
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : Philip John Urquhart, Coroner
HEARD : 13 June 2023 - 15 June 2023
DELIVERED : 21 DECEMBER 2023
FILE NO/S : CORC 864 of 2019
DECEASED : ROBERTS, SHANE NATHAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

S Markham, assisted the Coroner

D Van Nellestijn, assisted by E Tapsell, appeared on behalf of the Department of Justice

B Burke appeared on behalf of nurses D Etherington, T Deakin and S Kemp

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

Nil

AMENDED RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Shane Nathan ROBERTS** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 13 – 14 June 2023, find that the identity of the deceased person was **Shane Nathan ROBERTS** and that death occurred on 24 June 2019 at Hakea Prison, Nicholson Road, Canning Vale, from ligature compression of the neck (hanging) in the following circumstances:*

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LIST OF ABBREVIATIONS & ACRONYMS

Abbreviation	Meaning
ACM	Australian Corrections Medal
ARMS	At Risk Management System
the <i>Briginshaw</i> principle	the accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
CCU	Crisis Care Unit
CPR	cardiopulmonary resuscitation
the Department	the Department of Justice
the Document	the Department of Health’s “Principles and Best Practice for the Care of People who May Be Suicidal”
EcHO	the Department’s Electronic Health Online system for recording a prisoner’s medical information
the Expert Group	the group from the Stewardship of Prison Health and WHO European Network on Prisons and Health that produced “Good governance for prison health in the 21 st century: A policy brief on the organisation of prison health”
FTE	full-time equivalent
Hakea	Hakea Prison
MADRS	Montgomery - Asberg Depression Rating Scale
the MHT	the Mental Health Team
PCS	Prison Counselling Service
PRAG	Prisoner Risk Assessment Group
PTS	the Prisoner Telephone System
RACGP	the Royal Australian College of General Practitioners
ROI	Release of (Medical) Information provided by the prisoner’s community doctor
the SPGU	the Suicide Prevention Governance Unit
SAMS	Support And Monitoring System
WHO	World Health Organisation

INTRODUCTION

“Some of our important choices have a timeline. If we delay a decision, the opportunity is gone forever.”

James E Faust – American lawyer & politician

1. On 24 June 2019, the deceased (Mr Roberts), a prisoner at Hakea Prison (Hakea), was found inside his cell with a ligature around his neck. Despite resuscitation efforts, Mr Roberts could not be revived.
2. At the time of his death, Mr Roberts was a remand prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).¹ Hence, immediately before his death, Mr Roberts was a “*person held in care*” within the meaning of the *Coroners Act 1996 (WA)* and his death was a “*reportable death*”.² In such circumstances, a coronial inquest is mandatory.³
3. On 13-14 June 2023, I held an inquest into Mr Roberts’ death in Perth. The following nine witnesses gave oral evidence:
 - Colleen Sorensen (counsellor at Hakea);
 - David Etherington (mental health nurse at Hakea);
 - Dr Edward Petch (consultant psychiatrist at Hakea);
 - Ruth Dabell (mental health nurse at Hakea);
 - Samara Kemp (mental health nurse at Hakea);
 - Dr Adam Brett (independent consultant psychiatrist);
 - Trina Deakin (mental health nurse at Hakea);
 - Dr Joy Rowland ACM⁴ (Director of Medical Services at the Department); and
 - Thomas Perrin (review officer at the Department).
4. The documentary evidence at the inquest comprised of one volume of the brief which was tendered as exhibit 1 at the commencement of the inquest. Also, at the start of the inquest, Ms Van Nellestijn, counsel appearing on behalf of the Department, tendered a letter dated 12 June 2023 from Dr Joy Rowland. This letter became tab 21.1 in exhibit 1. Ms Van Nellestijn also tendered another letter dated 13 June 2023 from the

¹ *Prisons Act 1991 (WA)* s 16

² *Coroners Act 1996 (WA)* s 3, s 22(1)(a)

³ *Coroners Act 1996 (WA)* s 25(3)

⁴ Australian Corrections Medal

State Solicitor's Office in response to inquiries from the Court. That letter became exhibit 2.

5. During the inquest, counsel assisting, Ms Markham, tendered an email from Mr Roberts' ex-partner dated 13 June 2023. This email outlined some background to Mr Roberts' mental health issues. This document became exhibit 3.
6. At the conclusion of the inquest, I sought some information from the Department regarding the existence of a consultant psychiatrist position within the Department. The Court received an email response from Ms Van Nellestijn dated 17 October 2023.
7. The inquest focused on the treatment and care provided to Mr Roberts, primarily in regard to his mental health, during his time as a prisoner at Hakea.
8. When making my findings, I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the *Briginshaw* principle).⁵
9. I am also mindful not to insert hindsight bias into my assessment of the actions taken by those responsible for Mr Roberts' supervision, treatment and care when he was in prison. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.⁶

MR ROBERTS

*Background*⁷

10. Mr Roberts was born on 18 December 1977 at Subiaco. He was 41 years old when he died. From the age of two years, he was raised by his grandparents. Mr Roberts did not meet his biological father until he was 11 years old. His grandparents were able to provide a stable environment for him to grow up in.

⁵ *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362 (Dixon J)

⁶ Dillon H and Hadley M, *The Australasian Coroners Manual* (2015) 10

⁷ Exhibit 1, Tab 23 Statement of Chantell Morgan dated 26 July 2020; Exhibit 1, Tab 26, Report from Dr Adam Brett dated 12 January 2023; Exhibit 3, Email from Shantell Morgan to counsel assisting dated 13 June 2023

11. Mr Roberts was a qualified boilermaker and occupational health and safety advisor. He had previously been in a long-term relationship with a partner and they had one daughter together.
12. For many years, Mr Roberts used cannabis daily and methylamphetamine on most days. His illicit drug use became worse after 2012 and he was subsequently unable to maintain regular employment. Mr Roberts began displaying paranoid behaviour that was most likely drug-induced.
13. In July 2018, police took Mr Roberts to Rockingham General Hospital after he threatened to shoot himself. He was subsequently admitted for two days to the hospital's mental health unit.
14. The diagnoses listed on the discharge summary were adjustment disorder, methylamphetamine and cannabis abuse, cluster B personality disorder, depressed mood and suicidal ideation. It was also noted Mr Roberts had a chronic risk of poor judgement secondary to impulsivity, and that he had antisocial and borderline personality disorder traits. He was prescribed a short course of quetiapine (an antipsychotic) and follow up was arranged with a community mental health service.
15. Despite these follow up arrangements, it would appear Mr Roberts was never subsequently managed by a community mental health service.
16. On 9 August 2018, his general practitioner completed a mental health care plan with a referral to psychological services.
17. Mr Roberts' increasing violent and erratic behaviour led to the end of his relationship with his partner in November 2018.

Circumstances of imprisonment⁸

18. After being charged with a number of offences that included serious allegations of sexual offending, Mr Roberts was remanded in custody on 27 February 2019. Although he had a criminal record, Mr Roberts had not previously been sentenced to a term of immediate imprisonment.
19. From 27 February 2019 until his death on 24 June 2019, Mr Roberts was remanded in Hakea. He made no application for bail during this time⁹ and his next court appearance was scheduled for 24 July 2019 in Rockingham Magistrates Court.

⁸ Exhibit 1, Tab 26, Review of Death in Custody Report dated April 2023

⁹ Exhibit 2, Letter from the State Solicitor's Office dated 13 June 2023

*Prison history*¹⁰

20. Mr Roberts was not a management issue during his imprisonment and he received no internal prison charges or loss of privileges. He maintained regular contact with his family and friends through telephone calls. Mr Roberts also had regular visits and he maintained ongoing contact with his daughter through correspondence. He had also obtained employment in the laundry at Hakea.

**OVERVIEW OF THE TREATMENT AND CARE PROVIDED TO
MR ROBERTS FOR HIS MENTAL HEALTH**¹¹

27 February 2019: Mr Roberts' intake assessment

21. When Mr Roberts was initially remanded at Hakea, custody transfer documentation from police advised he was at high risk of suicide. It would appear that this assessment was mainly due to the incident in July 2018 when Mr Roberts threatened to shoot himself.
22. During his initial medical assessment by a prison nurse, Mr Roberts reported he had been receiving treatment for depression and anxiety, and that he had agoraphobia.¹² He also disclosed he was seeing a psychologist and had been prescribed 10 mg daily of citalopram (an anti-depressant) about one month ago. In addition, Mr Roberts admitted to smoking 30 cones of cannabis a day.
23. Although Mr Roberts denied having current suicidal ideation or intent, it was noted at this initial assessment that he had feelings of hopelessness, guilt, impulsive behaviour and suicidal thoughts in the previous two months. Consequently, a decision was made for Mr Roberts to be housed in a safe cell at the Crisis Care Unit (CCU) and that he be placed on "High" ARMS (At Risk Management System) with one-hourly observations.
24. ARMS is the Department's primary suicide prevention strategy and is used by all prisons in Western Australia. It aims to provide prison staff with clear guidelines set out in the ARMS Manual to assist with the identification and management of prisoners at risk of self-harm and/or suicide. Any prisoner exhibiting warning signs or risk factors that may increase the likelihood of self-harming or suicide behaviour is to be

¹⁰ Exhibit 1, Tab 26, Review of Death in Custody Report dated April 2023

¹¹ Exhibit 1, Tab 17, EcHO medical records; Exhibit 1, Tabs 17.1-17.10, Various ARMS, PHS and PRAG records; Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated 18 October 2022; Exhibit 1, Tab 26, Review of Death in Custody Report dated April 2023

¹² An anxiety disorder where a person fears and/or avoids situations and places that may cause panic.

immediately placed on ARMS and monitored according to the level of risk and care required.

