JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	1 MARCH 2023
DELIVERED	**:**	17 APRIL 2023
FILE NO/S	**:**	CORC 222 of 2019
DECEASED	**:**	AFRICH, EDWARD IVAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

SGT A. BECKER assisted the coroner
L. ITALIANO (State Solicitor's Office) appeared on behalf of the Department of Justice
C. BEETHAM, with him A. PERCY (Wotton Kearney) appeared on behalf of Serco Australia Pty Limited

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Edward Ivan AFRICH*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 1 March 2023, find that the identity of the deceased person was* ***Edward Ivan AFRICH*** *and that death occurred on 18 February 2019 at Fiona Stanley Hospital, Murdoch, from bronchopneumonia and sepsis with chronic obstructive pulmonary disease in a man with underlying advanced chronic myelomonocytic leukaemia and heart failure, medically palliated in the following circumstances:*

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
Acacia	Acacia Prison
the ***Briginshaw*** principle	the accepted standard of proof the Court is to apply when deciding if a matter has been proven on the balance of probabilities
BRS	Broadspectrum
Casuarina	Casuarina Prison
the cell	the four-person cell that Mr Africh occupied from 8 March - 13 December 2018 at Acacia
the cell risk assessment	Multiple Cell Occupancy – Risk Assessment
CT	computerised tomography
the Department	the Department of Justice
Department's submissions	written submissions dated 31 March 2023 from the State Solicitor's Office on behalf of the Department
ECG	electrocardiogram
EcHO	the Department's Electronic Health Online which contains a prisoner's health records in electronic form
FSH	Fiona Stanley Hospital
The form	Reception Intake Form
Hakea	Hakea Prison
PD 8	Policy Directive 8: Prisoners with a Terminal Medical Condition
Prisoner Movements Procedures	Policy Directive 82 – Appendix 1: Prisoner Movements - Procedures
the register	Acacia's Access Complaints Register
the risk assessment	External Movement Risk Assessment
Serco	Serco Australia Pty Ltd
SJOGMH	St John of God Midland Hospital
Supreme Court	Supreme Court of Western Australia
TOMS	the Department's Total Offender Management Solution database
Wooroloo	Wooroloo Prison Farm

INTRODUCTION

> "Alcohol affects the person who consumes it. Smoke will harm the smoker and also his neighbours." – Dr Sivakumar Gowder, Associate Professor (Pharmacology)

1 The deceased (Mr Africh) died on 18 February 2019 at Fiona Stanley Hospital (FSH), Murdoch, from bronchopneumonia and sepsis with chronic obstructive pulmonary disease. At the time of his death, Mr Africh was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1]

2 Accordingly, immediately before his death, Mr Africh was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2] In such circumstances, a coronial inquest is mandatory.[3]

3 I held an inquest into Mr Africh's death at Perth on 1 March 2023. The following witnesses gave oral evidence:

(i) Dr Jee Kong (Head of Gastroenterology Services at St John of God Midland Public and Private Hospital, and Consultant Gastroenterologist at Royal Perth Hospital);
(ii) Pansey Stewart (Health Services Manager at Acacia Prison);
(iii) Dr Katherine Gunson (Acting Director of Medical Services at the Department);
(iv) Anika Smith (Director of Women's Operations at the Department); and
(v) Toni Palmer (Senior Review Officer at the Department)

4 The documentary evidence at the inquest comprised of two volumes of the brief, which were tendered as exhibit 1. During the course of the inquest, Mr Beetham, counsel appearing on behalf of Serco Australia Pty Limited (Serco), tendered a six-page document which became exhibit 2.[4]

5 Following the inquest and at my request, Mr Beetham's instructing solicitors provided counsel assisting an email dated 9 March 2023. This email addressed the question whether Acacia Prison (Acacia) had received the health summary sheet from the general practitioner for Mr Africh from Hakea Prison (Hakea). Also at my request after the inquest, Ms Italiano, counsel appearing on behalf of the Department, provided submissions (with attachments) from the Department dated 31 March 2023 regarding its compliance with the relevant policies and procedures applicable to the use of restrains on Mr Africh when he was admitted to FSH from 15 - 18 February 2019.

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[1] *Prison Act 1991* (WA) s 16
[2] *Coroners Act 1996* (WA) s 3, s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)
[4] St John of God Midland Public and Private Hospital, Discharge Summary Referral dated 11 December 2018

6 The inquest focused on the medical care provided to Mr Africh during his time as a prisoner, with an emphasis on the care provided to him regarding his pre-existing emphysema. The inquest also examined the use of restraints on Mr Africh when he was at FSH.

7 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proven on the balance of probabilities (the ***Briginshaw*** principle).

8 I am also mindful not to assert hindsight bias into my assessment of the actions taken by those responsible for Mr Africh's treatment and care when he was in prison. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[5]

MR AFRICH [6]

9 Mr Africh was born on 12 January 1955 at King Edward Memorial Hospital, Subiaco. He was 64 years old when he died. He grew up in Mt Lawley, Cottesloe and also spent several years as a young boy living in Boulder. Prior to completing high school, Mr Africh began working for a plumbing business and later became a qualified plumber. He was able to fund an early retirement with rent he received from a number of investment units that had belonged to his mother after she died in 2015.

10 Mr Africh began smoking cigarettes when he was child. He did not stop smoking until about four years before his death. He also had an alcohol dependency that was ongoing when he was imprisoned.

11 Mr Africh never married and had no children. He enjoyed surfing, fishing, camping and listening to music.

Circumstances of imprisonment [7]

12 In August 2015, Mr Africh had an altercation with a person in his neighbourhood regarding the other person's dogs. This caused Mr Africh to have ongoing animosity towards this person.

13 On 4 June 2016, Mr Africh used an accelerant to deliberately set fire to the person's car that was parked at the front of the person's house.

[5] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[6] Exhibit 1, Volume 1, Tab 8A, Statement of Jelena Testa dated 7 April 2021
[7] Exhibit 1, Volume 2, Tab 1.1, Supreme Court sentencing remarks dated 15 February 2018; Exhibit 1, Volume 1, Tab 10B, Appeal Notice dated 24 August 2017 and Discontinuance Notice dated 14 March 2018

14 Mr Africh was subsequently charged with the offence of wilfully and unlawfully damaging a motor vehicle by fire, contrary to s 444(1)(a) of the *Criminal Code* (WA). Mr Africh pleaded not guilty, and the matter went to trial before a jury in the Supreme Court of Western Australia (the Supreme Court) in Perth. On 9 August 2017, the jury found Mr Africh guilty.

15 On 15 February 2018, the Supreme Court sentenced Mr Africh to two years and six months' imprisonment, with eligibility for parole. That meant Mr Africh would not be eligible for parole until he had served 15 months' imprisonment. This was the first time Mr Africh had been imprisoned.

16 In the judge's sentencing remarks, it was noted that Mr Africh had a number of physical health issues which included liver dysfunction, gout, emphysema, fatigue, breathlessness and chronic insomnia. It was also noted that Mr Africh's primary health concern was his liver dysfunction which had been caused by his alcohol dependency. In addition, a report from a neuropsychologist that was provided to the judge stated that Mr Africh had cognitive impairment.

17 On 24 August 2017, Mr Africh's lawyer lodged an appeal against Mr Africh's conviction in the Supreme Court's Court of Appeal. However, that appeal was subsequently discontinued on 14 March 2018.

Prison history [8]

18 Mr Africh had the following prison placements and transfers for the 12 months he was imprisoned:

(i) Hakea Prison: 15 February – 2 March 2018 (15 days)
(ii) Acacia Prison: 2 March – 13 December 2018 (286 days)
(iii) Casuarina Prison: 13 December 2018 – 18 February 2019 (67 days)[9]

19 When at Hakea at the start of his imprisonment, Mr Africh's security rating was reduced to medium, and he was recommended for transfer to Acacia. Mr Africh subsequently spent most of his imprisonment at Acacia.

20 As already noted, Mr Africh had a number of pre-existing medical conditions before he was imprisoned. By February 2017, he had been diagnosed with atrial fibrillation (abnormal heart rhythm), interstitial lung disease and emphysema. In February 2017, he had decompensated cirrhosis that was most likely due to his alcohol consumption. In March 2017, he was diagnosed with mild dysarthria (unclear articulation of speech). There was also a reduction in his fine motor skills.

[8] Exhibit 1, Volume 2, Tab 1, Death in Custody Report dated 28 October 2019; Exhibit 1, Volume 1, Tab 21, Health Summary Sheet and attachments
[9] These 67 days included the four days Mr Africh was a patient at FSH

21 A report dated 27 October 2017 from a consultant hepatologist and gastroenterologist noted Mr Africh had Child's B7 cirrhosis, an illness that has a one-year survival rate of 81%. At the time, he was also taking temazepam for sleep assistance.

22 It would appear that when Mr Africh was assessed at Hakea, these health conditions were not regarded as serious enough for him to be transferred to Casuarina Prison (Casuarina) where he would be able to receive treatment at its infirmary.[10] Whilst he was at Acacia, Mr Africh requested a placement at Wooroloo Prison Farm (Wooroloo) once his security status went from medium to minimum (when he would become eligible to be at Wooroloo). Nevertheless, when he acquired a minimum-security status, Mr Africh remained at Acacia due to his medical needs.

