JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	1 - 2 MAY 2024
DELIVERED	**:**	12 JUNE 2024
FILE NO/S	**:**	CORC 318 of 2019
DECEASED	**:**	EADES, ALF DEON

Legislation:

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

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Ms S Keighery (State Solicitor's Office) appeared for the Department of Justice.

Mr A Crocker (instructed by National Justice Project) appeared for Mr Robert Eades.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Hakea Prison between 1 March 2019 and 11 March 2019. Any such prisoner is to be referred to as "Prisoner [*Initial*]".

Order made by: MAG Jenkin, Coroner (1.05.24)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Alf Deon EADES*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 1 - 2 May 2024, find that the identity of the deceased person was* ***Alf Deon EADES*** *and that death occurred on 11 March 2019 at Royal Perth Hospital, Victoria Square, Perth from head injury complicated by bronchopneumonia, with palliation in the following circumstances:*

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INTRODUCTION

1. Alf Deon Eades (Alf)[1] was a remand prisoner at Hakea Prison (Hakea) when he was brutally assaulted in his cell by a number of other prisoners on 26 February 2019. Alf sustained serious injuries and he died at Royal Perth Hospital (RPH) on 11 March 2019 from head injury complicated by bronchopneumonia.[2,3,4,5,6,7,8]

2. As a remand prisoner at Hakea, Alf was in the custody of the Chief Executive Officer of the Department of Justice (the Department) and was thereby a "*person held in care*". Alf's death was therefore a "*reportable death*" and a coronial inquest is mandatory.[9,10]

3. Where (as here) the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care that the person received.[11] I held an inquest into Alf's death on 1 - 2 May 2024, which was attended by members of Alf's family. The inquest focused on the supervision, treatment and care Alf received in the period leading up to his death, as well as the circumstances of his death.

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

a. Mr William Cahoon, Prison Officer, Hakea (Officer Cahoon);
b. Mr Stephen Gulland, Prison Officer, Hakea (Officer Gulland);
c. Mr Robert Doyle, Prison Officer, Hakea (Officer Doyle);
d. Mr Bruce Williams, former Prison Officer, Hakea (Mr Williams);
e. Mr David Hall, Senior Prison Officer, Hakea (Officer Doyle);
f. Mr Sean Devereux, Acting Superintendent, Hakea (Officer Devereux);
g. Ms Toni Palmer, Senior Review Officer, (Ms Palmer); and
i. Dr Catherine Gunson, Acting Director, Medical Services, (Dr Gunson).

[1] Mr Eades' family requested that he be referred to as "Alf" at the inquest and in this finding. No disrespect is intended.
[2] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (11.03.19)
[3] Exhibit 1, Vol 1, Tab 3, Death in Hospital form - Royal Perth Hospital (11.03.19)
[4] Exhibit 1, Vol 1, Tab 4, P92 Identification of deceased person (11.03.19)
[5] Exhibit 1, Vol 1, Tab 5, P98 - Mortuary Admission Form (11.03.19)
[6] Exhibit 1, Vol 1, Tab 6.1, Supplementary Post Mortem Report (01.10.19)
[7] Exhibit 1, Vol 1, Tabs 7.1 - 7.3, Pathwest Reports - Brain, vertebral column & spinal cord (21.03.19, 26.03.19 & 06.07.19)
[8] Exhibit 1, Vol 1, Tab 8.1, Final toxicology report (29.04.19)
[9] Section 16, *Prisons Act 1981* (WA)
[10] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[11] Section 25(3), *Coroners Act 1996* (WA)

5. As I assess the evidence in this case and consider whether to make any adverse findings, I must be mindful of two key principles. The first is the phenomenon known as hindsight bias which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[12]

6. The other relevant principle with which I must engage is known as the Briginshaw test. This principle is derived from a High Court judgment of the same name, in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[13]

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

8. Later in this finding, I will review cell calls made from Alf's cell on 26 February 2019. I will apply the Briginshaw test to my analysis of the response to these calls by prison officers, and also to the question of whether Alf's death was preventable.

9. Although Alf's death occurred in 2019, the inquest could not be conducted until the Supreme Court of Western Australia had finalised criminal charges against the men who had assaulted Alf. This occurred on 24 November 2021. The inquest could also not be held until after the Western Australian Court of Appeal had dealt with appeals against conviction and sentence by various convicted prisoners, which occurred on 22 December 2022, and 16 May 2023 respectively.[14,15]

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[12] See for example: www.britannica.com/topic/hindsight-bias
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[14] Supreme Court of Western Australia - Transcript of sentencing remarks (24.11.21)
[15] [2022] WASCA 174 & [2023] WASCA 77 and ts 02.05.24 (Palmer), pp189-190

ALF

Background[16,17]

10. Alf was born in Katanning on 18 December 1972, and was 46 years of age when he died on 11 March 2019. Alf was the youngest of 10 siblings, and he experienced what his family described as a "*tumultuous childhood*". Alf had a passion for working on cars, and was employed in the meat works in Katanning before he and his wife married in 1990 or 1991.

11. Alf and his wife had two children, a son (born in 2005) and a daughter (born in 2008). Alf was described by his family as "*a very gentle and loving person*", whose life "*began to drift*" after the death of his wife.

12. Alf was also described as "*a loving and devoted father*". Very moving statements from Alf's brother, and each of Alf's children were read aloud at the inquest. These statements make it clear that Alf was dearly loved and is greatly missed.[18,19]

Overview of Medical Conditions[20]

13. Following Alf's death, the Department conducted a review of the health services he was provided during his incarceration (Health Review). The Health Review describes Alf's medical history as including: asthma, and bipolar affective disorder, with a differential diagnosis of schizoaffective disorder. A summary the Department received from Alf's GP stated that his clinical summary included chronic alcohol abuse, drug abuse, bipolar affective disorder, and schizophrenia.[21]

14. Alf was a heavy smoker of tobacco, and from 2013 when his asthma management was being reviewed, Alf was strongly urged to give up smoking. Alf also had a history of polysubstance use including cannabis and methylamphetamine. Although Alf had a previous history of alcohol misuse, in 2017 he told custodial staff that he "*rarely drank alcohol*".

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[16] Exhibit 1, Vol 1, Tab 9, Alf's Funeral service and eulogy
[17] Exhibit 1, Vol 1, Tab 9, File Note - Det. Sgt R Peters following discussion with Mr R Eades (25.05.22)
[18] Statements - Mr R Eades (Alf's brother), Mr A Eades (Alf's son), and Ms M Eades (Alf's daughter)
[19] ts 02.05.24 (Raaj), pp220-225
[20] Exhibit 1, Vol 1, Tab 53, Health Services summary (15.04.24), pp3-6
[21] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p9

Offending History[22,23]

15. Alf had an extensive criminal history. From 1991 to 2018, he accumulated 212 convictions for offences including: disorderly conduct, common assault, possession of drugs, breaches of bail, criminal damage, and breaches of various orders. In relation to these offences, Alf served several periods of imprisonment, and he also received fines and/or community based, and suspended imprisonment orders.

Circumstances of last incarceration[24,25,26]

16. On 11 January 2019, Alf was arrested by police and charged with disorderly behaviour and common assault. His arrest followed an incident in James Street in Northbridge when Alf was "*acting in an erratic and aggressive manner*" and was attempting to fight members of the public as he yelled obscenities and spat at them.

17. On 31 January 2019, Alf was in a carpark outside Lakers Tavern in Thornlie. Alf was armed with a wooden stake and followed two women around the carpark as he verbally abused them. After being chased away by the father of one of the women (who had been called and asked to come to the scene) Alf entered a nearby fast food outlet. He was still armed with the wooden stake and he went behind the serving counter and started yelling at customers.

18. Police arrived and after arresting Alf, offices took him to the Canning Vale police station, where he continued to act in an erratic and aggressive manner. Alf was refused bail by police, and he appeared in the Perth Magistrates Court on 1 February 2019.

19. Following his appearance in court, Alf was remanded in custody to Hakea. He was scheduled to appear in court again at the Armadale Magistrates Court on 26 March 2019.

[22] Exhibit 1, Vol 1, Tab 37, History for Court - Criminal & Traffic - Alf (1991 - 2018)
[23] Exhibit 1, Vol 1, Tab 45, Sentence Summary Report
[24] Exhibit 1, Vol 1, Tab 2, Homicide Squad Report (03.07.23), p3
[25] Exhibit 1, Vol 1, Tab 38, Statement of Facts (Brief No. 1884728-1, 13.01.19 & Brief Nos. 1890036-1 & 1890036-2, 31.01.19)
[26] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p8

ALF'S MANAGEMENT AT HAKEA

Overview[27]

20. When Alf was received at Hakea on 1 February 2019, he was noted to be "*very abusive and angry*" during a medical reception interview. Although Alf told medical staff he had broken his finger, he initially declined medical intervention. Alf's diagnosis of bipolar affective disorder was noted, and mental health staff (who had interacted with him during previous incarcerations) were advised that Alf was at Hakea.

21. Alf was also interviewed by a reception officer who completed an At Risk Management System (ARMS) assessment to assess Alf's likely risk of self-harm. Alf disclosed he had previously been treated for depression, and that he had seen a mental health professional in the community. Alf also said he would be withdrawing from cannabis and amphetamines, which he disclosed he had been using daily.

22. Alf's responses during the ARMS assessment were entered into an electronic form in the Total Offender Management Solutions (TOMS), the computer system the Department uses to manage prisoners in custody. At the conclusion of the ARMS assessment, the reception officer noted: "*Prisoner was compliant. Has requested to see medic in regards to pain relief, broken finger. No thoughts of (self-harm)*".[28]

23. On 3 February 2019, Alf received treatment for his fractured finger, and he was reviewed by a mental health nurse. Alf reportedly expressed remorse that he had relapsed in relation to his substance abuse and said he was aware of the risks to his health if his drug addiction continued. It was noted that Alf's prescribed medications were: olanzapine, sodium valproate, salbutamol (Ventolin), paracetamol and a zuclopenthixol depot injection.

24. No imminent self-harm risks were identified and when Alf was seen by a Mental Health Alcohol and Other Drugs nurse on 5 February 2019, he reportedly said he was "*better off in prison as he was off the drugs*".

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[27] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), pp8-10
[28] Exhibit 1, Vol 1, Tab 32, At Risk Management Assessment - Reception Intake Assessment (01.02.19), p6

25. Alf was assessed as suitable for a multiple occupant cell, and in accordance with departmental policy, his security rating was listed as "*high*".[29] Alf's cell placement history shows that he was moved between cells and units at Hakea on 13 occasions between 1 - 25 February 2019.[30] However, in a review of the circumstances of Alf's death conducted by the Department (the Review), Ms Palmer noted that:

> The movement reasons for the majority of these cell and unit changes are recorded on (TOMS) as standard cell allocation. Although (it is) not unusual for standard cell allocation transfers to occur, the rationale for the majority of transfers is not clearly evident based on the Cell Placement History Report.[31,32]

26. Records show Alf did not attend a scheduled appointment with a prison psychiatrist on 6 February 2019, and although the appointment was rescheduled for the following week, it was later determined that Alf did not attend the rescheduled appointment either. Whilst at Hakea Alf was compliant with his medication regime, and when seen by a mental health nurse on 21 February 2019, he was assessed as "*mentally stable with no overt psychotic symptoms evident*".[33]

27. On 24 February 2019, Alf was placed in Hakea's Multipurpose Unit (MPU) after he was abusive to staff during a cell call and damaged his TV. On 25 February 2019, Alf was transferred to Unit 9, where he was allocated cell A08, which he initially shared with Prisoner H.[34]

28. During his last incarceration at Hakea, Alf was not charged with any prison offences, although he was the subject of three "*non-critical*" incidents.[35] Alf was the subject of six active alerts on TOMS relating to risks to and from other prisoners, restricted visits, and threats to female staff. Alf received one social, and one official visit and he maintained regular contact with his family using the Prison Telephone System.[36]

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[29] Exhibit 1, Vol 1, Tab 33, Multiple Cell Occupancy - Risk Assessment (01.02.19)
[30] Exhibit 1, Vol 1, Tab 42, Cell Placement History - Offender (01-27.02.19)
[31] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p10
[32] See also: Exhibit 1, Vol 1, Tab 42, Cell Placement History Report
[33] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p10 and ts 02.05.24 (Gunston), pp196-197
[34] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p10 and ts 02.05.24 (Hall), pp127-128
[35] Exhibit 1, Vol 1, Tab 35, Incidents History - Prisoner (01, 23 & 24 February 2019)
[36] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), pp16-17 and ts 02.05.24 (Palmer), pp187-188

Cell call system[37,38]

29. Prisoners have access to a call system in their cells for use in emergencies. Calls made using the call system are usually answered by the control officer, who sits in the control office of the prisoner's unit. At the relevant time, Hakea's Local Order 45 Cell Call Alarms (LO45) provided that the cell call system:

> [I]s a primary method of communication between prison officers and prisoners in (a) cell. The cell call is used by prisoners to urgently contact officers. All cell call alarm activation and communications are recorded.[39]

30. If a prisoner makes a cell call but does not respond when the call is answered, the expectation is that officers will go to the prisoner's cell to investigate. In my view, this is sensible. There are various reasons why a prisoner may be unable to respond after making a cell call, including a medical episode affecting the prisoner's speech, or that the prisoner's cellmate is preventing the prisoner making a response. Given these potential issues, attendance at the cell by a prison officer makes obvious good sense.[40,41]

31. LO45 provides that if a cell call is not answered on the prisoner's wing within 45 seconds, the call will divert to the Gatehouse Control Room. LO45 also states that the prisoner making the cell call should identify themselves when the cell call is answered, and that the officer receiving the cell call is to "*Ascertain the identity of the prisoner(s) and the nature of the emergency*".

