Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 41/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Khamsani Victor JACKAMARRA (also known as Hajinoor)*** *with an Inquest held at Broome Coroners Court, Hamersley Street, Broome, on 30 and 31 October 2018 and 1 November 2018 find the identity of the deceased was* ***Khamsani Victor JACKAMARRA (also known as Hajinoor)*** *and that death occurred on 16 December 2015 at Broome Regional Prison as the result of Ligature Compression of the Neck (Hanging) in the following circumstances:-*

Counsel Appearing:

Ms F Allen assisted the Deputy State Coroner
Mr S Castan (instructed by National Justice Project) appeared on behalf of the family of Mr Jackamarra
Ms N Eagling (State Solicitors Office) appeared on behalf of the Department of Justice, then Department of Corrections.

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INTRODUCTION

On 16 December 2015 the deceased, Mr Jackamarra[1], attended Broome Courthouse, Broome, to appear via a video-link in the Stirling Gardens Magistrates Court, Supreme Court, Perth, on charges related to an offence of arson. He pleaded guilty to the charges and was granted bail pending sentencing on the 30 March 2016 in Perth.[2] There was a requirement for a surety, however, Mr Jackamarra's surety was unable to attend Court to sign the surety papers and Mr Jackamarra needed to remain in custody until the papers could be signed.

At approximately 11.40 am Mr Jackamarra was transferred to Broome Prison (as it was then, now Broome Regional Prison) B(R)P, [3] at the time an annexure of the West Kimberley Regional Prison (WKRP), at his request, while waiting for his papers to be signed. It was expected this would be an overnight stay only. Mr Jackamarra was processed through reception at B(R)P and escorted to the maximum security yard where all remand prisoners are located. There he spoke to a prison support officer, at his request, and left saying he wanted a shower. He last had direct interaction with a prison officer at 1.30 pm when he was advised he would be assisted with a telephone call as soon as he wanted one. He appeared calm.

[1] Mr Jackamarra is the preferred family reference for the deceased
[2] Exhibit 2, tab 37
[3] The acronym of B(R)P will be used throughout this finding to remind readers of reduced status and resourcing of that facility in December 2015.

At approximately 2.10 pm a prisoner approached the prison officers control room in the maximum security yard and advised them a person was hanging in the showers. Prison officers immediately ran to the showers while others initiated an emergency response. Despite vigorous resuscitation Mr Jackamarra could not be revived.

Mr Jackamarra was 36 years of age.

The fact Mr Jackamarra was in the custody of the Department of Corrections (the Department) via B(R)P pending the signing of the surety for his bail at the time of his death brought his death under the provisions of a "person held in care" for the purposes of the *Coroners Act 1996* (WA) (the Act). This mandates a public hearing by way of inquest (section 22 (1)(a)) and requires the coroner holding that inquest to comment upon the quality of the supervision, treatment and care of that person while held in that care (section 25 (3)).

Following the death of Mr Jackamarra the Department investigated its policies and procedures implemented to reduce the potential for those in custody to harm themselves and found there had been a lack of compliance with documentation intended to facilitate an exchange of information about the behaviour of prisoners transitioning into custody from the community or other custodial settings. SERCO, then the provider of security resources to courts, later lost its contract for services and as a result its employees lost their jobs. B(R)P

officers were also investigated for failures related to admission procedures. This finding will only touch upon the factual issues which arose from those investigations which I believe will contribute to the implementation of improvement to the systems in place for the safety of persons transitioning through the system.

The evidence for the purposes of the inquest into the death of Mr Jackamarra compromised four volumes of documentary evidence, exhibits 1 to 4 as well as the evidence of a number of witnesses called in person during the public hearing.

The purpose of this type of hearing was explained for the benefit of those in Court and outlined the fact the function of an inquest is to look at the facts of what had occurred without allocation of blame or liability (s25(5)). It was purely to examine the sequence of events to determine whether there were changes which could be made to processes which could improve the supervision, treatment and care of prisoners in custody.[4]

Following the conclusion of the oral evidence at the inquest parties were invited to make written submissions. These were received by the Court in November 2018 and January 2019 and I have noted those submissions.

Unfortunately it was not possible to hear oral testimony from three persons relevant to events on the 16 December 2015 and

[4] t 1.11.18, p 4-5

the Act does not compel the provision of written statements. However, I do not agree the fact the Court did not hear evidence from Prisoners Smith, Maru or Dorizzi precludes me from reaching a conclusion as to the death of Mr Jackamarra on a consideration of the whole of the evidence. Indeed, in order to comment appropriately on the supervision, treatment and care of Mr Jackamarra while in custody, it is preferable I do reach a conclusion as to how Mr Jackamarra died on the whole of the evidence, and I have done so.

BACKGROUND

Broome Regional Prison (B(R)P)

B(R)P is situated in Broome town site, almost opposite Broome Magistrates Court (BMC). It is a very old facility (circa 1945) and desperately in need of renewal. The old 1894 caged area is still part of the structure and used as a recreational room. The Court visited the facility on the morning of 1 November 2018 and it is my view the facility as a structure is both confronting and depressing, uncomfortable for both staff and inmates. A similar view was expressed by the Inspector of Custodial Services in his 2017 Inspection of B(R)P. The first heading in his Overview is:

> *"Broome Regional Prison : Unfit for purpose and in urgent need of investment and a plan".* [5]

This is in spite of a $11.2 million refurbishment in 2011 providing some air-conditioning and new health and education

[5] Report 112 Office of the Inspector for Custodial Services : 2017 Inspection of Broome Regional Prison

centres and, as I understand it, more improvements in 2017 to 2018. I appreciate the current prison superintendent[6] has worked very hard to improve the situation. I cannot begin to imagine what it was like in 2015. That having been said the atmosphere between prisoners and staff of B(R)P was good.

Throughout this finding I have used the acronym B(R)P to indicate its reduced status at the time of Mr Jackamarra's death.

The current location of B(R)P is very proximate to the major Court of the region and well known across the Kimberley. It is accessible for visits from Broome residents and, as importantly, services, and should be retained, in my view, by serious upgrade. Broome itself is considered a desirable location for the Kimberley which allows for greater access to a better living environment and so the potential for better resourcing for the facility.

I appreciate the Department for Justice (in all its many changing names,) was cognisant of the issues for B(R)P and had built a new prison facility outside Derby, WKRP, intending it replace the B(R)P. At the time of Mr Jackamarra's death B(R)P was considered an annexure of WKRP and staff at B(R)P had been advised that B(R)P was to be closed and they would need to relocate to Derby.[7] This resulted in a seriously unstable situation for prison officers in both their work and private lives; in addition to working in conditions unsuitable for the inmates

[6] t 1.11.18, p338
[7] t 31.10.18, p311

and requiring them to do the best they could with poor to no services and resources, including organising B(R)P visits from Derby, over 200 kilometres away.[8]

I understand the decision to close B(R)P has been reversed and it is again a facility in its own right. It is an essential facility and desperately needs all the services and resources necessary to care for inmates, and more importantly, the facility needs to be able to accommodate both inmates and services in an appropriate and relevant manner for inmates and staff alike. Prison officers cannot be expected to adequately provide all functions necessary for both security and welfare without appropriate support.

This was clearly the situation in 2015 in Broome and it is remarkable B(R)P managed as well as it did. This was due to a generally good relationship between the staff who were there at the time, despite some travelling to and from Derby, the inmates and the town.[9]

The Deceased

Mr Jackamarra was born on 22 February 1979 in Broome of Aboriginal and Indonesian heritage. He was part of a large, close and extended family around Broome. His parents separated when he was a child and his mother brought up seven children as a single mother. Mr Jackamarra also had numerous half siblings and the Department of Justice records indicated

[8] t 31.10.18, p312
[9] t 31.10.18, p238

Mr Jackamarra self-reported an abusive childhood. This is repeated in the Northern Territory sentencing details with respect to his offending in that territory.[10]

Nonetheless, it is clear Mr Jackamarra was well loved by his many siblings and significant adults in his life as he was growing up. His older brother operates a successful tourist business outside Broome and Mr Jackamarra saw his brother as a role model and looked to his family including his mother and godmother for stability at times of difficulty.[11]

Mr Jackamarra had a long history of offending since a child which would have adversely affected his education, corrected to some extent during later periods of incarceration. It is clear Mr Jackamarra was capable of reaching considerable potential had he successfully completed a reasonable education.

Mr Jackamarra's offending increased in severity to violence as he aged and he served a number of terms of imprisonment, including one with respect to a serious assault on his mother and another as the result of a very serious assault on a partner in the Northern Territory. It appears he was intoxicated at those times. Certainly Mr Jackamarra's medical records indicate increasing levels of violence when intoxicated with illicit substances or alcohol.

[10] Exhibit 3, tab 19
[11] t 1.11.18, p399

Mr Jackamarra had three children, two by the same mother. It is difficult to determine their exact ages from the papers, but I refer to Mr Jackamarra's information to Prison Officer (PO) Mundy on the morning of 16 December 2015, they were 10, 8 and 7 at that time.[12] As they were becoming older Mr Jackamarra wished to change his behaviour and provide his children with a better role model. He was attempting to change his lifestyle and obtain some employment training in areas in which he excelled. His passions appeared to be in cooking and music and he was very conscious of his appearance, attempting to always present well and keep fit. He was working in the kitchen at the local TAFE and was hoping to apprentice as a chef shortly before his death.[13] Despite past difficulties with his mother he was living with her in Broome and others in their extended family.

