JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART
HEARD	**:**	3 - 4 AUGUST 2021
DELIVERED	**:**	1 NOVEMBER 2021
FILE NO/S	**:**	CORC 1295 of 2017
DECEASED	**:**	ROE, JOSEPH THOMAS

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Ms C Wood and Ms B Challenor (Aboriginal Legal Services) appeared for the family.
Mr E Cade (State Solicitor's Office) appeared for the Department of Justice.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Joseph Thomas Cheeky ROE** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 3 - 4 August 2021, find that the identity of the deceased person was **Joseph Thomas Cheeky ROE** and that death occurred on 21 September 2017 at Sir Charles Gairdner Hospital, Nedlands, from subarachnoid and intracerebral haemorrhage in association with a ruptured berry aneurysm in the following circumstances:*

Contents

INTRODUCTION

1 Mr Roe died on 21 September 2017 at Sir Charles Gardiner Hospital (SCGH), Nedlands, from a subarachnoid and intracerebral haemorrhage in association with a ruptured berry aneurysm.

2 At the time of his death, Mr Roe was a sentenced prisoner at Casuarina Prison (Casuarina) in the custody of the Chief Executive Officer of the Department of Corrective Services (the Department), as the Department was known at the relevant time.[1]

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

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 whilst in that care.[4]

5 I held an inquest into Mr Roe's death at Perth on 3-4 August 2021. The following witnesses gave oral evidence at the inquest:

i. Dr Clive Cooke (Forensic Pathologist);
ii. Dr Rhian Moss (General Practitioner and ex-Prison Medical Officer with the Department);
iii. Akima Aranui (Prison Officer);
iv. Graeme Grover (Senior Prison Officer);
v. Christina Roe (sister of Mr Roe);
vi. Jahlana Rose (daughter of Mr Roe); and
vii. Toni Palmer (Senior Review Officer with the Department).

[1] Section 16, *Prisons Act 1991* (WA)
[2] Sections 3 and 22(1)(a), *Coroners Act 1996* (WA)
[3] Section 22(1), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)

6 The documentary evidence produced at the inquest comprised of two volumes of the brief, which were tendered as exhibit 1. An additional six exhibits were tendered during the inquest (exhibits 2-7) and another four documents were provided after the inquest, at my request, by the Department through its counsel, Mr Cade. Three of these documents were attached to an email dated 5 August 2021 and the fourth was attached to an email dated 29 October 2021. These documents were provided to counsel for the family.

7 The two prison nurses who treated Mr Roe on 18 September 2017 before he was taken by ambulance to Fiona Stanley Hospital (FSH) were not summonsed as witnesses. Prior to the commencement of the inquest, Mr Cade, counsel for the Department, provided written explanations as to why neither nurse would be in a position to give oral evidence. After considering those explanations, which were provided on a confidential basis, I was satisfied that for the matters I was required to investigate, no purpose would be served if either nurse was called.

8 My primary function has been to investigate the death of Mr Roe. It is a fact-finding function. I must find, if possible, how the death of Mr Roe occurred and the cause of his death.[5] Given the known circumstances of this matter, those findings can be made without difficulty.

9 I may comment on any matter connected to the death of Mr Roe, including public health or safety, or the administration of justice.[6] This is an ancillary function of a coroner.

10 I am prohibited from framing a finding or comment in such a way as to appear to determine any civil liability or suggest a person is guilty of an

[5] Section 25(1)(b),(c) of the *Coroners Act 1996* (WA)
[6] Section 25(2) of *Coroners Act 1996* (WA)

offence.[7] It is not my role to assess the evidence for civil or criminal liability and I am not bound by the rules of evidence.

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

12 I am also mindful not to insert any hindsight bias into my assessment of the actions taken by prison staff in their dealings with Mr Roe.[8]

13 The inquest focused on the care provided to Mr Roe while he was a prisoner at Casuarina from 12 November 2016, with an emphasis on the actions of prison staff on the night of 17-18 September 2017.

THE DECEASED

Background [9] [10]

14 Mr Roe was born on 25 February 1967 and was 50 years of age when he died on 21 September 2017. Mr Roe was the second of five children and he came from a well-respected Broome family. He had a stable upbringing and although his father was a regular drinker, Mr Roe always had the support of his parents and he was not exposed to substance abuse or domestic violence in the family home.

15 Mr Roe completed his schooling in Year 10 at Perth and then returned to Broome where he commenced an apprenticeship in carpentry until he was 18 years old. He then gained employment in the pearling industry where he

[7] Section 25(5) of *Coroners Act 1996* (WA)
[8] Hindsight bias is the tendency, after the events, to assume the events are more predictable or foreseeable than they really were: Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015)10
[9] Exhibit 1, Volume 2, Tab A, Death in Custody Report by Ms Palmer dated 26 September 2019
[10] ***The State of Western Australia v Roe*** [2016] WASCSR 226

worked for 13 or 14 years, before obtaining his skipper's ticket and a commercial fishing licence.

16 Mr Roe began drinking alcohol after completing his schooling. As he got older, he developed an alcohol dependency. He also became a regular user of cannabis.

17 Mr Roe had six children from several relationships, and he was much loved by his immediate and extended family. He was regarded as a protector of his siblings and children. His sudden death was very traumatic for his many close relatives.

Offending History [11] [12] [13]

18 In 1984, Mr Roe began a lengthy association with the criminal justice system, which commenced in Broome Children's Court when he was 17 years old. His adult offending started in 1985, which was characterised by offences of violence; and included convictions for assault, assaulting a public officer, assault occasioning bodily harm, unlawful wounding and grievous bodily harm. Mr Roe was sentenced to several periods of imprisonment for violent offending between 1992 and 2007. He also had numerous convictions for less serious offending, for which he received fines and other non-custodial dispositions.

Circumstances of final imprisonment [14] [15]

19 On 24 August 2016, Mr Roe was convicted of murder by a jury after a trial in the Supreme Court of Western Australia. On 25 November 2016, he was sentenced to a term of imprisonment for life, with a minimum of 21 years

[11] Exhibit 1, Volume 2, Tab A, Death in Custody Report by Ms Palmer dated 26 September 2019
[12] Exhibit 1, Volume 1, Tab 14, Offender Summary
[13] Exhibit 1, Volume 2, Tab 16, WA Court History of Criminal and Traffic Offences
[14] ***The State of Western Australia v Roe*** [2016] WASCSR 226
[15] Exhibit 1, Volume 2, Tab A, Death in Custody Report by Ms Palmer dated 26 September 2019

imprisonment before being made eligible for parole. Mr Roe's sentence was backdated to commence on 28 September 2014. This meant that his first review date for parole eligibility was 27 September 2035.

20 This offence took place in the early hours of 27 September 2014. Mr Roe and his male victim (the victim) were significantly intoxicated when they met on an oval in Broome late at night. They then went to Mr Roe's unit to continue drinking alcohol. They were previously not known to each other.

21 When at the unit, Mr Roe savagely assaulted the victim with a heavy metal pipe. The victim suffered multiple fractures to his skull, face and other parts of his body.

22 Following his arrest on 28 September 2014, Mr Roe remained in custody as a remand prisoner, until his conviction for murder. He was remanded during that period to West Kimberly Regional Prison, Hakea Prison and Albany Regional Prison. On 30 September 2014, Mr Roe requested that he be placed into protection, citing that he may be at risk from other prisoners who lived in the Kimberley, due to his offence and the region from which his victim came from. Due to this request, Mr Roe was eventually transferred to Casuarina. That occurred on 12 November 2016, and he remained at Casuarina until 18 September 2017 when he was taken by ambulance to FSH.

