JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : Sarah Helen Linton, Deputy State Coroner

HEARD : 20 SEPTEMBER 2022

DELIVERED : 13 DECEMBER 2022

FILE NO/S : CORC 101 of 2020

DECEASED : ANDERSON, WILLIAM FREDERICK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr J Tiller assisted the Coroner.
Ms E Langoulant (ALS) on behalf of the family.
Mr E Heywood (SSO) appeared for the Department of Justice.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of **William Frederick ANDERSON** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 20 September 2022, find that the identity of the deceased person was **William Frederick ANDERSON** and that death occurred on 24 December 2020 at Kalgoorlie Regional Hospital, Piccadilly Street, Piccadilly, from intracerebral haemorrhage in the following circumstances:*

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INTRODUCTION

1. William Anderson died on Christmas Eve, 24 December 2020, at Kalgoorlie Regional Hospital. Mr Anderson was serving a prison sentence at the time of his death. Until the day before his death, he had been held at the Eastern Goldfields Regional Prison in South Boulder. Mr Anderson was taken to hospital by ambulance from the prison after collapsing in his cell late in the evening of 23 December 2020. Upon arrival at the hospital in the early hours of 24 December 2020, doctors assessed Mr Anderson and determined that he had suffered an unsurvivable intracerebral haemorrhage (bleeding inside the brain). He was given palliative care and kept comfortable until he died late that evening.

2. As Mr Anderson was a prisoner at the time of his death, he came within the definition of a 'person held in care' under the terms of the *Coroners Act 1996* (WA) and a coronial inquest into his death was, therefore, mandatory.[1]

3. I held an inquest on 20 September 2022. Extensive written material was tendered in relation to the WA Police and Department of Justice's investigations into Mr Anderson's death.[2] It became apparent during the investigations that there was a delay between Mr Anderson's cellmate first notifying the prison officers of Mr Anderson's collapse and the cell being opened. There was also a delay in notifying emergency services that an ambulance was required to attend the prison, as well as a delay in the ambulance leaving the prison to take Mr Anderson to hospital. Additional oral evidence was heard at the inquest in relation to these issues.

BACKGROUND

4. Mr Anderson was born in Meekatharra. He lived with his parents and five siblings in Wiluna and Leonora, where Mr Anderson attended school. He enjoyed playing all sports, particularly football and basketball. After leaving school, Mr Anderson did not undertake any formal employment. He was in a long-term relationship and he had three children with his partner. Following the death of the mother of his children, Mr Anderson started a new relationship and lived with his new partner in Port Hedland. He had three grandchildren, who lived in Wiluna.[3]

5. Mr Anderson had a long history of criminal offending, which began when he was young and increased in seriousness over the years. He had served time in prison for various offences, including many assaults, and he also had a long history of traffic offences. A lot of his driving offences appeared to be alcohol-related and Mr Anderson had admitted to police that he was an alcoholic. Mr Anderson's driver's licence had been cancelled for life many times, the first occasion being on 6 February 1996. However, he continued to be charged and convicted of offences of driving while under the influence of alcohol and without a valid driver's licence over the following years.[4]

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[1] Section 22(1)(a) *Coroners Act*.
[2] Exhibit 1 and 2.
[3] Exhibit 1, Tab 11.
[4] Exhibit 1, Tab 20; Exhibit 2, Tab 7, p. 2..

6. On 24 August 2020, Mr Anderson was arrested and charged with new offences of driving without a valid driver's licence and while under the influence of alcohol. He was driving in Wiluna at 9.20 am in the morning when pulled over by police and found to have a blood alcohol level of 0.161% and to have never held a driver's licence, as well as having been issued with five life disqualifications. He told police he hadn't expected to be pulled over and admitted he was an alcoholic. Mr Anderson was sentenced in the Wiluna Magistrates Court on 24 November 2020 to a total sentence of 6 months 30 days' imprisonment. Mr Anderson's earliest eligibility date for parole was 8 March 2021.[5] He was approximately one month into serving this term of imprisonment at the Eastern Goldfields Regional Prison (the prison) when he collapsed on 24 December 2020.[6]

MR ANDERSON'S MEDICAL HISTORY

7. Upon his reception at the prison on 24 November 2020, Mr Anderson was identified as a returning offender. During his Reception Intake Assessment completed that day, Mr Anderson advised that he suffered from anxiety, high blood pressure and diabetes and he took regular medications for these health conditions.[7]

8. Mr Anderson underwent a health screen the following day and was clinically assessed. He advised he was currently taking medication for type 2 diabetes, hypertension and asthma and had last seen his GP in the community two weeks earlier. He indicated he was sometimes non-compliant with his medications, although not always. Mr Anderson was charted to continue on the same medications that he had been prescribed in the community, following confirmation from his community GP. Mr Anderson's blood pressure was noted to be slightly raised during the assessment, as was his blood sugar. Otherwise, his vital signs were within normal ranges.[8]

9. Mr Anderson was also noted to be 'Off Country' in his prison orientation on 25 November 2020 and he was referred to the Prison Support Officer for that reason.[9] He had advised in his health review that he had good support from his partner and had no known enemies in prison, and there were no general concerns about his welfare.[10]

10. Due to his elevated reading, Mr Anderson's blood pressure was reviewed again on 26 November 2020, and it was planned for him to have further daily blood pressure reviews until he started back on his medication, which occurred on 27 November 2020 after the community GP had provided the relevant information and a prison doctor had issued new prescriptions.[11]

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[5] Exhibit 2, Tab 1, p. 4 and Tab 7, p. 2.
[6] Exhibit 1, Tab 20.
[7] Exhibit 2, Tab 4.
[8] Exhibit 1, Tab 24.
[9] Exhibit 2, Tab 6.
[10] Exhibit 1, Tab 24.
[11] Exhibit 1, Tab 24.

11. On 2 December 2020, Mr Anderson was commenced on a routine Diabetes Care Plan, with reviews planned for every three to six months. His blood pressure was noted to be normal at this time. It was noted in his diet plan that he should not be given tomato due to his history of gout. A referral was also written for an optometrist review.[12]

12. On 8 December 2020, Mr Anderson was seen at the health centre with swelling of his knees after eating tomato. He was given an antihistamine and paracetamol and a medical certificate was issued in relation to his allergy to tomato and aluminium foil. Mr Anderson's blood pressure was noted to be slightly raised again at that time.[13]

13. Mr Anderson saw a nurse again a week later on 15 December 2020 for a routine blood glucose check. He asked about arranging left eye cataract surgery and complained of some pain in his toes, some of which appeared swollen. It was noted he had pain medications he could take as needed and Mr Anderson was booked in for a review with a medical officer on 31 December 2020.[14]

14. In the meantime, on 20 December 2020 Mr Anderson had an education session with a nurse in relation to his leg pain. She encouraged him to exercise. On 21 December 2020, Mr Anderson was given approval to self-administer his own medications while in prison. A medical review was still planned with a doctor for the end of the month, but unfortunately Mr Anderson died before it could occur.[15]

MR ANDERSON'S COLLAPSE

15. During the evening of 23 December 2020, Mr Anderson was in his cell with a fellow prisoner, who I will refer to by his first name, Jason, to protect his privacy. Jason was Mr Anderson's allocated cell-mate. They were relatives by marriage and Jason called Mr Anderson 'Uncle' as a mark of respect for their family connection. Jason had known Mr Anderson for approximately 20 years at the time of these events and they had a supportive relationship.[16]

