CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 16, 17th, 22nd and 23rd days of May, and 16th day of June, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Marshall Freeland Carter.

I, the said Coroner, do find that Marshall Freeland Carter, aged 19 years, late of Yatala Labour Prison, Northfield, died at Yatala Labour Prison on the 3rd day of May, 1998 as a result of heroin toxicity. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 7 February 1997 Marshall Freeland Carter was sentenced to four years and six months imprisonment, to be served at the Cavan Training Centre rather than in an adult prison. On 23 March 1998 he appeared in the Adelaide Youth Court, where he made an application to serve the balance of his sentence in an adult prison. This was granted, and he was transferred to Yatala Labour Prison ("YLP") that day, and remained there until his death.

1.2 Accordingly, on 3 May 1998 Mr. Carter was "detained in custody pursuant to an Act or law of the State" within the meaning of Section 12(1)(da) of the Coroners Act 1975, and an inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

2. **Background**

2.1 Marshall Carter was born on 4 March 1979. His father states that he grew up in a house where alcohol and drugs were not permitted. He excelled at sport, particularly football. He said:-

> "I was a strong role model by abstaining from alcohol and drugs, however this was not sufficiently strong to prevent my son from taking drugs and committing crime in company with his peers. His peers are also victims of the same system and society". (Exhibit C.40, p3).

2.2 Marshall Carter was first sentenced to detention in 1993 at the age of 14, and spent a large proportion of his life in custody from that time on. Social background reports prepared for his many court appearances record that he was a persistent drug abuser, particularly using marijuana, amphetamines and "pills" (see Exhibit C.37b).

2.3 When he was 16, Marshall Carter entered into a defacto relationship with Belinda Austin, and became the father of a son. Unfortunately, this failed to produce an increased sense of responsibility, and his offending continued.

2.4 The Cavan records reveal that Marshall Carter regularly engaged in overtly self-destructive behaviour:-

- in June 1995 he swallowed a number of "pills", as a result of which he was admitted to hospital;
- on 25 February 1996 he was observed inserting a television aerial cord into an air-conditioning vent. He was overhead telling another boy next day that he had been serious about hanging himself. He refused to discuss the incident with staff. His intentions were unclear, since this incident occurred in full view of staff and other residents;
- a "psycho-social screening report" in February 1996 records that Marshall said he would abuse alcohol several times a week, marijuana 11 to 19 times most days, hallucinogens and sedatives/hypnotics once or twice a week, and narcotics, stimulants and solvents/inhalants once or twice a month;
- a health analysis at Magill Training Centre in February 1997 records that he admitted using amphetamines and heroin intravenously.

2.5 On 5 June 1997 Marshall Carter appeared in the District Court of South Australia before Judge Bright. He entered pleas of guilty and was sentenced as an adult pursuant to Section 29 of the Young Offenders Act. Upon conviction for armed robbery a sentence of four years and six months, with a non-parole period of eighteen

months, was imposed. On a conviction for break, enter and steal, a concurrent sentence of nine months was imposed. As I have already mentioned, the sentence was ordered to be served at a training centre rather than an adult prison. A perusal of His Honour's sentencing remarks discloses that he placed great weight on Marshall's youthfulness, and imposed a relatively lenient sentence for a very serious crime, during which a stolen handgun was discharged.

2.6 I have also mentioned the transfer to YLP on 23 March 1998. Mr. Carter (Senior) states that he was opposed to his son's request for a transfer, but he acquiesced (Exhibit C.40).

2.7 When he arrived at Yatala, Marshall Carter was housed in E Division, J Wing, Unit 3, Cell 302. His earliest release date was recorded as 6 August 1998, a period of less than five months.

3. **Events of 2 May 1998**

3.1 At about 10.00a.m. on 2 May 1998 Correctional Officer W.A. Elliott found a cut-down syringe hidden in the ceiling of a toilet in a common area of Unit 3 during a routine search. A written report was submitted to the Manager (Exhibit C.36), but no obvious follow-up action was taken.

3.2 The statement of Ms. Maria Bordoni, then General Manager of YLP, suggests that this report did not come to her attention until the following day, when she handed the syringe over to the police (see Exhibit C.17a).

4. **Events of 3 May 1998**

4.1 At about 8.45a.m. on 3 May 1998 Correctional Officer Elliott took a telephone call from Mr. Carter (Senior), who said that he had some "bad news" for his son. When Marshall had finished the call, Mr. Elliott asked him if he was alright, to which he replied "Yes, I am fine boss" (Exhibit C.36a). He said that he observed Marshall on several occasions for the rest of that day, but he showed no sign of being unduly upset.

