Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 16/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Ayumi KIMOTO*** *with an inquest held at the* ***Perth Coroner's Court, Court 52, CLC Building, 501 Hay Street, Perth****, on* ***5 May 2014****, find that the identity of the deceased person was* ***Ayumi KIMOTO*** *and that death occurred on* ***21 March 2010*** *at* ***Hakea Prison*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Ms R Hill (State Solicitors Office) appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. Ayumi Kimoto (the deceased) died on 21 March 2010 at Hakea Prison (Hakea) after he was found suspended from a hand basin in his cell.

2. As the deceased was a prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA).

3. Pursuant to section 22(1)(a) of the *Coroners Act*, as the deceased was a person held in care immediately before his death in Western Australia, an inquest was required to be held.

4. I held an inquest at the Perth Coroner's Court on 5 May 2014.

5. Under s 25(3) of the *Coroners Act*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The inquest focused primarily on the admission of the deceased into prison and the assessment of his risk of self-harm at that time, as well as the steps taken by the Department of Corrective Services to minimise risk of suicide by hanging in the prison environment since the death of the deceased.

7. The documentary evidence tendered comprised a total of four volumes,[1] as well as some photographs[2] and a Management Review Report from the Department regarding the circumstances of the death of the deceased.[3]

[1] Exhibits 1 - 4.
[2] Exhibit 5.
[3] Exhibit 6.

8. Substantial documentary evidence was provided from the Department relating to the Department's Ligature Minimisation Program and suicide prevention strategies and two witnesses gave oral evidence expanding upon that information.

9. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department). The authors of both reports were called as witnesses.

10. In addition, oral evidence was heard from a number of key Departmental staff who had contact with the deceased in the days and hours preceding his death.

BACKGROUND OF THE DECEASED

11. The deceased was born on 23 June 1977 in the United States of America to Japanese parents. He held joint USA and Japanese citizenship.[4] His father's occupation required him to travel extensively, so the deceased lived in many parts of the world during his early years.

12. When he was 16 years old the deceased was sent to boarding school in the United States and later attended Boston University, where he studied computer science and photography. After one year he left Boston University, but continued to study photography and eventually started his own photography business.

13. The deceased based himself in Bangkok, Thailand, where he lived in an apartment owned by his family. He travelled the world as a freelance photographer.

14. The deceased was disciplined in his habits. He did not consume alcohol or use drugs. He was always careful about his safety when travelling to other countries.[5] He

[4] Exhibit 1, Tab 25 and Tab 26.
[5] Exhibit 1, Tab 26 [24] – [28].

had never been in trouble with the authorities before his visit to Perth.[6]

15. Although they lived in different countries, the deceased kept in regular contact with his parents and his sister by telephone and email. He was not always cheerful, and his family suspected that he was sometimes depressed about not being able to support himself financially as a photographer.[7]

16. However, the deceased's photographs had been selected for display in the FotoFreo Exhibition in Perth, Western Australia, held in March 2010. The deceased had told his father about his selection and appeared happy and proud, considering it a major achievement as a photographer.[8]

17. Before travelling to Perth, the deceased had no apparent reason to want to take his own life. He had never talked previously about suicide to his family.[9] He was last seen by his parents in February 2010 in Bangkok. At that time he appeared happy and healthy.[10]

ARRIVAL IN WESTERN AUSTRALIA

18. On 18 March 2010 the deceased flew to Perth to attend the FotoFreo Exhibition, which was part of the City of Fremantle Festival of Photography. On his arrival at the Perth International Airport the deceased's luggage was selected for examination by Australian Customs and Border Protection Service (Customs) staff.[11]

19. A search of the deceased's luggage located a computer hard drive. The hard drive was checked by Customs staff and found to contain movies and images that were alleged to come within the definition of child

