Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 79 /19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Tania Marie HODGKINSON*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***3 and 4 December 2019*** *find that the identity of the deceased person was* ***Tania Marie HODGKINSON*** *and that death occurred on* ***23 March 2017*** *at* ***Bandyup Women's Prison*** *as a result of* ***Ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr B Nelson assisting the Coroner.
Ms E Langoulant (ALS) appearing on behalf of the family of the deceased.
Mr J Bennett (State Solicitor's Office) appearing on behalf of the Department of Justice.

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INTRODUCTION

1. Tania Hodgkinson was a 48 year old Aboriginal woman who died on 23 March 2017 while being held in custody at Bandyup Women's Prison. Her family have asked that I call her 'Tammy'.

2. Tammy had been remanded in custody since 30 December 2016 in relation to violence related offences that apparently arose out of a family dispute. When she was first taken into prison Tammy had been suffering from heroin withdrawal and grief associated with the recent death of her partner, Mr Indich, from a drug overdose. Tammy had spoken of wanting to harm herself, so she was initially held in the Crisis Care Unit. Tammy was later moved to a mainstream unit, where she received additional support and counselling to assist with her drug withdrawals and grief and loss issues.

3. The general impression of prison staff and other prisoners was that Tammy was settling in to the new unit reasonably well. However, shortly before her death Tammy appeared to become unsettled and some concerns were raised about her wellbeing.

4. On the morning of 23 March 2017 Tammy attended a counselling session, during which she denied have any currents thoughts or plan to harm herself. She did mention wanting to move to a different prison with her cellmate, and the counsellor was following up this request for her. However, before that could be done, that afternoon Tammy was found hanging inside her cell. She had used a torn sheet as a ligature. Despite CPR being performed and the attendance of medical staff and ambulance officers, she could not be revived. Her death was confirmed by a doctor at the prison that afternoon.

5. Because she was being held in custody at the time of her death, Tammy was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 3 and 4 December 2019.

6. The main focus of the inquest was on the care, supervision and support provided to Tammy prior to her death, to establish whether her death could have been predicted and prevented. I heard evidence from two former prisoners who had been in close contact with Tammy prior to her death, as well as a psychologist who was providing ongoing counselling to Tammy and saw her on the morning of her death. They were able to provide some insight into how Tammy appeared in the days leading up to her death. The prison officer who found Tammy gave evidence about the circumstances in which she was found hanging. Finally, Assistant Superintendent Michael Henderson gave evidence about the subsequent prison review following Tammy's death, and what lessons were able to be learnt from it.

7. Tammy's family unexpectedly raised through their counsel some initial concerns at the inquest that someone else may have been involved in her death. The initial police investigation had considered that possibility at an

[1] Section 22(1)(a) *Coroners Act.*

early stage and had not found any suspicious circumstances or evidence suggesting any criminality in Tammy's death.[2]

8. Prison staff had been aware of possible ill-feeling towards Tammy from family and Aboriginal community members in relation to Mr Indich's death, so steps had been taken to ensure she was not housed with any of his relatives.[3] Evidence was given at the inquest by witnesses that no one had witnessed any aggression towards Tammy, she had not complained to anyone of feeling threatened, and there was little opportunity for anyone outside the unit to access Tammy's cell. Officer Schneider was also adamant that it wouldn't have been possible for anyone else to have placed Tammy in the position she was in when he opened the door.[4]

9. After hearing the evidence of the witnesses, I was advised that Tammy's family were satisfied that the evidence supported the conclusion that Tammy committed suicide and they did not seek to direct me to any other evidence that might suggest a different conclusion.[5]

10. At the conclusion of the inquest, I indicated that I was satisfied that Tammy unexpectedly took her own life. I also indicated that I was unlikely to make any adverse comments about the care, treatment and supervision provided to Tammy prior to her death. I did seek further information about the visits room at Bandyup Prison, after some concerns were raised about its inadequacy and the possible effect it had on Tammy receiving visits and having contact with her family. I deal with this issue at the conclusion of my finding.

BACKGROUND

11. Tammy was born in 1968 in Dalwallinu. She was one of eight children. The children lost both parents to emphysema. Prior to their deaths Tammy had taken on a lot of the responsibility for household duties and the care of her siblings. Tammy began to use illicit drugs and had an addiction to drugs from her teenage years. She had multiple drug related convictions as an adult, but they had all resulted in fines or community orders.[6]

12. As an adult, Tammy had three children of her own and it is very clear that she loved her children and grandchildren. There were some family issues that caused her personal stress, in particular some of her family having serious health issues. While in prison, these issues continued, which would have made it very hard for her to be separated from her family.[7]

13. Tammy had been in a relationship with Mr Indich prior to going to prison. They were both drug users. On 18 November 2016 Tammy and Mr Indich both injected heroin together and Mr Indich died as a result of alcohol and

[2] Exhibit 1, Tab 2, p. 3.
[3] Exhibit 2, Tab 24.
[4] T 18 – 19 – 4.12.2019.
[5] T 53 – 3.12.2019.
[6] Exhibit 1, Tab 2; Exhibit 2, Death in Custody Report, p. 6 and Tab 1.
[7] Exhibit 1, Tab 20 and Tab 21.

drug toxicity. Tammy felt great sadness, and considerable guilt, about the circumstances of his death. She also had some concerns that she might be held to blame for his death, both by his family and potentially in a criminal investigation.[8]

14. To the best of their knowledge, Tammy's family believed she had never experienced any mental health issues prior to this time but it is clear Mr Indich's death weighed greatly upon her.[9] Her only chronic physical condition was Hepatitis C, probably arising from her ongoing illicit drug use.[10]

15. On 10 December 2016 Tammy overdosed on heroin herself. It would appear to have been accidental, as her friend also overdosed with her at the same time, although later comments she made suggested it could have been deliberate. She was administered Naloxone, with good effect, and taken by ambulance to the Emergency Department at Armadale-Kelmscott Memorial Hospital. She discharged herself against medical advice the same day.[11]