4.2 Marshall Carter's cell-mate, George Wilson, confirmed that he was a "bit depressed" at hearing the news that his uncle, who was only 21, had died, and because it was doubtful that he would be able to attend the funeral in Sydney (Exhibit C.33, p3).

4.3 The prisoners in E Wing were locked in their cells at 3.45p.m. that day. The cells were double-locked, and the master key was taken to the control room, about 300 to 400 metres away, in accordance with normal practice.

4.4 Stanley Wells, a cousin of Marshall Carter's, said that as he went to his cell:-

> "I hit on the trap and I said 'Marty, look, you're already piddled out of your head ... and you got dope, so don't go taking any of the other stuff'". (Exhibit C.34a, p7).

This statement was given to Detective Sergeant Linton on 24 November 1999. Wells said in evidence that he did not know Marshall Carter was using heroin, and that he made the above comments to him "out of the blue" (T.60). I do not believe him, for reasons which I will discuss later.

4.5 Wells told the police on 4 May 1998 that Marshall Carter was "off-colour" and "uncoordinated" during the afternoon of 3 May (Exhibit C.34).

4.6 Wells also told Detective Sergeant Linton on 24 November 1999 that he had heard George Wilson ask Jimmy Fricker for heroin during the day, before lockdown, and he heard Fricker say "oh yeah, we'll fix you up later tonight" (Exhibit C.34a, p4);

4.7 Wells told Linton that he heard a "line" going across from cell 302 to Fricker's cell (309) at some stage that night (Exhibit C34a, p5). Another prisoner, Donald Gray, gave a similar statement to police, but he has not been located so his statement is not verified on oath. Michael Rigney also gave information to police along the same lines, but this information was hearsay (Rigney was not at YLP at the time), and Rigney has since withdrawn his allegations, saying that they were "untrue" (Exhibit C9a).

4.8 Both Fricker (Exhibit C.25b) and Wilson (T.45) denied all knowledge of these events, and Wilson denied that he was using heroin at all around the time of Marshall Carter's death (T.44-5). Wilson admitted that at one stage during the evening he sent a line across to Fricker's cell to get some cigarettes (T.24).

4.9 Incidentally, a "line" is a piece of thread or string, weighted at one end with a comb, ruler, or similar object. The weight is slid across the polished floor of the cell, under the door, across the corridor and under the door of the cell opposite. An article is then tied to the line, which is then pulled back to the original cell. I was told that this is a quite common method of exchanging contraband at the prison, and it is surprising that it is allowed to continue, since relatively simple physical barriers would seem to be sufficient to prevent it occurring.

5. **The evening of 3 May 1998**

5.1 George Wilson said that after lockdown, he and Marshall Carter watched television, smoked marijuana, and at about 6.00p.m. he fell asleep (T.22). This contradicts his statement to Detective Brown on 3 May 1998, when he said he watched television while Marshall Carter fell asleep (Exhibit C.33, p6).

5.2 Wilson said that some time later he heard Marshall Carter making "funny noises" as if he was choking. He shook him, and noticed blood come from his mouth when his head turned to one side. He said that it was at this point that he called the correctional officers on the intercom (Exhibit C.33, p7). Correctional Officer Luckett said that this call was made at "approximately 2036 hours" or 8.36p.m. (T.74).

5.3 Correctional Officers Luckett and Smith went to cell 302, and Luckett asked Wilson what was happening, and Wilson replied:-

> "He's been coughing up blood".

Luckett asked him if he was breathing and he said "yes". Luckett said that he also noticed what appeared to be blood and froth around Carter's mouth (T.76).

5.4 Luckett and Smith returned to the officers' station in Unit 3, where Smith telephoned the control room and asked that the master key be taken to E Wing immediately. In the meantime, Luckett contacted the infirmary on the intercom and requested the immediate presence of a nurse. Both officers then returned to the cell.

5.5 At the cell, Luckett said that he told Wilson to roll Carter on his side, and to check his mouth to ensure his airway was patent. He asked Wilson to check if Carter had a pulse. He saw Wilson put his finger on Carter's neck, and "then I think he stated there was" (T.79). He then told Wilson to roll Carter over into the "coma position".

Luckett asked Wilson how long Carter had been coughing up blood, and Wilson replied "about fifteen minutes" (T.79).

5.6 Luckett's evidence is contradicted somewhat by Wilson, who said that as soon as he woke up (i.e. before Luckett arrived outside the cell) and realised that Carter was not breathing properly, he checked for a pulse and could not find one (T.41). It is significant that he did not mention this to the correctional officers at the time.

5.7 Correctional Officer Wilkinson, who was senior officer on the watch, said that Smith's call was received in the control room at 8.38p.m., and she walked towards E Division (a distance of 300 to 400 yards) because she did not realise that it was an emergency. She understood that Marshall Carter was vomiting, and needed to be taken to the infirmary. It was not until she met Registered Nurse Evans at the E Division front door, who told her that Marshall Carter was unconscious, that she ran to the cell (Exhibit C.11a, p1).