23 Mr Africh was regarded as a quiet, polite and well-spoken prisoner who observed prison rules and was not regarded as a management issue. He interacted well with other prisoners in his unit and maintained his cell and personal hygiene to an acceptable level.

OVERVIEW OF MR AFRICH'S MEDICAL TREATMENT AND CARE IN PRISON [11]

At Hakea

24 Upon his arrival at Hakea on 15 February 2018, Mr Africh was assessed by a prison nurse. The only medical problem he identified was a heart condition. He also disclosed a previous high alcohol intake. At this assessment, Mr Africh signed a consent form for the release of medical information from his general practitioner.

25 On 19 February 2018, at a prison doctor's review, Mr Africh stated he had cirrhosis, gout, previous surgical issues and atrial fibrillation (irregular heartbeat). He repeated that he had an alcohol dependency. However, he did not disclose a history of chronic obstructive airways disease or lung disease. Mr Africh also said that he had stopped seeing his hepatologist for his cirrhosis. He was prescribed thiamine (vitamin B1), which is commonly given to people who have an alcohol dependency, and metoprolol and magnesium for his atrial fibrillation.

26 Although Mr Africh's general practitioner sent a health summary sheet with attached specialist reports and pathology results via a facsimile transmission on 16 February 2018, this material was not sighted by the prison doctor when she

[10] Casuarina is the only prison in Western Australia that has an infirmary

[11] Exhibit 1, Volume 1, Tab 15, Health Services Summary into the Death in Custody dated 13 October 2022; Exhibit 1, Volume 1, Tab 20, EcHO medical notes for Mr Africh; Exhibit 1, Volume 1, Tab 22, Report by Dr Cherelle Fitzclarence dated 20 September 2022

reviewed Mr Africh. However, the doctor recorded in the Department's Electronic Health Online (EcHO)[12] that the plan was for Mr Africh to be reviewed by a prison doctor who had access to the release of medical information from his general practitioner.

At Acacia

27 On 2 March 2018, Mr Africh was transferred to Acacia. On that day, Mr Africh only disclosed a history of atrial fibrillation and alcohol liver cirrhosis to the prison nurse conducting the admission assessment.

28 A prison doctor conducted a file review on 8 March 2018, when Mr Africh's prescriptions for thiamine, metoprolol and magnesium were updated.

29 At an appointment with a prison nurse on 14 March 2018 to discuss a cardiovascular care plan, Mr Africh disclosed for the first time that he had emphysema and that was why he did not exercise. The nurse noted that this diagnosis was not recorded in EcHO and entered a note on EcHO for a prison doctor to review Mr Africh's claim that he had emphysema at his next appointment.

30 Despite that note, it appears no investigation of Mr Africh's emphysema occurred at his next appointment with the prison doctor on 23 May 2018. The doctor noted on EcHO the history of alcohol cirrhosis and atrial fibrillation and prescribed amitriptyline (an antidepressant medication that is also used to treat neuropathic pain) after Mr Africh complained of numbness in the soles of his feet.

31 Although atrial fibrillation increases the risk of a stroke and/or heart attack, Mr Africh declined to take anticoagulants (blood thinning medication) to reduce these risks. However, he did agree to take small doses of aspirin which provides some mild protection.

32 For the next several months, there were haematology concerns regarding white cell blood counts in recent blood testing from Mr Africh. The blood results indicated a possible primary bone marrow disorder such as chronic myelomonocytic leukemia[13] and Mr Africh subsequently had an appointment with a haematologist at FSH on 28 August 2018. A bone marrow biopsy was then performed at FSH on 13 September 2018. At a further appointment with the haematologist at FSH on 2 October 2018, Mr Africh was advised that the bone marrow biopsy had confirmed he had chronic myelomonocytic leukemia.

[12] EcHO contains a prisoner's health records in electronic form

[13] Chronic myelomonocytic leukaemia is a hematologic malignancy (blood cancer) with features of a myeloproliferative neoplasm (too many blood cells) and a myelodysplastic syndrome (abnormal blood cells produced in the bone marrow). This leukemia is characterised by raised numbers of monocytes (a type of white blood cell) and bone marrow dysplasia (production of abnormal blood cells). It is accompanied by low blood cell counts and an enlarged spleen.

Nevertheless, the haematologist was of the view that no urgent treatment was presently required as Mr Africh was not anaemic and there were no prominent symptoms. Mr Africh also had elevated ferritin,[14] however the haematologist determined this was most likely a consequence of Mr Africh's liver disease. Haemochromatosis (a genetic disorder that causes raised iron levels) was therefore excluded.

33 On 13 November 2018, Mr Africh had another appointment with the haematologist at FSH. He was noted to be clinically well and his recent blood results were stable. However, the haematologist observed that Mr Africh appeared to be unaware he had been diagnosed with chronic myelomonocytic leukemia. Mr Africh was reassured that the disorder was unlikely to cause him trouble, or require treatment in the near future.

34 At a prison doctor's appointment on 16 November 2018, it was noted that Mr Africh appeared frail, gaunt and pale. Nevertheless, Mr Africh said he did not feel too bad. At this appointment the doctor explained to Mr Africh the diagnosis of chronic myelomonocytic leukemia and why there was not going to be any treatment for it.

35 On 7 December 2018, a Code Blue emergency was called by a prison nurse at Acacia when Mr Africh experienced shortness of breath whilst walking. He was given oxygen and a subsequent electrocardiogram (ECG) indicated heart failure. The prison doctor then completed a full assessment and diagnosed a cardiac failure. A decision was made to refer Mr Africh to hospital and an ambulance was summonsed to take him to the emergency department at St John of God Midland Hospital (SJOGMH).

36 Mr Africh remained at SJOGMH for four days. He was diagnosed with exudative pleural effusion (fluid between the lung and chest wall cavity) and a drain was inserted to remove the fluids. An ECG detected a right heart failure with severe tricuspid regurgitation (a leaking heart valve). A computed tomography (CT) scan showed severe emphysematous changes. A urinary catheter was inserted with a plan for it to remain for six weeks. Oxygen saturation levels were lower than normal at 88% to 92%, which was attributed to Mr Africh's underlying lung disease.[15]

37 Upon Mr Africh's discharge back to Acacia on 11 December 2018, the hospital discharge letter did not have any specific therapy for his severe emphysema.

38 On 12 December 2018, Mr Africh was reviewed by a prison nurse who documented some troubling observations including a pulse rate of 115 (which is

[14] Ferritin is a blood protein that contains iron
[15] A normal oxygen saturation level is 95% or above

regarded as high) and oxygen saturation levels of 83% and 85% (which are regarded as very low).

39 Although a prison doctor reviewed the discharge letter from SJOGMH and noted the emphysema diagnosis, this was not added to Mr Africh's "*Problem List*"[16] on EcHO, nor was any comment made on the lack of treatment for the emphysema. Due to his poor health, arrangements were made to have Mr Africh transferred to the infirmary at Casuarina.

40 On this same day, Mr Africh was added to the terminally ill register on the Department's Total Offender Management Solution database (TOMS). It was recorded he had cirrhosis of the liver and chronic kidney disease. It was also noted that the chronic myelomonocytic leukemia, by itself, was unlikely to alter Mr Africh's prognosis. He was classified as Stage 1 on the terminally ill register, which meant it was considered he could potentially die in custody.

At Casuarina

41 On 13 December 2018, Mr Africh was transferred from Acacia to Casuarina. He remained in the infirmary at Casuarina where he was reviewed daily by prison nurses. He received supplemental oxygen for a period of time and his blood pressure was intermittently low. Mr Africh was advised to restrict his fluid intake to 1½ litres daily.

42 On 14 December 2018, the prison doctor noted that Mr Africh's oxygen saturation levels remained very low at 84% when he was not receiving supplemental oxygen.

43 After another low blood pressure reading on 21 December 2018, a prison doctor advised withholding the diuretic, frusemide, for three days. This withholding was to continue from 24 December 2018 whenever Mr Africh's blood pressure fell below a certain level.

44 At a prison doctor's appointment on 31 December 2018, Mr Africh was noted to have swollen legs. Previous nursing notes had recorded his weight had increased by several kilograms, which indicated possible fluid retention. Frusemide was restarted on alternate days.

45 On 2 January 2019, Mr Africh's leg swelling had improved; however, his blood pressure was extremely low. The prison doctor acknowledged the difficulties in managing the leg swelling without causing a further drop in Mr Africh's blood pressure. Blood tests the following day showed borderline thyroid function, low

[16] Any confirmed health diagnosis for a prisoner is to be cited on the prisoner's EcHO under the heading "*Problem List*": ts 1.3.23 (Ms Stewart), p. 47

vitamin D levels and an elevated pro BNP count[17] consistent with heart failure. There was also a rise in the white cell counts.

46 On 9 January 2019, the prison doctor discussed Mr Africh's recent blood tests with him and pointed out the complexity of the treatment options for his various medical conditions.

47 Mr Africh had an appointment with the haematologist at FSH on 15 January 2019. It was noted that Mr Africh's blood counts had deteriorated, and that he had poor recall and understanding about his health issues, raising the possibility of cognitive impairment or hepatic encephalopathy (brain dysfunction related to liver disease). Treatment options with chemotherapy medications were discussed; however, in view of Mr Africh's comorbidities, the likelihood of complications with certain chemotherapy options remained high.

