
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : SARAH HELEN LINTON, ACTING STATE CORONER
HEARD : 15 - 16 JANUARY 2025
DELIVERED : 16 SEPTEMBER 2025
FILE NO/S : CORC 108 of 2023
DECEASED : WEAZEL, OWEN DUKER NUGGET

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Ms G Papalia and Ms Y Tamba (ALSWA) appeared for the family.
Ms H Cowie (SSO) 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, Sarah Helen Linton, Acting State Coroner, having investigated the death of **Owen Duker Nugget WEAZEL** with an inquest held at **Perth Coroner's Court, CLC Building, Court 51, 501 Hay Street, PERTH**, on 15 - 16 January 2025, find that the identity of the deceased person was **Owen Duker Nugget WEAZEL** and that death occurred on 10 August 2023 at Albany Regional Prison, Princess Avenue, Torndirrup, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Owen¹ was by birth and culture a Wakka Wakka man, having been born on Wakka Wakka Country in Queensland, an area traditionally associated with the Burnett River region, including the Bunya Mountains and Ban Ban Springs.² Owen moved to Western Australia as he came of age and he lived most of his adult life in Kojonup, Western Australia. I am told by his next of kin that he considered Kojonup home and he was accepted by the local Aboriginal community in that region. He also considered himself to be closely tied to the Noongar Community, as a result of the many years he spent in Noongar Country.³
2. Owen had experienced trauma in his childhood and this led to troubles in his life as an adult. In particular, it appears he had troubles with drug use, which contributed to some mental health issues. Owen came into contact with the criminal justice system and ended up serving several terms of imprisonment, starting in 2000.⁴
3. Owen was being held as a remand prisoner at Albany Regional Prison in early August 2023. On 10 August 2023, he was found hanging in his cell by his cell mate. Owen was taken by ambulance to Albany Hospital, but he could not be saved. His death was confirmed by a doctor at the hospital that afternoon.
4. As Owen was a remand prisoner at the time of his death, his death came within the definition of a ‘person held in care’ under the *Coroners Act 1996* (WA) and a coronial inquest into his death was mandatory.
5. I held an inquest on 15 to 16 January 2025. Significant documentary evidence was tendered at the inquest, including a comprehensive report prepared by the WA Police into the circumstances of Owen’s death, as well as two reports prepared by the Department of Justice setting out relevant information about Owen’s health care while incarcerated and his supervision.
6. A number of witnesses were called at the inquest to speak to their interactions with Owen prior to his death and the resuscitation efforts provided after he was found hanging. More general evidence was also given about relevant policies and practices associated with identifying risk of self-harm in prisoners and minimisation of hanging points, as well as changes made by the Department of Justice since Owen’s death. Owen’s long term partner and other family members attended the inquest and they provided information to assist me in understanding more about Owen’s life and also to express how Owen’s sudden and unexpected death has impacted upon them as a family.
7. Following the inquest, I am required to comment on the quality of the treatment, supervision and care provided to Owen while in custody, prior to his death. I make my comments below.⁵

¹ It is Owen’s family’s request that he be referred to simply as Owen in this inquest matter.

² *Miles v State Coroner of WA & Anor*, CIV 1970 of 2023, Tottle J, delivered *Ex tempore* 7.9.2023.

³ Correspondence from ALSWA to Counsel Assisting dated 6.1.25.

⁴ Exhibit 1, Tab 7; Exhibit 2, Tab 1.2.

⁵ Sections 22(1)(a) and 25(3) *Coroners Act 1996* (WA).

BRIEF BACKGROUND

8. Owen was born on Wakka Wakka country on 17 December 1981 and was raised by his kinship mother, Molly Miles (who is the sister of his biological mother, Dorothy Weazel) and her partner, whom he considered to be his parents, along with their five children, whom he considered to be his siblings. He was first and foremost by birth and culture a Wakka Wakka man. However, Owen left Queensland in 1998, at the age of 17 years, and moved with Ms Miles and the rest of the family to Katanning, Western Australia. He subsequently moved to Kojonup in 2002, and that became his primary place of residence for the rest of his life. As a result, he came to feel a strong sense of community and connection in Kojonup as well.⁶
9. Owen began a relationship with Ms Christie McVee in late 2002. They had three children together: Jamaine, Jayda and Jerome. Owen and Ms McVee's relationship was tumultuous at times over the twenty or so years they were together, but they continued to have a deep affection for each other. Owen also loved his three children very much and they loved him in return.⁷
10. Owen had several jobs in and around the Katanning and Kojonup area, working at different times in a shearing shed as a shed hand and as a butcher, amongst other things. In his spare time, he liked sport, hunting and gathering and generally spending time in nature. He also loved spending time with his family and friends. He didn't like nasty people or arguments and was usually softly spoken himself.⁸
11. As noted earlier, Owen had experienced trauma in his childhood and had troubles in his life as an adult with drug use and associated drug-induced psychosis. Ms McVee recalls that Owen had tried in the years prior to his death to get help for his drug addiction. He had engaged with rehabilitation programmes at Palmerston Centre in Katanning, Albany Hospital and St Lukes Kojonup, but after making some progress, he always relapsed into drug use again.⁹
12. Owen served several terms of imprisonment for various criminal offences, starting in 2000. Ms McVee recalled that in the last years of his life, Owen was in and out of prison. His last sentence was imposed in late 2022 and he was released in April 2023. Once he was out in the community, he began using drugs daily with his friends and was rarely home.¹⁰
13. In terms of other health issues, Owen often suffered from ulcers in his stomach and he had suffered some serious injuries from a motorcycle crash and had damaged his knee after falling off a chair in the past. He had no known ongoing physical health issues that required regular medications or treatment.¹¹

⁶ *Miles v State Coroner of WA & Anor*, CIV 1970 of 2023, Tottle J, delivered *Ex tempore* 7.9.2023; Exhibit 1, Tab 7.

⁷ *Miles v State Coroner of WA & Anor*, CIV 1970 of 2023, Tottle J, delivered *Ex tempore* 7.9.2023.

⁸ Exhibit 1, Tab 7.

⁹ Exhibit 1, Tab 7.

¹⁰ Exhibit 1, Tab 7; Exhibit 2, Tab 1.2.

¹¹ Exhibit 1, Tab 7.

OWEN'S MENTAL HEALTH HISTORY

14. Owen's medical records reveal he had presentations to hospital for suicidal ideation in the time leading up to his last periods of imprisonment, although he didn't engage regularly with any community mental health service.
15. On 4 August 2022, Owen was taken to Albany Hospital by police after he was arrested and indicated he had suicidal thoughts. He had also reportedly been hiding a cutlery knife. Owen's medical notes from this time record that Owen had experienced low mood and suicidal ideation for the last five years, which had worsened in the last year. There had been deaths in the family and he had been upset that he had not been able to attend family funerals in Queensland due to COVID-19 travel restrictions. Owen told health staff he had tried to hang himself twice in the past six months, but his family had called police for help. He said he did not have regular contact with any mental health services and had ceased his antidepressant medication. Owen also said he did not like the person he had become and had thought about finding a rope to hang himself. However, he cited his children as protective factors against harming himself. Owen was given an antipsychotic and was eventually discharged into police custody.
16. Owen remained in custody and was eventually sentenced to imprisonment for two burglary offences on 6 September 2022, as well as having some fines imposed for drug related offences.¹² While in prison, he was re-started on his antidepressant medication, with a notation that this was for ongoing mood issues. Owen mentioned having attempted suicide twice while in the community but there do not appear to have been any ongoing concerns for his mental health while in prison during this period. Owen told Prison Health Service (PHS) staff that he remained hopeful that he would be able to get his life back on track in terms of employment and being with family on release. He wanted to find ways to not fall back into substance use. It appears that some attempts were made to put Owen in contact with local rehabilitation services prior to discharge, but it doesn't appear he engaged with any services after his release on 19 April 2023.¹³
17. Ms McVee recalled Owen turned up at home within a few days of being released from prison in a drug-induced psychotic state. Owen told her that he was having suicidal thoughts and threatened to kill himself in front of Ms McVee and the children. He appeared to be having paranoid thoughts, was making accusations and experiencing hallucinations. His mental health then continued to be troubled.¹⁴
18. Owen was taken by police to the Katanning Hospital ED on 26 May 2023 due to concerns about his mental health. He stated that he had self-harmed by taking a large quantity of sleeping tablets three days before, then texted his partner to tell her he was going to attempt suicide by taking sleeping tablets. It seems Ms McVee had informed police and they had located Owen and brought him to the hospital. He mentioned he was feeling sad and depressed but otherwise didn't want to engage

¹² Exhibit 1, Tab 25; Exhibit 2, Tab 1.2.

¹³ Exhibit 1, Tab 19.

¹⁴ Exhibit 1, Tab 18 and Tab 27.2.

with the hospital staff. Owen was assessed as being at low risk of suicide if held in police custody and was discharged back into police custody with no medication.¹⁵

19. After being refused bail on charges related to aggravated stalking and nine breaches of family domestic violence restraining orders, Owen was remanded in custody the following day and transferred to Albany Regional Prison.

LAST ADMISSION TO PRISON

20. At reception into Albany Prison on 27 May 2023, Owen was noted to have been remanded in custody to await his next court date and he was identified as a returning prisoner. He advised reception staff he was unsure if his family would be able to provide him with support, but he indicated his partner would not be, given the charges. He reported he had attempted to self-harm in the days prior to imprisonment, apparently alluding to the recent overdose attempt. Owen also reported he had received treatment for his mental health, specifically depression, during his last period of imprisonment as well as in the past. He indicated he had feelings of hopelessness for the future and thoughts of self-harm on occasion.¹⁶
21. As a result of the information Owen provided, the reception officer recommended that Owen be placed on the moderate level of the Department's 'At Risk Management System' (ARMS) with two hourly observations and he should be placed in a ligature minimised cell until he was reviewed by the Prisoner Risk Assessment Group (PRAG). He was placed in a ligature minimised cell in E Section of Unit 1, which is where the higher ARMS prisoners are housed.¹⁷
22. The cell was described by an officer as "pretty much all concrete and brick"¹⁸, noting the mattress sits on a slab of concrete and there is a tv that is secured behind a glass screen. Everything in the cell is flat, to reduce any risk of hanging points. The minimalist design of the cell serves a purpose in terms of reducing the opportunity for a prisoner to self-harm, but it is designed for short-term crisis care and not with the level of comfort necessary for a prisoner to live in long-term.¹⁹
23. Owen had not been diagnosed with a major mental illness at any time and his general mental health needs were centred around substance misuse and anxiety/depression. It was felt his needs were appropriately met by general medical/nursing staff and psychological counselling, and he was not identified as requiring psychiatric review.²⁰

¹⁵ Exhibit 1, Tab 22 and Tab 27.2.

¹⁶ Exhibit 2, DIC Review Report.

¹⁷ Exhibit 2, DIC Review Report.

¹⁸ T 25.

¹⁹ T 25 – 26, 35.

²⁰ T 65.

SUPERVISION ON ARMS

24. Prior to the first PRAG meeting, Registered Psychologist Delroy Bergsma, who was working as a PHS counsellor, saw Owen on 29 May 2023. This was a couple of days after his admission and just over 10 weeks prior to his death. They met face to face in Owen's cell in E block. Mr Bergsma had not met Owen prior to this assessment. He was aware prior to their meeting that Owen had been placed on ARMS at intake as he had reported that he had a recent suicide attempt and he did not have any hope for the future. Owen engaged with Mr Bergsma and he appeared to have noticeably high levels of stress. He mentioned his ongoing problems with substance use and indicated he would like to try rehabilitation again, with the ultimate aim of restoring his relationship with his partner and children. It was apparent to Mr Bergsma that Owen had high levels of stress and ongoing mental health risks. This was solidified when Owen candidly stated that he was unable to guarantee his safety although he did not have a current suicide plan.²¹
25. Owen was also seen by a prison chaplain, Chaplain Jones, in his cell. Owen was willing to engage with the chaplain. He seemed upset and embarrassed that he had ended up in prison again and his mood was noted by the chaplain to be flat and low, saying a number of times that this was "the lowest point in in his life."²² They discussed how his children were his protective factors, although Owen also said he felt he had 'let them down again'.
26. The PRAG committee discussed the information provided by Mr Bergsma and Chaplain Jones, along with information from a Prison Support Officer (PSO) that Owen could not guarantee he won't harm himself. It was recommended by the PRAG that Owen remain on moderate two-hourly ARMS following the meeting. Ligature minimisation was discussed by the PRAG, but it was deemed not necessary.²³
27. A nurse performed a welfare check on Owen on the morning of 30 May 2023 in his cell. He appeared well at that time and raised no issues or concerns.²⁴
28. Owen had another PHS review on 1 June 2023 with a different PHS counsellor, Clinical Psychologist Celeste Lauren. Ms Lauren is the clinical supervisor for the psychological health service for PHS, managing the team of prisoners counsellors for Bunbury Regional Prison, Albany Prison and Pardelup Prison Farm. She provided back up support to the counsellors when required.
29. Ms Lauren's assessment with Owen on this date was done via MS Teams as she is based in Bunbury. Ms Lauren had met Owen previously when he was incarcerated at Pardelup Prison Farm, so she was familiar with his history. I note Owen had previously told Ms Lauren he preferred to do counselling sessions in person, so it

²¹ T 139; Exhibit 1, Tab 17 and Tab 28; Exhibit 2, Tab 1.7.

