JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	17-18 NOVEMBER 2025
DELIVERED	**:**	8 DECEMBER 2025
FILE NO/S	**:**	CORC 616 of 2023
DECEASED	**:**	BROPHO, ASHLEY JAMES

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Criminal Procedure Rules 2005 (WA)

Counsel Appearing:

Mr D McDonald and Ms E Lynch assisted the Coroner

Ms T De Souza-Meally (Aboriginal Legal Service) appeared on behalf of Mr Geoffrey Edgill

Ms C Lakewood and Ms K Durack (State Solicitor's Office) appeared on behalf of the Department of Justice

Cases referred to in decision:

Briginshaw v Briginshaw (1938) 60 CLR 336.
Inquest into the death of Ian Campbell Buchanan [2024] WACOR 8
Inquest into the death of Alf Deon Eades [2024] WACOR 26

Inquest into the death of Sam Phillip Chisolm Lynch [2025] WACOR 27
Rosenberg v Percival [2001] HCA 18; (2001) 205 CLR 434
Shire of Gingin v Coombe [2009] WASCA 92
The State of Western Australia v Martin [2022] WASCSR 38
The State of Western Australia v Martin [2024] WASCSR 7
The State of Western Australia v Martin [2024] WASCSR 7 (S)
The State of Western Australia v Phillips [2023] WASCA 104
The State of Western Australia v Tumata [2022] WASCA 161

SUPPRESSION ORDERS

On the basis it would be contrary to the public interest, the Court makes an order under section 49(1)(b) of the *Coroners Act 1996* (WA) that there be no reporting or publication of:

(a) the name of any prisoner (other than Mr Evan Martin) housed at Casuarina Prison in December 2020; or

(b) the name of any prisoner (other than the deceased or Mr Evan Martin) housed at Hakea Prison between 1 January 2023 and 9 March 2023.

Any such prisoner is to be referred to as 'Prisoner [*Initial*]'.

Order made by BD Nelson, Coroner (17/11/2025, ts 41)

On the basis it would be contrary to the public interest, the Court makes an order under section 49(1)(b) of the *Coroners Act 1996* (WA) that there be no reporting or publication of the details of any evidence regarding the current organisation or unit allocation of cohorts of prisoners with protection status.

Order made by BD Nelson, Coroner (18/11/2025, ts 113

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Ashley James BROPHO*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 17 and 18 November 2025, find that the identity of the deceased person was* ***Ashley James BROPHO*** *and that death occurred on* ***9 March 2023*** *at* ***Hakea Prison, Nicholson Road, Canning Vale****, from* ***neck injury in a man with atherosclerotic heart disease*** *in the following circumstances:*

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Introduction

1 Mr Bropho[1] was a remand prisoner placed in Unit 10, a protection unit, at Hakea Prison when, on 9 March 2023, he was violently killed in his cell by Evan James Martin, another prisoner housed within the unit.

2 Mr Martin was convicted of the murder of Mr Bropho by the Supreme Court of Western Australia, and on 8 March 2024 sentenced to a term of life imprisonment with a minimum non-parole term of 21 years.[2]

3 Mr Bropho was in the custody of the Chief Executive Officer of the Department of Justice (**Department**) at the time of his death, and therefore a person held in care for the purposes of the *Coroners Act 1996* (WA) (the **Act**).[3]

4 As such, a coronial inquest was mandatory,[4] and I am required to comment on the quality of the supervision, treatment and care that Mr Bropho received while in custody.[5]

5 I may also comment on any matter connected with Mr Bropho's death, including public health or safety or the administration of justice.[6]

6 The coronial inquest occurred on 17 and 18 November 2025.

7 Mr Bropho's younger brother, Mr Edgill, attended the entirety of the inquest and provided a compelling statement about the happy childhood he shared with Mr Bropho, and the impact Mr Bropho's death has had on him.[7]

8 I reiterate the gratitude that I expressed to Mr Edgill at the inquest for engaging with the Court and providing his statement.

[1] At the request of his brother, the deceased was referred to as Mr Bropho during the inquest (ts 41), and I will adopt the same approach in these findings.
[2] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [162]-[163].
[3] The Act, s 3 (definition of 'person held in care').
[4] The Act, s 22(1)(a).
[5] The Act, s 25(3).
[6] The Act, s 25(2).
[7] Exhibit 1, tab 38.

Issues raised at the inquest

9 The inquest focused on several matters, all related to the supervision, treatment and care of Mr Bropho in custody, including:

(a) the information available to the Department in late 2022 and early 2023 regarding the level of risk Mr Martin posed to prisoners housed in protection units at Hakea charged with sexual offences against children such as Mr Bropho;

(b) the maintenance of Mr Martin's status as a protection prisoner and his placement in Unit 10 during that time having regard to the information available to the Department (particularly after his sentencing for an attempted murder of another prisoner in Acacia Prison in December 2020);[8]

(c) what reviews of Mr Martin's protection status were undertaken, if any, by Departmental officers in late 2022 and early 2023;

(d) Mr Bropho's transfer from Unit 9 (another protection unit in Hakea) to Unit 10 on 8 March 2023, due to threats made toward him by other prisoners following media reports on 7 March 2023 which identified Mr Bropho by name and his charges;

(e) a physical attack on Mr Bropho in his cell by other prisoners within Unit 10 (including Mr Martin) on 8 March 2023, and whether that attack, or the injuries sustained by Mr Bropho, were known to any prison staff prior to Mr Bropho being killed; and

(f) related to (e) above, the lock-up procedure undertaken by prison officers in Unit 10 on the evening of 8 March 2023, and whether any injuries to Mr Bropho were, or should have been, identified.

10 Following the inquest, the Department filed detailed written submissions about a coroner's jurisdiction under the Act.[9]

11 In those submissions, the Department set out matters that it contended were sufficiently connected to Mr Bropho's death to be the subject of comment and could be relevant to the care Mr Bropho received in custody, and those that were not.[10]

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[8] ***The State of Western Australia v Martin*** [2022] WASCSR 38.
[9] 'Submissions on behalf of the Department of Justice' dated and filed 2 December 2025 (**Department's submissions**).
[10] At [28].

12 With respect, it is unnecessary to set out those submissions in any detail, because the Department's submissions appear to conform with my articulation of the issues at par [9] above, in any event.

Materials received at the inquest

13 At the inquest, I received the documentary evidence contained in the coronial brief as well as two additional exhibits, and the following witnesses gave oral evidence:

(a) Mr Gerry Costello, a senior prison officer at Hakea Prison, predominantly based in Unit 9;

(b) Mr Rod Curtis, a now retired senior prison officer at Hakea Prison, who was the senior officer in Unit 10 at the relevant time;

(c) Mr Mark Carroll, a prison officer at Hakea Prison who was involved in the emergency response to Mr Bropho after he was attacked on 9 March 2023;

(d) Ms Fiona Freehill, a clinical nurse at Hakea Prison who was also involved in the emergency response on 9 March 2023;

(e) Mr Veer Partap Singh, the Supervisor of the Assessments team within Corrective Services;

(f) Mr James August, Deputy Commissioner of Corrective Services, Adult Male Prisons;

(g) Ms Toni Palmer, author of the Department's Performance Assurance and Risk Directorate review report into Mr Bropho's death; and

(h) Dr Catherine Gunson, Deputy Director of Medical Services, who spoke to the Department's summary report concerning medical care provided to Mr Bropho in custody.

14 I have also considered the written submissions filed by the Department (referred to above), as well as written submissions filed by the Aboriginal Legal Service on behalf of Mr Edgill, concerning:

(a) what findings and comments I should make in relation to Mr Bropho's supervision, care and treatment, based on the evidence; and

(b) draft recommendations circulated after the inquest for comment.

15 I will address the content of those submissions when I deal with the relevant issues further below.

Summary of the evidence

16 In this part of the findings, I will summarise the evidence and make factual findings about the circumstances leading up to and including Mr Bropho's death, including any findings which may underpin comments on the matters identified at par [9] above.

17 In doing so, I apply the principles arising from ***Briginshaw v Briginshaw***[11] concerning the evaluation of evidence and standard of proof in relation to allegations of a serious nature.

18 I will reserve summarising the terms of applicable Departmental policies until I turn specifically to the issues arising in relation to Mr Bropho's supervision and care.

Mr Bropho's personal background

19 Mr Bropho was born in Subiaco.[12] His mother passed away when Mr Bropho was young.[13]

20 Mr Bropho was raised by his grandmother in Carnarvon.[14]

21 In 2014, Mr Bropho suffered a myocardial infarction which resulted in stent implantation. He also suffered from diabetes and experienced seizures. He was diagnosed with schizophrenia in 2003 and was noted to have a significant intellectual impairment.[15]

[11] (1938) 60 CLR 336.
[12] Exhibit 1, tab 38, par [4].
[13] Exhibit 1, tab 38, par [6].
[14] Exhibit 1, tab 38, par [7].
[15] Exhibit 4, p 4.

22 Mr Bropho spent periods in custody in 2003, 2004 and 2015.[16]

Circumstances of Mr Bropho's remand in 2022 to 2023

23 Mr Bropho was remanded in custody on 13 July 2022 on charges of:

(a) indecent dealing with a child under 13 years of age; and

(b) procuring, encouraging or inciting a child under 13 years of age to engage in sexual behaviour.[17]

24 Mr Bropho pleaded guilty to those charges on 7 September 2022.[18]

25 Upon intake at Hakea, Mr Bropho was identified as needing protection due to his charges and was placed in Unit 9.[19] He was housed in various cells within that unit until his transfer to Unit 10 on 8 March 2023.[20]

26 Mr Costello described Mr Bropho as pleasant and always respectful to staff, and a prisoner who did not cause any issues in Unit 9.[21]

27 From the time of his reception into Hakea, Mr Bropho was treated for his various physical and mental health conditions.[22]

28 It is unnecessary to set out the course of Mr Bropho's medical care in custody from 2022 in detail. The evidence within the coronial brief demonstrates that he was routinely seen by nurses and doctors, including psychiatrists, and provided support by mental health workers.[23]

29 It is noteworthy that in his psychiatric consultations in July and October 2022, Mr Bropho was recognised as being vulnerable to abuse and manipulation by others.[24]

[16] Exhibit 4, p 3.
[17] Exhibit 2, tab 1, p 4; tab 1.2.
[18] Exhibit 2, tab 1.21.
[19] Exhibit 2, tab 1, p 4.
[20] Exhibit 2, tab 1.19.
[21] Exhibit 2, tab 1.23, par [8]; ts 10.
[22] Exhibit 4, p 5.
[23] Exhibit 4, pp 13-14.
[24] Exhibit 4, pp 5-6.

