GOVERNMENT OF WESTERN AUSTRALIA

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

Directed Review into the Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody

March 2023

The Office of the Inspector of Custodial Services acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of this country, and their continuing connection to land, waters, and community throughout Australia. We pay our respects to them and their cultures, and to Elders, be they past, present, or emerging.

It is our standard practice to preserve the confidentiality of people in custody by not referring to them by their name in our reports. Where we use case studies to highlight our discussion, we either leave the person unnamed or apply a pseudonym so they cannot be identified. For this report we have strayed from this practice. All deaths in custody are tragic and to rightly reflect on the issues within this report, we believe their names are a vital part of the story. The inquests from which we have drawn our work are also publicly available and use the name of the deceased. As such we have chosen to refer to each person using an honorific and surname.

Reader advice: The following review contains the names of some Aboriginal and Torres Strait Islander peoples who have passed away. It also contains discussions on self-harming and suicide. Reader discretion is advised as some people may find the content of this report distressing.

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This report is available on the Office's website and will be made available, upon request in alternate formats.

Table of Contents

Inspector's Overview

Governance and oversight have improved considerably but there is more work to do

This review was commenced following a direction to me by the Minister for Corrective Services, the Hon. Bill Johnston MLA, under Section 17(2)(b) of the *Inspector of Custodial Services Act 2003* (WA). The objective of the review was to examine the Department of Justice's (the Department's) performance in responding to recommendations that arise from the Western Australian Coroner's inquiries into deaths in custody.

Following my acceptance of the direction, the Minister endorsed the draft terms of reference to examine deaths publicly reported on between 2017 and 2021 to determine the following:

- Does the Department implement recommendations made by the Western Australian Coroner appropriately?
- How effectively does the Department monitor its continued compliance with the recommendations made by the Western Australian Coroner?

In order to answer these questions, we selected a sample of closed recommendations and examined the evidence relied upon by the Department to close them, including looking at any changes implemented and their likely impact on preventing future deaths in custody. The details of these findings are set out in this report.

Overall, we found noticeable improvements in the governance and oversight processes, including independent oversight by the Department's Risk Management and Audit Committee, but there was more work required.

Not surprisingly, we saw significant similarities between the risks, issues and shortfalls identified by various Coroners and those identified during our inspection and review work. Common themes included: the adequacy of mental health services and supports available to prisoners; the availability of clinical and custodial staff resources; the level of appropriate staff training; and significant infrastructure limitations.

From our examination of the individual case studies, it was clear that the Department did not take the coroner's recommendations lightly. But it was hard not to form the view that in several cases the focus was more about closing the outstanding recommendation rather than implementing sustained change in a way that met the spirit and intent of the recommendation.

The Department's response to the draft copy of this report noted many of the concerns we had raised about closed recommendations. The Department also advised that more recently they had amended how they responded to coroner's recommendations. It appears they are now taking a more robust and pragmatic approach to proposed recommendations and their level of support is now balanced against what they feel is achievable and within resource limitations. They said they are also willing to proactively seek additional resources to address coroner's recommendations.

Unnatural deaths in custody are an absolute tragedy that have far reaching impacts for everyone involved, but none more so than for the families of those who pass. It is imperative that every preventative measure that is reasonably possible should be supported and implemented. Equally important is to ensure that preventative measures have a front-line impact and that adequate steps are in place to monitor and sustain those changes.

One unnatural death in custody is one too many, but one that could have been foreseen and prevented is entirely unacceptable.

Acknowledgements

It is important to acknowledge the contribution and assistance we received in undertaking this review from key personnel in the Department and at Serco, the private operator of Acacia Prison.

I acknowledge the contribution and hard work of the staff in our office who were involved in undertaking this review. I would particularly acknowledge and thank Cherie O'Connor for her hard work in leading this review and as principal drafter of this report.

Eamon Ryan
Inspector of Custodial Services

2 March 2023

Executive Summary

A directed review

Under Section 17(2)(b) of the *Inspector of Custodial Services Act 2003* (WA) the Minister for Corrective Services can direct the Inspector of Custodial Services 'to review a custodial service in relation to a prison or detention centre or a custodial service (CSCS Act) or an aspect of that service.'

On 24 September 2021 the Inspector of Custodial Services accepted the direction by the Minister for Corrective Services Hon. Bill Johnston MLA to undertake a review of the Department of Justice's (the Department's) performance in responding to recommendations that arise from the Western Australian Coroner's inquiries into deaths in custody. On 11 November 2021 the Minister endorsed the draft terms of reference to examine deaths publicly reported on between 2017 and 2021 to determine the following:

- Does the Department implement recommendations made by the Western Australian Coroner appropriately?
- How effectively does the Department monitor its continued compliance with the recommendations made by the Western Australian Coroner?

The approach we took

Between 2017 and 2021, the Coroner's Court has made 35 formal recommendations to the Department. One recommendation was noted and only one recommendation was not supported[1]. The 35 recommendations were from 13 inquests relating to 17 prisoners. Only two of these people were determined to have died from natural causes. One person died by way of an accident and the other 14 were determined to have been suicides.

To answer our terms of reference, we randomly tested a sample of 10 of the 35 coronial recommendations that had been directed to the Department, that were then supported, actioned, closed and verified. To test these recommendations, we requested the Department's closure evidence for each.

Deaths in custody must be reviewed by the Coroner

The *Coroners Act 1996* (WA) defines a person held in care as a person under, or escaping from the control, care, or custody of the CEO of the department of the Public Service principally assisting the Minister administering the *Prison Act 1981* (WA) or a person detained under the *Young Offenders Act 1994* (WA). In Western Australia, this is the Department of Justice.

Where possible, the Coroner investigating a death must find:

1. the identity of the deceased
2. how death occurred
3. the cause of death

1 The unsupported recommendation arose from the inquest into the death of Mr. Capper. Coroner Jenkin recommended the Department review the deployment of the Special Operations Group.

4. the information needed to register the death under the *Registration of Births, Deaths and Marriages Act 1961* (WA).

The Coroner can comment on matters connected with the death including public health or safety or the administration of justice and make recommendations aimed at preventing similar deaths from happening in the future. For people in custody, the Coroner must also comment on the quality of the supervision, treatment, and care they received while in custody. An annual report to the Attorney General on the deaths which have been investigated each year must be submitted by the State Coroner. This includes a specific report on the death of each person held in care.

The Coroner is also supported by the Western Australian Police who lead all investigations into the circumstances surrounding a death in custody.

Who has died in prison custody?

Between 2000 and 2021, 193 people died in prison custody in Western Australia. Approximately 60 per cent of these deaths (118) were from apparent natural causes. In these cases, either the State Coroner found the deaths occurred by natural causes, or enough evidence was available for the Department to determine a natural cause of death. The average age of a prisoner dying of natural causes was 56.3 years.

An apparent unnatural death is one which the Coroner has found to be caused by homicide, suicide, accident, or a drug overdose, or where the Department had enough evidence to determine the death occurred by unnatural means. About 38 per cent of deaths in prison custody since 2000 were from apparent unnatural causes (74), and 80 per cent of those were determined to be suicides.

The average age of a prisoner dying an unnatural death was 37.7 years, and slightly younger when examining those who took their own life (36.3 years).

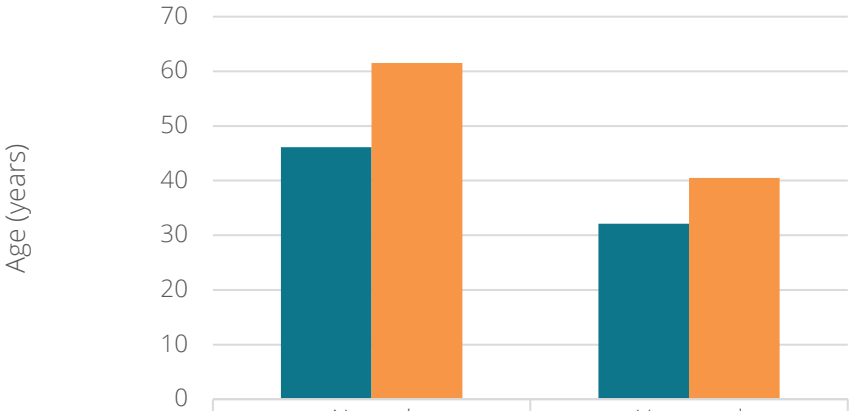
Table 1: The number and cause of deaths of people in custody in Western Australia (2000–2021)

Cause of death	Number of deaths
Apparent natural causes	118
Apparent unnatural causes	74
Accidental	9
Homicide	3
Suicide	59
Unknown	3
Unable to determine whether natural or unnatural causes	1
Total	193

Of the 193 deaths in custody, there was insufficient evidence for the Department to determine the cause of death for one prisoner who died at Acacia Prison in 2020. The Coroner has not yet held an inquest into this death (as of February 2023).

About 95 per cent of all deaths were for male prisoners. There were only nine female prisoners (4.7%) who died in custody, which is considerably lower than the average proportion of women in custody across that time (8.9%).

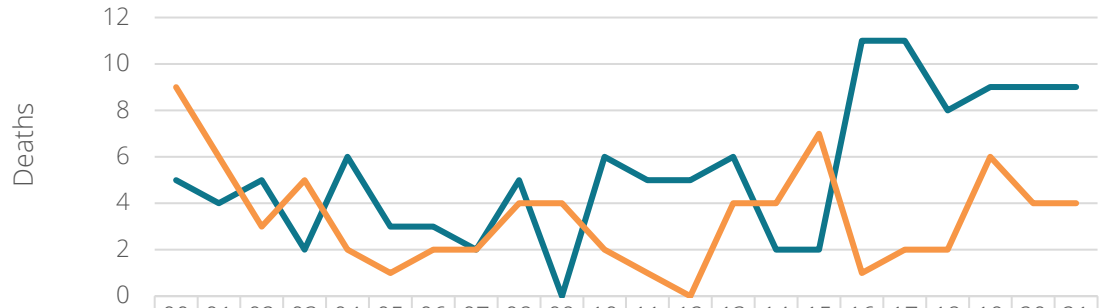
Just over one third of all deaths in custody were people identifying as Aboriginal (34.2%). This was consistent across both natural (33.9%) and unnatural causes (33.8%). The proportion of Aboriginal prisoners accounting for in-custody suicides was slightly higher at 35.6 per cent. Aboriginal people were also considerably younger at their time of death compared to non-Aboriginal prisoners.



	Natural	Unnatural
Aboriginal	46.1	32.1
Non- Aboriginal	61.5	40.5

Figure 1: Average age at time of death, by cause of death and Aboriginality (2000–2021)

Between 2000 and 2015 there was an average of 3.8 natural and 3.5 unnatural deaths per year, or about seven deaths in total. However, since 2016 the average annual total has increased to approximately 12 deaths per year. This presents as an increase in natural deaths (to an average of 9.5 per year) and a slight decrease in the average number of unnatural deaths each year (3.2).



	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
Natural	5	4	5	2	6	3	3	2	5	0	6	5	5	6	2	2	11	11	8	9	9	9
Unnatural	9	6	3	5	2	1	2	2	4	4	2	1	0	4	4	7	1	2	2	6	4	4

Figure 2: Number of deaths in prison custody (natural and unnatural causes), by year (2000–2021)

This increase in natural deaths aligns with the ageing prisoner population. The average age at death for prisoners who died in custody between 2000 and 2015 was about 46 years. This increased to 55 years for the 2016 to 2021 timeframe. The ageing of Western Australia's prison population is consistent with a trend being observed across Australia and abroad (OICS, 2021A).

Key findings

Governance is improving, but there is room for further progress

Since 2017, the Department has implemented a range of governance process improvements relating to the management of recommendations, internal audit activities and oversight practices.

Despite these changes, we still identified recommendations that had been closed with limited evidence of completion. We also identified opportunities to improve some processes and knowledge sharing to help prevent future deaths from occurring.

Frequent mental health recommendations highlight the crisis in prisons

Ten out of the 35 coronial recommendations related to improving the mental health care provided to prisoners. Mental health was also indirectly associated with many of the remaining 25 recommendations.

We tested four of these recommendations. We found the Department had made progress in some areas but remain concerned that some risks continue unmitigated.

Poor infrastructure increases risk of deaths in custody

Seven out of the 35 recommendations referred to infrastructure upgrades and investment. We tested two recommendations relating to ligature minimisation and other infrastructure changes at Broome Regional Prison and Casuarina Prison.

In both cases we found the Department made some progress to meeting the intent of the recommendations, but they were not fully implemented.

Limited staff training impacts both security and welfare

Eleven of the 35 coronial recommendations related to prisoner management, including general staffing and training for officers. We tested four recommendations that focussed on mental health, suicide prevention and critical incident training for custodial officers. The other recommendation sought to balance welfare and security considerations.

All four recommendations led to some limited changes in practice.

Conclusion

Despite governance processes being in place, we found the Department frequently closed recommendations without full implementation. Actions taken to improve processes and practices did not always meet the intention of the Coroner's recommendations, or at times only addressed them in part.

We recognise that the Department takes seriously its responsibility to prevent deaths in custody. It is hoped the findings of this report lead to changes that strengthen existing processes and help prevent future harm.

Recommendations

1 Governance is improving but there is room for further progress

1.1 Improvements have been made to the way recommendations are managed

Processes relating to the management of recommendations have improved since the amalgamation of the Departments of Corrective Services and the Attorney General in 2017, creating the Department of Justice (the Department). Internal audit activities, improved tracking of recommendations, formal recommendation follow-up procedures, and a more independent risk management committee have strengthened the Department's internal oversight.

Despite these changes, we still identified recommendations that had been closed with limited evidence that the associated actions had been completed or related to the intent of the recommendation. We also identified opportunities to improve some processes and knowledge sharing to help prevent future deaths from occurring.

Performance Assurance and Risk independently monitors the implementation of recommendations

The Performance Assurance and Risk (PAR) directorate is responsible for internal audit processes and activities, and embedding risk management capability across the Department. It provides independent assurance and risk management advice to the Director General, Corporate Executive and the Department's Risk Management and Audit Committee (RMAC).

One of PAR's core functions is to monitor the Department's implementation of internal audit and external agency recommendations, including those made by the Coroner's Court. To assist with this, the Department introduced a RiskShare Audit Recommendations Log (Audit Log) to track the implementation of recommendations. PAR is responsible for managing the Audit Log and liaising with relevant business areas in their monitoring and auditing function.

Formal recommendation follow-up processes have also been established to:

- monitor the actions taken by business areas to address recommendations made by internal audit processes and external oversight agency reviews
- ensure actions taken are effectively implemented and meet the intention of a recommendation
- ensure senior management have accepted the risk of not acting, where insufficient action has occurred.

These processes have been developed in accordance with the International Professional Practices Framework of the Institute of Internal Auditors and the *Western Australian Public Sector Audit Committees – Better Practice Guide* (OAG, 2020).

They have also recently introduced an initiative to issue automated reminders to business area managers 30 days before an action associated with a recommendation becomes overdue. Further reminders are issued every 30 days the action remains outstanding.

Additionally, PAR is responsible for reviewing all prisoner deaths reportable under the requirements of the *Coroners Act 1996*. Reviews are independent of business operations. All findings which lead to

business improvement initiatives are endorsed by the business area and then monitored through to implementation by the Corrective Services Performance, Audit and Risk Committee (PARC) and the RMAC. This report is also provided to the State Coroner and forms part of the coronial investigation.

All of these processes conducted by PAR assist the Department to maintain a focus on the implementation of coronial recommendations.