32. In practice this is done by the officer who answers the cell call by saying: "*State your name and the nature of your emergency*". However, LO45 makes it clear that even when officers are unable to ascertain the prisoner's identity, "*they must respond regardless*".[42]

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[37] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p11
[38] Exhibit 1, Vol 1, Tab 18.1, Statement - Mr B Williams (01.06.19), paras 27-38
[39] Exhibit 1, Vol 1, Tab 54.7, Local Order 45: Cell Call Alarms (30.05.16), para 1.1
[40] Exhibit 1, Vol 1, Tab 54.7, Local Order 45: Cell Call Alarms (30.05.16), para 1.7
[41] ts 01.05.24 (Cahoon), p49 and ts 02.05.24 (Devereux), p177
[42] Exhibit 1, Vol 1, Tab 54.7, Local Order 45: Cell Call Alarms (30.05.16), paras 1.5, 3.1 & 5.1

33. In a supplementary statement dated 23 May 2024, Officer Pring made the following general observations about the cell call system at Hakea:

> When we receive calls they sound very different to the cell call recordings. What you can hear from the prisoner's cells in the recorded calls is clearer and louder than what officers can hear in the control room. This is often why the officer's voices on the recordings sound so loud.[43]

34. At the inquest, other officers also observed that cell calls can be difficult to hear because of the quality of the system itself, and because of background noise in the control room.[44] In view of these observations, I determined it was appropriate to make a recommendation that the Department examine the call system at Hakea to determine whether it is fit for purpose and further, whether any modifications or enhancements to the system are required.

35. The evidence at the inquest established that prisoners often use the cell call system at Hakea for situations other than emergencies, for example by making requests for routine items.[45] Local Order 45 provides that where a prisoner persists in misusing the cell call system after being warned to stop doing so, they may be the subject of disciplinary action.[46]

36. During a cell call Alf made at 11.57 am on 26 February 2019, in which Alf said he had "*something*" to give the officer and "*It's very important*", Officer Singh warned Alf that the cell call system is "*for medical emergency only*" and that if Alf uses the cell call "*one more time*" he may be charged.[47]

37. As I will explain later in this finding, the officers who answered cell calls from Alf's cell on 26 February 2019 failed, on numerous occasions, to comply with even the most basic policy requirements I have just outlined.

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[43] Exhibit 1, Vol 1, Tab 21.3, Statement - Officer L Pring (23.05.24), para 7
[44] See: ts 02.05.24 (Hall), p167 and ts 02.05.24 (Devereux), pp184-185
[45] See: ts 01.05.24 (Cahoon), p48 and ts 02.05.24 (Devereux), pp177-178
[46] Exhibit 1, Vol 1, Tab 54.7, Local Order 45: Cell Call Alarms (30.05.16), para 3.3
[47] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (11.57 am, 26.02.19), p9

Cell calls - 26 February 2019[48,49]

38. Recordings of the cell calls made from Alf's cell on 26 February 2019 (the Cell Calls) were played during the inquest. At the relevant time, Mr Williams was the control officer on Unit 9, and one of his roles was responding to cell calls. At the inquest, Mr Williams identified himself as the officer who had responded to 19 of the Cell Calls.[50,51,52]

39. At the inquest, Officer Cahoon (who was a lobby officer on Unit 9 at the relevant time) identified himself as the officer who responded to eight of the Cell Calls. Officer Cahoon described his role as a "*lackey*" for the unit, and said he would answer cell calls if the control officer was unavailable.[53,54]

40. However, the officer who responded to the cell call made by Alf at 3.45 pm on 26 February 2019 (the 3.45 pm Cell Call) has not been identified. For reasons I will explain, this is utterly regrettable.[55]

41. In addition to a recording of the Cell Calls, the Court was also provided with a transcript of those calls, the content of which can be summarised as follows:[56,57]

a. *8.44 am*: Mr Williams answers the cell call and Alf asks for his medication. Alf is told he will be called down shortly and the call ends;

b. *9.03 am*: Mr Williams answers the cell call, and when Alf asks for his medication, he is asked why he didn't come to the medication parade. Mr Williams then tells Alf: "*to come to the grille*";

c. *11.14 am*: Mr Williams answers the call and Alf asks to be moved off the wing or he will "*murder some cunt*". Mr Williams says he "*will be there in a minute*", and Alf says: "*go and get fucked*";

[48] Exhibit 1, Vol 1, Tab 44, Cell call Log (26.02.19)
[49] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (8.44 am - 4.36 pm, 26.02.19), pp1-31
[50] Exhibit 1, Vol 1, Tab 18.1, Statement - Mr B Williams (01.06.19), paras 114-115 and ts 01.05.24 (Williams), pp73-74
[51] ts 01.05.21 (Williams), pp76-78, 80-83 & 103-104
[52] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), para 11
[53] Exhibit 1, Vol 1, Tab 15.1, Statement - Officer W Cahoon (15.03.19), paras 4-5 and ts 01.05.24 (Cahoon), pp8-19
[54] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), para 14
[55] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell calls (3.45 pm, 26.02.19), pp1-31
[56] Exhibit 1, Vol 1, Tab 44, Cell call Log (26.02.19)
[57] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (8.44 am - 4.36 pm, 26.02.19), pp1-31

d. *11.24 am*: Mr Williams answers the cell call, and when Alf says he doesn't want to be on the wing, Mr Williams responds: "*I don't want to be here either*";

e. *11.26 am*: when Mr Williams answers the cell call, Alf says: "*the safest place you can take me is crisis care otherwise I'm going to…*". Mr Williams responds: "*No I said what's your name and your medical emergency*", and Alf says: "*You know who it is boss and I want to go to…*" before the call ends;

f. *11.28 am*: when Mr Williams answers the cell call, Alf says: "*If I get hurt in the next three days before I go to court boss, your name is on the list*". Mr Williams asks: "*Are you threatening me*", to which Alf says: "*I'm not threatening you, but I asked you nicely if I can go to crisis care where I'm safe boss*". Mr Williams then says: "*You are not going to crisis care*", and Alf responds: "*Fuck you dog*";

g. *11.41 am*: Officer Cahoon answers the cell call and Alf's cellmate asks for some Panadol for Alf, but is told Alf will not be getting Panadol "*until the medic gets here*". Officer Cahoon also asks the cellmate to tell Alf "*to leave the cell call*";

h. *11.42 am*: Officer Cahoon answers the cell call and Alf's cellmate says he wants to "*go down the back*", and he needs "*protection*". Officer Cahoon responds: "*no you don't*" and "*we will get you down there*";

i. *11.57 am*: Mr Williams answers the call which is then taken by Officer Singh. Alf asks the officer to "*come down to where the button is*" as he has something to give him and "*It's very important*". Officer Singh warns Alf that the cell call system is "*for medical emergency only*" and he may be charged if he uses the cell call "*one more time*";

j. *11.58 am*: Officer Cahoon answers the cell call by saying "*Jason Windows*". When the caller asks for "*Panadol*", Officer Cahoon says: "*I'm sorry we don't do Panadol here. You have to phone a pharmacy for that. We do double-glazing*";

k. *11.59 am*: Officer Cahoon answers the cell call by asking "*how may I direct your call*", and Alf's cellmate says: "*I don't give a fuck you lice headed cunt*". Officer Cahoon responds: "*Do you want takeaway or what*" and "*Do you want fries with that?*". Alf's cellmate then threatens to "*knock out*" Officer Cahoon who responds "*You want to take me out? Why do you want to take me out, I'm married?*". Alf's cellmate repeats his threat, and Officer Cahoon responds: "*Yes, I look forward to it. You have a nice day now. Goodbye*";

l. *12.02 pm*: Officer Cahoon answers the call by saying: "*Hello Alfie, what's up mate?*", and Alf's cellmate responds by making various threats against Officer Cahoon and/or his wife. The cell call concludes with Officer Cahoon saying: "*I'm probably going to go to sleep, because you're going to knock me out, so when you get knocked out, you usually go to sleep. So I will enjoy my sleep. You have - you enjoy sleep together now. Love you. Bye.*";

m. *12.04 pm*: Officer Cahoon answers the cell call in a slow and stilted voice while pretending to be a message answering service. He tells the caller to state their name and medical emergency "*after the tone*", and that their message "*will be forwarded as a text*". There is no response from the cell occupants, and the call ends;

n. *12.06 pm*: Officer Cahoon answers the cell call in the same manner as the cell call at 12.04 pm, and again there is no response from the cell occupants before the call ends;

o. *12.06 pm*: Officer Cahoon answers the cell call and says: "*I can't hear you*", before asking the caller to speak up. There is no response from the cell occupants, and the call ends;

p. *12.07 pm*: Mr Williams answers the cell call in a falsetto voice and says "*Hello, hello. Can I help you? Is anyone there?*". There is no response from the cell occupants, and the call ends;

q. *12.08 pm*: Mr Williams answers the cell call but there is no response from the cell occupants and the call ends;

r. *12.09 pm*: Mr Williams answers the cell call but there is no substantive response from the cell occupants before the call ends;

s. *12.10 pm*: Mr Williams answers the cell call by saying "*What do you want?*", and Alf responds by saying he has been "*king hit*". Mr Williams says: "*I beg your pardon*" and Alf repeats that he has "*just been king hit*", before the call ends;

t. *12.12 pm*: Mr Williams answers the cell call but what he says is indistinct, and there is no response from the cell occupants;

u. *12.13 pm*: Mr Williams answers the cell call and tells Alf to "*speak up*". Alf says: "*I want to kill this motherfucker here*" and "*I'm going to kill this motherfucker here if you not getting me out*" before the cell call ends;

v. *12.14 pm*: Mr Williams answers the cell call but there is no response from the caller before the cell call ends;

w. *3.32 pm*: Mr Williams answers the cell call and Alf asks if he can "*go down and pick up my (indistinct) and shampoo at reception*". Mr Williams says: "*It's not a medical emergency*" and the call ends;

x. *3.45 pm*: An unidentified officer answers the cell call and Alf says that people are calling him a "*kiddie fucker*". The officer responds with "*State your name and your medical emergency*" and Alf says "*It's Eades. You heard what I said*". The officer then says: "*State your name and your medical emergency*" before the call ends;

y. *4.30 pm*: Mr Williams answers the cell call but there is no intelligible response from the cell occupants before the call ends;

z. *4.31 pm*: Mr Williams answers the cell call although what he says is indistinct. There is no response from the cell occupants before the call ends;

aa. *4.32 pm*: Mr Williams answers the cell call but there is no response from the cell occupants before the call ends; and

bb. *4.36 pm*: Mr Williams answers the cell call but Alf's response is indistinct. Mr Williams tells Alf to "*Come to control and we will sort it out. Come to control now and we will sort it out for you Okay*". and Alf responds "*Good*".

EVENTS LEADING TO ALF'S DEATH[58]

Threats during breakfast - 26 February 2019

42. As noted, on 25 February 2019, Alf was moved back to Unit 9 and placed in A Wing in cell A08.[59] His cellmate was Prisoner H who had known Alf for 8 or 9 years, and Prisoner H says that at about 7.15 am on 26 February 2019, Prisoner R and Prisoner S came to cell A08. Prisoner R said he had heard his name mentioned "*in this cell*", and Prisoner S, who was a member of an outlaw motorcycle gang (OMG) said: "*I want to know what the fuck has been going on you two cunts*". Prisoner H says he responded "*Na, nothing like that, we've just been talking about fellas on the outside*".[60]

43. Prisoner H says Prisoner S told him to leave the cell because he wanted "*to have a word with Alfie*", and as Prisoner H did so Prisoner S closed the cell door behind him. Prisoner S then spoke to Alf for a few minutes and when Prisoner H went back into the cell, he says Alf "*looked scared*" and told him: "*It's about how his name got mentioned in our cell*".[61]

44. Sometime prior to 8.30 am, Alf approached the security hatch on Unit 9 and asked Officer Phelan if she had any "*welfare smokes*", which she said she hadn't. Alf returned to the hatch at about 11.05 am as lunch was being served, and was again told that there were no "*welfare smokes*".[62]

45. Prisoner H says because of what Prisoner R had said to them, he and Alf were "*on our toes all day*". Prisoner H says Alf was in the cell for a while before walking up and down asking others for cigarettes. When Prisoner H asked Alf if he was "*alright*", Alf said: "*I can take on all the cunts in here*", to which Prisoner H replied: "*Na, we can't*". Prisoner H says he and Alf remained in their cell until lunch time, and that after collecting his lunch, he (Prisoner H) returned to the cell but found Alf had closed the cell door.[63]

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[58] Exhibit 1, Vol 1, Tab 39, Letter Commissioner, Corrective Services to State Coroner (30.03.19)
[59] Exhibit 1, Vol 1, Tab 30, Plan showing layout of cells at Hakea Prison
[60] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 10 & 24-35
[61] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 36-44
[62] Exhibit 1, Vol 1, Tab 20.1, Statement - Officer T Phelan (20.03.19), paras 21-47
[63] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 45-58

46. At about 10.30 am, Alf spoke to his nephew by phone. During the call, Alf said Prisoner R had "*chipped*" him again, and he didn't want to be on the same wing as him. Alf's nephew suggested Alf stay away from Prisoner R, and Alf replied: "*Yeah, I know. I don't want to be put in the same wing as the cunt. It's alright*". Alf's nephew suggested Alf ask to be moved to a different wing, and Alf replied: "*Yeah, send me, send me over to B-wing over here*".[64,65]

Threats during lunchtime - 26 February 2019

47. Prisoner H says he was sitting outside his cell eating his lunch, when Prisoner R came to a nearby cell and yelled: "*Those two raping dogs in the last cell are going to get fucked over, they're going to get bashed and Alfie is going to get a dog hiding*". Prisoner H says Prisoner S came to the next door cell and looked directly at him before saying: "*And this cunt is going to get a dog hiding*". Prisoner H says he went back into his cell and told Alf: "*This mob are going to get us as soon as we get out*".[66]

48. During the lunchtime lockdown, Prisoner H says he started "*thinking about how are we going to get out of here*" and that Alf was using the cell call system to ask for his medication. Prisoner H says he couldn't use the cell call system to tell officers he feared he and Alf were going to be bashed, as prisoners in adjacent cells would hear. Instead, Prisoner H told Alf to say he was going to bash Prisoner H, in order to get prison officers to come to the cell. Prisoner H's evidence is broadly consistent with the transcripts of the cell calls which I have examined.[67]