16. On 29 December 2016 Tammy was arrested at her home in relation to offences alleged to have been committed against the partner of a man who had allegedly assaulted one of Tammy's daughters. Tammy appeared in the Armadale Magistrates Court the following day and was remanded in custody at Bandyup. Although Tammy had a prior criminal record, this was her first time in prison.[12]

ADMISSION TO BANDYUP

17. On her arrival at Bandyup on 30 December 2016 Tammy was assessed by a clinical nurse. She was recorded as having no history of medical or psychiatric conditions. She was, however, experiencing heroin withdrawal symptoms and she verbalised self-harm intent. She also spoke of her grief at losing her partner, Mr Indich. These factors raised the level of concern about Tammy's risk to herself, so Tammy was admitted to the Crisis Care Unit and placed on a high level of the At-Risk Management System (ARMS). Her withdrawal symptoms were managed with standard medical treatment and she was placed under close observations (hourly). She was also referred to the Prison Alcohol and Substance Team and the Prison Counselling Service.[13]

18. Tammy was assessed by the Alcohol and Substance Team the day after her admission. She appeared tired and wanted to sleep. She stated the medications she had been given for withdrawal were helping. She was seen again the following day and she interacted well and denied any suicidal ideation.[14]

[8] Exhibit 1, Tab 2 and Tab 9 and Tab 10.
[9] Exhibit 1, Tab 2.
[10] Exhibit 1, Tab 2.
[11] Exhibit 1, Tab 19.
[12] Exhibit 1, Tab 2; Exhibit 2, Death in Custody report, p. 3.
[13] Exhibit 1, Tab 20.
[14] Exhibit 1, Tab 20.

19. On 3 January 2017 Tammy attended the Prison Counselling Service for the first time. The primary role of the service is self-harm and suicide prevention and the team is comprised of both registered psychologists and social workers. In the initial assessment, Tammy referred to a previous suicide attempt by hanging three years prior.[15] Tammy was assessed as emotionally fragile and she was noted to be grieving the loss of her partner. She was also concerned for the wellbeing of her daughter. Tammy strongly denied any thoughts of self-harm or suicide and reported she would tell someone if she felt like self-harming.[16]

20. The outcome of the assessment was a recommendation for Tammy to remain in the Crisis Care Unit but that she be reduced from high to moderate ARMS with two hourly observations. She was later transferred from the Crisis Care Unit to the Orientation Unit. This was approved by the Prisoner Risk Assessment Group (PRAG).[17]

21. Tammy attended counselling sessions through January, February and March 2017 with a psychologist employed by the Department of Justice, Ms Jeanne Neville. Ms Neville made notes following her sessions and recommendations to the Prisoner Risk Assessment Group. I refer to some of the more significant ones below, as well as some medical appointments.

22. On 5 January 2017 Ms Neville met Tammy for the first time although she was aware of her from a PRAG meeting a couple of days before. Tammy engaged well and was calm and cooperative. She mentioned experiencing heroin withdrawal but it appeared to be being managed. Tammy expressed some hope that she might be released from custody by the Court soon and was expecting her time in Bandyup to be relatively short. She denied any self-harm or suicidal ideation and cited her children and granddaughter as protective factors. Ms Neville recommended at the PRAG meeting after the counselling session that Tammy be removed from ARMS but be monitored on the Support and Monitoring System (SAMS), which duly took place.[18]

23. On 17 January 2017 Tammy saw Ms Neville for a SAMS review and reported an improvement in her thinking and emotions. Tammy continued to deny thoughts of self-harm. Tammy seemed to be adjusting well to prison life and said she was glad to be drug free and hoped to remain so upon her release, which she still hoped would be soon.[19]

24. However, six days later Tammy spoke to her daughter Joan on the phone and stated that she might be joining her deceased partner sooner than she thought and claimed it would be another of her daughter's fault if she killed herself. The following day Tammy spoke to Joan again and sounded a bit more positive.[20]

[15] Exhibit 1, Tab 20.
[16] Exhibit 1, Tab 20.
[17] Exhibit 1, Tab 20; Exhibit 2, Death in Custody Report, p. 9.
[18] Exhibit 1, Tab 20 and Tab 21.
[19] Exhibit 1, Tab 20 [36] – [40].
[20] Exhibit 2, Tab 2.

25. On 29 January 2017 Tammy was found in bed shaking and apparently suffering from a seizure. A Code Red (Medical Emergency) was called and she was examined by a nurse. Tammy advised she had a regular history of seizures, the last occurring approximately three weeks' before. She had a second seizure on the same day and was kept in the Medical Centre overnight for observation without further incident. She told a nurse the following day that she felt fine but had experienced another seizure overnight due to lights flickering in the Medical Centre. She returned to her unit that day.[21]

26. On 2 February 2017 Tammy was reviewed by Ms Neville again and she spoke of being pleased her daughter and family had returned to Perth and she was hopeful they might visit soon. She mentioned being unwell earlier in the week with 'fits', which she said she had not had in a long time and attributed to being stressed. Tammy reported feeling overwhelmed with multiple stressors related to issues happening outside in the community that she had no control over. However, she was positive about her family and was still pleased to be drug free. She declined the methadone program and expressed a preference to do drug and alcohol counselling instead. Anxiety reducing techniques were discussed and staff were advised to continue to monitor her. Ms Neville recommended Tammy remain on SAMS.[22]

27. On 3 February 2017 Tammy's daughter Joan informed Tammy in a phone call that their house had been broken into and threats of rape had been made against her daughters. Tammy would have been understandably concerned for the safety of her family. They visited her the following day, which presumably would have given her some reassurance that they were okay.[23]

28. On 10 February 2017 Joan informed Tammy that Joan's father (Tammy's ex-partner) had been remanded in custody.[24]

29. On 13 February 2017 Tammy had a medical review and following a comprehensive examination no medical concerns were identified.[25]

30. On 16 February 2017 during a counselling session with Ms Neville, it was noted that Tammy was coping well and feeling less overwhelmed. She denied any suicidal ideation or intent and mentioned she was expecting her charges to be downgraded and was meeting her lawyer the next day to discuss it further. She was waiting for full-time employment within the prison, which she hoped would ease her boredom. Ms Neville recommended Tammy remain on SAMS.[26]

