| | | |
|---|---|---|
| **JURISDICTION** | **:** | CORONER'S COURT OF WESTERN AUSTRALIA |
| **ACT** | **:** | CORONERS ACT 1996 |
| **CORONER** | **:** | Rosalinda Vincenza Clorinda Fogliani, State Coroner |
| **HEARD** | **:** | 14 - 16 FEBRUARY 2023 |
| **DELIVERED** | **:** | 27 FEBRUARY 2024 |
| **FILE NO/S** | **:** | CORC 585 of 2019 |
| **DECEASED** | **:** | BUCHANAN, IAIN CAMPBELL |

*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

Ms S Tyler assisted the State Coroner

Ms S Keighery and with her Ms Cowie (State Solicitor's Office) appeared on behalf of the Department of Justice and the Western Australia Police Force

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

Nil

*Coroners Act 1996*
(Section 26(1))

# AMENDED RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of* ***Iain Campbell BUCHANAN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 14 - 16 February 2023, find that the identity of the deceased person was* ***Iain Campbell BUCHANAN*** *and that death occurred on 1 May 2019 at Royal Perth Hospital, Wellington Street, Perth, from complications, including pneumonia, of traumatic brain injury in the following circumstances:*

## Table of Contents

## INTRODUCTION

1. Iain Campbell Buchanan (Mr Buchanan) died at Royal Perth Hospital on 1 May 2019 as a result of complications from a traumatic brain injury. Immediately before death he was a prisoner, serving his sentence at Hakea Prison. His death occurred two weeks after he was assaulted by another prisoner in one of the "*blind spots*" of the recreation compound at Hakea Prison. He was 65 years old.

2. Mr Buchanan was born in Wagin and moved to Perth with his family when he was about four years old. Mr Buchanan's parents separated when he was very young and he experienced a difficult life.

3. As an adult, Mr Buchanan married twice and had children. He had worked in carpentry and farmwork. Mr Buchanan had health issues including epilepsy, asthma and depression. He was known to the prison system, having previously been imprisoned primarily for offences relating to burglary on a number of occasions throughout his life.

4. The inquest explored the quality of his supervision, treatment and care while he was in custody, with particular focus on whether risks to his safety could have been avoided in the lead up to the assault, and whether his care and treatment at Hakea Prison following the assault was appropriate.

5. At Hakea Prison Mr Buchanan had been placed in the same unit as a male prisoner (Prisoner AB) who believed that he (Mr Buchanan) had made a police statement that implicated him (Prisoner AB) in an offence. On 15 April 2019, Mr Buchanan was assaulted by a prisoner who was an associate of Prisoner AB. The prisoner who assaulted him is referred to in this finding as Prisoner CD. The assault, being a punch to the jaw, caused Mr Buchanan to fall to the ground, hitting the back of his head.

6. Immediately after the assault, prison officers attended to Mr Buchanan in the recreation compound. Two nurses from the medical team promptly arrived to assess him, and he was taken to the Hakea Medical Centre. Mr Buchanan was assessed by the medical officer who initially considered he had sustained a concussion.

7. Mr Buchanan's condition deteriorated, and an ambulance was called. He was taken to Fiona Stanley Hospital, where a CT scan showed a bleed on the brain. After discussions between the neurosurgeons, he was transferred to Royal Perth Hospital where he underwent surgery followed by treatment in the ICU. Mr Buchanan's prognosis was poor. Despite ongoing care and monitoring in the Royal Perth Hospital ICU his condition did not improve and he died on 1 May 2019.

8. Prisoner CD, who assaulted Mr Buchanan was convicted, on his own plea, of an offence of Unlawful Assault Causing Death. On 7 May 2021 he was sentenced to a term of imprisonment of six years and six months, for the assault on Mr Buchanan, that caused his death.[1]

## THE INQUEST

9. Mr Buchanan's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Coroners Act) and it was reported to the coroner as required by the Coroners Act.

[1] Exhibit 1, tab 40

10. By reason of s 19(1) of the Coroners Act I have jurisdiction to investigate Mr Buchanan's death.

11. By reason of s 16 of the *Prisons Act 1981* (WA), as a sentenced prisoner, Mr Buchanan was in the custody of the Chief Executive Officer of the Department of Justice. Therefore, he was a "*person held in care*" within the meaning of s 3 of the Coroners Act and an inquest was mandated under s 22(1)(a) of the Coroners Act.

12. I held an inquest into Mr Buchanan's death between 14 and 16 February 2023. At the inquest I heard from nine witnesses and received three exhibits into evidence:

    a) Exhibit 1, containing 46 tabs;

    b) Exhibit 2, containing 22 tabs; and

    c) Exhibit 3.

13. Investigations continued and after the inquest, between 24 April 2023 and 4 May 2023 I received a further two exhibits into evidence (Exhibit 4, and Exhibit 5, with seven attachments).

14. My primary function has been to investigate Mr Buchanan's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how Mr Buchanan's death occurred and the cause of his death.

15. Pursuant to s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with Mr Buchanan's death including public health, safety or the administration of justice. This is the ancillary function.

16. Pursuant to s 25(3) of the Coroners Act, as Mr Buchanan was a person held in care, in this finding I must comment on the quality of his supervision, treatment and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

17. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil

liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

18. Pursuant to s 44(2) of the Coroners Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

19. After the inquest, on 20 February 2023 counsel assisting me circulated a written outline of my proposed potential adverse findings related to the Department of Justice, in order to provide the opportunity to respond. Those submissions also included my proposed recommendations, for comment from the Department of Justice and the Western Australia Police Force.

20. On 8 May 2023, after I had received all exhibits into evidence, through their lawyers the State Solicitor's Office (SSO), the Department of Justice provided their submissions in response.

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

22. In assessing the quality of Mr Buchanan's supervision, treatment and care at Hakea Prison on 15 April 2019, I am mindful of avoiding hindsight bias. Hindsight bias is the tendency to perceive events that have occurred as being more predictable than they were at the time.[2]

23. My findings appear below.

## CUSTODIAL HISTORY

24. Mr Buchanan's custodial history commenced in 1971, after he was charged with offences in connection with stealing and making false representations. His offending history included offences in connection with traffic

[2] www.britannica.com/topic/hindsight-bias

violations, nuisance behaviour, breaking and entering, burglary, receiving stolen property, resisting arrest, and violence and drug related offences.[3]

25. Having been convicted of these offences Mr Buchanan served periods of probation, good behaviour bonds, fines, drivers' licence disqualifications, conditional release orders and a number of terms of imprisonment. Previous custodial terms included a remand period of 17 days in July 2018, and term of custodial imprisonment for 458 days between May 2007 and August 2008.[4]

26. Mr Buchanan's final term of imprisonment was imposed for offences in connection with a home burglary and stealing (from a locked safe), committed on 18 May 2018. On 4 April 2019 he was sentenced to a term of imprisonment of two years, backdated to commence on 18 March 2019, to take account of time spent on remand. He was received into Hakea Prison on that same date, 4 April 2019. Approximately 10 days later he was assaulted and two weeks after the assault he died, from complications of the head injury he sustained from that assault.[5]

27. Mr Buchanan's earliest eligibility date for release to parole would have been 16 March 2020. His earliest date of release would have been 17 March 2021.[6]

## INTAKE AT HAKEA PRISON

28. Mr Buchanan underwent an intake process on his admission to Hakea Prison, for the purpose of ascertaining his history, and whether he was considered to be at risk of suicide or self-harm. The Prison Reception Officer who conducted Mr Buchanan's assessment under the At Risk Management System (ARMS) process noted that Mr Buchanan had previously self-harmed while in custody (when serving a previous sentence), and that he was upset about his former partner having died by suicide the previous year.[7]

[3] Exhibit 2, tab 22.
[4] Exhibit 2, tabs 2 and 22
[5] Exhibit 1, tab 41; Exhibit 2, tab 2.
[6] Ibid.
[7] Exhibit 2, tab 13.

29. The Prison Reception Officer, taking account of these stressors, recommended that initially, Mr Buchanan be placed into the Crisis Care Unit on ARMS, and that he be subject to two-hourly observations.[8]

30. As part of his intake on 4 April 2019, Mr Buchanan was also assessed by the nursing staff. They noted a medical history of asthma and epilepsy, and they also noted his mental health history, including his depression and previous self-harm attempts. His medications were recorded, an Asthma Care Plan was arranged and due to his epilepsy, he was recoded as being unsuitable for the top bunk in his cell.[9]

31. During his nursing assessment Mr Buchanan disclosed a history of intravenous drug use, and it was noted that he had been treated for hepatitis C. He had sustained a former head injury in 1992, as a result of a motor vehicle accident, for which he underwent a craniectomy and cranioplasty at that time. At the conclusion of the nursing assessment on 4 April 2019 a plan was made for an admission assessment with the admitting Medical Officer (which as will be seen below, occurred on 12 April 2019).[10]

32. The next day, 5 April 2019, Mr Buchanan was interviewed by the mental health worker from the Prison Counselling Service who appropriately noted his mental health history and stressors. Mr Buchanan denied current thoughts of self-harm. It was felt that he was stable and coping well despite low moods, and ongoing grief due to the death of his partner.[11]

33. After the interview with the mental health worker, the Prisoner Risk Assessment Group assessed that there was no further risk identified and recommended that Mr Buchanan be removed from ARMS and transferred to ligature minimised cell in Unit 7 with a compatible cellmate, with a referral to be made to a Prison Support Officer.[12]

34. The Superintendent of Hakea Prison, Mr Andrew Hughes (Superintendent Hughes) reported to the coroner on aspects of the intake process at this prison. He was not the Superintendent at the time of Mr Buchanan's death. Superintendent Hughes explained that with the exception of certain

[8] Exhibit 2, tabs 2 and 13.
[9] Exhibit 2, tab 20.
[10] Ibid.
[11] Ibid.
[12] Exhibit 2, tab 2.

specified prisoners, prisoners spend up to the first 10 days in Unit 7, that he referred to as the "*Induction Unit*" before they are moved into the general prison population.[13]

35. Hakea Prison is an amalgamation of two former and separate custodial facilities. It is the main is the main receival and remand facility in Western Australia. At the inquest Superintendent Hughes estimated that approximately 70 percent of the persons held in custody at Hakea Prison are remand prisoners, and the rest are sentenced prisoners. He noted that it is widely reported that the housing of prisoners with longer and shorter term sentences is not an "*ideal mix*," referring to prisoners with longer sentences being more likely resolved to their terms of imprisonment.[14]

36. On 12 April 2019 Mr Buchanan underwent a full medical assessment with the admitting Medical Officer who noted his medical, psychiatric and drug and alcohol history. Plans were made for blood tests and health screening tests. Anticonvulsant medication was prescribed, with a review planned in three months' time.[15]

37. In accordance with the established process, Mr Buchanan remained in Unit 7 for 10 days, for induction or orientation, and then he was transferred into the general prison population. Specifically, he was moved into Hakea Prison's Unit 10 on 14 April 2019.

