**Coroners Act 1996**
**[Section 26(1)]**

*Western* *Australia*

# RECORD OF INVESTIGATION INTO DEATH

*Ref No: 15/17*

*I, Barry Paul King, Coroner, having investigated the death of* ***Beasley (also known as Graeme Leslie Syme)*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***19 April 2017****, find that the identity of the deceased person was* ***Beasley*** *and that death occurred on* ***12 June 2014*** *at* ***Royal Perth Hospital*** *from* ***complications of penetrating sharp force injuries through the chest and abdomen (surgically treated) in a man with coronary artery atherosclerosis*** *in the following circumstances:*

**Counsel Appearing:**

Ms A Sukoski assisting the Coroner
Mr J M Carroll (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

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## SUPPRESSION ORDER

**No report may be published of the inquest or any part of the proceedings or any of the evidence given at the inquest that could lead to the identification of the deceased's partner or of the deceased's and his partner's son.**

## INTRODUCTION

1. At the time of his death, Beasley (the deceased) was a sentenced prisoner. He had been placed on parole, but on 26 May 2014 his parole order was suspended by Adult Community Correction (ACC) officers after he had tested positive to methylamphetamine. On 28 May 2014 the Prisoners Review Board (the Board) cancelled his parole order and, in accordance with the relevant legislation, notified him by letter that the parole was cancelled and that he would have to return to prison.

2. The Board issued a warrant for the deceased's arrest, but the warrant was never executed.

3. Rather than turning himself in, on 10 June 2014 the deceased attended the ACC Wangara Reporting Centre where he produced a knife and stabbed himself with it repeatedly. He was taken by ambulance to Royal Perth Hospital, but he died from his injuries two days later.

4. While the deceased was at Royal Perth Hospital he was placed into the muster of Hakea Prison and guards sat in his hospital room until he died.[1]

5. At the time of his death, the deceased was in the custody of the Chief Executive Officer of the Department of Corrective Services (DCS) under s16 of the *Prisons Act 1981* so he was a 'person held in care' under s 3 of the

[1] Exhibit 1, Volume 2, report before Tab 1

*Coroners Act 1996* (the Act). His death was therefore a 'reportable death' under the Act.[2]

6. Under s19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death.

7. Section 22(1)(a) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care. An inquest into the death of the deceased was therefore required under the Act.

8. Under s25(2) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while in that care.

9. On 19 April 2017 I held an inquest into the deceased's death.

10. The focus of the inquest was on ACC's supervision of the deceased while he was on parole, ACC's decision to suspend the parole order, and the legislative requirement that the Board notify parolees in writing of the cancellation of their parole orders.

11. The documentary evidence adduced at the inquest comprised:

    a. a report prepared by Detective First Class Constable Daniel Cawley of the Coronial Investigation Unit of the Western Australia Police;[3]

    b. a report by Richard Mudford, senior review officer of the Department of Corrective Services (DCS);[4]

    c. the DCS Health Services EcHO file for the deceased;

    d. the Board's file for the deceased;

[2] Section 3 *Coroners Act 1996*
[3] Exhibit 1, Volume 1
[4] Exhibit 1, Volume 2

e. Royal Perth Hospital medical notes for the deceased;

f. the Board's policy manual;

g. email correspondence between Professor David Joyce, the clinical director of PathWest's Clinical Pharmacology & Toxicology Laboratory, and Ms Sukoski;[5]

h. Urine Drug Screen Chain of Custody Form of 19/05/2014;[6] and

i. DCS Decision Making Guide – ACC.[7]

12. Following the inquest, Mr Mudford provided the court with the DCS Community Business Information System (CBIS) records for the deceased.

13. Oral evidence was provided by:

a. Alan Watkins, the assistant director of ACC;[8]

b. the deceased's case manager in the ACC North West Metropolitan region;[9]

c. Mr Mudford;[10]

d. Angela Delaney, the executive director of the Board.[11]

14. I have found that the deceased's treatment and care while at Royal Perth Hospital was appropriate, but that the ACC's supervision of him while he was on parole did not comply with the requirements of the conditions on the parole order.