²² Exhibit 2, Tab 1.7.

²³ Exhibit 1, Tab 17 and Tab 28; Exhibit 2.7.

²⁴ Exhibit 1, Tab 17, p. 16.

was not ideal that this session was conducted remotely, but I understand it was necessary as there was no PHS counsellor onsite at the time.²⁵

30. Owen had moved from an observation cell in E Block to Unit 3 and a standard cell allocation on 30 May 2023, so he was no longer in a ligature minimised cell by that time.²⁶
31. Ms Lauren's evidence was that she was disappointed for Owen that he had returned to prison so quickly, as when she had seen him at Pardelup he had been very hopeful for his release and talking about his plans once he was back with his family in the community. Ms Lauren wasn't aware of what had gone wrong for Owen after his release, but she recognised that he would be disappointed he had come back in after their previous conversations.²⁷
32. On this occasion when Ms Lauren saw him, Owen presented with low mood but was forthcoming in his responses. Owen spoke about how he had been feeling 'up and down' since his return to prison, especially as his new charges and VRO meant he could not contact his partner, who had been his primary support. He was open in reporting fluctuating suicidal ideation and intent, especially in the context of not having hope for the future. He spoke about taking pills previously in an attempt to overdose, but noted this was difficult to do in prison. Owen stated that being around others was his primary protective factor and his family and friends seemed to know that they needed to check on him, without him having to tell them too much about how he was feeling. He reported that being in a double-up cell was a protection from suicide. Ms Lauren encouraged Owen to identify reasons to live and they discussed making plans for him to engage in residential rehabilitation in the community upon his release. He also mentioned his partner and children generally as protective factors, although it was difficult given he was no longer able to contact his partner. Importantly, he indicated he felt his suicidal ideation was not reducing.²⁸
33. Ms Lauren noted the issues with Owen's partner were not just that he had one less person to talk to and from whom he could seek support. It seemed he was also feeling sad that he may have ruined the relationship and had a lot of hurdles he would now have to overcome in order to be able to have contact with his partner in the future.²⁹
34. Following this review, Ms Lauren recommended that Owen remain on low, 4 hourly, ARMS and she made a particular notation that he should remain housed with a supportive cellmate as this was a significant protective factor against suicide for Owen.³⁰
35. It was noted in the PRAG meeting minutes that the Unit Manager had advised that Owen had indicated after spending time in the unit and being with family he had

²⁵ T 50 – 52; Exhibit 2, Tab 5.4.

²⁶ Exhibit 2, Tab 1.5.

²⁷ T 57; Exhibit 2, Tab 5 [34].

²⁸ T 50, 85; Exhibit 1, Tab 17.

²⁹ T 85.

³⁰ Exhibit 1, Tab 17.

begun to focus on the future and realised that he has to look after himself and try to get help via rehabilitation so that he could go forward in his life and make a difference. Similarly, the PSO and Chaplain Jones advised Owen had appeared stable and denied further thoughts of self-harm, instead seeming focussed on addressing his drug abuse problem through rehabilitation. He had mentioned that when he arrived in prison he was probably still feeling the effect of the drugs and alcohol, but now his head had cleared and he was feeling more positive. They recommended reduction to low ARMS or removal from ARMS and placement on SAMS. It was agreed at the end of the PRAG meeting that Owen should be reduced to low ARMS four-hourly observation, which was consistent with Ms Lauren's recommendation (although she acknowledged she had perhaps mistakenly already thought he was on low arms at that time). Ligature minimisation was again discussed and deemed not necessary due to his reduced risk, indicated by his progression to low ARMS status. It was also indicated that Owen should continue to be included on the Aboriginal Visitors Scheme list.³¹

36. Ms Lauren explained at the inquest that the discussion about whether Owen required placement in a fully ligature-minimised cell was a requirement of the ARMS process, but it would not generally be considered for a prisoner unless they were felt to be at active risk of harming themselves, given the fully ligature-minimised cells are relatively inhospitable and only suitable for short periods. Ms Lauren gave evidence prisoners will often tell her that being in a fully ligature minimised cell makes them feel worse, so it is always a balancing exercise. The decision would usually be focussed around what supports could be put in place (such as a supportive cell-mate, placement near family etc) to improve the prisoner's mental health and reduce the risk while still keeping the prisoner in the general population, with movement to a fully ligature minimised cell reserved for a prisoner exhibiting a significant escalating risk of self-harm.³²
37. Owen had another PHS review with another PHS counsellor, Rebecca Forster, on 8 June 2023. Ms Forster is a qualified social worker who had been working as a prison counsellor at Albany Prison since October 2019. She had met Owen on a number of occasions between 2019 and 2023 while he was at Albany Prison and recalled that generally there was increased contact when Owen returned to the custodial setting following a period in the community, either because he was on ARMS at intake or because he had self-referred, seeking general counselling to adjust to his return to the prison setting. Ms Forster stated Owen would also engage with her when he saw her around the prison, separate to their formal counselling sessions.³³
38. Ms Forster's assessment of Owen on this date was conducted face to face. Owen presented with a somewhat low mood but also engaged well in the discussion and exhibited good self-reflection around his recent charges and the impact on his relationship. He reported that he had fleeting suicidal thoughts with no intent or plan and that he would redirect himself in those moments by seeking out the company of a family member or a cell mate. Ms Forster recalled that physically Owen looked similar to how he had appeared on previous occasions when he had returned to

³¹ T 59; Exhibit 2, Tab 1.8.

³² T 66 - 68.

³³ T 113 - 114; Exhibit 1, Tab 17; Exhibit 2, Tab 9.

custody; namely he looked physically tired and slimmer then when he had been in prison for a while.³⁴

39. Owen told Ms Forster, as his drug withdrawal symptoms were reducing, so were his suicidal thoughts. He said he was looking after himself better now and feeling more positive about the future after release, although he accepted there was a possibility of further incarceration after his next court appearance. After completing her assessment, Ms Forster recommended Owen remain on low ARMS due to the residual impact of his substance use and fleeting suicidal ideation, although he had strong protective factors, including family in his unit and his cell mate.³⁵
40. At the PRAG meeting that afternoon, the Unit Manager indicated Owen seemed in good spirits and had settled well into Unit 3 as he had good family support in the unit, which had helped him to gain a positive outlook on life. The Unit Manager felt further ARMS, or transition to SAMS, was unnecessary. The PSO also felt Owen seemed future oriented and had said he would seek out PHS and support services, so he no longer needed to be on ARMS. This view was supported by Chaplain Jones. There was no mental health nurse on site at Albany Prison at the time, so there was no input from mental health. Ultimately, and noting there was a divergence in views, it was decided by the PRAG chair that Owen should be removed from ARMS. It was also deemed that SAMS was not necessary at this time. No rationale was entered for why SAMS was considered unnecessary, contrary to general policy, but it was discussed at the inquest that SAMS is generally reserved for vulnerable prisoners, such as prisoners with an intellectual disability or some other particular need for support, which did not appear to be the case for Owen. Owen had also not been placed on SAMS previously when incarcerated. Further, Ms Forster recalled that Owen was noted to already have family members and strong support systems in his unit, including a supportive cell mate, and it was noted he had been in the same unit previously when incarcerated.³⁶
41. I note that the decision to remove Owen from ARMS was contrary to the recommendation of the prison counsellor, Ms Forster. Ms Forster indicated that her recommendation was informed by her familiarity with Owen, which was important. Ms Forster stated she was aware of Owen's long-term history of substance abuse and the residual effects of polysubstance use immediately prior to him returning to custody, as well as the fact he wouldn't generally eat well or look after himself while in the community. Further, he often "experienced conflict and difficult relationship dynamics,"³⁷ which was definitely true on this occasion. Even though Ms Forster could sense that Owen was trying to be optimistic and focussing on the future, she was concerned for him and was aware he was still experiencing fleeting suicidal ideation. In that context, I consider Ms Forster's opinion that Owen should have remained on low ARMS should have been given significant weight.
42. Ms Lauren also emphasised that the prison counsellor is one of the most qualified people in the ARMS group in conducting risk assessments. However, the views of

³⁴ T 115; Exhibit 2, Tab 9.

³⁵ T 115; Exhibit 1, Tab 17; Exhibit 2, Tab 9.

³⁶ T 71 – 73, 129 - 130; Exhibit 2, Tab 1.10 and Tab 9.

³⁷ Exhibit 2, Tab 9 [41].

all members of the PRAG are considered (as well as the wishes of the prisoner) and if there are split views, then it is for the Chairperson to try to facilitate a consensus. If a consensus cannot be achieved, then the Chair will make the final decision. Ms Lauren understands they will usually err on the side of caution in such cases, particularly if the prisoner has a significant date coming up.³⁸ However, Ms Forster gave evidence in this case there was a general discussion about the different views and she maintained her position that Owen should remain on low ARMS at the end of those discussions. The PRAG chair then made the decision that Owen would be removed from ARMS. Given her continuing concerns about Owen's mental state, Ms Forster confirmed with the ARMS Chairperson that she would follow up with Owen following his removal from ARMS, which she did a few days later on 14 June 2023, prior to her leaving her role with the Department.³⁹

AFTER REMOVAL FROM ARMS

43. Ms Forster saw Owen for the last time on 14 June 2023 for a general counselling session. It was noted Owen had asked for the session during his ARMS review with Ms Forster and Ms Forster also gave evidence she wanted to follow him up as she had still had some concerns after the PRAG meeting, noting her recommendation had been that he remain on low ARMS, so she wanted to see how Owen had adjusted to prison over that additional period of time before she departed. Ms Forster indicated in her statement that one of the reasons she had wanted to keep Owen on ARMS was because she was leaving and knew that PHS resources would be stretched, with the only PHS person onsite being Mr Bergsma, who worked three days a week at that time. She hoped that by keeping Owen on ARMS, he would be monitored for a bit longer, whereas it was unlikely he would be seen soon if he moved off ARMS.⁴⁰
44. At this session, Ms Forster documented Owen presented with "marked improvement in mood and demeanour"⁴¹ from when she had seen him last. He appeared future focussed, irrespective of whether he was released or received a further prison term after his next court appearance. He reported much improved mood and energy levels and reduced anxiety since he had last seen Ms Forster, which was likely related to sleeping and eating better. However, he did indicate that he continued to experience some situational stress and anxiety, which Ms Forster felt was reasonable in the circumstances. He remained linked in with Peer Support workers and had family members living with him in the unit for support. During the session, they discussed how he could work through his legal problems and the options available to him to work on his substance use, noting he had some insight into how his recent substance use had impacted on his mood and contributed to his anxiety. They also discussed what steps he could take to improve his position if released, in terms of surrounding himself with more 'pro social' supports.⁴²

³⁸ T 56 – 59, 81 - 82.

³⁹ T 118-119; Exhibit 2, Tab 9.

⁴⁰ T 119; Exhibit 2, Tab 9.

⁴¹ Exhibit 2, Tab 9.5.

⁴² T 119 - 121; Exhibit 2, Tab 9 and Tab 9.5.