Circumstances of Mr Martin's imprisonment from 2020 onward

30 From 31 August 2020, Mr Martin was incarcerated at Acacia Prison serving a term of imprisonment for aggravated armed robbery.[25]

Attack of another prisoner at Acacia in December 2020

31 Between September and December 2020, Mr Martin and a fellow prisoner (**Prisoner RP**) planned to attack another prisoner at Acacia Prison who had been convicted of child sex offences.[26]

32 Mr Martin had known the victim for many years and knew of his offending history. Mr Martin had dated one of the victim's daughters and disliked the victim because he had committed sexual offences against one of the victim's daughters.[27]

33 Mr Martin threatened to kill the victim in September 2020.[28]

34 A few days before Christmas 2020, Mr Martin told the victim that '[i]t's going to happen', meaning the attack upon him that eventuated later that month.[29]

35 On 27 December 2020, using two improvised sharp-edged weapons created and hidden by Mr Martin in a place where he told Prisoner RP they could be found, Prisoner RP stabbed the victim, inflicting 47 wounds.[30]

36 Prison guards searched Prisoner RP and found a three-page handwritten note in his pocket, saying that he intended to murder a paedophile.[31] I will return to this note later in my findings, as far as it becomes relevant to the information held by the Department about Mr Martin in early 2023.

37 Upon admission to the intensive care unit, it was considered that the victim may not survive although, ultimately, he did.[32]

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[25] ***The State of Western Australia v Phillips*** [2023] WASCA 104 (**Court of Appeal decision**), pars [4], [24].
[26] Court of Appeal decision, par [10].
[27] Court of Appeal decision, par [25].
[28] Court of Appeal decision, pars [9], [29].
[29] Court of Appeal decision, par [29].
[30] Court of Appeal decision, pars [2], [26]-[27].
[31] Court of Appeal decision, par [18].
[32] Court of Appeal decision, par [19].

38 On 5 January 2021, intelligence officers interviewed Mr Martin. A summary of the interview was produced in a security report stored within the Department's Total Offender Management Solution system (**TOMS**).

39 The summary indicates that Mr Martin told the officers that he does not care about other sex offenders (which I take to mean that he is not concerned about them, in a general sense), but that the victim of the attack was a part of his life and had affected people in Martin's family.[33]

40 During an interview with Police on 14 January 2021, Mr Martin admitted:

(a) that he knew the attack was going to take place;

(b) that he had made and secreted the weapons knowing they would be used to attack the victim;

(c) that he and Prisoner RP had planned the attack; and

(d) that he had chosen the victim because of his 'personal connection' with him and because the victim was the type of person who betrayed and sexually abused his own daughter.[34]

41 Mr Martin was charged with attempted murder on that date.[35]

Transfer from Acacia Prison to Albany Regional Prison

42 In January 2021, an officer at Acacia wrote to several Departmental staff concerning the need to transfer Mr Martin to another prison. The Supervisor, Movements based at Hakea Prison recognised the severity of the incident at Acacia and sought additional information.[36]

43 By email on 27 January 2021, a Deputy Director with Serco wrote to Departmental officers providing a summary of the charge against Mr Martin, and the fact that his status as a protection prisoner at Acacia had been reviewed and removed.[37]

[33] Exhibit 2, tab 5.
[34] Court of Appeal decision, par [32].
[35] Exhibit 2, tab 1, p 5.
[36] Exhibit 1, tab 39.5
[37] Exhibit 1, tab 39.5.

44 A prisoner movement risk assessment was conducted in relation to Mr Martin on 25 February 2021. The documentation of that assessment contained no reference to the events of December 2020, or the fact that Mr Martin had been charged for attempted murder, providing that his recent behaviour in prison had been 'Poor – disruptive'.[38]

45 Mr Martin was transferred to Albany Regional Prison (**ARP**).

46 On 3 March 2021 while at ARP, Mr Martin was moved to a single cell within the Multi-Purpose Unit, with a protection alert entered in TOMS.

47 It is apparent that Mr Martin was afforded protection status for reasons including his having tattoos depicting a swastika. ARP did not have a dedicated protection unit, so Mr Martin required transfer.[39]

Transfer from Albany Regional Prison to Hakea Prison

48 Another prisoner movement risk assessment was conducted in relation to Mr Martin on 4 March 2021.

49 The documentation of that assessment referred to Mr Martin's remand for attempted murder but provides no details,[40] and noted that he was a protection prisoner.[41]

50 There is no evidence that any review was undertaken of Mr Martin's protection status by staff at Hakea until, at least, 22 March 2021 (as to which, see par [232] below).

51 On 9 March 2021, Mr Martin was received at Hakea Prison as a protection prisoner and temporarily placed in Hakea's Multi-Purpose Unit (**MPU**) (also known as Unit 1). On 18 March 2021, he was transferred to Unit 7, a protection unit at the relevant time.[42]

52 A classification review was conducted in relation to Mr Martin on 3 June 2021 by staff at Hakea.

[38] Exhibit 1, tab 28, p 2.
[39] Exhibit 1, tab 33, p 7.
[40] Exhibit 1, tab 28.1, p 1.
[41] Exhibit 1, tab 28.1, p 3.
[42] Exhibit 1, tab 33, p 7.

53 The documentation of the review noted the reasons for his placement in protection at ARP, including his having tattoos depicting a swastika,[43] and contained a one-line reference to the charge for attempted murder at Acacia, with no further information.[44]

54 Mr Martin resided in Unit 9 at Hakea, along with Mr Bropho, on at least two occasions in 2022 without any known incidents – for seven days in July and five days in August.[45]

55 In his evidence at the inquest, Mr Costello said that he knew Mr Martin to be very manipulative, but not violent, and could not recall seeing any evidence that he was a particular risk to sex offenders.[46]

56 Mr Costello was not aware of Mr Martin's attempted murder charge at the time he interacted with him in Unit 9.[47]

Incident involving Mr Martin and Prisoner SB

57 On 14 September 2022, Mr Costello produced an incident report about Mr Martin and another prisoner housed in Unit 9 at Hakea, Prisoner SB.

58 Prisoner SB had advised a prison officer that Mr Martin had threatened to stab him should they come into contact due to Prisoner SB's charges.

59 Prisoner SB was incarcerated for the charge of possession or control of child abuse material.[48]

60 Mr Martin also threatened that he would arrange for others in Unit 9 to stab Prisoner SB.[49]

61 Upon being advised of the report, Mr Costello interviewed Prisoner SB, who confirmed the reported information.

62 Mr Costello advised Prisoner SB that a TOMS risk alert would be raised between him and Mr Martin.[50]

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[43] Exhibit 1, tab 29, p 2.
[44] Exhibit 1, tab 29, p 2.
[45] Exhibit 1, tab 33, p 10.
[46] Ts 16. I note that Mr Costello did not appear to have any independent recollection of the incident between Mr Martin and Prisoner SB addressed at par [57]ff.
[47] Ts 21.
[48] Exhibit 2, tab 1, p 11.
[49] Exhibit 2, tab 1.9.
[50] Exhibit 2, tab 1.9.

63 On 14 September 2022, Mr Costello raised an alert in TOMS in relation to Mr Martin, noting that Prisoner SB was concerned for his own well-being, and that he had claimed that Mr Martin had threatened to stab Prisoner SB if he were to be transferred to Unit 10.

64 The documentation indicates that Mr Costello referred the incident to the Assistant Superintendent Operational Practice[51] at Hakea, including with reference to Mr Martin's involvement in the stabbing at Acacia Prison.[52]

65 The report and 'alleged risk' were noted, with the resolution that no further action be taken.[53]

Mr Martin's sentencing for attempted murder

66 Mr Martin was convicted after trial of the attempted murder of the other prisoner at Acacia in 2020.

67 Mr Martin was sentenced in the Supreme Court of Western Australia by the Hon. Justice McGrath on 10 November 2022.

68 The sentencing remarks were published as ***The State of Western Australia v Martin*** [2022] WASCSR 38.

69 I infer the published sentencing remarks would have been publicly available on the Court's website for a period and otherwise could have been obtained by the Department, including upon request.[54]

70 McGrath J noted, in making findings of fact, that Mr Martin had told police during his interview that he 'had no beef' with anyone else within the unit, including paedophiles, just the victim because of the personal relationship he had with him.[55]

71 However, his Honour also determined that Mr Martin targeted the victim because he had decided to engage in 'vigilante behaviour', and because Mr Martin believed the victim was a paedophile who had sexually abused his own daughter.[56]

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[51] Ts 23.
[52] Exhibit 2, tab 1.9.
[53] Exhibit 2, tab 1.9.
[54] *Criminal Procedure Rules 2005* (WA) r 51(1) and (5).
[55] ***The State of Western Australia v Martin*** [2022] WASCSR 38 [24].
[56] ***The State of Western Australia v Martin*** [2022] WASCSR 38 [49].

72 McGrath J also noted that the offence was not a spontaneous act but a premeditated act of violence.[57]

73 Mr Martin was sentenced to a term of nine years' imprisonment with eligibility for parole.[58]

Further events at Hakea Prison prior to Mr Bropho's transfer

74 A management and placement (**MAP**) assessment was conducted in relation to Mr Martin in November 2022, following his sentencing.[59]

75 The MAP documentation refers to Mr Martin's conviction for assault occasioning bodily harm, relating to an occasion on 9 November 2020 when he punched another prisoner in the face several times.[60]

76 The offence was committed against a prisoner who was registered on the Australian National Child Offender Register (**ANCOR**). There is no evidence that Mr Martin was aware of that fact at the time of the offence.[61]

77 The MAP documentation also refers to the attempted murder, including the following statement:

> During a search of the co-offender, a three-page handwritten note was located in his pocket which referenced Mr Martin's intent to murder a paedophile.[62]

78 This statement is factually wrong, in that (as identified above at par [36]) the letter referred to Prisoner RP's intention to murder a paedophile.[63]

79 The inaccuracy appears to have arisen as a misinterpretation of the initial statement of material facts, which did not distinguish between Mr Martin and Prisoner RP in a clear way.[64]

80 The officer preparing the MAP appears to have made the error when summarising the material facts.[65]

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[57] ***The State of Western Australia v Martin*** [2022] WASCSR 38 [50].
[58] ***The State of Western Australia v Martin*** [2022] WASCSR 38 [71], [73]. This sentence was successfully appealed by the State, and Mr Martin resentenced to 11 years' imprisonment: Court of Appeal decision.
[59] Exhibit 1, tab 30.
[60] Exhibit 1, tab 30, p 1.
[61] Exhibit 1, tab 33, p 8.
[62] Exhibit 1, tab 30, p 2.
[63] Exhibit 1, tab 33, p 8.
[64] Exhibit 2, tab 1.7.
[65] Exhibit 2, tab 1.13, pars [13].