49. In his statement, Officer Cahoon says that during the lunchtime lockdown (11.30 am to 12.30 pm), Alf and his cellmate had made numerous cell calls asking for things and that he (Officer Cahoon) went to the cell to speak with them. Officer Cahoon says that when he lifted the viewing hatch on the cell door, Alf was sitting on a chair and Prisoner H was standing next to the door.[68]

[64] Exhibit 1, Vol 1, Tab 13, Transcript of phone call between Alf and his nephew (26.02.19)
[65] Exhibit 1, Vol 1, Tab 29, Statement - Mr C Eades (13.05.19), paras 27-48
[66] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 59-61
[67] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 59-61
[68] Exhibit 1, Vol 1, Tab 15.1, Statement - Officer W Cahoon (15.03.19), paras 7-11 and ts 01.05.24 (Cahoon), pp20-21

50. Prisoner H said he needed to be moved to another cell and Officer Cahoon says he told him "*it's not happening*". Prisoner H then said: "*You better get me out of here or I'm going to bash him*" (meaning Alf) and Officer Cahoon says: "*I told him that we would come to his cell again before unlock to deal with him*", and that Prisoner H accepted what he had been told.[69]

51. At the inquest, Officer Cahoon added that when he went to Alf's cell and lifted the viewing hatch, Prisoner H said in a low voice, words to the effect that he needed to get out of the cell because he was going to be hurt. Officer Cahoon says he then went to speak with Officer Hall (the senior officer on Unit 9 at the time)[70] and relayed what he had just been told. When questioned by Mr Crocker, Officer Cahoon denied it was Alf who had said he needed to be moved to another cell, and instead, said that: "*I was speaking to Prisoner H when I was down there. Alf really had no interaction with me*".[71]

52. Officer Cahoon agreed that when he went to Alf's cell he had intended to speak with Alf, but had only spoken with Prisoner H. Mr Crocker asked Officer Cahoon: "*In retrospect, do you agree that you ought not to have been so easily deflected from your original purpose and that you should have also checked on Alf?*", to which Officer Cahoon replied: "*I should have, sir. I didn't, and I can't change that*".[72]

Cell A08 breached during lunch lockdown

53. In two statements he made to police in 2019, Mr Williams says that during the lunchtime lockdown on 26 February 2019, he recalled telling Officer Hall there had been a number of cell calls from Alf's cell "*with random requests coming through*". Mr Williams also said: "*throughout the day there were numerous calls from Cell A08*", and that "*these were frivolous requests which weren't considered a medical emergency such as asking for tobacco*".[73,74]

[69] Exhibit 1, Vol 1, Tab 15.1, Statement - Officer W Cahoon (15.03.19), paras 11-14
[70] ts 02.05.24 (Hall), p122
[71] ts 01.05.24 (Cahoon), pp20-22 & 31-36 and see also: ts 01.05.24 (Cahoon), p50
[72] ts 01.05.24 (Cahoon), p44
[73] Exhibit 1, Vol 1, Tab 18.1, Statement - Mr B Williams (01.06.19), paras 116-117
[74] Exhibit 1, Vol 1, Tab 18.2, Statement - Mr B Williams (15.03.19), paras 8-9

54. In his statement, Officer Hall says that at about lunchtime, he was advised of a cell call from Prisoner H who had "*activated his Cell Call stating he needed to talk to staff*". Officer Hall says he went to Alf's cell with Officers Gulland and Cahoon, and they "*breached*" the cell, meaning they opened the cell door in order to speak to the occupants. At the inquest, Officer Hall confirmed that he had not been made aware of the frequent cell calls from Alf's cell earlier.[75,76,77,78,79]

55. Prisoner H says that after the cell door was breached, one of the officers said: "*You pair of arseholes, what's going on here*". Prisoner H says Alf then shouted: "*I want my fucking tablets*", and this evidence is partially corroborated by Officer Hall, who at the inquest said "*Alf was animated. He was talking really loud*".[80] Prisoner H says he then said: "*No, it's worse than that, I'm going to bash the fuck out of Alfie, I want out of here*".[81]

56. At the inquest, Officer Gulland said he was asked to accompany Officers Hall and Cahoon to Alf's cell at about 12.25 pm, but was not aware that numerous cell calls had been made by Alf and/or his cellmate.[82] In his 2019 statements to police, Officer Gulland says Prisoner H said he "*was going to belt* (Alf)" and wanted to "*go into protection*".[83,84]

57. Officer Gulland said that the only interaction he had with Prisoner H during the cell breach was when Prisoner H began swearing and shouting and he told him: "*If you keep that sort of language up, you will not be going anywhere*".[85] In his statements, Officer Gulland also says he warned Prisoner H he would not be going anywhere "*with that attitude*", and that Prisoner H then disclosed that he "*believed he was going to be assaulted*".[86,87]

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[75] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 31-33
[76] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 31-32
[77] Exhibit 1, Vol 1, Tab 18.2, Statement - Mr B Williams (15.03.19), paras 13-16
[78] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 53-60 and ts 02.05.24 (Hall), pp123-125 & 129-130
[79] Exhibit 1, Vol 1, Tab 15.1, Statement - Officer W Cahoon (15.03.19), para 18
[80] ts 02.05.24 (Hall), pp131-132
[81] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 87-92
[82] ts 01.05.24 (Gulland), p55
[83] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 34-37
[84] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 33-37
[85] ts 01.05.24 (Gulland), p56
[86] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 34-36
[87] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 36-37

58. Prisoner H says that after he pointed at the senior officer (Officer Hall) and said he would tell him "*what is going on*", he was taken to the Wing office. Prisoner H then asserts he told the officers "*three or four times 'Alfie and I are going to be killed, we need to get out of here'*" before he (Prisoner H) was placed in handcuffs and transferred to the Crisis Care Unit.[88,89,90,91]

59. At the inquest, Officer Hall confirmed that on his way to Alf's cell, his impression was that he was responding to an altercation between Alf and Prisoner H. When he arrived at the cell, Officer Hall says he focussed on Prisoner H and did not speak with Alf because: "*(Prisoner H) was the one that pushed the cell call. He was the one that wanted to get our attention. That was my impression*". Officer Hall also said that when he discovered there was no altercation between Alf and his cellmate, he focussed on Prisoner H "*because he was trying to get my attention*".[92]

60. In his statement, Officer Hall says he removed Prisoner H from his cell and took him to the A/B Wing office, where he spoke with him in the presence of Officer Cahoon and Officer Gulland. Prisoner H was "*visibly shaking and appeared fearful*", and told Officer Hall that: "*Prisoners in the unit found out he was in prison for offences of a sexual nature, and that he felt threatened within the unit*".[93]

61. Officer Hall says he checked Prisoner H's profile on TOMS and confirmed that Prisoner H had been incarcerated for an offence relating to sexual assault. Officer Hall then offered Prisoner H placement in another unit which was declined, and then called "*Operations*" to arrange for Prisoner H to be placed in the Crisis Care Unit pending "*protection placement*".[94] At the inquest, Officer Hall denied that during his conversation with Prisoner H in the Wing office, Prisoner H had said "*three or four times Alfie and I are going to get killed. We need to get out of here*".[95]

[88] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 92-96
[89] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), para 38
[90] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 38
[91] ts 02.05.24 (Hall), pp132-133
[92] ts 02.05.24 (Hall), pp133 & 146-147
[93] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 75-77 and ts 02.05.24 (Hall), p134
[94] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 78-81 and ts 02.05.24 (Hall), pp134-135
[95] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 92-96

62. Instead, Officer Hall gave the following account of his conversation with Prisoner H:

> He (Prisoner H) did say, "*I'm worried about Alf*", and I said: "*What are you worried about?*", and he said - and I remember this clearly, he said: "*I'm worried that they're going to mistake him - Alf for me and they might bash him*". And I told him - I said, "*Everyone knows Alf*". I said: "*He has even got family down the wing*". And that's - and that's what was said.[96]

63. At the inquest, Officer Cahoon was asked whether he had heard Prisoner H tell Officer Hall in the Wing office that he (Prisoner H) and Alf needed to be moved off the wing or they would be killed, and Officer Cahoon variously replied: "*I don't recall*" and "*I never heard those words. I'm not saying they weren't said, but I never heard those words getting said*".[97]

64. At the inquest, Officer Gulland was asked about Prisoner H's conversation with Officer Hall, and he (Officer Gulland) said "*I don't recall being part of that*". Officer Gulland also said that he had not been in the Wing office when the statements asserted by Prisoner H were said to have been made.[98] At the inquest, Officer Hall said if he had heard Prisoner H say "*Alfie and I are going to get killed. We need to get out of here*",[99] then after he had removed Prisoner H from the unit, he would have then taken Alf out of his cell and interviewed him in the Wing office. If Alf's concerns had been deemed genuine, then he would have been moved off the Wing.[100]

65. On the basis of the available evidence, I have found it difficult to accept Prisoner H's recollection that he expressed safety concerns for both himself and Alf when interviewed by Officer Hall. At the relevant time, Prisoner H was described as "*visibly shaking and appeared fearful*"[101], and it would be entirely understandable if his recollection of his discussion with Officer Hall was faulty.

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[96] ts 02.05.24 (Hall), p137 and see also: ts 02.05.24 (Hall), pp147-148
[97] ts 01.05.24 (Cahoon), pp23-24 & 27
[98] ts 01.05.24 (Gulland), p58
[99] Exhibit 1, Vol 1, Tab 24.1, Statement - Prisoner H (28.03.19), paras 92-96
[100] ts 02.05.24 (Hall), pp137-140 & 142
[101] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), para 77

66. Other than his concern that Alf would be mistaken for him and bashed, none of the officers recall Prisoner H making any reference to safety concerns relating to Alf. Given that Alf had been moved off Unit 9 on several occasions during his last incarceration at Hakea, if Prisoner H had expressed his concerns in the manner he recalls, there seems to be no reason why Alf would not have been spoken to and transferred if his concerns were found to be genuine.

67. Either way, what is abundantly clear is that after Prisoner H was spoken to in Cell A08 and then in the Wing office, the officers' focus shifted solely to Prisoner H. Alf's situation was not further considered or assessed, and in my view, this represents a missed opportunity to have assessed Alf's mental state and any safety concerns he may have had.

68. At the inquest, Officer Hall conceded that it would have been best practice to have spoken separately to both cell occupants when a cell had been breached in these circumstances.[102]

69. In view of the importance of all cell occupants being spoken to in these circumstances, I have recommended that the Department's policies be amended to make it clear that when a cell is breached as a result of concerns for any of the cell's occupants, officers are required to speak separately to all occupants of the cell to ensure that all relevant issues are fully investigated.

Assessment of Alf during the lunchtime unlock

70. Officer Gulland says that sometime between 12.45 pm and 1.00 pm he had a conversation with Officer Hall about "*an argument*" between Alf and Prisoner M. Officer Hall was due to attend a meeting during the recreation period at about 1.30 pm, and Officer Gulland says he spoke to Prisoner M to check "*everything was OK*", and was assured that it was.[103,104,105]

[102] ts 02.05.24 (Hall), pp153-154
[103] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 41-42 and ts 01.05.24 (Gulland), pp58-59
[104] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 41-42
[105] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 7-8

71. In his statement, Officer Hall says that he had been made aware of the altercation between Prisoner M and Alf, and that "*prior to the Unit unlock*", he unlocked Prisoner M from his cell and spoke with him. Officer Hall says that Prisoner M "*downplayed*" the incident and would not say what the argument with Alf was about. Prisoner M also told Officer Hall that the matter had been "*resolved*" and there was no longer an issue between him and Alf.[106]

72. Officer Hall also says that Prisoner M told him that he would ensure Alf "*would be left alone by other prisoners*". Officer Hall says Prisoner M made this comment "*at his own fruition*" and he did not ask Prisoner M "*why he had done this or why he felt it was necessary to tell me this*". However, Officer Hall says this was "*not unusual*" and he considered Prisoner M "*an Aboriginal elder and an influential character*".[107]

73. Officer Gulland said he also spoke with Alf and "*he didn't seem reluctant to leave his cell*". At the inquest, Officer Gulland said Officer Hall had asked him to speak with Alf as he was doing the lunchtime unlock and make sure Alf was "*OK*".

74. The extent of Officer Gulland's evidence at the inquest about his interaction with Alf was that he asked Alf if he was going to "*Rec*" (i.e.: Recreation) to which Alf replied "*Yes*". Officer Gulland then asked Alf is he was "*OK*", and Alf replied "*Yes*".[108,109,110]

75. Officer Hall says that when he returned to Unit 9 after attending a meeting that concluded at 1.55 pm, he spoke with Officer Gulland to confirm that Alf had been unlocked and to ask, "*if there had been any issues*". Officer Hall says that Officer Gulland told him "*there were no issues to report*" after which he (Officer Hall) "*continued on*" with his duties.[111]

[106] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 85-89 and ts 02.05.24 (Hall), pp150-152
[107] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 90-93
[108] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), para 43 and ts 01.05.24 (Gulland), p71
[109] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), para 43
[110] ts 02.05.24 (Hall), pp148-149 & 152-153
[111] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 95-98 and ts 02.05.24 (Hall), pp143-144

76. In some preliminary remarks I made at the conclusion of the evidence, I referred to Officer Gulland's interaction with Alf as "*brief*". In my view, that was an appropriate characterisation of Officer Gulland's evidence at the inquest on this point. However, during submissions on 2 May 2024, Ms Keighery (counsel for the Department) advised the Court that Officer Gulland had instructed her that he "*strongly denied*" his interaction with Alf had been brief.[112]

77. Out of an abundance of caution, I indicated I would be willing to receive a further brief statement from Officer Gulland outlining his recollections of his interaction with Alf during the lunchtime unlock on 26 February 2019. In a supplementary statement dated 15 May 2024, Officer Gulland said that with respect to his interaction with Alf during the lunchtime unlock: "*I strongly deny the conversation was brief or flippant*".[113]

78. Officer Gulland confirmed that Officer Hall had asked him to speak with Alf during the lunchtime unlock "*to see if there were any concerns/issues prior to unlocking his cell*".[114] Officer Gulland says he had known Alf "*for years*", had a "*good working relationship*" with him, and that in his opinion, Alf trusted him and "*would voice concerns he had to me*".

