STATE
CORONER
VICTORIA

CORONERS REGULATIONS 1996

Form 1

State Coroners Office
57-83 Kavanagh Street
Southbank 3006
Telephone: (03) 9684 4380
(All Hours)
Toll Free: 1300 309 519
(Only Country Victoria)
Fax: (03) 9682 1206

9th July 2009
**Case No:** 4303/05

## RECORD OF INVESTIGATION INTO DEATH[1]

I, **AUDREY JAMIESON**, Coroner,

**having investigated** the death of IAN THOMAS CAMPBELL WESTCOTT with Inquest held at the Coronial Services Centre, Southbank on 28, 29 and 30 November 2006 and 1 March 2007,

**find that** the identity of the deceased was **IAN THOMAS CAMPBELL WESTCOTT**

**and that** death occurred on **26 November 2005** at Port Phillip Prison, from:

1(a). ASTHMA

in the following summary of circumstances:

At 8.09am on Saturday 26 November 2005, Mr Ian Thomas Campbell Westcott was found deceased in his prison cell at Port Phillip Prison in Laverton.

His death was *reportable*[2] as it is defined in section 3 of the *Coroners Act 1985* (the Act).

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[1]The Record of Investigation/Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of Proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

[2]"reportable death" means a death-
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-
being a death-
(e) that **appears to have been unexpected**, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
(f) that occurs during an anaesthetic; or
(g) that occurs as a result of an anaesthetic and is not due to natural causes; or
(h) that occurs in prescribed circumstances; or
(i) **of a person who immediately before death was a person held in care**; or.....

The investigation into Mr Westcott's death found the medical cause of death attributable to asthma and identified issues associated with his status as *a person held in care,*[3] including issues related to his asthma treatment whilst in custody and the functionality of his cell intercom. Access to the prison by Emergency Services was also identified as an issue of concern.

An Inquest was held in accordance with section 17(1)[4] of the Act.

## THE ROLE OF THE CORONER - SECTION 19(1) *CORONERS ACT 1985*

A Coroner is required to find, if possible, the identity of the deceased, how death occurred, the cause of death and the particulars needed to register the death - the place and date of death. For the purposes of distinguishing 'how death occurred'[5] from the 'cause of death'[6], the practice is to refer to the latter as the *medical* cause of death and the former as the *context* in which the death occurred or the *background circumstances* and *surrounding circumstances.*

A Coroner's investigation and findings of fact in respect of the circumstances of the death must however, be contained so as to be sufficiently proximate to and connected to, the death.[7]

A Coroner may also comment on any matter connected with the death including public health or safety,[8] report to the Attorney-General on the death and make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9]

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[3] "person held in care" means-

(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or

(ab) a person-

(i) **in the legal custody of the Secretary to the Department of Justice** or the Chief Commissioner of Police; or.....

[4] s.17. **Jurisdiction of coroner to hold inquest into a death**

(1) A coroner who has jurisdiction to investigate a death **must** hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and-

(a) the coroner suspects homicide; or

(b) **the deceased was immediately before death a person held in care**; or.....

[5] Section 19(1)(b) *Coroners Act 1985*

[6] Section 19(1)(c) *Coroners Act 1985*

[7] *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, *Clancy v West* [1996] 2 VR 647, *Harmsworth v The State Coroner* [1989] VR 989

[8] Section 19(2) *Coroners Act 1985*

[9] Section 21(1) and (2) *Coroners Act 1985*

Mr Westcott's identity, date and place of death required no formal coronial investigation.

## BACKGROUND CIRCUMSTANCES:

Mr Westcott was born on 13 October 1955. He was 50 years old at the time of his death. He had previously been married to Lorraine Westcott. The couple had a daughter, Vanessa.

In approximately 1998, Mr Westcott entered into a defacto relationship with Ms Michelle Anderson.

Mr Westcott had a medical history of asthma, eczema, appendectomy, right inguinal herniorrhaphy, cholecystectomy and a right rotator cuff injury. He was a cigarette smoker of approximately 10 per day and a social drinker of alcohol.

Mr Westcott had a criminal history. On 5 July 2003, he was released from custody after serving part of a three year term of imprisonment.

On 16 June 2005, Mr Westcott was admitted into the Melbourne Assessment Prison (MAP). He was on remand awaiting trial over charges brought by Victoria Police and the Commonwealth Director of Public Prosecutions. He was scheduled to appear in the County Court of Victoria at Melbourne on 1 December 2005.

On admission to MAP, Mr Westcott was assessed by a general Registered Nurse and a Registered Psychiatric Nurse. He provided a medical history indicating that he did not suffer from any allergy and had not suffered from any major medical condition. He was taking the non-steroidal anti-iflammatory drug Brufen (Ibuproen). On physical examination he was noted to be hypertensive with a blood pressure reading of 163/104. No other abnormality was noted.

