FINDINGS and RECOMMENDATION of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Rickie Underwood Barron

Contents

Hearing date 3
Counsel 3
Introduction 3
Background 4
Mr Barron's time in gaol 4
Medical treatment and access to other services whilst in gaol 6
Circumstances of death 8
Investigation 9
Response to previous recommendations 10
Conclusion 12
Annexure A ....

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Rickie Underwood Barron, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing date

30 March 2023, with final written submissions received 13 June 2023.

Counsel

E Belonogoff – Counsel Assisting

L Brooks – The Secretary of the Department of Justice

Introduction

1. During the night of 10 – 11 January 2022, Rickie Underwood Barron died at Risdon Prison, Risdon Vale.

2. His death is subject to the *Coroners Act* 1995 (the "Act") because the Act relevantly provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in custody.[1]

3. Accordingly an inquest was held into Mr Barron's death in Hobart on 30 March 2023.

4. Prior to the inquest proceeding to hearing, those parties with a legal interest in the inquest were identified, all relevant evidence disclosed, case management conferences held and the scope of the inquest settled. In terms of the latter the inquest considered the general matters surrounding Mr Barron's death to enable findings to be made, if possible, under s 28 of the *Coroners Act* 1995 and consider the implementation of any previous coronial recommendations in respect of deaths in custody, particularly those concerning suicides by hanging.

5. The witnesses who gave evidence at the inquest were:

    (a) Natasha Barron (Senior Next of Kin);

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[1] See *Coroners Act* 1995, section 4(1)(b).

(b) Detective Senior Constable James Fenton (Investigating Officer); and

(c) Ian Thomas (Director of Prisons – Tasmanian Prison Service).

6. In addition to these three, the evidence of other witnesses was received in affidavit form (without the witnesses being called) and documentary and other evidence tendered. The complete list of all exhibits is annexed to this finding and marked with the letter A.

7. As a result of the evidence tendered at that inquest I make the following formal findings pursuant to section 28(1) of the Act:

(a) The identity of the deceased is Rickie Underwood Barron;

(b) Mr Barron died in the circumstances set out further in this finding;

(c) The cause of Mr Barron's death was hanging, the result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life; and

(d) Mr Barron died between 10 and 11 January 2022 at Division 4, Cell 6, Ron Barwick Minimum Security section of the Risdon Prison Complex, Risdon Vale in Tasmania.

Background

8. Mr Barron was born on 12 April 1960 in Hobart, Tasmania the son of Barry and Cynthia Barron. Mr Barron was married to Natasha Lee Barron. Together, the couple had three children. In addition, Mr Barron had a son from a previous marriage. He was 61 years of age and serving a lengthy sentence of imprisonment at the time of his death. His health was average; there was some evidence that Mr Barron suffered from Crohn's disease, and had had a history of other physical health issues, but otherwise he was in reasonable health.

9. There is no evidence of him suffering from, or receiving treatment for, any mental illness before he went to gaol in 2019. There is no evidence of any member of his family suffering mental illness.

Mr Barron's time in gaol

10. On 12 December 2019 Mr Barron was sentenced by Porter AJ to 13.5 years of imprisonment (with a non-parole period of 7 years) in relation to rape and child sex

offences. The sentence was backdated to commence on 27 November 2019, when Mr Barron first went into custody. At that time a so-called Tier 1 Assessment was completed with Mr Barron. The purpose of a Tier 1 Assessment is to determine immediate management needs of people being held in custody. It specifically canvasses previous suicide and self-harm attempts or any current or recent ideation.[2] Mr Barron did not disclose then, or at any time subsequently whilst in prison, that he had current suicidal ideation or intent.

