint Shop and found that the Paint Shop’s double doors had been barricaded from the inside. Mr Rampin managed to get in to the Paint Shop through another door (which had also been barricaded from the inside).

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<sup>76</sup> ts 31.03.26 (Rampin), p16

<sup>77</sup> Exhibit 1, Vol 1, Tabs 7 & 7.1-7.2, SJA Patient Care Records 24183302, 24183301 & 24183299 (14.10.24)

<sup>78</sup> Exhibit 1, Vol 1, Tab 8, Letter - Commissioner B Royce to State Coroner (05.11.24)

<sup>79</sup> Exhibit 1, Vol 1, Tabs 9 & 37.17, Statements - VSO M Rampin (14.10.24 & 12.01.26) & ts 31.03.26 (Rampin), pp8-28

<sup>80</sup> Exhibit 1, Vol 1, Tab 10, Statement - VSO A Clarke (14.10.24)

<sup>81</sup> Exhibit 1, Vol 1, Tab 11, Statement - Prison Officer N Iveson (14.10.24)

<sup>82</sup> Exhibit 1, Vol 1, Tab 12, Statement - Acting Senior Prison Officer F Caffrey (14.10.24)

<sup>83</sup> Exhibit 1, Vol 1, Tabs 13 & 37.28, Statement - Prison Officer R Schreuder (14.10.24 & 23.12.25)

<sup>84</sup> Exhibit 1, Vol 1, Tabs 14 & 37.23, Statements - Prison Officer N Beattie (14.10.24 & 08.01.26)

<sup>85</sup> Exhibit 1, Vol 1, Tab 15, Statement - Dr J Byrne (14.10.24)

<sup>86</sup> Exhibit 1, Vol 1, Tab 16, Statement - Paramedic M Montenegro (14.10.24)

<sup>87</sup> Exhibit 1, Vol 1, Tab 17, Statement - Paramedic J George (14.10.24) & ts 31.03.26 (George), pp28-35

<sup>88</sup> Exhibit 1, Vol 1, Tab 19, Statement - Prisoner T (14.10.24)

<sup>89</sup> Exhibit 1, Vol 1, Tab 20, Statement - Prison Officer L Groves (14.10.24)

<sup>90</sup> Exhibit 1, Vol 1, Tabs 22 & 37.25, Incident Description Reports (14.10.24)

<sup>91</sup> Exhibit 1, Vol 1, Tab 36, Statement - Clinical Nurse Manager N Cook (27.12.25)

<sup>92</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), pp6-7 & 14-20 & ts 31.03.26 (Palmer), pp49-60

<sup>93</sup> Exhibit 1, Vol 1, Tab 37.23, Statement - Prison Officer J McIlraith (08.01.26)

<sup>94</sup> Exhibit 1, Vol 1, Tab 37.24, Photographs showing Paint Shop doors barricaded with pieces of wood

<sup>95</sup> Exhibit 1, Vol 1, Tab 37.26, Photograph of steel cable tether

<sup>96</sup> Exhibit 1, Vol 1, Tab 37.27, Code Red Emergency Radio Call (2.33 pm, 14.10.24)

<sup>97</sup> Exhibit 1, Vol 1, Tab 37.29, Email - Dr J Smith to Ms T Palmer (16.12.25)

<sup>98</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Report (17.03.26)

<sup>99</sup> Exhibit 1, Vol 1, Tab 42, Health Services Review (23.03.26)

31. Once inside the Paint Shop, Mr Rampin found Corey, slumped against a workbench with a steel cable around his neck. Corey was not breathing and at about 2.33 pm, Mr Rampin used his prison radio to make a “*Code Red*” medical emergency call before placing Corey on the floor and starting CPR. A short time later, other prison officers arrived in the Paint Shop in answer to the “*Code Red*” emergency call.
32. As officers pulled up Corey’s shirt to attach pads from an automated external defibrillator (AED), they found a wound to his left upper chest that was bleeding. Blood from the wound made it impossible to apply the AED pads to his chest as they would not stick properly. As there were no spare pads in the first AED, a second AED had to be sourced, but when the pads from the second AED were attached, no shock was advised.
33. The first of two ambulances (which had been requested at 2.37 pm) arrived at BRP at 2.44 pm. By that time, several prison officers, a prison medical officer and two prison nurses were assisting Corey. Ambulance officers took over resuscitation efforts but Corey could not be revived. Corey was declared deceased at 2.53 pm on 14 October 2024.<sup>100</sup>
34. At the relevant time, the Paint Shop had three knives (a bread knife and two sharp kitchen knives) in a small kitchenette area. These knives were each attached to the wall by means of stainless steel tethers. Tools and other items in the Paint Shop were also attached to benches and walls using stainless steel tethers. An untethered bread knife and an untethered and blood-stained sharp kitchen knife were found near Corey’s body, and the steel cable that was around his neck was also attached to a paint tin opener.
35. One of the paramedics who attended BRP (Mr George) provided a statement and gave evidence at the inquest. At the inquest, Mr George said that when he and his partner arrived at the Paint Shop, Corey was being provided with appropriate CPR.<sup>101</sup>

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<sup>100</sup> Exhibit 1, Vol 1, Tab 4, Life Extinct Form (14.10.24)

<sup>101</sup> Exhibit 1, Vol 1, Tab 17, Statement - Paramedic J George (14.10.24) & ts 31.03.26 (George), pp31-32

36. As to the quality of emergency medical care provided to Corey by paramedics, Mr George said:

In the case, really, in response of an emergency service ambulance, there was nothing else that could be done in my professional or in my medical opinion. More could have been done, perhaps, if we had been able to get to a vascular surgeon and ultrasounds and (to an operating theatre), but not in that setting in our instance with my resources and skill set.<sup>102</sup>

37. At the inquest, Dr Gunson (the Department's Deputy Director, Medical Services) said she was satisfied with the quality of the emergency medical care provided to Corey and that resuscitation efforts were "*highly unlikely to have been successful*" given Corey's injuries.<sup>103</sup> When asked whether she had noticed any "*potential areas for improvement*" in the emergency medical care provided to Corey on 14 October 20204, Dr Gunson said:

Only that part where the defibrillator pads slipped off, and in hindsight, yes, there should be spare pads in the AED kits. I do not know if we...do that with our own kits now, but I would be able to follow up on that, because we've had that happen in other resuscitations where there were not spares, and the patient was sweaty, or something like that.<sup>104</sup>

38. As noted later in this finding, the evidence before me is that since Corey's death: "*all defibrillators on site have been issued with two sets of pads*".<sup>105</sup>
39. A police investigation concluded there was no evidence of criminality, third party involvement or suspicious circumstances relating to Corey's death.<sup>106,107</sup> On the basis of the evidence before me I agree with that conclusion.

