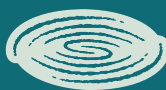
Report No. 22

The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001 - 2003



Office of The Inspector of Custodial Services
Western Australia

Cover photo: Hakea Prison Gatehouse.

The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001 - 2003

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Contents

THE INSPECTOR'S OVERVIEW:
PRISON DEATHS ARE NOT AN INTRACTABLE PROBLEM v

CHAPTER 1

PREVIOUS REVIEWS OF DEATHS IN PRISONS AND THE SCOPE OF THIS REVIEW 1

Summary 9

CHAPTER 2

THE OPERATIONAL FRAMEWORK: MEETING PRISONERS' WELFARE NEEDS 10

Point of Entry Services 12

Meaningful Activity 13

Access to Family and the Community 14

Contact with Outside Agencies 15

Health Care Services 16

Mental Health Services 17

Management of Risk Behaviour 19

General Behaviour Management 19

Meeting the Welfare Needs of Aboriginal Prisoners 20

Aboriginal Visitors' Scheme 21

The Application of Welfare Resources 22

The Delivery of Welfare Services 22

A Welfare Culture Across the Prison System 22

Prison Staff 22

The Strategies, Management and Control of the Welfare Services and Resources 23

Summary 24

CHAPTER 3

THE OPERATIONS AT HAKEA PRISON 25

Hakea Prison's Purpose and Role 25

Hakea's Business Plan 25

The Public Prisons Division 2003-07 Business Plan 26

Point of Entry Services at Hakea Prison 26

Reception 26

Induction and Orientation 28

Bail Coordinator 31

Health Care Services 32
Mental Health Services 33
The Crisis Care Unit 34
Prisoner Counselling Service 36
Relationship between PCS and the Prison System 36
Staffing 38
At-risk Management System 39
Management of Prisoners At-risk of Suicide or Self-harm 39
Lack of Ownership 39
Clarity of Roles and Functions 40
Training 40
Functioning of the Prisoner Risk Assessment Group 40
Narrow Focus of the At-risk Management System 41
System for Reporting Self-harm Incidents 41
Specific Welfare Services 42
Prisoner Support Officers 42
Prisoner Peer Support Program 43
Aboriginal Visitors' Scheme at Hakea Prison 44
Chaplaincy 46
Outcare 46
Staff Support Programs 47
Offender Treatment Programs 48
Education at Hakea 49
Summary 49

CHAPTER 4

CASE STUDIES AND ANALYSIS 51
Case Studies 51
Damien Garlett 51
Donald Keen 53
JHG 56
Lawrence Flowers 59
Dylan Green 61
Michael Vaughan 64
Mervyn Yappo 65
Evan Slater 67

Analysis of Case Studies 69
Reception 69
Induction and Orientation 70
Initial Health Assessment 70
Meaningful Activity 72
Access to Family and the Community 72
Health Care and Mental Health Management 73
Family Contact Following a Death in Custody 75
Summary 79

CHAPTER 5

THE INVESTIGATIONS OF DEATHS IN PRISON 80
The Initial Steps 80
Investigation by the Police Prison Unit 81
The Role of the Internal Investigations Unit 81
Completion of the Department's Process 82
Coronial Proceedings 83
Follow-up Processes 84
Summary 84

CHAPTER 6

REVIEW OF SUBMISSIONS 87
Summary 92

CHAPTER 7

DISCUSSION AND RECOMMENDATIONS 93

APPENDIX 1

DEPARTMENT OF JUSTICE RESPONSE TO THE RECOMMENDATIONS 110

APPENDIX 2

LITERATURE REVIEW 119
Size of the Problem 119
Nature and Causes of Death 119
Death by Natural Causes 119
Suicide 120
Risk Factors 121
Self - Harm 121
Coping Mechanisms 122

Negative Life Events 122
Drug Use 122
Psychiatric History 122
Demographic Factors....123
Other Issues....123
Health Screening on Arrival in Prison....124
Bibliography 125

APPENDIX 3

PERSONS, REPRESENTATIVES AND ORGANISATIONS WITH WHOM DISCUSSIONS AND CONSULTATIONS WERE HELD OR FROM WHOM SUBMISSIONS WERE RECEIVED 128

APPENDIX 4

THE REVIEW AND INSPECTION TEAM 130

The Inspector's Overview

PRISON DEATHS ARE NOT AN INTRACTABLE PROBLEM

It is almost two decades since the first Australian study of deaths in prisons was carried out by the Australian Institute of Criminology, at the request of the Australian Council of Corrections Ministers[1]. Subsequently, the national Royal Commission into Aboriginal Deaths in Custody has reported and there have also been numerous State inquiries, not to mention academic analysis and bureaucratic policy changes. Yet deaths – both by suicide and through natural causes – still occur at rates that are excessive in comparison with those amongst the general population. Is the problem intractable, therefore?

Clearly, deaths in prison can never be eliminated. However, avoidable deaths can be reduced, and it is essential that those of us involved in penal administration continue to strive to achieve this. The State has an enhanced duty of care in relation to incarcerated groups, arising out of the fact that they are under continuous supervision. Moreover, the distress and anger that such deaths cause – to families who feel so impotent and to staff who wonder what else they could have done – is often more intense than would be the case with a comparable death in the community.

When two young Aboriginal men died through suicide within a few weeks of each other at Hakea Prison in early 2003, it seemed to the Minister for Justice and to the Inspector of Custodial Services that the time had come to look at this issue yet again. To make the review more manageable, the Minister directed that it should be confined to deaths at Hakea Prison, not across the whole of the WA prison system. There were two reasons for this: first, that the broad lessons learned from Hakea were certain to have some relevance to the whole prison sector; second, that there was probably a 'Hakea overlay' arising from the fact that this prison had been performing below an acceptable level for several years. The intention, therefore, was to address the issue of prison deaths as well as the question of Hakea's current performance.

This Report vindicates that approach. Issues have emerged that are relevant to the whole prison system: technological issues such as obvious hanging points; organisational issues such as the proper utilisation of the medical facilities at Casuarina Prison; health issues such as the adequacy of mental health support services; human resource issues such as the training deficits of officers; equity issues such as funeral costs; and accountability issues such as the protocols and processes of the Internal Investigation Unit. And issues have emerged that are specific to Hakea such as: the need for improved reception and orientation processes; cultural issues including extremely poor communication between staff working in different occupational and professional areas; the question of how best to accommodate young prisoners; and financial issues such as an apparent under-funding of Hakea.

The working hypothesis of this Review is that a poorly managed prison will, other things being equal, over time have a higher custodial death-rate than a well-managed one.

[1] Hatty, S., and Walker, J. (1986) *Deaths in Australian Prisons* (Australian Institute of Criminology, Canberra).

With regard to suicide, this is because the coping behaviours of prisoners are influenced by the overall 'feel' or culture of the prison; and with regard to deaths from natural causes, this is associated with attitudes towards patient care when the patient is a prisoner. At the same time, it is crucial to recognise that the profile of prisoners is becoming more vulnerable – there is a recognisable increase in drug-dependency amongst prisoners, more prisoners are presenting with mental health problems and more (particularly Aboriginal) prisoners have chronic health problems.

In carrying out this Review, we have been acutely aware of the sensitivities of families and staff. Each of these groups has been extensively consulted; we hope that 'their stories' have come through sufficiently, and have not been lost in the more abstract level of analysis that must be made to bring our findings to the point of operational and organisational recommendations.

More generally, it should be put on the record that just as we have consulted widely (the list is included as Appendix 3), so we have received widespread cooperation. I would particularly refer to the Department of Justice, the State Coroner, the WA Police Service, the WA Prison Officers' Union and the management and staff at Hakea Prison. Everyone involved genuinely wants to do something positive about this problem. We believe that implementation of the 18 recommendations made herein will go a significant way to addressing the issues this Report has identified.

In carrying out this Review the Office was also fortunate to be able to obtain extensive consultancy advice from Dr Alison Liebling, who is the leading scholar in the English-speaking world in the area of suicide prevention and the organisational culture of prisons.

In broader strategic terms this Review fits well with the concern of this Office about safety issues in prisons, for prisoners and staff. The Report on Vulnerable and Predatory Prisoners (Report No. 15) was driven by this concern; the earlier Report on Hakea Prison (Report No. 12) put the question of fire safety back onto the Department's agenda, leading to the establishment of a joint taskforce involving the Fire and Emergency Services Authority; and the pending report relating to cognitive skills training will emphasise the value of these programs as a means of improving prisoners' coping skills as well as officer/prisoner interactions, with consequential impact upon safety. The safety of the prison environment will remain in the forefront of this Office's preoccupations, therefore.

Finally, it is pleasing to note that, since the commencement of this Review almost a year ago, there has not been a further death – suicide or natural causes – at Hakea Prison.

Richard Harding
Inspector of Custodial Services

10 March 2004

Chapter 1

PREVIOUS REVIEWS OF DEATHS IN PRISONS AND THE SCOPE OF THIS REVIEW

1.1 Early in 2003, within a month of each other, two suicides occurred at Hakea Prison. These events are always deeply distressing – to families particularly, to other prisoners and to prison staff – but what made these deaths particularly tragic was the fact that the victims were both young Aboriginal men only 18 years' old. It seemed shocking that people who apparently had their whole lives ahead of them (neither had been charged with an offence likely to result in a prolonged period of incarceration) had reached such levels of despair.

1.2 Further examination revealed that six additional deaths of prisoners had occurred at Hakea in the 24-month period preceding the more recent of these two deaths. Of the total eight deaths, five had been suicide and three had been attributed to natural causes. Of course, no prison can be immune to the risk of prisoner deaths. In the case of Hakea, with its enormous throughput of prisoners, the risk is somewhat higher: many of the prisoners at Hakea are at the beginning of their custodial experience.

1.3 Nevertheless, the Minister for Justice was sufficiently concerned to direct the Inspector to carry out a review with the following terms of reference:

- To consider the developments within the Department of Justice since the publication of the Ombudsman's Report 2000, including the strategies of the Department's Suicide Prevention Taskforce Report and their implementation;
- To examine the relevance of and compliance with Prison Regulations and Rules, Policy Directives and Operational Instructions that bear upon this issue;
- To assess the scope and application of resources within the Department, as well as those available in the public sector and the community generally, to provide for the welfare of prisoners. In this regard, the services relating to Aboriginal prisoners are especially significant, as well as general health services and family support arrangements;
- To comprehensively review the operations at Hakea Prison associated with the welfare of prisoners including:
  - The operation of reception and induction programs;
  - The quality of prisoner/staff interaction; and
  - The facilities and programs that provide intensive and specialised care and support for at-risk prisoners;
- To review the Departmental process for investigating deaths in custody; and,
- To make practical recommendations to assist and support prisoners who may be at-risk of self-harm and suicide, the next-of-kin of prisoners who have died in custody, and staff and other prisoners who may be affected by self-inflicted injury and custodial deaths.

1.4 The 1999 Annual Report of the Ombudsman notified that 'events in the prison system continue to cause serious concern'.[1] There had been a 150 per cent increase in complaints

[1] Ombudsman Western Australia, *Annual Report 1999–2000*, p. 39.

over a two-year period. The Ombudsman found that these complaints went beyond problems with prison overcrowding and reflected more structural and systemic issues within the Offender Management Division of the Department.

1.5 The Ombudsman had announced an 'own motion' investigation into deaths in Western Australia in February 1998 and estimated that it would take seven or eight months to complete. This turned out to be a significant under-estimate of the time required to carry out a thorough investigation in view of the rapid escalation of prisoner complaints, the riot at Casuarina Prison on Christmas Day 1998 and the complexity of issues found during the course of examining deaths in custody.

1.6 The Ombudsman's *Report on an Inquiry into Deaths in Prisons in Western Australia* was sent to the Department in November 2000 in draft form for comment, and published in December 2000. The report found that in many instances the system as a whole failed to provide sufficient and appropriate care to prisoners and that those failings contributed to some extent to the deaths of prisoners. There were 83 recommendations made. The Ombudsman commented that 'in some ways it is very disappointing that many of the recommendations need to be made at this time – because many of them have been made before, in this State and elsewhere, in one form or another'.[2] He added that 'one of the strongest themes to have emerged from my inquiry is that the Ministry [now the Department] has always been able (sometimes with the help of recommendations made externally) to identify what has been needed to be done to improve our prison system. Where the Ministry has failed, in my opinion, is in its inability over the years to move beyond the awareness and planning stages to the implementing and achievement stages'.[3]

1.7 The 2000–01 Annual Report of the Ombudsman summarised the issues identified during the inquiry as: dominance of prison operational considerations over other aspects of custodial management; under-resourcing of health and other functions; a need for improved prisoner/prison officer relations; a lack of a compliance system to ensure that the Department followed its own procedures; and the need for better coordination and commitment requirements for the various bodies investigating prison deaths.[4]

1.8 Deaths in custody have been a significant aspect of the national criminal justice agenda for the last two decades.[5] The greatest academic and bureaucratic attention has been paid to suicide and self-harm, rather than deaths from natural causes, with numerous attempts to identify at-risk profiles by such factors as age, Aboriginality, remand or conviction status, type of offence, time already served, month of the year, sentence length, security rating, and so on.

[2] Ombudsman Western Australia, *Report on an Inquiry into Deaths in Prisons in Western Australia* (2000), p. 5.
[3] Ibid., p. 6.
[4] Ombudsman Western Australia, *Annual Report 2000–01*, p. 34.
[5] Following the Royal Commission into Aboriginal Deaths in Custody, the Australian Institute of Criminology published a series of reports entitled 'Deaths in Custody Australia'. These reports, published between 1992 and 1996, provided statistics and related research on Indigenous and non-Indigenous deaths in custody. Since 1996, the Institute's National Deaths in Custody Monitoring and Research Program has produced and disseminated regular reports.

Whilst useful in understanding aggregated patterns, this approach has had very little (if any) predictive value in individual cases. Even fortified by clinical diagnoses, predictive tools are unreliable; at best, about 20–30 per cent of potential suicides can be identified by these means and the number of false positives is very high. Hence, prisons departments (including the Western Australia Department of Justice) have relied on prevention through technological approaches such as the 'Muirhead (safe) cell'. Although the design has improved markedly, these cells can also have the effect of further diminishing the experience of prison life, without eliminating risk. The Department has also adopted welfare support mechanisms including 'buddy cells', peer support members, and the Aboriginal Visitors' Scheme.

1.9 The drawback with each of these approaches – or even all of them in combination – is that they presume that one can isolate either 'imported vulnerability' (the at-risk qualities that prisoners bring into prison with them) or specific aspects of the prison regime or environment, and solve the problem. However, what we know from the literature and from the first round of prison inspections that this Office has now completed is that prisons are complex organisms whose overall health affects everything that happens there. Experience shows that, by and large, a well-run prison is well run in most of its activities; whilst a badly run prison is likewise badly run in most ways. The total prison environment sets the tone for safety, respect, purposeful activity and so on. This is so even though there is some reason to suppose that the imported vulnerability of the overall prisoner population may be becoming more acute. In other words, there is an apparent trend toward more prisoners with mental health, alcohol or drug-dependency problems and more with dysfunctional family backgrounds or impoverished educational capabilities.[6]

1.10 In the case of the Western Australian prison population, it is evident – though not yet precisely quantified – that the numbers of prisoners with mental health problems are almost certainly increasing.[7] In recognition of this the Department has continued to press Government for funding for a Comprehensive Forensic Mental Health Service for prisoners, with out-reach (to Health Department facilities); in-reach (from Health Department psychiatric services); intermediate care within prisons; and through-care following release into the community. An explicit objective of this proposed service is to reduce self-harm and suicide by prisoners.

6 The Western Australian Department of Justice has never conducted a Prisoner Health Profile Census to assist it in developing a measure of changing prison population characteristics and needs. Three other Australian States – New South Wales, Victoria and Queensland – have now conducted such a census.

7 In New South Wales, a census by the Corrections Health Service revealed that 74 per cent of prisoners had suffered 'any psychiatric disorder' (including psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder and neurasthenia) in the previous 12 months. This figure compares to 22 per cent in the general population. The prevalence was higher (80% as against 64%) amongst unsentenced prisoners, a point relevant to a remand and reception prison such as Hakea. See T. Butler and S. Allnut, *Mental Illness Amongst New South Wales Prisoners*, (Corrections Health Service of New South Wales, Sydney, August 2003).

1.11 Conceding the changing nature of the population entering prisons, it would nevertheless be surprising if, over a sufficient period, a well-run prison did not have a better record in suicide prevention than a badly run prison, other things being equal. In other words, if the imported vulnerability patterns (i.e. the prisoner social and mental health profiles) are comparable, the total prison environment should affect suicide rates. The potential relevance of this is that Hakea has been poorly managed, with a split culture and many unhappy staff.[8] If its suicide rates seem high, it could well be that this is a by-product of a dysfunctional total prison environment.

1.12 Certainly this was the Inspectorate's initial hypothesis and it appears that studies in the United Kingdom support this view.[9] During the 1990s, suicide rates in British prisons declined, until approximately 1999 when rates started to increase again. An internal Home Office review led to the establishment of the Safer Custody Group whose remit was to tackle the issue in a holistic way. One strategy involved identifying six prisons that had previously had a poor record and funding special facilities and programs at these locations. These included technological initiatives (such as better designed 'safe cells'); organisational initiatives (the appointment of a prison-based Suicide Prevention Coordinator); enhanced welfare support (extended use of prisoner peer support and 'Listener' systems); improved health services (the availability of in-reach mental health teams); and better data management (a standardised definition of self-harm and enhanced training to ensure record-keeping consistency).

1.13 The Home Office commissioned two evaluations of these initiatives – one of them by the Cambridge University group led by Dr Alison Liebling[10] (an expert consultant to this Review). These evaluations are crucial in that they provide a meaningful analysis of the success and ongoing relevance of the initiatives; they are expected to be completed by early 2004. This Office has had access to the preliminary, but nonetheless cogent, findings of the Cambridge University group's evaluation. For this work the group selected seven prisons as controls; five of which were high risk prisons seeking to improve their suicide prevention activities without the benefit of the newly-funded initiatives, the other two being prisons with lower than expected suicide rates. These control prisons were used not exactly as comparators with each other so much as to compare practices in all of the prisons and each prison with itself over time.

[8] Report No. 12, *Report of an Announced Inspection of Hakea Prison*, March 2002 (Office of the Inspector of Custodial Services, Perth, 2002).

[9] Dr Alison Liebling, an expert consultant to this project (see footnote 10, below), has pointed out that HMP Feltham in the United Kingdom seemed to suffer from very similar problems when two very different institutions with very different cultures were amalgamated in the early 1990s and that the resultant managerial dysfunctionality expressed itself in higher suicide rates, amongst other things. Indeed, Feltham Prison was the subject of no less than four inspections by HM Chief Inspector of Prisons in the course of little more than three years. However, since the prison achieved a much healthier environment the suicide rate has fallen away.

[10] Dr Liebling is a world leader in the analysis of coping mechanisms adopted by prisoners and in the measurement of the quality of the prison environment. She has also written the leading book about suicides in British prisons: A. Liebling, *Suicides in Prison* (Routledge, London, 1992).

1.14 The group calculated suicide rates and surveyed (300 questions) large samples of prisoners to rate the total environmental quality of each prison and to estimate the imported vulnerability of the prisoner cohorts. They applied complex regression analysis, the outcomes of which were as follows: first, the prison suicide rates reflected the distress rate of prisons; second, prison quality rather than the imported vulnerability of the prisoners explained more of the distress rate. From these preliminary results, Dr Liebling was able to state that total environmental quality factors explained 46 per cent of the distress rate of prisons while imported vulnerability measures explained 15 per cent.

1.15 This research confirms quantitatively what many commentators have argued intuitively or anecdotally.[11] The findings also refer to the role of prison staff, suggesting that levels of prisoner distress (and rates of suicide) are significantly related to staff perceptions of their safety, work climate, relations with management and their role. Staff who are 'comfortable in their role' and who have good relationships with senior managers are more successful in suicide prevention. Good communications (for example, across disciplines) was also significantly related to suicide prevention effectiveness.

1.16 It is possible that some aspects of deaths from natural causes also fit within this paradigm. In this Office's first round of prison inspections, it found that the quality of prisoner health services is uneven. Common sense would suggest that the total prison environment, distress levels and staff morale issues would spill over into this area of operations, as into other prisoner services. This is particularly so when the management structure for delivering health services reports to the custodial senior management, as is the case in Western Australia, rather than being autonomous and working to an external agency such as the Health Department or a separate organisation such as a Corrections Health Service Board (the New South Wales model).

1.17 Note that the total prison environment mode of analysis does not mean that technological approaches, such as safe cells, are irrelevant. These are aspects of the total prison environment. However, it does put into perspective other devices that have previously been relied upon as key interventions. For example, the hit-rate with individual risk assessments is quite low and a reassessment of how best to utilise those resources without abandoning elements of that approach altogether may be required.

1.18 On the other hand, this approach suggests that it is not enough to investigate these deaths simply from the point of view of determining whether a person or persons breached a duty of care or contravened Departmental Directives or Regulations. Of course, these issues are important and must be appropriately dealt with. For example, in the case of the death of a prisoner at Roebourne Prison in January 2000 it was found that the prisoner had activated his cell alarm three times in a short period. In response to this, an officer de-activated the alarm for one hour; during which time the prisoner hanged himself. Other officers were aware that

[11] WA Ombudsman, op. cit., p. 5; R. Harding, 'What can we learn from suicide and self-injury?' in A. Liebling and T. Ward, *Deaths in Custody: International Perspectives* (Whiting and Birch, London, 1994); R. Harding, "Prisons are the problem: A re-examination of Aboriginal deaths in custody" *Australia & New Zealand Journal of Criminology*, 32 (1999), 108.

an officer had turned off the alarm. Appropriately, the officers were disciplined and one of them was dismissed. However, Roebourne was a distressed total prison environment (as indeed it still was at the time of this Office's inspection in April 2002), wracked by poor practice and paralysed by weak management. It was those factors that needed to be addressed.[12]

1.19 A benefit of the above analysis is that it is congruent with the current official thinking of the Department. The Department's Suicide Prevention Taskforce, which reported in July 2002, made only 12 recommendations, all of which are reconcilable with the total prison environment approach. The first three sufficiently capture the tone:

- The enhancement of constructive and supportive relationships between staff and prisoners should continue to be a major priority for the prison system. Particular emphasis should be placed upon improvements to regimes, staff training and rostering arrangements to enhance these relationships;
- Opportunities should be expanded for prisoner interaction with the outside world, particularly with regard to family and friends.
- Each prisoner should be provided with the opportunity to participate in constructive activities such as employment, education, and programs that build competency and address offending behaviour.[13]

1.20 The Department's Suicide Prevention Project Team is responsible for implementing the recommendations of its Suicide Prevention Taskforce. The Department claims that it is now developing auditable standards by which it can assess progress on the implementation of recommendations.

1.21 These laudable aspirations have not yet been achieved, however. In the particular case of Hakea Prison, there is a chasm between the reality and the hope. In this regard, reference should be made to the Inspection Report of this Office arising out of the on-site inspection of Hakea that took place in March 2002. Without wishing to repeat the details of that Report here, the broad conclusions were stark:

> *The geographic unification [of Hakea from the maximum-security Canning Vale prison and the C W Campbell Remand Centre] was not matched by cultural integration; two different value systems remained. This is still the case. It is crucial to understand this if one is to understand the stresses that were evident not only from this Inspection but also, more publicly, in the industrial relations field. The amalgamation has not yet bedded down. Hakea is the unhappiest prison in the State. A prison that is bad for the staff is inevitably bad for the prisoners.*

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12 Report No. 14, *Report of an Announced Inspection of Roebourne Regional Prison – April 2002* (Office of the Inspector of Custodial Services, Perth, 2002), paragraphs 6.15–6.20.

13 Department of Justice, Suicide Prevention Taskforce, 'Suicide in Prison' (July 2002).

For that reason, this Report contains a good deal of discussion about management systems, staff morale and human resources policies… It does not matter how many physical resources, by way of capital improvements or maintenance, are put into the prison; until these other matters are resolved, the prison will remain to some extent dysfunctional. The Department's response to our Recommendations… whilst acknowledging these points is not … sufficiently focussed or committed. They require urgent attention.[14]

1.22 Unfortunately, those remarks were prescient. This Office knows from its frequent follow-up liaison visits that the prison is still in poor shape. If we had the resources and the survey instruments to carry out the Liebling prison quality measurements, we would certainly find that Hakea is in a state of distress. Our own surveys in 2002 revealed an extent of demoralisation that was unique across the state prison system, and this manifested itself in an extremely poor quality of staff/prisoner interaction. However, the Department has recently put a change management team in place at Hakea, and it is certainly hoped that the situation will soon start to improve.

1.23 It will be evident then, that this Office commenced this review half-expecting that looking at Hakea through the prism of prisoner deaths would tend to confirm our earlier impressions when inspecting it across-the-board. Nonetheless, we also believe that the observations that are made herein will also have some relevance to deaths in other prisons. In recent years, this particularly means Casuarina Prison (which has recorded seven deaths in two years) and Bandyup Women's Prison (which has recorded two suicides in the same period).

1.24 This Office adopted as comprehensive a methodology as possible, with particular emphasis on the need to consult widely and solicit input from affected parties. Family members of each deceased person were interviewed; their distress and their perceptions of how various elements in the justice system (including the Department of Justice, the Police, and the Coroner) treat them in the face of this terrible event are essential aspects of understanding the issues.[15] Likewise, prison officers generally and those staff that have had to deal with a death, particularly a suicide, face trauma and distress. Accordingly, we consulted with the Staff Support Team at Hakea, with individual officers and with the WA Prison Officers' Union, and took note of their comments and submissions. We also consulted widely with Department medical personnel, members of the Prison Counselling Service (PCS), prisoner support officers and Hakea management. The Peer Support Group of prisoners was also consulted. Submissions were sought from outside bodies, and a list of those who contributed submissions is included as Appendix 3. Discussions were held with the Internal Investigations Unit of the Department, the Police Prisons Unit and the State Coroner. This Office's Community Reference Group also discussed the issue and made valuable comments.

[14] Office of the Inspector of Custodial Services, Report No. 12, op. cit., p. 3.

[15] In the discussion that follows, seven of the eight deceased persons are, with the consent of families, identified by name; whereas the other deceased person is referred to by his initials.

The Inspector spent time with the Safer Custody Group of the Home Office (UK) and visited one of the prisons selected for special funding and programs (Feltham Young Offenders Institution). Finally, Dr Alison Liebling spent two days in Perth, the first visiting Hakea Prison and the second conducting an in-house seminar at which we brainstormed the emerging themes.

1.25 In addition, a literature review was undertaken. The available material is now voluminous. In fact, the WA Suicide Prevention Taskforce had itself produced a perfectly adequate literature review, as did the Home Office Internal Review and HM Chief Inspector of Prisons in its thematic review *Suicide is Everyone's Concern* (1999). Within Australia, the Tasmanian Ombudsman's *Report on an Inquiry into Risdon Prison*[16] is a high quality document that also covers the literature very thoroughly. Therefore, while the literature has informed our work, only a brief review is included at Appendix 2.

1.26 A document that was foremost in our mind, however, was the WA Ombudsman's Report on an Inquiry into Deaths in Prisons in Western Australia, published in December 2000. The 2001–02 Annual Report of the Ombudsman observed that budgetary constraints and anticipated changes in the population levels as a result of the opening of Acacia prison had resulted in a reduction in certain prison services such as: a reduction in the number of the Forensic Case Management Team staff; the termination of a number of contracts for education tutors which resulted in periodic reduction of access to educational and library facilities; the closure of the art room at Hakea Prison; the intention to cut nursing hours at some prisons; and the likelihood that funding would be cut for a number of research projects and initiatives to improve health services.[17]

1.27 The 2002 Annual Report of the Ombudsman noted that 60 per cent of prisoner complaints related to health services; prisoner placements; conduct of prison officers; visits; and facilities and conditions. Issues relating to officer conduct included harassment, failing to assist, and general manner and behaviour.

1.28 The 2003 Annual Report of the Ombudsman shows that there was a rapid increase in prisoner complaints from Hakea Prison in 2001 (84% higher than 2000), and that this level of complaint had persisted in 2002 (83%) and 2003 (58%).[18]

1.29 The 2001 Annual Report of the Department stated that 16 of the 83 recommendations previously made by the Ombudsman had been implemented that year. The 2002 Annual Report noted that a Suicide Prevention Taskforce had reviewed and reported on suicide prevention measures in prisons and a commitment was made to prioritising and addressing the recommendations of the Taskforce in the year ahead. The 2003 Annual Report noted the recruitment of a Suicide Prevention Project Manager to coordinate the implementation of

[16] Ombudsman Tasmania, *Report on an Inquiry into Risdon Prison* (Office of the Ombudsman, Hobart, June 2001).
[17] Ombudsman Western Australia, *Annual Report 2001-02*, p. 35.
[18] Ombudsman Western Australia, *Annual Report 2003*, p. 32 (table 4.1).

the 12 key recommendations made by the Taskforce. The Department announced that work had begun to develop a suicide prevention program for male Indigenous prisoners.

SUMMARY

1.30 The first term of reference that this Review has to address is to consider the developments within the Department of Justice since the publication of the Ombudsman's Report in 2000, including the strategies of the Department's Suicide Prevention Taskforce Report and their implementation.

1.31 Some five years after the Ombudsman commenced an investigation into prison deaths, many of the recommendations were yet to be fully implemented. Meanwhile, the total prison environment at Hakea Prison is known to be in urgent need of restoration. The Ombudsman's review drew attention to serious flaws in the operational culture throughout the WA prison system, as well as under-resourcing and lack of compliance. Some of the Suicide Prevention Taskforce's recommendations echo the need to address the fundamental values of the prison service, including the relationship between staff and prisoners, contact with the outside world and meaningful activities. The Department's efforts to date have been marginal and slow.[19]

1.32 The primary purpose of the previous reviews considered here was to learn from the past and to improve future delivery of services. A key point in this first Chapter is that new research has emerged that shows the way forward. Hence, the Department needs to first acknowledge the distressed state of Hakea Prison and to develop strategies to tackle its total prison environmental factors. The change management project that has recently begun at Hakea Prison has some promise in this regard.

[19] In its response to the draft of this Report, however, the Department referred the Inspectorate to a new policy document, 'The Future of Suicide Prevention in the Department of Justice', that has taken forward its theoretical understanding of the relevant issues, very much along the lines of Dr Liebling's approach to the subject.

Chapter 2

THE OPERATIONAL FRAMEWORK: MEETING PRISONERS' WELFARE NEEDS

2.1 The Review's second term of reference is to examine the relevance of and compliance with Prison Regulations and Rules, Policy Directives and Operational Instructions that bear upon the issue of deaths in custody at Hakea Prison. This Chapter describes the operational framework relevant to servicing the welfare needs of prisoners. The following Chapter reviews the operational performance of the prison within this framework.

2.2 The total prison environment must be positive to enable each of the functions of imprisonment to operate. This is not a matter of being 'liberal' or 'progressive'. It is a matter of principle and of good management. If a prison is not to be a place of anarchy and chaos, there must be a sense of justice, of decency, of fairness and consistency. These principles must apply to and be exercised by everyone who lives and works in a prison. These are relatively easy to state but require strong leadership and constant practice to be realised.

2.3 Flowing from long and well-established international standards for the treatment of prisoners,[20] welfare has become an accepted part of any contemporary western penal system. For prisons to be safe and for the care and wellbeing of prisoners to be properly attained, the Department must address the welfare needs of prisoners and staff. This requires holistic systems that address training, support and counselling for staff, as well as support, counselling and meaningful activity for prisoners.

2.4 The duty of care owed by the Department towards all prisoners in its custody currently finds detailed expression through its established legislation, policies and procedures. There is myriad documentation that constitutes the operational rules for prisons throughout Western Australia.

2.5 In 1997 the Department undertook a review of the current *Prisons Act 1981* (WA) and in doing so acknowledged that the policy framework for the administration of prisons is out of step with contemporary correctional thinking. The Act does not clearly identify the purposes of imprisonment, nor does it provide principles to guide the implementation of the Act. Rather, the underlying philosophy is only discernible from the prescriptive nature of the provisions and from its omissions. This is unlike the *Young Offenders Act 1994* (WA) and the *Mental Health Act 1996* (WA) and other contemporary international and national correctional legislation. The current Prisons Act has a heavy emphasis on security, control and good order with strong obligations placed upon prisoners and prison officers. When the emphasis of the legislation is purposefully assessed, and the extent of omissions that are evident are taken into account, then the difficulty in attaining a positive prison culture will begin to be realised. To achieve this goal the Department may need to seek a priority listing for legislative reform from Government.

2.6 The starting point for the basic statement of Departmental responsibility for prisoner welfare is stated in section 7 of the Prisons Act: 'The chief executive officer is responsible for the management, control and security of all prisons and welfare of all prisoners'. Section 8

[20] Examples include: The United Nations *International Covenant on Civil and Political Rights* (Articles: 7; 10.1; 10.2; 10.3), United Nations *Standard Minimum Rules for the Treatment of Prisoners* (Articles: 9; 21; 22; 37; 38; 39; 41; 77) and the *Standard Guidelines for Corrections in Australia* (Articles: 1.3; 1.5; 5.57; 5.66; 5.68).

delegates responsibility for carrying out these services to prison superintendents. In addition, section 95 states that 'the chief executive officer may provide services and programs for the welfare of prisoners at every prison and in particular services and programs may be designed and instituted with the intention of providing:

(a) counselling services and other assistance to prisoners and their families in relation to personal and social matters and problems;

(b) opportunities for prisoners to utilise their time in prison in a constructive and beneficial manner by means of educational and occupational training programs and other means of self improvement; and

(c) opportunities for work, leisure activities and recreation.'

2.7 The contemporary philosophical statement of the Department to provide the framework for delivering services to prisoners is called the four cornerstones. These cornerstones are: custody and containment; care and wellbeing; reparation; and rehabilitation and reintegration. For the purposes of this Report, welfare is synonymous with care and wellbeing. All prisons must balance these cornerstones in ways that are appropriate to their role in the total prison system if they are to operate effectively. This operational philosophy should be brought to life through the formal written policies and procedures developed by the Department, and therefore all the operational rules discussed below should reflect the Department's duty to meet the welfare needs of prisoners.

2.8 The documentation that establishes the operational rules for prisons generally, and Hakea Prison specifically are:[21]

- Prisons Act 1981 ('the Act');
- Prison Regulations 1982 ('the Regulations');
- Director General's Rules ('DG Rules');
- Operational Instructions;
- Policy Directives;
- Hakea Prison Standing Orders; and,
- Hakea Prison Local Orders.

2.9 The following sections examine the policy and procedure framework for the services required to meet prisoners' welfare needs. A brief examination will also be made of the relevant Departmental policies with relation to Aboriginal prisoners and the management of suicide in prisons. The section does not examine every aspect of prisoner welfare; rather, it distils those with the greatest impact on the welfare of prisoners and, in particular, issues relating to at-risk status and prisoner health. The overview demonstrates that prison officers and administrators have to deal with a complex number of 'rules' governing almost every aspect of their behaviour when endeavouring to meet these needs.

[21] The policies and procedures referred to here are those represented in the most recent versions of the relevant policy documents; however, this Office recognises that the deaths that are the subject of this Review date back to 2001, and that the relevant policy documents may have been somewhat different at that time.

POINT OF ENTRY SERVICES

2.10 The first time a prison receives a prisoner is a critical time for both the prisoner and the prison system. It is the point at which prison staff collect vital information about the prisoner to enable the assessment of risks and needs and determine how the prison can best meet these. A disproportionate number of suicides occur during the first month of imprisonment. From the prisoner's perspective, this can be a highly stressful time. Their experience in reception, and the information they receive in the formal orientation process, is essential to their welfare and to the minimisation of their suicide risk.

2.11 Whilst the Act and the Regulations do not specifically mention reception or orientation,[22] the DG Rules, Policy Directives and Hakea's Local and Standing Orders cover these procedures in detail. Generally, the latter two local procedural documents mirror each other.

