JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	4 JUNE 2025
DELIVERED	**:**	8 JULY 2025
FILE NO/S	**:**	CORC 287 of 2023
DECEASED	**:**	LOOKER, TIM ALAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Ms T M Weston assisted the Coroner
Ms K M Niclair (State Solicitor's Office) appeared on behalf of the Department of Justice

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Tim Alan LOOKER*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 4 June 2025, find that the identity of the deceased person was* ***Tim Alan LOOKER*** *and that death occurred on 3 October 2023 at Bunbury Regional Prison, Centenary Road, Bunbury, from ligature compression of the neck (hanging) in the following circumstances:*

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Abbreviation/ Acronym	Meaning
ADHD	attention deficit hyperactivity disorder
BRP	Bunbury Regional Prison
CCTV	closed-circuit television
CPR	cardiopulmonary resuscitation
the Department	the Department of Justice
EcHO	the Department's Electronic Health Online System
ELTP	Entry Level Training Program
LOC	loss of consciousness
PHS	Psychological Health Service
PSOLIS	Psychiatric Services Online Information System
SFMHS	State Forensic Mental Health Service
SWMHS	South West Mental Health Service
TOMS	Total Offender Management System

INTRODUCTION

"Anyone who exhibits the classic symptoms of ADHD will have difficulty with all or most of the seven core executive functions."[1]
Dr Russell A Barkley

1 Tim Alan Looker (Tim[2]) died on the afternoon of 3 October 2023 at Bunbury Regional Prison (BRP) from ligature compression of the neck (hanging). He was 29 years old.

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

3 Accordingly, immediately before his death, Tim 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 circumstances, a coronial inquest is mandatory.[5]

4 Where the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[6]

5 I held an inquest into Tim's death at Perth on 4 June 2025. The following witnesses gave oral evidence at the inquest:

i. Julie Clark (clinical nurse at BRP);

ii. Kerri Bishop (Superintendent at BRP); and

iii. Dr Catherine Gunson (Deputy Director, Medical Services, at the Department).

6 The documentary evidence at the inquest comprised of one volume of the brief which was tendered by counsel assisting as exhibit 1 at the inquest's commencement. During the inquest, Ms Niclair, counsel from the State Solicitor's Office (SSO) appearing on behalf of the Department, tendered four photographs depicting the front of the cell Tim was occupying at the time of his death (exhibit 2) and an email

[1] The seven core executive functions are self-awareness, inhibition, non-verbal working memory, verbal working memory, emotional self-regulation, self-motivation, and planning and problem-solving.
[2] The deceased's mother has requested that he be referred to as "Tim" during the inquest and in this finding.
[3] *Prisons Act 1981* (WA) s 16
[4] *Coroners Act* 1996 (WA) s 3
[5] *Coroners Act* 1996 (WA) s 22(1)(a)
[6] *Coroners Act* 1996 (WA) s 25(3)

dated 3 June 2025 from the Department's acting Director, Operational Support (exhibit 3).

7 After the inquest, Ms Niclair provided an updated form that is now used by prison officers at BRP when undertaking the fortnightly security checks of cells. Ms Niclair also provided responses from the Department to (i) the three proposed recommendations I had raised at the inquest and (ii) questions asked by Tim's mother that she had forwarded to the Court after the inquest had concluded.[7]

8 The inquest focused on the medical treatment and care Tim received at BRP, with an emphasis on the treatment he received for his previously diagnosed attention deficit hyperactivity disorder (ADHD) and Type 2 diabetes. The inquest also examined the existence of a protruding bolt from a window frame in Tim's cell that he had used as a ligature anchor point and the fortnightly security checks of cells performed by prison officers at BRP.

9 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.

10 I am also mindful not to insert hindsight bias into my assessment of the actions taken by the Department and its employees in their supervision, treatment and care of Tim whilst he was a prisoner at BRP. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[8]

TIM [9]

11 Tim was born on 9 February 1994, and was the youngest of three boys. His parents separated when he was about eight years old and Tim lived with his father following the separation. When he was 15 years old, Tim's father asked him to leave home following which Tim lived in a share house.

[7] Email with an attachment from Ms Niclair to the Court dated 30 June 2025; Email from Sarah Russell to counsel assisting dated 5 June 2025

[8] Dillon H and Hadley M, *The Australasian Coroners Manual* 2015 10

[9] Exhibit 1, Tab 1, Report of Detective Senior Constable Darcy Maher dated 24 June 2024; Exhibit 1, Tab 21, Review of Death in Custody Report dated September 2024; Exhibit 1, Tab 21.1, District Court sentencing transcript dated 26 June 2023

12 After completing Year 10 at high school, Tim commenced a pre-apprenticeship at TAFE and eventually completed a Certificate 2 in Heavy Duty Mechanical skills and an Event Scaffolder High Risk License. In addition, he had forklift and elevated work platform tickets.

13 Tim held various positions in South Australia and Western Australia which included a heavy duty diesel serviceman, machine operator, truck driver and a construction scaffolder.

Diagnoses of ADHD and diabetes

14 Whilst at primary school, Tim was diagnosed with ADHD. He was prescribed dexamphetamine to treat this condition and he was still taking this medication at the time he was imprisoned in 2023.

15 In January 2022, Tim was diagnosed with Type 2 diabetes and was prescribed metformin to treat this condition. He was also taking this medication when he was imprisoned.

Illicit drug use

16 When Tim was a remand prisoner in BRP for a short period of time in June and July 2020, he admitted to a prison nurse that he was using methylamphetamine.[10]

17 Tim also had convictions in March 2021 relating to cannabis possession and cultivation in June 2020.[11]

18 However, he denied any illicit drug use during his initial assessment with a prison nurse in June 2023.

Circumstances of Tim's imprisonment

19 On 24 June 2020, Tim was charged with the indictable offence of grievous bodily harm involving an altercation he had with another man on the previous day. He was also charged with several summary offences involving cannabis and the possession of weapons. Tim subsequently spent about two and a half weeks remanded in custody in BRP for the indictable offence before he was released on bail.

[10] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.5
[11] Exhibit 1, Tab 21.2, WA Court History Criminal and Traffic dated 2 August 2024

20 Tim eventually pleaded guilty to the grievous bodily harm charge.[12] On 26 June 2023, he was sentenced in the District Court sitting in Bunbury to a term of imprisonment of 4 years 6 months. This sentence was backdated to commence on 9 June 2023 to reflect Tim's time already served in custody on remand in mid-2020. As he was made eligible for parole, Tim's earliest eligible date for release on parole was 8 December 2025.