16. Jason later reported that Mr Anderson had appeared in good spirits in the week leading up to his death. He had been talking to other family members who were in the same prison and also talking to his wife on the telephone regularly.[17]

17. On the evening of 23 December 2020, Mr Anderson and Jason were in their cell together. Mr Anderson seemed happy and healthy. Jason asked whether Mr Anderson had taken his tablets, which Jason understood he took for his knee, and he said he had missed the tablet the day before but had taken it that day. They started telling each other stories and talking until Jason became tired and said he was going

[12] Exhibit 1, Tab 24.
[13] Exhibit 1, Tab 24.
[14] Exhibit 1, Tab 24.
[15] Exhibit 1, Tab 24.
[16] Exhibit 1, Tab 10.
[17] Exhibit 1, Tab 10.

to sleep. Jason turned over and faced the wall and fell asleep. He believes he had slept for a little while when he was woken by Mr Anderson getting up.[18]

18. Jason understood Mr Anderson was getting up to take a tablet for the pain in his knee. He asked Jason to hand him a bottle of water to wash down the tablet, which Jason did. Jason was still in bed at this stage and he then saw Mr Anderson walk the short distance from his bed to the toilet. Mr Anderson sat down on the toilet and was also holding on to the sink basin, which was next to the toilet. Mr Anderson then stood up quickly and suddenly. Jason felt instantly that something was wrong, so he rushed from his bed to the toilet. As Jason reached the toilet, Mr Anderson started to fall. Fortunately, Jason managed to catch him before he hit the ground.[19]

19. Jason assisted Mr Anderson to a nearby chair and sat him down. Jason then called for help via the cell intercom. Mr Anderson then asked Jason to help him to his bed, so Jason assisted him to move from the chair to the bed. Mr Anderson laid down and Jason got him some water and put it in his hand before wiping Mr Anderson's face. Jason said he began praying loudly at that time for his uncle to get better. However, Mr Anderson deteriorated and started throwing up blood and vomiting up his stomach contents. In the midst of these events, Mr Anderson started asking Jason to look after his family. Jason then recalled that the prison officers and ambulance officers entered the cell and took Mr Anderson away on a stretcher to the hospital. Jason remained in his cell. He was understandably very upset and described himself crying. He wanted to clean his cell, given Mr Anderson had vomited, so a prison officer helped him to get a bucket and mop and waited while he cleaned up the cell, before he was locked in again to go to sleep.[20] It does not seem there was any counselling or support offered to Jason at that time. Officer Milner acknowledged that the prison staff were very grateful to Jason for his help on the night and he regretted the fact that more was not done to support Jason and thank him for his help. He indicated that in future incidents he intended to be more conscious of the need to ensure the welfare of other prisoner involved, like Jason, after a medical emergency event.[21]

OPENING THE CELL

20. Prison Cell Call records show that Jason actually made two emergency cell calls. The first cell call was made at 10.20 pm and the second at 10.21 pm.[22]

21. Prison Officer Robyn Sauni, who was a relatively junior prison officer at the time, was sitting in the block office completing paperwork when she received the call from cell B1, which housed Mr Anderson and Jason. Officer Sauni pressed the button to connect with the cell and spoke to Jason. Officer Sauni asked him to state his emergency.[23] Officer Sauni made a note on the Cell Call Form that Jason stated Mr Anderson had a headache, had fallen over and blacked out and needed help.

[18] Exhibit 1, Tab 10.
[19] Exhibit 1, Tab 10.
[20] Exhibit 1, Tab 10.
[21] T 53 – 54.
[22] Exhibit 1, Tab 19.
[23] Exhibit 1, Tab 8.

Officer Sauni radioed to her colleague, Prison Officer Gary Campbell, after the first call to notify him of the situation and ask him to meet her at the cell.[24]

22. Before Officer Sauni could go to the cell, Mr Anderson's cellmate Jason made the second call. The second call is recorded on the Cell Call Form as Jason saying "Miss please get a doctor. Please. He had blacked out. Hurry miss, get a nurse."[25] In her statement, Officer Sauni recalled he was asking her to come quickly.

23. The cell calls are recorded, so I also had the opportunity to listen to the calls myself. Officer Sauni can be heard quite clearly, but the other voice is hard to hear. In the first call, Jason asks for a nurse and when he's told there are no nurses on site, he asks for 'the boss' to come quickly. The second call is brief and Jason indicates Mr Anderson has blacked out. It's fair to say Officer Sauni was a little brusque in her response during the second call, but she made it clear that this was because she couldn't come to the cell if she had to keep answering his calls. She then went straight to his cell, as he had requested, so I don't make any criticism of her conduct.

24. Officer Sauni had looked through the hatch on arrival and seen Mr Anderson was being propped up on the bed by Jason. He was conscious and talking, but his speech was slurred and the left side of his face was dropped down, so she knew immediately that something was wrong.[26]

25. After receiving the call over the radio, Officer Campbell informed master control he was leaving unit 1, made sure the unit was secure and then went straight to unit 2. He met Officer Sauni at Cell B1 at approximately 10.29 pm. They opened the observation hatch in the door and spoke to Jason and Mr Anderson through the hatch. They did not open the cell door at this time as they did not have the keys, which were in the possession of the Night Officer in Charge, Prison Officer Hori Milner.[27]

26. There are emergency keys available, but it did not seem to them at that stage that this was the kind of emergency that would warrant that action. The emergency keys would customarily be accessed when a prisoner is found hanging or there is a fire, or some other emergency where time is clearly of the essence. To access the keys, a prison officer has to leave the area and go to where the 'smash box' is located in a particular area, smash the box and get the keys and then return, so it also still takes time, and in this case would not have been much quicker than calling Officer Milner to attend. Mr Anderson was conscious and breathing, so it did not appear to either officer to be so urgent that this alternative step was required.[28]

27. Instead, Officer Campbell simply observed Mr Anderson through the hatch. He could see Mr Anderson was on a bed, leaning against his cell-mate, Jason. Officer Campbell could see that Mr Anderson was conscious, but he appeared to have some left-sided weakness and was not moving very well. He also recalled that he could see Mr Anderson was touching his head, which suggested it was sore. Officer Campbell

[24] Exhibit 1, Tab 19.
[25] Exhibit 1, Tab 19.
[26] Exhibit 1, Tab 8.
[27] T 10 - 11; Exhibit 1, Tab 9.
[28] T 11, 23, 27, 29.

hadn't met Mr Anderson before that night, but it was still very apparent that he was very unwell. Officer Campbell is a qualified nurse and has worked for most of his professional life in health, so although he was not working in that capacity on the night, he was able to bring his considerable training and experience to the task and make the assessment that this was more than a person suffering from a headache and he might be having a coronary event or stroke.[29]

28. Officer Campbell recalled that Jason was very anxious and distressed, so Officer Campbell tried to calmly reassure Jason while trying to find out what was wrong. Office Sauni opened the duties hatch on the door and Officer Campbell spoke to Jason and Mr Campbell through the hatch and indicated they would call for medical help. Officer Campbell also tried to get some history of what had occurred, but found it difficult as Mr Anderson was not very forthcoming and Jason was too distressed and anxious to provide much information. Officer Sauni also noted that Mr Anderson appeared to be speaking in his own language to Jason, rather than English, which made it impossible to understand what he was saying.[30]

29. The two officers decided to get the Night Officer in Charge (NOIC) to attend so they could breach the cell and find out more about what was wrong with Mr Anderson and make sure he was comfortable. They left the area to get help. Officer Sauni called the Night Officer in Charge, Officer Milner, over the radio at approximately 10.39 pm. She advised they had an emergency and requested he attend. They also checked the prison's computer system, TOMS, for any medical notes on Mr Anderson (separate to his medical notes which were on a different system not accessible to non-health staff). They only found a note that Mr Anderson was a diabetic. The two officers then returned to the cell to wait for Mr Milner's arrival.[31]

30. Officer Milner and another prison officer, Vijay Metkar, used a buggy to get there quickly and arrived at the cell at approximately 10.43 pm.[32] The other prison officers had continued to provide reassurance to Mr Anderson and Jason while they waited.