45. Ms Forster discussed with Owen the fact she was leaving her role at the prison and that she would hand over his case to Mr Begsma with PHS. Owen expressed some reluctance to contact Mr Bergsma, as he had only had limited contact with him in the past. However, after further discussion, Ms Forster noted Owen became more open to the opportunity to interact with a new counsellor so that he could have ongoing support and he agreed to his PHS referral remaining active. He also confirmed he knew he could contact the PHS Team in future for follow-up, if needed, on the understanding that PHS resourcing was limited so they were prioritising the most urgent cases and he might not be seen for a while. Ms Forster noted Owen was okay with this as he felt well supported in his current placement in the prison. Owen agreed he would self-refer if he felt he was at risk.⁴³
46. Owen also had a booking made by a doctor on 14 June 2023 for some bloods to be taken for general blood testing, with a follow up appointment to see a doctor on 5 July 2023 once the blood test results were available.⁴⁴
47. He saw a nurse on 21 June 2023 after making a request on 20 June 2023. Owen indicated in the request he couldn't sleep because he was thinking too much and worrying about things he couldn't control. It was noted he was due to see the doctor in a couple of weeks. Owen told the clinical nurse who reviewed him that he was feeling a bit stressed and sad due to his upcoming court appearance and was unable to sleep. He was given some reassurance and told he could have Valerium for three nights to help him sleep. He seemed happy with that plan, so the Valerium order was entered into his notes and a PHS referral was also sent, noting he was still on active PHS referral. Owen had an initial health screen on the same day in preparation for his doctor's appointment.⁴⁵
48. After a slight delay, Owen had his blood tests and then saw a doctor on 28 July 2023. Dr Kevin Fontana reviewed Owen and noted he was a remand prisoner with a history of head injuries and anxiety/depression. He denied any current thoughts of suicide or self-harm and seemed pleasant and interactive during the appointment. His poor dentition was noted, but he declined dental review. His mood was low and he requested medication to help improve his mood, so Dr Fontana prescribed amitriptyline at night, a medication he had been prescribed in the past.⁴⁶ Owen did not see any nursing or medical staff again until he was found hanging on 10 August 2023.
49. It was noted by witnesses at the inquest that any custodial staff member can arrange for a prisoner to be placed back on ARMS if they have any welfare concerns for the prisoner, and some prisoners will also make their own request to go back on ARMS if (like Owen) they are familiar with the process. In this case, no such concerns were raised in relation to Owen. If he had been on ARMS or SAMS, he would have been expected to be seen again by a PHS counsellor prior to his death as there would have been a set review date. However, as Owen was only on the general counselling list and had been seen recently by the counselling service before he came off ARMS, it

⁴³ T 120 - 123; Exhibit 2, Tab 9 and Tab 9.5.

⁴⁴ Exhibit 1, Tab 17.

⁴⁵ Exhibit 1, Tab 17.

⁴⁶ Exhibit 1, Tab 17.

seems he was rated low on the list of priorities, given the stretched service. Mr Bergsma gave evidence as the only counsellor onsite at the time, he was prioritising ARMS and SAMS clients, both at Albany Prison and Pardelup Prison, and then prisoners on the general counselling list were seen based on risk priority and then new referrals would be prioritised. As there was no reason noted on Owen's notes for his case to be prioritised, and he was not a new referral, he was not seen again by a PHS counsellor before his death.⁴⁷

50. It is difficult to say with certainty what might have happened if Owen had been seen by PHS staff again before his death. I note Ms Forster saw him on 14 June 2023 and in her opinion he had seemed much improved and she did not feel he needed to have him placed back on ARMS, whether high medium or low. However, it seems his mental state deteriorated after that time, so it is possible if he had been seen by a PHS counsellor again, some questioning may have prompted Owen to disclose information that could have led to him being placed back on ARMS. However, it would have required Owen to have "recognised within himself that his risk had increased"⁴⁸ and verbalised that, or given some other indication that his mood was deteriorating and his risk to himself was increasing, which was less likely to be appreciated by another counsellor who did not know him as well as Ms Forster. Nevertheless, the fact Owen was not seen by PHS staff again before his death, despite being on the PHS general counselling list, was a missed opportunity for a counsellor to engage with Owen and make an assessment of whether his mental state was consistently improving or fluctuating or deteriorating.

LAST KNOWN EVENTS

51. Records show that Owen was moved on 18 June 2023 into a different cell, cell D10, at his request. He remained in that cell until his death.⁴⁹
52. It is clear from the evidence that Owen was worrying about his upcoming court appearance, for which he did not have certain legal representation, and the effect the charges had on his ability to talk to Ms McVee and receive her support.⁵⁰
53. Another prisoner in the unit, RF, was a close friend of Owen's. They had known each other for about 20 years. Their cells were close to each other and RF would speak to Owen on a daily basis. He described Owen as a quiet and humble person. He hadn't noticed Owen behaving unusually in the months leading up to his death or particularly depressed. He was aware that Ms McVee had a restraining order preventing Owen from contacting her but believed Owen was able to speak to his children regularly. Owen approached RF at about 9.00 am on the day he died, being 10 August 2023. Owen showed RF a letter that he had received from ALS. RF read the letter and he then explained its contents to Owen.⁵¹

⁴⁷ T 53 – 55, 78 – 79, 123 – 124, 142 - 143.

⁴⁸ T 134.

⁴⁹ Exhibit 2, Tab 1.5.

⁵⁰ Exhibit 1, Tab 11.

⁵¹ Exhibit 1, Tab 10.

54. A copy of the letter from ALS was found in Owen's cell afterwards. It is apparent Owen was informed that ALS could not represent him due to a conflict, but he was also told in the letter that the ALS lawyer had contacted Legal Aid and Legal Aid had indicated they would take an application from him so that he could be represented by a lawyer at the forthcoming trial for his charges. If that application was unsuccessful, ALS also indicated that he could apply to them to assist him to pay for a private lawyer, although it was made clear that there was no guarantee either application would be successful and it was possible that he might have to represent himself at trial. Nevertheless, it was clear ALS was communicating to Owen they would do their best to assist him to obtain representation before his trial since they could not act for him. There is also evidence that Owen had met with a lawyer from Legal Aid for a 45 minute e-visit, during which it is presumed they discussed his possible representation.⁵²
55. RF recalled that he explained to Owen about the conflict and also explained that he might be able to get a grant of aid for another lawyer to represent him. RF believed Owen understood and he seemed normal after their conversation and did not seem sad about it. RF saw and spoke to Owen several more times during the morning and he did not think Owen was behaving out of character throughout this time.⁵³
56. However, one of the other prisoners in the unit recalled Owen appeared upset at about 10.00 am on the day of his death, after getting off the phone. He was complaining about not being represented by ALS. Owen apparently then played some table tennis then went to his cell. A prisoner checked up on him and gave him a few cigarettes. He seemed quiet but said he would 'push through it'. Owen gave no indication that he was thinking of harming himself at that time.⁵⁴
57. Owen's cellmate, TF, was Owen's cousin. He recalled that Owen had been talking about the letter from ALS and the fact that ALS couldn't help him. He also mentioned that he wanted to get back with Ms McVee. Owen said he didn't know what to do if he couldn't be with her.⁵⁵
58. Ms McVee told police after Owen's death that she believed a large factor that contributed to his death "was that he could not contact his main support person,"⁵⁶ which was Ms McVee. It was necessary for Ms McVee to be protected from contact as a consequence of the ongoing domestic violence that had occurred as a result of Owen's drug use. However, Ms McVee told police Owen had little extended family support, so she understood losing his regular contact with her affected him a lot.⁵⁷
59. Owen still had a lot of contact with his children, particularly his oldest son Jamaine, but in the last few days prior to his death he was struggling to get through and had limited phone credit left from his weekly allowance on 10 August 2023. A fellow prisoner, AW, recalled that Owen's desire was to get out of prison and reunite with

⁵² T 162 – 163; Exhibit 1, Tab 20.18.

⁵³ Exhibit 1, Tab 10.

⁵⁴ Exhibit 1, Tab 11.

⁵⁵ Exhibit 1, Tab 2, p. 5.

⁵⁶ Exhibit 1, Tab 8 [46].

⁵⁷ Exhibit 1, Tab 7.

his partner and children. Owen had mentioned problems communicating with his partner and a week before he died he had apparently had a few bad phone calls with his family, although he didn't elaborate on what was the problem.⁵⁸

60. Later review of Owen's phone records show Owen had spoken to his mother on 2 August 2023 and discussed a death in the community and issues getting through to his children and his lawyer. Over the following days he managed to speak with his daughter, his brother and his lawyer and he generally seemed to be focussed on his upcoming court proceedings and obtaining some money in his account. He did not mention any thoughts of self-harm and did not appear to be experiencing any conflict issues with anyone within the prison.⁵⁹
61. Call records show Owen tried to call three of his children a little before 11.30 am on 10 August 2023. He spoke to Jamaine for a short time, but when he tried to call Jamaine again a short time later, he didn't have any credit left. It appears he made the last call just before he returned to his cell at 11.32 am.⁶⁰
62. One of the prisoners in the unit, JN, was related to Owen and he considered Owen to be his uncle. JN shared a cell with another of Owen's relatives, RF. Their cell was next to Owen's cell in the unit. JN had been playing table tennis with Owen that morning until the lunchtime muster and he saw Owen going into his cell for lunch. JN had popped into Owen's cell to get a smoke and at that time Owen was in his cell alone as Owen's cellmate was working in the kitchen. As JN left the cell, he recalled Owen was listening to music and eating his lunch. JN closed the cell door as he left, leaving Owen in the cell on his own.⁶¹
63. Once the prisoners had an opportunity to collect their meals and take them back to their cells, the lunchtime muster was conducted. This commenced at about 11.30 am and took around 20 minutes. After all prisoners were accounted for, the prison officers then secured the landing grills so the prisoner officers could have their own lunch break. While the grill to landing is locked during this period, prisoners can still come and go from their cells and socialise. The lunch break ran from about 11.50 am to 1.00 pm.
64. Another relative of Owen's, RG, is recorded on CCTV footage opening and closing the door to Owen's cell at 12.36 pm. He recalled looking into the cell at the top bunk, where he knew Owen always slept. The room was quite dark, but from what he could see, Owen wasn't on the top bunk, so he simply left the room again.⁶²
65. Once the lunch period concluded, prison officers commenced getting the work party prisoners together so they could move them to their necessary locations for work, visits, education or medication rounds. Everything had seemed like an ordinary day

⁵⁸ Exhibit 1, Tab 11.

⁵⁹ Exhibit 2, Tab 22.

⁶⁰ Exhibit 1, Tab 16; Exhibit 2, DIC Review Report.

⁶¹ Exhibit 1, Tab 9.

⁶² Exhibit 2, Tab 1.18.

so far, but it was at this time, at around 1.05 pm, that the alert sounded as Owen was discovered hanging in his room.⁶³

66. JN had returned to Owen's cell to open the door for him after lunch as he understood that Owen's cell door was broken and couldn't be opened from the inside. When he opened the door he noticed the room was dark and he concluded that Owen had closed the curtain. The music had stopped and the room was quiet. JN looked towards the chair where he had last seen Owen eating his lunch. Even in the dark, he could see the chair was empty. JN checked the top bunk to see if Owen was in bed asleep but he could see he wasn't in bed and he could see Owen wasn't using the toilet. Uncertain where Owen had gone, JN began to leave the cell. However, as he was walking out, he suddenly saw Owen hanging from the cupboard. JN could see Owen had his spare bed sheet tied around his neck. He was leaning forward, being held up by the sheet around his neck. JN put his arms around Owen, lifted him up to support his weight and released the sheet from the cupboard while calling out for help.⁶⁴
67. JN's cellmate, RF was watching a movie in his cell at around 1.00 pm when he heard a scream from JN. He went to see what was happening and was directed by other prisoners to Owen's cell. He looked in and saw JN holding Owen, who appeared to be hanging from the top right of the cell with a white bed sheet around his neck. He could see JN was trying to support Owen's weight as Owen was unresponsive. RF immediately went to help as he is senior first aid trained. They lowered Owen to the floor and RF untied the knot of the ligature around Owen's neck. He checked for a pulse and, after finding no pulse, they laid Owen on his back and started CPR. He recalls that Owen seemed paler than normal and his skin felt cold to the touch as he was performing CPR.⁶⁵
68. A number of prisoners gathered on D Landing and began yelling to attract the attention of the prison officers. Officer Knulman was in the control room, approximately 10 metres from D Landing, at the time and he could hear prisoners yelling out but couldn't hear what they were saying. He couldn't leave the control room but could see them on the CCTV camera and could tell by the way they were waving their arms and facial expressions that something was wrong. As a result he called a code amber so officers would go to D Landing and ascertain the problem.⁶⁶
69. The code amber was called on D Landing at 1.05 pm and various prison officers immediately attended. The Code was called by the control officer who could see numerous prisoners appearing distressed and yelling out on the CCTV, although they couldn't hear what the prisoners were saying. Prison Officers Tomcsanyi and Stirling were the first on the scene. They recalled that as they approached the locked grill of the day room of D Landing they saw a number of prisoners standing at the grill. The prisoners were calling out to the prison officers for help and asking them to hurry up.

