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**FINDINGS and RECOMMENDATIONS of Coroner Robert Webster following the holding of an inquest under the *Coroners Act* 1995 into the death of:**

## Robert Harold Gerard

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Contents

# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995

*Coroners Rules* 2006

Rule 11

**(These findings have been de-identified in relation to the name of some family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)**

I, Robert Webster, Coroner, having investigated the death of Robert Harold Gerard, with an inquest held at Hobart in Tasmania, make the following findings.

**Hearing Dates**

25 October 2023 and 21 November 2023, with final written submissions received from Counsel Assisting, Mr Cameron Lee, on 23 February 2024, Mr Greg Barns SC on 21 March 2024, Ms Gretel Chen on 25 March 2024 and Ms Alexandra Darcey on 25 March 2024.

**Counsel**

Mr Cameron Lee - Counsel Assisting the Coroner.

Mr Greg Barns SC - Counsel for Mr Paul Gerard and Mrs Anna Gerard the parents of Mr Robert Gerard.

Ms Gretel Chen - Counsel for the Secretary of the Department of Justice (DoJ) and the Secretary of the Department of Health.

Ms Alexandra Darcey - Counsel for Dr Ruchi Bhalla.

**Notice of This Hearing**

Notice of the date of the case management conference (CMC), to be held on 16 August 2023, was provided to Mr Gerard's parents, his son, the Tasmanian Prison Service (TPS) and the Tasmanian Health Service (THS) by letter of 27 June 2023. The DoJ is comprised of a number of divisions or outputs one of which is Corrective Services which is made up of the TPS and Community Corrections. The CMC proceeded on 16 August 2023 at which time Mr Gerard's parents and Mr Lee were in attendance. The scope of the inquest was discussed and finalised and a summary of the relevant

issues was canvassed. The witnesses to be called to give evidence was finalised and the matter was adjourned for hearing.

Subsequent to the CMC disclosure of the evidence was made to Mr and Mrs Gerard, the TPS and the THS. By letter of 23 October 2023 Bold Lawyers indicated they acted for Mr and Mrs Gerard and they were instructed to brief Mr Barns SC to appear at the inquest. Mr Gerard's son, MZ, did not engage with the inquest process.

**Introduction**

1. In the early hours of 23 May 2022 Robert Harold Gerard (Mr Gerard) died at Risdon Prison Risdon Vale.

2. His death is subject to the *Coroners Act* 1995 (the Act) because the Act relevantly provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in custody.[1]

3. Accordingly an inquest was held into Mr Gerard's death in Hobart on 25 October 2023 and 21 November 2023.

4. In so far as the scope of inquest is concerned the inquest considered the general matters surrounding Mr Gerard's death to enable findings to be made, if possible, under s 28 of the Act and it considered the implementation of any previous Coronial recommendations in respect of deaths in custody, particularly those concerning suicides by hanging.

5. The witnesses who gave evidence at the inquest were:

    (a) Detective Constable Rebecca Berriman (one of the three investigating officers);
    (b) Dr Ruchi Bhalla (consultant psychiatrist);
    (c) Dr Rajan Darjee (consultant forensic psychiatrist and Deputy State-wide Specialty Director for Forensic Mental Health and of the Community Forensic Mental Health Service and Adjunct Associate Professor);
    (d) Ms Jenna Mays (policy officer within the TPS);
    (e) Mr Tristan Bell (Assistant Director, Communications, Policy and Stakeholder Engagement of the TPS); and
    (f) Mr Ian Thomas (Director of Prisons – TPS).

[1] See s24(1)(b) of the Act.

6. In addition to these six witnesses, the evidence of other witnesses was received in affidavit form without those witnesses being called to give evidence. Documentary and other evidence was also tendered. The complete list of all exhibits is annexed to this finding and marked with the letter A.

7. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to section 28(1) of the Act:

(a) The identity of the deceased is Robert Harold Gerard (Mr Gerard);

(b) Mr Gerard died in the circumstances set out further in this finding;

(c) The cause of Mr Gerard's death was hanging, the result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life ; and

(d) Mr Gerard died on 23 May 2022 in the bathroom area on the second storey of the Kara Delta unit of the medium security precinct[2] of the Risdon Prison Complex (RPC), Risdon Vale in Tasmania.

**Background**

8. Mr Gerard was born on 16 October 1973, the son of Paul and Anna Gerard. At the date of his death he was 48 years of age.[3] Mr Gerard was the middle child of three sons. His eldest brother is deceased and his youngest brother is disabled as a result of sustaining an acquired brain injury when he was run over by a motor vehicle when he was a child.[4]

9. Mr Gerard was in a long term relationship with CN from about 1996. They had three children together; two sons and a daughter. CN says her relationship with Mr Gerard was marred by family violence. He would assault her regularly. She says he was paranoid she was having affairs with other men and he was, in her view, an alcoholic. He also smoked cannabis heavily. CN says she encouraged Mr Gerard to seek help for his mental health. As a result he saw the psychologist Ruth Paul who CN says diagnosed Mr Gerard with post traumatic stress disorder, anxiety and depression. He ceased seeing Ms Paul due to delusions he had about her behaviour.[5]

[2] The medium security precinct of RPC consists of 7 two-storey units.
[3] Exhibit C1-Police Record of Death for the Coroner.
[4] Exhibit C13-statutory declaration of CN.
[5] Exhibit C13-statutory declaration of CN.

10. In or about May 2020 Mr Gerard commenced a relationship with Gabrielle Young. A very short time later she fell pregnant and she believes Mr Gerard is the father of her child. She gave birth to a daughter on 7 February 2021. Ms Young was also subject to violence at the hands of Mr Gerard. She says he had two other children to two other women and he also had a baby die from sudden infant death syndrome.[6] Mr Gerard's sons and his parents confirm he was delusional, his mental health had been poor for a very long time and he had a propensity to be violent.[7]

11. Mr Gerard had a history of offending in South Australia, the ACT and Western Australia which comprised mainly of traffic offences which were committed in 1996, 1998 and in 1999 to 2000 respectively. His record in Tasmania commenced in 1991 and consists of offences of dishonesty, drug offending, traffic offending, breaches of bail, drink-driving and assault. On 29 January 2020 it is alleged he wounded another person by stabbing that person in the abdomen with a knife. On 5 March 2020 he appeared in the Launceston Magistrates Court and after pleading not guilty he was committed to the Supreme Court for trial on that charge.

12. Mr Gerard had been remanded in custody prior to being released on bail and therefore in the custody of TPS on four prior occasions as follows:

- 6 May 1991 to 6 May 1991;
- 23 February 2006 to 23 February 2006;
- 13 September 2009 to 14 September 2009; and
- 3 February 2020 to 10 March 2020.[8]

**Mr Gerard's time in custody-overview**

13. Mr Gerard was taken into the custody of the TPS from 14 January 2021 and he remained at the Launceston Reception Prison (LRP) until he was transferred to RPC on 29 January 2021. He was remanded in custody having appeared before the Launceston Magistrates Court on one count of murder, one count of wounding or causing grievous bodily harm and a number of summary offences.[9]

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[6] Exhibit C14-affidavit of Gabrielle Young.
[7] Exhibit C11-affidavit of MZ, exhibit C12- affidavit of TO, exhibit C 15- affidavit of Anna Gerard and exhibit C16-affidavit of Paul Gerard.
[8] Exhibit C69-affidavit of Ian Thomas at paragraph 3.
[9] Exhibit C69-affidavit of Ian Thomas at paragraph 5.

14. The events which led to Mr Gerard's incarceration commenced on 12 January 2021 when it is alleged that shortly after 9:00am Mr Gerard punched and kicked his father leaving him unconscious, he has then stolen his father's car and has driven to a petrol station and a bottle shop before he has driven to an address in Mowbray. At that address two male passengers entered the vehicle which Mr Gerard was driving and in which Ms Young was also a passenger under the impression they were travelling to an address at Reedy Marsh[10] to go camping. Before leaving Launceston they went to at least two locations to purchase the drug ice which they have all used prior to continuing their journey. Mr Gerard then drove to a supermarket in Deloraine where Ms Young has purchased some supplies.

15. Mr Gerard then drove to Reedy Marsh towards an address which Mr Gerard and Ms Young had visited several times. Mr Gerard pulled into the neighbouring property, stopped the vehicle and without any conversation he has walked to the front door of the residence armed with a club and a large knife and kicked in the front door. It is then alleged he has murdered Michael Hawkes and wounded his wife Judith Hawkes. He then went back to the vehicle and entered it as a passenger where he directed one of the other occupants who had in the meantime got into the driver's seat to drive to the address with which Mr Gerard was familiar. He then got out of the vehicle and climbed a locked gate and walked towards a shed on the property while the driver reversed the vehicle and drove up the road a short distance where he and the other male witness left Ms Young in the vehicle. They continued walking along the Road where they waited for the police to arrive.

16. In the shed at the property Mr Gerard changed into camouflage pants and body armour that he had previously left there and he went into the bush in order to avoid police. At approximately 3:30pm the next day he was observed by a police drone at a residence at Maloney Road, Parkham where he forced the rear door to the residence to gain entry and then he stole several items. He was arrested a short time later. He was presented to the custody Sergeant at Launceston Police Headquarters at which stage his clothing and a number of forensic exhibits were collected and he was then taken to the Launceston General Hospital where he was physically examined and treated for minor injuries. Mr Gerard was then interviewed where he admitted to murder and wounding and he said the other occupants of the vehicle had no idea what he intended and nor did they know they were going to Mr and Mrs Hawkes' address until he pulled into the driveway. He declined to answer questions about the assault and motor vehicle stealing and he was not asked about the alleged offending at

[10] Which is north-west of the town of Westbury.

the Parkham property. The next day he was offered the opportunity to continue the interview which he declined after seeking legal advice. He was then formally charged and processed before being remanded in custody.[11]

17. Police believe the motive for Mr Hawkes' murder was as follows. While Mr and Mrs Hawkes lived at Reedy Marsh they also owned the adjoining property. Mr Dion Batt rented that property from Mr and Mrs Hawkes and was friends with Mr Gerard. On New Year's Day 2021 Mr Batt went to Mr Hawkes' property and advised Mr Gerard had assaulted him. Police were contacted, they investigated the matter and transported Mr Batt and Mr Gerard's son, TO, back to the Deloraine area. This was the last time Mr Gerard saw his son and thereafter he appeared to have delusional thoughts his son had been kidnapped and was being tortured. Mr Gerard believed, wrongly, that Mr and Mrs Hawkes were responsible for kidnapping his son. He became angry at his parents who did not believe their grandson had been kidnapped. Mr Gerard's behaviour continued to deteriorate and this prompted his parents to temporarily move out of their own home in order to seek refuge from him as he was living with them at the time.[12]

18. Ms Young says Mr Gerard had been delusional and she confirmed he believed his son, TO, had been kidnapped. He had also been saying that he wanted to kill himself in the week prior to the murder because he did not know where his son was.[13]

19. According to Dr Atherton, Consultant Forensic Psychiatrist and State-wide Specialty Director of the Forensic Mental Health Service, on the history provided by Mr Gerard himself, his psychotic symptoms had been present months prior to the alleged offending and potentially for much longer. His psychosis persisted well into his incarceration and at least until he was treated at Wilfred Lopes Centre (WLC) where access to substances was less likely. There had been a long history of substance use and abuse.[14]

20. People in custody with mental health issues and those who are at risk of suicide are co-managed by two services namely:

[11] Exhibit C61-Police Facts for the Prosecutor.
[12] Exhibit C61-Tasmania Police Subject Report pages 2 and 8.
[13] Exhibit C61-Tasmania Police Subject Report page 7.
[14] Exhibit C68-report of Dr Atherton at paragraphs 21 and 22.