OVERVIEW OF MR ROE'S MEDICAL TREATMENT IN CASUARINA PRISON [16]

23 Mr Roe's medical history included liver cirrhosis secondary to alcohol consumption, type 2 diabetes (which was diagnosed in March 2008), and hypertension (high blood pressure) He was not diagnosed with any major mental health illness, although he was placed on the Support and Monitoring

[16] Exhibit 1, Volume 1, Tab 54, Report of Dr Moss dated 21 September 2020

System (SAMS) register, for counselling support during periods of stress. This stress mostly related to his concerns regarding his mother's health.

24 Mr Roe was a heavy smoker. It does not appear that he ever attempted to stop smoking during his last period of incarceration. Whenever his ceasing of smoking was raised by prison health staff, Mr Roe always replied that he was not ready to stop smoking.[17]

25 The management of Mr Roe's diabetes was through the administration of tablets. Dr Moss was of the view that Mr Roe's diabetes was, "*quite well controlled*".[18] His HbA1c blood testing[19] were generally documented to be within the range of a good control.[20]

26 Similarly, the management of Mr Roe's hypertension was of the same standard as would be expected if he was in the general community.[21] On 11 April 2017 (which was the date of his last review by a prison medical officer), Mr Roe's blood pressure control was reasonable at 120/80 and his diabetic control was good with a HbA1c of 5.6.

27 As to the management of Mr Roe's cirrhosis, Dr Moss expressed a view that it was "*reasonable*" as he was "*having regular blood tests*" and "*regular clinical reviews*".[22]

28 One oversight in the Department's management of Mr Roe's cirrhosis was the failure to have an ultrasound of his liver completed every six months. This had been recommended by the Hepatology Immunology Clinic at the Broome Hospital. Dr Moss noted that the twice-yearly ultrasounds were not

[17] ts 3.8.21 (Dr Moss), p.25
[18] ts 3.8.21 (Dr Moss), p.39
[19] HbA1c is glycosylated haemoglobin, and is a blood test used to monitor a person's control of their diabetes.
[20] ts 3.8.21 (Dr Moss), p.39
[21] ts 3.8.21 (Dr Moss), p.26
[22] ts 3.8.21 (Dr Moss), p.28

always undertaken between 2015 and 2017. During that time, he only had two ultrasounds.[23] Nevertheless, Dr Moss was of the view that there was no detriment to Mr Roe as these ultrasounds were only undertaken to detect carcinomas that can occur with chronic liver disease. There were no such carcinomas in Mr Roe's last ultrasound.[24] Dr Moss was of the opinion Mr Roe's liver function during his last period in prison was "*relatively stable*"[25]

29 Another matter that Dr Moss addressed was the failure by the Department to have Mr Roe's medications transferred on two occasions in 2016, when he was relocated to another prison. As Dr Moss explained:[26]

> The way medication works in the prison is everybody gets a weekly pack of medication and that stays where you are, and it's administered by the nurses at medication parade or in some places you can have the packs on the person. The pharmacy in Hakea send those packs out to each site on a weekly basis. So they're sent all over the State. If a patient is transferred on a day when it's not a day for a new pack, their pack should go with them and there's a system in place for that to occur. Now, with the number of transfers that occur … sometimes the physical packs of medicines don't end up going with the prisoner.

30 Dr Moss then clarified that each prison has a small stock of commonly prescribed medicines in it, and on these two occasions, Mr Roe was given his missing medications from this stock. Although Mr Roe did not get access to one of his two blood pressure medications over a weekend, Dr Moss did not consider this to be a concern.[27]

31 I agree with Dr Moss that during his time in the prison system, Mr Roe "*received reasonable health care*". This includes the health care provided by

[23] ts 3.8.21 (Dr Moss), p.27
[24]ts 3.8.21 (Dr Moss), p.27
[25] ts 3.8.21 (Dr Moss), p.28
[26] ts 3.8.21 (Dr Moss), pp.28-29
[27] ts 3.8.21 (Dr Moss), p.29

prison health staff on 18 September 2017, which is examined in more detail later in this finding.

EVENTS LEADING TO MR ROE'S DEATH

Mr Roe's health prior to the night of 17 September 2017

32 There is nothing in Mr Roe's electronic prison medical record (EcHO) to indicate he was feeling unwell in the days leading up to the evening of 17 September 2017. Similarly, his cell mate did not observe anything wrong with Mr Roe:[28]

> [Mr Roe] seemed his normal self. He was not complaining of any aches or pains or anything.
>
> …
>
> I don't know what happened to [Mr Roe], or why he got sick and died.

33 In light of the evidence from the forensic pathologist, Dr Clive Cooke, the absence of any complaint of ill health by Mr Roe can be explained by the cause of death. This will also be addressed in more detail later in this finding.

Three cell calls made on the night of 17-18 September 2017

34 Prison Officer Akima Aranui (Mr Aranui) was on night shift at Casuarina, commencing at 6.00 pm on 17 September 2017. He was stationed at Unit 1, which held 78 inmates, including Mr Roe.[29] At about 8.55 pm, Mr Aranui conducted the first cell check across the entire unit for the night.

35 At about 10.50 pm, Mr Aranui was in the unit's control room when he received a cell call alert from Mr Roe's cellmate. As Unit 1 was one of the

[28] Exhibit 1, Volume 1, Tab 10, Statement of Mr Roe's cell mate dated 3 October 2017, pp.1-2
[29] Exhibit 1, Volume 1, Tab 35A, Unit 1 Reports and Occurrences Book dated 17 September 2017

older units at Casuarina, Mr Aranui had to physically attend the cell to respond to the call.[30]

36 Mr Roe's cell was in the B-wing of Unit 1, which was approximately 20 metres from the control room. As only the Officer in Charge (OIC) had keys to the cells, Mr Aranui spoke to Mr Roe's cell mate through the cell door hatch. The cell mate told Mr Aranui that Mr Roe was getting up and down from his bed and saying that he was sick. The cell mate also said that he saw Mr Roe "*shaking*".[31] As the cell light was on, Mr Aranui was able to view Mr Roe, without difficulty, through the hatch. He remained doing that for about five minutes and did not see Mr Roe have any type of seizure or start shaking. He was snoring and appeared to be in a deep sleep.[32] Mr Aranui decided to take no further action and advised the cell mate that if Mr Roe got any worse, the cell mate could call him. Mr Aranui did not call a Code Red[33] medical emergency over his radio on this occasion. When he returned to the control room he wrote in the Reports and Occurrences Book that this "*cell call alarm*" was "*non-urgent*".[34]

37 At about 11.55 pm, Mr Roe's cell mate made another cell call.[35] When Mr Aranui attended at the cell door, the cell mate told him again that Mr Roe was sick and that he had been shaking. Mr Aranui's observations of Mr Roe on this occasion were the same as before and he returned to the control room after advising the cell mate to call again if things changed.[36] Again, Mr Aranui did not call a Code Red medical emergency and he made the same

[30] Exhibit 1, Volume 1, Tab 58A, Statement of Mr Aranui dated 5 July 2021, p.2; ts 3.8.21 (Aranui), p.91
[31] Exhibit 1, Volume 1, Tab 10, Statement of Mr Roe's cellmate dated 3 October 2017, p.2; ts 3.8.21 (Aranui), p.67
[32] Exhibit 1, Volume 1, Tab 10, Statement of Mr Roe's cellmate dated 3 October 2017, p.2; ts 3.8.21 (Aranui), pp.68-69
[33] This is Casuarina Prison's highest priority emergency response, requiring urgent backup and immediate response.
[34] Exhibit 1, Volume 1, Tab 35A, Unit 1 Reports and Occurrences Book dated 17 September 2017
[35] Exhibit 1, Volume 1, Tab 35A, Unit 1 Reports and Occurrences Book dated 17 September 2017
[36] Exhibit 1, Volume 1, Tab 10, Statement of Mr Roe's cell mate dated 3 October 2017, p.2; ts 3.8.21 (Aranui), p.71

notation regarding this second cell call in the Reports and Occurrences Book as the earlier one.[37]