31. At the time Tammy went into custody the police investigation into her partner's death was still ongoing. On 17 February 2017 Tammy was interviewed by police in relation to Mr Indich's death.[27] This would appear to

[21] Exhibit 1, Tab 20.
[22] Exhibit 1, Tab 21 [42] – [46].
[23] Exhibit 2, Tab 2.
[24] Exhibit 2, Tab 2.
[25] Exhibit 1, Tab 20.
[26] Exhibit 1, Tab 20 and Tab 21 [48] – 50]; Exhibit 2, Tab 2.
[27] Exhibit 2, Death in Custody Report, p. 11.

have been a very significant event for Tammy, although it may not have been apparent to those around her at the time. A later review found that she was tearful when speaking to her daughter later that day and she spoke of how it was the 12 week anniversary of his death.[28]

32. Three days later, on 20 February 2017, Tammy was transferred from Unit 1 in the prison to Unit 4. The reasons for the transfer were not recorded at the time but evidence was given at the inquest that with the movement of prisoners to Melaleuca, Unit 4 was able to change back to its originally intended role as a quiet place that did not have general access from the main population, and it was felt that this was a more appropriate environment for Tammy.[29]

TRANSITION TO UNIT 4

33. When Tammy moved to Unit 1, she became friends with a fellow prisoner in the unit, who for the sake of her privacy I will refer to by her first name only, Rosemary. Rosemary and Tammy became close friends.[30]

34. When Tammy moved to Unit 4, Rosemary moved with her, and she became Tammy's roommate in Cell 6 in J Block. They shared a cell for approximately six weeks until Tammy's death. The new environment appeared to be a supportive one, and Rosemary spoke of one prisoner in particular who took care of all the new girls who came in to the unit. J Block was described as a semi self-sufficient block, housing about 13 women at any given time, who were able to look after themselves.[31]

35. Rosemary recalled that Tammy began to open up and come out of her shell in the new unit. Not long after they moved to J Block, Tammy told Rosemary about Mr Indich's death and how he had died from heroin that she had given him. Although this was a sad memory for her, in other ways Tammy seemed to be in fairly good spirits, and they would "regularly laugh and muck and around together."[32]

36. Tammy was also supported in the unit by a prisoner Peer Support member who again for the sake of her privacy I will simply refer to by her first name, Lynette. Lynette was based in J Block with Tammy and was the Peer Support Member for the unit.[33]

37. On 21 February 2017 Tammy spoke to her daughter Joan and indicated that she felt that her chances of getting out had now decreased. The following day she spoke to her daughter again and they spoke about how Tammy's property had been stolen from her house, which upset Tammy.[34]

[28] Exhibit 2, Death in Custody Report, p. 11.
[29] T 42 – 4.12.2019.
[30] T 25 – 26 – 3.12.2019; Exhibit 1, Tab 9.
[31] Exhibit 1, Tab 10, p. 1.
[32] Exhibit 1, Tab 9, p. 2.
[33] T 8 – 3.12.2019.
[34] Exhibit 2, Tab 2.

38. Tammy reported to staff on 25 February 2017 that she was having a rough day due to the recent death of a friend.

39. On 28 February 2017 Tammy had a video link court appearance and, contrary to her hopes of early release, she was remanded until May 2017. She was understandably disappointed, but told Ms Neville the next day that she felt she had a 'good lawyer' and was still hopeful that her charges would eventually be dismissed or downgraded. She felt she would be able to cope until the next court appearance in May, but did indicate she did not think she would be able to cope if her charges were not eventually downgraded or dismissed. During the session Tammy reported feeling physically unwell and had an obvious problem with her eyes. She also said she had a low mood but denied feeling suicidal. Tammy asked to cut the session short because she was feeling unwell. Ms Neville told Tammy she would be absent for the next two weeks and someone else from PCS would see her in the interim.[35]

40. Following this session Ms Neville spoke to the Manager of Unit 4 and advised of Tammy's presentation and her unwillingness to engage. Ms Neville requested the Unit Manager make contact with Tammy and indicated that she would recommend that Tammy remain on SAMS.[36]

41. Ms Neville attended a PRAG meeting the next day, being 2 March 2017, and the PRAG consensus was for Tammy to remain on SAMS for further support and monitoring.[37]

42. On 5 March 2017 Tammy received her last visit from her family.[38]

43. On 14 March 2017 Tammy was briefly seen by someone from the Prison Counselling Service but she was not willing to engage as her regular counsellor, Ms Neville, was on leave. She did, however, deny any suicidal intent when asked.[39]

44. On 19 March 2017 Tammy spoke to her daughter Joan for the last time. They discussed family issues on the outside, including a close family member who was threatening suicide. They also spoke about Tammy's lawyers and their joint concern that the lawyer did not have Tammy's best interests at heart. Tammy mentioned during the call that she had been unable to get a job and had no money, so she wouldn't be able to call again until Sunday, 26 March 2017. I will return to this later, but I note at this stage that evidence was given at the inquest that she was still being paid her gratuity despite not being able to get a job after her unit move.[40]

45. Around this time the Peer Support prisoner Lynette became concerned about Tammy. Tammy had spoken to another woman in Unit 4 about a drug overdose and, according to Lynette, this brought back memories for Tammy about Mr Indich's death. Since that time, Tammy had not appeared to be the

[35] Exhibit 1, Tab 21 [53].
[36] Exhibit 1, Tab 21 [54] – [55].
[37] Exhibit 1, Tab 21 [56].
[38] Exhibit 2, Death in Custody Report, p. 11.
[39] Exhibit 1, Tab 20.
[40] Exhibit 2, Tab 2.

same and Lynette had become worried about her. Tammy said she wanted counselling, so Lynette spoke to a prison officer to help push that request along, as she knew Tammy had been crying a lot that day.[41]

46. A prison officer spoke to Tammy on 21 March 2017 and Tammy mentioned she hadn't slept a lot the night before and was getting upset talking about Mr Indich. Tammy was referred to the Prison Counselling Service and met with Ms Neville that afternoon. Lynette believed Tammy seemed happier after she was told she was going to get counselling that day.[42]