PAR's annual audit process helps provide assurance for closed recommendations

An annual audit process introduced by PAR helps provide an additional assurance layer for closed recommendations. Implemented in 2020, the process seeks to evaluate the 'adequacy, effectiveness and timeliness of actions taken by management' to provide assurance that actions 'have been completed as agreed and meet the intended purpose of the recommendation' (DOJ, 2020B, p. 2).

As part of this audit, evidence of implementing recommendations is scrutinised by:

- reviewing documentation and evidence
- interviewing relevant staff
- conducting tests to verify the effectiveness of actions taken (DOJ, 2020B).

We were provided examples of how this audit process functions, including evidence reviewed for the audit of one coronial recommendation that had been closed. While we are encouraged by the development of this process, we acknowledge that it is relatively new and can be improved further. It is hoped that the Department will use the issues identified in this report as impetus for continued reform in this area.

For instance, we note that the annual audit process introduced by PAR only applies to half of closed coronial recommendations. PAR uses risk ratings to determine what proportion of recommendations are scrutinised in their annual audit process. As the Department does not allocate coronial recommendations a risk rating, only 50 per cent of those completed and closed are tested by PAR, as per Table 2.

Table 2: Risk rating categories (follow-up on closed recommendations procedure)

Risk rating	Sample selection
Extreme	100% of completed and closed recommendations
High/Significant	100% of completed and closed recommendations
Moderate	20% of completed and closed recommendations (random sampling)
Low	No samples will be selected
No risk rating	50% of completed and closed recommendations (random sampling)

The Department explained that external agencies are responsible for determining the risk rating allocated to each recommendation. For example, the Office of the Auditor General (OAG) allocates a risk rating to its recommendations. Therefore, 100 per cent of OAG recommendations rated significant or above undergo PAR's audit process. Other agencies, including the Coroner's Court, do not attach risk ratings to their recommendations. In these cases, only 50 per cent of the recommendations are audited.

During the first annual audit in 2020, all coronial recommendations were audited as an additional assurance measure. However, we were advised this would not be the practice going forward.

Recommendation 1 – Ensure a 'High/Significant' or 'Extreme' risk rating is attached to coroners' recommendations so that PAR audits 100 per cent of coroners' recommendations in the annual audit process

Risk Management and Audit Committee provides additional oversight

The RMAC provides independent assurance to the Director General by overseeing and monitoring the governance, risk, control and assurance frameworks across the Department (DOJ, 2020A). We reviewed the minutes from 16 RMAC meetings between September 2017 and October 2021, and found they demonstrated a high degree of governance, which has also improved over time. The meeting minutes are clear, specifying the required actions, the actioning officer, and the due date.

Other improvements include:

- introducing an external chairperson and three independent members in June 2020
- audio-recording meetings to improve the accuracy of minutes
- noting delays to the implementation of recommendations, rather than simply changing due dates.

A robust and independent RMAC improves oversight and accountability around departmental processes, such as the implementation of coronial recommendations.

1.2 Despite improvements in governance, recommendations were often closed prematurely or with limited evidence of implementation

A death in custody is one of the most serious areas of risk for the Department. It follows then, that recommendations intended to prevent similar deaths from occurring should be robustly considered by the Department with a genuine commitment towards prevention. Unfortunately, we found the Department closed many coronial recommendations before the actions to realise the recommendation were completed.

For example, Coroner Jenkin recommended the Department 'consult with an expert in the field of mental health, to provide training to custodial staff, specifically in relation to common mental health disorders and anti-social personality disorders' (Jenkin M. , 2019B, p. 61). In August 2020, the Department noted it was developing a Staff Mental Health Training Framework and closed the recommendation. As of March 2022, the Department could only provide us with a seven-page draft of this framework. And, according to that draft, the proposed training is intended for clinical staff rather than custodial staff.

In other cases, we found the Department's actions did not meet the intent of the recommendation, or only addressed part of a recommendation. For instance, in the inquest into the death of five men at Casuarina Prison, the Department ignored the portion of the Coroner's recommendation that urged them to review light fitting in cells.

The Department also used existing initiatives to close recommendations. For example, in the death of Mr Jackamarra at Broome Regional Prison, Coroner Vicker recommended 'the promotion of active involvement of prisoners in caring for one another' (Vicker, 2019, p. 64). The Department supported the recommendation, noting it was an existing initiative. However, our inspection of Broome found

peer support prisoners have not received appropriate suicide prevention training (OICS, 2020A), limiting their ability to provide mental health support to their peers.

1.3 The Coroner's Court does not independently verify the Department's closure evidence

The Coroner's Court does not have the legislative authority to independently verify evidence used to close coronial recommendations. This emphasises the need for the Department to have robust internal audit practices in place.

Agencies such as our Office and the OAG can review implementation of coronial recommendations from time to time. For instance, this review is an example of our Office exercising our oversight capacity for coronial recommendations. However, it is not our primary responsibility to complete a systematic review of these matters.

Conversely, the Corruption and Crime Commission (CCC) and the Western Australian Ombudsman are responsible for closing recommendations they make to other agencies. They receive closure evidence from the relevant agency and decide on whether it adequately addresses the recommendation. If satisfied that compliance has been achieved, the recommendation will be closed. The Coroner's Court does not have this ability.

This issue was recently discussed by the Select Committee on the Coronial Jurisdiction in New South Wales (NSW Legislative Council, 2022). It was recommended that the *Coroners Act 2009* (NSW) be amended to give the Coroner's Court authority to require a response or follow-up response to an agency they have previously made a recommendation to (NSW Legislative Council, 2022). This 'follow-up' authority would give coroners additional oversight.

1.4 The Department does not track 'suggestions' from the Coroner

The Department no longer tracks suggestions from the Coroner. Inquest reports often contain findings and suggestions that may not warrant a formal recommendation but are worthy of consideration. For instance, the Coroner regularly acknowledges where the Department has already made improvements or commenced work in an area of concern. On such occasions, the Coroner may 'suggest' or 'urge' the Department to act rather than make a recommendation. The Department formerly tracked these suggestions, but it no longer does so.

We view this as a missed opportunity. Not following up these findings and suggestions altogether is a disservice to the work of the Coroner, and to the deceased.

For example, the inquest into the death of Ms Bolton resulted in no formal recommendations (Jenkin M. , 2019C). However, the inquest identified that it was widely accepted that the medical centre at Bandyup Women's Prison was not fit for purpose. Furthermore, Coroner Jenkin noted that 'given the CEO's statutory responsibilities in this area, the CEO should take urgent action to remediate the medical centre's many short comings' (Jenkin M. , 2019C, p. 35).

Similarly, in the inquest into the death of Mr Cruz the Coroner made no formal recommendations. But Coroner Linton suggested the Department review its policy into managing prisoners with a terminal illness (Linton, 2019).

And, in the inquest into the five men who died at Casuarina Prison, Coroner Jenkin commented on the link between Adverse Childhood Events (ACE) and increased risk of suicide (Jenkin M. , 2019A). Given this link, Coroner Jenkin commented that it would be appropriate for the Department to consider ACE in risk assessments made by custodial, counselling and clinical staff. He further suggested that the Department should incorporate a section on ACE into the Gatekeeper Training syllabus.

Other suggestions made in the inquest into the five deaths at Casuarina Prison are listed below.

- In-service training for prison staff about the features and effective management of personality disorders (including Anti-Social Personality Disorder) to be conducted by an experienced mental health practitioner as soon as possible.
- All prison staff responsible for assessing a prisoner's eligibility for the Support and Monitoring System (SAMS) view the criteria in the broadest possible manner and err on the side of caution.
- Adopting body worn cameras for staff working within the Special Handling Unit (SHU) (Jenkin M. , 2019A).

The Department advised it was currently investigating the viability and funding required to introduce body worn cameras into the SHU.

Recommendation 2 – Track and disseminate 'suggestions' made by the Coroner

1.5 Initiatives to pass on learnings do not always reach facilities

The Department produced its first *From Deaths We Learn* report for the 2019–2020 financial year. Inspired by a similar report produced by the Department of Health, the report summarises the deaths examined by the Coroner's Court each year. The report is published by PAR and includes key learnings and discussion points. It is a great initiative with significant potential to influence change.

However, at the time of writing, none of the facilities we visited were aware of the report. This is a missed opportunity. Many superintendents stated they would find the information contained in the report useful and were surprised that the Department was producing this document but not disseminating it. Unless facilities are provided the relevant information, it is difficult for them to learn from deaths in custody at other facilities and use this information to reduce the likelihood of similar circumstances occurring within their own facilities.

More broadly, we observed a general lack of knowledge and information sharing on deaths in custody. For example, Mr Purnell died at Bunbury Regional Prison in 2018 from organ failure. Mr Purnell had heart disease and had recently used Kronic, a synthetic cannabis (Linton, 2020). We were told that the learnings from the inquest were not passed on to other facilities. As a result, many facilities did not know they could test specifically for Kronic, nor did they know the potential impacts of Kronic on individuals with pre-existing heart disease. Another man had died after ingesting Kronic at Karnet Prison Farm just days before Mr Purnell, (Jenkin M. , 2021).

Case Study: Bunbury Regional Prison

The Senior Management Team (SMT) at Bunbury Regional Prison proactively encourage discussion and learning from coronial inquests. When an inquest report is released, a member of the SMT reads the report making note of the recommendations and any other relevant findings. The SMT then use this knowledge to make appropriate operational changes. The SMT also recognise that coronial inquests can bring closure for staff involved and that disseminating information may be re-traumatising. Care is taken to implement changes sensitively.

Several prison leaders told us that learnings from deaths in custody used to be discussed regularly at internal conferences and forums for superintendents. However, this no longer appears to be the case. Another facility told us that learnings were sometimes discussed during Prisoner Risk Assessment Group meetings, but that practice had also ceased. And, one superintendent told us the only information they received about a death in custody at another prison was when they received the critical incident report.

Embedding learnings from other facilities is essential if prisons are to reduce the likelihood of deaths occurring in custody. This is particularly the case for unnatural deaths. Where possible, learnings should be discussed locally within prisons and in department-wide forums.

2 Frequent mental health recommendations highlight the crisis in prisons

Ten out of the 35 coronial recommendations sought to improve the mental health care provided to prisoners. These often related to procedural improvements, for instance by introducing a triage system for those with known histories of self-harm or suicidal ideation; implementing better information sharing between prisons and community care organisations; and providing health staff better access to prisoner health records.

Mental health was also indirectly associated with many of the remaining 25 recommendations.

This focus was not surprising. In December 2022, almost 12 per cent of the adult and youth custodial population were categorised as having a psychiatric condition or requiring an assessment for a suspected psychiatric condition. Our office has long reported that mental health services for prisoners in crisis were inadequate and accessible support is often scarce (OICS, 2020B; OICS, 2018A; OICS, 2017A).

We acknowledge the work staff do to keep prisoners safe and the personal toll this can have on them each day. Custodial staff are not adequately trained, and clinical staff are under significant pressure.

We tested four recommendations relating to mental health. The Department has made progress in some areas, but we remain concerned that some risks remain unmitigated.

2.1 Mental health services 'patently inadequate'

The inquest into the five deaths at Casuarina Prison examined the suicides of five men occurring between October 2014 and November 2015. Under the *Coroner's Act 1996* the State Coroner directed that the deaths be investigated at one inquest. The inquest explored the quality of the supervision, treatment and care each of the individuals received while in custody. This included their access to mental health care and supports.

The inquest established that on both 31 December 2015 and 31 December 2018, there were six Psychological Health Services (PHS) staff at Casuarina; one clinical supervisor position and five counsellors (Jenkin M. , 2019A). Due to part time arrangements, there were only 5.6 full-time equivalent (FTE) positions (Jenkin M. , 2019A). The Department could not confirm if all these positions were filled between 2015 and 2018.

In 2015, the daily average population at Casuarina was 788 and the PHS counsellor-to-prisoner ratio was one to 140. By 2018, the population had increased to 943 and the ratio shifted to one counsellor for every 168 prisoners. While not all prisoners need the support of PHS at any given time, this ratio highlights the considerable pressure placed on counselling staff. This led Coroner Jenkin to conclude that those resources were 'patently inadequate' (Jenkin M. , 2019A, p. 37). As such, Coroner Jenkin made the following recommendation:

INQUEST INTO THE FIVE DEATHS IN CASUARINA PRISON – CORONER JENKIN

Casuarina Prison

Deaths occurred: October 2014, and February, August, September and November 2015

Inquest finding delivered: May 2019

Inquest Recommendation 1: **The Department should take urgent steps to recruit additional Prison Counselling Service [PHS] and mental health staff for Casuarina Prison and more broadly, should consider the appropriate level of [PHS] and mental health staff for prisons across the State.**

Department's response: The Department fully supports this recommendation and understands the high priority for increasing the number of [PHS] and mental health staff, not only for Casuarina Prison but more broadly across the Estate. We are actively preparing a business case and a strong model of care for patients with severe and persistent mental illness to increase the FTE for [PHS] and MH staff in the new builds at Casuarina and the growing muster across the estate.

Interim approval has been given to increase [PHS] at Hakea and Casuarina.

Department's level of support: Supported

However, it was not just between 2015 and 2018 that the PHS system had been under pressure. Our inspection of Casuarina Prison in 2010 found that access to counselling services was becoming a 'luxury' with demand considerably surpassing resourcing (OICS, 2010). And, in our most recent Casuarina inspection, we found that prisoners were primarily receiving reactive rather than proactive support (OICS, 2020C).

Other inquests have also highlighted the inadequacy of mental health resources. In 2017, similar recommendations were made in two separate inquests. Coroner Linton recommended the Department:

> … invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care (Linton, 2017B, pp. 21-22).

In the inquest of Mr Bennell, Coroner Linton also emphasised the importance of Aboriginal mental health workers (Linton, 2017A, pp. 49-50).

The Department's closure of the recommendation

Coroner Jenkin's recommendation to recruit additional mental health staff was closed on 16 December 2019, six months after the inquest was publicly released (Jenkin M. , 2019A). The Department's final update to the recommendation stated:

> [Psychological Health Service] … was allocated 9 additional FTE. This included; 6 for the metropolitan area, and 3 for regional areas. Resources will be allocated as follows: 3 FTE each to Hakea and Casuarina, and 1 FTE each to Albany, Bunbury and EGRP. The staffing of

> Casuarina currently includes: Clinical Supervisor (1 FTE), Prison Counsellors (5.4 FTE). In addition to this, two staff from Hakea work on rotation x1 a week to assist with referrals. (DOJ, 2019A).

The Department's evidence included a PHS establishment report from 8 October 2019. This showed that with the additional three prison counsellors at Casuarina, there would be nine positions (equating to 8.4 FTE). The Department's closure documentation also included evidence that the new positions were advertised in September 2019 and it was intending the positions to be filled by late 2019.

PHS ratios have continued to deteriorate as resources fail to keep up with demand

In 2022, the ratios at Casuarina Prison were effectively worse than prior to the inquest. While staffing ratios met the International Association for Forensic and Correctional Psychology (IAFCP) Standards when all positions were filled, five positions were vacant (IAFCP, 2010). This resulted in a ratio of one counsellor for every 235 prisoners – well above these standards.

The Department's closure evidence indicates that they took the necessary steps to close this recommendation. However, the primary purpose of coronial inquests is to prevent further deaths. Without regular monitoring of population numbers and prisoners needs, and the vacancy levels of the support positions at each prison, the Department risks losing any progress it may have made. The one-off investment in additional resources in 2019 has not ensured appropriate service delivery at Casuarina.