- Correctional Primary Health Services (CPHS) which consists of doctors and nursing staff (psychiatric liaison nurses "PLN") and which is *"the primary access point for mental health care in prison"*; and
- Forensic Mental Health Services (FMHS) which includes the WLC and the Community Forensic Mental Health Service (CFMHS). Within FMHS are psychiatrists who provide clinical services to the prisons on referral from CPHS and this includes locum psychiatrists.[15]

21. The Therapeutic Services Unit (TSU) operates directly under the TPS (not THS). That unit has a role in the provision of counselling crisis response services in the prison.[16]

22. The risk intervention team (RIT) consists of staff from TPS, TSU and the CPHS PLN. Amongst other functions the RIT considers and reviews a prisoner's level of suicidal self harming risk and decides on the management of those prisoners within the TPS. The FMHS, and therefore the FMHS psychiatrist, has no formal role in the RIT. An RIT panel, when it consists of one staff member from TPS, TSU and a CPHS PLN, is a full RIT and when two out of the three services are present it is a partial RIT.[17]

23. In summary Mr Gerard was first reviewed by a CPHS nurse in the LRP on 14 January 2021. CPHS nursing staff remained involved in Mr Gerard's care thereafter, initially at LRP, and then at RPC. He was reviewed by the RIT on 15 January 2021 and remained under RIT review for periods throughout his time in custody. After being transferred to RPC on 29 January 2021, Mr Gerard was referred for FMHS psychiatric review. The first such review occurred on 5 February 2021, with the FMHS remaining involved in Mr Gerard's care thereafter.[18]

**Mental health care provided to Mr Gerard while he was in custody**

*The diagnosis*

24. At the initial psychiatric assessment at RPC, Mr Gerard was noted to be experiencing both psychotic and affective symptoms. A range of diagnostic possibilities were considered which included an affective disorder, a drug induced psychosis, or an enduring psychotic disorder such as schizophrenia. Over time, the diagnosis of an enduring psychotic disorder was

[15] Exhibit C68-report of Dr Atherton at paragraphs 7 and 8.
[16] Exhibit C68-report of Dr Atherton at paragraph 9.
[17] Exhibit C68-report of Dr Atherton at paragraphs 10 and 11.
[18] Exhibit C68-report of Dr Atherton at paragraphs 14 to 16.

favoured, with the diagnosis of paranoid schizophrenia being confirmed during Mr Gerard's admission to WLC from 12 April 2021 to 3 July 2021. Mr Gerard had a comorbid substance use disorder (including alcohol, cannabis, and methamphetamine). From mid-December 2021, he presented with a constellation of symptoms indicative of a major depressive episode. While that diagnosis was not explicitly documented, Dr Khan, who reviewed Mr Gerard around that time, suggested a likely diagnosis of 'schizoaffective disorder, depressive type', and Dr Keating noted prominent depressive symptoms. The treatment strategy employed to address those symptoms was initially to increase his antidepressant dose. Mr Gerard reported a historical diagnosis of PTSD, however this condition was not central to his care, where the clinical focus was overwhelmingly on the treatment of Mr Gerard's psychosis, and later his depressive presentation.[19]

*The basis for the diagnosis*

25. The diagnosis of paranoid schizophrenia was based on the presence of core diagnostic features including delusions with prominent grandiose and religious themes, as well as bizarre and persecutory themes, along with auditory hallucinations. Mr Gerard also presented with formal thought disorder (e.g. tangential thoughts) from time to time. Dr Atherton says *"[w]hile the boundaries between intoxication, drug-induced psychosis, and primary psychotic illness, can be difficult to delineate in the context of chronic and extensive substance use, Mr Gerard's symptoms of psychosis persisted well into his incarceration, at least until he was treated at WLC, where access to substances would have been very unlikely."* In relation to the diagnosis of substance use disorder, Mr Gerard had a long history of substance use, with significant alcohol use and illicit substance use from adolescence, including a history of heavy cannabis use, intravenous amphetamine use between 16 to 19 years of age, and other substances including frequent methamphetamine use in the two years prior to his incarceration. He used drugs up to the time of the alleged offending. There was significant harm caused by the use of those substances, including the deleterious effect on his mental state, and likely contribution of substances to the consequent risks to others which are reflected in the circumstances of the alleged offending. There were a number of symptoms indicative of a major depressive episode which were noted from around mid-December 2021. These symptoms included lowered mood, anhedonia, reduced energy, disturbed sleep, reduced appetite with weight loss, psychomotor slowing, feelings of hopelessness, and

[19] Exhibit C68-report of Dr Atherton at paragraphs 17 to 20.

suicidal ideation. His legal circumstances appeared to also be a prominent and ongoing stressor.[20]

*Summary of treatment*

26. Mr Gerard's pharmacological treatment consisted of various combinations of antipsychotic medications, antidepressant medications, mood stabilisers, and benzodiazepines[21]. At the time of death, Mr Gerard was prescribed the following psychotropic medications namely Zuclopenthixol decanoate (depot), 400mg, intramuscularly, fortnightly and Mirtazapine, 60mg, orally, at night.[22] Psychiatric reviews early in his incarceration did consider a prominent affective component to his presentation, and he was commenced on mood stabilising medication (initially lithium, and later sodium valproate), however he was not formally diagnosed with a manic or mixed episode.[23]

*A history of psychosis*

27. In December 2019, police attended Mr Gerard's house after he called them numerous times. He reported a black SUV with *'armed Muslims driving slowly past his house'*, and armed people lying in the fields behind the house. Police found Mr Gerard and his son both displaying symptoms of psychosis, wearing BMX gear and carrying machetes. Police requested a mental health assessment by the crisis assessment and treatment team (CATT), who attended Mr Gerard's home on 29 December 2019. He was reportedly reluctant to answer the door and he needed extensive encouragement to do so. He said he had been using methamphetamine recently which triggered his odd behaviour. He indicated his mental state had improved, he apologised to police, and he otherwise was not considered to display features of major mental illness. It was considered by CATT his symptoms were in keeping with the effects of methamphetamine use.

*Mental health treatment Mr Gerard received while in prison in detail*

28. At Mr Gerard's intake screening at LRP concerns were raised because of the significance of the charges against Mr Gerard, his flat presentation and his minimal engagement. He was

[20] Exhibit C68-report of Dr Atherton at paragraphs 21 to 23.
[21] The relevant medication prescription history is included in exhibit C68-report of Dr Atherton at Appendices A, B, and C.
[22] Exhibit C68-report of Dr Atherton at paragraphs 24 and 26.
[23] Exhibit C68-report of Dr Atherton at paragraph 27.

assessed using the Tier 1 assessment process which all prisoners and remandees undergo to determine their immediate management needs which includes the risk of suicide and self-harm, the need for protection, issues of vulnerability and other issues relevant to prisoner welfare, safety and security. This assessment has two components; first a custodial assessment conducted by the TPS which includes an initial classification and security assessment and second a health assessment conducted by CPHS. It is a requirement the custodial component of this assessment be conducted within two hours of the person's reception into custody unless the person is unable to participate due to their physical or mental state. In this instance the assessment did not disclose any previous suicide and self-harm attempts or current suicidal ideation however it did disclose Mr Gerard suffered from post-traumatic stress disorder and he regularly visited a psychologist and had displayed signs of paranoia.[24]

29. Based on the concerns referred to in paragraph 28 and the results of the Tier 1 assessment it was determined Mr Gerard required management under Director's Standing Order (DSO) 2.01 Suicide and Self -Harm Prevention[25] as he was a person at risk. He was therefore reviewed by the RIT via video link on 15 January 2021. The RIT comprised a high needs support counsellor, correctional supervisor and PLN. He presented as *'blunted'* in affect and tired and flat in mood. Some agitation was evident. He suggested the alleged offending was the result of *'police entrapment'*, but he was hesitant to engage, ceasing the review and requesting he be permitted to return to his cell. Potential risks to others were also identified. The RIT decided

[24] Exhibit C68-report of Dr Atherton at paragraph 30 and Exhibit C69-affifavit of Ian Thomas at paragraphs 6 to 8.
[25] Exhibit C71F.

Mr Gerard would be managed in an observation cell on a 'Level 3'[26] watch to monitor his mood and behaviour.[27]

30. Mr Gerard was reviewed by the RIT on 18 January 2021 by video link. While communicative, he spoke *'irrationally'* about things happening for a reason, that he'd used drugs at the time of the alleged offending and needed to be in Risdon Prison to help others. The LRP nurse noted Mr Gerard had been speaking about religious ideology and he was thought to be delusional. The Level 3 watch was maintained.[28]

31. At a RIT review on 20 January 2021 by video link, Mr Gerard asserted *'when the truth comes out they will see it's not my fault'*. Several risk factors were noted, but his immediate suicidal and self-harm risk appeared to be low. He was placed on a Level 4 watch. [29]

32. It seems a review by the RIT, which was planned for 25 January 2021, was not conducted however on 29 January 2021, Mr Gerard was transferred from LRP to RPC (Mersey Unit),

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[26] SASH risk levels are described in paragraph 8.1.1 of Exhibit 71F and they are outlined below:

| ALERT | DESCRIPTOR / MONITORING REQUIREMENTS |
|---|---|
| **ON WATCH – LEVEL 1** | Immediate high risk of suicide or self-harm identified or significant risk of attempt. **To be observed continuously.** |
| **ON WATCH – LEVEL 2** | Immediate risk of suicide or self-harm identified or significant risk of attempt or step down from more intensive level of watch. **To be observed at an interval no greater than 15 minutes.** |
| **ON WATCH – LEVEL 3** | Risk of suicide or self-harm identified requiring formal observation or step-down from more intensive level of management. **To be observed at an interval no greater 30 minutes.** |
| **ON WATCH – LEVEL 4** | Potential risk identified but no evidence of immediate risk identified or step down from higher level of observation. **To be observed at an interval no greater than two hourly.** |
| **ON WATCH – LEVEL 5** | Potential risk identified but no evidence of immediate risk or step down from higher level of observation. **Minimum of three contacts (documented) with staff per day** – contact to be spread across the day. |
| **ON ALERT** | Potential risk identified but no evidence of immediate risk or step down from higher level of observation. Person at risk continues to be reviewed by the Risk Intervention Team. |
| **PAST ALERT** | Previously identified as at risk or history of SASH behaviour during this episode. |
| **PREVIOUS SASH HISTORY** | ON ALERT or ON WATCH in previous episode. This is not an active alert status. This is an automatic flag raised through CIS which is placed on current episode to indicate past SASH concerns while previously in the custody of the TPS. |

[27] Exhibit C68-report of Dr Atherton at paragraph 31 and Exhibit C69-affidavit of Ian Thomas at paragraph 11.
[28] Exhibit C68-report of Dr Atherton at paragraph 32.
[29] Exhibit C68-report of Dr Atherton at paragraph 33.

remaining on a Level 4 watch. He was assigned a maximum security rating in line with the Tier 1 assessment.[30] The Mersey unit is a dedicated 15 bed needs assessment unit which enables TPS to comprehensively assess prisoner/remandees who present as potentially vulnerable in a prison environment and warrant further investigation prior to them being transferred to a mainstream accommodation area. Prisoners who require a high level of observation due to the potential suicide and self-harm risk may also be accommodated in this unit.[31] Mr Gerard spent four days in the Mersey unit before it was determined as a result of assessments that it was appropriate for him to be relocated to the mainstream maximum population of RPC on 2 February 2021.[32]

33. The RIT reported that Mr Gerard engaged well on 1 February 2021. He reflected he was withdrawing from cannabis and alcohol, and he expected he would likely be in prison for a prolonged period. He was reduced then to a 'Level 5' rating.[33]

34. Mr Gerard was reviewed by FMHS locum psychiatrist, Dr Stephen Patchett, on 5 February 2021, at which time he described chronic issues with insomnia. He said he had previously been diagnosed with post-traumatic stress disorder by a Centrelink psychologist who wrote a *'diagnostic letter that said [he] was a walking time bomb, anger'*. His past traumatic exposure included an accident in which his younger brother was hit by a car in childhood as a result of which his brother suffered a brain injury and subsequent disability. It seems Mr Gerard did not witness the accident, but answered the door when police returned his brother's blood-stained clothes. He also reported when as a young adult he found his older brother overdosed on heroin and he subsequently died in hospital. He advised Dr Patchett he had been *'seeing things'* in the context of methamphetamine use over the past 18 months, and increasingly so in the preceding three months. Mr Gerard said he had been *'feeling thoughts and things coming out of his mouth that the Holy Ghost was talking through his mouth'*. He said his ex-girlfriend was pregnant with his child, and he realised '*the baby was talking to him, Jesus complex, like I was something special and then I realised the baby was someone special, the second coming of Jesus Christ'. He clarified this was 'no voice', and that he '[felt] the thoughts'*, which Dr Patchett thought was more suggestive of *'thought insertion'* rather than auditory hallucinations. Mr Gerard referred to his years of daily cannabis use and alcohol use (up to a bottle of whisky a day), and recent intravenous methamphetamine use. He denied suicidal

[30] Exhibit C68-report of Dr Atherton at paragraph 34 and Exhibit C69-affifavit of Ian Thomas at paragraph 13.
[31] Exhibit C69-affifavit of Ian Thomas at paragraphs 14-15.
[32] Exhibit C69-affifavit of Ian Thomas at paragraph 17.
[33] Exhibit C68-report of Dr Atherton at paragraph 35.

ideation on this assessment. While cooperative and respectful, he was somewhat restless, made intense eye contact, and was affectively labile. Dr Patchett considered Mr Gerard's presentation was suggestive of a possible affective disorder, but drug induced psychosis and schizophrenia were also considered by him to be reasonable differential diagnoses. Antidepressant medications were prescribed.[34]

35. Mr Gerard was next reviewed on 13 February 2021 by members of the RIT, having earlier sent a health request which said *'[i]nsomnia sleepers abruptly stopped? WTF. Need to be transferred back to Mersey unit! No sleep! Thinking about suicide!'* Despite this he had to be woken in his cell for the RIT review. He complained about the unit he was placed in, and the restriction with *'lockdowns'*. He denied any *'planning or intent'* (of suicide) and *'guaranteed his safety'* at that time.[35]

36. When reviewed by the RIT on 19 February 2021 Mr Gerard was irritable and agitated. He complained of a lack of sleep and he asked to see a psychiatrist. He said he was getting *'psychic messages from people in the room'*. The RIT interview was terminated due to Mr Gerard's agitation.[36] Mr Gerard was discharged from the RIT process on 19 February 2021 as he had, at that time, no current suicidal self-harm thoughts. In addition he was receiving treatment through FMHS and CPHS. It was agreed to discharge him from the suicide and self-harm watch process at this time with ongoing reviews to occur through CPHS/FMHS. It was noted the RIT process seemed to be irritating Mr Gerard and there had been no actual suicidal self-harm behaviour since his incarceration. It was therefore agreed there was little to gain through ongoing RIT reviews and that reviews by a psychiatrist and a PLN were considered to be more beneficial.[37]

37. Mr Gerard was then reviewed by the CPHS mental health Medical Officer, Dr Gregory Spice, with a CPHS PLN, on 24 February 2021. At that stage, Mr Gerard was prescribed olanzapine 10mg at night, and citalopram 20mg in the morning. Dr Spice increased the olanzapine to 10mg twice daily, and added lithium carbonate 250mg at night. [38]

[34] Exhibit C68-report of Dr Atherton at paragraph 36.
[35] Exhibit C68-report of Dr Atherton at paragraph 37.
[36] Exhibit C68-report of Dr Atherton at paragraph 38.
[37] Exhibit C69-affifavit of Ian Thomas at paragraph 18.
[38] Exhibit C68-report of Dr Atherton at paragraph 39.

