Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 14/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the deaths of ***five male persons*** *(together referred to as "the deceased persons") incarcerated at Casuarina Prison with an inquest held at* ***Perth Coroner's Court, Court 51 and Court 85, CLC Building, 501 Hay Street, Perth****, on* ***26 – 29 March 2019 and 3 – 4 April 2019*** *find that the identity of the deceased persons, was as follows:*

Mervyn Kenneth Douglas BELL *and that death occurred on* ***8 September 2015*** *at* ***Casuarina Prison****, from* ***incised injury to elbow region veins****;*

Bevan Stanley CAMERON *and that death occurred on* ***2 November 2015*** *at* ***Casuarina Prison****, from* ***complications following ligature compression of the neck (hanging)***;

Brian Robert HONEYWOOD *and that death occurred on or about* ***16 February 2015*** *at* ***Casuarina Prison****, from* ***ligature compression of the neck (hanging)****;*

A male person "JS" (Subject to Suppression Order) *and that death occurred on* ***3 August 2015*** *at* ***Casuarina Prison****, from* ***ligature compression of the neck (hanging)****; and*

Aubrey Anthony Shannon WALLAM *and that death occurred on* ***22 October 2014*** *at* ***Casuarina Prison****, from* ***ligature compression of the neck (hanging)****.*

The deaths of the deceased persons occurred in the following circumstances:-

Counsel Appearing:

Mr D Jones appeared to assist the Coroner.

Ms N Eagling (State Solicitor's Office) appeared on behalf of the Department of Justice.

Ms H O'Hara (Aboriginal Legal Service WA) appeared on behalf of the family of Mr Cameron.

Mr N Barron (Aboriginal Legal Service WA) appeared on behalf of the family of Mr Wallam.

NOTE:

i. On 06 September 2018, the Deputy State Coroner made a suppression order pursuant to section 49(1)(b) of the *Coroners Act 1996 (WA)* with respect to one of the deceased persons, a male person "JS".

ii: The terms of that Order are set out below:

SUPRESSION ORDER

Suppression of the deceased's name from publication and any evidence likely to lead to his alleged victims. The deceased is to be referred to as JS.

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INTRODUCTION

1. On 25 February 2019, the State Coroner made a direction under the *Coroners Act 1996* (WA) that the deaths of the deceased persons be investigated at one inquest.[1]

2. I conducted an inquest into the deaths of the deceased persons on 26 – 29 March 2019 and 3 – 4 April 2019. Members of the family of some of the deceased persons were in attendance.

3. At the time of their respective deaths, the deceased persons were prisoners[2] in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[3]

4. Accordingly, immediately before their deaths, each of the deceased persons was a "person held in care" within the meaning of the *Coroners Act 1996* (WA) and each of their deaths was a "reportable death".[4]

5. In such circumstances, an inquest is mandatory.[5]

6. Where, as here, the deaths relate to persons held in care, I am required to comment on the quality of the supervision, treatment and care each of the deceased persons received while in that care.[6]

7. The documentary evidence adduced at the inquest included independent reports into each of the deaths of the deceased persons prepared by the Western Australia Police and by the Department of Corrective Services respectively. The Brief consisted of 12 volumes.

8. The court heard evidence from the following Department of Justice (DOJ) employees or contractors:

    i. Mr Richard Mudford, senior review officer;
    ii. Dr Daniel de Klerk, consultant psychiatrist[7];

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[1] Section 40, *Coroners Act 1996* (WA)
[2] Section 3, *Prisons Act 1981* (WA)
[3] Section 16, *Prisons Act 1981* (WA)
[4] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3) *Coroners Act 1996* (WA)
[7] Dr de Klerk provides services to DOJ on a sessional basis

iii. Mr Robert Scarparolo, social worker;
iv. Mr Brian Chadwick, Assistant Superintendent;
v. Ms Hendrina Marais, social worker;
vi. Ms Marie-Anne Deighton, psychologist;
vii. Ms Mariany Crone, social worker;
viii. Dr Joy Rowland, Director Medical Services; and
ix. Mr Shayne Maines; Executive Director, Professional Standards Division.

9. The court also heard evidence from the following non-departmental witnesses:

i. Ms Brooke Madolene[8], social worker;
ii. Dr Kaine Grigg[9], psychologist;
iii. Dr Steven Patchett[10], forensic psychiatrist; and
iv. Mr William Fairhead; father of Mr Bell.

10. The inquest focused on the supervision, treatment and care provided to each of the deceased persons while they were prisoners, as well as the circumstances of their respective deaths.

11. This Finding consists of four sections, namely:

i. background information about Casuarina Prison (the Prison), where the deaths of the deceased persons occurred;

ii. a section entitled "*Management of At Risk Prisoners*" dealing with some of the risk factors impacting on prisoner management and the strategies and tools the Department employs to address those factors;

iii. findings with respect to the incarceration and death of each of the deceased persons; and

iv. a section dealing with the Department's actions since the deaths of the deceased persons and a discussion of some opportunities for further improvement.

12. A list of abbreviations, which I hope will assist the reader, is included as annex A to this Finding.

[8] Former DOJ employee
[9] Former DOJ employee
[10] Former DOJ consultant/contractor

CASUARINA PRISON[11,12]

13. The deceased persons died at the Prison, located about 36 kilometres south of Perth in the suburb of Casuarina. The Prison opened in June 1991 as a replacement for Fremantle Prison and is Western Australia's primary male maximum-security prison.

14. The Prison has 568 cells divided into 14 units (i.e.: cell blocks) that are referred to by number (e.g.: unit 1, 2 3 etc.). Six of these units are designated "mainstream" units. Four of them have a capacity of 104 prisoners and two can hold 128. All up, the prison has a total of 1,066 beds.

15. In addition to the six mainstream units, there are six specific purpose units with the following designations: management, multi-purpose, self-care, protection, special handling, crisis care. The remaining two units are the infirmary and its overflow unit.

16. Originally, the Prison had a "campus" style design. However, following a riot there in 1998, units were compartmentalised by means of security fencing.[13].

17. Although the Prison primarily houses sentenced prisoners, the State's increasing prison population and a greater proportion of remand prisoners (ie: prisoners awaiting trial) has meant that it now houses both sentenced and unsentenced prisoners.

18. The following figures are illustrative:[14]

    i. In 2014, the average daily muster (i.e.: number of prisoners) at the Prison was 743. An average of 61% of prisoners were non-Aboriginal and 24% were remand prisoners;

    ii. In 2018, the average daily muster was 943 with 63% of prisoners being non- Aboriginal and 37% being remand prisoners.

[11] Exhibit 12, Tab 14, Statement - Mr Maines
[12] Exhibit 17, Table 1: Casuarina Prison Profile
[13] ts 03.04.19 (Maines), p503
[14] Exhibit 17, Table 1: Casuarina Prison Profile

19. The increasing number of remand prisoners housed at the Prison has placed significant pressure on available resources.[15] Remand prisoners are entitled to daily visits and phone calls from family, friends and lawyers and have also been found to require additional health and counselling services because of the mental and physical condition so many present with.[16]

20. The report of the 2016 inspection of the Prison by the Inspector of Custodial Services (the Report) notes:

> "*…a surge in remand prisoner numbers is largely responsible for overcrowding across the prison system, for many of the cost blow-outs in Corrections, and for the problems faced at Casuarina…*
>
> *Measured by national and international benchmarks, WA's prison system is chronically overcrowded…*
>
> *Compared with the rest of the country, WA already has a high rate of imprisonment and by far the highest rate of Aboriginal incarceration*".[17]

21. The Report[18] also highlights other challenges faced by the Prison, not the least of which is a 100% increase in its muster since 2006, and a 22% increase from 2014 to 2016.

22. A comprehensive review of the issues facing the Prison is outside the scope of this inquest. However, in addition to the increasing muster, the Report[19] highlights two issues which bear directly on the deaths of the deceased persons, namely:

    i. a growing number of prisoners with serious health and mental health issues; and

    ii. the under-resourcing of key services such as health and mental health.

[15] ts 03.04.19 (Maines), p508 & ts 04.04.19 (Maines), p546
[16] ts 03.04.19 (Rowland), pp372-373; ts 03.04.19 (Maines), p508 and ts 04.04.19 (Maines), p546
[17] Exhibit 12, Tab 14.2, Report - Office of the Inspector of Custodial Services, p iv
[18] Exhibit 12, Tab 14.2, Report - Office of the Inspector of Custodial Services, p iii
[19] Exhibit 12, Tab 14.2, Report - Office of the Inspector of Custodial Services, p iii

23. In addition to the role it has had to assume with respect to receiving remand prisoners, the Prison performs several high risk specialist functions including:[20]

    i. housing the state's highest risk prisoners (special handling unit);

    ii. housing those in need of a high level of protection from others (special protection unit); and

    iii. providing specialist medical care in the infirmary and its overflow unit.[21]

Crisis Care Unit (CCU)[22]

24. The CCU at the Prison is designed for the short-term management of prisoners where:

    i. a prisoner has carried out an act of self-harm;

    ii. a prisoner has said they intend to self-harm;

    iii. prison staff suspect a prisoner is in a suicidal crisis; or

    iv. a prisoner requires a "time out" placement.

25. The CCU is comprised of 12 ligature-minimised cells, all of which are fitted with a close circuit television camera (CCTV). Prisoners who satisfy the requirements of paragraph 24(i) – (iii) above, would automatically be placed on the At Risk Management System (ARMS).

26. Prisoners requiring a "time out" placement may or may not be placed on ARMS depending on whether any self-harm risk has been identified.

27. A prisoner's placement in the CCU is managed by the Prisoner Risk Assessment Group (PRAG). All of the deceased persons had placements in the CCU of the prison they were received at. In addition, Mr Bell had various placements in CCU and Mr Cameron had numerous placements in CCU during his incarceration.

[20] Exhibit 12, Tab 14.2, Report - Office of the Inspector of Custodial Services, Chapter 1, p1
[21] ts 03.04.19 (Maines), p503
[22] Exhibit 12, Tab 14, Statement - Mr Maines, paras 76-79

Special Handling Unit (SHU)[23]

28. The SHU is used to manage prisoners who pose a major threat to the prison system. Applications to place a prisoner in the SHU must address strict criteria. Prisoners in the SHU are the subject of a management plan and are visited weekly by senior prison staff. Prisoner placement in the SHU is also monitored by a committee.

29. Prisoners are not housed in the SHU as a form of punishment and have all of the entitlements of mainstream prisoners. The number and nature of the prisoners held in the SHU varies. This means that although prisoners in the SHU are supposed to spend a minimum of 3 hours outside of their cells, this does not always occur.

30. Three cells in the SHU are fitted with CCTV that are monitored continuously. Two are standard cells and the third is an observation cell which can be used for prisoners who are considered at risk.[24]

31. Dr Grigg, a psychologist with Prisoner Counselling Services (PCS) was based at the Prison at the relevant time, said that not many prisoners liked being in the SHU. This because prisoners in the SHU have limited time out of their cells and interaction with other prisoners is minimal.[25]

32. Dr Patchett (consultant psychiatrist) said the isolation of the SHU greatly increased the risk of suicide by prisoners placed there.[26] Further, Dr Grigg referred to research that suggests that prisoners can suffer irreversible psychological trauma if housed in solitary confinement for periods of 10 days or more.[27,28] Mr Bell was the only one of the deceased persons who was housed in the SHU and with the exception of periods of close confinement,[29] he spent about 13 months there.[30]

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[23] Exhibit 12, Tab 14, Statement - Mr Maines, para 19
[24] ts 03.04.19 (Maines), pp540-541
[25] ts 29.03.19 (Grigg), p318
[26] ts 03.04.19 (Patchett), p455
[27] ts 29.03.19 (Grigg), p318
[28] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J. L. & Pol'y 325 (2006), http://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24
[29] Ex 1, Tab 16.4, Unit File (Bell). His close confinement related to punishment for prison offences.
[30] Exhibit 12, Tab 14, Statement - Mr Maines, para 46

MANAGEMENT OF AT RISK PRISONERS[31,32]

Prevalence of mental health issues

33. The links between offending behaviour, substance abuse and mental health issues are complex and multi-faceted. These issues confront prison authorities on a daily basis.

34. Managing an ever-increasing prison muster and addressing and treating the often complicated mental health needs of prisoners is no doubt challenging and difficult. Mental health issues are over-represented in the Western Australian prison population.

35. A study of issues affecting recently received male prisoners in Western Australia found:[33]

    i. 40% met the criteria for a diagnosis of mood disorder, anxiety disorder, post-traumatic stress disorder (PTSD) and/or eating disorder;

    ii. 38% satisfied the criteria for personality disorder;

    iii. 24% had previously attempted suicide;

    iv. 13% had a lifetime diagnosis of a psychotic disorder (ie: schizophrenia, schizoaffective disorder or organic psychotic disorder);

    v. 10.1% satisfied the criteria for post-traumatic stress disorder;

    vi. 49% had previously sought help for mental health;

    vii. 51% had been diagnosed with a mental disorder;

    viii. 16% were on psychotropic medication prior to incarceration;

    ix. 17.9% had previously been inpatients in a psychiatric unit; and

    x. 50.9% of Aboriginal prisoners had experienced the death of a close family member in the previous 12 months.

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[31] Exhibit 12, Tab 14, Statement - Mr Maines, paras 55-88
[32] Exhibit 12, Tab 15, Statement - Dr Rowland, paras 27-36
[33] Exhibit 19, Davison, S et al, Mental health and substance use problems in Western Australian prisons. (2015) Report from the Health and Emotional Wellbeing Survey of WA Reception Prisoners & ts 03.04.19 (Rowland), pp380-381

36. The study concluded that the prevalence of mental disorders and substance abuse disorders in prisoners received into prison in Western Australia is much higher than in the general population.

37. For example, 32% of male prisoners had anxiety disorders compared with 10.8% of males in the general population whilst 77% of male prisoners had substance abuse disorders compared with 7% in the general male population.[34]

Adverse Childhood Events

38. An aspect of risk assessment that has been given more emphasis in recent times, is the pervasive impact of adverse childhood events (ACE). Examples of ACE include: family and domestic violence, sexual abuse, emotional abuse, physical abuse and neglect, the loss of parents and other loved ones (including by incarceration), parents or significant others with mental health issues and exposure to substance abuse at an early age.[35]

39. There is a strong link between ACE and an increased risk of suicide, such that those with ACE, (especially multi-factor ACE) are 30-40 times more likely to take their lives by suicide. There is also a strong link between ACE and the development of personality and mental health disorders and an increased risk of imprisonment.[36]

40. The evidence at the inquest establishes that four of deceased persons experienced ACE.

41. Mr Bell lost both parents before he was 5-years of age and was reportedly the subject of physical abuse as a child. Mr Cameron's father died from suicide as did one of his sisters and another died in a car accident.

42. Mr Honeywood was allegedly the subject of physical abuse at the hands of his father. Mr Wallam's parents separated when he was a child and both he, Mr Bell and Mr Cameron had early exposure to substance use. JS's early life is unknown.

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[34] Exhibit 19, Davidson, S - Ibid, p10.
[35] Ex 12, Tab 15, Statement - Dr Rowland, para 25 and ts 03.04.19 (Rowland), pp384-385
[36] ts 26.03.19 (de Klerk), p66 and ts 03.04.19 (Rowland), pp384-386

43. Despite the fact that ACE are known to increase the rates of mental ill health in young people and there is a well-documented and understood link between ACE and a very significant increase in the risk of suicide, Dr Rowland noted:

> "*In practice, the field of suicide prevention has yet to focus in earnest on the connection between ACE and how this manifests in the adult prison population (particularly for male prisoners).*"[37]

44. Given the impact that ACE have on suicide risk, and the fact that at least four of the deceased persons had identified ACE, it would be appropriate for these events to be factored into the risk assessments that are made by custodial, counselling and clinical staff.

45. I would also suggest that a section on ACE be incorporated into the syllabus for the Gatekeeper program[38]. The impact of ACE will no doubt vary from person to person, but given the links to suicide risk that have been identified, it would be folly to ignore ACE during any risk assessment process.

Personality Disorders (PD)

46. The personality of an individual is defined by:

> "*…their automatic patterns of thinking, emotions and behaviours, the manner in which they relate to others, and their response to their environment*".[39]

47. People's personalities are said to be "*disordered*" when they:

> "*…differ markedly from that expected in their cultures. People with personality disorders show lifelong, maladaptive responses to their environment, often associated with recurrent of persistent distress for those with the personality disorder and/or for others suffering from the consequences of their aberrant behaviour."* [40]

[37] Exhibit 12, Tab 15, Statement - Dr Rowland, para 26
[38] See paragraphs 84-98 of this Finding re the Gatekeeper program
[39] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p197
[40] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p197

48. The Diagnostic and Statistical Manual[41] groups PD into clusters A, B and C. Relevantly, Cluster B includes antisocial personality disorder (ASPD) and borderline personality disorder, the two personality disorders (PD) most commonly seen in prisons.[42]

49. APSD affects about 1 – 2% of the general community, but studies have suggested that perhaps as many as 1 in 2 males and 1 in 5 females in prison satisfy the diagnostic criteria for APSD.[43] A focus on this condition is therefore sensible.

50. The features of APSD include: a pervasive pattern of disregard for and violation of the rights of others, deceitfulness, irritability, aggression (including repeated physical fights), a reckless disregard for the safety of others, lack of empathy, impulsivity, irresponsibility and lack of remorse.[44]

51. Those with ASPD can also be perceived as deceitful, callous and hostile[45] and have difficulty regulating their emotions, coping with stress and "getting on" with people. For these reasons, ASPD affects how they experience and interpret what is going on around them, and they often struggle with the prison environment.[46] Part of the reason for the prevalence of APSD amongst male prisoners appears to be the link between impulsivity, substance abuse and criminal behaviour.[47]

52. The recommended treatment for ASPD is therapy, based on a future-focused, strength-focused and recovery model. This approach aims to equip those with APSD with "*survival and stress coping techniques*". The person with APSD is encouraged to develop an understanding of themselves and, through cognitive or dialectic behavioural therapy, to change the way they think.[48]

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[41] Exhibit 20, Extract - Diagnostic & Statistical Manual (5th Ed.)
[42] ts 26.03.19 (de Klerk), p67 ts 03.04.19 (Rowland), p382
[43] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p198
[44] Therapeutic guidelines: Psychotropic, (version 7, 2013), Melbourne, p198
[45] ts 26.03.19 (de Klerk), p68 and ts 03.04.19 (Rowland), p382
[46] ts 26.03.19 (de Klerk), p68 and ts 03.04.19 (Rowland), p383
[47] ts 26.03.19 (de Klerk), p76
[48] ts 03.04.19 (Rowland), p384

53. As will be seen, because of current PCS and mental health staff numbers at the Prison, there is no possibility of providing any level of therapy for those with APSD.[49]

54. Whilst the precise cause of ASPD is unknown, environmental factors are known to play a part and there is a link between ACE and the development of ASPD.[50]

55. There is a strong link between PD (including ASPD) and increased suicide risk. One study found that personality disorders were estimated to be present in more than 33% of individuals who die by suicide and about 77% of individuals who make suicide attempts.[51]

56. This is consistent with the ARMS manual[52] which states:

> "*Specific increases in suicide risk have been associated with prisoners with a personality disorder in particular Borderline and Antisocial personality disorders, as well as Avoidant and Schizoid (withdrawal into the self) personality disorders.*"

57. Apart from being at higher risk of suicide, prisoners with ASPD tend to be more difficult to manage. As Dr de Klerk pointed out, almost all of the "difficult" prisoners he had encountered had a PD.[53] Dr de Klerk has conducted in-service training at three prisons covering the features of ASPD and how to effectively manage people with this condition.[54] He offered to conduct more of these training sessions with custodial staff and the benefits of this training seem to me to be self-evident.

58. As an experienced PRAG chair, Mr Chadwick (Assistant Superintendent at Casuarina Prison) felt that this type of training would be valuable for custodial staff, and indeed felt "*the more training for custodial staff the better*", a sentiment with which Mr Maines and Dr Rowland agreed.[55]

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[49] ts 26.03.19 (de Klerk), p68 and ts 03.04.19 (Rowland), p383
[50] ts 03.04.19 (Patchett), p472
[51] Pompili, M; Ruberto, A; Girardi, P And Tatarelli, R: Suicidality in DSM IV cluster B personality disorders - An Overview, Ann Ist Super Sanità 2004;40(4):475-483 at 475-6 & ts 29.03.19 (Grigg), p348 re PD generally
[52] Exhibit 14, ARMS Manual (1998), p29
[53] ts 26.03.19 (de Klerk), p87
[54] ts 26.03.19 (de Klerk), pp86-87
[55] ts 27.03.19 (Chadwick), p195 & 201; ts 03.04.19 (Rowland), p395 and ts 04.04.19 (Maines), p573

59. A benefit of the training suggested by Dr de Klerk might be that staff would be better equipped to understand the challenging behaviours often associated with ASPD and learn some basic skills for better managing the prisoners so affected.[56]

60. Training of the sort suggested by Dr de Klerk might reduce the tendency for the behaviours typically exhibited by those with PD, (including ASPD), to be regarded as "*manipulative*" when in truth, those behaviours seem to be largely maladaptive ways of dealing with emotional distress.

61. Mr Bell and Mr Cameron were diagnosed with ASPD[57] and Mr Wallam either had ASPD, or exhibited traits thereof.[58]

62. It seems clear that Mr Cameron's persistent claims of self-harm and/or suicidal ideation were regarded by many staff as "*manipulative*".[59] However, as Dr de Klerk pointed out, Mr Cameron's challenging behaviours were used willingly but not intentionally:

> "*…a person like Mr Cameron is distressed in the circumstances and he employs behaviour that has got him places in the past…a person like this, because of their disruption in the development of their ability to get on with the world…they miss out on pro-social ways and effective ways of negotiating change.*"[60]

63. A documented example of a successful intervention by a PCS counsellor with a prisoner that had ASPD occurred with Mr Cameron at Greenough Regional Prison.

64. Simple techniques for regulating his mood were explained to Mr Cameron by PCS counsellor, Ms Marias.[61] These techniques included listening to music, going for a walk and sitting in the sun. After using these techniques, Mr Cameron reported they were "*calming*".[62]

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[56] ts 03.04.19 (Rowland), pp395-396
[57] ts 26.03.19 (de Klerk), p67
[58] ts 03.04.19 (Rowland), p434
[59] Exhibit 4, Tab A.20, Summary of PCS Involvement
[60] ts 26.03.19 (de Klerk), p80
[61] Exhibit 11, Tab 5, PCS Counselling Note (08.10.15)
[62] ts 26.03.19 (Marais), p100

65. As the ARMS manual eloquently points out:

> "*Elsewhere it has been stressed that the terms "manipulative" and "attention-seeking" are not appropriate labels to apply to a prisoner threatening or at risk of suicide or self-harm. However, there remains a commonly held belief that there are some prisoners whose suicidal threats or even actions seem to be a deliberate attempt to force a change in circumstances (e.g.: to change a transfer allocation)…*
>
> *In order to understand this sort of behaviour and respond professionally rather than dismissively, it is helpful to think of suicidal words or actions as having either or both of 2 motivations: to escape or to communicate (Beck et al, 1979). Those who find it difficult to communicate effectively, or who feel they are in a situation where no one is prepared to listen to them, can end up using drastic and desperate means to get their message across.*
>
> ***Our response to such people should not be to dismiss them as manipulative, but to encourage them to communicate in more appropriate ways and to reward a change in style on their part by ensuring we are listening***."[63] (emphasis added)

66. For custodial staff, who generally do not have professional qualifications in mental health, the challenges of dealing with a prison population where a significant number of prisoners have PD is obvious. I can see benefits in custodial staff being made more aware of the behaviours associated with PD, including ASPD and being taught simple techniques to help manage this behaviour.

67. I suggest that in-service training for prison staff about the features and effective management of PD (including ASPD) be conducted by an experienced mental health practitioner as soon as possible.

[63] Exhibit 14, ARMS Manual (1998), para 5.1.3.13

Gatekeeper and Mental Health Awareness Training

68. The Gatekeeper program is the Department's primary vehicle for delivering suicide prevention training to its staff. The training is delivered over a 2-day period and covers basic suicide statistics, high risk populations, risk factors, protective factors and how to engage with individuals at risk of suicide.[64]

69. The Gatekeeper program is designed to "upskill" staff to help them identify individuals who are at risk of suicide and take appropriate action, such as referring the prisoner to PCS or placing the prisoner on ARMS.[65]

70. At the time of Mr Bell's death (8 August 2015), Dr Grigg was a psychologist with PCS and Gatekeeper Suicide Prevention Coordinator. Dr Grigg made the point that staff attending the Gatekeeper program contextualised the knowledge gained into their practice so that for example, PCS staff would be expected to respond to suicide risk in a more therapeutic manner than custodial staff. Dr Grigg felt that the program provided a good baseline and that it was a sensible goal that everyone engaging with prisoners attend the training.[66]

71. Mr Maines said he had attended the Gatekeeper program and found it very informative. However, he felt that a greater emphasis on the custodial environment (as opposed to risk in the general community) would enhance the program.[67]

72. Dr Grigg noted that the Gatekeeper program is delivered over 2-days and covers a range of topics. Necessarily, its coverage of risk assessment was therefore not "*nuanced*".[68]

73. Both Dr Grigg and Dr Patchett agreed that more comprehensive training directed at key personnel (e.g.: reception officers), on how to effectively conduct risk assessments would be beneficial.[69]

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[64] ts 29.03.19 (Grigg), p312
[65] ts 29.03.19 (Grigg), pp311-312
[66] ts 29.03.19 (Grigg), p314
[67] ts 04.04.19 (Maines), p551
[68] ts 29.03.19 (Grigg), p345
[69] ts 29.04.19 (Grigg), p345 and ts 03.04.19 (Patchett), p461

74. Dr Grigg also felt that custodial staff would benefit from training about common mental health conditions and the impact those conditions can have on behaviour. He said that the high rates of prisoners with mental health conditions made delivering such training to custodial staff sensible.[70]

75. In my view, the enhancements to the Gatekeeper program suggested by Mr Maines and Dr Grigg would help to make the program even more useful and effective.

76. In addition to the Gatekeeper program, the Department provides or facilitates the following training:[71]

    i. a mental health first aid course developed by Mental Health Australia;

    ii. mental health awareness training conducted by the WA Prison Officer's Union; and

    iii. mandatory online courses on suicide prevention and mental health awareness.

77. The Gatekeeper program has been enhanced to incorporate contemporary knowledge. This happened in late 2014. In October 2015, after the program had been enhanced, staff that had attended the previous version were offered a 1-day refresher course covering the new material.[72]

78. The enhancements I have suggested to the Gatekeeper program and the more intensive module on risk assessment aimed at reception officers could be delivered in a similar manner.

79. On a more general point, it seems obvious that any form of training that involves skill development must be repeated periodically because skills can degrade over time. I am concerned that after completing the Gatekeeper program during their entry level training to become prison officers, custodial staff may not revisit this critical training for the rest of their careers.

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[70] ts 29.03.19 (Grigg), p314
[71] Exhibit 12, Tab 14, Statement - Mr Maines, paras 105-108
[72] Exhibit 8, Tab A, Death in Custody Report (JS), p18

80. Therefore, I urge the Department to take all necessary steps to ensure that staff receive refresher training in the Gatekeeper program on a regular basis.

81. I accept that training time is limited and that there are practical and budgetary implications in its delivery. Nevertheless, in the important areas of suicide and self-harm risk assessment and management, all staff have an obligation to maintain a level of competence that is commensurate with their role within the prison.

At Risk Management System (ARMS)[73,74]

82. ARMS is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.

83. ARMS is designed to operate at a "whole of prison" level and operates at three levels:

    i. primary intervention strategies designed to create a physical and social environment in the prison that is as stress free as possible;

    ii. secondary strategies to support prisoners at statistically higher risk of self-harm or suicide (e.g.: first time prisoners, young prisoners etc.);

    iii. tertiary strategies aimed directly at individuals who have been identified as being at risk of self-harm or suicide.

84. When a prisoner is received at a prison, an experienced prison officer (reception officer), conducts a formal assessment designed to identify any presenting risk factors. Within 24 hours of arriving at a prison, the prisoner's physical health needs are assessed by a nurse.