[6] Exhibit 1, Tab 25 [15] – [16].
[7] Exhibit 1, Tab 25 [22] – [23].
[8] Exhibit 1, Tab 25 [25].
[9] Exhibit 1, Tab 26 [29].
[10] Exhibit 1, Tab 25 [19].
[11] Exhibit 1, Tab 2, p 2.

pornography, importation of which is prohibited under the provisions of s 233BAB(5) of the *Customs Act 1901* (Cth).[12]

20. Customs officers Byron Nunn and Vesna Watt conducted a voluntary taped record of interview with the deceased about the circumstances surrounding the importation of the hard drive.[13] During the interview the deceased in effect admitted possession of the hard drive but stated he did not know that it contained child pornography and if he had known its contents he would not have brought it with him.[14]

21. Subsequent to the interview, the deceased was informed that he was under arrest for the offence of importing child pornography.[15] He was permitted to contact the Japanese consulate by telephone and to speak to a lawyer.[16]

22. He was then taken to the Perth Watch House. The admission form noted that he was compliant and cooperative, and was assessed as low risk.[17] The deceased spoke to a person at the Japanese Consulate via telephone during the evening. He spent the night in the cells. It appears from the observation running sheet that the deceased did not sleep well.[18]

23. The deceased appeared in the Perth Magistrates Court the following morning. Bail was refused as he had been charged with a serious offence and was considered to be a potential flight risk, given he had no ties to Australia.[19] He was remanded in custody to reappear in the Perth Magistrates Court on 22 March 2010 and taken to Hakea as a remand prisoner.[20]

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[12] Exhibit 1, Tab 2, p 2 & Tab 9 [7] – [8]; Exhibit 2, Tab 12.
[13] Exhibit 2, Tab 13.
[14] Exhibit 1, Tab 10 – handwritten notes; Exhibit 2, Tab 13.
[15] Exhibit 1, Tab 9 [15].
[16] Exhibit 1, Tab 9 [16] – [18].
[17] Exhibit 2, Tab 1.
[18] Exhibit 1, Tab 1, p. 3; Exhibit 2, Tab 1.
[19] Exhibit 2, Tab 6 & Tab 14.
[20] Exhibit 2, Tab 14.

HAKEA PRISON

24. The deceased was received at Hakea at approximately 6.15pm on 19 March 2010. He underwent an admission interview with VSO Reception Officer Neil Dent. Officer Dent is an experienced prison officer and had been working for the Department for approximately 20 years at that time, predominantly in Prisoner Reception.[21]

25. As part of the interview process Officer Dent completed an MR11 At-Risk Checklist form.[22] He asked the deceased the questions on the sheet and recorded the deceased's answers.[23] Officer Dent also noted that the deceased appeared calm and was cooperative during the interview.[24] Officer Dent recorded that the deceased expressed 'first time fears', by which he meant that the deceased had some anxiety about being in prison for the first time.[25] As part of the standard admission process, Officer Dent explained to the deceased what he could expect in the prison.[26]

26. The standard at-risk assessment process is a two-tier assessment involving both a custodial and health assessment.[27] Accordingly, after Officer Dent interviewed the deceased, the deceased participated in another interview with a fully qualified registered nurse, Christine Tingle. At that time Ms Tingle was employed at Hakea as a clinical nurse in the Medical Centre, and had been for approximately 10 years. Part of her duties was to conduct a health assessment of new prisoners, which is what she did with the deceased.[28]

27. Nurse Tingle assessed the deceased using a document called a Health Assessment AMR11.[29] Nurse Tingle

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[21] Exhibit 3, Tab 24 [1] – [3]; ts 16 – 17 (Dent, N.S.)
[22] Exhibit 3, Tabs 4 & 9.
[23] ts 17 (Dent, N.S.).
[24] Exhibit 3, Tab 4; ts 17, 19 (Dent, N.S.).
[25] Exhibit 3, Tab 24 [5]; ts 17, 19 (Dent, N.S.).
[26] Exhibit 3, Tab 24 [6].
[27] Exhibit 3, Mudford Report, p.12.
[28] Exhibit 1, Tab 12 [1] – [4].
[29] Exhibit 3, Tab 4; ts 21 (Tingle, C.).