Mr Jackamarra had a history of mental health issues and had a well-established diagnosis of cluster B personality disorder and poly substance abuse which chronically elevated his risk of harm to both himself and others at times of acute unwellness as demonstrated by his prior self-harm and escalating violence in his offending.[14]

The fact Mr Jackamarra's mental health issues were in areas of poly substance abuse and personality disorders, as opposed to psychiatric disorders, made him exceedingly difficult to treat

[12] Exhibit 2, tab 39
[13] Exhibit 1, tab 13
[14] Exhibit 4

without his full commitment to ongoing cognitive therapy. Medication in the form of mood stabilisers, while helpful, will not provide stability when non-compliant with that medication and still abusing non-prescribed substances.[15] The medication Mr Jackamarra was prescribed was a mood stabiliser, antipsychotic, sedative and also acted as an antidepressant and to reduce anxiety.

Information provided to the Supreme Court in Darwin in August 2007 noted Mr Jackamarra was already on an established regime of anti-psychotic medication which appeared to be a stabilising influence, although it was doubted he had an enduring psychotic illness, rather he experienced drug induced psychosis on a violent underlying temperament.[16] The consultant psychiatrist reviewing Mr Jackamarra in Northern Territory reported Mr Jackamarra self-reported cannabis use since the age of 11 and ongoing excessive consumption of alcohol and amphetamine based drugs with resultant paranoid delusions and suicidal ideational behaviour. Certainly Mr Jackamarra's prison history outlines a number of alerts for self-harming behaviours.[17]

The psychiatrist described Mr Jackamarra as cognitively intact and of normal intelligence and he understood his terms of imprisonment could provide him with the stability to undertake education and rehabilitation.

[15] t 31.10.18, p219-221
[16] Exhibit 3, tab 19
[17] Exhibit 2, tab 42

Once released from Northern Territory and eventually returning to Broome the indications are that Mr Jackamarra was attempting to improve his situation, but he continued to offend through 2013 to 2015 and continued contact with the Kimberley Mental Health and Drug Service (KMHDS) and Broome Regional Aboriginal Medical Service (BRAMS). He was a client of Broome Men's Outreach Program and had been referred by their counsellor to relevant mental health services, including Broome Regional Hospital (BRH), on a number of occasions following assessment for self-harm in the two years preceding his death.[18]

Mr Jackamarra had caused issues with his family which resulted in his mother obtaining a Violence Restraining Order in August 2014 due to his behaviour. This was modified to allow Mr Jackamarra contact with his mother, but under her terms following appropriate telephone contact and arrangements.

In May 2015 Mr Jackamarra's GP at BRAMS referred Mr Jackamarra to KMHDS for an urgent review by a consultant psychiatrist. This was done on 26 May 2015 by Associate Professor (A/P) Siva Bala (Dr Bala) when Mr Jackamarra was again living with his mother. Mr Jackamarra described his drug use in May 2015 as daily amphetamine and cannabis use, with alcohol intoxication every two to three weeks. It was, "his choice in life".[19]

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[18] Exhibit 1, tab 13
[19] Exhibit 4

Mr Jackamarra was always at chronic risk of self-harm or harm to others, but it was considered unlikely hospitalisation would assist him. He was agreeable to changes in his medication, but prescribers were concerned about both his compliance and risk of overdose. It was suggested that hospital for short (less than 48 hours) periods would be appropriate at times of acute risk of harm to himself or others, but it was not possible to predict when he would transition from a chronic to acute risk.

On 7 June 2015 Mr Jackamarra breached his Violence Restraining Order by setting fire to his bedroom in his mother's home in Broome. He was arrested by police and taken to BRH where he was treated for smoke inhalation and a mental health assessment was attempted following serious physical interactions with hospital staff and police. Mr Jackamarra was released into police custody from BRH with respect to the fire. Mr Jackamarra later advised the arson had been an attempt at self-harm which had been miscalculated.[20]

Following being charged with respect to the arson incident Mr Jackamarra was remanded in custody at WKRP for 11 days to appear at Broome Magistrates Court (BMC) on 15 June 2015. He had been given bail conditions of $25,000 personal undertaking with a $25,000 surety, but none of his family or friends were in a position to sign his surety and as a result he remained in custody. In 2015 all charges dealing with arson

[20] Exhibit 4

were required to be heard in the Supreme Court of Western Australia.

Mr Jackamarra was assessed on 8 June 2015 as not being at risk of suicide or self-harm, but it was noted that he had recently lost a brother to suicide which resulted in Mr Jackamarra being placed on the At Risk Management System (ARMS) and provided with a shared cell. Other prisoners reported Mr Jackamarra had behaved oddly overnight and he was then segregated for three days with an assessment he was displaying paranoid behaviours.

On 12 June 2015 Mr Jackamarra was transferred to a standard cell in the security unit and note was made of his prior self-harming history with a decision to transfer him to Hakea Prison Remand Centre (Hakea) if he was to remain in custody after his next court date on 15 June 2015. His remand was confirmed and he was transferred to Hakea on 18 June 2015 and Albany Regional Prison (ARP) on 29 June 2015, despite an incident of attempted self-harm on hearing of his transfer. He stated he was frustrated he had not succeeded in a bail application. He was "doubled up" with a friend who was a prisoner. He was assessed by the Prison Counselling Service (PCS) and assisted with a telephone call to his mother on 28 June 2015.

Once at ARP Mr Jackamarra was placed on high ARMS with one hourly observations and constant CCTV surveillance. Few people find this level of intervention therapeutic and he was placed on low (12 hourly) ARMS within two days to share a cell

with a supportive prisoner until transferred back to Hakea pending a release to bail. He was removed from ARMS entirely on 8 July 2015, but remained in the Crisis Care Unit (CCU) at his request until transferred back to WKRP where he was released on bail due to a successful bail variation on 10 July 2015. This reduced his bail to a $5,000 personal undertaking with a $5,000 surety which his uncle, Michael Teh, provided because Mr Jackamarra's father was away at the mines and was unable to sign a surety.[21]

Once Mr Jackamarra was released on bail with a signed surety he spent time away from Broome town site with his brother's family and returned to Broome from time to time to extend his bail and surety undertakings at the BMC.[22]

In August 2015 Mr Jackamarra returned to Broome town site and again became heavily involved in drug use despite assurances to his father he would abstain. He presented to KMHDS seeking referral to a rehabilitation facility or Kimberley Community Alcohol and Drug Service (KCADS) to assist with his drug issues. Mr Jackamarra confirmed he had a history of drug induced psychosis and suicide attempts, but presented without any thought disorder, perceptual disturbance or memory impairment. He was assessed as presenting without any mental health issues at that point in time and the plan was to support his application.[23]

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[21] Exhibit 1, tab 14 Exhibit 2, tabs 41 and 42, Exhibit 3
[22] Exhibit 1, tab 14
[23] Exhibit 4

Mr Jackamarra had been a client with the Men's Outreach Services in Broome for 2 to 3 years before his death and had been referred to various services in Broome by his counsellor and support worker numerous times following a risk assessment.[24] It is clear Mr Jackamarra was comfortable using that service when he believed it useful.

On Mr Jackamarra's return to Broome in August 2015 he was living with his mother and attending the local TAFE where he was hoping to complete a course which would allow him to become an apprentice chef which he really enjoyed. His family were impressed with his commitment to learning to become a chef.

The indications are Mr Jackamarra was attempting to improve his life and relationships, but was still vulnerable at 36 years of age to the temptations of illicit substances and not always compliant with his medications. At times of non-compliance and illicit drug use he was unpredictable and prone to violence, both to himself and others.

Mr Jackamarra was last referred to KMHDS on the morning of 9 December 2015 following a telephone referral by the Duty Medical Officer (DMO) for BRH Emergency Department (ED). It was the third time in 24 hours Mr Jackamarra had presented to the ED with possible paranoid delusions during "meth" use. He was assessed as appearing to respond to unseen stimuli and

[24] t 30.10.18, p15 and Exhibit 1, tab 3

experiencing vague command auditory hallucinations to harm others, and telling him he was going to be killed.[25] He stated he had been using "meth" heavily in the last 24 hours and he had a court appearance that morning which he needed to attend. No further action was instituted.[26]

Mr Jackamarra's prison history indicated he had been placed on the ARMS many times throughout his offending history, sometimes as a result of his own request, and was entirely familiar with the process.

EVENTS OF 16 DECEMBER 2015

On the last appearance of Mr Jackamarra in BMC he had been remanded to 16 December 2015 for his first appearance in the Supreme Court (SC). This was to be by video-link to Stirling Gardens Magistrates Court at the Supreme Court in Perth, where a lawyer appearing on his behalf attended. It is not clear from the papers whether Mr Jackamarra fully understood this was his first appearance in the SC for these charges and it was no longer a Magistrates Court matter. He would, however, have been aware that he intended to plead guilty and a surety would be necessary if he were to be released on bail. He was not naïve to the criminal justice system. Mr Teh, Mr Jackamarra's Uncle, advised the Court he had been Mr Jackamarra's surety from BMC appearance to BMC appearance and had attended Court on three to four occasions to sign the papers for Mr Jackamarra.[27]

[25] Exhibit 3 & 4
[26] Exhibit 4
[27] Exhibit 1, tab 14

Overnight on 15-16 December 2015 Mr Jackamarra was at his mother's house along with his mother, older brother, his sister-in-law and their children. There had been more family members there the evening before and his mother knew Mr Jackamarra had at least smoked cannabis which he did daily.