38. Mr Gerard refused to attend the RPC health clinic for his next appointment with Dr Spice on 11 March 2021. Dr Spice noted the instability in Mr Gerard's mental state over recent weeks, but that he had seemed *'more settled'* recently.[39]

39. Mr Gerard was reviewed by locum psychiatrist Dr Koruwage (Anthony) Fernando, on 26 March 2021, and he was accompanied by Dr Spice. TPS and CPHS staff had noted a deterioration in Mr Gerard's presentation, and it was suspected he may have been recently hoarding or diverting psychotropic medications. On review, he presented in an agitated, psychotic state, with religious and grandiose delusions. He admitted he had thoughts of harming others, which he would act on *'if they provoke me'*. The mood stabilising medication, sodium valproate, was initiated with a plan for up-titration. Diazepam was prescribed on a short-term basis to assist with agitation.[40]

40. On 26 March 2021 Mr Gerard was referred to be admitted to WLC for inpatient psychiatric treatment. On review with Dr Spice on 31 March 2021, Mr Gerard appeared more relaxed and reactive. He denied thoughts of self harm, or that he would act on agitation felt towards others. He noted his *'son had special powers to heal'*. Medication options were discussed, including the benefits of depot antipsychotic treatment. Mr Gerard was also advised of the referral to WLC.[41]

41. A CPHS PLN saw Mr Gerard on 11 April 2021 at his request, indicating he was going alright in his current placement, but *'remain[ed] concerned about his mental state'* and his future. Dr Spice reviewed Mr Gerard the next day during which he appeared to have gained some insight since the commencement of medication, but Dr Spice noted an increase in vigilance and *'re-emerging paranoia'*. Mr Gerard acknowledged concerns others were talking about him. Dr Spice noted Mr Gerard was reportedly beginning to appreciate the gravity of the charges he was subject to. It was also noted Mr Gerard was *'very needle phobic'*. [42]

42. Mr Gerard was admitted to WLC from 12 April until 3 July 2021 under FMHS locum psychiatrist Dr Patchett. During that admission, he was placed under an Authorisation of Treatment under the *Mental Health Act* 2013. The psychotic symptomatology was further explored and it included grandiose, religious, bizarre, and paranoid/conspiratorial delusions, auditory hallucinations, and other perceptual disturbances. In the lead-up to the alleged

[39]Exhibit C68-report of Dr Atherton at paragraph 40.
[40] Exhibit C68-report of Dr Atherton at paragraph 41
[41] Exhibit C68-report of Dr Atherton at paragraphs 42-43.
[42] Exhibit C68-report of Dr Atherton at paragraphs 44-45.

offending, Mr Gerard formed the delusional belief that Mr Hawkes had taken his son and raped, tortured, and killed him. He said the *'Holy Ghost'* took over his voice and spoke its own dialogue. He woke on the morning of the alleged offending *'convinced'* his son was dead, which he had to avenge. He also believed the victim was a *'Lizard Man'*, with conspiratorial implication. His mental state substantially improved with treatment, and he was able to develop some insight and accept that he was experiencing psychotic symptoms. He was diagnosed with paranoid schizophrenia. From at least May 2021, Mr Gerard become increasingly focused on wanting to return to prison, preferring prison to hospital for various reasons, including boredom at WLC and frustration with the ward's rules.[43] After 2 July 2021 Mr Gerard was returned to the mainstream maximum units within RPC where he remained until 22 December 2021.[44]

43. Mr Gerard was reviewed at RPC by FMHS locum psychiatrist Dr Fernando on 7 July 2021. Mr Gerard was considered to be slightly irritable, although he appeared to accept the schizophrenia diagnosis and that there were some benefits of the treatment he was receiving. He spoke *'insightfully'* about the circumstances of the alleged offending, and his relevant mental state. Despite having requested a return to prison, Mr Gerard advised Dr Fernando he wished to return to WLC. His reasons were the living spaces in prison were small and dirty, he disliked bunking with others, and preferred the quieter environment at WLC. He was frustrated at not being able to contact his lawyer and focused on obtaining a psychiatric report to support an insanity defence. Otherwise he did not present with overt psychotic symptoms during the review, but did seem *'somewhat despondent'* given his circumstances. His tolerance for frustration was low. He expressed some passive suicidal ideation, but he was not actively suicidal.[45]

44. Mr Gerard was reviewed by Dr Spice accompanied by a CPHS nurse, on 14 July 2021. He was noted to be polite and cooperative although he was still vigilant and anxious. Mr Gerard was returned to the RIT process and remained on a 'Level 4' rating in the *'inpatient'* area of RPC until 20 July 2021. He was regularly reviewed by the RIT during that period. He became frustrated that his placement in the inpatient area was prolonged due to operational constraints and lockdowns in prison. Mr Gerard was reviewed next by the RIT in the Mersey unit on 22 July 2021, at which time he was still being managed under a 'Level 4' RIT rating. His

[43] Exhibit C68-report of Dr Atherton at paragraph 46.
[44] Exhibit C69-affidavit of Ian Thomas at paragraph 21.
[45] Exhibit C68-report of Dr Atherton at paragraph 47.

depot antipsychotic medication was administered on 29 July 2021. RIT reviews continued on a weekly basis, as Mr Gerard remained on a Level 4 rating. Zuclopenthixol depots were administered fortnightly.[46]

45. On 18 August 2021 Mr Gerard was reviewed by FMHS locum psychiatrist Dr Fernando with a CPHS PLN present. This review occurred through the 'hatch', due to prisoners being in 'lockdown'; that is confined to their cells at the time. It was noted Mr Gerard's overall mental state had *'significantly improved'* with treatment, and he was more relaxed and less intense in his demeanour. His weight had increased, but he elected not to decrease his medication dosages at that time. He did not present with any overt psychotic symptoms, denied suicidal or self-harming ideation, denied thoughts to harm others, and denied recent conflicts with other detainees. It was agreed by those who comprised the RIT panel on 18 August 2021 that a 'Level 5' watch was appropriate.[47]

46. Dr Fernando appeared before the Mental Health Tribunal for the 60-day review of Mr Gerard's Treatment Order on 27 August 2021. The Treatment Order was continued. It was noted Mr Gerard had not been complying with his prescription of olanzapine, and therefore Dr Fernando decided to increase the depot zuclopenthixol dosage to 400mg fortnightly from 9 September 2021. He had been administered 350mg on 26 August 2021 with a plan to wean and cease the oral olanzapine over subsequent weeks.[48]

47. At a RIT review on 1 September 2021, Mr Gerard said he was receiving good support from CPHS, and did not consider he required additional support. He denied overwhelming concerns at that time, and denied suicidal or self-harming ideation or intent. It was decided he would be discharged from the RIT process.[49]

48. Mr Gerard remained in the Mersey Unit until late September 2021 and he was in contact with CPHS nurses during that time with ongoing fortnightly administration of his depot antipsychotic medication. His mental state remained relatively stable during this period, apart from some insomnia reported to a CPHS RN on 16 September 2021. On 24 September 2021 he was considered by a CPHS RN to be *'bright and reactive'*. He had lost some weight since his

[46] Exhibit C68-report of Dr Atherton at paragraphs 48-52.
[47] Exhibit C68-report of Dr Atherton at paragraphs 53-54.
[48] Exhibit C68-report of Dr Atherton at paragraph 55.
[49] Exhibit C68-report of Dr Atherton at paragraph 56.

previous depot injection, but a slight increase in weight was recorded at his subsequent depot administration on 8 October 2021.[50]

49. Mr Gerard was reviewed by Dr Spice on 11 October 2021. Mr Gerard reiterated his request to return to WLC which he considered a more benign environment. He seemed anxious which Dr Spice speculated might be due to Mr Gerard's upcoming court appearance. Mr Gerard reported little contact with his family and that, other than his mother, they *'all hate[d] [him]'*. There was some irritability noted initially during the review. His mood was reported as *'low'*, and appetite *'not good'*. He reported some anxiety and an inability to sleep. He discussed some of the circumstances of the alleged offending, including that he was being followed by *'a group of Muslims.' who 'talk[ed] to people behind [his] back.'*, encouraging them to steal from him and mistreat him. Mr Gerard agreed to a plan to utilise a low dose of the sedating anxiolytic antipsychotic, quetiapine, 100mg at night, to assist with his sleep. The prescribed mirtazapine was increased to 45mg at night having presumably been reduced since his return to RPC from WLC. Subsequently Mr Gerard continued his contact with CPHS nurses and he received his fortnightly depot injection.[51]

50. On 23 November 2021, Mr Gerard was reviewed by FMHS locum psychiatrist, Dr Bruce Kahn, via telehealth. Aspects of Mr Gerard's history were revisited. He said that while living in the community, he feared being killed, and that he worried about *'future events'*. He indicated he had a good appetite and adequate sleep. He reported he could read other people's minds in the past, but not at that time, and denied auditory hallucinations. He denied suicidal ideation. He reported some drowsiness which he associated with the depot antipsychotic medication, but said he was markedly less aggressive on it, and was happy to continue taking that medication. His background was explored, including aspects of his childhood and substance use history including a history of heavy alcohol and cannabis use and a three to four year history of MDMA and methamphetamine use although he reported on this occasion he only used methamphetamine intravenously for the first time on the day of the alleged offending. He reported using LSD six months prior to being taken into custody. Mr Gerard reported having never seen a psychiatrist prior to his incarceration, and that his recent admission to WLC had been his first psychiatric admission. Dr Khan otherwise found Mr Gerard to be polite and cooperative, though tense and wary. His affect was '*blunted, restricted, and constricted*', and although there may have been *'a subtle paranoid undertone'*, Dr Khan did not note any

[50] Exhibit C68-report of Dr Atherton at paragraph 57.
[51] Exhibit C68-report of Dr Atherton at paragraphs 58-59.

overt psychotic beliefs or perceptual disturbances. Dr Khan thought Mr Gerard exhibited some insight, that his judgement about treatment was reasonable, and that he was reasonably stable. Dr Kahn concluded Mr Gerard was a low risk to himself and others. No medication changes were made.[52]

51. Dr Khan next reviewed Mr Gerard by video link on 17 December 2021 with the CPHS PLN present. Mr Gerard reported he felt flat and unhappy most of the time, had little energy, experienced anhedonia and reduced interest, had occasional hopelessness and thoughts of giving up, and occasional suicidal ideation without active suicidal intentions. He continued to often feel wary and guarded, but at lower intensity than previously experienced. He was unkempt, some mild psychomotor slowing was noted, his affect was restricted, with relatively unspontaneous speech, and he was thought to display somewhat impoverished thinking. Dr Khan did not consider Mr Gerard's thought content exhibited severe depressive features, as he was not despairing or despondent. Mr Gerard denied active auditory hallucinations. Dr Khan considered the likely diagnosis of 'schizoaffective disorder, depressive type', though he also referred to the possibility of schizophrenia with occasional comorbid depression. Insight, and Mr Gerard's capacity to provide informed consent, were considered marginal, such that Dr Khan recommended Mr Gerard's management continue under a Treatment Order. Rather than prescribe quetiapine, per Mr Gerard's request, Dr Khan preferred to increase mirtazapine from 45mg to 60mg at night. No other medication changes were made.[53]

52. FMHS locum psychiatrist, Dr Claire Keating, reviewed Mr Gerard on 20 December 2021 in order to provide a second opinion with respect to an application to renew the Treatment Order which was in place. At that review Mr Gerard presented as *'very flat'*, with *'poor eye contact', 'delayed speech'*, and vague responses, though he was adequately kempt. Limited rapport could be established. Mr Gerard identified his past diagnosis as PTSD, describing his main symptoms as *'hypersensitive, anxiety, depression and paranoia'*. He denied flashbacks or *'voices'* but noted nightmares resulted in a poor sleep pattern. His mood was described as *'depressed'*, and he felt worried and hopeless about the future, ruminating about his upcoming court case, with the stress caused by that impacting on his sleep. He reported his appetite as *'ok'*, but he had low energy and motivation. There was no evidence of formal thought disorder or delusional thinking, and he denied 'voices' (i.e. auditory hallucinations). He reported recent suicidal ideation but denied plans or suicidal intent at the review. He

[52] Exhibit C68-report of Dr Atherton at paragraphs 60.
[53] Exhibit C68-report of Dr Atherton at paragraph 61.

struggled to identify protective factors, but remained in contact with his mother around twice weekly. Limited insight was noted along with ambivalence about the diagnosed psychotic disorder and antipsychotic treatment, which Mr Gerard asserted *'[made him] a veggie'.* Dr Keating's overall impression was of a psychotic illness with an affective component on a background of childhood trauma and long-standing polysubstance use. Depressive symptoms were considered prominent, and the potential increased risk to himself was noted in that context. In Dr Keating's opinion Mr Gerard lacked the capacity to make treatment decisions and therefore she supported the renewal of the Treatment Order.[54]