85. All staff (including custodial officers, health professionals, vocational trainers and counsellors) are responsible for identifying prisoners who may be at risk of self-harm or suicide.

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[73] Exhibit 12, Tab 14, Statement - Mr Maines
[74] Exhibit 14, ARMS Manual (1998)

86. For that reason, any staff member may place a prisoner on ARMS at any time using the Department's computerised record keeping system, Total Offender Management Solutions, (TOMS).

87. As soon as a prisoner is placed on ARMS, an interim management plan is developed and the prisoner will be managed with observations at high, moderate or low levels. Within 24 hours of a prisoner being placed on ARMS, a meeting of PRAG is convened to determine the appropriate levels of support and monitoring required to manage the prisoner's identified risk.

88. Until 2015, the ARMS observation levels were high (one or 2-hourly), moderate (6-hourly) and low (12-hourly). Following the deaths of the deceased persons, the ARMS observation levels were changed and are now: high (one-hourly), moderate (2-hourly) and low (4-hourly).[75]

89. When a prisoner is placed on ARMS because of a perceived increase in the risk of self-harm or suicide, monitoring of that risk usually requires some change to the prisoner's routine. For example, on high ARMS, a prisoner may be placed in CCU in a "safe cell", obliged to wear rip-resistant clothing and monitored by CCTV.[76]

90. These measures are designed to be short-term until the prisoner's mental state stabilises. Nevertheless, it appears that many prisoners resent these restrictions and do their best to avoid being placed on ARMS.[77]

91. Mr Cameron was the only one of the deceased persons who was on ARMS (low) at the time of his death. Mr Bell, Mr Honeywood and JS had been on ARMS at various times prior to their deaths. Mr Wallam was not on ARMS at any time during his last incarceration.

[75] Exhibit 12, Tab 14, Statement - Mr Maines, para 90(a)
[76] ts 26.03.19 (Mudford), pp36-37 and ts 03.04.19 (Rowland), p389-390
[77] E.g.: Mr Honeywood felt he was being monitored on ARMS because he "*said the wrong thing*" during his reception interview and did not provide an assurance that he wouldn't harm himself. See: Exhibit 5, Tab 28, Statement - Ms Deighton, para 21; ts 03.04.19 (Rowland), p390 and ts 04.04.19 (Maines), p524

Support and Monitoring System (SAMS)[78]

92. SAMS is a secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide. This includes first-time and/or younger prisoners, socially isolated or vulnerable prisoners and prisoners who have been identified as being at chronic risk[79] of self-harm or suicide.

93. To be placed on SAMS, a prisoner must generally satisfy two of the following criteria:[80]

- have a mental disorder
- have an acquired brain injury
- have a physical or intellectual disability
- be experiencing sensitive spiritual or cultural issues
- be identified as at chronic risk of suicide
- require intensive support, and/or would benefit from receiving coordinated services
- be experiencing or be demonstrating difficulty coping or adjusting to placement in custody

94. Thus, a prisoner who is assessed as being at chronic risk of suicide would not, without more, generally qualify for monitoring on SAMS.[81]

95. However, it appears that there have been cases where a prisoner who satisfied only one of the SAMS criteria has been placed on SAMS. This is said to be a matter for careful clinical judgement in each case.[82]

96. In the "Lessons Learnt" debrief that followed Mr Wallam's death, it was suggested that the eligibility criteria for placement onto SAMS should be reviewed. This apparently took place, but no changes were made.[83]

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[78] Exhibit 13, SAMS Manual (June 2009)
[79] Chronic here means "elevated lifetime risk", see for example: ts 03.04.19 (Rowland), p386
[80] Exhibit 13, SAMS Manual (June 2009). Note: the current legislation is the *Mental Health Act 2014* (WA). Further, the term "*mental disorder*" is not defined in either the 1996 Act or the 2014 Act, however, the term "mental illness" is.
[81] ts 26.03.19 (Mudford), p28
[82] ts 04.04.19 (Maines), p526
[83] Exhibit 10, Tab A.1, Lessons Learned (Wallam); ts 26.03.19 (Mudford) and p28 & ts 04.04.19 (Maines), p526

97. Dr Grigg thought that the current SAMS criteria were appropriate in their present form, but that a broader more holistic assessment was required when considering whether to manage a prisoner on SAMS.[84]

98. SAMS adopts a case management system to draw together a variety of staff with relevant expertise. SAMS is designed to provide support to prisoners who, whilst not an acute risk,[85] nevertheless require additional support, intervention or monitoring.

99. The SAMS manual acknowledges that all prisoners may be vulnerable at times, however, prisoners with minimal supports inside and/or outside the prison system are particularly vulnerable.[86]

100. A table in the SAMS Manual sets out the categories of prisoners who may experience particular difficulties in prison. Examples applicable to the deceased persons include:[87]

    i. adult males expecting or serving long sentences (Mr Bell, Mr Cameron, Mr Honeywood and JS);

    ii. sex offenders: (Mr Bell and JS);

    iii. motivating factors of guilt/shame (Mr Honeywood and JS); and

    iv. past suicide attempts, impulsive, unpredictable: [Mr Cameron, JS (later denied) and Mr Wallam].

101. The three main categories of prisoners managed by SAMS are: vulnerable prisoners; prisoners experiencing sensitive spiritual and cultural issues; and prisoners at chronic risk of suicide. Prisoners on SAMS are generally reviewed monthly.

102. All of the deceased persons except Mr Wallam had been managed on SAMS at some stage during their time in prison.

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[84] ts 29.03.19 (Grigg), p346
[85] Acute here means "*elevated risk in this immediate period of time*": ts 03.04.19 (Rowland), p386
[86] Exhibit 13, SAMS Manual (June 2009), Table 4, p11
[87] Exhibit 13, SAMS Manual (June 2009), Table 4, p11

103. With respect to the death of JS, the Death in Custody review conducted by Mr Mudford suggested that a more holistic assessment of JS's circumstances would probably have led to him being placed on SAMS.[88] With the benefit of hindsight, a similar argument could probably be mounted with respect to Mr Honeywood and Mr Wallam.

104. I would urge all prison staff responsible for assessing a prisoner's eligibility for SAMS to view the criteria in the broadest possible manner and to err on the side of caution.

105. If the Department urgently addresses the critical shortfalls in the numbers of PCS and mental health staff within prison system generally and at the Prison in particular, then any increase in the number of prisoners placed on SAMS as a result of a broader application of the SAMS criteria, could be accommodated.

Prisoner Risk Assessment Group (PRAG)[89]

106. PRAG is a group within each prison that manages prisoners on ARMS or SAMS. The group's membership can vary from prison to prison but typically includes senior custodial staff, PCS and mental health staff and, where appropriate, prison support officers, chaplains and members of the Aboriginal Visitor's Service (AVS).

107. PRAG is usually chaired by a member of the relevant prison's senior management group. The PRAG chair's role is to ensure that all voices at the meeting are heard and that all relevant matters which bear on a prisoner's risk are considered. The chair must then work to achieve a consensus view with respect to the management of each prisoner under consideration.[90] The frequency with which PRAG meets varies from prison to prison and depends on the number of prisoners on ARMS and SAMS respectively.

108. Mr Chadwick who was the chair of PRAG at the Prison during 2014 and 2015, said about 50% of his time was taken up with preparation for, and attendance at PRAG meetings.[91]

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[88] Exhibit 8, Tab A, Death in Custody Review (JS), p17
[89] Exhibit 14, ARMS Manual (1998)
[90] Exhibit 13, SAMS Manual (June 2009), p23
[91] ts 27.03.19 (Chadwick), p182

109. Mr Chadwick felt that although PRAG meetings were usually an effective way for information about prisoner risk to be shared, the process could be enhanced by improving the sharing of information as between custodial, Prison Health Service (PHS) and PCS staff.

110. Mr Chadwick said that custodial staff attending PRAG meetings were at a significant disadvantage when making decisions about the management of at-risk prisoners, because:

> "*We're told nothing by medical. We're told nothing by mental health. PCS don't want to share much of their information with us and yet we are the people that see the prisoners most and have to live with the prisoners, if you like, and yet…we only know what we learn from interacting with the prisoner.*"[92]

111. In my view, Mr Chadwick makes a very good point. As I point out in the section in this Finding dealing with information sharing between PCS and PHS staff, when balancing prisoner confidentiality against the sharing of information necessary to properly access risk, it is my view that the latter must always prevail.

112. Mr Chadwick also noted that at times, the relationship between mental health and PCS staff at the Prison had been strained and this had hampered the effectiveness of PRAG meetings.[93] However, it appears that input from PCS and mental health staff is given great weight and recommendations by these staff are routinely adopted.[94]

113. I would urge the Department to revisit the PRAG meeting concept so as to encourage more fulsome sharing of information about risk factors affecting prisoners by all attendees including custodial, PHS and PCS staff.

114. Dr de Klerk said he attended PRAG meetings where possible and found the opportunity to inform deliberations by explaining the impact of mental health issues on prisoner behaviour to be particularly valuable.[95]

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[92] ts 27.03.19 (Chadwick), p196 and see also: ts 27.03.19 (Chadwick), p188
[93] ts 27.03.19 (Chadwick), p212
[94] ts 27.03.19 (Chadwick), p212 and ts 28.03.19 (Mandolene), p257
[95] ts 26.03.19 (de Klerk), p76

115. As to the effectiveness of PRAG, Dr de Klerk observed:

> "*the decrease in suicides since this period…[late 2014 – 2015]…is evidence of the fact that the PRAG system does work, but it works at the cost of delivering counselling and…delivering a comprehensive mental health service.*"[96]

116. Given the obvious links between mental and physical health, I was surprised to hear evidence that whilst mental health staff routinely attend PRAG meetings, general health staff do not.[97]

117. I suggest that this should be reconsidered. The recent realignment of PCS and PHS under "Health Services" under a common director signals a renewed desire to adopt a multi-disciplinary approach to risk management. In my view, the attendance of general health staff at PRAG meetings would, if this were feasible, be a very positive step in improving prisoner safety.

118. I commend the current versions of the ARMS and SAMS manuals to all PRAG chairs and urge all staff in these important roles to periodically revisit these manuals to ensure their knowledge of the contents of these documents is current. For reasons I will explain, this needs to be done regularly, even by experienced PRAG chairs.[98]

Assessing suicide risk

119. As Dr Rowland and Dr Grigg made clear, predicting the risk suicide in the short-term is very difficult and is virtually impossible in the case of chronic suicidality. Chronic in this context means "*elevated lifetime risk*".[99]

120. The ARMS manual, current at all relevant times relevantly notes:

> "*There is a widely held assumption explicit in suicide prevention procedures that suicides can be predicted and action taken to avert them…*

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[96] ts 26.03.19 (de Klerk), p137
[97] Exhibit 4, Tab A.25, Statement of Interview - Mr Chadwick, para 3
[98] Exhibit 13, SAMS Manual (June 2009) and Exhibit 16, ARMS Manual (2019)
[99] ts 29.03.19 (Grigg), p342 & p 345 and ts 03.04.19 (Rowland), p386 & p487

The extent to which individual suicides are in fact predictable remains a complex and somewhat confused issue. It is likely that certain types of suicide are more predictable and preventable than others. There may be a number of factors which may mean a prisoner is more likely to be at risk. But these factors are poor predictors.

There is no sure way of "diagnosing" suicidal intentions or predicting the degree of risk. Assessments can only be of temporary value because moods and situations change. Self-harm can be an impulsive reaction to bad news or a sudden increase in stress."[100]

121. Prison staff who conduct suicide risk assessments use an online tool that asks the prisoner a series of questions to elicit information about factors tending to make it more likely the person will attempt suicide (risk factors) and factors which make this less likely (protective factors).[101]

122. In addition to the prisoner's self-reported history (including self-harm or suicidal attempts and/or ideation), reception officers conducting risk assessments look for signs that the prisoner is stressed or not coping. Further, the reception officer must consider whether the prisoner being assessed has any "protective" factors such as family support. The same factor may be given different weight depending on the particular prisoner.

123. Clearly the relevance and weight to be given to such factors will vary from prisoner to prisoner. Risk factors might include young or old age, childhood trauma and mental health issues whereas protective factors might include a supportive family and a focus on the future.

124. An important risk factor is a history of self-harm and/or suicide attempts. Self-harm has been described as a means of releasing distress and addressing internal pain by exchanging it for external pain, whereas with suicide attempts, the intent is to die.[102]

[100] Exhibit 14, ARMS Manual (1998), p35.
[101] Exhibit 12, Tab 14, Statement - Mr Maines, para 59
[102] ts 03.04.19 (Rowland), p393

125. As Dr de Klerk and Dr Rowland pointed out, the best predictor of future behaviour is past behaviour.[103] Dr de Klerk highlighted the importance of self-harm behaviour as a predictor of suicide risk, noting:

> *"…people who habitually and deliberately self-harm are at higher risk of, number 1, doing it again, and, number 2, actually dying from it."*[104]

126. I accept it can be very difficult to conduct meaningful risk assessments where, for example, a prisoner is withdrawing from illicit substances or where the prisoner's initial distress at being in prison is overwhelming.

127. I have no doubt that reception officers carefully consider all of the factors they are aware of. But they are not mental health professionals and must rely on their initial training, informed by experience, when making difficult decisions about a prisoner's risk of self-harm and/or suicide.

128. Reception officer's base their assessment of the risk of self-harm and/or suicide on the prisoner's presentation, the prisoner's responses to questions and any history about prisoner of which the Department has a record, by way of TOMS or otherwise. Reception officers are trained to err on the side of caution when making these assessments.[105]

129. Obviously, where a prisoner is guarded about what they disclose, the risk assessment process may be compromised.[106]

130. For example, during his reception interview, Mr Cameron denied losing relatives to suicide. In fact his father and sister had died in this manner. Loss of relatives to suicide is a known risk factor and ideally, the reception officer should have had this information before them when assessing Mr Cameron's risk.[107]

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[103] ts 26.03.19 (de Klerk), p72 and ts 03.04.19 (Rowland), p387
[104] ts 26.03.19 (de Klerk), p72
[105] ts 29.03.19 (Grigg), p339
[106] ts 04.04.19 (Maines), pp526-527
[107] Exhibit 4, Tab A.5, Reception Intake (Cameron), p3 (Question 6.3.4)

131. Clearly, prison staff who conduct risk assessments aimed at detecting the risk of suicide have a very difficult task. As both Dr Rowland and Dr Patchett observed, studies have shown that none of the commonly used suicide risk assessment tools work particularly well.[108]

132. The enormity of the task facing prison staff who conduct assessments aimed at predicting suicide risk is captured in the following extract from the ARMS manual:

> "*It is natural for those concerned with a self-inflicted death to ask themselves whether more could have been done to predict and prevent it. The burden of anxiety and guilt is made worse if critical judgements are made with the benefit of hindsight. It is all too easy to assume that suicide is preventable if certain techniques and procedures are followed.*"[109]

133. Dr Rowland emphasised the importance of the subjective aspect of suicide risk assessment, noting:

> "*I believe if you took your subjective part out of it…if you took your personality and your empathy and your humanity out of it and it was a tick score system, I don't think it would be nearly as accurate as the personal engagement.*"[110]

134. However, I am concerned that when conducting risk assessments, there may be a tendency to place too much reliance on a prisoner's denial of self-harm, especially where the prisoner has a significant self-harm history.

135. As Mr Mudford noted in his review into the death of JS:

> "*Denial of self-harm or suicide is not a protective factor in itself and must be taken into context. Individuals with suicidal intent are unlikely to disclose their level of distress and may even manipulate their circumstances to achieve that intent. This issue will feature in the latest suicide prevention training.*"[111]

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[108] ts 03.04.19 (Patchett) pp459-460 and ts 03.04.19 (Rowland), p387 & p393
[109] Exhibit 14, ARMS Manual (1998), p9
[110] ts 03.04.19 (Rowland), p387
[111] Exhibit 8, Tab A, Death in Custody Review (JS)

136. Both Dr Grigg and Ms Mandolene agreed that a denial of self-harm, when considered in isolation, is not a protective factor and must be considered in context with other relevant risk and protective factors.[112]

137. Further, as Dr de Klerk observed, the best predictor of future behaviour is past behaviour. This means that a person with a history of past self-harm is necessarily at higher risk regardless of any denial they might make about current self-harm or suicidal ideation.[113]

138. In Mr Wallam's case, his "*settled manner*" and denial of self-harm when received at Hakea Prison led to him not being placed on ARMS although he had a significant self-harm history and was withdrawing from amphetamines.[114]

139. Similarly, the denials of self-harm ideation by JS[115] and Mr Honeywood[116] may have provided a level of comfort that a more holistic assessment of their respective situations would not have supported.

140. I suggest that in addition to the Gatekeeper program, staff who are responsible for risk assessments on a routine basis (e.g.: reception officers), receive additional and more comprehensive training with respect to conducting risk assessments.

141. Both Dr Grigg[117] and Mr Maines[118] agreed that this would be beneficial.

142. A related issue is the potential for over-reliance on protective factors. Depending on the prisoner, protective factors might include: the support of family or friends, a focus on the future, meaningful employment or other activity within the prison, personal coping mechanisms and so on. Again, these factors need careful consideration in the context of an holistic assessment and over-reliance on any one factor would be ill-advised.

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[112] ts 29.03.19 (Grigg), p344 and ts 28.03.19 (Mandolene), p260
[113] ts 26.03.19 (de Klerk), p88
[114] Exhibit 10, Tab A-8, Reception intake & ARMS assessment summary
[115] Exhibit 8, Tab A, Death in Custody Review (JS), p18
[116] ts 28.03.19 (Crone), p280
[117] ts 29.03.19 (Grigg), p345
[118] ts 04.04.19 (Maines), pp550-551

143. JS's case is a good example of the competing factors that must be evaluated. His protective factors (supportive wife and religious beliefs) and his denials of self-harm were considered sufficient to outweigh his risk factors (first-time prisoner, numerous serious charges, estranged from other family members, expressing shame, not engaged in any meaningful activity, and minimal engagement with other prisoners).[119]

144. However, the ARMS Manual makes good point with respect to who can ultimately prevent death by suicide when it says:

> "*Suicide can be prevented, but ultimately only by the prisoner themselves. The responsibility of the Department of Justice is to provide care and support which reduces the risk of suicide and enables the prisoner to recover the will to live.*"[120]

145. In terms of the decision to take one's life by suicide, as Dr Rowland said:

> "*If a person makes that decision, then that is their decision. Someone else hasn't made that decision for them. Their capability to make the decision at the time would depend on their mental state. So for someone with severe depression or severe cognitive impairment, you may question whether or not they were competent to make that decision for themselves at the time. But somebody who was very competent and had thought it through over a long period of time and saw that as their only option, you may consider that, like we consider euthanasia, a person's choice…that doesn't say that that's necessarily acceptable from a moral and ethical point of view, because that's an indication of severe distress.*"[121]

146. After referring to the prevalence of mental health issues amongst the prison population, Mr Maines made the frank observation that he was surprised that the number of deaths in prison by suicide is not higher than it is.[122]

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[119] ts 28.03.19 (Mandolene), p229 & p233
[120] Exhibit 14, ARMS Manual (1998), p10
[121] ts 03.04.19 (Rowland), p394
[122] ts 04.04.19 (Maines), p519

147. As Mr Maines pointed out:

> "*The Department of Justice, does take the care and management of prisoners very seriously. There are a number of policies, procedures and operational practices that are in place which are designed to keep people safe as possible. But given the complexities and the vulnerabilities of the people who come into custody, which is generally a last resort where everything else has failed in the person's management, it does surprise me somewhat that more people don't take their own life.*"[123]

148. I accept that the Department is focussed on preventing suicides wherever possible. The death of a prisoner by suicide is an unfathomable tragedy for that prisoner's family and friends and as the Department's policies acknowledge:

> "*Where suicides do occur, staff who have acted with due care and done their best to help the prisoner should be fully supported. The causes of suicide are complex and cannot be attributed simply to the acts or omissions of any particular individual.*"[124]

PCS and Mental Health Staff Resources

149. PCS is comprised of social workers and psychologists who are responsible for providing a counselling service to prisoners. In fact, as will be seen, PCS is not able to offer any ongoing therapeutic intervention or what might be referred to as proactive, preventative counselling.[125]

150. Mental health staff (which includes psychiatrists, mental health nurses and substance abuse counsellors) are part of the PHS. Mental health staff are responsible for the management of prisoners with mental health conditions.[126]

151. As discussed later in this Finding, their work within the prison system has been hampered by the fact that PCS and mental health staff do not have access to each other's computer systems.

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[123] ts 04.04.19 (Maines), p519
[124] ts 04.04.19 (Maines), p523
[125] ts 27.03.19 (Deighton), p174; ts 28.03.19 (Crone), p298, and ts 29.03.18 (Grigg), pp315-316
[126] ts 03.04.19 (Rowland), p368

152. On 7 May 2018, PCS and PHS merged and became the Health Services Directorate. They now share the same director and sit within the Department's Offender Management Branch.[127]

153. As Dr Rowland pointed out, a multi-disciplinary team approach to managing prisoner health is made easier when the line management is the same. There are also benefits in terms of common policies and standardised assessment tools and documents.[128]

154. It was concerning that obtaining accurate information about PCS staff numbers for the relevant period proved surprisingly difficult and it appears, as Mr Maines observed, that:

> "*Counting staff has been a difficulty for the department for a long period of time.*"[129]

155. According to the Department, on both 31 December 2015 and 31 December 2018, there were six PCS staff at the Prison. Of those, one was said to be a clinical supervisor position and the other five were counsellors. In 2014 and 2015, there were three mental health nurses at Casuarina Prison[130]

156. The average daily population at Casuarina Prison in 2015 was 788 and 943 in 2018, so even on those figures (assuming all positions were filled on a full-time basis) the same number of staff were being asked to deal with an additional 155 prisoners.[131]

157. During the inquest, the Department was asked to provide further information about PCS staff numbers in the relevant period and to clarify whether the numbers in evidence were full or part-time equivalents. By letter, Ms Fiona Hunt (Director Performance Assurance & Risk) advised that in 2015, there were 5.6 PCS counsellors at Casuarina Prison, noting that:

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[127] Exhibit 12, Tab 15, Statement - Dr Rowland, para 16
[128] ts 03.04.19 (Rowland), p374
[129] ts 03.04.19 (Maines), p510
[130] Exhibit 17, Tables 2 & 3: Casuarina Prison – Health Services and Prison Counselling Service Profile
[131] Exhibit 17, Table 2: Casuarina Prison – Health Services and Prison Counselling Service Profile

> *"…the exact staffing contingency for 2015 is not readily available. The six PCS staffing positions at Casuarina are full time equivalents. The missing 0.4 FTE in 2015 likely equates to the roster being varied down."*[132]

158. It remains unclear whether the 5.6 positions referred to in Ms Hunt's letter were actually filled in 2015.

159. In his evidence, Dr Grigg said when he left PCS in December 2017, there were only 4 full-time PCS counsellors and one part-time counsellor at the Prison. In Dr Grigg's opinion, in order to provide "effective intervention" at least twice that number of PCS staff would be required. In fact, that had been the staffing situation at the Prison when he started with PCS in 2014.[133]

160. The dire situation with respect to PCS resources is not confined to Casuarina Prison. Ms Mandolene worked as a PCS counsellor at Hakea Prison between December 2009 and May 2017. She said that during the time she was employed, PCS numbers dropped from 12 counsellors when she started to four or five when she finished, at a time when the muster at Hakea Prison was steadily rising.[134]

161. What these figures do not disclose is that initially, two of the full-time positions at Casuarina and Hakea Prisons were "clinical supervisor" positions. These PCS staff acted as team leaders, allocated cases and most importantly conducted clinical supervision of other PCS staff.[135]

162. However, as PCS number dropped, the staff in these supervisor positions were no longer able to provide any meaningful level of supervision. In the 18 months before she left PCS, Ms Mandolene had received no supervision at all.[136, 137]

163. The absence of clinical supervision was identified as of major concern to both Dr Grigg and Ms Mandolene.[138]

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[132] Letter, Ms Fiona Hunt, (16.04.19), para 1
[133] ts 29.03.19 (Grigg), p347 & p348
[134] ts 28.03.19 (Mandolene), pp224-225 & p254
[135] ts 29.03.19 (Grigg), p347
[136] ts 29.03.19 (Grigg), p347
[137] ts 28.03.19 (Mandolene), p254-255
[138] ts 28.03.19 (Mandolene), pp254-255 and ts 29.03.19 (Grigg), p347

164. The work carried out by PCS and PHS staff is difficult and stressful. Regular supervision, case conferences and debriefs with an experienced colleague have obvious positive benefits. Conversely, the failure to offer regular supervision, in combination with ever increasing workloads is a recipe for staff burnout and subsequent turnover.

165. Ms Mandolene cited lack of supervision and an ever-increasing workload during her time as a PCS counsellor as major contributors to her decision to leave the Department. As she put it, the lack of supervision:

> "*…was certainly one of the major reasons I left the service – not because I did not love the job, not because I wasn't dedicated. I found the lack of support on the ground for frontline staff from management at times, was unacceptable.*"[139]

166. During the inquest, I heard evidence from a number of witnesses that because of rising musters and dwindling staffing levels, PCS and mental health staff were no longer able to do the kinds of proactive, preventative work that would help to lower the risk of suicide and self-harm.[140]

167. Instead, the evidence of these dedicated professionals is that they are almost exclusively engaged in managing prisoners on ARMS and SAMS and attending to acutely distressed prisoners.[141] That evidence is consistent with the findings of the Inspector of Custodial Services in his report on his inspection of the Prison in 2016 (the Report).[142]

168. Dr Grigg said that when he started with PCS in 2014, the breakdown of his workload was roughly: 30% ARMS/SAMS management and reviewing of acutely distressed prisoners; 30% proactive, therapeutic/ongoing counselling; and 30% brief referrals and other assessments. By the end of his time with PCS in January 2018, Dr Grigg was no longer able to do any proactive, therapeutic/ongoing counselling.[143]

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[139] ts 28.03.19 (Mandolene), p255
[140] For example: ts 28.03.19 (Mandolene), pp226-227
[141] ts 27.03.19 (Deighton), p174; ts 28.03.19 (Crone), p298, and ts 29.03.18 (Grigg), p315-316
[142] Exhibit 12, Tab 14.2, 2016 Inspection of Casuarina Prison, p20
[143] ts 29.03.19 (Grigg), p316

169. By this stage, 85% of Dr Grigg's time was taken up with ARMS/SAMS management and reviewing of acutely distressed prisoners and 15% with brief referrals and other assessments.[144]

170. Mr Chadwick agreed that PCS staff are working in crisis mode and concentrating almost exclusively on ARMS and SAMS assessments. He described the understaffing of PCS as a "*blight*" and considered that the PCS at the Prison required five times as many staff as it currently has, particularly given the plan to increase the Prison's capacity by 512 beds over the next 18 months.[145]

171. The explanation for the drop in PCS staff numbers in the period from 2013 was provided by Mr Maines who said:

> "*During the period 2013/14/15, the then Department of Corrective Services went through some very radical reform and change agendas. The department was subject to recruitment freezes over extended periods of time. In 2015, Workforce Renewal, which was a government mandate to reduce – effectively took about 10 per cent of salaries, budgets – like most government departments, the Department of Corrective Services wasn't exempt from those cuts.*"[146]

172. The PCS staffing situation at the Prison at the end of 2016 is described in the Inspector of Custodial Services report referred to earlier. The figures contained in the Report contradict the information provided by the Department. Relevantly, the Report notes:

> "*General counselling referrals to local PCS were no longer accepted. Instead, a new service called Specialist Psychological Services had been created which would provide centralised psychological treatment.* ***This left three staff doing ARMS work at the time of inspection, one of whom resigned during the inspection period****…*"[147] (emphasis added)

[144] ts 29.03.19 (Grigg), p316
[145] ts 27.03.19 (Chadwick), p206
[146] ts 03.04.19 (Maines), p509
[147] Exhibit 12, Tab 14.2, 2016 Inspection of Casuarina Prison, p20

173. In any event, regardless of the actual number of PCS and mental health staff at the Prison in late 2014 and 2015, those resources were patently inadequate.