47. Lynette stated that after raising her concerns about Tammy with a prison officer she started to check up on Tammy every few hours to make sure that she was okay. Tammy did not say anything to her to make her feel that Tammy was actively suicidal.[43]

48. This counselling session on 21 March 2017 was the first time Ms Neville had seen Tammy since returning from leave. It was not her regular SAMS meeting, but was prompted by the referral.[44] Tammy appeared tearful but engaged during the session. They discussed the circumstances of Mr Indich's death and how Tammy had used substances to cope with her grief and loss before coming to prison. She mentioned attempts to overdose during this period, which raises a question about her intention at the time of her heroin overdose in December, shortly before she went to prison. Tammy told Ms Neville that she tried not to think about her partner while in prison, but she had been contacted by the Coroner's Office in relation to his post mortem findings and some of the other prisoners had been talking about their experiences of people overdosing, which had triggered her feelings of grief and loss again. Tammy had not attended his funeral due to being under the influence of drugs and her partner's family requesting she did not attend, which was also upsetting her.[45]

49. Finally, she had begun to wonder whether she might be charged with manslaughter in relation to his death. Ms Neville gave evidence that it appeared that it seemed this was the "first real realisation"[46] for Tammy that this could happen, although there was some evidence it had been floated by other prisoners in the past. Ms Neville formed the impression that it added to Tammy's guilt more than anything,[47] although it could also have later preyed on her mind that it might lead to more time in custody.

50. Supportive counselling was provided with a focus on the stages of grief and techniques to assist in managing them. Ms Neville also suggested that the Prison Chaplain might be able to hold a memorial service for her partner, to help her process her grief. Tammy acknowledged during the session that she 'wished she was dead' as she was missing her partner, but she denied any active suicidal intent or plan. Further, Tammy said her preferred method of suicide was by heroin overdose, which was not available to her in prison. A

[41] T 9 - 10 – 3.12.2019; Exhibit 1, Tab 10, pp. 1 - 2.
[42] T 10 - 11 – 3.12.2019; Exhibit 1, Tab 10 and Tab 20 and Tab 21 [57].
[43] T 10 – 11 – 3.12.2019; Exhibit 1, Tab 10.
[44] T 27 – 4.12.2019.
[45] T 26 – 28– 4.12.2019; Exhibit 1, Tab 21 [60] – [62].
[46] T 31 – 4.12.2019.
[47] T 31 – 4.12.2019.

recommendation was made to discuss Tammy's case at the weekly PRAG meeting and she was to remain on SAMS. Prison staff were asked to monitor her mood, behaviour and social interaction.[48]

51. Ms Neville said in evidence that her primary concern for Tammy had been that she had quite often said she didn't know what she was going to do if she were to be given a long custodial sentence, which was why she had continuously recommended that she remain on SAMS as she felt Tammy's expectations about release might be unrealistic. In most other aspects, Tammy appeared to be adjusting to prison and she didn't exhibit behaviour or thoughts that required her to be escalated back on to ARMS.[49]

EVENTS ON 23 MARCH 2017

52. On the morning of 23 March 2017 Rosemary recalled that she and Tammy were let out of their cells at about 9.30 am but were locked inside J Block until 11.30 am because the prison officers were conducting urine testing.[50]

53. There is a suggestion that some prisoners in the unit may have been overheard suggesting to Tammy that she was responsible for her partner's death during that morning, although confirmation of this was unable to be found in the later investigation.[51]

54. Rosemary had been told that morning that she would be moving to the Melaleuca Remand and Reintegration Facility. Tammy had previously told her daughter on 15 March 2017 that she thought she might go to Melaleuca, but no firms plans had eventuated for her by that day. Rosemary said that Tammy was upset when she told her she was moving as Tammy didn't want Rosemary to go.[52]

55. Ms Neville saw Tammy that morning to follow up with her after their session a few days earlier. Ms Neville explained that the counselling service was quieter with the move of a number of their clients to Melaleuca, and she thought it was be a good opportunity to speak to Tammy regarding their previous conversation about having a service for her partner and to see how she was coping.[53]

56. Tammy indicated to Ms Neville she was coping better and did not wish to talk of the loss of her partner as she was feeling more settled, though emotionally exhausted, and wished to process her grief. Tammy's main concern during this session was that Rosemary was being transferred to Melaleuca. Tammy was upset as they had been a support to each other. Tammy indicated she was considering requesting a transfer to Melaleuca so she could go with her. Ms Neville told her that she could speak to someone about it, as there was no reason why Tammy should not be able to transfer

[48] Exhibit 1, Tab 20 and Tab 21 [62].
[49] T 29 – 4.12.2019.
[50] T 29 – 3.12.2019.
[51] Exhibit 2, Tab 24 and Tab 25.
[52] T 29 – 3.12.2019; Exhibit 1, Tab 2.
[53] T 32 – 4.12.2019; Exhibit 1, Tab 10 and Tab 20 and Tab 21 [64] – [69].

there, given she was still on remand. Tammy appeared quite surprised by this information. The transfer would mean not only that Tammy could go with Rosemary, but also might have more visits as the location was closer to her family, so it would have multiple benefits for her.[54]

57. Tammy denied any self-harm or suicidal ideation at this time and indicated she was feeling contained, displayed future focus and was able to cite protective factors. Tammy expressed a desire to end the session after about 20 minutes. Ms Neville thought their meeting, although only short, had a positive outcome and after Tammy left she followed up about Tammy's request for transfer to Melaleuca. She was told that there didn't appear to be any obstacle to the request and Tammy would be called up after lunch to discuss it. Unfortunately, she died before that could occur.[55]

58. Ms Neville gave evidence that, even with the benefit of hindsight, she had "gone over it and over it"[56] but nothing about that session gave any indication that Tammy was suicidal. Despite many years working as a psychologist and in the prison system, it was her first experience of a suicide of a client and it came as quite a shock to her. Ms Neville said that as a counsellor she paid close attention to Tammy's body language and demeanour from the time she arrived until she left, as well as what she said, and there was nothing that indicated to Ms Neville that Tammy had been planning to suicide. Ms Neville accepted Tammy could have been very good at concealing such thoughts, but Ms Neville also indicated that anything could have happened after Tammy left her office that changed her mindset.[57]