Ms Jackamarra woke first on the morning of 16 December 2015 and when Mr Jackamarra woke reminded him he had Court that day.[28] He appeared to have forgotten, and went to have a shower and get dressed. Ms Jackamarra says her son called someone at TAFE, presumably to advise he would not be at work that morning. He told his mother to defrost some meat so he could cook them a meal that night.

Mr Teh advised the Court he was driving from Broome to One Arm Point on the morning of 16 December 2015 for his work. He had left Broome at about 6.00 am and received a call from Mr Jackamarra sometime around 8.00 am asking him to go to Court for his surety.[29] Mr Teh told his nephew he would be happy to sign his papers, but could not do it that day because he could not be back in Broome until after 6.00 pm.[30]

Following that exchange it appears Mr Jackamarra rang the Men's Outreach Centre (MORC) and, at approximately 8.10 am, asked if he could be given a lift into town as he had a court appearance and was running late.[31] Mr Harris from MORC drove

[28] Exhibit 1, tab 35
[29] t 31.10.18, p10
[30] Exhibit 1, tab 14; t 30/10/2018, p 8
[31] Exhibit 1, tab 13

to Ms Jackamarra's house and collected Mr Jackamarra and took him back to MORC via St Vinnies and the purchase of a new shirt for his court appearance.

Mr Harris thought Mr Jackamarra seemed anxious and put it down to the pending court appearance, though I speculate it could relate to a concern Mr Teh was not in a position to attend court that morning and Mr Jackamarra knew he may be remanded into custody pending his surety papers being signed. Mr Harris stated he had seen Mr Jackamarra either the day before or thereabouts, and Mr Jackamarra had seemed relatively accepting of the fact he needed to attend Court on 16 December 2015. However, on the day Mr Jackamarra seemed anxious and repeated to Mr Harris as they walked to Court that he did not want to go back to gaol, he did not want to go to prison.[32]

Mr Harris tried to reassure Mr Jackamarra that things would work out and reassured Mr Jackamarra he would attempt to contact Mr Teh should the need arise. They arrived at the BMC at around 9.00 am and Mr Harris went into Court with Mr Jackamarra to support him.[33]

Supreme Court Hearing

Mr Jackamarra's matter proceeded by way of video-link at approximately 9.40 am. A lawyer was representing him in Perth and he pleaded guilty to the charge of damaging his mother's

[32] t 30.10.18, p21-22
[33] t 30.10.18, p24

house by fire on 7 June 2015 at Broome. He was then remanded to the Perth sessions of the SC for 30 March 2016 for sentence. Mr Jackamarra understood he would need to travel to Perth for that to occur. Mr Jackamarra's bail was extended, but his surety needed to be renewed. The Magistrate advised Mr Jackamarra he would need to remain at the BMC until his surety could attend and sign the papers.[34]

Steve Jones, SERCO (custodial services) officer at the Broome Courthouse that morning noted that Mr Jackamarra's demeanour changed once it became clear his surety needed to be signed before he could leave the court premises. Mr Jones was involved in attempting to find out where Mr Teh was working that day so arrangements could be made to fax the papers which needed signing through to Mr Teh.[35]

Once Mr Teh's work location had been established Mr Harris returned to MORC to try and contact Mr Teh through the Djarindjiri Community.[36] Mr Teh stated he recalled further telephone calls that day about surety for Mr Jackamarra, one from someone called Kim (Mr Harris) attempting to organise a method by which the surety undertaking could be faxed to the clinic at One Arm Point to be signed and then be faxed back to the courthouse in Broome. There were many calls involving court personnel as well. Mr Teh went to the clinic at One Arm Point, but it was closed and he rang the court in Broome to

[34] Transcript Supreme Court WA 16/12/2015 p3
[35] Exhibit 1, tab 15
[36] t 30.10.18, p24

explain he could not sign the papers and would do it the next day. He was advised that would be fine. Mr Teh believed all that occurred between 10 and 11.00 am that morning.[37]

Mr Harris noted that when he left Mr Jackamarra in Court with the SERCO officer he seemed more apprehensive than he had earlier because he understood he would be held in custody pending the signing of the papers,[38] but Mr Harris was not concerned Mr Jackamarra was suicidal despite knowing people with mental health issues can deteriorate very rapidly. Had Mr Harris had any concerns about Mr Jackamarra's state of mind he would have advised the SERCO officers in Court.[39]

Custody at Broome Court House (SERCO)

Mr Jones stayed with Mr Jackamarra in the back of the Court as a more comfortable place to wait while efforts were made to contact his surety. Mr Jones noted that earlier Mr Jackamarra had been laughing and joking in the court with Mr Harris,[40] but as it had become clear there would be a delay Mr Jackamarra became less responsive and withdrawn. Mr Jones knew Mr Jackamarra and attempted to chat with him while ensuring court security.[41]

Mr Jackamarra had a cast on his arm and it was necessary SERCO staff obtain a restraints variation order to enable them

[37] t 30.10.18, p10
[38] t 30.10.18, p30
[39] t 30.10.18, p31-32
[40] t 30.10.18, p42
[41] t 30.10.18, p45, 54

to cuff Mr Jackamarra with one arm only to take him down to the Custody Centre (CC) for processing. The restraints variation was obtained by Shannon Wellstead, Acting Client Services Manager (ACSM) for SERCO in Broome at that time. Mr Jackamarra was taken down to the CC where he was processed into the SERCO computer system at the SERCO Electronic Recording Station (SERS) with Mr Jones asking questions about his medical and mental state and any need for daily medication.

Mr Jackamarra told Mr Jones he required daily medication in the form of mood stabilisers, but did not have them with him and had not taken any that day.[42] Mr Jones believed Mr Jackamarra appeared quite unprepared for a stay in custody. Mr Jones noted Mr Jackamarra had become withdrawn and had stated in court he was about to pass out immediately after he had been told he would be required to stay in custody pending his surety.

Mr Jackamarra advised Mr Jones that he suffered from depression and had a prior self-harm attempt, all of which either Ms Wellstead or Mr Jones logged onto SERS. This was occurring at approximately 10.20 am.[43] Mr Jones also reassured Mr Jackamarra he would make his own attempts to find Mr Teh which he did once Mr Jackamarra was in the CC holding cells.

[42] t 30.10.18, p51
[43] t 30.10.18, p49

Each time Mr Jones went in to see Mr Jackamarra, Mr Jackamarra asked about progress on contacting Mr Teh. He was not really responding to any other conversation. All items with which Mr Jackamarra might harm himself were automatically removed before placing him in the holding cells, which are very sterile with nothing to do.[44]

At about 11.35 am Mr Jones realised Mr Jackamarra was banging his head against the cell wall. This did not appear to be particularly forceful when observed by SERCO officer Trevor Mitchell,[45] but reflected a certain amount of frustration on the part of Mr Jackamarra. Mr Jones went in to see Mr Jackamarra and asked that he stop banging his head because there was concern for his safety. He could see Mr Jackamarra was not injured and in fact Mr Jackamarra did not complain of anything other than to say "I just want to go over the road", by which Mr Jones believed he meant the prison.[46] Having satisfied himself there were no injuries on Mr Jackamarra and, with his undertaking he would not attempt further harm, the staff in the CC concentrated on attempting to get Mr Jackamarra into B(R)P as soon as was reasonable.

The fact Mr Jackamarra had banged his head on the wall was recorded on the event report.[47]

[44] t 30.10.18, p54
[45] Exhibit 1, tab 17
[46] t 30.10.18, p 62
[47] Exhibit 2, tab 38

Derek Lee, Custodial Services Officer with SERCO, had not expected to need his uniform that day, but was advised by Ms Wellstead he needed to put on his uniform because there was someone in custody. On his return he heard the radio call from Mr Jones that the person in custody was banging his head against the wall. All SERCO staff available rushed to the holding cell and Mr Lee realised the person in custody was his nephew. He was now calm.[48] Mr Lee spoke with Mr Jackamarra and he wanted to know when he would go "across the road". He was reassured it would be as soon as they could complete the paperwork and Mr Jackamarra said to tell his mum "I said goodbye". Mr Lee believed this was about going into prison and he did not think it referred to anything else.[49]

Part of the SERS process is the generation of a Person in Custody (PIC) form which records incidents while a person is in SERCO's care. It is supposed to be logged on the prison system, Total Offender Management System (TOMS), as part of the transfer. There seemed to be uncertainty between SERCO employees and B(R)P staff as to how exactly this was done. The procedures indicate the PIC form in its entirety goes from SERCO and records the transfer of a prisoner from BMC CC into B(R)P. TOMS is supposed to pick up information from SERS once generated and put it onto the TOMS system. Meanwhile the documentary PIC hard copy goes with the prisoner in the transfer truck. There was some difficulty from the prison staff perspective

[48] Exhibit 1, tab 19
[49] t 31.10.18, p252-253

as to how exactly that happened or what they received in hard copy. The different expectations between SERCO staff and B(R)P officers as to the form of documentation was undoubtedly confused in this instance.[50]

It is clear the hard copy PIC form was not taken with Mr Jackamarra in the truck, although other documentation was, and the expectation of SERCO employee, Derek Lee, was that the information from SERS on the PIC form would automatically transfer to TOMS. This is consistent with Mr Jones' recollection of Mr Lee's discussion with him in the sally port about the need for the prison to understand that Mr Jackamarra had banged his head in the holding cell and did not have his medication that day.[51] Mr Lee believed the hard copy custody intake form he had with him served as the exchange of information. He agreed he forgot to generate transfer of the electronic PIC.[52]

Although it was not clarified as to what, there was also the need to show documentation relevant to Mr Jackamarra at both the prison gate and prison reception.

