JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Philip John Urquhart, Coroner
HEARD	**:**	26-28 AUGUST 2020
DELIVERED	**:**	22 DECEMBER 2020
FILE NO/S	**:**	CORC 365 of 2017
DECEASED	**:**	ANDERSON, JORDAN ROBERT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Ms A V Barter & Ms E Langoulant (Aboriginal Legal Service) appeared for the family of the deceased

Ms B Burke (Australian Nursing Federation) appeared for Mr S Komar

Mr J Bennett & Mr McIlwaine (State Solicitor's Office) appeared for the Department of Corrective Services (the Department)

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Jordan Robert ANDERSON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 26 - 28 August 2020, find that the identity of the deceased person was* ***Jordan Robert ANDERSON*** *and that death occurred on 23 March 2017 at Fiona Stanley Hospital, from hypoxic brain injury and bronchopneumonia complicating ligature compression of the neck in the following circumstances:*

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INTRODUCTION

1. Mr Anderson died on 23 March 2017 at Fiona Stanley Hospital (FSH), from complications of ligature compression of the neck.

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

3. Accordingly, immediately before his death, Mr Anderson was a "*person held in care*" within the meaning of the *Coroner's Act 1996* (WA) and his death was 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 from the Department while in that care.[4]

5. I held an inquest into Mr Anderson's death at Perth on 26 - 28 August 2020. The following witnesses gave oral evidence at the inquest:

i. Mr Neil Dent (Prison Officer);

ii. Mr Joseph Cain (Senior Prison Officer);

iii. Mr Lyndon Jones (Prison Officer);

iv. Mr William Cahoon (Prison Officer);

v. Dr Cherelle Fitzclarence (former Deputy Director of Health);

vi. Mr Anthony Whittaker (Senior Prison Officer);

vii. Mr Stephen Komar (Nurse with the Department);

viii. Associate Professor Paul Bailey (Medical Director, St John Ambulance WA);

[1] Section 16, *Prisons Act 1981* (WA)
[2] Sections 3 and 22(1)(a), *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)

ix. Mr Richard Mudford (Senior Review Officer with the Department)

x. Mr Sean Devereux (Deputy Superintendent).

6. The documentary evidence adduced at the inquest comprised of three volumes which were tended as exhibit 1. An additional five exhibits were tendered during the course of the inquest (exhibits 2- 6) and five exhibits were provided after the inquest (exhibits 7-11).

7. Counsel for the interested parties, Counsel Assisting and I visited Hakea on 6 August 2020. The purpose of this visit was to view Unit 1 D Wing: specifically the cell that Mr Anderson was in on the night of 4 March 2017, the unit's exercise yards, that part of the corridor where Mr Anderson was treated and the unit's control room. The location of Units 2 and 3, the Health Centre and the sally port area where the ambulances were parked on 5 March 2017 were also viewed. The group was escorted by Assistant Superintendent (Operations) Andrea Rees-Carter. Counsel Assisting made notes of what was observed.[5]

8. In considering the care provided to Mr Anderson while he was a prisoner, the inquest focused on 4 and 5 March 2017, as well as on the circumstances of his death.

BACKGROUND MATTERS

Hakea Prison

9. Hakea officially opened in June 1982 as Canning Vale Prison. In 2000, the Canning Vale Prison and the C W Campbell Remand Centre were amalgamated to create Hakea. It is located in the suburb of Canning Vale.

10. 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 reception point for new prisoners. Hakea's capacity is 1,241 prisoners[6] and in March 2017 it held approximately 1,100 prisoners.[7] It has 649 cells which comprise of 592 two-man cells and 39

[5] Exhibit 6, Hakea Prison Scene Visit on 6 August 2020
[6] Exhibit 1, Vol 3, Tab 33, Hakea Prison Accommodation Overview
[7] ts 27.08.20 (Whittaker), p 210

one-man cells.[8] Hakea has 173 prison officers on duty during a week day and 116 prison officers on weekend days. However, during night shift hours it usually only has 17 prison officers on duty.[9]

Unit 1

11. Hakea is divided into 10 units. Units 1- 5 are on the west side of the prison and units 6-10 are on the east side.[10]

12. Unit 1, where Mr Anderson was placed on the night of 4 March 2017, is identified as "*the designated Multi-Purpose Unit, allocated for the management of prisoners who are deemed unfit for placement in the mainstream population and, generally, subject to an approved administrative sanction, or regime.*"[11] It is therefore used to house prisoners who have been disruptive or have been punished for breaches of prison regulations.[12] Unit 1 has 60 cells[13] divided into four wings which are identified as A, B, C and D. [14] D Wing has 12 cells and Mr Anderson was in this wing in Cell 03, which was a one-man cell.[15]

At Risk Management System (ARMS)

13. ARMS is the Department's primary suicide prevention strategy that aims to provide staff with clear guidelines to assist with the identification and management of prisoners at the risk of self-harm and/or suicide throughout their period of incarceration. A prisoner placed on ARMS is provided with a multi-disciplinary case-management system which includes different levels of monitoring.

14. When a prisoner is received into the prison, an experienced prison officer (reception officer), conducts a formal assessment designed to identify any presenting risk factors.[16] Within 24 hours of arriving at the prison, the prisoner's health needs are assessed by a nurse.

[8] Exhibit 1, Vol. 3, Tab 33, Hakea Prison Accommodation Overview
[9] Exhibit 1, Vol. 1, Tab 58, Statement - Sean Devereux, p 3
[10] ts 27.08.20 (Whittaker), p 162
[11] Exhibit 10B, Local Order 21- Prisoner Management and Placement Multi-Purpose Unit 1 (revision No. 11.0), p 2
[12] ts 26.08.20 (Cahoon), p 111
[13] Exhibit 1, Vol. 3, Tab 33, Hakea Prison Accommodation Overview
[14] Exhibit 1, Vol. 3, Tab 8, Total Offender Management Solution: Unit Count - by Wing and Cell
[15] Exhibit 1, Vol. 3, Tab 8, Total Offender Management Solution: Unit Count - by Wing and Cell
[16] Exhibit 1, Vol. 2, Tab 33, Statement - Neil Dent

15. All prison staff (including prison officers, health professionals, vocational trainers and counsellors) are responsible for identifying prisoners who may be at risk of self-harm or suicide. For that reason, any staff member may place a prisoner on ARMS at any time using the Department's computerised record keeping system, Total Offender Management Solutions (TOMS).

16. Prisoners who need extra support or supervision to help them cope but who are not assessed as being at risk of self-harm and/or suicide can be placed on the less intensive Support and Monitoring System (SAMS).

First-aid training for Prison Officers

17. Prison officers complete a senior first-aid course when they join the Department.[17] That course includes how and when to perform cardiopulmonary resuscitation (CPR). Prison officers then have an annual refresher course in first-aid, although this is at a basic level. However, senior prison officers continue to have refresher courses in more advanced first-aid.[18]

The predictability of suicide

18. Suicide is extremely unpredictable. It is a rare event and it is impossible to predict rare events with any certainty. Complicating factors are that a person's suicidal ideation can fluctuate, sometimes in a relatively short time frame.

19. In 2017, the Department of Health published a document called: *Principles and Best Practices for the Care of People Who May Be Suicidal* (the Document). Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable.

20. The Document points out that clinicians (and, for this matter, I would add reception officers and, more generally, prison officers) faced with the onerous task of assessing a person who may be suicidal will confront two issues. First, suicide is a rare event and secondly, there is no set of risk

[17] ts 26.08.20 (Cahoon), p 106
[18] ts 26.08.20 (Cahoon), p 106

factors that can accurately predict suicide in an individual. As the Document points out, the use of risk assessment tools which contain checklists of characteristics have not been found to be very effective:[19]

> The widespread belief within the community that suicide is able to be accurately predicted, had led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However, the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.

21. A reception officer conducts a suicide and self-harm risk assessment with each incoming prisoner using an online tool which asks the prisoner a series of questions to elicit information about factors tending to make it more likely that the prisoner will attempt suicide (risk factors) and factors which make it less likely (protective factors).

22. However well-intentioned this online tool is, the fact remains there is no sure way of determining suicidal intentions or predicting the degree of risk. The only fail-safe predictor is when a person discloses he or she is contemplating suicide. Otherwise, assessments can only be of temporary value because moods and situations change. Self-harm is often an impulsive reaction to bad news or a sudden increase in stress levels.

THE DECEASED

Background [20,21]

23. Mr Anderson was born on 20 May 1993 and was 23 years old when he died on 23 March 2017. Mr Anderson had a brother and sister and two half-sisters from his mother's prior relationship. Mr Anderson's parents were frequently imprisoned and he and his siblings were often looked after by grandparents. For several years, Mr Anderson lived with an uncle in Adelaide.

[19] Department of Health: Principles and Best Practices for the Care of People Who May Be Suicidal (2017), p 3
[20] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[21] Exhibit 1, Vol. 2, Tab C, Death in Custody Report

24. Mr Anderson left school early in year 10. He then enrolled in a construction course which he was unable to complete after experiencing epileptic seizures onsite. He was never employed.

25. Mr Anderson reported using illicit drugs and alcohol from a very early age. He stated that he was 8 years old when he was introduced to cannabis and began consuming alcohol at the age of 13 years. He was introduced to methylamphetamine at 18 years old and became dependent on that drug for the balance of his life.

26. Mr Anderson's relationship with his partner commenced when he was 17 years old and they had two daughters together. His relationship was marred by family and domestic violence and a number of his convictions related to assaults upon his partner.

Offending History [22]

27. Mr Anderson was convicted of his first offence two days shy of his 14th birthday. From May 2007 to December 2010, he was convicted of seven offences comprising of stealing a motor-vehicle, indecent assault, common assault, two aggravated assaults, carrying an article with intent to injure, and trespass.

28. His offending continued as an adult. He accrued 45 convictions, all in the Magistrates Court, which included offences of dishonesty, assaults, traffic-related, breaches of bail and breaches of community orders. There was a strong correlation between Mr Anderson's drug and alcohol dependency and offending behaviour.

Prison History

29. Prior to his last incarceration, Mr Anderson was imprisoned on four occasions in Hakea and Casuarina Prison (Casuarina) as either a remand or sentenced prisoner.