31. Officers Sauni and Campbell did not call to request an ambulance attend the prison at that stage. Officer Campbell gave evidence that he was not aware at that time that he had authority to do so, but he also said that it did not occur to him to do so at the time, as he was waiting for direction from Officer Milner, his senior officer.[33] In addition, he only had a radio on him, so the call could not be made from the cell.

32. When Officer Milner arrived, he spoke to the two other prison officers. They told Officer Milner that Mr Anderson looked very unwell and Officer Campbell said that he thought Mr Anderson may have had a stroke and appeared to have blood coming out of his mouth. They all agreed that the cell should be opened so they could observe Mr Anderson more closely.[34] Before doing so, they conducted a risk assessment to make sure that it was safe to do so, consistent with their training.

[29] T 10, 13; Exhibit 1, Tab 9; Exhibit 2, Tab 13.
[30] T 11; Exhibit 1, Tab 8.
[31] Exhibit 1, Tab 8; Exhibit 2, Tab 9.1.
[32] Exhibit 1, Tab 9.1.
[33] T 15.
[34] T 13; Exhibit 2, Tab 9.1.

Officer Milner noted that Mr Anderson was still moving around in the cell that time, as was Jason, so they needed to make sure they understood the situation before opening the cell.[35]

33. A code red medical wasn't called, as Officer Milner believed they had sufficient staff there (four prison officers) to deal with the situation, and they only required three to be present to unlock the cell.[36]

34. The cell was unlocked at approximately 10.45 pm. Officer's Campbell and Milner took a closer look at Mr Anderson. Relying on his own training and knowledge, Officer Campbell had ruled out epilepsy as the likely cause of Mr Anderson's symptoms, and after having a closer look at Mr Anderson, he suspected that Mr Anderson had suffered some sort of cerebral haemorrhage or stroke (as was later proved to be correct). He communicated his belief to Officer Milner, who having no particular health experience himself, relied upon Officer Campbell's greater training and experience.[37]

CALL TO SJA

35. Given there were no doctors or nurses at the prison as it was the evening, Officer Milner followed protocol and contacted the on-call prison doctor, who was Dr Ahmari that evening. He had to return to the front desk to get the doctor's phone number, as he didn't have it on him.[38] Officer Milner found it difficult to answer all of the doctor's questions, so he returned to the unit with the phone and asked Officer Campbell to speak to the doctor, given his nursing qualifications better equipped him to provide the relevant clinical information. Officer Campbell spoke to Dr Ahmari and relayed his observations of what he had seen and his suspicion as to what was wrong with Mr Anderson. The doctor concurred that it appeared that Mr Anderson may have suffered a stroke and that an ambulance was required.[39]

36. Officer Campbell conveyed this information to Officer Milner, who then made a radio call to another prison officer at master control to ask them to call for an ambulance to attend the prison. Officer Milner then made his way up to the reception area to start the paperwork necessary for Mr Anderson's transfer to hospital. When he arrived, the prison officer who had rung SJA said that it might take up to an hour for an ambulance to arrive. However, in the end it was much quicker than that.[40]

37. Officer Campbell, Officer Sauni and Officer Metkar remained at the cell with another prison officer. Mr Anderson was still talking at this stage, and asked for food and a drink of Coke, but given his diabetes they couldn't give him Coke. At some stage Mr Anderson coughed up a lot of dark, red blood. They assisted Mr Anderson to change his t-shirt, as it was covered in blood, He then wanted to lie down, but they

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[35] T 27, 35.
[36] T 36.
[37] T 14.
[38] T 36.
[39] T 15.
[40] T 15, 24, 36 38.

kept him propped up, with Jason holding his head to support him. Officer Campbell then returned and they all waited together for the ambulance officers to arrive.[41]

38. While waiting, Mr Anderson vomited a large amount of thick, brown material. Around this time the ambulance officers arrived, and the prison officers assisted them to remove Mr Anderson's vomit covered shirt and then supported him while the ambulance officers went to get a stretcher.[42]

39. SJA received the first call to attend the prison at 11.05 pm. The ambulance left the depot at 11.06 pm and arrived at the prison at 11.20 pm, approximately one hour after Jason had first raised the alarm. The ambulance officers were escorted into the prison and arrived at the cell a few minutes later.[43]

40. When the ambulance officers reached the cell, the prison officers stepped out of the way to allow them access to Mr Anderson. The ambulance officers were aware that Mr Anderson had possibly had a stroke based on the information provided to the dispatcher. Mr Anderson was incomprehensible (although noting a possible language barrier) and unable to stand when they first assessed him, and was being propped up by Jason. Mr Anderson was covered in vomit and it appeared he had been vomiting blood. He was given a GCS of 12 out of 15, which improved to 14 slightly after. There was noted to be limited paperwork and limited information available about his health status, with Mr Anderson not in a position to provide any information himself. Jason was able to say that Mr Anderson had woken up and started looking for medication for a headache, then used the bathroom and suddenly started vomiting.[44]

41. The prison officers assisted the ambulance staff to put Mr Anderson onto a stretcher and he was then transferred to the ambulance, where he was provided with reassurance and continuous monitoring. The ambulance officers made their way to the gatehouse sallyport so they could depart. Officer Milner was advised they were ready to leave at 11.40 pm. He advised Officer Metkar that he and Officer Campbell would accompany Mr Anderson to prison for security purposes.[45]

AMBULANCE DEPARTS

42. Officer Campbell was asked by Officer Milner to escort Mr Anderson to the hospital in the ambulance, and Officer Metkar was to follow with another prison officer. Officer Campbell got into the back of the ambulance with Mr Anderson and one of the ambulance officers and made sure Mr Anderson was secure for the journey. The doors were closed, so Officer Campbell was not sure what was happening outside, but he was aware there was a delay of around 15 to 20 minutes before the ambulance departed. He gave evidence he was a little surprised by the delay, but was not informed as to the reason for it.[46]

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[41] Exhibit 1, Tab 8.
[42] Exhibit 1, Tab 8.
[43] Exhibit 1, Tab 13; Exhibit 2, Tab 9.1.
[44] Exhibit 1, Tab 13.
[45] Exhibit 1, Tab 13.
[46] T 16 - 17.