5.8 Registered Nurse Evans, who has since died, told Detective Anderson that he also had no indication of an emergency, so he, too, walked to E Division from the infirmary (a much shorter distance). When he saw Marshall Carter through the trap door, he realised that the situation was serious, so he went back to the infirmary and collected the emergency box and the Air-Viva machine, and returned, meeting Wilkinson at the front door (see Exhibit C.10a, p1-2).

5.9 Both Evans and Wilkinson confirmed that the cell door was opened at 8.43p.m., seven minutes after Wilson raised the alarm, and five minutes after Smith had called the control room on the telephone. This is an unacceptably slow response, which I will discuss in further detail later.

5.10 Registered Nurse Evans described what occurred after the cell door was opened as follows:-

> "Upon examination, the prisoner had small amount of mucus on the left side of his mouth. Both nostrils were full of frothy mucus. His pupils were dilated. His digits were cool and pale. No pulse was discernible at either his carotid or femoral arteries.
>
> I requested an officer standing by to get an ambulance. I also asked for the patient's cell mate to be taken out of the cell.
>
> I pulled the patient off his mattress with the assistance of Officer Steve Smith. The patient was given pure oxygen via the Oxy Viva mask, assisted by Officer Ian Stroud. I

then commenced CPR on the patient. After a while Officer Smith relieved me with the CPR and then I relieved him.

Two ambulance officers then arrived at about 2055 hours and they took over management of the patient. The ambulance officers placed ECG pads on the patient but there was no response. They then inserted IV lines and an intratracheal tube. The ambulance officers continued with CPR on the patient.

At 2107 they ceased resuscitation attempts as it was considered to be of no further benefit". (Exhibit C.10a, p2).

6. **Cause of death**

6.1 Dr. J.D. Gilbert, forensic pathologist, attended at YLP at about 12.15a.m. on 4 May 1998. He formally certified life extinct at 12.20a.m. He noted some old needle marks in the right cubital fossa (inside elbow), and one recent mark in the same area. He noted the ambient temperature at 20°C, and the temperature of the body at 34.5°C.

6.2 Dr. Gilbert performed a post mortem examination later that day. An analysis of specimens of blood and urine taken at autopsy was undertaken. The blood contained morphine (0.06mg/L), tetrahydrocannabinol (THC) and 11-nor-9-carboxy-THC. The urine contained morphine, codeine and 6-monoacetylmorphine (report of Mr. Vozzo, Exhibit C3a). The combined effect of this evidence is that the morphine was probably taken in the form of heroin, and that the deceased had probably consumed cannabis within a few hours of his death, and may have still been under its influence at the time of death (Exhibit C2b, p4).

6.3 Dr. Gilbert attributed Marshall Carter's death to heroin toxicity. He added the following further comments:-

"2. The blood morphine level of 0.06mg/L was not high but was consistent with recent use of heroin. The period of survival after use of heroin was unknown at the time of the autopsy. Some deaths attributable to heroin occur very quickly after injection of the drug and blood levels of morphine in these cases are usually high. Other deaths appear to follow a prolonged period of survival, usually in a comatose state, with death ultimately due to respiratory depression. The deceased's morphine level was not sufficiently high to associate with the first pattern of heroin death. In the absence of any other apparent cause for death, it appears most likely that the death was due to heroin toxicity and that there was a period of survival after injection of the drug. Low tolerance to the drug due to infrequent availability and possibly lack of significant prior usage may have contributed to the deceased succumbing to a relatively low dose.

3. There were no injuries or other markings on the body to indicate the involvement of another person in the death.

4. No natural disease that could have caused or contributed to the death was identified at autopsy.

5. Rectal temperature measurement suggested an approximate time of death 8 to 9 hours (+/- 2.8 hours, 95% confidence limits) prior to the temperature measurement at 0030 hours 4/5/98. This is difficult to reconcile with the stated circumstances where, according to the deceased's cell mate, the deceased was showing some respiratory activity not long before help was summoned at around 2030 hours 3/5/98. No information about independent sightings of the deceased prior to his reported collapse was available at the time of this report nor at the scene".

(Exhibit C.2b, p5).

6.4 Dr AC Thomas, Associate Professor of Histopathology at Flinders Medical Centre, attended the latter part of Dr Gilbert's autopsy at the request of the Aboriginal Legal Rights Movement, and with my permission. He then undertook his own examination of relevant tissues. Dr Thomas records Dr Gilbert's full cooperation (Exhibit C32a, p1).