48 At an appointment with the prison doctor on 21 January 2019, Mr Africh complained of coughing at night that was keeping him awake and burning pains to the soles of his feet. He was prescribed a low dose of amitriptyline for this pain.

49 On 22 January 2019, Mr Africh had an appointment with a physician at SJOGMH. His breathlessness caused by exertion was attributed to a combination of his emphysema, atrial fibrillation, pulmonary hypertension (increased pressure in the lung blood vessels) and deconditioning (changes in the body that occur due to inactivity). The physician advised that metoprolol should be restarted, and that Mr Africh participate in an exercise program to improve his symptoms of breathlessness.

50 In the two weeks following this appointment, twice daily prison nursing assessments continued, with observations noting Mr Africh was stable.[18]

EVENTS LEADING TO MR AFRICH'S DEATH [19]

51 On 6 February 2019, Mr Africh reported feeling breathless to a prison nurse, but he declined to use oxygen. His oxygen saturation level was 85% and his respiratory rate was slightly elevated.

52 At his appointment with a prison doctor on 7 February 2019, Mr Africh complained that walking caused him to cough which produced a white phlegm. His oxygen saturation level had improved to 93% with deep breathing. However, his blood pressure remained low. The possibility of paroxysmal nocturnal dyspnoea (breathlessness at night indicating heart failure) was raised. Despite

[17] A pro BNP count is a diagnostic biomarker that is used to determine heart failure and/or cardiac dysfunction
[18] Exhibit 1, Volume 1, Tab 20, EcHO medical notes for Mr Africh
[19] Exhibit 1, Volume 1, Tab 15, Health Services Summary into the Death in Custody dated 13 October 2022; Exhibit 1, Volume 1, Tab 20, EcHO medical notes for Mr Africh; Exhibit 1, Volume 1, Tab 22, Report by Dr Cherelle Fitzclarence dated 20 September 2022

these issues, Mr Africh remained independent and was able to mobilise around the prison unit he was in. However, daily weight checks indicated that Mr Africh's weight had increased by three kilograms over the previous two weeks. Given Mr Africh's comorbidities, a weight increase of this magnitude indicated further fluid retention.

53 On 13 February 2019, Mr Africh reported to the prison doctor that he had not been sleeping well, had not gone for walks because it made him breathless and had nearly fainted after standing for some time.

54 On the morning of 15 February 2019, Mr Africh complained of continued breathing difficulties when walking and feeling generally unwell. His oxygen saturation level fell to an alarming low of 79% and even when he was encouraged to breath deeply, Mr Africh was unable to maintain a level above 90%. The assessment by the prison doctor was that Mr Africh may be having heart failure and arrangements were made to urgently transfer him by a Priority 1 ambulance to FSH.

55 Once at FSH, Mr Africh remained very unwell. He was diagnosed with pulmonary oedema secondary to decompensated heart failure and possible chest sepsis. His blood pressure remained low and he had low oxygen levels. He was also found to have an acute kidney injury and a right sided pleural effusion (fluid around the lungs). Mr Africh was commenced on albumin, steroids, antivirals and antibiotics.

56 Doctors from the intensive care unit at FSH reviewed Mr Africh and determined that given his frail pre-existing state, he was not suitable for treatment in either the intensive care unit or the high dependency unit. Consequently, Mr Africh was admitted under the haematology team for ward-based care. He specified he was not for resuscitation in the event of a cardiac arrest.

57 Mr Africh did not respond to treatment, and he remained extremely unwell. By the morning of 17 February 2019, his treating doctors at FSH determined that his death was likely to be soon. At 3.32 pm on that date, the Department's Director of Medical Services elevated Mr Africh to Stage 3 on the Department's terminally ill register.[20] This classification meant it was considered that his death may occur suddenly or within three months.[21]

58 In the early hours of 18 February 2019, Mr Africh's condition deteriorated further with ongoing low oxygen levels and low blood pressure. A chest x-ray showed worsening pulmonary oedema (fluid build-up within the lungs).

[20] Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 4

[21] Given Mr Africh's extremely poor prognosis, it is readily apparent he was given a Stage 3 status due to the high prospect of his death occurring suddenly.

59 When reviewed by the haematology team at FSH on the morning of 18 February 2019, a decision was made to direct Mr Africh's care to palliative only. Active treatment was subsequently ceased and Mr Africh was prescribed medications to keep him comfortable. His death was certified at 8.40 pm on 18 February 2019.

CAUSE AND MANNER OF DEATH [22]

60 On 21 February 2019, a forensic pathologist (Dr Jodi White) conducted a post mortem examination of Mr Africh's body.

61 The post mortem examination found that Mr Africh's lungs were heavy and congested, with abundant adhesions and severe pneumonia on a background of underlying fibrocystic lung disease. His heart was enlarged, softened and dilated with mild to moderate coronary artery disease. Mr Africh's liver was cirrhotic, and his kidneys were scarred.

62 Microscopic examination of tissues from Mr Africh's major body organs confirmed the above findings. In addition, these examinations found widespread infiltration of many of the organs including the bone marrow, liver and spleen in keeping with the history of chronic myelomonocytic leukemia. Post mortem biochemistry analysis also showed acute renal impairment.

63 Toxicological analysis detected the presence of prescription-type medications in keeping with Mr Africh's known clinical history and medical management at FSH.

64 At the conclusion of the post mortem examination, and after reviewing hospital medical records, Dr White expressed the opinion that the cause of Mr Africh's death was "*bronchopneumonia and sepsis with chronic obstructive pulmonary disease in a man with underlying advanced chronic myelomonocytic leukemia and heart failure, medically palliated*".[23]

65 I accept and adopt that conclusion expressed by Dr White and I find that Mr Africh's death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Mr Africh's pre-existing lung disease and emphysema not initially identified

66 As already noted above, Mr Africh's general practitioner sent a health summary sheet with attached medical reports to Hakea on 16 February 2018.[24] Although the

[22] Exhibit 1, Volume 1, Tabs 4A and 4B, Supplementary Post Mortem Report dated 21 February 2019, Post Mortem Report dated 21 February 2019; Exhibit 1, Volume 1, Tab 5, Toxicology Report dated 31 May 2019
[23] Exhibit 1, Volume 1, Tab 4A, Supplementary Post Mortem Report dated 21 February 2019, p. 1
[24] Exhibit 1, Volume 1, Tab 21, Health Summary Sheet and attachments

general practitioner's health summary sheet was lacking in some relevant details, a reading of the attached medical reports would have disclosed that Mr Africh had already been diagnosed with, amongst other health conditions, interstitial lung disease and emphysema.

67 It emerged from evidence at the inquest that this important information regarding Mr Africh's serious pre-existing medical conditions had not been read by prison health service providers who were treating Mr Africh. This problem was compounded when Mr Africh did not disclose his emphysema until nearly a month after he had been imprisoned.

68 Dr Katherine Gunson, the Acting Director of Medical Services at the Department, explained at the inquest that the prison doctor who saw Mr Africh at Hakea on 19 February 2018 did not have a copies of the health summary sheet and the attachments that had been sent by facsimile the previous working day (Friday, 16 February 2018). Nevertheless, the prison doctor noted on EcHO that she did not have this information from the general practitioner, and she placed an intervention for a prison doctor to review Mr Africh again when that information became available. As of 19 February 2018, the doctor was not aware it had already been sent.[25]

69 Before he was seen again by a prison doctor, Mr Africh had been transferred to Acacia. That should not have caused an issue with access to the health summary sheet and its attachments. As Dr Gunson explained at the inquest, this material ought to have been included in Mr Africh's medication pack when he was transferred to Acacia. Dr Gunson went on to explain:[26]

> However, the safety net here was that there was a request for an appointment for one month after his admission assessment asking for a review with the information from the ROI,[27] and if the doctor saw him and there was no information from the ROI, which was evident - had evidently been requested on his arrival to [Hakea] prison, if they couldn't lay their hands on it quickly, the logical thing would have been to ask him to sign another release form so that the GP could re-fax it to the prison he was now residing at.

70 The evidence of Dr Gunson and Ms Pansey Stewart, the Health Services Manager at Acacia, was that it did not appear the health summary sheet and the attachments were forwarded onto Acacia from Hakea. During the inquest, I sought clarification from Serco that this was correct. An email dated 9 March 2023 to counsel assisting from the solicitors representing Serco stated:[28]

> We confirm Serco/Acacia Prison have reviewed the EcHO notes and confirm that there is no evidence of the health summary ROI being sent with Mr Africh when he transferred to

[25] ts 1.3.23 (Dr Gunson), p. 51; Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 116
[26] ts 1.3.23 (Dr Gunson), p. 53
[27] Release of (medical) information
[28] Email dated 9 March 2023 from Mr Diviij Vijayakumar to Sgt Alan Becker

> Acacia from Hakea Prison on 2 March 2018. There is no other approved method to store health information/records of prisoners, besides in EcHO.

71 Although Hakea was remiss in not forwarding this documentation onto Acacia, Ms Stewart properly conceded that Acacia was responsible to correct this oversight: "*If the patient is now with us and we are aware of it and he has seen the doctor, we can then chase up on that report. So it will sit with the prison that the patient is in*".[29]

72 Mr Africh's health service providers at Acacia should have been aware of this documentation as it was referred to in EcHO as early as 19 February 2018.[30] Although a prison doctor at Acacia conducted a file review for Mr Africh on 8 March 2018, the EcHO records indicate he was not seen by a prison doctor until 23 May 2018.[31] Despite the prison doctor at Hakea specifying that the plan was for a doctor to review Mr Africh with the release of medical information, that did not take place at this appointment. Nor was the note on EcHO from 14 March 2018 made by the prison nurse at Acacia, for the prison doctor to review Mr Africh's claim that he had emphysema followed up on this occasion, or subsequently.

