JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	6 - 9 MAY 2024
DELIVERED	:	10 MARCH 2025
FILE NO/S	:	CORC 789 of 2022
DECEASED	:	COUND, RICKY-LEE

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)
Sentencing Act 1995 (WA)

Counsel Appearing:
Ms S Markham assisted the Coroner
Ms P Femia and Ms H Cowie (State Solicitor's Office) appeared on behalf of the Department of Justice and the Western Australia Police Force
Mr B. D. Luscombe and Ms V Bennett (instructed by the National Justice Project) appeared on behalf of the family

Case(s) referred to in decision(s):
Briginshaw v Briginshaw (1938) 60 CLR 336
Inquest into the death of five prisoners at Casuarina Prison, Ref: 14/19
Inquest into the death of Jordan Robert Anderson [2020] WACOR 44
Inquest into the death of Jomen Blanket [2023] WACOR 6
Inquest into the death of Wayne Thomas Larder [2022] WACOR 48
Inquest into the death of Iain Campbell Buchanan [2024] WACOR 8
Inquest into the death of Callum Mitchell [2022] WACOR 34
Inquest into the death of Shane Nathan Roberts [2023] WACOR 43

Coroners Act 1996

(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Ricky-Lee COUND*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 6 - 9 May 2024, find that the identity of the deceased person was* ***Ricky-Lee COUND*** *and that death occurred on 25 March 2022 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from ligature compression of the neck (hanging) in the following circumstances:*

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
Acacia	Acacia Prison
the Act	*Sentencing Act 1995* (WA)
ARMS	At Risk Management System
AVS	Aboriginal Visitors Scheme
Banksia Hill	Banksia Hill Detention Centre
the ***Briginshaw*** principle	the accepted standard of proof a court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
BWCs	body-worn cameras
B Wing	B Wing in Unit 1 at Hakea Prison
the casing	the casing of the damaged ceiling light fixture in Mr Cound's cell
Casuarina	Casuarina Prison
CCTV	closed circuit television
Cell 8	Cell 8 in D Wing
CERT	Correctional Emergency Response Team
COPP	Commissioner's Operating Policy and Procedure
the Court	the Coroner's Court
COVID-19	COVID-19 infection
the Department	the Department of Justice
DIC	death in custody
D Wing	D Wing in Unit 1 at Hakea Prison
EcHO	the Department of Justice's electronic medical system used to manage the health care of prisoners
FASD	Foetal Alcohol Spectrum Disorder
the 2016 FASD report	the report of Mr Cound's FASD assessment in 2016

FTE	full time equivalent
Hakea	Hakea Prison
the Manual	the ARMS Manual
MHAOD	Mental Health, Alcohol and Other Drugs Service
OIC	officer in charge
PAR Directorate	the Department of Justice's Performance Assurance and Risk Directorate
PHS	Psychological Health Services
PPE	personal protective equipment
PRAG	Prisoner Risk Assessment Group
PSO	Prison Support Officer
PSS	Prison Support Services
the Report	Deaths in Custody Lessons Learned Report dated March 2023
SAMS	Support and Monitoring System
SOG	Special Operations Group
SPGU	Suicide Prevention Governance Unit
SSO	State Solicitor's Office
the Taskforce	Hakea Prison Safer Custody Taskforce
TOMS	the Department of Justice's Total Offender Management System
Ts	transcript from the inquest

SUPPRESSION ORDER [1]

There will be no reporting or publication of the name, picture or any other identifying features of Special Operations Group officers called to give evidence in this inquest or Special Operations Group officers who may be referred to in evidence at the inquest.

INTRODUCTION

"FASD kids have symptoms, not behaviours. Let's start treating them that way."
FAFASD (Families Affected by Foetal Alcohol Spectrum Disorder)

1 Ricky-Lee Cound (Mr Cound) died on 25 March 2022 at Fiona Stanley Hospital, Murdoch, from ligature compression of the neck (hanging). As I will outline in this finding, a critical situation created by a concurrence of factors[2] allowed Mr Cound to tragically take his own life. He was just 22 years old.

2 At the time of his death, Mr Cound was a sentenced prisoner at Hakea Prison (Hakea) in the custody of the Chief Executive Officer of the Department of Justice (the Department).[3]

3 As he was a prisoner immediately before his death, Mr Cound was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[4] In such circumstance, a coronial inquest is mandatory.[5]

4 I held an inquest into Mr Cound's death in Perth from 6 to 9 May 2024. In the order in which they testified, the following witnesses gave oral evidence:[6]

i. Detective Senior Constable Marika Schulbergs (police officer from the Coronial Investigation Squad);

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[1] Although there is no suppression order in place regarding the identity of other prisoners in Unit 1 at the time of Mr Cound's death, I have elected not to refer to them by name in this finding. This is to protect their privacy. I have also decided not to specify actual numbers with respect to the rostered number of custodial staff on night shift at Hakea, and the staff shortages experienced for the night shift on 25 March 2022. This is due to the sensitive nature of such information.
[2] Also known as a "perfect storm".
[3] *Prisons Act 1981* (WA) s 16
[4] *Coroners Act 1996* (WA) s 3, s 22(1)(a)
[5] *Coroners Act 1996* (WA) s 25(3)
[6] Unless otherwise stated, the cited positions of these witnesses are the positions they held at the time of Mr Cound's death.

ii. Catriona MacKay Macleod (counsellor at Hakea);
iii. Officer A (Special Operations Group officer at Hakea);
iv. Richard Gateley (senior prison officer at Hakea);
v. Officer B (Special Operations Group officer at Hakea);
vi. Daniel Kemp (prison officer at Hakea);
vii. David Lyons (senior prison officer at Hakea);
viii. Dr Adam Brett (independent consultant psychiatrist);
ix. Dr Catherine Gunson (current acting Director, Medical Services, at the Department);
x. Matthew Hasson (prison officer at Hakea);
xi. Rowan Arnott (prison officer at Hakea);
xii. Toni Palmer (senior review officer at the Department); and
xiii. Sean Devereux (current Deputy Superintendent at Hakea).

5 At the end of the oral evidence, one of Mr Cound's sisters read a statement prepared by her mother, Laura Cound, which provided the Court with an outline of Mr Cound's life.

6 I also note that 18 members of Mr Cound's family and his friends attended the inquest.[7] This number reflected the close-knit nature of Mr Cound's family and their desire to have measures in place that will reduce the risk of further deaths in custody, particularly of young First Nations men.

7 The documentary evidence comprised of three volumes of the brief, which were tendered as exhibit 1 at the inquest's commencement. Other exhibits were tendered during the inquest and they became exhibits 2 to 11.

8 During the inquest, I asked the Department to provide some additional information arising from the evidence at the inquest. The Department responded to those matters via an email with attachments from Ms Cowie at the State Solicitor's Office (SSO) dated 11 July 2024. This email was subsequently forwarded by the Court to the solicitors for Mr Cound's family. This material included the Deaths in Custody Lessons Learned Report that was prepared following Mr Cound's death, the Mental Health Alcohol and Other Drugs Service (MHAOD) Summary into the Death in Custody, and a

[7] Ts 9.5.24 (closing submissions of Mr Luscombe), p.472

letter from the Department's Assistant Director, Infrastructure Maintenance, regarding the light fittings in cells at Hakea.

9 The inquest primarily focused on the supervision, treatment and care provided to Mr Cound by custodial staff and health service providers at Hakea after he had been transferred there from Acacia Prison (Acacia).

10 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities.

11 I am also mindful not to insert hindsight bias into my assessment of the actions taken by Department staff in their supervision, treatment and care of Mr Cound. Hindsight bias is the tendency, after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[8]

12 In addition, I am required to take note that at the time of Mr Cound's death, Western Australia had been greatly impacted by the COVID-19 infection (COVID-19). The Court must be conscious of the adverse effect the potentially deadly outbreak of this virus had on the capability of not just Hakea but all prisons, to operate in a safe manner for its prisoners and staff. The following statistics starkly illustrate what Hakea was facing.

13 On 25 March 2022, the WA Department of Health reported 8,133 new cases of COVID-19 to 8.00 pm the previous night, with a total of 45,306 active cases in Western Australia.[9]

14 At the relevant time, Hakea was being managed under its Pandemic Containment Plan. On the day of Mr Cound's death, Hakea had 168 prisoners and 20 custodial staff who were COVID-19 positive (with a further four custodial staff in self-isolation either waiting for COVID-19 testing or for some other reason).[10] As there were 892 prisoners housed at Acacia on 25 March 2022,[11] this meant that nearly 20% of Acacia's prisoners had COVID-19. Five (including Mr Cound) of the 13 prisoners in the wing

[8] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[9] https://www.health.wa.gov.au/Media-releases/2022/March/COVID-19-update-25-March-2022
[10] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.6
[11] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024, p.45

where Mr Cound's cell was[12] had COVID-19.[13] In addition, nearly 600 prisoners (or 2/3rd of the total prisoner population in Hakea) were in isolation.

15 These statistics demonstrate that as of 25 March 2022, the COVID-19 outbreak within Hakea was not only severe, but unprecedented.

16 Richard Gateley (Mr Gateley), a senior prison officer at Hakea, had worked in Unit 1 since 2011. He described that in the two days before Mr Cound's death:[14]

> Unit 1 was at full capacity, safe cells were full, there were a number of prisoners suffering from mental health issues, troublesome prisoners and we were short staffed. There had been a number of consecutive days of high temperatures, we had been dealing with incident after incident, and the staff at Unit 1 were under considerable stress. COVID was also having a huge impact on the prison, with increased lockdowns, short staffing due to staff being ill with COVID, and prisoners blaming staff for bringing COVID into the prison. Those few days were some of the most intense days I've had at Hakea.

17 Mr Gateley gave similar evidence at the inquest:[15]

> I don't recall Hakea or Unit 1 being so intense, on edge. It was hot, constantly short staffed. COVID rules and COVID protocols changed every single day. There was a panic about if we got COVID we could die. It was an extremely hard, intense time there.

MR COUND

Background [16]

18 Mr Cound was born on 11 January 2000. He was a Noongar man with bloodlines running deep within Boodja Country, Yamatji Country, Wangkthaa Country and Ballardong Country.

19 Mr Cound lived in Hilton in his early years and then spent most of his childhood in Willagee. He was very athletic and enjoyed playing many sports, particularly football and basketball. Mr Cound also liked camping, fishing and

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[12] B Wing in Unit 1.
[13] Exhibit 1, Volume 1, Tab 24, Photograph of B Wing Unit 1 cell allocation board on 25 March 2022
[14] Exhibit 1, Volume 2, Tab 9, Statement of Richard Gateley dated 24 April 2024, pp. 2-3
[15] Ts 6.5.24 (Mr Gateley), p.105
[16] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024; Exhibit 11, Statement of Laura Cound dated 9 May 2024

dirt bike riding. Growing up, he was very popular and he had a wide circle of friends. Mr Cound wanted to be a youth worker, so he could inspire others.

Mr Cound's FASD diagnosis [17]

20 The essential element of Foetal Alcohol Spectrum Disorder (FASD) is that the person has sustained a prenatal, permanent, organic brain injury as a result of their mother's alcohol consumption during pregnancy. Although there are no cures for this neurodevelopmental disorder, it can be managed.

21 In January 2016, shortly after his 16th birthday, Mr Cound had a FASD assessment which diagnosed him with this disorder.

22 The detailed report from this FASD assessment (the 2016 FASD report) documented Mr Cound's background, addressed the diagnostic criteria, outlined his strengths and difficulties, and suggested management strategies. It stated his impairments were in three domains: executive functioning, academic achievement and adaptive behaviour.

23 The 2016 FASD report also noted that Mr Cound had a previously diagnosed language disorder.[18]

Mr Cound's mental health history [19]

24 On 23 November 2016, Mr Cound inflicted superficial self-harm injuries to his left forearm whilst a detainee at Banksia Hill Detention Centre (Banksia Hill). On 5 September 2017, again when at Banksia Hill, he had multiple self-harm minor injuries to his left arm and had made threats to suicide.

25 In July 2021, a psychological report for Mr Cound was compiled for court proceedings. Psychometric testing showed that he had severe stress and moderate anxiety. The report also indicated that Mr Cound had a period of depression when his maternal grandmother died, and had experienced episodes of psychotic symptoms related to his methylamphetamine use. The drivers for his offending were recorded as:[20]

> FASD, intoxication with substances and resulted disinhibition, lifestyle instability, a lack of pro-social purpose in his life … a desire to please others,

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[17] Exhibit 1, Volume 1, Tabs 36.1-36.2, Telethon Kids Institute FASD report dated 2016, Strategies to Support [Mr Cound] (FASD diagnosis); Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024

[18] Exhibit 1, Volume 1, Tab 36.1, Telethon Kids Institute FASD report dated 2016

[19] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024; Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024

[20] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024, pp.21-22

poor self-awareness, impulsivity, anger control, poor judgement and poor consequential thinking.

26 Mr Cound was never managed by public mental health services and, as an adult, he was never assessed by a psychiatrist when he was in custody.

Circumstances of Mr Cound's final imprisonment [21]

27 On 9 November 2021, Mr Cound appeared in the Fremantle Magistrates Court for a number of matters, including a charge of aggravated home burglary and two charges of stealing a motor vehicle. He had been arrested by police on the previous day for these three charges. At the conclusion of this court appearance, Mr Cound was remanded in custody.

28 On 9 December 2021, Mr Cound appeared in the Perth District Court. On that day he was sentenced to a total of 3½ years' imprisonment for a number of offences including aggravated home burglary and being armed or pretending to be armed. He was made eligible for parole and the sentence was backdated to 13 September 2020. Mr Cound's earliest date for release on parole was 12 June 2022.

29 During the 4½ months he was imprisoned after he was remanded in custody on 9 November 2021, Mr Cound was placed at the following prisons:

i. Hakea Prison: 9 November – 13 December 2021 (34 days)

ii. Casuarina Prison: 13 December 2021 – 8 February 2022 (57 days)

iii. Acacia Prison: 8 February – 3 March 2022 (23 days)

iv. Hakea Prison: 3 – 25 March 2022 (22 days)

30 Mr Cound had been transferred from Hakea to Casuarina Prison (Casuarina) on 13 December 2021 due to his maximum-security rating and because of prison population management. On 8 February 2022, he was transferred from Casuarina to Acacia due to the downgrading of his security rating to "medium".

31 On 27 February 2022, Mr Cound was involved in a significant incident at Acacia when a large number of prisoners rioted and caused major damage to infrastructure.

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[21] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024; Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024

32 On 1 March 2022, Mr Cound was taken to the medical unit at Acacia after he made multiple superficial cuts to his left inner wrist. The wounds were treated and Mr Cound was subsequently placed in a "safe cell"[22] in the detention unit on "high" ARMS.[23]

33 On the following day, while he was still in the safe cell, Mr Cound was able to use a razor blade he had secreted to make further cuts to his left arm. These lacerations were treated and dressed; however, Mr Cound threatened to pull the dressing off after nursing staff had left.

34 That evening, Mr Cound refused to allow staff to treat his injuries which required the Correctional Emergency Response Team (CERT) to be called. It was only after CERT officers were in attendance that Mr Cound allowed nursing staff to treat his injuries. CERT officers located further razor blades in Mr Cound's possession and removed them.

35 Mr Cound remained in the detention unit at Acacia on "moderate" ARMS. On 3 March 2022, he was transferred to Hakea. The rationale for this transfer was cited as "management" reasons.

EVENTS LEADING TO MR COUND'S DEATH [24]

36 Unfortunately, Mr Cound's disruptive behaviour continued at Hakea. On 7 March 2022, he deliberately damaged his cell in Unit 1.[25] Mr Cound was punished by being placed on a "close supervision" regime, which meant he was confined to his unit and had various restrictions placed on his movements, spending, exercise and visitors.

37 On 22 March 2022, Mr Cound, with two other prisoners, damaged the corridor in B Wing[26] of Unit 1 (B Wing) by smashing the ceiling lights with brooms

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[22] Safe cells are special purpose cells designed for prisoners who are on "high" ARMS. They are fully ligature minimised, contain a mattress, a tear-proof blanket, a steel toilet bowl and a water fountain built into the wall. Prisoners in safe cells are required to wear tear-proof gowns, are not permitted outside of the cell and are provided with sandwiches as they are not allowed access to eating utensils. They can be constantly supervised through CCTV cameras.

[23] ARMS is an acronym for At Risk Management System which is the Department's primary suicide prevention strategy. It aims to provide all prison staff with clear guidelines to assist with the identification and management of prisoners deemed to be at risk of self-harm or suicide. When a prisoner is placed on ARMS, an interim management plan is developed and the prisoner is managed with observations at either "high" (one-hourly), "medium" (two-hourly) or "low" (four-hourly).

[24] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024

[25] Unit 1 is a multi-purpose/management unit that has four wings: A, B, C and D Wings.

[26] B Wing houses prisoners on various confinement regimes (including basic and close supervision) who have committed internal prison offences.

and hitting walls and windows. He was again placed on close supervision for a further 14 days with the same restrictions.

38 On 23 March 2022, Mr Cound was charged with rioting causing damage by fire[27] regarding his alleged involvement in the major incident at Acacia on 27 February 2022. This offence had a maximum penalty of 14 years' imprisonment and, if proven, was likely to extend Mr Cound's prison release date. He was aware of this possibility.

39 On the morning of 24 March 2022, Mr Cound had his first court appearance via video-link in the Midland Magistrates Court regarding his charge of rioting. Later that afternoon, he tested positive for COVID-19.

40 On 25 March 2022, Mr Cound was housed by himself in Cell 2 in B Wing. As B Wing is used for prisoners who are on close supervision, it was regarded by prisoners as a punishment wing. As of 25 March 2022, ten of the 13 prisoners in B Wing were subject to close supervision regimes. As outlined above, five of these prisoners also had COVID-19.

41 Just before 10.00 am on 25 March 2022, Mr Cound had a telephone conversation with his partner. He described the frequent lockdowns had caused him stress and that he had received a letter from his ex-partner. Mr Cound later told another prisoner that the contents of this letter had upset him. Mr Cound also told his partner that he did not want to be in a safe cell.

42 That afternoon, Mr Cound was discussed at the Prisoner Risk Assessment Group (PRAG) meeting and a decision was made to remove him from ARMS at 1.35 pm. This was the first time he had been removed from ARMS since his transfer to Hakea from Acacia 22 days earlier. It was also determined at this meeting that Mr Cound did not meet the criteria for placement on SAMS.[28]

43 At 4.11 pm, Mr Cound used the intercom system within his cell to communicate with a prison officer. This is known as a "cell call". This cell call from Mr Cound was answered by Rowan Arnott (Mr Arnott), a prison officer, who was in the control room at Unit 1. Mr Cound asked Mr Arnott if he could be placed in a safe cell as he was "*stressed out, feeling a bit down.*" When Mr Arnott asked why he needed to be in a safe cell, Mr Cound answered: "*So that I don't hurt myself.*" Mr Arnott advised Mr Cound that he

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[27] *Criminal Code*, s 67(2)

[28] SAMS is an acronym for Support and Monitoring System and is the Department's monitoring system designed to manage prisoners requiring additional support. It is a step down from ARMS.

would arrange for Mr Gateley, the senior prison officer in Unit 1, to speak to him.

44 At 4.16 pm, Mr Gateley spoke to Mr Cound through the hatch in his cell door for about 90 seconds. Mr Gateley offered Mr Cound a clock radio and subsequently spoke to Daniel Kemp (Mr Kemp), another prison officer on duty in Unit 1, to arrange for the clock radio to be provided.

45 Given the time of the day, Mr Kemp could not make arrangements for the clock radio and, instead, provided Mr Cound with a breakfast pack that he had asked for. This took place at 4.26 pm. Mr Cound was not moved to a safe cell.

46 At about 4.43 pm, Mr Cound and two other prisoners in B Wing broke their cell doors' viewing windows and propelled the broken glass onto the corridor floor. There was also broken glass inside their cells. Mr Cound also threw parts of a dismantled fan into the corridor. Attending prison officers spoke to Mr Cound through his cell door and the glass and debris in the corridor were swept up. The inside of the damaged cells were not checked or cleaned.

47 Mr Cound was last seen alive at 6.58 pm when David Lyons (Mr Lyons), a senior prison officer (who was also the OIC[29] for the night shift), observed him through the broken viewing window of his cell door. Mr Cound was standing inside the cell.