81 However, there is no suggestion that the fact of the error was known to the Department until after Mr Bropho was killed. The author of the MAP report did not raise the statement with anyone because he assumed it was known intelligence, having been derived from a statement of material facts, and had been appropriately recorded.[66]

82 The MAP also contains reference to Mr Martin's threat to stab Prisoner SB, but not the reason Prisoner SB said the threat was made.[67]

83 The MAP noted Mr Martin's history of violent offending, with his 'current offences being an escalation in severity'.[68]

84 The MAP simply noted Mr Martin's protection status.[69]

85 The author of the MAP noted in a statement provided to the Department after Mr Bropho's death that the assessment process is designed to give a security rating to a sentenced prisoner and assist in their placement.[70]

86 Mr Singh, the Supervisor of Assessments within Corrective Services, gave evidence at the inquest, and confirmed that the MAP is not a risk assessment,[71] but is undertaken solely to provide a security rating to assist in the determination of where a prisoner should be located.[72]

87 I digress to note that, in my view, this position was reasonably held by Mr Singh where, at that time, he and others performing or supervising a MAP did not have access to Departmental intelligence or security reports.[73]

88 In a treatment assessment report conducted in December 2022 in relation to Mr Martin, it was noted that the attempted murder was 'precipitated by [his] dislike for the victim and his need to act out in vengeance'.[74]

89 The treatment assessment report contained the same information identified above at par [77].

[66] Exhibit 2, tab 1, p 11; tab 1.13, par [15].
[67] Exhibit 1, tab 30, p 3.
[68] Exhibit 1, tab 30, p 7.
[69] Exhibit 1, tab 30, p 11.
[70] Exhibit 2, tab 1.13, par [6].
[71] Ts 56.
[72] Exhibit 2, tab 1.14, par [20].
[73] Exhibit 2, tab 1.14, par [23]; ts 62.
[74] Exhibit 1, tab 31, p 1.

90 It was noted in the minutes of an At Risk Management System – Prisoner Risk Assessment Group decision from 13 January 2023, that Mr Martin had reported to prison health services that he had experienced a decline in his mental state and had voiced thoughts to harm others 'but said he will not act on these thoughts as he does not want to stay in prison for longer than necessary'.[75]

Mr Bropho's transfer to Unit 10

91 On 3 March 2023, an officer in the Department's Intelligence Services circulated an email to Hakea Security Management, advising that Mr Bropho's upcoming District Court appearance would likely attract media attention due to his association with another well-known prisoner.[76]

92 On 7 March 2023, Mr Bropho attended Perth District Court for sentencing in relation to his charges. The hearing was adjourned to a future date.[77]

93 It was noted in the Support and Monitoring System Supervision Log, that Mr Bropho did not experience any issues ahead of his appearance.[78]

94 Later that day after Mr Bropho's return from Court, Mr Costello was advised by one of his staff that he had heard threatening and abusive comments being shouted out at Mr Bropho.[79]

95 At that time, Mr Costello was an experienced prison officer (having started with the Department in that role in July 1990[80]) who had been predominantly based at Hakea.[81]

96 Mr Costello observed that threats and abuse within units is common, and it is a matter of weighing up which ones are serious.[82]

97 Mr Costello spoke to Mr Bropho, who did not have any concerns.[83]

[75] Exhibit 1, tab 32, p 14.
[76] Exhibit 1, tab 33, p 11; tab 33.7.
[77] Exhibit 1, tab 33, p 11.
[78] Exhibit 2, tab 1.22, p 13.
[79] Exhibit 2, tab 1.23, par [13].
[80] Ts 9.
[81] Ts 9.
[82] Exhibit 2, tab 1.23, par [26].
[83] Ts 14.

98 It was reasonable that Mr Costello did not cease to act simply because Mr Bropho did not have any concerns, given the evidence which suggests that Mr Bropho was unlikely to be capable of fully understanding the risk to him behind such threats.

99 At this stage, Mr Costello began considering the options available to him in respect of Mr Bropho, including his transfer from Unit 9.

100 Mr Costello excluded moving Mr Bropho to the MPU because that would involve isolating him[84] (including from his cousin who was a support)[85] and the MPU was a unit generally used for punishment.[86]

101 Mr Costello attended the senior officers' briefing in the morning of 8 March 2024 and expressed his intention to move Mr Bropho to Unit 10 at Hakea to Mr Rod Curtis, another senior officer at Hakea Prison.

102 Mr Curtis was the senior officer in charge of Unit 10 during that shift.

103 At that time, Mr Curtis had over 30 years' experience as a prison officer,[87] and 12 years' experience as a senior officer.[88]

104 Mr Costello explained why he wanted to move Mr Bropho,[89] and Mr Curtis did not express any concerns.[90]

105 Ms Kylie Happ was the control officer at Unit 10 during the relevant shift.

106 Ms Happ was aware that Mr Bropho was getting threats within Unit 9, after pleading guilty to sexual offences relating to children.[91]

[84] Exhibit 2, tab 1.23, par [16].
[85] Ts 14.
[86] Ts 38.
[87] Ts 24.
[88] Ts 25.
[89] Ts 16; ts 26.
[90] Exhibit 2, tab 1.23, par [19].
[91] Exhibit 1, tab 17.1, par [6].

107 Mr Curtis and Ms Happ consulted TOMS to ascertain if:

(a) Mr Bropho had any alerts on TOMS with other prisoners;

(b) if Mr Bropho required a single cell; and

(c) whether Mr Bropho was a risk to himself or anyone else,

and they did not identify any alert that prevented Mr Bropho from moving into Unit 10.[92]

108 Mr Bropho's movement into cell A10 in Unit 10 is recorded as having occurred at about 1.15 pm on 8 March.[93]

Mr Martin's transfer to Unit 10

109 At about 2 pm the same day, Mr Martin was transferred from the MPU back to Unit 10, after having completed a period of separate confinement.

110 He was allocated cell A08.[94]

111 After his return to Unit 10, Mr Martin had a conversation with the prisoner sharing cell A10 with Mr Bropho, Prisoner MK, where they both expressed negative views about Mr Bropho's charges.[95]

112 Mr Martin told Prisoner MK that he would kill Mr Bropho.[96]

Attack on Mr Bropho on 8 March 2023

113 At least two prisoners (one of whom was Prisoner MK) spoke to one of the prison officers who was on duty in Unit 10 on 8 March and stated that they were upset that Mr Bropho was on the wing because of the nature of his charges, although they did not make any threats against him.[97]

[92] Exhibit 1, tab 16.1, pars [9]-[10]; tab 17.1, pars [8]-[9].
[93] Exhibit 2, tab 1.19.
[94] Exhibit 1, tab 33.12, p 10.
[95] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [41].
[96] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [42]-[46].
[97] Exhibit 1, tab 18, pars [27]-[38].

114 Around 4.50 pm on 8 March, Mr Martin went to cell A10, where Mr Bropho was located. Mr Martin held Mr Bropho in a headlock and smashed his head into shelving, causing him to fall to the cell floor. Mr Martin then laid on top of Mr Bropho and held him in a headlock while another prisoner repeatedly punched at, and stomped on, his head.[98]

115 Surprisingly, given the ferocity of the attack, Mr Bropho suffered few observable injuries.[99]

116 According to another prisoner who spent some time with Mr Bropho after the attack, said he had 'blood in his mouth and lump around eye (*sic*)'.[100]

117 Another prisoner who observed Mr Bropho soon after the attack noted that he did not appear 'to be too badly hurt, just a bit of blood on the lip and a black eye maybe'.[101]

118 A third prisoner observed that Mr Bropho was 'bleeding out of his mouth'.[102]

119 Prisoner MK observed that Mr Bropho had a 'really big lump to his right eye', and that there was blood on the cigarette he was smoking at the time, which Prisoner MK assumed must have been coming from his mouth.[103]

120 There is no evidence from any of the officers on duty in Unit 10 that they observed any injuries Mr Bropho sustained from the attack.

121 Ms Happ noted that on the day, she would have assisted with the distribution of medication and 'dish up', which usually occurred between 5.00 pm and 5.30 pm.[104]

122 Ms Happ had a vague recollection of Mr Bropho attending for his dinner, and that she did not notice any injuries, acknowledging that she would have been looking through glass from the control room.[105]

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[98] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [48]; exhibit 1, tab 12 [37]-[40].
[99] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [48].
[100] Exhibit 1, tab 11, par [49].
[101] Exhibit 1, tab 12, par [57].
[102] Exhibit 1, tab 13, par [34].
[103] Exhibit 1, tab 15, par [50]-[51].
[104] Exhibit 1, tab 16, par [16].
[105] Exhibit 1, tab 19.1, par [19].

123 In an entry in the SAMS Log at about 6pm, Mr Kynoch, an officer rostered on in Unit 10 on 8 March, noted that Mr Bropho was seen mixing in the afternoon and orientated into the Unit.[106]

Lockup of Unit 10 in the evening of 8 March 2023

124 According to the witness statement of Mr Taulanga, one of the other officers on duty in Unit 10, prisoners were placed in their cells at 5.00 pm, save for those on cleaning duties.[107]

125 Mr Kynoch recalled that this occurred at 5.30 pm.[108]

126 There is no need to resolve this difference in the evidence.

127 It is sufficient to note that on either account, the attack on Mr Bropho, which a witness suggests lasted about a minute,[109] had already occurred.

128 Mr Curtis provided a witness statement in 2025 which refers to the way lockup is usually conducted, with prison wing officers walking down and checking the prisoners, before – following instruction from the senior officer – the wing officers proceed to lock the cells and peer through the window on the door to ensure everything is correct.[110]

129 Mr Curtis did not expressly state, in his witness statement, that lockup occurred in this manner on 8 March 2023.

130 Similarly, at the inquest, Mr Curtis was asked about the process involved when a unit gets locked down for the night, in 'general terms'.[111]

131 Mr Curtis was not asked whether he had any independent recollection whether the lockup on 8 March occurred in the manner he described.