15. I have recommended that the Government consider amending or repealing the legislative requirement for the

[5] Exhibit 2
[6] Exhibit 3
[7] Exhibit 4
[8] ts 7 – 30, per Watkins A
[9] ts 30 – 34
[10] ts 34 – 42, per Mudford R
[11] ts 42 – 53 per Delaney, A

Board to notify parolees in writing as soon as practical of parole cancellation.

## THE DECEASED

16. Unless indicated otherwise in footnotes, the following information was obtained from a statement provided to police investigators by the deceased's brother, Shane Syme (Mr Syme).[12]

17. The deceased was born on 8 March 1965 in Subiaco to Bryan and Jill Syme. He was named Graeme Leslie Syme and was raised in Balga.

18. From childhood the deceased suffered from attention deficit hyperactivity disorder (ADHD) and a bad stutter. He found it difficult to speak a full sentence, so he tended to keep his thoughts bottled up.

19. When the deceased was about 15 years old he moved into a house with his then partner, Brenda. When he was 16, he got a tattoo on his arm that said 'Beasley', and a short time after that he took on the name Beasley, possibly after the name of his favourite football player, Simon Beasley.

20. When the deceased was about 18 years old, he and Brenda moved to Geraldton. They had three children together, but when he was in his 30's their relationship broke down and he left Geraldton to travel around Australia.

21. Over the next few years the deceased had no contact with his family. He then turned up unannounced at his mother's house. Mr Syme found him temporary work, but he did not enjoy living in Perth so he returned to Geraldton. From that time, Mr Syme was in regular contact with him.

22. The deceased was a user of illicit drugs, partly because his stutter would disappear when he was affected. He was also prescribed dexamphetamine for the ADHD, which allowed him to function reasonably well.

[12] Exhibit 1, Volume 1, Tab 6

23. The deceased had a long criminal history, primarily of a minor nature until 2001 when he began to have relatively frequent convictions relating to possession of cannabis and smoking implements. In December 2003 he was convicted of possession of amphetamine with intention to sell or supply. He was sentenced to two years and 8 months imprisonment and was declared a drug trafficker.[13]

24. While in Geraldton the deceased developed a relationship with a woman (the deceased's partner) with whom he lived and had a son.

25. The deceased was convicted of further charges of possession of amphetamine or methylamphetamine in 2006, 2007 and 2009 for which he was fined, indicating that the nature of the charges was relatively minor.[14]

26. In September 2009, the deceased was imprisoned for nine months for conspiracy to commit assault occasioning bodily harm. About two weeks later, he received fines for a series of charges relating to possession of cannabis in 2008.[15]

27. On 27 October 2010 the deceased was convicted of four charges relating to offering to sell or supply methylamphetamine. He was sentenced to a total of five years imprisonment.[16]

28. During this last period of the deceased's incarceration his behaviour in prison was exemplary. He showed a strong work ethic, completed treatment programs and was compliant while on re-integration leave.[17] Over this time, the deceased's partner was very supportive, and they maintained a good relationship. When the deceased was released on parole in October 2013, he moved back in with his partner and was able to obtain part-time work as a storeperson.

[13] Exhibit 1, Volume 3, Tab 2
[14] Exhibit 1, Volume 3, Tab 2
[15] Exhibit 1, Volume 3, Tab 2
[16] Exhibit 1, Volume 3, Tab 2
[17] Exhibit 1, Volume 2, report before Tab 1

29. About two months after the deceased had been released from prison, he and his partner had difficulties with their relationship. He moved out of their home to live with a friend, and on 8 March 2014 he moved to Craigie to live with Mr Syme.

30. Mr Syme assisted the deceased in getting his life back on track. He provided the deceased with free accommodation and employed him in his plumbing business. The deceased caught on quickly with work issues and appeared to be happy with how his life was going.

