JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	24 - 28 MARCH 2025
DELIVERED	**:**	12 JUNE 2025
FILE NO/S	**:**	CORC 654 of 2024
DECEASED	**:**	LYNCH, SAM PHILLIP CHISHOLM

Legislation:

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

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336
Browne v Dunn (1893) 6 R 67 (H.L)

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms K. Niclair and Dr A. Steinepreis (State Solicitor's Office) appeared for the Department of Justice.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Hakea Prison on or about 5 March 2024. Any such prisoner is to be referred to as "Prisoner [*Surname Initial*]

Order made by: SH Linton, Acting State Coroner (13.12.24)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Sam Phillip Chisholm LYNCH*** *with an inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 24 - 28 March 2025, find that the identity of the deceased person was* ***Sam Phillip Chisholm LYNCH*** *and that death occurred on 5 March 2024 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from the effects of fire in the following circumstances:*

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INTRODUCTION

1. Sam Phillip Chisholm Lynch (Sam)[1] was declared deceased at Fiona Stanley Hospital (FSH) on 5 March 2024 from the effects of fire, after he set the mattress in his prison cell alight. Sam was 27 years old.[2,3,4,5,6,7,8,9]

2. At the time of his death, Sam was a remand prisoner at Hakea Prison (Hakea) and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (the Department). As a result immediately before his death, Sam was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) (the Act), and his death was a "*reportable death*".[10,11,12]

3. In such circumstances, a coronial inquest is mandatory. Further, where the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received whilst under that care.[13]

4. Members of Sam's family attended the inquest I conducted into his death in Perth on 24 - 28 March 2024. The inquest focused on the supervision, treatment and care Sam received in custody, as well as the circumstances of his death.

5. The documentary evidence tendered at the inquest (the Brief) comprised three lever arch volumes, and the following witnesses gave evidence at the inquest:

a. Mr M Moore, Prison Officer, Hakea (Officer Moore);
b. Mr R Savage, Senior Prison Officer, Hakea (Officer Savage);
c. Ms E McGrath, Prison Officer, Hakea (Officer McGrath);
d. Mr M Longden, Senior Prison Officer, Hakea (Officer Longden);
e. Ms T Szeremenda, Acting Prin. Officer, Hakea (Officer Szeremenda);

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[1] At the request of his family the deceased was referred to as "*Sam*" at the inquest, and in this finding. No disrespect is intended.
[2] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (13.08.24)
[3] Exhibit 1, Vol 1, Tab 2, P98 - Mortuary Admission Form (05.03.24)
[4] Exhibit 1, Vol 1, Tab 3, P92 - Identification of Deceased Person by Other Than By Visual Means (07.03.24)
[5] Exhibit 1, Vol 1, Tab 3, Coronial Identification Report (07.03.24)
[6] Exhibit 1, Vol 1, Tab 3, Affidavit - Sen. Const. W Chandler (07.03.24)
[7] Exhibit 1, Vol 1, Tab 4, Death in Hospital Form (05.03.24)
[8] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24)
[9] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25)
[10] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24)
[11] Section 16, *Prisons Act 1981* (WA)
[12] Section 3, *Coroners Act 1996* (WA)
[13] Sections 22(1)(a) and 25(3), *Coroners Act 1996* (WA)

f. Mr J Ballinger, Prison Officer, Hakea (Officer Ballinger);
g. Mr M Batten, Prison Officer, Hakea (Officer Batten);
h. Mr S Grocott, Senior Prison Officer, Hakea (Officer Grocott);
i. Mr S McDuffus, Prison Officer, Hakea (Officer McDuffus);
j. Mr G May, Prison Officer, Hakea (Officer May);
k. Mr Z Cavanagh, Prison Officer, Hakea (Officer Cavanagh);
l. Mr S Andrews, Prison Officer, Hakea (Officer Andrews);
m. Det. Sen. Const. A Pearsall, Arson Squad (Officer Pearsall);
n. Det. FC Const, J Mooney, Coronial Investigation Squad (Officer Mooney);
o. Ms J Rowe, Team Leader, Specialist training (Ms Rowe);
p. Dep. Commr. J August, Dep. Commr. Operational Support, (Officer August);
q. Supt. C Tuck, Superintendent, Hakea (Officer Tuck);
r. Dr C Gunson, Acting Director Medical Services, (Dr Gunson);
s. Ms T Palmer, Senior Review Officer, (Ms Palmer); and
t. Mr E Ryan, Inspector of Custodial Services (Mr Ryan).

6. When assessing the evidence in this matter and determining whether I should make any adverse findings or comments, I have been mindful of two key principles. The first is the phenomenon known as "*hindsight bias*" which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[14]

7. The second principle which is known as the "*Briginshaw principle*" is derived from a High Court judgment of the same name, in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[15]

8. Essentially, the Briginshaw principle requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of that allegation.

[14] See for example: www.britannica.com/topic/hindsight-bias
[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362

SAM

Background[16,17,18,19,20]

9. Sam was born on 21 February 1997, and was 27-years of age when he died from the effects of fire on 5 March 2024 . Sam had two siblings and was reported to be in a relationship with a supportive partner. Although Sam started an apprenticeship as a diesel mechanic, his employer's business deteriorated and Sam had to leave. Before his death, Sam had been employed in positions involving labouring, woodwork, and metalwork.

10. At the time of his death, Sam was not working, and he lived with his mother and brother in Canning Vale. In a moving tribute she read at the end of the inquest, Sam's mother made a moving statement about her beloved son which included the following remarks:

> Sam played football as a young boy and enjoyed it. My son Sam was my darling son. He would never get offended when someone would tease him and say, "*You're a mummy's boy*". He would say: "*Well, why - why aren't you? Aren't you a mummy's boy? I love my mum*". Sam's school friends meant the world to him. He was very well liked at school and out of school. He had his friends, he held his friends in high regard and was personally a very loyal and kind, caring young boy right through to being a very caring young man.[21]

11. Sam's medical history included gastro-oesophageal disease, episodic back pain, high cholesterol, and flat feet. Although Sam was never diagnosed with a mental health condition, in January 2024 he sought a medical review for symptoms of depression and anxiety whilst he was incarcerated.

12. Sam had a history of self-harm and polysubstance use including: alcohol, heroin, methylamphetamine, and cannabis. In the past, Sam was reported to have injected himself with illicitly obtained buprenorphine, and he had also attempted to secrete prescribed medication.

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[16] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p33
[17] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (13.08.24)
[18] Exhibit 1, Vol 1, Tab 4, Death in Hospital Form (05.03.24)
[19] Exhibit 1, Vol 1, Tab 37, EcHO Prison Records (01.10.11 - 05.03.24)
[20] Exhibit 1, Vol 3, Tab 67, Health Services Review (17.03.25), pp4-5
[21] ts 28.03.25 (Lynch, P), p513

Offending and prison history[22,23,24,25]

13. Sam had an extensive criminal history, and as an adult he had accumulated 75 convictions for offences including: home burglary, stealing, drug offences, traffic offences, possession of controlled weapons, demanding property with threats, common assault, and disorderly behaviour in public. As a result of his offending behaviour, Sam had spent almost six years of his life in prison.

14. Sam had a demonstrated history of exhibiting impulsive and self-destructive behaviours in prison, possibly in an effort to manipulate his prison environment. Departmental records establish that at times Sam would threaten (and sometimes inflict) self-harm when prison staff did not action his requests, or in protest at decisions he did not agree with.

15. Sam was appropriately managed on the At Risk Management System (ARMS) on two occasions after he had self-harmed and expressed suicidal ideation (i.e.: 23 to 29 September 2023, and 14 December 2023 to 23 January 2024 respectively). During these periods Sam was seen by counsellors from the Department's Psychological Health Service.

16. In passing, I note that ARMS is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.[26]

Circumstances of admission to Hakea Prison[27,28,29,30,31,32]

17. Sam was arrested on 1 March 2024, and charged with four offences after he was apprehended following a police pursuit. Sam was refused police bail, and when he was assessed by a nurse at the Perth Watch House while he was in police custody, Sam disclosed a history of depression and self-harm.

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[22] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp33 & 36-37
[23] Exhibit 1, Vol 2, Tab 42.2, History for Court - Criminal and Traffic (compiled 20.08.24)
[24] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp4-29
[25] Exhibit 1, Vol 3, Tab 67, Health Services Review (17.03.25), pp3-5
[26] ARMS Manual (2019), pp2-3
[27] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p32
[28] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp8-14
[29] Exhibit 1, Vol 2, Tabs 42 & 42.1, Statements of Material Facts 2345431-1 & 2345431-2 (01.03.24)
[30] Exhibit 1, Vol 2, Tab 42.3, List of Police Custody Episodes Report (compiled 26.08.24)
[31] Exhibit 1, Vol 3, Tab 61.1, Screenshot of TOMS Remand Module
[32] Exhibit 1, Vol 2, Tabs 46 & 46.1, COPP 2.1 - Reception (v8.0: 01.09.24 & v10.0: 09.01.25)

18. When Sam appeared in court on 2 March 2024 his application for bail was refused and he was remanded in custody to Hakea. When Sam arrived at Hakea at about 7.00 pm, the details of his police assessment were provided to prison staff as part of the usual custodial handover.[33,34]

19. Sam underwent an ARMS Reception Intake Assessment by an experienced prison officer (reception officer) to identify any presenting risk factors.[35] After working through the risk assessment process, the reception officer who conducted Sam's ARMS intake assessment concluded that Sam was not at risk, and made the following observations in the ARMS assessment form:

> No current ideation of self-harm. The prisoner responded to questions appropriately without hesitation. The prisoner's family is not supportive. Previous ARMS noted. The prisoner did not become at risk during my interview.[36]

20. Sam underwent a nursing review on 3 March 2024, during which he disclosed he was experiencing symptoms relating to withdrawing from heroin. Sam was assessed as having a Clinical Opiate Withdrawal score (COWS) of 10. COWS is a tool used to assess the severity of opioid withdrawal symptoms, and Sam's score of 10 was on the upper end of the "*mild*" range.

21. The nurse assessing Sam noted that he was "*complaining of withdrawal symptoms, he states he is withdrawing from heroin*", and she emailed an "*e-consult*" to Dr Gunson seeking advice as to how best to manage him. Dr Gunson responded a short time later and advised as follows:

> Mr Lynch to be scripted for symptomatic management of acute opioid withdrawal: Diazepam 10mg (three times per day as needed) for 2 days, then reduce by 5mg per day…Withhold if excessively sedated. Commence if (Clinical Opiate Withdrawal) score is >10. Metoclopramide 10mg (three times per day as needed). Paracetamol 1g (three times per day as needed). Ibuprofen 400-800mg (twice per day as needed). Loperamide 2mg (three times per day as needed).[37,38]

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[33] Exhibit 1, Vol 1, Tab 10, WA Police Force Custody Handover Summary (02.03.24)
[34] Exhibit 1, Vol 1, Tab 11, WA Police Force Property Receipt (02.03.24)
[35] ARMS Manual (2019), pp14-15
[36] Exhibit 1, Vol 1, Tab 12, ARMS Reception Intake Assessment (02.03.24), p6
[37] Exhibit 1, Vol 1, Tab 36, Email - Ms C Jackson to Dr C Gunson (4.27 pm, 03.03.24)
[38] Exhibit 1, Vol 1, Tab 36, Email - Dr C Gunson to Ms C Jackson (5.24 pm, 03.03.24) and ts 27.03.25 (Gunson), pp395-399

General management issues[39]

22. After prison reception procedures were completed, Sam was placed in Unit 7, which was Hakea's orientation unit for prisoners recently received into prison. Although there are close circuit TV cameras (CCTV) in some of the units at Hakea, there were none in Unit 7 at the time of Sam's death.

23. As noted, in accordance with departmental procedures, Sam was reviewed by a nurse on 3 March 2024. Sam denied any suicidal or self-harm ideation, and he disclosed that he had been injecting himself with heroin on a daily basis when he was in the community.

24. At 4.16 pm on 3 March 2024, Sam had an "*officer-initiated*" phone call with his mother, during which she told him she loved him and forgave him. Sam's mother also said: "*Don't you dare take your life*", to which Sam replied: "*Love you, see you*", before the call ended.[40,41]

25. During his incarceration at Hakea, Sam was not employed in any prison positions, and he did not receive any visits. Sam's Alert History report shows that he was the subject of several active alerts relating to risks to, and risks from another prisoner. Sam was the subject of a routine personal search on 2 March 2024 which found nothing untoward, however, none of the cells Sam was accommodated in during his brief staff at Hakea were searched prior to his death.[42,43,44,45]

26. For reasons I will explain later in this finding, on 5 March 2024 Sam was moved to a single occupancy cell (G12) located in G Wing of Unit 7. In his report to the Court, the Superintendent of Hakea (Officer Tuck) confirmed that G12 is a "*standard cell*" and "*has never been classified as a management cell*". There was no basis to strip search Sam when he was moved to G12, and even if he had been searched, it seems he would have been permitted to retain the cigarette lighter that was on his person.[46]

[39] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp4-8 & 10-29 and ts 28.03.25 (Palmer), pp413-452
[40] Exhibit 1, Vol 3, Tab 61.4, Offender Notes (4.16 pm, 03.03.24)
[41] Exhibit 1, Vol 2, Tab 16, Security Report - Transcript of Call (4.16 pm, 03.03.24)
[42] Exhibit 1, Vol 3, Tab 61.19, Alert History - Offender
[43] Exhibit 1, Vol 2, Tab 13, Search Person - Offender (02-05.03.24)
[44] Exhibit 1, Vol 2, Tab 14, Cell Searches - Offender (02-05.03.24)
[45] Exhibit 1, Vol 2, Tab 15, Cell Placement History (02-05.03.24)
[46] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p9

EVENTS LEADING TO SAM'S DEATH[47,48,49,50,51,52,53]

Overview

27. The Brief of evidence in this case comprised three lever arch files, which together contain about 1,500 pages of documents. Further, the inquest into Sam's death was conducted in Perth over five days, and the transcript of those proceedings runs to 517 pages of transcript.

28. Given the sheer volume of material before me, it has not been possible (nor in my view has it been necessary) for me to do more than summarise the events which led to Sam's death, and outline key aspects of the issues raised by the evidence. On the basis of the available evidence, I determined that I should make 12 recommendations, which were forwarded the Department for comment.

29. As I will explain, the events in Unit 7 at Hakea on 5 March 2024 were both **tragic and a shambles**. The unit was four officers down on its usual complement, and of the seven prison officers who were on duty, three were probationary officers with very minimal experience.[54]

30. The staff shortages on Unit 7 meant that items prisoners had purchased at the prison canteen that day (canteen spends) could not be distributed. On the face of it, this may seem to be a trivial detail, but when understood in context, the failure to distribute canteen spends lies at the heart of this case.

31. The failure to distribute canteen spends on 5 March 2024 appears to have caused Sam great distress. Shortly after he was told he would not be receiving his canteen spends that night, Sam began damaging the fixtures and fittings in his cell before setting the cover of his mattress alight using a cigarette lighter. As I will outline, the response to the fire in Sam's cell was abysmal and Sam died from the effects of that fire.

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[47] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24)
[48] Exhibit 1, Vol 1, Tab 7.1, Homicide Squad Report - Det. Sen. Const. A McLean (07.03.24)
[49] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24)
[50] Exhibit 1, Vol 2, Tab 43.1, WAPOL Incident Report 050324 1854 9805 (05.05.24)
[51] Exhibit 1, Vol 2, Tab 43.2, WAPOL Action register Report 050324 1854 9805 (06.03.24 - 18.07. 24)
[52] Exhibit 1, Vol 3, Tab 69, Security check plan map of Unit 7
[53] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp7-13
[54] Exhibit 1, Vol 1, Tab 34, Hakea Daily Staff Roster Sheet (05.03.24) and ts 24.03.25 (Longden), pp91-92

Sam's interaction with Officer McGrath[55,56,57,58]

32. At about 9.31 am on 5 March 2024, Sam successfully made a call to his partner using the Prisoner Telephone System (PTS), although "*This call was not recorded and its contents are unknown*".[59] At about 9.40 am, Sam approached Officer McGrath, who was "*orientation officer*" on Unit 7 where Sam was housed.

33. Officer McGrath had a conversation with Sam through the E Wing "*grille*" and in her statement, she says Sam asked whether he could make another phone call, and he also said he wanted to add a number to his PTS approved number list.

34. Officer McGrath described Sam as being "*cordial*" initially, and he told her he had been given his initial phone call (i.e.: to Ms Lynch). However, during this conversation, Sam complained to Officer McGrath that the process for approving the form he had submitted two days ago (i.e.: the form required to add numbers to his PTS approved number list) was taking too long, and he asked if he could make another call in the interim.

35. Officer McGrath explained to Sam that there was a backlog in processing the PTS forms because of the high muster at Hakea and staff shortages, and that he "*would have to be patient*". Officer McGrath says Sam became "*belligerent and aggressive*" and he told her: "*I swear that if I don't get a phone call I am going to smash his wing up, so make it happen*".[60]

36. In accordance with standard practice, Officer McGrath completed an incident report, and reported Sam's comments to Officer Longden, who was the acting senior officer on Unit 7 at the time. At the inquest, Officer McGrath said she had felt threatened by Sam's aggressive behaviour, and she explained that Sam's conduct had to be reported to maintain good order in the Unit.[61]

[55] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp13-14
[56] Exhibit 1, Vol 1, Tab 23, Statement - Officer E McGrath (undated/unsigned)
[57] Exhibit 1, Vol 1, Tab 23.1, Incident Description Report - Officer E McGrath (05.03.24)
[58] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24) and ts 24.03.25 (McGrath), pp57-88
[59] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p9
[60] Exhibit 1, Vol 3, Tab 61.6, Incident Description Report & Incident Summary Report - Officer E Mc Grath (05.03.24)
[61] ts 24.03.25 (McGrath), pp62-63 & 86-87

37. Officer Longden confirmed that he spoke with Sam following Sam's interaction with Officer McGrath. Officer Longden says he explained to Sam that the unit was short-staffed, and also told him there was no way the number he wanted added to his PTS approved number list would be approved if his negative behaviour continued. Officer Longden says that after he explained all of this, Sam was understandably frustrated.[62,63,64,65]

38. In her statement, Officer McGrath noted that Sam had already been given an officer-initiated call (i.e.: to his mother). Officer McGrath also explained that "*in very extenuating circumstances*" a prisoner might be granted a further officer-initiated call, but this was not usually possible because it would set a precedent. Officer McGrath noted that there were in excess of 100 prisoners on the unit, and that if one prisoner was given an additional call, the rest might also request one.[66]

39. Officer McGrath noted that the approval process for adding phone numbers to a prisoner's PTS approved number list is cumbersome, and that a prisoner must submit a separate form for each number they wish to add. In practical terms, this means that there were "*potentially thousands of forms and numbers being confirmed*".[67]

40. I accept that each phone number a prisoner wants added to their PTS approved number list must be carefully checked. This is to ensure that the intended recipient is willing to accept calls from the prisoner, and to ensure there are no orders in place which make such contact unlawful. Nevertheless, the existing process seems unwieldy, and the delay in the approval of phone numbers is very unfortunate. This is especially so given the fact that for most prisoners, the PTS is their primary means of contacting loved ones during the brief periods they have out of cells.[68]

41. I acknowledge that the increasing prisoner muster and staff shortages at Hakea have placed intolerable pressures on custodial and administrative staff. Nevertheless, I urge the Department to explore ways to speed up process for adding phone numbers to the PTS approved number list.

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[62] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p14
[63] Exhibit 1, Vol 1, Tab 24, Statement - Officer M Longden (undated/unsigned) and ts 24.03.25 (McGrath), pp63-64
[64] Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25), paras 15-20
[65] Exhibit 1, Vol 3, Tab 61.7, Incident Report Minutes - Officer M Longden(05.03.24)
[66] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24), para 17
[67] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24), para 18
[68] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), pp32-34

Sam's attempt to secrete medication[69,70,71,72,73]

42. At about 1.05 pm, Sam attended a medication parade at the medical centre. During the parade, Sam was seen making suspicious movements with his mouth as he attempted to secrete the medication he was dispensed between his top lip and gum. Sam was told to open his mouth and a yellow tablet was observed, which Sam then swallowed.

