JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	14 DECEMBER 2021
DELIVERED	**:**	22 DECEMBER 2021
FILE NO/S	**:**	CORC 21 of 2019
DECEASED	**:**	DUTURBURE, BRETT ASHLEY

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Sergeant A Becker assisted the Coroner.

Mr T Ledger (State Solicitor's Office) appeared on behalf of the Department of Justice.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Brett Ashley DUTURBURE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 14 December 2021, find that the identity of the deceased person was* ***Brett Ashley DUTURBURE*** *and that death occurred on or about 14 November 2019 at Wyndham Work Camp, Arthur Street, Wyndham, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Brett Ashley Duturbure (Mr Duturbure) was 29-years of age when he died on or about 14 November 2019, at the Wyndham Work Camp (WWC) from ligature compression of the neck. At the time of his death, he was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (Director General). Thus, immediately before his death, Mr Duturbure was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory.[1,2,3,4,5,6,7,8,9]

2. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[10] On 14 December 2021, I held an inquest into Mr Duturbure's death. The documentary evidence adduced at the inquest included reports the Western Australia Police Force[11] and the Department of Justice (the Department),[12] with the Brief comprising two volumes.

3. The inquest focused on the care Mr Duturbure received while he was in custody, as well as on the circumstances of his death. The following witnesses from the Department gave evidence at the inquest:

a. Sen. Const. James Robinson (Investigating officer);
b. Mr Greg Sorell (Prison officer, Wyndham Work Camp);
c. Mr Stephen Gray (Prison officer, Wyndham Work Camp);
d. Mr Neil Branigan (Prison officer, Wyndham Work Camp);
e. Mr Nigel Smith (Superintendent, Custodial Services);
f. Ms Toni Palmer, (Performance Analyst); and
g. Dr Joy Rowland, (Director of Medical Services).

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (22.04.20)
[2] Exhibit 1, Vol. 1, Tab 5, P92 Identification of deceased person (14.11.19)
[3] Exhibit 1, Vol. 1, Tab 5, New South Wales Register of Births (31.08.90)
[4] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report (20.11.19)
[5] Exhibit 1, Vol. 1, Tab 6, Life Extinct Form (14.11.19)
[6] Exhibit 1, Vol. 1, Tab 6, Life Extinct Certification (14.11.19)
[7] Section 16, *Prisons Act 1981* (WA)
[8] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[9] Section 22(1)(a), *Coroners Act 1996* (WA)
[10] Section 25(3) *Coroners Act 1996* (WA)
[11] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report (22.04.20)
[12] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21)

MR DUTURBURE

Background[13,14,15,16]

4. Mr Duturbure was born in New South Wales and had three siblings. It appears he had a very traumatic childhood. He is said to have been subjected to regular physical abuse by his father and was allegedly sexually assaulted by one of his father's friends. Mr Duturbure is also said to have witnessed his father's alcohol fuelled, violent behaviour towards his stepmother, and it is also believed that he may have witnessed her take her own life.

5. Mr Duturbure was reportedly placed in foster care in his mid-teens and spent time in juvenile detention. He worked as a labourer at various times and was a carer for his older brother, a role he reportedly discharged with skill. Mr Duturbure had two children from a previous relationship and prior to his most recent imprisonment, he was living in Kununurra with his partner. He enjoyed writing in his journals and composing rap music.

Offending history[17]

6. Mr Duturbure had an extensive criminal history in the Northern Territory which began when he was a juvenile. As an adult, he accumulated 14 convictions for various offences including stealing and trespass and he was imprisoned in Darwin Prison after being convicted of robbery in company, an offence he committed in 2011.[18]

7. On 19 January 2018, in the District Court of Western Australia at Kununurra, Mr Duturbure was sentenced to 3 years imprisonment (with parole eligibility) for a violent and sustained assault on a police officer. His earliest possible release date (assuming parole was granted), was calculated to be 11 February 2019.[19,20,21]

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[13] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (22.04.20)
[14] Exhibit 1, Vol. 1, Tab 10, Sentencing submissions, District Court of WA, per Gething DCJ (19.01.18), pp8-9
[15] Exhibit 1, Vol. 1, Tab 11, Memo - Sen. Const. J Robinson (18.11.19)
[16] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), p8
[17] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), p8
[18] Exhibit 1, Vol. 2, Tab44.3, Information for Courts (Northern Territory)
[19] Exhibit 1, Vol. 2, Tab44.2, History for Courts (Western Australia)
[20] Exhibit 1, Vol. 1, Tab 10, Sentencing submissions, District Court of WA, per Gething DCJ (19.01.18), pp12 & 19
[21] Exhibit 1, Vol. 2, Tab 44.4, Sentence Summary - Offender

Medical history[22,23]

8. On admission to Broome Regional Prison (BRP), Mr Duturbure had a human bite mark on his right hand, sustained during incident for which he was imprisoned. Mr Duturbure was reviewed at Kununurra Hospital and prescribed a course of antibiotics, which he completed whilst in prison. He disclosed a past history of polysubstance use, including methylamphetamine and cannabis, but no chronic medical issues were identified.

9. Whilst he was in custody, Mr Duturbure occasionally attended prison medical centres for treatment of minor issues including chest infections, blocked ears, insect bites and an itchy scalp. When it was discovered that he had hypertension, he was prescribed medication and his blood pressure was regularly monitored.

10. On 9 July 2018, Mr Duturbure was reviewed by a physiotherapist after complaining of back pain. He had been exercising for one to two hours per day, having previously been inactive. He was advised to continue exercising but at a more gradual pace. Despite repeated reminders, he did not attend follow-up appointments.

11. At his annual health review on 14 August 2019, Mr Duturbure disclosed a long history of heavy smoking and drinking and was counselled about both issues. He was also advised to wear a hat and sun protection when outdoors, as he had indicated he did not normally take these precautions.

12. At the inquest, Dr Joy Rowland expressed the opinion that Mr Duturbure received comprehensive primary health care that "*was comparable to the care expected in the community*".[24]

Mental health history[25]

13. Records obtained by the Court establish that on 8 October 2005, Mr Duturbure was admitted to Royal Darwin Hospital (RDH) for treatment of facial fractures following an alleged assault.[26,27]

[22] Exhibit 1, Vol. 2, Tab 44.40, Health Services Review (Oct 2021), pp3-10 and ts 14.12.21 (Rowland), p108-127
[23] Exhibit 1, Vol. 2, Tab 44, Death in Custody Report (10.11.21), pp21-22
[24] Exhibit 1, Vol. 2, Tab 44.40, Health Services Review (Oct 2021), p10 and ts 14.12.21 (Rowland), p122
[25] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report (22.04.20), p8

14. At that time, Mr Duturbure was 15-years of age and he had reportedly threatened to harm himself with a knife, although he subsequently denied any suicidal ideation. He absconded from RDH on 10 October 2005, and nursing staff reported him to police. Hospital staff spoke with Mr Duturbure's father who said his son was staying with friends and did not want to return to hospital, however, police located Mr Duturbure and he agreed to return to RDH. His mental state was monitored and he was discharged on 12 October 2005.[28,29]

15. On 19 October 2008 (when he was 18-years of age) Mr Duturbure was brought to RDH by ambulance after attempting to hang himself following an argument with his then partner whilst intoxicated. Under the heading "*Past Medical History*", the emergency department nursing assessment lists "*previous suicide attempts*", although there is no further detail about these previous attempts.[30]

16. Mr Duturbure underwent a mental health assessment during which he reported family dysfunction from when he was 9-years of age. He also said he had been regularly physically assaulted by his father as child and disclosed being sexually assaulted by one of his father's friends. He had also watched his stepmother stab herself, apparently to death.[31,32]

17. On 28 November 2010, Mr Duturbure was brought to RDH by ambulance after taking an unknown number of cephalexin tablets with the intention of taking his life. He told staff he "*had his run in life and is over it*" and was sick of everything including harassment by police. During a mental health assessment, he mentioned his father was a violent alcoholic and he disclosed a history of self-harm. Mr Duturbure denied he was actively suicidal but told staff he had been charged with robbery and expected to be jailed and this was "*stressing him out*". He declined offers of counselling and was discharged home.[33,34]

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[26] Exhibit 1, Vol. 1, Tab 39, National Police Search records (10.10.05)
[27] Royal Darwin Hospital (1003394-1), Emergency Department medical records, (08.10.05)
[28] Exhibit 1, Vol. 1, Tab 39, National Police Search records (10.10.05)
[29] Royal Darwin Hospital (1003394-1), Inpatient Clinical Progress notes (08-12.10.05)
[30] Royal Darwin Hospital (1003394-1), Emergency Department medical records, (19.10.08)
[31] Royal Darwin Hospital (1003394-1), Mental Health Triage Assessment (19.10.08)
[32] Exhibit 1, Vol. 1, Tab 11, Memo - Sen. Const. J Robinson (18.11.19) and ts 14.12.21 (Robinson), p9
[33] Exhibit 1, Vol. 1, Tab 39, Northern Territory Police record (28.11.10)
[34] Royal Darwin Hospital (1003394-1), Mental Health Triage Assessment (28.11.10)

Adverse Childhood Events

18. The matters Mr Duturbure disclosed during his admissions to RDH in 2008 and 2010 are known as adverse childhood events (ACE). Examples of ACE include: family and domestic violence, sexual abuse, emotional abuse, physical abuse and neglect, the loss of parents and other loved ones (including by incarceration), parents or significant others with mental health issues and exposure to substance abuse at an early age.[35,36,37]

