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“He’s Never Coming Back”

People with Disabilities Dying in Western Australia’s Prisons



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Aboriginal and Torres Strait Islander peoples should be aware that this report contains images and names of people who have passed away. In many areas of Indigenous Australia, it is common practice that when a member of the community passes away, the person’s name is changed in accordance with cultural beliefs. Names and photographs in this report are used with the permission of the families.

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Terms

Aboriginal and Torres Strait Islander peoples: The first inhabitants and nations of Australia. The Australian government defines an Aboriginal person as “someone who: is of Aboriginal descent; identifies as an Aboriginal person; and is accepted as an Aboriginal person by the community in which he or she lives. Aboriginal people comprise diverse Aboriginal nations, each with their own language and traditions and have historically lived on mainland Australia, Tasmania and on many of the continent's offshore islands. Torres Strait Islander peoples come from the islands of the Torres Strait and are of Melanesian origin with their own distinct identity, history, and cultural traditions. ‘Aboriginal people’ is a collective name for the original people of Australia and their descendants, and does not emphasize the diversity of languages, cultural practices, and spiritual beliefs. This diversity is acknowledged by adding an ‘s’ to ‘people’ (‘Aboriginal peoples’). ‘Aboriginal people’ can also be used to refer to more than one Aboriginal person.”¹

Fetal Alcohol Spectrum Disorder (FASD): A range of physical or cognitive disabilities due to exposure to alcohol in utero. Behaviors associated with FASD can increase the likelihood of coming into contact with the criminal justice system because people with FASD are more susceptible to suggestion and to confess to crimes they have not committed without being aware of the consequences.² FASD is not easy to identify and is often undiagnosed.

Observation, crisis, or safe cell: Prison authorities, in consultation with health staff, can place a prisoner in an “observation cell,” “crisis cell,” or “safe cell” to monitor their

¹ Australian Human Rights Commission, “Questions and Answers about Aboriginal and Torres Strait Islander Peoples: Face the Facts 2005,” 2005, <http://www.humanrights.gov.au/publications/questions-and-answers-about-aboriginal-torres-strait-islander-peoples> (accessed December 3, 2017).

² Australian Medical Association, “AMA submission to Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia,” Submission 12, April 6, 2016, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/~/_link.aspx?_id=E88B9FB743E442FoA749542EA42D3960&_z=z (accessed August 15, 2017), p. 5; Amnesty International Australia, “Amnesty International Australia submission to inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia,” Submission 38, April 8, 2016, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/~/_link.aspx?_id=E88B9FB743E442FoA749542EA42D3960&_z=z (accessed August 15, 2017), p. 3.

medical or psychological condition, or if they are at high risk of self-harm.³ The cells can be specially designed with CCTV cameras; no ligatures, hooks, or sharp edges; and have furnishings bolted to the ground or flush to the wall to minimize risk of self-harm and suicide. If the risk of self-harm is high, prison staff provide a tear-proof gown and bedding and finger food. Observation, crisis, or safe cells are located away from mainstream units, sometimes in detention or medical units (for medical supervision), and have a higher staff-to-prisoner ratio. Lack of appropriate cells and overcrowding means prison staff often use punishment cells located in detention units for observation.

Punishment cell: A cell where prison authorities send a prisoner who has committed a prison offense.⁴ Depending on the state legislation and the severity of the offense, the superintendent or a visiting justice can impose a period of separate confinement in a punishment cell ranging from seven days or less for a minor offense—such as disobeying a prison rule or an officer—to 21 days for multiple offenses. For aggravated offenses, such as assaulting a prisoner or an officer, a magistrate or two Justices of the Peace may impose up to 28 days of separate confinement (with 48 hours out of the punishment cell after each seven days in separate confinement).⁵ Located in a detention unit, a punishment cell has a bed, table, shelf, and toilet. Prisoners in such cells lose privileges, such as access to work or leisure activities, and are let into an exercise yard for two hours a day at most.

Psychosocial disability: The preferred term to describe people with mental health conditions such as depression, bipolar, schizophrenia, and catatonia. The term “psychosocial disability” describes conditions commonly referred to—particularly by mental health professionals, courts, lawyers, corrections officials, and media—as “mental illness” or “mental disorders.” The Convention on the Rights of Persons with Disabilities (CRPD) recognizes that disability is an evolving concept and that it results from the interaction between people with impairments and social, cultural, attitudinal, and environmental barriers that prevent their full and effective participation in society on

³ Legal Aid Western Australia, “Prisoner Handbook: Your Rights, the law, and other information,” May 2016, <https://www.legalaid.wa.gov.au/InformationAboutTheLaw/crime/Documents/Legal%20Aid%20WA%20Prisoner%20Handbook.pdf> (accessed September 2, 2017), pp. 38-39.

⁴ Separate confinement is merely one of the penalties that prison authorities, a visiting justice, or a magistrate may impose on a prisoner. Other penalties can include a caution, a reprimand, cancellation of gratuities, confinement in sleeping quarters for 72 hours or less etc. Legal Aid Western Australia, “Prison Offenses Information Kit,” July 1, 2015, <https://www.legalaid.wa.gov.au/InformationAboutTheLaw/crime/Documents/Prison%20offenses%20information%20kit.PDF> (accessed September 2, 2017), pp. 2-3.

⁵ Ibid.

an equal basis with others. The term “psychosocial disability” as is used in this report is preferred as it expresses the interaction between psychological differences and social or cultural limits for behavior, as well as the stigma that society attaches to people with mental impairments.⁶

⁶ World Network of Users and Survivors of Psychiatry, “Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities,” February 2008, http://www.wnusp.net/documents/WNUSP_CRPD_Manual.pdf (accessed December 20, 2015), p. 9.

Summary

That morning when he went to court, he sang out “Mum, put the chicken out, I’ll come back and cook you supper.” But he never came back.

— Georgette Jackamarra, a mother whose son, an Aboriginal man with a psychosocial disability, died in Broome Regional Prison, Broome, Western Australia

Western Australia’s prisons are damaging and deadly for people with psychosocial disabilities, particularly Aboriginal and Torres Strait Islander peoples with disabilities. Nearly 30 years after the 1991 Royal Commission into Aboriginal Deaths in Custody, Aboriginal and Torres Strait Islander prisoners with disabilities remain at serious risk of self-harm and preventable deaths in custody.

Human Rights Watch’s analysis of coroners’ inquest reports between 2010 and 2020 found that about 60 percent of people who died in prisons in Western Australia had a disability. Of the 60 percent, 58 percent died as a result of lack of support provided by the prison, suicide, and violence—and half of these deaths were of Aboriginal and Torres Strait Islander prisoners with disabilities.

The 1991 Royal Commission into Aboriginal Deaths in Custody found that Aboriginal people were more likely to die in custody in part because they were incarcerated at disproportionate rates. This remains true. Aboriginal and Torres Strait Islander people comprise just 4 percent of Western Australia’s population, but make up 39 percent of the state’s full-time adult prison population. Within this group, Aboriginal and Torres Strait Islander people with disabilities are even more likely to end up behind bars. The *Guardian Australia* on June 1, 2020 reported that at least 437 Indigenous people have died in custody throughout Australia since 1991, and in over 40 percent of cases the person had a mental health condition or a cognitive disability. The figures of *Guardian Australia* capture all deaths in custody including police, prison, and immigration detention related custody.

This report examines the cases of eight people with disabilities who died in custody in Western Australia between 2015 and 2020, six of whom were Aboriginal people. Their cases are illustrative of the severely inadequate mental health support in prisons in Western Australia. The report is based on interviews, between September 2019 and August 2020, with 40 people including prisoners, family members, mental health professionals, lawyers, Aboriginal leaders, disability rights and death in custody experts in the cities of

Perth and Broome. The report draws on an extensive study of the 102 cases of deaths in custody that occurred in Western Australia between 2010 and 2020.

Even in cases where the prisoner's disability or mental health history was well-known and documented by prison authorities, staff failed to provide adequate and timely support that could have prevented the prisoner taking their own life or from being attacked by fellow prisoners.

Due to limited resources, mental health services in prisons are at times reduced to distributing medication through a slot in the cell door, monitoring prisoners to prevent self-harm, and acute crisis counseling. The quality of counseling varies across prisons and can often be limited to a perfunctory, "How are you doing?" through closed cell doors, allowing for the response to be heard across the unit, including by prison guards.

The Western Australian Office of the Inspector of Custodial Services, the independent agency that inspects places of detention and reports directly to Western Australia's parliament, stated in 2018 that "the State is not meeting the mental health needs of prisoners" and "daily management of people with serious mental health needs is left to custodial staff who have limited training, few management options and poor access to information."

Human Rights Watch found that corrective services' approach has largely been to reduce access to tools that can be used to self-harm and keeping at-risk prisoners under strict observation. But little has been done to address the deteriorating conditions of confinement, the inadequate access to support or mental health services, and the overuse and harm of solitary confinement. The 1991 Royal Commission report found solitary confinement causes "extreme anxiety" and has a particularly detrimental impact on Aboriginal and Torres Strait Islander prisoners, many of whom are already separated from family, kin, and community.

In each of the eight cases that Human Rights Watch investigated, corrective services failed to adequately recognize or address the risk, provide sufficient and timely support, and in some cases placed the individuals in conditions amounting to solitary confinement that increased the likelihood of self-harm and suicide. The deaths detailed in the research include:

- **Stanley**, 19, a Noongar man with a mental health condition, from the Fremantle area took his own life in Acacia Prison, Wooroloo on July 11, 2020. He had been sentenced to two years for burglary-related offenses and struggled to cope in

prison. With parole, he could have been released in six months. The coroner's inquest report is pending at time of writing.

- **Jomen Blanket**, 30, was transferred to a high supervision unit due to attempts at self-harm but took his life by hanging in his cell at Acacia Prison, in Wooroloo, on June 12, 2019. The coroner's inquest report is pending at time of writing.
- **Mr. Alf Eades**, 46, was assaulted by six prisoners in his cell at Hakea Prison, in Canning Vale, on February 26, 2019. The assailants attacked him as part of an initiation exercise to join a motorcycle gang. He died in the hospital on March 11, 2019, after sustaining severe brain swelling, a broken neck, and spinal injuries. Before his death, he had called a family member from prison and told them that he feared for his safety and had asked to be locked inside his cell for protection. The coroner's inquest report is pending at time of writing.
- **Annabel Nicol**, 50, was held on remand in Bandyup Women's Prison, in West Swan, when she took her life by hanging herself in a shower cubicle on June 15, 2016. During her three months in custody, Nicol spent most of her time in the crisis care or management unit. The coroner noted that while crisis care kept Nicol physically safe, it was far from a therapeutic environment and in fact proved to be damaging, significantly increasing her distress.
- **Mr. Jackamarra** (full name not included for cultural reasons), 36, was arrested on December 16, 2015 on a bailable offense. When his relative did not arrive in time to post bail, he was taken into custody in Broome Regional Prison, in Broome. Despite his repeated requests, prison officials failed to provide him with his mental health medication leading to severe psychological distress. Four hours later, he was found hanging in the shower block.
- **Mr. Bell** (full name not included for cultural reasons), 28, was in prolonged solitary confinement locked in his cell for over 22 hours a day when he took his own life on September 8, 2015 at Casuarina Prison in Perth. The prison psychiatrist and psychologist said "the isolation of the SHU [Special Handling Unit] greatly increased the risk of suicide" and can cause "irreversible psychological trauma if housed in solitary confinement for periods of 10 days or more." Yet Mr. Bell was kept in the SHU for 13 months. While in custody, he experienced multiple assaults by fellow prisoners and complained of mistreatment by prison staff. In the week before his death, Mr. Bell left several voicemails indicating his intention to take his life.
- **Mr. Cameron** (full name not included for cultural reasons), 26, was placed in a safe-cell after he tried to self-harm on October 9, 2015. On October 28, 2015, the day his risk-assessment dropped to "low" risk and staff supervision dropped, he

hanged himself from a light fixture at Casuarina Prison, in Perth. He reported being frequently bullied by other prisoners.

- **JS** (whose full name is subject to a suppression order), 68, hanged himself from a ligature in his cell at Casuarina Prison, in Perth, on August 3, 2015, after he was taken off the Support and Monitoring System (SAMS), a suicide prevention measure.

Although five of the eight cases date back to 2015-2016, the coroner only completed his investigation into those deaths in 2019. According to the Department of Corrective Services, as of June 17, 2020, coronial inquests into 46 deaths that occurred in the state's adult prisons were still pending.

The Western Australia Department of Corrective Services have taken several measures to reduce the number of deaths in custody. However, rates of self-harm are still very high for people with psychosocial or cognitive disabilities, particularly Aboriginal and Torres Strait Islander peoples.

The Department of Corrective Services approved a budget of A\$2.99 million (US\$2 million) for 2015 to 2019 to carry out a ligature-minimization program to prevent prisoners using ligatures to self-harm or hang themselves. However, the coroner's inquest report in May 2019 found that only 40 percent of cells at Casuarina Prison, where five of the deaths took place, were ligature-minimized. In addition, prisons also revised their At-Risk Management System (ARMS) to check in more frequently on prisoners in crisis.

