JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	14 JULY 2022
DELIVERED	**:**	5 AUGUST 2022
FILE NO/S	**:**	CORC 198 of 2020
DECEASED	**:**	HARDIE, MICHAEL JAMES

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Guardianship and Administration Act 1990 (WA)
Prisons Act 1981 (WA)

Appearances:

Sergeant A. Becker assisted the coroner.

Ms G. Mullins (State Solicitor's Office) appeared for the Department of Justice.

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

Rogers v Whitaker (1992) 175 CLR 479*In Re F* [1990] 2 AC 1

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Michael James HARDIE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 14 July 2022, find that the identity of the deceased person was* ***Michael James HARDIE*** *and that death occurred on 7 February 2020 at Fiona Stanley Hospital, from haemothorax due to ruptured thoracic aortic aneurysm in a man with Marfan syndrome and methylamphetamine effect in the following circumstances:*

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SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an order under section 49(1)(b) of the *Coroners Act 1996* (WA) that there be no reporting or publication of any document or evidence that would reveal any information about the methods of detecting illicit drugs, including methylamphetamine, with respect to persons under the care and control of the Director-General of the Department of Justice.

Order made by: MAG Jenkin, Coroner (14.07.22)

INTRODUCTION

1. Michael James Hardie (Mr Hardie) died on 7 February 2020 at Fiona Stanley Hospital (FSH) from haemothorax due to ruptured thoracic aortic aneurysm in a man with Marfan syndrome and methylamphetamine effect.[1,2,3,4,5]

2. At the time of his death, Mr Hardie was a sentenced prisoner in the custody of the Chief Executive Officer (CEO) of the Department of Justice (DOJ) and was therefore a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest must be held.[6,7]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[8]

4. I held an inquest into the circumstances of Mr Hardie's death on 14 July 2022. The Brief containing the documentary evidence adduced at the inquest comprised two volumes.

5. The inquest focused on the supervision, treatment and care that Mr Hardie received while he was in custody and the circumstances of his death. The following witnesses gave evidence at the inquest:

a. Mr John Pittard (Deputy Superintendent, Casuarina Prison);

b. Dr Joy Rowland (Director Medical Services, DOJ); and

c. Ms Toni Palmer (Senior Review Officer, DOJ).

[1] Exhibit 1, Vol 1, Tab 6B, Supplementary Post Mortem Report (23.03.20)
[2] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), paras 15-27
[3] Exhibit 1, Vol 1, Tab 1, P100 Report of Death (07.02.20)
[4] Exhibit 1, Vol 1, Tab 4, P92 Identification of deceased person, Visual means (13.02.20)
[5] Exhibit 1, Vol 1, Tab 5, Death in Hospital form (07.02.20)
[6] Section 16, *Prisons Act 1981* (WA)
[7] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[8] Section 25(3) *Coroners Act 1996* (WA)

MR HARDIE

Background[9,10,11]

6. Mr Hardie was born in Bentley on 21 May 1978 and was 41-years of age when he died. He had a younger sibling and had worked for a timber producer after completing Year 11. Mr Hardie never married and had no children. He also had a history of alcohol and methylamphetamine use.

Medical history[12,13,14,15]

7. Mr Hardie was born with Marfan syndrome, a genetic disorder affecting the body's connective tissues that can cause issues with the heart, eyes, blood vessels, and skeleton. Those with Marfan syndrome typically have unusually elongated limbs, fingers, and toes. Mr Hardie's most significant medical issue was a thoracoabdominal aortic aneurysm (an enlarged area of the lower part of his aorta).[16]

8. Mr Hardie underwent various surgical procedures including an aortic valve replacement in 2001, aneurysm repairs in 2011 and 2013, and the removal of his gallbladder in 2016. During the 2016 admission, CT scans showed Mr Hardie's abdominal aortic aneurysm (Mr Hardie's aneurysm) had enlarged. Because of the size of Mr Hardie's aneurysm, there were limited treatment options because there were no stents big enough for a closed repair, and an open repair "*would confer a high risk of paralysis and death*".[17]

9. There was a very high risk that Mr Hardie's aneurysm would eventually rupture and that when it did, his chances of survival would be "*minimal*". For that reason, Mr Hardie was managed "*conservatively*", meaning he was prescribed medication designed to ensure his blood pressure remained below 140 mmHg systolic.[18]

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[9] Exhibit 1, Vol 1, Tab 8A, File Note - Discussion with Mr B Hardie (13.02.20)
[10] Exhibit 1, Vol 1, Tab 8B, Statement - Sen. Const. A May (31.03.20)
[11] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), p8
[12] Exhibit 1, Vol 2, Tab 21, Health Services Summary - Acacia Prison (12.07.22)
[13] Exhibit 1, Vol 2, Tab 22, Health Services Summary - DOJ (13.07.22)
[14] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), pp8-10
[15] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), paras 4-11
[16] See: https://www.mayoclinic.org/diseases-conditions/abdominal-aortic-aneurysm/symptoms-causes/syc-20350688
[17] Exhibit 1, Vol 1, Tab 17A, Letter - Dr N Altaf (21.02.22)
[18] Exhibit 1, Vol 1, Tab 17B, Letter - Dr N Altaf (22.03.22)

10. Records clearly show that Mr Hardie repeatedly declined to attend specialist appointments and to have follow-up CT scans to check on his aneurysm because he "*did not wish to know*" about the progression of his condition. In January 2017, Mr Hardie declined a surgical follow-up and said he would arrange his own review after being released from prison.

11. There are multiple entries in Mr Hardie's prison records confirming he was encouraged to give up smoking, and had declined to do so. As Mr Hardie was prescribed anti-coagulant medication (warfarin), he underwent regular blood tests to assess the time taken for his blood to clot (INR test).[19] Although Mr Hardie generally attended these checks, there are examples of the tests having to be rescheduled when he did not.

12. Following his death, DOJ conducted a review of the health services Mr Hardie received whilst incarcerated (the Review). The Review summarised his medical care in these terms:

> Mr Michael Hardie was a 38-year-old man when he was admitted to custody for the final time on the 9th November 2017. He had a history of Marfan Syndrome for which he had required multiple cardiac and vascular surgeries. Also noted at the time of his admission was that he reported a cough present for a few months, productive of clear sputum. He denied any significant mental health history and reported that he smoked tobacco and used methamphetamine daily (smoked and intravenous use). At reception into prison, he was not assessed as requiring ARMS monitoring (At-Risk Management System), but 5-days after his reception into prison, he requested to see the Prison Counseling Service for support prior to going to court.[20]

13. The Review concluded that the management of Mr Hardie's medical conditon during his incarceration was "*commensurate with, and possibly of better quality, than community standards*".[21] However, as I will discuss later in this finding, the Review identified some areas for improvement.

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[19] INR stands for International Normalised Ratio and is a test used to monitor anticoagulant dosage. An INR of "2" means a patient's blood takes twice the normal time to clot (Oxford Concise Colour Medical Dictionary, 5th Ed., p379)
[20] Exhibit 1, Vol 2, Tab 22, Health Services Summary - DOJ (13.07.22), p3
[21] Exhibit 1, Vol 2, Tab 22, Health Services Summary - DOJ (13.07.22), p19

Offending history[22,23,24,25,26,27]

14. Mr Hardie had an extensive criminal record, and by 2020, he had accumulated 51 convictions for various offences including stealing, burglarly, armed robbery and drug-related offences. He was sentenced to various terms of imprisonment between 2002 and 2008. In 2009 and 2014, Mr Hardie was sentenced to lengthy terms of imprisonment (i.e.: 4 years; and 3 years 10 months respectively) in relation to possession of methylamphetamine with intent to sell or supply.