43. When Sam returned to Unit 7, Officer Longden spoke with him in the Senior Officer's office about his earlier interaction with Officer McGrath and his attempt to secrete medication. Officer Longden told Sam a report had been placed on the system, and that he would be dealt with for attempting to secrete his prescribed medication.[74]

44. Sam was also told he would be transferred to G12, a single occupancy cell on G Wing. However, although Sam was eventually placed in G12, he was moved to another cell first because of an error by the probationary officer tasked with arranging the transfer.[75,76]

45. I note that although some witnesses described G12 as a "*management cell*",[77,78] it appears this term is generally only used to describe cells in Hakea's management unit (i.e.: Unit 1).[79]

46. In any case, at the relevant time on Unit 7, G12 was being used to "*manage*" prisoners whose behaviour, while inappropriate, was not serious enough to warrant a transfer to Unit 1. Although this cell is a "*standard living cell*" it does not have a TV or aerial port, and prisoners are only permitted to have a clock radio.[80]

47. Sam spent the rest of the day in G12, and he attended an afternoon medication parade, apparently without incident, before he was secured in the cell again.[81]

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[69] Exhibit 1, Vol 3, Tab 61.8 & Vol 1, Tab 22, Incident Description Report - Officer L Pring (05.03.24)
[70] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp4
[71] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24), paras 19-26 and ts 24.03.25 (McGrath), pp66-69
[72] Exhibit 1, Vol 1, Tab 24, Statement - Officer M Longden (undated) and ts 24.03.25 (Longden), pp98-101
[73] Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25)
[74] Exhibit 1, Vol 3, Tab 61.9, Incident Report Minutes - Officer M Longden(05.03.24) and ts 24.03.25 (Longden), pp98-100
[75] ts 25.03.25 (Batten), pp166-167
[76] Exhibit 1, Vol 1, Tab 15, Cell Placement History (05.03.24)
[77] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24), para 21
[78] See also: Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp4, 6, 16 & 23
[79] See also: Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp40-44 and ts 28.03.25 (Palmer), pp419-420
[80] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p15
[81] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24), paras 21-26

Sam sets fire to his cell[82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100,101]

48. About 6.00 pm, prison officers in Unit 7 were securing prisoners in their cells as part of Hakea's standard nighttime "*lockdown*", and Sam was secured in his cell without incident by Officer Batten.[102]

49. Officer Longden says he was overseeing the lock-up, and that he heard Sam say words to the effect of "*I want my fucking spends*". Officer Longden told Sam he would not receive his canteen spends that day, and proceeded to check the remainder of the wings within Unit 7.

50. At 6.05 pm, Sam used the emergency call bell in his cell to ask when he would receive his canteen spends, and was told to ask the staff in the Wing. Sam was also reminded that the cell call button was only to be used for medical emergencies. A short time later, Sam spoke to Officer Batten through his cell's viewing hatch, and again asked when he would be receiving the items he had purchased earlier from the canteen.

51. Officer Batten says he told Sam that due to time constraints it was unlikely prisoners on G wing would receive their canteen spends that evening. Officer Batten says he also told Sam that if the canteen spends could not be handed out that night, they would be distributed the following day.

52. At the inquest Officer Longden confirmed that if Unit 7 had had its full complement of prison officers on 5 March 2024, then it may have been possible to issue canteen spends to all prisoners that night.[103]

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[82] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp17-31
[83] Exhibit 1, Vol 1, Tab 39, WAPOL Incident Report LWP 24030500170973 (05.03.24)
[84] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24)
[85] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p17
[86] Exhibit 1, Vol 1, Tab 35, Incident Description Reports - Various Officers (05.03.24)
[87] Exhibit 1, Vol 1, Tab 24, Statement - Officer M Longden (undated) and ts 24.03.25 (Longden), pp89-119
[88] Exhibit 1, Vol 1, Tab 24.1, Incident Description Report - Officer M Longden (05.03.24)
[89] Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25)
[90] Exhibit 1, Vol 1, Tab 23, Statement - Officer E McGrath (undated/unsigned)
[91] Exhibit 1, Vol 1, Tab 23.2, Incident Description Report - Officer E McGrath (05.03.24)
[92] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24) and ts 24.03.25 (McGrath), pp57-88
[93] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24) and ts 25.03.25 (Szeremenda), pp119-150
[94] Exhibit 1, Vol 1, Tab 25.2, Incident Description Report - Officer T Szeremenda (05.03.24)
[95] Exhibit 1, Vol 2, Tab 57.12, Statement - Officer T Szeremenda (18.07.24)
[96] Exhibit 1, Vol 1, Tab 26, Statement - Officer J Ballinger (18.07.24) and ts 25.03.25 (Ballinger), pp151-164
[97] Exhibit 1, Vol 1, Tab 26.1, Incident Description Report - Officer J Ballinger (05.03.24)
[98] Exhibit 1, Vol 2, Tab 57.2, Statement - Officer J Ballinger (11.01.25)
[99] Exhibit 1, Vol 1, Tab 27, Incident Description Report - Officer M Batten (05.03.25)
[100] Exhibit 1, Vol 2, Tab 57.3, Statement - Officer M Batten (21.01.25) and ts 25.03.25 (Batten), pp164-179
[101] Exhibit 1, Vol 3, Tab 61.3, Statement - Officer M Moore (20.02.25), paras 6-19 and ts 24.03.25 (Moore), pp25-37
[102] Officer Batten was at Hakea briefly prior to his direct entry into the Department's Special Operations Group
[103] ts 24.03.25 (Longden), pp96-97

53. Whilst the failure to distribute canteen spends may appear to be a trivial matter, it was particularly unfortunate in Sam's case, and appears to be the reason why he become so agitated.

54. At about 6.05 pm, banging noises were heard from G12 and it became clear that Sam was damaging the fixtures and fittings in his cell. Officer Longden says he was advised about Sam's behaviour, and that he went to G12 to try to speak with Sam.

55. In his statement, Prisoner P says he heard the sound of porcelain breaking from a cell opposite his and heard the occupant (i.e.: Sam) shouting at prison officers using words to the effect of "*white dog*" and "*piece of shit*". Prisoner P also says the prison guards were not trying to help Sam, and instead were "*tormenting him*".[104,105]

56. Prisoner P says he heard a "*guard*" who he believed was the Senior Officer, who had "*an English accent with tattoos on each arm*" bang on Sam's door and say: "*[S]tay in there and rot in hell forever you piece of shit*".[106,107]

57. At the inquest, Officer Longden (who was an acting senior officer at the time) denied he had said these words to Sam, although he conceded he had called Sam "*a brat*". Officer McGrath, who was outside G12 at the relevant time, said she had: "*heard nothing of the sort*".[108]

58. If Officer Longden (or indeed any prison officer) had said "*[S]tay in there and rot in hell forever you piece of shit*" to Sam, a prisoner who was clearly highly agitated, it would be a very serious matter, and would represent a grave failure to act in an appropriate and professional manner.

59. Given Officer Longden's denial, and the fact that Officer McGrath did not hear these words being said, I am unable to make any positive finding that these words were said.

[104] Exhibit 1, Vol 1, Tab 33, Statement - Prisoner P (27.06.24)
[105] Exhibit 1, Vol 2, Tab 33.1, Handwritten Notes - Prisoner P (undated)
[106] Exhibit 1, Vol 1, Tab 33, Statement - Prisoner P (27.06.24), paras 16-20
[107] Exhibit 1, Vol 2, Tab 33.1, Handwritten Notes - Prisoner P (undated)
[108] ts 24.03.25 (Longden), pp111-112 and ts 24.03.25 (McGrath), p76

60. Nevertheless, these types of allegations by prisoners underscore the importance of the Department expediting the roll out of body worn cameras (BWC) for all prison officers.

61. I will say more about the issue of BWC later in this finding, but for now I merely note that if Officer Longden and/or Officer McGrath had been wearing a BWC, it would have captured their interaction with Sam, and enabled me to make positive findings about what was or wasn't said.

62. In any case, Officer Longden says he heard Sam say words to the effect of: "*I told you I would do this*", which he (Officer Longden) took to be a reference to Sam damaging his cell after not being given his canteen spends. Despite his efforts, Officer Longden says Sam remained "*non-compliant and abusive*", and he used his prison radio to request the "Recovery Team" to attend G Wing.

63. Meanwhile, Officer McGrath (the next most experienced officer on the unit at the time) instructed other officers to go to the Senior Officer's office and fetch a Perspex shield, chemical agent (i.e.: capsicum spray), and respirators in case these items were required by the Recovery Team.

64. At the relevant time, Officer Longden was relatively inexperienced in the role of senior officer, and after he had asked for the Recovery Team to attend, he used his prison radio to contact Officer Szeremenda to request permission to use chemical agent on Sam, should this be required.

65. Officer Szeremenda was an Acting Principal Officer, and was Officer Longden's immediate supervisor. After his radio call to Officer Szeremenda, Officer Longden also rang her and they had a brief phone discussion Sam's behaviour.

66. Officer Longden sought permission for a "*planned use of force*" against Sam, and although Officer Szeremenda authorised the use of chemical agent, she recommended de-escalation options be tried first. Officer Szeremenda felt Officer Longden was talking through his options with her, and he said he would return to Sam's cell and make a further attempt to engage with him.

67. Officer Longden (accompanied by several other officers) went back to Sam's cell to try to speak with him. However, when the viewing hatch on the door of G12 was opened, the officers realised that Sam had placed his mattress against the door, thereby blocking vision into the cell. Although Officer Longden continued to try to engage with Sam, and also asked him to take the mattress down, Sam remained non-compliant and was swearing and yelling at the officers.

68. As Officer Longden continued his efforts to communicate with Sam and deescalate the situation, Officer McGrath went out of Unit 7 and walked through a courtyard to the back of G12 so she could look through the cell's rear window.

69. Although the cell window had been damaged and was cracked, Officer McGrath was still able to see through it, and she observed that Sam was "*still going off*", meaning he was shouting and moving about in an agitated manner.

70. As Officer McGrath was watching Sam she heard him say: "*You know what happens next, I light it up*", before she saw him use a cigarette lighter to set fire to middle of the cover of his mattress.

71. At the time, mattress covers at Hakea were not fire retardant, and when the mattress cover ignited Officer McGrath used her prison radio to make an emergency call in which she said: "*Code Red, Fire, Fire, Fire*". Departmental records show that Officer McGrath made her Code Red Fire call at 6.16 pm.[109]

72. In passing I note that although cells at Hakea are not protected by an automatic fire suppression system, cells are fitted with smoke detection sampling points which are monitored by a system known as VESDA (Very Early Smoke Detection Apparatus). Any VESDA activations "*are recorded by the system located in the gatehouse*" and the system is maintained and tested on a monthly basis by an external contractor. The last recorded test prior to Sam's death occurred on 16 February 2024.[110]

[109] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp16-17
[110] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p12

73. In this case, according to a review of incident data a "*fire alarm*" was activated 5.55 pm on 5 March 2024.[111] However, in a report provided to the Court, the Superintendent of Hakea (Officer Tuck) noted that:

> Vesda time clocks were identified to be not set to correct time. This has been rectified and they are now all synced to the correct time as of 11/03/2025.[112]

74. In any case, when Officer McGrath returned to Unit 7 moments after making the Code Red Fire call, she did not notice any smoke in the G Wing corridor. After briefly conferring with Officer Longden, Officer McGrath then made her way out of Unit 7 to an adjacent open area, where she remained until Sam was extracted from his cell by officers wearing breathing apparatus.

75. At the relevant time, Officer McGrath had been a prison officer for about seven years and given her level of experience, her decision to leave Unit 7 before being ordered to do so is both perplexing and troubling. On 5 March 2024, Unit 7 was four prison officers below its usual complement, and three of the officers on duty were probationary officers with very minimal experience.[113]

76. At the inquest Officer McGrath was asked why she had not remained on Unit 7 to assist her colleagues until an evacuation order was given, and her response was:

> I think that I didn't - I didn't want to be put in a situation where I could potentially be putting myself at risk or seeing my colleagues put at risk. So I removed myself from the situation".[114]

77. As it happens, shortly after Officer McGrath left Unit 7, the fire in Sam's cell took hold and smoke began pouring under the door of G12 and into the corridors of G Wing. As a result, the remaining staff in Unit 7 were ordered to evacuate, and Officer Longden said when he went into the courtyard outside G Wing, he saw smoke "*billowing out*" of the roof of the Wing.[115]

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[111] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p12
[112] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p5
[113] Exhibit 1, Vol 1, Tab 34, Hakea Daily Staff Roster Sheet (05.03.24)
[114] ts 24.03.25 (McGrath), p80
[115] Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25), para 52

78. Had Officer McGrath remained on Unit 7, she could have provided support to her less experienced colleagues, and she could also have briefed Officer Szeremenda about her observations of what had been going on in G12, when she (Officer Szeremenda) arrived on Unit 7. At the inquest, Officer Szeremenda agreed that this kind of information was "*absolutely important and helpful*".[116]

79. Given the appalling standard of fire equipment in Unit 7 at the time, it is fair to say there was little that Officer McGrath could have done if she had had chosen to stay on Unit 7. Nevertheless, given the dynamic and challenging situation that was unfolding in G Wing, the presence of an experienced officer would no doubt have been comforting to the three probationary officers who were on duty on Unit 7 at that time.

80. Regardless of whether she could or would have been able to actually do anything, in my view, Officer McGrath's decision to leave her post without being ordered to do so is unfortunate. However, I note with approval that Officer McGrath has clearly learned from this experience.

81. At the inquest, Officer McGrath was asked whether, with the benefit of hindsight, she though she ought to have remained on Unit 7 until the evacuation order had been given, and her response was: "*I think that I should have remained until I was given the order to leave, yes*".[117]

Response of Unit 7 staff[118,119,120,121,122,123,124,125,126,127,128,129,130]

82. Officer Ballinger (who was then a probationary officer with minimal experience)[131] heard the Code Red Fire call, and acting on his own initiative, he immediately went to the G Wing fire cupboard. This fire cupboard which was adjacent to the Senior Officer's office next to a food preparation area (Regi-therm area) and was closest to G12.

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116 ts 25.03.25 (Szeremenda), pp135-136
117 ts 24.03.25 (McGrath), p88
118 Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp17-18, 51-53 & 62-64
119 ts 28.03.25 (Palmer), pp425-428 & 433-437
120 Exhibit 1, Vol 1, Tab 24, Statement - Officer M Longden (undated) and ts 24.03.25 (Longden), pp88-119
121 Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25)
122 Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24) and ts 24.03.25 (McGrath), pp57-88
123 Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24) and ts 25.03.25 (Szeremenda), pp119-150
124 Exhibit 1, Vol 2, Tab 57.12, Statement - Officer T Szeremenda (18.07.24)
125 Exhibit 1, Vol 1, Tab 26, Statement - Officer J Ballinger (18.07.24) and ts 25.03.25 (Ballinger), pp151-163
126 Exhibit 1, Vol 2, Tab 57.2, Statement - Officer J Ballinger (11.01.25)
127 Exhibit 1, Vol 1, Tab 27, Incident Description Report - Officer M Batten (05.03.25)
128 Exhibit 1, Vol 2, Tab 57.3, Statement - Officer M Batten (21.01.25) and ts 25.03.25 (Batten), pp164-179
129 Exhibit 1, Vol 1, Tab 20, Photos - G & H Wing fire equipment and cell block area
130 See also: ts 27.03.25 (August), pp349-351
131 Officer Ballinger was at Hakea briefly prior to his direct entry into the Department's Special Operations Group

83. Like other fire cupboards at Hakea, the G Wing fire cupboard contained a reel holding a black PVC fire hose which was fitted with a metal nozzle. The hose was designed to deliver pressurised water which prison officers were expected to use to extinguish flames from any cell fire.

84. Officer Ballinger tried to open the G Wing fire cupboard door using a standard key that all custodial officers have on their uniform belts. However, in the first of a series of **appalling and inexcusable** equipment failures, Officer Ballinger found that the fire cupboard's heavy wooden door was jammed shut, and despite his efforts he could not get the door to open.

85. In his statement, Officer Ballinger said this about his attempts to open the G Wing fire door cupboard:

> Prior to evacuating the wing, myself and another prison officer went to the nearest fire door located near the Senior Officer Office to get the fire hose. However, upon getting there I was unable to open the fire cabinet door. At this time, I believed this was due to the door being locked however I later learned that the door was jammed and had been malfunctioning for a while prior to the incident. Due to the issue with the door, I decided to get the next closest fire hose which was within H-Wing.[132,133]

86. The evidence before me is that as part of standard weekly checks conducted on Unit 7, the G Wing fire cupboard door was checked on 2 March 2024, and was apparently functional at that time.[134]

87. However, I note that this check was conducted by Officer Moore, a probationary officer with minimal experience who had never performed these types of checks before. It is therefore understandable that at the inquest, Officer Moore said he was unaware that the intermittent jamming of fire cupboard doors was a known issue.[135,136]

[132] Exhibit 1, Vol 1, Tab 26, Statement - Officer J Ballinger (18.07.24), paras 18-21 and ts 25.03.25 (Ballinger), p157
[133] See also: Exhibit 1, Vol 1, Tab 57.2, Statement - Officer J Ballinger (11.01.25), paras 15-16
[134] Exhibit 1, Vol 1, Tab 17, Weekly Security and Maintenance Checks Form (02.03.24)
[135] Exhibit 1, Vol 3, Tab 61.3, Statement - Officer M Moore (20.02.25), paras 20-33 and ts 24.03.25 (Moore), pp12-37
[136] Exhibit 1, Vol 1, Tab 17, Weekly Security and Maintenance Checks Form (02.03.24)

88. At the inquest, Officer Moore said he couldn't recall if he had been directly supervised during the checking process. In any case, Officer's Moore's check sheet was signed off by Officer Savage (the senior officer on duty at the time), who said he trusted Officer Moore to conduct the equipment checks correctly, despite the fact that he (Officer Savage) had not conducted any "*spot checks*" to confirm that the checks had been performed correctly.[137,138,139,140]

89. I note that a "*critical urgency*" maintenance request form dated 16 December 2023 was submitted by a Unit 7 officer in relation to the G Wing firehouse cupboard door. That request form stated: "*fire hose door in Kitchen is completely jammed and unable to be opened*".[141]

90. Despite the fact that is a critical safety issue, there is no evidence before me that this obvious and dangerous fault was ever repaired, and in fact the available evidence is to the contrary.

91. In an email dated 10 October 2024, the "*WHS Coordinator*" at Hakea makes the following comments about the maintenance request:

> The maintenance worker responsible for repairing the broken hinge on the fire cupboard door in the Regi Area of Unit 7 mistakenly logged the job with ARA, the company responsible for the fixed fire equipment, rather than Midlolo, the preferred contractor for the Department. Unfortunately, there was also a lapse in tracking whether the job had been completed, which resulted in the delay.[142]

92. On the basis of the available evidence, it is possible that the G Wing fire cupboard door was jammed for some time, and this may have been overlooked, despite the weekly checks which were supposedly being conducted. However, all that can be said with any certainty is that there was a known issue with the door of the G Wing fire cupboard, and there is no evidence that this issue was properly addressed before 5 March 2024.

[137] See also: Exhibit 1, Vol 1, Tab 18, Weekly Security and Common Area Check Form (02.03.24)
[138] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer R Savage (06.01.25), paras 4-21 and ts 24.03.25 (Savage), pp40-41
[139] Exhibit 1, Vol 3, Tab 61.3, Statement - Officer M Moore (20.02.25), paras 20-33
[140] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp60-61 and ts 28.03.25 (Palmer), pp432-433
[141] Exhibit 1, Vol 3, Tab 61.2, Email - E Lloyd-Cresswell (10.10.24)
[142] Exhibit 1, Vol 3, Tab 61.2, Email - E Lloyd-Cresswell (10.10.24)

93. In any case, returning to 5 March 2024, it has been suggested that Officer Ballinger may have been unable to open the G Wing fire cupboard door because it had become swollen as a result of moisture or steam from the adjacent food preparation area.[143] It has also been suggested that Officer Ballinger may have panicked at the relevant time, and that this could explain why he was unable to open the G Wing fire cupboard door.[144]

94. At the inquest, when asked whether he was "*panicked*" as he tried to open the G Wing fire cupboard Officer Ballinger said: "*I don't believe, personally, I was too panicked at that point in time. I think I was still in control of what I was doing, if that makes sense*". When he was asked if he used sufficient force Officer Ballinger said: "*I would have made all reasonable attempts to open it*".[145]

95. Having had the opportunity to listen carefully to Officer Ballinger's evidence at the inquest, and after carefully considering the available evidence,[146] it is my view that it is far more likely that the G Wing fire cupboard door could not be opened at the relevant time because it had become jammed shut after becoming swollen, as a consequence of being exposed to moisture and steam from the adjacent food preparation area.

