CITATION: *Inquest into the death of Bernard Hector* [2023] NTLC 3

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JURISDICTION:	Darwin
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CATCHWORDS:	**Death in custody, self-inflicted hanging, Local Court 'At Risk' Practice Direction, adequacy of care and assessments, access to health services and missed appointments, Aboriginal Mental Health First Aid, prison staffing**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Department of Corrections:	Taylah Cramp
Counsel for Department of Health:	Michael McCarthy
Counsel for the family of the deceased:	John Lawrence SC
Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0158/2021

In the matter of an Inquest into the death of:

BERNARD HECTOR
ON: 30 AUGUST 2021
AT: DARWIN CORRECTIONAL CENTRE, HOLTZ

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Bernard Hector was born in Timber Creek in the Northern Territory of Australia on 14 April 1990. He passed away on 30 August 2021, aged 31. He was the third eldest of four children born to Colleen Long and Pieman Yamyurri Hector. He is survived by two children; a boy aged 10 years and a girl aged 11 months. His family have given us permission to use his name. His mother, Colleen, his Aunties and brother, attended the inquest and were supported by the Coroner's grief counsellor. We acknowledge their loss and their grief, and express our sympathy and condolences.

2. His father passed away when he was about two years and Bernard moved from Timber Creek to Katherine to live with an Aunt. He attended MacFarlane Primary School and Katherine High School, completing year nine. He then attended St John's boarding school in Darwin. He briefly worked at Mistake Creek Station in Western Australia but returned home after his grandmother passed away, in about 2010. Thereafter, Bernard mainly lived with his mother and extended family in Katherine.

3. Drinking was an issue for him and on numerous occasions he was taken into protective custody for intoxication. He was placed on at least three Mandatory Residential Treatment Orders ("MRTO"). On 16 September 2014 he went to Stringybark, Top

End Health Service, for three months. On 6 August 2015 he went to Saltbush for a little over three months. In May 2016 he was subjected to another MRTO for three months. In August 2020 he was court ordered to attend Venndale Rehabilitation Centre.

4. Bernard was also imprisoned on a number of occasions. On 31 January 2017 he was arrested for aggravated assault and other charges and later convicted and sentenced to 18 months imprisonment with a non-parole period of 13 months. He was released on parole on or about 26 May 2018 but served a further 2 days for a breach of parole on 2 August 2018. He moved to Western Australia in 2019 and was later arrested and convicted of aggravated assault and sentenced to 12 months imprisonment. On 28 December 2020 he was convicted of aggravated assault and sentenced to a further 4 months prison. On 9 July 2021 he was arrested and he was on remand when he passed away from self-inflicted hanging.

5. As his death was a "death in custody" an inquest was mandatory and his "care, supervision and treatment" while in custody must be investigated. Additionally, relevant recommendations must be made with respect to the prevention of future deaths in similar circumstances.

The prevalence of suicide in the Northern Territory

6. Suicide is not just a risk for prisoners and Correctional and Health services. Its terrible impact is felt across the breadth of the Northern Territory. In 2020 there were 44 deaths by suicide in the Northern Territory, in 2021 there were 46 deaths, and in 2022 there were 51 deaths, and for each year death by hanging was the most common means.[1] In the most recently published NCIS statistics, the rate of suicide is significantly higher in the Northern Territory (20.4 deaths per 100,000) as compared to any other jurisdiction (15.8 for Tas, 15.3 for WA and Qld, 13.9 for the ACT, 10.9 for NSW, 10.5 for SA and 6.3 for Vic), a trend which remains consistent with previous years.[2] Nationally: there are on average 9 suicide deaths each day; suicide death rates

[1] Records of the Office of the Coroner NT, the rate of increase is less than I had understood at the date of inquest.
[2] NCIS Fact Sheet June 2022; May 2021

for males are higher than for females across all age groups; and Indigenous people commit suicide at double the rate of non-Indigenous people and at a younger age.[3]

7. I do not raise these statistics gratuitously. I raise them to remind agencies dealing with Aboriginal clients that the risk of suicide is real, prevalent, and significant. Policies and procedures to address the risk should be regularly reviewed to ensure that they are current, reflect best practice, are appropriately resourced, and adopt recent learnings. To this end, links to the most recent Suicide Prevention Australia Fact Sheets specific to Men and First Nations people are included.

Male-Suicide-Fact-Sheet.pdf (suicidepreventionaust.org)

First-Nations-Fact-Sheet.pdf (suicidepreventionaust.org)

His mental health history

8. Bernard had a number of interactions with mental health services during his lifetime.

9. On 7 December 2011 he was referred to TEMHS because he was having trouble sleeping and was hearing voices. However, on review he was reported as having no suicidal ideation.

10. On 26 September 2014, while at Stringy Bark, he was referred for a mental health assessment as he was having trouble sleeping due to bad dreams. He was treated with Olanzapine and his sleep gradually improved.

11. On 23 November 2015, while at Saltbush, he reported hearing voices, having nightmares, and was suspicious of others. He was reported to be difficult to engage, erratic of speech, cautious and isolated. A mental health assessment was recommended but he refused. On 24 November 2015 he was observed to be talking to himself, having trouble sleeping and was described as "detached." He was placed on 15 minute observations. On 25 November 2015, he was referred to Cowdy Ward for

[3] NSW Health (2022), *NSW Suicide Monitoring System, Report 24*, (https://www.health.nsw.gov.au/mentalhealth/resources/Publications/sums-report-aug-2022.pdf) Data to August 2022; according to Suicide Prevention Australia, Stats and Facts, ABS 2021 Causes of Death Data males are around 3 times more likely to die by suicide than females and the median age of death by suicide for Aboriginal and Torres Strait Islander people was 30.2 across Australia, more than a decade younger than the median death by suicide for the general population of 44.8 years.

a mental health assessment for possible psychosis. He was discharged on 27 November 2015 with no mental illnesses detected. His discharge summary records the following,

> Bernard was observed closely for signs of psychosis and affective symptoms. None were observed on repeated interviews and observation on the ward. He was not given any psychotropic medication and no signs of psychosis, depression, anxiety disorders, BPADF, PTSD, OCD, or a personality disorder were observed during his stay. He repeatedly stated he just wanted to go back to Katherine to be with his family and was 'frustrated' for being at Stringy Bark
>
> …No abnormal perceptions, no FTD, no delusions, no thoughts of harm to self and others, positive plans for future, oriented, reasonable judgement and insight.