79. Officer Gulland says he went to Alf's cell and "*asked him questions about his welfare and how he was feeling and if he had any concerns/troubles*". Alf was "*cheerful and calm*" and there was "*nothing strange or out of the ordinary about Alf's behaviour*". Officer Gulland says he asked Alf if he wanted to remain locked in his cell, but that Alf replied he "*was happy to be unlocked for recreation*".[115]

80. Officer Gulland says he asked Alf if he wanted to move cells, but Alf had said he was "*happy in his cell*" and "*did not ask to leave*". Officer Gulland also says: "*Alf did not disclose any concerns to me*" and did not say "*he was in trouble*".[116]

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[112] ts 02.05.24 (Keighery), p215
[113] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), para 23
[114] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), para 9
[115] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 3-4, 9, & 12-15
[116] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 16-17

81. Officer Gulland says there was nothing about Alf's demeanour or behaviour which caused him any concern, and that he told Alf he would be in the Wing office all afternoon, and that Alf "*could come see me at any time*".[117]

82. Officer Gulland says Alf had come to the Wing office on "*many occasions*" and knew where and how to approach him. Officer Gulland says he would not have unlocked Alf's cell if he had any concerns about his welfare, and instead, would have kept the cell locked and spoken to Officer Hall.[118]

83. In his supplementary statement, Officer Gulland also says:

> I am a highly experienced, professional and highly regarded Prison Officer. I use my experience and knowledge in assessing risk every day. I used that professional experience on 26 February 2019 in the conversation with Alf. I strongly deny the conversation was brief or flippant. That is incorrect.[119]

84. Following receipt of Officer Gulland's supplementary statement (and a supplementary statement from Officer Pring dealing with the 3.45 pm Cell Call which I will comment on later in this finding), I agreed to receive brief written submissions from Mr Crocker and Ms Keighery dealing only with this new material.

85. In his submission, Mr Crocker suggested that the account Officer Gulland had given in his supplementary statement of the interaction he had with Alf during the lunchtime unlock was "*an innocent reconstruction*" made after Mr Gulland had "*sat through all the evidence and listened to all the submissions*". Mr Crocker also submitted it was "*remarkable*" that the account Officer Gulland gave in paragraph 16 of his supplementary statement was not given by him "*when any of the counsel took him to that point in time*".[120]

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[117] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 18-19
[118] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 20-21
[119] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 22-23
[120] Submission - Mr Crocker (28.05.24), paras 1.4-1.5

86. Mr Crocker also submitted I should give little weight to Mr Gulland's supplementary statement, and in particular to paragraph 16, in which Officer Gulland says: "*I recall I asked (Alf) if he wanted to move cells and he said he was happy in his cell. He did not ask to leave*". Mr Crocker says this topic was not expressly examined, was not tested in cross examination, and is self-evidently relevant.[121,122]

87. However, paragraph 16 relates to Officer Gulland's recollection of what occurred during the lunchtime unlock. In his supplementary statement, Officer Gulland also says that after speaking to Prisoner M about the earlier argument between Prisoner M and Alf and being assured "*everything was ok*", Officer Hall had asked him (Officer Gulland) to speak with Alf "*to see if there were any concerns/issues prior to unlocking his cell*".[123]

88. In his supplementary statement, Officer Gulland says he went to Alf's cell and had a conversation with him, during which he asked Alf "*questions about his welfare and how he was feeling and if he had any concerns/troubles*".[124]

89. Having assessed the available evidence, I do not see any inconsistency between any of these paragraphs of Officer Gulland's supplementary statement (including paragraph 16) and what he had earlier said in the two statements he gave police in 2019.

90. In his 2019 statements, Officer Gulland gives the following abridged version of his conversation with Alf, which is entirely consistent with the more fulsome account of that conversation in his supplementary statement, namely:

> (Senior Officer) Hall had gone to a meeting when recreation was called so I spoke with Prisoner M to make sure everything was ok. He said it was. I spoke with (Alf) and he didn't seem reluctant to leave his cell.[125,126]

[121] Submission - Mr Crocker (28.05.24), paras 1 & 1.1-1.3
[122] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), para 16
[123] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 8-9
[124] Exhibit 1, Vol 1, Tab 17.3, Statement - Officer S Gulland (15.05.24), paras 10-13
[125] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 42-43
[126] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 42-43

91. I accept that the two statements Officer Gulland gave to police in 2019 were given during the course of a homicide investigation, rather than a coronial investigation. I also accept that Officer Gulland's account of his interaction with Alf during the lunchtime unlock in those statements and at the inquest, is briefer than the account he gives in his supplementary statement.

92. It is clearly always preferable to record one's recollections of a significant event as fully as possible as close to the event as possible. That is because of the notorious fallibility of human memory. However, I accept that the events of 26 February 2019 and Alf's subsequent death have had a deep impact on Officer Gulland.[127]

93. At the inquest, Officer Gulland said that re-reading his statements in preparation for the inquest "*had brought back a lot of memories I had been trying to supress for quite a few years*".[128] I accept that this helps to explain why Officer Gulland's evidence at the inquest concerning his conversation with Alf during the lunchtime unlock was as brief as it was.[129]

94. Having carefully considered both the available evidence and Mr Crocker's submissions, it seems to me that the fulsomeness or otherwise of the interaction between Officer Gulland and Alf during the lunchtime unlock is somewhat beside the point.

95. It is not in dispute that Officer Gulland spoke with Alf during the lunchtime unlock, or that he made enquiries about Alf's welfare. Further, there is no evidence that during Officer Gulland's interaction with Alf (however brief or fulsome that interaction may have been) Alf repeated any of the concerns he had previously expressed in the Cell Calls, or on the phone to his nephew earlier that day.

96. Given the available evidence, there is no reason to think that had Alf mentioned any of these matters, Officer Gulland would not have referred them to Officer Hall.

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[127] ts 01.05.24 (Gulland), p68 and see also: ts 02.05.24 (Keighery), pp237-238
[128] ts 01.05.24 (Gulland), pp67-68
[129] ts 01.05.24 (Gulland), p71

97. In those circumstances, Alf would almost certainly have been spoken to and assessed, and he may well have been transferred to another unit, and possibly to the Crisis Care Unit.

Alf's cell call at 3.45 pm[130]

98. On the basis of the available evidence, the most obvious failing on the part of the Department is the fact that no action was taken after Alf made the 3.45 pm Cell Call, the transcript of which is as follows:

Alf:	(indistinct) leave my number.
Unidentified Officer:	State your name and your medical emergency.
Alf:	Boss, I still got people calling me (indistinct)
Unidentified Officer:	State your name and your medical emergency.
Alf:	They calling me a kiddie fucker, alright?
Unidentified Officer:	State your name and your medical emergency.
Alf:	It's Eades. You heard what I said.
Officer:	State your name and your medical emergency.

99. As I have noted, at the inquest Mr Williams identified himself as the officer who responded to a number of the Cell Calls, including one at 3.32 pm in which Alf asked if he could collect some shampoo.[131] However, at the inquest, Officer Williams said that after listening to the recording of the 3.45 pm Cell Call a number of times: "*that is not me who answered that call*".[132]

100. When asked to identify the officer who had responded to the call, Mr Williams said: "*It's a familiar voice, it, it is a familiar voice, but I could not put a face to that voice unfortunately*".[133] Mr Williams also said: "*I don't categorically deny it but I don't believe that it is my voice. There is doubt in my mind now, but I am not 100 per cent sure that that is my voice*" about whether he had answered the 3.45 pm Cell Call.[134]

[130] Exhibit 1, Vol 1, Tab 48, Incident Description Report - Officer J White (26.02.19)
[131] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (3.32 pm, 26.02.19), p26
[132] ts 01.05.24 (Williams), p78, 80 & 83-89
[133] ts 01.05.24 (Williams), p78, 80 & 83-89
[134] ts 01.05.24 (Williams), pp105-106

101. The following exchange then took place at the inquest:

> Mr Crocker: Do you accept it is probably you?
>
> Mr Williams: Probably or possibly, yes.
>
> Mr Crocker: Well, I'm asking do you accept it is probably you?
>
> Mr Williams: It is probably me, yes, but I'm not convinced that it is.[135]

102. However, on 2 May 2024, Ms Keighery provided the Court with the following information which was relevant to who had answered the 3.45 pm Cell Call:

> Your Honour, some information has come to light to me this morning regarding the phone call that Mr Crocker addressed Mr Williams on whether it was - he could identify it as himself or not. Mr Williams contacted me saying he "*listened to the recording again and again, and it's not me*", and I've been informed very recently that we believe it is another officer, but I have not spoken to that officer.[136]

103. In his evidence at the inquest, Officer Hall said "*Well, it sounds like Officer Pring*" after he (Officer Hall) had listened to the recording of the 3.45 pm Cell Call.[137]

104. Given the obvious importance of this call, and the fact that Officer Pring was not called as a witness at the inquest (although his police statement was in the Brief), I agreed to receive a supplementary statement from Officer Pring about his recollections (if any) of the 3.45 pm Cell Call.

105. In a supplementary statement emailed to the Court on 23 May 2024, Officer Pring said he was working on C and D Wings of Unit 9 on 26 February 2019, and that he recalled receiving one cell call from Alf's cell that day, sometime between 11.00 am and 1.00 pm "*when Prisoner H was also in cell A08*".[138]

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[135] ts 01.05.24 (Williams), pp105-106
[136] ts 02.05.24 (Keighery), pp118-119
[137] ts 02.05.24 (Hall), p167
[138] Exhibit 1, Vol 1, Tab 21.3, Statement - Officer L Pring (23.05.24), paras 8-11

106. Officer Pring said he recalled answering the cell call by saying: "*State your name and medical emergency*", and repeating the phrase after receiving only "*a garbled response*". After receiving a further garbled response, Officer Pring says he repeated the phrase for the third time, but "*did not hear anything identifiable in that call from Cell 08*". Officer Pring also said he did not know who made the call and that "*It may or may not have been Alf*".[139]

107. Officer Pring says when there was no response from the cell's occupants after he answered the cell call, he told Officer Doyle "*he better go down and check Cell A08*". Officer Pring says he believed Officer Doyle would have gone to check on the cell with another officer, but that he (Officer Pring) did not do so. Instead, Officer Pring says he remained in the control room until being relieved and returning to C and D Wings.[140]

108. I have been unable to identify a cell call made from Cell A08 on 26 February 2019 that matches the one Officer Pring says he recalls answering. In any case, in his supplementary statement Officer Pring makes the following comment about the 3.45 pm Cell Call: "*I have been played the cell call from Cell A08 on 26 February 2019. I feel I am not the officer on this cell call. I do not recall taking that call*".[141]

109. Given its obvious potential relevance to Alf's death, it is clearly regrettable that no attempt was made to identify the officer who answered the 3.45 pm Cell Call during the Department's review of the circumstances of Alf's death.[142] This is notwithstanding the obvious fact that the 3.45 pm Cell Call was clearly important, and that a finding to that effect was made in the Review.[143]

110. I note that although Mr Williams agrees that he answered calls before and after the 3.45 pm Cell Call, after he had completed his evidence at the inquest, Mr Williams instructed Ms Keighery that "*he had listened to the recording again and again, and it's not me*".[144]

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[139] Exhibit 1, Vol 1, Tab 21.3, Statement - Officer L Pring (23.05.24), paras 12-16
[140] Exhibit 1, Vol 1, Tab 21.3, Statement - Officer L Pring (23.05.24), para 17
[141] Exhibit 1, Vol 1, Tab 21.3, Statement - Officer L Pring (23.05.24), paras 18-20
[142] ts 02.05.24 (Palmer), p189 & 192-193
[143] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), pp18-19
[144] ts 02.05.24 (Keighery), pp118-119

111. After carefully considering the available evidence, and notwithstanding Mr Crocker's written submission inviting me to find that Mr Williams was the officer who answered the 3.45 pm Cell Call,[145] I have concluded (after applying the Briginshaw test to the available evidence) that it is not possible for me to make any finding, to the relevant standard, about the identity of the officer who answered the 3.45 pm Cell Call.

112. Once again, I note that there is no evidence before me that any action was taken to address the clear concerns Alf expressed during the 3.45 pm Cell Call. In my view, that is a major failure by the Department. It is patently obvious that a prisoner's assertion that others are referring to them as a child sex offender is a very serious matter. Child sex offenders are regarded with contempt by other prisoners, and the evidence at the inquest confirmed that these offenders generally require protective status due to the risk of them being attacked or injured by other prisoners.[146]

113. In an email response to a question from Ms Palmer, Officer Devereux said where a prison officer becomes aware a prisoner was claiming other prisoners are calling them a child sex offender, then:

> Staff should attempt to verify the prisoner's claims. Ensure that the prisoner is not exposed to a situation where the prisoner may be at risk from others, while enquiries are being conducted. If confirmed, staff should alert the Unit Manager, assess the risk to the prisoner and give consideration to the future placement of the prisoner. The issues would need to be documented in an incident report and consider raising alerts as required on TOMS.[147]

114. At the inquest, Officer Hall agreed that if he had been informed about the contents of the 3.45 pm Cell Call, he would have interviewed Alf to determine the genuineness of the concerns Alf was expressing.[148] However, as I have already noted, there is no evidence before me that any action was taken after Alf made the 3.45 pm Cell Call.

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[145] Submissions - Mr A Crocker (28.05.24), paras 2-3
[146] ts 02.05.24 (Hall), p140
[147] Exhibit 1, Vol 1, Tab 47, Email - Officer Devereux to Ms Palmer (09.01.23)
[148] ts 02.05.24 (Hall), p157

115. The importance of the 3.45 pm Cell Call was identified in the Review, where Ms Palmer noted: "*By not reporting* (Alf's) *claims or advising the senior officer of the cell call, there was a missed opportunity to assess the situation and move Mr Eades to another unit or cell*".[149] Given the contents of the 3.45 pm Cell Call, Alf should have been interviewed and the validity of his expressed concerns should have been determined.