132 In a witness statement he provided in 2023, Mr Taulanga stated that at about 6.00 pm, he and another officer did a lock and muster check, with Mr Curtis present. He stated that he and the other officer did the cell count and ensured that the doors were locked, and that they were simply conducting a number check rather than a welfare check.[112]

[106] Exhibit 2, tab 1.22, p 13.
[107] Exhibit 1, tab 18, par [45]-[46].
[108] Exhibit 1, tab 19, par [23].
[109] Exhibit 1, tab 12, par [48].
[110] Exhibit 1, tab 16, pars [16]-[18].
[111] Ts 30-31.
[112] Exhibit 1, tab 18, par [48].

133 Mr Taulanga's evidence was that, at that time at Hakea, the senior officer performed the welfare check.[113] He compared that to his experience at Casuarina Prison, where he noted that the wing officer does the inspection of prisoners at lock-up.[114]

134 In his statement, Mr Kynoch said that the count he performed was a number check to ensure all prisoners are present, and that he was not performing a welfare check.[115]

135 In his report prepared for the inquest, Mr August observed that 'Commissioner's Operating Policy and Procedure 10.2 – Daily Prison Routine and Population Counts' (**COPP 10.2**) makes plain that all officers involved in the evening lockup are individually responsible for observing and assessing each prisoner's presence, identification and apparent wellbeing before the cell is secured.[116]

136 I accept Mr August's evidence and will return to the content of COPP 10.2 at par [268] below.

137 Given the state of the evidence, I am unable to make any findings about precisely how the lockup of Unit 10 was performed on the evening of 8 March 2023.

138 It appears unlikely any welfare check was performed on Mr Bropho during the evening lockup, given the conflicting views expressed by officers about who was to undertake that duty.

139 However, for reasons developed below (at par [274]), given the apparent nature of Mr Bropho's injuries, I do not make any adverse comment against any individual officer.

140 I do expressly accept Mr Curtis's evidence that he did not observe any issues with Mr Bropho during the process.[117]

141 I am also satisfied, based on the evidence of the various officers, that had any officer observed any injuries to Mr Bropho, or been informed of any such injuries, those injuries would have been reported, and Mr Curtis would have taken the opportunity to speak to Mr Bropho after lockup.

[113] Exhibit 2, tab 1.27, par [13].
[114] Exhibit 2, tab 1.27, par [15].
[115] Exhibit 1, tab 19, par [27]-[28].
[116] Exhibit 1, tab 33, p 12.
[117] Exhibit 1, tab 16.1, par [19].

Attack on Mr Bropho on 9 March 2023

142 On the morning of 9 March, a prisoner officer on shift in Unit 10, Theresa Ward, conducted a movement check of the prisoners.[118] Ms Ward recalls every prisoner showing movement.[119]

143 As Prisoner MK went to get his breakfast pack, Mr Martin called out and told Prisoner MK to come into his cell, which was diagonally opposite.[120]

144 Prisoner MK went to Mr Martin's cell and stayed there[121] while Mr Martin went into Mr Bropho's cell.

145 It is unnecessary to provide a detailed account of the monstrous assault Mr Martin inflicted on Mr Bropho that killed him.

146 It is sufficient to note that Mr Martin placed Mr Bropho in a choke hold until he became unconscious and then stood on Mr Bropho's throat, fracturing his larynx.[122]

147 When leaving the cell, Mr Martin placed a towel over the cell door to conceal Mr Bropho's body.[123]

Emergency response

148 Following advice from medical staff at about 8.10 am that he had not attended, Ms Happ put a call out over the PA system for Mr Bropho to attend to collect his medication from near the control room.[124]

149 At about 8.12 am, three prison officers went down to Mr Bropho's cell to see where he was, including Mr Carroll and Ms Ward.[125]

150 Mr Carroll confirmed that attendance by multiple officers in this situation is standard practice.[126]

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[118] Exhibit 1, tab 20, par [20].
[119] Exhibit 1, tab 20, par [30].
[120] Exhibit 1, tab 15, par [65]-[66].
[121] Exhibit 1, tab 15, par [73].
[122] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [52]-[53].
[123] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [55]; exhibit 1, tab 12 [86]; tab 13, par [49].
[124] Exhibit 1, tab 17, pars [6]-[7].
[125] Exhibit 1, tab 17, par [10]; tab 20, par [60]; tab 21, par [8]-[9].
[126] Ts 43.

151 When they got to the cell, Mr Carroll opened the door and he and Ms Ward observed Mr Bropho lying, face-up, on the floor next to the bed.[127]

152 Mr Carroll observed that Mr Bropho had an injury to his face[128] and that he was non-responsive and not breathing.[129]

153 Mr Carroll immediately commenced CPR and advised the third prison officer to call a code red medical emergency which they did at 8.15 am.[130]

154 Ms Freehill, a nurse who worked at Hakea Prison at the time and was undertaking duties in Unit 9, attended a short time later[131] in immediate response to the code red.[132] She confirmed that Mr Bropho did not have any trauma or bleeding that she needed to stop,[133] before taking over CPR while Mr Carroll maintained Mr Bropho's airway.[134]

155 Ms Freehill immediately requested an ambulance be called.[135] A call was made for an ambulance at 8.21 am.[136]

156 Ms Freehill attached the defibrillator which had been obtained from the control room to Mr Bropho[137]; inserted a guedel airway to properly maintain Mr Bropho's airway; and inserted a cannula by which adrenaline was administered.[138]

157 Paramedics arrived at about 8.35 am.[139] They continued resuscitation efforts, including by use of a Lucas machine,[140] until around 8.57 am.[141]

158 An attending paramedic certified Mr Bropho as life extinct at 8.58 am.[142]

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[127] Exhibit 1, tab 20, par [62].
[128] Exhibit 1, tab 21, par [12].
[129] Exhibit 1, tab 21, pars [13]-[14].
[130] Ts 45. See also exhibit 1, tab 20, par [73]; tab 16, par [14]; tab 17, par [12]; tab 22.1, par [9].
[131] Ts 46, 49.
[132] Exhibit 1, tab 22, par [5].
[133] Ts 50.
[134] Exhibit 1, tab 20, par [86]; tab 21, par [19]; tab 22, par [9]; ts 43.
[135] Exhibit 1, tab 22, par [10]; ts 50.
[136] Exhibit 1, tab 24.
[137] Exhibit 1, tab 22, par [10].
[138] Exhibit 1, tab 22, pars [11], [14].
[139] Exhibit 1, tab 21, par [24]; tab 22, par [16]; tab 23, par [7].
[140] Exhibit 1, tab 23, pars [19]-[20].
[141] Exhibit 1, tab 21, par [25]; exhibit 1, tab 22, pars [16]-[17].
[142] Exhibit 1, tab 4.

159 The remainder of the unit was locked down during the code red emergency response,[143] including Mr Martin.[144]

160 The evidence contained in the brief demonstrates that the prison staff's response to the incident, in terms of preservation of what was then a potential crime scene, was satisfactory.

161 There is no need to detail all the steps taken in this regard in these findings.

Conviction and sentencing of Mr Martin

162 Mr Martin pleaded guilty to Mr Bropho's murder and in sentencing, the Hon. Justice Fiannaca concluded that he held a belief that he was justified to kill someone who was a child sex offender.

163 Significantly, Mr Martin had engaged in what his Honour characterised as 'vigilante behaviour',[145] the same characterisation given by McGrath J to Mr Martin's conduct when sentencing him in November 2022 for attempted murder.

164 Fiannaca J concluded that Mr Martin was aware of his actions and the gravity of what he was doing, and suggestive of a calculated decision to act on his determination of who was 'worthy of being murdered'.[146]

165 His Honour also noted the evidence that Mr Martin was not suffering from any overt 'positive' psychotic symptoms at the time of the offence.[147]

Cause and manner of death

166 Forensic pathologists conducted a post mortem examination on 14 March 2023.

167 The pathologists identified signs of neck compression, including bruising and fracture of the anterior neck cartilage, as well as blunt force facial injuries, including bruises and laceration of the tongue. The pathologists also identified severe coronary artery atherosclerosis.[148]

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[143] Ts 35.
[144] Exhibit 1, tab 16, pars [15], [25]; exhibit 1, tab 17, par [19]-[20].
[145] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [70].
[146] ***The State of Western Australia v Martin*** [2024] WASCSR 7 (S) [49].
[147] ***The State of Western Australia v Martin*** [2024] WASCSR 7 (S) [50].
[148] Exhibit 1, tabs 5.1 and 5.2.

168 Following microscopic examination of body tissues and consideration of biochemical and toxicological analysis, the pathologists formed the opinion that Mr Bropho had died from injury to the neck on a background of atherosclerotic heart disease.[149]

169 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

170 As identified above, Mr Martin has been convicted by the Supreme Court of Western Australia of the murder of Mr Bropho.

171 For the purposes of s 25(1)(b) of the Act, I find that Mr Bropho's death occurred by way of unlawful homicide.

Treatment, supervision, and care of Mr Bropho

Management of Mr Bropho's medical conditions

172 I accept the evidence from Dr Gunson that during his time in Hakea Prison in 2022 and 2023, Mr Bropho was treated for his various physical and mental health conditions in an appropriate and holistic manner,[150] comparable to community standards.[151]

173 I accept the Department's submission that the comparatively minor procedural issues identified by Dr Gunson in her report did not materially impact his overall medical treatment.[152]

174 I find that Mr Bropho's general medical care during his remand in Hakea Prison was satisfactory.

Information available concerning risk posed by Mr Martin

175 As identified above, a key issue considered at the inquest was the information that was known, or readily available, to the Department concerning the risk posed by Mr Martin as of early 2023 to other prisoners in protection units such as Mr Bropho.

[149] Exhibit 1, tab 5.
[150] Exhibit 4, p 10.
[151] Exhibit 4, p 12.
[152] Department's submissions, par [83].

176 In assessing the evidence that relates to this issue, I remain mindful of the potential cognitive influence referred to as 'hindsight bias'.[153]

177 Also, although trite, in assessing the known risk in early 2023 I have not had regard to any statements of Mr Martin which only become known to the Department after Mr Bropho had been killed – for example, Mr Martin's statement to another prisoner in February 2023 that he would 'stab or kill sex offenders and do the public a service.'[154]

178 I accept the Department's submission that this is not intelligence that the Department was aware of or could have acted upon.[155]

179 I am also cognisant that in assessing the known risk, it is important to avoid 'cherry-picking' parts of the evidence rather than assessing the available evidence in the fullest possible context.