12. On 5 September 2017, while he was serving a term of imprisonment, he was placed 'at risk' due to hearing voices and having thoughts of self-harm. He was put on observation and was reviewed by the Forensic Mental Health Service team ("FMHS") the following day. In their first assessment he is reported to have said, "he was placed at-risk because he wanted to hurt himself. Says he still has those thoughts today" and it was decided by the At Risk Assessment Team ("ARAT") that he should remain 'at risk'. He was assessed again on 7 September 2017 by a Mental Health Nurse who noted,

> He did report that he was thinking of harming himself yesterday and that he had thoughts of jumping over the first level balcony he stated he was feeling angry with himself for hurting his family and because he keeps doing it (hurting family).
>
> States that he has no plan or intention to harm himself or other now. States he woke up and said to self, no more of doing this - meaning he is not going to harm himself as he does not want to hurt family more.
>
> …
>
> He said that he feels safe in the sector and now wants to spent time with family. I am ready to move forward.
>
> States he has future goals to get work and help his family Acknowledged that alcohol is a problem for him when not in prison.
>
> States he stopped drinking in January this year but restarted prior to current index incidents. Declined link to AOD services.
>
> MSE

Appearance: Medium build Aboriginal male, short hair. Seated in AT RISK gown and appearing stated age, cooperated in interview process superficially.

Behaviour: Sat calmly on the edge of the bed throughout, elbows on knees and eyes mostly downcast.

Reasonable eye contact no psychomotor agitation or retardation evident.

Speech: Softly spoken, slow speech however coherent.

Mood: Affect flat but warmed up as assessment continued, stated his mood is good and he feels strong.

Thought Stream: clear and coherent.

Thought Content: Nil unusual themes all content was appropriate to the situation.

Thought Form: Connected to time and place, Nil pre-occupation or reported concerns. No themes of persecution or reference, feels safe. No evidence of thought block.

Perception: Nil reports of any hallucinations, auditory of visual. No overt responses to unseen stimuli.

Cognition: No apparent cognitive impairment. Good range of vocabulary.

Insight: Good.

Declined to talk to psychologist, rather continue to speak with Chaplin who is currently engaged

Risks

Self: denies current thoughts or plans to harm himself by jumping off the first level of the sector area.

Today not expressing any explicit plans to hurt himself and states "no more doing this." States he has no plan or intention to harm himself and has future goals and direction.

Others: Did not report any plans to hurt anyone and stated that he feels safe in Sector 5.

From others - Denies that others want to hurt him or that he wants to hurt others, denies payback issues.

13. Based on that final assessment the Mental Health Nurse recommended that he be taken off ‘at risk’ and later that day the ARAT removed his ‘at risk’ status.

14. Although from time-to-time there were concerns about his mental health and he was referred to TEMHS or the FMHS for assessments, on each occasion he was <u>found not to be suffering from any mental illness or disorder</u>, any assertion to the contrary is

incorrect. There were no further contacts with the TEMHS until his final imprisonment.

His arrest and initial mental health assessments

15. On Friday 9 July 2021, Bernard was arrested and taken to the Katherine Watch House on charges that included Aggravated Assault and Sexual Intercourse without Consent. He was denied bail and remanded to appear in the Katherine Local Court on Monday 12 July 2021. While on remand at the Katherine Watch House he was seen by a Registered Nurse on 9, 10 and 12 July 2021 (and declined to be seen on 11 July 2021). The Registered Nurse recorded that on each health review he denied thoughts of self-harm and noted that he was eating his meal and engaging with other prisoners. As he had cold-like symptoms he was swabbed for COVID-19 and was required to wear a mask when engaging with other persons. There is ample information to find that his care, treatment and supervision in the Katherine Watch House was adequate.

16. Before going into court on Monday, Bernard spoke to his North Australian Aboriginal Justice Agency (NAAJA) duty lawyer in private. In contemporaneous notes his lawyer recorded that he kicked a chair and said, "I'm going to kill myself when I go to prison. I'm going to hang myself. Tell my mum." When the matter was dealt with in court it was adjourned to 20 September 2021 and his lawyer said, "I'm also asking Your Honour to mark Mr Hector 'at risk' of self-harm." Although the audio of the proceedings is of poor quality it is possible to hear the Judge reply, "done."

17. On 13 July 2021, Bernard was taken to the Darwin Correctional Centre ("the prison"). He was seen by a Registered Nurse at 2.17pm. The Registered Nurse recorded in the Patient Care Information System ("PCIS") that Bernard was placed 'at risk' by the court and that he "was hesitant to say why but officers said for self-harm reasons." She also noted that he was "somewhat quiet." She initiated an 'At Risk' Care Plan and sent a referral to FMHT. He was housed in an 'at risk' observation cell at the Medical Centre in Sector 2 and was monitored by CCTV and 15 minute observations, which were recorded.

18. The FMHT referral was received and actioned by a Clinical Nurse Specialist (Forensic) ("Mental Health Nurse") employed with TEMHS who provided an

affidavit and gave evidence in the inquest. On 14 July 2021 he commenced Bernard's mental health assessment with a review of the patient records, including records held in the Community Care Information System ("CCIS" which includes TEMHS records), PCIS (which includes primary health care records) and the Integrated Offender Management System ("IOMS" which includes records maintained by Correctional Services). He did not have access to records held by the various rehabilitation centres. In his affidavit he said,

> From my review of those records, I noted that Mr Hector had no current mental health diagnosis, and was not on any medication, however that he was known to FMHT through prior presentations in 2015 and 2017, and had previously been diagnosed in 2015 with a mental / behavioural disorder due to harmful alcohol use. Since that time, Mr Hector had not come into contact with mental health services and had not required case management. Mr Hector had been admitted into the IPU on 25 November 2015, due to an alcohol use disorder, however only for a period of two days. Mr Hector had attended alcohol rehabilitation at Stringybark.
>
> I also noted Mr Hector's forensic history, including that he was currently remanded for sexual-related charges, with a Court hearing scheduled for 20 September 2021, and that he had six previous episodes of incarceration. The prison environment was therefore one Mr Hector had some familiarity with.