11. Upon his entry to prison, Mr Barron received a medium security rating classification and was initially housed in the Barrington Unit of the Risdon Prison Complex. Whilst accommodated in the Barrington Unit Mr Barron worked in the prison tailors shop and bulk store of the prisoner reception area.[3]

12. On 8 December 2021 the prison's Sentence Management Review Panel reviewed Mr Barron's security classification and unanimously agreed to reduce it to minimum Security.[4] This change in his security classification meant that he became eligible for transfer to the Ron Barwick Prison (Minimum Security). Given that the Ron Barwick Prison is a minimum security facility, it has security features and an environment consistent with that classification. In practical terms this means that the inmates live a less restrictive life than in other areas of the Risdon Prison Complex. There are reduced security features, including CCTV coverage and fewer staff than elsewhere within the complex generally.[5]

13. The evidence was that before a prisoner could be transferred to the Ron Barwick Prison medical clearance was required. The evidence was that Mr Barron received an appropriate clearance before being transferred to the Risdon Prison on 5 January 2022. Upon his transfer he was initially housed in Division 4, a so-called protection unit within the facility, used to accommodate prisoners serving sentences in relation to sex offences. Initially he was placed in Cell 31 within Division 4. The evidence was that Cell 31 is a standard single cell located on the upstairs level of the Division. The next day (6 January), Mr Barron was moved to Cell 6, a so-called "disability" cell, larger in size and located on the lower, or down stairs, landing. The evidence was that the cell contained a shower and other amenities appropriate for someone with a physical disability.[6] Mr Barron was, at the time of his death, housed in that cell.

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[2] Exhibit C 26 (B), C 29 appendix A.
[3] Exhibit C 29, Affidavit - Ian Pugh Thomas, sworn 9 March 2023, paragraph 20.
[4] *Supra,* paragraph 28.
[5] *Supra*, paragraph 30.
[6] *Supra*, paragraphs 34 – 36.

Medical treatment and access to other services whilst in gaol

14. Mr Barron's Correctional Primary Health Service (CPHS), the Tasmanian Prison Service Therapeutic Services Unit (TSU)[7] and Tasmanian Health Service medical records were all tendered at the inquest.[8] In summary, his CPHS and TSU records show he received regular, consistent and appropriate treatment and access to treatment, whilst incarcerated at HMP Risdon. The same records disclose no suggestion by Mr Barron of any suicidal or self-harm ideation at any time whilst in prison. His Tasmanian Health Service records, which relates to treatment received before he was sentenced to prison, give no hint of any suicidal or self-harm ideation prior to his incarceration.

15. Mrs Barron gave evidence on the inquest about her husband's physical and mental health. In respect of his mental health there is evidence that Mr Barron had exhibited signs of low mood but never sought or received any treatment for any mental health issues at all. Following entering custody Mrs Barron had no concerns, at all, for his mental health. She gave evidence that early in his imprisonment he reflected upon challenging times in his life and worked on reducing his anxiety through things like reading.

16. In her evidence at the inquest Mrs Barron said that she could not remember when it started, but that after he went into custody Mr Barron would go through cycles of being angry for a period, then suddenly be fine. She said sometimes he showed anger towards her and that when he did, he would make threats to kill himself. When her husband made these threats, Mrs Barron said she told him she would "tell the prison". She said that when that happened Mr Barron would demand that she not to tell anybody as it would "affect his life in custody".

17. Mrs Barron said in her evidence that Mr Barron would only bring up suicide when he was angry, noting she said "when he was really down". This made Mrs Barron believe it was just a threat to "get to her".

18. There was evidence from Mrs Barron that in the three or so months leading up to his death her husband exhibited frustration, anxiety and what she described as "paranoia". Although concerned about her husband's mental health, and acknowledging the potential at least for self-harm, she decided not to tell anyone as she was concerned that to do so may have a negative impact upon him in prison – something he had

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[7] The TSU comprises psychologists and counsellors, trained in suicide and self-harm risk assessment and management.
[8] See Exhibits C 7 and C 26, generally.

impressed upon her on several occasions. In any event, the result was that neither the Tasmanian Prison Service nor CPHS were made aware by Mrs Barron (or indeed Mr Barron or for that matter anyone at all) that there was reason to be concerned about Mr Barron's potential for self-harm or suicide.