## PAROLE SUPERVISION

31. Before the deceased was released on parole by the Board on 19 October 2013, he had been assessed as a marginal candidate for parole due to his re-offending after previous parole. Concerns were held about his risk of relapse to substance abuse. Among other requirements, the parole order issued by the Board required him to undergo 'Frequent and random urinalysis for all illicit substances' and 'to attend programmes and counselling as directed'.[18]

32. Between the deceased's released from prison and 4 March 2014 the deceased had frequent contacts with staff at the ACC office in Geraldton, including for random urinalysis. On each occasion that he underwent urinalysis, he tested positive to amphetamine consistent with his prescription of dexamphetamine. No other common drugs, including methylamphetamine, were detected. It appears that his last urinalysis in Geraldton occurred on 20 January 2014.[19]

33. On 17 February 2014 the deceased attended the ACC office in Geraldton and informed a community corrections officer that he was thinking of speaking to Mr Syme about moving in with him. On 4 March 2014 the deceased told the officer that he was planning to go to Perth on 8 March 2014 and would stay with Mr Syme from then.[20]

[18] Exhibit 1, Volume 2, Tab 1
[19] DCS CBIS records for the deceased
[20] DCS CBIS records for the deceased

34. The deceased was directed to report to the Mirrabooka ACC office on 18 March 2014. When he attended that office, he was directed to attend the ACC office again on 1 April 2014, after which he would be able to report to the Wangara Reporting Centre.[21]

35. On 1 April 2014 the deceased attended the ACC office as directed. On 3 April 2014 he went to the Wangara Reporting Centre and spoke to a community corrections officer who noted that the deceased had said that he had not attended any programs while on parole. The community corrections officer told him to report again on 15 April 2014.[22]

36. A progress case review of the deceased's parole on 10 April 2014 by the same community corrections officer identified that the deceased had not had urinalysis since January 2014. The officer attempted to call the deceased but the deceased did not answer or return the call, so the officer left a message for the deceased to complete a urinalysis the next day. It seems that the deceased did not have a phone at the time. The community corrections officer noted that the deceased had a program requirement on his parole order and that he would benefit by the ongoing support of SAC, which I take to mean 'substance abuse counselling'.[23]

37. The deceased attempted to attend the Wangara Reporting Centre on 15 April 2014 as directed, but he arrived too late due to work commitments and traffic. He was given a new direction to return on the next day, which he did. He underwent urinalysis, which detected amphetamine but not methylamphetamine. He was directed to attend again on 29 April 2014.

38. When he attended the Wangara Reporting Centre on 29 April 2014 the deceased met his new case manager for the first time. They discussed the parole order's supervision requirements, including urinalysis, and

[21] DCS CBIS records for the deceased
[22] DCS CBIS records for the deceased
[23] DCS CBIS records for the deceased

confirmed arrangements for future contact. She directed that he return on 13 May 2014.[24]

39. The deceased's case manager found it difficult to get the deceased to open up and start talking. She was not afraid, but he made her feel apprehensive and 'there was always a weird vibe' about their meetings.[25]

40. The deceased attended as directed on 13 May 2014, at which time he told his case manager that he had attended an alcohol and drug addiction centre and had another appointment for the following Tuesday. She directed him to undergo urinalysis on 16 May 2014.[26]

41. On 15 May 2014 the deceased contacted his case manager to say that he needed to work over the time he had been directed to attend urinalysis. She directed that he attend on 19 May 2014 instead.[27]

## DECEASED TESTS POSITIVE TO METHYLAMPHETAMINE

42. The deceased attended the urinalysis on 19 May 2014 and methylamphetamine was detected in his sample. A urine drug screen chain of custody form signed by the deceased,[28] together with a memo chain between Ms Sukoski and Professor David Joyce,[29] in which Professor Joyce explains the process and the results of the urinalysis, satisfy me that the deceased had used methylamphetamine.

43. It is possible, if not probable, that on 16 May 2014 the deceased sought a deferral of the urinalysis scheduled for that day because he was concerned that he would show positive to methylamphetamine that he had used recently.