96. In his report, Officer Tuck confirmed "*after the event*" Hakea's Industry and Facilities Manager (Mr Philpott) "*was able to open the door, albeit with more than normal force*". This establishes that at the time of Sam's death the G Wing fire cupboard door was not working correctly, and if the weekly check on 2 March 2024 is correct, it was subject to swelling.[147]

97. In any case, in his report, Officer Tuck confirmed that "*All fire hose reel Cabinets and doors across the site have been checked and all were operational*", and the wooden door of the G Wing fire cupboard had been encased in metal sheeting to ensure it cannot swell. Officer Tuck also said Hakea's metal shop had manufactured new metal doors for fire cupboards on Unit 7 "*damaged by prisoners*", and the doors of the other fire cupboards at Hakea were progressively being upgraded.[148]

[143] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer R Savage (06.01.25), paras 22-29
[144] ts 24.03.25 (Savage), pp44-48 & 55
[145] ts 25.03.25 (Ballinger), p157
[146] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer J Ballinger (11.02.25), paras 15-16 and ts 25.03.25 (Ballinger), pp156-157
[147] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p3 and ts 27.03.25 (Tuck), pp368 & 370
[148] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p4 and ts 27.03.25 (Tuck), pp368-370

98. As Officer Ballinger was struggling to open the G Wing fire cupboard door, Officers Batten and Lauder, who were also probationary officers, acted on their own initiative and went to the fire cupboard in H Wing. Although these officers were able to unlock the fire cupboard door and access the fire hose before rolling it out and placing it in front of G12, for reasons I will explain, their efforts proved to be pointless.

99. At the relevant time some of the fire hoses at Hakea were fitted with "*twist type*" nozzles where water flow was controlled by turning the nozzle itself. However, nozzles on other fire hoses at Hakea were fitted with a lever which controlled water flow.

100. As I will explain, Officers wearing breathing apparatus (BA officers) arrived on Unit 7 to extract Sam from his cell. However, as these officers were soon to discover, the fire hose from the H Wing fire cupboard was inoperative. This fire hose was fitted with a "*lever type*" nozzle and the lever had fallen off and was lurking, unnoticed in the bottom of the H Wing fire cupboard as a result of a loose bolt. Without this lever, the flow of pressurised water could not turned on.[149]

101. This equipment failure had occurred notwithstanding the fact that, at the relevant time, fire cupboards and hoses at Hakea were supposedly being checked biannually by external contractors.[150,151]

102. In his report, Officer Tuck noted that the H Wing fire hose had been checked by the Department's contractor on 30 June 2023, and again on 22 November 2023, and that: "*It was not identified in either of these checks that the nozzle was missing the lever*". Further, the H Wing fire hose "*passed inspection*" in the contractor's report.[152]

103. On the basis of the available evidence, it is possible that the loose bolt holding the lever in place was serviceable on 22 November 2023, and that sometime between then and 5 March 2024, (for unknown reasons) the bolt loosened and the lever fell off and remained in the bottom of the H Wing fire cupboard where it was discovered after Sam's death.[153]

[149] Exhibit 1, Vol 1, Tab 20, Photos - G & H Wing fire equipment and cell block area
[150] Exhibit 1, Vol 1, Tab 19, Email - Mr A Philpott (06.03.24)
[151] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer R Savage (06.01.25), paras 35-38
[152] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p3
[153] Exhibit 1, Vol 1, Tabs 19 & 20, Photos - H Wing fire cupboard

104. The issue of fire hoses at Hakea being fitted with different types of nozzles has been addressed since Sam's death. In an email dated 6 March 2024, Mr Philpott confirms the Department's contractor had visited and a "*new twist nozzle is now fitted to the hose*" in the H Wing fire cupboard.[154]

105. I also note that in his report, Officer Tuck confirmed that: "*All fire hoses now have been fitted with the same twist nozzle across the site*" and that "*All firehoses that require replacing have been identified through 'ARA Building Maintenance Servicing' (ARA) checks*".[155]

106. As I will explain in more detail later in this finding, at the time of Sam's death, the expected primary response to cell fires at Hakea was for prison officers on the relevant unit to don "*R-Kit*" respirators before dousing the cell fire by directing pressurised water from fire hoses on the relevant wing, through the large hatch in the prisoner's cell door.[156]

107. None of these things occurred in Sam's case because, at the relevant time, "*R-Kits*" at Hakea (which are stored in the control room of each Unit) had been "*tagged out*" on 23 January 2024, by an employee health and safety representative on the basis the masks were "*an unsafe work system*".[157,158]

108. This meant that prison officers were not authorised to use respirators in R-Kits, but as I will explain later in this finding, the issue is more complex. For now I merely note that even if the officers on Unit 7 had used the "*tagged out*" R-Kit respirators, they would have been unable to extinguish the fire in Sam's cell.

109. That is because firstly, fire extinguishers would have been ineffective in dousing the flames in Sam's cell, because the fire was on the other side of Sam's mattress. Secondly, pressurised water (which might have penetrated through the cover of the mattress in Sam's cell and thereby doused the flames, was unavailable. As I have explained, that was because the G Wing fire cupboard could not be opened, and the nozzle on the fire hose in the H Wing fire cupboard was missing a lever and for that reason was unserviceable.[159,160]

[154] Exhibit 1, Vol 1, Tab 19, Email - Mr A Philpott (06.03.24)
[155] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p4 and ts 27.03.25 (Tuck), pp370-372
[156] Exhibit 1, Vol 3, Tab 68, Attachment 6 - EMF-DIR-009 Cell Fire Response (01.07.23)
[157] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp36-37
[158] See Also: ts 24.03.25 (Savage), pp53-54 and ts 25.03.25 (Ballinger), pp155 & 162
[159] Exhibit 1, Vol 1, Tab 26, Statement - Officer J Ballinger (18.07.24)
[160] Exhibit 1, Vol 2, Tab 57.2, Statement - Officer J Ballinger (11.01.25)

Evacuation order[161,162,163,164,165]

110. Meanwhile, after Officer Szeremenda had spoken with Officer Longden on the phone, she decided to attend Unit 7 to provide him with additional support. At the inquest, Officer Szeremenda explained that she was aware that Officer Longden was relatively inexperienced in the role of senior officer, and that she considered her presence on the unit might be helpful.

111. As Officer Szeremenda was making her way to Unit 7, she says she heard the Code Red Fire call, although at the inquest Officer Szeremenda said she that she was unsure whether she had correctly heard the "*Fire, Fire, Fire*" portion of that call.[166]

112. When she arrived at Unit 7, Officer Szeremenda noticed prison officers, including several probationary officers, standing in G and H Wings "*looking slightly lost*". In her statement, Officer Szeremenda said it appeared that no one was taking control of the situation: "*due to a lack of experience amongst the present staff as it appeared they had exhausted their options as a group*".[167,168]

113. After speaking briefly with Officer Longden, Officer Szeremenda decided she needed further information, so she went to G12 to try and engage with Sam. After calling out to Sam using his first name, Officer Szeremenda says she could hear noises coming from inside the cell, but it was unclear whether this was Sam was talking to himself or just moving about the cell.

114. Officer Szeremenda could not see or smell any smoke, and when she opened G12's viewing hatch, Sam's mattress was still against the door, so she was unable to see into the cell. Officer Szeremenda decided she needed to get further information about what was going on in Sam's cell, and so she made her way into the court yard and looked through the rear window of Sam's cell, as Officer McGrath had done a short time earlier.

[161] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp18-19
[162] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), paras 15-50
[163] ts 25.03.25 (Szeremenda), pp127-136 & 147
[164] Exhibit 1, Vol 1, Tab 24, Statement - Officer M Longden (undated) and ts 24.03.25 (Longden), pp104-108
[165] Exhibit 1, Vol 2, Tab 57.6, Statement - Officer M Longden (21.01.25)
[166] ts 25.03.25 (Szeremenda), pp127-128
[167] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), para 24
[168] See also: ts 25.03.25 (Szeremenda), pp128-129

115. In her statement and at the inquest, Officer Szeremenda said she was shocked to see a large flame and orange glow on the back of Sam's cell door, which she described as "*fierce*". Officer Szeremenda says she saw Sam had his arms above his head and seemed to be trying to pat the fire out, and when Officer Szeremenda returned to G Wing moments later, she noticed smoke and could smell "*toxic chemicals*".

116. By this stage prisoners in nearby cells (who had obviously smelled smoke) became concerned, and had started yelling out. Given the fact that smoke was now pouring out of G12 and into G Wing, Officer Szeremenda ordered staff to evacuate the Unit and await the arrival of officers wearing breathing apparatus (BA officers).

117. As prison officers in Unit 7 were complying with this order, Officer Szeremenda used her prison radio to request an update on the arrival of BA officers, and was told it would be about seven to eight minutes before BA officers arrived.

118. At 6.26 pm, the prisoner in the cell adjacent to G12 used the cell call button in his cell to alert officers to the fact that he was having an asthma attack, presumably due to smoke inhalation. During all of this time, as the fire continued to burn, Sam remained trapped in G12.

Sam is extracted from his cell[169,170,171,172,173,174,175,176,177,178,179]

119. Once the Code Red Fire call was made, four BA officers (Officers McDuffus, Grocott, May and Cavanaugh) donned BA equipment and made their way to G Wing. The first BA team arrived at G Wing at about 6.22 pm, and at about 6.29 pm, following a briefing by Officer Grocott (who had assumed the role of Entry Control Officer), Officers McDuffus, May and Cavanaugh approached G12. At that time, visibility was low because the Wing was filled with smoke.

[169] ts 25.03.25 (Szeremenda), pp148-149
[170] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), ppp18-19
[171] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp15-21
[172] Exhibit 1, Vol 1, Tab 28, Incident Description Report - Officer S Grocott (05.03.24)
[173] Exhibit 1, Vol 2, Tab 57.5, Statement - Officer S Grocott (11.01.25) and ts 25.05.25 (Grocott), pp179-210
[174] Exhibit 1, Vol 1, Tab 29, Statement - Officer S McDuffus (18.06.24) and ts 25.05.25 (McDuffus), pp210-225
[175] Exhibit 1, Vol 1, Tab 29.1, Incident Description Report - Officer S McDuffus (05.03.24)
[176] Exhibit 1, Vol 2, Tab 57.7, Statement - Officer S McDuffus (30.01.25)
[177] Exhibit 1, Vol 1, Tab 30, Statement - Officer G May (24.07.24) and ts 26.05.25 (May), pp229-249
[178] Exhibit 1, Vol 1, Tab 30.1, Incident Description Report - Officer G May (05.03.24)
[179] Exhibit 1, Vol 1, Tab 31, Incident Description Report - Officer Z Cavanaugh (05.03.24)

120. Officer McDuffus (who knew Sam from his previous admissions to prison) repeatedly called out to him and banged on his cell door, but there was no response. Officer McDuffus then opened the G12 observation hatch but couldn't see anything because the cell was filled with thick smoke.

121. Officer McDuffus picked up the H Wing fire hose that had been placed in front of G12 and tried to spray water into the cell through the observation hatch. However, he noticed that a lever had come off the nozzle of the fire hose meaning it was inoperable, and he handed the hose to Officer Cavanaugh to see if he could assist.

122. Officer Cavanaugh was unable to get the hose to work and handed it to Officer May, who managed to forcibly yank the nozzle off the end of the fire hose. Once the nozzle had been removed, some water did flow from the fire hose, but the pressure was very low. Nevertheless, Officer McDuffus pushed the end of the fire hose through the observation hatch, and the fire in Sam's cell fire was eventually extinguished.

123. BA officers breached G12 at about 6.32 pm, and when they did so, visibility in the cell was poor as the cell was dark and filled with dense smoke. Using a technique known as the "*BA shuffle*", Officer McDuffus and Officer Cavanaugh entered G12 and found Sam in the back left corner of the cell near his bedframe.

124. Sam was unresponsive, and his body was limp, and as Officer McDuffus grabbed him, Sam fell forward into his arms. The officers placed Sam face down on the cell floor with his head facing the door. Visibility was still extremely poor, and Sam was dragged out of G12 by Officers McDuffus and Cavanaugh.

125. Because of the bulky BA equipment they were wearing, and the cramped nature of G12, the officers grasped Sam's arms but were unable to raise his legs, as they dragged him out of the cell face down in order to get him out of the cell as quickly as possible. As I have noted, prior to setting fire to his mattress Sam had "*smashed up*" the fittings and fixtures in his cell, including his porcelain toilet pan. This meant that the floor of G12 was littered with shards of porcelain of various sizes.[180]

[180] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24), pp4-7

126. After Sam had been removed from G12, it was noted that he had a laceration to his abdomen which was later described as a "*penetrating sharp force injury*".[181,182,183,184,185,186,187,188,189] There are three obvious possibilities for how Sam obtained this injury. First, Sam may have deliberately inflicted the injury on himself while he was damaging his cell. Second, Sam may have sustained the injury accidentally before he was extracted from his cell, and third the injury may have occurred accidentally as Sam was being removed from G12.[190]

127. After carefully considering all of the available evidence, it seems to me that the most likely explanation for how Sam sustained the injury to his abdomen is that it occurred accidentally as he was being dragged from his cell.[191,192,193]

128. Meanwhile, other BA teams had arrived at Unit 7, and they successfully extracted all other prisoners from their cells before those prisoners were escorted to the Hakea gym. As mentioned, the smoke pouring out of G12 had filled the Unit, and Officer Grocott requested BA teams to place extraction fans in key locations to help clear this smoke which was visible from his command post.[194]

129. As Officer Andrews was placing extraction fans in Unit 7 to help clear smoke, he had identified that one of the fans (which he had sourced from the west side of Hakea) was unable to be used.[195,196,197,198,199] The reason was that this extraction fan was fitted with a "*three-phase socket*" which was incompatible with the power outlets available on Unit 7. Nevertheless, it appears that the other extraction fans which were working did assist in removing smoke from the unit.

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[181] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24)
[182] Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (08.03.24)
[183] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p13
[184] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Sen. Const. A Pearsall (03.05.24), pp4-7 & 18-19
[185] Exhibit 1, Vol 1, Tab 30, Statement - Officer G May (24.07.24), paras 30-34 and ts 26.03.25 (May), pp238-239
[186] Exhibit 1, Vol 1, Tab 61.11, Statement - Officer G May (19.02.25), paras 25-28
[187] Exhibit 1, Vol 1, Tab 26, Statement - Officer J Ballinger (28.05.24), para 29
[188] Exhibit 1, Vol 1, Tab 33, Statement - Prisoner P (27.06.24), paras 47-52
[189] See also: ts 27.03.25 (Gunson), pp406-407
[190] Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p2
[191] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24)
[192] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24)
[193] ts 27.03.25 (Gunson), pp399-400 & 407
[194] Exhibit 1, Vol 1, Tab 28, Incident Description Report - Officer S Grocott (05.03.24) and ts 25.05.25 (Grocott), pp184-186
[195] Exhibit 1, Vol 1, Tab 32, Statement - Officer S Andrews (26.06.24), paras 27-33
[196] Exhibit 1, Vol 1, Tab 32.1, Incident Description Report - Officer S Andrews (05.03.24)
[197] Exhibit 1, Vol 2, Tab 57.1, Statement - Officer S Andrews (dated 09.01.24, but presumably meant to be 09.01.25)
[198] See also: ts 25.03.25 (Grocott), pp184-185 & 197
[199] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp56-57 and ts 28.03.25 (Palmer), pp430-431

130. In his report, Officer Tuck stated that: "*Smoke extraction fan plugs were replaced so they are now operational in all regithermic areas*". However, at the inquest, Officer Tuck clarified that the extraction fan fitted with a "*three-phase socket*" had not been modified, and instead had been clearly labelled as only being useable on Hakea's "*East Wing*".[200]

Sam's death[201,202,203,204]

131. After Sam was removed from G12, he was placed into the recovery position in the corridor outside his cell. It was noted that Sam's skin was blackened, he had burns on his body, and he was not breathing. BA officers moved Sam into a courtyard area outside Unit 7, where "*a temporary medical triage area was set up*".

132. Sam was treated by nursing staff who, with the assistance of prison officers, started CPR at 6.34 pm. Hakea staff continued CPR on a rotational basis. Emergency services were contacted and ambulances were requested at 6.38 pm.

133. The first of five ambulances arrived at Hakea at about 6.47 pm, and ambulance officers took over Sam's care. A mechanical chest compression device (LUCAS machine) was fitted to Sam's chest, and he was transported FSH by ambulance.

134. Sam was admitted to the emergency department at FSH at about 7.53 pm, but despite further resuscitation efforts he could not be revived. Sam was declared deceased at 8.08 pm on 5 March 2024.[205]

Attendance of DFES officers[206,207,208]

135. Despite the fact that the Code Red Fire was called at Hakea at 6.16 pm, there is no evidence before me that anyone at Hakea requested the attendance of officers from the Department of Fire and Emergency Services (DFES).[209,210,211]

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[200] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p5 and ts 27.03.25 (Tuck), pp373-374
[201] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp2-7
[202] Exhibit 1, Vol 1, Tab 38, SJA Patient Care Records: 23401298, 23401302, 23401315, 23401318 & 23401325 (05.03.24)
[203] Exhibit 1, Vol 1, Tab 37, EcHO Prison Records (05.03.24), pp2-3 and ts 27.03.25 (Gunson), pp402-404
[204] Exhibit 1, Vol 1, Tab 41, FSH Adult Triage Nursing Assessment (05.03.24)
[205] Exhibit 1, Vol 1, Tab 4, Death in Hospital Form (05.03.24)
[206] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp2-3
[207] Exhibit 1, Vol 3, Tab 77, Letter - Ms K Niclair to Mr W Stops (02.05.25)
[208] See also: ts 28.03.25 (Palmer), pp441-442 & 448-449
[209] A "late entry" in the incident notes made by Officer Ballinger states: "*1834 DFES called*". This entry is clearly wrong.
[210] Exhibit 1, Vol 3, Tab 70, Typed notes Officer Ballinger (Entry: 6.34 pm, 05.03.24)
[211] ts 25.03.25(Grocott), pp207-209

136. The failure of staff at Hakea to request the attendance of DFES Officers is not only contrary to departmental policy, it is another example of the abysmal response to the fire in Sam's cell.[212,213,214]

137. Radio logs of calls made by prison officers at the relevant time suggest that Hakea staff were under the impression that the attendance of DFES officers had been requested.[215] However, a review by DFES of recordings of the "*000*" emergency calls it received between 6.25 pm and 7.00 pm on 5 March 2024 confirms that although DFES received two calls from St John Ambulance (SJA) staff (see below) **no** "000" calls were received from Hakea regarding the G12 fire.[216]

138. The DFES Event Log makes it very clear that it was SJA staff who asked DFES officers to attend Hakea. The call log in the DFES incident report confirms that SJA called DFES at 6.40 pm (two minutes after SJA had been contacted by Hakea), and again at 6.44 pm. The details of these two SJA calls to DFES are as follows:

> 6.40 pm: *They've (i.e.: SJA have) received a call from the Prison saying a prisoner has been injured while trying to light a fire. There is no current fire*.
>
> 6.44 pm: *Active fire mattress on fire in cell. Person receiving CPR*.[217]

139. The grave risks from fire to ageing facilities such as Hakea are obvious. I also note the ventilation ducts at Hakea have apparently never been cleaned, and at the relevant time were caked in dust which could easily have ignited.[218,219]

140. At the inquest Officer Tuck said it would cost $150,000 to have the vents cleaned by an external contractor.[220] In my view this would be money well spent, and I have recommended that the ventilation ducts at Hakea be regularly cleaned to remove dust and/or other materials which may represent a fire hazard.