25. The ARMS Manual has guidelines for assessing the degree of risk for a prisoner. The prisoner is then allocated one of three levels: “High” (acute risk of suicide or self-harm), “Moderate” (not functioning well, with an increased risk of self-harm), or “Low” (difficulty coping, with fleeting thoughts of self-harm or suicidal ideation).¹³
26. An important feature of ARMS is that custodial and non-custodial staff share responsibility for suicide prevention and a prisoner can be placed on ARMS by any prison staff member at any time.
27. The Prisoner Risk Assessment Group (PRAG) comprises of a chairperson and includes representatives from the prison’s health service providers, counsellors, custodial staff, prisoner support and Aboriginal support. PRAG is responsible for the management of prisoners who are on ARMS and meets daily to discuss those prisoners.
28. For a prisoner who is on ARMS, PRAG is required to:¹⁴
 - Form a comprehensive risk assessment on the prisoner.
 - Develop a risk management plan for the prisoner.
 - Arrange for the support and interventions that have been identified in the risk management plan.
 - Review the prisoner’s progress (which includes an assessment of the ARMS level and/or whether the prisoner can be removed from ARMS).

28 February 2019: Mr Roberts is reviewed by PRAG

29. On 28 February 2019, Ruth Dabell (Ms Dabell), a mental health nurse at Hakea, assessed Mr Roberts for the purpose of the PRAG meeting later that day. Mr Roberts also had an appointment with the prison doctor on the same day.
30. Ms Dabell noted Mr Roberts said that he had a supportive mother and was keen to access treatment at Hakea for his depression. He stated he had no current plans or intent to self-harm and no thoughts of suicide.

¹³ At Risk Management System (ARMS) Manual 1998 updated October 2016, pp.52-53.

¹⁴ At Risk Management System (ARMS Manual 1998 updated October 2016), p.85

31. The prison doctor noted that Mr Roberts “*looked depressed,*” that his speech was “*monotonous*” and described his mood as “*very low.*”¹⁵ The prison doctor recommended that Mr Roberts increase his citalopram dosage from 10 mg to 20 mg per day.
32. The prison doctor also recommended that the Mental Health Team (MHT) at Hakea, “*assess Shane, appears very depressed, ?melancholic depression, states this related to being in prison, but from the ROI*¹⁶ *it is longstanding.*”¹⁷
33. In contrast to the prison doctor’s assessment, Ms Dabell noted there was “*nil current indication for MH [Mental Health] intervention.*”¹⁸ Ms Dabell also recommended that Mr Roberts be reduced to “Moderate” ARMS.
34. At the subsequent PRAG meeting on 28 February 2019 it was noted that Mr Roberts had no self-harm or suicide risk identified. It was agreed that he could be removed from the safe cell at CCU, and be reduced to “Moderate” ARMS with two-hourly observations. It was also recommended that Prison Counselling Service (PCS)¹⁹ was to follow-up.
35. Mr Roberts was placed in Unit 6 at Hakea (which was also known as the Protection Unit).

5 March 2019: Mr Roberts is reviewed by PRAG

36. Ms Dabell conducted another assessment of Mr Roberts on 1 March 2019. Although his mood was low, Mr Roberts denied any current suicidal ideation or self-harm intent. After he had been provided with information regarding prison systems and processes, Mr Roberts was more positive by the completion of the consultation. Ms Dabell recommended that Mr Roberts remain at “Moderate” ARMS and that PCS continue its management of him.
37. Colleen Sorensen (Ms Sorensen), a counsellor with PCS, met with Mr Roberts. On 5 March 2019. Although Mr Roberts denied any current self-harm or suicide ideation, he did state that his daughter and family would be better off without him. Although he maintained he would not actively take his life, Mr Roberts stated he did not wish to be in prison. Nevertheless, he appeared future focused on having his daughter visit him and contacting

¹⁵ Exhibit 1, Tab 16, EchO medical records, p.12

¹⁶ An abbreviation for Release of (Medical) Information which is the health summary provided to the Department (with the consent of the prisoner) by the prisoner’s general practitioner in the community.

¹⁷ Exhibit 1, Tab 16, EchO medical records, p.9

¹⁸ Exhibit 1, Tab 16, EchO medical records, p.9

¹⁹ As of 2020, PCS became known as Psychological Health Services (PHS)

his lawyer. Mr Roberts also expressed a willingness to explore strategies, including perspective taking, which was considered as a protective factor.

38. After evaluating the risk assessment for Mr Roberts, Ms Sorensen made a recommendation that he be reduced to “Low” ARMS.
39. At the PRAG meeting on 5 March 2019 it was noted that Mr Roberts had commenced anti-depressant medication therapy, he appeared settled in Unit 6 and had a family visit planned for the weekend. The decision by PRAG was to reduce Mr Roberts to “Low” ARMS with four-hourly observations, in order to provide further support and monitoring.

13 March 2019: Mr Roberts is reviewed by PRAG

40. On 11 March 2019, Ms Sorensen met with Mr Roberts for the purpose of an ARMS review. On this occasion, Mr Roberts appeared relaxed and displayed a settled mood and demeanour. Ms Sorensen noted that he engaged in an open and forthright manner, and reported no issues or concerns other than his court matter, which was regarded as appropriate to his circumstances. Mr Roberts also reported that he was settled in his unit and pleased he had recently commenced employment in the prison laundry.
41. When asked, Mr Roberts firmly denied any current thoughts of self-harm or suicidal ideation. He stated he was now feeling much better. After noting that, and Mr Roberts’ future focusing, Ms Sorensen recommended he be removed from ARMS.
42. At the PRAG meeting on 13 March 2019, Mr Roberts’ placement on ARMS was discussed. His unit manager was in attendance and also recommended he be removed from ARMS. PRAG subsequently accepted these recommendations, noting there were no current thoughts of self-harm or suicidal ideation and that Mr Robert appeared settled in his unit.
43. Mr Roberts was subsequently removed from ARMS and he remained in Unit 6. It does not appear that consideration was given by PRAG to placing him onto the Support and Monitoring System (SAMS) for ongoing support.
44. SAMS is a step down from ARMS. The SAMS Manual sets out that its focus is to provide additional support, monitoring and intervention to prisoners presenting as vulnerable within the prison environment. This vulnerability may be either short term or long term. Eligibility for management through SAMS is not restricted by precise adherence to any particular criteria. Management by SAMS extends to those prisoners who meet two or more criteria. That criteria includes prisoners who may benefit

from receiving coordinated services and prisoners who may be demonstrating difficulty with coping or adjusting to custody.

45. As specified in the SAMS Manual, the advantages of the support and monitoring offered by SAMS is that prisoners are observed and monitored in their own units by unit staff, and any adverse issues or problems can be identified firsthand and addressed in a more timely manner.

6 May - 17 June 2019: management of Mr Roberts' mental health concerns

46. On 6 May 2019, Mr Roberts attended the medical centre at Hakea for anxiety-related issues. He reported to a nurse that he felt no anxiety when he was in his cell with the door closed; however, he would become anxious when he has to leave his cell. At one point he became teary when he was asked what happens before these feelings begin. An appointment with the prison doctor was arranged for the next day.
47. On 7 May 2019, Mr Roberts saw the prison doctor who noted that he looked anxious, had mild tremors and was sweating. Mr Roberts reported that he could not shut his brain off and that he was stressing and worrying. He denied thoughts of self-harm or suicide. The doctor also noted that Mr Roberts had a MADRS²⁰ score in the severe range and recorded in Electronic Health Online (EcHO) that he had, "*extremely severe anxiety & depression.*"²¹ The prison doctor prescribed diazepam for three nights, and increased Mr Roberts' dose of citalopram from 20 mg to 30 mg daily.
48. The prison doctor also sent a referral to the MHT requesting that it assess Mr Roberts. This referral identified that he was, "*extremely anxious, depressed, history of self-harm, panic attacks.*"²²
49. On 8 May 2019, a note was made by a mental health nurse acknowledging the referral from the prison doctor.²³ On 9 May 2019, an administrative staff member made an appointment for Mr Roberts to see a mental health nurse on 21 May 2019.
50. An EcHO entry on 13 May 2019 indicated that Mr Robert had submitted a pink slip²⁴ on this day asking for help as his anxiety was getting worse and he could not sleep. An appointment was administratively made for

²⁰ Montgomery-Asberg Depression Rating Scale: a widely used standardised assessment tool for measuring the severity of depression, anxiety and stress.

²¹ Exhibit 1, Tab 17, EcHO medical records, p.5

²² Exhibit 1, Tab 17, EcHO medical records, p.4

²³ Exhibit 1, Tab 17, EcHO medical records, p.4

²⁴ A written request for a medical appointment that is completed by the prisoner and delivered to health service providers by custodial staff.

Mr Roberts to see a general nurse on 16 May 2019. He did not attend that appointment and there is no entry in EcHO to indicate the reason for his non-attendance.

51. Nor did Mr Roberts attend the appointment with a mental health nurse on 21 May 2019. Following his non-attendance to this appointment, David Etherington (Mr Etherington), a mental health nurse, noted in EcHO that he was not sure the MHT needed to be involved with Mr Roberts as he had already had multiple ARMS assessments. Mr Etherington made a further entry that Mr Roberts would be discussed at the MHT meeting on 17 June 2019 (nearly four weeks later). It does not appear there were any attempts made to ascertain why Mr Roberts did not attend the appointment on 21 May 2019. In addition, there is no evidence before me that the prison doctor who made the referral was advised of Mr Roberts' non-attendance.
52. On 25 May 2019, Mr Roberts submitted a further pink slip in which he repeated that his anxiety was "*playing up*" and that it had not improved despite the increase in his medication two weeks ago.²⁵ The clinical nurse who received the pink slip noted there was an existing referral to the MHT by the prison doctor and noted that the plan was to wait for the MHT meeting scheduled for 17 June 2019.
53. As there is no record in EcHO of any interaction by health service providers with Mr Roberts to discuss his anxiety issues, it can be safely assumed this did not take place after he had submitted either of the two pink slips.
54. On 17 June 2019, the MHT meeting discussed Mr Roberts as planned. It was recorded in EcHO that this meeting identified anxiety as Mr Roberts' primary issue. It was recommended that Mr Roberts have another appointment with the prison doctor to consider anti-depressant therapy and whether his long-term cannabis use was a possible contributing factor to his anxiety.
55. The planned appointment with the prison doctor did not take place prior to Mr Roberts' death.