73 Dr Jee Kong, the consultant gastroenterologist who the Court engaged to provide an independent report, stated this should have been done as Mr Africh had "*alluded to a reduced effort to exercise and to me that would be a sign that an assessment should be done to assess the severity*".[32]

74 Unfortunately, these were two missed opportunities which remained unaddressed. An explanation by Ms Stewart at the inquest for these oversights is plausible. She said that by May 2018, Mr Africh had abnormal blood results that indicated another illness (chronic myelomonocytic leukemia) and that became, "*the key focus at the time and not around his emphysema diagnosis*".[33] Nevertheless, that explanation is not an excuse.

75 It was regrettable none of Mr Africh's prison health service providers accessed the health summary sheet and its attachments that had been provided by his general practitioner. I accept there were deficiencies in that documentation that were identified by Dr Gunson at the inquest. These included the front summary sheet stating there were no current active problems and that Mr Africh's "*past medical history*" only included duodenitis and a colon polyp.[34] It was astounding to read that, notwithstanding Mr Africh's serious ongoing medical issues, under the

[29] ts 1.3.23 (Ms Stewart), p. 27
[30] Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 116
[31] Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 106
[32] ts 1.3.23 (Dr Kong), p. 9
[33] ts 1.3.23 (Ms Stewart), p. 32
[34] ts 1.3.23 (Dr Gunson), p. 53; Exhibit 1, Volume 1, Tab 21, Health Summary Sheet and attachments, pp. 1-2

heading "*Current active problems*" on the health summary sheet, it was written, "*None recorded*".[35]

76 Nevertheless, a reading of the specialist reports that were attached would have disclosed that Mr Africh had been diagnosed with interstitial lung disease and emphysema. However, as noted by Dr Gunson, there was no evidence that any treatment had been commenced for Mr Africh's emphysema, which left open the possibility that he was not even being treated for it in the community.[36]

77 Dr Gunson also identified another source available to Mr Africh's prison health service providers to verify the accuracy of his statement that he had emphysema. His medical history from Sir Charles Gairdner Hospital, which the Department's Health Services had access to, also referred to his emphysema diagnosis.[37]

78 Furthermore, reports from the Haematology Outpatient Clinic at FSH addressed to the medical officer at Acacia identified emphysema under the heading "*Diagnoses*". The first of those reports in the Court's possession is dated 28 August 2018 and predated the diagnosis of severe emphysema at SJOGMH in December 2018.[38]

79 The significance of Mr Africh's pre-existing diagnosis of emphysema concerned his potential exposure to second-hand smoke whilst in prison.[39]

Mr Africh's placement in a shared cell with smokers at Acacia

80 An issue that was explored at the inquest was the decision to place and then keep Mr Africh in a four-person cell at Acacia in which, at one stage, his three fellow cell occupiers were all smokers. The harmful effects of second-hand smoke exposure to a person with emphysema is obvious. As Dr Jee Kong said at the inquest:[40]

> In a person who has emphysema, when there is ongoing exposure to cigarette smoke, there is a risk of further deterioration and that deterioration could be manifesting of a decreased quality of life or increased breathlessness on a day-to-day basis. It also predisposes risk of having exacerbations of chest infections.
>
> …
>
> In my opinion no second-hand smoke is acceptable.

[35] Exhibit 1, Volume 1, Tab 21, Health Summary Sheet and attachments, p. 1
[36] ts 1.3.23 (Dr Gunson), pp. 53-54
[37] ts 1.3.23 (Dr Gunson), p. 59
[38] Volume 1, Exhibit 1, Tab 19A, FSH Haematology Clinic Report dated 28 August 2018; see also Volume 1, Exhibit 1, Tab 19B, FSH Haematology Clinic Report dated 2 October 2018 and Volume 1, Exhibit 1, Tab 19C, FSH Haematology Clinic Report dated 13 November 2018
[39] Exhibit 1, Volume 1, Tab 16, Report of Dr Jee Kong dated 29 May 2022
[40] ts 1.3.23 (Dr Kong), p. 11

81 It was not in dispute at the inquest that a prisoner with emphysema should not be in a cell with others who actively smoked in the enclosed environment of the cell, particularly at night-time when the cell was locked. The questions that arose were (i) when did the prison become aware Mr Africh had emphysema, (ii) when did the prison became aware Mr Africh was being exposed to second-hand smoke in his cell and (iii) whether the actions taken by the prison to address that exposure were adequate.

82 A "*Reception Intake Form*" (the form) was completed when Mr Africh arrived at Acacia on 3 March 2018.[41] The form contained a number of questions, including the suitability of the prisoner to be placed in a shared cell. Mr Africh's signature appeared at the bottom of the first page.

83 It was recorded on the form that Mr Africh had previously been identified as being able to share a cell at Hakea on 15 February 2018.[42]

84 The box marked "*Yes*" was ticked to the question, "*Does TOMS alerts indicate any active medical alerts?*", and in the comments section it was written "*frail – need bottom bunk*".[43]

85 Critically, the box marked "*No*" was ticked for the question, "*Is there any medical reason that may affect the placement of this prisoner in a shared cell placement?*" Similarly, the box marked "*No*" was also ticked for the question, "*Are there any new and/or previous non-recorded medical condition/situation that may affect the placement of this prisoner in a shared cell placement*?".[44]

86 The "*No*" box was also ticked for the question, "*Does the prisoner identify any issues that may require further advice from Health Services?*". The form indicates that had the box marked "*Yes*" been ticked for this question, then an assessment was to be made as to whether the prisoner was "*High Risk*", "*Medium Risk*" or "*Low Risk*". "*High Risk*" was defined as: "*Confirmed medical related issues serious enough to warrant single cell placement*".[45]

87 With the advantage of hindsight, and in light of Mr Africh's previous diagnosis of emphysema, inaccurate answers have been given to the medical questions on the form. Some responsibility for this rests with Mr Africh. It is evident he did not raise with the prison nurse completing this checklist that he had emphysema. His lack of information regarding that condition may well have been raised by the nurse had she had access to the release of medical information that Mr Africh's general practitioner had provided to Hakea two weeks earlier. Hence, some of the

[41] Exhibit 1, Volume 1, Tab 13A, Acacia Prison Reception Intake Form dated 2 March 2018
[42] Exhibit 1, Volume 1, Tab 13A, Acacia Prison Reception Intake Form dated 2 March 2018, p. 1
[43] Exhibit 1, Volume 1, Tab 13A, Acacia Prison Reception Intake Form dated 2 March 2018, p. 2
[44] Exhibit 1, Volume 1, Tab 13A, Acacia Prison Reception Intake Form dated 2 March 2018, p. 2
[45] Exhibit 1, Volume 1, Tab 13A, Acacia Prison Reception Intake Form dated 2 March 2018, p. 2

responsibility for these questions not being answered accurately must also rest with Hakea's failure to forward the health summary and its attachments to Acacia.

88 There is another process for the determination of whether a prisoner should be placed in a shared cell. It is called a "*Multiple Cell Occupancy – Risk Assessment*" (the cell risk assessment), the purpose of which is, "*to assess the prisoner's suitability for multiple cell occupancy*". The cell risk assessment is completed on the initial reception and all subsequent receptions.[46] It is filled in by a prison officer and a signed hard copy is to accompany the prisoner to whatever unit he is allocated to and placed on his file.[47]

89 With respect to the cell risk assessment for Mr Africh, the answer was "*Yes*" to the first question, "*Is sharing with a smoker an issue for the prisoner*?". As this question was answered "*Yes*", "*further evaluation and comment*" was required. However, the only comment recorded was "*non-smoker*". To the question, "*Does the prisoner identify any issues that would preclude this prisoner from sharing a cell*?", the answer was "*No*".[48]

90 Accepting that these answers fully recorded Mr Africh's responses, it again appears Mr Africh, for reasons unknown, failed to state the critical health reason why he should not be sharing a cell with any smokers; namely, that he had emphysema. It is therefore understandable why the prison officer completing the cell risk assessment subsequently inserted the answer "*No*" to the question, "*Do the comments above or prisoner's Alerts justify the initiating of the 'Not to Share Cell Alert'?*".[49]

91 Consequently, from 8 March 2018 until his transfer to Casuarina on 13 December 2018, Mr Africh was placed in a four-person cell at Acacia in Lima Block, Unit 1 (the cell).[50]

92 Although no mention was made by Mr Africh of his emphysema on 2 March 2018, he did raise it with a prison nurse 12 days later.[51] However, I note this was raised in the context of him not exercising, and not with respect to any issue with his cell placement. Furthermore, it was the nurse's intention to have that claim by Mr Africh independently verified at his next appointment with the prison doctor. In those circumstances, it was understandable why no reconsideration was done at that stage regarding his cell placement.