15. On 11 May 2018, in the District Court of Western Australia at Perth, Mr Hardie was sentenced to a term of 5 years and nine months' imprisonment (without eligibility for parole), in relation to one count of posessing stolen property (i.e.: $2,800 in cash) and two counts of possessing methylamphetamine with intent to sell or supply.

Prison history[28]

16. During his last period of incarceration, Mr Hardie had the following prison placements:

a. *Hakea Prison:* 09.11.17 - 08.12.17 (29 days);
b. *Casuarina Prison:* 08.12.17 - 06.04.18 (119 days);
c. *Acacia Prison:* 06.04.18 - 11.10.19 (553 days); and
d. *Casuarina Prison::* 11.10.19 - 07.02.20 (119 days).

17. Following an intake assessment to identify prisoners at risk of self-harm (conducted at Hakea on 9 November 2017) the reception officer noted:

> Prisoner presented (as) calm and co-operated well. Answering all questions asked of him. Did not present any issues, has supportive family and partner. Prisoner stated he has a serious medical condition. Prisoner states he has no issues with drugs and alcohol. Prisoner states he has no history or current thoughts of self-harm and shows no signs of being at risk at time of interview.[29]

[22] Exhibit 1, Vol 1, Tab 16, Court outcomes history - Criminal & Traffic
[23] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), pp8-9
[24] Exhibit 1, Vol 1, Tab 14, Sentencing Remarks, Troy DCJ (11.05.18), p5
[25] Exhibit 1, Vol 1, Tab 15, Warrant of Commitment(11.05.18)
[26] Exhibit 1, Vol. 1, Tab 2A, Report - Sen. Const. S Rohde, Coronial Investigation Squad (22.05.21), pp2-3
[27] Exhibit 1, Vol. 2, Tab 18.1, Sentence Summary - Offender
[28] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), pp9-14
[29] Exhibit 1, Vol 2, Tab 18.3, At Risk Management System - Reception intake assessment (09.11.17), p6

18. A multiple cell occupancy assessment determined that Mr Hardie was not suitable to share a cell with a smoker because of his medical issues. Records indicate that during several previous periods of incarceration, Mr Hardie had asked for permission to share a cell. However, on the basis of a medical certificate signed by a prison medical officer in 2015, Mr Hardie was assessed as needing a single cell "*indefinitely*".[30]

19. During his orientation assessment, Mr Hardie told prison staff he expected his partner would visit him and that he was willing to engage in prison employment. On 10 November 2017, Mr Hardie's security level was reduced to "*medium*" and he was assessed as suitable for transfer to Acacia Prison (Acacia), "*to facilitate visits*". However, it was noted that Mr Hardie may need to be temporarily transferred to Casuarina Prison (Casuarina) in the first instance for "*muster pressure relief*".[31]

20. As it happens, Mr Hardie was transferred to Casuarina on 8 December 2017. His time at Casuarina was uneventful, and he was transferred to Acacia on 6 April 2018, and allocated a single cell. An assessment report completed on 28 November 2018 concluded that Mr Hardie was at "*high risk*" of reoffending and recommended he attend a "*medium intensity program*" aimed at addressing criminal thinking, self-management, problem solving and substance use (MIP).[32]

21. At around this time, Mr Hardie was described in various assessments as being a polite and respectful prisoner who was hardworking and displayed "*a good work ethic*". Periodic reviews also noted Mr Hardie maintained acceptable levels of personal and cell hygiene. An individual management plan completed on 5 December 2018, noted that Mr Hardie was happy to remain at Acacia where he received visits from his family.[33,34,35]

[30] Exhibit 1, Vol 2, Tab 18.5, Multiple cell occupancy risk assessment (09.11.17)
[31] Exhibit 1, Vol 2, Tab 18.6, Orientation checklist (10.11.17)
[32] Exhibit 1, Vol 2, Tab 18.12, Treatment assessment report (28.11.18)
[33] Exhibit 1, Vol 2, Tab 18.13, Classification review (03.12.18)
[34] Exhibit 1, Vol 2, Tab 18.15B, Individual management plan (05.12.18)
[35] Exhibit 1, Vol 2, Tab 18.28, Visits history

22. Whilst Mr Hardie was at Acacia, he was subjected to two random drug tests, both of which returned negative results. Following a targeted cell search on 9 October 2019, it was discovered that Mr Hardie was in possession of a pair of scissors and had tampered with the security seal of his personal DVD player. As a result, he was placed in close confinement for three days and subjected to a further drug test, which was also negative.[36,37,38]

23. A classification review on 9 October 2019 noted that Mr Hardie's participation in the MIP had been terminated, and he was subsequently transferred to Casuarina. The transfer was prompted by security reports suggesting that Mr Hardie may be involved in drug trafficking activities. The move to Casuarina was designed to disrupt the "*drug network*" at Acacia. However, as I will outline later in this finding, due to an appalling breakdown in communication, security staff at Casuarina were not told the reason for Mr Hardie's transfer.[39]

24. During his last period of incarceration, Mr Hardie received regular visits from his partner and from his family and friends. He kept in touch with them between visits by way of numerous phone calls and occasional letters, and other than two minor breaches of prison procedures, he was not charged with any prison offences.[40]

25. On 23 October 2019, Mr Hardie's partner was apprehended in the visitor carpark at Casuarina and searched. A plastic bag containing "*clear residue*" and a capped syringe was found in her handbag and two more capped syringes were found in her car. As a result, Mr Hardie's partner was banned from visiting Casuarina. A security report dated 6 November 2019, suggested that Mr Hardie and his cellmate may be involved in trafficking contraband into Casuarina. A cell search on 11 November 2019 found a razor with three detachable blades that Mr Hardie had purchased whilst he was at Acacia.[41,42,43,44]

[36] Exhibit 1, Vol 2, Tab 18.20, Substance use test results
[37] Exhibit 1, Vol 2, Tab 18.24, Cell searches report
[38] Exhibit 1, Vol 2, Tab 18.17, Close confinement documents (09.10.19)
[39] Exhibit 1, Vol 2, Tab 18.18, Classification review (09.10.19)
[40] Exhibit 1, Vol 2, Tab 18.28, Visits history, Prisoner Mail report & Recorded calls report
[41] Exhibit 1, Vol. 1, Tab 2A, Report - Sen. Const. S Rohde, Coronial Investigation Squad (22.05.21), p3
[42] Exhibit 1, Vol. 2, Tab 18.22, Incident summary report (23.10.19)
[43] Exhibit 1, Vol. 2, Tab 18.22, Incident description reports (23.10.19)

26. Mr Hardie's cell was searched again on 20 November 2019, but the record for this search is woefully inadequate and merely states "*prisoners acting suspicious, numerous items found*". As there is no indication in the record of exactly what items were discovered, it is impossible to make any assessment of whether any follow-up action was warranted. Mr Hardie's cell was searched for the last time on 6 January 2020, but nothing untoward was found.[45]

27. Astonishingly, despite a security report dated 26 January 2020 suggesting that Mr Hardie may be involved in drug trafficking activities at Casuarina, he was not subjected to drug tests or cell searches Even given the fact that security staff had not been made aware of the reason for Mr Hardie's transfer to Casuarina, it is difficult to understand why he would not have been subjected to immediate checks and ongoing monitoring, following the adverse security report.