EVENTS LEADING TO MR ROBERTS' DEATH²⁶

56. At 7.24 am on 23 June 2019, Mr Roberts telephoned his mother on the Prisoner Telephone Service (the PTS). In that conversation he said he

²⁵ Exhibit 1, Tab 17, EcHO medical records, p.3

²⁶ Exhibit 1, Tab 6, Unsigned statement of Mr Roberts' cell mate; Exhibit 1, Tab 8, Statement of Carmen Mackie dated 24 June 2019; Exhibit 1, Tab 9, Statement of Paul Stott dated 28 October 2022; Exhibit 1, Tab 26, Review of Death in Custody Report dated April 2023; Exhibit 1, Tabs 18.1-18.25, Incident Description Reports

would not be able to attend a scheduled visit from her that day. His explanation was that he felt sick. It was evident from the way Mr Roberts spoke that he was in a distressed state.²⁷

57. At about 7.10 am on 24 June 2019, Mr Roberts' cell was unlocked by prison officers during the Unit 6 morning unlock. Mr Roberts informed the prison officers that he had a migraine and asked that he not attend work. His request was granted and Mr Roberts was able to return to his cell. At about 8.00 am, those prisoners who were employed left the unit to attend their places of work. This included Mr Roberts' cell mate. At about 9.00 am, the prisoners who were not working had their cells unlocked.
58. At about 11.30 am, the lunchtime muster for Unit 6 occurred. This required prisoners who were in their cells to stand by their doors. When Mr Roberts did that, prison officers noted he looked unwell as he was coughing and appeared to have flu-like symptoms. Mr Roberts was directed to return to his cell which, in accordance with procedure, was locked by prison officers. Procedurally, it was later unlocked at about 12.30 pm.
59. At 1.38 pm, two prison officers commenced a routine walk-through of Unit 6. They saw Mr Roberts briefly look out from his cell door before he went back into his cell. He did not speak to anyone at that time.
60. At about 2.00 pm, those prisoners who had been working returned to Unit 6. Prison officers in Unit 6 reported that at this time there was significant movement and they were busy with various duties to complete.
61. On his return from work, Mr Roberts' cell mate was unable to open his cell door. He assumed Mr Roberts was using the cell's toilet, so he walked away, returning about five minutes later. When he was still unable to open the cell door, he looked through the door's viewing hatch. When he did not see Mr Roberts in the cell, he again tried to open the door and was able to pull it slightly open towards him. He then saw Mr Roberts with his back against the door in a sitting position on the floor with his legs straight out. There was green fabric around his neck, which appeared to be attached to the door's locking mechanism. This fabric came away from the door as the cell mate opened it further.
62. The cell mate placed Mr Roberts, who was unresponsive, onto the floor just outside the cell and began CPR with the assistance of another prisoner. This other prisoner also removed the fabric from around Mr Roberts' neck.

²⁷ Telephone calls made by prisoners on the PTS are recorded.

63. Prison officers responded to prisoners yelling for an ambulance and saw Mr Roberts lying unconscious on the floor. At 2.14 pm, a Code Red medical emergency was called over the radio and prisoners were instructed to return to their cells as prison officers took over CPR.
64. At about 2.17 pm, staff from Hakea's medical centre attended Unit 6 and observed that CPR was underway with oxygen being administered as well. Medical staff attached the defibrillator they had with them which showed that Mr Roberts had no pulse. At about 2.20 pm, a telephone call was made for an ambulance.
65. Prior to the arrival of an ambulance, CPR continued on a rotational basis amongst prison staff. Ambulance officers from the first of four ambulances that attended were in Unit 6 by 2.40 pm, and they assumed responsibility for Mr Roberts' medical care.
66. Despite maximal resuscitation efforts from prison staff and ambulance officers, Mr Roberts could not be revived. His death was declared at 3.00 pm.²⁸

CAUSE AND MANNER OF DEATH

*Cause of death*²⁹

67. On 28 June 2019, two forensic pathologists, Dr Jodie White and Dr Joseph Ong, conducted a post mortem examination on Mr Roberts' body.
68. It was noted there was a ligature mark to Mr Roberts' neck which corresponded with the ligature that had been provided. Mr Roberts' lungs were congested, which was a non-specific finding that can be seen with a compression of the neck. Some pinpoint haemorrhages were also seen to Mr Roberts' eyes (petechial haemorrhages), which may also be evident with neck compressions. In addition, it was found that Mr Roberts had moderate coronary atherosclerosis (narrowing and calcification of the arteries that supply the heart muscle).
69. A neuropathology examination of Mr Roberts' brain found no significant abnormalities and no features of any recent traumatic brain injury.

²⁸ Exhibit 1, Tab 3.1, Life Extinct Certification.

²⁹ Exhibit 1, Tabs 4.1-4.2, Supplementary Post Mortem Report dated 28 June 2019, and Post Mortem Report dated 28 June 2019; Exhibit 1, Tabs 5.1-5.3, Supplementary Toxicology Report dated 25 November 2021, Final Toxicology Report dated 28 August 2019, Email correspondence between ChemCentre and the Court dated 23 November 2021 – 2 December 2021.

70. Toxicological analysis detected a therapeutic level of citalopram, and very low levels of amitriptyline and nortriptyline, which are anti-depressant medications. I note that Mr Roberts had not been prescribed either of these medications, which would suggest that he acquired these from another prisoner or prisoners and was self-prescribing.
71. At the completion of their investigations, the forensic pathologists expressed the opinion that the cause of death was ligature compression of the neck (hanging).
72. I accept and adopt the conclusion expressed by the forensic pathologists as to the cause of Mr Roberts' death.

Manner of death³⁰

73. I am satisfied that at or about 1.38 pm, Mr Roberts was sighted by prison officers at the doorway to his cell as they conducted a routine welfare check of prisoners in Unit 6. This was the last time Mr Roberts was seen alive.
74. Shortly after that, Mr Roberts closed his cell door and accessed some green fabric he had in his cell that he most likely acquired when he was working in the laundry. I am satisfied he used this fabric as a ligature by attaching it to the locking mechanism on the inside of his cell door and placing it around his neck. Although he was in a seated position on the floor, Mr Roberts was able to place the necessary pressure to his neck from the ligature by leaning forward. By the time his cell mate first attempted to open the cell door at about 2.00 pm, Mr Roberts was most likely unresponsive. I am also satisfied it was almost certain he had already died before resuscitation attempts commenced about five minutes later.
75. Based on the information available, I find that Mr Roberts' death occurred by way of suicide.

ISSUES RAISED BY THE EVIDENCE

76. The primary issue raised by the evidence at the inquest was whether Mr Roberts' mental health concerns were adequately addressed. The Department's "Health Services Summary into the Death in Custody" made the following conclusion:³¹

³⁰ Exhibit 1, Tab 2.1, Coronial Investigations Squad Report of Detective Senior Constable Dave Abbott dated 20 October 2021

³¹ Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated 18 October 2022, pp.10,16

The notes and history above record a failure of the systems in place in 2019 to adequately address the severe distress and dysfunction that Mr Roberts was experiencing. In particular there was a failure in escalation of care, with a ceiling of care imposed by rejected referrals. Processes failed to maintain clarity for the patient or staff regarding access to care and who was responsible for providing care.

...

Multiple gaps in care have been identified for Mr Roberts' time in custody, within both the Health Services and the interactions with the MHAOD³² branch. These include lost opportunities to better understand the severity of his mental health illness, and the failure of referral attempts to achieve engagement of specialist mental health services.

77. Similarly, the Department's "Review of Death in Custody" found that: "*Mr Roberts' anxiety and requests for assistance did not appear to be adequately addressed.*"³³
78. As set out below, I am prepared to find that there were some missed opportunities to address Mr Roberts' mental health concerns in a more timely manner after 7 May 2019. However, having heard the oral evidence from Hakea's health service providers at the inquest, I do not find that any person or persons were responsible for those missed opportunities. These missed opportunities were brought about by factors completely out of the control of these individuals.

Mr Roberts' removal from ARMS

79. As outlined above, Mr Roberts was entirely removed from ARMS on 13 March 2019.
80. Having considered the evidence, I am satisfied that it was appropriate for Mr Roberts to be removed from ARMS on that date. At his assessment on 11 March 2019 with Ms Sorensen, Mr Roberts gave no indication that warranted he remain on "Low" ARMS. He denied any current thoughts of self-harm or suicidal ideation and said he was feeling much better. In addition, Mr Roberts' unit manager agreed with Ms Sorensen's assessment that Mr Roberts be removed from ARMS.
81. However, there is no indication that PRAG gave consideration to placing Mr Roberts on SAMS for ongoing support.

³² Abbreviation for Mental Health, Alcohol and Other Drugs

³³ Exhibit 1, Tab 6, Review of Death in Custody dated April 2023, p.19

Should Mr Roberts have been placed on SAMS after his ARMS removal?