Exhibit 2 tab 38 contains the documents in question. They consist of a hand written Custody Intake Summary form, a hand written occurrence log of events and a printed PIC form. Mr Jones' evidence was the PIC form was generated on SERS then to a tablet[53] which was populated by the operator of the

[50] t 30.10.18, p67
[51] t 30.10.18, p68 & 272
[52] t 31.10.18, p254, 256, 268 & 270
[53] t 30.10.18, p77

tablet in the truck escort, in this case Mr Lee. The Custody Intake Summary Form outlined that Mr Jackamarra required mood stabilisers which were at home and they were needed because he had not taken any that day and emphasised he needed medication. It noted that Mr Jackamarra had become more withdrawn since saying in Court he felt like he would pass out. The Occurrence Log filled out by Mr Jones indicated that at 11.36 am Mr Jackamarra was banging his head against the wall and that he was spoken to by Mr Jones before leaving for the prison, which occurred at 11.41 am.

Ms Wellstead indicated her understanding of the SERS computer system was that the PIC information would be transferred to the prison via email, but she did not understand precisely how it worked.[54] Ms Wellstead said she could have telephoned the prison or emailed them directly, but she was under the impression the information put on SERS would be generated and go to the prison. She did not consider there was anything particularly untoward with Mr Jackamarra's presentation, but she was concerned about his lack of medication and had been alerted to the fact Mr Jones believed he was self-harming.

It is clear from the documentation Mr Jackamarra's court hearing occurred at 9.30 am and Ms Wellstead's timings in her statement[55] are out by one hour.

[54] t 30.10.18, p113
[55] Exhibit 1, tab 18

Ms Wellstead went onto say it was her understanding that Mr Jackamarra just wanted to get out of the holding cells and go to the prison until his surety was organised. She believed that would be more likely to happen through the prison. She commented on how unfriendly the holding cells were in the CC at the BMC.

It was Ms Wellstead's recollection Mr Lee went into the office to get the tablet. She understood the tablet hooked into the SERS system and recorded the information already in SERS about prisoners in custody, through their transport then into the prison. A red or green envelope was recorded on the tablet to indicate whether the information from SERS had been communicated to the prison via email.[56]

It was Ms Wellstead's understanding that Mr Jackamarra's behaviour in banging his head was frustration because he wanted to go to the prison. This was notwithstanding Mr Jones was very concerned Mr Jackamarra was depressed. There were areas of the custody area that did not have adequate CCTV coverage at that time.[57]

The SERCO operational instructions specify that where a person in custody is suspected as being at risk of self-harm then a completed PIC event report (SERS) should be supplied to, in this case, B(R)P. If SERS was not available then it should be done by

[56] t 30.10.18, p116
[57] t 30.10.18, p119

way of the manual forms.[58] Mr Jones was unaware of the mechanism of transferring information, but he believed B(R)P would understand that Mr Jackamarra was at risk because as far as he was concerned he had filled out the PIC which then needed to be transferred to the prison. Mr Jones had noted that Mr Jackamarra had said that he would feel better in custody.[59]

Ms Wellstead said she put on SERS that Mr Jackamarra was to be moved as soon as possible because he did not like being in the holding cell.[60] It is Ms Wellstead's memory that Mr Jackamarra kept asking about his surety and she understood that the PIC was transferred via email on the tablet.

Ms Wellstead agreed she did not communicate with the prison once Mr Lee advised her he had not generated the PIC Event Form.[61] Ms Wellstead also agreed she did not report adequately on the Incident Report Form to SERCO later that night.[62] There would have been little point in reality by then.

Following Mr Jackamarra leaving the CC sally port in the truck bound for the prison, Mr Jones went on with his attempts to facilitate the faxing of Mr Jackamarra's surety papers to the community for signature by Mr Teh. Mr Jones' last contact with Mr Teh, recorded on his telephone, was at 12.10 pm on 16 December 2015.[63]

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[58] t 30.10.18, p99
[59] 30.10.18, p98, Ex 2, tab 38
[60] Exhibit 1, tab 18
[61] t 30.10.18, p121
[62] Exhibit 3, tab 12
[63] t 30.10.18, p60-61, Exhibit 1, tab 15

Transfer to B(R)P

Mr Jackamarra was transferred the 500 metres to B(R)P from BMC CC in the SERCO truck at about 11.40 am. The Escort Officer was Mr Lee and the driver Pauline Fitzgerald. Mr Lee was related to Mr Jackamarra and was concerned about his conduct. He advised the Court he spent his time during the escort from the holding cells to B(R)P watching Mr Jackamarra through the truck CCTV. He was very anxious that Mr Jackamarra be transferred without mishap having been aware of the head banging incident earlier.[64]

Mr Lee had the tablet and he was of the understanding that the tablet transferred the SERS information onto TOMS and it recorded the observation checks. Mr Lee agreed he had not pressed the button to transfer the transfer information from the journey onto the prison system as he approached B(R)P gate which is when it was normally done. He did have with him the custody intake form.

Mr Lee recorded all observations during the transfer that he believed to be relevant to Mr Jackamarra's safe transport.

Mr Lee understood they required the paperwork through the Court system containing Mr Jackamarra's warrant before he could be transferred to the prison. It was his understanding the warrant and the Custody Intake Summary were to be transferred

[64] t 31.10.18, p257, 259

to the prison with the prisoner. Mr Lee said he checked the Custody Intake Summary was attached to the warrant.[65]

It is clear from Exhibit 2 tab 38 the Custody Intake Summary Form and the PIC Event Report are different SERCO documents. I do not believe this was functionally clear to Mr Jones and Mr Lee at the time and there seemed to be some confusion the documents were substantially the same. Mr Lee was clear he took the hard copy of Mr Jackamarra's Supreme Court Warrant, his Custody Intake Summary Form and his property to transport to prison with Mr Jackamarra. That was Mr Lee's responsibility and he was clear that was what he did as well as observe Mr Jackamarra intently during the actual transfer.[66]

Mr Lee did not check the observations on the tablet because he was focusing on Mr Jackamarra's welfare through the cameras. The route they took to the B(R)P took between 3 and 4 minutes. He was aware of Mr Jackamarra's behaviour in the holding cells and just wanted to get him safely to the prison where it was his belief he would be assisted with his bail issues.

The other officer, Ms Fitzgerald, was solely the driver. It is clear the CCTV within the transfer pod is better than that available in the CC.[67] Mr Lee rang the prison and advised them they were coming across to the prison with Mr Jackamarra. Mr Lee advised the prison that Mr Jackamarra was being "non-compliant" when

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[65] t 31.10.18, p254
[66] t 31.10.18, p257
[67] t 31.10.18, p255

he advised them of his imminent arrival due to Mr Jackamarra's behaviour to one of the other SERCO officers as he was first put into the truck.[68]

On arrival at B(R)P the truck was reversed up to the gates and two prison officers came down to escort Mr Jackamarra to reception. Mr Lee told them Mr Jackamarra was sitting down and was quite calm. Mr Jackamarra was handed over to the prison officers and Mr Lee took his paperwork to the reception area while Ms Fitzgerald stayed with the truck. At the reception the paperwork was assessed by a prison officer.

Mr Lee again advised the reception prison officer that Mr Jackamarra was being non-compliant because he was not listening to what he was being told. Mr Lee did not advise the prison officer at reception that Mr Jackamarra had banged his head on the cell wall or use the term self-harming.

Mr Lee thought Mr Jackamarra appeared to be lively and pretty happy and he had no concerns for Mr Jackamarra about delivering him to the prison which is where he wanted to go. Had Mr Lee had any concerns about his nephew he would have advised the prison gate and the reception area.[69]

Mr Lee was clear he had handed over the warrant, Mr Jackamarra's property and the Custody Intake

[68] t 31.10.18, p256
[69] t 30.10.18, p261

documentation. He did not raise the head banging incident because he understood it would be in the paperwork he had handed over. Mr Lee's main concern was Mr Jackamarra's behaviour whilst being transferred. Mr Lee advised the Court he had forgotten to do a PIC generation report on this occasion, but he understood the relevant information would be on the Custody Intake Summary form he had provided.[70] Mr Lee observed his nephew as he was leaving and returned to the truck, leaving B(R)P at 11.48 am. His last view of Mr Jackamarra was that he was calm and seated.[71]

When Mr Lee heard about Mr Jackamarra's death later that day he was in shock because his impression of Mr Jackamarra was that he was okay.

Mr Lee advised Ms Wellstead he had not generated the PIC Event Report and it was sent through the system that night.[72]

There seems to have been an issue with documentation at the admission to prison point. The production of paperwork is required both at the gate and at reception. It is not clear what happened to the Custody Intake Form. At the time of Mr Jackamarra's transfer there appears to have been no clarity with staff about precise documentation. The documentation which is required and which gets retained is the warrant and the PIC Event Report which had not been generated electronically.

[70] t 31.10.18, p263
[71] t 31.10.18, p264
[72] t 30.10.18, p121

ADMISSION TO B(R)P

Mr Jackamarra arrived at the B(R)P gates at about 11.45 am. The A/OIC for the B(R)P that day was Richard Swarbrick and he had been advised by SERCO that Mr Jackamarra was on his way over to the prison, was not happy and had been punching walls. A/OIC Swarbrick knew Mr Jackamarra and went down to receive Mr Jackamarra at the gate. He took with him another officer in case Mr Jackamarra was intending to be difficult.[73]

A/OIC Swarbrick found Mr Jackamarra to be fine, he came out of the truck without issue and A/OIC Swarbrick noted he had a cast on his arm. Mr Jackamarra, in response to his query, advised he had a broken arm, but did not expect to be at the prison for long. A/OIC Swarbrick believed Mr Jackamarra was waiting for his mother to go surety for him.

