[2022] WACOR 30

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	24 - 26 MAY 2022
DELIVERED	**:**	21 JUNE 2022
FILE NO/S	**:**	CORC 34 of 2019
DECEASED	**:**	LANE, ASHLEY ADRIAN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Ms S. Tyler appeared to assist the coroner.

Mr T. Bishop and Ms G. Beck (State Solicitor's Office) appeared for the Department of Justice.

Ms A. Barter and Mr J. Higgins (Aboriginal Legal Service of Western Australia Ltd.) appeared for members of Mr Lane's family.

Ms B. Burke (ANF Legal Services) appeared for Ms W. Evans.

Ms K. Crispe (Max Crispe Barristers & Solicitors) appeared for Ms K. Lewis.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Ashley Adrian LANE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, between 24 - 26 May 2022, find that the identity of the deceased person was* ***Ashley Adrian LANE*** *and that death occurred on 26 April 2019 at Kalgoorlie Regional Hospital from acute exacerbation of chronic obstructive pulmonary disease (bronchial asthma) in an man with atherosclerotic heart disease 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* that there be no reporting or publication of the name of the deceased's cell mate on 26 April 2019. The cell mate is to be referred to as "Prisoner D".

Order made by: MAG Jenkin, Coroner (24.05.22)

INTRODUCTION

1. Ashley Adrian Lane (Mr Lane) died on 26 April 2019 at Kalgoorlie Regional Hospital (KRH) from acute exacerbation of chronic obstructive pulmonary disease (bronchial asthma). At that time, Mr Lane was a remand prisoner at Eastern Goldfields Regional Prison (EGRP) in the custody of the Chief Executive Officer (CEO) of the Department of Justice (DOJ) and thereby a "*person held in care*". As a result, Mr Lane's death was a "*reportable death*" and a coronial inquest is mandatory.[1,2,3,4,5,6]

2. 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 that the person received.[7] On 24 - 26 May 2022, I held an inquest into Mr Lane's death. The inquest focused on the care provided to Mr Lane while he was in custody as well as the circumstances of his death.

3. The Brief containing the documentary evidence adduced at the inquest comprised two volumes and the following witnesses gave evidence:

a. Ms Wendy Evans, former Clinical Nurse (Ms Evans);
b. Mr Chris Johnston, Clinical Nurse Manager (Mr Johnston);
c. Dr Cathryn D'Cruz, Prison Medical Officer (Dr D'Cruz);
d. Mr Jason White, Prison Officer (Officer White);
e. Mr Michael Fox, Prison Officer (Officer Fox);
f. Mr David Lutz, Prison Officer (Officer Lutz);
g. Ms Kathleen Lewis Prison Officer (Officer Lewis);
h. Ms Pauline Davis, Prison Officer (Officer Davis);
i. Mr John Houweling, Senior Prison Officer (Officer Houweling);
j. Detective Sergeant Dean Ovens, Investigating Officer (Det. Sgt. Ovens);
k. Ms Toni Palmer, Senior Review Officer, DOJ (Ms Palmer);
l. Dr Scott Claxton, Independent Respiratory Physician (Dr Claxton);
m. Dr Joy Rowland, Director, Medical Services, DOJ (Dr Rowland); and
n. Mr Scott Mortley, Principal Prison Officer (Officer Mortley).

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[1] Exhibit 1, Vol 1, Tab 7.1, Second Supplementary Post Mortem Report (01.11.21)
[2] Exhibit 1, Vol 1, Tab 4, P92 Identification of deceased person (26.04.19)
[3] Exhibit 1, Vol 1, Tab 6, Death in Hospital form - Kalgoorlie Regional Hospital (26.04.19)
[4] Section 16, *Prisons Act 1981* (WA)
[5] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 22(1)(a), *Coroners Act 1996* (WA)
[7] Section 25(3), *Coroners Act 1996* (WA)

MR LANE

Background

4. Mr Lane was born in Warburton and grew up in the Jameson and Blackstone communities on the Ngaanyatjarra Lands. He had three siblings and he and his wife had an adult son. Mr Lane's date of birth is variously stated as 10 February 1962 or 10 June 1962, but enquiries with the Registrar of Births, Deaths and Marriages established 10 June 1962 is correct, meaning Mr Lane was 56 years old when he died.[8,9,10,11,12]

Overview of Medical Conditions[13,14,15,16]

5. Following Mr Lane's death, a DOJ review of the health services he was provided in custody summarised his medical conditions as follows:

> Mr Lane was a smoker and had Chronic Airways Disease with frequent exacerbations and, since February 2019, had required one hospital admission and several courses of treatment within the prison for such exacerbations. Mr Lane also had liver disease and cardiac disease, for which he was on medication and also had recent investigations. He was on regular medication for his lung disease and self-administered nebulised medication overnight as required.[17]

6. According to Dr Claxton, a respiratory physician who undertook a review of Mr Lane's medical management for the Court, Mr Lane's medical conditions included: ischaemic heart disease, asthma and chronic obstructive pulmonary disease (COPD). Other records indicate Mr Lane had mild fatty liver, and chronic kidney disease and that he experienced a myocardial infarction (i.e.: heart attack) in January 2019. Mr Lane also had a history of polysubstance use including alcohol and cannabis, and he smoked cigarettes (tobacco).[18,19,20]

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[8] Exhibit 1, Vol 1, Tab 2.1, Police Investigation Report - Sen. Const. M Eales (17.03.20), pp2-3
[9] Exhibit 1, Vol 1, Tab 2.2, Victimology Report - FC. Const. S Cervenak (03.09.19)
[10] Exhibit 1, Vol 1, Tab 1, P100 - Report of death (26.04.19)
[11] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp4-5 & 8
[12] Email – Registry of Births, Deaths and Marriages to Coroner's Court (10.06.22)
[13] Exhibit 1, Vol 1, Tab 2.1, Police Investigation Report - Sen. Const. M Eales (17.03.20), p3
[14] Exhibit 1, Vol 1, Tab 9.1, Report - Dr S Claxton (20.06.21), pp1-3
[15] Exhibit 1, Vol 1, Tab 51, Health Services summary (27.08.19)
[16] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p5
[17] Exhibit 1, Vol 1, Tab 51, Health Services summary (27.08.19), p3
[18] Exhibit 1, Vol 2, Tab 72, Bega Garnbirringu Health Service - Patient Summary records
[19] Exhibit 1, Vol 1, Tabs 9.1 & 9.2, Report - Dr S Claxton (20.06.21 & 13.09.21)
[20] Exhibit 1, Vol 1, Tab 2.2, Victimology Report - FC. Const. S Cervenak (03.09.19)

7. Given his clinical history, Dr Claxton felt that Mr Lane's condition was more in keeping with unstable and uncontrolled asthma. From December 2018 to February 2019, Mr Lane frequently presented to KRH with exacerbations of his asthma/COPD. His treatment typically included steroid medication (prednisolone) and salbutamol (Ventolin). Mr Lane sometimes discharged himself against medical advice and the evidence establishes that his asthma management was complicated by his non-compliance with puffer medication and the fact he continued to smoke, despite advice that he should stop doing so.[21,22,23,24,25,26]

Asthma[27]

8. Asthma is a condition that affects the airways (breathing tubes carrying air into the lungs) and is characterised by intermittent and reversible obstruction of those airways. Acute asthma is caused by inflammation that causes the airways to narrow, along with excessive production of mucus secretions which plug the airways.

9. Symptoms include wheezing, shortness of breath, tightness in the chest and coughing. Triggers may include exercise, cigarette smoke, colds and flu and airborne allergens such as pollen and smoke particles. An "*asthma attack*" occurs when an inflammatory cascade is activated within the bronchial tree. Asthma patients who smoke can go on to develop COPD, and asthma and COPD can co-exist.

COPD[28]

10. COPD is caused by an abnormal inflammatory response that causes a chronic and progressive narrowing of the airways, commonly as a result of cigarette smoking. COPD is characterised by persistent respiratory symptoms, including a cough and breathlessness. that are not fully reversible.

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[21] Exhibit 1, Vol 1, Tab 2.2, Victimology Report - FC. Const. S Cervenak (03.09.19)
[22] Exhibit 1, Vol 2, Tabs 66-71, Discharge Letters - KRH (10.10.18; 05.11.18 & 6, 19, 24 & 28.12.18)
[23] Exhibit 1, Vol 2, Tabs 62-65, Discharge Letters - KRH (03, 10, 15 & 17.01.19)
[24] Exhibit 1, Vol 2, Tab 61, Discharge Summaries - KRH (11.01.19; 06.02.19 & 12.02.19)
[25] Exhibit 1, Vol 1, Tab 2.2, Victimology Report - FC. Const. S Cervenak (03.09.19)
[26] ts 26.05.22 (Claxton), p296
[27] See: www.nationalasthma.org.au/understanding-asthma and ts 26.05.22 (Claxton), pp297
[28] See: www.mayoclinic.org/diseases-conditions/copd/symptoms-causes and ts 26.05.22 (Claxton), pp297-299 & 315

11. An important aspect of managing COPD is the prevention of further lung damage, primarily by encouraging the patient to give up smoking. Ongoing management includes the use of inhalers, prompt treatment of acute exacerbations and supplemental oxygen may be require for patients with end-stage COPD.

12. Encouraging people to stop smoking is difficult enough in the general community and there are additional challenges in the prison system. As Dr Rowland explained, there are numerous reasons why prisoners continue to smoke even when they have chronic and/or serious health conditions. Smoking is seen by many prisoners as having a calming effect and as a sociable activity that consumes time. Cigarettes are also "tradeable" in prison and for many prisoners, including Mr Lane, their smoking habit is of very long-standing.[29]

13. DOJ recognises the serious health risks associated with smoking and the feasibility of a State-wide smoking ban within the prison system is currently being examined. In the meantime, nicotine patches (which Mr Lane was prescribed) along other suppression medications are used and education and support is provided to prisoners by prison medical officers, nursing staff and Aboriginal health workers. However, ever increasing prison musters and restrictions on the availability of health staff, mean that education and counselling efforts relating to smoking cessation are necessarily rather limited.[30]

14. Acute exacerbations of COPD can be triggered by viral or bacterial infections and airborne pollutants. Treatment includes using bronchodilators (e.g.: salbutamol), oral steroids (e.g.: prednisolone), supplemental oxygen and, where indicated, antibiotics. Severe exacerbations usually require admission to hospital. Clinicians distinguish between asthma and COPD by measuring a patient's level of a type of white blood cell known as an eosinophil. In asthma, eosinophil levels are usually raised whereas, in COPD they are not.

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[29] ts 26.05.22 (Rowland), pp361-362
[30] ts 26.05.22 (Rowland), p362

15. According to Dr Claxton, Mr Lane's eosinophil levels supported the conclusion that the primary process in Mr Lane's airways was an asthma-type condition. Although asthma is generally regarded as reversible, COPD is not. However, as Dr Claxton pointed out, this "reversibility" is relative rather than absolute and as noted, there can be overlap between COPD and asthma

Puffers and spacers[31,32]

16. Medication used to treat asthma and COPD is typically delivered by means of an inhaler or puffer, with or without the use of a "*spacer*". A standard puffer consists of a plastic case or holder with a cap, and a metal cannister containing medication. A spacer is a plastic container into which the medication from a puffer is sprayed. The spacer is designed to slow the speed of the aerosol medication released by the puffer enabling more effective delivery of the medication.

17. There are several types of inhaled medication including relievers, such as salbutamol (commonly marketed as Ventolin); corticosteroid preventers (e.g.: Alvesco); and dry powder inhalers (e.g.: Turbuhaler). A patient may be prescribed more than one type of inhaled medication and dosages and frequency of use will vary between patients. For those with severe or poorly controlled asthma, regular reviews (especially by a respiratory physician) are beneficial.

Nebulisers[33,34]

18. A nebuliser is a machine that converts liquid medication into a vapour. The nebuliser works by pumping pressurised air through the liquid medication and the resultant mist is inhaled through a mask worn on the patient's face. Some patients prefer nebulisers, apparently because of the psychological benefit of seeing (and hearing) the misting medication "working". However, research has clearly shown that a puffer/spacer works just as well for treating asthma symptoms, including flare ups.[35]

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[31] See: www.nationalasthma.org.au/living-with-asthma/resources/patients-carers/factsheets/puffer-and-inhaler-care
[32] ts 26.05.22 (Claxton), pp299-300
[33] See: www.nationalasthma.org.au/living-with-asthma/resources/patients-carers/factsheets/nebuliser-use-and-care
[34] ts 26.05.22 (Claxton), pp300-303
[35] ts 24.04.22 (D'Cruz), pp98-99

19. Nebulisers and puffers/spacers are able to deliver the same dose of medication to a patient's lungs. However, nebulisers require 25 times more medication in order to do so and are therefore not as efficient. Some users find nebulisers more complicated to use than a puffer/spacer, although this varies between patients. In any case, for a number of years there has been a move away from using nebulisers in the community, with nebulisers more commonly reserved for patients in hospital.

Offending History[36,37,38]

20. Mr Lane had an extensive criminal history and between 1982 and 2018, he accumulated 92 convictions for offences including: disorderly conduct, assault occasioning bodily harm, grievous bodily harm, possession of drugs, breaches of bail, criminal damage, and weapons offences. He served several periods of imprisonment and also received fines and/or community based orders.

21. On 24 January 2019, Mr Lane was arrested and charged with unlawful wounding before being released on bail. He was due to appear in the Kalgoorlie Magistrates Court (KMC) on 1 February 2019 and when he did not appear on that day, a warrant was issued for his arrest. In accordance with the warrant, Mr Lane was arrested on 13 February 2019. On 14 February 2019, Mr Lane appeared in KMC and was remanded in custody to EGRP, pending his next court appearance.[39,40]

Incarceration at EGRP[41]

22. When Mr Lane was received at EGRP on 14 February 2019, he was interviewed by a reception officer. Part of the reception process involved a suicide and self-harm risk assessment during which the reception officer asked Mr Lane a series of questions. Mr Lane's responses were entered into an electronic form in the Total Offender Management System (TOMS), the computer system DOJ uses to manage prisoners in custody.

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[36] Exhibit 1, Vol 1, Tab 43.5, Warrant Charges (2013 - 2014)
[37] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p8
[38] Exhibit 1, Vol 2, Tab 52.4, Criminal & Traffic history - Mr Lane (1982 - 2018)
[39] Exhibit 1, Vol 1, Tab 50, Remand Warrant (14.02.19)
[40] Exhibit 1, Vol 1, Tab 2.1, Police Investigation Report - Sen. Const. M Eales (17.03.20), p3
[41] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp9-11

23. After interviewing Mr Lane, the reception officer made the following entry in TOMS:

> Mr Lane presented in a very calm and quiet manner answering questions with good eye contact and being cooperative with reception staff. Mr Lane stated that he does not have any self-harm history or any current thoughts or plans to self-harm. **Mr Lane did not have any immediate health issues but stated that he is on medication for kidneys and is asthmatic. Mr Lane currently has his Ventolin is his possession**. During the reception process Mr Lane showed no signs of being at risk".[42] [Emphasis added]

24. The electronic form is known as the At Risk Management System - Reception Intake Assessment form (the Form). One of the sections of the Form is entitled "*Current Health Issues*" in which the reception officer asks the prisoner whether they have any serious health issues needing immediate attention. The prisoner is also asked whether they are taking any prescribed medication and whether they are withdrawing from alcohol and/or illicit drugs.