The Department established its ratios of PHS counsellors as per IAFCP Standards, which state the ratio of mental health professionals (defined as psychologists, counsellors and social workers) is one to 150-160 for the general prison population (IAFCP, 2010). For specialist drug treatment and mental health units the recommended ratio is one to 50-75. When we queried the Department on this, they noted:

> By comparison the average counsellor-to-prisoner ratio across DOJ prisons exceed these recommended staffing levels. The majority of sites also accommodate specialist units or populations (e.g. remandees, female, or confined prisoners). These populations would be considered to require additional staffing (e.g. 1:50-75). As such the numbers of staff to prisoner ratio does not meet the recommended levels (DOJ, 2021C).

Given the trauma histories of Aboriginal prisoners and the increased complexities associated with managing prisoners with a disability, we would argue that many of these prisoners should also be categorised as specialist populations. With the above parameters considered, up to 66 per cent of the adult prison population could be categorised as a 'specialist population'.

However, due to vacancies we found many facilities were not meeting the recommended staffing ratios. As of November 2021, the Department funded 42 FTE counsellors for the adult estate, including psychologists (15) and social workers (26). Bandyup Women's Prison and Casuarina Prison also employ an occupational therapist. Twelve positions were vacant. Two of the women's prisons, Boronia and Melaleuca, did not meet the specialist population guidelines.

Acacia Prison, privately operated by Serco, had a counselling staff to prisoner ratio of one to 180 at the time of the November 2021 inspection.

Table 3: FTE of counsellors ratios per facility (November 2021)

Facility	Prison counsellor positions (FTE)	Counsellor to prisoner ratio	Filled positions at November 2021	Actual counsellor to prisoner ratio
Albany Regional Prison	2.0	1: 154	1.0	1:308
Bandyup Women's Prison	3.6	1:60	3.6	1:60
Boronia Pre-release Centre	0.4	1:210	0.4	1:210
Broome Regional Prison	1.0	1:54	1.0	1:54
Bunbury Regional Prison	3.0	1:163.3	3.0	1:163.3
Casuarina Prison	10.0	1:118.1	5.0	1:236.2
Eastern Goldfields Regional Prison	2.0	1:112	1.0	1:224
Greenough Regional Prison	2.0	1:95	1.0	1:190
Hakea Prison	10.0	1:90.1	9.0	1:100.1
Karnet Prison Farm	1.0	1:354	0	1:354
Melaleuca Women's Prison	3.0	1:63.7	1.0	1:191
Pardelup Prison Farm	0	0:81		
Roebourne Regional Prison	1.0	1:201	1.0	1:201
Wandoo Rehabilitation Prison	1.0	1:50	1.0	1:50
West Kimberley Regional Prison	1.0	1:195	1:0	1:195
Wooroloo Prison Farm	1.0	1:372	1.0	1:372
	42.0	121.2	30.0	169.7

The Department acknowledges that unfilled PHS positions compromise capacity. This can increase risk in the management of vulnerable prisoners including those at risk of self-harm and suicide. Further, despite a higher number of threats and actual self-harm incidents in management units, there are no dedicated counsellor resources for these specialist populations.

Recommendation 3 – Ensure PHS is adequately resourced for all prisons across Western Australia

2.2 The Department's triage system misses the mark

During the inquest examining the five deaths at Casuarina Prison, a consultant psychiatrist gave evidence that within 24 hours of admission a mental health nurse should review all prisoners with a known history of self-harm or attempted suicide. Coroner Jenkin found that if a 'three ticks' triage process had been in place prior to the deaths of Mr Bell, Mr Cameron, JS (name suppressed) and Mr Wallam, they would have received mental health assessments. Under this triage system, prisoners with a previous history of suicide attempts, a family history of suicide, or a history of mental illness would receive a mental health assessment on reception.

While this triage process may not have altered the outcome for the above prisoners, a mental health assessment would have likely identified the prisoners at risk and referred them to the At-Risk Management System (ARMS) or the Support and Monitoring System (SAMS). The regular monitoring of prisoners on ARMS and SAMS reduces the opportunity for self-harm and suicide. Taking this evidence into consideration, Coroner Jenkin recommended:

INQUEST INTO THE FIVE DEATHS IN CASUARINA PRISON – CORONER JENKIN

Casuarina Prison

Deaths occurred: October 2014, and February, August, September and November 2015

Inquest finding delivered: May 2019

Inquest Recommendation 4: **The Department should consider introducing a "triage" system into prisons where all prisoners who have a known history of self-harm and/or suicide attempts are reviewed by a mental health professional within 24 hours of being received into prison. Consideration should be given to the use of video-conferencing facilities for regional prisons where mental health staff are unavailable.**

Department's response: All prisoners are assessed by a primary health care nurse upon reception into prison and are subsequently referred to mental health and [PHS] staff if assessed at risk for self-harm or suicide ideation. [PHS] staff will be introducing an evidenced based risk assessment screening tool for both self-harm and suicidality and are in the process of education and implementation for staff. This tool is currently utilised within correctional services internationally.

Department's level of support: Supported

The Department's closure of the recommendation

Our review found the Department's closure evidence for this recommendation was lacking. The Department's final update simply reiterated the initial response and did not outline any changes to practice. The closure evidence also stated that PHS staff had completed relevant training.

The 'triage system' recommended mental health practitioners review all known cases, and not just those referred to them. Coroner Jenkin stated, 'consideration should also be given to whether the triage system can be implemented using existing staff or whether additional staff will be required and if so, how many' (Jenkin M. , 2019A, p. 122). Despite supporting the recommendation, we did not identify any evidence the Department undertook any work to assess the impacts implementing this triage system would have on existing staff resources.

Although the policy has improved, it falls short without specifying a 24-hour timeframe

To seek further clarity, we asked the Department to outline the screening process for a prisoner with a known history of mental ill-health being transferred from a receival prison to Casuarina Prison. The Department outlined the following steps in its response.

- Patients received by transfer must as a minimum have their medical records reviewed by a clinician as soon as possible after receival.
- Mental health staff check the discharges and transfer list for any patient that are transferring to another site. For patients transferring to another facility, the mental health team email relevant information and documentation to the receival prison. Prisoners received at a receival prison are triaged by the primary care team, who send a task to the mental health team to follow up.

- Known mental health patients are placed on the mental health register. When transferred, prisoners are automatically transferred to the receival prison's mental health register.
- The night nursing staff at the Casuarina infirmary, review the last three months of notes for any prisoner transferred in during each day. They review future appointments in EcHO and follow up on incomplete tasks or re-book appointments when necessary. Nurses then send a task to the Senior Medical Receptionist to book appointments or task Mental Health Alcohol and Other Drugs (MHAOD) nursing (DOJ, 2022D).

Neither the Department's response, nor the policy document guiding these practices, ensures the 24-hour timeframe is followed (DOJ, 2020C). Rather, the policy states that '[a]ll patients received by transfer must have their medical records reviewed by a clinician as soon as possible after receival as a minimum' (DOJ, 2020C, p. 7)'. This does not meet the Coroner's recommendation.

A representative from Casuarina Prison told us they try to see prisoners within 24 hours. But the deadline was the 'gold standard' of care and was not always met, with staff shortages the key barrier. Casuarina has also been receiving an increasing number of remand prisoners, who had not yet been assessed, putting pressure on their already busy workloads.

However, components of the policy were leading to good practice. The policy states that patients with known mental health conditions are placed on the mental health register in EcHO, and the patient information is automatically transferred to the receiving prison when the prisoner is transferred (DOJ, 2020C). Furthermore, the policy sets out that infirmary night nurses check patients notes and follow up on any incomplete tasks. This appears to be an appropriate measure to improve the identification of patients with mental health histories and limit those falling through the cracks.

We were told that health care staff at Casuarina Prison have good relationships with staff at other prison health centres, which enables information sharing.

Recommendation 4 – Change policy to ensure that prisoners with a mental health history are seen by a mental health professional within 24 hours of reception

A risk averse approach and under-utilisation of SAMS placed prisoners at increased risk

Prisoners at risk of self-harm or suicide are managed according to the ARMS or SAMS processes. When we inspected Acacia Prison in November 2021, we found the Prisoner Risk Assessment Group (PRAG), responsible for managing those on ARMS or SAMS, was taking a risk averse approach (OICS, 2023). While this has obvious benefits for ensuring prisoner safety, prisoners told us that this had the potential to deter them from reporting feelings of self-harm or suicidal ideation for fear of being removed into an isolated observation cell and away from their supports within their unit.

In many of the inquests, coroners have identified that the person would have benefited being placed on SAMS (Jenkin M. , 2019A). Coroners have highlighted circumstances where prisoners missed out on SAMS placement because the criteria had been misinterpreted. For example, in the inquest into the five deaths at Casuarina Prison, Coroner Jenkin commented that JS may have benefited from being placed on SAMS (Jenkin M. , 2019A). This aligned with the Department's internal review which noted that due to JS's vulnerability he 'would have been an ideal candidate for SAMS' (Jenkin M. , 2019A, p. 93).

In 2020, Serco engaged the services of Professor Neil Morgan to review at-risk monitoring, including policies, procedures, practices and compliance. Professor Morgan's report was commissioned after the suicide of a young Aboriginal man on 11 July 2020 at Acacia Prison (Morgan, 2020). His death occurred after two other deaths at Acacia; an apparent natural cause death in June 2020 and an apparent suicide in June 2019. These deaths are yet to be investigated by the Coroner.

The review included health, mental health and Psychological Wellbeing Services and endorsed Coroner Jenkin's finding that SAMS should be better utilised (Morgan, 2020). Professor Morgan found that SAMS was generally underdeveloped and under-resourced (Morgan, 2020). Both Coroner Jenkin and Professor Morgan urged greater use of SAMS placements, and that the eligibility criteria should be interpreted in the broadest sense (Jenkin M. , 2019A; Jenkin M. , 2019B; Morgan, 2020).

Threats of self-harm are at times being interpreted as manipulation

The inquest into Mr Cameron's death identified occasions where health staff interpreted his threats of self-harm as 'manipulative' (Jenkin M. , 2019A, p. 16). The inquest found Mr Cameron's repeated threats of suicidal ideation were viewed as attempts to change his accommodation (Jenkin M. , 2019A). PRAG minutes to this effect included:

> ...Cameron uses threats of self-harm to manipulate his placement, this method is effective in achieving his needs, the PRAG team is aware of his manipulation and is working towards Cameron using other methods to achieve his needs.
>
> ...
>
> The threats made by Cameron are for manipulation of placement, this is consistent and ongoing.
>
> ...
>
> Remove from safe cell, remove from ARMS, threats made in an attempt to manipulate placement unrealistic demands on all staff (Jenkin M. , 2019A, pp. 62-63).

Despite Mr Cameron's extensive history of ARMS and SAMS placement and engagement with both the psychiatrist and counselling services, he was not in a ligature minimised cell when he died.

It is possible that some threats of self-harm may be an attempt by the prisoner to control their situation. However, officers and health professionals cannot reliably predict a prisoner's intention. Furthermore, a history of threats does not negate the validity and intent behind future threats. As noted in the inquest report, '[a]ccurately predicting the risk of suicide is... very difficult, and essentially impossible where that risk is chronic' (Jenkin M. , 2019A, p. 75).

All threats of self-harm should be taken seriously. The Department's ARMS manual states that staff should not dismiss threats but recognise that they may be an attempt by the prisoner to escape the situation or communicate emotions such as anger and frustration (DOJ, 2016). Despite this, we have also identified instances where staff have interpreted threats of self-harm as opportunities to manipulate placement or gain access to additional entitlements (OICS, 2022A; OICS, 2018A). It is

incumbent on the Department to ensure that all staff treat threats of self-harm seriously, regardless of any perceived or actual intention the prisoner may have to manipulate their situation.

2.3 A lack of information sharing can increase risk of death in custody

The 2019 inquest into the death of Mr Jackamarra at Broome Regional Prison found mental health information was not adequately communicated in his transfer from court custody into prison. Mr Jackamarra had been self-harming in the court cells after his appearance and was then transferred to Broome Regional Prison while awaiting bail. Coroner Vicker found there were limitations in his handover to the prison, noting that '[c]onfidentiality has no place where there is a duty of care to minimise risk' (Vicker, 2019, p. 59). Coroner Vicker recommended the following:

INQUEST INTO THE DEATH OF MR JACKAMARRA (ALSO KNOWN AS HAJINOOR) – CORONER VICKER

Broome Regional Prison

Deaths occurred: December 2015

Inquest finding delivered: May 2019

Inquest Recommendation 2: **Information sharing between medical, [PHS] and mental health services in prison and appropriate sharing of information between custodial facilities and organisations in the community caring for those with mental health issues.**

Department's response: The Department fully supports the sharing of appropriate information in accordance with the *Privacy Act 1988*. We currently share relevant information with State Forensic Mental Health Services in-reach transition team for care transfer and continuing care with community health services. Health and [PHS] staff have contributed to a review of the Policy Directive 85 (reception procedures), and made recommendations regarding information sharing procedures between prisons, courts, and community mental health services, where there is a concern about client risk to self or mental health issues following release from court or prison.

Department's level of support: Supported

The Department's closure of the recommendation

In response to the recommendation, the Department expanded the categories of health staff who can access the Department's health record system, EcHO. All clinical staff can now add records and access EcHO, including psychiatrists, doctors, general nurses, mental health nurses and all PHS staff. Existing staff were trained, and new staff receive training during their induction. This ensures health staff have access to necessary information to adequately care for at-risk people in their custody.

In its closure response the Department stated that the MHAOD team now also provide a transfer of care summary to community mental health providers. This process was said to be occurring estate-wide.

The Department also noted that it had reviewed Policy Directive 85 and recommended changes to improve sharing of information with community mental health services. However, we found limited evidence of this review occurring. When we asked the Department to provide a copy of the review and recommendations, its response differed considerably to the explanation provided in the closure documentation:

> A meeting was arranged between Operational Policy and Health Services to discuss any changes to [Policy Directive 85] on 24 June 2019. The discussion focused on medical screening, transport to medical appointments, and release if at risk however, the PHS referral process was discussed in relation to how they were made/ how ARMS referrals were received. It was agreed that court staff should be advised if a prisoner was at risk, so they would not be released without appropriate support from family or community services if needed.

There was no formal record of the meeting, as feedback was provided verbally to the Operational Policy division. Despite referring to recommendations as a result of this 'review', the Department could not provide these to us.

Without written documentation arising from this meeting, and the response we received, there is limited evidence of discussions and recommendations related to information sharing between prisons, courts, and community mental health services. This was the crux of the Coroner's recommendation.

Policy Directive 85 was eventually replaced with *Commissioner's Operating Policy and Procedure (COPP) 2.1 Reception* in June 2021 (DOJ, 2021B). The new policy is largely silent on information sharing between prisons, the courts and other external providers. Instead, processes for sharing information to external health providers and other third parties are contained in *COPP 9.6 Access to Information* (DoJ, 2021D). However, this is a one-way process and does not improve access to health information held by community providers required when a person is received into prison.

Good relationships aid information sharing with external health providers

Representatives at Broome Regional Prison told us that there are no formal information sharing agreements between local health service providers and the prison. Instead, health and mental health staff rely on good relationships they have built over time. This process is personality driven, not systemic in nature. While commendable that staff build positive relationships, it is vulnerable to collapsing when staff leave either the prison or the local health provider. This, in turn, presents health risks for the prisoner/patient. Essentially, this is a foreseeable risk that resulted in a coronial recommendation.

The Department does have a formal process where prison staff request a prisoner's physical and mental health records from external providers. However, we were told that this process was rarely used as it took too long for information to be received. A representative from Broome Regional Prison told us of an example where they requested the health records of a prisoner. They received the information 10 months after the initial request, long after the prisoner had returned to the community.

Professor Morgan also identified inadequacies in information sharing between the adult and youth justice systems and noted pre-existing relationships and personality differences as factors impacting the retrieval of information (Morgan, 2020).