82. As stated by the SAMS Manual, those prisoners who are considered to be vulnerable can be placed on SAMS. The inquest heard evidence that “vulnerable” prisoners placed on SAMS comprise of prisoners with an intellectual disability or those who have been diagnosed with a major mental illness.³⁴ As Mr Roberts did not fall within either of those categories, he was not considered “vulnerable” for the purposes of a SAMS placement.³⁵
83. It is certainly arguable that a prisoner who is depressed with anxiety issues, and who has recently had suicidal ideation, is “vulnerable.” However, I fully appreciate that for practical purposes, vulnerable prisoners placed on SAMS are limited to the two cohorts that Ms Sorensen identified. Given the known high numbers of prisoners with anxiety and/or mood disorders who have had recent suicidal ideation,³⁶ I accept it would simply be impractical to place all these prisoners on SAMS given the present custodial and non-custodial staffing numbers in prisons.

Responses to the prison doctor’s referral and to Mr Roberts’ two pink slips

84. As outlined above, the prisoner doctor referred Mr Roberts to the MHT on 7 May 2019. Prior to being seen by the MHT, Mr Roberts had then completed two pink slips on 13 and 25 May 2019 highlighting his increased anxiety. Mr Roberts failed to attend an appointment to see a general nurse on 16 May 2019, and then failed to attend a scheduled appointment with a mental health nurse on 21 May 2019. The only action taken by the MHT after this was to make an entry that Mr Roberts be discussed at the MHT meeting on 17 June 2019.
85. A very grim picture was painted at the inquest as to the reasons why Mr Roberts was not given a higher priority by the MHT after the prison doctor’s referral. As explained by Mr Etherington: “*The fundamentals of psychiatry and mental health nursing at Hakea Prison [is] in trying to sort out who gets priority and who doesn’t, and I think sadly in Mr Roberts’ case because of his anxiety, again we don’t see that in our mind as acute...or even sub-acute, we just see that as anxiety.*”³⁷

³⁴ Ts 13.6.23 (Ms Sorensen), p.36.

³⁵ Exhibit 1, Tab 31, Statement of Colleen Sorensen dated 12 June 2023, p.8

³⁶ Mental Health and Substance Use Problems in Western Australian Prisoners, Report from the Health and Emotional Wellbeing Survey of Western Australian Reception Prisoners, Executive Summary dated April 2015, p.10

³⁷ Ts 13.6.23 (Mr Etherington), p.51.

86. It was clear from the evidence of the Department’s mental health service providers that the low staffing numbers at Hakea and the high numbers of prisoners on either ARMS or with major mental health disorders meant that prisoners such as Mr Roberts with increased anxiety and depression could not be prioritised for treatment. This means that even if they are accepted for treatment by the MHT, there are still substantial delays before these prisoners can be treated.
87. Ms Trina Deakin (Ms Deakin) had worked as a mental health nurse with the Department since 2011. She stated that the small size of the MHT at Hakea and the high numbers and acuity of major mental illness amongst prisoners meant that, “*our remit in the Mental Health Team is they will only get psychiatric status ... if there is a mental health history [of a major mental illness]. So, anxiety and depression would not necessarily mean that.*”³⁸
88. Ms Deakin testified that a prisoner with anxiety and depression would only fall within the MHT’s remit if they had “*debilitating anxiety, major depression*” that “*affects function.*”³⁹ Again, this was solely due to the reasons mentioned above, and not that prisoners with less acute anxiety and depression would derive no benefit from treatment by the MHT.
89. I asked Ms Deakin these questions at the inquest:⁴⁰

Did the team, as of 2019, have the resources to effectively treat those prisoners who were presenting with the symptoms that Mr Roberts had? --- We’ve – since 2011, we’ve never had the resources to follow up on, you know, the less acute – less acutely mentally.

And nothing has improved since 2019 obviously? --- The current situation is in crisis and much worse. At least in 2019 we had a full-time psychiatrist, and the staffing was not – the staffing shortage was not acute as it is now.

90. Both the Department’s psychiatrist and the independent psychiatrist supported this evidence from the mental health nurses. Dr Edward Petch (Dr Petch), a consultant psychiatrist at Hakea, stated:⁴¹

Well, the amount of psychological intervention that can be provided by those services is minimal because they spend the majority of the time doing the risk assessments required for the PRAG system – the ARMS system, the risk management system. So every day they would be assessing people and doing risk assessments, which is the prime – has turned, alas, into the prime purpose

³⁸ Ts 14.6.23 (Ms Deakin), p.148

³⁹ Ts 14.6.23 (Ms Deakin), p.148

⁴⁰ Ts 14.6.23 (Ms Deakin), p.148

⁴¹ Ts 13.6.23 (Dr Petch), p.93

or the prime role of these services. So I much prefer it if we could have more psychological input of primary anxiety and depressive illnesses, which is negligible in prison. So there is next to no psychological input of treatment for those conditions. (underlining added)

91. Dr Adam Brett (Dr Brett), an independent consultant psychiatrist who provided a report for the Court, was asked these questions by counsel assisting at the inquest:⁴²

... it's sometimes difficult to understand, I think, for people from the outside looking in that the nurses' notes reflect on a number of occasions there's no need for mental health intervention for this man. He does have mental health issues, so why is Mental Health Team treatment not required? --- That's a good question. I think the prevalence of mental disorder in prisons is extremely high, much higher than that in the community. And so the mental health team's ambit, if you like, is to look after the more seriously mentally ill. So that's people with psychosis, people who are acutely suicidal, people with major mental illnesses. So the mental disorder that Mr Roberts had wouldn't fulfill the criteria for management of that mental health service. Now, that's not saying he doesn't have mental health issues. It's just saying that the service that is provided in prisons isn't set up to manage those. So they're two different things.

Right. So they're barely managing the acutely unwell people with major mental illness? They're taken up with that? --- Yes. their time is taken up with that. And as you say, there's a tsunami of mental health in the prison system and the resources to manage that is inadequate. And so for people with less acute mental health issues, they will not be seen by the Mental Health Team. (underlining added)

92. Dr Brett's evidence at the inquest was that he could find "*absolutely no evidence*" that the health service providers at Hakea did anything wrong in their treatment and care of Mr Roberts.⁴³ I agree with that assessment. I also agree with the following passage from Dr Brett's evidence:⁴⁴

And I think it was the system at fault and I think that needs to be made quite clear. And if you're working in system which is flawed, any decisions you make in that system are going to be impacted within the system you're working in. ... If you see someone who you think needs alcohol and drug counselling and you can't get access to an alcohol and drug counsellor, what do you do? The management for anxiety disorders and depression should be much more psychosocial, but I think the management of Mr Roberts highlights the issues that they have and, that is, very medication orientated. And medication may have had a part to play in his mental health, but what he needed much more

⁴² Ts 14.6.23 (Dr Brett), pp.129-130

⁴³ Ts 14.6.23 (Dr Brett), p.133

⁴⁴ Ts 14.6.23 (Dr Brett), pp.133-134

was the psychosocial interventions. The counselling, the talking to, the liaison, the drug and alcohol work, risk management, making sure that he was coping ok. And ... you don't need specialist mental health services for that, so that could be provided by counselling services and whatever, but the system is not set up for that, because it's focusing on the acute mental illness [of prisoners].

The MHT's response to Mr Roberts' non-attendance on 21 May 2019

93. Mr Etherington explained at the inquest that given the workloads of the MHT, there was no follow up as to why Mr Roberts did not attend his appointment with the mental health nurse on 21 May 2019.⁴⁵ He explained that unless a prisoner is presenting in an acutely distressed state or is in an acute risk phase, no follow up is undertaken if they fail to attend an appointment.⁴⁶ Mr Etherington accepted that the reasons for Mr Roberts' appointment on 21 May 2019 were not urgent enough to require a call to Unit 6 to find out why he had not attended.⁴⁷
94. In an ideal environment there ought to have been attempts made to find out why Mr Roberts did not attend this appointment, and for a rescheduling to take place as soon as possible. However, as the evidence at the inquest clearly established, the circumstances that Hakea's health service providers worked in (and still continue to work in) are far from ideal. I agree with Dr Brett's sentiments when he said:⁴⁸

So mental health nurses do a fantastic job with the resources that are available to them. So unfortunately, a lot of their role is putting out fires. So, it's managing the acutely unwell people and manage them as best they can, again in a very difficult situation. But what that means is, is that their time is taken away from managing people who don't have as severe mental disorders.

95. Accordingly, it would not be fair to criticise the lack of follow up as to why Mr Roberts did not attend his appointment on 21 May 2019.

The scheduling to discuss Mr Roberts at the MHT meeting on 17 June 2019

96. Following Mr Roberts' failure to attend his appointment on 21 May 2019, Mr Etherington decided to list Mr Roberts for a discussion at the MHT meeting on 17 June 2019. It was noted at the inquest this was nearly four weeks later with respect to a prisoner whose anxiety levels were known to be increasing. Nevertheless, I accept the likely explanations provided by

⁴⁵ Ts 13.6.23 (Mr Etherington), p.55

⁴⁶ Ts 13.6.23 (Mr Etherington), p.55

⁴⁷ Ts 13.6.23 (Mr Etherington), p.58

⁴⁸ Ts 14.6.23 (Dr Brett), p.137

Mr Etherington for this delay.⁴⁹ Sadly, those explanations again related to staff shortages and the need to prioritise other prisoners.

