[2026] WACOR 23

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	25 MAY 2026
DELIVERED	**:**	8 JUNE 2026
FILE NO/S	**:**	CORC 3462 of 2024
DECEASED	**:**	SHAHZAD, MASON

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Counsel Appearing:

Mr G Chin assisted the Coroner

J Hang (State Solicitors Office) appeared on behalf of the Department of Justice

Cases referred to in decision:

Nil

SUPPRESSION ORDER

On the basis it would be contrary to the public interest, the Court makes an order under s 49(1)(b) of the *Coroners Act 1996* (WA) that there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Acacia Prison on 11 November 2024.

Order made by BD Nelson, Coroner (24/04/2026)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Brendyn Dean Nelson, Coroner, having investigated the death of **Mason SHAHZAD** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 25 May 2026, find that the identity of the deceased person was **Mason SHAHZAD** and that death occurred on 11 November 2024 at Acacia Prison, Wooroloo from ligature compression of the neck (hanging) in the following circumstances:*

Introduction

1 Mr Mason Shahzad was a 40-year-old sentenced prisoner when he died after hanging himself in his cell at Acacia Prison on 11 November 2024.

2 Mr Shahzad was in the custody of the Chief Executive Officer of the Department of Justice (**Department**) at that time, and therefore a person held in care for the purposes of the *Coroners Act 1996* (WA) (the **Act**).

3 Mr Shahzad was first remanded into custody at Hakea Prison in July 2021 after having been charged with over twenty offences, alleging severe and sustained criminal conduct against his immediate family. He was convicted of the offences and sentenced on 30 June 2023 in the Perth District Court to a total effective sentence of 30 years' imprisonment.

4 Mr Shahzad was then imprisoned at Casuarina Prison from 31 August 2023 to 28 October 2024, before being transferred to Acacia as part of his management plan as a sentenced prisoner.

5 Acacia is operated by Serco Australia Pty Ltd (**Serco**).

6 Given Mr Shahzad was a person held in care, a coronial inquest was mandatory, and in addition to determining the cause and manner of his death, if possible, I am also required to comment on the quality of the supervision, treatment and care he received while in custody.

7 The coronial inquest occurred on 25 May 2026.

8 I received the documentary evidence contained in the coronial brief and the following witnesses gave evidence at the inquest:

(a) Mr Randy Hayes, a prison officer at Acacia who was involved in the emergency response on 11 November 2024;

(b) Mr Shane Horseman, Deputy Superintendent at Acacia;

(c) Ms Toni Palmer, who conducted the Department's Performance Assurance and Risk (**PAR**) review; and

(d) Dr Catherine Gunson, who reviewed the healthcare provided to Mr Shahzad during his time in custody.

Factual findings

9 In this part, I will make factual findings about the circumstances leading up to and including Mr Shahzad's death.

Mr Shahzad's personal background

10 Mr Shahzad was born in Kabul, Afghanistan in 1984.

11 He lived in Pakistan, before moving to Iran and then the United Arab Emirates. He worked as a self-employed mechanic in Dubai.

12 Mr Shahzad was married in 2008 and had a daughter with his wife before he migrated to Australia as a refugee in 2010. He became an Australian citizen in 2014 and sponsored his wife and daughter to join him in Australia in 2015. He and his wife had a son in 2017.

13 Mr Shahzad had a Certificate II in security operations and worked in security at Perth Airport for ten years.

14 Mr Shahzad and his wife separated in January 2021. At the time of his arrest in July 2021, Mr Shahzad was living alone in Beckenham.

15 Between 2017 and his arrest in July 2021, Mr Shahzad engaged in persistent family violence towards his wife. It is unnecessary to detail the instances of this offending, or the nature of the other serious offences committed by Mr Shahzad for which he was ultimately imprisoned.

16 Mr Shahzad's medical history included hypertension, jaundice and hypertriglyceridemia. He had also been diagnosed with depression and Post Traumatic Stress Disorder (**PTSD**).