19. I am aware from previous inquests I have conducted that in recent years, the pervasive and long-lasting impacts of ACE have been given more emphasis in the context of risk assessments directed at self-harm and suicide.[38]

20. At the inquest, Dr Rowland confirmed that studies have repeatedly demonstrated a strong link between ACE and an increased risk of suicide. Indeed, people with significant history of ACE (especially multi-factor ACE) have been shown to be many times more likely to take their lives by suicide.[39]

21. There is also a strong link between ACE and the development of personality and mental health disorders, including antisocial personality disorder (ASPD), which is associated with increased impulsivity. A greater level of impulsivity leads to a greater propensity to engage in criminal behaviour and for that reason, ASPD is associated with higher rates of imprisonment.[40]

22. Dr Rowland said that on the basis of the matters Mr Duturbure had disclosed to RDH in 2008 and 2010, his ACE score would have been 7 or higher, meaning he was up to 50 times more likely to take his life than a person without a history of ACE.[41]

[35] Royal Darwin Hospital (1003394-1), Mental Health Triage Assessment (28.11.08)
[36] Royal Darwin Hospital (1003394-1), Mental Health Triage Assessment (28.11.10)
[37] ts 14.12.21 (Rowland), pp102-121 & 122-123
[38] Inquest into Five deaths at Casuarina Prison (14/19, 22.05.19)
[39] ts 14.12.21 (Rowland), p122
[40] ts 14.12.21 (Rowland), pp122-123
[41] ts 14.12.21 (Rowland), pp118-119

23. The Court obtained documents from the Northern Territory relating to Mr Duturbure's imprisonment at Darwin Prison with no difficulty. One of these documents was an "*Immediate Risk/Needs Assessment*" (IRNA) dated 17 August 2011, in which Mr Duturbure disclosed a history of juvenile detention and his attempt to take his life in 2010 by means of an overdose. In an IRNA dated 20 December 2013, Mr Duturbure also disclosed a history of polysubstance use and a history of self-harm and suicide attempts.[42,43]

24. A security classification assessment (SCATE) dated 17 April 2012 from Darwin prison referred to Mr Duturbure's attempt to take his life in 2010 and well as his poor prison record which included assaults on other prisoners. The SCATE recommended Mr Duturbure's security classification be upgraded from low to medium noting:

> Due to Duturbure's recent conduct and overall behaviour within the institution, he is not suitable for a low security rating. Sentence Management have been advised by the Deputy Superintendent Operations…to upgrade Duturbure to a medium rating. It is noted that as a low rating prisoner, LSU [Low Security Unit] senior staff refused to allow Duturbure to transfer to the LSU as they deemed him unsuitable.[44]

25. The information contained in these three documents was obviously highly relevant to Mr Duturbure's management whilst he was in custody in Western Australia. For that reason, records from Darwin Prison should have been obtained by the Department when Mr Duturbure was received into BRP.

26. The Court also obtained Mr Duturbure's medical records from RDH and, as I have outlined, those records disclosed his significant history of self-harm and his two attempts to take his life. Clearly, this information was also highly relevant to Mr Duturbure's management and the Department should have taken steps to obtain these documents.

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[42] Exhibit 1, Vol. 2, Tab 44.42B, Darwin Prison records - IRNA (17.08.11)
[43] Exhibit 1, Vol. 2, Tab 44.42C, Darwin Prison records - IRNA (20.12.13)
[44] Exhibit 1, Vol. 2, Tab 44.42A, Darwin Prison records - SCATE (17.04.12)

Intake Assessment[45,46]

27. When a prisoner is received at a prison, an experienced prison officer (i.e.: a reception officer) conducts a formal assessment designed to identify any presenting risk factors. Within 24-hours of arriving at a prison, the prisoner's physical health needs are also assessed by a nurse.[47] During his reception interview at BRP on 12 August 2017, Mr Duturbure was asked various standard questions about his past and present mental health. He denied any self-harm or suicidal ideation and said he had never attempted to take his life or lost a family member to suicide. He also denied ever being hospitalised for mental health issues and said he had never been seen by a mental health professional.

28. Mr Duturbure also disclosed he had previously been incarcerated at Darwin Prison and said that his only current stressor was his concern for his partner, who had been imprisoned for her role in assisting Mr Duturbure to assault a police officer. I note that the Death in Custody Review in this matter states that Mr Duturbure disclosed "*he had spent time in a Darwin Prison approximately two years earlier*",[48] although the reception officer's assessment report notes:

> Prisoner was polite and compliant throughout the interview, answered all questions put to him in what appeared to be an open, honest and polite manner advising the writer he had spent time in Darwin Prison, is fully aware of his current situation and the possibility that he is facing mandatory sentencing.[49]

29. Although Mr Duturbure's responses may well have been polite, they were clearly neither open nor honest. As I have explained, Mr Duturbure had a significant mental health history and his responses to the reception officer were demonstrably false. It is deeply troubling that despite Mr Duturbure having disclosed his previous incarceration at Darwin Prison, the Department took no steps to obtain his Northern Territory prison records.

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[45] Exhibit 1, Vol. 2, Tab 44.1, ARMS Reception Intake Assessment (12.08.17)
[46] Exhibit 1, Vol. 2, Tab 44.5, Statement - Mr M Anderson (10.02.20)
[47] ts 14.12.21 (Rowland), p110
[48] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), p9
[49] Exhibit 1, Vol. 2, Tab 44.1, ARMS Reception Intake Assessment (12.08.17), p5

30. Had the Department obtained these records, they would have been given the SCATE (obtained by the Court) that records Mr Duturbure's attempt to take his life in 2010.[50] Once this information had been obtained, the most basic of enquiries would have unearthed Mr Duturbure's RDH medical records and revealed the significant mental health history I have just outlined.[51]

31. Had the reception officer at BRP been privy to Mr Duturbure's mental health history at the time of the intake assessment on 12 August 2017, it is almost certain that Mr Duturbure would have been referred to a mental health professional who could have challenged his denials of previous self-harm and suicide attempts.[52]

32. As I will explain later in this finding, this information would also have been relevant to the assessment of Mr Duturbure's suitability for placement at WWC. It is my view that the Department's failure to make basic enquiries about the circumstances of Mr Duturbure's previous imprisonment was a very serious error.

Prison history[53]

33. During his incarceration, Mr Duturbure had the following placements:

a. *Broome Regional Prison:* 12.08.17 - 25.08.17 (13 days);
b. *West Kimberley Regional Prison:* 25.08.17 - 18.01.18 (146 days);
c. *Broome Regional Prison:* 18.01.18 - 25.01.18 (7 days);
d. *West Kimberley Regional Prison:* 25.01.18 - 10.10.19 (623 days);
e. *Broome Regional Prison:* 10.10.19 - 18.10.19 (8 days); and
f. *Wyndham Work Camp:* 18.10.19 - 14.11.19 (27 days).

34. Five days after Mr Duturbure was received at BRP, his partner was transferred to West Kimberley Regional Prison (WKRP). Mr Duturbure requested a transfer to WKRP to facilitate intra-prison visits with his partner and he was transferred there on 25 August 2017.

[50] Exhibit 1, Vol. 2, Tab 44.42, Darwin Prison SCATE Assessment (17.04.12), p2
[51] Royal Darwin Hospital (1003394-1), Medical records (2005-2010)
[52] ts 14.12.21 (Rowland), pp116-118
[53] Exhibit 1, Vol. 2, Tab 44, Death in Custody Report (10.11.21), pp9-14

35. On 28 August 2017, Mr Duturbure had a routine consultation with a counsellor from the Prison Counselling Service (PCS)[54] during which he disclosed he had spent time in juvenile and adult prisons in the Northern Territory. Mr Duturbure also described a dysfunctional childhood, but he denied any current self-harm or suicidal ideation, and stated "*he has never had those thoughts*". Once again, these disclosures prompted no action on the part of the Department. [55]

36. The reason for Mr Duturbure's persistent denial of his history of self-harm ideation and attempts to take his life is unclear. Perhaps he was motivated by a desire to avoid any potential restrictions on his movement within the prison system [as may have happened had he been placed on the At Risk Management System (ARMS)[56] at any stage]. All that can be said is that if the counsellor who conducted what she described as a "*meet and greet*" with Mr Duturbure had access to his previous history she would surely have explored the reason for his denials (as well as his current mental state) in more detail.[57]

37. Whilst at WKRP, Mr Duturbure completed several training courses and indicated an interest in working in the automotive industry. As a result it was suggested that he undertake classes at the prison's TAFE facility.[58]

38. A treatment assessment conducted in May 2018, identified that Mr Duturbure had issues with violence and alcohol consumption and recommended he undertake the Department's "*Pathways Program*" to address these issues. The treatment assessment report states "*He has no previous violent convictions recorded on his Northern Territory criminal history*", however, this statement is false. Mr Duturbure's criminal history from the Northern Territory lists a variety of violent offences including weapons and disorderly conduct offences, including one that involved resisting arrest by a police officer.[59,60]

[54] Prison Counselling Service is now known as Psychological Health Services
[55] Exhibit 1, Vol. 2, Tab 44.9, Prison Counselling Session - File Note (28.08.17)
[56] ARMS is the is the Department's primary suicide prevention strategy
[57] Exhibit 1, Vol. 2, Tab 44.9, Prison Counselling Session - File Note (28.08.17) and ts 14.12.21 (Rowland), pp118-119
[58] Exhibit 1, Vol. 2, Tab 44.10, Education and Vocational Training Checklist (13.04.18), p7
[59] Exhibit 1, Vol. 2, Tab 44.3, Northern Territory Criminal Record
[60] Exhibit 1, Vol. 2, Tab 44.12, Treatment Assessment Report (15.05.18), p2

39. Perhaps more importantly, the offence for which Mr Duturbure had been imprisoned in Darwin Prison was robbery in company, an offence categorised in the SCATE from Darwin Prison as "*Violent - Serious*".[61]

40. By the time of the treatment assessment, the Department had known that Mr Duturbure had spent time in Darwin Prison for over nine months. Had the Department taken the trouble to obtain Mr Duturbure's records from Darwin Prison, it would have had a much clearer understanding of his background, and thereby his treatment needs.[62]

41. In the absence of records from Darwin Prison, the treatment assessment proceeded on the basis that Mr Duturbure had only committed one offence of violence, namely the assault on a police officer for which he had been imprisoned in Western Australia. That simply wasn't true and therefore, the assessment process was flawed because Mr Duturbure's background was not adequately understood.