2.12 The procedures to be followed when first receiving a prisoner at Hakea Prison are found in Local Order 63 and Standing Order B3. It is stipulated that the reception room is to be staffed from 7.00 a.m. to 8.00 p.m. each day, with a maximum staff of seven during the hours 12.00 p.m. to 3.00 p.m., but generally to be serviced by five staff including one senior officer. During this time, it is a prison officer's duty to conduct an initial at-risk assessment and to ensure adequate accommodation placement within Hakea.[23]

2.13 The procedural documents require staff to complete a number of checklists during the reception process. DG Rule 13(10.2) provides for prison staff to process all remand prisoners through an admission checklist in order to determine their appropriate security rating within 24 hours of receival. The Rule states that all new remand prisoners should have a maximum-security rating, but there is provision to allocate a lower rating where there are strong welfare grounds to do so. The security rating may also be reviewed (security placement checklist) where the prisoner is hospitalised for treatment.

2.14 DG Rule 14(9.4) refers to the Management and Placement security checklist, which staff must complete within 72 hours of admitting a prisoner. The security rating is important as it affects accommodation placement and the prisoner's privileges. The same Rule applies if a remand prisoner has served at least six months and is likely to serve at least 12 months, in which case the prisoner may have an Individual Management Plan (IMP) developed and be allocated a case officer. An IMP sets out the individualised rehabilitation management plan for a prisoner. A case officer, with whom the prisoner has regular contact, assists them through the plan.

2.15 All prisoners are required to undergo an induction and orientation process, which 'will provide prisoners with an awareness of their entitlements, rights and responsibilities, developmental opportunities, the disciplinary process, and prison operations'.[24]

[22] Prison Regulation 78 could be considered to refer to reception procedures as it details the conditions under which a prisoner can be searched (which includes for any reason) including at admission to prison and all times moving in or out of the prison.
[23] Hakea Prison Standing Order B3.
[24] Hakea Prison Standing Order B5.

Policy Directive 18 stipulates that each prisoner must participate in an orientation process, that must include the issue of a copy of a Department of Justice General Orientation Handbook and a site specific Local Orientation Handbook; also, they should view an orientation video within the orientation unit.[25] To ensure the process is followed, the orientation officer and the prisoner should complete and sign an orientation checklist showing that the officer has explained all relevant areas.

MEANINGFUL ACTIVITY

2.16 Meaningful activities for prisoners have the aim of enhancing prisoners' life skills as well as providing an avenue for the release of stress; therefore, access to such activities is essential to the welfare of prisoners. Section 95 of the Act provides for 'services and programmes for the welfare of prisoners'. It states that these services should include: counselling services for personal and social matters and problems, constructive use of time and opportunities for work, leisure and recreation.

2.17 Regulation 59 places responsibility directly upon the prison superintendent to provide access to such leisure and recreation as he or she considers necessary. DG Rule 3 refines this, providing a list of privileges, including recreation, which should be available to prisoners subject to good order, security and good government or any other reasons as approved by the Chief Executive Officer.

2.18 Whilst, in general, leisure and recreational activities are not detailed in Hakea's Local and Standing Orders, access to Hakea's two ovals is covered under Local Order 28, including use by high security risk prisoners.

2.19 Employment is also considered a meaningful activity for prisoners. Policy Directive 25 states that the intent of work is to 'ensure that prisoners are constructively occupied during their sentence and to supply prisoners with work experience so as to provide them with opportunities for employment on release'. Education is covered under the same heading. Regulation 43 states that remand prisoners are not required to work and must, therefore, submit a request to the superintendent if they wish to do so. However, if the prisoner chooses not to work then he will not receive gratuities (pay).[26]

2.20 Treatment programs are an important part of a prisoner's meaningful activity whilst incarcerated. Of the framework documents examined for this Review, the Prisons Act was the only document to make specific reference to programs. The Department adopted a new policy framework in 2000 to roll out an Integrated Prison Regime Project. The main components of this initiative include: unit management; case management; cognitive skilling; constructive day; and the incentives and earned privileges scheme. Following the piloting of the project at five targeted sites, work began to implement that framework across the State.

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[25] Ibid.
[26] Operational Instruction 12(4).

In January 2001 the Offender Programs Branch was established to bring several groups of offender programs into a single administrative structure. This includes the substance abuse, sex and violent offending, and disability programs. Hakea Prison was meant to play a central role in conducting assessments of male prisoners with an effective sentence length of more than nine months.

2.21 The various projects and initiatives of the Department mentioned above have yet to mature into cogent policies and to manifest in routine and functioning service delivery. Most previous Inspection Reports of this Office have been critical about these matters.

ACCESS TO THE FAMILY AND THE COMMUNITY

2.22 Access to family and friends is an important welfare measure. Policy Directive 36(2) acknowledges the vital role of family contact and access to the community for its ability to 'reduce the impact of imprisonment by maintaining family, community and cultural ties and to facilitate access to legal representation, prisoner support groups and independent statutory government agencies'.

2.23 Section 59 of the Act allows for visits from family and friends. This contact can be extended to those accommodated in other prisons under DG Rule 7(11) through inter-prison visits. The superintendent may revoke visits or terminate visits on the grounds of good order or security under Section 66(1) of the Act. Alternatively, DG Rule 7(5) provides that visits can also be reduced to non-contact.

2.24 Specifically with regard to remand prisoners, Regulation 56 and DG Rule 7(2.1.1) states that prisoners on remand should be permitted visits:

- As soon as is practicable after admission to prison;
- Daily, thereafter; and
- At other times, as may be authorised by the superintendent.

2.25 Hakea Local Order 50 sets out the times and conditions of social visits and states that sentenced prisoners have access to two visits per week and remanded prisoners daily, with up to three adults visiting at a time. The exception to this appears to be remand prisoners who are on restricted visits (due to their alleged offences against children) and do not have daily access under Local Order 50(2.4) and (2.5). Under Regulation 53(2), prisoners may refuse visits.

2.26 Family and friends are also able to contact and inform the prison directly of concerns they have about the prison, in particular in relation to self-harm risk, and this is provided for in DG Rule 7(13).

2.27 Mail is another way that prisoners keep in contact with family, friends and their community. The need for this contact is expressed in Policy Directive 36 as being to 'reduce the impact of imprisonment by maintaining family, community and cultural ties and to facilitate access to legal representation, prisoner support groups and independent statutory government

agencies'. Section 67 of the Act allows prisoners to send and receive mail, with both incoming and outgoing mail subject to screening. The Act allows for specified recipients, usually bodies that assist prisoners with complaints and other issues, to be exempt from screening.

2.28 Policy Directive 36 states that telephone and mail communication by prisoners with the outside world should be encouraged, and prisoners should have reasonable access. Hakea Local Order 18 specifies what reasonable access is, and details the volume and size limitations of mail. Standing Order A11 provides extra telephone entitlements for remand prisoners, who receive five free calls each week and have access to officer-initiated calls (subject to the discretion of prison officers). Unfortunately, as with so many other matters, the reality falls short of the abstract policy. The process by which remand prisoners can get their chosen telephone numbers security-cleared and placed on the system is somewhat cumbersome and can take two or three days. In the meantime, the capacity of officers to permit officer-initiated calls is limited by the constraints of other duties.[27]

CONTACT WITH OUTSIDE AGENCIES

2.29 Prisoners need to access a range of services that are not provided directly by the Department. Sections 61 to 65 of the Act provide for access,[28] but this access is subject to the maintenance of good order and security of the prison under section 66. In addition, section 95 of the Act may enable outside agencies to provide services and programs to fulfil the Department's obligations under that section 'for the welfare of prisoners in relation to personal and social matters and problems'.

2.30 DG Rules 7(1.1) provides a list of external agencies that may enter the prison to meet prisoners' needs. This includes official visits from specified agencies including the Aboriginal Visitors' Scheme (AVS), members of the Parole Board, legal practitioners and religious/cultural representatives. Prisoners are also able to request that an agency or representative not specified by the DG Rules be permitted to visit for the purpose of their welfare or advocacy, if the person assists the Department and superintendent by disclosing welfare issues and working towards a solution. Policy Directive 36(5.3) extends these rights to telephone and mail contact.

2.31 Local Order 5 makes particular mention of the objectives, status and procedure for AVS visits within Hakea. It allows for AVS visitors to attend daily for up to six hours and also provides for emergency access (with the permission of the Officer in Charge of the prison). Prisoners must pre-book appointments the day prior to the visit; however, the prison administration can request AVS to attend a prisoner at any time. The Order does not state whether the AVS can initiate visits, or if they would be permitted to enter the prison if no visits had been

[27] It was submitted to the Review that this problem could easily be circumvented if the Senior Officer group had access to the telephone computer system.

[28] Sections 61–65 provide for access to certain officials such as the prisoner's parole officer or the Ombudsman (section 61); legal practitioners (section 62); police officers (section 63); public officers (section 64); and others authorised by the Chief Executive Officer of the Department (section 65).

booked. Local Order 52 states that visits should normally be held in the interview room, but that arrangements can be made for them to be held within the accommodation units. It also requires the AVS visitor to brief the officer in charge of the prison on any matters of concern raised by prisoners before leaving for the day.

2.32 DG Rule 7(1.1) and Policy Directive 7(5) allow for visits from religious and cultural representatives, permitting such services as required that do not disturb the maintenance of security and good order in the prison. These services are to be administered via the delegated Prison Chaplaincy and extend to religious groups and representatives.

2.33 The bulk of welfare services available from the community voluntary sector are not catered for, and formalised processes to access these services are ambiguous at best.

HEALTH CARE SERVICES

2.34 Whilst prisoners have health needs similar to those in the community there is a concentration of some issues – such as substance abuse and mental health – that require a more intensive level of service delivery. Importantly, imprisonment itself can add to the complexity by restricting access to family networks, informal carers and over-the-counter medication.[29] Prisoners may suffer emotional deprivation and may become drug abusers or develop mental illness as a consequence of imprisonment. There is a particular challenge in ensuring a thriving health care ethos in an environment where the priorities are security, order and discipline:

- Custody affects care in that it removes the opportunity for self-care and independent action – prisoners have to ask staff for the most simple remedies;
- Access to prisoners by health care teams may be curtailed in the interest of security and control;
- The proposed actions of medical staff may clash with security and good order considerations;
- Nurses may be asked to carry out duties unrelated to health care;
- Some prisoners may be manipulative, trying to obtain medication that they do not require and thereby create suspicion amongst health care staff of all prisoners; and
- The health centre is often seen as a sanctuary or a 'social care' option for some prisoners, particularly those that are being bullied.[30]

2.35 Prison Health Services has just completed an accreditation process through the Australian Council on Healthcare Standards for all prison health clinics throughout the State. The outcome of this process is pending. According to the Department's Director of Health Services, this will define standards that are comparable with the community and provide a

[29] Dr Liebling and her colleagues have identified continuity of medication from outside the prison to inside as a major health care issue.

[30] T. Marshall, S. Simpson and A. Stevens, *Health Care in Prisons: A Health Care Needs Assessment* (University of Birmingham, 2000).

benchmark for the improvement of services. We understand that the Health Services Directorate is not optimistic about achieving this outcome, as additional funding will be required to deliver the services to the new benchmark.

2.36 A robust and comprehensive health system is essential to the wellbeing of prisoners and in the reduction of deaths by natural causes within a prison. Sections 38(1) and 39(b), (c), (f), (g) and (h) of the Act outline the origins of the authority and the responsibilities for medical care within a prison. These are expanded upon to some extent in Regulations 62 and 74 and Policy Directive 8, which covers the care of prisoners with terminal illness. In addition, DG Rule 13(3.1) requires prisoners to be placed in a prison suitable to their needs, including health and treatment needs.

2.37 The Department recognises that the responsibility for prisoners' health needs go beyond that placed upon the medical staff. It includes, under section 12(b) of the Act, that every officer has a responsibility to 'report to the superintendent every matter coming to his notice which may jeopardise the security of the prison or the welfare of prisoners'; this includes health needs.

2.38 DG Rule 10 details the processes, checks and balances that prison officers are to follow in the distribution of medication within a prison. Hakea Local Order 44 expands on this and gives specific instructions on an accommodation unit basis. Hakea Local Order 22 and Standing Order B7 also establish that each unit should have an emergency first aid kit with specific mention of its use in cases of self-harm.

2.39 DG Rule 13(5.1.5) states that, whilst the primary purpose of the Crisis Care Unit (CCU) at Hakea is for prisoners at-risk of suicide or serious self-harm, those in the critical stage of a difficult detoxification should also have access. In addition, in exceptional circumstances the CCU can be used for prisoners in personal crisis, prisoners undergoing treatment for a psychiatric disorder that requires intensive monitoring or prisoners who have a suitable and unstable medical condition. Related to this, Policy Directive 11 establishes the conditions and processes to be followed in placing a prisoner within a general observation or medical observation cell.

MENTAL HEALTH SERVICES

2.40 The accurate and reliable detection of prisoners with mental health problems is essential to the welfare and at-risk management of these prisoners. Without comprehensive assessments, staff cannot recognise the needs of these prisoners and meet their medical, psychological and general prison management needs.

2.41 The origins of the onus for mental health care are the same as those for the responsibility for physical health and wellbeing. With the inclusion of section 95, the Prisons Act specifically refers to counselling services and 'assistance to prisoners and their families in relation to personal and social matters and problems'.

2.42 Operational Instruction 16 relates to the placement of young prisoners within an adult prison. Because of their perceived vulnerability, section 4 of that Instruction states that all prisoners aged 20 years or younger should be flagged with an alert on the prison's computerised prisoner management system (TOMS). In addition, if the prisoner has been in juvenile detention, the reception officer must fax Rangeview Juvenile Detention Centre, and Rangeview must provide a range of information to be used by the reception officer in determining suitable placement within the prison. Further, any information provided to reception by the juvenile justice system on health issues, should be passed on to the Prisoner Counselling Service (PCS) and the prison medical services as soon as practicable. Hakea Local Order 74 reflects these procedures in a localised context.

2.43 The Department is currently negotiating an agreement with the Health Department for the provision of statewide psychiatric services. The Joint Department of Health (DOH) and Department of Justice Mental Health Taskforce (convened by the Offender Health Joint Executive) have recently completed a statewide review of forensic mental health services. The Taskforce identified the following areas as gaps in current service delivery:

- Screening, identification and assessment of mental health illness and other disorders;
- Options for alternative sentencing;
- Treatment services for prisoners;
- Services for Aboriginal and Torres Strait Islander offenders;
- Re-entry and integration support;
- Services for juvenile offenders; and,
- Regional services.

2.44 The *Comprehensive Forensic Mental Health Service Strategy* (CFMHSS) was therefore developed to address these gaps and to coordinate a comprehensive mental health service delivery for offenders. The areas covered under the CFMHSS are:

- Culturally secure forensic mental health program;
- Court liaison for mentally ill offenders;
- Identification and assessment on reception;
- Mental health services in prison;
- Services for offenders with an acute mental illness;
- Re-entry and integration;
- Establish a taskforce to investigate the establishment of a mental health court in Western Australia; and
- Establish a taskforce to provide recommendations for the development of a comprehensive forensic mental health service for adolescent offenders.

2.45 A joint Cabinet submission is now being developed by the two departments to secure the necessary funding for this Strategy. The Department of Justice should acknowledge the service deficits evident at Hakea Prison and develop an interim plan to improve services whilst the statewide strategy is under consideration.

MANAGEMENT OF RISK BEHAVIOUR

2.46 As previously mentioned, section 12(b) of the Act states that each officer is responsible for reporting 'to the superintendent every matter coming to his notice, which may jeopardise the security of the prison or the welfare of prisoners.' This includes self-harming or other at-risk behaviour. Section 95 outlines the provision of 'services and programmes for the welfare of prisoners' including 'counselling services and other assistance to prisoners and their families in relation to personal and social matters and problems'.

2.47 The Department of Justice's primary tool for preventing suicides in custody is the At-risk Management System (ARMS). Its operation is covered in detail within Standing Order B11.

2.48 Other rules and procedures have also been established to reduce the risk of suicide and self-harming amongst prisoners. These include:

- Hakea Local Order 15 that sets out the philosophy and objectives of the CCU, particularly its suicide prevention focus (as contained in DG Rule 13). Local Order 62 also relates to the CCU, in that discharge from CCU can only be at the unanimous decision of the team put together to monitor those in the unit (the Prisoner Risk Assessment Group or 'PRAG');
- Alternative placement for prisoners at-risk may be in an observation/safe/multi-purpose cell. Hakea Local Order 62 sets out the terms and conditions under which a prisoner may be placed in such accommodation, foremost being that such an action should not be a first resort. If placement is due to suicide risk it must be part of a well thought-out detailed management plan, must involve PRAG and must be for the shortest possible time. It also makes it clear that placement in isolation must be tailored to the needs of the prisoner and that it should not be for the purposes of punishment;
- Hakea Local Order 45 states out that all cells should have a call alarm system that is monitored and recorded at all times to enable prisoners to contact staff when confined to cells; and
- Hakea Local Order 49 sets out the requirements for night-time counts, where prison officers must check that some part of the prisoner is visible and that there is movement to identify signs of life.

GENERAL BEHAVIOUR MANAGEMENT

2.49 A critical component of prisoner welfare is the appropriate management of prison life, good order and the maintenance of security within the prison. Section 36(3) of the Act gives the superintendent the right to issue orders and to enforce those orders with such force as reasonably required (sections 36(4) and 42(1-3)). This includes confinement of a prisoner in isolation (section 43 of the Act and DG Rule 1)[31] and the placement of a prisoner in close supervision under the direct management of prison officers within a confined area; however,

[31] See also Prison Standing Orders B12–B16 and Policy Directive 11.

the latter should not 'be used as a punishment or as part of a punishment' (Operational Instruction 1 and Policy Directive 7). Such confinement should only be used in cases of violence or threats of violence and serious non-conformist behaviour as a means of protecting the prisoner involved.

2.50 The DG Rules do not ignore the welfare of the prisoner in prescribing prisoner behaviour management. They state that all prisoners in separate confinement must have access to daily exercise, food and water and be visited at least once daily by a senior member of the prison administration and at least once each shift by the unit manager to ensure their health and welfare. DG Rule 1 also demands health service access for both physical and mental health reasons on a regular, if not daily, basis.

2.51 Within DG Rule 13 a number of welfare issues are also covered, including:

- Prisoner placement in a prison suitable to their needs: health, education, treatment, protection (3.1); and
- Taking into account the likely impact on at-risk prisoners of a transfer, particularly away from family and community support (3.6).

MEETING THE WELFARE NEEDS OF ABORIGINAL PRISONERS

2.52 The policy basis underpinning the delivery of services to Aboriginal prisoners resides in the Department's Prisons Division Strategic Plan for Aboriginal Services 2002–05. There are no specific references to welfare services in the plan; however, there are references to actions to address objectives with a welfare basis. One of these key objectives[32] is 'developing a comprehensive physical, spiritual and mental health care strategy addressing the special needs of Aboriginal prisoners with particular reference to high risk categories'. As is the case with the majority of objectives in the plan, without firm commitments to timeframes and resources these are largely aspirational proposals. The Department merely intends to incorporate such objectives into various strategic and operational business plans.

2.53 The Aboriginal Policy Unit has a budget of $3.17 million and employs a staff of 20. As would be expected of a policy unit, it operates at a strategic level across the Department and, as such, has little involvement in operational issues arising within the various directorates. However, within the Prisons Division there is a Manager Aboriginal Services who is responsible for advising on Aboriginal issues at an operational level. There is, however, a paucity of operational performance information available from the Department to assess the extent to which the special welfare needs of Aboriginal prisoners are met.[33]

32 Department of Justice, 'Strategic Plan for Aboriginal Services', op. cit., p. 10.

33 For example, Aboriginal representation at various levels of incentive accommodation and employment are matters about which this Office has repeatedly commented in its Inspection Reports.

Aboriginal Visitors' Scheme

2.54 The Aboriginal Visitors' Scheme (AVS) was established in January 1988, pursuant to a recommendation in the Interim Report of the Inquiry into Aboriginal Deaths in Custody in Western Australia. The AVS was originally an external program beyond the management and control of the Department.

2.55 The visitor's role under the AVS is:

- To provide one means of reducing the likelihood of Aboriginal deaths/self-harm in custody;
- To ensure that the condition of Aboriginal prisoners, detainees and juveniles improves by consulting with government departments and decision-makers with information and advice on just and humane treatment; and
- To ensure the advancement of the AVS.

2.56 In September 1999, the then Department of Justice commissioned Dr Ann Butorac, Rick Downie and Frances Rowland to undertake an independent review of the AVS. The aim of the review was to determine the extent to which the scheme provided an effective and efficient service relevant and responsive to the needs of Aboriginal people in prison. This review identified the following areas that required attention: the AVS operational guidelines; training; recruitment of visitors; procedures; detainee access to visitors; entitlements of detainees; security issues; and resourcing, location and expansion issues. The Department considered these recommendations and, in 2002, published a report entitled *An Evaluation of Management Processes and Operational Structure of AVS*.

2.57 The scope of the evaluation was to:

- Review and assess resource allocation mechanisms and to recommend process improvements;
- Evaluate existing management and operational policies and processes for AVS and provide recommendations that will enable the provision of cost effective services;
- Review the service planning and priority processes and identify improvements requiring action by management; and
- Analyse AVS demand drivers and provide a forecast of demand and capacity requirements for AVS for the period 2002/03 to 2005/06.

2.58 The Department has in recent months appointed a new manager to the AVS. The manager's first priority is to establish the Board of Management so that the recommendations of this review can be progressed. The Department's current position is that the role of AVS has to change to respond to the needs of today's prisoners, and that this perspective will drive the development of the new role of AVS visitors.

THE APPLICATION OF WELFARE RESOURCES

2.59 In order to achieve the outcomes of the delivery of the welfare services outlined above, prisons must be allocated appropriate resources. The Department claims to base their allocation of resources to individual prisons upon projected prisoner numbers, commensurate resourcing requirements, and the overall funds available. However, the Department has traditionally funded its prisons on an historical basis, which means it does not always fund additional or new projects in the year they occur. Importantly, the Department funding model does not allow us to identify the specific amount that is spent on welfare services.

The Delivery of Welfare Services

2.60 The delivery of welfare services within a prison is derived from a broad spectrum of operational functional areas. Prison officers and non-uniformed staff such as educators, programs and industrial officers, PCS, chaplains, and health services staff, all play an important role in the delivery of welfare services to prisoners. Importantly, other prisoners, whether or not they are in designated roles such as peer support prisoners, play a key role in maintaining the welfare of their peers. It is not the spread of people the prison designates or mandates to have a role in welfare and self-harm reduction that is important, rather there needs to be a prevailing culture that creates an expectation of active involvement in prisoner's welfare.

A Welfare Culture Across the Prison System

2.61 'The most gains to be made in prevention of self-harm and suicide in prison are seen to require a cultural change in which the care and well-being of prisoners becomes a primary focus for all staff.'[34] To facilitate this cultural change the Department has implemented a strategy known as the Integrated Prison Regime (IPR). Its aim is to improve the overall functioning of prisons, particularly in the areas of prisoner safety, prisoner support, and the development of a culture of mutual respect between officers and prisoners. The Department stresses that the cultural change process is a major factor in their efforts to prevent or reduce, self-harm and suicides.

Prison Staff

2.62 Uniformed prison staff provides the most basic forms of welfare services on a daily basis. The job description form (JDF) describing the responsibilities of the position states that officers' duties include: 'Monitors and responds to the needs and concerns of offenders including health, safety and welfare'. The JDF for a senior prison officer is more specific and denotes a much higher level of responsibility and accountability; it requires senior officers to ensure and respond '… to the needs and concern of offenders, including health, safety and welfare'. The superintendent's JDF specifies that the incumbent is 'responsible for ensuring a safe, secure and humane environment and with the effective delivery of the four key outputs of custody and containment, care and well-being, reparation and rehabilitation'. Clearly then, uniformed

[34] Department of Justice, 'Suicide Taskforce Report', op. cit., p. 13.

prison staff and senior management have obligations to the welfare needs of prisoners and a high level of accountability is indicated.

2.63 Prior to 1987, the Department had a prison welfare branch. This provided a focus for welfare service delivery. The Department closed the branch and devolved its services to prison officers in a stated effort to broaden the scope of their role in managing prisoners. In practice, prison officers respond to the welfare needs of prisoners on a selective and limited basis. There is no accountability mechanism that ensures that the Department monitors this important aspect of their work. Although the Department's unit and case management initiatives suggest this is so, in reality unit and case management are yet to be grounded as a core role of prison officer work. Some officers are extremely good at working with prisoners on their welfare needs, others less so.

2.64 The Department does not provide specific training to staff that acknowledges their role in dealing with a high-risk prisoner population. As mentioned in 1.10, above, it seems likely that the imported vulnerability of the prisoner population as a whole is increasing, with the consequence that this aspect of the prison officer's role is becoming more crucial whilst training remains in limbo.

THE STRATEGIES, MANAGEMENT AND CONTROL OF THE WELFARE SERVICES AND RESOURCES

2.65 The management and control of welfare services and resources within the Department is convoluted. There is no single entity responsible for service delivery. This is unlike the clearly articulated arrangements for the security and control functions of custodial management. In many instances, such as with the PCS, AVS, education and programs staff, there are split management arrangements between the superintendents and the Perth-based head office functional managers.

2.66 The strategies that underpin the management of the prison welfare services are as diverse as the services themselves. The business units within the Prison's Division responsible for the delivery of welfare services are:

- Prisons Division executive;
- Prison superintendents;
- Operational Services and Sentence Management;
- Health Services; and
- Aboriginal Policy and Services.

2.67 There is no single position, entity or forum that bears this responsibility, either in prison or in head office. The closest any position comes is at the executive level, with the General Manager Public Prisons or the Executive Director Prisons apparently at the top of the hierarchy. Because welfare services cross numerous managerial boundaries, various people bear individual or collective responsibility. There is neither a process nor a responsible individual to

set standards, monitor performance or compete for scarce resources.

2.68 Greater efforts are needed to develop and maintain integrated and coordinated welfare services at the operational levels of prisons.

SUMMARY

2.69 Particular reference in this Chapter has been made to the framework that underpins the philosophy and delivery of welfare services in Western Australian prisons that have a direct bearing on the deaths in custody. While a comprehensive suite of policies and practices has been developed, the complexity and cross-referencing often involved in its application can be problematic. A single clear and concise set of procedures would be highly beneficial to those at the prison level who must understand the policy context to deliver the services.

2.70 The heavy emphasis of the current Prisons Act on security, control and good order with strong obligations placed upon prisoners and prison officers, and the extent of omissions relating to welfare services, adds to the difficulty in attaining a positive prison culture.

2.71 Also fundamental are the arrangements for resourcing welfare services and the delegation of ownership and control for their successful operation. Welfare services cannot be delivered successfully unless both these aspects are priorities of the Department.

2.72 It is the extent to which policies and procedures are followed on-site and in everyday routine circumstances that will deliver the stated service outcomes. This is the true measure of meeting the duty of care owed by the Department to prisoners. The stories of the individuals who are the subject of this Review, and an analysis of those stories in the context of the stated purpose of Hakea Prison, will show the extent to which this framework has been operationally realised.

Chapter 3

THE OPERATIONS AT HAKEA PRISON

HAKEA PRISON'S PURPOSE AND ROLE

3.1 The fourth term of reference requires a comprehensive review of the operations at Hakea Prison associated with the welfare of prisoners. The operations of the reception and induction programs, the quality of prisoner/staff interaction, and the facilities and programs that provide intensive and specialised care and support for at-risk prisoners are fundamental aspects of prisoner welfare services that were examined during this Review.

3.2 In 2000, the Department amalgamated the CW Campbell Remand Centre and Canning Vale Prison into the Hakea Remand, Receival and Assessment Prison.[35] The Department now identifies Hakea as 'the primary remand, receival and assessment centre for male metropolitan prisoners'. The mission statement of Hakea states that it is 'a professional team leading the way in the management of remand and assessment prisoners'.

3.3 The Department acknowledges the unique status of the Hakea population and the risks that come with such a population.

3.4 This population is recognised as being a vulnerable and potentially high–risk group requiring specialised management … Remand prisoners can also experience high levels of anxiety and depression … Newly sentenced prisoners, a significant aspect of Hakea's population, are also considered to be at high risk of self-harm. The nature and characteristics of the population significantly influence the role of the prison within the Department's operational service configuration and the way in which services are delivered at the prison.[36]

3.5 The vulnerability of the Hakea population is also acknowledged in the report of the Department's Suicide Prevention Taskforce,[37] which identified that, in general terms, remand and maximum-security prisoners were found to be at greater risk of suicide than were the wider prison population. All of the Hakea prisoners who are the subject of this Review and who committed, or apparently committed, suicide were on remand at the time of their death. Given that the Department acknowledges Hakea's role in managing such a high-risk, vulnerable population, we could expect both the Prison Division as well as Hakea's Business Plan to reflect this.

Hakea's Business Plan

3.6 The Hakea Prison Business Plan is a comprehensive document.[38] It specifies that Hakea Prison requested a budget of $18.1 million for 2003/04 but was only allocated $16.4 million with an approved overrun of $1 million for additional prisoners over 560. The plan indicates that the reduced funding is based upon an FTE (staffing) model that the prison will find difficult to achieve, but that the prison must nevertheless meet its budgetary targets.

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35 Department of Justice, 'WA Prison System: Role and Function Profile', May 2003.
36 Ibid.
37 Department of Justice, 'Suicide Taskforce Report', op. cit., p. 13
38 Department of Justice, 'Hakea Prison Business Plan 2003–04'.

Hakea Prison has been under severe strain for the past four years. The discrepancy between the estimated operational costs and allocated budget for the 2003/04 financial year and the pressure on all staff to work within the budget has led to further strain and disharmony, which has impacted adversely upon prisoner welfare.

3.7 The Business Plan articulates the issues and problems that have confronted Hakea since its establishment as the remand, receival and assessment prison: including poor staff morale, a lack of corporate identity and staffing problems. It identifies strategies for addressing these issues as well as key milestones and indicators: 'The prime strategy is to manage the significant changes that the re-engineering of the service has produced. For the next 12 months all strategies are targeted at the consolidation of the amalgamation'.[39] In other words, the primary focus of the prison's management efforts is to juggle the priorities between the completion of the complex operational amalgamation commenced some three years ago and the delivery of operational efficiencies.

The Public Prisons Division 2003-07 Business Plan

3.8 There are two references in the Public Prisons Division Business Plan which impact upon this high-risk vulnerable population. Firstly, the Department identifies under its Service Delivery Projects (2003/04) that it will address suicide prevention through the following mechanisms:

- Implement recommendations of the Suicide Prevention Taskforce; and,
- Review the functional cell standards of accommodation.

3.9 Secondly, 'apparent suicides' are performance indicators under the Department's care and wellbeing cornerstone performance measures. The other performance indicator relates to prisoner 'out of cell hours' (which is the time prisoners are supposed to be unlocked and out of their cells). Neither indicator provides any realistic measure of whether the prison is effectively managing the prisoner's welfare. These are extremely crude indicators of the healthiness of the total prison environment. There is little corporate governance providing specific direction for operational managers attempting to develop effective welfare services.

3.10 While the framework documents examined in Chapter 2 supply the formal basis as to what welfare services should be provided in prisons, it is vital that these are in fact provided in a systematic and coherent way at the prison operational level.

POINT OF ENTRY SERVICES AT HAKEA PRISON

Reception

3.11 The reception room at Hakea is clean and well presented. The reception centre is not always adequately staffed to perform its function, but staff conduct themselves in a pleasant and professional manner. None of the reception staff had received any training relevant to their roles within a high-risk reception environment. All the officers interviewed expressed a desire

[39] Ibid.

to receive at-risk and drug awareness training, but were cynical about the likelihood of this from past experience.

3.12 There are two fewer officers in the reception room after 3.00 p.m. when prisoner receivals from the courts are at their peak.[40] There is a likelihood that the processes are rushed and that vital information is missed as a consequence of these organisational arrangements. The Hakea Inspection in 2002 identified that arrangements for late arrivals were a problem. Prisoners usually arrive from 2.30 p.m. onwards, placing reception officers under pressure to process prisoners and get them to their designated accommodation unit before the general prison lockup at 7.30p.m.

3.13 All new prisoners proceed through the reception, induction and orientation processes. Prisoners returning from court appearances are searched and returned to their units. The practice of not interviewing or monitoring these prisoners could present a number of problems, particularly if prisoners have an adverse court outcome.

3.14 Once prisoners have progressed through the reception process, health services staff conduct health and at-risk assessments. The Department advised this Review that only permanent nurses employed by them undertake this reception process. On the day of our Inspection visit an agency nurse was working in reception area. This nurse had only received a brief orientation to the prison and its processes and had not received any training on the administration of the at-risk assessment and Aboriginal health/cultural issues. The nurse stated that an experienced nurse had given some guidance on signs to look for when performing an at-risk assessment and that he felt confident in this role. A great deal of health information was provided verbally to the prisoner in each of the cases reviewed, without any written handouts. The appropriateness and utility of this approach is questionable.

3.15 A new pilot MRO12 risk assessment form has recently been developed. The process for introduction of the revised assessment process has not yet been decided. Health services staff acknowledged that the old MRO12 form was not particularly useful for at-risk assessment and is difficult for non-specialist nurses (e.g. agency nurses) to use. Health services staff believe that the new assessment form will better enable the assessment of a prisoner's risk. While the new form has the potential to identify more prisoners at-risk, it is yet to be seen whether it is sensitive enough to screen out those prisoners who are currently falsely identified as being at-risk. The Mental Health Nurses (MHN) employed by the Department have been delegated the responsibility for developing and undertaking training for nurses in risk assessment once the new MRO12 is released for trial. The links to the Department's intentions to attain nationally accredited competency training standards through this approach are tenuous at best.

[40] The Department now reports that the roster has been changed so that the area is "adequately staffed" until 7.30 p.m. In addition, a new induction team, consisting of a senior officer and two prison officers, has recently been introduced on a 2.00 p.m.–10.00p.m. shift to attend to late arrivals.

3.16 There was insufficient privacy when the nurse was assessing prisoners. During this Review the interview room door was observed to be open and prison officers walked freely in and out of the room whilst the interview was in progress.

3.17 The MHNs stated that they were often required to adjust the Total Offender Management Solutions (TOMS) information data base to reflect new information received during a subsequent interview. In one case, the prisoner had previously reported being asthmatic, but when asked in his current interview denied this was ever the case. Consequently, staff changed his record on TOMS. There did not appear to be a process in place to note the change or to recognise the possible risk involved if the prisoner was indeed asthmatic. Further, this change was made without reference to the prisoner's medical records. There is a real and present danger in any system that allows overwriting data of this nature. The example serves to demonstrate gaps in training and supervision.

3.18 In the interim action plan provided in response to the Inspection of Hakea in 2002, the Department agreed that peer support prisoners would have access to reception and their role in the reception process would be further developed. Our observations during this Review suggest that this has not happened; as well, Prisoner Support Officers (PSO) and peer support prisoners believe that there is resistance to this idea.[41]

Induction and Orientation

3.19 Induction and orientation practices at Hakea Prison do not meet the overall needs of new prisoners although there are designated orientation officers for these purposes. One of the two orientation officers is rostered-on daily and orientation is conducted between 8.00 a.m. and 4.00 p.m. The role is shared between two prison officers designated for this purpose. There is no process for after-hours orientations, even though the prison receives the majority of new prisoners from 2.30 p.m. onwards. There is a clear need for an after hours orientation service to ensure that the immediate welfare needs of new prisoners are met.

3.20 The orientation Policy Directive 18 states that the orientation program may be divided into three phases:

- Stage 1: Provision of an information kit and basic information (to be completed on the day of arrival);
- Stage 2: Detailed orientation (to be completed within three working days) to include matters relating to: transition to institutional living; regulations, rules and prison orders; services available to prisoners; systems that aid vulnerable/suicidal prisoners or those with special needs; and procedures for requests and complaints; and,

[41] In its response to the draft of this Report the Department states that there has been a peer support worker in reception for "approximately two years". Our concern at the time of the March 2002 Inspection of Hakea Prison is that the presence of such a person was fortuitous, rather than systematic and planned, and this appears still to be the case.

- Stage 3: Explanation of sentence management systems (to be completed within one month of arrival) including: assessment; personal development courses; addressing offending behaviour; and any compulsory course requirements (such as, Occupational Health and Safety requirements and awareness of blood borne communicable diseases).