[24] DCS CBIS records for the deceased
[25] Exhibit 1, Volume 1, Tab 7
[26] DCS CBIS records for the deceased
[27] DCS CBIS records for the deceased
[28] Exhibit 2
[29] Exhibit 2

44. The results from the urinalysis on 19 May 2014 were provided to the deceased's case manager on 26 May 2014. Following departmental procedures, she reported the urinalysis result to her team leader in a breach advice, which the team leader referred to the branch manager. The branch manager's decision was to suspend the deceased's parole, to issue a warrant for the deceased's arrest and to email the breach advice to the Board.

45. The deceased attended the Wangara Reporting Centre on 27 May 2014 and saw his case manager for a scheduled meeting. In accordance with ACC policy, she did not inform him that his parole had been suspended and a warrant issued. She instructed him to attend for urinalysis on 3 June 2014 and to report again at 5.00 pm on 10 June 2014.

46. Also on 27 May 2014 the Board cancelled the deceased's parole, and on 28 May 2014 it sent a letter to the deceased advising him that it had cancelled his parole order and had issued a warrant. The letter also informed the deceased that he could apply for a review of the Board's decision by writing to the Board.[30] He received the letter on Friday 30 May 2014. When he received it, he told Mr Syme that he had done nothing wrong.[31]

47. On that weekend, the deceased's partner came to Perth to visit a friend of hers and the deceased's who was in hospital. The deceased went to see her and their friend and, when he returned home he told Mr Syme that he had given his car to his partner to use to get back to Geraldton. The deceased then seemed dazed and confused.[32]

48. On 3 June 2014 the deceased attended the Wangara Reporting Centre with Mr Syme. He spoke to an officer, showed him the letter which he had received from the Board, and denied using methylamphetamine. He insisted on speaking to his case manager, but eventually indicated that he would call the team leader that afternoon.

[30] Exhibit 1, Volume 1, Tab 15
[31] Exhibit 1, Volume 1, Tab 6
[32] Exhibit 1, Volume 1, Tab 6

49. The deceased called the team leader and adamantly denied using methylamphetamine. The team leader encouraged him to hand himself into police, but the deceased said that he had too much to lose. The deceased passed his phone to Mr Syme who asked about the best avenue to deal with the situation. The team leader told him that the deceased should hand himself in. He also said that the deceased could write to the Board to request a review, but did not feel that the Board would entertain that if the deceased was still in the community.[33] He told Mr Syme that it would be in the deceased's best interests to get as many character witness letters as possible.[34]

50. On 6 June 2014 the deceased attended the North West Metropolitan ACC office in Mirrabooka with Mr Syme and demanded to see his case manager. When informed by the receptionist that she was not there, he left a note to her enclosing a submission which he asked her to send to the Board. In the submission he asserted that he had done nothing wrong and offered some possible explanations for how he could have tested positive to methylamphetamine nonetheless.[35]

51. During the time following the cancellation of the deceased's parole and the issuing of a warrant to arrest him to return him to prison, the deceased remained at large.

52. The ACC Handbook, a manual of policies and procedures for ACC officers, provided a procedure to apply to a situation where there is concern about the execution of a warrant, including where the parolee continues to report to the community corrections officer after the parole suspension. The procedure was for ACC to contact the relevant police unit by telephone.[36] It seems that no such contact was made in relation to the deceased.

[33] DCS CBIS records for the deceased
[34] Exhibit 1, Volume 1, Tab 6
[35] Exhibit 1, Volume 1, Tabs 5 and 17
[36] Exhibit 1, Volume 2, Tab 18

## 10 JUNE 2014 – EVENTS LEADING TO THE DECEASED'S DEATH

53. The deceased's appointment at the Wangara Reporting Centre to see his case manager on 10 June 2014 was for 5.00 pm, but he told Mr Syme that he wanted to get it out of the way first thing, so they went there at 8.00 am. When the deceased checked in at the reception counter, he was told that his case manager would not arrive until 10.30 am. He said, incorrectly, that he had an appointment at 5.30 pm and that he would return later in the day. He and Mr Syme then went to Welshpool to look at vehicles for auction.