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<sup>102</sup> Exhibit 1, Vol 1, Tab 17, Statement - Paramedic J George (14.10.24) & ts 31.03.26 (George), p34

<sup>103</sup> ts 31.03.26 (Gunson), p70

<sup>104</sup> ts 31.03.26 (Gunson), p70

<sup>105</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), p20

<sup>106</sup> Exhibit 1, Vol 1, Tab 2.1, Report - Det. FC Const. A Wroe (20.06.25), p14

**CAUSE AND MANNER OF DEATH**<sup>108,109,110</sup>

40. A forensic pathologist (Dr Inglis) conducted a post mortem examination of Corey’s body at the State Mortuary on 22 October 2024, and reviewed post mortem CT scans.
41. During her post mortem examination Dr Inglis noted a ligature mark around Corey’s neck, with an underlying fracture and associated soft tissue damage to the left superior horn of the thyroid cartilage.
42. Dr Inglis also noted a penetrating sharp force injury (stab wound) to the left anterior side of Corey’s chest which had passed into his chest cavity and injured his heart. There was blood loss into Corey’s heart sac and left chest cavity, and “*extreme pallor*” (intense paleness) of his organs.
43. Toxicological analysis did not detect any medications, alcohol, or common drugs (including cannabis) in Corey’s system.
44. At the conclusion of her post mortem examination, Dr Inglis expressed the following opinion as to the cause of Corey’s death:

Ligature compression of the neck (hanging) and penetrating sharp force injury (stab wound) to the chest.<sup>111</sup>

45. I accept and respectfully adopt Dr Inglis’ opinion and find that Corey died from ligature compression of the neck and his self-inflicted stab wound to the left chest.
46. On the basis of the available evidence as to the circumstances of Corey’s death, I find that death occurred by way of suicide.

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<sup>107</sup> Exhibit 1, Vol 1, Tab 2.2, Memo - Det. FC Const. A Wroe (18.10.24), p9

<sup>108</sup> Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (31.01.25)

<sup>109</sup> Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (22.10.24)

<sup>110</sup> Exhibit 1, Vol 1, Tab 6, Toxicological Report - ChemCentre WA (04.11.24)

<sup>111</sup> Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (31.01.25), p1

## LESSONS LEARNED WORKSHOP

### *Overview*<sup>112,113,114</sup>

47. Departmental policy requires that following a critical incident in a prison an immediate debrief is conducted. This is essentially to ensure relevant procedures have been followed and that the immediate welfare needs of staff and prisoners have been addressed. This immediate debrief is then followed by a Superintendent's review (with comments required to be recorded in TOMS within five days of the critical incident). The Superintendent's review aims to capture any immediate lessons learned.
48. Following the Superintendent's review, a more in-depth workshop is conducted. This workshop is designed to document what went well and to identify any further lessons learned. In this case, for reasons unexplained, a Superintendent's review was not conducted.<sup>115</sup> Although a lessons learned workshop (the Workshop) was conducted, this did not occur until 6 March 2026.
49. In my view the Workshop was seriously flawed. Firstly, there is the obvious point that the Workshop was conducted almost **17 months** after Corey's death. By that time valuable insights may well have been lost given that memories inevitably dim over time (as Mr Brampton conceded at the inquest).<sup>116</sup> Secondly, none of the Workshop's 17 attendees (nor the 14 apologies to the Workshop) had had any direct contact with Corey, and **none** of the first responders (including Mr Rampin) attended.<sup>117</sup>
50. At the inquest, Mr Brampton (Deputy Commissioner, Operational Support) was asked whether he agreed that the delay in conducting the Workshop was **completely unacceptable**, and his response was: "*Yes, I do agree*".<sup>118</sup> In my view this was an appropriate (though perhaps obvious) concession for Mr Brampton to have made on behalf of the Department, and he went on to say:

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<sup>112</sup> COPP-13.1 Incident Notification

<sup>113</sup> EMF-DIR-022 Operational debriefing & COPP-13.1 Incident Notification

<sup>114</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26) & ts 31.03.26 (Brampton), pp81-82

<sup>115</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp22-23 & see also: ts 31.03.26 (Brampton), p73

<sup>116</sup> ts 31.03.26 (Brampton), pp72-74 & 83

<sup>117</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp4-6 & ts 31.03.26 (Brampton), p72

<sup>118</sup> ts 31.03.26 (Brampton), p72

[W]e're taking measures to put that right. Ideally, between three to six months should be the ideal time for a lessons learned. It really depends on differing factors, to be honest. The order in which this court lists matters has an impact...There's only one full-time person that does this role, and sadly we've had a number of deaths in the last three years. So look, there's a lot of compounding factors...But yes, in this case it took too long.<sup>119</sup>

### ***Lessons learned***<sup>120</sup>

**51.** The five “*lessons*” and associated actions identified by the Workshop may be summarised as follows:

a. ***Lesson 1 - Supervision of prisoners in the industries area***<sup>121,122</sup>

The Workshop noted that after Prisoner C left at about 10.20 am, Corey was left alone and unsupervised in the Paint Shop.<sup>123</sup> At the time of Corey's death there was no Standard Operating procedure (SOP) at BRP that defined “*direct*” and “*indirect*” supervision prisoners, and what restrictions (if any) are placed on these prisoners. This remains the situation today.

b. ***Lesson 1 - Actions:***

- i. Standard Operating Procedure 10.1 Prisoner Behaviour Management - Bunbury (the SOP) be expanded to include definitions of “*direct*” and “*indirect*” supervision, and guidance on the supervision requirements for prisoners working in the industries area. The SOP is also to include “*safety and security parameters*” applying to indirect supervision, and the number and timing of daily checks required for a prisoner working alone.
- ii. Consideration be given to developing a Commissioner's Operating Policy and Procedure (COPP) applicable to the whole prison estate relating to the “*parameters*” applicable to prisoners working alone in an industries area.