6.5 Dr. Thomas agreed with Dr. Gilbert's diagnosis as to the cause of death. He said that the level of morphine was "well within the range known to cause fatalities" (p.7). Dr. Thomas' findings at autopsy were essentially the same as those of Dr. Gilbert. He added to the picture by advising that:-

- histological examination of the acute venepuncture mark in the cubital fossa suggested that it had been made several hours before death (C.32a, p4);
- he estimated the time of death at between 3.00p.m. and 8.30p.m. on 3 May 1998, but described these estimates as "notoriously inaccurate" (Exhibit C.32a, p5).

He added:-

> "In view of the given history of the deceased being found by his cell mate around 2030 hours on 3 May unarouseable, lying on his back and making 'gurgling' noises, the actual time of death would be closer to 2030 hours. The finding of an acute inflammatory reaction related to one of the venepuncture marks in the right antecubital fossa would then be in keeping with the deceased having received an injection around 1630 to 1730 hours but this is again a very approximate estimation. This would suggest that the deceased may have been lying unconscious or semiconscious for several hours prior to actual death. This may well have led to loss of body heat (hypothermia) prior to actual death and could explain the calculation of the timing of death as ranging from 1500 hours to 2030 hours. Any hypothermia existing at the time of death would lead to a spuriously high calculated death interval. If the body temperature at the time of death was 36°C rather than the normal 37°C, the calculated death interval would range from between 1630 hours and 2200 hours". (Exhibit C.32a, p5-6).

6.6 In view of that evidence, there is nothing to contradict George Wilson's evidence that Mr. Carter was still alive, but perhaps only barely so, when he called on the intercom for assistance at 8.36p.m. His evidence before me that there was no pulse when he

checked before calling on the intercom is confusing. To this should be added the evidence of Registered Nurse Evans, who also found no pulse, and found cooling and pallor of the fingers.

6.7 The pathological evidence suggests that Mr. Carter had been comatose for a much longer period than the fifteen minutes or so reported to Mr. Luckett by George Wilson. Dr. Thomas said:-

> "The finding of the metabolite of tetra-hydro cannabinol is an indication of cannabis use in the past weeks to months whereas the finding of THC itself is an indication of cannabis use within hours of death. Morphine, codeine and monoacetylmorphine were identified in the urine. Heroin is diacetylmorphine which is metabolised to monoacetylmorphine and morphine. Codeine is a common contaminant of street heroin. It may also be found in analgesic compounds such as Panadeine. Morphine is a powerful narcotic analgesic used medically for the treatment of intractable pain. Repeated use may produce addiction.
>
> Morphine can be found in blood as a result of the administration of morphine itself or heroin which is rapidly metabolised to morphine but the presence of monoacetylmorphine in the urine can be considered as evidence of heroin use. There is considerable overlap between the reported therapeutic concentration range of morphine in blood (0.04 to 0.5mg/L) and reported fatal concentrations with different studies quoting different ranges of blood morphine in heroin fatalities:
>
> 1. One report of 56 putative deaths where death occurred within three hours of a morphine or heroin intravenous injection quotes morphine levels ranging from 0.08 to 1.65mg/L with a mean of 0.38mg/L.
> 2. A report of 101 deaths involving heroin or morphine where the death was thought to have occurred more than three hours after the dose, the blood morphine concentrations ranged from 0.004 to 2.2mg/L with a mean of 0.23mg/L.
> 3. A third report of 15 heroin fatalities quotes blood morphine levels ranging from 0.01 to 1.1mg/L.
> 4. Another report of 27 fatalities resulting from intravenous administration of heroin quotes blood morphine levels ranging from 0.05 to 3.0mg/L.
>
> This emphasises the overlap in the therapeutic and fatal ranges.
>
> Post mortem fluid concentrations of morphine in victims may vary considerably depending on prior narcotic history. The finding of the metabolite monoacetylmorphine in the urine suggests that the administration of the heroin occurred some time prior to death and this would be in accord with the histological examination of the skin of the right antecubital fossa which suggested that an injection had been made several hours prior to death. Presumably this resulted in progressive and irreversible unconsciousness whilst the time elapse between the injection and death may have allowed some metabolism of the drug prior to actual death. This could mean that the level of the drug in the blood around the time of the injection was higher than that measured at autopsy i.e. late drug death". (Exhibit C.32a, p6-7).

6.8 In view of the totality of pathological evidence, I find that the cause of death was heroin toxicity. The time of death was probably around 8.30p.m., although this was probably preceded by a lengthy period of unconsciousness.

7. **Heroin in prison**

7.1 Obviously, Marshall Carter obtained heroin in YLP through some clandestine means. It seems most likely that he obtained it from another prisoner, probably that day.