174. The Report paints a depressing picture with respect to PCS resources at the Prison in 2016, noting:[148]

> "*…Morale was very low. Counsellors regretted no longer having the ability to provide ongoing counselling to those prisoners who need coping skills, but were not in crisis. They found it psychologically intense and limiting to be dealing only with people at high risk of self-harm or suicide, especially with so few staff members…PCS staff reported that they are often directed at short notice to other prisons, making it difficult to provide continuity to the prisoners they were dealing with.* ***Burnout and loss of experienced staff to other job opportunities are real risks.****"*[149] (emphasis added)

175. The evidence of Dr de Klerk, Mr Scarparolo, Ms Deighton, Ms Mandolene, Ms Crone and Dr Grigg was that if staff numbers made it possible for PCS and mental health workers to carry out proactive, therapeutic intervention and counselling, then prisoner welfare would be improved.[150]

176. According to Dr Grigg, a prisoner like Mr Bell would probably have been placed on SAMS had PCS resources been greater at the time of his incarceration.[151] Further, Mr Bell, would have been offered treatment for PTSD had PCS resources allowed,[152] a point which Mr Bell's family highlighted in submissions made by on their behalf by their solicitor.[153]

177. Mr Honeywood had unresolved grief issues with respect to his wife and would have benefitted from PCS intervention, had this been possible.[154]

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[148] Exhibit 12, Tab 14.2, 2016 Inspection of Casuarina Prison, p20
[149] This risk manifested, at least insofar as Ms Mandolene's case
[150] ts 26.03.19 (de Klerk), p84; ts 26.03.19 (Scarparolo), p110; ts 27.03.19 (Deighton), pp146-147; ts 28.03.19 (Mandolene), pp255-256; ts 28.03.2019 (Crone), pp297-298; ts 29.03.19 (Grigg), p315; and ts 03.04.19 (Rowland), p371
[151] ts 29.03.19 (Grigg), p346
[152] ts 29.03.19 (Grigg), pp321-322
[153] Submissions, Mr Meyers (01.05.19), para 27
[154] ts 03.04.19 (Patchett), p466; ts 27.03.19 (Deighton), p175 and ts 03.04.19 (Rowland), p417

178. Mr Cameron would probably have benefitted an intensive therapy known (dialectic behaviour therapy) had PCS resources allowed,[155] a point noted by counsel for Mr Cameron's family.[156]

179. Whether any of these interventions would have prevented the deaths of the deceased persons is of course speculative. What cannot be disputed is that because PCS resources did not allow this type of work to be carried out, the question of whether proactive therapeutic engagement would have changed the outcomes for any of the deceased persons will never be known.

180. In terms of increasing PCS resources, the Report made the following recommendation: "*Improve prisoner access to counselling for trauma and distress*", having relevantly, and in my view, tellingly observed:

> "*We understood some recruitment was planned. This needs to be prioritised. The current situation [with respect to PCS staffing levels] is not acceptable and [is] high risk*".[157]

181. I concur with the views expressed by the Inspector of Custodial Services with respect to PCS resources at the Prison.

182. An issue related to the urgent need to increase PCS and mental health staff is the need to provide those staff with appropriate office and therapeutic spaces in which to carry out their important work. Dr Rowland said that in an effort to address the barriers faced by prisoners seeking to access PCS and PHS staff (e.g.: limited time out of their cells), consideration has been given to conducting clinics and sessions on the units themselves.

183. As Ms Mandolene observed, there are limited appropriate spaces available in the unit environment,[158] nevertheless, as Dr Rowland put it:

> "*…none of the solutions necessarily are perfect, but it's trying to be creative to make good use of what we have.*"[159]

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[155] ts 27.03.19 (Deighton), pp166-167
[156] ts 04.04.19 (O'Hara), p607
[157] Exhibit 12, Tab 14.2, 2016 Inspection of Casuarina Prison, p20
[158] ts 28.03.19 (Mandolene), p225
[159] ts 03.04.19 (Rowland), p374

184. Of major concern is the fact that medical and custodial staff said that the current situation with PCS and mental health staff numbers is placing prisoner's lives at risk.[160]

185. As noted, the custody of prisoners vests in the Chief Executive Officer of the Department of Justice (CEO).[161] Section 7 of the *Prisons Act 1981 (WA)* places important statutory responsibilities on the CEO and relevantly provides:

> "*Subject to this Act and to the control of the Minister, the chief executive officer is responsible for the management, control, and security of all prisons and the* ***welfare and safe custody of all prisoners***." (emphasis added)

186. Given the two factors I have just referred to, I urge the CEO to take urgent steps to recruit additional PCS and mental health staff for Casuarina Prison and more broadly, to consider the appropriate level of PCS and mental health staff across the State.

187. I agree with Dr de Klerk when he says that PHS and PCS: "*do very well with what* [they] *have*", however, the present situation is untenable and ought not to be allowed to continue.

[160] ts 27.03.19 (Chadwick), p186 and ts 03.04.19 (Rowland), p371
[161] Section 16, *Prisons Act 1981* (WA)

MERVYN KENNETH DOUGLAS BELL[162]

Background

188. Mervyn Kenneth Douglas Bell (Mr Bell) was born in Western Australia on 4 June 1987 and was 28-years of age when he died on 8 September 2015. Both of Mr Bell's parents died when he was a child and he and his sibling were raised by other family.[163] Mr Bell is said to have suffered severe physical abuse at the hands of his stepfather.

189. As a child, Mr Bell was diagnosed with attention deficit disorder and received medication until he was 10-years of age. He left school after completing year 11 and worked for a time as a labourer and a farm hand.[164]

190. Mr Bell began using cannabis when he was 13-years of age and by the time he was about 17-years of age, he had progressed to alcohol and amphetamines.

191. In 2008, Mr Bell and his then partner had a child. The relationship subsequently broke down, apparently as a result of family violence perpetrated by Mr Bell. It appears that Mr Bell had limited face-to-face contact with his partner and his daughter.

192. Mr Bell's substance abuse is said to have become problematic by the time he was 21-years of age and he was registered as a drug addict in 2009.

Overview of Medical Conditions

193. On 6 June 2012, at Albany Regional Prison, Mr Bell was reviewed by consultant psychiatrist, Dr de Klerk who concluded that Mr Bell had mild to moderate depression and prescribed an antidepressant.[165]

194. It would appear that Mr Bell was also thought to have antisocial personality disorder.[166] There is no evidence in the Brief to suggest that Mr Bell was not physically well.

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[162] Exhibit 2, Tab A, Death in Custody Review (Bell)
[163] Exhibit 1, Tab 6, Statement - Ms Bell (sister)
[164] Exhibit 1, Tab 7, Statement - Mr Fairhead (uncle and foster father)
[165] Exhibit 2, Tab 1, Report - Dr de Klerk [attachment to Letter: G Cartwright (20.04.18)]
[166] Exhibit 2, Tab 1, Report - Dr de Klerk [attachment to Letter: G Cartwright (20.04.18)]

Offending History[167]

195. As a juvenile (2002 to 2005), Mr Bell was convicted of offences including burglary and stealing. His offending behaviour continued and in September 2009, he was sentenced to imprisonment for assault offences. In October 2011, Mr Bell was again sentenced to a term of imprisonment for assault offences.[168]

196. In March 2013, Mr Bell sexually assaulted and murdered a 10-month old child. He appeared in the Magistrates Court at Karratha on 22 March 2013 and was remanded in custody to Roebourne Regional Prison.

197. On 12 December 2014, Mr Bell was sentenced to concurrent terms of imprisonment in the Supreme Court of Western Australia with respect to the offences of sexual penetration of a child under 13-years of age (3 years) and murder (life imprisonment). Mr Bell's appeal against this sentence on 27 January 2015 was unsuccessful.

198. On 22 May 2015, Mr Bell was sentenced in the District Court of Western Australia to imprisonment for 4 years and 10 months for the offence of grievous bodily harm in circumstances of aggravation.

Prison History[169]

199. From 22 March 2013 until his death on 8 September 2015, Mr Bell had placements in Roebourne Regional, Albany Regional, Hakea and Casuarina Prisons.[170] Prior to his last incarceration, Mr Bell had been imprisoned on two other occasions for a total of 729 days (almost 2 years). He was first imprisoned when he was 18-years of age.[171]

200. When he was admitted to Roebourne Regional Prison on 22 March 2013, Mr Bell denied self-harm or suicidal ideation but had made some self-harm references whilst he was in police custody.

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[167] Exhibit 2, Tab A, Death in Custody Review (Bell)
[168] Exhibit 2, Tab A.7, Criminal Record
[169] Exhibit 2, Tab A, Death in Custody Review (Bell)
[170] Exhibit 1, Tab 16.8, Cell Placement History
[171] Exhibit 12, Tab 14, Statement - Mr Maines, para 45

201. As a result, and given the serious nature of his offences and the fact his family was some distance away, he was placed on high ARMS (one-hourly observations).[172]

202. Mr Bell's ARMS observations were reduced to moderate (6-hourly observations) on 25 March 2013. When reviewed by PCS on that day, Mr Bell denied self-harm or suicidal ideation.[173]

203. Mr Bell was reviewed by Dr de Klerk via video-link on 26 March 2013. Dr de Klerk noted Mr Bell's flat affect and his difficulty sleeping but Mr Bell denied self-harm or suicidal ideation. Dr de Klerk's conclusion was that Mr Bell's presentation was not a recurrence of his depressive illness but rather: "…*related to his anti-social personality construct and the situational crisis he finds himself in.*" Dr de Klerk prescribed a sedating antidepressant at night to assist with sleep.[174]

204. On 27 March 2013, Mr Bell was placed on high ARMS following concerns about his emotional interactions with his family when speaking to them on the phone, his history of violence and the nature of his charges.[175]

205. Mr Bell was deemed at risk from other prisoners and in order to avoid a lengthy placement in an observation cell, he was transferred to Hakea Prison on 2 April 2013. He remained in safe cell accommodation until 4 April 2013. On 5 April 2013, Mr Bell was assaulted by a prisoner who was related to the mother of Mr Bell's victim.

206. Mr Bell was placed on low ARMS on 8 April 2013 on the basis that his risk to himself had diminished.[176] He was removed from ARMS altogether on 16 April 2013.[177] Mr Bell was subsequently transferred to Casuarina Prison on 18 April 2013. On 20 April 2013, Mr Bell was assaulted by a prisoner who was an uncle of his victim. He declined an offer of "protected prisoner" status and for management reasons, was transferred to Hakea Prison on 30 July 2013.

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[172] Exhibit 11, Tab 1, PRAG Minutes (25.03.13)
[173] Exhibit 11, Tab 1, PRAG Minutes (25.03.13)
[174] Exhibit 2, Tab 1, Report - Dr de Klerk [attachment to Letter: G Cartwright (20.04.18)]
[175] Exhibit 11, Tab 1, PRAG Minutes (27.03.13)
[176] Exhibit 11, Tab 1, PRAG Minutes (08.04.13)
[177] Exhibit 11, Tab 1, PRAG Minutes (16.04.13)

207. In view of his maximum-security status and because he was the subject of a number of threats, Mr Bell was transferred to Albany Regional Prison on 2 September 2013. During his placement at Albany Regional Prison, Mr Bell displayed abusive and threatening behaviour on several occasions.[178]

208. Dr de Klerk reviewed Mr Bell on 9 December 2013 and found him sullen and non-responsive. Mr Bell told Dr de Klerk that he had stopped taking his prescribed anti-depressant medication. Mr Bell complained of insomnia and Dr de Klerk mentioned the possibility of the sedating anti-depressant Avanza if Mr Bell developed low mood. Dr de Klerk did not detect any sign of psychotic illness during this review.[179]

209. On 23 June 2014, Mr Bell was involved in a serious incident in which he stabbed another prisoner and sustained a fractured skull after being assaulted with a hammer.[180]

210. Mr Bell was convicted of several prison charges under the *Prisons Act 1981 (WA)* and served three separate periods of close confinement at Albany Regional Prison. After receiving treatment, Mr Bell was transferred to Casuarina Prison on 27 June 2014.[181]

211. On arrival at the Prison, Mr Bell was housed in the CCU for security reasons and remained there until 18 July 2014 when he was transferred to the SHU where he remained until his death.

212. Mr Bell's placement in the SHU was for his protection and to maintain the good order of the prison. The application to house Mr Bell in the SHU noted that he satisfied two of the SHU placement criteria because he:

    i. had demonstrated a serious incident of violence in the prison system (i.e.: assault at Albany Regional Prison); and

    ii. was a serious threat to the good order of the prison.[182]

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[178] Exhibit 2, Tab A.14, Incidences & Occurrences Record
[179] Exhibit 2, Tab 1, Report - Dr de Klerk [attachment to Letter: G Cartwright (20.04.18)]
[180] Exhibit 1, Tab 3, Report - Coronial Investigation Squad
[181] Exhibit 1, Tab 3, Report - Coronial Investigation Squad
[182] Exhibit 1, Tab 16.4, Unit File (Bell)

213. Mr Bell's SHU management plan explained the reason for his placement in these terms: [183]

> "*BELL is at risk from other offenders due to the nature of his crimes. BELL's offences are known within the prison system, and due to the abhorrent nature of his crimes, he has been ostracized and is under significant threat by his peers. This was evidenced by two significant assaults in June 2014, with the latter assault resulting in BELL receiving a fractured skull whilst one of his assailants received a stab wound to the chest.*
>
> *Because BELL's life was under threat it was reported that he had begun to carry homemade weapons to defend himself. BELL has demonstrated he is capable of responding violently to any perceived threat. His criminal history is of a violent nature, and his behaviours indicated that he continues to pose a threat to other prisoners, and with a risk to staff who may become involved in stopping any fights.*
>
> *BELL was deemed unsuitable for protection due to his violent behaviour and was placed in the SHU to mitigate the risks to him, staff members and also preventing him from attacking others.*"

214. Given these concerns and the fact that Mr Bell had refused to be placed in the protection unit, I accept that prison authorities had limited placement options.[184] The dilemma posed by Mr Bell's placement in the SHU is reflected in the following entry in the June 2015 SHU monthly progress report:

> "*Placement is the main issue for this prisoner. He is not really a SHU prisoner but due to the nature of the offence, he will be targeted by others wherever he is placed*".[185]

215. As noted, Mr Bell was the victim of assaults by other prisoners when placed in mainstream cells. In the SHU, he was subject to a management plan and regular reviews.[186]

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[183] Letter, Ms Fiona Hunt, (16.04.19), Attachment 10, SHU Management Plan (Bell)
[184] Exhibit 1, Tab 16.4, Unit File (Bell)
[185] Letter, Ms Fiona Hunt, (16.04.19), Attachment 10 - SHU Monthly Progress Report (25 Jun 15)
[186] ts 04.04.19 (Maines), p586

216. Mr Bell was initially housed in a "camera cell" in the SHU. As the name suggests, these cells are equipped with a CCTV which is continuously monitored. At the time of his death, Mr Bell was still in the SHU, but was not in one of the camera cells. Placement in a camera cell subjects a prisoner to continuous monitoring and is clearly intrusive. This would usually only occur when a prisoner's level of risk of self-harm or suicide warrants it.[187]

217. Mr Bell was first seen by Dr Grigg on 24 October 2014. On that occasion, Mr Bell seemed calm and settled. He disclosed frequent thoughts of self-harm but denied any plan or intent to act on those thoughts.[188]

218. Although Mr Bell reported receiving frequent visits from his family, he described heightened feelings of isolation and disconnection from others since being placed in the SHU. Mr Bell was unsure whether the PCS session had been helpful, but said he was keen to engage with PCS again so as to reassess the usefulness of such contact.[189]

219. Dr Grigg saw Mr Bell again on 27 October 2014 apparently at the request of the SHU senor officer who had asked for an urgent review because Mr Bell was reportedly not eating. When seen, Mr Bell denied he was on a hunger-strike but seemed depressed and irritable. He broke down in tears at times as he described ongoing perceived mistreatment by custodial staff.[190]

220. Mr Bell told Dr Grigg that mistreatment by custodial staff led to an incident on 25 October 2014 that resulted in him being charged with assault. Mr Bell said that he would not eat during any period of close confinement (punishment) as a protest against his treatment.[191]

221. Mr Bell confirmed ongoing suicidal ideation but denied any plan. He said if he did decide to take his life, he wouldn't tell anyone because: "*what would be the point*".[192]

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[187] ts 04.04.19 (Maines), p579
[188] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 15-20
[189] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 15-20
[190] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 21-23
[191] Exhibit 1, Tab 17, Statement - Dr Grigg, para 23-24
[192] Exhibit 1, Tab 17, Statement - Dr Grigg, para 23-24

222. Dr Grigg discussed the procedure for placement on a voluntary starvation regime with Mr Bell and encouraged him to self-refer to PCS if he felt suicidal or if he was going to self-harm. Mr Bell said his experience with PCS had been positive and he was interested in continuing contact.[193]

223. At the inquest, Dr Grigg could not recall the details of the mistreatment alleged by Mr Bell.[194] However, Dr Grigg said that after seeing Mr Bell, he (Dr Grigg) spoke to the senior officer of the SHU about the hunger strike issue was told Mr Bell had denied starting a hunger strike.[195]

224. Through their solicitor, Mr Bell's family referred to the fact that Mr Bell had told Dr Grigg that he had been mistreated by officers. Mr Bell's family says further that there are a lack of adequate records about Mr Bell's complaints and an apparent lack of action with respect to those complaints. I will deal later with the suggestion by Mr Bell's family that interactions between prisoners and custodial staff should be recorded, either by means of CCTV or by body cameras.[196]

225. Dr Grigg saw Mr Bell on 30 October 2014 and found him calm and settled. Mr Bell raised the incident on 25 October 2014 and said he had been threatened with additional charges if he lodged a complaint about the matter. Mr Bell's perception about the cause of the incident was that he had been provoked and mistreated and he was uncertain about what action to take.[197]

226. Dr Grigg encouraged Mr Bell to lodge any complaint with the SHU senior officer or use the Department's ACCESS compliments and complaints line. Mr Bell said he had been unable to access either and Dr Grigg encouraged Mr Bell to maintain contact with PCS.[198] After the session, Dr Grigg spoke to the SHU senior officer about Mr Bell's allegations and Mr Bell's difficulties in accessing the senior officer and the ACCESS line. The SHU senior officer said he would follow the matter up with Mr Bell.[199]

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[193] Exhibit 1, Tab 17, Statement - Dr Grigg, para 25-27
[194] ts 29.03.19 (Grigg), p319
[195] Exhibit 1, Tab 17, Statement - Dr Grigg, para 27
[196] Submissions, Mr Meyers (01.05.19), paras 50-54
[197] Exhibit 1, Tab 17, Statement - Dr Grigg, para 28
[198] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 29-30
[199] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 29-30

227. TOMS records show that Mr Bell was seen by his lawyer on 30 October 2014, and that on 4 November 2014, Mr Bell asked for copies to be made of his letter of complaint about the incident.[200]

228. On 13 November 2014 when seen by Dr Grigg, Mr Bell continued to express his frustration about being charged for assaulting staff but told Dr Grigg that he had engaged with both the ACCESS line and the Ombudsman. Dr Grigg encouraged Mr Bell to continue to pursue his perceived mistreatment though appropriate channels.[201]

229. Mr Bell felt his family were distancing themselves from him and told Dr Grigg that when seen by a psychologist for the purposes of a pre-sentence report, he had been diagnosed with PTSD. Mr Bell said he had been advised to take medication to help with sleep. Dr Grigg discussed PTSD with Mr Bell and suggested they continue their fortnightly sessions.[202]

230. On 18 November 2014, Mr Bell was placed on ARMS after several letters addressed to his family expressing an intention to self-harm were found in his cell.[203] When reviewed by Dr Grigg on 19 November 2014, Mr Bell said the letters had been written some time before and he used them as a way to "*vent*" when he was "*feeling down*". Mr Bell denied any current thoughts of self-harm. Nevertheless, in view of the presenting issues, Mr Bell was maintained on low ARMS in the SHU in a camera cell.[204]

231. When seen by Dr Grigg on 24 November 2014, Mr Bell disclosed frequent thoughts of suicide. Although he denied any plans or intent he indicated he had considered various methods of suicide including hanging, cutting his wrists and drowning. Mr Bell said that family issues and his court attendances were his main concerns. He confirmed he would approach PCS or the SHU senior officer if he felt his risk of self-harm was increasing.[205]

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[200] Exhibit 2, Tab A-1, TOMS records (30.10.14) & (04.11.19)
[201] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 32-35
[202] Exhibit 1, Tab 17, Statement - Dr Grigg, para 36
[203] Exhibit 11, Tab 1, PRAG Minutes (18.11.14)
[204] Exhibit 11, Tab 1, PRAG Minutes (19.11.14) and ts 29.03.19 (Grigg), p323
[205] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 44-46

232. The PRAG review on 26 November 2014 noted Dr Grigg's review but referred to Mr Bell's suicidal thoughts as "fleeting" (as opposed to "frequent"). Dr Grigg was asked about this discrepancy and said he could only assume it was a typographical error by the minute taker. Although this error is serious, nothing turns on it because Mr Bell was maintained on low ARMS.[206]

233. Mr Bell continued to receive regular support from Dr Grigg and was seen on 3, 10 and 15 December 2014. On 17 December 2014 Mr Bell reported no increase in suicidal ideas, plans or intent and was maintained on low ARMS.[207]

234. Mr Bell was reviewed again by Dr Grigg on 28 January 2015. He denied any risk to himself but said he experienced low intensity suicidal ideation when stressed. He was removed from ARMS and placed on SAMS.[208]

235. Mr Bell remained on SAMS and was scheduled for monthly reviews, however he declined to be seen on 19 March 2015 and 16 April 2015. Although unable to attend the PRAG meeting on 2 April 2015, Dr Grigg provided a colleague with notes indicating his (Dr Grigg's) view that Mr Bell remained at chronic risk of suicide and that an improvement in his risk profile needed to occur before he was removed from SAMS.[209]

236. On 24 April 2015, Dr Grigg saw Mr Bell for a SAMS review. Dr Grigg noted Mr Bell's lowered mood, consistent with previous reviews, but thought his mental state had improved. Mr Bell said he was having visits from family members and felt his appeal with respect to his conviction was going well. He reported rarely experiencing suicidal or self-harm ideation and had no plans or intent.[210]

237. At the PRAG meeting on 7 May 2015, Mr Bell was removed from SAMS. Dr Grigg's recommendation that PCS continue to try to engage Mr Bell was noted, however Mr Bell declined to attend counselling sessions on 11 and 20 May 2015.[211, 212]

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[206] Exhibit 11, Tab 1, PRAG Minutes (26.11.14)
[207] Exhibit 11, Tab 1, PRAG Minutes (17.12.14)
[208] Exhibit 11, Tab 1, PRAG Minutes (28.01.15)
[209] Exhibit 1, Tab 17, Statement - Grigg, para 98 & ts 29.03.19 (Grigg), p333
[210] Exhibit 1, Tab 17, Statement - Grigg, paras 101-102
[211] Exhibit 2, Tab A.18, SAMS summary (07.05.16) & Exhibit 1, Tab 17, Statement - Dr Grigg, paras 105-107
[212] ts 29.03.19 (Grigg), p334

238. Mr Bell self-referred to PCS on 11 June 2015 and was seen by Dr Grigg on 12 June 2015. Mr Bell seemed irritable, complained of spending limited time out of his cell and mentioned some increase in night-time "*visions*".[213]

239. Through their solicitor, Mr Bell's family raised a concern that Mr Bell had been shackled when he made telephone calls. Mr Bell's family submitted that there was no need for him to be restrained whilst in the SHU and that shackling would be seen as a degrading event.[214]

240. In response, the Department advised that given the nature of the SHU, restraints are used when required to ensure the safety of staff. Restraints are also applied as a standard escorting procedure based on the behaviour of the individual prisoner. The use of restraints is authorised by the Deputy Superintendent Operations as a standard escorting procedure.[215]

241. The Department also advised that a record is made when restraints are in the SHU. In Mr Bell's case, there is no record of restraints being applied for the safety of others, including staff.[216]

242. I note that the SHU monthly progress reports does contain records of restraints being used with respect to some prisoners, but that Mr Bell is not amongst them.[217]

243. When Dr Grigg saw Mr Bell on 19 August 2015, his ongoing vague, fluctuating suicidal ideation was noted but Mr Bell denied any intent or plan.[218] Mr Bell told Dr Grigg that when he (Mr Bell) was on the phone, a prison officer swore at him and abused him.[219] Dr Grigg reinforced the importance of Mr Bell raising his concerns with the SHU senior officer and/or making a complaint via the "ACCESS" line.[220] Dr Grigg discussed the issues raised by Mr Bell with the senior officer of the SHU but it is unclear how Mr Bell's concerns were then addressed.[221]

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[213] Exhibit 11, Tab 3, PCS Notes (11.06.15) and Exhibit 2, Tab A.19, Summary of PCS involvement
[214] Submissions, Mr Meyers (01.05.19), paras 43-45
[215] Submissions, Department of Justice (09.05.19), paras 12-14
[216] Submissions, Department of Justice (09.05.19), para 15
[217] Letter, Ms Fiona Hunt, (16.04.19), Attachment 10 - SHU Monthly Progress Report (25 Jun 15)
[218] Exhibit 11, Tab 3, PCS Notes (19.08.15) and ts 29.03.19 (Grigg), p335
[219] Exhibit 11, Tab 3, PCS Notes (19.08.15)
[220] The Department's compliments and complaints phone service available to all prisoners
[221] Exhibit 11, Tab 3, PCS Notes (19.08.15)

244. Mr Bell's sister visited him on 3 September 2015 and did not notice anything unusual about him. Ms Bell did not have access to her mobile phone following her visit and so she did not receive a call Mr Bell made to her at 5:11 pm on 7 September 2015. Mr Bell left a voicemail message saying goodbye and telling her he loved her.[222]

245. At the time of his death, Mr Bell was not regarded as being at imminent risk of self-harm nor were there any security or other reasons which would have warranted Mr Bell's phone calls being monitored.[223] For that reason, several other messages and one call made by Mr Bell in the week prior to his death, in which he clearly indicated suicidal ideation, were not detected.[224]

246. With respect to the time he spent in his cell whilst in the SHU, the SHU monthly progress report for November 2014notes that Mr Bell had completed a period of close confinement (related to the 25 October 2014 assault incident) and that he: "*now spends days in his cell without coming out at all*". The progress report goes on to note that Mr Bell had been encouraged to come out of his cell by the senior officer of the SHU and that Mr Bell "*does do so at times*".[225]

247. In January and February 2015, Mr Bell was noted to be refusing recreation, telephone calls and official visits. He also declined to attend the monthly SHU meetings in January and February 2015.[226] Unit records refer to him having become a "*recluse*" and "*living in a fantasy world preferring to play video games*".[227] Following prompting by unit staff, a new routine of encouraging Mr Bell to spend one hour out of his cell daily was introduced.[228]

248. By April 2015, a positive change had occurred and Mr Bell was noted to be spending more time out of his cell and making more use of the Prisoner Telephone System (PTS) to call relatives and friends. Although he appeared withdrawn, he was accepting of his new recreation time.[229]

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[222] Exhibit 1, Tab 6, Statement - Ms Bell
[223] ts 04.04.19 (Maines), pp584-585
[224] Exhibit 2, Tab A, Death in Custody Review (Bell), p22
[225] Letter, Ms Fiona Hunt, (16.04.19), Attachment 10 - SHU Monthly Progress Report (06 Nov 14)
[226] Exhibit 2, Tab A, Death in Custody Review (Bell), p14
[227] Exhibit 2, Tab A, Death in Custody Review (Bell), p14
[228] Exhibit 2, Tab A, Death in Custody Report (Bell), p14 and ts 04.04.19 (Maines), pp588-589
[229] Exhibit 2, Tab A, Death in Custody Report (Bell), p14 and ts 04.04.19 (Maines), pp588-589

249. In his review, Mr Mudford noted that the Department was investigating whether intelligence gathering technology to identify threat words or phrases might be available to detect potential self-harm threats made in phone calls using the PTS. In addition, the Department indicated it intended to increase the level of real-time monitoring of phone calls made by prisoners housed in the SHU.[230]

250. Through their solicitor, Mr Bell's family expressed their concern that that two of Mr Bell's relatives, who were inmates at Casuarina Prison at the relevant time, were refused permission to visit him in the SHU.[231] In response, the Department advised that there is no record of Mr Bell asking for visits from other prisoners and no record of any prisoners asking to visit him.[232]

251. Further, the Department advised that all visits, whether successful or unsuccessful, are recorded in TOMS. Prison records show that whilst in the SHU at Casuarina Prison, Mr Bell received 27 visits from family and friends and he was also visited by his lawyer on a number of occasions.[233,234]

Events Leading to Death[235,236]

252. On 8 September 2015, Mr Bell was housed in cell A2 in the SHU. At approximately 7.00 am prison officers were conducting the morning unlock muster and welfare check of prisoners in the SHU. At about 7.15 am, Mr Bell declined breakfast and remained in his cell.[237]

253. At 11.15 am, Officer Pimlott unlocked the observation hatch of Mr Bell's cell to tell him that lunch was ready. There was no response and Officer Pimlott could not see Mr Bell through the hatch. Officer Brodin unlocked Mr Bell's cell and found him slumped in the shower in a seated position with the water running.