48 At 7.09 pm, another prisoner in B Wing made a cell call. That call was answered by Matthew Hasson (Mr Hasson), a prison officer stationed in the control room at Unit 1. The prisoner advised that Mr Cound was self-harming by "*cutting up*" and urged the prison officers to attend.

49 At or about the time of this cell call, Mr Hasson saw from CCTV monitors in the control room that the corridor of D Wing[30] in Unit 1 (D Wing) had water entering into it from a prisoner's cell in that wing. Mr Lyons decided that he and Mr Hasson would first deal with this incident in D Wing.

50 Upon attending D Wing at 7.10 pm, and after turning off the water supply, the two prison officers began mopping up a large amount of water that had spread some distance along the D Wing corridor. After about seven minutes, they became aware of the prisoner in Cell 8 of D Wing (Cell 8) banging on his door. This prisoner had been responsible for directing water out of his cell into the corridor. Mr Lyons looked through the viewing window of the door to

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[29] Officer in Charge.

[30] D Wing has a restraint cell, punishment cells, glass-fronted observation cells and safe cells.

Cell 8 and saw the prisoner with a plastic bin lining bag over his head and holding a piece of metal from the cell's toilet. Although this prisoner eventually removed the bag from his head, he would not pass the bag or piece of metal over to Mr Lyons.

51 As the two prison officers were mopping up the water from the corridor of D Wing and dealing with the prisoner in Cell 8, prisoners from B Wing were using their cell calls which were diverted from the unmanned control room in Unit 1 to Hakea's master control room.[31] All these cell calls were asking for prison officers to perform an urgent check on Mr Cound. Having been contacted by master control about the cell calls coming from B Wing, Mr Lyons and Mr Hasson entered the B Wing corridor at 7.26 pm. CCTV footage showed them directly going to Mr Cound's cell.

52 When he looked through the broken viewing window of Mr Cound's cell door, Mr Lyons saw Mr Cound hanging from a damaged light fixture casing in the ceiling with a cloth ligature around his neck. Mr Lyons immediately used his radio to call a Code Red medical emergency. The two prison officers then entered the cell, released Mr Cound from the ligature and took him to the end of the corridor that could not be seen by other prisoners in B Wing. Mr Cound was unresponsive and CPR was commenced within 90 seconds of the prison officers entering his cell.

53 At 7.28 pm, additional prison officers began to arrive to provide assistance and a radio request was made to the Front Gate at Hakea to call for an ambulance. That call was made at 7.30 pm.

54 Prison nursing staff arrived at 7.30 pm with a defibrillator and oxygen tank. The defibrillator was attached to Mr Cound and a shock was administered at 7.36 pm. CPR continued until 7.46 pm when a second shock from the defibrillator was administered.

55 Ambulance officers arrived a short time later and took over resuscitation efforts, which included the affixing of a LUCAS[32] machine to perform mechanical chest compressions. Mr Cound was then taken by ambulance to Fiona Stanley Hospital under priority conditions, arriving at 8.35 pm.

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[31] The master control room is also referred to as the "Front Gate".
[32] Acronym for Lund University Cardiopulmonary Assist System.

56 Despite the extensive resuscitation efforts by prison officers, Hakea nursing staff and ambulance officers, Mr Cound remained unresponsive. He was subsequently declared life extinct at 8.51 pm on 25 March 2022.[33]

CAUSE AND MANNER OF DEATH

Cause of death [34]

57 Following an objection by Mr Cound's family to an internal post mortem examination, Dr Daniel Moss (Dr Moss), a forensic pathologist, conducted an external post mortem examination on 30 March 2022. Part of this examination involved a CT scan.

58 The external examination found a faint ligature mark to Mr Cound's neck as well as evidence of resuscitation efforts. Dr Moss also noted multiple superficial incised wounds to Mr Cound's feet with associated bloodstaining. Small fragments of glass were in these wounds.

59 A toxicological analysis of blood and urine samples from Mr Cound detected a small amount of aripiprazole (an antipsychotic medication) and olanzapine (a medication to treat schizophrenia and bipolar disorder). Although Mr Cound had not been prescribed either of these drugs,[35] Dr Moss did not consider they had contributed to his death. Paracetamol was also detected.

60 Although a low level of alcohol was detected in the urine sample (0.014%), no alcohol was detected in blood samples. I am satisfied that this urine alcohol reading was most likely due to post mortem changes, and not due to any alcohol consumed by Mr Cound prior to his death.

61 During the external post mortem examination, a small syringe was found secreted on Mr Cound's body. Toxicology testing of the inside of this syringe found the presence of buprenorphine and naloxone. These drugs were not detected in the toxicological analysis of Mr Cound's blood and urine samples.

62 At the conclusion of the external post mortem examination, Dr Moss expressed the opinion that the cause of death was ligature compression of the neck (hanging).

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[33] Exhibit 1, Volume 1, Tab 2, Death in Hospital form dated 25 March 2022

[34] Exhibit 1, Volume 1, Tabs 4.1-4.3, Post Mortem Report dated 30 March 2022, Supplementary Post Mortem Report dated 30 March 2022, Interim Post Mortem Report dated 30 March 2022; Exhibit 1, Volume 1, Tabs 5.1-5.2, Final Toxicology Report dated 20 May 2022, Urgent Interim Toxicology Report dated 1 April 2022

[35] The Court had information from another prisoner that he had supplied Mr Cound with olanzapine on the day of his death: Exhibit 1, Volume 1, Tab 13, Statement of a prisoner in B Wing dated 30 August 2023, p.1

63 I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Mr Cound's death.

Manner of death

64 Based on all the information available, I am satisfied that Mr Cound was experiencing considerable stress and anxiety on the day of his death. I am also satisfied his request to Mr Arnott at 4.11 pm that he be placed in a safe cell so that he did not hurt himself, indicated he was having thoughts of self-harm.

65 Sadly, Mr Cound put those thoughts into action when he was alone in his cell, at some point shortly after prison officers left B Wing at 6.58 pm when he was seen by Mr Lyons standing inside his cell.[36]

66 Mr Cound was able to thread a portion of a torn bed sheet through a crack and a hole on either side of a damaged light fixture casing in the ceiling of his cell (the casing). The casing was not flush with the ceiling and could be reached by standing on the bed in the cell. It would appear Mr Cound used a cigarette lighter to create the hole, as a burn mark was visible on this side of the casing, and used blunt force to create the crack on the other side of the casing. He then used one end of the torn bed sheet as a ligature, with the casing acting as an anchor point.[37]

67 Accordingly, I find that Mr Cound's death occurred by way of suicide.

ISSUES RAISED BY THE EVIDENCE

Was it appropriate to remove Mr Cound from a safe cell on 8 March 2022?

68 On 3 March 2022, Mr Cound was transferred from Acacia to Hakea on "moderate" ARMS and he initially remained at that level.[38]

69 On 7 March 2022, Mr Cound damaged his cell and was subsequently moved to a safe cell on "high" ARMS.[39] He was seen by a mental health nurse the next day and said that he had damaged his cell in an attempt to get moved back to Casuarina. Mr Cound was in a low mood and said he was not coping because he believed the mother of his children had been unfaithful.

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[36] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024, p.37
[37] Exhibit 1, Volume 1, Tab 1.1, Police Attendance report dated 4 April 2022, p.3
[38] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.5
[39] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.5

Nevertheless, he denied any suicidal thoughts, plans or intent and requested he be released from the safe cell.[40]

70 At the PRAG meeting on 8 March 2022, it was decided that Mr Cound would be removed from the safe cell.

71 At the inquest, counsel for Mr Cound's family raised the question whether adequate steps had been taken in removing Mr Cound from the safe cell on 8 March 2022.[41]

72 I am satisfied of the steps taken by PRAG in its decision to remove Mr Cound from the safe cell. In forming that conclusion I note that he was to be transferred to an observation cell that night, he was to remain on "moderate" ARMS, that Psychological Health Services (PHS) was to follow up and there were referrals to the Prison Support Service (PSS) and also the Aboriginal Visitors Service (AVS).[42]

73 In addition, I note Mr Cound had denied any thoughts of self-harm or suicide, and had expressed a desire to come out of the safe cell which, by their very nature, are stark and very rudimentary.

Was it appropriate to place Mr Cound on "low" ARMS on 11 March 2022?

74 On 11 March 2022, Mr Cound was assessed by a counsellor from PHS for the purpose of the PRAG meeting later that day. The counsellor noted that his demeanour was settled and that he had described his mood as "*good*", with no issues or concerns. When the subject matter of current thoughts of self-harm and suicidal ideation was explored, Mr Cound said: "*No, I've had family and mates who have done it and [I have] seen the way it impacts on family and loved ones*". He also provided assurances that he would seek help from prison staff if he was unable to cope. The PHS file note concluded:[43]

> Whilst [Mr Cound] presents with a history of engaging in maladaptive coping strategies (aggressive and SH[44]) as a result of impulsivity, poor distress tolerance and poor emotional and behavioural dysregulation, at the time of contact, he impressed accepting of his situation and provided a safety plan to implement should he find himself unable to cope with his situation. Taking the above information into consideration, I am recommending he be removed

[40] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 4
[41] Item 3(a) of the Draft Issues List.
[42] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 4
[43] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 5
[44] Self-harm

> from ARMS. [Mr Cound] expressed interest in being waitlisted for PHS information sessions on coping.

75 Notwithstanding the above recommendation that Mr Cound be removed from ARMS, the PRAG meeting on 11 March 2022 determined Mr Cound was to remain on ARMS at the reduced "low" level. It was also recorded in the minutes of that meeting that PRAG had discussed at length the management and behaviour of Mr Cound.[45]

76 I am satisfied that careful consideration was given by PRAG on 11 March 2022 as to the ongoing management of Mr Cound. Although it was apparent Mr Cound was more settled and future-focused, the decision was made to continue providing support and monitoring by placing him on "low" ARMS. This was so despite the recommendation from the counsellor at PHS that he be completely removed from ARMS.

77 Accordingly, I am satisfied it was appropriate to reduce Mr Cound's ARMS rating to "low".

78 This level of ARMS was maintained at the next PRAG meeting on 18 March 2022. Given the positive interaction that Mr Cound's unit manager had with him (as recorded in the PRAG minutes), I am satisfied this was also an appropriate recommendation to make.[46]

Was the risk review for Mr Cound on the morning of 25 March 2022 appropriate?

79 At about 8.15 am on 25 March 2022, Catriona MacKay Macleod (Ms MacKay Macleod), a counsellor from PHS, conducted a risk review with Mr Cound. As he had been diagnosed with COVID-19 the previous day,[47] it was not possible to interview Mr Cound in an enclosed room. Instead, Ms MacKay Macleod attended Unit 1. As Mr Cound had just showered, she arranged to speak with him at the entrance to the unit's shower area, with both of them standing on either side of the grille.[48]

80 Although prison policy at that time required a staff member and a prisoner with COVID-19 to both wear full personal protective equipment (PPE) when interacting, Ms MacKay Macleod decided that as she had not previously met

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[45] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 6
[46] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 9
[47] Exhibit 1, Volume 1, Tab 35, Mr Cound's EcHO records, p.4
[48] Exhibit 1, Volume 2, Tab 6 , Statement of Catriona MacKay Macleod dated 26 April 2024, p.7

Mr Cound, it was best if she saw him "*face-to-face*" without either of them wearing PPE.[49]

81 Ms MacKay Macleod was aware of Mr Cound's FASD diagnosis and consequently conducted a more "*narrative form of therapy*".[50] Ms MacKay Macleod testified that she spoke to Mr Cound for between about 20 minutes to half an hour.[51] She summarised their discussions as follows:[52]

> Early on in our conversation, Mr Cound said he didn't want to die, he wanted to live. I asked him more about that, and he spoke about wanting to do training when he got to Casuarina so he could get work when he was released.
> ...
>
> Mr Cound said that he had been feeling stressed and isolated when he last self-harmed. He said that he had been working on coping with those feelings through breathing and meditation.
>
> My impression was that there was hope for this in Mr Cound's narrative and that he had some insight into his future and what that could look like.
>
> I asked Mr Cound if he was thinking about harming himself, and he said he wasn't and he would reach out if he felt overwhelmed. Help-seeking is a positive sign.

82 I am satisfied that given the circumstances, Ms MacKay Macleod conducted the risk review of Mr Cound in an appropriate manner. In so finding, I note that Dr Adam Brett (Dr Brett), the court-appointed independent consultant psychiatrist, agreed that Ms MacKay Macleod's questions were appropriate.[53] I also note Ms Mackay Macleod's efforts to speak to Mr Cound in a less restrictive environment, notwithstanding he had very recently tested positive to COVID-19. Her efforts in that regard, although posing a risk to her own health, were commendable.

Was it appropriate for PRAG to remove Mr Cound from ARMS on 25 March 2022?

83 At the completion of her risk review on the morning of 25 March 2022, Ms MacKay Macleod recommended that consideration be given for his removal from ARMS, and for a PSO (Prison Support Officer) referral be put in place for supportive contact and peer support.[54] As the file note from Ms MacKay Macleod's risk review recorded: Mr Cound "*strongly denied any*

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[49] Ts 6.5.24 (Ms MacKay Macleod), p.60
[50] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.7
[51] Ts 6.5.24 (Ms MacKay Macleod), p.62
[52] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.8
[53] Ts 8.5.24 (Dr Brett), p.247
[54] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.8

thoughts, plan or intent of self-harm or suicide, he stated he has reason to live, and he wants to focus on his future. ... He assured he would speak to officers if the thoughts returned." [55]

84 The PRAG meeting was held on the afternoon of 25 March 2022. Although Ms MacKay Macleod did not go to this meeting, a PHS representative was in attendance and those who were there had access to Ms MacKay Macleod's file note. After a lengthy discussion regarding the management and behaviour of Mr Cound, a decision was made to remove him from ARMS as he had, "*settled well into the structured environment of the prison with nil self-harm or suicide ideation.*"[56] As recommended by Ms MacKay Macleod, the referral to PSO was also made.

85 When asked at the inquest whether he had any issues with this decision to remove Mr Cound from ARMS, Dr Brett answered: "*I don't have an issue with the decision made on that day with the information that they had available.*"[57] I accept that evidence from Dr Brett, and given what Mr Cound had said to Ms McKay Macleod, I am satisfied that it was appropriate for PRAG to remove him from ARMS.

86 However, a separate question arises as to the appropriateness of the decision at this PRAG meeting not to place Mr Cound on SAMS. This is dealt with below.

Was it appropriate for PRAG to decide Mr Cound did not meet the criteria for placement on SAMS?

87 After deciding to remove Mr Cound from ARMS on 25 March 2022, PRAG agreed, "*that SAMS placement is not endorsed on this occasion as he does not meet the criteria of section 2 subsection 2.1.2 of the SAMS Manual.*"[58]

88 The heading for section 2 of the SAMS Manual is "Identification". Section 2.1.2 is titled "Criterion" and relevantly states:[59]

> Eligibility for management via the Support and Monitoring System is not restricted by a precise adherence to particular criterion. Whereas the focus of the At Risk Management System (ARMS) is the management of prisoners at immediate risk of suicide or self-harm, management via the Support and

[55] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 12, p.1
[56] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 13
[57] Ts 8.5.24 (Dr Brett), p.247
[58] Ts 8.5.24 (Dr Brett), p.247
[59] Exhibit 7, Support and Monitoring System (SAMS) Manual, p.6

Monitoring System will extend to those who meet **two or more**[60] of the following criteria:

- has a mental disorder as defined under the *Mental Health Act 1996*;
- has an acquired brain injury;
- has a physical or intellectual disability;
- is experiencing sensitive, spiritual or cultural issues;
- is identified as at chronic risk of suicide;
- requires intensive support, and/or would benefit from receiving coordinated services;
- may experience or is demonstrating difficulty coping or adjusting to placement in custody.

89 It is difficult to understand how the attendees at this PRAG meeting reached the conclusion that Mr Cound did not meet "*two or more*" of the above criteria.

90 As Dr Brett identified at the inquest, Mr Cound actually had five of this seven criteria: (i) an acquired brain injury, (ii) an intellectual disability, (iii) was identified with a chronic risk of suicide, (iv) required intensive support, and (v) had demonstrated difficulty coping or adjusting to placement in custody.[61]

91 Ms MacKay Macleod agreed that Mr Cound satisfied at least three of the criteria, and accepted he should have possibly been placed on SAMS. She surmised that an explanation for PRAG not placing him on SAMS was due to an insufficient emphasis on his FASD diagnosis.[62]

92 Sean Devereux (Mr Devereux), the current Deputy Superintendent at Hakea, said that the placement of Mr Cound on SAMS should have "*certainly been considered*" on 25 March 2022.[63]

93 Despite Mr Cound's denials of having thoughts of self-harm or suicide on 25 March 2022, there were static factors still at play. These included his history of self-harm attempts, his history of substance abuse, his recent COVID-19 and the need for him to isolate, and his FASD diagnosis. These factors meant he had a tendency to act impulsively.[64]

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[60] This bold type is in the original document.
[61] Ts 8.5.24 (Dr Brett), pp.250-251
[62] Ts 6.5.24 (Ms MacKay Macleod), pp.68-69
[63] Ts 9.5.24 (Mr Devereux), p.458
[64] Deaths in Custody Lessons Learned Report dated March 2023, p.12

94 Given the contents of the SAMS Manual and the above evidence, it was not surprising that Ms Femia, on behalf of the Department, conceded it was open to the Court, "*to conclude that Mr Cound should have been placed on SAMS*" by PRAG at its meeting on 25 March 2022.[65] That concession was properly made.

95 I have noted Ms Femia's follow-up submission to this concession, which was that had Mr Could been placed on SAMS, it "*would not have changed the outcome given the next available check would have probably been conducted at 7.00 am on 26 March.*"[66] This submission was based on evidence from Ms MacKay McLeod that prisoners on SAMS are checked once a day by prison officers, usually at 7.00 am.[67] However, Ms MacKay McLeod also added, "*in addition to any other interactions they might have during the day.*"[68]

96 I am satisfied there was a sound basis for PRAG to place Mr Cound on SAMS following his removal from ARMS. Unfortunately, I have not been able to ascertain why PRAG decided he did not meet the criteria for SAMS. Clearly he did. The minutes of the PRAG meeting do not state the reasons for the decision, nor did I hear from any of the attendees at the meeting as to how this decision was reached.[69] In addition, there are two other factors.

97 First, I must take note the SAMS Manual does not mandate that a prisoner is to be placed on SAMS if two or more of the criteria listed in section 2.1.2 are identified. The decision involves the exercise of a discretion.

98 Secondly, following the inquest, I was advised that on 25 March 2022 there were already 64 prisoners at Hakea on SAMS (as well as 63 prisoners on ARMS). This total of 127 prisoners represented over 14% of the prisoner population. It was noted that this "*volume could potentially be the reason for the SAMS criteria being strictly applied.*"[70]

99 Notwithstanding these two factors, I am satisfied Mr Cound should have been placed on SAMS by PRAG after his removal from ARMS. That finding

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[65] Ts 9.5.24 (closing submissions of Ms Femia), p.513
[66] Ts 9.5.24 (closing submissions of Ms Femia), p.513
[67] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.9
[68] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.9
[69] Mr Gateley was listed as an attendee in the minutes of this PRAG meeting and was the only listed attendee who was a witness at the inquest. However, he did not have any recollection of attending and had also sent an email on the morning of 25 March 2022 advising that he may not be able to attend due to other work commitments: Exhibit 8, Email from Richard Gateley to Emma Wood dated 25 March 2022; Ts 6.5.24 (Mr Gateley), pp.106-107
[70] Deaths in Custody Lessons Learned Report dated March 2023, p.12

cannot be adverse in nature as I did not hear from the attendees at the meeting and they were therefore unable to provide their reasoning for not placing Mr Cound on SAMS. This has meant procedural fairness has not been afforded to them. In those circumstances it would not be appropriate to make an adverse finding.

100 Instead, I find there was a missed opportunity (of some significance) by PRAG to place Mr Cound on SAMS.

101 Had Mr Cound been placed on SAMS on 25 March 2022, the outcome of his cell call at 4.11 pm may have been different as it could have influenced the decision whether to place him on ARMS. I raised this with Ms Femia during her closing submissions at the inquest and it was a proposition that she accepted.[71]

102 However, it would be too speculative for me to find that had Mr Cound been on SAMS, he would have been placed on ARMS after his 4.11 pm cell call.