53. On 21 December 2021 the Sentence Management Review Panel of RPC reviewed Mr Gerard's security classification. The majority of the panel agreed to reduce his security classification from maximum to medium security. On 22 December 2021 Mr Gerard was moved to mainstream medium accommodation within the Kara Delta unit of RPC where he was located on the upper level of that unit. Only prisoners who are placed on a level 5 watch can be accommodated and managed within the medium precinct of RPC whereas prisoners on higher watch levels are managed in the maximum security units.[55]

54. On 31 December 2021, RPC was in lockdown, although Mr Gerard did receive his depot antipsychotic medication at the health clinic, where he was reviewed again by Dr Keating who was accompanied by the CPHS PLN. Dr Keating found Mr Gerard's presentation to be relatively unchanged. Her impression was that he continued to exhibit prominent depressive symptoms. He requested medication *'to lift [him] up'*, and also requested 'Valium' (diazepam). Given the mirtazapine dose was only recently increased to 60mg at night, no medication changes were made at that time. The Treatment Order was renewed by the Tasmanian Civil and Administrative Tribunal with an expiry date of 30 June 2022.[56]

55. Mr Gerard received his depot antipsychotic medication on 14 January 2022. The CPHS nurse noted a blunted affect. Mr Gerard denied hearing *'voices'* or other perceptual disturbances. It was noted Mr Gerard often did not come out of his cell and he kept to himself. [57]

56. On 27 January 2022, Mr Gerard's mother emailed CPHS expressing concern about her son's mental health. The CPHS Acting Specialty Director sought a further psychiatric review. On 2 February 2022, a CPHS nurse on medication rounds who had not seen Mr Gerard for several

[54] Exhibit C68-report of Dr Atherton at paragraph 62.
[55] Exhibit C69-affidavit of Ian Thomas at paragraphs 23-24.
[56] Exhibit C68-report of Dr Atherton at paragraphs 63-64.
[57] Exhibit C68-report of Dr Atherton at paragraph 65.

weeks, noted he had lost weight and started to look *'gaunt'*. Mr Gerard advised he was not eating and he had a reduced appetite.[58]

57. Mr Gerard was reviewed by FMHS locum psychiatrist Dr Ruchi Bhalla[59] on 02 February 2022 and she was accompanied by a CPHS PLN. Dr Bhalla considered Mr Gerard to be stabilised in terms of his psychosis, but she noted unresolved symptoms of depression, which were likely to be perpetuated by his ongoing court matters. She noted his recent move from the maximum to medium secure unit in the prison. Mr Gerard did indicate he had improved on the increased dose on mirtazapine. Dr Bhalla wondered whether sodium valproate was contributing to Mr Gerard's depression and tiredness, so she reduced the sodium valproate dose to 500mg daily.[60]

58. At a RIT review on 4 February 2022, Mr Gerard presented as *'flat'*, with minimal engagement which was characterised by mostly monosyllabic answers. He identified feelings of hopelessness, while denying suicidal or self-harming ideation or intent. Weight loss was noted, and the RIT planned to monitor Mr Gerard *'on alert'*[61], pending further investigation. The upcoming court hearing was noted.[62]

59. Mr Gerard's depot antipsychotic medication was administered on 11 February 2022. He was reviewed by Dr Bhalla and a CPHS PLN, at which time he presented as more flat in affect, and he was not forthcoming with information. There were no imminent risk concerns noted and it was observed he was under the RIT. No medication changes were made. A plan was made for a monthly psychiatric review, with PLNs monitoring Mr Gerard's mental state with his fortnightly depot administration, and particularly around his March 2022 court date.[63]

60. Mr Gerard was administered his antipsychotic depot by the CPHS nurse on 25 February 2022, at which time he was noted as being *'blunted'* but more reactive in conversation. He reported fleeting thoughts of suicide and self-harm and he was frustrated with court delays. He indicated he was able to *'guarantee his safety'*. He requested a review of his medication because he had reduced energy.[64]

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[58] Exhibit C68-report of Dr Atherton at paragraphs 66-67.
[59] Dr Bhalla is employed by Zeep Medical which contracted her services to the Tasmanian Health Service-see Transcript volume 1 page 35 lines 21-23 and her counsel's submissions at paragraph 10.
[60] Exhibit C68-report of Dr Atherton at paragraph 68.
[61] See the table at footnote 26.
[62] Exhibit C68-report of Dr Atherton at paragraph 69.
[63] Exhibit C68-report of Dr Atherton at paragraph 70.
[64] Exhibit C68-report of Dr Atherton at paragraph 71.

61. Mr Gerard was reviewed by the RIT on 3 March 2022. Again, he was considered to be *'flat'* in affect, he did not make eye contact, he reported anhedonia, and he spent his time sleeping. His weight loss was noted with Mr Gerard reporting a dislike for the food he was provided. He reported ongoing anxiety about the upcoming court appearance and some fleeting suicidal ideation. He mentioned a shoelace in that discussion with the CPHS PLN. It was recorded again that Mr Gerard's mother was his main support. The PLN noted that Mr Gerard's presentation might be indicative of *'negative symptoms'* of his diagnosed mental illness. He was placed on a 'Level 5' watch, which the RIT considered would be beneficial to allow increased interactions and behavioural observation.[65] Dr Bhalla's evidence was that the CPHS PLN was a very experienced psychiatric nurse and that if Mr Gerard required an adjustment to his level of observations she would have made that adjustment.[66] In addition Dr Bhalla reviewed Mr Gerard 8 days later.

62. Dr Bhalla reviewed Mr Gerard with the CPHS PLN on 11 March 2022, when he received his depot antipsychotic medication. He was more reactive on this review and was verging on irritable. He insisted the depot antipsychotic medication be discontinued due to lethargy, which would impede his ability to defend himself in court or against co-detainees. After negotiations he agreed to continue the medication on the basis that he would, at his request, be referred in order to be considered for opioid replacement therapy. He was seeking medication that would make him *'happy'*, preferring to be treated with Buvidal (depot buprenorphine) and quetiapine. Concerns about his insight were highlighted. Sodium valproate was ceased. It was recommended Mr Gerard remain under RIT alert while his court matters continued.[67] Dr Darjee did not expect there to be a link between reducing someone's dose of sodium valproate and that person taking their own life. In this particular case he noted there was actually an improvement in Mr Gerard's mental state.[68]

63. Mr Gerard was reviewed by the RIT on 21 March 2022 at which time he presented as quiet and blunted, with slow responses. He admitted to suicidal ideation, without any specific intent or plan. He asserted the depot antipsychotic had taken away his energy and therefore he could not exercise. He was nervous about his upcoming court hearing. As he could not be

[65] Exhibit C68-report of Dr Atherton at paragraph 72.
[66] Transcript Volume 1 page 76 lines 36-40.
[67] Exhibit C68-report of Dr Atherton at paragraph 73.
[68] Transcript Volume 1 page 80 lines 25-33.

actively engaged in any meaningful discussion about his suicide and self-harm risk it was agreed he would be maintained on a 'Level 5' watch pending court on 30 March 2022.[69]

64. Dr Bhalla reviewed Mr Gerard on 25 March 2022, after administration of his depot antipsychotic medication. There had been some shift in Mr Gerard's mental state since the sodium valproate had been ceased, with some warmth in his rapport, he was not irritable, and he did not ask for the depot to be ceased. It was considered Mr Gerard, broadly, had prominent negative symptoms of schizophrenia. He declined an offer to be reviewed by the WLC psychiatrist for an opinion on WLC admission and medication review, preferring to *'leave it'*. It appears from the records a potential reduction in mirtazapine was discussed.[70]

65. Mr Gerard was administered his depot antipsychotic medication on 8 April 2022. When reviewed by the RIT on 13 April 2022, he was still *'flat'* and *'blunted'*, but there was improvement noted. He denied suicidal or self-harming ideation. He admitted to worrying about his court matters. He asked to discuss some issues with the psychiatrist. The RIT decided to discharge Mr Gerard at that stage, with ongoing mental health follow-up via CPHS. Next he was administered his depot antipsychotic medication on 22 April 2022. His weight was recorded at 85.5kg.[71]

66. On 7 May 2022 Mr Gerard was briefly reviewed by the CPHS PLN and he was given his depot antipsychotic medication. He reported some 'low level' anxiety when thinking about his court case, but was otherwise doing well, was easily engaged, and made good eye contact. He denied feeling paranoid and reported he was coping well in his unit. His weight had decreased to 83.5kg. On 21 May 2022 Mr Gerard's antipsychotic medication was administered. His weight was recorded at 83.4kg. On review with the CPHS nurse, he was noted to be *'blunted'* in interactions, but he said he was coping in the unit and denied any current suicidal or self-harming ideation. He denied any paranoid ideation or psychotic symptoms, and his conversation otherwise seemed logical. He was scheduled for follow-up with the FMHS locum psychiatrist on 23 May 2022.[72]

67. As to missed appointments Mr Gerard refused to attend a scheduled review with the CPHS mental health medical officer on 11 March 2021 and a review with the FMHS locum psychiatrist on 3 August 2021 could not be facilitated *'due to Corrections staff unavailability /*

[69] Exhibit C68-report of Dr Atherton at paragraph 74.
[70] Exhibit C68-report of Dr Atherton at paragraph 75.
[71] Exhibit C68-report of Dr Atherton at paragraphs 76-78.
[72] Exhibit C68-report of Dr Atherton at paragraphs 79-81.

*lockdowns'*. [73] In addition Mr Gerard missed a review with Dr Bhalla in April 2022 because she was on leave that month and he was rescheduled to be reviewed on the date of his death.[74]

68. As indicated in paragraphs 42, 43 and 49 Mr Gerard was discharged from WLC to RPC on 2 July 2021 but on the 7 July 2021 and 11 October 2021 he indicated that he wished to return to WLC. Dr Bhalla who reviewed Mr Gerard on 2 February, 11 February, 11 March and 25 March 2022[75] was of the opinion Mr Gerard did not meet the threshold for an urgent transfer to WLC despite his poor mental health. Her reasons for that view were that although Mr Gerard was subject to a treatment order he was not refusing his fortnightly depo medication at which time he engaged with a PLN. In addition she said he accepted a referral which Dr Bhalla initiated to the counselling service within the prison so that he could discuss the challenges of being on remand on a serious charge.[76]

69. Dr Bhalla 's advised that when she took over the care of Mr Gerard it was her view he was *"receiving appropriate treatment for his mental illness within the remit of the Mental Health Act."*[77] She noted individuals with a major mental illness particularly depression or schizophrenia, are at an increased risk of suicide within a prison environment[78] and it *"can be difficult for clinicians to differentiate between depressive illness and negative symptoms of schizophrenia, and also to identify an intention to self-harm, especially if the patient is not forthcoming about such an intent."*[79] In addition Dr Bhalla advised low mood, feelings of isolation and hopelessness were common within the prison population[80] and that she believed such symptoms would be present in half the prison population.[81]

70. At the time of Mr Gerard's death Dr Darjee said there was only one permanent psychiatrist working in RPC, namely Dr Bhalla, although when he gave evidence he indicated there was one permanent psychiatrist Dr Gray, who works four days per week, and a trainee psychiatrist, Dr Jasper, who works two days per week although her placement in the TPS was not permanent.[82] He went on to say that *"… the level of resource in the prison mental health*

[73] Exhibit C68-report of Dr Atherton at paragraphs 83-84.
[74] Transcript Volume 1 page 50 lines 9-35.
[75] Exhibit C25-report of Dr Bhalla at paragraphs 17, 25, 26 and 28.
[76] Transcript Volume 1 page 48 lines 26-43.
[77] Exhibit C25-report of Dr Bhalla at paragraph 14.
[78] Exhibit C25-report of Dr Bhalla at paragraph 12.
[79] Exhibit C25-report of Dr Bhalla at paragraph 13.
[80] Exhibit C25-report of Dr Bhalla at paragraph 12.
[81] Transcript Volume 1 page 37 lines 35-39.
[82] Transcript Volume 1 page 83 lines 26-42.

*service is the lowest I've come across in any developed country."* [83] To put this evidence into context Dr Dargee gave evidence he believed there are over 900 people in prison in Tasmania[84] whereas Mr Thomas indicated the number was, at the date he gave evidence[85], 798.[86]

**The Kara Delta Unit and lockdowns within the medium security precinct of RPC**

71. This unit, in which Mr Gerard died, was commissioned in 2006. It houses male medium security rated prisoners. Only those prisoners who have a "level 5" watch classification can be accommodated and managed within this precinct of RPC.[87]

72. The medium precinct of RPC is comprised of seven x two story units with each unit containing a common room, kitchenette and a communal bathroom with two showers and two toilets. The lower level of each unit is comprised of two self-contained areas with six cells each whereas the upper level of each unit is comprised of two self-contained areas with eight cells in each.[88]

73. Mr Thomas indicated that although minor improvements have been carried out in the medium precinct of RPC the TPS was aware some ligature points remained. He said this was due to the nature of the environment and the age of the infrastructure.[89]

74. When Mr Gerard moved into the Kara unit in December 2021 he was placed in cell 5 Delta which is a double bed cell located in the upstairs level of the unit. Shortly thereafter he was moved to cell 1 which is a standard single cell. [90]

75. On 18 May 2022 a prisoner in Mr Gerard's unit tested positive for the COVID-19 virus. The unit was therefore quarantined for seven days pending further positive test results. Mr Gerard tested positive to that virus the day prior to his death.[91]

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[83] Transcript Volume 1 page 87 lines 8-11.
[84] Transcript Volume 2 page 18 lines 13-14.
[85] 21 November 2023.
[86] Transcript Volume 2 page 18 line 20. On 20 November 2023 Mr Thomas said they opened the prison with 801 people in custody which is the highest TPS has ever had in custody.
[87] Exhibit C69-affidavit of Ian Thomas at paragraphs 24, 25 and 28.
[88] Exhibit C69-affidavit of Ian Thomas at paragraph 26.
[89] Exhibit C69-affidavit of Ian Thomas at paragraph 27.
[90] Exhibit C69-affidavit of Ian Thomas at paragraph 29.
[91] Exhibit C71-affidavit of Ian Thomas at paragraphs 11-12.