On 17 June 2005, he was reviewed by a Medical Officer. His blood pressure was recorded as 130/90. He was provided with scripts for Diprosne OV (Betamethasone dipropionate) ointment to be used topically, a Ventolin inhaler and Brufen - to be taken twice daily.

On 4 July 2005, Mr Westcott was remanded in custody at Port Phillip Prison.

### Port Phillip Prison:

Port Phillip Prison (PPP) is a privately operated maximum security prison, owned by Australian Correctional Facilities Pty Ltd who contract Global Solutions Limited (GSL) to operate and manage the prison. PPP commenced operation in 1997.

PPP is comprised of 13 separate accommodation units. Mr Westcott was located in Scarborough South Unit (SSU), a 'mainstream' unit with a total of 47 cells across 2 levels. At the time of Mr Westcott's death, there were 71 prisoners in SSU in either single, double or triple accommodation cells.

Mr Westcott occupied Cell number 428, a single accommodation cell, on the lower floor.

**Admission to PPP - 4 July 2005:**

The provision of health services at PPP is provided through St Vincent's Correctional Health Service (the Health Service).

Following Mr Westcott's arrival at PPP an assessment of his physical and mental health was undertaken by a Registered Psychiatric Nurse. It was noted that Mr Westcott provided a history of having been diagnosed with asthma which he described as mild. The medication he used was a Ventolin inhaler and that he had one with him. He also advised the nurse that he was a sufferer of eczema and that he had a right shoulder problem for which he was currently taking Brufen 400mg twice daily. His weight and pulse rate were recorded and it was also noted that he had some problems with his teeth. He denied any history of illicit drug use, gambling problems or any mental health problems. A referral was made for Mr Westcott to be examined by a Medical Officer.

On 15 July 2005, Mr Westcott presented to the Medical Officer. His right shoulder was examined and noted to be tender. An ultrasound was recommended. His blood pressure was recorded as 150/90. Ongoing monitoring was recommended. Blood for fasting serum cholesterol and triglycerides was ordered and subsequently taken on 20 July 2005.

On 28 July 2005, Mr Westcott was reviewed by a Medical Officer. He presented with flu-like symptoms and headaches over 2 days and a non-productive cough over 1 week. The results of his blood tests were reported to be within normal range, his BP 150/100. He was prescribed Perindopril 2mg in the morning for blood pressure control.

On 1 August 2005, Mr Westcott presented to a Registered Nurse with complaints of sneezing, feeling lethargic, suffering headache, dry cough and sweats. His vital signs were recorded and a diagnosis of upper respiratory tract infection made. He was advised to take a 3 day course of Sudafed (pseudoephedrine) cough mixture and Paracetamol as required.

Mr Westcott was not seen again by a health professional in relation to any respiratory complaints or problems until 4 November 2005. On this occasion he complained to a Registered Nurse of hay fever like symptoms. He was advised to take the antihistamine Claratyne (Loratadine) for 5 days.

## SURROUNDING CIRCUMSTANCES:

On 8 November 2005, Mr Westcott attended a Registered Nurse stating that his Ventolin was not helping. Forced exhalation was low - recorded at 200 peak flow. He was administered 5mg of Ventolin via a nebulizer with noted improvement to 275 peak flow. He reported feeling symptomatically better and was permitted to return to his cell. He was advised to return to see the doctor within the week.

On 10 November 2005, Mr Westcott was reviewed by a Medical Officer, Dr Al Raheb. Hay fever treatment was discussed. He was prescribed Beconase (Beclomethasone) nasal spray. His ongoing shoulder pain was discussed and he was also prescribed Zopiclone 15mg for 3 nights to assist with sleep. There was no review of his use of Ventolin or his peak flow rates.

On Friday 25 November 2005, Mr Westcott spoke to a number of PPP staff working in SSU. There were no issues of concern observed or noted. At approximately 11.00am Mr Westcott and fellow prisoner in SSU, Marcus Soames, attended the prison gymnasium together where they did a workout. At approximately 4.30pm, Mr Soames and Mr Westcott sat and ate dinner together. At approximately 7.30pm, Mr Soames said goodnight to Mr Westcott. Mr Soames occupied the Cell number 429, which shared a common wall with Mr Westcott's cell.

Correctional Officer (CO) Brian Dixon and CO Amanda Beer also spoke to Mr Westcott around this time while they were locking him in his cell for the night (lockdown). There was an exchange of pleasantries between Mr Westcott and the two Officers. Nothing untoward was noted by either Officer Dixon or Officer Beer.

Following the lockdown of the prisoners, staff vacated the Unit for the night.