Was Mr Cound's cell call at 4.11 pm dealt with appropriately?

103 As briefly outlined above, Mr Cound made the above cell call which was answered by Mr Arnott in the control room at Unit 1. Cell calls should only be made by a prisoner to report a medical emergency. I heard evidence that Mr Cound was not a "*serial abuser*" of the cell call system.[72] I am satisfied this factor should have been considered when any assessment was being made of the genuineness of what Mr Cound was saying in this cell call. From what subsequently occurred, I have grave doubts that it was.

104 Given the importance of the contents of this cell call, which was recorded, I will reproduce the entirety of that conversation.[73]

> *Mr Arnott*: State your name and medical emergency.
>
> *Mr Cound*: Boss, it's Cound.
>
> *Mr Arnott*: Yes, Cound.
>
> *Mr Cound*: Um, I think, I think I just got off ARMS today or I might still be on it.
>
> *Mr Arnott*: You're off it.

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[71] Ts 9.5.24 (closing submissions of Ms Femia), p.513

[72] Ts 8.5.24 (Mr Lyons), p.334

[73] Having listened to this conversation repeatedly, I have made some changes to the transcript of this conversation that appears in Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, attachment 2

> *Mr Cound*: Um, look, I'm stressed out, feeling a bit down. Can I go to a safe cell please?
>
> *Mr Arnott*: Are you serious?
>
> *Mr Cound*: I'm serious, but I don't – I don't wanna get the safe cell shit, like I just wanna be on the observation.[74] I just wanna be – well, I don't wanna be getting them fucken sandwiches and that or …
>
> *Mr Arnott*: Yeah, I understand that Cound, but unfortunately if you go to a safe cell that's what you get. So, think very carefully.
>
> *Mr Cound*: So, what if, if – cos that's not really helping is it? You say when I – when I feel frustrated to just ask for help.
>
> *Mr Arnott*: Yeah, I understand that and there's ways officers can help you. But how – do you think you need help to be under camera?
>
> *Mr Cound*: So that I don't hurt myself.
>
> *Mr Arnott*: Yeah, it, it doesn't always work that way. Look I'll, I'll put that to the boss, Mr Gateley and I'll see what we can do. But I'm not guaranteeing that you won't go into a safe cell, in a gown and - and sandwiches only, unfortunately. But I'll let him know and then he can come over and chat to you and he might be able to go through a few things with you and see what he can resolve.
>
> *Mr Cound*: Yeah, cheers.
>
> *Mr Arnott*: Roger.
>
> (underlining added)

105 As to why he asked the question, "*Are you serious?*" when Mr Cound requested placement in a safe cell, Mr Arnott explained that a move to a safe cell would have meant Mr Cound would go back onto ARMS. And this would have been after custodial staff:[75]

> had all worked hard to get Mr Cound to a place where he was addressing his cycle of poor behaviour, could come off ARMS and could now look at moving forward to transition into becoming a standard prisoner after serving out his period of close supervision.

106 Another reason Mr Arnott gave for asking this question was because a move to a safe cell would require Mr Cound going to D Wing,[76] and he had a "*strong suspicion*" Mr Cound wanted to be transferred to D Wing because he had a

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[74] I am satisfied Mr Cound was referring to an observation cell, which also has 24-hour CCTV monitoring.
[75] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, pp.2-3
[76] D Wing had two safe cells and three observation cells: Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, p.3

friend there who had been very disruptive that day.[77] As Mr Arnott explained:[78]

> I didn't feel that this would benefit Mr Cound as the environment created over in D Wing by the disruptive prisoner was not conducive to someone that was saying he was stressed out or feeling down as it would probably only make things worse.

107 Mr Arnott gave the following answers to these questions from counsel assisting at the inquest:[79]

> Well, the problem is though that [you] say, "How would it help you to be under camera?" and he says, "So that I don't hurt myself"? --- Yes. I've done a lot of control shifts. If he said to me, "I am going to hurt myself", every effort would have been made to move him to a safe cell. If he said, "So I don't hurt myself", that to me is not a direct threat. Like, if you're under camera that's not going to stop yourself – stop you hurting yourself necessarily.
>
> No. It means that someone else will stop him, doesn't it? --- Well, yes.
>
> You don't go under camera to stop yourself. You go under camera so that someone comes in and stops you? --- Yes, yes, yes, yes.
>
> And that's what he wanted, wasn't it? --- Well, that's what he suggested to me, yes, yes.
>
> He's not suggesting it. He's asking for a safe cell? --- Yes.

108 At the inquest, Mr Arnott denied that he was trying to talk Mr Cound out of going to a safe cell. In that same answer, he added: "*He has said to me he was stressed out. The call didn't sound stressed out. He didn't sound stressed out or like he was doing it hard.*"[80]

109 Either one or up to five days after Mr Cound's death, Mr Arnott was required to provide Hakea's senior management with a written account of the conversation he had with Mr Cound during the cell call.[81] In that account, Mr Arnott said:[82]

> [Mr] Cound stated that he wasn't going to hurt himself but wanted to be under camera for the night. I explained to [Mr] Cound that if he wasn't going to

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[77] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, p.3
[78] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, p.3
[79] Ts 8.5.24 (Mr Arnott), p.366
[80] Ts 8.5.24 (Mr Arnott), p.367
[81] As to precisely when this written account was provided, Mr Arnott recalled it was the next day: Ts 8.5.24 (Mr Arnott), p.376. However, Mr Devereux was of the view he had requested the written accounts from prison officers about five days after Mr Cound's death: Ts 9.5.24 (Mr Devereux), p.458
[82] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, attachment 1

> hurt himself there would be no reason for him to go into a cell with a camera and there were other options possibly available to him to put him in a better space.

110 Counsel assisting pointed out to Mr Arnott that Mr Cound had not said he was not going to hurt himself. Mr Arnott responded:[83]

> As I recollected, on the cell call, I recollect he had [said] something along the lines of, or words to the effect of, "I'm not going to do anything silly." No, it's not actually in the cell call. It's not in the transcript of the cell call, and I don't even know why I thought it was there, but obviously, this was the next day, so it's probably as fresh as it's going to be, so yes. My thoughts were, and I've maintained this all the way through, that I thought he said to me, "I'm not going to do anything silly", and that was a positive for me to say, alright, no worries, he wasn't going to hurt himself.

111 Having carefully considered the material relevant to this matter, and applying the ***Briginshaw*** principle, I am satisfied Mr Arnott had formed the view that Mr Cound did not have genuine thoughts of self-harm or suicide. That was a view he should not have taken. In making this finding, I rely on the following evidence.

112 First, Mr Arnott's distinction between a prisoner stating, "*I am going to hurt myself*" (which he said meant every effort would be made to move the prisoner to a safe cell) and Mr Cound's statement, "*So I don't hurt myself*" (which Mr Arnott regarded as "*not a direct threat*" to self-harm).[84] In my view, that distinction is dubious and one that should not be made. It is also inconsistent with the contents of the ARMS Manual.

113 Secondly, Mr Arnott's erroneous recollection that Mr Cound had said he was not going to do anything silly (or words to that effect). One plausible explanation for this error was that Mr Arnott had reached this conclusion and later assumed it was because of something that Mr Cound had said.

114 Thirdly, Mr Arnott's "*strong suspicion*" Mr Cound had an ulterior motive behind his request to be moved to D Wing. This was reflected in how he spoke and what he said to Mr Cound during the cell call. For example, after Mr Cound's request for a move to a safe cell, Mr Arnott asked, "*Are you serious?*". A second example was when Mr Cound explained that he needed to be under camera observations so he did not hurt himself, Mr Arnott began his response, "*Yeah, it doesn't always work that way*". That is simply wrong.

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[83] Ts 8.5.24 (Mr Arnott), p.374
[84] Ts 8.5.24 (Mr Arnott), p.366

Continuous CCTV monitoring of cells is undertaken for precisely the reason why Mr Cound was asking to be placed in such a cell. It would only not "*always work that way*" if a decision had been made (or was going to be made) that the prisoner asking to be placed under such monitoring was not at risk of self-harm or suicide.

115 The next question to be addressed is what it was Mr Arnott passed onto Mr Gateley regarding the contents of the cell call. Related to this question is whether I can be satisfied to the required standard, that Mr Arnott's doubts as to the veracity of Mr Cound's request to be placed in a safe cell influenced what he subsequently said to Mr Gateley.

116 It is not in dispute that Mr Arnott spoke to Mr Gateley about the cell call with Mr Cound, and that Mr Gateley then spoke to Mr Cound through his cell door at 4.16 pm for about 90 seconds.

117 However, it is not entirely clear precisely what Mr Arnott passed onto Mr Gateley regarding the cell call. My task to determine this has not been made any easier by the evidence from Mr Arnott and Mr Gateley. Their evidence is not only inconsistent with each other's, but their accounts also had internal consistencies.

118 In his written statement to the Court, Mr Arnott said he passed on "*the relevant information*" to Mr Gateley so that "*he could go and manage the situation in person*".[85] This very general account was not very helpful.

119 Consequently, at the inquest, counsel assisting asked Mr Arnott what he told Mr Gateley. Mr Arnott responded:[86]

> I would have given him as much information as I can. Just it would have gone along the lines but, like, I – well, I can't tell you the exact quote, but it would have gone along the lines of, "Prisoner Cound has rung up on the cell call. He's not in a good headspace necessarily. He's – he feels he needs to be under camera so would you be able to go and have a chat to him and, yes, see what you think has happened from there".
>
> (underlining added)

[85] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, p.4
[86] Ts 8.5.24 (Mr Arnott), p.368

120 Mr Arnott was then asked if he told Mr Gateley that Mr Cound requested that he be placed in a safe cell. Notwithstanding his evidence that is underlined above, he answered: "*I wouldn't know.*"[87]

121 Initially Mr Arnott could not recall if he told Mr Gateley about his suspicions that Mr Cound had an ulterior motive to be moved.[88] He then conceded it was "*a possibility*" that he did so.[89]

122 As to whether he told Mr Gateley it was his opinion that he did not think Mr Cound needed to be moved to a safe cell, Mr Arnott answered: "*No, not necessarily; no.*" When asked by counsel assisting whether he might have, he said: "*Not that I know of.*"[90]

123 I then had the following exchange with Mr Arnott:[91]

> Well, let's put it this way. If you've got a communication with a prisoner who is threatening self-harm and then you regard that threat as genuine, would you not in those circumstances pass your views onto the senior officer? --- Yes. So if he has said to me directly, "I'm going to hurt myself", I would have said to Mr Gateley, "Cound has rung up on the cell call and threatened to hurt himself so we need to put him in a safe cell". So that's what would have got done.
>
> Yes. So the other side of the coin though is the situation where someone has mentioned self-harm or going to hurt themselves, but you don't place a great deal of reliance on that. So would you not convey that to the senior officer? --- Yes. Possibly. I would have passed as much information on as I could to Mr Gateley to give him the general outline of what was happening.

124 In his written statement to the Court, Mr Gateley said: "*I cannot recall how I was made aware of the cell call, although I think I may have been informed by the control officer, Mr Arnott. I also cannot recall the content of the conversation.*"[92] This account was even less helpful than the one provided by Mr Arnott in his written statement to the Court.

125 At the inquest, Mr Gateley was asked what was the gist of the conversation he had with Mr Arnott that required him to go and see Mr Cound. Mr Gateley answered:[93]

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[87] Ts 8.5.25 (Mr Arnott), p,368
[88] Ts 8.5.25 (Mr Arnott), p.370
[89] Ts 8.5.25 (Mr Arnott), p.370
[90] Ts 8.5.25 (Mr Arnott), p.370
[91] Ts 8.5.25 (Mr Arnott), pp.370-371
[92] Exhibit 1, Volume 2, Tab 9, Statement of Richard Gateley dated 24 April 2024, p.4
[93] Ts 6.5.24 (Mr Gateley), pp.109-110

> My recollection is – and it – it isn't in my statement but I seem to recall him popping his head out from the control room, stating that [Mr Cound] had pressed his cell intercom, could somebody go and have a chat to him.

126 As to whether he was told that Mr Cound wanted to be moved into a safe cell so that he did not self-harm, Mr Gateley answered: "*I certainly wasn't – wasn't aware of – of that.*"[94] Mr Gateley agreed that if Mr Cound had said that to Mr Arnott it was something he should have been told.[95] Although Mr Gateley later conceded Mr Arnott may have told him that, he maintained he had no recollection he was told.[96]

127 When Mr Gateley was asked what now was his best recollection of what Mr Arnott had said to him, he answered:[97]

> My best recollection is that I recall being told he had pressed his cell call, could somebody go have a chat – a chat to him. And that's what I recall and since this tragedy occurred, I've gone through it over and over and over and I – I cannot have – I cannot recall at all being told at that time – he had requested to go into a safe – a safe cell. And the – the – the conversations I had with [Mr Cound], he certainly didn't raise any concerns. If he had, I would've had him in the safe – the safe cell. Being – look, I've – I've had almost 24 years' experience. I'm – I can – I can't assess whether or not a prisoner is at that point, and it was during those three days I did put three people in safe cells because I had concerns. But at that particular point – at that particular point in time [Mr Cound] had raised no concerns. If he had, I would have put him in a safe cell.

128 The shortness of Mr Gateley's conversation with Mr Cound at 4.16 pm may indicate he was not aware Mr Cound had told Mr Arnott he wanted to be in a cell with CCTV monitoring so that he did not self-harm. I accept Mr Gateley's account that he did conduct a welfare check with Mr Cound and asked "*the standard questions regarding his wellbeing*".[98] I also accept his account that Mr Cound "*did not appear to be anxious and he did not present in a way or say anything that caused me to be concerned for his welfare.*"[99]

129 However, it is clear from CCTV footage from the corridor of B Wing that the conversation between Mr Gateley and Mr Cound was very brief

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[94] Ts 6.5.24 (Mr Gateley), p.111
[95] Ts 6.5.24 (Mr Gateley), p.111
[96] Ts 6.5.24 (Mr Gateley), p.112
[97] Ts 6.5.24 (Mr Gateley), pp.111-112
[98] Exhibit 1, Volume 2, Tab 9, Statement of Richard Gateley dated 24 April 2024, annexure 1
[99] Exhibit 1, Volume 2, Tab 9, Statement of Richard Gateley dated 24 April 2024, p.4

(approximately 90 seconds). Consequently, it was unlikely to have involved a detailed exploration of what Mr Cound had said to Mr Arnott.

130 The CCTV footage from the cameras in B Wing (and also D Wing) do not have sound.

131 What Mr Cound had told Mr Arnott about why he thought he needed to be in a safe cell was undoubtedly critical information for an assessment whether Mr Cound should be placed on ARMS. But if Mr Gateley had not been provided with the information regarding Mr Cound's thoughts of self-harm, he would not have sought an explanation from Mr Cound regarding what he had said to Mr Arnott regarding those thoughts.

132 Mr Gateley said: "*If he had presented in any way that caused me concern, I would have put him on ARMS and moved him into a safe cell.*"[100] One would expect this would have also included how Mr Cound had presented to Mr Arnott a short time earlier. And had Mr Gateley been aware of that, then based on his evidence cited above, it would be expected he would have arranged for Mr Cound to be placed in a cell with CCTV monitoring. That would have been the outcome even if Mr Cound had not repeated his statement to Mr Gateley that he had made to Mr Arnott regarding a placement under camera observations so that he did not self-harm.

133 The counter argument to the above assertion is that as Mr Arnott had decided Mr Cound's cell call warranted Mr Gateley speaking to Mr Cound, then it would be expected he would have provided all relevant information to Mr Gateley. This would include Mr Cound's request to be placed in a CCTV monitored cell so that he did not self-harm.

134 After a careful consideration of the evidence (including the statements from other prisoners in B Wing regarding this matter[101]), and applying the ***Briginshaw*** principle, I cannot be satisfied precisely what it was that Mr Arnott told Mr Gateley. Accordingly, I am not able to determine whether Mr Gateley was aware of the most pertinent part of the cell call conversation; namely, that Mr Cound wanted to be placed in a cell with CCTV monitoring so that he did not self-harm.

135 Not without some hesitation, I am not satisfied Mr Arnott's view that Mr Cound's threat of self-harm was not genuine influenced what he then told

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[100] Exhibit 1, Volume 2, Tab 9, Statement of Richard Gateley dated 24 April 2024, p.4
[101] Exhibit 1, Volume1 Tabs 12-20, Statements from nine prisoners in B Wing

Mr Gateley. I have a suspicion that it might have; however, that falls short of the standard required under the ***Briginshaw*** principle.

136 Nevertheless, I am satisfied to the required standard, that Mr Cound's cell call was not dealt with appropriately. Inadequate inquiries were made and insufficient attention was given to the question whether Mr Cound should be placed on ARMS and into a safe cell (or, at the very least, a cell with 24-hour CCTV monitoring). I agree with what Mr Devereux had to say regarding this matter:[102]

> I consider that more detailed inquiries should have been made to determine whether Mr Cound needed to go into a safe cell (the assumption being that he did, given his request), and inquiries should have been made to identify a suitable safe cell either in Unit 1 or elsewhere.

137 The safe cells were all occupied at the time of Mr Cound's cell call.[103] However, I am satisfied that even if it was not possible to move a prisoner from a safe cell so that one was available for Mr Cound, arrangements could have been made to place him in an observation cell that had continuous CCTV monitoring. I was told this option was available when all safe cells are occupied.[104]

Should Mr Cound been placed on ARMS after his cell call at 4.11 pm?

138 Under the heading "The Objectives of ARMS", the ARMS Manual (the Manual) states: "*The objective of the 'At Risk Management System' is to enable a high quality of care to be given to prisoners who are identified as being at possible risk of self-harm or suicide.*"[105] The Manual cites six ways of achieving this, one of which is, "*encouraging the prisoner him/herself to be involved in identifying action to improve coping.*"[106]

139 The Manual then identifies four key stages in the ARMS process, with Stage 1 concerning "Identification". Stage 1 provides: "*If a staff member is concerned about or obtains information regarding a prisoner's potential risk to self, they are required to ensure the safety of the prisoner and commence the ARMS process by placing the prisoner on ARMS (Referral via TOMS).*"[107]

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[102] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.3
[103] Ts 7.5.24 (Mr Lyons), p.226
[104] Ts 7.5.24 (Mr Kemp), p.176
[105] Exhibit 1, Volume 2, Tab 2.1, At Risk Management System (ARMS) Manual1998 (Updated October 2016), p.2
[106] Exhibit 1, Volume 2, Tab 2.1, At Risk Management System (ARMS) Manual 1998 (Updated October 2016), p.2
[107] Exhibit 1, Volume 2, Tab 2.1, At Risk Management System (ARMS) Manual 1998 (Updated October 2016), p.3

140 I note this passage sets out a mandatory requirement for a prisoner to be placed on ARMS by a staff member if information is obtained "*regarding a prisoner's potential risk to self*" (underlining added).

141 Under the heading "Referral to ARMS", the Manual also states:[108]

> All staff are to be alert for any change in mood or behaviour of any prisoner, particularly those being monitored via ARMS. Any officer who knows or suspects that a prisoner is "at risk" at any time during the prisoner's imprisonment shall identify the prisoner as being "at risk" or potentially "at risk" and refer to ARMS.

142 Staff at PHS had made considerable efforts with Mr Cound to encourage him to seek help if he was not coping. Examples of those efforts are documented as having taken place on 11 and 25 March 2022.[109] On the morning of Mr Cound's death, he assured Ms MacKay Macleod that if his thoughts of suicidal ideation were to return, "*he would speak to officers*".[110]

143 I am satisfied Mr Cound was referring to those conversations with PHS when he said to Mr Arnott during his cell call at 4.11 pm, "*you say when I – when I feel frustrated to just ask for help.*"[111] Sadly, having activated his safety plan, Mr Cound's plea for help was not given the attention it required. As Mr Devereux said at the inquest: "*That, for me, was a clear cry for help, and that was an opportunity for proper intervention to occur.*"[112]

144 In addition, Mr Devereux made the following concession in his letter to the Court:[113]

> Where a prisoner has requested to go under an observation camera, that prisoner should be put into a safe cell immediately, unless a considered and detailed inquiry has been undertaken, including seeking the views of a health professional, to determine that the move is not necessary.