42. In June 2018, a case conference report (whilst Mr Duturbure was at WKRP) noted that his cell cleanliness and personal hygiene were of a good standard. Although he had received sanctions for being out of bounds on two occasions, it was noted that this had occurred shortly after his arrival at WKRP and he may not have been fully aware of local rules.[63]

43. The case conference report also noted that Mr Duturbure had not been the subject of community supervision in Western Australia, but that on 20 April 2017, he had completed community service in the Northern Territory. The case conference report notes: "*Katherine Corrections advised he completed those hours in a timely manner*".[64]

44. This indicates that the Department must have obtained Mr Duturbure's community service records from the Northern Territory and makes its failure to obtain his Darwin Prison records even more difficult to understand.

[61] Exhibit 1, Vol. 2, Tab 44.42A, Darwin Prison records - SCATE (17.04.12)
[62] Exhibit 1, Vol. 2, Tab 44.1, ARMS Reception Intake Assessment (12.08.17)
[63] Exhibit 1, Vol. 2, Tab 44.13, Case Conference Report (07.06.18)
[64] Exhibit 1, Vol. 2, Tab 44.13, Case Conference Report (07.06.18), p4

45. Mr Duturbure's security classification and placement options were reviewed on a number of occasions between January 2018 and October 2019. These reviews noted his "*positive work attitude and excellent work ethic*" in the laundry and as a cleaner and on 7 August 2019, his security rating was reclassified to minimum.[65]

46. On 5 September 2019, Mr Duturbure self-referred to the PCS, and presented as "*agitated and anxious*". He said he was confused about his current relationship and that the Pathways program he was undertaking had brought "*a lot of things to the surface*" which left him feeling "*somewhat overwhelmed with emotions*". He disclosed unspecified childhood events that continued to "*haunt him*", but denied suicidal ideation citing his children as protective factors.[66]

47. Mr Duturbure saw the prison counsellor on a further four occasions. At his last session on 1 October 2019, he said he did not wish to continue with counselling and had applied for a transfer to WWC. During the counselling sessions he attended, Mr Duturbure spoke about anger relating to childhood issues, although it is unclear exactly what information he disclosed.[67,68]

48. During his last session, Mr Duturbure also said he "*does not experience feelings*" and had closed off his feelings for most of his life and "*will be happy to do it again*". He spoke about his relationship with his partner and the prison counsellor noted:

> He seems to have made up his mind that he wants to finish the relationship with his partner in the female unit. He seems to think she has been unfaithful and he does not trust her any more. He has no evidence that she has been unfaithful and tends to believe the word of another prisoner rather than have trust that his partner is being faithful.[69]

[65] Exhibit 1, Vol. 2, Tab 44.16, Classification Reviews (02.10.18; 18.03.19; and 07.08.19)
[66] Exhibit 1, Vol. 2, Tab 44.19, Prison Counselling Session - File Note (05.09.19)
[67] Exhibit 1, Vol. 2, Tab 44.19, Prison Counselling Session - File Notes (05, 09, 16 & 23.09.19 & 01.10.19)
[68] See also: Exhibit 1, Vol. 2, Tab 44.19, Mental Health, Alcohol & Other Drugs Summary (August 2021)
[69] Exhibit 1, Vol. 2, Tab 44.19, Prison Counselling Session - File Note (01.10.19)

49. These counselling sessions proceeded in the absence of crucial information about Mr Duturbure's ACE and his previous self-harm and suicide history. Had the prison counsellor had access to this information, it is inconceivable that these matters would not have been discussed with Mr Duturbure, and may have helped explain his anger issues, his inability to trust his partner and his sense of being emotionally overwhelmed.

50. Whilst in prison, Mr Duturbure underwent seven illicit substance tests, all of which returned negative results. He was employed as a general worker, cook's assistant and laundry hand and he was also a leading hand on the cleaning party. Although he did receive some adverse comments on TOMS, no alerts were noted and he was not the subject of any prison charges. [70,71,72,73,74]

51. Whilst he was at WKRP, Mr Duturbure had numerous intra-prison visits with his partner and they sent letters to each other on a regular basis. He also maintained regular contact with family members and friends using the Prison Telephone System. During Mr Duturbure's last recorded call with his partner, she sounded distressed and said she thought he was going to leave her. Despite what Mr Duturbure had earlier told a prison counsellor about his relationship, he reassured his partner that he was not going to leave and also told her he loved her.[75,76,77]

Applications for parole[78]

52. Mr Duturbure's suitability for parole was first assessed on 29 November 2018. At that time, a review officer noted that there were no effective protective strategies in place to prevent reoffending and that Mr Duturbure had declined to transfer to another prison to undertake the Pathways program (which was not available at WKRP at the time).

[70] Total Offender Management System is the computer system the Department uses to manage prisoners
[71] Exhibit 1, Vol. 2, Tab 44.29, Alert History - Offender
[72] Exhibit 1, Vol. 2, Tab 44.30, Work History - Offender
[73] Exhibit 1, Vol. 2, Tab 44.31, Charge History - Offender and Loss of Privileges History - Offender
[74] Exhibit 1, Vol. 2, Tab 44.32, Substance Use Test Results - Prisoner Copy
[75] Exhibit 1, Vol. 2, Tab 44.33, Prisoner Mail - Offender and Visits History - Offender
[76] Exhibit 1, Vol. 2, Tab 44.19, Prison Counselling Session - File Note (01.10.19)
[77] Exhibit 1, Vol. 2, Tab 44.34, Transcript of phone conversation between Mr Duturbure and his partner
[78] Exhibit 1, Vol. 2, Tab 44, Death in Custody Report (10.11.21), pp12-13

53. Mr Duturbure's application was also rejected because he was unable to demonstrate a viable accommodation plan and had no employment prospects.[79] Mr Duturbure's suitability for parole was also rejected on 15 October 2019. Although he had completed the Pathways program by that time, he still had no suitable accommodation or employment options.[80,81]

Wyndham Work Camp[82,83,84,85,86,87]

54. WWC opened in 2011, and is a purpose-built minimum-security facility located about 100 kms from Wyndham. The facility aims to give prisoners the opportunity to develop new skills while "*helping the local community with valuable work such as conservation, maintenance and community projects*".[88]

55. The work camp model aims to: "*maximise prisoner rehabilitation and community reparation*". Future employment opportunities for prisoners at WWC are enhanced by encouraging self-responsibility and the development of job-ready skills through appropriate community work projects.[89]

56. WWC can accommodate up to 40 prisoners in five identical units, each with eight, single occupancy cells. The muster at WWC usually ranges from 12 to 25 prisoners, with staff preferring a higher muster because it allows more meaningful work projects to be undertaken.

57. Facilities at WWC include shared ablutions, a cultural area, recreation room and fully equipped gym. Cells are furnished with a bed, desk and cupboards and are lockable by prisoners, although prisoner officers have an override key that allows them to access cells at will.

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[79] Exhibit 1, Vol. 2, Tab 44.14, Parole Review Report (29.11.18)
[80] Exhibit 1, Vol. 2, Tab 44.21, Parole Review Report (15.10.19)
[81] Exhibit 1, Vol. 2, Tab 44.18, Printout of Treatment and E&VT Assessment Outcomes
[82] Exhibit 1, Vol. 2, Tab 44.24, Statement - Mr B Wilson (13.09.21), paras 4-53
[83] Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), paras 10-27
[84] ts 14.12.21 (Sorrell), pp11-17, 27-28 & 29-32 and ts 14.12.21 (Branigan), pp53-53
[85] Exhibit 1, Vol. 1, Tab 16.1, Statement - Mr S Gray (06.03.20), paras 4-9 and ts 14.12.21 (Gray), p34
[86] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 4-22
[87] Exhibit 1, Vol. 1, Tab 17, Statement - Mr D Daniel (11.03.20), paras 4-11
[88] Media statement, Minister for Corrective Services (29.06.11)
[89] Exhibit 1, Vol. 2, Tab 44.24, Statement - Mr B Wilson (13.09.21), para 4

58. The daily routine at WWC includes a morning muster at 6.00 am, job tasks at the facility or in the local community and a recreation period at the end of the work day. Prisoners have some freedom of movement during periods of recreation but are required to be on the verandahs of their units by 9.30 pm, ready for the final evening muster at 10.00 pm. Prisoners must remain in their cells overnight, but are not locked in and are not subject to overnight checks. Prison officers retire to their quarters at 10.00 pm, and are on "*stand by*" until the next morning. Prisoners may leave their cells to use the shared ablutions or to seek help from prison staff in the case of an emergency.