28. There is at least a possibility that had Mr Hardie been subjected to drug tests and/or cell searches following this security report, his use of illicit substances at Casuarina (and specifically methylamphetamine) might have been detected.

29. As I will discuss later in this finding, methylamphetamine played a significant role in Mr Hardie's death. Although it is not possible to determine exactly when Mr Hardie used the methylamphetamine that was found in his system after his death, had he been subjected to drug testing on or after 26 January 2020, he may have been more circumspect about using the substance.

30. In any event, on security grounds alone, the failure to subject to Mr Hardie to cell searches and/or drug testing is troubling.[46]

[44] Exhibit 1, Vol 2, Tab 18.24, Cell searches report
[45] Exhibit 1, Vol 2, Tab 18.24, Cell searches report and ts 14.07.22 (Palmer), pp67-68
[46] ts 14.07.22 (Pittard), pp5 & 19-23

CIRCUMSTANCES OF DEATH

Observations prior to death

31. At the time of his death, Mr Hardie had been sharing a cell with another prisoner (who I have chosen to identify as Prisoner A) for about six months. There is no evidence that Prisoner A, or anyone else for that matter had identified any medical issues with Mr Hardie other than his persistent cough. Prisoner A said Mr Hardie had "*a lot of coughs*" on the morning of 7 February 2020, and although Mr Hardie's cough had "*appeared better*" during the course of the previous week, his sleep remained poor.[47]

Mr Hardie becomes unresponsive[48,49]

32. Prior to the morning unlock on 7 February 2020, Mr Hardie was chatting to Prisoner A as he cleaned their cell. Shortly before 8.10 am, Mr Hardie suddenly reached his hand towards Prisoner A and said "*I'm a bit fucked*" before collapsing to the floor.

33. Prisoner A initially thought Mr Hardie was joking, but moments later realised something was seriously wrong. Mr Hardie was not responsive and his face had turned white. He was struggling to breathe and had bitten his tongue. Prisoner A activated the emergency call button in the cell and called for help as he banged on the cell door.

34. At about 8.10 am, Senior Officer Wall and Officers Surrey, Stocker and Atkinson responded to Prisoner A's call for help and opened the cell door. The officers placed Mr Hardie onto his back and checked for a pulse whilst administering a "*sternal rub*" to try to elicit a response. The officers started CPR and Mr Hardie was subsequently removed from his cell and placed in an adjacent walkway where there was more room.

35. Prison officers on Unit 1, and other staff, continued CPR in rotation. A total of seven nurses, two prison medical officers (PMO) and 19 prison officers had some involvement in these resuscitation efforts.[50]

[47] Exhibit 1, Vol. 1, Tab 9, Statement - Prisoner A, (07.02.20)
[48] Exhibit 1, Vol. 1, Tab 2A, Report - Sen. Const. S Rohde, Coronial Investigation Squad (22.05.21), pp4-5
[49] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), pp14-15
[50] Exhibit 1, Vol 2, Tab 18.25, Incident description reports x 26 (07.02.20)

Adequacy of resuscitation response[51,52,53,54,55]

36. When assessing the adequacy of the resuscitation response in this case, I accept there was a very high risk that Mr Hardie's aneurysm would eventually rupture and that when it did, his chances of survival were minimal. Any attempt to resuscitate Mr Hardie following such a rupture would therefore be futile, although prison staff would not know that at the time of his collapse. The risk that Mr Hardie's aneurysm would rupture was significantly increased by his persistent smoking (despite advice he should stop) and his methylamphetamine use, although he claimed to have abstained since November 2017.[56,57]

37. At the time of Mr Hardie's collapse a targeted search operation was underway in Unit 1. This meant additional officers were in the unit and prisoner's personal items had been placed outside their cells as the search proceeded. Nevertheless, as the St John Ambulance (SJA) patient care record starkly records, the response of prison staff to Mr Hardie's collapse was shambolic.

38. Things got off to a bad start. When the first of two ambulance crews arrived at Casuarina at 8.25 am, the escorting prison officer was unable to give the crew any information about the number of patients or the situation. The SJA patient care record describes the scene in these terms:

> **Scene - extremely chaotic / approximately 20 - 25 staff on scene. No clear team leader of resuscitation.** Clutter of bags around area. Unknown down time ?Cell mate alerted officers to patient unresponsive / not breathing. ?Resuscitation approximately 10-15 minutes prior to SJA arrival. When trying to determine situation conflicting information given - initially being told 5 x shocks then confirming 1 x shock administered via AED (i.e.: defibrillator). **SJA attempted to take control of scene - partner spoke loudly advising all parties to listen to myself taking control.**[58] [Emphasis added]

[51] Exhibit 1, Vol. 1, Tab 12, SJA Patient Care Record, Crew KW121D2 (07.02.20)
[52] Exhibit 1, Vol. 1, Tab 10, FSH Emergency Department records (07.02.20)
[53] Exhibit 1, Vol. 1, Tab 2A, Report - Sen. Const. S Rohde, Coronial Investigation Squad (22.05.21), pp4-5
[54] Exhibit 1, Vol. 1, Tab 13A, Targeted search operation documents (07.02.20)
[55] ts 14.07.22 (Rowland), p57-61 and ts 14.07.22 (Palmer), pp65-67
[56] Exhibit 1, Vol 2, Tab 18.12, Treatment assessment report (23.11.18), p4 and ts 14.07.22 (Rowland), p39
[57] Exhibit 1, Vol 1, Tab 17A, Letter - Dr N Altaf (21.02.22)
[58] Exhibit 1, Vol. 1, Tab 12, SJA Patient Care Record, Crew KW121D2 (07.02.20), p2

39. When first assessed by ambulance officers, Mr Hardie was in asystole,[59] a rhythm which persisted during the entire time he was at Casuarina. Mr Hardie was given 11-doses of adrenaline by means of a bone gun inserted into his left ankle. He was also given amiodarone, a medication used to treat cardiac arrythmias and he received six shocks from the defibrillator. Mr Hardie was taken to FSH by ambulance, but despite further resuscitation efforts he could not be revived and was declared deceased at 9.29 am.[60]

40. I accept that responding to an unconscious patient, especially in a custodial setting, is a highly stressful event and that those on the scene have an understandable desire to do whatever they can to help. However, the old saying "*too many cooks spoil the broth*" is never more clearly demonstrated when, in reacting to a critical first aid situation, no one steps forward to assume a leadership role.

