Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 57/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***David Anthony RICE*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***14 October 2019*** *find that the identity of the deceased person was* ***David Anthony RICE*** *and that death occurred on* ***19 August 2015*** *at* ***Fiona Stanley Hospital****, from* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner.

Ms N Eagling (State Solicitor's Office) appeared on behalf of the Department of Justice (the Department).

Ms T Hollaway (WorkSafe) appeared on behalf of WorkSafe and Ms Kerr.

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INTRODUCTION

1. David Anthony Rice (the deceased) died on 19 August 2015 at Fiona Stanley Hospital (FSH) from multiple injuries. He was 49 years of age.

2. At the time of his death, the deceased was being held on remand at Hakea Prison (Hakea) and was in the custody of the Chief Executive Officer of the Department of Corrective Services, as the Department was then called.[1]

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

4. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

5. I held an inquest into the deceased's death at Perth on 14 October 2019. The documentary evidence adduced at the inquest included independent reports concerning the deceased's death prepared by the Western Australia Police[5] and the Department.[6] Together, the brief of evidence comprised three volumes.

6. The following witnesses gave oral evidence at the inquest:

i. Senior Constable A Van Andel (investigating officer);
ii. Inspector S Kerr (WorkSafe WA);
iii. Mr J Steel (vocational services officer);
iv. Mr P Vose (custodial officer); and
v. Mr R Mudford (senior performance analyst).

7. The inquest focused on the care provided to the deceased while he was in custody and the circumstances of his death.

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[1] Section 16, *Prisons Act 1981 (WA)*
[2] Section 3, *Coroners Act 1996 (WA)*
[3] Section 22(1)(a), *Coroners Act 1996 (WA)*
[4] Section 25(3) *Coroners Act 1996 (WA)*
[5] Exhibit 1, Vol 1, Tab 2, Police investigation report
[6] Exhibit 1, Vol 2, Death in custody review

THE DECEASED

Background

8. The deceased was born in Sydney on 24 February 1966.[7] He had three brothers and a sister and when he was about 17-years of age, he moved to Queensland. He subsequently lived in the Northern Territory, before coming to Western Australia in 2003.[8]

9. The deceased was married and he and his wife had five children together. The deceased also had two children from a previous relationship. The deceased was described as someone who got into "*mischief*" because he was easily led, but who had "*a very loving nature*" with "*a beautiful heart*" for the people he cared about, especially his mother.[9,10]

Offending History

10. As a juvenile in New South Wales, the deceased was convicted of a number of dishonesty, public order, traffic and assault offences. His offending behaviour continued as an adult, with further convictions for traffic and drink driving offences.[11]

11. After he moved to Queensland, the deceased was convicted of various public order and assault offences and in April 1992, he was convicted of robbery and sentenced to a term of 5 years imprisonment. After his release from prison, the deceased moved to the Northern Territory, where in 2002, he was imprisoned for two years following a conviction for grievous bodily harm.[12]

12. After the deceased moved to Western Australia he accrued 27 convictions for traffic, dishonesty and drug offences. He served custodial terms in 2009, 2010 and 2014.[13]

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[7] Exhibit 1, Vol 1, Tab 1, P100 - Report of death
[8] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2
[9] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2
[10] Exhibit 1, Vol 1, Tab 24, File note of discussion with Ms J Musty, the deceased's sister (20.05.17)
[11] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p3
[12] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p3
[13] Exhibit 1, Vol 1, Tab 21, Deceased's criminal record

13. The deceased appeared in the Joondalup Magistrates Court on 12 March 2015 in relation to one count of breach of bail; one count of possessing a prohibited drug (amphetamine) and one count of attempting to manufacture a prohibited drug (amphetamine). He was remanded in custody and was due to appear in court on 28 August 2015.[14]

Overview of Medical Conditions

14. The deceased had a history of neck and back pain dating back to at least 2010. An MRI scan showed multi-level cervical spondylosis (age-related wear and tear of the neck vertebrae) and spinal canal stenosis (abnormal narrowing of the spinal canal causing pain). The deceased was prescribed medication for pain relief.[15]

