JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, ACTING DEPUTY STATE CORONER
HEARD	**:**	5 & 6 OCTOBER 2026
DELIVERED	**:**	26 OCTOBER 2026
FILE NO/S	**:**	CORC 1342 of 2025
DECEASED	**:**	WIMBRIDGE, JASON DAVID

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Counsel Appearing:

Ms G Horstmann assisted the Coroner

Mr C Burke and Mr L Lasko (State Solicitor's Office) appeared on behalf of the Department of Justice

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Brendyn Dean Nelson, Acting Deputy State Coroner, having investigated the death of **Jason David WIMBRIDGE** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 5 and 6 October 2026, find that the identity of the deceased person was **Jason David WIMBRIDGE** and that death occurred on 9 May 2025 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch from complications, including out-of-hospital cardiac arrest with hypoxic brain injury, following ligature compression of the neck (hanging) in the following circumstances:*

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Introduction

1 Jason David Wimbridge was remanded into custody at Hakea Prison on 1 May 2025.

2 Based on initial assessments at intake during which he disclosed recent self-harm and previous suicide attempts, it was determined that Jason[1] should be managed as a moderate risk under the At-Risk Management System (**ARMS**), with CCTV monitoring, until further determination by the Prisoner Risk Assessment Group (**PRAG**).

3 ARMS is a multidisciplinary system used by the Department of Justice (**Department**) in custodial settings to identify, monitor and support prisoners who are deemed to be at risk of self-harm or suicide.

4 Jason was placed in the Crisis Care Unit (**CCU**).

5 On the morning of 2 May 2025, Jason was the subject of a security assessment, which concluded that he was at a heightened risk from other prisoners at Hakea. The security officer recommended to Hakea's Senior Management Team that Jason be moved to Casuarina Prison to mitigate the risk, which was a transfer that Jason was hoping for, in any event.

6 At 9.15 am, Jason was also the subject of a risk assessment by a prison counsellor for the purposes of the PRAG meeting later that morning.

7 The counsellor found Jason to be polite and forthcoming with information, but with low mood. Jason expressed passive suicidal ideation, without specific plan or intent, and referred to the previous suicide attempts and two recent acts of self-harm. The counsellor considered that Jason was future-focused, including in relation to a potential transfer to Casuarina.

8 The counsellor recommended that Jason continue to be managed as a moderate risk under ARMS.

9 Later that morning, PRAG met and determined that Jason:

(a) should continue to be managed as a moderate risk under ARMS;

(b) could be housed in a standard cell; and

(c) did not need to be in a fully ligature minimised cell at that time.

[1] Jason's family requested that he be referred to by his given name at the inquest, and I have adopted that same approach in these findings.

10 These conclusions were based on the assessment that while Jason was a 'prominent' risk to himself, he presented as future focused, particularly in respect of a possible transfer to Casuarina. PRAG also identified the capacity for Jason to be in a 'double-up' cell as a protective factor.

11 As a result of the PRAG decision, Jason was required to continue to be the subject of observations by custodial staff at two-hourly intervals.

12 Following the PRAG meeting, and consistent with a recommendation of the security officer, Jason was moved from the CCU to cell six in the C-wing of Unit 1 (also known as the Multi-Purpose Unit (**MPU**)). The cell was a fully ligature minimised cell with capacity for two prisoners.

13 Despite that capacity, prisoners in the MPU often occupy a double-up cell as a single occupant for protection and security purposes. The PRAG was unaware, when it met and made its recommendations, that Jason would likely be placed as a single occupant in a cell in the MPU. As a consequence, the protective factor of being in a double-up cell with a cellmate was not, in reality, a protective factor for Jason.

14 During the morning of 3 May 2025, Jason made phone calls to a friend, during which he made statements indicating a risk of self-harm.

15 Sometime between 6.30 pm and 8.20 pm that day, two days after intake, Jason hanged himself in his cell using an electrical cord attached to a television set.

16 Jason was discovered by a prison officer performing an ARMS two-hourly welfare check. Custodial and medical staff attended immediately and provided emergency care before Jason was transferred to Fiona Stanley Hospital (**FSH**) by ambulance under priority conditions. At FSH, Jason was admitted to the Intensive Care Unit where it was determined that he had suffered a non-survivable, severe hypoxic-ischaemic brain injury.

17 In consultation with family members, Jason was extubated and he died at 11.40 am on 9 May 2025.

18 Although Jason was formally released from custody on 5 May 2025 during the course of his hospitalisation, I am satisfied that in the circumstances (including his ongoing incapacitation from 4 May 2025) he was a person held in care immediately before his death within the meaning of s 22(1)(a) of the *Coroners Act 1996* (WA) (**Act**).

19 As such, a coronial inquest was mandatory,[2] and I am required to comment on the quality of the supervision, treatment and care that Jason received while in custody of the Department.[3] I may also comment on any matter connected with Jason's death, including matters of public health or the administration of justice.[4]

20 The coronial inquest occurred on 5 and 6 October 2026. Jason's family and friends, including his mother, father, brother, uncle and de facto partner attended the inquest (either in person, or by video link). As I expressed at the conclusion of the oral evidence, I am grateful for their engagement with the coronial process.

Issues raised at the inquest

21 The inquest focused on issues concerning Jason's supervision, treatment and care at Hakea, including, in particular:

(a) the rationale for PRAG's decision on 2 May 2025, and whether their risk assessment (as informed by the risk assessment performed by the prisoner counsellor earlier that day) was adequate;

(b) relatedly, whether the PRAG was aware of the outcome of Jason's security assessment, or his likely placement in the MPU as the sole occupant of a double-up cell;

(c) whether Jason was aware of the outcome of the security assessment and the officer's recommendation to the Senior Management Team, and the likelihood that he would be transferred to Casuarina;

(d) assuming his classification under ARMS was appropriate, whether Jason was monitored accordingly, particularly on 3 May 2025;

(e) whether Jason's phone calls made on the morning of 3 May were known to staff before he hanged himself (and, if they were not, whether there is any system that might alert staff to similar expressions by at-risk prisoners in the future); and

(f) whether the emergency response to Jason's hanging was adequate, including where custodial staff were delayed (albeit, minimally) in locating the defibrillator housed in the MPU's control room.