17 On 5 July 2021, as police officers attended his home in Beckenham to arrest him, Mr Shahzad cut his own throat using a meat cleaver, causing major blood loss. He was admitted to Royal Perth Hospital with a principal diagnosis of a self-inflicted complex laceration of the neck.

18 Mr Shahzad underwent surgery, and following treatment and psychiatric review, he was discharged into the custody of WA Police on 8 July 2021.

Remand at Hakea

19 Mr Shahzad was remanded into custody at Hakea on 8 July 2021 and identified as being a prisoner requiring protection.

20 Due to the recent self-harm, Mr Shahzad was assessed as being unable to guarantee his own safety and an active risk of suicide and was identified as high risk on the At-Risk Management System (**ARMS**).

21 Due to the above, Mr Shahzad was placed in a safe cell in Unit 6, a protection unit, and observed hourly.

22 Mr Shahzad was also referred to the Prisoner Risk Assessment Group (**PRAG**). According to the minutes of a PRAG review dated 9 July 2021, Mr Shahzad had been reviewed by the mental health team by that time and denied self-harm or suicidal ideation. He stated that he was glad to be alive and that the suicide attempt was a mistake that he would not repeat.

23 On that basis, Mr Shahzad was reduced to moderate ARMS with two-hourly observations, removed from the safe cell, and was for follow up by Psychological Health Services (**PHS**).

24 According to the minutes of a PRAG review dated 3 August 2021, Mr Shahzad had, by that date, settled well into the structured environment of prison, and had no thoughts of self-harm or suicidal ideation. PRAG recommended his removal from ARMS, and provision of ongoing management by Mental Health Services (**MHS**). A placement on the Support and Monitoring System (**SAMS**) was not endorsed at the time, given Mr Shahzad did not fit within the existing criteria.

25 Mr Shahzad underwent psychiatric review on 16 August 2021 and was prescribed the anti-depressant escitalopram. During a mental health nurse review on 28 September 2021, Mr Shahzad indicated that the medication had been beneficial.

26 On 31 December 2021, Mr Shahzad commenced medication for insomnia.

27 Mr Shahzad remained in Unit 6 until 19 January 2022, when he was moved to a standard cell in Unit 10 (also being used as a protection unit).

28 On 2 February 2022, Mr Shahzad collapsed, and presented as very drowsy, nauseous and pale. He was transferred to Fiona Stanley Hospital, where he was diagnosed with having experienced a vasovagal syncope episode. He was treated and returned to Hakea on 3 February 2022.

29 On 10 February 2022, Mr Shahzad was returned to low ARMS with four-hourly observations, after disclosing during a PHS counselling session that he was experiencing suicidal ideation with no method or intent.

30 He remained on low ARMS until 11 March 2022, at which time he was removed, with recommended ongoing management by MHS.

31 Mr Shahzad returned to low ARMS with four-hourly observations on 21 April 2022, after he presented as being scared and shaken, but not specifying the exact problem.

32 During a subsequent interview, it was identified that he was experiencing strong suicidal ideation with plan and intent. Following a disclosure, his cell was searched, and three shards of plastic were located. A Code Green was called, Mr Shahzad was placed on high ARMS with hourly observations, and he was transferred to a safe cell.

33 Mr Shahzad was subsequently transferred to the Crisis Care Unit for what was referred to as a ‘day/night regime’, being an approach to manage heightened risk at night while also reducing a prisoner’s potential distress and isolation during the day.

34 On 26 April 2022, PRAG recommended that Mr Shahzad be reduced to moderate ARMS with two-hourly observations and moved from a safe cell to a two-person cell in Unit 10 as the sole occupant.

35 On 27 April 2022, an alert was placed on the Total Offender Management Solution system (**TOMS**) providing that Mr Shahzad was not to share a cell, for mental health reasons. This was recommended following psychiatric review and review of his medication.

36 I interpose that such an alert remained in place on TOMS until Mr Shahzad’s death and was not removed at any stage.

37 In late April 2022, Mr Shahzad was reduced to low ARMS with four-hourly observations, with psychiatric review the following week and PHS to provide ongoing follow up and support.