## PREVIOUS ALTERCATION WITH PRISONER AB

38. When he was in the community, Mr Buchanan had been involved in an altercation with Prisoner AB, that resulted in charges being laid against Prisoner AB.

39. Unit 10, which is where Mr Buchanan was transferred, was the same unit that housed Prisoner AB and Prisoner CD, the prisoner who assaulted Mr Buchanan the next day.[16]

[13] Exhibit 2, tab 22.
[14] ts 84, 91 and 107.
[15] Exhibit 2, tab 20.
[16] Exhibit 1, tabs 16 and 40.

40. Back in December 2018, Prisoner AB (also then in the community) had been evicted from a residential property in the metropolitan area, together with his partner, for non-payment of rent. On 26 December 2018 Prisoner AB returned to the residence to collect some property he had left behind. Mr Buchanan, who was looking after the residence on behalf of the owner, was inside and refused to allow Prisoner AB to enter. Prisoner AB became aggressive and charged at the security door twice, damaging the security mesh and pulling it apart from the frame of the security door. Mr Buchanan contacted the police. Prisoner AB left prior to the police's arrival.[17]

41. The owner of the residence subsequently reported the criminal damage to police and in January 2019, Prisoner AB was charged with offences of criminal damage or destruction of property (and other unrelated offences). Prisoner AB was later fined in respect of this criminal damage to the security mesh door.[18]

42. In April 2019 Prisoner AB was in Hakea Prison, having been remanded in custody in respect of the criminal damage charge and other charges. The reasons for Prisoner AB's remand in custody are not relevant to the inquest.

43. Prisoner AB claimed to be a "*friend*" of Mr Buchanan, but he also spoke to other prisoners about Mr Buchanan in a disparaging manner, in the context of his belief that Mr Buchanan had given a statement to police about him, in connection with his criminal damage prosecution.[19]

44. It appears that Mr Buchanan found out and was unhappy about Prisoner AB telling other prisoners that Mr Buchanan had given police a statement implicating him. Mr Buchanan expressed his displeasure to at least one other prisoner. As it transpires, there is no evidence that Mr Buchanan had given a written witness statement to police about this matter.[20]

45. Prisoner AB had the paperwork to do with these criminal damages charges in his cell. One of the prisoners with whom Prisoner AB had discussions concerning his prior altercation with Mr Buchanan, and who had seen the

[17] Exhibit 2, tab 19.
[18] Ibid.
[19] Exhibit 1, tabs 31, 36, 39 and 40.
[20] Ibid.

criminal damages paperwork, was his cell mate Prisoner CD, who subsequently assaulted Mr Buchanan.[21]

46. The details appear below.

## THE ASSAULT

### *The heated interaction prior to the assault*

47. On the morning of 15 April 2019, Mr Buchanan, Prisoner AB and Prisoner CD, together with a number of other prisoners from Unit 10, were in the recreation compound of Hakea Prison that was situated between Units 9 and 10. It included an outdoor area with a basketball court, and an undercover area with gym equipment. The designated recreation period for Unit 10 was between 9.00 am and 10.00 am.[22]

48. Shortly after 9.00 am Mr Buchanan was walking around the recreation compound with another prisoner. Prisoner AB approached Mr Buchanan and there was a short, heated discussion between them. There is some evidence that Prisoner AB had put out his hand to shake Mr Buchanan's hand and that Mr Buchanan declined to shake his hand. There is insufficient evidence before me as to what was said between them. What is clear is that the interaction ended with Prisoner AB using both of his hands to push Mr Buchanan in the chest, and then he walked off. It was an action done by Prisoner AB in anger.[23]

49. After being pushed, Mr Buchanan remained standing. Mr Buchanan did not push or touch Prisoner AB in retaliation, but he was angered by Prisoner AB's behaviour. After Prisoner AB walked off Mr Buchanan continued to walk around the recreation compound "*doing laps*."[24]

50. There are varying accounts as to why Prisoner AB approached Mr Buchanan in the first place, but on the evidence before me it is reasonable to infer that it had something to do with their December 2018

[21] Exhibit 1, tabs 1, 31, 39 and 40.
[22] Exhibit 1, tabs 15, 16, 31, 39 and 40.
[23] Exhibit 1, tabs 15, 16, 31, 36, 39 and 40; ts 34 to 39; ts 68 to 69.
[24] Ibid.

dispute regarding access to the residence, that resulted in the criminal damage by Prisoner AB.[25]

51. The two prison guards who were responsible for supervising the prisoners in the recreation compound made statements and gave evidence about what they saw and heard, in connection with this initial heated interaction.[26]

52. In his statement Prison Officer Jordan Andrews (Officer Andrews) explained that he and Prison Officer Sharon Crudeli (Officer Crudeli) were supervising the prisoners in the recreation compound. The prisoners enter and exit the recreation compound though gates at the front of the recreation compound. When all the prisoners have entered, the gates (that have a grill mesh) are closed and locked by the prison officers, who supervise the prisoners from the sides of the outdoor recreation compound, behind bars, in a secure area.[27]

53. On 15 April 2019, as he was shutting the gates to the recreation compound, Officer Andrews reported that he saw Prisoner AB push Mr Buchanan in the chest area. He recalled that they then argued briefly, but Officer Andrews could not recall what words were used. Officer Andrews was standing approximately 25 metres away from them and his view was partially obscured by the grill mesh on the gates. At the inquest Officer Andrews explained that he heard raised voices, and as he turned to look in that direction, he saw the push to the chest. He did not see what had preceded it.[28]

54. When this push occurred, Mr Buchanan was facing Officer Andrews and Prisoner AB had his back to Officer Andrews. After the push he inferred that Mr Buchanan wanted to be left alone and he saw that Prisoner AB walked off looking irritated. Officer Andrews concluded that they were in "*heated disagreement*" with each other. However, Officer Andrews formed the impression that Mr Buchanan did not appear worried or fearful as a result of being pushed to the chest.[29]

[25] Ibid.
[26] Exhibit 1, tabs 15 and 16; ts 34 to 35; ts 62.
[27] Exhibit 1, tab 15.
[28] Exhibit 1, tab 15; ts 34 to 38.
[29] Exhibit 1, tab 15; ts 34 to 38; ts 41; ts 56.

55. After Officer Andrews closed and locked the gate, he walked over to Officer Crudeli to advise that something did not seem right, and they should keep an eye on Mr Buchanan and Prisoner AB. At the inquest Officer Andrews explained that he wanted Officer Crudeli's opinion, to consider whether there was something to be worried about.[30]

56. Officer Andrews saw that after Prisoner AB walked off, he went to the undercover area, that was right in front of him. At the undercover area Prisoner AB spoke with three or four other prisoners who were near the gym area, but it was in another language, so Officer Andrews does not know what was said. Prisoner AB later reported that some prisoners were encouraging him to fight Mr Buchanan, but he did not wish to do so.[31]

57. At this stage, Officer Andrews was assessing the situation in his own mind, and considering the involved prisoners' body language. In his experience, he very often sees arguments and pushes between prisoners. On his assessment he believed that there was an unfinished conversation as between Mr Buchanan and Prisoner AB, but at the time he felt there was nothing to indicate that there would be a subsequent assault.[32]

58. At the inquest Officer Andrews explained that prisoners pushing each other happens frequently. It is not horseplay. There is aggression involved. Essentially, he must apply his judgement as to whether to take steps to remove a prisoner from the recreation compound:

> "*…. it happens so often, people pushing each other. It's a hostile environment. People push each other every single moment of every second. It happened on the basketball court probably a second later. I saw another push in another area.*"[33]

59. Officer Crudeli also confirmed that verbal altercations, pushing, and shoving are very common in the prison yard.[34]

60. At the inquest Officer Crudeli testified that she did not see Prisoner AB push Mr Buchanan to the chest, nor did she see an altercation between them.

[30] Exhibit 1, tab 15; ts 39.
[31] Ibid.
[32] ts 39 to 41.
[33] ts 43.
[34] ts 70.

She recalled that Officer Andrews told her there had been "*words*" between the two prisoners, that the prisoners were now separated, and that they should keep an eye on them. She did not recall Officer Andrews telling her about the push to the chest. In her experience, there are "*words*" (meaning altercations) between prisoners all the time, and it does not generally provide a basis for removing those prisoners from the recreation compound.[35]

61. At the inquest, concerns were expressed about aggressive "*pushing*" and "*shoving*" behaviour becoming normalised within the prison environment, and not made the subject of investigation. It was posited that many fights begin with a push or a shove. Mr Buchanan's family felt that such behaviour, if occurring in the community would likely be punished.[36]

62. Officer Andrews considered this aspect and offered suggestions as to how it can be addressed, but ultimately the view he expressed was: "*It's very hard to stop that behaviour within a prison.*"[37]

63. At the inquest Superintendent Hughes agreed that they get "*rough points*" and "*tension*" within the prison system and that pushing and shoving is not uncommon. However, in his experience he did not consider it to be as common as the prison officers found it to be. Superintendent Hughes did however evince the same approach as the prison officers, in that, if the prisoners then walk away from each other, it is appropriate for the prison officers to remain watchful.[38]

64. Turning back to the events of that date, after they had conferred about the heated interaction, Officer Andrews and Officer Crudeli agreed to keep a further watch on Mr Buchanan and Prisoner AB. They could see where both prisoners were; they were separated and far apart from each other. Mr Buchanan was walking around the basketball court and Prisoner AB was standing with other prisoners in an under-cover area.[39]

[35] ts 62 to 63; ts 70.
[36] ts 51.
[37] ts 52.
[38] ts 93 to 94.
[39] ts 40.