38 At about 12.25 am on 18 September 2017, Mr Aranui received a third cell call from Mr Roe's cell mate.[38] When Mr Aranui attended at the cell door, the cell mate said that Mr Roe had vomited and had then gone back to sleep. On this occasion, Mr Aranui saw the vomit on the cell floor, which had not been there previously. Although Mr Roe was snoring loudly, Mr Aranui's loud calls through the cell door hatch failed to get a response from Mr Roe.[39]

39 Despite Mr Roe's unresponsiveness, Mr Aranui did not call for a Code Red medical emergency over his radio. Instead, he returned to the unit's control room and telephoned the administration building where the OIC for the night, Senior Officer Graeme Grover (Mr Grover), was located. Mr Aranui advised Mr Grover that Mr Roe had vomited and asked him to attend Unit 1.[40] He also told Mr Grover that Mr Roe was not responding to his calls and that a medic should also attend to check on him.[41]

40 Mr Grover arranged for a prison nurse to attend the cell and also arranged for other prisoner officers to attend to enable him to open the cell door, in accordance with prison policy. Given the distance between the administration building and Unit 1, it is likely Mr Grover used an electric-powered buggy to attend.[42]

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[37] Exhibit 1, Volume 1, Tab 35A, Unit 1 Reports and Occurrences Book dated 17 September 2017

[38] Mr Aranui wrote in the Reports and Occurrences Book that the cell call was made at 12.50 am: see Exhibit 1, Volume 1, Tab 35B, Reports and Occurrences Book dated 18 September 2017. However, Mr Aranui clarified in his evidence that the more accurate time would be the one he noted in his Incident Description Report, which was 12.25 am (see Exhibit 1, Volume 1, Tab 58, Incident Description Report dated 18 September 2017); ts 3.8.21 (Aranui), pp.75-79

[39] Exhibit 1, Volume 1, Tab 58A, Statement of Mr Aranui dated 5 July 2021, p.3

[40] Exhibit 1, Volume 1, Tab 58A, Statement of Mr Aranui dated 5 July 2021, p.3

[41] Exhibit 1, Volume 1, Tab 58A, Statement of Mr Aranui dated 5 July 2021, p.3

[42] Exhibit 1, Volume 1, Tab 55, Statement of Mr Grover dated 22 May 2021, pp.3-4

Mr Roe is assessed

41 When Mr Roe's cell door was opened, he was still snoring. After he did not respond to Mr Grover's calls, Mr Grover attempted to rouse him by shaking his foot. His cell mate informed Mr Grover that Mr Roe had vomited, was making strange noises and that he had been shaking.[43]

42 Mr Grover's attempts to rouse Mr Roe were unsuccessful and he continued to snore very loudly. Attending prison officers assisted in sitting Mr Roe up, so that the prison nurse could undertake a medical assessment of him.[44]

43 During that assessment, Mr Roe had two seizures, which Mr Grover described as a "*tremor*" that lasted for two to three seconds the first time and then for about five seconds the second time, which was more intense.[45] After the second seizure, the nurse said that Mr Roe had to be taken to the prison's medical centre. The nurse was of the view that Mr Roe had to be transported in a wheelchair, rather than on the electric-powered buggy (which was normally used to take ill prisoners to the medical centre). Arrangements then had to be made for prison officers to collect a wheelchair from the medical centre and bring it to Mr Roe's cell.[46] Although this caused some delay, the nurse's reasoning was soundly based, as she correctly suspected that Mr Roe was exhibiting signs of intracranial hypertension and to transfer him lying flat could cause further damage.[47]

44 As Mr Roe was taken to the medical centre, the nurse was maintaining his airway by holding his head upright and administering oxygen. Two prison officers held Mr Roe in an upright position, while another prison officer

[43] Exhibit 1, Volume 1, Tab 55, Statement of Mr Grover dated 22 May 2021, p.4
[44] Exhibit 1, Volume 1, Tab 55, Statement of Mr Grover dated 22 May 2021, p.4
[45] ts 3.8.21 (Grover), p.107
[46] Exhibit 1, Volume 1, Tab 55, Statement of Mr Grover dated 22 May 2021, p.5
[47] ts 3.8.21 (Dr Moss), p.33

pushed the wheelchair. This journey took some time as Unit 1 is the farthest unit from the medical centre.[48]

45 Once at the medical centre, Mr Roe continued to remain unresponsive. He had to be physically lifted onto the bed in the resuscitation bay. He was kept in an upright position to reduce the pressure to his head.[49] Due to his medical condition, Mr Roe was not restrained.

46 It was evident to the clinical nurse at the medical centre that Mr Roe was in a critical condition. As the clinical nurse recounted:[50]

> He did not respond to stimuli, including calling his name or rubbing of his sternum. He did not speak and only groaned. The groan was not in answer to any attempts by staff to get a response from him.
>
> I was then able to continue a more thorough examination of his Glasgow Coma scale score which provides an indication of brain function and his cardiovascular status. Ms [the other nurse] continued to maintain his airway. I was unable to insert the Guedels (a specifically designed "tube" that keeps an airway patent) as his mouth was clenched.
>
> My initial impression was that Mr Roe had had a catastrophic cerebral event. I had that impression because his pupils were initially noted to be unequal and they changed to fixed and constricted.
>
> It was his overall presentation that caused me to think that there was a cerebral issue. He had an all over body tremor, which was different to a seizure.

47 After completing a brief examination, the clinical nurse called triple zero to request a priority ambulance.

Mr Roe is taken to hospital

48 Although the clinical nurse recalled making her triple zero call at about 1.05 am,[51] St John Ambulance records show the call was received at 1.32 am

[48] Exhibit 1, Volume 1, Tab 52, Statement of clinical nurse on duty dated 8 November 2019, p.4; Exhibit 3, Annotated aerial image of Casuarina Prison
[49] Exhibit 1, Volume 1, Tab 52, Statement of clinical nurse on duty dated 8 November 2019, p.4
[50] Exhibit 1, Volume 1, Tab 52, Statement of clinical nurse on duty dated 8 November 2019, pp.4-5
[51] Exhibit 1, Volume 1, Tab 52, Statement of clinical nurse on duty dated 8 November 2019, p.4

and 29 seconds.[52] This is the more accurate time as Ms Palmer had arranged for Telstra to provide a record of the timing of the call and she received a printout which recorded the call was made at 1.31 am and 46 seconds.[53]

49 The ambulance arrived at Casuarina at 1.50 am on 18 September 2017. It departed at 2.30 am bound for FSH.[54] During the transport, Mr Roe continued to snore, although there was no further seizure activity until he was transferred onto a bed at FSH.[55]

50 Mr Roe was triaged at FSH as a category 1 patient at 2.51 am. He was unresponsive, with laboured breathing and an increased heart rate. A computerised tomography (CT) angiogram suggested Mr Roe had sustained a ruptured left anterior cerebral artery aneurysm with associated haemorrhage.[56] A decision was made to transfer him to the neurosurgical unit at SCGH and an ambulance conveyed him to that hospital at 7.50 am on 18 September 2017.[57]