2.4 Management prisoners involved in critical incidents do not routinely receive mental health assessments

Mr Anderson died in Hakea Prison in March 2017. The Coroner identified missed opportunities for mental health staff to assess Mr Anderson, who was serving a period of confinement after his involvement in a critical incident. This formed the basis of the recommendation:

INQUEST INTO THE DEATH OF MR ANDERSON – CORONER URQUHART

Hakea Prison

Death occurred: March 2017

Inquest finding delivered: December 2020

Inquest Recommendation 3: **A suitably qualified prison mental health staff member should conduct a mental health assessment as soon as it is practicable upon any prisoner who has been involved in a critical incident regarding violent behaviour or who has been the subject of punishment requiring placement in a specialised unit for disciplinary purposes.**

Department's response: The Department supports in principle the intent of the Coroner's recommendation however, it would be resource intensive for the MHAOD branch to review all critical incidents regarding violent behaviour and all prisoners subject to punishment within already constrained resources particularly where the incident may not relate to elements of mental health concern.

The Department will however aim to prioritise mental health assessments for those prisoners who have a known mental health concern and may be subject to punishment.

In addition, custodial staff receive mental health training to provide them with an understanding of mental illness and assists them in identifying early warning signs of mental illness. Should a custodial officer have concerns for a prisoner's mental health following a critical incident they are able to refer these prisoners to Mental Health staff for assessment.

Department's level of support: Supported in principle

The Department's closure of the recommendation

Despite supporting the recommendation in principle, the Department provided no documentary evidence when closing the recommendation. Management commented that while the Department supported the recommendation in principle, it would be resource intensive to implement. The Department's overview table then stated that 'approval for Closure Form not required as recommendation was closed prior to release of the final report' (DOJ, 2020D).

In commenting on Coroner Urquhart's draft recommendations, the Department also noted the challenges with the recommendation, including the broad range of situations that are viewed as critical incidents and the lack of mental health resources.

The Department stated that it would 'aim to prioritise mental health assessments for those prisoners who have a known mental health concern and may be subject to punishment' (DOJ, 2020D). However, as pointed out by the Coroner, Mr Anderson was not classified as a mental health patient at the time of his death. Therefore, it is unlikely that this change in practice would have altered the outcome for Mr Anderson.

Recommendation 5 – Include mental health assessments by a qualified mental health practitioner in applications to place prisoners on a confinement order

Recent policy changes have potential to improve mental health outcomes for prisoners

The Department has made other policy changes that may improve mental health outcomes for prisoners subject to disciplinary measures and separate confinement.

For instance, the Department's policy on separate confinement now requires a mental health assessment to occur at the earliest reasonable opportunity and at latest within 72 hours of a prisoner being confined (DOJ, 2021H). We were advised that this was the result of consultation and advice from the MHAOD team and the State Forensic Mental Health Services.

In 2021, the Department also operationalised *COPP 10.5 Prison Offences and Charges*. This policy:

- gives a superintendent the discretion to withdraw a charge where they feel the impact of a penalty may be overly detrimental to a prisoner due to their cognitive impairment or mental health condition
- allows a superintendent to suspend a prisoner's punishment confinement regime if a healthcare worker advises it is necessary for a prisoner's physical or mental health. The confinement restarts when they are determined fit to serve the remainder of their punishment (DOJ, 2021G).

We will continue to monitor the implementation and impact of these policies to see if they have the intended results.

Despite policy changes, no practical changes appear to have eventuated since the recommendation was closed

Following a visit to Hakea Prison in February 2022, we found there had been no substantial changes to practice after the recommendation was closed. We were advised that the best-case scenario would include a senior officer interviewing and assessing the prisoner and determining if a referral to ARMS was required. Despite changes to the policy, prisoners on confinement regimes who are involved in critical incidents are not routinely seen by a mental health professional, unless requested.

A senior representative also told us there had been no increase in mental health support to prisoners in Unit 1, Hakea's management unit. We were also told that staff who work in Unit 1

receive no additional training to identify and manage prisoners with mental health issues. It was suggested by the senior representative that a psychologist should be in every unit, but particularly in Unit 1. This appears to be a reasonable suggestion for the unit, given its volatility.

Our review into the use of confinement and management regimes found Unit 1 represented 6.4 per cent of Hakea's total capacity, but accounted for 45 per cent of all cell fire incidents and 37.8 per cent of use of force incidents across the facility (OICS, 2022A).

Recommendation 6 – Physically locate mental health staff in management units

Despite being closed, this recommendation has not resulted in any practical changes for prisoners who are at risk and the staff whose responsibility it is to manage them. The Department's closure evidence did not provide any documentation indicating it had sought any additional resources, training for staff, or make any practical change from what was happening when the Coroner made the finding and recommendation.

3 Poor infrastructure increases risk of deaths in custody

Seven out of the 35 recommendations referred to infrastructure upgrades and investment. This included increasing the number of safe cells, fast tracking ligature minimisation programs, and creating a subacute mental health unit at Bandyup Women's Prison.

Two of the recommendations we tested related to ligature minimisation and other infrastructure considerations at Broome Regional Prison and Casuarina Prison. These were supported by the Department. In both cases we found the Department made some progress to meeting the intent of the recommendation but did not fully implement the Coroner's recommendation.

3.1 Ligature minimisation can be an effective safeguard against prisoner harm

Coroner Jenkin's inquest into the five deaths at Casuarina Prison found that all five men died by way of suicide, with four of the men dying from ligature compression (hanging). Although mitigation strategies against suicide and self-harm, such as ligature minimised cells, do not always guarantee prisoner safety, they can be an effective safeguard. The inquest found that about 40 per cent of cells at Casuarina had some form of ligature minimisation. However, the Coroner agreed with evidence given by the Department that this was not enough (Jenkin M. , 2019A).

Coroner Jenkin also highlighted that none of the cells in the prison's orientation unit were ligature minimised at the time of Mr Cameron's death. This is despite these cells being designated for vulnerable prisoners. This prompted the following recommendation:

INQUEST INTO THE FIVE DEATHS IN CASUARINA PRISON – CORONER JENKIN

Casuarina Prison

Deaths occurred: October 2014, February, August, September and November 2015

Inquest finding delivered: May 2019

Inquest Recommendation 2: **The Department should increase the number of three point and fully ligature-minimised cells available at Casuarina Prison without delay. Priority should be given to those cells routinely used to house vulnerable prisoners (e.g.: the orientation cells in unit 5). In addition to increasing the number of ligature-minimised cells at Casuarina Prison, the Department should review whether the light fitting covers currently used in all cells at Casuarina Prison (and which are regarded as suitable for use in ligature-minimised cells) are fit for purpose.**

Department's response: The Department has completed full ligature minimisation in all of C Wing Unit 1 at Casuarina Prison. A total of 13 cells.

Current approved cell light covers are hardened polycarbonate specifically designed for prison cells and utilised throughout Australia and the large majority of WA Prisons. The light cover is engineered to withstand 'robust' conditions; however, no cover can withstand prolonged attack to failure.

Department's level of support: Supported

The Department's closure of the recommendation

The Department's closure evidence stated that they had fully ligature minimised 13 cells in C-wing of Unit 1 at Casuarina Prison. But it made no mention of Unit 5 – the prison's orientation unit.

The Department's closure evidence also did not include any reference to reviewing the light fittings used at Casuarina Prison. When we queried this, we were advised that the Department was 'not aware of any reviews or testing that has been conducted in relation to the light fittings for both 3-point and fully ligature minimised cells' (DOJ, 2022C). This ignores an important part of the Coroner's recommendation.

Recommendation 7 – Reconsider the Coroner's recommendation to review light fittings in cells

The increase in ligature minimised cells at Casuarina is due to new infrastructure and not retrofitting

As of March 2022, about 58 per cent of the 833 cells at Casuarina Prison were ligature minimised. This is an increase of nearly 20 per cent since June 2018. Nearly two-thirds (60.6%) of these were deemed to be fully ligature minimised and the remaining cells were three-point ligature minimised (39.4%).

As explained by Coroner Jenkin:

> Three-point ligature-minimised cells have the three most obvious ligature points (i.e.: window bars, light fittings and shelving brackets) remediated. Full ligature-minimised cells have all identified ligature points addressed (Jenkin M. , 2019A, p. 111).

Table 4: Number of ligature-minimised cells at Casuarina Prison

Unit (Wing)	Number of cells	Ligature minimised status	Purpose of cell
1 (A)	13	Full	Special Purpose Cell - Management
6 (B, C, D)	39	3-point	Standard Cell - Secure
8 (MPU)	4	3-point	Special Purpose Cell - Management
8 (MPU)	4	Full	Special Purpose Cell- Management
9 (SHU)	1	Full	SHU- Special Purpose Cell - crisis care/ observation, management
9 (A, B)	16	3-point	SHU - Special management cell- management
10 (C, OBS)	8	Full	Special Purpose Cell - infirmary
10 (B)	4	3-point	Special Purpose Cell - infirmary
11 (C, D)	12	Full	Special Purpose Cell - management/ observation
13 (A, B, C, D)	64	3-point	Standard Cell - Secure
14 (A, B, C, D)	64	3-point	Standard Cell - Secure
15 - Mallee (A, B, C, D)	64	Full	Standard Cell - Secure
16 (A, B, C, D)	64	Full	Standard Cell - Secure
17 (A, B, C, D)	64	Full	Standard Cell - Secure
18 (A, B, C, D)	64	Full	Standard Cell - Secure
	485		

However, to a large extent, the Casuarina 512-bed expansion project accounts for a large proportion of the recent increase in ligature minimisation. This project saw the construction of Units 15 – 18, which were all fully ligature minimised. The first of these opened in June 2020.

Progress in retrofitting existing cells to reduce ligature points has been much slower. In March 2022, the Department advised us that the ligature minimisation program was suspended due to site access issues as a result of COVID-19 restrictions. The Department expected the program to recommence as soon as practicable. Furthermore, the Department advised that its budget submission had not yet been approved for 2022-2023. The budget allocations for the ligature minimisation program were $500,000 per financial year.

While we applaud the Department's overall increase in ligature minimised cells at Casuarina Prison, we encourage them to expedite the retrofitting of existing cells to help prevent any future harm.

3.2 Broome Regional Prison is deteriorating, and a new prison is still years away

Despite only being in custody for only a few hours, Mr Jackamarra took his own life in the maximum-security ablutions block. As noted by Coroner Vicker, impulsivity is high in prisoners with mental health issues, and therefore, ligature minimisation and better CCTV coverage can minimise risk. As such, Coroner Vicker made the following recommendation:

INQUEST INTO THE DEATH OF MR JACKAMARRA (ALSO KNOWN AS HAJINOOR) – CORONER VICKER

Broome Regional Prison

Deaths occurred: December 2015

Inquest finding delivered: May 2019

Inquest Recommendation 3: **Effective CCTV and practical ligature minimisation. I am not suggesting CCTV directly into toilet or shower facilities, but good coverage on adjacent points may avoid issues to do with welfare. It is a sad fact that rarely in inquests are all relevant CCTV monitors operational.**

Department's response: The Department is currently undertaking a review of the location and numbers of CCTV within its major Metropolitan Sites. Hakea Prison has been completed and it is anticipated that Casuarina Prison will be next. Hakea Prison was located as the initial site as due to the works being undertaken in regard to the construction of the new Units, the location of additional CCTV has not yet been confirmed.

Any increase in CCTV would be subject to additional funding approval.

All monitors are considered to be a critical component of the sites security system and are repaired/replaced as and when breakdowns are reported by the site.

Department's level of support: Supported

The Department's closure of the recommendation

The Department's evidence used to close this recommendation included a review of the location and number of CCTV cameras at Hakea Prison, with the intent to examine other major metropolitan prisons. This resulted in a budget submission for a CCTV pilot project at Hakea Prison. While

conducting these reviews and enhancing capabilities at other sites is important, this does not address the Coroner's concerns about Broome Regional Prison.

The Department included no evidence in its closure documents that any steps had been taken to improve CCTV capabilities at Broome. It appears the Department simply used evidence of another project to justify closing this recommendation, which does not meet its spirit or intent.

Furthermore, the closure evidence ignores the Coroner's concerns about practical ligature minimisation at Broome Regional Prison.

Ongoing uncertainty about the future of Broome Regional Prison has led to a lack of investment

A decision to close Broome Regional Prison in 2013 had meant that no major works or investment into the facility occurred, despite it still operating. The prison operated as an annexe of West Kimberley Regional Prison until being reinstated as a standalone facility in 2016. Then in 2019, the State Government announced a new prison would be constructed. Throughout this time, the existing facility continued to hold prisoners but received limited investment into capital works. The Department was unable to provide us with any reviews into CCTV capacity at the prison, or any upgrades in CCTV equipment that had occurred since 2015.

In May 2022, the Minister for Corrective Services reiterated the need for a new facility and the long journey ahead, stating:

> We need to get out of the Broome prison as soon as we can, not before that. The Broome prison cannot function as a prison for much longer. Even after site selection, it will be years before we can execute the prison. We have approval from the Expenditure Review Committee only for planning; we do not have approval for construction… We are still years away from having a prison anywhere. In the end, we cannot use the current prison because it was first used as a prison in 1894 and it is past its use-by date. It does not provide security for the prisoners, for the workforce and certainly not for the Broome community and it is in the wrong location (Johnston, 2022, p. 7).

We understand that the Department has a responsibility to minimise large scale infrastructure expenditure at a facility it is intending to close. However, it also must ensure that the prisoners who are held there are safe and have adequate services. Our 2017 inspection found that the Broome Regional Prison was unfit for purpose, and in need of urgent investment (OICS, 2017C). We reiterated these concerns in our 2019 inspection, noting that while there had been improvements in some areas, acceptable conditions and services needed to be maintained (OICS, 2020A).

During our visit to Broome in April 2022, we were told the security cameras were operational and that there were at least 10 security cameras in the Maximum-Security Section (MSS). This was an increase since Coroner Vicker made her findings, although the prison was unable to advise us by how much.

Recommendation 8 – Ensure a minimum standard of infrastructure and services is maintained at Broome Regional Prison until the new prison is built

The minimum-security ablutions block still contains several ligature points

Mr Jackamarra died in the MSS shower block at Broome Regional Prison. During our 2019 inspection we commented that the ligature risks had been minimised in the MSS ablutions, but these risks were not addressed in the minimum-security area. We commented:

> The Department addressed the identified physical security risks associated with this death by refurbishing both MSS ablutions areas and minimising ligature points. But the ablutions in the minimum-security area, with the same identifiable risks, were not renovated. When we enquired about this, Broome staff were unable to advise us of the rationale. Arguably, minimum-security prisoners pose less risk as most are sentenced and settled. However, a minimum-security rating comes with a reduced level of supervision which, in times of distress, can be detrimental if prison staff are unaware of a prisoner's change in circumstance (OICS, 2020A, p. 6).

During our visit to Broome in April 2022, we found no further work had been completed on reducing ligature risks in the minimum-security area. We counted a minimum of 40 ligature points. A representative from the prison told us they were 'stuck with what they had', as the Department did not want to spend additional funds on a prison that was going to be decommissioned in the future.

The Department provided a list of 10 cells that had been ligature minimised and when this had occurred. These can be broken down into two types:

- fully ligature minimised: three multi-purpose cells designed to hold prisoners in need of crisis care or to regulate behaviour.
- 3-point ligature minimised: seven cells in Unit 4 (A and B wing).

The 3-point ligature minimised cells were completed in August 2012, and the multi-purpose cells were fully ligature minimised in August 2019. No additional cells have been ligature-minimised since this time.

This means that only the three multi-purpose cells were ligature minimised after the death of Mr Jackamarra, and after the Coroner's inquest.