25. As noted, prior to his reception at EGRP, Mr Lane had repeatedly presented to KRH with exacerbations of his asthma, indicating it was very poorly controlled. Although Mr Lane told the reception officer he was asthmatic and had Ventolin, prison authorities were unaware of Mr Lane's recent admissions to KRH.[43]

26. At present, DOJ has no foolproof mechanism to gather information about a prisoner's medical history. Although prisoners are asked to disclose their GP and/or any health service they have treated by in the community, a prisoner may be reluctant to disclose their medical history. One reason might be a concern that certain health conditions may affect the prisoner's placement within the prison system, but it may also be (in common with many people in the general community) the prisoner has poor "*health literacy*" and is unaware, or not sufficiently aware, of their medical history.[44]

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[42] Exhibit 1, Vol 2, Tab 52.5, At Risk Management Assessment System - Reception Intake Assessment (14.02.19), p6
[43] ts 26.05.22 (Claxton), p327
[44] ts 24.05.22 (Johnston), p57

27. Obtaining accurate medical information about a person being received into prison is essential if they are to be managed effectively during their incarceration. In this regard, important statutory obligations are imposed on the CEO by virtue of section 7(1) of the *Prisons Act 1981* (WA) (the Prisons Act), which relevantly provides:

> Subject to this Act and to the control of the Minister, the chief executive officer is responsible for the management, control, and security of all prisons and **the welfare and safe custody of all prisoners**. [Emphasis added]

28. When interpreting this provision, the term "*welfare*" takes its ordinary English meaning, namely: "*the health, happiness, and fortunes of a person or group*" [Emphasis added].[45] It is significant that in addition to being responsible for the welfare of prisoners, the CEO must ensure their "*safe custody*". Section 7 of the Prisons Act draws a distinction between "*security*" and "*safe custody*" and in my view, the term "*safe custody*" reinforces the CEO's obligations with respect to prisoner welfare.

29. At the inquest, Dr Rowland (Director, Health Services at DOJ) advised that work is underway to explore the feasibility of using the Federal Government's "*My Health Record*" system as a means of accessing a prisoner's medical history.[46] At present, security issues (i.e.: the fact the doctors are identified by name in the My Health Record) have meant that this avenue of information is not yet able to be relied on.[47]

30. In my view, in addition to asking prisoners being received into prison to disclose their treating health professionals, those persons should be asked whether they have recently presented at, or been admitted to hospital. I accept that during his initial health screen, Mr Lane was noted to be a poor historian and in fact, he actually denied having asthma.

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[45] Compact Oxford English Dictionary (3rd Ed, 2005), p1179
[46] See: www.myhealthrecord.gov.au
[47] ts 26.05.22 (Rowland), pp379-380

31. Nevertheless, had Mr Lane been asked about any recent hospital admissions, he may have disclosed his numerous presentations to KRH. Had Mr Lane done so, EGRP could have requested copies of the discharge summaries for these presentations and on receipt of that information, DOJ would have realised how poorly controlled Mr Lane's asthma had been. In turn, this would have factored into considerations about the suitability of Mr Lane's placement at EGRP and/or the support he required to be effectively and safely managed there.[48,49]

32. In my view, the Form should be amended so that under "*Current Health Issues*", prisoners should also be asked: "*In the past 12-months have you attended, or been admitted to a hospital*". This question should be repeated by nursing staff when they conduct their initial health screen. Where a prisoner answers "*Yes*" to this question (to either a reception officer or a nurse) details of the hospital or medical facility should be requested. As soon as is practicable thereafter, DOJ should then obtain records relating to those attendances or admissions.

33. The multiple cell occupancy risk assessment completed for Mr Lane identified no issues that would prevent him from sharing a cell. It is unfortunate that Mr Lane's respiratory issues were not appreciated at that time, because the assessment also concluded there was no reason why he could not share a cell with a smoker. Cigarette smoke is a known trigger for an asthma attack and although prisoners are not supposed to smoke in their cells, it appears that they commonly do so.[50]

34. Mr Lane was identified as being "*Out of Country*" and was referred to the prison support officer. His security rating was assessed as "*medium*" and he was housed in Unit 2. No medical issues that would affect his placement were identified and at the time of his death Mr Lane was in a shared cell. For privacy reasons, I have chosen to identify Mr Lane's cellmate as "Prisoner D".[51,52,53]

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[48] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes, per Nurse P Chan (14.02.19)
[49] Exhibit 1, Vol 2, Tab 61, Discharge Summaries - KRH (December 2018 - March 2019)
[50] ts 24.05.22 (Johnston), pp58-59
[51] Exhibit 1, Vol 2, Tab 52.6, Multiple Cell Occupancy - Risk Assessment (14.02.19)
[52] Exhibit 1, Vol 2, Tab 52.6, Orientation Checklist (14.02.19), p1
[53] Exhibit 1, Vol 2, Tab 52.7, Management and Placement - Remand assessment (19.02.19)

35. Mr Lane underwent an initial health screen with Nurse Chan on 14 February 2019. Mr Lane denied any self-harm or suicidal ideation and as noted, also denied having asthma. As a consequence, Mr Lane's "*Offender Summary*" in TOMS incorrectly stated he did not have asthma or cardiac issues, when in fact he had both.[54,55]

36. Dr Rowland explained that the information on a prisoner's Offender Summary is used by prison staff when arranging to transport a prisoner to medical appointments and court commitments, as well as in the event of an after-hours transfer to hospital. It is therefore critical that the information on a prisoner's Offender Summary is correct because this is the only medical information prison officers can access within TOMS.[56]

37. Mr Lane's denial of asthma and serious health issues presumably explains why his Offender Summary was initially incorrect. However, by 18 February 2019, Mr Lane's community health records had been received and showed he had COPD and had experienced a heart attack. Further, Mr Lane was admitted to KRH for three days on 8 March 2019 and treated for a very serious exacerbation of his asthma. Despite having this information, on neither occasion was Mr Lane's Offender Summary updated. This represents a serious failure on DOJ's part.[57,58]

38. During his incarceration at EGRP Mr Lane did not engage in prison employment and was not charged with any prison offences. It was noted that his English literacy skills were not well developed, which is presumably why he did not send letters to his family. Mr Lane was described by several prison officers as an intelligent person who was quiet, polite, respectful, and cooperative. He was regularly visited by family members and friends and he kept in regular contact with them by phone between visits.[59,60,61,62,63,64]

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[54] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes, per Nurse P Chan (14.02.19)
[55] Exhibit 1, Vol 21 Tab 43.2, Offender Summary (as at 27.04.19)
[56] ts 26.05.22 (Rowland), pp342-344 and see also: ts 26.05.22 (White), p115
[57] Exhibit 1, Vol 2, Tab 72, Bega Garnbirringu Health Service - Patient Summary records
[58] Exhibit 1, Vol 2, Tab 61, Discharge Summaries - KRH (11.03.19)
[59] Exhibit 1, Vol 2, Tab 52.14, Work History - Offender (14.02.19 - 24.05.22)
[60] Exhibit 1, Vol 2, Tab 52.15, Prisoner mail - Offender (14.02.19 - 24.05.22)
[61] Exhibit 1, Vol 2, Tab 52.16, Charge History - Prisoner (14.02.19 - 24.05.22)
[62] Exhibit 1, Vol 2, Tab 52.15, Visits History - Offender (18.02.19 - 24.05.22)
[63] Exhibit 1, Vol 2, Tab 52.15, Recorded Call Report (15.02.19 - 24.05.22)
[64] ts 24.05.22 (Evans), pp13-14; ts 24.05.22 (Johnston), pp53-54 and ts 25.05.22 (Davis), p201

MR LANE'S MEDICAL MANAGEMENT

Management - February 2019[65,66,67]

39. On 18 February 2019, a bag of medication including asthma puffers, was delivered to the front gate at EGRP. Mr Lane's community medical records were also obtained from Bega Garnbirringu Health Service (BGHS).[68,69] Those records show that Mr Lane experienced a heart attack on 7 January 2019, and that his other medical conditions included fatty liver, chronic kidney disease and COPD.[70,71]

40. On 18 February 2019, Mr Lane participated in a telehealth consultation with prison medical officer (PMO), Dr D'Cruz. At the relevant time, Dr D'Cruz was conducting two-day clinics at EGRP each fortnight (although clinics sometimes occurred monthly) with "telehealth" consultations by video in-between clinics. During the consultation, Mr Lane said he hadn't used his asthma puffer "*for a few days*" and his chest felt "*tight*". He also reported sleeping poorly because of shortness of breath.

41. On examination, Mr Lane appeared breathless and was using accessory muscles to help him to breathe. His peak flow measurement[72] was very low and he was diagnosed with an exacerbation of his asthma. Mr Lane was prescribed prednisolone and was to be reviewed the next day (or sooner if required) and sent to hospital if his condition deteriorated.

42. When Mr Lane was reviewed by an Aboriginal Health Worker on 20 February 2019, his peak flow measurement remained low despite three days of prednisolone. During a telehealth consultation with Dr D'Cruz on 25 February 2019, Mr Lane said he was sleeping better but he was still breathless on exertion. His peak flow measurement was still low and he was advised to use his asthma puffer and stop smoking.

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[65] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p9
[66] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes (18-28.02.19)
[67] Exhibit 1, Vol 2, Tab 81, Statement - Dr C D'Cruz (18.05.22), paras 10-13 and ts 24.04.22 (D'Cruz), pp93-94
[68] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes, per clinical Nurse Manager C Johnston (18.02.19)
[69] Exhibit 1, Vol 2, Tab 72, Bega Garnbirringu Health Service - Patient Summary records
[70] Exhibit 1, Vol 1, Tab 43.2, Offender Summary (printed on 27.04.19)
[71] Exhibit 1, Vol 2, Tab 72, Bega Garnbirringu Health Service - Patient Summary records
[72] Peak flow uses a meter to measure the amount of air flowing out of the patient's lungs

Management - March 2019[73,74,75]

43. On 1 March 2019, Mr Lane was reviewed by Dr D'Cruz. Mr Lane remained breathless on exertion and although he said he had been compliant with his puffers, he continued to smoke. On examination, Mr Lane had reduced air entry throughout his chest and occasional wheezes. Nicotine patches were prescribed and weekly reviews by a nurse were ordered.

44. On 7 March 2019, Mr Lane was seen by Mr Johnston (the Clinical Nurse Manager at EGRP) who noted Mr Lane had been coughing all night. On 8 March 2019, Mr Lane was breathless and was given a nebuliser. It was noted he was non-complaint with his asthma puffers and needed constant reminders to use them. He was again advised to use his asthma puffers and give up smoking.

45. On 8 March 2019, Nurse Mandiri conducted an "*on-person*" medication assessment to determine whether it was appropriate for Mr Lane to have personal access to puffers. Nurse Mandiri concluded that Mr Lane was able to read medication labels, could use a puffer and understood the nature of his medical conditions. Mr Lane was therefore authorised to continue to have personal access to his Ventolin puffer/spacer.[76,77,78]

46. On the evening of 8 March 2019, Mr Lane was admitted to KRH collapsed following an asthma attack. His oxygen saturations were extremely low (i.e.: 66%) and he was cyanosed and drowsy. On admission to KRH, Mr Lane was diagnosed with an acute infective exacerbation of his COPD and treated with nebulisers, steroidal medication and respiratory support. Although as Dr Claxton observed, Mr Lane experienced "*hypercapnic respiratory failure which is a very serious illness and a marker of very serious disease*", it appears the seriousness of this event was not fully appreciated.[79,80,81]

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[73] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp9-10
[74] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes, (01-31.03.19)
[75] Exhibit 1, Vol 2, Tab 81, Statement - Dr C D'Cruz (18.05.22), paras 14-25 and ts 24.04.22 (D'Cruz), p96
[76] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes (11.04 am, 08.03.19)
[77] Exhibit 1, Vol 2, Tab 80.1, Statement - Ms E Mandiri (18.05.22), paras 10-14
[78] Exhibit 1, Vol 2, Tab 80.2, On Person Medication Risk Assessment (08.03.19)
[79] Exhibit 1, Vol 1, Tab 43.25, Incident Description Reports & Incident Report Minutes (08.03.19)
[80] Exhibit 1, Vol 2, Tab 55, Discharge Summary - KRH (11.03.19)
[81] ts 26.05.22 (Claxton), pp312-313

47. Mr Lane's condition gradually improved and he was returned to EGRP on 11 March 2019.[82] Thereafter, Mr Lane was reviewed regularly by prison nurses and on 12 March 2019, Dr D'Cruz corrected an error that had been detected with the dosage and frequency of Mr Lane's steroidal medication. A review by Dr D'Cruz on 14 March 2019, concluded that Mr Lane was recovering from an acute exacerbation of his COPD. On 15 March 2019, Dr D'Cruz noted that Mr Lane was able to walk briskly without breathlessness, was feeling well, and that his peak flow measurement had improved.

48. Medical reviews by Dr D'Cruz on 21, 23 and 25 March 2019 were similarly encouraging. Mr Lane said he was feeling well and his peak flow measurements remained improved. Blood tests showed no significant abnormalities, although Mr Lane's liver function was slightly abnormal and his iron, blood sugar and cholesterol levels were slightly raised.

49. On 29 March 2019, Mr Lane was seen by a prison nurse and subsequently by Dr D'Cruz. He reported increased breathlessness and a cough and said he had needed additional Ventolin over the previous two days. On examination, Mr Lane was breathless at rest, his peak flow measurement had deteriorated and his chest sounds revealed reduced air entry. He was prescribed steroidal medication and an antibiotic, with a plan that if his condition did not improve he would be returned hospital.

Management - April 2019[83,84,85]

50. During a telehealth consultation on 1 April 2019, Dr D'Cruz noted that Mr Lane's condition had improved. He was able to walk without becoming breathless, was sleeping better and his peak flow measurement had improved. On 4 April 2019, Dr D'Cruz reviewed Mr Lane again and noted that his current medical concern was "*frequent exacerbations of COPD*". Mr Lane was also referred for an optometry review because of issues with his left eye, and prescribed medication for gastro-oesophageal reflux.

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[82] Exhibit 1, Vol 2, Tab 55, Discharge Summary - KRH (11.03.19)
[83] Exhibit 1, Vol 2, Tab 53, DOJ Medical Notes (01-26.04.19)
[84] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp10-11
[85] Exhibit 1, Vol 2, Tab 81, Statement - Dr C D'Cruz (18.05.22), paras 26-33

51. When seen by Dr D'Cruz on 12 April 2019, Mr Lane reported feeling well and had minimal shortness of breath. His peak flow measurement had improved, and apart from a small hernia, his physical examination was normal. During a nursing review on 18 April 2019, Mr Lane told Ms Evans he had been breathless overnight and Ventolin had not helped. He was coughing up yellow mucus and had wheezes in his chest.

52. Mr Lane was given a nebuliser in the prison medical centre, following which his condition reportedly improved. He was placed in the crisis care unit (CCU) for observation and an eConsult letter was sent to Dr Moss (the on-call PMO) who recommended keeping Mr Lane in the CCU with hourly observations for four hours. Ventolin could be repeated every 20 minutes and if there was a poor response, Mr Lane was to be sent to hospital. Later, Ms Evans spoke to Dr D'Cruz who was conducting telehealth consultations at EGRP that afternoon, who said she was happy with Mr Lane's management. As a result of personal leave, this was the last occasion on which Dr D'Cruz had any involvement in Mr Lane's care.[86,87]

53. Mr Lane was reviewed by Ms Evans at 12.00 pm, 1.30 pm and 2.30 pm on 18 April 2019. During the 2.30 pm review, Mr Lane was able to smile and joke and he demonstrated the correct way to use a spacer. He was also aware that he needed to take 12 puffs of Ventolin (in three lots of four) if he was breathless. Following this review, Mr Lane was returned to the main prison.[88]

54. On 23 April 2019, Mr Lane was reviewed by Mr Johnston following an overnight exacerbation of his asthma. By the afternoon, Mr Lane had no symptoms and was able to walk 400 m uphill to get to the medical centre, without becoming breathless. Mr Lane had a slight wheeze in his chest but his oxygen saturations and pulse rate were within normal limits. As I will explain, Mr Lane had been issued with a nebuliser and Mr Johnston says he again explained the correct use of the device to Mr Lane who confirmed he was happy to use it.