21 From 26 June 2023, Tim was incarcerated in BRP where he remained for 99 days until his death on 3 October 2023.

Summary of Tim's stay at BRP up to 1 October 2023

22 As with all incoming prisoners, a reception intake was completed by a prison officer for Tim shortly after he arrived at BRP on 26 June 2023. During this interview process, standard questions are asked of the prisoner to assess their current risk of self-harm and/or suicide and their answers are recorded. Tim indicated that his brother and mother would be supportive of him whilst he was in prison and that he would possibly have visits from them and from friends. He denied having ever tried to take his life or harm himself, and said that he had not lost any family or friends to suicide. He indicated that he had ADHD and that he was prescribed a daily amount of dexamphetamines.

23 Although he denied having any thoughts of self-harm or suicide since his arrest and that he did not have any current plans to take his own life or self-harm, when asked if there had been any major changes or incidents in his life for the past 12 months, Tim answered: "*Dad died, [I]got engaged, [my] fiancé had a miscarriage and they [sic – we] broke up, now in jail*." Nevertheless, he did go on to say he believed there was hope for his future and that there were no current stressful issues in his life.[13]

24 The prison officer completing the reception intake did not consider Tim to be at risk of suicide or self-harm, noting:[14]

> On completion of intake interview, I do not consider this prisoner to be at immediate risk of suicide or self-harm. The prisoner did not say anything or behave in any manner that would indicate to me that he is at current risk of suicide or self-harm. There was no information received

[12] Tim delayed pleading guilty so that he could care for his dying father.
[13] Exhibit 1, Tab 21.4, At Risk Management-Reception Intake Assessment dated 26 June 2023
[14] Exhibit 1, Tab 21.4, At Risk Management-Reception Intake Assessment dated 26 June 2023, p.5

> from other sources that would indicate that this prisoner is at immediate risk of suicide or self-harm.

25 Julie Clark (Ms Clark), a clinical nurse at BRP, conducted a "nurse admission" appointment with Tim on 27 June 2023. Part of this appointment included standard observation tests such as temperature, pulse and respiratory rates, and blood pressure and blood glucose testing. These were all noted by Ms Clark to be normal.

26 Ms Clark also spoke to Tim regarding his mental health and he said he had no current thoughts of self-harm or suicidal ideation, and that he had not previously self-harmed.[15]

27 Tim also advised Ms Clark that he had been diagnosed with ADHD since he was eight years old and was prescribed seven 5 mg tablets of dexamphetamine daily. He said he had previously engaged with a psychiatrist at South West Mental Health Service (SWMHS) regarding his ADHD. Ms Clark had Tim complete a form authorising the release of medical information from SWMHS to BRP.

28 Tim did not disclose to Ms Clark that he had been diagnosed with diabetes and was prescribed metformin to treat this condition.[16]

29 A BRP report dated 28 June 2023 recommended that based on Tim's antecedents, his security rating be reduced from maximum security to medium security. It was also determined that he would remain at BRP to facilitate future visits.[17]

30 On 10 August 2023, another BRP report indicated that Tim was assessed as having a low risk of general reoffending and subsequently did not require criminogenic interventions.[18]

31 On 29 August 2023, prison staff observed injuries to Tim's face. When questioned, he indicated that he had slipped on a towel. However, CCTV footage identified another prisoner entering Tim's cell and striking him. Mediation was subsequently held between Tim and this prisoner and it was recorded that the mediation had been successfully completed.[19]

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[15] Exhibit 1, Tab 16, EcHO records for Tim, p.13; Exhibit 1, Tab 25, Statement of Julie Clark dated 12 May 2025, p.2
[16] Nor did Tim advise the prison officer of this diagnosis during his intake assessment on 26 June 2023.
[17] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024, p.9
[18] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024, p.9
[19] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024, p.10

32 Tim was reviewed by the prison's Psychological Health Services (PHS) on one occasion. This was done following a referral to PHS by a prison officer who had noted Tim's depressed appearance during a case conference on 17 August 2023. However, when PHS made contact with Tim on 12 September 2023, he declined the offer to engage with this service.[20]

33 Tim was not placed on the Department's At Risk Management System (ARMS) or the Support and Monitoring System (SAMS) during the time he was imprisoned at BRP.[21]

EVENTS LEADING TO TIM'S DEATH [22]

34 As at 1 October 2023, Tim was housed in Unit 6. At about 9.40 am on that day, prison officers heard an altercation between Tim and another prisoner. Prison officers intervened and separated Tim and the other prisoner. Tim advised the prison officers that the issue related to a matter that had occurred outside of prison and it was unlikely to be resolved. A decision was therefore made to separate Tim and the other prisoner into different units. On the same day, Tim was placed in cell 3 in A Wing of Unit 2.[23] Although this was a two-person cell, Tim was the only occupant. It was a cell that had not been ligature minimised.[24]

35 At about 7.15 am on 3 October 2023, the cells in A Wing of Unit 2 were unlocked. At 8.25 am, Tim left his cell carrying a cup, returning about one minute later. He then left his cell again and emptied his rubbish bin before returning to his cell and closing the cell's door. He remained in his cell for about an hour before leaving to apparently refill his cup with water. After returning to his cell, Tim's cell and the other cells in A Wing were locked at about 9.30 am.

36 The cells on A Wing were unlocked at about 10.20 am. Tim remained in his cell until 11.17 am when he left his cell and stood at the end of a table tennis table in the common area of the wing. He remained there for a short time before returning to his cell and closing the door. Shortly

[20] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024, p.14
[21] ARMS is the Department's primary suicide prevention strategy and aims to provide all prison staff with guidelines to assist with the identification and management of prisoners deemed to be at risk of self-harm or suicide. SAMS is a step down from ARMS and is the Department's monitoring system designed to manage prisoners requiring additional support.
[22] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024; Exhibit 1, Tab 27, Letter from Superintendent Kelli Bishop to the Court dated 28 May 2025
[23] Exhibit 1, Tab 21.10, TOMS Incident Report dated 1 October 2023
[24] Exhibit 1, Tab 21, Review of Death in Custody dated September 2024, p.11

after that, a prison officer approached Tim's cell and asked him why he had not come for lunch and Tim responded that he did not want any.

37 At about 11.45 am, prisoners were required to return to their cells for a scheduled lockdown whilst prison staff had their lunch break. As Tim's cell door was being locked, a prison officer asked him if he was okay and Tim responded that he was.