Recommendation 9 – Remove ligature points in the minimum-security ablutions block at Broome Regional Prison

4 Limited staff training impacts both security and welfare

Eleven of the 35 coronial recommendations related to prisoner management, including general staffing and training for officers.

We tested four of these recommendations. They related to providing custodial staff with additional mental health training, enhanced suicide prevention training, and critical incident management training; and recognising the link between welfare and security. Two were supported by the Department, one was supported in principle and another was supported as an existing practice.

For all four recommendations we found that there had been limited practical changes to staffing capacity and training arrangements.

4.1 Training for personality disorders has not been implemented

Mr Capper died by suicide at Hakea Prison in 2016. He had a known history of mental health conditions, including anti-social personality disorder, polysubstance abuse and dysthymia (persistent mild depression). He had a history of self-harm, suicidal ideation and had been managed on ARMS at various times during his incarceration. Although he was not on ARMS at the time of his death (Jenkin M. , 2019B). Within this inquest, Coroner Jenkin noted the high rates of personality disorders among prisoners, and the limited resources and training staff have to manage these prisoners. As such, Coroner Jenkin made the following recommendation:

INQUEST INTO THE DEATH OF MR CAPPER – CORONER JENKIN

Hakea Prison

Death occurred: January 2016

Inquest finding delivered: November 2019

Inquest Recommendation 6: **The Department should consult with an expert in the field of mental health with a view to providing training to custodial staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.**

Department's response: The Department is developing the Staff Mental Health Training Framework and will take into consideration the recommendation provided.

Department's level of support: Supported in principle

The Department's closure of the recommendation

The Department supported this recommendation in principle, and it was closed in August 2020. The closure evidence included a memo approving recommendations from the Mental Health Review and approvals for two new governance positions.

The review into mental health recommended the Department:

- Realign the Prisoner Counselling Services (PCS), MHAOD nursing and Prison Support Services (PSS), including Aboriginal Visitors Scheme (AVS) to form a MHAOD branch reporting to the Deputy Commissioner Offender Services.
- Change of title of service from PCS to Psychological Health Services (PHS) to more accurately reflect the business.
- Review the roles and functions of staff working within the PSS team, to better align with the Mental Health and PCS teams, and to improve overall response from the branch.

This review addressed service structure, as opposed to the types and quality of training prison officers receive. It is difficult to see how the Mental Health Review addressed the Coroner's recommendation, as the two appear to have limited relevance to one another.

The Department's final update on its closure request document identified the two governance positions as a Consultant Psychiatrist Clinical Governance and Clinical Nurse Consultant Workforce. The document stated that the 'two roles will assist in providing clinical leadership as well as identifying and developing training needs' (DOJ, 2020E). Despite it being over two years since the recommendation was closed, neither position has been substantively filled and no such training has been developed.

The approval for the establishment of the MHAOD branch was granted in February 2020. In its response to our questions about the lack of training developed, we were also told that the 'onset of COVID generated further challenges for the Department' (DOJ, 2022B). While we acknowledge that COVID-19 has impacted all agencies, this does not negate the responsibility of the Department to fill these positions and facilitate much needed training.

Furthermore, as part of its closure evidence the Department said it was developing the Staff Mental Health Training Framework. We requested a copy of this framework and, as of March 2022, could only be provided with a seven-page draft. Given the time that has lapsed since the recommendation was closed, it is disheartening that the framework has not been developed further. But even if such a framework had been developed and implemented, it would not address the Coroner's recommendation. The framework applies to MHAOD staff, not custodial staff.

The Department closed the recommendation before completion and implementation of the framework. This may have resulted in limited oversight of its progression, which could explain the long delay.

Prison officers have not received additional mental health or personality disorder training

Coroner Jenkin identified a gap in the availability of mental health training accessible by custodial officers, including training related to anti-social personality disorder. However, since the death of Mr Capper over six years ago, no such training has been developed. This is unacceptable.

In February 2022, a senior representative from Hakea Prison told us that nothing had changed since the recommendation was made. They said that officers do not receive enough training to manage prisoners with mental health conditions. Further, they felt that the training officers did receive was

too generic. While this may be an anecdotal perspective, it shows some officers feel they are not being provided the skills and training to adequately manage the prisoners they care for.

Hakea staff stated they were not aware of any outcomes resulting from the development of the framework. This is not surprising, given the framework is still in draft. It appears this recommendation has been prematurely closed given the business area, in this case Hakea Prison, is unaware of any changes.

Recommendation 10 – Deliver anti-social personality disorder training to custodial staff

Prison officers do not feel adequately trained to manage prisoners with mental health issues

Between 2018 and 2022, only 36 per cent of prison staff we surveyed felt they received adequate mental health training. This was down from the previous round of inspections, where 43 per cent of officers felt they had received enough training. Perceptions of adequacy at Broome Regional Prison reduced from 57.1 per cent to 18.8 per cent. Casuarina Prison (-28.1%) and Melaleuca Women's Prison (-27.3%) also experienced large declines in confidence. These results suggest there are concerns with the quality or regularity of training being provided.

Table 5: Percentage of custodial staff who responded that they had adequate training in mental health

Facility	Sixth round (%) 2015 - 2019	Seventh round (%) 2018 - 2022	Percentage point difference
Acacia Prison	32.8	33.3	0.5
Albany Regional Prison	46.7	30.8	-15.9
Bandyup Women's Prison	28.6	41.3	12.7
Boronia Pre-release Centre	71.9	58.6	-13.3
Broome Regional Prison	57.1	18.8	-38.3
Bunbury Regional Prison	55.4	40.0	-15.4
Casuarina Prison	61.1	33	-28.1
Eastern Goldfields Regional Prison	44.2	30.2	-14
Greenough Regional Prison	23.9	33.8	9.9
Hakea Prison	36.1	28.8	-7.3
Karnet Prison Farm	15.9	24.5	8.6
Melaleuca Women's Prison/Melaleuca Remand and Reintegration Facility	58.8	31.5	-27.3
Pardelup Prison Farm	33.3	33.3	0
Roebourne Regional Prison	8.1	36.4	28.3
Wandoo Rehabilitation Centre	48.9	74.2	25.3
West Kimberley Regional Prison	63.8	51.4	-12.4
Wooroloo Prison Farm	56.9	44.4	-12.5
Total	43.0	36.2	-6.8

However, some facilities did see some improvement. Roebourne Regional Prison increased from a very low baseline of 8.1 per cent to 36.4 per cent. Wandoo Rehabilitation Centre and Bandyup Women's Prison also saw large improvements.

Only three facilities had a response rate of greater than 50 per cent of staff identifying they had adequate training.

4.2 Access to suicide prevention training remains an issue

The Gatekeeper Program is a two-day suicide prevention training program designed to give staff the skills to identify at-risk prisoners and make referrals to ARMS or SAMS where appropriate. Evidence at the inquest of the five deaths at Casuarina Prison indicated that the content of the program was 'very informative' (Jenkin M. , 2019A, p. 18). However, it was suggested that 'a greater emphasis on the custodial environment (as opposed to risk in the general community) would enhance the program' (Jenkin M. , 2019A, p. 18). The Gatekeeper Program is delivered as part of initial training for new prison officers, and it is occasionally made available to small groups of peer support prisoners.

The Coroner also urged the Department to 'ensure that staff receive refresher training in the Gatekeeper program on a regular basis' (Jenkin M. , 2019A, p. 19). This formed the basis of the recommendation seven:

> The Department should consider further enhancing its Gatekeeper training program to ensure that it is primarily focussed on risk in the custodial setting. Consideration should also be given to including additional guidance for relevant custodial staff (e.g.: reception officers) on conducting self-harm and suicide risk assessments. Gatekeeper refresher training should be conducted for all staff on a regular basis (Jenkin M. , 2019A).

The Department's closure of the recommendation

The Department's response to the recommendation outlined that the Gatekeeper Program was not developed by the Department, but the Ministerial Council for Suicide Prevention. This Council no longer exits, and Gatekeeper is now managed by the Mental Health Commission (MHC). The Department's response outlined the focus of the Gatekeeper Program as developing 'a deeper understanding and knowledge of suicidal behaviour, the skills and confidence in identifying, assessing risk and intervening with suicidal people' (DOJ, 2019D).

The response elaborates that the program is 'co-delivered by a clinician and a non-clinician (custodial officer) who contextualises to the custodial environment via scenarios and relevant examples to the work place as required' (DOJ, 2019D).

The recommendation was closed on 8 June 2020. Despite this, we found little evidence that the Department had addressed all the concerns highlighted by Coroner Jenkin. There were two core components to the recommendation:

- consider enhancing the content of the program to focus on risks in the custodial setting
- provide regular refresher training for staff.

The evidence provided by the Department included the timetables of four Entry Level Training Program (ELTP) cohorts. These showed that each cohort was scheduled for the two-day Gatekeeper Program. While this demonstrates that new recruits were scheduled to participate in the Gatekeeper training during their ELTP, it does not relate to the concerns of the Coroner in making this recommendation, particularly about refresher training for existing staff.

INQUEST INTO THE FIVE DEATHS IN CASUARINA PRISON – CORONER JENKIN

Casuarina Prison

Deaths occurred: October 2014, February, August, September and November 2015

Inquest finding delivered: May 2019

Inquest Recommendation 7: **The Department should consider further enhancing its Gatekeeper training program to ensure that it is primarily focussed on risk in the custodial setting. Consideration should also be given to including additional guidance for relevant custodial staff (e.g.: reception officers) on conducting self-harm and suicide risk assessments. Gatekeeper refresher training should be conducted for all staff on a regular basis.**

Department's response: The Suicide Prevention - Gatekeeper training program is a generic program developed by the Ministerial Council of [sic] Suicide Prevention. It is designed to cover the needs of a range of professionals and paraprofessionals e.g. nurse, teachers or prison officers who have direct contact and management of offenders.

The focus of the two-day course is to develop a deeper understanding and knowledge of suicidal behaviour, the skills and confidence in identifying, assessing risk and intervening with suicidal people.

In the custodial setting, the program is co-delivered by a clinician and a non-clinician (Custodial Officer) who contextualises to the custodial environment via scenarios and relevant examples to the work place as required. The program does not cover specific procedures/processes such as reception procedures.

Outside of the Entry Level Training Program (ELTP) for new Prison officers, the delivery the Suicide Prevention – Gatekeeper training is not currently funded, and the refresher requirements are yet to be determined.

The ELTP trains participants in the "At Risk Management System", as well as Reception Procedures and in taking [sic] of new offenders. Particular focus is placed on the importance of conducting reception "intake risk assessments". The Total Offender Management System (TOMS) training covers how to access offender alerts and how to conduct checks on deactivated alerts. Every alert within any status - including remand and historical sentences is always permanently recorded on TOMS. At the point of reception all of the previous history and de-activated alerts are accessible to staff through the individual prisoner's TOMS profile. The only exclusion is when receiving officers do not check for an existing TOMS ID number to correspond with the entry point warrant.

TOMS and Reception Procedures training is available through the local Satellite Trainer on a needs basis.

Department's level of support: Supported

Despite evidence of an attempt to address the recommendation, no change eventuated

The Department's closure evidence included an email which showed attempts to progress a one-day refresher course for existing officers, which would be contextualised to the custodial environment. However, this training did not eventuate.

The Department's final update explained that in April and May 2019, the Corrective Services Training Academy had been in consultation with the Gatekeeper Suicide Prevention Coordinator, who worked in association with the Mental Health Commission (MHC). The Coordinator informed the Department that the Gatekeeper Suicide Prevention Training Reference Group drafted a tailored Suicide Prevention Gatekeeper package. This new package was 'designed to maximise delivery efficiency and make it more relevant to the custodial setting' (DOJ, 2020H).

However, the Coordinator position was abolished, and the associated duties were not apportioned to another position. The Department then contacted the MHC, who advised it to continue to deliver the existing two-day format.

The Department's final update in part states:

> In the present operational training environment, rigor is applied to the contextualisation by the non-clinician co-facilitator (prison officer) to ensure the scenarios are included to contextualise the delivery to address the required focus around the related suicide "risk in a custodial setting" (DOJ, 2019D).

While the evidence of the Department's engagement with the MHC may satisfy the Coroner's direction to 'consider' the recommendation, the situation in practice remains unchanged.

It is positive that the Department considered the recommendation had merit and took steps to implement it. We accept there may be factors outside the Department's control. However, by closing this recommendation, it effectively means the issue 'falls' off the agenda. This may reduce the likelihood of the Department re-engaging and seeking other means to achieve the core components of the recommendation.

Recommendation 11 – Re-engage with the Mental Health Commission in an effort to secure contextualised and ongoing Gatekeeper training for custodial staff

Peer support prisoners also missing out on Gatekeeper training

Peer support is part of the Department's secondary prevention mechanisms against suicide (DOJ, 2021F). As outlined in the Department's ARMS manual, the goal of the peer support scheme is:

> To influence the prison community in a way which reduces the level of distress and the incidence of self-harm (DOJ, 2016, p. 19).

As acknowledged in the manual, prisoners may feel more comfortable talking to other prisoners, rather than staff. However, this is can involve a considerable degree of risk and responsibility for peer support prisoners, especially if a prisoner discloses thoughts of self-harm or suicidal ideation.

Because of this, it is important that peer support prisoners receive adequate and appropriate training. However, this has not been routinely occurring.

We commented on the lack of access peer support prisoners have to the Gatekeeper program in our most recent inspections of Melaleuca Women's Prison and Wooroloo Prison Farm (OICS, 2021B; OICS, 2022C). In both reports we recommended the Department provide training for peer support prisoners. In its response to the Wooroloo recommendation, the Department stated:

> The [MHC] is in the process of realigning the Gatekeeper training and has confirmed training will be delivered to the Department. Initial focus will be on train the trainer to establish a cohort of facilitators. It is anticipated Gatekeeper training will be rolled out to the Peer Support Program in 2022 (OICS, 2022C, p. 67).

In 2022, we again recommended the Department expedite the delivery of mental health training for peer support prisoners (OICS, 2022D). In response the Department advised that:

> Gatekeeper training for the Peer Support Team took place on 20 and 21 December 2021 at Casuarina Prison facilitated by internal DOJ staff. Additional training for staff and prisoners is planned for other sites in 2022. (OICS, 2022D, p. 25).

Mental health is important to get right in terms of service provision. Having a volunteer support base of peer support prisoners is positive but comes with risks if they are untrained. It is encouraging to see this training begin to roll-out. Without adequate training and support, vulnerable prisoners may be at a greater risk of self-harm and suicide.

4.3 Few senior officers receive critical incident management training

During the inquest into the death of Mr Capper, Coroner Jenkin criticised how the incident prior to his death was managed. Mr Capper had barricaded himself in the day room and blocked the windows with wet bags. Officers engaged with Mr Capper and tried to gain access to the day room. However, Mr Capper took his own life before access was obtained. The Coroner highlighted the chaotic scenes throughout the incident, including the noise, lack of leadership, and staff milling about (Jenkin M. , 2019B). This conclusion was supported by the Department's own internal death in custody review.

Noting that Senior and Principal Officers receive very little training to manage critical incidents, the following recommendation was made:

> In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should consider providing critical incident management training to its senior custodial officers (i.e.: senior officers and above) (Jenkin M. , 2019B).

INQUEST INTO THE DEATH OF MR CAPPER – CORONER JENKIN

Hakea Prison

Death occurred: January 2016

Inquest finding delivered: November 2019

Inquest Recommendation 5: **In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should consider providing critical incident management training to its senior custodial officers (i.e.: senior officers and above).**

Department's response: The Department provides first responder training to all staff through the entry level training program. Incident Management Team training is identified as a key deliverable as part of the enhancement of Security and Response Services across the state.