After lockdown, Mr Soames could hear Mr Westcott constantly coughing. He thought Mr Westcott was trying to clear his throat, which was not unusual.[10]

At around midnight Mr Soames heard 4 loud bangs which he attributed to someone falling to the ground. Within the next minute he heard three more identical noises. He was unable to distinguish the direction of the noise and heard no voices.

On Saturday 26 November 2005, at approximately 8.09am - during "trap muster"[11]- CO Brett Britton-Stanley could not initially see Mr Westcott through the trap door. On closer scrutiny he could see Mr Westcott to the right of the door, sitting on the floor with his back against the wall. CO Britton-Stanley got no response when he called Mr Westcott's name. He opened the cell door and entered the cell with CO Scott Hayes. CO Britton-Stanley checked Mr Westcott's vital signs but was unable to detect any signs of life. Mr Westcott was deceased.

At approximately 8.10am, CO Britton-Stanley hit the duress button on his portable radio and then radioed the control room advising them of a Code Black. CO Britton-Stanley also noticed there was some blood on a shelf above Mr Westcott and a small laceration to the right parietal area of his head.

Supervisor Lydia Koukmenides and Nurses Dianne Bull and Darryl Hucker arrived at Cell 428 in SSU, soon after. Nurse Bull requested that a Mobile Intensive Care Ambulance (MICA) be called.

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[10] See Transcript of Proceedings @ p 421 - Detective Senior Constable McWilliam

[11] At trap muster the prisoner is required to come to the door of his cell to be identified before the CO unlocks the cell.

The Metropolitan Ambulance Service (MAS) was contacted by the prison control room and requested to attend PPP.

At 8.17am, MAS MICA Paramedic, Alexander Medancic, was despatched to PPP, backed up by the Emergency Medical Response pumper tanker. On arrival at PPP, at approximately 8.25am, Paramedic Medancic encountered delays at the front gate, the cell block gate and in being redirected to the rear of SSU before he reached Mr Westcott at Cell 428. The delay amounted to 7 minutes.

Nurse Bull provided a handover to Paramedic Medancic. There was no respiratory effort and no pulse detected and there were other physical signs that Mr Westcott had been deceased for sometime. Attempts at resuscitation were deemed inappropriate. MICA Paramedic, Alexander Medancic pronounced Mr Westcott deceased at approximately 8.32am.

At approximately 8.40am, off-duty prison doctor, Dr Jia Li Li was notified of Mr Westcott's death. Dr Li arrived at PPP at approximately 9.25am. He examined Mr Westcott, confirming the death at this time.

At approximately 11.00am, the State Coroner arrived at PPP.

## INVESTIGATIONS:[12]

### The medical investigation into cause of death:

Dr Malcolm Dodd, Forensic Pathologist, from the Victorian Institute of Forensic Medicine (VIFM) attended Port Phillip Prison and examined the scene. An external examination of Mr Westcott showed minor abrasions to the scalp but Dr Dodd found no evidence of offensive or defensive injuries. Dr Dodd also noted that a Ventolin inhaler and several tubes of cortisone based skin cream were located within the cell as was a note on the desk which read:

> **"Asthma Attack Buzzed For Help No Response"**

The following day, Dr Dodd performed a full post mortem examination at the VIFM. The autopsy identified mild cardiomegaly but no other naturally occurring disease. Dr Dodd attributed the cause of death to asthma, commenting:

> *'The post mortem examination disclosed all of the features one would expect to find in a case of asthma.*
>
> *Acute asthma may cause sudden unexpected death, with or without optimal management.*
>
> *The mechanism of death is acute airway obstruction secondary to muscle spasm and/or mucus plug occlusion.*

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[12] Investigation includes Inquest - Section 3 *Coroners Act 1985*

*At autopsy, any evidence of muscle spasm disappears leaving only the expected findings of asthma as seen in this case.'*

Dr Dodd concluded that:

*'There is no evidence to suggest that this death was due to anything other than natural causes.'*

Toxicological analysis did not initially identify the presence of alcohol or drugs, prescription or otherwise. On subsequent analysis, Salbutamol[13] was identified in blood at ~ 15 ng/mL.

**The Police Investigation** of the scene was conducted by members from Victoria Police Prison Squad and Werribee Crime Investigation Unit.

The search of Mr Westcott's cell identified droplets and smears of blood in various locations within the cell. The bed was made and appeared undisturbed. Police examined the note on the desk regarding the asthma attack and other paperwork. The medication located in the cell included 1 x Ventolin inhaler in the name of another prisoner, Shane Walker, 1 x Beconase spray in the name of Max Walker, 2 x Ventolin inhalers with no pharmacy labels one of which was almost empty and the other ~ full. There was also 4 x bottles of Diprosone lotion in Mr Westcott's name and 1 x Poly-Tears with no pharmacy label.