30. On 9 August 2013, Mr Anderson was remanded in custody in Hakea until 20 August 2013. Although the formal assessment by the reception officer of Mr Anderson did not identify any presenting risk factors, he was a

[22] Exhibit 1, Vol. 2, Tab 1, Criminal and Traffic History for Court

young offender incarcerated for the first time.[23] He was therefore initially placed on ARMS in the Crisis Care Unit (CCU) in compliance with section 7 of the Department's Local Order 74 - Management of Young Offenders (Local Order 74).[24]

31. Mr Anderson's next imprisonment was from 28 October 2013 to 26 June 2014 at Hakea and his Reception Intake Assessment was completed by Reception Officer Neil Dent.[25] Mr Anderson's answers to Mr Dent's questions did not identify any risk factors.[26] Nevertheless, Mr Dent raised a new alert identifying Mr Anderson as a "*repeat*" young offender as defined in section 3.1 of Local Order 74.[27] However, as Mr Dent did not consider him to be at risk of self-harm or suicide, Mr Anderson was placed in Unit 7, which was a mainstream unit.[28]

32. The third time Mr Anderson was imprisoned was at Casuarina from 13 July 2014 to 26 August 2014. No presenting risk factors were identified in Mr Anderson's Reception Intake Assessment.[29]

33. The final time Mr Anderson was incarcerated prior to his last imprisonment was at Hakea from 5 February 2015 to 3 June 2016. Again, the answers given by Mr Anderson as recorded in the Reception Intake Assessment did not identify any presenting risk factors.[30] However, it was recorded that the police handover report stated Mr Anderson "*suffers from depression and head-butted the wall*." Mr Anderson denied to the reception officer that he had done that.[31] It was also recorded that Mr Anderson was "*calm and cooperative*" and "*did not present any issues*" and that he said he had "*no thoughts of self-harm/suicide.*"[32]

34. On 11 December 2015, Mr Anderson was assaulted by another prisoner with a broom and sustained a fractured jaw. He was given first-aid by prison health staff before he was taken by ambulance to St John of God Hospital, Midland and then to Royal Perth Hospital. He was treated there

[23] Exhibit 1, Vol. 2, Tab 33B, ARMS - Reception Intake Assessment created 9 August 2013
[24] Exhibit 1, Vol. 2, Tab 33D, Local Order 74 - Management of Young Offenders
[25] Exhibit 1, Vol. 2, Tab 33, Statement - Neil Dent
[26] Exhibit 1, Vol. 2, Tab 33C, ARMS - Reception Intake Assessment created 28 October 2013
[27] Exhibit 1, Vol. 2, Tab 33D, Local Order 74 - Management of Young Offenders
[28] Exhibit 1, Vol. 2, Tab 33, Statement - Neil Dent
[29] Exhibit 9A, ARMS - Reception Intake Assessment created 13 July 2014
[30] Exhibit 9B, ARMS - Reception Intake Assessment created 5 February 2015
[31] Exhibit 9B, ARMS - Reception Intake Assessment created 5 February 2015, p 5
[32] Exhibit 9B, ARMS - Reception Intake Assessment created 5 February 2015, pp 5-6

and discharged back to Hakea on 13 December 2015.[33] I find that the Department's care of Mr Anderson for this injury was reasonable.

35. During his periods of incarceration, Mr Anderson's ongoing physical ailments, including his epilepsy and the complications with his liver were appropriately managed.[34]

Circumstances of Mr Anderson's last incarceration

36. On 5 November 2016, Mr Anderson appeared in the Perth Magistrates Court charged with 29 offences. These included two counts of aggravated robbery, three counts of stealing a motor vehicle and driving recklessly, one count of aggravated burglary, one count of assault occasioning bodily harm and six counts of assault to prevent arrest.[35] After his court appearance, Mr Anderson was remanded in custody and was received at Hakea.[36]

37. That afternoon he underwent the Reception Intake Assessment (Assessment) completed by Mr Dent. Mr Anderson was asked a number of questions aimed at gauging his current level of risk of self-harm or suicide. One question was whether Mr Anderson ever tried to take his own life or harm himself. To that question he answered "*yes*", advising that he had taken an overdose a couple of months ago.[37] However, Mr Anderson gave no other answers suggesting an increased risk of self-harm or suicide and he denied having previously self-harmed whilst in custody. He denied having lost any family or friends to suicide. He stated he had not been treated for a mental health issue and that he had not had any thoughts about harming himself or taking his life since being arrested.[38] However, Mr Anderson did state that he normally used "*a lot of"* amphetamines and marijuana.[39]

[33] Exhibit 1, Vol. 1, Tab 11, Report of Dr Vicki Pascu, pp 3-4
[34] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 4
[35] Mr Anderson was eventually charged with nine further offences: Exhibit 1, Vol. 3, Tab 2, Department of Corrective Services - Offender Summary, pp 3-4
[36] Exhibit 1, Vol. 2, Tab C, Death in Custody Review, p 7
[37] Exhibit 1, Vol. 2, Tab 33A, ARMS Reception Intake Assessment created 5 May 2016, questions 6.3.1 and 6.3.2
[38] Exhibit 1, Vol. 2, Tab 33A, ARMS Reception Intake Assessment created 5 May 2016, p 3
[39] Exhibit 1, Vol. 2, Tab 33A, ARMS Reception Intake Assessment created 5 May 2016, p 4

38. At the end of the Assessment under the heading "*Officer's Summary*" the question was asked of the reception officer: "*Do you consider this prisoner to be at risk of suicide or self-harm?*" Mr Dent recorded "*No.*"[40]

39. The Assessment required the reception officer to consider the following potential factors when answering the above question:[41]

> Impact of Nature of Offences, Ethnicity, Cultural and/or Spiritual Issues, Age/Relationships, Minimal Social Supports, Self-Harm History, Mental Health History and/or Drug Withdrawal maybe factors for suicidal thoughts and suicidal behaviour.

40. During his evidence, Mr Dent agreed that a number of these factors were relevant to Mr Anderson. These were the seriousness of the offences he was facing, that he was a young Aboriginal person, that he disclosed a relatively recent incident of self-harm and that he maybe encountering drug withdrawals.[42] Nevertheless, Mr Dent was of the view that Mr Anderson did not need to be referred onto ARMS. He gave two reasons for reaching that conclusion. First, Mr Anderson had said he had family and friends in Hakea who would assist in supporting him. And secondly, Mr Anderson's demeanour did not suggest there was any risk.[43] Although Mr Dent was unable to specifically recall Mr Anderson's demeanour (because of the passage of time), if Mr Anderson's demeanour had suggested he was potentially at risk, Mr Dent said he would have recorded that in the Assessment.[44]

41. Mr Anderson's disclosure of a suicide attempt at a relatively close point of time to his remand in custody may well have justified him being placed on ARMS. However, there were other factors that indicated a placement on ARMS was not necessary. In light of those factors, I am satisfied that Mr Dent gave sufficient consideration to Mr Anderson's suicide attempt when he made a decision not to place Mr Anderson on ARMS. Self-harm history was just one of eight factors cited in the Assessment for the reception officer to consider. I also accept Mr Dent's evidence that

[40] Exhibit 1, Vol. 2, Tab 33A, ARMS Reception Intake Assessment created 5 May 2016, p 5
[41] Exhibit 1, Vol. 2, Tab 33A, ARMS Reception Intake Assessment created 5 May 2016, p 5
[42] ts 26.08.20 (Dent), pp 22-25
[43] ts 26.08.20 (Dent), p 25
[44] ts 26.08.20 (Dent), p 25

Mr Anderson was not exhibiting signs of any drug withdrawal at the time of the Assessment.[45]

42. In addition, I note that the Prison Medical Officer (PMO) saw Mr Anderson four days later on 9 November 2016 and completed a thorough medical assessment. The PMO noted that although Mr Anderson was on "*big charges*" he appeared to be in good spirits and denied any thoughts of self-harm.[46]

43. I am also mindful not to insert hindsight bias into my assessment of the appropriateness of Mr Dent's decision not to place Mr Anderson on ARMS.[47]

44. On 24 November 2016, Mr Anderson assaulted another prisoner with a metal crutch, breaking some of that prisoner's fingers.[48] As a result, he was detained in Unit 1 on a confinement regime for 14 days from 25 November to 8 December 2016.[49] Prison health staff were not notified of this outcome.

45. On 2 December 2016, Mr Anderson was in his cell at Unit 1 when he began smashing the cell's basin and throwing objects at the windows causing the glass to break.[50] There were also cells damaged by fire on that day by other prisoners and although some reports that were prepared after Mr Anderson's death refer to him being involved in those fires,[51] he was only subsequently charged with damaging his cell as outlined above.

46. After damaging his cell, Mr Anderson was forcibly restrained by four prison officers. As he was face down on the floor, a prison nurse was asked to assess him. Mr Anderson denied any respiratory problems, pain or injury.[52] Less than two hours later, another nurse assessed Mr Anderson through his cell door hatch when he was in restraints. This nurse noted

[45] ts 26.8.20 (Dent), p 25
[46] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3
[47] Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable then they really were: *The Australasian Coroner's Manual*, Hugh Dillon and Marie Hadley, 2015, p 10
[48] Exhibit 1, Vol. 2, Tab 5, Incident Description Report - P Lucas; Exhibit 1, Vol. 2, Tab C, Death in Custody Report
[49] Exhibit 1, Vol. 2, Tab 5, Confinement Regime Rules created 25 November 2016
[50] Exhibit 1, Vol. 1, Tab 51C, Police Statement of Material Facts
[51] For example, Exhibit 1, Vol 2, Tab C, Death in Custody Report, p 8
[52] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3; Exhibit 1, Vol. 3, Tab 27, EcHO records for Mr Anderson, pp 12-13

that he was not suffering from any harm due to the restraints and had no complaints of injury at that time.[53]

47. Just over 40 minutes later, the nurse was called by the night senior officer who advised that Mr Anderson was claiming to have swallowed some glass. The nurse made another check 18 minutes later and Mr Anderson did not mention to her that he had swallowed any glass.[54] Although the nurse made a note that she was to advise the day shift health staff of the reported ingestion of glass, there appears to have been no further follow up of this claim by prison health staff. There is no notation that a PMO was consulted about it. However, on 2 December 2016, Mr Anderson was put into a safe cell in Unit 1 and placed on "*high*" ARMS with one hourly reviews.[55] The reason for this placement was not due to concerns that Mr Anderson may self-harm but for "*management issues*".[56]

48. The next recorded health check for Mr Anderson was on 5 December 2016 when a prison mental health staff member spoke to him through the hatch of his cell door. He was polite and cooperative on that occasion and denied that he had swallowed any glass. He also denied having any current thoughts or plans to harm himself. As a result, it was recommended he be removed from the safe cell and that no mental health intervention was required.[57] This recommendation was subsequently reviewed by the Prisoner Risk Assessment Group (PRAG) and the decision was made to remove Mr Anderson from Unit 1 and place him back into a mainstream unit. He was also removed from ARMS.[58]

49. Mr Anderson's behaviour on 2 December 2016 was concerning. He was responsible for causing over $3,300 damage to his cell.[59] Several hours later he asserted he had ingested glass. It is evident from Mr Anderson's

[53] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3; Exhibit 1, Vol. 3, Tab 27, EcHO records for Mr Anderson, pp 12-13
[54] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3; Exhibit 1, Vol. 3, Tab 27, EcHO records for Mr Anderson, pp 12-13
[55] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3; Exhibit 1, Vol. 3, Tab 27, EcHO records for Mr Anderson, pp 12-13
[56] Exhibit 1, Vol. 2, Tab 29D, Department of Corrective Services - Prison Counselling Consultation file note 5 December 2016
[57] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 3; Exhibit 1, Vol. 3, Tab 27, EcHO records for Mr Anderson, pp 12-13
[58] Exhibit 1, Vol. 2, Tab 31C, ARMS - Prisoner Review Assessment Group Minutes 5 December 2016
[59] Exhibit 1, Vol. 1, Tab 51C, Police Statement of Material Facts

Electronic Health Records (EcHO) that a PMO was not informed of this claim. I accept Dr Cherelle Fitzclarence's opinion when she stated:[60]

> Ideally, if a patient claims self-harm via swallowing a potentially lethal substance, the doctor on site or the on call doctor if there is no doctor on site, should be informed with further management being directed by the medical practitioner.