41. As noted, ambulance officers observed there was "*no clear team leader*" and this was the case despite the fact that two PMOs were actually on the scene. I would have expected that one or other of the PMOs would have assumed a leadership role and directed resuscitation efforts. At the inquest, Dr Rowland agreed and said that since Mr Hardie's death, she has been actively providing opportunities for PMOs to develop and enhance their leadership skills.[61]

42. An excellent way to develop skills in the management of emergency situations is to practice. This Court has previously made recommendations relating to the conduct of scenario-based training exercises designed to assist staff to respond to medical emergencies.[62] Following a recent inquest relating to the death of Mr Lane at Eastern Goldfields Regional Prison, I recommended DOJ conduct bi-monthly scenario based training exercises relating to medical emergencies. That recommendation was supported and I would **strongly urge** DOJ to conduct regular scenario-based training exercises with respect to medical emergencies at all of its prisons.[63]

[59] Asystole is the total cessation of electrical activity in the heart and is the most serious form of cardiac arrest.
[60] Exhibit 1, Vol 1, Tab 5, Death in Hospital form (07.02.20)
[61] ts 14.07.22 (Rowland), p57-61
[62] For example: [2020] WACOR 44, Inquest into the death of Jordan Robert Anderson, p47, Rec. 4 (Coroner PJ Urquhart)
[63] [2022] WACOR 30, Inquest into the death of Ashley Adrian Lane, p64, Rec. 7 (Coroner MAG Jenkin)

CAUSE AND MANNER OF DEATH

Post mortem examination[64,65]

43. A forensic pathologist, Dr Dan Moss (Dr Moss) carried out an external post mortem examination of Mr Hardie's body at the State Mortuary on 11 February 2020 and reviewed CT scans. Dr Moss noted that Mr Hardie had features of Marfan's syndrome including elongated fingers and toes and that both tibia bones had a "*somewhat bowed appearance*".

44. Dr Moss' examination also found that Mr Hardie had a large descending thoracic aortic aneurysm which had apparently ruptured, causing bilateral haemothoraces (i.e.: collections of blood in the pleural cavity).

45. At the conclusion of his post mortem examination, Dr Moss expressed the opinion that the cause of Mr Hardie's death was haemothorax due to ruptured thoracic aortic aneurysm in a man with Marfan syndrome and methylamphetamine effect. However, Dr Moss noted:

> Due to the presence of methylamphetamine, I am not in a position to determine that the death was due to natural causes and leave manner (of death) determination to the Coroner.[66]

Toxicological analysis[67,68]

46. Toxicological analysis detected several prescribed medications in Mr Hardie's system, namely the anticoagulant, warfarin; the blood pressure medications amlodipine and metoprolol; and omeprazole which is used to treat gastroesophageal reflux. Professor Joyce noted that two other blood pressure medications which had been prescribed to Mr Hardie (prazosin and ramipril) were not detected but observed that:

> That is not unexpected as both are effective at low prescribed doses, so yield plasma concentrations that may not be detected on routine blood screening.[69]

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[64] Exhibit 1, Vol 1, Tab 6A, Post Mortem Report (11.02.20)
[65] Exhibit 1, Vol 1, Tab 6B, Supplementary Post Mortem Report (23.03.20)
[66] Exhibit 1, Vol 1, Tab 6B, Supplementary Post Mortem Report (23.03.20), p1
[67] Exhibit 1, Vol 1, Tab 7, ChemCentre toxicology report (13.02.20)
[68] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), paras 13 & 16

47. A significant level of methylamphetamine (0.27 mg/L) was also detected in Mr Hardie's system along with a smaller level of its metabolite, amphetamine (0.02 mg/L). Professor Joyce said the detected level of methylamphetamine was "*quite high if it had arisen from a single administration by smoking or injection*". Professor Joyce also observed that a large dose by mouth could achieve the same concentration, but that this was not the method preferred by most users.

Effects of methylamphetamine[70]

48. In his report, Professor Joyce explained that there are several well recognised pathways to sudden death during methylamphetamine intoxication including: uncontrolled seizures, agitated delirium, ventricular tachyarrhythmias, coronary artery spasm, cerebral haemorrhage and ruptures of major arteries.

49. Professor Joyce also noted that methylamphetamine has a "*substantial*" effect on blood pressure and there is an appreciable risk of arterial rupture and tears to the inner lining of the aorta (aortic dissection). As to the cause of Mr Hardie's death, Professor Joyce stated:

> Mr Hardie's aortic aneurysm was at high risk of rupture. The risk was being managed by lowering the blood pressure in the aorta. Methylamphetamine use would have increased blood pressure, negating the benefit of his blood pressure medications and exposing his aorta to unaccustomed internal pressures that threatened its integrity. The methylamphetamine use therefore seems to have a well substantiated role in precipitating the rupture and causing death.[71]

Cause and manner of death

50. I adopt Dr Moss' conclusion as the cause of Mr Hardie's death, namely: haemothorax due to ruptured thoracic aortic aneurysm in a man with Marfan syndrome and methylamphetamine effect. Further, on the basis of Professor Joyce's evidence, I am satisfied that methylamphetamine caused Mr Hardie's aortic aneurysm to rupture. As there is no evidence Mr Hardie used methylamphetamine with the intention of ending his life, I find that the manner of Mr Hardie's death was accident.

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[69] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), para 14
[70] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), paras 16-24
[71] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), para 27

METHYLAMPHETAMINE IN PRISON

Overview

51. As Professor Joyce pointed out in his report, using methylamphetamine is a highly dangerous business and carries the risk of serious health issues and death. Quite apart from the devastating health consequences to the user of illicit substances, drug trafficking represents a clear and present danger to the good order and security of the prison system in general and to individual prisons in particular.[72,73]

52. For a start, there are the obvious risks associated with managing prisoners who are intoxicated with illicit substances. As Professor Joyce has pointed out in other inquests, acute methylamphetamine intoxication may be characterised by agitation, increased physical activity and a propensity for aggression as well as involvement in risky, reckless or violent behaviour. Paranoid beliefs about others are common and intoxicated persons can become delirious and exhibit confusion and bizarre behaviour.[74]

53. In addition, a whole raft of undesirable behaviours are associated with drug trafficking itself. Here I am referring to assaults, intimidation and stand-over tactics, and the well-known practice of prisoners attempting to obtain "desirable" prescription medications from prison medical centres in order to trade them for illicit substances.[75]

Strategies for elimination[76,77,78,79]

54. The evidence before me demonstrates that DOJ is making a concerted effort to address the scourge of illicit substances in the prison system. Those efforts include, but are not limited to, targeted and inter-agency operations; routine and specific searches of prisoners, cells and other areas within the prison estate; and the use of specialist resources and emergent technologies in relation to drug testing and detection.

[72] Exhibit 1, Vol 2, Tab 19, Report - Prof. D Joyce (01.07.22), para 19-23
[73] ts 14.07.22 (Pittard), pp-8
[74] [2020] WACOR 24, Inquest into the death of Chad Riley, para 127
[75] ts 14.07.22 (Rowland), p45
[76] Exhibit 1, Vol. 2, Tab 20, Statement - Dep. Supt. J Pittard (12.07.22), paras 6-45
[77] Exhibit 1, Vol. 2, Tab 20.1, Offender Drug and Alcohol Strategy 2010-2014
[78] Exhibit 1, Vol. 2, Tab 20.2, Drug and Alcohol Agency Action Plan 2010-2014
[79] Exhibit 1, Vol. 2, Tab 20.3, Western Australian Prisons Drug Strategy 2018-2020

55. Information about the methods, technologies and resources used by DOJ to minimise illicit drugs in prisons is obviously highly sensitive. If such information were to become widely known, the effectiveness of current and future strategies would be severely compromised. In light of those concerns, I made a suppression order at the start of the inquest with respect to evidence about these matters, and I do not intend to traverse that evidence in this finding. However, having carefully reviewed the available materials, I am satisfied that DOJ's efforts are squarely aimed at reducing the prevalence of illicit substances (including methylamphetamine) in the prison system within the limits of the currently available technology.