38 From about 1.00 pm, the cells in A Wing were unlocked. That process simply involved prison officers unlocking the doors without sighting the prisoners within the cells. Tim's cell was unlocked at 1.03 pm.

39 At about 1.20 pm, two prison officers escorted another prisoner to Tim's cell where that prisoner was going to be relocated. When the prison officers opened the door, the prisoner stepped into the cell and saw Tim suspended near the toilet. He immediately left the cell and advised the prison officers. When the prison officers entered they saw Tim was hanging from a ligature made from a ripped bedsheet that had been attached to a bolt protruding from a window frame that was above head height and immediately above the toilet. He was unresponsive, and his face was discoloured and his hands appeared to be blue. At 1.22 pm, one of the prison officers called a Code Red medical emergency over his radio and requested a Hoffman knife.[25]

40 Other prison officers immediately attended the cell in response to the Code Red radio call. Two prison officers held Tim's weight whilst another cut the ligature. Tim was then lowered to the floor and moved out of the cell into a space just outside of the cell's door to enable CPR to commence. A defibrillator was called for and within two minutes, prison medical staff arrived and took over the medical care of Tim while prison officers continued CPR.

41 At 1.23 pm, a request for an ambulance to attend was made. Prison officers continued CPR on a rotational basis until the arrival of paramedics at about 1.35 pm. After assessing Tim for evidence of life, paramedics declared that Tim was deceased at 1.41 pm.[26]

[25] A Hoffman knife is specifically designed to safely release a person from a ligature.
[26] Exhibit 1, Tab 3, Life Extinct Form dated 3 October 2023

CAUSE AND MANNER OF DEATH

Cause of death [27]

42 Two forensic pathologists, Dr Jodi White and Dr Jagbir Grewal, conducted a post mortem examination upon Tim's body on 6 October 2023.

43 The examination found a ligature mark around Tim's neck and there was a fracture to the voice box (larynx). There were also superficial soft tissue injuries to his head, chest and limbs. One of the arteries supplying the heart muscle was narrowed.

44 Microscopic examination of heart tissues confirmed there was severe narrowing of a major coronary artery (coronary artery atherosclerosis), with no significant abnormalities in the heart.

45 Specialist neuropathology examination of Tim's brain found no significant abnormalities.

46 A toxicological analysis of blood and urine samples from Tim detected no alcohol or common illicit drugs.

47 The forensic pathologists noted Tim's medical history of Type 2 diabetes, ADHD, smoking, a previous head injury and a fractured right ankle, in addition to a reported episode of hallucinations. After considering this information, the forensic pathologists found that none of these conditions had contributed to the cause of death.

48 At the conclusion of their investigations, the forensic pathologists expressed the opinion that the cause of death was ligature compression of the neck (hanging).

49 I accept and adopt the opinion expressed by the forensic pathologists as to the cause of Tim's death.

50 It is also relevant to note that given Tim's young age, the forensic pathologists expressed the opinion that genetic factors may have influenced the severity of his coronary artery atherosclerosis. They advised that Tim's immediate relatives should seek medical advice

[27] Exhibit 1, Tabs 5, 5.1 and 5.2, Supplementary Post Mortem Report dated 13 September 2024, Final Post Mortem Report dated 23 November 2023 and Interim Post Mortem Report dated 6 October 2023; Exhibit 11, Tab 6, Toxicology Report dated 12 October 2023; Exhibit 1, Tab 7, Neuropathology Report dated 22 November 2023

from their GP regarding this possibility. PathWest has stored a post mortem blood sample from Tim for potential genetic testing if required.

Manner of death

51 I am satisfied that the prospect of being imprisoned for a minimum period of nearly two and a half years would have caused Tim significant anxiety and stress. Apart from his short stint on remand in mid-2020, Tim had never previously been imprisoned in Western Australia.

52 The two incidents with fellow prisoners that I have already referred to would have only added to Tim's anxiety. Sadly, Tim did not seek any help from mental health service providers at BRP and when someone from PHS did speak to him three weeks before his death, he declined to engage with the service.

53 Based on all the information available, I find that Tim's death occurred by way of suicide when he used a torn bedsheet to create a ligature by which he hanged himself using a bolt as an anchor point that was protruding from a window frame in his cell. He most likely stood on the toilet bowl in the cell so he could reach this bolt and then stepped off the toilet bowl in order to suspend himself. Tim was able to do all of this undetected as he was the sole occupant of the cell at the time and all cells in the wing had been locked for over an hour during the scheduled lunch break for prison officers.

ISSUES RAISED BY THE EVIDENCE

Dexamphetamine was not prescribed for Tim during his imprisonment

54 As already noted above, Tim had disclosed to BRP staff (from the custodial and health service sections) that he had been diagnosed with ADHD for which he was prescribed dexamphetamine.

55 Prisoners are not prescribed dexamphetamine in prison.[28] This is the case even if the prisoner had been prescribed dexamphetamine in the community on a long-term basis to treat their ADHD. Although the Department has acknowledged that stimulants (which dexamphetamine is) can be therapeutic to ADHD management, "*they are not determined to be essential medications*".[29]

[28] Exhibit 1, Tab 25, Statement of Julie Clark dated 12 May 2025, p.4
[29] Exhibit 3, Email from the Department's acting Director, Operational Support to Ms Niclair dated 3 June 2025, p.1

56 Given it is a short-acting stimulant, dexamphetamine is not prescribed to prisoners as it is a medication that would be highly trafficable in a prison setting.[30]

57 I therefore understand why it was that Tim was not able to have access to his dexamphetamine medication, despite being prescribed it for, it seems, in excess of 20 years. Accordingly, I make no adverse finding with respect to the Department's treatment and care of Tim with respect to the ceasing of his dexamphetamine.

58 As to whether an alternative stimulant medication should be made available for prisoners who have been prescribed dexamphetamine for their ADHD is covered later in this finding.

Metformin was not prescribed for Tim during his imprisonment

59 Tim was prescribed metformin (a tablet medication) since January 2022 to treat his Type 2 diabetes. However, he was not prescribed this medication at BRP, and no alternative medication was provided. Unlike dexamphetamine, metformin is not a sought after drug in a prison setting. Nevertheless, I am satisfied there was a reasonable explanation for Tim not receiving this medication.