15. During his At Risk Management Assessment (ARMS) on admission to Hakea, the deceased was asked a series of questions aimed at assessing his risk of self-harm or suicide. The deceased denied any thoughts of self-harm or suicide and said he had never attempted either. He also said that he had never seen a counsellor or mental health professional in prison or in the community.[16]

16. The reception officer's summary was:

> Prisoner was calm and cooperative. Did not present any issues. Prisoner states no thoughts of self-harm/suicide. Prisoner hopeful of bail on Monday.[17]

17. The deceased was subsequently deemed fit for an upper bunk, for work and for sport.[18]

18. Hakea is a maximum security adult male prison, and is the largest custodial facility in Western Australia. It houses a large number of remand prisoners and is the State's usual receival point for new prisoners.[19,20]

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[14] Exhibit 1, Vol 2, Death in Custody Review, p3
[15] Exhibit 1, Vol 2, Death in Custody Review, p8
[16] Exhibit 1, Vol 2, Tab 3, ARMS reception intake assessment, questions 6.3.1-6.4.2 & question 6.5.2
[17] Exhibit 1, Vol 2, Tab 3, ARMS reception intake assessment, question 8.1
[18] Exhibit 1, Vol 2, Death in Custody Review, p8
[19] Exhibit 1, Vol 1, Tab 39, Statement - Supt S Blenkinsopp, paras 5-9
[20] ts 14.10.9 (Mudford), p58

THE EVENTS OF 19 AUGUST 2015

Work party tasks

19. On 19 August 2015, the deceased was a member of a work party tasked to clean units 11 and 12 at Hakea. Unwanted items from these units were to be loaded into a large truck (the Truck) and taken to a storage area in the Industries Service Yard (the Yard), where there was a loading area (the Dock).[21,22] The Truck, which is depicted in Photo 1, is a Fuso 8-tonne, fixed axle vehicle with an 8-speed syncromesh gearbox and side curtains.

Photo 1: The Truck[23]

20. The day before the deceased's death (18 August 2015), Vocational Services Officer (VSO) Grocott was told that he would be driving the Truck the following day. VSO Grocott asked his supervisor if there was anyone else more experienced who could drive the Truck instead and was told: "*No*" and that he would have to drive it.[24]

[21] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 21-23
[22] ts 14.10.19 (Grocott), p28
[23] Exhibit 1, Vol 1, Tab 22, Police Photographs, photo 12
[24] ts 14.10.19 (Grocott), pp30-31

21. VSO's supervise prisoners in a range of work environments in prisons, including gardens and kitchens. VSO's differ from prison officers in that they are not responsible for the day to day management of prisoners. Instead, VSO's are employed to teach work skills to prisoners and to supervise small work parties.[25,26]

22. VSO Grocott asked a colleague, Officer Scary whether there was anything he needed to know about the Truck, such as touchy brakes, and was told: "*It has an engine and eight wheels*". This light-hearted remark was to be the only familiarisation or briefing that VSO Grocott received about the Truck's operation.[27,28]

23. At the inquest, VSO Grocott said he would have been greatly assisted if someone with experience in driving the Truck had sat with him, or in fact had driven the Truck, while he observed.[29] Although he had a heavy rigid (HR) driver's licence and was, therefore authorised to drive the Truck, he had limited experience.[30,31]

24. On 19 August 2015, VSO Grocott got into the passenger side of the Truck as Officer Scary got into the driver's seat. The Truck had only travelled a short distance before another officer stopped them and said they had limited time to "*get everything done*". Officer Scary drove the Truck out of Hakea to a nearby stores area, so that some crates in the back of the Truck could be unloaded.[32,33]

25. After the crates were unloaded, Officer Scary gave VSO Grocott a brief rundown on how to operate the Truck's hydraulic tailgate. He then handed the keys to VSO Grocott who got behind the steering wheel, feeling "*a little overwhelmed*".[34,35]

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[25] Exhibit 1, Vol 1, Tab 38A, Statement - Senior Officer P Moses, paras 6 & 11
[26] Exhibit 1, Vol 1, Tab 39, Statement - Supt S Blenkinsopp, paras 11-12
[27] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 25-26
[28] ts 14.10.19 (Grocott), pp28-30
[29] ts 14.10.19 (Grocott), p30
[30] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 35-36
[31] ts 14.10.19 (Grocott), pp29-30
[32] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 30-32
[33] ts 14.10.19 (Grocott), p29
[34] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 32-34
[35] ts 14.10.19 (Grocott), pp29-30