[2] The Act, s 22(1)(a).
[3] The Act, s 25(3).
[4] The Act, s 25(2).

Materials received at the inquest

22 To address the matters identified at pars [19] and [21] above, I received the documentary material contained in the coronial brief, and the following witnesses gave oral evidence:

(a) Ms Hendrina Marais, the prison counsellor who assessed Jason on 2 May 2025, and who was also a member of the PRAG that day;

(b) Ms Cinity Grundy, Assistant Superintendent, Safer Practice at Hakea, who chaired the PRAG meeting on 2 May 2025;

(c) Mr Matthew Bender, the Night Officer in Charge at Hakea on the evening of 3 May 2025;

(d) Dr Catherine Gunson, who reviewed the healthcare provided to Jason in custody, including the quality of the emergency response;

(e) Mr Richard Mudford, who spoke to the Department's Performance Assurance and Risk (**PAR**) review report; and

(f) Mr Jim August, Deputy Commissioner of Corrective Services, who gave evidence in relation to the issues addressed at the inquest, including steps that the Department has already taken to address matters that were identified through its 'Lessons Learned' process.

Materials received after the inquest

23 Following the inquest, Jason's brother provided a letter to the Court which provided some additional information about Jason's life and family. I am grateful to Jason's brother and family for providing that perspective for the benefit of the Court.

24 The letter also expressed some concerns on behalf of Jason's family about his supervision at Hakea. They included the family's view that there was sufficient information known to staff (particularly in relation to his previous suicide attempts, and likely withdrawal from substances upon his remand) to warrant Jason being categorised as a high risk of self-harm, and housed in a cell under CCTV monitoring until more thorough assessments of his risk could be undertaken.

25 While I have not received Jason's brother's letter into evidence formally, I have had regard to the family's concerns, and address them within my analysis of the issues identified at par [21(a)-(c)] above.

26 Jason's father also sent a separate letter to the Court after the inquest, outlining a number of concerns he holds in relation to Jason's death.

27 Again, I have not received the letter from Jason's father into evidence, but I have considered its contents carefully and, where appropriate, I have incorporated his concerns into my consideration of the issues identified above (nearly all of which overlap with matters raised in his letter, in any event).

Factual findings

28 In this part, I will make factual findings about the circumstances leading up to and including Jason's death, including any findings necessary to make comment on the matters identified at par [21] above.

Jason's personal background

29 Jason was born on 29 April 1974. He had a younger brother, and completed school to year 10 before commencing an apprenticeship with a panel beater. He had two sons, from a relationship which ended in 2016. Amongst his family, Jason was known to be witty and loyal, and generous and fiercely protective of those he loved. He enjoyed technology and building things.

30 Jason's medical history included hypertension, asthma and gastro-oesophageal reflux disease. He also had a longstanding history of drug use, and had previously suffered a heroin overdose in 2020.

31 Over the course of his life, Jason had frequent interactions with law enforcement and had been incarcerated on numerous occasions for varying durations, including at Casuarina in 2022 and 2024. The longest period Jason had spent in the community since 1993 was two years and 24 days between July 1996 and August 1998.

32 During previous terms of imprisonment, Jason gained certification in skills including cabinetmaking, and completed a Bachelor of Fine Arts.

Intake on 1 May 2025

33 On 30 April 2025, Jason was arrested and charged with offences against his de-facto partner. He was refused bail by police, and was remanded in custody after appearing in the Joondalup Magistrates Court on 1 May 2025. He was conveyed to Hakea, arriving at 1.23 pm.

34 The Commissioner's Operating Policy and Procedure (**COPP**) 4.9 concerning 'At-Risk Prisoners' provides (at cl 6.3.2) that upon initial reception, each prisoner is to be screened by a reception officer using the ARMS Reception Intake Assessment.

35 A reception officer assessed Jason in accordance with that requirement at 2.44 pm. I find, based on the following, that the assessment was thorough and clearly documented Jason's risk of self-harm, and the reception officer's recommendations were sound.

36 Jason answered all questions appropriately, and maintained good eye contact throughout. He advised that he tried to harm himself two days earlier by cutting his own wrist during an argument. The cut was observed by the reception officer on Jason's left wrist. Jason denied that it was a suicide attempt, and stated that although he had no hope for the future, he had no plans to take his own life or to hurt himself. Jason confirmed that since his arrest he had experienced thoughts about harming himself or taking his own life, but that although he wanted to die, he did not want to do it himself. He denied any current plan to commit suicide or self-harm.

37 In response to the question '*have you self-harmed whilst previously in custody*', the reception officer recorded the response '*yes*', but then – under the subheading '*Comments*', immediately below – recorded '*States no*'. As part of the PAR review, the reception officer clarified that the first entry was a mistake, and Jason did not disclose previous instances of self-harm whilst in the custody of police or in prison. I find that Jason advised the reception officer that he had self-harmed in the two days prior to his arrest but that it was not a suicide attempt, and that he had not previously self-harmed whilst in prison or police lock-up.

38 The reception officer recommended '*ARMS2HRLY under cam*'.

39 I interpret this to mean that the reception officer recommended that Jason be managed as a moderate risk under ARMS, with CCTV monitoring. I draw this inference where the guideline for management contained in the ARMS Manual concerning moderate risk prisoners states (at cl 5.1.2.2) that observations should be made at 2-hourly intervals.

40 Jason made an officer-assisted telephone call in the afternoon of 1 May 2025, during intake, to a male friend. During the phone call, Jason stated:

> I don't even want to live anymore….

41 There is no evidence suggesting that the statement was overheard. In any event, the statement is consistent with the ideation that Jason had already expressed to the reception officer which informed his recommendations.

42 In the ARMS – Interim Management Plan produced for Jason following the Reception Intake Assessment, it was recorded that a reception nurse had also recommended '*MOD ARMS under camera for PRAG to assess*'.

43 The Department's Electronic Health Online (**EcHO**) records confirm that Jason had a standard admission consultation with a nurse at Hakea at about 3 pm. During the consultation, Jason confirmed that the cut on his wrist was an attempt at self-harm two days earlier, but that it was a '*silly mistake*'. The cut was cleaned and dressed.