60 As I have already outlined, Tim did not disclose he had been diagnosed with Type 2 diabetes at his Reception Intake Assessment, and, more relevantly, to Ms Clark during his "nurse admission" appointment on 27 June 2023. Tim's blood glucose test at that appointment returned a blood sugar level of 6.7 mmol/L. This reading did not automatically raise a "red flag" in the electronic nurse admissions form for a further review of any medical issues. At the inquest, Ms Clark indicated that a blood sugar level at or above 7.5 mmol/L would automatically trigger the need for a review.

61 Although Dr Gunson said a blood glucose level of 6.7 mmol/L should have triggered a repeat test and other blood tests to clarify the reading,[31] I am not prepared to find that Ms Clark should have undertaken that exercise. That is because it was a reading that was below the level that automatically triggered the need for further investigations. To find otherwise, would be inserting impermissible hindsight bias.

[30] Exhibit 3, Email from the Department's acting Director, Operational Support to Ms Niclair dated 3 June 2025, p.1
[31] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.19

62 It is readily apparent from Tim's health service records at BRP that there is no recording that he disclosed to any other health service provider of his diagnosis of Type 2 diabetes. Had he made such a disclosure to Ms Clark or another health service provider, then arrangements would have been made to obtain his consent to have the medical records from his GP released to the Department's Health Services at BRP and for further follow-up once those records had been received.

63 From the information available, the only documented record of Tim mentioning to a prison staff member he had diabetes for which he was prescribed medication was an Education and Vocational Training Checklist that was completed on 16 August 2023.[32] However, this type of document is not expected to be seen by a health service provider at BRP. The document recorded the following:[33]

> Is there any evidence of specific learning difficulties or disabilities that may affect engagement in education and training?
>
> Yes
>
> **Comments**
>
> The prisoner stated that he had poor literacy and numeracy skills and has suffered with Attention Deficit Hyperactivity Disorder, Depression and Diabetes (diet and medication).
>
> …
>
> Are there any significant issues of concern to the prisoner, not already covered, that may prevent full engagement?
>
> Yes
>
> **Comments**:
>
> The prisoner stated he has a concern regarding his medication and was advised to complete a Unit Interview Form to the Medical Centre.

64 It is not clear whether Tim was expressing a concern with respect to his medication for ADHD, his medication for his diabetes, or both. However, it is apparent from the information available that Tim did not complete the form that he was advised to do.

[32] Exhibit 1, Tab 21.7, Educational and Vocational Training created 16 August 2023, p.1
[33] Exhibit 1, Tab 21.7, Educational and Vocational Training created 16 August 2023, pp.2,4-5

65 The question arises as to why Tim did not disclose his diagnosis of diabetes to a health service provider at BRP. Records obtained by the Court from Tim's GP indicated he was angry about the diagnosis in 2022 and that he refused treatment through insulin injections, stating he would never do that.[34] Therefore, one possible explanation for Tim's failure to alert health service providers at BRP he had diabetes was that he was in denial mode. Another could be that, given his blood sugar reading on 27 June 2023, he believed his blood sugar levels would be adequate without continuing to take his metformin. That is a less likely explanation as every adult with diabetes that requires medication to stabilise their blood sugar levels would understand the need to continue taking that medication regularly.

66 Given the degree of speculation involved in trying to determine an answer, Tim's reasons for not disclosing his diabetes to a health service provider at BRP must remain as unknown.

Information from Tim's psychiatrist regarding his ADHD diagnosis was not received

67 As outlined above, and despite a request for the release of these records, health service providers at BRP never received any material from SWMHS. There was no dispute that this information should have been provided well before Tim's death. At the inquest, Ms Clark explained that the following up of a response to a request for release of medical information is an administrative responsibility i.e. a receptionist within the Health Services section at BRP. From the information available to me, no such follow up was undertaken for Tim's records from SWMHS.

68 I am satisfied there was a missed opportunity to undertake this follow up. In so finding, however, I do note that even if this information was available, it would not have led to Tim being prescribed dexamphetamine. This was because of the Department's policy regarding that medication.

Tim was not seen by a prison doctor for a medical review before his death

69 As ADHD is not seen as a health condition requiring urgent medical review and as Tim had not disclosed his diabetes diagnosis, his "doctor

[34] Exhibit 1,Tab 26, Progress Note-Allied Health dated 20 January 2022

admission" assessment was booked as a non-urgent, routine appointment.[35]

70 Department policy stipulates that non-urgent "doctor admission" assessments are to be completed within 90 days of a prisoner's admission into prison. In Tim's case that would mean on or before 25 September 2023.[36] However, Tim's assessment was booked to take place on 5 October 2023, which was two days after his death and 101 days after his arrival at BRP.[37] The booking for this appointment was made on 31 August 2023.[38]

71 I am aware from previous inquests that the shortage of prison doctors has meant it is difficult to comply with the 90 day time frame for a routine appointment for a "doctor admission" assessment. I am therefore not surprised that Tim was not seen within this period as it is an issue across the entire adult prison estate.

72 I am satisfied there was a missed opportunity by the Department in not having the prison doctor assess Tim in compliance with its policy. However, it was the case that had Tim raised concerns of a medical nature, an appointment for a nurse or doctor consultation would have been made for him as required.[39]

73 I would simply encourage the Department to make every effort to have any vacant positions for prison doctors in the adult prison estate filled as soon as possible. By failing to have Tim seen by the doctor within the 90 day period meant that the opportunity was lost for him to raise any concerns he might have regarding his ADHD, his diabetes and his mental health.

The protruding bolt in Tim's cell

74 BRP was opened in 1971. Although additional units have been added since it was opened, Unit 2 was part of the original prison.[40] Unsurprisingly, the cell infrastructure in Unit 2 is not how prison cells would be built today. As Superintendent Bishop noted in her report,

[35] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.14
[36] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.14
[37] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.14
[38] Exhibit 1, Tab 25, Statement of Julie Clark dated 12 May 2025, p.2
[39] Exhibit 1, Tab 25, Statement of Julie Clark dated 12 May 2025, pp.2-3
[40] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5

there had been no changes to the physical structure of Tim's cell since it was built, except for routine refurbishments.[41]

75 Tim's cell was a standard cell which was neither fully ligature minimised or three-point ligature minimised.[42] Prison units that are now built containing standard cells are constructed to minimise the number of ligature points within them. Unfortunately, the vast majority (if not all) of the standard prison cells constructed in the 1970s and 1980s were not originally built to be three-point ligature minimised. Tim's cell fell into that category.