56. In 2017, the Office of the Auditor General (OAG) undertook a performance audit to assess the effectiveness of DOJ's strategies to minimise drugs and alcohol in prisons. The OAG acknowledged it was unrealistic to expect prisons to be completely free of these substances and made a number of recommendations aimed at "*practical and achievable actions*".[80]

57. The OAG also suggested that DOJ build on existing strategies and at the inquest, Officer Pittard confirmed that DOJ is continuing to explore new methods of detection and elimination. This is necessary because those seeking to smuggle illicit substances into the prison system are using increasingly more sophisticated methods to do so.

Education and rehabilitation services[81,82]

58. In addition to detection efforts, DOJ has attempted to reduce demand for illicit drugs through prisoner education and rehabilitation services. According to Deputy Superintendent John Pittard (Officer Pittard):

> Casuarina currently offers weekly voluntary Narcotics Anonymous and Alcoholics Anonymous meetings, intensive residential Alcohol and Drugs Programs in Unit 15 (Malley Unit) and Pathways programs in an effort to educate prisoners on the effects of drug use.[83]

[80] Exhibit 1, Vol. 2, Tab 20.4, Minimising Alcohol and Drugs in Prisons (22.11.17)
[81] Exhibit 1, Vol. 2, Tab 20, Statement - Dep. Supt. J Pittard (12.07.22), paras 43-45
[82] Exhibit 1, Vol. 2, Tab 20.3, WA Prisons Drug Strategy 2018-2020
[83] Exhibit 1, Vol. 2, Tab 20, Statement - Dep. Supt. J Pittard (12.07.22), paras 45

59. While these efforts are commendable, with the benefit of hindsight, a more targeted and proactive approach to educating Mr Hardie about the dangers of illicit substances, especially methylamphetamine, might have been beneficial. However, I accept that the evidence clearly shows that Mr Hardie had essentially disengaged from specialist advice and management for his condition. In those circumstances, it is likely Mr Hardie would have rebuffed efforts to educate him about the catastrophic risks of using illicit substances.[84]

THE PASSAGE OF INFORMATION

The issue[85,86]

60. Mr Hardie was transferred from Acacia to Casuarina on 11 October 2019 because it was suspected he was involved in the movement of illicit substances (i.e.: drug trafficking) within the prison. The intent was to disrupt "*drug networks*" at Acacia by moving Mr Hardie to Casuarina. On the face of it, this seems to be a very sensible strategy, and the transfer was clearly thought to be beneficial to Acacia.[87]

61. Notwithstanding the sound basis for moving Mr Hardie out of Acacia, it is astonishing that security staff at Casuarina were not made aware of the intelligence underpinning his transfer. Frankly, it beggars belief this could have occurred. At the inquest, Officer Pittard explained that intelligence concerning prisoners, including information about those suspected of involvement in drug trafficking, is forwarded to a central repository known as the Intelligence Management System (IMS).[88]

62. The intent is that information gathered by the IMS is then distributed to relevant prisons as appropriate. However, in Mr Hardie's case the system failed spectacularly. Although information about the reason for Mr Hardie's transfer was disclosed to the Assistant Superintendent at Casuarina (and other officers involved in effecting the transfer), this information was not provided to the Security Manager at Casuarina.[89]

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[84] ts 14.07.22 (Rowland), pp46-47
[85] Exhibit 1, Vol 2, Tab 18, Death in custody review (23.05.22), pp17-18 and ts 14.07.22 (Palmer), p63
[86] ts 14.07.22 (Pittard), pp8-17
[87] ts 14.07.22 (Pittard), p8
[88] ts 14.07.22 (Pittard), pp9-14
[89] Exhibit 1, Vol. 2, Tab 18.19, Email A/Sentence Mgr. Acacia to Asst. Supt. Casuarina (7.10 am, 09.10.19)

63. Thus the security team at Casuarina were blissfully unaware of the fact that they now had in their facility, a prisoner who was suspected of being involved in the trafficking of illicit substances within the prison system. Clearly anything that can be done to disrupt the flow of illicit substances into prisons should be done, if for no other reason than these measures make the prison system safer for both inmates and staff.

64. In this case, had the security team at Casuarina been aware of the concerns that led to Mr Hardie being transferred, it would have been possible for targeted searches and random drug tests to have been implemented from the moment Mr Hardie arrived. I have already dealt with subsequent missed opportunities to instigate these investigations, but the fact remains that important information about Mr Hardie that should have been in the hands of the security team at Casuarina, was not. As Officer Pittard relevantly observed at the inquest:

> **Communication between facilities…for me, that's the biggest issue**…and as I said to you, the disruption of drug networks is something that every individual facility focuses on, whether it's for minimum security all the way up to maximum security. We've got to improve the communication between the facilities so that the security sections can actually manage…information that comes to hand and see what's being transferred here.[90] [Emphasis added]

65. Moving forward, in order to ensure that critical information about drug trafficking within prisons is in the hands of relevant security staff, I recommend DOJ implement the two key suggestions canvassed at the inquest, which I will now outline.

TOMS alert relating to drug trafficking[91,92]

66. I am aware that a number of alerts are currently available within the Total Offender Management System (TOMS), the electronic system DOJ uses for prisoner management. One alert identifies prisoners being managed on the At-Risk Management System (ARMS), whilst other alerts identify prisoners who are a risk from (or to) other prisoners.

[90] ts 14.07.22 (Pittard), p13
[91] ts 14.07.22 (Pittard), pp15 & 29-30 & 32
[92] Letter to the Court, Ms G Mullins (01.08.22), paras 6-13

67. Alerts within TOMS are accessed under the "*Alerts Module*". Further information about the alert is available in the "*narrative*" screen that sits behind the relevant alert. Certain alerts, for example those indicating a prisoner is on ARMS, are visible on the prisoner's offender summary within TOMS, and do not require the user to click into the Alerts Module. These types of alerts have the benefit of being immediately visible without any additional action on the part of the TOMS user.

68. At the inquest, Officer Pittard made the breathtakingly simple suggestion that a new TOMS alert should be created to identify prisoners who are suspected of involvement in drug trafficking. I was initially attracted to this idea, but following the inquest, the Court received a letter from Ms Mullins which explained that DOJ plans to create a broader alert to cover transfers on security grounds in a range of circumstances, including but not limited to, drug trafficking.[93]

69. Numerous prisoner transfers occur for routine reasons such as muster management, or to enable a prisoner to be closer to family members. However, the new alert proposed by DOJ will identify prisoners subject to a "*Management Transfer*" and thus target that smaller cohort of prisoners being transferred for a range of security reasons.

70. I suggest that the proposed Management Transfer alert, replicate the ARMS system alerts, to ensure maximum visibility within TOMS. This will ensure that this important information is not overlooked by the security team at the receiving prison.

71. In this regard, Ms Mullins advised that security managers have access to the "*Security Report*" module of TOMS which contains concise reports of relevant security concerns. Whilst not all custodial staff have access to the Security Report module of TOMS, the intent of the proposed Management Transfer alert is that in future, the type of communication breakdown that occurred in this case will be avoided. For that reason, I have recommended that a Management Transfer alert be created within TOMS as a matter of **urgency**.