44 Jason also disclosed that he had attempted to hang himself '*before Christmas*' but that the '*rope broke*'. Jason stated that he '*wants to end it*' and that he'd '*rather be dead than alive but want someone else to do it*'. He denied having an active plan to suicide, stating that there was '*no way to do it here*'. As a consequence, I find that during the nursing assessment, Jason confirmed the recent act of self-harm by cutting, but also referred to an attempt to hang himself in 2024.

45 On my review of the documentary evidence, the initial nursing assessment was comprehensive – in relation to Jason's physical health needs, but also in respect of his mental health. The nurse obtained highly relevant information concerning Jason's history of self-harm, and reinforced the reception officer's recommendations in order to mitigate risk. At the inquest, I expressed the view that the assessment appeared to be of a high standard, a view shared by Dr Gunson.

46 Based on the recommendations of the reception officer and the intake nurse, Jason was placed in the CCU, which had the capacity for CCTV monitoring. According to the entries made in the ARMS supervision log by officers conducting observations, Jason was settled overnight.

47 I interpose that the Department's Lessons Learned review report noted that there was no detail provided by the PRAG about why Jason was moved from the CCU to the MPU and why an observation cell was no longer required. In the response to the recommendation contained in the report, it was suggested that Jason was initially placed in an observation cell (which I take to mean a cell in the CCU under CCTV monitoring) '*as an extra precautionary measure due to known security intelligence*'.

48 This is not what the evidence reflects.

49 As Mr August observed at the inquest, the information concerning Jason's potential link to an outlaw motorcycle gang was contained in Department's Total Offender Management Solution system (**TOMS**) from his previous time in custody, and would have been identifiable to prison staff at intake. However, the documentary evidence supports the inference that Jason was initially placed in the CCU due to the recommendation of the intake and nursing assessments that he be managed as moderate risk on ARMS under CCTV monitoring at least until he was assessed by PRAG. As noted above, a placement in CCU enabled CCTV monitoring. Ms Marais's recollection was that, at the time of Jason's remand, a requirement for CCTV monitoring could only have been achieved in the CCU (although I acknowledge the evidence that there are, now, other parts of Hakea outside of the CCU in which a prisoner can be monitored using CCTV).

50 There is nothing to suggest that the security concern had any bearing on the decision to place Jason in the CCU initially. The intelligence clearly did prompt a security interview to be undertaken the following morning, which led to the recommendation for Jason to be placed in the MPU.

Events on 2 May 2025

Security interview

51 During the morning of 2 May 2025, Jason was interviewed by a security officer due to a flag on TOMS indicating his potential affiliation with an outlaw motorcycle gang. Although the exact time of the interview is unclear, I find that it took place prior to the assessment with Ms Marais, given her notes refer to Jason being '*seen by security this morning*'. During the interview, Jason denied any involvement with the particular gang noted in TOMS, but disclosed that he owed money to a different gang for drugs. As a result of the disclosure, Jason was assessed as being at a heightened risk while at Hakea, and it was recommended that he be moved to Casuarina.

52 The security report was submitted to Hakea's Senior Management Team at about 1.08 pm by email for endorsement. Given this occurred after Ms Marais's assessment, and after the PRAG meeting (which as I find below, occurred at 11 am), I find that neither Ms Marais nor PRAG were aware, during their respective risk assessments, of the information that had been gleaned during the security report, or its potential consequence in relation to Jason's placement and management.

53 At the inquest both Ms Marais and Ms Grundy confirmed that they were aware that Jason had been interviewed by security earlier that day because Jason had disclosed it (in the context of explaining his strong desire to transfer to Casuarina). However, both confirmed that they were not aware of the outcomes of that security assessment when PRAG met.

ARMS review consultation

54 On 2 May 2025 at 9.15 am, Jason had an ARMS review consultation with Ms Marais. Ms Marais produced a witness statement, and gave oral evidence. I find that she was an honest and reliable witness, and that the best evidence of her assessment is the detailed, contemporaneous note she made in EcHO on the day of the consultation. At the inquest, Ms Marais confirmed that the record in EcHO was a typed account based off handwritten notes she had taken during the assessment.

55 Ms Marais has been employed as a counsellor within the Department's Psychological Health Services (**PHS**) since 2012. She initially worked at Greenough Regional Prison before transferring to Hakea in 2019. Ms Marais's primary role at Hakea is conducting assessments of prisoners considered to be at risk, for the purposes of PRAG reviews.

56 Prior to her review of Jason, Ms Marais reviewed documentation in EcHO and TOMS to identify any background information that might have been relevant to her risk assessment. At the inquest, she confirmed that she would have read the Reception Intake Assessment in TOMS, and the notes made by the nurse in EcHO from the previous day. As a consequence, Ms Marais was aware, before speaking with Jason, that he had self-harmed in the two days prior to his arrest but that it was not a suicide attempt, and that he had attempted to hang himself in 2024.

57 Ms Marais's in-person review with Jason was about 20 minutes in duration. She recalls he was willing to engage, was polite and forthcoming with information, but that he exhibited a restricted affect and low mood, and presented as sombre, sad and tired. He expressed 'limited future focus', and passive suicidal ideation, without specific plan or intent. He expressed a hope to contact external supports and transfer to Casuarina.

58 In denying a current plan to suicide or self-harm, Jason stated that he was:

> …currently too scared to try to end his life again as he might [fail]…[and] that he would try to find a way to kill himself at the first opportunity he should get if he should have to remain in Hakea.

59 Jason disclosed a history of suicide attempts by hanging in 2020, becoming upset and stating that he was very disappointed that he was still alive. He disclosed two incidents of self-harm just prior to intake, triggered by his difficulties coping with relationship instability. He referred to the self-inflicted cut, as well as taking '*several Valium tablets as well as fanta with the hope to not wake up*'. I infer Jason's reference to 'fanta' is a reference to gamma-hydroxybutyrate (**GHB**).