54. An officer at the Wangara Reporting Centre made arrangements with police officers to attend at 5.30 pm to arrest the deceased.

55. At about 10.45 am, the deceased and Mr Syme returned to the Wangara Reporting Centre. When they entered, the deceased's case manager was at the reception counter. The counter was about 1.5 metres high with thick glass slats above it to prevent anyone from jumping over it. Behind the counter was a secure area to which the public had no access.[37]

56. The deceased told his case manager that he was there for his supervision and he indicated the supervision room. She told him that there would be no supervision and that his parole was cancelled. He asked if she had seen his letter, and she replied that she had not. He asked her to pass it along to the Board. She said that she would, but that he had to hand himself in to police in order to go through the process, and the Board would assess him.[38]

57. Up until that point, the deceased appeared calm and rational, but he then began to yell that he was not going back to prison. He produced a folding knife and began to stab himself in the chest and to cut his neck area, yelling terribly. He went down a hallway, banged on a door to the secure area of the office and fell to the floor.

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[37] Exhibit 1, Volume 1, Tab 7
[38] Exhibit 1, Volume 1, Tab 7

58. Mr Syme followed the deceased and managed to remove the knife, but not before the deceased had inflicted further wounds to himself. Mr Syme took the knife outside and placed it behind a bollard so that the deceased would not find it.

59. As Mr Syme went back to the door of the office to re-enter, the deceased came to the door and dropped to one knee. Mr Syme told him to get into the car to go to the hospital, but the deceased said that it was better if he died and that he was not going back to prison.[39]

60. Mr Syme took off his shirt and used it to apply pressure to the deceased's throat until ambulance officers arrived and conveyed the deceased to Royal Perth Hospital. On the way, his pulse became very weak and slow. Full resuscitation was administered.[40]

61. At Royal Perth Hospital the deceased was placed on life support. His condition deteriorated until about 6.00 pm on 12 June 2014, when the life support was withdrawn and he died.

62. At about 3.00 pm that afternoon Mr Syme had found a letter from the deceased in which he indicated his intention to end his life. He also asked Mr Syme to give all his possessions to his partner. With the letter was a heartfelt letter to the deceased's partner.[41]

## CAUSE OF DEATH AND HOW DEATH OCCURRED

63. On 16 June 2014 forensic pathologist Dr A V Spark conducted a post mortem examination of the deceased's body and found multiple sharp and blunt force injuries, including penetrating sharp force injuries (stab wounds) to the chest and abdomen, with an incised sharp force injury to the neck and injuries to:

    a. the left external jugular vein;

[39] Exhibit 1, Volume 1, Tab 6
[40] Exhibit 1, Volume 1, Tabs 6 and 12
[41] Exhibit 1, Volume 1, Tab 16

b. the left ulnar artery at the level of the wrist;

c. the right internal mammary artery;

d. the upper lobe of the right lung;

e. the epicardial surface; and

f. the liver.

64. There was evidence of extensive surgical and medical intervention, including the absence of the anterior part of the pericardial sac and anterior mediastinal tissues and the bowel from the distal small intestine to the rectum. There was also severe coronary artery atherosclerosis.

65. Microscopic examination showed haemorrhage and minor scarring around the vessels in the elbow creases and interruption to the blood supply to the bowel wall. Neuropathological examination showed no significant abnormalities, and toxicological analysis detected only therapeutic drugs.

66. Dr Spark reviewed the Royal Perth Hospital notes from the deceased's last admission and noted ongoing haemodynamic instability, extensive resuscitation with fluid and blood products, multiple surgeries, and multiple organ failure resulting in death.

67. Dr Spark formed the opinion, which I adopt as my finding, that the cause of death was complication of penetrating sharp force injuries through the chest and abdomen (surgically treated) in a man with coronary artery atherosclerosis.

68. On the basis of the information available, I am satisfied that, with an intention to end his life, the deceased used a knife to stab himself in the chest and abdomen, causing injuries that led to complications which, in the context of severe coronary artery disease, caused his death.