Prisons currently conduct live and desktop emergency management exercises to practice and validate their preparedness.

Department's level of support: Supported

The Department's closure of the recommendation

In order to close this recommendation, the Department relied on evidence that facilities had completed emergency management exercises, both at Hakea and in the wider prison estate. Overall, the Department had achieved a compliance rate of 99 per cent. The Department's policy states that each mandatory exercise should be completed at least once a year (DOJ, 2020F).

However, emergency management and critical incident management are not the same. Coroner Jenkin made this recommendation as senior and principal officers need to have the skills and training to manage these critical incidents (Jenkin M. , 2019B, pp. 50-51). The Department's response does not acknowledge the greater responsibility on senior and principal officers in managing critical incidents, and therefore, their need for additional training.

To close the recommendation, the Department noted that live 'death in custody' training and desktop exercises had occurred. This evidence pertained to a single live 'death in custody' emergency management exercise in 2020 at Hakea Prison. However, only five senior officers participated in this exercise, and two of these were the training officers.

In 2020, Hakea had 56 senior officer positions for an average population of 1,002 prisoners. At the rate of training three senior officers each year, excluding the two senior training officers, it would take over 18 years for all senior officers at Hakea to receive this training.

The Department's evidence also included training records of a single 'death of a prisoner within a prison' desktop exercise conducted at Casuarina Prison. However, the positions of the officers involved were not documented.

We acknowledge that Coroner Jenkin did not specify critical incident management training only in relation to deaths in custody (Jenkin M. , 2019B). On querying whether senior and principal officers

received other training in managing critical incidents, the Department stated that all custodial staff, including senior and principal officers, receive incident management training via the following means:

- the Entry Level Training Program
- prison-based desktop and live scenario testing conducted in accordance with *COPP 13.4 – Emergency Management Exercises* (DOJ, 2020F)
- incident reporting guidance included in *COPP 13.1 – Incident Notifications, Reporting and Communications* (DOJ, 2020G).

In 2021, the SOG also delivered local incident management training and the role of a forward commander on a trial basis to Hakea Prison and Karnet Prison Farm. Consideration is being given to the inclusion of this training as part of the Department's Emergency Management Framework.

We acknowledge that skills learnt in different emergency management training scenarios are likely to be transferable between one another. However, there is insufficient evidence to suggest that the specific training needs of senior and principal officers in managing critical incidents has been met.

Recommendation 12 – Ensure all senior officers receive regular critical incident management training

Some opportunities for further development exist

There is an expectation that senior officers provide leadership and management, especially during critical incidents. Senior officers need to competently manage and effectively deal with situations while waiting for SOG deployment, or in situations where the SOG will not be deployed or cannot attend in a timely manner, such as in regional locations.

The Corrective Services Training Academy runs the Assistant Senior Officer Program (ASOP) course, designed to develop the leadership skills of future senior officers. The course provides training in skills such as critical incident management, leadership and setting up an incident control facility. However, capacity is limited. Hakea staff told us that they are only able to send two staff on each course and that completing the course does not guarantee the participant a position as a senior officer.

Still, we are encouraged that these opportunities for developing skills exist. The ASOP has been running since 2016 and each program has 30 participants, all of whom must be an assistant senior officer to be eligible to apply. Participants from regional prisons have their travel and accommodation costs provided while undertaking the program.

Officers can also take on higher duties as a senior officer, which helps strengthen their skills.

4.4 Vacancies limit prisoner access to support services

Mr Jackamarra was a high-risk prisoner, at chronic risk of suicide and known to destabilise quickly. Given these facts, Mr Jackamarra would have been a prisoner in need of monitoring and support. However, at the time of Mr Jackamarra's death, the prison was facing uncertainty and instability. Broome was an annexure of West Kimberley Regional Prison and staff had been advised the site

would be closing and they would need to relocate to Derby. Coroner Vicker commented on this, stating:

> This [had] resulted in a seriously unstable situation for prison officers in both their work and private lives; in addition to working in conditions unsuitable for the inmates and requiring them to do the best they could with poor to no services and resources, including organising [Broome] visits from Derby, over 200 kilometres away (Vicker, 2019, pp. 6-7).

During this period of uncertainty, many prison officers felt unsupported. As explained by Coroner Vicker, 'prison officers cannot be expected to adequately provide all functions necessary for both security and welfare without appropriate support' (Vicker, 2019, p. 7). This led to the following recommendation:

> Realisation on behalf of custodial services that welfare and security go hand in hand. I appreciate that prisons are involved in security on behalf of the community, but destabilised prison populations due to successful suicides are distressing for all concerned, staff and other prisoners, and can rapidly become a security issue of itself (Vicker, 2019, p. 64).

The Department's closure of the recommendation

The Department closed this recommendation noting that it was an existing departmental initiative. The closure document stated:

> Additionally, the business area has responded that the "existing practice completion dates can be closed off straight away in accordance with the response addressing the recommendation in full with no defined future actions being applicable" (DOJ, 2019B).

The wording of the recommendation allowed the Department to respond in a broad nature. The information did not directly relate to Mr Jackamarra or Broome Regional Prison, and links between the recommendation and the Department's response were opaque. It is important to note that there have been longstanding resourcing issues with many of the support mechanisms noted in the Department's response.

For example, the Department included information about the Aboriginal Visitor Scheme (AVS) and peer support system (DOJ, 2019C). However, there was no information about the functional status of the AVS and peer support in Broome at the time the recommendation was closed. While the Department may have these support systems in place, there was no evidence provided to demonstrate they were resourced sufficiently and were consistently meeting demand.

In 2019, we identified that the AVS and prison support officer positions at Broome Regional Prison were only filled on a part time basis (OICS, 2020A). We concluded that this was not meeting demand and recommended the Department implement a full support service to meet the needs of Aboriginal prisoners.

During this review, we asked the Department how many Aboriginal Visitors were employed in May 2019 when the inquest findings of Mr Jackamarra's death were delivered. Instead we were provided with the total number of AVS employees, employed per year between 2018 and 2022.

INQUEST INTO THE DEATH OF MR JACKAMARRA (ALSO KNOWN AS HAJINOOR) – CORONER VICKER

Broome Regional Prison

Deaths occurred: December 2015

Inquest finding delivered: May 2019

Inquest Recommendation 6: **Realisation on behalf of custodial services that welfare and security go hand in hand. I appreciate that prisons are involved in security on behalf of the community, but destabilised prison populations due to successful suicides are distressing for all concerned, staff and other prisoners, and can rapidly become a security issue of itself.**

Department's response: The Department agrees with the Coroner that welfare and security go hand in hand and is committed to the security and safety of offenders in custodial facilities and the community.

The Department's aim is to ensure a safer community by focusing on –

- the security of detainees and prisoners in correctional facilities and offenders on community based orders;
- the safety of staff;
- the safety of offenders, detainees and prisoners; and
- rehabilitation

Prisoners are assessed and allocated to accommodation compatible with their assessed risks and needs to ensure their safety and security and the good order of the facility.

Prisoners are supported to address their primary health, mental health and social care needs through facilitated access to appropriate services, including rehabilitative programs, individual psychological interventions, suicide prevention, prison counselling and support services, and health and mental health services.

Prisoners who are identified as being at risk of self-harm are placed under a management regime appropriate to their level of risk and individual needs to ensure their well-being.

The Department's At Risk Management System (ARMS) and the Support and Monitoring System (SAMS) are part of a multi-disciplinary suicide prevention strategy that provides a 'whole of prison' approach to prevent and manage prisoners facing acute risk of self-harm or suicide.

Prisoner support is also available under the Peer Support Scheme which is a suicide prevention initiative that provides prisoners with support from their peers who are trained to identify and assist those managed on ARMS and SAMS and those experiencing difficulty while in custody.

The Aboriginal Visitors Scheme facilitates assistance and support to Aboriginal prisoners from Aboriginal visitors in their local areas.

The Department is also committed to supporting the wellbeing of staff through de-briefs and support programs such as the Employee Assistance Program (EAP) and Staff Support that can be accessed by staff experiencing personal and/or work-related problems.

Department's level of support: Supported – Existing Departmental Initiative

The information provided by the Department indicated a total of 42 individuals were employed by the AVS at some point in time in 2019, as either a visitor or coordinator. However, this information is not an accurate representation of how AVS was functioning at the time.

For instance, the data provided does not specify how long an individual worked for the AVS during the year or if employees took periods of leave, leaving facilities without an AVS presence. Without accurate information regarding staffing, we cannot be sure that the allocation of FTE positions was adequate to warrant the closing of the recommendation in 2019.

Prisoners are still not able to access the AVS

According to the Department's response to the recommendation, the AVS 'facilitates assistance and support to Aboriginal prisoners from Aboriginal visitors in their local areas' (DOJ, 2019B). Yet, in March 2022, over half (15 FTE) of the 27 AVS positions across Western Australia were vacant.

Table 6: Department provided positions and vacancies in AVS (as at March 2022)

Facility	Position	No. FTE filled	No. FTE vacant	Daily average population (Mar '21 – Mar '22)
Albany Regional Prison	Visitor (1)	1	0	308
Bandyup Women's Prison	Visitor (2)	1	1	216
Banksia Hill Detention Centre	Visitor (0.7)	0.7	0	112
Boronia Pre-release Centre	No funded positions			84
Broome Regional Prison	Visitor (1)	0	1	53
Bunbury Regional Prison	Elder (Casual) (1) Visitor (1)	1 0	0 1	490
Casuarina Prison	Visitor (4)	2	2	1,179
Eastern Goldfields Regional Prison	Visitor (1)	0	1	224
Greenough Regional Prison	Elder (Casual) (1) Visitor (1)	1 0	0 1	190
Hakea Prison	Visitor (Long- term leave) (1) Visitor (2)	1 2	0 0	898
Karnet Prison Farm	No funded positions			354
Melaleuca Women's Prison	Visitor (3)	1	2	189
Pardelup Prison Farm	No funded positions			81
Roebourne Regional Prison	Visitor (1)	0	1	201
Wandoo Rehabilitation Prison	Visitor (Casual) (1)	0	1	50
West Kimberley Regional Prison	Visitor (1)	0	1	194
Wooroloo Prison Farm	Visitor (1)	0	1	372
Unspecified	Elder (Casual) (1) Visitor (Casual, Regional) (1) Visitor (Casual, Welshpool) (1)	1 0 0	0 1 1	-
Total	26.7	11. 7	15	5,195

This included six facilities with no AVS positions filled. Concerningly, four of these have a high proportion of Aboriginal prisoners. We understand there had been an arrangement (but this has recently ceased) where the AVS visitor for Acacia Prison also visited Wooroloo on occasion. There are no AVS positions allocated to Boronia Pre-release Centre, Karnet Prison Farm, and Pardelup Prison Farm.

There are also discrepancies between the level of service among facilities. For example, between March 2021 and March 2022, the AVS conducted 1,356 visits at Casuarina Prison but only 231 visits at Acacia Prison. This is despite both facilities having a similar daily average population. And, in April 2022, the Department informed Acacia they would no longer be providing AVS services to the prison.

The Department claimed this was due to limited resources and contractual obligations for Serco to provide such services.

Prisoners can also access the AVS via telephone. However, our experience during inspection processes tell us that this model of service is not well received by prisoners.

Table 7: Number of individual AVS visits (Q1 2021 – Q2 2022)

Facility	Q1 2021 (March only)	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Total
Acacia Prison	27	57	58	53	36	231
Albany Regional Prison	26	67	83	77	47	300
Bandyup Women's Prison	89	276	197	228	83	873
Banksia Hill Detention Centre	216	411	411	260	131	1,429
Boronia Pre-release Centre	No funded position					
Broome Regional Prison	95	165	0	32	0	292
Bunbury Regional Prison	0	13	62	54	94	223
Casuarina Prison	98	342	248	411	257	1,356
Eastern Goldfields Regional Prison	0	0	0	0	0	0
Greenough Regional Prison	15	34	4	1	0	54
Hakea Prison	80	306	192	224	161	963
Karnet Prison Farm	No funded position					
Melaleuca Women's Prison	48	223	20	120	11	422
Pardelup Prison Farm[2]	3	7	1	7	4	22
Roebourne Regional Prison	0	0	0	0	0	0
Wandoo Rehabilitation Prison	3	5	0	0	0	8
West Kimberley Regional Prison	0	0	0	0	0	0
Wooroloo Prison Farm	2	16	10	15	19	62
Total	702	1,922	1,286	1,482	843	6,235

The AVS is one of the key recommendations arising from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991). It is incumbent on the Department to ensure the service is available to all prisons in Western Australia.

We understand that the Department undertook an internal review of the AVS in 2019, but the review was not finalised. We were told that another review is underway.

Recommendation 13 – Ensure AVS positions are filled across the prison estate

Vacant Prison Support Officer positions increase the risk of prisoner self-harm and suicide

As of March 2022, there were 20 (19.5 FTE) Prison Support Officer (PSO) positions across the estate. One of the duties within the PSO role is to lead the peer support program which, like the AVS, was introduced in response to the Royal Commission into Aboriginal Deaths in Custody. It was identified that an individual's risk of suicide was greatly reduced when there was access to peer prisoners (RCIADIC, 1991). They were found to be a valuable support to their peers, as they were available outside core hours and could provide a friendly, familiar face.

The Department relies on PSOs and peer support prisoners as a key suicide prevention mechanism. However, four of 20 PSO positions were vacant in March 2022, including one at Albany Regional

[2] The Peer Support Officer from Albany Prison visits Pardelup Prison Farm on a fortnightly basis to provide a level of coverage.

Prison, Bandyup Women's Prison, Bunbury Regional Prison and Roebourne Regional Prison. Further, Boronia Pre-release Centre, Broome Regional Prison and Pardelup Prison Farm do not have an allocated FTE for a PSO, making them reliant on PSOs at other facilities.

The Department must ensure that PSO vacancies are filled and there is adequate coverage in every facility if its role in reducing unnatural deaths in custody is to succeed.

Similarly, Serco must also ensure that the peer support program at Acacia Prison functions well. At the time of the Acacia inspection in November 2021, there were no PSOs on site. One position had been vacant for most of the year and another was on an extended absence. This was having a major impact on how the peer support team was functioning.

Psychological Health Services are overstretched

In its closure evidence the Department relied on ARMS and SAMS as part of their suite of welfare measures, demonstrating it understood that 'welfare and security go hand in hand' (Vicker, 2019, p. 64). The objective of ARMS is to 'enable a high quality of care to be given to prisoners who are identified as being at possible risk of self-harm or suicide' (DOJ, 2016, p. 2). The SAMS system is designed to monitor and provide psychological care for prisoners who are at chronic risk of self-harm or suicide, or those who are otherwise vulnerable (DOJ, 2016).

We have been repeatedly told that the workload of PHS staff is largely occupied by managing prisoners on ARMS and SAMS (OICS, 2018B; OICS, 2020C; OICS, 2022B). This is especially true at larger metropolitan facilities where prisoners with mental health concerns are typically transferred to from across the estate. Those facilities include Acacia Prison, Bandyup Women's Prison, Casuarina Prison, Hakea Prison, and Melaleuca Women's Prison.

The daily average population across the custodial estate between 2017 (6,674) and 2021 (6,600) has remained relatively stable. But during this period, the average daily number of prisoners being managed on SAMS increased by 25.8 per cent and the number managed on ARMS increased by 11.6 per cent. Despite this, the report by Professor Morgan and Coroner Jenkin's report into the five deaths at Casuarina Prison have identified instances where chronically at-risk prisoners were not being placed on SAMS (Jenkin M. , 2019A; Morgan, 2020). Supporting this recommendation, but closing it based on existing practice, is disingenuous. The intent of this recommendation has not been met by the various mechanisms cited by the Department. And, it has not made any changes which could potentially prevent a further death in custody.