97. One likely reason for the delay was that although MHT meetings are scheduled to take place weekly, they did not always take place every week because of the inability to have a forum due to staffing numbers.⁵⁰
98. Another explanation was the priority rating scale the MHT uses for its meetings. That rating scale is P1 to P4. Those prisoners with a P1 rating are in the acute phase of a mental illness under the *Mental Health Act 2014* (WA). Prisoners with a P2 rating have sub-acute presentations of a mental illness that require discussion. Prisoners with a P3 rating require ongoing general management at MHT meetings. Prisoners rated P4 (which Mr Roberts was) are new referrals.⁵¹
99. As described by Mr Etherington, what frequently happens is that the list of prisoners requiring consideration at MHT meetings are so long that the lower priority matters get, “*pushed further down as we were discussing more acute cases, the more P2 and P1 presentations.*”⁵²
100. I am satisfied these are acceptable explanations for the delay in having Mr Roberts discussed at an MHT meeting. Nevertheless, I fully agree with Mr Etherington’s observation, made with the benefit of hindsight, that “*it is sad, he should have been discussed earlier.*”⁵³

The outcome from the MHT meeting on 17 June 2019

101. The decision from the MHT meeting on 17 June 2019 was to refer Mr Roberts to another appointment with the prison doctor to consider further anti-depressant therapy and to consider if his previous long-term cannabis use was a contributing factor to his anxiety.⁵⁴ This meant the treatment plan for Mr Roberts had completed a full circle back to the prison doctor who had made the referral to the MHT on 7 May 2019. During that time, Mr Roberts had not seen a health service provider (although it should be noted he had failed to attend two appointments with prison nurses).
102. Mr Etherington was at the MHT meeting on 17 June 2019. His explanation for this decision was: “*His primary diagnosis was anxiety, but he was on*

⁴⁹ Given the passage of time, Mr Etherington had no specific memory of this matter, so he provided the most likely explanations for the delay: Ts 14.6.23 (Mr Etherington), pp.58-59

⁵⁰ Ts 13.6.23 (Mr Etherington), p.59

⁵¹ Ts 13.6.23 (Mr Etherington), p.59

⁵² Ts 13.6.23 (Mr Etherington), p.59

⁵³ Ts 13.6.23 (Mr Etherington), p.60

⁵⁴ Exhibit 1, Tab 17, EchO medical records, p.3

treatment, and that there had been no indication of risk [of self-harm or suicide] occurring at any point after that. So that is how I make my decision.”⁵⁵

103. Although Mr Roberts’ pink slips had indicated a worsening anxiety, they did not refer to thoughts of self-harm or suicidal ideation. And there is no evidence before me that any member of Hakea’s health service providers or custodial staff were aware that Mr Roberts had expressed or was contemplating thoughts of self-harm and/or suicide before 24 June 2019.
104. There is evidence that the day after Mr Roberts had died, a prisoner advised a custodial staff member that he had found Mr Roberts hanging in his cell several weeks earlier. The prisoner recounted that he had removed the ligature from Mr Roberts and got rid of it. He did not advise prison staff at the time as he had been told by other prisoners not to say anything “*to the screws*”.⁵⁶
105. I am satisfied that this incident was not brought to the attention of prison staff until after Mr Roberts had died. I am also satisfied with the explanation from Paul Stott, a prison officer at Hakea:⁵⁷

If staff had been aware of Mr Roberts’ prior attempt at hanging, he would have been immediately placed on ARMS in a safe cell and monitored thereafter. Mr Roberts’ actions came as a complete shock to me and others.

106. I would be now inserting impermissible hindsight bias if I was to criticise the actions taken by the MHT after the meeting on 17 June 2019.
107. I am also satisfied Mr Etherington was using the benefit of hindsight when he accepted that Mr Roberts was “*somewhere in the middle*” between a prisoner with a major mental illness and a prisoner with generalised anxiety and depression who required some input from the prison psychiatrist to get the treatment regime right.⁵⁸
108. However, even if Mr Roberts was scheduled for an appointment with the prison psychiatrist, the delay before that appointment would likely to have been considerable. As Ms Deakin explained, as at the time of the inquest, Hakea’s mental health nurses were making appointments with the prison psychiatrist three months into the future.⁵⁹

⁵⁵ Ts 13.6.23 (Mr Etherington), p.70

⁵⁶ Exhibit 1, Tab 9, Statement of Paul Stott dated 28 October 2022, p.6

⁵⁷ Exhibit 1, Tab 9, Statement of Paul Stott dated 28 October 2022, p.6

⁵⁸ Ts 13.6.23 (Mr Etherington), p.63

⁵⁹ Ts 14.6.23 (Ms Deakin) p.156

109. With those grim statistics in mind, I asked Mr Etherington the following question:⁶⁰

So really if you had more resources at your disposal in the Mental Health Team in 2019 [Mr Roberts] might well have not slipped through the cracks. Would that be a fair description? ---- Absolutely oh God, absolutely. I can't – it is hard for me to describe to people. It is so sad. It really is so sad.

Ligature minimised cells at Hakea

110. There are three descriptions given to cells with respect to the capacity for them to be used for ligature points. A three-point ligature-minimised cell means that the most obvious points (lights, windows and shelving) have been removed. Cells classified as being fully ligature-minimised are cells where all obvious ligature points including furniture, fixtures within the cell and plumbing are removed. A safe cell is an operational term used to describe a fully ligature-minimised cell with CCTV cameras installed and with the means to supervise the prisoner at all times.

111. Mr Roberts was housed in a three-point ligature-minimised cell.⁶¹ As a result, he was able to use the internal locking mechanism of his cell door as a ligature point as this fixture had not been modified so as to be ligature-free.

112. As of September 2022, a mere 3.9% of cells at Hakea had been fully ligature-minimised.⁶²

113. The Department is no doubt acutely aware of this Court's strident views regarding the parlous state of affairs at Hakea regarding ligature-minimised cells. The large number of cells that remain in Hakea and other medium and maximum-security prisons in Western Australia that remain replete with ligature points that can be removed with relatively minor modifications is, quite frankly, an embarrassment.

114. I am not going to add to the previous recommendations from this Court that stress this appalling situation must be dealt with as matter of urgency. The Court can only repeat the same recommendation so many times. I will simply quote again what I said in my findings delivered in another inquest on 21 August 2023:⁶³

The situation regarding the unacceptable portion of prison cells with a high number of ligature points remains an acute crisis; a crisis that this Court has

⁶⁰ Ts 13.6.23 (Mr Etherington), p.64

⁶¹ Ts.14.6.23 (Mr Perrin), p.225

⁶² *Inquest into the death of Wayne Thomas Larder* [2022] WACOR 48, p.37

⁶³ *Inquest into the death of Jomen Blanket* [2023] WACOR 6, p.54

now been pointing out for over 20 years. The Court will undoubtedly continue to encounter deaths in prisons from hangings in cells that use these ligature points.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MR ROBERTS

115. After careful consideration of the documentary evidence and having heard the oral evidence of the inquest's witnesses, I am satisfied that Hakea's health service providers provided an appropriate standard of supervision, treatment and care of Mr Roberts' mental health concerns from when he was incarcerated on 27 February 2019 until 7 May 2019. This period included his placement on ARMS for 15 days.
116. However, there is a proviso to my assessment of the supervision, treatment and care of Mr Roberts' mental health concerns from 7 May 2019 when the prison doctor referred him to the MHT. I am only prepared to find that from this time until his death seven weeks later, Mr Roberts' mental health concerns were addressed by Hakea's health service providers in accordance with the limited time and resources they had. Unfortunately, those limitations meant that the standard of supervision, treatment and care provided to Mr Roberts for his mental health concerns was not satisfactory during this period as there were a number of missed opportunities to address his increasing anxiety.
117. However, for the reasons outlined below, I am unable to conclude that had the mental health services at Hakea been adequately resourced to treat prisoners like Mr Roberts, then his death would have been prevented.
118. Although Dr Brett agreed with the proposition that the most mentally unwell prisoner at Hakea on 24 June 2019 was Mr Roberts, he was careful to point out that, "*to predict who's going to suicide is an impossible feat.*"⁶⁴ That observation by Dr Brett is well-grounded.
119. Even in a prison setting, suicide is rare, and it is impossible to predict rare events with any certainty. In 2017, the Department of Health published a document titled "Principles and Best Practice for the Care of People Who May Be Suicidal"⁶⁵ (the Document). Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable.

⁶⁴ Ts 14.6.23 (Dr Brett), p.139

⁶⁵ <https://www.health.wa.gov.au/~media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf>

120. The Document points out that clinicians faced with the onerous task of assessing a person who may be suicidal will confront two issues. First, suicide is a rare event and second, there is no set of risk factors that can accurately predict suicide in an individual. The Document explains that the use of risk assessment tools that contain checklists of characteristics have not always been found to be very effective:⁶⁶

The widespread belief within the community that suicide is able to be accurately predicted, has led to the assumption that suicide reflects a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However, the evidence is clear that, even with the best risk assessment practices and care, it is not possible to foresee and prevent all deaths by suicides.

121. With that in mind, I do not find that custodial and/or non-custodial staff at Hakea should have been aware that Mr Roberts was at a high risk of suicide in the period leading up to his death. Sadly, there is no guarantee that even with optimal treatment and care of his mental health in the seven weeks before 24 June 2019, Mr Roberts' death was preventable. Regrettably, suicide is often driven by impulsivity.

CHANGES AND IMPROVEMENTS SINCE MR ROBERTS' DEATH

122. As would be expected of all governmental departments, the Department is always on the pathway of continual improvement with respect to the operations of its prisons.
123. As there is ordinarily a gap of some duration between the date of the death requiring a mandatory inquest and the inquest's date, entities connected to death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

Documentation

124. Since Mr Roberts' death, improvements have been made by the Department concerning information that is gathered in ECHO. These improvements have addressed the recording of information regarding the mental health concerns of prisoners. These improvements were listed in the Department's "Health Services Summary into the Death in Custody."⁶⁷

⁶⁶ <https://www.health.wa.gov.au/~media/Files/Corporate/general-documents/Mental-health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf> p.3

⁶⁷ Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated 18 October 2022, pp.12-13

125. A recent innovation has involved the introduction of a comprehensive suicide risk assessment form in EcHO. At another inquest in 2022, Dr Rowland outlined what is included in this form:⁶⁸

It includes information-gathering regarding past background history and risk, so underlying risk, and it includes history regarding previous thoughts of self-harm, previous attempts, how serious those attempts have been, how persistent those thoughts have been, how detailed their plans have become, if they've tried [suicide], ... how bad was that attempt in terms of how close to success have they been in the past etcetera, and some of the details.

