Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 9/09

*I, Alastair Neil Hope, State Coroner, having investigated the death of **Ian WARD**, with an Inquest held at Coroners Court, Warburton Court on 10-11 March 2009 and adjourned to Kalgoorlie Court House on 12-20 March 2009 and adjourned to Kalgoorlie Court House on 11-14 May 2009 find that the identity of the deceased person was **Ian WARD** and that death occurred on 27 January 2008 at Kalgoorlie District Hospital, Kalgoorlie, as a result of Heatstroke in the following circumstances -*

Counsel Appearing :

Mrs Felicity Zempilas assisting the State Coroner

Mr Michael Rynne (instructed by Ngaanyatjarra Council) on behalf of the family of the deceased

Ms Lisa Eddy (State Solicitor's Office) on behalf of the Department of Corrective Services and the Commissioner of Police

Mr Jeremy Allanson SC (instructed by Allens Arthur Robinson) on behalf of G4S Custodial Services Pty Ltd

Ms Linda Black (instructed by D J Price & Co) on behalf of Graham Powell

Mr Sam Vandongen (instructed by Noble Lawyers) on behalf of Leanne Jenkins

Mr Curt Hofman appearing on behalf of Nina Stokoe

Mr Lachlan Carter (instructed by Mr Peter Collins Aboriginal Legal Service WA Inc) as an interested party

Mr Brook Hely (Human Rights and Equal Opportunity Commission) as an interested party

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INTRODUCTION

Ian Ward (the deceased) was a 46 year old Aboriginal male who died on 27 January 2008 at Kalgoorlie District Hospital, Kalgoorlie, in Western Australia

At the time of his death the deceased was in custody, having been arrested by police in relation to traffic offences while driving a Toyota Personnel Carrier on Alderstone Street, Laverton, at about 9:30pm on Saturday 26 January 2008.

The following day the deceased was transported by employees of GSL Custodial Services Pty Ltd (GSL) in the back section of a van. The van was a Mazda E2500 vehicle registration number 1APR-049 and the vehicle had been modified to carry prisoners and had two security cells or pods. The deceased had been placed in the rear pod which was of metal construction and contained inward facing steel bench seats on each side.

The deceased was the only prisoner who was transported in that vehicle on that day.

The deceased was transported in the vehicle from Laverton to Kalgoorlie, a distance of approximately 360 kilometres. The deceased was taken on a journey of

approximately 3 hours and 45 minutes on an extremely hot day with the outside temperatures being over 40°C.

At a point during that journey the deceased collapsed and at Kalgoorlie the deceased was taken to the Emergency Department at Kalgoorlie Regional Hospital (the hospital) where it was noted that he had a laceration on his forehead and a large burn on the right side of his abdomen. Evidence at the inquest subsequently revealed that the burn had been caused by contact between the deceased's flesh and the metal steel pod in which he had been held in custody.

At the hospital a doctor who assisted in removing the deceased from the rear of the van, Dr Lucien Lagrange, stated that as he opened the doors to the pod, although external conditions were very hot, the air from the van was "…like a blast from a furnace"[1].

Despite efforts to resuscitate the deceased, he passed away at the hospital.

A subsequent post mortem examination revealed that the deceased had died from heatstroke and it is clear that the deceased died as a result of being held in the rear pod of the vehicle in conditions of grossly excessive heat.

[1] ts 346

This inquest has been held in order to explore the circumstances of the death and, as the deceased was in custody at the time of his death, it has been necessary to comment on the quality of the supervision, treatment and care of the deceased while in custody (section 25 of the *Coroners Act 1996*).

It is clear that the deceased suffered a terrible death while in custody which was wholly unnecessary and avoidable and it has, therefore, been important at the inquest to explore the circumstances in which he came to be in custody as well as how he came to die.

POST MORTEM EXAMINATION EVIDENCE

A post mortem examination was conducted on the body of the deceased by forensic pathologist, Dr G A Cadden, on 30 January 2008 and, following the results of a number of investigations, Dr Cadden concluded on 12 August 2008 that the cause of death was consistent with heatstroke[2].

In evidence Dr Cadden noted that clinical records at the hospital revealed that over a 35 minute period in the hospital four recordings of the deceased's temperature gave readings of 41.7, 41, 41 and 41°C in spite of efforts at

[2] Exhibit 1, Police Report, Annexure 1

cooling and provision of fluids. This was extremely significant as the normal body temperature is 36-37°C.

Dr Cadden stated that at the time of death the deceased's body temperature was likely to have been even higher than the 41.7°C first recorded at the hospital.

Dr Cadden explained that heatstroke is a process by which the body's cooling mechanisms break down because the body can no longer lose heat either by way of conduction, radiation or evaporation. The mechanism of death can be by way of a cardiac arrhythmia or heart failure. In this case there would have been multi-organ failure and the central nervous system would not have been able to function leading to death. There may have been coma or seizure prior to death.

The onset of heatstroke may be gradual or sudden but will usually be characterised by some cognitive impairment (ie confusion or delirium), eventual cessation of sweating and hot, dry skin, tachycardia, hypotension and hyperventilation.

These symptoms may not be readily apparent except by close examination of the person or by attempts to communicate with that person.

While in his initial report Dr Cadden had expressed some reservations in respect of the cause of death, this was because heatstroke does not cause specific identifiable changes which would be visible at autopsy. However, as a result of the further investigations which had been conducted and the lack of any other explanation of the death, such as lack of oxygen within the pod, it appeared clear that the death resulted from heatstroke.

The heatstroke clearly resulted from the hot conditions within the pod and in this case, because there was limited airflow with no windows (although there was air exchange through leaks in the pod), that lack of airflow would have constituted an additional hazard. With limited airflow to take sweat from his body there would have been limited convection so the body's defence of producing sweat would have been less effective.

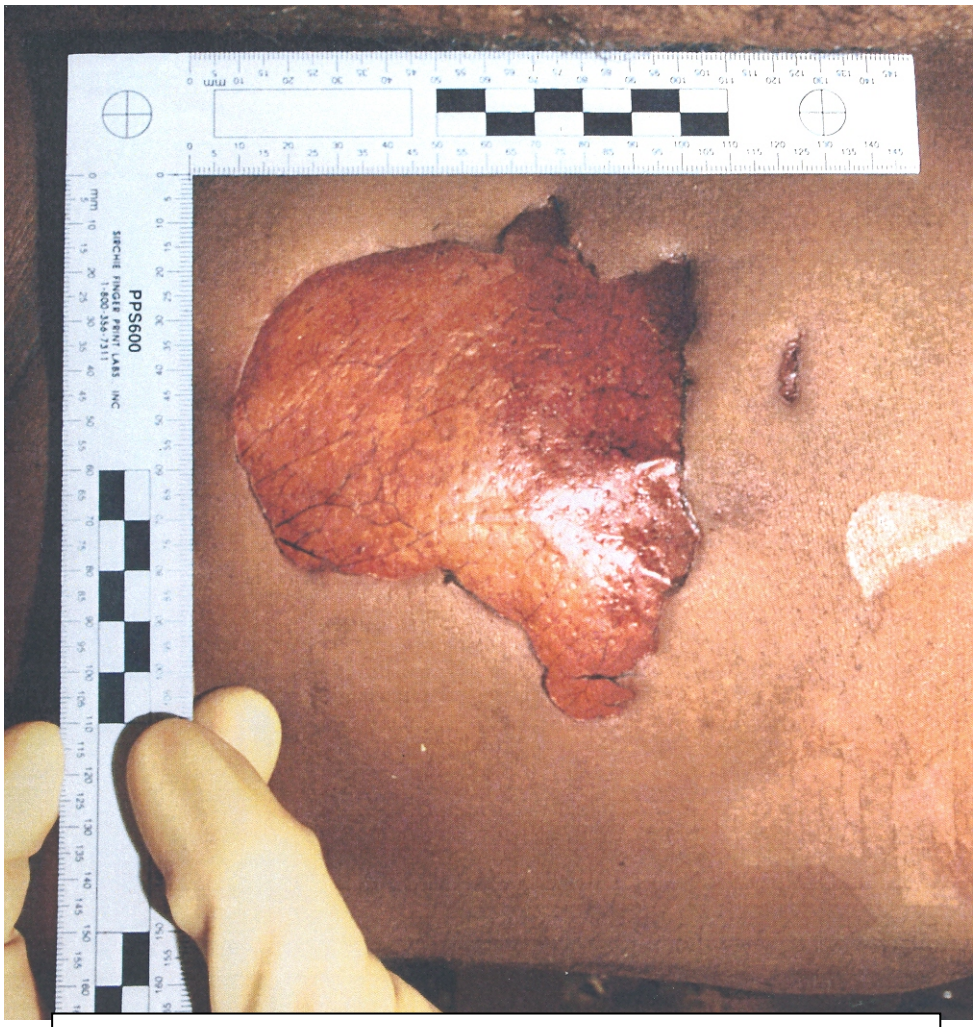
Dr Cadden noted that the deceased otherwise appeared to have been in reasonable health but had suffered a recent laceration in the area of the left eyebrow (this injury had occurred while the deceased was in the pod).[3] The area of laceration was in the order of 20mm in length and 6mm in depth. This was a nasty cut and photographs taken by police showed a certain amount of bleeding from the cut in the rear pod. This was a "collapse-

[3] Photographs of the vehicle pod (Exhibit 15) depict blood which appears to have come from this injury and which was later confirmed as coming from the deceased.

type" injury which may have occurred when the deceased fell from a standing or seated position to the floor of the van.

The deceased's blood was found by police who examined the van on the edge of the metal bench "seat" and it is likely that his head struck that area as he fell.

Of particular significance was large area of burn over the side surface of the abdomen on the right. The area of burn was in the order of 9cm vertically and 6.5cm transversely at its lower aspect and 10cm transversely at its upper aspect. Dr Cadden had discussed the injury with Professor Fiona Wood, Director of the Burns Unit at Royal Perth Hospital, who agreed that the injury was a thermal injury[4] and that the area was in keeping with a contact burn. The



The above photograph taken during the post mortem examination depicts the burn

[4] A burn.

burn was a full thickness burn through the skin and the top layer of skin[5] had been separated off[6].

In relation to the time taken for such a burn to occur, that would depend on the temperature of the surface with which the skin was in contact. The lower the temperature, the longer the time of exposure which would be required. Assuming that the surface temperature was over 50°C, contact would have had to have taken place for at least five minutes although longer exposure time could not be excluded.

The burn would have been painful which suggests that the deceased was unconscious or at least in an altered state of consciousness to have remained still while the hot metal of the pod burned his skin.

Dr Cadden was questioned about the fact that other evidence revealed that the deceased had been given a 600ml bottle of water for the journey which he had not entirely consumed. He commented that as the deceased was becoming distressed as a result of the heat he was experiencing, he normally would have been expected to take any means available to reduce that distress which would have included consuming the water. The fact that water

[5] The epidermis.
[6] Subsequent investigations by police forensic officers identified areas of what appeared to be skin which appeared to have come away as the deceased was removed from the prison van.

was left after the journey may be consistent with the deceased becoming critically ill early in the journey.

Based on the pathology evidence, there is no doubt that the deceased died as a result of being subjected to conditions of grossly excessive heat over an extended period of time.

BACKGROUND OF THE DECEASED

The evidence at the inquest established that the deceased was –

- a central figure in his own family, both for his wife and four sons and for his extended family, he was an excellent provider and a loving and supportive family figure;

- a central figure in his community at Warburton and in the surrounding lands with a unique knowledge of culture, land and art; *and*

- a central figure who played a crucial role in forging relationships between his own community and non-Aboriginal communities in Western Australia, Australia and overseas.

I accept the observation contained in the submissions of Mr Rynne, counsel for the family, that –

> While his loss was and is profound, the realisation of what led to and caused his death – as evidenced during the course of the Coronial Inquiry – has caused substantial despair. Accordingly the family can only conclude that Mr Ward could be here today had it not been for the litany of errors that followed his detention at

Warburton on 26 January 2008 coupled with a refusal by the Department of Corrective Services and its various contractors to deal with and accept that the fleet of vehicles transportation of persons in detention in remote areas was wholly inadequate.

Over a number of years the deceased assisted and worked in outback Western Australia with a variety of scientists, geologists, paleontologists, geophysicists and others associated with geological survey.

Although he was a "culture man" – a man of the Law, the deceased was known for his cross-cultural scientific ideas.

In the mid 1960s the deceased, who was then a child, was filmed with his family by film maker Ian Dunlop leading a traditional lifestyle. The deceased was proud of the films and the life they depicted.

The deceased was involved in Landcare, he looked after water holes, baited foxes, dingoes and wild cats. He was a highly skilled hunter, but also assisted many non-indigenous people to see native wildlife such as bilbies and rock wallabies.

The deceased had been a chairperson in his local community and was chosen to represent the Ngaanyatjarra lands in a delegation to China. He had represented the lands and attended meetings both within Western Australia and in Canberra.

The deceased had worked for many years in a battle to have the rights of his people in the Gibson Desert Nature Reserve recognised.

In addition the deceased was a renowned artist who had skills across many art forms. He was a well known dancer and speaker and created works in glass including the art glass series "The Seven Seals of the Ngaanyatjarra Lands".

The deceased was a traditional owner of the land and he had worked as an interpreter in transactions relating to native title.

The deceased was universally known as one of the leaders of his generation and an example to the younger generation.

When the deceased died, a large funeral was held for him at Warburton which was attended, not only by people from the desert lands, but also by people, particularly Aboriginal people, from all over Australia. One witness described the airport as being filled with aircraft which had been chartered to take people to the funeral. After his death a sorry camp was established, which again was attended by a large number of persons.

There is no doubt that no person should have died in the circumstances in which the deceased died, a captive in the

back of an overheated prison van, but the death was particularly poignant, being the death of such a highly regarded man who had achieved so much during his relatively short life. A man who had worked for many years to bring together Aboriginal people and non-Aboriginal people and to promote cross-cultural interaction.

THE CONDITION OF THE VAN
MAZDA VEHICLE : 1APR-049

The prisoner transporter in which the deceased had been held immediately prior to his death was a Mazda E2500 van which had a four cylinder diesel engine. It had been manufactured in February 2000 and had been subsequently converted by its then owner, Australian Integration Management Services Corporation Pty Ltd (AIMS), to a prisoner transporter by the addition of two security cells or pods.

In 2005 the vehicle had been acquired by the then Department of Justice (which subsequently became the Department of Corrective Services and the Department of the Attorney General) when that department took over ownership of the prisoner transportation fleet.

The rear pod of the vehicle in which the deceased was held was examined by forensic police and multiple photographs were taken of it. The pod was also examined by the court.

In my view any reasonably compassionate person who viewed the prisoner pod in which the deceased was transported would be shocked by its appearance. The photographs taken of the pod do not adequately depict its appearance and make it appear larger, brighter and less unpleasant than it was on inspection by the court.

The above photograph taken by police forensic officers depicts the rear pod of the vehicle (Exhibit 15(23).

In my view it is a disgrace that a prisoner in the 21st century, particularly a prisoner who had not been convicted of any crime, was transported for a long distance in high temperatures in this pod.

What is particularly striking when viewing the rear pod is its small size and almost total enclosure by metal surfaces. There is little natural light and no natural ventilation. The metal bench seats face inwards rather than in the direction of travel and are hard and slippery. There are no restraints to prevent prisoners from sliding about when the vehicle is in motion or if the vehicle is stopped quickly. There is no view to the outside world except through thick mesh and

there is no available method of communication to the front of the vehicle other than by hitting the walls of the pod or shouting out.

The floor of the rear security pod was painted with a non-slip surface which according to scientific expert, David Tranthim-Fryer, was several microns thick. Otherwise the entirety of the pod was metal apart from the closely grilled window at the rear of the pod.

The rear pod had two doors, an inner door and an outer door.

The outer door had steel mesh or grill on the inside and outside of the window and so the only visibility for a prisoner sitting within the pod was an extremely limited view through the grill out of the rear of the vehicle.

The inner door was constructed with thick Perspex which prevented any airflow through the mesh into the pod.

On the internal wall of the pod there was an emergency escape hatch, which was covered by a piece of metal which could only be opened with a key.

Within the pod there were only two small air inlet vents situated at floor level and two outlet vents to the rear. There was no opening window or access to outside air.

A video camera was located within the pod, but did not cover the first 600mm from the rear of both steel bench seats, nearest the rear door.

The booster fan for the air-conditioning in the rear security pod was mounted under the seat in the front security cell and that fan failed to operate when tested. As a result no effective air-conditioning was being supplied to the rear pod of the vehicle.

There was no temperature monitor within the vehicle which would enable security officers sitting in the front cab to monitor the temperature within the prisoner pods.

While there was a CCTV screen situated above the dash at the front of the vehicle for observation of passengers in the front and rear pods, subsequent examination of the vehicle by police forensic officers revealed that the screen worked intermittently while the vehicle was in motion.

While there was a panic button or duress alarm situated within the rear pod, that was not marked or labelled in any way and was virtually useless. Even when the button was pressed, all it achieved was to illuminate a warning light on the upper left of the instrument cluster on the dash of the vehicle and that light, which was itself inadequate, would cease to be illuminated at any time when the button was not pressed.

Police forensic officers who subsequently examined the vehicle and conducted testing on it did not even locate the duress alarm on their first examination of the vehicle and only subsequently learned that the alarm system was fitted. On later examination forensic officer, Senior Constable Derek Pitcher, observed that if the day was sunny persons in the front of the vehicle might not be able to see the warning light even when it was illuminated[7].

There was no provision of any toilet facilities within the pod and according to the various GSL employees who gave evidence at the inquest, in the event that prisoners were able to communicate a need to go to the toilet on long trips, those prisoners were usually handed an empty drink bottle or jerry can to use. The vehicle would only be stopped for a comfort break if there was an available nearby police sally port at a police station where officers were available to assist.

It is difficult to imagine a more uncomfortable environment for travelling over even short distances. In my view the use of this pod for long distance travel was inhumane.

The Mazda vehicle was fitted with two pods, the forward pod in which the deceased had not been placed, was not nearly as barbaric in appearance as the rear pod.

[7] ts 1015

In this pod, situated immediately behind the cabin, there was a padded seat which faced the front of the vehicle and windows which could be opened, although covered by an internal grill. In addition seat belts could be fitted to the seats. In this pod, therefore, prisoners could sit on a relatively normal seat facing the front of the vehicle, could look out of the vehicle and could open the windows.