50. On 28 February 2017, police officers attended Hakea to speak to Mr Anderson about the damage to his cell on 2 December 2016. On entering the interview room, Mr Anderson immediately refused to speak to the police officers and left. He was subsequently charged with criminal damage with a court appearance scheduled for 6 March 2017.[61]

EVENTS LEADING TO DEATH

Disciplinary hearing before the Justice of the Peace on 2 March 2017

51. On 2 March 2017, Mr Anderson appeared before the visiting Justice of the Peace with respect to the assault upon the prisoner with the metal crutch on 24 November 2016. He pleaded guilty and received a further five days confinement in a punishment cell, effective immediately. This resulted in him being transferred to Unit 1 for a second time on another confinement regime with respect to the same incident.[62] Again, prison health staff were not notified of this outcome.[63]

52. The conditions of the second confinement regime were stricter than the previous one. Mr Anderson was only permitted to exercise alone, his meals were taken in his cell, he was not permitted any visits, writing materials would only be provided on request and telephone calls were restricted to one social call and, if it could be facilitated, one legal call for the duration of his confinement.[64] By comparison, he was permitted non-contact visits and there were no documented restrictions on the telephone calls he could make during his confinement in Unit 1 in late 2016.[65]

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[60] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 6
[61] Exhibit 1, Vol. 1, Tab 51B, Police Statement of Material Facts
[62] Exhibit 1, Vol. 2, Tab 4, Incidents and Occurrences - Prisoner, p 3; Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 5
[63] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 5
[64] Exhibit 1, Vol. 2, Tab 10, Confinement Regime Rules created 5 March 2017, pp 2-3
[65] Exhibit 1, Vol. 2, Tab 5, Confinement Regime Rules created 25 November 2016, pp 2-3

Fire incident on 4 March 2017

53. What happened on the afternoon of 4 March 2017 makes it clear that Mr Anderson was not coping with his confinement in Unit 1. The day was a particularly hot one. The neighbouring suburb of Gosnells had a maximum temperature of 37°C.[66] Unit 1 has two enclosed exercise yards parallel to each other. They are not air-conditioned. During the afternoon, Mr Anderson was in one exercise yard and another prisoner was in the adjacent one. They both became aggressive and refused to re-enter their respective cells after their allotted exercise time. At about 4.20 pm, Mr Anderson lit a small fire in the alcove area outside the entrance to the exercise yards. A Code Red[67] emergency was called by prison staff and the fire was easily extinguished.[68]

54. Mr Anderson and the other prisoner maintained their refusal to leave the exercise yards and continued to be verbally aggressive towards prison staff. As a result, an extraction team comprising of a number of prison officers in personal protective equipment were tasked with removing Mr Anderson and the other prisoner from the exercise yards.[69]

55. Camcorder footage taken by probationary Prison Officer Sandeep Phor[70] confirms Senior Prison Officer Joseph Cain's account that Mr Anderson was initially hostile towards attempts to negotiate his removal from the exercise yard. Mr Anderson was in a highly agitated state and expressed his wish to be transferred to Casuarina. After being told that efforts would be made to have him transferred after the completion of his five day punishment, Mr Anderson voluntarily allowed himself to be restrained in handcuffs and leg iron chains. He was then compliant when moved the short distance to Cell D03 in Unit 1 D Wing. Mr Anderson was confined in his cell at about 6.30 pm.[71] He was subsequently given a pillow and a meal. He was noted to be calm and appeared fine.[72]

[66] http://www.bom.gov.au/climate/current/month/WA/archive/201703.perth.shtml
[67] Hakea's highest priority emergency response requiring urgent backup and an immediate response
[68] Exhibit 1, Vol. 1, Tab 15, Statement - Joseph Cain
[69] Exhibit 1, Vol. 1, Tab 15, Statement - Joseph Cain
[70] Exhibit 1, Vol. 1, Tab 26, Incident Description Report - S Phor
[71] Exhibit 1, Vol. 1, Tab 15, Statement - Joseph Cain
[72] Exhibit 1, Vol. 1, Tab 15, Statement - Joseph Cain

56. I commend the prison officers involved in the negotiated resolution of Mr Anderson's standoff which did not require the use of force to extract him from the exercise yard.

Mr Anderson's conversation with a fellow prisoner

57. The prisoner who had the cell opposite to Mr Anderson's cell spoke to him at about 7.00 pm or 8.00 pm on 4 March 2017. Mr Anderson told this prisoner about an upsetting phone call he had with his mother and girlfriend. Mr Anderson said that his girlfriend was supposed to visit him the previous day but she was not able to as she was affected by drugs.[73] The prisoner was adamant that Mr Anderson did not use any words indicating he may self-harm, stating Mr Anderson was "*quite fine*". He further stated: [74]

> No he wasn't upset. He didn't show signs of upset. He wasn't crying or showing anger in his voice. He just told me what happened. It wasn't in an upset voice. That's why I didn't know it [Mr Anderson's death] was going to happen. You could see he was disappointed, but not upset.

The discovery of Mr Anderson

58. Prison Officer Lyndon Jones commenced his night shift at 6.00 pm on 4 March 2017. He was deployed to Unit 1.[75] One of his duties was to conduct visual checks on the cells in Unit 1.[76] During his cell checks commencing at about 10.00 pm, Mr Jones noted there were no issues. Mr Anderson was checked through the glass viewing window on his cell door at approximately 10.05 pm and he appeared to be asleep on his bed.[77]

59. Mr Jones conducted his next cell welfare check of Unit 1 D Wing after midnight on 5 March 2017. The following times are obtained from the digital 24-hour clock displayed on CCTV footage of the corridor outside the cells located in Unit 1 D Wing.[78] The actions of the prison staff are summarised from what is depicted on the CCTV footage, their statements

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[73] As Mr Anderson's punishment imposed on 2 March 2017 prevented him from having any visitors for five days, this was the reason why any scheduled visit by his girlfriend did not occur: Exhibit 1, Vol. 3, Tab 4, Visits History - Offender 5 November 2016 to 5 March 2017, p 2
[74] Exhibit 1, Vol. 1, Tab 46, Record of Audio Witness Statement of Prisoner with Detective Sgt Rob Witt on 5 March 2017
[75] Exhibit 1, Vol. 1, Tab 47, Statement - Lyndon Jones
[76] ts 26.08.20 (Jones), p 53
[77] Exhibit 1, Vol. 1, Tab 47, Statement - Lyndon Jones, p 2
[78] Exhibit 2, CCTV Footage of Corridor outside Mr Anderson's cell

contained in exhibit 1 and their evidence at the inquest.[79] The CCTV footage has no audio.

60. At 00:24:15,[80] Mr Jones commenced his welfare checks at Unit 1 D Wing. At 00:25:10, he looked through the viewing window of the door to Mr Anderson's cell and noted that he was not on the bed. Mr Jones then used his torch to scan the cell and noticed a sheet tied to the single tap located on the right-hand side of the cell's basin which was to the left of the cell door.

61. At 00:25:35, Mr Jones commenced to unlock the medical hatch of the cell door for a better view.[81] The medical hatch was opened at 00:25:44 and when Mr Jones looked through he could now see Mr Anderson sitting on the floor near the basin with the sheet tied around his neck. Mr Jones called out to Mr Anderson but there was no reply. He was not moving and Mr Jones could not tell if he was breathing.

62. At 00:25:53, Mr Jones used his radio to call a Code Red medical emergency, stating a H-Kit was required. This was the terminology used by prison officers to indicate that the medical emergency related to a prisoner who has hanged himself.

63. Mr Jones was not able to immediately open the cell door for two reasons. The first was that Hakea policy at the time meant only the officer-in-charge and his second-in-command held the keys to cell doors. Mr Jones held neither of those positions on this particular night. Secondly, it was the commonly held belief by prison officers at Hakea that, for safety reasons, policy required the attendance of at least three prison officers before a cell door could be unlocked.[82]

[79] Exhibit 1, Vol. 1, Tab 47, Statement- Lynton Jones; Exhibit 1, Vol. 3, Tab 28, Statement - William Cahoon; Exhibit 1, Vol. 2, Tab 17, Statement - Anthony Whittaker; Exhibit 1, Vol. 2, Tab 19, Statement - Stephen Komar; Exhibit 1, Vol.1, Tab 55, Statement - Mary Stuart; ts. 26.08.20 (Jones), pp 51-100; ts. 26-27.08.20 (Cahoon), pp 101-126; ts. 27.08.20 (Whittaker), pp 152-220; ts. 27-28.08.20 (Komar), pp 221-286

[80] As this is a 24-hour digital clock, times from 12.00 am to 12.59 am begin as 00:

[81] The medical hatch (also known as a Judas hatch) is larger than the viewing window and has no glass

[82] This belief, however, was inconsistent with Local Order 42 - Night Recovery Team Duties which I have addressed later in this finding

64. After calling the Code Red medical emergency, Mr Jones continued to look through the medical hatch of Mr Anderson's cell door and attempted to get a response from Mr Anderson.

65. A Code Red medical emergency requires all available prison officers to attend the location of the call immediately and without delay. As he waited for other prison officers to attend, Mr Jones used his radio at least once.

66. At 00:27:25, Senior Prison Officer Anthony Whittaker, the officer-in-charge for this night shift, entered the corridor and reached Mr Jones at 00:27:33. He did not run along the corridor. At 00:27:38, Mr Whittaker looked through the medical hatch of Mr Anderson's cell door and then left Mr Jones by himself as he walked back up the corridor; disappearing from view at 00:27:58.

67. Mr Jones remained at the cell door whilst continuing to look through the medical hatch. Mr Anderson had remained unresponsive throughout this time.

68. At 00:29:03, Prison Officer William Cahoon walked down the corridor and joined Mr Jones outside Mr Anderson's cell door at 00:29:11. At that precise moment the lights in the corridor were turned on.

69. At 00:29:16, Mr Jones began running up the corridor and was passed by Mr Whittaker who was running back towards Mr Anderson's cell. Mr Jones continued to run away from Mr Anderson's cell, disappearing from the CCTV's view.

70. Mr Whittaker got to Mr Anderson's cell door at 00:29:27. He and Mr Cahoon were joined by Mr Jones just as the door was opened by Mr Whittaker at 00:29:33. By then 3 minutes 40 seconds had elapsed since Mr Jones called the Code Red emergency on his radio.