76 At BRP there are fortnightly security checks of cells. These security checks are undertaken by two prison officers who are required to complete a form titled "Fortnightly Security Checks". From the available information, the last four security checks of Tim's cell before his death took place on 20 July 2023, 12 August 2023, 2 September 2023 and 20 September 2023.[43] As the name implies, these checks are undertaken to ensure that cells are secure, in addition to examining the cell for cleanliness, contraband, safety and the presence of any ligature points. No issue was identified regarding Tim's cell during the last four security checks undertaken prior to his death. Consequently, the bolt that was used by Tim as the ligature anchor point was not identified as an issue of concern.

77 The first matter that requires my determination is whether I can be satisfied that the bolt was present at the time those cell security checks were performed. I am so satisfied for the reasons outlined below.

78 After Tim's death, a number of photographs were taken of the bolt in situ, including two close-up photographs.[44] These two photographs illustrate two items of interest that were identified by counsel assisting, Ms Weston, at the inquest. The first is that the exposed thread of the bolt had paint on it that matched the colour of the paint of the cell's walls and window hatch. Superintendent Bishop confirmed at the inquest that the cell's walls and windows had been painted some time before Tim was imprisoned at BRP.

[41] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5
[42] Three-point ligature minimised cells have the three most obvious ligature points (window bars, light fittings and shelving) modified. Full ligature minimised cells have all identified ligature points addressed.
[43] Exhibit 1, Tab 21.24, Fortnightly Security Checks completed forms
[44] Exhibit 1, Tab 19, Photographs of Tim's cell; Exhibit 1, Tab 21.22, Photographs of the window hatch in Tim's cell

79 The second item of interest was that these two photographs showed what appeared to be brown rust colouring on the bolt's thread where it met the window hatch. Again, this indicates that the bolt had been in this position for some time. When these two matters were pointed out to Superintendent Bishop at the inquest, she accepted that the bolt had not been inserted by Tim when he was placed in the cell.

80 I accept Superintendent Bishop's explanation as to why the bolt had not been previously moved because it posed a risk of a prisoner using it as an anchor ligature point:[45]

> To my knowledge there have been no prior incidents, including attempts, using such a ligature point and therefore the existence of holes, screws or bolts in cells were not considered obvious ligature points, prior to this incident.
>
> Accordingly, if the prison had undertaken a risk assessment of a bolt, screw and/or a hole in a cell prior to this incident, if identified as a risk, I suggest it would have been categorised as low risk, due to no prior incidents across the prison estate. If there had been any prior similar incidents, including attempts, I suggest the risk would have been categorised as a higher risk, and steps would have been taken to rectify the existence of bolts, screws and/or holes.

81 Following Tim's death, an audit was undertaken at BRP to ascertain the existence of bolts or screws in the walls of cells. It became readily apparent that the bolt in Tim's cell was not an isolated incident. This bolt was removed after Tim's death, and the bolts and screws were also removed from other cells and the holes filled. These bolts and screws had been commonly used to hang towels, hats, jumpers or jackets belonging to prisoners.[46]

82 As there had been no previously recorded incident at BRP of a bolt or screw being used as a ligature anchor point, I am satisfied that the neither the Department nor any of its staff at BRP should be the subject of an adverse finding for failing to remove the bolt in Tim's cell prior to his death. Instead, I will find there was a missed opportunity for it to be removed prior to 3 October 2023. Given my conclusion that the bolt was present in the cell for some length of time, there were a significant number of occasions in which that missed opportunity occurred i.e. every time a cell security check was undertaken.

[45] Exhibit 1, Tab 27, Letter from Superintendent Bishop to the Court dated 28 May 2025, p.3
[46] Exhibit 1, Tab 27, Letter from Superintendent Bishop to the Court dated 28 May 2025, p.3

Ligature anchor points in cells at BRP

83 Like a number of prisons in Western Australia, BRP has units with too many cells that have not been ligature minimised. As Superintendent Bishop explained, there are only 22 cells in Unit 2 with three-point ligature status. The remaining cells in Unit 2 and, it would appear, all those cells in Unit 3 have no ligature minimisation.[47]

84 Unsurprisingly, Superintendent Bishop expressed the opinion that, "*all cells should be ligature minimised, subject to the availability of funding.*"[48]

85 The Department would be fully aware of the Court's criticism in numerous previous inquests of the unacceptable number of cells in Western Australian prisons that have not been three-point ligature minimised. This is a crisis that the Court has now been pointing out for over 20 years.

86 I will simply repeat what I expressed in an inquest finding handed down earlier this year:[49]

> 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.

Questions from Tim's mother

87 As I mentioned at the beginning of this finding, the Department responded to questions that Tim's mother raised with the Court after the inquest was completed.

88 The first question was: "*If a person has been assaulted or part of a situation where he may have been injured - is a medical assessment undertaken in that case? If so where is that report*" [50]

89 The Department advised: "*All persons involved in an assault or altercation are required to undergo a medical assessment as soon as practicable.*" The Department also stated that prison clinical staff are to examine the person who has been subjected to the assault and to document in the prisoner's medical records: the findings of the

[47] Exhibit 1, Tab 27, Letter from Superintendent Bishop to the Court dated 28 May 2025, p.6
[48] Exhibit 1, Tab 27, Letter from Superintendent Bishop to the Court dated 28 May 2025, p.6
[49] ***Inquest into the death of Ricky-Lee Cound***, [2025] WACOR 13, [375]
[50] Email from Sarah Russell to counsel assisting dated 5 June 2025

examination, the description of injury/signs and symptoms, treatment or assistance given and follow-up if required.[51]

90 With respect to the assault by another prisoner on 29 August 2023, the following notations appeared in Tim's medical records:[52]

> **29th August:** Nurse Review - asked to be seen by custodial staff following a suspected assault in Unit 6. Prisoner was transferred to Unit 1 and assessed.
>
> Prisoner claims to have fallen and hit his head - lumps and abrasions apparent to forehead. Bleeding from left side of his mouth.
>
> Denies LOC.[53] Alert and orientated. Nil loose teeth to note. Declined simple analgesia.
>
> **Plan:** For two hourly medical observations overnight.
>
> **30th August:** Nurse Review - Welfare Check.
>
> Checked in Unit 1 - nil issues overnight.
>
> Cleared from medical observations. Fit to return to Unit 6.