In July 2019, the Department of Corrective Services conducted a review of mental health services in prison. The final report made 14 recommendations relating to support services including prisons support officers, Aboriginal visitors, and peer support programs, which were approved by the Department of Corrective Services in February 2020 but are yet to be implemented.

Most recently, after three suspected suicides in the state's prisons since the beginning of 2020, the Western Australian government announced a taskforce to assess the current management of at-risk prisoners.

Ahead of publication, Human Rights Watch sought additional information from the commissioner of corrective services in Western Australia and their response is reflected in relevant sections of this report and is also reproduced in full in the Annex.

Recommendations

To prevent the overimprisonment and deaths in custody of people with disabilities, particularly Aboriginal and Torres Strait Islander peoples, Australia's federal, state, and territory governments should implement all the recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody, the Australian Law Reform Commission's 2018 *Pathways to Justice* report, and the Change the Record Campaign, including:

- End the overimprisonment of Aboriginal and Torres Strait Islander peoples by repealing punitive bail laws; mandatory sentencing laws; and decriminalizing public drunkenness.
- Raise the age of criminal responsibility from 10 to at least 14 years.
- End racist policing.
- End the abuse, torture and solitary confinement of Aboriginal and Torres Strait Islander people in police and prison cells through legislative safeguards and by urgently establishing independent bodies to oversee the conditions of detention and treatment of people in accordance with Australia's obligations under the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).
- In partnership with relevant Aboriginal and Torres Strait Islander organizations, set up Aboriginal Justice Advisory Committees.

To Western Australia's Minister for Corrective Services and Commissioner of Corrective Services

- Systematically screen prisoners for all types of disabilities upon entry into prison and provide appropriate support and accommodations.
- Ensure prisoners with disabilities have adequate access to support and quality mental health services. Work in close collaboration with Aboriginal health services, to ensure mental health services are culturally appropriate.
- Improve mental health services in prisons by ensuring there are sufficient numbers of qualified mental health professionals, adequate resources, services are culturally competent and based on free and informed consent, and the quality of care meets community standards.

- To ensure mental health services in prison are culturally appropriate, in line with the Mental Health Act, provide an option for the disability or mental health assessment of a person of Aboriginal or Torres Strait Islander descent to be conducted in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the person's community, including elders and traditional healers.
- Develop a strategy of engagement with family, friends, and culturally appropriate support networks for prisoners at risk of self-harm or suicide.
- Include the impact of Adverse Childhood Events (ACE) in prisoner safety and self-harm risk assessments.
- Introduce the use of body cameras, particularly in the Special Handling Unit, multi-purpose, separate confinement, and crisis care units, to enhance prisoner and staff safety and sanction prison officers who turn their body cameras off, with no justifiable reason.
- Ensure health services in prisons are delivered by the Department of Health instead of the Department of Corrective Services.
- Improve information-sharing between the prison system and medical services.
- Publicly report on the number of near deaths or self-harm incidents that lead to serious injury.
- Recruit adequate Aboriginal and Torres Strait Islander prison and health staff.
- Ensure that all prison officers receive regular, gender and culturally sensitive, training on how to interact with people with disabilities, particularly those with psychosocial or cognitive disabilities. Custodial staff assigned to separate confinement and crisis units should receive additional mental health and disability training.
- In consultation with organizations of Aboriginal and Torres Strait Islander people and people with disabilities, develop a comprehensive range of culturally appropriate resources and training materials that can be used by prison staff, service providers, police, and the judiciary to better engage with Aboriginal and Torres Strait Islander peoples with disabilities in prison.
- Increase partnerships with Aboriginal community-based organizations to deliver mental health services in prison.
- Provide resources to organizations led by Aboriginal and Torres Strait Islander people to provide specialized and culturally appropriate support to Aboriginal and Torres Strait Islander peoples with disabilities in prison.

- Ensure health services in prisons are delivered by the Department of Health instead of the Department of Corrective Services.
- Improve information-sharing between the prison system and medical services.

To Western Australia’s Suicide Prevention Taskforce to Examine At-Risk Prisoners

- Meaningfully consult at-risk prisoners, particularly prisoners with psychosocial or cognitive disabilities and Aboriginal or Torres Strait Islander prisoners.
- Examine the conditions of solitary confinement for prisoners with disabilities and Aboriginal and Torres Strait Islander prisoners in observation cells or crisis care.
- Examine the conditions of solitary confinement (i.e. locked alone in a cell for over 22 hours or more a day without meaningful human contact), including in observation cells or crisis care, for prisoners with psychosocial or cognitive disabilities and Aboriginal and Torres Strait Islander prisoners.
- Examine the effectiveness of mental health assessments upon entry into prison to address the heightened risk of suicide early on in custody.
- Examine reforms aimed at shifting prison culture from a predominantly punitive and security-centered approach to one geared towards prisoner well-being and rehabilitation so that “difficult” behavior is not automatically perceived as manipulative but a sign of distress.
- Examine disability and mental health training for prison staff and ensure that it is culturally appropriate.
- Look at institutional factors that contribute to self-harm and suicide such as uncertainty around sentencing, overcrowding, lack of purposeful activity, number of hours locked in a cell, conditions of confinement, lack of privacy, and access to adequate mental health services.
- Conduct an in-depth review of suicide prevention across all prisons, not only privately run prisons.
- Assess the adequacy and quality of health services provided by the Department of Corrective Services in prison as opposed to services delivered by the Department of Health.

To Western Australia’s Government, and Parliament, including Cabinet Ministers

- Ensure the Office of the Inspector of Custodial Services has adequate resources to carry out in-depth and regular monitoring and investigations of prisons and

includes adequate Aboriginal and Torres Strait Islander staff to ensure a culturally sensitive approach. In particular, the independent inspector should investigate neglect and abuse experienced by prisoners with disabilities, including Aboriginal and Torres Strait Islander prisoners with disabilities.

- Amend the 1981 Prisons Act to prohibit the use of solitary confinement, including isolation and behavioral management techniques that can amount to solitary confinement, for prisoners with disabilities.
- Amend the 1981 Prisons Act to prohibit the use of prolonged solitary confinement for all prisoners.
- Review sentencing guidelines for low-level offenses, to minimize resorting to custodial sentencing in favor of diversion schemes and community-based service orders. Expand access to such measures and ensure Aboriginal and Torres Strait Islander people have equal access to them.
- Raise the age of criminal responsibility for children from 10 to at least 14 years.
- Increase availability of sentencing alternatives encompassing non-custodial options for all prisoners, including prisoners with disabilities.
- Ensure health services in prisons are delivered by the Department of Health instead of the Department of Corrective Services.
- Improve information-sharing between the prison system and medical services.

To the Coroner's Court of Western Australia

- Investigate deaths in prisons in a timely manner to ensure the Department of Corrective Services can take swift action to address the situation and improve services and support for prisoners to prevent additional deaths in custody.

To the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

- Investigate the neglect and abuses people with disabilities, specifically Aboriginal and Torres Strait Islander prisoners with disabilities, experience on a daily basis in prison.
- Recommend that state and territory laws, policies, and guidelines be amended to prohibit the use of solitary confinement for prisoners with disabilities.

For an extended list of recommendations to end neglect and abuse of prisoners with disabilities, see the 2018 Human Rights Watch report, “‘I Needed Help, Instead I Was Punished’: Abuse and Neglect of Prisoners with Disabilities in Australia.”

Methodology

The research for this report was conducted between September 2019 and August 2020, based on 10 days of fieldwork across Perth and Broome, Western Australia, with additional background research over several months of cases of people with disabilities who died in prisons for adult prisoners across Western Australia.

This report is based on a review of the 102 cases of deaths in custody that occurred in Western Australia between 2010 and 2020. In particular, Human Rights Watch examined eight emblematic death in custody cases of people with psychosocial disabilities, six of whom were Aboriginal, that exposed inadequate mental health support in prisons in Western Australia.

Human Rights Watch interviewed 40 people including prisoners with psychosocial disabilities, family members of prisoners with psychosocial disabilities who died in prison in Western Australia, lawyers, and disability and death in custody experts.

This research builds on Human Rights Watch's 2018 report, "I Needed Help, Instead I Was Punished": Abuse and Neglect of Prisoners with Disabilities in Australia,"⁷ based on visits to 14 prisons, including three women's prisons, and two forensic or secure units across Western Australia and Queensland that housed in total around 7,200 prisoners.

Ahead of publication, Human Rights Watch sought additional information from the commissioner of corrective services in Western Australia and their response, dated July 14, 2020, is incorporated into this report and reproduced in full in the Annex.

Human Rights Watch informed interviewees of the purpose of the interview and the manner in which the information would be used. No remuneration or incentives were promised or provided to people interviewed.

⁷ Human Rights Watch, *'I Needed Help, Instead I Was Punished': Abuse and Neglect of Prisoners with Disabilities in Australia*, (New York: Human Rights Watch, 2018), https://www.hrw.org/report/2018/02/06/i-needed-help-instead-i-was-punished/abuse-and-neglect-prisoners-disabilities#_ftn84.

The interviews were conducted in person and on the phone, in English. Although English was not always the first language for Aboriginal and Torres Strait Islander prisoners, all spoke fluent English.

Human Rights Watch worked closely with and regularly consulted Aboriginal and Torres Strait Islander organizations. However, all research interviews were conducted solely by Human Rights Watch staff.

Names of some interviewees have been withheld to protect their identity. Footnotes for Human Rights Watch interviews have minimal information. These have been evaluated on a case-by-case basis to avoid identification of the person.

Human Rights Watch made every effort to corroborate claims through various means, including media reports, direct observation, medical or psychiatric records, and interviews with family members, mental health professionals or staff, and disabled persons' organizations.

Human Rights Watch reviewed relevant domestic and international media reports, official government documents, coronial inquest reports, nongovernmental organization reports, and academic articles. Lawyers acting on a pro bono basis helped to review media reports, coronial inquest reports and investigations by the Office of the Inspector of Custodial Services.

I. Background

Lack of Disability Assessment

Life behind bars is profoundly challenging for everyone. But prisoners with disabilities often struggle more than others to adjust to the extraordinary stresses of incarceration. The problem starts with lack of proper assessment and identification of a disability upon entry into prison. Without such information, prisons fail to provide appropriate and adequate services and accommodations for the specific needs of prisoners with disabilities, or to track them within the prison system.

In Western Australia's prisons, disability identification relies heavily on self-reporting, which is inadequate since many prisoners are not aware of their disability; do not identify as having one, especially for many Aboriginal and Torres Strait Islanders who have no equivalent word in their traditional languages; have never been diagnosed prior to entering prison; or hesitate to disclose a disability for fear of stigma.⁸ Persistent institutional racism and discrimination further marginalizes Aboriginal and Torres Strait Islanders with a disability in prison.

Human Rights Watch found that Department of Corrective Services staff have not had the time, training, or tools to effectively identify people with disabilities and their support needs upon their entry into prison.

Human Rights Watch found that prisons in Western Australia were not consistently assessing or collecting data on disability. A nurse working in a Western Australian prison said: "There is no disability assessment here. We don't have time, we don't have the

⁸ Expert organizations such as First Peoples Disability Network (FPDN) have found that Aboriginal and Torres Strait Islander people rarely identify as having a disability. First, there is no concept of disability or equivalent word in traditional languages. Second, if they have already faced discrimination based on their Aboriginality, they may be hesitant to take on an additional and potentially stigmatizing label. Since disability is only one factor among many that contribute to disadvantage in Aboriginal and Torres Strait Islander communities, members rarely speak about their own disability as a "front of mind" [priority] issue; Damian Griffis, "Disability in Indigenous communities; addressing the disadvantage," *ABC News*, April 20, 2012, <http://www.abc.net.au/rampup/articles/2012/04/20/3481394.htm> (accessed October 5, 2017); First Peoples Disability Network (Australia), "Response to the Productivity Commission Position Paper on National Disability Insurance Scheme (NDIS) Costs," July 2017, https://www.pc.gov.au/__data/assets/pdf_file/0019/220492/subppo355-ndis-costs.pdf (accessed September 5, 2017), p. 14.

facilities, and we don't have the nursing staff. Prison is not set up for people with disabilities.”⁹

Inadequate Mental Health Services

Approximately two in five people entering prison in Western Australia have a mental health condition.¹⁰ However, prisons are struggling to meet the demand for services and the quality of care falls short of community standards.¹¹

According to a 2018 investigation by the Inspector of Custodial Services, the “daily management of people with serious mental health needs is left to custodial staff who have limited training, few management options and poor access to information.”¹²

A prisoner with a psychosocial disability in Western Australia told Human Rights Watch:

There is no money for individual counselling—there's triage, and if it's not suicidal then it's not a priority. Take me, it took eight months for me to see a counselor at Hakea [Prison]. The counseling was just a 40-minute session—basically it's a suicide assessment. They ask questions like do you feel like you want to harm yourself?¹³

Even medical and custodial staff at Casuarina Prison, the largest male high security facility in Western Australia, expressed concern in a coroner's report that “the current situation

⁹ Human Rights Watch interview with a nurse (name and details withheld by Human Rights Watch), Western Australia, December 2016.