3.21 Stage 1 and 2 of orientation immediately affects the settlement of prisoners and officers are to conduct this within three days. In the orientation interview the officer meets with each prisoner on an individual basis, observations of at-risk status are made and noted, and any welfare issues are noted which are then referred to the relevant services or acted upon. A tour of the prison is undertaken, a video providing a general introduction to Hakea Prison is played and necessary administration forms are completed in Unit Seven.

3.22 Hakea Prison does not have a comprehensive orientation booklet. The prison utilises a generic booklet containing basic information developed for the whole prison system and, in addition, the reception staff give new prisoners handouts developed locally outlining in rudimentary terms details on peer support, daily timetables/routines, education opportunities, and information on how to contact legal aid services. There is no information on support services to maintain contact with their family or other welfare orientated services either available within the prison or accessible from the broader community.[42]

3.23 The orientation officer estimated that orientation takes about two hours and comprised a walk tour of the prison, a 20-minute orientation video and an individual interview with each prisoner. Officers, including the accommodation unit wing officers, provide the prisoner with initial orientation to the wing and notify them of their rights and privileges in regard to telephone usage. We were advised that the wing officers should give the prisoner a handout containing general orientation information but none were evident when we visited the wing.

3.24 The second component of the orientation checklist requires that new prisoners be given a tour of the prison. This Office observed four prisoners being given a rushed tour of the prison consisting of a very quick walk, with the officer pointing in the general direction of the different areas of the prison. This tour took approximately ten minutes. They entered very few facilities and there was no peer support prisoner present during the tour. In most other prisons, a peer support prisoner is involved in showing new prisoners around the prison.

3.25 We interviewed a group of prisoners who had just completed orientation. They were not aware of crucial services, such as the PCS and the right to their initial phone calls, even though they had been in the prison since 4.00 p.m. the previous day. There was strong evidence from prisoners to suggest that provision of the initial phone call is ad hoc; the responsibility for facilitating this is also not clear. Prisoners are not receiving their calls early enough and, in some instances, they are not receiving them at all. The prison needs to implement a process that guarantees that prisoners are able to make the initial phone call at the earliest time possible after entering the prison, preferably in the reception area itself.

[42] The information booklet for male prisoners and young offenders in the UK is a comprehensive 198-page document developed by the Prison Reform Trust for the Prison Service.

3.26 This Review was advised that two peer support prisoners see the new prisoners prior to the video being played. On the day of observation two peer support prisoners were present but they did not speak with the prisoners until after the video was played. They later informed this Office that this was the first time they had participated in the process. Although they were not usually involved with orientation, the peer support prisoners were eager to become involved. The lack of participation of peer support in orientation was also evident in the summary of peer support activity for March 2003. These records indicate that peer support prisoners had only been involved in welcoming six prisoners.

3.27 There is provision within the gratuity system for a position of prisoner orientation assistant; however, according to staff, no prisoner has been employed in this position for over 12 months. One of the reasons given for this was the difficulty in identifying a prisoner who was trustworthy enough to have access throughout the entire prison. It was also stated that there were difficulties for the prisoner orientation assistant to move around the prison, as the gate control officers were not always aware of the status of free access granted to the person that holds this position. To overcome some of these issues, selected peer support prisoners could be employed to operate a 'drop-in' centre as an alternative means for new prisoners to access information about the prison and available welfare services.

3.28 The lack of interest in achieving the necessary outcome exemplifies the absence of a single point of responsibility for this necessary welfare support service.[43] It would appear that significant delegations of responsibility have occurred in an environment where training and supervision are largely absent.

3.29 During our review of Hakea, staff provided examples of the numbers of prisoners requiring orientation accumulating to an unsatisfactory level. For example on 15 July 2003 there were approximately 30 prisoners waiting for orientation. This situation caused extra pressure on (the orientation) Unit Seven staff and stress for prisoners as they are waiting to be allocated to other accommodation units. A backlog like this leads to overcrowding in Unit Seven and is reported by staff to be a regular occurrence. Ideally, there should be a steady flow of prisoners into and out of the orientation unit. For this to occur, the orientation officer must deal only with orientation. Staff pointed out that H Wing tended to be close to or over its designated capacity most of the time, and consequently E Wing had become an overflow option. Instead of finding an appropriate solution to this problem, the prison operational procedures have been adapted to allow the problem to grow.

3.30 The prison management is able to utilise the orientation officers as relief staff in other sections of the prison under the current industrial agreement in place at Hakea Prison. Staff estimate that this happens, on average, two days a week. Based on what appears to be an

[43] The Department responded that the Zone Four Manager is responsible for peer support. The concept of zone management, combining geographic areas with some functional responsibilities, has produced confusion and hiatuses. Whilst, formally, the Zone Four Manager may be responsible, this may not be fully grasped or implemented on the ground.

extensive and long-standing practice, it is obvious that orientation is considered a low priority within the overall operation of the prison.[44]

3.31 The redeployment of the orientation officer also influences the quality and standard of orientation received by prisoners. Orientation officers appear to be rushing prisoners through orientation and are 'cutting corners', which leads to their not meeting the stated objectives of this important service. The procedures at Hakea Prison are mechanical, with a focus on completing a series of tasks rather than informing and inducting prisoners to better enable them to cope with the rigours of imprisonment early in their custodial period. It has become a process of ticking boxes. It is apparent from this Review that officers do want the opportunity to perform better when they are carrying out the orientation of prisoners. The problems and deficiencies are not the fault of individual officers but a fault of an under-resourced and poorly supervised system.

3.32 It is evident that the orientation process is rushed and fragmented. In Chapter 7, we refer to the fact that there is a strong body of opinion that far more content should go into the orientation process, such as material relevant to coping in prisons and anti-bullying policies and practices. The whole orientation package, which is currently too rule-bound and overly procedural, needs to be revised and improved.

Bail Coordinator

3.33 Appropriate management of remand prisoners requires that those who do not pose a risk to the community should not be detained in custody any longer than is necessary. It is in the interests of the Department and the prison to assist remand prisoners to obtain release on bail at the earliest opportunity. It is one means by which the Department can mitigate cost and risk whilst benefiting the remand prisoner and his family.

3.34 Some prisoners entering the prison system claim not to have had a clear opportunity to apply for bail before the courts. They are unclear about the processes and lack the opportunity to discuss their cases.

3.35 Throughout the Review prisoners described a level of frustration at not being able to access the Bail Coordinator and to follow up opportunities to negotiate suitable sureties for bail undertakings. The Bail Coordinator's office is located within the official visits area, which is not readily accessible to prisoners. They stated that there was insufficient assistance to have bail conditions clarified in cases when the warrants do not have clear endorsements as to the decisions of the court.[45]

[44] The Department has now reported that in October 2003 the Hakea Superintendent instructed that the position be left totally for orientation duties and only be redeployed on Mondays (there being no receivals on Sundays).

[45] In the *Report of an Announced Inspection of Hakea Prison* (Report No. 12, Office of the Inspector of Custodial Services, Perth, 2003) it was stated, at paragraph 2.11, that: "A second bail coordinator ideally should be appointed." A response to the Draft Report from a Hakea prison officer strongly endorses that position.

3.36 At the time of Review, Hakea Prison was experiencing ongoing difficulties with AIMS prisoner transport services. One of the issues reported by prisoners and prison staff is that AIMS staff do not provide enough time for prospective sureties to be contacted and for the applications to be processed prior to defendants being removed to the prison. It has been reported that the prisoner transport system will not hold up escorts to accommodate bail arrangements. Their dilemma is that, if they do so, other prisoners have to spend more time either in holding cells or in the vans and, moreover, they will arrive at Hakea at a time that exacerbates the reception difficulties at the prison.

3.37 The peer support prisoners group mentioned bail as the biggest issue for remand prisoners at Hakea Prison. Many of the instances that they recounted during this Review were previously identified and adversely criticised in this Office's Inspection Report relating to Hakea Prison.[46]

HEALTH CARE SERVICES

3.38 Health Services are a critical element in the provision of welfare for prisoners. A prisoner's physical and mental wellbeing in many instances is greatly influenced by how readily they can access health services. The Department advised that 'the Health Services Directorate provide a comprehensive range of health care services at a standard comparable to that available in the general community corresponding with a duty of care and safe custody'.[47]

3.39 The Hakea Inspection found that, generally, staff operated the health service well and demonstrated good leadership skills; however, there were problems with some of the interactions between health staff and prisoners and with the level of resources. Since that time, the Department's Prison Health Services have reviewed overall operations across the State with the view to reallocating resources and identifying areas of need. This review has led to the night nursing coverage being cut from two nurses to one. This reduction seems surprising and leaves night medical services in a vulnerable situation.[48]

3.40 There have also been attempts as a part of this process to address the issue of the over-representation of agency nurses at Hakea Prison. The Department's strategy was to offer and encourage agency nurses to accept short-term contracts. Unfortunately, this idea has not been successful, with only four permanent nurses employed at Hakea Prison.

3.41 The Department has not previously been in a competitive position to attract permanent nursing staff because of poor salaries and working conditions. The Department has addressed the issue of wages to a certain extent by providing conditions comparable to those enjoyed by nurses employed in the community and covered by the Australian Nursing Federation.

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[46] Office of the Inspector of Custodial Services, Report No. 12, op. cit., paragraph 2.11.

[47] Correspondence from the Executive Director of Prisons dated 11 August 2003.

[48] The Ombudsman too was concerned about how thin health services were on the ground throughout the prison system: see Ombudsman Western Australia, *Deaths in Prisons*, op. cit., chapter 6 *passim* and paragraphs 6.74-6.75 in particular.

However, given the difficult conditions that prison staff work under, this is only a small improvement. Given the general nurse shortage in the wider community, and acknowledging that working with prisoners is not an attractive option, more will need to be done. Meanwhile, the number of permanent nursing staff employed continues to be low and the quality of health care continues to be compromised by the lack of continuity and by high cost custodial supervisory requirements.

3.42 This Review was advised that many Aboriginal prisoners do not feel comfortable routinely accessing health services under the current arrangements and would prefer to see Aboriginal health workers being employed. The Department has acknowledged this issue in many of the regional prisons by entering into partnerships with Aboriginal health service providers. This is a systemic issue, and if the health care of Aboriginal prisoners is to be improved the Directorate of Health Services must review the Hakea Prison arrangements.

MENTAL HEALTH SERVICES

3.43 The services of a Mental Health Nurse (MHN) at Hakea Prison has been extended by the allocation of an additional 16 hours per week to allow more time to manage and coordinate patients on the mental health caseload. Despite this, there are still considerable gaps in the availability of mental health services. The Review was advised that administrative demands, involving attendance on a number of committees, both inside the prison and at head office, had eroded clinical practice to such an extent that the additional 16 hours was insufficient. This rings true, given the stringent efforts required by management to develop operational plans in a still developing remand and receival facility. On a good note, Hakea Prison's psychiatric service provision has been increased from four to eight sessions per week, with 3.5 hours provided per session. This is likely to better represent the true nature of the actual service demand.

3.44 The MHN caseload during the period of the Review was 120 prisoners, with approximately ten new prisoners being added each week. We were told that this caseload was reasonably stable; approximately ten prisoners with recognised current and active mental health needs were transferred from Hakea Prison each week.

3.45 As we have found at every other prison inspection, there is no reliable process in place to inform health services staff when a prisoner is to be transferred from Hakea Prison. The MHN often discovers the transfer of a prisoner days after the prisoner has left the prison, when following up medication issues. As a result, prisoners are often transferred without completed management summaries. Case summaries are a critical issue in the management of mental illness. To try to overcome this issue the MHN has been placing alerts on TOMS to the effect that a prisoner should not be transferred without discussion with the MHN. The Ombudsman's recommendation 5.7 called upon the Department to ensure that 'a culture prevails within prisons that permits health services staff to make decisions about the health

care of prisoners, which pay proper regard to non-health issues but which are, essentially, based only on an assessment of what is in the best medical/health interests on the prisoner'. Hakea has not responded adequately to this recommendation.

3.46 The criteria for the allocation of cases to the MHN and PCS are still confused and unclear. The stated first priority is for those patients who were actively psychotic, and this is as it should be, but lesser priorities may not be adequately serviced. Many of these cases are managed through the medical officers and the PCS (despite PCS stating that this was not their role within the prison). It is evident that mental health management focuses mainly upon medication prescription, with little or no case management planning or conferencing that takes in both mental health services and the PCS. Once a prisoner is allocated to the MHN, the case is considered to be a health responsibility and psychological intervention may not follow, unless there is a specific referral. It appears that service demand is causing functional barriers to emerge. In any event integration and coordination needs to be improved.

3.47 It was apparent that there is no other process in place to detect mental illness at times outside of the reception screening process, except in cases where the prisoner is actively at-risk or suicidal. Consequently, prisoners with mental health issues can be left untreated and unmanaged. The lack of communication and interaction between health services and the PCS clearly affects prisoner services. This is a matter of concern about which we make a specific recommendation in the last Chapter.

3.48 There is a lack of formalised orientation for new nurses, no specific in-service training or support offered to undertake the forensic caseload. Uniformed staff also do not receive specific training in self-harm or suicide risk identification and consequently are not in a good position to refer cases.

THE CRISIS CARE UNIT

3.49 The Crisis Care Unit (CCU) at Hakea is located in-between the health centre and the reception centre. The unit caters for 12 prisoners, and two cells are equipped as safe cells. All cells are fitted with closed circuit television for observation.

3.50 The operation and management of the CCU is the responsibility of Zone Manager One from Monday to Friday. On weekends, the responsibility falls to the duty manager, which is a rotational rostering of the four zone managers.[49]

3.51 The Hakea CCU is staffed from a pool of eight selected custodial staff members, with two officers from this pool rostered in the unit on each 12-hour shift. Deployment of staff within the CCU is arranged by way of expression of interest sent out by Zone Manager One. There are no formalised selection criteria or processes for uniformed staff to work within crisis care.

[49] For a description of the Hakea zone management system, see Office of the Inspector of Custodial Services, Report No. 12, paragraphs 7.1–7.2. The administrative arrangements are unsatisfactory and are in immediate need of review.

The nightshift CCU officer is not in possession of cell keys, as there is a union agreement with management that officers working alone in units at Hakea Prison will not carry keys to avoid complaints that might be made against them.[50] The CCU does not have a unit manager in post. The Senior Officer (Visits) supervises and assists with the lockdown and unlock of the CCU, but plays no other management role within the unit.

3.52 The CCU is currently being utilised to accommodate the following categories of prisoners: prisoners who are at an immediate risk of self-harm and/or in crisis; prisoners requiring 24-hour medical observation; and prisoners who are vulnerable and need time out of the prison mainstream because of protection issues. At least one third of these categories should be managed by some other means.

3.53 CCU staff expressed concern about the long-term placement of prisoners who required consistent medical observation. The situation is reported to have worsened in the last six months with reluctance at Casuarina Prison to take prisoners on medical transfer. The relationship between the CCU and the health care facility at Casuarina has not been formalised and has not matured since the operational parameters were determined for Hakea Prison.

3.54 A more formal approach to providing training for prison officers is needed. This should be based on a thorough needs assessment of working with mentally ill prisoners.

3.55 Some of the officers in this unit had just received CPR refresher training for the first time in many years. Some training officers suggested that the CCU officers might benefit from training in the following: mental health issues; regular first aid and a CPR refresher course; drug and alcohol awareness, including effects of drug and alcohol withdrawal and of drug and alcohol use; and crisis intervention. They appreciated the efforts of the MHN to provide briefing sessions on topics of relevance. The staff viewed this as their most valuable (if not only) source of skills training in this area. That these small efforts are so highly valued is a sad commentary on the actual state of affairs. The proper care of prisoners cannot depend on ad hoc learning opportunities. The prison and the Department owe a duty to the prisoners and to the staff and they need to do more to effectively discharge this duty.

3.56 The prisoners in the CCU are assessed on a daily basis during the working week by a PRAG team consisting of the relevant zone manager, the MHN, a member of PCS and prison officers. According to CCU staff, these meetings do not function adequately on the weekends. A partial explanation is that the zone management arrangement is rotated and the duty manager may lack confidence or see the CCU as a lesser priority. Whatever the explanation the result is that that placements and regimes for prisoners are not reviewed or amended in a timely way.

[50] The WA Prison Officers' Union states in its submission to this Review that it had sought extra staff to work in the CCU because of concern that a single officer with keys could be assaulted, leading to a security problem. However, the Department would not agree to the rostering of an additional officer so, to ensure security, the single officer does not carry keys. Whatever the basis of the decision, the current arrangement creates a potential duty of care anomaly.

PRISONER COUNSELLING SERVICE

Relationship between PCS and the Prison System

3.57 Prior to 2002, the Forensic Case Management Team (FCMT) was managed by Prison Health Services and provided psychological services in Western Australian prisons. The Bandt/Gatter Review of the FCMT (September 2001) recommended the formation of a separate psychological service managed within the Offender Management Division. This, it was believed, would provide the service with a more natural fit in regard to management, particularly at the professional level, and would generate a better service to the prison system. The Department acted upon this recommendation to establish the Prison Counselling Service (PCS) via a change management process. The first component was the formation of an implementation committee to oversee and drive the process. While an implementation committee was established and did meet a number of times, this group no longer meets and no initiatives or change management processes have been evident. From our observations and discussion with PCS and offender management staff, it appears that the transition from FCMT to PCS was a simple process of organisational realignment rather than an opportunity to refocus the service delivery, and consequently a number of significant issues have arisen.

3.58 PCS and health services staff in Hakea Prison seem to be unsure about how they should interact. There are no written protocols on what information, in which format, should be shared between them. The ARMS manual gives no formal guidance on what information is to be provided to assist in risk assessment. Further, there is considerable uncertainty about who has clinical oversight responsibility of a prisoner when the prisoner has multiple issues that could be deemed both psychiatric and psychological in nature. Nor is there a clear process or protocol for identifying when or how a prisoner moves from being managed by health services to PCS or even ongoing communication about cases. One particularly worrying aspect of this is that there is a noticeable lack of shared perspective between the information provided in the PCS file-notes and the health services' medical notes. These two information sources, potentially vital in managing suicide risk, are placed in separate files: PCS file-notes on the ARMS file and the health services' medical notes on the prisoner's medical file.[51] Health services staff do not have routine access to ARMS files and risk management plans, and PCS staff (and other staff directly involved under the ARMS process) reported great difficulty in gaining access to prisoners' health files.[52] This relationship between PCS and health services, whilst strained, appears to be slowly improving with the instigation of case management discussions between PCS and the MHN in May 2003, but is still sufficiently fraught to be the subject of a recommendation.

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[51] In its response to the Draft Report, the Department stated that a copy of the PCS notes is filed on the medical file. This may be the intended protocol, but our direct observations do not confirm this. The Department also states that the ARMS copy of the PCS file notes is now printed on yellow paper so that it is clearly recognisable and thus should not be inadvertently mislaid.

[52] In its response to the Draft Report the Department stated that PCS now have regular access to medical files.

3.59 Many of these issues appear to be due to confusion as to the current role of PCS and how that role differs from what the previous FCMT and the current health (particularly mental health) services provide. PCS was established to provide 'short term interventions to prisoners identified as at-risk of suicide or self-harm/harm to others'. Whilst specifically excluding 'identifications, treatment or continuity of care and management of mental illness' outside of that impacting on suicide risk, its staff 'provide a multidisciplinary model of service delivery by assisting prison services management in seeking to reduce the incidence of suicidal and self-harming behaviour of prisoners through risk assessment and risk management procedures and through the application of preventative and therapeutic interventions for individuals and groups'.[53]

3.60 Hence, the PCS identifies three interlinked and indispensable roles:

- Risk assessment;
- Risk management; and
- Short-term therapeutic interventions.

3.61 PCS prioritises these as:

- At-risk assessment for prisoners coming onto and exiting ARMS;
- At-risk assessment for prisoners aged 18–22 years;
- Crisis interventions involving clearly apparent high levels of distress and risk to life that are not actively psychotic and more appropriately managed by psychiatric services.

3.62 Apart from these priorities, and only where time permits do PCS allocate staff to work on:

- At-risk assessment for prisoners new to the adult prison system;
- Dealing with the issues of newly sentenced prisoners; and
- On-going counselling and interventions with prisoners on ARMS.

3.63 The provision of ongoing counselling might be thought to include therapeutic interventions, even in the long term. PCS management acknowledge this, particularly where the prisoner has been introduced to PCS for at-risk reasons, but stress that this is at the bottom of their priority list, with at-risk assessments very much the priority. This change in focus, driven by factors such as a lack of training, low staff numbers and other restrictive service priorities, has persisted over time. There is a clear gap in the mental/psychological care for prisoners between the psychiatric services provided by the health section and the suicide risk assessment and short-term interventions provided by PCS. New boundaries have emerged between the various service providers who should be acting in concert and with a single objective.

3.64 The relationship between PCS and other prison staff also appears to be problematic, with poor communication, lack of understanding of roles, unrealistic expectations and under-utilisation commonplace. During the course of the Review greater efforts were made to deploy additional PCS staff, but the lack of integration and coordination have persisted.

[53] Offender Psychiatric Services Management Committee, 'Business Case: A Strategy to Coordinate Comprehensive Mental Health Service Delivery at the Hakea Prison Complex' (April 2001), p. 11.

3.65 PCS staff also reported being frequently bullied by other prison staff. This bullying takes many forms, including use of emotive language when PCS staff are not able to see a prisoner immediately, intimidation and passive-aggressive behaviour. For example, one PCS staff member complained that 'late afternoon (and sometimes early evening) a PCS staff member receives a telephone call from a unit asking for a prisoner to be seen urgently. If we decline, we are subject to intimidating comments such as 'so you'll tell the coroner you refused to see him then, will you'. Although Hakea Prison and PCS management are aware that this bullying of PCS staff is an issue, to date, little or no headway has been made in overcoming this issue and no specific interventions are evident. Of course, the intimidation of PCS staff is also a symptom of the sense of powerlessness that uniformed officers feel in trying to deal with at-risk issues on their own without adequate training.[54]

Staffing

3.66 A number of critical issues for the successful provision of counselling services at Hakea Prison revolve around PCS staffing issues, including the training of PCS staff, their professional competency to fulfil the roles set for them and the number of staff in posts. These are priority issues where deficiencies are evident.

3.67 Since at least 2000, training of PCS staff has been on an ad hoc basis, with no training provided at all in the 2002/2003 financial year due to funding constraints. Alarmingly, none of the current staff at Hakea Prison has received the Department sponsored training in the recognition of suicide risk in prison populations, the assessment of suicide risk, Indigenous mental health issues or mental health management in custodial settings. Clinical supervision is also problematic. Currently no staff members are adequately trained to provide clinical supervision nor are there sufficient funds to pay for external clinical supervision.[55] Even staff that are required by law to undergo supervision (eg. Clinical Psychologist Registrars) are advised to arrange and pay for their own external supervision, with the Department's only role being to provide time off to attend.

3.68 Extensive clinical experience in the custodial setting can partially offset the lack of training. Unfortunately, even this is not the case amongst the PCS staff at Hakea Prison. Many are new to the prison and new to forensic psychology, most with less than six months' experience, and only one staff member having more than 16 months' experience. Most are on short-term contracts and, when asked during the course of the Review, the Department was not able to demonstrate evidence of their competency to assess suicide risk in youth, aged, Indigenous or ethnic groups. Poor contractual arrangements, a lack of training, support and supervision, and the resultant high staff turnover have hindered attempts to improve the quality of service.

[54] A Senior Officer commented that the working hours of PCS staff members have to be questioned. They do not work past 6.00 p.m., yet the later hours can be the most testing. The WA Prison Officers' Union also attributed this tension to the fact that PCS working hours are not adjusted to the needs of the prison. Nevertheless, this Office has subsequently been reliably informed that the degree of hostility has markedly diminished.

[55] In August 2003, subsequent to our on-site assessment, a highly qualified clinical psychologist was retained to provide some training.

AT-RISK MANAGEMENT SYSTEM

Management of Prisoners At-risk of Suicide or Self-harm

3.69 The ARMS manual states that the system was developed with a philosophy 'towards an integrated approach based on the responsibility of the whole prison community for the care of those in distress'. ARMS was developed by the Offender Management Division within the Department and consists of four key components:

- Primary Care – creating a safe environment and helping prisoners cope with custody;
- Special Care – identifying and supporting prisoners at-risk of suicide and treating them with dignity;
- Aftercare – caring for the needs of those affected by suicide and self-harm; and
- Community Responsibility – involving the whole prison community in the awareness and care of the suicidal.

3.70 The ARMS process assumes a 'whole of prison' approach to suicide detection and management of risk factors. This involves coordination of all welfare services in the prison in an attempt to prevent suicide and reduce the risk. For ARMS to work effectively prison management, unit officers and other services within the prison have to work cooperatively. Each person involved is meant to be aware of his or her roles and responsibilities and is equipped not only with a range of options to deal with the acute risk of suicide but also to address the underlying causes.

Lack of Ownership

3.71 We were unable to identify a reliable structure for the management of prisoners on ARMS at Hakea Prison. There are inconsistencies with the type of information collected, a diversity of management records, and immature processes for consultation, notification and referral. Prisoner Support Officers play a vital role in recognising and managing suicide risk, but are not required to document their action on the ARMS form. Prison officers and the PCS are required to supply a file-note and a brief notation in the daily supervision and support record on the ARMS form in the unit file. Health staff have separate reporting procedures and record information in the prisoner's medical file. They are not required by the current procedures to write in the ARMS form, but they often do so. This is also the case with the MHN. Due to obvious issues with confidentiality, only health services and PCS staff have access to medical files.[56]

3.72 PCS staff reported feeling that the prison as a whole had given over responsibility for suicide risk management to them. Whatever the case, the service outcome falls short of the 'community responsibility' intended for the ARMS system.

[56] See also discussion at paragraph 3.58 and footnotes 51 and 52, above.

Clarity of Roles and Functions

3.73 The Prison Support Officers and peer support prisoners are not sure of their role in relation to ARMS or how they are expected to assist in the management of a prisoner. Often the PCS and health services staff work with the same cases in isolation of each other. The ARMS manual acknowledges prisoners' families as an important factor in the management of at-risk prisoners, yet our review of the eight deaths in custody found that at no stage during the management of each case on ARMS was the family involved. Services such as the AVS and the chaplaincy were also isolated from ARMS, despite their obvious importance as support services for prisoners.[57]

Training

3.74 From discussions with staff, management, Head Office and a review of the extent of, and expenditure upon, training conducted since 2000, it is evident that:

- Most, if not all, reception prison officers have not had training in risk assessment or ARMS;
- Almost all the nurses conducting the reception level risk assessment have not had specialist training in the suicide area or with ARMS (MHN is the exception);
- Orientation staff have not had training in orientation or risk assessment;
- Most if not all prison officers have not had training in risk assessment or ARMS;
- Unit managers have only recently had training in ARMS (five years after it was introduced);
- Industrial officers, education officers and program staff have had no training;
- Nurses and doctors working in the medical centre have not had specialised training; and,
- Many of the PRAG members have not had any training in suicide/self-harm awareness, or have only very recently been trained.

3.75 Many of the nursing positions are covered by agency nurses who have had little or no specific training in risk assessment, ARMS, or forensic mental health issues, and a number of these nurses are not sufficiently orientated to the prison environment.

Functioning of the Prisoner Risk Assessment Group

3.76 One of the lynch pins of ARMS is the Prisoner Risk Assessment Group (PRAG). PRAG has many functions generally divided into two primary categories:

- PRAG was intended as a collegiate system where all prison personnel with responsibility for the risk management of prisoners could meet together (often with the prisoner) and devise realistic and appropriate management structures to reduce a prisoner's risk of suicide and address the issues contributing to that-risk (the ARMS module guaranteeing the integrity of the ARMS process); and

- Monitor the appropriateness of assessments, risk level allocations and follow up on recommendations and management plans.

[57] The Department has now reported that the AVS manager and the PCS group met in late January 2004 with a view to clarifying processes for the greater involvement of AVS in the management of at-risk Aboriginal prisoners.

3.77 PRAG at Hakea Prison is clearly failing in both these critical roles. A common criticism of PRAG at Hakea Prison is that it is not collegiate and that its meetings are not inclusive. Groups such as PCS appear to be excluded from the process[58] and others (such as unit officers) are seriously sidelined. Dissatisfaction with this process has led some groups, most noticeably prison officers, to minimize their input:

3.78 During PRAG meetings senior officers have little input. If they know the prisoner, they are able to give an opinion, however often they read from the ARMS form. Regardless of whether they want to or not, they are often not encouraged to be involved in the decision-making process and do not sign to agree to any changes made to the management plans.[59]

3.79 There are often inconsistencies over who attends PRAG meetings and, contrary to the ARMS manual, there does not appear to be a process in place that ensures that management recommendations made in the meetings are followed through.

Narrow Focus of the At-risk Management System

3.80 The ARMS manual details a range of at-risk management options. These are: allocation of a case manager; practical help such as assistance with arranging bail or contacting family; accessing the Chaplain, PSO, peer support or AVS; ensuring meaningful activity; involving the family or other prisoners in the care (risk management) of the prisoner; establishing a 'contract' with the prisoner; reviewing the accommodation; and providing individual counselling as well as individual and group therapeutic interventions.

3.81 A review of the ARMS files at Hakea Prison found little beyond the obvious options of supervision and observation. More innovative unit level management initiatives (shared cells, officer interaction) and the level of comment from officers was scant. What was most striking was the minimal level of resources directed at the issues underlying the prisoner's risk at Hakea Prison. Therapeutic interventions from obvious sources, such as families, outside agencies or even internal supports such as PSO and peer support prisoners were not evident. The Review did not find established 'contracts' between prisoners-in-need and a counsellor, there were no case managers allocated; and meaningful activity was almost non-existent at the prison.

SYSTEM FOR REPORTING SELF-HARM INCIDENTS

3.82 The Department has formalised a system for the collection of self-harm data. This information is collected through the TOMS incident reporting system and relies solely on the discretion of prison officers to judge the nature of an incident and grade it accordingly. A list of definitions is provided to guide this process. The main categories are assaults, death, incidents, self-inflicted injury, substance testing and unlawful absence. These categories are then broken down into sub-categories, which for the identification of a self-inflicted injury

[58] The Department states that PCS are now included in the ARMS process; although, this was certainly not the case at the time of the on-site investigations for this Report.

[59] Comment from Hakea prison officer made during this Review.

are attempted suicide, self-harm and serious self-harm. Within each of these categories is an explanation to assist the officer in deciding how to allocate the incident. Officers have not received training in how to appropriately operate this system, particularly from the point of view of grading incidents that are often complex and require investigation and follow-up.

3.83 During discussions with officers at Hakea Prison it appeared that the reporting of attempted suicide and self-harm was entered on the TOMS system, but these incidents were sometimes considered to be to be routine occurrences that did not require to be followed up. During this Review, the Office also found a case where a prisoner had attempted to hang himself, which was notified in the Department's Daily Situation Reports but was not recorded on TOMS. This served as an example of obvious gaps in a system nominated to collect and analyse self-harm data.

3.84 Once a month the Prison Services business analyst extracts the TOMS data and compiles a report, which is distributed as a component of the Prison Performance Measurement System to the superintendents at each prison. This report records the name of the facility, date of occurrences, security rating, name of offender and the incident category. It is largely utilised for information purposes only, rather than a management report to guide decision-making. Its principal end-use is to generate the statistical report for consideration by the Steering Committee for the Review of Commonwealth/State Service Provision.

3.85 In recommendation 8.1, the Ombudsman recommended that the 'Department formulate a single means of reporting incidents of self-harm, attempted self-harm and threats of self-harm to facilitate the reliable collection of data and to enable comprehensive and regular research into the characteristics of the prisoners involved and the circumstances in which incidents occur'. There is no single system that is dedicated to the purpose of recording and responding to self-harm incidents. The Department has a number of incident tracking systems; however, these are not linked in such a way as to enable an accurate and verifiable report to be generated.

3.86 A dedicated and responsive system needs to be developed, with an applied process that will monitor, follow-up and record specific information about an incident and the circumstances that led to that incident, so that they can be addressed and reviewed appropriately and in a timely manner. Special care should be taken to ensure that the efforts of each functional area are documented and are in compliance with the Department's policy and procedures.

SPECIFIC WELFARE SERVICES

Prisoner Support Officers

3.87 There are 12 Prisoner Support Officers (PSOs) based in prisons throughout the State, with two of these located at Hakea Prison. PSOs have a limited role in the orientation of new prisoners. They receive a daily list of incoming prisoners from which they are able to identify those who may have family in prison and, if appropriate, liaise with the placement officers to promote the local placement with family members.

3.88 A coordinator is responsible for the management and administration of the PSOs. The role includes the induction and training of PSOs employed in all prisons. The PSOs at Hakea Prison reported that they have not received any in-service training since their initial induction and orientation program when they were first employed.

3.89 PSOs have heavy workloads and feel that they are performing duties beyond their role and level of training. A review of the PSOs' activity statistics for March 2003 revealed 238 contacts with prisoners. The majority of contacts, 78 (32%), were for family and welfare issues, 45 (19%) were contacts with prisoners who wanted to talk and 34 (14%) were with prisoners on ARMS. A further 32 (13.5%) contact the peer support prisoners for the purpose of supervision. Twenty contacts (8.5%) were with prisoners for the purpose of parole and release and 14 (6%) for legal issues. Nine (4%) were for the purpose of meeting and greeting new prisoners and six (2%) for attending actual self-harm incidents.

3.90 The PSOs are another service operating in isolation and without support. The PSOs feel their expertise is under-valued, and other workers in the prison do not always consult them when making important decisions about a prisoner's welfare. They felt that they should have a greater role in providing advice on Indigenous culture to better inform operational decision-making.

Prisoner Peer Support Program

3.91 The original purpose of the peer support program in prisons was suicide prevention. The peer support charter is 'to engender a sense of wellbeing within the prison by expanding the knowledge base of prisoners and empowering them to offer support to their peers'. However, the Department has no policy, standing or local order that supports and guides the work of peer support in the prison system.[60]

3.92 Prisoners interested in becoming a member of the peer support team at Hakea Prison inform the PSO. The PSO then assesses the suitability of the applicant and seeks a prison security clearance from the security officer via the relevant zone manager. The PSOs advised that whilst they prefer that the team is representative of the prisoner population, they also need to take account of the mobility restrictions within the prison so that there is service accessibility for all units. Each peer support prisoner is issued with a yellow ID tag, and a green prisoner t-shirt with a peer support logo. The prison does not pay peer support prisoners or offer any other incentives for performing this role, although that is the case at some other prisons.

3.93 There are two peer support teams operating at Hakea under the guidance of PSOs. The separate teams hold meetings once a fortnight, and hold joint meetings every four to six weeks. The Prisoner Support Program Coordinator is responsible for facilitating and coordinating training for peer support prisoners throughout the State. A survey taken during this Review on 30 July 2003 found that 18 out of 22 peer support members at Hakea Prison had not received any training.

[60] Recently, peer support prisoners have been designated 'core workers' so as to quarantine them from transfers to other prisons.

3.94 The Department does not maintain a central record of prisoners who have been trained as peer support workers. It would not be difficult for each prison to record this information on TOMS. The information is valuable in identifying prisoners being transferred and those re-entering the prison system that have previously had training. Hakea Prison does not keep any reliable records for this program, and the Coordinator was unable to report when the last session for peer support training was held at the prison.

3.95 The success of any peer support program depends upon having access to the client group. The PSOs displayed a level of frustration at the inability of peer support prisoners to access all units within the prison. The process for peer support to move throughout the prison is rigid. PSOs must specifically request access to other units including access to the CCU, and unit staff can, and do, deny this access. During the course of this Review a unit officer was observed turning away a peer support prisoner from the Self Care Unit. Peer support members described access to prisoners as worse on weekends when PSOs are not on duty.

3.96 Later in this Report, the need for a 'Listeners' Scheme' at Hakea Prison is discussed. Such schemes would be unworkable when unnecessary barriers are placed in the way of reasonable movement for properly assessed and trusted prisoners. At this stage Hakea Prison seems to have difficulty accepting the notion that selected prisoners can actually assist in making the prison environment more supportive and safer.

Aboriginal Visitors' Scheme at Hakea Prison

3.97 Visitors from AVS attend Hakea Prison on Monday, Tuesday, Thursday and Friday from 9.00 a.m. to 12.00 p.m. and on Wednesday from 3.00 p.m. to 5.00 p.m. On Monday, Tuesday, Thursday and Friday, the AVS visitors are restricted to the official visits centre for interviews. On Wednesdays, visitors are able to walk unescorted around the prison. When interviewed, the visitors stated that they were content to have at least some unescorted access to prisoners, but would prefer to have unfettered access within the prison.