26. VSO Grocott checked the Truck's gears, mirrors and brakes and tried to familiarise himself with its operation. Other from some lessons he had prior to obtaining his HR truck driver's licence in 2010, VSO Grocott had never driven a heavy rigid vehicle, like the Truck. The last time he had driven a truck of any kind was in 2011, when he was employed as a storeman at Hakea and had driven the smaller stores truck.[36,37]

27. VSO Grocott cautiously drove the Truck back towards Hakea, whilst Officer Scary remained at the external stores area. As VSO Grocott pulled away from the loading bay, he swung the Truck out wide as he was unsure how far the rear of the Truck would swing when he turned. At the front gate of Hakea, he collected his keys and duress alarm and then drove to units 11 and 12 so that unwanted items could be loaded into the Truck.[38,39]

Photo 2: The industries services yard[40]

[36] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 34-36
[37] ts 14.10.19 (Grocott), pp29-30 & p31
[38] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 37-39
[39] ts 14.10.19 (Grocott), pp31-32
[40] Exhibit 1, Vol 3, Tab 2, Photographs, Inspector Kerr, photograph 3 (19.08.15)

28. Once the Truck had been loaded with unwanted mattresses, furniture and rubbish from units 11 and 12, VSO Grocott drove it to the Yard, (see Photo 2), where it was unloaded.[41,42]

29. The Yard is accessed through a narrow passageway and is surrounded on all sides by prison buildings. The Yard is only 11.36 metres wide at its narrowest point.[43,44]

30. As you drive into the Yard, (see Photo 2), there is a secure walkway on the left (the Walkway), which has grilles and lockable access gates. On the right, there is an elevated loading area (the Dock) which is accessed by means of brick stairs with a yellow handrail. Workshops are located beyond the brown roller doors and the roadway slopes gently downwards towards the Dock. The large white structure to the left of the access stairs, is a coolroom, (see Photo 3).[45,46]

Photo 3: Showing the Dock (19.08.15)[47]

[41] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 41-48
[42] ts 14.10.19 (Grocott), p32
[43] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 23
[44] Exhibit 1, Vol 3, Tab 4, Plan of Industries Yard (19.08.15)
[45] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 24-25
[46] Exhibit 1, Vol 1, Tab 39, Statement - Supt S Blenkinsopp, paras 13-16
[47] Exhibit 1, Vol 3, Tab 2, Photographs, Inspector Kerr, photograph 4 (19.08.15)

The deceased assists with backing the Truck

31. At about 12.30 pm on 19 August 2015, VSO Grocott was instructed to drive the Truck from where it had been parked before lunch, back to units 11 and 12 to collect more furniture and rubbish. Given the confined space in the Yard, he correctly determined that it would be necessary to reverse the Truck into the area in front of the Dock and thereby perform a three-point turn.[48,49]

32. Meanwhile, the deceased and two other prisoners, accompanied by VSO Skitt, were walking back to the Yard to collect a list of tasks for the rest of the day. As the deceased walked past the Dock, he noticed VSO Grocott having difficulty reversing the Truck.[50,51]

33. VSO Grocott stopped the Truck and called out to no one in particular: "*How close am I?*", by which he meant how close was the Truck to the side of the coolroom. The deceased approached VSO Grocott and offered to help by guiding the Truck as it reversed. VSO Grocott accepted the offer and the deceased walked towards the rear of the Truck on the driver's side. The other prisoners in the work party waited about five metres away.[52,53,54,55] VSO Grocott had never been instructed that prisoners should not be used as guides and the issue is not dealt with in the Prison Officer (VSO) Induction Workbook.[56,57]

34. As VSO Grocott began slowly reversing the Truck, he was looking in the driver's side mirror but did not see the deceased. After reversing a short distance, he considered he had enough clearance to drive forward and complete the three-point turn. He put the Truck into first gear, checked there was no one in front of him and slowly drove forward.[58,59]