Due to the contents of the note found on the desk, Police checked the intercom system within Cell 428 and found that it was unable to make any outgoing calls or receive incoming calls.

Detective Senior Constable Greg McWilliam prepared the Inquest Brief for the Coroner.

**The Intercom System:**

Port Phillip Prison has an Austco Communications Intercom System ("intercom system") which was installed by the company Chubb. The system consists of cabling, circuitry and a MS DOS operating computer system. It is used to make announcements both general and to specific inmates in their cells and enables prisoners to contact Correctional Officers after lockdown.

The computerised intercom system is situated at the Officers' post in SSU. An Officer can call up the intercom in a prisoner's cell by selecting the last 2 digits of the cell number. When a prisoner activates the intercom from their cell an audible tone is created and a red light appears on the front panel and the system displays the cell number at the Officers' post. Daytime operation of the system generally operates by calls from cells being transmitted to the Officers' post, and would default to the Central Control after 60 seconds if not answered.

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13 Salbutamol is a sympathetic amine related to adrenaline used commonly as a bronchodilator in asthma and chronic bronchitis. Proprietary formulations containing salbutamol include aersol sprays (Ventolin, Respolin) and liquid for injection (Ventolin) or as a solution for use as a metered aerosol. ( Source: VIFM)

After lockdown in the evenings Central Control can remove the 60 second delay by changing the status of units from 'Attended' (staffed) to 'Unattended' (not staffed). At the time of Mr Westcott's death, the changing of the status did not routinely occur before staff vacated the unit, immediately after lockdown.

**PPP's procedural inspection of cells:**

PPP Operational Instruction No. 25 *Unit Security Checks*, requires COs to, amongst a number of things, visit each cell and check the operational capacity of the intercom system.

A daily cell inspection is performed by Correctional Officers and recorded in document *Daily Cell Security & Cleanliness Check Scarborough South*. The check involves:

- A general visual inspection of the cell to identify any damage or vandalism, or inappropriate things hanging on the walls;
- A visual inspection of the cell intercom system to ensure that there was nothing stuck on or covering the intercom speaker;
- Any excess linen or other things that needed to be addressed; and
- The general tidiness of the cells.[14]

On 25 November 2005, CO Patricia Stanton inspected all the cells on the lower level of SSU[15]. The inspection did not identify any issues requiring maintenance or rectification. Mr Westcott did not report any matters requiring attention within his cell.

The extent of the inspection performed by CO Stanton appeared to be consistent with a culture and practice of PPP staff. It was a visual inspection only. No manual inspection testing for functionality was performed.

Operational Instruction No. 25 was not being complied with in that cell intercoms were not tested daily to determine functionality.

**Routine maintenance of the intercom system:**

Honeywell Limited was contracted by GSL in 2002,[16] for all matters relating to the security systems which included conducting routine preventative maintenance of the cell intercom systems.

Each cell within PPP is fitted with an intercom system with the capacity of providing communications to and from the local officer post/station within an accommodation unit and

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[14] See Exhibit 19 - Statement of Correctional Officer Patricia Stanton, Inquest Brief @ p.218

[15] ibid @p.220 Inquest Brief

[16] See Transcript of Proceedings @ p 328 - Mr Murray Walls. Other documentation indicates 2003.

any one cell, and to and from the prison central control room to any one cell and the local officer post/station.

All cell intercoms are hard wired to a locked panel housed in a locked services cupboard situated in a secure area within the airlock[17] of the unit. This panel is referred to as Local Control Equipment (LCE). The LCE connects to the unit Local Operators Station (LOS) and the prisons Central Control Room (CCR). Security to the services cupboard is enhanced by restricted access and a computerised alarm system which records the date and time everytime the cupboard is opened.

Each cell intercom has its own connection point on a board on the communications rack within the services cupboard, which in turn is connected to a centralised computer system within the prison. The connection points for each of the individual cell intercom system are 6 pin standard telephone plugs.

The routine maintenance on the intercom system was performed quarterly by Honeywell Ltd. and involved a manual test of the communication connection between each cell's intercom and the local officer's station. In addition, 4 intercoms would be randomly selected and checked for their communication viability with the prison control system.

Overall, the intercom system was viewed as reliable. The majority of issues requiring attention by Honeywell stemmed from prisoner interference with the intercom unit in the cells. Toothpaste squeezed into the unit was not uncommon and served to reduce the volume of the transmissions into and out of the cell. The presence of toothpaste squeezed into the cell unit was not, at this time, viewed as a fault *per se* and was not identified by the daily visual inspections performed by the Corrections Officers.[18]

**Maintenance in the relevant period:**

On 29 July 2005, Honeywell employees conducted and completed a routine maintenance on the intercom systems in SSU. The next routine maintenance, scheduled for 25 October 2005, was postponed due to the unavailability of a onsite facility leader.