19. At about 9.40am the Mental Health Nurse commenced an in-person assessment of Bernard that took about 15 minutes. Both the nurse and Bernard wore COVID-19 masks. In his affidavit the Mental Health Nurse described the assessment and his opinions,

> Mr Hector was very friendly during my assessment of him. I recall that he engaged well with me, made good eye contact with me, and that he displayed a generally happy or positive disposition. Mr Hector appeared settled. There were no signs of distress at all.
>
> One of the first questions I asked Mr Hector was why he had been placed 'at risk'. He said to me that, *"I was just angry that I didn't get bail, that was why I mentioned in Court that I would hurt myself. I am not stupid. I am not going to hurt myself. I just didn't want to go to prison."*
>
> Initial anger at being in prison is something I see almost every day as a Clinical Nurse Specialist (Forensic). People often become frustrated when they are not released on bail, particularly if they believe that they

will be bailed, because that is what their lawyer has told them, for example. I recorded in my notes that Mr Hector was 'coherent and logical in conversation'. When I asked how he was feeling currently, Mr Hector stated that he was 'feeling alright now, however felt angry at court when he was remanded by the court and expressed he will harm himself.' Mr Hector 'maintained that he made the statement out of frustration'. I asked him about the threat of self-harm on a number of occasions during our discussion, and he repeated that it was just because he was angry. Further, in response to my questions, Mr Hector 'denied [that he had] any intent or plan at the time of making the statement'.

Mr Hector informed me that he was feeling safe and was supported by family and a friend in his prison block. I do not now recall who those persons were, however it was pleasing to know that Mr Hector had support within his block at the prison. I considered Mr Hector having family and a friend within the block to be a protective factor. I discussed the circumstances in which Mr Hector had come to be arrested, and he informed me that he had been heavily using alcohol, prior to his arrest. I discussed a referral for Mr Hector to the AOD Service, and he said he was happy to engage.

Mr Hector reported no signs of psychosis or mental disturbance during the assessment, and I did not observe any. Mr Hector did not present as irritable or aggressive. He reported eating and sleeping well and denied any thoughts of harming himself or others.

Mr Hector repeated that "*Yes I will be safe*" if he was returned to the block.

I recorded the following by way of mental state examination for Mr Hector:

> *Medium build Indigenous male, short curly hair. Wearing a face mask and at risk attire engaging well in assessment. Good eye contact. Speech is normal in tone and volume. Coherent and logical. Euthymic in mood, bright and reactive. Was appropriate, Nil pre-occupation or reported concerns. No themes of persecution or reference, feels safe. No evidence of thought block. Nil reports of any hallucinations, auditory or visual. No overt responses to unseen stimuli. No apparent cognitive impairment. Insight and Judgment reasonable.*

My impression was that Mr Hector was not experiencing a severe or enduring mental illness or major mood disorder. Rather, he had experienced a situational crisis when confronted with the prospect of a period of incarceration, and he had voiced his frustration. That crisis appeared to have resolved. Mr Hector denied having any thoughts, plan or intent to harm himself, guaranteed to me that he would be safe on the

block, and reiterated to me that he had family and a friend to support him there, which I considered to be a protective factor.

My plan for Mr Hector was as follows:

Discuss in ARAT, suggest remove at risk

Refer to AOD

Does not require ongoing follow up with FMHT

Consider close to FMHT

My assessment of Mr Hector was that he was engaging well with me, was very friendly, in no distress at all, and was clear in his statement that the threat of self-harm was made only out of frustration. He assured me that he had family in the prison to support him, and he had been in prison before, so he was aware of how to navigate the system. Mr Hector had previously been placed 'at risk', however that had not resulted in a need for ongoing mental health support, and there had been no reports of actual self-harm. Mr Hector had completed his previous sentence without any further reports of not coping or anger, after the prior 'at risk' episode. Mr Hector had no psychotic illness that could potentially cause him to harm himself. He presented as someone who was understandably frustrated at the disruption to his normal life and the prospect of being in custody. I did not consider him to be at a higher risk of self-harm than other people within the prison. There was no reason to say that he needed to remain 'at risk'. Based on that assessment of him, I recommended that Mr Hector's 'at risk' status be removed.

I did not consider that follow up or case management from the FMHT was required, as Mr Hector did not display any signs of mental illness or major mood disorder. We provide tertiary care to people in prison, and Mr Hector did not demonstrate a need for that level of intervention. In the event that Mr Hector subsequently showed concerning behaviour, he could be re-referred to our team and case management reconsidered.

20. Following the assessment, the Mental Health Nurse recommended to the ARAT that Bernard be removed from his 'at risk' status. The ARAT met and the team members unanimously decided that Bernard could be taken off 'at risk', which occurred at 1.50pm that day. Bernard was moved from the 'at risk' cells into medium security residential housing (Sector 5). The following day (15 July 2021) the FMHT met to discuss Bernard's case. They decided to close his FMHT case and determined that no further follow up was required.

Issue: Is the procedure for being marked 'at risk' at court adequate or could it be improved?

21. When his lawyer saw Bernard in the Katherine Court House interview rooms he told her "I'm going to kill myself when I go to prison. I'm going to hang myself. Tell my mum." However, these statements were not recorded in the 'at risk' documentation that accompanied him to the prison. The next day when he was asked at the prison by the Registered Nurse why he was 'at risk' he was quiet. The following day, when he was assessed by the Mental Health Nurse, he said "I was just angry that I didn't get bail, that was why I mentioned in Court that I would hurt myself. I am not stupid. I am not going to hurt myself. I just didn't want to go to prison." The Mental Health Nurse had no other information to question the accuracy of this account and proceeded with the assessment.

22. In his evidence the Mental Health Nurse agreed that it would have been preferable to have accurate information about the reasons why Bernard was placed 'at risk' by the court, and agreed that had that information been available he would have asked Bernard about what he actually said to his lawyer. However, he maintained that in this case the specific information would not have changed the outcome of his assessment because on either version he was aware the concern was self-harm but when he was assessed he was not showing any signs of mental illness, distress or thoughts of self-harm.