¹⁰ Australian Institute of Health and Welfare, “The health of Australia's prisoners 2018,” May, 30, 2019, <https://www.aihw.gov.au/getmedia/2e92fo07-453d-48a1-9c6b-4c9531cfo371/aihw-phe-246.pdf.aspx?inline=true> (accessed May 20, 2020).

¹¹ Office of the Inspector of Custodial Services, *Prisoner Access to Secure Mental Health Treatment*, September 2018, <https://www.oics.wa.gov.au/wp-content/uploads/2018/11/Prisoners-access-to-mental-health-treatment.pdf> (accessed May 20, 2020); Office of the Inspector of Custodial Services, *2019 Inspection of Hakea Prison*, February 2019, <https://www.oics.wa.gov.au/wp-content/uploads/2020/05/Casuarina-Report-129.pdf> (accessed May 20, 2020).

¹² Office of the Inspector of Custodial Services, *Prisoner Access to Secure Mental Health Treatment*, September 2018, <https://www.oics.wa.gov.au/wp-content/uploads/2018/11/Prisoners-access-to-mental-health-treatment.pdf> (accessed May 20, 2020), p. ix.

¹³ Human Rights Watch interview with a prisoner with a psychosocial disability (name and details withheld by Human Rights Watch), Western Australia, 2019.

with Prison Counselling Services (PCS) and mental health staff numbers are placing prisoners lives at risk.”¹⁴

Western Australia’s prisons are not designed to support prisoners with psychosocial disabilities, particularly in acute crises. When a prisoner experiences severe psychological distress, they are referred to a specialized forensic facility. However, in Western Australia, there is just one 38-bed forensic facility, the Frankland Centre at Graylands Hospital, for more than 7,000 prisoners across the state.¹⁵ While the prison population has tripled since the center opened in 1993, the number of beds remains the same.¹⁶ At 1.9 beds per 100,000 people, Western Australia has the lowest number of forensic beds, compared to the national average of 3.4 beds.¹⁷

Aboriginal and Torres Strait Islander people comprise 39 percent of Western Australia’s full-time adult prison population, but just 4 percent of the state’s population.¹⁸ And almost half of all Aboriginal and Torres Strait Islander people over 15 years of age are living with a disability. The Australian Bureau of Statistics’ National Aboriginal and Torres Strait Islander Health Survey 2018-2019 found that one in four Aboriginal and Torres Strait Islander peoples have a “mental or behavioral condition” and experience three times the rate of psychological distress, compared to their non-Indigenous peers.¹⁹ A recent study on male prisoner entrants in Western Australia also found that over 50 percent of Aboriginal prisoners had experienced the death of a close family member in the 12 months prior to entering prison, increasing the risk of depression, self-harm and suicide.

¹⁴ The Coroner of Western Australia published a joint coronial inquest for Mr. Mervyn, Mr. Cameron, Mr. Honeywood, JS (Subject to Suppression Order) and Mr. Wallam’s deaths which all took place in Casuarina prison in 2015. Coroner’s Court of Western Australia, “Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam,” (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf.

¹⁵ Human Rights Watch, *‘I Needed Help, Instead I was Punished.’*

¹⁶ Office of the Inspector of Custodial Services, *Prisoner Access to Secure Mental Health Treatment*, September 2018, <https://www.oics.wa.gov.au/wp-content/uploads/2018/11/Prisoners-access-to-mental-health-treatment.pdf> (accessed May 20, 2020).

¹⁷ Ibid.

¹⁸ Australian Bureau of Statistics, “4517.0 – Prisoners in Australia, 2019,” June 30, 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2019~Main%20Features~Western%20Australia~25> (accessed September 8, 2020); Australian Bureau of Statistics, “3238.0.55.001 – Estimates of Aboriginal and Torres Strait Islander Australians, June 2016,” August 31, 2018, <https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001> (accessed September 8, 2020).

¹⁹ Pat Dudgeon, Maddie Boe, and Roz Walker, “Addressing Inequities in Indigenous Mental Health and Wellbeing through Transformative and Decolonizing Research and Practice,” *Research in Health Science*, vol. 5, no. 3. (2020), p. 49.

The current approach to mental health service delivery in prison, which is informed by a biomedical model focus on diagnosis and medication, fails to take a genuinely culturally sensitive approach to Aboriginal mental health.²⁰

These problems are compounded because, despite having the highest rate of Aboriginal incarceration in the country, the Western Australian government has not ensured adequate Aboriginal staff members including mental health staff.²¹ Across the state's prisons only 4 percent of all custodial and health staff are Aboriginal or Torres Strait Islander. For example, although Aboriginal men constitute a third of the Casuarina Prison population, there are no Aboriginal healthcare workers on staff.²² In Hakea Prison, the state's main remand facility, only 1.26 percent of the custodial staff are Aboriginal.²³ According to the Department of Corrective Services, in the vast majority of the state's prisons there are no Aboriginal or Torres Strait Islander healthcare workers on staff.²⁴ As a result, even when there are well-meaning staff, the cultural barrier means that Aboriginal and Torres Strait Islander prisoners with disabilities often do not feel comfortable seeking services. At times, they are confronted with racist stereotypes or negative staff attitudes.²⁵ The demand for the Aboriginal Visitors Scheme and Aboriginal Prison Service also regularly exceeds supply as there is a shortage of Aboriginal staff.²⁶

²⁰ Pat Dudgeon, Maddie Boe, and Roz Walker, "Addressing Inequities in Indigenous Mental Health and Wellbeing through Transformative and Decolonizing Research and Practice," *Research in Health Science*, vol. 5, no. 3. (2020); Andreea Lachsz, "2018 Churchill Fellowship to Investigate Overseas Practices of Monitoring Places of Detention," *Winston Churchill Trust*, 2019, <https://www.churchilltrust.com.au/project/to-investigate-overseas-practices-of-monitoring-places-of-detention---canada-new-zealand-uk-ireland-switzerland/> (accessed September 9, 2020).

²¹ Australian Bureau of Statistics, "Key Statistics: Persons in Custody," Corrective Services, Australia, March Quarter 2020, March 2020, <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0> (accessed June 10, 2020).

²² Office of the Inspector of Custodial Services, *2019 Inspection of Casuarina Prison*, March 2020, <https://www.oics.wa.gov.au/wp-content/uploads/2020/05/Casuarina-Report-129.pdf> (accessed May 20, 2020), p. vi.

²³ Letter from the Corrective Services of Western Australia to Human Rights Watch, dated June 23, 2020 (see Annex).

²⁴ *Ibid.*

²⁵ Human Rights Watch, *'I Needed Help, Instead I was Punished.'*

²⁶ Casuarina prison has only one full-time and one part-time Aboriginal Visitor's Service worker for about 330 Aboriginal prisoners. Coroner's Court of Western Australia, "Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam," (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 2, 2020), p.66. Office of the Inspector of Custodial Services, *2019 Inspection of Casuarina Prison*, March 2020, <https://www.oics.wa.gov.au/wp-content/uploads/2020/05/Casuarina-Report-129.pdf> (accessed May 20, 2020), p. v-vi; Hannah McGlade, "Australia's Treatment of Indigenous Prisoners: The Continuing Nature of Human Rights Violations in West Australian Jail Cells," *The Routledge Handbook of Disability Activism*, (New York: Routledge, 2019), chap. 20, pp. 274-288, (accessed September 9, 2020), <https://www.taylorfrancis.com/books/e/9781351165082/chapters/10.4324/9781351165082-22>.

Solitary Confinement

Prisons in Western Australia use solitary confinement to punish, manage, protect, or ostensibly to keep prisoners alive. Corrective Services in Western Australia uses euphemisms such as “segregation,” “separate confinement,” “crisis” or “safe” cells to characterize prison conditions that amount to solitary confinement, identified as being locked alone in a cell for 22 hours or more a day without meaningful human contact.²⁷

According to the Department of Corrective Services, there is “no limit on how long a prisoner being managed on ARMS [At-Risk Management System] can be in a safe cell or crisis care unit.”²⁸

The United Nations special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has stated that the imposition of solitary confinement “of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment.”²⁹

However, Human Rights Watch research found that people with disabilities are overrepresented in these units because staff are not adequately trained on disability and mental health to distinguish between conduct that stems from the disability or a mental health crisis and one of defiance. Instead of providing psychosocial support, prison staff can reprimand or punish the prisoner for behavior that is perceived as “disruptive,” “disobedient,” or “acting up.”

Furthermore, security concerns inform rules governing solitary confinement units that prevent any meaningful counseling or mental health services and are largely limited to the distribution of medication through a slot in the cell door.

²⁷ Human Rights Law Center, “Stopping Solitary Confinement: Submission to the Royal Commission into Violence, Neglect and Exploitation of People with Disability: Criminal Justice System Issues Paper,” March 31, 2020, <https://www.hrlc.org.au/submissions/2020/9/7/solitary-confinement-must-not-be-used-as-a-response-to-covid-19?rq=solitary> (accessed September 10, 2020).

²⁸ Letter from the Corrective Services of Western Australia to Human Rights Watch, dated June 23, 2020 (see Annex). Until 2015, the ARMS observation levels were high (1 or 2-hourly), moderate (6-hourly) and low (12-hourly). Following the deaths of the deceased persons, the ARMS observation levels were changed and are now: high (1-hourly), moderate (2-hourly) and low (4-hourly).

²⁹ UN General Assembly, “Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment,” A/66/268, August 5, 2011, <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf> (accessed January 18, 2018).

A prisoner with a psychosocial disability in Western Australia told Human Rights Watch:

I was in a punishment unit for 44 days straight. It was horrible. I was fed through a hatch and didn't see sunlight except for three to six hours in that time. It felt like there was no light at the end of the tunnel, that this was the end.³⁰

When his family visited, he told prison staff: "I'm not going back in that cell, I will hang myself from the sink" but instead got sent to the crisis unit³¹ for two days. That not only amounts to solitary confinement, but in addition prisoners have to wear tear-proof gowns and eat finger food. "This was demoralizing.... A way of shaming people who ask for help," he said.

The Office of the Inspector of Custodial Services stated that the "sterile physical environment of the CCU [Crisis Care Unit] was also not therapeutic, and completely inappropriate for treating people with a mental illness."³² The office's 2018 inspection into Hakea Prison, Canning Vale, found the CCU to be "chronically full."³³

The stress of a closed and heavily monitored environment, absence of meaningful social contact, and lack of activity can exacerbate mental health conditions and have long-term adverse effects on the mental well-being of people with psychosocial or cognitive

³⁰ Human Rights Watch interview with a prisoner with a psychosocial disability (name and details withheld by Human Rights Watch), Western Australia, 2019. Under the 1981 Prisons Act, the superintendent or a visiting justice can impose a period of separate confinement in a punishment cell ranging from seven days or less for a minor offense—such as disobeying a prison rule or an officer—to 21 days for multiple offenses. For aggravated offenses, such as assaulting a prisoner or an officer, a magistrate or two Justices of the Peace may impose up to 28 days of separate confinement (with 48 hours out of the punishment cell after each seven days in separate confinement). Located in a detention unit, a punishment cell has a bed, table, shelf, and toilet. Prisoners in such cells lose privileges, such as access to work or leisure activities, and are let into an exercise yard for two hours a day at most. Legal Aid Western Australia, "Prison Offences Information Kit," July 1, 2015, https://www.legalaid.wa.gov.au/sites/default/files/Prison_offences_kit.PDF (accessed June 9, 2020), pp. 2, 3.

³¹ Prison authorities, in consultation with health staff, can place a prisoner in a crisis care unit to monitor their medical or psychological condition, or if they are at high risk of self-harm. The cells can be specially designed with CCTV cameras; no ligatures, hooks, or sharp edges; and have furnishings bolted to the ground or flush to the wall to minimize risk of self-harm and suicide. If the risk of self-harm is high, prison staff provide a tear-proof gown and bedding and finger food. Observation, crisis, or safe cells are located away from mainstream units, sometimes in detention or medical units (for medical supervision), and have a higher staff-to-prisoner ratio. Lack of appropriate cells and overcrowding means prison staff often use punishment cells located in detention units for observation.

³² Office of the Inspector of Custodial Services, *2018 Inspection of Hakea Prison*, February 2019, <https://www.oics.wa.gov.au/wp-content/uploads/2019/02/OICS-Report-121.pdf> (accessed June 16, 2020), p. 43.

³³ *Ibid.*

disabilities.³⁴ All too frequently, people with psychosocial or cognitive disabilities can decompensate in solitary confinement, attempting suicide or requiring emergency psychosocial support or psychiatric hospitalization.

While a death in custody triggers a coronial inquest, Australian prisons do not publicly report on the near deaths or incidents of self-harm that lead to serious injury.

Disruptive Prisoner Policy

Under a Corrective Services Disruptive Prisoner Policy, some prisoners at Casuarina Prison are spending more than 23 hours a day in solitary confinement with as little as 30 minutes of fresh air a day, according to court documents filed in the State Supreme Court on July 29, 2020. The documents were filed by the law firm Roe Legal, on behalf of three 26-year-old Aboriginal men. The affidavits of the three men filed in court state that some prisoners have spent nearly eight weeks in solitary confinement under the punitive Disruptive Prisoner Policy.