In September 2005, several of the accommodation units, including SSU, lost communications due to a lighting strike. On 10 September 2005, the intercom systems were restored by Honeywell employees but found to be inoperable again on 11 September 2005. Repairs to intercom systems throughout PPP were completed and operable by 12 September 2005.

No further intercom testing was performed by Honeywell at SSU prior to Mr Westcott's death. The next scheduled routine maintenance was to be completed by the end of November 2005[19].

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[17] The airlock is an area between 2 doors which separates the entry into and exit of persons from the accomodation unit.

[18] See Transcript of Proceedings @ pp 205-206 - Mr Chris Kemp

[19] See Statement of Murray Walls @ p.165 Inquest Brief

**Maintenance of the Service cupboard:**

Honeywell was also responsible for maintenance of the service cupboard. Dirt, dust and debris would enter the cupboard under the door. The cupboard was not situated in an environmentally controlled space. Every 3 months cleaning of accumulated dirt and dust within the cupboard was attended to with a vacuum cleaner however, the cleaning did not extend to the accumulation of dust and moisture on the circuit boards.[20] Cleaning of the service cupboard was inadequate.

The Department of Justice conducted a yearly audit of all the prison services which included checking on Honeywell's maintenance procedures. Although predominately a paper audit, some testing and visual inspection[21] would occur but did not extend to any meaningful scrutiny of the service cupboard.

**Intercom communications with Mr Westcott / Cell 428 in the relevant period:**

On 15 November 2005, at approximately 5.00am, 3 calls in quick succession, were made from the Control Room to Cell 428.[22] These were likely to have been wake-up calls to Mr Westcott as he was required to be on the transport to attend a scheduled Court appearance. The call recording indicates that there had been two-way communication[23].

No further intercom communication with the Control Room occurred from or with Cell 428.

**Testing of the intercom system after Mr Westcott's death:**

Testing undertaken by Honeywell employees, Mr Chris Kemp, Security Technician and Mr George Thost, Services Technician, on 26 November 2005, demonstrated that the intercom system was only functioning one way - communication from the Officer's station to Cell 428 was possible but not from Cell 428 to the Officer's station.

Detective Senior Constable McWilliam also tested the intercom system on 26 November 2005, and found that there was no communication in either direction.[24]

Mr Kemp checked the telephone plug for Cell 428 in the services cupboard by removing it and reinserting/re-seating it back into the rack and then testing the intercom 4-5 times. The intercom system worked leading Mr Kemp to form the view that the telephone connection

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[20] See Transcript of Proceedings @ pp 212-213 - Mr Chris Kemp

[21] See Transcript of Proceedings @ p.366 - Mr Murray Walls

[22] See Transcript of proceedings @ p. 207 - Mr Chris Kemp and Brief of Evidence @ p. 1268

[23] See Transcript of Proceedings @ p.240 - Mr Chris Kemp

[24] See Transcript of proceedings @ p.434 - D/S/C McWilliam

for Cell 428 was not seated correctly in the rack in the services cupboard.[25] The fault was considered rectified.

Subsequent testing undertaken on 30 November 2005, as the quarterly maintenance testing, demonstrated all intercoms in SSU to be functioning.

On 2 December 2005, the intercom in Cell 428 failed again. On this occasion the telephone plug in the services cupboard was replaced on the grounds that it was *probably not seating in the socket properly.*[26] No subsequent testing was performed on the removed plug.

**PPP's response to the identified intercom failure:**

On 30 November 2005, the Director, Mr Dennis Roach issued the following instruction to staff:

> *Cell intercoms are to be tested on a daily basis at unit level to ensure that they are operational. This test should involve the Officer pushing the cell intercom button to ensure connection back to the Unit Officer Station.*
>
> *Notations including any faults, should be made in the Daily Cell Security book which is issued to each unit.*
>
> *In the event of a fault, the Area Supervisor is to be informed immediately and they will contact maintenance to address the situation and ensure the system is fully operational before lock up. If not, the Area Manager must be contacted and the cell taken off line or other communication processes implemented.*
>
> *A revised version of Operating Instruction No. 25 Unit Security Checks will be issued.*

**The medical management of Mr Westcott at PPP:**

Relevant to this investigation is the medical management of Mr Westcott's asthma. Despite being informed of this condition, the Health Service made no attempt to obtain his medical records from the community or from his previous period of imprisonment.

Mr Westcott's few attendances for medical attention for this known condition in part supports Mr Westcott's own assessment, that is, that his asthma was *mild.* However, no formal assessment was ever performed to corroborate his own assessment, he never received any education about the management of his asthma and no asthma plan was generated.