***The subsequent assault***

65. After his discussion with Officer Crudeli where they agreed to keep a watch on Mr Buchanan and Prisoner AB, Officer Andrews had intended to walk over to his designated observation area on the Unit 9 side of the recreation compound, behind the grilles. Their discussion had occurred at the corner near the gate and then Officer Crudeli went to her designated observation area, on the Unit 10 side of the recreation compound, behind the grilles. The gate is closer to Officer Crudeli's designated observation area.[40]

66. However, events escalated, and Officer Andrews did not end up going to his designated observation area. Officer Andrews saw Prisoner AB walk towards Mr Buchanan, who was still doing laps around the recreation compound, and speaking with another prisoner. A prisoner who was subsequently identified as Prisoner CD joined Prisoner AB, both of them walking towards Mr Buchanan. Officer Andrews was focussed on Prisoner AB and his impression was that his demeanour as he was walking along appeared calmer.[41]

67. At this stage there were numerous prisoners running around the basketball court, shooting hoops. Officer Andrews walked over to get a better look and stood near the left grille entrance gate. He then saw Mr Buchanan get punched once to the face, and immediately fall backwards, his head hitting the concrete. Prisoner AB and Prisoner CD were close together when the assault occurred, and Officer Andrews was not able to see which one of them punched Mr Buchanan, because there was a post on the grille door blocking his view, and there were other prisoners running around. Officer Andrews initially thought Prisoner AB had punched Mr Buchanan. It was later established that Prisoner CD punched Mr Buchanan.[42]

68. Prior to Mr Buchanan being punched, Officer Andrews did not hear any words or argument between them. He formed the impression that Mr Buchanan was not expecting any assault as he was continuing to speak with another prisoner and appeared to be in "*deep conversation*" when he was suddenly punched to the face. Officer Andrews had been looking at

[40] ts 40; ts 68 to 69.
[41] Exhibit 1, tab 15 and 33; ts 41.
[42] Exhibit 1, tabs 15 and 40; ts 39 to 42

Mr Buchanan to see if he was aware that Prisoner AB and Prisoner CD were walking towards him.[43]

69. Officer Andrews was between 40 and 50 metres away when he saw the punch. Mr Buchanan fell backwards and remained on the ground. Officer Andrews called a Code Red Medical Emergency on his portable radio and entered the recreation compound through the gate, with Officer Crudeli, jogging towards Mr Buchanan to render first aid.[44]

70. I turn now to what Officer Crudeli was able to observe. She did not see the assault, namely the punch to Mr Buchanan's face because, as she explained at the inquest, it occurred in a "*blind spot*" of the recreation compound. She could not see the prisoners in that particular spot from her designated observation area. She clarified that the blind spot is by reference to where she was designated to observe, and that is the meaning to be given to it in this finding. For example, from where Officer Andrews was standing, at or near the gate, it was not a blind spot.[45]

71. Concerning the assault, the only thing Officer Crudeli was able to see from her designated observation area was Prisoner AB and Prisoner CD leaving the verandah area to walk towards the Unit 10 side, and that is when Officer Andrews said he was going back to his designated observation area (on the other side). Very shortly afterwards, she heard him call a Code Red Medical Emergency.[46]

72. In elaborating on the meaning of the blind spot, Officer Crudeli's evidence was that her observation of those prisoners was impeded by a brick wall at the end of the grille. If prisoners are walking around the basketball court of the recreation compound, they are always going to go into the blind spot. In other words, they cannot do a loop around the basketball court without at certain points, walking through the blind spot (which is the section that she cannot see).[47]

[43] Exhibit 1, tab 15; ts 41 to 42.
[44] Ibid.
[45] Exhibit 1 tab 16; Exhibit 2, tab 17; ts 69 to 71; ts 81 to 82.
[46] ts 68.
[47] Exhibit 2, tab 17; ts 69.

73. Officer Crudeli was aware that Prisoner AB and Prisoner CD were walking towards Mr Buchanan, and she felt there was not much else she could do other than keep an eye on them.[48]

## MEDICAL TREATMENT AT HAKEA PRISON

### *Initial treatment at the site*

74. Immediately after the assault, at approximately 9.20 am, Officer Andrews called a Code Red Medical Emergency on his radio and he and Officer Crudeli promptly entered the recreation compound to attend to Mr Buchanan, who had remained lying on the ground.[49]

75. Officer Crudeli immediately attended to Mr Buchanan while Officer Andrews made inquiries about the assault. One of the other prisoners had already placed Mr Buchanan in the recovery position and was supporting his head. Officer Crudeli saw that Mr Buchanan had a bleeding injury to the rear of his head. More prison officers arrived, and it began raining heavily.[50]

76. Mr Buchanan was moaning, he was breathing, and his eyes were flickering, but he was not responsive to questions asked of him. Officer Crudeli and three other prison guards, assisted by one of the prisoners, carried Mr Buchanan to the undercover area to get him out of the rain. They then put him back in the recovery position and waited for the medical team to arrive.[51]

77. At the inquest Officer Crudeli confirmed she had a Basic First Aid Training qualification, and that at the material time she was conscious of the support to Mr Buchanan's head to prevent unnecessary movement, and the need for him not to be "*off balance*" as they carried him to the undercover area.[52]

78. The clinical nurses from the Hakea Prison Medical Centre arrived promptly to assess Mr Buchanan. The nurse assessing him brought the emergency resuscitation trolley. When she arrived, she saw that Mr Buchanan was

[48] ts 70.
[49] Exhibit 2, tab 20.
[50] Exhibit 1, tab 16.
[51] Exhibit 1, tab 16; ts 72.
[52] ts 72 to 73.

trying to move and open his eyes as prison officers were speaking to him. However, Mr Buchanan was not speaking. He had previously been unconscious for an unknown period of time.[53]

79. The clinical nurse took Mr Buchanan's observations, noting that his pulse was between 60 and 70 beats per minute and his oxygen saturation was 98%. His Glasgow Coma Score for consciousness was 9. The clinical nurse noted grazes to the back of Mr Buchanan's head and a laceration to his chin.[54]

### *Conveyance to Hakea Medical Centre*

80. As he was being assessed by the clinical nurse, Mr Buchanan became more rousable, and at approximately 9.26 am he was placed on a wheelchair and taken to the Hakea Prison Medical Centre for further assessment, arriving there within approximately two minutes. The question subsequently arose as to whether Mr Buchanan ought to have been transported to the Medical Centre on a stretcher. At the inquest Officer Crudeli described Mr Buchanan's posture in the wheelchair. His arms were flopped over the sides and the clinical staff had to put them back into the wheelchair. His head was down, and she could not see his face.[55]

81. The matter of the use of a stretcher is addressed later in this finding under the heading: "*Spinal precautions*."

### *Assessment at Hakea Prison Medical Centre*

82. Upon arrival at Hakea Prison Medical Centre Mr Buchanan's injuries were documented by attending prison officers.

83. The clinical nurse took further observations from Mr Buchanan, at 15-minute intervals, commencing from 9.45 am (by which time his Glasgow Coma Score had returned to normal, being 15). Mr Buchanan told the clinical nurse that his head hurt (describing 10 out of 10 pain), he felt bad,

[53] Exhibit 1, tabs 27, 28 and 30; Exhibit 2, tab 20.
[54] Exhibit 1, tab 28; Exhibit 2, tab 20.
[55] Exhibit 1, tab 28; Exhibit 2, tab 20; ts 73 to 74.

and he felt nauseous. The clinical nurse asked the Prison Doctor to assess the laceration under Mr Buchanan's chin.[56]

84. The Prison Doctor arrived to assess Mr Buchanan at approximately 9.45 am, being situated directly outside the area where Mr Buchanan was being held. Mr Buchanan was nauseous and agitated, and he appeared confused. The Prison Doctor had been informed that Mr Buchanan had been assaulted and during his assessment he observed the injury on the back of Mr Buchanan's head. When he asked Mr Buchanan what had occurred, Mr Buchanan was unable to respond, save to say that he needed to use the bathroom to open his bowels.[57]

85. This raised an immediate concern for the Prison Doctor as it is an indicator of a more serious head injury. The Prison Doctor informed one of the nurses that Mr Buchanan needed to go to hospital, though it remains unclear as to whether he gave that nurse specific instructions to call an ambulance. The Prison Doctor ordered an injection of metoclopramide, that was administered by the clinical nurse, to alleviate Mr Buchanan's nausea and make him more comfortable and returned to his room to make his case note entry at 9.51 am. At this stage Mr Buchanan was sitting upright in bed.[58]

86. Mr Buchanan was then assisted to the wheelchair by the nurses, in order to be taken to the bathroom. He was unsteady on his feet, though able to sit relatively (but not fully) upright in the wheelchair. Within minutes after his return from the bathroom, the Prison Doctor returned to see Mr Buchanan, and observed him to be pale, sweaty, drowsy, complaining of a worsening headache, with increasing confusion and agitation.[59]

87. The Prison Doctor made another medical assessment, noting that Mr Buchanan was able to use his arms and legs, that there was no facial asymmetry, that his speech was clear, that he was able to respond to some of the questions asked, and that his pupils were normal. The Prison Doctor determined that Mr Buchanan did not have the focal neurological signs of a head injury but instead had the global features of concussion. The Prison

[56] Exhibit 1, tabs 28 and 44; Exhibit 2, tab 20.
[57] Exhibit 1, tabs 29, 30 and 44; Exhibit 2, tab 20.
[58] Ibid.
[59] Ibid.

Doctor returned to his room at 10.24 am to make his follow up case note entry and complete his Emergency Department Patient Transfer letter.[60]

88. Records reflect that the Prison Doctor completed the Emergency Department Patient Transfer letter at 10.27 am. In addition to recording the salient features of Mr Buchanan's condition as outlined above, the Prison Doctor also recorded that Mr Buchanan's pulse rate, blood pressure and oxygen saturation: "*have been normal*."[61]

89. Between 10.15 am and 10.45 am Mr Buchanan was closely observed. Initially his Glasgow Coma Score was recorded as 14 and he was disoriented to place and time. Shortly afterwards Mr Buchanan's condition deteriorated, and he became more agitated. Within a few minutes his Glasgow Coma Score dropped to 9, his respiratory rate rose to 28, and he was making incomprehensible sounds. He was placed in the recovery position, an intravenous cannula was inserted and he was administered 15 litres of oxygen. He was reassured that an ambulance was on the way.[62]

90. Records reflect that St John Ambulance was called at 10.52 am, that the paramedics departed within one minute, arriving at the scene at 11.06 am. On their arrival Mr Buchanan showed minimal response to the paramedics' verbal cues and/or touch. He was given ketamine and ondansetron, headblocks were applied to immobilise his neck, and his airways were suctioned. At 11.15 am the paramedics recorded his Glasgow Coma Score as 11.[63]

91. The paramedics continued to take Mr Buchanan's observations and he continued to deteriorate. His blood pressure was high. At 11.25 am his Glasgow Coma Score was recorded as 9 and at 11.30 am it deteriorated to 6. The St John Ambulance left the prison with Mr Buchanan at 11.30 am and arrived at Fiona Stanley Hospital Emergency Department at 11.36 am.

92. The punch to Mr Buchanan's face occurred at approximately 9.20 am and the ambulance was called at 10.52 am, one and a half hours later. In between that time, he was assessed at the Hakea Prison Medical Centre as outlined above. There inquest explored the question of whether there was

[60] Ibid.
[61] Exhibit 1, tabs 28, 44 and 45.
[62] Exhibit 1, tab 44.
[63] Exhibit 1, tab 13.

an unacceptable delay in calling an ambulance and this is addressed later in this finding under the heading: *Time taken to call an ambulance*.