The deceased was the only prisoner being transported on 27 January 2008. The GSL officers who picked him up were told that he would be "no trouble"[8] and was "very compliant"[9]. In these circumstances an issue arose at the inquest as to why it was necessary for him to be placed in the rear pod of the vehicle. All GSL staff stated that there was an arbitrary and inflexible rule of the company that all male remand prisoners taken from police lockups were to be regarded as being at "high risk" and were placed in the rear pod which as considered to be more "secure".

Although a number of these witnesses were asked why the front pod was not considered to be as secure as the rear pod no adequate explanation for this view was given. It is a disturbing feature of the case that neither the Department of Corrective Services nor GSL appeared to have gone to the trouble of reviewing this arbitrary rule. In my view there

[8] Exhbit 73, Video interview with Nina Stokoe.
[9] Exhibit 81, Video interview with Graham Powell.

was no good reason for the deceased to be placed in the rear pod rather than the front pod.

THE AIR-CONDITIONING AVAILABLE TO THE REAR POD

As the pod in which the deceased was placed for the 3 ¾ hours prior to his arrival at the hospital was constructed of metal and the journey was conducted in conditions of extreme heat, it was obvious that unless adequate air-conditioning was available the interior of the pod would become excessively hot and would be likely to cause extreme discomfort or death. In this context the condition and adequacy of the air-conditioning available to the rear pod was particularly important.

It appears that the Mazda E2500 prisoner transporter vehicles and their air-conditioning systems were never designed to be used in remote locations in conditions of extreme heat.

This fact was known to the owner of the vehicles, the Department of Corrective Services. On 13 September 2001 the then contractor responsible for carrying prisoners using the same vehicles, AIMS, had commissioned a report from Car Air Wholesale Pty Ltd[10] relating to the fleet and that report had identified this fact and made a number of

[10] Exhibit 77 : Statement of Graham Doyle (GD9)

comments namely –

- the vehicle's engine location restricted the mounting of a larger capacity compressor;
- the proximity of the vehicle to the ground was too low which resulted in the vehicle drawing an excessive amount of road heat;
- the prisoner pod and the middle cell were not insulated;
- the passenger compartment, located above the motor, absorbed heat; *and*
- the prisoner pod at the rear had two vents permanently open to ambient air.

The report concluded that the problems were manageable in and around the metropolitan area but in conditions experienced north of the 26 parallel, it was not possible to provide suitable prisoner comfort.

In the context of the identified problems with providing adequate air-conditioning, I interpret this as meaning there was inadequate cooling available for the prisoner pods in hot conditions even with the system working to maximum capacity.

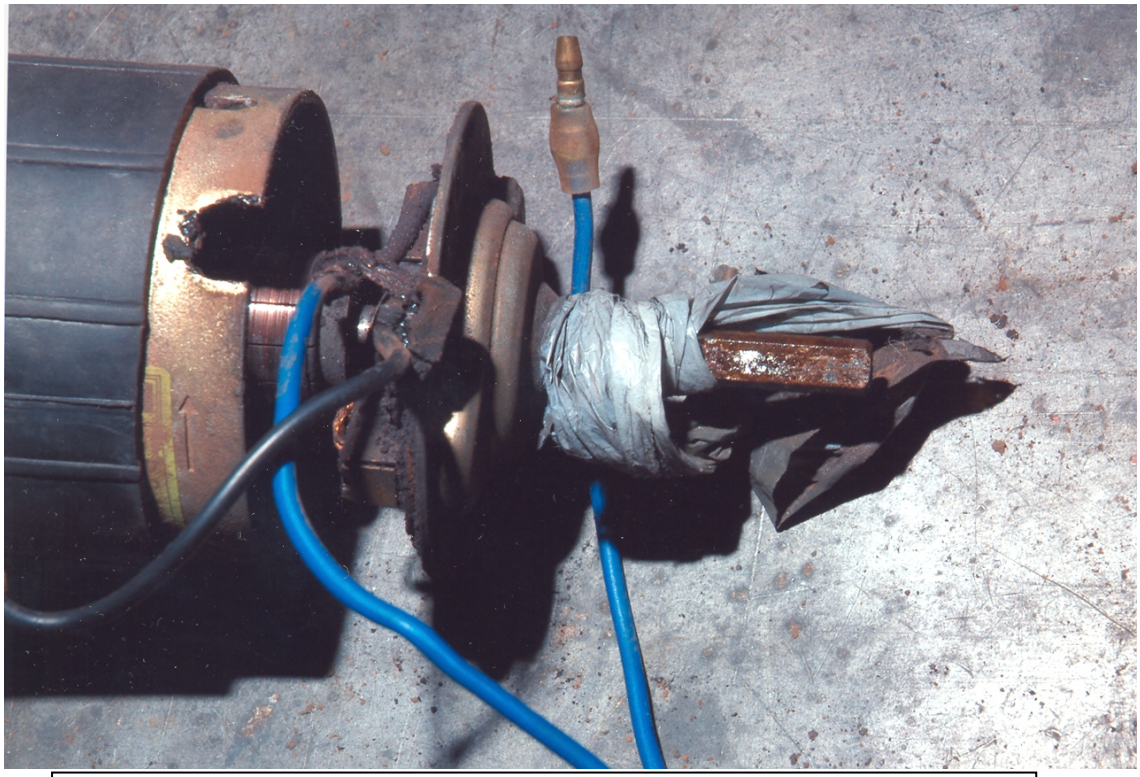
Mr Gavin Lyons of Lyons Airconditioning Services (WA) Pty Ltd gave evidence at the inquest and provided a report[11] in respect of the vehicle in question, Mazda van 1APR-049.

[11] Exhibit 74

Mr Lyons noted that the van had two air-conditioning systems; one for the cabin, which it appears was factory installed, and a second air-conditioning system for the two rear pods, which had been retro fitted.

In respect of the rear pod of the van, that compartment received air-conditioning by way of two flexible ducts which ran from the booster fan located under the seat in the forward pod. In order for air-conditioning to be adequately provided to the rear pod it was necessary for that fan to be operating effectively. That fan did not operate at all.

Mr Lyons found that one of the fan motor shafts had the remains of a plastic bag wrapped around it, the other fan



The above photograph depicts the plastic bag wrapped around the area of the fan motor shaft (Exhibit 75(3)

motor shaft had the remains of string or hair wrapped around it. In addition there was a significant amount of dust and other dirt in the area of the shaft. A combination of the bag, string and dust had compromised the fan motor bearings and the shaft of the bearings was quite worn. Eventually this had resulted in a fuse failing and the fan motor stopping completely.

According to Mr Lyons the process of the fan motor becoming compromised would have taken place over a period of weeks or longer during which time there would have been increased noise and the fan would have been slowing down and producing inadequate cooling prior to the complete failure of the fan.[12]

When the fan failed a very small amount of cool air would have entered the pod, but only to the extent that air was dragged out of roof vents.

In addition Mr Lyons discovered that scotch lock connectors had been used to effectively make the solenoid operate continuously. A scotch lock connector is a device which allows two wires to be connected together. The solenoid controls the flow of refrigerant. A scotch lock had been used to bypass the thermister which measures temperature and would have effectively resulted in the electric thermostat running continuously. Mr Lyons also

[12] ts 668

found that the thermister had been unplugged and the potentiometer, which also is a device used for temperature control, had failed. The effect of the use of the scotch locks was to make the solenoid operate continuously which would eventually lead to freezing of the evaporator, blocking airflow and providing poor performance from the air-conditioner.

In Mr Lyons' view the use of the scotch locks was clearly a bandaid measure and he thought that whoever put the scotch locks in place expected that the vehicle would be returned for further repairs.

Mr Lyons agreed with the conclusion and reasoning of the report provided to AIMS by Mr Robinson of Car Air Wholesale Pty Ltd in 2001 to the effect that the original design of the air-conditioning system in the Mazda was never adequate for use in long trips in conditions of considerable heat.

In Mr Lyons' view, therefore, the air-conditioning system in respect of the rear pod was deficient in that –

- the air-conditioning system for the rear pod was inadequate and was not, and had never been, capable of providing adequate cooling for long trips in high temperatures;

- the use of scotch locks on an earlier maintenance of the vehicle effectively bypassed the temperature control system and would have allowed freezing of the evaporator and blocking of airflow on longer trips; *and*

- over a period of time the booster fan motor bearings had failed resulting in the resister fuse failing and the fan motor not working, without which almost no cool air would have entered the rear pod where the deceased had been detained.

The expert evidence at the inquest, therefore, revealed that the air-conditioning system, even when first installed, would not have provided adequate cooling for the rear pod on trips such as the trip of 27 January 2008. The system had deteriorated over time and for a significant period would have been operating at a substantially reduced capacity. On 27 January 2008 it was not providing any significant amount of cool air to the rear pod.

THE MAINTENANCE OF VEHICLE MAZDA 1APR-049

(a) The Vehicle Generally

The vehicle 1APR-049 in which the deceased was transported immediately before his death was in a disgraceful condition.

The vehicle was owned by the Department of Corrective Services[13] which acquired the fleet in May 2005. Repairs were organised by GSL staff through EasiFleet, who had entered into a contract with the Department of Corrective Services for provision of maintenance.

[13] Then the Department of Justice

It would appear that the vehicle in question had been subject to maintenance on a large number of occasions, but still was in a state of disrepair.

The problem with the vehicle was that it had not been replaced since first put in use in 2000 and, in the context of its usage, was effectively beyond repair.

Leanne Jenkins, GSL supervisor for the Kalgoorlie region who was responsible for supervision of staff who used the vehicle, stated that she had regularly expressed concerns to senior GSL staff about the state of the vehicles provided including the Mazda vans.

According to Ms Jenkins she had attended a GSL supervisor's meeting as an acting supervisor in late 2007 and when the topic of the vehicles being used was raised, she stood up and said; "If these vehicles are not replaced there is going to be an incident and it won't be a good one"[14].

She further stated that by saying this she meant that "…someone will eventually die"[15].

These comments were consistent with the views of other GSL staff, who stated that at regular meetings of the Kalgoorlie GSL staff it was agreed that the vehicles needed

[14] ts 431
[15] ts 432

replacement. Nina Stokoe, for example, stated that at the meetings "everyone" agreed that the vehicles were "crap"[16].

Police officers attached to the Forensic Field Operation Section of WA Police, who conducted a subsequent re-enactment using the vehicle, also described the vehicle as being old and very run down. Senior Constable Pitcher, for example, stated that the vehicle was "horrible" to drive[17], it was seriously underpowered and it was necessary for him to put his foot flat on the accelerator to achieve a speed of 100kph. He stated that he had commented in respect of the odometer, which recorded a distance travelled of about 86,000kms, that it looked as though the vehicle had, "...already gone around the clock and then reached 86,000"[18].

In respect of the odometer it did appear that a new speedometer or odometer had been fitted to the vehicle in 2005 which explained the relatively low number of kilometres recorded.

Senior Constable Pitcher stated that the CCTV view of the rear pod was inadequate and kept turning on and off during the course of travel on the road and that the driver's seat appeared to be broken so that it was necessary to sit on an angle to drive.

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[16] s
[17] ts 1016
[18] ts 1007

The vehicle was extremely dirty and there was a significant amount of rubbish left in the vehicle.

It is clear that 8 years of use was an excessive period for such a vehicle and a number of police officers gave evidence in respect of the replacement policy for police vehicles used for the same purpose which was to the effect that, although the time period or number of kilometres travelled differed from vehicle to vehicle, police would certainly ensure that any of their vehicles used to carry prisoners would be replaced well before a period of 8 years and many vehicles were replaced within 12 to 18 months.

It was the evidence of Ms Jenkins and other GSL staff that the vehicles, including the Mazda vehicles, continuously broke down and were regularly taken to be repaired.

This was confirmed in respect of the particular Mazda vehicle by the evidence of Mr Graham Doyle of the Department of Corrective Services who advised that servicing or repairs had been carried out on the Mazda vehicle 45 times in the two and half year period prior to the death; an average of once every three weeks.[19]

[19] Exhibit 77, (Statement of Mr Doyle) [43]

(b) Repairs to the Air-conditioning System

In respect of the air-conditioning in the Mazda vehicle 1APR-049, that had been reported as not working or not working correctly on a number of occasions prior to the fatal trip; recently on 2 October 2007, 21 December 2007, 31 December 2007 and 2 January 2007. On 31 December 2007, for example, a GSL Vehicle Damage Report was completed by GSL officers which recorded as a fault, "back pod air-conditioner doesn't work". This observation was repeated in the Motor Vehicle Sign Out Report for the same day and on 2 January 2008 officers recorded in another Motor Vehicle Sign Out Report that the air-conditioner in the rear pod was "N/W", which presumably indicated that it was not working.

An issue at the inquest was whether the back pod air-conditioner was working after 31 December 2007 as it appeared that the air-conditioner was not repaired after that date.

The vehicle was taken to repairer Seeley Auto Electrical Pty Ltd on 7 January 2008 for a review of the air-conditioning system but the service details for that date, which claim that the air-conditioning system had been checked, reveal that no repairs were conducted. The total cost for the check conducted on that day was only $23.38 and although the conclusion of the tax invoice in question

recorded "Unable to fault system",[20] it appears clear that the air-conditioning system for the rear pod was not adequately checked on that date.

According to Mr Lyons, an expert in repair of air-conditioning systems, the charge of $23.38 would not pay for a comprehensive review of the air-conditioning system and the invoice does not provide any support for a contention that the rear pod air-conditioning system was adequately checked. While there is a reference in the invoice to "Aircon system cycling between 4 and 11°C", it would appear that this reference must have been to the front air-conditioning system which provided cool air to the driving compartment. In Mr Lyons' view the air-conditioning for the rear pod would not have been capable of providing cool air to that degree unless the vehicle was in a very cool environment.

It is clear from the invoice that the scotch locks were not installed on 7 January 2008 as there is no charge in the invoice made for their installation and the necessary work which would have been involved in that process. In my view the scotch locks must have been put in place during earlier maintenance or repair work.

Had a comprehensive review been conducted of the air-conditioning system, then I have no doubt that the

[20] Exhibit 1, Annexure 25

temporary repairs effected by use of the scotch locks would have been identified and some action taken to remedy the situation.

Unfortunately the person who conducted the review for Seeley Auto Electrical Pty Ltd on 7 January 2008 is now deceased, but in the light of the evidence of Mr Lyons and the objective facts, I have no doubt that the examination, such as it was, did not include any form of comprehensive check of the air-conditioning to the rear pod and so the problems with the rear pod identified on 31 December 2007 remained uncorrected.

In addition it is my view that any competent person presented with an invoice for only $23.38 would have had serious reservations as to whether that any comprehensive examination of the air-conditioning system had been completed for that charge and certainly would have been aware that no repairs had been effected.

It is my view, therefore, that as the air-conditioning system was not working for the rear pod on 31 December 2007 and 2 January 2008 and it was not fixed after those dates, it is likely that it was never working from then until 27 January 2008. It is certain that the air-conditioning system for the rear pod was not working well for a significant time period prior to its failure.

It is a concerning feature of the case that the vehicle was taken to the repairer on 7 January 2008 because air-conditioning for the back pod was noted by several GSL staff to be not working and then, even though no repairs had been effected, it was assumed that the air-conditioning system must have somehow fixed itself on the basis of this inadequate tax invoice. The vehicle should have been taken back to the repairer with a request that it be repaired or some explanation provided as to why it had not been working. The safety and wellbeing of prisoners depended on the air-conditioning system working so this was a matter which should have been followed through.

It was the submission of Mr Allanson SC on behalf of GSL that it should be inferred that the air-conditioning was working after 7 January 2008 because the van was used regularly without recorded incident and on 17 January 2008 was used on a trip to Perth and on 25 January 2008 was used for a trip to Leonora.

The majority of trips for which the Mazda was used between 7 January 2008 and 27 January 2008 were very short so it is perhaps not surprising that no issues were raised about the air-conditioning on those occasions. In respect of the longer trips the evidence about these was limited. What is clear, however, is that the trip to Leonora on 25 January 2008 must have been extremely uncomfortable for the prisoner placed in the rear pod of the

vehicle. The air-conditioning was certainly not working well and the pod must have been very hot on any view of the evidence.

It is a matter of concern that Mazda vehicles were used for 8 years, taking prisoners vast distances in Western Australia in conditions of gross discomfort (even when the limited air-conditioning available was working) and yet there is very little record of the complaints of prisoners about their treatment.

A possible explanation for the apparent lack of recorded complaints over this period may be that GSL staff may not have taken complaints about air-conditioning sufficiently seriously. Such an approach was exemplified in the following exchange from part of Ms Stokoe's video recorded interview with police –

> Have any detainees mentioned to you of late any problems with the air-conditioner?
> No a while ago we had them banging on the side of the door cause there was quite a few of them cause we were taking them out prison and they were bangin sayin "It's stuffy" and they were all havin it was a joke to them but you know they were rocking the bus from side to side sort of seeing having a joke at our expense and we were telling them to shut up [sic].[21]

I do not accept Mr Allanson's submission and do not believe that the air-conditioning to the rear pod was working effectively, if at all, after 7 January 2008.

[21] Exhibit 73 : Video and ts.14

(c) The Absence of a Spare Wheel

Another serious deficiency in the maintenance of this vehicle was the fact that on inspection it was discovered that there was no spare wheel with the vehicle. According to Ms Jenkins the vehicle had been brought to Kalgoorlie from Perth several months earlier without a spare wheel and although efforts had been made to secure a replacement, these had been unsuccessful.

If the vehicle had had a flat tyre on a long trip in summer conditions at a remote location, the absence of a spare wheel could have resulted in the vehicle being stopped for an extended period until assistance could have been provided which could have placed any prisoners at considerable risk. The fact that the vehicle was used on long trips without a spare wheel demonstrated a reckless approach to prisoner safety on the part of all concerned.

(d) The CCTV

In respect of the CCTV which was described by Senior Constable Pitcher and David Tranthim-Fryer as providing a poor picture and only working intermittently during their use of the vehicle during the subsequent re-enactment, it appears that on a number of occasions in the months preceding the death GSL staff had identified problems with the CCTV.

These problems continued and it appears that the system was not repaired up until the day of the death when Ms Stokoe recorded that the "cameras" were "not good" in the Motor Vehicle Sign Out Report document for 27 January 2008[22].

The continued use of the vehicle when the only means of monitoring prisoners in the rear pod, the CCTV, was experiencing regular problems also demonstrates a lack of appropriate concern for prisoner safety.