Similarly, a formal review and assessment of Mr Westcott's asthma was not initiated following his presentation on 8 November 2005, with complaints of his *Ventolin not working.* Neither the recording of a peak flow of 200 or the marginal improvement following the administration of nebulised Ventolin, prompted the initiation of a formal

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[25] See Transcript of Proceedings @ pp 202 & 218 and Brief of Evidence at p.150

[26] See Brief of Evidence @ p. 162 - Statement of Mr George Thost

assessment or the implementation of an asthma plan. His use of Ventolin is not recorded so as to obtain any meaningful information of his condition and there appears to have been no reference to the 2002 Asthma Management Handbook for guidance.

When reference was made to the Handbook during the Inquest, Dr Tuck agreed with Mr Freckleton of Counsel that as of 8 November 2005, Mr Westcott would have been classified as having a *moderate level of severity of asthma.*[27]

**FINDINGS and COMMENTS:**

The procedural issues which led to the delay in MICA Paramedic Alexander Medancic accessing PPP and Mr Westcott's cell did not contribute to Mr Westcott's death. I am satisfied on the evidence that Mr Westcott was already deceased and not capable of resuscitation by the time he was located at trap muster. A seven (7) minute delay to Emergency Services reaching a prisoner could be critical in other life threatening situations. It is not however necessary for me to expand on this matter further, save to say that I am satisfied PPP have responded appropriately to rectify this identified issue.

A number of other reforms have also occurred since Mr Westcott's death however, many matters are still deserving of comment.

The functionality of the intercom system was not done on a daily basis. Maintenance relied upon the reporting of faults by prisoners or CO's or the quarterly maintenance inspections of Honeywell Ltd. There was a systemic non-compliance with Operational Instruction No.25. A daily cell inspection that purports to be in part about cell *security* should incorporate meaningful checks on the functionality of the intercom system in each cell. Two-way communication is a fundamental part of the safety and security of the incarcerated, particularly during the lockdown period. The circumstances of Mr Westcott's death highlights the vulnerability of prisoners. Personal security was reduced by a practice that placed the same importance on a "cleanliness check," which was effectively no more than a tokenistic *inspection* of each cell.

I accept that Honeywell Ltd complied with its contractual maintenance obligations of the intercom system. They relied on the information contained in the intercom system User Guide,[28] went beyond the recommended 4 monthly service on all cell call systems to 3 monthly, a systematic cleaning of local circuit boards was not recommend by Asco Communications[29] and its procedures for the purposes of testing the ongoing functionality of the intercom system appeared appropriate and reasonable.[30] However, the exact cause of the failure of Mr Westcott's intercom system on 25-26 November 2005, has not been

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[27] See Transcript of Proceedings @ p 83 - Dr Tuck

[28] See Exhibit 9 - System 3200 User Guide

[29] See Transcript of Proceedings @ p.303 - Mr Neil Debut

[30] See Brief of Evidence @ p200 - Mr Geoff Perkins and Transcript of Proceedings @ p 293-294 - Mr Neil Debut

identified and remains the subject of some speculation.[31] The probable cause was identified as a poor connection of the intercom plug at the local control equipment socket.

No responsibility for the intercom system failure rests with Mr Westcott. There is no evidence that he had tampered with his cell's intercom system. Possible causes of the failure have been attributed to the plug that was ultimately removed on 2 December 2005, or an intermittent cable fault away from the plug.[32] The plug seems to be the most likely source of the fault. A single pin on the 6 pin plug resulting in an intermittent faulty connection on the circuit board/rack housed in SSU's service cupboard. The cleaning of the service cupboard was inadequate and may have contributed to the fault occurring to the plug which in turn, affected Mr Westcott's intercom.

The inability to identify the cause of the intercom system failure is indicative of a system, by computer standards, that is archaic. The system has a limited internal fault diagnostic capability. As stated in the Corrections Inspectorate Report[33]:

> *'The risk of hard drive failure resulting in loss of data and functionality increases significantly with age when it comes to PC equipment.[34]'*

Honeywell's compliance with standards and the User Guide and the additional functionality testing, was not sufficient to ensure the provision of a reliable security system for prisoners. The benchmark of reliability in the circumstances of prolonged periods of isolation must, by necessity, be extremely high. Mr Westcott's death highlights this. The technology must be capable of meeting the security needs of the isolated at all times.