Western Australia's Office of the Inspector of Custodial Services raised concerns over the legality of the policy after a 2019 inspection of Casuarina Prison, saying that it created a "risk of prisoner mistreatment." The inspector's report stated:

It is not appropriate (and arguably not lawful) for the department to create a regime equivalent to separate confinement that does not comply with the legislation. Ignoring legislative requirements creates a risk of prisoner mistreatment, and exposes the department to a potential legal challenge.³⁵

While Western Australia's law allows for 23 hours of solitary confinement, under the Western Australia Prisons Act 1981 confinement should not exceed 30 days nor should it be used as a punishment. The Department of Corrective Services introduced the Disruptive Prisoner Policy in July 2019 to separate prisoners who are deemed to "negatively" influence other prisoners. It outlines distinct confinement levels of up to 60 days, which exceeds the Department of Corrective Services' own 30-day limit under the Prisons Act.

³⁴ Human Rights Watch, *'I Needed Help, Instead I was Punished.'*

³⁵ Office of the Inspector of Custodial Services, *2019 Inspection of Casuarina Prison*, March 2020, <https://www.oics.wa.gov.au/wp-content/uploads/2020/05/Casuarina-Report-129.pdf> (accessed May 20, 2020), p. 19.

On July 30, 2020, the State Solicitor's Office said that the Department of Corrective Services would review the Disruptive Prisoner Policy and that no prisoners would be held under that policy until the review was completed.

II. Cases of Deaths in Custody in Western Australia

The *Guardian Australia* recently reported that at least 437 Indigenous people have died in custody throughout Australia since 1991, and in over 40 percent of cases the person had a mental health condition or a cognitive disability.³⁶

Human Rights Watch's analysis of coronial inquest reports between 2010 and 2020 found that about 60 percent of people who died in prisons in Western Australia had a disability. Of these, 58 percent died as a result of lack of support, suicide, or being targets of violence—and half of these deaths were of Aboriginal and Torres Strait Islander prisoners with disabilities.

According to the Department of Corrective Services, as of June 17, 2020, coronial inquests into 46 deaths that occurred in the state's adult prisons were still pending.³⁷

The 1991 Royal Commission into Aboriginal Deaths in Custody

The 1991 Royal Commission into Aboriginal Deaths in Custody found that Aboriginal people were more likely to die in custody in part because they were incarcerated at disproportionate rates. This remains true. Aboriginal and Torres Strait Islander people comprise just 2 percent of the national adult population, but make up 28 percent of Australia's full-time adult prison population.³⁸ Within this group, Aboriginal and Torres Strait Islander people with disabilities are even more likely to end up behind bars.

³⁶ Lorena Allam, "'Deaths in Our Backyard': 432 Indigenous Australians Have Died in Custody Since 1991," *Guardian Australia*, June 1, 2020, <https://www.theguardian.com/australia-news/2020/jun/01/deaths-in-our-backyard-432-indigenous-australians-have-died-in-custody-since-2008>, (accessed June 19, 2020).

³⁷ Letter from the Corrective Services of Western Australia to Human Rights Watch, dated June 23, 2020 (see Annex).

³⁸ At the time of the 1991 Royal Commission into Aboriginal Deaths in Custody, Aboriginal people constituted just under 1.1 percent of the total adult population but 14.3 percent of the total prison population. "Royal Commission into Aboriginal Deaths in Custody," National Report, 1991, Volume 3, Chapter 25, 25.1.1, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol3/163.html> (accessed June 19, 2020). Australia Bureau of Statistics, "4517.0 – Prisoners in Australia, 2018," June 12, 2018, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2018~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics%20~13> (accessed September 9, 2020).

The *Guardian Australia* on June 1, 2020 reported that at least 437 Indigenous people have died in custody throughout Australia since 1991, and in over 40 percent of cases the person had a mental health condition or a cognitive disability.³⁹ The figures of *Guardian Australia* capture all deaths in custody including police, prison, and immigration detention related custody.

The 1991 Royal Commission report had found a strong link between repeated incarceration and attempted suicide.⁴⁰ The importance of kinship and community in Aboriginal culture make the prison experience, rooted in enforced separation from family and physical isolation, “highly traumatic and occasionally potentially lethal” for Aboriginal prisoners.⁴¹

The Royal Commission described how Aboriginal people’s psychological distress, exacerbated in custody, was deeply rooted in the “‘loss’ and ‘bereavement’ they... experienced from... loss of land, social fragmentation, loss of cultural and legal norms, generalised discrimination, institutionalisation, poverty and the forced removal of children.”⁴²

According to Dr. Hannah McGlade, member of the United Nations Permanent Forum on Indigenous Issues and First Nations Peoples Strategic Advisory Group to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: [The 1991 Royal] Commission “did not stem the tide of deaths in custody nor Indigenous incarceration, which has doubled since it made almost 300 recommendations to address over-incarceration.”⁴³

³⁹ Allam, “Deaths in Our Backyard,” *Guardian Australia*; Lorena Allam, Calla Wahlquist and Nick Evershed, “Indigenous Deaths in Custody Worsen in Year of Tracking by Deaths Inside Project,” *Guardian Australia*, August 22, 2020, <https://www.theguardian.com/australia-news/2019/aug/23/indigenous-deaths-in-custody-worsen-over-year-of-tracking-by-deaths-inside-project>, (accessed June 19, 2020).

⁴⁰ “Royal Commission into Aboriginal Deaths in Custody,” National Report, 1991, vol. 3, chap. 25, 25.2.4, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol3/164.html> (accessed June 19, 2020).

⁴¹ “Royal Commission into Aboriginal Deaths in Custody,” National Report, 1991, vol. 3, chap. 25, 25.2.6, 25.2.10, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol3/164.html> (accessed June 19, 2020); McGlade, *The Routledge Handbook of Disability Activism*, chap. 20, pp. 274-288.

⁴² “Royal Commission into Aboriginal Deaths in Custody,” National Report, 1991, vol. 3, chap. 23, 23.3.9, <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol3/71.html> (accessed June 19, 2020).

⁴³ McGlade, *The Routledge Handbook of Disability Activism*, chap. 20, pp. 274-288.

Stanley, Acacia Prison

Stanley (whose full name is not used for cultural reasons), 19, a Noongar man with a mental health condition, from the Fremantle area is suspected to have taken his own life. His cellmates found him hanging in a storeroom in Acacia Prison, Wooroloo, on July 11, 2020. Stanley was taken to Midland Hospital, but never regained consciousness and died two days later.

According to his family, Stanley had anxiety and depression and was on mental health medication at the time of his death.⁴⁴ He was a talented artist who had been planning an exhibition of his artwork upon his release. His older sister, Jacinta Miller, told Human Rights Watch that her brother was struggling to cope in prison and the family had been concerned for his mental health.

She told Human Rights Watch:

He had his struggles with depression. I know he had anxiety. It was his first stint in the adult section of jail. He would tell me that he was sorry for being in there. Telling me it's not a place for kids so he didn't want his nieces or nephews going in there. And I remember his voice, he just said I'm never coming back here again.

The 19-year-old was sentenced to two years for burglary-related offenses and with parole, could have been released in six months.⁴⁵ Stanley spent time at Casuarina and Hakea prisons before being moved to Acacia Prison.

His family noted that he had no “uncle” mentor figures in his life at Acacia Prison. Stanley told his sister that he had asked to be transferred to another section where he had older family members, but his request had been refused. Jacinta told Human Rights Watch her brother was noticeably distressed on the phone when she spoke to him the week before he took his life:

⁴⁴ Human Rights Watch interview with Jacinta Miller sister of Stanley, Perth, Western Australia, August 17, 2020.

⁴⁵ Heather McNeill, “Sorry Won’t do. I’m so angry, I’m so hurt and I’m so let down,” *WA Today*, July 20, 2020, <https://www.watoday.com.au/national/western-australia/sorry-won-t-do-i-m-so-angry-i-m-so-hurt-and-i-m-so-let-down-20200717-p55d4z.html> (accessed September 7, 2020).

He was telling them that he wanted to be moved and they wouldn't listen. I remember him saying to me, "Oh I just want to go over to the next block." [He] tried to tell them "I need to go and be with my uncles." That week that he was not coping, I could hear the distress in his voice, and I said to him, go and do some painting and he just said to me, "Yeah, I will go do some painting." And it broke my heart because when I had to say goodbye to my brother, he still had paint under his nails.

When Jacinta called to speak with Stanley on one occasion in the week before he died, she says she was told by prison staff that he was in the "self-care" unit:

I said I want to speak to your social worker, where is she? And he said we don't have a social worker in prisons. I said can you just give him a message and tell him that I love him, and he said yeah, I can do that. But I don't know if they gave him that message because look what he gone and did?

The family said Stanley was back in the general prison population the day before he died. On the morning of Saturday, July 11, his mother received a call from the prison management. She said the person gave incorrect information about the state he was in, informing them that her son had cut himself and was being taken to Midland Hospital. Once the family arrived, doctors informed them that Stanley had actually hanged himself and he was unconscious. While he was in intensive care, Jacinta says that two prison guards were in her brother's room for much of the time:

They were monitoring who was coming in and seeing him, who was saying goodbye to him. Towards the end of it we started getting irritated and agitated at it, because there was nowhere he could go! He had a machine helping him breathe. There were times when they were giggling and laughing [the guards] and we were sitting there holding his hand and crying. It was really, really horrible for me. I felt like I was in a third world country, I didn't feel like I was in my country.



Jacinta Miller holds a painting by her brother Stanley, a 19-year-old Noongar man with a mental health condition, who is suspected to have taken his own life in Acacia Prison, Wooroloo, on July 11, 2020. Stanley was a talented artist who had been planning an exhibition of his artwork upon his release. © 2020 Sophie McNeill/Human Rights Watch

While Stanley was in the hospital before he passed away, his family noticed evidence that he had been self-harming while in prison. Jacinta said that when she tried to take photos of the injuries, the guards in his room tried to stop her.

Jacinta Miller told Human Rights Watch:

They got up and actually tried to grab our phones off us to tell us that we are not allowed to take photos. But I already had. I'm seeing my brother with physical signs all over his chest and all over his arms. That he was cutting himself. These were weeks old. How was this beautiful boy who was always smiling and laughing, how could they not pick up that he was suicidal? How?

In a tour of Acacia Prison in November 2018, the Office of the Inspector of Custodial Services noted the demand for mental health services “cannot be met” and that short-staffing threatened the quality of service to mental health. He said that, “The team is still very small given it services 1,500 prisoners with high mental health needs and/or AOD [Alcohol and Other Drug] needs.”⁴⁶

Stanley’s sister Jacinta and other members of his family went to Acacia Prison for a special ceremony to remember their brother. Jacinta said she was inundated with distraught relatives who told her they had tried to warn the guards that Stanley was not well:

I had my uncles coming up to me crying and sobbing, my cousins crying and sobbing. They told me they tried to tell the guards, “Stanley’s not coping he needs to come and be with us.... They don’t listen to me sister. They didn’t listen when we tried to tell them about Stanley, and they don’t listen, and they don’t care”.... They [the prison] get paid a lot of money to care for human lives and they did not even treat my brother like a human being. They just need cultural awareness. It just comes down to cultural awareness. If somebody important hears this and hears how special Stanley was to us, then maybe they can actually think, hey if this happened to my family, I would want things right.

Stanley’s death is being investigated by the Western Australia coroner.

Jomen Blanket, Acacia Prison

Jomen Blanket, 30, an Aboriginal prisoner with a psychosocial disability, took his life by hanging in his cell at Acacia Prison, Wooroloo, on June 12, 2019. Prison authorities found him unresponsive in his cell and attempts to revive him were not successful.⁴⁷

Jomen Blanket had a psychosocial disability, and had been moved to a unit for at-risk prisoners due to previous attempts to self-harm. His mother, Karen Blanket, said her son was depressed sometimes. She remembers visiting him in prison to find he had an abrasion on his forehead and was underweight. Jomen Blanket had been in some fights

⁴⁶ Office of the Inspector of Custodial Services, *2018 Inspection of Acacia Prison*, November 2019, <https://www.oics.wa.gov.au/wp-content/uploads/2019/10/OICS-Report-123.pdf> (accessed July 21st, 2020), p. 38.

⁴⁷ Lorena Allam, “Aboriginal Man Dies in Custody Days After Jail Was Told He Was Suicidal,” *Guardian Australia*, June 17, 2019, <https://www.theguardian.com/australia-news/2019/jun/17/aboriginal-man-dies-in-custody-days-after-jail-was-told-he-was-suicidal> (accessed June 16, 2020).

and had a difficult time in prison. According to family members, he was “always down the back” in the segregation unit of the prison, away from the other prisoners. His family stated that he was sent there for disciplinary measures, but also sometimes because he requested isolation when he was depressed.

Karen Blanket said that her son had called her and said he was going to hurt himself, and that she told prison authorities of her concerns before his death. She added that the last time she went to visit her son he would not come out to see her.

Karen Blanket told Human Rights Watch:

[He] had rang me and said he's not the same and there's something wrong with him, you know? And he's experiencing things. I'd never heard him talk like that before, hurting himself and stuff. And even turning me down for a visit. And then I told them [the prison administration] that he said to me that he was going to hang himself.