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[86] Exhibit 1, Vol 2, Tab 59, eConsult and response from PMO (18.04.19)
[87] Exhibit 1, Vol 2, Tab 81, Statement - Dr C D'Cruz (18.05.22), paras 32-33
[88] See also: ts 24.05.22 (Evans), p20

55. It appears that after Mr Lane had been breathless on several occasions overnight he asked if he could have the use of a nebuliser in his cell, apparently because he had been given nebulisers during his hospital admissions and found them helpful. At the inquest, Mr Johnston said that after Mr Lane's request, he took the initiative and obtained the necessary security approvals for Mr Lane to be issued with a nebuliser for overnight use in his cell.[89]

56. From Mr Johnston's perspective, the fact that Mr Lane had asked for a nebuliser and had a prescription for vials of salbutamol (Ventolin) for use in a nebuliser, were major considerations. Mr Johnston confirmed he had watched Mr Lane setting up the nebuliser and that Mr Lane knew how to use the device correctly.[90]

57. At the inquest, Ms Evans said she recalled checking that Mr Lane was able to use his puffer/spacer and that because the nebuliser was new to him, she had also made sure he was comfortable using the device. Ms Evans also said that on 24 April 2019, Mr Lane had told her he had used the nebuliser "*one or two times during the night*" and that she had reminded him that he also had his puffer/spacer which he could use.[91]

58. It is notable that neither Dr D'Cruz, nor any other PMO was involved in the decision to provide a nebuliser to Mr Lane. Further, nobody seemed to appreciate that Mr Lane's need for Ventolin overnight represented a serious deterioration in his condition. At the inquest, Dr D'Cruz referred to the risk that a patient might overuse their nebuliser and might "*call for help too late*". Dr D'Cruz also said that had she been involved in the decision to provide Mr Lane with a nebuliser for use in his cell overnight, she would have wanted "*parameters*" in place, namely:

> [W]e would have to make sure that Mr Lane (1) knew exactly how to use the nebuliser, (2) knew exactly when he should be calling for help, and not to overuse and delay calling for help and (3) that he knew how to work it, he knew how to work the nebuliser.[92]

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[89] ts 24.05.22 (Johnston), pp61-62
[90] ts 24.05.22 (Johnston), pp62-63 & 67
[91] Exhibit 1, Vol 2, Tab 87, Statement - Ms W Evans (18.05.22), paras 10-11 and ts 24.05.22 (Evans), p20
[92] ts 24.05.22 (D'Cruz), p97 and see also: ts 24.05.22 (D'Cruz), p98

59. As Dr D'Cruz noted, when Mr Lane experienced a very serious exacerbation of his asthma on 8 March 2019, he did not have a nebuliser in his cell and had called for immediate help. However, by the time Mr Lane experienced a further exacerbation on 26 April 2019, he had been issued with a nebuliser, and it is possible this caused him to delay seeking help.[93] Ms Evans said that with the benefit of hindsight, she thought that providing Mr Lane with a nebuliser had "*complicated the situation*" because it may have given prison officers a false sense of security and "*might slow the process down of calling an ambulance*".[94]

60. As noted, Mr Lane's prescription for salbutamol (Ventolin) vials was one of the factors Mr Johnston considered when arranging for Mr Lane to be issued with a nebuliser. However, Dr D'Cruz confirmed that when she wrote the prescription for the Ventolin vials, it was her understanding they would be used by nurses when they gave Mr Lane a nebuliser in the medical centre. Dr D'Cruz said had she known Mr Lane was requiring Ventolin at night, she would have been concerned about the extent to which his asthma was under effective control.[95]

61. In any event, at 2.48 pm on 23 April 2019, Mr Johnston sent an email to various staff confirming that Mr Lane had been authorised to have a nebuliser in his cell at bight after lockup "*[T]o administer Ventolin so he can ease the symptoms of his lung disease*". Unit staff were asked to assist by giving the nebuliser to Mr Lane at "*lockup*" and recovering it the next morning at "*unlock*"[96]

62. In his email, Mr Johnston also asked Unit staff to check the equipment and "*refer to medical if any needs arise*". At the inquest, Mr Johnston clarified that he was asking that unit staff check the components of the nebuliser were present, rather than make any assessment of whether the device was actually working. In addition to the nebuliser and power cord, Mr Lane was also issued with plastic tubing, a mask, the nebuliser's barrel, and vials of salbutamol.[97,98]

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[93] ts 24.05.22 (D'Cruz), p102
[94] ts 24.05.22 (Evans), p39
[95] ts 24.05.22 (D'Cruz), p98
[96] Exhibit 1, Vol 2, Tab 52.8, Email Mr C Johnston (2.48 pm, 23.04.19) and ts 24.05.22 (Johnston), pp61 & 68-69
[97] Exhibit 1, Vol 2, Tab 52.8, Email Mr C Johnston (2.48 pm, 23.04.19) and ts 24.05.22 (Johnston), pp69 & 79
[98] See also: Exhibit 1, Vol 1, Tab 43.38, Offender Notes (23.04.19)

63. To ensure all staff at EGRP were aware of the situation, Officer Mortley sent an email at 6.35 am on 24 April 2019, (the Broadcast Email) advising that Mr Lane had been authorised to have a nebuliser in his cell overnight and:

> [T]his is a medically issued piece of equipment. The item is to assist with his breathing (symptoms of lung disease). The item is to be issued at lockup to the prisoner and retrieved at unlock.[99]
>
> [Original emphasis]

64. At the inquest, Officer Mortley said that from his perspective, "*it was a very strong point*" for him that officers should only be responsible for issuing and retrieving the nebuliser and he did not want officers to have the custody of the nebuliser at all.

65. Although the Broadcast Email makes it clear that the nebuliser was to be retrieved at unlock, the device was in Mr Lane's cell prior to lockup on 26 April 2019. The strong inference to be drawn from the available evidence is that the nebuliser was not being recovered at unlock as had been directed. At the inquest, Officer Mortley was asked why the daily retrieval of the nebuliser seemed to have been overlooked. He said there was never any formal approval for Mr Lane to retain the nebuliser in his cell during the day, but that: "*From my initial review, it looks like…[Mr Lane]…requested [the nebuliser] would stay in [his cell] , and it kind of evolved that it would stay there*".[100,101]

66. On 24 April 2019, Mr Lane walked 400 m uphill to the medical centre for a review. On examination, he was moderately short of breath and his peak flow measurement was lower than it had been previously. Mr Lane said he was feeling slightly worse but was getting good relief from his nebuliser, which he had used twice overnight. Mr Lane was encouraged to use his Ventolin puffer/spacer if he had mild symptoms and was again shown how to use the puffer/spacer which he said he understood.[102]

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[99] Exhibit 1, Vol 2, Tab 52.9, Email broadcast, Officer S Mortley (6.35 am, 24.05.22)
[100] ts 24.05.22 (Evans), pp25-26 and see also: ts 25.04.22 (Palmer), p278
[101] ts 26.05.22 (Mortley), pp382-383
[102] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p5

67. Dr Claxton explained the implications of Mr Lane's overnight use of Ventolin via a nebuliser in these terms:

> [T]he use of reliever therapy is a mark of asthma control...so if you need your reliever therapy overnight, if you're waking up with asthma symptoms, that is a strong indicator that things aren't controlled…I guess needing to have access to reliever therapy at night, again, would to me be a signal that perhaps, you know, there is an issue with asthma control and that needs to be reviewed.
>
> In the short term…generally there's no limit on how much reliever therapy you should take if you have asthma. So I think…having access to the nebuliser if symptoms are getting worse is certainly, I think, appropriate for the short term but with a view to this is not how asthma should be (and therefore) having it reviewed.[103]

68. Although providing Mr Lane with access to a nebuliser at night may have been justifiable in the short-term, this would only have been appropriate for the period before Mr Lane underwent a comprehensive review.

69. As noted, Dr Claxton explained that the events that led to Mr Lane being admitted to KRH on 8 March 2019 represented "*a marker of very serious disease*" and were a stark indicator that Mr lane's asthma was very poorly controlled. In that context, long term use of the nebuliser, especially at night, indicated that a review of Mr Lane's asthma was urgently required.[104,105]

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[103] ts 26.05.22 (Claxton), pp309-310 & 314
[104] ts 26.05.22 (Claxton), pp312-313
[105] ts 26.05.22 (Rowland), pp337-339

EVENTS LEADING TO MR LANE'S DEATH[106,107]

Lockdown and a special delivery

70. As a result of staff shortages (which Officer White said were a daily occurrence at EGRP) prisoners were locked in their cells for the majority of the day on 25 April 2019. As a consequence of being locked in their cells, prisoners did not have their usual access to nurses at the prison medical centre for the treatment of routine matters.[108]

71. Ms Evans was one of the nurses on duty on 25 April 2019 and said she recalled that at about 5.00 pm, she had encountered Mr Lane as she was changing a dressing for another prisoner. Mr Lane told Ms Evans that a part he needed for his nebuliser was missing and she agreed to come to his cell to check. Although she ought to have had an escort, in view of the shortage of prison officers, Ms Evans decided to make her way to Mr Lane's unit without one.

72. When she got to Mr Lane's cell, Ms Evans got down on her hands and knees and located the missing part which she described as a "*spinner*" that was essential to the delivery of vaporised medication. The part was damaged and Ms Evans says she told Mr Lane that she would arrange for a replacement to be delivered to his cell.

73. Although it was getting close to the end of her shift, Ms Evans was able to source a replacement part for Mr Lane's nebuliser. She placed the part in plastic zip-lock bag and attached a pink post-it note to the bag, on which she had written "*ASHLEY LANE*" in block capitals.

74. Ms Evans then placed the bag containing the part in a red box at the front gate. Up to that point, the red box was part of system (the Red Box system) that had only been used to deliver medication to prisoners after hours. I will have more to say about this system later in this finding.[109,110]

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[106] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp11-13
[107] Exhibit 1, Vol 2, Tab 87, Statement - Ms W Evans (18.05.22), paras 12-34 and ts 24.05.22 (Evans), pp13, 23-34 & 47
[108] ts 24.05.22 (White), p126 and see also: ts 26.05.22 (Mortley), p385
[109] Exhibit 1, Vol 2, Tab 82, Att. SM4 - Staff Notice 5/2018: After hours issuing of Medication/Panadol (24.05.18)
[110] Exhibit 1, Vol 2, Tab 82, Att. SM3 - Local Order 01 - Night Shift Routine (01.03.19)

75. Although it would have been possible for Ms Evans to have delivered the nebuliser part to Mr Lane herself, there were several barriers to her being able to do so. First, Ms Evans was coming to the end of her shift and it was getting dark. Second, although Ms Evans could have used an electric buggy to get to Mr Lane's unit, she naturally felt uncomfortable moving about the prison at night on her own.[111]

76. Third, the prison was short-staffed and this was a very busy time of day. Thus, even if Ms Evans had managed to get Unit 2 by herself, it is unclear how long she would have to have waited before a prison officer became available to assist her to enter the unit and give Mr Lane the replacement part. For all of these reasons, Ms Evans concluded that her only option of getting the part to Mr Lane was to use the Red Box system.[112,113]

77. Prior to leaving EGRP at the end of her shift, Ms Evans participated in a handover between nursing staff and prison officers, including the Night Officer-in-Charge (OIC), Officer Houweling. Ms Evans is adamant that during that handover, she gave explicit instructions that the nebuliser part needed to be delivered to Mr Lane that night.[114]

78. As she was leaving EGRP after the handover, Ms Evans says she paused and said to the officers about to start their shift, words to the effect of "*You won't forget that part for Mr Lane will you*". Nurse Chan, who was leaving at the same time, jokingly said something like "*I think they get the message*", which Ms Evans took to mean that her instructions about the nebuliser part would have been understood by the officers.[115]

79. Despite Ms Evans' clear recollection, there is significant dispute about exactly what information she conveyed during the handover. Further, other than the fact that note attached to the bag containing the nebuliser part was bright pink, there was nothing on the note to indicate the urgency with which the part needed to be delivered to Mr Lane.[116]

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[111] ts 26.05.22 (Mortley), pp385-386 and ts 24.05.22 (Evans), p25
[112] Exhibit 1, Vol 2, Tab 82, Statement - Officer S Mortley (19.05.22), paras 31-32
[113] ts 24.05.22 (Evans), pp30 & 43 & 47
[114] ts 24.05.22 (Evans), pp32-33
[115] ts 24.05.22 (Evans), p31
[116] ts 24.05.22 (Evans), pp31-32

80. In his statement, Officer White says he was unaware of the Broadcast Email but recalled that Mr Lane was mentioned during the shift handover. As a result, Officer White says he was aware that:

> Mr Lane had a device and that part of that device would be at the front gate. No one told me that the piece at the front gate was vital and no one instructed and/or advised me to collect the piece and bring it to the unit.[117,118]

81. Officer Davis, who was on duty at the front gate, says Mr Lane was mentioned during the shift handover, but her recollection of what she was told is slightly different. In her statement, Officer Davis says:

> I recall during handover that night being advised by the medical staff that the nebuliser piece was in the red box if Mr Lane needed it. I was not asked to take it to Unit Two at that stage but informed that if he required it then it was to be taken to him.[119]

82. Despite the fact that Ms Evans is adamant she told Officer Houweling that the nebuliser part was needed by Mr Lane that night, Officer Houweling is equally adamant that this is not what he was told. In his statement, Officer Houweling says he was aware of the Broadcast Email but that during the shift handover he was told that should Mr Lane need it, "*there was another nebuliser in the red box*".[120,121]

83. At the inquest, Officer Houweling clarified that by using the phrase "*another nebuliser in the red box*" in his statement, he was referring to a part for the nebuliser. He confirmed his understanding was that the part in the red box was a backup that was available should Mr Lane require it. At the inquest, Officer Houwelling said that had he been made aware that Mr Lane needed the part urgently, he would have it delivered it straight away.[122]

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[117] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J White (22.01.20), para 32 and ts 24.05.22 (White), p109
[118] See also: Exhibit 1, Vol 1, Tab 12, Statement - Officer J White (08.08.19), paras 3-5
[119] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer P Davis (07.02.20), para 12 and ts 25.05.22 (Davis), pp202-203 & 228-229
[120] ts 25.05.22 (Houweling), pp262-263
[121] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 10-11
[122] ts 25.05.22 (Houweling), pp239-242 & 261-262

84. Officer Houweling also said that he had inspected the contents of the red box at the start of his shift, and that as the night progressed, "*there were no issues*".[123] Had Ms Evans' note indicated the urgency with which Mr Lane required the part, it is possible that when Officer Houweling checked the contents of the red box, he might have appreciated the importance of getting the part to Mr Lane that night, despite what he recalls he was told during the shift handover.

85. At the inquest, Dr D'Cruz was asked what she thought about the decision to place the nebuliser part in the red box for delivery to Mr Lane. Dr D'Cruz said:

> I don't think that would be good because I believe, if Mr Lane was having an asthma attack, you know, cognitively, he would have been not…100 per cent because his mind would be lacking oxygen while he's…trying to get a breath. So…the last thing he needed was somehow to put a part in a machine. I just think it would have been too much to ask. I think if he was to have a nebuliser, it just had to be almost ready to go. You just…it's already filled up with the liquid (and) all he had to do was turn the "on" switch and put it on his face.[124]

86. As I will explain in more detail later in this finding, at the time Ms Evans used the Red Box system to deliver the nebuliser part to Mr Lane, there was nothing in the relevant policy which stated this was impermissible, and no one raised any objections to her doing so. Mr Johnston said in his opinion, Ms Evans had acted sensibly and further, he would have done the same thing if had been in her position.