7.2 I have already mentioned that Stanley Wells told the police that he heard George Wilson arrange a sale with James Fricker that afternoon, and that he heard a "line" go across from Fricker's cell to cell 302 during the evening.

7.3 When he gave evidence at the inquest, Wells retreated from the information he gave to the police. He said:-

> "In my interview I did say that I did hear that out in the yard. I don't think that I did hear the precise words, what Jimmy and George were saying". (T.63).

It is obvious that Wells thought that either George Wilson or Marshall Carter were arranging for the supply of heroin that night, otherwise his comment to Carter through the trap about not taking the "other stuff" was completely pointless.

7.4 Mr. Collett, counsel for the Carter family, submitted that George Wilson had lied on several points about his involvement in Marshall Carter's death. I have already mentioned his self-contradictions about whether he was asleep or not. There is a suggestion in the Department for Correctional Services ("DCS") investigation report (Exhibit C.30a, p11) that Wilson was affected by drugs the following day (4 May) as well, which he also denied. Mr. Collett submitted that an inference can be drawn from these "lies" that Wilson had "some significant involvement with the deceased's injection of heroin" (written submissions, p10). I do not accept that this inference can be drawn. Many prisoners are secretive and uncooperative in relation to drugs in prison.

7.5 A finding that Wilson and/or Fricker supplied heroin to Marshall Carter, as a result of which he died, is a very serious matter, which requires clear evidence. As Dixon J (as he then was) said in Briginshaw v Briginshaw (1938) 60CLR 336 at p.361:-

> "In such matters 'reasonable satisfaction' should not be produced by inexact proof, indefinite testimony, or indirect inferences".

See also G.vH. (1994) 181CLR 387.

The evidence before me is not strong enough to make such a finding.

7.6 In those circumstances, I must leave the finding open as to how Marshall Carter obtained heroin in YLP. Clearly, from the report of Dr. Gilbert, which I will discuss presently, he took it intravenously. The syringe has never been recovered. It must be assumed, in the absence of evidence to the contrary, that he administered it to himself.

7.7 It is trite to say that drugs, particularly "hard" drugs which are taken intravenously, are a scourge which DCS must make every effort to exclude from its prisons. The concomitant risks of cross-infection of AIDS and Hepatitis C from needle-sharing are also obvious.

7.8 I am sure that DCS conducts drug and health education programs. I have heard evidence about that in other cases. Clearly, "demand reduction" is the strategy most likely to be effective in reducing the incidence of drug-taking.

7.9 It is impossible to stamp out the exchange of contraband in prisons without imposing a regime of separation of prisoners which would be harsh and unjust. However, it seems from the evidence in this case that this traffic could be reduced if steps were taken to prevent "lines" being exchanged between cells. There is evidence of camera surveillance and passive infra-red movement indicators having been installed, but this has not succeeded in preventing the practice. Mr. Elliott said that he had picked up five lines in one watch (T.123).

7.10 The installation of physical barriers to prevent lines going across would seem to merit consideration. There is presently a large gap (20mms or so) under the cell door which allows the practice. The simple expedient of a rope or piece of wood down the corridor to block the sliding weight might also prove effective. I recommend that this be further considered by DCS.

8. **Admission/induction procedures at Yatala Labour Prison**

8.1 It will be recalled that Marshall Carter was admitted to YLP on 23 March 1998 following an order made in the Youth Court pursuant to Section 63(3) of the Young Offenders Act that day.

8.2 The documentation sent to YLP included a "Young Offenders Special Need Information Sheet" which recorded that Marshall Carter had no history of suicidal tendencies and/or self-harm (see Exhibit C.37a). It was recorded that it was "unknown" whether he was a known drug user, although it was stated that his behaviour might be unpredictable and he could be physically violent.

8.3 On 1 April 1998, a written pro forma request was forwarded from the Prisoner Assessment Unit at YLP to Cavan, requesting "any information available please" concerning Marshall Carter. On 2 April 1998, a letter was sent from Cavan which purported to enclose two social background reports and a psycho-social screening report. Unfortunately, it appears that, through an oversight, the last-mentioned report was not enclosed. No follow-up request for the report was made, which may suggest that insufficient attention was paid to the material at YLP when it arrived.

8.4 It was this psycho-social screening report which contained the information about Marshall Carter's extensive history of drug abuse, including use of alcohol, marijuana, hallucinogens, sedatives/hypnotics, narcotics, stimulants, and solvents/inhalants. Since the only other information that YLP had was that his drug history was "unknown", this was important information which was not followed up.

8.5 Similar information was contained in the Child and Youth Health Service file, which was never transferred to the Prison Medical Service. A note dated 11 February 1997 discussed Marshall Carter's drug abuse, and in fact found "track marks" on his right arm.