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[230] Exhibit 2, Tab A, Death in Custody Review (Bell), p23
[231] Submissions, Mr Meyers (01.05.19), paras 33-34
[232] Submissions, Department of Justice (09.05.19), para 11
[233] Submissions, Department of Justice (09.05.19), paras 9-11
[234] Letter, Ms Fiona Hunt, (16.04.19), Attachment 9 - Visits Record and ts 04.04.19 (Maines), p542
[235] Exhibit 1, Tab 4, Statement - Officer Pimlott
[236] Exhibit 2, Tab A.5, Incident Description Reports, Officers Pimlott & Brodkin
[237] Exhibit 1, Tab 5, Statement - Officer Rayner and Exhibit 1, Tab 16.6, SHU Occurrence book

254. Officer Brodin called a code red medical emergency and prison officers began CPR. Nursing staff attended the SHU and assisted with resuscitation efforts and were joined by medical officers and additional nursing staff. Meanwhile, emergency services were contacted and ambulance officers arrived at about 11.36 am.[238]

255. Despite resuscitation efforts, Mr Bell could not be revived and he was declared dead at 11.57 pm on 8 September 2015.[239]

256. Through their solicitor, Mr Bell's family raised a concern about the frequency with which Mr Bell was monitored on the morning of his death.[240]

257. The evidence of Mr Maines is that monitoring levels may have been less frequent at this time because prisoners had been locked in their cells prior to custodial staff attending a training course.[241]

258. Mr Bell was not on ARMS or SAMS at the time of his death because of perceived improvements in his mood and the intensity of his suicidal ideation.[242] In the context of his assessed level of risk, I do not accept that the observation frequency with respect to Mr Bell on the morning of his death (i.e.: a 4-hourly interval with observations at the breakfast and lunch musters)[243,244] was inappropriate.

259. Through their solicitor, Mr Bell's family raised a concern about the availability of CCTV footage in the SHU that might have captured footage relevant to Mr Bell's death and further, whether there was any CCTV footage that had not been disclosed.[245]

260. At the time of his death, Mr Bell was not in a camera cell. Footage from the camera located in the landing outside Mr Bell's cell was unavailable due to a technical issue with a recording device attached to that camera.[246]

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[238] Exhibit 1, Tab 8, St John Ambulance Patient Care Record
[239] Exhibit 1, Tab 8, St John Ambulance Patient Care Record
[240] Submissions, Mr Meyers (01.05.19), paras 17 & 19
[241] ts 04.04.19 (Maines), pp589-590
[242] Exhibit 1, Tab 17, Statement - Dr Grigg, paras 76-79, 102-105 & 106-107
[243] Exhibit 1, Tab 5, Statement - Officer Rayner & Exhibit 1, Tab 16.6, SHU Occurrence book
[244] Exhibit 2, Tab A.5, Incident Description Reports, Officers Pimlott & Brodkin
[245] Submissions, Mr Meyers (01.05.19), paras 7-16
[246] Exhibit 2, Tab A, Death in Custody Review (Bell), p21 and ts 04.04.19 (Maines), pp580-581

261. Because of its location, footage from the landing camera (had it been recorded) would not have shown what was happening inside Mr Bell's cell in the lead-up to his death. It may possibly have shown any person entering Mr Bell's cell prior to his death, and/or resuscitation efforts that took place on the landing outside Mr Bell's cell.[247]

262. It is unfortunate that the footage from the CCTV camera outside Mr Bell's cell is not available, mainly because its absence makes it impossible to allay suspicion on the part of Mr Bell's family. However, the police investigation into Mr Bell's death found no evidence of criminal involvement.[248]

Cause and Manner of Death

263. When found by custodial staff, Mr Bell had deep lacerations to the inside surfaces of both forearms and injuries to his forehead and left eyelid.[249]

264. A forensic pathologist, (Dr Cadden) conducted a post mortem of Mr Bell's body on 11 September 2015. Dr Cadden noted injuries to Mr Bell's body, including to the superficial veins underlying the front surface of each elbow region, an area of injury to the outer aspect of the left lower eyelid and the central forehead.[250]

265. After describing Mr Bell's forehead injury, Dr Cadden concluded: "*The overall appearances of this area would appear to be in keeping with a laceration*".[251] The injury to Mr Bell's left eyelid was also described in detail and Dr Cadden observed that "*The appearances of this area of injury were in keeping with an incised-type injury.*"[252]

266. Through their solicitor, Mr Bell's family raised a concern about an injury to Mr Bell's nose that a relative had reportedly observed whilst viewing Mr Bell's body after his death. The injury was described as a "hole" or puncture mark" in the vicinity of the bridge of Mr Bell's nose.[253]

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[247] Exhibit 2, Tab A, Death in Custody Review (Bell), p21 and ts 04.04.19 (Maines), pp580-581
[248] Exhibit 1, Tab 3, Report - FCC J Edwards, p6 and ts 04.04.19 (Maines), p582
[249] Exhibit 2, Tab A.5, Incident Description Reports, Officer Pimlott & Nurse Saegi
[250] Exhibit 1, Tab 11, Post Mortem Report
[251] Exhibit 1, Tab 11, Post Mortem Report, pp9-10
[252] Exhibit 1, Tab 11, Post Mortem Report, pp9-10
[253] Submissions, Mr Meyers (01.05.19), paras 1-6

267. The post mortem report describes an injury to the bridge of Mr Bell's nose in the following terms:

> "*Over the bridge of the nose, immediately below the glabellar aspect, an area of scarring in the order of approximately 6mm was present.*"[254]

268. It is unclear whether the injury to the bridge of Mr Bell's nose noted during the post mortem examination is the same as the one noticed by Mr Bell's relative when she viewed his body. On the basis of the evidence before me, I am unable to draw any conclusion about this injury.

269. The police investigation found "*various razor blades within the bathroom and on the cell floor*" of Mr Bell's cell and blood on sheets and the mattress, which had dripped onto the cell floor, as well as bloodstains on the wall in the shower cubicle.[255]

270. The investigation concluded that:

> "*…the deceased used a blade from a plastic razor owned by the deceased to create incisions in the inside of each elbow and his forehead whilst in his cell.*"[256]

271. As I have noted, the police investigation into Mr Bell's death found no evidence of criminal involvement of another person in his death.[257] Further, neuropathological assessment of Mr Bell's brain found no significant abnormalities and there were no features of recent traumatic brain injury.[258]

272. In light of the evidence, it seems sensible to conclude that Mr Bell sustained the injuries to his forehead and his eyelid whilst moving between the bed and shower in his cell. Given that his eyelid injury was noted to be an "*incised-injury*" and his forehead injury was described as "*in keeping with a* laceration", it is also possible that Mr Bell inflicted these injuries on himself.

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[254] Exhibit 1, Tab 11, Post Mortem Report, p6
[255] Exhibit 1, Tab 3, Police Report - FCC J Edwards, p4
[256] Exhibit 1, Tab 3, Police Report - FCC J Edwards, p6 and Exhibit 1, Tab 15, Photos of Mr Bell's cell
[257] Exhibit 1, Tab 3, Police Report - FCC J Edwards, p6 and ts 04.04.19 (Maines), p582
[258] Exhibit 1, Tab 13, Neuropathology Report

273. Toxicological analysis found the prescription medications: amitriptyline, tramadol and paracetamol in Mr Bell's system. Amitriptyline had been prescribed to help Mr Bell sleep[259] and tramadol and Panadol were for pain relief. Amphetamines, benzodiazepines, cannabinoids, and opiates were not detected in Mr Bell's blood samples and alcohol was not detected in his urine.[260]

274. Dr Rowland confirmed that amitriptyline is known for its limited side effects and that at the dosage being taken by Mr Bell was safe and unlikely to have increased his suicidal ideation.[261]

275. Dr Cadden expressed the opinion that the cause of death was incised injury to elbow region veins.[262] I accept and adopt that opinion as to the cause of death.

276. I find Mr Bell's death occurred by way of suicide.

Quality of Supervision, Treatment and Care

277. Analysis of the PTS after Mr Bell's death found he made one call and left several voicemail messages in the week before his death that clearly indicated suicidal intent. Had it been possible to monitor the PTS in real time, it may have been possible to have provided Mr Bell with extra support.

278. The implement used by Mr Bell to inflict the wounds to his forearms was identified as a blade from a disposable razor.[263] Following Mr Bell's death, the policy relating to razor blades in prisons was changed. Mr Maines noted that:

> "*…a number of local policy directives were issued surrounding the management of razor blades to ensure that these are individually issued for a set period of time and then accounted for after use.*"[264,265]

279. The hygiene policy provides that prisoners who do not have an electric razor may, on a daily basis, request and be issued with a single disposable safety razor. [266]

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[259] ts 26.03.19 (de Klerk), p131
[260] Exhibit 1, Tab 12, ChemCentre Report
[261] ts 03.04.19 (Rowland), pp420-421
[262] Exhibit 1, Tab 11, Post Mortem Report
[263] Exhibit 1, Tab 3, Police Report - FCC J Edwards, p6
[264] Exhibit 12, Tab 14, Statement - Mr Maines
[265] ts 04.04.19 (Maines), pp568-569
[266] ts 04.04.19 (Maines), p569

280. The issue of the razor is recorded and it must be returned 90 minutes after issue. On return, the razor is checked to ensure it has not been tampered with before being disposed of.[267] Prisoners housed in the CCU may only use razors whilst they are under direct observation.[268]

281. Through their solicitor, Mr Bell's family submitted that all interactions between custodial staff and prisoners housed on the SHU should be recorded either by way of CCTV, or by means of "body cameras" worn by custodial staff.[269]

282. Relevantly, the Department advised that:[270]

    i. body worn video technology (body cameras) are worn by officers in its Special Operations Group and at the Banksia Hill Detention Centre;

    ii. it is currently investigating the viability of, and funding required to introduce body cameras to various operational areas including the SHU;

    iii. it is working with the WA Police with respect to their body camera technology and procedures in order to simplify the Department's adoption and deployment of body cameras; and

    iv. the broader deployment of body cameras will depend on budget submissions and approvals.

283. In my view, given the nature of the SHU and prisoners generally housed there, the Department's plans with respect to the adoption of body cameras are appropriate. The use of body cameras by custodial staff in the SHU may help to allay some of the concerns of family members and others with respect to the manner in which prisoners on the SHU are managed. The use of body cameras may also enhance the safety of custodial staff.

284. As the Department's plans with respect to this issue appear to be advanced, I do not propose to make a recommendation about this issue. However, I would urge the Department to pursue this initiative as expeditiously as possible.

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[267] Letter, Ms Fiona Hunt, (16.04.19), Attachment 8, PD19 - Prisoner Hygiene, sections 4A & 4B
[268] ts 04.04.19 (Maines), p569
[269] Submissions, Mr Meyers (01.05.19), paras 53-55
[270] Submissions, Department of Justice (09.05.19), paras 3-7

285. On 12 December 2013, Mr Bell was noted to have fleeting, often vague thoughts of self-harm, yet he was removed from ARMS on 28 January 2015 and from SAMS on 7 May 2015. It seems clear that Mr Bell was categorised as being at chronic risk of suicide.

286. If Mr Bell had still been on SAMS at the time of his death, he would have been seen monthly by a PCS counsellor. Given that Mr Bell took his life on 8 September 2015, he would have been seen on a maximum of three occasions.

287. As it was, after Mr Bell was removed from SAMS, he refused to be seen on two occasions in May 2015 but he was seen twice by Dr Grigg before he died (i.e.: on 11 June 2015 & 19 August 2015).

288. Although Mr Bell sometimes refused to engage with PCS, in June and August 2015, he self-referred. In those circumstances, it is impossible to say whether the outcome in this case would have been any different had Mr Bell been on SAMS at the time of his death.

289. The critical incident debrief conducted after Mr Bell's death raised the possibility of a system to periodically review prisoners removed from ARMS and SAMS. The idea would be to conduct a risk assessment of these prisoners to ensure that additional supports were not required.[271]

290. Although the suggestion has some merit, such a system would be very difficult to implement within the confines of existing PCS resources.[272]

291. Dr Rowland referred to a new approach to the management of prisoners called "trauma informed custodial care" (TICC) which, in her view, can be effective in managing prisoners like Mr Bell.[273] I will make some further comments about TICC later in this Finding.

[271] Exhibit 2, Tab A.2, Lessons Learnt (Cameron)
[272] ts 28.03.19 (Mandolene), p235
[273] Exhibit 12, Tab 15, Statement – Dr Rowland, paras 37-45 and ts 03.04.19 (Rowland), p425

BEVAN STANLEY CAMERON[274,275]

Background

292. Bevan Stanley Cameron (Mr Cameron) was born in Kalgoorlie on 21 February 1989 and was 26-years of age when he died on 28 October 2015.

293. Mr Cameron was the middle child of five children and when he was about 4 or 5 years of age, he went to live with his grandparents in Geraldton. As a young person, he enjoyed sport, especially hockey and football.

294. Mr Cameron's father was reportedly diagnosed with schizophrenia and hung himself in prison when Mr Cameron was about 9-years of age. Mr Cameron is said to have started using illicit substances when he was 13 years-of-age.

295. After completing year 9, Mr Cameron had a couple of labouring and bricklaying jobs, but thereafter, does not appear to have had a consistent employment history. He never married but had a daughter from a previous relationship.

296. According to his mother, Mr Cameron was addicted to alcohol and when intoxicated, would threaten to self-harm.

Overview of Medical Conditions

297. In 2008-9, at Greenough Regional Prison, Mr Cameron was assessed by a psychiatrist and diagnosed with drug induced psychosis and depression and treated with antidepressants and antipsychotic medication.[276]

298. By August 2009 he had stopped the antipsychotics and did not require further psychiatric follow up.[277]

299. Mr Cameron was also diagnosed with panic attacks (2010), underlying psychotic or mood disorder (2011) and behaviour and adjustment disorders (2012).[278]

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[274] Exhibit 3, Tab 6, Statement - Ms Dimer
[275] Exhibit 4, Tab A, Death in Custody Review (Cameron)
[276] Exhibit 4, Tab A, Death in Custody Review (Cameron), p15
[277] Exhibit 4, Tab A, Death in Custody Review (Cameron), p15
[278] Exhibit 12, Tab 15, Statement - Dr Rowland, para 52

300. Mr Cameron was reviewed on several occasions by Dr de Klerk, (consultant psychiatrist) as follows:[279]

i. 20 April 2015: following a discussion with a mental health nurse on that day, Dr de Klerk reviewed Mr Cameron's clinical notes and concluded: "*there is ample evidence that this man does not have a history of serious mental illness, but rather that he has an emotionally unstable personality structure and that is impulsive*".

ii. 28 April 2015: Dr de Klerk reviewed Mr Cameron following complaints Mr Cameron made to the Ombudsman about being observed by satellites, a claim he later acknowledged was untrue. Dr de Klerk concluded: "*Mr Cameron does not display symptoms or signs of serious mental illness. He has an unstable affect in the context of impulsive antisocial personality construct. He does not require any regular medications*."

iii. 25 May 2015: Dr de Klerk reviewed Mr Cameron at Albany Regional Prison after a noose was found in his cell. Dr de Klerk noted: *"I again found no symptoms or signs of serious mental illness during my mental state examination with him on this day. I formed the impression that as before that he experienced emotional distress due to poor coping skills. In view of his stated intent not to harm himself any further, I advised that his ARMS level could be decreased.*"

iv. 8 June 2015: Dr de Klerk reviewed Mr Cameron in the observation cell at Albany Regional Prison after a report that Mr Cameron had "*made a gesture implicating* (sic) *a noose around his neck*". In his report, Dr de Klerk notes: "*Mr Cameron did not present with any signs or symptoms of serious mental illness…I noted that he was using threats and gestures of self-harm to manipulate his environment*."

[279] Exhibit 4, Tab 1, Report - Dr de Klerk

v. 29 September 15: Dr de Klerk reviewed Mr Cameron at Greenough Regional Prison. In his report, Dr de Klerk notes: "*I have seen him on a number of occasions with deliberate self-harm ideation against a background of cluster B personality vulnerabilities; poor distress tolerance when experiencing overwhelming psychosocial stressors…I noted he had an external locus of control (a way of thinking where people blame outside forces for their internal distress)*".

Dr de Klerk did not consider that Mr Cameron had signs or symptoms of serious mental illness before noting: "*there will no doubt be future crises in prison*" but that sedating medications were not warranted.

Dr de Klerk considered that the best option for managing Mr Cameron was: "…*to engage with PCS for mindfulness techniques and distress tolerance training.*[280] *When distressed, the ARMS process is appropriate, and regular review/support by PCS, MHN and peer support/Elders is completely appropriate. He has a long sentence ahead, and a consistent approach would work best*".

301. Although Mr Cameron was not thought to have a major psychiatric condition, he was clearly thought to have antisocial personality disorder and his impulsive behaviour raised the question of whether he might also have foetal alcohol syndrome disorder.[281] It is unclear whether this concern was ever investigated.

Offending History

302. Mr Cameron's criminal history began in 2002, when he was about 13-years of age. From 2002 – 2012 he was regularly convicted of offences including: stealing, burglary, breaching court orders, damage and assault.[282]

[280] However, as already noted, PCS had no capacity to offer this type of therapeutic support.
[281] Exhibit 12, Tab 15, Statement - Dr Rowland, para 52
[282] Exhibit 4, Tab A.4, Criminal History

303. On 21 April 2014, Mr Cameron appeared before the Perth Magistrate's Court in relation to the offences of: dangerous driving causing bodily harm, leaving the scene of an accident, aggravated assault, being armed in a way that may cause fear, criminal damage and stealing a motor vehicle. He was remanded in custody at Hakea Prison.[283]

304. The circumstances of the offences were that Mr Cameron became intoxicated, assaulted a 16-year girl with a baseball bat and drove off with his one year old daughter. He then had an accident, fled the scene and the car burst into flames. Mr Cameron's daughter was rescued from the car and taken to hospital with serious injuries.[284]

305. On 7 November 2014 Mr Cameron was sentenced to a period of 7 years and 6 months imprisonment for those offences. Mr Cameron's sentence was backdated to 20 April 2014 and he was made eligible for parole, meaning he had an earliest release date of 19 October 2019.[285]

306. On a number of occasions, Mr Cameron reported that, because of the nature of his offences, he felt he was being bullied by other prisoners and/or receiving limited contact from family members.[286,287]

Prison History

307. Prior to his last incarceration, Mr Cameron had been imprisoned on six occasions as an adult, for a total of 1,894 days (a little over 5 years) and on 5 occasions as a juvenile. He was first detained when he was 14-years of age.[288]

308. Between his admission to Hakea Prison on 21 April 2014 and his death on 2 November 2015, Mr Cameron's prison placements were characterised by repeated reports of self-harm and/or suicidal ideation, which he would invariably withdraw.

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[283] Exhibit 4, Tab A, Death in Custody Review (Cameron), pp6-7
[284] Exhibit 4, Tab A.8, Case Conference Report
[285] Exhibit 4, Tab A, Death in Custody Review (Cameron), p7
[286] Exhibit 4, Tab A.20, Summary of PCS Involvement and Exhibit 11, Tab 5, PCS Notes
[287] See for example: PRAG Minutes: (01.08.14), (29.06.14), (25.02.15), (03.07.15) & (24.07.15)
[288] Exhibit 12, Tab 14, Statement - Mr Maines, paras 51-52

309. As a result, Mr Cameron was placed on ARMS on 26 occasions and on SAMS on 4 occasions. He was also placed in CCU on various occasions and had numerous transfers between prisons and between units within prisons.[289] PCS counselling records for the period 28 April 2014 to 28 October 2015, record numerous reviews and assessments.[290]

310. There seems little doubt that Mr Cameron's fluctuating mood and challenging behaviours presented prison staff with ongoing management issues. The number of complaints he made about aspects of his incarceration was regarded as being: "*at the high end of the scale".*[291]

311. The PCS and PRAG records make it clear that Mr Cameron's repeated reports of self-harm and/or suicidal ideation tended to be viewed by prison staff as largely related to his attempts to orchestrate changes to the prison where he was housed, or with respect to cell or unit placements within a particular prison.

312. Examples include:[292]

    i. PRAG minutes (01.08.2014): Mr Cameron was placed in an observation cell after expressing thoughts of self-harm. The minutes record: "*Prisoner freely admitted that he threatened self-harm to manipulate his placement…Remove from ARMS no risk identified. Cameron uses threats of self harm to manipulate his placement, this method is effective in achieving his needs, the PRAG team is aware of his manipulation and is working towards Cameron using other methods to achieve his needs.*"

    ii. PRAG minutes (08.08.2014): Mr Cameron placement in a safe cell was reviewed. The minutes record: "*Based on Bevan's numerous Safe Cell placements over the last 12 weeks and the absence of any self harm behaviour, the author supports an aversion therapy approach with a view to shifting Bevan's tendency to seek comfort and respite in* [a] *Safe Cell by threatening self harm/suicide.*"

[289] Exhibit 4, Tab A, Death in Custody Review (Cameron)
[290] Exhibit 4, Tab A.20, Summary of PCS Involvement
[291] ts 27.03.19 (Chadwick), p187
[292] Exhibit 4, Tab A.20, Summary of PCS Involvement

iii. PRAG minutes (27.08.2014): Mr Cameron was placed in CCU after making threats of self-harm with a razor. The minutes record: "*Remove from ARMS, no risk to self identified. The threats made by Cameron are for manipulation of placement, this is consistent and ongoing. At no time in the last three months [has] any self harm [been] committed on himself.*"

iv. PRAG minutes (02.09.2014): Mr Cameron damaged the toilet in his cell. The minutes record the following comment from PCS: "*Bevan's behaviour and 'cries for help' seem to be instrumental behaviours designed to get him out of situations where he perceives himself under threat or does not want to be placed.* ***If there is a deeper more substantial issue to be addressed with Bevan it is proving difficult to ascertain or identify because his behaviour attracts the focus of ARMS and PRAG intervention primarily in terms of determining his next placement***." [emphasis added]

v. PRAG minutes (13.10.2014): Mr Cameron had been placed in CCU following threats of self-harm. The minutes record: "*Remove from safe cell, remove from ARMS, threats made in an attempt to manipulate placement unrealistic demands on all staff. No commitment from Bevan to assist in any changes or discussion on behaviour.*"

vi. PRAG minutes (01.05.2015): Mr Cameron threatened self-harm on 30 April 2015 and was placed in an observation cell. The minutes record: "*Cameron made it clear he did not have any intention to self-harm or suicide. He said he threatened self-harm to orchestrate a placement in a single cell, as he did not like his cell placement with a man who was diabetic and had the bottom bunk…Cameron has a history of trying to manipulate the system to benefit himself.*"

vii. PRAG minutes (12.10.2015): Mr Cameron was placed in an observation cell following a self-harm incident. The minutes record: "*He presented with limited understanding of the seriousness of his self-harming behaviour. He did acknowledge that he self-harmed in order to manipulate his transfer. Bevan denied current self-harm and suicide ideation but insisted that he would need to see some paperwork about his transfer to Albany prior to him accepting it. His impulsive nature, lack of consequential thinking and the pending transfer are increasing his risk to self.*"

313. Mr Cameron was last seen by PCS on 28 October 2015 when his presentation was described as "*reasonable, calm and settled*". He made some vague comments about having issues with prisoners on A and C wings, but firmly denied any self-harm risk, although it was noted: "*Behaviour is difficult to predict in future as he is reactive to actions of others*". It was recommended that his 6-hourly ARMS observations be reduced to 12-hourly.[293]

Cultural Issues

314. The importance of culture to many Aboriginal prisoners cannot be overstated,[294] particularly for prisoners like Mr Cameron who was considered to be "out of country" whilst incarcerated in the metropolitan area.[295] Mr Chadwick said that at Casuarina Prison, a concerted effort is made to involve Aboriginal Elders, the AVS, peer support officers, chaplains and the Aboriginal Prisoner Service (APS) where appropriate. He said the involvement of these resources had been effective.[296]

315. On a number of occasions during his incarceration, Mr Cameron told staff he was experiencing issues related to culture and needed to see an Elder or an AVS worker. Examples of his requests appear in PCS file notes on: 26 May 2014, 25 September 2014, 4 May 2015 and 6 October 2015.[297,298]

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[293] Exhibit 4, Tab A.20, Summary of PCS Involvement
[294] ts 03.04.19 (Patchett), pp454-455 and ts 03.04.19 (Rowland) p412
[295] Exhibit 12, Tab 14, Statement - Mr Maines, para 51
[296] ts 27.03.19 (Chadwick), p185
[297] Exhibit 4, Tab A.20, PCS Counselling Notes (26.05.14; (25.09.14); (04.05.15) & (06.10.15)
[298] Mr Cameron didn't raise cultural issues whilst at Casuarina Prison: ts 27.03.19 (Chadwick), p205

316. Ms Marais said that in accordance with her usual practice, when Mr Cameron raised cultural issues with her on 6 October 2015, she referred his request to the peer support officer. She was unsure if this referral was actioned.[299]

317. I accept the submission by counsel for Mr Cameron's family that the cultural needs of Aboriginal prisoners must be recognised.[300] As Ms O'Hara points, Aboriginal prisoners can be greatly assisted by support from an appropriate Aboriginal Elder and support networks with these Elders need to be nurtured and strengthened.[301]

318. The availability of Aboriginal Elders able to assist prisoners seems to vary between prisons[302] and it appears that the key is to engage the "right" Aboriginal Elders.[303] Dr de Klerk observed that the paucity of Aboriginal prison officers and mental health workers was "*deeply saddening*".[304]

319. The AVS at Casuarina Prison has one full time and one part-time visitor at Casuarina Prison and employs several Aboriginal support officers.[305] Pleasingly, the Department advised that it is currently recruiting additional staff for the AVS. The Department conceded that its efforts in this regard had previously been "clunky".[306]

320. The APS at Casuarina Prison, which consists of Ms Lee McKay, offers a range of excellent supports to Aboriginal prisoners. This includes Kaartidijin Mia (meaning "knowledge place"), a space where Aboriginal prisoners (particularly those out of country) can meet and engage in music, art and yarning.[307] Mr Chadwick commented favourably about the benefits of this service.[308]

[299] Exhibit 3, Tab 22, Statement - Ms Marais, para 32 and ts 26.03.19 (Marais), pp100 & 103
[300] Submissions 21.05.19 (O'Hara) re recommendation 1
[301] Submissions 21.05.19 (O'Hara) re recommendation 1
[302] ts 26.03.19 (Marais), p103
[303] Discussion with Ms McKay during my visit to Casuarina Prison with counsel (01.04.2019)
[304] ts 26.03.19 (de Klerk), p82
[305] ts 27.03.19 (Chadwick), p185
[306] ts 03.04.19 (Maines), pp554-555
[307] Discussion with Ms McKay during my visit to Casuarina Prison with counsel (01.04.2019)
[308] ts 27.03.19 (Chadwick), p204

321. Given that at any one time, about 38% of the adult male population is Aboriginal,[309] (ie: about 350 prisoners in 2018) it is unsurprising that demand for AVS and APS services routinely outstrips supply.[310]

322. Given the Department's current recruitment drive, I have not made a formal recommendation about the recruitment of AVS staff. However, I urge the Department to do everything possible to address the cultural needs of Aboriginal prisoners, by enhancing both the AVS and the APS and by recognising these needs when it recruits additional PCS and mental health staff.