87. Following Mr Lane's death, Ms Palmer 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's findings are set out in a document called Review of Death in Custody (the Review).[125]

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[123] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), para 12
[124] ts 24.05.22 (D'Cruz), p100
[125] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p4

88. I will deal with Ms Palmer's findings later in this finding, but for now, I note that the Review refers to an interaction between Superintendent Hedges and Mr Johnston that is said to have occurred on 26 April 2019. During that interaction, which Superintendent Hedges says he noted in his diary, Superintendent Hedges says he instructed Mr Johnston that nursing staff were to ensure equipment provided to prisoners was in good working condition before leaving EGRP for the night. For his part, Mr Johnston said he could neither recall this conversation, nor did he receive an email to this effect.[126]

89. In any event, the Review made the following sensible recommendation:

> It is recommended that the Superintendent EGRP formalise a request to medical staff to ensure that all medical equipment and items required to be in a prisoner's cell are in good working order prior to leaving the prison facility at the end of the day.[127]

90. The Review also noted that despite the fact that the suggested recommendation had been supported by Superintendent Hedges, an email confirming these arrangements was not sent to the current Clinical Nurse Manager at EGRP until 6 April 2022.[128]

91. In this case, there was confusion on the evening of 25 April 2019 as to what prison staff were supposed to do with the part for Mr Lane's nebuliser that Ms Evans had placed in the red box. None of the officers appreciated it had to be delivered to Mr Lane urgently, with the prevailing view being that it was a part that Mr Lane may or may not require overnight.

92. This sort of confusion is clearly unfortunate and should not have occurred. However, the evidence in this case does not enable me to conclude that this issue had any material impact on Mr Lane's death.

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[126] ts 24.05.22 (Johnston), pp73-74
[127] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p18
[128] ts 25.05.2 (Palmer), p277

Mr Lane's cell call[129,130,131,132,133,134,135,136,137,138,139,140]

93. Prisoners have access to a call button in their cells for use in emergencies. Calls made using the call button (cell calls) are usually answered by officers in the relevant unit office. However, if a cell call is not answered on the unit (because officers are attending to other duties) the call diverts to the "Master Control" room at the front gate, where it is answered by the officer on duty there.

94. Mr Lane made the first of several cell calls at about 1.32 am on 26 April 2019 and his call was answered by Officer White in the unit office. Mr Lane said, " *I can't breathe properly*" and Officer White asked Mr Lane if he had been given "*the piece of the machine that helps you breathe*". Mr Lane replied that his nebuliser was not working and on the basis of the information he had received during the shift handover, Officer White realised the part Mr Lane needed would be in the red box at the front gate.

95. Officer White told Mr Lane he would "*call the boss*" and arrange for the part to brought to Mr Lane's cell. Officer White then called the front gate and his call was answered by Officer Davis. Surprisingly, Officer White did not tell Officer Davis that Mr Lane had said he couldn't breathe properly, but in any case, Officer Davis said she would bring the part to Unit 2 and used an electric buggy to do so.[141]

96. When Mr Lane had not received the part by 1.40 am, he made another cell call asking where it was. During that cell call (which was answered by Officer White) Prisoner D could be heard saying the "*machine wasn't working*", which I take to have been a reference to Mr Lane's nebuliser.

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[129] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer J White (26.04.19)
[130] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J White (22.01.20), paras 11-18 and ts 24.05.22 (White), pp110-114
[131] Exhibit 1, Vol 1, Tab 12, Statement - Officer J White (08.08.19), paras 2-9
[132] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer P Davis (26.04.19)
[133] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer P Davis (07.02.20), paras 8-19 and ts 25.05.22 (Davis), pp205-212
[134] Exhibit 1, Vol 1, Tab 11.1, Statement - Officer P Davis (22.04.20), paras 3-9
[135] Exhibit 1, Vol 2, Tab 52. 11, Incident Description Report - Officer M Fox (26.04.19)
[136] Exhibit 1, Vol 2, Tab 52. 11, Incident Description Report - Officer K Lewis (26.04.19)
[137] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer K Lewis (09.03.20), paras 7-8 and ts 25.05.22 (Lewis), pp171-178
[138] Exhibit 1, Vol 1, Tab 16, Statement - Officer K Lewis (08.08.19), paras 2-4
[139] Exhibit 1, Vol 2, Tab 52. 11, Incident Description Report - Officer J Houweling (26.04.19)
[140] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 14-16
[141] ts 24.05.22 (White), p131 and ts 25.05.22 (Davis), pp205-208

97. Mr Lane made a further cell call at 1.43 am asking about the nebuliser part and once again, his cell call was answered by Officer White. By this stage, Officer Davis was entering Unit 2, and Officer White reassured Mr Lane the part would be with him "*in about 30 seconds*". Officer White and Officer Davis then went to Mr Lane's cell and handed Mr Lane the part through the observation hatch in his cell door.

98. As the part was being handed over, Officer White says Mr Lane asked for "*a new can of chemical as the one he had was empty*". Officer Davis recalls Mr Lane asking for another "*can of stuff*" and there was confusion between the officers as to what Mr Lane was referring to. For her part, Officer Davis thought Mr Lane may have been referring to medication for his nebuliser.[142]

99. There is also a divergence of view about Mr Lane's condition at this point. Officer White says he saw Mr Lane sitting on a chair at the desk in his cell using a puffer, and that Mr Lane was "*speaking clearly*". In stark contrast, Officer Davis says that Mr Lane appeared to be "*struggling to talk and was hard to understand*", and at the inquest Officer Davis recalled Mr Lane was leaning forward and breathing in a laboured manner.[143]

100. Given Officer Davis' observations and the fact that Mr Lane had earlier told Officer White that he couldn't breathe properly, it is regrettable that neither officer initiated a Code Red medical emergency and/or called for an ambulance at this point. I accept that initiating a Code Red medical emergency does not necessarily mean an ambulance will be called,[144] but it does put everyone on notice (including the officer on duty in Master Control) that an ambulance may be required.

101. At the inquest, there was some evidence that more junior officers may be reluctant to initiate a Code Red and/or call for an ambulance without approval from a more senor officer. One officer even expressed a concern that a reprimand could be issued if an officer called for an ambulance that later turned out not to be required.[145]

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[142] ts 24.05.22 (White), p112 and ts 24.05.22 (Davis), pp208-210
[143] ts 24.05.22 (White), pp112-113 and ts 25.05.22 (Davis), pp209-211, 213, 228 & 233
[144] ts 24.05.22 (Lutz), pp150-151
[145] ts 25.05.22 (Houweling), pp248-250 & 256 & 258 and 25.05.22 (Lewis), pp192-193

102. At the Inquest, Officer Houweling made it clear that although prison officers do have an independent discretion with respect to calling for an ambulance and/or initiating a Code Red, this was not always widely appreciated. Officer Houweling agreed that it would be appropriate for officers to be reminded of their independent discretion by means of a State-wide bulletin or broadcast. He also agreed that at night, when prisoner officers do not have nursing support, an ambulance should be called whenever officers were unsure.[146] As Officer Houweling put it:

> That is the way I believe it should be. However, I do understand from the staff perspective that they look at the hierarchy of control overnight, and they are concerned that, "Hang on a minute. You didn't need to call an ambulance." And they would probably be concerned that it was superfluous.[147]

103. At the inquest, Dr D'Cruz said her expectation was that if a prisoner told prison officers they couldn't breathe properly (as Mr Lane had done), then an ambulance should be called, because "*breathing is very important*". In his evidence at the inquest, Officer Lutz agreed that it would be a good idea to train responding officers they should call an ambulance when in doubt, and Officer Fox said that with the benefit of hindsight, he thought an ambulance should have been called earlier.[148]

104. Although neither Officer Davis nor Officer White knew what Mr Lane was referring to when he had asked for a "*can of stuff*", Officer Davis recalled an email about Mr Lane's condition, and she and Officer White went back to the unit office to find it. As Officers Davis and White were in the unit office reading the Broadcast Email, Officer Michael Fox arrived. He was on duty as a night recovery officer and as such, was tasked with patrolling the prison. Quite by chance, Officer Fox had seen Officer Davis heading to Unit 2 "*with purpose*" and had decided to follow her to see if there was anything going on he could assist with.[149]

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[146] ts 25.05.22 (Houweling), pp247-248, 250 & 252 and see also: ts 25.05.22 (Palmer), p290
[147] ts 25.05.22 (Houweling), p248
[148] ts 24.05.22 (D'Cruz), pp104-105; ts 24.05.22 (Lutz), pp145& 149-150 and ts 24.05.22 (Fox), pp157-158
[149] ts 24.05.22 (Fox), pp153-154

105. Meanwhile, Officer Houweling says he was told that staff had attended Mr Lane's cell and that Mr Lane appeared to be unwell. Officer Houweling says he contacted Officer Davis and told her to get the nebuliser from the red box. When she asked him what the "*can of stuff was*", Officer Houweling told her it was the nebuliser located in the red box at the front gate.[150]

106. At around this time, Officer Lewis (who was on duty in the Master Control room) received a phone call from Officer Davis. Officer Lewis' responsibilities including monitoring CCTV cameras in the prison and answering cell calls not picked up by Unit staff.[151]

107. Officer Lewis says Officer Davis told her she was on Unit 2 trying to sort out Mr Lane's medication. Officer Lewis replied she didn't know where Mr Lane's medication was and "*did not know what was going on*". Officer Lewis also told Officer Davis that if Mr Lane's medication was not in the red box it must already be on Unit 2.

108. Officer Davis says that because officers were unable to find anything that resembled a "*can of stuff*", it was decided Mr Lane would have to be given oxygen using an Oxiboot instead.[152] Officer White returned to the unit office to fetch the Oxiboot and as he walked back to Unit 2, he was joined by Officer Lutz (who was on duty in Unit 3) and had happened to see Officer White walk past.

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[150] ts 25.05.22 (Houweling), p246
[151] ts 25.05.22 (Lewis), pp170-171 and ts 25.05.22 (Davis), p212
[152] An Oxiboot is an oxygen resuscitator that can provide supplemental oxygen to a patient

Prisoner D's cell call[153,154,155,156]

109. At about 1.49 am, some 17 minutes after Mr Lane's first cell call asking for a part for his nebuliser, Prisoner D made a cell call demanding that officers come and help Mr Lane (the Cell Call). The Cell Call was answered by Officer Lewis and in her statement, she says:

> I did not know what was going on at the time and I recall saying words to the effect of 'there should be an officer there'. I did not know why…(Prisoner D)…was telling me to hurry up, he did not tell me that Mr Lane was not breathing. If I had been made aware…(Mr Lane)…was not breathing I may have called a code red medical emergency, but all the staff were already there and already knew what was going on.[157]

110. A recording of the Cell Call was made available to the Court and reveals that the following interchange took place between Prisoner D and Officer Lewis:

> Officer Lewis: *State your name and medical emergency*
> Prisoner D: *Can you tell them to fucking hurry up.*
> **Officer Lewis:** ***I beg your pardon***
>
> Mr Lane: *Can you please.*
> Prisoner D: *Can you fucking hurry up.*
> **Officer Lewis:** ***Well with that sort of talk I don't think I will.***
>
> Prisoner D: *Fuck you.*
> **Officer Lewis:** ***And to you too. They're already trying to do their best for you and that's the thanks we get.***
>
> Prisoner D: *Hurry the fuck up man.*
> **Officer Lewis:** ***I am not gonna pass that message on that's just being insolent.***[158]
>
> [Emphasis added]

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[153] Exhibit 1, Vol 1, Tab 10, Statement - Prisoner D (26.04.19), para 14
[154] Exhibit 1, Vol 1, Tab 41.1, Cell Call Form (26.04.19)
[155] Exhibit 1, Vol 1, Tab 41.2, Email Mr D Shilton re downloading Cell Calls to Unit 2 Cells (5.48 pm, 26.04.19)
[156] Exhibit 1, Vol 1, Tab 16, Statement - Officer K Lewis (08.08.19), paras 5-6 and ts 25.05.22 (Lewis), pp178-1191
[157] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer K Lewis (09.03.20), paras 9-10
[158] Exhibit 1, Vol 2, Tab 52.3, Audio recordings of cell call - Officer K Lewis & Prisoner D (26.04.22)

111. In her statement, Officer Lewis confirmed that she did not tell anyone about the Cell Call at the time because she "[B]*elieved that everyone was in Unit 2 and I was unaware of what was occurring there at that time*".[159] At the inquest, Officer Lewis emphasised the fact that she "*was being kept in the dark*" and did not know what was going on in Unit 2. Officer Lewis also reiterated that she had been unaware Mr Lane was not breathing.

112. As to "*being kept in the dark*" about what was going on, following some pointed questions from Counsel Assisting and me, Officer Lewis conceded that the reason she had been unaware of what was happening on Unit 2 was because she had not bothered to ask relevant questions, either of Officer Davis during their telephone conversation, or of Prisoner D during the Cell Call.[160]

113. In his statement, Officer Houweling said he only became aware of the Cell Call on 29 April 2019, which was his next shift at EGRP after Mr Lane's death. As Officer Houweling explained:

> I became aware of the cell call when prisoners indicated that they were going to assault [Officer Lutz] because they believed that he had sworn at the prisoners on the night of the incident involving Mr Lane. They told me they could hear the interaction through the cell wall.[161]

114. As can be seen, Officer Lewis' failure to report the Cell Call at the time it was made created a potential threat to the good order and discipline at EGRP. Officer Houweling also said:

> It is my opinion that as the OIC it would have been advantageous to have been advised by officers of the existence of a cell call where [Prisoner D] was making demands to hurry up. I should have been advised that things in the cell were escalating quickly.[162]

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[159] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer K Lewis (09.03.20), para 14
[160] ts 25.05.22 (Lewis), pp190-191 & 199
[161] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), para 36
[162] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), para 37

115. When considering whether to make an adverse finding in relation to Officer Lewis' conduct in relation to the Cell Call, I must be mindful of two key principles. The first is the phenomenon known as hindsight bias which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[163]

116. The other relevant principle is known as the Briginshaw test, from a High Court judgment of the same name, where Justice Dixon stated:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[164]

117. In a nutshell, the Briginshaw test requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of the allegation.

118. In approaching my task, I accept that prison officers perform a challenging and difficult job and that they are routinely subjected to verbal (and at times physical) abuse by the prisoners they supervise. This must be very frustrating, especially when prisoners do not display any gratitude or courtesy in relation to the efforts of officers. Nevertheless at the relevant time, Officer Lewis was an experienced prison officer with 10 years of service under her belt.[165]

119. At the inquest, Officer Mortley was asked for his view of the way in which Officer Lewis handled the Cell Call and his response was "*there was room for improvement*". In my view, this assessment unreasonably downplays the nature of Officer Lewis' conduct and having reviewed the recording of the Cell Call a number of times, I can confirm it is painful to listen to.