116. Whilst it is now impossible to know for certain, it does seem highly likely that had the concerns Alf expressed during the 3.45 pm Cell Call been investigated and found to be genuine, he would have been moved off Unit 9, and possibly to the Crisis Care Unit. I will have more to say about this issue later in this finding.

Alf is attacked[150,151,152,153,154,155]

117. As noted earlier, although four cell calls were made from Alf's cell between 4.30 pm and 4.36 pm on 26 February 2019, only one of which was audible. In the cell call at 4.36 pm, although Alf's request is inaudible, Mr Williams can be heard telling Alf to: "*Come to control now and we will sort it out*", to which Alf responds "*Okay*".[156]

118. At the inquest, Officer Williams also confirmed that he answered a further cell call from Alf's cell at about 4.45 pm, but that there was no response from whoever made the call. On the basis of the available evidence, it seems likely that this call was probably made by Alf who at around this time was in his cell having dinner.[157]

119. In a judgement relating to an application for leave to appeal against sentence by one of the prisoners convicted of Alf's manslaughter, the Western Australian Court of Appeal made the following observations about the events which took place in Alf's cell and which led to him being severely injured:

[149] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p18
[150] Exhibit 1, Vol 1, Tab 2, Homicide Squad Report (03.07.23), p3
[151] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p5
[152] Exhibit 1, Vol 1, Tab 25, Statement - Prisoner Z (14.03.19), paras 140-170
[153] Exhibit 1, Vol 1, Tab 26.1, Statement - Prisoner E (14.03.19), paras 38-57
[154] Exhibit 1, Vol 1, Tab 26.2, Statement - Prisoner E (01.04.19), paras 41-100
[155] Exhibit 1, Vol 1, Tab 27, Statement - Prisoner M (15.03.19), paras 21-44
[156] Exhibit 1, Vol 1, Tab 51.2, Cell call transcripts, p31 (4.36 pm, 26.02.19)
[157] Exhibit 1, Vol 1, Tab 18.2, Statement - Mr B Williams (15.03.19), paras 24-25

> The prosecution case was that on the afternoon of 26 February 2019, (Alf) was alone in his cell eating his dinner. Six men, including the appellant, entered the cell without warning. Some of the men were wearing T-shirts wrapped around their faces and gloves on their hands. The attack was planned to take place at dinnertime when prison officers would be occupied supervising inmates and other inmates would be having their dinner and be less likely to intervene. The men attacked (Alf) by kicking and punching him. There were multiple kicks and punches, predominantly to the head. During the assault (Alf) fell to the floor of the cell and bled from the wounds inflicted on him. He later died as a result of his injuries.[158]

120. Although prisoners are not authorised to go into units other than their own, the available evidence is that this does happen from time to time. At the inquest Officer Hall confirmed that during the recreation period a day or so before 26 February 2019, four or five prisoners from Unit 9 had "*jumped the wall and made their way into Unit 10*" where they were involved in an assault that was related to OMG issues. Officer Hall said a number of prisoners from Unit 9 were detained in the Unit 10 Day Room before being taken to the MPU. It appears that the prisoners who assaulted Alf had come into Unit 9 from adjacent units.[159]

121. For the purposes of this finding, it is not necessary to provide further detail of Alf's assault or the injuries he sustained. It is enough to say that the assault on Alf was brutal, prolonged, and merciless and that the injuries he sustained were catastrophic.[160]

Alf is discovered and Code Red[161,162,163,164,165,166]

122. Prisoner M who had known Alf for about 30 years and regarded Alf as family, says that on 26 February 2019, he had finished his dinner in the day room and was "*preparing to clean up*" when he overheard Prisoner S say: "*the old bloke in the end cell got a hiding*".

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[158] [2023] WASCA 77, (16.05.23), paras 5-7
[159] ts 02.05.24 (Hall), p144
[160] See also: Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 112-118
[161] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p5
[162] Exhibit 1, Vol 1, Tab 53, Health Services summary (14.04.24)
[163] Exhibit 1, Vol 1, Tab 36, Offender Movement Information (26.02.19)
[164] Exhibit 1, Vol 1, Tab 16, Statement - Officer R Doyle (22.03.19), paras 19-47
[165] Exhibit 1, Vol 1, Tab 14, Statement - Officer D Hall (29.03.19), paras 99-134
[166] Exhibit 1, Vol 1, Tab 27, Statement - Prisoner M (15.03.19), paras 3-27

123. Prisoner M says he immediately knew who Prisoner S was referring to and realised the "*old bloke*" was Alf. At about 4.45 pm, Prisoner M found Alf on the floor of his cell bleeding profusely, and went straight to the Wing office to report what he had seen.

124. Meanwhile, Prisoner Z (Alf's new cellmate) had eaten his dinner on the floor outside his cell after finding the cell door was locked. At some point the cell door opened, and Prisoner Z says he saw a number of prisoners assaulting Alf. Prisoner Z says he went straight to the Wing office, and by the time he arrived Prisoner M was already there.[167,168,169]

125. After being alerted to what had happened, several officers rushed to Alf's cell, and found him lying on the floor with a large pool of blood around his head. Officer Gulland called a "*Code Red*" medical emergency using his prison radio, and requested a "*blood kit*" advising that Alf was unresponsive "*and bleeding profusely*". [170,171,172]

126. Medical and custodial staff responding to the Code Red call were confronted by a gruesome scene. Alf was barely alive, and there was a significant amount of blood in and around his cell which had to be cleaned up.[173,174,175,176,177]

127. Officer Gulland, who comforted Alf, and treated his injuries until ambulance officers arrived, is to be highly commended for his efforts. While Alf was being given first aid, other prisoners in Unit 9 were locked in their cells as emergency services were called.[178,179,180,181]

[167] Exhibit 1, Vol 1, Tab 18.2, Statement - Mr B Williams (15.03.19), paras 14-19
[168] Exhibit 1, Vol 1, Tab 25, Statement - Prisoner Z (14.03.19), paras 140-170
[169] Exhibit 1, Vol 1, Tab 27, Statement - Prisoner M (15.03.19), paras 28-31
[170] Exhibit 1, Vol 1, Tab 17.1, Statement - Officer S Gulland (18.04.19), paras 49-74
[171] Exhibit 1, Vol 1, Tab 17.2, Statement - Officer S Gulland (25.03.19), paras 49-73
[172] Exhibit 1, Vol 1, Tab 20.1, Statement - Officer T Phelan (20.03.19), paras 60-67 & 80-87
[173] Exhibit 1, Vol 1, Tab 21.2, Statement - Officer L Pring (02.05.19), paras 19-31
[174] Exhibit 1, Vol 1, Tab 22, Statement - Officer J Hale (18.03.19), paras 49-55
[175] Exhibit 1, Vol 1, Tab 23, Statement - Officer A Singh (15.03.19), paras 2-6
[176] Exhibit 1, Vol 1, Tab 27, Statement - Prisoner M (15.03.19), paras 32-33
[177] Exhibit 1, Vol 1, Tab 16, Statement - Officer R Doyle (22.03.19), paras 41-47
[178] Exhibit 1, Vol 1, Tab 20.1, Statement - Officer T Phelan (20.03.19), paras 68-73
[179] Exhibit 1, Vol 1, Tab 21.2, Statement - Officer L Pring (02.05.19), paras 32-39
[180] Exhibit 1, Vol 1, Tab 22, Statement - Officer J Hale (18.03.19), paras 56-64
[181] Exhibit 1, Vol 1, Tab 23, Statement - Officer A Singh (15.03.19), paras 7-10

Alf's transfer to hospital and subsequent death[182,183184,185,186,187]

128. Ambulance officers arrived at the wing at about 5.10 pm, and took over Alf's care before transporting him to Fiona Stanley Hospital (FSH). Alf arrived at FSH at about 5.45 pm, and after he has given intravenous midazolam for agitation, Alf underwent a CT scan of his neck and cervical spine that showed a "*left epidural haematoma (bleeding into the outer membrane of the brain and skull)*". Alf was also intubated and a chest x-ray showed changes in his lungs that were consistent with infection or aspiration.

129. As there is no acute neurosurgical service at FSH, Alf was transferred to Royal Perth Hospital (RPH) at about 8.10 pm on 26 February 2019. When Alf arrived at RPH, a repeat CT scan confirmed bleeding in his brain, including subdural haematomas. Alf's facial injuries were treated, and he was taken to the intensive care unit where he received "*maximum sedation and neuroprotective measures*".

130. On 27 February 2019, officers from Broadspectrum (a private company the Department engages to supervise prisoners whilst they are in hospital) assumed responsibility for Alf's supervision. On 2 March 2019, RPH requested that Alf's restraints (which he was wearing when he was transferred to hospital) be removed, and this was authorised by the Hakea Superintendent on 3 March 2019.[188]

131. A member of Alf's treating team at RPH made the following comments about Alf's injuries:

> The injuries were of such a nature as to endanger or be likely to endanger life. Without medical treatment his life could have been endangered by airway compromise, seizure, expansion of intracranial haematoma and compression of critical parts of the brain.[189]

[182] Exhibit 1, Vol 1, Tab 53, Health Services Summary (15.04.24)
[183] Exhibit 1, Vol 2, Tab 55, EcHO Health Records (D0913152)
[184] Exhibit 1, Vol 1, Tab 31, SJA Patient Care Record 18296782 (26.02.19)
[185] Exhibit 1, Vol 1, Tab 11, Report - Dr H Weaving - Fiona Stanley Hospital (26.09.19)
[186] Exhibit 1, Vol 1, Tab 10, Report - Dr M Rasouli - Royal Perth Hospital (22.05.19)
[187] Exhibit 1, Vol 1, Tab 12, Report - Dr R Bakmeedeniya - Royal Perth Hospital (23.10.19)
[188] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p5
[189] Exhibit 1, Vol 1, Tab 10, Report - Dr M Rasouli (22.05.19)

132. Alf's neurological state was closely monitored, but he failed to show any signs of improvement and his prognosis remained poor.[190] Following discussions between Alf's family and his treating team, it was decided to withdraw active treatment. Alf was extubated on 11 March 2019, and declared deceased at 5.36 pm that day.[191]

Management on Terminally ill list[192,193]

133. At the time of Alf's admission to hospital, prisoners with a terminal condition were managed in accordance with a departmental policy known as "*Policy Directive 8 Prisoners with a Terminal Medical Condition*" (PD8).

134. Although PD8 has been replaced, at the relevant time it provided that when a prisoner was identified as having a terminal illness, a note to that effect was to be placed in the terminally ill module of that prisoner's TOMS profile. The prisoner's expected prognosis was designated by identifying them as a Stage 1, 2, 3 or 4 terminally ill prisoner.[194]

135. Alf was identified as a Stage 3 terminally ill prisoner on 1 March 2019, meaning that his death was expected within three months. Alf's terminally ill status was escalated to Stage 4 on 8 March 2019, (meaning his death was expected imminently) due to "*his poor prognosis for neurological recovery*".[195]

136. Under PD8, Stage 3 and 4 terminally ill sentenced prisoners could be considered for early release pursuant to an exercise of the Royal Prerogative of Mercy. However, as Alf was a remand prisoner this option was not available. In any event, given the catastrophic nature of his injuries, the prospects of Alf recovering sufficiently to be considered for bail were nil.

[190] Exhibit 1, Vol 1, Tab 10, Report - Dr M Rasouli (22.05.19)
[191] Exhibit 1, Vol 1, Tab 3, Death in Hospital form - Royal Perth Hospital (11.03.19)
[192] Exhibit 1, Vol 1, Tab 53, Health Services Summary (15.04.24), p6
[193] Exhibit 1, Vol 2, Tab 55, EcHO Health Records (D0913152)
[194] Policy Directive 8 Prisoners with a Terminal Medical Condition, pp2-5 (paras 4.1.1 - 4.4.6)
[195] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p5

Why was Alf assaulted?

137. Since his death, there have been several suggestions about why Alf was assaulted. Prisoner E (who was housed in Unit 9 on A Wing) says he was aware of rumours "*going around on the unit*" that "*Alfie was a kiddy-fiddler and a rapist*". Prisoner E also said he had heard: "*there were people on the unit who were going to bash Alfie…because of his reputation for being a kiddy-fiddler*".[196]

138. As I have noted Prisoner H asserts that a member of an OMG (Prisoner S) spoke to Alf and Prisoner H on 26 February 2019, and threatened to assault them. Further, at the inquest, Officer Hall agreed that in the days prior to Alf's assault there had been an increase in tension relating to OMG issues, and that on 26 February 2019, the morning recreation period was cancelled "*because of high tension*".[197]

139. Although it has been suggested that Alf's assault was directed by a member of an OMG for some unknown reason, I note that the trial judge dealing with the prisoners charged in relation to Alf's assault found:

> [I]t was not possible to determine if there were other persons who ordered that (Alf) be assaulted.[198]

140. In my view, I am bound by that determination.

141. Ultimately, I have concluded that the available evidence does not enable me to make any finding, to the relevant standard, as to the reasons why Alf was brutally assaulted in the manner that he was.

[196] Exhibit 1, Vol 1, Tab 26.1, Statement - Prisoner E (14.03.19), paras 33-37
[197] ts 02.05.24 (Hall), pp144-145
[198] [2022] WASCA 174, (22.12.22), para 22

CAUSE AND MANNER OF DEATH

142. A forensic pathologist, Dr Victoria Kueppers (Dr Kueppers) carried out a post mortem examination of Alf's body at the State Mortuary on 13 March 2019. Dr Kueppers noted evidence of head injury including healing wounds to Alf's face, bruising to the scalp, and bleeding over the surface of his brain.[199]

143. Dr Kueppers also noted soft tissue injuries to Alf's upper limbs, and a rib fracture on the right-side which was healing. Alf's lungs were congested and showed signs of infection, and this was confirmed by microscopic analysis of tissues, and microbiological testing which found *Pseudomonas aeruginosa* (a bacterium which can cause infections, including pneumonia).[200]

144. Specialist examination of Alf's brain, spinal cord, and vertebral column was also conducted. Traumatic brain injury was identified and numerous subdural and subarachnoid haematomas and related injuries were noted.[201]

145. Toxicological analysis by the ChemCentre found medications in Alf's system which were consistent with his medical care. Alcohol and common illicit drugs were not detected.[202]

146. At the conclusion of her post mortem examination, Dr Kueppers expressed the opinion that the cause of Alf's death was: "*head injury complicated by bronchopneumonia, with palliation*".[203]

147. I accept and adopt Dr Kueppers' conclusion as my finding in relation to the cause of Alf's death. Further, given that several prisoners who assaulted Alf were convicted of his manslaughter, I find that Alf's death occurred by way of unlawful homicide.