180 I should also make plain that in making findings about the state of knowledge of the risk Mr Martin might have posed to other protection prisoners, including Mr Bropho, in early 2023, I am referring to the knowledge of the Department and, at most, the group of the most senior officers at Hakea at the time, and not to any individual prison officers.

181 That is necessarily so, for four reasons.

182 **First**, the evidence is clear that not all Departmental officers would have had the same access to all information held by the Department, including security and intelligence reports.[156]

183 **Secondly**, and relatedly, some intelligence information was said to have fallen into what was described during the inquest as 'black holes',[157] or 'cracks',[158] and it is not clear to me exactly where particular evidence might have been stored within the Department's data holdings at the relevant time.

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[153] Although arising in different legal contexts which are not analogous, the principle is described in general terms in ***Rosenberg v Percival*** [2001] HCA 18; (2001) 205 CLR 434 [68]; ***Shire of Gingin v Coombe*** [2009] WASCA 92 [43].
[154] ***The State of Western Australia v Martin*** [2024] WASCSR 7 [162]-[163].
[155] Department's submissions, par [92].
[156] Exhibit 2, tab 1.14 par [23].
[157] Ts 89.
[158] Ts 90.

184 **Thirdly**, as of June 2021, the information in the Department's security portal was not being updated, and Intelligence Services had advised that information from that source should be treated as unreliable.[159]

185 It would be unfair to draw a conclusion critical of any individual prison officer for failing to draw information together, where there was advice to treat a source of potentially relevant information with caution.

186 **Fourthly**, prison officers are dealing with regular musters and prisoners coming and going regularly, so they will generally not have a huge amount of time to dig deep into an individual prisoner's profile.[160]

187 It would be unreasonable to expect those officers to draw together disparate information in order to conduct detailed and dynamic risk assessments as part of their standard, day-to-day duties.

188 Having regard to all the above, I find, based on my summary of the evidence above, that as of March 2023, the Department and senior staff responsible for the security of protection prisoners at Hakea knew, or would have known had proper inquiries been made:

(a) that between September and December 2020, Mr Martin had been part of a pre-meditated attempted murder of another prisoner at Acacia Prison which was motivated, in part, because of the victim having committed sexual offences against a child;

(b) that in committing the offence of attempted murder, Mr Martin had been involved in what a Judge of the Supreme Court had decided represented vigilante behaviour;

(c) that in September 2022, Mr Martin was reported to have threatened to stab another protection prisoner at Hakea due to his child sex-related offending should they come into contact;

(d) that it was also reported that Mr Martin had threatened to get others in that prisoner's protection unit to stab him;

(e) that Mr Martin had previously assaulted another prisoner occasioning bodily harm, where that prisoner was registered on ANCOR (and on that basis it could be inferred had been convicted of a sexual offence against a child);

[159] Exhibit 1, tab 29, p 2.
[160] Ts 12.

(f) relatedly and in addition to (e) above, that Mr Martin had previously violently assaulted three other prisoners, one of whom was also registered on ANCOR;[161]

(g) that Mr Martin had a history of violent offending, which (as was expressly noted by Departmental staff assessing him) had escalated in severity; and

(h) that Mr Martin had recently reported experiencing a decline in his mental state and thoughts to harm others, although he had stated he would not act on those thoughts.

189 In addition, the Department's records included documentation that suggested that at the time of the attempted murder in 2020, Mr Martin had created a note referencing the intention to kill a paedophile.

190 As identified already, this information was incorrect, but it informs the state of the Department's knowledge as of early 2023.

191 As such, it remains relevant to the assessment of the actions the Department took in respect of Mr Martin's protection status.

192 The Department submits, in relation to the matter at par [188(c)] that there is no evidence available to the Court by which it could conclude that Mr Martin was actually aware of the nature of Prisoner SB's charges.[162]

193 I do not accept that submission, for the following reasons.

194 **First**, Mr Martin knew that Prisoner SB was a protection prisoner, in circumstances where 75% of the current protection population at Hakea are charged with or convicted of child sex offences,[163] and I infer (in the absence of any evidence to the contrary, or any basis to doubt the correctness of such inference) that the percentage would have been similar in early 2023.

195 **Secondly**, Prisoner SB's report was that Mr Martin expressly said that he knew what Prisoner SB was in custody for, and that Mr Martin said that 'it was on the computer'.[164]

[161] Exhibit 1, tab 33, p 9.
[162] Department's submissions, [88].
[163] Exhibit 1, tab 33, p 5.
[164] Exhibit 2, tab 13.9.

196 An online search of Prisoner SB's full name identifies an article from a popular news publication, published a month prior to the incident, clearly identifying Prisoner SB and the nature of his offending history.

197 In my view, that evidence would be sufficient to infer that Mr Martin was aware of Prisoner SB's charges in September 2022.

198 However, it is unnecessary to make that finding. The Department's submission elides the relevance of the evidence.

199 It is not Mr Martin's actual knowledge that is critical – it is the fact that a prisoner reported to the Department that he had been threatened by Mr Martin with violence because of his charges.

200 There is no evidence to suggest that the Department had any grounds to dismiss or disbelieve Prisoner SB's report, including where it did not take any further action (beyond the addition of the alert on TOMS).

201 To that end, and contrary to the premise of a submission of the Department,[165] it is unnecessary for this Court to reach a conclusion that Mr Martin's actions were to deliberately target a child sex offender for this incident to hold relevance.

202 Instead, the Court finds that the Department was provided information, which it had no apparent cause to doubt at the relevant time, which suggested that Mr Martin (both directly, and by inciting violence by others) posed a risk of serious violence to prisoners in Units 9 and 10 who were charged with child-sex offences.

203 Having regard to the matters at par [188] above, I do not accept, as contended by the Department,[166] that – with the exception of the attempted murder – the known incidents are incapable of demonstrating that Mr Martin posed a heightened risk to prisoners beyond what is ordinarily managed within the prison environment.

204 In any event, the attempted murder cannot sensibly be divorced from the rest of Mr Martin's known history in this context.

[165] Department's submissions, [88].
[166] Department's submissions, [94].

Review of Mr Martin's status as a protection prisoner

205 'Commissioner's Operating Policy and Procedure 4.10 – Protection Prisoners' (**COPP 4.10**) came into effect on 28 December 2021.[167]

206 COPP 4.10 properly recognised the need for the maintenance of protection prisoners' safety and security.[168]

207 COPP 4.10 was introduced in the context of a report of the Office of the Inspector of Custodial Services (**OICS**) into the management of protection prisoners.[169]

208 In that report, OICS expressed a concern that some prisoners were being kept in protection to the detriment of others.[170]

209 Clause 4.1.1 of COPP 4.10 required each prison to have a Protection Multidisciplinary Team (**PMDT**).

210 Pursuant to cl 4.1.2, the role of a PMDT included to:

(a) recommend a management plan for prisoners placed on protection;

(b) review and make recommendations regarding a prisoner's ongoing protection;

(c) recommend removal from protection; and

(d) add, update or remove protection alerts as required.

211 Clause 4.3.1 of COPP 4.10 required a PMDT to conduct, at a minimum, 6-monthly reviews of each prisoner with protection status.

212 The purpose of such biannual reviews was to determine:

(a) if the prisoner should remain on protection or be removed;

(b) if the prisoner's management plan required amendment; or

[167] Exhibit 1, tab 33.1, p 10.
[168] Exhibit 1, tab 33.1, p 3.
[169] As per the Department's press release published 17 May 2022, available at: <https://www.wa.gov.au/government/announcements/new-policy-safeguard-prisoners-who-need-protection>.
[170] At p 3 of the report, available at: <https://www.oics.wa.gov.au/wp-content/uploads/2022/05/Protection-Prisoners-Review-March-2022.pdf>.

(c) if the prisoner required placement at an alternative facility.

213 I note that there was no evidence produced at the inquest that indicates that Hakea had a fully functioning PMDT by the end of 2022 or in early 2023, save that 'Standing Order 4.10 – Protection Prisoners – Hakea Prison' referred to the existence of a PMDT.[171]

214 It appears unlikely, where:

(a) there is evidence that in May 2022 there were only 'trials' of PMDT reviews occurring; and

(b) by the date of Mr Bropho's death, mechanisms were not in place to conduct the reviews, with the suggestion that the COPP had been implemented prematurely.[172]

215 I also note that Ms Palmer was unable to locate any PMDT management plans related to either Mr Palmer or Mr Bropho.[173]

216 It is unnecessary to make a finding as to whether a fully functioning PMDT had been created at Hakea by early 2023, because what is clear from the evidence is that even if a PMDT was operational, Mr Martin's protection status was never the subject of a PMDT review (as required by cl 4.3.1 of COPP 4.10) prior to March 2023.[174]

217 The Department (and Hakea, specifically) clearly failed to comply with its own policy – a policy specifically developed to keep prisoners such as Mr Bropho safe and secure.

218 Beyond the failure to comply with cl 4.3.1 of COPP 4.10, there is no evidence that any group of senior officers at Hakea, equivalent to the intended membership of a PMDT, conducted any ad-hoc review of Mr Martin's protection status prior to March 2023.[175]

219 This is so, notwithstanding the state of the Department's knowledge identified above at par [188].

[171] Exhibit 1, tab 33.2, p 3.
[172] Exhibit 1, tab 33.12, p 23.
[173] Exhibit 2, tab 1, p 21.
[174] Ts 77; 114-115.
[175] Ts 78; 91.

220 In my view, Mr Martin's sentencing for attempted murder in November 2022 was, alone, sufficient to warrant a review (by either a PMDT or senior staff within Hakea of equivalent status) of Mr Martin's continued status as a protection prisoner.

221 I agree with Mr August's view that such a review was warranted not just because the attempted murder was committed against a child sex offender, but because it was a violent crime committed against another prisoner.[176]

222 The failure to conduct the assessment in early 2023 is exacerbated by the absence of any review by the PMDT (or any equivalent) following Martin's reported threat to Prisoner SB in September 2022.

223 In Mr August's view, such a threat would have been enough, in terms of how he expects COPP 4.10 to be implemented today, to warrant a review of Martin's protection status.[177]

224 The Performance Assurance and Risk report noted that there were no TOMS notes or alerts that expressly identified Mr Martin posed a risk to prisoners charged with or convicted of sex offences.[178]

225 In my view, that is not a fact that demonstrates that Mr Martin posed no known risk to other protection prisoners such as Mr Bropho or somehow reduces the severity of the Department's failures.