59. There are no medical or mental health staff based at WWC and staff therefore perform a range of duties including providing basic medical assistance, overseeing visits, facilitating hospital or medical appointments and counselling prisoners who have "*had a bad phone call*" or "*are feeling down*".[90] Vulnerable prisoners can also be referred to Peer Support prisoners and have access to Elders and Traditional Owners. Staff can also facilitate contact with mental health professionals by phone, and more recently, via telehealth video consultations. Prisoners requiring more intensive support may be offered face-to-face consultations with local mental health professionals or through PCS following a transfer to BRP.

60. Prisoners currently have access to telephones at WWC until the evening muster and receive a weekly phone card allowance. Calls to family and friends in other prisons can be arranged. Calls are not presently recorded, but the Department is currently upgrading the phone system at WWC so that this will be possible. Two prison officers are generally on duty 24-hours per day, with a senior officer on-site for eight hours per day. As it happens, on 13 November 2019 there were three prison officers on duty because of a leave roster issue. Unlike all other work camps (except Walpole, which is a one officer outpost) WWC does not have a senior officer on site overnight. This regrettable situation is currently being reviewed and hopefully, this anomaly will soon be rectified.[91,92,93]

[90] Exhibit 1, Vol. 1, Tab 17, Statement - Mr D Daniel (11.03.20), para 9
[91] Exhibit 1, Vol. 2, Tab 44.24, Att. BW1, Wyndham Work Camp Unit Plan 2021 (April 2021), p5

61. There are no facilities at WWC to detain volatile or violent prisoners and staff had been directed to call local police in the first instance. However, at the inquest, Officer Gray said that the local Police Superintendent had advised that police would no longer attend WWC for this purpose. This leaves WWC staff in a very vulnerable position and highlights the critical importance of ensuring that the suitability of all prisoners transferred to WWC is carefully and rigorously assessed.[94]

62. The evidence before me was that this screening process has not always been as thorough as it should be and that the views of WWC staff about the suitability of certain prisoners for transfer to WWC, have not always been considered. In this case, a number of WWC staff had significant concerns about Mr Duturbure's suitability for placement there.[95,96]

Work Camp assessment criteria[97,98]

63. The suitability of all prisoners transferred to WWC is assessed against established criteria. Prisoners must have a minimum-security classification, demonstrate "*good behaviours*", and be approved for what is referred to as "*s95 status*".

64. This is a reference to section 95 of the *Prisons Act 1981* (WA) (Prisons Act), which empowers the Director General to provide prisoners with access to programs (including work skills and employment projects) inside and outside of a prison.

65. The Department's work camps policy states:

> A work camp placement is a privilege and prisoners need to meet stringent criteria in order to be selected. As such the 'Suitability for External Activities or Work Camp Placement' on TOMS must be completed for all prison placements.[99]

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[92] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 61 & 65
[93] ts 14.12.21 (Branigan), pp68-69 &73
[94] ts 14.12.21 (Sorrell), pp31-32 and ts 14.12.21 (Gray), pp38-39
[95] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 26
[96] ts 14.12.21 (Branigan), pp60-61 and ts 14.12.21 (Gray), pp37-38
[97] Exhibit 1, Vol. 2, Tab 44.43, Statement - Mr N Smith (13.12.21), para 22
[98] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 4-22
[99] Exhibit 1, Vol. 2, Tab 44.24, Att. BW3, Prisons Procedure 302 - Work Camps (29.06.19), para 6.1

66. The use of the words "*privilege*" and "*stringent*" in this section of the work camps policy suggests that the suitability of prisoners must be very carefully considered. Work camps are minimum-security facilities that are generally isolated and have much lower staff ratios than higher security prisons. In addition to those characteristics, WWC lacks appropriate facilities to deal with unstable, violent or agitated prisoners and has no senior officer available after about 3.00 pm.[100]

67. All of these factors strongly suggest that a prisoner whose suitability is deemed to be marginal should not be considered for placement at WWC until such time as they meet the relevant criteria without difficulty.

68. Certain categories of prisoners are ineligible for work camp placement, including those detained for some serious sexual offences and those with outstanding Prison Act charges. Assessment criteria for placement in a work camp include: victim issues (e.g.: the likely proximity of any identified victims to the external activity location); the nature of the prisoner's offences and the prisoner's mental health history.[101,102]

69. Prisoners approved for s95 activities are classified as either "*supervised*" or "*unsupervised*". Unsupervised prisoners do not require the physical presence of prison officers at their work site locations, whereas supervised prisoners do. Prior to 2017, only prisoners with unsupervised status were eligible for transfer to a work camp. However, following a policy review, both supervised and unsupervised prisoners are now routinely placed at work camps. Departmental policy provides that prisoners at work camps may not participate in either supervised or unsupervised external activities without being assessed and approved.[103]

70. Officer Gray said he and other WWC staff had argued against this policy change on the basis that it was not possible to monitor supervised prisoners at night at WWC because there were only two prison officers on site, and after 10.00 pm, those officers were on "*standby*". It appears these concerns were ignored.[104]

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[100] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 5-7 and ts 14.12.21 (Branigan), pp68-69
[101] Exhibit 1, Vol. 2, Tab 44.24, Att. BW3, Prisons Procedure 302 - Work Camps (29.06.19), section 8, pp7-9
[102] Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), paras 11-12
[103] Exhibit 1, Vol. 2, Tab 44.24, Att. BW4, Prisons Procedure 301 - External Activities (10.07.20), paras 4.1 & 5.1.3
[104] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), para 13 and ts 14.12.21 (Gray), pp35 & 36

71. Prisoners may transition from supervised to unsupervised status after successfully completing 10-days of supervised external activity.[105] For prisoners at WWC, management at BRP are responsible for this reclassification process, however, Officer Gray said:

> Unfortunately, this reclassification rarely occurs, with 60% of our muster still classified as supervised. At times the number of supervised prisoners has been higher.[106]

72. Assistant Superintendent Smith (Officer Smith) explained that the distinction between supervised and unsupervised prisoners relates to external activities, not whether the prisoner requires monitoring overnight. With respect, this distinction is ludicrous. Given that a supervised prisoner is deemed to require the physical presence of an officer during all external activities, I fail to understand how the Department can assert that such a prisoner is suitable for placement at WWC, given the staffing levels and lack of detention facilities I have referred to. In any event, there is no policy guidance about the status of supervised prisoners at WWC overnight.[107]

73. Officer Smith explained that prior to the policy change, it was considered that the assessment process was too long and rigorous and could take up to three months to complete. The 2017 review had the effect of enabling minimum-security prisoners serving short sentences for non-violent crimes to be considered for the work camp program. This provided an opportunity for a large number of prisoners to be placed in a less punitive environment, thus "*reinforcing community expectations and engagement in community reparative programs*".[108]

74. As laudable as these sentiments may be, staff at WWC have (what appear to me to be) legitimate concerns about the manner in which the suitability of prisoners for placement at their facility is being assessed. Officer Gray said he did not think supervised prisoners should be received at WWC for several reasons.

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[105] Exhibit 1, Vol. 2, Tab 44.43, Statement - Mr N Smith (13.12.21), para 22
[106] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), para 13
[107] Exhibit 1, Vol. 2, Tab 44.43, Statement - Mr N Smith (13.12.21), paras 51-54 and ts 14.12.21 (Smith), pp77-78
[108] Exhibit 1, Vol. 2, Tab 44.43, Statement - Mr N Smith (13.12.21), paras 35-37 and ts 14.12.21 (Smith), pp83-84

75. First, with only two officers available during the day it is extremely difficult, if not practically impossible, to appropriately manage supervised prisoners at external locations given the "*constant line of sight*" monitoring that is required.[109]

76. Further, a large muster of supervised prisoners effectively limits the activities that prisoners housed at WWC can engage in. A number of WWC's standard work locations also have physical barriers affecting the line of sight requirement. This includes the Kununurra Police station where one prison officer can only effectively supervise two prisoners at a time.[110]

77. Whilst I can see great merit in ensuring that as many suitable prisoners as possible can be placed in work camps, the appropriateness of allowing supervised prisoners into the program seems questionable. At the inquest, Officer Smith agreed that there would be no impediment to reverting to the previous arrangements (i.e.: where only prisoners with unsupervised status are placed at work camps) and I would urge the Department to seriously consider doing so.[111]

78. Pleasingly, I note that senior officers at WWC are now involved in prisoner assessments at "*intake meetings*". In my view, this is absolutely essential and it is to be hoped that due regard is taken of the opinion and lived experiences of these senior staff.[112]

Mr Duturbure's suitability for WWC[113,114]

79. Mr Duturbure's suitability for placement at WWC was assessed on two occasions, just under one month apart. The first assessment occurred on 19 September 2019, at WKRP, where Mr Duturbure had been incarcerated for a total of 602 days. On that occasion, placement at WWC was not approved.