Mr Westcott was a known asthmatic. He was on minimal medication. He had never required emergency medical intervention for an "attack". He continued to smoke cigarettes despite the presence of this condition, his need for prophylactic Ventolin and his propensity for coughing. Mr Wetscott's asthma was never assessed at PPP. He had been incarcerated at PPP for approximately 5 months. The prison lacked a co-ordinated approach to the management of prisoners with asthma. The clinical judgement of individual practitioners[35] took precedence over the accepted use of preventative medication or of the formulation of a written Asthma Action Plan. The initial failure to assess Mr Westcott on admission could have been rectified when he presented with compromised respiratory function on 8 November 2005. This was not done and represents the loss of an opportunity to provide Mr Westcott with a standard of medical management equivalent to what he would have received in the community.[36] The medical records/record keeping were also of questionable standard

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[31] See Transcript of Proceedings @ p. 297 - Mr Neil Debut

[32] See Transcript of Proceedings @ p. 310 - Mr Neil Debut

[33] Prepared by IPP Consulting Pty Ltd - also referred to as "the IPP Report" - Inquest Brief pp 198-209

[34] @p 206 Inquest Brief

[35] See Transcript of proceedings @ p 116 - Dr Tuck

[36] See Transcript of Proceedings @ pp 503-505 - Dr Al Raheb

and were not properly utilized or capable of being utilized as a means of communication between the health care providers.

I find that St Vincent's Correctional Health Services failed to inform itself or assess and manage Mr Westcott's asthma condition and failed to provide him with any education of how he should best manage his own condition.

I accept Dr Tuck's evidence that asthma can cause sudden unexpected death even with optimal management.[37] The onset of Mr Westcott's "attack" was, in all probability, sudden and unexpected to the extent that it was sufficiently debilitating to prevent him from effectively communicating with his friend in the neighbouring cell. He did however, have sufficient time and self control from the onset of the attack, to write a note - a note which states that he tried to use his intercom system to get help. The handwriting was confirmed to be that of Mr Westcott's. There was no evidence that the note had been written at some earlier time.

I thus find that Mr Westcott's death was not "sudden" or without warning, or sufficient warning so as to render his death unpreventable.

I find a direct correlation between the failure of the intercom system and Mr Westcott's death.

I find that the failure of the intercom system denied Mr Westcott the opportunity to receive medical attention. Accepting that his communications to the control room would have led to prompt medical attention, I find, on the balance of probabilities, that the outcome would have been different if a secure and functioning communication system had been in place.

I find that GSL failed to take proper measures to ensure the functionality of its security/ communication/intercom system

There is no evidence to suggest self-harm.

I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and find that **Ian Thomas Campbell Westcott** died from asthma in circumstances that lead me to conclude that his death was preventable.

## RECOMMENDATIONS:

A number of recommendations for improvements and prevention of like incidents contained in the IPP Report, made by witnesses and in submissions have provided me with assistance. I acknowledge and commend the prompt response to Mr Westcott's death by Mr Roach particularly in relation to enforcing meaningful daily testing of the intercoms.

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[37] See Transcript of Proceedings @ p. 105 and Brief of Evidence @ p. 67 - Dr Malcolm Dodd

I make and/or adopt the following recommendations:

**Recommendation 1:**

That a review of intercom/security systems in all Victorian prisons be commissioned by the State for the purposes of implementing and/or upgrading system technology to ensure the availability of the highest possible standard of reliable communication systems to all prisoners throughout the State.

**Recommendation 2:**

That the Department of Justice review its own procedures for the delivery of effective, thorough and regular auditing of maintenance of prisoner intercom/communication systems in all Victorian prisons.

**Recommendation 3:**

That there be annual independent audits to confirm the maintenance procedures are in place and meet Australian, manufacturer and accepted industry standards.

**Recommendation 4:**

That prior to the outcome of a Statewide prison review, the operator of PPP attend to the upgrade of the Ausco computer associated equipment in the Main Equipment Room and Main Control Room to ensure that the risk of failure is minimised.

**Recommendation 5:**

That the company contracted by the operator of PPP for matters related to the security system implement additional maintenance including the frequent removal and replacement of plugs to reduce the risk of security failure and to maximise the life of the communications system.

**Recommendation 6:**

That seals be placed on the bottom of all service cupboards, and additional maintenance cleaning of the service cupboard be undertaken, so as to minimise the risks that accumulated dirt, dust, cobwebs and the like may have on the integrity of the system.

**Recommendation 7:**

That there be strict daily adherence to the Director's Orders for the physical testing of functionality of all cell intercoms in all Units by Correctional Officers and that the documentation of the daily testing accurately reflect that communication between the cell and the Officers' post is viable in both directions.

**Recommendation 8:**

That the Director of PPP implement directions to ensure strict adherence to changing the status of the intercom system to 'Unattended' before COs vacate the Unit after lockdown.

**Recommendation 9:**

That all prisoners on arrival at the prison be provided with information and education on the working of their intercom system, and the measures to adopt in the event of failure or malfunctioning of their system, including notifying Correctional Officers of faults and with requests for an alteration to the volume of the communications.