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<sup>119</sup> ts 31.03.26 (Brampton), p72

<sup>120</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26) & ts 31.03.26 (Brampton), pp71-87

<sup>121</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp13-14

<sup>122</sup> ts 31.03.26 (Brampton), pp76-78

<sup>123</sup> Exhibit 1, Vol 1, Tab 37.22, Statement - Prisoner C (04.12.25)

c. ***Lesson 2 - Tethering of knives in the Paint Shop:***<sup>124</sup>

The Workshop confirmed that at the relevant time there were three knives in the kitchenette in the Paint Shop (a bread knife and two sharp knives) attached by stainless steel tethers to a base plate. Two of the knives (the bread knife and one of the sharp knives) had been removed from their tethers. The bread knife was found on a bench near Corey's body, and the sharp knife was on the floor near him.

d. ***Lesson 2 - Actions:***

- i. Discussions with relevant stakeholders are underway to consider replacing sharp knives in kitchenette area across BRP with wooden knives.
- ii. A security audit of all knife tethers is to be conducted by "Security Management", who have also been tasked with developing minimum standards for such tethers.<sup>125,126</sup>
- iii. Once the Senior Executive has endorsed the minimum standards for such knife tethers, consideration should be given to updating the relevant COPP.

e. ***Lesson 3 - Title:***<sup>127</sup>

On 21 August 2024, the Paint Shop VSO raised concerns about changes in Corey's behaviour with a prison officer.<sup>128</sup> Corey told the prison officer he was: "*suffering from anxiety brought on by 20 years of meth use*", and although he also disclosed hearing voices, he denied suicidal or self-harm thoughts. Corey declined a referral to Psychological Health Services (PHS) saying he had an appointment with a nurse on 22 August 2024), which in fact he didn't. Corey was told if he felt worse he should speak to staff or activate his cell call button at night. A change in Corey's behaviour was also noted during the treatment assessment conducted on 24 September 2024, but Corey was not referred to ARMS. The Workshop said this was: "*a missed opportunity to have wrap around services such as PHS, nursing, mental health and Prison Support Officer (PSO) services provided to (Corey) depending on the PRAG discussion*".

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<sup>124</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp15-16

<sup>125</sup> See also: Exhibit 1, Vol 1, Tab 37.30, Memo to Ms K Bishp (18.10.24)

<sup>126</sup> See also: Exhibit 1, Vol 1, Tab 37.31, Email - Mr S Heath (18.12.25)

<sup>127</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp17-19

<sup>128</sup> Exhibit 1, Vol 1, Tab 35, Statement - VSO S Tomlinson (10.12.25)

f. ***Lesson 3 - Actions:***

A notice will be issued to all staff reiterating that all staff can activate referrals to ARMS if they notice changes in a prisoner's behaviour. Staff will also be reminded that once an ARMS referral is made, PRAG will determine what intervention (if any) is required.

g. ***Lesson 4 - Personal protective equipment and defibrillator pads:***<sup>129</sup>

The Workshop noted that when the first responding officer (Mr Rampin) started CPR on Corey he was not wearing gloves. The Workshop also noted that when AED pads would not attach to Corey's chest, the AED did not have spare pads, and a second AED had to be sources.

h. ***Lesson 4 - Actions:***

i. A notice will be issued to staff reminding them of the importance of carrying the correct personal protective equipment on their person (i.e.: needle proof gloves, glove keeper and medical pouch containing mask and gloves).

ii. Consideration will be given to implementing a review system to check the medical pouches worn by prison officers and VSO.

iii. It was also noted that since Corey's death: "*all defibrillators on site have been issued with two sets of pads*".<sup>130</sup>

i. ***Lesson 5 - Incorrect templates and critical incident debrief:***<sup>131</sup>

The Workshop noted that 12 of the 17 incident reports completed by officers following Corey's death had used the incorrect template. Further, the Workshop found that requirement to conduct "*a critical incident debrief (Part 2) within 5-days was not adhered to*" and in fact the Part 2 (i.e.: Superintendent's review) had not been conducted at all.

b. ***Lesson 5 - Actions:***

i. Operational Compliance will conduct a compliance check to ensure correct incident report templates are being used.

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<sup>129</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp20-21

<sup>130</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), p20

<sup>131</sup> Exhibit 1, Vol 1, Tab 38, Lessons Learned Workshop Report (17.03.26), pp22-24

- ii. Operational Compliance will conduct a compliance check to ensure that the requirement to undertake a “Part 2” within a defined timeframe is being complied with.
- iii. Consideration is being given to extending the timeframe within which the Part 2 must be completed.
- iv. A reminder has been sent to all prisons reminding superintendents of the importance of complying with the relevant policy relating to incident notifications.

## **ISSUES ARISING FROM THE EVIDENCE**

### ***Overview***

**52.** I will now make some comments about the delay in undertaking Corey’s treatment needs assessment, and two issues raised in the lessons learned workshop, namely the failure to place Corey on ARMS, and the supervision he received in the Paint Shop on 14 October 2024.

### ***Delays in completing Corey’s treatment assessment***<sup>132,133,134,135</sup>

**53.** According to the relevant departmental policy, an Initial Individual Management Plan (IMP) must be completed within six weeks of the prisoner’s sentencing date. In Corey’s case that meant he should have been reviewed for his initial IMP by 12 January 2024. The purpose of an IMP is to assist with the prisoner’s management by identifying information relevant to their care and wellbeing and their prospects of rehabilitation and reintegration.<sup>136</sup>

**54.** As part of the Initial IMP process, a qualified assessor is required to complete a treatment assessment. The purpose of that assessment is to identify the prisoner’s unmet treatment needs (if any). The assessor then prepares a report to document any recommendations for programs or courses the prisoner should attend (and/or any other treatment interventions) to address the treatment needs identified.