43. There is evidence that Officer Milner had asked the ambulance officers if it was urgent or if they could wait for the relevant escort paperwork to be completed. They apparently told him that they could wait. He noted they did not seem stressed or hurried, which reassured them that it was not urgent. If they had said it was too urgent for any delay, then Officer Milner said he would have let them go and advised the Superintendent of his decision. As it was, they seemed happy to wait until he finished the paperwork and got everything ready for Mr Anderson to go to hospital, including applying his restraints.[47]

44. The ambulance had remained stationary for approximately 20 minutes at the sallyport doors within the prison confines before Officer Milner completed the paperwork and the ambulance was let through the sallyport. The ambulance then waited outside the prison for another approximately 7 minutes before the additional escorting officers in the escort vehicle arrived and were then able to follow the ambulance to the hospital.[48]

45. Mr Anderson was restrained and accompanied by Officer Campbell in the ambulance to the hospital. They alerted the hospital Emergency Department to their imminent arrival.[49]

46. The ambulance left the prison at 12.16 am on 24 December 2020. It was noted that Mr Anderson was transported to hospital without issue whilst being continuously monitored, although his blood pressure had remained elevated during the journey.[50]

TREATMENT AT KALGOORLIE HOSPITAL

47. The ambulance arrived at the Kalgoorlie Hospital Emergency Department at 12.25 am. They had rung ahead to alert the hospital staff of their impending arrival. Mr Anderson was triaged as a Category 3 patient (to be seen within 30 minutes) at 12.36 am. The triage sheet noted a history of haematemesis (vomiting blood) and headache. A nursing entry at 1.00 am recorded a history of haematemesis and a fall, followed by left-sided weakness.[51]

48. Whilst in the ED, Mr Anderson's condition deteriorated. His blood pressure increased, he was not opening his eyes and he had no movement on his left side. He was diagnosed with a likely stroke and a head CT scan was performed at approximately 1.40 am, which showed a very large acute cerebral haemorrhage with surrounding brain oedema, mass effect and midline shift. There was also a small acute haemorrhage of the left basal ganglia. A carotid angiogram showed atherosclerotic disease of the internal carotid arteries but no significant arterial stenosis or aneurysm. [52]

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[47] T 32, 40; Exhibit 2, Tab 16 [32], [37].
[48] Exhibit 2, Tab 1, DIC Review report, p. 12.
[49] Exhibit 1, Tab 13.
[50] Exhibit 1, Tab 13.
[51] Exhibit 1, Tab 14 and Tab 16.
[52] Exhibit 1, Tab 15 and Tab 16.

49. Mr Anderson's case was discussed with the neurosurgeons at Royal Perth Hospital, who advised Mr Anderson was not suitable for surgical treatment and he should be managed palliatively. After discussion with his family, Mr Anderson was commenced on palliative care.

50. The medical notes indicate that hospital staff were given permission to speak to Mr Anderson's next of kin at 5.30 am and the Prison Superintendent was aware that Mr Anderson probably wouldn't survive and was to be palliated, with his death likely within the next 48 hours.[53] Hospital staff tried unsuccessfully to contact family members before asking the prison for assistance. Prison staff eventually managed to speak to Mr Anderson's partner, who lived in Port Hedland, at 7.30 am and she was given Mr Anderson's treating doctor's details. At 7.50 am Mr Anderson's sister rang the prison and advised that she would contact the only family member living in Kalgoorlie and ask them to go to the hospital. Mr Anderson had some family members visit him in the early evening. They left at about 6.45 pm and Mr Anderson died at 9.00 pm that evening.[54]

51. The WA Police were notified of the death and a coronial investigation commenced. Police officers attended the hospital and took photographs and arranged for Mr Anderson to be formally identified by fingerprints.[55]

CAUSE AND MANNER OF DEATH

52. A post mortem was performed by Forensic Pathologists Dr White and Dr Junckerstorff on 18 January 2021. The examination showed a middle aged Aboriginal man with signs of medical intervention. The brain was swollen and the heart was enlarged with thickening and scarring of the heart muscle and narrowing of the coronary arteries. Cirrhosis of the liver was also observed.[56]

53. Microscopy showed areas of scarring (fibrosis) of the heart, coronary artery atherosclerosis, bronchopneumonia and acute bronchitis and chronic changes in the kidney that may be seen with hypertension and diabetes.[57]

54. A post mortem CT scan showed intracranial haemorrhage with midline shift in the right side of the brain and a smaller area of bleeding in the left side of the brain. Macroscopic (naked eye) specialist neuropathology examination of the brain showed bleeding in the right side of the brain (large non-traumatic lobar recent haemorrhage) with cerebral swelling and pressure-effect on the brain and a small recent bleed (recent non-traumatic haemorrhage) in the deep grey matter.[58]

55. Biochemical testing showed impaired long-term control of the blood glucose level.[59]

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[53] Exhibit 1, Tab 16 and Tab 17.
[54] Exhibit 1, Tab 16 and Tab 9; Exhibit 2, Tab 9.6..
[55] Exhibit 1, Tab 2 and Tab 16.
[56] Exhibit 1, Tab 6.1.
[57] Exhibit 1, Tab 6.1.
[58] Exhibit 1, Tab 6.1 and Tab 21.
[59] Exhibit 1, Tab 6.1.

56. Toxicology showed medications consistent with Mr Anderson's documented medical care.[60]

57. At the conclusion of all investigations, the forensic pathologists formed the opinion the cause of death was intracerebral haemorrhage.

58. An intracerebral haemorrhage (or haemorrhagic stroke) is bleeding into the brain by the rupture of a blood vessel. Hypertension (high blood pressure) is a common cause, and the forensic pathologists who conducted the post mortem examination noted Mr Anderson had a history of high blood pressure. Other risk factors include cigarette smoking, heavy alcohol use, blood thinners, diabetes mellitus and chronic liver disease, all of which Mr Anderson also had. Symptoms of a haemorrhagic stroke typically include headache, nausea, vomiting and progression to altered consciousness, which matches the description of Mr Anderson's symptoms on the night.[61]

59. The forensic pathologists expressed the opinion that Mr Anderson's death occurred as a result of natural causes, and I accept and adopt their opinion as to both the cause and manner of death.[62]

DID THE DELAY IMPACT ON THE DEATH?

60. The exact timing of events varies a little between witnesses, but based upon the various accounts and documents, the suggested timeline between the first cell call and Mr Anderson reaching hospital was approximately two hours, as set out below:

- 10.20 pm – collapse reported to Officer Sauni by Jason
- 10.21 pm – Jason made second cell call
- 10.29 pm – Officer Sauni and Officer Milner arrive at the cell
- 10.39 pm – Radio call to Officer Milner (NOIC) to attend
- 10.43 pm – Officer Milner and Officer Metkar arrive at cell.
- 10.45 pm – cell door opened.
- 10.55 pm – on-call doctor contacted
- 11.05 pm – ambulance contacted
- 11.20 pm – ambulance arrived at prison
- 11.22 pm – ambulance officers arrived at cell
- 11.40 pm – ambulance left the unit
- 12.16 am – ambulance departed prison
- 12.25 am – ambulance arrived at hospital.