3.98 AVS essentially provide their service from a controlled environment, which is not accessible to prisoners unless they have an appointment. AVS staff do not routinely visit the accommodation units or other sections within Hakea Prison. The AVS staff stated that if they were able to walk freely around the prison more frequently, this would increase the interaction between themselves, prisoners and other staff. They also believed that this approach would be less intimidating to prisoners.

3.99 The manner in which the visitors identify their clients is somewhat disordered. The management provides AVS with a prisoner count on the day of a visit. They highlight all the Aboriginal prisoners and new prisoners on the same count. AVS then randomly select 12 prisoners from that count for interview at the next visit. An audit of records for the period 1 July 2003 to 22 July 2003 showed that AVS called 111 prisoners to see them. Of those, 53 declined to attend the visit and they interviewed 46 prisoners. This equates to 47 per cent of

Aboriginal prisoners declining to see AVS. The current arrangement demonstrates that AVS is a marginalised and under-valued welfare service that must struggle for its very existence. The split management responsibility for the service between the Perth-based line managers and the administration at the prison is not a sufficient explanation for their poor treatment. It is little wonder that prisoners decline to seek support from this source when the service has reached such a low point. Prison management should allow AVS unfettered access to relevant areas of the prison to promote the service and communicate with prisoners.[61] The quality of information provided to prisoners during their induction and orientation should also be reviewed.

3.100 AVS visitors are frustrated with the lack of communication between themselves and other welfare support providers within the prison. They stated that they never had contact with members of the PCS or with the prison psychiatrists. They also commented on the minimal interaction with the PSOs. Basic information relevant to risk, such as whether the prisoner is a first-timer or is on ARMS, is only infrequently made available to them.

3.101 Access to Unit One and even the CCU is inadequate.[62] One of the AVS staff commented that she had never been to Unit One and did not know where it was located. AVS staff must obtain formal permission from a zone manager to enter the unit. For AVS staff to carry out their duties effectively, and in accordance with program objectives, they should have ready access to the CCU and Unit One on a daily basis.

3.102 The AVS protocol requires that visitors meet with the Prison's management delegate on arrival and departure from the prison. The purpose of meeting with management at the start of the visit is to facilitate a general briefing on conditions within the prison and to allow cases to be referred. The visitors commented that in practice they only meet with Hakea Prison administration at the completion of a visit. AVS staff felt these debrief sessions were unproductive and mostly failed to resolve the prisoners' issues that they raise. The staff felt that they lack status within the prison and that they are barely tolerated by the prison management and the uniformed staff.

3.103 Throughout prisons in the metropolitan area, the AVS has a rotation system that operates on a fortnightly basis. The Department claims that the main reason for this change was to limit staff burn out and stress. Although the rationale behind the rotation system may be legitimate, AVS staff stated that the rostering system did not allow for consistency and developing knowledge of local practices and processes. Instead they felt stressed by the limited role they were allowed, and by the unresolved prisoner welfare issues that passed from one rostered AVS group to the next.

[61] The marginalised status of AVS is a matter that has been identified frequently in earlier reports of this Office. The Department appointed a new AVS Manager in late 2003 with a brief to improve the service and strengthen its role. The Inspectorate is glad to acknowledge that some progress is at last being made. This includes allocation of funds for training. The AVS has also, in response to the Draft Report, been involved in meetings with the Hakea Change Management team.

[62] In response to the Draft Report and in the context of the changes referred to in footnote 57, above, the Hakea Superintendent has approved open access to AVS members throughout the prison, including Unit One and the CCU.

3.104 AVS continue to struggle with the challenges confronting them when they go about their duties. Training continues to be an issue. The Department has not conducted training since 2001, when Lifeline held a workshop on suicide prevention. No training was offered in 2002, reportedly due to budget constraints.

3.105 The role of AVS has gradually shifted away from suicide prevention to a more limited one dominated by welfare tasks. The visitors confirmed that this commenced in 1987 when the Department abolished the position of welfare officer and introduced unit management, making prison officers primarily responsible for prisoner welfare. Prison officers at Hakea Prison are not consistently performing a welfare role and do not necessarily accept it as a legitimate part of their duties.

3.106 If the service that AVS provides is to be more effective, the Department and the superintendent need to address their role and standing in the prison.[63] As with many other aspects of service delivery a much higher priority needs to be given to integration, training and supervision.

Chaplaincy

3.107 There are four chaplains assigned to Hakea prison; two of them – the Catholic and the Anglican – are full-time. The chaplaincy portfolio is the responsibility of the manager of Zone Two. Chaplain services are available seven days a week; however, there are no formal processes in place for prisoner access to the chaplains. Their office is situated in a secure environment, making it difficult for prisoners to access it without complicated applications and permissions.

3.108 Like other welfare service providers at Hakea Prison, the Chaplains have reported problems gaining access to prisoners. The chaplains felt that access to Unit One (the disciplinary unit) was important, but difficult to achieve. They reported that on those occasions that they did attend at Unit One there was no opportunity for privacy and they were required to conduct interviews within the sight and hearing of prison officers. The chaplains have stated that they would prefer to interview prisoners in an environment that is conducive to the establishment of trusting relationships and the maintenance of confidentiality.

3.109 Like AVS, the chaplains feel disconnected and isolated when working within Hakea Prison. As a group, they do not believe the prison staff value their role and are of the opinion that prison management should better promote the chaplaincy service. This needs to be done in a way that maintains their independence within the prison system.

Outcare

3.110 Outcare provides a wide range of contracted services and programs to assist ex-offenders to re-enter the community, as well as providing some welfare support for families and visitors to Hakea Prison.

[63] See notes 61and 62, above.

3.111 Outcare workers play a supplementary role in receiving information from families about suspected at-risk behaviour of prisoners. Upon receipt of such information, Outcare staff complete an 'additional information' ARMS form. Any concerns raised by visitors are documented and the form is submitted to the appropriate unit manager for action. Outcare does not have a direct role in providing a service to prisoners; their primary focus is on family issues including arranging family visits. Outcare staff suggested that the Department should provide a brochure highlighting indicators of at-risk behaviour and the action that the family can take if they identify these risks.

Staff Support Programs

3.112 There are two support programs available to staff – the Staff Support Program and PRIME. The current coordinator of the Staff Support Program has been employed since March 2003 and is a registered psychologist. The coordinator's role is to:

- Manage and support all staff support services throughout the State including recruiting staff support persons, training and selection;
- Manage and coordinate the employee assistance program (PRIME), including managing of the contract and collecting and analysing statistics; and
- Provide training and counselling for staff support members.

3.113 Staff support has been operating at Hakea Prison since 1995, commencing with a team of 22 members and a designated team leader. The coordinator stated that, for the Staff Support Program to be effective, there should be at least a ten per cent ratio of staff support members to staff. These staff support members should represent a cross section of prison staff. In practice, at this time the ratio exceeds that figure, being in the order of 15 per cent.

3.114 A recent statewide survey of the Staff Support Program found that fellow officers thought the program was valuable and necessary and assisted in managing stress. A high percentage of officers agreed that there is a need for more staff support members to be recruited. Whilst most of the respondents were positive about the service, a small percentage of staff indicated that Staff Support was unable to help them personally. The survey also showed that staff that utilised the internal staff support system were more likely to also utilise external (employee assistance program) services offered by PRIME. The survey found that there is a developed relationship between the staff support team and PRIME. Despite these arrangements workers' compensation stress claims had not reduced.

3.115 During the course of this Review staff spoke of being directed by the senior staff to return to their posts without any debrief or counselling following deaths in custody. As with the welfare support services for prisoners, the arrangements for staff support lacked the maturity and reach expected of a program into its tenth year.

Offender Treatment Programs

3.116 Hakea Prison no longer provides any offending behaviour programs for prisoners.[64] The Department's rationale for the cessation of program provision is that as a remand, receival and assessment prison, Hakea's role is not in program provision and prisoners need to be transferred at the earliest opportunity to make room for new prisoners.

3.117 The Department's Policy Directive 32 states that '[s]ome responsibility for dealing with problems which could lead to suicide or self-harm must be accepted by prisoners themselves. They need to be involved as much as possible in identifying their problems and ways of tackling them'.

3.118 An argument can be made, however, that remand prisoners can benefit greatly from access to certain programs. The Department has purchased the 'Reasoning and Rehabilitation Program' – a well-known cognitive skills program (CSP). The Department acknowledges that the rationale for this program is to target a range of social cognitive deficit areas allowing for links between thinking and behaviour.[65] The Department previously submitted that the program was linked to prisoners' wellbeing services. At the time that the program was being procured the Department outlined its purpose to be as follows:

- Strengthening the range of provided programs, ideally commencing during the remand period;
- Likely to make prisoners more amenable to cooperating and benefiting from more specialist programs;
- Providing the opportunity to constructively engage prisoners early in the process of settling into their sentence;[66] and
- Reducing the risk of self-harm and suicide.[67]

3.119 The prison's senior management advised that the average length of stay at Hakea Prison is between 14 and 28 days for sentenced prisoners undergoing assessment. This makes it difficult, although not impossible, for sentenced prisoners to complete the CSP. Nevertheless, it is possible that prisoners could commence the program at Hakea Prison and conclude it at the next receiving prison. Furthermore, remand prisoners spend periods ranging from days to years at the prison and there are opportunities to provide such programs, particularly when many remand prisoners complain of boredom due to the lack of meaningful activity.

[64] Until the end of 2002, Hakea Prison provided both the intensive sex offender and violent offender treatment programs.
[65] Correspondence from the Executive Director of Prisons dated 11 August 2003.
[66] The Department appears to have lost its way with the CSP and is now primarily targeting the program at the end of a prisoner's sentence.
[67] Department of Justice, August 1999, Application for Sole Provider Status.

Education at Hakea

3.120 The two key objectives of the education service at Hakea Prison are:

- To re-engage all incoming offenders in education and skills training so as to facilitate suitable career and/or employment options and set realistic, achievable goals; and
- To assess incoming offenders' current work skills and provide opportunities for up-skilling that will improve their chances of gaining employment (these opportunities involve training pathways within the prison system, as well as external agencies).

3.121 Education services at Hakea Prison are well targeted and relevant to the population. The education branch has taken the initiative by changing its practices and approach to ensure that services align with the needs of the prison profile, which encompasses both a very short term (two to four weeks) as well as a long-term (two years) prisoner population. However, there are problems in actually delivering the services because of the inconsistent deployment of uniformed prison officers who are there for good order and control purposes. The education centre plans to cater for approximately 30 prisoners; although, in circumstances where only one uniformed officer is available (rather than the expected two) the number of prisoners attending the education centre is reduced to fifteen.

SUMMARY

3.122 The effectiveness of welfare services in the prison system as a whole, and at Hakea Prison itself, is extremely difficult to determine by any objective means. There are no evaluation processes in place and the data collected by the Department relating to the performance of the care and wellbeing cornerstone is limited to out-of-cell hours and apparent suicides.[68] There are no standards attached to these, and neither is a true indicator of the care and wellbeing of prisoners. Out of cell hours is a minor factor that may or may not – according to how that time is structured in terms of meaningful activity – contribute to care and wellbeing, and 'apparent suicides' indicates a post event failure.

3.123 It is essential that the Department commit itself to collecting information that demonstrates by qualitative and quantitative means that it is achieving the key objectives of these crucial welfare services.

3.124 It is apparent that the totality of services and systems that are intended to contribute to the identification and support of at-risk prisoners, the prevention of self-harm and the provision of welfare services, are chaotic and uncoordinated. The confusion of roles and responsibilities, the absence of appropriate management controls, the lack of in-service training, and the immature operational systems, have lead to a proliferation of operational arrangements with a high cost profile without the desired result being achieved.

[68] Department of Justice, 'Public Prisons Directorate Business Plan 2003-04'.

3.125 Overall, the quality of prisoner/staff interaction is in a state of despair, though there are notable individual exceptions. Staff lack, because of inadequate training, a full comprehension of the extent of welfare services required to appropriately manage a high risk remand and newly received population. In some instances prisoners are not taking up welfare services because the induction and orientation systems are not effective or because of the low status of the providers within the prison. Unit and case management strategies, that are the Department's preferred operational methods to guide quality interaction between prison groups, are not functioning at this prison. Furthermore, the quality of interaction between some staff groups is also dysfunctional; this results in considerable energy being spent on negotiating access to prisoners and unit locations and seeking permission to perform work that is sponsored by the Department, but is interrupted or even disallowed at the prison level.

Chapter 4

CASE STUDIES AND ANALYSIS

4.1 To provide adequately for the welfare needs of prisoners an appropriate scope and application of resources within the Department, as well as those available in the public sector and the community generally, must be provided. The welfare services for Aboriginal prisoners, as well as general health services and family support arrangements are also considered an important aspect.

4.2 Eight men died between 2001 and 2003 whilst in custody at Hakea Prison. The custodial experiences of these men – Damien Garlett, Donald Keen, JHG, Lawrence Flowers, Dylan Green, Michael Vaughan, Mervyn Yappo and Evan Slater – are recounted here.[69] The narratives of their time at Hakea are detailed, and this is essential to understanding the issues surrounding deaths in custody. Following the accounts, there is a discussion of the operational realities of Hakea's health and welfare services that provides the stories with a context and an identification of the outcomes that need to be achieved to provide a positive total prison environment.

4.3 It is important when considering each account to remember that 'many prisoners enter prison in a particularly vulnerable state – often experiencing remorse for the crime and with physical and psychological problems that are the results of traumatic pasts and drug dependencies that have frequently been significant contributory factors in their crime'.[70] Many such prisoners do not have the ability to deal with their situation and are in need of care and protection. As the Ombudsman argues, when we expose such vulnerable people 'to the (often extreme) pressures of prison life, the potential for further psychological harm, self-harm and ultimately suicide is obvious'.[71]

CASE STUDIES

Damien Garlett

4.4 Garlett was aged 18 years when, on 10 February 2003, he was remanded without bail to Hakea Prison on counts of unlawful wounding and assault occasioning bodily harm. Damien, a young Aboriginal man, had an extensive juvenile history and one prior admission in the adult prison system. He was rated as a maximum-security prisoner.

Reception and Orientation

4.5 On Monday 10 February, an administration checklist, security checklist, and the MR011 reception officer at-risk checklist were all completed. The MR011 detailed a prior self-harm incident in a juvenile facility two years previously, but made no mention of Damien being on ARMS in Casuarina five months before. It also stated that Damien had a supportive partner

[69] Each man's family was consulted in the formation of the case studies and they are presented with the full knowledge and consent of the next-of-kin. Subsequently, one family requested that the identity of their deceased family member be protected, and as this can be done without prejudicing the points that need to be made, initials have been used throughout in relation to that person.

[70] Ombudsman Western Australia, *Deaths in Prisons*, op. cit., p. 4.

[71] Ibid.

with children and family, that he would receive visits and had not experienced any personal losses. This did not reflect the fact that Damien's de facto partner had an active restraining order against him and that his de facto was not listed as his next-of-kin.

4.6 As a routine measure, a new young offender alert was activated on the TOMS database, however, an RR105 Information on a Young Offender from Juvenile Custodial Services request was evidently not required under the applicable DG Rule, as this was Damien's third entry into an adult prison since attaining the age of 18.

4.7 During his reception health assessment, the nurse noted his prior history of self-harm, but did not note his ARMS status at Casuarina. In this interview, Damien denied his self-harm history; however, his TOMS medical status continued to record his self-harm history. He was deemed not to be currently at-risk of suicide and was routinely referred to the medical officer. Subsequent to this, on 20 November, Damien's TOMS medical status was updated to reflect his ARMS history.

4.8 As a previous Hakea prisoner, Damien was given the opportunity to attend a re-orientation, but declined in favour of an induction interview. In the interview, Damien reported that he had no current thoughts of self-harm and had no undue fears or concerns regarding his current situation. He was also expecting to receive regular visits from members of his family.

Meaningful Activity

4.9 From 20 to 25 February 2003, Damien worked in the kitchen at level four gratuities ($2.60 per day). On the 25 February, he registered as not willing to work (level six gratuities, $0.00 per day) and then the following day as waiting for work (level five gratuities, $2.15 per day). Damien's financial records indicate that, even though his gratuity level changed to a five on 25 February, he did not receive any gratuity payments for the remainder of his time at Hakea.

4.10 On entering Hakea, Damien carried over a $9.36 debt from his prior incarceration that he was required to pay back to the Department. Damien had no injection of private money to pay the outstanding balance and was reliant on his gratuity entitlements. However, with no gratuities credits that he was entitled to coming through, he died owing more money than when he entered Hakea Prison.

Access to Family and Community

4.11 Damien did not receive any family visits while he was in prison. His family had booked visits on four occasions, but cancelled just before each visit. On the day Damien died, an officer allowed him an officer-initiated call after he expressed considerable distress at his situation. Damien called his de facto, who had an active restraining order against him. While Damien made a number of telephone calls throughout his imprisonment, he appears to have limited himself to only those five calls per week paid for by the Department for remand prisoners.

Access to Outside Agencies

4.12 Damien had two visits with his lawyers, one visit with AVS and, on the day of his death, he saw a Community Justice Services officer. No one reported him as a suicide risk. Although Damien was not receiving visits, he informed the AVS that he was and talked with them about his family, his de facto and their children.

Health

4.13 As a new young offender, the PCS interviewed Damien on 17 February. From this interview, it was reported that Damien was not receiving visits, had a history of self-harm and wanted to contact his estranged girlfriend. It was recommended that he be placed on the disturbed and vulnerable list (the 'D&V list'), as he 'seems emotionally vulnerable'. It is not apparent from the PCS file-note if Damien's medical file was reviewed and there is no indication that his juvenile history was considered. It appears that unit officers were also concerned about Damien's age and behaviour and independently raised the possibility of inclusion on the D&V list at a meeting on 18 February. Follow-up action from that meeting was for an assessment by PCS or a MHN.

4.14 Despite repeated requests for PCS to review Damien, there was no attempt to interview him until 4 March. According to the PCS entry in his medical file, Damien declined to see them. A PCS staff member spoke to unit staff, who indicated that he was not coming to their notice and following a discussion with a senior officer, recommended that he be removed from the D&V list. Records indicate, however, that Damien was not removed from the list.

4.15 PCS conducted another interview with Damien on Wednesday 26 March after a referral from unit staff. From this assessment, it was noted that Damien had threatened to kill himself during a telephone conversation, and it was recommended that Damien be further assessed after his court appearance on Tuesday 22 April 2003. This file note was not placed in the medical record until 17 days after Damien's death. Damien was found hanging from his cell light fitting, on 4 April 2003 after being in Hakea for 54 days.

Donald Keen

4.16 Donald Keen was aged 18 years when, on 16 August 2002, he was remanded to Hakea on charges of aggravated burglary, armed robbery and stealing a vehicle. Donald, a young Aboriginal man, had an extensive juvenile history, but this was his first contact with the adult prison system. Donald was rated as a maximum-security prisoner and had bail set at $10,000 by $10,000 (surety). Donald had an extensive medical history within the juvenile system, including an attempt to hang himself in East Perth Lockup on 13 October 1997 at 13 years of age. There was evidence of onset of psychosis at 16 years of age, with auditory hallucinations and evident bizarre behaviour.

Reception and Orientation

4.17 At reception, the MRO11 recorded that Donald had no fears or anxieties about being in custody, he expected the court to sentence him to a prison term, and Donald's partner and family were supportive. Despite a note that this was Donald's first time in an adult prison, no new young offender alert was placed on the TOMS database (as required by the DG Rules) and no note made on TOMS of his juvenile records identifying him as at-risk for self-harm. Also, Donald's MAP was not completed.

4.18 Donald's MR012 concluded that Donald was not an identifiable current risk. His previous suicide attempt was not noted, despite this information being available in his juvenile record file at the rear of his medical file. He was referred to a medical officer, a PCS member and the Prisoner Peer Support officer due to this being his first time in an adult prison, yet no alert was activated to this effect on the TOMS database.

4.19 Donald's MR010 identified the main health issues as hepatitis C, asthma, a history of intravenous drug use (amphetamines) and marijuana use. No psychiatric history was noted. The medical officer saw Donald pursuant to the normal prison processes, which concluded Donald was not at-risk of self-harm. No withdrawal or detoxification plan was made to address Donald's illicit drug use history.

4.20 During his orientation interview the following day, Donald stated he had no thoughts of self-harm, and added that he had no fears or concerns regarding his current placement and was expecting to receive visits from members of his family and also his girlfriend.

Meaningful Activity

4.21 Donald had a good work history in the concrete products and paint workshop, before moving to the laundry at the time of his court appearance and his accommodation in the Protection Unit.

Access to Family and Community

4.22 Donald had regular visits and phone contact with his family, including a sister, his girlfriend, his mother and stepfather, as well as a visit with his daughter and stepdaughter. Further, Donald's brother was initially in prison with him, which provided considerable support. His brother was eventually granted home detention, for which Donald also applied but was never eligible.

Access to Outside Agencies

4.23 Lawyers attempted to visit Donald on three occasions; however, he was unable to attend one of these appointments because there was no officer available to escort him and he refused to attend a second. Child Witness Services and Community Justice Services (CJS) also visited him. Donald phoned the Ombudsman several times during his imprisonment; however, as he would call on the weekends and not leave messages there are no records of complaint. Donald saw the AVS once, at which time he discussed his health and his desire to have home bail.

Health

4.24 On Friday 25 October, an alert was activated on Donald's TOMS profile recording he was at possible risk from another prisoner against whom Donald was a witness. The alert stated that 'they should not be in the same prison' and the risk level was high.

4.25 Following an emotional telephone conversation with his girlfriend on Friday 1 November, Donald self-harmed by inflicting superficial cuts to his arm. He was transferred to the crisis care unit and ARMS initiated. The next day PCS reviewed Donald and he denied any further self-harm or suicidal ideation. It was recommended that he be returned to his unit with PCS follow-up over the next few days, and specifically that he be assessed on return from a court appearance on Wednesday 6 November. Donald subsequently remained on moderate ARMS.

4.26 On Thursday 7 November, a PCS psychologist interviewed Donald for an ARMS review and noted that he was alert, calm and relaxed but slightly stressed about arranging home detention bail and future court appearances. The notes state that there was no evidence of self-harm or suicide ideation, but that Donald might require additional support as his brother had been released. Donald was referred to the PSO to receive assistance to apply for home detention bail and a PCS review recommended for Wednesday 13 November or as required. Donald was taken off ARMS that day, although his file contains no supporting documentation and his removal was not recorded in PRAG minutes.

4.27 On Tuesday 14 January 2003 Donald claimed another prisoner threatened him while at court, so he was moved to Unit Seven in the disturbed and vulnerable wing as an interim protection measure. On 24 January, he was transferred to the CCU, as he was 'hearing voices' telling him to kill himself or to hurt other prisoners. During a PCS interview that day he stated that these voices had been evident over the last couple of days and that he had been thinking about hanging himself. He was not sleeping and said he constantly heard voices like trains travelling over tracks. He felt paranoid that the other prisoners were talking about him and laughing at him. He also said he had been having a phone conversation with his sister, who told him that his girlfriend went to the doctor that day and the doctor said he could not detect their baby's heartbeat when his telephone money ran out. Donald stated that he could not deal with the stress and presented as distant and distracted. It was recommended Donald be retained in crisis care, and that an attempt be made to contact either his sister or girlfriend. Recommendations were also made that the MHN assess Donald, presumably due to the possibility of a psychotic episode, and left it to the MHN to determine if an ARMS should be activated.

4.28 A MHN interviewed Donald that day and recommended that he remain in crisis care, but did not initiate ARMS. The same MHN reviewed Donald the next day, and referred him for further assessment after he denied suicide or self-harm ideation. The entry did not stipulate who would conduct this assessment. Another MHN saw Donald the following day; he appeared quite communicative and disclosed a history of hearing voices, seeing things and

feeling paranoid over the past three years. He denied any suicide or self-harm ideation (despite hearing voices telling him to kill himself), but complained about not being able to sleep. The MHN organised for Donald to be prescribed Largactil, and recommended that the psychiatrist review him, but again no ARMS file was initiated. The unit staff in CCU tried to contact Donald's sister to find out about his girlfriend's health condition. Later that day, Donald was transferred from CCU back to Unit Seven.

4.29 On 19 February Donald assaulted another prisoner without apparent provocation, and as a result was placed under close supervision in Unit One until 6 March. On Tuesday 25 February, Donald self-harmed in his cell. When questioned, he stated voices were telling him to do things to himself. As there were no safe cells available, Donald was placed in a medical observation cell in Unit One and was administered medication to help calm him. ARMS was now initiated. That afternoon, the PCS psychologist interviewed Donald. It was reported that his medical file indicated no previous psychiatric or self-harm history, despite his juvenile records stating otherwise. The PCS assessment attributed the hearing of voices to stress and that this may be because of placement in close supervision. Donald stated he was not ready to leave the safe cell and it was recommended that he remain in the safe cell pending a further review on Wednesday 26 February, and that the MHN organise for his Largactil to be reinstated. On Thursday 27 February, his eighth day under close supervision and two days after self-harming, the PRAG meeting reduced his risk rating from high to moderate.

4.30 On 1 March, Donald was booked for a social visit. This visit was cancelled as the visitors failed to attend. The PCS psychologist saw Donald that day and recorded that he was maintaining his level of emotional stability, had settled in B Wing and was receiving good support from some other prisoners. He had not received his Largactil medication and the PCS staff member recorded in Donald's ARMS form the following comments: 'Alert. No psychiatric symptoms. No self-harm thoughts. Settled in U1 and has support from other prisoners.' The file note from this interview was submitted ten days after Donald's death.

4.31 At 6.30 p.m., unit officers observed on his ARMS sheet that Donald was 'travelling well'. At 7.00 p.m. Donald was secured into his cell; and at 10.35 p.m. he was found hanging from his cell window. Donald had been in Hakea 195 days.

JHG

4.32 JHG, aged 38 years, was remanded in custody without bail on 9 December 2002 on one charge of wilful murder. Prior to this, on 18 November, the Perth Court of Petty Sessions had referred JHG to the Frankland Centre at Graylands Hospital pursuant to section 5 of the Criminal Law *(Mentally Impaired Defendants) Act 1996* (WA). The Frankland Centre discharged JHG to Hakea Prison with a diagnosis of adjustment disorder with narcissistic personality traits, poly substance use and hepatitis C. He was considered to be at chronic risk of suicide and was being treated for self-inflicted injuries to his arm. JHG, a non-Aboriginal man, had one prior imprisonment within Western Australia and was rated as a maximum-security prisoner.

Reception and Orientation

4.33 Although JHG was a direct transfer from Graylands Hospital, this fact was not noted anywhere on the MR011 checklist. It noted that his partner was unsupportive, he had no children, but he had other supportive family who would visit him. It also stated he had had no personal losses, despite his having been charged with murdering his girlfriend. JHG stated to the reception officer that he had no fears and was not anxious about being in custody and believed the court would downgrade his charges. He disclosed no previous self-harm attempts whilst in custody.

4.34 An admission checklist regarding welfare needs noted that JHG stated that no family (or any other significant person) knew he was in prison, so he was given an officer-initiated phone call to his sister, whom he nominated as his next-of-kin. It also recorded that he was asked, 'Are you able to understand, read or speak in the English language?' to which he replied, 'yes'. He was asked if his family needed assistance, if he needed legal assistance, whether he was in receipt of either a pension or benefit from the Department of Social Security, and if he had other urgent matters to discuss. JHG answered 'no' to all these inquiries.

4.35 An at-risk assessment completed on Monday 9 December by health staff noted a history of 'speed psychosis'[72] and his current mental state as alert and orientated, with good eye contact and denying suicidal or self-harm ideation. While it identified that JHG had just been discharged from the Frankland Centre and that a copy of his interim summary from the hospital was faxed to Hakea that day, the nurse did not consider him to be at any identified risk. The TOMS medical status form was also not updated to reflect JHG's psychiatric diagnosis or information from his stay at Graylands Hospital. The risk assessment recommended that he be referred to the MHN but documentation shows this was not followed through.

4.36 A medical officer completed a medical examination on Tuesday 10 December, which noted his recent admission to Graylands Hospital, history of speed psychosis and lacerated right hand; nevertheless, he was again not considered to be suicidal. JHG was referred for physiotherapy and follow-up at the plastics clinic at Sir Charles Gardiner Hospital. He was also referred for blood tests, which were collected the same day. JHG received a Hakea prison orientation interview on 9 December and was eventually placed in Unit Seven.

Meaningful Activity

4.37 Due to his injured arm, JHG did not work during his time in prison. However, on the day before his death he was employed as a cleaner. There was no documentation to indicate the reason why a prisoner with a badly damaged hand would be employed in that capacity.

[72] Presumably the nurse meant 'drug induced psychosis'.

Access to Family and Community

4.38 JHG had regular visits from and telephone conversations with his sister and brother-in-law.

Access to Outside Agencies

4.39 JHG's only contact with outside agencies was through his lawyer, whom he saw twice, including on the day before his death.

Health

4.40 JHG self-harmed on 15 December. He was seen by a MHN and then transferred to Fremantle Hospital for further treatment. Upon arriving back at Hakea, the MHN placed him on ARMS, recommended that PCS assess him, that he be subjected to close observation and that he be moved to a safe cell in the crisis care unit. During his interview with PCS on 16 December JHG openly admitted to suicide ideation, but managed to convince PRAG that he had no current plan to carry this out and that being in the safe cell was 'driving him crazy'. It was therefore recommended that he be discharged from the safe cell, but remain in the CCU on moderate ARMS. The PRAG team was to review JHG daily, with follow-up from PCS and the MHN. JHG remained on moderate ARMS until 30 December when he was downgraded to low risk.

4.41 On Tuesday 17 December, a psychiatrist assessed JHG and concluded that he was not psychotic or actively suicidal. A follow up review was recommended for two months. A MHN interview on the same day stated that he 'remains at-risk of suicide due to his current situation/charges and probable outcome' and recommended that he remain in crisis care until his mood settles. Some time after this JHG was prescribed anti-depressants but there was no documented evidence of any monitoring of their effect. There was also no evidence of staff communication or coordination of services in the assessment or care of JHG.

4.42 On Monday 30 December the PRAG reduced JHG's risk rating from moderate to low and his observation checks reduced from six hourly to 12 hourly. PCS assessed JHG later that day and made the following comments:

4.43 He presented as alert, oriented and was openly communicative. He reported no sleep or appetite disturbance. There was no self-harm or suicide ideation evident or acknowledged. He was finding his current term of imprisonment difficult. He stated he ruminates frequently about the alleged offence and attempts to keep himself occupied by watching TV. He admits to isolating himself and is not interested in interacting with other prisoners at the present time. JHG acknowledges that his recent suicide attempt was when he was at his lowest point. He is annoyed that he was unsuccessful. He declares that he is not currently suicidal or experiencing self-harm ideation. He acknowledged the longevity of his situation and advises that he is not at a stage to consider a course, programmes and other options. He concedes that a future in prison is something he will have to arrange in due course. He acknowledges that anti depressants are no wonder pills but is finding them beneficial. He is still receiving internal

support by the two peer support prisoners and externally from his two sisters. He stated he had settled into Unit 10, but was interested in receiving an orientation of Unit 5 if possible.

4.44 JHG was advised that the PCS would discuss a transfer with the PSO and to investigate the matter himself with Unit Ten staff. Uniformed staff informed him that, even though he is presently unable to work due to his injured hand, this would not prevent him from relocating to Unit Five should a position become available. As a result of this interview, it was concluded that JHG was not considered to be at immediate risk to himself, and it was recommended that he be referred to the PSO for possible orientation to Unit Five and to be seen by PCS on an as needs basis. This is despite clearly stating (and it being noted in the file-note) that in relation to the suicide attempt 'he is annoyed that he was unsuccessful'.

4.45 On Tuesday 31 December, the PRAG meeting confirmed that JHG was to be seen on an as needs basis and recommended that he be reviewed at the next PRAG meeting with the intention of removing him from PRAG. His approaching court appearance on Wednesday 8 January 2003 was noted. On the same day, JHG engaged in conversation with unit staff during which he stated that he was slowly accepting prison life. Staff noted that he appeared to be genuine.

4.46 JHG was discharged from PRAG on 3 January 2003. There was no action plan for future management and no mention was made of his up-coming court appearance or the possible impact that might have on his mental state.

4.47 The psychiatrist conducted a review on Tuesday 7 January. This appeared to be a cursory mediation review and there was no evidence that support and medical staff discussed JHG or attempted to coordinate his management.

4.48 On Wednesday 8 January 2003, JHG appeared in court and was further remanded without bail for a committal hearing by video link to the Perth Court of Petty Sessions on 5 February. On the 30 January, JHG received an official visit from a lawyer and on the 31 January 2003 he was found hanging in his cell. JHG had been in custody at Hakea for 54 days.

Lawrence Flowers

4.49 Lawrence Flowers was aged 48 years when he was remanded to Hakea on 14 November 2002 on counts of disorderly conduct, assaulting a public officer and breach of a restraining order. Lawrence, an Aboriginal man with a long custodial history, was rated as a medium-security prisoner. Lawrence first entered the prison system at the age of 22 and had a history of relatively minor offences. He had many minor prison incidents recorded against him, but only four prison charges, and he had a previous self-harm history whilst in prison.

Reception and Orientation

4.50 Lawrence reported to the reception officer that he had no supportive partner or family, but that he would receive visits. It was noted that he suffered from epileptic fits and was withdrawing from alcohol. The nursing admission health data sheet (MR010) documented

Lawrence's medical record as a long history of alcohol and solvent abuse, alcohol dementia with Korsakoff features, related epileptic disorder, and cirrhosis of the liver secondary to alcohol abuse. This nurse also completed the MR012 health at-risk checklist.

4.51 During his orientation to the prison, his rights and responsibilities were explained to him; he was given a local orientation handbook and received an interview from the orientation officer. There is no evidence that Lawrence was given a physical tour of the prison and it is unclear whether he participated in the video component of the orientation process. Following orientation Lawrence was transferred to Unit One where he remained until transfer to hospital on 28 November.

Meaningful Activity

4.52 Prisoners on remand are not required to work, and on this occasion Lawrence chose not to do so. However, on the day of his death and despite being in hospital, inexplicably, he was allocated to canteen duties at Level One gratuities (the highest gratuity level).

Access to Family and the Community

4.53 Despite his stated belief upon reception that he would receive visits, he had no visits from or other contact with family or friends during his time in prison. When Lawrence was transferred to Royal Perth Hospital, the prison did not notify any family members of his hospitalisation, despite prison records showing that during a previous imprisonment Lawrence had listed several phone contacts. Hospital staff also reported being unable to locate a next-of-kin to notify them of the extent of his illness before he passed away.

Access to Outside Agencies

4.54 Lawrence's only phone call whilst in Hakea was an officer initiated call to Outcare soon after his reception. AVS saw Lawrence once during his 30 days in Hakea, when he requested information on his charges and court appearance.

Health

4.55 Soon after reception as part of his initial health assessment, a medical officer saw Lawrence. His medical assessment included a request for liver function tests and Dilantin levels, but there is no record of these having been carried out. Despite an extensive and chronic prior health history no recorded individual health care plan was developed for Lawrence.

4.56 On Sunday 24 November, health services staff received a call from Unit One stating that Lawrence was unresponsive and lying on his bed with his arms crossed over his chest. On arrival, the nurses reported that Lawrence was sitting up in bed, was verbally abusive and orientated to time and place. Health service staff referred him to the night staff for review, which consisted of night staff noting that Lawrence was asleep. No other follow-up of this incident is apparent in his files. Other prisoners in Unit One complained to officers about his smell (Lawrence was developing pneumonia at this stage), but there is no evidence that

officers were aware of his chronic health problems or that anyone followed up on these complaints.

4.57 On Thursday 28 November, Unit One staff referred Lawrence to health services for review by the medical officer. At this time he was unable to walk, was frothing at the mouth, coughing, wheezing, and displaying irrational behaviour by washing his face from water in the toilet bowl. After a medical examination was carried out, the doctor suspected he had pneumonia and arranged for his transfer to Royal Perth Hospital for further investigation.