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<sup>132</sup> Exhibit 1, Vol 1, Tabs 41 & 41.1, Statements - Mr B Goff (20.02.26 & 25.03.26) & ts 31.03.26 (Goff), pp36-48

<sup>133</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-A & BG-B, COPP 2.3 Assessments & Sentence Management (versions 9.0 & 11.0)

<sup>134</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-C-BG-FH, Deputy Commissioner’s Broadcasts (1/2024, 10/2024, 15/2024 & 16/2024)

<sup>135</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-G & BG-H, Deputy Commissioner’s Broadcasts (13/2025 & 19/2025)

<sup>136</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-A & BG-B, COPP 2.3 Assessments & Sentence Management (versions 9.0 & 11.0)

55. At the relevant time at BRP there was a backlog of 90 prisoners waiting to have their treatment assessments completed. By 9 February 2026, that number had climbed to 100 prisoners and across the State there are 1,143 prisoners who are waiting for a treatment needs assessment.<sup>137</sup>
56. A prisoner cannot be released on parole if they have unmet treatment needs. Further, the only way for a prisoner to access relevant treatment programs to address those unmet needs is to undergo a treatment assessment and have a program(s) recommended by the assessor.
57. As a direct result of the current backlog many prisoners are, through no fault of their own, being denied access to relevant treatment programs (and thereby the chance of applying for parole). In my view, this is **deplorable**.
58. The backlog in treatment assessments appears to be partly due to the fact that the assessment process is detailed and time consuming, and partly because at the relevant time (and now) there were only two qualified assessors at BRP.<sup>138</sup> To address the backlog of treatment assessments a temporary measure was introduced whereby Initial IMPs could be completed without a full treatment assessment.<sup>139,140</sup>
59. Corey was not reviewed for his initial IMP until 15 February 2024, and in accordance with the temporary measures I have just referred to, his treatment assessment was deferred. It was documented that after Corey's treatment assessment had been completed an IMP Review would be conducted to document any identified treatment needs and to book any relevant treatment programs.<sup>141</sup>
60. On 3 April 2024, a Parole Review Report was completed ahead of Corey's earliest release date of 25 May 2024. The Report noted that Corey was yet to undergo a treatment needs assessment, and that he had not undertaken any voluntary programs or courses.<sup>142</sup>

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<sup>137</sup> Exhibit 1, Vol 1, Tab 41, Statement - Mr B Goff (20.02.26), para 25 & ts 31.03.26 (Goff), pp38 & 44

<sup>138</sup> ts 31.03.26 (Goff), pp38-46

<sup>139</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-C-BG-FH, Deputy Commissioner's Broadcasts (1/2024, 10/2024, 15/2024 & 16/2024)

<sup>140</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-G & BG-H, Deputy Commissioner's Broadcasts (13/2025 & 19/2025)

<sup>141</sup> Exhibit 1, Vol 1, Tab 37.42, Individual management Plan (15.02.24)

<sup>142</sup> Exhibit 1, Vol 1, Tabs 26 & 37.7, Parole Review Report (03.04.24)

61. On 22 April 2024, the Prisoners Review Board refused Corey’s application for release on parole citing his unmet treatment needs in relation to family violence and substance abuse. It was noted Corey had not had an opportunity to participate in treatment programs and until he had, he remained: “*an unacceptable risk to the safety of the community*”.<sup>143</sup>
62. According to the relevant departmental policy, an IMP Review should have been scheduled for 26 May 2024, being the day after Corey’s earliest date of release, in circumstances where he had been denied release on parole. Regrettably, there is no evidence that this occurred.<sup>144</sup>
63. On 29 April 2024, one week after he was denied parole, Corey completed a referral to Communicare’s “*Breathing Space*” program, an intensive family violence program that he could have completed while on parole.<sup>145</sup> On 12 June 2024, Corey received a letter advising him that he had not been accepted into the program. No reason was documented, but it appears that because “*Breathing Space*” this is a residential program, Corey would have to have been on parole to participate.<sup>146</sup>
64. When Corey’s IMP was finally reviewed on 19 June 2024, it was noted that he had not undergone a treatment assessment, although no plan to address this failure was documented.<sup>147</sup> In his statement, Mr Goff (Case Management Coordinator at BRP) noted:
- At the time of sentencing (Corey) had approximately five months and 14 days to serve until his EED (i.e.: 25 May 2024). The likelihood of a program being identified and completed during this space of time would be doubtful.<sup>148</sup>
65. In my view, while this observation is correct, it misses the point. The fact is that if Corey’s treatment needs had been assessed when they should have been, he may have been able to complete relevant programs and then successfully apply for parole.

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<sup>143</sup> Exhibit 1, Vol 1, Tab 37.8, Decision Slip - Parole Review (22.04.24)

<sup>144</sup> Exhibit 1, Vol 1, Tab 41.1-Atts. BG-A & BG-B, COPP 2.3 Assessments & Sentence Management (versions 9.0 & 11.0)

<sup>145</sup> Exhibit 1, Vol 1, Tab 37.10, Offender Note (29.04.24)

<sup>146</sup> Exhibit 1, Vol 1, Tab 37.10, Amendment to Offender Note (12.06.24)

<sup>147</sup> Exhibit 1, Vol 1, Tab 37.41, Individual management Plan (19.06.24)

<sup>148</sup> Exhibit 1, Vol 1, Tab 41, Statement - Mr B Goff (20.02.26), para 13

66. Corey finally met with a treatment assessor on 24 September 2024, over nine months after he had been sentenced, and four months after he became eligible for release on parole. The assessment was conducted remotely using Microsoft Teams, and according to notes made by the assessor Corey was uncooperative and he refused to answer numerous questions relevant to the assessment.<sup>149</sup>

67. The assessor terminated the treatment assessment after Corey made an inappropriate comment and in her report, she noted:

During the interview, (Corey) was short with his answers and appeared unhappy. (Corey) refused to answer multiple questions relating to the assessment, particularly, questions regarding domestic violence (past and present), current offending, sexual habits (relevant for the sex offence assessment) and gave superficial information. (Corey) became belligerent and talked over the assessor multiple times, told the assessor the questions were irrelevant for his treatment assessment and that they should be skipped. (Corey) advised the interviewer did not know how to do her job and told her how to do it while refusing vehemently to answer domestic violence questions. (Corey's) behaviour was disrespectful towards the assessor, displayed a combative attitude and raised his voice to speak over the interviewer without allowing her to explain.<sup>150,151</sup>