323. Mr Chadwick noted that cell "double-ups" with family members or countryman are always considered for Aboriginal prisoners at Casuarina Prison.[311]

324. Whilst these placements are often protective, Mr Chadwick noted that doubling prisoners up can be problematic. The cells at Casuarina Prison were not designed to accommodate two people and spending up to 12 hours a day in close proximity to another person can obviously be stressful.[312]

325. When Casuarina Prison opened, it had "buddy-up" cells where two adjacent cells had an interconnecting door. This allowed each prisoner to maintain their own space, but still interact with a family member or countryman in the adjoining cell. The current state-wide muster means that none of the buddy-up cells at Casuarina Prison can be used as originally intended.[313]

326. Mr Chadwick noted that because of Mr Cameron's challenging behaviour, it was difficult to find a prisoner willing to share a cell with him for more than a few days.[314] However, Mr Cameron had said that he found being in a cell by himself difficult and that he preferred to be doubled-up.[315]

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[309] ts 03.04.19 (Maines), p505
[310] Exhibit 17, Table 1: Casuarina Profile & Discussions with Ms Lee McKay and Mr Allan Oldridge (AVS visitor) during my visit to Casuarina Prison with counsel (01.04.2019)
[311] ts 27.03.19 (Chadwick), p190
[312] ts 27.03.19 (Chadwick), pp202-203
[313] ts 27.03.19 (Chadwick), pp203
[314] ts 27.03.19 (Chadwick), p189 & p203
[315] For example, see: Exhibit 4, Tab A.20, PCS counselling notes (22.04.15)

327. The SAMS manual contains a detailed plan for responding to the cultural needs of indigenous prisoners. Counsel for Mr Cameron's family asked Mr Chadwick if Casuarina Prison had the resources to enact the plan when required. In the context of the current muster at the Prison, Mr Chadwick's response was "*we try our best*".[316]

Mr Cameron's Placement in Cell A2 in Unit 5

328. After a self-harm incident at Greenough Regional Prison on 9 October 2015 (when he cut his wrist or arm with a razor blade and then placed the razor blade in his mouth)[317], Mr Cameron was placed on ARMS and subject to medical observation. He remained in safe cell accommodation (medical observation or CCU) until 23 October 2015 when he was transferred to Casuarina Prison, via Hakea Prison.[318]

329. On arrival at Casuarina Prison, Mr Cameron was placed in cell A2 in A wing on unit 5. At the time, B and D wings of unit 5 were used as "orientation wings" for prisoners received at the Prison from other prisons and A and C wings of unit 5 housed disturbed and vulnerable prisoners. An attempt was made to keep turnover on A and C wings to a minimum in order to provide a quieter environment.[319]

330. Notwithstanding the fact that vulnerable prisoners are routinely housed there, none of the cells in unit 5 are ligature-minimised.[320] Further, the availability of ligature-minimised cells is: "*…a continuing challenge with prison musters being so high.*"[321]

331. Mr Chadwick, PRAG chair at Casuarina Prison at all relevant times, was (and is) firmly of the view that all cells in unit 5 should be ligature-minimised. Mr Chadwick said this would reduce the risk of prisoners taking their lives by suicide.[322] I deal with the issue of ligature minimisation later in this Finding.

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[316] Exhibit 4, Tab A.25, Statement – Mr Chadwick and t 27.03.19 (Chadwick), p204
[317] Exhibit 4, Tab A, Death in Custody Review (Cameron), p14
[318] Exhibit 4, Tab A, Death in Custody Review (Cameron), pp14-15
[319] ts 27.03.19 (Chadwick), p192 & p216 and ts 03.04.19 (Maines), p506-507
[320] ts 27.03.19 (Chadwick), p192 and Exhibit 17, Table 1: Casuarina Prison Profile
[321] Exhibit 4, Tab A.25, Statement of Interview - Mr Chadwick, para19 & ts 03.04.19 (Maines), p506
[322] ts 27.03.19 (Chadwick), p216

332. Although ligature-minimised cells were available in other units within Casuarina prison, Mr Cameron did not want to be placed in those units for various reasons.[323]

333. The PRAG minutes for 23 October 2015 record a decision to reduce Mr Cameron to moderate ARMS (6-hourly observations). Mr Cameron's placement in unit 5 was the subject of a management plan that had been implemented in an effort to control what was regarded as his frequent requests to transfer to the CCU for reasons unrelated to self-harm risk.[324]

334. The management plan required Mr Cameron to be placed in a cell with a compatible prisoner and managed on the wing in the first instance. Any actual self-harm would still have prompted placement on ARMS and a transfer to the CCU.[325]

335. Initially, Mr Cameron was doubled-up with another prisoner, but on 25 October 2015, that prisoner was transferred, leaving Mr Cameron as the sole occupant of his cell until his death. The ARMS supervision log shows that Mr Cameron was checked at least hourly for the period 12.00 am to 5.00 pm on 23 October 2015.[326]

336. Mr Cameron was reduced to low ARMS at the PRAG meeting on 28 October 2015.[327] The ARMS manual then in force, set out guidelines for the management of prisoners who, like Mr Cameron, were on low ARMS. Guidelines in broadly similar terms are provided for those prisoners on moderate and high ARMS.[328]

337. With respect to the management of prisoners on low ARMS, the ARMS manual relevantly states:

> "*It is a mandatory condition that the Chair of PRAG considers the use of a modified ligature cell on placement decisions. A decision not to place a prisoner in a modified ligature cell* ***shall*** *be documented with the rationale of this decision within the PRAG* minutes".[329] (original emphasis)

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[323] E.g.: Mr Cameron did not want to be placed in "protection" on unit 14, (which had ligature-minimised cells), because of the stigma attached to placement on that unit: ts 27.03.19 (Chadwick), p211
[324] Exhibit 4, Tab A.20, PRAG minutes (23.10.15) & ts 27.03.19 (Chadwick), p198
[325] Exhibit 12, Tab 14, Statement - Mr Maines, paras 83-84 and ts 27.03.19 (Chadwick), p198
[326] Exhibit 11, Tab 6, ARMS Supervision Log (23.10.15)
[327] Exhibit 4, Tab A, Death in Custody Review (Cameron), p18
[328] ARMS Manual (1998), sections 5.1.2.1-5.1.2.3
[329] ARMS Manual (1998), section 5.1.2.3, a similar requirement applies to moderate and high ARMS

338. In my view, the language used in this section of the ARMS manual suggests that the general rule is that prisoners on ARMS should be placed in ligature-minimised cells. I have come to that conclusion because where the PRAG decides not to place a prisoner on ARMS in a ligature-minimised cell, the ARMS manual requires that both the decision and the rationale for that decision must be recorded in the relevant PRAG minutes.

339. In my view, this strongly suggests that placement of an ARMS prisoner in a non-ligature-minimised cell is intended to be the exception rather than the rule.

340. Mr Cameron had requested placement in A wing on unit 5 and had been housed there on previous occasions. However, because he was on ARMS and because none of the cells on unit 5 were ligature-minimised, the decision to place Mr Cameron in a cell on unit 5 required careful consideration. Risk factors, protective factors and any other relevant matters would have to be weighed up carefully by the PRAG in coming to its decisions.

341. In Mr Cameron's case, the mandatory requirement to record the rationale for placing him in a non-ligature-minimised cell was not complied with.[330] In my view, this failure is regrettable.

342. During submissions, counsel for the Department conceded that with respect to this issue, there had been failures in respect to record keeping in relation to some decision-making processes.[331]

343. In a statement dated 6 May 2016, Mr Chadwick (the PRAG Chair at the relevant time) made a number of observations about Mr Cameron's personality and anti-social behaviour and concluded:

> "*At times he [Mr Cameron]…appeared to cry wolf and he definitely knew that by playing up he could facilitate a change to his environment*".[332]

[330] Exhibit 4, Tab A, Death in Custody Review (Cameron); Exhibit 4, Tab A.25, Statement – Mr Chadwick, para 19 and ts 27.03.19 (Chadwick), p191
[331] ts 04.04.19 (Eagling), pp617-618
[332] Exhibit 4, Tab A.25, Statement of Interview - Mr Chadwick, para 11

344. Mr Chadwick further stated that Mr Cameron often initiated moves to CCU because he liked the fact that the cells were clean and larger and were equipped with showers and TV sets.[333]

345. In a statement he made on 22 March 2019, Mr Chadwick said he had a "*very strong independent recollection*" of the PRAG meeting he chaired on 23 October 2015 where Mr Cameron's placement was discussed.[334]

346. Mr Chadwick recalled contacting the senior officer of unit 5 to discuss Mr Cameron's placement and receiving an assurance that he (Mr Cameron) was "*travelling well*".[335,336]

347. Mr Chadwick also recalled PRAG members being happy with Mr Cameron's placement in a non-ligature-minimised cell. He said he followed his standard practice and checked whether PRAG members agreed with Mr Cameron's placement by asking: "*are we all happy with where he will be living*". He said he received affirmative responses.[337]

348. At the time of Mr Cameron's death, Mr Chadwick was an experienced PRAG Chair and had fulfilled that role on numerous occasions over a 4 to 5 year period, including a 12-month period where he had been PRAG chair almost continuously.[338] Given Mr Chadwick's evidence that he periodically reviewed the ARMS manual to check for updates, I find it surprising that he was, at the relevant time, unaware of the mandatory requirement to which I have referred.[339]

349. This is particularly so considering the mandatory requirement is contained in the section of the ARMS manual headed "Management" which, as I have explained, is integral to the role of PRAG and is in fact a key reason for its existence.

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[333] Exhibit 4, Tab A.25, Statement of Interview - Mr Chadwick, para 12 & ts 27.03.19(Chadwick), p189
[334] Exhibit 3, Tab 24, Statement – Mr Chadwick, para 7
[335] Exhibit 3, Tab 24, Statement – Mr Chadwick, para 7
[336] Exhibit 4, Tab A.25, Statement of Interview - Chadwick, para 17
[337] Exhibit 4, Tab A.25, Statement of Interview - Chadwick, para 19
[338] ts 27.03.19 (Chadwick), p216
[339] ts 27.03.19 (Chadwick), pp216-217

350. Mr Chadwick's evidence that no-one had ever brought this mandatory requirement to his attention nor had anyone noticed that the requirement was not being complied with is both surprising and of concern.[340]

351. Mr Chadwick asserted that even though this important mandatory requirement had not been complied with, it made no difference to Mr Cameron's cell placement.[341]

352. As mentioned, Mr Chadwick recalled there being a clear consensus at the PRAG meeting about the appropriateness of Mr Cameron's placement in a standard cell. However, as I have observed, other than a report he received that Mr Cameron was "*travelling well*", Mr Chadwick could not recall any other detail of the rationale for PRAG's placement decision, including what protective and/or risk factors may or may not have been considered.[342]

353. Mr Cameron had a lengthy history of reported and actual self-harm. Indeed, there had been a recent incident of self-harm, when on 9 October 2015, he cut his arm or wrist with a razor blade and then placed the razor blade into his mouth. Mr Cameron's ARMS observations had only just been reduced to low and although he was familiar with Casuarina Prison, he was newly arrived from Greenough Prison.

354. Given that the relevant PRAG minutes do not record the rationale for placing Mr Cameron in a standard cell, it is impossible to assess whether, in arriving at its decision, PRAG appropriately considered all relevant factors. More broadly, I am concerned that non-compliance with this important mandatory requirement appears to have been widespread, at least up until the time of Mr Cameron's death.

355. I suggest that all persons who currently chair PRAG meetings be offered further training to ensure that they are familiar with the important policies that guide the decisions of the group that they chair. Mr Chadwick agreed this would be appropriate.[343]

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[340] ts 27.03.19 (Chadwick), p218
[341] Exhibit 3, Tab 24, Statement - Mr Chadwick, para 7
[342] ts 27.03.19 (Chadwick), p218
[343] ts 27.03.19 (Chadwick), p218

356. More pressingly, I suggest that all staff who currently attend PRAG meetings on a regular basis be reminded (by email or other appropriate means) that compliance with this important requirement is mandatory.

Events Leading to Death

357. At about 3.10 pm on 28 October 2015, prison officers began the afternoon muster in Unit 5. Officer Hall noticed the door to Mr Cameron's cell was closed and he was not standing outside his cell as required.[344] Officer Hall lifted the observation hatch to Mr Cameron's cell and found that it appeared to be blocked by a piece of cardboard. Officer Hall called out to Mr Cameron, but received no reply.[345]

358. Officer Skinner opened cell A2 and Officer Hall entered and saw Mr Cameron in the centre of the cell, hanging from a ligature attached to the cell's light fitting.[346]

359. Officer Hall lifted Mr Cameron while Officer Skinner called a code red medical emergency and used his Hoffman knife to remove the ligature from Mr Cameron's neck.[347,348] The ligature used by Mr Cameron was a bed sheet that had been torn into a long strip.[349] Once Mr Cameron had been lowered to the floor, Officer Hall began CPR, assisted by Officer Skinner.

360. At about 3.13 pm, the recovery team arrived, followed closely by medical staff who arrived at 3.15 pm. Mr Cameron was moved onto the wing landing where resuscitation efforts continued.[350,351]

361. Ambulance officers arrived at 3.37 pm and initially were able to locate a pulse. Mr Cameron appeared to go into cardiac arrest at 3.34 pm, but was revived and a spontaneous return of circulation was achieved at 3.52 pm.

[344] Exhibit 3, Tab 7, Statement - Officer Hall and Exhibit 3, Tab 8, Incident Description Form (Hall)
[345] Exhibit 3, Tab 7, Statement - Officer Hall and Exhibit 3, Tab 8, Incident Description Form (Hall)
[346] Exhibit 3, Tab 19, Photos of ligature and interior of Mr Cameron's cell
[347] Exhibit 3, Tab 7, Statement - Officer Hall and Exhibit 3, Tab 8, Incident description form (Hall)
[348] Exhibit 3, Tab 9, Statement - Officer Skinner
[349] Exhibit 3, Tab 7, Statement - Officer Hall and Exhibit 3, Tab 8, Incident description form (Hall)
[350] Exhibit 3, Tab 7, Statement - Officer Hall and Exhibit 3, Tab 8, Incident description form (Hall)
[351] Exhibit 3, Tab 9, Statement - Officer Skinner

362. Mr Cameron was taken to Fiona Stanley Hospital by ambulance.[352] On arrival, he was found to have a hypoxic brain injury. His condition remained critical and tests on 31 October 2015 confirmed that he was brain dead.[353] After consultations between Mr Cameron's family and his treating doctors, he was extubated. He was declared dead at 2.30 pm on 2 November 2015.[354]

Cause and Manner of Death

363. A forensic pathologist (Dr White) conducted a post mortem examination of Mr Cameron's body on 5 November 2015. Dr White found a dried ligature mark to his neck and that his lungs were heavy and fluid filled (oedematous).[355]

364. Neuropathological examination of Mr Cameron's brain tissue found cerebral swelling with a shifting of cerebral tissue (transtentorial herniation).[356]
365. Toxicological analysis found medications in his system consistent with his medical care. A blood sample taken when Mr Cameron was first admitted to hospital found no alcohol or common drugs.[357]

366. Dr White expressed the opinion that cause of death was complications following ligature compression of the neck (hanging).[358] I accept and adopt that conclusion.

367. I find Mr Cameron's death occurred by way of suicide.

Quality of Supervision, Treatment and Care

368. Mr Cameron spent a considerable part of his adult life in prison. Several psychiatric opinions concluded that he did not have a major psychiatric condition but rather antisocial personality disorder that was characterised by impulsive and manipulative behaviour and difficulties coping with stress.

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[352] Exhibit 3, Tab 13, St John Ambulance Patient Care Record
[353] Exhibit 3, Tab 12, Fiona Stanley Hospital Records
[354] Exhibit 3, Tab 3, Death in Hospital Form
[355] Exhibit 3, Tab 14, Supplementary Post Mortem Report
[356] Exhibit 3, Tab 16, Neuropathology Report
[357] Exhibit 3, Tab 15, Toxicology Report
[358] Exhibit 3, Tab 14, Supplementary Post Mortem Report

369. Mr Cameron appeared to have difficulties adapting to whichever prison he was housed in and made frequent requests to transfer between prisons. Most of these requests were accommodated. Mr Cameron's numerous requests to be placed in CCU or in safe cells were also generally accommodated.

370. It seems likely that Mr Cameron's history of making and then withdrawing or minimising claims of self-harm led to a situation where his reports tended to be viewed as attempts by Mr Cameron to obtain some benefit for himself, rather than as genuine reflections of his distress.

371. It seems to me that Mr Evans, the PCS counsellor who saw Mr Cameron on 2 September 2014, put his finger squarely on the relevant issue when he observed:

> *"If there is a deeper more substantial issue to be addressed with Bevan it is proving difficult to ascertain or identify because his behaviour attracts the focus of ARMS and PRAG intervention primarily in terms of determining his next placement."* [359]

372. In Mr Cameron's case, if there was indeed a "*deeper or more substantial issue*", it was never identified. As I have observed, PCS resources were unable to offer the sort of therapeutic support that would almost certainly have been required to address Mr Cameron's ASPD.

373. There is no doubt that Mr Cameron's pattern of making claims about self-harm which he later withdrew presented a challenging and difficult management issue. Mr Cameron was regularly reviewed by PCS and PHS staff and he repeatedly denied any intention to self-harm or suicide.

374. On the day of his death he did not appear to display any concerning signs that would have indicated his intentions to hang himself on that day. However, it is of concern that despite his known chronic risk of self-harm, his impulsive behaviour and the difficulties he had in dealing with stress, that he was placed in a cell that had not been ligature-minimised.

[359] Exhibit 11, Tab 5, PCS Notes (02.09.14)

375. As I have noted, the rationale for the decision to place Mr Cameron in this cell was not recorded in the relevant PRAG minutes, contrary to the clear requirements of the ARMS manual.

376. At the time of his death, and contrary to the plan which was in place with respect to managing his behaviour, Mr Cameron was the sole occupant of his cell. This meant there was no chance that a cellmate might have observed what Mr Cameron was doing and intervened to prevent his death.

377. I am aware of the evidence that Mr Cameron's behaviour made it difficult to find someone willing to share a cell with him.[360] Nevertheless, Mr Cameron's cellmate up until 25 October 2015 was transferred for behavioural reasons, not because he didn't want to continue sharing a cell with Mr Cameron.[361]

378. Clearly, the protective factors that Mr Cameron frequently cited, namely: his mother, other family members and at times, his daughter, needed to be carefully evaluated and placed in context. Whether this occurred at the PRAG meeting on 23 October 2015 is, for the reasons I have explained, unknown.

379. Accurately predicting the risk of suicide is, as Dr Rowland pointed out in her evidence, very difficult, and essentially impossible where that risk is chronic.[362] Nevertheless, even without the benefit of hindsight, it seems clear that Mr Cameron should have been housed in a ligature-minimised cell due to his ongoing, chronic risk of impulsive, self-harming behaviour and the fact that he was on low ARMS at the time.

380. As it happens, the method used by Mr Cameron to take his life involved the light fitting in his cell and had apparently never been used before.[363] The style of light fitting in Mr Cameron's cell is found in all of the cells at Casuarina Prison, including those that have been ligature-minimised.[364]

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[360] ts 27.03.19 (Chadwick), p189
[361] Exhibit 4, Tab A, Death in Custody Review (Cameron), p22
[362] Exhibit 12, Tab 15, Statement - Dr Rowland and ts 03.04.19 (Rowland), p487
[363] ts 03.04.19 (Maines), p503
[364] ts 04.04.19 (Maines), pp534-535

381. It follows that even if Mr Cameron had been placed in a ligature-minimised cell, the same method he used to take his life would have been available.

382. Be that as it may, the relevant point is that a prisoner like Mr Cameron ought to have been placed in a ligature-minimised cell. I accept that prisoners have taken their lives in ligature-minimised cells, but the risk of them doing so is reduced when they are placed in these types of cells.[365]

383. There are a limited number of ligature-minimised cells at Casuarina Prison. However, given that the total prison muster is increasing year on year, the prevalence of mental health issues amongst prisoners,[366] and the fact that only about 40% of the cells at Casuarina Prison are currently ligature-minimised,[367] there is an urgent need to provide more of these types of cells, as quickly as possible.

[365] Exhibit 4, Tab A, Death in Custody Review (Cameron)
[366] Exhibit 12, Tab 15, Statement - Dr Rowland, para 18
[367] Exhibit 17, Table 1: Casuarina Prison Profile

BRIAN ROBERT HONEYWOOD

Background[368]

384. Brian Robert Honeywood (Mr Honeywood) was born on 6 October 1953 in the United Kingdom and was 61-years of age when he died on 17 February 2015. He came to Australia with his wife in the mid-1970's and worked as a diesel mechanic.

385. Mr Honeywood and his wife had one child, a son who was born in 1988. In about 2002, Mr Honeywood's wife died as a result of a brain tumour. Mr Honeywood met his second partner, Ms Baumback, in 2003 and they began a relationship in 2004.[369]

386. In 2008, Mr Honeywood's son was involved in a car accident and sustained serious injuries that left him a paraplegic and resulted in the death of his partner.[370] Mr Honeywood made modifications to his home to accommodate his son and after a two-year stay at Shenton Park Hospital, his son returned home. Mr Honeywood's son had a carer who visited several times per week.

Overview of Medical Conditions

387. Mr Honeywood's medical history was unremarkable and he was never formally diagnosed with any mental health disorder, although his unresolved grief issues surrounding the death of his first wife were noted.[371]

Offending History

388. At about 8.00 am on 21 March 2014, a carer went to Mr Honeywood's home and found Mr Honeywood's son in his bedroom with serious head wounds and clearly deceased.[372] On 22 March 2014, Mr Honeywood was charged with the murder of his son. It appears that he repeatedly struck his son in the head with an axe after they argued.[373]

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[368] Exhibit 6, Tab A, Death in Custody Review (Honeywood)
[369] Exhibit 5, Tab 8, File Note - discussion with Helen Baumback
[370] ts 03.04.19 (Patchett), pp465-466
[371] ts 27.03.19 (Deighton), p175 and ts 03.04.19 (Patchett), p466
[372] Exhibit 5, Tab 21, Statement - Mr Payne
[373] Exhibit 5, Tab 20, Statement of Material Facts

389. Mr Honeywood pleaded guilty to a charge of murder on 28 January 2015[374] but had not been sentenced at the time of his death.

Prison History[375]

390. Mr Honeywood was admitted to Hakea Prison on 24 March 2014 and by the time of his death (17 February 2015), had spent 330 days in custody, including 326 days at Casuarina Prison. This was the first occasion that Mr Honeywood had been imprisoned.[376]

391. During his reception interview at Hakea Prison, Mr Honeywood denied self-harm or suicidal ideation.[377] However, he was considered to display an emotional and depressed mood, said he had no friends or family for support and very little hope for the future. In view of his presentation, he was placed on moderate ARMS (6-hourly observations) and allocated to the CCU.[378]

392. Mr Honeywood was reviewed by a PCS counsellor on 25 March 2014. He denied thoughts of self-harm or suicidal ideation but said he deserved to be assaulted for what he had done.[379]

393. When reviewed by a PHS worker the same day, Mr Honeywood was teary, seemed in shock and spoke about his son in the present tense. Although no psychiatric concerns were identified, Mr Honeywood was regarded as a risk to himself with few protective factors.[380]

394. At the PRAG meeting on 25 March 2014, it was noted that the Mr Honeywood had said he should receive the death penalty for what he had done. His observation regime under ARMS was maintained at 6-hourly and he remained in the CCU.[381]

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[374] Exhibit 5, Tab 20, DPP letter dated 7 July 2015
[375] Exhibit 6, Tab A, Death in Custody Review (Honeywood)
[376] Exhibit 12, Tab 14, Statement - Mr Maines, para 35
[377] Exhibit 6, Tab A.14, ARMS Reception Intake Assessment
[378] Exhibit 6, Tab A.4, ARMS Interim Management Plan
[379] Exhibit 6, Tab A.4, PRAG minutes (25.03.14)
[380] Exhibit 6, Tab A.4, PRAG minutes (25.03.14)
[381] Exhibit 6, Tab A.4, PRAG minutes (25.03.14)

395. When reviewed by a PCS counsellor on 27 March 2014, Mr Honeywood presented as calm and more settled. His de-facto, Ms Baumback had visited on 26 March 2014 and was assisting him with financial and legal issues. Mr Honeywood denied self-harm or suicidal ideation but (as he would do repeatedly) he admitted that suicide was option if he received a long sentence.