19. It is evident too from Mrs Barron's evidence at the inquest, that for much of the time her husband was in prison his interactions with her were demanding, controlling and erratic. However, it is also clear from her evidence, that during the period closer to his death Mr Barron appeared at times at least to be calmer and making plans for the future. Specifically, Mrs Barron suggested that her husband seemed to be positive about his move to the Ron Barwick Prison.

20. Mr Barron's prison records indicate that during his time in custody, he periodically made self-referrals for services provided by CPHS and TSU, including for mental health concerns. At the time of his death, Mr Barron was being treated for anxiety and depression with standard prescribed antidepressant and antipsychotic medication.[9]

21. However, staff in those services who are routinely involved in assessment and management under Directors Standing Order (DSO) 2.01 did not identify Mr Barron as a person at risk of suicide or self-harm. And in my view there was no reason for them to have done so. There is no evidence to suggest that Mr Barron demonstrated or reported any suicide or self-harm history, intent or ideation to CPHS or TPS staff at any time during his incarceration. This is consistent with Mrs Barron's belief that Mr Barron would not confide in anyone about his plan or desire to commit suicide. The evidence seems very clear that Mr Barron kept any intention to himself. Even Mrs Barron, who held concerns at other times, did not consider him at risk of self-harm or suicide in the lead up to his death.

22. The evidence of Mr Thomas suggests that had such a risk been identified, the procedures in DSO 2.01 would have been followed. I accept that this was so. The methods in DSO 2.01 to manage the risk would, I consider, have reduced (but not completely eliminated) the likelihood of Mr Barron's death by suicide. Most significantly, if Mr Barron had presented a risk of suicide or self-harm he would not have been placed or allowed to remain in the Ron Barwick Prison.

23. Nonetheless it is apparent to me, viewing the evidence as a whole, that Mr Barron was obviously intent on committing suicide and concealed that fact from prison and

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[9] Toxicological analysis of samples taken at autopsy showed the presence in his body at the time of his death, in therapeutic quantities, of antidepressant and antipsychotic medication – see exhibit C5.

medical staff, as well as his own wife. The evidence satisfies me that he knew how to access mental health services (and did so regularly). The evidence also satisfies me that Mr Barron appeared to have been generally aware of suicide and self-harm interventions and treatment plans. I say this on the basis of Mrs Barron's evidence of her husband's articulation of concerns he held about the impact upon him, particularly in regard to his security classification, of prison staff becoming aware of any self-harm or suicidal ideation on his part.

24. It is evident too from the efforts Mr Barron went to in writing letters, constructing a ligature, creating and securing a hanging point and delaying access to his cell, that a degree of planning was involved in his decision to take his own life. Further planning may be inferred from the requests (demands may be a better word) made of Mrs Barron regarding funeral plans and insurance.

25. It is difficult to know whether his transfer on 6 January 2022 to Cell 6 formed any part of this planning. It seems to me it is just as likely that Mr Barron made the request for transfer to the double cell to better manage aspects of his physical health, and that he then recognised that the transfer presented an opportunity for suicide – an opportunity that on the basis of Mr Thomas's evidence would have been available in most other cells within the Ron Barwick Prison. The materials (bed sheets and light cords) and furniture (steel bedframes) used to create the ligature and hanging point were available to almost all prisoners in Ron Barwick Prison.