226 The absence of such alerts is symptomatic of the failure of the Department to perform any substantive review of Mr Martin's protection status, at least after his sentencing for the attempted murder charge. COPP 4.10, by its terms, makes it plain that the entry of such alerts was precisely one of the intended functions for which the PMDTs were created.

227 I accept that there is a great degree of complexity in carefully balancing the threats to and from a potential protection prisoner[179] and that Mr Martin was just one of hundreds of protection prisoners in the State.

228 However, it is simply not clear that any complex balancing was ever undertaken in relation to Mr Martin, at least in late 2022 or early 2023, including prior to Mr Bropho's placement in Unit 10.

[176] Ts 92.
[177] Ts 91.
[178] Exhibit 1, tab 33, p 7.
[179] Exhibit 1, tab 33, p 5.

229 I note that during the inquest, Mr August agreed with my observation that it appeared from the evidence that protection prisoners retained protection status when moving between prisoners seemingly by default.[180]

230 That evidence was given before it became apparent during Ms Palmer's evidence that there were entries located within the alerts module on TOMS, with free text comments associated with an alert, that suggested that officers at various prisons had performed some kind of reviews of Mr Martin's protection status over time.[181] One such entry could be seen in a screenshot annexed to Ms Palmer's report.[182]

231 At my request, following the inquest, the Department provided a summary of the one-line entries.[183]

232 It is apparent from the summary document that senior officers within protection units at Hakea Prison considered Mr Martin's protection status on 22 March 2021, 18 July 2021, 17 October 2021 and 18 June 2022.

233 There is no detail to understand the nature and extent of any of those reviews. It is tolerably clear from the brevity of the entries that the reviews were not representative of the reviews expected of the PMDT.

234 I infer, given the lack of any detail in the entries, that the reviews that were performed occurred in a similar manner to OICS's reported observations as to how reviews were performed historically under Operational Instruction 4 – Management of Prisoners Requiring Protection.[184]

235 In any event, there is no indication that any review of this more limited nature occurred at Hakea in relation to Mr Martin after June 2022.

236 The Department submits that it cannot be assumed or hypothesised that had a PMDT review occurred, it would have resulted in any change to Mr Martin's protection status.[185]

237 That submission is premised on:

[180] Ts 83.
[181] Ts 114.
[182] Exhibit 2, tab 1.3.
[183] Ts 116.
[184] At p 3 of OICS report.
[185] Department's submissions, par [54].

(a) the fact that one of the reasons Mr Martin entered protection, being his tattoos, remained unchanged;[186]

(b) the complexity involved in balancing competing risks when reviewing the status of a protection prisoner;[187]

(c) the limited options for placement at Hakea,[188] including the absence of any evidence that the MPU would have been a probable or sustainable placement option;[189] and

(d) because (as identified by the Court and acknowledged by the Department) COPP 4.10 does not expressly require the PMDT to consider the risk that a protection prisoner poses to other protection prisoners.

238 I accept the matters at (a)-(c) above.

239 I do not accept that a PMDT would have necessarily neglected to consider the risk Mr Martin posed to other protection prisoners had a PMDT review been convened as was required, given the self-evident relevance of his attempted murder conviction and the threat to Prisoner SB, in particular.

240 I accept that it cannot be concluded, as a certainty, that had a PMDT review occurred in early 2023, Mr Martin's protection status would have been cancelled, or he would have been moved out of Unit 10.

241 I reach that conclusion primarily because it must be accepted that any decision in relation to the maintenance of a protection prisoner's status, and their placement, is a complex one which requires the balancing of a multitude of dynamic factors.

242 However, I also find the obverse to be true – it cannot be said with certainty that his status would have remained unchanged.

243 I find that had a PMDT conducted a review of Mr Martin's protection status after his sentencing in November 2022, or in early 2023 (either because a 6 monthly review was overdue, or because an ad hoc review was warranted), there is a real prospect that it would have concluded that Mr Martin was not suitable to remain in a protection unit like Unit 10.

[186] Department's submissions, par [49].
[187] Department's submissions, par [50].
[188] Department's submissions, par [50]
[189] Department's submissions, par [52].

244 I accept that:

(a) Mr Martin had been in protective custody for some time by early 2023;

(b) that he would have remained vulnerable if returned to general population because of his tattoos; and

(c) that he had made statements that suggested that his primary motivation for the attempted murder at Acacia Prison was a personal connection to the victim, and that he did not have a general issue with prisoners charged with child sex offences, like Mr Bropho.

245 However, none of the above detracts from the apparent ability, in early 2023, to observe a pattern of conduct towards child sex offenders like Mr Bropho, having regard to the attempted murder (characterised as a vigilante act), the threat to Prisoner SB, and the assaults against two ANCOR registered offenders.

246 It also does not detract from the real prospect that the PMDT might have determined that Mr Martin was unsuitable to remain in a unit like Unit 10 on the basis of his escalating violent offending generally, given at-risk prisoners like Mr Bropho were within protective custody.

247 A PMDT, acting reasonably and notwithstanding the absence of specific provision in COPP 4.10, could have justifiably concluded that the apparent risk Mr Martin posed to other prisoners in protection like Mr Bropho, including prisoners convicted of child sex offences, outweighed the apparent threat posed to Mr Martin due to his tattoos, or that it warranted consideration being given to his being placed in a more controlled environment at Hakea or another facility, if that were available.

248 Those outcomes are reasonable possibilities, particularly where, as noted above 75% of the current protection population at Hakea are charged with or convicted of child sex offences,[190] and I have inferred the percentage would have been similar in early 2023.

249 I note that Mr August's evidence at the inquest was that had the relevant information been considered holistically, he expects that the outcome would have been Mr Martin being placed in the Special Handing Unit or the MPU.[191]

[190] Exhibit 1, tab 33, p 5.
[191] Ts 81, 91-92.

250 The Department seeks to refute that evidence, including because Mr August has not served on a PMDT.[192]

251 I consider that Mr August's evidence is relevant, in that Mr August was simply referring to his expectation of the outcome of a hypothetical PDMT review at the time, based on his extensive knowledge and experience within policing and custodial services.

252 Neither Mr August, nor the Court, can say with certainty what the outcome of a complex risk assessment would have been. What can be said with certainty is that a PMDT review never took place, as it should have. Further, I am satisfied on the evidence that a PMDT review in early 2023 may have resulted in a change to Mr Martin's status and placement.

253 As I expressed at the end of the inquest, the Department's failure to conduct a PMDT (or substantive review) in late 2022 or early 2023, which may have resulted in a change to Mr Martin's protection status or his placement within Hakea, represents a missed opportunity.

254 However, it is clear that it was a missed opportunity which preceded a deliberate, criminal act, the responsibility for which has been determined and ascribed to Mr Martin by the Supreme Court of Western Australia.

255 The above findings should not be mistaken as conclusions that the Department, or any of its staff should, or could, have anticipated the criminal act that occurred.

256 Further, it is also clear that the Department has viewed this tragedy as a reason to continue to strive to make improvements in the way it manages protection prisoners.

257 Most notably, Mr August's evidence demonstrates that as of 31 October 2025, all 196 protections prisoners have a PMDT review scheduled, and all custodial facilities will be required to report on PMDT compliance every six months.[193]

Mr Bropho's transfer from Unit 9 to Unit 10

258 At the inquest, Mr Costello was asked whether he had considered that prisoners in Unit 10 might have seen the news item concerning Mr Bropho that appears to have preceded the threats against him within Unit 9.

[192] Department's submissions, par [52].
[193] Department's submissions, par [56]-[57].

259 It is apparent from the evidence within the coronial brief that at least two prisoners in Unit 10 saw the news item on 7 March 2023.[194]

260 The utility in moving Mr Bropho from Unit 9 to Unit 10 in response to the threats may be debatable, given there was no real difference between them in terms of how they functioned as protection units.[195]

261 Notwithstanding, I make no criticism of Mr Costello's decision to move Mr Bropho from Unit 9 to Unit 10.

262 Mr Costello was faced with an immediate threat to Mr Bropho, and I accept that there is a great degree of complexity in carefully balancing the threats to a protection prisoner.[196]

263 Mr Costello considered and excluded the option of the MPU, a decision which was entirely defensible.

264 There is no evidence that Mr Costello considered moving Mr Bropho to another prison, but the utility of doing that would have been just as debatable, given the prospect of others at that prison also having seen the news item. Such a movement may also have been considered to be disproportionate, given the nature of the threats at the time.

265 I am satisfied that Mr Costello's decision was taken in response to a clear risk, that it was taken after a timely and reasoned assessment of the options available and made in the context of few alternatives.

Detection of the physical attack on 8 March 2023

266 I find that the physical attack on Mr Bropho on 8 March was not detected by, or known to, any Departmental officer prior Mr Bropho's killing for the following reasons:

(a) neither the Department's internal review, nor the inquest process, identified any evidence of any prison officer becoming aware of the attack prior to Mr Bropho's death; [197]

[194] Exhibit 1, tab 11, par [18]; exhibit 1, tab 15, par [17].
[195] Ts 10, 15.
[196] Exhibit 1, tab 33, p 5.
[197] Ts 119.

(b) there is no evidence to suggest that Mr Bropho sought or received any medical treatment in relation to any injuries sustained from the 8 March assault;[198]

(c) I am confident that any medical staff would have reported and acted upon any injuries to Mr Bropho had they been observed;

(d) Mr Bropho suffered a disability that meant he was less likely to make a fuss, and more likely than others to tolerate things;[199]

(e) as a consequence of his disability, Mr Bropho was less likely to have complained about the assault to prison officers or medical staff;

(f) Unit 10 was short staffed on 8 March 2023, and an adaptive routine had been implemented, including barrier management;[200]

(g) as a consequence of the above, I infer prisoner officers in Unit 10 during the relevant shift had less close interaction with prisoners than might otherwise occur;

(h) as a further consequence of the above, there was less of an opportunity for Mr Bropho to make a report to staff than might otherwise have been the case (had he been willing), and certainly less opportunities for staff to observe injuries coincidentally;

(i) Ms Happ did not recall observing any injuries when she saw Mr Bropho in the evening of 8 March;

(j) as Ms Happ said in her evidence, if any violent attack on Mr Bropho had become known to any officer, the incident would likely have been reported and the unit locked down because it is in the officers' own interest to protect their safety just as much as it is to protect the safety of the prisoners;[201]

(k) there is no evidence of any report, let alone any report concerning any injuries, being made by any prison officer in respect of Mr Bropho on 8 March, and no evidence that the unit was shut down for any reason at the relevant time; and

[198] Exhibit 2, tab 1, p 16.
[199] Ts 127-128.
[200] Exhibit 1, tab 33.12, p 10.
[201] Exhibit 1, tab 17.1, par [28].