76. In the 22 days leading up to Mr Gerard's death in May 2022 a part of the median precinct of RPC was in lockdown on each of those days. There was a total of 79 lockdowns during that 22 day period. On 20 of those 22 days there were two or more lockdowns in the medium precinct of RPC with the breakdown being as follows:

- 2 lockdowns – 3 days
- 3 lockdowns – 2 days
- 4 lockdowns – 10 days and
- 5 lockdowns – 5 days.[92]

77. Of the 79 lockdowns during the 22 day period the entire prison population in the medium unit was locked down on 46 occasions and between four and 40 prisoners were locked down on the remaining 33 occasions. A lockdown during this period lasted for between 30 minutes and 11 hours. There were nine lockdowns in excess of five hours and five lockdowns in excess of eight hours.[93] The planned out of cell hours for the median precinct of RPC in May 2022 was 07:30 hours to 18:30 hours and this included a one hour lockdown for lunch. Lockdown data is not available for individual units in the RPC median precinct.[94]

78. There are a number of reasons specified for the lockdowns. Mr Thomas advised "Operational Requirements" denoted a lockdown was the result of unforeseen or unexpected operational matters such as an incident resulting in the redeployment of staff, an unanticipated medical escort, or given the time it may have been for rapid antigen testing of prisoners for COVID-19.[95] There were 40 lockdowns for operational requirements in the 22 days leading to Mr Gerard's death.

79. "Unusual or Special Event" denoted a lockdown was due to COVID-19 quarantine. During May 2022 the strategy of TPS to this virus was in Response Mode 2 which included directions that close contact with symptomatic prisoners were to be quarantined in their allocated cell/unit and not to be moved unless medically necessary.[96] There were 34 such lockdowns over this 22 day period.

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[92] Exhibit C71A. The only days in which there was one lockdown was on 6 and 20 May 2022.
[93] Exhibit C71A.
[94] Exhibit C71-affidavit of Ian Thomas at paragraphs 3 and 5.
[95] Exhibit C71-affidavit of Ian Thomas at paragraph 8.
[96] Exhibit C71-affidavit of Ian Thomas at paragraph 9.

80. Other reasons included staff shortages (four lockdowns) and disciplinary matters (1 lockdown).[97]

**The Events leading to Mr Gerard's death**

81. CCTV footage from inside the Kara Delta unit was seized by me.[98] This footage depicts Mr Gerard entering the communal bathroom area of his unit at 4:43am on 23 May 2022. No other person was in the bathroom at that time and no other person was seen to enter or exit that area of the unit until approximately 7:30am.[99]

82. Vision is also available in the master control room which is monitored although there are hundreds of cameras in the prison which appear on a monitor which scrolls through what is being captured on each of the cameras. If an incident is captured then that camera will automatically appear on a monitor as a fixed screen. Unless that occurs there is nothing which will capture the attention of staff.[100]

83. Staffing levels within the prison at the time of Mr Gerard's death consisted of a central pool of 9 staff for the entire prison complex plus a supervisor. There was no staff member in the Kara Delta unit itself.[101]

84. At approximately 7:20am the morning roll call or muster for Mr Gerard's unit was conducted. Mr Gerard failed to present himself and so another prisoner, Rodney Crosswell, went to Mr Gerard's cell to attempt to establish his whereabouts. Mr Gerard could not be found in his cell. Mr Crosswell then went to the shower area where he discovered Mr Gerard hanging after which he immediately informed the two custodial officers who were present.[102]

85. At approximately 7:25am a code blue was called whereupon custodial officers entered the shower area and found Mr Gerard hanging by a ligature from the shower cubicle doorframe. The floor was noted to be slippery and wet. It was later determined this was a mixture of water and detergent. Mr Gerard was found to be cold and grey and he was unresponsive.[103]

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[97] Exhibit C71A.
[98] Exhibit C55.
[99] Exhibit C22-affidavit of Detective Constable Rebecca Berriman at paragraph 13.
[100] Transcript Volume 1 page 126 lines 29-43.
[101] Transcript Volume 1 page 128 lines 20-22 and page 129 lines 19-30.
[102] Exhibit C50-TPS incident investigation report at paragraphs 3.1-3.3.
[103] Exhibit C50-TPS incident investigation report at paragraphs 3.6 and 3.10.

86. A defibrillator was requested and it was brought to the Kara Delta Unit by a Dedicated Response Team at which time it was deployed.[104] This device was stored in the medium precinct office block which is about 50 to 60 m away from the Kara Delta Unit.[105]

87. At 7:33am an ambulance was called.[106] Attempts, using the defibrillator and CPR, were made to try and revive Mr Gerard until 8:10am.[107]

88. At 8:05am the first ambulance arrived[108] followed by the second ambulance at 8:10am. At 8:13am a rapid response vehicle arrived with a doctor.[109] The paramedics in attendance declared Mr Gerard to be deceased at 8:15am.[110]

89. In his investigation with respect to Mr Gerard's death Mr Thomas determined there was an initial reporting of a serious assault or a possible murder. This was incorrect. He says this error demonstrated confusion on the part of staff and he described it as showing a lack of clear command and control. He also determined there was a lack of clarity as to who the incident controller was.[111]

**Autopsy and blood testing**

90. The forensic pathologist Dr Christopher Lawrence conducted an autopsy on Mr Gerard on 24 May 2022. As a result of conducting an internal and external examination, and after considering the results of histology, toxicology and microbiology together with the results of a post-mortem CT scan Dr Lawrence says Mr Gerard died as result of a partially suspended hanging. He also had Covid – 19. There were no suspicious circumstances and no evidence that he had been assaulted and/or murdered. I accept the opinion of Dr Lawrence.[112]

91. The toxicology results confirmed the presence of therapeutic levels of the antipsychotic Zuclopenthixol and mirtazapine.[113]

**The Police investigation**

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[104] Exhibit C50-TPS incident investigation report at paragraphs 3.11 and 3.13.
[105] Transcript Volume 1 page 131 lines 10 – 16.
[106] Exhibit C6 Ambulance Tasmania electronic patient care record at page 4.
[107] Exhibit C50-TPS incident investigation report at paragraph 3.15.
[108] Exhibit C6 Ambulance Tasmania electronic patient care record at page 4.
[109] Exhibit C50-TPS incident investigation report at paragraphs 3.22-3.23.
[110] Exhibit C50-TPS incident investigation report at paragraph 3.24.
[111] Exhibit C50-TPS incident investigation report at paragraphs 4.4 and 4.7.
[112] See exhibit C4.
[113] Exhibit C5-affidavit of the forensic scientist Mr Neil McLachlan–Troup.

92. On the morning of 23 May 2022 officers from Tasmania police attended TPS to investigate Mr Gerard's death. Detective Constable Berriman attended with Detective Sergeant Preshaw and Detective Sergeant Adams from the Bellerive Criminal Investigation Branch. Uniformed officers were also in attendance. Police received a briefing and inspected the Kara Delta unit. Detective Constable Berriman says she examined Mr Gerard and noticed a mark on his neck which she says was consistent with something having been tightly placed around his neck.[114] She noted no other injuries.[115] Detective Constable Berriman searched Mr Gerard's cell but did not locate anything of interest.[116] She also searched the bathroom and located shoelaces on the floor at the entrance to a toilet cubicle.[117] She thought the laces were black in appearance however she did not know what type of lace it was.[118]

93. Four other inmates were present in the Kara Delta Unit at the time of Mr Gerard's death namely John Robert Bennett, Rodney Gene Dwayne Crosswell, Brock Mathew Everett and Samuel Jayden Paul Smith. Each inmate was interviewed by Detective Sergeant Preshaw and Detective Constable Berriman. The interviews were conducted on video at RPC using a police issued tablet. It was not apparent at the time of the interviews that the audio function on the tablet was not working.[119] Fortunately police made notes and Detective Constable Berriman based her affidavit as to what each inmate said from those notes.[120] The inmates did not raise any concerns about Mr Gerard and she considered their versions of events to be consistent.[121] Detective Constable Berriman says the inmates told her the detergent on the floor was *"just them stuffing around."*[122]

94. As a result of their investigations which included speaking to TPS staff, interviewing the four inmates mentioned above, examining the scene and examining Mr Gerard Detective Constable Berriman concluded there was no evidence Mr Gerard was assaulted.[123] Consistent with this conclusion is the evidence of Mr Thomas who said TPS staff assumed Mr Gerard had been assaulted without entering the unit.[124]

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[114] Exhibit C22-affidavit of Detective Constable Berriman at paragraph 8
[115] Exhibit C22-affidavit of Detective Constable Berriman at paragraph 10.
[116] Exhibit C22-affidavit of Detective Constable Berriman at paragraph 11.
[117] Exhibit C22-affidavit of Detective Constable Berriman at paragraph 12.
[118] Transcript Volume 1 page 27 lines 28 – 30.
[119] Exhibit C22-affidavit of Detective Constable Berriman at paragraphs 5 and 14 and exhibit C21-affidavit of Detective Sergeant Preshaw at paragraphs 6, 13 and 17.
[120] Transcript volume 1 page 27 lines 10 -30.
[121] Exhibit C22-affidavit of Detective Constable Berriman at paragraph 16.
[122] Transcript Volume 1 page 27 line 43.
[123] Transcript Volume 1 page 27 lines 17-19.
[124] Transcript Volume 1 page 130 lines 17-31.

95. Detective Constable Berriman said there was nothing suspicious with respect to Mr Gerard's death and there was no evidence to suggest that anyone else was involved.[125] I agree.

**The TPS investigation**

96. Mr Thomas investigated the circumstances surrounding Mr Gerard's death and his report is in evidence.[126] He found that the practice of prisoners needing to report to the window for a head count at daily muster which was in place at the time of Mr Gerard's death meant that TPS staff were initially reliant on another prisoner establishing Mr Gerard's whereabouts and that prisoner being exposed to Mr Gerard's hanging.[127]

97. Keys to the Kara Delta Unit were located about 50 m away from the shower area in which Mr Gerard died.[128] Mr Thomas also found the practice of staff needing to seek access to the units from a control area causes critical delays when a unit needs to be accessed in an emergency.[129] As a result of this finding all unit keys are now issued to the medium security communications officer post which are personally issued at the commencement of a shift. If this post is not covered the keys are issued to the medium security correctional supervisor. These posts operate within the medium security precinct and they provide closer proximity to the units in an emergency thereby reducing potential delays associated with accessing the medium security units.[130]

98. A cut-down knife was carried by a supervisor.[131] He arrived within two minutes of the alarm being raised.[132] First responders had difficulties trying to cut Mr Gerard down and there was no cut-down knife allocated to their post.[133] Director's standing order 1.39 (Cut-Down Knives) was at the time of this inquest under review and it was expected to include an increase in the personal use of such knives in the medium precinct of RPC.[134] Mr Thomas in his evidence referred to a "fish knife" with the intention being that such a device be issued to all staff.[135] Mr Thomas described these knives in the following terms[136]: *"– we're we're going to*

[125] Transcript Volume 1 page 28 line 41 to page 29 line 2.
[126] Exhibit C50.
[127] Exhibit C50 at paragraph 4.2.
[128] Transcript Volume 1 page 125 at lines 27-36.
[129] Exhibit C50 at paragraph 4.3.
[130] Exhibit C69 – affidavit of Ian Thomas at paragraph 48 (b).
[131] Transcript Volume 1 page 126 lines 14-15.
[132] Transcript Volume 1 page 126 lines 19-20.
[133] Exhibit C50 at paragraph 3.8.
[134] Exhibit C69 – affidavit of Ian Thomas at paragraph 48 (d).
[135] Transcript Volume 1 page 130 lines 41-44 to page 131 lines 1-3.
[136] Transcript Volume 1 page 130 lines 43-44.

*introduce what is called a a fish knife, it's only called a fish knife 'cause it looks like a fish but the mouth allows you to place it over a ligature and cut through a ligature without exposing your hands or anyone else's to the blade."*

99. Mr Thomas also determined that during the initial stages of this incident the VoIP phone system[137] (which operate all internal phones within RPC) was off-line. The cause of this outage has not been able to be determined.[138]

100. A live "Code Blue"[139] exercise was conducted on 16 November 2022 to test the lines of communication and their effectiveness which was aimed at addressing the issues raised in Mr Thomas' investigation of Mr Gerard's death.[140] The target is six such tests are to be run in each facility each year.[141]

101. Mr Thomas did not consider there was anything suspicious about Mr Gerard's death and he said it was *"unfortunately a tragic event."*[142]

**Hanging Points**

102. The hanging point within the bathroom of the Kara Delta unit is depicted in photograph 10 of exhibit C47. It is a metal rail or cap situated at the top of a shower cubicle which has two panels on either side of a gap from which a shower curtain might be hung. Despite being commissioned as recently as 2006 it is obvious this represents a potential hanging point.