And it includes their current status, so their current level of stress and how that compares to the past and includes protective factors and what would be required or what works for them in terms of managing that level of stress and what other flags for them that [indicate] they're deteriorating. So, it is fairly comprehensive. It is not a five-minute assessment. Depending on your experience and background knowledge of a person, that may take quite some time to do thoroughly, or it might be quite quick to review. So, the form will pre-populate with prior information.

126. As I have done previously, I commend the Department for this initiative. With more prison service providers now having access to EcHO, this suicide risk assessment form will provide important information to these providers.

Education

127. Prison doctors have been educated and encouraged to update the Active Problem List that appears in a prisoner's EcHO medical records. All prison staff have been made aware of the importance of adding any past history of self-harm or attempted suicide to the prisoner's Active Problem List, and this is included in the orientation of any new prison doctors.⁶⁹

Mental health referral processes

128. It was clearly evident that the referral process by the prison doctor to the MHT failed with respect to Mr Roberts.
129. A referral pathway model has been drafted and had an expected implementation date of 30 June 2023.⁷⁰ It is expected that this new referral process for access to mental health service providers will include the following:

⁶⁸ *Inquest into the death of Jomen Blanket* [2023] WACOR 6, p.61

⁶⁹ Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated 18 October 2022, p.13

⁷⁰ Exhibit 1, Tab 26, Review of Death in Custody dated April 2023, p.21

- The triaging of all referrals to the MHT will be undertaken by a mental health nurse and be based on the template completed by the referrer and include consideration to the prisoner's distress and dysfunction as well as prior history and involvement with community mental health services.
- The outcome of this triage will be documented in EcHO and communicated to the referrer.
- All referrals from prison doctors will result in an initial assessment conducted in-person by a MHT member.
- The outcome of the initial assessment will be documented into EcHO and communicated to the referrer. This will include the situation where involvement by the MHT is not agreed to and the responsibility for providing care to the prisoner remains with the prison's primary health service providers.⁷¹

Consideration of SAMS for a prisoner removed from ARMS

130. As already outlined above, it did not appear that consideration was given by PRAG to place Mr Roberts on SAMS for ongoing support after he had been removed from ARMS. Prior to the inquest, the Department's review of Mr Roberts' death made the following recommendation:⁷²

PRAG should record any consideration given to provide additional support and monitoring via the SAMS system to prisoners who have recently been on ARMS and who may have or may be experiencing difficulty coping or adjusting to placement in custody.

131. Arising from that recommendation, the Department has introduced a policy requiring the PRAG chairperson to ensure that consideration has been given to ongoing monitoring through SAMS of a prisoner who has been removed from ARMS. The outcome of that consideration is to be recorded on the prisoner's risk management plan.⁷³

PROPOSED RECOMMENDATIONS

132. The inquest heard alarming evidence from Hakea's health service providers regarding chronic staff shortages, onerous workloads, lack of morale and general disillusionment with the system. Ms Deakin, a mental health nurse with considerable experience working in the prison system, was asked at the inquest if she was concerned that she could not actually

⁷¹ Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated 18 October 2022, p.15

⁷² Exhibit 1, Tab 26, Review of Death in Custody dated April 2023, p.21

⁷³ Exhibit 1, Tab 26, Review of Death in Custody dated April 2023, p.21

deliver what she was required to do. Ms Deakin answered: *“I am so concerned that I will probably resign in the next two weeks.”*⁷⁴

133. Dr Rowland, who was seated in the back of the hearing room when Ms Deakin gave that evidence, expressed considerable empathy for Ms Deakin, stating: *“This is one of the tensions particularly that I’ve heard from Trina [Ms Deakin] and I’ve heard from other staff out there, this imbalance between what they see and what they’re able to do themselves to fix it.”*⁷⁵

134. Staff shortages within the Department’s prison health services have been at crisis levels for a number of years now. Two examples that were provided at the inquest highlighted the severity of this crisis. The first was from Dr Rowland, who provided these statistics:⁷⁶

An audit in June 2019 showed 34% of patients were overdue a planned GP⁷⁷ review at Hakea. GP FTE⁷⁸ in March 2019 was 13.20 of 25.10 positions for all DOJ⁷⁹ facilities and the muster (inclusive of Acacia) hit a peak of 6983 in May 2019.

135. The second example was from Mr Etherington, who provided this sobering evidence:⁸⁰

The mental health service at Hakea Prison has approximately 130-150 mentally ill prisoners requiring follow-up and treatment within the prison structure.

For context, this is $\frac{3}{4}$ the size of Graylands Hospital. Graylands Hospital has multiple teams, multiple psychiatrists, multiple registrars, multiple nursing staff, occupational therapists, psychologists and social workers.

The Mental Health Team at Hakea Prison comprises of 2-3 mental health nurses on shift per day and a psychiatrist four days per week in 2019.

Hakea Prison has no capacity to adequately treat the acute phase of the seriously mentally ill. Our referral rates per day can range between 7-15, seven days per week. They are rated on degrees of risk and those on the acute phase and sub-acute phase have priority access to the psychiatrist.

Unfortunately, non-urgent referrals, that is, those who are not in the acute or sub-acute phase of a mental illness, wait for extended periods to be processed and managed. This is purely due to the lack of FTE and capacity of the Mental

⁷⁴ Ts 14.6.23 (Ms Deakin), p.152

⁷⁵ Ts 14.6.23 (Dr Rowland), p192

⁷⁶ Exhibit 1, Tab 21, Health Services Summary into the Death in Custody dated October 2022, p.12

⁷⁷ General practitioner i.e. prison doctor

⁷⁸ Abbreviation for “full-time equivalent”

⁷⁹ Department of Justice

⁸⁰ Exhibit 1, Tab 28.1, Statement of David Etherington dated 8 June 2023, pp.4-5

Health Team. Since 2019, nothing has improved, in fact staffing is worse and there is limited psychiatrist time at Hakea Prison.

136. The frustration felt by Dr Petch for what he described as the “*chronic lack of funding of the mental health services within custodial environments*”⁸¹ was palpable during his evidence at the inquest. Pulling no punches, Dr Petch described it in this way:⁸²

... I can't remember how many briefing notes I've written to various ministers, but it's just not an area that the government would be particularly interested in following. So the [prison mental health] service that there is, is the service that has been purchased and its inadequate, and, I think, that has been widely acknowledged in numerous coroner's recommendations, but also in numerous reports. The Office of the Inspector of Custodial Services has made reports on this particular topic many times.

...

There's an active choice that has been made over 15 years. Call it deliberate indifference if you like, but its – this is not an area that wins votes. This is an area that the politicians have decided we're not going to invest in, not something I've ever agreed with, but that's the decision that's been taken. We have the service that is as large as the money will allow it to be, and it's still woeful in terms of being able to deliver the services that are required. So, I'm not going to defend it to you, sir.

137. I am left in no doubt at all from the despairing evidence I heard at the inquest that there is a compelling argument for a drastic and long overdue reform regarding the provision of not just mental health services, but health services in general, to prisoners.
138. It is now time to understand the value, to not only prisoners but also to the community, of providing well-resourced health care in prisons. This is particularly the case with mental health care. Although I have already referred to this in an inquest finding from several months ago,⁸³ I consider it necessary to repeat.
139. Many crimes that are punished by terms of imprisonment are linked to the mental health of the offenders. Those mental health issues are often either undiagnosed or have been left untreated in the community. A prison environment may actually be better than the community for the treatment of a prisoner's undiagnosed or untreated mental health issues. That is

⁸¹ Ts 13.6.23 (Dr Petch), p.83

⁸² Ts 13.6.23 (Dr Petch), pp.83-84

⁸³ *Inquest into the death of Jomen Blanket* [2023] WACOR 6, p.69

because there is often the time, opportunity and potential incentive for the prisoner to have them treated. As Dr Rowland explained at the inquest:⁸⁴

We've got a chance of actually using the prison environment as a healing environment where ... , whilst they're with us, we optimise that opportunity to identify what their needs are, start to address those needs, and have them leaving us ready for reintegration, ready for occupation, meaningful activities, meaningful relationships, etcetera.

140. Dr Rowland was referring to the healing opportunities that a prison environment provides for the physical and mental health of prisoners.

141. This evidence from Dr Rowland has obvious benefits to the community and, in my view, is extremely difficult to logically challenge. With that in mind, I considered making recommendations in the following areas.

Prison health services to be the Department of Health's responsibility

142. In its 2nd edition of "Standards for health services in Australian prisons", the Royal Australian College of General Practitioners (RACGP) made the following pertinent points when considering the complexity of health challenges in prisons:⁸⁵

People in prison are one of the most vulnerable and disadvantaged groups in Australia.

...

In addition to socioeconomic vulnerabilities, people in prison have complex long term health needs characterised by a combination of mental health issues, trauma, alcohol and substance misuse, chronic health conditions and disabilities. Mental health issues are also disproportionately prevalent among the prison population, with close to 40% of prisoners reporting having had a history of mental health issues prior to imprisonment.

...

The prison setting is a unique environment for the provision of health services because it affords health professionals the opportunity to provide whole-person care to those disadvantaged groups that are typically harder to reach. Where possible, health services should seek to address health challenges that are more prevalent in the prison population than in the community.

143. In 2013, the Europe Regional Office for the World Health Organisation (WHO) produced a document titled "Good governance for prison health in

⁸⁴ Ts 14.6.23 (Dr Rowland), p.185

⁸⁵ RACGP's "Standards for health services in Australian prisons," 2nd edition, p.2

the 21st century: A policy brief on the organisation of prison health”.⁸⁶ An Expert Group from the Stewardship of Prison Health and members of the WHO European Network on Prisons and Health (the Expert Group) contributed to this document. The Expert Group concluded that with respect to the institutional arrangements for prison health:⁸⁷

- Managing and coordinating all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility.
- Health ministries should provide and be accountable for healthcare services in prisons and advocate healthy prison conditions.