(l) there was no CCTV in Unit 10 at the time which may have enabled a prison officer in the control room to observe multiple prisoners entering Mr Bropho's cell, possibly giving cause for suspicion or further inquiry by a prison officer.

Lock-up procedure in the evening of 8 March 2023

267 As identified above, there is insufficient evidence to determine precisely how the lockup occurred in Unit 10 on 8 March 2023.

268 COPP 10.2 was annexed to the report of Mr August.[202] Like Mr August and Ms Palmer, I consider that its terms are clear, insofar as there is no basis to conclude that only one officer is responsible for observing or assessing the apparent wellbeing of prisoners during lockup, or that the responsibility is exclusive to the senior officer.[203]

269 Notwithstanding that clarity, the evidence at inquest demonstrated that prison officers do not have a uniform understanding of the lockup requirements as identified in COPP 10.2.

270 It was clear at least one prison officer who gave evidence had a different understanding as to the role of the senior officer than one of the senior officers who gave evidence.[204]

271 The evidence suggests that varied approaches to lockup procedure have arisen because of the different daily regimes in various parts of a prison, and because senior officers have, historically, done lockups differently to one another.[205]

272 I also anticipate that regular departure from COPP 10.2, and variations its requirements, will have occurred where units have been short staffed.

273 The evidence at the inquest was that Unit 10 was routinely short staffed,[206] and at least two officers short on 8 March.[207]

274 In this case, any non-adherence to COPP 10.2 (to the extent it occurred) did not have any significant impact.

[202] Exhibit 1, tab 33.10.
[203] Exhibit 1, tab 33, p 12.
[204] Ts 44.
[205] Exhibit 2, tab 1.27, par [10].
[206] Exhibit 1, tab 16.1, par [11].
[207] Exhibit 1, tab 18, par [11]; exhibit 1, tab 19, par [11].

275 I draw that conclusion because, as identified above, the injuries to Mr Bropho were not as extensive as one might have expected given the nature of the assault.

276 I accept that even done properly, a lockup including welfare checks will only involve review and observation of prisoners in a relatively quick way,[208] and only for a few seconds.[209]

277 I expect that where a unit is short staffed, as Unit 10 was on the relevant date, any welfare check performed as part of the lockup procedure will be necessarily short, and relatively cursory.

278 I do not consider that a welfare check done in that way on 8 March would have identified any injury to Mr Bropho.

279 That is aside from the question as to whether Mr Bropho would have even been prepared to disclose what had happened to him if an injury had been noticed, given his vulnerability.[210]

280 I also accept the Department's submission, that it cannot be said with any certainty that even if Mr Bropho's injuries had been observed it would have resulted in an immediate outcome that would have interfered with Mr Martin's ability to carry out the fatal attack the following day.[211]

281 I interpose that, in my view, COPP 10.2 is entirely clear and does not require amendment.

282 At the inquest, I noted that Hakea's corresponding Standing Order had not been reviewed since its inception.

283 However, I am satisfied from Mr August's evidence that any need to update that Standing Order is already under active consideration.[212]

Quality of the emergency response on 9 March 2023

284 I adopt Dr Gunson's view that the care provided to Mr Bropho on 9 March 2023 after he was located unresponsive was entirely appropriate.[213]

[208] Exhibit 2, tab 1.27, par [26].
[209] Ts 18.
[210] Ts 39.
[211] Department's submissions, par [64].
[212] Ts 95.
[213] Exhibit 4, p 12.

285 It is clear from the evidence that all prison and medical officers acted with haste and used their best efforts to revive Mr Bropho.

286 The two people involved in the response that gave evidence at the inquest, Mr Carroll and Ms Freehill, both considered that everything had been done according to procedure[214] and there were no missed opportunities.[215]

287 I concur based on my examination of the evidence, and commend all staff involved for their emergency response on the day.

Recommendations

288 Departmental staff undertook a comprehensive and fulsome review of Mr Bropho's death at a 'Lessons Learned' workshop at Hakea on 20 July 2023.[216]

289 It is apparent from reading the report of that process that the attending staff gave detailed and thoughtful consideration to what could be learned from Mr Bropho's death.

Recommendation 1 – installation of CCTV

290 In respect of opportunities for improvement, it was identified in the Lessons Learned report that Hakea did not have closed-circuit television (**CCTV**) resulting in inadequate coverage of incidences.[217]

291 In response to this issue (which was referred to as 'Lesson Learned 2'), it was noted that CCTV had been installed in unit wings, unit dayrooms, common areas and recreation yards in Units 9 and 10, with live monitoring capability from the master control room, the Incident Control Facility, security office, and the control rooms in both units.[218]

292 While that advance was commendable, the evidence given at the inquest is that protection prisoners have now been relocated to other units in Hakea, including Units 6 and 7.[219]

[214] Ts 51.
[215] Ts 46.
[216] Exhibit 1, tab 33.12, p 3.
[217] Exhibit 1, tab 33.12, p 14.
[218] Exhibit 1, tab 33.12, p 20.
[219] Exhibit 1, tab 33, p 7.

293 There is CCTV coverage in the recreation yard at Unit 7, but none internally.[220] I have no evidence in relation to the CCTV coverage at Unit 6 but infer that there is also none internally.

294 In the Lessons Learned report, there is reference to Hakea being identified as a priority site for rollout of body worn cameras.[221]

295 While that development is also commendable and to be supported, it does not resolve the lacuna in CCTV coverage in areas at Hakea inhabited by some of the most vulnerable members in the prison estate.

296 At the inquest, it was suggested that there is complexity in installation of CCTV at Hakea given the age of the facility. Reference was made to issues including funding, asbestos and the introduction of further ligature points.[222]

297 There is no evidence that suggests that any of these issues are incapable of being overcome.

298 In its submissions, and in response to draft recommendations which were circulated by the Court to the Department and Mr Edgill for any response, the Department indicated support in principle for a recommendation concerning introduction of CCTV in Units 6 and 7 as a matter of urgency.

299 The Department submitted that it would continue efforts to further expand CCTV capabilities across Hakea, including by advocating for necessary funding.[223]

300 To the extent that is assists the Department in securing any necessary further funding, I expressly note that this issue is not new.

301 In findings delivered on 27 February 2024 concerning a death of a prisoner at Hakea in 2019 (as a result of complications from a traumatic brain injury following an assault by another prisoner), the State Coroner recommended that the Department continue to take all necessary and practical steps directed towards investment in body worn cameras and improved CCTV coverage for high-risk areas of Hakea Prison including coverage of recreation areas within Hakea Prison.[224]

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[220] Ts 118.
[221] Exhibit 1, tab 33, p 14.
[222] Ts 100.
[223] Department's submissions, par [97]-[98].
[224] ***Inquest into the death of Ian Campbell Buchanan*** [2024] WACOR 8, p 51.

302 In my view, a protection unit is, by definition, a high-risk area.

303 In his findings delivered 12 June 2024, following the inquest into the death of a prisoner who died after being assaulted in his cell at Hakea by other prisoners in 2019, Coroner Jenkin recommended that the Department seek internal funding to ensure that CCTV cameras were installed in all remaining accommodation units not currently fitted with CCTV, and that installation should be completed as a matter of urgency.[225]

304 Despite the Coroner's recommendation for urgency, it appears from the available evidence that there has been little progress since the installation of CCTV infrastructure in areas including Units 9 and 10.

305 In his findings delivered 12 June 2025 following the inquest into the death of a prisoner at Hakea who died from the effects of a fire, Coroner Jenkin recommended that to ensure the safety of prisoners and staff at Hakea, the Department of Justice should expedite the installation of closed-circuit TV cameras in all accommodation units and common areas at Hakea.[226]

306 In his findings, the Coroner noted that any logistical and financial challenges in the installation of additional CCTV coverage at Hakea was an unavoidable and necessary cost of running a safe and effective prison in 2025.[227]

307 I share and reiterate that view.

308 When asked at the inquest, Ms Palmer was not aware of any plans to prioritise the installation of CCTV in protection units at Hakea.[228]

309 In my view, such a priority is a minimum requirement to best guard the safety of protection prisoners like Mr Bropho.

310 I accept that CCTV may not provide a deterrent to someone motivated to commit a criminal offence, but as Mr August acknowledged it at least provides an opportunity for problematic behaviour to be observed at an early stage and will assist in ensuring that the responsibility for any violent offences that occur within protection units is capable of being attributed at the earliest possible opportunity (thereby preserving the safety of other protection prisoners) and prosecuted as efficiently as possible.

[225] ***Inquest into the death of Alf Deon Eades*** [2024] WACOR 26, p 59.
[226] ***Inquest into the death of Sam Phillip Chisolm Lynch*** [2025] WACOR 27, p 77.
[227] At par [304].
[228] Ts 119.

311 As such, I recommend as follows:

> **1. As a matter of urgency, the Department of Justice ensure the installation of closed-circuit cameras in any unit wings, unit dayrooms, commons areas and recreation yards within Units 6 and 7 at Hakea Prison.**

Recommendations 2 and 3 – reinforcement of lock-up procedure

312 This case demonstrates that prison officers' understanding of COPP 10.2 needs to be addressed, and the contents of the COPP reinforced.

313 In response to a draft recommendation concerning the same, the Department has indicated support for a Commissioner's Broadcast to all prison officers,[229] and the intention to instruct satellite trainers at each custodial facility to ensure refresher training is provided to all prison officers regarding COPP 10.2 and any applicable Standing Orders.[230]

314 I recommend as follows:

> **2. The need for compliance with 'Commissioner's Operating Policy and Procedure 10.2 - Daily Prison Routine and Population Counts' and any applicable Standing Order be reinforced by:**
> **(a) distribution of a Commissioner's Broadcast (or similar) to all prison officers requiring compliance, notwithstanding any existing, historical practice; and**
> **(b) the Department of Justice providing refresher training to prison officers.**

315 Mr Edgill urged the Court to consider recommending that:

(a) COPP 10.2 be amended to require the entry of the prisoner count following lockup, and confirmation of the health and well-being check, in TOMS (amongst others); and

(b) TOMS be programmed to introduce a capacity for the recording of the same.[231]

[229] Department's submissions, par [100].
[230] Department's submissions, par [101].
[231] Closing Submissions on behalf of Geoffrey Nathaniel Edgill, par [8].