noted that it was the deceased's first time in prison and that he reported feeling a little stressed for that reason, which is not unusual.[30] The deceased did not report any health issues. He confirmed that he had no history of self-harm or suicidal ideation[31] and laughed when asked about any concerns for his mental health.[32]

28. Notwithstanding his response, if she had formed a view that the deceased was, in fact, at risk of suicide or self-harm, Nurse Tingle indicated she would have recorded it on the form.[33] However, Nurse Tingle considered he displayed no sign of having such intentions.[34] Accordingly, the deceased was not placed on the At Risk Management System (ARMS).

29. Even though the deceased was not assessed as being at risk of harming himself, he was placed in the Crisis Care Unit overnight. This is standard procedure for all prisoners charged with child sex offences due to the risk they may be harmed by other prisoners.[35] This is the same place he would have been housed if he had been assessed as being at risk of self-harm.[36] There is no evidence to suggest there were any issues and problems with the deceased that night.

30. The deceased was assessed the following morning as a protection prisoner (due to the nature of his alleged offence). He was moved from the Crisis Care Unit and placed in D Wing of Protection Unit 6 (cell D10) as a protection prisoner at 10.35am.[37]

UNIT 6

31. On arrival at Unit 6 the deceased was interviewed by Senior Prison Officer Christopher Lowe. Officer Lowe

[30] ts 21 (Tingle, C.).
[31] Exhibit 1, Tab 12 [10]; Exhibit 3, Tab 15 [6].
[32] Exhibit 1, Tab 12 [9].
[33] ts 23 (Tingle, C.).
[34] Exhibit 3, Tab 15 [6].
[35] Exhibit 3, Mudford Report, p.6, Tab 6 & Tab 24 [8].
[36] ts 19 (Dent, N.S.).
[37] Exhibit 3, Mudford Report, p.6.

explained to the deceased he had been placed in Unit 6 due to the nature of his offences, and that he may be at risk if placed in the mainstream prison population.[38] The deceased expressed concern about possible media coverage of his arrest. He also indicated he wanted to contact his lawyer but was uncertain of the lawyer's contact details.[39] The deceased believed the representative from the Japanese Consulate he had spoken to earlier would know the lawyer's details. Accordingly, Officer Lowe facilitated the locating of her number and rang the number. No one answered the call so he left a message containing his telephone number.[40] He told the deceased he would try again around lunchtime.[41]

32. The deceased was asked about contacting a family member but he was evasive and did not suggest a contact person.[42] It is possible that the deceased was reluctant to notify his family of his arrest and imprisonment as he was ashamed of his predicament.[43]

33. The deceased was asked whether he had any other concerns but he told Officer Lowe he was "fine".[44] Officer Lowe, who has considerable experience with assessing the risk levels of prisoners,[45] observed no reason to believe that the deceased was at risk of harming himself.[46]

34. The deceased was allocated to cell D10, which is a two man cell. The deceased's cellmate, Peter Gregory, was considered to be like a peer support prisoner. The deceased was placed with Mr Gregory for that reason.[47]

[38] Exhibit 1, Tab 17 [33].
[39] Exhibit 1, Tab 17 [34] – [35].
[40] Exhibit 1, Tab 17 [36] – [41].
[41] ts 30 – 31 (Lowe, C.).
[42] Exhibit 1, Tab 17 [43].
[43] Exhibit 1, Tab 25 [27] – [28] & Tab 26 [29].
[44] Exhibit 1, Tab 17 [47].
[45] Exhibit 1, Tab 17 [48]
[46] Exhibit 1, Tab 2, p.5; ts 28 (Lowe, C.).
[47] ts 28 (Lowe, C.).