Mr Roe's death

51 Mr Roe was reviewed by the neurosurgical team at SCGH. He was diagnosed with a Grade V subarachnoid haemorrhage and hydrocephalus. He had no improvement in his neurological condition when sedation was withdrawn. A repeat CT scan on 20 September 2019 showed a significant increase in the size of the bleeding and swelling of Mr Roe's brain.[58] He remained on life support systems to enable his family to visit from Broome and because of his status as an organ donor.[59]

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[52] Exhibit 1, Volume 1, Tab 51, St John Ambulance case sheet, p.1
[53] Exhibit 1, Volume 2, Tab 47A, Statement of Ms Palmer dated 9 June 2021, p.2
[54] Exhibit 1, Volume 1, Tab 51, St John Ambulance Patient Care Record, p.1
[55] Exhibit 1, Volume 1, Tab 51, St John Ambulance Patient Care Record, p.2
[56] FSH Emergency Medical Summary
[57] Exhibit 1, Volume 1, Tab 51, St John Ambulance Patient Care Record, pp.1-2
[58] SCGH Medical Records
[59] Exhibit 1, Volume 2, Tab A, Death in Custody Report by Ms Palmer dated 26 September 2019, p.15

52 On 21 September 2017, Mr Roe's condition had continued to deteriorate neurologically, and he had lost brain stem reflexes.[60]

53 At 11.35 am on 21 September 2017, a doctor at SCGH certified life extinct.[61]

CAUSE AND MANNER OF DEATH [62] [63]

54 Dr Cooke conducted a post mortem examination on Mr Roe's body on 26 September 2017.

55 That examination noted that Mr Roe had had recent medical treatment. There was bleeding around his brain (subarachnoid haemorrhage) and brain softening. Mr Roe's lungs were congested, with features of basal pneumonia. He had cirrhosis of the liver and his heart was enlarged, with some thickening of the heart muscle (left ventricular hypertrophy), early age-related thickening of one of the heart valves (aortic valve sclerosis), and arteriosclerotic narrowing of the arteries on the surface of the heart (coronary arteriosclerosis). A subsequent microscopic examination confirmed the presence of bronchopneumonia in the bases of Mr Roe's lungs and his cirrhosis of the liver. Microbiology examinations showed the presence of a bacteria associated with pneumonia.

56 A neuropathology examination showed a ruptured dilatation in one of the small arteries at the base of Mr Roe's brain (ruptured berry aneurysm) resulting in a subarachnoid and intracerebral haemorrhage.

57 Toxicological analysis showed the presence of a number of medications consistent with recent medical care.

[60] Exhibit 1, Volume 1, Tab 34, Report of Dr Moss dated 21 September 2020, p.9
[61] Exhibit 1, Volume 1, Tab 5, Sir Charles Gairdner Hospital – Death in Hospital form dated 21 September 2017
[62] Exhibit 1, Volume 1, Tab 7A-C, Supplementary Post Mortem Report, Post Mortem Report and Interim Post Mortem Report dated 26 September 2017
[63] ts 3.8.21 (Dr Cooke), pp.7-24

58 Following the receipt of the results of further investigations, Dr Cooke formed the opinion on 20 November 2017 that the cause of death was subarachnoid haemorrhage in association with a ruptured berry aneurysm.

59 In his evidence at the inquest, Dr Cooke noted that Mr Roe also had some bleeding into his brain (intracerebral haemorrhage). This was in addition to the subarachnoid haemorrhage. Dr Cooke was therefore of the view the cause of death could be more precisely described as subarachnoid and intracerebral haemorrhage in association with a ruptured berry aneurysm.

60 I accept and adopt this conclusion expressed by Dr Cooke as to the cause of Mr Roe's death.

61 I find Mr Roe's death occurred by way of natural causes, when he suffered an immediate catastrophic aneurysm at the base of his brain which caused significant bleeding in and around his brain.

62 At the inquest, Dr Cooke provided some further information regarding berry aneurysms, so named because they are shaped like a berry. Approximately 2% of the population will have a berry aneurysm, however most of these are asymptomatic and people do not know they have one. Although they tend to grow in size as a person ages, berry aneurysms are usually just a few millimetres in size and a person has no symptoms. In contrast, Mr Roe's berry aneurysm was about seven millimetres in size when it ruptured. When a berry aneurysm does rupture, the person has a "*thunderclap*" headache and immediate loss of consciousness.

63 Dr Cooke stated that excessive use of alcohol, smoking cigarettes and high blood pressure are associated with the development and even the rupture of berry aneurysms. A rupture can be spontaneous and although there are surgical options to treat berry aneurysms before the rupture, these procedures

are very delicate and high risk, and can result in strokes or even death. As a ruptured berry aneurysm causes intracranial pressure, symptoms apart from the thunderclap headache include vomiting and seizures.

64 Dr Cooke described the haemorrhaging from Mr Roe's ruptured berry aneurysm as "*very severe*". He was of the view that Mr Roe's chance of surviving was always going to be "*very limited*".

65 Dr Cooke also noted that Mr Roe's early pneumonia in his lungs developed as a consequence of being in hospital care in an intensive care unit for several days, which is a very common occurrence for people in those circumstances. Dr Cooke also attributed Mr Roe's cirrhosis to the severe haemorrhaging he sustained from the ruptured berry aneurysm. That is because cirrhosis can cause blood thinning (coagulopathy), which reduces the effectiveness of the person's blood being able to clot properly. In Mr Roe's case, as his blood did not clot so easily, it was less effective in stopping the bleeding event caused by the ruptured berry aneurysm.

ISSUES RAISED BY THE EVIDENCE

Failure by prison officers to call a Code Red medical emergency

66 The policies and procedures for a medical emergency at Casuarina are contained within Local Order 24E.[64] Addendum 22 to the applicable Local Order 24E at the time detailed the procedures for when medical emergencies occur.[65] The policy for medical emergencies stated:[66]

[64] The inquest brief contained the version of Local Order 24E dated 1 October 2020 (Exhibit 1, Volume 1, Tab 58C, Local Order 24E – Emergency Management Plans). At my request, Mr Cade provided (by email dated 29 October 2021) the version of Local Order 24E applicable as at September 2017. With the exception of the requirement of the OIC to notify the front gate of the impending arrival of an ambulance to the prison, the relevant policies to this inquest are identical in each version.
[65] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, pp.158-170
[66] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, p.159

> It is the responsibility of any officer or staff member who becomes aware of the illness or injury of any person that constitutes an emergency medical situation to report the observation to Medical Staff immediately.

67 If the incident is considered to "*be serious or life threatening*", a Code Red medical emergency, "*should be immediately called over the prison radio*" by the prison officer.[67] Those medical emergencies that warrant a Code Red call for a prisoner are listed as:[68]

- found hanging
- bleeding
- self-inflicted wound
- unconscious
- overdose/poisoning
- electrocution
- fit or convulsion
- noxious inhalation; smoke, gas, fumes
- head injuries

68 Despite Mr Roe's unresponsive state and evidence of shaking and seizures, a Code Red medical emergency was never made over the radio. The question arises whether a Code Red ought to have been called and, if so, when?