59. After the urine testing was completed the prisoners had lunch and then were locked back into their cells so that the prison officers could eat their lunch. The cells were unlocked again at 1.15 pm.[58]

60. Rosemary recalled that Tammy seemed her normal self that day and gave no indication that she was going to harm herself. Indeed, she had never told Rosemary that she had any plan to harm herself. Tammy did tell Rosemary that she had tried self-harm a couple of years before by hanging herself with a rope, but had not mentioned any recent attempts or plans. Rosemary said that Tammy had told her that she did not feel like talking to Ms Neville that day, but she did not explain why. She did not seem any different as a result of the counselling session but Tammy did indicate she was going to try to move to Melaleuca with her.[59]

61. Lynette also spoke to Tammy during the morning of 23 March 2017 and she recalled that Tammy was joking around and appeared happy and fine. Lynette went to check on Tammy again at about 1.00 pm, just before the cells were unlocked. Tammy was in her cell with Rosemary and she still appeared fine. Lynette told her that the lockdown was nearly finished. Lynette say Tammy come out of her cell after lockdown but then Lynette left

[54] T 32 – 4.12.2019.
[55] T 32, 36 – 4.12.2019; Exhibit 1, Tab 10 and Tab 20 and Tab 21 [64] – [69].
[56] T 33 – 4.12.2019.
[57] T 32 - 34 – 4.12.2019.
[58] Exhibit 1, Tab 9.
[59] T 37 - 38 – 3.12.2019; Exhibit 1, Tab 9, pp. 4 - 5.

to attend a peer support meeting, the canteen and another appointment and did not see Tammy again.[60]

62. Lynette described her impression of Tammy as someone who had a lot of issues and "a very sad person,"[61] but she was also someone who got along well with others. Lynette expressed her regret that she had not checked on Tammy earlier but indicated that Tammy had never spoken to her of suicide and her death that day came as a shock.[62]

63. Prison Officer Christopher Schneider was the orientation officer for new prisoners in the unit that shift. He had not met Tammy before that day, but made a note of her name because he checked who was on ARMS and SAMS at the start of his shift and she was on the SAMS list, which would usually require him to check on her once a day. Officer Schneider recalled speaking to Tammy during the morning and she seemed cheerful and he thought she was travelling well.[63] Officer Schneider last saw Tammy alive at the lunch-time unlock. He did not recall anything unusual about her behaviour at that time.[64]

64. After they were released from their cells at about 1.15 pm, Rosemary left the unit to go and see the lady who ran the textiles area. Tammy had remained in their cell and was lying on the bed watching television when Rosemary left at about 1.30 pm. Tammy often spent time alone watching television as she didn't have a job at the time, so Rosemary did not think her lack of activity was out of the ordinary.[65]

65. Rosemary estimated she was gone for about half an hour. When she returned to the cell the door was closed and locked. The usual practice was for prisoners in that unit to be given keys to their cells, but the key to Tammy and Rosemary's cell had been lost (which I am told is not uncommon) and they had not yet received a replacement. This meant that Rosemary didn't have a key with her.[66]

66. Rosemary noticed at this time that there was something at the top of the cell door in the middle, but it appeared to her to be a bit of white paper so she didn't think much of it and didn't investigate further.[67] Rosemary left the unit and went to a scrapbooking program. She believes she spent about half an hour there, before returning again to J Block. The cell door was still locked. Rosemary knocked but Tammy didn't answer, so she assumed Tammy had gone somewhere else. Rosemary then went outside for a cigarette.[68]

67. While she was outside, Rosemary was called over by some prison officers and given some bags to pack her belongings into, in preparation for the move

[60] T 13 – 3.12.2019; Exhibit 1, Tab 10, pp. 3 - 4.
[61] Exhibit 1, Tab 10, p. 5.
[62] T 16 – 3.12.2019; Exhibit 1, Tab 10, pp. 5 – 6.
[63] T 10 - 11 – 4.12.19.
[64] T 17 – 4.12.2019.
[65] T 31 – 3.12.2019.
[66] T 15, 31 – 32 – 3.12.2019, 20 – 4.12.2019; Exhibit 1, Tab 9.
[67] Exhibit 1, Tab 9.
[68] T 33 – 3.12.2019; Exhibit 1, Tab 9.

to Melaleuca Prison. One of the officers was Officer Schneider. Rosemary told him that she could not get into her room and asked him if he could open the door for her. Officer Schneider gave evidence that this was a common request in the unit as prisoners were often misplacing their keys or accidentally locking them in their cells.[69]

68. Officer Schneider went with Rosemary to her cell. He inserted his latch key into the cell door and tried to unlock it. The door would not open. He believed it must be jammed, so he pulled on the padlock that secures the medication hatch and with that leverage he was able to open the door.[70]

69. As the door opened out towards them, Officer Schneider and Rosemary saw Tammy's body fall down from the door and land on the floor in front of them. Rosemary screamed and walked away to a friend's room in distress. Officer Schneider saw a piece of what looked like a torn strip of sheeting around Tammy's neck. He went to get out his knife to cut the strip from around Tammy's neck, but then realised it was loose enough to remove, so he simply pulled it off. Officer Schneider gave evidence that he realised later the sheeting had been knotted and placed over the top of the cell door and then the knot released when he pulled the door open. Tammy had only put a single loop around her neck and used her body weight against it, so she came free from it easily.[71]

70. Officer Schneider called a 'Code Red' over the radio at 2.45 pm and asked for medical assistance. This prompted immediate action from other prison staff and medical staff. Prison Officer Leah Furness, who was in the office of J Block immediately ran to assist him and was the first to arrive. She ordered the other prisoners to return to their cells as she went to find him outside Cell 6, where Tammy was lying on the floor. Officer Furness touched Tammy to try to get a response from her and noticed that she was cold to the touch and unresponsive and showed no signs of life. Officer Furness and Officer Schneider then commenced CPR. Nursing staff and other prison officers attended within minutes and took over resuscitation efforts. Despite intensive resuscitation efforts, Tammy remained unresponsive.[72]