⁶³ T 21 - 23; Exhibit 2, Tab 1.14.

⁶⁴ Exhibit 1, Tab 9.

⁶⁵ Exhibit 1, Tab 10.

⁶⁶ Exhibit 2, Tab 1.12.

Both officers recalled at least one prisoner saying, ‘someone is dying down here.’ Once the grill was opened, the prisoners pointed the way to the relevant cell.⁶⁷

70. Officer Tomcsyani and Officer Stirling quickly proceeded down the landing to cell D10, where they found Owen lying on the floor of his cell with another prisoner, RF, performing CPR on him. Officer Tomcsyani noted Owen was not breathing and could see what appeared to be a ligature that had already been removed. Officer Tomcsyani immediately called to upgrade the incident from a Code Amber to a Code Red medical emergency over the radio then entered the cell and did a quick assessment on Owen. With the help of Officer Stirling, he then moved Owen out of the cell and onto the landing so that there was sufficient room to perform CPR. Officer Stirling commenced compressions while Officer Tomcsyani performed mouth to mouth. Other officers took steps to lock the remaining prisoners into their cells so that the area would be secure and accessible for ambulance staff when they arrived.⁶⁸
71. The emergency Code Red was called at 1.08 pm and prison health staff immediately attended the location in response. Dr Fontana took the lead in resuscitation efforts on arrival and continued to coordinate the resuscitation efforts, with the help of nursing staff and prison officers, until the ambulance crew arrived.⁶⁹
72. St John Ambulance WA received a call from the prison at 1.13 pm and an ambulance arrived at the prison at 1.23 pm. The SJA staff were immediately taken inside and they were by Owen’s side at 1.33 pm. On arrival, a defibrillator was in use and a doctor was in attendance. The doctor explained that no shocks had been delivered following the directions on the defibrillator. The SJA crew took over Owen’s care and advanced life support was undertaken while Owen was transferred to the ambulance.⁷⁰

CAUSE OF DEATH

73. Owen was taken by ambulance to Albany Hospital. He arrived at the hospital at 2.10 pm with CPR still in progress. Hospital staff took over his care and assessed him for signs of life. A defibrillator showed no shockable rhythm, despite adrenaline being administered, and after a full assessment it was determined that Owen could not be recovered. Owen’s death was certified by an ED physician at Albany Hospital at 2.19 pm on 10 August 2023.⁷¹
74. Forensic Pathologist Dr Reimar Junckerstorff performed a post mortem examination on 16 August 2023. The examination showed a middle-aged Aboriginal man with a ligature mark on the neck, that was compatible with the supplied ligature, and fractures in the front of the neck, that may be seen in hanging. There were signs of attempted resuscitation consistent with the known history. The examination found

⁶⁷ T 23, 32 - 33.

⁶⁸ T 24, 31; Exhibit 1, Tab 13.

⁶⁹ Exhibit 1, Tab 17.

⁷⁰ Exhibit 1, Tab 14.

⁷¹ Exhibit 1, Tab 3 and Tab 21.

focally moderate to severe coronary artery disease and focal changes of emphysema in the lungs. Specialist neuropathology examination of the brain showed no significant abnormalities. Toxicology analysis showed the presence of the antidepressant amitriptyline and its metabolite. No alcohol or common drugs were detected.⁷²

75. At the conclusion of all post mortem investigations, Dr Junckerstorff formed the opinion the cause of death was ligature compression of the neck (hanging). I accept and adopt Dr Junckerstorff's opinion as to the cause of death.⁷³

MANNER OF DEATH

76. WA Police were notified of Owen's sudden death at 2.19 pm, immediately after his death was certified at the hospital. Police officers from Albany Detectives Office attended the hospital first and then went to the prison. They conducted an investigation into the circumstances of Owen's death, which included examining Owen's cell where he was found hanging, reviewing CCTV footage and speaking to prison staff and numerous prisoners who were present in the unit at the relevant time, including some prisoners who were relatives of Owen and knew him well. Detectives attended the prison to determine whether there was any evidence of criminality involved, and after satisfying themselves there were no suspicious circumstances and nothing to suggest third party involvement, the investigation was given to uniformed officers to complete the coronial investigation.⁷⁴
77. The notes of discussions with a number of prisoners who had interacted with Owen that day indicated the prisoners had thought he seemed fine, although a little quiet. They were aware he had been having arguments with his partner, he had been trying to get in touch with other family members but couldn't get through by telephone and he was concerned about the letter he had received from ALS. Some prisoners mentioned a broken lock on the cell door for a few months, which had meant it couldn't be opened from the inside, but it is unclear how that was connected to the events of the day, if at all. The issue of the lock was explored further during the inquest and is discussed later in this finding, but I note at this stage that due to the statements made by other prisoners about the lock, a large number of photographs of the lock were taken by the WA Police forensic officers.⁷⁵
78. The police reviewed Owen's telephone records, which supported the prisoners' recollections that Owen had been making calls to family members in the week leading up to his death. He had spoken to his children a number of times, but it seems he had been having trouble getting through on the last day of his life. He has also telephoned ALS.⁷⁶

⁷² Exhibit 1, Tab 5 and Tab 6

⁷³ Exhibit 1, Tab 5.

⁷⁴ T 9 - 10; Exhibit 1, Tab 2, Tab 12 and Tab 15.

⁷⁵ T 11 - 12; Exhibit 1, Tab 11, Tab 12.2.

⁷⁶ T 10 - 11.

79. Overall, the evidence from the prisoners indicated Owen was struggling to cope with not being able to talk to Ms McVee and difficulty getting through on the phone to his children. His mood was further negatively affected by the letter from ALS that morning, which his cellmate, TF, believed was the trigger for Owen to impulsively go into his cell and hang himself. I find the manner of his death was by way of suicide.

INDEPENDENT REVIEW

80. Dr Adam Brett is a Consultant Psychiatrist with extensive experience in forensic mental health in Western Australia. Dr Brett has prepared expert reports for many courts in this State, including the Coroners Court, and currently holds a clinical position in the Magistrate Courts' Start Court/Mental Health Court as part of the Mental Health Court Diversion and Support Program. Dr Brett was asked to review Owen's relevant records and provide an opinion as to the quality of the mental health care provided to Owen at Albany Prison in the months prior to his death, including the decision with respect to his removal from ARMS and his overall support and supervision while in custody within the context of his known history of suicidal ideation.⁷⁷
81. Dr Brett reviewed Owen's history and observed that Owen had experienced trauma as a child and had poor coping skills as an adult, so he turned to alcohol and drugs on an increasing basis. Owen had not been diagnosed with a major mental illness (such as schizophrenia or bipolar disorder) but he had been diagnosed with anxiety and depression, which can cause significant problems for an individual. He had been treated with medication but was often non-compliant, which may have impacted on his symptoms as Dr Brett noted there is a significant withdrawal symptom when a person stops medication, so it should be managed slowly over time.⁷⁸
82. Dr Brett noted that Owen underwent a PHS risk assessment on 29 May 2023, two days after being remanded in custody at Albany Prison and Dr Brett considered the review to be a comprehensive review that properly outlined Owen's previous and current problems. It was noted in the review that Owen was unable to guarantee his safety and an increase in his stress levels was predicted if he was placed in the general population, so he was placed on ARMS with regular monitoring. Dr Brett considered the "plan was clearly articulated and the rationale for the decision was easy to follow."⁷⁹ Dr Brett observed that Owen was "very vulnerable"⁸⁰ at this time, given what had been happening for him while in the community, and it was appropriate for him to be closely monitored at that stage.
83. In his report, Dr Brett referenced the prevalence of studies that demonstrate there is a much greater demand for mental health and counselling services for prisoners, particularly when they are remanded into custody and have a lot of acute stressors, like Owen did. However, given the prevalence of problems with the majority of the

⁷⁷ Exhibit 1, Tab 27.1.

⁷⁸ T 91 - 92.

⁷⁹ Exhibit 1, Tab 27.2 [6], p. 2.

⁸⁰ T 94.

prisoners, it is difficult for the prison health staff to provide the individual service that is required. Dr Brett commented that Justice Services need to look more seriously at how they can implement a more therapeutic approach to imprisonment, which is currently seriously lacking in our custodial system, but it seems that will require significant resourcing as well as a change in approach.⁸¹

84. Based upon what is currently in place, Dr Brett commented that Owen's PRAG review later that same day provided sensible input, noting Owen was coming down off methamphetamine and alcohol, so he was to remain on moderate ARMS. Dr Brett also considered there was a clear rationale for the reduction to low ARMS on 1 June 2023. Dr Brett noted that Owen had been on ARMS before when incarcerated and transitioned off ARMS once settled without major incident, which was reassuring for the staff dealing with Owen as they had that experience with him longitudinally. However, it also showed that Owen's mental health needs had not been addressed, both in the community and in prison, as he was continuing to struggle with suicidal ideas and low mood and still using substances when released.⁸²
85. It was noted that Owen was seen again by psychological health services staff by MS Teams video link on 2 June 2023 and 8 June 2023. Dr Brett observed that unfortunately post-COVID remote counselling services are being used more often and in his view it is suboptimal as it is "much harder to build rapport."⁸³ Dr Brett accepted that it is easier if you already know the client and have established a relationship face to face, however he believes a lot of clients still struggle with remote counselling sessions,⁸⁴ which appeared to be the case for Owen. Nevertheless, Dr Brett agreed that remote video assessments are certainly better than nothing, if that is the alternative.
86. On the second occasion, there was a documented improvement in Owen's mental health and Dr Brett considered the conclusions and recommendations made on that date reflected this improvement and he considered they were sensible changes. At that time, it was noted that Owen was accepting of the possibility of future incarceration following his next court hearing.⁸⁵
87. Dr Brett observed that at the PRAG review on 8 June 2023, most sources recommended his removal from ARMS other than PHS. PHS recommended that he remain on ARMS due to the residual effects of his polysubstance use and fleeting suicidal ideation. However, his strong protective factors were noted and, in the end, there was a group decision to remove him from ARMS.⁸⁶
88. From that time, Owen was seen by PHS on 9 and 14 June 2023 and he generally seemed to be doing well, with a marked improvement in his demeanour and mood noted on 14 June 2023. He was first seen by a GP on 28 July 2023 and prescribed amitriptyline, a tricyclic antidepressant, to be taken at night. Owen had been

⁸¹ T 97.

⁸² T 93 - 94; Exhibit 1, Tab 27.2.

⁸³ T 96.

⁸⁴ T 96.

⁸⁵ Exhibit 1, Tab 27.2.