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[163] See for example: www.britannica.com/topic/hindsight-bias
[164] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[165] ts 25.05.22 (Lewis), pp168 & 180

120. During the call, Prisoner D was clearly agitated for the obvious reason that his cellmate, Mr Lane, was extremely unwell. However, instead of trying to find out what was actually going on in the cell, Officer Lewis seemed more intent on admonishing Prisoner D for his use of foul language, a fact she acknowledged at the inquest.[166]

121. Had Officer Lewis attempted to calm the situation and/or had she made even the most basic of enquiries of Prisoner D, she might have discovered that Mr Lane was having breathing difficulties. Armed with that knowledge, Officer Lewis might have called a Code Red medical emergency and/or made enquiries about whether an ambulance was required. Instead, Officer Lewis did not call for an ambulance until she was asked to do so some seven minutes later. In fairness however, on the evidence before me, it is unlikely any delay in calling for an ambulance had any material impact on Mr Lane's clinical journey.[167]

122. At the inquest, counsel for Officer Lewis asked Dr Rowland whether she thought prison officers required additional training "*around eliciting proper information to work out whether there is in fact an emergency*". The assertion appeared to be that if Officer Lewis had received such training her responses during the Cell Call might have been different. However, Dr Rowland agreed with me that training was not required to ask the obvious question: "*What is going on?*".[168]

123. Following Mr Lane's death, Officer Lewis was "*counselled by the on-duty Principal Officer, educated and issued a formal warning*" with respect to her behaviour during the Cell Call. In his statement, Officer Mortley described Officer Lewis' conduct as "*a minor breach*" of the code of conduct applicable to prison officers (the Code). Under the heading "*Personal Behaviour Expectations*", the Code relevantly provides: *We exercise proper courtesy, consideration and sensitivity in the performance of our duties and our dealing with all persons*.[169]

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[166] ts 25.05.22 (Lewis), p183
[167] ts 26.05.22 (Claxton), pp314 & 317
[168] ts 26.05.22 (Rowland), pp366-367 & 368
[169] Exhibit 1, Vol 2, Tab 82, Att. Code of Conduct (07.05.18), p5, section 3.1

124. As was her right, by way of an email dated 28 June 2020, Officer Lewis challenged the formal warning she had been given. In her email, Officer Lewis said she didn't agree her formal warning was warranted because she had followed procedures and "*dealt with the situation accordingly*". In support of this assertion, Officer Lewis stated:

> In relation the cell call itself, I did not respond to the caller in any negative tone. I did not swear at any time during the call. I spoke clearly throughout the cell call, so there was no misunderstanding of what I was saying. I believed I was polite, considering the swearing I was receiving. I may have been short in the cell call, but this would not be any different to how I would handle a call from anyone else swearing at me.[170]

125. Quite apart from the breathtaking lack of self-awareness Officer Lewis displays in her email, it is deeply troubling that by choosing to challenge the formal warning she received, Officer Lewis appears to demonstrate a stubborn refusal to learn from past mistakes. Rather than acknowledge her error, Officer Lewis attempted to defend the indefensible. Simply put, Officer Lewis had an opportunity to make relevant enquiries of Prisoner D and she spectacularly failed to do so.

126. After having due regard to the principles I have referred to, it is my view that Officer Lewis's conduct during the Cell Call was inappropriate and unprofessional and constitutes a serious breach of the Code of Conduct. Further, Officer Lewis' failure to advise Officer Houweling of the Cell Call shortly after she received it was a dereliction of her responsibilities as a prison officer.

127. Despite her previous reluctance to do so, it was heartening that at the inquest, after intense questioning from Counsel Assisting, Officer Lewis accepted that her conduct during the Cell Call had been inappropriate. Officer Lewis also said if she had her time again, she would have handled the interaction differently.[171]

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[170] Exhibit 1, Vol 1, Tab 16.2, Email - Officer K Lewis (28.06.20) and ts 25.05.22 (Lewis), pp195-196 & 198-199
[171] ts 25.05.22 (Lewis), pp182-183, 191-192, 195-196 & 198-199

128. Further, during submissions at the end of the inquest on 26 May 2022, Officer Lewis' counsel advised that Officer Lewis had recently contacted senior management at EGRP to say she now understood her conduct during the Cell Call had been inappropriate. Officer Lewis had also called her counsel before the inquest resumed on 26 May 2022, to express remorse about her behaviour.[172] Whilst it is regrettable that this epiphany came so late to Officer Lewis, it is nonetheless welcome. I now return to the events that transpired after the Cell Call.

Mr Lane is found unresponsive[173,174,175,176,177,178,179,180,181,182,183,184185,186,187,188,189,190,191]

129. Prisoner D made a further cell call at 1.50 am that was answered by Officer Davis. Officer Fox, who was near the Unit 2 office, overheard the cell call and could tell Prisoner D was agitated. Officer Fox said he was also was aware Mr Lane would require oxygen because of his medical condition and because he (Officer Fox) had helped transfer Mr Lane to KRH on 8 March 2019, when Mr Lane experienced a near fatal exacerbation of his asthma.

130. As Officers Fox and White headed to Mr Lane's cell, a radio call was made to the Night OIC (Officer Houweling) asking him to come to Unit 2 as soon as possible and unlock Mr Lane's cell. At that time, only the Night OIC held cell keys meaning that at night, unit officers were unable to unlock cells themselves. Since Mr Lane's death cell keys have been strategically positioned within EGRP and can now accessed by unit officers in emergency situations.[192,193]

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[172] ts 26.05.22 (Crispe), pp434-435
[173] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer J White (26.04.19)
[174] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J White (22.01.20), paras 19-29 and ts 26.05.22 (White), pp116-120
[175] Exhibit 1, Vol 1, Tab 12, Statement - Officer J White (08.08.19), paras 10-30
[176] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer P Davis (26.04.19)
[177] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer P Davis (07.02.20), paras 20-30 and ts 25.05.22 (Davis), pp208-225
[178] Exhibit 1, Vol 1, Tab 11.1, Statement - Officer P Davis (22.04.20), paras 10-39
[179] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer M Fox (26.04.19)
[180] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer M Fox (08.05.20), paras 5-24 and ts 24.05.22 (Fox), pp155-160
[181] Exhibit 1, Vol 1, Tab 13, Statement - Officer M Fox (08.08.19), paras 3-27
[182] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer J Houweling (26.04.19)
[183] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 17-31 and ts 25.05.22 (Houweling), pp252-255
[184] Exhibit 1, Vol 1, Tab 15, Statement - Officer J Houweling (08.08.19), paras 3-24
[185] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer K Lewis (26.04.19)
[186] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer K Lewis (09.03.20), paras 15-18
[187] Exhibit 1, Vol 1, Tab 16, Statement - Officer K Lewis (08.08.19), paras 7-9
[188] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer D Lutz (26.04.19)
[189] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer D Lutz (07.05.20), paras 10-26 and ts 24.05.22 (Lutz), pp138-146
[190] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Lutz (08.08.19), paras 3-23
[191] Exhibit 1, Vol 1, Tab 10, Statement - Prisoner D (26.04.19), paras 18-22
[192] ts 24.05.22 (White), pp123-124; ts 25.05.22 (Houweling), p259 and ts 25.05.22 (Davis), p217
[193] ts 25.05.22 (Palmer), pp280-281 and ts 25.05.22 (Mortley), pp389-390

131. After 5.30 pm when there was no nursing support at EGRP, officers were instructed to call for an ambulance in the event of a medical emergency. Nevertheless, despite the fact that by this stage it was clear that Mr Lane was having breathing difficulties and attempts were being made to give him supplemental oxygen, nobody called for an ambulance.

132. While the officers waited for Officer Houweling to arrive, Officer Fox opened the observation hatch to speak to Mr Lane, who was sitting in a chair in his cell. Officer Fox says Mr Lane's head was "*slumped backwards*" and he was unresponsive. Prisoner D was understandably distressed and Officer Fox's attempts to calm him were unsuccessful. Officer Fox also tried to get Prisoner D to place the Oxiboot mask on Mr Lane's face, but Prisoner D was too upset to do so.

133. In his statement, Officer Houweling said when he was called to Unit 2, he was made aware that staff were trying to give Mr Lane "*more oxygen via the Oxiboot thought the cell door*" but had been unsuccessful because they could not get Mr Lane close enough to the cell door.[194] About four minutes after he was called, Officer Houweling arrived at Unit 2 in an electric buggy driven by Officer Davis.[195]

134. Officer Houwelling says that when he opened the observation hatch and looked in, Mr Lane was conscious. Officer Houweling directed Prisoner D to stand back from the cell door which he did, and the cell was unlocked at about 1.55 am. As the cell door was being unlocked, Officer Houweling realised that Mr Lane had lost consciousness and he ordered Mr Lane be removed from the cell.[196]

135. Officer White carried Mr Lane to a couch in an adjacent common room and once the cell had been relocked by Officer Houweling, Officer Fox went to help his colleagues. The officers checked Mr Lane's pulse as they were assessing his breathing. Mr Lane was unresponsive and so the officers placed him on the floor and started CPR at about 1.56 am.

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[194] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 38-39
[195] The Death in Custody Review erroneously states that Officer Houweling arrived within two minutes.
[196] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 38-39 and ts 25.05.22 (Houweling), pp252-253

136. While Officer White performed chest compressions, Officer Fox used "*the mask with handpump to provide breaths*" and Officer Lutz attached defibrillator pads to Mr Lane's chest. At 1.59 am, Officer Houweling contacted Officer Lewis and instructed her to call an ambulance, which she immediately did.

137. As the officers waited for an ambulance to arrive, they took turns performing CPR. There is no evidence that their efforts in this regard were anything other than efficient and appropriate. The defibrillator attached to Mr Lane's chest did not advise a shock should be administered and it appears that at all relevant times, Mr Lane's heart was in asystole.[197]

138. Ambulance officers arrived at EGRP at 2.14 am and were taken to Unit 2. The ambulance officers took over resuscitation efforts and noted that Mr Lane was not breathing and had no pulse. The ambulance officers inserted an airway and attached Mr Lane to a monitor, which confirmed Mr Lane's heart was not in a shockable rhythm.[198]

139. As before, no shocks were delivered by the defibrillator and despite the fact that Mr Lane was given four doses of adrenalin by means of a "*bone gun*" that had been inserted into his left upper arm bone (humerus), his heart remained in asystole.[199] Mr Lane was transferred into the ambulance and left EGRP at 2.32 am. Officers Fox and Lutz accompanied Mr Lane in the ambulance and assisted with CPR on the way to the hospital.

140. The ambulance arrived at KRH at 2.43 am, and resuscitation efforts continued for a further 20 minutes. However, despite the efforts of prison staff, ambulance officers and the clinical team at KRH, Mr Lane could not be revived and was declared deceased at 3.00 am on 26 April 2019.[200,201,202,203,204]

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[197] Asystole is the total cessation of electrical activity in the heart and is the most serious form of cardiac arrest.
[198] Exhibit 1, Vol 1, Tab 17, SJA Patient Care Record: KLG21NC (26.04.19)
[199] Exhibit 1, Vol 1, Tab 17, SJA Patient Care Record: KLG21NC (26.04.19)
[200] Exhibit 1, Vol 2, Tab 54, Letter - Dr E Evans, KRH (26.04.19)
[201] Exhibit 1, Vol 2, Tab 60, Emergency Department Notes - KRH (26.04.19)
[202] Exhibit 1, Vol 1, Tab 6, Death in Hospital form - KRH (26.04.19)
[203] Exhibit 1, Vol 1, Tab 20, Incident Summary Report - Prin. Officer S Mortley (26.04.19)
[204] Exhibit 1, Vol 1, Tab 42, Discharge to Death - EGRP (26.04.19)

CAUSE AND MANNER OF DEATH

141. A forensic pathologist, Dr Gerard Cadden, carried out a post mortem examination of Mr Lane's body at the State Mortuary on 1 May 2019. Dr Cadden noted chronic pulmonary changes which were "*obviously long-standing*" and pooling of fluid in Mr Lane's lungs. Based on the information he had at that stage, Dr Cadden described the cause of death as "*unascertained pending investigations and background medical history*".[205]

142. On 7 August 2019, Dr Cadden wrote to the coroner at Kalgoorlie and advised that specialist examination of Mr Lane's brain had revealed no significant abnormalities. He also noted that toxicological analysis by the ChemCentre and microbiology and virology testing had been unremarkable, and confirmed that at post mortem "*no primary pathology was identified such as would readily explain the death*". Dr Cadden also noted he had not been provided with Mr Lane's medical history and said he would consider the matter further once this material arrived.[206]

143. On 10 March 2020, Dr Cadden again wrote to the coroner at Kalgoorlie and confirmed he had now reviewed Mr Lane's medical records. Those records indicated that Mr Lane had been diagnosed with an acute myocardial infarction (heart attack) "*as early as January 2019*" and had a fatty liver, chronic kidney disease, and COPD. There was also mention of a "*fit*" in November 2018 which had resulted in a hospital presentation and another admission related to exacerbation of Mr Lane's COPD.[207]

144. Dr Cadden noted that Mr Lane's respiratory issues, including asthma, were long-standing and that Mr Lane was a heavy smoker and drinker who was only partially compliant with medication and demonstrated "*poor use of inhalers*". Dr Cadden also noted: "*It is evident from a review of histology of the coronary vessels that coronary atherosclerosis was more readily evident, at least of moderate severity as reviewed histologically*".[208]

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[205] Exhibit 1, Vol 1, Tab 7.4, Post Mortem Report (01.05.19)
[206] Exhibit 1, Vol 1, Tab 7.3, Letter - Dr G Cadden to Kalgoorlie Coroner (07.08.19)
[207] Exhibit 1, Vol 1, Tab 7.3, Letter - Dr G Cadden to Kalgoorlie Coroner (10.03.20), p1
[208] Exhibit 1, Vol 1, Tab 7.3, Letter - Dr G Cadden to Kalgoorlie Coroner (10.03.20), pp1-2

145. Dr Cadden also noted that toxicological analysis had identified paracetamol and salbutamol in Mr Lane's system, but that alcohol and other common drugs were not detected. On the basis of the evidence before him, Dr Cadden expressed the opinion that the cause of Mr Lane's death was atherosclerotic heart disease in a man with long-standing chronic obstructive pulmonary disease.[209,210,211]

146. On 1 November 2021, Mr Lane's case was reviewed by Dr Clive Cooke, another experienced forensic pathologist. By that time, Dr Cadden had retired and an opinion had been obtained from Dr Claxton who said:

> I felt that his history was more in keeping with unstable and uncontrolled asthma, and the events leading up to his death was probably more likely a severe asthma exacerbation rather than a primary cardiac event.[212]

147. In a second supplementary post mortem report, Dr Cooke stated:

> Dr Cadden's case file and histology slides have been reviewed, with additional histology slides being prepared and examined. The slides show increased mucus and cellularity in the small airways to the lungs, features indicating an acute exacerbation of chronic obstructive pulmonary disease (bronchial asthma).[213]

148. At the conclusion of his review, Dr Cooke expressed the opinion that the cause of Mr Lane's death was: "*acute exacerbation of chronic obstructive pulmonary disease (bronchial asthma) in a man with atherosclerotic heart disease*".[214]

149. I accept and adopt Dr Cooke's conclusion as my finding in relation to the cause of Mr Lane's death. Further, on the basis of the available evidence, I find that Mr Lane's death occurred by way of natural causes.

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[209] Exhibit 1, Vol 1, Tab 7.3, Letter - Dr G Cadden to Kalgoorlie Coroner (10.03.20), p2
[210] Exhibit 1, Vol 1, Tab 7.1, Supplementary Post Mortem Report (10.03.20)
[211] Exhibit 1, Vol 1, Tab 8, ChemCentre Report (08.07.19)
[212] ts 26.05.22 (Claxton), pp296 & 306
[213] Exhibit 1, Vol 1, Tab 7.1, Second Supplementary Post Mortem Report (01.11.21)
[214] Exhibit 1, Vol 1, Tab 7.1, Second Supplementary Post Mortem Report (01.11.21)

ISSUES RELATING TO MR LANE'S CARE

Findings of the Death in Custody review[215]

150. The Review found that Mr Lane's nebuliser "*did not appear to be in good working order*" and that after Mr Lane was discovered unresponsive, a Code Red medical emergency was not called. The Review also concluded that Mr Lane should have been considered for the terminally ill register because of his diagnosis of COPD. I will now address these issues in more detail, and also cover several other matters relating to Mr Lane's care during his incarceration.

Should Mr Lane have been placed on the terminally ill register?