71. An ambulance had been requested to attend as a Priority 1 and a number of ambulances quickly arrived. Officer Schneider had run to the gates to facilitate their entry and the ambulance staff were directed by him to J Block. Ambulance Paramedics assessed Tammy and advised that she showed no signs of life. The prison doctor attended and, in consultation with the paramedics, confirmed Tammy's death at 5.10 pm.[73]

CAUSE OF DEATH

72. On 28 March 2017 a Forensic Pathologist, Dr Jodi White, conducted a post-mortem examination. The examination showed an evident ligature mark to

[69] T 34 – 3.12.2019.
[70] T 12 – 4.12.2019; Exhibit 1, Tab 12.
[71] T 34 - 35 – 3.12.2019, 13 – 14 – 4.12.2019; Exhibit 1, Tab 9.
[72] Exhibit 1, Tab 11 and Tab 17.
[73] Exhibit 1, Tab 17 and 18.

the neck consistent with the ligature provided to the State Mortuary for examination. There was no significant natural disease. Routine toxicology was undertaken, which was negative for any common drugs or alcohol. At the conclusion of all investigations Dr White formed the opinion the cause of death was ligature compression of the neck (hanging).[74] I accept and adopt the opinion of Dr White as to the cause of death.

MANNER OF DEATH

73. The police investigation into Tammy's death found no evidence that another person was involved in her death. Rosemary gave evidence that Tammy did not appear to have any enemies inside the prison and she always appeared to be respectful of others and to get along with other prisoners and prison officers.[75]

74. There was evidence before me that Tammy had attempted suicide on at least one occasion in the past. She had expressed suicidal thoughts on admission to prison, but her mental health had then appeared to improve and she had denied having any current intention of taking her life in prison.

75. After her death, police were advised by Tammy's daughters that they believed she had called her mobile telephone from Bandyup and left a message on her phone for them prior to her death. The mobile phone was in the possession of detectives as it had been seized during her arrest. Police checked the phone and did not find any voice or text message, but did find a note attached to the contact listing for her deceased partner. The note appeared to be a message to her daughters in the event of her death. Given the phone was in the possession of police from 29 December 2016, it must have been written at an earlier time. It is possible Tammy wrote it prior to her overdose, although that is purely speculative.[76]

76. Tammy did, however, also leave written notes in her cell that were found by police after her death. The notes were made up of several statements written on the back of a Bandyup canteen receipt. They include the word "EROM,"[77] which was a unique term she often used with her children and grandchildren in the context of telling them how much she loved them. She also left a message to her "soul mate"[78] Mr Indich and spoke of seeing her family on the "other side."[79]

77. It is unclear when Tammy wrote the notes, as the notes are undated and the canteen receipt is from 3 January 2017, sometime before her death. It is possible that she wrote them at different times as they are written in different writing and in different positions on both sides of the page. Nevertheless, I am satisfied that they show Tammy had an active intention to

[74] Exhibit 1, Tab 6 and Tab 7.
[75] Exhibit 1, Tab 9.
[76] Exhibit 1, Tab 2, pp. 7 – 8.
[77] Exhibit 1, Tab 2, p. 3.
[78] Exhibit 1, Tab 2, p. 3.
[79] Exhibit 1, Tab 2, p. 3.

take her life at the time of writing the notes, which must have been on or after 3 January 2017 and prior to her death.

78. The circumstances in which Tammy died also indicate that no one else was involved in her death and would not suggest that her act was a 'cry for help'. It would also appear to have been an impulsive act, rather than one she had planned for some time.

79. Based upon all of the evidence available to me, I find that the manner of death was by way of suicide.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

General Supervision, Care and Support

80. I was impressed by the evidence of Rosemary, Lynette, and Ms Neville, all of whom showed a commendable level of caring and empathy towards Tammy. She was not a person lost in the system, but rather someone who had people actively looking out for her and checking on her to see how she was coping. Tammy's sudden death took all of them by surprise, and it is apparent they had all reflected upon her death to see if there were signs they had missed on the day. None of them were able to point to anything that suggested Tammy had begun to feel hopeless and at increased risk of suicide. Instead, they all spoke of Tammy as appearing to generally be travelling well, although her partner's death still weighed on her heavily.

81. Ms Neville described Tammy as "a likeable lady who was very robust and down to earth."[80] However, she sensed that Tammy was "holding a lot of history and hurt which she was not willing to divulge"[81] and she had used heroin to mask her feelings. Once the heroin was gone from her system, Tammy was happy to be free of drugs, but being drug-free would have required her to sit more with her feelings.

82. I am satisfied the ARMS and SAMS systems were helping to support her and that prison staff generally were also supportive and alert to the need to keep a check on Tammy's welfare. Officer Schneider, who is a very experienced prison officer, explained how prison officers have found that the systems work well to try to prevent deaths in custody, so they are happy to include the checks in their already busy schedules, although he also acknowledged that unfortunately there are still some people who slip through.[82]

83. The evidence of Rosemary and Ms Neville does indicate that Tammy had been saddened and unsettled by the news that Rosemary was moving to Melaleuca. However, Ms Neville had reassured Tammy that there was no reason why she couldn't move to the same place and that she was going to make enquiries for her, so her concerns should have been allayed.[83]

[80] Exhibit 1, Tab 21 [27].
[81] Exhibit 1, Tab 21 [27].
[82] T 16 – 4.12.2019.
[83] Exhibit 1, Tab 9, p. 5.

84. Like those in the prison, Tammy's family were also shocked and confused at her sudden death. She had made comments to them that she felt good as she was 'drug free' for the first time since becoming an addict at the age of 13 years. She had also spoken of looking forward to being released from prison.

85. However, that second topic is perhaps one of the reasons why she may have begun to lose hope. Tammy had been expressing some optimism that the charges that had led to her incarceration would be downgraded and she could be released. When Tammy was interviewed by police in relation to Mr Indich's death, she may have considered that there was an increased possibility that she might be charged in relation to his death, which would have made her release much less likely. The comments made to her by other prisoners, that had prompted her second last session with Ms Neville, wouldn't have helped in that regard. While it is speculation, when considered in the context that it was known Tammy was concerned at how she would cope if not released soon, the prospect of being charged with manslaughter would have been very troubling for her. Also, being held criminally responsible for Mr Indich's death would have weighed further on her mind, knowing that his family already directed some blame towards her.