145 And at the inquest, Mr Devereux said:[114]

> So I take into consideration the context upon which Unit 1 was operating that day. They were busy throughout the day. Regardless, when you get a call like that, you make serious inquiries with regards to what is the level of risk here. And I would – I've heard Mr Gateley's evidence as well. I don't care how

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[108] Exhibit 1, Volume 2, Tab 2.1, At Risk Management System (ARMS) Manual 1998 (Updated October 2016), p.32
[109] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexures 5 and 12
[110] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, annexure 12, p.1
[111] Exhibit 1, Volume 2, Tab 10, Statement of Rowan Arnott dated 30 April 2024, annexure 2, p.1
[112] Ts 9.5.24 (Mr Devereaux), p.449
[113] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.2
[114] Ts 9.5.24 (Mr Devereaux), p.450

> much experience you have as a prison officer, you need to consult with health experts with regards to ascertaining the level of risk and if you don't have that opportunity to be able consult with a health expert, you err on the side of caution and you start making preparations to put that prisoner in a safe cell. That is standard protocol for us in the prisons.

146 In her written statement to the Court, Ms MacKay Macleod said: "*I have been informed that Mr Cound requested to be put into a safe cell after he had been removed from ARMS. I am surprised that he was not put into a safe cell after making the request.*" [115]

147 At the inquest, Ms MacKay Macleod agreed it was "*black and white*" that Mr Cound should have been placed on ARMS after his request.[116]

148 I am satisfied that notwithstanding the number of disturbances in Unit 1 on the day, the particularly stressful environment that prison officers were working under and the staff shortages at the time, Mr Cound should have been placed on ARMS and into a safe or observation cell, shortly after his cell call. In making that finding I note that Ms Femia, on behalf of the Department, made no submissions challenging that finding.[117] That concession was properly made as the provisions I have cited from the Manual makes it clear that Mr Cound ought to have been placed on ARMS following his cell call.

149 As to the genuineness of Mr Cound's request for help when he made his cell call, Dr Brett was asked at the inquest:[118]

> But the thing is … just because he was taken off ARMS at 1.30 [on 25 March 2022], doesn't mean that by 11 minutes past 4, which is when he made his call, that he felt quite differently and it was a genuine request for help? --- Yes. I think that's one of the important things about risk assessment and risk management, is that risk can change rapidly depending on what's occurring for the individual and so we talk about static risk factors and dynamic risk factors. So static risk factors are factors which are there all the time and dynamic risk factors are things which change within the individual. So a good example with Mr Cound would be FASD, [which] was a chronic static risk factor.
>
> Yes? --- So that doesn't change overtime. That's always going to be there. Dynamic risk factors, things like hearing bad news, getting upset over

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[115] Exhibit 1, Volume 2, Tab 6, Statement of Catriona MacKay Macleod dated 26 April 2024, p.9
[116] Ts 6.5.24 (Ms MacKay Macleod), p.74
[117] Ts 9.5.24, p.473
[118] Ts 8.5.24 (Dr Brett), p.248

> something, they're things which can't always be predicted but they change the risk factors significantly.

150 Given the high level of surveillance and the fully ligature minimised environment Mr Cound would be subjected to had he been placed in a safe cell, I am satisfied the risk of him ending his life when in that environment was very low. The risk would have also been low had he been placed in an observation cell. The same could not be said for what existed in his cell in B Wing. There was an easily accessible ligature anchor point from the damaged light casing and there was fabric within the cell to create a ligature.

151 Having carefully considered the information available, applying the ***Briginshaw*** principle and being mindful to not insert hindsight bias, I am satisfied that the failure to place Mr Cound on "high" ARMS and into a safe cell after his cell call at 4.11 pm contributed to his death approximately three hours later.

Was it appropriate for Mr Cound to remain in his damaged cell?

152 As I have already outlined above, at about 4.43 pm on 25 March 2022, Mr Cound and two other prisoners in B Wing broke their cell door viewing windows and propelled broken glass and parts of damaged fans into B Wing's corridor. Although there was broken glass inside Mr Cound's cell, it was not checked or cleaned.

153 At the inquest, counsel for Mr Cound's family raised the question whether it was: "*Appropriate for Mr Cound to have been placed in his damaged cell on 25 March 2022 which contained broken glass and an exposed ligature point?*"[119]

154 As to the broken glass from the cell door's viewing window, Mr Devereux advised the Court:[120]

> The glass panels in the viewing window in Unit 1, B Wing are fitted with a 6 mm - 6.25 mm laminated toughened safety glass. The glass is designed to reduce the risk of injury and, if broken, disintegrates into small granular pieces that are not shards (rather than small beads of glass).

155 As I have previously noted, Dr Moss found small fragments of glass in incised wounds to Mr Cound's feet during the post mortem examination.[121] I therefore

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[119] Item 9 of the Draft Issues List.
[120] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.1
[121] Exhibit 1, Volume 1, Tab 4.1, Post Mortem Report dated 30 March 2022, p.3

have some difficulty accepting that the "*small granular pieces*" described by Mr Devereux significantly reduces the risk of injury.

156 Ideally, in those circumstances, Mr Cound (and the other two prisoners) should not have been left in their cells with broken glass on the floor. I say "ideally" as there were circumstances that rendered it difficult for a cleaning of Mr Cound's cell to take place in a timely manner.

157 First, the day shift staff in Unit 1 had been dealing with a significant number of disruptions. Secondly, it is not in dispute that Hakea was significantly understaffed by the time night shift officers took over on 25 March 2022. Thirdly, Mr Cound had COVID-19 which made movement of him more complex and time consuming.[122] Finally, Unit 1 had no available cells to place these prisoners in whilst the cleaning occurred.[123]

158 Although it was not appropriate to keep Mr Cound in a cell with broken glass for the length of time that he was, I am satisfied there were valid reasons why that was the case.

159 As to the damaged light casing in Mr Cound's cell. Based on the information before me, I am not able to determine precisely when the damage was done to the casing that enabled it to become a ligature anchor point. Nor do I have any information as to whether custodial staff were even aware this potential anchor point existed prior to Mr Lyons discovering Mr Cound hanging from the casing.

160 Had I been able to find that the damage to the casing was there for some time and/or the damage was known to custodial staff or the Department prior to Mr Cound's death, it would have been of great concern that he (or indeed any prisoner) was allowed to remain in a cell with this potential anchor point.

161 Mr Cound's cell was not a fully ligature minimised cell. It was, however, a cell that had modifications undertaken so that it was regarded as a "three-point ligature minimised cell". As Mr Devereux explained:[124]

> This means that the three most obvious points in a cell, including window bars, light fittings, and shelving brackets have been removed. When a cell is fully ligature minimised, all identified ligature points in a cell have been removed, including furniture, fixtures within the cell and plumbing.

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[122] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.7
[123] Exhibit 1, Volume 1, Tab 33.9, Incident Description Report, p.1
[124] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.2

> The same type of light fitting that was in cell B02 as at the date of Mr Cound's death is still in that same cell.
>
> I am informed by Infrastructure Maintenance that it is not in their scope of works to replace these light fittings with a flush type of light fitting.
>
> Regrettably, prisoners continue to come up with new anchor points for ligature. I am not aware of any other prisoner using the light fitting from which to anchor a ligature in the same manner as Mr Cound, either prior to his death or since.

162 I accept that Mr Devereux was not aware of another prisoner using the same method as Mr Cound. However, I am aware of this identical method being used by a prisoner more than six years before Mr Cound's death.

163 Coroner Michael Jenkin (Coroner Jenkin) investigated the deaths of five prisoners at Casuarina in an inquest held in March and April of 2019. One of those prisoners died by suicide in November 2015 after he attached a cloth ligature to the ceiling light fitting in his cell. As Coroner Jenkin said:[125]

> Despite having "virtually vandal proof" features, Mr Cameron was able to use the light fitting to secure the ligature with which he hanged himself. Admittedly, Mr Cameron burnt a hole in the light fitting (apparently using a cigarette lighter), a method of securing a ligature that had never been seen before.

164 Coroner Jenkin also noted: "*The style of light fitting in Mr Cameron's cell is found in all of the cells at Casuarina Prison, including those that have been ligature-minimised.*"[126] His Honour made the pertinent point that as the light fitting used by this prisoner was standard in all cells at Casuarina, "*it may be that 'three-point ligature minimised cells' should actually be regarded as 'two-point ligature minimised cells', unless the ubiquitous light fittings can be replaced with a flame-resistant alternative.*"[127]

165 As there has now been two deaths by hanging through the use of the casing of ceiling light fittings that are found in "three-point ligature minimised cells", there is now even greater merit in Coroner Jenkin's observation.

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[125] ***Inquest into the deaths of five prisoners at Casuarina Prison***, Ref: 14/19, [580]
[126] ***Inquest into the deaths of five prisoners at Casuarina Prison***, Ref: 14/19, [380]
[127] ***Inquest into the deaths of five prisoners at Casuarina Prison***, Ref: 14/19, [581]

Was it appropriate for prison officers to attend D Wing at 7.10 pm?

166 Shortly after the night shift custodial staff commenced at 7.00 pm on 25 March 2022, there were only two prison officers (Mr Lyons and Mr Hasson) in Unit 1.

167 As already outlined, a prisoner in B Wing made a cell call which was answered by Mr Hasson at 7.09 pm 40 seconds.[128] The call was very short. Mr Hasson answered with the standard request that the prisoner states his name and the medical emergency. After identifying himself, the prisoner said: "*Where - Cound, man, cutting up down here. Blood's everywhere. Blood's everywhere, Chief. Hurry up!*".[129] The recording of the cell call provided to the Court had no response from Mr Hasson.

168 At or about the time of this cell call, Mr Hasson had noticed on CCTV monitors in the control room of Unit 1 that the corridor of D Wing had water entering into it from a cell in that wing. When he was advised of this by Mr Hasson, Mr Lyons decided, in his capacity as the more senior officer and the night shift OIC, that he and Mr Hasson would attend the incident in D Wing.

169 The question arose at the inquest as to whether Mr Lyons and Mr Hasson should have instead attended the incident in B Wing that the prisoner had referred to in his cell call at 7.09 pm.

170 In his written statement to the Court, Mr Lyons explained his decision making process:[130]

> From my experience at Hakea, I knew flooding/excess water in a wing can cause management issues – including adding risks to the safety of staff and prisoners, who may slip over, or cause an electrical hazard in the cell.
>
> ...
>
> I made a quick decision to continue on and attend D Wing prior to responding to the cell call from B Wing because I was hoping I could just turn the water off quickly and then immediately go to B Wing to investigate the cell call. I decided to do this because I believed the cell call was a ploy to get prison officers into B Wing so that the prisoners in the damaged cells could throw objects at and assault attending prison staff.

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[128] For ease of reference, the time of this call will hereafter be identified as "7.09 pm".
[129] Exhibit 1, Volume 2, Tab 12, Statement of Matthew Hasson dated 1 May 2024, annexure 2
[130] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, pp.3-4

> I also decided to prioritise the flood in D Wing because I knew that a short time prior to the cell call, the prisoners in B Wing had fan motors tied to sheets and were throwing them out of the broken cell windows.

171 At the inquest, Mr Lyons gave the same reasons for his decision to initially attend D Wing.[131]

172 In his written statement to the Court, Mr Hasson said that at the time of the other prisoner's cell call:[132]

> I recall asking myself whether [the prisoner's] cell call was a ploy to get prison officers to go over to B Wing again so that the prisoners could throw things at them through the broken cell windows.
>
> ...
>
> From my experience at Hakea, I knew that flooding happened quite frequently and could cause significant management issues, depending on where the water originated from. For example, if the flooding was from the toilets, this could be a significant health hazard for both prisoners and staff.

173 It is relevant to note that the three prisoners in B Wing who had broken the viewing windows of their cell doors less than three hours earlier, had already thrown items from their cells into the corridor. This adds further weight to the reasonableness of Mr Hasson's concerns regarding the legitimacy of the cell call.

174 In his letter to the Court, Mr Devereux provided his view of the decision made by Mr Lyons to attend D Wing before B Wing:[133]

> Because of the configuration and design of prison doors in Unit 1, prisoners are not able to see from their cell into a neighbouring cell. This is the case even if their cell viewing window has been smashed or compromised.
>
> ...
>
> At the time that the cell call came from the prisoner at the end of the corridor, it was not possible for that prisoner to have been aware of whether someone had "slashed up" or whether there was "blood everywhere" inside another cell, because that prisoner would not have been physically able to see it.
>
> ...
>
> The cell call ... was in circumstances where prisoners in B Wing had been disruptive throughout the day, had broken the glass on their cell viewing windows ... and had been throwing material (including broken fan and clock radio components) out of the broken viewing windows. Against that

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[131] Ts 7.5.24 (Mr Lyons), pp.232-233
[132] Exhibit 1, Volume 2, Tab 12, Statement of Matthew Hasson dated 1 May 2024,
[133] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.3

> background, the officers may have suspected that [the prisoner making the cell call] was trying to entice officers to the wing to continue being disruptive. Because of the broken viewing windows and compromised cell doors, the officers needed to protect themselves with shields before they're able to go and check the wing.
>
> ...
>
> At the same time, those officers could see water coming out of a cell in D Wing on the CCTV - and they could see that the water was flowing very fast. I consider that those officers made an appropriate split-second decision in circumstances where they had direct and confirmed visual confirmation of a flooding incident occurring on the CCTV cameras, and what was being said by [the prisoner] during the cell call could not be verified at that stage, although it, of course, warranted investigation.
>
> I do not consider that they had sufficient evidence at that point in time to decide to respond to the cell call over the flood. The officers may have made a quick assessment that the flood in D Wing would be quick to respond to (i.e. inspect the site where the water was coming from and turn off the water) and they would then be free to get to the next high priority task (the cell call check-up in B Wing).

175 I accept these observations made by Mr Devereux. I also accept his explanation that the unanticipated staff shortages at the time prevented Mr Lyons from seeking assistance from other prison officers to attend B Wing whilst he and Mr Hasson were in D Wing.[134]

176 In addition, the CCTV footage depicting the corridor of D Wing as at the time the two prison officers attended, clearly showed a considerable amount of water had spread across the corridor with no signs of abating.

177 Accordingly, and being mindful not to insert hindsight bias, I am satisfied that it was appropriate for Mr Lyons and Mr Hasson to prioritise the flooding in D Wing and then the threat to self-harm from the prisoner in Cell 8, before responding to the cell call that had been made at 7.09 pm.

Was there an appropriate response by prison officers to the cell calls by prisoners in B Wing that commenced at 7.14 pm?

178 Once Mr Lyons and Mr Hasson left the control room at Unit 1 to attend D Wing, all cell calls made by prisoners within Unit 1 were redirected to the master control room at Hakea (the master control room). At the time of Mr Cound's death, the master control room was always staffed by two Special Operations Group (SOG) officers working in twelve-hour shifts.

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[134] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.4

One of the duties of these SOG officers was to answer cell calls.[135] Those officers answering cell calls from the master control room are aware from what cell the call is coming from.[136]

179 The primary tasks for SOG officers is to provide specialist security and emergency response support for all correctional facilities within the state. They also assist with high security escorts and patrols, both within a prison and outside its perimeter walls.

180 Relevant to Mr Cound's death, the two SOG officers[137] in the master control room from 7.00 pm received five cell calls from prisoners in B Wing between 7.14 pm and 7.25 pm. These calls were recorded and the times (including seconds) the calls commenced are registered.[138]

181 The CCTV camera footage from B Wing and D Wing also have a digital clock recording the time on the screen (including seconds). It is apparent that the times from these two CCTV cameras are synchronised. What is not so apparent is whether the times from the CCTV cameras are synchronised with the times identifying when cell calls are commenced. I suspect they are not. However, having scrutinised and compared the times from these two sources, I am satisfied there is not a significant difference between the times depicted.

182 CCTV footage of the D Wing corridor depicted Mr Lyons and Mr Hasson arriving at 7.10 pm 49 seconds. Within 30 seconds, Mr Lyons had turned off the water supply.

183 The two prison officers then walked back up the corridor and out of camera range. Mr Lyons returned to the corridor at 7.11 pm 35 seconds with a mop to clean up the water that had accumulated in the corridor. Twenty seconds later, Mr Hasson appeared with another mop and a bucket in preparation to assist Mr Lyons. For the next seven minutes, initially Mr Lyons and then Mr Hasson, attended to clearing the water in the corridor.

184 During this period, Mr Lyons unlocked a door to the right of the corridor (which was the D Wing day room) and obtained a towel which he placed on the floor at the bottom of the door to Cell 8 at the end of the corridor.

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[135] Exhibit 1, Volume 2, Tab 13, Statement of Officer A dated 1 May 2024, p.1
[136] Exhibit 1, Volume 2, Tab 13, Statement of Officer A dated 1 May 2024, p.1
[137] Identified as Officer A and Officer B at the inquest and in this finding due to the Suppression Order.
[138] Having repeatedly listened to these recordings, I have made some changes to the transcripts of these recordings that appear in Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room.

185 At 7.14 pm 40 seconds, Officer B answered a cell call from the same prisoner who had spoken to Mr Hasson at 7.09 pm. I will therefore identify this call as the second cell call from this prisoner. Once his call was answered by Officer B (who advised the prisoner he was at "*the Front Gate*"), this prisoner said:[139]

> Well Chief, I'm trying to tell you screws here, to check on my little brother because there's glass all in his cell and he's not answering and they're not even answering me yet. Duty of care is to come and check on him. He might be doing something stupid to himself there.

186 When Officer B advised that he will call the prison officers and tell them the prisoner wanted a check to be made, the prisoner said: "*Well Chief, he's not answering. Chief, and there's glass, his cell is smashed right up, you know what I mean?*" When Officer B asked what cell the other prisoner was in, the prisoner responded: "*I don't know Chief, number 2 on the left here somewhere.*"[140] This was the cell Mr Cound was in.

187 Officer B then used the prison radio to contact Mr Lyons. I do not have any direct information as to the time when this radio transmission occurred.

188 However, at 7.17 pm 15 seconds, as Mr Lyons mopped the corridor in D Wing, he appeared to briefly use the hand-piece of his radio.[141] Very shortly after that, at 7.17 pm 32 seconds, he attended the door of the cell where the water had come from and spoke to the prisoner.[142] I am satisfied this conversation Mr Lyons had with the prisoner was the one he is referring to when he stated:[143]

> While I was mopping, [the prisoner] who was in cell D08[144] was banging what sounded like a metal object on the cell window. I started talking to [this prisoner] while I was mopping up. When I opened up the viewing window to cell D08, I saw that [the prisoner] had a piece of metal in his hand and a plastic bag over his head. I was not at all expecting to see this. [The prisoner] started speaking about self-harming.
>
> ...
>
> I believe the metal [the prisoner] had in his hand came from his cell toilet.
>
> ...

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[139] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, p.1
[140] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, p.1
[141] Exhibit 1, Volume 1, Tab 1, Coronial Investigation Squad report dated 29 February 2024, p.44
[142] None of the CCTV footage has sound.
[143] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, pp.5-6
[144] Cell 8 in D Wing.

> While I was speaking to [the prisoner] at cell D08, I received a radio call from the SOG officers at the front gate asking me to call them on the landline.

189 Given what is depicted in the CCTV footage from the D Wing corridor at 7.17 pm 15 seconds, I am satisfied that Mr Lyons took this radio call just before he spoke to the prisoner in Cell 8, and not during his conversation with this prisoner.

190 In the audio recording of the radio call, Officer B stated: "*When you get a chance, can you call Control 668644, over?*" Mr Lyons responded, "*Yeah, will do, over.*"[145]

191 At the inquest, Officer B was asked why he did not indicate the precise nature of the concern raised in the prisoner's 7.14 pm cell call during this radio call. Officer B gave two explanations. The first was that the longer a radio transmission is, the less chance other prison staff members can use the radio. As Officer B explained, if you simply request the prison officer to call you back it frees up the radio for others to use. The second reason was that as prisoners can hear radio transmissions, it is appropriate to keep information to a minimum so that prisoners do not know what is going on.[146] I accept these explanations from Officer B.

192 Although it was not appropriate for Officer B to state over the radio why he wanted to speak to Mr Lyons, I am satisfied that he did not adequately convey the urgency of the need for Mr Lyons to call the master control room.