[109] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 14-16
[110] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 18-20 and ts 14.12.21 (Smith), pp88-89
[111] ts 14.12.21 (Smith), pp78-79
[112] ts 14.12.21 (Gray), pp46-47
[113] Exhibit 1, Vol. 2, Tab 44.17, Suitability for External Activities or Work Camps (19.09.19)
[114] Exhibit 1, Vol. 2, Tab 44.22, Suitability for External Activities or Work Camps (17.10.19)

80. Instead, it was recommended that Mr Duturbure undergo a number of s95 supervised placements to gauge his suitability, before being considered further. Despite this recommendation, Mr Duturbure did not complete any s95 activities whilst he was at WKRP, and instead was employed in the laundry.[115]

81. WWC's Operational Philosophy and Guidelines Manual states that assessments for placement at WWC will be determined by the host prison, namely WKRP. Notwithstanding this provision, Mr Duturbure's suitability for WWC was assessed for a second time during the period 15-17 October 2019, at BRP where Mr Duturbure had been incarcerated for a total of only 27 days.[116]

82. The report on this second assessment (the Report) stated that Mr Duturbure was approved for "*External activities and placement at the Wyndham Work Camp*". The Report contains no analysis of why, less than one month after his first unsuccessful assessment, Mr Duturbure was now deemed suitable for placement at WWC.[117]

83. The Report also fails to mention that Mr Duturbure had not completed the supervised s95 placements that had been recommended and therefore, how it had been established that he was now suitable to be transferred to WWC. In my view, it is also the case that issues related to Mr Duturbure's offending were not adequately addressed, given that the victim of his unprovoked assault was a police officer.[118,119]

84. Although the Report makes a brief reference to the circumstances of Mr Duturbure's assault offence, it merely notes: "*Victim issues in the Kununurra area are not a concern at this time*". Presumably this is because it was thought that the police officer Mr Duturbure assaulted was no longer in Kununurra. However, this analysis completely fails to address the fact that witnesses to the assault and the police officers who responded to the incident still lived there.[120,121]

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[115] Exhibit 1, Vol. 2, Tab 44.30, Work History - Offender
[116] Exhibit 1, Vol. 2, Tab 44.25, WWC Operational Philosophy & Guidelines Manual (2011), para 2.1.5
[117] Exhibit 1, Vol. 2, Tab 44.22, Suitability for External Activities or Work Camps (17.10.19), p7
[118] Exhibit 1, Vol. 2, Tab 44.25, WWC Operational Philosophy & Guidelines Manual (2011), para 2.1.5
[119] ts 14.12.21 (Smith), pp86-87
[120] Exhibit 1, Vol. 2, Tab 44.22, Suitability for External Activities or Work Camps (17.10.19),
[121] ts 14.12.21 (Gray), pp45-46

85. Setting to one side the fact Mr Duturbure's Offender Severity Scale remained "*high*", there is a more fundamental problem. Neither assessment took any account of Mr Duturbure's Northern Territory prison record or his significant mental health history. This was because the Department had failed to obtain Mr Duturbure's Northern Territory records, as it should have.

86. On 16 October 2019, Officer Branigan received an email from Mr Ian West, Assistant Superintendent, Operations (Officer West) advising him that Mr Duturbure was to be transferred to WWC. Officer Branigan made some enquiries about the violent nature of Mr Duturbure's offending and identified that offender notes on TOMS suggested he had issues with authority figures. Officer Branigan felt these factors made Mr Duturbure an unsuitable candidate for WWC, and his staff agreed.[122,123,124]

87. Officer Branigan emailed Mr West to express his grave concerns about Mr Duturbure's suitability for placement at WWC. Officer West called to discuss the matter and Officer Branigan told Officer West that a number of WWC staff had also raised concerns, and said that:

> During our telephone call, Mr West conceded that it was **a line ball call**, but on this occasion, he was going to allow the transfer to take place. Mr West did not give any reason for supporting Mr Duturbure's transfer, and as he was my Assistant Superintendent, I did not push the matter despite my concerns.[125,126,127]
> [Emphasis added]

88. Officer Branigan had only been a senior officer at WWC since 23 September 2019, and at the inquest, he said he now regretted not pressing his concerns more forcefully.[128]

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[122] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 10-20 and ts 14.12.21 (Branigan), p55
[123] ts 14.12.21 (Branigan), pp55-57
[124] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 23-29 and ts 14.12.21 (Gray), pp36-38
[125] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 21-32
[126] ts 14.12.21 (Branigan), pp57-58 & 60-62
[127] See also: Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 23-29 and ts 14.12.21 (Gray), pp45-49
[128] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), para 3 and ts 14.12.21 (Branigan), p57-58

89. As it happens, Mr Duturbure was not the subject of any adverse comments about his behaviour whilst he was at WWC and on 12 November 2019, he was assessed as suitable to progress to "*unsupervised*" status for external activities, although he died before participating in any.[129]

90. Notwithstanding the fact that Mr Duturbure's behaviour at WWC was not a cause for concern, it is troubling that the Report's analysis was so superficial and that the concerns of staff at WWC appear to have been brushed aside. It is least possible that had the Department been aware of Mr Duturbure's interstate prison record and his mental health history, the "*line ball call*" made by Officer West in October 2019, might have gone the other way.[130]

91. In an email to Ms Palmer on 21 April 2021, Officer West confirmed that the 10-day trial period prisoners usually complete before being assessed for unsupervised activities might be extended to 28-days where a prisoner has had no previous exposure to external activities. Neither trial period occurred in Mr Duturbure's case. Mr West also stated that:

> There may be variance due to individual circumstances including age, health, length of sentence and logistics etc that generally increase the time for a prisoner to achieve placement at the work camp. **From time to time there has been a push from Adult Male Prisons to increase placements at the work camp also, however, this has not been at the expense of eligibility criteria to the best of my knowledge.**[131] [Emphasis added]

92. The "*push*" referred to in Mr West's email may account for the fact that Mr Duturbure's second assessment for placement at WWC was approved, notwithstanding the fact it was a "*line ball call*" which appears to have been made in the absence of any detailed assessment of the nature of Mr Duturbure's offending and without access to records relating to his Northern Territory incarceration or his significant mental health history.

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[129] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), p14
[130] ts 14.12.21 (Branigan), p71
[131] Exhibit 1, Vol. 2, Tab 44.23, Email Mr I West to Ms T Palmer (21.04.21)

93. At the inquest, Officer Branigan said that if he had access to this information at the time of his phone call with Mr West, it would have assisted him to make the case that Mr Duturbure was not an appropriate candidate for placement at WWC.[132]

Death in Custody review

94. Whenever there is a death in custody, the Department conducts a review of the circumstances of the death with a view to identifying whether there are any "*business improvements*" to be made. In appropriate cases, these business improvements might include recommendations for changes to policies or procedures; identifying areas requiring additional resources and/or physical improvements to the prison estate.[133]

95. The review into Mr Duturbure's death (DIC review) was conducted by Ms Toni Palmer, the Department's Senior Review Officer. The introduction section of the DIC review states that the Department's Performance Assurance and Risk Directorate (PAR) carries out a coronial coordination function on behalf of the Department in preparing matters of inquest and that:

> Independent reviews are undertaken by PAR for the purpose of supporting the Department in proactively identifying systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future. The objectives of the review undertaken by the PAR are to:
>
> - Provide information relating to custodial management, supervision and care of the deceased while in custody to assist the Coroner's investigation; and
>
> - **Proactively identify policy or procedural opportunities for improvement.** [Emphasis added][134]

[132] ts 14.12.21 (Branigan), pp70-72 & 73-74
[133] ts 14.12.21 (Palmer), p99
[134] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), p4

96. In conducting her review, Ms Palmer had access to a range of documents including those listed in Appendix 1 to the DIC review. One of those documents is described as "*Coronial Police Investigation Report*", which is a reference to the investigation report completed by Senior Constable Robinson (Officer Robinson). As I have outlined, Officer Robinson's report specifically refers to Mr Duturbure's self-harm ideation in 2005 and his suicide attempt by means of an overdose in 2010.[135,136]

97. Given the stated purpose of the death in custody review process, I was surprised that there was no mention of Mr Duturbure's history of self-harm and suicide in the DIC review and, presumably for that reason, no suggestions for business improvements in this respect. It would appear that Ms Palmer has been directed not to review documents other than those contained within the Department's own records.[137]

98. In my view, such an approach places Ms Palmer in a difficult position and significantly impacts on the scope of her reviews. At the inquest, Ms Palmer agreed that with the benefit of hindsight, the Department's lack of knowledge of Mr Duturbure's mental health history (caused by its abject failure to make even the most basic of enquiries) was an issue that should have been addressed in the DIC review.[138]

99. If the Department really is interested in "*proactively*" identifying policy or procedural improvements, then it is patently obvious that in appropriate cases (like Mr Duturbure's) it may be necessary to examine failures to obtain such information. Relying solely on documents that actually form part of the Department's own records is clearly overly restrictive and renders the death in custody review process somewhat pointless.

100. The DIC review should have squarely addressed the fact that after Mr Duturbure's death, the Department became aware of information about his mental health history that was clearly of critical importance to its risk assessment and management processes.

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[135] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report (22.04.20), p8
[136] Exhibit 1, Vol. 2, Tab 44, Appendix 1 to Death in Custody Review (10.11.21), p23
[137] ts 14.12.21 (Palmer), pp98-100
[138] ts 14.12.21 (Palmer), p99

101. The reasons why that information was not obtained should also have been explored, especially given the fact that Mr Duturbure told the reception officer about having been incarcerated in Darwin Prison during the ARMS risk assessment process on 17 August 2017. Finally, suggested improvements to procedures to prevent this serous error from ever happening again should have been outlined. At the inquest, Ms Palmer agreed that with the benefit of hindsight, these issues should have been canvassed in the DIC review.[139]

Obtaining interstate records

102. At the inquest, Ms Palmer also said she had anticipated that she might be asked about obtaining access to a prisoner's interstate prison records and had raised the question with relevant parties. Ms Palmer said:

> I did make some inquiries with both the receiving prison on this occasion and with a metropolitan prison, to see what the process was for a prisoner coming from interstate, and both facilities advised me that **they don't request interstate records because of the volume [or] potential volume** [of the records that might be forthcoming].[140] [Emphasis added]

103. If that response actually represents the Department's position, then this is completely unacceptable, and runs counter to the Director General's statutory obligations. Relevantly, section 7(1) of the *Prisons Act 1981* (WA) provides:

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

104. Given this clear and unequivocal statement, I have difficulty understanding why the Department would not make every effort to obtain information about a prisoner's previous history of incarceration, and where relevant, that prisoner's medical history.