91 Tim's mother also asked this question: "*If a person is injured or possibly in a fragile or more vulnerable state after an assault or fight, is it procedure to then move that person into a new unit or cell alone with no peer support or another person?*"[54]

92 Part of the Department's answer to this question was as follows:[55]

> With respect to the assault on [Tim] on Thursday 29 August 2023, a review of Incident Report I142622118 indicates that [Tim] was transferred to Unit 1 per section 36(3) of the *Prisons Act 1981* which allows Superintendents to make separate confinement orders necessary for the good order and security of a prison. The decision to transfer [Tim] to Unit 1 under a section 36(3) order was not as punishment, but to enable further investigations to occur into the incident and to ensure the safety of prisoners involved.
>
> Following transfer, Mr Looker was placed on two-hourly medical operations to enable ongoing monitoring to further ensure his safety.

[51] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.2
[52] Exhibit 1, Tab 16, EcHO records for Tim, p.4; Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, pp.6-7
[53] Loss of consciousness.
[54] Email from Sarah Russell to counsel assisting dated 5 June 2025
[55] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.3

93 It is apparent from the balance of the Department's answer that an injured prisoner may be moved into a single cell (as Tim was). However, it was stressed that a prisoner in Tim's position still has access to health care which remains a paramount consideration.

94 I also note that Tim was seen by Peer Support Services as part of his orientation process; however, he made no further contact with this service.[56]

95 The next question from Tim's mother was a follow up to the above question and read: "*If that is common procedure - should it be recommended that that procedure is reviewed?*"[57]

96 The Department responded: [58]

> It is common procedure for prisoners to be moved to other units, [or] management or observation cells following serious incidents, including assaults.
>
> As above, movements of this kind are imbedded with Departmental policy namely section 3 of COPP 10.7 - Separate Confinement. It is not necessary to review these procedures as this is a common operational practice designed to carefully manage risks for everyone involved, ensuring the duty of care remains paramount.

97 The final questions from Tim's mother was: "*Whether cell inspections and security checks ordinarily pick on things such as added nails to walls/holes in walls etc and if so, if training is provided at the Academy that takes trainees through things to look out for when conducting a cell inspection/security checks?*"[59]

98 The Department's answer was:[60]

> Through the ELTP,[61] training is delivered on the following topics relevant to conducting a cell search/cell integrity check:
>
> - **Security Awareness** which involves an introduction to prison security and all aspects of security including physical; and
>
> - **Searches** is the introduction to searches and includes cell searches.

[56] Exhibit 1, Tab 20.1, Letter from the Department's Director General to the Minister for Corrective Services dated 17 October 2023, p.1
[57] Email from Sarah Russell to counsel assisting dated 5 June 2025
[58] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.4
[59] Email from Sarah Russell to counsel assisting dated 5 June 2025
[60] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.4
[61] Entry Level Training Program

> - **Cell Searches/Checks** – 7.2.1 all cells are to be security/ integrity checked at a minimum of once per fortnight **to ensure all physical components of the cell are to designed standard and are safe and secure.**
> (bold type in the original)
>
> In addition, trainees are also required to undertake a security and integrity check of a prisoner's cell to locate any unauthorised items, any hazards which may be present, and security issues which may be present or any repairs and maintenance which may be required. Trainees must satisfactorily undertake this task to enable them to progress through the ELTP.
>
> In addition, when a cell is built or has any infrastructure work done on it (for example add an extra bed to turn a single cell into a double cell), Infrastructure Services will carry out a check to ensure it is to standard. Then once handed over to the prison, the cell integrity check process comes into effect.

QUALITY OF TIM'S SUPERVISION TREATMENT AND CARE

99 As to the treatment and care provided to Tim by health service providers at BRP, with the exception of two missed opportunities, I am satisfied that it was appropriate.

100 The first of these missed opportunities related to the lack of any follow up to the request for material from SWMHS regarding Tim's diagnosis of ADHD. However, even if this information was available, it would have not led to Tim being prescribed dexamphetamine as Department policy prohibited its use within a prison setting.

101 The other missed opportunity concerned Tim not having an initial assessment by the prison doctor within the 90 day time frame stipulated by the Department for such an appointment. Although it had been scheduled for 5 October 2023, this was 101 days after Tim's arrival into prison and two days after his death. As I have already noted, this missed opportunity meant that Tim was not provided with the opportunity to raise any concerns he might have had regarding his ADHD, his diabetes and his mental health.

102 Although Tim's medication for treatment of his diabetes was not provided, that was not the fault of health service providers at BRP as Tim had not advised them of his diagnosed diabetes. In addition, his blood sugar level taken at his initial nurse assessment was not at a level that required further investigation.

103 As to the supervision, treatment and care provided by custodial staff at BRP, I am satisfied it was appropriate, apart from one missed opportunity. That related to the non-removal of the bolt in Tim's cell that he used as a ligature anchor point to hang himself. I was satisfied that this bolt would have been present in the window hatch of the cell for some length of time. The likely explanation for it escaping the attention of prison officers undertaking fortnightly security checks of the cell is because a protruding bolt or screw in a cell at BRP had never been previously used by a prisoner as a ligature anchor point.

104 I am satisfied there was no reason for custodial staff to discover Tim's hanging before it was. I am also satisfied that Tim had given no indication to any BRP staff member (custodial or non-custodial) of his intention to end his life.

105 In addition, I am satisfied that the response by prison officers and health service providers following the discovery of Tim after his hanging incident was appropriate. The Code Red medical emergency and request for an ambulance were both made in a timely manner. The resuscitation efforts were commenced promptly by prison officers and subsequently taken over by the prison doctor and nurses who had arrived a short time later. These efforts continued for about 20 minutes.

CHANGES AND IMPROVEMENTS SINCE TIM'S DEATH

106 As would be expected of all government departments, the Department is always on the pathway of continual improvements with respect to the supervision, treatment and care of its prisoners. Given there is ordinarily a gap of some duration between the date of the death that is the subject of a coronial investigation and the inquest's date, the prison where a death has occurred will often implement changes that are designed to improve practices and procedures before the inquest is heard.

The audit undertaken by BRP for bolts, screws or holes in cells

107 By the end of 2024, BRP had undertaken an audit of holes and protruding bolts of its cells. At the completion of that audit Superintendent Bishop directed that all screws and bolts were to be removed, and all holes discovered during the audit to be filled.[62] That task was completed by 24 December 2024.[63]

[62] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.3
[63] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, attachment 4

Changes to the "Fortnightly Security Checks" form

108 During Superintendent Bishop's evidence at the inquest, I asked whether the form used by prison officers when completing their fortnightly security checks of cells could be amended so that there is an emphasis on the requirement to check for any unauthorised modifications creating potential ligature points. Superintendent Bishop agreed with that suggestion and the Court was subsequently provided with the amended form for the fortnightly security checks now used at BRP.