193 The prisoner who made the cell call to Officer B at 7.14 pm 40 seconds provided more details regarding his concerns compared to what he had said to Mr Hasson in his very brief cell call at 7.09 pm. He told Officer B that the reason why he wanted a check on Mr Cound to be made was "*because there's glass all in his cell and he's not answering, and they're not even answering me yet.*"[147]

194 Unfortunately, Officer B began his request for Mr Lyons to contact the master control room with the words, "*When you get a chance*".

195 At the inquest, I asked Officer B:[148]

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[145] Exhibit 1, Volume 1, Tab 31, Transcript of prison radio transmissions, p.3
[146] Ts 7.5.24 (Officer B), p.168
[147] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, p.1
[148] Ts 7.5.24 (Officer B), p.169

> You used the phrase, "When you get a chance". Do you think that appropriately reflected the urgency of the situation, looking back on it now? --- I wouldn't say it's a wonderful thing, so yes, I don't think it did. No.

196 That concession by Officer B was appropriate. The lack of urgency in his short conversation with Mr Lyons over the radio meant that Mr Lyons did not necessarily consider contacting the master control room in a more timely matter. As it transpired, Mr Lyons did not make that contact for more than four minutes.

197 At 7.17 pm 46 seconds, Mr Lyons had finished speaking to the prisoner in Cell 8. He and Mr Hasson then continued with the clean-up of the corridor.

198 At 7.17 pm 56 seconds, another prisoner from B Wing made a cell call. It was answered by Officer B and after he said he was at the Front Gate and not at Unit 1, the following conversation took place:[149]

> *Prisoner*: Excuse me, sir, I need you to check on Ricky Cound because he's not responding to us.
>
> *Officer B*: Yeah, I'm making calls now, okay
>
> *Prisoner*: Respond Chief, it is just going to make – escalate things and the boys are just going to start running amok again.
>
> *Officer B*: Hey, I've already made the call to the night OIC[150] okay. I'm waiting for him to call me back. They're very busy, but I've already made the call for him to contact me and advise him of this, okay.
>
> *Prisoner*: I'm not saying like thing to you. I'm just saying – I'm just helping you.

Officer B then said he had to end the call in order to answer another cell call.

199 At 7.18 pm 9 seconds, Mr Lyons entered the day room of D Wing for the second time. I am satisfied this was when he got a cannister of chemical agent. Mr Lyons returned to the door of Cell 8 at 7.18 pm 44 seconds. This is what Mr Lyons said took place, which I accept:[151]

> [I] returned to cell D08 where I again spoke with [the prisoner] and again asked him to remove the plastic bag from his head and to give me the bag and piece of metal. He refused to do so. I said to him, "I can't have you do

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[149] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, pp.1-2
[150] i.e. Mr Lyons.
[151] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, p.6

this" and I warned [the prisoner] that if he did not take the bag off his head, I would have to deploy the chemical agent.

200 I note that at this time when Mr Lyons returned to the door of Cell 8, it appeared that much of the water from the corridor had been cleared (although Mr Hasson was still using a mop on the floor). I also note that the CCTV footage clearly showed that Mr Lyons was having at times, a very animated conversation with the prisoner in Cell 8.

201 At 7.18 pm 59 seconds, the prisoner who had already made two cell calls from B Wing made his third call. Again, Officer B took this cell call and the following conversation occurred:[152]

> *Officer B*: [states the prisoner's name] Yep, you've come through to the Front Gate again.
>
> *Prisoner*: Yeah Chief, duty of care, he might be, he might have slit his wrists or something in there because he's not answering me, man.
>
> *Officer B*: Yeah, I know I've put out a radio call, okay, for the OIC to contact me and advise him, okay. So I'm just waiting for him to contact me, okay.
>
> *Prisoner*: Well Chief it's been a half an hour, you know what I mean, duty of care man. Come and check on him you know. I mean he's – he's suicidal, Chief.
>
> *Officer B*: Yeah, I know, I'm trying to get hold of him okay, so I've already put out the call. I'm waiting for him to contact me. Okay. I'm gonna send him down.

202 Listening to this call, it is plainly evident that the prisoner was extremely concerned for the welfare of Mr Cound.

203 At 7.20 pm 23 seconds, Mr Lyons walked away from the door of Cell 8. As he did that he took one of the mops and the bucket, and placed them off screen. He then returned and had a short conversation with Mr Hasson who continued to mop up the remnants of water in the corridor.

204 After that conversation, Mr Lyons walked up the corridor and off screen at 7.21 pm 42 seconds.

205 I am satisfied that when Mr Lyons was off screen at this point, he used the OIC mobile phone to contact the master control room.[153] Officer B spoke to

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[152] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, p.2

[153] On 11 July 2024, the Court was provided with additional information from the Department via the SSO. One document provided was a spreadsheet recording calls made on the Sisco corporate telephone system (Sisco) on 25 March 2022 between 7.00 pm and 10.30 pm. Calls made from Mr Lyons' OIC mobile phone were highlighted in

Mr Lyons and advised him that the master control room had been receiving cell calls that a prisoner was self-harming in B Wing.[154] Mr Lyons informed Officer B that he would attend B Wing as soon as possible as he was currently still managing the incident in D Wing.[155]

206 Mr Lyons returned to the D Wing corridor at 7.22 pm 37 seconds, by which stage Mr Hasson had completed the mopping of the corridor. At 7.23 pm 8 seconds, Mr Lyons went to the door of Cell 8 and had another conversation with the prisoner. That conversation occurred for about 35 seconds.

207 At 7.23 pm 44 seconds, Officer B answered a cell call from a third prisoner in B Wing. The following exchange took place:[156]

> *Officer B*: Pressed cell call, you've come to the Front Gate. State your name and emergency.
>
> *Prisoner*: Chief, can you check on the young fella down here?
>
> *Officer B*: Yeah man, we've notified them and umm - twice now and they're on the way.
>
> *Prisoner*: On their way? But the young fella's not answering and there's a lot of glass in the cell.
>
> *Officer B*: Yeah, I know. I've been notified by other guys as well. So we've made a couple of calls and they're gonna try and get to him as soon as possible.
>
> *Prisoner*: Possible! Fucken he could be dead soon as possible, Chief.
>
> *Officer B*: Yeah, I know we've advised them, okay. They're doing the best they can. Yeah, they're on the way.
>
> (another voice[157]): Is that B Wing?
>
> *Prisoner*: B Wing, Chief.
>
> *Officer B*: Yeah, yeah B Wing. They're on the way. They're going now.

208 At the completion of this cell call, Officer B asked Officer A to use the master control room's landline to contact Mr Lyons on the OIC mobile phone.

209 Following his conversation with the prisoner in Cell 8 that began at 7.23 pm 8 seconds, Mr Lyons walked halfway up the corridor. However, he then

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yellow. From this spreadsheet, I ascertained that Mr Lyons' call to the master control room was, according to the time used by Sisco, at 7.21 pm 37 seconds.

[154] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, p.6

[155] Exhibit 1, Volume 2, Tab 14, Statement of Officer B dated 2 May 2024, p.4

[156] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, pp.2-3

[157] This would appear to be Officer A.

returned to the door of Cell 8 at 7.23 pm 57 seconds. I am satisfied this is what took place, as recounted by Mr Lyons: [158]

> As I was negotiating with [the prisoner] seeking him to hand over the plastic bag and piece of metal, I received a telephone call on the OIC mobile from the control room. I was advised that they were still getting multiple cell calls that something was happening in B Wing.
>
> I then raised my voice at the prisoner in D Wing and told him to take the plastic bag off his head and to sit on his bunk. I informed him that I had to go to B Wing as something was happening. I told him that I would be back.

210 The CCTV footage of the D Wing corridor appears to show Mr Lyons reach into his shirt pocket and retrieve a mobile phone. This took place at 7.24 pm 6 seconds. I am satisfied this was the telephone call that Officer B asked Officer A to make (as outlined above). Officer A's account of this telephone call was that he informed Mr Lyons that the master control room was receiving several cell calls from prisoners inquiring about a fellow prisoner who had "smashed up his cell" and may be in possession of broken glass. Officer A said that Mr Lyons indicated he was still in D Wing.[159]

211 After this telephone call, Mr Lyons continued to speak to the prisoner and walked away from the door of Cell 8 at 7.24 pm 52 seconds. He walked up the corridor of D Wing and off screen at 7.24 pm 59 seconds. Mr Hasson followed him but then gestured to the unlocked door to the day room. Mr Lyons reappeared two seconds later and entered the day room, followed by Mr Hasson. Mr Lyons remained in the day room for 30 seconds before he locked the door at 7.25 pm 44 seconds.

212 At 7.25 pm 4 seconds, the prisoner who initially raised the alarm at 7.09 pm makes his fourth cell call. That conversation was as follows:[160]

> *Officer B*: Hey, [states the prisoner's name], the guys' gonna check now, okay?
>
> *Prisoner*: Well Chief, it's bit – it's gonna be too late man, by the time they come, Chief.
>
> *Officer B*: We just spoke to them again, and we got told that they are on the way and that they know about it. They are going down okay, D Wing, yeah?
>
> *Prisoner*: Nah, B Wing, B Wing.
>
> *Officer B*: B Wing. Yes, well, they're on the way anyway okay.

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[158] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024. p.6
[159] Exhibit 1, Volume 2, Tab 13, Statement of Officer A dated 1 May 2024, p.4
[160] Exhibit 1, Volume 1, Tab 30, Transcript of cell calls to the master control room, pp.3-4

Prisoner: Well, Chief (indistinct) by then it's been a half an hour. Duty of care man.

Officer B: Yeah, I know. It's duty of care, so I've notified them. The other guy I'm working with notified them as well, and they're making their way to him now, okay.

Prisoner: Well, Chief, man, what – you know what I mean, we've been waiting here for 20 minutes, half an hour. And what's, what's going on here?

Officer B: I don't know because I'm in the – at the Front Gate. Okay, so all we can do is pass on the information we receive to the officers and they gotta go and do the checks, okay. Other than that, we are helpless here, okay. All we can do is pass on the information and we got told that they're on the way.

Prisoner: Well, Chief they need do it man.

Officer B: Yeah, yeah, they're on the way. They should be there in just the next few minutes.

Prisoner: Chief![161]

213 The CCTV footage from the corridor in D Wing showed Mr Lyons and Mr Hasson walking off screen at 7.25 pm 46 seconds. After they each obtained a shield, the CCTV footage from the corridor in B Wing depicted them entering the corridor at 7.26 pm 14 seconds.

214 As to the five cell calls that went to the master control room, I make the following observations.

215 First, Officer B did not doubt the veracity of the cell calls he began receiving from prisoners in B Wing from 7.14 pm. As Officer A said: "*I recall [Officer B] indicating concern about the calls because he knew [the prisoner who made the multiple cell calls] and he made a comment to me along the lines of 'He wouldn't be making a call over nothing'.*"[162]

216 This is consistent with Officer's B's account: "*I recall thinking that something was wrong as [the prisoner who made the multiple cell calls] was a difficult prisoner who I had experience with through the Hakea riot in March 2021, and it was uncharacteristic of him to express genuine concern.*"[163]

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[161] The increased volume of this exclamation suggests it was not directed to Officer B but to Mr Lyons and Mr Hasson who by this stage would have been in the corridor of B Wing.
[162] Exhibit 1, Volume 2, Tab 13, Statement of Officer B dated 1 May 2024, p.3
[163] Exhibit 1, Volume 2, Tab 14, Statement of Officer B dated 1 May 2024, p.4

217 Secondly, having listened to these five cell calls, it is clearly evident to me that the prisoners in B Wing held grave concerns for Mr Cound's welfare; concerns which I am satisfied were soundly based.

218 Accordingly, I am also satisfied that none of those calls (as well as the first one at 7.09 pm) was an attempt to have prison officers attend B Wing under a false pretence.

219 Thirdly, I am able to conclude that Mr Cound was not responding to other prisoners at a time prior to 7.09 pm and most likely after 6.58 pm, when Mr Lyons saw Mr Cound standing in his cell. In those circumstances, I can readily appreciate the increasing frustration of the prisoners in B Wing that, as far as they were concerned, their pleas were being ignored.

220 It was a chilling portent that these prisoners predicted what had occurred in Mr Cound's cell.

221 However, it was not known to these prisoners that at the relevant time, Hakea was considerably understaffed with the unanticipated absence of a number of prison officers. Furthermore, the two prison officers best placed to personally respond to a welfare check for Mr Cound were dealing with a significant incident in D Wing. This incident initially concerned a flooded corridor but then escalated when a prisoner was observed threatening to self-harm with the means to carry out that threat.

222 I accept what Mr Devereux said regarding this matter:[164]

> When the officers first reached D Wing, they would have thought they only had a flood to deal with - but it was only when they arrived at D Wing and the flood site that they were confronted with another pressing issue of [the prisoner] who had a plastic bag over his head and who was refusing to remove the plastic bag from his head.
>
> Officer training and prison policies (including the ARMS Manual at 2.4 and 4.1, and the ARMS Procedural Instructions at 13.8 and 15.14) refer specifically to the risks and vulnerabilities posed by plastic bags in the prison environment and the need for specific preventative measures to counteract any negative effects of plastic bags on prisoner safety. The officers then stopped to deal with that immediate self-harm risk to a prisoner that was clearly in their line of sight at that time. I cannot be critical of their decision to do this.

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[164] Exhibit 10, Letter from Mr Devereux to the Court dated 8 May 2024, p.4

223 As to why Mr Lyons did not send Mr Hasson to B Wing whilst he dealt with the incident in D Wing, Mr Lyons said:[165]

> I made the decision not to send Mr Hasson to B Wing because I could not visually see what was happening in that wing, because I knew cells had been damaged by the prisoners in B Wing and because I was concerned Mr Hasson might have been placed at risk if he went to B Wing by himself.

224 At the inquest, Mr Devereux was of the view that given the disruptive behaviour that had been exhibited in B Wing, it would not have been appropriate for one prison officer to respond to the cell calls being made by the prisoners in that wing.[166] I agree with Mr Devereux. Therefore no criticism can be made of Mr Lyons' reasons for not sending Mr Hasson to B Wing on his own.

225 It was also appropriate for Mr Lyons and Mr Hasson to obtain shields before they attended B Wing as they were entering a wing where the viewing windows of several cells had been broken. There was a legitimate safety concern that projectiles could be thrown at the prison officers through those broken windows.

226 I am also not critical that Officer A and Officer B, despite their concerns regarding the content of the cell calls they were receiving, did not personally attend B Wing to conduct a welfare check on Mr Cound. As Officer A said in answer to this question at the inquest:[167]

> And are there any circumstances in which you and your fellow officer could leave the control room like, for example, if there was a Code Red? I'm thinking the answer to that is no? --- No. My understanding, your Honour, is unless the building is directly on fire that we were to stay in there.

227 Nor am I critical of Officer A and Officer B for not calling a Code Red medical emergency over the prison radio regarding the cell calls they were receiving. A Code Red medical emergency is called when there is a life-threatening emergency. I accept the following evidence from the two SOG officers regarding this matter.

228 Officer A testified: "*My training in calling a Code Red is based on incidents that you see or that you hear. ... But not being able to see inside the cell or*

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[165] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, p.7
[166] Ts 9.5.24 (Mr Devereux), p.447
[167] Ts 6.5.24 (Officer A), p.99

have direct communication, I didn't see where the threat was."[168] Officer B said that he "*didn't have enough information on hand to call a Code Red.*"[169]

229 After a careful consideration of the available information and ensuring I adhere to the ***Briginshaw*** principle, in addition to noting the impermissible use of hindsight bias, I make no findings adverse in nature against the four prison officers[170] for the actions taken in response to the cell calls by the prisoners in B Wing that began at 7.14 pm. However, I am satisfied there were three missed opportunities.

230 One was the missed opportunity Officer B had to make sure Mr Lyons understood the urgency to contact the major control room following the radio call Officer B made to Mr Lyons at 7.17 pm.

231 The other two concerned missed opportunities by Mr Lyons to deal with the incidents in D Wing more promptly. As to the first one: although Mr Lyons quickly turned off the water supply in D Wing, it was almost seven minutes after he and Mr Hasson arrived before he spoke to the prisoner in Cell 8 who had been responsible for the flooding of the D Wing corridor. It was only then that Mr Lyons realised this prisoner was threatening self-harm.

232 The second missed opportunity by Mr Lyons was to respond more quickly to the welfare check for Mr Cound once he had used the OIC mobile phone to contact Officer B at 7.21 pm, and then when he had another conversation with Officer A at 7.24 pm. It was more than four minutes after the first conversation with Officer B (in which Mr Lyons accepts he was told the major control room "*had been receiving calls that someone was self-harming in B Wing*"[171]) before he and Mr Hasson left D Wing.

233 Unfortunately, particularly after the second conversation with Officer A, Mr Lyons' movements as seen from the CCTV footage of the D Wing corridor do not reflect the degree of urgency that the matter in B Wing required; namely, a welfare check of a prisoner who had access to broken glass, who was not responding to other prisoners in B Wing for an extended period of time, and who had only been removed from an extended stint on ARMS less than six hours earlier.

234 In identifying this missed opportunity, I am satisfied to the required standard, that Mr Lyons and Mr Hasson were aware it was Mr Cound who required the

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[168] Ts 6.5.24 (Officer A), pp.97-98
[169] Ts 7.5.24 (Officer B), p.160
[170] Mr Lyons, Mr Hasson, Officer A and Officer B.
[171] Exhibit 1, Volume 2, Tab 8, Statement of David Lyons dated 29 April 2024, p.6

welfare check. I make this finding notwithstanding the evidence from the two prison officers that they were unaware of the identity of the prisoner requiring the welfare check. In so finding, I note that Mr Cound had been mentioned by name when the first cell call was made to Mr Hasson at 7.09 pm. I also note that Mr Lyons went directly to Mr Cound's cell after entering B Wing and had his shield up against the viewing window, indicating he knew it was one of the cells with broken glass.

235 Alternatively, if Mr Lyons was not aware whose cell he was supposed to be checking,[172] he should have found out; either on the two occasions when he spoke to the SOG officers on his OIC mobile phone or by making a radio call to the major control room as he completed the matters which required his attention in D Wing.

236 A final matter which concerned me was the evidence from Officer A and Officer B that they were not aware the cell intercom system could be used by the master control room to initiate a call into a cell.[173] It was confirmed at the inquest that this capability existed at the time of Mr Cound's death.[174]

237 One of two possible conclusions can be drawn from this evidence from Officer A and Officer B. One is that they had received training regarding that capability and had completely forgotten about that training; both on the night and in their evidence. The other possibility is they received no training or advice about that capability. Having heard the evidence from the two SOG officers, I am satisfied there was a failing by the Department to ensure SOG officers rostered to the master control room were aware that they could initiate a call into a cell.

238 Had the two SOG officers been so aware, they may have considered attempting to speak to Mr Cound via his cell intercom. And if he did not respond, it may have led to more urgent attention being given to the need for an in-person welfare check to be conducted for him.

239 Since Mr Cound's death, there has been a change in policy by the Department regarding the use of SOG officers in the master control room. This will be addressed later in my finding.

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[172] As he maintained at the inquest: Ts 8.5.24 (Mr Lyons), p.304

[173] Exhibit 1, Volume 2, Tab 13, Statement of Officer A dated 1 May 2024, p.3; Ts 6.5.24 (Officer A), p.93; Ts 7.5.24 (Officer B), p.165

[174] Ts 7.5.24 (Ms Femia), p.172

The management of Mr Cound's FASD

240 From the information available to me, a matter that caused me great concern at the inquest was the lack of attention given to Mr Cound's diagnosis of FASD. The prison officers who gave evidence at the inquest were all unaware that Mr Cound had FASD. They also had no training as to the management of a prisoner with FASD.

241 In Mr Cound's Total Offender Management System (TOMS),[175] there was a reference to the symptoms of Mr Cound's FASD and suggestions as to how to communicate with him. This could be found in TOMS by clicking onto Mr Cound's "Disability Status".[176] However, this material did not identify he had been diagnosed with FASD.[177] Nor was it easily accessible.