61. Dr Sasha Rogers, a Consultant Neurologist at Sir Charles Gairdner Hospital, reviewed Mr Anderson's post-mortem imaging and clinical case reports, and provided a brief report indicating that in his opinion, a delay of around 40 minutes between Mr Anderson's collapse in his prison cell and his transport in an ambulance

[60] Exhibit 1, Tab 7.
[61] Exhibit 1, Tab 6.1.
[62] Exhibit 1, Tab 6.1.

to Kalgoorlie Hospital "would have made no difference to the outcome of Mr Anderson."[63] Dr Rogers explained his reasoning was due to the size of the haemorrhagic stroke and his pre-existing co-morbidities, which required Mr Anderson to be taking the blood thinners Aspirin and Clopidogrel that would have significantly increased the chances of a poor outcome.[64] I note the timeframe given to Dr Rogers is less than the actual delay that occurred when taking into account the chronology from the initial call from the cell to the ambulance arriving at hospital, but I understand there is no difference if the time delay was, in fact, greater.

62. Professor Stephen Dunjey, the WACHS ED Clinical Director, also reviewed the relevant documents relating to Mr Anderson's ED admission at Kalgoorlie Hospital on 24 December 2020. Professor Dunjey expressed the opinion that Mr Anderson suffered a huge intracerebral haemorrhage (a bleed into the brain tissue) in this case, which was almost certainly due to his long standing high blood pressure. Professor Dunjey noted that it is "a terrible disease, which usually results either in death or lifelong disability."[65] Some factors known to predict a bad outcome include, amongst other things, the age of the patient, the presence of heart disease, conscious state on arrival, size of the bleed, ventricular extension (bleeding into fluid spaces in the brain), ventricular effacement (compression of the fluid spaces). Professor Dunjey noted that Mr Anderson had many of the predictors of death, including some evidence of heart disease seen at autopsy, decreased consciousness, extension of the bleed in his ventricles and signs of compression of his brain. However, the biggest factor was likely the enormous size of the bleed, and the fact that he had an additional bleed into his brain stem, which worsens an already terrible prognosis.[66] Therefore, Professor Dunjey expressed the opinion that due to his catastrophic brain bleed, even if Mr Anderson had been transported straight to hospital, his outcome would not have changed. Professor Dunjey noted that whilst the "delay to Mr Anderson receiving medical care is extremely regrettable"[67] it was not a contributor to his death.

63. It was noted by the Department's Director of Medical Services, Dr Joy Rowland, that massive unheralded brain haemorrhages are something that does occur in the community, and even in those cases it is often fatal. Some of these risk factors are very prevalent in the Indigenous population generally in Western Australia, and are also common in many older Western Australians of a non-Indigenous background. In Mr Anderson's case, he had no preceding symptoms to warn of this event, other than his known risk factors, and once it occurred there was nothing realistically that anyone could do to save him, and the same would have been the case even if he was in hospital and able to immediately undergo specialist neurosurgical treatment.[68]

64. I am satisfied that Mr Anderson suffered a catastrophic stroke while in his cell and even with urgent medical treatment, he would not have been saved. Therefore, while

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[63] Exhibit 1, Tab 23.
[64] Exhibit 1, Tab 23.
[65] Exhibit 2, Tab 22.1, p. 2.
[66] Exhibit 2, Tab 22.1.
[67] Exhibit 1, Tab 22.1, p. 12.
[68] T 62 – 63, 92 - 93.

the delay in getting him to hospital was concerning, it did not cause or contribute to his death in any way.

COMMENTS ON CARE, TREATMENT AND SUPERVISION

65. I was satisfied on the evidence that the medical care provided to Mr Anderson on his admission to prison up until the day he collapsed was appropriate and of a high standard. He had a number of known chronic health issues and steps were taken to manage them appropriately, including monitoring his high blood pressure and making sure he was recommenced on the appropriate medication.

66. However, a number of issues arose in this matter in relation to the care and treatment provided to Mr Anderson after his sudden collapse in his cell. There was evidence before me that the delay did not ultimately affect the outcome in this case as it would seem Mr Anderson would not have survived, even with more prompt medical treatment. I do not consider that to be the end of the matter, as the delay in opening the cell and calling for an ambulance to attend meant that Mr Anderson's cell mate was left in the distressing situation of trying to care for a critically ill person on his own. There is also a real concern that if a similar situation occurs, it might actually affect the outcome for a different prisoner, so there is a public health interest in ensuring medical emergencies at night at the prison are managed appropriately. Accordingly, it was important for me to consider what changes have been made since Mr Anderson's death.

Delay in Opening the Cell

67. In addition to the NOIC having keys to open all cells, I am advised that there are 'smash boxes' available in a number of locations at the prison and that staff were notified on 19 February 2020 of their locations and the fact they are there to be used in an emergency situation where staff are "required to preserve life."[69] It is obviously a judgment call in each case, and I understand that in this case the fact that Mr Anderson was conscious and talking did not suggest to the prison officers that it was the kind of urgent situation that required this drastic action. There was also evidence that calling the NOIC to attend did not take much longer and had the benefit of more prison officers being present (both for safety reasons and for discussion about what to do next).[70]

68. It is, however, important that prison officers are reminded that the boxes are there for use in medical emergencies, when necessary. I am sure that this can be done as part of the scenario based training that is mentioned below, so I do not make a specific recommendation in relation to that matter and merely suggest that it be incorporated into the training programme, when it is finalised.

[69] Exhibit 1, Tab 14.
[70] T 21 – 23; Exhibit 3.

Delay in calling SJA

69. Officer Milner described himself as being "dropped in the deep end"[71] on the night, given it was his first shift as the NOIC and so his first time at that prison managing a medical emergency without the usual staff on a day shift. He was trying to understand the situation and then get medical advice to decide what to do. Although he knew Officer Campbell had some medical training, he understood the procedure was to call the on-call prison doctor, so that is what he did. After that time, he became aware that he could have made the decision to send Mr Anderson to hospital by ambulance without calling the doctor, but at the time he thought it was a necessary first step.[72]

70. Information provided in the brief of evidence and from Dr Rowland indicated that the on-call prison doctor is meant to be able to assist as an additional resource as they are able to access the prison health records, which are not available to prison officers, as well as providing their expert medical advice.[73] However, it is a case-by-case basis and dependant on the prisoner's symptoms and presentation, so it is ultimately up to the NOIC whether they access this resource, when the prisoner is conscious and breathing. However, the East Goldfields Regional Prison Local Emergency Management Plan makes it clear that if the patient is in an "unresponsive state of collapse,"[74] then an ambulance should always be called immediately.

71. Officer Milner indicated that when there is now a medical issue at night during his shifts as NOIC, he simply calls for an ambulance rather than calling the on-call doctor first. He indicated that he had done this in the last three incidents that have occurred during one of his night shifts and has found the process is done much more quickly and he is able to get the prisoner to hospital much faster as a result. Officer Milner indicated that they would often have three or four of such incidents each month, although it is sometimes less. Although the symptoms vary, knowing that so many of the prisoners at this prison have significant health issues, he treats them all as critical now.[75] Officer Milner explained that he had generally found it unhelpful to call the prison doctor in these situations as they ask a lot of questions that require the officers to look up their history on TOMS but the information available is limited and makes it difficult to answer.[76]

72. I note Officer Campbell in comparison gave evidence that he found talking to the on-call prison doctor helpful, as he could effectively confer with a colleague.[77] He also acts on occasion in the role of NOIC and obviously sees a benefit in seeking the advice of the in-house doctor in that role. Similarly, the Principal Officer at the Eastern Goldfields Regional Prison, Officer Scott Mortley, gave evidence that he has often found speaking to the on-call doctor has avoided the necessity to send a prisoner to hospital, which is important when considering the limited ambulance service available in Kalgoorlie to the entire population of the local area, as well as

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[71] T 37.
[72] Exhibit 1, Tab 16.
[73] Exhibit 2, Tab 19.
[74] Exhibit 2, Tab 20, p. 122 and Tab 27, p 122.
[75] T 45, 48 - 49.
[76] T 18, 45 46.
[77] T 20.

providing reassurance and guidance in more critical situations when the ambulance is delayed.[78] It would seem that some of the difference comes from Officer Campbell and Officer Mortley having more experience and training with medical situations, which might be rectified for officers like Officer Milner, if the recommendation I make below in relation to senior first aid training is implemented.