[139] ts 14.12.21 (Palmer), p102
[140] ts 14.12.21 (Palmer), pp101-102

105. As was starkly demonstrated in Mr Duturbure's case, information that was critically important to his welfare and safe custody was readily available, and was hardly voluminous. Taken together the three key documents from Mr Duturbure's Darwin Prison records comprised 15 pages. His medical record from RDH (which any reasonable person reviewing the Darwin Prison records would have requested) comprised a few dozen more.

106. However, even if the records in Mr Duturbure's case had been voluminous, in my view, the Director General's statutory responsibilities mean that those records should have been obtained and reviewed.

107. At the inquest, Officer Smith was asked whether it would be burdensome or difficult for departmental officers to review interstate records for prisoners like Mr Duturbure. His response was "*No*", but he agreed that the intake assessment process might take longer than it currently does for these types of prisoners. However, Officer Smith also agreed that access to a prisoner's interstate record would make the reception assessment process more comprehensive and therefore more appropriate.[141]

108. In my view, the situation is very clear. Regardless of how burdensome or otherwise it might be to obtain a prisoner's interstate prison record, those records should be obtained. In view of the onerous statutory responsibilities placed on the Director General with respect to prisoner welfare, a failure to take reasonable steps to obtain relevant records would not just be unwise, it would be reprehensible.

109. As I have outlined, Mr Duturbure's Northern Territory prison records contained a trove of important information about his previous behaviour and mental health. It is difficult to argue with the proposition that had this information been available to the Department, Mr Duturbure's ARMS assessment reception interview would have been different. The information would also have been of enormous value to the PCS counsellor who Mr Duturbure consulted.

[141] ts 14.12.21 (Smith), pp92-93

110. In addition, the assessment of Mr Duturbure's suitability for placement at WWC would have been more comprehensive had the Department been aware of his history. In this case, Mr Duturbure's first assessment for WWC was negative and his second, less than a month later, was "*a line ball call*". It is tantalising to consider whether that second assessment would also have been negative, had the information obtained by the Court been obtained by the Department instead.

111. To be clear, I am not suggesting that Mr Duturbure might not ultimately have taken his life even if the Department had obtained his Northern Territory records. His ACE history meant that he was always at chronic risk of doing so. What I am suggesting is that at the very least, his second assessment for suitability for transfer to WWC would have been more informed and might have yielded in a different outcome.

CIRCUMSTANCES OF DEATH

Observations of other prisoners[142,143,144,145,146,147,148,149,150,151,152,153,154,155,156,157]

112. In the period following Mr Duturbure's death, police interviewed inmates that were located at WWC at the relevant time. Officer Branigan also spoke to these prisoners as a group.

113. None of these prisoners mentioned anything that might have suggested that Mr Duturbure had expressed any self-harm or suicidal ideation in the period leading up to his death, and several said that they were shocked when they learnt he had died.

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142 Exhibit 1, Vol. 1, Tab 2, Police Investigation Report (22.04.20), pp5-8
143 Exhibit 1, Vol. 2, Tab 44-28, Incident Report - Mr N Branigan (14.11.19)
144 Exhibit 1, Vol. 1, Tab 20, Statement - Prisoner MS (10.12.19), paras 10-14
145 Exhibit 1, Vol. 1, Tab 21, Statement - Prisoner DL (29.11.19), paras 9-14
146 Exhibit 1, Vol. 1, Tab 22, Statement - Prisoner CN (29.11.19), paras 6-13
147 Exhibit 1, Vol. 1, Tab 23, Statement - Prisoner CP (29.11.19), paras 10-14
148 Exhibit 1, Vol. 1, Tab 24, Statement - Prisoner NG (10.12.19), paras 5-9
149 Exhibit 1, Vol. 1, Tab 25, Statement - Prisoner KF (29.11.19), paras 17-43
150 Exhibit 1, Vol. 1, Tab 26, Statement - Prisoner MM (10.12.19), paras 8-15
151 Exhibit 1, Vol. 1, Tab 27, Statement - Prisoner KB(10.12.19), paras 6-11
152 Exhibit 1, Vol. 1, Tab 28, Statement - Prisoner MM (10.12.19), paras 5-8
153 Exhibit 1, Vol. 1, Tab 29, Statement - Prisoner JC (29.11.19), paras 6-21
154 Exhibit 1, Vol. 1, Tab 30, Statement - Prisoner JL (29.11.19), paras 8-16
155 Exhibit 1, Vol. 1, Tab 31, Statement - Prisoner LM (10.12.19), paras 8-28
156 Exhibit 1, Vol. 1, Tab 32, Statement - Prisoner EM (29.11.19), paras 7-10
157 Exhibit 1, Vol. 1, Tab 33, Statement - Prisoner AJ (29.11.19), paras 9-20

114. The majority of prisoners said Mr Duturbure was a happy person who could be quiet at times. Several prisoners noted he had been having relationship issues with his partner and two said they had heard rumours that Mr Duturbure had burnt one of his partner's recent letters. Two other prisoners said that Mr Duturbure had been "*stressed out*" about his partner and that he had not heard from her for a few days.

115. One prisoner said that Mr Duturbure had mentioned hearing voices, that his water bottle smelled of perfume, and seemed "*paranoid*" that someone was coming into his room at night. Another prisoner says Mr Duturbure said he could hear singing when no one else could. Two prisoners said that Mr Duturbure had stopped taking his medication several days before he died and another said for some unknown, Mr Duturbure had stopped lifting weights at the gym recently. Seven prisoners said they had seen Mr Duturbure talking with others on the night before he died and several said he had been laughing.

116. One prisoner said that on the afternoon of 13 November 2019, Mr Duturbure had asked him how to tie a fishing knot that wouldn't snap. This prisoner says he demonstrated a reef knot and how to tie a snapper rig and a sinker line. The same prisoner also said that Mr Duturbure had mentioned something "*about the smell of death*". Officer Sorrell said that even if he had been aware of this information at the time, he would have seen it as a good sign, because it would have indicated that Mr Duturbure was interested in the recreational activities offered at WWC.[158,159]

Observations of prison officers

117. Officer Branigan said he was in the office at WWC at about 2.50 pm on 13 November 2019, when Mr Duturbure knocked on the door and came in. Officer Branigan saw what he described as "*the lack of light*" behind Mr Duturbure eyes and wondered whether something was wrong. A short time later, Officer Branigan told Officers Daniel, Sorrell and Gray that he was concerned about Mr Duturbure and that in his view, "*something was not quite right*".[160]

[158] See also: Exhibit 1, Vol. 1, Tab 12, Statement - Sgt. S Womersley (17.11.19), paras 33-34
[159] See also: Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), para 62 and ts 14.12.21 (Sorrell), p29
[160] Exhibit 1, Vol. 2, Tab 44-41, Statement - Mr N Branigan (17.11.21), paras 38-41 and ts 14.12.21 (Branigan), pp63-65

118. Officer Sorrell told Officer Branigan that Mr Duturbure had been laughing and joking during the day and Officer Branigan replied: "*That may well be the case, but I need you to keep a close eye on him for me*".[161,162]

119. At the inquest, Officer Branigan said he had "*a gut instinct*" that something was wrong with Mr Duturbure, based on his lengthy experience of managing offenders when he was a police officer. He said he couldn't quantify what he thought was wrong with Mr Duturbure, but he had not been concerned that Mr Duturbure was at risk of self-harm or suicide.[163] Officer Branigan said that if he had thought that Mr Duturbure was at risk of self-harm or suicide, he would have stayed at WWC and placed Mr Duturbure on ARMS, even though this would have been problematic given the facility's remote location.[164]

120. Officers Sorell and Gray say that after Officer Branigan raised his concerns with them, they kept an eye on Mr Duturbure during the rest of the day until the night time muster at 10.00 pm. Both said their observations were discreet and unobtrusive, and neither noted anything out of the ordinary.[165]

121. Officer Gray said he conducted an evening muster check at WWC at about 9.15 pm on 13 November 2019. He saw Mr Duturbure sitting with other prisoners having a chat and that there was nothing about Mr Duturbure's demeanour that caused him any concern.[166]

122. Officer Daniel said he had thought about his interactions with Mr Duturbure in the days leading up to 14 November 2019, and that there was nothing about Mr Duturbure's presentation that caused him any concern. Officer Daniel also noted that no prisoners had raised any concerns with him about Mr Duturbure's mental state.[167]

[161] Exhibit 1, Vol. 2, Tab 44-41, Statement - Mr N Branigan (17.11.21), paras 42-44 and ts 14.12.21 (Branigan), p64
[162] ts 14.12.21 (Sorrell), p19-21 and ts 14.12.21 (Gray), p39-42
[163] ts 14.12.21 (Branigan), p65-67
[164] ts 14.12.21 (Gray), pp42-43 and ts 14.12.21 (Branigan), pp64-66
[165] ts 14.12.21 (Sorrell), pp19-21 and ts 14.12.21 (Gray), p39-42
[166] Exhibit 1, Vol. 1, Tab 16.1, Statement - Mr S Gray (06.03.20), para 15 and ts 14.12.21 (Gray), pp41-42
[167] Exhibit 1, Vol. 1, Tab 17, Statement - Mr D Daniel (11.03.20), para 31

123. Officer Sorrell said he spoke to Mr Duturbure on the evening of 13 November 2019 when affixing a nametag to a cell door. During their conversation, Mr Duturbure had said he thought Officer Sorrell had sounded angry while making an announcement on the PA system earlier that day. Officer Sorrell replied that was just his normal PA voice and the pair "*had a laugh*" about the matter. There was nothing about this interaction that caused Officer Sorrell any concern.[168]

Mr Duturbure is discovered[169,170,171,172173,174,175,176,177]

124. At about 4.00 am on 14 November 2019, one of the prisoners at WWC, (LM) says he woke up and saw Mr Duturbure's door open. LM assumed that Mr Duturbure had got up early for a shower and went back to sleep.[178]

125. Sometime after 4.30 am, another prisoner at WWC, (MS), got up and as he did every morning, went outside to water the lawn and fill up the bird feeder troughs. MS says that as he picked up a hose to move it, he looked up and saw Mr Duturbure hanging from a tree branch in the recreation area adjacent to the prisoner accommodation, with a garden hose tied around his neck. MS ran to fetch another prisoner (DL) and together, they ran to the staff accommodation to alert prison officers as to what they had discovered.[179,180]

126. Officer Sorrell said he was in bed when, at about 5.00 am, he heard banging on the door of his quarters. He got up and spoke with MS and DL who pointed in the direction of Unit 3 and told him that a prisoner was hanging. Unit 3 was about 75 metres away, and at the time was vacant. Officer Sorrell ran towards Unit 3 and as he did so, he heard Officer Gray say that he would grab a phone and a knife.