TEMPERATURES INSIDE THE VEHICLE

On 12 March 2008 an attempted re-enactment was conducted using the vehicle 1APR-049. This involved driving the vehicle on essentially the same journey in slightly cooler weather conditions.

Members from the Perth Chemistry Centre placed instruments into the rear compartment of the van prior to leaving Kalgoorlie for measurement of inside surface temperatures, air temperatures, gas analysis and tracer gas analysis[23].

Of particular significance, on reaching the Kalgoorlie Police Station, the air temperature within the rear pod of the van was over 50°C.

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[22] Exhibit 2, Annexure 22

[23] To determine air changes within the compartment.

The maximum outside temperatures on the re-enactment day were 38.5, 40.8 and 39.7°C at Kalgoorlie, Leonora and Laverton respectively, while on 27 January 2008 these were 42.9, 42.2 and 41.3°C respectively. It is noted that the hottest time of the day at each location was after 1pm until 6pm where the temperature was still 41°C at Kalgoorlie. The time of the deceased's arrival at the hospital, therefore, was during the hottest period of the day.

In addition the testing revealed that surface temperatures within the pod, while these varied, were as high as over 56°C on arrival at the hospital.

It is my view that the air-conditioning in the rear of the van was not working throughout the entirety of the return trip to Kalgoorlie and probably for the entire journey and that these temperatures are a reasonable reflection of the temperatures experienced by the deceased on the day of his death. The temperatures would explain his death by way of heatstroke and the large burn to the area of his abdomen.

The high temperatures over an extended period experienced during the course of this re-enactment would also explain how it was that the deceased's core temperature was over 41°C on his arrival at the hospital.

Dr Matthew Allen, who treated the deceased on his arrival at the Hospital, gave evidence to the effect that the deceased must have been experiencing excessive temperatures for a period of a number of hours, probably at least over three hours, for his temperature to reach the recorded temperature of 41.7°C. He explained that with a healthy person, such as the deceased prior to the trip, there are various mechanisms which the body has in place to protect itself and these are self-regulating (hypothalamus). It is only after these protections have been broken down by excessive heat over a period of time that the core temperature will commence to rise and this will take place gradually. Dr Allen anticipated that after the period when the body's self-regulating process had broken down, the body of the deceased would have become hotter at approximately 1.1°C per hour.

As the deceased came from the Warburton area and would have had experience with hot conditions, it is clear that his body's ability to protect him would have been relatively good and so he must have endured a substantial period of great heat prior to his suffering multiple organ failure, which ultimately resulted in his death.

Mr Tranthim-Fryer, in his evidence, stated that the temperatures experienced by the deceased could have been expected to be higher than those recorded by the instruments during the re-enactment as the pod was empty

for the purposes of the re-enactment and the presence of the deceased would have provided a further source of heat and a slight increase in temperature.

Mr Tranthim-Fryer stated that there was some air exchange in the vehicle and that the gas levels were not concerning. The relatively significant air exchange could have resulted from leakage into the pod from a number of sources, particularly the escape hatch which although bolted over, was described by another witness as not fitting securely.

On viewing the pod it is surprising that the recorded temperatures in the vehicle were not even higher and that there was any air exchange. The fact that air was able to enter the pod through a number of leaks may explain why there were not prior deaths through usage of the same pod.

Mr Tranthim-Fryer further explained that the lack of windows preventing light and heat from entering the pod would have been a contributing factor to the temperatures not being higher.

In summary, while the pod reached great temperatures, sufficient to burn the skin of the deceased and to cause his death, the pod did not reach the temperatures which an objective observer might have expected, in part because of the disrepair of the vehicle

which enabled a surprising amount of air exchange to take place. It is also noted that the pod reached those temperatures over a period of hours rather than quickly, as might have been expected, again because of the extent of air exchange in the pod and the lack of windows.

THE ARREST AND REFUSAL OF BAIL

The deceased had travelled from his home in Warburton to another community and was returning by way of Laverton. On Saturday 26 January 2008 he had consumed alcohol, something he was not normally able to do in Warburton which was and is a dry community.

At about 9:30pm he was driving a community vehicle on a dirt track towards the Wangatha Wonganarra Village on the outskirts of Laverton. Unfortunately in order to travel to the village it was necessary for the deceased to travel a short distance on a public road, Alderstone Street.

On the police version of events the deceased was stopped approximately 100 metres from the dirt track along Alderstone Road where he was travelling relatively slowly[24].

Police officers, Constable George Kopsen and Senior Constable Steven Sliskovic, who were on duty at the time,

[24] This version of events is inconsistent with an account given by witness Adrian Argent in a statement, part of exhibit "105" which was provided late in the inquest but is based on the accounts of other witnesses including the police officers involved.

stopped the vehicle which the deceased was driving in order to conduct a random breath test. They saw nothing untoward about the deceased's driving.

In order to travel to the Wonganarra Village it would have been necessary for the deceased to travel a further short distance along Alderstone Street and then to cross the slightly busier Beria Road. There was no suggestion that there were any pedestrians in the area at the time and the streets in question are on the outskirts of the small town of Laverton.

The police officers asked the deceased to undergo a preliminary breath test and he complied with that request. The preliminary test resulted in a positive reading.

The deceased was then taken back to the Laverton Police Station where a breath analysis test was conducted. The sample of breath gave a breath alcohol reading of 0.231% which was calculated back to 0.222% at the time of the occurrence.

The deceased was then advised that he was under arrest for driving under the influence of alcohol and that he had the right to be examined by a medical practitioner nominated by him, if available, and the right to contact a legal representative of his choice or any other person of his choice.

At that point the deceased replied, "I just want to have a sleep".

The deceased was then placed in the lockup for the night.

At about 10:10pm, immediately after the breath test had been conducted, Sergeant Martin Timmers of the Laverton Police Station signed a Form 5, a bail record form, refusing his bail (Section 26(4)(b) of the *Bail Act 1982*).

The reasons given in the bail record form for refusing bail were –

- if the accused is not kept in custody, he/she may fail to appear in Court in accordance with his/her bail undertaking; *and*
- if the accused is not kept in custody, he/she may commit an offence.

At that stage the deceased had been charged with two offences, namely driving under the influence of alcohol and driving contrary to conditions of an extraordinary licence.

Sergeant Timmers, according to a statement provided to the inquest, made the decision to refuse bail based on three reasons –

- the deceased's prior record in relation to breaches of the Bail Act (six recorded, the most recent being approximately six years earlier);

- the deceased was currently subject to a suspended sentence issued by the Kalgoorlie Magistrates Court on 12 July 2007 in respect of driving without a licence; *and*

- the deceased's prior history of driving offences.

At about 10:15pm Sergeant Timmers contacted Ms Jenkins, the GSL Supervisor in Kalgoorlie, to advise her of the deceased's arrest and to arrange for the deceased to be transported from Laverton to Kalgoorlie the following morning. Ms Jenkins then advised GSL staff, Ms Stokoe and Mr Graham Powell, to conduct the escort early on the next morning.

In evidence Sergeant Timmers stated that in deciding the question of bail he took into account a number of factors including the very high reading obtained from the deceased on the breathalyser.

He also stated that in respect of breaches of bail, he took into account a "…breach of bail which was not preferred before the Magistrate's Court on 9 June 2007[25]". When questioned by counsel for the family, Mr Rynne, Sergeant Timmers explained that he had been a witness in respect of a charge to which the deceased had pleaded not guilty and

[25] ts 55

was to go to trial on 17 May 2007. On that occasion Sergeant Timmers had attended, but the deceased did not turn up, then on 9 June 2007 the deceased attended the Warburton Magistrates Court in respect of the original offence, but on that date no charge in respect of the breach of bail was preferred[26].

It was suggested to Sergeant Timmers that the fact that the deceased had not been charged suggested that he had a good reason for breaching his bail to which Sergeant Timmers responded, "I don't know. I would only be assuming[27]".

This was an inappropriate matter to take into account when deciding whether or not the deceased should be refused bail. Clearly the deceased may well have had a good explanation for any non-attendance at court on 17 May 2007, assuming that he had been summonsed to attend on that day. In taking this matter into account it appears that Sergeant Timmers was not acting objectively and was treating as a prior conviction an incident which, on any objective review of the situation, could not be classed as a prior conviction.

Sergeant Timmers did not provide the deceased with the prescribed information in writing required by section 8(1) of the *Bail Act*.

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[26] ts 70
[27] ts 70

On the morning of 27 January 2008 GSL staff Ms Stokoe and Mr Powell attended for work at the Kalgoorlie GSL office before 7am and shortly after 7am commenced to travel in Mazda van 1APR-049 towards Leonora.

At approximately 10:14am a resident Justice of the Peace (JP), Barrye Thompson, attended at the Laverton Police Station.

Prior to his attendance Mr Thompson had received a telephone call from a police officer at about 9am, at which time he had been told that a person was in custody who was then asleep in the cells. Mr Thompson was advised that the person had recently had his licence taken away for a drink driving offence and had been apprehended for a similar offence. Mr Thompson had also been told over the telephone that a GSL van was not far away, available to take the prisoner to Kalgoorlie.

Regulation 8 of the *Magistrates Court Regulations 2005* provided that a JP "must not" constitute a country court unless requested to do so by a Deputy Registrar who has been directed by a magistrate or a Registrar to make the request. This provision was not complied with. The police officer who requested Mr Thompson to convene the court was not a Deputy Registrar.

The only Deputy Registrar at the Laverton Police Station was Senior Sergeant Shaun Denness, the Officer in Charge. Sergeant Denness did not ask Mr Thompson to constitute the court.

Sergeant Denness had been appointed a Deputy Registrar as and from 9 July 2007 by the Principal Registrar of the Magistrates Court of Western Australia and had been advised of that fact by letter dated 21 August 2007. That letter attached a summary of the powers of a Deputy Registrar and a copy of the *Magistrates Court Regulations 2005*.

Sergeant Denness stated that he was never officially told that he had been appointed as a Deputy Registrar. When shown his letter of appointment, he claimed that it would have just been filed by a clerical officer and that he may not have ever read it. He had no appreciation of the limits of his powers as a Deputy Registrar and it had never crossed his mind to read the regulations which specifically dealt with the powers of a Deputy Registrar.

When Mr Thompson arrived at the Laverton Police Station he was presented with a charge sheet by Senior Constable Mark Chamings who gave him a verbal outline of the detainee's charges and history[28]. This took place in the absence of the deceased.

[28] Statement of Barrye Thompson para 11

According to Mr Thompson, he then went to the cell where the prisoner was housed and the door was opened. The deceased was woken up but was still half asleep and according to Mr Thompson appeared "heavily affected by alcohol".

According to Mr Thompson he conducted a court hearing at the cell door during which he asked the deceased to identify himself which he did. According to Mr Thompson, this process was difficult due to "his apparent level of intoxication". Mr Thompson then explained to the deceased that he was going to be remanded in custody to reappear in the Kalgoorlie Magistrates Court on 28 January 2008.

Mr Thompson made no written record of his reasons for the decision to refuse bail and, according to his statement, his decision to remand the deceased in custody was based on a number of reasons, including that the nature of the offences was such that they were beyond his ability to deal with as a lone justice of the peace and because he knew that a GSL van was in the area and the next Magistrates Court was at least one month away.

In respect of this last point it appears that Mr Thompson was in error. Sergeant Denness gave evidence that the Magistrates Court sat at Laverton on the

first Tuesday of every month and so the next court was only about one week away on 5 February 2008.

In evidence Mr Thompson stated that he did not appreciate that he was required to consider the question of bail at all. He said that he understood that his function was limited to ensuring that the charges were not "trivial" and if they were not, to signing the remand warrant. He also said that unless the defendant specifically asked for bail he believed that he did not have to decide whether bail should be given.

This approach was contrary to the provisions of section 7(1) of the Bail Act, which required him to consider the deceased's case for bail, whether or not an application for bail was made.

He made no notes of any information provided to him by police and knew nothing about the deceased apart from the fact that he came from Warburton. He knew "nothing" about the deceased's ties with Warburton. He made no enquiries as to whether the deceased was likely to abscond if given bail.

Mr Thompson did not supply the deceased with prescribed information about bail as required by section 8(1) and (2) of the Act.

Mr Thompson did not comply with section 26 of the Bail Act which requires a record to be kept of the reasons for refusing bail.

Although he said that he was not given a copy of the deceased's prior convictions, he understood that the deceased was subject to a suspended sentence of imprisonment. He believed that the deceased had been apprehended on the same night for another drink driving offence, although if he had been told that this was an earlier offence, he said that would have made no difference to him as he did not consider the question of bail at all.

According to Mr Thompson; "Sunday court sittings in Laverton are quite normal and occur on occasions"[29]. Mr Thompson could see no issue with the fact that the court sitting was on a Sunday.

Subsequently, after the GSL staff had arrived at Laverton to take the deceased to Kalgoorlie, it was ascertained that the Magistrates Court would not be sitting on 28 January 2008, which was a public holiday, and Senior Constable Chamings contacted Mr Thompson by telephone who agreed that the date on the remand warrant should be amended to read 29 January 2008. The remand warrant was subsequently amended to record that decision.

[29] Statement of Barrye Thompson at para 21

The *Magistrates Court Regulations 2005* which were applicable, specifically limited the circumstances in which a JP could constitute a court.

Regulation 8(1) of the Regulations provided as follows –

> A JP must not constitute a country court, either alone or with another JP, unless he or she has been requested to so by –
>
> (a) a Registrar; or
> (b) a Deputy Registrar who has been directed by a magistrate or a Registrar to make the request.

In this case the JP had not been requested to constitute a court by a Registrar and no Deputy Registrar had been directed by a magistrate or Registrar to make the request.

The Kalgoorlie Magistrate, Magistrate S Sharrett, had made the following written direction in a document titled Instrument of Delegation –

- Registrars and Deputy Registrars located within the Kalgoorlie Magisterial District have the delegated authority to constitute a court between the hours of 9.00am to 4.00pm Mondays to Friday and 10.am to 1.00pm on Saturdays.
- No Courts to sit on Sundays.[30]

Laverton was and is within the Kalgoorlie Magisterial District.

[30] Exhibit 1 – Part of Annexure 25

As the JP purported to deal with the issue of bail and remand the deceased on a Sunday, that was clearly not consistent with the magistrate's direction.

There was, therefore, not only no request by the magistrate to constitute a court, but the magistrate had made it very clear that no courts were to sit on Sundays.

The Instrument of Delegation document had been sent by the Kalgoorlie Court by facsimile transmission to the Laverton Police Station on 20 May 2005 and this was recorded on a transmission notification report.

As noted above the Deputy Registrar for the Laverton Court was Sergeant Denness. He stated that he had no knowledge of the magistrate's direction that the court was not to sit on Sundays. Sergeant Denness stated that he had never read the Instrument of Delegation and assumed that it had been placed in a file and had been overlooked by him when he later reviewed the file. He said that the previous Officer in Charge of Laverton Police Station had left before he commenced in that position and so there had not been a direct handover which could explain his ignorance of the direction.

Sergeant Denness further stated that he had received no training in the role of a Deputy Registrar.

In the above context a question arises as to whether or not the deceased was lawfully in custody at the time of his death. The original order in respect of his custody by Sergeant Timmers made on 26 January 2008 had been to attend the Laverton Magistrates Court on Sunday 27 January 2008 at 8:45am. While that order could be taken to have extended to 10:15am when Mr Thompson arrived at the police station it is doubtful that the order could be extended to apply to a remand to the Kalgoorlie Court until 10am on 29 January 2008 and enable the transportation by GSL of the deceased in custody from Laverton to Kalgoorlie.

For the purpose of these reasons it is not necessary for me to determine that legal question.

It was the evidence of both GSL staff and police that a prisoner could only be transported by GSL staff if there was a remand warrant requiring the transportation signed by a JP. GSL was not permitted to transport prisoners from police lockups to Kalgoorlie Court on the basis of an order of a police officer. If the legislation had been complied with the deceased would not have been transported by GSL staff on 27 January 2008 and other arrangements would have had to have been made; he would not have died when he did.

The whole procedure adopted in this case in respect of the proceedings before the JP was concerning.

In addition it is noted that arrangements had already been made for GSL staff to transport the deceased prior to the bail hearing commencing.

While witnesses suggested that if the JP had decided to grant bail, police could have contacted the GSL Supervisor in Kalgoorlie who in turn may have been able to contact the staff on the road using a satellite telephone, it would appear to have been taken for granted that the deceased would not be granted bail.

The way in which the bail proceedings wre conducted is also very concerning. It would appear that the JP had received a considerable amount of information about the matter in the absence of the deceased; first during the course of telephone conversation when arrangements were made for him to attend the Laverton Police Station and later after he arrived during an oral briefing by Senior Constable Chamings prior to their attendance on the deceased.

The deceased, therefore, was not in any position to refute any arguments put forward or to challenge any of the statement of facts or other comments made in his absence by police to the JP. The fact that the final proceedings, such as they were, took place at the door of the lockup is likely to have contributed to a perception that police were effectively running the proceedings.

Mr Thompson said that he was given no information by police as to the deceased's employment, work commitments and family commitments in Warburton. He said, "I knew nothing about the gentleman".[31]

It is clear that Mr Thompson had a very poor understanding of his role and responsibilities as a JP, particularly in respect of considerations of bail. He said, "[my] role was to assess whether the charges were of a frivolous nature".[32] While the evidence revealed that the Department of the Attorney General does provide training for JPs, Mr Thompson had been exempted from having to complete that training, apparently because of the lack of availability of JPs in Laverton and the fact that he was busy.

Mr Thompson had been provided with a manual or handbook, of which he had only read part. He did not have direct access to the relevant legislation but would have relied on police to provide access to copies of Acts at the police station[33].

THE GSL OFFICE AT KALGOORLIE

The Supervisor of the GSL office at Kalgoorlie had been Ms Jenkins since December 2006, initially in an acting capacity and then permanently from mid 2007. She had

[31] ts 1073
[32] ts 1073
[33] ts 1081

started her employment with AIMS in June 2005. She had been provided some training, but had received limited "management" training for her role as supervisor.

There were about ten GSL staff employed in Kalgoorlie for court security and prisoner transport duties. Some of the staff worked on a casual basis, others were on a permanent/flexi basis. Even the permanent officers were only guaranteed a limited number of hours. For all of these GSL employees there was a financial incentive to work additional hours, particularly on weekends and public holidays. For working on a Sunday they were paid double time.