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[212] Exhibit 1, Vol 3, Tab 77.1, Hakea Prison: Emergency Management Plans 9, Section: Fire, p4
[213] Exhibit 1, Vol 3, Tab 77.2, Hakea Prison: Standing Order 11.9 Compressed Air Beathing Apparatus (28.07.20), para 5.2
[214] See also: Exhibit 1, Vol 3, Tab 77.3, Hakea Prison: Superintendent's Notice to Staff 12 of 2025 (30.04.25), p2
[215] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p10
[216] Exhibit 1, Vol 3, Tab 73, Email - District Officer M Laing, DFES Communication Centre (17.04.25)
[217] Exhibit 1, Vol 1, Tab 40, DFES Incident Report No. 659966 (05.03.24), p6
[218] Exhibit 1, Vol 2, Tab 57.5, Statement - Officer S Grocott (11.01.25), paras 88-90 and ts 25.05.25 (Grocott), pp199-200
[219] ts 28.03.25 (Palmer), p432
[220] ts 27.03.25 (Tuck), p377

141. In any case, it is **outrageous** that nobody at Hakea contacted DFES as soon as it was clear that BA protocols had been initiated. Instead, 24 minutes elapsed before DFES were contacted, and this only occurred because of the commendable actions of SJA staff.

142. By the time DFES officers arrived at Hakea at about 6.55 pm, the fire in G12 had already been extinguished by BA officers. Nevertheless, DFES officers were able to confirm that the fire in G12 had not spread using a thermal imaging camera, and after doing so, DFES officers left Hakea at about 7.27 pm.[221]

143. Obviously the attendance of DFES officers should have been requested by Hakea staff. The fact that in this case the cell fire been extinguished before their arrival is irrelevant. As noted, DFES officers were able to assess the situation and provide comfort to Hakea prisoners and staff by confirming that the fire in G12 had not spread.

144. Given the ageing nature of Hakea's facilities, and in the absence of any automatic fire suppression system, I **strongly** urge the Department to recommend that staff at Hakea adopt a low threshold for requesting the attendance of DFES whenever a Code Red Fire call is made.

Homicide Squad investigation[222]

145. Following Sam's death, officers from the Homicide Squad attended Hakea at 10.45 pm on 5 March 2024 and conducted an investigation. Sam's mother later told officers from the Coronial Investigation Squad that she did not believe that Sam would ever take his life, and instead:

> (Sam) was murdered due to an outstanding drug and money debt owed to (her ex-partner). (Sam's mother) advised that (Sam) had committed a robbery on (the ex-partner) stealing about $25,000 and two ounces of meth from his address. From here, (the ex-partner) put out a hit on (Sam) and paid a substantial amount of money to guards within Hakea to facilitate the deceased being bashed by another prisoner before having his cell set alight.[223,224,225]

[221] Exhibit 1, Vol 1, Tab 40, DFES Incident Report No. 659966 (05.03.24), p6
[222] Exhibit 1, Vol 1, Tab 7.1, Homicide Squad Report - Det. Sen. Const. A McLean (07.03.24)
[223] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p32
[224] See also: Exhibit 1, Vol 1, Tab 20, File Note - Det. Const. J Mooney (27.06.24)
[225] See also: Exhibit 1, Vol 2, Tab 43, WAPOL Running Sheet 050324 1854 9805

146. The Homicide Squad investigation noted that at the relevant time Sam had been locked in his cell alone, no injuries to Sam were reported prior to the final muster, and no significant "*blood events*" were observed "*on the exterior of cell G12*". Further, the injury to Sam's abdomen appeared to be "*a laceration as opposed to a penetrating injury*", and there were no cuts to Sam's clothing which were consistent with the injury observed.[226]

147. At the conclusion of their investigation, Homicide Squad officers concluded that Sam's injuries were either self-inflicted, or had been caused accidentally, noting:

> Given the presence of broken porcelain within the cell, it is plausible the injury occurred during the extraction of the deceased from his cell. (and) **The absence of any further information or intelligence to give rise to a suspicion of criminality**.[227,228,229] [Emphasis added]

Arson Squad investigation [230]

148. Following Sam's death, officers from the Arson Squad attended Hakea and conducted an investigation to determine the origin and cause of the fire in Sam's cell. The officers noted that G12 shared common walls with cells on either side, and had one window reinforced with metal bars and a reinforced door.

149. The Arson Squad officers also noted that:

> The cell interior contained a metal single bed frame positioned against the rear wall and three timber shelves attached to the right wall. To the left of the door a metal basin and ceramic toilet bowl were located. A light was attached to the ceiling near the window.
>
> A light switch and intercom were located on the rear wall. A single general power outlet (GPO) was located adjacent to a television aerial point, under the second shelf, on the right wall.[231]

[226] Exhibit 1, Vol 1, Tab 7.1, Homicide Squad Report - Det. Sen. Const. A McLean (07.03.24), p4
[227] Exhibit 1, Vol 1, Tab 7.1, Homicide Squad Report - Det. Sen. Const. A McLean (07.03.24), p5
[228] See also: Exhibit 1, Vol 1, Tab 7.2, Memorandum - Det. Sen. Const. K McLeod (28.07.24), p3
[229] See also: Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), pp1-2
[230] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24) and ts 26.03.25 (Pearsall), pp282-292
[231] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24), p2

150. In the Arson Squad investigation report he authored, Detective Senior Constable Pearsall (Officer Pearsall) noted the following about the fire in Sam's cell: "*The interior of the cell displayed heavy soot/smoke staining on the ceiling and on the walls down to floor level. This indicated a low intensity smouldering fire had occurred*".[232]

151. At the inquest, Officer Pearsall gave the following explanation for what is meant by the term "*low intensity smouldering fire*":

> When you have the presence of heavy smoke staining - soot staining - in an environment like that, it's indicative of limited flame activity, because once you get a hot fire and you have considerable flame activity, it will actually…burn away the…soot and the smoke, and more of it is consumed. When you have a low intensity fire, it produces a lot of smoke and soot which will - as you can see in this environment…what we call the smoke horizon will go all the way down to the floor. In a hot fire, most of that's burned away.[233]

152. In his report, Officer Pearsall expressed the following conclusion about the origin and cause of the fire in Sam's cell:

> The fire's area of origin was located near the door, inside Cell G12. The fire ignited through some form of human intervention, the most likely being through the introduction of a mobile heat source to combustible material. In this instance, it is likely the cigarette lighter was used to ignite the mattress or bedding material.[234,235]

153. On the basis of the eye witness accounts of Officer McGrath and Officers Szmerenda, and the expert evidence of Officer Pearsall, I am satisfied that the fire in G12 was started when, in circumstances where he was highly agitated, Sam used a cigarette lighter to set fire to the cover of the mattress in his cell.[236,237,238,239,240]

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[232] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24), p2
[233] ts 26.03.25 (Pearsall), p284
[234] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24), p7
[235] See also: Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p1
[236] Exhibit 1, Vol 2, Tab 57.8, Statement - Officer E McGrath (30.12.24) and ts 24.03.25 (McGrath), pp57-88
[237] Exhibit 1, Vol 1, Tab 23.1, Incident Description Report - Officer E McGrath (05.03.24)
[238] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24) and ts 25.03.25 (Szeremenda), pp119-150
[239] Exhibit 1, Vol 1, Tab 25.2, Incident Description Report - Officer T Szeremenda (05.03.24)
[240] Exhibit 1, Vol 1, Tab 8, Arson Squad Report - Det. Const. A Pearsall (03.05.24)

CAUSE AND MANNER OF DEATH[241,242,243]

154. Two forensic pathologists (Dr Junckerstorff and Dr Grewal) conducted a post mortem examination of Sam's body at the State Mortuary on 8 March 2024. During their examination, Dr Junckerstorff and Dr Grewal noted that Sam had sustained thermal injuries, and a penetrating sharp force injury to his abdomen.

155. There were "*abundant gastric contents*" in Sam's airways, and his brain was swollen. Microscopic examination of Sam's heart tissues also noted mild coronary artery disease (atherosclerosis).

156. Although Sam's lungs showed no signs of bronchopneumonia, there was "*foreign material (probable food and probable soot) in the major airways*" which was compatible with terminal aspiration. Further, although Sam's liver showed "*focal chronic inflammation*", there was no cirrhosis.

157. With respect to the injury to Sam's abdomen, Dr Junckerstorff and Dr Grewal noted that: "*No major internal vascular injury was identified in relation to the penetrating sharp force injury to the abdomen*".[244] When Sam was admitted to Hakea Prison on 2 March 2024, he denied suicidal ideation, and at the inquest, Dr Gunson noted that it was unusual for patients to make self-harm injuries to their abdomen.

158. As noted, because of cramped nature of G12, when Sam was removed from his cell he was dragged out by his arms face down. There was obviously a need to get Sam out of the cell as quickly as possible, and visibility in the cell was virtually zero. Further by that stage, Sam had damaged the porcelain toilet pan in his cell, and there were numerous shards of porcelain all over his cell floor.

159. Given all of these circumstances, it is my view that the most likely explanation for the "*penetrating sharp force injury*" to Sam's abdomen is that it occurred accidentally as he was being removed from G12.

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241 Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24)
242 Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (08.03.24)
243 Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp5, 14-15 & 38-39
244 Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24), p2

160. Toxicological analysis found methylamphetamine (and its metabolite amphetamine) in Sam's system, along with diazepam, temazepam, metoclopramide, and paracetamol. Alcohol, cannabinoids, and other common drugs were not detected.[245]

161. The toxicological analysis also found that that Sam's carboxyhaemoglobin levels were raised. Carboxyhaemoglobin is a complex formed when carbon monoxide (one of the gases produced by a fire) binds to haemoglobin in red blood cells.[246]

162. In their post mortem report, Dr Junckerstorff and Dr Grewal also noted that: "*Most fires produce large amounts of carbon dioxide as well as toxic fumes that can contribute to death*".[247]

163. At the conclusion of their post mortem examination, Dr Junckerstorff and Dr Grewal expressed the opinion that the cause of Sam's death was "*effects of fire*".[248]

164. I accept and respectfully adopt Dr Junckerstorff and Dr Grewal's opinion and find Sam died from the effects of fire.

165. Following an investigation, officers from the Coronial Investigation Squad concluded there was no evidence of criminality or of the involvement of another person or persons in relation to Sam's death.[249]

166. There is also no evidence before me that at the time Sam set fire to his mattress he was experiencing any self-harm or suicidal ideation.[250]

167. Therefore, on the basis of the available evidence I find that Sam's death occurred by way of accident.

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[245] Exhibit 1, Vol 1, Tab 6, Toxicology Report (22.03.24)
[246] Palmeri R & Gupta G, *Carboxyhemoglobin Toxicity* (17.04.23), see: www.ncbi.nlm.nih.gov/books/NBK557888/
[247] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24), p2
[248] Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (20.06.24), p1
[249] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p39
[250] ts 27.03.25 (Gunson), pp399-401 & 404-405

ISSUES ARISING FROM THE EVIDENCE

Staff shortages at Hakea

168. Ongoing staff shortages at Hakea prison create numerous issues in terms of managing the prison population safely. In his report, Officer Tuck noted there are currently 70 to 80 officers on leave in relation to workers compensation claims, and at the inquest he said that the daily staff roster at Hakea is on average 30 - 50 officers short.[251,252]

169. Most relevantly, in Sam's case, staff shortages on Unit 7 meant that canteen spends could not be distributed on the evening of 5 March 2024. This appears to have triggered Sam's agitation and distress before he damaged his cell and set his mattress cover alight.

170. Another serious consequence of lower staff numbers at Hakea is that the prison must operate on "*adaptive regimes*", which is a polite way of saying that prisoners are locked in their cells for extended periods. The report issued after the Inspector of Custodial Services' inspection of Hakea in May 2024 (OICS Hakea Inspection Report) includes these observations about adaptive regimes:

> During periods of short staffing, the prison implemented an adaptive routine, which involved closing non-essential industries and services and redeploying staff to run a restricted daily regime. Low staffing levels were a critical issue, with on average 25% fewer staff on shift than scheduled each day. This shortage, coupled with frequent lockdowns through adaptive routines, severely limited prisoners' time out of cells. Prisoners often had only up to an hour for essential activities like showering, cleaning, making inquiries, and telephone calls, often forcing them to choose between these activities.[253]

171. The OICS Hakea Inspection Report also referred to a broader cultural issue caused by the need to rely on adaptive regimes, noting that:

> New officers were not provided mentoring or the opportunity to participate in a structured daily routine. We were concerned many staff now seen as experienced, had worked at the prison for several years,

[251] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p9 and ts 27.03.25 (Tuck), pp383-384
[252] See also: ts 24.03.25 (Longden), pp91-97; ts 28.03.25 (Palmer), pp443-446 and ts 28.03.25 (Ryan), pp459-463
[253] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), p8

> but had rarely, if ever, worked a standard structured day. The risk-mitigating focus of the adaptive routines, resulted in staff adopting barrier management at the expense of rapport building, which was further hindered by interaction through wing grilles or hatches in cell doors.[254]

172. Another very significant consequence of the ongoing staff shortages at Hakea relates to staff training. In his report Officer Tuck noted that a half day lock down occurs at Hakea on Wednesday mornings so that mandatory training can be delivered. However, Officer Tuck noted that "*[W]ith reduced staffing there are lower numbers of staff available for training which creates a lower than desirable achievement of our training objectives*". Officer Tuck said he had attempted to address this issue by offering overtime on weekends, but that "*the take up has not been good*".[255]

173. At the inquest, Officer August outlined his ambitious plan to recruit an additional 1,200 prison officers over the next three years.[256] This is a commendable goal, but as these officers will be inexperienced, retaining existing staff is also clearly important. I have therefore recommended that the Department redouble its efforts to recruit, and importantly retain, suitably skilled custodial officers.

Lack of fire suppression system[257,258,259]

174. Hakea is an ageing facility, and it currently does not have an automatic fire suppression system, meaning that cells at Hakea are not protected in the event of fire. At the inquest, Officer Savage was asked if he thought that Hakea should be fitted with a fire suppression system and his response (with which I agree) was:

> Yes. Absolutely. Absolutely, there should be. I can't believe there's not one…I don't think that a facility that holds so many men and with the potential…risk footprint that it doesn't have one.[260,261]

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[254] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), p8
[255] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), pp9-10
[256] ts 27.03.25 (August), pp355-356
[257] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp58-59
[258] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8 and ts 27.03.25 (Tuck), pp377-378
[259] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp24-25
[260] ts 24.03.25 (Savage), p50 and see also ts 24.03.25 (Savage), pp47-49
[261] See also: ts 25.03.25 (Szeremenda), p141

175. Officer Tuck said that at the time the CW Campbell Remand Centre and the Canning Vale Prison (which were later amalgamated and became Hakea) were constructed in the early 1980's, the relevant building codes "*did not mandate the installation of fire sprinklers*".[262]

176. Officer Tuck also said that current building codes only require fire sprinklers if a building is four stories or exceeds 25 metres in height, and that after discussing the matter with the Department's infrastructure and maintenance area: "*[T]he Department of Justice maintain the Hakea fire system in compliance with AU/NZ Safety Standards*.[263]

177. With all due respect, the evidence at this inquest makes it very clear that at the relevant time, Hakea's fire system (if that term can be said to include fire hoses and fire cupboards) was not being properly maintained. Further, the fact that current building codes do not require sprinklers for multi-storey buildings is irrelevant. A key factor here is that prisoners are locked in their cells for long periods, and if a fire starts in a cell at Hakea, prisoners must rely on a first response from staff. As the response to the fire in Sam's cell so clearly demonstrated, **Hakea's preparedness to deal with cell fires was (and is) poor**.[264]

178. I accept that the installation of a fire suppression system at Hakea presents significant challenges, not the least of which is financial. As Officer Tuck points out in his report:

> The retrofitting of a fire sprinkler system into an existing building not originally designed for such a solution presents several significant challenges. These include navigating the building's structural and services limitations, which in this instance would make this option likely unfeasible due to cost.[265]

179. However, at the inquest, Officer August said he did not believe a costings exercise had been conducted. This means it is impossible to know what the project costs would be for the installation of an automatic fire suppression system on the basis of the currently available evidence.[266]

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[262] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8
[263] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8 and ts 27.03.25 (Tuck), pp393-394
[264] ts 24.03.25 (Savage), p50
[265] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8
[266] ts 27.03.25 (August), pp347-348 and see also: ts 28.03.25 (Ryan), p459

180. In my view, the situation boils down to this. The State's ongoing decision to house vulnerable prisoners at an ageing facility like Hakea, does not obviate the need to ensure that those prisoners (and the staff looking after those prisoners) are housed in safe and appropriate circumstances. Section 7(1) of the *Prisons Act 1981* (WA) relevantly provides:

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

181. The statutory obligations of the Director General are clear, and in my view must extend to providing an environment where prisoners and staff are not exposed to the grave risk of fire, as is currently the case at Hakea.

182. I have therefore recommended that to enhance the safety of prisoners and staff at Hakea, and to prevent any future loss of life, the Department should install a fire suppression system at Hakea so that all cells and common areas are protected in the event of fire. I have also recommended that the Department consider whether this initiative can be funded by way of an internal funding allocation, or whether it is necessary to seek additional funding from the Treasury.

Primary response to cell fires at Hakea[267,268,269,270,271]

183. In March 2022, a fire at Casuarina Prison was responded to by a response team wearing riot control personal protective equipment and "*standard issue respirators and filters*". Three response team members "*suffered smoke inhalation as the filters on their respirators only protected them from chemical agents and riot munitions*."[272]

184. As a result, of this incident, the Department embarked on the Respiratory Protection Program project (the RPP Project) "*to provide safe methods of work to protect workers from workplace respiratory hazards during prison emergencies*".[273]

[267] Exhibit 1, Vol 3, Tab 68, Attachment 6 - EMF-DIR-009 Cell Fire Response (01.07.23)
[268] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), p27
[269] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), paras 96-100
[270] See also: ts 27.03.25 (Tuck), pp378
[271] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp30-34
[272] Exhibit 1, Vol 3, Tab 68, Report - Supt. D Jones (21.03.25), p2
[273] Exhibit 1, Vol 3, Tab 68, Report - Supt. D Jones (21.03.25), p3

185. The RPP Project identified the need for a respirator that was easy to don, clean and maintain, and which would provide protection for 15 - 20 minutes, which was the "*gap*" before the BA teams arrived, so as to:

> Protect wearers providing first response while entering a prison wing or day-room type environment (after a dynamic risk assessment from outside the wing). This involves attending the door of the cell of fire origin, assessing the situation via the cell door window, and if safe to do so, opening a small hatch and extinguishing the fire using an extinguisher or small diameter hose reel. Additionally, if safe (e.g. risks from potentially combative prisoner are assessed as manageable and if the fire is extinguished or deemed to not pose an immediate threat through heat/ignitability), to enable responders to unlock a cell and extract the occupant(s).[274]

186. The Department's expectations of prison officers who are the primary responders to a cell fire are set out in a checklist to EMF-DIR-009 Cell Fire Response (Cell Fire Policy). In relation to the initial response to a cell fire, the policy provides that:

> Upon notification of a fire by way of alarm called by control or by a prisoner or other person, officers should immediately attend the identified area…Following a confirmed outbreak of fire, trained officers shall act quickly to protect the safety of prisoners and others, and to prevent escalation.[275]

187. The Cell Fire Policy requires that once a Code Red Fire has been called, prison officers who are first responders are to collect, don and check the approved type of respirator (i.e.: R-Kit respirators), before fetching a portable fire extinguisher and/or fire hose and checking the cell's power supply to is off. In summary, first responders are then required to carry out the following tasks:

> Go to the cell, look through the observation panel and assess the fire's location, stage, size; the conditions in the cell (smoke, heat, igniting gases); and the location of occupant(s) and communicate with the occupant(s) to assess their compliance/responsiveness;

[274] Exhibit 1, Vol 3, Tab 68, Attachment 1 - Respiratory Protection Program Project Closeout Report (17.01.24), p7
[275] Exhibit 1, Vol 3, Tab 68, Attachment 6 - EMF-DIR-009 Cell Fire Response (01.07.23), paras 7.1.1.1 - 7.2.1, p17

> Use a fire extinguisher to extinguish the fire where there is minimal smoke and fire. Where there is significant smoke and fire, immediately instruct the occupant(s) to shelter (low, cloth over mouth, and shower/water on), before inundating the cell via the hatch using a fire hose;
>
> Confirm that the fire is extinguished and where necessary repeat the inundate/observe cycle;
>
> Confirm compliance/responsiveness of occupant(s) and that cell conditions are safe before opening the cell door and removing the occupant(s) from cell; and
>
> Close the cell door to contain remaining smoke and the incident scene.[276]

188. Although the Cell Fire Policy sets out a very clear process for prison officers to follow, there are several issues with the policy. The first and most obvious is that at the time of the fire in Sam's cell, the R-Kits tagged out as unsafe, and therefore unavailable. The Lessons Learned report following the Department's "*lessons learned*" process notes:

> Pre-workshop enquiries identified that prior to the critical incident, all R-Kits (i.e. respirators) had been tagged out and were not available for use. This was done by a Hakea employee on 23 January 2024 on the basis that the masks were an '*unsafe system of work*' and that by deploying the RPE Kits[277] to operational locations and training workers on site on their use is likely to mislead workers to use them and is putting the workers at risk of the hazards associated with cell and structural fires. This hazard report had a cascading impact, with all RPE at Hakea, Eastern Goldfields Regional Prison, Broome Regional Prison and Pardelup Prisons Farms being tagged out following this. The masks were not subsequently tagged back in until August 2024 - five months following the initial tagging out.[278][279]

189. The second issue was that at the inquest, a number of prison officers expressed a reluctance to use R-Kit respirators, even if they had not been tagged out at the relevant time. Several key issues were highlighted at the inquest.