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[48] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 50-55
[49] ts 14.10.19 (Grocott), pp32-33
[50] Exhibit 1, Vol 1, Tab 10, Statement - VSO D Skitt, paras 17-24
[51] Exhibit 1, Vol 1, Tab 9, Statement - Prisoner JB, paras 18-22
[52] Exhibit 1, Vol 1, Tab 10, Statement - VSO D Skitt, paras 25-28
[53] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 57-61
[54] ts 14.10.19 (Grocott), pp33-34
[55] Exhibit 1, Vol 1, Tab 9, Statement - Prisoner JB, paras 23-25
[56] See: Exhibit 1, Vol 1, Tab 38B, Prison Officer (VSO) Induction Workbook
[57] See also: Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 65
[58] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 68-74
[59] ts 14.10.19 (Grocott), pp34-35

35. As VSO Grocott slowly drove the Truck forward, he turned the steering wheel to the left causing the rear of the Truck to swing to the right, towards the side of the coolroom. VSO Grocott said that did not check the driver's side mirror before he pulled forward.[60,61]

36. A split second before the Truck moved forward, the deceased suddenly appeared at the back of the Truck on the driver's side. He became pinned between the rear the Truck and the wall of the coolroom (the Accident").[62,63,64]

37. Moments earlier, Officer McCormick, who was escorting prisoners along the Walkway, saw the deceased waving his hands at the rear of the Truck in an apparent attempt to get it to stop. The deceased's hand movements had attracted his attention and Officer McCormick suddenly realised that the deceased had become pinned. He yelled out: "*Stop, stop, a prisoner is pinned*" and the Truck immediately stopped.[65,66,67]

38. VSO Grocott says he looked in the driver's side mirror to see why he had been told to stop and was shocked to see the deceased was pinned at the rear of the Truck. VSO Grocott says that in an effort to free the deceased, he released the Truck's brake and that after the third short movement backwards, the deceased fell to the ground.[68,69]

39. Officer McCormick (with whom Officer Williams agrees) says that after he (Officer McCormick) yelled out and the Truck stopped, it then moved forward a short distance. Officer McCormick yelled out: "*Stop, he's still stuck*" and it was at that point, that the Truck reversed a short distance and the deceased fell to the ground.[70,71,72]

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[60] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 73-75
[61] ts 14.10.19 (Grocott), p35
[62] Exhibit 1, Vol 1, Tab 14, Statement - Officer C McCormick, paras 15-21
[63] ts 14.10.19 (Grocott), p35
[64] ts 14.10.19 (Williams), p40
[65] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 71-78
[66] ts 14.10.19 (Grocott), p35
[67] Exhibit 1, Vol 1, Tab 14, Statement - Officer C McCormick, paras 15-23
[68] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 79-80
[69] ts 14.10.19 (Grocott), p36
[70] Exhibit 1, Vol 1, Tab 14, Statement - Officer C McCormick, paras 23-27
[71] Exhibit 1, Vol 1, Tab 13, Statement - Officer P Williams, p3
[72] ts 14.10.19 (Williams), p40

40. Given the horrific nature of the Accident, and the fact that Officers McCormick and Williams was observing the incident, as opposed to being directly involved in it, I prefer their evidence to that of VSO Grocott's on this point. In any event, after the deceased had fallen to the ground, VSO Grocott applied the Truck's air parking brake and ran to help the deceased.[73,74]

41. Another officer used a wooden pallet to chock the Truck's rear wheels, to prevent it from rolling backwards and further injuring the deceased. After the Truck was driven out of the way, the pallet was moved to one side.[75,76]

First aid and hospital care

42. Meanwhile, Officer McCormick called a "code red" emergency using his prison two-way radio and ran to assist the deceased. Other officers arrived, including the Recovery Team, who are the first response officers that deal with critical incidents. Prison nurses and a doctor also arrived to assist with the deceased's care.[77,78]

43. Prisoner AB says that after the deceased fell to the ground, he ran to help him and held the deceased's head. The deceased said: "*I want to get up*", and Prisoner AB told him to stay still. The deceased was staring straight ahead as Prisoner AB tried to comfort him.[79]