60 In terms of protective factors, Ms Marais identified that:

(a) Jason was willing to engage with her in a forthcoming manner and provide assurances over his own safety while waiting for the outcome of his placement decision (having seen security that morning);

(b) Jason hoped to transfer to Casuarina where he reported he would be able to cope; and

(c) Jason expressed a future focus on making a phone call to either his partner or his best friend; walking around freely in fresh air; talking to peers; and transferring to Casuarina.

61 Following her review, Ms Marais recorded her recommendation that Jason continue to be managed as a moderate risk on ARMS given his '*passive suicidal ideation, currently without plan*'.

PRAG review and determination

62 PRAG met at 11 am to discuss Jason. This accorded with the requirement that PRAG convene within 24 hours of an Interim Management Plan being implemented, in order to develop a Risk Management Plan for a prisoner determined to be at-risk.

63 PRAG decisions are made collaboratively, to ensure oversight and collective responsibility in making decisions about at-risk prisoners. In formulating a Risk Management Plan, the PRAG may determine that interventions should be pursued, including medical assistance, mental health assessment, cultural assistance, placement interventions, chaplaincy involvement, or peer support.

64 The PRAG meeting concerning Jason was chaired by Ms Grundy, and attended by three others including Ms Marais. PHS staff such as Ms Marais attend PRAG meetings to speak to the risk assessments with others, including the PRAG chair. The outcomes of the PRAG meeting are recorded in the Risk Management Plan and minutes of the meeting.

65 In this case, the minutes were produced by an administrative staff member, rather than by any of the attendees. The majority of the minutes are parts of Ms Marais's assessment notes that were incorporated into the document. I find that the deliberation and decision-making by PRAG is documented under the subheading '*PRAG Decision/Recommendation*'. That part of the document is, with respect, not detailed and the rationale for PRAG's decision is not readily understandable from the minutes alone. I acknowledge the evidence at the inquest that the PRAG will review a number of prisoners during any one meeting, which necessarily impacts the amount of information that is documented.

66 The minutes reference (and excerpt parts of) Ms Marais's comprehensive notes. As a consequence, I infer that PRAG was aware of the disclosures made by Jason regarding: the suicide attempts in 2020; the attempted hanging prior to Christmas 2024; and the two recent instances of self-harm, being the self-cutting and the ingestion of GHB and Valium.

67 The minutes indicate that the PRAG identified Jason as a '*prominent risk*' and that the risk of self-harm, '*protective factors and recommendations*' were discussed and considered. I infer that the protective factors discussed were those identified by Ms Marais in her note in EcHO, where the PRAG minutes otherwise refer to '*Able to provide assurances for his own safety*' and '*Future Focused for Transfer*'. This inference is consistent with the oral evidence of Ms Marais and Ms Grundy at the inquest.

68 The minutes record PRAG's determination that Jason continue to be managed as a moderate risk on ARMS. I note that in the Risk Management Plan itself, it is recorded that this should occur under COPP 4.9 with Jason '*under the primary care of PHS*'. Ms Marais explained at the inquest that the reference to PHS, in that context, should be interpreted as the requirement that PHS review Jason again prior to the next review by PRAG (scheduled for 5 May 2025 at 1.15 pm). I accept this evidence, and find that PRAG was not directing that Jason should be the subject of ongoing counselling by PHS outside of the suicide risk assessments.

69 Unusually, the minutes contain the statement '*Recent SH ? No*'. I infer, from context, that 'SH' was a reference to self-harm. If that is correct, that statement does not accord with the known history. Neither Ms Marais nor Ms Grundy were able to explain the note, although Ms Grundy observed that it may have been a typographical error or the scribe interpreting 'recent' very narrowly.

70 In either event, Ms Marais confirmed that the facts of Jason's recent self-harm (including its timing) would have been communicated to the PRAG. I find that to be so, and do not find that there was any misunderstanding based on what may have been a typographical error or characterisation as to timing by the author of the minutes.

71 The minutes indicate that PRAG determined that a fully ligature minimised cell was not necessary at this time. At the inquest, Ms Marais and Ms Grundy confirmed that that decision was reached on the basis of the protective factors, in particular Jason's apparent future focus including the potential transfer to Casuarina.

72 The minutes also include the statement '*Double up cell – security placement*'. At the inquest, Ms Marais and Ms Grundy confirmed that statement to be a record of PRAG determining that the potential for Jason to be in a double-up cell, with a cellmate, was a protective factor.

Cell placement

73 Due to the decision by PRAG that Jason continue to be managed as a moderate risk under ARMS, Jason was to be subject to observations and interactions at two-hourly intervals, at a minimum.

74 The security officer's report (including his recommendation that Jason be housed in the MPU pending any transfer to Casuarina) was provided to Hakea's Senior Management Team by email at about 1 pm. The recipients of the email from the security officer included Ms Grundy. Following the decision of PRAG and the sending of that email, at 2.37 pm Jason was placed in cell six in the MPU, which is used to hold prisoners including at-risk prisoners who are subject to more frequent monitoring. I infer that Jason was placed in the MPU because of the security risk that had been identified and his ARMS classification, and where it was expected that he would be transferred to Casuarina in the near future. I draw that inference where the evidence at the inquest was that prisoners often spend only a few days in the MPU until an alternative suitable placement is confirmed. Mr Bender agreed that placements in MPU are generally 'transient'. The available email correspondence also indicates that steps were taken that day to begin the process of a transfer, including contact with Casuarina.

75 There is no evidence that Jason was aware (at any time between his move to the MPU and the evening of 3 May 2025) that his transfer to Casuarina had received the support of the Senior Management Team at Hakea, or that Casuarina had indicated a preparedness to receive him.

76 Given the available evidence, I am not prepared to infer that Jason was aware by the evening of 3 May 2025 that the transfer had been approved in principle. I infer, given his previous experience in custody, that he would have been aware that the prospects of a transfer were good, however, during the period between his transfer to the MPU and the evening of 3 May 2025, Jason would not have had any understanding of when any transfer might occur, assuming it were to be approved.