38 On 20 May 2022, Mr Shahzad was transferred to SAMS for coordinated support and monitoring. SAMS logs record regular engagement with PHS, and discussion of his coping strategies and management of his PTSD.

39 On 1 September 2022, it was determined that Mr Shahzad no longer required management under SAMS due to a reduction in his vulnerability, and a stabilising of his behaviour in the prison environment.

40 On 19 November 2022, Mr Shahzad was found unconscious by officers in Unit 10. He appeared to have collapsed onto the floor. A code red medical emergency was called, and Mr Shahzad was provided first aid by responding officers. On examination, it was determined that Mr Shahzad had low blood pressure. He was given IV fluids and monitored.

Conviction and sentencing

41 On 12 May 2023, Mr Shahzad was convicted by the Perth District Court, upon his guilty pleas, of the various offences for which he had been charged. On 30 June 2023, he was sentenced to 30 years' imprisonment. Mr Shahzad's earliest release date was 6 July 2051.

42 Mr Shahzad was visibly upset upon his return to prison after the sentencing. Officers spoke with him, and he assured them he would not self-harm, and that he had no plan or suicidal ideation.

43 Mr Shahzad's management and placement was assessed following his becoming a sentenced prisoner, resulting in a recommendation that he be reduced to medium security, and that he be transferred to Acacia to enable completion of his individual management plan and to facilitate visits. The assessment recorded that temporary placement at another prison may be required, pending bed space at Acacia.

44 According to minutes of the PRAG review dated 4 July 2023, Mr Shahzad acknowledged experiencing passive suicidal thoughts multiple times throughout the day. He was placed on low ARMS, with PHS intervention due to depressed mood after his sentencing.

45 On 11 July 2023, Mr Shahzad was transferred back to SAMS.

46 At that time, Mr Shahzad denied having any current plan or intent to end his life, and protective factors were noted including his reassurance that he would seek support from staff if he felt unable to cope. SAMS logs indicate that officers interacted with Mr Shahzad daily between 11 July and 30 August 2023, with no issues identified.

Custody at Casuarina

47 Mr Shahzad was transferred from Hakea to Casuarina on 31 August 2023. He was placed in a single-occupancy cell in Unit 6 as a protection prisoner, in line with existing alerts.

48 Mr Shahzad remained on SAMS until 6 February 2024. Supervision logs indicate that he settled well at Casuarina Prison, was engaged in employment, and was polite and friendly toward staff.

49 Further management and placement assessments conducted on 6 February 2024 and 14 August 2024 maintained that Mr Shahzad should remain at medium security and be transferred to Acacia.

50 In early September, Mr Shahzad submitted a medical request, stating that he needed to see a psychiatrist urgently. Mr Shahzad was booked for a review by a mental health nurse, which occurred on 8 September 2024.

51 Mr Shahzad was still taking the antidepressant escitalopram at this time, and he reported it was having limited benefit from its current dosage. He expressed anxiety about being placed in a shared cell and wanted a letter from his psychiatrist to support his remaining in a single cell. He made several threats to end his life if he was placed into a shared cell.

52 I interpose that I have identified no evidence to suggest that it was ever proposed, at any time (including at Casuarina or at Acacia) that Mr Shahzad would or should share a cell. As noted above, the alert providing that he should not share a cell remained in place throughout. I can only infer that Mr Shahzad was concerned about the possibility of having to share a cell, given he was at times accommodated in a cell with capacity for two people, but as a single occupant.

53 Mr Shahzad denied any current plan or intent to act on his statements, and an appointment for a doctor review of his medication was made. It is not apparent that a review occurred prior to his transfer to Acacia.

Transfer to Acacia

54 Mr Shahzad was transferred to Acacia on 28 October 2024, in line with his security rating and the previous assessment recommendations.

55 Mr Shahzad was accommodated at Juliet Block (or 'J' Block), which is made up of four units across both an upper and lower landing and typically holds prisoners with protection status.