⁸⁶ Exhibit 1, Tab 27.2.

prescribed amitriptyline (as well other antidepressant medications) in the past, both in prison and in the community, but generally his compliance with antidepressant medications had been poor.⁸⁷

89. Dr Brett gave evidence the amitriptyline would likely have had a positive effect on Owen's sleep in the short period he had recommenced taking it in late July/early August 2023, which would help improve his state of mind, but it is unlikely it would have had an effect on his depression at that early stage. Dr Brett commented that for someone with depression and acute needs, Owen would have benefitted from seeing a GP earlier than two months after his re-admission to prison. However, Dr Brett considered the mainstay of Owen's treatment should have been psychological therapy, as medication was not going to alter the things that were happening in his life which were causing him to be depressed.⁸⁸
90. Dr Brett noted that Owen made 50 phone calls between 3 to 9 August 2023, with 48 of those calls being to his children. He also made a call to his kinship mother on 8 August 2023 and told her that after his trial in October he planned to travel to Queensland to visit family and get away from his partner, since he could not contact her. Dr Brett observed that the calls showed Owen wanted to talk to people, and that's where the lack of regular psychological input⁸⁹ was important as it's clear he was looking for support. Dr Brett agreed the letter from ALSWA indicating they could not represent him would also have been a destabilising influence, as it would likely have felt to Owen like many of his usual supports were not available to him.⁹⁰
91. On 10 August 2023, Owen spent some time with his nephew, JN, who was allocated the cell next to Owen. They played table tennis together during lunch and they spoke briefly in Owen's cell after lunch, at which time he said he was alright. Other prisoners also recalled that Owen seemed his usual self around this time. JN later found Owen hanging that afternoon.⁹¹
92. Dr Brett concluded from the notes that Owen had a long history of mental health concerns and it is clear his mood had been worse in 2022 due to multiple deaths of family members. He had been given psychological support in prison in late 2022 to try to work through his grief. Owen had been on ARMS during this previous incarceration, but had been removed from ARMS in December 2020 and remained off ARMS from that time until his release in April 2023. He had told PHS that he would reach out to them if he needed further help, but he seemed to manage without requiring extra support. Owen was given suggestions for community counselling options for when he was released, but it doesn't seem he accessed them when he was eventually released in April 2023.⁹²
93. When he returned to prison in May 2023, he was once again struggling with his mental health. In his report, Dr Brett commented that he believes Owen had a

⁸⁷ Exhibit 1, Tab 27.2.

⁸⁸ T 101 - 103; Exhibit 1, Tab 27.2.

⁸⁹ T 104.

⁹⁰ T 104; Exhibit 1, Tab 27.2.

⁹¹ Exhibit 1, Tab 27.2.

⁹² Exhibit 1, Tab 27.2.

number of mental health issues at the time of his death, with a documented history of poor coping mechanisms, low mood, substance abuse and suicidal ideas. He had had trials of antidepressant medication but demonstrated poor compliance. Dr Brett expressed the opinion that the mainstay of Owen's management should have been psychological to address his coping mechanisms and strategies to address his substance use.⁹³

94. Dr Brett observed that the Principles of Forensic Mental Health suggest that prisoners should get equivalent care to community members and in his view Owen's mental health care was probably more comprehensive in prison than when he was in the community. In prison, he received counselling, substance abuse work, peer work and medical reviews. His support team explored community options for management for when he was released and he was seen by members of a team that had good longitudinal knowledge of him. Accordingly, Dr Brett considered that the mental health care provided to Owen in Albany Prison in the months prior to his death was "good and appropriate."⁹⁴
95. Dr Brett believes the decisions to remove Owen from ARMS were well documented and reasoned and he expressed the opinion the decisions were appropriate and consistent with previous decisions regarding Owen in the past, and from which he had not suffered any adverse outcomes.⁹⁵
96. Dr Brett observed that suicide is very difficult to predict. Suicide risk can be managed, to a certain extent, and the steps put in place for Owen to manage his risk had been appropriate and there were no acute risk factors noted to be present before his death. He had appeared future oriented and to have a reasonable understanding of his legal challenges. Dr Brett believes that within the context of the resources available, Owen was given sufficient support and supervision and he had a good therapeutic alliance with the prison counsellor, who had long term knowledge of Owen.⁹⁶
97. Dr Brett observed Owen had a lot of static or long-term risk factors such as trauma and poor coping skills and there was no release valve for him for many of the things troubling him. If something situational then occurred, such as a bad phone call with someone or a letter from his lawyers, his risk would change from a chronic risk to a more acute risk and this change in risk needed to be managed and the supports needed to be reactive to the changing situation. Unfortunately, without Owen sharing with others how he was feeling, it was unlikely to have been understood by those around him that his risk to himself had become more acute again that day.⁹⁷
98. Whilst there was a lot more that might have been able to be done to address Owen's risk factors if there had been greater resources available, Dr Brett acknowledged that the medical and psychological support Owen received was compatible with what he would have got in the community. Dr Brett considered Owen would have benefitted

⁹³ Exhibit 1, Tab 27.2.

⁹⁴ Exhibit 1, Tab 27.2 [3], p. 8.

⁹⁵ Exhibit 1, Tab 27.2.

⁹⁶ Exhibit 1, Tab 27.2.

⁹⁷ T 106 – 108, 110.

from being seen more frequently by the counsellors, and he accepts the clinicians would have done so if the resourcing had permitted, but within the constraints of the resources Dr Brett considered Owen was given good care by the clinicians involved.⁹⁸

99. Having expressed his opinion that Owen's support and supervision was sufficient, and following on from the comments noted above, Dr Brett observed that prisoners have high rates of mental disorder and a number of risk factors for suicide, with some statistics indicating 24% of men remanded in prison have attempted suicide previously and 16% have suicidal ideation in the month before imprisonment. Imprisonment then carries its own risks. Given these statistics, Dr Brett believes that the mental health resources in the prisons are insufficient to meet those needs. That includes both staff resourcing and the infrastructure, which is not therapeutic and does not meet the mental health needs of the clients. However, he does not believe this lack of resources impacted specifically on Owen's care.⁹⁹
100. The primary suggestion that Dr Brett offered as a possible alternative that might have helped Owen, and potentially changed his trajectory, was if a mental health court diversion program might have been available to him. Dr Brett is involved in the Start Court in Peth and gave evidence that he has seen firsthand how involvement with a program like it can address the various factors (eg: trauma, mental health, substance use, offending behaviours) that contribute to recidivism. He noted Owen had cycled through the prison system many times and he believes if Owen had been given the opportunity to engage with a more holistic treatment approach it may have helped him to break the cycle. Dr Brett considered Owen would have been suitable for the program from a mental health perspective, but Dr Brett acknowledged that he was unaware of Owen's specific legal matters, which might have affected his suitability for the program.¹⁰⁰
101. Overall, Dr Brett expressed the opinion there is a need for the clinical governance of mental health services, including psychological services, in the justice system to be reviewed as in his view it is currently "severely lacking."¹⁰¹ There are no psychiatrists involved in clinical governance now and very few psychiatrists in the whole prison system as they cannot attract staff to the available positions. The same applies to mental health positions, which was demonstrated in Albany Prison as there was no mental health nurse on site during Owen's last period of imprisonment. In Dr Brett's view, the failures in infrastructure, such as the absence of a Crisis Care Unit at Albany Prison, is just one aspect of the whole clinical governance of mental health services in prisons in Western Australia at the present time. Dr Brett expressed his view that mental health should be leading risk assessments, rather than how the PRAG group is currently configured, namely chaired by a non-clinician. However, Dr Brett still accepted that Owen's documented care generally demonstrated a reasonable approach was taken towards reaching a consensus approach.¹⁰²

⁹⁸ T 106 - 107.

⁹⁹ T 98; Exhibit 1, Tab 27.2.

¹⁰⁰ T 109; Exhibit 1, Tab 27.2.

¹⁰¹ T 98.

¹⁰² T 98 - 100.

102. In addition, Dr Brett advocated for a broader consideration of how a more therapeutic approach can be taken within the prison system for offenders like Owen, who would benefit from programmes designed to address his complex trauma and associated mental health and substance use issues and support him to make longer term changes that he can maintain in the community and break the cycle of reoffending. Dr Brett expressed the opinion the Health Department should take over the care of mental health in prisons and provide care by way of multidisciplinary teams to address the unmet mental health needs of the prison cohort, amongst which the prevalence of chronic suicidal risk factors is high.¹⁰³
103. In conclusion, in Owen's case Dr Brett emphasised that he made no criticism of the individual clinicians involved in Owen's care and considered they identified and documented all of his risk factors quite well and managed his initial acute risk appropriately. However, they did not have the resources to provide the ongoing psychological assistance that Owen needed, and which had the potential to change the trajectory for him, both in terms of reoffending and risk of harm to himself. Dr Brett also considered that Owen would potentially have benefitted from a more culturally appropriate mental health service, with the use of Aboriginal support workers, although noting that not all Aboriginal people want to make use of such services.¹⁰⁴

DEPARTMENT'S INTERNAL REVIEWS

DIC Review Report

104. The Department of Justice conducted a Death in Custody Review (DIC Review) following Owen's death. The report prepared following that review was provided by the Director General to the State Coroner on 25 November 2024. Ms Toni Palmer, a Senior Review Officer at the Department, spoke to the report at the inquest.¹⁰⁵
105. In the report, Ms Palmer, identified that Owen was placed on ARMS with two hourly observations and into a ligature minimised cell while awaiting review by PRAG, and then he remained on moderate ARMS until 1 June 2023, when his ARMS status was reduced to low ARMS with four hourly observations. Finally, Owen was removed from ARMS on 8 June 2023. The report writers formed the view these processes were properly documented and showed that considerable thought was given to Owen's specific circumstances before each decision was made.¹⁰⁶
106. In terms of the ligature minimisation of cells, it is noted in the DIC review that the PRAG had considered whether Owen should be placed in a ligature minimised cell (which are only available in E Block) and it was determined it was not necessary. Owen was instead housed in a cell D10, a double occupancy cell, in Unit 3 D-Landing.¹⁰⁷

¹⁰³ T 109 - 111.

¹⁰⁴ T 110 – 112.

¹⁰⁵ Exhibit 2, DIC Review Report.

¹⁰⁶ Exhibit 2, DIC Review Report.

¹⁰⁷ Exhibit 2, DIC Review Report.

107. The DIC Review Report identified an initial discrepancy in the telephone records, as the Prisoner Telephone System call report indicated five telephone calls were made on Owen's telephone account between 11.52 am and 11.58 am on the day he died. However, CCTV showed he returned to his cell at approximately 11.32 and did not leave his cell again. Enquiries established that the Prisoner Telephone System was approximately 12 minutes fast, which explained the discrepancy and confirmed that Owen made the phone calls before going to his cell for the last time.¹⁰⁸
108. The DIC Review considered the CCTV footage and compared it with other statements of prison officers and prisoners who interacted with Owen, and all accounts were consistent with what happened in terms of Owen being found in his cell by a relative first and another prisoner, and then prison officers and medical staff, performing CPR until SJA staff arrived and took Owen away and transported him to hospital. It was noted in the review that witnesses had confirmed that, despite what was recorded on some paperwork, Owen was not restrained during his transfer to hospital or while at the hospital prior to his death.¹⁰⁹
109. After Owen was taken to hospital, prison officers secured his cell until police officers arrived to conduct their investigation.¹¹⁰
110. Shortly after Owen's death, steps were taken to remove the wardrobe doors from prisoners' cells, given Owen had used the door as a ligature point.¹¹¹
111. Sometime after Owen's death, Albany Prison Senior Management Team also conducted a 'Lessons Learned' session on 15 May 2024, which noted the following relevant areas for improvement:¹¹²
- Owen was housed in an old cell. Although it was a 'three point ligature minimised cell', which meant the three most obvious hanging points had been removed, there were still multiple ligature points present, one of which (the hinge of the door of a wardrobe fixed to the cell) was used by Owen to hang himself;
 - The Offender Movement Information and Transfer and Discharge Sheet incorrectly recorded that handcuffs and leg irons were applied while Owen was transported from the prison to hospital.;
 - The reason for not placing Owen on SAMS following removal from ARMS was not documented – whereas the policy requires it must be well documented and the rationale for the decision should be outlined.
112. In relation to the cell door, an immediate audit of the cells within Albany Prison was conducted to identify cells with the same wardrobe as the one in Owen's cell. The doors of all of these wardrobes were then removed.¹¹³

¹⁰⁸ Exhibit 2, DIC Review Report and Tab 1.16.

¹⁰⁹ T 156; Exhibit 2, DIC Review Report.

¹¹⁰ Exhibit 2, DIC Review Report.

¹¹¹ T 151 – 152.

¹¹² T 153 - 154; Exhibit 2, DIC Review Report, p. 16 and Tab 1.22.

¹¹³ Exhibit 2, Tab 1.22, p. 12.