44. Officer Siby, who was a member of the Recovery Team said that when he arrived on the scene, the deceased was lying on his side behind the Truck. The deceased said words to the effect of: "*my ribs are aching*" and "*I'm having trouble breathing*". When prison nurses arrived, the deceased said: "*I can't breathe*".[80,81]

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[73] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 80-83
[74] ts 14.10.19 (Grocott), p36
[75] Exhibit 1, Vol 2, Tab 6, Incident description report - Officer J Mortley
[76] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 85-86
[77] Exhibit 1, Vol 1, Tab 14, Statement - Officer C McCormick, paras 28-35 & para 40
[78] Exhibit 1, Vol 2, Tab 6, Incident description report - Clinical Nurse Manager D Donaldson
[79] Exhibit 1, Vol 1, Tab 11, Statement - Prisoner AB, paras 37-40
[80] Exhibit 1, Vol 2, Tab 6, Incident description report - Officer J Siby
[81] Exhibit 1, Vol 2, Tab 6, Incident description report - Senior Officer M Buscumb

45. Prisoner JB says that the deceased's eyes were open and although they tried to get him to respond, at no stage did the deceased speak.[82]

46. Similarly, VSO Grocott says that when he reached him, the deceased was conscious and his eyes were open but he was not talking.[83]

47. An ambulance subsequently arrived at Hakea and took the deceased to FSH.[84] Despite the efforts of prison staff, ambulance officers and hospital medical and nursing professionals, the deceased could not be revived. He was declared deceased at 1.50 pm on 19 August 2015.[85]

CAUSE AND MANNER OF DEATH

48. A forensic pathologist (Dr McCreath) conducted a post mortem examination of the deceased's body on 25 August 2015. Dr McCreath found fractures to the deceased's ribs and pelvis and blood in his chest and abdominal cavities. There were tears to the deceased's spleen as well as to the tissues attached to his bowel (the mesentery).[86]

49. Microscopic examination of tissue showed fatty change and scarring of the deceased's liver.[87] Toxicological analysis found paracetamol in the deceased's blood and gabapentin in his urine. Alcohol and common drugs were not detected.[88]

50. At the conclusion of her examination, Dr McCreath expressed the opinion that the cause of death was multiple injuries.[89] I accept and adopt that conclusion.

51. I find that the deceased's death occurred by way of accident.

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[82] Exhibit 1, Vol 1, Tab 9, Statement - Prisoner JB, paras 42-43 & para 47
[83] Exhibit 1, Vol 1, Tab 12, Statement - VSO S Grocott, paras 84
[84] Exhibit 1, Vol 1, Tab 26, St John Ambulance patient record
[85] Exhibit 1, Vol 1, Tab 6, FSH Death in hospital form and emergency department notes
[86] Exhibit 1, Vol 1, Tab 7, Supplementary Post Mortem Report
[87] Exhibit 1, Vol 1, Tab 7, Supplementary Post Mortem Report
[88] Exhibit 1, Vol 1, Tab 8, ChemCentre WA Report
[89] Exhibit 1, Vol 1, Tab 7, Supplementary Post Mortem Report, p1

EVENTS SINCE THE INCIDENT

WorkSafe WA investigation and charges

52. After being advised of the Accident, Inspector Kerr, (an inspector with WorkSafeWA) attended Hakea on 19 August 2015. She led an investigation into the Accident and was assisted by two other WorkSafe WA inspectors.[90]

53. On arrival at Hakea, Inspector Kerr viewed the Truck and the scene of the Accident. During the investigation numerous photographs were taken and a number of witnesses were interviewed.[91]

54. Inspector Kerr established that vehicles, including the Truck, regularly entered the Yard to pick up and deliver goods and that prisoners and prison staff could be in the Yard when these vehicles were moving.[92]

55. On 20 August 2015, the then superintendent of Hakea, Superintendent Schilo, advised Inspector Kerr that he had implemented the following measures immediately after the Accident:

a. Allocation of a VSO to be responsible for managing vehicles in the Yard;

b. VSO's will act as spotters, but this did not include guiding a vehicle; and

c. No prisoner was to be in the Yard when vehicle movement was occurring.[93]