68. Though obviously regrettable, Corey's apparent frustration with the assessment process is understandable. By the time the treatment assessment was finally conducted (24 September 2024) Corey had been refused parole for not addressing his unmet needs by attending relevant courses. Further, the assessment was conducted remotely via Microsoft Teams nine months after it should have been.<sup>152</sup> Corey's final IMP review took place on 8 October 2024. It was noted that although Corey had been given the opportunity to be assessed for treatment intervention the assessment had not been able to be completed.<sup>153</sup>

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<sup>149</sup> Exhibit 1, Vol 1, Tabs 27 & 37.11, Treatment Assessment Report (24.09.24), p1

<sup>150</sup> Exhibit 1, Vol 1, Tabs 27 & 37.11, Treatment Assessment Report (24.09.24), p1

<sup>151</sup> See also: Exhibit 1, Vol 1, Tab 23, TOMS Offender Notes (24.09.24)

<sup>152</sup> Exhibit 1, Vol 1, Tabs 27 & 37.11, Treatment Assessment Report (24.09.24)

<sup>153</sup> Exhibit 1, Vol 1, Tab 37.40, Individual management Plan (08.10.24)

69. Following a classification review on 8 October 2020<sup>4</sup>, Corey's security rating was reduced to minimum. The review report noted Corey had indicated his preference was to stay at BRP for the remainder of his sentence. With respect to his work ethic and his voluntary participation in treatment programs, the review report noted:

(Corey) continues to work in Bunbury Regional Prison's Paint Shop and is reported by his instructor to be an average worker who is enthusiastic and diligent in his work. He is also said to interact appropriately with both Staff and his peers...(Corey) currently refuses to participate (includes programs not currently offered) or refuses to transfer to participate.<sup>154</sup>

70. The **shambles** that was Corey's treatment assessment process makes the exhortations made by the sentencing judge in the District Court on 1 December 2023 even more poignant. During those remarks, the learned judge advised Corey to:

Sign up for as many courses as you can as both the psychiatrist and the neuropsychologist have recommended you would benefit from engagement in drug and alcohol counselling, anger management counselling and general offending programs.<sup>155</sup>

71. While Corey had declined to participate voluntarily in any treatment programs, he had applied (albeit unsuccessfully) to attend a residential program run by Communicare.

72. It is by no means certain that Corey would have agreed to attend any treatment programs that might have been recommended to him, or that he would have successfully completed any such programs. Nevertheless, the Department's **object failure** to assess Corey's treatment needs in a timely manner denied Corey the opportunity to attend such programs and thereby made it inevitable that any application he might make for release on parole would be refused due to his unmet treatment needs.

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<sup>154</sup> Exhibit 1, Vol 1, Tab 37.12, Classification Review (08.10.24), pp4-5

<sup>155</sup> Exhibit 1, Vol 1, Tab 39, Transcript of Sentencing Remarks - DCJ V Stewart (01.12.23), pp147-148

73. At the inquest, Mr Goff was asked whether he agreed that the delays in assessing the treatment needs of prisoners at BRP were unacceptable, and his response was “*Yes, absolutely*”. Mr Goff also explained that the delay in treatment assessments was predominantly due to the lack of suitably qualified assessors, with only two psychologists available at BRP when in a perfect world he would like there to be five to 10.<sup>156</sup> Mr Goff also noted each treatment assessment takes time, noting:

Well, as I said earlier, the assessments that they do are very in-depth and detailed and can take sometimes a week to complete. So, I’ve thought that possibly they could streamline it and slim it down a little bit, but that’s not my call. I’m not 100 per cent sure on their processes, but I believe that the treatment assessments are very, very detailed.<sup>157</sup>

74. In the first of his statements, Mr Goff also noted that:

The Department continues to work proactively to address the backlog. The triaging and prioritisation process for treatment assessments is governed by internal policies and procedures and focusses on each prisoner’s release dates, time overdue, available resources and current demand.<sup>158</sup>

75. Whilst I acknowledge the Department is working “*proactively to address the backlog*” clearly, with 1,143 prisoners across the State waiting for treatment assessments, much more needs to be done.

76. In view of the **parlous state** of the treatment assessment process (not only at BRP but across the entire prison estate) I have recommended that the Department should, without delay, take all necessary steps to reduce the number of outstanding treatment assessments. I have suggested that the Department consider measures including, but not limited to, streamlining the assessment process, placing greater reliance on external expert reports (where available), and engaging additional psychologists.<sup>159</sup>

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<sup>156</sup> ts 31.03.26 (Goff), p39

<sup>157</sup> ts 31.03.26 (Goff), pp39-44 & 45

<sup>158</sup> Exhibit 1, Vol 1, Tab 41, Statement - Mr B Goff (20.02.26), para 26

<sup>159</sup> See also: ts 31.03.26 (Goff), pp42-44 & ts 31.03.26 (Gunson), pp68-69

***Response to hearing voices and request for an appointment***<sup>160,161,162,163,164</sup>

77. As noted, Corey's disclosure (on 21 August 2024) that he was experiencing anxiety and hearing voices did not result in him being placed on ARMS. Corey also declined a referral to PHS saying he had an appointment to see a nurse on 22 August 2024.<sup>165</sup>
78. Had even the most basic of enquiries been undertaken at the time, it would have been realised that Corey had not made an appointment to see a nurse. Armed with that information, it is at least possible that one of Corey's unit staff might have placed him on ARMS and/or referred him to a mental health professional for further review.
79. Had Corey been placed on ARMS he would have been reviewed by the PRAG and either kept on ARMS and monitored or removed from ARMS depending on the outcome of his mental health assessment. Regrettably, none of these things occurred.
80. After Corey's death, his cellmate reported that Corey appeared to be hearing voices, and Corey was also reported to have expressed "*paranoid thoughts*" about other prisoners calling him names. Taken at its highest, this evidence suggests that Corey may have benefitted from having his mental health assessed and may explain why he had asked to see a nurse "*ASAP*" on 14 October 2024.<sup>166,167,168</sup>
81. At 8.41 am on 14 October 2024 (the day he took his life) Corey left a voicemail asking for an appointment with a nurse "*ASAP*". At the time, this was the procedure used by prisoners who wanted an appointment with a health professional. The system was clearly flawed because the telephone prisoners had to use to leave a message was in a public area, meaning anyone walking past could hear what the prisoner said.