[93] Letter - Ms G Mullins, SSO to Sgt. A Becker (01.08.22)

Importance of sharing security information[94]

72. The second suggestion canvassed at the inquest dealt with how to ensure that relevant security information was passed from one facility to another. The solution proposed by Officer Pittard was also remarkably simple. He suggested that, as used to occur in the past, the security manager of the transferring prison should telephone the security manager of the receiving prison and discuss the circumstances of the transfer and any suggested surveillance strategies.

73. To Officer Pittard's elegant suggestion, I would add that telephone contact between the relevant security managers should be followed up by a brief email to ensure there is a record of the interaction, and so that there is no possibility of relevant issues being overlooked. Had such a system been in place at the time Mr Hardie was transferred from Acacia to Casuarina, there would have been no possibility of him "*falling through the cracks*", and a regime of random and/or targeted cell searches and drug tests could have been implemented.

74. Had Mr Hardie been the target of cell searches and drug tests, not only might any involvement by him in drug trafficking activities at Casuarina been detected, but his use of methylamphetamine might also have been identified.

75. If it had been possible to identify the fact that Mr Hardie had, contrary to his previous assertions, started using methylamphetamine again, then he could have been counselled by nursing, medical and psychological staff about just how dangerous this was.

76. Unsuccessful attempts had been made to encourage Mr Hardie to give up smoking and he may also have disregarded counselling in relation to the extraordinary danger he placed himself in by continuing to use methylamphetamine. Nevertheless, attempts in this regard could still have been made, had Mr Hardie's propensity to involve himself in trafficking activities been known.[95]

[94] ts 14.07.22 (Pittard), pp16-18 & 32
[95] ts 14.07.22 (Rowland), p39

OTHER OPPORTUNITIES FOR IMPROVEMENT

Continuity of care enhancements[96]

77. The Review identified several areas for improvement in relation to the management of Mr Hardie's medical issues, namely:

> a. *Disengagement from specialist advice*: despite Mr Hardie's well-documented refusals to accept specialist medical care, there is no evidence that the reason for these refusals was explored in any detail. These refusals were also not documented in Mr Hardie's "active problem list" (see below) meaning that clinicians would not have been prompted to periodically explore this issue with him. Whilst it is likely that Mr Hardie was well aware of his likely prognosis as a result of Marfan Syndrome, had he been offered in-depth counselling, he may have decided to make an advance health directive (see discussion of this issue later in this finding);
>
> b. *Terminally ill list*: Mr Hardie was not referred to DOJ's terminally ill prisoner register, presumably because of his age and the fact he was at risk of a sudden rupture of his aneurysm, rather than a progression of degenerative illness. In my view, there is no practical consequence of Mr Hardie not having been placed on the register because he was subject to routine INR monitoring in any event;
>
> c. *Active problem list not optimally maintained*: Mr Hardie's thoracic abdominal aneurysm was not added to his medical record as a separate issue, although it was visible as a comment in relation to the diagnosis of abdominal aneurysm. Further, Mr Hardie's chronic cough/chest symptoms (which may have been related to the increasing size of his aneurysm) were not on the active problem list despite two years of presentations with these symptoms;
>
> d. *Gaps in continuity of care*: records show that there were failures to follow-up interventions due to errors in the use of the records system. Despite these errors Mr Hardie had demonstrated he was able to seek appointments himself and as noted, because he underwent regular INR checks, he had frequent attendances at the medical centre and was able to request to see a prison doctor on those occasions;

[96] Exhibit 1, Vol 2, Tab 22, Health Services Summary - DOJ (13.07.22), pp16-19 and ts 14.07.22 (Rowland), pp47-49

e. *Management of chronic cough*: although Mr Hardie was repeatedly seen with cough symptoms, there were no examinations or investigations to exclude the possibility of the symptoms being caused by his aortic aneurysm. As the Review notes: "*The prescription of long-term asthma-type medications without formal diagnosis or completion of investigation may have contributed to assumptions made by the next clinician regarding the diagnosis*". Further, although a chest x-ray was performed on 1 February 2019, the result was never entered into Mr Hardie's medical record; and

f. *Lack of a cardiac care plan*: Mr Hardie did not have a cardiac care plan whilst he was at Acacia or Casuarina.

78. The Review addressed two broad areas of improvement to address the issues identified in Mr Hardie's care , namely:

a. *Education, improvements to electronic tools and policy updates*: these enhancements include an improved admissions template to identify the need for specialist referrals and policy changes to help ensure a prisoner's active problem list is maintained; and

b. *Patient centric care*: DOJ is promoting a culture of patient centric care including collaborative decision-making and the documentation of such discussions, especially where there is a "ceiling of care" or where a prisoner declines treatment.

Advance Care Directives and Do Not Resuscitate declarations

79. At the inquest, Dr Rowland acknowledged there was no evidence that a clinician had ever attempted to speak to Mr Hardie about his prognosis, in the context of his serious medical conditions.[97] I accept this would have been a difficult conversation to initiate and that clinical staff have limited time and many prisoners to deal with. Nevertheless, in my view this was a lost opportunity.

80. After Mr Hardie's death, his father told police: "*[Mr Hardie] believed that his illness was terminal and so he took whatever drugs he could to stop him thinking about when he was going to die*".[98]

[97] ts 14.07.22 (Rowland), pp49-51
[98] Exhibit 1, Vol 1, Tab 8A, File Note - Discussion with Mr B Hardie (31.12.19)

81. Even if that perception were only partly true, Mr Hardie may have found it helpful to have discussed his prognosis and further, what ceilings of care he wished to put in place in relation to his medical treatment. As part of this discussion, the possibility of Mr Hardie making an advance health directive might have been touched on, and in addition, he may also have wished to express his views about whether, in the event of a collapse, he wished to be resuscitated.

82. Following amendments to the *Guardianship and Administration Act 1990* (WA) (the Guardianship Act), Western Australians have been able to make an advance health directive (AHD) setting out decisions about: "*[F]uture medical , surgical or dental treatment and other health care, including palliative care and life-sustaining measures*".[99,100]

83. An AHD sets out the types of treatment the maker will accept and the circumstances in which the maker is willing to accept them, at a time when they still have legal capacity. Treatment decisions in an AHD operate: "*at any time the maker of the directive is unable to make reasonable judgments in respect of that treatment*", as if the treatment decision had been made by the maker at that time and the maker was "*of full legal capacity*".[101]

84. Provisions in the Guardianship Act deal with the situation where, after the making of the AHD, circumstances exist or have arisen that the maker could not have anticipated, and which would have caused a reasonable person in the maker's position to have changed their mind about a treatment decision. One example would be where a new treatment is developed after the AHD is made, to which the maker would have agreed had they been aware of it.[102]

85. I can see no statutory impediment which would prevent a prisoner from making an AHD. Further, where the prisoner makes an AHD and subsequently loses capacity, it is my view that the CEO (and their employees) would be obliged to comply with the treatment decisions set out in the AHD, even when doing so may result in the prisoner's death.