As Ms Stokoe explained in her evidence, on 27 January 2008 when she and Mr Powell were asked to transport the deceased, if they had not taken the vehicle out, the Supervisor would have arranged for two other GSL employees to take the vehicle out. She was a casual employee who would be paid double time for the trip and she had never "knocked back" any jobs offered to her as she believed that if she did so she might not get any further work.

The GSL staff came from a wide variety of backgrounds and some had no prior security or custodial experience. All of the staff who gave evidence had received some training when they commenced which they described as mostly

involving reading materials and subsequently being tested on what they had read. Little explanation was provided unless it was specifically requested. The only practical training which they received was in the use of restraints and the use of force. Some employees[34] had received training in 2001 but no refresher courses since then. Most had learned the practical aspects of the job by observing others.

The result was a wide variance in practice between the officers in performing their everyday duties. This variance was evident when the employees described how they undertook vehicle checks and the practical transportation of prisoners. It was, for example, the evidence of Mr Norman and Ms Stokoe that it was never their practice to check the functioning of the air-conditioner prior to a trip of any length, whereas Ms Collins, Mr Akatsa, Ms Sugars, Mr Prempeh and Mr Powell all said that it was their practice to do this, although Mr Powell said that it may not have been done on every occasion.

Mr Akatsa stated that he had worked with Ms Stokoe and mentored her when she started with GSL and he could recall her at that time checking the air-conditioning during vehicle checks. Mr Powell also claimed he had seen Ms Stokoe check the air-conditioning. Her practice, therefore, may have been irregular in that regard.

[34] For example Mr Powell

As to welfare checks on the trips from Kalgoorlie to Laverton and return, Mr Norman, Ms Collins and Mr Akatsa all said that they would stop at Leonora and Menzies on a trip to or from Laverton to do a physical check on the prisoner and offer food or drink or a toilet break if possible. Ms Sugars said that she would always stop at least at Leonora to do that, and sometimes stopped more often.

Mr Powell said that usually he would stop at least once on the trip to or from Laverton to refuel or to purchase food or drink, but such stops would usually be dictated by the needs of the GSL staff rather than initiated for the benefit of any prisoners.

Ms Stokoe stated that she had stopped on the Laverton to Kalgoorlie trip at Leonora 98% of the time[35], but that on "a couple"[36] of occasions she had not stopped. She claimed that the non-stop trips had occurred on one occasion when she was with Mr Akatsa and one occasion when she was with Mr Powell (other than the occasion when the deceased was transported).

These explanations as to what actually took place were inconsistent with Ms Jenkins' evidence of instructions which she claimed that she had given to staff orally either informally or at meetings. She gave evidence that she had instructed staff to do the following –

[35] ts 459
[36] ts 460

- stop at least twice on a trip to or from Laverton to do welfare checks, whether petrol was needed or not;
- contact her from those stops to advise of their location and welfare of any prisoners;
- change drivers every two hours; *and*
- check the air-conditioning prior to starting a journey to ensure that it was working and not to leave on any trip if the air-conditioner was not working.

A number of staff recalled being given some of these instructions by Ms Jenkins although it was clear that any instructions which were given were not written or provided in a formal manner. Most staff claimed that they checked the air-conditioning and made regular welfare checks of prisoners on long trips both because they had been told to do so and of their own volition, as a matter of commonsense.

Ms Stokoe, however, claimed that she did not recall being given any instructions by Ms Jenkins. Her evidence as to meetings between Ms Jenkins and staff was also inconsistent with the evidence of the other witnesses who attended those meetings. She said these were not "proper meetings" but were occasions on which Ms Jenkins just "yelled" at staff or "would go off her narna" about things[37] and in particular criticised staff for not doing paperwork properly. According to Ms Stokoe the vehicles were never

[37] ts 509

discussed at these meetings although "... everyone agreed that the vehicles were crap"[38].

Other staff, however, where generally of the view that the meetings were constructive and that Ms Jenkins raised practical issues with them. Mr Powell, for example, stated that the meetings with Ms Jenkins were "helpful" and that while at a couple of meetings people got their "feathers ruffled" she had never "yelled" at him although he had heard of her yelling at other people[39]. According to Mr Powell the condition of the vehicles was often mentioned at these meetings when "every staff member" commented on their unreliability. It was at these meetings that the poor standard of vehicles supplied for prisoner transport was regularly discussed[40].

According to Mr Powell every staff member mentioned the unreliability of the vehicles, both the Mazda and the Rodeo, and when asked why he raised the issue his evidence was –

> Okay. Why did you raise it? What did you hope would be achieved by raising it? - Well, I would have thought after eight years that the government may have decided to actually upgrade the fleet and provide a new vehicle so that it would be safe for people to travel in it.[41]

[38] ts .507
[39] ts 808; 810
[40] ts 808
[41] ts 808

KNOWLEDGE BY GSL STAFF OF THE PROBLEMS WITH THE VEHICLES USED FOR PRISONER TRANSPORTATION

All of the staff at GSL Kalgoorlie who gave evidence were aware of ongoing problems with the vehicles supplied to them for prisoner transportation. Since the commencement of the contract with AIMS there had been a Holden Rodeo Utility and a Mazda vehicle at Kalgoorlie. At the time of the deceased's death, the Holden Rodeo Utility was the same vehicle that had been there since the commencement of the contract and the odometer recorded 327,927kms. The Rodeo Utility comprised a two door space cab with a security cell to the rear.

The Mazda vehicle 1APR-049 had arrived in Kalgoorlie in October or November 2007 but was of an identical type to that used previously. That vehicle had only 85,854kms on the odometer, although this was not the true distance travelled in that van. According to Mr Powell the speedometer or odometer had been replaced on an earlier occasion when the Mazda vehicle was in Kalgoorlie.

Both vehicles were old, well worn and barely serviceable. On 27 January 2008, the Holden Rodeo vehicle was not available for use as it was being repaired.

Often one of the vehicles would be out of service, leaving staff with only one vehicle to use. When the vehicles were

replaced, it was always with another old, well worn vehicle, never with a new one.

The Holden Rodeo vehicle was considered more suitable for long distance trips because it had a refrigerator, there were remote temperature sensors in the rear and there was direct communication with the back pod as well as CCTV. Frequently, however, the Mazda vehicle was used for long trips because the Holden Rodeo was out of service.

In this context Ms Jenkins stated –

> For the distance we do and the amount of trips we do, neither vehicle is suitable, but I can only work with what I've got.[42]

THE INVOLVEMENT OF NINA STOKOE AND GRAHAM POWELL – THE TRIP OF 27 JANUARY 2008

Both Ms Stokoe and Mr Powell were contacted by telephone by Ms Jenkins late on the evening of 26 January 2008 and asked to transport a prisoner from Laverton to Kalgoorlie on the following day. Both persons accepted the job. They were to be paid at double time for working on a Sunday.

Mr Powell had been an insurance assessor for motor vehicles for 25 years. Of the two, Mr Powell was far more experienced as a custodial officer as he had worked for

[42] ts 438

either AIMS or GSL since 2001 and had been a supervisor for a period of time in 2003-4.

While working for AIMS Mr Powell's employment had been terminated on 8 February 2007 as a result of perceived breaches of procedures and his responsibilities as a supervisor. These alleged breaches mainly related to security issues.

Mr Powell had appealed the decision to terminate his employment to the Australian Industrial Relations Commission, following which AIMS had reinstated his employment on a permanent flexi-time basis from 2 July 2007 but he was not re-instated as a supervisor.

The disciplinary proceedings had been based on a number of complaints relating to Mr Powell's performance of his duties made by other AIMS staff including Ms Jenkins.

Ms Stokoe had worked for GSL since April 2007. This was the first occasion on which she had worked as a custodial officer. She had previously worked as an industrial paramedic on a mine site and had some training qualifications to perform that role.

Ms Stokoe arrived first at the GSL office in Kalgoorlie at about 6:50am and she collected paperwork which consisted of the fuel management record, prisoner

movement log and vehicle check list. She then went to the vehicle and commenced to fill out the Motor Vehicle Sign Out Report form[43]. This was a GSL document designed to ensure that each vehicle was checked prior to use. Mr Powell arrived at about 6:55am and assisted with the vehicle check.

On the Motor Vehicle Sign Out Report form Ms Stokoe noted that there was no spare wheel and that the view from the cameras to the rear pod was "not good" (this is a reference to the CCTV system).

There was no place on the form to record whether the air-conditioning was working or not and it was the evidence of Ms Stokoe and Mr Powell that they did not check to ensure that the air-conditioning to the rear pod was functioning.

According to Ms Stokoe the cameras had not worked properly for some time and this was something that the supervisor knew about. She also stated that the supervisor knew that there was no spare tyre.

According to Ms Stokoe she had little idea as to how she should check the air-conditioning, she never did check the air-conditioning and she had never seen any other

[43] Exhibit 1, Annexure 22

officer check the air-conditioning in the rear of the vehicle. She said that she had never been told to check the air-conditioning before leaving on a journey.[44]

According to Mr Powell he could not recall ever having been told that they must check the air-conditioning. He stated that he had seen Ms Stokoe check the air-conditioning previously on more than one occasion[45] and he said that all that had to be done to check the air-conditioning was to feel for the air coming through. He stated that checking the air-conditioning was a practice that he had adopted and carried out on "just about every occasion" unless the vehicle was only being taken for repairs or for some other purpose unconnected with prisoner transportation.[46]

According to Mr Powell he did not know whether Ms Stokoe checked the air-conditioning on this occasion and he assumed that she had checked that it was working while he checked the oil and water to the vehicle.

It was of vital importance for the safety of the deceased that the air-conditioning for the rear pod was working. This was not a matter about which assumptions should have been made. Mr Powell should have, at the very least,

[44] ts 471
[45] ts. 821
[46] ts 821

questioned Ms Stokoe to make sure that she had checked the air-conditioner and it was working.

It is possible that Mr Powell and Ms Stokoe had never been formally instructed that they must check the air-conditioning to prisoner pods at the start of each journey. Ms Jenkins, although she claimed that all staff would have been aware that this should be done, conceded that there had never been a "straightforward instruction" to that effect.

As a matter of common sense, however, it should have been abundantly clear that on a hot day prior to transporting a prisoner in a pod without windows it was of fundamental importance to check that the air-conditioning was working.

Ms Stokoe stated in respect of her knowledge that there was no spare tyre, that while she appreciated that it was unsafe to proceed on the trip without one, she had been told by Ms Jenkins to take the vehicle and said –

> If we did not take the vehicle out the Supervisor would have got two other people to take that vehicle out. Someone would have taken that vehicle out that day[47].

The GSL officers departed from Kalgoorlie shortly after 7am with Mr Powell driving and drove to Leonora where they stopped to obtain fuel for the vehicle. A receipt for the fuel indicates that they refuelled at 9:55am and they

[47] ts 827

apparently stayed in Leonora for approximately twenty minutes in order to go to the toilet and purchase food and drinks at a service station across the road.

Neither GSL officer contacted Ms Jenkins from Leonora when they stopped and they first contacted her on their departure from Laverton. They arrived in Laverton at approximately 11:20am. Ms Stokoe drove from Leonora to Laverton.

On arrival at the Laverton Police Station Ms Stokoe and Mr Powell parked the vehicle in the sally-port and went inside. They can be seen on CCTV footage inside the lockup talking to a police officer[48] and filling in paperwork. Ms Stokoe asked for food and water for the deceased and was told that he had a pie, the police officer then obtained a bottle of water for him.

While Ms Stokoe and Mr Powell had stopped at Leonora on the way to Laverton and purchased drinks for themselves, they had not purchased or brought with them from Kalgoorlie water for the deceased. Mr Powell claimed he had additional water with him in the cab that could have been provided to the deceased if necessary.

All GSL staff said that no water was provided by their employer to give to prisoners, but if they purchased water

[48] Senior Constable Chamings

for prisoners, they could later recoup their money. All staff said they did not bother doing this, as it was a cumbersome process.

While GSL had an obligation under the CSCS contract to provide adequate food and water to detainees, in the Kalgoorlie region at least there was no clear instruction about provision of such items. The staff were confused about their obligations as a result.

On a long hot journey what should have been provided was a regular supply of clean, cold drinking water. In respect of the water which was provided to the deceased Senior Constable Chamings can be heard on the CCTV from Laverton police station remarking as he handed over the bottle of water to Ms Stoke "it's only 600ml"[49], which suggested that he considered the deceased would require more than that on the trip in order to keep well hydrated.

Both GSL officers claimed that the air-conditioning was on in the forward and rear pods for the duration of the outward journey. Ms Stokoe claimed that the switch was "on" at the outset and the air-conditioning was at the maximum setting and was never changed. Mr Powell claimed that the air-conditioning was about "half on" for the outward journey and he turned it up to the absolute

[49] Exhibit 3

maximum setting in Laverton[50]. In accounts given during an internal GSL investigation conducted in February 2008, however, it appears that both stated that it was not turned on during the outward leg of the journey "...because there was no prisoner on board and running the system on this leg imposed an avoidable load on the engine"[51]. Unfortunately this internal report was not available to the inquest until after Ms Stokoe and Mr Powell gave their evidence and so neither could be questioned on its contents.

There is no CCTV footage of the deceased getting into the van. Ms Stokoe stated that she told the deceased "the quicker you get in, the quicker the air-conditioner kicks in"[52] but could not recall any other conversation with him.

Ms Stokoe claimed in her evidence that, "It didn't feel hot in the back of the vehicle when I opened the back doors and the vehicle had been running from Kalgoorlie all the way to Laverton when we stopped"[53]. She stated that this caused her to assume that the air-conditioning had worked on the outward journey[54]. It is clear, however, from the comment made to the deceased that the pod must have felt uncomfortably warm or hot and in my view Ms Stokoe was attempting to deflect criticism of her performance when she claimed otherwise.

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[50] ts 834
[51] Exhibit 108, Internal investigation into the Death in Custody; Annexure 2 to documents supplied for the Coroner by GSL.
[52] Exhibit 73, Statement of Nina Stokoe, para 27
[53] ts 72
[54] ts 472

There was no conversation with the deceased about what he should do if he required attention. In particular, he was not told about the duress alarm although as pointed out by Ms Stokoe during her evidence, this only involved a very small light coming on with no "buzz" or "flash".

Mr Powell drove the vehicle for the entire return trip of approximately 360kms and according to the evidence of both GSL employees, there were no stops until they had almost reached Kalgoorlie.

During the trip Ms Stokoe was listening to an iPod and claimed that she was watching the CCTV monitor intermittently. In her video recorded interview with police after the death Ms Stokoe stated that the CCTV camera had turned off twice and that she had turned the camera on and off to get a picture again. She also said during that interview that looking at the deceased was "...like looking through a tunnel at him and I have not seen it like that before"[55].

In her evidence, however, Ms Stokoe claimed that she could not remember the camera going off on that trip but said that sometimes there would be a "black" screen and "the cameras were always playing up in both vehicles".[56] She also said that every so often the vision would "roll like an old black and white TV you see in the movies where the

[55] Exhibit 73, Video recorded interview.
[56] ts .467

screen rolls and the lines go through it. That's what we used to put up with"[57].

According to Mr Powell he did not watch the monitor because he was driving and he relied on Ms Stokoe to advise him as to the state of the prisoner. He stated that the view from the monitor, even when it was working, was "not great" and the picture was in black and white.

The above photograph depicts the interior of the cab showing the monitor (Exhibit 15(142)

Even when the monitor was working it is clear that the image was very small (about ¼ of the 10cm by 10cm screen), it was fairly monochromatic (which was because of lack of light in the rear pod) and there was little detail in the image.

It is clear that the CCTV picture was not of sufficient quality to enable Ms Stokoe to tell whether the prisoner was awake or asleep, conscious or unconscious, and it certainly was not of sufficient quality for her to tell whether he was sweaty, confused or disoriented.

[57] ts 465

This was, however, the only view of the deceased available to Ms Stokoe and Mr Powell and the one that they relied upon for the trip of about three hours and forty-three minutes to ascertain the condition of the deceased as they drove without stopping to Kalgoorlie.

OBSERVATIONS OF THE DECEASED DURING THE JOURNEY AND THE DISCOVERY OF THE EMERGENCY SITUATION

It was obviously important in the context of the purposes of the inquest to determine what took place during the journey from Laverton to Kalgoorlie on 27 January 2008. Unfortunately the only direct evidence as to the condition of the deceased during that journey was the evidence of observations of Ms Stokoe and Mr Powell. In my view the evidence of both of these persons in respect of the journey was untruthful on occasions and certainly mistaken on other occasions.

In assessing the evidence of Ms Stokoe and Mr Powell it was necessary to review the various accounts which they gave to police and to their employer prior to their evidence in court.

Mr Powell and Ms Stokoe arrived at the hospital at about 3:23pm. Ms Jenkins, the Supervisor, arrived at the hospital within a matter of minutes and while medical staff at the hospital treated the deceased, Ms Stokoe gave

Ms Jenkins an account as to what she said had occurred prior to the collapse.

Subsequently police arrived at the scene and the three GSL staff returned to the Kalgoorlie Police Station. Ms Stokoe left briefly to go to her home to look after her dogs and then returned.

There was then a substantial period during which the three persons were together prior to any interviews with police taking place. The first interview, which was with Ms Stokoe, took place at 9:26pm and it was not until 11:15pm that Mr Powell was first interviewed by police.

During the intervening period the three GSL staff initially sat in the GSL office which was within the police station and subsequently detectives took them upstairs to the detectives' offices.

During this period reports were prepared for GSL by all three persons. Although the events were not openly discussed in detail as such, it is clear that Ms Stokoe and Mr Powell were aware of the account which each was preparing for GSL and each spoke of the incident in the presence of the other. According to Ms Jenkins –

> Nina [Stokoe] was probably the one that continuously repeated herself. Nina was actually in quite a state and she repeated herself over and over again, "This is what we did." You know,

she wishes she could have done more. No, it wasn't a great deal to discuss, really[58].

The accounts given to police by Ms Stokoe and Mr Powell were, not surprisingly, very consistent in respect of the observations of the deceased prior to his collapse. According to their account Ms Stokoe checked the CCTV and advised Mr Powell orally of her observations. The observations were essentially as follows –

- not far from Laverton the deceased laid down on the floor of the pod and went to sleep;
- about 20 kilometres past Menzies the deceased was seen to drink water out of his bottle;
- about 50 kilometres before they reached Kalgoorlie they came across a vehicle towing a large boat and at that time the deceased was seen looking out of the window; *and*
- as they approached Kalgoorlie they heard a bang or thump and Ms Stokoe advised that the deceased had fallen over shortly after which Mr Powell stopped the vehicle.