151. Prisoners with a terminal illness are managed in accordance with a policy known as "*Policy Directive 8 Prisoners with a Terminal Medical Condition*" (PD8), which defines a "*terminal illness*" as:

> One or more medical conditions that on their own or as a group may significantly increase a prisoner's potential to die in custody, having regard to the nature of the condition(s) and the length of the prisoner's sentence.[216]

152. Once the Director Health Services identifies a prisoner as having a terminal medical condition, a note is made in that prisoner's record in the terminally ill module in TOMS. The likely prognosis is identified by categorising prisoners as Stage 1, 2, 3 or 4. Whereas a Stage 1 terminally ill prisoner is expected to die within 12-months, the death of prisoner who is categorised as Stage 4 is regarded as imminent.[217]

153. There are two main implications for a prisoner being identified as terminally ill. The first relates to the monitoring prisoners on the list receive, although all prisoners with serious health conditions are subject to regular reviews regardless of whether they are on the list or not.[218,219]

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[215] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp4, 6 & 17
[216] Exhibit 1, Vol 2, Tab 84, Policy Directive 8 Prisoners with a Terminal Medical Condition, p2, para 4
[217] Exhibit 1, Vol 2, Tab 85, Prisoners with a Terminal Medical Condition - Procedures, pp2-6, section 4
[218] Exhibit 1, Vol 2, Tab 85, Prisoners with a Terminal Medical Condition - Procedures, pp6-9, sections 5 & 6
[219] ts 26.05.22 (Rowland), pp376-377

154. The second implication relates to Stage 3 and Stage 4 prisoners who may be considered for early release, either by the exercise of the Royal Prerogative of Mercy in the case of sentenced prisoners, or by being released on bail, in the case of remand prisoners.[220,221]

155. Dr D'Cruz said that at the time she was caring for Mr Lane, she was unaware of the terminally ill list. At the inquest, Dr Rowland confirmed that following Mr Lane's death, it had been recommended that PMOs receive additional training about the terminally ill register. Nevertheless, the evidence of Dr Claxton and Dr Rowland establishes that Mr Lane's medical condition was not "*terminal*" in the PD8 sense. [222,223]

156. Mr Lane had poorly controlled asthma and he continued to smoke despite advice to the contrary.[224] From my perspective, the relevant issue in this case is not whether Mr Lane's condition was or was not terminal (in the PD8 sense) but rather whether his condition was properly managed while he was incarcerated at EGRP.

Should Mr Lane have been managed at EGRP?

157. The question of whether someone with Mr Lane's medical conditions should have been housed at EGRP raises complex and competing issues. At the relevant time, EGRP had no nursing cover between 5.30 pm and 6.30 am. During that period, the medical needs of prisoners were (and are) managed by prison officers who have first aid qualifications but generally no clinical skills.

158. None of WA's eight regional prisons (including EGRP) provide 24-hour, 7-days per week nursing support. Of WA's nine metropolitan prisons, only Bandyup Women's Prison, Banksia Hill Juvenile Detention Centre, Casuarina Prison, Hakea Prison and Melaleuca Prison do so.[225]

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[220] Exhibit 1, Vol 2, Tab 85, Prisoners with a Terminal Medical Condition - Procedures, pp6-9, sections 5 & 6
[221] ts 26.05.22 (Rowland), pp376-377
[222] Exhibit 1, Vol 1, Tabs 9.1 & 9.2, Report - Dr S Claxton (20.06.21 & 13.09.21)
[223] ts 26.05.22(Claxton), p299 and ts 26.05.22(Rowland), pp358-360 & 371
[224] See for example: ts 24.05.22 (D'Cruz), pp103-104
[225] Exhibit 1, Vol 2, Tab 88.1, WA Prisons - 24/7 Nursing cover summary document

159. As mentioned, the standing rule at EGRP is that at night, in the case of a medical emergency relating to a prisoner, officers are to call for an ambulance. This sensible policy is in fact, the only viable option in the absence of overnight nursing support. Although at night officers are able to contact the on-call PMO, in many emergency situations (as was the case with Mr Lane) there simply isn't the time to do so.[226]

160. In addition to the rule that officers should call an ambulance in the event of a medical emergency at night, I wish to emphasise the point that officers should be strongly encouraged to adopt a low threshold when deciding whether to do so. In other words, in relation to whether to request an ambulance, the mantra should be "*when it doubt, call it out*".[227]

161. At the inquest, Ms Evans (with whom Dr D'Cruz and Officers Davis and Houweling agreed) said that in view of the fact there were no nurses at EGRP at night, it was essential that prison officers "*act quickly and promptly*" in relation to calling for an ambulance for any prisoner who was experiencing medical issues.[228,229,230]

162. Prisoners like Mr Lane, who have serious medical conditions that are not under effective control can experience breathing difficulties and progress to respiratory arrest without there necessarily being a predictable pathway. Relying on officers to make clinical assessments of patients like Mr Lane is therefore fraught with difficulty.

163. I accept that there are practical and logistical issues associated with calling for an ambulance. However, the consequence of calling an ambulance that turns out not to be required is mainly inconvenience. Delaying calling an ambulance, or not calling one at all when it turns out to have been required, may result in catastrophic consequences. This illustrates the point that when considering whether an ambulance is required, a low threshold should be adopted.

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[226] ts 26.05.22 (Mortley), pp392-393
[227] ts 24.05.22 (Davis), pp230-231
[228] ts 24.05.22 (Evans), pp35-36; ts 25.05.22 (Davis), p231; ts 25.05.22 (Houweling), pp257-258
[229] ts 25.05.22 (D'Cruz), pp104-105 and see also: ts 26.05.22 (Claxton), pp313-313
[230] See also: ts 26.05.22 (Rowland), pp345-347 & 365

164. The dilemma faced by officers at EGRP about whether or not to call an ambulance at night is a direct consequence of DOJ's decision not to provide overnight nursing cover at EGRP. Further adding to the difficulty is the fact that at night at EGRP, DOJ chooses to leave decisions about whether an ambulance is required to prison officers, the majority of whom only have basic first aid qualifications.

165. The obvious risks associated with DOJ's strategy would be partly ameliorated by encouraging officers to call an ambulance whenever they are unsure whether one is actually required. To further assist prison officers at EGRP, it would be sensible to maintain a list of prisoners who have serious medical conditions and make that list available to officers on the relevant prisoner's unit and the Master Control room. The purpose of maintaining the list would be that if a prisoner on the list makes a cell call at night, prison staff would be on notice that an ambulance is likely to be required.[231]

166. In terms of his prison placement, Mr Lane was a remand prisoner who was identified as being "*Out of Country*" and he was regularly visited by his family and friends. Housing Mr Lane in a prison that offered overnight nursing support would necessarily have meant transferring him to the metropolitan area. Quite apart from the fact that such a transfer would have been completely dislocated Mr Lane from his Traditional Lands, the vast distances involved would also have made regular visits from his family and/or friends essentially impossible.[232]

167. The medical and nursing witnesses who gave evidence at the inquest expressed different perspectives about the appropriateness of Mr Lane being managed at EGRP. However, the caveat I would place on the evidence of all of the departmental witnesses is that at the relevant time, the seriousness of Mr Lane's condition was not properly appreciated, even after Mr Lane's return from hospital on 11 March 2019.

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[231] ts 26.05.22 (Rowland), pp377-378
[232] ts 26.05.22 (Rowland), pp339-340

168. Mr Johnston said that in his view it was appropriate for Mr Lane to be managed at EGRP after his discharge from KRH on 11 March 2019. However, with the benefit of hindsight, Mr Johnston agreed that Mr Lane should have been managed at a prison facility that had overnight nursing care.[233]

169. Dr D'Cruz said that if she had been aware that Mr Lane had been issued a nebuliser and if he had required "*many nebs at night*", then it was her view that it would not have been appropriate for Mr Lane to have remained at EGRP. Instead, Dr D'Cruz said she "*would have liked for him to have been in a place where he could have been monitored, not just on his own in his cell*."[234]

170. Dr D'Cruz said that following Mr Lane's admission to KRH on 8 March 2019, she would have expected Mr Lane's treating team to have referred him to the respiratory outpatient clinic, but that this had not occurred. That aside, Dr Cruz said that she felt would have independently referred Mr Lane to a respiratory physician had she been treating him for longer.[235]

171. Following his review of the available evidence, Dr Claxton expressed the opinion that it was not appropriate for Mr Lane's condition to have been managed at a facility that did not have overnight nursing care. In support of his view, Dr Claxton cited the fact that Mr Lane's asthma was not under effective control, that Mr Lane was not under the care of a respiratory physician and that Mr Lane required Ventolin at night.[236]

172. In terms of the benefits of Mr Lane's care being supervised by a respiratory physician, Dr Caxton immediately identified that the dose of one of Mr Lane's puffers should have been doubled to bring his asthma under better control. Mr Lane could have been trialled on other control mechanisms, referred to as "*biologicals*" and a more holistic approach could have been taken with respect to Mr Lane's care.[237]

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[233] ts 24.05.22 (Johnston), p88
[234] ts 24.05.22 (D'Cruz), p98
[235] ts 24.05.22 (D'Cruz), p102
[236] ts 26.05.22 (Claxton), pp314
[237] ts 26.05.22 (Claxton), pp306, 310, 322-323, 325-326 & 329 and see also: ts 26.05.22 (Rowland), pp332 & 336

173. The need to adopt a "*bigger picture*" view of Mr Lane's care was highlighted by Dr Rowland. In her evidence at the inquest, she conceded that because DOJ had been unaware of Mr Lane's numerous and recent admissions to KRH, there was a lack of understanding about just how fragile Mr Kane was and how poorly controlled his asthma had been. Had all of this this been properly appreciated, Dr Rowland considered that the exacerbation that occurred on 8 March 2019, and Mr Lane's subsequent requirement for overnight Ventolin would have led to a deeper understanding of appropriate management options.[238]

Nursing support at EGRP

174. Since Mr Lane's death, nursing staff at EGRP now complete 12-hour shifts and finish duty at 6.30 pm, thus providing one extra hour of cover per day. In addition, the daily routine at EGRP has been amended so that visits, recreation periods and medication parades no longer occur simultaneously. These changes have meant there is less need to rely on the Red Box system, which I will discuss in more detail later.[239,240,241]

175. As welcome as these changes may be, the fact remains that during the hours of darkness, prison officers are obliged to respond to the medical needs of prisoners, including emergency situations. I can see that the safety and security of EGRP would be enhanced if overnight nursing care was provided. At the inquest, several prison officers and nurses as well as Dr D'Cruz and Dr Claxton all agreed that overnight nursing support at EGRP was a good idea and was clearly justifiable.[242,243,244]

176. Whilst this is a sensible and uncontroversial proposition, I am well aware that providing overnight nursing support at EGRP is a complex matter. For a start, there are the resource implications and I accept that providing overnight nursing support would no doubt be expensive. There is also a more immediate concern, namely the availability of suitably experienced local nurses willing to work at EGRP.

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[238] ts 26.05.22 (Rowland), pp334, 338, 342, 353 & 374-376 and see also: ts 26.05.22 (Claxton), pp306 & 310
[239] ts 24.05.22 (Johnston), pp87-88; ts 25.05.22 (Palmer), pp279-280 and ts 26.05.22 (Mortley), pp390-391
[240] Exhibit 1, Vol 2, Tab 82, Att. SM10, Prisoner Notice - Daily Routine Change (30.05.19)
[241] Exhibit 1, Vol 2, Tab 82, Att. SM10, EGRP Standing Order B1 - Daily Routine (29.05.19)
[242] ts 25.05.22 (Davis), pp225-226 and ts 25.05.22 (Houweling), p257
[243] ts 24.05.22 (Evans), p51; ts 24.05.22 (Johnston), p80; ts 24.05.22 (D'Cruz), p105 and ts 26.05.22 (Claxton), p314
[244] ts 26.05.22 (Mortley), pp390-391 and see also: ts 25.05.22 (Palmer), pp279 & 285-286

177. In a recent inquest, I canvassed the difficulties with recruiting and retaining medical and nursing staff in regional areas. I also examined the various "pull" and "push" factors that encourage or inhibit professional staff contemplating working in regional areas. I noted that the answer to recruiting and retaining staff in regional areas was not purely financial, although such incentives were obviously important. Other factors such as subsided housing, additional annual leave, increased opportunities for professional development, and regular mentoring were also important.[245]

178. Nevertheless, despite the challenges associated with attracting professional staff to regional areas, I urge DOJ to review the nursing support currently provided at EGRP to determine whether the statutory responsibilities of the CEO set out in section 7(1) of the Prisons Act are being properly discharged. In my view, such a review should consider whether additional nursing staff should be employed at EGRP during the day and also whether nursing staff should be employed to provide cover at EGRP between the hours of 6.30 pm and 6.30 am.

179. At the inquest, Dr Rowland considered that providing additional nursing staff at EGRP during the day would be preferable to providing cover at night. Her reasoning was that the current staffing levels, combined with an ever increasing muster, meant that nurses had limited time with each patient and are essentially not able to provide much more than "*band-aid*" style care to prisoners attending the medical centre.[246]

180. Engaging extra nurses and Aboriginal Health Workers during the day would enable health staff to spend more time with prisoners and to undertake proactive, preventative work. This work could include more regular reviews of prisoners with chronic diseases, health audits and proactive self-management education aimed at helping prisoners better manage their medical conditions and make positive lifestyle changes.[247]

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[245] [2022] WACOR 16, Inquest into the death of Jordan James Williams (25.02.22), paras 187-193
[246] ts 26.05.22 (Rowland), pp339-341
[247] ts 26.05.22 (Rowland), pp339-341

181. At the inquest, Dr Rowland also made a convincing argument for the creation of a staff development nursing position within DOJ. The occupant of this position would be responsible for monitoring and enhancing the clinical skills of nursing staff employed by DOJ and would also be able to develop patient education materials and training programs for clinical and non-clinical staff dealing with the management of common chronic conditions routinely encountered amongst the prison population.[248]

182. In my view, this is a sensible suggestion, and because the incumbent could be based in Perth and attend the regions in person and/or remotely, the recruitment and retainment issues that apply to positions based in the regions could be more easily overcome.

Asthma management and action plans

183. An asthma management plan sets out a patient's longer term goals, whereas an asthma action plan tells the patient what to do in the event of an acute exacerbation or "asthma attack". Despite the availability of asthma/COPD management plans within TOMS, Mr Lane was on neither. Further, Mr Lane had not been issued with an asthma action plan reminding him what to do in the event of an attack.[249]

184. I accept that Mr Lane had limited literacy skills and that a written asthma action plan may have been of limited value. However, as Dr Claxton pointed out, action plans can be presented in a variety of formats, and the Brief contains excellent examples of asthma and COPD action plans specially designed for Aboriginal patients.[250,251,252]

185. Had the seriousness of Mr Lane's asthma/COPD been fully appreciated, a copy of his action plan could also have been placed in the Unit 2 office for the benefit of prison officers who would be obliged to respond to any overnight exacerbations of Mr Lane's condition. Mr Johnston agreed that this was a good idea and would "*empower prison officers*".[253,254,255]

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[248] ts 26.05.22 (Rowland), pp340-341
[249] ts 26.05.22 (Rowland), pp371-372
[250] ts 26.05.22 (Claxton), pp307-309 and ts 26.05.22 (Rowland), pp371-373
[251] Exhibit 1, Vol. 2, Tabs 83.1 - 83.3 Respiratory Care Plan, COPD Action Plan & Asthma Action Plan
[252] Exhibit 1, Vol. 2, Tabs 83.4 - 83.5 Aboriginal Asthma Action Plan & Indigenous COPD Plan
[253] Exhibit 1, Vol. 2, Tabs 83.1 - 83.3 Respiratory Care Plan, COPD Action Plan & Asthma Action Plan
[254] ts 24.05.22 (Johnston), pp66, 83-84 & 85

The Red Box system

186. As noted, at the time of Mr Lane's death, nursing cover at EGRP ceased at 5.30 pm after which time officers were obliged to deal with the medical needs of prisoners, including emergencies. In the absence of overnight nursing support an obvious issue that arose was how to deal with requests for over-the-counter medications at night, and how to administer time-critical prescribed medications, such as antibiotics.