23. In its Northern Territory Duty Lawyer Handbook, NAAJA provides its lawyers with guidelines for seeing a new client in court cells. If a lawyer has concerns that a client might hurt themselves they are guided as follows,

> 3.3.1 At times you will encounter in custody might seem to be at risk of suicide or self-harm. Include clients who say they feel they don't get bail or clients who react very badly once they stop at the school are not well equipped to deal with these situations or ascertain whether a client is at risk. However sometimes we are required to do so
>
> There are obligations in relation to prisoners at risk. In the Court of Summary Jurisdiction, under a practice direction of 9 February 2007, counsel for a defendant should disclose to the court any information

available that the defendant may be 'at risk' of suicide or self-harm if remanded in custody.

…

Making such notifications is part of our duty to the court and so overrides our obligation of client confidentiality.

You should, however, tell a client that you are required to notify the court soon for their welfare before you do so.

You should be conscious that if a prisoner is marked 'at risk' by the Court, it means he or she will be held under observation and this is very intrusive amongst other things. Clients may therefore not wish to be marked 'at risk' and it is sometimes a difficult call to make. If in doubt, speak to your manager or a senior practitioner urgently.

24. Local Court Practice Direction 12 regulates the court's practice and procedure concerning persons who may be 'at risk' of harm when remanded into custody. Relevantly, it provides that a person will be considered 'at risk' of self-harm if the person is, inter alia, suicidal. In those circumstances,

12.6 Where there is information available to a prosecutor or counsel for a defendant indicating that a person may be at risk of harm or self-harm, at risk of harm from a medical or physical condition, or at risk of harm from another prisoner or prisoners if that person is remanded into custody or sentenced or committed to a term of imprisonment, that information should be disclosed to the Court as soon as possible.

12.7 Where such information is disclosed to the Court, it may order that:

12.7.1 the defendant may be at risk in one or more of the respects referred to in 12.2; and

12.7.2 all persons responsible for the custody of the defendant be advised that the defendant may be at risk in one or more of those respects and be provided with the information available to the Court in relation to the defendant's "at risk" status, including relevant medial or psychological reports.

12.8 Where the Court makes an order under 12.7, the presiding Judge must sign an order using the Prisoner at Risk Form and place it on the court file.

25. Both guidelines seemingly envisage the judge being provided with all the information that forms the basis for an opinion that the person should be marked 'at risk'. However, at Bernard's court appearance the information that formed the basis for concern was not offered by the lawyer nor sought by the judge. In my experience, a brief and subtle exchange between counsel and the judge concerning 'at risk' applications is not uncommon and may in fact be the norm. Local Courts are busy places. The court rooms are often full of lawyers, family members, other defendants and members of the public. In such a public forum, defence counsel are likely reluctant to disclose distressing and personal information about their client. Were they to do so, their client may be shamed and such disclosures might trigger an adverse reaction or outburst from their client in the court room. In addition, given the pressing demands of the court list, defence counsel might also feel reluctant to request closure of the court so that private information can be discussed. It is likely that judges share those concerns. Although it is normal to order a transcript when a person is marked 'at risk', transcripts of such brief exchanges between counsel and the judge provide no insight as to the grounds for the order. Additionally, audio recordings often fail to record exchanges in busy and noisy court rooms and so transcripts run the risk of not accurately reflecting what is said.

26. If the basis or reasons for an 'at risk' application were reduced to writing, this might alleviate concerns about broadcasting such information in open court. A simple form could be provided as part of the courts Practice Direction for any concerns to be documented in writing. Commonly, such a form might be completed by defence counsel whose concerns are raised because of observations of their client's behaviour outside the court room. However, the judge or prosecutor could also complete such a form if they observed concerning behaviour. One (or more) forms outlining the basis for concern could then be attached to the 'at risk' order thereby more accurately informing prison and health staff as to the reasons for the order.

27. While it may have made no difference to this assessment, all the Corrections and Health witnesses agreed that the provision of accurate information disclosing the basis for a court 'at risk' order was preferable and desirable moving forward.

Issue: Was it appropriate for Bernard to be removed from his 'at risk' status?

Should he have been referred to Mental Health Services for further follow up and review?

28. At the inquest Bernard's family challenged the adequacy of the assessment conducted by the Mental Health Nurse. Additionally, they were concerned that there was no FMHT follow up of Bernard after he was removed from 'at risk'.

29. It was submitted, for example, that the assessment was potentially inadequate because there may have been a failure to communicate between Bernard and the Mental Health Nurse. However, the evidence did not support that submission. Although English was not Bernard's first language he was educated beyond year 9 in English speaking schools; there was evidence on the brief of his excellent hand writing; his interview with and statements of concern to his lawyer were in English; and his recorded dealings with Health and Correctional services over the years were all in English. There was no evidence that in any of his dealings of him ever requesting or being assessed as requiring an interpreter. Although English was not the first language of the Mental Health Nurse, he had completed his Masters in Mental Health Nursing at an Australian university, he had a minimal accent, and communicated eloquently in English when called as a witness.

30. It was also submitted that communication was possibly inhibited because the nurses and Bernard were wearing COVID-19 masks. However, as Bernard had cold-like-symptoms, masks would have been required in all clinical settings, in or out of custody. Further, the Mental Health Nurse did not consider that the masks impinged on their communication or the efficacy of his assessment. His recorded interactions with Bernard support that impression.

31. The evidence established that the Mental Health Nurse was well qualified and appropriately experienced to undertake the assessment. All the relevant health records were accessed and considered by the Mental Health Nurse. In particular, as part of his assessment he considered Bernard's previous referrals to TEMHS and the FMHS, the reasons for, and the outcomes of, those interactions. After reviewing the records the Mental Health Nurse conducted an in-person assessment. The 15 minute observation

sheet records that at 9.30am Bernard was looking out the window, 9.35am he was talking to FMH (Forensic Mental Health), (but there is no note of when the nurse entered between 9.30 and 9.35) and records that at 9.45am the conversation was complete. The Mental Health Nurse recalled that the assessment took about 15 minutes. Whether the assessment took 10 minutes, 15 minutes, or somewhere in-between, the contents of the assessment was contemporaneously documented, including Bernard's responses and the nurse's observations of his demeanour. Although the in-person assessment was not lengthy, the Mental Health Nurse also considered the 15 minute observation sheets that had been maintained since Bernard's reception into the 'at risk' cell. The 15 minute observations did not identify any concerning behaviours, distress, or any other indicators of mental disorder or illness. There was a well-founded and documented basis for the Mental Health Nurse's opinion, that there was no mental illness or major mood disorder, no thoughts or plans to hurt himself, and Bernard's stated belief that he was safe "on the block" with "family and friend support". There was no evidence that indicated the assessment was anything less than adequate and appropriate.