56. On 21 August 2015, Inspector Kerr issued an improvement notice (the Notice) to the Department of Corrective Services, as the Department was then known. As the name suggests, an improvement notice requires the person or entity to whom it is issued to take specified actions by a specified date.[94,95]

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[90] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 9-11 and para 14
[91] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 19-22
[92] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 26-28
[93] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 31
[94] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 33
[95] Exhibit 1, Vol 3, Tab 5, Improvement notice 90007354 (21.08.15)

57. The Notice demanded compliance by 26 February 2016, and required the Department to:

> Ensure that the movement and speed of vehicles and plant at the workplace are managed in a way that minimises the risk of injury to pedestrians and persons operating vehicles.[96]

58. A further improvement notice was issued to the Department on 7 September 2016 (the Second Notice).[97] The Second Notice demanded compliance by 28 October 2016 and required the Department to:

> Provide an adequate induction program for all new employees, which includes the safety hazards and risks by following the Department of Corrective Services existing procedures.[98]

59. On 10 September 2015, Superintendent Schilo issued a notice to staff setting out the procedure to be followed by all vehicles and plant entering Hakea. The procedure included the following requirements:

a. A VSO Spotter shall have total control of the Industries Service Yard and will ensure that there is no pedestrian activity in the area during vehicular access, delivery process and the vehicle departing;

b. The VSO Spotter is not to guide, direct or instruct the driver when manoeuvring the vehicle and the driver and the VSO Spotter must always be in direct line of sight of each other and are to wear high viz vests at all times during this procedure; and

e. No person is permitted to stand behind any reversing vehicle and a minimum of 5 metres clearance from the vehicle must be maintained at all times.[99]

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[96] Exhibit 1, Vol 3, Tab 5, Improvement notice 90007354 (21.08.15)
[97] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 45-46
[98] Exhibit 1, Vol 3, Tab 6, Improvement notice 42700061 (07.09.16)
[99] Exhibit 1, Vol 3, Tab 19, Staff Notice No. 26/2015 (10.09.15)

60. Inspector Kerr's investigation established that there were no uniform procedures with respect to traffic management within prisons in Western Australia, and that each prison appeared to adopt its own system.[100]

61. On 18 November 2015, Inspector Kerr revisited Hakea and inspected the control measures that had been implemented since the Accident. Those measures included:

a. Yellow bollards around the coolroom at the kitchen loading dock (see Photo 4);

b. 'No entry authorised personnel only' and 'danger look out for trucks' signage on the grille gates in the Walkway; and

c. Yellow 'keep clear' cross-hatching on the ground in front of the industry workshop roller doors (see Photo 4).[101]

Photo 4: Improvements to the Dock (18.11.15)[102]

[100] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 40
[101] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 41
[102] Exhibit 1, Vol 3, Tab 3, Photographs, Inspector Kerr, photograph 19 (18.11.15)

62. Inspector Kerr noted that Hakea had developed a traffic management plan along with a safe movement of vehicles/plant checklist.[103,104,105] She expressed the opinion that the infrastructure and policy changes made by Hakea after the Accident were sensible and consistent with measures she had seen implemented in other workplaces.[106]

63. For the sake of completeness, I note that on 23 October 2018, the Department (as the responsible agency of the State of Western Australia) pleaded guilty in the Armadale Magistrates Court to an offence against section 21(2) of the *Occupational Safety and Health Act 1984* (the OSH Act) and was fined $100,000. On 27 March 2019, following a trial in the Perth Magistrates Court, VSO Grocott was convicted of an offence against section 20(1)(b) of the OSH Act and fined $4,000.[107]

Hakea safety representatives and investigation

64. Officer Vose, a prison officer at Hakea, is also a safety and health representative (SHR). He said that where custodial staff at Hakea consider something is unsafe, they can submit a "hazard notice" or speak directly to a SHR and that either way, the matter is addressed by the Hakea Occupational Safety and Health committee (OSH committee) of which he is a member.[108] The OSH Committee meets monthly.[109]

65. Prisoners can raise safety issues with custodial staff, who may then refer the matter to a SHR. Quarterly safety audits aimed at identifying safety issues are conducted at Hakea by SHR's.[110,111]