69 Mr Aranui's understanding of when a Code Red medical emergency is to be called is when a prisoner is "*not breathing*" or is "*unresponsive*".[69] On the first occasion he attended outside the door of Mr Roe's cell, he did not call a Code Red as, "*it just looked like he was sleeping, moving around and snoring*".[70]

70 As to his attendance after the second cell call, Mr Aranui did not call a Code Red medical emergency, even though the cell mate had repeated that Mr

[67] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, p.161
[68] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, p.164
[69] ts 3.8.21 (Mr Aranui), p.61
[70] ts 3.8.21 (Mr Aranui), p.61

Roe was shaking.[71] Mr Aranui said he would have called a Code Red on this occasion if he had seen Mr Roe shaking, but as he did not, he told the cell mate, "*just to keep an eye on him, press the buzzer again if it happens*."[72] As Mr Aranui still believed Mr Roe was "*just sleeping*", he did not see a reason to call a Code Red medical emergency.[73]

71 I questioned Mr Aranui as to what he knew of Mr Roe's cell mate at the time. He agreed that, unlike other prisoners, this cell mate was a reliable prisoner and one who, if he told you something, you would accept what he was saying. To use the words or Mr Aranui, "*he was quite genuine*".[74] After stating that he believed the cell mate when he said Mr Roe was sick and shaking, I asked Mr Aranui the following:[75]

> So that being the case, I need to ask you then, Mr Aranui, why you had to witness this shaking before you did anything? --- I just had my – the only answer I can give is I just had to see it, like, because it just looked to me like he was snoring. And he was doing it for a little while.
>
> Yes. Yes. And I appreciate if [the cell mate] was one of these prisoners that you couldn't trust and would just say things or make things up. So [the cell mate] isn't one of those prisoners? ---Yes.
>
> So I just wonder why you weren't prepared to accept his word for it? --- I don't believe – in most cases, I don't believe the prisoner 100 per cent.
>
> …
>
> Okay. Did you think about getting [the cell mate] to try and wake him up? --- I can't recall if I did.
>
> You certainly didn't ask [the cell mate] to do that, did you? --- No. I don't think I did.

[71] ts 3.8.21 (Mr Aranui), p.71
[72] ts 3.8.21 (Mr Aranui), p.72
[73] ts 3.8.21 (Mr Aranui), p.72
[74] ts 3.8.21 (Mr Aranui), p.73
[75] ts 3.8.21 (Mr Aranui), pp.73-74

72 After agreeing with Counsel Assisting that there would not be any harm done if he called a Code Red, even if he did not see the shaking himself, he was asked:[76]

> Okay. So, in that case, wouldn't you just call the Code Red? --- I suppose you could. Yes.
>
> Would you in the future? --- Yes.

73 Although Mr Aranui was aware that one of the specified medical emergencies for a Code Red was if a prisoner was having a fit or convulsing, he did not consider the cell mate's description of Mr Roe "*shaking*" as meaning he was having a fit or was convulsing.[77]

74 It was unfortunate that Mr Aranui did not make a radio call that there was a Code Red medical emergency on either of his first two attendances outside Mr Roe's cell. There were sufficient grounds for doing so. However, without the benefit of hindsight, there was a basis for Mr Aranui to conclude that Mr Roe may have simply been in a deep sleep. He was snoring loudly, and Mr Aranui had not seen him shaking, as described by the cell mate. In those circumstances, and being mindful not to insert hindsight bias, I do not criticise Mr Aranui for his failure to call a Code Red medical emergency over the radio. Had the cell mate described Mr Roe as "*fitting*" or "*convulsing*", instead of "*shaking*", I would have most likely have made a different finding, as "*fit or convulsion*" are deemed as warranting a Code Red medical emergency.

75 On his third attendance to the cell, Mr Aranui had now seen that Mr Roe had vomited. Although Mr Roe had gone back into a deep sleep and was snoring very loudly once Mr Aranui attended, it was obvious that Mr Roe's situation

[76] ts 3.8.21 (Mr Aranui), p.75
[77] ts 3.8.21 (Mr Aranui), p.83

had escalated. After Mr Aranui had given evidence that prisoners frequently vomit, he was asked the following by Counsel Assisting:[78]

> This wasn't a situation of Mr Roe just vomiting, though. You had had two calls previously from his cellmate, and you've mentioned that that included him saying that he was shaking. On reflection, should you have called a Code Red? --- The third one I should have, not the first two.

76 After Mr Aranui called out to Mr Roe without getting a response on this third occasion,[79] I find that with all the information he now had, he ought to have called a Code Red medical emergency over the radio. Instead, Mr Aranui returned to the unit's control room and telephoned Mr Grover to advise him of the situation, and request that a nurse attend to conduct a medical assessment. When asked why he did not make the call to the OIC over the radio, Mr Aranui replied, "*I have no idea.*"[80] He agreed that he did not regard it as urgent enough for him to use his radio.[81] This reflected an unfortunate degree of complacency.

77 As to whether a Code Red ought to have been called after the cell door had been opened, Mr Aranui did not consider making such a call, "*because the medic was already there and there were enough prison officers present*."[82]

78 Similarly, Mr Grover was not of the view that at any stage he should have called a Code Red:[83]

> There's not much point in me calling a Code Red because I'm the one responding and [sic - with] the nurses. So night shift is very different to day shift as well. So night shift, the only thing that – yes – if a Code Red was called, it would have saved me the time to make a phone call and maybe grab my couple of staff. So realistically, it would have had the same result. One nurse would have turned up because one nurse must remain in the infirmary because it has got all sick people.

[78] ts 3.8.21 (Mr Aranui), p.84
[79] ts 3.8.21 (Mr Aranui), p.82
[80] ts 3.8.21 (Mr Aranui), p.80
[81] ts 3.8.21 (Mr Aranui), p.81
[82] ts 3.8.21 (Mr Aranui), pp.87-88
[83] ts 3.8.21 (Mr Grover), pp.108-109

> So they're required – they can't leave. So only one person goes out at any time to an incident at night shift.

79 I do not accept there was "*not much point*" in Mr Grover calling a Code Red medical emergency following the telephone conversation he had with Mr Aranui. A Code Red call must be made over the radio and therefore all prison staff, including nurses, are on notice that a medical emergency exists, and the reason for it. All prison staff would have known at the outset of what they were required to do. As Mr Grover conceded:[84]

> With the benefit of hindsight and knowing the outcome of this incident resulted in the death of a prisoner, a Code Red should probably have been called.

80 Mr Grover should have definitively called a Code Red medical emergency by the time prison staff had accessed the cell and observed Mr Roe to be unresponsive and having a seizure. That conclusion can be made without the benefit of hindsight as Mr Roe was exhibiting not one but two symptoms that were listed in Addendum 22 of Local Order 24E as requiring a Code Red medical emergency radio call. This would have ensured that an ambulance was called immediately, and initiated other measures that are required whenever a Code Red medical emergency is made.

81 Although the delays that occurred in the treatment of Mr Roe may have been avoided if the Code Red call was made, it is highly unlikely those delays contributed to Mr Roe's death. As Dr Cooke testified, the morbidity rate associated with a ruptured berry aneurysm, "*is very substantial*" and that in Mr Roe's case, "*it was clear very early on that his chance of making a successful survival was very limited.*"[85]

82 Dr Cooke was also of the view that the delays encountered with (i) the prison officers and nurse accessing the cell, (ii) obtaining the wheelchair to transport

[84] Exhibit 1, Volume 1, Tab 55, Statement of Mr Grover dated 22 May 2021, p.3
[85] ts 3.8.21 (Dr Cooke), p.13

Mr Roe to the medical centre and (iii) the ambulance gaining access to the prison[86] would not have detrimentally impacted on Mr Roe surviving his "*immediate catastrophic rupture.*"[87]

83 For those responsible for calling a Code Red, it is only by good fortune that their inaction had little to no influence on the unfortunate outcome for Mr Roe following his ruptured berry aneurysm.