103. Mr Thomas has advised that despite minor improvements having been made in the medium precinct of RPC, TPS is aware that some ligature points remain.[143] In addition he advised that a *"hanging point minimisation strategy"* is adopted wherever possible however some of the facilities were commissioned as early as the 1960s and in some cases hanging point minimisation is not achievable due to limitations for the aged infrastructure or the nature of the environment. He says eliminating the ability for a self-inflicted death in prison for every

[137] My understanding of a VoIP phone system is that it uses IP (Internet Protocol) technologies for placing and transmitting telephone calls over an IP network such as the Internet.
[138] Exhibit C69 – affidavit of Ian Thomas at paragraph 47.
[139] This is where an inmate requires resuscitation or otherwise is in need of immediate medical attention.
[140] Exhibit C69 – affidavit of Ian Thomas at paragraph 48 (c).
[141] Transcript Volume 1 page 126 lines 1-2.
[142] Transcript Volume 1 page 132 lines 12-15.
[143] Exhibit C69 – affidavit of Ian Thomas at paragraph 27.

prisoner is insurmountable which is why the approach of the TPS is driven by *"structured professional judgement"* incorporating individual assessments.[144]

104. When asked Mr Thomas conceded that no risk assessments had been conducted in the shower area where Mr Gerard died since 2006 and this included after Mr Gerard's death.[145] He also advised there had been no modifications to the ligature point used by Mr Gerard since his death.[146]

105. Mr Thomas also conceded no work had been done with respect to rectifying the particular hanging point used by Mr Gerard because there were literally thousands of ligature points across the TPS that they would need to find ways to remove and which would make the prison environment very sparse and punitive in approach. It would mean some of the units would be unusable for significant periods while rectification work was being carried out and this would result in more prisoners sharing cells and a worsening of conditions generally. In addition the Ron Barwick Prison is over 60 years old and rectifying that facility is *"probably unrealistic"*. Even then he says the risk is not completely removed because if *"somebody wants to hurt themselves or kill themselves, unfortunately statistics tell us they will find a way to do it."* [147] In addition Mr Thomas advised there are 28 shower blocks at RPC identical to the shower block in which Mr Gerard died. [148]

106. Ms Chen pointed out that in addition to there being 28 identical shower blocks to the one in which Mr Gerard died the evidence also established:

- the 28 shower blocks have been in place since 2006; that is 17 years up until the time of this inquest;
- prisoners using those shower blocks have been assessed as low risk for SASH;
- the total number of prisoners that can be held in medium security, where Mr Gerard's death occurred, is 196[149];
- tens of thousands of prisoners have used the shower blocks since 2006; and
- Mr Gerard's death is the first and only death by hanging in one of those 28 shower blocks.

[144] Exhibit C71 – affidavit of Ian Thomas at paragraphs 33, 34 and 36.
[145] Transcript Volume 1 page 110 line 39 to page 111 line 3.
[146] Transcript Volume 1 page 111 lines 23-25.
[147] Transcript Volume 2 page 66 line 36 to page 67 line 12.
[148] Transcript Volume 2 page 75 lines 1-3.
[149] Transcript Volume 2 page 36 line 38.

107. I agree the evidence establishes all but the fourth dot point in paragraph 106. There is no evidence with respect to the fourth dot point which appears to be an inference from the fact that there are 28 identical shower blocks together with the first and third dot points. While I am prepared to accept the showers in these 28 blocks have been used on tens of thousands of occasions since 2006 I am not prepared to infer that equates to tens of thousands of prisoners.

**The availability of shoelaces to inmates and detainees**

108. The availability of shoelaces to inmates and detainees was a significant issue at this inquest for three reasons:

- first this was the ligature used by Mr Gerard to take his own life;
- second it had previously been recommended by Coroner Cooper in 2017, with respect to the death of Robin Michael, that slip on footwear replace all footwear with laces for all prisoners and detainees in the TPS; and
- third there has been 3 deaths in Tasmanian prisons since 2012 whereby inmates have hung themselves using shoelaces namely Mr Percy in 2012[150], Mr Michael in 2015[151] and Mr Gerard in 2022; that is a 3 deaths in 10 years for inmates who had been housed in the medium security precinct of RPC.[152]

109. Mr Bell's evidence was that he did not believe there had been any review of policies in respect of shoelaces despite Coroner Cooper's recommendation.[153]

110. The TPS has a number of policies in relation to clothing and footwear which include the following:

- While being escorted externally from a TPS facility all prisoners are required to wear non-laced shoes. This instruction was contained in a memorandum issued to all staff on 18 August 2022 by the RPC Operations Superintendent; that is after Mr Gerard's death.[154] This direction was incorporated into DSO 1.20 *External Escorts, Medical Appointments and Hospital Admissions* on 1 September 2022.[155]

[150] [2014] TASCD 236.
[151] [2017] TASCD 254.
[152] Transcript Volume 2 page 39 lines 38-42.
[153] Transcript Volume 1 page 99 lines 29-30.
[154] Exhibit C 71 – affidavit of Ian Thomas at paragraph 14 and Exhibit 71B.
[155] Exhibit C 71 – affidavit of Ian Thomas at paragraph 16 and Exhibit 71C at clause 8 and Appendices G-J at clause 3.

- Adult watch house detainees are required to remove their shoes prior to entering cells. This order has been in place since at least 20 September 2013 and it was contained in an updated DSO 1.35 *Adult Watch House Detainees* issued in January 2023.[156]
- Prisoners' property is provided for under DSO 4.14 titled *Prisoner Property* which was issued in October 2022. That DSO sets out the standard prison issue property list which in appendix G includes footwear (one pair of shoes) and work specific clothing and footwear. The previous DSO, issued in 2006, did not contain a standard prison – issue property list.[157] The current DSO makes no mention of shoelaces.
- DSO 2.01 titled *Suicide and Self-Harm (SASH) Prevention* issued in December 2018 provides that shoes are not permitted for prisoners in observation and safe cells. The order was scheduled for review in 2021 and that review, at the time of this inquest, was underway with an expected completion date of early this year.[158] Mr Thomas agreed there needed to be a focus on shoelaces given there has been 3 deaths since 2012 where prisoners have used a shoelace as a ligature.[159]

111. There is no other evidence with respect to footwear and the use of, or prohibition of using, laces. It appears from the evidence that an individual approach is taken so that a risk assessment is conducted with respect to each inmate and that a risk assessment is conducted with respect to each prisoner at any given point in time. Therefore if the prisoner or detainee is deemed to be a low risk of SASH the use of shoelaces is permitted whereas if they are assessed as being a high risk of SASH the use of shoelaces by that prisoner is prohibited.[160]

112. At the time of his death Mr Gerard was wearing velcro sneakers. They are depicted in photographs 4 and 10 of exhibit C47.

113. The ligature used by Mr Gerard was according to TPS two brown boot laces tied together. These laces were supplied to specific employment positions within the medium security precinct of RPC. No boots were located in the Kara Delta unit with missing laces. After investigating this matter it is not known where Mr Gerard obtain those laces from. While 5 prisoners were allocated work boots for gardening purposes at any one time no further

[156] Exhibit C 71 – affidavit of Ian Thomas at paragraph 18 and Exhibit 71D at Appendix B at clause 5.
[157] Exhibit C 71 – affidavit of Ian Thomas at paragraph 19 and Exhibit 71E.
[158] Exhibit C 71 – affidavit of Ian Thomas at paragraph 20 and Exhibit 71F.
[159] Transcript Volume 1 page 137 lines 31-35.
[160] Exhibit C 71 – affidavit of Ian Thomas at paragraph 30.

investigations were made as to whether the garden crew were missing laces from their boots. Mr Gerard was not part of that working group and his only purchases of laces from the canteen were replacement sandshoe laces and a pair of sandshoes with laces which would not have contained brown boot laces. Twelve prisoners had purchased brown boot laces within the prison in addition to those who had been allocated boots as part of their employment but no further evidence was available with respect to those transactions.[161]

114. It is clear from the evidence in this case the laces used by Mr Gerard were in fact black in colour and not brown.[162] Detective Constable Berriman also believed the laces were black[163] and she indicated in her evidence that prisoners swap laces with one another.[164]

115. Mr Thomas says that the absolute restriction or prohibition on laced shoes within prisons is not common practice in Australia.[165] Although Mr Thomas agreed to provide further information in relation to this point that has not been received. I can only infer from his statement that there is a prohibition on laced shoes in some prisons in Australia.

116. As to the individualised approach to risk assessments Dr Darjee made the following concessions in his evidence:

- a risk assessment applies only to the day on which it is conducted because on the next day a trigger can cause a different risk profile[166];
- psychiatry is not a precise science[167];
- a lie by a patient, in respect of he or she having no suicidal thoughts, can lead a clinician into error[168]; and
- a lie by patient, in terms of he or she having no active suicidal plan, can also lead a clinician into error.[169]

117. In an Australian Institute of Criminology trends and issues paper titled *Self inflicted deaths in Australian prisons* (number 513 August 2016) it says that in the period between 1999 and

[161] Exhibit C69 – affidavit of Ian Thomas at paragraphs 41, 43, 44, 45 and 46.
[162] See Exhibit 47 photograph number 15.
[163] Transcript Volume 1 page 27 line 28.
[164] Transcript Volume 1 page 33 line 35.
[165] Exhibit C 71 – affidavit of Ian Thomas at paragraph 32.
[166] Transcript Volume 2 page 13 lines 7-10.
[167] Transcript Volume 2 page 14 lines 23-26.
[168] Transcript Volume 2 page 15 lines 16-18.
[169] Transcript Volume 2 page 15 lines 25-27.

2013 prisoners were more likely to take their own lives by hanging (86%) than by any other means.

118. Both Mr Thomas and Dr Darjee gave evidence that a blanket ban on shoelaces would be ineffective in eliminating and/or reducing suicide rates in prison[170]. Dr Darjee says the reasons for this are:

- prisoners have access to various everyday items that could be used as ligatures in prisons including bras, ropes, belts, scarves, towels, bedclothes, shoelaces and electric cables[171];
- it would be impossible for there to be a blanket ban on prisoners having access to all "everyday" potential ligatures[172];
- studies show that while people in prisons and other closed institutions do sometimes use shoelaces to commit suicide it is more common for people to use other everyday items, such as clothing, underwear, bedclothes etc.[173]; and
- he is unaware of any scientific or statistical evidence which demonstrates that a wholesale ban on shoelaces has any effect on suicide rates in prison.

119. Dr Darjee also advised of possible unintended consequences of implementing such a ban which included prisons feeling more dehumanised and perhaps prisoners or detainees turning to other means of self-harm.[174] He was unaware of any prisons outside of the USA that banned shoelaces as a blanket measure. I note Counsel Assisting submitted that in this respect Dr Darjee had no evidence to support his view. Ms Chen countered by saying that maybe so however Dr Darjee's professional observations and opinions on these matters should not be readily dismissed.

120. Mr Thomas says the national data does not suggest that shoe laces are the most significant risk in relation to self-inflicted deaths in custody. He cited the study referred to in paragraph 117 which revealed 10% of hanging deaths involve the use of shoelaces and that prisoners most often used bedsheets (59%).

**Discussion**

[170] Exhibit C 72 – affidavit of Dr Darjee at paragraph 7.
[171] Exhibit C 72 – affidavit of Dr Darjee at paragraph 8.
[172] Exhibit C 72 – affidavit of Dr Darjee at paragraph 8.
[173] Exhibit C 72 – affidavit of Dr Darjee at paragraph 9.
[174] Exhibit C 72 – affidavit of Dr Darjee at paragraphs 14-17.

*Section 28(5) of the Act*

121. Where an inquest is held in circumstances where the person died while he or she was in custody this section requires me to report on the care, supervision or treatment of that person while they were held in custody. Counsel for DoJ, Ms Chen, quite properly did not dispute that Mr Gerard was a person held in custody at the time of his death and therefore I must report on his care, supervision or treatment.[175]

122. Counsel assisting submitted Mr Gerard's *"treatment was adequate and in that sense his death was not preventable."* [176] Ms Chen submitted the evidence demonstrated that the care, treatment or supervision of Mr Gerard was at all times reasonable and appropriate. Ms Darcey, on behalf of Dr Bhalla, submitted her client provided a high standard of mental health care to Mr Gerard during those occasions when he was under her care.[177] Mr Barns SC, on behalf of Mr Gerard's parents, submitted Mr Gerard *"is a victim of a grossly inadequate mental health care system in the TPS"*[178]

123. The evidence establishes Mr Gerard had a long history of mental illness and substance abuse. Leading up to the alleged murder Mr Gerard showed symptoms of psychosis and he was described by his girlfriend as psychotic. He believed his son TO had been kidnapped and he wanted to take his own life because he could not locate his son. In addition he must have known police had a strong case against him and that if convicted of the criminal charges which had been laid he would receive a lengthy period of imprisonment and would perhaps spend the best part of the remainder of his life serving that sentence. In addition while in prison his girlfriend had given birth to a child who Mr Gerard believed was his, and in the circumstances described, it was likely he would have little involvement in that child's life. His mental health fluctuated during his time in prison. There were periods during his incarceration when he was clearly very unwell.