35. The deceased was introduced to his cellmate at about 11.30am.[48] They had a brief conversation and then walked to lunch together and Mr Gregory informed the deceased of some of the prison rules. After lunch, Mr Gregory went back to his cell and observed that the deceased appeared stressed.[49] The deceased mentioned that he was having difficulty contacting his lawyer but he believed the consulate was trying to work it out for him.[50]

36. Mr Gregory invited the deceased to play pool, so they walked to another wing and waited for the pool table to become available. Mr Gregory went outside for a cigarette and when he returned he noticed the deceased had left and was told that the deceased had gone to speak to a prison officer.[51]

37. Mr Gregory later spoke to the deceased again, who told him that he hadn't slept in a few days and hadn't been to prison before.[52] They shared some cigarettes and made small talk before having dinner at 4.20pm.[53] The deceased then spent some time on his own watching television.

38. After they were locked in their cell at 6.30pm, the deceased and Mr Gregory chatted and shared cigarettes while watching television. The deceased spoke about his girlfriend in Thailand and described their relationship as a happy one. He indicated that he did not want to tell her about his imprisonment as he didn't want to worry her. At about 10pm the deceased appeared to fall asleep.[54]

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[48] Exhibit 1, Tab 11 [14].
[49] Exhibit 1, Tab 11 [20].
[50] Exhibit 1, Tab 11 [21] – [23].
[51] Exhibit 1, Tab 11 [27] – [29].
[52] Exhibit 1, Tab 11 [37].
[53] Exhibit 1, Tab 11 [40] – [42].
[54] Exhibit 1, Tab 11 [50] – [65].

EVENTS ON 21 MARCH 2010

39. The next morning they were woken at 6.30am and Mr Gregory left their cell at 7.15am to go to breakfast. The deceased did not accompany him.[55] They spoke later at the cell and, at sometime around 9 to 9.30am, the deceased asked Mr Gregory if he could leave the cell so the deceased could have a sleep. Mr Gregory agreed and told the deceased that he would not need to be up until 11am muster. Mr Gregory saw the deceased get into his bunk and then Mr Gregory left the cell, closing the door behind him.[56] Mr Gregory thought at that time that the deceased seemed fine, just tired.[57]

40. A unit patrol was conducted at 9.30am, which took 15 to 20 minutes to complete. Cell door observation hatches were checked on every cell in Unit 6 and nothing untoward was observed.[58]

41. Mr Gregory returned to the cell just prior to the 11am muster. He opened the cell door with a key as the personal lock was on.[59] The personal lock on the cell door locks automatically and only the cell occupants and prison officers have keys.[60] On opening the cell door, Mr Gregory immediately saw the deceased hanging from the hand basin inside the cell. He stepped out into the corridor and told another prisoner, Gregory Hine, to go and get a prison officer.[61]

42. Mr Hine went to the control room, knocked on the window and pointed to the D wing.[62] Officer Lowe and prison officer Kenneth Brown were about to carry out the muster in D Wing when they were approached by Mr Hine. He said to them "oh my God, you need to look in 12."[63] They both went to cell D12 and checked on

[55] Exhibit 1, Tab 11 [67] – [72].
[56] Exhibit 1, Tab 11 [74] – [81].
[57] Exhibit 1, Tab 11 [81].
[58] Exhibit 1, Tab 14 [4] – [5].
[59] Exhibit 1, Tab 11 [86] – [94] & Tab 17 [9].
[60] Exhibit 1, Tab 18 [8].
[61] Exhibit 1, Tab 11 [86] – [94].
[62] Exhibit 1, Tab 19 [26] & Tab 20, [28] – [32].
[63] Exhibit 1, Tab 17 [6] & Tab 18 [4] – [5].

the occupants and then Mr Hine said “No, two down” and indicated with his hand towards cell D10.[64]