Karen Blanket holds a photo of her son, Jomen Blanket, who took his own life in his cell at Acacia Prison, Wooroloo, on June 12, 2019. © 2019 Human Rights Watch

Mr. Alf Eades, Hakea Prison

Prisoners attacked Mr. Alf Eades, 46, an Aboriginal prisoner with a psychosocial disability, in his cell at Hakea Prison on February 26, 2019. He died in the hospital on March 11, 2019, after sustaining severe brain swelling, a broken neck, and spinal injuries. Six men have been charged with murder for the beating, which was allegedly carried out on the orders of two motorcycle gang members.⁴⁸ Before his death, Mr. Alf Eades called a family member from prison and told them that he feared for his safety and had asked to be moved to full protection.⁴⁹

People with disabilities, like Mr. Alf Eades, are seen as easy targets. Human Rights Watch research found that people with disabilities are repeatedly picked on, bullied, and harassed by other prisoners or prison staff due to their disability. They are intimidated and blackmailed or cheated out of their cigarettes, food, or other belongings.⁵⁰

According to Steven Caruana, a former inspection and research officer at the Office of the Inspector of Custodial Services in Western Australia:

Mr. Eades was well known to have a psychosocial disability... [and] that his behavior could be considered annoying to other people. He was known to go around prison asking for cigarettes, constantly badgering people for things. He was vulnerable in the sense of his disability but also vulnerable in the sense he could make himself a target because of his impulsive actions and his behavior.⁵¹

Mr. Alf Eade's older brother, Robert Eades, told Human Rights Watch:

My nephew was the last person from our family that spoke to him... he rang saying that he was fearful of his life, there was rumours that certain people were gonna bash him.

⁴⁸ AAP, "Six Perth prisoners deny murdering inmate Hakea inmate Alf Eades," *Perth Now*, December 18, 2019, <https://www.perthnow.com.au/news/court-justice/six-perth-prisoners-deny-murdering-inmate-hakea-inmate-alf-eades-ng-b881414899z> (accessed June 16, 2020).

⁴⁹ AAP, "Fears Over Bikies in WA Prisons After Inmate's Death," *Perth Now*, June 26, 2019, <https://www.perthnow.com.au/community-news/comment-news/fears-over-bikies-in-wa-prisons-after-inmates-death-c-885499> (accessed June 9, 2020).

⁵⁰ Human Rights Watch, *'I Needed Help, Instead I was Punished.'*

⁵¹ Human Rights Watch phone interview with Steven Caruana, former inspection and research officer at the Office of the Inspector of Custodial Services in Western Australia, August 20, 2020.



Robert Eades sits with a photo of his brother Mr. Alf Eades, who died on March 11, 2019, after being attacked in his cell at Hakea Prison, Canning Vale. © 2019 Nicole Tooby/Human Rights Watch

Robert Eades said that while his brother lay unconscious in the hospital his feet were shackled to the bed, and that the restraints were only removed after the family complained. He said his family were heartbroken by his brother's death, which had left his two children orphaned. Robert Eades remembers seeing his brother in the hospital:

He had a very strong heart, he had a very strong will that kept him going and going until his organs shut down.... He had severe brain damage. He was clinically brain dead. Where they booted [kicked] him, and jumped all over his head, and bashed him he had a broken neck, he had spine damage. Swelling and lacerations to the face.⁵²

Mr. Alf Eades' family said he had schizophrenia since he was 16. They were concerned that his psychosocial disability put him at risk in the prison system. His brother said that he had been previously beaten and raped in prison in 2016, requiring hospitalization. No one was held to account for the rape, as far as the family were aware.

⁵² Human Rights Watch interview with Robert Eades, brother of Mr. Alf Eades, Perth, Western Australia, September 10, 2019.

Robert Eades told Human Rights Watch:

When he had come out we knew there was something wrong. Because his life just went downhill. When he spoke out about it to us, then we have seen the signs, the pattern, of how his life changed. And it wasn't for the better.... How can life be cruel with someone so vulnerable? That justice was never even done about it.... What I can say, is that he was just another black person, another number and they didn't really care.

Mr. Alf Eades' cousin, Mervyn Eades, is the former chairman of the Deaths in Custody Watch Committee and founder of Ngalla Maya, an organization that helps Aboriginal and Torres Strait Islander ex-prisoners find employment. He told Human Rights Watch that Mr. Alf Eades' death was preventable, and that he should have been provided with mental health support rather than being sent to prison.

Hakea Prison is not able to effectively provide mental health services despite housing over 25 percent of Western Australia's prisoners with severe mental health conditions which ultimately "creates knock on effects for rest of the prisoner's sentence, and continuity of care into community."⁵³ According to the Office of the Western Australia Inspector of Custodial Services, "Hakea was operating in crisis mode" and a large number of Aboriginal prisoners reported feeling "isolated, sad, and unsupported," particularly during times of grieving and loss."⁵⁴

At the time of his death, Mr. Alf Eades was in custody on remand on minor charges relating to trespassing and disorderly conduct, including spitting at a police officer.⁵⁵

"Even today, my heart aches with pain," Robert Eades told Human Rights Watch. "The reality is that he's gone, he's never coming back."⁵⁶

⁵³ Office of the Inspector of Custodial Services, *2018 Inspection of Hakea Prison*, February 2019, <https://www.oics.wa.gov.au/wp-content/uploads/2019/02/OICS-Report-121.pdf> (accessed June 16, 2020), p. 41.

⁵⁴ *Ibid.*, p. 56, 29.

⁵⁵ Heather McNeill, "Family of Man 'Murdered by Prison Gang on Biekie Boss Orders' Want Justice for His Orphaned Children," *WA Today*, June 26, 2019, <https://www.watoday.com.au/national/western-australia/family-of-man-murdered-by-prison-gang-on-biekie-boss-orders-want-justice-for-his-orphaned-children-20190626-p521hx.html> (accessed July 1, 2020).

⁵⁶ Human Rights Watch interview with Robert Eades, September 10, 2019.

Annabel Nicol, Bandyup Women's Prison

Annabel Nicol, 50, a woman with a psychosocial disability, was on remand in Bandyup Women's Prison, West Swan, when she took her life by hanging herself in a shower cubicle on June 15, 2016.⁵⁷

Nicol had three children and experienced emotional, physical, and sexual violence after marriage. When she was no longer able to cope in her abusive marriage, she turned to alcohol and committed a number of minor crimes to obtain alcohol or under the influence of it.⁵⁸

When she failed to abide by her community-based order, she was taken into custody where she struggled to cope. Although Nicol's pre-sentence psychological report raised serious concerns about her health and psychosocial well-being, she did not receive adequate support in prison. During her time in Bandyup Women's Prison, custodial and the Prison Counselling Service (PCS) raised concerns that Nicole's behavior was "unusual," "childlike," "bewildered," or that she had trouble walking.⁵⁹ Staff suspected she might have a cognitive disability or multiple sclerosis but she was not provided any support or services for it.⁶⁰

In Australian prisons, and specifically in Western Australia, the principal way of preventing prisoners from self-harming or dying by suicide is to reduce the opportunity by placing them in an environment that is so sterile that there are no possible instruments or ways to cause harm. As a result, Nicol spent most of her time in custody in the crisis care or management unit.⁶¹

According to the coroner's report, "the problem with this relocation was that, although it removed the possibility that Ms Nicol would take her life, it increased her distress."⁶²

⁵⁷ AAP, "Urgent Mental Health Care Need in WA Jail," *Perth Now*, July 25, 2019, <https://www.perthnow.com.au/community-news/the-advocate/urgent-mental-health-care-need-in-wa-jail-c-887553> (accessed June 9, 2020).

⁵⁸ Coroner's Court of Western Australia, "Inquest into the Death of Annabel Nicol (715/2015)," https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Nicol%20finding.pdf (accessed July 7, 2020), p. 4.

⁵⁹ *Ibid.*, pp. 5, 7, 12-15, 20.

⁶⁰ *Ibid.*, p. 5.

⁶¹ *Ibid.*, p. 24.

⁶² *Ibid.*

Life in the Crisis Care Unit (CCU) amounts to solitary confinement with prisoners spending up to 23 hours a day in their cells with no meaningful social interactions and very little to do. Nicol found the stress of a closed and heavily monitored environment increasingly distressing, especially as she was not allowed to go outside, smoke, make phone calls and socialize when she wanted.⁶³

Human Rights Watch research suggests that prisoners often experience the CCU as humiliation and punishment for help-seeking behavior and over time can resort to concealing their distress instead of accessing services.⁶⁴ According to the staff, Nicol found the CCU to be a punitive environment where “she was being punished for bad behaviour rather than being taken [...] to keep her safe.”⁶⁵ After a court appearance left her feeling hopeless, PCS staff were concerned that Nicol might try to conceal her distress so as not to be sent back to the CCU. Five days later, Nicol took her own life.

The coroner noted that while the CCU kept women physically “safe,” it “did not provide a dedicated therapeutic environment for women in psychological distress.”⁶⁶ The coronial inquest report found evidence that the CCU was so damaging that staff were reluctant to send prisoners to the CCU because it was “at odds with their commitment and dedication to caring for their patients.”⁶⁷ While management acknowledged the need to improve the CCU, the coroner noted that as of February 2019, “nothing had changed.”⁶⁸

The coroner’s report and the Inspector of Custodial Services both recommended an overhaul of mental health services for women in prison, including the establishment of a subacute unit at Bandyup Women’s Prison.⁶⁹ While better mental health services are urgently needed in Western Australia’s prisons, it would be critical to ensure that a subacute unit does not amount to involuntary treatment or solitary confinement, in line with Australia’s obligations under the Convention on the Rights of Persons with

⁶³ Ibid., p. 25.

⁶⁴ Human Rights Watch, *‘I Needed Help, Instead I was Punished.’*

⁶⁵ Coroner’s Court of Western Australia, “Inquest into the Death of Annabel Nicol (715/2015),” https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Nicol%20finding.pdf (accessed July 7, 2020), p. 17.

⁶⁶ Ibid., p. 31.

⁶⁷ Ibid.

⁶⁸ Ibid.

⁶⁹ Ibid.

Disabilities.⁷⁰ It is also critical to ensure the unit provides mental health services that are culturally competent and appropriate.

Mr. Jackamarra, Broome Regional Prison

Mr. Jackamarra (whose full name is not used for cultural reasons), 36, an Aboriginal prisoner with a psychosocial disability, died on December 16, 2015, at Broome Regional Prison. He appeared in court that day on charges related to a bailable arson offense but was placed in custody when a relative did not arrive in time to sign the necessary documents.

When he left for court that day, Mr. Jackamarra's family had no reason to believe he would never return. "That morning when he went to court, he sung out 'Mum, put the chicken out, I'll come back and cook you supper,'" said his mother, Georgette Jackamarra. "But he never came back."

While he waited in the court's holding cell, Mr. Jackamarra became increasingly distressed and began banging his head against the wall and asking for his medication. He was transferred across the road to Broome Regional Prison, in Broome. Four hours after being taken into custody, he took his own life by hanging in the shower block.⁷¹

Mr. Jackamarra had a psychosocial disability and had been on daily medication for many years, including during his time in custody. Although he had been in Broome Regional Prison more than 20 times and his mental health history was well known to the prison authorities, he was not identified as being at risk of self-harm.

In 2019, the coronial inquest into his death recommended improved information sharing between the prison system and medical services, and said that mental health staff should assess prisoners with psychosocial disabilities or past self-harm attempts on arrival.⁷²

⁷⁰ Convention on the Rights of Persons with Disabilities (CPRD), adopted December 13, 2006, G.A. Res. 61/106, annex I, U.N. GAOR, 61st Sess., (No. 49) at 65, U.N. Doc A/61/49 (2006), entered into force May 3, 2008, ratified by Australia on August 16, 2008.

⁷¹ Rhiannon Shine, "Aboriginal Death in Custody Inquest Hears Man Died Waiting for Bail Paperwork to be Signed," *ABC News*, October 31, 2018, <https://www.abc.net.au/news/2018-10-31/indigenous-man-died-after-four-hours-in-custody/10449054> (accessed June 16, 2020).

⁷² Coroner's Court of Western Australia, "Inquest into the Death of Khamsani Victor Jackamarra," (F/No: 16037/2015), May 9, 2019, [https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Jackamarra%20\(Khamsani\)%20finding.pdf](https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Jackamarra%20(Khamsani)%20finding.pdf) (accessed June 16, 2020).

Mr. Bell, Casuarina Prison

Mr. Bell (whose full name is not used for cultural reasons), 28, an Aboriginal prisoner with a psychosocial disability, was held in prolonged solitary confinement in his cell for over 22 hours a day for 13 months when he took his own life on September 8, 2015, at Casuarina Prison.⁷³

Mr. Bell was serving concurrent sentences including life imprisonment for sexual assault and murder of a 10-month-old baby. At his sentencing hearing, his lawyer contended Mr. Bell would be targeted and killed in prison due to the nature of his crime.⁷⁴

Fellow prisoners assaulted Mr. Bell multiple times and on one occasion even fractured his skull.⁷⁵ Mr. Bell also complained of ongoing mistreatment by custodial staff. However, the coronial inquest found little evidence of the records of these complaints and how they were addressed.⁷⁶ Notwithstanding the heinous nature of his crime, corrective services had a duty to ensure Mr. Bell was safe and protected in custody.