Failure to have a nurse attend prior to the third cell call

84 As already outlined, Mr Aranui did not make a Code Red medical emergency radio call. The question arises is whether he should have, instead, radioed or telephoned the medical centre for a nurse to medically assess Mr Roe before the third cell call.

85 At his first attendance outside Mr Roe's cell door, Mr Aranui was asked the following:[88]

> So you've said you were told by the cellmate that he was – Mr Roe was shaking and wailing [in his sleep]. Could you have taken that information to a prison nurse? --- I could have. Yes.
>
> And requested their advice? --- Probably.
>
> Was there anything made you think that you should do that? --- Not at the time. No.

86 During the inquest, I was provided with the Department's current policy and procedure regarding prisoner access to healthcare.[89] Under the heading "Access to Prison Health Centre", there is a clause that reads:[90]

> Prison Officers are to contact the Health Centre and request an assessment by Health Services staff, where there are concerns for the health and wellbeing of a prisoner.

[86] This delay is dealt with later in my finding.
[87] ts 3.8.21 (Dr Cooke), pp.13-15
[88] ts 3.8.21 (Aranui), p.70
[89] Exhibit 4, COPP 6.1 – Prisoner Access to Healthcare
[90] Exhibit 4, COPP 6.1 – Prisoner Access to Healthcare, p.5

87 The contents of this clause would strongly suggest that Mr Aranui ought to have contacted a prison nurse to request an assessment of Mr Roe.

88 When Ms Toni Palmer was asked whether medical staff should have attended to assess the situation after the first two cell calls, Ms Palmer responded:[91]

> Again, it's – it's difficult for me to say but based on what Mr Aranui said in evidence earlier potentially he should have.

89 Had the clause cited above existed in September 2017, I would be inclined to agree with Ms Palmer. However, she had earlier stated in her evidence that this policy had only been in place in the last 6-12 months.[92] At the conclusion of the inquest, I asked Ms Palmer to provide, through Mr Cade, the relevant policy that existed at the time of Mr Roe's death.

90 This policy, in addition to other material I had requested, was attached in the email from Mr Cade dated 5 August 2021 to Counsel Assisting. None of the policies provided contain any comparable clause to the one that presently exists. The nearest clause is found in "Health Services Policy: PM19 (Version 5) – Medical Emergency and Resuscitation of a Prisoner or Detainee", under the heading "Outside Heath Centre Hours", which reads:

> All Prison Officers/Youth Custodial Officers are trained in Basic Life Support and have access to emergency equipment. Custodial staff also has telephone access to the HS [Health Service] on-call Medical Practitioner.

91 Casuarina is only one of several prisons in Western Australia that has nursing staff available 24/7.[93] Hence, the reference to telephone access for prison officers to the on-call medical practitioner after hours would logically only be for those prisons without a 24/7 medical centre. However, this clause from 2017, unlike the current one, is unclear as to what a prison officer is to do

[91] ts 4.8.21 (Palmer), p.194
[92] ts 4.8.21 (Palmer), p.192
[93] ts 3.8.21 (Dr Moss), p.30

when there are concerns with the health and wellbeing of a prisoner in a situation that is not deemed a medical emergency.

92 In those circumstances, I do not find that Mr Aranui was required to contact a nurse to assess Mr Roe after attending either of the first two cell calls. However, given the clear directive in the current policy, that would not be the case today if a prison officer was aware of an unwell prisoner who the officer did not regarded as requiring a Code Red medical emergency.

Mr Grover did not personally call for an ambulance

93 As noted above, the on-duty clinical nurse called triple zero to request a priority ambulance shortly after Mr Roe had been taken to the medical centre.[94] The question arises is whether Mr Grover, as OIC, was required to make that call and whether the call should have been made earlier.

94 Addendum 22 to Local Order 24E states that for a serious or life-threatening incident:[95]

> **Note:** OIC to ensure that an ambulance is called immediately upon being advised that a prisoner has been found in an unresponsive state of collapse, even if the prisoner is without apparent signs of life.
> (Bold type in the original)

95 I do not read this provision as requiring the OIC to personally call for an ambulance. The OIC is only required to "*ensure*" that that is done.

96 Although it was clear that Mr Roe was "*in an unresponsive state of collapse*" following the nurse's assessment when he was still in his cell, an ambulance was not then "*called immediately*". A strict reading of the above provision required that to be done.

[94] Exhibit 1, Volume 1, Tab 52, Statement of clinical nurse on duty dated 8 November 2019, p.4
[95] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, p.167

97 However, in this instance, a nurse was in attendance and I accept it was not inappropriate for Mr Grover to rely on the nurse's appraisal of the situation. Mr Grover's evidence at the inquest was that once Mr Roe was taken to the medical centre, both nurses were able to have a better look before they said:[96]

> 'We need to get an ambulance'. As current practice at Casuarina, the nurses call the ambulance. We've had issues before where no one knew who the OIC was and things, so they didn't know who was calling the ambulance. So, it was determined the nurse would always call the ambulance from that stage. I was there while she made that call for the ambulance.

98 This procedure does make sense, particularly when the nurse and the OIC are assessing the ill prisoner at or about the same time (as was the case here). It is also consistent with the relevant Health Services Policy in existence at the time. This policy stated that the responding nurse to a Code Red medical emergency may, amongst other matters, "*arrange transfer of the patient to the nearest Emergency Department via ambulance*".[97] That would logically include making the triple zero call.

99 In the circumstances of this case, I find that it was appropriate for Mr Grover to rely on the attending nurses to determine when to call for an ambulance and for one of them to then make that call.

Mr Grover did not notify the prison's front gate that an ambulance had been called

100 Addendum 15 to the current Local Order 24E states:[98]

> The Senior Officer of the area/SO recovery will ensure that an ambulance is called immediately upon being advised that a person has been found in an unresponsive state of collapse even if the prisoner is without apparent signs of life. They will then advise the gate staff an ambulance has been called.
>
> **If an Ambulance has been called the gate needs to be advised.**
> (Bold type in the original).

[96] ts 3.8.21 (Grover), p.108
[97] Health Services Policy: PM19 (Version 5) – Medical Emergency and Resuscitation of a Prisoners or Detainee, p.3
[98] Exhibit 1, Volume 1, Tab 58C, Local Order 24E – Emergency Management Plans, Annex B, p.177

101 In his evidence at the inquest, Mr Grover stated that given how busy he was, he did not give the gate staff, "*a courtesy call to say an ambulance is coming in*".[99]

102 When taken to the provision cited above, Mr Grover stated that he was unaware of this written policy requirement.[100] He repeated that he believed it was only normally done as a "*a courtesy*".[101]

103 Although Mr Grover was unaware of the current requirement for the senior officer to notify the gate staff, this requirement did not exist under the version of Local Order 24E that applied in September 2017. The only task the OIC was required to undertake regarding the front gate was to, "*Restrict gate movement*".[102]

104 The reason for the current policy (and the one that existed in 2017) is obvious. It is to ensure that there is a minimum amount of delay to the ambulance accessing the prison. The question arises as to whether there was a delay in this instance as a result of the prison officer at the gate not being aware of the impending arrival of the ambulance.