187. At EGRP, the solution was the introduction of the Red Box system, the idea for which had apparently come from Bunbury Regional Prison. As the name suggests, the system involves using a red coloured plastic box, which is stored at the front gate at EGRP. Common over-the-counter medications (such as Panadol and the antacid, Mylanta) are placed into the box, along with any prescription medication that needs to be administered to particular prisoners overnight.[256]

188. At the inquest, Officer Mortley explained he had helped draft a notice to staff regulating the Red Box system (i.e.: Staff Notice 5/2018), which relevantly provides:

> On Duty Medical Staff will hand over scripted oral medications (in envelopes), Panadol and Mylanta to the Senior Officer Gate at the conclusion of their shift for after-hours use. The Senior Officer will secure the medication/s in the red box at the front gate. The Gate Senior Officer will hand over the medications to the NOIC (i.e.: the Night Officer-in-Charge).[257]

189. In accordance with Staff Notice 5/2018, the Night OIC is required to "*assist in dispensing all medication*" by attending the relevant prisoner's cell with the prescription medication still in its envelope. The medication is administered to the relevant prisoner through the observation hatch in their cell and recorded in the Unit and Gate occurrence books and in the medication register. The issuing of Panadol and/or Mylanta from the red box is noted in the medication register.[258]

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[255] See also ts 24.05.22 (Lutz), p150 where Officer Lutz agreed that access to asthma action plans would be beneficial to officers.
[256] ts 26.05.22 (Mortley), p384
[257] Exhibit 1, Vol 2, Tab 82, Att. SM4 - Staff Notice 5/2018: After hours issuing of Medication/Panadol (24.05.18)
[258] Exhibit 1, Vol 2, Tab 82, Att. SM4 - Staff Notice 5/2018: After hours issuing of Medication/Panadol (24.05.18)

190. Local Order 01 - Night Shift Routine (LO1) provides that the Night OIC is to "*Ensure the issue of after-hours medication as per Staff Notice 15/2018*".[259] However, the evidence before me is that from time to time, prescription medication that should have been administered overnight has been found in the red box the following morning, meaning that the Red Box system is far from foolproof.[260]

191. At the inquest, Ms Evans was critical of the Red Box system and said it was inappropriate to require prison officers, who lack clinical skills, to administer prescribed medication to prisoners overnight.[261] Further, and this is particularly significant in this case, although neither LO1 nor the Notice makes any mention of the Red Box system being used to deliver medical equipment and/or components of medical equipment, neither document explicitly prohibits this practice.[262]

192. Ms Evans said she was unaware of LO1 and in any case, nobody raised any concerns when she placed the nebuliser part in the red box. Mr Johnston said that as far as he knew the Red Box system had never previously been used to deliver medical equipment to prisoners. However, Mr Johnston thought that Ms Evans had acted reasonably by using the Red Box system to do so, especially given staff shortages at the time, and he would have done the same thing had he been on duty.[263]

193. In my view, LO1 should be amended to make it clear that the Red Box system is not to be used to deliver medical equipment (or components thereof) under <u>any</u> circumstances. An unequivocal statement of that kind would mean that nurses would be required to ensure medical equipment was delivered to the relevant prisoner before leaving EGRP at end of their shift. At the inquest, Officer Mortley said he supported amending LO1 in the manner suggested and I would point out that this change would be consistent with the recommendation made in the Review.[264,265]

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[259] Exhibit 1, Vol 2, Tab 82, Att. SM3 - Local Order 01 - Night Shift Routine (01.03.19)
[260] ts 24.05.22 (Evans), p35 and ts 24.05.22 (Johnston), p71
[261] ts 24.05.22 (Evans), p35; and see also: ts 25.05.22 (Houweling), pp237-238
[262] ts 26.05.22 (Mortley), pp384-385
[263] ts 24.05.22 (Evans), pp42 & 50-51 and ts 24.05.22 (Johnston), pp71-73
[264] ts 26.05.22 (Mortley), p385 and Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p18
[265] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), p18

194. Had the suggested change to LO1 been in place prior to Mr Lane's death, it would have meant that Ms Evans (or one of her colleagues) would have to have delivered the nebuliser part to Mr Lane, presumably with an escort. Ms Evans (or another nurse) could then have spoken to Mr Lane directly as the part was handed over and assessed Mr Lane's physical condition to determine whether any further intervention was necessary.

Serviceability of the nebuliser and puffers in Mr Lane's cell[266,267,268,269]

195. The evidence establishes that at the time nursing staff left EGRP on 25 April 2019, the nebuliser in Mr Lane's cell was not working because it needed a replacement part. As noted, the part was left at the front gate and before Ms Evans left EGRP, she believed she had taken adequate steps to ensure it would to be delivered to Mr Lane via the Red Box system. However, as I have described, the replacement part was not brought to Mr Lane's cell until shortly before he collapsed.

196. Once Prisoner D had been taken to CCU, Officer Houweling placed Officer Davis "*in charge at the cell door*" and at 3.54 am, a senior officer arrived and secured the cell "*with a security lock*". At about 5.45 am, Det. Sgt. Ovens and another police officer arrived to begin a coronial investigation into Mr Lane's death.[270,271]

197. Det. Sgt. Ovens spoke to Prisoner D, who told him that Mr Lane had been "*coughing during the night*" and "*been sick for a long time*". Prisoner D also said Mr Lane had woken him in the early hours of the morning "*having trouble breathing*" and that Mr Lane had "*a mask in his room but didn't use it because it wasn't working*". Det. Sgt. Ovens took this comment to be a reference to the nebuliser issued to Mr Lane, which he (Det. Sgt. Ovens) found was in its box on a shelf in the cell.

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[266] Exhibit 1, Vol. 1, Tab 4.1, Statement - Det. Sgt. D Ovens (10.06.21), paras 17-36
[267] ts 26.05.22 (Ovens), pp269-271
[268] Exhibit 1, Vol. 1, Tab 18.3, Photographs taken inside Mr Lane's cell (26.04.19)
[269] Exhibit 1, Vol. 1, Tab 4.2, Screenshots of computer system used to log exhibits (26.04.19)
[270] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer P Davis (26.04.19)
[271] Exhibit 1, Vol 2, Tab 52.11, Incident Description Report - Officer J Houweling (26.04.19)

198. A label on the nebuliser stated that the device had been tested in June 2018 and was due to be tested again in June 2019. Det. Sgt. Ovens seized the nebuliser and several asthma puffers he located in Mr Lane's cell and took the items back to the Kalgoorlie Detectives Office. Det. Sgt. Ovens then logged the seized items in a Police computer used to track exhibits. Because of his familiarity with asthma, Det. Sgt. Ovens was able to confirm that each of the puffers contained medication and was operating normally.

199. As for the nebuliser, Det. Sgt. Ovens noted that a plastic fitting used to connect the face mask to tubing attached to the nebuliser was missing. He contacted EGRP and a senior officer confirmed that the fitting had been found on the desk in Mr Lane's cell. Det. Sgt. Ovens returned the nebuliser to EGRP at about 10.20 am, and viewed the fitting that had been located. After doing so, Det. Sgt. Ovens confirmed that "*all parts required were accounted for and in good order*" and that there were vials of salbutamol with the nebuliser.[272]

200. The evidence of Prisoner D establishes that Mr Lane had attempted to use his nebuliser in the early hours of the morning on 26 April 2019, but because it had a part missing, the device would not work. Although it would have been possible for Mr Lane to have used the nebuliser once he had been given the replacement part, by the time this happened, his clinical pathway was almost certainly irreversible.[273]

[272] Exhibit 1, Vol. 1, Tab 4.1, Statement - Det. Sgt. D Ovens (10.06.21), paras 35-36
[273] ts 24.05.22 (Johnston), pp74-75 and ts 26.05.22 (Claxton), pp311 & 314

Destruction of puffers[274,275,276,277]

201. In accordance with Police procedures, items seized during a coronial investigation are retained until the investigation of the death has been finalised by a coroner issuing a Record of Investigation into Death. In this case, the puffers were destroyed after Dr Cadden issued his Confidential Report to the Coroner (the PM report), in which Dr Cadden expressed his opinion as to the cause of death.

202. At the inquest, Det. Sgt. Ovens confirmed that the officer who authorised the disposal of the puffers had mistakenly assumed that the issuing of the PM Report signified the conclusion of the coronial investigation. Luckily in this case, the seized puffers were photographed, catalogued and inspected before being destroyed. For that reason, it is my view that the coronial investigation into Mr Lane's death was not compromised by the premature destruction of the puffers.

203. Nevertheless, in order to ensure that this type of incident does not occur again, I suggest that the Western Australia Police Force issue a bulletin to all police officers reminding them that evidence seized during a coronial investigation is not to be destroyed without an order from a coroner or, where no order is made, until after a coroner issues a Record of Investigation into Death.

Failure to call a Code Red

204. The term "*Code Red*" refers to a radio call made by prison officers to signify an emergency. The Review noted that a Code Red "*is not only* (used) *to summons help, but to alert the whole prison community of an incident, secure their prisoners and cease all movement*". In this case, a Code Red was not called in relation to the medical emergency involving Mr Lane and in my view, it clearly should have been.[278]

205. At EGRP, Local Order No. 16 (LO16) deals with emergency responses, including the calling of a Code Red, and relevantly provides:

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[274] Exhibit 1, Vol. 1, Tab 4.1, Statement - Det. Sgt. D Ovens (10.06.21), paras 3-17
[275] Exhibit 1, Vol. 1, Tab 18.3, Photographs taken inside Mr Lane's cell (26.04.19)
[276] Exhibit 1, Vol. 1, Tab 4.2, Screenshots of computer system used to log exhibits (26.04.19)
[277] ts 26.05.22 (Ovens), pp272-275
[278] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp12-13

> A Code red informs Recovery and designated responding Officers that their services are required in a location as soon as practicable or without delay. Recovery Officers and designated responding Officers shall attend and assist as required.
>
> All non-essential radio transmissions are to cease. Surrounding areas are to start containing/securing prisoners in Wings and Cottages until the Code is stood down. All prisoner movement across the site is to cease until the Code is stood down.[279]

206. The Review notes that by way of an email dated 30 March 2022, Superintendent Hedges had confirmed the calling of a "*code of any colour*" is a matter for the judgment of individual officers and "*On nightshift all prisoners are secure so there is no real need or advantage to calling a Code Red*".[280] In his email, Superintendent Hedges also said staff would instead "*radio or telephone the OIC for assistance*". The Review also states that Officer Houweling arrived at Unit 2 within two minutes of being called, all available night staff were already on Unit 2 at the relevant time and, that "*radio traffic is typically quiet at night*".[281]

207. In my view, these purported justifications for the failure to call a Code Red are not only irrelevant, two of them are unsupported by the available evidence. For a start, the assertion that Officer Houweling arrived on Unit 2 within two minutes of being called is contradicted by the evidence of Officers Fox, Davis and Lutz, and by the available CCTV footage. In fact, Officer Houweling arrived on Unit 2 in an electric buggy at 1.55 am about four minutes after he was called on the radio, either by Officer White or Officer Fox.[282,283,284,285]

208. As to the assertion that all available night staff were already on Unit 2, the reality is that this occurred by pure chance.[286] Officer Lutz (who was on duty in Unit 3), happened to see Officer White walking past carrying

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[279] Exhibit 1, Vol 2, Tab 82.8, Local Order No. 16 - Emergency Response, p4, section 2.3
[280] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp12-13
[281] Exhibit 1, Vol 2, Tab 52, Death in Custody Review (07.04.22), pp12-13
[282] Exhibit 1, Vol 1, Tab 12, Statement - Officer J White (08.08.19), paras 14-18
[283] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer M Fox (08.05.20), paras 10 & 12 and ts 24. 05.22 (Fox), pp158-159
[284] Exhibit 1, Vol 1, Tab 11.1, Statement - Officer P Davis (22.04.20), paras 10-14 and ts 25. 05.22 (Davis), p216
[285] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Lutz (08.08.19), paras 3 & 12 and ts 24. 05.22 (Lutz), pp141-142
[286] ts 25.05.22 (Davis), p213

an Oxiboot and decided to follow to see if he could help. Had Officer Lutz not seen Officer White, there is every likelihood that he (Officer Lutz) would have stayed on Unit 3.[287]

209. As for Officer Fox, he just happened to see Officer Davis walking towards Unit 2 from the front gate (with a replacement part for Mr Lane's nebuliser) and decided to follow her to see if there was anything he could assist with. Had Officer Fox not seen Officer Davis, there is no guarantee he would have been on Unit 2 at the relevant time.[288]

210. The assertion that calling a Code Red was unnecessary in this case, seems to me to be little more than an attempt, after the fact, to justify what was in reality an unfortunate lapse. In my opinion, Officer Davis correctly explained why a Code Red was not called when at the inquest, she observed: "*I think it was just forgotten because everyone was there*".[289]

211. While it may be true that by luck (rather than design) all available officers were already on Unit 2 at the relevant time, Officer Lewis in the Master Control room was blissfully unaware that a medical emergency involving Mr Lane was unfolding. Officer Lewis' responsibilities including monitoring CCTV cameras within the units at EGRP. These cameras have no sound and even though an audible alarm sounds in Master Control whenever officers enter a unit, given her varied duties, there are any number of reasons why Officer Lewis did not appreciated what was happening in Unit 2.[290,291]

212. Had a Code Red medical emergency been called, Officer Lewis would obviously have been put on notice about the situation involving Mr Lane. Given that it was likely that an ambulance would need to be called and be admitted into the prison, had a Code Red medical emergency been initiated, Officer Lewis would have been able to start making the necessary arrangements for this to occur.

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[287] ts 24.05.22 (Lutz), pp138-140
[288] ts 24.05.22 (Fox), pp153-154
[289] ts 25.05.22 (Davis), p214
[290] ts 25.05.22 (Lewis), pp191 & 194 and ts 25.05.22 (Davis), pp234-235
[291] ts 25.05.22 (Lewis), pp191 & 194

213. In their respective statements, Officer Mortley said that calling a Code Red would not "*have made any difference in the circumstances*" whilst Officer Houweling said calling a Code Red would not "*have made the actions of staff any quicker*".[292,293] However, at the inquest, Officer Houwelling was asked whether he agreed that a Code Red should have been called and he replied:

> Yes, somewhat. I think it possibly might have alerted us all better. From what I heard from Ms Lewis this morning, it may have been better off.[294]

214. With great respect to these senior and experienced officers, the observations they made in their respective statements are beside the point. Even accepting that by happy coincidence all available officers happened to be on the scene at the relevant time, Officer Lewis (in Master Control) was unaware of the medical emergency occurring in Unit 2 precisely because a Code Red had not been called.

215. LO16 does not contain any provision suggesting that at night time, a Code Red need not be called. Further, the fact that few consequences seem to have flowed from the failure to call a Code Red in this case cannot be used to justify the fact that a Code Red was not called. All that can be said is that on this occasion, luck favoured the officers.

216. Given my view that a Code Red should have been called, the obvious question that arises is when should this have occurred? With the benefit of hindsight, I consider that a Code Red should have been called when Mr Lane made his first cell call at 1.32 am and said he couldn't breathe properly. A further opportunity arose when Officers Davis and White first attended Mr Lane's cell with the replacement part for his nebuliser and Officer Davis noticed that Mr Lane was having breathing difficulties and was struggling to speak.