71. Mr Jones and Mr Whittaker entered Mr Anderson's cell whilst Mr Cahoon remained at the doorway. Mr Jones used his Hoffman knife[83] to cut the ligature around Mr Anderson's neck. Mr Anderson was placed on the cell's floor, but remained unresponsive and Mr Whittaker could not find a pulse. Due to the confines of the cell, Mr Anderson was removed from the

[83] A knife specifically designed for the safe and quick cutting of fabric and fibrous ligatures

cell at 00:30:33 and taken the short distance to the end of the corridor where there was more room.

72. At 00:30:53, Mr Whittaker placed Mr Anderson in the recovery position on the floor of the corridor.

73. At 00:31:02, prison nurses Stephen Komar and Mary Stuart attended where Mr Anderson had been placed.

74. At 00:31:50, Ms Stuart commenced her examination of Mr Anderson. As she had a sore knee, she did not kneel down to do that. By this stage there were six prison officers in attendance.

75. At 00:33:03, Mr Komar began his examinations using a stethoscope. Although he detected no heartbeat, he found that Mr Anderson was warm to the touch and that he still had contours to his veins which led Mr Komar to believe that the hanging had only recently happened.

76. At 00:33:45, Mr Komar directed the prison officers to reposition Mr Anderson onto his back. At 00:34:33, Mr Komar placed defibrillator pads on Mr Anderson's chest. After the defibrillator machine registered no shockable rhythm, he commenced CPR at 00:35:00. This was 9 minutes 50 seconds after Mr Jones opened the viewing window to Mr Anderson's cell door and 4 minutes 10 seconds after Mr Anderson had been placed in the more accessible area of the corridor floor. No CPR was done by anyone prior to Mr Komar.

77. By this stage, a triple zero call had been made for an ambulance to attend. St John Ambulance Patient Care Records indicate that this call was received at 12:28:08 am on 5 March 2017.[84]

78. The attending prison officers and Mr Komar provided CPR in rotation until ambulance officers took over resuscitation efforts at 00:57:57, having attended the scene at 00:57:09. Prior to the ambulance officers

[84] Exhibit 1, Vol. 1, Tab 53, St John Ambulance Patient Care Record. That time is not consistent with the time displayed on the CCTV camera footage. According to the time on the CCTV camera, Mr Anderson's cell door was not opened until 12:29:33 am and the evidence establishes that the triple zero call was not made until after the prison nurses had arrived to treat Mr Anderson. An examination of the times when radio transmissions were made by prison officers during the Code Red emergency indicate that the time displayed on the CCTV camera footage was approximately seven minutes fast

attending, the defibrillator machine had continued to register no shockable rhythm and CPR had been maintained.

79. At 00:59:22, ambulance officers fitted a LUCAS chest compression machine to Mr Anderson and commenced compressions. At 01:01:00, officers from a second ambulance also attended.

80. Ambulance officers were successful in establishing a pulse and Mr Anderson was placed on a stretcher at 01:09:46 and conveyed to an ambulance.

81. At 1.29 am on 5 March 2017, the ambulance arrived at Fiona Stanley Hospital's emergency department.[85]

Treatment at Fiona Stanley Hospital (FSH) [86]

82. Upon his arrival at the emergency department of FSH, Mr Anderson was in cardiac arrest and was receiving intensive resuscitation support. Blood tests reflected Mr Anderson's prolonged time without circulation and a computerised tomography (CT) scan of his brain showed swelling and features of severely reduced blood flow to the brain tissue. Mr Anderson was transferred to the intensive care unit (ICU) of FSH later that morning.

83. Brain stem testing, neurology reviews and electroencephalograph (EEG) testing occurred over the following days.

84. At 5.16 pm on 10 March 2017, a cerebral perfusion scan confirmed brain death. FSH medical staff informed Mr Anderson's family that in those circumstances it was appropriate to cease artificial respiration. However, Mr Anderson's family sought additional time to seek legal advice regarding their options. Artificial respiration was continued to allow for that to occur and Mr Anderson continued to be managed in the ICU.

85. Despite ongoing supportive care, Mr Anderson continued to deteriorate and he developed kidney failure. At about 6.40 am on 23 March 2017, Mr Anderson became bradycardic (a very slow pulse). Following this, there was an electrocardiograph (ECG) change detected (which occurs when a person has a heart attack). Mr Anderson then had an asystolic

[85] Exhibit 1, Vol. 1, Tab 53, St John Ambulance Patient Care Record
[86] Exhibit 1, Vol. 1, Tabs 12A and 12B, report of Dr Simon Towler and FSH Discharge Summary

arrest (cardiac flat line). This is the most serious form of cardiac arrest as all electrical activity in the heart ceases; resulting in no blood being pumped through the body.

86. After hospital staff spoke with Mr Anderson's parents, his ventilator was turned off at approximately 7.00 am. A doctor certified his life as extinct at that time.[87]

ISSUES RAISED BY THE EVIDENCE

Disciplinary hearing before the Justice of the Peace on 2 March 2017

87. As already noted, prison health staff were not notified that Mr Anderson received five days of confinement in a punishment cell by the Justice of the Peace on 2 March 2017.

88. I agree with Dr Fitzclarence's assessment that this was a *"significant"* event *"which unless notified by custodial staff, prison health staff would not have been aware of."*[88]

89. This matter was raised at a Lessons Learned Workshop on 12 April 2017 at Hakea (Workshop) which was convened as a result of Mr Anderson's death. The Workshop found that a prisoner's level of vulnerability and potential risk to themselves needed to be considered following a regression in their regime or upon receipt of adverse findings from visiting Justices of the Peace. It was decided that the Deputy Superintendent at Hakea would commission a review into the supervision regime associated with welfare checks of prisoners serving separate confinements.[89]

90. That review has led to changes to the relevant Local Order which I have addressed later in this finding.

Attendance by prison health staff in response to the exercise yard incident

91. A prison nurse was asked to attend Unit 1 D Wing at approximately 4.20 pm on 4 March 2017 following the report of the small fire that had been lit by Mr Anderson.[90] At the time this nurse attended, Mr Anderson

[87] Exhibit 1, Vol. 1, Tab 7, FSH - Death in Hospital Form
[88] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 5
[89] Exhibit 1, Vol. 2, Tab C, Death in Custody Report
[90] Exhibit 5, Incident Description Report - Nurse Scanlan

was still in the exercise yard refusing to leave voluntarily and behaving aggressively. Unsurprisingly in those circumstances, the nurse was not requested to make any assessment of Mr Anderson's mental well-being. Her attendance was requested in case he had to be forcibly removed from the exercise yard.

92. There is no record of any request for prison health staff to assess Mr Anderson after he was placed in his cell at about 6.30 pm and prior to the Code Red emergency that was called when he was found unresponsive in his cell at about 12.20 am on 5 March 2017. Although a nurse did attend Mr Anderson's cell door that evening at about 9.00 pm,[91] it was only for the purpose of giving him his epilepsy medication. That did not eventuate as he was asleep at the time.[92]

93. I accept that Mr Anderson was behaving in a calm manner when he was secured in his cell at 6.30 pm. However, this was in stark contrast to his behaviour in the exercise yard that afternoon. It is unfortunate that a suitably qualified prison mental health staff member (or if none was available, a prison nurse) was not asked to speak to Mr Anderson and assess his mental state after he had been secured in his cell. Again, I agree with Dr Fitzclarence's assessment that this was another significant event for Mr Anderson.[93]

94. Mr Anderson's conduct in the exercise yard during the afternoon of 4 March 2017 was a serious behaviour management issue. It was undoubtedly a regression in his regime. Nevertheless, he was not considered for ARMS or the less intensive SAMS which would have seen him closely monitored.

95. I am of the view that where a prisoner has engaged in disruptive behaviour of the magnitude displayed by Mr Anderson during the afternoon of 4 March 2017, an assessment of their mental health by a suitably qualified prison mental health staff member should be undertaken as soon as is practicable. I have addressed this matter later in this finding.

[91] Exhibit 1, Vol. 2, Tab 12, Reports and Occurrences 4 March 2017, p 2
[92] Exhibit 1, Vol. 2, Tab 19, Statement - Stephen Komar, pp 1-2
[93] Exhibit 1, Vol. 1, Tab 54, Report of Dr Cherelle Fitzclarence, p 5

The delay in opening Mr Anderson's cell door

96. As stated above, Mr Anderson's cell door was not unlocked until 3 minutes 40 seconds had elapsed from when Mr Jones made the Code Red emergency on his radio. It was only unlocked once three prison officers were present. For the following reasons, I find this delay was unreasonable.

97. The unlocking of a cell door due to a prisoner requiring medical attention at night-time was governed at the relevant time by Local Order 42 - Night Recovery Team Duties (Local Order 42).[94] Section 3.16 was titled "*Medical Unlocks*" and the relevant provisions regarding this matter were as follows:

> 3.16.1
> In the event of a prisoner requiring medical attention during the hours of lockup, the attending officer/s will notify the Senior Officer Recovery or Officer-in-Charge who will contact a nurse, explaining the situation and request their assistance/attendance.
>
> 3.16.2
> The Officer-in-Charge will ensure that at least three recovery staff attends the relevant unit with the nurse in order to address to [sic] the medical alert.
>
> 3.16.3
> If a cell is required to be unlocked during a lockup period, then either the Officer-in-Charge or 2nd Night Senior Officer must be present in order for this to occur.

98. Section 3.15 was titled "*All Unlocks During Lock Up Hours*" and section 3.15.1 stated:

> Other than in extreme life-threatening emergency situations, a cell occupied by a prisoner during the lockup period may only be unlocked with the approval of the Officer-in-Charge.

99. Clearly Mr Anderson was "*a prisoner requiring medical attention during the hours of lockup*." It was also the case that once Mr Jones ascertained

[94] Exhibit 8A, Local Order 42 - Night Recovery Team Duties (revision no. 4.1). This Local Order was superseded on 18 December 2018.

Mr Anderson was unresponsive with a ligature tied around his neck it became an "*extreme life-threatening emergency situation."*

100. A review of the CCTV footage of the manner in which Mr Whittaker and Mr Cahoon attended the Code Red emergency, without context, would be a matter of concern. Both can be seen only walking at normal pace along the corridor to Mr Anderson's cell door. In his evidence, Mr Cahoon explained as follows:[95]

> As much as you get there as quick as possible, you also have to be fit to perform. So if you are running like a bat out of hell, you will arrive there being a waste of space to everyone because we're too tired to do anything.

101. That evidence is entirely consistent with a boxed and shaded part in section 3.2.1 of Local Order 42 which read:[96]

> ***Note:*** Response to Code Red emergencies should not be at a pace that will reduce the responding staff member's ability to intervene immediately upon arrival.

102. I therefore make no criticism of the manner in which Mr Cahoon and Mr Whittaker first attended the Code Red emergency or the time that it took them to respond.

103. However, I find that the provisions of Local Order 42 at the relevant time did not require the presence of three prison officers before Mr Anderson's cell door could be unlocked.