43. Officer Lowe used his key to open the cell door to cell D10. He observed the deceased in a slumped position with his legs extended on the floor between the hand basin and the doorframe with what appeared to be a television aerial cord covered with material tied tightly around his neck and looped over the handle to the hand basin.[65] Officer Lowe put his arms around the deceased’s torso and lifted him up while Officer Brown attempted to take the cord from around the tap. It took two attempts to remove it.[66]

44. They then laid him on the ground, with the ligature removed, and Officer Lowe checked for vital signs while Officer Brown left the cell and raised the alarm.[67] The deceased did not have a pulse and was not breathing.[68]

45. Officer Brown returned to the cell with the Oxy-Viva and Oxy boot resuscitation equipment from the control room and Officers Lowe and Brown commenced cardiopulmonary resuscitation (CPR).[69]

46. Minutes later Nurse Tingle and another medical officer arrived at the cell.[70] They had been initially requested to attend by the officer in the control room as a precautionary measure before they knew what type of incident had occurred and as they were preparing to leave, they were notified that a code “H” had been called, which they understood to relate to a hanging.[71] They arrived with additional resuscitation equipment.

47. The medical staff took over CPR and continued until the arrival of ambulance officers.[72]

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[64] Exhibit 1, Tab 17 [7] – [8] & Tab 18 [7].
[65] Exhibit 1, Tab 17 [9] – [10].
[66] Exhibit 1, Tab 17 [12] – [13] & Tab 18 [12] – [13].
[67] Exhibit 1, Tab 17 [14] – [16] & Tab 18 [14] – [15].
[68] Exhibit 1, Tab 17 [16] & Tab 18 [20].
[69] Exhibit 1, Tab 17 [17] – [19] & Tab 18 [16] – [21].
[70] Exhibit 1, Tab 18 [21].
[71] Exhibit 1, Tab 12 [18] – [20] & Tab 19 [29].
[72] Exhibit 1, Tab 12 [23].

48. Neither the medical officers nor the ambulance officers could detect any signs of life.[73]

49. While working on the deceased Nurse Tingle noticed some superficial cuts on the deceased's inner forearms, which had not been present on the night he was admitted.[74]

50. At 12.06pm Dr Hames attended the cell and, after examining the deceased, signed the life extinct certification form at 12.10pm.[75]

51. A forensic examination was conducted of the cell and various items were seized and later examined for DNA. The majority of the DNA profiles matched the DNA reference sample taken from the deceased.[76]

CAUSE OF DEATH

52. On 24 March 2012 Chief Forensic Pathologist Dr Cooke carried out a post mortem examination of the deceased. The examination revealed a ligature-type mark to the skin of the deceased's neck, with internal neck injury. Multiple incised injuries (superficial cuts) were also noted to the fronts of both arms. There was congestion to the skin of the face and the lungs, consistent with neck compression and asphyxiation. Incidental findings included early arteriosclerosis in the arteries and early emphysema of the lungs.[77]

53. Dr Cooke concluded that the cause of death was ligature compression of the neck (hanging).[78]

54. I accept and adopt Dr Cooke's conclusion as to the cause of death.

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[73] Exhibit 1, Tab 12 [24] – [27] & Tab [46].
[74] Exhibit 1, Tab 12 [28].
[75] Exhibit 1, Tab 5.
[76] Exhibit 1, Tab 48; ts 10 – 11 (Saunders, G.R.).
[77] Exhibit 1, Tab 7.
[78] Exhibit 1, Tab 7.

MANNER OF DEATH

55. Until March 2010 the deceased had never given any indication that he was likely to take his own life. However, the events of his arrest on 18 March 2010 and subsequent remand in custody were a significant departure from his ordinary life.