Ms Stokoe claimed that the deceased was lying on the floor of the pod until after Leonora, it is noted that temperatures recorded in the re-enactment of 12 March 2008 for the floor of the pod[59] were 53.8^{0}C (rear) and 50.6^{0}C (front) at Leonora. Assuming that temperatures were similar on the day in question it is difficult to believe that the deceased intentionally lay on the floor.

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[58] ts 605
[59] Exhibit 93

In respect of the claim that the deceased was drinking from a water bottle and seemed otherwise normal past Menzies, temperatures of the seat measured in the re-enactment were 48^{0}C and 47^{0}C at Menzies. It is difficult to believe that the deceased sat on such a hot seat without complaining or showing signs of distress.

In respect of the claim that the deceased was seen looking out of a window about 50 kilometres before they reached Kalgoorlie, it is noted that the seat temperatures recorded in the re-enactment were all well over 47^{0}C from Menzies to Kalgoorlie. Again it is difficult to accept that the deceased was not showing some signs of distress in that environment.

In respect of this account it is noted that the reference to the precise distances of 20 kilometres outside Menzies and 50 kilometres outside Kalgoorlie were given by both witnesses to police in both their video recorded interviews and in subsequent statements.

It is a surprising feature of their evidence that both witnesses would refer to exactly the same distances when there was no suggestion that there was any particular landmark which would have enabled such an estimate to be given. For both witnesses to have given the same estimates of distance in these circumstances suggests that either there must have been some form of collusion or,

alternatively, one was aware of the estimate given by the other, and adopted that estimate. It is difficult to accept that each witness acting independently gave an identical approximation of the location of these apparently innocuous events in a landscape devoid of significant landmarks.

The accounts of Mr Powell and Ms Stokoe did, however, differ on the important question of why they did not stop at Leonora or Menzies on the return trip.

Ms Stokoe stated in evidence that the deceased had appeared to be sleeping, lying down on the floor of the van from near Laverton until after Leonora when he "got up and sat up in the chair"[60]. Mr Powell claimed that they did not stop at Leonora because Ms Stokoe told him that the deceased was sitting up[61].

In respect of the decision not to stop at Menzies both Ms Stokoe and Mr Powell claimed in their Officer's Reports and accounts to police that it was 20 kilometres on the Kalgoorlie side of Menzies that Ms Stokoe commented that the deceased was sitting up and drinking water. In evidence, however, Mr Powell claimed that the decision not to stop at Menzies was made because Ms Stokoe had made that comment, which by inference meant that the comment must have been made prior to their reaching Menzies[62].

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[60] ts 487
[61] ts 898
[62] ts 898

Immediately before the deceased collapsed it was the account of both witnesses that Ms Stokoe had contacted the Eastern Goldfields Regional Prison to advise that they would be arriving within a short period of time.

Ms Stokoe's statement to police completed on 28 January 2008 was as follows –

> As we passed the speedway I phoned the prison to tell them we were almost there.
>
> As I hung up I heard a bang from the rear of the van and saw on the monitor, Ward go from a slouched seating position falling over to his right[63].

Ms Stokoe's various other accounts in that regard were consistent.

Mr Powell, in his evidence, also claimed that prior to the collapse he thought "…she phoned Eastern Goldfields Regional Prison to say that we were on our way there with Mr Ward"[64]. When asked further about this matter he said "I seen her on the phone"[65]. He also said that he heard her ask for the front gate and advised that they would be there in about 10 or 15 minutes with Mr Ward. He said that he believed she used her mobile telephone.

As part of the investigation police obtained the telephone records from the mobile telephones of both

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[63] Exhibit 73, Statement of Nina Stokoe page 5 paras 45-46
[64] ts 849
[65] ts 849

Ms Stokoe and Mr Powell as well as the telephone records for the satellite telephone which was in the vehicle at the time. These telephone records do record Mr Powell attempting to call Ms Jenkins and getting through for short periods of time at 3:12 and 3:14pm and Ms Stokoe ringing Ms Jenkins at 3:18pm for a period of 69 seconds. The telephone records for the mobile telephone of Ms Jenkins were also obtained and these confirmed that those calls had taken place. There were no telephone calls to the Eastern Goldfields Regional Prison on the records of the mobile telephones of Ms Stokoe and Mr Powell and there were no calls on the records of the satellite telephone. Records of the Eastern Goldfields Regional Prison confirm that there was no relevant telephone call at that time.

The account of both Ms Stokoe and Mr Powell as to this event, said to have occurred immediately before the collapse, is therefore unreliable.

According to Ms Stokoe, the location where they stopped the vehicle was close to Piccadilly Street and the sign for the hospital was visible from that location. According to Mr Powell they stopped about five or six kilometres from Kalgoorlie, although he also stated that they stopped just south of the Mining Hall of Fame, which apparently is less than one kilometre from Kalgoorlie.

According to both witnesses they left the cab of the vehicle and went to the rear where the outer door was opened and Mr Powell put a chain on the inner door so it could be opened slightly.

They claimed that Ms Stokoe then reached through the partially opened door and felt for a pulse on the leg of the deceased.

According to Ms Stokoe the inner door was never opened because; "Procedures dictate that when stopping in an insecure area you are not allowed to open the inner door"[66].

In her video recorded interview with police, Ms Stokoe stated that they had not opened the second door which was still on a chain[67] and subsequently made the following observations –

> … I guess because of my work at the BHP I've always gone diving straight in because I was … emergency response team as well my first reaction in normal circumstances would have been rip that door off its sockets and gone in there and dragged him out and done gave him mouth to mouth but that is against our procedure.[68]

While Mr Powell's accounts to police were consistent with the evidence of Ms Stokoe to the effect that the inner door of the vehicle was left on the chain and not fully

[66] Exhibit 73, Statement of Nina Stokoe para 50.
[67] Video interview of Nina Stokoe p. 10
[68] Video interview of Nina Stokoe p.18

opened, during the course of his questioning at the inquest his account changed completely. At the inquest he stated that the interior door of the van had been completely opened so that he could throw water on the deceased in an attempt to rouse him.

The following exchange took place during Mr Powell's questioning by Mr Carter, who represented the Aboriginal Legal Service –

> Why didn't you tell the police and why didn't you record in your officer's report, that you opened the door completely - - - I don't know. It was only yesterday when I was being questioned that I realised we must have had the other door open to throw the water over Mr Ward.
>
> Was Nina Stokoe there at that time? Were you and Nina Stokoe both at the door? - - - Yes. [69]

It is difficult to believe that this could have possibly been an innocent mistake. The collapse of the deceased shortly before his death was a major event which was the focus of questioning by police. If Mr Powell's final version is the correct one and both rear doors of the van were fully opened prior to arrival at the hospital, then there would have been no good reason for Ms Stokoe or Mr Powell not conducting a proper examination of the deceased by entering the rear pod of the vehicle. It would not have been necessary for Ms Stokoe to have relied upon reaching through a gap between the door and its frame to feel for the deceased's pulse.

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[69] ts 941

If the door was open and the deceased was examined, then Mr Powell and Ms Stokoe must have had a clear idea of the gravity of his condition prior to their arriving at the hospital.

If Mr Powell's final version is correct, that also casts considerable doubt as to the entirety of the evidence of both witnesses as to the circumstances of the journey and the collapse of the deceased. For both witnesses to have previously wrongly claimed that the rear doors were not fully opened, they must have either colluded in their evidence or one must have adopted the account of the other when both knew that account was false.

Another concerning feature of the evidence of the two witnesses relates to the question of whether the deceased's shirt was taken off at some stage.

According to Mr Powell's account in his video recorded interview with police, at one stage Ms Stokoe told him that the deceased had taken his shirt off[70]. In his evidence Mr Powell agreed with the proposition that if he had made the statement during the course of the video recorded interview, then it must have been correct although he could not then recall Ms Stokoe making that comment[71]. Ms Stokoe, when questioned about this account in Mr Powell's interview, stated that she could not remember

[70] Exhibit 80, Video record of Graham Powell p. 4.
[71] ts 843-844

him taking his shirt off but said that he had his shirt unbuttoned. She said that she could recall him going into the vehicle with an unbuttoned shirt and then coming out of the vehicle with an unbuttoned shirt but that he did not take his shirt off at any time[72].

It was subsequently put to her that CCTV of the deceased at the police station showed the deceased immediately before entering the prison van with his shirt buttoned up and it was suggested that his shirt had been buttoned when he entered the van. In that context Ms Stokoe conceded that she might have been wrong in claiming that his shirt was unbuttoned on entering the vehicle, but persisted in claiming that he did not take his shirt off at any time.

If the deceased did take his shirt off, that would have been consistent with his having experienced a hot environment in the rear pod of the vehicle and if Ms Stokoe had commented on that fact, it would have been appropriate for the vehicle to have been stopped and for some enquiry to be made as to his condition. It is difficult to understand how Mr Powell could have claimed that Ms Stokoe told him that the deceased had taken his shirt off if that event had not taken place.

[72] ts. 488

If the deceased had at some stage had his shirt off, but at the time when he left the van the shirt was back on, only the deceased, Mr Powell or Ms Stokoe could have put it back on his body. As there would have been no reason for the deceased to have put his shirt back on in conditions of extreme heat, this is a potentially sinister aspect of the evidence especially if the shirt had been put on in an attempt to conceal their knowledge that the deceased had experienced difficulties during the course of the journey.

Another concerning aspect of the evidence relates to the timing of events after the van stopped until it arrived at the hospital. According to Mr Powell's evidence the van was stopped, the deceased checked on and the doors secured before he attempted to contact Ms Jenkins using his mobile telephone.

Telephone records for Mr Powell's mobile telephone record that he made two calls to Ms Jenkins; at 15:12:12 and 15:14:03, the records for Ms Jenkins' mobile telephone record those calls at 15:12:13 and 15:14:03. The records, therefore, give almost identical timing for the calls. There is no explanation on Mr Powell's account as to why these calls, which were essentially unsuccessful, should have been as much as 2 minutes apart. In an emergency situation this was a long period of time.

Later the records reveal that Ms Jenkins called Ms Stokoe's mobile telephone and spoke to her for 69 seconds at 15:18:04. This telephone conversation took place on the journey from the stop on the side of the road to the hospital according to Ms Stokoe.

On Ms Stokoe's account the van arrived at the hospital at 15:20. The hospital documentation reveals that CPR commenced at 15:25.

As the location where the vehicle was stopped was quite close to the hospital and the journey should have only taken a few minutes, there appears to be an unexplained period of almost 10 minutes.

I do not accept the evidence of Ms Stokoe and Mr Powell as to the events which took place when the van stopped as reliable. If Mr Powell's final account, that both rear doors were fully opened, is correct it would appear that both his earlier account and all of the evidence of Ms Stokoe is untruthful on this point. If the doors were opened the question arises, what happened then?

Unfortunately these inconsistencies in the evidence do not assist in determining what did happen. Accepting that there was some degree of collusion between the witnesses and their evidence was not truthful in a number of respects, does not advance the available knowledge about these

crucial events. It is possible, for example, that in the context of Mr Powell's prior termination for disciplinary reasons he was particularly reluctant to admit to any possible breaches of GSL's policies such as the requirement that only in exceptional circumstances was the inner rear door to be fully opened. Ms Stokoe may also have been concerned about possible disciplinary action and tailored her account for that reason. It does not, therefore, necessarily follow from the conclusion that their evidence was untruthful that some more sinister events took place.

Mr Powell and Ms Stokoe - Conclusion

Temperatures on the day in question were crushingly hot and in these conditions Mr Powell and Ms Stokoe should have checked the air-conditioning to ensure that it was working adequately in the rear pod of the van prior to leaving Kalgoorlie and particularly prior to placing the deceased in the pod in Laverton. They should have run the engine for long enough for the air-conditioning to work, if it was going to work, and then checked the pod. To take a prisoner in the pod in such high temperatures without checking the air-conditioning was a breach of their duty of care.

As there was not a temperature monitor for the rear pod and there had been past problems with the vehicle's air-conditioning they should have taken particular care on an

extremely hot day to ensure that the air-conditioning was functioning throughout the trip. Both knew that the vehicle they were using was old and in a number of respects unsafe and they had no reason for confidence that any of its parts, including its air-conditioning systems, would function efficiently irrespective of how often those parts had been repaired.

Both Mr Powell and Ms Stokoe knew that the CCTV view of the rear pod was inadequate. They should have stopped the vehicle at least once to ensure that the prisoner was not in distress and should not have continued for the entire journey without stopping.

As a matter of humanity, they should have checked as to whether he required a toilet break and whether he was in some form of distress. On any view the rear pod of the vehicle was extremely uncomfortable for long journeys and their failure to stop at any time demonstrated a lack of concern as to the prisoner's welfare.

Unfortunately in my view neither witness was a witness of truth and it is not possible to determine precisely what took place when they discovered that the deceased had collapsed. It would appear that a decision was made by the two officers to provide a concocted story in relation to events with a view to minimising their involvement.

As well as demonstrating a lack of compassion for the deceased, their failure to check that the air-conditioning for the deceased was working at any stage and the failure to make any welfare checks in the context of the known hazards contributed to the death.

I do not, however, believe that either officer deliberately caused harm to the deceased and it is clear that they took the deceased to the hospital. At the time of his arrival at the hospital the deceased was still alive.

REPORTS ON PRISONER TRANSPORTATION BY THE OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

The Inspector of Custodial Services had, prior to the fatal trip, identified a number of serious safety concerns in respect of the continuing use of the Mazda vehicles of the type used to transport the deceased prior to his death.

The same vehicle fleet which was introduced when prisoner transportation was privatised and AIMS commenced providing services in August 2002 was in 2008, and is still, in operation.

In November 2001 the Inspector published Report No. 3 “Report of an Announced Inspection of Adult Prisoner Transport Services”. At the time of that report the transport fleet was owned and operated by AIMS. In that report the

Inspector's Overview referred to a number of concerns in respect of vehicle design and movement procedures and under a sub-heading which included the words "... The Alarm Bells Ring" the following observation was made –

> On 4 October 2000, as part of my program of familiarisation visits to every prison in the State, I had gone to Karnet Prison. It was there that I had my first encounter with the AIMS transportation system. A Mazda van was about to be loaded with prisoners for medical escorts. The locked compartment contained two inward-facing metal benches with no restraints or grab handles to prevent passengers from sliding around as the vehicle braked. There was no natural airflow and very little natural light, for the back window was very closely grilled. The compartment was claustrophobic and cramped. An elderly Aboriginal prisoner, scheduled in the near future for transportation to Bunbury Prison, told me that he had been ill on his last journey because of the shaking and discomfort of the van and, more particularly, because he had no sense of where he was or what land he was passing through because there were no windows.
>
> It was evident even from such a brief encounter that safety, comfort and duty of care issues were taking second place to security ... I wrote to the Department of Justice Contract Manager at once, raising my concerns.[73]

It is noted that the description of the Mazda van above accurately describes the van 1APR-049 as it was on 27 January 2008.

In the same overview the Inspector, Professor Richard Harding, went on to describe the benefits of contracting out such services but noted that the hazards to that point had offset those benefits and divided responsibilities had enabled questions of passenger safety, dignity and

[73] Report of Announced Inspector of Adult Prisoner Transport Services, p.3.

reasonable comfort to be evaded. He stated that "... the Department and the contractor have focused on commercial issues and had reached such a stage of mutual disillusionment that service quality is at risk, and neither party has monitored service quality in an appropriate way"[74].

It is interesting to note that Professor Harding's observations were as true in 2008 as they were when he made them on 30 October 2001.

The report described how the 16 Mazda transport vehicles, which would have included the van 1APR-049, came to be licensed. The report noted that documentation which the Department of Transport (Transport) had provided to the Inspector was fragmented and confusing, but taking Transport's explanations on face value, concluded that Transport's actions had facilitated the transportation of prisoners in conditions considered unsafe by the Inspector[75].

The same report contained a quotation from a prison administrator as follows –

> It is terrible, poor. The vehicles are not fit for humans to be transported in. We are just waiting for a death to happen[76].

[74] Supra at p.6
[75] "Report of an Announced Inspector of Adult Prisoner Transport Services" p.16.
[76] Page 17

The report reviewed the cooling systems contained in the various vehicles, noted that problems had arisen in relation to the multi compartment vans and contained advice that the Department of Justice had acknowledged the problems with providing adequate air-conditioning and airflow and had committed itself to a review of escort vehicles in the near future[77].

It would appear that following provision of a draft of Report No. 3 to AIMS and the then Department of Justice, air-conditioning within the prisoner transportation fleet was reviewed by Mr Robinson, Director of Car Air Wholesale Pty Ltd, who recommended that in respect of the Mazda E2500 vans, including the van in question, the vehicles and their air-conditioning systems were never designed to operate in remote areas with extreme climatic conditions and should only be operated in and around the metropolitan area. Unfortunately that advice was not acted on by either AIMS or the then Department of Justice, now Department of Corrective Services.

In May 2007 the Office of Inspector of Custodial Services published a further review of prisoner transport services, Report No. 43 "Thematic Review of Custodial Transport Services in Western Australia".[78] This report contained the observation that generally the fleet was below acceptable operating standards with frequent breakdowns,

[77] Page 23
[78] Report No. 43

particularly in regional areas. It was noted that these breakdowns cause safety and duty of care issues when they occur in regional areas during the heat of summer[79].

The report noted that when the contract for prisoner transportation had first commenced the fleet was owned by AIMS, but subsequently had been bought by EasiFleet, the government provider (in fact it appears that the fleet was purchased by the government and EasiFleet was to manage repairs etc as required). This had occurred at a time when AIMS was arranging to tender for a replacement fleet, a process which stopped at that point and that consequently the fleet had outlived its lifespan. According to the report this resulted in the situation where the service provider (AIMS) had no responsibility for the vehicles while the owner of the vehicles (EasiFleet) had "absolutely no knowledge about the nature of the service involved and no experience in running a fleet of that kind".

The report's analysis continued –

> The Department and the Government have managed to achieve the worst of all worlds by these arrangements. A new fleet is urgently required. The arrangements which are currently in place are not the appropriate ones by which to achieve, manage and sustain a good quality fleet[80]

In the same report it was noted that prisoners were often taken on long journeys in vehicles with no onboard

[79] "Thematic Review of Custodial Transport Services in Western Australia" p.16
[80] "Thematic Review of Custodial Transport Services in Western Australia" p.16

toilets and the runs were often undertaken without stops, a practice which could only be regarded as "inhumane"[81].