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[276] Exhibit 1, Vol 3, Tab 68, Attachment 6 - EMF-DIR-009 Cell Fire Response, (1.07.23), Appendix 2 to Annex F, p44
[277] I have referred to "*RPE kits*" as "*R-Kits*" in this finding as this appears to be the more commonly used term
[278] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p36
[279] See also: ts 27.03.25 (Tuck), pp380-382

190. The first issue related to a lack of familiarity with the R-Kits generally, and related concerns about the lack of training on fire hoses, and lack of refresher training on fire extinguishers and fire blankets.[280,281,282,283]

191. At the inquest, Officer Grocott (an experienced BA trained officer) made this comment about the purpose the R-Kit respirators:

> My understanding of them would be for first responders to be able to assess the situation, but again, when it comes to a fire, in my opinion, you would bump it up to the BA level anyway, because if you get exposed to fire that aren't protecting your body from burns or again if you've got shrapnel from somebody that's not compliant, again, the level 2 PPE will protect you from that point of view as well.[284]

192. At the inquest, Officer McDuffus (an experienced BA trained officer) expressed his reluctance to use R-Kit respirators in these terms:

> I also believe - this is my own personal view - those - the RP masks, they shouldn't be used…Yes, they're great, they're great in an environment to put the smokes on, but Hakea is a very old prison. The paint in that…prison is…is toxic, basically, and you're going to walk down the wing…full of smoke with just your uniform on, and all that stuff's going to go on your skin. Let alone you're going to go home with your uniform and give it to your kids - my kids or anyone's kids…you could pay me $1 million and I still wouldn't use that RP mask, because…(1) I don't want to get toxic things, and (2) I don't want to go home and take it to my family.[285]

193. Notwithstanding these concerns, the Lessons Learned Report noted that:

> In August 2024, a determination was made that the tagging of safety-critical devices such as the respirators was inappropriate, and a direction was given that the tags be removed to enable respirators to be freely used by staff. This decision was made following Mr Lynch's death.[286]

[280] ts 24.03.25 (McGrath), pp83-84; ts 24.03.25 (Longden), pp114-115; and ts 25.03.25 (Szmerenda), pp137
[281] ts 25.03.25 (Ballinger), pp158-159; ts 25.03.25 (Batten), pp172-174 and ts 25.03.25 (Cavanaugh), pp262-263
[282] See also: ts 26.03.25 (May), pp243-246
[283] See also: ts 27.03.25 (August), pp351-355
[284] ts 25.03.25 (Grocott), p203
[285] ts 25.03.25 (McDuffus), pp223-224
[286] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p36

194. The Lessons Learned Report also made this comment about the significance of the R-Kits having been tagged out in the first place:

> During the workshop, attendees noted that the tagging out of the equipment demonstrated the culture around the use of RPE and responding to cell fires at Hakea. It was noted that despite two officers at the scene having been recently trained in respirator and fire response (at the Academy), all officers were directed to evacuate the area and wait for the BA Team. **Had the respirators been available, first responders would likely have been able to effect a rapid response - approaching Mr Lynch's cell door, to place the hose through the hatch**.[287] [Emphasis added]

195. Whilst the comments about the culture at Hakea may well be accurate, the highlighted words in the passage above demonstrate a complete lack of understanding of the situation in Unit 7 on 5 March 2024. As I will explain later in this finding, none of the first responders to Sam's cell that day were invited to the Department's lessons learned process.

196. Had any of the first responders been invited to that lessons learned process, they could have explained that even if officers had donned R-Kit respirators (assuming they had not been tagged out at the relevant time), they would **not** "*have been able to affect a rapid response*" to the fire in Sam's cell because a fire extinguisher would have been ineffective, and the nearby fire hoses were either inaccessible, or inoperative.

197. Despite some evidence to the contrary from the team leader of specialist training at the Academy (Ms Rowe),[288] several prison officers said they had received no training on how to use fire hoses during their initial employment course at the Academy. Further, although officers agreed they had received basic training on how to use fire extinguishers during their initial employment course, no refresher training was provided to them thereafter. Several officers also mentioned there are limited fire drills at Hakea.[289,290,291,292,293,294]

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[287] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p36
[288] ts 27.03.25 (Rowe), pp307-308
[289] Exhibit 1, Vol 3, Tab 61.3, Statement - Officer M Moore (20.02.25), para 27 and ts 24.03.25 (Moore), p32
[290] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer R Savage (06.01.25), paras 35 & 44
[291] See also: Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), para 96
[292] ts 25.03.25 (Szeremenda), pp136-137
[293] ts 24.03.25 (Longden), p107; ts 25.03.25 (Ballinger), pp158-159 and ts 25.03.25 (Ballinger), pp173-175
[294] ts 26.03.25 (May), p246 and ts 26.03.25 (Cavanaugh), pp271-272

198. Another key concern relates to the fact that although R-Kit respirators are provided, prison officers do not have ready access to any form of personal protective gear (PPE) on their Units. I note that the Cell Fire Policy contains a depiction of the "*Indicative response organisation*" to a minor cell fire which shows prison officers in standard short sleeved uniforms.[295] At the inquest, several officers commented that their prison uniforms are flammable and they have safety concerns about responding to a cell fire without some form of PPE.[296,297]

199. Several officers also expressed safety concerns about "*backdraft*", by which is meant introducing more oxygen into a cell fire by opening a cell's observation hatch. The other concern expressed was that when opening the prisoner's cell door observation hatch, prisoner officers may be struck by items being from inside the cell thrown by a combative prisoner.[298,299]

200. As I have outlined, the current plan to respond to cell fires at Hakea is manifestly inadequate. Although the primary response by prison officers using R-Kits and fire hoses and/or fire extinguishers may be sound, it appears many prison officers are unconvinced that using R-Kit respirators is safe. This is a problem because BA trained officers take anywhere from 10 to 20 minutes to respond to a cell fire.

201. The question of whether R-Kits were or were not legitimately tagged out is beyond the scope of my investigation of Sam's death. However, this issue may be an example of the friction that was identified in the OICS Hakea Inspection Report, where it was noted that:

> Over the past decade, five different superintendents have faced many challenges, with varied success in maintaining a constructive working relationship with the Hakea prison officer group and their union. This suggests the problem lies beyond individual superintendents or individual union representatives. The union has consistently led Hakea staff in criticising prison management for attempting to operate the prison with what they say is insufficient staffing levels.

[295] Exhibit 1, Vol 3, Tab 68, Attachment 6 - EMF-DIR-009 Cell Fire Response (01.07.23), Figure 1, p17
[296] ts 25.03.25 (McDuffus), pp223-224
[297] ts 25.03.25 (Grocott), p203
[298] See for example: ts 24.03.25 (Longden), pp103 & 107-109 and ts 25.03.25 (Ballinger), pp162-163
[299] See also Ms Rowe's discussion on safe door opening procedures: ts 27.03.25 (Rowe), pp315-317

> The union and prison staff are within their rights to argue that the Department has failed to implement effective recruitment and retention strategies to adequately staff Hakea. On the other hand, Hakea management and Department leadership may have a different view, seeing the arguments as unreasonable or the solutions as unrealistic. Such is the nature of industrial disputes.
>
> But it is fair to say that the absence of effective strategic workforce planning has contributed to the current staffing crisis. Likewise, budget restrictions over time and infrastructure limitations have played significant parts in the dispute.
>
> By the time of our inspection, many of these problems had become entrenched in dispute between the custodial workforce and management. We believe, however, that there has been a lack of appreciation of the impacts these disputes have had over many years in undermining prison management and their efforts to effectively run the prison.
>
> **Attempts to introduce improvements are often resisted, constant workplace health and safety issues are raised and reported, and the daily regime appears to prioritise minimising risk to staff over all other obligations**. [Emphasis added] We resist taking sides and express no view one way or another on which party to these disputes is right, other than to say it remains an ongoing issue that needs resolution.

202. The question of how to encourage prison officers to enthusiastically embrace the first response to cell fires strategy may lie in further frank and open communication, provision of basic PPE (in terms of trousers and jackets to wear over prison uniforms), and additional training, including realistic scenarios.[300,301] As Officer Tuck noted at the inquest:

> I believe that we could have done that maybe a little bit better with a bit more - bit better communication. From what I've been hearing here, a lot of the staff have concerns in relation to contaminants in the air. Perhaps a lightweight covering, a fireproof or fire retardant covering, to go along with the R-Kit may be a suggestion that we could introduce to actually progress that through and have some solution for both sides.[302]

[300] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp30-34
[301] ts 27.03.25 (Rowe), pp314-315
[302] ts 27.03.25 (Tuck), p378

203. In my view, the Department must address this crucial issue as a matter of **absolute priority**, because at Hakea, cells are not protected by an automatic fire suppression system, and BA officers can take up to 20 minutes (or even longer) to arrive once a Code Red Fire emergency call has been made.

204. I have also recommended that the Department conduct refresher training for prison officers on the first response to fire including: safe work procedures for the use of R-Kits, fire extinguishers, fire blankets, and fire hoses using realistic scenarios and environments.

Maintenance of fire equipment[303,304]

205. At the relevant time, the standard of maintenance of fire equipment at Hakea was completely inadequate. As I have explained, the door of G Wing fire cupboard was jammed shut at exactly the wrong time, and has now been encased in metal to ensure this cannot happen again.[305]

206. Further, the nozzle on the fire hose in the H wing fire cupboard was also inoperative because of a missing lever, but since Sam's death, all fire hose nozzles at Hakea have now been replaced with "*twist type*" nozzles, meaning that this fault will not occur again.[306]

207. In his report, Officer Tuck said he had recently implemented a system of quarterly checks of fire equipment at Hakea by external contractors, and that this initiative will be reviewed in June 2026.[307] I commend Officer Tuck's proactivity in this regard, and I have recommended that the Department continue quarterly checks by external contractors of fire extinguishers and fire hose reels at Hakea.

208. In my view, the importance of this increased level of checks of fire equipment at Hakea cannot be emphasised enough. This is particularly the case where prisoners continue to have access to lighters when cells at Hakea are not protected by an automatic fire suppression system.

[303] Exhibit 1, Vol 1, Tab 7, Coronial Investigation Squad Report - Det. Const. J Mooney (13.08.24), pp10-11
[304] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp27-29
[305] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p4
[306] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p4
[307] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p4

Access by prisoners to tobacco products and lighters[308,309,310,311,312]

209. Prisoners at Hakea are permitted to buy tobacco products and cigarette lighters at the prison canteen. Although smoking is not permitted in cells, prisoners are permitted to retain their lighters during the overnight lockdown. Previous efforts to remove cigarette lighters from prisoners overnight led to unsafe practices including attempts to light cigarettes using the use of "*slow matches*", and the insertion of metal objects into electrical power points to create a spark.[313,314,315]

210. The issue of a smoking ban has been on the Department's agenda since at least 2005, when a smoking reduction trial was implimented at Greenough Regional Prison. Since then, much has been written about the health, security, and safety benefits of a smoke free prison system, including a report on smoking in prisons published in September 2021 (OICS Report) by the Inspector of Custodial Services, Mr Ryan.[316]

211. The OICS Report noted that prisoners in Western Australia were not permitted to smoke inside buildings or in their cells, however:

> [T]hese restrictions appear ineffective in Western Australia, as we were told by staff and prisoners that they were regularly exposed to second-hand smoke, particularly for non-smokers overnight in cells and for staff at morning unlock.[317]

212. The obvious health risks of smoking (including the risks to non-smokers of passive smoke) are well understood. However, the OICS Report also pointed out that most prisoners cannot afford to buy tobacco products using gratuities earned from prison employment, which places financial pressure on them and their families. Prison staff have also reported that the supply and trade of tobacco "*leads to aggression and bullying*", although the OICS Report noted: "*the true extent of smoking-related bullying and violence remains hard to gauge*".[318]

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[308] Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p2
[309] Exhibit 1, Vol 2, Tab 48, COPP 6.7 - Smoke Free Prisons (18.03.24), p2 and ts 28.03.25 (Ryan), pp454-459
[310] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), pp2-4 and ts 27.03.25 (August), pp331-337
[311] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p38
[312] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), pp7-8 and ts 27.03.25 (Tuck), pp374-376 & 393-394
[313] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pp18-19
[314] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p7
[315] See also: ts 24.03.25 (Savage), pp50-55
[316] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21)
[317] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pii
[318] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pp16-18

213. As was so tragically demonstrated in Sam's case, smoking and the availability of cigarette lighters in prisons creates opportunities for fires, and means prisoners and staff at Hakea face a grave and ongoing risk. That is especially the case at Hakea, where cells are not protected by an automatic fire suppression system, and where, at the relevant time, mattresses did not have flame-retardant covers.

214. In the period 2019 to 2022, there were 143 custodial fires in Western Australia, 51 of which (i.e.: 36%) occurred at Hakea. The number of fires at Hakea is astonishing, and exceeds total number of fires in the same period at Casuarina, Acacia, and Melaleuca Prisons combined.[319,320]

215. The OICS Reports notes that restricting access to lighters alone has not worked in Western Australian prisons, because as noted, prisoners used "*unorthodox*" and highly dangerous methods to light cigarettes in their cells.

216. Nevertheless, as the OICS Report notes a significant reduction in cell fires has been demonstrated when a smoking ban is implimented and that:

> Jurisdictions that have implemented smoke-free prisons where lighters are banned have reported reduced rates of fire related incidents. At a youth prison in the United Kingdom, fire incidents decreased from 27 in the first 10 months of the previous year to a single incident following the introduction of a smoking ban…In New Zealand, there were 18 arson incidents in the month before the policy was enacted, four in the month after and only one the following month.[321]

217. At the time it was published (i.e. 1 September 2021), the OICS Report noted that Western Australia and the Australian Capital Territory were the only jurisdictions which had not implemented a smoking ban in prisons. However, since then smoking has now been banned in all prisons in Australia, except for men's prisons and regional shared men's/women's prisons in Western Australia.[322]

[319] Exhibit 1, Vol 3, Tab 68, Respiratory Protection Program Project Closeout Report (17.01.24), p5
[320] ts 28.03.25 (Ryan), pp463-464
[321] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), p19
[322] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pii

218. The OICS Report also noted that although the Department has implemented various policies and initiatives aimed at limiting or reducing smoking "*over the years*":

> It is fair to say that these initiatives have had little overall impact on the level of smoking by prisoners in Western Australian prisons. It remains that the risks of smoking and exposure to second-hand smoke are well known but largely unmitigated.[323]

219. In his report, Officer August outlined the work the Department has been doing since 2022 to implement a smoking ban in Western Australian prisons, and noted that in February 2024, Commissioner's Operating Policy and Procedure 6.7 Smoke Free Prisons, (COPP 6.7) was updated and approved, and that:

> (COPP 6.7) provided custodial sites with a procedure, with each superintendent to develop a smoking cessation support strategy for their prison. This included the sites reducing supply and access to tobacco products available to prisoners during the smoking reduction phase.[324]

220. I acknowledge there are difficult issues that must be grappled with when implementing a ban on smoking in prisons, including the illicit trafficking of cigarettes and tobacco products. There is also the fact that rates of smoking amongst prisoners are much higher than the general community, and many prisoners have mental health issues and are "*reliant on tobacco just to get through their days*".[325,326,327]

221. However, I agree with the following observations in the OIC Report:

> We believe that there is now a compelling case for a smoking ban in Western Australian prisons. We recognise that it is not a simple matter of having a policy to ban smoking. There must be high level support and commitment. There needs to be a comprehensive plan with sufficient lead time and enough supports and resources.[328]

[323] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pii
[324] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), p3
[325] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), pv
[326] ts 24.03.25 (Savage), p51 and ts 27.03.25 (August), pp331-333
[327] See also: ts 28.03.25 (Ryan), pp468-469
[328] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), piii

222. However, the fact that every other Australian jurisdiction apart from Western Australia has successfully banned smoking in all prisons "*with good results and without major incidents or disturbances*, demonstrates that implementing a smoking ban is not impossible.[329]

223. To the Department's credit, by the end of 2024 a smoking ban was in place in all women's prisons, and at the Academy. However, although the Department had planned to make metropolitan men's prisons (including Hakea) smoke free by July 2025, this plan has been delayed. At the inquest, the Deputy Commissioner Operational Support (Officer August) explained that the unprecedented prison muster at Hakea, and ongoing staff shortages meant a smoking ban was impossible for now, noting:

> There are a number of factors that we've just had to pause, very conscious of the incidents that occurred in the Eastern states, certainly the one in Victoria in 2015 where extensive damage to infrastructure occurred and, you know…Corrective Services can't afford to have - given our current population issues, we can't afford to have infrastructure damage.[330]

224. In his report, Officer August also noted:

> A decision was made to pause the Smoke-Free Policy as the Department continued to experience unprecedented prisoner population pressures, which also saw a rapid rise in critical incidents further supporting a longer reduction phase. As a result of this, the statewide implementation based on current pressures is anticipated to be delayed by 12 months to May 2026.[331]

225. Officer Tuck noted that Hakea is: "*currently drafting a Standing Order dedicated to a local Smoking Policy*", but highlighted the difficulties with implementing a smoking ban at Hakea noting:

> Smoking reduction progressing to a smoking ban has inherent risks and more so in a remand prison environment. Hakea Prison is the main receival prison for the state and manages on average, 50% of the state's male "At Risk" category prisoners, which adds further complexity into the introduction of a smoking ban…

[329] Exhibit 1, Vol 2, Tab 54.1, OICS Report - Smoking in Western Australian prisons (01.09.21), piii
[330] ts 27.03.25 (August), p332
[331] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), p4

> To progress locally, without having a clear understanding of how the Department intends to provide supports and controls, would add additional risks to an already high risk environment. I would suggest that when the strategy is rolled out it will commence in the lower security rated prisons with lessons learned progressed to the larger more complex prisons.[332]

226. In his report, Officer August referred to the fact that as the Department prepares to ban smoking in men's prisons, work is being done to manage access to lighters by prisoners who have been charged with arson offences and/or have been involved in "*fire incidents*" whilst in prison. Officer August noted that:

> To this end, I have requested that a report is prepared to ensure sites are aware of prisoners within their prison that meet these criteria to enable informed decisions to be made on whether the cohort identified should be permitted to purchase lighters and where they are permitted to purchase ignition sources, to assist sites in implementing controls to manage the risk.[333,334]

227. I fully acknowledge the concerns eloquently expressed by both Officer Tuck and Officer August. However, the fact remains that in addition to health and security risks, prisoners and staff at Hakea are exposed to **grave** and ongoing safety risks for as long as smoking is permitted. This is particularly the case at Hakea given it does not have an automatic fire suppression system in its cells, and given its level of fire preparedness.

228. In light of my concerns for the safety of prisoners and staff at Hakea, I have recommended that the Department expedite a ban on smoking at Hakea, and take all reasonable steps to ensure that prisoners do not have access to tobacco products (including cigarettes), matches and/or lighters.

229. I have also recommended that whilst the smoking ban is being implemented, the Department should ensure that prisoners have access to nicotine substitutes such as patches and lozenges, as well as medication, support services, counselling, and diversionary activities.