[199] Exhibit 1, Vol 1, Tab 6.1, Supplementary Post Mortem Report (01.10.19)
[200] Exhibit 1, Vol 1, Tab 6.1, Supplementary Post Mortem Report (01.10.19)
[201] Exhibit 1, Vol 1, Tabs 7.1 - 7.3, Pathwest Reports - Brain, vertebral column & spinal cord (21.03.19, 26.03.19 & 06.07.19)
[202] Exhibit 1, Vol 1, Tab 8.1, Final toxicology report (29.04.19)
[203] Exhibit 1, Vol 1, Tab 6.1, Supplementary Post Mortem Report (01.10.19)

ISSUES RELATING TO ALF'S CARE

Findings of the Death in Custody review

148. In the Review (completed after Alf's death), Ms Palmer expressed the following conclusion:

> This review found (Alf's) custodial management, supervision and care were generally within the Department's policy and procedures as listed in Appendix 1. Records indicate that the critical incident response by Hakea officers was prompt with life preservation measures administered following (Alf's) discovery. Relevant death in custody procedures, including notifications and handover to WA Police were followed.[204]

149. However, the Review made the following finding in relation to the 3.45 pm Cell Call: "*Action was not taken by officers when (Alf) reported that prisoners were calling him a child sex offender*".[205] The Review also made the following observations, with which I agree:

> When a prisoner makes a claim that they are at risk from other prisoners, staff should attempt to verify the prisoner's claim and ensure that the prisoner is not exposed to a situation where they may be at risk from others, whilst enquiries are being conducted.
>
> If confirmed, staff should alert the senior officer, assess the risk to the prisoner and give consideration to the future placement of the prisoner. The issue would then need to be documented in an incident report and consideration would then be given to raising an alert on TOMS.[206]

150. Further, as Ms Palmer correctly noted in the Review:

> By not reporting (Alf's) claims or advising the senior officer of the cell call, there was a missed opportunity to assess the situation and move (Alf) to another unit or cell.[207]

[204] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p7
[205] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p18
[206] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p18 and ts 02.05.24 (Palmer), pp188-189
[207] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p18

151. In addition to her finding, Ms Palmer also made the following recommendation in the Review: "*Reinforce with officers the need to assess all claims of risk to prisoners and put into place relevant and necessary safeguards*". The Review notes that with respect to this recommendation, a Superintendent's Notice providing guidance to staff "*in the event that a prisoner reports that they are potentially at risk or are being threatened by others*" was issued on 26 September 2023, and that staff would receive periodic reminders.[208,209]

152. As it happens, Officer Devereux who at the relevant time was the Acting Superintendent of Hakea, sent an email to custodial staff at Hakea on 19 March 2019, in which he clearly set out his expectations in relation to responding to cell calls. Officer Devereux's email also reminded staff of their obligations under the Department's Code of Conduct, including that officers must:

> [E]xercise proper courtesy, consideration and sensitivity in the performance of our duties and our dealings with prisoners".[210]

153. As I have explained, on 26 February 2019, Alf and/or his cellmate made numerous cell calls which were either not responded to at all, or were dealt with in an unprofessional manner. Given the potential importance of the information that may be conveyed in a cell call, it is my view that there is considerable merit in a wider circulation of the information contained in Officer Devereux's email, and the subsequent Superintendent's Notice that was issued to staff at Hakea.

154. For that reason, I have recommended that a Commissioner's Bulletin (or similar) be issued to all custodial staff reminding them of the importance of complying with relevant policies when answering cell calls. I have also made a recommendation which adopts the very sensible suggestion made by Mr Crocker during submissions, namely that officers responding to cell calls be required to identify themselves.[211]

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[208] Exhibit 1, Vol 1, Tab 41, Death in Custody Review (17.10.23), p19 and ts 02.05.24 (Palmer), p190
[209] Exhibit 1, Vol 1, Tab 54.8, Superintendent's Notice to Staff 37 of 2023 (22.09.23)
[210] Exhibit 1, Vol 1, Tab 19.2, Email - Officer S Devereux to custodial staff at Hakea (19.03.19)
[211] ts 02.05.24 (Devereux), pp180-181

CONDUCT OF CERTAIN OFFICERS

Relevant considerations

155. I now turn to assess the conduct of Officer Cahoon and Mr Williams (the Officers) who, at the inquest, identified themselves as being the officers who answered a number of the Cell Calls.[212] In making my assessment, I have regard to the Briginshaw test when deciding whether to make adverse findings about either of the Officers.

156. I have also listened to the recordings of the Cell Calls and reviewed the transcripts, and I can confirm that this was a distressing experience.

157. In making my assessment, I acknowledge that prison officers perform a challenging and difficult job, and that they are routinely subjected to verbal (and sometimes physical) abuse by the prisoners they supervise. This is no doubt a very frustrating aspect of a prison officer's job, especially when prisoners do not display any gratitude or courtesy in relation to the efforts of the officers trying to assist them.

158. I also note that the evidence at the inquest was that the cell call system at Hakea is often misused by prisoners for matters other than genuine emergencies.[213] As can be seen in the transcripts of the Cell Calls, the language used by the occupants of Cell A08 was abusive and disrespectful, and I accept that dealing with cell calls of this nature must be a wearying, and frustrating experience.

159. Nevertheless by February 2019, Mr Williams had been a prison officer for 14 years,[214] and Officer Cahoon for at least five.[215]. Neither of the Officers can therefore be said to have been inexperienced at the relevant time. Further, at the inquest, neither Officer Cahoon nor Mr Williams asserted that they were unaware of the policy requirements relating to the appropriate manner of responding to cell calls which I have outlined.

[212] ts 01.05.24 (Cahoon), pp8-19 and ts 01.05.24 (Williams), pp76-78, 80-83 & 103-104
[213] ts 01.05.24 (Cahoon), p48 and ts 02.05.24 (Devereux), pp177-178
[214] Exhibit 1, Vol 1, Tab 18.1, Statement - Mr B Williams (01.06.19), para 1 and ts 01.05.24 (Williams), pp72-73
[215] Exhibit 1, Vol 1, Tab 15.1, Statement - Officer W Cahoon (15.03.19), para 3 and ts 01.05.24 (Cahoon), p8

160. At the inquest, Officer Hall said that in the months after Alf's death he had listened to some of the Cell Calls, and he was present when recordings of the Cell Calls were played during the inquest. Officer Hall said that the way many of the calls were responded to concerned him because "*it wasn't professional*". Officer Hall also said that where an officer answering a cell call did not receive a response from the cell's occupants, "*normal procedure would be to attend the cell if there was no answer*".

161. In his statement, Officer Devereux said he had listened to the Cell Calls on 11 March 2019, and he said that:

> I was very disappointed with the unprofessional manner that some of the staff used whilst speaking with (Alf). I was not happy with the response from staff. I could hear a person, who I assumed was (Alf), asking for assistance as he feared he was going to get assaulted. I didn't know what (Alf's) voice sounds like but I assumed it was his on the cell call as it was his cell number. He said words to the effect of "*Boss get me out, I need to go to CCU*". The staff were dismissive of him. Within the context of what had occurred, I was disappointed.[216,217]

Conduct of Officer Cahoon[218]

162. Officer Cahoon responded to eight of the Cell Calls in a way which was at times contrary to applicable policy, and in several cases in a manner that can only be described as bizarre. The following examples from the Cell Calls answered by Officer Cahoon are illustrative.

163. At 11.42 am, Officer Cahoon answered a call in which Alf's cellmate said: "*I need protection*". Officer Cahoon's response was "*No you don't, are you finished now*". At the inquest, Officer Cahoon said he did not go to the cell and check on the prisoner because "*at that time he was still locked up and we would have dealt with that before he had done the unlock*".[219]

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[216] Exhibit 1, Vol 1, Tab 19.1, Statement - Officer S Devereux (03.04.19), paras 43-49 and ts 02.05.24 (Devereux), p183
[217] See also: ts 02.05.24 (Palmer), p191
[218] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell calls (26.02.19), p1-31
[219] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (11.42 am, 26.02.19), p8

164. However, as Officer Cahoon was obliged to concede, without checking on the prisoner, he (Officer Cahoon) was unable to say whether the prisoner making the call was seeking protection from his cellmate. Officer Cahoon also agreed that with the benefit of hindsight, when no reply was made by either of the cell's occupants, he should have gone to the cell to check on the situation.[220]

165. At 11.58 am, Officer Cahoon answered a cell call by saying "*Jason Windows*". When Alf's cellmate asked for "*a Panadol*", Officer Cahoon said "*I'm sorry we don't do Panadol here. You have to phone a pharmacy for that. We do double-glazing*". When the cellmate says: "*Please help me*", Officer Cahoon thanks him for the call and says: "*You have a nice day*", and the cellmate says: "*Fuck you, you pile of cunt*".

166. During a call at 11.59 am, Officer Cahoon asks "*Do you want takeaway or what?*", and "*Do you want fries with that?*". In a call at 12.02 pm, Alf's cellmate threatens to assault Officer Cahoon, who responds: "*I'm probably going to go to sleep, because you're going to knock me out, so when you get knocked out, you usually go to sleep. So I will enjoy my sleep. You have - you enjoy your sleep now. Love you. Bye*".[221]

167. At 12.04 pm and 12.06 pm, Officer Cahoon responded to cell calls from Alf's cell in a slow and stilted voice and pretended to be a message bank service. Officer Cahoon asked the caller to "*State your name and nature of your medical emergency after the tone…beep*" and then said: "*Your message will be forwarded as a text*". There was no response from the caller and at the inquest, Officer Cahoon agreed he should have attended Alf's cell to investigate what was going on.[222,223]

168. The reason why Officer Cahoon's failure to do so is important is obvious. If it was the case that the prisoner making these calls was having a medical episode that rendered them unable to respond, then the potential gravity of Officer Cahoon's failure to go to the cell to find out what was going on, can be readily appreciated.

[220] ts 01.05.24 (Cahoon), p11
[221] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (12.02 pm, 26.02.19), pp13-14
[222] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (12.04 pm & 12.06 pm, 26.02.19), pp15-16
[223] ts 01.05.24 (Cahoon), pp16-17

169. At the inquest, Officer Cahoon attempted to explain the manner he answered a number of the Cell Calls by saying he was attempting to use humour to "*bring Alf down*", by which he meant he was trying to deescalate and calm Alf. Although Officer Cahoon said he had used this technique with Alf successfully on other occasions, he denied ever having previously answered cell calls in the manner he had done on 26 February 2019.[224]

170. In passing I note that at the inquest, Dr Gunson said that the purported use of humour by prison officers to deal with a prisoner's agitation or altered mental state was "*a relatively unsophisticated*" technique and that:

> [I]t might engage them and create a rapport. But I don't know that it would change much about their mental state. But it might give you the time to…how about I call (a) mental health nurse or somebody, or we get you into a quiet space. Something like that.[225]

171. At the inquest, Officer Cahoon agreed that a number of his responses to the Cell Calls were "*very unprofessional*" and "*entirely inappropriate*". He also agreed that he had been the subject of disciplinary proceedings following a review by the Department's Professional Services Directorate (PSD),[226] and had "*almost lost his job through this*".[227]

172. Having regard to the principles I have referred to, and after carefully reviewing the available evidence, it is my view that Officer Cahoon's conduct during a number of the Cell Calls he answered was highly inappropriate and unprofessional. His conduct was frankly appalling, and constitutes a serious breach of the Department's Code of Conduct.

173. Whilst I will refrain from commenting on the appropriateness of the penalty imposed on Officer Cahoon following the review of his conduct by the PSD, the fact that he was sanctioned for the manner in which he responded to a number of the Cell Calls was entirely appropriate.

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[224] ts 01.05.24 (Cahoon), pp13-14 & 37-39
[225] ts 02.05.24 (Gunson), p202
[226] Exhibit 1, Vol 1, Tab 15.3, Letter - Professional Standards Division to Officer Cahoon (21.08.19)
[227] ts 01.05.24 (Cahoon), pp13, 37, 40 & 48

174. It is also my view that Officer Cahoon's failure to take action when there was no response from the cell's occupants after a number of the Cell Calls were answered, and his failure to advise Officer Hall of the cell calls in which Alf (and/or his cell mate) requested to be transferred off Unit 9 was inappropriate and unprofessional.

Conduct of Mr Williams[228]

175. At the inquest, Mr Williams confirmed he had responded to 19 of the Cell Calls. At 8.44 am, Mr Williams answered a cell call but when there was no response from either of the cell occupants, Mr Williams failed to investigate why the call had been made. At 11.14 am, Alf made a cell call and asked to be moved off the Wing before he "*murders some cunt*", but there was no response from Mr Williams. At 11.24 am when Alf made a cell call and said he did not want to be on the Wing, Mr Williams responded with: "*I don't want to be here either*".

176. At 11.26 am and 11.28 am, Alf made cell calls asking to be moved to the Crisis Care Unit, where he would be safer. Mr Williams made no response to the first call, and in response to the second call, he told Alf: "*You are not going to crisis care*". There is no evidence that following either of these calls Mr Williams made any attempt to alert Officer Hall about the content of these calls, or to otherwise investigate the concerns Alf was expressing.

177. At 12.06 pm, Mr Williams answers a cell call from Alf's cell using a falsetto voice by saying: "*Hello, hello. Can I help you? Is anyone there?*" There is no response from the cell occupants before the call terminates, and Mr Williams does not take any steps to investigate what might be going on in the cell.