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[99] *Guardianship and Administration Act 1990* (WA), Part 9B
[100] See: www.healthywa.wa.gov.au/Articles/J_M/~/media/Files/HealthyWA/Original/OA004251_preparing_an_advance_health_directive.ashx
[101] *Guardianship and Administration Act 1990* (WA), s110S(1)
[102] *Guardianship and Administration Act 1990* (WA), s110S(2) - 110(6)

86. If Mr Hardie had decided to make an AHD, then clearly the document would have bound health professionals (e.g: doctors and nurses) because an AHD deals with "*treatment decisions*". The Guardianship Act defines "*treatment*" to mean medical or surgical treatment (including a life sustaining measure or palliative care), dental treatment or "*other health care*".[103]

87. Although an AHD undoubtedly applies to health professionals it is unlikely to apply to ambulance officers and would certainly not apply to prison officers. Therefore, the question that arises is whether a prisoner can prospectively indicate their wish not to be resuscitated by prison staff and/or ambulance officers in the event of their collapse. For reasons which I will now explain, the answer to that question is "*Yes*".

88. At common law, consent is required before treatment may be given. It follows that any adult person with legal capacity (including a prisoner) is entitled to refuse treatment, even when that treatment could be lifesaving.[104] In certain circumstances, an act of Parliament may oblige a person to receive treatment, for example involuntary treatment under the *Mental Health Act 2014* (WA) in relation to a mental illness.[105]

89. However, those limited statutory exceptions aside, the common law requirement that consent is required before treatment may be given would prevail. In passing, I note the Guardianship Act specifically preserves a person's common law entitlements to make treatment decisions in respect of "*the person's future treatment*".[106]

90. Where a person cannot provide consent (e.g.: because they are unconscious), treatment that is reasonably necessary and in that person's best interests may be administered, but not where to do so is contrary to the person's known wishes.[107]

[103] *Guardianship and Administration Act 1990* (WA), s3
[104] See for example: *Rogers v Whitaker* (1992) 175 CLR 479
[105] See for example: *Mental Health Act 2014* (WA), Part 6
[106] *Guardianship and Administration Act 1990* (WA), s110ZB
[107] *In Re F* [1990] 2 AC 1

91. The upshot is that an adult with legal capacity (including a prisoner) may make a declaration that they do not wish to be resuscitated in the event of a collapse. Whilst there is no standard format for the making of a "*Do Not Resuscitate*" declaration (DNR), for obvious reasons such a declaration should be in writing.

92. In her letter to the Court, Ms Mullins advised that the issue of DNR decisions is the subject of active discussions within DOJ's Health Management Committee (the Committee). Specifically, the Committee is examining how DNRs will be recorded in a prisoner's medical record and the policies and procedures that are required to manage DNRs generally.[108]

93. I was initially attracted to the concept of creating a DNR alert within TOMS. However, having carefully considered the content of Ms Mullins' letter, I accept that at this early stage of DOJ's deliberations about this issue, such a recommendation may be counterproductive. Instead, a recommendation that DOJ finalise its DNR policies and procedures as soon as possible, is more likely to ensure that a prisoner's wishes in relation to a DNR will be respected and, more importantly, complied with.

94. The Committee is currently grappling with a range of complex issues including the scope of DNRs, and nuances such as the circumstances in which the maker of the DNR intended it to apply. Further, some prisoners are the subject of guardianship orders, meaning that the responsibility of making treatment decisions vests in a person other than the prisoner.[109]

95. I accept that it is entirely appropriate for the Committee to develop the policies and procedures that will govern the way in which DNR can have practical effect. I would only observe that this important work ought to be completed as soon as practicable, and that any inordinate delay in this regard would be unacceptable.

[108] Letter - Ms G Mullins, SSO to Sgt. A Becker (01.08.22), para 15
[109] *Guardianship and Administration Act 1990* (WA), Part 5

96. I also note that consideration is being given to requiring medical staff to confirm the existence and applicability of a DNR, and for medical staff to be responsible for confirming that resuscitation efforts should cease.[110]

97. In my view, this is an eminently sensible approach. If this policy were to be adopted, it would no doubt provide comfort to custodial staff, who are usually the "first responders" in an emergency situation because of their proximity to prisoners. Custodial staff generally do not have any relevant clinical skills and it is clearly appropriate for them to rely on the judgement and skills of those who do.

98. I accept that custodial staff (who will generally only have a first aid certificate) may be understandably reluctant to cease resuscitation efforts without direction from a health professional. I also accept that the decision to cease resuscitation would need to take account of the terms of the DNR and the apparent reason for the prisoner's collapse. For those reasons, I agree that it would be reasonable for DOJ's DNR policy to provide that prison officers should cease resuscitation efforts when directed to do so by a health professional.

Targeted searches

99. Following Mr Hardie's death, Ms Toni Palmer (a senior review officer with DOJ) conducted a review "*for the purposes of supporting the Department in proactively identifying systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future*". Ms Palmer made two findings which are set out in a document called Review of Death in Custody (the DIC Review).[111]

100. The DIC Review's first finding relates to cell searches and drug testing and states: "*Cell searches and drug and alcohol tests of Mr Hardie were not always conducted after intelligence suggested he was involved in trafficking and/or use of contraband*".[112] Officer Pittard confirmed that the recommendation that was prompted by this finding had been fully implemented.[113]

[110] Letter - Ms G Mullins, SSO to Sgt. A Becker (01.08.22), para 24 and ts 14.07.22 (Rowland), pp48-51
[111] Exhibit 1, Vol 2, Tab 18, Death in Custody Review (23.05.22), p4
[112] Exhibit 1, Vol 2, Tab 18, Death in Custody Review (23.05.22), p17
[113] ts 14.07.22 (Pittard), pp23-26

101. The text of that recommendation is as follows:[114]

> Where there is an indication of potential involvement in trafficking of contraband, the prisoner will be added to the targeted cell search and drug testing regime. Additionally, the Security Managers will be added to the movements distribution group.[115]

102. The DIC Review's second finding related to inconsistencies in training advice between facilities about whether to check for a pulse before starting CPR.[116] This Court has dealt with this issue in several inquests relating to deaths in custody.[117,118] As I have previously observed, current first aid guidance on this issue is clear and modern first aid training recognises that: "*Palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation*".[119,120]

103. The DIC Review recommended that:

> Corrective Services Academy to consolidate training standards [in line with the ANZCOR (Australia and New Zealand Resuscitation Council) guidelines] with all First Aid and CPR instructors. Consolidation to include records to register training once completed.[121]

104. At the inquest, Ms Palmer confirmed that an email broadcast had been sent out to DOJ first aid and CPR trainers to remind them of the current ANZCOR guidelines.[122] That email, dated 1 June 2022 states in part:

> Please be advised that when delivering Provide First Aid or CPR training that the practice of checking for a pulse before commencing or during CPR is **obsolete** and that CPR should be commenced whenever a patient is not breathing regularly, not responding and/or not moving.[123] [Original emphasis]

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[114] ts 14.07.22 (Pittard), pp23-26
[115] Exhibit 1, Vol 2, Tab 18, Death in Custody Review (23.05.22), p18
[116] Exhibit 1, Vol 2, Tab 18, Death in Custody Review (23.05.22), p19
[117] Inquest into the death of Mr Jordan Anderson, [2020] WACOR 44, (published 22.12.20)
[118] Inquest into the death of Mr Ashley Lane, [2022] WACOR 30, (published 21.06.22)
[119] St John Ambulance HLTAID011 Provide First Aid - Student Guide (Dec 2020), p34
[120] See also: Exhibit 1, Vol 2, Tab 18.37, Email - Manager Learning Support Services to Ms Palmer (12.01.22)
[121] Exhibit 1, Vol 2, Tab 18, Death in Custody Review (23.05.22), p20
[122] ts 14.07.22 (Palmer), pp64-65
[123] Exhibit 1, Vol 2, Tab 23, Email - Manager Specialised Training to First Aid trainers (01.06.22)

105. Whilst this is a good start and will capture prison officers undertaking their initial training as well as those completing annual refresher training, it does not cover prison officers yet to undergo refresher training.