104. Section 3.16.3 only required the presence of the officer-in-charge or the second night senior officer for a cell to be unlocked for medical reasons during the lock-up period. It did not specify the number of officers that are required to be present. Section 3.16.2 is the only section that refers to the requirement of "*at least three recovery staff.*" However, that section is only concerned with the need to address "*the medical alert.*"

105. In all the circumstances, I find that Mr Whittaker should have unlocked Mr Anderson's cell door shortly after he met up with Mr Jones outside the cell for the first time at 00:27:33. Instead, he left Mr Jones and walked

[95] ts 26.08.20 (Cahoon), p 112
[96] Exhibit 8A, Local Order 42 - Night Recovery Team Duties (revision no. 4.1), p 3

back up the corridor and did not return to the cell door until nearly two minutes later. His explanation for that was he went to the front of Unit 1 to see where the third officer was coming from as policy dictated he needed a minimum of three officers to conduct an unlock; adding that he may have also done it "*to enforce the urgency*".[97] However, he was not able to offer an explanation as to why he did not simply make a call over his radio to find that out.[98]

106. I find that the relevant provisions of Local Order 42 would have been complied with if Mr Whittaker had immediately unlocked the cell door in the presence of Mr Jones. This could have happened less than two minutes after the Code Red emergency.

107. I also find that two prison officers would have been able to enter Mr Anderson's cell without a concern for their safety. Mr Anderson was in the cell by himself and there was no prospect the two prison officers would be confronted by the same or higher number of prisoners in the unlikely event that Mr Anderson had fabricated what he had done.

108. Each of the four prison officers who gave evidence at the inquest stated it was their belief that Hakea policy at the time required the presence of three officers before a cell door was opened during a lock-up. By email dated 22 September 2020 to Counsel Assisting, counsel for the Department (Mr Bennett), advised that the relevant provisions of section 3.16 of Local Order 42:[99]

> … have been understood by staff at Hakea (including senior staff) as a requirement that before a cell is opened on night-shift there must be at least three officers present with at least one of those three officers being the OIC or 2nd Night Senior Officer. This understanding was influenced by a previous serious assault on an officer by a prisoner in 2010 which resulted in a significant Union campaign around officer safety.

109. The provisions of Local Order 49 - Night Shift Unlock and Body Check Procedures (Local Order 49) that existed at the time provides a further explanation as to why prison officers believed three officers needed to

[97] ts 27.08.20 (Whittaker), p 169
[98] ts 27.08.20 (Whittaker), p 169
[99] Email, J Bennett to L Housiaux, 22 September 2020, p 2

attend before a cell could be unlocked. Section 5.0 of Local Order 49 is titled "*Medical Unlocks".* Section 5.2 stated:[100]

> The Senior Officer Recovery will ensure that at least three recovery staff attend the relevant Unit with the Nurse in order to tend to the medical alert. Cells will not be opened until the Recovery Team are in attendance. (underlying added)

110. In those circumstances, I do not make a finding adverse to Mr Whittaker regarding his actions which caused the delay in the unlocking of Mr Anderson's cell door. He held a commonly shared, albeit mistaken, belief that Local Order 42 required the presence of three officers. However, as rightly conceded by Mr Bennett in his closing submissions at the inquest, the delay in opening the cell door was unreasonable.[101]

111. Since Mr Anderson's death, Hakea has introduced important changes in the response to a Code Red medical emergency during a night shift. I have addressed these changes later in my finding.

The delay in commencing CPR on Mr Anderson

112. As stated above, CPR on Mr Anderson was only commenced 9 minutes 50 seconds after Mr Jones opened the viewing window to Mr Anderson's cell door and 4 minutes 10 seconds after he had been placed in the more accessible area of the corridor floor. For the following reasons, I find the delay in commencing CPR was unreasonable.

113. It was universally accepted by the witnesses called at the inquest that CPR should have been carried out sooner. Mr Jones agreed, in hindsight, that it should have started earlier; although he could not explain the delay in commencing CPR.[102] Mr Cahoon conceded, again in hindsight, that CPR should have been administered earlier than it was.[103] Although Mr Whittaker accepted there was no indication Mr Anderson had a pulse or was breathing when found in his cell and that he was moved from his cell to the corridor so that CPR could be performed,[104] he did not know

[100] Exhibit 1, Vol. 2, Tab 18, Local Order 49 - Night Shift Unlock and Body Check Procedure (revision no. 2.0), p 2
[101] ts 28.08.20 (closing submissions by Mr Bennett), p 384
[102] ts 26.08.20 (Jones), pp 85-86
[103] ts 27.08.20 (Cahoon), p 121
[104] ts 27.08.20 (Whittaker), p 182

why CPR had not commenced once Mr Anderson was lying in the corridor.[105] That was despite agreeing his first-aid training was that CPR should commence immediately if a person is not responsive, there are no signs of breathing and a pulse cannot be found.[106]

114. Although I accept that the nursing staff were to assume control of Mr Anderson's treatment after they arrived,[107] in view of Mr Whittaker's seniority and his training, I find that he ought to have ensured CPR had started by the time the two nurses had begun their examination of Mr Anderson. One possible explanation explored with Mr Whittaker as to why he did not make sure CPR had commenced sooner was that he had formed the view that Mr Anderson had already died. However, he maintained this thought "*never entered my mind*."[108]

115. As already outlined, Mr Komar arrived with Ms Stuart at 00:31:02. Nevertheless, CPR was not commenced by Mr Komar until 00:35:00 (nearly four minutes later). I accept Mr Komar's evidence that he was required to make his own assessments prior to determining the appropriate treatment. However, given that his initial observations led him to believe Mr Anderson's hanging "*was a recent event*",[109] I find that Mr Komar should have commenced CPR earlier than he did.

116. Mr Komar gave evidence that he did not detect a respiration (which was the first thing he was looking for) and that he could not detect a heartbeat using his stethoscope.[110] He admitted that those two observations were strong indicators that CPR would be required as soon as possible.[111] However, Mr Komar proceeded to use the defibrillator machine which detected no shockable rhythm. It was only then that CPR compressions were commenced; at a point just under two minutes after no heartbeat had

[105] ts 27.08.20 (Whittaker), p 183
[106] ts 27.08.20 (Whittaker), p 182. It should be noted that by March 2017 training in CPR did not specify that a pulse needs to be checked: "*Palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation*" Exhibit 1, Vol. 2, Tab 16, ANZCOR Guideline 6 - Compressions January 2016, p 2
[107] In accordance with the Department's procedure as set out in PM 19 Medical Emergency and Resuscitation of an Adult Patient (version 6): Exhibit 1, Vol 3, Tab 29
[108] ts 27.08.20 (Whittaker), p 185
[109] ts 27.08.20 (Komar), p 236
[110] ts 27.08.20 (Komar), p 246
[111] ts 27.08.20 (Komar), p 246; the lack of a heartbeat also discounted the contention by prison officers that they had located faint pulses on Mr Anderson's arm: Exhibit 1, Vol. 1, Tab 32, Incident Description Report - J Brown; Exhibit 1, Vol. 1, Tab 34, Incident Description Report - B Charis

been detected. Mr Komar admitted that in hindsight, in similar circumstances, he would have instructed somebody to start compressions once he had ascertained there was no detectable heartbeat.[112]

117. Associate Professor Paul Bailey, the Medical Director of St. John Ambulance Western Australia, gave expert evidence regarding CPR. He stated that it was not necessary to wait for a defibrillator to confirm that CPR should commence.[113] Associate Professor Bailey also gave evidence that chest compressions should immediately commence whenever a person is non-responsive; whether it is unclear they are breathing and/or whether it is unclear if there is a heartbeat.[114]

118. Although Mr Komar admitted, with hindsight, he should have started CPR after detecting no heartbeat, counsel for Mr Komar (Ms Burke) contended during her closing submissions that Mr Komar had "*resorted to his training, which is get the defibrillator pads on and run that analysis and then commence the CPR.*"[115] After making that submission, Ms Burke was asked to provide Counsel Assisting the material presented at Mr Komar's CPR training session immediately prior to Mr Anderson's death that would establish this contention.

119. By email dated 17 September 2020 to Counsel Assisting, Ms Burke advised that Mr Komar had instructed her that the annual training sessions at Healthcare Australia completed before Mr Anderson's death did "*not provide any documents or lecture notes as part of the training, the training is more an informal chat or hands on arrangement."* Instead, Ms Burke provided the 2019 edition of the manual for the defibrillator which was used on Mr Anderson which was "*almost identical"* to the edition of the manual available at Hakea in March 2017.[116]

120. Notwithstanding Mr Komar's instructions to his counsel, Mr Bennett not only provided confirmation that Mr Komar had attended a Healthcare Basic Life Support and Manual Handling training on 14 September

[112] ts 27.08.20 (Komar), pp 261-261
[113] Exhibit 1, Vol. 3, Tab 31, Letter from Associate Professor Paul Bailey dated 25 August 2020; ts 28.08.20 (Bailey), p 289
[114] ts 28.08.20 (Bailey), p 290
[115] ts 28.08.20 (closing submissions by Ms Burke), p 371
[116] Email, B Burke to L Housiaux, 17 September 2020, p 1

2016[117] but also a copy of the material presented to participants of this training session titled "*Basic Life Support*".[118]

121. This material cites the seven steps of resuscitation (referred to by the acronym DRSABCD). Compressions are listed to commence before attaching a defibrillator.[119] The section dealing with defibrillation states: "*If available, attach an Automated External Defibrillator (AED) as soon as possible and follow the prompts.*"[120] This section also states "*It is recommended an AED be attached if available during commencement of CPR."* Immediately under that sentence the following paragraph appears in bold type:[121]

> It is universally recognised that early defibrillation significantly improves survival rates. Survival can be significantly improved even 6-10 minutes after arrest, as long as effective CPR is [sic] been started early in the arrest. It is thought that good CPR may even increase the likelihood of defibrillation success.

122. However the document then states:[122] "*An AED should only be used if the victim is found to be* ***unresponsive and not breathing. CPR should be in progress while awaiting the arrival of an AED****."* (original emphasis)

123. I accept there are two inconsistent statements in this document, both of which could be said had application to the circumstances of this matter. One is the recommendation that the defibrillator be attached if available during commencement of CPR and the other, which states CPR should be in progress while awaiting the arrival of the defibrillator. In those circumstances, my finding that Mr Komar should have commenced CPR earlier than when he did should not be regarded as a finding that is adverse in nature. I also accept Mr Komar's concession that CPR should have commenced earlier was made with the considerable advantage of hindsight.