178. At the inquest, Mr Williams said the way he answered this call was "*a lapse in professionalism*" and that it would have been best practice to attend the cell when no response was heard from the cell's occupants.[229]

[228] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls from Cell A08 (26.02.19)
[229] ts 01.05.24 (Williams), p80-81

179. In three calls made from Alf's cell between 12.08 pm and 12.14 pm, there was no response from the cell occupants when Mr Williams answered the call. Again, there is no evidence Mr Williams took any action to investigate what was going on in the cell. Similarly, no action was taken by Mr Williams when he answered a cell call at 12.10 pm in which Alf claimed he had been "*king hit*", or to a cell call at 12.12 pm, during which Alf threatens to bash his cellmate.

180. At the inquest, Mr Williams offered no excuse for his conduct during the Cell Calls he answered, other than to say it was "*a lapse in professionalism*" on his part. He also conceded that his behaviour was "*unprofessional*" and "*inappropriate*", and that he should have investigated those calls where no response was heard.[230]

181. Having due regard to the principles I have referred to, it is my view that Mr Williams' conduct during a number of the Cell Calls he responded to was highly inappropriate and unprofessional. His conduct was appalling, and constitutes a serious breach of the Department's Code of Conduct.

182. Mr Williams was disciplined following a review by the PSD, but only in respect of the cell call at 12.07 pm on 26 February 2019, which he answered in a falsetto voice.[231] At the inquest, Mr Williams agreed that his conduct during this call was "*a breach of appropriate professional standards*" and that he "*needed to be disciplined*".[232]

183. In my view, Mr Williams should have been subject to disciplinary action with respect to his responses to a number of other Cell Calls. However, as he is no longer employed by the Department, the issue is now moot.

184. At the inquest, Mr Crocker asked Mr Williams if there was anything he wanted to say to the family, and Mr Williams' response was: "*Yes. I would like to pay my respects to the Eades family and offer my sincere condolences for their loss, and I apologise for my lack of action and professionalism on that day*".[233]

[230] ts 01.05.24 (Williams), pp80, 88, 94-99, & 101-102
[231] ts 02.05.24 (Devereux), p179
[232] ts 01.05.24 (Williams), p98
[233] ts 01.05.24 (Williams), p103

185. When Mr Crocker asked him about his "*lack of action*", Mr Williams replied: "*I let Alf down…and I let myself down*". Mr Williams also said: "*I should have done a better job*".[234]

Conduct of the officer who answered the 3.45 pm Cell Call[235]

186. For reasons I have outlined, I have concluded that I cannot identify the officer who answered the 3.45 pm Cell Call. Further, as I have also mentioned, there is no evidence before me that any action was taken by any person following the 3.45 pm Cell Call to investigate the serious concerns that Alf was expressing.

187. In those circumstances, had I been able to make a finding (to the relevant standard) as to the identity of the officer who answered the 3.45 pm Cell Call, then I would have referred the matter to the PSD for investigation, as a matter of public interest.

188. I am aware that section 50(1) of the *Coroners Act 1996* (WA) (the Act), empowers me to "*refer any evidence, information or matter*" which comes to my notice in the carrying out of my duties "*to a body having jurisdiction over a person carrying on a trade or profession*", if in my opinion doing so would cause the body to inquire into (or take any other step) in respect of the conduct "*apparently disclosed*" by "*the evidence, information or matter so referred*".[236]

189. However, I do not think section 50 of the Act applies in the present case because a prison officer is not "*a person carrying on a trade or profession*", and neither the Department, nor the PSD is:

> [A] body empowered under a written law to: (a) register, license or otherwise approve a person as a prerequisite to the person lawfully carrying on that trade or profession; and (b) impose or recommend any punishment or liability in respect of wrongful, incompetent or otherwise unsatisfactory conduct of that person in relation to that trade or profession.[237]

[234] ts 01.05.24 (Williams), p103
[235] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call from Cell A08 (3.45 pm, 26.02.19), p27
[236] s50(2), Coroners Act 1996 (WA)
[237] s50(2), Coroners Act 1996 (WA)

QUALITY OF SUPERVISION, TREATMENT AND CARE

Medical care

190. The Health Review completed after Alf's death expressed the following conclusion about the medical care and treatment that Alf received during his various periods of incarceration:

> Over his multiple periods in custody, (Alf) received holistic and high-quality health care. This was despite repeated interruptions to continuity of care imposed by his repeated short incarceration periods interspersed with short periods in the community. Some issues pertaining to delivery of care were identified during his periods of custody, and moving forward, these continue to be addressed. However, it is highly unlikely that any of these affected (Alf's) ultimate health outcome.
>
> Staff were pro-active in ensuring (Alf) was reviewed when he disclosed any health concerns. He was also followed up when he missed appointments, by re-scheduling as needed and also by speaking to him and encouraging his engagement. When custodial staff raised concerns, these were also responded to appropriately. In conclusion, the health care provided to (Alf) was overall of an excellent quality, and certainly equivalent or better than the standard he would have received in the community.[238]

191. After considering the available evidence, including the oral evidence of Dr Gunson at the inquest, I have concluded that the medical treatment provided to Alf whilst he was at Hakea was of an acceptable standard.

Missed opportunities

192. After carefully assessing the available evidence, I have concluded that the supervision and care provided to Alf during his last incarceration at Hakea was demonstrably unacceptable. With the benefit of hindsight, it is my view that the available evidence discloses a number of missed opportunities where Alf's safety and welfare could have been more comprehensively assessed. Further, the fact that there was no response to the 3.45 pm Cell Call was a major failure on the Department's part.

193. In summary, the missed opportunities I identified are:

[238] Exhibit 1, Vol 1, Tab 53, Health Services summary (14.04.24), p33 and ts 02.05.24 (Gunston), pp195-196

a. *Lack of response to requests to move cells*: at 11.26 am and 11.28 am, Alf made cell calls in which he referred to his safety and asked to be transferred to the Crisis Care Unit. Both of these calls were answered by Mr Williams, who made no substantive response to the first call, and merely told Alf: "*You're not going to crisis care*" in the second. At the inquest, Mr Williams said he could not recall taking any action following either of these calls and that he should have "*Alerted his (i.e.: Alf's) wing officer and the senior officer of the unit*". Had Officer Williams taken this action, it is probable that Officer Hall would have spoken with Alf, and there is at least a possibility that Alf might have been transferred to the Crisis Care Unit;[239,240]

b. *Lack of response to cell calls where no response was heard*: during the lunchtime lockdown Officer Cahoon answered three cell calls from Alf's cell where there was no reply from the cell occupants after the call was answered. At the inquest, Officer Cahoon accepted that he or another officer should have gone to Alf's cell to find out what was going on. Had this occurred, there is at least a possibility that Alf might have expressed concerns about his safety which might then have been investigated;[241,242,243]

c. *Lack of response to cell call alleging assault*: at 12.10 pm, Mr Williams answered a cell call from Alf alleging he had just been "*king hit*". At the inquest Mr Williams agreed that if Alf was telling the truth, the only person who could have assaulted him was his cellmate because the call was made during the lunchtime lockdown. Mr Williams also agreed that after receiving a call of this type, the correct protocol was "*to inform the senior officer*", but that there was no indication that he had done so. Mr Williams said he had no explanation for "*not doing what he was supposed to*" and agreed that this was "*another lapse in professionalism*".[244,245]

[239] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (11.26 am & 11.28 am, 26.02.19), pp5-6
[240] ts 01.05.24 (Williams), pp93-94
[241] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (26.02.19), pp15-21 & 23, 25
[242] ts 01.05.24 (Cahoon), pp11-12
[243] See also: Local Order 45: Cell Call Alarms (Jun 2020), para3.2
[244] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell calls (12.10 pm, 26.02.19), p22
[245] ts 01.05.24 (Williams), pp95-97 & 109

d. *Lack of response to cell calls during the lunchtime lockdown*: between 12.12 pm and 12.14 pm, Mr Williams answered three cell calls from Alf's cell. Although two are indistinct, in one call Alf threatens to kill his cellmate. At the inquest, Mr Williams agreed that receiving three cell calls in three minutes was unusual, and although he did not recall what he did following these calls, "*there's no indication that I escalated it*".[246,247]

e. *Cell breach during the lunchtime lockdown*: during the lunchtime lockdown, Officer Hall was given information which caused him to go to Alf's cell with Officers Cahoon and Gulland and breach the cell door. Officer Hall's initial impression was that there was an altercation between the cell occupants (namely Alf and Prisoner H), but on finding this was not the case, Officer Hall's focus shifted to Prisoner H, and he did not engage with Alf in any meaningful way.

Prisoner H was taken to the Wing office, and as a result of the safety concerns Prisoner H expressed when interviewed, Officer Hall arranged for him to be transferred to the Crisis Care Unit, pending an assessment for protected prisoner status.

At the inquest, Officer Hall properly accepted that on reflection, he should have spoken with Alf to determine whether Alf had any safety concerns. Officer Hall also conceded that with the benefit of hindsight, it was best practice to speak to all occupants of a cell when a safety concern was raised.[248]

f. *Cell call at 3.45 pm*: as I have explained, during the 3.45 pm Cell Call, Alf expressed concern that he had been identified as a child sex offender. There is no evidence that any action was taken following this call, and clearly this is an appalling failure on the Department's part. Had the 3.45 pm Cell Call been responded to, and had Alf been interviewed in the Wing office, there is at least a possibility that his concerns might have been deemed to be genuine and that he might have been moved off Unit 9, perhaps to the Crisis Care Unit. Had this occurred, Alf would not have been assaulted in his cell on Unit 9 in the manner that he was.

[246] Exhibit 1, Vol 1, Tab 51.2, Transcripts of cell calls (12.12 pm - 12.14 pm, 26.02.19), pp23-25
[247] ts 01.05.24 (Williams), pp95-97
[248] ts 02.05.24 (Hall), pp153-154

g. *Failure to advise Officer Hall of the content of the Cell Calls*: at the inquest Officer Hall confirmed he had not been made aware of relevant information in a number of the Cell Calls by officers on Unit 9. Officer Hall said he expected staff on the unit to refer information about the management of prisoners to him, and he agreed he had not been given "*relevant information*" contained in some of the Cell Calls.

Officer Hall agreed that if he had been told about the content of the Cell Calls he would have interviewed Alf. Further, if Alf had expressed any safety concerns or worries, Officer Hall says he would have moved him off the Unit. When Mr Crocker put to Officer Hall "*The only reason he (Alf) didn't get moved was you didn't get told things. Do you accept that?*", Officer Hall replied "*I accept that, yes*".[249]

194. At the inquest, the following exchange took place between Mr Crocker and Officer Devereux:

Mr Crocker: Knowing what you now know, do you accept the proposition that the prison system on 26 February 2019 failed Alf in not providing a safe place for him to be?

Officer Devereux: Yes. I do believe that. I believe there (were) opportunities where interventions could have occurred which possibly could have prevented the circumstances and the incident that occurred to Alf.

Missed medication

195. At the inquest, the evidence appeared to suggest that Alf did not receive his medication on the morning of 26 February 2019, probably because he had not attended the routine scheduled medication parade held each morning on the Unit.[250]

196. At the inquest, Officer Gulland said that if he became aware that a prisoner was claiming not to have received their medication, then he would take the following action:

[249] ts 02.05.24 (Hall), pp157-158
[250] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (9.03 am, 26.02.19), p2

> I would ask the prisoner, "*Is it essential medication or is it an aspirin or something that you require*?" And…If I felt that was genuine, I would ring the medical centre and say, "*Prisoner X has not had his medication this morning. Is there any way it can be sent down*?" And depending on who was on staff in the medical centre, we could write them a pass and they would go down and get it.[251,252]

197. Officer Gulland was asked whether this type of response was a requirement set out in "*some standing instruction or protocol*", or was just how he would respond. Officer Gulland's response was: "*I think that's how most officers would respond. Obviously not everyone responds in the same fashion*".[253]

198. At the inquest Mr Crocker suggested that the Department should amend its medication policy to deal with the situation where a prisoner misses medication by not attending a scheduled medication parade. Mr Crocker suggested that the senior officer on the prisoner's unit should be required to liaise with clinical staff about the matter. In its response to my draft recommendation on this issue, the Department suggested that a policy amendment aimed at ensuring the onus was on clinical staff to inform custodial staff about a prisoner missing significant medication (rather than the other way around) should be implemented. I have adopted this sensible suggestion.[254,255]

Lessons learned workshop - 12 September 2019

199. On 12 September 2019, the Department conducted a workshop to review matters related to Alf's death. The workshop was attended by custodial, management, medical, and administrative staff, and a document published after the workshop set out seven "*lessons learned*". I will now briefly review these lessons learned because in several cases, I have made recommendations about the matters discussed.