56 During his time at Acacia, Mr Shahzad remained subject to various alerts, including not to share a cell.

57 Mr Shahzad did not have any active ARMS or SAMS alerts when he arrived at Acacia Prison.

58 Mr Shahzad was reviewed by a nurse upon his arrival at Acacia. During the review, he denied any thoughts of self-harm or suicidal ideation. His requirement for a single cell was expressly noted. There is no evidence that Mr Shahzad raised the concerns he had expressed at Casuarina on 8 September about the efficacy of his anti-depressant medication.

59 Outstanding follow-ups regarding recent liver lesion investigations and referral for a chronic disease care plan were identified and recorded.

60 In the weeks leading up to his death, Mr Shahzad did not have any visitors, and did not make any phone calls.

61 On 29 October 2024, a prison doctor completed an administrative review which noted Mr Shahzad's medical history including his anxiety, depression and PTSD, and the medications he was currently taking.

62 Mr Shahzad saw nursing staff on the same day for pain symptoms. Testing was undertaken, with no evidence of infection. He was reviewed again by nursing staff on 1 November 2024, and his symptoms had resolved. Again, there is no evidence that, on either 29 October or 1 November 2024, Mr Shahzad raised the concerns he had expressed at Casuarina on 8 September about the efficacy of his anti-depressant medication.

63 Mr Shahzad experienced a delay in the transfer and receipt of his personal property from Casuarina to Acacia. He first made a request regarding his property through the Custodial Management System (**CMS**) on 31 October 2024. CMS is a system that is provided by Serco at Acacia and is not otherwise operative at adult male prisons in Western Australia.

64 In his request through the CMS, Mr Shahzad referred to his need for '*toiletries and electrical items*'. An '*approved*' response was provided, with the automated statement that he would be contacted by '*Property in due course*'.

65 On 7 November 2024, Mr Shahzad made a further complaint about not having his property through the CMS. Mr Shahzad received the same automated response he received on 31 October 2024.

66 On 10 November 2024, Mr Shahzad sent another message regarding his property via the CMS. He used language in this message that demonstrated growing upset and frustration with the delay of the transfer of his personal property. He received the same automated response.

Events on 11 November 2024

Early morning

67 Between around 8.00 am and 9.00 am on 11 November 2024, Mr Shahzad was playing cards with another prisoner housed in J Block (**Prisoner BN**), and two other prisoners.

68 Prisoner BN had met Mr Shahzad at Casuarina, had known him for about two years, and considered him a good friend. He considered that Mr Shahzad had not seemed himself since he had been transferred from Casuarina to Acacia.

69 Prisoner BN said that Mr Shahzad had expressed some frustration because he had not received his property from Casuarina yet, including his television, games, food, magazines and other things important to him.

70 Prisoner BN was aware that Mr Shahzad had self-harmed in the past, but Mr Shahzad had never mentioned anything about harming himself to Prisoner BN during the time they had known each other.

71 Prisoner BN saw Mr Shahzad outside his cell, cell 8, during a muster at about 11.20 am, and in the lunchroom at about 11.30 am.

72 According to Prisoner BN's observations, Mr Shahzad did not demonstrate any signs of crisis or overt distress during this time.

Random search

73 During that morning, Officer Hayes conducted random basic searches of about 14 prisoners in J Block, including Mr Shahzad.

74 Mr Shahzad was wearing a white singlet and green prison shorts.

75 Officer Hayes noted that Mr Shahzad was polite and compliant during the random search. Nothing untoward was identified during the random basic search.

76 Officer Hayes had also interacted with Mr Shahzad briefly earlier that day, around about 8.00 am, in the movement area within J Block.

77 According to Officer Hayes's observations, Mr Shahzad had appeared happy. Officer Hayes noted that Mr Shahzad was polite, as usual.

Critical incident

78 At about 1.12 pm, and as depicted in available CCTV footage which I have reviewed, Mr Shahzad entered cell 8 alone, after placing what I infer was part of the ligature he subsequently tied around his neck over the top of the door, before closing the door.

79 There is only one other person in the vicinity of cell 8 at that time, who appears to be another prisoner. Mr Shahzad does not catch the attention of the other prisoner at any time, seemingly including because Mr Shahzad's back was turned toward the other prisoner, partially blocking any view.