73. On 12 August 2022, a Deputy Commissioner's Broadcast was issued to the Superintendents of all prisons to remind all prison officers that, regardless of rank, they have an independent discretion to call a Code Red medical emergency and/or call for an ambulance to attend a prison in a medical emergency. The broadcast was issued in response to a recommendation from a previous coronial inquest.[79] It was clarified at the inquest that the directive is intended to ensure that in a medical emergency, the first responding officer knows they have the option to bypass the usual process of contacting the Officer in Charge or medical staff if the officer deems the situation critical and an ambulance is necessary to preserve life.[80] It was apparent that the witnesses in this inquest were aware of the broadcast and their right to call an ambulance without repercussions in a medical emergency, so it seems to have achieved the desired effect.

74. I do also note that it was apparent from the evidence of the individual officers, as well as Officer Mortley, that it would be an unusual step for a prison officer to take to call an ambulance without involving the NOIC during a night shift. It was noted that all night staff have radios on their person, which allows for direct communication from anywhere in the prison, so usually a prison officer would speak to the NOIC over the radio and it would be a rare situation where they would call for an ambulance without making that radio contact first. However, it is, and has always been the case, than any prison officer can do so if the urgency of the situations requires it.[81]

Delay in the ambulance departing

75. Officer Milner gave evidence at the inquest that this was the first time he had filled the role of NOIC at the prison, although he had performed a similar role in a previous job in New Zealand. It was, therefore, a challenging experience for him to have a medical emergency occur on this first shift in charge. He assumed he had to fill in all the paperwork before the ambulance could take Mr Anderson away.[82] Officer Milner indicated he would have expected the ambulance officer to say if it was not appropriate to wait and Mr Anderson needed to go to hospital urgently, but they had indicated they were willing to wait. He rushed to get the paperwork done, but it still took some time.[83]

76. After the incident, Officer Milner learnt that he could have let the ambulance leave (if it was urgent) and then completed the paperwork afterwards. He gave evidence

[78] T 67.
[79] *Inquest into the death of Ashley Lane* [2022] WACOR 30, Recommendation 5; Exhibit 2, Tab 30.
[80] Exhibit 2, Tab 31.
[81] T 60; Exhibit 3.
[82] T 33.
[83] T 42; Exhibit 2, Tab 1, DIC Review Report, p. 12.

that if he had known that at the time, he would have sent the ambulance with Mr Anderson straight to the hospital without asking them to wait.[84]

77. Officer Milner was candid in his statement that as a result of this critical incident, he has learnt a lot of things and taken it upon himself to learn better ways to try and manage such situations. He noted that at the time, there were a lot of inexperienced staff on the shift so there was little opportunity to delegate tasks, but he has learnt that some things (such as the paperwork) can be done later in an emergency. He noted that there is "an enormous amount of responsibility on the NOIC"[85] and he clearly takes his role seriously. There is no specific training course for the role and most of his knowledge has been learnt on the job and from other colleagues performing the same role.[86] It's clear that Officer Milner has developed a lot more experience in the role since this incident, and has applied what he learnt from the sad event of Mr Anderson's death as part of his learning and development. There was evidence that, following this incident, Officer Milner was moved to the Senior Officer Reception role to support him in learning some of the other components of the Officer in Charge role, and he is now fully competent in organising escorts with all of the necessary paperwork.[87]

78. In addition, during the Department's internal review of Mr Anderson's death in custody, it was identified that whilst the East Goldfields Regional Prison Local Emergency Management Plan addressed actions to be taken for the rapid entry of an ambulance into the prison during a medical emergency, the plan did not address the process for its subsequent rapid exit where necessary to transport a prisoner to hospital. On this occasion, the ambulance took approximately 34 minutes to depart from the prison due to waiting for the completion of transfer paperwork and for escorting officers to collect the escort vehicle to follow the ambulance. The Director General of the Department of Justice, Dr Tomison, indicated to the State Coroner that following the identification of this issue in the review, the local Emergency Management Plan would be updated to include a section that "will ensure the rapid exit of the ambulance and ensure staff are available to conduct escort requirements promptly."[88] Ms Toni Palmer, a Senior Review Officer from the Department, gave evidence that she understands the change has been implemented to ensure that staff are instructed to, in effect, prepare for a rapid exit of ambulance officers after facilitating their rapid entry.[89]

79. However, my reading of the change to the procedure is that it only refers to ensuring a rapid exist when prison officers are "advised of a life threatening situation by Ambulance medics."[90] The difficulty is that in this case, there was a communication issue between Officer Milner and the ambulance officers as to the urgency of the situation. As we didn't hear evidence from the ambulance officers, it is unclear if they were under the impression they could not leave until the paperwork was done,

[84] T 40.
[85] Exhibit 2, Tab 16 [44].
[86] Exhibit 2, Tab 16.
[87] Exhibit 3.
[88] T 40; Exhibit 2, Tab 1, Letter from Director General to State Coroner, dated 26 July 2022 and DIC Review, p. 15.
[89] T 99.
[90] Exhibit 2, Tab 27, p. 126.

even though the situation was urgent, or if they didn't think it was an urgent situation. The latter seems unlikely, given it was suspected Mr Anderson had suffered a stroke, but I do note the evidence of Officer Milner that they did not offer any resistance when he asked if they could wait. In any event, in my view, the change to the procedure needs to be reworded to ensure that the prison staff apply their own minds, or prompt a discussion with the ambulance officers, regarding the urgency of the situation. Officer Milner suggested the plan should be reworded to emphasise that the preservation of life supersedes the need for completion of paperwork. I agree that this would be a useful addition to the procedure, or some wording to similar effect, as well as ensuring that prison officers ask the right questions.

Recommendation 1

I recommend that the Superintendent of the Eastern Goldfields Regional Prison consider rephrasing the Local Emergency Plan for Medical Emergency – Injury or Illness at p. 126 and p. 129 to ensure that the prison officers in the roles of Senior Officer Gatehouse and Senior Officer – Night Shift, understand that preservation of life is more important than completion of paperwork and that communication with the Ambulance medics to ask them the level of urgency of the case is required, rather than simply expecting the Ambulance Medics to provide that information unprompted.

80. Some changes have also been made to the way escorts can accompany prisoners in an ambulance, with approval given for two prison officers to travel in the ambulance, thus negating the need for an escort vehicle before leaving the prison. This reduces the risk of delay. It is a local workplace practice, rather than a formalised procedure, but a very positive initiative by the local prison and ambulance staff.[91]

24 Hour nursing care

81. Officer Milner commented in his statement that he believes there would be significant benefits to having a 24-hour medical service at the prison, or at least a nurse on the night shift, as there are a high proportion of Aboriginal prisoners with significant health issues and it is often very difficult to ascertain what their healthcare needs are without the assistance of trained health staff.[92] Officer Sauni also supported having a nurse on duty on the night shift.[93]

[91] T 66; Exhibit 3.
[92] Exhibit 2, Tab 16.
[93] Exhibit 2, Tab 10.