A/OIC Swarbrick did the prisoner property hand over at reception while PO Jason Mudry completed the check list. A/OIC Swarbrick stated that in his experience the hand over from SERCO was verbal,[74] he could not recall any paperwork being provided in 2015 other than a warrant and he was not aware of ever having received a PIC. He observed the Peer Support reception prisoner, Joseph McCarron, provide Mr Jackamarra with a pie for lunch and noted an interaction between the two over some crumbs.

[73] t 30.10.18, p127
[74] t 30.10.18, p130

Mr McCarron advised the Court that while he thought Mr Jackamarra was quieter than he remembered, he believed that he was fine. He had overheard the question about self-harm to which Mr Jackamarra had replied, "no".[75] Mr McCarron told Mr Jackamarra he would go up to the security yard to see him later and to see how he was going, but was not concerned about Mr Jackamarra or he would have told someone.[76]

The rest of the process for admission was completed by PO Mudry who had been waiting for Mr Jackamarra at reception. Mr Jackamarra was recorded as arriving at reception at 11.59 am.[77] PO Mudry completed the ARMS reception intake assessment[78] with Mr Jackamarra and agreed Mr Jackamarra appeared calm and relaxed, although unhappy about being back in prison. He did not think Mr Jackamarra was suicidal and did not see any reference to Mr Jackamarra's behaviour while at BMC CC in the documentation, though he knew from A/OIC Swarbrick that Mr Jackamarra would be arriving and had been agitated at BMC. Mr Jackamarra told PO Mundy he was expecting both to get bail and support from his family. He knew Mr Jackamarra needed medication, but had only been advised about pain killers, not mood stabilisers. He thought that could be sorted out once he contacted his family.

PO Mudry saw from the warrant Mr Jackamarra had bail and was attempting to get his Uncle to go surety. He advised

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[75] t 31.10.18, p327
[76] t 31.10.18, p330
[77] Exhibit 2, tab 22; t 30.10.18, p77
[78] Exhibit 3, tab 14

Mr Jackamarra he would try and get him through the admission process as soon as he could and then told Mr Jackamarra to go up to the security yard and organise his family for the surety.[79] PO Mudry did not receive a PIC and advised the Court they did not receive them regularly as a piece of paper, later clarified to never,[80] nor did he expect to receive one electronically.[81]

PO Mudry did not believe it was his responsibility to chase the PIC, and he had not been trained that it was. PO Mudry's focus was the intake assessment he was required to do, for his view as to how Mr Jackamarra presented. He did not believe Mr Jackamarra was suicidal, was not told he was, and had no concerns about him. He specifically asked Mr Jackamarra about the head banging incident and was told he was frustrated.[82] Had PO Mudry believed Mr Jackamarra was suicidal he would have placed him on ARMS. PO Mudry believed Mr Jackamarra was focused because he wanted to spend time with his kids and gave their ages.[83] Aside from asking Mr Jackamarra the specified questions PO Mudry did not check TOMS for prior alerts to do with self-harm, only whether there was a current ARMS alert on TOMS.[84] PO Mudry did not believe Mr Jackamarra was at risk of self-harm at the time he was in reception. He seemed fine and so PO Mudry processed him through to go up to the security yard.[85] If PO Mudry had been concerned he would have entered

[79] t 30.10.18, p179
[80] t 31.10.18, p324
[81] t 30.10.18, p179
[82] t 30.10.18, p180
[83] t 30.10.18, p103
[84] t 30.10.18, p185, 190
[85] t 30.10.18, p186

the concern on the computer and been guided automatically to the ARMS process which would have involved another prison officer in the decision-making process as to the level of ARMS pending medical assessment. In December 2015 there were no health service staff present in reception for the reception process.[86]

Following the reception process Mr Jackamarra was escorted to the security yard by PO Jeremy Van Schie at approximately 12.25 pm. PO Van Schie thought Mr Jackamarra was in a low mood, but did not appear to be distressed. Mr Jackamarra asked if he could speak to an Aboriginal Visitor Scheme person and PO Van Schie advised him there was an Aboriginal female support officer in B(R)P that day.[87] He arranged via PO Anthony Hebble for that to occur. Once in the security area Mr Jackamarra was told where he could smoke and it was suggested he look for a cell to move into once unlock had occurred in approximately 5 minutes.

PO Hebble had been advised earlier by A/OIC Swarbrick that Mr Jackamarra was on his way to B(R)P. He later escorted Ms Taz Kaino, prison support officer, into the security yard to talk to Mr Jackamarra, whom Mr Hebble believed he knew reasonably well.[88] Once PO Hebble had escorted Ms Kaino to the dining room he called Mr Jackamarra to the dining room to talk to her.

[86] t 30.10.18, p192
[87] t 31.10.18, p294
[88] t 31.10.18, p306

PO Hebble advised Mr Jackamarra that when he had finished talking to Ms Kaino he should find PO Hebble so PO Hebble could orientate him and help him with telephone calls to his family to organise his bail/surety.[89]

Ms Kaino advised the inquest her role as a prison support officer was to help prisoners with contacting their families and talking to them about any concerns with respect to self-harm. She was actually employed at WKRP in Derby, but visited B(R)P on the 3rd week of each month. It just happened she was there that day and she had known Mr Jackamarra since he was a child.

Ms Kaino believed Mr Jackamarra was upset about his bail, but was pleased to see her. Once he sat down he started to cry and asked Ms Kaino to go and see his mother and apologise to her and say goodbye. He understood she was not supposed to do home visits. Ms Kaino asked Mr Jackamarra if he was going to do anything silly and he replied no and he would not be there for long. Ms Kaino took that to mean that Mr Jackamarra was expecting his surety to be finalised in the near future.[90] Ms Kaino advised Mr Jackamarra she would ask for a special visit so Men's Outreach could go and get his mother so she could visit him. Mr Jackamarra seemed angry no-one had paid his bail,[91] but was confident it would be done the next morning. Ms Kaino believed the term he used "gone in the morning" meant he was sure his Uncle would come in and sign the surety the following

[89] t 31.10.18, p307
[90] t 30.10.18, p198
[91] t 30.10.18, p199

day. She said he stopped crying and told her he would see her in the morning after they had talked for a while about his intentions for the future.

Ms Kaino advised the Court he laughed about some things and she was not concerned about him at all or she would have spoken to a PO and he would have been put on ARMS.[92]

PO Van Schie[93] and PO Hebble[94] agreed Mr Jackamarra was not upset or crying once Ms Kaino left. Ms Kaino then went to talk to A/OIC Swarbrick after talking to PO Van Schie because she was querying whose job it was to contact Mr Jackamarra's family.[95] Ms Kaino advised she went to see A/OIC Swarbrick to ask for a special visit for Mr Jackamarra's mother, although A/OIC Swarbrick's recall (which he had noted on the reverse of a scrap of paper on 20 December 2015) was that Ms Kaino had asked him about contacting Mr Jackamarra's mother on Mr Jackamarra's behalf. A/OIC Swarbrick did not believe that necessary as Mr Jackamarra was in security and would be assisted by the prison officers there in any telephone contacts he needed to make.[96]

PO Hebble confirmed he had advised Mr Jackamarra to see him about arranging telephone contacts following his visit with Ms Kaino.[97] After he saw Ms Kaino leave PO Hebble went to see

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[92] t 30.10.18, p200
[93] t 31.10.18, p295
[94] t 31.10.18, p307
[95] t 31.10.18, p295
[96] t 30.10.18, p153
[97] t 31.10.18, p308

Mr Jackamarra to advise him of any changes to processes and procedures in B(R)P since his last stay. The main difference was the procedure with respect to visits which were now required to be organised through WKRP in Derby.[98] PO Hebble recalled Mr Jackamarra was sitting in the dining area and he told PO Hebble he would go and find him if he felt he needed to make any telephone calls.

Ms Kaino's recall was that Mr Jackamarra had walked out of the dining room saying he was going for a shower. PO Hebble found Mr Jackamarra in the dining room and advised him he would go through the orientation check list with him.[99] PO Hebble believed he had completed his talk with Mr Jackamarra by 1.30 pm and that he then went and entered details on the computer in the security office.[100]

After 1.30 pm there is little specific information about Mr Jackamarra. Prisoner Michael Rex in cell 4 stated he had noticed a new bag of prison greens in P4 prison cell which he shared with prisoner Andrew Dorizzi, at about lunchtime.[101] He noticed it before a new group of people came through after dinner. He did not know who they belonged to.

The prison officers in the security yard office believed they observed Mr Jackamarra interact with other prisoners, but

[98] t 31.10.18, p312
[99] Exhibit 1, tab 26B; t 31.10.18, p310
[100] t 31.10.18, p315
[101] Exhibit 1, tab 34

nothing specific. It is clear he had chosen a cell by that time because it was recorded by PO Hebble on the board.

Prisoner Fred Maru stated he went into the security area shower block at about 1.00 pm and sometime after that saw Mr Jackamarra walk past his cell, but he was unsure of the time. He knew Mr Jackamarra well and recognised him.[102] Mr Maru wanted to say hello so he went to find him. Mr Jackamarra was not in his cell, but he had seen him with Mr Dorizzi so he went to ask him where Mr Jackamarra was. Mr Dorizzi told Mr Maru that Mr Jackamarra was in the toilet and told him to go and check it out.