77 Cell six in the C-wing of the MPU has capacity for two occupants, but Jason was housed alone in the cell at the relevant time. The evidence at the inquest was that prisoners housed in two-person cells in the MPU at Hakea frequently occupy a cell alone, due to security concerns. As a consequence, although a security concern is mitigated, the opportunity for increased safety for an at-risk prisoner by having a 'buddy' (as noted in the ARMS manual as a potential protective factor) is lost. According to the evidence at the inquest, cell 6 is fully ligature minimised, which means that hanging points in the cell (to which a ligature could be affixed) have been systemically identified and removed.

Supervision log entries

78 The entries in the ARMS supervision log from 2 May 2025 do not reveal any concerns or unusual behaviour by Jason. He was recorded as watching television, or sleeping, generally.

79 Jason was sighted at 2-hourly intervals, as per the ARMS manual, with two exceptions where the checks were performed late. As explained by Mr Bender at the inquest, delays in ARMS checks are usually the result of operational matters, including staff shortages. There is no evidence that the delay in either of those two checks had any consequence.

Events on 3 May 2025

Prison calls

80 Phone records show that Jason made three phone calls between 9.35 am and 10.04 am on 3 May 2025. One was unanswered, and the other two were calls to a friend who he spoke with for about ten minutes in total.

81 During the first phone call, Jason referred to an attempt to kill himself on his birthday (which as noted above, is 29 April). This could suggest, contrary to what he had told the intake officer and nurse, that the recent self-harm by Jason was, in fact, a suicide attempt.

82 During the second phone call Jason made statements including:

> My whole life is too hard, everything is just too hard at the moment, I cut my wrists, tried to hang myself.
>
> …
>
> I go up for bail in two weeks, but I doubt I'll see two weeks.

83 He also asked for the caller to pass a message on to his partner, advising that he '*will not fail again, goodbye*'.

84 The evidence at the inquest was that while all telephone calls made using the Prison Telephone System (**PTS**) (which operates in prisons including Hakea) are recorded, a prisoner's individual calls are, generally, not monitored in real time. In the ordinary course, the recordings of PTS calls are only reviewed upon prison authorities receiving intelligence which indicates a risk to prisoner's safety or good order of the prison.

85 There is no evidence to indicate that Jason's statements during the phone calls were overhead by anyone at the prison, or were reported to prison staff on 3 May 2025 by anyone from the public. Further, there is no evidence that any of Jason's phone calls were listened to in real time, or reviewed prior to his death.

86 Ms Marais and Ms Grundy agreed that the statements made by Jason during those phone calls would have been highly relevant to any risk assessment, had they become known. Ms Grundy went further to hypothesise that they would likely have resulted in Jason's management being escalated to high ARMS.

Supervision log entries

87 The entries in the ARMS supervision log from midnight to 4 pm on 3 May 2025 do not indicate any unusual behaviour by Jason. He was consistently sighted within 2-hourly intervals (other than two occasions in the very early morning, when the checks were late by only a few minutes). As identified in the Lessons Learned review, there were two entries in the supervision log from 3 May 2025 at 10.05 pm, and 4 May 2025. I infer that these entries were made in error and I disregard them.

88 According to an entry on TOMS made at 3.07 pm:

(a) Jason accepted meals at 8.30 am, 11 am and 4 pm; and

(b) he was given run of the wing with access to showers and phones from 9.30 am to 10.12 am and although he declined recreation at 10.12 am, he demonstrated compliance throughout the day.

89 I accept the TOMS entry and the ARMS supervision log entries (save for the two made in error) as an accurate, contemporaneous record of Jason's observable behaviour throughout the course of 3 May 2025. I find that there was no observable behaviour which would have caused any prison officer to escalate Jason's classification on ARMS. This is consistent with the information provided by Jason's father in his letter to the Court, in which he records being advised by those who saw Jason on the morning of 3 May 2025 that he appeared to be in good spirits.

Welfare check at 6.30 pm

90 At about 6.30 pm on 3 May 2025, a prison officer conducted the ARMS visual welfare check through the observation window of Jason's cell.

91 The officer has no independent recollection of the check, but recorded in the supervision log that Jason was observed to be present in the cell, and that no concerns or irregularities were noted. I find that account to be accurate, including where the documentation indicates that the officer logged the outcome of the check himself contemporaneously (as opposed to relaying the information to the Control Officer to be logged).

Welfare check at 8.20 pm

92 At about 8.15 pm, another prison officer, Mr Singh, started conducting physical cell checks in the A and C wings in the MPU.

93 At about 8.20 pm, he opened the viewing hatch to Jason's cell, and observed Jason on his knees, hanging forward with cable, from what he described as looking like a small portable fan that had been placed on the top bunk and held down with a mattress, wrapped tightly around his neck. I find, based on other evidence, that rather than a fan, Jason had fashioned a ligature using the cord connected to a television, which was lodged between the bedrest on the upper bunk with a mattress placed on top to provide downward force. Jason's face was dark purple in colour.

Emergency response

94 Mr Singh immediately called a code red over the radio. Given he was not a senior officer, he was not in possession of keys to be able to open the cell himself. Mr Bender, who as Night Officer in Charge of the entire prison happened to be in the MPU at the time, heard the code and moved from the control room in the MPU to the cell, taking no more than 30 seconds. He used the keys he held to open the cell door.

95 Mr Bender observed that no one else was in the cell other than Jason. He held Jason to prevent him from falling forward while Mr Singh used his Hoffman knife to cut the cable. Jason was unresponsive. Mr Bender dragged him into the corridor and started CPR, directing another officer to retrieve the defibrillator from the control room. That officer went to the control room but was unable to locate the defibrillator. He returned with a Laerdal facemask and assisted in CPR.

96 Medical staff arrived shortly after at 8.26 pm. A Guedel airway was inserted and adrenaline was administered. I find that by this stage a defibrillator had been procured and brought to the incident, most likely as a result of attendance of the medical team.

97 An ambulance was called at 8.27 pm, and arrived at Hakea at 8.38 pm. Paramedics took over CPR from a nurse and prison officer. The nurse advised that the defibrillator had not administered any shocks. A rhythm check was performed, and Jason presented with a non-shockable rhythm and no spontaneous ventilations. A return of spontaneous circulation was achieved at 8.44 pm, with paramedics then turning to a plan for transfer to hospital. Jason was conveyed by ambulance to FSH under priority one conditions, and the C-wing was locked down in compliance with policy.