4.58 Lawrence was in hospital for 17 days where he was held in restraints. Lawrence complained of sore ankles on a number of occasions and the nurse had to apply padding to stop chaffing. The restraints were only removed so that hospital staff could carry out emergency procedures on 13 December 2002 at 10.33 a.m. when his condition deteriorated. Lawrence passed away that same day after 31 days in custody.

Dylan Green

4.59 Dylan Green was aged 26 years when, on 26 April 2002, he was remanded without bail on counts of murder and stealing a motor vehicle. Dylan, a non-Aboriginal man, was rated as a maximum-security prisoner.

Reception and Orientation

4.60 Eastern Goldfields Prison had initially received Dylan on 25 April 2002 and had completed all components of reception. On the MR011 and MR012 Dylan was noted as being stressed but not at-risk of suicide. The MR010 identified Dylan as having previous psychiatric history and queried a self-harm incident in 2002.

4.61 On 27 April Dylan was transferred to Hakea, where he did not undergo reassessment and was placed directly into crisis care. There is no documentation showing he received any orientation apart from a possible interview with the orientation officer. Following this interview, and taking account of the seriousness of Dylan's offences, he was 'routinely' placed on moderate ARMS to ensure observation by unit staff. He denied having any thoughts of self-harm and said he expected to be remanded in custody because of his charges, but staff observed him as being nervous and stated that he feared others might harm him.

4.62 The next day a nurse saw Dylan and completed a new MR012 at-risk checklist. Dylan's previous stay in the Fremantle Hospital psychiatric ward and his prior psychiatric issues were noted, and a recommendation was made that he be put on moderate ARMS, and that he should see a medical officer and a psychiatric nurse about his time in Fremantle Hospital psychiatric ward.

Meaningful Activity

4.63 Dylan was a unit cleaner from 3 May to 26 June, and thereafter was reported as being unwilling to work.

Access to Family and Community

4.64 Dylan did not have any family visits or telephone contact while he was in prison. He was estranged from his family and said that he had 'divorced them'.

Access to Outside Agencies

4.65 Dylan made only one phone call whilst in Hakea, to his lawyer. His lawyer also visited him on 15 May and again on 10 July 2002, the day before his death.

Health

4.66 When reviewed by the medical officer, Dylan was identified as having a substantial drug-taking history. He also noted a history of depression and an attempt to commit suicide two months prior. The MHN and PCS saw Dylan together that day, where he disclosed that he had attempted to commit suicide in March. He stated he was depressed at the time due to family problems. Dylan's in-patient discharge summary from Fremantle Hospital indicated that his family were concerned about his delusional and inappropriate behaviour and had organised for him to be admitted as an involuntary patient, which he was for two weeks. His diagnoses on discharge were first episode psychosis and co-morbid poly substance abuse. The MHN concluded that there was no mental illness evident on interview and it was agreed that PCS would provide follow-up regarding his self-harm risk.

4.67 On Wednesday 1 May, the MHN again interviewed Dylan but terminated the interview as Dylan was not communicative. Despite this lack of communication, Dylan was discharged from the CCU. There is no explanation documented for why this occurred.

4.68 Dylan attended court on 2 May, where he was remanded without bail. The PRAG had met the same day, recommended that the unit manager follow him up after he returned from court, and, if needed, PCS and medical staff should see him. The following day PRAG again reviewed his case and recommended a PCS interview, which recorded that Dylan had put in an application for legal aid, he was 'settled' and working, and denied any self-harm/suicidal intent or plan. He said that he had made contact with his mother, although he had 'divorced his parents'. It was recommended that his ARMS status be reduced to low, with follow-up by PCS.

4.69 A consultant psychiatrist who saw Dylan on 6 May concluded that he had a history of mental illness and continued to exhibit disorganisation and paranoid beliefs that suggested a chronic paranoid delusional disorder. He referred Dylan to another more senior psychiatrist for a second opinion and for further management and a follow-up review in a month's time.

4.70 On 8 May, PRAG requested a follow up by PCS following his psychiatric assessment. PCS interviewed Dylan that morning and noted that he presented as bright, alert and orientated, reported no problems inside or outside the prison and said that he was working. He had no contact with his parents and was happy with this. He consistently denied any thoughts of self-harm or suicide. He was recommended for removal from ARMS at the next PRAG meeting,

and was discharged from ARMS on Thursday 9 May. There was no documentary evidence that PCS and medical staff (MHN or psychiatrists) discussed Dylan's case, read each other's interview notes or attempted to manage his situation jointly.

4.71 As per his referral, the senior psychiatrist attempted to review Dylan on Thursday 16 May, but Dylan was at court. He discussed Dylan with a MHN and was satisfied that PCS was looking after Dylan. This same psychiatrist interviewed Dylan on Tuesday 21 May and concluded that he was not overtly psychotic, presently not a self-harm risk and recommended monitoring if his mental state deteriorated. The MHN added to the progress sheet that Dylan was aware of the health resources available if he required any further assistance.

4.72 The next occasion Dylan saw medical staff was on Sunday 2 June. A MHN documented that Dylan was not interested in contact with mental health services and denied any self-harm or suicide issues. It was noted that Dylan had an injury to his eye received after involvement in a fight, and the MHN suggested that he be monitored from time-to-time. There appears to be no record on TOMS of this 'fight' incident.

4.73 On Tuesday 25 June, Dylan was caught smoking in the Unit Ten day room and as a result became abusive towards the unit manager and staff. Dylan was removed from the unit, placed in Unit One (the disciplinary unit), and his supervision level reduced from standard to direct. On 27 June, the zone manager approved this recommendation and suggested that Dylan be charged with abusive language towards staff. That night Dylan activated the cell alarm stating that he felt 'depressed and suicidal', he had been crying and stated that he 'might slash up'. There were no safe cells available in the CCU, so he was placed in a safe cell in Unit One. He was given medication and an ARMS form was initiated.

4.74 According to the PRAG minutes of Thursday 27 June, the PRAG team was to review Dylan daily; and his current basic supervision level and a court date for 11 July 2002 were noted. From 28 June through to 1 July, Unit One staff recorded no reportable incidents relating to his behaviour. There were no records to indicate that Dylan was seen daily by health services staff as per policy.

4.75 A psychiatrist again assessed Dylan on 1 July 2002 and found that although he was anxious about his upcoming court appearance on 11 July, he did not have a clear suicide plan and was at low risk. Dylan was prescribed medication and listed for review in a week's time. This review did not occur and again there was no evidence of communication or coordination between health staff and PCS.

4.76 PCS interviewed Dylan on the same day, noting no problems other than his not liking his placement in Unit One; once his basic supervision regime was completed he wanted to return to Unit Ten where he had friends. It was recommended that ARMS be reduced to low, that Dylan return to Unit Ten, and that PCS follow up. This file-note was completed and filed in the medical record after the relevant staff member returned from holidays on 22 July, 11 days after Dylan's death.

4.77 On 2 July, Dylan's management regression was reviewed, and he was moved to standard supervision. According to the medical file, PCS also interviewed Dylan on 3 July, however, there is no file-note to support this and, according to prison management, PCS did not see him that day.

4.78 During the morning of Thursday 4 July, a PCS social worker saw Dylan and recorded that he presented well and mood and affects were normal. He was happy to be out of Unit One and he said that he was not concerned about his upcoming court date. When he was informed that his parents had contacted the prison again, he reiterated that he did not want to have contact with them, but commented that if they wish to pursue contact it was up to them. PCS recommended that Dylan be removed from ARMS and at the PRAG meeting that day he was removed from the at-risk system despite his court date being only one week away.

4.79 On Thursday 11 July 2002, Dylan attended the Supreme Court for the hearing of the charge of wilful murder. Reports indicate that there had been some media coverage of Dylan's case on that night's evening news, yet neither PCS nor the MHN saw Dylan, and there is no evidence of referral to the PSO or peer support. That evening after lockup Dylan was found hanging from a bar on his window. Dylan had been in Hakea 77 days.

Michael Vaughan

4.80 Michael Vaughan was aged 57 years when, on 1 February 2002, he was sentenced for possession of child pornography. He was placed in Hakea Prison where he was rated as a minimum-security prisoner. Michael, a non-Aboriginal man, had been in prison on five previous occasions. He was separated from his wife, and had no recorded next-of-kin.

Reception and Orientation

4.81 All components of Michael's reception in Hakea appear to have been completed, with the exception of his security checklist. Michael's MR011 reception at-risk checklist indicated that he had a risk of self-harm in the community, in hospital and in custody. However, no TOMS alerts were raised.

4.82 Michael's MR010 health assessment documented that he had been admitted to Graylands Hospital three weeks prior to his imprisonment following a medication overdose. He said that this attempt at self-harm was due to the shock of his current charge but that he was over this. He stated that he had not received any follow-up treatment after the hospital discharged him. He was assessed as not having any identified current risk and referred to the medical officer who conducted a basic examination the next day. Blood tests were ordered and a request for release of medical information to Fremantle Hospital was filed, however, the blood tests were not performed prior to Michael's death. The nursing admission health data sheet identified Michael's medical history as acute lymphoblast leukaemia (diagnosed in 1989) now in remission, angina, early onset emphysema and tremors. No orientation and induction records were present on Michael's file.

Meaningful Activity

4.83 Michael did not work, and there is no reference to recreation or participation in any other activity on his file.

Access to Family and Community

4.84 Michael had no family visits and made no phone calls while he was in Hakea. Neither did he access any outside agencies.

Health

4.85 Early on 17 February 2002 Michael's cellmate activated the cell call alarm. Officers attended the cell and the cell-mate told the officers that Michael was not responding to his calls. The officers attempted to rouse Michael, without success. They felt for a pulse and unsuccessfully tried to ascertain life signs. The officers returned to the control room and advised the senior officer that Michael had probably died and immediately requested that medical staff attend. The cause of death was determined at that time as being ischaemic heart disease and Coronary arteriosclerosis. Michael had been in Hakea 17 days.

Mervyn Yappo

4.86 Mervyn Yappo, an Aboriginal man aged 34 years, was placed in Hakea Prison on 25 January 2001 charged with indecent dealings. Mervyn had been in prison previously on multiple occasions.

Reception and Orientation

4.87 The formal documentation for Mervyn's admission was all complete. The nursing admission health data sheet MR010 documented his medical history, which included self-harm, hepatitis B and cirrhosis of the liver. He was currently taking prescription medication as well as medication for pain and night sedation. A medical examination on 26 January resulted in the ordering of blood tests and prescriptions for vitamins and directed that his current medication be continued. Multiple social and behavioural problems were noted.

4.88 Mervyn's at-risk checklist MR011 documented that he had no identified problems; he had a supportive partner, four children, and would receive family visits. It also noted that he had no personal losses, no fears or anxiety about being in custody and no history of self-harm. In the summary of this assessment, it was stated he would be placed in protection because of the nature of his charges.

4.89 Mervyn's MR012 noted his previous psychiatric history and time in a psychiatric hospital after attempting self-harm. He reported current suicidal ideation, but this was noted as fleeting due to his feelings for his children. He also stated that he was 'up shit creek without a paddle, nothing left for me'. He described his attitude towards his offence and imprisonment as accepting, and commented that he should not have committed the offence. Against plans

for the future, he noted 'If still alive – depends'. Also on the checklist, he indicated 'Yes' to the following: self-blame, remorse, anxiety, agitation, guilt, shame, sense of failure, and concern about personal finances. He was worried about personal safety in prison and had recently lost his grandmother. ARMS was initiated, but again there was no evidence of communication between staff involved in the reception process or recognition of the contradictions in some of the collated material.

Meaningful Activity

4.90 Mervyn was employed for a short period as a cleaner. Due to his medical conditions he was authorised by medical staff as unfit to work for extended periods during his imprisonment.

Access to Family and Community

4.91 Mervyn had regular visits from his family and had visits with outside agencies, including two contacts with the AVS.

Health

4.92 On 26 January, the MHN saw Mervyn because of his ARMS status. She reported that he had no current thoughts of self-harm or suicide, and was in a double-up cell. He had written a letter to his daughter, which he described as therapeutic. He was regretful that he had broken his parole; his mood was even and reactive. He denied any psychotic signs or symptoms. Mervyn was monitored on ARMS for seven days.

4.93 Mervyn attended the health clinic on 29 January complaining about feeling lethargic. He was asked to come back the next week once the results of his blood tests were available. Again he presented at the clinic on 12 February. As he was unfit to work, a letter was sent to his unit informing the officers that Mervyn required rest when necessary due to his chronic health condition. On 15 February he again visited the clinic complaining of tightness across his shoulders and some tingling down his arms. He was recommended for review, which found no evidence of health problems to account for his symptoms. The next day he felt unwell and was vomiting. His blood pressure was elevated. The nurse suggested that the medical officer examine him, but Mervyn declined.

4.94 Mervyn was transferred by request to Bunbury Regional Prison on 8 March. The nursing medical status report recorded that he was a high health risk, had a history of self-harm, was awaiting an organ transplant and that the Director of Nursing was to be informed of any admission, discharge or transfer of this prisoner. Mervyn saw the doctor twice during his stay at Bunbury Prison before being transferred back to Hakea on 15 March for a parole board interview.

4.95 On 25 March, Mervyn presented at the health clinic at Hakea stating he had severe abdominal pain and that he had not eaten for four days. He was referred to the medical officer, whom he saw the next day, and was ordered to be transferred to Fremantle Hospital. His family were informed that he was in hospital, where they visited regularly. On 4 April 2001, the family was

advised that Mervyn had suffered multiple organ failure and was being maintained on medication and machines. His family elected to shut down these supports to end his suffering and they were all present when he died that day.[73]

Evan Slater

4.96 Evan Slater, a 28-year-old Aboriginal man, was remanded to Hakea on 29 January 2001 for a breach of a violence restraining order (against his de facto), assault occasioning bodily harm and damage to property. He had an extensive juvenile and adult prison history and on this occasion, Hakea rated him as a medium-security prisoner. Evan was not eligible for bail.

Reception and Orientation

4.97 Upon arrival at the prison, all components of Evan's reception were completed with the exception of his Management and Placement checklist (MAP). The TOMS database displayed active alerts for 'substance abuse', 'self-harm potential' and 'other' from a previous term of imprisonment in 2000. The required MR011 at-risk assessment form noted Evan's home address as that of his de facto despite stating that he was in a new relationship with someone else, that his new girlfriend was supportive and that he would receive visits from her. Evan reported no fears or anxieties about being in custody, and believed that the charges against him would be dropped. This checklist also stated that Evan had no previous history of self-harm whilst in custody, contradicting his TOMS alert for 'self-harm potential' and juvenile records that indicated a history of attempted suicide.

4.98 The nurse in reception completed an MR010 which recorded his history of self-harm, alcohol and substance abuse. The medical officer observed that Evan had no current suicide ideation, but was depressed over the death of his mother to the extent that he referred Evan to the MHN and the PCS, and recommended placement in the CCU. The MR012 at-risk patient assessment checklist also recorded the distress from the death of his mother and he was generally worried about being in prison. Additional stress was caused by a history of problems with his de facto. Previous self-harming behaviour was noted. Following this interview, the nurse placed Evan on ARMS as moderate risk, placed him in a safe cell in the CCU (the reason given was for depressive symptoms) and referred him to the PCS for review. The medical officer diagnosed Evan as depressed and prescribed medication; however, he did not see a psychiatrist.

4.99 There were contradictions between the MR010, MR011 and MR012 forms and lack of crosschecking and resolution of inconsistencies – for example, a failure for the MR011 to identify Evan's history of self-harm and inconsistent statements about his feelings towards his imprisonment. No processes are in place through which all staff involved in the reception process share information, identify inconsistencies or discuss prisoners identified as at-risk.

[73] Prison records for that day state that Mervyn was returned to prison on 4 April 2001; the offender movement information did not refer to a medical emergency or to his death but rather recorded that Mervyn would be under normal prison routine.

Meaningful Activity

4.100 Evan worked as a cleaner for a short time between 16 and 25 February 2001 but was otherwise unemployed.

Access to Family and Community

4.101 Evan had regular visits from his girlfriend and a visit from his de facto. He also made regular phone calls. He had visits with AVS representatives on three occasions, the last being on 4 March – the week before he died. The AVS notes did not indicate any concerns about a suicide risk.

Health

4.102 On 30 January, whilst in CCU, Evan was given an officer initiated phone call to his de facto, despite a notation on his form stating that she had a restraining order against him. After this call, the officer noted on Evan's ARMS form that he felt considerably more settled and denied immediate suicidal ideation, but said he still felt vulnerable. On the same day, PCS spoke to Evan, who admitted suicidal ideation and thinking about various methods for carrying this out. Evan stated clearly that he felt he was at-risk of self-harm if officers removed him from the safe cell. The PCS staff member recommended he remain in CCU and be reviewed by the PRAG meeting the next day. A short time after this the MHN in CCU conducted an assessment, determining that Evan was not at immediate risk and recommended that he be removed from the safe cell to a normal cell in crisis care. On 31 January, the MHN recommended discharge from crisis care, placement on low ARMS, and referral to PCS for follow-up. Subsequently, Evan was transferred to Unit Six (a general accommodation unit). There was no evidence of communication between the staff involved in the assessments or any awareness of the contradictory assessments.

4.103 Evan denied any current thoughts of self-harm or suicide when interviewed by PCS on 1 February. He did complain of insomnia and that the prescribed anti-depressants had not been provided to him. In light of his upcoming court appearance on 6 February and the nature of his offence, it was decided that he should remain on low ARMS, pending the outcome of his court visit. Evan received his prescribed medication that day and every day until his death. Again, there was no evidence of Evan's case being discussed jointly by relevant staff.

4.104 Evan was removed from ARMS on 5 February despite the PCS recommendation that he remain on the list at least until his court appearance. During his time on ARMS there is no record of him in the PRAG meeting minutes and no documentation found to indicate who approved his discharge from the list. The last entry on Evan's ARMS file was made on 4 February at 6.15 p.m., indicating that Evan was removed from ARMS. Consequently, on 6 February when he arrived back from his court appearance, PCS did not check on Evan as previously recommended.

4.105 On 4 March, AVS representatives interviewed Evan, who recorded that his health was fine but that he was taking anti-depressants and they gave him general counselling. Following this visit, Evan made four phone calls to his girlfriend, a pattern that was indicative of his time at Hakea. Evan often made calls to both his de facto and his girlfriend, generally occurring in multiples within a short duration of each other and which often left him distressed. On one occasion, such a series of calls resulted in Evan acting out aggressively and he was handcuffed (to prevent further violent behaviour) and escorted to Unit One (the disciplinary unit). Notes from an interview with uniformed staff following this incident stated that Evan was 'cured', and returned him to Unit Six. There are no notes on Evan's file to indicate referral to any counselling, support or health related service as a result of this incident.

4.106 Following Evan's death a prisoner reported that he had previously requested that Evan be transferred to his unit – Unit Nine – after conversations with Evan where he had threatened to self-harm.[74] On 12 March Evan was moved to Unit Ten. This prisoner claimed that, when Evan was placed in Unit Ten, he again asked for a transfer of Evan to Unit Nine and was told this was not possible. There is no formal record of this prisoner's concern for Evan's wellbeing.

4.107 On the day of his transfer to Unit Ten Evan received a visit from his girlfriend. It was recorded that Evan appeared to be tense and his girlfriend appeared to be upset and was wiping her eyes as she walked away. Following this visit, Evan's girlfriend wrote to the prison stating that she wished to have her phone number removed from Evan's phone account and wanted no further contact with him. At the subsequent coronial inquest, Evan's girlfriend informed the Coroner's Court that they had argued about his de facto.

4.108 On 13 March 2001 Evan received a one-hour visit from his de facto. Some time after securing Evan in his cell that evening, officers found Evan deceased, hanging by a sheet from the bars in his window. Evan had been in custody at Hakea for 43 days.

ANALYSIS OF CASE STUDIES

Reception

4.109 Whilst the at-risk checklists were completed for all cases, there were several inconsistencies between the information that prisoners gave and information already recorded on TOMS.

4.110 In the case of Damien Garlett, previous attempts of self-harm in a juvenile facility were noted, but a TOMS alert was not generated. Damien was a new young offender with a juvenile history, and consequently, a RR105 (Information on a Young Offender from Juvenile Custodial Services request form) should have been faxed to the juvenile remand prison for completion. However, it is evident that this did not occur. The juvenile and adult system should communicate with each other so this information can be shared automatically.

[74] The Coroner's Inquest finding in March 2003 was that 'whilst accepting [that prisoner's] credibility I am concerned that the wish for an approach involving "double-up" may have been [a manifestation of] his remorse in hindsight'.

4.111 Hakea Local Order 74 imposes an obligation on the senior officer in reception for ensuring that relevant juvenile records are requested and obtained for new prisoners with a juvenile history. However, blame for this omission should not rest solely with the senior officer; the reception nurse, his doctor, PCS and the MHN should all have been aware that Damien had a juvenile history, which was not in his current file, and could have followed it up. Clearly, the culture of the prison was simply not alert to such matters.

4.112 All eight deaths in custody had a prior history of self-harm, either in the community or in prison or both. The prison system uses the MR011 to identify prisoners with a self-harm history or risk factors to enable them to be placed appropriately within the prison. In seven of the eight cases, a prior history of self-harm was not identified during the initial reception process, but the nurse subsequently identified this during the health and at-risk assessments. The reception process worked in such a way that information was not linked together with the consequence that:

- Damien Garlett was identified as having a supportive partner, although she had an active restraining order against him and was not recorded as being his next-of-kin.
- JHG had just been transferred from Graylands Hospital, but this real and significant risk was not noted anywhere on his checklist.
- JHG's checklist noted that his partner was unsupportive and noted that he had had no personal losses, despite being on charges for murdering his girlfriend.

4.113 Evan Slater's case and Damien Garlett's case were similar in that both had a history of self-harm and were monitored on ARMS on a previous occasion, but it appears that this information was not recorded on TOMS for the appropriate alert to be generated.

4.114 Despite reception policy stating that prisoners are to be permitted to make telephone calls upon reception into the prison, only three of the prisoners were recorded as having done so.

Induction and Orientation

4.115 A review of induction and orientation records reveals that this process is ad hoc. It is unclear whether it is the records or the actual process, or both, that staff are not completing correctly. For instance, according to the records Michael Vaughan did not receive an orientation. In the other seven cases, the orientation process was incomplete. There were no records to indicate whether any of the eight men had seen the orientation video. Only JHG and Donald Keen are recorded as having received a tour of the prison. In all cases, the orientation process is minimal and appears rushed – this is well short of best practice given that its objective is to increase prisoners' coping abilities.

Initial Health Assessment

4.116 A review of the health assessment process indicates that staff conducted the at-risk assessments adequately. However, this Office was unable to ascertain whether the MR012 at-risk assessment was completed within four hours of receival in accordance with the policy. The

MR010 health assessment was completed as per policy.

4.117 While the MR012 was completed, there are problems with collected information and reviewing information recorded on TOMS and in the medical file. This Office was told that when new prisoners are being assessed their prison medical record is available for nursing staff, however, staff report that they do not have time to review past history.

4.118 There are a number of specific problems in the cases of Damien Garlett and Donald Keen. In the case of Damien Garlett, he denied a history of self-harm to the nurses on reception. However, a record of his self-harm history was available on the medical status form on TOMS. Nurses updated this on 20 November 2002. If his health status had been checked when he was processed at reception, this information should have generated an alert. In Donald Keen's case, he had a juvenile medical record, which was available in the back of his active medical file. Apparently no one referred to this, as there was an extensive mental health history documented going back to 1997 when he was 13 years old and attempted to hang himself in the East Perth lock-up. The MR010 did not note his self-harm history, although this had already been noted in the MR011 admission checklist, which was also filed in the medical record.

4.119 It is encouraging to see that Eastern Goldfields Regional Prison performed Dylan Green's health and at-risk assessments thoroughly, and developed an appropriate management plan.

4.120 The MR010 nursing admission health data sheet is designed to record a comprehensive medical history for all new prisoners. While this form identifies health conditions, it does not allow for the recording of how these conditions are to be managed and followed up for any diagnostic or investigative tests. For instance, Michael Vaughan, Mervyn Yappo and Lawrence Flowers, who all had chronic health conditions, required individual care plans to be developed and recorded to ensure ongoing care. Evan Slater, Dylan Green, JHG, Damien Garlett and Donald Keen all required individual management plans to address their mental health issues.

4.121 Health service policy requires that the medical officer examine new prisoners within 72 hours of receival and this was confirmed to have occurred in all cases. However, there was a systemic problem with following up requests made by the medical officer for pathology tests for Lawrence Flowers, Michael Vaughan and Dylan Green.

4.122 The health assessment is the final stage of the reception process. Usually this occurs towards the end of the day; and consequently, nurses are under pressure to process prisoners before 6.00 p.m. so that they can be allocated to a unit before lock up at 7.00 p.m. There is an undue focus on the routine operation of the prison rather than a properly resourced system that enables the proper processing of newly received prisoners.

4.123 A summary in the front of all medical records is commonplace in community health practice and would clearly assist custodial nursing staff. Medical summaries in the front of all medical records would also enable easier access to this information by medical professionals and PCS. These summaries should be updated when a prisoner is transferred or released.

Meaningful Activity

4.124 Work and other meaningful activity is important to the wellbeing of prisoners and is also fundamental in the prevention of bullying.[75] The review of cases reveals that only Donald Keen worked consistently. Damien Garlett and Dylan Green's work history was ad hoc. Mervyn Yappo and JHG wanted to work, but could not do so because of poor health and injury. Michael Vaughan was too vulnerable to work. Inconsistencies also exist where prisoners were allocated employment when they were clearly incapable.

Access to Family and the Community

4.125 Access to family and community is vital to the wellbeing of prisoners. In the case of the eight prisoners under review, Lawrence Flowers, Michael Vaughan, Dylan Green and Damien Garlett did not receive visits from family or friends. On a number of occasions, Damien had family visits booked, but they were subsequently cancelled. Unit officers were aware that this had occurred, but little effort appeared to have been made to communicate with the PSO or AVS to clarify why this was occurring and to offer supportive assistance.

4.126 Dylan Green had distanced himself from his family; however, his mother made several calls to the prison inquiring about his welfare. In such a circumstance, the prison should have done more to ensure that the prisoner and family receive counselling to deal with the situation and, ideally, to restore contact.

4.127 The cases of Damien Garlett and Dylan Green highlight a lack of communication between the prisoner, unit officers and welfare services. For instance, in Damien's case while he had not received any visits he told AVS that he had. There needs to be a mechanism for bringing all people concerned with prisoner welfare together to discuss their cases so that they can identify any issues of concern and manage the issues collectively. Hakea Prison should have a formal line of communication between unit officers, PSOs and AVS to prevent these services from retaining vital information and working in isolation. These services need better integration, coordination, training and supervision.

4.128 Damien Garlett and Dylan Green's deaths occurred within a day of speaking with a legal representative about their case or likely outcome of their court appearance. This appears to be a particularly stressful time for prisoners, which the prison needs to recognise. The prison should be alert to the fact that the risk profile of a prisoner may become more acute at such times.

4.129 In only four of the cases, prisoners made telephone calls to family and friends. Damien Garlett relied completely on his free phone calls to contact family, and therefore had limited community contact.

[75] See the discussion on the relationship between purposeful activity and bullying in Report 15, *Vulnerable and Predatory Prisoners in Western Australia: A Review of Policy and Practice* (Office of the Inspector of Custodial Services, Perth, May 2003), p. 35.

4.130 Access to external agencies, especially to a prisoner's legal representative, is important to newly received and remanded prisoners. In four cases, prisoners had contact with a lawyer and in three cases prisoners had contact with AVS. The limited resources made available to prisoners to conduct their affairs suggests that the importance of maintaining contact with the external community is not as highly valued as it should be by the prison.

4.131 The overall responsibility for the care and wellbeing of prisoners lies with the prison superintendent. The zone managers have a duty to ensure that everything is functioning efficiently in their zone and they are therefore looking after prisoners' welfare needs properly. For this to occur the prison needs to implement a communication system that facilitates the proper sharing of information with a focus on the welfare of prisoners and their families. Such a communication system does not appear to be in place; in the cases of JHG and Damien Garlett their families had vital information on their mental state and wellbeing that they were willing to pass on, but did not know how to communicate this to prison management.

Health Care and Mental Health Management

4.132 From this Review it is evident that staff require better training in relation to a range of core functional responsibilities: recognising suicide risk in the prisoner population, assessing the degree of risk, understanding and participating fully in ARMS, and in adopting realistic management options for the remand and receival prison setting. Serious risk factors appear to have been either missed or inappropriately assessed. These occurred in the cases of Dylan Green, Evan Slater, JHG, Damien Garlett and Donald Keen.

4.133 The ARMS model was established to manage prisoners at-risk of suicide. At other prisons throughout the State this has meant active management of prisoners by PRAG. A range of interventions and resources are available and are being used in other prisons. At Hakea Prison, it is apparent that PRAG's management planning for prisoners is seriously deficient. Of the six prisoners who were placed on ARMS, there is no evidence of PRAG setting a management regime beyond the simple process of establishing a routine for prison officer observation and review by PCS. In the case of Donald Keen, PCS had recommended, independent from the PRAG process, that he should be assisted to access bail, that attempts be made to contact his sister and that the MHN review his sleep medication. A further five prisoners (Damien Garlett, JHG, Donald Keen, Evan Slater and Dylan Green) were removed from ARMS just short of crucial court appearances and no follow-up assessment of their state of mind or suicide risk was made. There is no record of Evan Slater's situation having been discussed within a PRAG meeting.

4.134 There appears to be a lack of coordination or follow up of prisoners within the health system, with psychiatrists not discussing cases, medication and treatment not being followed through to ensure that they had been given, and seriously ill prisoners not being referred for further tests where the doctor was not able to determine a reason for their symptoms. In the medical treatment of three prisoners (Lawrence Flowers, Michael Vaughan and Dylan Green) medical interventions were called for by the doctor but were not carried out. For Lawrence Flowers and

Michael Vaughan this was in relation to potentially vital blood tests that do not appear to have been performed. There does not appear to be an adequate process in place to ensure that tests are carried out in accordance with the doctor's instructions. For Dylan Green, he was prescribed anti-depressants without any review of their effectiveness, side effects or appropriateness of the dosage. There was no documented review of his medication and he did not see a psychiatrist. The procedures in place are evidently not adequate to ensure that medication reviews occur or that the appropriateness of psychotropic medication for prisoners is assessed.

4.135 This Review also queries the appropriateness of:

- Not initiating ARMS for prisoners in CCU for at-risk issues or for prisoners who state that they have current suicidal ideation;
- Transferring Mervyn Yappo to Bunbury Regional Prison in an extremely ill state;
- Placing Evan Slater on antidepressants without review or referral to the psychiatrist;[76]
- The delay in diagnosis and treatment of Dylan Green, who was already on ARMS. Dylan had one psychiatrist diagnose him as exhibiting disorganisation and paranoid beliefs that suggested a chronic paranoid delusional disorder. He then experienced a delay of over two weeks before he was seen by a more senior psychiatrist for a second opinion diagnosis. The senior psychiatrist's diagnosis was radically different to his colleague's earlier diagnosis, suggesting that Dylan was not overtly psychotic and not at-risk of suicide;
- The finding that Donald Keen was without suicidal ideation, when he had stated that he was hearing voices telling him to kill himself; and
- Not placing seriously ill prisoners (Mervyn Yappo and Lawrence Flowers in particular) in the Casuarina infirmary, contrary to the Ombudsman's Report recommendation 5.9.

4.136 In three cases (Evan Slater, JHG and Dylan Green) health and PCS appear to have acted in isolation, with insufficient communication and coordination of information and action. PCS reviewed their suicide risk and provided some counselling support whilst health services managed specific mental health issues. Further, peer support, PSO and AVS were not centrally involved in the management of any of the prisoners.

4.137 It is evident from this Review that prison officer training is required to recognise suicide risk in vulnerable prisoner populations and to develop the skills necessary to manage these prisoners. Serious risk factors appear to have been missed in four cases. Lawrence Flowers had developed complex pneumonia and the symptoms were manifest from his custodial circumstances; the behaviour of Donald Keen, Dylan Green and Evan Slater was deteriorating and they were becoming management problems. Dylan Green was hearing voices telling him to hurt himself or others. Yet these did not alert prison officers to possible health and suicide risk issues. Established procedures appear to have been overlooked, with officers not reporting Slater's tearfully terminated visit with his girlfriend, an event the officer later thought sufficiently important to record after his death. Management options for the prisoners' suicide risk appear to have been overlooked, with peer support and the PSO not being actively involved in cases where prisoners were experiencing considerable turmoil and acting out of character.

[76] However, this sort of decision is always somewhat marginal, depending on the doctor's own experience and the extent of the disturbance that the patient is manifesting.

Family Contact Following a Death in Custody

4.138 Staff from the Review team contacted family members of each of the deceased prisoners with the intention of ascertaining whether the official agencies were sensitive and helpful in their post-death dealings with family. It was also important for the families to have an opportunity to express their perceptions and feelings about the events. Understandably, some families were more prepared than others to make comments that would become public through this Report.

JHG

4.139 Representatives of this Office met and spoke with Ms G, the sister of the prisoner. She raised many concerns about the care of her brother before his death, and also about her treatment by the Department and the Coroner's Court after his death. She said that no one had notified them that her brother was in the Frankland Unit at Graylands Hospital. She requested information about Graylands' responsibility for notifying the next-of-kin. Similarly, when he was transferred to Hakea Prison, the family was again not notified. Ms G thought that this would have been a particularly difficult time for her brother and she felt that he would have benefited from contact with his family.

4.140 Ms G said that the prison did not give the family any information about life in prison, including information about services that are available to prisoners. She did not know who to contact in the event that the family had concerns about their family member, and no one contacted them about JHG's attempts to self-harm. She said that her brother told her about his suicidal ideation but, because she did not know whom to contact, she did not pass this information on. She would have liked more involvement with her brother's health care while he was in prison.

4.141 Police officers notified Ms G of her brother's death at 3.00 a.m. and gave her a brochure from the Coroner's Office entitled 'When Somebody Dies Suddenly: Information for the Family' and details about how to contact the Superintendent of Hakea Prison. She received an information and support pack from the Coroner's Court about five weeks later, after her brother had been buried. She said that she would have benefited from this information earlier and felt insulted that it was sent so late.

4.142 Ms G stated that the Coroner's Court did not offer any counselling, so she wrote a letter of complaint to the coronial counsellor and received a standard reply. She also sent a copy of her complaint to the Coroner's Office but, she stated to us, received no reply. She felt that there was a lack of sensitivity, support and access to counselling.[77] However, she did say that her contact with the Police Prison Unit was positive and staff treated her sensitively.

[77] It must be emphasised that the focus of this Chapter is to ensure that the experience and perceptions of family members are represented and understood. Official versions and records may differ somewhat. In the case of Ms G, the State Coroner's Office has notified the Inspector of one important difference between Ms G's account of her dealings and the recorded version, namely that a coronial counsellor wrote a letter of apology to Ms G with regard to delay in or misunderstanding about counselling services. There were also some other non-essential differences of detail as to the dealings between that Office and Ms G.

4.143 Ms G expressed her concerns about the management of her brother's risk status, and questioned why staff took him off ARMS high risk within 52 hours. She felt that this was far too soon. She also wanted to know why he had access to shoelaces and matches while on ARMS. After her brother's death, she received an appointment card from Sir Charles Gairdner Hospital (sent on to her from Hakea Prison) to notify him of his next appointment. She found this upsetting.

Dylan Green

4.144 Representatives of this Office met with members of Dylan Green's family – his mother Mrs Green, his step-father and his sister, Zoe Green. The family was still terribly upset about the chain of events that led to the death of their son. Prior to committing this offence Dylan had been a patient at Alma Street Clinic in Fremantle. His mother had organised his admission because of his delusional and inappropriate behaviour. The Alma Street Clinic discharged him on 28 March 2002, after two weeks, to group accommodation in Medina. Mrs Green said that the hospital had initially told her he would be there for two months and was surprised that they had released him earlier. He stayed only one night in this accommodation before making his way to Kalgoorlie.

4.145 In Kalgoorlie, the police apprehended Dylan and charged him with stealing a motor vehicle. On 24 April 2002, Mrs Green's brother, who lived in Kalgoorlie, informed her of his situation. Mrs Green contacted the police station and spoke briefly to Dylan. She said that she also informed the police of his psychiatric history and medication needs. Early the next morning, at 1.30 a.m., the local police came to the house to inform her that police in Kalgoorlie had charged Dylan with wilful murder. That same day Eastern Goldfields Regional Prison transferred him to Hakea Prison. Mrs Green spoke to Dylan after he arrived at Hakea Prison, where he informed her that he did not want any contact with his family.