109 The amended form has a highlighted rectangular box as set out below:

> **Check walls and ceiling for unauthorised modifications that may be a possible ligature point, these must be immediately removed or maintenance notified.**

110 I commend Superintendent Bishop for making this change. In my time as a Coroner, I am only too aware of the innovative ways in which prisoners are able to create ligature anchor points in their cells.

Welfare checks of prisoners before and after a day time lock down

111 Superintendent Bishop advised the Court that welfare checks of prisoners are routinely undertaken during the night time lock down and morning unlock of prisoners. The purpose of this welfare check is to ensure there are no issues with a prisoner's state of physical and mental health.[64] Superintendent Bishop accepted that following the unlock for the scheduled lock down in A Wing of Unit 2 on the day of Tim's death, no welfare check of Tim or any other prisoner was undertaken.[65] As I have already noted above, the unlock process simply involved prison officers unlocking the doors without sighting the prisoners within the cells.

112 As Superintendent Bishop observed, if a welfare check had been undertaken, Tim's hanging incident was likely to have been identified earlier than when it was.[66] However, I also accept Superintendent Bishop's observation that as there was no evidence to indicate precisely when Tim used the ligature to hang himself, it remains unknown

[64] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5
[65] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5
[66] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5

whether a welfare check during the unlocking of his cell at 1.03 pm would have changed the outcome.[67]

113 Following Tim's death, and despite a current policy outlining general unlock procedures, Superintendent Bishop became aware of a perception from some prison officers that a prisoner's general health and well-being welfare check was only for lockdowns at night and in the morning. She subsequently drafted a staff notice for BRP that was circulated on 10 September 2024 which reinforced the procedure for every lockdown and unlock.[68] That Staff Notice was titled "Welfare Checks Prior to Unlock" and stated:[69]

> With immediate effect, a welfare check is mandatory prior to any unlock of prisoners following a lockdown. This includes a lockdown for Operational purposes including but not limited to security incident, short staffing or staff meal break.
>
> The welfare check is to site [sic – sight] the prisoner and gain movement prior to reporting to the Senior Officer or Supervising Officer correct or otherwise.
>
> Once this has been completed unlock is to commence.

114 I commend Superintendent Bishop for this action.

Lessons Learned process

115 The Operational Support section of the Department conducted a "Lessons Learned" review for Tim's death on 4 December 2025. Although that report had not been finalised by the time of the inquest or the writing of this finding, the Court was provided with a summary of the identified issues and remedial actions being progressed by the Department.[70]

116 A number of these issues I have already identified in this finding. The only response I did not agree with regarded the non-use of any type of ADHD medication for prisoners. However, it appears the Department has had a change of heart regarding that position and this is addressed in more detail below.

[67] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5
[68] Exhibit 1, Tab 27, Letter from Superintendent Kerri Bishop to the Court dated 28 May 2025, p.5
[69] Exhibit 1, Tab 21.16, BRP Staff Notice 27/2024
[70] Exhibit 3

RECOMMENDATIONS

117 I identified three potential recommendations that arose during the inquest and invited the Department to provide a response to those. They are dealt with below.

An alternative medication for prisoners with ADHD

118 As stated by Dr Gunson in her report to the Court:[71]

> ADHD is a neurodevelopmental disorder, typically with an onset before the age of 12 years. Symptoms include difficulties with attention and/or hyperactivity and impulsivity, which are incongruent with a person's age and that interfere with activities and participation. A diagnosis of ADHD is made when an individual has a constellation of symptoms and functional impairment.

119 Dr Gunson explained that the symptoms of ADHD include intention, hyperactivity and impulsivity. As to impulsivity, Dr Gunson noted that this "*includes a tendency to act in response to immediate stimuli, without consideration of risks and consequences.*"[72] Dr Gunson also noted:[73]

> As per guidelines, there is strong evidence that pharmacological treatment (such as stimulant medication) is highly effective at improving the symptoms of ADHD; additionally, non-pharmacological interventions play a role in improving patients' overall functioning and wellbeing.

120 Dr Gunson continued:[74]

> It is therefore possible that without treatment for his ADHD, [Tim] was more susceptible to impulsive behaviour, possibly due to difficulties he may have been experiencing in a stressful environment. However, one could not state that this directly led to his suicide.
>
> …
>
> Unfortunately, we will never know what pressures and thoughts led [Tim] to his suicide.

[71] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.13
[72] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.13
[73] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 2025, p.15
[74] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 225, p.15

121 I thank Dr Gunson for her comprehensive analysis of how prisoners with ADHD are cared for in the prison environment. It is clear that improvements ought to be made in this area; particularly given the high incidence of ADHD amongst prisoners.

122 One such improvement that Dr Gunson noted was:[75]

> Prisons should establish safe processes of administering long-acting stimulant medications to those with ADHD (similar to ways of administering other controlled drugs and ensuring the safety of the person in prison receiving stimulant medication). Specific screening for comorbid substance use disorders should be undertaken before administering stimulant medication.

123 At the inquest, I said I would consider a recommendation that the Department permits the prescribing of long-acting stimulant medication to prisoners with diagnosed ADHD who had been prescribed and were using dexamphetamine at the time of their imprisonment. A long-acting stimulant such as lisdexamphetamine is less likely to be trafficked in a prison setting compared to the short-acting dexamphetamine.

124 The Department's response was:[76]

> This recommendation if made will be supported in principle. The Department will consider whether the provision of long-acting stimulants such as lisdexamphetamine is an appropriate alternative that can be prescribed to prisons instead of dexamphetamine. Further it will consider the controls that will need to be implemented at medication parades (such as is the case for methadone) to reduce the possibility of this medication being trafficked.

125 I am strongly of the view that a recommendation to this effect should be made. There would be a large number of prisoners with diagnosed ADHD who have been prescribed dexamphetamine since their childhood. Tim would in no way be an outlier with respect to that. If their use of dexamphetamine has stabilised their ADHD in the community then there are compelling grounds for an alternative medication to be prescribed in prison that does not have the same trafficable attraction that dexamphetamine would have. As Dr Gunson rightly pointed out in her report to the Court:[77]

> The mandate for the Justice Health and Wellbeing Service is that we must provide health care of a standard equivalent to that which a patient

[75] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 225, p.26
[76] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.2
[77] Exhibit 1, Tab 28, Health Services Summary into the Death in Custody dated 30 May 225, p.21

> can access in the community. While some medical conditions and medications present safety concerns and security challenges within the prison environment, nonetheless, where at all possible, this should always be the minimum standard of care.