Mr Maru sat in the day room waiting for Mr Jackamarra thinking he was either busy or "doing drugs". Mr Maru thought Mr Dorizzi was acting "a bit strange" and kept looking over to the shower blocks. Eventually Mr Maru went back to his cell, but was not aware of the time.

Prisoner Dennis Smith stated he went to the toilet block sometime before supper to urinate at the urinal. No-one else was there. When he turned around to walk out he saw a male hanging in the shower next to the door. He did not know who it was, but believed he was dead. He immediately ran out to tell the prison officers.[103]

[102] Exhibit 1, tab 32
[103] Exhibit 1, tab 31

The Coroners Court of WA does not currently have the power to compel the making of statements, but can summons witnesses. Mr Dorizzi declined to make a statement at the time and the Court has not been able to locate him to give evidence. Mr Maru and Mr Smith were both summonsed, but Mr Maru was not served. Arrangements were put in place for Mr Smith to give evidence via video-link from Alice Springs, but he did not re-attend the Alice Springs Court after attending first thing in the morning. The police officers serving him on behalf of the Coroners Court of WA could not then locate Mr Smith despite making serious efforts.[104]

The prison officers in the security yard office noted Mr Smith come to the window at roughly 2.12 to 2.15 pm on 16 December 2015. There were three prison officers then present in the office, PO Van Schie, PO Hebble and PO Hellwood. None of them heard Mr Smith clearly and PO Hebble stood up and put his ear to the grille and heard Mr Smith say, "Boss, there is someone hanging in the shower".[105]

PO Hebble immediately instructed PO Hellwood to call a medical emergency and PO Van Schie asked what was happening. On being told what Mr Smith had said PO Van Schie ran to the showers and PO Hebble accessed the restraints cupboard to obtain a Hofmann knife. He then ran to A Block, passing Mr Smith who repeated "in the shower".

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[104] t 31.10.18, p 303, 323, 336
[105] t 31.10.18, p 297, 315

PO Van Schie reached the shower block and saw Mr Jackamarra hanging, he saw no-one else present. He immediately lifted Mr Jackamarra up to relieve the pressure on his neck and heard the code red being called. He also called for a kit to be brought urgently. Mr Jackamarra had used his shirt as a ligature and it was difficult to free him. PO Hebble arrived with the Hofmann knife and between them they released Mr Jackamarra and placed him on the ground to commence cardiopulmonary resuscitation (CPR) with PO Hebble doing compressions. A/OIC Swarbrick arrived and instructed the ambulance be called and for the prisoners to be secured in their cells while he and PO Hebble continued with CPR.[106] PO Van Schie started scribing events. Medical staff arrived with the defibrillator and resuscitation continued until the St John Ambulance (SJA) service arrived.

Daniel McKirdy, Ambulance Paramedic, advised the Court SJA service received a call from B(R)P at 2.17.31 pm, although the call centre telephone call is recorded at 2.14 pm on the Patient Care Records.[107] They arrived at the prison at 2.25 pm,[108] with his back up crew arriving at 2.28 pm.[109] The paramedics were taken straight through to the shower block and observed CPR and oxygen being applied. Mr McKirdy stated the SJA records revealed no concern about the quality of the prison staff resuscitation[110] including proper use of a defibrillator.

[106] t 31.10.18, p 134, 298, 318
[107] Exhibit 2, tab 49
[108] t 31.10.18, p282; Exhibit 1, tab 6
[109] t 31.10.18, p284
[110] t 31.10.18, p287

I am satisfied that once the situation was understood Mr Jackamarra received prompt and effective resuscitation. He was transferred to BRH still under resuscitation efforts which were unsuccessful and he was declared deceased at BRH.

POST MORTEM REPORT

The post mortem examination of Mr Jackamarra occurred on 24 December 2015 and was performed by Dr C T Cooke, then the Chief Forensic Pathologist at the PathWest Laboratory of Medicine WA.

Dr Cooke observed a faint mark to the skin of the neck with internal neck injury comprising two small areas of bleeding into the muscles of the neck, one associated with the fractured right superior horn of the upper thyroid cartilage. In Dr Cooke's view these injuries are typical of neck compression. Other than early indications of ischemic heart disease internal organs revealed no pathology.

There was a fracture at the base of the left thumb and a wide scar on the left mid and lower forearm. There were other signs of medical intervention including rib fractures consistent with resuscitation.[111]

The external examination of Mr Jackamarra revealed no suspicious soft tissue injuries and Dr Cooke noted

[111] Exhibit 2, tab 33

Mr Jackamarra's fingernails were long and smooth with no bending back or breakage. One of the purposes of a thorough forensic post mortem examination is to ensure there are no unexplained injuries inconsistent with the history given surrounding the death. There were none in this case.

Post mortem toxicology revealed methylamphetamine and tetrahydrocannabinol,with traces of amphetamine, citalopram and quetiapine in the post mortem urine.[112]

Inquiry of Dr Bala during the course of the inquest concerning Mr Jackamarra's need for mood stabilisers, which he had prescribed in May 2014, indicated there was enough of his prescribed medication in his system for Dr Bala not to be concerned that Mr Jackamarra's mood that day had been affected by a lack of medication.[113]

At the conclusion of all the investigations Dr Cooke was of the opinion the death of Mr Jackamarra was caused by ligature compression of the neck, as opposed to any other type of compression, and there were no unexplained injuries of concern.

CONCLUSION AS TO THE DEATH OF MR JACKAMARRA

I am satisfied Mr Jackamarra was a 36 year old Aboriginal male. He had a significant criminal history with offences of considerable violence, mostly against women, including his

[112] Exhibit 2, tab 45
[113] t 31.10.18, p234, 240

mother. The majority of his offending reflected his use of alcohol and illicit substances, and when not intoxicated he expressed a desire not to be violent.[114]

Mr Jackamarra's substance misuse coincided with a significant history of mental health issues in the form of personality disorders for which he was medicated, but was not always compliant. The difficulty with personality disorders is that they do not respond to medication in a way psychiatric disorders may respond. While mood stabilisers are useful they are ineffective as long term management without engagement with significant long term psychological therapy and the avoidance of substance abuse.[115] Attempts to self-medicate by the use of illicit substances often has the opposite effect.

Mr Jackamarra had been a long term client of KMHDS and was well known to the service. In May 2015 his GP at BRAMHS had requested Mr Jackamarra be reassessed by the Consultant Psychiatrist at KMHDS for a diagnosis to assist BRAMHS in his ongoing management. This was undertaken by Dr Bala on 26 May 2015.

Dr Bala's opinion was that Mr Jackamarra's principle diagnosis was of anti-social and border-line personality disorder (cluster B) and substance use disorder consisting of amphetamines, cannabis and alcohol.[116] Mr Jackamarra had a chronically

[114] Exhibit 4
[115] t 31.10.18, p217-219
[116] t 31.10.18, p217

elevated risk of harm to himself and others, with limited treatment options in the absence of addressing his substance use and learning emotional regulation skills. A change in Mr Jackamarra's medication was suggested, but he needed to be compliant and engage in substance abstinence.

In evidence Dr Bala described the personality disorders affecting Mr Jackamarra as having moods and emotions which fluctuate rapidly and a lack of empathy for others with difficulty in assuming responsibility or learning from experience. The management options in Mr Jackamarra's situation revolved around crisis management, risk assessment and keeping patients safe at times of elevated risk. However, keeping patients like Mr Jackamarra safe was hard because of the tendency to exploit others, be manipulative and untruthful, and not accept they are in need of therapy.[117] Dr Bala believed Mr Jackamarra's risk of suicide was always high (chronic) and that he could destabilise to acute risk very rapidly. Dr Bala did not consider admission to hospital was likely to reverse Mr Jackamarra's risk of self-harm or harm to others, and felt he should only be admitted in the short term (24 to 48 hours) to contain the risks. There were occasions on which the risks for Mr Jackamarra actually increased in hospital, such as his attempted suicide by running in front of a car.

[117] t 31.10.18, p219

> *"He presented as someone who was chronically risky and impulsive, who could change very quickly. So the role of hospital admission is limited in this spectrum of care".*[118]

Dr Bala recommended a longer acting medication, but restricted the dispensing option to weekly in view of Mr Jackamarra's risk of overdose. The safety plan at times of acute of suicidality was a very short hospital stay, with the involvement of police if Mr Jackamarra appeared to be threatening towards others. This was explained to Mr Jackamarra and he was given the option for further review.

It was following this review in late May 2015 that Mr Jackamarra's offending in respect to his mother's house occurred in early June 2015.

Mr Jackamarra's serious episodes of elevated risk frequently coincided with his extreme poly-substance abuse. In the weeks prior to his arson offences he had been expressing concern as to paranoid delusions and seeking engagement with KMHDS for a referral for rehabilitation. On the night of the fire Mr Jackamarra had expressed different versions of the reasons for the fire to KMHDS psychiatric liaison staff and police. Conversations with neighbours alerting authorities to the fire did not reflect any self-harming behaviour on the part of Mr Jackamarra at the time, although he appeared intoxicated. He was released from hospital care to police with a warning as to his chronic potential for self-harm when unwell.

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[118] t 31.10.18, p221

Once Mr Jackamarra was released back into police care he was charged and the events transpired with respect to his remands and the need for bail and surety evolved. Mr Jackamarra was well acquainted with the criminal justice system and aware of the fact he would need to renew his surety for Court extensions of his bail as outlined by Mr Teh, regardless of whether he understood he was now appearing in the SC rather than the BMC.

It is against this background Mr Jackamarra entered custody on 16 December 2015. He was always at chronic risk of self-harm and to others, it took very little to elevate that risk to acute. He had a history of self-harm and harm to others and it was impossible to predict exactly how or when he would destabilise.