124. The Workshop noted the time delay between Mr Anderson's placement in the recovery position in the corridor and the start of CPR compressions by

[117] Exhibit 8D, Email, I Newall (Manager at Healthcare Australia) to E Molloy, 21 September 2020
[118] Exhibit 8E, Basic Life Support Training Booklet version 8, June 2015
[119] Exhibit 8E, Basic Life Support Training Booklet version 8, June 2015, p 5
[120] Exhibit 8E, Basic Life Support Training Booklet version 8, June 2015, p 22
[121] Exhibit 8E, Basic Life Support Training Booklet version 8, June 2015, p 22
[122] Exhibit 8E, Basic Life Support Training Booklet version 8, June 2015, p 23

nursing staff.[123] The improvement action determined was to issue a Superintendent's Notice to Staff dated 15 August 2017 (Superintendent's Notice) stressing the importance of commencing CPR immediately if the person is unresponsive and not breathing. It also recommended not delaying commencement of CPR by seeking a pulse.[124] This action was commendable.

The delay in calling for an ambulance

125. The evidence before me established that the triple zero call for the ambulance did not occur until after the two nurses had attended the corridor of Unit 1 D Wing. Acting Senior Officer Michael Reeves was one of the prison officers who attended and completed an Incident Description Report (Report) following the matter on 5 March 2017. In the Report Mr Reeves stated the following: [125]

> I asked Nurse Komar if we needed an Ambulance now, he stated "let me perform my check first". Nurse Komar performed various medical examinations and proceeded to use the Defibrillator. I asked Nurse Komar after he had completed his test with the Defibrillator if he required an Ambulance, Nurse Komar stated "yes". I contacted 000 and stated we have an unresponsive, no pulse, not breathing prisoner to the operator and our location.

126. If Mr Reeves' sequence of events is correct, based on the CCTV's 24 hour digital clock, he would have made the triple zero call from the Unit 1 control room at or about 00:35:00.[126]

127. According to Mr Komar's written statement, when he was asked by a prison officer if an ambulance was required he indicated that it was. His statement says that was before he commenced his own examinations using his stethoscope.[127] As Mr Komar commenced his examination of Mr Anderson with his stethoscope at 00:33:03, based on this account the triple zero call would have been made at or about that time.

[123] Exhibit 1, Vol. 2, Tab C, Death in Custody Report, p 18
[124] Exhibit 1, Vol. 3, Tab 30, Superintendent's Notice to Staff (SN 9 of 2017) dated 15 August 2017
[125] Exhibit 1, Vol. 1, Tab 40, Incident Description Report - M Reeves; see also Exhibit 1, Vol. 1, Tab 57, Statement - M Reeves, pp 3-4
[126] As this clock was approximately seven minutes fast, the actual time would have been about 12.28 am
[127] Exhibit 1, Vol. 2, Tab 19, Statement - Stephen Komar, p 3

128. When the above passage from the Report was read to Mr Komar at the inquest, he stated he did not know whether Mr Reeves' version was correct and that he couldn't remember the exact sequence.[128]

129. The delay before an ambulance was summonsed is unfortunate. On either of the above versions, at least seven minutes had expired since the Code Red emergency. Mr Whittaker's explanation for not arranging that an ambulance be called was because he was waiting for a medic who was far more qualified than he was to medically assess Mr Anderson.[129] When Mr Whittaker was advised by Counsel Assisting that it may have been four minutes after the nurses arrived that an ambulance was called, Mr Whittaker responded:[130]

> There's a lot going on, sir, to be honest in an incident like that. A lot of things going through my mind. A lot of thoughts going through my mind.

130. It need not be the sole responsibility of attending prison nurses to determine if an ambulance is required. That responsibility extends to the first responding prison officers in an emergency to call an ambulance if the circumstances require it. The Superintendent's Notice recognised that. It stated, amongst other things, "*The first responding Officer(s) in all emergencies involving an unconscious person who is not breathing shall call an ambulance."*[131]

The failure to properly secure Mr Anderson's cell

131. CCTV footage showed Mr Cahoon and Mr Whittaker entering Mr Anderson's cell at 00:33:44 and 00:33:49 respectively. They both exited the cell at 00:33:54 with Mr Cahoon then closing the door, after being told by Mr Whittaker to do so, at 00:34:09.

132. Mr Jones then entered the cell at 00:36:09 and is followed by Ms Stuart at 00:36:13. I note this is after CPR has commenced on Mr Anderson which begs the question why one of the two attending nurses would leave at that critical point in time. Mr Jones' explanation was that Ms Stuart had asked

[128] ts 27.08.20 (Komar), p 239
[129] ts 27.08.20 (Whittaker), p 185
[130] ts 27.08.20 (Whittaker), p 185
[131] Exhibit 1, Vol. 3, Tab 30, Superintendent's Notice to Staff (SN 9 of 2017) dated 15 August 2017, p 1

to see what position Mr Anderson was in when he was found. He explained that he didn't ask why she wanted to see that and he simply showed her.[132] This was similar to the explanation given by Ms Stuart; that she only wanted to see where it had happened and what had been used, even though she knew about scene preservation.[133] They both exited the cell at 00:36:54. Mr Whittaker is seen locking the cell door at 00:38:20.

133. Mr Richard Mudford, Senior Review Officer with the Department, agreed these entries into the cell contravened basic principles of crime scene preservation and, in particular, the Department's procedures for the preservation of evidence in which a critical incident had taken place.[134] The cell was not sealed as a crime scene until 2.35 am.[135]

134. I agree with Mr Mudford's assessment and find that the cell ought to have been locked and sealed as a crime scene much earlier than it was. The Workshop identified that "*Basic principles of crime scene management, specifically preservation and non-contamination must be followed by all staff."*[136]

135. The Superintendent's Notice addressed this issue. It stated that where a serious incident has occurred in a cell, the cell will be declared a crime scene. And where practicable to do so, the cell's door is to be secured and the discovering officer shall not permit access to the area unless authorised to do so by the designated Superintendent.[137]

136. I find that that was an appropriate course of action to take and it is hoped that such a basic breach will not be committed in the future.

Mr Anderson's cell placement on 4 March 2017

137. Safe cells in Hakea are those that are totally ligature-free and have CCTV cameras within them.[138] Presently, Hakea has a total of six safe cells: two in Unit One, two in Unit Six and two in the CCU.[139] Mr Anderson was not placed in any one of those cells on the night of 4 March 2017. The cell he

[132] ts 26.08.20 (Jones), p 87
[133] Exhibit 1, Vol. 1, Tab 55, Statement - Mary Stuart, pp 4-5
[134] Exhibit 1, Vol. 2, Tab C, Death in Custody Report, p 12
[135] Exhibit 1, Vol. 2, Tab C, Death in Custody Report, p 12
[136] Exhibit 1, Vol. 2, Tab 26, Department of Corrective Services - Summary of Lessons Learned, p 1
[137] Exhibit 1, Vol. 3, Tab 30, Superintendent's Notice to Staff (SN 9 of 2017) dated 15 August 2017, p 4
[138] ts 28.08.20 (Devereux), p 335
[139] ts 28.08.20 (Devereux), p 334

was placed in had not, at the time, been modified to reduce or eliminate potential ligature points.

138. Mr Devereux explained in his evidence why the decision was made to not place Mr Anderson on ARMS and therefore into a safe cell after he was removed from the exercise yard on 4 March 2017. He noted that Mr Anderson voluntarily returned to his cell and by that stage there were no arguments. He also said the conversation was civil and there was no animosity between the parties.[140] As Mr Devereux described it, he *"didn't get any red flags*" to suggest what was to happen a matter of hours later.[141]

139. In contrast, Mr Devereux would have placed Mr Anderson on high ARMS and into a safe cell and have nursing staff speak to him if Mr Anderson had said to him or to another prison officer that he was feeling down or depressed.[142]

140. In all the circumstances that existed at the time and taking due care not to apply hindsight bias, I make no criticism of the decision not to place Mr Anderson on ARMS on the night of 4 March 2017. In drawing that conclusion, I also take into account Mr Devereux's evidence that as safe cells are not particularly comfortable and are sparsely fitted, he did not want Mr Anderson or the other prisoner involved thinking their placement into a safe cell environment was somehow retribution for their earlier poor behaviour in the exercise yards.[143]

The number of safe cells at Hakea

141. In my view, the number of safe cells at Hakea is inadequate.

142. As Mr Devereux testified, "*six does not equate into a population of 1,000 plus prisoners"*[144] and I also accept his evidence that Hakea has "*a volatile cohort of people with a high risk"*.[145] In those circumstances the community would have an expectation that there be a sufficient number of cells to accommodate those prisoners who are at high risk of self-harm. I am of the view that a minimum of 12 safe cells that are fully ligature

[140] ts 28.08.20 (Devereux), p 325
[141] ts 28.08.20 (Devereux), p 326
[142] ts 28.08.20 (Devereux), p 328
[143] ts 28.08.20 (Devereux), p 330
[144] ts 28.08.20 (Devereux), p 334
[145] ts 28.08.20 (Devereux), p 335

minimised and with CCTV surveillance would meet those community expectations.

CAUSE AND MANNER OF DEATH [146]

143. Dr Kueppers, a forensic pathologist, conducted a post mortem examination on Mr Anderson's body on 27 March 2017.

144. That examination noted there was scarring focal bruising under the skin of Mr Anderson's left elbow crease and grazing that was healing present on both knees. No other injuries were apparent. Mr Anderson's lungs were congested and fluid laden and showed possible infective changes. Fluid was present in his chest and abdominal cavities.

145. Microscopic examination of tissue from Mr Anderson's major organs showed features of a recent global ischaemic insult to his heart muscle, which was in keeping with the clinical history. His lungs showed accumulation of fluid (pulmonary oedema) and some acute infected changes (pneumonia). Minor scarring and chronic inflammation was noted in Mr Anderson's liver.

146. A specialist neuropathological examination of Mr Anderson's brain showed cerebral swelling with transtentorial herniation (a life-threatening condition) when examined by the naked eye. Microscopic features were in keeping with the history of permanent global cerebral ischaemia (when blood flow to the brain is altered or drastically reduced), in keeping with the clinical history.

147. Toxicological analysis detected medications in Mr Anderson's system consistent with his hospital care. Alcohol and common illicit drugs were not detected.

148. At the conclusion of her investigations, Dr Kueppers expressed the opinion that the cause of death was hypoxic brain injury and bronchopneumonia complicating ligature compression of the neck.

149. I accept and adopt the conclusion expressed by Dr Kueppers as to the cause of Mr Anderson's death.

[146] Exhibit 1, Vol. 1, Tab 8C, Supplementary Post Mortem Report

150. I find Mr Anderson's death occurred by way of suicide when he tied a bedsheet to the basin tap in his cell and then used it as a ligature around his neck.

151. I am aware that prior to the inquest, members of Mr Anderson's family expressed a view that he had not committed suicide and that his death was suspicious. With respect to that I note the following.

152. The CCTV footage of the corridor outside Mr Anderson's cell did not show anyone entering his cell after he was placed in it at approximately 6.30 pm on 4 March 2017. Mr Anderson remained alone in his cell until his cell door was unlocked and prison officers attended to him following the Code Red emergency.