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[332] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8
[333] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), p2 and ts 27.03.25 (August), pp335-337 & 346-347
[334] See also: ts 28.03.25 (Palmer), pp442-223 and ts 28.03.25 (Ryan), pp468-469

230. In addition, I have recommended that in the period before a smoking ban is implimented at Hakea, the Department develop and institute an interim management policy to restrict access to lighters and matches by prisoners with a heightened risk profile, including but not limited to prisoners convicted of arson and/or prisoners who have lit fires in prison.[335,336]

Fire drills[337]

231. In his report, Officer Tuck refers to COPP 13.4 *Emergency Management Exercises*, which requires each prison to conduct fire evacuation drills:

> [A]t least every six months to ensure that staff and prisoners are aware of procedures in the event of a fire as well as their respective evacuation assembly areas.[338,339]

232. Officer Tuck said that in 2024, Hakea conducted four fire drills, and that five fire drills will be conducted in 2025.[340] However, the effectiveness and reach of these fire drills appears to be inadequate, at least on the basis of the evidence before me.

233. For example, only 14 prison officers participated in a fire drill conducted in the medical centre on 19 May 2023, and only 10 officers participated in the fire drill conducted on Unit 9 at Hakea on 30 June 2023. The debrief notes for both drills noted that more training scenarios to familiarise staff with procedures.[341,342]

234. Whilst I accept that not all prison officers will be on duty when any particular fire drill is conducted, at the inquest two experienced prison officers said that had never participated in a fire drill during their time at Hakea. In her statement, (dated 18 July 2024), Officer Szeremenda said: "*Throughout my time at Hakea Prison, I do not believe an Emergency Management exercise for a comprehensive fire drill has been conducted, that included a site-wide response*".[343]

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[335] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp20-21
[336] See also: See also: ts 27.03.25 (August), pp365-366
[337] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp30-35 and ts 28.03.25 (Palmer), pp413-417
[338] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p9
[339] Exhibit 1, Vol 2, Tab 53, COPP 13.4 - Emergency Management Exercises, section 3.3.1
[340] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p9
[341] Exhibit 1, Vol 2, Tab 44.2, Emergency Management Exercise Report (19.05.23)
[342] Exhibit 1, Vol 2, Tab 44.1, Emergency Management Exercise Report (30.06.23)
[343] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), para 95

235. In his statement (dated 18 June 2024), Officer McDuffus said he had worked at Hakea for five years, and that: "*Within my time at Hakea, I believe there has been one fire drill to my knowledge however I have never participated in one*".[344]

236. On the basis of the evidence Officer Szeremenda and Officer McDuffus, the frequency and scope of fire drills at Hakea is inadequate, notwithstanding the fact that the current frequency exceeds policy requirements. I **strongly** urge the leadership team at Hakea to consider whether the current fire drill regime is appropriate, and whether anything can be done to improve the reach and coverage of these crucial drills.

Fire extinguishers, fire hoses and fire blankets[345]

237. At the inquest, numerous officers said they had received no training on how to use fire hoses during their initial course at the Corrective Services Academy (Academy) at the start of their prison careers. These officers also confirmed that although they received some training on how to use fire extinguishers during their initial course at the Academy, no refresher training was provided thereafter. It also appears that the fire extinguisher training at the Academy is fairly rudimentary, and it does not include exposure to a "real" fire.[346,347,348,349,350]

238. During the inquest, Ms Rowe said that the Department is investing in an electronic fire system with the aim of adding more realism to the training given to prison officers. However, she confirmed there are no current plans to expose trainee prison officers to "*real*" fires, which in my view is a pity, as realism in training is critical.[351]

239. Given the crucial role prison officers at Hakea are expected to play in responding to fires, I have recommended the Department conduct refresher training on first response to fire including safe work procedures for the use of R-Kits, fire extinguishers, fire blankets, and fire hoses using realistic scenarios and environments.

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[344] Exhibit 1, Vol 1, Tab 29, Statement - Officer S McDuffus (18.06.24), paras 3 & 8
[345] See also: Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p2
[346] ts 27.03.25 (Rowe), pp307-308 & 323-324
[347] Exhibit 1, Vol 3, Tab 61.3, Statement - Officer M Moore (20.02.25), para 27 and ts 24.03.25 (Moore), p32
[348] Exhibit 1, Vol 2, Tab 57.11, Statement - Officer R Savage (06.01.25), paras 35 & 44
[349] ts 24.03.25 (McGrath), pp83-84; ts 24.03.25 (Longden), pp114-115; and ts 25.03.25 (Szmerenda), pp137
[350] ts 25.03.25 (Ballinger), pp158-159; ts 25.03.25 (Batten), pp172-174 and ts 25.03.25 (Cavanaugh), pp271-272
[351] ts 27.03.25 (Rowe), pp307-308

Fire-retardant mattress covers[352]

240. The fact that the mattress cover in G12 was not fire-retardant was identified by Hakea following Sam's death. In a letter to the Court dated 18 April 2024, Commissioner Royce stated that all mattress in Unit 7 (induction unit), Unit 1 (multi-purpose unit), and the Crisis care unit had been replaced with fire-retardant mattresses. Commissioner Royce also noted that:

> The Department will also be reviewing mattresses and fire equipment across all custodial facilities to ensure that the issues identified at Hakea are addressed across the estate".[353,354]

241. It appears that all mattresses at Hakea now have fire-retardant covers, and in his report (dated 17 March 2025), Officer Tuck states:

> All mattresses across the site have been replaced with fire-retardant Natritex mattresses sourced externally from Queensland or internally produced fire retardant mattresses compliant as per Department requirements, in line with Deputy Commissioners Broadcast 06/2025, outlining future requirements for compliance with fire retardant mattresses.[355]

Breathing apparatus training[356,357,358]

242. In the past, all prison officers underwent BA training during their initial training at the Academy. However, at the time of Sam's death, training was only being undertaken by officers who self-nominate. At the inquest, Officer August said: "*I'm aware that 60% of trainees from the academy are trained in CABA*", which is disappointingly low.[359,360]

243. A prison officer's initial BA training takes place at the Academy over two days, and includes equipment familiarisation, and instruction on pre-don testing procedures, how to don and doff the equipment, and basic BA procedures.

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[352] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp22-23
[353] Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p2
[354] See also: Exhibit 1, Vol 2, Tab 45, Dep. Commr. Broadcast 6/2024: Prisoner Mattress (14.05.24)
[355] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p5 and ts 27.03.25 (Tuck), p385
[356] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp45-50 and ts 28.03.25 (Palmer), pp420-425
[357] Exhibit 1, Vol 3, Tab 62, Report - Ms J Rowe (12.03.25), pp3-4 and see also: ts 27.03.25 (August), pp355-358
[358] See also: Exhibit 1, Vol 1, Tab 9, Letter - Commr. B Royce (18.03.24), p2
[359] ts 27.03.25 (August), p355
[360] "*CABA*" is the abbreviation for "*compressed air breathing apparatus*"

244. To retain their BA qualification after their initial training, prison officers must attend an annual one day refresher course and (depending on which witness is relied on) practice donning and doffing BA equipment once, or twice per year.[361,362,363]

245. BA equipment is stored in two rooms (referred to as Zone 1 and Zone 2) on either side of Hakea, and consists of protective trousers and jacket, face mask and tubing, and a cylinder of compressed air worn on the officer's back on a harness. The cylinder provides about 20 minutes of air, and in addition to practicing how to properly check and don their BA equipment (a process that takes about five minutes), officers must familiarise themselves with the disconcerting sensation of going "*under air*".[364]

246. Like any manual skill, the correct donning and use of BA equipment is a degradable skill. The evidence before me is that the only way to maintain an appropriate level of competency is to regularly practice donning, checking, and doffing the BA equipment.[365] The importance of prison officers frequently practising the correct use of the equipment cannot be overemphasised.

247. In his evidence at the inquest, Officer McDuffus said that at a time before staff shortages at Hakea prevented it, BA officers would practice donning and doffing their equipment and "*walk around the prison oval*" on a weekly basis. Officer McDuffus said this regular practice promoted familiarity and confidence with the BA equipment.[366]

248. This is in stark contrast to the current situation at Hakea where the high prison muster, and ongoing staff shortages make such training logistically impossible. Several of the BA officers who responded to Sam's cell fire noted that some of their colleagues were fumbling with their BA equipment through no fault of their own, due to unfamiliarity as a result of limited practice.[367,368,369]

[361] Exhibit 1, Vol 3, Tab 62, Report - Ms J Rowe (12.03.25), p3 and ts 27.03.25 (Rowe), pp304-306
[362] ts 25.03.25 (Grocott), pp180-181; ts 25.03.25 (McDuffus), p223 and ts 26.03.25 (Cavanaugh), p172
[363] Regardless of whether the requirement is to don/doff once or twice a year, both these levels of practice are grossly inadequate.
[364] Exhibit 1, Vol 3, Tab 62, Report - Ms J Rowe (12.03.25), pp3-4, 6 & 8-9 and ts 27.03.25 (Rowe), pp304-307
[365] See for example: ts 25.03.25 (Batten), pp178-179 and ts 26.05.25 (May), pp242-244
[366] ts 25.03.25 (McDuffus), pp222-223 and see also: ts 25.03.25 (Grocott), pp180-183
[367] Exhibit 1, Vol 2, Tab 57.5, Statement - Officer S Grocott (11.01.25), paras 28-34 and ts 25.05.25 (Grocott), pp183-186
[368] Exhibit 1, Vol 2, Tab 57.7, Statement - Officer S McDuffus (30.01.25), para 41 and ts 25.05.25 (McDuffus), pp221-222
[369] See also: ts 25.05.25 (Batten), pp177-178

249. At the inquest, Officer Cavanaugh was asked about whether any aspect of BA training could be improved, and his response was:

> More…time or exposure. We don't rise to the occasion when something bad happens, we only fall back on the knowledge that we have and the training that we have, and where you've had minimal training, you…don't rise to the occasion and you're not effective. So you might be qualified, but you're not competent…So I…just think more…training, more opportunities, more exercises.[370]

250. Although BA officer protocols are supposed to be initiated automatically when a "*Code Red Fire*" call is called, the evidence before me is that before a BA officer can deploy to a critical incident, they must first be released from their unit by their senior officer. Further, before they can deploy to a critical incident, BA officers must make their way to whichever of the two BA equipment storage rooms is the closest.[371,372]

251. Officers must then check and don their equipment, a process which takes several minutes, and once "*kitted up*" they must then make their way as quickly and efficiently as possible to the incident location. This process takes time and must be performed methodically, and it is therefore critical that BA officers are released from their units at the earliest opportunity.[373]

252. However, in this case, the deployment of at least three of the BA officers who responded to the fire in Sam's cell after Code Red Fire call had been made, (i.e.: Officers May, Cavanaugh and Andrews) was delayed by their respective senior officers.

253. Officer May was a wing officer on Wing 10, and when he heard the Code Red Fire call he was told by his senior officer to "*standby*". Officer May says that "*less than five minutes later*" he heard a female voice on the prison radio requesting all BA officers to go to the courtyard outside G Wing, and he immediately left Unit 10 and made his way to Zone 2. Despite being delayed by his senior officer, Officer May was the first to arrive at Zone 2, and he "*unlocked the BA equipment as other officers arrived*".[374]

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[370] ts 26.03.25 (Cavanaugh), p263
[371] ts 25.05.25 (Szeremenda), p134 and ts 25.05.25 (Grocott), pp189-190
[372] ts 26.03.25 (May), pp230-231
[373] Exhibit 1, Vol 3, Tab 62, Report - Ms J Rowe (12.03.25), pp3-4, 6 & 8-9
[374] Exhibit 1, Vol 1, Tab 30, Statement - Officer G May (24.07.24), paras 6-12 and ts 26.05.25 (May), pp230-232

254. Officer Cavanaugh (who was a probationary officer in Unit 2)[375] was not released from his unit by his senior officer until the third radio call for BA officers to deploy to Unit 7. Officer Cavanaugh said his senior officer had refused to release him on two occasions in case he was needed to deal with a situation in Unit 2, or another unit. However at the relevant time, Unit 2 was quiet and orderly, and prisoners were locked in their cells.[376,377]

255. Despite the fact that his senior officer had refused to release him on two occasions, when Officer Cavanaugh heard the third call for BA officers, he ignored his senior officer's ludicrous refusals and deployed (as he is required to do under departmental policy), to the Zone 2 storeroom.[378,379]

256. To add insult to injury, as Officer Cavanaugh was rushing to the Zone 2 storeroom, an unknown prison officer yelled at him to stop running in case he "*caused panic*". To his enormous credit, Officer Cavanaugh ignored this absurd advice, and as a result he was one of the first BA officers to arrive at Unit 7, notwithstanding the fact that through no fault of his own, his release from his unit had been unnecessarily delayed.[380]

257. Officer Andrew says that on 5 March 2024 he was on duty in the reception area at Hakea when he heard the Code Red Fire call, and that:

> As a BA trained officer, I was prepared to assist however (I) was told to wait by my immediate supervisor. About 15 minutes later, there was another call over the radio however this one asked for all BA trained officer to assist at Unit 7. I was relieved of my duties and allowed to attend and assist the incident.[381]

258. When he was eventually released, Officer Andrews ran to the Zone 2 storeroom which was only about 30 seconds away. However, all of the BA equipment in the storeroom was already in use, and Officer Andrews had to go the equipment store on the west side of the prison. By the time he arrived at Unit 7, Sam had already been extracted from his cell.

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[375] Officer Cavanaugh was at Hakea briefly prior to his direct entry into the Department's Special Operations Group
[376] Exhibit 1, Vol 1, Tab 31, Incident Description Report - Officer Z Cavanaugh (05.03.24)
[377] ts 26.05.25 (Cavanaugh), pp252-253
[378] Exhibit 1, Vol 1, Tab 31, Incident Description Report - Officer Z Cavanaugh (05.03.24)
[379] ts 26.05.25 (Cavanaugh), pp253-255
[380] ts 26.03.25 (Cavanaugh), pp254-255
[381] Exhibit 1, Vol 1, Tab 32, Statement - Officer S Andrews (26.06.24), paras 15-17

259. Given the grave and mortal danger faced by a prisoner in a cell that is on fire, the early attendance of BA officers is crucial in ensuring the prisoner is removed from the cell as quickly as possible. In my view, the fact that Officers May, Cavanaugh, and Andrews were not released from their respective units as soon as the Code Red Fire call was made is **appalling**, and represents an egregious lack of judgement on the part of their respective senior officers.

260. The evidence before me is that a response time for the attendance of BA officers of 10 minutes is regarded as good, even with skilled officers. In some cases (for various reasons) response times of 25 minutes or even longer have occurred.[382] In the context of a cell fire, this is manifestly inadequate, especially where the expected first response by officers using R-Kit respirators and fire hoses and/or fire extinguishers has not occurred.

261. In his evidence at the inquest, Officer Grocott said that although he and Officer McDuffus had conducted a BA equipment training scenario, the response times of the BA officers who participated in the exercise were woeful, and this was directly related to ongoing staff shortages meaning BA officers have limited don/doff practice causing a slower response.[383]

262. Officer Grocott's observations are consistent with feedback in three Emergency Management Exercise Reports for BA training scenarios conducted at Hakea in 2023, where the following comments appear: 19 May 2023: "*Only issue was ECO took a bit too long to arrive. More scenarios required*;[384] 30 June 2023: "*More exercises to hone in work practices*",[385] and 19 October 2023: "*Further ongoing training. Remind BA staff that time is of the essence when responding*".[386]

263. To improve response times, and improve BA competencies, I have recommended the Department conduct quarterly BA training exercises at Hakea using realistic scenarios. I have also recommended that all BA qualified officers conduct monthly don/doff practices (under air) with BA equipment.

[382] Exhibit 1, Vol 2, Tab 57.5, Statement - Officer S Grocott (11.01.25), paras 36-37 and ts 25.03.25 (Grocott), pp187-188
[383] ts 25.03.25 (Grocott), pp187-188 & 200-202
[384] Exhibit 1, Vol 2, Tab 43.2, Emergency Management Exercise Report (19.05.23)
[385] Exhibit 1, Vol 2, Tab 43.1, Emergency Management Exercise Report (30.06.23)
[386] Exhibit 1, Vol 2, Tab 43, Emergency Management Exercise Report (19.10.23)

264. Officer Grocott also noted that during a critical incident, an officer known as the Entry Control Officer (ECO) is responsible for the coordinating the deployment and safety of BA officers. Despite the onerous responsibilities of the ECO position, no specific training is provided to officers prepared to take on this crucial role.[387,388] In my view this is a mistake, and I have therefore recommended that the Department provide additional training for officers willing to assume the ECO role.

265. A further issue affecting the number of BA officers available is that many officers who undergo initial BA training do not maintain their competency by completing the required annual refresher training. On the basis of the evidence before me, it is not clear why this is the case. However, in my view it is noteworthy that although BA officers are expected to deploy to dangerous, potentially life threatening incidents, they receive minimal ongoing training, and they are paid an allowance of $38.00 per fortnight, as an "*incentive*" to maintain their qualifications.[389]

266. In my view the current fortnightly allowance BA officers are to be paid, and the planned increased in the allowance to $50.00 per fortnight, are paltry sums which are woefully inadequate. I have therefore recommended that the Department enhance BA officer incentives (whether financial or otherwise) in an effort to encourage more prison officers to maintain the currency of their BA qualification.

267. I also note that unlike many other prisons in Western Australia, Hakea does not currently have any system in place to centrally identify and record the number and location of BA officers on shift. Although a staff roster which shows a prison officer's BA qualifications is produced, this information is not made widely available.[390]

268. In some prisons, information about the location of BA officers is captured by those officers simply writing their names on a whiteboard when they arrive at the prison to start their shift. When responding to a critical incident, it is of course crucial that key staff are aware of the location of BA officers.[391]

[387] ts 25.03.25 (Grocott), p189
[388] See also: ts 27.03.25 (Rowe), pp306-307
[389] ts 27.03.25 (August), pp344-345 and see also: ts 25.03.25 (McDuffus), p224 and ts 27.03.25 (Rowe), p303
[390] ts 25.03.25 (Szeremenda), pp142-143
[391] ts 27.03.25 (Rowe), pp307-308

269. I have recommended the Department develop a system to ensure that staff in the Master Control Room at Hakea are aware of all BA qualified officers on shift, and their respective locations.

Training issues - training for Senior and Principal officers[392]

270. At the inquest it became clear that the Department does not offer any specific training to officers aspiring to (or acting in) the roles of senior officer, or principal officer. In a critical situation, prison officers will look to their respective senior officers for guidance, and also to any principal officers that are on duty. In that context, it is my view that the failure to provide tailored training to officers occupying the roles of senior officer or principal officer is a mistake.

271. I have therefore recommended that the Department introduce training packages aimed at officers preparing to undertake the positions of senior officer (i.e. Unit Manager) and principal officer respectively. I have also recommended that the training packages for these positions include advanced training in de-escalation techniques for managing disruptive and aggressive prisoners, as well as leadership, tactical commander, and other key skills deemed necessary for officers undertaking in these positions.

272. In her evidence, Officer Szeremenda said she had developed a training package for senior officers, and in the de-brief notes she prepared following Sam's death, she noted:

> My senior officer training package should be expedited and implemented into Hakea for ALL ACTING and CURRENT Senior Officers on effective emergency management response, and unit management. (Hakea aware of the package prior to the event, has never given the time for it to be implemented by me. No one listening).[393,394] [Original capitalisation maintained]

273. Given that Officer Szmerenda's senior officer package already exists (and given her relevant experience in the roles of senior officer and principal officer, I **strongly** suggest that the Department examine the contents of Officer Szmerenda's senior officer training package to see if can be used.

[392] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp54-55 and ts 28.03.25 (Palmer), pp428-430
[393] Exhibit 1, Vol 1, Tab 25.1, Critical Incident De-brief Notes - Officer T Szeremenda (05.03.24), p5
[394] See also: ts 25.03.25 Szeremenda (25.03.25), p145

Lessons learned process[395,396,397,398,399]

274. Departmental policy requires that following a critical incident, there is an immediate debrief, and later a more in-depth debrief to capture what went well and identify lessons learned.[400,401] These debriefs are colloquially referred to as "*hot*" and "*cold*" debriefs respectively, which is the terminology I have adopted.