**Recommendation 10:**

That all prisoners be provided with periodic education/reminders about the important role a fully functional intercom system plays in respect to their health and well-being.

**Recommendation 11:**

That the operator of PPP explore the potential for installing duress buttons, or other emergency back-up cell communication systems that could be activated only during lockdown, or alternatively installed in a number of cells that could be allocated to prisoners identified at risk for medical reasons.

**In relation to medical management issues identified in this investigation, I make the following recommendations that St Vincent's Correctional Health Service in conjunction with Justice Health:**

**Recommendation 12:**

Develop standards for documentation for patient records and implement education to all healthcare providers in respect of the same.

**Recommendation 13:**

Ensure prompt and thorough medical assessments of all incoming prisoners.

**Recommendation 14:**

Identify and record all prescription and non-prescription medication on admission and ensure all are labelled with the prisoner's name. All subsequent dispensed medication - prescription or nurse initiated, be labelled with the patient's name.

**Recommendation 15:**

Implement procedures for the timely obtaining of medical records from community medical providers and records associated with previous periods of imprisonment for all prisoners identified with pre-existing medical conditions.

**Recommendation 16:**

Implement a standard of asthma management for prisoners, consistent with the expectations of the community and the medical profession, through the utilisation of the current edition and any subsequent editions, of the Asthma Management Handbook and that the assessment and management of all prisoners with asthma include a base line Peak Flow on admission, a written asthma care plan reviewed periodically, and prisoner education on personal management and minimisation of triggers.

**Recommendation 17:**

Ensure all medical and correctional staff be provided with education on the emergency treatment of asthma including the use of Ventolin and oxygen for resuscitation purposes.

**Recommendation 18:**

Undertake a review of the case loads of medical practitioners and nursing personnel with a view to ensuring that the standard of delivery of health services to prisoners is at a standard equivalent to the provision of health services in the community and is not compromised by excessive demands on limited staff.

## OTHER MATTERS:

Ms Vanessa Westcott raised a number of concerns to the Corrections Inspectorate and the State Coroners Office, regarding the priority of communications provided to Ms Anderson above herself and her mother, the status of senior-next-of-kin attributed to Ms Anderson, the release of property to Ms Anderson, and the distress of viewing her deceased father without sufficient prior warning.

I am grateful to Ms Westcott for her own submissions and comments.

I acknowledge that timely communication and the provision of information is important for family members who unwittingly become involved in the coronial process. Disputes over senior-next-of-kin[38] status can add to the distress experienced by family members at the outset but is determined in accordance with the Act and on information available at the time. Any additional distress experienced by family members by delays in the Inquest being finalised and the delay to which I have contributed, in the delivery of this Finding, was unintended and regrettable. *The Record of Investigation* is not however the appropriate

[38] See Section 29(5) *Coroners Act 1985*

vehicle to respond to all of the concerns expressed by Ms Westcott, as the document is intended to facilitate the discharge of my statutory role in relation to the death under investigation, as prescribed in Section 19 of the Act.

AUDREY JAMIESON
CORONER
9 July 2009

**Appearances:**

Senior Constable Alistair Hodgeman, State Coroners Assistants Unit - assisting the Coroner
Dr Ian Freckleton of Counsel - on behalf of Ms Vanessa Westcott (Fitzroy Legal Service)
Mr Andrew Halse of Counsel - on behalf of GSL Custodial Services Pty Ltd
Ms Debra Coombs of Counsel - on behalf of Corrections Victoria
Mr John Goetz of Counsel - on behalf of St. Vincent's Correctional Health Services
Mr Jason Gullaci of Counsel - on behalf of Honeywell Ltd (Baker and McKenzie)

**Witnesses providing *viva voce* evidence:**

Mr Christopher Kemp (previous Honeywell Security Technician)
Mr Murray Walls (Honeywell Team Leader)
Mr Dennis Roach (Director of Port Phillip Prison)
Mr Neil Debut (Director, IPP Consulting - Security and Risk Consultant)
Ms Patricia Stanton (Correctional Officer)
Dr Eugenie Tuck (St Vincent's Correctional Health Service, Port Phillip Prison)
Professor John William Wilson (Department of Allergy, Immunology & Respiratory Medicine, The Alfred Hospital)
Dr Eiman Al-Raheb (previously employed by St Vincent's Correctional Health Service)
Detective Senior Constable Greg McWilliam (Investigating Officer)

**Distribution of Finding:**
Ms Vanessa Westcott
Ms Michelle Anderson
Attorney-General of Victoria
Mr Dennis Roach, Director, Port Phillip Prison
Chief Executive Officer, St Vincent's Correctional Health Services
Chief Executive Officer, Justice Health