4.146 Mrs Green continued to ring the prison to speak to her son, but staff told her that he did not want any contact with her. Mrs Green said she had wondered if he had received these messages. This Office checked his notes, and it appears that PCS relayed a message to this effect to Dylan and the PSO contacted the family and provided information about Dylan's welfare.

4.147 The local police told the family about Dylan's death at 3.15 a.m., and gave them the brochure, "When a person dies suddenly" and the contact details of Hakea Prison's Superintendent. Mrs Green rang the prison for details surrounding her son's death, but felt that she did not get sufficient information about what to do next. She also wanted to know if she could have viewed the cell.

4.148 The family received a letter from the Coroner's Office on 18 July 2002. The letter was to notify the family that the Coroner was aware of Dylan's death, and it stated the cause of death. There was no information about what the Coroner would do next. More importantly, the family did not know whether a coronial inquest would be held, or what input they could

have in this process. The family received the standard suicide pack after Dylan's funeral.[78]

4.149 Dylan's family was concerned that he did not have adequate access to psychiatric care and proper treatment for drug withdrawal while he was in prison. They were also concerned that Dylan was not mentally fit to enter a plea to his offence.

4.150 The family still want access to his prison records, autopsy report and medical records. They did not know that they were entitled to access this information from the Coroner's Office.

Evan Slater

4.151 Representatives of this Office met with Evan's sister, Joanne Slater. Evan was in prison on remand for allegedly breaching a restraining order against his de facto wife. However, Evan had identified his de facto as the next-of-kin on his prison documentation. Prison staff therefore sent Evan's personal items, property and information about the circumstances of Evan's death to her following his death. His sister, Joanne, had heard of Evan's death from other family members. The prison did not provide her with sufficient information about his death. For the first week, the family did not know where to go to get help and assistance, until eventually an external agency welfare officer referred Joanne to a counsellor at the Coroner's Office, who let Joanne read the documents they had about Evan. The counsellor also assisted the family with the viewing of the body. He then telephoned the prison and spoke with the Superintendent.

4.152 When Joanne spoke to this Office about her experience with the Coroner's Court, she said that a close family friend (an Aunt) spoke to someone in the Coroner's Office on behalf of the family. Joanne said that the Coroner's Court was not considered to be sensitive to the cultural needs of the Aboriginal community. The Aunt asked whether the Coroner's inquest report made reference to the next-of-kin issue. She expressed frustration with the inability of the family's lawyer to cross-examine a witness and commented that the Coroner's process was not helpful to her family.[79] Joanne and her immediate family received grief counselling through the assistance of the Deaths in Custody Watch Committee (DICWC).[80]

78 The State Coroner advises that a coronial counsellor spoke to Mrs Green on 16 July 2002, five days after Evan's death. A second letter was also sent, which arrived on 22 July, about the availability of the counselling service; this letter contained a contact number for further information. Obviously, the Inspector accepts these assurances. What they bring out is the difficulty of communicating effectively with distressed persons at this crisis point in their lives; the message that is sent is not always the one that is heard.

79 It must be emphasised again, as in footnote 77, that the question is not whether, objectively judged, the State Coroner's Office was well intentioned and helpful but whether family members perceived it as such.

80 This case likewise illustrates the difficulty of effective two-way communication in these situations. The State Coroner's Office advises that the official Record of Investigation of Death indicates that the next-of-kin issue had been discussed at some length. Our own advice is that it was never resolved in the perception of the family members, because the deceased was a Wongi and his de facto a Noongar with the consequence that two different cultural needs had to be met. This illustrates that the problem of communication – acute at such times at best – is exacerbated when a white bureaucracy (regardless of its good intentions) is dealing with the complexities of Aboriginal family relationships. Also, the only witness who could not be cross-examined was the de facto wife of the deceased and the mother of his children, who was becoming very distressed and who in the judgment of the presiding Deputy State Coroner needed to be protected from further anxiety. This seems to confirm that family disagreement and stress lay behind the apparent miscommunications and misunderstandings.

4.153 Two days after Evan's death, the Superintendent and a staff member from Hakea Prison escorted family members and close friends to view the cell through a small window. Staff did not allow them to enter the cell or leave them unsupervised to gather their thoughts and talk among themselves. They were not able to perform a ceremony of their own, such as a smoking ceremony, which could help them, other prisoners and staff to grieve for Evan.

4.154 Evan's family had not been initially contacted by the police or prison management. They had no formal or direct contact from the Department, AVS or the PSO. Two of Evan's brothers were in regional prisons at the time of the interview and the family stated that they needed support to deal with their fears about the welfare of these other relatives. Evan's brothers had not received counselling following his death, even though they were in prison at the time.

Damien Garlett

4.155 Representatives of this Office met with Damien Garlett's sister, Natasha Garlett, to discuss the circumstances surrounding his death. Natasha and her father advised that they had made a booking to visit Damien, but could not attend because their car broke down and consequently they did not see him before he died.

4.156 Natasha's telephone had been disconnected, so it was her grandmother who the police contacted and who later told her of Damien's death. She said that the police had contacted them on two occasions since then, and that the police had been very polite. However, she had no formal or direct contact with the Department or with AVS, though the Aboriginal Legal Service had made contact.[81] Natasha and Damien's father spoke with ATSIC about help with funeral arrangements, but they were told that they could not be assisted. He then went to the Department of Community Development for financial support for the funeral, but was not prepared to accept the conditions attached to the support.[82]

4.157 Representatives of this Office also met with Damien Garlett's de facto, Alma Slater, to discuss the circumstances surrounding his death. Damien was in prison for an alleged physical assault on Alma for which she had obtained a restraining order. Consequently, Alma was not recorded as next-of-kin, and it was her mother who told her about Damien's death. Alma rang the prison the following day and spoke with the Superintendent, who confirmed the death. She received no other contact from the Department or from AVS. However, on the Monday following his death, the Department telephoned to inform her that they were transferring Damien to Acacia.[83] That degree of administrative incompetence is difficult to comprehend. Not surprisingly, Alma Slater expressed her anger about this lack of coordination.

4.158 According to Alma, at the time of Damien's arrest police informed her that Damien would not be going to jail but would be released to the care of his sister Natasha. Alma was upset

[81] The Department states that, with the assistance of the Deaths in Custody Watch Committee and the ALS, Ms Garlett was able to gain mobile phone access to the Superintendent on 5 April 2003 (the day following Damien's death) at 11.00 a.m.

[82] See further paragraphs 7.54–7.57.

[83] The Department denies that any such conversation occurred.

when she heard Damien was going to prison, so she attempted to rescind the restraining order, and had told Damien that she would go to court to support him.

4.159 Alma spoke with Damien a number of times following his imprisonment and he told her that he had not received any support or seen anyone in prison. Damien was crying at the end of their last telephone conversation late Friday afternoon, and she agreed to come and see him. Alma attempted to make a booking but was unable to do so at that hour. At their last conversation Damien stated that he was having heroin; however, it is not clear he meant that he was actually using the drug or that there was heroin available in the prison.

Donald Keen

4.160 Donald's sister was nominated as the next-of-kin. She was generally satisfied with the agency arrangements for notification and follow up. Donald's mother was disappointed that she was not directly notified.

4.161 The family members were not satisfied that the Department had done all that was reasonable to prevent the death. They questioned Donald's access to shoe laces whilst on an active ARMS regime. They wanted to know how the Department had failed to properly inform itself about his extensive prior juvenile medical history. These matters have not been satisfactorily resolved.

SUMMARY

4.162 The analysis above emphasises the need for the Department to better support all aspects of prisoner welfare services. The current application of resources does not deliver all the welfare services necessary for the profile of prisoners at Hakea Prison. Support should be provided at the local prison level as well as general access from the prison system. Not enough has been done to engage the prisoners, their families, communities and the voluntary and business sectors.

4.163 The Department has made some progress to link up with other public sector agencies that have a specific welfare service mandate. There have been recent improvements in mental health service delivery through negotiations with the Health Department and there is a mature relationship with the Department of Education and Training with regard to the provision of prisoner educational services. The Community Re-entry initiative has only just begun to take hold.

4.164 The full involvement of the private and voluntary sector needs an innovative approach and strategic thinking. New strategic policies will need to be developed and sufficient resources committed to build and maintain the links necessary to sustain these partnership approaches.

4.165 A Departmental review of prisoner access to resources at Hakea Prison should be undertaken to fully identify the gap between risk/need and service delivery. Unless the Department can improve welfare service delivery at the prison by working jointly with others (and this is unlikely in the short term) it will be necessary to directly fund the necessary resources.

Chapter 5

THE INVESTIGATION OF DEATHS IN PRISON

5.1 There are four distinct phases to the investigation of a death in prison:

- Enquiries by the Police Prison Unit;
- investigations by the Internal Investigations Unit of the Department of Justice;
- Preparation of the Department's submission to the coronial inquest by a project manager within the Department of Justice; and
- The coronial inquest itself. This process can take up to two years (Evan Slater) and seldom takes less than eighteen months (Michael Vaughan).

THE INITIAL STEPS

5.2 Upon discovery of a death, it is the duty of the prison superintendent to notify a wide range of relevant personnel. Offender Management Policy Directive 30 governs this. The persons to be notified are:

The prison medical officer;
- The relevant Director;
- The police officer in charge of the nearest police station;
- The Police Prison Unit;
- The manager of the Department of Justice Internal Investigations Unit (IIU);
- The relevant prison chaplain; and
- If the prisoner is Aboriginal, the Aboriginal Legal Service.

5.3 Offender Management Policy Directive 30 provides for the immediate securing of the location of the death and the seizure by the superintendent of all records relating to that prisoner. These will be handed over to the Police Prison Unit, in their role as Coroner's Investigators (*Coroners Act 1996* (WA), section 14).[84] The Guidelines for Police published by the State Coroner pursuant to that Act are the legal source for such matters.

5.4 At this stage, steps must be taken to ensure that no communication can be made from within the prison to the relatives of the deceased until the police have notified them. Both the Guidelines for Police (paragraph 5) and Policy Directive 30 (paragraph 6.1) cover this point. After the superintendent has verified that the police have notified the next-of-kin, the superintendent shall arrange for them to be contacted to offer condolences and a face-to-face meeting. A prison chaplain or, where relevant, a member of AVS may be requested to assist. It should be noted that the police will have notified the State Coroner (pursuant to Guideline 4(b)(a)) and this, in turn, potentially activates the Coroner's counselling service in dealings with the next-of-kin.

5.5 The police now seal and take control of the location of deaths in custody to carry out their initial investigations (Guidelines 14–17). Meanwhile, the uniformed officers from the Department who discovered the deceased or who were otherwise involved in the aftermath

[84] Note that copies of the relevant documentation are made under Police fiat for Departmental purposes. This point is material when the role of the Internal Investigations Unit is being considered: see below. The seizure and handing over of the original documentation is to guard against retrospective entries.

of the event will have remained in the prison to allow for immediate interview. In this regard, it should be noted that one of the points strongly made to this Review by the WA Prison Officers' Union and the Staff Support Group is that the staff themselves seldom receive any counselling and often are required to stay at the work site for many hours before they are allowed home. This is, in their view, the first stage in a long period of questioning and uncertainty, and it is evident that they do not feel fully supported by the Department at this time. The Review accepts that there is some justice in their perception.[85]

INVESTIGATION BY THE POLICE PRISON UNIT

5.6 The initial stages of the police investigation are carried out reasonably expeditiously. Thus, statements are taken, the first observations and forensic analysis of the scene carried out, and preliminary views reached as to what other matters have to be addressed as part of the investigation. However, after this point a series of delays begin to emerge. Despite the fact that the core work seems to have been done within a week – or at worst two – many months can then pass before the completion of the police investigation file. For example, in the case of Evan Slater about nine months elapsed, and a period of four or five months is usual.

5.7 It was not easy to ascertain precisely why this happens. It was suggested that the availability of relevant non-uniformed Department personnel (such as health service staff, psychiatrists, psychologists and social workers) was unpredictable and that this held up the completion of the police report. The point was also made that the Police Prison Unit had higher priorities in dealing with prison matters than a relatively straightforward death and that, in a context of perceived under-resourcing, these matters could be held over without prejudice to the outcome. Whatever the explanation, the delays between the commencement and the completion of the police investigation report seem excessive. In a context where there is a strong public interest in bringing the circumstances of a death into the public forum and where both witnesses and next-of-kin must endure great stress until some kind of closure of the formalities has been achieved, the delays are not acceptable.[86]

THE ROLE OF THE INTERNAL INVESTIGATIONS UNIT

5.8 The impact of delays such as this is felt at the second stage of the process – the investigation by the Department's IIU. For reasons that are not altogether easy to fathom, the IIU does not apparently commence its own investigation until it has received the police investigation report. The IIU informed us that there was often an additional delay in obtaining the relevant documents from the Coroner's Court, even after the police had signed off on their own enquiry. However, the Review found that the Coroner's own in-house processes are such that

[85] In its response to the Draft Report, the Department invoked the formal position that 'extensive support is provided by Staff Support and by Prime Resources and staff are relieved from duty'. However, the testimony of staff who had been directly involved in such events does not support the Department's assertion.

[86] In the very occasional case where the case appears to involve criminal wrongdoing, the situation would be different. However, this was not the case in any of the deaths under review.

any delay would be highly exceptional, and we accept that the transmission of the completed police documentation to the IIU is normally achieved promptly via the State Coroner's Office.

5.9 The purpose of the investigation by the IIU is different from that of the police in that it is mainly concerned with Departmental management issues. Thus, procedural questions are investigated such as whether Policy Directive 30 has been properly followed and whether the internal processes for interviewing officers have been effective. So too are more fundamental questions such as whether the assessment of a prisoner's risk profile was adequate or the approach to medical intervention was timely.

5.10 The IIU investigative processes inevitably overlap with those of the police, so that many witnesses who have previously been interviewed are re-interviewed. However, the investigation also goes wider, taking in some additional witnesses and examining different documentation or the same documentation from a different perspective.

5.11 As with the Police Prison Unit, the IIU investigation can take a period of time that seems almost incomprehensible to the external observer. For example, in the case of the death of Evan Slater there was a nine-month IIU investigation period. A period of six months is not unusual. Once more, an acceptable explanation is difficult to find. The manager of the IIU referred to the increasing workload in relation to other matters and the diminished resources of his unit as a partial explanation. However, it does appear to the Review that deaths in prison simply have not in the past been given the priority that such a crucial aspect of prison administration demands.

COMPLETION OF THE DEPARTMENT'S PROCESS

5.12 When the IIU has completed its own investigation, the file is passed on to the Project Manager Prisoner Deaths. Before explaining her role, it must be commented that there are some organisational oddities evident at this point. The project manager holds a generic position in relation to which the JDF has a reference to the task of dealing with coronial inquests. This hardly seems an adequate way of acknowledging the importance of developing positive and strategic responses to deaths in custody. At any rate, the officer reports, via one other line manager, to the Executive Director Prisons, which is a strong point. It is puzzling, however, that she has no organisational link to the Suicide Taskforce Implementation Manager, who reports to the Director of Operational Services. Indeed, the two offices are located in different buildings, and if they have any interaction with each other it is at a personal rather than an organisational level.

5.13 It appears to the Review that the project manager is over-extended. At the time we interviewed her, the workload comprised 14 outstanding coronial inquests as well as the follow-up work of the previous 50 inquests that have occurred over the four years prior to this time.

5.14 The IIU Investigation Report is sent to the project manager in draft form towards the end of the investigation. She is given five working days to comment on the draft, which does not include the attachments or even a list of the attachments, but merely the summary report. The full report and her own comments then go to the Investigation Review Committee, and it is only after this that the project manager gains access to the final IIU Report and the attachments (which include the Police Prison Unit Report). At this stage she compiles a Management Review Report for the Executive Director Prisons, and this as well as the whole document generated by the IIU, including the Police Prison Unit Report, is sent on to the Coroner.[87]

CORONIAL PROCEEDINGS

5.15 The fourth level of investigation involves the Coroner's Office itself. In the light of the documentation that has been received, counsel assisting will prepare the Inquest Brief, arrange for witnesses to be notified and deal with the relevant family issues through the counselling service. According to the complexity of the inquest and the accessibility of witnesses, there may be a further delay of up to six months before an inquest is actually heard. The Coroner informed the Review that delays often occur at the request of family members; also, there are sometimes considerable complications with representation and attendance in regard to who claims to be the next-of-kin for these purposes. The Coroner also stated that it would be possible to move from the stage of receiving the completed reports to holding an inquest within about two months if prior notification of a firm date for the completion of the Department's processes could be given.

5.16 The inquest itself is necessarily somewhat legalistic, with witnesses (including uniformed officers) subject to cross-examination by counsel for family members. In this regard, the Aboriginal Legal Service almost invariably makes representation available for the families of deceased Aboriginal prisoners, but it is unusual for non-Aboriginal prisoners to be represented. Prison officer witnesses are usually represented at the expense of the Western Australian Prison Officers' Union, and Department management, including other public servants, will invariably be represented by the State Solicitor's Office.

5.17 It should be said at this point that the Review considers the coronial proceedings as a whole to be reasonably family-friendly. However, prison officers, as well as their Union, told us that they find the inquest itself, as the culmination of several investigative stages, intimidating. There is in fact no contradiction between these perceptions; they each seem valid. The State Coroner and his Deputy have stated – and we accept – that they do all that they can to keep cross-examination within bounds. However, the inquest is, in the final analysis, an inquisitorial process calculated to ascertain the facts surrounding a death, and almost inevitably there will be some conflict and discomfort for some of the parties. There does not seem to be any escape from this dilemma.

[87] The Department reports that the process has been changed so that the Project Manager Prisoner Deaths receives the report in its completed form. The precise implications of this for her ability to make an input are not clear, but prima facie it would seem to marginalise her even further.

5.18 It is clear from the inquest findings examined by this Office that the State Coroner and the Deputy State Coroner attempt to take their analysis of a death well beyond the stage of establishing the legal characterisation – suicide, accident, misadventure, natural death. The findings are notable for the great effort that is made to contextualise and understand the situation of the prisoner, both as a human being and in the context of the prison experience. This approach is facilitated by the fact that the Department's documentation that finally reaches the Coroner's Office has addressed these matters thoroughly.[88] The consequence is that the Coroner's recommendations often relate to matters of prison administration or operational process. The Review welcomes this; there was a time in the past when Coroners bypassed issues of this kind and addressed deaths in a much more technical or legalistic way; clearly the current practice is preferable.

FOLLOW-UP PROCESSES

5.19 The question arises as to how the Department should respond to the Coroner's findings. This is where the project manager comes in again; as discussed above, it is her task to attempt to follow-up and monitor implementation of those recommendations. Policy Directive 30 (paragraph 11) requires that a report be made to the Minister within three months of the handing down of a Coroner's findings and recommendations, but this does not appear to be happening on a regular basis. It was the intention that the same report would go to the Coroner's Office in the same timeframe, but the Coroner stated to the Review that he has been unilaterally informed by the Department that this constitutes too much of an administrative burden and that such Reports will not be made until six months have elapsed.[89]

5.20 It has not been entirely easy for the Review to determine what is happening on the ground with regard to implementation. The project manager and an assistant are attempting to create a matrix or inventory of all recommendations made at inquests in the last four years or so, as well as their current status with regard to Departmental processes. However, even if this is done thoroughly, the State Coroner's Office to some extent has dropped out of the loop in that it has no basis upon which to evaluate the impact of its recommendations on suicide or death rates, or upon prison administration generally.

SUMMARY

5.21 The procedures set out above are extraordinarily cumbersome. They are not in the interest of the family of the deceased, the witnesses or the good administration of justice. The State Coroner believes that the optimum time to hold an inquest is somewhere between ten and fourteen months after a death. This view is based upon the need for family members to overcome their immediate distress and grief and be ready to deal with the issues involved and

[88] Criticism of the delay should not be construed as criticism of the thoroughness of the documentation that is eventually put together. However, it should be possible to have the latter without the former.

[89] The Department stated in response to the Draft Report that the three-month reporting regime is still being followed.

yet at the same time to prevent the process from being strung out unduly so as to become a problem in itself.

5.22 He believes – and the Review agrees upon this point – that police input into the investigation is crucial to ensure objectivity. For this reason it is appropriate that the police, and only the police, are authorised as Coroner's investigators under section 14 of the Coroner's Act; it would not be appropriate for Department of Justice IIU staff to be given this status and to take primary or equal responsibility for the investigation. However, the delays at the police level are a source of great frustration to the Coroner and, in the view of this Office, deleterious to the good administration of the Department's Prisons Division. The Coroner has told the Review that he will accordingly consider the possibility of amending his Guidelines so that reports are required from the Police Prison Unit within one month of a death. In doing so, he accepts the likelihood that some of these reports, particularly from medical personnel, will not have been obtained within that time, but nevertheless believes that the key witness statements will have been able to have been obtained and can then be promptly passed onto the IIU through his Office.[90]

5.23 As for the IIU itself, there seems to be absolutely no sensible impediment to their commencing their own aspect of the investigation as soon as the Police Prison Unit has satisfied itself that the place of death is not a crime scene. Although it is said that the police 'seize' documentation for the Coroner, that documentation is copied as required. As stated previously, it usually relates to the prison experience and antecedents of the deceased, and it is these matters that are important to the IIU Report and which have given breadth and depth to the Coroner's own findings in recent years.

5.24 The Coroner is of the view, and the Review endorses this, that the IIU Report should be able to be completed within a period of a further three months after the police witness statements have been sent on.[91] If these periods were adhered to, and allowing for a reasonable slippage for valid reasons, the Coroner would indeed be able to schedule inquests within the period that he considers acceptable, that is, between ten and fourteen months after the death.

5.25 With regard to the Coroner's recommendations relating to prison administration matters, the only source of advice is that of the Department itself. The Inspector has suggested to the Coroner that once an Inquest Brief has been completed and prepared, this Office should review it in order to identify any relevant issues of prison administration or policies that may not be immediately apparent and advise him about these issues either by letter or more formally by appearance as a witness. The benefit of this would be to contextualise this crucial element of prison administration more widely than has previously been the case. From the point of view of this Office, deaths in prison – whether by way of suicide, natural deaths or from any other cause – are an element of core business.

[90] In a letter to this office dated 6 January 2004 the State Coroner advised that these steps were finalised in January 2004.

[91] This time period will have to be adjusted to take account of delayed statements, but inasmuch as the Department can influence these, then the delay should not be excessive.

5.26 A corollary would be that the Office should actively be involved in the monitoring of the recommendations made by the Coroner. This would involve its being brought into the loop of the reports that are intended to be made back to the Coroner (and to the Minister) in relation to such recommendations and, if necessary, reviewing their implementation on the ground. The latter is a task that the Coroner's Office does not currently have the capacity to undertake.

5.27 Within the Department itself, it would seem desirable that the following matters be done. First, the IIU must be directed to give greater priority to investigations into deaths. Second, the project manager must be brought more fully into those investigations at an earlier stage. Third, there is clearly an artificial division of related responsibilities within the Department and it would seem appropriate to have a small unit, reporting to the Executive Director Prisons, which is concerned with all aspects of deaths in prisons, including suicides. In other words, the Suicide Taskforce Implementation Manager should be in the same workgroup as the project manager and the part-time assistance that has occasionally been received probably needs to be regularised and consolidated.

5.28 With regard to the Police Prison Unit, it seems necessary that this group also should revise and improve the priority that it gives to these kinds of investigation and set out to complete them in an acceptable and timely period. Commitment from the highest command level would ensure that this occurs.[92] It was pleasing to note, however, that several families of deceased prisoners commented favourably on the way in which personnel from the Police Prison Unit dealt with them.

5.29 Finally, it should be reiterated that the proceedings before the Coroner are as family-friendly as the legalistic framework permits. This is an important matter, one that is increasingly being recognised around the world (for example, in the UK where the European Charter of Human Rights has led to revisions in the coronial procedures so as to be more family-friendly). It should perhaps be added that in the UK, investigations (other than those involving a criminal death within prison) are shortly to be transferred to the Prisons and Probation Ombudsman.[93] A similar move is not recommended by this Review, but is mentioned inasmuch as it serves to highlight the immense importance that a mature prison system gives to timely and objective external scrutiny to this core area of prison administration. The changes recommended above reflect the same value.

[92] Subsequent communication to the Inspector from the Commissioner of Police and from the Police Prison Unit indicates a strong commitment to expediting investigations.

[93] It was intended that this would be done by legislation in 2005. However, on 22 August 2003 the Home Office requested the Prisons and Probation Ombudsman to investigate a suicide at Styal Women's prison – the sixth such death in a period of twelve months. This delegation is intended to act as a trial run in an important and controversial case for the permanent transfer of this jurisdiction. (Subsequently, after the issue of the draft of this Report, the notorious British murderer, Dr Harold Shipman, committed suicide in Wakefield Prison. The Prisons and Probation Ombudsman was requested to conduct an urgent investigation into this case, and it was announced that his full jurisdiction in relation to the investigation of deaths in prisons would be brought forward to April 2004.)

Chapter 6

REVIEW OF SUBMISSIONS

6.1 In recent years, many Australian health and welfare agencies have identified youth suicide as a growing concern within the general community, and have begun working to address this tragic and increasing problem. There is an accumulating body of knowledge emanating from the genuine efforts of individuals and groups to respond to the sense of loss that the community experiences when young men and women are taken away in these circumstances. When suicide occurs in prison, there is an additional layer of anguish.

6.2 Custodial suicides have also in recent times been the subject of specialised research and publications. Here too, there is a strong body of knowledge to draw upon. This Review purposefully invited submissions from a spectrum of groups and agencies that have an interest and some knowledge of custodial deaths in Western Australia. All the submissions received by this Office were concerned with systemic problems and many proposed specific interventions that sought to improve the total prison environment.

6.3 The Prison Reform Group of Western Australia (PRGWA) argued the position that prison administration needs to base its policies and practices on fundamental human rights principles. Likewise, a number of other submissions suggest that, if basic human rights underlie policies relating to staff and prisoners, it is more likely that a healthy prison environment would develop. They suggest that the Department and Hakea management need to commit to the full implementation of recommendations in relevant reports, such as the Ombudsman, this Office, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), and the Suicide Prevention Taskforce.

6.4 The Western Australian Prison Officers Union of Workers (WAPOU) and Outcare submitted that for the prison system to run well the Department needs to demonstrate that it values prison officers and other staff. As they point out, prison staff deal with the day-to-day care of prisoners. They are usually the first point of contact prisoners have when they need welfare services, and are therefore pivotal to providing prisoners with a safe, secure and healthy environment. Further, they add, it is also prison staff who have to deal most closely with prisoners who commit self-harm or suicide. They emphasised the emotional and psychological pain and stress to staff, their colleagues and families. They suggest that in order to provide prisoners with appropriate welfare support, staff need to be appropriately supported by the Department, the superintendent and other management. This support includes safe working conditions, adequate staff numbers, controlled staff selection, in-service training, and a forum for reporting their workplace concerns.

6.5 WAPOU submits that it is important to remember that the prison environment affects the lives of prisoners, staff, the families of both, and the community. They cited the responsibility of the Department and Hakea Prison for implementing policies and practices that create a healthy environment, to providing equivalent health care to that in the wider community, and facilitating appropriate communication with family, friends and outside agencies. They acknowledged the key roles that prison staff, their families and the community could play in creating a healthy environment and sought greater opportunities for this to occur.

6.6 In their submission to this Review, the PRGWA made the point that preventing self-harm and suicides relies on all those responsible for prisoners – including the Department, prison management and officers – understanding the nature of the prison population. They claimed that their analysis revealed that the majority of prisoners who commit suicide have a history of self-harming, and have psychological problems that make them more vulnerable in a prison context, particularly in the early stage of their imprisonment. The PRGWA further suggests that most vulnerable prisoners are also struggling with cultural and social issues, often linked to drug abuse. They suggest that the vulnerability of some prisoners with a history of drug abuse increases after entering the prison system because they do not get appropriate medical and psychological assistance.

6.7 The Aboriginal Legal Service (ALS) and the Aboriginal and Torres Strait Islander Commission (ATSIC), drawing on the WA Ombudsman's report on deaths in prisons, submit that those prisoners who are at the highest risk of self-harm are young male remand prisoners who are in the early stages of their sentence.[94] They may or may not have been in a juvenile detention facility. They may have a history of self-harm, drug taking, and/or mental health problems. Most significantly, many do not have time to adjust to life in prison and do not have the skills to deal with the many stresses of being in prison, away from family and personal support. They do not necessarily have the ability to manage relationships with other prisoners, who may be predatory and who have their own personal problems and stresses. ALS and ATSIC suggest that many prisoners do not have the skills to deal with prison staff, who may not understand them or their welfare needs, or may take their own frustrations out on already vulnerable prisoners. Further, they may not have the ability to object effectively to services that are inadequate or are inappropriate to their needs.

6.8 The ALS, ATSIC and PRGWA recommended that the Department should house young offenders separately. They pointed out that even prior experience of juvenile detention does not prepare a vulnerable young offender for adult imprisonment. PRGWA points out there is a stark contrast between the two environments; juvenile facilities have a focus on child protection and development (welfare) that is not the priority in Hakea Prison or elsewhere in the adult system. These submissions suggest that housing young offenders separately would provide the Department with a better opportunity to deal with their risks and needs and reduce the situational dangers that are endemic in adult prisons. PRGWA suggests having a separate facility would also reduce the danger of sexual abuse.

6.9 The ALS and ATSIC submitted that much of the hardship of being in prison comes from the prisoners' isolation from their families and community. In making this point, they refer to the reports of the RCIADIC,[95] the WA Ombudsman, the Aboriginal and Torres Strait Islander Social Justice Commissioner,[96] the Suicide Prevention Taskforce, and the Department's own

[94] Ombudsman Western Australia, *Deaths in Prisons*, op. cit., paragraph 8.35.
[95] RCIADIC, Report of the Royal Commission into Aboriginal Deaths in Custody (AGPS, Canberra, 1991), p. 228.
[96] Aboriginal and Torres Strait Islander Social Justice Commissioner, *Indigenous Deaths in Custody: 1988–1996*, recommendation 35(b).

website,[97] all of which acknowledge the importance of family visits for the welfare of prisoners. They pointed out that one of the young men discussed in this Review who took his life had not received any visits for at least six weeks before he committed suicide and Hakea Prison did not intervene in this regard.

6.10 A number of the other submissions recommended that Hakea Prison should do more to facilitate family contact. They pointed out that Hakea Prison could draw on the knowledge and support of organisations such as Outcare and the Aboriginal Visitors' Scheme (AVS) to locate and facilitate communication between prisoners and potential family visitors. The ALS and ATSIC and Outcare suggested that the Department should take some responsibility for assisting those families who experience financial hardship in visiting relatives in prisons.

6.11 Outcare submitted that greater family involvement and contact could also occur through regular telephone calls to be made available on an ex gratia basis to encourage family contact. They also recommended that the Department should provide information to families on how to keep in contact and how to report matters of welfare concern. Additionally, they proposed that the families could have a role in the orientation and induction process.

6.12 DICWC submits that services such as an Elders' and speakers' program and peer support networks can provide additional support for prisoners to complement family visits. They suggest that the Department gives priority to the programs recommended in its Aboriginal Strategic Plan 2002–05. They advise against limiting speakers to people who do not have a prison record, as this would eliminate some useful people who have first-hand knowledge of the system. They also suggest that the Department involve Indigenous and non-Indigenous people in the speakers' program to promote reconciliation within the prison, and thus acknowledge the tenets underpinning the RCIADIC.

6.13 DICWC and Outcare stressed the positive role of the peer support system as a way of identifying and helping vulnerable prisoners by creating links between them, the prison and community-based services. They suggest that Peer Support Officers (PSOs) should have a greater role in induction and orientation of new prisoners. DICWC recommended increasing the scale of the peer support system and offering incentives for participation in the service.

6.14 Many of the submissions to this Review pointed out that Hakea Prison must heed recommendation 165 of the RCIADIC, which recommended that prisons remove obvious hanging points. They point out that, while it is not possible to remove everything that a prisoner might use as a means to self-harm or suicide because it would make the environment so sterile as to be harmful in itself, that Hakea Prison has failed to take basic precautions. There was also a call for the Department to implement systems to continuously monitor prisons in this regard.

6.15 ALS and ATSIC, referring to the Ombudsman's *Deaths in Prisons* report,[98] submitted that Hakea Prison needed to make fundamental changes to the way in which staff interact with prisoners.

[97] See Department of Justice website (http://www.justice.wa.gov.au), 'Suicide Prevention Strategies'.
[98] Ombudsman Western Australia, *Deaths in Prisons*, op. cit., paragraph 10.82.

6.16 The ALS, ATSIC and Outcare cited RCIADIC recommendation 150 on the equivalent community standard for prison health care.[99] They suggested that the Department should not be responsible for providing health services and argued that the intent of the recommendation would more likely be achieved by a change in the administrative arrangements. Outcare commented that such an arrangement may encourage more prisoners to access health care services.

6.17 Acknowledging that the majority of prisoners who committed suicide and self-harm have had a drug problem, a number of submissions called for improved training and better operational staff access to this form of at-risk information. DICWC went further, calling for the establishment of a community-at-risk register, to record information relevant to a prisoner's mental and physical health. They acknowledged that confidentiality issues would arise, but submitted that such a register would be a valuable information tool to improve the services for prisoners.

6.18 Outcare reported that the induction and orientation process was rushed and that prisoners receive too much information upon arriving in the prison and are often unable to absorb important details because they are sometimes in a state of shock. Similarly, DICWC suggest that the Orientation Unit at Hakea Prison should be audited to assess the speed with which prisoners are moved into other parts of the prison. Several submissions advocated for a greater role by peer support prisoners in the reception and induction processes.

6.19 Several submissions recommended that a bail assistance system should be an integral part of the reception and induction process. These argue that someone needs to be available to deal with bail issues and provide basic legal advice. This might be a matter of organising bail or of explaining why a prisoner is ineligible for bail. Outcare also prompted the Department to review and address the issue of prisoners who are unable to raise often small amounts of surety bail.

6.20 The Ombudsman, PRGWA, Outcare, prison staff and others submitted that the level of support to the families of those who die in custody, whether by natural causes or through suicide, should be improved. PRGWA raised an important point about the inappropriateness of language used by some staff to report cases of death by hanging. The use of the term 'swingers' in reference to a prisoner found hanging in a cell is undignified and PRGWA suggests that this would cause offence and pain to the families of these people.[100]

6.21 ALS and ATSIC noted that a disproportionately high percentage of prisoners are Aboriginal, and called upon the Department and Hakea Prison to ensure that their practices are as culturally appropriate as possible. They reiterated previous recommendations calling for staff to receive appropriate cross-cultural training and for the prison to put culturally appropriate

[99] RCIADIC, op. cit., Recommendation 150.

[100] For the record, it should be said that the WA Prison Officers Union believes that the use of the word "swinger", and also the parallel word "slasher" for those who have cut themselves, is no more than a highly effective form of shorthand that serves the purpose of immediately alerting everyone. These words, they say, are not intended to be derogatory or contemptuous.

practices into place. These practices included consideration for the immediate and extended families of prisoners, which may have the added benefit of encouraging more Aboriginal people to visit the prison and give assistance when prisoners are depressed or isolated. ALS and ATSIC noted that the family of one of the prisoners in this Review was not allowed time alone in his cell to grieve and could not perform a ceremony for him. They pointed out that, in dealing with death, ceremonies are vital for people from all cultures and, in their opinion, making allowances for this would not be a significant difficulty for Hakea Prison.

6.22 DICWC recommend that identified stakeholders work to set up an 'implementation team' that would scrutinise the implementation of all recommendations arising from this Review. Another submission also comments on the need for independent monitoring of the prison's responses through independent prison visitors.

6.23 WAPOU reports that staff are traumatised by deaths in custody and this impacts on their families, who are their main source of support. They suggest that the Department and the Superintendent of Hakea Prison need to publicly acknowledge the efforts made by officers to reduce deaths and self-harm, and implement procedures to limit the trauma officers experience when such incidents occur. There appear to be no comprehensive records of the number of occasions when prison officers save lives – by prompt action in cutting would-be suicides down or in rescuing prisoners from cell-fires that they themselves have started or in calling medical assistance for heart attack victims or prisoners with self-inflicted knife wounds.[101] They submitted that the policies and practices that the Department or Hakea Prison implement to improve the prison environment, or to reduce deaths and self-harming, should specify measures to provide for the welfare of prison officers, and other staff.