32. The recommendations of the Mental Health Nurse, that Bernard be removed from 'at risk' and that he be referred to Alcohol and Other Drugs ("AODS") were not final decisions. Each of these recommendations were subject to consideration by the ARAT, a multidisciplinary team comprising of staff from Prison Health, FMHT, a Corrections Officer who has direct contact with the prisoner and other relevant stakeholders such as AODS. Any decision by the ARAT to remove a person from 'at risk' must be unanimous. The ARAT considered the recommendations and the basis for them, and decided to remove Bernard from 'at risk' and refer him to AODS.

33. In addition, there was a separate FMHT clinical review meeting the following day which considered the recommendation of the Mental Health Nurse that Bernard "did not require ongoing follow up with the FMHT". The FMHT noted that his AODS referral had been accepted, and given that there was no mental illness identified, that he had no current plans to harm himself, that he presented as settled, was familiar with the prison and had family and friends there, it was determined that the FMHT referral could be closed without further follow up, and consistent with the level of care he

would have received in the community.[4] There is no evidence to indicate that those decisions were not appropriate on the available information, or that relevant information was missed.

34. Finally, even though his initial referral to FMHT was closed, that did not prevent Bernard from being referred again if his feelings or circumstances changed.

His housing and security classification

35. Before he was moved out of the 'at risk' cells an Immediate Needs/Risk Assessment ("IRNA") was conducted to record information relevant to his management in the prison. He was assessed as suitable for placement in the Induction Unit and was moved there. On 21 July 2021 a Security Classification and Transfer Eligibility ("SCATE") assessment was conducted, which reviewed his Prisoner's Institutional File, IJIS, IRNA, Custodial Assessments and IOMS, and he was classified as medium security. In accordance with the short transition period recommended by RCADIC 175, on 28 July 2021 he was moved to Sector 6, which provided low and medium security classified accommodation.

His passing

36. On the evening of Monday 29 August 2021, Bernard was locked in his accommodation wing along with other inmates. CCTV from the corridor records him leaving his room on three occasions for a short period of time but he does not appear to interact with any other person. At 11:11pm Bernard re-entered his room which is the last time he is seen alive. The CCTV does not record anyone else entering his room until the next morning. From the CCTV footage it appears that all of the prisoners had their green towels hung over the door windows throughout the night of the 29/30 August 2021.

37. From approximately 11pm and for a period of at least an hour, a banging noise was heard by some of the prisoners in Bernard's block. It is not certain where the noise came from and it was not reported to the prison officers.

[4] T165 Dr Ruth Derkenne

38. The next morning (30 August 2021) Bernard was missing from the morning muster and inmates went to raise him. At approximately 8.15am the CCTV records inmates knocking on Bernard's door and trying to turn the doorknob. Three correctional officers are recorded approaching and unlocking the door with a key. One officer immediately made a call on her radio and ran from the room. The other two officers entered the room. Two minutes later, nurses and additional staff arrived and entered the room. Paramedics arrived 19 minutes after the room door was opened.

39. When the prison officers unlocked Bernard's door they saw that he had wrapped a green sheet around his neck at one end and had secured the other end to the top of the bunk bed. His feet were touching the ground and the bed sheet was holding him in an upright position. An officer cut the sheet with a Hoffman tool and lowered Bernard's body to the ground. His body was stiff and cold. Although the officers could not find a pulse they commenced cardiopulmonary resuscitation. Additional staff who entered the room were wearing body worn video recorders which captured the resuscitation attempts including the use of a defibrillator and adrenaline. Hand written notes were maintained which also recorded those efforts. Shortly after the paramedics arrived they declared life extinct at 8.39am.

The autopsy

40. An autopsy was performed on 31 August 2021. A ligature abrasion with three scratch abrasions were evident on the neck. There were no other traumatic injuries. The only drug detected in his body was paracetamol. The opinion as to the medical cause of death was by hanging.

Issue: Was it appropriate for Bernard to be housed in Sector 6 in a room on his own with a bunk bed?

As prison officers do not conduct health and safety checks of prisoner's in Sector 6 during the night shift, should there be CCTV surveillance of Sector 6 rooms?

41. Bernard's family were concerned that Bernard was not checked on in person overnight by prison officers or by CCTV in his room, and that he was isolated in a room on his own that contained a risk for hanging, namely a bunk bed.

42. Based on the information contained in his IRNA, the removal of his 'at risk' status, and his SCATE assessment, Bernard was found suitable to be accommodated in low-medium classified accommodation. Deputy Commissioner David Thompson explained that the living arrangements in Sector 6 are "normalised" with the aim of providing suitably classified prisoners greater autonomy and responsibility, which in turn is intended to promote their rehabilitation and reintegration back into the community. In Sector 6 prisoners are housed in accommodation wings. During the day during any lock-down periods the prisoners have access to a kitchen and communal living area. At evening muster the prisoners are provided dinner and a breakfast pack and secured in their accommodation wing which consists of 6-8 rooms (at the time capable of sleeping two per room in bunk beds), a shared bathroom, and a shared secure outdoor sleeping/veranda area. Prisoners are not locked in their rooms and can move around their accommodation wing at night. They can lock their own rooms from the inside if they wish. A locked room can be opened from the inside or with a key from the outside. Prison officers have keys but prisoners do not. Prison officers do not check on the prisoners during the night but each room has an intercom if any of the prisoners need to contact the prison staff. The room doors have a window but prisoners often covered this with a towel to increase their privacy. There is CCTV of the corridor in the accommodation wing but not inside the rooms. The accommodation wing is unlocked again each morning for muster.