86. Assistant Superintendent Michael Henderson from Bandyup Women's Prison gave evidence on behalf of the Department at the inquest, and he indicated that the Department is aware that official visits can be a trigger for prisoners to become distressed, depending on the nature of the visit, and similarly court appearances can have an adverse effect, depending on the outcome. The Department's review of events after Tammy's death found that there could have been benefits in documenting Tammy's mental state after her interview with police on 17 February 2017, given her level of stress/anxiety in relation to the death of her partner.[84] Assistant Superintendent Henderson indicated that there is an expectation that officers in the official visits area will monitor people as they come in and out of the area, and if they appear distressed this information should then be referred back to the unit manager, but at the time there was no specific requirement to write anything down about their observation in the Clinical Management Plan. His understanding was that Tammy was not seen to be distressed at that moment, but there was no documentation to that effect.[85] It is now his expectation that something will be written down in those circumstances.[86]

Employment, Finances and Welfare Calls

87. The issue of employment arose during the inquest, partly due to a suggestion by Tammy prior to her death that she could not afford phone calls and cigarettes as she did not have a job. Tammy did have employment as a kitchen worker for 20 days when in Unit 1, but when she moved to Unit 4 she could no longer perform that job and a new job had not been allocated to her prior to her death. She had spoken of boredom and having no money.

[84] Exhibit 2, Tab 26, p. 6.
[85] T 48 – 4.12.2019.
[86] T 45 – 4.12.2019.

Options for her to work in the prison gardens had apparently been explored but did not eventuate.

88. It was acknowledged in the Department's review that identification of alternative employment opportunities prior to her moving units might have enabled a better opportunity for her to remain continually engaged in meaningful activity, or that at least giving her a better timeframe in which a new job would eventuate might have assisted her frame of mind.[87] It was also suggested that in future, this could be incorporated within the Clinical Management Plan for a vulnerable prisoner, to ensure that subsequent tasks or actions are assigned in that regard.[88]

89. Rosemary gave evidence that Tammy had spent a lot of time watching television as she didn't have a job in the new unit. Rosemary also believed this had affected her finances as Tammy was a smoker and Rosemary had had to lend her cigarettes to "tide her over"[89] and Tammy had also had to borrow cigarettes off other people. Rosemary also understood it had affected Tammy's ability to pay for phone calls. Rosemary gave evidence Tammy was still hopeful at the time of her death that she would get a job as the unit gardener, so there seemed to be an end in sight.[90]

90. Lynette also recalled that Tammy was struggling for money at certain times in terms of being able to buy cigarettes and items like that.[91]

91. Ms Neville, on the other hand, did not recall any concerns being raised by Tammy about employment or her finances.[92]

92. Assistant Superintendent Henderson gave evidence that while Tammy had lost her job due to her unit transfer, she did not lose her wages because the prison had initiated the move. She would only have lost her wages if she refused to work, which was not the case. He acknowledged that the lack of work did lead to problems with boredom, but there was not a financial penalty as she continued to receive her gratuity. Assistant Superintendent Henderson also confirmed that there were plans to try to get her a job in the gardens, which had not eventuated at the time of her death.[93]

93. Based upon the information provided by Assistant Superintendent Henderson, the loss of Tammy's employment does not appear to have been the reason for her financial difficulties.

94. There was evidence that mobile phone calls were very expensive at the time, which may well have been a cause of Tammy's lack of funds in her phone account. This raised the question whether officers could use their discretion to allow prisoners to make 'welfare calls' when they did not have sufficient funds. Assistant Superintendent Henderson confirmed that this can occur. He indicated that it is a common practice for people who have recently

[87] Exhibit 2, Death in Custody Report, p. 12.
[88] Exhibit 2, Death in Custody Report, p. 17.
[89] T 38 – 3.12.2019.
[90] T 38 – 39 – 3.12.2019.
[91] T 20 – 3.12.2019.
[92] T 37 – 38 – 4.12.2019.
[93] T 43 – 4.12.2019.

entered prison and have not had an opportunity to set up a phone account. It is also possible for prison officers to allow it in their discretion when prisoners have run out of money and are desperate to talk to their family, although Rosemary gave evidence that it was necessary to pick and choose from the officers as to who would allow it.[94]

95. I note that the Department provided information that Tammy received officer-assisted welfare calls to her daughter on the first two days of custody and on 1, 4 and 20 January 2017, which indicates that at least early on the officers were exercising that discretion in her favour. However, Rosemary gave evidence that towards the end Tammy of her time in prison, Tammy had said she was unable to call her daughter, who was pregnant and close to her delivery date, which was causing Tammy some frustration.[95] It's not clear whether Tammy had made requests for welfare calls that were denied or had chosen to simply wait for more funds in her phone account.

96. The issue of the expense of phone calls was acknowledged by Assistant Superintendent Henderson. I note it was also a concern that was raised by the Inspector of Custodial Services in the report on the 2017 Inspection of Bandyup Women's Prison, with a recommendation that the Department should ensure prisoners have access to cheaper calls to mobile phones.[96] Assistant Superintendent Henderson advised at the inquest that the situation has improved since Tammy's death and the new contractual arrangement has led to more reasonable phone costs, so I don't take the issue any further.[97]

Bandyup Visits Room

97. Tammy received only two visits from family, on 4 February 2017 and 5 March 2017.[98] She had indicated to Ms Neville her hope that if she moved to Melaleuca it would be closer to family, which would facilitate visits.