[168] Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), para 31 ts 14.12.21 (Sorrell), p19-21
[169] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report (22.04.20), pp3-5
[170] Exhibit 1, Vol. 2, Tab 44, Death in Custody Review (10.11.21), pp17-21
[171] Exhibit 1, Vol. 2, Tab 44-28, Incident Report Minutes (14-15.11.19)
[172] Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), paras 34-56 and ts 14.12.21 (Sorrell), pp22-27
[173] Exhibit 1, Vol. 2, Tab 44-28, Incident Report - Mr G Sorrell (14.11.19)
[174] Exhibit 1, Vol. 1, Tab 16.1, Statement - Mr S Gray (06.03.20), paras 16 - 24 and ts 14.12.21 (Gray), pp43-45
[175] Exhibit 1, Vol. 1, Tab 17, Statement - Mr B Daniel (11.03.20), paras 19-28
[176] Exhibit 1, Vol. 2, Tab 44-28, Incident Report - Mr B Daniel (14.11.19)
[177] Exhibit 1, Vol. 1, Tab 41, Scene photos showing recreation area, tree and hose
[178] Exhibit 1, Vol. 1, Tab 28, Statement - Prisoner LM (10.12.19), paras 31-32
[179] Exhibit 1, Vol. 1, Tab 20, Statement - Prisoner MS (10.12.19), paras 15-21
[180] Exhibit 1, Vol. 1, Tab 21, Statement - Prisoner DL (29.11.19), paras 16-25

127. When Officer Sorrell arrived at the recreation area he noticed there was a chair next to the tree Mr Duturbure was hanging from. Officer Sorrell stood on the chair and used the knife Officer Gray handed to him to cut the garden hose around Mr Duturbure's neck.[181] The hose had been doubled over and after Officer Sorrell cut through two sections of hose Mr Duturbure slid to the base of the tree.

128. At 5.09 am, Officer Gray called emergency services to request an ambulance while Officer Sorrell started CPR. Meanwhile, Officer Daniel had run to the administration area (located about 50 metres away) to grab a defibrillator and an Oxy-boot,[182] as requested by Officer Gray.[183]

129. The officers attached defibrillator pads to Mr Duturbure's chest but no shockable heart rhythm was detected and therefore, no shock was delivered by the defibrillator.

130. When the officers took the Oxy-boot out of its carry bag, they discovered its mask was missing and Officer Sorrell ran off to fetch it. The officers continued with CPR in rotation and an ambulance arrived at WWC at 5.33 am.[184]

131. As the prison officers continued with CPR, ambulance officers tried to intubate Mr Duturbure, but were unsuccessful. The ambulance officers then checked Mr Duturbure's blood sugar levels and temperature and from time to time, the prison officers briefly suspended CPR so that the defibrillator could analyse Mr Duturbure's heart, but no shockable rhythm was ever detected.[185,186,187]

132. Resuscitation efforts were discontinued and ambulance officers declared that Mr Duturbure had died at 5.44 am on 14 November 2019.[188,189]

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[181] Exhibit 1, Vol. 1, Tab 43, Photos 93 and 94 showing the knife Officer Gray had grabbed
[182] An Oxy Boot is a compact oxygen resuscitator which delivers oxygen therapy to the patient
[183] Exhibit 1, Vol. 1, Tab 38, SJA Patient care record, Crew WYN21NC (14.11.19)
[184] Exhibit 1, Vol. 1, Tab 38, SJA Patient care record, Crew WYN21NC (14.11.19)
[185] Exhibit 1, Vol. 1, Tab 38, SJA Patient care record, Crew WYN21NC (14.11.19), pp2-3
[186] Exhibit 1, Vol. 1, Tab 18, Statement - Ambulance Officer A Porter (14.11.19)
[187] Exhibit 1, Vol. 1, Tab 19, Statement - Ambulance Officer S Laws (14.11.19)
[188] Exhibit 1, Vol. 1, Tab 38, SJA Patient care record, Crew WYN21NC (14.11.19), p2
[189] Exhibit 1, Vol. 1, Tab 6, Life Extinct Certification(14.11.19)

Aftermath[190,191,192,193,194,195]

133. Sergeant Simon Womersley (Officer Womersley), the officer in charge of the Wyndham Police station, received a call at about 5.35 am on 14 November 2019, advising him of Mr Duturbure's death. He and First Class Constable Aaron Briggs (Officer Briggs) travelled to WWC, and arrived there at about 5.45 am, with First Class Constable Brad Manera (Officer Manera) arriving later, at about 6.55 am.

134. Officers Womersley and Briggs (and later, Officer Manera) inspected Mr Duturbure's body and noted marks around his neck consistent with a nearby length of hose. There was also a blue wipe cloth tied loosely around Mr Duturbure's left wrist that was covering an incised wound that appeared recent.

135. On searching Mr Duturbure's cell, Officers Womersley and Briggs found what appeared to be drops of fresh blood on the bed and handwritten pages of what appeared to be song lyrics referring to child abuse and depression.

136. The officers also found a small pair of black scissors (which are not restricted items at WWC)[196] and on a desk, there was a mental health first aid manual that was open to an action plan for anxiety.[197]

137. At the request of prison staff, local Aboriginal Elders attended WWC on 14 November 2019, and conducted several smoking ceremonies. Prison officers checked on the welfare of all prisoners and Officer Daniel took prisoners on a bus trip. Prisoners were also offered a transfer to BRP if they wished.[198,199,200]

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[190] Exhibit 1, Vol. 1, Tab 12, Statement - Sgt. S Womersley (17.11.19), paras 2-17
[191] Exhibit 1, Vol. 1, Tab 13, Statement - FC Const. A Briggs (17.11.19), paras 2-36
[192] Exhibit 1, Vol. 1, Tab 14, Statement - FC Const. B Manera (14.11.19), paras 3-17
[193] Exhibit 1, Vol. 1, Tab 41, Scene photos showing Mr Duturbure's cell and Mental health First Aid Manual
[194] Exhibit 1, Vol. 1, Tab 3, Memo - Det. Sgt P Brunini (03.12.19)
[195] Exhibit 1, Vol. 1, Tab 3, Memo - Det. Snr. Const. C Stone (20.11.19)
[196] Exhibit 1, Vol. 2, Tab 44.43, Statement - Mr N Smith (13.12.21), para 59
[197] Aboriginal and Torres Strait Islander Mental Health First Aid Manual (3rd Edition)
[198] Exhibit 1, Vol. 1, Tab 15, Statement - Mr G Sorrell (06.03.20), paras 61
[199] Exhibit 1, Vol. 1, Tab 16.1, Statement - Mr S Gray (06.03.20), paras 29
[200] Exhibit 1, Vol. 1, Tab 17, Statement - Mr B Daniel (11.03.20), paras 29

138. Following Mr Duturbure's death, letters between himself and his partner was examined by police. That correspondence appears to chart the decline of the couple's relationship, particularly letters from Mr Duturbure's partner dated 7 November 2019 and 9 November 2019. The letter dated 9 November 2019, also refers to a debt of $20,800 which police later established related to criminal injuries compensation paid to the police officer assaulted by Mr Duturbure and his partner. Recovery action for $7,500 each was being pursued against Mr Duturbure and his partner by the Assessor of Criminal Injuries Compensation.[201,202,203,204]

139. Detectives from the Homicide Squad travelled to WWC and conducted an investigation into Mr Duturbure's death. In these circumstances, the Homicide Squad's investigation runs parallel with the investigation undertaken by the Coronial Investigation Section until a decision is made as to the future conduct of the matter. The Homicide Squad concluded:

> Taking into account all the evidence and information that has been gathered, physical evidence and speaking to fellow witnesses who dealt with the deceased in the weeks prior to his passing, it was deemed that the sudden death was not suspicious.[205]

140. For the sake of completeness, I note that at the time of Mr Duturbure's death the CPR credentials of Officers Sorrell, Gray and Daniels were current. I also note that since Mr Duturbure's death, emergency resuscitation equipment at WWC is now regularly checked for serviceability.[206,207]

141. Although not directly related to Mr Duturbure's death, it emerged at the inquest that fire alarms in prisoner's cells at WWC did not sound in the staff quarters. Thankfully, this wholly unsatisfactory situation has now been resolved, but I would urge the Department to conduct an audit of its other work camps to ensure that the situation at WWC is unique.[208]