I accept entirely that when not feeling stressed Mr Jackamarra could be a loving and caring individual as described by his family. I have no doubt that when stable Mr Jackamarra longed to have a good relationship with those around him and wished he could be a stable mentor to his young children. He certainly had the potential to succeed as a useful contributor to his community.

On the morning of the 16 December 2015 Mr Jackamarra realised he would need surety for his court appearance on that day. He had not made prior arrangements. He rang his Uncle to discover he had other commitments for work that day and would not be in a position to attend in Court. I speculate

Mr Jackamarra anticipated that may cause him difficulties later in the day and was an additional anxiety for him when he asked Mr Harris to take him to court for his hearing. That would have been in addition to the uncertainty as to what would happen following his plea of guilty to the charges he was facing. Whether he knew he would be required to re-attend court at a later date for sentencing is not clear, but it was highly likely. He could have been remanded in custody or released on bail for which he needed surety. Either way, without surety, he would be spending time in custody.

The hearing proceeded and he was remanded for sentence with bail and a surety. Mr Teh could not be there and it is clear from Mr Harris' and Mr Jones' attempts to contact Mr Jackamarra's family no-one else was in a position to act as surety. I am satisfied on the evidence significant attempts were made by various people during the course of the morning to enable Mr Teh to sign the surety undertaking in a remote location. Those attempts were unsuccessful.[119] Making appropriate arrangements for Mr Jackamarra's surety were always Mr Jackamarra's responsibility.

Matters once Mr Jackamarra was in custody were then uncontrollable from Mr Jackamarra's perspective. He was the responsibility of SERCO employees in the BMC CC holding cell, with nothing to distract him and was entirely reliant on others. I have no doubt he found that destabilising and frustrating.

[119] t 30.10.2018, p61

Partly because he would have realised he should have discussed the matter with Mr Teh prior to that morning. After consistently asking Mr Jones what was going on Mr Jackamarra began to bang his head against the wall of the holding cell. I have no doubt this was frustration rather than self-harm, but I am also satisfied that it was a very real signal Mr Jackamarra was becoming increasingly agitated, and in view of his potential to destabilise, a real signal for concern.

Mr Jones appropriately communicated with Mr Jackamarra and Mr Jackamarra promised to stop, but also requested transfer to B(R)P. This is entirely understandable despite the conditions in B(R)P. There he would have access to people he knew, he could move around and possibly, more importantly, access the means to communicate with his family about his surety problems.

SERCO staff were understandably anxious Mr Jackamarra be removed to an undeniably more friendly environment. He had expressed he felt he would have more support in prison[120] and I am satisfied he was familiar enough with B(R)P for that to be true. Unfortunately, the understanding of the need for Mr Jackamarra to be moved to a more comfortable environment did not translate into a proper understanding of the continuity of documentation. While Mr Jones was clear the PIC form needed to be communicated to the prison, no-one from SERCO at that time seemed to understand the mechanism by which that was

[120] t 30.10.18, p98

successfully achieved.[121] Perceived compliance with the standing orders and policies did not translate into the appropriate channels for receipt of the information into B(R)P in a recordable form.

Mr Lee believed the documents he had taken with him in the truck included the PIC whereas I suspect it was only the SERCO custody intake summary form, which was disregarded as not being the PIC form, and that Mr Lee's assurance to Mr Jones it was, "On TOMS" was his understanding the PIC was automatically downloaded from the transfer process onto the prison system via the tablet. It would have been, had that been done. It only occurred with a positive manual intervention later that night, once Ms Wellstead understood from Mr Lee it had not been generated into the prison system.[122] It was too late for the specific information contained with respect to medications and head banging to be of use.[123]

Nevertheless, it is clear Mr Lee was very attentive to his nephew's well-being during the course of the transfer to B(R)P and believed him to be calm by the time he was handed over at the gate and Mr Lee attended reception. Mr Lee was not concerned about Mr Jackamarra at that stage.[124] Every SERCO employee and prison officer was clear about the need for the warrant authorising Mr Jackamarra being in custody. The need for other paper work was mostly confused with A/OIC Swarbrick and

[121] t 30.10.18, p64
[122] t 30.10.18, p121 and t 31.10.18, p263
[123] Exhibit 2, tab 38
[124] t 31.10.18, p264

PO Mudry fairly clear they had no expectation for a hard copy PIC accompanying any prisoner from BMC[125] or even an electronic one.[126] Both prison officers agreed they took more note of the verbal handover with respect to a prisoner and their demeanour at the time. A/OIC Swarbrick, who had been expecting a problem with Mr Jackamarra on the information from SERCO,[127] was not worried about Mr Jackamarra and due to his interaction with Mr Jackamarra at the time believed he was waiting for his mother to come and bail him out.[128]

PO Mudry checked he had the warrant authorising Mr Jackamarra's custody pending surety, but without any other paperwork. He advised the inquest that Mr Jackamarra had told him about the need for pain medication only, and his prior banging of his head out of frustration.[129] PO Mudry did not see it as a self-harm attempt and on checking the system for current ARMS alerts found none were activate. He did not look at past or inactive ARMS alerts, but accepted what Mr Jackamarra told him. There is a warning on the intake form that prisoners may not be truthful, although in the circumstances there would not have been any active alerts on ARMS.

PO Mudry, on the information he had,[130] did not consider Mr Jackamarra to be at risk of self-harm and did not consider an

[125] t 30.10.18, p130
[126] t 30.10.18, p179 and 184
[127] t 30.10.18, p127
[128] t 30.10.18, p129
[129] t 30.10.18, p180
[130] Exhibit 2, tab 39

ARMS assessment to be necessary.[131] He understood any self-harm attempts to be in the community and in the past, and Mr Jackamarra's stated future hope to be spending time with his children was a positive future intent.[132] PO Mudry confirmed that in December 2015 health services were not available to do a separate risk assessment for every reception into custody[133] and his only training in respect of Aboriginal prisoners had been in about 2012.

A/OIC Swarbrick agreed that at the times he observed Mr Jackamarra he did not think he needed to consider ARMS. His first concern when he understood Mr Jackamarra to be pressuring Ms Kaino with respect to contact with his family was that he had inadvertently placed Mr Jackamarra in an environment where he had a dispute with other prisoners.[134]

A/OIC Swarbrick explained that even if Mr Jackamarra had been placed on ARMS pending an assessment (24 hours) the reality was he would have been treated in exactly the same way. Where he was in the security yard facilitated prison officer assisted telephone calls to talk to family and was the only option available without putting someone in the medical observation cells, an environment worse than the BMC CC holding cell from which Mr Jackamarra had asked SERCO staff to remove him.[135]

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[131] t 30.10.18, p185
[132] t 30.10.18, p183
[133] t 30.10.18, p192
[134] t 30.10.18, p140-150
[135] t 30.10.18, p162

A/OIC Swarbrick confirmed his training in suicide prevention and Aboriginal Cultural Awareness, but not specifically Aboriginal suicide prevention.[136]

PO Hebble advised he was offering to assist Mr Jackamarra with telephone calls should he need it, but Mr Jackamarra's immediate priority appeared to be a meeting with an Aboriginal Liaison person which in the circumstances at B(R)P on that day fell to Ms Kaino, a person he called Aunty.[137] Mr Jackamarra appears to have considered his mother would be more open to personal contact from another person than his telephoning her about his issue with surety.

In hindsight, some of Mr Jackamarra's comments to Mr Lee and Ms Kaino could be construed as a warning he was going to self-harm, but on Ms Kaino directly asking if he was going to do anything silly he specifically denied it. Ms Kaino believed he was wanting her to personally organise a meeting with his mother on an urgent basis. Something she was not authorised to do. Neither Ms Kaino or Mr Lee believed Mr Jackamarra was intending self-harm at the times they last observed him.

The last confirmed sighting of Mr Jackamarra by a prison officer took place at about 1.30 pm on 16 December 2015 in the security yard. This was approximately 40 minutes before prison officers were alerted to a person hanging in the showers and there is no

[136] t 30.10.18, p158
[137] t 30.10.18, p244

evidence Mr Jackamarra had approached any prison officers about his medication or state of mind. The indicators are all it was understood Mr Teh would not sign surety papers until the next day and that other people were not in a position to go surety for him. Mr Jackamarra did not ask for telephone access to his family, nor was there any evidence other than his request to Ms Kaino to contact his mother. There was no indication he was contemplating anything other than an overnight stay in prison with release the next day.

The issue for Mr Jackamarra at that point would be what was then going to happen on 30 March 2016.

MANNER AND CAUSE OF DEATH

I am satisfied on the whole of the evidence that Mr Jackamarra became increasingly unstable at the prospect of remaining in custody. The evidence is that Mr Jackamarra was using substances heavily. He had smoked cannabis the night before his court appearance and his post mortem toxicology indicated he had used methamphetamine at some point as well. He was vulnerable to his emotions at those times and showed little ability to control his impulses, on this occasion to suicide.

It is unclear what Mr Dorizzi saw when he went into the shower, but there was no evidence at post mortem examination that Mr Jackamarra had been involved in an altercation at the time of his death, nor did other prisoners report any injuries to Mr Dorizzi. I would suggest Mr Dorizzi was badly shaken by what

he saw, and I have no idea as to what his own state of mind and vulnerabilities were at that time.

I am satisfied Mr Jackamarra used a shirt to hang himself in the showers, which were old, with accessible hanging points for a person angry and impulsive enough with his situation in life to use that method to suicide.

I find death occurred by way of Suicide.