[46] Exhibit 1, Volume 1, Tab 13B, Multiple Cell Occupancy – Risk Assessment dated 2 March 2018
[47] Exhibit 1, Volume 1, Tab 13B, Multiple Cell Occupancy – Risk Assessment dated 2 March 2018, p. 2
[48] Exhibit 1, Volume 1, Tab 13B, Multiple Cell Occupancy – Risk Assessment dated 2 March 2018, p. 2
[49] Exhibit 1, Volume 1, Tab 13B, Multiple Cell Occupancy – Risk Assessment dated 2 March 2018, p. 2
[50] Exhibit 1, Volume 1, Tab 11, Cell Placement History – Offender
[51] Exhibit 1, Volume 1, Tab 20, EcHO Medical Notes, p. 113

93 The Court was supplied with a redacted screenshot from TOMS showing all the prisoners who were housed with Mr Africh in the cell between 8 March 2018 and 13 December 2018. A review of that information indicated that Mr Africh shared the cell with 25 different prisoners, of whom 23 had a history of purchasing tobacco whilst incarcerated at Acacia; with 12 of those having a history of purchasing tobacco whilst sharing the cell with Mr Africh. Serco accepted that whilst smoking is not permitted in cells at Acacia, there was evidence before the Court that suggested it did occur in the cell occupied by Mr Africh.[52] Based on that evidence, I find that smoking did occur in the cell when it was locked at night-time, contrary to the existing Local Order that forbade smoking in non-designated areas (which included cells).

94 As the following evidence shows, when Mr Africh was presented with other procedural opportunities to raise his concerns with Acacia staff about his cell placement and the effect on his health, he did not do so.

95 On 3 June 2018, he signed a "*Primary Contact Report*" in which he reported, "*No issues at the moment*" in respect of issues or problems he had experienced during his imprisonment.[53]

96 On the same date, Mr Africh also signed a "*Regular Contact Report*" in which it was recorded that: "*At this current time he is housed in the 4 out cell and has no issues to report*".[54]

97 At a "*Classification Review*" on 7 August 2018, Mr Africh was recorded as saying, "*he is doing well in the block and has no issues with his current placement*".[55]

98 On 24 October 2018, a prison nurse recorded in EcHO that Mr Africh had, "*mentioned he had asked to move to Foxtrot Block as he is finding it difficult to mobilise to medical due to his frail state*".[56] The Foxtrot Block is next to Acacia's health care facility and is used to house elderly prisoners and/or those who need closer access to the health care building. The inquest heard that there are current issues at Acacia regarding a waitlist for prisoners that need to be in Foxtrot Block.[57] It is safe to assume that it was most likely a waitlist would have also existed at the time Mr Africh asked to be transferred.

99 At another appointment with a prison nurse on 12 November 2018, Mr Africh was recorded as saying he was, "*in a four out cell with three heavy smokers. This*

[52] Exhibit 1, Volume 1, Tab 15A, Letter from Wotton Kearney dated 11 November 2022, p. 2
[53] Exhibit 1, Volume 1, Tab 12A, Primary Contact Report dated 3 June 2018
[54] Exhibit 1, Volume 1, Tab 12B, Regular Contact Report dated 3 June 2018
[55] Exhibit 1, Volume 2, Tab 5A, Classification Review Report dated 7 August 2018, p. 3
[56] Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 81
[57] ts 1.3.23 (Ms Stewart), p. 36

makes him cough when he is in his cell". Mr Africh also said at this appointment that he was "*still waiting to be reviewed about changing block*" and "*he had heard nothing from the unit manager at this time*".[58]

100 An examination of the redacted screenshot from TOMS detailing the prisoners Mr Africh shared the cell with shows that one of these "*heavy smokers*" had been in the cell since 7 June 2018 and that another had been there since 23 July 2018.[59]

101 In addition to the above, the Court had a photograph of a handwritten letter from a general practitioner at the practice that Mr Africh had attended in the community. This letter was dated 8 May 2018 and was addressed, "*To whom it may concern*". It stated that Mr Africh is a "*current inmate*" and that, "*he is struggling to maintain his non-smoking status in his current cell and we would like him to be moved somewhere away from other smokers please*".[60] There is also a handwritten notation on this letter that read, "*had been faxed 8/5/18*" with a red stamp marked, "*Faxed*". However, there are no imprinted facsimile transmission details appearing on this copy of the letter.

102 The Court was advised that in undertaking its investigations, Serco had reviewed the Access Complaints Register (the register). The register is an Excel spreadsheet composed and managed by Acacia's Prison Assurance and Compliance Team. Serco provided instructions to its solicitors that it had undertaken an extensive review of the register and had not located:[61]

> any complaints from Mr Africh (beyond those noted earlier in this letter)[62] or anyone associated with him regarding being housed with smokers; and
>
> a copy of the unaddressed letter from Dr Hancock dated 8 May 2018 and marked as "faxed".

103 Ms Jelena Testa, a close friend of Mr Africh and his senior next of kin, provided a statement detailing conversations she had with Mr Africh when he was at Acacia. In those conversations he mentioned having breathing difficulties as he was sharing a cell with smokers and that towards the end of his stay at Acacia he could not sleep as the cell was full of smoke. Mr Africh relayed that his three cell mates who smoked tried to help him by smoking in the toilet and moving his bed to the front of an air vent to help him breath.[63]

[58] Exhibit 1, Volume 1, Tab 20, EcHO medical notes, p. 80
[59] Exhibit 1, Volume 1, Tab 15A, Redacted TOMS screenshot attached to letter from Wotton Kearney dated 11 November 2022
[60] Exhibit 1, Volume 1, Tab 8C, Letter from Dr Natasha Hancock dated 8 May 2018
[61] Exhibit 1, Volume 1, Tab 15A, Letter from Wotton Kearney dated 11 November 2022, p. 3
[62] These complaints have already been referred to in this section of the finding
[63] Exhibit 1, Volume 1, Tab 8A, Statement of Jelena Testa dated 7 April 2021, pp. 4-5

104 Unsurprisingly, Dr Kong expressed concern regarding the involuntary second-hand smoke exposure that Mr Africh complained of experiencing. Dr Kong stated:[64]

> In someone with emphysema, exposure to second-hand smoke is associated with development of respiratory symptoms, reduced quality of life, risk of severe exacerbations and development of respiratory infections.
>
> Due to underlying severe health comorbidities of liver cirrhosis, chronic myelomonocytic leukemia and emphysema, development of respiratory tract infection can be a life-threatening condition for Mr Africh.

105 At the inquest, Ms Stewart outlined the practical difficulties in finding suitable placements for prisoners who do not want to be housed with smokers. As she explained:[65]

> There's always issues regarding the number of smokers, number of single cells available, and trying to meet the needs of all the prisoners within the prison.
>
> If somebody does have emphysema, for argument's sake, is every effort made to keep them away from smokers, or to have a single cell? --- That would be the best outcome, but we do have only a small number of single cells across the site. So it's quite difficult to manage the needs of all prisoners on the site, but I think every effort is made to place them in the correct environment.

106 It has also been identified that as of 14 October 2022, 75% of Acacia's prison population were smokers.[66] It is open to assume that a similar high percentage of smokers would have existed at the time Mr Africh was at Acacia. As Ms Stewart stated at the inquest, generally prisoners like to smoke and, "*use it as a coping mechanism to help them deal with stress and anxiety*".[67]

107 Nevertheless, on the face of it, if it was said that a prisoner with pre-existing emphysema had been placed in a cell with other prisoners who regularly smoked when the cell was locked at night-time, one would expect the obvious question to be asked: "*How could that possibly happen?*".

108 Bare facts, with no additional details, do not give the full story. As I have sought to detail above, those responsible for the cell placement of Mr Africh at Acacia did not have the relevant information concerning his emphysema or, for that matter, his interstitial lung disease. It was only towards the end of Mr Africh's stay at Acacia that confirmation he had severe emphysema became apparent.[68] Apart from the one occasion on 14 March 2018 when he disclosed his emphysema to a

[64] Exhibit 1, Volume 1, Tab 16, Report of Dr Jee Kong dated 29 May 2022, p. 5
[65] ts 1.3.23 (Ms Stewart), pp. 35-36
[66] Exhibit 1, Volume 1, Tab 15A, Letter from Wotton Kearney dated 11 November 2022, p. 2
[67] ts 1.3.23 (Ms Stewart), pp. 38-39
[68] A CT chest scan at SJOGMH during Mr Africh's admission from 7-11 December 2018 showed severe emphysematous changes

prison nurse, there is no notation on any Acacia documentation that the Court has which states that Mr Africh had disclosed he had emphysema. Even his request to be moved to the Foxtrot block was recorded as being due to his frailty, and not his emphysema.[69]

109 Even if the handwritten note from his community doctor was received at Acacia in May 2018, it is unlikely to have caused another placement for Mr Africh in a different cell, as it did not state he had emphysema.

110 By 12 November 2018, Mr Africh was still placed in a four-person cell that contained three heavy smokers who smoked when the cell was locked. This was at the time when Mr Africh's emphysema would have been severe. Ms Stewart properly conceded in her evidence at the inquest that this did not reflect well on Acacia.[70]

111 Nevertheless, as I have outlined above, there was a combination of factors that meant Mr Africh was kept in the same cell at Acacia from 8 March 2018, despite the deleterious effect this had on his health. These factors included (i) the practical difficulties of housing non-smoking prisoners away from the high percentage of prisoners who smoke, (ii) Mr Africh's reticence to disclose his emphysema and (iii) the oversight by his health service providers at Acacia to independently verify his emphysema once he had disclosed it.