8.6 Upon admission to YLP, Marshall Carter underwent a "prison stress screening" process, which involved a number of questions being asked with a view to ascertaining his psychological state. He answered "No" to most such questions, including:-

- Have you ever overdosed, either accidentally or intentionally?
- Have you ever tried to commit suicide or intentionally hurt yourself?
- Have you used drugs regularly to relax or block out problems in the last month?

In a "drug and alcohol screening", he also answered "No" to:-

- Do you have a substance abuse problem?

8.7 Upon the basis of this information, Mr. Carter was assessed as having no potential for self-harm.

8.8 In a health assessment carried out at YLP, Mr. Carter answered "Never" to a question whether he used narcotics, "occasional" in relation to alcohol, and admitted taking "speed" intravenously fourteen months earlier. He was assessed as a "pleasant, non-distressed young man" (see casenotes, part of Exhibit C.37a).

8.9 Mr. Collett, counsel for the Carter family, was critical of this lack of communication of important information between Cavan and YLP. I agree that the DCS should be criticised for this lapse. It is of particular concern that in Goldsmith (Inquest No. 6/96) I recommended that:-

> "The Department of Correctional Services consider ways in which information concerning prisoners is exchanged between departments when prisoners are transferred from the custody of one to the other ...".

8.10 The recommendation was in line with Recommendation 157 of the Royal Commission into Aboriginal Deaths in Custody:-

> "That, as part of the assessment procedure outlined in Recommendation 156, efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment and where necessary prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner's medical history files accompany the prisoner on transfer to other institutions and upon readmission, and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information".

8.11 As to the questionnaires, the Royal Commission also commented:-

> "It is obvious that some, and perhaps many, prisoners will be unwilling to volunteer information to a police officer regarding their medical problems or previous attempts at suicide or self-harm. Therefore, questions such as "Have you ever tried to take your own life" or "Do you have any serious medical or mental problems" are unlikely to elicit any useful or reliable information". (Volume 3, p199).

8.12 Correspondence tendered by Mr. Charles, solicitor instructing Mr. Collett, indicates that the then General Manager at YLP, Ms. Maria Bordoni, indicated that a "Local Operating Procedure" for this exchange of information was being developed (see her letter of 23 September 1997). The system did not seem to work with great efficiency by March/April 1998 when these events occurred.

8.13 I note, however, that this process has now improved considerably. Mr. M.J. Gieschke, the Manager, Assessments for DCS, told me that a protocol was developed, and that more recent discussions have resulted in a new system, whereby the Department of Family and Youth Services ("FAYS") give DCS two months' advance notice of impending transfers, and a full assessment process, taking four to six weeks, is initiated. This process includes face-to-face meetings between FAYS and DCS staff, and means that more sophisticated decisions can be made concerning the prisoner (T.165-6). This seems like a much more satisfactory process.

8.14 It is difficult to form a judgment as to whether the lack of information transfer in this case had any influence upon Marshall Carter's treatment at YLP. He had shown no sign of giving up drug abuse, and so it cannot be argued that Wilson, who was regarded as a drug user, enticed him to continue. If Carter had been placed in a cell with a prisoner who did not use drugs, prison management could be criticised if he enticed the other prisoner into drug abuse. Ideally, of course, these problems would not arise if prisoners did not need to be "doubled up".

8.15 <u>Doubling up in cells</u>

A basic problem is that the chronic over-crowding in South Australian prisons requires multiple occupation of cells. One only has to look at photographs of cell 302 to realise the miserable and over-crowded conditions in which these prisoners lived. The lack of privacy and hygiene involved in sharing toilet and hand-washing facilities in the cell, and the fact that there is only one small desk and a couple of plastic trays

for their private possessions, create a negative impression of conditions endured by these prisoners. Marshall Carter so disliked sleeping on the top bunk that he used to take his mattress and put it on the floor and sleep there next to the toilet bowl each night.

8.16 Recommendation 144 of the Royal Commission into Aboriginal Deaths in Custody provides:-

> "That in all cases, unless there are substantial grounds for believing that the wellbeing of the detainee or other persons detained would be prejudiced, an Aboriginal detainee should not be placed alone in a police cell. Wherever possible, an Aboriginal detainee should be accommodated with another Aboriginal person ...".

Admittedly, the Recommendation is directed at police cells, rather than prison cells, but the principle is the same.

8.17 It is clear from George Wilson's file that he was Hepatitis C positive. A form in his case management file (Exhibit C.33b) called a "Communicable Disease Notification Form" dated 15 March 1997 recommends to the prison management:-

> "Single cell accommodation for prisoner necessary".