105 Although the identity of the prison officer who was on the gate that night was known, given the passage of time, that officer had no recollection of the night in question.[103] However, I am able to find that there was an undue delay with the ambulance accessing the prison because of the Patient Care Record completed by the ambulance officers. In that record, there is a notation,

[99] ts 3.8.21 (Grover), p.109
[100] ts 3.8.21 (Grover), p.115
[101] ts 3.8.21 (Grover), p.115
[102] Local Order 24E – Emergency Management Plans dated 19 March 2015, Addendum 22, p.168
[103] ts 4.8.21 (Palmer), p.183; Exhibit 1, Volume 2, Tab 48, Statement of Deputy Superintendent John Pittard dated 30 July 2021, p.1,

"*Extended time getting into prison and to assess Pt* [patient], *nil response at front gate*".[104]

106 The Patient Care Record notes that the ambulance arrived at the prison at 1.50 am[105] and the gate occurrence book noted that it arrived at 1.58 am.[106] Although Mr Grover denied that there would have been an "*eight minute delay*",[107] I do find there was a delay of such a magnitude that the ambulance officers deemed it necessary to make an entry to that effect in the Patient Care Record. I find that the most likely explanation for this delay was that no one notified the gate staff of the ambulance's impending arrival.

107 It is open to draw an inference that part of an OIC's requirement in 2017 to "*restrict gate movement*" would logically include advising the gate of the impending arrival of the ambulance. However, that was not Mr Grover's understanding. He thought that such a call was only "*a courtesy*". Given the ambiguity of precisely what, if any, notification to the gate was required under this provision as worded in September 2017, I am not prepared to find that Mr Grover breached Local Order 24E by failing to notify the front gate.

108 Fortunately, this ambiguity no longer exists with the present wording in Local Order 24E.

Unavailability of CCTV footage and cell call records

109 Unfortunately, by the time of the inquest, there was no CCTV footage available[108] and no access to the recordings of the three cell calls that Mr Roe's cell mate made to Mr Aranui. As the CCTV footage would have a digital time stamp, a precise time line could have been established to

[104] Exhibit 1, Volume 1, Tab 51, St John Ambulance Patient Care Record, p.2
[105] Exhibit 1, Volume 1, Tab 51, St John Ambulance Patient Care Record, p.1
[106] Exhibit 1, Volume 1, Tab 37, Gate Occurrences – 18 September 2017
[107] ts 4.8.21 (Grover), p.123
[108] Although there is no CCTV footage available inside cells (aside from those in the Crisis Care Unit), there is CCTV footage of unit corridors and other areas of the prison.

determine how long it took various events to take place. The recordings of the cell calls would also provide independent evidence of the timing of these calls and the contents of the conversations Mr Roe's cell mate had with Mr Aranui.

110 Ms Palmer gave evidence that at the time of the original review (which she was not involved with), a request for relevant CCTV footage was not made. By the time she attempted to acquire this footage, it had already been overwritten by the server.[109] CCTV footage is stored on a local sever for a period of approximately three months before it is overwritten.[110]

111 As to the cell calls, Ms Palmer's enquiries revealed that cell calls are retained on the sever until it gets filled, which takes approximately 12 months, depending on the volume of the cell calls and the size of them. They are then overwritten. [111]

112 It was regrettable that no attempts were made by Department staff responsible for the initial review to ensure copies were kept of the relevant CCTV footage and cell call recordings. Fortunately, the Department's procedures regarding deaths in its custody have been updated since then. Those updated procedures are outlined later in this finding.

Marks on Mr Roe's forehead and his complaints of being tasered

113 The family of Mr Roe noticed black marks on his forehead when he was at SCGH. His sister, Christina Roe, had also seen them when she had visited Mr Roe in prison.[112] At my request, and through their counsel, the family provided to me, after the inquest, some photographs of Mr Roe that were taken at SCGH. Those photographs clearly depict black marks on Mr Roe's forehead. I fully appreciate why this has caused the family of Mr Roe some

[109] ts 4.8.21 (Palmer), p.172
[110] Exhibit 1, Volume 2, Tab 47C, Statement of Ms Palmer dated 29 July 2021, p.1
[111] ts 4.8.21 (Palmer), p.173
[112] ts 4.8.21 (C Roe), p.143

concern as he had told his sister they were caused by prison officers using tasers.[113]

114 Dr Cooke also noted these marks on Mr Roe's forehead during his post mortem examination. Dr Cooke described the marks as "*deep pigmentation*" and was not evidence of any physical injury or bruising.[114]

115 Dr Cooke did not see evidence of any taser use on Mr Roe's body. Relating to another matter, he had previously conducted a post mortem examination where the deceased had been tasered immediately prior to their death. Dr Cooke was therefore able to say he would typically see, "*marks on the skin surface from the marks or prongs, depending on how the taser is activated.*" Dr Cooke added that, "*In Mr Roe's case, I didn't see any of those marks.*"[115]

116 Given Dr Cooke's explanation for the darker colouring to Mr Roe's forehead, I am satisfied it was not an injury caused by an application of force by a taser, or any other means, to Mr Roe's head shortly before his death.

117 As to whether Mr Roe was tasered at some point in 2017 when he was at Casuarina, I have considered the statements of Assistant Superintendent Benjamin Leadbeatter and Superintendent Peter Anderson.[116] The only prison officers who carry tasers are those who are part of the Special Operations Group (SOG).[117] Whenever a taser is deployed, there is a record of its deployment and tasers used by SOG officers are downloaded for auditing purposes. For the 2017 calendar year, there was only one incident when a taser was deployed and that was at Hakea Prison on 13 December 2017. The

[113] ts 4.8.21 (C Roe), p.145
[114] ts 3.8.21 (Cooke), pp.17-18
[115] ts 3.8.21 (Dr Cooke), p.20
[116]Exhibit 1, Volume 1, Tab 57, Statement of Assistant Superintendent Leadbeatter dated 13 July 2021; Exhibit 1, Volume 1, Tab 59A, Statement of Superintendent Anderson dated 12 July 2021
[117] Exhibit 1, Volume 1, Tab 59A, Statement of Superintendent Anderson dated 12 July 2021, p.2

taser was only drawn and not fired.[118] A review of the TOMS[119] system did not record Mr Roe as being involved in any incidents which required SOG involvement, nor was he involved in any assault related incidents.[120]

118 Mr Roe had told his sister that he was tasered in the same cell that he was sharing with the cell mate who has been referred to in this finding.[121] Although I am prepared to accept that Mr Roe said this to his sister, it is not consistent with the following portion of the statement from Mr Roe's cell mate (who was his friend):[122]

> As far as I know [Mr Roe] had not been in any fights in prison. As far as I know [Mr Roe] had not had any accidents in prison. I never saw any injuries on [Mr Roe] in prison.

119 Despite Mr Roe's comments to members of his family, I am not satisfied that he was tasered at any time during his incarceration at Casuarina. Nor am I satisfied that he was electrocuted, whether by a taser or otherwise, as he alleged to his sister and other members of his family.[123] In so finding, I have also noted this answer at the inquest from Jahlana Roe, a daughter of Mr Roe:[124]

> So, moving now to – in your statement you've mentioned that Mr Roe told you that he was being tasered. Did he use those exact words, that he was being tasered, or was it in different language? --- Yes. He actually – he would say – he, kind of, like – to be honest, he would joke around – joke around about it.

Time spent in a punishment cell by Mr Roe prior to his death [125] [126]

120 On behalf of Mr Roe's family, Christina Roe raised concerns that Mr Roe had been placed in "*the pits*" (a punishment cell) for four weeks and was not permitted to make frequent telephone calls.