153. Nevertheless, at my request, Counsel Assisting sought a report from Dr Kueppers that addressed homicidal hangings.[147]

154. Dr Kueppers noted that homicidal hangings based on available scientific literature and clinical experience are very rare.[148] Dr Kueppers consulted with her fellow forensic pathologists and they are only aware of one example of homicidal hanging in Western Australia in the past 30 years. That case involved a small child. Dr Kueppers added that in a case of homicidal hanging it would be expected to see defensive-type injuries, suggesting a struggle prior to death. Dr Kueppers noted that no suspicious injuries were observed on Mr Anderson's body.

155. Dr Kueppers also pointed out that she did not find any evidence during her post mortem examination to support a finding that Mr Anderson's hanging was staged by a third party to cover up a homicide. She noted that no other cause of death was apparent in Mr Anderson, meaning that there was no obvious alternative cause of death caused by a homicide that was covered up by a staged hanging. Nor was there any indication that Mr Anderson had been rendered unconscious by another means prior to the hanging episode.

[147] Exhibit 7, Letter to Counsel Assisting from Dr Victoria Kueppers dated 1 September 2020
[148] Dr Kueppers defined homicidal hanging as where another person hangs the deceased person to achieve death

QUALITY OF SUPERVISION, TREATMENT AND CARE

156. With the exception of what happened following the Code Red emergency on 5 March 2017 as outlined below, I am satisfied that Mr Anderson's physical health needs were adequately addressed at all times he was imprisoned.

157. I am also satisfied his mental health needs were adequately addressed. In so finding, I note that Mr Anderson was not diagnosed with any psychiatric disorders. He only disclosed one incident of attempting to take his life, which was two months before his most recent incarceration. His EcHO records disclosed no reporting by Mr Anderson to prison health staff that he had suicidal thoughts or thoughts of self-harming. There is no evidence that he had confided in another prisoner of such thoughts. Mr Anderson's last known conversation with a fellow prisoner just hours before he was discovered in an unresponsive state gave no indication of any intention to take his own life. Similarly, he was compliant with prison officers in the early evening of 4 March 2017 once he was advised efforts would be made to transfer him to Casuarina the following week.

158. The circumstances outlined above are atypical of many suicides in a custodial setting that are investigated by this court. To use the phrase cited by Mr Devereux in his evidence, there was a conspicuous absence of the "*red flags*" that are often prevalent in a prisoner's suicide.

159. However, I am not satisfied in Mr Anderson's case that the unlocking of his cell door and the commencement of CPR occurred in a timely manner. It was with some disquiet that I noted the following paragraph from the finding in an inquest from 2010 regarding the death of a prisoner in June 2008:[149]

> I am concerned the issue of the appropriateness of conducting CPR as soon as possible has arisen at this time. It is many years since I have felt the need to comment on the adequate resuscitation of a collapsed prisoner. Usually prison officers implement appropriate resuscitation techniques very quickly as a result of their training.

[149] Inquest into the death of Dennis Njamme (Ref No: 26/10) delivered 17 March 2011, p 44

160. My disquiet is because the conclusion to draw from this passage is that a delay in conducting CPR by prison officers is a very uncommon event. Unfortunately, in 2017 it occurred again with respect to Mr Anderson.

161. All prison officers have training in CPR which is maintained annually. It is no excuse for prison officers who are first responders to a Code Red medical emergency involving a non-responsive prisoner to wait for prison medical staff to arrive to make the decision to commence CPR.

162. In his letter dated 25 August 2020, Associate Professor Bailey stated that "*hanging is an infrequent but devastating cause of cardiac arrest with outcomes worse than cardiac arrest of presumed cardiac aetiology."*[150] He noted that of the 1,018 persons in Western Australia who have been found after "*unwitnessed"* hangings and in cardiac arrest between 2015 and 2019, 331 had bystander CPR. Of these patients, 79 had return of spontaneous circulation (ROSC) at hospital arrival, similar to Mr Anderson. However, only four of those patients survived to hospital discharge, and their quality of survival was not known.[151] Notwithstanding these low numbers, every effort must always be made to resuscitate, without unnecessary delay, prisoners with cardiac arrest secondary to hanging.

163. Although I accept the grave consequences of oxygen deprivation to the brain are measured in minutes,[152] there is simply no way of knowing whether the outcome in this case would have been different if Mr Anderson had his cell door unlocked and given CPR as soon as possible.

ACTIONS BY THE DEPARTMENT SINCE MR ANDERSON'S DEATH

Amendments to Local Order 21

164. Hakea's Local Order 21 deals with prisoner management and placement in Unit 1. The version of Local Order 21 in place at the time of Mr Anderson's death had no provisions concerning a prisoner's potential

[150] Exhibit 1, Vol. 3, Tab 30, Letter from Associate Professor Paul Bailey dated 25 August 2020, p 2
[151] Exhibit 1, Vol. 3, Tab 30, Letter from Associate Professor Paul Bailey dated 25 August 2020, p 2
[152] Exhibit 1, Vol. 2, Tab 20, Spinal Cord Injury Journal - What Happens After a Lack of Oxygen to the Brain, 13 June 2016, pp 2-3

mental health issues when involved in a major incident (section 6) or when a prisoner is sentenced to separate confinement by visiting Justices of the Peace (section 7).[153] The current version of Local Order 21 has addressed those omissions.[154]

165. Section 6 is titled "*Incident Management*" and now stipulates what is required when "*a critical incident occurs within Unit 1*". Section 6.4 states:[155]

> Post any report or incident, a TOMS Incident Report is to be generated, with Incident Descriptions added by all staff involved in, or witness to, the event. The Unit Manager must ensure a debrief is conducted, post incident (where relevant), with staff welfare and lessons learned prioritised. The Assistant Superintendent Operations, or Senior Supervisor, and where self-harm is a factor, the Senior Supervisor Safe Custody shall be informed, as soon as practicable, following such incidents. Out of normal administration hours, the Deputy Principal Officer or OIC is to be advised.

166. I commend the Department for adding this section to the current version of Local Order 21. However, I am of the view that following the placement of a prisoner in a specialised unit for disciplinary purposes, a suitably qualified prison mental health staff member should always conduct a mental health assessment upon the prisoner involved as soon as it is practicable.

167. Section 7.3 of Local Order 21 now reads:[156]

> The Unit Manager shall conduct a welfare interview with all prisoners sentenced to separate confinement on the day the penalty is imposed. The welfare interview is to be recorded on the prisoner's Notes on TOMS and include:
>
> - The prisoner's general reaction to the separate confinement period handed down

[153] Exhibit 10A, Local Order 21- Unit 1 Management and Placement (revision no. 7.3), p 5
[154] Exhibit 10B, Local Order 21- Prisoner Management and Placement Multi-Purpose Unit 1 (revision no. 11.0), pp 6-7
[155] Exhibit 10B, Local Order 21- Prisoner Management and Placement Multi-Purpose Unit 1 (revision no. 11.0), p 6
[156] Exhibit 10B, Local Order 21- Prisoner Management and Placement Multi-Purpose Unit 1 (revision no. 11.0), pp 6-7

- Any requests made to speak with prison based support services i.e., Psychological Health Services (PHS), Chaplain, Medical staff or Peer Support Officer (PSO) and confirmation of any relevant referral submission
- Where a prisoner expresses thoughts of self-harm or where the Unit Manager or staff hold self-harm concerns for a prisoner - the ARMS process is to be commenced
- Whether or not the prisoner has upcoming social visits scheduled - which are to be cancelled for the period of confinement. If so, Visits Bookings has been contacted to request visitors be called and advised of the visit cancellation(s)
- Any welfare or stress related concerns the prisoner has verbalised, related to their ability to complete the confinement period

168. Although this measure is certainly an enhancement of what existed at the time of Mr Anderson's death, a further improvement could be made. In my view, allocating the welfare interview to the Unit Manager places an unnecessary burden on a prison officer to make assessments that he or she will invariably lack the expertise to make. That could be overcome if section 7.3 mandates that the welfare interview is to be conducted by a suitably qualified prison mental health staff member.

Code Red medical emergencies during a night shift

169. Local Order 42 has now been superseded. Since 12 December 2018, the procedural requirements for Night Recovery Team Duties is contained in Local Order 19 - Night Shift and Day Internal Recovery Team Duties[157] (Local Order 19). Significant improvements have been made which should avoid the delays that occurred when the Code Red medical emergency was made for Mr Anderson.

170. Keysets containing cell keys are now issued to four Night Officers, instead of two. Nightshift staff are now organised into four teams comprising of three prison officers. Two teams operate on the east side and two teams

[157] Exhibit 11, Local Order 19 - Night Shift and Day Internal Recovery Team Duties (revision no. 9.0)

operate on the west side of Hakea. Significantly, each team is to include a prison officer who has a keyset with a cell key attached.[158]

171. Furthermore, prison officers are now required to perform nightshift requirements in teams with a minimum of three officers.[159] Hence, cell checks take place with a minimum of three officers, one of whom will have a cell key.

172. Section 6 of Local Order 19 is titled "*Incident Intervention Guidelines".* The provisions of this section state that once a team of three prison officers has made an assessment that there is a life threatening emergency in a cell and have considered it safe to conduct an emergency cell extraction, a Code Red medical alert is to be called and authorisation requested from the officer-in-charge to open the cell.[160]

173. Section 6.5 of Local Order 19 precisely identifies what is to be done in circumstances similar to when Mr Anderson was seen by Mr Jones:[161]

> Where a prisoner is found to be attempting or has engaged in the act of serious self-harm or a prisoner is having a serious, life threatening health event, in accordance with Hakea Prison Emergency Management Plans, first responding Officers and the OIC shall:
>
> - consider the requirements for immediate medical assistance and an ambulance and call a Code Red
> - ensure own safety and that of staff and prisoners
> - where safe to do so, commence and continue DRSABCD in accordance with Local Order 19 Appendix 1- Basic Life Support
> - where CPR is required, immediately ensure an ambulance is called
> - where an ambulance is required this should be called by an officer or the nurse at the scene to provide immediate information about the prisoner's apparent condition

[158] Exhibit 11, Local Order 19 - Night Shift and Day Internal Recovery Team Duties (revision no. 9.0), sections 4.2 and 4.5
[159] Exhibit 11, Local Order 19 - Night Shift and Day Internal Recovery Team Duties (revision no. 9.0), section 4.12
[160] Exhibit 11, Local Order 19 - Night Shift and Day Internal Recovery Team Duties (revision no. 9.0), section 6.2
[161] Exhibit 11, Local Order 19 - Night Shift and Day Internal Recovery Team Duties (revision no. 9.0), p 7

- ensure crime scene and continuity of evidence practises that do not impact the immediate basic life support and medical treatment priorities
- complete reporting and debriefing requirements

174. I commend the Department for these provisions in Local Order 19 which I find were necessary following the death of Mr Anderson.