275. In this case, a "*hot*" debrief was conducted in the Hakea gym in the period after Sam had been taken to FSH and other prisoners had been returned to their cells. However, on the evidence before me this hot debrief was little more than a welfare check, and it appears that not all first responders were present.[402,403] At the inquest, Ms Palmer was asked whether all relevant staff had attended the hot debrief, and her response was: "*If they all didn't, a good majority of them did*".[404]

276. However, a "*cold*" debrief in relation to the critical incident at Hakea on 5 March 2024, was not conducted until 4 October 2024, some six months after Sam's death. This process was therefore not in accordance with the relevant policy, which requires that a "*cold*" debrief be held as soon as possible after the critical incident.[405]

277. In my view the Lessons Learned process that was conducted was seriously flawed. Not only did it occur months after Sam's death, **none** of the first responders attended. Shockingly, despite the fact that Officer Szeremenda had specifically asked to attend the cold debrief after she found out it was being conducted, she was told she was not required.[406]

278. In my view, the failure to invite Officer Szeremenda to the cold debrief is extraordinary, especially given she was the most senior officer who attended Unit 7, and she gave the evacuation order after assessing the situation.

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[395] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24)
[396] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp65-68 and ts 28.03.25 (Palmer), pp450-451
[397] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), p2 and ts 27.03.25 (August), pp337-344
[398] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24) paras 103-104 and ts 25.03.25 (Szeremenda), pp145-146
[399] ts 28.03.25 (Palmer), pp437-440
[400] Exhibit 1, Vol 2, Tabs 59.1 & 59.2, COPP-13.1 Incident Notification (v3.0 & v6.0)
[401] Exhibit 1, Vol 3, Tab 71, EMF-DIR-022 Operational debriefing (30.11.23), pp3-7
[402] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), paras 102-104
[403] See also: Exhibit 1, Vol 3, Tab 61.2, Email - Officer R Savage (10.10.24)
[404] ts 28.03.25 (Palmer), p451
[405] Exhibit 1, Vol 3, Tab 71, EMF-DIR-022 Operational debriefing (30.11.23)
[406] ts 25.03.25 (Szeremenda), pp140-141

279. Attached to her statement, Officer Szeremenda provided a detailed set of notes recording her observations and assessments about the response to the fire in Sam's cell. Officer Szeremenda identified key systemic issues and had clearly put a great deal of thought into the debrief notes she prepared.[407] None of these invaluable insights were considered at the cold debrief, and in my view this was a **disgraceful** oversight.

280. Not only should Officer Szeremenda have been invited to attend the cold debrief, the debrief notes she prepared should have been tabled at that meeting and discussed. Of the 20 people who attended the cold debrief, none of them were present in Unit 7 on the night of 5 March 2024.

281. In my view, if the cold debrief process is to have any point, the Department should obviously ensure the attendance of as many key first responders to the critical incident as possible. The flimsy post-fact justification advanced by the Department, namely that some first responders may be too traumatised to attend and/or may be the subject of disciplinary or criminal investigation is ludicrous and in any case, neither excuse applies to any of the first responders who attended Unit 7 on 5 March 2024.

282. To take a few examples, not only was Officer Szeremenda willing and able to attend the cold debrief, she actually asked to do so - but was rebuffed. At the inquest, both Officer McDuffus and Officer Grocott said they had not attended the cold debrief, and Officer Grocott said he would have attended if he had been asked.[408]

283. The fact that none of these experienced and key staff were invited to attend the cold debrief is another **inexcusable error** in the litany of errors made by the Department in this case.

284. In my view a failure to ensure that as many key first responders as possible attend the "*cold*" debrief held after a critical incident makes a mockery of the process and fails to ensure that these important perspectives are captured. Relying on incident reports is insufficient because such reports cannot hope to capture all of the subtle detail so invaluable to the review of actions taken during a critical incident.

[407] Exhibit 1, Vol 1, Tab 25.1, Critical Incident De-brief Notes - Officer T Szeremenda (05.03.24)
[408] ts 25.03.25 (Grocott) pp203-205 and ts 25.03.25 (McDuffus) p221

285. I have therefore recommended that the Department take all reasonable steps to ensure that the provisions of EMF-DIR-022 Operational debriefing are complied with. I have also recommended that in particular, in relation to critical incidents involving deaths in custody, the Department should ensure that wherever possible, personnel involved in the critical incident participate in immediate and formal debriefs, so that valuable insights from those officers can be captured and incorporated into any "*lessons learned*" process.

286. In relation to the dissemination of the lessons learned from a cold debrief process, I note with concern the evidence that Officer Szeremenda gave at the inquest on this point, where she said:

> I know there has been a lessons learned, your Honour…I'm not privy (to) what has been found, and I have seen some things come out over the last 12 months. So, I would…have to imagine that there is something happening in the background. Not necessarily that I'm part of it, of course.[409]

287. I also note with dismay that despite the fact that training issues were identified in the lessons learned process, the officer responsible for emergency management training at the Academy (i.e.: Ms Rowe) said she was not provided with a copy of the Lessons Learned Report, noting:

> The Corrective Services Academy does not receive formal reports or lessons learned from incidents occurring in prisons. There is no system in place requiring prisons to inform the Academy of such matters…any event that jeopardises the good order and security of a prison must be reported to the Superintendent. However, there is no mandated requirement for the Academy to be notified or involved in post-incident analysis or training adjustments based on lessons learned.[410]

288. There does not seem to be much point in conducting a "*cold*" debrief unless the lessons learned are widely distributed to relevant staff, and my view, the failure to do so is **indefensible**. I have therefore recommended that lessons learned reports be distributed to all relevant staff.[411,412]

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[409] ts 25.03.25 (Szeremenda), p146
[410] Exhibit 1, Vol 3, Tab 62, Report - Ms J Rowe (12.03.25), p5 and see also: ts 27.03.25 (Rowe), pp310-312
[411] Officer August said there was no reason why Ms Rowe (and presumably others) could not receive these reports
[412] See: ts 27.03.25 (August), p358

Staff support[413]

289. Following a critical incident, departmental policy provides that first responders and other key staff are provided with "*stress checks and support mechanisms*"[414]. However, in her statement (and at the inquest) Officer Szeremenda said she received no such support following her attendance on Unit 7 and Sam's death. In her statement she said:

> There is a lack of support from senior staff, no lessons learnt or formal debrief for the immediate staff involved, including myself, has been conducted with Senior Management Team or by Head Office at the time of the statement. The only debrief that had occurred was the hot brief that Officer Scanlan and I conducted directly after the incident that was for welfare, reporting, injuries and concerns on the night of March 5th, 2024.[415]

290. At the inquest, Officer Szeremenda made these comments about the support she received following Sam's death:

> So I finished work…at 1.30 in the morning. I came back to work 8.30 in the morning for my next shift - my choice and no, no one in the senior management team up until this statement had actually had a chat to me to find out what's…you know, a cold brief.[416]

291. None of Officer Szeremenda's evidence was challenged by counsel for the Department whilst Officer Szeremenda was in the witness box. This is notwithstanding the fact that Officer Szeremenda's statement was signed on 18 July 2024 and has been part of the Brief - and therefore in the Department's possession - for many months.

292. When Ms Palmer gave her evidence at the inquest on 28 March 2025, she outlined the supports which she said the Department provided to Officer Szmerenda in the aftermath of Sam's death.[417]

293. These supports were explained in the following exchange between Ms Palmer and Ms Niclair (counsel for the Department):

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[413] Exhibit 1, Vol 3, Tab 71, EMF-DIR-022 Operational debriefing (30.11.23)
[414] Exhibit 1, Vol 3, Tab 71, EMF-DIR-022 Operational debriefing (30.11.23), pp7-8
[415] Exhibit 1, Vol 1, Tab 25, Statement - Officer T Szeremenda (18.07.24), paras 102-104
[416] ts 25.03.25 (Szeremenda), p145
[417] ts 28.03.25 (Palmer), p451 and see also: ts 27.03.25 (August), p361-362

> *Ms Niclair:* All right. So, we've heard evidence from Principal Officer Szeremenda that she received no support from the S&T following this incident. Is that the same information that she provided you when she was interviewed?
>
> *Ms Palmer:* Yes.
>
> *Ms Niclair:* And do you have any information regarding that issue?
>
> *Ms Palmer:* I made some inquiries, and I was made aware that on the night of the incident two deputy superintendents spoke with her. And in the day…and a deputy, the duty deputy commissioner. And then in the days after…a further deputy commissioner…sorry, deputy superintendent also engaged with her checking on her welfare.
>
> *Ms Niclair:* And is it your understanding…(that) Deputy Commissioner Beck had a long conversation with her. He says that he offered her support, reminded her of the support mechanisms available from the Department should she need them?
>
> *Ms Palmer:* That's my understanding, yes.[418]

294. I am aware of the position now adopted by the State Solicitor's Office when it represents Government departments and agencies, namely that it only acts for the entity, and not for individual staff members. Nevertheless, in my view it was inappropriate for the evidence Ms Palmer gave about the support supposedly provided to Officer Szeremenda, not to have been put to Officer Szeremenda while she was in the witness box.

295. Although section 41 of the Act provides that I am not bound by the rules of evidence, courts have consistently held that provisions of this kind do not permit courts to completely ignore the underlying wisdom of these rules. Basic procedural rules, such as the longstanding rule derived from the case of *Browne v Dunn*,[419] should be observed unless there is a statutory provision to the contrary.

296. It is not to the point to say that until Officer Szeremenda gave her evidence her assertion of a lack of support from the prison hierarchy was not known.

[418] ts 28.03.25 (Palmer), p451
[419] *Browne v Dunn* (1893) 6 R 67 (H.L.)

297. As I have pointed out, Officer Szeremenda's assertion appears in her statement, and that document has been in the Brief for months. After careful consideration I have concluded that whilst some Hakea staff did receive welfare support following Sam's death,[420] on the basis of the discrepancy in the evidence before me, I am unable to make any conclusions about what support, if any, was provided to Officer Szeremenda.

298. In any case, the provision of timely and appropriate support to prison staff following a critical incident, is vital in the promotion and maintenance of staff welfare. Appropriate staff support following a critical incident is also important in the retention of staff, and may also assist in arresting the staff attrition rates referred to by Officer Tuck in his evidence at the inquest.[421]

299. I have recommended the Department take all reasonable steps to ensure that all relevant staff are provided with the "*stress checks and support mechanisms*" referred to in "*EMF-DIR-022 Operational debriefing*".[422] I have also recommended that the Department provide standdown leave for all staff directly involved in a critical incident, including, but not limited to, incidents involving a death in custody.[423]

CCTV & Body worn cameras[424,425,426]

300. Although some units at Hakea have close circuit TV camera (CCTV), there were no cameras on Unit 7 at the relevant time. I have previously recommended that, as a matter of urgency, CCTV be installed in all accommodation units at Hakea.[427]

301. In relation to CCTV at Hakea, the OICS Hakea Inspection Report noted:

> CCTV was outdated and remained inadequate due to technical issues, frequent malfunctions, and the insufficient range of some cameras which failed to provide adequate coverage of their intended areas. Some coverage across multiple units was covered by a single camera…

[420] ts 28.03.25 (Palmer), p451 and see also: ts 27.03.25 (August), pp361-362
[421] ts 27.03.25 (Tuck), p384
[422] Exhibit 1, Vol 3, Tab 71, EMF-DIR-022 Operational debriefing (30.11.23), pp7-8
[423] See also: ts 27.03.25 (August), p363
[424] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p36 and ts 28.03.25 (Palmer), pp417-418
[425] ts 27.03.25 (August), pp327-331 & 348-349 and ts 27.03.25 (Tuck), pp388-389
[426] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p26
[427] See for example: Record of Investigation into Death: Mr A D Eades, [2024] WACOR 26, Recommendation 4, p59

> CCTV coverage was adequate in some areas but fell short in others. While CCTV upgrades were planned in reception by 2025, significant gaps remained elsewhere in Hakea.[428]

302. In his report, Officer August noted the first stage of the Department's roll out of "*modernised*" body worn cameras (BWC) had been delivered into the "*Youth Estate*" in July 2024. Officer August said that funding has been requested for the Stage 2 roll out which will include Hakea. At the inquest, Officer August also said that in terms of priority, Hakea was "*number one*" in his mind,[429] and in his report Officer August also noted that:

> Staff and prisoner safety and wellbeing is the primary focus for this request, introducing a tactical solution that aims to enhance security and build upon current evidence capture capabilities. Significant investment is required to undertake capital works, to accommodate the supporting hardware, including refurbishment and extension of current gatehouses due to ageing infrastructure, inadequate storage capacity and technology constraints.[430]

303. In relation to body worn cameras (BWC), the OICS Hakea Inspection Report notes that despite the fact that BWC had been used at Banksia Hill for many years:

> [T]here use had not yet been extended to other facilities such as Hakea. Body-worn cameras offer a cost-effective way to increase surveillance and improve staff safety. At the time of writing, some camera units had arrived. The full roll-out of these cameras at Hakea to address the existing coverage gaps and improve overall security and safety of staff and prisoners is long overdue.[431]

304. Whilst I agree with the comments by the Inspector of Custodial Services, I also acknowledge that the roll out of BWC and the installation additional CCTV at Hakea involve considerable logistical and financial challenges. Nevertheless, in my view (and consistent with the statutory obligations imposed on the Director-General by section 7 of the *Prisons Act 1981*), these challenges merely constitute the unavoidable and necessary costs of running a safe and effective prison in 2025.

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[428] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), p2
[429] ts 27.03.25 (August), p328
[430] Exhibit 1, Vol 3, Tab 64, Report - Officer J August (17.03.25), pp4-5
[431] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), p2

305. I have therefore recommended that in order to ensure the safety of prisoners and staff at Hakea, the Department should expedite the rollout of Body Worn Cameras for all custodial staff at Hakea. I have also recommended that the Department expedite the installation of CCTV cameras in all accommodation units and common areas at Hakea that are not already equipped with CCTV.

Sam's restraints[432,433,434]

306. During his transfer to FSH, Sam's ankles and wrists were restrained, which was contrary to departmental policy that relevantly states: "*Prisoners with significant medical and/or mobility issues shall not be placed in restraints unless there is a requirement following the completion of an (External Movement Risk Assessment)*".[435,436]

307. The policy requires that amongst other categories of prisoner, particular emphasis is given to "*prisoners who are not conscious*". In my view, the use of restraints in Sam's case was inappropriate. At the relevant time, he was unconscious and CPR was in progress.[437,438] The Department's Lessons Learned report includes the following observations about the use of restraints on Sam:

> Whilst the use of restraints appears to be accepted where restraints are applied in the case of an emergency, it is imperative that further emphasis is provided within the policy ensuring that the use of restraints must be **proportionate and appropriate** with **due regard to the extent of a prisoner's condition**. [Original emphasis]
>
> At the workshop, attendees queried whether the prevalence of restraints on Mr Lynch impacted the treatment provided. Whilst the clinical nurse advised that on the face of it, it does not appear that the restraints had an adverse impact on the medical treatment, attendees noted the use of restraints on Mr Lynch in these circumstances was not necessary given the extent of his injuries and acknowledged that further investigation is required on why restraints continue to be used in situations such as this.[439]

[432] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), pp22-23 & 37-39
[433] ts 28.03.25 (Palmer), pp418-419 & 449-450
[434] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp14 & 17-19
[435] Exhibit 1, Vol 2, Tab 58.1, COPP-12.3 Conducting Escorts (v7.0), p9
[436] Exhibit 1, Vol 2, Tab 58.2, COPP-12.3 Conducting Escorts (v10.0), pp9-10
[437] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p23 and also: ts 27.03.25 (August), pp345-346 & 365
[438] Exhibit 1, Vol 2, Tabs 58.1 & 58.2, COPP-12.3 Conducting Escorts (v7.0 & v10.0)
[439] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), p18

308. The Department's Lessons Learned report also noted that a policy amendment was planned to ensure that prison staff are aware that in an emergency situation, levels of restraint should be proportionate with a prisoner's medical condition and determined in consultation with treating medical staff.[440]

309. Whilst there is no evidence before me to suggest that Sam's restraints had any effect on resuscitation efforts, I **strongly** suggest that the Department remind all prison officers (and especially senior officers) about the provisions of COPP-12.3 *Conducting Escorts* relating to restraints in these circumstances.[441]

310. I also note that following Sam's death, his restraints were not removed for some time, and in my view this is clearly an affront to human dignity. I have recommended that the Department amend its policy to make it clear that after a prisoner has been declared life extinct by an authorised person, any restraints on the prisoner at that time should be removed as soon as reasonably practicable.

WorkSafe WA Investigation[442,443,444]

311. During my preliminary remarks at the conclusion of the inquest I raised the issue of whether I should refer Sam's case to WorkSafe WA under section 50 of the Act which is headed "*Reference to disciplinary body*". In considering whether section 50 applies to Sam's case, I was greatly assisted by written submissions forwarded by Ms Niclair on the Department's behalf.

312. On balance, and after careful consideration, I have decided that it would not be appropriate for me to make a section 50 referral in this case. In any case, I note that a WorkSafe WA investigation into the circumstances of Sam's death is currently underway, and I agree with the Department's submission that in those circumstances, a referral under the Act is unnecessary.

[440] Exhibit 1, Vol 3, Tab 64.1, DIC Lessons Learned Report (04.10.24), pp18-19
[441] See also: ts 27.03.25 (August), pp345-346
[442] Letter - Ms K Niclair to Mr W Stops (12.05.25)
[443] Email - WorkSafe WA to Mr W Stops (14.05.25)
[444] Letter - Ms K Niclair to Mr W Stops (12.05.25), p6

IS HAKEA FIT FOR PURPOSE?

313. As noted, the infrastructure at Hakea is ageing, and its prisoner muster is at record highs, meaning that from time to time, prisoners have to be doubled up and in some cases triple bunked. Ongoing staff shortages mean that prisoners must be managed under "*adaptive regimes*". As Officer Tuck noted in his report:

> Hakea Prison is the main receival prison for the state and manages on average, 50% of the state's male "At Risk" category prisoners, which adds further complexity into the introduction of a smoking ban".[445]

314. On any measure Hakea's level preparedness to deal with fires was poor at the relevant time, and in my view remains so.[446] As I have also noted, cells at Hakea are not protected by an automatic fire suppression system, and prisoners have free access to tobacco products and lighters.

315. The OICS Hakea Inspection Report documented "*several very concerning findings about the conditions in Hakea Prison*", and the Inspector of Custodial Services (Mr Ryan) noted:

> The conditions we observed during the inspection were of such concern that on 27 May 2024 I took the unusual step of issuing the Director General of the Department of Justice with a Show Cause Notice under section 33A of the *Inspector of Custodial Services Act 2003.* This Notice set out the grounds upon which I formed a view that at that time prisoners in Hakea were being treated in a manner that was cruel, inhuman, or degrading.
>
> We observed increasing levels of anger and frustration in prisoners, which was leading to challenging or dangerous behaviour, including suicides, suicide attempts, serious self-harm, and assaults.[447]

316. As I have noted, Hakea asserts that even without an automatic fire suppression system, it complies with relevant building codes because the structures on its site do not exceed 25 metres in height or four storeys.[448]

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[445] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8
[446] ts 25.03.25 (Grocott), p206 and ts 25.03.25 (McDuffus), p222
[447] Exhibit 1, Vol 3, Tab 72, OICS Report 158: 2024 Inspection of Hakea Prison (14.02.25), piv
[448] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), p8 and ts 27.03.25 (Tuck), pp393-394

317. At the inquest, Officer Tuck was asked whether, in the absence of a fire suppression system, it was his view that Hakea was still fit for purpose, and he made the following comments:

> In general - and it has been doing it for years - it has been housing prisoners safely. We need to make sure that we're doing everything we can to reduce and introduce the smoking ban as soon as possible.[449]…(and)…In relation to fire safety, like I said, it meets the design requirements. It meets all of the Australian design requirements. And, you know, the information I got in relation to the retrofitting of the sprinklers came from the infrastructure area, and I double-checked with them, and Hakea Prison meets all building codes and design requirements.[450]

318. In my view, and with great respect to Officer Tuck, this response misses the point of the question. The relevant point is that whether or not Hakea complies with applicable building codes, its current ability to deal with cell fires is **pitiable**.