106. For that reason, I repeat the recommendation I made following the inquest into the death in custody of Mr Lane, namely:

> DOJ should consider issuing a bulletin to **all staff** reminding them that the previous practice of checking for a pulse before starting cardio-pulmonary resuscitation (CPR) is obsolete and that CPR should be commenced whenever a patient is not breathing, not breathing properly, not responding and/or not moving.[124] [Emphasis added]

[124] [2022] WACOR 30, p63 - Recommendation 4, (published 21.06.22)

QUALITY OF SUPERVISION, TREATMENT AND CARE

107. After carefully considering the available evidence, I am satisfied that during the time he was incarcerated, the treatment and care provided to Mr Hardie with respect to his medical condition was appropriate and commensurate with community standards.

108. Further, I find that Mr Hardie's abdominal aortic aneurysm was appropriately managed conservatively, after surgical options had been carefully considered and found to be contra-indicated. Mr Hardie's aneurysm was monitored to the extent that he permitted, and blood pressure and anticoagulant medication was appropriately administered and the subject of regular monitoring.

109. However, Mr Hardie was able to obtain methylamphetamine whilst he was in custody at Casuarina, in circumstances where he was not subjected to random or targeted cell searches or drug tests. On that basis, I find that the supervision Mr Hardie received whilst incarcerated was clearly and demonstrably substandard.

110. I accept that DOJ is engaged in an ongoing battle to stop illicit substances from entering prison facilities, and I commend these valiant efforts. The ingenuity of those seeking to traffic illicit substances within the prison estate is boundless, and DOJ is appropriately using a variety of methods to thwart this ugly trade. However, the timely and efficient passage of information is critical to the goal of eliminating drugs from the prison estate. In this case, a shocking communication error meant that opportunities to detect Mr Hardie's illicit activities were lost.

111. I accept there was a serious risk that Mr Hardie's aneurysm could rupture at any time, with catastrophic consequences. I also accept Mr Hardie's smoking and his use of methylamphetamine, significantly increased the risk his aneurysm would rupture. However, Mr Hardie should have been the subject of cell searches and drug tests while he was at Casuarina. This may have detected his methylamphetamine use, although I accept that the ultimate outcome in this case may have been the same.

RECOMMENDATIONS

Comments relating to recommendations

112. After reviewing the available evidence, I determined that it would be appropriate to make three recommendations. In accordance with my usual practice, Sergeant Becker forwarded a draft of these recommendations to counsel for DOJ, Ms Mullins, on 14 July 2022.[125]

113. Feedback was requested by 26 July 2022, but following an email request from Ms Mullins on 22 July 2022, that deadline was extended until 1 August 2022. By way of an email dated 1 August 2022, Ms Mullins forwarded a letter to the Court setting out DOJ's response to my proposed recommendations, which I summarise as follows:[126,127]

a. *Recommendation 1*: DOJ proposed broadening the scope of this recommendation and suggested a "Management Transfer" alert be created on TOMS to cover situations where a prisoner was transferred to another facility for a range of security reasons, including suspicion of involvement in the trafficking of illicit substances. I adopted this sensible suggestion;

b. *Recommendation 2*: DOJ supports this recommendation and intends to "*review, amend where necessary, and communicate procedures regarding the need to ensure that security and safety information is appropriately communicated to the receiving prison*"; and

c. *Recommendation 3*: DOJ does not presently support an alert on TOMS relating to DNR. That is because policies and procedures to regulate this complex area of prisoner management have yet to be developed. Instead, DOJ advised it would support a recommendation that it should develop and finalise these policies and procedures and as part of that process, that it should consider the appropriateness of a DNR alert in TOMS. I have adopted this sensible suggestion.

[125] Email - Sgt A Becker to Ms G Mullins, State Solicitor's Office (14.07.22)
[126] Email - Ms G Mullins, State Solicitor's Office to Sgt A Becker (22.07.22)
[127] Letter - Ms G Mullins, SSO to Sgt. A Becker (01.08.22)

Recommendation 1

As a matter of urgency, the Department of Justice (DOJ) should create a "Management Transfer" alert within the Alerts Module of the Total Offender Management System (TOMS) which will be activated whenever a prisoner is being transferred between prisons due to matters relating to security and/or safety, including circumstances where the prisoner is suspected of being involved in the movement of illicit substances, whether by drug trafficking or otherwise.

Recommendation 2

Whenever a prisoner is being transferred from one custodial facility to another because of concerns they are or may be involved in the movement of illicit substances whether by drug trafficking or otherwise, DOJ should require the security manager (or equivalent) of the transferring facility to contact the security manager (or equivalent) of the receiving facility to alert them to the reason for the prisoner's transfer and to discuss suggested surveillance measures. Wherever possible this contact should occur verbally and be appropriately documented by means of a follow up email.

Recommendation 3

As soon as practicable, DOJ should develop and finalise policies and procedures dealing with end-of-life planning for prisoners, including:

a. the discussion and documentation of prisoners' goals of care, including advanced health directives; and

b. processes and procedures dealing with:

   i. the ability of prisoners to make "Do Not Resuscitate" (DNR) decisions; and

   ii. the response of prison staff to medical emergencies in circumstances where a prisoner has made a DNR decision.

As part of this process, DOJ should give consideration to the appropriateness of creating a DNR alert within TOMS.

CONCLUSION

114. This case illustrates the scourge of methylamphetamine addiction and the tragic consequences that can flow from that use. Mr Hardie was 41-years of age when he died at FSH from haemothorax due to a ruptured thoracic aortic aneurysm. The evidence before me establishes that Mr Hardie became unresponsive as he collapsed, meaning he would have been completely unaware of his situation.

115. Although Mr Hardie received appropriate medical care and treatment whilst he was incarcerated, the fact that he was able to obtain and use methylamphetamine whilst at Casuarina demonstrates that his supervision was substandard. Mr Hardie was suspected of being involved in drug trafficking at Acacia and was transferred to Casuarina to disrupt these activities. A major communication breakdown meant that security staff at Casuarina were not made aware of the reason for Mr Hardie's transfer and as a result, he was not subjected to random cell searches or drug tests.

116. There was always a high risk that Mr Hardie's aneurysm would eventually rupture and that when it did, his chances of survival were minimal. In those circumstances, any resucitation efforts were likely to be futile, but in this case the efforts of prison staff were shambolic because nobody took a leadership role.[128]

117. I commend DOJ's ongoing quest to rid prisons of illicit substances and I have made two recommendations aimed at enhancing those efforts. I also made one recommendation designed to advance DOJ's deliberations regarding end-of-life planning for the prisoners in its care.

MAG Jenkin
Coroner
5 August 2022

[128] ts 14.07.22 (Rowland), p57-61