56. Although the deceased appeared to be coping relatively well with his first-time imprisonment, he was still obviously stressed[79] and it seems likely that the possible consequences of the impending court proceedings weighed upon his mind. The deceased had expressed concern to Officer Lowe about possible media coverage of his arrest[80] and was reluctant to tell his family or his girlfriend about his whereabouts.[81]

57. Both of the deceased's parents understood that the deceased would have felt great shame about his arrest and imprisonment and would have been concerned about the hurt it would cause to his family and embarrassment for the photo exhibition organisers.[82] It is apparently recognised in their culture that a person must take responsibility for their mistakes and big mistakes may be seen to warrant committing suicide.[83]

58. At his own request, the deceased was left alone in his cell with the door closed for approximately an hour and a half, commencing at around 9.30am. A cell check was conducted around that time and nothing untoward was observed, which may suggest that the deceased was still well at that time. However, given the location where the deceased was eventually found in the cell, it is also possible he could have been there and remained unobserved during a cell check.[84]

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[79] Exhibit 1, Tab 12 [20].
[80] Exhibit 1, Tab 17 [34].
[81] Exhibit 1, Tab 11 [62] & Tab 17 [41].
[82] Exhibit 1, Tab 25 [27] – [29] & Tab 26 [29].
[83] Exhibit 1, Tab 25 [30]
[84] ts 28 – 29 (Lowe, C.).

59. The cuts on the deceased's inner forearms were fresh and superficial[85] and were not noted to have any role in the cause of death. They are consistent with the deceased inflicting them himself with a razor blade, most likely on the morning of the day he died.[86] A razor blade seized from the cell tested positive for blood and the DNA matched the deceased.[87]

60. I am satisfied the deceased also used the razor blade to cut a section of the aerial coaxial cable from the television in the cell.[88] He attached that part of the aerial cable to a pillow slip to form a ligature, which he tied around his neck and attached to the hand basin in the cell in order to hang himself.

61. Unfortunately, by the time the deceased's cellmate returned at close to 11.00am and discovered his body, too much time had elapsed to allow the deceased to be successfully resuscitated, although I am satisfied that everything that could be done to try to resuscitate the deceased was done by prison staff.

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

QUALITY OF SUPERVISION, TREATMENT AND CARE

63. The deceased was interviewed by two experienced staff members upon his admission to Hakea prison. They assessed his history, answers and demeanour and both considered that he did not pose a risk of harm to himself at that time. There is no evidence to suggest that they should have concluded otherwise at that time, based upon the deceased's responses and behaviour during the interviews.

[85] Exhibit 1, Tab 7, pp. 2, 7 & diagram.
[86] Exhibit 1, Tab 2, p. 23.
[87] Exhibit 1, Tab 29 [20] & Tab 48, p. 2.
[88] Exhibit 1, Tab 2, p. 23.

64. Despite their assessment, because of the nature of the charge for which he had been remanded in custody, the deceased spent his first night in the crisis care unit. He was transferred into a protection unit the following morning, after what appears to have been an uneventful night.

65. The deceased was placed in a double bunk cell with another prisoner, who appears to have been welcoming and supportive towards the deceased. The deceased's first night in the protection unit was similarly uneventful.

66. On the morning of 21 March 2010, the deceased appeared to his cellmate to be tired but otherwise fine. He gave no indication that he was feeling suicidal and his request to his cellmate to have some time alone in the cell to sleep appeared reasonable in the circumstances.

67. The deceased did not communicate his decision to take his own life that morning to any other person and I find that there was nothing in his demeanour or behaviour generally that should have alerted other prisoners or the prison staff of his intent.

68. Following the death of the deceased, a review of the circumstances of his death was conducted by Mr Richard Mudford, a Senior Review Officer from the Professional Standards Division of the Department. Mr Mudford prepared a detailed report and made seven recommendations for business improvement.[89] Mr Mudford identified those recommendations in his oral evidence.[90] In April 2014 a Management Review Report was prepared by Ms Monica Csaba from the Department's Critical Reviews Unit, updating the Department's progress in responding to those recommendations.[91] Some of the recommendations are not of relevance to this inquest.

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[89] Exhibit 3, Mudford Report.
[90] ts 33 – 39 (Mudford, R.).
[91] Exhibit 6.