144. The Expert Group noted that several European countries had already transferred the responsibility for prison health to their health ministries. Those countries, “*had concluded that clearly dividing roles between the ministry in charge of prisons and the health ministry would be the most effective and efficient arrangement to achieve sustainable high standards in both prison security and prison health.*”⁸⁸ These countries included Norway, France, the United Kingdom and Italy.⁸⁹

145. The following unanimous conclusion of these countries was reported at a 2004 international conference in London:⁹⁰

... the gains [of transfer] can be great. Evaluations that have been carried out indicate that the standard of care to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and quality of staff has improved. Links with the community have been strengthened.

146. Nevertheless, the Expert Group acknowledged that transferring prison health care to health ministries would be a long process, and for it to be successful required governments to give it the highest political commitment, to communicate fully across all levels of management and personnel, and to carefully plan and execute the practical steps, including all necessary budgetary implications and transfers of funding.⁹¹

⁸⁶ [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

⁸⁷ “Good governance for prison health in the 21st century: A policy brief on the organisation of prison health”, p.viii [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

⁸⁸ “Good governance for prison health in the 21st century: A policy brief on the organisation of prison health”, p.vi [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

⁸⁹ Good governance for prison health in the 21st century: A policy brief on the organisation of prison health, p.18 [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

⁹⁰ “Prison health and public health: The integration of prison health services,” Report from the London conference, International Centre for Prison Studies, 2004

⁹¹ Good governance for prison health in the 21st century: A policy brief on the organisation of prison health, pp.18-19 [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

147. The Expert Group made it clear that this approach to prison health will have beneficial effects in the longer term, including:⁹²

- lower health risks and improved health protection in prisons;
- improved health of prisoners;
- improved performance of health systems;
- improved health of deprived communities;
- improved public health of the whole community;
- improved integration of prisoners into society on release;
- lower rates of reoffending and reincarceration that leads to a reduction of the prison population size; and
- greater governmental credibility based on increased efforts to protect human rights and reduce health inequalities.

148. Of the Australian states and territories, only Western Australia and Victoria have their prison health services run by the same department responsible for prisons. In New South Wales, Queensland, South Australia, Tasmania, the ACT and the Northern Territory, prison health services are the responsibility of their health departments. It is readily apparent that Western Australia is somewhat of an outlier within Australia and the rest of the world with respect to the operation of its prison health services.

149. The three doctors who gave evidence at the inquest supported the Department of Health taking over prison health services.

150. Dr Petch testified:⁹³

I think people who work in prisons are very isolated, so bringing the whole of health, the prison health services, I've long argued into the Department of Health, so it's run by the Department of Health under the governance of the Department of Health. Department of Health know what they're doing, allegedly, in running health services. It's not, with the greatest of respect, the Department of Justice. It's not the Department of Justice's business running health services any more than it is the Department of Health's business running custodial services. It's not the prime function of the Department of Justice. Let the Department of Justice do what it's expert at and let the Department of Health do what it's expert at.

And in most jurisdictions in Australia now, and around the world, in European countries and in other western countries, services that run health within prison environments are run by departments of health, not departments of

⁹² Good governance for prison health in the 21st century: A policy brief on the organisation of prison health, p.19 [who.int/europe/publications/i/item/9789289000505](https://www.who.int/europe/publications/i/item/9789289000505)

⁹³ Ts 13.6.23 (Dr Petch) pp.85-86

corrections. And this is widely recognised in UN resolutions and the World Health Organisation and other international bodies as being the correct model for governance. And as long it remains ... within the Department of Justice there will be difficulty recruiting to those positions because they're seen as being less glamorous, less good, outside the Department of Health ... So that would be one thing that I would strongly recommend, but not everybody agrees.

151. Dr Petch was also of the view that the mental health services within prisons would likely be enhanced and better run if it was aligned with the way the Department of Health operates.⁹⁴

152. Dr Brett was of the view that “*a change in culture*” is required with respect to the operation of mental health services within prisons. He stated:⁹⁵

It's recommended and there has been a recommendation by the Royal Australian and New Zealand College of Psychiatrists that [departments of] health should lead mental health services in a prison setting, and I think that's what is needed. So the governance of mental health systems in a prison system, in my opinion, is inadequate.

153. Dr Rowland also advocated for changes to be made to the present structure. She noted the following:⁹⁶

Certainly, the international literature and the World Health Organisation refer to the necessity of separating [prison] health services from [the Department of] Justice, that health services should be able to operate independently to protect the health rights and to provide a service to prisoners. So that's one of the underlying reasons. There's also the underlying reason that the health service delivery and the health outcomes for people in prison have a direct and very significant impact on the health of the whole community because of the cohort whom we look after. And if we do prison health well, we actually benefit the whole of community.

154. Dr Rowland identified that a fundamental problem with prison health services being run by the Department was a governance issue as, “*there are non-clinicians that have control over what happens in [prison] health.*”⁹⁷

155. As Dr Rowland further explained:⁹⁸

Who holds the authority to make decisions, who has the capacity to allocate funds and decide what is serviced and what isn't serviced? That authority is

⁹⁴ Ts 13.6.23 (Dr Petch), p.87

⁹⁵ Ts 14.6.23 (Dr Brett), p.130

⁹⁶ Ts 14.6.23 (Dr Rowland), pp.180-181

⁹⁷ Ts 14.6.23 (Dr Rowland), p.181

⁹⁸ Ts 14.6.23 (Dr Rowland), p.181

sitting outside roles such as mine and the director of nursing and even our director that sits above us. We have accountability and responsibility, here I am today, and we have knowledge and we have visibility and we have potential concerns about what's happening within our service but our level of control is quite limited. So, there's a mis-match between authority and power, and control and clinicians. So, one thought in moving us to Department of Health is that the connection there between clinicians and authority to control what's happening is better.

156. Dr Rowland advocated a health service for prisons under a single director that was either outside the Department providing a service as a single entity or under the Department of Health providing that service.⁹⁹
157. Having read the relevant literature from WHO and hearing the above evidence from the doctors at the inquest, it was my view that there was considerable merit in making significant operational changes to the delivery of health services within prisons.

Improvements to the retaining and recruiting of prison health services staff

158. A fundamental problem facing the Department is the retaining and recruitment of staff for virtually every position within prison health services.
159. There are a variety of reasons for this crisis. As to the inability to attract applicants to positions, they range from prospective employees having concerns for their safety in a prison environment through to the unavailability of salary sacrificing that employees in the Department of Health can access. The high stress levels and workloads, and the inability to provide proper assistance to prisoners in need due to resource issues are some of the reasons why prison health service providers leave their job disillusioned.
160. Ms Deakin described the “*knock-on effect*” of having fewer applicants to positions. She described that previously, because of the nature of the work in prisons, a mental health nurse needed to have five years post-qualified grounded experience before they would be offered a position. As Ms Deakin described: “*Now that's not the case. We are taking people coming in with quite limited experience and it falls down straightaway...*”¹⁰⁰
161. Mr Etherington had worked in England and said that mental health service providers who worked in prisons received additional funding.¹⁰¹

⁹⁹ Ts 14.6.23 (Dr Rowland), p.183

¹⁰⁰ Ts 14.6.23 (Ms Deakin), p.149

¹⁰¹ Ts 13.6.23 (Mr Etherington), p.46

162. It is my firm view that the Department must look at ways it can encourage its health service providers to remain working in the prison system and, just as importantly, provide incentives for suitably qualified health service providers to apply for positions within the prison system.

Recruitment of additional mental health service providers at Hakea

163. It was disconcerting to hear the evidence from witnesses regarding the inability to provide treatment and care to prisoners like Mr Roberts who were experiencing increasing levels of anxiety and depression. The underlying reasons for this was the high numbers of prisoners at Hakea with major mental illnesses and/or heightened risks of self-harm and suicide, and staffing issues.
164. Sadly, the situation since 2019 has not improved, and in fact I was told by witness after witness it has become worse.¹⁰² It is therefore imperative that this sorry state of affairs is addressed urgently. Otherwise, there will be more prisoners with high levels of untreated anxiety and/or depression taking their lives.

Upgrade of health service facilities at Hakea

165. In her evidence at the inquest, Dr Rowland brought to my attention the practical difficulties should there be an increase in the number of health service providers at Hakea. After identifying the need to expand psychological and counselling services at Hakea, Dr Rowland noted:¹⁰³

But the ability to deliver those programs and to deliver more counselling versus crisis management, depends on their resources at each site. So Hakea is probably a site that is one of the hardest sites to progress out of acute and into counselling, because of the volume that come through, but also the infrastructure at Hakea. So one of the main limitations to the operations of the Psychological Health Services and expanding at Hakea is the lack of rooms. So for them to have a therapeutic space or a room to do counselling is a huge challenge. There is – they don't have – the clinic space is small. It limits our doctors as well. So with a lack of rooms, they can't ... make appointments and follow up an appointment day with counselling, because there may not be the room for them to use.