82. Officer Campbell's previous training as a registered nurse and a mental health nurse made him well placed to consider what lessons might be learnt in terms of health care in this case. However, as Officer Campbell noted, given the post-mortem showed Mr Anderson's death was a "devastatingly tragic death,"[94] it wouldn't have mattered what they had done on the night as he sadly could not have been saved. Officer Milner suggested that on-site health staff overnight would be helpful in these events and Officer Campbell agreed in principle, but noted from a more practical perspective that issues of cost and ability to hire staff in a less desirable location like Kalgoorlie would make it difficult to implement.

83. Officer Mortley also acknowledged the difficulties recruitment would pose to this proposal, stating "I don't believe it would ever happen"[95] even though he "would love it to, in a perfect world." [96] He noted that they have struggled to recruit a mental health nurse as part of their health team, having tried for the last five years, but they struggle to attract staff to the location and to compete with greater pay from the mines.[97]

84. In the Health Services Summary provided to the Court, the authors suggested that no change in the outcome in this case would have resulted from having health staff, nursing or medical, available overnight to respond to Mr Anderson in his cell.[98] Dr Rowland also gave oral evidence to this effect, noting that "there was no first aid that was going to make a difference to this man"[99] in terms of the outcome. Given the catastrophic nature of his brain haemorrhage, I accept that this is true.

85. However, I note the prison officers were put in a difficult position at the time in trying to assess what was wrong with Mr Anderson, and the process of speaking to an on-call doctor was not of great assistance to Officer Milner, although fortunately Officer Campbell was there and was able to use his own nursing training to good effect. Although having a nurse on site would not have changed the outcome, it might have saved a lot of anxiety for Mr Anderson and Jason as there would have been a nurse there to assist more quickly, as well as for the prison officers.

86. I note that this issue has also been covered in another inquest this year, where a recommendation was made that the Department should conduct a review to consider, in part, whether additional nursing staff should be employed to provide cover at the Eastern Goldfields Regional Prison between the hours of 6.30 pm and 6.30 am.[100] The circumstances of the death were different in that case, involving an issue with a part for a nebuliser (to deliver Ventolin) not being delivered to the deceased by the night shift prison staff, despite being requested to do so by the departing daytime nursing staff, before he suffered a fatal asthma attack. The finding was only delivered in June 2022, so it is very recent and I am told it is still under consideration by the Department with a review to be conducted in the coming months.[101] Therefore, there

[94] T 28.
[95] T 70
[96] T 70
[97] T 70.
[98] Exhibit 1, Tab 24.
[99] T 85.
[100] *Inquest into the death of Ashley Lane* [2022] WACOR 30, Recommendation 1.
[101] T 102.; Submissions filed on behalf of the Department of Justice, filed 21 October 2022, [8].

is no need for me to make a further recommendation to the same effect, although I support the terms of the recommendation already made.

87. Dr Rowland made some comments at the inquest about the practical difficulties that will likely arise in providing night nurses at the prison, both in terms of finding work for them to do for the majority of their shifts and also in terms of hiring suitable staff. However, Dr Rowland also acknowledged in her evidence that often the people providing the information are not well equipped to do so, having performed the roll of on-call doctor herself. She said that often it is very difficult to get a clear picture of what is happening, so the on-call doctor will default to telling the prison officers to send the prisoner to hospital.[102]

88. With that in mind, Dr Rowland suggested that, if a night nurse is not ultimately found to be feasible, an alternative might be to work towards "upskilling officers in basic first aid to get them to a level of what a night nurse could provide on her own and to try to fill in that knowledge gap"[103] that appeared to be an impediment to someone like Officer Milner talking to the on-call doctor. Dr Rowland suggested this might equip prison officers with essential skills such as how to recognise someone who is ill and what does severe illness look like and what does someone who is well look like, along with general observations skills and the language necessary to describe that in a "systematic, logical way."[104] Obviously someone like Officer Campbell already has those essential skills, but Dr Rowland suggested that you do not need a nursing degree to be able to achieve the upskilling necessary to perform this role.[105]

89. The concern I raise about this suggestion flows from Officer Mortley's evidence in relation to the difficulty retaining officers at the East Goldfields Regional Prison. Officer Mortley is the Principal Officer at the prison and has been working there since February 2018, so he was in the role at the time of Mr Anderson's death. Officer Mortley's primary duties include reviewing the prison's policies and procedures, daily operation and staff development, which obviously involves training.[106] He gave evidence that the Eastern Goldfields Regional Prison is 'a training nightmare"[107] as they have a high attrition rate and staff turnover rate. For example, in the year 2020 – 2021 they had a staff turnover of approximately 123% of their staff cohort.[108]

90. Training officers to equip themselves with these skills takes time, and then at this particular prison there is a high likelihood they will then move on, taking that newly acquired skillset with them. Alternatively, hiring a nurse for the night shift means that they will arrive with those skills. Therefore, while I recognise the value of Dr Rowland's comments in relation to Perth-based prisons, it would seem that there may be some practical difficulties with doing so in this particular prison.

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[102] T 89.
[103] T 86.
[104] T 86.
[105] T 86.
[106] Exhibit 3.
[107] T 58.
[108] T 58.

Nevertheless, it is something definitely worth considering, particularly in relation to more senior officers such as Officer Milner, who has shown a willingness to remain in Kalgoorlie and who takes on the role of NOIC, to have that kind of training if it transpires that the prison will choose the preferred option of a qualified nurse on shift overnight. Officer Mortley advised that all prison officers are supposed to have senior first aid training, but at least at the time of the inquest, most of the prison officers at the prison were not current in their senior first aid training.[109]

91. Officer Mortley gave evidence that he understands some of this is related to staff shortages, as it is difficult to set aside two days to train every staff member. However, in circumstances where there are at least currently no night-time nursing staff, it is critical that the staff on those shifts have appropriate high-level first aid training. Therefore, while I accept that it is "a training conundrum,"[110] it needs to be resolved.

92. I was advised in submission filed on behalf of the Department after the inquest that all prison officers are trained in the equivalent of Senior First Aid, now called Provide First Aid (the First Aid Qualification), when they are first employed. However, they are not required to maintain the full qualification thereafter, only the CPR component. Senior Officers apparently must maintain the First Aid Qualification, although I note that on the night of this incident, Officer Milner was the Senior Officer and he was only up to date with his CPR component of the First Aid Qualification. In order to remain current, there is a req-qualification required every three years which is a one day course. It does not seem to me that this is a particularly onerous training obligation in the circumstances, given the importance of that kind of training for staff working in a facility with many prisoners with significant health issues and where they are often going to be the first responder to a medical emergency. Accordingly, I make the recommendation below to ensure that staff are current in their First Aid Qualification.

Recommendation 2

I recommend that the Department of Justice prioritise ensuring that all prison officers at the Eastern Goldfields Regional Prison are current in their First Aid Qualification, with the first priority given to ensuring that all Senior Officers are current as they will generally be required to be involved in making decisions during medical emergencies when no health staff are available.

[109] Exhibit 3.
[110] T 59.