## HOSPITAL CARE

### *Fiona Stanley Hospital*

93. Mr Buchanan arrived by ambulance at the Fiona Stanley Hospital Emergency Department at 11.36 am on 15 April 2019. He underwent emergency intubation. A CT scan of his head was performed at 11.51 am, showing a severe traumatic brain injury.[64]

94. Following consultations between the neurosurgeons, it was determined that Mr Buchanan should be transferred to Royal Perth Hospital for specialised treatment. There was no acute neurosurgical service at Fiona Stanley Hospital. He was transferred by ambulance under Priority 1 conditions, with a doctor escort.[65]

95. The independent expert, Consultant Neurosurgeon Mr Stephen Honeybul (Dr Honeybul) prepared a report for the coroner regarding the medical management of Mr Buchanan, and he gave evidence at the inquest, based upon his review of the medical records from Hakea Prison, Fiona Stanley Hospital and Royal Perth Hospital.[66]

96. Dr Honeybul reported that the CT scan performed at Fiona Stanley Hospital showed a large acute subdural haematoma with right sided parenchymal intracerebral haematoma. He noted that there was extensive traumatic subarachnoid blood, midline shift and effacement of the of the third ventricle. He explained that this is in keeping with: "*a very severe traumatic brain injury*."[67]

97. Dr Honeybul reported that Mr Buchanan's management at Fiona Stanley Hospital was extremely timely and very appropriate, and that he was transferred to Royal Perth Hospital in a timely fashion. At the inquest Dr Honeybul elaborated, opining that timing for the performance of the CT

[64] Exhibit 1, tabs 11 and 13; Exhibit 2, tab 20.
[65] Exhibit 1, tab 11.
[66] Exhibit 1, tab 11; ts 124 to 144.
[67] Exhibit 1, tab 11.

scan at Fiona Stanley Hospital was "*excellent*" and that Mr Buchanan was appropriately managed there. I accept this opinion.[68]

***Royal Perth Hospital***

98. Mr Buchanan arrived at Royal Perth Hospital at 1.20 pm and he was immediately assessed by the neurosurgical team. He was transferred directly to the operating theatre and underwent a right sided decompressive hemicraniectomy (to reduce the pressure on the brain) and evacuation of the haematoma.[69]

99. At the inquest Dr Honeybul, having reviewed the notes of the surgery and the post operative scan, opined that the craniectomy at Royal Perth Hospital was performed in a very timely manner and that, having reviewed the outcome of the surgery, he had no concerns about it (noting that the haematoma was evacuated, and the swelling was relieved). I accept this opinion.[70]

100. Post operatively, Mr Buchanan was transferred to the ICU. An ICU Registrar contacted Hakea Prison to provide an update on his severe head injury. The Registrar advised that prognosis for recovery of function was very poor, and there was a high risk that Mr Buchanan would not survive the acute recovery phase.[71]

101. The Commissioner for Corrective Services was made aware of this advice, and Mr Buchanan was added to the Terminally Ill Register, Stage 4, meaning that his death was expected imminently.[72]

102. Over the next week, Mr Buchanan's condition continued to deteriorate and there were regular updates provided by Royal Perth Hospital to Hakea Prison. He remained in ICU, intubated and ventilated. There were no signs of neurological improvement. He developed hypertension and a fever. He was unshackled, with two guards in attendance. Several meetings were

[68] Ibid.
[69] Ibid.
[70] ts 134 to 135.
[71] Exhibit 2, tab 20.
[72] Ibid.

held with members of his family to advise them of the significance of his brain injury and his poor prognosis.[73]

103. On 24 April 2019 the decision was made to remove his breathing tube and provide comfort care only. He was managed palliatively with hydromorphone and kept comfortable. Family members visited frequently. His death was expected. Mr Buchanan died at 4.20 pm on 1 May 2019.[74]

## CAUSE OF DEATH

104. On 6 May 2019 the forensic pathologist Dr G A Cadden (Dr Cadden) made a post mortem examination at the State Mortuary on Mr Buchanan's body. On Dr Cadden's examination it was evident that a neurosurgical procedure had been carried out to the right side of Mr Buchanan's brain. Dr Cadden found pulmonary congestion and appearances in keeping with pneumonia. He also found coronary and generalised atherosclerosis.[75]

105. Dr Cadden ordered a neuropathology assessment of the brain, and results became available on 18 November 2019. Dr Cadden reviewed these and reported that the macroscopic neuropathology findings were concluded as "*Traumatic Brain Injury*" with the right cerebral hemisphere showing flattening, midline shift to the left, and transtentorial herniation. The neuropathology examination also found an organising haematoma of the right temporal/parietal lobes, an organising right subdural haemorrhage, and contusions and lacerations of the right frontal and temporal lobes.[76]

106. Dr Cadden ordered lung histology, which confirmed pneumonia. Toxicological analysis was undertaken and showed various medications in keeping with Mr Buchanan's medical treatment.[77]

107. At the conclusion of all of the examinations and receipt of the results, on 19 November 2018 Dr Cadden formed his opinion on the cause of Mr Buchanan's death. I accept and adopt Dr Cadden's opinion.

[73] Ibid.
[74] Exhibit 1, tabs 3 and 4; Exhibit 2, tab 20.
[75] Exhibit 1, tab 6.
[76] Exhibit 1, tabs 6 to 8.
[77] Exhibit 1, tabs 6 to 9.

108. **I find that the cause of Mr Buchanan's death was complications, including pneumonia, of traumatic brain injury.**

## MANNER OF DEATH

109. On 7 May 2021 Prisoner CD was sentenced in the Supreme Court of Western Australia, on his guilty plea to the charge of unlawful assault causing death, contrary to s 281 of the *Criminal Code Act Compilation Act 1913* (WA). He was sentenced on the basis of it being accepted by the State that he did not know Mr Buchanan's age, that he did not intend to kill Mr Buchanan, that he believed (albeit wrongly) that a fight was about to commence, that he believed Mr Buchanan was associated with another prisoner who had a "*reputation*" at Hakea Prison, and that he formed a "*fear*" about this association.[78]

110. The sentencing took account of the fact that there was no pre-existing dispute between Prisoner CD and Mr Buchanan, that Prisoner CD allowed himself to become involved in a dispute between Prisoner AB and Mr Buchanan, that the incident between Prisoner AB and Mr Buchanan had ended, and that Mr Buchanan had resumed walking laps of the recreation area when Prisoner CD and Prisoner AB approached him. The sentencing took account of there being no evidence that Mr Buchanan intended to fight with Prisoner CD or Prisoner AB. It was noted that Prisoner CD was subsequently assaulted by two prisoners [79]

111. In respect of the charge of unlawful assault causing death, Prisoner CD was sentenced to a term of imprisonment of six years and six months, with eligibility for parole.[80]

112. Under s 53(2) of the Coroners Act, my finding on this inquest must not be inconsistent with the result of any earlier proceeding where a person has been charged on indictment for an indictable offence, in which the question of whether the accused person caused the death is in issue.

113. **I find that the manner of Mr Buchanan's death was by way of Unlawful Homicide**.

[78] Exhibit 1, tab 40.
[79] Ibid.
[80] Ibid.

## QUALITY OF SUPERVISION, TREATMENT AND CARE

114. Mr Buchanan's death was caused by the unlawful actions of Prisoner CD. The Department of Justice did not cause or contribute to his death.

### *Conclusions on supervision*

115. I am satisfied that the standard and quality of supervision provided by each of the individual prison officers involved in the supervision of Mr Buchanan was reasonable, within the limits of the systems, infrastructure, policies and procedures available to them.

116. However, I am satisfied that there was room for improvement by the Department of Justice, in that the prison infrastructure was not conducive to appropriate supervision due to there being blind spots obscuring part of the prison officers' view of the prisoners in the recreation compound.

117. Further, and with the benefit of hindsight, there could have been better access for the Department of Justice, to information held by the Western Australia Police Force reflecting upon the potential for animosity as between Mr Buchanan and Prisoner AB arising from their previous altercation in the community, resulting in Prisoner AB's criminal damage charges. At the material time this access was not possible, and I have addressed this aspect later in this finding under the heading: *Recommendations – Information Sharing*.

118. The areas that I considered in coming to my conclusions on Mr Buchanan's supervision appear under the headings in this part of the finding: *Number of prison guards, De-escalation training, "Blind spots" in the recreation compound, and Alerts.*

### *Conclusions on medical treatment and care*

119. I am satisfied that the standard and quality of medical treatment and care provided by each of the clinicians at Hakea Prison was appropriate, again within the limits of the systems, infrastructure, policies and procedures available to them.

120. However, there was room for improvement in Mr Buchanan's medical treatment and care. The Acting Director of Medical Services for the

Department of Justice – Corrective Services, Dr Catherine Gunson (Dr Gunson) reported to the coroner on the issues that she identified, in coming to her opinion that the Hakea Prison's response to Mr Buchanan's acute traumatic injury was less than ideal, and she gave evidence at the inquest.[81]

121. In her report to the coroner, Dr Gunson felt that the staff at the Hakea Prison Medical Centre did not have a systematic format to follow, were unaware of what examinations and observations were required, and that the response lacked clear clinical leadership.[82]

122. The areas that I considered in coming to my conclusions on Mr Buchanan's medical treatment and care appear under the headings in this part of the finding: *Spinal precautions* and *Time taken to call an ambulance*.

### *Number of prison guards*

123. The evidence at the inquest showed that through a combination of persons moving around in a volatile environment, and the assault occurring in one of the blind spots, not all of the material events for this incident were able to be seen by both of the supervising prison officers. One of the factors I considered was whether the allocation of two prison officers to supervise 128 prisoners in the recreation compound was sufficient.

124. The evidence at the inquest was that Unit 10 held a maximum of 128 prisoners at the material time. There were two prison officers allocated to supervise this number of prisoners, from behind the grilles, stationed at opposite sides of the compound.[83]

125. Through its lawyer the SSO, the Department of Justice has responded to this concern, noting that Hakea Prison is the main metropolitan remand and reception prison for Western Australia, and that it is by its very nature an environment where staff are required to constantly assess and address the "*dynamic*" security, and need to remain vigilant and respond to escalating tensions between prisoners at all times. The court is informed that the staffing levels are discussed and agreed between the Western Australian

[81] Exhibit 2, tab 20; ts 145 to 162.
[82] Exhibit 2, tabs 2 and 20.
[83] ts 21 to 22.

Prison Officer's Union, Departmental staff and management for all areas within a custodial facility.