69. I find that death occurred by way of suicide.

## CHANGES TO ACC PROCEDURES

70. Mr Watkins said that, following the deceased's death, ACC changed the focus of their decision-making process when a parolee's urinalysis results were positive to an illicit drug.

71. At the time of the deceased's death, the chapter relating to urinalysis testing in the ACC Handbook noted that any positive result for any drug should be considered as a sign of elevated risk and action must be taken as identified in the Enforcement Policy'.[42]

72. The Enforcement Policy, found in another chapter of the handbook, directed case managers to ensure that any non-compliance was 'enforced in a manner that mitigates the risks posed to the community and meets the requirements of legislation, departmental policy and the expectations of sentencing and releasing authorities'. All incidents of non-compliance were to be referred to the Board, and if the recommendation to the Board was to suspend the parole order, the branch was to undertake the suspension.[43]

73. While the deceased was not considered a risk of harm to community safety, ongoing drug use was considered detrimental. For that reason, the branch manager's decision was to suspend the parole order without considering an alternative.[44]

74. Following the deceased's death, ACC amended that chapter to include reference to the results of urinalysis being a strong motivator for change which may be used in parallel with the Enforcement Policy or alternative appropriate action.

75. Mr Watkins agreed that ACC recognised that urinalysis can be something that parolees can rely on to their own benefit and that, by not requiring the deceased to undergo urinalysis from 20 January 2014 to 16 April 2014, ACC

[42] Exhibit 1, Volume 2, Tab 16A
[43] Exhibit 1, Volume 2, Tab 18
[44] Exhibit 1, Volume 2, report before Tab 1

did not comply with the expectations of the Board and, at the same time, let the deceased down.[45]

76. The change of focus was to bring staff and managers to think about what the consequences of their decisions would be.[46] Mr Watkins considered that, if the deceased had been dealt with today for his positive urinalysis, there might be a different result. He said that ACC tries to engage people more now.[47]

77. Another change implemented by ACC was the creation of a decision making guide,[48] which assists community corrections officers to ensure that all relevant issues are considered when decisions are made, including with respect to positive urinalysis results. Mr Watkins explained that one of the issues identified was whether there was sufficient risk to issue a warrant and suspend parole, or whether an officer could talk to the offender about the results and try to re-engage with him or her to form a treatment or action plan for the Board to consider.[49]

78. ACC also undertook a 'lessons learned' process whereby the following issues, among others, were identified:[50]

    a. a need to remind staff and managers to use the option to temporarily suspend parole rather than permanently suspend it, where 'apparent'[51]; and

    b. a need for staff to track warrants and to call police where there was an outstanding warrant.

79. In a case summary of the deceased's management, four 'clear learnings' were identified, the first of which was to have a clearly recorded analysis of elevated risk before determining a course of action.[52]

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[45] ts 26 per Watkins, A
[46] ts 8 per Watkins, A
[47] ts 25 per Watkins, A
[48] Exhibit 4
[49] ts 20 per Watkins, A
[50] Exhibit 1, Volume 2, Tab 28
[51] Possibly meaning 'appropriate'
[52] Exhibit 1, Volume 2, Tab 29

80. In his report,[53] Mr Mudford identified three further case management practices relevant to the deceased's management:

    a. no senior officer oversight of the deceased's case for the first seven weeks;

    b. no documented justification for a lack of urinalysis for three months; and

    c. a delay of six months in the initiation of the deceased attending a drug and alcohol intervention program.

81. Mr Mudford recommended that ACC raise the findings of his report to centre managers, highlighting the importance of timely offender case reviews and adherence to releasing authority expectations.[54] The CEO of the DCS indicated in a cover letter to Mr Mudford's report that his recommendation would be tracked internally.