However, instead of being housed in a protection unit for at-risk prisoners, corrective services placed Mr. Bell in the crisis care unit and in the Special Handling Unit (SHU) for his “protection and to maintain the good order of the prison.”⁷⁷ Prison staff shackled Mr. Bell when he left his cell to make phone calls to family members, which his family says was degrading for him. While shackling can be a part of the SHU escort procedure, in Mr. Bell’s case, the coroner found no record of restraints being required for the safety of others.⁷⁸ This lapse in record-keeping is particularly concerning for the SHU where prisoners are isolated, at heightened risk of abuse by staff, and oversight is limited. In his 2019 inspection of Casuarina’s SHU, the Inspector of Custodial Services also expressed concern about the lack of up-to-date records.⁷⁹

⁷³ As per international law, the term “prolonged solitary confinement” refers to solitary confinement for a time period in excess of 15 consecutive days. United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules), A/RES/70/175, January 8, 2016, <https://undocs.org/A/RES/70/175> (accessed July 2, 2020).

⁷⁴ Stephanie Dalzell and Joanna Menagh, “Mervyn Bell, Man Who Killed Baby Stepson, Found Dead in Casuarina Prison Near Perth,” *ABC News*, September 8, 2015, <https://www.abc.net.au/news/2015-09-08/baby-murderer-mervyn-bell-found-dead-in-casuarina-prison-cell/6759990> (accessed July 6, 2020).

⁷⁵ Coroner’s Court of Western Australia, “Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam,” (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 2, 2020), p. 44.

⁷⁶ *Ibid.*, p.49.

⁷⁷ *Ibid.*, p.43.

⁷⁸ *Ibid.*, p.49.

⁷⁹ *Ibid.*, p. 18.

The SHU imposes the greatest restrictions on prisoners' freedom and amounts to prolonged solitary confinement, which has devastating consequences for a person's mental health.⁸⁰ According to both the Casuarina Prison psychiatrist and psychologist, "the isolation of the SHU [Special Handling Unit] greatly increased the risk of suicide" and can cause "irreversible psychological trauma if housed in solitary confinement for periods of 10 days or more"—and yet Mr. Bell was kept in the SHU for 13 months.

The UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has said that "prolonged solitary confinement may amount to an act of torture and other cruel, inhuman or degrading treatment or punishment and recommended that solitary confinement should not be used in the case of minors or the mentally disabled."⁸¹

Furthermore, the coroner's report referenced Mr. Bell's difficult childhood and the strong correlation between Adverse Childhood Events (ACE), the development of mental health conditions, and an increased risk of imprisonment.⁸² Mr. Bell lost both his parents before the age of five and was physically abused by his stepfather.

Prisoners who experience ACE are 30 to 40 times more likely to die by suicide than other prisoners. In the week before his death, Mr. Bell left several voicemails indicating his intention to take his life. And yet, Mr. Bell was not placed on the Support and Monitoring System (SAMS), a suicide prevention measure, at the time of his death.

According to the prison psychologist, Mr. Bell would "probably have been placed on SAMS had PCS resources been greater at the time of his incarceration" and he would have been "offered treatment for PTSD had PCS resources allowed."⁸³

⁸⁰ Human Rights Watch, *'I Needed Help, Instead I was Punished.'* p. 42-44.

⁸¹ UN General Assembly, "Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment," A/66/268, <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf>, para. 58.

⁸² As per the coroner's report, Adverse Childhood Events (ACE) refers to neglect, domestic violence, emotional, physical or sexual violence, the loss of loved ones (including by incarceration), parents or significant others with mental health conditions and exposure to alcohol or drug use at an early age. Coroner's Court of Western Australia, "Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam," (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 2, 2020), p. 12.

⁸³ Coroner's Court of Western Australia, "Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam," (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 7, 2020), p. 37.

Mr. Cameron, Casuarina Prison

Mr. Cameron (whose full name is not used for cultural reasons), 26, an Aboriginal prisoner with a psychosocial disability, was placed in a safe-cell after he tried to self-harm on October 9, 2015.⁸⁴ Following the incident, Mr. Cameron was transferred from Greenough Regional Prison in the suburbs of Geraldton to Casuarina Prison in Perth.

At Casuarina Prison, Mr. Cameron expressed reluctance to stay in a ligature-minimized cell within the protection unit, due to the stigma attached to it.⁸⁵ Instead of placing him in a ligature-minimized cell in another unit, prison staff assigned Mr. Cameron to a regular cell. Despite his well-documented history of self-harm, prison staff perceived Mr. Cameron as “cry[ing] wolf” and “playing up” to create a change in environment.⁸⁶

The coroner’s report found it “regrettable” that prison staff failed to respect the mandatory requirement of recording the rationale for Mr. Cameron’s placement in a non-ligature minimized cell.⁸⁷

Being “out of country,” was a source of distress for Mr. Cameron and he asked to see an elder or Aboriginal Visitor’s Service worker on numerous occasions in May and September 2014 and again in May and October 2015.⁸⁸ Mr. Cameron’s last request was made a mere three days before he self-harmed at Greenough Regional Prison. However, the coroner’s report did not find any evidence to suggest that any of the referrals were actioned.⁸⁹

⁸⁴ As a child, Mr. Cameron was exposed to ACE, including losing his father to suicide in prison when he was 9 years old. One of his sisters took her own life and another died in a car accident. The coroner’s report noted that in addition to a “personality disorder,” Cameron was suspected to have FASD but there was no evidence of an assessment. Coroner’s Court of Western Australia, “Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam,” (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 7, 2020), p. 12, 60.

⁸⁵ The special protection unit is meant for prisoners at special risk from the rest of the prison population. It often houses former police or prison officers as well as child sex offenders who are targeted and attacked by fellow prisoners.

⁸⁶ Coroner’s Court of Western Australia, “Inquest into the deaths of Mervyn Bell, Bevan Cameron, Brian Honeywood, JS (Subject to Suppression Order) and Aubrey Wallam,” (File No. 1132/15, 1347/15, 206/15, 940/15, 1258/14), https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Casuarina_Deaths_Finding.pdf (accessed July 7, 2020), p. 69.

⁸⁷ Ibid.

⁸⁸ Ibid., p. 64.

⁸⁹ Ibid., p. 65.

As per his management plan, Mr. Cameron was supposed to be placed with a compatible cellmate to prevent him from self-harming.⁹⁰ However, on October 25, 2015, his cellmate got transferred, leaving him alone in his cell. Three days later, on October 28, Mr. Cameron took his own life.

JS, Casuarina Prison

JS (whose full name is subject to a suppression order), 68, a prisoner with a psychosocial disability, hanged himself from a ligature in his cell on August 3, 2015, three days before he was scheduled to appear in court.

At the time of his death, JS was on remand. Upon entry into prison, he had alerted prison and PCS staff of his previous attempts to self-harm. However, he was taken off their At-Risk Management System (ARMS).

His entry into prison at a more advanced age, deep shame with regards to his crimes, and previous attempts at self-harm, placed him at increased risk. The coroner's report states that JS "would have been an ideal candidate for SAMS."⁹¹ However, prison staff failed to identify JS as a prisoner who required more support or monitoring.

⁹⁰ Ibid., p. 37.

⁹¹ Ibid., p. 93.

III. Government Efforts

The Western Australia Department of Corrective Services have taken several measures that have helped reduce the number of deaths in custody. However, rates of self-harm remain very high for people with psychosocial or cognitive disabilities.

Response to the Coroner's Recommendations in the Cases of Mr. Alf Eades, Jomen Blanket, Mr. Jackamarra, Mr. Bell, Mr. Cameron, and JS

The Department of Corrective Services told Human Rights Watch that it was not able to disclose information in the cases of on-going coronial inquests but shared information on Mr. Jackamarra, Mr. Bell, Mr. Cameron and the JS cases.

Following Mr. Jackamarra's death, the Department stated that Broome Regional Prison created a team of five people who can be called in to support at-risk prisoners, including those who may be in prison for the first time, those who have received bad news, or those confined to safe cells. The prison also enables prisoners to identify family members or prisoners from the same cultural group and to "buddy up" with them for additional support. Human Rights Watch suggests an independent review of how this new system is working in practice.

One response to the deaths in custody was to change the Department of Corrective Services' policy on razor blades so that prisoners could only use them for a set period of time and had to return them immediately.⁹² Mr. Bell and Mr. Cameron had used razor blades to self-harm.

The Department of Corrective Services further approved a budget of A\$2.99 million (US\$2 million) for 2015 to 2019 to carry out a ligature-minimization program to prevent prisoners using ligatures to self-harm or hang themselves.⁹³ However, the coroner's inquest report in May 2019 found that only 40 percent of cells at Casuarina Prison, where five of the deaths took place, were ligature-minimized.⁹⁴

⁹² Ibid., p. 109.

⁹³ Ibid., p. 111.

⁹⁴ Ibid., p. 114.

In addition, prisons also revised their At-Risk Management System (ARMS) to check in more frequently on prisoners in crisis.⁹⁵ Following the five deaths in Casuarina prison, the Department of Corrective Services took steps to recruit additional staff for the Prison Counselling Service.

A direct consequence of Nicol's death was the provision of free nicotine replacement therapy for Crisis Care Unit (CCU) prisoners.⁹⁶

Improvement to Services, Based on Information Provided by Corrective Services

In February 2020, the Department of Corrective Services created the Mental Health Alcohol and Other Drug (MHAOD) branch incorporating mental health nursing, consultant psychiatry, psychological health services (prison counselors) and prison support services, which includes Aboriginal visitors and peer support workers. The MHAOD prison support services includes Aboriginal and Torres Strait Islander staff.⁹⁷

In January 2020, the Department of Corrective Services introduced the Mental Health First Aid training into the training curriculum for new trainee prison officers and vocational support officers. The aim of the training is to “cultivate awareness of mental health issues, build appreciation for humane responses to mental health and trauma amongst staff and prisoners and rehearse skills for appropriate officer responses to prevent crisis and reduce risks.”⁹⁸

In July 2019, the Department of Corrective Services conducted a review of mental health services in prison.⁹⁹ The final report made 14 recommendations relating to support services including prisons support officers, Aboriginal visitors, and peer support programs, which were approved by the Department of Corrective Services in February 2020.¹⁰⁰ However, the focus of the review was to realign service delivery to ensure a “cohesive and

⁹⁵ Ibid., p. 114.

⁹⁶ Coroner's Court of Western Australia, “Inquest into the Death of Annabel Nicol (715/2015),” https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Nicol%20finding.pdf (accessed July 7, 2020), p. 25.

⁹⁷ Letter from the Corrective Services of Western Australia to Human Rights Watch, dated June 23, 2020 (see Annex).

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

multidisciplinary case management approach to suicide and self-harm prevention” rather than to address the nature or quality of mental health services.¹⁰¹ The Department of Corrective Services is currently in the process of consulting “key stakeholders including Aboriginal prisoners” before moving to implement the 14 recommendations.¹⁰²

According to the Department of Corrective Services, in the last year, the Psychological Health Services has “rolled out a new model of service to better meet the clinical needs of prisoners, and introduced new protocols in the assessment of suicide risk.”¹⁰³

The Department of Corrective Services also instituted a system to manage the transition to the National Disability Insurance Scheme (NDIS) which will result in the development of NDIS access pathways for prisoners. According to the Department of Corrective Services, it will also enable NDIS training for prison officers, improvements to disability identification, and ensure prisoners are linked to the appropriate disability services upon release.¹⁰⁴ In addition, the Department of Corrective Services health services have provided additional training to health staff on the importance of recognition of disability, specifically sensory and cognitive disabilities.¹⁰⁵

The Department of Corrective Services is working to create new units at Casuarina prison in 2022-23 that will include 344 new beds and a dedicated mental health unit as part of the expansion.

Improvement to Services, Based on Information Provided by SERCO, the Company Running Acacia Prison

Acacia Prison officials told Human Rights Watch that they were unable to disclose information in the cases of ongoing coronial inquests but shared information on efforts to improve support and services for prisoners.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

Following the 2018 inspection by the Inspector of Custodial Services, Acacia Prison created the Community Partner Network Acacia to work collaboratively with local and culturally competent community organizations to provide holistic support to prisoners. As part of this effort, Acacia Prison in 2019 launched a peer support program in conjunction with the Australian Red Cross to address the health and well-being of prisoners. Prisoners who volunteer as team leaders identify issues to try and improve health, well-being, and safety. The methodology is aimed at encouraging personal development, empowerment, and ownership for volunteers. This is based on a model used in prisons in Ireland.¹⁰⁶

In early 2019, Acacia extended mental health services to include two in-prison services for consultation and liaison with prisoners and a transition service to support men moving towards release.

Acacia Prison partnered with the Aboriginal health organization Derbarl Yerrigan to provide culturally appropriate support for Aboriginal and Torres Strait Islander prisoners. According to the prison management, while Derbarl Yerrigan does not provide mental health services, the cultural support contributes to better psychological well-being.

In August 2020, the prison initiated a Memorandum of Understanding with Wungening Aboriginal Corporation for two Indigenous mental health support officers to be placed at the prison. Acacia Prison is also in the process of filling three extra positions to provide mental health support.

Acacia Prison reviewed its ARMS manual and is considering introducing an after-hours telepsychiatry model to advise and support its health and custodial staff.