Prisoners continue to miss out on rehabilitative programs

The Department relied on its suite of welfare and rehabilitative supports as part of its evidence to close this recommendation. The Department stated:

> Prisoners are supported to address their primary health, mental health and social care needs through facilitated access to appropriate services, including rehabilitative programs, individual psychological interventions, suicide prevention, prison counselling and support services, and health and mental health services (emphasis added) (DOJ, 2019B).

Our Office has consistently reported on the obstacles prisoners face when attempting to access programs. We have made these findings across several inspection reports and during reviews of specific cohorts, such as protection prisoners and survivors and perpetrators of family and domestic violence (OICS, 2017B; OICS, 2017C; OICS, 2017D; OICS, 2016B; OICS, 2018C; OICS, 2022D; OICS, 2022E).

More critically, an independent review of the Department's programs found many did not demonstrate efficacy (Tyler, 2019).

Given these findings, it is unclear how the Department could have had reasonable confidence in stating that the delivery of programs was a means to addressing this aspect of Coroner Vicker's recommendation. The Department has closed the recommendation without making any meaningful change or improvement.

Recommendation 14 – Ensure criminogenic programs that are delivered demonstrate efficacy

Response to Directed Review:

Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody

December 2022

Response Overview

Introduction

The directed review into the *Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody* (the Directed Review) was announced by the Office of the Inspector of Custodial Services (OICS) on 15 November 2021. A wide range of documentation, statistics and access to systems, policies, processes, custodial facilities including staff and prisoners were made available to OICS upon request for the purpose of the review.

On 28 October 2022, OICS provided a debrief on the review findings and on 14 November 2022, the Department of Justice (the Department) received the draft report on the Directed Review for comment. The draft report highlighted the key findings and made 14 recommendations. The Department has reviewed the draft report and provides comments and responses to the recommendations as outlined below.

Appendix A contains further comments linked to sections in the report for the Inspector's attention and consideration.

Review Comments

The Department provides a crucial public service to the community through its administration of the State's courts, custodial facilities, community corrections, and youth justice systems. All aspects of the Department's operations are subject to numerous reviews, audits, and investigations on an annual basis to ensure the quality and integrity of the services it provides.

These activities are performed by various assurance providers, including but not limited to, the Office of the Auditor General, the Corruption and Crime Commission, the Ombudsman WA, the Coroner's Court of WA, OICS and the Department's Performance Assurance and Risk (PAR) directorate. In total, 292 recommendations were made to the Department in the 2021-22 financial year and 1,090 recommendations over the past five years.

The Department's management of these recommendations has evolved over the years, particularly following the amalgamation of the former Departments of Corrective Services and the Attorney General, into the Department of Justice in July 2017. Changes to processes across the Corrective Services division and within the PAR directorate has further refined how recommendations are managed, including their implementation, monitoring and subsequent closure.

The amalgamation coincided with the Department's implementation of a recommendation tracking system *RiskShare*. This, together with a reinvigorated governance process has enabled recommendations to be recorded, responsibilities assigned, and progress monitored and reported to the Department's Risk Management and Audit Committee. The closure of recommendations is also tracked through *RiskShare* with the appropriate evidence and approval/verification process in line with the Department's Managing Recommendations Process.

The Department takes deaths in custody very seriously and places great importance on recommendations made by the Coroner. It draws the basis for each of the recommendations from the Coroner's record of investigation to assist in identifying targeted solutions to address the intent of the recommendations.

The Department is open to recommendations that will improve the safety and wellbeing of people in its care. It is however often faced with significant challenges implementing recommendations due to the inherent complexities of the prison environment, those in our care and limited resources available.

In the past the Department had a practice of supporting all coronial recommendations prior to undertaking a cost/feasibility assessment and before consultation with external relevant stakeholders. This resulted in an accumulation of recommendations that were unable to be achieved, including major infrastructure developments and long-term Department-wide strategies that required significant funding and resources, and could take several years to implement.

The Department now works with the State Coroner to identify solutions that are achievable within resourcing capabilities. In addition, the Department is proactive in requesting additional resources that are critical for the fulfillment of Coronial recommendations.

Since the closing of the Coronial recommendations reviewed by OICS, the Department has also initiated a number of suicide prevention strategies to better manage at-risk and vulnerable prisoners. These have taken effect through the establishment of a dedicated suicide prevention project that aims to improve the safety and wellbeing of these prisoners; reduce incidents of suicide and self-harm; and improve the Department's focus on prevention and safer custody in line with the State's Suicide Prevention Strategy. The Department has also set up a Suicide Prevention Taskforce to provide support, guidance and oversight of progress on project achievements and outcomes.

The suicide prevention project includes a review of the At-Risk Management System (ARMS) for prisoners and the governance processes around the decisions made by the Prisoner Risk Assessment Group (PRAG). Extensive training is being provided to the PRAG Chair and staff involved in the decision-making process.

The Department has expanded its ligature minimisation program to address opportunistic self-harm through a program of ligature removal, retrofitting ligature-proof fixtures in existing cells and ensuring that new builds are based on ligature-minimised standards. As ageing facilities such as Broome Regional Prison are decommissioned and replaced with new builds, the cells will be ligature minimised as a standard.

The Department has a budget of $1.5 million across three years, ending in the 2022/23 financial year, for its ligature minimisation program. Given the limited budget available, it is not possible to cover all cells or locations and priority is given to facilities with the highest risk and need. The Department continues to actively seek additional resources to further extend the program across all facilities.

The Department has also established a lessons-learned process whereby workshops are held following an unnatural death in custody. The intent of the workshops is to examine the circumstances of the death in custody with a view to identifying opportunities that will improve the safety of prisoners in the Department's care and to reduce the likelihood of future deaths in custody.

The 10 coronial recommendations examined by OICS for the purposes of this review were submitted for closure based on circumstances and actions taken to address the recommendations at the time, noting that changes to policy, strategic direction and the current environment may warrant further action.

The Department has supported 11 of the 14 recommendations made by OICS and has identified further actions that will be taken to implement these recommendations.

The PAR directorate will perform a one-off audit of all closed coronial recommendations in its next annual follow-up audit. This will include previously audited recommendations, reinforcing the need to have recommendations not only appropriately closed, but with adequate management monitoring controls in place so they remain closed.

PAR, as the internal audit function of the Department, has also committed to continue with the methodology of sample testing 50 per cent of closed Coroners' recommendations strictly in accordance with the Institute of Internal Auditors Standards and Treasurer's Instruction 1201-2.

Response to Recommendations

1 Ensure a high / significant or extreme risk rating is attached to coroners' recommendations so that PAR audits 100 per cent of coroners' recommendations in the annual audit process.

Level of Acceptance: Supported in Principle
Responsible Division: People, Culture and Standards
Responsible Directorate: Performance Assurance and Risk

Response:

Assurance providers who make recommendations to the Department regarding deaths in custody are responsible for allocating a risk rating to those recommendations.

For example, the Office of the Auditor General (OAG) allocates a risk rating of significant, moderate, or low to its recommendations. The Coroner's Court of Western Australia does not assign a risk rating to its recommendations in regard to a death in custody. It is noted that OICS also does not assign risk ratings.

In the conduct of internal audits, risk rating and sampling are conducted strictly in accordance with the *Institute of Internal Auditors' (IIA) Standards and Treasurer's Instruction (TI) 1201-2.* As such, PAR cannot allocate a risk rating to the recommendations of an external body, only doing so for its own issued recommendations. PAR has also a higher level of coverage (50 per cent) than what is the internal audit practice for sample testing. It is noted that this compares well with the OICS sample tested of 10 out of 35 coronial recommendations (29 per cent).

Considering the findings in this report, PAR will take an additional assurance measure as was done in the first audit in 2020 by performing a one-off audit for all closed coronial recommendations in the next annual follow-up audit. This will include previously audited recommendations, reinforcing with management the need to have recommendations not only properly closed but with adequate monitoring controls in place so they remain closed. Moving forward, PAR will continue with the methodology of sample testing 50 per cent of closed coroners' recommendations in line with PAR's internal audit role.

2 Track and disseminate 'suggestions' made by the Coroner.

Level of Acceptance: Supported in Principle
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The Department is subject to numerous reviews, inspections, inquiries, and audits each year by a range of independent external oversight bodies including the Coroner, the Office of the Auditor General, the Corruption and Crime Commission, the Ombudsman WA and OICS.

These activities result in a significant number of recommendations being made. A total of 292 recommendations were made to the Department in the 2021-22 financial year and 1,090 recommendations over the past five years.

The Department welcomes the independent oversight and the recommendations and suggestions that are made to improve the quality and integrity of the services it provides

While suggestions made are acted upon where possible, the Department currently does not track suggestions as formal recommendations.

Noting the importance of the suggestions made by the Coroner, the Department will assess the feasibility of adopting a mechanism that will assist in formally tracking and disseminating these suggestions.

3 Ensure PHS is adequately resourced for all prisons across Western Australia.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The Department recognises the importance of Psychological Health Service (PHS) resources in prisons and the critical role they play in providing mental health and counselling support to people in custody.

Over the years, the Department has increased PHS positions across the custodial estate. However, recruiting to these positions has been challenging due to the specialised nature of the role and the shortage of clinical staff in health and mental health care.

Since 2017, PHS staffing levels increased by 15.5 FTE to meet the increasing demand, and these positions were allocated to various prisons based on need. Vacancies, however, affect the ability to maintain an appropriate level of service. The Department continues to submit business cases for additional resources, including:

- dedicated PHS resources to operate the Alcohol and Other Drugs Rehabilitation Program (Mallee Unit) and a new Mental Health Unit at Casuarina; and
- an Expenditure Review Committee (ERC) submission as part of the 2023/24 budget process to address key deficits in PHS resources, primarily at Hakea and Casuarina Prisons.

Vacancies continue to be monitored and recruitment carried out to ensure adequate PHS resources are maintained across prisons. Referrals made for counselling services are being monitored daily and prioritised for contact. To reduce the waitlist and associated risk, group interventions and telehealth consults have also been held.

The Coroner's original recommendation was closed in 2019 having demonstrated significant efforts to recruit counselling staff and successfully filled 80 per cent of positions at the time of closing the recommendation, with further recruitment processes underway.

4 Change policy to ensure that prisoners with a mental health history are seen by a mental health professional within 24 hours of reception.

Level of Acceptance: Supported in Principle
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

Due to the demand on mental health professionals, all prisoners are assessed by primary health care nurses within 24 hours of reception to identify their health needs, including mental health, and make referrals to mental health specialists.

The senior health and mental health practitioners within the Department also have access to the Department of Health's Psychiatric Services Online Information Service (PSOLIS), which is the state-wide mental health services database that contains information on a person's mental health history. This information is also used as part of the assessment process.

The Department is seeking to improve the triage process for prisoners with known histories of self-harm and/or suicide ideation through an updated health and mental health model of care. As part of this work, consideration will be given to the practice of mental health staff conducting initial assessments within 24 hours of reception.

5 Include mental health assessments by a qualified mental health practitioner in applications to place prisoners on a confinement order.

Level of Acceptance: Supported in Principle
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

It would be resource intensive and not feasible for mental health assessments to be conducted by qualified mental health practitioners as part of the application process for separate confinement.

COPP 10.7 Separate Confinement requires mental health assessments to be conducted at the earliest reasonable opportunity and at the latest within 72 hours following the prisoner's placement in separate confinement.

Section 5.1 Application Process of COPP 10.7 requires Superintendents to consider the impact separate confinement may have for prisoners with vulnerabilities (i.e., disability, mental health conditions), including those on the At-Risk Management System (ARMS) or Support and Monitoring System (SAMS), and those under medical observation. This is reflected in the application, including management strategies for managing their mental health needs as part of their regime.

The Department acknowledges this recommendation is a repeat of recommendation 5, made in the Review into the Use of Confinement and Management Regimes, tabled in Parliament on 22 November 2022.

6 Physically locate mental health staff in management units.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

Due to the demand on mental health resources and the challenges faced recruiting these resources, it is not practical for mental health staff to be permanently located in management units.

Custodial unit infrastructure does not provide the appropriate office and consulting space required by mental health staff. In addition, mental health staff are not trained custodial officers and would require an increased presence of custodial staff to ensure their safety and security while performing day-to-day duties.

Mental health staff make every effort to visit prisoners in management units daily to ensure their ongoing mental health needs are being met. PHS has a weekly booking to see prisoners referred from the management unit, creating care plans and informing custodial staff as to the specific needs of the individual, as well as an assessment of risk and any concerning factors to be aware of. Custodial staff can contact PHS (nursing, psychology and prison support services) at any time should there be a need to attend sooner.

Vacancies continue to be monitored and recruitment processes are ongoing, with a further ERC submission being made as part of the 2023/24 budget process for additional FTE.

7 Reconsider the Coroner's recommendation to review light fittings in cells.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corporate Services
Responsible Directorate: Procurement, Infrastructure and Contracts

Response:

The Department utilises vanguard correctional light fittings in all prison cells, which are ligature approved. These have previously been tested with a selection of tools and objects found within a compliant cell and against 'obvious ligature reduction' requirements. The Department has committed to a further review of light fittings as part of the ligature minimisation program.

While it is acknowledged that light fittings may become vulnerable when exposed to heat and fire sources, prisoners are not permitted to possess items which generate heat/fire (e.g., heaters, lighters, electrical items) unless the appropriate security checks and risk assessments have been conducted. The Department is also transitioning to smoke-free facilities where the possession of lighters will become prohibited.

The Department is ultimately reliant on security and searching controls in place to prevent light fittings from being manipulated or damaged by unauthorised items which compromises its ligature-approved status.

8 Ensure a minimum standard of infrastructure and services is maintained at Broome Regional Prison until the new prison is built.

Level of Acceptance: Supported – Current Practice
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

While Broome Regional Prison has significant infrastructure limitations due to the age of the facility, the Department is committed to undertaking critical and regular maintenance. For example, recent maintenance undertaken includes installation of a replacement kitchen roof and moisture barrier.

The prison has also strengthened its surveillance monitoring to enhance the safety and security of prisoners through the installation of additional CCTV cameras across the facility. Essential offender services will continue to be provided for the working life of the prison.

9 Remove ligature points in the minimum-security ablutions block at Broome Regional Prison.

Level of Acceptance: Not Supported
Responsible Division: Corporate Services
Responsible Directorate: Procurement, Infrastructure and Contracts

Response:

The Department has expanded its State-wide ligature minimisation program, retrofitting ligature proof fixtures in existing cells as far as possible across all facilities with the funding made available, and ensuring that cells as part of new builds meet the ligature-minimised standards.

The number of potential ligature points is an issue for all prisons in the custodial estate. The Department has a budget of $1.5 million across three years, ending in the 2022/23 financial year, for its ligature minimisation program. Given the limited budget available, priority is given to facilities with the highest risk and need.

Whilst improvements to reduce ligature points in high-risk areas within Broome Regional Prison, including the maximum-security ablutions block have been made, the minimum-security ablutions block is not included in the current ligature minimisation program.

Furthermore, the Department utilises other controls to ensure the safety and wellbeing of prisoners such as continued monitoring through the ARMS and SAMS processes and referrals to PHS staff for additional support as required.

10 Deliver anti-social personality disorder training to custodial staff.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

Prison officers are required to undertake mandatory annual training, including training on managing prisoners with various challenging and complex human conditions, specifically in relation to mental health and behavioural issues. The training includes:

- communication and de-escalation;
- trauma informed approaches;
- offender manipulation and deception (grooming);
- psychology of the offender;
- Mental Health First Aid; and
- Mental Health Commission (MHC) online modules.