124. In addition during May 2022 the medium precinct of RPC was locked down on numerous occasions as set out in paragraph 76 and 77 and Mr Gerard's unit was quarantined from 18 May 2022 due to the COVID 19 virus. Mr Gerard himself contracted that virus the day prior to his death. There is also evidence that his court proceedings were causing him stress and anxiety.

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[175] Submissions dated 25 March 2024 at paragraph 3.
[176] Submissions dated 23 February 2024 at paragraph 106.
[177] Submissions dated 25 March 2024 at paragraph 38.
[178] Submissions dated 21 March 2024 at page 3.

125. In so far as mental health treatment and care is concerned he was taken into custody on 14 January 2021 and remained in the custody of TPS for just in excess of the next 16 months. Mr Gerard underwent a Tier 1 assessment on him entering custody after which he underwent 6 RIT reviews until he was discharged from that process on 19 February 2021. He was returned to the RIT process on 14 July through to 1 September 2021. He was finally returned to the RIT process on 4 February 2022 where he was regularly reviewed up until 13 April 2022 before he was again discharged.

126. In addition to the treatment set out in paragraph 125 he was an impatient at WLC between 12 April and 3 July 2021. Outside of the psychiatric treatment received during that period he was reviewed by six separate locum psychiatrists on a total of 18 occasions; the last occasion being 25 March 2022. Each fortnight he was administered his regular depot medication at which time he was reviewed by a PLN. A PLN also saw Mr Gerard each time he was reviewed by a psychiatrist.

127. In addition Mr Gerard was subject to urgent circumstances treatment (an authorisation of treatment) and then a treatment order under the provisions of the *Mental Health Act* 2013 from 2 July 2021. This order was renewed in January 2022 and was due to expire on 30 June 2022.

128. In my view Mr Gerard's medical treatment and care was reasonable but this finding is in the context of Dr Darjee's unchallenged evidence that the level of resources in the mental health service provided by the entities described in paragraphs 20- 22 is the lowest he has come across in **any** developed country.[179] He went further and said he did not think anyone he knew would disagree with that proposition.[180] Dr Darjee said at the time he gave evidence they had 80 to 90 mental health patients within the prison who have to be reviewed by the mental health team. At that time that caseload had to be dealt with by one psychiatrist, one PLN and one other nurse. He understood there had been two reviews previously looking at the resourcing of mental health services and his understanding was there needed to be between 12 and 15 mental health staff not including a psychiatrist. He said one review was conducted by an external consultant in 2017 and the other was a prison task force review conducted in 2019.[181]

[179] My emphasis.
[180] Transcript Volume 1 page 87 lines 8-11.
[181] Transcript Volume 1 page 87 line 35 to page 88 line 27.

129. The missed appointment with Dr Bhalla in April 2022 given her absence on leave may well not have occurred if additional resources were provided for mental health services within the prison system. I note almost two months had elapsed between the time of Mr Gerard's last psychiatric assessment on 25 March 2022 and his death. Had there been more resources he may have been seen more frequently by a psychiatrist. Likewise the mention of the shoelace at the RIT review on 3 March 2022 on a background of weight loss, suicidal ideation and anxiety about upcoming court appearances may have been treated with greater significance if those tasked with the responsibility of providing mental health services at the prison had more time to assess and treat their patients.

130. Mr Gerard was provided with appropriate and reasonable supervision by TPS staff during the time which led to his death. I do not criticise prison staff for not noticing Mr Gerard enter the shower area and re-emerge within a reasonable time, given the time of morning. While Mr Thomas identified a number of systems issues relating to Mr Gerard's death as a result of his investigation none of those issues contributed in any way to his death as those issues arose well after Mr Gerard had passed away. Attending staff rendered appropriate first-aid to Mr Gerard but were unable to prevent his death.

131. As a result of Mr Thomas' investigation he made a number of recommendations which are set out in his report[182] and which have been approved. I agree with each and every one of them and trust they will be implemented.

132. Similar to what occurred in the case of Robin Michael[183] there was a delay in obtaining a cut-down knife. Although the delay was of no consequence in this case it may be life-threatening in any future, similar cases. It seems evidence in this case, at paragraph 98, where first responders had no access to a cut-down knife is contrary to the direction given on 10 July 2015, after Mr Michael's death, that from that date all first and second response teams were to carry a cut-down knife. I therefore agree with the proposal canvassed in paragraph 98 that all staff be issued with a "fish knife" which will enable any first responder to cut down an inmate without delay.

*A review of mental health services within the TPS?*

[182] Exhibit C50.
[183] [2017] TASCD 254.

133. At paragraph 116 of his submissions Counsel Assisting suggests I comment, pursuant to s28(3) of the Act, that the Tasmanian Government provide greater funding for psychiatric services within the Tasmanian prison system. Mr Barns SC, in his submissions goes further and suggests I recommend that a panel of experts be appointed immediately to review the current mental health care provision of the service in the TPS and to advise what is required in terms of resources and cultural change to ensure international and national correctional healthcare standards are met consistently by the TPS.

134. Ms Chen submits, at paragraph 9 of her submissions, that while an increase in such funding is a laudable aim and further resources would be welcomed, matters of government expenditure are the domain of the executive arm of government and are not ordinarily matters upon which courts comment. She submits such a comment, and by inference a recommendation, *"would run counter to widely accepted principles of the separation of powers"* and therefore she submits such a comment would not be appropriate and I infer she would also submit such a recommendation would be inappropriate.

135. The power of a coroner to comment and/or to make recommendations is set out in s28 of the Act in the following terms:

> *"(2) A coroner **must**, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.*
> *(3) A coroner **may** comment on any matter connected with the death including public health or safety or the administration of justice."* (my emphasis).

Those provisions are couched in very wide terms and are not fettered in any way. It is the statutory duty of a coroner to make recommendations with respect to ways of preventing further deaths and she or he has a discretion to comment on any matter connected with the death including public health or safety.

136. Coroner Stanton, in *Liam Mead – Ruling on Evidence* dated 2 August 2019, discussed the authorities concerning the proper scope of an investigation into the circumstances of a death and the associated functions of making comments and recommendations. In his ruling at paragraph 16, his Honour said:

> *"It is well established that an inquest ought not be held solely to enable comments or recommendations to be made. The power to make such comments and*

*recommendations is not free standing. The coroner has no power to conduct a roving commission of inquiry into any matter connected with the death.*
*Indeed, the power to comment and make recommendations is subordinate and incidental to the power to make findings relating to how death occurred and their causes. The powers to comment and make recommendations arise as a consequence of the prime function to make findings about how death occurred and the cause of death: Harmsworth v State Coroner [1989] VR 989 per Nathan J at 996. But once an inquest is held, although the limits on the power to comment are not easily defined, it is wide so long as it is connected with the death: Commissioner of Police v Hallenstein [1996] 2 VR 1 per Hedigan J at 7. Similarly recommendations must be made with respect to ways to prevent further deaths whenever appropriate. The reference to "further deaths" requires that the recommendations arise out of, or have some connection to, the findings in respect of this death. In Attorney General v Copper Mines of Tasmania Pty Ltd referred to above, Blow CJ said that the duty to investigate the circumstances leading up to the death includes doing so with a view to making recommendations with respect to ways of preventing further deaths and other appropriate matters: at [45]."*

137. I respectfully agree his Honour has set out the proper approach to a coroner's power to comment and make recommendations. It is clear from many past cases recommendations have been directed towards, for example hospitals (both public and private), regulatory bodies, private companies and government departments. There are many past recommendations which if implemented would involve government expenditure. Recent examples where recommendations have been made and if implemented would involve government expenditure include *Kane Leary* [2024] TASCD 147, *Rickie Underwood Barron* [2023] TASCD 431, Damian Crump [2023] TASCD 437 *and Paul George Hunt and Others* [2023] TASCD 561.

138. While I would normally agree with Ms Chen's submission, in this case it should be noted an inquest is an inquisitorial proceeding and not a proceeding between parties.[184] In addition it is clear from the plain words of s28(2) and (3) that the power to make recommendations and/or comments is wide and unfettered so long as it is connected with the death under investigation. To agree with Ms Chen's submission would mean a coroner would be

[184] *R v South London Coroner; ex parte Thompson* (1982) 126 Sol Jo 625 at 628; *Annetts v McCann* (1990) 170 CLR 596 at 616; *R v North Humberside Coroner; ex parte Jamieson* [1995] QB 1 at 17; *R v State Coroner; ex parte Minister for Health* [2009] WASCA 165, 38 WAR 553 at [21].

prevented, for example, from making a recommendation which would prevent further deaths simply because the recommendation involves the expenditure of public monies. That would defeat the making of comments and recommendations with respect to improvements to any systemic issues that would enhance prison safety, for example, in the future. It may also impede independent and public scrutiny by a coroner of government practice and procedures and it may also prevent continual improvements in those procedures. It has been said this enhances accountability, transparency and responsible government.[185] If I accepted Ms Chen's submission it would prevent a coroner from undertaking his or her mandatory statutory duty in so far as recommendations are concerned. I therefore reject her submission.

139. Is a review of mental health services within the TPS therefore necessary? The starting point is the *United Nations Standard Minimum Rules for the Treatment of Prisoners* which are known as the Nelson Mandela Rules (The Mandela Rules). Rule 24 provides as follows:

> *"1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*
> *2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence."*

140. The Mandela Rules provide guidance for interpreting Australia's treaty obligations under the

United Nations' international covenant on civil and political rights and convention against torture and other cruel, inhumane or degrading treatment or punishment which were signed by Australia in 1980 and 1985 respectively.[186]

141. In addition in the publication *Guiding Principles for Corrections in Australia* it is said the principles *"represent a national intent around which each Australian state and territory* [including Tasmania] *will develop its practices, policies, and performance standards."* The principles are intended to reflect social expectations of correctional services within Australia and they are aligned to recognise international best practice. The principles support

[185] Tasmanian Coronial Practice Handbook at page 160.
[186] Anita Mackay, *Human rights guidance for Australian prisons: Complementing implementation of the OPCAT* (2021) 46 Alternative Law Journal 20-26.

correctional services in this country to achieve best practice in a number of outcomes which includes health and well-being of prisoners. These outcomes are seen as critical to achieving results by way of a reduction in reoffending and the provision of value for money in corrections services in Australia. To inform the principles internationally accepted rules such as the Mandela Rules have been examined. In so far as health and well-being is concerned guidelines 4.14 4.15 are as follows:

> *"4.1.4 Prisoners are provided a standard of health care equal to services available in the community that meet their individual physical health, mental health and social care needs fostering continuity of care between custody and the community.*
> *4.1.5 Prisoners are provided with appropriate health practitioners to deliver the right care at the right time, consistent with equivalent codes of conduct and professional/ethical standards as those applying to public health services in the community."*

142. I was also referred to the World Health Organisation publication *"Good governance for prison health in the 21st century"*[187] which at page 15 says:

> *"States have a special, sovereign duty of care for prisoners. They are accountable for all avoidable health impairments to prisoners caused by inadequate health care measures or inadequate prison conditions with regard to hygiene, catering, space, heating, lighting, ventilation, physical activity and social contacts."*

143. That governments, such as the Tasmanian Government, through the TPS has a duty of care to its prisoners is beyond doubt. In *M v Secretary, Department of Immigration and Multicultural and Indigenous Affairs and Another* (2005) 216 ALR 252 the applicants were inmates of the Baxter immigration detention centre in South Australia. They had been held in immigration detention centres in South Australia and Western Australia since 2000. In January and February 2005 they commenced proceedings in negligence against the Secretary of the Department and the Commonwealth claiming they breached the duty to take reasonable care to ensure their safety while in detention, a duty which includes the provision of reasonable physical and mental health care. The court found, amongst other things, the Commonwealth's relationship to immigration detainees who suffer from a mental illness, and the non-delegable

[187] https://iris.who.int/handle/10665/326388

duty of care arising from it, is analogous to the relationship between hospitals and their patients, and gaols and their prisoners. The relationships are similar in the degree of control exercised over detainees, the responsibility assumed for their medical care and their extreme vulnerability and dependence. The minimum which must be expected of the Commonwealth in the fulfilment of its duty is that it take reasonable care of detainees, who by reason of their detention are unable to take care of themselves. It must ensure that a level of medical care is available to detainees, which meets their needs in respect of both their physical and mental health.[188] The same reasoning is equally applicable to the relationship which existed between the TPS and Mr Gerard.