242 It also came to my attention that FASD was not cited in Mr Cound's "*Active Problem List*" in his EcHO[178] records.[179] This oversight was magnified when Dr Catherine Gunson (Dr Gunson), the Department's acting Director, Medical Services, said that she could not find a reference to the FASD diagnosis anywhere in Mr Cound's EcHO records.[180] Dr Gunson agreed that this did surprise her.[181]

243 Dr Brett was particularly scathing in his assessment of the weight (or lack thereof) placed on Mr Cound's FASD diagnosis. He noted that Mr Cound had "*an excellent, comprehensive Foetal Alcohol Spectrum Disorder assessment in 2016.*"[182] Yet the 2016 FASD report was not utilised by the Department's Health Services.[183]

244 Dr Brett also noted the lack of reference to Mr Cound's FASD in EcHO and that he could not find any management strategies for his FASD. Dr Brett concluded: "*This is a significant deficit.*"[184]

245 Dr Brett did not hold back in his criticism, repeating this conclusion later in his report:[185]

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[175] TOMS is the Department's main electronic source that has information for the management of prisoners.
[176] Ts 6.8.24 (Ms Mackay McLeod), p.86
[177] Exhibit 1, Volume 1, Tab 36.3
[178] EcHO is the acronym for Electronic Health Online which is the electronic system used by the Department's Health Services to record a prisoner's medical information.
[179] Exhibit 1, Volume 1, Tab 35, Mr Cound's EcHO records, p.1
[180] Ts 8.5.24 (Dr Gunson), p.262
[181] Ts 8.5.24 (Dr Gunson), p.263
[182] Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024, p.8
[183] Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024, p.8
[184] Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024, p.8
[185] Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024, p.9

> Mr Cound does not appear to have had a significant management plan in custody to manage his FASD. This is a significant deficit. Plans should include education of staff and strategies as outlined in his 2016 report. His FASD appears to have been unknown or ignored by staff who were managing him.
>
> His FASD impacted on his functioning, his coping mechanisms and his communication skills. He had increased self-harm ideas and self-harm behaviours in the lead up to his death. He appeared to be able to present reasonably to staff who assessed him.
>
> It is noted that people with FASD have higher rates of suicide than the general population. FASD is a significant risk factor for suicide.

246 At the inquest, Dr Brett stated that the risk of suicide for a person with FASD was 20 times greater than the normal population. He provided the following explanation:[186]

> I think it's associated with those other mental health issues. So the difficulty in coping, impulsive behaviours, and not thinking through the consequences of what you're doing, and also the difficulties in controlling your emotions.

247 The 2016 FASD report identified that Mr Cound had deficits in three domains, two of which were executive functioning and adaptive behaviour.[187] As Dr Brett explained at the inquest:[188]

> Executive functioning is really how your frontal lobe works; so it's organisation, making decisions, having judgment, impulse control. It has been compared to the conductor of an orchestra and so it coordinates all the different parts of the brain and results in decision making. And adaptive functioning is really how that person adapts to the community, their circumstances, and things like that.

248 At the inquest, Dr Gunson acknowledged that the Department's management of Mr Cound's FASD and the Department's assistance to help him acquire the tools to manage this neurocognitive disability "*was lacking*".[189] When counsel assisting asked whether this management was "*poor*" rather than "*lacking*", Dr Gunson answered: "*Well, I guess considering we did not know about it, it has to be poor because if it had been there, it might have flavoured how we dealt with him all the way along.*"[190]

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[186] Ts 8.5.24 (Dr Brett), pp.246-247
[187] Exhibit 1, Volume 1, Tab 36.1, Telethon Kids Institute FASD report dated 2016, p.22
[188] Ts 8.5.24 (Dr Brett), p.245
[189] Ts 8.5.24 (Dr Gunson), p.280
[190] Ts 8.5.24 (Dr Gunson), p.280

249 That concession by Dr Gunson was appropriate.[191] I am satisfied to the required standard that the Department's management of Mr Cound's FASD was inadequate.

250 Had there been better management and awareness of Mr Cound's FASD, it may have reduced his risk of self-harming. Two examples come to mind. The first regarded the evidence I heard from prison officers that Mr Cound was often smiling. This reassured them that there was no need to be concerned about his wellbeing.[192] However, Dr Brett explained:[193]

> ... if you knew that diagnosis [of FASD] you would interpret it differently. I understand Mr Cound often had a smile on his face which is fantastic, but that may have been misinterpreted as to say that he's not experiencing any problems. We talk about smiling depression. Some people respond with [sic-to] bad things by smiling. Shouldn't this be looked at individually?

251 The second example concerned the punishment Mr Cound received for misbehaving that involved a regime of isolation and restriction. At the inquest, Mr Luscombe asked Dr Brett:[194]

> But can you comment on whether someone in Mr Cound's position who was subject to a cycle of inappropriate acts and the punishment, what that cycle may do to them, but particularly do to them given their diagnosis of FASD? --- I think that's the critical issue, is that his behaviours and how he – what he did in prison needed to be seen through a FASD lens and it wasn't. So what I mean by that, is if someone understood what was happening in his brain, he would have been managed rather than punished. And that's a big difference and I think that's what all the literature says - the equal justice bench book articulates that very well and likewise, I think it was in that publication where Judge Antoinette Kennedy quotes about, "if we know the people with disorders like FASD are going to reoffend, why are we surprised when they do reoffend and why aren't we doing something about it?" I paraphrased that a bit, but it was words to that effect.
>
> ...
>
> And so there shouldn't be routine responses as to behaviours. It needs to be addressed within a FASD lens. And so that's why there needs to be specific policies and protocols. Education would be one of the first things that is needed.

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[191] Although I am satisfied Ms Mackay McLeod was aware of Mr Cound's FASD diagnosis and tailored her interview with him on 25 March 2022 with that in mind, this was the only example I had regarding the management of Mr Cound that took into account his FASD.
[192] For example, Ts 7.5.24 (Mr Gateley), p.138
[193] Ts 8.5.24 (Dr Brett), p.257
[194] Ts 8.5.24 (Dr Brett), pp.256-257

252 Dr Brett also addressed this need in his report:[195]

> The Department of Justice should have clear policies and procedures regarding FASD. This would include education of all staff and clear individual plans for those affected. Diversion pathways need to be developed.

253 I wholeheartedly agree with Dr Brett's opinion regarding the need for the introduction of specific policies and procedures that address the management of prisoners with FASD.

254 The absence of such policies and procedures impacted on the care provided to Mr Cound. As Dr Brett noted at the inquest:[196]

> It was very clear from his history that something needed to be changed in his management to change his trajectory. And because there weren't protocols in place of how to best manage people with FASD, he was managed like a person who didn't have FASD.

255 I also agree with this assessment from Professor Pat Dudgeon (Professor Dudgeon):[197]

> As stated in the psychiatric report [from Dr Brett], not having access to Mr Cound's FASD diagnosis and the management plan (in his 2016 diagnosis by TKI[198]) will make any risk assessment inappropriate and inadequate. The evidence on the cognitive impairments on people living with FASD, and the resulting risk factors of offending behaviour and contact with the criminal justice system is unequivocal.

256 At the time of the inquest, the Department had no treatment or management system in place for prisoners with FASD.[199] This is addressed later in my finding.

QUALITY OF MR COUND'S SUPERVISION, TREATMENT AND CARE

By custodial staff at Hakea

257 I was satisfied that the prison officers who gave evidence at the inquest were committed to providing a safe environment for prisoners and fellow staff at Hakea. I also have no hesitation in accepting Hakea is well past its use-by date, having been commissioned in 1981. I completely agree with Mr Devereux's candid admission it is a prison that is "*no longer fit for*

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[195] Exhibit 1, Volume 2, Tab 1.1, Report of Dr Adam Brett dated 5 March 2024, p.10
[196] Ts 8.5.24 (Dr Brett), p.252
[197] Exhibit 1, Volume 2, Tab 7, Statement of Professor Pat Dudgeon dated 23 April 2024, p.20
[198] Telethon Kids Institute
[199] Ts 9.5.24 (closing submissions of Ms Femia), p.504

purpose."[200] Hot weather, regular staff shortages, the widespread presence of COVID-19 and the constant disruptive behaviour from prisoners (particularly in Unit 1) would have made working in this ageing prison extremely stressful for custodial staff at the time of Mr Cound's death.

258 Given the lack of information provided to them regarding Mr Cound's FASD and its management, I am satisfied that the supervision, treatment and care provided to Mr Cound by custodial staff in Hakea leading up to 25 March 2022 was appropriate.

259 However, and notwithstanding the shortcomings of the infrastructure and working environment of Hakea that I have identified above, I am satisfied to the required standard, that the supervision, treatment and care of Mr Cound by custodial staff fell well short in one significant area, was not appropriate in another area, and was subject to three missed opportunities. It was most unfortunate that these all occurred during a critical phase; namely, the final hours of Mr Cound's life.

260 Most notable was the failure to place Mr Cound on ARMS and have him moved to an appropriate cell with camera monitoring. This failure took place after his cell call at 4.11 pm on 25 March 2022. I am satisfied that insufficient inquiries were made of Mr Cound and inadequate attention was given to the need to place him on "high" ARMS and into a safe cell (or an observation cell if no safe cell was available) following that cell call.

261 I have also found that although it was not appropriate for Mr Cound to remain in his damaged cell with broken glass in the late afternoon and early evening of 25 March 2022, I am satisfied there were adequate reasons which explained why that occurred.

262 Although there was a delay of 17 minutes from the first cell call by a prisoner alerting custodial staff to his concerns for Mr Cound's welfare to when prison officers checked Mr Cound's cell, I was satisfied that an unfortunate set of circumstances prevented a more timely welfare check. Those circumstances included Hakea being significantly under-staffed for the night shift on 25 March 2022 and the two disturbances in D Wing[201] that required the attendance of the two prison officers who were best placed to conduct the welfare check on Mr Cound.

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[200] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.1

[201] The flooding and self-harm threat by the prisoner in Cell 8.

263 Nevertheless, I identified a missed opportunity by one prison officer and two missed opportunities by another which, had those opportunities been taken, would have led to an earlier welfare check for Mr Cound.

264 Notwithstanding the existence of these missed opportunities, I am unable to conclude that had the welfare check been made earlier, the outcome for Mr Cound would have been different. That is because of the very low survival rate from a cardiac arrest following a hanging. There is a very high degree of uncertainty whether Mr Cound would have survived and made a full recovery, even if there was a more prompt intervention by prison officers after the incidents in D Wing had been dealt with.[202]

265 Once Mr Cound was found, I was satisfied that the resuscitation efforts by the prison officers, Hakea nursing staff, and the attending ambulance officers were promptly and efficiently performed. Mr Hasson deserves particularly high praise for his mouth-to-mouth resuscitation efforts that he performed, even though he knew Mr Cound had COVID-19. I agree with Mr Luscombe's assessment at the inquest that what Mr Hasson did was "*incredibly brave*".[203]

By PRAG at Hakea

266 Aside from one missed opportunity, I am satisfied that the decisions made by PRAG with respect to Mr Cound were appropriate. The actions by PRAG to keep Mr Cound on ARMS on 11 March 2022, even when there was a recommendation from PHS to remove him, is to be commended. I was also satisfied it was appropriate for PRAG to remove Mr Cound from ARMS on the afternoon of 25 March 2022.

267 However, the decision by PRAG not to place Mr Cound on SAMS after his removal from ARMS was a missed opportunity of some significance. I am satisfied he clearly met the criteria for monitoring on SAMS as set out in the SAMS Manual. And given Mr Cound's FASD and the long duration of his management on ARMS at Acacia and then at Hakea, the discretionary

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[202] ***Inquest into the death of Jordan Robert Anderson*** [2020] WACOR 44, [162]:
In his letter dated 25 August 2020, Associate Professor Bailey stated that "*hanging is an infrequent but devastating cause of cardiac arrest with outcomes worse than cardiac arrest of presumed cardiac aetiology.*" He noted that of the 1,018 persons in Western Australia who have been found after "*unwitnessed*" hangings and in cardiac arrest between 2015 and 2019, 331 had bystander CPR. Of these patients, 79 had returned of spontaneous circulation (ROSC) at hospital arrival, similar to Mr Anderson. However, only four of those patients survived to hospital discharge, and their quality of survival was not known.

[203] Ts 9.5.24 (closing submissions of Mr Luscombe), p.491

exercise that was undertaken by PRAG should have favoured him being placed on SAMS.

By MHAOD at Hakea

268 MHAOD is responsible for delivering mental health, and alcohol and other drugs health care to prisoners. It comprises of a consultant psychiatrist, mental health nurses, PHS, PSS and AVS.[204]

269 Notwithstanding the two matters outlined below, I am satisfied that the care and treatment provided to Mr Cound by MHAOD was appropriate.

270 One of those matters concerned the call AVS received from Mr Cound's mother on 14 March 2022. It was noted:[205]

> She is concerned for him as he is in Unit 1 and has been implicated in some of the events at Acacia Prison recently. [She] would like someone to do a welfare check and to ask him to call his mother. Please action as soon as practicable.
> (underlining added)

271 Despite attempts by PHS to see Mr Cound on 16, 18 and 23 March 2022, he was not seen on any of these days. The reason cited was "*due to operational issues*" that related to unit staff shortages or COVID-19 restrictions.[206]

272 Contact was eventually made with Mr Cound by PHS, but not until the morning of 25 March 2022. Although I am satisfied there were valid reasons for PHS not being able to contact Mr Cound before then, what occurred later that day verified the concerns his mother had expressed 11 days earlier.

273 It should also be noted that AVS visited Mr Cound on 18 March 2022 as a follow-up to the call from Mr Cound's mother on 14 March 2022. It was recorded Mr Cound was "*settled*", and that he said he was "*doing okay, physically, mentally and emotionally.*"[207]

274 The second matter concerned the overall management of Mr Cound's FASD. At an individual level, I heard evidence from a MHAOD staff member who conducted her interactions with Mr Cound by taking into account his FASD.[208]

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[204] MHAOD Summary into the Death in Custody dated 26 June 2024, p.3
[205] MHAOD Summary into the Death in Custody dated 26 June 2024, p.5
[206] MHAOD Summary into the Death in Custody dated 26 June 2024, pp.5-6
[207] Exhibit 1, Volume 1, Tab 8.2, Incident Report, p.5
[208] Ms MacKay Macleod's interview with Mr Cound on 25 March 2022.

However, at a macro level, I am satisfied the management of Mr Cound's FASD was suboptimal.

275 I must stress that this was not the fault of staff at MHAOD. I accept, without hesitation, their workload is very large and is taken up with simply looking after prisoners with acute mental health conditions. I unequivocally endorse the following comments by Dr Brett at the inquest:[209]

> Look, I think his management was poor. I want to make it clear I don't think that had anything to do with the individuals who were involved in his care.
> ...
> There's a tsunami of mental health problems within the prisons. Ten per cent of prisoners should be in hospital at any one time. That's 700 prisoners. There's realistically access to about two or three beds in [the] Frankland [Centre] so the numbers just don't fit. And so it's a bit like looking for a needle in a haystack with the individuals. I think what's needed is there needs to be very clear protocols and policies on how to manage people with specific problems. FASD being one of those problems.
>
> And just to exploring that a little bit before I finish. You need staff and resources and extra time to do that, don't you? --- Yes. And at the time of his death, obviously, they were in COVID and staff numbers were down across the board which made his management much harder.

276 The responsibility for the shortfalls regarding the management of Mr Cound's FASD must lie with the Department.

CHANGES AND IMPROVEMENTS SINCE MR COUND'S DEATH

277 As would be expected of all government entities, the Department is always on the pathway of continual improvement with the respect to its operations.

278 As there is ordinarily a gap of some duration between the date of a prisoner's death requiring a mandatory inquest and the inquest's date, the Department will often implement changes that are designed to improve practices and procedures connected to the death before the inquest is heard. This was the case with respect to Mr Cound.

279 Following Mr Cound's death, a Lessons Learned Workshop was held on 11 October 2022 at Hakea. A Deaths in Custody Lessons Learned Report (the Report) was subsequently prepared in March 2023 and provided to the

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[209] Ts 8.5.24 (Dr Brett), p.253

Court post-inquest on 11 July 2024.[210] The purpose of the Report was to provide:[211]

> ... a means of sharing ideas for improving processes, operations, service delivery, safety of both staff and the people within the care of the Department of Justice (the Department) and helps improve decision making in respect to the supervision and care of prisoners, as well as the response and recovery phases of a DIC.[212]

280 A number of changes and improvements were identified in the Report and included the following.

Oversight of PRAG decisions and additional training

281 The Report analysed the decision making process regarding Mr Cound at the PRAG meeting on 25 March 2022. It noted the shortcomings of that meeting, in particular, the failure to place Mr Cound on SAMS after his removal from ARMS.

282 At the time of Mr Cound's death, there was no unit responsible for suicide prevention governance in prisons. Although there had previously been such a unit, it was abolished in 2017. I have previously noted in another inquest how disturbed I was to find out about this abolition.[213] It meant that for a number of years, no entity had been responsible for leading suicide prevention governance in the Department.

283 Thankfully, there has been a reinstatement of the Suicide Prevention Governance Unit (SPGU). The SPGU was permanently established on 4 January 2024 and, "*will undertake the oversight function of PRAG decisions and will provide guidance to the PRAG where needed.*"[214]

284 It was reassuring to learn that since Mr Cound's death there has been enhanced training for PRAG chairpersons. The SPGU has developed a one-day training package consisting of eight modules for these individuals. In addition, the online training in ARMS and SAMS, which was revised in 2023, has a separate module specific to the role of PRAG chairpersons.[215]

285 The training for PRAG chairpersons is now reinforcing the fact that section 2.1.2 of the SAMS Manual is not an exhaustive list of prerequisites that

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[210] Deaths in Custody Lessons Learned Report dated March 2023
[211] Deaths in Custody Lessons Learned Report dated March 2023, p.3
[212] DIC is an abbreviation for death in custody.
[213] ***Inquest into the death of Jomen Blanket*** [2023] WACOR 6, [283]
[214] Deaths in Custody Lessons Learned Report dated March 2023, p.13
[215] Deaths in Custody Lessons Learned Report dated March 2023, p.14

prisoners must satisfy before placement on SAMS is recommended. There is also an expectation that face-to-face training for PRAG chairpersons is to be introduced that incorporates scenario-based training, role plays and other appropriate delivery methods to educate, assess and support PRAG chairpersons.[216] In my experience from hearing evidence of Department staff at inquests over a number of years, training which involves scenarios and role plays is a far more effective delivery method.

286 Since Mr Cound's death, there has also been an emphasis on the importance for PRAG to consider static and dynamic risk factors when assessing a prisoner's risk of self-harm and/or suicide. In 2023, a Deputy Commissioner's Broadcast was sent to the relevant staff at the Department reminding them of these factors. This broadcast also reinforced the requirement to adequately record a decision regarding the outcome of a PRAG meeting's risk assessment for a prisoner, including factors that supported the decision.[217]

287 As the Report noted, a number of these improvements and changes came into effect following the recommendations by Coroner Jenkin in an inquest regarding the death from suicide of a prisoner in Hakea that took place in February 2021. This inquest occurred in October 2022 (about seven months after Mr Cound's death), and the finding from Coroner Jenkin was delivered on 28 November 2022.[218]

288 It was also reassuring to hear from Ms McKay McLeod that since Mr Cound's death, PHS are placing a greater emphasis on recommending that prisoners be placed on SAMS if they are removed from ARMS.[219]

Response to prisoners requesting monitoring due to thoughts of self-harm

289 Unsurprisingly, the Report recognised the need to reinforce to prison officers that the ARMS Manual requires that a prisoner who is "at risk" must be referred to ARMS. The Report also acknowledged that when a prison officer is assessing risk levels, that determination is best considered in consultation with a mental health staff member or a member of PHS.[220]

290 In response, a Superintendent's Notice was issued in 2023 to relevant Hakea staff that emphasised:[221]

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[216] Deaths in Custody Lessons Learned Report dated March 2023, pp.15-16
[217] Deaths in Custody Lessons Learned Report dated March 2023, pp.16-17
[218] ***Inquest into the death of Wayne Thomas Larder*** [2022] WACOR 48
[219] Ts 6.5.24 (Ms McKay McLeod), p.81
[220] Deaths in Custody Lessons Learned Report dated March 2023, p.21
[221] Deaths in Custody Lessons Learned Report dated March 2023, p.21

... the need for staff to undertake the following when a prisoner presents with risk factors associated with suicide/non suicidal self-injury:

1. make necessary ARMS referrals;
2. consult with relevant support services (PHS, Mental Health, Health Services)
3. inform relevant staff (Unit Manager, Principal Officer, PRAG); and
4. consider immediate placement of a prisoner into a safe cell.