396. When subsequently reviewed by PHS, Mr Honeywood said he was surprised and heartened by the level of community support he was receiving. He was still "*overwhelmed by event*s" but denied feelings of self-harm or suicide and asked about employment in prison.[382]

397. At the PRAG meeting on 27 March 2014, it was decided to reduce Mr Honeywood's observation regime under ARMS to 12-hourly and transfer him to a mainstream cell.[383]

398. On 28 March 2014, Mr Honeywood was transferred to Casuarina Prison and was reviewed by a mental health nurse on 29 March 2014. He said that following his first wife's death, he had derived little benefit from counselling in the community. He said he did not believe in counselling or anti-depressants. The mental health nurse felt that Mr Honeywood had probably had depression for some years without seeking treatment.[384]

399. Mr Honeywood firmly denied thoughts of suicide or self-harm, although he reiterated that suicide was an option should he receive a lengthy prison term. In terms of protective factors, he mentioned his cell placement, his employment and his regular visits from Ms Baumback. He was maintained on low ARMS (12-hourly observations).[385]

400. Mr Honeywood was reviewed by a prison doctor on 31 March 2014. He refused counselling and medication but verbally contracted with the doctor not harm himself or others.[386]

[382] Exhibit 6, Tab A.4, PRAG minutes (27.03.14)
[383] Exhibit 6, Tab A.4, PRAG minutes (27.03.14)
[384] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p6
[385] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p6
[386] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p7

401. During reviews by PCS and PHS on 1, 9 and 16 April 2014, Mr Honeywood consistently denied self-harm or suicidal ideation. He said he expected a long prison term and that suicide remained an option after he was sentenced. The decision of the PRAG team on each occasion was that he remain on 12-hourly observations under ARMS.[387]

402. Mr Honeywood was first seen by Ms Deighton (PCS psychologist), on 22 April 2014 for an ARMS review. He presented as stable but somewhat withdrawn. He denied any self-harm risk but said that suicide was an option if he received a lengthy term.[388]

403. After his PRAG review on 23 April 2014, Mr Honeywood was removed from ARMS and placed on SAMS. He had settled into his prison unit and was working in the metalwork shop. He presented as stable and denied self-harm or suicidal ideation. He continued to say he may consider suicide depending on the length of sentence he was given.[389]

404. Mr Honeywood's case was reviewed at the SAMS case conferences held on 1 May 2014, 5 June 2014, 3 July 2014 and 7 August 2014. On each occasion, he was noted to be subdued with low mood, but stable. He was interacting with other prisoners and working in the metalwork shop. He continued to say that suicide was an option depending on the sentence he received.[390]

405. Mr Honeywood was seen by Ms Deighton on 15 and 16 May 2014 and continued to deny suicidal or self-harm ideation. He was seen by Ms Deighton again on 29 May 2014 after a trade instructor raised a concern about his mood.[391]

406. Mr Honeywood again firmly denied any current thoughts of suicide or self-harm and said he needed to attend court to receive his sentence.[392]

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[387] Exhibit 6, Tab A.4, PRAG minutes (01.04.14), (09.04.14) & (16.04.14)
[388] Exhibit 5, Tab 28, Statement - Ms Deighton and ts 27.03.19 (Deighton), p153
[389] Exhibit 6, Tab A.4, PRAG minutes (01.05.14), (5.06.14), (03.07.14) & (07.08.14)
[390] Exhibit 6, Tab A.7, SAMS Case Conference Details
[391] Exhibit 6, Tab A.8, Statement - Mr Ellis, (Metal Shop Trades Instructor), para 4
[392] Exhibit 5, Tab 28, Statement - Ms Deighton, paras 38-61

407. Dr Patchett (consultant psychiatrist) saw Mr Honeywood on 4 June 2014 and found no evidence of major mental illnesses such as depression or psychosis. Mr Honeywood again made it clear that he did not intend to kill himself before his trial.[393]

408. Mr Honeywood's treatment plan was to continue ongoing support through PCS with referral to a psychiatrist or mental health worker on an "*as needed*" basis.[394]

409. Mr Honeywood was seen by Ms Deighton on 24 June 2014. Although he continued to deny suicidal or self-harm ideation, she thought he should remain in SAMS so that his potential risk could be monitored and so that he didn't "*fly under the radar*".[395]

410. Ms Deighton made the same recommendation at the SAMS review on 3 July 2014.[396] On 18 July 2014, Mr Honeywood was transferred to the self-care unit (SCU) after his application to do so was successful.[397] The SAMS case conference on 7 August 2014 noted that Mr Honeywood had made positive comments about his placement in the SCU. He said it was quieter, he was getting more sleep and had more support in the unit.[398]

411. On 8 August 2014, Mr Honeywood was reviewed by Ms Crone (PCS social worker) as Ms Deighton (his usual counsellor), was on leave. He was removed from SAMS and placed on a "*date of interest*" regime (DOI).[399] In Mr Honeywood's case, the DOI regime was related to the dates of his court attendances and meant he would be seen by a PCS counsellor in the lead up to those appearances.[400]

412. When he saw Ms Crone, Mr Honeywood strongly denied any current thoughts of self-harm or suicidal ideation. Ms Crone noted his previous statements about killing himself if he received a long sentence but felt that his expectation of the "*court process*" was more realistic.[401]

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[393] Exhibit 5, Tab 30, Statement - Dr Patchett, p2
[394] Exhibit 6, Tab A.7, SAMS case conference details
[395] Exhibit 5, Tab 28, Statement - Ms Deighton, para 73
[396] Exhibit 5, Tab 28, Statement - Ms Deighton, para 74
[397] Exhibit 6, Tab A.9, SCU Application
[398] Exhibit 12, Tab 10, SAMS Case Conference Notes (07.08.14) and ts 28.03.19 (Crone), p277
[399] Exhibit 6, Tab A.18, Alerts Record & Exhibit 5, Tab 29, Statement - Ms Crone, para 10
[400] ts 28.03.19 (Crone), p279
[401] ts 28.03.19 (Crone), pp275-81 & p295

413. In terms of protective factors, Ms Crone noted visits from Mr Honeywood's partner, his employment in the metal workshop and the fact that he was engaged with the court process.[402] Ms Crone also noted that Mr Honeywood had said he would not kill himself in prison because he would not want to burden either his defacto, Ms Baumback, prison staff or his cellmate – although I note that at the time of his death, Mr Honeywood was in a SCU cell alone.[403]

414. As for risk factors, Ms Crone considered the fact that Mr Honeywood he was in prison and the fact that he was going through the court system were significant.[404] Other risk factors such as the nature of his crime, his feelings of guilt, his unresolved grief issues regarding his wife, his previously expressed intentions to kill himself and the fact he was facing a long sentence appear to have received less attention.[405]

415. Ms Crone did not feel that Mr Honeywood was at either acute or chronic risk of suicide, predominantly it seems, because he had assured her that he had no current plan to end his life after he was sentenced.[406] When asked, during her evidence, if she was really convinced by his assurance, her reply was: "*Yes*".[407]

416. When she returned from leave shortly after Mr Honeywood had been removed from SAMS, Ms Deighton said she was initially surprised about PRAG's decision. However, she did not consider raising the issue at a PRAG meeting because on reflection:

> "*…there had been some improvements, and I felt hard pressed to then recommend he got back on SAMS, given that there had been no elevation in risk.*"[408]

417. Ms Deighton was asked whether there was anything that might have led her to consider placing Mr Honeywood back on ARMS or SAMS in the period December 2014/January 2015.

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[402] ts 28.03.19 (Crone), pp275-81 & p295
[403] ts 28.03.19 (Crone), pp275-81 & p295
[404] ts 28.03.19 (Crone), pp280-285
[405] ts 28.03.19 (Crone), p285
[406] ts 28.03.19 (Crone), p285
[407] ts 28.03.19 (Crone), p280
[408] ts 27.03.19 (Deighton), p156

418. Ms Deighton said that with the benefit of hindsight, she may:

> "*…have made a case to put him back on SAMS, reiterating what I perceived to be the chronic risk to self, despite his…adequate functioning, improvement in mood and…establishing protective factors within the prison.*"[409]

419. Dr Patchett made the point that the prospect of a lengthy prison term meant that as the date of Mr Honeywood's sentencing approached, he was at elevated risk of suicide.[410]

420. Dr Patchett said that Mr Honeywood's decision to take his life was a "*rational decision*".[411] This no doubt made the task of assessing Mr Honeywood's risk of suicide at any particular time, more complicated.

421. Had Mr Honeywood remained on SAMS, he would have been seen monthly, on perhaps six occasions. As it was, even though he wasn't on SAMS, Mr Honeywood was seen by PCS on five occasions between 8 August 2014 and his death on 17 February 2015.[412]

422. Mr Honeywood was last seen by Ms Deighton on 29 January 2015, the day after he entered a plea of guilty to his son's murder in the Supreme Court of Western Australia.[413] Mr Honeywood's next court appearance would have been on 31 March 2015 for sentencing.[414]

423. During his incarceration, Mr Honeywood received numerous visits, including 195 from Ms Baumback. Her last visit was on 15 February 2015, two days before Mr Honeywood's death.[415]

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[409] ts 27.03.19 (Deighton), p161
[410] ts 03.04.19 (Patchett), pp467-468
[411] ts 03.04.19 (Patchett), pp467-468
[412] Namely: (21.08.14), (22.09.14), (24.11.14), (11.12.14) & (29.01.15)
[413] Exhibit 6, Tab A.10, PCS counselling notes and Exhibit 5, Tab 28, Statement - Ms Deighton, para 103
[414] Exhibit 5, Tab 18, Remand Warrant
[415] Exhibit 6, Tab A.11, Visits History

Events Leading to Death[416]

424. At 4.50 am on 17 February 2015, custodial staff were conducting routine checks in the SCU. Officer Bodenham was unable to either see, or get a response from Mr Honeywood when he looked into his cell (D12). Other officers were alerted and the cell was unlocked.

425. Officer Bodenham found Mr Honeywood hanging from a bed sheet in the shower cubicle of his cell. Officer Gallagher cut Mr Honeywood down using his Hoffman knife while Officer Bodenham started CPR and a code red medical emergency was called.

426. Responding to the medical emergency, Nurse Anne found Mr Honeywood's pupils fixed and dilated, his skin was cold and there were signs of rigor mortis. Resuscitation efforts were ceased and he was declared dead by Nurse Anne at 5.00 am on 17 February 2015.[417]

427. A suicide note addressed to Ms Baumback, was found in Mr Honeywood's cell. In it, Mr Honeywood said he was having trouble living with what he had done and was frightened that he could do a similar thing again.[418]

Cause and Manner of Death

428. A forensic pathologist (Dr Cadden), conducted a post mortem examination of Mr Honeywood's body on 20 February 2015. Dr Cadden found markings around Mr Honeywood's neck consistent with the sustained application of a ligature. Toxicological analysis was negative for alcohol, amphetamines, benzodiazepines, cannabinoids and opiates. [419]

429. Dr Cadden expressed the opinion that the cause of death was ligature compression of the neck (hanging).[420] I accept and adopt that conclusion.

430. I find Mr Honeywood's death occurred by way of suicide.

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[416] Exhibit 6, Tab A.23, Incident Description Report (Officer Bodenham)
[417] Exhibit 6, Tab A.23, Incident Description Report (Nurse Anne)
[418] Exhibit 6, Tab A.28, Suicide Note
[419] Exhibit 6, Tab 7, Toxicology Report
[420] Exhibit 5, Tab 5, Post Mortem Report

Quality of Supervision, Treatment and Care

431. Mr Honeywood's mental state was the subject of monitoring under ARMS from the time of his admission into Hakea Prison on 24 March 2014 until 23 April 2014. He was then monitored on SAMS until 8 August 2014 when he was placed on a DOI regime, related to his court appearances. He remained an active PCS client and was on seen on five occasions from 8 August 2014 until his death.[421]

432. Although he routinely denied thoughts of suicide and self-harm, a recurrent theme in Mr Honeywood's interactions with PCS was that he stated that suicide was an option depending on the sentence he received. By 8 August 2014, this theme seemed less prominent and Mr Honeywood began saying he did not want to be a burden to his defacto, prison staff or his cellmate by taking his life.[422]

433. In terms of his risk of suicide, Ms Deighton put it this way:

> "*Mr Honeywood did not report any specific thoughts or plans to suicide, however, [he] had previously indicated his intention to end his life if he received a long sentence. It appeared he continued to process his grief and loss issues, while over-regulating himself in the unit and at work. Although he had voiced ambivalence about suicide, it was my opinion that he may be at greater risk of self-harm post-sentencing.*"[423]

434. Mr Honeywood appeared in the Supreme Court of Western Australia on 28 January 2015 when he entered a plea of guilty to the charge of murdering his son and was last seen by PCS counsellor, Ms Deighton on 29 January 2015.

435. It seems that Mr Honeywood's persistent denials of self-harm and suicidal ideation may have provided a degree of comfort about his mental state that, with the benefit of hindsight, was not warranted.

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[421] Exhibit 6, Tab A, Death in Custody Review (Honeywood), pp7-8
[422] Exhibit 5, Tab 10, Statement - Ms Crone, para 10 and ts 28.03.19 (Crone), p281
[423] Exhibit 5, Tab 28, Statement - Ms Deighton, para 113

436. As Mr Mudford noted in the Death in Custody Review report he compiled after Mr Honeywood's death:

> "*Mr Honeywood's denials of self-risk were not necessarily protective factors in themselves and needed to be taken into context with all issues impacting on his vulnerability. From a professional practice perspective this issue warrants further exploration during clinical supervision of specialist staff. Likewise, this issue could be workshopped during future Gatekeeper (Suicide Prevention) training.*"[424]

437. I agree with Mr Mudford's assessment. Whilst it is very easy to be wise in hindsight, Mr Honeywood had, on numerous occasions, telegraphed an intention to take his life, if he received a long sentence.

438. As Mr Mudford observed:

> "*With the benefit of hindsight, Mr Honeywood's plea of guilty was yet another factor likely impacting on his level of vulnerability. Although having been in custody for 11 months, he continued to meet many of the categories of an "at-risk" prisoner. He was mature in years, a first timer to prison and was on remand facing a serious charge and a lengthy term of imprisonment. The very nature of his charge is likely to have increased his level of guilt and distress.* [425]

439. I agree with Mr Mudford's observation that:

> "*…a more structured and consistent level of monitoring leading up to his sentencing date and beyond was warranted. Whether additional contact/s would have altered the final outcome or not can only be speculated.*"[426]

440. Had Mr Honeywood stayed on SAMS, he would perhaps have been seen on six occasions between the time he was removed from SAMS until his death. As noted he was in fact seen by PCS on five occasions during that period.

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[424] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p9
[425] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p14
[426] Exhibit 6, Tab A, Death in Custody Review (Honeywood), p14

441. Changes in Mr Honeywood's mental health status might perhaps have been detected with that greater level of monitoring. However, I accept that with a reserved and self-contained person like Mr Honeywood, this would probably have been difficult.

442. In any case, as Dr Rowland pointed out:

> *"…it is recognised that once someone has come to a firm decision for themselves about what they want to do, they may at that point stop talking about it and stop raising alarms to other people, and may actually deny it, but be quietly…planning on going through with it. And having made that firm decision, they may appear more settled because they're no longer in conflict with themselves over it."*[427]

443. With the benefit of hindsight, I consider that it may have been appropriate for Mr Honeywood to have been placed on SAMS in the lead up to his court appearance for sentence on 31 March 2015. I accept that even if this had been done, the outcome in his case may well have been the same.

[427] ts 03.04.19 (Rowland), p417

JS

Background

444. JS was born overseas on 5 February 1947 and was 68-years of age when he died on 3 August 2015. JS and his wife came to Australia in August 1988 and had two children. He was retired at the time of his death.[428]

Overview of Medical Conditions[429]

445. JS had a number of health issues including: depression, paroxysmal atrial fibrillation, hyperlipidaemia, and a mildly enlarged prostate.[430]

446. JS was known to have consulted a psychologist on 11 February 2015 (before his incarceration) about suicidal thoughts which were "*contained and managed rather than developed into active plans*". He also consulted his GP on 3 March 2015 with suicidal ideation after his wife reportedly "*moved out*".

447. According to his wife, JS had never attempted suicide. When she visited him on the day before his death, she had "*no concerns in regards to his mental state.*"[431]

Offending History

448. On 31 March 2015, JS appeared in the Fremantle Magistrates Court charged with numerous sexual offences. He was remanded in custody and was due to appear in court again on 6 August 2015.[432]

Prison History

449. JS was admitted to Hakea Prison on 17 March 2015. By the time of his death on 3 August 2015, JS had been incarcerated for a total of 139 days, including 108 days at Casuarina Prison.[433]

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[428] Exhibit 7, Tab 8, Statement - JS's Wife, paras 3-8
[429] Exhibit 7, Tab 42, Medical Record (JS)
[430] Exhibit 7, Tab 42, Medical Record (JS)
[431] Exhibit 7, Tab 8, Statement - JS's Wife, para 14
[432] Exhibit 7, Tab 4, Remand Warrant
[433] Exhibit 12, Tab 14, Statement - Mr Maines, para 39

450. During his admission interview at Hakea Prison, JS's history of depression was noted. JS said he had given up hope and two weeks previously, had walked into the sea before changing his mind.[434] JS was emotional and said he had thoughts of self-harm. He said he would self-harm if given the opportunity.[435]

451. As a result, he was housed in a safe cell in the CCU and placed on high ARMS (2-hourly observations). He was also referred to PCS.[436] JS was subsequently allocated to cell 8 in A Wing of Unit 14, which at the time, was being used to house prisoners who, because of the nature of their alleged offences or crimes, were considered to be in need of protection.

452. On 18 March 2015, JS was the subject of an ARMS review by PCS. He presented with low mood and flat affect and was teary at times. He expressed guilt and shame about the nature of his offending but strongly denied suicide and self-harm ideation. JS said he had made a solemn promise to his wife not to harm himself and that killing himself was "*not the honourable thing to do*". JS also volunteered that he had lied during his reception interview about trying to drown himself because he was frustrated with being repeatedly asked about self-harm and suicide.[437]

453. When reviewed by PHS on 18 March 2015, JS denied any current self-harm intent, citing as protective factors, his religious faith and his wife. He disclosed he had been seeing a counsellor in the community.[438] At the PRAG meeting on 18 March 2015, JS was assessed as not being suicidal. He was placed in a standard CCU cell on low ARMS (12-hourly observations).[439]

454. On 24 March 2015, when reviewed by Ms Mandolene, (a PCS social worker), JS presented with low mood and flat affect. He denied any suicidal thoughts and said words to the effect that he "*did not wish to make things worse for his family by killing himself*".

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[434] Exhibit 7, Tabs 43.1, ARMS Reception Intake Assessment
[435] Exhibit 7, Tabs 43.1, ARMS Reception Intake Assessment & 43.4, ARMS Interim Management Plan
[436] Exhibit 8, Tab A.8, ARMS Interim Management Plan (17.03.15)
[437] Exhibit 8, Tab 1, Att. 6, PCS notes (18.03.15)
[438] Exhibit 7, Tab 43.6, Offender Supervision Log
[439] Exhibit 8, Tab A.8, PRAG Minutes (18.03.15)

455. Ms Mandolene did not consider that JS required referral to SAMS because his vulnerability had been addressed (i.e: he was housed in the protection unit), he did not have a major mental health illness, was not intellectually impaired and his behaviour was not problematic.[440] Further, Ms Mandolene considered that JS's depressed mood, restricted affect and anxiety were congruent with him being incarcerated for very serious offences at an advanced age.[441]

456. At the PRAG meeting on 26 March 2015, it was decided to remove JS from ARMS because there was no identified risk and because his attitude regarding acceptance of a possible long sentence appeared to have changed. JS also seemed to be coping with the prison routine.[442]

457. On 16 April 2015, JS was transferred to Casuarina Prison and referred to PCS and the mental health team. On 17 April 2015, a clinical nurse referred JS to PCS, apparently without his knowledge. The reason for the referral was that JS had reportedly voiced feelings of self-harm and seemed depressed.[443]

458. For reasons which are unclear, that referral was not acted on before a further referral to PCS was made on 19 April 2015. It was noted that JS had been seeing a counsellor in the community, and was requesting ongoing support from PCS.[444]

459. In response to that referral, JS was seen by PCS counsellor Ms Crone on 20 April 2015. He presented as settled in mood and denied self-harm or suicidal ideation. He said he was receiving support from his wife and would like to think about whether he wanted to continue to engage with PCS.[445] On 30 April 2015, JS was taken to Fiona Stanley Hospital with an acute episode of atrial fibrillation. After treatment, he was returned to Casuarina Prison the next day (1 May 2015).[446]

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[440] Exhibit 7, Tab 50, Statement - Ms Mandolene, paras 14-19 and Exhibit 8, Tab 1, Att. 6, PCS notes (24.03.15)
[441] Exhibit 7, Tab 50, Statement - Ms Mandolene, para 19 and ts 28.03.2019 (Mandolene), pp230-231
[442] Exhibit 8, Tab A.8, PRAG minutes (26.03.15)
[443] Exhibit 8, Tab 1, Att. 6, PCS referral (17.04.15)
[444] Exhibit 8, Tab 1, Att. 6, PCS referral (19.04.15)
[445] Exhibit 8, Tab 1, Att. 6, PCS notes (20.04.15) and ts 28.03.19 (Crone), p268
[446] Exhibit 8, Tab A, Death in Custody Review (JS), p9

460. JS received regular visits from his wife during his incarceration, and spoke to her regularly by phone. His last visit from his wife was on 2 August 2015[447] and their last phone conversation was on 3 August 2015.[448]

461. Following JS's death, a multi-lingual prison officer reviewed a recording of that call (which lasted 9 minutes and 39 seconds) and determined that nothing about the content of the call would have been cause for concern.[449]

Events Leading to Death

462. At about 9.40 am on 3 August 2015, Officer Preece went to JS's cell to let him know that another prisoner would be moving in with him. There was a note on the cell door saying JS was in the shower and Officer Preece attended to other duties. [450]

463. At 9.53 am, the prisoner who was to move into JS's cell approached Officer Johnson and asked her to unlock the cell so he could place his gear inside. Officer Johnson asked the prisoner to enter first to ensure JS was dressed.[451] Officer Johnson then entered and found JS hanging from a ligature attached to the cell's window frame. She immediately called a code red medical emergency on her radio.[452]

464. The ligature used by JS had been fashioned from a bag used by prisoners to carry items purchased from the prison canteen. Although the bag had no handles that could be used for the purposes of self-harm, JS had managed to hook it over a metal knife wedged into the cell's window frame.[453]

465. Presumably to ensure that his suicide would be successful, JS had placed both legs into one of the legs of his tracksuit pants and tied his hands behind his back with a singlet.[454]

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[447] Exhibit 7, Tab 46, Visits History
[448] Exhibit 7, Tab 47, Record of telephone calls
[449] Exhibit 8, Tab A, Death in Custody Review (JS), p15
[450] Exhibit 7, Tab 22, Incident Description Report (Officer Preece)
[451] Exhibit 7, Tab 19, Incident Description Report (Officer Johnson)
[452] Exhibit 7, Tab 19, Incident Description Report (Officer Johnson)
[453] Exhibit 7, Tabs 11 & 38, Ligature and cell photographs
[454] Exhibit 7, Tab 5, Report - Coronial Investigation Unit

466. Senior Officer Grover used a Hoffman knife to cut JS down and remove the singlet binding his hands together. JS was moved out of his cell and into the wing's landing where CPR was commenced and emergency services were contacted.[455] In response to the Code Red medical emergency, a medical officer and four prison nurses attended the unit and assisted with resuscitation efforts.[456]

467. JS was taken to Fiona Stanley Hospital by ambulance.[457] He was unable to be revived and he was declared dead at 3.30 pm on 3 August 2015.[458]

468. A detailed suicide note written by JS and addressed to his wife was found in his cell. In it, JS expressed shame and extreme regret for his actions, saying: "*I cannot live in dishonour of the wrong I have done*". He acknowledged the harm that he had caused and asked for forgiveness.[459]

Cause and Manner of Death

469. A forensic pathologist (Dr Cadden), conducted a post mortem examination of JS's body on 7 August 2015. Dr Cadden found markings on JS's neck suggestive of ligature application, marked pulmonary oedema, mild atherosclerosis and a simple renal cyst.[460]

470. Dr Cadden expressed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[461] I accept and adopt that conclusion.

471. I find JS's death occurred by way of suicide.

Quality of Supervision, Treatment and Care

472. JS's medical needs were addressed during his incarceration and he was seen at the medical centre on a number of occasions for minor issues. He was appropriately referred to hospital after suffering an acute episode of atrial fibrillation.

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[455] Exhibit 7, Tab 12, Statement - SO Grover and Tab 18, Incident Description Report (SO Grover)
[456] Exhibit 7, Tab 28, Incident Description Report (Nurse Turpin)
[457] Exhibit 7, Tab 33, St John Ambulance Patient Care Record
[458] Exhibit 7, Tab 2, Fiona Stanley Hospital Death in Hospital Form
[459] Exhibit 7, Tab 10, Suicide Note - English translation
[460] Exhibit 7, Tab 36, Post Mortem Report
[461] Exhibit 7, Tab 36, Post Mortem Report

473. After his reception to Hakea Prison on 17 March 2015, JS was appropriately placed on high ARMS in a safe cell in CCU. He was a first time prisoner of mature years, had disclosed a self-harm attempt and had a history of depression.

474. JS was reviewed by PCS staff on several occasions and routinely denied suicidal intentions. He was able to identify protective factors, namely his religious faith and his supportive wife. JS was removed from ARMS on 26 March 2015.

475. After careful consideration of the evidence, I am concerned that JS was not placed on SAMS and that too much reliance may have been placed on JS's persistent denials of suicidal ideation.

476. Although his wife remained supportive, JS was apparently estranged from the rest of his family, was expressing feelings of shame and was having difficulty reconciling his actions. He was also advanced in years, was charged with numerous very serious offences and did not seem to interact much with others. He was not working in prison, nor was he engaged in any other diversionary activities.[462]

477. As Mr Mudford noted in his Death in Custody review:

> *"Liaison with the Department's Counselling and Support Services confirmed that* [JS]*, due to his level of vulnerability, would have been an ideal candidate for SAMS."*[463]

478. In her evidence, Ms Mandolene stood by her decision with respect to not placing JS on SAMS. However, she agreed that with the benefit of hindsight, JS may have benefitted from placement on SAMS. Nevertheless, as Ms Mandolene pointed out, she had assessed a number of prisoners over the years that presented in similar ways to JS who were not placed on SAMS and who did not take their lives.[464]

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[462] Exhibit 8, Tab A, Report - Death in Custody Review (JS), p4 & 16-17
[463] Exhibit 8, Tab A, Report - Death in Custody Review (JS), p17
[464] ts 28.03.19 (Mandolene), pp261-262

479. After considering all of the evidence, and with the benefit of hindsight, I consider that JS may have benefitted from being placed on SAMS so that his mental state could have been monitored over a longer period of time.

480. SAMS caters for prisoners identified as requiring additional support, monitoring or intervention whilst in custody and it seems to me that JS ought to have been so identified.

481. I acknowledge that mental states fluctuate and that suicide is extremely difficult to predict. The note left by JS made it clear that his decision to take his life was based largely on his inability to live with what he had done.[465]

482. It is therefore arguable that even if JS had been monitored on SAMS, the outcome in this case may well have been the same.

[465] Exhibit 7, Tab 10, Suicide Note - English translation

AUBREY ANTHONY SHANNON WALLAM

Background[466]

483. Aubrey Anthony Shannon Wallam (Mr Wallam) was born in Western Australia on 30 November 1982 and was 31-years of age when he died on 22 October 2014.

484. Mr Wallam's parents separated when he was young and he was raised by his grandmother until he was 10-years of age and then by his aunt until he was 13-years of age.

485. Mr Wallam began using cannabis and alcohol when he was about 13-years of age before moving on to amphetamine when he was older. He left school without completing year 8 and does not appear to have had paid employment.

486. Mr Wallam never married or had children but was in what was described as a volatile relationship with Ms Coyne, who had six children of her own.

Overview of Medical Conditions[467]

487. Mr Wallam was known to be an intravenous drug user (amphetamine) and was diagnosed with hepatitis C in 2008.[468]

488. On 5 February 2014, while he was in prison, Mr Wallam collapsed in his cell and was taken to the emergency department at Swan Districts Hospital by ambulance.

489. On admission, he was diagnosed with a syncope episode (faint) but an ECG was reported to have shown signs that can indicate critical stenosis of the left anterior descending artery of the heart (Wellens syndrome).

490. Although Mr Wallam was referred to the cardiology outpatients' clinic at Royal Perth Hospital, he was not offered an appointment because considering his age, it was very unlikely he had Wellens syndrome.

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[466] Exhibit 10, Tab A, Death in Custody Review (Wallam), p6 and Exhibit 9, Tab 22, File note: conversation with Ms Wallam

[467] Exhibit 10, Tab A, Death in Custody Report (Wallam)

[468] Exhibit 9, Tab 11, Microbiology Test Results

491. A detailed medical assessment was conducted by the prison doctor at Hakea Prison on 27 June 2014. No health concerns or self-harm ideation was identified. A similar assessment was conducted on 4 August 2014, when Mr Wallam was transferred to Casuarina Prison and again, no concerns were identified.

492. On 21 August 2014, Mr Wallam asked to see a counsellor from the Prison Addiction Services Team (PAST) about his illicit drug use. He didn't attend his scheduled appointment on 4 September 2014 and a further appointment was for booked for 31 October 2014. On 1 October 2014, Mr Wallam attended the medical centre complaining of pain in his wrist and shoulder and he saw a physiotherapist on 9 October 2014.

Offending and Previous Prison History[469]

493. Mr Wallam's extensive criminal history began when he was a juvenile. From 1995 to 2000, he accumulated 35 convictions for offences including stealing, assault, breach of bail and robbery. He was detained on five occasions as a juvenile.

494. As an adult, Mr Wallam served terms of imprisonment with respect to offences including: burglary, stealing a motor vehicle and driving offences. Not including his last incarceration, Mr Wallam was imprisoned six times as an adult and had served 4,586 days in custody (about 12.5 years) with his longest period of imprisonment being a term of 1,833 days (about 5 years).[470]

495. Mr Wallam told prison authorities that his offending behaviour was directly related to his use of illicit drugs.[471]

496. Mr Wallam had a significant history of self-harming behaviour and suicide attempts. The first recorded occasion was in 2000, when he attempted to hang himself while in juvenile detention. In August 2013, he was placed on ARMS for nine days after attempting to strangle himself with a t-shirt and swallowing a razor blade.

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[469] Exhibit 10, Tab A, Death in Custody Report (Wallam)
[470] Exhibit 12, Tab 14, Statement - Mr Maines, para 30
[471] Exhibit 9, Tab 35, Case Conference Report

497. Relationship issues with Ms Coyne were identified as a common stressor in PCS notes relating to Mr Wallam's previous incarcerations. Mr Wallam was also noted to be impulsive and to struggle with isolation.

498. Mr Wallam was released from prison on 11 February 2014, but on 19 April 2014, he was received at Hakea Prison awaiting trial for aggravated burglary and stealing.

499. On 6 May 2014, Mr Wallam was sentenced to 18 months imprisonment for aggravated burglary and stealing. He was made eligible for parole and his sentence was backdated to 10 November 2014 meaning his earliest release date was 17 January 2015.[472]

Most Recent Admission to Prison[473]

500. During the reception process at Hakea Prison on 19 April 2014, Mr Wallam's previous history of self-harm, the fact that he had lost a relative to suicide in 2010 and the fact that he was withdrawing from amphetamines were noted. The reception intake form also recorded: "*information from other sources*" showed "*numerous mentions of risk of self harm*".