126. The Department of Justice also draws attention to the evidence that shows Officer Andrews witnessed the heated interaction prior to the assault, and the subsequent assault, though as the evidence established, he did not clearly see who punched Mr Buchanan.

127. At the inquest Officer Andrews was not able to confirm whether the full complement of 128 prisoners were in the recreation compound during this incident. A prisoner may have a visitor, an education session or a court commitment. Otherwise, it may be assumed they will avail themselves of the time in the recreation compound, though he noted that some might prefer to remain in their cell. Officer Andrews estimated that there were close to 100 prisoners in the recreation compound at the material time.[84]

128. Ultimately on the question of whether he felt two prison officers could safely supervise 128 prisoners, Officer Andrews considered that within the recreation compound: "*it isn't too bad*." He drew attention to the availability of a further three officers (the "*recovery team*") who are able to attend the area and assist if required.[85]

129. Superintendent Hughes reported that if there is an incident within the recreation compound, and the supervising prison officers seek assistance, the standard response for between three to six staff to arrive to assist is one to two minutes, often faster. If prison officers know that help is arriving momentarily, two prison officers may make the decision to enter the recreation compound together.[86]

130. At the inquest Superintendent Hughes did not agree that that the two allocated prison officers are burdened with having to watch multiple instances of pushing or shoving. In his experience prisoners in the recreation compound will generally be found to be walking around: "*I will challenge that there's lots of incidents going on everywhere on every single exercise, because 99 per cent of the time there isn't*."[87]

[84] ts 21.
[85] ts 50.
[86] Exhibit 2, tab 22.
[87] ts 104 to 105.

131. Superintendent Hughes' evidence also assisted in establishing the reason for the Unit 10 prisoners being in the recreation compound. Ordinarily at the material time these prisoners would have been taking their recreation at the yard and ovals within the prison. However, on 15 April 2019 Hakea Prison was short of approximately 12 prison officers. Prison officers being unavailable for duty is not an uncommon occurrence. To place it into context, Superintendent Hughes testified that Hakea Prison was 50 staff short on the day of the inquest, and 52 staff short on the previous day. He considered that being 12 staff short was normal, or reasonable, and would not consider that to be "*understaffed*."[88]

132. Superintendent Hughes posited that the yard and oval could not be used for prisoner recreation on 15 April 2019 because for these areas, an additional three prison officers would have been required to be stationed at other vantage points.[89]

133. At the inquest Superintendent Hughes described the ovals as "*staff hungry*" and he also alluded to other prisoner services being potentially cancelled due to there being insufficient staff (for example the library). He suggested that some of the challenges experienced by prison officers in supervising prisoners could be ameliorated by the installation of CCTV cameras. This aspect is addressed later in this finding under the heading: *Recommendations: CCTV and Body Worn Cameras*.

134. I have no criticism relating to the number of prisoner officers allocated to supervise the prisoners at the recreation compound on that date of this incident.

### *De-escalation training*

135. I have considered whether there was a missed opportunity to de-escalate tension between Mr Buchanan and Prisoner AB, thereby potentially avoiding the later interactions between Mr Buchanan, Prisoner AB and Prisoner CD, that ended in the assault, and the death of Mr Buchanan. I have also considered whether this could be improved by better guidance for prison officers regarding the appropriate management of aggressive

[88] Exhibit 2, tab 22; ts 105 to 106.
[89] Ibid

behaviour by prisoners within the prison environment, with the aim of pre-emptively avoiding an escalation.

136. At the inquest Officer Andrews was asked about his de-escalation options, within the context of having seen the heated interaction prior to the assault. Officer Andrews' evidence was that if he had seen a prisoner pacing up and down in an agitated state, who looked like he was about to commit an assault he would call that prisoner over to the grille, remove them from the recreation compound and advise his senior officer.[90]

137. At the inquest Officer Crudeli's evidence was that, hypothetically, if she were informed that prisoners had been pushing each other, but that they were now separated, she would keep an eye on them. If they walk away from each other, her sense would be that the argument: "*would have been finished with*."[91]

138. If there is an apparent argument between prisoners, Officer Crudeli's de-escalation practices include speaking privately with the prisoner so as to encourage disclosure about the argument. She testified that, having regard to the confined spaces, where a prisoner approaches her to disclose "*an issue*" with another prisoner, depending on the circumstances, that prisoner may be moved to another unit. In her experience it is not difficult to move a prisoner to another unit.[92]

139. The tenor of the evidence was that it is undesirable to put prisoners on the spot, in front of other prisoners, and commence inquiry as to why a push or a shove occurred and/or whether either of them is feeling unsafe about it. Removing a prisoner from the recreation compound in such cases is left to the judgement of the prison officers who are carrying out the supervision.

140. In his report to the coroner Superintendent Hughes acknowledged that pushing and shoving commonly occurs during the prison environment (although as indicated he did not think it to be ubiquitous). He explained that prison officers are required to make dynamic risk assessments constantly and are trained to judge what does and does not warrant a response, in connection with pushing or shoving.[93]

[90] ts 42.
[91] ts 63; ts 76.
[92] ts 76 to 77.
[93] Exhibit 2, tab 22.

141. At the inquest Superintendent Hughes acknowledged that the recreation compound environment is very dynamic and there is a lot for the prison officers to be watching. He described it as a "*very tough*" environment. In connection with what Officer Andrews saw of the initial push to Mr Buchanan's chest, Superintendent Hughes' evidence goes to show that de-escalation interventions are largely dependent on the circumstances, and individual judgement: "…. *I am quite confident the officer saw what he saw and made the right – the decision that he felt was right at the time, which perhaps with hindsight was wrong at the time. Don't know. I wasn't there*."[94]

142. Superintendent Hughes had placed the scenario before a number of other prison officers and with the benefit of his own experience, posited that de-escalation intervention following the push to the chest would likely not occur in a case such as this due to a number of factors:

    a) Mr Buchanan and Prisoner AB both walked off afterwards;

    b) In relation to Mr Buchanan there was already a perception that he was an "*informant*" (though the prison officers did not know this, and I address this aspect later under the heading: *Alerts*);

    c) They do not embarrass prisoners in front of other prisoners;

    d) He was quite certain that, if Officer Andrews had called Mr Buchanan up for a conversation after the push to his chest, Mr Buchanan would have indicated there were no problems and they would have let him go about his business;

    e) He agreed that an option for Officer Andrews would have been to call Prisoner AB up for a conversation, but noted that prison officers are needing to make thousands of judgment calls all day long in a very tough environment.[95]

143. Superintendent Hughes also referred to the need for prison officers to be "*hypervigilant*" in case a "*scuffle*" is orchestrated by prisoners in order to

[94] ts 94.
[95] ts 93 to 95.

distract their attention, away from an area where an illegal act may be occurring. In his experience this does occur, and he gave evidence within the context of there being an awareness, amongst prison officers at the material time, that a delivery or exchange of drugs was being planned.[96]

144. Through their lawyer the SSO, the Department of Justice has outlined the practical and theory-based training for prison officers which focusses on options for managing incidents involving aggressive behaviour and/or physical violence between prisoners. This training is covered as part of the Entry Level Training program and is supplemented with annual refresher training, mandatory emergency management exercises, and regular post-incident feedback and de-briefs.

145. The Department of Justice further submits that there is no evidence that a different response to the initial push to Mr Buchanan's chest would have resulted in any different outcome for Mr Buchanan. That cannot be known, though with the benefit of hindsight, if they had been separated at that stage, it may have reduced the risk. It may have given time for discussions to be held and for Mr Buchanan to tell the prison officers that Prisoner AB was telling other prisoners that he was, essentially, an informant. As to whether or not Mr Buchanan would have offered that information, that is speculation.

146. I have taken account of the fact that Mr Buchanan was an elderly prisoner, and that Prisoner AB, who pushed him was younger than him, and likely fitter and stronger than him. Further, that many fights will commence with a push or a shove.[97]

147. While I have no criticism of the supervision performed by the individual prison officers on that date, I am satisfied that there is room for improvement in the Department of Justice's training for prison officers who are required to undertake this role in a volatile environment.

148. A recommendation directed towards improving the training for prison officers in respect of the management of aggressive behaviour by prisoners is addressed later in this finding under the heading: *Recommendations – Training in management of aggressive behaviour*.

[96] ts 97.
[97] Exhibit 1, tab 31.

***"Blind spots" in recreation compound***

149. I have considered whether the infrastructure at Hakea Prison's recreation compound was sufficiently conducive to appropriate supervision of the prisoners, having regard to the evidence concerning the blind spots.

150. Self-evidently as outlined earlier in this finding, an area becomes a blind spot depending on where a prison officer is standing or sitting, when supervising the prisoners in the recreation compound. A blind spot is undesirable, from the perspective of a prison officer in their designated observation area, who finds their line of sight impeded by infrastructure.

151. The evidence at the inquest established that there were blind spots that existed, from the perspective of the prison officers supervising the recreation compound due to:

a) The layout of the recreation compound;

b) The grilles obscuring part of the view for the prison officers; and

c) The presence of a solid brick wall obscuring part of the view.[98]

152. At the inquest Officer Crudeli explained that prison officers try and position themselves, in their designated observation areas for the recreation compound, where they can get the best view possible. However, she felt that it is not well set up to supervise all the blind spots and all the corners of the recreation compound. In her experience the blind spots are known to the prisoners.[99]

153. Officer Crudeli was asked to offer her view on changes that would make it easier for her to supervise. Office Crudeli posited that she would not have a brick wall at the end of the grilles. She referred to another prison where she has previously worked with the "*same setup*" but with rails in that area, instead of the brick wall that impedes the view.[100]

154. Officer Andrews testified that there are some corners in the recreation compound that are very hard to see into, having regard to the positioning of

[98] ts 29 to 32.
[99] ts 70.
[100] ts 70 to 71.

the grilles and the brick wall. In his experience, some prisoners go into those areas to use or exchange illicit drugs, and that checking those areas can be "*challenging*."[101]

155. The former Commissioner of Corrective Services Mr Mike Reynolds (Mr Reynolds) provided a report to the coroner responding to a number of questions. In respect of the mesh or grille areas, in the context of the security requirements, Mr Reynolds confirmed that they are part of the recognised strategies to ensure safe working practices. In respect of the designated observation areas, Mr Reynolds reported that the location provides a good vantage point which allows good observation of the recreation compound, allowing good observation of the whole location, whilst maintaining good lines of sight back to the units and along the internal perimeter fence line.[102]

156. Through its lawyer the SSO, the Department of Justice submits to me that the heated interaction prior to the assault (being the push to Mr Buchanan's chest) did not occur in a blind spot. I accept that the prior heated interaction was able to be seen by Officer Andrews, and did not occur in one of the blind spots.