The form also makes a number of further recommendations including:-

- "room should be cleaned with detergent, rinse and then clean with standard disinfectant";
- "strict maintenance regarding sex and sharing of personal articles is essential at all times";
- "activities to discourage include homosexual activity, tattooing, sharing of razors, needles and other personal articles";
- "prisoner should have no contact sports".

8.18 In those circumstances, I consider that there were substantial grounds for believing that the "wellbeing" of Marshall Carter would have been prejudiced by doubling him up with a prisoner who had a communicable disease. If doubling up had to be done, it should have been done with a prisoner whose health status did not put Marshall Carter at risk.

8.19 Mr AM Wright, a supervisor in E Division, said it was simply not possible to house all prisoners with a communicable disease in a single cell. He said that, in his experience, the number of prisoners with a communicable disease was about 80% (T184).

8.20 The sum of this evidence is that prison officers had no choice but to place George Wilson in a double cell with another prisoner, even though a recommendation against this had been made by the Prison Medical Service.

8.21 George Wilson said that he shared a cell with Marshall Carter by mutual agreement with him. He said:-

> "Yes, I asked him - because the cell he was in, he didn't have no TV or nothing, and he kept asking to come into my cell, I said 'yeah', because he was my cousin. I had a colour TV and that. I was trying to look after him yes". (T.33).

Mr. Wright acknowledged that this was probably the reason why the decision was made to put Carter in with Wilson (T.203).

8.22 Mr Collett argued that if DCS had complied with the Prison Medical Service recommendation about George Wilson's communicable disease, then Marshall Carter's death may have been avoided, because Wilson obtained the heroin which Carter used, causing his death. I do not accept this submission. Firstly, there is insufficient evidence to find that Wilson did obtain the heroin which caused Carter's death. Secondly, the question of communicable diseases and drug use are not causally connected. Marshall Carter did not die because he contracted a communicable disease from George Wilson. He died because he took an overdose of heroin. He was already an intravenous user of heroin before he ever arrived at YLP. I do not think that the 'but for' argument put by Mr Collett can be upheld in these circumstances.

8.23 I agree that it is highly inappropriate that prisoners who have a communicable disease should be "doubled up" with prisoners who do not. The health risks are obvious. If a prisoner does develop a communicable disease as a result of this process, then the Department will have to bear the consequences. In this particular case, however, I am unable to find that Marshall Carter died as a result of this policy. I am therefore unable to make a recommendation pursuant to Section 25(2) of the Coroners Act on this topic.

9. Response to emergency

9.1 I have already described how Correctional Officers Luckett and Smith answered George Wilson's call on the intercom by proceeding to cell 302, ascertaining the nature of the problem, then returning to the officers' station, where Smith telephoned the control room and Luckett used the intercom to call the infirmary. The result of this process was that neither Correctional Officer Wilkinson, who brought the master key from the control room, nor Registered Nurse Evans, who needed to bring his equipment from the infirmary, thought the matter was urgent. It took a total of seven minutes from the time of Wilson's initial call, and five minutes from the time Smith telephoned the control room, to open the cell door.

9.2 Mr. Collett, counsel for the Carter family, criticised this response time. Had Luckett asked Wilson for more details of Carter's condition over the intercom, he should have apprehended an emergency at that time and issued a "Code Black" soon after 8.36p.m.

9.3 Local Operating Procedure No.5, issued on 23 January 1997, is Exhibit C.30b. The procedure does not specify what a medical emergency is, but that should be a matter of commonsense. The procedure reads:-

> "3.1 The staff member at the scene of the emergency must immediately contact control by means of either:
> 3.1.1 radio - ...
> 3.1.2 telephone - ...
> 3.1.3 intercom
>
> 3.2 Report the emergency in the following format:-
> 'Alert Alert
> Code Black
> Location'
>
> 3.3 All officers in the immediate vicinity should secure all barriers and cease prisoner movement.
>
> 4.1 On receipt of notification of a medical emergency the control room personnel will immediately:-
>
> 4.1.1 obtain information on the emergency including the number of prisoners injured
>
> 4.1.2 contact the infirmary staff and notify them of the emergency and of the location of the emergency
>
> 4.1.3 raise an incident log".

9.4 Luckett argued that he did not call a Code Black because he thought that the method he and Smith adopted was quicker. He said:-

> "I think it probably may have quickened the response, mainly because it's possible that the control room or the medical staff may have tried to contact us in Unit 2 which is the level where we'd normally sit during the watch. They may not have tried to contact us at that level in Unit 3". (T.78).

I think this is an *ex post facto* rationalisation. The evidence of both Wilkinson and Evans clearly demonstrates that they did not appreciate the existence of an emergency until they realised that Carter was unconscious. Had Luckett called a Code Black at 8.36p.m., the outcome may well have been different.