Ligature minimised cells

175. Hakea's audit report of its cell inspection for self-harm minimisation brings into sharp focus the monumental task facing the Department in minimising ligature points in the cells of a prison that is nearly 40 years old.[162]

176. As at the time Mr Anderson was ordered to serve five days of separate confinement in one of Hakea's punishment cells in Unit 1 D Wing, none of those cells had been ligature minimised. That was so even though renovations to Unit 1 D Wing to reduce ligature points in all punishment cells were scheduled to occur before 4 March 2017.[163] The renovations were to include the installation of new basins, tap fittings, toilets, beds and headboards.[164]

177. On 23 April 2017, exactly one month after Mr Anderson's death, the six punishment cells in Unit 1 D Wing were certified completed to the Department's self-harm minimisation standards. The new fixtures and fittings are specifically designed to reduce the risk of self-harm through the use of a number of ligature points that previously existed in these cells.[165]

178. A desk top review by the Department to address potential ligature points took place in 2004.[166] Sixteen years later, the following statistics of ligature minimised cells at Hakea provided by the Department is

[162] Exhibit 1, Vol. 3, Tab 35E, Hakea Regional Prison Cell Ordered Inspection for Self-Harm Minimisation Audit Report
[163] Exhibit 1, Vol. 2, Tab 26, Department of Corrective Services- Summary of Lessons Learned, p 3
[164] Exhibit 1, Vol. 2, Tab C, Death in Custody Report, p 15
[165] Exhibit 1, Vol. 2, Tab C, Death in Custody Report, p 17
[166] Exhibit 1, Vol. 3, Tab 35E, Hakea Regional Prison Cell Ordered Inspection for Self-Harm Minimisation Audit Report, p 2

concerning.[167] As at 22 September 2020, for the 649 cells: only 25 (4%) have been fully ligature minimised,[168] 365 (56%) have been three-point ligature minimised[169] and 259 (40%) remain non-ligature minimised.

179. It is essential that the Department expedites the alterations to the remaining non-ligature minimised cells at Hakea so that they become, at the very least, three-point ligature minimised cells.

180. A prison designed today would simply not have the number of ligature points in its cells that were evident in Mr Anderson's cell on the night of 4 March 2017.

COMMENT ON RECOMMENDATIONS

181. Four draft recommendations were forwarded to counsel for the Department on 25 November 2020. The Department was asked to provide any comments on those draft recommendations by 7 December 2020. That response was provided by Mr Bennett, counsel for the Department, by email on 7 December 2020.[170]

182. Draft recommendation 1 concerned increasing the number of ligature minimised cells at Hakea as soon as possible. The Department made the following comments regarding this recommendation:

> The Department has undertaken a program to reduce ligature points in the State's prisons since 2005/06. The intent is to address the issue of opportunistic self-harm through its ongoing program of ligature removal complimented by the implementation of comprehensive suicide prevention strategies.
>
> The current funded Ligature Minimisation Program for the entire prison estate provides for approximately 10 - 12 cells per financial year over the next 3 financial years. The Ligature Minimisation Program is developed in conjunction with the Corrective Services Division and is prioritised based on the number of available ligature-minimised cells versus the number of prisoners on ARMS and SAMS. There are

[167] Exhibit 8C, Ligature Minimised Cells at Hakea Prison as at 22 September 2020
[168] All identified ligature points in the cell have been addressed
[169] The three most obvious ligature points have been removed (window bars, light fittings and shelving)
[170] Email, J Bennett to Court Support Officer, 7 December 2020

> currently more fully ligature minimised beds available in Hakea, than prisoners on ARMS.
>
> There are currently 6 cells scheduled for works in 2022/23 within the current funded program. In addition to the fully ligature minimised cells, Hakea currently has 365, three-point ligature minimised cells (698 beds).

183. I am concerned about the rate of cells being ligature-minimised. By my calculations, at the rate of 10 - 12 cells per financial year, it could take decades before it is completed for every prison in the state. If only six cells in Hakea are scheduled for ligature minimisation each financial year from 2022/2023 then it will be over 40 years before all cells in that prison are ligature minimised.

184. When it is noted predicting suicidal behaviour is very difficult, little comfort can be taken from the fact that there are presently more fully ligature minimised beds available in Hakea than prisoners who are on ARMS. The death of Mr Anderson sadly highlights the inadequacy of that comparison. He was not even on ARMS at the time of his death.

185. Draft recommendation 2 concerned increasing the number of safe cells in Hakea from six to 12. In its response to this recommendation the Department pointed out that the internal fit out of a standard cell to a safe cell costs approximately $70,000 to $80,000. The Department advised that "*the option can be considered to establish an additional 6 'safe cells' in the 2021/22 Ligature Minimisation Program in place of the current program state wide*."

186. I would urge the Department to do that. Presently, Hakea only has one safe cell per 200 prisoners. I doubt whether a jail built today would have such a ratio given the high percentage of prisoners with mental health issues.

187. Draft recommendation 3 concerned having a mental health assessment conducted on any prisoner who has been involved in a critical incident or has been the subject of punishment requiring placement in the specialised unit for disciplinary purposes. The Department's comments on this recommendation noted the broad range of situations that are viewed as "*critical incidents*". The Department also referred to the lack of resources

it has for suitably qualified mental health practitioners to be "*on site 24 hours a day, 365 days a year*". I have taken into consideration these comments and have modified the wording in my final draft of this recommendation.

188. The Department also noted:

> Furthermore, reference to a prisoner who has been subject of punishment requiring placement in [a] specialised unit for disciplinary purposes includes prisoners who are not mental health patients and are confined for prison misdemeanours. As above, this reference may need to be further defined to enable better addressing the recommendation.

189. I do not agree with this comment. Mr Anderson was not regarded as a "*mental health patient*".

190. Draft recommendation 4 concerned prison officers participating in drills involving hanging scenarios during their training for CPR. The Department noted that whilst all trainee prison officers undertake multiple scenario assessments for responding to medical emergencies, the scenario of hanging is not included. The Department further commented that:

> Further consideration and a risk assessment would be required to determine options for this type of scenario, taking into account the ability to effectively mimic the scenario (realism) and achieve the desired learning outcomes.

191. In my view, no further consideration needs to be taken beyond an examination of the evidence given by prison officers at the inquest who agreed that a drill involving a hanging scenario during CPR training would certainly assist.[171]

192. Mr Bennett, counsel for the Department, stated in his closing submissions that the responsibility for the unreasonable delay in commencing CPR upon Mr Anderson was the Department's and could be addressed by training its staff better.[172] That better training should include a simulated hanging scenario when prison officers are trained in CPR.

[171] ts 27.08.20 (Cahoon), p 123; ts 27.08.20 (Whittaker), p 211; ts 28.08.20 (Devereux), p 354
[172] ts 28.08.20 (closing submissions of Mr Bennett), p 384

RECOMMENDATIONS

193. Ms Barter, counsel for the family, submitted that I should make recommendations regarding more resourcing for mental health and training of prison staff in relation to prisoners' mental health issues.[173] I do not take issue with those submissions.

194. However, these issues were the subject of a number of recommendations made in two inquests in 2019 regarding suicides in Hakea and Casuarina.[174] I have been provided with an update of the Department's responses to the various recommendations that were made at these inquests.[175] I am satisfied with the action taken by the Department to date and urge it to continue with the implementation of those recommendations.

195. I am also encouraged by the contents of a statement provided by Mr Dennis Hodges, a Manager with the Department's Prison Support Services.[176] Mr Hodges is a Koori, a Ngemba man from New South Wales, who is deeply committed to assisting Aboriginal prisoners with various programs. I hope he will continue to obtain the support of the Department for these invaluable projects.

196. In light of the observations I have made, I make the following recommendations:

Recommendation No. 1

As a matter of urgency, the Department should consider increasing the number of ligature minimised cells at Hakea Prison with a view to having all cells at Hakea Prison either fully ligature minimised or three-point ligature minimised as soon as possible.

[173] ts 28.08.20 (closing submissions of Ms Barter), pp 366-367
[174] Inquest into the deaths of five male persons (Ref No.: 14/19), 22 May 2019; Inquest into the death of Bret Lindsay Capper (Ref No: 56/19), 13 September 2019
[175] Exhibit 8B, Recommendations Update dated 22 September 2020 re inquests into the five deaths in Casuarina Prison and the death of Bret Lindsay Capper
[176] Exhibit 1, Vol. 3, Tab 36, Statement - Dennis Hodges

Recommendation No.2

In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department should increase the number of safe cells from six to 12.

Recommendation No.3

A suitably qualified prison mental health staff member should conduct a mental health assessment as soon as it is practicable upon any prisoner who has been involved in a critical incident regarding violent behaviour or who has been the subject of punishment requiring placement in a specialised unit for disciplinary purposes.

Recommendation No. 4

In order to ensure that prison officers are better equipped to deal with situations where prisoners attempt to take their lives by way of hanging, officers should participate in drills involving simulated hanging scenarios during their initial employment training and during refresher training for CPR.

CONCLUSION

197. Mr Anderson was a 23 year old man who at the time of his death was in custody on remand at Hakea with respect to a number of serious charges.

198. On 2 March 2017, a Justice of the Peace ordered that he serve five days punishment in confinement for an assault upon another prisoner several months earlier.

199. On 4 March 2017, Mr Anderson was not coping with his confinement. He refused to leave one of the exercise yards in Unit 1 and was verbally abusive towards prison officers. At one point he lit a small fire. He was eventually compliant and was taken to his cell without incident after he was advised his request to be transferred to Casuarina would be considered. He was calm when he was locked in his cell at approximately 6.30 pm.

200. Sometime between approximately 10.05 pm and 12.20 am that night, Mr Anderson removed his bed sheet and used it as an improvised ligature around his neck, tied it to the basin's tap in his cell and hanged himself. He gave no prior indication of his intention to take his life.

201. An unreasonable time elapsed from when Mr Anderson was first found to be unresponsive by a prison officer to when his cell door was unlocked. There was a further unreasonable delay before CPR was commenced by prison staff. Though attending ambulance officers were able to achieve a return of circulation and a pulse, Mr Anderson remained in a critical condition and he died at FSH on 23 March 2017.

202. Since Mr Anderson's death, steps have been taken by the Department to prevent the delays in unlocking a cell door and commencing CPR following a self-harm incident by hanging within a prisoner's cell. Those changes are to be commended.

203. However, more can be done with the involvement of prison mental health staff following a prisoner's participation in a critical incident involving violent behaviour or a prisoner being sent to a specialised unit for disciplinary purposes.

204. I am also of the view that prison officers would benefit from CPR training if it included a drill involving a simulated hanging incident so that they are better prepared should such an incident occur.

205. I am satisfied that the supervision, treatment and care provided to Mr Anderson by the Department was reasonable throughout his five periods of incarceration, except for the failure by prison staff to unlock his door and then commence CPR within a reasonable time frame on 5 March 2017.

206. I have made four recommendations aimed at addressing the issues I have identified during the inquest. It is my hope that these recommendations, and the changes already made by the Department following Mr Anderson's death, will provide some solace to his family for their tragic loss.

P J Urquhart
Coroner
22 December 2020