Custodial staff numbers at Hakea

291 The Report correctly noted that: [222]

> It appears Hakea did not have sufficient resourcing on the night of 25 March 2022 to deal with the high workload in reception and multiple incidents occurring simultaneously. This resulted in competing priorities when critical decisions were being made from a preservation of life perspective.

292 The Report also acknowledged that, "*there is further work required to ensure that facilities are operating with an appropriate compliment of staff to adequately maintain the good order and management of the prison.*"[223]

293 Furthermore, the Report noted it was not uncommon for Hakea to be understaffed on a Friday,[224] and that Friday nights frequently involved a larger number of prisoner intakes into Hakea.[225]

294 In order to provide sufficient coverage of custodial staff on night shift, the Report considered the following options: [226]

1. placing officers "on-call";
2. establishing a pool of part-time officers; and
3. sharing human resources within the metropolitan area.

295 I sought feedback from the Department regarding its efforts to address the shortage of custodial staff, particularly at Hakea.

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[222] Deaths in Custody Lessons Learned Report dated March 2023, p.25
[223] Deaths in Custody Lessons Learned Report dated March 2023, p.25
[224] 25 March 2022 was a Friday.
[225] Deaths in Custody Lessons Learned Report dated March 2023, p.25
[226] Deaths in Custody Lessons Learned Report dated March 2023, p.25

296 I was advised that a pool of casual retired prison officers has been established to undertake hospital sits of prisoners in order to relieve custodial staffing pressures.[227] As some prison officers were required to leave Hakea to attend a hospital sit on the night of Mr Cound's death, I commend the Department's introduction of this pool and also its plan to extend the use of the pool to other custodial estates that are experiencing staffing challenges.[228]

297 It was also reassuring to hear that the Department has undertaken a review of staffing in prisons, "*in order to develop a new prison staffing model that is operationally flexible and capable of meeting current and future demands.*" In addition, the Department has undertaken "*bulk recruitment processes*" this year and in 2026 with the successful candidates "*directed towards metropolitan prisons that are experiencing significant constraints, with the aim to recruit 1200 prison officers over the next three years.*"[229]

298 I was encouraged by these developments as there is no sign the prison population will be reduced any time soon. Of course, what this also means is there is going to be an urgent need to address the dilapidated state of many prisons, of which Hakea is a prime example.

299 In addition to the above changes and improvements, the Court was advised of the following.

Availability of Health Services staff

300 One issue from the inquest was that because Mr Cound made his cell call at 4.11 pm, it was unlikely a MHAOD staff member would have been on site to provide assistance to custodial staff in determining whether he should be placed in a safe cell.

301 Since the completion of the inquest, I have been advised that there now exists "*an overtime budget for mental health and psychological health staff to assist in ensuring prisoners identified as high risk are provided with support.*"[230] In addition, there is a pool of medical staff that allows for clinical resources to be deployed to Hakea as and when needed.[231]

302 I welcome the introduction of these initiatives.

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[227] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8
[228] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8
[229] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, pp.8-9
[230] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8
[231] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8

Policy and procedure regarding responses to critical incidents

303 The Department's Performance Assurance and Risk (PAR) Directorate identified a need to assist prison officers to prioritise the preservation of life over other events such as flooding in a cell.[232]

304 The relevant document regarding this matter, as identified by the PAR Directorate, was the Commissioner's Operating Policy and Procedure (COPP) 13.1 which is titled "Incident Notifications, Reporting and Communications" (COPP 13.1). The PAR Directorate noted that COPP 13.1 "*is not clear on prioritising preservation of life.*"[233]

305 At the time of Mr Cound's death, Appendix B of COPP 13.1 defined a flood as being "*excess water causing flooding which affects the operation of the prison*". A flood may be classified as a critical incident depending on its scale, severity and/or potential consequences of the incident. Included in the circumstances when a flood is regarded as a critical incident includes where it "*creates a dangerous or hazardous environment on Departmental properties.*"[234]

306 Self-harm is also defined in Appendix B of COPP 13.1 and, like a flood, may be classified as a critical incident depending on the scale, severity and/or potential consequences of the incident. In addition, attempted suicide is defined in Appendix B of COPP 13.1 and states that every attempted suicide is classified as a critical incident. [235]

307 The PAR Directorate considered that COPP 13.1 should be enhanced, "*to help officers prioritise the preservation of life over other events such as flooding in a cell.*" [236] I supported that recommendation made by the PAR Directorate and sought an update from the Department regarding its response to this recommendation.

308 The Department advised that it had taken the view that COPP 13.1 was not the appropriate document to assist prison officers to prioritise the preservation of life over other events.[237] Instead, another document has been created that mandates the steps to be taken in such a situation. It is the Department's "Statewide Emergency Management Plan" which was approved

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[232] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024
[233] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024, p.29
[234] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024, p.29
[235] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024, p.29
[236] Exhibit 1, Volume 3, Tab 1, Review of Death in Custody dated April 2024, p.30
[237] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.9

on 31 October 2023.[238] I was provided with a copy of this document and was advised:[239]

> Within the Plan, the PEARL framework is used (People, Secure Environment, Assets and Infrastructure, Reputation and our Legal Responsibility). This provides staff a structured approach to prioritising emergency response efforts. It ensures that decision-making aligns with key priorities in managing risks and protecting essential elements during an emergency.
>
> In the event there are more than one person at risk, and the decision rests with which one person is to be prioritised, this will always be circumstantial, but prioritisation should be given to those who are at the highest risk.

The placement of SOG officers in the master control room at Hakea

309 At the time of Mr Cound's death, SOG officers were always stationed in the master control room at Hakea. However, that is no longer the case. As Mr Devereux explained:[240]

> SOG were moved from the control rooms as a strategy to have SOG officers focus on their core duties. This plan was put in place in 2014 when the SOG were removed from the control room at Casuarina. Hakea was delayed due to low staffing numbers and other training requirements for Hakea staff. This decision was not a consequence of COVID.

310 I was surprised to hear that although SOG officers had been removed from the master control room at Casuarina a considerable time ago, they were still working in the master control room at Hakea in 2022.

311 It is my view it made no sense for SOG officers to perform duties in a master control room; duties that were not part of their core responsibilities. That included the answering of cell calls. Officer B agreed with me. At the inquest, he was asked:[241]

> Do you have any view on whether that would be a better process for answering those cell calls with officers that work within the prison?
> --- Yes, 100 per cent. They know, not all of them, but they know quite a lot of the prisoners, they know the staff, they know the layout, [the] procedures, so I believe it should have always been Hakea staff that man that control room, to be honest.

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[238] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.9
[239] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.9
[240] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.2
[241] Ts 7.5.24 (Officer B), p.165

312 To compound the problem of SOU officers being tasked with this role was the evidence I heard from Officer A and Officer B. It indicated their training (including the answering of cell calls) for working in the master control room was less than adequate. Officer A was asked:[242]

> ... did you have training in answering this sort of call - how to deal with them? --- Not that I remember. In the SOG the training that we received for working in the MCR[243] was some shifts we would watch SOG officers up there. I think possibly an hour and a half, and then we would shadow other officers on duty up there in a way we could see how they were answering calls to different incidents that would occur.

313 Officer B provided the following evidence regarding training:[244]

> As SOG officers, you are given this job of answering what can often be emergency calls. Did you have any training in how to answer those calls, like a triple zero operator? --- No. Basically, we got shown or told how to answer the cell calls. ... "State your name and medical emergency". That is how we got taught. Yes. Or that is what people did. Yes.
>
> So, there is no formal training in how to deal with people who might be in a crisis situation? --- No. There is none.

314 As I have already referred to above, Officer A and Officer B were not aware they were able to use the cell call system to make an incoming call to a prisoner from the master control room.

315 In light of the evidence I heard with respect to this matter, it is appropriate that prison officers are now responsible for the work undertaken in the master control room. It is regrettable it took so long for this to occur at Hakea.

Changes to the recording of matters on EcHO's "Active Problem List"

316 I have already noted the oversight to include Mr Cound's diagnosis of FASD on the "Active Problem List" in his EcHO's records. Unfortunately, his incidents of self-harm were also not recorded in that list. As the Department's Health Services Summary into the Death in Custody report noted:[245]

> Despite several incidents of self-harm recorded over [Mr Cound's] periods in custody, his Problem List was not updated to reflect this. Staff would regularly enquire about this history and record his responses, but the increased visibility of it being noted on the Problem List would cause staff to

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[242] Ts 6.5.24 (Officer A), p.93
[243] The master control room at Hakea.
[244] Ts 7.5.24 (Officer B), p.159
[245] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, p.17

> be more aware of any potential risks which might need to be explored, during their interactions with the patient. This was of particular importance during the COVID-19 pandemic, when prisoners in isolation might be more vulnerable.

317 Although the Department's Health Services templates have always included prompts to discuss risks of self-harm or suicide with incoming prisoners when they are admitted to a prison, "*there are now subsequent reminders included to add new information to the Active Problem List.*"[246]

318 As Dr Gunson explained at the inquest:[247]

> We changed our admission assessment template now so that it specifically says history of suicidal ideation or self-harm. Is it recorded on a problem list? Yes, no. [And] do it if it's not.

Ensuring appointments with the prison doctor take place

319 For a prisoner who does not have significant health issues, a health assessment by a prison doctor (called an admission assessment) is ordinarily done within three months of a prisoner's admission to a prison.[248]

320 During his penultimate term of imprisonment from July 2020 to September 2021, Mr Cound was schedule for his admission assessment on 27 October 2020. He did not attend that appointment; however, the appointment was not rescheduled. Although case note entries in April and July 2021 noted the overdue admission assessment, no appointment was ever made for Mr Cound during this term of imprisonment.[249]

321 During his final term of imprisonment, Mr Cound again missed his admission assessment with a prison doctor. The appointment had been booked to take place in Hakea on 9 February 2022. However, he had been transferred to Acacia on 8 February 2022. The Department accepted it was likely the rescheduling of his admission assessment appointment was overlooked, "*due to pandemic precautions taking precedence.*"[250]

322 This meant that for the 18 months Mr Cound had been imprisoned over two periods from July 2020 until his death on 25 March 2022, he never had an

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[246] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, p.17
[247] Ts 8.5.24 (Dr Gunson), p.269
[248] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, p.17
[249] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, pp.17-18
[250] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, p.18

admission health assessment performed by a prison doctor. This was less than satisfactory.

323 The Department has advised that the following improvements have been made:[251]

> Regular education of all health staff continues around ensuring that overdue interventions are identified and reviewed. Where necessary, administrative staff are requested to expedite appointment[s] if they are overdue. Education has also improved communication when prisoners move sites before they can attend their booked appointments, so that these can be transferred to the destination sites.

324 These improvements are welcomed. However, whilst appreciating that prisoners cannot be compelled to attend medical appointments, one would expect that systems should have always been in place to avoid the events from occurring that have been identified in the passage quoted above.

Establishment of the Hakea Prison Safer Custody Taskforce

325 In September 2024, the Hakea Prison Safer Custody Taskforce (the Taskforce) was created by the Department. This was after a number of deaths in custody over a 20-month period and a Show Cause Notice issued in May 2024 by the Inspector of Custodial Services after an inspection of Hakea.[252] The issuing of a Show Cause Notice on the Department by the Inspector of Custodial Services is a rare event.

326 The Taskforce is "*shaping and driving*" actions that are aimed to reduce the incidence of self-inflicted harm and violence by prisoners in Hakea. It has identified 47 short, medium and long-term actions since its inception.[253]

327 The Department is to be commended for taking this initiative and I hope it will bring about changes that will reduce the risk of self-harm and suicide by prisoners at Hakea.

PROPOSED RECOMMENDATIONS

328 The Court's proposed recommendations were forwarded to the Department via the SSO on 10 February 2025. The Department was invited to make submissions regarding these recommendations, and the Court received those submissions from Brad Royce (Mr Royce), the Commissioner for Corrective

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[251] Exhibit 2, Health Services Summary into the Death in Custody dated 2 May 2024, p.18
[252] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8
[253] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.8

Services, by letter dated 28 February 2025. The proposed recommendations related to the seven topics that appear below.

1: The care of prisoners with FASD

329 This inquest was the first in Western Australia involving the death of a prisoner with a confirmed diagnosis of FASD.

330 As I have already outlined above, I was concerned with the information I received at the inquest regarding the Department's management of prisoners with FASD.

331 The excellent work by the Telethon Kids Institute[254] in its assessment of the neurological disorders of detainees in Banksia Hill in 2015 and 2016 revealed some very disturbing numbers.

332 This multidisciplinary assessment was conducted on 99 detainees aged between 10 years and 17 years 11 months.[255] It found that 89% of these detainees had at least one severe neurodevelopmental impairment and 36% were diagnosed with FASD.[256] Sadly, these numbers indicate it is a foregone conclusion that for many years to come, there will be an ongoing influx of prisoners with FASD and other neurodevelopmental disorders.

333 It was disturbing to hear that notwithstanding this inevitability (something that would have been known when the results of these assessments were published in 2017), the Department has seemingly not addressed the issue of managing adult prisoners with FASD.

334 I was satisfied that the Department did not avail itself of the 2016 FASD report as much as it could or should have. The information that was in TOMS[257] suggested that the Department at some stage, either had access to the 2016 FASD report or a summary of its contents.

335 However, as I have already noted, this material was not easily accessible. This was most regrettable. The 2016 FASD report contained detailed and vital information that would have been helpful in assisting Mr Cound's general functioning and wellbeing within a prison environment. As the accompanying document to the 2016 FASD report stated: "*For [Mr Cound's] future, his*

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[254] Now known as the Kids Research Institute Australia.
[255] One of whom was Mr Cound.
[256] oics.wa.gov.au/wp-content-uploads-2018-08-FASD-and-youth-justice-telethon-kids-study.pdf
[257] Exhibit 1, Volume 1, Tab 36.3

circle of care including family, teachers, case workers, employers, and therapists, should be told of his areas of strengths and difficulties."[258]

336 None of the prison officers who gave evidence at the inquest had received training regarding the management of prisoners with FASD. Nor is such training delivered to prospective prison officers at the Corrective Services Training Academy.[259]

337 With that in mind, I was of the view it would be appropriate to make a recommendation that mandatory training be introduced for prospective prison officers and experienced prison officers with respect to the management and care of prisoners with FASD.

338 The Department supported this recommendation and I was advised that in order to progress such a recommendation, "*the Department's Disabilities team are currently working to source an on-line package that can be shared with the Academy to assist with custodial staff in this area.*"[260]

339 I have therefore made a recommendation with respect to this matter.[261]

340 As outlined above, I received information at the inquest regarding the absence of policies and procedures for the management and care of prisoners with FASD. I was therefore of the view that a recommendation for the drafting of specific policies and procedures to provide guidance to prison health service providers and custodial staff in the management and care of prisoners with FASD would be appropriate. As there is no cure for FASD and given the permanency of the disorder, I was also of the view that this recommendation should include the introduction of policies and procedures that provide support for these prisoners to manage their FASD.

341 With respect to this proposed recommendation, Mr Royce advised that COPP 4.8, which is titled "Prisoners with Disability" (COPP 4.8), provides guidance to custodial staff for the management and care of prisoners with an intellectual disability, including FASD.[262]

342 Having examined COPP 4.8, I am not satisfied it specifically addresses the needs of a prisoner with FASD. The only time the word "FASD" appears is when it is named as one of the neurocognitive disabilities in the "Definitions

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[258] Exhibit 1, Volume 1, Tab 36.2, Strategies to Support [Mr Cound], p.23
[259] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.1
[260] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.1
[261] See Recommendation No.1
[262] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.2

and Acronyms" section. COPP 4.8 certainly has no information regarding the support that can be offered to a prisoner as to the management of their FASD.

343 Mr Royce advised that if this proposed recommendation was made, "*the Department will consult with relevant stakeholders*" as to how further training will improve the management of prisoners with FASD and any other intellectual disability. He also proposed that this consultation would examine ways in which prisoners can be supported to manage their FASD or any other intellectual disability.[263]

344 I was encouraged by Mr Royce's preparedness to widen the consultation process to include other intellectual disabilities a prisoner may have. I have therefore made a recommendation that extends beyond FASD to include any other intellectual disabilities.[264]

2: The Department's use of court-ordered reports

345 During her closing submissions at the inquest, Ms Femia, counsel for the Department, indicated there may be legislative restrictions preventing the Department from obtaining psychiatric and psychological reports that are ordered by courts for the sentencing of offenders.[265]

346 After the inquest, I reviewed the relevant provisions of the *Sentencing Act 1995 (*WA) (the Act). My reading of those provisions is that such reports can be provided to the Chief Executive Officer of the Department. These provisions are in sections 21 and 22 of the Act.

347 Section 21(3) of the Act states: "*A pre-sentence report may include reports as to the physical or mental condition of the offender, whether or not the Court has asked for them.*"

348 Section 22(4) of the Act provides: "*A written pre-sentence report must not be given to anyone other than the Court by or for which it was ordered and the CEO (corrections).*" (underlining added)

349 Section 22(4a) of the Act states: "*The CEO (corrections) may use the information in a pre-sentence report to assist with the management of the convicted or sentenced offender to whom the report relates.*"

350 It is clear that "*reports as to the physical or mental condition of the offender*" would not only include psychiatric and psychological reports, but also a report

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[263] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.2
[264] See Recommendation No.2
[265] Ts 9.5.24 (closing submissions of Ms Femia), p.514

regarding a FASD assessment. Provided it is part of the pre-sentence report, then such a report would fall within section 22(4) of the Act.

351 It was not clear from the information available to the Court at the time of the inquest whether the Department utilised these provisions of the Act and if so, how frequently. If it did not, then I was of the view that a recommendation would be appropriate to remind the Department to use these provisions of the Act for a prisoner who is subsequently sentenced to an immediate term of imprisonment. I had in mind that the recommendation would also encompass the Department providing any relevant information from those reports to its Health Services for the management of that prisoner (as section 22(4a) of the Act would permit).

352 The response the Court received from Mr Royce regarding this matter indicated the Department was aware of the above provisions of the Act, as he noted that "*Corrective Services own all court ordered specialist reports and subsequently are responsible for appropriate release and dissemination.*"[266]

353 In addition, Mr Royce stated that relevant health service providers involved in the management of self-harm and suicide risk amongst prisoners "*have full access to all reports completed*".[267] However, he then said: "*In line with the recommendation, an instruction was issued to ensure that relevant pre-sentencing reports are available to staff*" and added that an "*operational procedure*" is currently being prepared to formalise information sharing practices.[268]

354 Mr Royce also advised that the Department is "*ensuring there are appropriate mechanisms in place so staff are (1) aware of the existence of the reports and (2) can access them to inform the services and care provided to prisoners.*"[269]

355 Given the response from Mr Royce, I have some concerns as to whether court-ordered reports have been previously used as much as they could have been in the management and care of prisoners. Unfortunately his response did not directly answer the Court's request for "*advice from the Department as to whether it regularly utilises these provisions of the Act.*"[270] In those

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[266] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.3
[267] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.3
[268] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.3
[269] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.3
[270] Letter from counsel assisting to the SSO dated 10 February 2025

circumstances, I have decided a recommendation addressing the use of these reports should be made.[271]

356 I had also reached the view that the provisions of section 22(4a) of the Act would permit the Department to provide relevant information to custodial staff who are directly responsible for the care of prisoners with diagnosed mental health or neurodevelopmental disorders, provided those disorders may impact their behaviour and/or how they are managed.

357 As to that potential recommendation, Mr Royce advised that TOMS has information for custodial staff as to the engagement and management of prisoners, including medical issues, mental health and any disability needs.[272]

358 Whilst I accept that custodial staff have access to this information, the problem I have identified is that it is up to each prison officer to make the effort to actually access that information. A far simpler and more effective measure is for prison officers to be informed of any prisoner in their immediate care who has a diagnosed mental health or neurodevelopmental disorder that may affect their behaviour or how they are managed, without requiring every prison officer to access TOMS for that information.