80 The other prisoner goes into another cell shortly after.

81 A few minutes later, Mr Shahzad briefly opens the door to cell 8 again and adjusts something over the door. I infer, including based on what is visible in the footage, that he adjusted the ligature before closing the door again.

82 No one else is in the hallway outside or near cell 8 at that time.

83 The feeds from CCTV cameras at Acacia are not monitored at all times.

84 On that basis, I find that the actions by Mr Shahzad at 1.12 pm and shortly after were unobserved by another other prisoners or prison staff.

Cell check in cell 7

85 At about 1.58 pm, Officer Hayes and another prisoner officer, Ms Hanna Gee conducted a check on a prisoner housed in cell 7 in J Block. That cell is directly opposite cell 8.

86 The purpose of the check was to check on a prisoner who was subject to ARMS.

87 In his witness statement to WA Police, Officer Hayes stated that he spoke with the prisoner inside cell 7, and that he did not look into Mr Shahzad's cell when he was in cell 7.

88 This accords with the CCTV footage, from which it is apparent that Officer Hayes and Officer Gee walked directly to and from cell 7 and did not turn to directly face cell 8 at any point in time.

89 I also infer, given the nature of the ligature and from what can be seen on the CCTV footage, that any part of the ligature protruding from the door to cell 8 at that time would not have been readily visible to any person if they had walked directly to or from cell 7.

Discovery of Mr Shahzad

90 At about 2.26 pm, Prisoner BN went to Mr Shahzad's cell to see if he wanted to play cards.

91 When he arrived, Prisoner BN noted that the lights in the cell were off. He looked into the cell and thought that he could see Mr Shahzad standing against the door with a chair at his feet.

92 Prisoner BN turned the light on, using the control outside the cell, and looked into the cell again, and saw Mr Shahzad's head and chin were pointing down. Prisoner BN saw something around Mr Shahzad's neck, which he thought looked like the lace from prison issued pants and called out to Mr Shahzad. When he got no response, he called for help.

93 Prisoner BN tried to open the cell door, but it was locked. He observed that there was a knot from the lace on the outside of the cell door.

Emergency response

94 Officer Hayes heard a commotion, and prisoners yelling. He heard someone say, '*Mason is hanging himself*'.

95 In his statement to WA Police, Officer Hayes said that he called a code red as he ran to cell 8.

96 Ms Palmer, the author of the PAR report, undertook a review of all radio transmissions, and was unable to identify any recorded code red call.

97 Officer Hayes confirmed at the inquest that he has a distinct, independent recollection of recalls calling the code red.

98 Officer Hayes raised the possibility that it was not heard because another radio call was going through at the same time as he called the code red. Ms Palmer confirmed at the inquest that this was a possible reason why the code red would not have been identifiable in her review.

99 I am satisfied, based on his written and oral evidence, that Officer Hayes was an honest and reliable witness, with a strong independent recollection of events. On that basis, I accept his evidence and find that he attempted to call a code red at the time he was running to the cell.

100 I am also satisfied in any event, for reasons that follow, that there was no negative consequence of the code red call potentially not being heard by others, including the imminence of the attendance by other staff and the calling of a code blue emergency soon thereafter.

101 When he got to cell 8, Officer Hayes found that the door was locked and unable to be opened from the outside, which he concluded meant that it had been locked from the inside. He unlocked the door and as he opened the door Mr Shahzad slid down the door and on to the floor. He was hanging by a green cord, which appeared to have been removed from prison-issued green shorts. Another prisoner standing nearby (**Prisoner FC**) removed the ligature from around Mr Shahzad's neck.

102 Officer Hayes observed that Mr Shahzad's lips were blue, that he had no pulse, and that he was cold and clammy. He commenced CPR, assisted by a prisoner, until they were relieved by two other officers who attended. After being relieved from performance of CPR, Officer Hayes secured the ligature which had been removed by Prisoner FC, and other prisoners were secured in their cells.

103 A code blue, denoting a medical emergency, was called at 2.28 pm, and an ambulance was called at 2.33 pm. Nurses arrived in response to the code blue, followed by the full resuscitation team. A medical officer and another nurse attended shortly after and provided further assistance including administration of intravenous adrenaline and airway management.