112 Accordingly, although I find that it was not appropriate for Mr Africh to be placed in a cell where he was exposed to cigarette smoke, I am satisfied there were reasonable explanations as to why he continued to remain in the cell for a further nine months. To find otherwise would be to insert impermissible hindsight bias.

Failure to implement a treatment plan for Mr Africh's emphysema at Casuarina

113 As noted above, Mr Africh was diagnosed with severe emphysema during his admission at SJOGMH in December 2018. Nevertheless, upon his admission to the infirmary at Casuarina, Mr Africh was not placed on any specific emphysema treatment. As Dr Cherelle Fitzclarence, a Senior Medical Officer with the West Australian Country Health Service, noted in her report that was prepared for the inquest:[71]

> While prison doctors and all general practitioners tend to take the advice of specialists and there was none forthcoming in this instance,[72] it would have behoved the team[73] to ask the question as to the value of specific emphysema treatment such as puffers and

[69] ts 1.3.23 (Ms Stewart), p. 37
[70] ts 1.3.23 (Ms Stewart), p. 40
[71] Exhibit 1, Volume 1, Tab 22, Report by Dr Cherelle Fitzclarence dated 20 September 2022, p. 5
[72] The SJOGMH discharge summary did not specify any ongoing treatment for Mr Africh's emphysema
[73] The health service providers at Casuarina

physiotherapy, which while noting that there is no cure, it may have assisted with symptom management.

114 In her evidence at the inquest, Dr Gunson agreed with that observation by Dr Fitzclarence. Dr Gunson also noted that there was a failure to add "*severe emphysema*" to Mr Africh's "*Problem List*" in EcHO.[74] Dr Gunson made the observation that with respect to treatment for Mr Africh's emphysema at the Casuarina infirmary, "*a little independence of thought might have been useful*".[75] Dr Gunson also noted that although Mr Africh was having oxygen therapy, it did not appear that he was trialled on any kind of bronchodilator medication or short acting reliever medication to see if his shortness of breath or sense of wellbeing would improve.[76] Dr Gunson added, "*it was not going to reverse his disease, but it might've made his day-to-day quality of life much improved*".

115 Although the treatment of Mr Africh's other extensive comorbidities at the Casuarina infirmary was of a high standard, there was a missed opportunity to extend the same level of treatment to his severe emphysema.

The use of restraints on Mr Africh at FSH

116 The guarding of Mr Africh during his transfer by ambulance and then admission to FSH on 15 February 2019 was the responsibility of prison officers from Casuarina. From 16 February 2019, the guarding of him at FSH was handed over to Broadspectrum (BRS).[77] The relevant contract held by BRS in Western Australia at the time of Mr Africh's death was, "*to provide 24-hour centralised oversight of all movements of persons in custody for outer metropolitan courts, or major regional courts, and custodial transport throughout Western Australia*".[78]

117 The Department's "*Offender Movement Information*" dated 15 February 2019 for Mr Africh stated that he was: "*To be transport* [sic] *by wheelchair vehicle*" and that he was "*very frail and requires oxygen*".[79]

118 Notwithstanding Mr Africh's frailty and extremely poor health, he was subjected to the standard restraint regime for the escorting of prisoners. This meant that he was to have a two-point restraint, requiring handcuffs and leg irons.[80]

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[74] ts 1.3.23 (Dr Gunson), p. 59
[75] ts 1.3.23 (Dr Gunson), p. 62
[76] ts 1.3.23 (Dr Gunson), p. 60
[77] Exhibit 1, Volume 2, Tab 1.8, Death in Custody Package
[78] https://www.ventia.com/page/west-australia, p. 1
[79] Exhibit 1, Volume 2, Tab 1.8A, Offender Movement Information, p.1
[80] Exhibit 1, Volume 2, Tab 1.8A, Offender Movement Information, p.1. This form specified that if handcuffs are to be used, they "*may only be removed at the destination point when the prisoner:*

- *is secured in a secure vehicle or*
- *has been admitted to hospital and is restrained to a bed or using ablutions in accordance with procedure, or*
- *requires a procedure at the non-secure destination that prohibits the application of handcuffs to an officer."*

119 At 9.10 am on 17 February 2019 (the day before Mr Africh's death), a haematology registrar at FSH made the following written request to the Department: "*Please remove the patient's restraints given already severe discomfort, limited mobility due to progressive critical/pre-terminal illness and hypoxia*".[81]

120 At 10.07 am on 17 February 2019, approval was only given to have the two-point restraint reduced to a one-point restraint and to alternate the use of both legs for that restraint. It was also noted, "*perhaps (nil) to follow later*".[82] That afternoon, Mr Africh was elevated to Stage 3 on the Department's terminally ill register.

121 When asked at the inquest why only one restraint was removed notwithstanding the medical advice from FSH that no restraints were required, Ms Toni Palmer (the Department's Senior Review Officer) said that she did not know.[83]

122 At 9.00 am on 18 February 2019 (the day Mr Africh died), a haematology registrar at FSH wrote again to the Department advising: "*Mr Africh is now in the terminal phase of his illness and is receiving palliative care at Fiona Stanley Hospital. For his comfort, we request the chains to come off his legs*".[84] At 10.25 am, approval was given for the leg restraint to be removed.[85] Mr Africh died approximately 10 hours later.

123 Ms Testa visited Mr Africh on the morning of 18 February 2019. She recounted:[86]

> He told me he was placed in palliative care and that he was scared of dying.
>
> …
>
> And he asked me to look at his swollen ankles and feet, there was blood where the restraints were on his ankles and had hurt him.
>
> The guard told me that he had to get the doctor to make a request to Casuarina Prison to have them removed as they were hurting him, they only got removed on Monday morning.[87]
>
> Even on his death bed, Eddie was shown cruelty and lost all his dignity.
>
> He was chained to the hospital bed by his ankles that were bleeding when he was on a breathing machine and being treated as palliative by the amazing nurses and doctors at Fiona Stanley.
>
> The way we were treated in the room on the day was unbelievable and heartbreaking, the doctor even pleaded with the guards to drop all the unnecessary restrictions on Monday.

[81] Exhibit 1, Volume 2, Tab 1.8K, Facsimile transmissions from FHS re visitors and removal of restraints
[82] Exhibit 1, Volume 2, Tab 1.8C, Restraints Risk Assessment, p. 2
[83] ts 1.3.23 (Ms Palmer), p. 76
[84] Exhibit 1, Volume 2, Tab 1.8K, Facsimile transmissions from FHS re visitors and removal of restraints
[85] Exhibit 1, Volume 2, Tab 1.8D, PIC Record of Events 154291
[86] Exhibit 1, Volume 1, Tab 8, Statement of Jelena Testa dated 7 April 2021, pp. 13-14
[87] 18 February 2019

124 After reading the above passages to Ms Palmer at the inquest, I expressed my concern that an older, very frail prisoner who had been well-behaved during his imprisonment and who had a minimum-security status, had to be restrained in any manner when he was at Stage 3 on the Department's terminally ill list and receiving palliative care in a hospital. In those circumstances, I expressed a preliminary view that the decision to only remove one restraint when a treating doctor requested the removal of all restraints was inappropriate.[88]

125 After the inquest, I sought a written submission from the Department as to whether the Department's policies and procedures that applied to the restraining of a prisoner as of February 2019 were complied with regarding Mr Africh. I was concerned that there may have been non-compliance when he was subject to the standard two-point restraint regime when he was taken to FSH, which was then maintained after he was admitted. My concerns also extended to Mr Africh remaining on a one-point restraint on the same day he was placed at Stage 3 of the terminally ill register, and after a doctor at FSH had asked for all restraints to be removed.

126 On 31 March 2023, I received a submission from the Department's counsel, Ms Italiano, from the State Solicitor's Office (the Department's submissions). The Department's submissions also had various policies and procedures attached.

127 One of the relevant policies was "*Policy Directive 82 - Appendix 1: Prison Movements - Procedures*" (Prisoner Movements Procedures). As the Department's submissions correctly noted with the use of restraints for prisoner movements: "*the default position was that prisoners were to be restrained using approved instruments of restraint at all times. This was subject to the policy as is related to prisoners who are escorted from secure facilities*".[89]

128 Prisoners held in secure facilities, which included Mr Africh, were to be restrained when outside of the prison unless a medical condition dictated otherwise, or unless the prisoner had a minimum-security status. In each instance, approval that there be no restraints applied may be granted following the completion of an External Movement Risk Assessment form (the risk assessment).[90]

129 The Prisoner Movements Procedures states that: "*Risk assessments must be approved by the designated superintendent. This may be delegated to the security manager, or, in the absence of both, the superintendent*".[91]

130 Ordinarily, the risk assessment is to be completed and approved prior to the commencement of the prisoner's escort from the secure facility.[92] However, where

[88] ts 1.3.23 (Ms Palmer), pp.78-79
[89] The Department's submissions, at [5]
[90] Prisoner Movements Procedures, clause 30.4.1
[91] Prisoner Movements Procedures, clause 30.4.3

a medical emergency exists and a Priority 1 ambulance is called to convey the prisoner to hospital, the risk assessment, "*is to be completed as soon as practicable*".[93] This scenario existed when Mr Africh was taken by ambulance to FSH on 15 February 2019.