359 I have therefore made a recommendation to that effect.[273]

360 If the Department is concerned this recommendation may breach the confidentiality that is attached to the medical records of a prisoner, the Court notes section 22(4a) of the Act would override the confidentiality of such reports if the information in them is used for the purpose of assisting with the management of the prisoner.

361 In addition, I note section 7(1) of the *Prisons Act 1981* (WA) is relevant as it states, "*the chief executive officer is responsible for ... the welfare and safe custody of all prisoners.*" I am of the view a sound argument exists that the dissemination of relevant material from pre-sentence reports to those responsible for the care, treatment and supervision of prisoners would certainly assist in maintaining their "*welfare and safe custody*".

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[271] See Recommendation No.3
[272] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.4
[273] See Recommendation No.4

3: The introduction of body-worn cameras for prison officers

362 At the inquest, Mr Lyons gave evidence supporting the introduction of body-worn cameras (BWCs). His explanation was it would provide assistance when viewing CCTV footage as it is a record of what was being said.[274]

363 The Court is aware that youth custodial officers in detention centres wear BWCs, as do operational police officers. I am of the view that the obvious benefits of BWCs would logically extend to prison officers. I note that a recommendation regarding the use of BWCs by prison officers has already been recently made by the State Coroner in the ***Inquest into the death of Iain Campbell Buchanan*** [2024] WACOR 8.[275]

364 I decided that if the Department considered another recommendation would assist with the implementation of BWCs for prison officers then I would make such a recommendation.

365 The feedback I received from Mr Royce regarding this matter was positive. He advised: "*The Department continues to take all practical steps towards implementing body-worn cameras (BWCs) throughout the wider custodial estate*", with maximum security prisons being prioritised and funding being sought as part of the 2025/26 State Budget process.[276]

366 In those circumstances, I consider it is appropriate to make a recommendation that will hopefully assist this process for Hakea.[277]

4: Ligature minimised cells

367 As I have already noted, Mr Cound was in a cell known as a "three-point ligature minimised cell". One of those three-point ligature minimised fittings was the casing surrounding the ceiling light in the cell. Despite the casing being part of an approved ligature minimised fixture, Mr Cound was able to use it as a ligature point.

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[274] Ts 8.5.24 (Mr Lyons), p.320

[275] This recommendation was:

> That the Department of Justice continues to take all necessary and practical steps directed towards investment in body-worn cameras and improved CCTV coverage for high-risk areas of Hakea Prison including coverage of recreational areas within Hakea Prison.

[276] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.5

[277] See Recommendation No.5

368 The Report noted: "*The Department faces difficulty where prisoners have access to items that could be used to manipulate ligature minimised fixtures. This is because all fixtures, if manipulated, present ligature risks.*"[278]

369 Nevertheless, in 2023, the Lessons Learned Workshop recommended that the Department's Infrastructure Services should: "*Undertake a review of the light fixtures used in Mr Cound's cell to ascertain whether improvements can be made to prevent the fixture being manipulated and used as an anchor point.*"[279]

370 This was a very sensible recommendation, given that there has now been two prisoners who have hanged themselves by using the casing of ceiling light fixtures as a ligature point in an identical manner.

371 Regrettably, the response to this recommendation was:[280]

> In the case of Mr Cound, a review of the fixture (light fitting) used to anchor the ligature was conducted. It was determined the existing fitting is the most appropriate, subject to suitable management practices being in place by the prison regarding provision of cigarette lighters to prisoners.

372 The reference to cigarette lighters refers to the Department's process of introducing a smoke-free policy in all its prisons. Once implemented, no one within a prison will be permitted to have in their possession tobacco-related products such as cigarette lighters.[281]

373 After noting that flush mounting of light casings is not possible at all sites (such as the ground floor cells in double storey units), I was advised by the Department's Assistant Director, Infrastructure Maintenance:[282]

> Whilst it would be possible to flush mount lighting in Units 1-8 at Hakea Prison due to their ceiling cavities, the estimated cost for flush mounting lights is approximately $6,000 - $8,000 per cell.
>
> ...
>
> It is not currently in the Department's scope of works to replace the Vanguard[283] with another light fitting.

374 The Department would be very well aware of the Court's criticism in previous inquests of the very slow progress (which I have previously described as

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[278] Deaths in Custody Lessons Learned Report dated March 2023, p.19
[279] Deaths in Custody Lessons Learned Report dated March 2023, p.19
[280] Deaths in Custody Lessons Learned Report dated March 2023, p.20
[281] Exhibit 10, Letter from Sean Devereux to the Court dated 8 May 2024, p.2
[282] Letter from Andrew Daniels to the Court dated 9 July 2024, p.2
[283] The type of light casing currently in cells at Hakea.

"*glacial*")[284] to the modification of prison cells to reduce the number of ligature points within them. I remind the Department that a member of its senior management team (the Director, Infrastructure Services) has previously accepted that if a prison was built today, it would not have the number of ligature points that are still available in the currently modified cells that are categorised as "three-point ligature minimised cells". That is because all cells would be "*fully ligature minimised*".[285]

375 The state of affairs at Hakea regarding ligature minimised cells can only be described as parlous. I accept that anchor points for ligatures in cells cannot ever be entirely eliminated. Nevertheless, every coroner in this State, past and present, who has presided over prison suicides by hanging has been extremely concerned about the large number of cells in obsolete prisons that remain with ligature points which can be removed with modifications.

376 I will simply repeat what I said 19 months ago in my finding from the ***Inquest into the death of Jomen Blanket*** [2023] WACOR 6 at [247]:

> The situation regarding the unacceptable proportion of prison cells with a high number of ligature points remains an acute crisis; a crisis that this Court has now been pointing out for over 20 years. The Court will undoubtedly continue to encounter deaths in prisons from hangings in cells that use these ligature points. All too frequently, those deaths involve First Nations young men and leave behind devastated mothers, fathers, partners, children and extended family members asking: "*How was this allowed to happen?*"

377 I therefore proposed making a recommendation that the Department take immediate steps to ensure that all cells at Hakea are three-point ligature minimised as quickly as possible, with a view to ensuring all cells are fully ligature minimised.

378 I decided that this recommendation should mirror the one made three years ago by Coroner Jenkin that concerned the cells in Casuarina.[286]

379 Mr Royce responded:[287]

> The Department continues to work with Infrastructure Services to ensure as many cells across the custodial estate are ligature minimised and an internal audit of every cell across the system has now been conducted. In addition, following review by the Hakea Prison Safer Custody Taskforce (HPSCTF),

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[284] ***Inquest into the death of Jomen Blanket*** [2023] WACOR 6, [394]
[285] ***Inquest into the death of Jomen Blanket*** [2023] WACOR 6, [242]
[286] ***Inquest into the death of Wayne Thomas Larder*** [2022] WACOR 48, recommendation no.3
[287] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.6

> approvals are currently being progressed to undertake the installation of ligature minimised personal locks and taps in Unit 7 at Hakea Prison to ensure these cells are three-point ligature minimised as they are the first night centre and induction unit at Hakea.
>
> Whilst the Department does not oppose the proposed recommendation, the recommendation if made will reinforce work that is currently in progress.

380 In those circumstances, I considered it was appropriate to make the recommendation that I had proposed.[288]

5: Treatment of prisoners at Hakea with complex behavioural needs

381 Not for the first time, I heard evidence at the inquest regarding the inadequate number of MHAOD staff and lack of available infrastructure at Hakea to manage prisoners with complex behavioural needs such as Mr Cound's FASD.

382 There have been previous recommendations from the Court addressing these matters.

383 In the ***Inquest into the death of Callum Mitchell*** [2022] WACOR 34, Coroner Jenkin received evidence that included Hakea's psychiatrist describing a wing in Unit 1 as "*a modern day dungeon*",[289] and Mr Devereux giving this description of Unit 1:[290]

> I do not feel that Unit 1 is the best kind of environment for the management of prisoners with mental health impairments. The restrictive nature of the regime and the environment often contributes to the prisoner's behaviour regressing further.

384 Coroner Jenkin subsequently made this recommendation:[291]

> The Department of Justice should conduct a review to determine whether the resources and facilities currently available at Hakea Prison to manage prisoners with complex behavioural needs are adequate. The review should consider the feasibility of establishing a behavioural management unit at Hakea, staffed by specialist mental health practitioners and custodial staff, to enable prisoners with complex behavioural needs to be appropriately managed.

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[288] See Recommendation No.6
[289] ***Inquest into the death of Callum Mitchell*** [2022] WACOR 34, [11]
[290] ***Inquest into the death of Callum Mitchell*** [2022] WACOR 34, [12]
[291] ***Inquest into the death of Callum Mitchell*** [2022] WACOR 34, recommendation no.1

385 I made a recommendation along similar lines in the ***Inquest into the death of Shane Nathan Roberts*** [2023] WACOR 43, which read:[292]

> In order to provide an appropriate level of health care and treatment for prisoners in Hakea, urgent funding be provided for a project definition plan regarding an extension of the facilities at Hakea that are used to provide health care (including counselling and mental health care) to prisoners.

386 Counsel assisting sought an update from the Department regarding the implementation or otherwise of these recommendations.[293] Upon receipt of that information, I would consider whether these recommendations, or something similar, should be repeated by the Court. Clearly the implementation of either or both of these recommendations, or another similar recommendation, would improve the treatment and care of prisoners with FASD at Hakea.

387 As to the recommendation of Coroner Jenkin, Mr Royce advised that the Department sought funding for an additional 30+ full time equivalent (FTE) employees, of which 15 FTE was granted to expand health care services at Hakea, including mental health.[294]

388 With regard to Coroner Jenkin's recommendation for a review to consider the establishing of a behavioural management unit and my recommendation for a project definition plan to extend health care facilities at Hakea, Mr Royce stated:[295]

> The Department intends on submitting a further budget request to further expand the services and resources to better support prisoners across the estate and would be supportive of any recommendation that supports the Department's case.
>
> As noted above, now that funding has been received for an additional 15 FTE at Hakea to expand primary health care services, the recommendation for expanding the facilities at Hakea has now been formally submitted to Infrastructure Services for inclusion in the Strategic Asset Plan (SAP) for a determination on the works.

389 I have taken up Mr Royce's invitation to make a recommendation supporting the Department's efforts to improve the provision of mental health and general

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[292] ***Inquest into the death of Shane Nathan Roberts*** [2023] WACOR 43, recommendation no.3
[293] Letter from counsel assisting to the SSO dated 10 February 2025
[294] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, p.6
[295] Letter from Commissioner Brad Royce to counsel assisting dated 28 February 2025, pp.6-7

health care to prisoners at Hakea.[296] I am firmly of the view that such improvements to the infrastructure at Hakea are desperately needed.

6: Response to a prisoner requesting placement in a safe cell

390 As outlined above, I have found that Mr Cound should have been placed on ARMS after his cell call at 4.11 pm on 25 March 2022. The fact that he was not is very troubling.

391 Although there was a Superintendent's Notice issued in 2023 to Hakea staff that addressed the need to make an ARMS referral and undertake other measures when a prisoner presents with risk factors,[297] it was my view this matter needed to be disseminated to the entire adult prison estate and be enshrined into policy. This policy would require the placement of a prisoner into a safe cell who has made that request due to the prisoner's concerns they may self-harm. The policy should make it clear that if the placement does not take place, there must be a sound basis for doing so and only after consultation with the prison's MHAOD. The reasons for not complying with the prisoner's request must also be recorded.

392 With respect to this proposed recommendation, Mr Royce advised:

> The Department supports in principle the intention of the proposed recommendation, noting the importance of ensuring sufficient action is taken when a prisoner expresses concerns they may self-harm.
>
> As such, the Department will consider the processes for when a prisoner requests placement in a safe cell for fear they may self-harm. Where it is indicated that additional processes are required to guide prison staff in supporting prisoners who may self-harm, Operational Policy, in consultation with the Clinical Governance Unit, will implement any required amendments within the Department's custodial operational policies and procedures.

393 Given the Department's response, I will make this recommendation.[298]

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[296] See Recommendation No.7
[297] Deaths in Custody Lessons Learned Report dated March 2023, p.21
[298] See Recommendation No.8

RECOMMENDATIONS

394 In light of the observations I have made, and after a careful consideration of the responses from the Department, I make the following recommendations:

Recommendation No.1

In order to enhance the care of prisoners with FASD, the Department introduces mandatory training regarding the management and care of prisoners with FASD to new prison officers undertaking training at the Corrective Services Training Academy and to current prison officers.

Recommendation No.2

In order to enhance the care of prisoners with FASD and other intellectual disabilities, the Department reviews its operating policies and procedures in order to provide specific guidance to Health Services and custodial staff as to the management and care of these prisoners. Further, this review should address how these prisoners can be supported to manage their intellectual disabilities.

Recommendation No.3

In order to enhance the care of prisoners, the Department is to ensure it applies the relevant provisions of the *Sentencing Act 1996* (WA) in order to use court-ordered psychiatric or psychological reports prepared for the sentencing process of a prisoner who is subsequently sentenced to an immediate term of imprisonment. The Department should continue its efforts to formalise its internal information sharing practices to ensure its Health Services staff are aware of the existence of such reports and can readily access them.

Recommendation No.4

In order to enhance the care of prisoners and thereby the security of the prison, custodial staff directly responsible for the care of prisoners with diagnosed mental health conditions or intellectual disabilities that may affect their behaviour and/or how they are managed, are informed of these disorders without requiring them to access TOMS in order to obtain that information.

Recommendation No.5

The Department continues to take necessary and practical steps directed towards investment in body-worn cameras for prison officers at Hakea.

Recommendation No.6

In order to better manage vulnerable prisoners and thereby enhance security, the Department should take immediate steps to ensure all cells at Hakea are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Hakea are fully ligature minimised over time. Further, the Department should conduct an urgent review of all three-point and fully ligature minimised cells at Hakea to ensure those cells are fit for purpose and in particular, that the light fittings in those cells can properly be described as "ligature approved".

Recommendation No.7

In order to improve the provision of health care (including mental health care) to prisoners, the Department should, as a matter of utmost urgency, prioritise the funding for works to improve the infrastructure used to provide health care at Hakea.

Recommendation No.8

In order to better manage vulnerable prisoners, the Department introduces an operational policy that requires the placement in a safe cell of a prisoner who has made that request due to the prisoner's concerns they may self-harm. If the placement does not occur, there must be a sound basis for doing so and only after consultation with the prison's MHAOD services. The reason(s) for not complying with the prisoner's request must be recorded.

CONCLUSION

395 Mr Cound was a young man when he died in Hakea on 25 March 2022. He was a much loved member of his family but sadly, he was also a deeply troubled man with previous episodes of self-harm. His FASD diagnosis was a likely cause of his impulsivity, and would also be an explanation for his misbehaviour and incidents of self-harm in a custodial setting.

396 Mr Cound had been on ARMS for some time. However, on the morning of 25 March 2022, a risk assessment by PHS recommended that he be removed from ARMS. That removal took place at the PRAG meeting early that afternoon. Yet despite there being a sound basis to do so, he was not placed on SAMS by PRAG.

397 At 4.11 pm on 25 March 2022, Mr Cound made a cell call to advise a prison officer he needed to be placed in a cell that had CCTV monitoring so that he did not self-harm. By doing this, Mr Cound was applying the safety plan his counsellors at PHS advised him to follow should he be unable to cope with his situation.

398 Mr Cound is to be commended for taking that action. However, he was not placed on "high" ARMS and into a safe cell following this cell call. I have found that he clearly should have been. Instead, he was offered a radio and when that was not available, a breakfast pack.

399 Within several hours after his cell call, Mr Cound had hanged himself in his cell. At 7.09 pm, a prisoner in the same wing as Mr Cound made a cell call to alert a prison officer in Unit 1 of his concerns for Mr Cound. A check of Mr Cound did not immediately take place as under-staffed prison officers attended critical incidents in another wing of Unit 1.

400 Despite further cell calls from prisoners pleading with officers stationed in the master control room to arrange a welfare check for Mr Cound, this did not take place until 17 minutes after the first cell call was made at 7.09 pm. What these prisoners said in the cell calls that began at 7.14 pm was harrowingly prescient. These three prisoners are deserving of high praise for the concerted efforts they made to have Mr Cound checked.

401 Although I have made no adverse findings regarding the length of the 17-minute delay, I identified three missed opportunities that had they been taken, were likely to have reduced the time it took for prison officers to check Mr Cound.

402 Once Mr Cound was discovered, I am satisfied there were timely and thorough resuscitative attempts by prison officers, the nursing staff at Hakea and ambulance officers. Notwithstanding those efforts, Mr Cound remained unresponsive and could not be revived.

403 I was satisfied that the failure to place Mr Cound on "high" ARMS and into a safe cell after his cell call at 4.11 pm contributed to his death several hours later. Had he been in a safe cell, the risk of Mr Cound being able to end his life would have been significantly lower than the level of risk that existed within his cell in B Wing.

404 I was also not satisfied that the care and management of Mr Cound's FASD was appropriate. The responsibility for that does not rest with Hakea's health service providers in MHAOD; it lies with the Department. For far too long, the Department's Health Services have had to perform in an under-staffed and under-resourced environment within the prison estate. I will therefore repeat what I have said in previous inquest findings.[299]

405 It is now time to understand the value, to not only prisoners but also to the community, of providing well-resourced health care in prisons. This is particularly the case with mental health care. Well-funded and properly resourced treatment and care of a prisoner's mental health should be recognised as an essential part of a prisoner's rehabilitation. If a mental health condition cannot be effectively treated because of insufficient resourcing when the prisoner is incarcerated, it is likely to remain untreated when that prisoner is eventually released into the community. With that comes all the dangers of reoffending that existed before the term of imprisonment began.

406 And so the circle of a life of crime will continue; with all the detriments this causes to the community, the offender and their family.

407 I am satisfied that some improvements and changes have been made by the Department since Mr Cound's death. However, a lot more still needs to be done to lower the risk of suicide amongst vulnerable prisoners, particularly those who are First Nations.

408 I have made eight recommendations, with an emphasis on the treatment and care of prisoners with FASD, and on reducing the risk of suicide amongst prisoners. Although there are three recommendations specific to Hakea,[300] the other five would apply to the entire adult prison estate if adopted. Two

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[299] See ***Inquest into the death of Jomen Blanket*** [2023] WACOR 6, [316] and ***Inquest into the death of Shane Nathan Roberts*** [2023] WACOR 43, [138]

[300] Recommendation Nos. 5-7

recommendations[301] also come with a significant financial cost as they include providing additional and/or improved infrastructure at Hakea, and one has the potential to increase staffing levels within the Department's Health Services. However, if these changes are not made then more families like Mr Cound's will bear the inconsolable loss of a loved one to suicide in prison.

409 I also recommend the Department carefully analyses the report that was prepared by Professor Dudgeon for the inquest.[302] It was a comprehensive review that highlighted the need for:[303]

> … a culturally safe environment for a proper and appropriate assessment of Mr Cound's mental health, and social and emotional wellbeing, to facilitate a culturally appropriate and tailored risk management plan and support.

410 The contents of Professor Dudgeon's report should be considered as the ideal framework for the care of prisoners, particularly young First Nations men with neurodevelopmental impairments who have a high risk of self-harming behaviours.

411 Finally, I extend my appreciation for the written statement from Mr Cound's mother that was read on the last day of the inquest by her daughter. Included in that statement was:[304]

> My Ricky's death has caused a lot of heartache and pain; my other children and I are torn apart and my family members are also broken.
>
> I had to plan my son's funeral and bury him.
>
> I wish this was not true but my heart is weeping because I talked to my son about hanging and self-harm and we promised each other we would never take our lives.
>
> We're on Aboriginal land. And yet our boys keep dying in this criminal system.
>
> …
>
> My broken family will never heal from this nightmare that still seems to happen to this day.

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[301] Recommendation Nos. 6 and 7
[302] Exhibit 1, Volume 2, Tab 7, Statement of Professor Pat Dudgeon dated 23 April 2024
[303] Exhibit 1, Volume 2, Tab 7, Statement of Professor Pat Dudgeon dated 23 April 2024, p.2
[304] Exhibit 11, Statement of Laura Cound dated 9 May 2024, pp.3-4

412 As I did at the conclusion of the inquest, and on behalf of the Court, I extend my sincere condolences to Mr Cound's family and loved ones, especially his mother, for their sad loss.

PJ Urquhart
Coroner
10 March 2025