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[118] Exhibit 1, Volume 1, Tab 57, Statement of Assistant Superintendent Leadbeatter dated 13 July 2021, p.2
[119] Total Offender Management Solution
[120] Exhibit 1, Volume 1, Tab 59A, Statement of Superintendent Anderson dated 12 July 2021, p.3
[121] ts 4.8.21 (C Roe), p.147
[122] Exhibit 1, Volume 1, Tab 10, Statement of Mr Roe's cellmate dated 3 October 2017, p.2
[123] ts 4.8.21 (C Roe), p.151
[124] ts 4.8.21 (J Roe), p.161
[125] Exhibit 1, Volume 2, Tab A, Death in Custody Report by Ms Palmer dated 26 September 2019
[126] Exhibit 1, Volume 2, Tab 47D, Statement of Ms Palmer dated 29 July 2021

121 TOMS cell placement history records show that when at Casuarina, Mr Roe was placed on a punishment regime and transferred into a punishment cell on three occasions from 23 August 2017 to 29 August 2017, from 1 September 2017 to 7 September 2017 and finally, from 10 September 2017 to 16 September 2017. During these periods of punishment, Mr Roe made a number of telephone calls.[127]

122 This 21-day punishment regime was imposed by a visiting Justice of the Peace on 23 August 2017. The Justice of the Peace found Mr Roe guilty of prison offences relating to the possession of illicit drugs (cannabis and buprenorphine) and insubordination/misconduct. Section 78(2) and (3) of the *Prisons Act 1981* (WA) stipulates that a prisoner subject to punishment regimes must spend no more than seven days at one time in a punishment cell.

123 Between each seven-day period of punishment Mr Roe spent two days within the mainstream prison setting, before returning to a punishment cell.

124 I am satisfied from all the evidence before me that Mr Roe did not spend more than seven consecutive days in a punishment cell. I also find on the evidence before me that he was accorded the rights he was entitled to as a prisoner who is confined to a punishment cell, including being permitted to make telephone calls as stipulated by prison policy.

IMPROVEMENTS SINCE MR ROE'S DEATH

125 As would be expected of all governmental departments, the Department is always on a pathway of continual improvement. There is frequently a gap of some duration between the date of the death requiring a mandatory inquest and the date of the inquest. In those circumstances, a governmental department connected to the death will often implement changes that are

[127] Exhibit 1, Volume 1, Tab 33, Recorded Call Report for Mr Roe

designed to improve practices and procedures before the inquest is heard. There have been several changes made by the Department since Mr Roe's death that should eliminate the missed opportunities that were identified at the inquest.

Increase in night shift staff numbers

126 In 2017, there were only 16 prison officers rostered on night duty at Casuarina, which included one senior officer who was the OIC. Only the OIC had a full set of keys, including the keys to unlock the cells.[128]

127 Presently, there are 24 prison officers that comprise the night shift staff at Casuarina, including two senior officers who have a full set of keys.[129] However, there has been an increase in prisoner population at Casuarina and extra staff have been allocated as a result of that. Nevertheless, the fact that two prison officers have a full set of keys should reduce the response time if a cell needs to be accessed due to a medical emergency.

Policy for when a prison officer has concerns for the health and wellbeing of a prisoner

128 I have already referred to the policy that now exists that requires prison officers to contact the prison's health centre to request an assessment by medical staff when they have concerns for the health and wellbeing of a prisoner.[130] No such provision existed in September 2017.

129 If this policy is complied with, then it would be expected that a prison officer in the circumstances that Mr Aranui found himself in would contact a prison nurse after receiving the first cell call. That is because the policy requires this contact to be made, even if the prison officer is of the view the circumstances do not warrant the calling of a Code Red medical emergency.

[128] Exhibit 1, Volume 1, Tab 59A, Statement of Superintendent Anderson dated 12 July 2021, pp.3-4
[129] Exhibit 1, Volume 1, Tab 59A, Statement of Superintendent Anderson dated 12 July 2021, pp.3-4
[130] Exhibit 4, COPP6.1 – Prisoner Access to Health Care Policy, p.5

130 The requirement for an assessment of an unwell prisoner by a qualified prison health carer is critically important, especially at night time when prisoners can be locked in their cells from 6.15 pm until the unlocking of their cells in the morning.[131] A prisoner's access to health care during these hours is completely reliant on a prison officer making the decision to contact the prison's health centre (or the after-hours service if the prison does not have a 24/7 health centre). Prison officers on night shift should never under-estimate the important obligations they have towards a prisoner who is unwell, even if the prisoner's condition does not meet the requirements that would necessitate the calling of a Code Red medical emergency.

131 I would urge the Department to undertake any necessary measures that would ensure all prison officers are aware of their obligations to request an assessment by prison medical staff whenever they have a concern for the health and wellbeing of a prisoner. There should be a clear message that it is always safer to request an assessment than to later regret that it was not made.

The retention of evidence following the death of a prisoner

132 It was troubling to hear of the Department's failure to retain relevant CCTV footage and cell call recordings in this matter.

133 The evidence of Ms Palmer as to what now occurs is, however, reassuring. The updated procedures for the Department's review of a prisoner's death now means that all relevant CCTV footage and cell calls are requested at an early stage to avoid risk of deletion.[132]

134 It is now the practice of Ms Palmer to contact the relevant prison superintendent and provide a list of items that are required for the review of a

[131] Exhibit 1, Volume 1, Tab 58D, Local Order 24A – Counts, Lockups, Unlocks and Parades, pp.7 and 9
[132] ts 4.8.21 (Palmer), p.175

prisoner's death.[133] If the practice doesn't already exist, I would recommend that the Department's Review Officer has a pro forma checklist of items that are needed for the review of a prisoner's death. A box can be ticked next to each item on the checklist, indicating that the prison is required to provide those items.

QUALITY OF SUPERVISION, TREATMENT AND CARE

135 I am satisfied that Mr Roe's health needs were adequately addressed at Casuarina by health care staff, from the time he was transferred there in November 2016 until 18 September 2017 when he was taken by ambulance to FSH.

136 I am also satisfied of the supervision, treatment and care of Mr Roe by the general prison staff at Casuarina, up until the night of 17 September 2017. I do not find that he was mistreated in the manner he outlined to members of his family.

137 As to the treatment and care of Mr Roe from the time his cell mate made his first cell call to Mr Aranui, I have already outlined in this finding some deficiencies in that regard; most notably the failure to call a Code Red medical emergency. However, I am satisfied that those deficiencies did not contribute to Mr Roe's death. As the evidence of Dr Cooke made clear, the catastrophic haemorrhaging caused by the ruptured berry aneurysm always meant that the prospect of Mr Roe surviving was very low.

CONCLUSION

138 Mr Roe was 50 years old when he died at SCGH on 21 September 2017. He had only served approximately three years of a life imprisonment term,

[133] ts 4.8.21 (Palmer), p.175

following his conviction of a murder committed in September 2014. His first review date for parole eligibility was not until 27 September 2035.

139 There was no immediate warning that Mr Roe was about to sustain a ruptured berry aneurysm, which occurred sometime in the evening of 17 September 2017. Nor could it have been predicted that Mr Roe was going to have an aneurysm of this type. The severity of the subsequent haemorrhaging meant his chances of surviving were always going to be extremely low.

140 Although I have found that a Code Red medical emergency ought to have been called, at the latest, by the time prison staff saw that Mr Roe was unresponsive and fitting, the failure to do so did not contribute to his death.

141 I am satisfied that the Department has identified the missed opportunities that arose in the care of Mr Roe in the three hours before he was transferred by ambulance to hospital on 18 September 2017. I am satisfied it has implemented policies and procedures to minimise those from occurring again. I am also satisfied the failure to obtain relevant evidence by the initial Department review of Mr Roe's death should not be repeated with the introduction of a better procedure for the collection of such evidence before it becomes unavailable.

142 Mr Roe was a much-loved member of his family, and he received regular visits from his family throughout his last incarceration at Casuarina. He will be deeply missed by his siblings and children.

PJ Urquhart
Coroner
1 November 2021