166. It is my view this issue needs to be addressed as a matter of priority.

¹⁰² Ts 13.6.23 (Mr Etherington), p.45; Ts 13.6.23 (Dr Petch), p.82; Ts 14.6.23 (Ms Deakin), p.148; Ts 14.6.23 (Dr Rowland), p.187

¹⁰³ Ts 14.6.23 (Dr Rowland), p.199

Notification to PRAG when a prisoner declines a visit

167. As I have outlined earlier, Mr Roberts cancelled a scheduled visit from his mother the day before he died.
168. Ms Sorenson testified that had mental health service providers been aware of this action by Mr Roberts, “*it would have raised a red flag.*”¹⁰⁴ However, Ms Sorenson went on to explain that as Mr Roberts was not on ARMS at the time, she would not have been advised.¹⁰⁵
169. This evidence caused me some concern. I have already highlighted that suicide is very unpredictable. Any potential signs that a person is having thoughts of suicide must be actioned and brought to the attention of those who may be able to treat the prisoner concerned. Yet the “red flag” that existed here was not brought to the attention of those who may have been able to assist Mr Roberts.
170. This is not the only inquest in which a prisoner has cancelled a visit from a loved one shortly before they have suicided. In those circumstances, I had considered that a system should be in place for the chairperson of PRAG to be notified whenever a prisoner who had recently been on ARMS declines a visit from a family member and/or loved one.

COMMENTS RELATED TO THE PROPOSED RECOMMENDATIONS

171. My draft recommendations were forwarded to the Department via its counsel on 27 November and 1 December 2023. The Department was invited to make submissions regarding these draft recommendations on or before 15 December 2023. The Department’s response was received on 14 December 2023.¹⁰⁶

Prison health services to be the Department of Health’s responsibility

172. As to my proposed recommendations in this matter, the Department responded:¹⁰⁷

The suggestion to transfer the provision of prison health services to the Department of Health is not something the Department of Justice can commit to or has control over. Furthermore, the Department of Health is not currently equipped to take on this role and is not the specialist in primary health care in a custodial environment.

¹⁰⁴ Ts 13.6.23 (Ms Sorenson), p.35

¹⁰⁵ Ts 13.6.23 (Ms Sorenson), p.35

¹⁰⁶ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment.

¹⁰⁷ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, p.1

To enable the delivery of more effective health care for prisoners, the Department has commenced an Integrated Health Project which includes the development of a Model of Care which aims to draw on best practice that already exists, with aspirational standards to improve health care in prisons and make it comparable to community standards.

The project also involves the establishment of an integrated multi-disciplinary team under a new clinical governance structure and accountability that is independent from custodial hierarchical control. It is expected the governance structure will include the appointment of a Clinical Lead and have the authority and independence to ensure the prioritisation and resourcing to achieve equitable outcomes for the people in custody.

173. The contents of the Department's first paragraph is hardly a ringing endorsement, and it is somewhat trite to say that the proposed recommendation is not something the Department "*has control over*" and that "*the Department of Health is not currently equipped to take on this role*". As I have already noted, the Expert Group identified that such a transferral would be a long process requiring a high level of commitment given the changes that would have to be made.
174. Nevertheless, the contents in the second and third paragraphs of the Department's response do appear to address the governance question that Dr Rowland had identified at the inquest.¹⁰⁸
175. This Court must always exercise caution when making a substantial recommendation that does not have the support of the relevant governmental department. It remains my strong view that a fundamental reform of prison health services is required in order to achieve better health care for prisoners, particularly with respect to improved mental health care. After careful consideration, I will refrain from making a recommendation that the provision of health services within prisons should become the responsibility of the Department of Health.
176. However, I make the following observation: This Court will continue to have the opportunity via inquests to monitor the adequacy of health care within prisons, particularly the mental health care of prisoners. If significant improvements are not being made, then I anticipate this Court will start making recommendations that will advocate the need for substantial reforms.

¹⁰⁸ See [151]-[153] of this finding.

Improvements to the retaining and recruiting of prison health services staff

177. The Department expressed support for this proposed recommendation as drafted.¹⁰⁹ I will therefore make this recommendation.

Recruitment of additional mental health service providers at Hakea

178. As to this proposed recommendation, the Department submitted:¹¹⁰

The success of this recommendation is dependent on the allocation of additional funding. The proposed recommendation, if made into a formal recommendation, is only able to be *supported in principle* until such time additional funding is approved to allow the Department to increase the FTE to recruit additional Psychological Health Service and mental health staff at Hakea Prison. A treasury submission to obtain funding is in progress.

179. In light of this response, I will make this recommendation. I expect the treasury submission that the Department refers to would contain compelling evidence to support it. The evidence from the inquest that is summarised in this finding demonstrates the urgent need for this funding.

Upgrade of health service facilities at Hakea

180. My proposed recommendation for this matter concerned the funding be provided for a project definition plan regarding the upgrade of health service facilities at Hakea.

181. The Department's response was:¹¹¹

While the intention of this recommendation is supported, urgent funding will need to be requested and approved by Treasury to enable a project definition plan to be developed. Once developed and approved, further funding will have to be requested for the subsequent implementation of the plan.

182. I accept that the project definition plan is just the first step in a long process to have the health service facilities at Hakea upgraded. However, as Dr Rowland made clear in her evidence at the inquest, this upgrade is desperately needed, particularly if additional mental health service providers are allocated to Hakea.

183. The number of prisoners housed at Hakea requiring treatment for their mental health is not going to decrease in the future. Presently, staffing levels in this area at Hakea are so under resourced that mental health staff are unable to treat prisoners like Mr Roberts who not only needed help

¹⁰⁹ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, p.1

¹¹⁰ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, p.2

¹¹¹ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, pp.2-3

with his mental health issues, but was also actually crying out for assistance. It is therefore hardly surprising that Mr Etherington described Mr Roberts' plight as "*so sad*".

184. Accordingly, I have made this recommendation.

Notification to PRAG when a prisoner declines a visit

185. The Department did not support this recommendation. In its reasoning the Department noted that staff training in the detection of risk of self-harm or suicide is more likely to support improved outcomes in suicide prevention. The Department identified its recent reinstatement of the Suicide Prevention Governance Unit (the SPGU). One of the SPGU's functions is to reinvigorate the Department's training strategy in at risk management for staff.¹¹²

186. The Department also submitted that from April to June 2023 there were approximately 1155 ARMS referrals made across all adult prison facilities, and noted: "*This reflects the operational challenges of tracking and implementing this recommendation*".¹¹³

187. Given this submission from the Department, I have decided not to make this proposed recommendation.

RECOMMENDATIONS

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

Recommendation No.1

In order to improve the standard of health care to prisoners, the Department of Justice undertakes an assessment of employment contracts for prison health service providers to determine whether changes can be made that would:

- (a) encourage health service providers to remain working in the prison system; and**
- (b) provide a motivation for suitably qualified health service providers to apply for positions within the prison system.**

¹¹² Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, p.1

¹¹³ Email from Ms Duska Van Nellestijn to the Court dated 14 December 2023, with attachment, p.1

Recommendation No.2

In order to provide an appropriate level of mental health care and treatment for prisoners at Hakea, the Department of Justice should take urgent steps to recruit additional Psychological Health Service and mental health staff for Hakea.

Recommendation No.3

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

CONCLUSION

189. Even before he was remanded in custody on 27 February 2019, Mr Roberts had mental health issues. He was receiving treatment for depression and anxiety, and had already been prescribed anti-depressant medication.
190. Following Mr Roberts' initial assessment at Hakea, and noting a threat he had made to shoot himself the previous year, a decision was made to place him on "High" ARMS. He subsequently remained on ARMS until 13 March 2019. This action taken by the Department was commendable.
191. However, Mr Roberts continued to struggle with his anxiety. On 7 May 2019, a prison doctor referred him to the MHT. For reasons unknown, Mr Roberts did not attend appointments with a prison nurse on 16 or 21 May 2019. Subsequently, due to its work load, the MHT was unable to make any assessment of Mr Roberts, or even communicate with him, before his suicide by hanging in his cell on 24 June 2019.
192. It is likely the inadequate resourcing of mental health services at Hakea weighed on Mr Roberts' mind in the period before his death. I am able to

make that conclusion based on what Mr Roberts had said to others. He kept in contact with his ex-partner through letters and conversations on the PTS. His ex-partner said:¹¹⁴

On at least three occasions, I recall Shane stating he had been waiting a long time to see the doctor to discuss medication as he felt he wasn't doing well mentally. In multiple letters and conversations, he stated "this place is hell," "I don't think I'm ever going to get out of here", "I feel helpless", "I don't know what to do", "I can't live like this". I tried my best to talk to him and help relieve his fears but was unsure what else to do or who to turn to. I did attempt to contact the prison but all phone calls rang out or went unanswered.

193. A handwritten letter addressed to his daughter was found in Mr Roberts' possessions after his death. That letter included the following: "*Even things like seeing a doctor is a struggle and unless your [sic] dying you gotta get over it coz there's nothing they can do to help you.*"¹¹⁵
194. I have found that the treatment and care Mr Roberts received regarding his mental health after 7 May 2019 was not satisfactory. However, that was entirely expected given the lack of resources available to Hakea's mental health service providers. For many years now, these providers have used what limited resources they have available as effectively as they can to treat the large cohort of prisoners with mental health issues that have, and will, always exist in Hakea.
195. It was clear to me from the evidence I heard from Hakea's mental health nurses and psychiatrist that drastic changes are required if prisoners who are experiencing the level of anxiety and depression that Mr Roberts had are to be effectively treated. These changes come with a not insignificant financial cost.
196. If changes are not made, then more families like Mr Roberts' will bear the heartbreaking loss of a loved one to suicide in prison. And the community overall will ultimately bear the cost of released prisoners who have not had effective treatment in prison for their physical and mental health conditions because of resourcing issues.
197. I have made three recommendations that I expect would, if implemented, go some way to reverse the trend of prison health services, particularly mental health services, from continuing to get worse.

¹¹⁴ Exhibit 3, Email from Chantell Morgan to counsel assisting dated 13 June 2023

¹¹⁵ Exhibit 1, Tab 20, Undated letter from Mr Roberts to his daughter.

198. On behalf of the Court, I extend my condolences to Mr Roberts' family and loved ones, particularly his daughter, for their sad loss.

PJ Urquhart
Coroner
21 December 2023