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<sup>160</sup> Exhibit 1, Vol 1, Tab 36, Statement - Clinical Nurse Manager N Cook (27.12.25)

<sup>161</sup> Exhibit 1, Vol 1, Tab 37.14, Statement - Clinical Nurse manager J Kirby (08.12.25)

<sup>162</sup> Exhibit 1, Vol 1, Tab 42, Health Services Review (23.03.26), pp9-11 & ts 31.03.26 (Gunson), pp60-71

<sup>163</sup> Exhibit 1, Vol 1, Tab 35, Statement - VSO S Tomlinson (10.12.25)

<sup>164</sup> Exhibit 1, Vol 1, Tab 24, EcHO Medical Records (14.10.24), p2

<sup>165</sup> ts 31.03.26 (Gunson), pp62-64

<sup>166</sup> Exhibit 1, Vol 1, Tab 18, Statement - Prisoner G (04.12.25) & Exhibit 1, Vol 1, Tab 37.22, Statement - Prisoner C (04.12.25)

<sup>167</sup> Exhibit 1, Vol 1, Tab 24, EcHO Medical Records (14.10.24), p2

<sup>168</sup> Exhibit 1, Vol 1, Tab 37.14, Statement - Clinical Nurse manager J Kirby (08.12.25)

82. The nurse who listened to Corey’s voicemail request did not consider his tone of voice suggested an urgent appointment was required, and despite Corey’s use of the phrase “*ASAP*”, no attempt was made to speak to him to find out why he wanted an appointment.<sup>169</sup> Instead, nursing staff identified Corey was overdue for a comprehensive review by a prison medical officer (which should have occurred on 15 June 2024), and an appointment was made for Corey to see a nurse on 21 October 2024.
83. It is **deeply regrettable** that no effort was made to follow up Corey’s request for an appointment with a nurse “*ASAP*”. It can never be known why Corey wanted to see a nurse and whether, if he had seen a nurse, he would have taken his life in the manner that he did.
84. When asked whether, despite Corey’s apparently calm tone of voice, his use of the phrase “*ASAP*” warranted follow up, Dr Gunson said:
- I absolutely agree. I think that there might be many reasons why somebody would have presented a particular way on a phone call, where other people might hear them speaking. My impression of Corey’s personality was that he...sounded like a very reasonably upbeat kind of person who presented (in) a particular way most of the time, and showing vulnerability on the phone might have been an issue, if there were people around he did not want to show that to, and at the time I read the note, I did think, well, maybe they should have called the unit just to ask for some background, because then, at that point, the August issue (i.e.: Corey’s disclosure of hearing voices) might have come to light.<sup>170</sup>
85. Since Corey’s death, the voicemail system has been replaced with a system where prisoners fill in a “pink slip” and place it in a confidential envelope. Under the new system, if a prisoner does not provide any (or any sufficient) information on their “pink slip” a member of the health staff follows them up and seeks further information.<sup>171,172</sup>

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<sup>169</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), p14

<sup>170</sup> ts 31.03.26 (Gunson), p64

<sup>171</sup> Exhibit 1, Vol 1, Tab 36, Statement - Clinical Nurse Manager N Cook (27.12.25)

<sup>172</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), p14 & ts 31.03.26 (Palmer), pp50-52

*Supervision of prisoners in Paint Shop*

86. I will now make some comments about the supervision Corey (a prisoner with a self-disclosed history of self-harm and a long-term history methylamphetamine use) received in the Paint Shop on 14 October 2024.
87. I want to start by saying that I accept that the Industries area at BRP (including the Cabinet Shop, Metal Shop, and Paint Shop), is an incredibly valuable part of the prison. The Industries area offers prisoners the opportunity to develop not just relevant technical skills, but also workplace and people skills. Apart from anything else, it also gives prisoners something productive to do with their time and presumably this has a positive impact on their mental health.
88. I also accept that as part of the process, VSOs aim to develop a level of trust with prisoners working in the Industries area, particularly as this necessarily involves prisoners having access to dangerous tools and substances.<sup>173</sup>
89. However, it is a notorious fact that in general terms prisoners have higher levels of physical and mental health disorders, as well as higher rates of substance use and personality issues. These factors mean that as group, prisoners are more likely to be vulnerable than members of the general community.
90. That vulnerability is precisely why basic levels of direct and indirect supervision of prisoners working in the Industries area are so important. I acknowledge that at the relevant time, the Paint Shop at BRP had been closed for several weeks and that there was a genuine desire on the part of Mr Rampin to arrange for it to be opened so that Corey and Prisoner C could undertake work that they both appeared to genuinely enjoy.
91. However, the fact remains that despite random checks by Mr Rampin and two Recovery officers at various times during the morning, Corey and Prisoner C were left alone and unsupervised for lengthy periods of time.

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<sup>173</sup> See: ts 31.03.26 (Rampin), p26

92. After about 10.20 am on 14 October 2024, Corey was alone in the Paint Shop after Prisoner C had returned to his unit. From about 11.15 am (after the Paint Shop's double doors had been closed following a downpour or rain) there was no visibility from the Mental Shop (where Mr Rampin was supervising nine prisoners) into the Paint Shop. In my view it is **unacceptable** that Corey was permitted to work unobserved from about 1.30 pm until he was discovered hanging at about 2.30 pm.
93. I have recommended that the Department conduct an urgent review to determine the appropriate levels of supervision for prisoners working in the Industries area at BRP. I have also suggested that (amongst other things) consideration be given to installing close circuit TV (CCTV) cameras in workshops within the Industries area at BRP to be monitored by officers located at the Multi-Function office. At the inquest, two witnesses (Mr Rampin and Mr Brampton) raised concerns about the idea of installing CCTV cameras in workshop areas.
94. Mr Rampin said he was concerned that if the Paint Shop VSO was absent, then he might be expected to monitor prisoners working in the Paint Shop by using CCTV cameras. Mr Rampin said this monitoring responsibility would be required at the same time he was supervising prisoners in the Metal Shop as well as doing various administrative tasks (e.g.: quotes, ordering materials etc.), and that: "*It just creates more work*". However, Mr Rampin was more supportive of CCTV cameras in Industries area workshops if they were monitored from the Multi-Function office.<sup>174</sup>
95. In his evidence, Mr Brampton explained his concerns in this way:

My biggest fear with that is one of complacency, where I have seen CCTV put in into areas, and it's then monitored. And because there's a screen there where you can see, then you don't go out. Human nature, it's then do I do these audit slips or emails, or whatever, as opposed to going out and walking out there. So that monitor may not show you anything, but if there's something else going on elsewhere you still wouldn't know, unless you actually physically went out there...So there is a huge complacency issue with it.<sup>175</sup>

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<sup>174</sup> ts 31.03.26 (Rampin), pp20-21

<sup>175</sup> ts 31.03.26 (Brampton), p79

96. Nevertheless, if the Department is going to allow Industries area workshops to be opened in circumstances where there is no VSO physically present, then in my view it should consider the feasibility of all available options. The plain facts in this case are that if Corey had been visible to prison staff between 1.30 pm and 2.30 pm while he worked in the Paint Shop alone, it is very unlikely he would have been able to barricade the Paint Shop doors, remove two knives from their tethers in the kitchenette, and then stab and hang himself.

## QUALITY OF SUPERVISION, TREATMENT AND CARE

### *Overview*

97. In assessing the supervision, treatment and care that Corey received whilst he was incarcerated, I have applied the standard of proof as set out in the High Court's decision in the case of *Briginshaw v Briginshaw*<sup>176</sup> (Briginshaw case). The Briginshaw case requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.
98. I have also been mindful not to insert hindsight bias into my assessment of Corey supervision, treatment and care. Hindsight bias is the tendency, after an event, to assume the event is more predictable or foreseeable than it actually was at the time.<sup>177</sup>

### *Quality of treatment and care*

99. The Health Services Review completed after Corey's death (Health Review) makes the following observations about Corey's medical care:

After completing a comprehensive review of this matter, the Justice Health and Wellbeing Service has formed the opinion that during his time in custody, overall, (Corey) received appropriate medical treatment, and care of reasonable quality and timeliness, for the most part. The care he received was comparable to community standards...

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<sup>176</sup> (1938) 60 CLR 336, per Dixon J at pp361-362

<sup>177</sup> Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

In relation to the care provided to (Corey) on 14<sup>th</sup> October 2024, when he was located unresponsive, the Justice Health and Wellbeing Service is of the opinion that the emergency medical treatment and care provided to (Corey) was appropriate.<sup>178</sup>

**100.** Having reviewed the available evidence, I agree in general terms with the conclusions expressed in the Health Review, and I find that the standard of care and treatment Corey received whilst incarcerated was adequate. However, in my view (for the reasons I have outlined) it is **regrettable** that neither Corey’s disclosure of feeling anxious and hearing voices (i.e.: on 21 August 2024), nor his request for an appointment with a nurse “*ASAP*” (14 October 2024) were met with a more assertive response.

### *Quality of supervision*

**101.** Following Corey’s death, Ms Palmer conducted a review of his custodial management and supervision and expressed the following conclusion:

This review found (Corey’s) custodial management, supervision and care were in accordance with the Department’s policy and procedures listed in **Appendix 1**. Reports indicate that the response was prompt after officers discovered (Corey) in the paint shop mixing room. Relevant death in custody procedures, including notifications and handover to WA Police were followed.<sup>179</sup> [Original emphasis]

**102.** With two glaring exceptions, I find that Corey’s management and supervision during his incarceration was adequate. However, for the reasons I have expressed it is my view that:

- a. The Department’s failure to conduct a timely assessment of Corey’s treatment needs was **reprehensible**; and
- b. The standard of supervision Corey received while he was working in the Paint Shop on 14 October 2024 was **demonstrably poor**.

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<sup>178</sup> Exhibit 1, Vol 1, Tab 42, Health Services Review (23.03.26), p13

<sup>179</sup> Exhibit 1, Vol 1, Tab 37, Death in Custody Review (22.01.26), pp7-8

*Was Corey's death preventable?*

103. I accept that suicide is impossible to predict and that a person's suicidality can fluctuate on relatively short timeframes.<sup>180</sup>

104. I also note the following comments made by Dr Palmer (a consultant psychiatrist who prepared a pre-sentence report after assessing Corey) in the report she provided to this Court, namely:

(Corey's) death appears to have occurred in the absence of any recently documented disclosure of suicidal ideation to health staff, any active involvement of specialist prison psychiatric services, or any clearly documented warning of imminent self-harm in the medical notes available to me.

**His actions leading to his death appear unexplained on the face of the available records and not clearly foreshadowed by prior requests for psychiatric review or recorded suicidal disclosure.**

I would, however, be cautious about drawing conclusions from the records alone, as the absence of documented suicidal ideation does not exclude the possibility of unreported suicidal thinking or a rapidly evolving mental state.<sup>181,182</sup> [Emphasis added]

105. It can never be known why Corey decided to take his life in the manner that he did.

106. Nevertheless, it is difficult not to conclude that had Corey been adequately supervised on 14 October 2024, it is very unlikely he would have been able to barricade two sets of doors to the Paint Shop before stabbing himself in the chest with a kitchen knife and then hanging himself.

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<sup>180</sup> ts 31.03.26 (Gunson), pp65-67

<sup>181</sup> Exhibit 1, Vol 1, Tab 40, Report - Dr K Palmer (24.03.26), p6

<sup>182</sup> See also: ts 31.03.26 (Gunson), p67 regarding the fluctuation of suicidality often on very short timeframes.

## RECOMMENDATIONS

107. On the basis of the observations I have made in this finding, I make the following recommendations:

### **Recommendation No. 1**

In order to better manage prisoners and thereby enhance security at Bunbury Regional Prison, the Department of Justice (the Department) should, **without delay**, take all necessary steps to reduce the number of outstanding treatment assessments. The Department should consider measures including, but not limited to:

- a. Streamlining the assessment process;
- b. Placing greater reliance on external reports from psychiatrists, psychologists (where available) when assessing a prisoner's treatment needs; and
- c. Engaging additional psychologists (whether on a full-time, part-time, or contract basis) to conduct treatment assessments.

### **Recommendation No. 2**

The Department should undertake an **urgent** review of Commissioner's Operating Policy and Procedure (COPP) 8.1 - Prison Based Constructive Activities to ascertain if a definition of direct/indirect supervision level is required and if so, clarify issues relating to safety and security parameters.