104 Ambulance officers arrived at about 3.00 pm, and continued efforts with medical staff to attempt to revive Mr Shahzad.

105 At 3.18 pm, given the length of CPR both by prison medical staff and then paramedics, and the absence of any response during that time, Mr Shahzad was declared deceased.

106 Mr Shahzad was subsequently formally identified by way of fingerprints.

Subsequent investigation and reviews

Police investigation

107 Two prison officers maintained the security of the scene of Mr Shahzad's death until handover to WA Police later that afternoon.

108 Police officers attended the prison and assessed the scene, including by conducting a search of Mr Shahzad's cell. The cell was tidy, except for the mattress which was off the bed. No suicide notes, or other documents of interest, were located. Police officers found no evidence of criminality, or third-party involvement.

109 The Detective Sergeant within WA Police's Homicide Squad investigating Mr Shahzad's death produced a report to this Court in June 2025, in which he also concluded, based on his review, that there was no evidence of any suspicious circumstances.

110 On 2 December 2025, WA Police's Major Crime Division received a letter from Prisoner FC, dated 5 November 2025, regarding Mr Shahzad's treatment in prison. Prisoner FC had also been imprisoned at Casuarina in 2023 during the time when Mr Shahzad was incarcerated there.

111 In his letter, Prisoner FC alleged:

(a) that Mr Shahzad had pressed the panic button in cell 8 on the date of his death, but officers delayed responding;

(b) that Mr Shahzad was distressed due to what Prisoner FC considered to be poor induction at Acacia, including a failure to provide certain basic items including clothing and eating utensils;

(c) that Mr Shahzad's requests for assistance were ignored by prison staff at Acacia, or met with contempt; and

(d) that the alleged lack of professionalism and care by prison staff at Acacia led to Mr Shahzad's suicide.

112 These allegations were investigated by a Detective Sergeant in WA Police's Coronial Investigation Squad. The Detective Sergeant's conclusions are contained in a report dated 19 December 2025.

113 The Detective Sergeant found no evidence that a panic button was activated in Mr Shahzad's cell on 11 November 2024, or that there was any delayed response to the same.

114 At the inquest, Ms Palmer confirmed that she had requested that staff at Acacia conduct an audit in relation to this allegation and confirmed that there was no record of the panic button in Mr Shahzad's cell being pressed or activated on the day. Ms Palmer was also satisfied through her own review of the available material, that there was no evidence to suggest Mr Shahzad had activated the panic button in his cell that day.

115 The Detective Sergeant examined the CCTV footage and concluded that staff responded promptly once they were alerted to the emergency. I concur, having reviewed the footage myself.

116 The Detective Sergeant examined available records and concluded that Mr Shahzad was inducted into Acacia according to the prison's protocols and had access to essential items. Ms Palmer confirmed that she held the same view, upon her review. I have not identified any evidence which is inconsistent with these conclusions and find accordingly.

117 The Detective Sergeant concluded that there was property of Mr Shahzad which was pending transfer from Casuarina to Acacia. This is a matter I return to below, including in relation to Mr Shahzad's CMS inquiries.

118 The Detective Sergeant did not identify evidence, including amongst interview material and CCTV footage, of unprofessional behaviour by staff at Acacia, including any behaviour that could reasonably be said to have caused or contributed to Mr Shahzad's apparent suicide. Ms Palmer

reached the same conclusion. Again, I have not identified any evidence which is inconsistent with these conclusions and find accordingly.

Serco's post-incident review

119 Serco conducted an internal review of Mr Shahzad's death, which involved the review of documentation as well as the CCTV footage. The review identified the issues concerning the CMS requests by Mr Shahzad, and the responses provided at the time.

120 In respect of his property, the review report stated that Mr Shahzad arrived at Acacia with more than eight boxes of property. Serco's position was that due to the volume of the property (which had to be assessed and itemised), the time taken for Mr Shahzad's property to be available for collection was consistent with typical processing times.