Circumstances of death

26. Mr Barron was last seen alive at about 6.00 pm on Monday, 10 January 2022 by correctional officers after the evening muster. He was certainly still alive at about 8:45 pm that night when he rang his wife. Mr Barron made a number of phone calls to his wife that day. In her evidence, Mrs Barron described the calls between them that day as being concerned with her loneliness and her desire to potentially meet another man.[10] She said Mr Barron rang constantly on Monday, 10 January 2022 and he "would go between aggro, sensible and crying his eyes out". She described however the last phone calls as "beautiful" in which Mr Barron praised her as a "wonderful mother". She said the last few phone calls from Mr Barron were "loving and caring and the Rick [she] remembered".[11] Certainly, he gave no indication to her of any suicidal intention during any of their discussions on 10 January 2022, despite having done so in the past

[10] Exhibit C 9, Affidavit - Natasha Lee Barron, sworn 15 February 2022.
[11] *Supra*, page 6 of 7.

– comments Mrs Barron in her evidence at the inquest regarded as 'threats' as opposed to actual statements of intent.

27. The following morning, Tuesday, 11 January 2022 at 7.00 am correctional staff commenced muster in the Ron Barwick Prison. At 7.18 a.m. Correctional Officer Bunney noticed that Mr Barron had not presented for muster.[12] Correctional Officers Bunney, Clark and Lidster went to Mr Barron's cell and found the doors were secured from the inside with a prison issued jumper.[13] The doors were able to be opened sufficiently to enable the jumper to be cut by Correctional Officer Lidster (who was carrying a cut down knife) and allow entrance to the cell.[14] The correctional officers who entered the cell found Mr Barron suspended from his neck by a fabric cord tied to an up ended steel bedframe that in turn had been secured upright with more fabric ties.

28. Mr Barron was cut down, the ligature removed from his neck, a "Code Blue" called and Ambulance Tasmania immediately notified. Ambulance Tasmania records indicate that the call was received at 7.24 am, an ambulance dispatched at 7.27 am and arrived at the prison at 7.30 am.[15] By any standard, the response by Ambulance Tasmania was praiseworthy.

29. In the meantime, the correctional officers present immediately commenced effective CPR, assisted by the Ron Barwick Prison Nurse on duty Mr Petrusma, who arrived within two minutes with an automated external defibrillator (AED).[16] The AED advised no shock and so chest compressions were continued.

30. The Ambulance paramedics arrived at the cell at 7.32 am. The paramedics took over CPR from correctional officers CPR was continued until about 7.43 am when Mr Barron was declared deceased.[17]

Investigation

31. The fact of Mr Barron's death was reported in accordance with the requirements of the *Coroners Act* 1995. Police, including uniform, detectives and forensic experts, attended the prison and carried out a thorough investigation. I also attended and

[12] Exhibit C11, Affidavit – Nicholas Bunney, sworn 9 August 2022.
[13] *Supra.*
[14] Exhibit C12, Affidavit – David Clark, sworn 28 July 2022.
[15] Exhibit C 6, Ambulance Tasmania Electronic Patient Care Record, Case 73, 11 January 2022.
[16] Exhibit C 10, Affidavit – Timothy Petrusma, sworn 16 August 2022.
[17] Exhibit C 6, *op cit*.

inspected the scene of Mr Barron's death in the company of Constable Olivia Pearce-Tomes, Coroner's Associate.

32. Several hand written notes were found in Mr Barron's cell.[18] Those notes were seized for subsequent forensic examination. They were in their terms clearly suicide notes. In one, Mr Barron was complimentary about the care he had received whilst serving his sentence at Risdon Prison. The notes, as well as the circumstances in which Mr Barron's body was found, only support a conclusion that his death was suicide.

33. The cell itself was secured, forensically examined and photographed.[19] The results of that process informed these findings. Detective Senior Constable James Fenton, of Bellerive CIB was involved in the investigation. He gave evidence at the inquest and said there was no evidence at all that Mr Barron's death was anything other than it appeared.

34. In fact nothing at all was identified as part of the investigation which would suggest that Mr Barron's death was anything other than suicide or anyone else was involved.