69. Recommendation 2 related to priority being given to ensuring that all Hakea Prison Officers in Reception/Admission attend Suicide/Prevention Gatekeeper training. This recommendation was supported by the Department and all prison staff have now completed the training.[92] This is a positive step for the Department in its aim to prevent suicides in custody. However, in terms of this particular death, although Officer Dent had not completed the relevant training at the time he assessed the deceased, I note that Officer Dent was a very experienced officer and Mr Mudford did not suggest that his lack of participation in that course at that time would have affected his assessment of the deceased.[93]

70. Recommendation 3 related to a new ARMS reception intake assessment form, known as the ARMS-RIA, replacing the former MR011 form. I am advised the new form was rolled out state-wide in March 2011.[94] The form is more comprehensive than its predecessor and thus far the data suggests that it identifies a larger number of prisoners at risk of self-harm.[95] This also is a positive step by the Department towards suicide prevention generally.

71. Officer Dent now uses the ARMS-RIA form and he was positive about its implementation, considering it to be a very good improvement.[96] However, in Officer Dent's opinion, using the new form would not have made any difference to his assessment of the deceased.[97]

72. Therefore, it does not appear that this alteration to procedure might have affected the outcome in this particular case.

73. The other recommendations relevant to this inquest, namely Recommendations 4 and 5, were dealt with by the Department's Acting Director of Infrastructure

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[92] Exhibit 4, Tab 2 [36]; Exhibit 6, p. 3.
[93] ts 35 (Mudford, R.).
[94] Exhibit 4, Tab 2 [21]; Exhibit 6, p. 4.
[95] Exhibit 4, Tab 2 [22] - [23]; Exhibit 6, pp. 4 - 5.
[96] ts 18 (Dent, N.S.).
[97] ts 19 (Dent, N.S.).

Services, Mr Andrew Daniels. Mr Daniels provided a detailed statement and annexures,[98] and also gave oral evidence,[99] in relation to the Department's Ligature Minimisation Program. The program was initiated by an earlier inquest into a death in custody.[100] That inquest was heard in July 2009. In that earlier inquest the Deputy State Coroner did not make a specific recommendation in relation to the length of coaxial cables in cells, but it was such a cable that was used by the deceased as a ligature in that case. The Department has, quite properly, identified that cable/cord as a risk factor for suicide in prison.

74. It is apparent from Mr Daniel's evidence that since that time the Department has taken some steps to reduce the number of ligature points in cells as far as possible, within the limits of available funding. A '3 point' ligature minimisation involves removing the three most obvious hanging points in a cell, including window bars, light fittings and shelving brackets.[101] A '15 point' ligature minimisation involves removing a larger number of hanging points including, relevantly to this inquest, the hand basin and reduction of the length of power cords and television aerial (coaxial) cables.[102] It involves installing electrical and television outlets in locations that allow for modified coaxial cords with a maximum length of 30cms.[103]

75. In 2013, notices and policy directives were issued to all Prison Superintendents instructing Superintendents to ensure, where practicable, all cables within safe cells (which include multipurpose cells, medical observation and crisis care cells) were at a maximum length of 30cms.[104] A compliance check in May 2013 has

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[98] Exhibit 4, Tab 1.
[99] ts 39 – 44 (Daniels, A.).
[100] Exhibit 4, Tab 1 [8]; *Record of Investigation into Death of Simon John Loveless*, Ref: 23/09, 6 August 2009.
[101] Exhibit 4, Tab 1 [15]; Email response from Department 20.5.2014.
[102] Exhibit 4, Tab 1 [16].
[103] Exhibit 4, Tab 1 [19].
[104] Exhibit 4, Tab 1 [27] – [29].

confirmed that all prisons were compliant at that time.[105]

76. Due to limited funding, similar works in unsecure cells have not been prioritised.[106]

77. When new cells are constructed or old cells upgraded, the Department endeavours to design the cells in such a way that the shorter cables can be accommodated.[107]