98. There was evidence that the visits room at Bandyup was a less than ideal environment. Lynette indicated that the visit room was "tiny"[99] and "horrible."[100] Lynette explained in her evidence that the room is small, so it is hard to have privacy and there is no 'break out' room for children, so it can be a very noisy space.[101] Rosemary did not recall Tammy ever mentioning feeling frustrated by the visit room facilities, but she did agree that the visit rooms at Bandyup were quite noisy.[102]

99. Tammy's family submitted through their counsel that the difficulties with the social visits room at Bandyup had impacted on Tammy. They instructed that the visits room was small and cramped. It was often hard to find a seat, and people had to sit very close to each other. There was no separate area

[94] T 40, 49 - 50 – 3.12.2019.
[95] T 40 – 3.12.2019.
[96] Report No. 114, 2017 Inspection of Bandyup Women's Prison, December 2017, p. 27.
[97] T 18 – 3.12.2019, 49 – 4.12.2019.
[98] Exhibit 2, Death in Custody Report, p. 11 and Tab 7.
[99] T 19.
[100] T 19.
[101] T 19.
[102] T 40. – 3.12.2019

for children, which made it very noisy. When Joan had visited Tammy, she had become upset at the difficulty they had hearing each other. Tammy had begun to cry at one stage and said words to the effect, "I can't do this. What is the point of you coming if I can't even hear you." Her distress led her family to avoid further visits out of concern that they might cause Tammy further distress.[103]

100. Assistant Superintendent Henderson conceded in his evidence that Bandyup has "one of the worst visits room in the State" and noted it has been highlighted in every report by the Inspector of Custodial Services.

101. In the most recent report referring to the May 2017 inspection of Bandyup Women's Prison, the Inspector of Custodial Services noted that the Bandyup Visits Centre is (still) unfit for purpose and does not meet the needs of officers, prisoners or visitors. The Inspector commented that it is "too small to adequately service Bandyup's population, and too sterile to support a friendly family atmosphere."[104] The Inspector also expressed the opinion that it is "inappropriate for a women's prison and utterly incompatible with the Department's new Women's Standard."[105] The Inspector noted that the Department has actually supported all the previous recommendations to either upgrade or replace the Visits Centre, but nothing has eventuated. That remains the case today, despite the Department having independently identified the deficiencies and recommending their improvement or upgrade.[106]

102. Assistant Superintendent Henderson said that he hoped that the government might have plans to make changes and improve the Visits Centre, and indicated that there is some work going on at the moment to try to create a children's play area. He noted the irony that most of the male prisons have large play areas for children, and yet the main (and previously only) women's prison still does not have one, despite the obvious need for one. Assistant Superintendent Henderson explained that the problem arises from the nature of the Bandyup Prison facility, which is old and has limited space, so in order to build a new visits room, they would have to demolish the old one, but there would be no facility to continue visits in the interim. Assistant Superintendent Henderson has considerable experience in the strategic projects area, and he described the process of building in prison as "extremely complex," and this particular project would have those additional problems.

103. In the meantime, Assistant Superintendent Henderson reiterated that Bandyup continues to have "one of the worst visits rooms in the State."[107] Clearly, something more needs to be done. The Inspector commented that "the continued failure by the Department, Government and Treasury to ensure that funds for long overdue upgrades to Bandyup's Visits Centre are prioritised must be addressed."[108] I agree. It is unacceptable that one of the

[103] Submissions on behalf of Tammy's family provided to the Court by email from Ms Langoulant dated 10 December 2017.
[104] Report No. 114, 2017 Inspection of Bandyup Women's Prison, December 2017, p. 24.
[105] Report No. 114, 2017 Inspection of Bandyup Women's Prison, December 2017, p. 24.
[106] T 52 – 4.12.2019.
[107] T 52.
[108] Report No. 114, 2017 Inspection of Bandyup Women's Prison, December 2017, p. 25.

main women's prisons in this State has the worst facilities for family visits in this State. Tammy's family have provided a personal example of why more needs to be done. I am sympathetic to the practical difficulties that creating a new visits room entails on a restricted site and within a working prison, but the problem has been raised for many years and a solution must be found.

Recommendation

I endorse the recommendation of the Inspector of Custodial Services that a new Visits Centre be built at Bandyup Women's Prison to facilitate:

- **Increased capacity and privacy,**
- **Separate spaces for children's play area, search and change rooms facilities,**
- **Appropriate CCTV and staff levels, and**
- **Incorporated official visits.**

104. I am satisfied that Tammy's care in prison overall was reasonable and appropriate. The evidence indicates she was reviewed regularly by a psychologist from the counselling service, who was able to establish some rapport with her. She continued to deny plans to harm herself during her counselling sessions and there appeared to be no reason to suspect she was contemplating suicide during the last session on the day she died. Her roommate, with whom she had become close and who was the last person to see her alive, also saw nothing to cause her concern that Tammy was actively suicidal.

105. Tammy's decision to take her life appears to have been impulsive. The main triggers seem to have been her concern that she might be charged in relation to her partner's death, which would have dashed her hopes of imminent release, and the news that her roommate was moving, even though there was a chance she might be able to follow her to the new prison. The evidence indicates that Tammy did not give any overt sign of her decision, prior to taking her life, that could have prompted others in the prison to take steps to prevent her.

106. By the time Tammy was found, it was too late to save her despite prompt and concerted efforts by the prison staff, nursing staff and paramedics to resuscitate her.

CONCLUSION

107. When Tammy first entered prison, she was acknowledged to be fragile and potentially suicidal, so she was placed in a more closely supervised environment until she settled. It appears that Tammy's mental and emotional state was variable from then on but with a gradual improvement

noted until a few days before her death. The evidence suggests she began dwelling on her partner's death in those last few days, and her grief and concern about possible criminal charges led to a downward spiral in her mental state. On the day of her death she had also received the unexpected news that her cellmate, who had become her friend, was moving to another prison. There was a good chance Tammy could move with her, but she did not know that was certain prior to her death.

108. Tammy was given good support while in prison, both from fellow prisoners and Ms Neville, but unfortunately this was not enough to stop her from making an impulsive decision to take her life.

109. It was apparent at the inquest that Tammy had been dearly loved by her family and they are still struggling with their loss. They have accepted that Tammy committed suicide, but raised some concerns about the inadequate visits facility at Bandyup, that prevented them from having more contact with Tammy prior to her death. I hope that the recommendation that I have made reassures them that their concerns have been heard and give them some hope that there will be a positive change for other families in the future.

S H Linton
Coroner
5 February 2020