131 The Department's submissions stated there was no record of a risk assessment having been completed.[94] In light of that admission, I am satisfied no risk assessment was completed for Mr Africh after he was taken by ambulance to FSH. As Mr Africh was triaged at FSH at 12.01 am on 15 February 2019,[95] I am of the view that the risk assessment should have been completed that afternoon in order to comply with the requirement that it "*be completed as soon as practicable*". For the following reasons, I find that the failure to complete a risk assessment was a grave oversight.

132 In circumstances where a prisoner's medical condition does not necessitate the use of restraints, the risk assessment is to include the requirement that, "*medical staff are to confirm that the prisoner's medical condition precludes the use of restraints*".[96] As the risk assessment is ordinarily completed prior to the commencement of an escort, the reference to "*medical staff*" must relate to the prison's medical staff.

133 There were very sound reasons why Mr Africh was urgently transferred to FSH on 15 February 2019. His oxygen saturation levels and blood pressure were very low. Due to Mr Africh's breathing difficulties when attempting to walk, a wheelchair was being used. He also needed to have an oxygen supplement. Given his extremely poor health and existing comorbidities, the prison doctor had a very understandable concern that Mr Africh may be experiencing heart failure. In those circumstances, I find that any prospect of Mr Africh breaching security if he was to be unrestrained out of the prison setting was negligible.

134 I have no doubt that had his health service providers at Casuarina been consulted as part of a risk assessment (as required by clause 30.4.1 of the Prisoner Movements Procedures), they would have recommended that Mr Africh's medical condition "*precludes the use of restraints*". And given his frailty and lack of mobility, it would defy common sense to ignore that recommendation and not approve the risk assessment.

135 Had a risk assessment been done, another factor confirming the correct decision to approve the non-use of restraints was Mr Africh's status as a minimum-security prisoner. He would have qualified for a placement at a minimum security facility

[92] Prisoner Movements Procedures, clause 30.4.3
[93] Prisoner Movements Procedures, clause 30.4.3
[94] The Department's submissions, at [8]
[95] Exhibit 1, Volume 1, Tab 17, FSH Emergency Registration Record, p. 1
[96] Prisoner Movements Procedures, clause 30.4.1

had he not required treatment for his medical conditions.[97] Clause 30.4.2 of the Prisoner Movements Procedures states: "*Prisoners held in minimum security facilities may be escorted unrestrained outside a prison subject to completion of a risk assessment*".[98]

136 Even if a risk assessment is not completed, it was still an option for Mr Africh to be escorted without restraints if, "*the prisoner's general medical condition renders handcuffing/leg restraints inappropriate (e.g. incapacity to walk, seriously ill etc)*". If these circumstances exist, the escorting officers can seek advice on the use of restraints from the relevant superintendent.[99]

137 The Department's submissions noted:[100]

> There is no record that advice was sought from the superintendent on the use of restraints prior to Mr Africh's emergency transfer to FSH on the basis that his general medical condition rendered the use of restraints inappropriate. However, the Department submits that this aspect of the policy relied on individual officer's assessment of a prisoner's general medical condition.

138 It should have been obvious to Mr Africh's escorting prison officers that he was very gravely ill. I find that a simple glance of him would have confirmed the details on the "*Offender Movement Information*" form that he was "*very frail*".[101] However, and not without some hesitation, I am prepared to accept the following passage from the Department's submissions on this point:[102]

> The Department acknowledges that there could have been a failure to comply with the Prisoner Movements Procedures by failing to seek the superintendent's advice on the use of restraints based on Mr Africh's general medical condition. However, the Department submits that this possibility should be viewed with caution, given that the individual officers involved have not given evidence in this matter. Therefore, there are inherent difficulties with drawing conclusions as to why this advice was not sought. The Department also noted that even had advice been sought, it remained the superintendent's decision whether to use restraints or not.

139 Clause 30.4.4 of the Prisoner Movements Procedures also provides that escorting prison officers could remove restraints if, in their opinion, "*a prisoner was so seriously ill it was apparent that security will not be breached*".[103] If this occurs, the superintendent need only be notified immediately.

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[97] Exhibit 1, Volume 2, Tab 1, Death in Custody Report dated 28 October 2019, p. 6
[98] Prisoner Movements Procedures, p. 70
[99] Prisoner Movements Procedures, clause 30.4.4
[100] The Department's submissions, at [15]
[101] Exhibit 1, Volume 2, Tab 1.8A, Offender Movement Information, p. 1
[102] The Department's submissions, at [17]
[103] Prisoner Movements Procedures, clause 30.4.4

140 However, the Department's submissions noted, "*this was a discretionary provision, dependent upon the perception of individual escorting officers*".[104] In addition, I note that there is no record of a Casuarina health service provider specifically advising against the use of restraints on Mr Africh prior to his emergency transfer to FSH.[105]

141 I also accept the submission from the Department that prison officers ought not be criticised for processing prisoners out of a prison as quickly as possible in the event of a medical emergency.[106]

142 Accordingly, and being mindful not to insert hindsight bias in my decision making, I am prepared to find that the restraining of Mr Africh before he was allocated a bed at FSH on 15 February 2019 was not inappropriate.

143 However, I find that the continued use of restraints on Mr Africh after he had been placed in a bed at FSH was inappropriate. The Department's failure to complete the risk assessment that its policies mandated meant that Mr Africh was not granted the opportunity to have the use of restraints reassessed. Hence the status quo remained until the first request from the haematology registrar at FSH two days later.

144 As I have already outlined above, had that risk assessment been undertaken, I have no doubt that Mr Africh's health service providers at Casuarina would have recommended the removal of all restraints as his extremely poor health would have excluded any meaningful prospects of a security breach or escape attempt. Unfortunately, the unjustified use of restraints was only magnified following the response to the written request from the haematology registrar for their complete removal on 17 February 2019.

145 The Prisoner Movements Procedures provides that:[107]

> Instruments of restraint may be removed at the request of a medical officer while the patient is undergoing consultation, examination or treatment subject to the directions of the prison superintendent and any delegations to the senior escorting officer who may do so after assessing that their removal will not jeopardise the security of the escort. If this occurs, the superintendent is to be advised immediately.

146 For reasons not explained by the Department,[108] the two-point restraint was only reduced to a one-point restraint with a leg shackle to one of Mr Africh's legs to be

[104] The Department's submissions, at [16]
[105] The Department's submissions, at [13]
[106] The Department's submissions, at [20]
[107] Prisoner Movements Procedures, clause 30.4.4
[108] The Department's submissions at [14] simply states: "*The Department observes that medical officers at FSH did advise against the use of restraints after Mr Africh had been admitted to hospital, and that advice was considered and ultimately followed.*"

maintained. This would have involved attaching the chain link of the leg shackle to a secure section of Mr Africh's bed. [109]

147 I find that there were compelling reasons for the removal of all restraints from Mr Africh as requested by the haematology registrar on 17 February 2019. Those compelling reasons would have been abundantly clear to the person who had to approve that request. The haematology registrar clearly spelt them out: "*given already severe discomfort, limited mobility due to progressive critical/pre-terminal illness and hypoxia*".[110] If further evidence was required regarding the precarious state of Mr Africh's health, he was elevated to Stage 3 on the Department's terminally ill register several hours later.

148 Applying the ***Briginshaw*** principle and being mindful not to insert hindsight bias, I find that (i) it was inappropriate for Mr Africh to remain restrained after he was allocated a bed at FSH on 15 February 2019 and (ii) it was not only inappropriate but completely unnecessary and inhumane to have Mr Africh shackled to his bed by his leg after the first request from the FSH haematology registrar to have all the restraints removed.

149 It should therefore come as no surprise that I have no hesitation in accepting Ms Testa's observation that: "*Even on his death bed, Eddie was shown cruelty and lost all his dignity*".[111]

The Royal Prerogative of Mercy

150 At the time of Mr Africh's death, prisoners with a terminal illness were managed in accordance with the Department's "*Policy Directive 8: Prisoners with a Terminal Medical Condition*" (PD 8).

151 From late 2014, a prisoner's expected prognosis was designated by identifying them, with increasing levels of seriousness, as Stages 1, 2, 3 or 4. As already noted above, Mr Africh was placed at Stage 3 on 17 February 2019.

152 An outcome of a classification at Stage 3 or Stage 4 is that the prisoner can be considered for release on compassionate grounds by the Governor before the expiration of the term of their imprisonment (i.e. the grant of a pardon in the exercise of the Royal Prerogative of Mercy).

153 PD 8 required that certain tasks must be undertaken once a prisoner is classified at Stage 3. One of those tasks is that the Department's Manager, Sentence

[109] Department's Escort Procedures dated 20 March 2018, p. 25
[110] Prisoner Movements Procedures, p. 71
[111] Exhibit 1, Volume 1, Tab 8, Statement of Jelena Testa dated 7 April 2021, p. 14

Management (or their delegate) will, within seven working days of the notification of the classification:[112]

> Prepare a briefing note for the Minister of Corrective Services which notifies the Minister of the prisoner's medical situation and life expectancy, the likelihood of the prisoner dying in custody and any other relevant information.

154 This briefing note commences the process for the exercise of the Royal Prerogative of Mercy. A similar briefing note is to be prepared when a prisoner is classified at Stage 4.

155 The position of Manager, Sentence Management was not filled at the Department from January 2018 to June 2020. Nor was the task regarding the preparation of briefing notes delegated to another employee at the Department during this period. The Department has already conceded in previous inquests that this was a serious failure in judgement.