501. Mr Wallam denied thoughts of suicide or self-harm and the reception officer noted: "*At the time of interview prisoner appeared to be settled and not at* risk".[474] Mr Wallam was not placed on ARMS but apparently as a precaution, he was admitted to the CCU overnight. He was assessed as suitable for mainstream placement and the following day and he was transferred to a mainstream cell.

502. Mr Wallam remained at Hakea Prison until 4 August 2014, when he was transferred to Casuarina Prison. At Casuarina Prison, Mr Wallam was not subject to any formal monitoring. During his last admission to prison, Mr Wallam was seen at the medical centre on 10 occasions for various minor medical issues. No mental health concerns were identified or disclosed.

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472 Exhibit 9, Tab 36, Individual Management Plan
473 Exhibit 10, Tab A, Death in Custody Review (Wallam)
474 Exhibit 9, Tab 34, Reception Intake and ARMS Summary

503. Mr Wallam's began his release planning in August 2014, showing that at least at that time, he appeared to be future focused. In early October 2014, his work as day room cleaner received praise from staff.

504. At the time of his death, Mr Wallam was the sole occupant of cell B1 in unit 14. His cellmate since 19 October 2014 was moved out on 22 October 2014. Although PCS had previously noted Mr Wallam had difficulties dealing with isolation, he had been housed in single cell accommodation on two previous occasions during his last period of incarceration, apparently without incident.

505. During the period 27 April 2014 to 16 October 2014, Mr Wallam's partner, Ms Coyne, visited him on 36 occasions. Her last visit occurred on 16 October 2014 and lasted one hour and 10 minutes.[475]

506. For the sake of completeness, I note that in June 2014, Mr Wallam was convicted of a prison charge (use/possess illicit drugs) under section 70(d) of the *Prisons Act 1981* (WA). He was sentenced to confinement in a punishment cell for 7 days, to be served on successive weekends in October 2014. He had served two of these terms without incident at the time of his death.

Events Leading to Death[476]

507. On the night of 22 October 2014, Officer Zammit was conducting routine checks in unit 14, in the company of four prison officers and a nurse. At approximately 9.10 pm, Officer Zammit lifted the observation hatch on Mr Wallam's cell and saw him hanging from the top bunk. Officer Zammit immediately called a Code Red medical emergency and unlocked the cell.

508. As Officer Zammit supported Mr Wallam's body, Officer Mills cut the ligature from his neck and they lowered him to the floor. Officer Zammit and Officer Mills began CPR. Nurse Frizzell assisted with resuscitation efforts and was joined by Nurse Anne.

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[475] Exhibit 9, Tab 37, Visits History

[476] Exhibit 9, Tab 13, Statement - Officer Zammit and Exhibit 9, Tab 14, Statement - Officer Mills

509. Despite these efforts, Mr Wallam could not be revived[477] and Nurse Frizzell declared him dead at 9.35 pm on 22 October 2014.[478] Ambulance officers arrived at the prison shortly after Mr Wallam's death had been declared.[479]

510. Officer Zammit noted that the ligature Mr Wallam had used was made using a torn bed sheet. The ligature had been anchored by means of a knot which Mr Wallam had wedged between the glass shower screen and the top of the bunk in his cell.

511. Some of the sealant around the shower screen had been removed to allow the ligature to be secured.[480] This was the first recorded use of this method of securing a ligature.[481]

512. A suicide note addressed to Ms Coyne was found on Mr Wallam's body. The note made it clear that Mr Wallam was angry and frustrated that she had not answered his calls.[482]

513. The evidence about Mr Wallam's state of mind on 22 October 2014 is limited. A prisoner on the same wing as Mr Wallam recalled kicking a footy with him in the afternoon of 22 October 2014 and said Mr Wallam did not disclose any concerns and seemed "OK".[483] Officer Owen, who was working on unit 14 in the afternoon of 22 October 2014 recalled asking Mr Wallam to re-vacuum a training room and that he seemed fine.[484]

514. The unpredictability of suicide is reflected in an observation by Ms Lee McKay, the Coordinator of Aboriginal Services at Casuarina Prison. She noted that following Mr Wallam's death, there was a great deal of anger and disappointment amongst prisoners and staff because nobody had any inkling that Mr Wallam was planning to take his life.[485]

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[477] Exhibit 9, Tab 19, Incident Description Report (Nurse Anne)
[478] Exhibit 9, Tab 3, Life Extinct Report
[479] Exhibit 9, Tab 12, St John Ambulance Patient Care Record
[480] Exhibit 9, Tab 13, Statement - Officer Zammit and Exhibit 9, Tab 43, Photos of Cell B1/ligature
[481] ts 26.03.19 (Mudford), p53 and ts 03.04.19 (Maines), p507 & p528
[482] Exhibit 9, Tab 44, Suicide Note
[483] Exhibit 9, Tab 25, File Note re conversation with Mr Y
[484] Exhibit 9, Tab 18, Statement - Officer Owen
[485] ts 04.04.19 (Maines), p532

Issues Relating to the Phone Calls

515. On 21 October 2014, Mr Wallam made over 40 calls to his partner, Ms Coyne and on 22 October 2014, he tried calling her 121 times. Of those 121 attempts, only 10 actually connected and Mr Wallam was only able to speak to Ms Coyne on 5 of those occasions. The last call where Mr Wallam spoke to Ms Coyne occurred at 10.48 am and lasted 10 minutes and 13 seconds. [486]

516. Mr Wallam continued to call Ms Coyne on numerous occasions during the day on 22 October 2014, but she did not answer. His last attempt to call her was at 5.59 pm.[487] Ms Coyne later said that she and Mr Wallam had argued about the fact she wasn't at home to receive his calls and he didn't have much money to call her mobile. Ms Coyne said she eventually turned her mobile off because she was out shopping and had things to do.[488]

517. Meanwhile, on the day of Mr Wallam's death, Ms Blanket (who is Ms Coyne's sister), asked that her (Ms Blanket's) number be removed from Mr Wallam's telephone account because Ms Coyne no longer lived with her and she (Ms Blanket) did not wish to receive calls from the prison.[489]

518. Ms Blanket's number was removed from Mr Wallam's PTS account. According to the Death in Custody Review, at about 4.30 pm, Mr Wallam requested that her number be reactivated.[490]

519. It is not clear how Mr Wallam became aware that Ms Blanket's number had been deactivated from his PTS account or whether he was told that his request for its reactivation had been refused.[491]

520. The Death in Custody review authored by Mr Mudford after Mr Wallam's death and finalised on 23 September 2015 relevantly states:[492]

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[486] Exhibit 9, Tab 26, Casuarina Prison Phone Log
[487] Exhibit 9, Tab 26, Casuarina Prison Phone Log
[488] Exhibit 9, Tab 20, Statement - Ms Coyne, para 39
[489] Exhibit 10, Tab A, Death in Custody Review (Wallam), p11
[490] Exhibit 10, Tab A, Death in Custody Review (Wallam), p11
[491] Exhibit 10, Tab A, Death in Custody Review (Wallam), p11
[492] Exhibit 10, Tab A, Death in Custody Review (Wallam), p11

"*Until recently, telephone procedures contained within Policy Directive 36 – Communication provided no direction to staff to inform prisoners when a telephone call recipient requested their telephone number be removed or not added to a prisoner's PTS account.*

During a post incident 'Lessons Learnt' exercise, in recognition that some prisoners may experience adverse emotional reactions, the decision was made to amend the policy to include a requirement to inform prisoners when this occurs.

In accordance with the ARMS manual, any concerns regarding risk of self-harm or suicide would result in an ARMS referral as per standard practice. Likewise concerns regarding a prisoner's wellbeing would result in liaison with Peer Support, PCS and/or the Aboriginal Visitor's Scheme where applicable."

521. In his evidence, at the inquest, Mr Mudford said that contrary to the information he received when he compiled his review, the relevant policy is still silent on whether prisoners must be informed when numbers are removed or not added to their PTS accounts.[493]

522. It appears that whether or not prisoners are informed about these matters depends largely on the particular prison officer dealing with the matter. It is surprising that the recommendation that prisoners be informed when telephone numbers are removed or not added to their PTS accounts has not been enacted.[494]

523. In my view, this very sensible suggestion should be implemented without delay. In his evidence, Mr Maines said that this could be done swiftly by means of a local (interim) order.[495] If, at the time of Mr Wallam's death, there had been a policy that prisoners would be advised whenever a number was removed or not added to their PTS accounts, then it is possible that the outcome in this case might (and I stress the word might) have been different.

[493] ts 26.03.19 (Mudford), p35
[494] ts 26.03.19 (Mudford), p35
[495] ts 04.04.19 (Maines), p533 and see also: ts 04.04.19 (Eagling), pp622-623

524. The reason I make that observation is as follows. In the two days before his death, Mr Wallam made over 160 calls on his PTS account. On the day of his death only 10 of those calls connected and he was only actually able to speak to Ms Coyne on five of those occasions.

525. Given the frequency of his calls to Ms Coyne, it is reasonable to conclude that Mr Wallam became frustrated and angry that he was not able to speak with her and his suicide note says as much.[496]

526. If Mr Wallam had been advised that Ms Blanket's number was removed from his PTS account and/or that his request to have it reinstated had been refused (in accordance with a policy positively requiring this), then the prison officer who told him so would have had the opportunity to assess his presentation and mental state.

527. Consideration could then have been given to whether or not intervention by PCS or other services was appropriate. Mr Chadwick agreed that this was certainly a possibility and said that he would have informed Mr Wallam about the changes to his PTS account in any event.[497]

528. As it was, Mr Wallam's repeated calls to Ms Coyne over the period 21-22 October 2014, apparently went undetected by both custodial staff and the PTS.

529. I accept that the volume of calls made and received by the PTS is considerable.[498] However, it would be sensible to explore whether it is possible to at least identify a situation where an inordinate number of calls was being made on a prisoner's PTS within a relatively discrete period.

Cause and Manner of Death

530. A forensic pathologist (Dr Cadden) conducted a post mortem examination of Mr Wallam's body on 27 October 2014. Dr Cadden found a prominent marking around Mr Wallam's neck consistent with a ligature marking.

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[496] Exhibit 9, Tab 44, Suicide Note
[497] ts 27.03.19 (Chadwick), p214 & p215
[498] ts 04.04.19 (Maines), p533

531. Dr Cadden also found congestion of the body organs, specifically the lungs and brain.[499] Toxicological analysis found no alcohol or common drugs in Mr Wallam's system.[500]

532. Dr Cadden expressed the opinion that the cause of death was ligature compression of the neck (hanging).[501] I accept and adopt that conclusion.

533. I find Mr Wallam's death occurred by way of suicide.

Quality of Supervision, Treatment and Care

534. Mr Wallam's general health issues were appropriately managed and he saw health staff on a number occasions for minor medical issues and he was appropriately referred to hospital following a fainting incident.

535. I note that Mr Wallam's requests to be seen by PAST to address his illicit substance abuse were actioned appropriately.

536. Mr Wallam had threatened or attempted self-harm (including suicide attempts) on a number of occasions during periods of incarceration. This behaviour was often in response to an episode of frustration and it was clear that he had poor coping skills.

537. There does not appear to be any evidence that Mr Wallam suffered from a major depressive or psychiatric illness at the time of his death, although he seems to have satisfied the criteria for a diagnosis of ASPD.

538. Given the fact that some 6 months elapsed between his last admission into prison and his death, it is not possible to conclude that the outcome in this case would have been different had Mr Wallam been placed on ARMS when he was received at Hakea Prison on 19 April 2014, and then, after an appropriate period, been placed on SAMS.

[499] Exhibit 9, Tab 8, Post Mortem Report
[500] Exhibit 9, Tab 9, Toxicology Report
[501] Exhibit 9, Tab 8, Post Mortem Report

539. If the number of phone calls made by Mr Wallam from 21 - 22 October 2014 could have been detected or if he had been observed spending extended periods of time standing at the prison telephones, some attempt to assess his mental state might have been made.

540. It is impossible to know whether any such assessment would have altered the outcome in this case, but nevertheless, it would have been desirable.

541. Although Mr Wallam had experienced two previous stints of sole occupancy of his cell during his last incarceration, PRAG minutes had noted he had difficulty dealing with isolation.

542. It seems that Mr Wallam ruminated on his anger and frustration at not being able to contact Ms Coyne after he was locked in his cell on the evening of 22 October 2014. Indeed, as noted, his suicide note says as much.[502]

543. Having decided to take his life, he then appears to have fashioned a ligature from his bed sheet and removed "pick-resistant" sealant from the glass shower screen in his cell in order to secure that ligature. These activities would almost certainly have attracted the attention of a cellmate, had he had one.

544. Although the SAMS eligibility criteria have been reviewed since Mr Wallam's death, no changes have been made. In his evidence, Mr Mudford confirmed it was possible that a prisoner who presented to prison today with Mr Wallam's profile would not be treated any differently than he was.[503]

545. With respect to SAMS, I agree with the submission made by counsel for Mr Wallam's family that, where appropriate, prison staff be encouraged to refer prisoners directly to SAMS,[504] as is provided for in the SAMS Manual. Such direct referrals would be managed by PRAG.[505]

[502] Exhibit 9, Tab 44, Suicide Note
[503] ts 26.03.19 (Mudford), p48
[504] Exhibit 13, SAMS Manual (1998), p17
[505] ts 04.04.19 (Barron), p603

546. Mr Wallam's case brings into sharp focus the potential benefits of the triage system recommended by Dr de Klerk. Under the proposed system, prisoners who present with a known history of self-harm or suicide attempts would be reviewed by a mental health nurse within 24 hours of admission.[506]

547. Had a triage system been in place at the time of Mr Wallam's reception into Hakea Prison, he would have been reviewed by a mental health nurse. At that point, his limited coping skills and impulsive behaviour may have been more clearly identified and he may have been monitored more closely.

548. I accept that even if Mr Wallam had been triaged as suggested, the outcome in his case may not have been different. His death certainly appears to be the result of an impulsive decision on his part.

549. With respect to the ligature point Mr Wallam used, the Lessons Learnt workshop conducted after his death recommended that:

> "*Infrastructure Services to arrange for a risk assessment on the ligature points in units 13 and 14.*"[507]

550. In his Death in Custody review, Mr Mudford relevantly states:

> "*The Department's Infrastructure Services has subsequently engaged the consultant architect, involved in the cell design, to explore viable options to mitigate risks associated with this ligature point.*
>
> *Options will likely include a combination of infrastructure changes (e.g. coloured sealant or enclosed bracket) and local procedures (e.g. additional integrity checks).*"[508]

[506] ts 26.03.19 (de Klerk), p86
[507] Exhibit 10, Tab A.1, Lessons Learnt Workshop (Wallam)
[508] Exhibit 10, Tab A, Death in Custody Review (Wallam), p14

551. However, during a visit to Casuarina Prison with other counsel on 12 March 2019, Mr Jones (Counsel Assisting) was shown Mr Wallam's former cell. Mr Jones noted that the gap between the shower screen and the top bunk (which Mr Wallam used to secure the ligature he hanged himself with) was still there.[509]

552. During a visit I made to Casuarina Prison with counsel on 1 April 2019, I noted that remediation work had occurred. Surprisingly however, Mr Maines confirmed that none of the other cells which had showers in them had been remediated, although it remained the Department's intention to do so.[510] This lack of remediation of a known hazard, is very troubling to say the least.

553. I suggest that an urgent review of the ligature point used by Mr Wallam should be carried out in all cells at Casuarina Prison and the remediation suggested by Mr Mudford in his review[511] should be undertaken without delay. Whilst this particular ligature point had apparently not been used before, it is known about now and ought to be fixed.

[509] ts 26.03.2019 (Jones), pp59-60
[510] ts 04.04.2019 (Maines), pp529-530
[511] Exhibit 10, Tab A, Death in Custody Review (Wallam), pp13-14

ACTIONS TAKEN SINCE THE DEATHS

554. Since the deaths of the deceased persons, the Department has made a number of changes to policies and procedures. I will now briefly deal with some of those changes.

ARMS Enhancements

555. In 2016, the Department conducted a review of at risk management systems in other Australian jurisdictions and found that the monitoring requirements for at-risk prisoners in Western Australia were less frequent than for other jurisdictions.[512]

556. The review led to the following changes in the minimum monitoring intervals for prisoners on ARMS:[513]

    i. High ARMS: now a minimum of one-hourly (was one or two-hourly);

    ii. Moderate ARMS: now 2 hourly (was six-hourly); and

    iii. Low ARMS: 4-hourly (was 12-hourly).

557. Mr Maines highlighted the significance of the change to monitoring levels[514] and I surmise that this may explain, at least in part, why suicide rates in WA prisons have dropped.

558. Mr Maines advised that a triage process for all critical incident notifications to identify prisoners at risk of suicide and/or self-harm has been implemented and that a quarterly compliance review of ARMS and SAMS referrals is now conducted.[515]

559. Mr Maines also confirmed that training for PRAG chairs was introduced in late 2016. The impetus for the training was the deaths of the deceased persons and the training involved PCS staff meeting with PRAG chairs and discussing their roles and responsibilities.[516]

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[512] Exhibit 12, Tab 14, Statement - Mr Maines, para 90 and ts 04.04.19 (Maines), pp546-547
[513] Exhibit 12, Tab 14, Statement - Mr Maines, para 90(a)
[514] ts 04.04.19 (Maines), pp546-547
[515] Exhibit 12, Tab 14, Statement - Mr Maines, paras 90(b) & (c) and ts 04.04.19 (Maines), pp548-549
[516] Exhibit 12, Tab 14, Statement - Mr Maines, paras 90(d) and ts 04.04.19 (Maines), p539

Changes to Policies & Practice[517]

560. Between January and March 2017, new Deputy Superintendent and Assistant Superintendent positions were created at Casuarina Prison to place a greater focus on the care and wellbeing of prisoners, including prisoners with special needs as well as the management of special programs.[518]

561. A review of all custodial polices that began in November 2018 is expected to be complete by 2020. In the meantime, several policy changes have been implemented since the deaths of the deceased persons.[519]

562. The policy changes and the deceased person (or persons) who would potentially have benefitted from those changes is as follows:

    i. **Policy initiative – transfer of prisoners:** updated procedures in relation to the inter-prison transfer of prisoners at risk of self-harm in order to specify the minimum procedures which must be applied in respect of management and transfer of prisoners at risk from self-harm.

    This ensures all prisoners assessed or considered as being of self-harm concern shall receive additional risk management in respect of their transfer.

    Relevant deceased person: Mr Cameron

    Potential benefit: Mr Cameron was repeatedly transferred between prisons. When he was transferred from Greenough Regional Prison to Casuarina Prison, it was known that 2 weeks prior, he had self-harmed by cutting his arm or wrist.

    Although it appears his transfer was without incident, this policy change would help to ensure prisoners like Mr Cameron are carefully monitored.

[517] ts 04.04.19 (Maines), p544 & pp568-569
[518] Exhibit 12, Tab 14, Statement - Mr Maines, para 92 and ts 04.04.19 (Maines), p570
[519] Exhibit 12, Tab 14, Statement - Mr Maines, para 91(d)

ii. **Policy initiative – plastic cutlery:** all maximum-security prisoners at Casuarina started using plastic cutlery in December 2015.

Deceased person: JS & Mr Wallam

Potential benefit: JS used a metal knife to secure the ligature he used to take his life to the window frame in his cell. Mr Wallam managed to remove sealant between the shower screen and bunk bed in his cell. Although not clear on the evidence, I surmise Mr Wallam used a metal knife or similar to do this. Had plastic cutlery been used at the time, these methods would have been unavailable to JS and probably Mr Wallam respectively.

iii. **Policy initiative – razor blades:** since 2015 disposable razor blades are now issued to prisoners for a set time period and returned and accounted for after use.

Deceased person: Mr Bell, Mr Cameron and Mr Wallam

Potential benefit: Mr Bell used a piece of razor blade to slash his forearms. Mr Cameron used a razor blade to make a cut to his arm or wrist and placed it in his mouth whilst at Greenough Prison and Mr Wallam was noted to have placed a piece of razor blade in his mouth on a previous incarceration. Although Mr Maines acknowledged that the new arrangements do not provide "*foolproof control*" and there have still been instances where razors have been used for self-harm, the new arrangements provide "*reasonably effective control*".[520]

Increased Capacity[521]

563. On 17 December 2017, the Government announced the allocation of $120 million to increase custodial capacity in the male prison estate by construction of 160 beds and support infrastructure at Bunbury Regional Prison and 512 beds and support infrastructure at Casuarina Prison.

[520] ts 04.04.19 (Maines), p544
[521] Exhibit 12, Tab 14, Statement - Mr Maines, paras 93-96

564. Four, two-storey cell blocks (each with 256 beds) will be built at Casuarina Prison. Two blocks will accommodate general prisoners and two blocks will provide a therapeutic space for prisoners with alcohol and drug and possibly mental health issues.

565. As I have observed and as counsel for Mr Cameron's family pointed out, overcrowding at the Prison (and in other prisons across the State), has meant that when two prisoners are doubled-up, they occupy a space designed for one person.[522] It remains to be seen whether the additional beds being constructed at the Prison will allow any of the existing cells to be returned to single occupancy. Mr Maines indicated that the new cells are larger than existing cells and that instead of bunk beds, beds in cells being used for two prisoners will be side by side.

566. According to Mr Maines, the plan is that 256 beds will be available at the Prison by December 2019 and the remaining 256 beds will be available in April/May 2020.[523] The Department's annual reports for 2014 to 2017 record the steady recruitment of custodial staff to cope with increasing prison musters. Those reports are silent about the recruitment of PCS and/or mental health staff.

567. The future of the proposed 128-bed mental health subacute facility referred to by Dr Rowland in her evidence, (which would be included in the increased capacity figures referred to above), appears to be uncertain.[524] The facility would provide a stable, safe and therapeutic environment in which to address the needs of prisoners with mental health disorders who are neither on ARMS or SAMS and would seem to offer an extraordinarily valuable addition to the State's prison estate.[525]

568. Mr Maines said that a project team is addressing the level of PCS and mental health staff required to service the new beds both in terms of providing an alcohol and drug counselling service in particular and dealing with vulnerable prisoners more generally.[526]

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[522] ts 04.04.19, (O'Hara), p612
[523] Exhibit 12, Tab 14, Statement - Mr Maines, paras 95-96 and ts 04.04.19 (Maines), pp551-552
[524] ts 03.04.19 (Rowland), pp409-411 & p412
[525] ts 03.04.19 (Rowland), pp409-411 & p412
[526] ts 04.04.19 (Maines), p572

569. On the basis of the evidence I heard at the inquest, it seems that unless PCS and mental staff numbers are increased significantly (so that an appropriate level of service can be provided to the increased muster), prisoner's lives will be placed at risk.[527]

Ligature-minimisation

570. Ligature-minimisation strategies are designed to address the issue of opportunistic self-harm. The strategy aims to reduce risk to vulnerable prisoners and ultimately to save lives.[528]

571. There are two levels of ligature-minimisation. Three point ligature-minimised cells have the three most obvious ligature points (ie: window bars, light fittings and shelving brackets) remediated. Full ligature-minimised cells have all identified ligature points addressed.[529]

572. I accept that prisoners have taken their lives by suicide in ligature-minimised cells. Nevertheless, there is obvious merit in making it more difficult for this to occur by ensuring that as many cells as possible have been made ligature-minimised.

573. As to whether ligature-minimised cells were a safeguard against prisoner suicide, Dr de Klerk said: "*It contributes to keeping them safe but it does not guarantee it.*"[530]

574. Between 2005 and 2012, the Department invested $12.898 million on its ligature-minimisation program. A budget of $2.991 million was approved for a further four-year program in the financial years 2015-16 to 2018-19.[531]

575. From that sum, $881,000[532] was allocated for the 2018 - 2019 period and part of that amount will fund the remediation of 13 cells at Casuarina Prison. All of these cells are located in unit 1 of C Wing which houses prisoners on punishment or supervision regimes.[533]

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[527] ts 04.04.19 (Maines), p572
[528] Exhibit 12, Tab 14, Statement - Mr Maines, para 99
[529] Exhibit 12, Tab 14, Statement - Mr Maines, para 99
[530] ts 26.03.19 (de Klerk) p91
[531] Exhibit 12, Tab 14, Statement - Mr Maines, para 98
[532] Down from $1,040,000 in the period 2015-2016
[533] Letter, Ms Fiona Hunt, (16.04.19), Attachment 5, Ligature Minimisation Options

576. As at June 2018, 1,539 cells across the prison estate have some form of ligature minimisation. Of these, 466 are fully ligature-minimised and 1,073 are 3-point ligature-minimised.[534] At Casuarina Prison, about 40% of all cells have some form of ligature-minimisation.[535]

577. However, with a muster of well over 6,500 prisoners across the State and about 950 at Casuarina Prison, as commendable as these figures may be, they are, in my view, inadequate. As Mr Chadwick observed: the availability of ligature-minimised cells is: "*…a continuing challenge with prison musters being so high.*"[536]

578. Mr Cameron, who was on low ARMS at the time of his death, was placed in a cell in A wing on unit 5. This wing is used to house vulnerable prisoners but none of the cells on this wing are ligature-minimised[537] and Mr Maines expressed the view that if a prisoner had some level of risk, they should not be placed in unit 5.[538]

579. Mr Cameron died by suicide after he attached a ligature to the light fitting in his cell. Prior to his death, these "*Vanguard*" light fittings used in all cells at Casuarina Prison were regarded as "*ligature-minimised*".[539] The light fitting is designed to be shatterproof and consists of a one piece, injection moulded polycarbonate diffuser which the manufacturer describes in these terms:

> "*The luminaire has a reinforced hidden back plate, tamperproof stainless steel retaining screws and its construction ensures that it is virtually vandal proof.*"[540]

580. Despite having "*virtually vandal proof*" features, Mr Cameron was able to use the light fitting to secure the ligature with which he hanged himself. Admittedly, Mr Cameron burnt a hole in the light fitting (apparently using a cigarette lighter), a method of securing a ligature that had never been seen before.[541]

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[534] Exhibit 12, Tab 14, Statement – Mr Maines
[535] Exhibit 17, Table 1: Casuarina Prison Profile
[536] Exhibit 4, Tab A.25, Statement of Interview - Mr Chadwick, para 19
[537] ts 27.03.19 (Chadwick), p192 and Exhibit 17, Table 1: Casuarina Prison Profile
[538] ts 04.04.19 (Maines), p553
[539] ts 04.04.19 (Maines), p572
[540] Letter, Ms Fiona Hunt, (16.04.19), Att. 2 (Vanguard Light fitting) and ts 04.04.2019 (Maines), pp534-535
[541] ts 03.04.2019 (Maines), p507 and ts 04.04.2019 (Maines) p535

581. Given that the light fittings used by Mr Cameron are standard in all cells at Casuarina Prison, it may be that "three-point ligature-minimised cells" should actually be regarded as "two-point ligature-minimised cells, unless the ubiquitous light-fittings can be replaced with a flame-resistant alternative.

582. In this regard, I accept the submission made by counsel for Mr Cameron's family, that:

> "*Given the manner and means Mr Cameron used…*[to take his life]…*particular account now needs to be taken of this, and the materials used for light covers, the structure of the fittings, should be re-examined as part of the ligature minimisation process.*"[542]

583. Prisoners are not permitted to smoke in their cells, and Mr Maines noted that the idea of removing cigarettes and lighters from prisoners overnight had been trialled. However, there were issues with the practice.

584. Lighters can become "trafficable items" and this can lead to stand-over behaviour. Lighters may be also secreted and prisoners have been known to use potentially fatal alternatives to light cigarettes.[543]

585. Given that the light fitting used by Mr Cameron is present in ligature-minimised cells, it is arguable that even if he had been placed in such a cell, the result in his case may have been the same. Although for the reasons explained, the outcome in Mr Cameron's case may not have been different had he been placed in a ligature-minimised cell, the outcome in JS's case might well have been.

586. Mr Maines confirmed that the Department has set a standard that all future cell developments and upgrades will, as a minimum, be three-point point ligature-minimised.[544] Further, where practicable, all identified ligature points will be addressed. Whilst this is commendable, this commitment needs to be backed up by a budget allocation that is sufficient to ensure this laudable aim can become a reality.