144. Given Dr Darjee's unchallenged evidence set out in paragraph 128, the Mandela Rules cited above, the Guiding Principles for Corrections which the State Government has agreed to, the statutory right every prisoner and detainee has to reasonable medical care and treatment for the preservation of health, and if mentally ill, the right to have reasonable access to such special care and treatment as a medical officer considers necessary or desirable in the circumstances[189] and the duty of care which the State Government owes to all inmates **I recommend an urgent review be conducted of the current mental health care services being provided to inmates in the TPS and that the recommendations of any such review be implemented in order to ensure the TPS meets its international and national correctional healthcare obligations.**

*Hanging Points*

145. Counsel Assisting, Mr Lee, submitted that based on the evidence at this inquest I should recommend TPS undertake a risk assessment in respect of the particular hanging point used by a prisoner whenever there is a death or an attempt by a prisoner to take his or her own life, with a view to eliminating that hanging point and any identical points within the prison system. Further it was submitted that I recommend TPS give greater consideration to identifying potential hanging points when reviewing draft architectural plans for new building works and all modifications. Mr Lee noted the medium precinct of RPC was commissioned as recently as 2006 and is not part of the Ron Barwick Prison. He submitted what was apparent from looking at the photographs of the curtain rail of the shower was that it was a blatantly obvious hanging point. He queried the necessity for a railing and questioned why the panels

[188] See paragraphs 207, 208, 209, 210 and 212 of the judgment.
[189] S29(1)(f) and (g) of the *Corrections Act* 1997.

on either side of the railing could not extend to the ceiling. He also questioned how even an apprentice architect would permit that shower structure *"to pass muster"* and he was surprised to learn that no risk assessment had been carried out of the ligature point after Mr Gerard's death or remedial building works undertaken. That there were still 28 similar structures within the prison was, he said, difficult to accept in this day and age.

146. Mr Barns SC submitted TPS should act to eliminate hanging points from existing prison cells and that DOJ engage an independent consultant to conduct an immediate review of all prison cells and implement solutions to eliminate obvious hanging points.

147. Ms Chen indicated there was no issue taken with either of the recommendations suggested by Mr Lee and she made no submissions with respect to those made by Mr Barns SC. As to the questions and queries raised by Mr Lee which are set out in paragraph 145 Ms Chen submitted there was no expert architectural engineering evidence as to the design and construction standards applying to prison shower blocks in 2006 and nor was there evidence as to how those standards might differ to contemporary standards. In addition there was no expert evidence given as to what steps might be required to make prison shower blocks constructed in 2006 comply with 2023 standards – or whether retrospective compliance was even possible. There was no evidence as the construction costs or the logistics of attempting to conduct modifications across 28 shower blocks within the context of a working prison. There was no evidence given of the comparative cost of servicing the existing showers blocks versus the costs of a newly built facility. Accordingly in the absence of such evidence she submitted I had a limited capacity to properly answer any of Mr Lee's rhetorical questions and/or queries.

148. It was submitted by Ms Chen the evidence in paragraph 106, which in my view is subject to the qualification in paragraph 107, does not demonstrate the shower block in question poses a significant or unreasonable risk of hanging. That of course is not the test in relation to any civil liability that might lie against the State. That test is whether a reasonable person in the position of the TPS would have foreseen that its conduct involved a risk of injury to Mr Gerard or to a class of persons including Mr Gerard; ie mentally ill prisoners or detainees. A risk of injury which is remote in the sense that it is extremely unlikely to occur may nevertheless constitute a foreseeable risk. A risk which is not far-fetched or fanciful is real and therefore foreseeable. In this case I do not think it could be reasonably argued the risk was far-fetched or fanciful. It certainly could not be after Mr Gerard's death. It is then for a civil court to determine what a reasonable person in the position of the TPS would do by way of response

to the risk. The assessment of the reasonableness of that response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the TPS may have.[190] Clearly the magnitude of the risk is very significant because death results if an inmate succeeds in hanging him or herself. So far as the probability of the risk is concerned there have been five deaths of people in the custody of TPS since 2012; three of whom died by hanging through using shoelaces. I agree with Ms Chen that I have no evidence with respect to expense, difficulty and inconvenience of taking any alleviating action. This analysis suggests to me something needs to be done about hanging points. Mr Lee's suggested recommendations, which Ms Chen agrees with, only looks at hanging points used by a prisoner in a successful and/or unsuccessful suicide attempt and that greater consideration be given to eradicating hanging points when plans for new building works and all modifications are being considered. Those recommendations do nothing for hanging points which remain on TPS property but which have not been used by inmates to hang themselves.

149. It is to be noted Coroner Cooper has recommended in so far as hanging points in the Ron Barwick Prison are concerned that the only practical solution is a complete replacement of that facility and short of that he recommended the TPS continue to develop and implement plans to remove all, or as many as are reasonably possible, hanging points in the accommodation areas in that prison.[191]

150. Nationally there have been calls, in excess of over 33 years ago, for the removal of hanging points in prison cells.[192] More recently there have been numerous comments and/or

[190] *Wyong Shire Council v Shirt* (1980) 146 CLR 40 per Mason J, as he then was, at 47-48.
[191] *Rickie Underwood Barron* [2023] TASCD 431.
[192] Royal Commission into Aboriginal Deaths in Custody the recommendations of which were made on 30 March 1991. The relevant recommendation is recommendation 165.

recommendations made in a number of States with respect to the removal of hanging points from prison cells.[193]

151. While I accept it is difficult to remove all hanging points from the Ron Barwick Prison because of the age of the infrastructure and perhaps the significant cost, the medium security precinct was commissioned in 2006 some 17 years after the findings of the Royal Commission into Aboriginal Deaths in Custody were handed down. There have been numerous recommendations and/or comments made in inquests Australia wide for prison authorities to remove hanging points in cells.[194] While something is being done by way of risk assessments of hanging points in Tasmania after a death or attempted suicide or when new facilities are being planned or when modifications are being conducted nothing is being done with respect to assessing old infrastructure and/or removing obvious and potential hanging points.

152. As Mr Thomas acknowledged he is aware some hanging points remain.[195] Further no risk assessments have been conducted after Mr Gerard's death nor has there been any remedial works undertaken with respect to the hanging point used by Mr Gerard. This position is untenable.[196]

153. The medical evidence suggests there are significant difficulties in predicting suicides with inmates because of the shortcomings with respect to risk assessments which are highlighted by Dr Darjee in paragraph 116. Given these limitations my view is more effort must be made to make each cell and communal living quarters safer by removing obvious hanging points. I therefore repeat Coroner Cooper's recommendation which he made with respect to the Ron Barwick prison but this time it is made with respect to the medium precinct of RPC**. I**

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[193] Examples include:
**Victoria**: Brouwer, G E --- *"Investigation into deaths and harm in custody"* [2014] VicOmbPRp 4 (26 March 2014)- recommendation 19; Finding into death with inquest of Brandon, Darren (COR 2018 2778) [2020] VicCorC 26432 (6 April 2020) at paragraph 162.3.
**Tasmania**: Rickie Underwood Barron [2023] TASCD 431;
**New South Wales**: Inquest into the death of Kerry-Ellen (Nikki) Knight (2021/64779) [2022] NSWCorC 64 (28 September 2022)- a hanging that occurred through the use of a shower railing- at paragraph 145; Inquest into the death of Tane Chatfield (2017/288854) [2020] NSWCorC 53 (26 August 2020) at page 33;
**Queensland**: SVE (2019/1180) [2021] QldCorC 50 (24 May 2021) at paragraphs 73, 74 and 101;
**South Australia**: Stachor, Joshua Marek - Inquest Number 45/2020 (2363/2017) [2021] SACorC 8 (28 June 2021) at Paragraph 33.3 recommendation no.1;
**Western Australia**: Inquest into the Death of Jordan Robert Anderson (CORC 365 of 2017) [2020] WACorC 74 (22 December 2020) page 46 recommendation 1 and Inquest into the 5 Deaths in Casuarina Prison who are Mervyn Kenneth Douglas Bell and Bevan Stanley Cameron and Brian Robert Honeywood and JS and Aubrey Anthony Shannon Wallam (Ref No: 14/19) [2019] WACorC 18 (22 May 2019) page 128 recommendation no.2.
[194] See footnote 193 for some examples.
[195] See paragraph 103.
[196] See paragraphs 104 and 105.

**recommend TPS continue to develop and implement plans to remove all, or as many as are reasonably possible, hanging points in the accommodation and communal living areas of the medium precinct of RPC. This includes removal of the hanging point used by Mr Gerard and any similar hanging point in the medium security precinct of RPC.**

*The availability of shoelaces to inmates and detainees*

154. Mr Lee is submitted I make a recommendation that slip on footwear replace all footwear with laces for all prisoners and detainees in the TPS. Mr Barns SC agreed with that submission. In response Ms Chen provided detailed submissions which referred to the evidence of Dr Darjee and Mr Thomas. She submitted Counsel assisting was inviting me to disregard their evidence and recommend a blanket ban on the availability of shoelaces within the TPS. She submitted I should refrain from making such a recommendation. Ms Chen submitted Dr Darjee's evidence was the only expert evidence before the court as to the state of current scientific and statistical data *"going to prison suicides by a ligature."*

155. There is no doubt, as submitted by Ms Chen, Dr Darjee is a highly credentialed and experienced consultant forensic psychiatrist. His reasoning for recommending there not be a blanket ban on the availability of shoelaces is set out in paragraph 118. He also spoke about unintended consequences of such a policy at paragraph 119 and referred to prisoners feeling more dehumanised as a result of the implementation of such a policy. Mr Thomas' reasoning for his opposition to a blanket ban is set out in paragraph 120. Mr Thomas' position appears to conflict with his evidence whereby he agreed there needed to be a focus on shoelaces.[197] As explained in paragraph 111 an individualised risk assessment is conducted with each inmate.

156. As previously mentioned an individualised risk assessment has its shortcomings and it does not prevent death by hanging in the TPS. This case is evidence of that proposition. While I respect the joint position of Dr Darjee and Mr Thomas and the evidence on which they rely that evidence ignores what has actually occurred in the TPS since 2012. What has occurred in the TPS since 2012 is that three prisoners[198] housed in the medium security precinct of RPC have hung themselves by using shoelaces. Another[199], who was housed in the Ron Barwick Prison, used a fabric cord and fabric ties while the final inmate[200] hung himself in a prison van,

[197] See paragraph 110.
[198] Mr Percy, Mr Michael and Mr Gerard.
[199] Mr Baron.
[200] Troy Colin Monson [2017] TASCD 253.

using a seatbelt, while he was being transported from LRP to RPC. That is over a ten-year period from 2012 five prisoners have committed suicide by hanging within the TPS and 60% of those prisoners have used a ligature made out of a shoelace.

157. I also question the reasoning behind the supposed dehumanisation of prisoners if they are denied access to items such as shoelaces. Dr Darjee indicated in his evidence he thought *"anything we can do to make life in prison as normal as possible"* is worthwhile and a blanket ban on shoe laces was disproportionate.[201] The plain fact of the matter is life within a prison is not normal. For example an inmate cannot come and go as he or she pleases and they are subject to restrictions such as what times meals are and when they have to retire in the evening and get up in the morning. They are provided with prison issue clothing which they must wear within RPC. They are subject to lockdowns. Prisoners are restricted in what property they are entitled to possess in their cell.[202] In my view the provision of shoelaces cannot overcome such restrictions on a prisoner's life and liberty.

158. I note a number of years ago the TPS banned prisoners from smoking. One might think a prisoner who was a long term smoker and addicted to nicotine may well have felt dehumanised by the implementation of this blanket ban. The evidence is this blanket ban was imposed to improve the health of inmates, to eliminate tobacco becoming a highly attractive contraband in the prison[203] and in the UK, at least, prisons were work places and public buildings and to be consistent with the ban in other workplaces and public buildings smoking in prisons was banned.

159. I would venture to suggest it would be more dehumanising to lockdown sections and/or the entirety of the medium section of RPC on the 79 occasions in the 22 days leading to Mr Gerard's death than it would be to deny him access to shoelaces. It would be dehumanising not to provide him with footwear but that of course is not the case here. Mr Gerard was provided with footwear and he was able to purchase his own.

160. I therefore do not accept the argument that prisoners are dehumanised if they are denied items such as shoelaces. Contrary to the evidence of Dr Darjee and Mr Thomas the evidence in this State is as set out in paragraph 156. I am required by statute, whenever appropriate, to make recommendations with respect to ways of preventing further deaths**. I therefore**

[201] Transcript volume 2 page 18 lines 16-17 and lines 23-24.
[202] Exhibit C71E DSO 4.14.
[203] Transcript volume 2 page 47 line 38 to page 48 line 3 (Mr Thomas) and page 32 lines 16-24 (Dr Darjee).

**recommend that slip on footwear replace all footwear with laces for all prisoners and detainees in the TPS.** This recommendation is consistent with the recommendation of Coroner Cooper in 2017.

**Conclusions and recommendations**

161. The findings required by s28(1) of the Act are set out in paragraph 7.

162. My report, pursuant to s28(5) of the Act, on the care, supervision or treatment of Mr Gerard, while he was a person held in custody is set out in paragraphs 121 to 132.

163. I repeat the **recommendations** set out in paragraph 144, 153 and 160.

164. The evidence when viewed as a whole satisfies me to the requisite legal standard that the actions which caused Mr Gerard's death were undertaken by him voluntarily, alone and with the express intention of ending his own life. The circumstances in which his body was found, the findings at autopsy, the circumstances in which he found himself prior to death and his poor mental health all lead to this conclusion.

165. In addition there are no suspicious circumstances associated with Mr Gerard's death. No other person was involved in the acts which led to his passing.

166. I consider the response of TPS staff and Ambulance Tasmania personnel was swift and professional. By the time they were alerted to Mr Gerard's absence from his cell he had been deceased for some time. Nothing else could have been done to save him.

167. I thank all counsel, namely Mr Lee, Mr Barns SC, Ms Chen and Ms Darcey, for their assistance in this matter.

168. In concluding, I convey my sincere condolences to the family and loved ones of Mr Gerard.

**Dated:** 18 April 2024 at Hobart in the State of Tasmania.

**Magistrate Robert Webster**
**Coroner**