Hospitalisation

98 On arrival at the FSH's Emergency Department, Jason's pupils were found to be fixed and non-reactive. He was admitted to the Intensive Care Unit at 12.35 am on 4 May 2025. Despite treatment and after gradual reduction of sedating medication, Jason demonstrated no signs of meaningful neurological activity including response to pain, voice or other stimuli. Physicians in the ICU advised Corrective Services that Jason was not expected to survive due to his having suffered severe hypoxic-ischaemic brain injury. He was identified as not suitable for further CPR due to the serious neurological injury.

99 Following conferences with his de-facto partner and other family members, Jason was extubated. He was certified life extinct at 11.40 am on 9 May 2025.

Subsequent investigations

100 Police officers from the Homicide Squad, Coronial Investigation Squad and Forensic Field Operations attended Hakea at 2.20 am on 4 May 2025 in light of the report of the critical incident and Jason's prognosis.

101 A review of available CCTV footage did not identify any signs of third-party involvement, criminality or suspicious circumstances. CCTV footage of the corridor including the door to cell six was reviewed, including between the welfare check at 6.30 pm and the welfare check at 8.20 pm. The review confirms that no person entered or exited Jason's cell during that period of time. Accordingly, I find that no other person was directly involved in Jason's death.

102 Police located a note in Jason's cell which appeared to be from him to his de facto partner, expressing his affection and apologising to her.

Cause and manner of death

103 At the recommendation of a forensic pathologist, and with the agreement of Jason's family, an external post mortem examination only, including CT scan, was conducted on 16 May 2025.

104 The pathologist identified a faint ligature mark to the neck in keeping with the accompanying ligature, and evidence of medical intervention. The CT scan showed changes in the brain, in keeping with the clinical findings of hypoxic ischaemic brain injury. There was no other evidence of recent skeletal injury.

105 Toxicological analysis detected the presence of several medications in keeping with recent medical care. A low level of cannabis was detected.

106 Following the examination, the pathologist formed the opinion that the cause of death was complications, including out-of-hospital cardiac arrest with hypoxic brain injury, following ligature compression of the neck (hanging).

107 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

108 Based on the available evidence, I find that at some time between about 6.30 pm and 8.20 pm on 3 May 2025, Jason hanged himself in his cell using a cord attached to a television set with the intention of ending his own life. As a result of this act, he suffered cardiac arrest and an irreversible hypoxic brain injury that ultimately resulted in his death.

109 In those circumstances, for the purposes of s 25(1)(b) of the Act, I find that Jason's death occurred by way of suicide.

Supervision, treatment and care of Jason while in custody

110 For the reasons which follow, although there were missed opportunities (particularly in relation to communication between staff about the potential for Jason to be placed in double-up cell, and to provide Jason with an update or assurance about the progress of the transfer to Casuarina), Jason's supervision, treatment and care was adequate.

Was the PRAG decision on 2 May 2025 appropriate?

111 An issue arises whether the risk assessment and decision-making by PRAG was adequate on the basis of the information known at the time. In his letter to the Court, Jason's father has raised his concern that those undertaking assessments of Jason risk of self-harm took what he had to say (including assurances as to his own safety) at face value.

112 Jason's brother expressed a similar concern in his letter to the Court on behalf of Jason's family, querying whether someone who planned to hurt themselves would openly admit that to a person who had a role in detecting a risk of self-harm by a prisoner. As identified above, Jason's family also questioned whether Jason ought to have been categorised as a high risk and kept under CCTV monitoring while at Hakea.

113 In assessing the evidence that relates to these issues, I remain mindful of the need to avoid 'hindsight bias', being the cognitive tendency to perceive past events as having been more predictable than they actually were before the outcome was known.

114 In relation to the decision to continue to manage Jason as a moderate risk under ARMS rather than escalate him to high ARMS, Ms Marais's evidence was that a prisoner is suitable for placement on high ARMS if they are exhibiting thoughts of self-harm or suicidal ideation, and present as an acute risk to themselves. An acute risk is usually manifested by the prisoner having a plan to give effect to their thoughts of self-harm.

115 Ms Marais's understanding accords with the terms of the ARMS manual, which sets criteria for identification of high risk, including that high-risk prisoners will usually have, or be suspected of having, a well-developed plan including method, time, place and a high degree of lethal intent. Given that definition, I am satisfied that based on the information available to PRAG (particularly the information obtained from Jason through the Reception Intake Assessment, the nursing assessment, and Ms Marais's assessment), Jason's classification as a moderate risk was acceptable.

116 PRAG were cognisant that Jason was a real and not theoretical risk of self-harm, but had formed the view that he was not an acute or imminent risk at that time. Such a conclusion was reasonably open, based on the information available.

117 Further, I do not consider that Ms Marais simply took what Jason had to say about his own safety at face value. The evidence is clear that Ms Marais was undertaking an assessment based not just on what assurances Jason was prepared to give during their interview, but also on her observations of his manner and tone, and what she, with her experience and expertise, could discern from his statements about level of risk. For example, Ms Marais explored the history of suicidality and suicidal behaviour to understand what might have been the reasons Jason undertook those actions, in order to compare them to his current circumstances. She noted that the recent self-harm appeared to relate to his social situation and the potential influence of substance use, acknowledging that withdrawal from substances now that he was in custody would be a risk factor. In performing a suicide risk assessment, Ms Marais was performing a complex task of balancing a number of dynamic factors. I also remain mindful of the well-known fact that suicidality is not static, and can fluctuate in persons even hour to hour.

118 The tragic outcome in this case does not, of itself, indicate that any risk assessment was inadequate or that PRAG's decision making was inappropriate. I am satisfied, having reviewed the documentation and having heard Ms Marais's and Ms Grundy's evidence, that the risk assessments were considered and sufficient.

119 As identified, PRAG also formed the view that Jason did not require a fully ligature minimised cell. That decision assumed less significance, ultimately, by virtue of Jason being moved into a fully ligature minimised cell in the MPU in any event.