157. However, the assault leading to Mr Buchanan's death occurred in an area that was not able to be adequately witnessed by the prison officers because:

    a) Having regard to Officer Crudeli's location, it occurred in her blind spot (meaning an area that she could not see from the vantage of her own designated observation area due to the presence of the brick wall blocking her view);[103]

    b) Having regard to Officer Andrews' location, it occurred in an area where his view was obscured by the post on the grille door such that, while he was able to see Mr Buchanan being punched, he was not able to see whether it was Prisoner CD or Prisoner AB who punched him.[104]

158. I accept the Department of Justice's submission, through its lawyer the SSO, that the unlawful assault causing Mr Buchanan's death did not come

[101] ts 31 to 32.
[102] Exhibit 1, tab 17.
[103] Exhibit 1, tab 15.
[104] Exhibit 1, tab 16.

about by reason of the infrastructure of Hakea Prison, nor as a result of the layout of the recreation compound, the grilles or the solid brick wall. Prisoner CD is responsible for the unlawful assault.

159. However, it is clear that the prison officers who testified felt impeded in their observations of the prisoners in the recreation compound. They both have experience of prisoners being aware of and/or utilising the blind spots to carry out activities in the hope that they are not observed. This can be counterproductive.

160. An inquiry into the re-design of Hakea Prison is outside the scope of the inquest. After the inquest information was provided about the prison walls at the end of the grilles, that impede the prison officers' views, forming part of the building structure. They cannot be readily removed.[105]

161. A better and more efficient approach, to avoid the effects of blind spots, and to support a safer environment, may be found through improvements to the monitoring environment. This is further addressed under the heading: *Recommendations – CCTV and Body Worn Cameras*.

### *Alerts*

162. I have considered whether there was a missed opportunity to avoid the assault by Prisoner CD, if it had been known at the earlier stage that there had been a previous altercation between Mr Buchanan and Prisoner AB in the community, and that Mr Buchanan was identified on the police database as a "*witness*" to Prisoner AB's criminal damage charge.

163. Appropriate access to this information within Hakea Prison may have enabled an Alert to be placed upon Mr Buchanan's Total Offender Management Solutions (TOMS) record, with the aim of ensuring he was not placed in the same unit as Prisoner AB, to minimise the likelihood of arguments and/or recriminations.

164. The area of focus at the inquest concerned the lack of systems capable of sharing such information as between the Western Australia Police Force and the Department of Justice.

[105] Exhibit 2, tab 22.

165. Specifically, the Incident Report on the Western Australia Police Force's Incident Management System identified Prisoner AB as the "*offender*" and Mr Buchanan as the related "*witness*" in respect of a criminal damage charge. They were linked together in this manner. This data is confidential and not available to the Department of Justice officers responsible for Mr Buchanan's intake into Hakea Prison, and placement in a specific unit. Therefore, in considering the most appropriate unit placement for Mr Buchanan, no account was able to be taken of this prior connection with Prisoner AB.[106]

166. At the inquest Officer Crudeli confirmed that in her experience, there can be "*an issue*" meaning a problem, as between prisoners, where one prisoner believes that another prisoner has made a statement to police about them. She testified that they would normally put an Alert on the TOMS System if they thought there was any chance there would be such an issue. She explained that in the case of such an Alert the prisoners would be segregated, they would not be in the same unit, and they would not come into contact with one another.[107]

167. In the case of Mr Buchanan and Prisoner AB, however, Officer Crudeli testified that they (meaning the prison guards) knew nothing of the prior altercation in the community as between Mr Buchanan and Prisoner AB.[108]

168. At the request of the court, the Divisional Acting Superintendent of the Coronial Inquest Coordination Division of the Western Australia Police Force, Pauline Grant (Superintendent Grant), reported on processes for information sharing with the Department of Justice.[109]

169. Superintendent Grant informed the court of a Memorandum of Understanding between the Western Australia Police Force and the Department of Justice with regards to intelligence sharing. She reported that the Department of Justice's Intelligence Services have full access to the Western Australia Police Force's Incident Management System.[110]

[106] Exhibit 2, tab 19.
[107] ts 81.
[108] ts 80 to 81.
[109] Exhibit 1, tab 46.
[110] Ibid.

170. However, with respect to the intake of a sentenced or remand prisoner it appears that the Department of Justice's process for managing prisoner safety is to encourage prisoners to self-nominate persons who may be a threat to them while in prison.[111]

171. Detective Sergeant Robert Cox (Detective Cox), then of the Homicide Squad, prepared a report for the coroner and he gave evidence at the inquest. He confirmed that the naming of a person as a "*witness*" on that database does not mean they have voluntarily given a witness statement. It means they have observed something or been present when something happened (as was the case with Mr Buchanan).[112]

172. At the inquest Detective Cox referred to his review of the matter and noted the potential for "*animosity*" between Mr Buchanan and Prisoner AB, because Mr Buchanan was a witness in Prisoner AB's offence. However, on his analysis Detective Cox did not consider there was anything "*deeper*" regarding that potential animosity. Nor was he specifically aware of the nature of any animosity.[113]

173. Detective Cox informed the inquest that, hypothetically, a police officer who is aware of animosity as between prisoners may make a report about it, that may become available to the Department of Justice. In his experience it is not uncommon for people who are charged with offences to have animosity towards each other.[114]

174. At the inquest Superintendent Hughes considered the information linking Prisoner AB as offender, and Mr Buchanan as witness, on the Western Australia Police Force's Incident Management System. He considered the merits of a computer system that would "*self-populate*" or that would "*somehow talk to a system that generates the custody checklist that we receive from police …. Because then, straightaway, we would go, well, he's in unit 9. We would have put an alert on not to go to unit 9 or unit 10*."[115]

[111] Ibid.
[112] Exhibit 1, tab 1; ts 12 to 14.
[113] ts 10; ts 14.
[114] ts 15.
[115] ts 112.

175. Superintendent Hughes described this in positive terms, and informed the court that he has seen a system like that in another jurisdiction where he previously worked, overseas.[116]

176. Further comment on this aspect is made later in this finding under the heading: *Recommendations – Information sharing*.

### *Spinal precautions*

177. Given that Mr Buchanan had sustained a head injury, questions arose at the inquest as to:

a) whether he should have been left onsite pending the arrival of the Hakea Prison medical team to assess him, instead of being carried out of the rain and placed in undercover area of the recreation compound; and

b) whether there should have been access to a stretcher for the medical team to convey him from the undercover area to the Hakea Prison medical centre, instead of that conveyance being effected in a wheelchair.

178. On these points I was assisted by the evidence of the independent expert, consultant neurosurgeon Dr Honeybul.

179. Turning first to getting Mr Buchanan out of the rain, Superintendent Hughes confirmed that prison officers have first aid training, and it is noted that on each occasion that they moved him, they placed him in the recovery position. At the inquest Dr Honeybul acknowledged that there is a lot of emphasis placed upon potential for cervical spine injury but opined that it was reasonable for the prison officers to lift Mr Buchanan and move him out of the rain in the way that they did.[117]

180. Dr Honeybul explained that in the ideal world you would have full spinal precautions with a neck brace and complete spinal protection, but in a lot of cases this is not possible. The main concern for Mr Buchanan was the head injury. On the question of whether moving Mr Buchanan in this way

[116] Ibid.
[117] ts 107; ts 125.

had any impact on the ultimate outcome for him, Dr Honeybul's response was: "*absolutely not*." He explained that in the context of an intracranial bleed, this manner of moving the patient will not affect the bleed.[118]

181. In connection with moving Mr Buchanan to get him out of the rain, Dr Gunson testified that it would have been best practice if the prison officers could have waited until the medical team arrived so they could perform a full primary survey of Mr Buchanan and identified what injuries he may have experienced. She explained that they had rigid collars that can be applied to immobilise the cervical spine until further assessment could be made. However, if he were conscious and moving all limbs, she felt it was reasonable and understandable to get him out of the rain.[119]

182. Turning next to placing Mr Buchanan into a wheelchair (as opposed to using a stretcher) to convey him to Hakea Prison Medical Centre, Dr Honeybul expressed no concerns about the use of the wheelchair. He had regard to the evidence about Mr Buchanan's condition at that point: "…. *given the fact that he seemed to be recovering – the fact that he was starting to verbalise – starting to move. That's more consistent with a post-concussive type injury rather than the actual injury he developed subsequently*."[120]

183. In her report to the coroner, Dr Gunson opined that Mr Buchanan's transfer from the recreation compound to the Hakea Prison Medical Centre by wheelchair, as opposed to the internal ambulance with the stretcher, did not alter the outcome for Mr Buchanan and resulted in a faster arrival, given the respective locations. If he had been transported by stretcher, in the internal ambulance or other vehicle, the pathway for that vehicle to reach the destination would have been longer.[121]

184. At the inquest Dr Gunson further explained that, hypothetically, transportation by means of the stretcher, on such a vehicle, would have taken longer due to the number of security gates they would have needed to traverse (as opposed to taking the shorter route with the wheelchair over the pathways straight to the Hakea Prison Medical Centre).[122]

[118] ts 125.
[119] ts 147 to 148.
[120] ts 126.
[121] Exhibit 2, tab 20.
[122] ts 146 to 147.

185. Dr Gunson had regard to the evidence about Mr Buchanan's condition at this point, and testified that in her view, it would have been reasonable to suppose that he did not have a major cervical spinal injury. It appeared he was improving after the assault. She had no criticism about the use of the wheelchair. She posited that at this stage the medical team were unsure as to whether an ambulance would be required and therefore: "…. *it would have been reasonable to move him to the health centre for observation*."[123]

186. I am satisfied that in the circumstances of Mr Buchanan's injury, lifting him to get him out of the rain and then conveying him to the Hakea Prison Medical Centre by wheelchair did not impact adversely on his intracranial bleed.

187. However, that could not have been known at the material time. He might have had a cervical spinal injury given the nature of his backwards fall onto a hard surface. A lesson to take from this inquest is for the Department of Justice to ensure training in this area and availability of appropriate response equipment (including a neck brace). Further comment is made later in this finding under the heading: *Improvements – Checklist: emergency bag and response equipment*.

### *Time taken to call an ambulance*

188. In her report to the coroner Dr Gunson noted the delay in calling an ambulance, given that the assault occurred at 9.20 am and the ambulance was called at 10.52 am, a time lapse of approximately one and a half hours.[124]

189. The time taken to call an ambulance is inextricably connected with the quality of the medical assessment of Mr Buchanan's injury at Hakea Prison Medical Centre, the quality of his monitoring, and the clarity of internal procedures concerning the calling for an ambulance.