Anti-social personality disorder (ASPD) requires a clinical diagnosis that recommends calm, receptive, and non-judgmental communication as best practice strategies for managing people with ASPD. These techniques are frequently used by prison officers for managing various common prisoner behaviours, as addressed in Module 3 (Communication) of the MHC online training.

Although there are no specific references to ASPD in the Mental Health First Aid or MHC online modules, these training programs address a comprehensive range of common mental health illnesses and disorders, including the strategies and techniques for effectively communicating and managing prisoners with challenging behaviours and personality traits which are common in those with ASPD.

Prisoners that are clinically diagnosed with ASPD are managed by prison officers in collaboration with mental health staff, who undertake risk assessments of prisoners to formulate a targeted support plan.

11 Re-engage with the Mental Health Commission in an effort to secure contextualised and ongoing Gatekeeper training for custodial staff.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

As part of the Suicide Prevention Project, the Department is working in collaboration with the MHC to improve gatekeeper training, including the development of a program tailored specifically for delivery in a custodial setting. The feasibility of refresher training is also being considered as part of this process.

It should be noted however that the development and implementation of a revised gatekeeper program for the Department is dependent on support from the MHC.

In the interim, the Suicide Prevention Project has secured Suicide Prevention Training from Lifeline which is being rolled out across the Prison Estate for prison-based staff

further sessions to follow. Feedback on the training has been positive and well received. Online training is also being revised with the new updates anticipated to be rolled out in 2023.

12 Ensure all senior officers receive regular critical incident management training.

Level of Acceptance: Supported in Principle
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The Department notes the basis for this recommendation within the report relates to senior officers requiring the skills and training to respond to critical incidents at the tactical level, e.g., Forward Commander / Team Leader. This training is currently delivered by the Department's Special Operations Group where requested by individual facilities.

The Department will look at ways in which to promote the training and increase its uptake by senior officers across all facilities.

The Department will also consider the inclusion of this training in the Assistance Senior Officer Program.

13 Ensure AVS positions are filled across the prison estate.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The filling of Aboriginal Visitor Scheme positions across the prison estate will remain a priority for the Department. However, the challenges associated with attracting and retaining suitable staff continues to prevent the filling of vacancies. This issue is more prevalent in regional areas due to the lack of incentives for public sector positions, resulting in staff losses to other sectors.

Work on a revised service delivery model for AVS is expected to address the current staffing issues and improve conditions and outcomes for Aboriginal people in custody. This includes exploring the possibility of contracting Elders from the regions to undertake support work.

In the meantime, efforts to fill vacancies continue with a recruitment process underway to ensure AVS positions are filled across the prison estate.

14 Ensure criminogenic programs that are delivered demonstrate efficacy.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

In 2019, Corrective Services initiated an independent review of its criminogenic treatment programs across the adult prison and community corrections environments to ensure programs are contemporary and meet the needs of the prisoner/offender cohort.

The independent review was completed in October 2019 and indicated that criminogenic programs appeared to be having a positive impact. The review made several recommendations across a range of areas including data, evaluation, governance, staffing, mode of program delivery and identification of programs to address current gaps in service delivery.

Work on implementing these recommendations is in progress.

Appendix B Serco's response to recommendations

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17 January 2023

Eamon Ryan
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Dear Eamon

The Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody

Thank you for providing Serco the opportunity to provide a response to the directed review into the Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody.

Please note the below response include comments relating only to those recommendations that may be applicable to Acacia Prison.

Finding	Comment
1.	It is agreed that recommendations made by the Coroner should be treated with the appropriate degree of concern, that these need to be recorded, and any progress made tracked. Going forward, any recommendations made by the Coroner pertaining to Acacia Prison will be tracked and this will be achieved by including Coronial Recommendations as a standing item to the Agenda of quarterly Acacia Prison Risk Meeting.
5.	Consideration will be given to this recommendation during the next review of the relevant Acacia Prison Standing Order.
7.	Serco liaises with the Department of Justice who is ultimately responsible for all matters related to infrastructure.
10.	Serco has provided related training, such as working with people with FASD, and will work with the State to determine whether the State is able to provide any additional anti-social personality disorder training to staff.
11.	The need for Gatekeeper training for custodial staff is ongoing and Serco is looking forward to the State re-introducing this.

12. Thirty-one Acacia Prison staff, across all levels of seniority, have completed the Australasian Inter-service Incident Management System (AIIMS) Level II Incident training.

I trust the above comments will add value to the final report and look forward to reading it.

Yours sincerely

John Harrison
Superintendent
Acacia Prison

Appendix C Methodology

Data sets for death in custody was obtained via the Department. We used pre-constructed reports from the Department's reporting framework and from the offender database. We examined data for the period between 2000 to 2021.

We also examined Western Australian legislation and departmental documentation including policies and procedures. As part of the review we conducted site visits to Bandyup Women's Prison, Broome Regional Prison, Bunbury Regional Prison, Casuarina Prison, Greenough Regional Prison and Hakea Prison.

We also engaged with key stakeholders, including meeting with representatives from the Coroner's Office. We also attended several coronial inquests and utilised information on the Coroner's Court website, primarily inquest reports.

A preliminary findings briefing was presented to Minister for Corrective Services Hon. Bill Johnston in August 2022 and to the Department in October 2021.

The draft report was sent to the Department and Serco in November 2022 and responses were received in January 2023. A draft was also provided to the Minister for Corrective Services and the State Coroner, Ms. Ros Fogliani.

Appendix D Coronial recommendations (2017- 2021)

Year	Inquest	Recommendation	Theme (sub-theme)	Level of Support	Departmental Status
2021	MR DUTURBURE	When a prisoner is first received at a prison in Western Australia, the prisoner should be asked whether they have ever been incarcerated in another State or Territory prison. Where a prisoner discloses having been incarcerated in another State or Territory prison then, as soon as is practicable, the Department should obtain records relating to that interstate incarceration (including medical records) in order to ensure that the prisoner is appropriately managed.	Communication (information sharing)	Supported	Open
2021	MR SATHITPITTAYAYUDH	To help reduce demand for synthetic cannabinoids (such as Kronic) in the prison system in Western Australia, the Department of Justice (the Department) should consider proactively delivering targeted education to prisoners aimed at raising awareness of the unpredictable and potentially lethal consequences of using these substances. To ensure that the education being delivered is as accessible and relevant as possible, the Department should consider consulting with prisoners as well health, education and communications professionals in the development of the education materials and should consider asking Peer support Prisoners to help health professionals deliver this education.	Physical health (education)	Supported	Open
2021	MR SCOTT	To ensure that when prisoners are referred to external agencies those referrals are managed in a timely and appropriate manner, the Department of Justice (DOJ) should consider establishing a system that alerts the Prison Health Service when such referrals are overdue. DOJ should also consider allocating sufficient resources to enable a project team to be established to finalise the work currently being undertaken by Dr Joy Rowland in establishing a system to monitor and track these referrals.	Echo (IT upgrade)	Supported	Open
		The Department of Justice (DOJ) should consider amending the Health Services Policy relating to annual health reviews so that priority is given to reviewing vulnerable and older prisoners. Furthermore, DOJ should allocate appropriate resources to enable these annual reviews to be conducted in a timely manner.	Physical health (policy change)	Supported	Open
2020	MR ANDERSON	As a matter of urgency, the Department should consider increasing the number of ligature minimised cells at Hakea Prison with a view to having all cells at Hakea Prison either fully ligature minimised or three-point ligature minimised as soon as possible.	Infrastructure (ligature minimise)	Supported in Principle	Open
		In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should increase the number of safe cells from six to 12.	Infrastructure (safe cells)	Supported in Principle	Open

		A suitably qualified prison mental health staff member should conduct a mental health assessment as soon as it is practicable upon any prisoner who has been involved in a critical incident regarding violent behaviour or who has been the subject of punishment requiring placement in a specialised unit for disciplinary purposes.	Mental health (assessment)	Supported in Principle	Completed and verified
		In order to ensure that prison officers are better equipped to deal with situations where prisoners attempt to take their lives by way of hanging, officers should participate in drills involving simulated hanging scenarios during their initial employment training and during refresher training for CPR.	General staffing (Training - emergency response simulation)	Supported	Open
2020	MS HODGKINSON	I endorse the recommendation of the Inspector of Custodial Services that a new Visits Centre be built at Bandyup Women's Prison to facilitate: - Increased capacity and privacy, - Separate spaces for children's play area, search and change rooms facilities, - Appropriate CCTV and staff levels, and - Incorporated official visits.	Infrastructure (visits centre)	Noted	Completed and verified
2020	MS KELLY	In order to ensure that referrals of prisoners to external agencies, made by prison clinical staff, are appropriately actioned, the Department should consider using its health records system (EcHO) to generate automatic reminders to clinical staff. These reminders would prompt clinical staff to check whether an appointment had been received from the external agency for the prisoner and/or whether the appointment had been attended by the relevant prisoner.	EcHO (IT upgrade)	Supported	Open
2019	FIVE PRISONERS AT CASUARINA	The Department should take urgent steps to recruit additional Prison Counselling Service (PHS) and mental health staff for Casuarina Prison and more broadly, should consider the appropriate level of [PHS] and mental health staff for prisons across the State.	Mental Health (Recruitment)	Supported	Completed and verified
		The Department should increase the number of three point and fully ligature-minimised cells available at Casuarina Prison without delay. Priority should be given to those cells routinely used to house vulnerable prisoners (e.g.: the orientation cells in unit 5). In addition to increasing the number of ligature-minimised cells at Casuarina Prison, the Department should review whether the light fitting covers currently used in all cells at Casuarina Prison (and which are regarded as suitable for use in ligature-minimised cells) are fit for purpose.	Infrastructure (ligature minimise)	Supported	Completed and verified
		In order to better manage prisoners and thereby enhance security at Casuarina Prison, the Department should, without delay, take all necessary steps to ensure that [PHS] and Prison Health Service staff have reciprocal access to prisoner information stored in	Mental health (EcHO access)	Supported	Completed and verified

		the EcHO computer system and the [PHS] module of the Total Offender Management Solutions system respectively.			
		The Department should consider introducing a "triage" system into prisons where all prisoners who have a known history of self-harm and/or suicide attempts are reviewed by a mental health professional within 24 hours of being received into prison. Consideration should be given to the use of video-conferencing facilities for regional prisons where mental health staff are unavailable.	Mental health (assessment)	Supported	Completed and verified
		The Department should consult with an expert in the field of trauma informed custodial care (TICC) to determine a process for incorporating the principles of TICC into its management of prisoners at Casuarina Prison.	Prisoner management (Trauma Informed Custodial Care)	Supported – Existing Departmental Initiative	Completed and verified
		The Department should consult with an expert in the field of mental health with a view to providing training to all staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.	General staffing (training - mental health)	Supported	Completed and verified
		The Department should consider further enhancing its Gatekeeper training program to ensure that it is primarily focussed on risk in the custodial setting. Consideration should also be given to including additional guidance for relevant custodial staff (e.g.: reception officers) on conducting self-harm and suicide risk assessments. Gatekeeper refresher training should be conducted for all staff on a regular basis.	General staffing (training - mental health)	Supported	Completed and verified
		The Department should consider amending Policy Directive 36 – Communication so that where practicable, there is a positive obligation on custodial staff to advise a prisoner when changes are made to that prisoner's Prison Telephone System account.	Communication (policy change - PTS- positive obligation	Supported	Completed and verified
2019	MR CAPPER	The Department should review the deployment procedure for the Special Operations Group (SOG) and in doing so, should consider the views of experienced custodial and operational officers, that the current system is inefficient. The Department should give consideration to reverting to the previous deployment system where officers in charge of prisons could contact SOG directly when seeking assistance.	General staffing (SOG deployment procedure)	Not supported	Not supported – no further action
		Now that funding for nine additional Prison Counselling Service [PHS] staff has been approved, the Department should take urgent steps to recruit these staff and more broadly, should consider the appropriate level of [PHS] and mental health staff for prisons across the State.	Mental health (recruitment)	Supported – Existing Departmental Initiative	Completed and verified
		In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should, without delay, take all necessary steps to remove any remaining impediments so as to ensure that [PHS] and Prison Health Service staff have reciprocal	Mental health (EcHO access)	Supported – Existing	Completed and verified

		access to prisoner information stored in the EcHO computer system and the [PHS] module of the Total Offender Management Solutions system respectively.		Departmental Initiative	
		The Department should consider expanding the delivery of information sessions about the SOG (currently being presented to prison health staff) to custodial officers.	General staffing (training - SOG info sessions)	Supported	Completed and verified
		In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should consider providing critical incident management training to its senior custodial officers (i.e.: senior officers and above).	General staffing (training- critical incident management)	Supported	Completed and verified
		The Department should consult with an expert in the field of mental health with a view to providing training to custodial staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.	General staffing (training - mental health)	Supported in Principle	Completed and verified
2019	MR JACKAMARRA	Retain and ensure B(R)P has appropriate services which acknowledge it is a major transition facility with all the known risks that raises.	Infrastructure (mental health)	Supported – Existing Departmental Initiative	Completed and verified
		Information sharing between medical, [PHS] and mental health services in prison and appropriate sharing of information between custodial facilities and organisations in the community caring for those with mental health issues.	Mental health (information sharing)	Supported	Completed and verified
		Effective CCTV and practical ligature minimisation. I am not suggesting CCTV directly into toilet or shower facilities, but good coverage on adjacent points may avoid issues to do with welfare. It is a sad fact that rarely in inquests are all relevant CCRTV monitors operational.	Infrastructure (CCTV and ligature minimise)	Supported	Completed and verified
		Prison officer training that those with prior suicide attempts are at elevated risk in custody regardless of their demeanour.	General staffing (training - mental health)	Supported – Existing Departmental Initiative	Completed and verified
		The promotion of active involvement of prisoners in caring for one another.	Prisoner management (peer support)	Supported – Existing Departmental Initiative	Completed and verified
		Realisation on behalf of custodial services that welfare and security go hand in hand. I appreciate that prisons are involved in security on behalf of the community, but destabilised prison populations due to successful suicides are distressing for all concerned, staff and other prisoners, and can rapidly become a security issue of itself.	Prisoner management (prisoner welfare)	Supported – Existing Departmental Initiative	Completed and verified

		I recommend that the Government commit funding to the establishment of a subacute mental health unit in Bandyup Women's Prison, properly staffed with a multidisciplinary mental health team, as a matter of priority.	Infrastructure (sub- acute mental health)	Supported in Principle	Completed and verified
2019	MS NICOL	I recommend that the Honourable Attorney General give consideration to amending the Sentencing Act 1995 (WA) to permit the release of court ordered medical reports to the medical and nursing staff who are treating remand and sentenced prisoners in Western Australia to ensure that this valuable source of information is able to be accessed to improve the level of care and treatment that can be provided to prisoners.	Legislative change (Sentencing Act)	Supported in Principle	Completed and verified
2017	MR BEASLEY	That the Western Australian government review and, if appropriate, amend or repeal the requirement in s107B *Sentencing Administration Act 2003* for the Prisoners Review Board to give a prisoner written notice of a decision to amend, suspend or cancel an early release order as soon as practicable after the decision is made. **[Departmental response: Legislative Services will take carriage of recommendation. It will be considered as part of the review of the Sentence Administration Act.]**	Legislative change (Sentencing Act)	Supported	Completed and verified
2017	MR BENNELL	I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care. Efforts should be made where possible to hire some Aboriginal mental health workers to form part of the mental health team.	Mental health (recruitment)	Supported	Completed and verified
2017	MR STUART	I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should invest significantly more resources in ensuring that prisoners are given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care.	Mental health (recruitment)	Supported	Completed and verified

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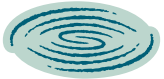

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