**Recommendation No. 3**

The Department of Justice i.e.: (the Department) should conduct an **urgent** review to determine the appropriate levels of supervision for prisoners working in the Industries area at Bunbury Regional Prison (i.e.: Paint Shop, Metal Shop, Cabinet Shop etc). The review should also consider:

- a. Determining the minimum supervision levels appropriate for the Industries area workshops, and the minimum acceptable ratio of Vocational Support Officers to prisoners;
- b. The minimum supervision levels appropriate for the Industries area workshops, and the minimum acceptable ratio of Vocational Support Officers to prisoners;
- c. The feasibility of installing Close Circuit TV cameras in Industries area workshops so as to allow remote monitoring by prison officers on duty in the Multi-Function office; and
- d. A policy of closing Industry workshops when the identified basic level of supervision cannot be provided.

**Recommendation No. 4**

The Department of Justice should institute a mechanism for regularly checking all Automated External Defibrillators (AED) at Bunbury Regional Prison to ensure that each AED has a spare set of defibrillator pads.

*Comments on recommendations*

108. At my request, Ms Lynch (Counsel Assisting) forwarded a draft of my recommendations to Ms Femia (counsel for the Department) by way of an email on 1 April 2026. Feedback (if any) was requested to be received by the Court no later than the close of business on Friday, 24 April 2026.<sup>183</sup>

109. By way of emails dated 23 April 2026 and 24 April 2026, Ms Femia advised that the Department’s response to the recommendations I had proposed was as follows:<sup>184,185</sup>

- a. *Recommendation 1*: the Department supports paragraphs (a) and (c) of Recommendation 1 and is currently deploying a range of strategies “to streamline the assessment process”. Further, by “re-purposing” vacancies in other business areas the Department has provided and additional nine treatment assessors and one supervisor (across the State) for a period of two years. A budget submission seeking permanent funding for these positions has been prepared.<sup>186</sup> The Department does not support paragraph (b) of Recommendation 1 on the basis that:

The internal provision of Treatment Assessments allows for clinical governance including review by Supervisors to ensure accuracy. As such it is the Department’s position that current practice in terms of utilising previous external reports to inform but not determine Treatment Assessment outcomes balances both efficiency and effective treatment planning recommendations.<sup>187</sup>

With respect, the Department’s response misunderstands the intent of paragraph (b) of Recommendation 1. My suggestion is **not** that external reports from psychiatrists and psychologists replace the Department’s internal treatment assessments. Rather, my suggestion is that greater reliance be placed on such reports as a way of streamlining the internal assessment process. For that reason, I do not intend to modify the text of this recommendation.

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<sup>183</sup> Email - Mr E Lynch to Ms P Femia (01.04.26)

<sup>184</sup> Email - Ms P Femia to Mr E Lynch forwarding Department’s response to Recommendations (23.04.26)

<sup>185</sup> Email - Ms P Femia to Mr E Lynch forwarding Department’s response to Recommendations (25.04.26)

<sup>186</sup> Department’s response to Recommendations (23.04.26), p1

<sup>187</sup> Department’s response to Recommendations (23.04.26), p1

- b. *Suggested Recommendation 2*: the Department has suggested I make a new Recommendation 2 that a review be conducted of *COPP 8.1 Prison Based Constructive Activities* to determine whether a definition of direct/indirect supervision is required and if so, to clarify issues relating to safety and security parameters. The Department says that this recommendation is necessary because:

[T]he Department must consider the supervision expectations / requirements for prisoners working in industries units within the overarching COPP first, prior to determining whether amendments to supervision requirements are warranted and supported from a custodial operations perspective.<sup>188,189</sup>

After careful consideration, I have decided that the Department's suggested recommendation is appropriate, although I have added the word "*urgent*" before the word "*review*".

- b. *Original Recommendation 2 (now Recommendation 3)*: the Department proposed some minor changes to the wording of paragraph (a) of this recommendation, which I have adopted.<sup>190,191</sup>
- c. *Original Recommendation 3 (now Recommendation 4)*: the Department says that an audit of AED at BRP has been completed, and this has confirmed that all AED have an additional set of pads.

The Department also says that since Corey's death, daily checks are now made of all AEDs at BRP, and that the results of these checks are recorded into "*the occurrence books*".<sup>192</sup>

Whilst this is a pleasing development, I have decided to maintain what has become Recommendation 4 to ensure that the current system is entrenched.

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<sup>188</sup> Attachment to Email - Ms P Femia to Mr E Lynch outlining Department's response to Recommendations (23.04.26), p2

<sup>189</sup> Email - Ms P Femia to Mr E Lynch outlining Department's response to Recommendations (24.04.26)

<sup>190</sup> Attachment to Email - Ms P Femia to Mr E Lynch outlining Department's response to Recommendations (23.04.26), p2

<sup>191</sup> Email - Ms P Femia to Mr E Lynch outlining Department's response to Recommendations (24.04.26)

<sup>192</sup> Department's response to Recommendations (23.04.26), p2

## CONCLUSION

- 110.** Corey was 41 years of age when he stabbed and hanged himself at BRP on 14 October 2024. Corey was a complex man, whose life was adversely affected by his polysubstance use and offending behaviour. Nevertheless, Corey was loved by his family and his death has undoubtedly had a significant and long-lasting impact on them all.
- 111.** After reviewing the available evidence, I concluded that the treatment and care Corey received while he was incarcerated was adequate. However, I noted it was regrettable that Corey’s disclosure about hearing voices, and his request for an appointment with a nurse “*ASAP*” were not dealt with in a more assertive manner.
- 112.** I also concluded that in general terms, Corey’s supervision whilst he was in custody was adequate. However, I found that the delay by the Department in assessing Corey’s treatment needs was **reprehensible** and that the standard of supervision Corey received on 14 October 2024 was **demonstrably poor**.
- 113.** I have made four recommendations which arise from the evidence before me, one of which was suggested by the Department. It is my sincere hope that each of these recommendations will be fully embraced.
- 114.** Finally, as I did at the conclusion of the inquest, I wish to again offer Corey’s family and friends, on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin  
**Acting Deputy State Coroner**  
28 April 2026