43. Although rooms are designed for two persons, depending on prison numbers they may be occupied by one person only. However, as everyone is free to move around the accommodation wing, including at night, the inmates are not physically isolated from each other. Additionally, as inmates can choose to sleep in the outdoor sleeping area instead of their allocated room, even when rooms are shared there is no guarantee there will be two persons actually occupying their allocated room on any given night.

44. On the night of his death, although Bernard was allocated a room on his own, the evidence establishes he was not isolated from other prisoners and had a means of accessing prison staff.

45. It was explained by the Deputy Commissioner that the "normalised" or "therapeutic" environment of Sector 6 is not compatible with the removal of all potential hanging points. Further, the "normalised" environment, which permits congregation of prisoners at night, does not support individual safety checks on prisoners overnight. In this context, the efficacy of health and safety checks as a means of preventing suicide was discussed and it was noted that death can occur swiftly and health and safety spot checks that occur in other sectors have their own limitations when it comes to deterring, detecting or preventing suicide.

46. Similar safety concerns were raised in the *Inquest into the death of Vernon Bonson*[5], in those findings former Territory Coroner Judge Cavanagh said,

> 53. It was explained by the Commissioner that there is a balance that needs to be struck in the low security areas of the prison. The balance is between normalising the living conditions for inmates and minimising hanging points.
>
> 54. There are many hanging points in the rooms and the communal areas. Having doors on the rooms and allowing free access around the inside and outside of the housing block inevitably means that there are hanging points. In addition, the bunks, the table and chair in the room create additional hanging points.
>
> 56. Where that balance should be struck is not a matter for this inquest. It is a policy decision for Correctional Services who are expected to be experts in such areas or able to access that expertise. If there are good reasons to question those decisions that can be done.

47. Although Bernard's family questioned where the balance should be struck, I understand the conditions in Sector 6 are a response by Correctional Services to RCADIC recommendation 173, namely, that initiatives directed to providing a more humane environment through introducing shared accommodation facilities for community living, and other means should be supported, and pursued in accordance with experience and subject to security requirements. I accept that considerations of privacy in bedrooms and bathrooms are sufficient to explain why low risk prisoners should not be subjected to constant CCTV surveillance.

[5] [2018] NTLC 006

Socialisation with other prisoners

48. While housed in Sector 6, prisoners are always able to mix with other prisoners but they can also choose to be alone in their rooms. Bernard spent some of his time mixing with others, and some of his time alone in his room. Wesley, Bernard's brother, was also in Sector 6 when he first arrived. Wesley said that Bernard never talked to him about hurting himself, and was shocked when he heard the news of his passing.

49. Simon, described himself as "like a brother" to Bernard. He said they grew up together and their families are related. Simon said that when Bernard first arrived in prison he was initially ok but later became quiet and was not himself. He explained,

> "Oh a bit, I seen him bit worried. And you don't like, before he usually just talk to me but I like, to me like it wasn't him anymore, you know, bit different. He's been like thinking too much."

50. Lawrence, described himself as Bernard's cousin-brother (their grandfathers were brothers). He was sharing a cell with Bernard from approximately 20 August 2022 until 25 August 2022. Lawrence said that Bernard was worried about receiving a long sentence and was concerned that he might get a sentence of 6-7 years. He said that Bernard said "the devil is in me" and "I sold my soul to the devil" and played the Ouija board. Lawrence told him not to play that game. He also recalled that Bernard twice spoke about suicide and made a hand gesture that he was going to hang himself. Lawrence told him to "stop it" and to "cut it out". Lawrence said he told another prisoner, Barry, about it. Police did not speak to Barry until 10 August 2022. At that time he could not recall any conversations with or about Bernard, save to say that when in prison together they passed the time of day.

51. Ernest described Bernard as his big cousin brother. He had known Bernard since he was 12 and they had grown up together. Ernest said that he and other family regularly socialised with Bernard at the prison. Bernard was generally happy and chatting with his relations. He talked with them about his Ouija board. Most of the prisoners told him "not to muck around with it". Ernest said he did notice a change in Bernard's behaviour, that he became "a bit quiet for a bit". He asked Bernard if he was ok and "he looked at me" and replied "I'm all right [and asked] for teabag and sugar."

52. Isiah shared a room with Bernard from 25 to 27 August 2021. He said that Bernard seemed normal and that he had normal conversations with him. Bernard was not allocated another roommate after Isiah and was then in the room by himself but was still mixing with the other prisoners. On the afternoon of 29 August 2021 Ernest said that he saw Bernard joking and laughing with another inmate, Simeon. Simeon said he was Bernard's cousin brother and described him as mostly happy, though on occasions he was "quiet" and he got worried for him. Another inmate, Lucas, saw Bernard on 29 August 2021 and said he was "happy" and "smiling around us" that morning and afternoon.

Issue: As he had spoken of suicide to at least one other prisoner, and other prisoners had noticed a change in his behaviour, why was this not reported to the Corrections Staff?

How might prisoners be encouraged to recognise and report concerns they might have about themselves or others?

53. The ability to live and socialise with other prisoners, particularly family members, is considered to be a broadly protective factor. One of the reasons Bernard was housed in Sector 6 was because he had family members there. The combination of proximity, familiarity and time, also provides opportunities for fellow inmates to observe changes in each other's thoughts or behaviour. In Bernard's case, some prisoners noticed a deterioration in his thoughts and behaviour pointing to a possible increased risk of self-harm. However, it does not appear that they encouraged him to speak with Corrections or Health staff, and nor did they report their concerns for him. Although the other prisoners did not say why they did not report their concerns to staff, there may well be reasons for their reluctance to do so. Some may be naturally disinclined to get involved in what is perceived as another person's business. In some cases the onerous conditions of being placed 'at risk' may be a disincentive to self-report or report on others. Alternatively, there may be no one a prisoner is comfortable reporting to.

54. It would be much safer for prisoner's, such as Bernard, if his fellow prisoners felt able to communicate such matters. While it might be easy to imagine less intrusive ways of supporting prisoners than putting them in an isolation cell, any alternative approaches would have to be balanced against risk, and it might be difficult to mitigate the impact of the 'at risk' process. Nevertheless, there may be ways to encourage prisoners to not only recognise concerning behaviours, but to also recognise that they should be reported to staff.