121 According to Serco's records, the property was made available for collection on 10 November 2024, but '*operational pressures*' meant that Mr Shahzad was not escorted to the property store to collect it.

122 There is no evidence that Mr Shahzad was advised, prior to his death, that his property had arrived at Acacia, nor that it was ready for collection.

123 The review recommended that Acacia review their property processes to ensure that prisoners arriving with larger quantities of personal property can access a small number of more essential items, including toiletries, more immediately after their transfer, while awaiting the processing of the total contents of their property.

124 The review also recommended that a process be created which ensures that any CMS requests received which indicate that a prisoner may be in distress or at risk are identified.

Department of Justice's PAR review

125 The Department's PAR review is intended to identify systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future. The review also seeks to identify opportunities for improvement in Departmental policies and procedures. Although the review is performed by officers employed by the Department, those officers do not form part of Corrective Services and are not custodial officers. Consequently, a PAR review is intended to have greater independence then an internal review conducted by prison staff.

126 The PAR review found that Mr Shahzad's custodial management, supervision and care were generally in accordance with Departmental policies and procedures, and that the response of Acacia custodial staff to the critical incident was prompt and appropriate. The review also concluded that Departmental death in custody procedures, including notifications and handover to WA Police, were followed.

127 The author of the PAR review otherwise noted that the Department endorsed the conclusions of Serco's internal review.

Cause and manner of death

128 Forensic pathologists conducted a post mortem examination on 20 November 2024.

129 The pathologists identified a ligature mark around the neck with features consistent with the ligature provided by police for examination. There were no other significant injuries.

130 The vessels supplying the heart muscle were narrowed by plaques (coronary artery atherosclerosis).

131 Toxicological analysis detected the presence of the antidepressant medication citalopram (and its metabolite) in blood (at 0.2 mg/L) and urine. Alcohol and common drugs were not detected.

132 Following their analysis of these results, the pathologists formed the opinion that the cause of death was ligature compression of the neck (hanging).

133 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

134 Based on the available evidence, I find that Mr Shahzad used part of his prison-issued clothing to fashion a ligature to hang himself, with the intention of ending his life.

135 In those circumstances, for the purposes of s 25(1)(b) of the Act, I find that Mr Shahzad's death occurred by way of suicide.

Treatment, supervision, and care of Mr Shahzad while in custody

Quality of Mr Shahzad's mental healthcare

136 As identified, prior to his being taken into custody, Mr Shahzad was diagnosed with PTSD and other health conditions.

137 Mr Shahzad clearly suffered periods of depressed mood and anxiety while in custody, was medicated for the same, and was the subject of reviews by psychiatric and engagement with counselling services when it was apparent that they were necessary.

138 I infer that Mr Shahzad's depressed mood was, in part, a result of his recognition of the lengthy prison sentence imposed upon him. Clinicians were responsive to his changes in mood, and appropriate referrals were made by PRAG as and when required.

139 In her review, Dr Gunson identified that Mr Shahzad had not been formally discharged from the MHT in 2023.

140 I am satisfied that this was, as characterised by Dr Gunson during her oral evidence, an administrative irregularity, and that Mr Shahzad was well-managed after that time by primary care medical officers who were equipped to deal with any issues concerning his medication.

141 I do not consider that the irregularity had any significant bearing on his subsequent healthcare or holds any relevance to his death.

142 The only missed opportunity was the doctor medication review that was intended to occur after the nursing review at Casuarina in September 2024. I assume that this may have not occurred because Mr Shahzad was transferred from Casuarina to Acacia around this time. However, it is not apparent that any absence of such a review led to any immediate issues or precipitated a severe decline in Mr Shahzad's mental state.

143 There were also at least three separate opportunities for Mr Shahzad to have raised the issue with nurses at Acacia (at intake and when he was seen twice for physical health issues) if he remained concerned that the efficacy of the anti-depressant was decreasing. It is apparent from the records of previous interactions with healthcare staff at Hakea and Casuarina that Mr Shahzad did not have difficulty raising any healthcare concerns he held, including as to his medication.