316 Mr Edgill submitted that the addition of this requirement would encourage prison officers to follow procedure more thoroughly.[232]

317 While I can see some merit in the submission, I do not consider that the amendment is necessary.

318 Requiring the exercise proposed by Mr Edgill has the potential to result in officers performing a check-mark exercise, rather than substantively engaging with what is required (which I consider is better achieved through the Broadcast proposed, and targeted refresher training).

319 I also accept that the Department's alternative amendment to COPP 10.2 (proposed in response to Mr Edgill's submission), to require an additional notation in the Occurrence Book at the completion of lockup concerning the undertaking of visual checks for well-being,[233] is a more proportionate addition to existing procedures.

320 I also consider it will serve the function which underpins the proposal made on Mr Edgill's behalf.

321 I recommend as follows:

3. Clause 5.3.3 of 'Commissioner's Operating Policy and Procedure 10.2 - Daily Prison Routine and Population Counts' be amended to insert an additional step to the procedures to be followed at lock-up, requiring the Unit Manager to sign the Occurrence Book stating that the general health and well-being visual check of all prisoners has been undertaken.

Recommendations 4 and 5 – amendment of COPP 4.10

322 I am satisfied from the evidence of Mr August that PMDT reviews are now occurring according to the requirement in COPP 4.10.[234]

323 I am also satisfied, based on Mr August's evidence, that there is no need to make any recommendation concerning the production of materials through the Department's security or intelligence teams to best inform PMDT processes.

[232] Closing Submissions on behalf of Geoffrey Nathaniel Edgill, par [9].
[233] Department's submissions.
[234] Exhibit 1, tab 33, p 14.

324 I am confident from Mr August's evidence that there are steps already being taken to improve access to information, and the identification and production of material within the Department, to best inform dynamic risk assessments.[235]

325 That is coupled with the evidence of all staff being directed to report any information they believe could significantly impact the safety of prisoners within Hakea, including relating to placement in protection, to security or their supervisor urgently.[236]

326 In my view, there are two deficiencies with the terms of COPP 4.10 that arise from the evidence in this matter that should be addressed.

327 First, the COPP does not expressly recognise the capacity for a protection prisoner's status to reviewed (and, possibly, revoked) outside the 6-month mandatory review.

328 Mr August agreed that this should be recognised.[237]

329 Also, as this case makes clear, there is a need for a more dynamic risk assessment by the PMDT that picks up trends in alerts, holistically.[238]

330 Part of that risk assessment clearly requires the PMDT to consider the risk that the prisoner the subject of any review poses *to* others within the protection population.

331 Mr August also agreed with this proposition.[239]

332 The enumerated matters that the PMDT is required to consider in a review should be amended to include that consideration.

333 Amendment to the COPP would require some consideration of whether related Standing Orders, including Standing Order 4.10,[240] would also need to be amended.

334 The Department supports the proposed amendments, including on bases that they represent current practice.[241]

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[235] Exhibit 1, tab 33, p 4.
[236] Exhibit 2, tab 1, pp 11-12.
[237] Ts 103.
[238] Ts 86.
[239] Ts 105.
[240] Exhibit 1, tab 33.2.
[241] Department's submissions, pars [110], [113].

335 I recommend as follows:

> **4. 'Commissioner's Operating Policy and Procedure 4.10 – Protection Prisoners' be amended:**
> **(a) to reflect the ability for an ad-hoc review of a prisoner's protection status outside the 6-month review; and**
> **(b) to include a requirement (at cl 4.2.3) for the PMDT to consider 'the likelihood of any risk the prisoner the subject of the assessment poses to the safety of another prisoner or class of prisoner within a protection unit',**
> **with necessary amendments to all related Standing Orders.**

336 As noted by the officer who prepared the MAP, when a prisoner is transferred between facilities with a protection status, that status will continue at the next prison.[242]

337 Existing policies do not appear to expressly require any review of the protection status upon transfer.[243]

338 In this case, Mr Martin was initially afforded protection status at ARP and, necessarily, housed within the MPU at that facility.

339 When he moved to Hakea, there were placement options including protection units with other prisoners.

340 Self-evidently, ARP would not have been considering that potential when they first afforded Mr Martin protection status.

341 Protection status should be reviewed when a prisoner is moved to another facility, because there is the potential that, at least, options for placement and prisoner cohorts will be different.

342 However, I am mindful that dictating the addition for the requirement for such a review upon transfer between prisons in the COPP 4.10 may be unnecessary, if it would be duplicative of detailed security planning and any reviews already being undertaken through the transfer process.

343 There would also need to be consideration as to the timing of any such review, if done by a prison's PMDT.

[242] Exhibit 2, tab 1.13, par [21].
[243] Ts 64.

344 Rather than recommending an amendment, a proposal that the addition be considered is, in my view, more appropriate.

345 The Department supported the draft recommendation, on the basis it reflects current practice, arising as a consequence of the implementation of other clauses within COPP 4.10.[244]

346 As a consequence, I recommend as follows:

5. The Department of Justice consider whether COPP 4.10 should also be amended to expressly require consideration of the maintenance of a prisoner's protection status when the prisoner is transferred between prisons.

Recommendation 6 – addition of TOMS alert

347 As identified by Serco on behalf of Acacia Prison, TOMS currently does not have a functionality to raise a generic 'risk to/from' alert on the profile of an individual prisoner relating to threats they pose to cohorts or categories of prisoners.[245]

348 The ability to add such an alert would be of great utility to individual prison officers in dealing with any prisoners in protection placements, and to PMDTs and any officers involved in the placement of a protection prisoner upon transfer between facilities.

349 The senior prison officers who gave evidence at the inquest, and Mr August, all agreed with the clear utility and relevance of such an alert.[246]

350 The Department supports the draft recommendation in principle, but notes that several tasks will need to be undertaken prior to the alert being developed.[247]

351 Having reviewed the tasks as outlined by the Department, I remain of the view that the addition of the alert should be progressed.

[244] Department's submissions, par [117].
[245] Exhibit 1, tab 39, p 1.
[246] Ts 21, 36, 40, 84.
[247] Department's submissions, par [120].

352 I recommend as follows:

> **6. The Department of Justice create a capacity in the Total Offender Management Solution for the placement of an alert on a prisoner which clearly indicates that the prison poses a risk to the health and safety of a specified cohort of prisoners (separate from the existing capacity to raise an alert identifying a risk of harm by one identified prisoner to another identified prisoner).**

Recommendation 7 – placement of high-risk prisoners

353 It is clear from the evidence that there has been an increase in compliance with PMDT review requirements and that this has been achieved by, in part, introduction of a reporting requirement.[248]

354 'Lesson Learned 5' considered the introduction of a group or committee that was responsible for the review of placement, and movement, of prisoners who posed a significant risk to the good order and security of a prison because they had been involved in incidences of violence within the prison system resulting in serious injury or death.[249]

355 Although the report indicated that there was some initial support for that proposition, the action was closed on the basis the proposal did not provide additional benefit to existing decision-making processes.[250]

356 I note that notwithstanding that approach, Mr August has (prudently, in my view) been reviewing the current placement and management arrangements for all prisoners who have been involved in the attempted murder or murder of another prisoner while in custody.[251]

357 I understand Mr August has been conducting that review, in part, to determine if there is merit in reopening the proposal and establishing the committee.

358 Mr August's evidence was that there is no impediment to the proposal.[252]

[248] Exhibit 1, tab 33, p 14.
[249] Exhibit 1, tab 33.12, p 24.
[250] Exhibit 1, tab 33, p 14.
[251] Exhibit 1, tab 33, p 14.
[252] Ts 92.

359 The Department's position is that foundational work is required before a recommendation for the creation of such a group can be supported.[253]

360 In my view, the creation of that group is warranted.

361 The creation of such a high-level body, responsible for scrutinising and managing the placement of that cohort of prisoners presenting the most significant risk to the safety of other prisoners, could potentially act as an oversight to the individual PMDTs, and ensure consistency in decision-making across the prison estate.

362 In its submission, the Department noted that the creation of such a group would need to be preceded by development of clear parameters as to the prisoners to whom it relates.

363 The Department also suggested that creation of such a group should be preceded by a process involving the identification of any other like entities in other States in order to consider their approaches to membership and structure.[254]

364 I do not cavil with either of the Department's propositions but consider that those are matters which can comfortably form part of the development of the group, and do not act as fundamental reasons why the group should not exist at all.

365 I recommend as follows:

7. The Department of Justice prioritise the creation of the group contemplated by Action 5.1 in the Lessons Learned Report, such group to be expressly responsible for the movements of high-risk prisoners who have been involved in serious incidences of violence within the prison system resulting in serious harm or death.

[253] Department's submissions, par [124].
[254] Department's submissions, par [125].

Conclusions

366 In the context of a criminal sentencing, the Hon. Chief Justice Quinlan has previously said:

> The community, on whose behalf and for whose benefit prisoners are lawfully detained, are entitled to expect that those prisoners will be treated in a civilised manner, and that they will be given the same protection under the law as the rest of the community. [*Offending against other prisoners in custody*], which takes advantage of the vulnerability brought about by the victim's involuntary detention by the State, therefore offends against the criminal justice system itself. It undermines the good order and discipline of the prison environment, and so undermines both the punitive and rehabilitative aims of that environment.[255]

367 As identified above, Mr Bropho was a particularly vulnerable prisoner.

368 While it is evident that individual officers made attempts to ensure his safety within the prison setting, it is also clear that the Department missed an opportunity in late 2022 and early 2023 to review and potentially act upon the level of risk posed by another protection prisoner to a cohort of offenders that included Mr Bropho.

369 The Department's clear engagement with the issues arising from the 'Lessons Learned' process was particularly evident in Mr August's oral evidence at the inquest.

370 The Lessons Learned report and Mr August's evidence demonstrate that the Department is motivated to make all reasonable improvements, including to avoid any similar tragedy in future if at all possible.

371 The recommendations made by the Court are directed to the same end.

BD Nelson
Coroner
8 December 2025

[255] ***The State of Western Australia v Tumata*** [2022] WASCA 161 [14].