6.24 WAPOU submitted that prison officers have to remain at the site of the death for a long time after a death in custody. One officer reported having to stay there four to five hours after the event. These officers also have to recount the facts of the case many times. Although they appreciate that these procedures are necessary, they recommend that a review is undertaken to minimise the extent of time taken and to provide them with sufficient welfare support. They also submitted that some officers may then have to wait for up to 12 months before the coronial inquiry. During this time they are often left wondering if there was anything they could have done to prevent a custodial death. There is currently insufficient contact between the Department and the officer to advise the status of cases.

6.25 Officers also requested WAPOU to seek improved access to the Staff Support Group, rather than the contracted service PRIME, following a death in custody. The submission commented that the source issue may be financial, rather than procedural.

[101] This is a fair point. This Office has become aware of at least six occasions when officers have rescued prisoners from cell-fires at considerable danger to themselves, and the daily situation reports give some measure of other occasions of attempted suicide. But whereas there is a register of deaths, there is no comparable log of lives saved, the information being fragmented and incomplete.

6.26 WAPOU reports that the Department does not properly train officers to deal with prisoners' emotional and psychological problems. They also lack training to identify issues with new young prisoners, who often do not have the skills or confidence to seek help.

SUMMARY

6.27 The issues and proposals raised in these submissions have been of great benefit in assisting the development of the recommendations resulting from this Review. The Office has considered each of them in the context of the detailed analysis of the case studies (summarised in Chapter 4). Many of the points that have been made here are further reflected in the discussion and recommendations in Chapter 7.

Chapter 7

DISCUSSION AND RECOMMENDATIONS

7.1 There have been more recommendations about deaths in custody made over the years by various inquiries than in any other area of custodial administration. The first Western Australian report – the Vincent Report[102] (1988) – made 32 recommendations, many of them multi-faceted; the Royal Commission into Aboriginal Deaths in Custody (1991) made 339; the Western Australian Ombudsman's *Deaths in Prisons* Report (2000) made 83; the Tasmanian Ombudsman's *Report on an Inquiry into Risdon Prison* (2001) made 65. Yet the situation has remained frustratingly intractable.

7.2 This Review has already referred to at least 90 practices or policies that seem in some way inappropriate, and on one view these could form the basis of separate recommendations. However, we do not believe it would be productive to give each of them such a status. Recommendations that are too detailed tend to become quickly outmoded in the evolving operational context. It is preferable to focus on the major strategies and leave the detailed mode of implementation to those whose business it is to manage the prison system. In doing this, the Department can take note of the matters that have been highlighted but which have not formed the basis of a distinct recommendation to the extent that they seem to enhance the broad strategies that are reflected in our recommendations.

7.3 The analysis in Chapter 1 indicated that the problem – and thus the potential solution – lay primarily with the quality of prison life and the total prison environment, of which detailed suicide and self-harm prevention and management protocols, though very important, are but one aspect. The UK Chief Inspector's thematic review, "Suicide is Everyone's Concern' (1998), reflected this in its core recommendation:

> *Ministers and the Director General of the Prison Service should endorse the principles of 'a healthy prison' given in this report which should be used to take forward the treatment of prisoners and the management of staff in every Prison Service establishment.*

7.4 That approach was not, in the event, implemented quickly or energetically enough and this may have contributed, amongst other things, to the post-1999 increase in prison suicides.[103] In turn, this necessitated the establishment and initiatives of the Safer Custody Group. The evaluation research by Dr Liebling and her team confirm that the Chief Inspector was absolutely on the right track.

7.5 As mentioned previously, the Department of Justice's Suicide Prevention Taskforce (2002) also perceived the issue in holistic terms:

1. The enhancement of constructive and supportive relationships between staff and prisoners should continue to be a major priority for the prison system. Particular emphasis should be placed on improvements to regimes, staff training and rostering

102 P. Vincent et al., *Report of the Interim Inquiry into Aboriginal Deaths in Custody*, Office of the Western Australian Attorney General, January 1988.

103 Other contributing factors include the rapid rise in the prison population and the increasing need for effective drug detoxification measures.

arrangements to enhance these relationships.

2. Opportunities should be expanded for prisoner interaction with the outside world, particularly with regard to family and friends.
3. Each prisoner should be provided with the opportunity to participate in constructive activities such as: employment, education and programs that build competency and address offending behaviour.

7.6 There were nine additional recommendations, and it must be said that, from the point of view of suicide and self-harm (natural cause deaths were not within the scope of the Taskforce's inquiries), they should, if implemented, do much to improve the situation. Certainly, they complement the total prison environment approach.[104]

7.7 In that context, we should place on the record our observations of the Hakea Prison environment, not merely as it was in March 2002 but updated during this review period. The snapshot that follows particularly represents our own views and also the impressions of our consultant, seeing it with fresh eyes. An outsider's analysis is reassuring because it is more likely to be completely objective.

7.8 In Dr Liebling's view, Hakea exhibited an over-investment in security, exemplified by the fact that there were two recovery teams on call within the prison. Generally, the regime was unnecessarily harsh. The uniformed staff were alienated from management, cynical and disempowered, and felt they were left to take the flak when there were system failures or incidents with prisoners. Some of them felt a sense of loss – that is, loss of the former prison culture and certainties of the former Canning Vale Maximum-Security Prison. Generally, they had no confidence in the various layers of management. There was for them a lack of clarity as to what the amalgamation of the previous prisons into Hakea Prison was meant to achieve; and in this regard there was no sense of ownership of or commitment to Hakea. Communication between the various categories of prison staff – uniformed officers, zone managers, Prison Counselling Service psychologists, health services staff, Aboriginal Visitors' Scheme workers, the chaplaincy, and so on – was ineffectual. Demoralisation was widespread. From the prisoners' point of view, the regimes were largely purposeless, with inadequate work opportunities and virtually no programs. There was also a sense of fear and intimidation in some parts of the prison. The overall culture was antagonistic and destructive.[105]

7.9 Of course, there were some positive aspects. Much of the built environment is of impressive quality[106] and there were some good, enthusiastic younger staff, who had not yet been touched

[104] The January 2004 policy paper 'The Future of Suicide Prevention', subsequently developed by the Department, adopts this theoretical approach even more clearly.

[105] The Change Management group was dismissive of Dr Liebling's assessment of the prison. The WA Prison Officers Union considered that her perceptions were accurate. As pointed out in paragraph 7.10, Dr Liebling's perceptions are borne out by our own ongoing observations of the prison.

[106] Some of the worst accommodation has been temporarily mothballed, including Unit Four. In this Office's *Thematic Review of Vulnerable and Predatory Prisoners* (Report No. 15), adverse comment was made about that area of the prison.

by the prevailing cynicism. Dr Liebling found some evidence of improved practices, but against the culture, rules and habits of the establishment. She was also impressed by the staff in the Health Centre.

7.10 These impressions fortified not only our own observations of March 2002 but also our impressions since then on our regular, semi-formal follow-up or liaison visits. Hakea Prison is a prison that has been functioning in a state of low-grade, passive crisis for several years and to date management have not succeeded in turning it around. Accordingly, the most pressing need, from the point of view of preventing deaths and self-harm, is to make the prison 'healthy' – to use the terminology of the UK Inspectorate. The environment is not as safe as it should be; there is little respect of staff for prisoners and prisoners for staff, of staff for management and management for staff; the regime is not purposive or sufficiently structured. Of course, the notion of preparation for release can hardly be given substantial emphasis in a remand and assessment prison, and it is appreciated that convicted prisoners (about 50% of the total population) are held there principally so that their Individual Management Plans can be worked out. Nevertheless, there is a core of convicted prisoners for whom Hakea has become 'home', and in relation to these some kind of programmatic or training effort should be made. The basic cognitive skills training, purchased by the Department for several reasons, including its relevance to improving coping skills in prison, would be appropriate.

7.11 A surprising fact that emerged about Hakea is that, despite the stressful nature of its role, it is one of the cheapest prisons in the State by the measure of recurrent on-site costs per prisoner per day.[107] That very fact is indicative that the Department has not properly assessed the nature of its risks in relation to that population. To compound matters, the prison is expected to operate within what appears to be a constantly diminishing budget, even though there does not seem to be any fat left to trim.

7.12 Our first recommendation therefore must encompass the broad-ranging and self-evident value that the Prison must be run in ways that reflect the notion of a healthy prison and take into account the broad thrust of this Office's earlier report. Acknowledging that a change management team is now in place and is drawing on the skills and experience of a wide cross-section of Hakea staff, we recommend as follows:

1. That the Department of Justice continue with, and accelerate the implementation of, its change management program at Hakea Prison; and recognising that the nature of a remand, receival and assessment prison is that its per capita prisoner costs must be expected to be markedly higher than the system-wide average per capita costs, unequivocally commits the necessary financial and human resources to implement the requisite changes.

[107] Department of Justice, 'Prison Performance Measurement System, Performance Report' (September quarter 2002), p. 35. The Department responded that, given Hakea's role as a single security rating, male only, program-free prison within the Metropolitan area, the funding is understandably and appropriately set at its present levels. The WA Prison Officers Union, on the other hand, submitted that 'without significantly increased resources the problems at Hakea can never be resolved'.

7.13 In this regard, it must be said that the problems at Hakea Prison are such that a rapid turnaround is unlikely. Realistically, it could be two years before the benefits of even the most well directed change management program become fully apparent.[108]

7.14 Some matters arose from the submissions we have received or in the course of our consultations that have not expressly been discussed in earlier chapters. Each of them fits within the broad question of what kind of imprisonment experience is survivable – that is, the coping paradigm so central to the best modern research. Most notably, these matters were: the question of whether young prisoners should be accommodated together rather than fully integrated into the general prison population; related to this, whether first-time prisoners of whatever age require special orientation services; and whether the support of fellow prisoners for their vulnerable co-prisoners can be more effectively harnessed by some mechanism such as a 'Listeners' Scheme'.

7.15 The first of these questions – special conditions for young offenders – is particularly apposite in the context of the deaths of Donald Keen and Damien Garlett. Donald Keen had never previously been in an adult prison; and although Damien Garlett had previous adult prison experience, it was noted that his behaviour and demeanour had caused concern because of his immaturity. The style of incarceration is completely different at Hakea Prison than it is at Rangeview or Banksia Hill Juvenile Detention Centres, where the environment is generally much more supportive and the level of service provision is intensive.

7.16 In this context, responses to the Draft Report indicated the level of distress that Banksia Hill staff felt upon hearing of Donald Keen's death. They said that they had recognised his vulnerability and had managed him with the greatest care within the juvenile detention system. Their distress about the death of Damien Garlett was equally strong. It was reported to the Inspector that:

7.17 Aboriginal staff in particular felt strongly about the deaths. A special meeting of the Aboriginal Support group was called to discuss the issue. While they were careful not to point the finger at Hakea staff, they certainly felt that more could be done to prevent such deaths.

7.18 Many prison systems around the world try to differentiate regimes according to age, with more steps between being a child and being an adult than is the case in Western Australia. In this State, for the purposes of the criminal justice system one is a child at 17 years and 364 days and an adult on one's 18th birthday. This would seem unduly abrupt. In the UK, different regimes are applicable for 12–14 years olds, 15–17 year olds, 18–20 year olds and adults of 21 plus. In practice, each of those steps is somewhat flexible, able to be held back or sometimes accelerated to reflect the judgment of the staff as to the individual maturity of the child or young person to cope with the next level of custody.

[108] Several responses to the Draft Report, including that of the WA Prison Officers' Union, expressed cynicism about the likely efficacy of the change management team. The view of this Office is that its role should be welcomed and supported as one of the means – not the exclusive one – by which cultural improvement may be brought to Hakea Prison.

7.19 Of course, in such a large system as the UK's there can also be separate institutions for these categories; there is a critical mass of prisoners that permits a degree of cost-effectiveness to be achieved, even allowing for the fact that the younger the detainee the more expensive his or her incarceration. One reason for the cost is the need for greater care, with much higher staff ratios than in adult prisons. This is not simply because of the greater commitment to programmatic and educational inputs but also because of safety. Young people are no less likely – and probably overall more likely – to bully each other than adult prisoners, and of course bullying is a factor in self-harm and suicide. So the built environment, the custodial regime and the staffing levels must anticipate this problem.

7.20 In relation to the issues arising out of deaths at Hakea Prison, it is not suggested that Western Australia should, or realistically could, have a separate institution for young adult offenders (i.e., in the age range up to 21).[109] However, now that the prison is not overcrowded, a Unit could be set aside for this purpose.[110] A census conducted by this Office at the end of August suggested that about 65 prisoners prima facie, on the basis of age alone, fell within the relevant categorisation. Doubtless that figure will vary upwards and downwards.[111] There should be enough accommodation flexibility to start to pilot such an approach and assess its viability. The accommodation should be away from the main cut and thrust of the prison – probably Unit Eight; though in the end that is a matter for the Department to sort out in the light of overall pressures upon the Hakea Prison site.

7.21 Of course, it is not simply a question of accommodation. The regime would have to be more supportive and the staff ratio higher, for reasons mentioned in paragraph 7.18. A side benefit would be that the mere fact of identifying that group in this discrete way should facilitate better communication between the juvenile and the adult systems. The case studies showed gaps and discontinuities in the information flow – made possible to some extent because the young prisoners were simply 'newly received prisoners' just like any others. Organisational arrangements that differentiated them for accommodation and regime purposes would inexorably demand that questions relating to previous health and at-risk status would be followed up as a matter of course, both upon initial receival at the prison and when transferred to the dedicated accommodation area.

7.22 Following conviction and assessment, a young prisoner will then face transfer to another facility. It is important for the support mechanisms to continue until he is properly settled into the wider prison system. A safe environment needs to be purposefully identified during the assessment process, taking into consideration support and welfare needs. The transfer should only proceed when a case management plan is developed and approved to accompany the young prisoner to his new location.

[109] In its comments on the Draft Report the Prison Reform Group of Western Australia stated that it would prefer to see a dedicated facility for young offenders, whilst accepting that this would not be practical in the immediate future.

[110] The WA Prison Officers' Union submitted that 'to put a large number of young prisoners together would create an environment that is exceptionally difficult to manage'. It is acknowledged that the management problems would be somewhat different in some respects, but experience elsewhere indicates that such an arrangement is viable.

[111] It has been suggested to us that the number of such prisoners is usually somewhat lower than this, at about 40–50.

7.23 In the light of the above, we recommend that:

2. *The Department should plan for and pilot at Hakea arrangements whereby young offenders are accommodated separately from the mainstream population, with more supportive regime services and a higher staff ratio.*

7.24 Although this Recommendation stands in its original form, as circulated in the Draft Report, it should be put on the record – as submitted to us subsequently – that another way of approaching this might be to create a 'dual track' system whereby some offenders in the 18–21 age group are held at Banksia Hill Juvenile Detention Centre, rather than at Hakea Prison. The capacity of Banksia Hill at the present time is such that not all such offenders could be accommodated there. Moreover, even a relatively small number of such offenders would cause short-term management problems for the remainder in that the hierarchy system might be undermined by the need to set aside accommodation for such offenders. So, at best, only a relatively small number could be managed in this way. To select them would involve making risk assessments and other judgments such as those relating to family support and so on, and some anomalies would undoubtedly arise. Nevertheless, the Department of Justice is a single department with responsibility for all incarcerated offenders,[112] of whatever age, and there is certainly a case for thoroughly exploring this possibility.

7.25 As mentioned, young offenders are not alone in their possible vulnerability. First-time and inexperienced prisoners generally can, and do, feel isolated and at-risk. It has emerged clearly from the body of this report that the orientation process is rushed, inconsistent and fragmented. The fact that the orientation officer is liable to be taken off that duty and assigned elsewhere if the roster is inadequate on any particular occasion indicates a fundamental failure by local management and/or the Department to pay sufficient attention to the needs of the population with which they are dealing. Generally – and not just in relation to first-time or inexperienced prisoners – the orientation period needs to be longer and the programs need to be more informative and better-focused on coping/survival skills.

7.26 In our 2002 Inspection Report, we noted that prisoners had in their survey responses expressed deep dissatisfaction with the orientation process. However, 'this negative response pre-dates the introduction of the new orientation program, which appears to be operating reasonably well, though it is perhaps unduly rule-orientated rather than service-focussed'.[113] There seems to have been serious slippage since then; certainly, perceived from the perspective of suicide and self-harm risks, the orientation process is inadequate. In many prison systems, the process takes considerably longer. The UK research commissioned by the Safer Custody Group and carried out by the Cambridge University team asked itself the question: what is it worth spending money on? One of the answers it arrived at was 'induction units'– dedicated areas where incoming prisoners spend periods of up to five days or more in

[112] One respondent to the Draft Report, who has had previous experience of the UK system, expressed 'amazement' that the Department does 'not have a policy for young prisoners'.

[113] Office of the Inspector of Custodial Services, Report No. 12, op. cit., paragraph 2.9.

certain cases. This could be a model for Hakea Prison and, if adopted, would enable the stresses of first-time or inexperienced prisoners to be managed within that context. The challenge is always the same: how to make the prison experience survivable, in the short-term and in the long-term. Orientation is a key aspect of this.

7.27 There are competing arguments as to whether young prisoners should go through the general orientation process or whether that should occur from within their dedicated accommodation. Given that the orientation unit also should be properly staffed and given the cost-effectiveness of having only one orientation unit, we favour the former. Young prisoners would therefore move on to their dedicated unit after orientation has been completed. Accordingly, we recommend that:

3. An intensive orientation process must occur within a properly resourced Unit. Specially trained staff should not be deployed into other duties. The process must be reviewed to ensure that it addresses fully questions relevant not only to Hakea Prison processes and rules but the prison experience generally.

7.28 The UK has had Listeners' Schemes operating within many prisons for a long time. The essence of these schemes is that prisoners who show themselves to be concerned about their fellow prisoners are designated to assist them during their personal crises. It cannot be emphasised too strongly that prisoners, like the rest of us, have 'life crises' too, not confined to events within the prison setting. In fact, they tend to be subject to even more such crises, and their relative powerlessness to address them makes their impact even more severe. In the UK Listeners' Scheme, prisoners self-identify or self-refer; Listeners are responsive rather than proactive, as the name implies. To ensure that they have some basic understanding of risk issues and counselling protocols, these prisoners are trained by the Samaritans, and they regularly de-brief with a trained Samaritan counsellor. Their interaction with prisoners is confidential – except to the extent that it is evident from the very circumstance of having to make contact that there has been some interaction. This would particularly occur if help were sought after hours (in some prisons Listeners will be escorted through the prison after hours to attend to a crisis). Also, in some prisons there is a Listeners' suite, somewhat akin to the Australian notion of a "buddy cell", where the Listener and the distressed prisoner can share accommodation during a crisis.

7.29 It is not straightforward to evaluate the efficacy of this scheme. Some prison managements are sceptical, seeing it in terms of possible manipulation of the system or standover of vulnerable prisoners by experienced prisoners. From a research point of view, the perennial problem of how to prove a negative – that there were not a certain number of suicides as a consequence of Listener interventions – overshadows the scheme. The Safer Custody Group tried to pursue this issue, and in one of its newsletters published testimony from some prisoners who said that they were saved from suicide or serious self-harm because of a Listener intervention and also from Listeners describing their experiences.[114]

[114] Safer Custody News, Issue No. 15 (Home Office, London, May 2002).

7.30 From the Western Australian point of view, the Department already subscribes to the value that prisoners can and do help other prisoners cope – that is the essence of the Peer Support Group schemes found in every prison in the State. However, as we have seen, there is considerable institutional ambivalence about peer support, with impediments being placed in the way of movement around the prison for these prisoners even though they have been vetted in the first place.

7.31 A formalised Listeners' Scheme is really nothing more than a logical extension of a properly functioning Peer Support Group system. Probably, designated Listeners would also be members of the Peer Support Group, though we do not contemplate that all Peer Support Group members would necessarily become Listeners. The degree of confidentiality involved, the personal qualities required and the necessity for training would mean that some prisoners would be more suitable than others. The Peer Support Group would continue to play its general role within the prison, however.

7.32 In the course of this Review, the Inspector held discussions with WA Lifeline, and received assurances that they could assist with the training of prisoners as Listeners and with the subsequent de-briefing. We understand that the WA Samaritans likewise have appropriate skills and background. Organisations such as these are dependent on external income sources, and thus would require some kind of fee for service, rather as in the case of Outcare with regard to visits and resettlement assistance. However, the amount involved would be relatively trivial and the potential return considerable. The Inspector believes that some such scheme is worth piloting, initially at Hakea but perhaps thereafter progressively at Bandyup, Casuarina, Acacia and possibly at prisons throughout the State. Accordingly, we recommend that:

4. The Department of Justice should establish a Listeners' Scheme at Hakea Prison. This should be done on a trial basis. The training of Listeners should be contracted out to a well-credentialed organisation, and counsellors should be involved in de-briefing with the designated Listeners. In the light of the trial experience, consideration should be given to extending Listeners' Schemes to other prisons, particularly Bandyup, Casuarina and Acacia.

7.33 The remaining recommendations draw upon material in the previous chapters. The UK research indicates that the effectiveness of suicide and self-harm prevention measures – which must always be seen in the context of a healthy prison environment – depend upon the built environment plus good processes for handling prisoners plus positive staff attitudes plus good coordination between the various services. Changes to the use of the existing built environment have already been recommended with regard to accommodation for young offenders. Some small conversion costs might be required, but these would be minimal. Possibly a Listeners' Scheme would require some quite minor adaptations to be made, so as to provide Listener's suites in at least two areas of the extensive prison site; however, mostly its implementation would be procedural.

7.34 At this stage in the development of Hakea Prison, it would not be realistic to make recommendations that require additional construction work or major refurbishment. However, there are still numerous hanging points in the prison. We found that the very cells where several prisoners had hanged themselves were still unchanged. There is a pressing need to remove hanging points. It is true that in a well-run prison, suicides will occur less frequently even if there are hanging points. And it is also true that in a badly run prison suicides will occur even if hanging points have largely been eliminated. However, a key aspect of the total prison environment and the culture that it encourages or engenders is the presence or absence of hanging points. As mentioned in Chapter 1, cell design has now improved to the point where a safe cell no longer has to be an oppressive cell, lacking amenities. Accordingly, it is recommended that:

5. The Department of Justice should inventory and review hanging points at Hakea Prison and develop a management plan for their prompt removal.

7.35 With regard to reception procedures, we recommend that:

6. The Department of Justice review and improve reception processes, taking into account the matters raised in this Report, including:

- *Improved training in risk assessment for officers and nursing staff;*
- *Minimisation of the use of agency nurses, unless it is ascertained that they have been trained in risk assessment, the ARMS processes and forensic mental health issues;*
- *The creation of a process to ensure that health and at-risk records from previous periods of juvenile or adult incarceration or detention at the Frankland Centre are available and are consulted during the initial reception;*
- *A re-examination of first night accommodation arrangements;*
- *A review of rostering arrangements so as to ensure that there is sufficient staffing at all times of the day and in particular in the evenings to cover late arrivals from court; and*
- *The employment of a peer support prisoner (or preferably a Listener when that scheme is established) in the reception area.*

7.36 With regard to induction and orientation procedures, the overarching Recommendation 3, if properly implemented, should meet most of our concerns.

7.37 The lack of coordination between the various staff groups has been graphically illustrated throughout this Review. This characteristic epitomises a prison where management routines are dysfunctional and staff either are grossly over-stretched and/or they feel very little sense of ownership of or pride in their jobs. Recommendation 1 is relevant generally to the resolution of this problem, but some specific matters require to be addressed. We accordingly recommend that:

7. The change management team should pay particular attention to the question of achieving effective communication and coordination between the various components of the Hakea Prison staff. In particular, they should address the following issues:

- *The question of possible intimidation or denigration of PCS staff within the prison;*
- *The work load and distribution of PCS staff, in particular what appears to be a disproportionate amount of duplicated paperwork thus prejudicing the amount of time available for casework;*
- *The poor working relationships that seem to have developed between PCS and Prisoner Health Services personnel;*
- *The improvement of access of Aboriginal Visitors' Scheme workers to the prison and to the Aboriginal population;*
- *The inadequate communication between uniformed staff, PCS workers, health service workers including visiting psychiatrists, zone managers, prisoner support officers and Aboriginal visitors; and*
- *Improved training of all staff as to factors relevant to the identification of risk and the working of the ARMS and the TOMS systems insofar as they are intended to ensure effective information flow and interventions in relation to at-risk prisoners.*

7.38 The operation of the PRAG system was a matter of concern. An important aspect of this was the lack of coordination between the groups referred to above, resulting in their either not being invited to meetings or not being available to attend. The initiative taken by the UK Safer Custody Group has demonstrated already that there is great value in having one person whose sole responsibility is to coordinate suicide and self-harm prevention policies and practices within the prison. At Hakea the most proximate thing to such a role is that of PRAG Chairman – currently one of the zone managers. By definition, that person's responsibilities are spread widely. The Department's own Suicide Prevention Taskforce recommended that a Suicide Prevention Coordinator should be established, but that seems to have contemplated a single position, located in Head Office, with policy responsibility across the portfolio. What is needed is an operational person, right there on the ground – someone with direct access in reporting terms to the superintendent and who sees his or her job in terms of probing, pushing, questioning, exhorting and ultimately criticising and sanctioning the service providers (including prisoner Listeners).[115] We recommend, therefore, that:

8. A position of Suicide Prevention Coordinator should be established at Hakea Prison with responsibility for leading the PRAG and developing ARMS as well as supervising all aspects of the policies and practices relating to the prevention of suicides and self-harm at the prison.[116]

[115] In the UK it has been found that uniformed officers have operated particularly well in these roles.

[116] See also Recommendation 15. On further reflection and in response to some comments about the Draft Report, a preferable concept is that of a 'Safe Custody Coordinator'. Such a designation would naturally open up responsibility not just for suicide and self-harm prevention policies but anti-bullying processes and welfare coordination. The Department's response to this Recommendation – that a prison-based Manager Offender Services should be appointed whose responsibilities would include coordinating suicide prevention – is welcome but does not appear to afford sufficient priority to the broad question of safe custody.

7.39 Throughout this Review, the absence of a dedicated welfare service at Hakea Prison has emerged as a theme. Ever since the category of welfare officers was abolished about 15 years ago and the welfare function notionally transferred to uniformed officers as an aspect of their role in case management, calls have been made for the reinvention of this function. The Department's own Taskforce recommended that "the Department should consider the reinstatement of a generic social work/social welfare service".

7.40 Our concern about this recommendation is that it would seem to endorse the value that welfare is not really the work of uniformed officers. This is a value that has crept back into the Hakea Prison environment. It is not a value that this Office accepts. What is evident is that uniformed officers have not been sufficiently supported in this role or assisted in reconciling it with the core custodial duties that must always remain central to the work of prison officers. The failure of support is shown by the lack of training, the way in which administrative matters such as TOMS entries have been allowed to overwhelm their work days, poor levels of management support, and so on.

7.41 In this context what is needed is not the creation of yet another workplace sub-group, creating more risks of fractured communication and coordination, but some kind of support or leadership as to how best to implement the welfare role. This will support cultural change, which in turn will foster an understanding of the centrality of the welfare role to prison officers' responsibilities. This could take the form of the appointment of one or two welfare coordination officers, perhaps as part of the change management team, whose task would be to train and sensitise uniformed officers to this aspect of their responsibilities. These welfare coordination officers should be of such status that they can ensure that coordination occurs across all elements of the on-site workforce with regard to welfare services – something that has been so singularly lacking at Hakea. At this stage we would recommend that this be done as a pilot project only for Hakea Prison where the need is most urgent (though comparable arguments could be made for Bandyup Women's Prison). Consideration could then be given to statewide extension with the benefit of experience.

7.42 In addition to this, what also emerged is the sheer complexity of the relevant Policy Directives, Regulations and Local Orders that make up the totality of what is expected of a prison officer in terms of welfare duties. They may, to a lawyer or to a review team collating and analysing them over a lengthy period, be comprehensive – but they are virtually incomprehensible. Prison officers are entitled to 'plain English' guidelines as to what is expected of them – not just in the welfare area, but generally. Expectations that are scattered and fragmented through so many disparate sources will not be met. Confronted with such complexities, the natural habit is to turn off, shrug one's shoulders, and hope that someone else will do it. There was evidence of this attitude in the case studies, and it was not really surprising.

7.43 Accordingly, we recommend that:

9. The Department of Justice should pilot a scheme at Hakea Prison whereby on-the-job training for welfare matters is available to uniformed officers. The impact should be evaluated with a view to possibly extending this approach to other prisons. In any event, the raft of Policy Directives, Regulations, Standing Orders, Local Orders etcetera that in totality cover the welfare duties of officers and managers should be consolidated into one plain English document. Staff should receive training in relation to the requirements and expectations of that new document.

7.44 We have already stated that the attitudes of health care workers at Hakea Prison were on the whole positive. However, they are operating in an environment where resources are inadequate. This Office believes that in the long run the delivery of health services to prisoners must become the responsibility of a provider that is separate from the Department of Justice. Only then can budgetary and resource needs be properly addressed; at present they are subsumed within the overall prison services budget, subject to the same pressures and reductions. Health services, including mental health, are the single most important item in the prison regime, given the profile of the population.

7.45 It would not be helpful to recommend transfer of prisoner health services to the Department of Health or some other external provider as an aspect of this Review. This is a matter of governmental policy that inevitably will have low priority in the light of the current challenges facing the general WA public health system. For the present the objective is to try to improve the working of the Department of Justice controlled system for prisoner health services. In this regard, it should be noted that in at least two cases of deaths from natural causes, individual health care plans should have been developed for these prisoners, but were not. Moreover, the prisoners should have been accommodated in the Casuarina Prison infirmary; their health status was such that the notion of managing them in a cell situation was entirely inappropriate. When at last one of these prisoners was moved to a public hospital to die, it was unnecessary and inhumane that he remained shackled for 17 days, until the last hours of his life. As previously with women in labour, the Department seems to have some remarkably oppressive instincts in these situations, putting the fanciful possibility of the escape of a near-corpse ahead of basic human dignity. It should also be noted that there is a Ministerial power to permit the release of terminally ill prisoners, and possibly consideration should be given to the development of guidelines to facilitate greater use of this mechanism.[117]

7.46 In a parallel way, mental health issues were inadequately identified and no care plans developed for several of the prisoners who subsequently suicided. Generally, mental health services at Hakea Prison were inadequate for the needs of the population. It is understood

[117] One prisoner who died in hospital in 2002 remained on a life support machine for a considerable time despite medical opinion that he was brain dead and despite the wishes of his family that no attempts at resuscitation should be made. However, the machine could not be turned off because of his status as a prisoner and the legal inhibitions arising out of the Department's duty of care. It was necessary to seek a guardianship order so that the guardian could then authorise this procedure. Had he been formally released, this dilemma would not have arisen.

that the arrangements with the statewide Forensic Psychiatry Service are in the course of development, and the arrangements need to be reviewed in the light of what this inquiry has shown are serious shortcomings. Also, no Aboriginal health worker was employed at the prison; given the nature of the population and the notoriously poorer physical and mental health profiles of Aboriginal prisoners, this is unfortunate.

7.47 In the light of these matters, we recommend that:

10. Prisoners with serious physical health problems must have a care plan developed and should be held in the Casuarina Prison infirmary.

11. The practice of shackling terminally ill prisoners in public hospitals should cease forthwith.

12. The Department should continue negotiations with the statewide Forensic Psychiatry Service with a view to increasing the coverage at Hakea Prison.

13. Hakea Prison should employ at least one and preferably two Aboriginal health workers.

7.48 The reference to the Casuarina Prison infirmary may invite a response in terms of its already stretched capacity. We acknowledge the veracity of this. However, persons who really are geriatric, rather than acute, cases, occupy some of the beds. Persons who are not really ill at all, such as a cook and a cleaner, fill others. This happens because prisoners can be transferred into that area without the authorisation of a medical officer – an astonishingly wasteful arrangement that epitomises the continuing dominance of custodial or prison management issues over health service issues. The Department needs to look again at how best to utilise the resources available across the system – in particular, the Casuarina Prison infirmary and the geriatric wing at Acacia Prison (which currently houses a number of non-geriatric cases).[118]

7.49 Generally, the frontline workers – uniformed officers – are the staff that have received the least training and support in relation to risk assessment and the prevention of suicide and self-harm. We recommend, therefore, that:

14. The Department should earmark funds and deliver training modules to all uniformed staff at Hakea Prison to assist them in detecting and determining the extent of suicide risk in prisoners, the correct use of the ARMS and TOMS systems, and the relationship and interdependency of the various staffing groups within the prison from the point of view of minimising risk.

7.50 The Review has discussed issues and problems relating to the investigation of prisoner deaths. Some of the most important items in that discussion do not need to be the subject of formal recommendations inasmuch as they have already been addressed during and as a consequence of this Review. These include the need to accelerate the process of bringing a death to the inquest stage; the potential benefit of close liaison with this Office; improved communication with families by officers in the Coroner's Office; and protection of prison officer-witnesses from excessively antagonistic cross-examination.

[118] Report No.19, *Report of an Announced Inspection of Acacia Prison – March 2003* (Office of the Inspector of Custodial Services, Perth, 2003), p. 24.

7.51 In more detail, the State Coroner has already addressed the delays by issuing new instructions to the Police Prisons Unit and the Department's Internal Investigation Unit as to the time lines and reporting processes for their respective investigations. Likewise, the Coroner both in discussion and in correspondence has indicated that he considers there would be benefit in seeking the advice of this Office as a matter of course in relation to prisoner deaths; this may be done by examination of the Inquest Brief. Subsequently, this Office will also assist the Coroner in following up the outcomes of his recommendations. This should act as a goad to the Department, which, as mentioned, has not been reporting back to the Coroner in a timely manner. Next, the Coroner is well aware of the distress to families that can be caused by delayed or inappropriate communication from officers working in the Coronial Counselling Service, and these matters are being addressed in-house. Finally, the supposed antagonism to officer-witnesses displayed by some lawyers is an issue that we were satisfied is being addressed as effectively as possible, consistent with the fact that the nature of an inquisitorial proceeding is that parties are entitled to probe the facts and that the best available way to do this is by cross-examination. However, we believe that witnesses are protected by the Coroner and his Deputy as well as can be done consistent with the purpose of the inquest. We note also, and welcome, that the WA Prison Officers' Union invariably supports its members by retaining legal counsel.

7.52 There are some other matters that should be the subject of recommendations. Administratively, there does seem to be a lost opportunity within the Department in fragmenting the roles of the project manager responsible for dealing with prisoner deaths and the Suicide Prevention Coordinator based in Head Office.[119] With the establishment of the position of a Hakea-located Suicide Prevention Coordinator and the possible extension of such positions to other prisons, these more strategic activities should be brought within a unified small group. Their reporting line should be to a high point in the organisation – probably the Director of Public Prisons. New terminology should be adopted to avoid confusion. We recommend, therefore, that:

15. A Prison Deaths Monitoring Group should be established within the Department. It should consist of the Head Office Suicide Prevention Coordinator (to be known as the Prison Deaths Project Director), the Project Manager Prisoner Deaths (to be known as the Prison Deaths Project Assistant Director) and all prison-based Suicide Prevention Coordinators. Its remit shall be to develop and monitor the implementation of suicide and self-harm prevention policies, to analyse the circumstances of all deaths including those from natural causes, to manage the Department's dealings with the Coroner, to monitor the performance of the Internal Investigations Unit's prompt handling of inquiries into prison deaths, and to report and make recommendations to the Director of Public Prisons.

7.53 We were concerned at the apparent lack of sensitivity shown to staff who are on duty when a prisoner is found dead. We were told stories of officers being required to stay in the prison for many hours in order to be interviewed; and though we understand the need for the preservation and the continuity of evidence we believe that this can be done more efficiently.

[119] Confusion might arise out of the use of the same name in our proposal for a prison-based person. The recommendation that follows changes the terminology to Prison Deaths Project Director.