190. I have considered whether there was a missed opportunity to call for an ambulance:

[123] ts 149.
[124] Exhibit 1, tab 13; Exhibit 2, tab 20.

a) Following the Prison Doctor's assessment at approximately 9.51 am; and

b) Following the Prison Doctor's assessment at approximately 10.24 am.[125]

191. On these points I was assisted by the evidence of the independent expert, consultant neurosurgeon Dr Honeybul.

192. In his report to the coroner Dr Honeybul reviewed the medical records and provided a response to the question of whether, in his opinion, there was a delay in calling for an ambulance (and if so whether that delay was reasonable). Dr Honeybul reported as follows:

> "*He was mobilising unaided and whilst unsteady this may have been merely a post concussive type condition and it is highly unlikely that one could clinically diagnose a large acute subdural with potential for acute deterioration. That said, the timeline in terms of delay in calling the ambulance was minimal and I think the health care provided at Hakea prison managed the clinical situation appropriately.*"[126]

193. At the inquest Dr Honeybul's evidence was that, with the benefit of hindsight, an ambulance should have been called at an earlier stage, and I accept that. However, he testified that he commonly sees instances of a fall with a head strike, followed by a slow return to consciousness. His experience is that people can recover completely and that it is not necessarily appropriate to perform a CT scan straight after a fall with a head strike.[127]

194. Dr Honeybul was confident that it is appropriate to observe a patient in such a case, without medical scans, in order to establish whether there is an underlying injury. In such a case, observations are taken to ascertain whether the patient deteriorates (in which case an ambulance is required) or progresses towards a gradual return to normal consciousness.[128]

[125] Exhibit 1, tab 44; Exhibit 2, tab 20.
[126] Exhibit 1, tab 11.
[127] ts 127.
[128] ts 127 to 128.

195. On his review of the medical records, Dr Honeybul noted that Mr Buchanan deteriorated in the hours after the head strike, which meant that the bleed was ongoing. At the inquest Dr Honeybul had regard to the symptoms Mr Buchanan initially displayed at Hakea Prison Medical Centre and opined that at that stage, on the available information, he would have considered it to be: "*more post concussive than not*."[129]

196. It is now known that Mr Buchanan kept deteriorating at the Hakea Prison Medical Centre. By the time the CT scan was taken at Fiona Stanley Hospital, it was clear that Mr Buchanan had a very severe injury with significant swelling of the brain. By this stage in Dr Honeybul's opinion, Mr Buchanan would not have been able to speak, and was unlikely to have been able to move.[130]

197. At the inquest Dr Honeybul was asked, essentially, for his views on what a reasonable management plan for Mr Buchanan would have been, based upon his presentation to Hakea Prison Medical Centre. The Prison Doctor first reviewed him at approximately 9.51 am. Dr Honeybul would not expect a doctor, who is not a consultant neurosurgeon, to have suspected that ongoing bleeding was an issue. Dr Honeybul gave an indication of what he, hypothetically, would have said if his advice had been sought at the early stages of Mr Buchanan's presentation:

> "*If I had been given that information over the phone, I would say, 'Just see how he gets on for the next half an hour. If he doesn't continue to improve, then, we need to think again.' But, I wouldn't be saying someone who's talking, is a bit agitated, who has had a head strike – my first thought would not be a large acute subdural with intra – with bleeding within the brain itself and a significant midline shift. I would not be thinking that at all*."[131]

198. In Dr Honeybul's opinion, at this stage a plan for observations to be taken every 15 minutes was reasonable.[132]

199. The Prison Doctor next reviewed Mr Buchanan at approximately 10.24 am and recorded that he was going to the toilet, that his gait during the walk

[129] Ibid.
[130] Ibid.
[131] ts 129.
[132] Ibid.

was very uncoordinated, that he was pale and sweaty, he did not know what day of the week it was (but knew he was at Hakea Prison), he had increasing headaches, he was agitated, he remained nauseated and vomiting, he moved all four limbs, he had no facial asymmetry and his speech was clear.[133]

200. On being asked what he, hypothetically, would have considered at this stage, regarding Mr Buchanan's condition, on the basis of these developments, Dr Honeybul responded:

> "*I will be getting slightly suspicious but I would still be – more in keeping with a post-concussive type recovery rather than a large acute subdural hematoma with blood within the brain itself*."[134]

201. In Dr Honeybul's opinion, by this stage it would be perfectly reasonable to commence a plan to potentially transfer Mr Buchanan to an emergency department, due to there being a suspicion that something is going on (though as indicated he would not expect that it was a large acute subdural haematoma).[135]

202. After the 10.24 am review by the Prison Doctor a further 28 Minutes (approximately) passed before an ambulance was called. Dr Honeybul was asked to comment on the proposition, essentially, that Mr Buchanan should have been considered a high risk and referred to a hospital immediately after his fall, having regard to his mechanism of injury (being punched and falling backwards from a standing height, experiencing loss of consciousness immediately afterwards, being 65 years old and in light of his past history of a significant head injury).[136]

203. Dr Honeybul did not agree with that proposition, expanding on his views as follows:

> "*I've seen an awful lot of head injuries where the patient is knocked unconscious and then, he comes into hospital for observation and he completely recovers with much less evidence of injury on the brain scan. So much less. So it's unusual for someone to have this mechanism when they have such a large*

[133] Exhibit 1, tab 44.
[134] ts 130.
[135] Ibid.
[136] ts 131.

> *hematoma and be talking afterwards. It's far more likely that this sort of injury was sustained, the patient was rendered unconscious and did not recover*."[137]

204. In Dr Honeybul's view, the fact that Mr Buchanan was able to verbalise (albeit being a bit confused) was not consistent with the injury that was eventually seen. He considered it an unusual case. Overall, Dr Honeybul felt it would be very difficult to criticise the clinical staff of the Hakea Prison Medical Centre. He would not expect them, in that acute setting, to recognise that Mr Buchanan was going to develop a large acute subdural haematoma with significant midline shift.[138]

205. I accept Dr Honeybul's opinions and have no criticism of the quality of Mr Buchanan's medical treatment and care at Hakea Prison.

206. Dr Gunson took a different approach. She is not a neurosurgeon, and she has assessed the incident from the perspective of the Department of Justice's duty of care towards persons who may be more vulnerable than the general population. For example, a prisoner in such a position cannot make their own decision to go to hospital, and she takes account of that in recognising that she may act: "*a lot more cautiously than might be recommended by a specialist in the community*."[139]

207. I have received Dr Gunson's evidence within the context of, and expectation of, the Department of Justice's commitment to continual improvement.

208. Upon Dr Gunson's own review of this matter, she noted that the rationale given to her for not calling an ambulance earlier was that a period of observation was required to fully assess Mr Buchanan's injury. In her opinion earlier treatment would have been very likely to have offered Mr Buchanan the best opportunity, but she noted that such comments are made in retrospect.[140]

[137] ts 131.
[138] ts 133.
[139] ts 158.
[140] Exhibit 2, tab 20.

209. In her report to the coroner, Dr Gunson opined that referral to the hospital would have been immediately indicated having regard to the following factors, which made it a high-risk injury:

    a) The mechanism of injury (being struck and falling backwards from his standing height);

    b) The immediate period of loss of consciousness;

    c) His age; and

    d) His past history of significant head injury (which was readily visible on his medical records).[141]

210. Dr Gunson reported to the coroner that in her view, the Hakea Prison Medical Centre staff did not recognise the signs of severe injury and the call for the ambulance appears to have been triggered by the rise in blood pressure, whereas there were multiple prior signs of a severe head injury to indicate that transfer to the hospital was required much earlier (altered and asymmetrical gait, irritability, anxiety, confusion, nausea and a 10 out of 10 headache, even allowing for some uncertainty regarding the timing of these signs).[142]

211. Dr Gunson reached these views at an earlier stage and prior to hearing all of the evidence at the inquest.

212. At the inquest Dr Gunson acknowledged the possibility that Mr Buchanan initially appeared to be much better, and that he may have had quite a rapid deterioration. While she described herself as: "*more of a conservative or a worrier*" and would have been more likely to have called an ambulance sooner, at the inquest on the further information available to her, Dr Gunson opined that the medical team at Hakea Prison were managing the head injury: "*appropriately*."[143]

213. Within the context of the time taken to call an ambulance, in her report to the coroner Dr Gunson had regard to a potential failure to communicate and

[141] Ibid.
[142] Ibid.
[143] Exhibit 2, tab 20; ts 149 to 151.

ensure that an ambulance was called, and she raised the following matters for consideration:

a) It is possible that some clinical staff thought an ambulance had already been called, given that a 10.08 am a nursing entry in the medical notes indicated that the Prison Doctor had advised hospital transfer, with the entry under the patient's plan being "*for transfer to ED*";

b) The Prison Doctor's 10.24 am medical note documents his plan for referral to the Emergency Department.[144]

214. As is known, the ambulance was called for at 10.52 am.[145]

215. Dr Gunson was asked for her opinion about the time taken to call an ambulance at the inquest, within the context of further information available to her and she testified as follows: "*In hindsight it sounded reasonable that they waited to see if his – if he was going to continue to improve, and then when he did deteriorate they did call an ambulance. So that was reasonable*."[146]

216. I am satisfied that there was room for improvement in the Department of Justice's procedures at Hakea Prison for calling an ambulance at the material time. Further comment is made later in this finding under the heading: *Improvements – Training*.

***Survivability***

217. In his report to the coroner, Dr Honeybul expressed his opinion regarding Mr Buchanan's survivability. The inquiry on the point of survivability is important to understand whether earlier treatment would have improved Mr Buchanan's prospects of survival.

218. On the question of the expected outcome for Mr Buchanan having regard to his injury, Dr Honeybul opined that, taking account of Mr Buchanan's CT scan, the degree of brain swelling, the degree of bleeding within the

[144] Exhibit 2, tab 20.
[145] Exhibit 1, tab 13.
[146] ts 150.

brain substance, and his age, there was: "…. *a very high chance of not recovering*."[147]

219. On the question of survivability if, hypothetically, there had been earlier medical intervention, Dr Honeybul's opinion was that that was unlikely:

> "*I do not think earlier surgical intervention would have changed the overall outcome. This was a severe traumatic brain injury and I think the likelihood of him surviving even he had had surgical decompression a couple of hours earlier would have been unlikely*."[148]

220. Dr Honeybul is very well versed in the outcomes for patients undergoing decompressive craniectomy. In the case of Mr Buchanan, whilst there was no evidence of the prospect of survival being wholly absent, Dr Honeybul opined that the prospect was very small. I accept that opinion.[149]

221. Dr Gunson reported that earlier treatment would likely have afforded Mr Buchanan the best opportunity. That would apply generally to injuries of this type. I am satisfied that earlier treatment is of greater benefit to the patient. Whilst it is unlikely to have changed the outcome, ideally Mr Buchanan should have had that earlier treatment.