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[201] Exhibit 1, Vol. 1, Tab 34, File Note - Sen. Const. M Purver (26.11.19)
[202] Exhibit 1, Vol. 1, Tab 34.1, Letter to Mr Duturbure from his partner (07.11.19)
[203] Exhibit 1, Vol. 1, Tab 34.2, Letter to Mr Duturbure from his partner (09.11.19)
[204] Exhibit 1, Vol. 1, Tab 37, Letter - Assessor of Criminal Injuries Compensation to Mr Duturbure (11.10.19)
[205] Exhibit 1, Vol. 1, Tab 4, Memo - Det. Snr. Const. C Stone (20.11.19), p5
[206] Exhibit 1, Vol. 2, Tab 44-27, Email - Mr A Myers to Ms A Palmer (15.10.21)
[207] ts 14.12.21 (Sorrell), p16 and ts 14.12.21 (Branigan), p55
[208] ts 14.12.21 (Branigan), p75

Predicting suicide

142. I am aware from previous inquests I have conducted, that predicting the risk of suicide in the short-term is very difficult and is virtually impossible in the case of chronic suicidality. Chronic in this context means "*elevated lifetime risk*", which would apply to Mr Duturbure, given his level of ACE.[209]

143. Although many people contemplating suicide give some indication of their intentions, some don't. The impulsive nature of many suicides has been demonstrated by several studies of survivors of nearly fatal suicide attempts, that found that the time between the decision to suicide and the actual attempt was less than 10 minutes.[210]

144. The Department's ARMS manual relevantly notes:

> There is a widely held assumption explicit in suicide prevention procedures that suicides can be predicted and action taken to avert them. The extent to which individual suicides are in fact predictable remains a complex and somewhat confused issue. It is likely that certain types of suicide are more predictable and preventable than others. There may be a number of factors which *may* mean a prisoner is more likely to be at risk. But these factors are poor predictors. There is no sure way of "diagnosing" suicidal intentions or predicting the degree of risk. Assessments can only be of temporary value because moods and situations change. Self-harm can be an impulsive reaction to bad news or a sudden increase in stress.[211]

145. It is possible that the reason Mr Duturbure's intentions went unnoticed by prison officers and prisoners alike, is that he only made the decision to take his life in the early hours of 14 November 2019, at which time he was alone is his cell.

146. On separate note, Officer Gray expressed the view that had Mr Duturbure's suitability for WWC been properly assessed, his offending history would have excluded him from placement. This would have meant that Mr Duturbure would have remained at BRP.

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[209] ts 14.12.21 (Rowland), pp117-118
[210] See: www.hsph.harvard.edu/means-matter/means-matter/duration/
[211] At Risk Management System (ARMS) Manual v4 (October 2016), p9

147. According to Officer Gray, if Mr Duturbure had remained at BRP, he would have been placed in a multiple occupancy cell and would not have been alone during the night. Officer Gray suggested that had Mr Duturbure displayed any signs of mental health issues or have attempted to take his life, his cell mate could have raised the alarm using the cell call system.[212]

148. Although Officer Gray's assertion is plausible, it is worth noting that prisoners have taken their lives at maximum-security prisons. Therefore (and given what I have just said about the unpredictability of suicide) it is impossible to know whether the outcome in this case would have been any different had Mr Duturbure remained at BRP.

CAUSE AND MANNER OF DEATH[213,214,215]

149. A forensic pathologist, Dr Gerard Cadden (Dr Cadden) carried out a post mortem examination of Mr Duturbure's body at the State Mortuary on 20 November 2019. Dr Cadden noted prominent markings around Mr Duturbure's neck that were consistent with the garden hose ligature that had accompanied his body.

150. Dr Cadden found marked pooling of fluid within Mr Duturbure's lungs (pulmonary congestion) and an incised injury to the inside of his left wrist. Dr Cadden described this injury as "minor" and noted that no major structures or blood vessels were involved.

151. The only other findings noted by Dr Cadden were minor injuries to the tibial aspects of both of Mr Duturbure's legs (with associated bruising) and an area of bruising on the lower right femoral area. Specialist examination of Mr Duturbure's brain was unremarkable, and toxicological analysis did not detect common drugs.

[212] Exhibit 1, Vol. 1, Tab 16.2, Statement - Mr S Gray (29.11.21), paras 29-33
[213] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report (20.11.19), pp1 & 16
[214] Exhibit 1, Vol. 1, Tab 8, Neuropathology Report (09.12.19)
[215] Exhibit 1, Vol. 1, Tab 9, ChemCentre Toxicology Report (27.11.19)

152. At the conclusion of the post mortem examination, Dr Cadden expressed the opinion that the cause of Mr Duturbure's death was ligature compression of the neck (hanging).

153. I accept and adopt Dr Cadden's opinion as to the cause of Mr Duturbure's death and in view of all the circumstances in this case, I find that death occurred by way of suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

154. After carefully considering the available evidence, I have come to the conclusion that the quality of primary medical care Mr Duturbure received while he was in custody was commensurate with the standard of care he would have received in the general community.

155. However, as I have explained, the Department failed to obtain records relating to Mr Duturbure's incarceration in Darwin Prison and the most superficial of enquiries would also have unearthed his RDH records. Had the Department obtained these records, it would have been aware of Mr Duturbure's significant level of ACE, his history of self-harm and suicide attempts and his previous criminal and prison behaviour history in the Northern Territory.

156. That information should have formed part of any proper assessment of Mr Duturbure's level of risk when he was admitted to BRP on 17 August 2017, and would have been of enormous significance to the PCS counsellor Mr Duturbure consulted between 5 September 2019 and 1 October 2019. The information would also have been relevant to the assessment of Mr Duturbure's suitability for transfer to WWC.

157. The Department's failure to make even the most basic of enquiries about Mr Duturbure's Darwin Prison history must necessarily mean that the quality of supervision, treatment and care it provided to him whilst he was imprisoned in Western Australia was potentially of a lower standard than might otherwise have been the case.

158. The fact that Mr Duturbure did not appear to exhibit any signs of self-harm or suicidality whilst he was incarcerated in Western Australia is irrelevant. So too is the fact that he repeatedly denied any suicidal or self-harm ideation. The inescapable fact is that there was information about his mental health history that was readily available and it simply was not requested. It should have been.

RECOMMENDATIONS

159. In view of the observations I have made in this finding, I make the following recommendation:

Recommendation

When a prisoner is first received at a prison in Western Australia, the prisoner should be asked whether they have ever been incarcerated in another State or Territory prison.

Where a prisoner discloses having been incarcerated in another State or Territory prison then, as soon as is practicable, the Department should obtain records relating to that interstate incarceration (including medical records) in order to ensure that the prisoner is appropriately managed.

Comments relating to recommendations

160. In accordance with my usual practice, a draft of this recommendation was forwarded to the Department by Sergeant Alan Becker, on 10 December 2021.[216]

161. Mr Tom Ledger (counsel for the Department) replied to that email on 20 December 2021, advising that he was instructed that although that the Department broadly supported the proposed recommendation, it had some suggested amendments.[217]

[216] Email - Sgt. A Becker to Mr T Ledger (10.12.21)
[217] Email - Mr T Ledger to Sgt A Becker (20.12.21)

162. Essentially, the Department did not consider it was reasonable to make enquires about a prisoner's interstate incarceration history on a "*speculative basis*", because of the resource implications of doing so. The Department also suggested that the nature of the interstate records that were to be obtained should be specified along the applicable timeframe. Finally, the Department suggested that the prisoner's consent should first be obtained before their interstate records were requested.[218]

163. After careful consideration, I determined that it would be appropriate to amend my recommendation to address the issues raised by the Department. I acknowledge that my recommendation may have resource implications however, as this case clearly demonstrates, the Director General cannot properly discharge the statutory responsibilities imposed by section 7 of the Prison Act, unless records about a prisoner's known interstate incarceration are obtained and reviewed.

164. In order to avoid speculative enquiries, I consider that it would be appropriate for prison reception officers to routinely ask prisoners being received into prison for the first time, whether they have previously been incarcerated in an interstate prison, and to obtain records with respect to those who have.

CONCLUSION

165. Mr Duturbure was 29-years of age when he hanged himself on or about 14 November 2019 at WWC. The reasons why he chose to take his life at such a young age will never be known and this must make the tragedy of his death more difficult for his family and friends to bear.

166. Mr Duturbure had a significant history of ACE and had attempted to take his life on two occasions. Although the Department was aware that he had been incarcerated in Darwin Prison, it took no steps to obtain his Northern Territory prison records. Had it done so, it would have discovered important information about Mr Duturbure's background and his mental health history.

[218] Email - Mr T Ledger to Sgt A Becker (20.12.21)

167. It is possible that access to this information may have had some impact on Mr Duturbure's management whilst he was in prison in Western Australia. However, given the unpredictability of suicide and the multitude of factors impacting on his life, it is not possible to say that the outcome in Mr Duturbure's case would have been different had the Department obtained this information.

168. I have made one recommendation relating to obtaining interstate prison records which I hope will be embraced. It is also my hope that the Department will give very careful consideration to the suitability of prisoners being considered for transfer to a work camp. Where a prisoner's suitability is not overwhelmingly clear (or is a "*line-ball call*" to adopt the phrase attributed to a senior officer at BRP)[219] then I urge the Department to adopt a conservative approach and refuse the transfer.

MAG Jenkin
Coroner
22 December 2021

[219] Exhibit 1, Vol. 2, Tab 44.41, Statement - Mr N Branigan (17.11.21), paras 21-32 and ts 14.12.21 (Branigan), pp58 & 61