We also believe that better use can be made of the Staff Support Group at Hakea Prison.[120] We therefore recommend that:

16. The Department and Hakea Prison management consult with the Staff Support Group with a view to agreeing upon procedures in the case of a death that both meet the Departmental needs and those of the Police Prison Unit with regard to evidence-gathering and also the needs of officers to be treated with proper dignity and compassion in the face of a traumatic event such as a sudden death.

7.54 Furthermore, we were not satisfied that Hakea Prison has yet developed consistent and sensitive practices for either notifying the families of prisoners of their death or for permitting access to the death location. These matters are more fully described above. We recommend, therefore, that:

17. The Department and Hakea Prison management examine in the light of this Report the processes for notifying families of the deaths of prisoners and for facilitating access to the death location.

7.55 Our final recommendation relates to funeral costs. One of the most demeaning aspects that we have encountered has been the difficulty that some families have in meeting the funeral costs of deceased prisoners. At a time when they should be grieving, they are trying to find funds to give their loved one a decent burial. In at least one of the cases, that of Damien Garlett, this entailed taking a collection. Although the Department of Community Development had offered some assistance, the family considered that the conditions had been too humiliating to be acceptable.[121] Most though not all of the families of persons who die in prison custody have difficulty in covering funeral costs.

7.56 It is the view of the Office that the Department of Justice should accept responsibility in the first instance for the costs of a standard funeral. A contract could be entered into with several undertakers, covering the metropolitan and the various regional areas, and those acceptable to Aboriginal people as well as non-Aboriginals. Upon the occurrence of a death, the next-of-kin should be notified of the name or names of available undertakers and authorised to deal directly with them. Charges within the tender provision would then be billed directly to the Department. The basis of this recommendation is that, although the Department's duty of care technically ends upon a prisoner's death, it should be seen as having an enduring quality in that the circumstances of prison life for the deceased will have had a bearing upon the circumstances or timing of death.

7.57 Of course, there is also a welfare element underlying the proposal. In those circumstances, it would be reasonable to give the Department a right of recourse against families who have no difficulty in meeting the expenses. Accordingly, we recommend that:

[120] The Hakea Change Management group surprisingly did not see this as a Departmental or Prison responsibility but one for the Staff Support Group itself. The WA Prison Officers' Union stated that the union itself should speak on behalf of the staff in any such negotiations rather than the Staff Support Group.

[121] See paragraph 4.156, above.

18. In all cases of prisoner deaths, the Department of Justice should pay reasonable funeral expenses to an approved undertaker chosen by the next-of-kin from a pre-approved list. However, where in the view of the CEO the family will suffer no hardship by meeting funeral expenses from their own resources, the Department shall have a right of recourse for reimbursement of any such expenses.

7.58 The likelihood is that those who can afford these expenses would not in any case be satisfied with a 'standard' funeral and would be likely to contract directly with an undertaker of their own choice, so that in practice it will not so much be a right of reimbursement as a case where Departmental funds are not outlaid in the first place. Current death rates suggest that the cost of this proposal would not exceed $50,000 per annum – a small price to pay for the dignity of already grieving families.[122]

7.59 Other very detailed recommendations could be made. However, if the Department appreciates the spirit of these recommendations, other matters will undoubtedly come to light and be attended to in the implementation of these recommendations. The philosophy underlying these recommendations and this Review is straightforward. First, Hakea Prison's overall regime must be improved; the total prison environment sets the context for prisoner deaths. Improvement must encompass staff services and conditions as well as those for prisoners. Within that overarching approach, attention must be paid to the built environment, to general prison processes, to health care, to risk management processes, to staff and Departmental attitudes and, above all, to effective communication and coordination.[123]

7.60 Hakea Prison has for too long been under-performing. This emerged clearly at the full Inspection in March 2002, and now, seen through the prism of how prisoner deaths have occurred there, it has emerged clearly again. Yet it is by no means impossible to get its settings right. This will not happen passively or by some form of organisational osmosis. Change and improvement has to be positively engineered. The change management processes already in place must be further energised, unequivocally supported and re-focussed to take account of the particular issues arising in this Review. In reality, the re-focussing is not radical. Changes that would make Hakea a good prison would also reduce its risk profile with regard to future prisoner deaths.[124]

[122] The strongest support for this Recommendation was received from the group that has the closest on-the-ground contact with the families of deceased prisoners – the Deaths in Custody Watch Committee. The 'means test' approach that the recommendation effectively takes was seen to be acceptable, far better than the present arrangements.

[123] In that regard, we welcome the development within the Department of a "Conceptual Model of Suicide Prevention." This paper has been developed in response to and concurrently with the Draft Report, and specifically adopts the underlying philosophy of Dr Alison Liebling, to which this Report refers throughout: see footnote 19, above.

[124] The Change Management Group submitted to the Inspector that it believes the Prison has now moved forward, although there is an extensive list of work yet to be completed. The Group was concerned that not sufficient weight had been accorded to the improvement in the Prison. The Inspector is satisfied that the tone and balance of this Report is appropriate, and the change management process has been specifically endorsed: see Recommendation 1.

7.61 The terms of reference for this Review were set out in paragraph 1.3, above. Each of these has been addressed. The conclusions of this Office are as follows:

- The developments within the Department since the publication of the Ombudsman's Report and the Department's own Suicide Prevention Taskforce Report have not been sufficiently energetic and committed;
- Prison Legislation and Rules, Policy Directives and Operational Instructions, and Standing and Local Orders do not really drive the on-site practices to the extent that ideally they should;
- There are insufficient resources and inappropriate organisational arrangements to provide for the welfare of prisoners;
- Hakea operations concerned with reception and orientation, staff/prisoner interaction and intensive care and support for prisoners are not satisfactory;
- Departmental and related processes for investigating deaths in custody need to be improved; and
- We have been able to identify numerous practical steps set out in this Review that should enable improvements to be made.

7.62 The thrust of this Report should have applicability, suitably adapted for each prison, across the whole of the Western Australia prison system.

Appendix 1

DEPARTMENT OF JUSTICE RESPONSE TO THE RECOMMENDATIONS

Recommendations	DOJ Response
1 That the Department of Justice continue with, and accelerate the implementation of, its change management program at Hakea Prison; and recognising that the nature of a remand, receival and assessment prison is that its per capita prisoner costs must be expected to be markedly higher than the system-wide average per capita cost, unequivocally commits the necessary financial and human resources to implement the requisite changes.	The Department is continuing its active change management program at Hakea Prison. The Department does not agree with the resourcing model proposed in the report. Whilst there are aspects of the functioning of Hakea as a remand, receival and assessment prison that drive a higher than system-wide average per capita cost (for example, reception and induction, health and prisoner counselling services); remand prisoners are not heavy consumers of other prisoner services (for example, programs). There are also characteristics of Hakea Prison that off-set these costs. Hakea has by far the largest prisoner population in the State's public prison system and economies of scale drive down the cost of the facility. It also has an homogenous prisoner population by comparison to other prisons such as Greenough, Roebourne and Broome, and this factor assists in controlling costs through not having to run a range of security regimes across the prison. Regional Prisons also have additional costs associated with their remote location. Overall the funding of Hakea Prison is commensurate with its role and characteristics and is appropriately aligned to its cost structure.
2 The Department should plan for and pilot at Hakea arrangements whereby young offenders are accommodated separately from the mainstream population, with more supportive regime service and a higher staff ratio.	The Department notes this recommendation and will examine alternative options for accommodation arrangements for young offenders, as part of its normal planning process.

Recommendations	DOJ Response
3 An intensive orientation process must occur within a properly resourced Unit. Specially trained staff should not be deployed into other duties. The process must be reviewed to ensure that it addresses fully questions relevant not only to Hakea Prison processes and rules but the prison experience generally.	The orientation process will be examined by the Change Management Team at Hakea, with reference to the role of Hakea as a receival and remand prison. Orientation staff are no longer deployed to other duties.
4 The Department of Justice should establish a Listeners' Scheme at Hakea Prison. This should be done on a trial basis. The training of Listeners should be contracted out to a well-credentialed organisation, and counsellors should be involved in de-briefing with the designated Listeners. In the light of trial experience, consideration should be given to extending Listeners' Schemes to other prisons, particularly Bandyup, Casuarina and Acacia.	The Department has already commenced development of a pilot Listeners' program at Hakea and Bandyup, supported by the Samaritans. The program may involve the delivery by the Samaritans of the same training as is provided in selected UK prisons. It may also include a Samaritans visiting service, in which the Listeners can de-brief and other prisoners can access confidential support. Under the proposal, improved access to telephones with the Samaritans phone line will also be considered.
5 The Department of Justice should inventory and review hanging points at Hakea Prison and develop a management plan for their prompt removal.	The Department has developed a functional brief for standard cell accommodation and is about to commence a priority project to examine and recommend appropriate cell modifications. The audit and refurbishment of existing cells will be conducted on a risk management basis, with priority at Hakea Prison given first to the Special Purpose Unit, then the Orientation/Receival Unit and then the Protection Unit.

Recommendations	DOJ Response
6 The Department of Justice review and improve reception processes, taking into account the matters raised in this Report, including:	The Department is committed to further improving reception processes across prisons and has effected change at some locations. The Change Management Team has already identified the reception process as an item for review at Hakea.
a. Improved training in risk assessment for officers and nursing staff;	a. Agree. This will be progressed through the suicide prevention project. ARMS refresher training will be developed and delivered to prison staff during the late unlock period. This will also cover the relationship and interdependency of staff in minimising risk. Staff from Offender Services (Prison Support Officers, Suicide Prevention staff and PCS Supervisors) have been trained as 'regional trainers' to deliver the 'Gatekeeper' suicide prevention course in WA prisons. Prison Support Officers will be delivering the Gatekeeper course to peer support prisoners at every prison by May 2004. A proposal is being developed to deliver the Gatekeeper course (which includes modules on risk assessment) to prison staff, including officers and nurses.
b. Minimisation of the use of agency nurses, unless it is ascertained that they have been trained in risk assessment, the ARMS processes and forensic mental health issues;	b. Over the last six months the use of agency nurses has been reduced by 66 per cent.
c. The creation of a process to ensure that health and at-risk records from previous periods of juvenile or adult incarceration or detention at the Frankland Centre are available and are consulted during the initial reception;	c. While records of a prisoner's previous sentence in a juvenile facility are accessed it is agreed that the systems should be improved to ensure timeliness and completeness. This matter is currently under consideration.
d. A re-examination of first night accommodation arrangements;	d. The Department has reviewed first night arrangements and introduced a late receival team in November 2003.
e. A review of rostering arrangements so as to ensure that there is sufficient staffing at all times of the day and in particular in the evenings to cover late arrivals from court; and	e. A roster change occurred in January 2003, which ensured that the area is adequately staffed until 7.30 p.m.
f. The employment of a peer support prisoner (or preferably a Listener when that scheme is established) in the reception area.	f. A peer support prisoner has been employed in reception since May 2002.

Recommendations	DOJ Response
7 The change management team should pay particular attention to the question of achieving effective communication and coordination between the various components of the Hakea Prison staff. In particular, they should address the following issues:	In addition to work being conducted by the Change Management Team, service groups have taken the initiative to improve communication and the Department is encouraging these initiatives.
a. The question of possible intimidation or denigration of PCS staff within the prison;	a. The integration of PCS staff within the prison has been addressed through strategies that have resulted in the improved relationships. Initiatives include: • All PCS staff attending and contributing to PRAG meetings; • PCS being allocated specific prison units to improve continuity in relationships with prison officers; and • PCS conducting prisoner interviews in prison units.
b. The workload and distribution of PCS staff, in particular what appears to be a disproportionate amount of duplicated paperwork thus prejudicing the amount of time available for casework;	b. PCS prepare one file-note that is comprehensive and distributed to all appropriate persons concerned. Duplication is due to communication delays which are being addressed. Currently the Department is exploring the possibility of introducing an electronic system to ensure rapid distribution of PCS file-notes.
c. The poor working relationships that seem to have developed between PCS and Prisoner Health Services personnel;	c. This has improved and is reported by both parties to no longer be an issue.

Recommendations	DOJ Response
7 Continued	
d. The improvement of access of Aboriginal Visitors' Scheme workers to the prison and to the Aboriginal population;	d. To improve the Aboriginal Visitors' Scheme service an initiated visits list will be commenced to include prisoners at-risk, prisoners on remand, young first time offenders and prisoners who have not had visits from family or friends in the last 3 to 6 months. Following discussion between the AVS Manager and Superintendent the AVS visitors now have unfettered access to all areas of Hakea Prison.
e. The inadequate communication between uniformed staff, PCS workers, health service workers including visiting psychiatrists, zone managers, prisoner support officers and Aboriginal visitors; and	e. The AVS Manager met with the Prison Counselling Service team at Hakea Prison on 21 January 2004. These discussions were focussed on the involvement of AVS in the ARMS process to ensure information is shared, particularly in relation to a prisoner's family issues and contacts that AVS have had with the family that they can share within PRAG meetings. The PCS Team welcomed the involvement of AVS, and gave specific examples of how AVS can assist.
f. Improved training of all staff as to factors relevant to the identification of risk and the working of the ARMS and the TOMS systems insofar as they are intended to ensure effective information flow and interventions in relation to at-risk prisoners.	f. Communication with officers, zone managers and PSO's has improved since PCS started working in the prison rather than in the Health Services building. There is now improved communication with AVS. Further, it is intended to introduce case conferences with all parties involved and discussions have commenced about how these can be managed. Currently prisoners are discussed informally on an 'as needs' basis.

Recommendations	DOJ Response
8 A position of Suicide Prevention Coordinator should be established at Hakea Prison with responsibility for leading the PRAG and developing ARMS as well as supervising all aspects of the policies and practices relating to the prevention of suicides and self-harm at the prison.	The position recommended by the Suicide Prevention Taskforce has been established with the title Project Manager, Suicide Prevention. As the name implies, it has been established initially to implement the Taskforce recommendations. However the need for 'ongoing development and refinement of suicide prevention strategies' and for a system-wide ownership of suicide prevention has been clearly recognised by the Department. To this end the position and role have been incorporated into the proposed new structure of Offender Services. The position will have oversight of the standards and work-practice issues of the Peer Support Officers and peer support prisoners. There is a commitment for this operational stream to be strengthened in the course of subsequent budgets. The need for an on-site position with a focus on suicide prevention strategies has also been recognised by the Department. A senior position of Manager, Offender Services, Casuarina Prison was established in 2003 and it is intended to establish similar roles in other prisons.
9 The Department of Justice should pilot a scheme at Hakea Prison whereby on-the-job training for welfare matters is available for uniformed officers. The impact should be evaluated with a view to possibly extending this approach to other prisons. In any event, the raft of Policy Directives, Regulations, Standing Orders, Local Orders etcetera that in totality cover the welfare duties of officers and managers should be consolidated into one plain English document. Staff should receive training in relation to the requirements and expectations of that new document.	Additional case management training will be considered as part of the Gatekeeper training package, with a view to providing training appropriate for Hakea as a remand prison. A project is underway to review the policy and procedures for Prisons as a whole. This project will: • Simplify the current operational rule structure to a system that is meaningful and manageable for operational staff. • Consolidate the rules into focus areas based on the four cornerstones of prison management plus a fifth to cover the area of Business Management. • Consolidate policies that are currently in existence and provide an avenue for staff to access them.

Recommendations	DOJ Response
10 Prisoners with serious physical health problems must have a care plan developed and should be held in the Casuarina Prison Infirmary.	Agreed. The Department notes that there are infirmary facilities at Acacia Prison which may also be utilised for this purpose.
11 The practice of shackling terminally ill prisoners in public hospitals should cease forthwith.	The need for restraints is determined on a risk assessment basis by the prison. The decision is then communicated to the Contract Manager who will advise AIMS accordingly. The use of restraints occurs in instances where there is deemed to be a potential risk to public safety.
12 The Department should continue negotiations with the statewide Forensic Psychiatry Service with a view to increasing the coverage at Hakea Prison.	A joint review of psychiatric services at Hakea Prison by the statewide Forensic Mental Health Service and the Department has resulted in an increase to five psychiatrist sessions per week. Sixteen hours' additional coverage per week by a Mental Health Nurse has also been negotiated for Hakea Prison. Ongoing cooperation between the Department and the statewide Forensic Mental Health Service continues with work on the Comprehensive Mental Health Strategy to provide improved psychiatric care across all adult prisons in the State.
13 Hakea Prison should employ at least one and preferably two Aboriginal health workers.	Agreed in principle, subject to resource issues.
14 The Department should earmark funds and deliver training modules to all uniformed staff at Hakea Prison to assist them in detecting and determining the extent of suicide risk in prisoners, the correct use of the ARMS and TOMS systems, and the relationship and interdependency of the various staffing groups within the prison from the point of view of minimising risk.	ARMS refresher training is being developed as part of the suicide prevention project and in conjunction with the Training Branch, will be delivered to all uniformed staff at Hakea during the late unlock period. A proposal for suicide risk training for officers will also be developed with the Training Branch and this will include the relationship and interdependency of various staffing groups in regard to minimising risk.

Recommendations	DOJ Response
15 A Prison Deaths Monitoring Group should be established within the Department. It should consist of the Head Office Suicide Prevention Coordinator (to be known as the Prison Deaths Project Director), the Project Manager Prisoner Deaths (to be known as the Prison Deaths Project Assistant Director) and all prison-based Suicide Prevention Coordinators. Its remit shall be to develop and monitor the implementation of suicide and self-harm prevention policies, to analyse the circumstances of all deaths including those from natural causes, to manage the Department's dealings with the Coroner, to monitor the performance of the Internal Investigations Unit's prompt handling of inquiries into prison deaths, and to report and make recommendations to the Director of Public Prisons.	Refer to response to Recommendation 8 above. The Department will take into account the views expressed in this Report when considering any future organisational restructures in this area.
16 The Department and Hakea Prison management consult with the Staff Support Group with a view to agreeing upon procedures in the case of a death that both meet the Departmental needs and those of the Police Prison Unit with regard to evidence-gathering and also the needs of officers to be treated with proper dignity and compassion in the face of a traumatic event such as a sudden death.	Agreed. The Department will follow up on this issue. However, the procedures are largely out of the control of the Department of Justice as the Western Australia Police Service conduct the investigations on behalf of the Coroner.
17 The Department and Hakea Prison management examine in the light of this Report the processes for notifying families of the deaths of prisoners and for facilitating access to the death location.	The Department recognises its responsibilities in this area, which are detailed in Policy Directive 30. As identified in the Government's response to the Royal Commission into Aboriginal Deaths in Custody, in normal circumstances notification is provided by the Police who, because of their greater distribution across the State, are better placed to provide personal notification.

Recommendations	DOJ Response
18 In all cases of prisoner deaths, the Department of Justice should pay reasonable funeral expenses to an approved undertaker chosen by the next-of-kin from a pre-approved list. However, where in the view of the CEO the family will suffer no hardship by meeting funeral expenses from their own resources, the Department shall have a right of recourse for reimbursement of any such expenses.	Assistance in paying for funerals is provided on behalf of the State by the Department for Community Development. The Department of Justice pays for the transportation of deceased persons within West Australia for burial/cremation where required.

Appendix 2

LITERATURE REVIEW

SIZE OF THE PROBLEM

1.1 Since the Royal Commission into Aboriginal Deaths in Custody, there has been a gradual increase in the number of deaths in custody in Western Australia as well as the rate of deaths per 1,000 prisoners. This increase in custodial deaths has been most marked in Aboriginal prisoners. Over the same period, Western Australia's share of the national total of deaths in custody has also increased. This increase (both in Western Australia and across Australia generally) has occurred in both Indigenous and non-Indigenous prisoner populations.

1.2 Of particular concern is the high number of deaths in custody attributable to suicide. Across all jurisdictions, the rate of suicide is higher in prisoner populations than in the community. In Western Australia, the suicide rate for males in the general community has shown a gradual increase since the early 1980s, peaking in 1997 before levelling off at a rate of 0.303 suicides per 1,000 of the population. This broad community rate is highest in younger males (0.354 for 20–24 year olds) but pales in comparison to the general prisoner rate of almost ten times this, and depending on the calculation used, an Indigenous prisoner rate as much as 100 times higher.[1]

1.3 The factors that typically contribute to deaths in custody are complex, particularly where death is the result of suicide as opposed to natural or medically related death. They include genetic, personality, social and environmental factors, which events both in and outside of the prison trigger. It is therefore vital for prison staff to have the ability to identify risk factors. The following discussion attempts to highlight the major issues and risk factors for deaths in custody. This is not a comprehensive review of the literature on either suicide or death by natural causes; however, each risk factor or issue highlighted has had a direct impact on one of the eight deaths in Hakea Prison since 2001.

NATURE AND CAUSES OF DEATH

Death by Natural Causes

1.4 A substantial number of deaths in custody each year are the result of natural causes. These deaths arise from a range of medical conditions, each with commonly known risk factors and aetiology. To provide a comprehensive review, in the context of this report, would needlessly repeat the vast array of medical summaries in the literature. People in prison tend to be from lower socio-economic groupings and have a poorer health status. Consequently, the pattern and prevalence of health problems is different in prisons compared to the general community. As shown in Table 1, male prisoners tend to have a substantially higher incidence of disease than males in the general community. This is particularly the case for drug related conditions and mental disorders.

[1] Prison suicides are statistically infrequent events and this limits the precision of rate estimates, except in large populations.

Table 1: Comparative summary of common health conditions

Condition	Percentage reporting each condition	
	Prisoners (male)	Community
Sensory system	35%^	38%
Mental Disorders	34%^ (78%*)	10%
Blood borne (hepatitis)	30%^	1%
Circulatory	21%^	17%
Musculoskeletal complaints	25%^	28%
Digestive system	18%^	3%
Respiratory conditions	16%^	12%
Nervous system	3%^	3%
Diabetes	3%^	3%
Injecting drug use	30%#	1>-3%~
Alcohol abuse	45%#	5%@

* Singleton et al (1998).
^ Butler (1997).
# Jones (2002).
@ ABS (2001).
~ Higgins et al (2000).
> Adhikare & Summerill (2000).

1.5 With such a high prevalence of health problems, one would expect to find a burgeoning literature on the management of prisoner health. This is not the case. There is a paucity of studies on the management of health issues in prison. There appears to be a general disregard for the reality that provision and operation of a health service within a custodial setting is different to that within the community. Most studies fail to take into account the limitations on the range of prescribing options, the impact of the patient also being a prisoner, and the impact of the prison regime on issues such as the range of therapeutic options and compliance.

Suicide

1.6 The primary cause of deaths in custody is suicide. In the general population, a wide range of factors have been identified as contributing to suicide risk including adverse life events, negative interpersonal relationships, social and economic disadvantage, alcohol and drug addiction, contact with the criminal justice agencies, poor educational and employment history, low self-esteem, poor problem-solving ability, and low motivational drive (Walmsley et al., 1992; Liebling and Krarup 1993). The majority of prisoners have multiple risk factors, contributing to the very high rates of suicide among prisoners.

1.7 Life in prison imposes levels of chronic and acute risk not typically experienced in the wider community. Lack of control over daily life events, limited and largely intractable living conditions and the nature of the relationship between staff and prisoners are notable examples of chronic environmental factors contributing to such risk. Examples of acute contributors to risk are court appearances, parole reviews and personal safety issues (Zamble & Porporino, 1988).

RISK FACTORS

Self-harm

1.8 In the community, those who suicide are 40 times more likely to have self-harmed in their past compared to those who do not suicide (Clark & Fawcett, 1992; Hawton & Catalan, 1987; Maris, 1992; Pfaff & Acres, 2000). This association is even higher in prison populations (Backett, 1987; Bogue & Power, 1995; Dooley, 1990; Fleming, McDonald & Biles, 1992; Lester & Danto, 1993; Liebling, 1992) with some studies indicating that prisoners who suicide are up to 4000 times more likely (Hawton and Catalan, 1987) to have self-harmed in the past than people in the wider community. In addition, persons who self-harm have a substantially elevated subsequent suicide rate (Hawton & Catalan, 1987; Maris, 1992).

1.9 Prisoners who self-harm tend to do so by lacerating themselves, with injuries involving little or no risk to life (Fleming, McDonald & Biles, 1992; Inch, Rowlands & Soliman, 1995; Liebling, 1992, 1993; Liebling & Krarup, 1993, Power & Spencer, 1987, Wool & Dooley, 1987; Jones, 1986; Lester & Danto, 1993; Kerkhof & Bernasco, 1990). The majority of people who self-harm are Caucasian or non-Indigenous (Fleming, McDonald & Biles, 1992) and come from families with histories of self-harm and suicide (Jones, 1986; Polvi, 1997; Bonner, 1992).

1.10 There is little direct research on the relationship between self-harm and suicide in prisons (Fleming, McDonald & Biles, 1992; Hawton & Catalan, 1987; Lester & Danto, 1993; Liebling, 1992; Liebling & Krarup, 1993; Maris, 1992). The very high rate of self-harm in prisons (up to 10 times more than in the community) and the issues of prison environment and the nature of the prison population, tend to cloud the issue. Prisoners who repeatedly self-harm do not differ from non-repeaters in degree of suicidal intent, type of reported precipitating factors, or the intended outcome of self-harming. However, in general, those who self-harm report a greater number of traumatic or disruptive events in their past (Inch, Rowlands & Soliman, 1995; Ivanoff, 1992; Jones, 1986; Liebling, 1992, 1993; Liebling & Krarup, 1993).

1.11 The factors that determine if a person will commit suicide or self-harm are specific to the person and their interpretation and response to their environment. Predicting whether a person will commit suicide is therefore difficult. However, we know that internal factors including bullying and intimidation by other prisoners, having a request denied, long lock-down periods and transfer to another institution are important factors which may contribute to self-harm. This trend is strongest with younger prisoners (25 years' old or less) (Inch, Rowlands & Soliman, 1995; Liebling, 1992, 1993; Liebling & Krarup, 1993, Power & Spencer, 1987). External factors such as domestic problems (Wool & Dooley 1987) can also act as stressors or triggers.

Coping mechanisms

1.12 Prisoners who self-harm often have maladaptive or inefficient mechanisms for coping. They display evidence of poor coping skills through high levels of hopelessness (Dexter, 1993), sleep disturbance, distress in relation to their current problems (Liebling & Krarup, 1993) and current psychological disturbance (Inch, Rowlands & Soliman, 1995). These prisoners appear vulnerable, are socially isolated, and find the prison experience stressful (Bonner & Rich, 1990). Their vulnerability and the resultant isolation may itself interact with both suicidal ideation and their ability to cope with stress, to exacerbate their risk (Bonner & Rich, 1988). This may be particularly acute in Aboriginal populations (Tatz, 2001). Conversely, prisoners who feel that they have some level of control over their environment are generally less suicidal and more likely to navigate their risk factors successfully (Dexter 1993).

Negative life events

1.13 The literature on negative life events is complex, indicating that both the degree of impact from a singular event (often acting as a trigger) and the cumulative effect of multiple life events have a significant impact on the likelihood of a person committing suicide. It is likely that negative life events play a critical role in at least triggering suicide attempts but the extent and nature of interaction with other risk factors is not yet known.

Drug use

1.14 A considerable body of research links substance abuse to suicidal behaviour, both in custodial settings and in the community (Bogue & Power, 1995; Green, Kendall, Andre, Looman, & Polvi, 1993; Lester, 1982; Suokas & Lonnqvist, 1995). However, the research dealing with the prison sector is often inconclusive. We do not know if drug withdrawal, drug induced psychotic behaviour, long-term psychotropic influences, or toxicity of the drugs increases the risk of suicide in custodial settings. Nevertheless, illicit drug use whilst in prison and poor coping skills with side-effects and/or withdrawal symptoms stand out as clear and significant behaviours that greatly increase the likelihood of suicide for those already at risk.

Psychiatric History

1.15 A previous psychiatric history is a strong predictor of future suicidal behaviour (Anno, 1985; Backett, 1987; Bogue & Power, 1995; Bonner 1992; Burtch & Ericson, 1979; Dooley, 1990; Jones, 1986; White & Schimmel, 1995). Whist only around 30 per cent of prisoners who self-harm have a history of mental illness (Inch, Rowlands & Soliman, 1995; Liebling, 1992; Liebling & Krarup, 1993; Power & Spencer, 1987), the majority of those who subsequently suicide demonstrated clear clinical signs of mental illness in the period leading up to their suicide. This is consistent with research in hospital and community settings (Silburn et al, 1999; Pfaff & Acres 2001), particularly where the mental illness is unrecognized or poorly managed within the prison system.

1.16 There has been little research on the relative importance of different types of disorders, or whether chronic conditions (as found more prevalently in prisoners) further increase risk in prison populations. However, this appears likely based on research in the community (Beck, Steer, Beck, & Newman, 1993).

Demographic Factors

Age

1.17 In Australia, as in most developed countries, suicide risk is highest in youth populations and is elevated in the elderly. The age distribution of suicides in prisons mirrors this bimodal distribution (Anno, 1985; Bogue & Power, 1995; Burtch & Ericson, 1979).

Marital status

1.18 Marital status or more correctly, relationship status, has an important but complex association with suicide risk. Isolated and unsupported individuals, including people who have never established meaningful relationships, are at high risk of suicide. People not in a stable supportive relationship may have limited access to a sufficient range of supports at times of stress and so may be more vulnerable to suicide (Heikkinen, Aro, & Lonnqvist, 1993).

Nature of the offence

1.19 Violent offenders and those committing offences against the person have elevated suicide rates (Anno, 1985; Bogue & Power, 1995). Here it is difficult to determine if the nature of the offence itself increases risk or if the increase is due to associations with other known risk factors such as impulsivity, lack of anger-management skills and the extended nature of the sentence. Interestingly, researchers have found that prisoners on short sentences have equally high suicide rates as those on very lengthy sentences (Anno, 1985; Salive, Smith & Brewer, 1989; Lariviere, 1997). It may be the prisoner's perception of their ability to cope with either the sentence or its impact on their life that contributes to their suicidal behaviour (Burtch & Ericson, 1979). This may partly explain why prisoners on remand have elevated suicide rates (Cookson 1977; Liebling 1993, 1999).

Other Issues

Place of suicide

1.20 Regardless of whether it is during the day or the night, almost all prison suicides (84%) occur when the prisoner is alone and most often (96%) when they are in their cell. Worryingly, a disproportionately high number of suicides occur when the prisoner is in a special placement such as an observation cell.

Intent

1.21 Liebling is one of the few researchers to look at the role of suicidal intent within custodial settings. Mirroring research found in the community (Silburn, Acres, Zubrick, Cook & Hamilton, 1999), Liebling, in two studies, (Liebling, 1992; Liebling & Krarup, 1993) reported that less than half of all prisoners who self-harmed reported an active intent to die. While the method a prisoner chose (those with higher intent generally choosing lethal methods) and the prisoner's motive relate to suicidal attempt, these relationships were not strong. As is found in the wider community, prisoners with high suicide intent participated in minor wrist lacerations and those with minimal evident intent often selected highly lethal methods.

1.22 Prisoners with serious suicidal intent displayed a greater degree of suicidal ideation and reported greater difficulty coping, particularly in unstructured times or circumstances, than non-suicidal prisoners. However, they were no more depressed, hopeless, impulsive, or distressed by recent stressors and did not evidence a greater degree of problems with anger expression. Research in prison populations and in the wider community has repeatedly shown that there are more similarities than differences between those with high and low suicidal intent. Consequently, researchers have seldom relied on comparing the two groups as a means of differentiating those who progress to suicide from those who do not.

HEALTH SCREENING ON ARRIVAL IN PRISON

1.23 A primary defence against suicides in prisons is the widespread use of risk assessment and screening on reception. The nature of the relationship between the health care professional and/or prison officer conducting the screening, the conditions within the reception process, and the time constraints under which the screening is conducted, erode the effectiveness of the process.

1.24 The sensitivity and specificity of the instrument or technique used is central to the screening process. 'Sensitivity' refers to the ability of the person conducting the reception screening to detect a prisoner who is actually at risk of suicide. 'Specificity' refers to their ability to determine what the actual risk level is and what the contributing factors may be. Screening for suicide risk at reception is not particularly effective, with studies in remand prisons showing detection rates of 16 to 30 per cent for major risk factors (Butler, 1997). Reception screening is highly dependent on self-disclosure. Studies show that without staff asking direct questions, almost half of all prisoners screened failed to report serious risk factors at reception. This is because prisoners – like the general community – are largely unaware of key risk factors, are embarrassed or ashamed to admit them, or are intimidated or afraid to disclose them within the penal system. Studies in the community have shown that it may be possible to overcome this to some extent through direct and appropriate questioning (Pfaff, Acres & Wilson, 1999).

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Appendix 3

PERSONS, REPRESENTATIVES AND ORGANISATIONS WITH WHOM DISCUSSIONS AND CONSULTATIONS WERE HELD OR FROM WHOM SUBMISSIONS WERE RECEIVED

Families of deceased prisoners

Family members of all deceased prisoners were consulted by members of the Office during the Review. Chapter 4 – 'Case Studies and Analysis' – was distributed to all family representatives in draft form and comments received were assessed and acknowledged.

WA Police Service

The Officer in Charge of the Police Prison Unit was consulted during the preparation of this Report. Copies of the draft of this Report were also sent to the Commissioner of Police and the Officer in Charge of the Police Prison Unit, and the comments received were taken into account.

State Coroner's Office

The State Coroner, the Deputy State Coroner, Counsel Assisting and a member of the Coronial Counselling Service were all consulted. Verbal discussions and written comments from the State Coroner's Office in response to the Draft Report were taken into account.

WA Prison Officers' Union

Two formal meetings were held with the Secretary and Executive of the WA Prison Officers' Union. A formal response to the Draft Report was received and has been taken into account.

State Ombudsman

The State Ombudsman's Office was consulted.

The Office of the Inspector of Custodial Services' Community Reference Group

Members of the Community Reference Group were regularly briefed on the progress of the Review and copies of the Draft Report submitted to them for comment. Specific submissions were received from ATSIC, the Aboriginal Legal Service, the Deaths in Custody Watch Committee, Outcare, the Prison Fellowship of Australia, the Prison Reform Group of Western Australia and the Anglican Social Responsibilities Commission.

Hakea Prison Personnel

Discussions were held with the Superintendent and a wide cross section of management and other personnel at Hakea Prison, as well as representatives of the Staff Support Group. Discussions were also held with the Change Management Group. In addition, representatives of all relevant work groups were consulted at various times at Hakea, including the PCS Group, the Prisoner Support Officers, the Orientation Officers, the Reception Officers, the Bail Coordinator, staff in the Crisis Care Unit and zone managers, Health staff including

mental health nurses, the Aboriginal Visitors' Scheme personnel working at Hakea and various individual senior officers. Focus group discussions were also held with peer support prisoners. Written submissions and responses to the Draft Report were received from a range of such persons and are reflected in the Report.

Department of Justice

Wide ranging discussions were held with managerial personnel, including: the Director General; the Executive Director Prisons; the Department of Justice Suicide Prevention Coordinator; the project manager responsible for inquests; the Director of Prison Health Services; the Manager of the Internal Investigations Unit; the Director of Operational Services; Head Office personnel responsible for the Prison Counselling Service; the Manager of the Aboriginal Visitors' Scheme; and a wide selection of other persons associated with the management of the prison system. The responses of these persons to the Draft Report are reflected in the Department's overall response in Appendix 1.

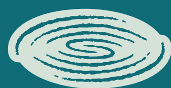
Other persons

Submissions were also received from the Chief Executive Officer of Lifeline WA; personnel from the Safer Custody Group of the UK Prison Service; the Derbarl Yerrigan Health Services; and the Noongar Alcohol and Substance Abuse Service.

Appendix 4

THE REVIEW AND INSPECTION TEAM

Professor Richard Harding	Inspector
Dr Alison Liebling	Expert Consultant
Mr Robert Stacey	Director of Operations
Mr Peter Upton-Davis	Senior Inspections Officer
Ms Lynn Atkinson (until August 2003)	Manager Research and Publications
Ms Jocelyn Jones (until January 2004)	Senior Research Officer, Special Projects
Mr Andy Fitzgerald (until June 2003)	Inspections Officer
Ms Natalie Gibson (until November 2003)	Inspections Officer
Mr John Acres	Inspections Officer
Ms Kerri Bishop (until August 2003)	Inspections Officer
Ms Leonie Sinclair (from August 2003)	Inspections Officer
Ms Diane Broadby	Coordinator, Independent Prison Visitors' Scheme
Mr Joseph Wallam	Community Liaison Officer



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