Further in the report the following observation was made –

> These journeys are undertaken in vehicles that sometimes have hard metal seats and are often overcrowded. They lack room to stretch, outside views, seatbelts, natural ventilation, dignified toilet arrangements and music or any other distraction. The operation of such journeys for long periods without decent breaks in such conditions is inhumane and requires correction.
>
> In addition, this Report has identified a range of serious risks to life, well-being or security from issues such as driver fatigue, vehicle breakdown, air-conditioning failure or unpassable road conditions including flood events.[82]

In my view all of the above observations made by the Office of the Inspector of Custodial Services were accurate and should have been acted upon as a matter of urgency.

At the inquest Professor Harding was shown the report prepared by Car Air Wholesale Pty Ltd in 2001. He stated that he had never been shown a copy of the report. He said that he believed that he should have been provided with a copy of it and stated that the views expressed in his 2007 report relating to the use of the Mazda vehicles would have been in even stronger terms had he been aware of it.

In his reports Professor Harding made a number of

[81] Supra p.42
[82] Supra p.114

recommendations of direct relevance to the circumstances in this case. For example, recommendation 1 of his Report No. 43 was in the following terms –

> That a standard be established for all custodial transport services : no escort journey should be planned in short-haul secure transport vehicles without a comfort break for all passengers at least every 2-2.5 hours. Journeys likely to take longer must be undertaken in long-haul vehicles.

It is clear that the Mazda vehicle used on this occasion was a "short haul" secure transport vehicle and had this recommendation been implemented, it would have been contrary to such a standard that the Mazda be used on the Laverton to Kalgoorlie route.

OWNERSHIP OF THE TRANSPORT OF THE FLEET AND THE OUTSOURCING OF PRISONER TRANSPORTATION

Outsourcing of prisoner transportation commenced in 2000 and was effected by the passing of the *Court Security and Custodial Services Act 1999* and the subsequent contract for service provision between the State of Western Australia and Corrections Corporation of Australia Pty Ltd, the Courts Security and Custodial Services Contract ("the CSCS contract").

In late 2000 Corrections Corporation of Australia Pty Ltd changed its name to Australian Integration Management Services Corporation Pty Ltd (AIMS).

Following an arbitration in 2002 the commercial framework of the CSCS contract was defined as a "costs plus contract".

On 31 March 2005 AIMS was advised that the State would exercise the first extension option provided for in the contract and the CSCS contract was extended until 31 July 2008.

In May 2005 the Department of Justice acquired the prisoner transport fleet and on 28 November 2006 a deed of contract variation was executed which reflected that fact and changed the name from the Department of Justice to either the Department of the Attorney General or the Department of Corrective Services.

It appears that the decision for government to take over the fleet was made in 2004 and payment was made in 2005.

In July 2007 a Deed of Novation of the CSCS contract from AIMS to GSL Custodial Services Pty Ltd ("GSL") was executed, effective from 31 July 2007.

By letter dated 22 August 2007 GSL was advised that the state was exercising the second extension option of the CSCS contract for a further period of three years to expire on the 30 July 2011. GSL is a wholly owned subsidiary of

GSL (Australia) Pty Ltd which itself is a wholly subsidiary of GSL Overseas Holdings Limited which again is a wholly owned subsidiary of Global Solutions Limited, which in May 2004 was bought by two venture capital companies, Engelfield Capital and Electra Partners Europe.

Recently it appears that GSL Custodial Services Pty Ltd has been taken over, directly or indirectly, by another company known as G4S.

The Involvement of GSL

The company in which the Department of Corrective Services entrusted the transportation of prisoners pursuant to the CSCS Contract at the time of the death was GSL Custodial Services Pty Ltd.

It was not apparent at the inquest what services this particular company could provide, although it appears that the Department had made some inquiries in respect of another company associated with that company, GSL (Australia) Pty Ltd. Precisely how the various proprietary companies interacted was not evident at the inquest and it appears was not known to the Department's representative at the inquest[83]. It did appear, however, that GSL Custodial Services Pty Ltd was one of a chain of subsidiary companies which at the time was ultimately owned by the two venture

[83] ts. 1380-81

capital companies, Englefield Capital and Electra Partners Europe.

Essentially it appears that GSL Custodial Services Pty Ltd provided staff for custodial services who had been previously employed by AIMS[84] and was paid through a cost plus contract. It was not required to hold substantial assets or otherwise conduct business.

In the circumstance that the company was driven by profit motive and did not have other known ongoing business interests, it was particularly important for the Department to ensure that the company and its staff were subject to detailed instructions which would ensure that the duty of care, which the Department itself owed to prisoners and anyone in its custody, was adequately provided.

This case has highlighted some of the dangers associated with the privatisation of services when the state owes a non-delegable duty of care.

It is crucial that government departments which are planning to enter into such contracts make a thorough investigation of the real capabilities of the potential contractor to deliver the services in accordance with duty of care obligations. Such departments must take adequate steps to ensure that the company which is to provide the

[84] This was required by a deed entered into by the State and GSL

services has in place policies and procedures which ensure the safety and dignity of those to whom the duty is owed.

I am not satisfied that such measures were taken by the Department when it approved the novation of the contract to GSL which took effect from midnight on 31 July 2007.

THE DEPARTMENT OF CORRECTIVE SERVICES

The Department of Corrective Services (the Department) clearly owed the deceased a duty of care. The deceased was in the custody of the Department at the time of his death.

In addition the Department, as the owner of the prisoner transportation fleet, owed a duty to ensure that the fleet was of a suitable standard for prisoner transportation and in particular that the vehicle supplied for transportation of the deceased was suitable for that purpose.

The Fact that the Vehicle was in Very Poor Condition

It is clear that at the time of the death the van 1APR-049 was not the only vehicle in the transportation fleet which was beyond repair.

The fact that the vehicle was known to be in very poor condition by GSL staff at Kalgoorlie was commented on by GSL witnesses Mr Akasta, Ms Corcoran-Sugars, Ms Jenkins, Ms Stokoe and Mr Powell.

The vehicle was described by Senior Constable Pitcher as being "horrible to drive". There was extreme noise coming from the engine of the vehicle, the driver's seat did not fit properly, the vehicle was underpowered and was deficient in a number of other identified ways such as not having meaningful duress alarms, having no temperature monitoring in the prisoner pods, not having adequate CCTV in operation, not having any backup air-conditioning system or access to ambient air, not having any padding for seats in the rear pod and not having any toilet facilities for use on long trips.

The Inspector of Custodial Services made the following observation in his report No. 43 –

> The same vehicle fleet that was commissioned when AIMS commenced services under the Court Security and Custodial Services Act 1999 (CS&CS) Contract in August 2000, is still in operation. These vehicles are increasingly prone to breakdown, notwithstanding engine rebuilds, various upgrades and other major maintenance. There were few weeks during the summer of 2006/07 in which some kind of vehicle breakdown in a remote location did not occur with prisoners on-board, if only of the air-conditioning system.

At the time when AIMS had owned the fleet, it was planned that the fleet would be fazed out over a five year

period. At the time when the government made arrangements to acquire the fleet, AIMS was in the process of arranging for tender for a replacement fleet. The process stopped at that point.

It appears that at the time the Department took over fleet ownership, arrangements had not been put in place for a budget to allow for the recurrent cost of replacement vehicles. According to the Department's representative, Graham Doyle, the Assistant Commissioner, Corporate Support, at the time of progressing the purchase of the fleet from AIMS it was intended that a replacement program would commence immediately. In May 2005 a tender process was commenced but the preferred supplier ceased trading before a contract could be executed.

At the time when the then Department of Justice acquired the fleet in May 2005 the vehicles were assessed by EasiFleet to determine the market value, but it appears that there was no comprehensive assessment of the fleet in respect of safety and duty of care issues.

The Department's approach to procurement of a replacement fleet for prisoner transport was a long and involved process. It had commenced shortly after the Cabinet decision was made to acquire the prisoner transport fleet in 2003 but funding for replacement of the prisoner transport fleet was not first requested until the 2006/07

budget process when an amount of $336,000 per annum was sought. In the 2007/08 budget process additional funding of $686,000 in 2007/08 rising to $1.419 million in 2010/11 was sought for leasing costs for the replacement of the fleet. These requests were not approved.

Advice was provided at the time of the inquest hearing that in the recent budget for 2009 funds have finally been allocated for a replacement fleet.

This situation was unsatisfactory. At the time when the Department took over ownership of the fleet there should have been in place a budget for replacement on an ongoing basis to ensure that as vehicles became effectively unroadworthy, they would be replaced.

In the interim the Department's approach to managing safety issues pending replacement of old and worn out vehicles was to require the contractor to ensure that the vehicles were regularly maintained.

The evidence of a number of the GSL witnesses was to the effect that for many of these vehicles no amount of repairs and maintenance could make them safe or roadworthy.

This was also the view of the Inspector of Custodial Services who in Report No. 43 observed that the fleet had outlived its lifespan[85].

The Department required the contractor to ensure that regular services would be undertaken in accordance with the manufacturer's scheduled servicing intervals as well as to ensure that other maintenance and repairs were undertaken as required.

The cost of maintenance, service and repairs for the relatively small fleet of approximately 40 prisoner transport vehicles appears to have reflected their very poor condition. From January to December 2007 the cost was $480,121.20. The expenditure from January to December 2008 was $813,549.91.[86] In other words by 2008 the annual cost of maintenance, service and repairs averaged over $20,000 per vehicle.

By 2007 it was noted by the Inspector of Custodial Services that some of the vehicles had travelled over 600,000kms and a number required engine replacements, gearbox rebuilds and other major repairs. It is noted that the EasiFleet records relating to van 1APR-049 reveal that there were numerous electrical problems requiring the replacement of the battery on at least four occasions over a

[85] See page 16
[86] Exhibit 111, Supplementary Statement of Mr Doyle; p.18.

two year period and there was a need to repair the engine mounts "because they had fallen off"[87].

The Department did employ Contract Monitors for the CSCS contract and during the six months prior to 27 January 2008 the Contract Monitors conducted on-site inspections in Bunbury, South Hedland, Geraldton, Carnarvon and Broome. These inspections confirmed the fact that the fleet was old and in an unsafe condition. All of the vehicles required some form of repair at the time of the inspection. In South Hedland, for example, where vehicles were required to make trips to Roebourne Court (200km), Newman Court (450km), Tom Price Court (450km), Onslow Court (550km), Karratha Court (245km) and Marble Bar Court (200km), there were two prisoner transportation vehicles available; a Mazda and a Holden Rodeo, and those vehicles were rated as "elevated risk" and "high risk". In Roebourne where required trips included trips to Newman Court (650km) there were two prisoner transportation vehicles, both rated as "high risk".[88] In Geraldton there were two vehicles, one of which was off site and had been replaced with a vehicle the bodywork of which was being held together with duct tape and the other vehicle had brakes "apparently in need of some attention".[89] In Carnarvon where vehicles were required to travel to Exmouth police lockup (370km) and Greenough Regional

[87] Exhibit 26, EasiFleet Chart
[88] Exhibit 76, Statement of Mark Corbett, Annexure MC6
[89] Supra

Prison (490km) there was one Mazda E2500 series van, the air-conditioner of which was not working which was described as "unacceptable in this region" and the supervisor had already booked the vehicle in for repair.

There can be no doubt that the Department was well aware that use of these vehicles was becoming increasingly hazardous and difficult to manage. Even if it had not been apparent from the cost of maintenance and repairs or the appearance of the vehicles themselves, the Inspector of Custodial Services had forcefully pointed the situation out both prior to and in the content of his report No. 43 and the reports of the Contract Monitors had confirmed his advice.

In the submissions for the State of Western Australia (Department of Corrective Services) Ms L Eddy stated, in respect of comments made by the Inspector of Custodial Services in Report No. 43-[90]

> The statements by Harding in relation to redundancy in ventilation and cooling systems are made with respect to a situation where a vehicle is stopped or broken down. Those issues are irrelevant to the matters in question in this inquest as the circumstances relevant to Mr Wood's death included the failure of air-conditioning caused by a problem with the fan motor bearings.
>
> …
>
> The quotes … related to a large extent to issues of vehicle breakdown and roadworthiness of vehicles. It is clear on the evidence that neither of these factors was an issue in how the death occurred in this case.

[90] Para 97 and 99

It was then submitted that, as Professor Harding admitted he was prone to hyperbole, this fact ought to be taken into account in assessing the weight of his comments contained in Reports No. 3 and 43.

Mr Doyle said in his statement, "DCS did not have any knowledge of any systemic or ongoing issues with air-conditioning failure in any specific vehicle, type of vehicle or amongst the fleet generally"[91].

I reject the suggestion that, because the specific circumstances of Mr Ward's death, were not foreseen and detailed in either Report of the Custodial Services, the Department did not then have sufficient knowledge to anticipate what might occur.

The weight of the evidence is clear that by mid 2007 the Department had an abundance of information of –

- a systemic problem with the design and condition of the fleet generally , both when it was new and when it had aged;
- ongoing issues with air-conditioning functioning and adequacy, especially in pod-type vehicles such as the Mazda E2500 vans; *and*
- a predisposition of the fleet to regularly break down.

[91] Exhibit 111 [38]

THE USE OF THE MAZDA VEHICLES

The Department took no action to restrict the use of the Mazda vehicles, even after receiving the Car Air Wholesale Report of 13 September 2001 which had revealed that the air-conditioning systems were inadequate as designed to provide adequate cooling in hot temperatures.

According to Mr Doyle this was because the Department did not see the report as being of particular importance at the time as the Mazda vehicles were believed to be "predominantly" used for local transport only in both regional and metropolitan area.

Mr Doyle went on to explain that unfortunately, "perhaps as it did not raise any issues that seemed to need to be addressed at the time the correspondence was received, the report was filed away and the information contained in that report relating to the appropriate use of the Mazda vehicles was not transmitted to subsequent Contract Managers and was effectively lost to the Department's corporate knowledge".[92]

While at the time AIMS owned and operated the fleet, it was important for the Department to ensure that vehicles were used safely and there was no good reason to fail to address the contents of this report. The fact that even on

[92] Exhibit 111, Supplementary Statement of Graham Doyle; para 111

the Department's understanding the vehicles were "predominately" used for local transport, indicates that it was known by the Department that the vehicles would be used in other ways from time to time.

This was an issue which did need to be addressed at the time. The Department should have given AIMS an instruction to the effect that the vehicles should only be used for short trips and when the Department took over ownership of the fleet, ensured that the vehicles were never used on long journeys in hot conditions.

By 27 January 2008, while there may have been a preference to use other vehicles on long trips, Mazda vehicles of the type in question were regularly used on long journeys and evidence at the inquest revealed that in the Kalgoorlie region, as there was only one other vehicle which was often in need of repairs and unavailable, the Mazda was often used on long trips.

Following the death GSL was issued with a Performance Improvement Request for an improved method of providing the service of escorting prisoners in secure escort vehicles.

In response to that request, GSL responded and agreed to a number of actions to be taken and implement within five working days –

(a) Urgent examination of all existing policies and procedures in relation to the management of prisoners transported in secure vehicles;

(b) Urgent examination of all documentation to include matters surrounding prisoner duty of care, vehicle temperature controls and appropriate mechanisms to ensure their good working order, hydration of prisoners being transported and vehicle maintenance;

(c) Urgent examination of checklist documentation to reflect not only that vehicle air-conditioning turned on, but that there are measures in place to track that the air-conditioning is operational both at commencement of the escort and throughout the entirety of the escort;

(d) Water and road conditions to be considered when transporting prisoners; *and*

(e) Escort staff to sight a prisoner prior to loading to check for any obvious health issues.

In addition, remote temperature monitoring equipment was evaluated and in March 2008 the process commenced to install a temperature monitoring system in the secure vehicle fleet. The system is independent of the vehicles' electronic systems and can be transferred between vehicles. Installation was performed by Ashley Electrical and was completed by August 2008. This system included a display of the temperature of each pod on the vehicle dash and enabled data to be retrieved subsequently in respect of time, date and temperature.

In addition the system provided for an alarm buzzer to sound in the event that the temperature within a pod exceeded 31°C.

This system also provided for a back to base alarm by way of tracking equipment.

The cost of the system and installation was only $600 per vehicle and clearly had such a system been in place in January 2008 there would have been no excuse for the GSL officers failing to respond to the increasing heat in the rear pod of the van.

In addition to the temperature monitoring equipment, existing fleet vehicles were also fitted with updated duress buttons within the prisoner pods.

While it is pleasing to see that all of these changes have been effected, it is most unfortunate that they were not put in place after the very clear identification of the problems contained in the reports No. 3 and 43 of the Office of the Inspector of Custodial Services. The Department was aware of all of the problems well before Mr Ward's death but took no direct action to rectify them. It was only following the death and the attendant glare of publicity that the Department took positive steps to put in place these important steps.

Conclusions in Respect of the Department's Involvement in the Death

As indicated earlier in these reasons, the Department was aware of the condition of the fleet and in particular was aware of the condition of the Mazda vehicles of the type used to transport the deceased.

The Department's failure to ensure that these vans were replaced by a more humane system of transport following the report of the Inspector of Custodial Services in 2001 constituted a failure to comply with its duty of care. The ongoing failure to address the issues associated with the vehicle, particularly as its condition deteriorated, over the next seven years was inexcusable.

A major factor in this death was the unsafe vehicle owned by the Department used to transport the deceased.

The vehicle was unsafe in a number of respects identified earlier in these reasons from the time of conversion to transport prisoners in 2000 and had become more unsafe over time.

Of particular relevance to the death is the fact that the metal pod in which the deceased was detained was an all metal enclosure which was poorly insulated and which did not have any window providing access to reasonable airflow

or a back up air-conditioning system which would provide a source of cool air in the event of the air-conditioning system malfunctioning.

The hazards associated by use of such an enclosure in a hot environment were substantially increased by the fact that there was no proper system for a prisoner in distress in the pod to communicate with custodial officers in the cab of the vehicle; the duress alarm was effectively useless and the ability of custodial officers to monitor the condition of prisoners in the pod was limited to a poorly functioning CCTV system with inadequate coverage.

In addition there was no temperature monitoring equipment available to the custodial officers which would enable them to check on temperatures in the rear pod without stopping the vehicle and doing a physical check.