35. Mr Barron's body was formally identified and then taken by mortuary ambulance to the Royal Hobart Hospital where Dr Andrew Reid carried out an autopsy. Dr Reid found a ligature mark around Mr Barron's neck. That ligature mark matched a ligature formed from plaited bedsheet removed by forensic officers from Mr Barron's body at the scene. Dr Reid found no evidence to indicate Mr Barron had been the victim of violence or that a third party was involved.[20]

36. Toxicological analysis of samples taken at autopsy identified the presence of several prescription drugs in Mr Barron's body at the time of his death within, or below, their respective reported therapeutic ranges. I observe that their presence is entirely consistent with a conclusion that his medical treatment was appropriate.

37. I am satisfied that neither alcohol nor illicit drugs played any role in Mr Barron's death. The forensic pathology evidence satisfies me that the cause of his death was hanging.

Response to previous recommendations

38. As I mentioned earlier, Mr Ian Thomas, Director of Prisons, Tasmania Prison Service, made a detailed affidavit[21] and gave evidence at the inquest. His evidence dealt with

[18] Exhibit C 25.
[19] Exhibit C 24, Affidavit - First Class Constable Tania Curtis APM, sworn 16 February 2022, and photographs.
[20] Exhibit C 4, Affidavit – Dr Andrew Reid, sworn 10 March 2022.
[21] Exhibit C 29, *op cit*.

the particular circumstances of Mr Barron's death, accommodation within the Ron Barwick Prison generally and Tasmanian Prison Service responses to previous Coronial recommendations.

39. What is abundantly plain from Mr Thomas's evidence is that the Ron Barwick Prison has numerous hanging points everywhere in the facility. Mr Thomas said that the Ron Barwick Prison "has been a commission since the early 1960s, and although significant works have been undertaken over the years to modernise the facility, and remove obvious ligature points, this has not always been achievable, and in some instances impossible, due to limitations with the aged infrastructure".[22]

40. It is also clear that the risk of suicide by a prisoner accommodated in the Ron Barwick Prison is ameliorated by the simple expedient of ensuring, so far as is possible, that any prisoner thought to be at any risk of suicide is housed elsewhere.

41. In my view the only conclusion open from Mr Thomas's evidence is that the replacement of the whole facility by a new and contemporary correctional facility designed to eliminate to the extent possible hanging points is the only way to eliminate hanging points from the Ron Barwick Prison.

42. Nonetheless, some steps can, and should be taken short of replacing the entire facility. At the very least it is obvious, I think, that the steel framed bed which Mr Barron used to hang himself from, and is a standard piece of furniture in many (perhaps most) cells in the whole Ron Barwick Prison, should be fixed to the cell floor or perhaps replaced altogether with contemporary furniture.

43. I note Mr Thomas's evidence in relation to aspects of the internal review conducted by the Tasmanian Prison Service. I consider that that review was comprehensive and identified some areas for improvement including the ability to access TSU services after hours and changes to therapeutic clearance procedures prior to transfer, following changes to security classification. I do not think that either of those issues played any role in the death of Mr Barron, but I comment, without making formal recommendation, that it seems to me the TPS continuing with any such measures as will assist to identify and deal with promptly and in a timely manner prisoner is at risk of suicide or self-harm.

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[22] *Supra*, paragraph 31.

44. I note also Mr Thomas's evidence in respect of works that have been undertaken within particular areas of the Ron Barwick Prison to eliminate, where possible, hanging points and the practical issues associated with that occurring.

Conclusion

45. As I think should be very clear, the evidence viewed as a whole satisfies me to the requisite legal standard that the actions which caused Mr Barron's death were undertaken by him voluntarily, alone and with the express intention of ending his own life. The circumstances in which his body was found, the findings at autopsy and the contents of the notes written by Mr Barron and left in his cell all lead to this conclusion.

46. Moreover, there are no circumstances of suspicion associated in any way with Mr Barron's death. No other person was involved in the acts which led to his passing. The same evidence I have just pointed to leads to this conclusion.