Response to Recent Deaths in Custody

After three suspected suicides in the state's prisons since the beginning of 2020, the Western Australian government announced a taskforce to assess the current management

¹⁰⁶ Australian Red Cross, "Red Cross prison wellbeing program launches in Perth," undated, <https://www.redcross.org.au/news-and-media/news/prison-wellbeing-perth> (accessed September 9, 2020).

of at-risk prisoners.¹⁰⁷

The main aim of the taskforce will be to review existing policies, determine whether prison practice aligns with the state's suicide prevention strategy, including whether it is culturally appropriate, and whether privately run prisons are effectively managing prisoners, as per the terms of their contract. It will also examine the state of staff suicide prevention training.

¹⁰⁷ Government of Western Australia, "Suicide prevention taskforce to examine management of at-risk prisoners," August 18, 2020, <https://www.mediastatements.wa.gov.au/Pages/McGowan/2020/08/Suicide-prevention-taskforce-to-examine-management-of-at-risk-prisoners.aspx> (accessed August 25, 2020).

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Most importantly, Human Rights Watch thanks all those who shared their personal experiences, all of whom spoke with great courage and dignity.

This report is dedicated to those who lost their lives in Australian prisons and their families, in the hope that additional families can be spared their pain.

Annex

Letter to Human Rights Watch from Western Australia Department of Corrective Services



Government of Western Australia
Department of Justice
Corrective Services

All enquiries:
Phone:
Your Ref:



Ms Elaine Pearson
Australian Director
Human Rights Watch
PO Box 4278
Sydney NSW 2001

Dear Ms Pearson

Prisoners with Disabilities in Corrective Services Australia

Thank you for your letter dated 18 June 2020 regarding the steps the Department of Justice, Corrective Services (the Department) has taken to improve the situation for people with disability in Western Australian prisons.

Please see below responses to the questions you raised in your correspondence.

1. *Over the last two years, what steps has WA Corrective Services taken to improve the situation of prisoners with disabilities in WA Prisons?*

The disability sector in Australia has undergone significant reform in recent times with the introduction of the National Disability Insurance Scheme (NDIS). The Department, in line with an enhanced focus on disability, has implemented a number of initiatives to improve the outcome for prisoners with disabilities. In the last 12 months the Department has implemented a strategic NDIS change management project to manage the transition to the NDIS. This project is nearing completion and will result in the development of NDIS access pathways for prisoners, access to NDIS training for staff and prison officers and ongoing access to relevant information regarding disability in the criminal justice system and NDIS processes to support staff. In addition, improvements to disability identification and alert mechanisms and data capture will assist to identify disability related needs and ensure individuals are linked in with appropriate NDIS funded disability services on release.

In parallel with this project, the Disability Coordination team in the Department's Rehabilitation and Reintegration directorate has increased its resourcing to take on additional functions and improve outcomes for prisoners with disabilities.

This includes an increased capacity to action disability related internal and external referrals/enquiries which ensures that internal and external parties are able to efficiently escalate matters relating to individuals with a disability for attention and action; coordination and provision of training internally and externally, as well as respond to recently acquired significant functions relating to the roll out of the NDIS including the coordination of: NDIS access, planning and review related matters for prisoners and NDIS training.



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The Department of Health's State Forensic Mental Health Services Prison In Reach Transition team and departmental Psychiatrists are assisting prisoners in completing NDIS applications and preparing the necessary evidence. The focus of this has mainly been on ensuring funding for the allocation of case workers in the community management and the rehabilitation of patients with chronic mental illness or autism, poor social functioning, and general lack of supports.

Training is currently being arranged for Mental Health Alcohol and Other Drug (MHAOD) staff including nursing, psychological health services and prison support services (including Aboriginal Visitors) in the new NDIS processes for Psychosocial Disability to assist in identifying what supports are available and how applications can be progressed.

The Department's Health Services has provided additional training to Health staff on the importance of recognition of disability, especially with previously unrecognised sensory and cognitive disability. The inclusion of disabilities into the summary notes and/or active problem lists and alerts in the prisoner's electronic medical record is also encouraged as is the inclusion of NDIS status into standard documentation.

Referral pathways for assessment and management of prisoners with disability have been assured including access to Hearing Australia, a tender with optometry and podiatry services, access to neurocognitive testing referral pathways especially for youth and the Department of Health rehabilitation services for neurological and spinal disabilities.

NDIS access has been promoted including written information to Health Services staff on referral pathways and education sessions from Disability Services regarding referral pathways, assessments and service availability.

Equipment beneficial to the daily function and inclusion of people with disability into normal prison activities is made available when possible, including hearing aids, visual aids, walking aids, hygiene/ablutions equipment.

2. *Has the mental health training for prison staff or mental health services available in WA prisons changed in any way since February 2018?*

A Review of Mental Health services occurred in July 2019. The review highlighted that the Department's Mental Health services could be improved by changes to the structure, procedures and training of staff. This would better align the service approaches of each area and deliver a more cohesive and multidisciplinary case management approach to suicide and self-harm prevention and to address the very complex needs of prisoners arising from Alcohol and Other Drug (AOD) and Mental Health co-morbidity or dual diagnosis. The final report from the review included 14 recommendations that were signed off in February 2020.

In February 2020 the MHAOD Branch was created incorporating mental health nursing, consultant psychiatry, psychological health services (prison counsellors) and prison support services which includes aboriginal visitors and peer support workers. An implementation plan has been developed to progress the remaining recommendations.

Since February 2018, the Department has augmented existing mental health training opportunities for staff working in WA Prisons through the introduction of the following programs:

- Mental Health First Aid (MHFA) was introduced into the curriculum for foundation training for new Trainee Prison Officers and Vocational Support Officers in January 2020. The aim of the MHFA training is to enable staff to develop the skills they need to reach out and provide initial help and support to someone who may be developing a mental health condition or experiencing a crisis. The MHFA training teaches staff how to recognise the cluster of symptoms of different illnesses and mental health crisis, how to offer and provide initial assistance and how to guide the person towards appropriate treatment and other supportive help. The training assists to cultivate awareness of mental health issues, build appreciation for humane responses to mental health and trauma amongst staff and prisoners and rehearses skills for appropriate officer responses to prevent crisis and reduce risks.
 - Stand T.A.L.R (Talk, Ask, Listen, Refer) was developed after the first annual Western Australian Prison Officers Union (WAPOU) Respect Your Mental Health Seminar held in August 2017. Since then, Stand T.A.L.R has been delivered to over 1,500 correctional staff across Western Australia and New Zealand. STAND T.A.L.R is designed to encourage prison officers to overcome the resistance, fear and stigma within the Department of seeking professional help when faced with the challenges of poor mental health. Feedback on the effectiveness of the program has been positive with staff indicating the training has provided them with a greater understanding of the practical steps to take if they, their colleagues or members of their family require immediate professional support. The Stand T.A.L.R program was included in the curriculum for the Entry Level Training Program (ELTP) for new Trainee Prison Officers from June 2019. The program better prepares new prison officers for the demands of the role through awareness of the professional support available if faced with the challenges of poor mental health.
3. *Could you share information on the new units at Casuarina Prison for prisoners with mental health conditions or cognitive disabilities?*

The new units at Casuarina Prison will include an AOD Rehabilitation unit which will have dedicated and specifically trained staff, including training in MHAOD. The staff consists of uniformed and non-uniformed Department staff as well as Non-Government Organisations.

The staff will work collaboratively as a team to provide holistic, trauma informed, culturally secure and recovery focused care with each individual having a dedicated MHAOD case manager and individualised care plan. Prisoners will be provided with evidence-based interventions to support them in addressing MHAOD related harm and comply with their offending treatment needs.

Additional MHAOD positions have been created to accommodate the expansion and are currently being recruited to. The MHAOD team are involved in the planning for a future dedicated Mental Health unit at Casuarina Prison as part of the proposed 344 expansion.

4. *What steps is corrective services taking to prevent the spread of COVID-19 in prisons?*

The Department has worked collaboratively with the Western Australia Department of Health in the management of prisons to prevent the spread of COVID-19 and the provision of care to all prisoners and detainees. A range of measures have been introduced including:

- provision of Personal Protective Equipment to frontline and medical staff;
- provision of face masks, face coverings and hand sanitiser to prisons and detention centres (in addition to the range of soaps provided as a matter of course);
- implementation of infection control measures such as social distancing, personal hygiene and increased cleaning regimes;
- temperature testing of staff and official visitors before they enter a facility, and new prisoners and detainees at Reception;
- increasing the health literacy of prisoners, detainees and staff around hygiene and social distancing through leaflets and posters, and online training for staff; and
- development of isolation areas to care for prisoners presenting with flu-like symptoms, who are then tested for COVID-19 and Influenza.

On 23 March 2020 all social visits to prisoners were suspended. While official and legal visits continued, they were carefully managed by prison staff and official visitors were encouraged to use alternate contact options such as telephone or video-conferencing. Any face-to-face visits which did occur did so in line with social distancing measures.

On 29 March 2020, the Prisoner Employment Program and Reintegration Leave were suspended. Prisoners in paid employment continued to receive gratuities.

On 1 April 2020, restrictions were placed on Section 95 activities, which normally allow community, charitable or voluntary work outside prison boundaries. Some of these activities were transferred to prison estates, while others have been suspended.

There are some exceptions for essential services and where contact with non-prisoners is minimal. Work camps also continued to operate.

All departmental prisons, detention centre and community sites have Business Continuity Plans in place to ensure the continued delivery of core services during the management of COVID-19.

5. *During the COVID-19 pandemic, what type of mental health services do prisoners have access to?*

MHAOD services have continued to operate business as usual including Mental Health Prison In reach provided by State Forensic Mental Health Services. Prisoners continue to be referred to Mental Health Services including nursing, Consultant Psychiatry, Psychological Health Service and Prison Support Services including Aboriginal Visitors.

The Department's MHAOD Branch have prepared a MHAOD Pandemic plan in response to COVID-19 (in accordance with the Department's COVID-19 Taskforce overarching strategy). The plan includes identifying risks and appropriate mitigation strategies as well as business continuity plans to ensure continuity of essential MHAOD services.

Strategies are in place to ensure that prisoners suspected of having or confirmed to have COVID-19 are identified. If the prisoner is a MHAOD patient or has MHAOD needs, alerts will be added outlining any risks to self or others as well as the MHAOD supports that will be provided. This includes identifying whether individuals, including young persons can be safely managed in isolation and how.

Staff and Prisoner wellness toolkits were prepared and distributed by MHAOD team to offer support during this time.

6. *How many deaths in custody have there been in WA prisons over the last five years (by year)? How many of them were of people with disabilities (including cognitive disabilities or mental health conditions)? What were the causes of death? And how many of the prisoners who died in custody were in the special handling unit, in separate confinement, in crisis or safe cells or other solitary confinement regimes at the time of death?*

The Department has had a total of 64 adult deaths in custody over the last five financial years (data as at 17 June 2020).

- 18 have been subject to Coronial Inquests with outcomes determined by the Coroner. Further information can be obtained from the Coroner's Court website.
- 46 are pending Coronial Inquests and outcomes are yet to be determined by the Coroner.

The Department does not disclose the health information of prisoners nor their security placement within a facility.

7. *As of January 2020, how many treatment assessments are overdue and what is the reason for the delay?*

As of 1 January 2020 there were 429 treatment assessments that were overdue state-wide. This backlog was due to:

- Existing staff resources were unable to keep up with demand for assessments for the increase prison population
- Dual role of treatment assessment and offender program delivery in regional prisons, with program delivery limiting the capacity for treatment assessments
- Difficulty recruiting to staff vacancies at regional prison locations.

The timely treatment assessment of prisoners has been reviewed through the Department's Individual Management Plan (IMP) Review and the report has been endorsed in principle pending negotiations with relevant unions, affected staff and management prior to final approval by the Commissioner.

8. *In Hakea Prison, how long do prisoners have to wait for medical appointments?*

Standard wait times for non-urgent appointments for prisoners at Hakea Prison is two weeks to see a Prison Medical Officer, two to three weeks to see a Primary Health Nurse and four weeks to see a Dentist.

9. *What percentage of WA adult prison staff is Aboriginal or Torres Strait Islander? What percentage of health staff in WA adult prisons is Aboriginal or Torres Strait Islander? Could you provide a breakdown of Aboriginal and Torres Strait Islander staff and health workers by prison?*

Please see attachment one which provides a breakdown of the data requested.

10. *What is the maximum amount of time a person can spend (consecutively) in separate confinement or in a safe or crisis cell?*

Superintendents are responsible for the good order and security of the prison and the provision of a safe, secure and humane custodial environment. Superintendents achieve this outcome by identifying and minimising the threat of subversive behaviour, negative influence and violent acts amongst both individuals, and groups of prisoners, in prisons.

There may be cases where a prisoner needs to be separated from other prisoners in order to maintain the good order and security of the prison, when this occurs the length of time a prisoner spends in separate confinement is managed in line with the relevant Departmental policy and/or regulation.

Prisoners who are considered at a high risk of self-harm or suicide are managed on the Department's At Risk Management System (ARMS). The objective of ARMS is to enable a high quality of care to be given to prisoners. These prisoners can be placed in a safe or crisis cell or be subject to separate confinement.