120 Jason's father raised a concern in his letter about Jason having access to a cord in his cell, given what was known about his recent self-harm and previous suicidality. I accept the evidence at the inquest that Jason having access to a television was, on balance, reasonable to ensure that he had some form of entertainment or distraction, particularly during periods of lockdown. In my view, it was reasonable for Jason to have access to the television where he was assessed as experiencing passive suicidal ideation rather than presenting as an acute risk. I also accept Mr August's evidence that resourcing and cost precludes fitting built-in televisions into all existing cells at Hakea.

121 In my view, the remaining issue of concern is that PRAG's risk assessment proceeded on the basis that Jason could be housed in a double-up cell when, in fact, that was not possible in light of the security report and the approach adopted in the MPU generally.

122 I take no issue with the general policy adopted by management at Hakea in relation to the MPU and sharing of cells. I accept that rigorous risk assessment is needed before placement of a prisoner in a double-up cell to avoid poorly matched placements, and that given the cohorts of prisoners being housed in the MPU, usually on a transient basis, a default approach of housing prisoners as sole occupants in double-up cells is sensible.

123 However, the issue arises whether Ms Marais and the PRAG were aware of those matters in Jason's case, in circumstances where there appear to have been very few other protective measures implemented.

124 Further, I take no issue with the precept (as emphasised in the PAR report) that PRAG's purpose is not to, directly, determine prisoner placement decisions, and that such responsibility ultimately resides with others. However, it does not confuse or mistake PRAG's function to question whether PRAG:

(a) was aware of the outcome of Jason's security assessment (and its likely consequence); and

(b) should have been made aware of the placement decision in relation to Jason once it had been taken, where it appears that a double-up cell was one of the few protective factors that had been identified.

125 I accept the recommendation in the PAR report that PRAG should carefully consider and document how competing risks are weighed and to be managed, where a prisoner is simultaneously at risk of self-harm and unable to be accommodated in shared cell accommodation. However, that recommendation is also premised on PRAG being made aware of the fact that a placement in the MPU would likely result in a prisoner being the sole occupant of a cell with double-up capacity.

Was the PRAG aware of the security assessment?

126 Based on their oral evidence, I find that neither Ms Marais nor Ms Grundy were aware, prior to the PRAG meeting, that Jason was likely to be housed in the MPU prior to his potential transfer to Casuarina.

127 Further, I am also satisfied from her oral evidence that even if she had been aware of this likely placement, Ms Marais was unaware, at the relevant time, that a placement in the MPU would likely have the consequence of Jason being a sole occupant in a double-up cell.

128 Ms Marais became aware of this management approach in relation to the MPU, as a result of Jason's death. During her evidence, Ms Marais commented that '[w]*e are not always aware of operational matters on the day*', which I take to mean that counsellors and those performing the risk assessments for the benefit of PRAG may not be informed of all operational matters concerning existing and future placements.

129 It is inevitable that senior officers managing a prison will have more information about custodial and placement practices than those performing risk assessments for PRAG. However, at the inquest, Ms Grundy observed that as the chair of PRAG at Hakea she relies heavily on the knowledge, skills and experience of counsellors like Ms Marais in the performance of risk assessments.

130 It is, therefore, important that those conducting suicide risk assessments for the benefit of PRAG are kept aware of general approaches being adopted by custodial management regarding placements. This is particularly so where custodial practices concerning placements and management of particular units will have a direct bearing on the efficacy of protective factors that might be recommended to, and by, PRAG.

131 I am satisfied by Mr August's evidence that there was no reason why the security report, or its recommendations, could not have been shared with Ms Marais or PRAG. In this case, the timing of the respective assessments resulted in the information not being exchanged. I acknowledge and accept Ms Marais's evidence that it would have been helpful for the PRAG to have been made aware of the potential move from the CCU to the MPU, including whether it was going to occur before Jason was told about whether any transfer would proceed.

132 Counsel for the Department conceded at the conclusion of the evidence that the absence of exchange of information on these matters was a missed opportunity. The concession by the Department was appropriately made. It does not reflect a personal failure by any staff member, but simply emphasises that the value of any risk assessment will likely be negatively impacted if it proceeds on inaccurate or, as in this case, incomplete information.

133 I am satisfied that, in future cases, there will generally be no impediment to such relevant information being shared between officers undertaking a security assessment, and PRAG (including any staff from PHS).

Was Jason aware of the progress of any transfer to Casuarina?

134 In his letter to the Court, Jason's father raised concerns about exactly when any transfer of Jason to Casuarina was to take place, and queried whether Jason was aware that his transfer had been recommended.

135 As I have identified above, Jason was not aware of the progress of his potential transfer to Casuarina by the evening of 3 May, nor did he have any indication as to when this might occur. As a remand prisoner, Jason was not in a position to dictate the outcome, or timing, of that process. However, provision of information to Jason on this matter took on extra significance where the protective factor of a double-up cell had fallen away, and his future-focus was, as he had articulated to Ms Marais in very direct terms, entirely dependent on obtaining such a transfer.

136 The email correspondence shows that: the process of Jason's transfer was commenced in a timely way; it had support of senior staff at Hakea; there had been no impediment raised by staff at Casuarina which suggested it was unlikely to occur. There was, clearly, a basis to anticipate that the transfer would (or at the very least, could) occur after the intervening weekend.

137 In light of the above, counsel for the Department made an appropriate concession at the close of the inquest that Jason not being advised of the likely outcome of his transfer request was a further missed opportunity.

Was Jason adequately supervised under ARMS?

138 In his letter, Jason's father queried why, given Jason was on ARMS, he was not in a room under CCTV monitoring, or at least with a cellmate. Jason's family also expressed the view, through the letter from Jason's brother, that he should have been under CCTV monitoring.

139 I have reviewed the ARMS Manual and associated policies, and am satisfied that Jason was adequately supervised under ARMS. He was the subject of two-hourly checks during his management as a prisoner on moderate ARMS, with limited exceptions where the checks were performed late. There was no requirement that Jason, as a moderate risk, continue to be monitored through CCTV supervision.