Scenario Training for Medical Emergencies

93. Officer Sauni signed a statement in January 2022 indicating that she believed her previous training had not prepared her sufficiently for the situation she faced on this night, and was keen to be involved in more critical incident based scenarios for medical incidents (rather than the usual violent or security incidents).[111] Officer Milner indicated at the inquest that they have recently begun conducting some situational training of medical emergencies for staff, which includes doing CPR and responding to different levels of emergency.[112]

94. Ms Palmer also gave evidence that, following a recommendation made in a previous inquest this year in relation to the prison conducting bi-monthly scenario based training exercises to enhance the skills of prison officers and nursing staff in responding to medical emergencies within the prison, the prison is currently looking into how to implement that additional training and it is still subject to review but a new emergency training schedule is expected to be implement by 31 March 2023.[113][114] Given this matter is already appropriately in hand, I do not make any further recommendation, but simply indicate my support for the steps that are currently being taken in that regard.

95. I note that some of the suggestions given by Dr Rowland in terms of calling an on-call doctor and providing useful clinical information from the prisoner's bedside could be practiced in this type of training, giving the prison officers more skills and confidence to perform this task in an emergency, and helping them to understand the practical ways this needs to be done (such as having the on-call doctors number easily accessible in the units and taking a mobile phone with them when attending a medical emergency so that there is less of a delay in providing the necessary clinical information).[115]

96. Dr Rowland also noted, as some of the prison officer witnesses raised, that the ambulance services operator will ask many similar questions to the on-call doctors, to assist them in prioritising the nature of the emergency, so it is important that all prison officers are trained to provide the kind of information relevant to assessing the level of urgency.[116]

97. Officer Mortley, who is responsible for the delivery of training to prison officers at the East Goldfields Regional Prison, exhibited a genuine passion for improving their training and making it fit for purpose. He noted that when the prison officers commence work, they have completed various scenario training as part of the certification at the academy, but he has found that there are ways to improve their practical training through utilising actual CCTV footage of previous incidents. This

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[111] Exhibit 1, Tab 10.
[112] T 51 – 52.
[113] *Inquest into the death of Ashley Lane* [2022] WACOR 30, Recommendation 7; Exhibit 3, [13]; Submissions filed on behalf of the Department of Justice, filed 21 October 2022, [41].
[114] Exhibit 3, [13].
[115] T 95 – 97.
[116] T 97.

is currently being done at the prison and Officer Mortley gave evidence that he found the use of real footage "kind of woke them up for the training,"[117] with the recognition that it could be them facing this situation on a different day.

98. Officer Mortley was also very supportive of the same proposal as Dr Rowland in relation to the Night Officer in Charge having access to a departmental mobile telephone for medical emergencies. There are obviously security issues with mobile phones being available in a prison, but Officer Mortley gave evidence that he is aware that other facilities have adopted the practice of issuing a mobile phone to the NOIC, so it obviously can be done. In this particular case, Officer Milner ended up bringing the escort phone down to the unit anyway, so there is no real practical difference, except that if the NOIC had a mobile phone with them at all times, it was suggested "it would increase communication ten-fold."[118]

99. The Department of Justice indicated in submissions filed after the inquest that it supports the implementation of a mobile phone for the Senior Officer (NOIC) at the Eastern Goldfields Regional Prison so that during a medical emergency the on-call doctor and ambulance can be called quickly, and this has been implemented and was in current use as at 21 October 2022. That is a very positive proactive step taken by the Department arising from this inquest and I am pleased not to have to consider any further whether such a recommendation needs to be made.

100. Also in relation to training, I note that there was evidence from Officer Milner and Officer Mortley that there is currently no Department approved training course for senior officers who are transitioning to a supervision-level management-type position in the prison. Officer Milner explained he had learnt how to be a Night Shift OIC from watching others on the job, and it is clear that on the night he performed his first shift, there were some gaps in his knowledge, which he candidly acknowledged. Officer Mortley gave evidence that in the past there had been formalised senior officer training, but it had ceased in 2005.[119] As there is no formal training, Officer Mortley advised that "the Principal Officer group have developed a Senior Officers Handbook to act as an informal self-development guide to assist acting and substantive Senior Officers in their duties,"[120] but it is only an informal guide.

101. It seems obvious that Senior Officers, who are taking responsibility on a night shift on important matters such as how to approach a medical emergency, should be fully trained by the Department to perform those duties. Officer Mortley gave evidence he has put forward a submission through the academy to have an online learning Senior Officer course, so that officers can self-pace their learning, wherever they are based in Western Australia. This seems a very sensible and practical solution to an important training matter.

[117] T 56.
[118] T 61.
[119] T 71, 73.
[120] Exhibit 3, [11].

Recommendation 3

I recommend that the Department of Justice should consider developing a formal online Senior Officer course so that prison officers who aspire to take on a promotion to a more supervisory role within Western Australian prisons, can complete the course at their own pace whilst still learning the practical aspects of the position 'on the job'.

CONCLUSION

102. Sadly, Mr Anderson died while serving a relatively short term of imprisonment for traffic offences on a background of a long history of driving without a licence and while intoxicated. Mr Anderson had a number of chronic health conditions when he came into prison, which were identified and monitored by prison health staff. Steps were made to contact his doctor in the community to make sure that he continued on his regular medications until he could be reviewed by a doctor in the prison. Unfortunately, he died a few weeks after he was imprisoned and before he could have that review.

103. He was known to be at increased risk of a stroke, due to his various health issues including hypertension, and tragically this is what occurred on the night of 23 December 2020. His relative was in the cell with him and he immediately called for help. The prison officers on duty that night immediately attended and tried to assess the situation and work out what was wrong with Mr Anderson. There was some confusion about what steps needed to be taken before an ambulance was called, but one was eventually called and when the ambulance officers arrived, they did their best to make Mr Anderson comfortable while getting ready to take him to hospital. There were further delays in the ambulance leaving, but the expert evidence indicates that this made no difference to the ultimate outcome for Mr Anderson, as he was never going to survive the catastrophic brain haemorrhage he had suffered.

104. However, Mr Anderson's family have understandably suffered significant distress and frustration from hearing about the delays that occurred on the night in getting Mr Anderson to hospital.

105. Officer Campbell commented in his statement that all the decisions being made by the prison officers were "made with the best of intentions"[121] and I agree with that statement, but note that there was a lack of understanding of some of the steps they could take to expedite getting an ambulance to the prison and having Mr Anderson taken to hospital. It is important that lessons are learnt from this case so that when a prisoner suffers a medical emergency at night, they get appropriate medical help as soon as reasonably possible.

[121] Exhibit 1, Tab 13 [16].

106. I was impressed by the sincerity of the prison officers in giving their evidence. Officer Campbell and Officer Milner had both clearly reflected on Mr Anderson's death more than once. They voluntarily expressed their condolences to his family for their loss and seemed open to considering whether they could or should have done things differently and whether there could be any meaningful changes made arising out of his death. Officer Mortley, who plays an important role in training staff at the prison and managing these sorts of emergencies himself, made a number of considered suggestions, many of which have already made their way into practice. Some others are still outstanding, and I have made some recommendations in support of those.

107. I hope that the grief of Mr Anderson's loved ones at his sudden death when he was away from his home and family, is assisted in some small way by knowing that his death has led to some important changes in procedures for other people who are in the same position as him.

S H Linton
Deputy State Coroner
13 December 2022