There is no limit on how long a prisoner being managed on ARMS can be in a safe cell or crisis care unit, this will be determined by the Department's Prisoner Risk Assessment Group (PRAG) and is dependent on a comprehensive risk-assessment of the prisoner.

11. *What measures has Corrective Services taken to prevent deaths in custody, especially those as a result of self-harm or attacks by other prisoners?*

Please see answer to question 2 above. In addition to this please note the following points:

- Over the last year the Psychological Health Service has progressively rolled out a new model of service to better meet the clinical needs of prisoners, and introduced new protocols in the assessment of suicide risk.
- The Review of Mental Health Services that was approved in February 2020 includes key recommendations that relate to Prison Support Services. Prison

Support Services consist of Prison Support Officers, Aboriginal Visitors and peer Support program. These services provide cultural support and assist prisoners who are at risk of self-harm and ensure appropriate interventions working closely with prison officers, nursing staff and psychological health services. A project is currently underway to progress these recommendations, as part of this project, consultation is occurring with a range of key stakeholders including Aboriginal Prisoners.

- The creation of the MHAOD Branch including a review of the existing staff allocation for Prison Support Services. An additional 18 permanent positions have been included in the budget for this financial year across the prison estate including regional to enable the existing casual staff the opportunity to hold permanent roles to provide more stability and consistency in service.

12. – 14. *Information on the case of Jomen Blanket.*

The Department is not authorised to disclose this information.

15. – 17. *Information on the case of Alf Dean Eades.*

The Department is not authorised to disclose this information.


18. *Information on Department's progression against the Coroner's recommendations regarding the case of Khamsani Victor Jackamarra.*

Please see attachment two which provides the Department's progress against each recommendation.

19. *Information on the Department's progression against the recommendations from the Coroner's inquest into five deaths in custody in Casuarina Prison.*

Please see attachment three which provides the Department's progress against each recommendation.

Yours sincerely


Tony Hassall
COMMISSIONER
CORRECTIVE SERVICES

 July 2020

Attachments: Attachment 1
Attachment 2
Attachment 3

- 9) What percentage of WA adult prison staff is Aboriginal or Torres Strait Islander? What percentage of health staff in WA adult prisons is Aboriginal or Torres Strait Islander? Could you provide a breakdown of Aboriginal and Torres Strait Islander staff and health workers by prison?

BRANCH	Location	Self-identified Aboriginal
Adult Custodial Operations	Albany Regional Prison	2.16%
	Broome Regional Prison	12.70%
	Bunbury Regional Prison	2.34%
	Casuarina Prison	1.76%
	Dowerin Work Camp	0.00%
	Eastern Goldfields Regional Prison	5.29%
	Greenough Regional Prison	5.59%
	Hakea Assessment Centre	0.00%
	Hakea Prison	1.26%
	Karnet Prison Farm	1.90%
	Pardelup Prison Farm	2.04%
	Prison Industries	0.00%
	Roebourne Regional Prison	5.15%
	Roebourne Work Camp	12.50%
	Walpole Work Camp	25.00%
	Warburton Work Camp	0.00%
	West Kimberley Regional Prison	10.66%
	Wooroloo Prison Farm	1.85%
	Wyndham Work Camp	0.00%
Adult Custodial Operations Total		3.11%
Health Services	Albany Regional Prison Health Centre & Medical	0.00%
	Bandyup Womens Prison Health Centre & Medical	0.00%
	Banksia Hill Detention Health Centre	0.00%
	Boronia Regional Prison Health Centre	0.00%
	Broome Regional Prison Health Centre	0.00%
	Bunbury Regional Prison Health Centre	0.00%
	Casuarina Prison CoMorbidity Health Services	0.00%
	Casuarina Prison Health Centre & Medical	0.00%
	Eastern Goldfields Regional Prison Health Centre & Medical	10.00%
	Greenough Regional Prison Health Centre & Medical	0.00%
	Hakea Prison Health Centre & Medical	0.00%
	Health Services & Medical	0.00%
	Karnet Prison Farm Health Centre	0.00%
	Nursing	7.14%
	Pardelup Prison Farm Health Centre	0.00%

	Pharmacy Health Services	0.00%
	Roebourne Regional Prison Health Centre	0.00%
	Wandoo Rehabilitation Prison Health Centre	0.00%
	West Kimberley Regional Prison Health Centre & Medical	14.28%
	Wooroloo Prison Farm Health Centre	0.00%
	Health Services Total	1.54%
Mental Health Alcohol & Other Drugs	MHAOD Central Office Staff	20.00%
	MHAOD Consultant Psychiatry	0.00%
	MHAOD Nursing	3.33%
	MHAOD Prison Support Officers	100.00%
	Prison Support Services	80.85%
	Psychological Health Services Pod 1	0.00%
	Psychological Health Services Pod 2	5.56%
	Psychological Health Services Pod 3	7.14%
	Mental Health Alcohol & Other Drugs Total	32.88%
	Grand Total	4.27%

Implemented Recommendations – Inquest into the Death of Khamnsani Victor JACKAMARRA (also known as Hajinoor)

Findings delivered on: 9 May 2019

Recommendation 1:

Retain and ensure BRP has appropriate services which acknowledge it is a major transition facility with all the known risks that raises.

Responsible Business Area: CORRECTIVE SERVICES – OFFENDER SERVICES

Management Comment: While Specialist Psychological Services (SPS) provides psychological assessment and intervention to metropolitan public prisons to assist with the management of prisoners with high risk and complex needs, this service is not currently available to prisoners at BRP due to no resources. Prison management staff at BRP are able to contact SPS for consultation in relation to the management of prisoners with complex needs.

Closure Date: Completed prior to delivery of findings.

Recommendation 4:

Prison officer training that those with prior suicide attempts are at elevated risk in custody regardless of their demeanour.

Responsible Business Area: CORRECTIVE SERVICES – OPERATIONAL SUPPORT

Management Comment: The Suicide Prevention – Gatekeeper program references the use of Interpersonal Theory of Suicide, which includes "past suicidal behaviour is a robust predictor of future suicidal behaviour". The Suicide Prevention Strategy – At Risk Management System online refresher training is completed by Prison officers annually. The training is designed to assist staff with the identification and management of offenders in custody presenting either as at risk to self, or as requiring multidisciplinary intervention and additional support and monitoring.

Closure Date: Completed prior to delivery of findings.

Recommendation 5:

The promotion of active involvement of prisoners in caring for one another.

Responsible Business Area: CORRECTIVE SERVICES – ADULT MALE PRISONS / WOMEN AND YOUNG PEOPLE

Management Comment: Prisoners have access to a Prisoner Peer Support Team under the guidance and supervision of the Prison Support Officer (PSO) in all prisons. Prisoners can volunteer to become Peer Support Prisoners and go through a specific training module under the PSO. They sign contracts that specifies their role and function and get paid the highest prison gratuity level as recognition for their peer support.

Broome Regional Prison currently has a team of five who are called on to assist in speaking and offering support to prisoners who may have had bad news and need greater support, those who are assessed as 'at risk', supporting prisoners temporarily confined to multi-purpose cells where they are new arrivals at the prison and may be first time in prison, withdrawing from drugs or alcohol or highly distressed about being in prison as either a new young offender or just first time in prison.

Another support for prisoners in any of the above categories is the identification of others already within the prison who may be related through either birth, extended family or cultural group. Where offered and accepted, current prisoners are approved to "buddy up" with prisoners who need extra support. This is achieved by placing vulnerable prisoners with a like support prisoner in a mainstream cell or allowing a support prisoner to "buddy up" in a safe cell or other suitable available cell for day and/or night times to offer the required amount of support.

A further support mechanism is permitting prisoners, where appropriate, to "choose" who they are housed with to match-up as much as possible with family, friends or prisoners from the same cultural community. Some prisoners agree to become "carers" for prisoners who have mental impairment or other psychological/health issues that makes them vulnerable to the general prison population. Those who volunteer as carers are rewarded with higher gratuity pay levels and extra considerations above what mainstream prisoners have access to.

Closure Date: Completed prior to delivery of findings.

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.

Responsible Business Area: CORRECTIVE SERVICES – ADULT MALE PRISONS / WOMEN AND YOUNG PEOPLE

Management Comment: 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 debriefs 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.

Closure Date: Completed prior to delivery of findings.

IMPLEMENTED RECOMMENDATIONS – INQUEST INTO THE 5 DEATHS AT CASUARINA PRISON

Findings delivered on 22 May 2019

Recommendation 1:

The Department should take urgent steps to recruit additional Prison Counselling Service (PCS) and mental health staff for Casuarina Prison and more broadly, should consider the appropriate level of PCS and mental health staff for prisons across the State.

Responsible Business Area: CORRECTIVE SERVICES – OFFENDER SERVICES

Management Comment: The Prison Counselling Service (PCS) was allocated 9 additional FTE. This included; 6 for metropolitan area, and 3 for regional area. 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.

There are 3 vacant FTE (newly created following recommendations from the Coroners Court hearings in March 2019).

The current **Pool Ref 014885 - Prison Counsellor** was advertised between 4 to 17 September. Interviews are planned for 9/10/19 - 28/10/19. There was a strong response to the advertisement so PCS anticipate appointing successful applicants to these positions in late 2019.

PCS provides the following services:

- Risk assessment/ intervention for prisoners at acute risk of suicide or self-harm and managed on ARMS;
- Assessment/ interventions for prisoners presenting as vulnerable within the prison system and managed on SAMS;
- Clinical assessment and interventions for prisoners having difficulties coping, adjusting to prison or in transition to release; and
- Consultation - risk management.

*Group interventions are being introduced gradually across sites as a part of the new model of care changes.

Closure Date: 31 October 2019

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.

Responsible Business Area: CORPORATE SERVICES

Management Comment: 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.

Closure Date: Completed prior to delivery of findings.

Recommendation 5:

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.

Responsible Business Area: CORRECTIVE SERVICES - OFFENDER SERVICES

Management Comment: Specialist Psychological Services (SPS) provides psychological assessment, intervention and consultation services to metropolitan public prisons to assist with the management of prisoners with high risk and complex needs. This can involve psychological assessment to inform management of prisoners who present as a harm to themselves or others, where previous attempts to manage risk has not been successful. Services also involve the development of management plans and strategies to engage the offender in prosocial and healthy behaviours. SPS Psychologists can work with custodial and prison staff to provide information, training and consultation services regarding the behaviour of prisoners who present with complex needs, including working with prisoners with various mental health, cognitive and personality needs.

At the request of prison management SPS can supplement training for officers in relation to trauma informed custodial care, and the features of mental health and personality disorders relevant to assisting with management of these offenders. In consideration of resources, it is suggested that training packages be sourced for such training and that SPS Psychologists supplement this training via reinforcement of learning through consultation.

Closure Date: Completed prior to delivery of findings.

Recommendation 8:

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.

Responsible Business Area: CORRECTIVE SERVICES – OPERATIONAL SUPPORT**Management Comment:**

COPP7.1 - Prisoner Communications is due to replace PD36. I Section 8.1.5 states: "Prisoners shall be advised when a telephone number is removed or added to their PTS list." This COPP is scheduled to be tabled with the Project Steering Committee on 6 January 2020 for approval.

The implementation phase the COPPs project will run until 31 December 2020. A draft implementation plan and schedule have been developed identifying implementation dates for all the approved COPPS (45 of 119 completed and approved) and including tentative dates for the remaining COPPS that are progressing.

Corrective Services commitment to implement the COPPS has been demonstrated through the approval of resources, oversight through the Project Steering Committee and a commitment in the Corrective Services Reform Program.

Closure Date: 6 November 2019

Aboriginal and Torres Strait Islander peoples should be aware that this report contains images and names of people who have passed away. In many areas of Indigenous Australia, it is common practice that when a member of the community passes away, the person's name is changed in accordance with cultural beliefs. Names and photographs in this report are used with the permission of the families.

“He’s Never Coming Back”

People with Disabilities Dying in Western Australia’s Prisons

Nearly 30 years after a Royal Commission inquiry into Aboriginal deaths in custody, Western Australia’s prisons remain damaging and too often deadly for people with disabilities, particularly Aboriginal and Torres Strait Islander peoples. A Human Rights Watch analysis of deaths in those prisons between 2010 and 2020 found that about 60 percent of adult prisoners who died had a disability. Due to limited resources, mental health services in prisons are inadequate.

“*He’s Never Coming Back*”—based on interviews with 40 people, including prisoners, family members, mental health professionals, lawyers, Aboriginal leaders, and disability rights advocates—examines emblematic cases of deaths in custody, revealing repeated failures by authorities to provide adequate and culturally competent mental health services in prisons in Western Australia. It finds that prisoners with disabilities often fall prey to violence or resort to self-harm because proper support is lacking. Prisoners with mental health conditions can spend weeks, months, or even years locked in solitary confinement for over 22 hours a day, causing severe psychological distress and pushing many over the edge.

The report urges the Western Australia government to end the use of solitary confinement for prisoners with disabilities, particularly Aboriginal and Torres Strait Islander peoples, and ensure timely access to effective and culturally competent mental health services in prisons.



Broome Regional Prison in Western Australia.

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