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[292] Exhibit 1, Vol 2, Tab 82, Statement - Officer S Mortley (19.05.22), para 42 and see also: ts 26.05.22 (Mortley), pp387-388
[293] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 38-39
[294] ts 25.05.22 (Houweling), pp255-256 and see also: ts 25.05.22 (Houweling), p257

217. However, having expressed that view, I accept that if prison officers been aware of the severity of Mr Lane's medical condition, they would almost certainly have called a Code Red. I also note that the Broadcast Email states that the purpose of Mr Lane's nebuliser "*is to assist with his breathing (symptoms of his lung disease) and well-being*".[295]

218. Nothing in the Broadcast Email alerted staff to the fact that Mr Lane's asthma was poorly controlled and that he had recently been admitted to hospital with a very serious (potentially fatal) exacerbation of his asthma. In my view, the Broadcast Email should have instructed staff that if Mr Lane experienced breathing difficulties overnight, then urgent medical assistance was required and an ambulance should be called immediately. Unfortunately, it did none of things.[296]

219. In making the point that the Broadcast Email lacked crucial detail, I am not critical of the email's author. Officer Mortley does not have medical training and cannot be expected to have appreciated the significance of Mr Lane requiring a nebuliser in his cell overnight. The same applies to the prison officers responding to the Mr Lane's calls for assistance.[297]

220. Part of the issue seems to have been that allowing Mr Lane to have a nebuliser in his cell overnight was regarded as a security issue, rather than a medical one. This explains the focus in the Broadcast Email on the issuing and recovery of the nebuliser and the requirement for staff to check all of the nebuliser's components were present.[298,299]

221. Precisely because the nebuliser was issued without the knowledge or approval of a PMO, medical issues associated with Mr Lane's need for overnight Ventolin were not fully appreciated and were certainly not outlined in the Broadcast Email. With the benefit of hindsight, this proved to be an unfortunate omission.

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[295] Exhibit 1, Vol 2, Tab 52.9, Email broadcast, Officer S Mortley (6.35 am, 24.05.22) and ts 26.05.22 (Mortley), pp388-389
[296] ts 25.05.22 (D'Cruz), pp104-105 and see also: ts 26.05.22 (Claxton), pp312-313
[297] ts 26.05.22 (Rowland), pp347-348 & 369
[298] ts 25.05.22 (Lewis), p169 and ts 25.05.22 (Houweling), pp259-260
[299] ts 26.05.22 (Mortley), pp381-383; ts 26.05.22 (Rowland), pp356-357 and see also: ts 25.05.22 (Palmer), p278

222. As I have suggested, one way to better manage the health of prisoners at EGRP at night, especially given the absence of overnight nursing support, would be to maintain a list of prisoners with serious medical conditions. The list should be made available to officers in the relevant units and the Master Control Room. Cell calls from prisoners on the list would be treated with absolute priority and a low-threshold adopted with respect to calling for an ambulance.

223. Had such a system been operating at EGRP at the relevant time, it seems likely that Mr Lane's first cell call would have triggered a Code Red medical emergency and a thereby, more urgent response. It also seems probable that Officer Lewis' response to Prisoner D's cell call would have been different had she been privy to such a list.[300]

[300] See for example: ts 24.05.22 (White), p116

224. It is impossible to know whether the outcome in this case would have different if staff had been able to gain access to Mr Lane's cell earlier than they were able to. At the time Officer Houweling received the radio call asking him to come to Unit 2, his understood that staff were trying to give Mr Lane oxygen through the observation hatch in his cell door using an Oxiboot, but had been unsuccessful because they could not get Mr Lane close enough to the cell door.[301]

225. It is unclear whether Officer Houweling would have arrived at Unit 2 any earlier if a Code Red had been called and there is evidence that he was already aware that the situation was urgent. Officer Fox says that Officer Houweling was asked to attend Unit 2 with a cell key because Mr Lane required "*urgent medical attention*" and he (Officer Fox) asked Officer Houweling to attend as soon as possible.[302]

226. Since Mr Lane's death, arrangements have been made to provide unit officers with access to cell keys in emergency situations. Had these arrangements been in place at the relevant time, and had officers been aware of the seriousness of Mr Lane's medical condition, there is a possibility Mr Lane's cell may have been unlocked earlier than it was.[303,304,305]

CPR

227. The evidence establishes that Mr Lane's cell was breached about 17-minutes after his first cell call, by which stage, Mr Lane had lost consciousness. It is clear that prison officers started cardio-pulmonary resuscitation (CPR) promptly and that it was performed correctly and efficiently as the officers waited for the ambulance to arrive.

228. However, it also seems clear that by the time Mr Lane had become unresponsive in his cell, his condition was almost certainly irreversible, meaning that nothing could have been done to have saved his life.[306]

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[301] Exhibit 1, Vol 2, Tab 52.17, Statement - Officer J Houweling (09.03.20), paras 38-39
[302] Exhibit 1, Vol 1, Tab 13, Statement - Officer M Fox (08.08.19), paras 3-27 and ts 24.05.22 (Fox), p159
[303] Exhibit 1, Vol 2, Tab 82, Statement - Officer S Mortley (19.05.22), paras 44-45
[304] Exhibit 1, Vol 2, Tab 82.9, Staff Notice - Emergency Cell Key Location (19.02.20)
[305] ts 25.05.2 (Palmer), pp280-281
[306] ts 26.05.22 (Claxton), p317

229. First aiders used to be taught to check for a pulse and to only start CPR if no pulse was felt.[307] However, modern first aid training recognises that: "*Palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation*".[308]

230. At an inquest into the death of a prisoner at Hakea Prison, Coroner Urquhart heard evidence from Associate Professor Bailey, (Medical Director, St John Ambulance Western Australia) who said it was not necessary to wait for a defibrillator to confirm that CPR should be commenced and that chest compressions should begin immediately whenever a casualty was unresponsive.[309,310]

231. Prison officers complete basic first aid qualifications during their initial training and as a minimum, complete annual refreshers in CPR thereafter. Some officers undertake advanced first aid training but this is not mandatory, except for senior officers. Despite the changes in CPR training to which I have referred, a number of officers confirmed that Mr Lane's pulse was checked as his breathing was being assessed.

232. At the inquest, Officer White said that in the training he had received "*its mentioned to check for a pulse*" although officers are instructed "*not to linger*" while doing so. Officer White also said most officers he had seen performing CPR check for a pulse as they are assessing whether the patient was breathing, but that training on this issue "*changes every year*".[311]

233. Officer Fox said he believed "*you should always check for a pulse*" whereas Officer Davis recalled being trained to check for a pulse in the past, but that this had changed in the last few years and that while breathing must always checked, there is now "*not so much checking for the pulse*". In his evidence at the inquest, Officer Houweling said "*I think my last training was that in fact that we check for a pulse again*".[312]

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[307] See for example: St John Ambulance Australian First Aid (2nd Ed. 1996), Volume 1, p37
[308] St John Ambulance HLTAID011 Provide First Aid - Student Guide (Dec 2020), p34
[309] [2020] WACOR 44, Inquest into the death of Jordan Robert Anderson, para 117 (Coroner PJ Urquhart)
[310] ts 26.05.22 (Claxton), pp330-331
[311] ts 24.05.22 (White), pp121 & 130-131
[312] ts 24.05.22 (Fox), pp162-163; ts 25.05.22 (Davis), pp 218 & 232 and ts 25.05.22 (Houweling), p254

234. As I have noted, in this case the evidence of attending prison officers is that Mr Lane's pulse was checked while his breathing was being assessed, meaning there was no unnecessary delay before CPR was started. While that may well be the case, it is obviously unfortunate there is confusion about current first aid practice.[313,314]

235. I therefore urge DOJ to issue an urgent bulletin reminding staff that the previous practice of checking for a pulse before starting CPR is obsolete and that CPR should be commenced whenever a patient is not breathing, not breathing properly, not responding and/or not moving.

236. Officers Lutz, Davis and Houweling also thought that scenario based training using specific examples of situations that had actually occurred in the prison would be useful. Officer Lutz also said he would value more advanced training in CPR.[315] All of these suggestions have considerable merit.

[313] ts 24.05.22 (White), pp121 & 130-131 and ts 24.05.22 (Lutz), p142
[314] ts 24.05.22 (Fox), p162 and ts 25.05.22 (Davis), pp218-219 &232
[315] ts 24.05.22 (Lutz), pp144 & 149; ts 25.05.22 (Davis), p232 and ts 25.05.22 (Houweling), p264

QUALITY OF SUPERVISION, TREATMENT AND CARE

237. After carefully examining the available evidence, I have concluded that the supervision and care provided to Mr Lane whilst he was at EGRP was acceptable. However, although Mr Lane's medical treatment was often commensurate with standards in the general community, in my view, his medical conditions were not managed in a holistic way.

238. In making that observation, I accept that this case demonstrates the challenges faced by DOJ in managing a prison population where, on average, prisoners have higher rates of serious and/or chronic medical conditions than the general community. It is also true that management of Mr Lane's asthma/COPD was complicated by his non-compliance with medication and his refusal to stop smoking.

239. However, it is also the case that rather than view the control of Mr Lane's asthma/COPD as part of a bigger picture, exacerbations tended to be treated in isolation. He became unwell, he was treated with steroids and Ventolin and he appeared to recover. At no stage does a "bigger picture" view seem to have been taken.

240. As I have explained, Mr Lane experienced a very serious and potentially fatal exacerbation of his asthma on 8 March 2019. Further, shortly before his death, Mr Lane was needing overnight Ventolin by means of the nebuliser in his cell. However, neither of these events was seen as a matter for immediate concern, nor as a clear indication that Mr Lane's asthma was not under effective control.

241. On the basis of Dr Claxton's evidence, I find that Mr Lane should have been under the care of a respiratory physician, if not at the time he was received at EGRP, certainly by the time he was discharged from KRH on 11 March 2019. At the inquest, Dr Claxton reviewed Mr Lane's medication regime and noted that had he been caring for Mr Lane, he would have immediately doubled the strength of one of the puffers Mr Lane had been prescribed. However, I accept that on the basis of the evidence before me, it is impossible to say that the outcome for Mr Lane would have been any different had any of these things occurred.

RECOMMENDATIONS

242. In view of the observations I have made in the finding, I make the following recommendations:

Recommendation No. 1
Given the higher incidence of serious and/or chronic health conditions amongst the prison population, the Department of Justice (DOJ) should conduct a review of the level of nursing support provided at Eastern Goldfields Regional Prison (the Review) to determine whether the statutory responsibilities of the Chief Executive Officer set out in section 7(1) of the *Prisons Act 1981* (WA) are being properly discharged.

The Review should consider whether additional nursing staff should be employed at EGRP during the day to enable proactive health education and health audits to be performed in addition to routine nursing duties.

The Review should also consider whether additional nursing staff should be employed to provide cover at EGRP between the hours of 6.30 pm and 6.30 am.

Recommendation No. 2
DOJ should consider employing a staff development nurse who would be responsible for ensuring that the skills of nursing staff employed within the prison system are continually enhanced, especially with respect to health education and the management of prisoners with chronic medical conditions. The staff development nurse could also assist in the conduct and review of scenario-based training exercises conducted for the benefit of prison officers that relate to responding to medical emergencies.

Recommendation No. 3
A list of prisoners with serious medical conditions should be maintained in the Master Control Room at EGRP and on the respective prisoners units, so that officers receiving cell calls from prisoners on that list are aware that the prisoner making the call may require the urgent attendance of an ambulance.

Recommendation No. 4
DOJ should consider issuing a bulletin to all staff remining them that the previous practice of checking for a pulse before starting cardio-pulmonary resuscitation (CPR) is obsolete and that CPR should be commended whenever a patient is not breathing, not breathing properly, not responding and/or not moving.

Recommendation No. 5
DOJ should consider issuing a bulletin reminding prison officers that regardless of rank, all officers have an independent discretion to call a Code Red medical emergency and/or call for an ambulance to attend at a prison. Officers of lower rank and/or less experienced officers should be reminded that the approval of a more senior officer is not required and no disciplinary consequences will apply where the ambulance was called and/or the Code Red medical emergency was initiated in good faith.

Recommendation No. 6
Local Order 1 should be amended to make it clear that the Red Box system which operates at EGRP is only to be used for the delivery of oral medication and that under no circumstances is the Red Box system to be used to deliver medical equipment and/or parts or components of medical equipment.

Recommendation No. 7

EGRP should consider conducting bi-monthly scenario-based training exercises (i.e.: 6 per year) to enhance the skills of prison officers and nursing staff in responding to medical emergencies within the prison. Consideration should be given to including training on issues such as how to obtain information from prisoners during emergency cell calls and how to de-escalate situations as well as appropriate cell breach and resuscitation procedures. This training could include scenarios based on past medical emergencies to highlight effective and ineffective responses by prison officers and/or nursing staff.

Recommendation No. 8

DOJ should consider amending section 6.6 of the *At Risk Management System - Reception and Intake Assessment* form used by prison officers receiving prisoners into prison, by including the following question: "*In the past 12-months have you attended, or been admitted to a hospital*".

DOJ should also consider ensuring that nurses conducting the initial health screen on a prisoner being admitted to a prison ask the same question.

Where a prisoner answers "*Yes*" to this question (either to a reception officer or to a nurse), the prisoner should be asked for details of the hospital or medical facility, and as soon as is practicable thereafter, DOJ should obtain records relating to those hospital attendances or admissions.

Comments relating to Recommendations

243. In accordance with my usual practice, a draft of my proposed recommendations was forwarded to the counsel for all parties, by Ms Tyler (Counsel Assisting), on 27 May 2022. Counsel were asked to forward any comments on the proposed recommendations to the Court, by close of business on 10 June 2022.[316]

244. In an email dated 27 May 2022, Ms Barter advised that Mr Lane's family were supportive of all the proposed recommendations. Ms Barter also made a very sensible suggestion about Recommendation 7, which I adopted.[317]

245. By way of an email dated 8 June 2022, Ms Crispe advised that Officer Lewis agreed with the proposed recommendations and had nothing to add,[318] and in an email dated 10 Jun 2022, Ms Burke advised that Ms Evans had no comments to make.[319]

246. Finally, by way of a letter and attachment emailed to the Court on 10 June 2022, Mr Beck forwarded DOJ's very helpful response to the proposed recommendations. In its response, DOJ gave in-principle support to Recommendations 1 and 2, but noted that such support was subject to resource considerations. DOJ also advised that Recommendations 4, 5, 6 and 7 were "*reasonable and actionable*".[320]

247. As for Recommendation 3, DOJ said that the medical status alerts module on TOMS already addressed the function of the proposed list of prisoners with serious medical conditions. However, as I explained earlier in this finding, Mr Lane's Offender Summary fundamentally misstated his medical conditions and was of no use to officers trying to manage him. At the inquest, officers at the "*coal face*" agreed that the list proposed by Recommendation 3 would have been be beneficial and I remain strongly of the view that DOJ should consider introducing it.

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316 Email - Ms S Tyler to counsel for parties appearing at the inquest (27.05.22)
317 Email - Email - Ms A Barter (Counsel for Mr Lane's family) to Counsel Assisting (27.05.22)
318 Email - Email - Ms K Crispe (Counsel for Ms K Lewis) to Counsel Assisting (08.06.22)
319 Email - Email - Ms B Burke (Counsel for Ms W Evans) to Counsel Assisting (10.06.22)
320 Letter and attachment - Mr G Beck (Counsel for DOJ) to Counsel Assisting (10.06.22)

CONCLUSION

248. After carefully considering all of the available evidence, I decided to make eight recommendations aimed at improving the health and safety of prisoners at EGRP. It is my hope that these recommendations will be implemented.

249. Finally, I note that Mr Lane's family were unable to attend the inquest because of logistical reasons. For that reason, at the conclusion of the inquest, I asked counsel for Mr Lane's family to extend to family members, on behalf of the Court, my very sincere condolences for their loss. I do so again now.

MAG Jenkin
Coroner
21 June 2022