319. Earlier in his evidence at the inquest, Officer Tuck identified what, in my view, is the most crucial issue in relation to Hakea's fire preparedness:

> In relation to that, all I can say there is that it meets all of the building codes that it was required to do at the time. The problem we've got is from ignition to a BA team getting there, 15 to 20 minutes on average depending on the location in the prison. **We've got to find a solution for that ignition to the BA team**.[451] [Emphasis added]

320. At the inquest, Mr Stops (Counsel Assisting) asked Mr Ryan the following question:

> Based on your office's most recent review of Hakea, bearing in mind that there's no fire suppression systems in Hakea prison, it's an old build, there's no plans in place to retrofit any fire suppression systems…smoking is not going to be banned any time soon in Hakea Prison, lighters are going to remain at Hakea Prison, arson risk will remain in prison. I guess the question is do you have a view as to whether or not Hakea Prison at this stage is actually fit for purpose.[452]

[449] ts 27.03.25 (Tuck), pp336-394
[450] ts 27.03.25 (Tuck), p394
[451] ts 27.03.25 (Tuck), p377
[452] ts 28.03.25 (Stops), pp465-466

321. Mr Ryan's stark response was:

> I know from conversations with Superintendent Tuck, the last time I was out there, which was within the last several weeks, he spoke of improving or testing their fire equipment and a second BA station and all those things. I haven't looked at that in detail, so I take that on face value. But the risk that sadly came to pass in this case still exists today. There needs to be an active response, a capability with all the available equipment - where all of that is right there and available. So that probably means that there's that sort of equipment available in each unit. That would probably give me better comfort. **But overall, Hakea, is it fit for purpose? No. Is it fit for purpose in the context of what we're looking at today? No.**[453] [Emphasis added]

322. I acknowledge the considerable efforts that have been, and are being made by Officer Tuck and his team to improve levels of fire preparedness at Hakea.[454] However, despite these commendable efforts, the fact remains that over 1,000 prisoners and 300 staff are currently housed in (or work at) a facility which, in my view, exposes them to unacceptably high level of risk from fire.

323. The sad reality is that cells at Hakea are not protected by an automatic fire suppression system and prisoners have ready access to cigarette lighters. Further, the current level of fire-preparedness at Hakea through improving, remains **poor**.[455] In those circumstances, I agree with the opinion expressed by Mr Ryan, namely that in view of its level of fire preparedness, **Hakea is not fit for purpose in its current state**.

324. In passing I note that note that Mr Ryan's evidence at the inquest was not challenged by the Department, and during the Department's closing submissions, Ms Niclair did not suggest that there was any basis on which I could, or should make an alternative finding.

325. Given the clear and onerous statutory obligations which rest on the Director General and the clear and present danger from fire that currently persists at Hakea, I beseech the Department to take **decisive and urgent** action before another prisoner (or a member of staff) loses their lives to the effects of fire.

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[453] ts 28.03.25 (Ryan), p466
[454] Exhibit 1, Vol 3, Tab 65, Report - Officer C Tuck (17.03.25), pp4-6 and ts 27.03.25 (Tuck), pp385-387
[455] See also: ts 25.03.25 (Grocott), pp205-206

WAS SAM'S DEATH PREVENTABLE?

326. The vexed question of whether Sam's death could have been prevented requires me to have due regard to the Briginshaw principle (which I have outlined), and the concept of hindsight bias which is the is the tendency, after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[456]

327. I acknowledge the uncomfortable truth that Sam would not have died on 5 March 2024 if he had not set fire to the cover of the mattress in his cell. Nevertheless, after applying the principles I have referred to above to the available evidence, I have concluded that Sam's death could have been prevented if the following things had been in place at the time he set his mattress alight:

a. Canteen spends had been distributed to prisoners on Unit 7 (including Sam) on the evening of 5 March 2024;

b. Sam' cell had been fitted with an automatic fire suppression system and the mattress in Sam's cell had been fitted with a fire-retardant cover;

c. A smoking ban was in place at Hakea and prisoners (including Sam) were not permitted to have access to cigarette lighters;

d. R-Kits containing respirators had not been tagged out and custodial staff had been willing to use them, and further custodial staff had been provided with training on the correct use of fire hoses and undergone realistic training scenarios; and

e. The fire hose in the G Wing fire cupboard had been accessible, and the fire hose in the H Wing fire cupboard had been fitted with a functioning nozzle.

328. As I have explained, none of the above factors were in place at the time Sam lit the fire in his cell, meaning that his death was essentially inevitable. I have made 12 recommendations which are designed to improve the safety of prisoners and staff at Hakea. Notwithstanding the difficult issues raised by these recommendations, I **strongly** urge the Department to support all of them.

[456] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

QUALITY OF SUPERVISION, TREATMENT AND CARE

329. The Health Summary expressed the following conclusion about Sam's treatment and care during his incarceration:

> In conclusion, the health care provided to (Sam) was generally holistic and patient-centred. During his most recent previous term in prison prior to March 2024, difficulties were identified regarding access to opioid substitution therapy; currently our team is working to improve this situation. However, otherwise Mr Lynch received health care of an equivalent standard to that which he would receive in the community. This was especially important due to the fact that between 2016 and 2024, the majority of Mr Lynch's health care was provided by custodial health services.[457]

330. Having carefully considered the available evidence, I am satisfied that the management of Sam's physical and mental health was appropriate, and that the standard of treatment and care he received during his last brief period of incarceration was acceptable.

331. In the DIC review she authored after Sam's death, Ms Palmer expressed the following conclusion about the quality of Sam's supervision, custodial management, and care:

> This review found instances where the supervision, custodial management and care of Mr Lynch was not fully in accordance with the Department's policy and procedures as listed in Appendix 1. Records indicate that after Mr Lynch was removed from his cell the response by medical staff and other responding officers was prompt. Relevant death in custody procedures, including notifications and handover to WA Police were followed.[458]

332. Having carefully considered the available evidence, I have concluded that Sam's general management during his final brief period of incarceration was appropriate. However, for reasons I explained, the fact that staff shortages meant that canteen spends were not distributed on Unit 7 on the evening of 5 March 2024 is clearly regrettable.

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[457] Exhibit 1, Vol 3, Tab 67, Health Services Review (17.03.25), p19 and see also: 09.10.24 (Gunson), pp172-178
[458] Exhibit 1, Vol 3, Tab 61, Death in Custody Review (17.02.25), p9

333. The inability of Hakea's custodial staff to effectively respond to the fire in Sam's cell was adversely affected by a range of factors. These factors include: the lack of an automatic cell fire suppression system, the ready access by prisoners to cigarette lighters, the lack of serviceable fire-fighting equipment on Unit 7, the poor maintenance of fire cupboard doors and fire hoses, and the chronic and ongoing staff shortages resulting in adequate supervision of prisoners.

334. In this case, after Sam was seen to light a fire in his cell it took 16 minutes for BA officers to extract him from his cell. By that stage Sam was unresponsive, and despite resuscitation efforts at Hakea and FSH, Sam could not be revived.

335. As a result, carefully considered the available evidence, and having due regard to the Briginshaw principle, I have concluded that the standard of supervision Sam received at Hakea was **grossly and manifestly inadequate**.

336. Whilst I acknowledge that since Sam's death, staff at Hakea have made concerted efforts to improve the preparedness of staff to deal with fires, the fact remains that staff and prisoners at Hakea remain at grave risk from the effects of fire. That is because prisoners (even those with a demonstrated history of committing arson and/or of lighting fires in their cells) have ready access to cigarette lighters, and the fact that there is no automatic fire suppression system in cells at Hakea.

337. I accept that addressing the access prisoners at Hakea currently have to cigarette lighters raises complex issues. Further, the prison population at Hakea is currently very large, and ongoing staff shortages mean prisoners are subjected to "*adaptive regimes*" meaning they spend longer periods in their cells. The environment at Hakea is therefore tense and difficult to manage. I also accept that retrofitting an automatic fire suppression system in cells at Hakea is logistically challenging and prohibitively expensive.

338. Nevertheless given the grave risks from fire that prisoners and staff at Hakea are currently exposed to, I have made recommendations on both of these issues.

RECOMMENDATIONS

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

Recommendation No. 1

To enhance the safety of prisoners and staff at Hakea Prison (Hakea), and to prevent any future loss of life, the Department of Justice (the Department) should install a fire suppression system at Hakea so that all cells and common areas are protected in the event of fire. The Department should consider whether this initiative can be funded by way of an internal funding allocation, or whether it is necessary to seek additional funding from the Treasury.

Recommendation No. 2

To ensure the safety of prisoners and staff at Hakea Prison (Hakea) the Department of Justice (the Department) should expedite a ban on smoking at Hakea, and take all reasonable steps to ensure that prisoners do not have access to tobacco products (including cigarettes), matches and/or lighters. To ensure the good order and safety of prisoners at Hakea whilst the smoking ban is being implemented, the Department should ensure that all prisoners who were smokers are given access to nicotine substitutes (e.g.: patches, lozenges), and support services including counselling, and diversionary activities.

Recommendation No. 3

To ensure the safety of prisoners and staff at Hakea Prison, whilst the initiatives referred to in Recommendations 1 and 2 are being implemented, the Department of Justice should develop and institute an interim management policy to restrict access to lighters and matches by prisoners with a heightened risk profile, including but not limited to prisoners convicted of arson and/or prisoners who have lit fires in prison.

Recommendation No. 4

To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should enhance the preparedness of staff at Hakea to respond to fires by all possible means, including by:

1. Reviewing Hakea's Emergency Management Plan and Fire Safety Plan to ensure they are fit for purpose and effectively implemented;

2. Conducting refresher training for custodial staff on first response to fire including safe work procedures the use of R kits; fire extinguishers; fire blankets; and fire hoses, using realistic scenarios and environments;

3. Enhancing the skills of officers qualified to use Breathing Apparatus (BA) by:

    a. Conducting quarterly BA training exercises using realistic scenarios;

    b. Requiring all BA qualified officers to conduct monthly don and doff practices (under air) with BA equipment and PPE;

    c. Providing additional training for officers willing to assume the position of Entry Control Officer;

    d. Enhancing incentives (whether financial or otherwise) to encourage custodial officers to maintain the currency of their BA qualification; and

    e. Developing a system to ensure that staff in the Master Control Room at Hakea are aware of all BA qualified officers on shift and their respective locations.

Recommendation No. 5

To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should expedite the installation of Closed-Circuit TV cameras in all accommodation units and common areas at Hakea.

Recommendation No. 6

To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should expedite the rollout of Body Worn Cameras for all custodial staff at Hakea.

Recommendation No. 7

The Department of Justice should introduce training packages aimed at officers preparing to undertake the positions of Senior Officer (i.e. Unit Manager), and Principal Officer, respectively. The training packages for these positions should include advanced training in de-escalation techniques for managing disruptive and aggressive prisoners, as well as leadership, tactical commander, and other key skills deemed necessary for officers undertaking in these positions.

Recommendation No. 8

The Department of Justice should redouble its efforts in recruiting and importantly, retaining, suitably skilled custodial officers.

Recommendation No. 9

The Department of Justice (the Department) should take all reasonable steps to ensure that the provisions of "*EMF-DIR-022 Operational debriefing*" are complied with.

In particular, in relation to critical incidents involving deaths in custody, the Department should ensure that wherever possible, personnel involved in the critical incident participate in immediate and formal debriefs, so that valuable insights from those officers can be captured and incorporated into any "*lessons learned*" process.

The Department should also ensure that lessons learned reports are disseminated to relevant staff, including those involved in the management and conduct of emergency response skills.

Recommendation No. 10

The Department of Justice (the Department) should consider providing automatic standdown leave for all staff directly involved in a critical incident, including, but not limited to, incidents involving a death in custody. The Department should also take all reasonable steps to ensure that all relevant staff are provided with the "*stress checks and support mechanisms*" referred to in "*EMF-DIR-022 Operational debriefing*".

Recommendation No. 11

The Department of Justice should continue the current regime of quarterly checks by external contractors of fire extinguishers and fire hose reels at Hakea Prison (Hakea), and the ventilation ducts at Hakea should be regularly cleaned to remove dust and/or other materials which may represent a fire hazard.

Recommendation No. 12

The Department of Justice should consider amending relevant policies to make it clear that after a prisoner has been declared life extinct by an authorised person, any restraints on the prisoner at that time, should be removed as soon as reasonably practicable.

Response to recommendations

340. At my request, Mr Stops emailed a draft of my recommendations to Ms Lynch, and Ms Niclair on 2 April 2025. Feedback (if any) was requested no later than the close of business on 5 May 2025.[459]

341. As at the date of publishing this finding, Ms Lynch has not provided any feedback about the proposed recommendations, and I have therefore assumed she is content with their terms.

[459] Email - Mr W Stops to Ms Lynch and Ms N Niclair (02.04.25)

342. By way of an email dated 12 May 2025, Ms Niclair advised that the Department's response to the proposed recommendations I had proposed was as follows:[460]

a. Recommendation 1: the Department advised that Recommendation 1 "*will be supported in principle*", and notes that it has: "*actively advocated for the installation of an automatic fire suppression system at (Hakea) within prisoner accommodation precincts for some time*".

The Department advised that "*Plans are underway to include this action as an emerging priority within the Department's Justice Strategic Asset Plan*", and that significant, external funding "*would be required to fulfill this recommendation*". I am keenly aware that there are significant issues in retrofitting an automatic fire suppression system at Hakea including, as the Department points out:

> [T]he age of the facility, the complexity and extensive modifications required to install a fire suppression system that is fit for purpose without presenting additional ligature risks. In addition, the Department would need to establish alternative sleeping arrangements for prisoners further adding to the complexities with installing such a system.

Nevertheless, despite these significant and obvious difficulties, the grave and obvious risks from fire that prisoners and staff at Hakea continue to be exposed to while prisoners have free access to cigarette lighters, means that the installation of an automatic fire suppression system is an **absolute** priority.

b. Recommendation 2: the Department advised that Recommendation 2 "*will be supported in principle*", and that it:

> [R]emains focused on ensuring a staged, cautious, and considered approach is undertaken for the wider rollout of the smoke-free prisons to ensure the safety and good order of prisons and the Western Australian Community is maintained".

The Department noted that an "*unprecedented prisoner population pressures currently across the adult estate*", and a rise in "*critical incidents*" had meant that the roll out of smoke free prisons to the adult male estate "*was put on hold due to an increased risk to staff and prisoner safety*".

[460] Email - Ms N Niclair to Mr W Stops (12.05.25)

The Department also claims that it cannot expedite the ban on smoking at Hakea until the prison population decreases, the "*environment at Hakea settles*", and safety measures (including body worn cameras for custodial staff) are implemented.

I accept that there are issues with expediting a ban on smoking at Hakea. However, women's prisons in Western Australia have been smoke free since 2024, and Western Australia is the last state in the country where smoking is permitted in male prisons.

After careful consideration, I have concluded that Recommendation 2 is appropriate in its current form. That is because of the grave and obvious risks from fire that prisoners and staff at Hakea continue to be exposed to while prisoners have free access to cigarette lighters.

c. Recommendation 3: the Department advised that Recommendation 3 will be supported:

> [A]s (a) current practice/project on the basis that following the death in custody and subsequent lessons learned review, the Department initiated a jurisdictional scan to determine what policies and/or procedures other jurisdictions have/had in place to better manage prison issued lighters within their correctional facilities (prior to becoming smoke-free).

The Department also advised that it has identified prisoners with arson related offences (or alleged offences), and those with a history of lighting fires in their cells, and "*is in the process of considering appropriate controls to ensure this cohort are appropriately managed*".

d. Recommendation 4: the Department advised that Recommendation 4 was supported, and made a number of suggested amendments, some of which I have adopted. However, I have rejected those suggestions which in my view, unreasonably watered down the effect of the particular recommendation.

For example, I recommended that BA qualified officers conduct monthly don and doff practices with BA equipment, whereas the Department suggested six-monthly practices. With respect, the evidence before me was that in the past, BA qualified officers at Hakea conducted weekly don and doff practices, until the increasing prison muster and staff shortages made this impossible. In my view, to maintain familiarity with the BA equipment, monthly don and doff practices is the minimum that is required.

e. Recommendation 5: the Department advised that Recommendation 5 was supported, but noted that a significant investment was required to:

> [U]ndertake capital works, to accommodate the supporting hardware, including refurbishment and extension of current gatehouses due to inadequate infrastructure/storage capacity and technology constraints.

The Department claims that until funding is provided to support the rollout Tranche 2 (which would include Hakea) "*there are no further actions*" it can take to expediate the roll out of BWCs. Nevertheless, given the grave and obvious risks from fire that prisoners and staff at Hakea continue to be exposed to while prisoners have free access to cigarette lighters, I urge the Department to make concerted efforts to obtain the necessary funding.

f. Recommendation 6: the Department advised that Recommendation 6 was supported, and that it "*continues to advocate for necessary funding to install additional (CCTV) cameras across Hakea Prison and has recently increased CCTV coverage in high-risk areas throughout the site including in the Crisis Care Unit*.

g. Recommendation 7: the Department advised that Recommendation 7 was supported, and that a senior officer training course is currently under development with an expected delivery date of June 2025. The Department suggested minor amendments (which I have adopted) to ensure consistency with departmental policy.

h. Recommendation 8: the Department advised that Recommendation 8 was supported, and noted that Hakea's staff recruitment rate was currently higher than its attrition rate. The Department also outlined the considerable efforts it is making to recruiting and retain custodial staff, and these efforts are to be congratulated.

i. Recommendation 9: the Department advised that Recommendation 9 was supported in principle, but that it was not always possible to ensure that first responding officers were involved in the cold debrief conducted some days after the critical incident.

Whilst I acknowledge that first responding officers may not always be able to attend the cold debrief conducted after a critical incident, in this case, despite her request to attend, Officer Szeremenda (the most senior officer involved in the critical incident in this case) was deliberately excluded from the lessons learned process that followed Sam's death. This was **reprehensible**.

j. Recommendation 10: the Department advised that Recommendation 10 was supported as a current project and that the Department is "*exploring the possibility of implementing critical incident leave with a view to support staff where they have been involved in a critical incident such as a death in custody*".

k. Recommendation 11: the Department advised that Recommendation 11 was supported as a current project. In relation to the cleaning of ventilation ducts at Hakea, th4 Department has obtained a quote for this work and will need to secure funding so that this project can proceed. In the interim some cleaning of the ventilation ducts on the west side of Hakea has been completed.

l. Recommendation 12: the Department advised that Recommendation 12 was supported in principle. The Department intends to consult with the Western Australian Police Force and WorkSafe WA, as well as "internal stakeholders" to ensure that appropriate amendments can be implemented.

343. I am grateful to the Department for considering the recommendations I have proposed, and I acknowledge its comprehensive response and the helpful amendments that were suggested.

CONCLUSION

344. Sam was a much loved family member, who was 27 years of age when he died from the effects of fire at Hakea on 5 March 2024. At the conclusion of the evidence, Sam's mother made a statement to the Court, which included the following comments:

> I'm proud to say that Sam under all the many hurdles and issues he has experienced through his young life, Sam is a loyal and good man to those he feels needs it and deserves it, and that would be all of you in here.[461]

345. In a moving statement that was forwarded to the Court, Sam's older brother explained how much he loved Sam, and said this about the effect on him of Sam's death:

> The day I found out my baby brother was no longer with us was the worst day of my life, and I relive it every day because I was so close to Sam. [S]ince his passing there isn't a day that has gone by that he isn't on my mind. I cherished the ground that boy walked on. Mentally and spiritually, since my little brother's passing I officially know the meaning of what a broken man means and feels like.[462]

346. For the reasons I have explained, I concluded that management of Sam's physical and mental health which he was in custody was appropriate, and the standard of treatment and care he received during his last brief period of incarceration was acceptable.

347. However, on the basis of Hakea's unacceptable level of preparedness to deal with cell fires, I concluded that the standard of supervision that Sam received while he was incarcerated at Hakea was **grossly and manifestly inadequate**.

348. After carefully considering all of the available evidence, I made 12 recommendations aimed at improving the safety of prisoners and staff at Hakea. I **strongly** urge the Department to fully support and embrace all of these recommendations and implement them as soon as possible.

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[461] ts 28.03.25 (Lynch), p513
[462] Exhibit 1, Vol 3, Tab 74, Statement - Mr J Lynch (27.03.25)

349. The death of a loved one is always a sad occasion, but Sam was only 27 years old. The death of such a young man, and in such truly awful circumstances, is almost an unfathomable tragedy. I simply cannot imagine the grief and sadness that Sam's death has caused his family and loved ones.

350. It is a common misconception that at some point after a loved one's death there is "*closure*". Those who have experienced profound loss know this is not the case. The void left by the loved one's death does not get filled, nor do the feelings of grief and sadness disappear.

351. However, with the passage of time, it may be the case that the sense of loss becomes a little easier to bear. Memories of happier times can emerge and these memories may help to deaden the ache. It is my sincere hope that Sam's family may have this experience.

352. In concluding this finding, I wish to convey to all of Sam's family and loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
12 June 2025