66. Officer Vose was asked if he was satisfied that the new procedures with respect to vehicle movements at Hakea were being complied with and he replied: "*Absolutely, yes*".[112]

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[103] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, para 42
[104] Exhibit 1, Vol 3, Tabs 20 & 21, Safe movement of vehicles and plant template and checklist
[105] Exhibit 1, Vol 3, Tab 22, Hakea Prison Traffic Management Plan, Feb 2016
[106] ts 14.10.19 (Kerr), pp21-23
[107] Exhibit 1, Vol 3, Tab 1A, Statement - Inspector S Kerr, paras 49-53
[108] ts 14.10.19 (Vose), p51-52
[109] Exhibit 1, Vol 1, Tab 39, Statement - Supt S Blenkinsopp, paras 24-25
[110] ts 14.10.19 (Vose), p51-52
[111] Exhibit 1, Vol 1, Tab 39, Statement - Supt S Blenkinsopp, paras 22
[112] ts 14.10.19 (Vose), p50

67. Officer Vose further observed that:

> [T]here's now some control over how vehicles move in that area…where previously there were no controls, so it has definitely improved.[113]

68. Following the Accident, a safety and health investigation was conducted by departmental officers: Ms J Vitale (Coordinator Safety and Health) and Ms V Clark (Senior OSH Consultant). They prepared a report and made a number of recommendations.[114]

69. The report's recommendations included: eliminating all non-essential vehicles and personnel from the Yard; issuing high visibility safety vests to all VSO's; identifying and marking pedestrian exclusion zones; installing bollards at potential collision points; and the development of a traffic management plan which, amongst other things, includes a requirement that spotters assisting vehicles to reverse are not to stand behind the vehicle and are always to stay in sight of the driver.[115,116]

70. In an email to the Court dated 16 October 2019, counsel for the Department Ms Eagling confirmed that all of the recommendations made by Ms Vitale and Ms Clark had been addressed.[117]

QUALITY OF SUPERVISION, TREATMENT AND CARE

71. Whilst the deceased's medical needs appear to have been addressed during his last incarceration at Hakea, quite obviously, he should never have been permitted to assist VSO Grocott as a spotter. Further, the deceased should not have been allowed anywhere near a moving vehicle.

72. With the exception of this lapse in supervision, which had unintended and catastrophic consequences, I am otherwise satisfied that the supervision, treatment and care provided to the deceased during his incarceration, was adequate.

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[113] ts 14.10.19 (Vose), p50
[114] Exhibit 1, Vol 2, Tab 2, OSH Investigation - Vehicle Incident Hakea Prison, p1
[115] Exhibit 1, Vol 2, Tab 2, OSH Investigation - Vehicle Incident Hakea Prison, pp9-11
[116] See also: Email to Court from Ms N Eagling setting out action taken on recommendations (16.10.19)
[117] Email to the Court from Ms N Eagling, State Solicitor's Office (16.10.19)

CONCLUSION

73. The deceased was a 49 year old man being held on remand at Hakea. He died from the injuries he sustained when he was pinned against the wall of a coolroom by a truck on 19 August 2015.

74. As Mr Mudford, the author of the Department's Death in Custody review put it, "*this critical incident can only be described as a tragic accident*".[118] Had the deceased not chosen to move the right rear of the Truck, at the precise moment when it began to move forward, it is unlikely that he would have been killed.

75. Since the deceased's death, a number of infrastructure and policy changes have been implemented at Hakea. These changes are aimed at reducing the likelihood of a critical incident involving vehicles.

76. Hakea now has a traffic management plan, designed to ensure that prisoners and non-essential staff are not in the vicinity of moving vehicles/plant. Physical barriers, signs and road markings have also been installed in the Industries Service Yard.

77. Given the remedial measures which have been put in place since the deceased's death, I do not consider it is necessary or appropriate for me to make any recommendations in this matter.

78. I can only hope that the changes that have been made provide some solace to the deceased's family and friends for their terrible loss.

MAG Jenkin
Coroner
14 November 2019

[118] Exhibit 1, Vol 2, Death in custody review, p5