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[542] ts 04.04.19 (O'Hara), p610
[543] ts 04.04.2019 (Maines), p536
[544] Exhibit 12, Tab 14, Statement - Mr Maines, para 100

587. At the risk of repeating myself, when compared to the general population, the current prison muster contains a disproportionate number of men with PD[545] (including ASPD) and/or mental health disorders. ASPD is characterised by impulsive behaviour, lack of consequential thinking and difficulty with regulating emotions. Prisoners with PD (including ASPD) and mental health disorders have higher rates of suicide than those who do not.

588. Given what is now known about the prevalence of PD and mental health issues amongst male prisoners in Western Australia and the fact that these men are more likely to attempt suicide, there is a cogent argument that section 7 of the *Prison Act 1981* (WA) places a positive obligation on the CEO to take all reasonable steps to reduce the risk of harm to the prisoners in his care.

589. In that context, the urgent provision of more ligature-minimised cells (whether three point of fully minimised) is more than just a worthy goal. In the context of the duties imposed upon the Chief Executive Officer by the Act - it is arguably a practical necessity.

590. The Gatekeeper program and the ARMS and SAMS systems are clearly designed to reduce and manage self-harm and suicide risk. However, it is not acceptable that only about 40% cells at Casuarina Prison are currently ligature-minimised.[546] The Department should increase the number of ligature-minimised cells available at the Prison without delay, and cells routinely used to house vulnerable prisoners ought to be prioritised.[547]

591. Sadly, this issue is not a new one. In 2008, the then State Coroner conducted an inquest into a death by hanging at Casuarina Prison. His Honour made recommendations calling for an ongoing review of the best means to remove obvious hanging points from cells and the funding of a capital works program to achieve this.[548] I hope that the Department will now make this issue an absolute priority.

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[545] Personality Disorders
[546] Exhibit 17, Table 1: Casuarina Prison Profile
[547] ts 04.04.19 (Eagling), p522
[548] Annual Report, Office of the State Coroner (2008-2009), p63 re: The Death of Mark John Briggs

FURTHER OPPORTUNITIES

Information Sharing - Mental Health & PCS Staff

592. Medical and mental health information about a prisoner is entered into a computer system called EcHO. Notes of counselling sessions conducted by PCS counsellors are recorded in an area in TOMS known as the PCS module.

593. Prison medical staff, including mental health nurses and psychiatrists, do not have access to information in the PCS module on TOMS. Similarly, PCS staff do not have access to EcHO.

594. This was not always the case. At some point, many years ago, PHS and PCS staff had access to each other's notes. For reasons now lost in the mists of time and subject to folklore[549] (that may or may not be accurate), this two-way access was removed.

595. ARMS and SAMS assessments whether made by PCS or mental health staff are recorded in the ARMS and SAMS modules in TOMS respectively. Interestingly, all staff, including custodial staff, do have access to this information.[550]

596. The ARMS manual current at the time of the deaths of the deceased persons, relevantly states:

> "***Suicide, therefore, is a complex problem to which there is no single answer. It is not simply a medical problem and the solutions do not lie entirely with Health Services or the Prison Counselling Service.*** (emphasis added)
>
> *A strategy for tackling suicide and self-harm must embrace all those who experience distress, not only those with identifiable and treatable medical symptoms. The responsibility for suicide awareness and the care of the suicidal has to be shared by the whole prison community. This can be described as an "integrated approach" to suicide prevention."*[551]

[549] See for example: ts 27.03.19 (Deighton), p163
[550] ts 27.03.19 (Deighton), p162
[551] Exhibit 14, ARMS Manual (1998), p12 and see also: Exhibit 16, ARMS Manual (2019), p38

597. The ARMS manual clearly supports a multi-disciplinary approach to the assessment of the risk of self-harm and suicide.[552] Further, in the section of that manual that covers a departmental policy directive dealing with at risk prisoners (referred to as PD32),[553] the following words appear under the heading "*Suicide is not simply a medical problem*":

> "*Officers and employees of all the disciplines shall work together to share information, knowledge and skills in assessing and managing prisoners.*"[554]

598. Dr de Klerk[555] (psychiatrist), Ms Crone[556] (PCS social worker), Ms Mandolene[557] (former PCS social worker), Dr Grigg[558] (former PCS psychologist) and Mr Maines[559] (Executive Director, Professional Standards Division) were all strongly of the view that access by PHS and PCS staff to EcHO and the PCS module on TOMS respectively (reciprocal access) was very important to their work and indeed, many said it was "vital".

599. Ms Mandolene had worked with PCS at a time when reciprocal access was available. She said this access improved: "*collaborative working processes and communication*" and was "*vitally important*". In her view, the current lack of reciprocal access detrimentally affected the effective management of prisoners and was counter-productive to that management.[560]

600. Ms Crone recalled working in PCS when reciprocal access was suddenly withdrawn. When asked if this access was important and she replied:

> "*It is, absolutely. When we're being cut off just one day, just suddenly, one day it's being cut off. It was just, like, my gosh. What's going on? We're supposed to work together.*"[561]

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[552] Exhibit 15, ARMS Manual (1998), p1
[553] PD32 relates to the management of "at-risk" prisoners
[554] Exhibit 15, ARMS Manual, p4, para 1.2 and ts 04.04.19 (Eagling), p620
[555] ts 26.03.19 (de Klerk), p122
[556] ts 28.03.19 (Crone), pp298-300
[557] ts 28.03.19 (Mandolene), p237
[558] ts 29.03.19 (Grigg), p332
[559] ts 04.04.2019 (Maines), p574
[560] ts 28.03.19 (Mandolene), p237 & p253
[561] ts 28.03.19 (Crone), p299

601. Ms Crone considered that reciprocal access should include access to prisoner health records on the basis that this would allow her to check the veracity of what a prisoner was telling her and because physical health issues can have a profound impact on mental health.[562]

602. Dr Grigg was of the view that the current lack of reciprocal access puts the lives of prisoners at risk. As he said:

> "*I believe both psychiatric and non-psychiatric health conditions can contribute to risk, and as we're working with risk we're trying to make assessments and recommendations based on an incomplete picture.*"[563]

603. Dr de Klerk explained that reciprocal access would improve the clinical service he offers to prisoners. He said that in his experience, PCS counsellors were meticulous history takers and it can be counter-therapeutic for a prisoner to have to rehash often painful history with a mental health worker, having previously provided it to a PCS counsellor (or vice-versa).[564] This was a point with which Dr Grigg and Ms Mandolene agreed.[565]

604. Dr de Klerk went on the note that he has very limited time to see prisoners (because of muster and lockup requirements) and reciprocal access would allow him to prepare for his sessions with prisoners more thoroughly and efficiently.[566]

605. Dr de Klerk could think of no impediment with respect to enabling reciprocal access.[567]

606. Dr de Klerk also made the following potent observation with respect to risk assessment:

> "*I have always said that knowledge is power. And the more you know, the better you are in a position to make difficult calls.*"[568]

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[562] ts 28.03.19 (Crone), p298
[563] ts 29.03.19 (Grigg), p332
[564] ts 26.03.19 (de Klerk), p122
[565] ts 26.03.19 (de Klerk), p122; ts 29.03.19 (Grigg), p349 and ts 28.03.19 (Mandolene), p237
[566] ts 26.03.19 (de Klerk), p122 & p135
[567] ts 26.03.19 (de Klerk), p135
[568] ts 26.03.19 (de Klerk), p137

607. On this point, Mr Maines put the point unequivocally when he said:

> "*There should be no impediment to sharing any information in relation to the security and safety of a person in our custody.*"[569]

608. In his evidence, Mr Fairhead (Mr Bell's father) identified information sharing as being of critical importance. Mr Fairhead said he felt Mr Bell might have received extra assistance if his case had been spoken about more.[570]

609. Ms Deighton (PCS psychologist) was in favour of PCS staff having access to information on EcHO and thought that this would make PCS interactions with prisoners more efficient and would save time.[571]

610. However, with respect to PHS staff accessing information in the PCS module on TOMS, Ms Deighton was more circumspect and in fact said she did not support access in this direction.[572] Her main concern related to prisoner confidentiality.

611. Ms Deighton referred to what she saw as the difficult balance between confidentiality and information sharing in the interests of risk management.[573]

612. I accept, as Ms Deighton properly identified, that building rapport and trust is a vitally important component in a truly therapeutic relationship. Confidentiality assists in this process, especially where sensitive information has been divulged.[574]

613. I note in passing that through their solicitor, Mr Bell's family made a submission that interactions between prisoners and PCS staff should be electronically recorded so as to: "*provide a permanent record of what was said or done to assist in reviews such as this inquest*".[575]

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[569] ts 04.04.19 (Maines), p574
[570] ts 04.04.19 (Fairhead), p600
[571] t 27.03.19 (Deighton), pp162-163
[572] t 27.03.19 (Deighton), p163 & p164
[573] t 27.03.19 (Deighton), p165
[574] t 27.03.19 (Deighton), p164
[575] Submissions, Mr Meyers (01.05.19), para 55

614. Given what Ms Deighton has said about the development of a therapeutic relationship between a prisoner and their counsellor, I do not accept that it would be appropriate to electronically record interactions between prisoners and PCS staff. The numerous PCS notes that I reviewed during the inquest impressed me in terms of their level of detail.

615. Where, in an interview, a prisoner disclosed a matter which was relevant to their safety, the professional obligations that rest on PCS and PHS staff would require that disclosure to be the subject of appropriate action. I am satisfied that the present arrangements for recording counselling observations (by way of entries into the PCS module on TOMS or EcHO respectively) are satisfactory.

616. I appreciate the concerns expressed by Ms Deighton about access to PCS information. However, in light of the vulnerability of the prison population, the balance between prisoner confidentiality on one hand and the sharing information aimed at minimising prisoner risk on the other, must always be titled firmly in favour of minimising risk.

617. The fact that PCS and PHS staff have been brought together under the umbrella of "Health Services" and share the same director[576] offers many positive opportunities. The most obvious benefit is a truly multi-disciplinary approach to the management of prisoner health, both physical and mental.

618. However, it seems to me that in order to maximise the opportunities which flow from the organisational realignment of PHS and PCS staff, an appropriate flow of information between PHS and PCS staff is critical. There is a further benefit in promoting and encouraging the sharing of information between PCS and PHS staff. Doing so will almost certainly have a positive impact on managing "at risk" prisoners and that in turn will help to enhance the security and good order of the prison itself.

619. It appears that the previously permitted reciprocal access may have been removed because of a concern about the inappropriate use of information, although this is by no means clear.[577] In my view, any such concern is illusory.

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[576] Exhibit 12, Tab 15, Statement - Dr Rowland, para 16
[577] ts 27.03.19 (Deighton), p163

620. Staff members logging on to either TOMS or EcHO require a password and their use of either system is traceable.[578] Thus, any inappropriate access can be readily detected and the Department's code of conduct[579] relevantly provides:

> "*We do not release or use for any purpose, other than for the discharge of official duties, information gained by or conveyed to us through our employment.*"

621. All staff employed by the Department are required to abide by its code of conduct and must also:

> "*…act with integrity in the performance of official duties and are to be scrupulous in the use of official information, equipment and facilities*"[580]

622. If any further comfort is required, the *Criminal Code* makes the unauthorised access of information derived from a restricted-access computer system (like EcHO or TOMS) a crime punishable by imprisonment for 2 years.[581]

623. On the basis of the evidence at the inquest, I have concluded that reciprocal access is vital to both maximise the clinical and psychological care of prisoners and to facilitate a more effective assessment of suicide and self-harm risk and thereby, potentially, save lives.

624. In addition, as I have already pointed out, a prison in which the clinical and psychological care of prisoners is well managed is also going to be safer and more secure.

625. Counsel for the Department confirmed that the Department would support a recommendation to give effect to the section of the ARMS manual dealing with PD 32, namely:

> "*Officers and employees of all the disciplines shall work together to share information, knowledge and skills in assessing and managing prisoners.*"[582]

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[578] ts 28.03.19 (Mandolene), p252
[579] https://department.justice.wa.gov.au/_files/Code_of_Conduct.pdf
[580] section 9, *Public Sector Management Act 1994* (WA)
[581] Section 440A(3)(c), Criminal Code
[582] Exhibit 15, ARMS Manual (1998), p4, (para 1.2), and ts 04.04.19 (Eagling), p620

626. In her evidence, Dr Rowland said the Department recently purchased additional licenses for EcHO and that these additional licenses would facilitate access to EcHO by PCS staff.[583] This is encouraging, but it is unclear whether the number of licenses purchased will be sufficient to meet operational demand.

627. Dr Rowland confirmed that work is also underway to create the necessary electronic environment to allow PCS staff to access information stored in EcHO. She also referred to functionalities within EcHO which allow for case management and care plans.[584]

628. It seems these functionalities will assist in optimising prisoner care because detailed information about each prisoner can be entered into the system by members of the multidisciplinary team and can then be viewed by members of that team, both PCS and PHS.[585]

629. This is a positive development, but as Dr Rowland pointed out, "*implementation always requires resources*" for establishing new systems, staff training etc.[586] The necessary funds must obviously be made available and prioritised if reciprocal access is to become a reality.

630. In my view, as a matter of the upmost urgency, the Department should take all necessary steps to ensure that PHS and PCS staff have reciprocal access to information in the EcHO system and the PCS module on TOMS respectively. That includes ensuring that sufficient resources have been allocated to the project and that the timeframe for full implementation is as limited as possible.

Triage by mental health nurse re previous self-harm

631. Dr de Klerk expressed the opinion, with which I agree, that all prisoners admitted to prison who have a known history of self-harm or attempted suicide should be reviewed by a mental health nurse within 24-hours of admission.[587]

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[583] ts 03.04.19 (Rowland), p375 & p378
[584] ts 03.04.19 (Rowland), p379
[585] ts 03.04.19 (Rowland), p379
[586] ts 03.04.19 (Rowland), p379
[587] ts 26.03.19 (de Klerk), pp73-74 & 88

632. Dr Rowland and Dr Patchett agreed that the proposed triage system had merit and Dr Patchett noted it was similar to the "three ticks" system used in the United Kingdom. Under that system, prisoners with either: a previous history of suicide, a family history of suicide and/or a history of mental illness receive a mental health assessment on their reception to prison.[588]

633. Had the triage system proposed by Dr de Klerk been in place prior to the deaths of the deceased persons, Mr Bell, Mr Cameron, JS and Mr Wallam would all have been the subject of a mental health assessment.

634. Dr de Klerk referred to a study that found people with a self-harm history were 66 times more likely to die by their own hand, either intentionally or by accident. Past behaviour is thus one of the best predictors of future behaviour.[589]

635. Given that a survey of male prisoners found 24% had attempted suicide at some time in their lives; 38% appeared to have APSD; and 13% had a psychotic disorder[590] the need for a triage system such as proposed by Dr de Klerk seems obvious.

636. As a matter of urgency, I suggest that the Department consult with relevant experts with a view to introducing the triage system proposed by Dr de Klerk.

637. Consideration should also be given to whether the triage system can be implemented using existing staff or whether additional staff will be required and if so, how many. For regional prisons that lack resident mental health staff, video-links could facilitate the triage process.[591]

638. Pleasingly, Counsel for the Department confirmed that the Department would give in-principle support to a recommendation relating to the triage system proposed by Dr de Klerk.[592]

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[588] ts 03.04.19 (Rowland), p416 & ts 03.04.19 (Patchett), pp460-461
[589] ts 26.03.19 (de Klerk), p72
[590] Exhibit 19 - Davison, S et al, Mental health and substance use problems in Western Australian prisons. (2015) Report from the Health and Emotional Wellbeing Survey of Western Australian Reception Prisoners.
[591] ts 26.03.19 (de Klerk), p74 & p89
[592] ts 04.04.19 (Eagling), p622

Trauma Informed Correctional Care (TICC)

639. In her evidence, Dr Rowland spoke about TICC, an approach to the management of prisoners. TICC can be defined as follows:

> "*…a strength, space, delivery approach that is granted in an understanding of and responsiveness to the impact of trauma that emphasises physical, psychological and emotional safety for both providers and survivors, and it creates opportunities for survivors to rebuild a sense of control and empowerment.*"[593]

640. Dr Rowland pointed out that given higher rates of trauma histories among correctional populations as well as the increased potential for both new and re-traumatisation within correctional facilities, TICC is increasingly being considered and adopted in prisons around the globe.[594]

641. The TICC model operates on the basis that each prisoner has a history which affects the way they deal with their environment. The interactions that prison staff have with prisoners can be either beneficial or detrimental to that prisoner.[595]

642. Under TICC, the impacts of trauma are viewed as being amendable to recovery and repair and in that way, the model is an optimistic recovery model based on the strength of the prisoner.[596]

643. In her evidence, Dr Rowland gave examples of simple environmental changes that could support TICC:

> "*…an environment which is calmer and quieter and…*[where]*…there's less surprises, where things are forecast in advance about what's going to happen, where they're informed about why…there's a lockdown…and, preferably, there's some pleasant environment in terms of colours, plants, trees, outdoor air and safe spaces where they can come.*"[597]

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[593] ts 03.04.19(Rowland), p397
[594] Exhibit 12, Tab 15, Statement - Dr Rowland, para 38, citing: Creating trauma-informed correctional care: a balance of goals and environment. *Eur J Psychotraumatol.* 2012:3:10:3402
[595] ts 03.04.19(Rowland), pp397-398
[596] ts 03.04.19 (Rowland), pp397-398
[597] ts 03.04.19 (Rowland), p405

644. A fundamental principle of TICC is that prisoners are treated with dignity and respect. One manifestation of this principle relates to the way prisoners are referred to by custodial staff. In some iterations of TICC, the formula that has been adopted is: "Mr/Ms (Prisoner surname).[598] Other examples include: prior explanations of procedures or practices, advanced warnings of events and referring to cells as rooms.[599]

645. Thus, in subtle ways like these and in other ways not so subtle, implementing TICC at Casuarina Prison would require significant cultural change. It would be essential that the principles of respectfulness and humanity that underpin TICC were not seen by custodial staff as weakness, but rather as superior ways of managing the prisoners in their care.[600]

646. As Dr Rowland points out, there is a balance to be struck between creating a secure and safe environment and the development of an empathetic caring environment. However, as she points out, the punishment meted out by the State to those sentenced to prison is deprivation of liberty - and every effort should be made to reduce the traumatising effect of that incarceration.[601]

647. In his evidence, Dr de Klerk referred to the unique opportunity that presents itself when a person with mental health issues is imprisoned, noting:

> "*…we have a unique opportunity when people who are unwell, for whatever reason, or distressed come to prison and for a period they have relative sobriety, they have three squares a day, they don't have to worry about accommodation, I think we are missing an opportunity to deliver more rehabilitation services in order to* [reduce] *recidivism*".[602]

648. In my view, this sentiment aligns with a model of prisoner management that is forward looking and optimistic, like TICC.

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[598] ts 03.04.19 (Rowland), p403
[599] ts 03.04.19 (Rowland), p404
[600] ts 03.04.19 (Rowland), p458
[601] ts 03.04.19 (Rowland), p400
[602] ts 03.04.19 (de Klerk), p138

649. It seems to me that the successful implementation of a model of prisoner management based on the principles of TICC would depend on two critical factors - leadership and training.

650. That is because a prison's culture builds up over time and almost becomes ingrained in the very fabric of the prison itself. A model based on TICC would be a departure from the management model currently used at Casuarina Prison.[603]

651. Without strong, resolute leadership, any model of prisoner management based on TICC would surely be doomed. Senior staff at the prison would need to model behaviours consistent with TICC so that those behaviours become "normalised" and part of the accepted culture of the prison.[604]

652. As for training, Dr Rowland said this would firstly involve giving staff an understanding of self and then exploring how their reactions to the behaviours exhibited by prisoners can be either detrimental or positive.[605]

653. Dr Rowland said that TICC was based on a consistency of approach so that prisoner behaviour is treated in a logical manner and prisoners are made aware of the consequences of particular behaviour.

654. It appears that TICC has the potential to improve the experience of prison for both prisoners and staff in a number of ways, including: safer physical/emotional environments for prisoners and staff; reducing the risk of re-traumatisation; increasing the quality of services and reducing costs – to name just a few.[606]

655. According to Dr Rowland, TICC could help address the needs of prisoners generally, but would also be useful in dealing with prisoners with chronic suicidality and those like Mr Cameron, who have developed maladaptive ways of responding to their environments.[607]

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[603] ts 03.04.19 (Rowland), pp404-405
[604] ts 03.04.19 (Rowland), pp404-405
[605] ts 03.04.19 (Rowland), p400 & p458
[606] Exhibit 12, Tab 15, Statement - Dr Rowland, para 41
[607] ts 03.04.19 (Rowland), p415 & p426

656. Under a TICC model, Mr Cameron's challenging behaviours (e.g.: his persistent threats of self-harm which he invariably withdrew) would not be viewed as "manipulative", but rather as signs of genuine distress. Distress which would then be addressed.[608] Dr Rowland felt Mr Bell would also have benefitted from a management model based on the principles of TICC.[609]

657. Preliminary research suggests that outcomes in prison management models based on TICC include:[610]

    i. reduced trauma symptoms;

    ii. an enhanced sense of safety;

    iii. greater collaboration among service providers;

    iv. cost effective programming; and

    v. increased effectiveness of services (including reduced need for acute care and crisis services).

658. The potential benefits of a model based on TICC, in terms of improving prisoner management and enhancing the security of the prison whilst at the same time saving money - are tantalising. For that reason, it is my view that a model based on TICC is worthy of very careful consideration.

659. I urge the Department to consult relevant experts with a view to determining the feasibility of implementing a model of prisoner management based on the principles of TICC at Casuarina Prison.

Use of Technology - Tablets

660. The Death in Custody review that followed Mr Bell's death suggested exploring the feasibility of using portable tablets to improve consistency with regard to the recording of interactions between custodial staff and prisoners.[611] In my view, this sensible suggestion should be investigated further by the Department.

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[608] ts 03.04.19 (Rowland), p421
[609] Exhibit 12, Tab 15, Statement - Dr Rowland, paras 37-45 and ts 03.04.19 (Rowland), p425
[610] Exhibit 12, Tab 14, Statement - Dr Rowland, para 42, citing: DeCandia CJ, Guarino K, & Clervil R *Trauma-informed care and trauma-specific services: A comprehensive approach to trauma intervention*, Washington, DC: American Institutes for Research (AIR): 201.4.
[611] Exhibit 2, Tab A, Death in Custody Review (Bell), p27

661. Mr Maines supported the concept, noting:

> "*I probably have a very strong view on the use of technology. The Department currently still relies on a lot of handwritten documentation in occurrence books. A prisoner officer having a conversation with a prisoner is required to make some sort of annotation in a notebook and, at some later point during their shift, go back, find a desktop computer and actually log into TOMS…I think having access to technology in the 21st Century would be very helpful in enabling real time engagement and recordkeeping.*"[612]

Observations about further opportunities

662. Some of the opportunities discussed in this section will require additional resources if they are to be fully implemented. I accept that departmental resources are scarce and must be managed carefully. I also accept that difficult decisions must sometimes be made with respect to competing priorities.

663. Nevertheless, in circumstances where the opportunities discussed offer not only the chance to improve prisoner welfare, but also as a direct consequence, the chance to enhance the security of Casuarina Prison, it would seem imperative that the Department should give each of these opportunities very detailed and careful consideration.

664. Many of the issues I have canvassed in this Finding are not new. Indeed, the issues of over-crowding, risk assessment, ligature-minimisation and PCS and mental staff numbers have bedevilled the Department's management of prisoners for years.

665. The further opportunities canvassed in this Finding offer the Department a tangible opportunity to make real enhancements to prisoner welfare and prison security. It is my sincere hope that the issues that I have canvassed will be carefully considered and that the recommendations I have made will be adopted.

[612] ts 04.04.19 (Maines), p544

RECOMMENDATIONS

666. In light of the observations I have made, I make the following recommendations:

Recommendation No.1

The Department should take urgent steps to recruit additional Prison Counselling Service (PCS) and mental health staff for Casuarina Prison and more broadly, should consider the appropriate level of PCS and mental health staff for prisons across the State.

Recommendation No.2

The Department should increase the number of three point and fully ligature-minimised cells available at Casuarina Prison without delay. Priority should be given to those cells routinely used to house vulnerable prisoners (e.g.: the orientation cells in unit 5). In addition to increasing the number of ligature-minimised cells at Casuarina Prison, the Department should review whether the light fitting covers currently used in all cells at Casuarina Prison (and which are regarded as suitable for use in ligature-minimised cells) are fit for purpose.

Recommendation No.3

In order to better manage prisoners and thereby enhance security at Casuarina Prison, the Department should, without delay, take all necessary steps to ensure that PCS and Prison Health Service staff have reciprocal access to prisoner information stored in the EcHO computer system and the PCS module of the Total Offender Management Solutions system respectively.

Recommendation No.4

The Department should consider introducing a "triage" system into prisons where all prisoners who have a known history of self-harm and/or suicide attempts are reviewed by a mental health professional within 24 hours of being received into prison. Consideration should be given to the use of video-conferencing facilities for regional prisons where mental health staff are unavailable.

Recommendation No.5

The Department should consult with an expert in the field of trauma informed custodial care (TICC) to determine a process for incorporating the principles of TICC into its management of prisoners at Casuarina Prison.

Recommendation No.6

The Department should consult with an expert in the field of mental health with a view to providing training to all staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.

Recommendation No.7

The Department should consider further enhancing its Gatekeeper training program to ensure that it is primarily focussed on risk in the custodial setting. Consideration should also be given to including additional guidance for relevant custodial staff (e.g.: reception officers) on conducting self-harm and suicide risk assessments. Gatekeeper refresher training should be conducted for all staff on a regular basis.

Recommendation No.8

The Department should consider amending Policy Directive 36 – Communication so that wherever practicable, there is a positive obligation on custodial staff to advise a prisoner when changes are made to that prisoner's Prison Telephone System account.

CONCLUSION

667. With the benefit of hindsight, much that was not clear at the relevant time becomes clear. Indeed, during this inquest, much has been said about the unpredictability of suicide and the many uncertainties that surround the assessment of those who are most at risk.

668. However, one thing that is certain, is that the loss of a loved one, particularly in tragic circumstances, causes immeasurable sorrow and sadness. Quite obviously, the death of each of the deceased persons will have affected their respective families and friends very profoundly.

669. Since the deaths of the deceased persons, the Department has made a number of changes to its policies and procedures. After careful consideration of the evidence, I have made eight recommendations which I hope will improve prisoner wellbeing and as a consequence, further enhance security at Casuarina Prison.

670. The Department now has an opportunity to take further positive steps to address some of the issues canvassed at this inquest. In part, this will require an allocation of additional resources but it will also require a renewed commitment to fulfilling the statutory responsibilities of the CEO with respect to the welfare and safety of the prisoners in his care.

671. I hope that the changes which have already been made by the Department, and the changes I have recommended (which I hope will be implemented), will provide the families and friends of the deceased persons with some level of solace for their respective terrible losses.

M A G Jenkin
Coroner
22 May 2019

Annex A to Finding
dated 22 May 2019

LIST OF ABBREVIATIONS

Abbreviation	Meaning
ACE	Adverse Childhood Events
APS	Aboriginal Prisoner Service
ARMS	At Risk Management System
ASPD	Anti-Social Personality Disorder
AVS	Aboriginal Visitor Service
CCTV	Closed Circuit Television
CCU	Crisis Care Unit
CEO	Chief Executive Officer
CPR	Cardio-Pulmonary Resuscitation
DOI	Date of Interest
ECG	Electrocardiogram
EcHO	Computer system used by PHS staff
MHN	Mental Health Nurse
PAST	Prison Addiction Services Team
PCS	Prison Counselling Services
PD	Personality Disorder
PHS	Prisoner Health Services
PRAG	Prisoner Risk Assessment Group
PTS	Prisoner Telephone System
PTSD	Post-traumatic Stress Disorder
SAMS	Support and Monitoring System
SHU	Special Handling Unit
TICC	Trauma Informed Custodial Care
TOMS	Total Offender Management Solutions