This combination of an unsafe vehicle with poor monitoring ability for prisoners constituted a very serious hazard which was not addressed by the Department, by requiring GSL to ensure staff conducted regular checks on the welfare of prisoners or had in place systems which would require checks to be done on the air-conditioning system.

The actions of the Department in providing an unsafe vehicle and its failure to put in place procedures to reduce

the hazards associated with use of that vehicle clearly contributed to the death.

GSL

GSL became involved in prisoner transportation in Western Australia in July 2007 and it was staff of that company, Mr Powell and Ms Stokoe, who were driving the van at the time of the death.

At the inquest John Hughes, the General Manager of the CSCS Contract for GSL, gave evidence on behalf of that company. Mr Hughes had involvement with the CSCS contract since July 2002, initially as a AIMS employee.

Mr Hughes had been the manager of operations with AIMS from 2002 until 2005 when he was appointed General Manager, prior to the novation of the CSCS Contract from AIMS to GSL.

At the time when GSL took over responsibility for prisoner transfers, Mr Hughes was well aware of the parlous state of the fleet of vehicles. He claimed, however, that the company believed that it would be able to comply with its responsibilities and expressed the view that if vehicles did not meet required standards, they should not be used.

On 8 November 2006 Mr Hughes, who was then an employee of AIMS, wrote to Greg Rickie, Acting Contract manager for the Department of Corrective Services, expressing the following views in respect of the fleet –

> The recent incident of the vehicle breakdown with fourteen prisoners on board near Sandfire Roadhouse highlighted the actual and potential risks to PIC's, public, AIMS staff, the AIMS Corporation and the Department of Corrective Services. I have outlined the risks in the attached risk register.
>
> While I appreciate the Department is doing what it can to accelerate a fleet replacement program, the identified risks are real and current and present themselves every time a vehicle is in use. In addition the exposure of AIMS Corporation to reputation as well as operational risk is of significant concern to us. The recent political and media focus on the incident at Sandfire Roadhouse strongly implicated AIMS as being responsible for the incident and the way it was managed. This was misleading, unfair and seriously damaged our reputation.
>
> AIMS Corporation requests a formal response to advise the intended fleet replacement program and relevant timeframes. This information can then be used to advise AIMS staff involved in transport and to reassure them that action is being taken.[93]

The attached risk register recorded against "Death in Custody CSCS – Transport" a "moderate" likelihood, defined as "quite possible", against "consequence" the word "catastrophic" appeared and against "risk level" were the words: "Urgent executive attention and intervention required. Develop risk minimisation strategies. Treatment plan required."

[93] Exhibit 108 index 3

Mr Rickie responded by letter of 20 November 2006 –

> As previously advised, a replacement fleet is currently being built. A preferred contractor status was awarded last year however the company went out of business. After recently obtaining sole provider status for a Queensland company (SVM) the process has recommenced afresh. The first inter prison vehicle is expected to be delivered in May 2008. The new vehicles will have new prisoner transport pods that meet contemporary requirements, including toilet facilities and the provision for fresh air to be reticulated through the vehicle pods when the motor is not operating.
>
> In the interim and because of the high kilometreage of the inter prison trucks, 2 new chassis are currently being delivered and will use existing pods until such time as the new vehicles are delivered. The suppliers have indicated that these vehicles are 'in stock' and the vehicle body builders have indicated that they can undertake the work prior to Christmas 2006.[94]

It is clear from the above correspondence that Mr Hughes was well aware of the problems with the fleet and the risk it posed prior to the novation of the contract and had expressed concerns to the Department in respect of the issue.

At the time of the novation of the contract, however, very little appears to have been done to manage the risk.

GSL effectively took over the ongoing operation from AIMS, together with AIMS staff and used the vehicles then owned by the Department. There was no comprehensive review of existing policies and procedures in relation to the management of prisoners being transported in secure vehicles.

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[94] Exhibit 106

No effective action was taken to ensure that duty of care to prisoners could be complied with in vehicles with inadequate temperature controls, poor communication between prisoner pods and vehicle cabs and other such matters. In addition little was done to address the issue of hydration of prisoners being transported and staff do not appear to have had ready access to water for prisoners.

In spite of the concerns expressed by the Inspector of Custodial Services in respect of air-conditioning issues, GSL took no action to review their checklist documentation to ensure that vehicle air-conditioning would be checked and that air-conditioning was operational at the commencement of an escort and throughout the entirety of the escort.

No action was taken to review the written policies and procedures with a view to ensuring that there would be regular stops which could provide comfort breaks for prisoners and enable direct observations to be made of the health and well-being of prisoners.

According to Mr Hughes management believed that staff would have received oral instructions from supervisors in relation to a number of these issues. The present case has highlighted the inadequacy of this reliance as neither Mr Powell nor Ms Stokoe was charged with any disciplinary offence for breaching instructions by failing to stop over a journey of approximately 3¾ hours or failing to check the

air-conditioning at all, according to Mr Hughes, because of a lack of evidence as to the instructions which had been given.

It appears, therefore, that while GSL had responsibility for prisoner transportation in Western Australia for a relatively short period of time prior to the death, the company was aware at the time of the novation of the CSCS Contract that there were significant problems with the fleet which would have to be managed and at the time of the death had done little to implement procedures to manage the hazards.

The failure by GSL to take action to manage these hazards was a factor which contributed to the death.

CONCLUSION

The deceased died on 27 January 2008 as a result of heatstroke which he suffered while in custody, being transported in the rear pod of a Mazda prisoner transport van.

The air-conditioning in the van was not working at the time of the deceased's death. He was being transported from Laverton to Kalgoorlie a distance of approximately 360kms which took almost 3¾ hours.

The failure of the air-conditioning was not some sudden, unforeseeable event. The air-conditioning in the vehicle for the pod in which the deceased was placed had been inadequate for use on such trips from the time of its first use and there had been a number of ongoing problems with it. The fact that failure of the air-conditioning in conditions of extreme heat would result in a dangerous situation for prisoners must have been obvious to all concerned.

At some stage in the trip the deceased fell or collapsed against the hard metal surfaces of the prisoner pod in which he was contained and suffered a laceration to his head.

Prior to his death the deceased collapsed onto the floor of the van where he suffered thermal injury on the side surface of his abdomen. The thermal injury was a contact burn, which appeared to be a full thickness burn. The area of the burn was irregular in shape and in the order of 9cm vertically and 6.5cm transversally at its lower aspect and 10cm transversally at its upper aspect. This was a large burn injury. It is clear that the surface temperature of the van was extremely great at the time when the deceased collapsed onto it.

The deceased's body temperature recorded at the hospital was 41.7°C; an extremely high temperature as the normal temperature is 36-37°C. Subsequent testing of the

vehicle revealed that the temperature within the pod increased relatively slowly and in my view it is clear that for the temperature in the pod to have reached temperatures sufficient to cause the death of the deceased and the burn injury inflicted to his abdomen, the air-conditioning was not working in the rear pod for the entirety of the journey.

The deceased died from heatstroke.

For the reasons outlined earlier I have concluded that the Department, GSL, Mr Powell and Ms Stokoe all contributed to the death.

The deceased was conveyed in the pod of a vehicle which at the time of its constructions was not suitable for transportation of prisoners over lengthy journeys. Over the course of eight years of use the vehicle and all of its parts, including its air-conditioning system, which had been inadequate at the outset, deteriorated with use and wear.

I am precluded by section 25(5) of the *Coroners Act 1996* from making a finding which would appear to suggest that any person is guilty of an offence and so I am not able to determine whether the death arose by way of unlawful homicide or misadventure. It is in that context I make an open finding as to how the death arose[95].

[95] I do not agree with the contention by ALSWA that an open finding should be a finding of last resort; this argument confuses the ultimate verdict with identification of the direct cause of death which has been done in this case.

COMMENTS ON THE QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CARE

As the deceased was a person held in care for the purposes of the *Coroners Act 1996*, it is necessary to comment on the quality of the supervision, treatment and care which he received while in care.

I note that as part of submissions to the effect that my comments in this matter should be of limited ambit, counsel for the State of Western Australia (Department of Corrective Services), Ms L Eddy, contended –

> The power to comment is not free ranging. It must be comment on a matter connected with the death. The powers to comment are inextricably connected with, but not independent of the power to enquire into death for the purposes of making findings. They are not separate or distinct sources of powers. ***Harmsworth v State Coroner*** [1989] VR 989, 996

While there have been considerable developments in coronial law since Harmsworth (see e.g. ***WRB Transport and Ors v Chivell*** [1998] SASC S7002), importantly in this context the applicable legislation is different. The relevant legislation considered in Harmsworth was section 19(2) of the *Coroners Act 1985* (Vic) which provided –

> A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

Following the delivery of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody, the *Coroners Act 1996* (WA), which was proclaimed in 1997, contained a specific provision, which was not contained in the Victorian legislation, dealing with deaths in custody, section 25(3) which provides –

> Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

This provision mandates the making of comments about the quality of the supervision, treatment and care of a person who has died in custody while that person was in custody. There is, therefore, not just a power to comment on matters connected with the death (see section 25(2)) there is a requirement to comment on the quality of the care generally.

In my view the correct approach in this state is described by Watterson R, Brown P and McKenzie J, ***"Coronial Recommendations and the Prevention of Indigenous Death"*** –[96]

> The Royal Commission's National Report provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an

[96] 2008 12 (SE2) AILR(6)

> expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.

While the deceased was in the custody of police, the quality of the supervision, treatment and care was quite good. Over the night reasonably regular checks were conducted on his welfare and in the morning he was permitted to make himself a cup of tea in the kitchen area of the police station and was given two meat pies to eat. He was given several cigarettes to smoke and was permitted to have a visit from his son, Tyrone Ward, and a friend. On at least two occasions the deceased was permitted to leave his cell to go into the exercise yard.

When his custody was transferred from police to the Department, however, this situation changed dramatically and from the time when he was placed in the rear pod of the Mazda vehicle at Laverton police station the quality of his supervision, treatment and care was disgracefully bad.

It is also important to note that this transfer of custody would not have happened at all if police and the JP, Mr Thompson, had complied with relevant legislation. The

transfer only took place because of the existence of a remand warrant signed by the JP in circumstances where there were multiple breaches of the legislation and a court should not have been convened at all. The fact that both the Deputy Registrar, Sergeant Denness, and JP, Mr Thompson, appear to have known almost nothing about their relevant roles and responsibilities is, at the very least, an embarrassment.

The quality of the deceased's treatment, supervision and care in the rear pod of the vehicle could hardly have been worse.

The deceased could, but for an inflexible rule imposed by GSL, have been placed in the forward pod of the vehicle. In that pod he could have sat on a padded seat facing the front and could have looked out of windows. There he would have been able to open a window when he became aware that the air-conditioning system was not working.

Instead the deceased was placed in the rear pod. The rear pod was of all metal construction apart from a window in the rear doors. Visibility through that window was severely restricted because of grills on the window of the outer door and there was no window which could be opened to allow air into the pod.

The bench seats were metal, slippery and inward facing. They were not padded or softened in any way. There were no grab handles or seat belts. At some stage during the journey the deceased fell onto the edge of one of the seats and sustained a bad cut to his head. This was a most unsafe environment for travel.

The vehicle was old and repairs could not make it safe. It was under-powered and could not overtake other vehicles safely. It had required repairs on a great many occasions.

The air-conditioning system for the vehicle was inadequate at the time of its fitting to provide a comfortable temperature in hot conditions. Over time it had deteriorated and prior to its complete failure, had been operating poorly for some time.

The quality of supervision of the deceased was very poor. The CCTV was inadequate and gave a poor picture which did not cover the whole pod even when working. It had not been working well for a lengthy period of time to the knowledge of GSL staff in Kalgoorlie.

As the condition of the deceased deteriorated in the enclosed, extremely hot rear pod there was no effective system of communication available to him.

There was no system of direct communication from the pod to the vehicle's cab and GSL staff appeared to have relied on prisoners shouting out or banging the walls of the pod to communicate distress. For much of the trip the deceased may have been unwell and incapable of making sufficient noise to be heard over the engine noise of the vehicle which police tests showed was extremely loud.

The only form of a duress alarm was an unlabelled button in the pod which, while pressed, caused a light to be illuminated on the dash of the vehicle. It is most unlikely that the deceased was aware of this button or its purpose as it was not pointed out to him when he was placed in the pod. Even if the deceased had been able to locate the button and guessed its purpose (which police forensic officers who inspected the vehicle after the death were not at first able to do) and even if he was able to press it and did press it, it is unlikely that the inadequate light on the dash was seen by the GSL officers in the cab, Mr Powell and Ms Stokoe, whose attention may have been directed elsewhere.

In spite of the obvious difficulties associated with monitoring the prisoners' welfare in the rear pod of the Mazda vehicles there were no written policies of GSL to require reasonably regular physical checks to take place on the welfare of prisoners and these had never been required by the Department. No welfare checks were conducted on

the deceased by Mr Powell or Ms Stokoe and they did not stop the vehicle during the journey in spite of the obvious limitations they experienced in monitoring the prisoner's welfare and their knowledge of the poor reliability of the vehicle's air-conditioning.

The deceased was provided with only a meat pie and a 600ml bottle of water for sustenance on the long trip. At no time did Ms Stokoe or Mr Powell ask the deceased if he required more to eat or drink or offer him cold water in place of the bottle he had which must have become warm very quickly. Again there were no written procedures in place to ensure this occurred and none were required by the Department.

These failures reflected a lack of concern by all concerned for the safety and welfare of prisoners.

There was no toilet provided in the rear pod for the deceased's use. Comfort breaks were only permitted by GSL if there was an available police station with a sally-port with police in attendance. On this occasion no effort was made by Mr Powell or Ms Stokoe to ring ahead to the police stations at Leanora or Menzies to ascertain whether police would be in attendance to permit such a stop to take place. It appears that if the deceased had been able to communicate a toilet need he would have been given an empty bottle or jerry can for use. This failure to

accommodate toileting needs reflected a lack of concern by all concerned for the dignity of prisoners.

For the reasons outlined earlier in these reasons I am satisfied that the Department, GSL, Mr Powell and Ms Stokoe each failed to comply with their duty of care obligations to the deceased and each contributed to the death. I do not repeat those reasons at this stage but comment that there could be no excuse for those failures.

In the submissions on behalf of Western Australian Police and the Department it was contended that it was not open for me to find that any person(s) caused or contributed to the death as such a statement would appear to determine questions of civil liability or suggest that a person(s) is guilty of an offence. I do not accept that submission. In my view a finding that a person or persons caused or contributed to a death is often necessary in order to determine how a death occurred (see e.g. ***Perre v Chivell*** (2000) 77 SASR 282) and there is a gulf between such a finding and a determination of civil or criminal liability. I endorse the observations of Callaway JA in ***Keown v Khan*** [1997] 1VR 69 [16] –

> The findings by a coroner as to how a death occurred and the cause of death should, where that is possible, identify any person who contributed to the cause of death.

Western Australia is Australia's largest state comprising 2,525,500 square kilometres, and is about the same size as Western Europe.[97] In that context it is clear that many prisoners, including many Aboriginal prisoners, have to endure being transported over vast distances often through remote areas, spanning extremes of climatic conditions, in order to be relocated from police lockups to prisons.[98]

A question which is raised by the case is how a society which would like to think of itself as being civilised, could allow a human being to be transported in such circumstances.

A further question arises as to how a government department, in this case the Department of Corrective Services, could have ever allowed such a situation to arise, particularly when that department owned the prisoner transportation fleet including the vehicle in question.

It has not been possible at this inquest to find adequate responses to these questions.

[97] Exhibit 97, Inspection Standards for Aboriginal Prisoners, July 2008 p.6.
[98] Exhibit 97, Inspection Standards for Aboriginal Prisoners : Office of the Inspector of Custodial Services : Version 1; p.6.

Report to the Director of Public Prosecutions : Section 27(5) of the Coroners Act 1996

Section 27(5) of the *Coroners Act 1996* provides in part –

> A coroner may report to –
>
> (a) The Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated;
>
> (b) …

Importantly in the context of considering any possible report, section 25(5) of the Act provides –

> A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

In the context of section 25(5) of the Act I do not consider that it is appropriate for me to review evidence in respect of possible criminal charges in any detail in these reasons.

The submissions on behalf of the family and on behalf of the Aboriginal Legal Service both contended that I should make a report to the Director of Public Prosecutions in this case.

It is noted that section 27(5) does not require me to specify by whom I believe an indictable offence may have

been committed or to review whether or not there is sufficient admissible evidence to establish a prosecution case.

In that context I do propose to make such a report to the Director of Public Prosecutions.

I accept that in the context of this avoidable death, as stated in the submissions on behalf of the Aboriginal Legal Service, "there is anger, disbelief, emptiness and calls for justice"[99]. In that context I do not wish to create unrealistic expectations on the part of the family or the hope that they will see "justice" as a result of such a report being made.

As indicated earlier in these reasons, the death was contributed to by the actions of Mr Powell, Ms Stokoe, the Department and GSL.

In respect of the involvement of Mr Powell and Ms Stokoe, it needs to be recognised that there are deficiencies in respect of the evidence which was obtained relating to their involvement and, in particular, they were not kept separate following the death and were able to spend a considerable period of time in each other's company during which time they had the opportunity to communicate to each other a version of facts. In addition, both were

[99] ALS Submissions, p.4

interviewed in the presence of their supervisor, Ms Jenkins, who was a material witness.

In the circumstance that Ms Stokoe and Mr Powell were the only two witnesses of the events which took place immediately prior to the time of the death, it was important that they should have been separated at an early stage and had no opportunity to collaborate on an account. There appeared to be no good reason for involving Ms Jenkins, particularly when, as the supervisor of the two witnesses being interviewed, it was likely that she had some involvement in giving instructions to the witnesses and in decisions relating to the use of the vehicle.

Recommendation 35 of the Royal Commission into Aboriginal Deaths in Custody provides that police standing orders should require investigations to be approached on the basis that the death may be a homicide.

Detective Sergeant Robinson, the investigator in charge in the case, did give evidence that he approached the investigation in this way. In that context it is unfortunate that two persons who had involvement in the circumstances prior to the death were not kept separate. Detective Sergeant Robinson's running sheet contains an entry at 17:50 hours –

> Speak to GSL guards, ensure they no longer spoke with each other to avoid contamination of story.[100]

In evidence Detective Sergeant Robinson stated that before he arrived at work they had not been separated, but when he arrived action was taken to keep the witnesses apart.