COMMENTS ON THE DECEASED'S SUPERVISION, TREATMENT AND CARE

The reality of the situation for staff at B(R)P on 16 December 2015 was that there was no therapeutic alternative to keep an inmate safe in the circumstances of Mr Jackamarra. This was regardless of the transfer of documentation or otherwise. Mr Jackamarra was not asking for help with his state of mind nor was the extent of his destabilisation clear. Mr Jackamarra's concern appeared to focus on a means to have his surety papers signed that day without him personally asking his family. The fact that issue was enough to cause him to suicide on the background of his severe personality disorders can only be understood in the context of Dr Bala's diagnoses and Mr Jackamarra's potential to change demeanour very quickly, become violent, on this occasion with himself and behave very impulsively. All a function of his disorders and his circumstances on that day.

The problem for the community in dealing with these types of patients with personality disorders is how to keep them contained at times when they destabilise, which can occur very quickly, and cause the least amount of harm. It is a significant problem for the criminal justice system where many individuals with mental health issues find themselves.[138]

It is a system ill adapted to deal with these issues no matter how well-meaning individuals in the system are. We heard from Dr Bala it was almost impossible for those trained in mental health to contain these situations. It is a community issue, not just an Aboriginal issue. It is a situation which prison officers at B(R)P in December 2015, with depleted resourcing and no good access to full medical services, could not hope to address.

Realistically, it is one most prisons cannot address adequately when the fact of the incidents of mental health problems is so high in the prison population. It is a population with an elevated risk of violence to self or others of itself and becomes a security issue along with the welfare concerns for all involved. To try and address these issues without the availability of medical or counselling resources is unacceptable.

It is essential there is an understanding that even prisoners with no mental health issues will be at elevated risk of self-harm in a custodial environment, especially at times of change and elevated

[138] t 1.11.18, p341

stress.[139] This is even more the case with those with known mental health issues.

Documentation of abnormal behaviours in a proximate timeframe and adequate sharing of information over medical and mental health issues is essential, but will not always prevent those suffering mental health issues from successful suicide. As Dr Bala said it is a matter of risk assessment not suicide prevention. It seems to have been a particular problem in the prison system generally in 2014-2015 when there was a cluster of suicides corresponding to a relative decrease in risk assessment resources to prison muster across the system.[140]

With this in mind custodial facilities of all types need to understand prior histories of self-harm and known diagnoses of mental health issues automatically warrant prompt mental health assessments. And the system needs to provide the resources for that to happen. Something not available in B(R)P in December 2015 and unfortunately still not available across many custodial services. As musters increase, it seems provision of resources for mental health services decrease.

All training and full compliance with policies and standing orders will be of little use if the facilities themselves are not designed and resourced with the fact of custody being a high risk environment in mind for those most frequently entering the

[139] t 30.10.2018, p236
[140] t 1.11.18, p340

system. Ironically, the fact of shared cells in places such as B(R)P probably reduces the instances of self-harm in cells, but means environments, such as shower blocks, need to be seriously ligature minimised with effective entry and exit CCTV coverage. There is evidence the automatic placing of mentally unstable prisoners into safe cells, unless they are specifically expressing suicidality, is not an effective way of dealing with them in custody.[141]

In the circumstances known about Mr Jackamarra at 1.30 pm on 16 December 2015 there was no indication that placing him on ARMS would have made any difference to his treatment. Had the PIC form been received at reception and had a decision been made to place him on ARMS, pending assessment as to his mental state, he would not have been placed in a medical observation cell. He was not expressing suicidality and he would not have been assessed in an immediate time frame.[142]

Even an assessment made at reception he be placed on ARMS would not have provided him with a risk assessment in the time frame before he made his decision in the shower block.[143]

It is quite possible Mr Jackamarra may have been assessed as requiring an ARMS assessment had the PIC form been accessed. He still would not have had the relevant assessment by the time he successfully suicided, nor would he have been placed in the

[141] t 31.10.18, p247
[142] t 1.11.18, p347-349
[143] t 1.11.18, p344-346

medical observation cell on the information on the PIC form. Knowledge of his prior self-harm attempts in custody may have elevated his risk assessment, but not with enough certainty to place him in a medical observation cell in view of his behaviour in the BMC CC and his apparent preference to no longer be isolated and at B(R)P at his request. There is no evidence he requested transfer as a precursor to suicide.

While I am of the view the Department needs to ensure proper risk assessment for all prisoners entering a custodial environment from the community with known mental health issues, at the time of reception into the facility, with proper appreciation of prior behaviour while in custody, I am not of the view it is appropriate that be the responsibility of prison officers, no matter how well trained. With the known incidence of mental health issues in a custodial setting it should be done by properly trained psychiatric liaison nurses with access to all available relevant information. It is a risk assessment and requires the full and proper sharing of information between all care providers both medical and custodial. Confidentiality has no place where there is a duty of care to minimise risk. The same goes for the physical environment. Risk minimisation is especially important at times of transition into a custodial facility, and B(R)P is always going to hold prisoners transitioning into a custodial setting.

The location of B(R)P in the Broome town site is essential for the community it serves, it is proximate to a major regional Court. It has easy and good access to essential services as discussed by

Dr Bala. It is small and there is generally a good rapport with the community and services. Taking those facts, in conjunction with the fact it is a major entry and exit to the criminal justice system,[144] well recognised as a time of change and stress for those needing to be transitioned to other facilities or significant changes in environment, it is essential it be as effective as it can be in supporting its internal community.

Despite the deficiencies in documentation and communication seen in the facts of this case, there is no doubt in my mind the individuals involved in the whole custody issue did the best they could with the system they had. As Dr Bala stated confining Mr Jackamarra further when he was not asking for help was unlikely to reverse his risk of suicide or his potential to change very quickly.[145]

The issue in this case was knowledge of Mr Jackamarra and involved information access and sharing, and the ability to do something about it,[146] none of which was possible in B(R)P on 16 December 2015.[147] It is surprising there were not more incidents of self-harm generally, probably due to collaboration between the services.[148] But for Mr Jackamarra specifically it was very difficult to best know how to support him.[149]

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[144] t 1.11.18, p337
[145] t 30.10.18, p220
[146] t 31.10.18, p231
[147] t 31.10.18, p226
[148] t 31.10.18, p238
[149] t 31.10.18, p228-229

The immediate issue which arises from the above discussion is firstly the retention and improvement of B(R)P. The reality is B(R)P was still in a state of significant facility decrepitude in both 2017 and 2018, even though it was again a facility in its own right with a dedicated Superintendent.

The other issue which arises from the above discussion relates to risk assessment for those suffering with mental health issues going through reception in a B(R)P in December 2015 and desirable for all prisons in 2019.

(a) Broome (Regional) Prison in 2015

- Mechanisms were in place for sharing of important information between custodial sites on the day;
- It did not happen;
- Had it happened reception at B(R)P would have been better informed with respect to Mr Jackamarra's need for medications, his actions in BMC CC and the fact he appeared to have calmed down on transfer;
- That should have prompted interrogation of TOMS for past histories of self-harm in custody;
- That hopefully should have prompted an ARMS review;
- If placed on ARMS pending assessment it would have been at a low level on the given information, and assessment would not have occurred prior to his suicide;
- Would Mr Jackamarra have been assessed by a mental health nurse at reception – no;

- Would Mr Jackamarra have received any different treatment – no;

(b)Prison System in 2019 and into the future

- Information sharing extending to mental health should be in place in all custodial settings and include access to mental health facilities in the local community who have ongoing knowledge of specific prisoners. Whether this be done by consent or memorandum of understanding is irrelevant, it is essential custodial systems understand the potential for individuals, over and above the elevated risk for mental health patients generally, to attempt self-harm within custodial settings;
- All prisoners with mental health issues and/or past self-harm attempts in custody should be assessed by mental health staff at reception before they go any further. This may not prevent self-harm, but would be a tool to indicate best practice.

The Department needs to improve its risk assessment capacity with more trained staff to deal with its acknowledged at risk population.

Risk Minimisation

My view as to ligature point reduction and effective CCTV in the past has been that these do not promote well-being and are band-aid solution to a much greater problem.

However, I have to acknowledge, that impulsivity is high in prisoners with mental health issues and that a significant section of the prison population suffers mental health problems or are in an anxious state due their situation, which promotes impulsivity. I am then reduced to agreeing that ligature minimisation and better coverage by CCTV would better facilitate the care of prisoners vulnerable to self-harm and so minimise the risk of impulsive suicide.

RECOMMENDATIONS

Recommendation No. 1

Retain and ensure B(R)P has appropriate services which acknowledge it is a major transition facility with all the known risks that raises.

Recommendation No. 2

Information sharing between medical, PCS and mental health services in prison and appropriate sharing of information between custodial facilities and organisations in the community caring for those with mental health issues.

Recommendation No. 3

Effective CCTV and practical ligature minimisation. I am not suggesting CCTV directly into toilet or shower facilities, but good coverage on adjacent points may avoid issues to do with welfare. It is a sad fact that rarely in inquests are all relevant CCTV monitors operational.

Recommendation No. 4

Prison officer training that those with prior suicide attempts are at elevated risk in custody regardless of their demeanour.

Recommendation No. 5

The promotion of active involvement of prisoners in caring for one another.

Recommendation No. 6

Realisation on behalf of custodial services that welfare and security go hand in hand. I appreciate that prisons are involved in security on behalf of the community, but destabilised prison populations due to successful suicides are distressing for all concerned, staff and other prisoners, and can rapidly become a security issue of itself.

E F Vicker
Deputy State Coroner
9 May 2019