55. The Aboriginal and Torres Strait Islander Mental Health First Aid, 14 hour course, "teaches members of the public how to provide culturally appropriate assistance to an Aboriginal or Torres Strait Islander person who is developing a mental illness or is in a mental health crisis. The course is designed for the public to learn how to give the initial assistance…"[6] In addition to providing strategies on to how to assist a person directly, the training also teaches how to encourage the person to get professional support and when the intervener should seek professional support.[7]

56. The delivery of Aboriginal Mental Health First Aid to Correctional officers is a positive step and a testimony to its accepted efficacy. But, particularly for persons like Bernard who do not confide in the staff, it may not always be staff that identify the signs of potential crisis. In her evidence the Director of Medical Services, Top End region, Dr Ruth Derkenne, said, "…the only person…who did detect that there was a change in Mr Hector, was his friends. So that if we can introduce a system that enables his friends and family to be able to speak out and seek help, then we consider this is the best change that we can make to the system to prevent this from happening again."[8]

57. Accordingly, it may be of assistance if a version of the Aboriginal Mental Health First Aid training was made available to the prisoners who have greater opportunities to notice changes in each other's behaviour. Given the difficulties of mitigating the risks associated with housing prisoners in a "normalised" environment discussed earlier, perhaps consideration should be given as to whether such a course should be a

[6] Hart LM, Kitchener BA, Jorm AF and Kanowski LG, *Aboriginal and Torres Strait Islander Mental Health First Aid Manual.*2nd ed. Melbourne: Mental Health First Aid Australia; 2010, at iii
[7] Ib id p128
[8] T187

prerequisite to receiving a medium-low classification? One can imagine further benefits of such a course being undertaken by prisoners. In addition to potentially reducing the risk of suicide inside the prison and promoting positive cultural change, similar benefits may transmit back to Aboriginal communities when prisoners who have received the training are released.

58. It is also plausible that prisoners might be disinclined to report on their own or others well-being, because there is no one they feel comfortable reporting to. Aboriginal prisoners may find it culturally safer and be more inclined to report personal matters to another male Aboriginal person. On the evidence it was not clear precisely how many Correctional Officers are Aboriginal, but four Prisoner Support Officers and the Cultural Engagement Program Coordinator are Aboriginal. There are 5 Aboriginal nurses and two Aboriginal Health Practitioners (with recruitment underway for a third). Accordingly, Corrections and Health combined could only identify 12 Aboriginal staff[9] for a prison population of approximately 1244 prisoners, of whom 83% are Aboriginal.[10] Prisoners are able to access nurses on the block when they attend for medication rounds, but it is not clear on the evidence whether prisoners understand that they can report mental health concerns to the nurses, nor whether rounds are conducive for those types of conversations. I understand that while there is an aspiration to recruit Aboriginal persons to both general and specific positions, recruitment is challenging. Corrections and Health should continue to endeavour to recruit Aboriginal Prison Officers, Aboriginal Prisoner Support Officers, Aboriginal Health Workers, and Aboriginal Liaison Officers and ensure that their Aboriginal employees are utilised throughout the prison and are available to all prisoners.

59. The Elders Visiting Program might provide another avenue for prisoners to voice concerns. There was some evidence that some Visiting Elders assist in training staff in Cross Cultural training and Aboriginal Mental Health First Aid but there was no evidence as to whether the Visiting Elders are themselves trained in Aboriginal Mental Health First Aid. COVID largely prevented Elders from visiting the prison so Bernard

[9] Gender not specified
[10] Northern Territory Aboriginal Justice Agreement 2021-2027 p13, citing ABS (2020) Table 14, ABS website 5 February 2021

did not have the opportunity to engage with or benefit from their visits. However, I consider that the Elders Visiting Program provides an important avenue for communication and connection and the program should continue to be supported and promoted throughout the prison.

Referral to the Alcohol and Other Drugs Program

60. As discussed with Bernard at his assessment, on 14 July 2021 the Mental Health Nurse made a referral to the Alcohol and Other Drugs Prison In-Reach Program ("AODPIP") and the AODPIP records confirm that the referral was received by them and allocated to a team member that day.

61. Dr Derkenne, provided an affidavit dated 21 July 2022 and gave evidence at the inquest. Concerning the AODPIP referral she explained,

> On 19 July 2021, Alcohol and Other Drugs Prison In-Reach Program (PIP) sent an acceptance letter to Mr Hector, through DCC's support services. The letter stated:
>
> > *You have been accepted into the service and one of our clinicians will book a time as soon as possible to talk to you. If your referral is urgent, please see your Prison Support Officer. We look forward to meeting you.*
>
> On 26 July 2021, an appointment was scheduled with PIP. However, Mr Hector could not attend because the industries sector had shut down due to staff shortages within Corrections.
>
> On 30 July 2021, Mr Hector failed to attend a scheduled appointment with the PIP team. The team were notified that this was because Sector 5 had been locked down intermittently throughout the day. The appointment was rescheduled.
>
> On 1 August 2021, Mr Hector was scheduled for an Adult Health Check, as part of his initial reception screen, however there is no record of this having occurred.
>
> On 4 August 2021, a PIP Senior Clinician waited 45 minutes for Mr Hector to arrive to a scheduled appointment, before requesting prison staff "to call PIP office if client arrives." The appointment was rescheduled.
>
> On 10 August 2021, a PIP Senior Clinician became aware of an opportunity to see Mr Hector in the resource area of Sector 6. They asked staff to use meeting room one in order to complete Mr Hector's intake. This occurred, and Mr Hector was assessed as suitable for the

> Early Recovery Skills groups. Mr Hector was added to the waiting list for the next group, which was anticipated to start in three weeks' time.

62. On 10 August 2021 the AODPIP intake assessment was completed by the PIP Senior Clinician. Her contemporaneous notes record that during her assessment she engaged with Bernard and detected "no abnormal behaviour". She recorded that his affect was "relaxed", his cognition was "memory intact, oriented to TPP", his thoughts were "clear and logical" and his speech was of "normal rate and volume." She noted that Bernard "keeps to himself" in prison and that he had no current mental health issues though he "sometimes feels a bit down. Situational (prison)." In addition she recorded that he told her he had no "recent/current suicidal ideation/suicidal attempts."