144 According to Officer Hayes, Mr Shahzad did not demonstrate any '*red flags*' to him in relation to his mental wellbeing, and he appeared to

be polite and settled. He was not aware of Mr Shahzad having concerns about the transfer of his personal property from Casuarina.

145 I am satisfied, based on his evidence, that if Officer Hayes had held any concerns about Mr Shahzad's risk, including following either of his interactions with Mr Shahzad earlier on the date of his death, he would not have hesitated to refer Mr Shahzad to ARMS.

146 I find that Mr Shahzad's mental healthcare while in custody was adequate.

Quality of Mr Shahzad's physical healthcare

147 Having regard to Dr Gunson's report, and upon my review of the records, I am satisfied that the Mr Shahzad's physical health was managed at a standard commensurate with what would have been expected had he been in the community (if not better).

148 During his time in custody, Mr Shahzad had few physical healthcare related issues beyond those described above in relation to syncopal episodes. Those episodes, and other abnormal results from routine tests, were investigated and appropriate specialist referrals made.

Custodial issues

149 Having reviewed all the evidence, I am satisfied that Mr Shahzad's management, supervision and care while in custody was adequate, and in accordance with Departmental policies and procedures.

150 I address the issue around transfer of Mr Shahzad's personal property, and the response to his CMS queries, below.

Property processes

151 I accept that the time required for the transfer, search and itemisation of Mr Shahzad's personal property would have been considerable and longer than may ordinarily be required, given the volume of property.

152 I am also cognisant that Mr Shahzad would have been one of a few prisoners being transferred to Acacia during the relevant period, and the three property officers at Acacia would have been required to undertake duties in relation to property beyond that solely belonging to Mr Shahzad.

153 Ms Palmer's evidence was that a period of a week is standard for the assessment and itemisation of property during prisoner transfer.

154 Having regard to all the above, I do not make any adverse finding in relation to the time taken by property staff at Acacia for the search and itemisation of Mr Shahzad's personal property.

155 One of the recommendations of the Serco review was for property collection processes to be reviewed, to ensure that there is an opportunity for prisoners arriving at Acacia with large amounts of personal property to be provided with early access to a small number of more essential items.

156 This was a sensible and proportionate suggestion, both to enable a prisoner to have more immediate access to personal items of significance or importance, but also to ensure that a prisoner would have greater awareness of the property transfer and review process. This would have been particularly helpful to a prisoner like Mr Shahzad, who received no specific information about the process following his multiple queries through the CMS.

157 Mr Horseman confirmed in his oral evidence that this process had not been in place when Mr Shahzad arrived at Acacia but had now been implemented as recommended by the review.

158 I am satisfied that there is no need for any recommendations in relation to property processes at Acacia, considering the above.

CMS requests

159 As identified, Acacia is the only prison currently using the CMS.

160 At the inquest, Mr Horseman confirmed that Acacia has reviewed the workflow associated with CMS requests and confirmed that any requests in relation to property from a prisoner will now go directly to the property department, rather than through a unit manager.

161 This will enable property officers to be able to, more readily, prioritise any requests, and determine any need for urgency.

162 I note that the automated responses received by Mr Shahzad appear to have, understandably, increased his frustration in relation to receipt of his property. I am satisfied that the internal review by Serco has resulted in the identification and implementation of improvements in relation to the CMS to ensure more efficient and meaningful responses in future.

163 I am also satisfied that although some responses are automated, CMS queries such as those made by Mr Shahzad are reviewed by officers who can escalate matters as required

Quality of the emergency response

164 I am satisfied, including on my review of the evidence and having regard to the opinion expressed by Dr Gunson, that the quality of the emergency response on 11 November 2024 was appropriate.

165 I find that the response of attending custodial and medical staff was prompt and diligent.

166 I am satisfied that the potential lapse in time between Mr Shahzad hanging himself and his body being discovered would have resulted in any efforts to resuscitate Mr Shahzad being made more difficult.

Conclusions

167 As identified, I am satisfied that Mr Shahzad's supervision, treatment and care while in custody were adequate. On the evidence, I conclude that his suicide was an unexpected and unpredictable outcome.

BD Nelson
Coroner
8 June 2026