113. In relation to the second issue, clarification was sought directly from the officers involved to ensure appropriate processes had, in fact, been followed and some consideration was to be given to how the information could be better documented in future cases and compliance with the policy improved more generally.¹¹⁴
114. For the SAMS documentation, the recommendation was for all PRAG Chairs to be reminded of the need to document within TOMS the rationale for not placing a prisoner on SAMS and the information considered as part of that decision-making process.¹¹⁵
115. It was confirmed on 30 September 2024 that all of the other recommendations had also been completed.¹¹⁶
116. Given there was some concern about why prisoners were yelling out to prison officers at the landing gate, rather than pressing the cell call button to speak to the Control officer, A/Superintendent Pedrick was asked about education of prisoners on the use of the cell call system. A/Supt Pedrick advised that all prisoners are educated on the use of the cell call system on orientation, but in situations like the one involving Owen, when prisoners' emotions are understandably heightened, it is not uncommon for the prisoners to try to yell out to attract the attention of officers when they are not locked in their cells.¹¹⁷
117. Ultimately, the DIC Review concluded that Owen's custodial management, supervision and care were in accordance with the Department's internal procedures policies and, noting the improvements identified in the lessons learned process had been implemented, no further business improvements were recommended.¹¹⁸

Health Services Summary

118. In addition to the DIC Review, the Department also provided to the Court a Health Services Summary¹¹⁹ and Dr Catherine Gunson, Deputy Director of Medical Services, spoke to the report at the inquest. It was noted that on reception to prison, Owen had some ongoing health problems, including gastro-oesophageal reflux disease but he advised he was not taking any prescribed medications whilst in the community. His history of mental health issues was also noted and he complained of insomnia. Owen denied active suicidal ideation when speaking to health staff, although he did tell a nurse he felt stressed and had trouble sleeping and requested medication to help his sleep and low mood. He had reported a high level of alcohol and illicit drug use while in the community, and a history of solvent use as a child, so he likely had some withdrawal symptoms on return to custody, which would have negatively affected his mood.¹²⁰

¹¹⁴ Exhibit 2, Tab 1.22, p. 13 – 15.

¹¹⁵ Exhibit 2, Tab 1.22, p. 16.

¹¹⁶ T 156 - 157; Exhibit 2, DIC Review Report, p. 16.

¹¹⁷ T 152 - 153; Exhibit 2, DIC Review Report.

¹¹⁸ T 150 - 151.

¹¹⁹ Exhibit 1, Tab 10.

¹²⁰ Exhibit 1, Tab 10 [3.1].

119. Dr Gunson commented in her evidence that if she had been involved in Owen's readmission, she would likely have started him on a multivitamin, thiamine and magnesium as a starting point, given his history of heavy alcohol consumption. However, this was more from the perspective of best practice than a particular failing in Owen's medical care.¹²¹
120. Owen was started on the antidepressant amitriptyline while in custody, but the first medication dose was not dispensed until 5 August 2023. Dr Gunson advised the medication at the dose he was prescribed would be expected to help with both sleep and mood symptoms. It would have taken at least a couple of weeks for all of the positive effects of the medication, so he was unlikely to have yet felt the full benefit at the time of his death, but it should have had an immediate effect on his ability to sleep. Consistent with Dr Brett's observations, Dr Gunson commented that better sleep patterns would have had an indirect benefit to Owen's overall mental state. In the past, Owen had been non-compliant with similar medications or asked to come off them, so it's also unclear if he would have been willing to stay on it long-term, although this time he had taken every prescribed dose up to his death, with the last given on the evening of 9 August 2023.¹²²
121. Dr Gunson observed that it was also unclear whether Owen's depressive symptoms were endogenous (due to a lack of serotonin) or simply a normal response to a stressful situation, which would have impacted on the effectiveness of the medication. Dr Gunson commented that it is common for prisoners who are released into the community and then return to prison in a very short space of time to have difficulty coping at first, as everything has changed so rapidly. They have just had time to get used to being back at home when they are locked back up again, and they will often have feelings of regret around the circumstances that have led to them going back into prison. In those cases, antidepressants haven't been shown to be as useful. In that respect, Dr Gunson agreed with Dr Brett's opinion that for Owen, counselling and support would have been his primary therapy.¹²³
122. Prior to his death, Owen had some bloods taken for a metabolic screen and he had been placed for follow-up review, but he died before the follow-up appointment took place. However, there is nothing to suggest he had any significant physical health issues at that time. His poor dentition had been noted, but he declined offers of dental review.
123. The conclusion of the Department's internal health review was that Owen's health care in custody during his last period of imprisonment was holistic and patient-centred and, overall of a standard equivalent to or better than the standard of care he would have received in the community. This is consistent with the independent opinion of Dr Brett.

¹²¹ T 175 – 176.

¹²² T 168 – 169, 172 - 173; Exhibit 1, Tab 10.

¹²³ T 170 – 175.

124. To the best of their knowledge, none of the prison officers recalled any concerns being raised by any prisoners in relation to Owen's welfare prior to Owen being found hanging.¹²⁴

Cell Door Lock

125. As noted above, when police attended the prison after Owen's death, some of the prisoners told the police officers that they believed Owen's cell door lock had been broken so he had been unable to open his cell from the inside. Owen had been placed in cell D10. The photographs show it had what was referred to as a 'pop button lock' on the inside, the style of which is to reduce the risk of a cell door handle being used as a ligature point.¹²⁵
126. Senior Constable Michael Fazio was the investigating officer for the coronial investigation and as part of his enquiries, he contacted Mr Craig Tester, the Security Manager at Albany Prison, to enquire whether there was any record of Owen's cell door internal locking device/handle being broken or missing. Mr tester indicated that to his knowledge there were no maintenance reports to record an issue with the cell locking mechanism and he did not find any records that the prisoners in D10 had reported such a problem in their cell. Mr Tester also checked CCTV footage, which showed Owen going in and out of his cell on 10 August, in the hours prior to his death, and the door appeared to be opening and functioning correctly at that time and Owen appeared able to enter and leave freely without assistance.¹²⁶
127. Evidence was given at the inquest that if a cell lock was not functioning, generally a maintenance lock request would be submitted and the cell would be decommissioned until the repair was completed. An issue with an internal cell door lock would either be brought to the attention of officers by a prisoner, or it would be anticipated it would be identified during the cell condition inspection conducted every Saturday, which would include officers checking the inside of the personal lock on the door.¹²⁷
128. Enquiries located a maintenance hazard repair request to the Albany Prison Superintendent that showed the personal locks in D10 (Owen's allocated cell) and two other cells in D wing of Unit 3 had personal barrels missing or loose. That report was lodged on 10 June 2023 and Owen was moved into the cell on 18 June 2023, so evidence was given that the issue should have been repaired in the period between 10 June and 18 June 2023.¹²⁸
129. Following the inquest, the Department provided additional information in relation to the status of the personal lock on cell D10. It was indicated that there had indeed been an issue identified with the personal barrel of the cell lock in D10 being either missing or loose on 10 June 2023. Owen had not moved into the cell until 18 June 2023, when another prisoner who had been in the cell moved out. A further cell checklist conducted on 15 July 2023 also showed an issue with the internal personal

¹²⁴ Exhibit 1, Tab 13; Exhibit 2, Tab 1.14.

¹²⁵ T 12; Exhibit 1, Tab 2 and Tab 20.

¹²⁶ T 13 – 14, 17 - 18; Exhibit 1, Tab 2.2 - Email from Craig Tester dated 21 August 2024.

¹²⁷ T 26 – 30, 36 - 37.

¹²⁸ T 159 – 161; Exhibit 3.1 and 3.2.

lock on cell D10, with it noted to be missing, but then the checklist for the cell check conducted on 29 July 2023 did not identify any further issue with the personal lock on D10 (although it was still noted for another cell that had been noted to have a similar issue). The Department was unable to confirm the date the maintenance request was actioned, but the Assistant Superintendent Operations at Albany Prison indicated he was confident that the lock would have been fixed as a matter of urgency, and certainly before 10 August 2023.¹²⁹

130. Importantly, it was noted that where the personal lock is not functioning, the cell can still be locked and unlocked by prison officers and the prisoner could use the cell call system to contact the control officer if they needed assistance to get out of their cell at any time.¹³⁰
131. As I indicated at the inquest, I am satisfied in this case that there was no evidence before me that Owen's decision to take his life had any connection to a possible issue with his cell door lock. I note he had family members actively checking in on him and ensuring that he was able to come in and out when he wanted to do so.
132. Whilst the maintenance system itself does appear to have left something to be desired in terms of its accuracy and the follow up for maintenance (somewhat contrary to the direct evidence at the inquest), I am advised in 2024 the Department upgraded its paper-based maintenance request system to an electronic system. Therefore, I am satisfied that the tracking of the progress and completion of maintenance requests is now better managed and recorded.¹³¹

COMMENTS ON TREATMENT, SUPERVISION AND CARE

133. In terms of my comments about Owen's treatment, supervision and care, I am guided by the expert opinion of Dr Brett. In Dr Brett's opinion, the care was reasonable and appropriate, including the decisions in relation to Owen's ARMS rating being reduced and, ultimately, Owen being removed from ARMS entirely. I have reviewed the evidence of the interactions for myself and I respectfully concur with Dr Brett's opinion. I note the Department's Health Services Summary also reveals that efforts were made to monitor Owen's general health and provide him with medication that might assist with his mental health issues, although he was still in the early stages of treatment when he died.
134. Dr Gunson, who has extensive experience treating prisoners with mental health issues and conducting risk assessments, also expressed the opinion Owen received generally good medical care while in prison. Dr Gunson observed that the medical doctor who saw Owen prior to his death on 28 July had clearly asked Owen about his mental health and whether he had thoughts of harming himself, which likely had led to his disclosure of low mood and the prescription for amitriptyline. However, Dr

¹²⁹ Exhibit 4.

¹³⁰ Exhibit 4.

¹³¹ Exhibit 4.

Gunson considered Owen's thoughts of self-harm may have fluctuated greatly, over the space of a day or even hours, so his level of risk would have been variable.¹³²

135. I also note the evidence of Owen's fellow prisoners, including a number of close relatives who knew him well and had a lot of contact with him, indicates that Owen did not give any indication he was feeling suicidal on the day that he died. This included Owen's nephew, JN, who played table tennis with him in the morning and saw him eating his lunch in his cell, then found him hanging less than an hour later. JN indicated that he knew Owen had been going through some personal issues but Owen never spoke about it and always came out with a smile on his face, laughing and joking with the other prisoners, keeping up a brave front.
136. Successful acts of suicide are notoriously difficult to predict and there was nothing overt in his final days, or even on the day he died, that showed Owen had shifted back to a negative mindset and was intending to harm himself. While Owen was aware that he could self-refer to ARMS or seek out some of the other forms of support offered in the prison, it seems he chose not to seek that help prior to his death. However, it is also concerning that the evidence shows Owen had indicated a willingness to remain on the general counselling list, but no such counselling was offered to him in the weeks prior to his death due to staff resourcing constraints. I return to this issue later in this finding, but at this stage I simply note that there was a missed opportunity for Owen to speak to a trained counsellor and possibly disclose that he was struggling again.¹³³
137. In terms of resuscitation efforts, JN told police he believed Owen could have been hanging for around half an hour before he found him, based on the timeframe of when he saw him last and when he found him. JN told police he knew straight away that Owen was dead when he found him; it was clear to him that his soul had left his body. He specifically recalled Owen face was white, he wasn't breathing, he had no pulse, his chest was not rising and the sheet was very tight around his neck.¹³⁴ RF reached a similar conclusion, but both men still acted immediately to do everything they could to try to revive Owen, just in case. Sadly, despite their very prompt and best efforts, Owen had already died by that time and he could not be resuscitated.
138. I accept there was a very short delay between a Code Amber and a Code Red being called. In the short period before the prison officers were on the scene, Owen's relatives had already taken the appropriate steps to lower him to the floor, remove his ligature and commence CPR. One of them had senior first aid training, so he was well qualified to do this task, although I acknowledge it would have been very confronting and distressing for him and his nephew. I am satisfied the prison officers responded appropriately in the circumstances and all reasonable efforts were made to try to resuscitate Owen, but sadly he had already suffered an irrecoverable brain injury by the time he was first discovered.