156 However, even if this position was filled at the time of Mr Africh's death, it is almost inevitable that he would not have been granted a pardon in the exercise of the Royal Prerogative of Mercy. There are two reasons for this: the first is the short timeframe from when Mr Africh was classified at Stage 3 to his death the next day. This meant it was very unlikely a briefing note would have been prepared and forwarded in time for the Minister for Corrective Services to consider before Mr Africh died. Secondly, it is extremely rare for a Minister of Corrective Services to grant such a pardon.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MR AFRICH

157 Having carefully considered the documents tendered into evidence, and the oral evidence of the witnesses at the inquest, I am satisfied that, with the exceptions I have identified in this finding, Mr Africh's various chronic and progressive medical conditions were appropriately managed by his prison health service providers. The exceptions related to the treatment and care he was provided with respect to his emphysema. However, I must emphasise that even if those exceptions had not occurred, the outcome for Mr Africh would have still been the same. It simply would have meant that he may have experienced less discomfort in his final months.

158 I therefore agree with the concluding comments from Dr Fitzclarence in her report:[113]

> It would appear to me from careful review of his notes that other than in the two instances mentioned above,[114] the health care of Mr Africh who was unwell on admission

[112] Policy Directive 8: Prisoners with a Terminal Medical Condition, p. 2
[113] Exhibit 1, Volume 1, Tab 22, Report of Dr Cherelle Fitzclarence dated 20 September 2022

> to prison and became more unwell, was compassionate and commensurate or better than community standard care.

159 Accordingly, I am generally satisfied that the standard of supervision, treatment and care Mr Africh received from prison health service providers whilst he was in custody was appropriate.

160 However, I am not satisfied that the manner in which Mr Africh was restrained at FSH from 15 February 2019 until the morning of 19 February 2019 was necessary or appropriate. It is my view Mr Africh fell within both exceptions specified in clause 30.4.1 of the Prisoner Movement Procedures regarding the use of restraints. Mr Africh was in obvious frail health, lacked mobility, required an oxygen supplement and had a minimum-security status. Had a risk assessment been completed which involved input from Casuarina medical staff after he was transferred to FSH, I am satisfied it would have recommended the removal of all his restraints. In those circumstances it would have been inexplicable for an approval to remove the restraints not to be given.

IMPROVEMENTS SINCE MR AFRICH'S DEATH

161 As would be expected of all government departments, the Department should always be on a pathway of continual improvement. The evidence at the inquest has satisfied me that a number of improvements have been made regarding matters arising from Mr Africh's death.

The proposed redesign of the Department's requests for medical information

162 As outlined above, there were deficiencies in the health summary sheet provided by Mr Africh's general practitioner.

163 In her evidence at the inquest, Dr Gunson said the Department's Health Services are currently redesigning the request for release of medical information that is sent to general practitioners. Dr Gunson was of the view that the request should specifically ask for information regarding recent investigations, specialist letters, ECGs and imaging results.[115]

164 In light of Dr Gunson's evidence, I am satisfied that I need not make a recommendation with respect to the redesign of the request for release of medical information from a prisoner's general practitioner. I would simply encourage the Department to make the necessary changes and introduce them as quickly as possible.

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[114] These two instances concerned Mr Africh's placement in a cell where other prisoners smoked when they were confined to the cell and the lack of specific treatment for his emphysema at Casuarina.
[115] ts 1.3.23 (Dr Gunson), p. 62

Changes to address the failure by prison health service providers to review the health summary sheet

165 As previously noted, the health summary sheet and its attachments provided by Mr Africh's general practitioner were not reviewed by prison doctors at Hakea or Acacia. Ms Stewart outlined that changes have been made since 2019. She said:[116]

> We're now 2023. So we are doing more. We've got an extra doctor onsite; we are aware of doing more file reviews. I know Dr Joy Rowland increased the file review time for our doctors, so making sure that we are able to review the patient's notes before we see him, so things have improved. And that's because of going through the coronial investigations and looking at our practice and also having the aging population as well highlights more risk.

166 In another development in this area, Dr Joy Rowland, the Department's Director of Medical Services, is currently looking at ways in which health summaries can be scanned directly into EcHO. This will ensure they are brought to the attention of the relevant prison doctor in a timely manner.[117]

Changes to questions asked at a prisoner's first medical assessment

167 The present template for questions to be asked by a prison doctor reviewing a prisoner for the first time includes specific references to lung disease and exercise tolerance.[118] In light of those changes that have been made since Mr Africh's death, a prisoner who does not self-report their emphysema or lung disease are likely to be prompted to disclose those health conditions in response to direct questions.[119] Although this template exists for prisons operated by the Department, Ms Stewart gave evidence that Acacia adopts the same or a similar template for prisoners who are transferred to that prison.[120]

The banning of smoking in prisons

168 It was very clear from the evidence before me that at the time of Mr Africh's death, prisons throughout the state encountered significant difficulties in enforcing the prohibition of smoking in non-prescribed areas of a prison. This led to the extremely unsatisfactory position that Mr Africh found himself in: sharing a cell with other prisoners who smoked after the cells had been locked down for the night. Unsurprisingly, Ms Anika Smith, the Director of Women's Operations at the Department, conceded that it was impossible to regulate prisoners who smoked in their cells at night.[121]

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[116] ts 1.3.23 (Ms Stewart), pp. 40-41
[117] ts 1.3.23 (Dr Gunson), p. 58
[118] Exhibit 1, Volume 1, Tab 22, Report by Dr Cherelle Fitzclarence dated 20 September 2022, p. 3
[119] ts 1.3.23 (Ms Stewart), p. 29
[120] ts 1.3.23 (Ms Stewart), p. 28
[121] ts 1.3.23 (Ms Smith), p. 71

169 I endorse the decision made by the Minister for Corrective Services in 2021 to commence a project for transitioning all prisons in the state to become smoke-free. Bandyup Women's Prison was chosen as the pilot site and that commenced in October 2022.[122] It is the intention of the Department to have all prisons smoke-free by December 2024.[123]

170 I fully support the decision that has been made since Mr Africh's death to eventually make all prisons smoke-free. I also commend the Department for the implementation of programs and projects that have been designed to assist prisoners who smoke transition towards the introduction of this significant measure.

The use of restraints for terminally ill prisoners who are receiving palliative care in hospital

171 Since Mr Africh's death, the Department's policies and procedures regarding the use of restraints for prisoners being admitted to hospital have been updated, including for those prisoners who are admitted for palliative care. Those changes may reduce the likelihood of a prisoner being restrained in the inappropriate manner that Mr Africh was following his admission to FSH.

172 The application of these updated policies and procedures was considered in an inquest before me on 31 January 2023. This inquest related to the death of an elderly prisoner in June 2021 who was in hospital receiving palliative care.[124] At the time of handing down this finding into the death of Mr Africh, I was still waiting for written submissions from the Department regarding matters that arose in that inquest. Any recommendations that I am to consider regarding the Department's current policies and procedures will take into account those submissions from the Department and will be included in my finding with respect to that inquest.

CONCLUSION

173 Mr Africh had been diagnosed with atrial fibrillation, alcohol-related liver disease, interstitial lung disease and emphysema prior to his incarceration on 15 February 2018. While in custody, he was further diagnosed with chronic myelomonocytic leukaemia and right side heart failure with severe tricuspid regurgitation and moderate pulmonary stenosis. Severe emphysematous changes were also identified on imaging during Mr Africh's incarceration.

174 In combination, Mr Africh's various medical conditions were very complex, and would have been challenging to manage even outside of a prison setting.

[122] ts 1.3.23 (Ms Smith), p. 65
[123] ts 1.3.23 (Ms Smith), p. 66
[124] *Inquest into the death of* ***Errol Warren Bartlett-Torr*** CORC 1551 of 2021

175 Accordingly, I am satisfied that the medical care provided to Mr Africh was generally appropriate. Those areas that I have identified where there were some shortcomings have been addressed by the Department in the improvements it has made since Mr Africh's death over four years ago.

176 Nevertheless, it is becoming very evident to me that in a state where only one prison has an infirmary, it is becoming more difficult to manage the increasing number of frail and/or elderly prisoners who have complex medical conditions.

177 As I have outlined in some detail in this finding, I was not satisfied with the manner in which Mr Africh was restrained after he was admitted to FSH on 15 February 2019. Even putting to one side the grave oversight by the Department not to undertake a risk assessment for Mr Africh, at the very latest all restraints should have been removed on 17 February 2019 once the first request was made for their removal by the FSH haematology registrar. The Department's unwarranted actions in keeping Mr Africh in a leg shackle chained to his bed (which included the day he died) before the second request was made, understandably caused significant distress to his loved ones who were visiting him for the final time. It would have also been a very traumatic and humiliating experience for Mr Africh.

178 The Department's current policies and procedures for the transport of persons in custody proudly proclaim that such transports are to be, "*conducted in a safe and humane manner, taking into account the dignity of the person being transported*".[125] Although that principle was not expressly stated in its policies and procedures that applied in February 2019, the Department's practises at that time should have embodied that ideal. What I have found, however, is that the restraints applied to Mr Africh in the lead up to his death fell well short of this principle.

179 I extend my condolences to the loved ones of Mr Africh.

PJ Urquhart
Coroner
17 April 2023

[125] Commissioner's Operating Policy and Procedure (COPP) 12.3 – Conducting Escorts, p. 1