47. I consider that the response of the correctional officers, nurse and Ambulance Tasmania Paramedics was swift and professional. Nothing else could have been done to save Mr Barron.

48. I am required by the *Coroners Act* 1995 to report on Mr Barron's "care, supervision or treatment… [while he] was a person held in custody]".[23] It is sufficient to say that I consider that the evidence at the inquest satisfies me to the requisite legal standard that the care, supervision and treatment of Mr Barron whilst incarcerated at HMP Risdon was adequate and in no way caused or contributed to his death. Similarly, the treatment received from Ambulance Tasmania was of a high standard.

49. Ms Belonogoff, Counsel Assisting submitted, correctly in my view (as I hope is clear from much of the finding above), that in all the circumstances, there was little that could have be done to prevent Mr Barron's death in custody.

50. The question of what, if any, recommendations should be made is not without difficulty. I have highlighted the obvious problem in relation to the myriad of hanging points spread throughout most of the accommodation in the Ron Barwick Prison. I have highlighted the only practical solution to my mind – the complete replacement of the Ron Barwick Prison. Short of that it seems to me appropriate to **recommend** that the Tasmania Prison Service continue to develop and implement plans to remove

[23] See section 28 (5).

all, or as many as are reasonably possible, hanging points in accommodation in the Ron Barwick Prison.

51. I thank both counsel, Ms Belonogoff and Ms Brooks for their assistance in relation to this matter.

Dated 30 June 2023 at Hobart in the State of Tasmania.

Simon Cooper

Coroner

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

ANNEXURE A

LIST OF EXHIBITS

Record of investigation into the death of
RICKIE UNDERWOOD BARRON

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	Police Report of Death	S/Cst Benjamin Gough
C2	Life Extinct Affidavit	Dr Andrew Reid
C3	Affidavits x4 of Identification	Cst Benjamin Gough Det Cst Amelia Baker Anthony Cordwell, Mortuary Ambulance Christie Hagger, Fingerprint Expert
C4	Autopsy Report	Dr Andrew Reid
C5	Toxicology Report	Neil McLachlan-Troup
C6	VACIS Report & 000 Calls Audio on Disc x1	Ambulance Tasmania
C7	Medical Record on USB x1	Tasmanian Health Service
C8	Email re Destroyed Records	Calvary Lenah Valley Hospital
C9	Affidavit	Natasha Barron (SNOK)
C10	Affidavit	Timothy Petrusma
C11	Affidavit	Nicholas Bunney
C12	Affidavit	David Clark
C13	Affidavit	Chris Lidster
C14	Affidavit	John Heiermann
C15	Affidavit	Damian Foggitt
C16	Affidavit	Peter Wilson
C17	Affidavit	Ashly Cowen
C18	Affidavit	Sarah Monaghan

C19	**Affidavit**	**Martin Oppitz**
C20	**Affidavit**	**1/C Cst Stacey Harmond**
C21	**Affidavit**	**S/Cst Benjamin Gough**
C22	**Affidavit**	**S/Cst James Fenton**
C23	**Affidavit**	**Det S/Cst Amelia Hodge (nee Baker)**
C24	**Affidavit & Photographs**	**1/C Cst Tania Curtis**
C25	**Copies of Suicide Note and Letters**	
C26	**Prison Records** **A. Contents/Episodes Summary** **B. Case notes** **C. Directors Standing Order – Suicide & Self Harm Prevention** **D. Correctional Primary Health Service** **E. Death in Custody Notification** **F. Internal review – Death in Custody** **G. Phone Calls Audio on CD x1 & Recorded Call Summaries** **H. Selected Clips of CCTV Footage on Hard Disk x1**	**HMP Risdon**
C27	**Sentencing Records** **A. Porter AJ's Comments on Passing Sentence** **B. Police Brief for DPP**	**DPP**
C28	**Offence Reports**	**Tasmania Police**
C29	**Affidavit – 9/3/23**	**Director of Prisons**