¹³² T 179, 183.

¹³³ Exhibit 1, Tab 9.

¹³⁴ Exhibit 1, Tab 9.

COMMENTS ON AREAS OF CONCERN

139. While I accept that there was a reasonable level of care and support provided to Owen by the staff at the prison during his last period of incarceration, I note that this is within the context of the resources that were available. It was evident that those resources are limited and do not put the Albany Prison staff in the position to be able to be proactive in the support they offer to prisoners like Owen. Instead, they are largely crisis-driven.

Ligature Minimised Cells

140. Albany Prison does not have a Crisis Care Unit, so the safe-cells in the Multi-Purpose Unit are the only fully ligature minimised cells available to prisoners who are experiencing acute suicidal thoughts. The problem with these safe cells is they do not have access to a common area, which means the prisoners housed in these cells are quite isolated at a time when they might benefit from greater support. Ms Lauren was asked whether she could see any benefit to having fully ligature minimised cells within a mainstream unit, to create a safer space for prisoners who are experiencing thoughts of self-harm but who would benefit from greater social interaction? Ms Lauren agreed that it might provide a better balance between the need for extra monitoring on ARMS while still providing people with access to social support. Ms Lauren also supported having a designated crisis care unit at Albany Prison, rather than simply having safe cells available for that purpose.¹³⁵
141. Similarly, Mr Bergsma agreed that it might be helpful for some prisoners to be able to be in the general population unit, while being housed in a ligature minimised cell.¹³⁶
142. Ms Palmer, who spoke to the DIC Review Report, noted that Owen had been housed in a three point ligature minimised cell, which meant the most obvious hanging points (such as bars on the window) had been removed. She acknowledged that the wardrobe door was another hanging point, which Owen had utilised in this case. After Owen's death, the wardrobe doors were removed, but I understand other ligature points remain in the cell. As noted earlier in this finding, it is difficult to remove all of the ligature points and still make the cell comfortable for regular use. Further, as Ms Palmer noted, prisoners have been able to take their own lives even in a fully ligature minimised cell.¹³⁷
143. Nevertheless, the Department continues to run a ligature minimisation program. However, Ms Palmer gave evidence that it is expensive to retrospectively fully ligature minimise a cell, costing up to \$60,000 per cell. The Department includes requests for funding for ligature minimisation in its business plan submitted to Treasury, and whatever funding is allocated is then used by the infrastructure staff to determine which prisons and areas of prisons will be done next. The problem is that a lot of the existing prison infrastructure is old and requires significant retrospective

¹³⁵ T 85; Exhibit 1, Tab 29.

¹³⁶ T 147.

¹³⁷ T 154.

works. That is certainly the case for Albany Prison.¹³⁸ The ageing infrastructure of Albany Prison is well known, having been identified by the Inspector of Custodial services in his recent report on Albany Prison tabled in Parliament at the start of this year.¹³⁹

144. I note the suggestion in questioning that more fully minimised cells, or at least more than three point minimised cells, could be made available within general population units to assist at risk prisoners to feel supported by friends and family, whilst reducing the risk that they may impulsively harm themselves. I am not sure whether this is practical to implement, but I mention it for the benefit of the prison management to consider, particularly given the lack of a Crisis Care Unit at Albany Prison and the need to consider all options to reduce the risk.
145. Following the inquest, the Department provided additional information on the status of the Ligature Minimisation Program, indicating that the Department has upgraded 160 cells to full ligature minimisation status since 30 June 2022, with the cells upgraded at Hakea Prison and Melaleuca Prison. None of the upgrades were done at Albany Prison and it was noted that the Department's current ligature minimisation program ended on 30 July 2025, so the Department planned to seek additional resources to further extend the program across the prison estate.¹⁴⁰
146. I am aware that other coroners in other recent inquests have made recommendations that the WA Government prioritise funding to ensure Corrective Services (as part of the Department of Justice) is able to properly undertake the extensive program of work required to fully ligature minimise cells throughout the prison estates, including older prisons such as Albany Prison. Noting that the immediate response of the management team at Albany Prison was to rectify the specific ligature point that Owen used (namely the wardrobe door), I simply add my support now to the recommendations made by other coroners in this regard.¹⁴¹

Suicide Prevention Governance Unit and the PRAG

147. Deputy Commissioner Andrew Beck is responsible for Offender Services for Corrective Services. In that role, Deputy Commissioner Beck oversees all of the support services that are delivered to offenders, both in the community and in custody, such as psychological services, education and training, sentence management, reintegration services and the Suicide Prevention Governance Unit.¹⁴²
148. The Suicide Prevention Governance Unit (SPGU) was created following a review conducted in 2021 into the operation of ARMS and SAMS in WA's custodial

¹³⁸ T 164, 202.

¹³⁹ <https://www.oics.wa.gov.au/wp-content/uploads/2025/01/00.2-Clean-Copy-of-Report-Inspection-Report-157-%E2%80%93-Albany-Regional-Prison.pdf> -

¹⁴⁰ Exhibit 4.

¹⁴¹ For example, see the related recommendations in the findings of *Inquest into the death of Tim Alan LOOKER* [2025] WACOR 34; *Inquest into the death of Suzzanne Denise DAVIS* [2024] WACOR 13; *Inquest into the death of Kingsley Dean GARLETT* [2024] WACOR 50(S); *Inquest into the death of Callum MITCHELL* [2025] WACOR 34; *Inquest into the death of Jordan Robert ANDERSON* [2020] WACOR 44.

¹⁴² T 187; E

facilities. The review recommended an oversight body for those systems, and in response the SPGU was created and commenced operations on 1 February 2023. This followed the abolition of a previous similar governance unit a few years before. The new SPGU has transitioned from a project with the objective of addressing priority recommendations from the review, and now “forms part of a wider departmental approach committed to reducing incidents of suicide and non-suicidal self-injury”¹⁴³ in custody in WA. At the time of the inquest, it had 5 permanently established full time positions, including a clinical psychologist as Principal Manager and a Cultural Development Officer performing a cultural advisor role.¹⁴⁴

149. Deputy Commissioner Beck explained that the role of the SPGU team now is to oversee how policy and practice is developed and delivered across the prison system, so they manage relevant documents such as the At-Risk Manual, and perform audit reviews, rather than taking on any kind of operational role. Relevant to the inquest process, the SPGU team also seek to learn from deaths and other serious incidents and so they participate in the Lessons Learned Process and review the outcomes of coronial inquests. The SPGU facilitates bi-monthly meetings with the PRAG Chairs across all prison estates, both metropolitan and regional, to provide support in managing at risk people in custody/detainees.¹⁴⁵
150. I note that questioning of witnesses at the inquest raised some concerns about how the PRAG is set-up, noting that the Chair of the PRAG is not a clinician, but has final decision-making powers if a consensus is unable to be reached by the members in a particular case. Ms Forster was asked about the decision-making process within the PRAG and whether she considered there could be improvements to the process. Ms Forster expressed her opinion that the PRAG process would benefit greatly from more discussion and consideration around how the process works, with the suggestion that in its current form best practice would be to err on the side of caution where there is not a consensus amongst the members.¹⁴⁶
151. I accept that in Owen’s case it is likely that even if Ms Forster’s opinion that he remain on low ARMS had been adopted at that last ARMS meeting, it is possible Owen would have still come off ARMS prior to his death. However, it does raise a question over whether closer monitoring may have elicited more information from Owen about how he was feeling. Therefore, questions about what weight is given to the prison counsellor’s view when the PRAG makes these decisions is relevant to this inquest and in my view, the SPGU would do well to consider further the question of whether the PRAG Chair should be filled by a clinical position. Alternatively, there should be greater clarity about what steps are required to be taken by the Chair in the event there is no consensus, to ensure the risk that is appreciated by a member of the PRAG is managed. This fits squarely within the role of the SPGU as they provide training and support to PRAG Chairpersons.¹⁴⁷

¹⁴³ Exhibit 1, Tab 29, p. 1.

¹⁴⁴ T 188 - 190; Exhibit 1, Tab 29; Exhibit 2, Tab 2.

¹⁴⁵ T 188 – 192; Exhibit 1, Tab 29.

¹⁴⁶ T 128 – 129.

¹⁴⁷ T 193 - 194; Exhibit 1, Tab 29.

Counselling Services at Albany Prison

152. Ms Lauren gave evidence about the changes in staffing for psychological services for Albany Prison, noting that first Ms Forster resigned in the period leading up to Owen's death, and then Mr Bergsma resigned sometime after Owen's death. Ms Forster had been a full-time counsellor at Albany Prison so Mr Bergsma had increased his days from three days a week to four days a week for a period, and eventually up to five days, to assist with managing the workload, but there was obviously still a significant gap in the service, which meant there was a period of time when Ms Lauren provided back-up assistance by doing counselling services via MS Teams from Bunbury, where she is based. However, it appears the main focus for Mr Bergsma and Ms Lauren at that time was to manage the ARMS, SAMS and priority counselling, due to the pressure on their resources.¹⁴⁸
153. Mr Bergsma was the only site based counsellor at Albany Prison for a long period, running from the end of 2023 to the end of 2024, with some assistance provided by the telehealth team, before he then also resigned. This left two positions to be filled. It took some time to fill the two counsellor positions, which meant there was a period of time when Ms Lauren and other counselling staff were providing the sole counselling services for that region via MS Teams from Bunbury. Ms Lauren gave evidence she had gone to Albany Prison to get a handover from Mr Bergsma before he left, but then the service continued to work remotely until the new staff could commence.¹⁴⁹
154. Dr Brett expressed the opinion that one counsellor on site four days a week at a prison the size of Albany Prison was "awful"¹⁵⁰ and the build-up of the wait list for general counselling, as a result of that limited service (followed by no on-site counsellors later) was "very concerning."¹⁵¹
155. Ms Lauren agreed that the service provided by Mr Bergsma on site, and then solely by the MS Teams service, wasn't sufficient to meet the needs of the prison population over that period. Ms Lauren explained that the general expectation within PHS is for a counsellor to see three prisoners if they are doing ARMS/SAMS reviews (noting these are given priority), or perhaps four or five prisoners if they are providing general counselling, so their ability to get through a long wait list is quite limited. This led to an increase in the number of prisoners on the general counselling list waiting to be seen.¹⁵²
156. At the time of the inquest, there were 115 prisoners on the counselling list, whereas in August 2023 there were 58 on the list (although Mr Bergsma recalled there was sometimes up to 70 waiting around that time).¹⁵³ Ms Lauren explained the increase in the general counselling list size over that time was due to the fact the two counsellor roles were vacant for a time. The recruitment exercise took some time, despite the

¹⁴⁸ T 40 – 44, 141 - 144; Exhibit 2, Tab 5.

¹⁴⁹ T 45, 59, 142.

¹⁵⁰ T 101.

¹⁵¹ T 101.

¹⁵² T 59, 77.

¹⁵³ T 143.

Department actively trying to fill the positions. As with many regional positions, there had been difficulties with the recruitment due to a lack of suitably qualified applicants willing to work in a remote area. However, the issues had been resolved and Ms Lauren gave evidence the two full-time prisoner counsellor positions at Albany Prison (also servicing Pardelup Prison Farm) had been filled, although one had only just commenced at the time of the inquest in January 2025. With both positions filled, the counsellors were working through the wait list.¹⁵⁴

157. Nevertheless, even with the two full-time positions now filled, Ms Lauren gave evidence she believes Albany Prison, as a maximum facility with regular new intakes, would be better served by at least one additional FTE to fully cover the counselling needs for prisoners, which would also assist with covering leave requirements and to work through the backlog. This is within the context that the counselling provided is not usually able to address general counselling needs, as there is already too great a demand for crisis counselling for people on ARMS and SAMS, so the waitlist for general counselling continues to build up.¹⁵⁵
158. Ms Lauren also gave evidence that the mental health service, which is separate to the counselling service, has been limited due to the inability to recruit an on-site mental health nurse for Albany Prison, which then places additional pressure on the PHS services.¹⁵⁶ I have been advised the mental health nurse position was eventually able to be filled on 24 June 2025, but it is a part-time service, providing services only on Wednesday, Thursdays and Fridays at Albany Prison.¹⁵⁷
159. The PHS also appears to have had some issues with staffing, although the counselling positions are now filled. Mr Bergsma, who is an Albany local, gave evidence “the prison is not considered a particularly desirable place to work if you’ve got options to work in the community,”¹⁵⁸ so the recruiting issues are real. Nevertheless, Mr Bergsma gave evidence his experience working at Albany Prison “was great in terms of support”¹⁵⁹ from his line manager and the telehealth team.
160. Ms Lauren also spoke about the impact of structural issues on the waiting list, noting that the lack of interview space at Albany Prison for prisoners to access MS Teams for remote counselling sessions meant prisoners were having to attend the visits area for sessions. Ms Lauren emphasised the need for a dedicated area for counselling sessions to take place, noting prisoners had expressed concern in the past about the lack of privacy for sessions at Pardelup Prison Farm, which had led to visits being arranged at the medical centre, but this was not an option at Albany Prison. PHS staff conducting face to face sessions are also very limited with available private spaces, noting that they share an office that is not an appropriate interview space.
161. Ms Forster gave evidence that the logistical impact of not having a suitable interview space meant it was an ongoing challenge to look at suitable locations where they

¹⁵⁴ T 45, 59, 78; Exhibit 2, Tab 5.