78. The difficulty arises with the old cells that were not designed to accommodate electrical equipment.[108] I am informed the biggest impediment to refitting these cells is funding.[109] At Hakea, 68.7% of the cells have been '3 point' minimised and 4.7% have been fully minimised in line with the '15 point' schedule.[110] In a number of prisons, no cells have been fully minimised and have as few as 16.4% minimised in any form.[111] However, at least one of those prisons with no fully minimised cells does have safe cells that prevent the occupant from accessing cords in any event.[112] The high percentage of cells minimised at Hakea reflects the high volume of prisoners admitted on remand and who are hence more likely to be 'at risk'.[113]

79. According to Mr Daniels, the limited funding for the ligature minimisation program means that all works that can be done, have been done.[114] Any future ligature minimisation works must be funded from within existing maintenance and improvement budgets.[115]

80. I note that on the table provided there appears to be some funding for full ligature minimisation in some cells

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[105] Exhibit 6, p. 7.
[106] Exhibit 4, Tab 1 [24].
[107] ts 43 (Daniels, A.); Exhibit 6, p.7; Email response from the Department 20.5.2014.
[108] ts 43 – 44 (Daniels, A.).
[109] ts 44 (Daniels, A.); Email response from the Department 20.5.2014.
[110] Exhibit 4, Tab 1 [35] & Attachment 5.
[111] Exhibit 4, Tab 1, Attachment 5.
[112] Exhibit 6, p. 6 (Bandyup Prison).
[113] Exhibit 4, Tab 1 [38]; Exhibit 6, p. 6.
[114] Exhibit 4, Tab 1 [36].
[115] Email response from the Department 20.5.2014.

at Bandyup Prison and unfunded plans to fully minimise some cells at Greenough Regional Prison and Roebourne Regional Prison.[116]

81. It is clear from the photographs that the coaxial cord adapted for use as a ligature by the deceased was in excess of 30cms[117] and hence was not consistent with a fully minimised cell. However, given the deceased was not housed in a safe cell as he had not been deemed 'at-risk', there is some doubt as to whether the situation would have changed in relation to his cell if the ligature minimisation program had been implemented prior to his death. Mr Daniels suggested that it would not have[118] and I note that cell D10 has been '3 point' minimised since the deceased's death[119] but not fully minimised.

82. It is obviously desirable that the opportunities for prisoners to create and site ligatures be reduced wherever possible. The Department has recognised this need and commenced a comprehensive program of ligature minimisation that attempted to do this in as many cells as possible. The difficulty in completing the program appears to be one of funding for the retrofit of older cells.

83. Given the high personal costs involved in a hanging in a prison, not only for the deceased and his/her family, but also to other prisoners and the staff who must deal with the aftermath, it is to be hoped that priority will be given to funding the Department to continue this project's implementation into unsecured cells in the future.

84. The comments I have made in relation to the ligature minimisation program relate to prevention of further suicides of this kind, as each death can be learnt from. In relation to the use of a long coaxial antennae cable,

[116] Exhibit 4, Tab 1, Attachment 5.
[117] Exhibit 5.9.
[118] ts 43 (Daniels, A.).
[119] Exhibit 6, p. 6.

more than one death points to it as presenting a risk. I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death. It is simply that more can be done to prevent further deaths of this kind.

CONCLUSION

85. The deceased was a 32 year old man who arrived in Perth with great hopes for his role in a photography exhibition, only to be arrested and imprisoned for allegedly importing prohibited material into Australia.

86. Following his incarceration, the deceased became concerned for himself, his family and the organisers of the photography exhibition as to the consequences of his arrest and the likelihood of publicity. It appears that this led him to thoughts of suicide. However, he did not communicate these thoughts to any other person.

87. On the morning of 21 March 2010, having decided to take his own life, the deceased utilised the means at hand, namely an aerial cable and pillow case, to fashion a ligature and hanged himself. He died as a result.

S H Linton
Coroner
23 May 2014