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[251] ts 01.05.24 (Gulland), p64
[252] See also ts 01.05.24 (Williams), pp89-92 & 109-110
[253] ts 01.05.24 (Gulland), pp64-65
[254] ts 02.05.24 (Crocker), pp206-207
[255] Email and Attachment - Ms S Keighery (Counsel for the Department) to Counsel Assisting (30.05.24)

200. The seven "*lessons learned*" can be summarised as follows:[256]

a. *CCTV cameras at Hakea*: the workshop acknowledged that the identification of the persons who had assaulted Alf was hampered by the lack of closed circuit TV cameras (CCTV) in Unit 9.[257] At the inquest, Officer Devereux agreed that if CCTV had been installed in Unit 9 at the relevant time, that would have acted as "*some level of deterrent against the assailants*".[258]

I note that CCTV have recently been installed in Hakea's reception area and in some accommodation units, but that other area are still without CCTV. At the inquest, Officer Devereux was asked if he thought CCTV should be installed at Hakea to assist in maintaining good order and prisoner safety and welfare, and his response was:

> Absolutely. I would agree with that, absolutely. And I would even go one step further and ask that prison staff wear lapel cameras as well. So, for example, in the conversations that we've been discussing today and throughout the hearing, voice recording or audio recording would have been very helpful to identify exactly who said what.[259]

I have made a recommendation about the installation of CCTV at Hakea, and I also strongly endorse Officer Devereux's comments about prison staff wearing lapel cameras. I invite the Department to consider the feasibility of introducing this technology across the prison estate.

b. *Responding to and documenting cell calls*: the workshop noted that a review of cell calls made from Alf's cell had "*raised serious concerns regarding the professionalism of staff (who) responded to these cell calls*". The review also made the following observation, with which I agree: "*Incident reports suggest, prior to (Alf's) assault, staff were aware he was in conflict with other prisoners. Staff relied on the assistance of a prisoner to defuse the conflict without also interviewing (Alf) and undertaking their own risk assessment*".[260]

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[256] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19)
[257] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p6
[258] ts 02.05.24 (Devereux), p175
[259] ts 02.05.24 (Devereux), p173
[260] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), pp6-7

b. *Responding to and documenting cell calls*: (continued) I have already discussed the conduct of the officers who were identified as having answered various Cell Calls. In this regard, the workshop recommended that the role of senior officers in supervising the work of officers within their units be reinforced. The workshop also noted deficiencies in the way cell calls were being recorded and recommended the reintroduction of "*books to record cell calls received within the units identifying cell number, prisoner's name and issue*", and that random audits to assess the quality of cell call responses be regularly conducted.[261,262]

c. *Managing challenging prisoner cohorts*: the workshop noted that at the relevant time, Hakea was accommodating a large number of OMG members from rival factions, and that "*the current infrastructure at Hakea did not allow for adequate separation of varying cohorts*".[263] For reasons I have explained, I have been unable to determine why Alf was assaulted, and so it is not possible to say whether this issue has any relevance to Alf's cause of death.

d. *Consistent recording of rationales for cell movements*: the workshop noted that Alf had been moved a number of times during his last incarceration at Hakea but that "*the rationale for his Unit or cell changes were not always documented*". This issue was also referred to in the Review. The workshop recommended that the cell allocation module within TOMS be reviewed to include further detail, "*including the rationale for prisoner unit/cell movement for record keeping purposes*".[264]

e. *Monitoring vulnerable prisoners like Alf on SAMS*: the workshop noted that Alf was seen by mental health staff, had a major mental illness, and took medication to "*level his mood*". The workshop also noted Alf's aggressive and/or irritable behaviours, and his mood swings and discussed whether he should have been referred to the Department's Specialist Psychological Services (SPS), or monitored under the Department's Support and Management System (SAMS).[265]

[261] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p7
[262] See also: ts 02.05.24 (Devereux), pp182-183
[263] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p7
[264] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p8
[265] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), pp8-9

e. *Monitoring vulnerable prisoners like Alf on SAMS*: (continued) SAMS is the Department's secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide. This includes first-time and/or younger prisoners, socially isolated or vulnerable prisoners, and prisoners who have been identified as being at chronic risk[266] of self-harm or suicide.[267] The workshop recommended that there be liaison with SPS to determine what services could be offered to vulnerable prisoners like Alf, and also to identify alternative methods for referring a prisoner to SAMS.[268]

f. *Custodial access to medical records to inform decision making*: the workshop noted that some custodial officers felt that having access to (or knowledge of) a prisoner's mental health/medical status would enable them to "*make better informed decisions*". However, Dr Rowland (who was then Director, Medical Services) pointed out the importance of patient confidentiality and the legal and ethical implications of breaching that confidentiality. As an alternative the workshop recommended that custodial staff be provided with training "*in the support and management of prisoners with cognitive and mental health issues*".[269]

The issue of more specialised training for custodial staff is not new. On 22 May 2019, in a finding I published dealing with five deaths by suicide at Casuarina Prison, I recommended that:

> The Department should consult with an expert in the field of mental health with a view to providing training to all staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.[270]

In order to assist custodial staff to better manage vulnerable prisoners like Alf, I considered it was appropriate to make a recommendation about training for custodial staff to assist them to more effectively manage prisoners with personality disorders, common mental health illnesses, and/or common behavioural issues.[271]

[266] The term "chronic" in this context means "elevated lifetime risk"
[267] SAMS Manual (June 2009), pp1-5
[268] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p8
[269] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p10
[270] Record of Investigation of Death: Relating to Five male prisoners (14/19, 22.05.19), Recommendation 6, p129
[271] See also: ts 02.05.24 (Gunston), pp200-202

g. *Peer support prisoner not utilised*: the workshop noted that staff had reported "*the existence of strained relations between Alf and other Aboriginal prisoners within the unit prior to the assault*". This had not been brought to the attention of the Peer Support Prisoner Group (PSPG) which could potentially have explored and helped to resolve these concerns. The workshop recommended that the importance of the role of the PSPG be promoted "*at Hakea and across prisons in managing disputes amongst Aboriginal families and groups*".[272]

Was Alf's death preventable?

201. During submissions at the conclusion of the inquest, Mr Crocker submitted that it was open to me to find that Alf's death was preventable. The basis for this submission was that had the contents of the 3.45 pm Cell Call been conveyed to Officer Hall (the senior officer at the relevant time), then Officer Hall would have gone to Alf's cell to investigate Alf's concerns before moving him to another unit, or to the Crisis Care Unit.[273]

202. I accept that had Alf been moved to the Crisis Care Unit prior to being attacked, he could not have been assaulted in his cell on A Wing of Unit 9, and he would not have sustained the injuries that ultimately caused his death. However, it seems less clear that Alf would have had the same protection had he been moved to another unit. I say that simply because there is no way of knowing which unit Alf might have been moved to, and which prisoners might or might not have been able to access him whilst he was accommodated on that unit.

203. Although Alf asserted that "*They* (are) *calling me a kiddie fucker*" during his cell call at 3.45 pm on 26 February 2019,[274] on the basis of the available evidence, I have been unable to determine the validity of Alf's concerns. Further, although Alf's criminal record does contain one conviction for "*indecently deals with a child over 13 under 16*",[275] this conviction occurred on 12 December 2008, and was clearly not related to Alf's final incarceration at Hakea.

[272] Exhibit 1, Vol 1, Tab 49, Lessons Learned Workshop summary (12.09.19), p11
[273] ts 02.05.24 (Crocker), pp225 & 229-232
[274] Exhibit 1, Vol 1, Tab 51.2, Cell call transcripts, p27 (3.45 pm, 26.02.19)
[275] Exhibit 1, Vol 1, Tab 37, History for Court - Criminal & Traffic, p27

204. It follows that on the basis of the available evidence, other than the fact that the words "*They* (are) *calling me a kiddie fucker*" were spoken by Alf, it is not possible to make any assessment of the validity of the concerns that Alf was apparently expressing.

205. As I have noted, the evidence at the inquest was that prisoners regard child sex offenders with contempt, and that such offenders generally require protection.[276,277] It therefore seems likely that Officer Hall would have spoken to Alf if he had been apprised of the contents of the 3.45 pm Cell Call.[278]

206. However, given the available evidence, there are obvious difficulties in determining what Alf might have said to Officer Hall had he been reviewed, and therefore what action Officer Hall might then have taken. During a previous cell call for example, Alf claimed he had been "*king hit*" when there is no evidence that this had occurred.[279] Whilst it is the case that Alf had recently been moved to another unit for his protection, the question of whether this would have happened again remains open.

207. Ultimately after carefully assessing the available evidence, and after applying the Briginshaw test to the known facts, I have concluded that it is not possible to find, to the relevant standard, that Alf's death was preventable.

208. However, it remains the case that had the 3.45 pm Cell Call been responded to (as it obviously should have been), there is a possibility that Alf may have been transferred off Unit 9 to another unit, (or to the Crisis Care Unit), meaning he may not have been assaulted in the manner that he was.

[276] ts 02.05.24 (Hall), p140
[277] Exhibit 1, Vol 1, Tab 19.1, Statement - Officer S Devereux (03.04.19), paras 43-49 and ts 02.05.24 (Devereux), p183
[278] ts 02.05.24 (Hall), pp157-158
[279] Exhibit 1, Vol 1, Tab 51.2, Transcript of cell call (12.10 pm, 26.02.19), p22

RECOMMENDATIONS

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

Recommendation No. 1
Given the critical importance of responding to cell calls in an appropriate and professional manner, the Department of Justice should consider issuing a Commissioner's Bulletin (or similar) reminding all custodial staff of the importance of complying with relevant policies (e.g.: Hakea Prison's *Local Order 45 Cell Call Alarms*).

Recommendation No. 2
In order to ensure that custodial staff receiving cell calls can be identified, the Department of Justice should consider amending its cell call policy so that when responding to a prisoner's cell call, custodial staff are required to say: "*Officer [Surname], state your name and the nature of your emergency*".

Recommendation No. 3
The Department of Justice should reinforce the protocols for reporting any issues relating to the cell call system at Hakea, and the requirement to conduct regular audits of the cell call system. The Department of Justice should also ensure that any remedial action required to address any issue with the cell call system is completed as soon as practicable.

Recommendation No. 4
In order to better manage prisoners at Hakea Prison, the Department of Justice should seek internal funding to ensure that closed circuit cameras (CCTV) are installed in all remaining accommodation units not currently fitted with CCTV. The installation of these additional CCTV should be completed as a matter of urgency.

Recommendation No. 5
The Department of Justice should consider amending its policies to make it clear that if a cell is breached during a period of lockdown as a result of concerns for any of the cell's occupants, custodial staff are required to speak separately to all occupants of the cell to ensure that all relevant issues are fully investigated.

Recommendation No. 6
The Department of Justice should consider providing training to all custodial staff in the effective management of prisoners with personality disorders, common mental health illnesses, and/or common behavioural issues.

Recommendation No. 7
The Department of Justice should consider amending relevant policies to ensure that when a prisoner does not attend a scheduled medication parade to receive prescribed medication, clinical staff must, where the missed medication is significant, inform the senior officer of the relevant unit that the missed medication is significant and needs to be given to the prisoner as a matter of urgency. Appropriate steps must then be taken to ensure that the prisoner is provided with the missed medication as soon as is practicable.

Comments relating to Recommendations

210. In accordance with my usual practice, a draft of my proposed recommendations was forwarded to counsel appearing at the inquest by Mr Stops (Counsel Assisting the coroner), on 7 May 2024. Counsel were asked to forward any comments on the proposed recommendations to the Court, by the close of business on 24 May 2024.[280]

211. In an email dated 8 May 2024, Ms Keighery requested an extension of time for the Department to provide its feedback in relation to the draft recommendations because of "*the unprecedented work load on the coronial section of the Department of Justice*".[281]

212. I approved the Department's request, and authorised an extension of time to provide feedback until the close of business on 31 May 2024. Mr Stops communicated this extension to Ms Keighery by way of an email on 8 May 2024.[282]

213. In an email dated 15 May 2024, Mr Crocker provided his client's feedback about the draft recommendations. A minor typographical error he identified in Recommendation 1 has been corrected, and I have partially adopted a suggested amendment to Recommendation 7.[283]

214. In an attachment to an email forwarded to the Court on 30 May 2024, Ms Keighery advised that the Department's response to my proposed recommendations was as follows:[284]

a. *Recommendation 1*: this recommendation is actionable as drafted.

b. *Recommendation 2*: this recommendation is actionable as drafted, and as an interim measure a Commissioner's Bulletin setting out the expectations when responding to cell calls has been issued. The Bulletin also requires superintendents to undertake regular audits to ensure cell calls are dealt with appropriately.

[280] Email - Mr W Stops to counsel for parties appearing at the inquest (07.05.24)
[281] Email - Ms S Keighery (Counsel for the Department) to Counsel Assisting (08.05.24)
[282] Email - Ms S Keighery (Counsel for the Department) to Counsel Assisting (08.05.24)
[283] Email - Mr A Crocker (Counsel for Mr R Eades) to Counsel Assisting (15.05.24)
[284] Email and Attachment - Ms S Keighery (Counsel for the Department) to Counsel Assisting (30.05.24)

b. *Recommendation 2*: (continued) a Deputy Commissioner's Bulletin has also been issued advising staff of imminent changes to the cell calls policy, including that staff are required to answer cell calls by saying: "*Officer (Surname), state your name and the nature of your emergency*". The Bulletin also sets other requirements including that staff are to identify the prisoner making the cell call, and are to urgently attend the cell when the prisoner makes no audible or coherent response after the cell call has been answered.

c. *Recommendation 3*: the Department suggested a sensible amendment to Recommendation 3 which I have adopted.

d. *Recommendation 4*: the Department noted that CCTV have been installed in Hakea's reception area, the Crisis Care Unit, and in Units 1, 8, 9 and 10. The Department also suggested a sensible amendment to Recommendation 4 which I have partially adopted.

e. *Recommendation 5*: this recommendation is actionable as drafted.

f. *Recommendation 6*: the Department referred to the "*Mental Health First Aid Training*", and the "*Mental Health Online Training*" provided to custodial staff "*at the foundation and operational level*", the later of which must be refreshed every three years. Whilst this training is useful, it remains my view that Recommendation 6 is appropriate as drafted, and I have decided not to amend it.

g. *Recommendation 7*: the Department suggested an amendment to this draft recommendation aimed at ensuring that the onus is on clinical staff to inform custodial staff about a prisoner missing significant medication, rather than the other way around. The suggested amendment is sensible, and I have adopted it.

CONCLUSION

215. Alf was 46 years of age when he was brutally assaulted whilst being held on remand at Hakea. Alf died on 11 March 2019 from the head injury he sustained during that beating, and several of the prisoners who assaulted him were subsequently convicted of his manslaughter.

216. After carefully considering the available evidence, I concluded that the standard of supervision and care Alf received whilst he was incarcerated at Hakea was unacceptable. Although I was unable to make a finding (to the relevant standard) that Alf's death was preventable, I identified several missed opportunities where his safety could and should have been assessed.

217. I have made seven recommendations aimed at improving the welfare and safety of prisoners at Hakea which I hope will be actively embraced by the Department and fully implemented.

218. As I did at the conclusion of the inquest, I wish to again convey to Alf's family and friends, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
12 June 2024