¹⁵⁵ T 59 – 60; Exhibit 2, Tab 5 [24].

¹⁵⁶ T 63.

¹⁵⁷ Letter from SSO to CA dated 3 September 2025.

¹⁵⁸ T 144.

¹⁵⁹ T 144.

could undertake the work they needed to do. This limited the ability of the two counsellors to provide an efficient service, as they wasted considerable time on a daily basis trying to find an appropriate confidential space to use for counselling sessions, particularly if the Education or Visitor's Centre was not available. Ms Forster also commented that one of the other problems with constantly finding different available places to conduct their work meant that there was no sense of consistency or level of predictability for the prisoners coming to see them, which is detrimental to the building of a therapeutic relationship. When Ms Forster was working at the prison, the office was also unsuitable for the two counsellors to do administrative work, due to its small size, but I am advised this has now been rectified.¹⁶⁰

162. Mr Bergsma advised after Ms Forster's departure the PHS counsellors were given a new office that was an appropriate size for two counsellors to fit comfortably and also separate from the counselling space, which meant the counselling space was able to be used again. However, I understand from Ms Lauren's evidence that there is still significant room for improvement. It seems clear that the PHS staff require a permanent space that will accommodate the PHS staff to do both their administrative, telehealth and face to face work, with an appropriate amount of privacy and consistency for both them and the people they are seeing. Ms Lauren has been advised that senior management at Albany Prison are supportive of the need for counselling staff to have dedicated interview rooms, but multiple requests for funding for infrastructure changes to create a dedicated interview space have been unsuccessful.¹⁶¹
163. Deputy Commissioner Beck gave evidence at the inquest that the Offender Services team work very closely with the Prison Superintendents to try to ensure that the PHS staff have access to the correct rooms and other infrastructure they need to perform their important work on a day to day basis, and in a broader sense he is responsible for considering the prison infrastructure plan for all prisons. However, it is relevant to note that there is an ever-growing prison population across the State and all prison facilities are under significant pressure, including Albany Prison. Deputy Commissioner Beck indicated they are looking at things like crisis care units and improving conditions across the custodial setting State-wide, but not currently planning any major infrastructure changes to Albany Prison specifically.¹⁶²
164. Deputy Commissioner Beck acknowledged also that the clinical supervisor and team in Bunbury Prison have done their best to support the Albany Prison PHS counsellors, but telehealth has its limitations in certain cases.¹⁶³
165. Following the inquest, additional information was provided that PHS had recently been designated primary use of one interview room within the education centre to use for counselling sessions. This could be used by one PHS counsellor at a time, but only when the education centre is open (noting it is closed Fridays, during school holidays and sometimes on an *ad hoc* basis when education staff are redeployed).

¹⁶⁰ T 52, 61 – 63, 125 - 127; Exhibit 2, Tab 5 [27]; Exhibit 4.

¹⁶¹ T 52, 61 – 63, 145.

¹⁶² T 197.

¹⁶³ T 200.

However, I was then informed through additional correspondence on behalf of the Department that due to unexpected building maintenance related issues, the education centre has been closed since February 2025, which dramatically reduced the opportunity for counsellors to use that space. The education centre apparently reopened on 1 September 2025, and PHS is now able to use the interview room more regularly, and there is an intention to repurpose an adjoining storeroom to also be available for counselling use towards the end of this month.¹⁶⁴

166. There are other counselling spaces, such as in the Chapel, that can also be utilised by PHS counsellors when the education centre rooms are not available due to the centre being closed. However, it remains that there will be times when there is no designated space available. I note the counsellors who had worked there gave evidence not having a designated, reliably accessible space was an obstacle to seeing more prisoners. Although I accept that counsellors will often be seeing the most at risk prisoners in the Multi-Purpose Unit, which is a different area again, it does not answer the need to accommodate more general counselling, both in terms of time and place.¹⁶⁵
167. My focus is specifically on the counselling availability at Albany Prison, given that is where Owen's death occurred, he had moved to the general counselling list and there was very clear evidence before me that there is a lack of appropriate resourcing for the counsellors at Albany Prison to regularly provide anything more than crisis counselling for the most 'at risk' prisoners. The stretched PHS counselling service at Albany Prison, in conjunction with the inability to recruit a specialist mental health/AOD nurse, was also noted by the Inspector of Custodial Services at the start of this year.¹⁶⁶ In addition, in further material provided by the Department at the conclusion of the inquest, it was acknowledged that based on the International Association for Forensic and Correctional Psychology (IAFCP) Standards, the current numbers of PHS staff at Albany Prison do not meet the set rations, given the specialist needs of prisoners, and PHS should realistically have four to five FTE Prison Counsellor positions to adequately service the population.¹⁶⁷
168. In recent correspondence provided to the Court on behalf of the Department, I am advised that since the inquest hearing, the general counselling services have ceased entirely. Albany Regional Prison has apparently seen a significant increase in the number of ARMS/SAMS referrals over the past 12 months. As at 2 September 2025, of the 472 prisoners held at Albany Prison, 127 prisoners (or 26%) were under the care of PHS or mental health services, with 3 prisoners at that time on ARMS (2 under PHS and 1 under mental health services), 26 prisoners on SAMS (20 under PHS and 6 under mental health services) and 98 prisoners on the general counselling list. Due to the increasing number of ARMS/SAMS referrals and ongoing issues with the availability of confidential counselling spaces, on 21 July 2025 a decision was made to cease general counselling services at Albany Prison. I am informed the decision to reinstate the general counselling services is dependent upon there being

¹⁶⁴ Exhibit 4; Letter from SSO to CA dated 3 September 2025.

¹⁶⁵ Exhibit 4.

¹⁶⁶ <https://www.oics.wa.gov.au/wp-content/uploads/2025/01/00.2-Clean-Copy-of-Report-Inspection-Report-157-%E2%80%93-Albany-Regional-Prison.pdf>.

¹⁶⁷ Exhibit 5.

either a reduction in the number of ARMS/SAMS reviews needed to be conducted by each counsellor, or an increase in resources to provide these services.¹⁶⁸

169. Therefore, I consider that it is appropriate for me to make a specific recommendation for better resourcing in this regard.

Recommendation 1

I recommend that Treasury give priority to funding the Department of Justice to undertake infrastructure changes to create appropriately private and therapeutic dedicated interview spaces for counselling services to be provided to prisoners at Albany Regional Prison. The spaces should be available at all times that the counselling service is operating.

Recommendation 2

I recommend that Treasury prioritise funding the Department of Justice to create a permanent additional full-time PHS counsellor position at Albany Prison to ensure that a general counselling service is able to be consistently provided to prisoners seeking additional support, along with assessments for ‘at-risk’ prisoners on ARMS and vulnerable prisoners on SAMS.

Aboriginal Visitors Scheme and other cultural supports

170. Some questioning also focussed on the Aboriginal Visitors Scheme and its operation in Albany Prison. Ms Palmer gave evidence there was one female member of the Aboriginal Visitors Scheme operating in Albany Prison at the time of Owen’s death and she did visit Owen, but this sole member of AVS left in late October 2024. Currently, there is no one in the role, but the AVS are trying to recruit to fill the vacancies. However, as has been shown in relation to PHS and the mental health nurse role, it appears the recruitment exercise for the AVS has experienced challenges.¹⁶⁹
171. Ms Palmer gave evidence that in terms of other cultural supports, the Albany Prison Prison Support Officer is an Aboriginal man, and 50% of the peer support prisoners are of Aboriginal descent.¹⁷⁰ However, there is clearly a need to do more, given there are a large number of prisoners of Aboriginal descent in the prison who require

¹⁶⁸ Letter from SSO to CA dated 3 September 2025.

¹⁶⁹ T 165.

¹⁷⁰ T 166.

support, noting that Aboriginal men comprised almost 50% of the population of the prison at the start of this year.¹⁷¹

172. I note the information provided by Deputy Commissioner Beck indicates the SPGU is developing an Aboriginal Suicide Prevention Strategy to address the high incidence of suicide and self-harm incidents amongst Aboriginal people in custody in Western Australia, recognising as well the over representation of Aboriginal people in prisons in this State and across the nation. This is an important step in identifying strategies to better support Aboriginal people in custody, but hopefully also to consider better ways to reduce the number of Aboriginal people incarcerated through improvements in the psychological and other supports provided to these prisoners while in custody to address generational trauma and rehabilitation programs to address associated substance use issues.¹⁷² I suggest the Aboriginal Visitors Scheme should also be looked at in this context, noting that it is a service that has not been fully functional at least at Albany Prison for some time.

CONCLUSION

173. Owen was a loving father, partner and friend and the evidence at the inquest spoke to his big heart, his friendly nature and his generosity towards others. Over the final years of his life Owen struggled with substance use and mental health issues as he grappled with trauma from his childhood and grief from the loss of family members. Owen had been hopeful when he was last released from prison that he would manage to follow a new path of abstinence, but unfortunately he quickly succumbed again to substance use and returned to prison. By that time, he had also damaged his relationship with his partner Ms McVee and she had been forced to take steps to protect her safety and the safety of her children. Nevertheless, I accept Ms McVee and their children never stopped loving Owen and they hoped that this time he might get some of the support that he needed to turn his life around. Sadly, he never made it home to them again.¹⁷³
174. The evidence before me indicates that the individual staff members, and indeed the many prisoners who knew and cared for Owen, all tried to provide him with support and supervision that would help keep him safe. Unfortunately, after initially being willing to accept help when he couldn't guarantee his own safety, Owen seems to have withdrawn into himself and stopped sharing with those around him how he was feeling. He suffered a number of situational stressors in the day or two leading up to his death, including a change in his legal representation and some issues contacting family members, and it seems that Owen's state of mind deteriorated to the point that he decided impulsively to take his own life. By the time he was discovered by a family member, it was too late to save him.
175. The means by which Owen took his life, namely the cupboard door, has been rectified in similar cells and I know Owen's family are glad that this change was

¹⁷¹ <https://www.oics.wa.gov.au/wp-content/uploads/2025/01/00.2-Clean-Copy-of-Report-Inspection-Report-157-%E2%80%93-Albany-Regional-Prison.pdf>.

¹⁷² T 195; Exhibit 1, Tab 29.

¹⁷³ T 204.

made immediately by the management of Albany Prison. However, they support the full implementation of the ligature minimisation program throughout all cells in all prisons in Western Australia, to address the risk of impulsive acts of suicide by limiting the means by which it can occur. They submit that unless changes are made, more unnecessary deaths like Owen's will occur.¹⁷⁴

176. I accept the evidence heard at the inquest that there was an opportunity to support Owen more to deal with his ongoing trauma and chronic risk factors, which might have supported him better to deal with the situational stressors that he experienced. Unfortunately, due to resource limitations, this was not provided. I have made recommendations that, if implemented, will hopefully assist others in Owen's position to know they have support to make a different choice. The changes will not bring Owen back to his family, but they will at least know that the loss of his life has led to lessons being learned for the future.

SH Linton
Acting State Coroner
16 September 2025

¹⁷⁴ T 207.