## THE PRISONERS REVIEW BOARD NOTIFICATION TO THE DECEASED

82. ACC's policy as provided in the ACC Handbook is not to advise a parolee that a return to prison warrant had been issued because that advice might enable the parolee to avoid arrest or trigger behaviour that could escalate the danger to the community, the police or ACC staff.[55] Mr Watkin's recollection was that the policy was implemented after police officers arrested a parolee who had been advised of a warrant, and found at his home a large cache of weapons which he had collected to be ready for police.[56]

83. As noted above, the Board notified the deceased of its decision to cancel the parole order in a letter sent on 28 May 2014. The deceased received the letter on 30 May 2014 but remained at large until 10 June 2014.

[53] Exhibit 1, Volume 2, report before Tab 1
[54] Exhibit 1, Volume 2, report before Tab 1
[55] Exhibit 1, Volume 2, Tab 18
[56] ts 16 per Watkins, A

84. On 17 June 2014 the assistant commissioner of ACC spoke with the chairperson of the Board, and asked him to review the Board's practice of sending a parolee a letter explaining its decision.[57]

85. The chairperson wrote to the assistant commissioner by letter dated 18 June 2014, explaining that the Board was bound by s107B(1) and s107B(2) of the *Sentencing Administration Act 2003* to give parolees written notice of any decision made in respect of the parolee as soon as practicable after the decision is made. The chairperson said that he would be happy to consider any suggestion that may assist to reduce the potential risk posed to a parolee or departmental staff upon receipt of advice from the Board of cancellation of parole.[58]

86. Mr Watkins said that in his view it would be useful for the Board to be given some discretion as to when it notifies a parolee so that it could take the risk into account. However, he also agreed that the problems associated with the deceased having been notified by the Board would not have occurred if he had been arrested immediately upon the warrant of arrest being issued.[59]

87. In my view, the legislative requirement for the Board to notify parolees of the cancellation of their parole while the parolee is still at large has the clear potential to result in dire consequences, as identified in the ACC Handbook. In these circumstances, I make the following recommendation:

## Recommendation

**That the Western Australian government review and, if appropriate, amend or repeal the requirement in s107B *Sentencing Administration Act 2003* for the Prisoners Review Board to give a prisoner written notice of a decision to amend, suspend or cancel an early release order as soon as practicable after the decision is made.**

[57] Exhibit 1, Volume 2, Tab 20
[58] Exhibit 1, Volume 2, Tab 20
[59] ts 29 – 30 per Watkins, A

88. In relation to the fact that the deceased was at large for an extended period despite the fact that a warrant had been issued for his arrest, Mr Watkins said ACC's relationship with the West Australian Police in relation to the execution of arrest warrants is much better than it was at the time of the deceased's death. Now, if branch managers are having difficulty, they can contact the assistant commissioner, who can take the matter to senior management to contact the police direct.[60]

## COMMENT ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

89. There is no evidence to suggest that the treatment and care of the deceased in Royal Perth Hospital while under guard was anything but appropriate.

90. I am not required to comment on the supervision of the deceased while he was on parole or when he was at large after the parole order had been cancelled. However, it is appropriate that I record my view that in failing to ensure that the deceased underwent frequent and random urinalysis for three months, and in failing to ensure that the deceased attended an alcohol and drug intervention program for even longer, ACC failed to comply with the Board's requirements under the parole order.

91. Those failures exposed the community to a risk, albeit an apparently nominal risk in the case of the deceased, and also removed a regimen that may have assisted the deceased to re-integrate into the community.

92. I am satisfied that ACC has since taken steps to rectify the circumstances which gave rise to its failures with respect to supervision of the deceased's parole.

[60] ts 29 per Watkins, A

## CONCLUSION

93. After learning that his parole order had been cancelled, the deceased committed suicide in a dramatic and disturbing way rather than having to face a return to prison.

94. While the supervision of the deceased's parole was characterised by two significant failures, it is not possible to determine whether there would have been a different outcome had the supervision accorded completely with the conditions imposed by the Board.

95. This is especially so because the deceased used methylamphetamine with full appreciation that in doing so he was risking his freedom, which he was not willing to live without.

B P King
Coroner
11 July 2017