126 Accordingly, I make the following recommendation:

> ***Recommendation No.1***
>
> **To improve the care and treatment of prisoners with previously diagnosed ADHD, those prisoners who were prescribed and using a short-acting stimulant (such as dexamphetamine) in the community at the time of their imprisonment, be given the option of having prescribed a long-acting stimulant (such as lisdexamphetamine) as an alternative medication for the treatment of their ADHD.**

Access to PSOLIS by prison medical officers

127 During Dr Gunson's evidence at the inquest, access to PSOLIS[78] by prison medical officers arose as these doctors do not currently have this access. Dr Gunson supported a proposed recommendation from the Court that would permit prison medical officers to have "read-only" access to PSOLIS.

128 The Department's response to this potential recommendation was as follows:[79]

> This recommendation if made will be supported as [a] current practice/ project on the basis that the Department has commenced engagement with the State Forensic Mental Health Service (SFMHS) regarding obtaining writeable access for all Mental Health Practitioners. Discussions are also on-going for primary health care physicians to obtain Read Only access. The Department will continue to engage with SFMHS to progress this matter.
>
> This recommendation should also be made to the Department of Health and SFMHS as they control access to PSOLIS.

[78] PSOLIS (Psychiatric Services Online Information System) is the mental health database used in Western Australia for managing clinical risk, patient information, and administrative processes within community mental health services. It contains patient data, alerts regarding risk factors, and is used for tracking service events and patient activity.

[79] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.1

129 Given the support from the Department and noting the necessary involvement from the Department of Health and SFMHS, I make the following recommendation:

> ***Recommendation No.2***
> **To assist the treatment of prisoners with previously diagnosed mental health issues, the Department of Health and the State Forensic Mental Health Service permit "read-only" access to PSOLIS by prison medical officers.**

Following up a response to a request for a prisoner's medical information

130 As I have already outlined above, I identified a missed opportunity for Health Services at BRP to follow up a response from SWMHS to a request for a release of medical information regarding Tim's ADHD diagnosis. From the evidence I heard at the inquest, it would be desirable if there was a prompt for a follow up to occur if the information has not been provided within a reasonable time. Dr Gunson suggested this prompt should be one or two weeks after the request was made.

131 As to this proposed recommendation, the Department responded:[80]

> This recommendation if made will be supported in principle and the Department of Justice (the Department) will review the Electronic Heath Online System (EcHO) to ascertain if there is functionality to record a prompt to ensure medical information is returned and/or responded to in a timely manner.
>
> In the event this functionality is available, the Department will develop a process on how this will be achieved taking into consideration resources available.
>
> Should this functionality be unavailable, the Department will undertake a business needs assessment to seek the necessary funding to develop and implement this functionality into EcHO.

[80] Attachment to Ms Niclair's email to the Court dated 30 June 2025, p.1

132 I am of the view that this recommendation should be made. The material from SWMHS was not provided to BRP prior to Tim's death, even though more than three months had passed since the request was made. A prompt within the time frame proposed by Dr Gunson would most likely have led to further enquiries being made.

Recommendation No.3

To assist the health care and treatment of prisoners, the Department introduces a prompt on its EcHO system for staff to follow up a request for a prisoner's medical information that has not been provided within a reasonable time.

Other recommendations

133 In light of Superintendent Bishop's evidence at the inquest, I am inclined to make a recommendation regarding the modification of cells in BRP so that they become three-point ligature minimised.

134 As to the issue of the ligature minimisation of cells, the Department advised:[81]

> Infrastructure and Environment has also prepared a statewide Business Case for Ligature Reduction funding, which has been submitted to Treasury for review. Should Treasury approve the funding, Infrastructure and Environment will present the option to either partially or fully minimised ligature risks in Unit 2 cells to AMP for consideration.

135 This is an encouraging development and I commend the Department for undertaking this Business Case. In order to assist that process, I make the following recommendation:

Recommendation No.4

In order to better manage vulnerable prisoners and thereby enhance security, the Department should take immediate steps to ensure all cells in Unit 2 are either three-point or fully ligature minimised as quickly as possible.

[81] Exhibit 3, p.3

136 A final matter that arose following the inquest was the updated "Fortnightly Security Checks" form that is now in operation at BRP. This updated form highlights the important task for prison officers to check walls and ceilings in cells for any modifications that may be used as a ligature anchor point. The Court was recently advised that: "*The Department has been made aware of this change, to consider whether the change needs to be made to the form across the prison estate*."[82]

137 I am firmly of the view that this change should be made to the forms in every adult prison that are used by prison officers during their scheduled security checks of cells. I therefore make the following recommendation:

Recommendation No.5

In order to enhance the care of prisoners, the Department adopts across the entire prison estate the recent change made by BRP to its "Fortnightly Security Checks" form so that prison officers are reminded of the importance to identify potential ligature anchor points in cells.

CONCLUSION

138 Sadly, Tim was still a young man when he died in BRP on 3 October 2023. From the information available, it is clear to me that he was experiencing difficulties adjusting to his first term of imprisonment. Unfortunately, Tim did not seek help from prison health service providers regarding his mental health during the three months he was incarcerated.

139 Although I have identified several missed opportunities, I was generally satisfied that the supervision, treatment and care provided to Tim by custodial staff and health service providers at BRP was appropriate.

140 Tim was one of a high number of prisoners with diagnosed ADHD. It will never be known whether his ADHD was a factor in his suicide. However, what is known is that he (like every other prisoner who had previously been prescribed dexamphetamine in the community to treat their ADHD) was prescribed no medication for his ADHD whilst he was in prison.

[82] Email from Ms Niclair to the Court dated 30 June 2025

141 I am satisfied that improvements can be made in the treatment of prisoners with ADHD and I have made a recommendation that an alternative long-acting stimulant medication be offered to prisoners like Tim who were prescribed dexamphetamine in the community. I have also made four other recommendations. If these are all implemented I expect it will lead to improved treatment and care for prisoners; thereby reducing the risk of prisoners dying by way of suicide.

142 I hope these recommendations may provide some small solace to Tim's family and loved ones. As I did at the inquest, and on behalf of the Court, I extend my sincere condolences to Tim's family, especially his mother, for their sad loss.

PJ Urquhart
Coroner
8 July 2025