This does not appear to have happened in fact. Certainly, for whatever reason, the witnesses remained together in the supervisor's office and later in the detectives' staff room for a number of hours up until the time when they were interviewed.

As indicated earlier in these reasons, there are aspects of the evidence of the two witnesses which I do not accept as reliable and in that context it is most unfortunate that this situation was allowed to occur.

To be fair to Detective Sergeant Robinson, from the stage when his report was provided to the Office of the State Coroner and throughout the inquest he responded promptly to all requests for evidence gathering. I make no criticism of Detective Sergeant Robinson in this regard.

The fact that aspects of the evidence of these witnesses is not credible does not provide a basis for conclusions as to precisely what did occur.

---

[100] Exhibit 38

In respect of the involvement of the Department, there are obvious legal issues as to whether the Department could be charged. The submissions on behalf of the Aboriginal Legal Service contain the following –

> There is no doubt some complexity as to the proper defendant in relation to both GSL and the Department of Corrective Services, but the evidence available against each entity in relation to the alleged breaches of duty is sufficiently strong to justify a report to the DPP.[101]

In the context of the Department's involvement this submission does not address the legal issue of how a government department could be charged with a criminal offence.

In respect of GSL, while section 69(1) of the *Interpretation Act 1984* states that provisions relating to offences apply to bodies corporate as well as to individuals, the involvement of the relevant entity in the CSCS contract was relatively short and the evidence at the inquest relating to its involvement was limited.

In summary, therefore, while the deceased suffered a terrible death which was not only preventable but easily foreseeable, issues relating to the involvement of the various individuals and organisations are complicated.

[101] ALS Submissions, p37 para 156.

Breaches of Australia's International Legal Obligations

Australia has a number of specific international legal obligations pursuant to the International Covenant on Civil and Political Rights (ICCPR).

Article 7 of the ICCPR provides that –

> No-one shall be subjected to torture or cruel, inhumane or degrading treatment or punishment.

In addition to the prohibition against torture and cruel, inhumane treatment or punishment, Article 10(1) of the ICCPR imposes further positive obligations directed to the rights of detained persons. Article 10(1) provides –

> All persons deprived of liberty shall be treated with humanity and with respect for the inherant dignity of the human person.

I agree with the submissions on behalf of the Human Rights and Equal Opportunity Commission to the effect that the purpose of Article 10(1) is to impose on states a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty.

I further agree with the submission to the effect that the state's duty under international law to provide adequate care to persons deprived of their liberty is non-delegable, as under the Australian common law. In that context privatisation of prisoner transport services cannot remove

from a state the duty of ensuring that human rights standards are met by contractors.

In the present case for the reasons outlined herein for determining that the quality of the supervision, treatment and care of the deceased in the hours before his death was disgracefully bad, I am satisfied that the deceased was subjected to degrading treatment and he was not treated with humanity and with respect for the inherent dignity of the human person. There has been, therefore, a breach of the ICCPR.

The deceased was transported in a pod of a prisoner transportation vehicle which for the reasons outlined earlier herein was unsafe for the purpose. The deceased was injured, burnt and eventually died as a result of heatstroke in that pod.

In the context of the rear pod of the Mazda vehicle I agree with the observation of the prison administrator, whose comments were recorded in the report of the Inspector of Custodial Services in 2001, that the vehicle was "not fit for humans to be transported in"[102].

[102] Report No. 3, p.17

The Lack of Action Following Reports by the Office of the Inspector of Custodial Services

As indicated in these reasons many of the problems highlighted by this case had already been identified by the previous Inspector of Custodial Services who in unambiguous language had stressed the need for urgent action to take place for safety reasons. Also as discussed earlier in these reasons, it is clear that the recommendations and observations of the Inspector were not acted upon in a timely manner and this failure to act resulted in the circumstances which contributed to the death.

I accept the submissions made on behalf of the current Inspector, Professor Neil Morgan, to the effect that the effectiveness of the WA inspections system relies on the professionalism of the inspection process and other ongoing activities, the clarity of the recommendations which are made and the willingness of the Department (and, where relevant, private contractors) to adopt the recommendations and it is not generally the Inspectorate's role to attempt to manage operational Departments. However, some matters which relate to human rights, safety and welfare are so fundamental that there is little room for debate and in such circumstances the Department should be obliged to respond to such recommendations.

While I accept that some form of "enforcement notice" may not be the best way forward, it does appear that it would be helpful if the Inspectorate could provide the Department or contractor with a written "Show Cause" Notice. Such a "Show Cause" Notice would require the Department to respond to particular questions and allow the office to set a timeframe in which responses were to be received. It would be important for this system to work that the Inspector should be able to require a response to specific questions as to plans, project timeframes etc.

In the present case such a notice could have required the Department in 2001 to explain why, in the relevant vehicle –

- there was no padding on the seats;
- seat belts were not installed;
- grab rails were not installed; *and*
- whether the Department agreed with the concerns expressed in the report about air-conditioning and ventilation, and what measures would be taken to address the problems.

This would have meant that the Office and Minister would have been better informed and better able to monitor progress.

Such a notice could also have been used in respect of recommendation 1 of Report No. 43, referred to previously, that journeys of more than 2½ hours should not be undertaken in short-haul vehicles such as the Mazda and would have required the Department to address that issue. If the Department had acted on the recommendation the deceased would not have died when he did.

Recommendation No. 1

I RECOMMEND THAT A STATUTORY SYSTEM BE PUT IN PLACE WHICH WOULD ENABLE THE INSPECTOR OF CUSTODIAL SERVICES TO ISSUE THE DEPARTMENT OF CORRECTIVE SERVICES WITH A "SHOW CAUSE" NOTICE IN CASES WHERE THE INSPECTOR IS AWARE OF ISSUES RELATING TO THE HUMAN RIGHTS AND SAFETY OF PERSONS IN CUSTODY.

It is noted that pursuant to the *Terrorism (Preventative Detention) Act 2006* the Inspector is given jurisdiction with respect to people detained under that Act. Under Section 39(1) detainees must be "treated with humanity and with respect for human dignity; and must not be subject to cruel, inhumane or degrading treatment". The Inspector is charged with reviewing any detainee's detention to determine whether that section is being complied with.

The Inspector does not have a similar power of review in respect to persons detained who are not suspected terrorists. It is unfortunate that in this regard there is less protection for a person detained in respect of relatively minor traffic charges, such as the deceased, than there is for suspected terrorists.

These provisions provide a possible model for amendments to other legislation relating to prisons, prisoner transport and court security.

Such a power of review by the Inspector would provide a mechanism for monitoring the State's compliance with Australia's international legal obligations.

Recommendation No. 2

I RECOMMEND THAT THE TERMS OF SECTION 34 AND 39 OF THE TERRORISM (PREVENTATIVE DETENTION) ACT 2006 BE INSERTED IN RELEVANT LEGISLATION DEALING WITH THE INSPECTOR'S POWERS SO THAT THOSE PROTECTIONS BE EXTENDED TO ALL PERSONS IN CUSTODY AND TO ALL AREAS OF THE INSPECTOR'S JURISDICTION.

Bail Issues

It is an understatement to observe that the deceased was not well served by the Justice system.

There were a number of deficiencies in the initial approach to bail taken on the evening of 26 January 2007 by Sergeant Timmers, particularly his failure to provide the deceased with the prescribed information as required by section 8 of the Bail Act, but more alarming was the "court hearing" before Mr Thompson JP.

The Court was not convened in accordance with the law. The person who had been appointed as a Deputy Registrar, Senior Sergeant Shaun Denness, had no real knowledge or understanding of his duties and responsibilities. Sergeant Denness was not even aware of the letter of his appointment until it was shown to him at the inquest and had not read the attached documentation including the summary of powers of a Deputy Registrar and a copy of the *Magistrates Court Regulations 2005*.

The police officer who purported to convene the court was not a Deputy Registrar.

The *Magistrates Court Regulations 2005* specifically limited the circumstances in which a JP could constitute a court and in the context of this case a JP was not to

constitute a court on a Sunday. That situation had been made very clear by the relevant local magistrate in a written direction which had been sent by the Kalgoorlie Court to the Laverton Police Station by facsimile transmission on 20 May 2005.

The above evidence displays a disappointing lack of concern on the part of the police officers involved in ensuring that they complied with their duties and responsibilities in respect of the convening of courts. In addition the evidence revealed broader systemic problems. Sergeant Denness and Senior Constable Chamings, for example, both appeared to believe that the deceased was ineligible for bail as a result of having breached a suspended sentence.[103] Similarly, none of the other officers who gave evidence was familiar with the relevant procedural obligations under the Bail Act[104].

Recommendation No. 3

I RECOMMEND THAT WA POLICE REVIEW ITS TRAINING PROCEDURES TO ENSURE THAT POLICE OFFICERS HAVE A BETTER UNDERSTANDING OF THE BAIL ACT 1982.

[103] ts 146 (Chamings), 115, 1121, 1123 (Denness)
[104] ts 43-44 (Kopson), p.94 (Timmers)

Recommendation No. 4

I RECOMMEND THAT THE DEPARTMENT OF THE ATTORNEY GENERAL NOT DELEGATE TO POLICE OFFICERS THE POWERS OF A DEPUTY REGISTRAR OF THE MAGISTRATES COURT OF WESTERN AUSTRALIA UNDER SECTION 26 OF THE MAGISTRATES COURT ACT 2004 UNLESS THE DEPARTMENT CAN BE SATISFIED THAT THOSE POLICE OFFICERS DO HAVE AN UNDERSTANDING OF THE POWERS AND RESPONSIBILITIES OF A DEPUTY REGISTRAR.

The involvement of the JP in this matter is particularly concerning.

It is clear that the JP had a very poor understanding of his role and responsibilities as a JP. He had never undergone any training as a JP and had been exempted from having to complete the training which was usually provided because of the limited availability of JPs in Laverton and the fact that he claimed that he was busy.

The JP had not read all the relevant handbook or legislation and did not have direct access to relevant legislation such as the Bail Act.

The JP did not know that he was required by Section 7(1) of the Bail Act to consider the deceased's case for bail

whether or not an application for bail was made by him. The JP did not give any consideration to that issue.

The JP did not provide the deceased with the prescribed information as required by section 8 of the Bail Act.

The JP did not make any record of any reasons for refusal of bail as required by section 26 of the Bail Act.

The JP understood his role as being only to assess whether the charges were of a frivolous nature[105].

In addition the events which took place at the deceased's cell on the morning of his death did not have the appearance of an independent court hearing. The JP received information about the deceased in his absence prior to attending the cell and the "hearing" took place at a cell door in circumstances not conducive to a perception of independence on the part of the JP.

It was the evidence of the JP and police officers at the inquest that other JPs also convened courts on a Sunday and conducted bail hearings at the cell doors.

The above evidence raises serious concerns about the use of JPs in country areas.

[105] ts 1073

While it should be recognised that JPs over many years have performed an important role in regional areas in a voluntary capacity, this case has highlighted a need for change. In my view no JP should constitute a country court, either alone or with another JP, unless that JP has satisfactorily completed an adequate course of training. It does appear that the Department provides JPs with a comprehensive handbook and training was available. It is unfortunate that the JP in this case was not required to complete the available training.

Recommendation No. 5

I RECOMMEND THAT THE DEPARTMENT OF THE ATTORNEY GENERAL REVIEW THE USE OF JUSTICES OF THE PEACE, PARTICULARLY IN REMOTE LOCATIONS, TO ENSURE THAT JUSTICES PERFORMING COURT DUTIES HAVE RECEIVED TRAINING IN THEIR DUTIES AND RESPONSIBILITIES AND HAVE SUCCESSFULLY COMPLETED ASSESSMENTS AFTER SUCH TRAINING.

This case raises concerns as to the extent to which the Department of the Attorney General monitors the performance of JPs. According to the witnesses the court at Laverton had sat on other occasions on Sundays contrary to the express direction of the magistrate. The fact that this

was occurring should have been identified and the problem remedied. In addition, there should have been some form of audit which would have identified the fact that the JP had little understanding of his role and was, for example, not recording his reasons in writing.

Recommendation No. 6

I RECOMMEND THAT THE DEPARTMENT OF THE ATTORNEY GENERAL ENSURES THAT JPS WHO PERFORM COURT DUTIES ARE MONITORED REGULARLY TO ENSURE THAT THEY ARE PERFORMING THEIR DUTIES APPROPRIATELY.

It is clearly not an optimal situation where local members of a community act in a voluntary capacity as JPs conducting court proceedings in an environment where they are likely to know police officers and others in the court. In the 21st Century when immediate communication is available across the globe, it is most unfortunate that reliance has to be placed on local volunteers in remote communities to perform this essential service. In my view the time has come for increased use of technology, such as video conferencing and even telephone conferencing, to ensure that these court hearings wherever possible are conducted before qualified magistrates.

Recommendation No. 7

I RECOMMEND THAT THE DEPARTMENT OF THE ATTORNEY GENERAL REVIEW PRESENT PROCEDURES TO EXTEND THE AVAILABILITY OF VIDEO CONFERENCING AND, IN THE ABSENCE OF AVAILABLE VIDEO CONFERENCING, GIVE CONSIDERATION TO INCREASED USE OF TELEPHONE CONFERENCING SO THAT DECISIONS, PARTICULARLY THOSE RELATING TO THE LIBERTY OF THE SUBJECT, CAN BE WHEREVER POSSIBLE MADE BY QUALIFIED MAGISTRATES.

In the present case the deceased had strong ties with Warburton and could have been bailed to appear either at Laverton or, preferably, to his home town Warburton. The effect of the remand in custody in this case was that the deceased was transported approximately 360kms away from his home environment and he would have spent at least three days in custody prior to his first appearance before a magistrate in Kalgoorlie. No one considered the deceased to be violent or, if sober, a threat to others. At a stage when he had sobered up after being in the Laverton lockup overnight, there seemed little benefit to be achieved by transporting him to Kalgoorlie.

This case has highlighted the importance of avoiding unnecessary transportation of accused persons over long distances. Such transportation can be particularly distressing for Aboriginal persons who have a close affiliation with the land.

Recommendation No. 8

I RECOMMEND THAT THE DEPARTMENT OF THE ATTORNEY GENERAL REVIEW CURRENT COURT PROCEDURES WITH A VIEW TO LIMITING UNNECESSARY TRANSPORTATION OF ACCUSED PERSONS OVER LONG DISTANCES.

It should be emphasised that the above recommendations relating to JP courts are made in a context of reducing the amount of time persons unnecessarily spend in custody, care needs to be taken to ensure that any changes which take place do not lead to the unintended consequence of increasing such time in custody, which would defeat the purpose of making such changes.

The Department of Corrective Services

As noted earlier in these reasons many of the vehicles in the prisoner transportation fleet are beyond repair and many were unsafe as constructed.

Recommendation No. 9

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES REPLACE THE CURRENT FLEET OF PRISONER TRANSPORTATION VEHICLES WITH VEHICLES WHICH ARE BOTH SAFE AND HUMANE.

A problem in the present case resulted from the fact that the Department did not have in place a replacement strategy and budget at the time when it took over the prisoner transportation fleet even though the fleet was already quite old and many vehicles were probably beyond repair at that time.

Recommendation No. 10

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES ENSURE THAT THERE IS IN PLACE A REPLACEMENT STRATEGY AND BUDGET TO ENSURE THAT IN FUTURE VEHICLES ARE REPLACED ON A REGULAR BASIS AND THERE ARE NO OLD OR UNSAFE VEHICLES IN USE.

The State's duty both under Australian Common Law and under International Law is to provide adequate care to persons deprived of their liberty and that duty is non-delegable. While the Department had entered into a

contract which resulted in privatisation of prisoner transportation, it remained the Department's duty to ensure that prisoners were transported in conditions of safety and that there was respect for the inherent dignity of the human person.

Recommendation No. 11

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES CONDUCT ONGOING REVIEW OF ALL G4S POLICIES AND PROCEDURES RELATING TO THE WELFARE OF DETAINEES AND DUTY OF CARE TO ENSURE THAT PROCEDURES IN PLACE ARE SUFFICIENTLY COMPREHENSIVE AND ADDRESS THE KNOWN RISKS.

In this case it does appear that the Department had Contract Monitors who were well aware of the widespread deficiencies with the transport fleet. The regional reports for the six months prior to the death, for example, show that almost all of the vehicles required significant repairs or replacement[106]. It is important that the Contract Monitors have the ability to effect changes in the fleet when prisoner safety is compromised and are able to review operations to ensure that G4S staff are complying with policies and procedures.

[106] Exhibit 76 Statement of Mark Corbert (Annexure MC6)

Recommendation No. 12

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES ENSURE THAT THERE ARE SUFFICIENT CONTRACT MONITORS TO REGULARLY REVIEW OPERATIONS IN REGIONAL LOCATIONS SO AS TO ENSURE THAT THE PRISONER TRANSPORTATION FLEET IS MAINTAINED IN A SAFE MANNER AND THAT G4S STAFF ARE COMPLYING WITH THE COMPANY'S POLICIES AND PROCEDURES.

G4S

The evidence at the inquest revealed that GSL staff (now G4S staff) received limited training. All of the staff who gave evidence had received some training when they commenced their employment which they described as mostly involving reading materials and subsequently being tested on what they had read. Little explanation was provided unless it was specifically requested. The only practical training which they received was in the use of restraints and the use of force. Most learned the practical aspects of the job by observing others.

It appeared that there was no specific training provided for supervisors apart from their attending an annual supervisors conference.

Recommendation No. 13

I RECOMMEND THAT ALL G4S STAFF SHOULD BE PROVIDED WITH APPROPRIATELY DETAILED PRACTICAL TRAINING IN RESPECT OF DUTY OF CARE OBLIGATIONS AND THAT SUCH TRAINING BE REFRESHED ON A REGULAR BASIS FOR ALL STAFF.

Recommendation No. 14

I RECOMMEND THAT G4S ARRANGE TRAINING SPECIFIC TO THE ROLE OF SITE SUPERVISORS IN REGIONAL LOCATIONS IN RESPECT OF MANAGEMENT SKILLS AND DUTIES IN PARTICULAR IN RESPECT OF MONITORING STAFF COMPLIANCE WITH POLICIES AND PROCEDURES RELATING TO THE WELFARE OF DETAINEES AND DUTY OF CARE.

A N HOPE
State Coroner
12 June 2009

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