## IMPROVEMENTS

### *Re-instatement of Royal Prerogative of Mercy staff*

222. At the inquest Ms Toni Palmer (Ms Palmer) the Department of Justice's Senior Review Officer, Performance Assurance and Risk, informed the court that when Mr Buchanan was classed as a Stage 4 Terminally Ill Prisoner (when he went into the ICU) a Briefing Note should have been prepared, in compliance with the departmental policies, in relation to the consideration, for Mr Buchanan, of the Royal Prerogative of Mercy.[150]

223. Ms Palmer explained that this did not occur because at the material time, there was no person in such a role (for preparing the Briefing Note). This

[147] ts 135.
[148] Exhibit 1, tab 11; ts 141.
[149] ts 141.
[150] ts 164 to 165.

failure was subsequently rectified. The relevant staff position that generates the Briefing Notes about the exercise of the Royal Prerogative of Mercy has been reinstated. Through its lawyers the SSO, the Department of Justice informs the court that the issue is unlikely to reoccur.[151]

224. At the inquest Ms Palmer was asked about the practical effect of the exercise of the Royal Prerogative of Mercy on a Stage 4 terminally ill prisoner, but having regard to her own experience she was unaware of any having been granted.[152]

225. Whilst, through its lawyers the SSO, the Department of Justice submits that the failure to prepare the Briefing Note made little difference to Mr Buchanan's circumstances, the staff position should have been instated and the policy should have been complied with.

### *Training*

226. Through its lawyer the SSO, the Department of Justice accepts that there is no documentary evidence that an assessment of spinal precautions was undertaken prior to moving Mr Buchanan out of the rain and of transporting him via wheelchair to the Hakea Prison Medical Centre.

227. As outlined earlier in this finding, it is now known that Mr Buchanan did not have a spinal injury. I have accepted Dr Honeybul's opinion that the manner in which Mr Buchanan was moved on each occasion did not impact adversely upon the development of his intracranial bleed. Nonetheless at the time Mr Buchanan was so moved, this could not have been known.

228. Through its lawyer the SSO, the Department of Justice informs the court of the improvements in its emergency management procedures for prison officers and health staff as follows:

a) It is a prerequisite for all new prison officers and a requirement for all senior prison officers, that they attend training related to the mobilisation and movement of a patient in circumstances such as a head or spinal injury; it is delivered as part of their First Aid qualification training; and

[151] Ibid.
[152] ts 165.

b) The Department of Justice's Health Services has conducted advanced life support training for nurses to assist in the management of all emergency presentations, including for head and/or spinal injury; doctors are encouraged to access various courses in advanced training in management of acute medical emergencies.[153]

229. As outlined earlier in this finding, I have accepted Dr Honeybul's evidence that with the benefit of hindsight, an ambulance should have been called at an earlier stage. For the reasons outlined earlier in this finding, Dr Honeybul was not critical of Mr Buchanan's medical care and treatment at Hakea Prison, and I have also accepted that opinion.

230. Nonetheless there was room for improvement regarding the calling of an ambulance, particularly in the area concerning communication of the requirement for an ambulance. Through its lawyer the SSO, the Department of Justice informs the court that the Medical Emergency and Resuscitation of Patient procedure requires nursing staff to complete a Patient Transfer to Emergency Department form in the event of a prisoner needing to be transferred to hospital. This form is located within the prisoner's Electronic Health Online (EcHO) medical records and accessible to the clinicians treating the prisoner.

231. There is also a requirement to complete a written template that documents key events in a resuscitation or response to acute injury, which includes important times such as when the ambulance was called. The aim is for the prompt to ensure that actions are completed, or otherwise alert staff if they are still outstanding.[154]

### *Checklist: emergency bag and response equipment*

232. At the inquest Dr Gunson explained that upon her subsequent inquiry after Mr Buchanan's death, she had initially been informed that the stretcher was not "*working*" at the material time.[155]

[153] Exhibit 2, tab 20.
[154] Ibid.
[155] ts 145 to 146.

233. Given the circumstances attending Mr Buchanan's death, an investigation into the availability and suitability of the stretcher and an intercampus ambulance is outside the scope of the inquest. The evidence was that the transportation to Hakea Prison Medical Centre by wheelchair did not adversely impact upon his medical condition.

234. However, there has been some improvement in the area of availability of equipment. Through its lawyer the SSO, the Department of Justice informs the court that their procedure concerning the Checking of Emergency Bags, Emergency Equipment and Defibrillator has been updated. There is now a checklist for use across all prison sites, and the usage is being monitored.

## RECOMMENDATIONS

### *Training in management of aggressive behaviour*

235. It was concerning, at the inquest, to hear of the degree to which management of aggressive prisoner behaviour is at the judgement of individual prison officers and that they are frequently exercising this judgement on the spot depending on what they have just seen and heard, and the surrounding circumstances. It is a difficult job performed in a volatile environment.

236. This recommendation is aimed at supporting prison officers in the exercise of this judgement by further training, to ensure consistency of approach and promote a safer environment for prisoners.

237. Whilst the Department of Justice, through its lawyer the SSO, submits that this proposed recommendation is unnecessary, it has nonetheless provided assistance with the wording, in order to support its workability:

***Recommendation No. 1***

**That the Department of Justice develop clear and consistent training for prison officers in respect of the management of aggressive behaviour by prisoners, including how to respond to physical altercations between prisoners in accordance with governing legislation, policies, and procedure.**

***CCTV and Body Worn Cameras***

238. At the inquest Superintendent Hughes suggested that the usage of CCTV cameras may improve the monitoring of prisoners in areas such as the recreation compound (including the blind spots) and the ovals, at Hakea Prison. He posited that this could not only improve monitoring, but also address potential deficits where prison officers are not available for duty, and prisoner services get cancelled.[156]

239. Superintendent Hughes referred to former endeavours on his part to seek the funding for Hakea Prison's CCTV coverage.[157]

240. In Superintendent Hughes' experience, the introduction of monitoring, such as by CCTV and/or body worn camera would be an additional control to help minimise risk.[158]

241. After the inquest and following further inquiry Superintendent Hughes reported that the prison walls at the end of the grilles (that create the blind spots), form part of the building structure. He informed the court that without major capital works, these cannot be changed. In his opinion, rather than erecting a barrier to inhibit access to the blind spots, the better option is full CCTV coverage so the blind spot can be better monitored. I accept that opinion.[159]

242. Through its lawyer the SSO, the Department of Justice informs the court that it remains supportive of enhancing CCTV capability at Hakea Prison, complemented by body worn cameras, to ensure all incidents are recorded and for reviews of incidents to occur. Further, that it has submitted a business case for assessment and funding in respect of this.

243. I therefore make the following recommendation, that is also in support of the recommendation made by the Office of the Inspector of Custodial Services in connection with Hakea Prison:[160]

[156] ts 106 to 107.
[157] Ibid.
[158] ts 111 to 112.
[159] Exhibit 2, tab 22.
[160] Exhibit 2, tab 18; ts 203 to 204.

***Recommendation No.2***

**That the Department of Justice continues to take all necessary and practical steps directed towards investment in body worn cameras and improved CCTV coverage for high-risk areas of Hakea Prison including coverage of recreation areas within Hakea Prison.**

### *Information sharing*

244. At the inquest I heard evidence about the desirability of Alerts if there is a reasonable basis for having a concern about a pre-existing animosity between prisoners. This information could be sourced by the Department of Justice's officers responsible for prisoner intake, if there were to be developments in the information sharing arrangements with the Western Australia Police Force, with appropriate protections in place to address confidentiality requirements and potential security risks.

245. Through its lawyer the SSO, the Western Australia Police Force informs the court that they would welcome the opportunity to increase information sharing with other agencies, including strengthening and expanding existing information sharing practices.

246. Through its lawyer the SSO, the Department of Justice informs the court that it is supportive of the implementation of an integrated information sharing system that allows for information to be shared between agencies. It advises that such implementation would require multi-agency collaboration, significant funding investment and resource allocation. Further, that implementation would include identifying the information to be shared, review of legislative requirements, review of established memorandums of understanding with the various agencies, and privacy issues with sharing witness information.[161]

[161] Exhibit 4

***Recommendation No.3***

**That the Department of Justice and the Western Australia Police Force consult and consider pathways for the implementation of an integrated information sharing system that would allow Offender, Victim and Witness information populated in the Western Australia Police Force Incident Management System to be shared with the Department of Justice for the purpose of flagging any crossover between named Offenders, Victims and/or Witnesses in custody, and contemplated to be housed in the same prison, so that a risk assessment can be undertaken as to appropriate placement.**

## CONCLUSION

247. A death in custody is a serious matter that warrants careful scrutiny by the coroner. When that death in custody occurs by way of an unlawful homicide within a prison setting, it is to be regarded as a catastrophe.

248. A prisoner is a "person held in care", within the meaning of s 3 of the Coroners Act. They are in the care of the State. When it comes to their safety and medical treatment, a prisoner has a limited range of choices that they can independently make. A prisoner cannot unilaterally decide to move themselves to a different, or apparently safer, part of the prison, or a different unit. Nor can they exercise independent choice as to what doctor they consult, within or outside the prison, whether that clinician should be a specialist doctor, whether they should call an ambulance and/or take themselves to hospital.

249. For this reason, the Coroners Act requires the coroner to comment on the quality of a prisoner's supervision, treatment and care, so that the family of the deceased person and the community can be apprised of the conditions under which the deceased person was held, and the rights afforded to them, when they were deprived of their liberty and reliant on the care of the State. Further, so that those responsible for the conditions under which the deceased person was held may reflect upon their actions and consider whether any improvements are warranted, to avoid a death in similar circumstances.

250. In this case, while I have made no specific criticism of the officers involved, nor of the Department of Justice, I have outlined the areas where there is room for improvement and made recommendations in support of these. It is my expectation that these will be carefully considered. An absence of criticism may mean that the minimum standards of acceptability have been met, but if such deaths are to be avoided in the future, there needs to be a commitment to continual improvement in these areas, beyond a mere minimum standard of acceptability. Prisoners are required to serve their sentences, and it is the clear expectation of the community that they not be subjected to violence, much less become the victims of unlawful homicide while serving their sentences.

251. The assault that caused Mr Buchanan's death occurred with a day of him being placed in Unit 10. It might have been avoided if the prior connection with Prisoner AB's prosecution had been known.

252. Mr Buchanan had a loving and supportive family who was awaiting his release from custody and who continue to mourn his loss.

R V C Fogliani
State Coroner

27 February 2024