Follow up medical assessments

63. Bernard was scheduled to attend his day 5 Adult Health Check on 19 July 2021 and further Adult Health Checks were scheduled for 1, 4, 13 and 24 August 2021 but none proceeded because of lockdowns, staff shortages, and medical prioritisation. On 25 August 2021 Bernard was seen by a nurse and given a COVID-19 vaccine and some paracetamol to take as required. This was the last medical visit Bernard had before his passing. The nurse recorded that:

> O: client looks well, alert and cooperative,
> denies feeling unwell at time of vaccination.
> eating and sleeping well.

Issue: Were there missed opportunities for Corrections and/or Health staff to assess Bernard and perhaps identify a change in his mental health?

If so, how can the system be improved?

64. Missing his 5 day adult health check and several medical call ups in addition to the delay in his AOD assessment was not ideal and it was conceded that opportunities to assess him were lost. His care and treatment during the period of missed appointments was less than it should have been and the reason for the missed appointments and how that could be improved were significant issues. Although there was one diarising error, and some appointments may have been cancelled due to medical prioritisation, the

majority were missed due to there being insufficient Corrections staff. Insufficient staff meant that there was either no one to escort Bernard to his appointments or resulted in lockdowns in the areas where the appointments were to take place and the appointments were cancelled. There was poor communication between Corrections staff and AOD staff concerning the missed AOD appointments. The COVID pandemic was blamed.

65. In spite of delays, on 10 August 2021 he was seen by the Senior Clinician in the Prison In-Reach Program for his AOD assessment who went out of her way to ensure the assessment was completed. Although he admitted to her that he was feeling down at times and not wanting to go 'at risk' again, she said that he was not presenting as distressed, he was relaxed, oriented, clear and logical. He told her he was not thinking of suicide or hurting himself and he did not wish to speak to anyone from mental health. If he had answered yes to thoughts of self-harm or suicide she said she would have immediately referred him to FMHS. She was an experienced and well qualified counsellor and I accepted her evidence that there were no identified concerns for Bernard on the day of her assessment.

66. Dr Derkenne acknowledged the limitations of point-in-time assessments. A persons circumstances may change after any assessment or period of monitoring. As discussed earlier, she considered that it was important to ensure that there are processes in place that encourage prisoners to support each other and report concerns. As I understand the evidence, Care Plans developed by Health staff in consultation with a prisoner are designed to assist prisoners to identify the supports available to them and how to access them. I understand that Care Plans are commenced upon reception and should be developed further on Day 5 health check[11], which Bernard missed. However, even in light of missed appointments, Dr Derkenne said that the care that Bernard received was certainly not less than he would have received in the community as required by section 82 *Correctional Services Act,* and I readily recall similar issues with delays

[11] According to the New Reception Prison Health Flow Charts

and cancellations being experienced in the community as GP and hospital services were retracted due to COVID.

67. The impact of staffing issues and lockdowns were issues clearly relevant to Bernard's care while being held in custody. Accordingly, it was disappointing that these issues were not squarely addressed in the Correction's Incident Review. I was told the solution to the problem was the recruitment of more officers via a rolling recruitment and training drive which was well underway. When specific and limited information concerning staffing at the prison was directly requested for four particular days, Corrections provided the total prisoner population and the actual numbers of Correctional Officers present during day shift for each of those day. Albeit a crude analysis, the information revealed that:

    - on 13 July 2021 there were 7.18 prisoners per Correctional Officer on duty,
    - on 29 August 2021 there were 12.29 prisoners per Correctional Officer on duty,
    - on 17 January 2023 there were 7.5 prisoners per Correctional Officer on duty,
    - on 8 February 2023 there were 8.8 prisoners per Corrections Officer on duty.

68. Accordingly, although recruitment is an apparent priority for Corrections, the measures adopted to date, at least so far as these numbers reveal, have not improved the situation, and COVID cannot be blamed. Given that staffing seems to be an endemic problem in the prison, in any future inquests I would expect Corrections to provide a considered analysis of whether, and if so how, staffing issues have positively or negatively impacted the care, supervision and treatment of the person while being held in custody.

69. While the staffing issue may take some time to rectify I was told that there were other changes designed to rectify the problem of prisoner's missing medical and therapeutic appointments. In particular, I am told there is a new "flow chart" for Corrections staff to follow designed to ensure that prisoners who need to access the health centre are prioritised even in lock downs[12], and that Corrections and Health were committed to

[12] T217, Dr Derkenne

working together to enable prison health clients to attend scheduled health appointments during lockdowns.

Formal findings

70. Pursuant to section 34 of the Coroner's Act, I find as follows:

    (i) The identity of the deceased was Bernard Hector born 14 April 1990 in Timber Creek.

    (ii) The time of death was between 11.11pm on 29 August 2021 and 8.15am on 30 August 2021. The place of death was Room 3 Block 6B, Sector 6, Darwin Correctional Precinct, Holtz, Northern Territory.

    (iii) The cause of death was self-inflicted hanging.

    (iv) The particulars required to register the death:

    1. The deceased was Bernard Hector.
    2. The deceased was of Aboriginal descent.
    3. The deceased was a prisoner and not employed at the time of his death.
    4. The death was reported to the Coroner by the Darwin Correctional Precinct staff.
    5. The cause of death was confirmed by Forensic Pathologist, Dr Bjorn Swigelaar.
    6. The deceased's mother was Colleen Long and his father was Pieman Yamyurri Hector.

Recommendations

71. I **recommend** that the Chief Judge of the Local Court of the Northern Territory amend Practice Direction 12 to provide that written reasons are to accompany an 'at risk' order.

72. I **recommend** that the Commissioner of the Northern Territory Correctional Services make available Aboriginal Mental Health First Aid Training to all prisoners.

73. I **recommend** that in accordance with RCADIC recommendation 178, that Corrective Services make efforts to recruit Aboriginal staff not only as correctional officers but to all employment classifications within Corrective Services, and endeavour to ensure

that their Aboriginal employees are utilised throughout the prison and are available to all prisoners.

74. I **recommend** the Commissioner of the Northern Territory Correctional Services and the CEO of the Northern Territory Department of Health together ensure that all prison health clients attend scheduled health appointments.

Dated this 24 day of February 2023

ELISABETH ARMITAGE
TERRITORY CORONER