140 According to Ms Marais, continued management on moderate ARMS but under CCTV monitoring would be unusual. I also accept Ms Marais's evidence that any decision to require Jason to continue to be managed under CCTV monitoring may have impeded or at least delayed a transfer to Casuarina.

141 Given the risk assessment performed by Ms Marais, and his behaviour as described in the supervision log entries and on TOMS, there was no observable cause to escalate Jason to high ARMS, or to recommend that he be returned to the CCU so that he could be monitored under CCTV. As noted at the inquest, observations cells in the CCU are spartan. Ms Marais explained that being managed under CCTV monitoring at the time of Jason's remand would have meant management in a way which would have been very restrictive, isolating and not necessarily therapeutic at all. Such cells are, appropriately, not used unless there is a very clear indication that they are required in order to keep a prisoner safe. I am satisfied that the ARMS manual and associated policies are suitable, in this respect, and do not require revision.

142 In this case, there was sufficient information to satisfy the PRAG that Jason could be housed, safely, in a cell other than in the CCU. As I have already indicated, it was clear that Ms Marais thought it would be a protective factor for Jason to be in a double-up cell. Given that was not possible in the MPU then, as I have identified above, it would have been preferable for Jason to have been provided some information about the progress of his transfer to Casuarina, being his primary protective factor. That information would clearly have been of assistance in his maintaining a future-focus.

Were Jason's statements during the calls on 3 May known to anyone?

143 I find, on the evidence, that Jason's statements made during the phone calls on 3 May were not known to any prison staff prior to his hanging, nor was there any cause to review Jason's phone calls before then.

144 In his letter to the Court, Jason's father questioned why Jason's calls were not monitored including in light of his being managed on ARMS. As identified in the PAR review, over 4,800 phone calls were made by prisoners in Hakea on 2 May 2025 using the PTS. I infer that a similar number of calls would have been made on 3 May 2025. Given that volume, there is simply no way that all calls by prisoners being managed on ARMS across the prison estate could be monitored by staff in real time to detect any statements indicating an imminent risk of self-harm.

145 In the PAR review, it was recommended that as part of the replacement of the PTS that is currently underway, consideration be given to the application of artificial intelligence or other technical solutions to enable better monitoring of telephone calls by at-risk prisoners for the purpose of identifying indicators of self-harm or suicidal ideation.

146 In response, the Department noted the priority is to deliver the core replacement service (the Telephone Service Application (**TSA**)) without delay. For that reason, additional functionalities are being considered through a separate pilot program. As part of that pilot (referred to as Extended Business Services (**EBS**)), the Department intends to trial additional technology capable of identifying key words and indicators during prisoner telephone calls. That functionality is an additional module outside the TSA, which is yet to be costed, and which would require separate purchase and an ongoing subscription.

147 At the inquest, Mr August confirmed that the EBS pilot is occurring concurrently with the work to implement the TSA. The Department is working with the project team to determine how the capability could be applied within the custodial environment, and the pilot will provide an opportunity to test and evaluate the technology before any decision is made. Mr August's evidence was that such works are expected to be completed next year.

148 As a consequence, to the extent this issue arises in future inquests, I expect the Department will be in a position to provide an update as to the progress and outcomes of the EBS pilot.

Was the emergency response adequate?

149 In his letter to the Court, Jason's father raised a concern about whether the emergency response to Jason was timely, including the calling of the code red.

150 I have made findings above about the immediacy of the response based on my review of the evidence. I reiterate that there was no delay by any staff, and Mr Bender being in the MPU at the time of the code red meant that Jason's cell was breached earlier than it might otherwise have been.

151 At the inquest, Dr Gunson was asked about the quality of the emergency response provided by staff on 3 May 2025. Her opinion, which I accept, is that the response was timely and of a high standard. Dr Gunson noted that the fact that a spontaneous return of circulation was achieved is evidence that the CPR provided to Jason was of a high quality.

152 In addition to finding that the emergency response was of a high quality, I also conclude that the apparent delay in custodial staff locating the defibrillator in the MPU control room did not impact the quality of the response or Jason's prospects of survival.

153 I reach this conclusion, in particular, where it is apparent that Jason had a non-shockable rhythm at all times once a defibrillator had been applied, and where, given the timing, Jason had very likely already suffered the severe hypoxic brain injury by the time he was discovered during the ARMS welfare check at 8.20 pm.

154 Since the incident, control rooms within all units at Hakea have been updated so that emergency response equipment is easily locatable. The equipment is colour-coded with clear signage, and generally housed on uniformly painted green walls (referred to as 'green boards'). All staff were informed of that change by global email.

155 The prison officer who was unable to find the defibrillator on the day of the incident provided evidence that if the same events were to occur today, he would have no difficulty finding the defibrillator immediately if required. I accept his evidence, and find that all officers at Hakea would be able to readily find the equipment.

156 The Department is also commended for accepting and adopting the recommendation in the PAR review that the remedial action taken by Hakea in relation to visibility of emergency equipment in control rooms should be implemented across the Western Australian prison estate.

157 Given all of the above, there is no need for any recommendations to be made in this matter.

Conclusion

158 Jason's death, so soon after his remand into prison, was a tragic outcome. Given his risk profile, I can understand that Jason's family continue to struggle to comprehend how he was able to commit suicide and query whether he ought to have been supervised more closely.

159 Having reviewed the evidence, I am satisfied that staff acted appropriately prior to, and after Jason's death, and that although there were opportunities for better communication (both between staff, and with Jason), the risk assessments that were performed were sufficient and his supervision adhered to the policy requirements.

160 Areas for improvement have been identified through the PAR review process, and I am satisfied by Mr August's evidence that the recommendations have either been implemented already or are being investigated by the Department in a meaningful way.

161 As I indicated to Jason's family and friends at the close of the inquest, I do not expect that the coronial inquest has provided them with any closure in relation to Jason's death. I hope it has provided some transparency and information about his time in custody and the Department's response to his death.

162 It is very clear from their letters to the Court that Jason was loved by all of his family and that he is missed, deeply. I express my condolences to Jason's loved ones.

BD Nelson
A/Deputy State Coroner
26 October 2026