9.5 I do not agree with the conclusion of the DCS Review Team in its report (Exhibit C.30a, p9) that:-

> "As a result of the response of all staff, cell 302 was still able to be accessed within three minutes of the control room being notified of the incident. The Review Team therefore considers that the issue of a Code Black not being called had little impact on the outcome of the incident".

I believe the evidence clearly demonstrates that had a Code Black been called, both Wilkinson and Evans would have appreciated the urgency of the situation from the start and several minutes could have been saved. The evidence as to whether Carter was still alive at that stage is, as I have already said, confusing. However, it is possible that he was, and if so the outcome could have been different if the cell had been opened more quickly.

9.6 In Henry (Inquest. No. 58/93), I recommended:-

> "That the Department reconsider the system whereby access to a prisoner's cell may only be gained with a master key kept in the main control room. If no other way can be found by which access can be guaranteed within three minutes, the Department should consider installation of electronically operated doors to all cells".

The reference to three minutes was made because that is the maximum time which should be allowed to elapse following an interruption to the blood supply to the brain (whether by heart failure, hanging, choking on food, epileptic seizure, stroke or a variety of other causes including drug overdose) before permanent brain damage can be expected.

9.7 Following that recommendation, I received a letter from the then Chief Executive Officer of the Department for Correctional Services, in which she stated:-

> "All prisons were requested to assess their staff's ability to meet this timeframe during a period when the least number of officers were rostered on duty. It is considered that all cells can be accessed within three minutes of a fire being detected, however this period may increase if other incidents are occurring simultaneously. The installation of electronically operated cell doors is not considered appropriate as it severely restricts the ability of staff and prisoners to interact, as described above". (see Bonney Inquest No. 28/96, p14).

9.8 In Bonney, I had observed that the facts in that case and others "amply demonstrate" that DCS were unable to guarantee access to a prisoner's cell within three minutes of an incident being detected.

9.9 The facts of this case clearly demonstrate that DCS is still unable to guarantee that access can be gained to a prisoner's cell within three minutes. Accordingly, I must repeat the recommendation made in Bonney:-

> "That the Department for Correctional Services should install a system whereby a cell at Yatala may be opened electronically in the event of an emergency".

10. **The investigation**

10.1 Detective Senior Constable Brown attended at YLP at about 10.20p.m. on 3 May 1998, with Detectives Vincent, Clark, Dawes and Anderson. Following Dr. Gilbert's attendance, cell 302 was searched by Correctional Officers Visintin, Richards and Whelan. A number of items were retained, including a matchbox used for smoking cannabis, two syringe caps apparently discarded by the ambulance officers, and a small piece of metal, perhaps the blade from a disposable razor, was found under the writing desk. This was later analysed by Dr. Pigou at State Forensic Science, and found to have traces of heroin on it (Exhibit C.38a).

10.2 After the nurse arrived at the cell, George Wilson was placed in cell 310, which was then unoccupied, at some time before 8.50p.m. He was not searched before being placed in the cell. When it was put to Luckett that Wilson could have disposed of anything in his possession when alone in cell 310 (particularly if he still had the syringe used by Carter), he said that Wilson could have disposed of it before that time. I do not think that this is an appropriate response. Wilson was not strip-searched until 10.30p.m. In my view, Wilson should have been strip-searched and urine-tested

before he was placed in the cell alone, since a drug overdose was an obvious possible cause of Marshall Carter's death.

10.3 It was explained that the officers did not want to further distress Wilson before an Aboriginal Liaison Officer arrived. The DCS investigation team commented that System Operating Procedure No.6 does not stipulate when a strip-search is to be conducted, and only requires such a search "where there are suspicions regarding a particular prisoner or prisoners" (Exhibit C.30a, p8). The review team points out that a suspicion may arise at any time, particularly after the pathologist has examined the scene. The review team recommended, and I agree:-

> "... that SOP6 be amended to ensure that in all incidents of death, a strip search of all prisoners who had contact with the deceased immediately prior to the incident be conducted as soon as practicable, and their clothing is bagged and labelled and provided to police if required. If, because of the circumstances, a strip search cannot be conducted shortly after the incident, the prisoner or prisoners should be secured separately". (Exhibit C.30a, p8).

I would add, though, that any such prisoner should be kept under observation by a correctional officer at all times prior to the search, to ensure that he does not dispose of anything, for example, in the toilet. The syringe used by Marshall Carter to inject himself with heroin has never been found.

10.4 At about 11.00p.m., Wilson was interviewed by Detective Brown in the presence of Mr. Tom Karpany from the Aboriginal Liaison Unit, DCS, and Mr. Tauto Sansbury from Aboriginal Legal Rights Movement. As I have already outlined, he said that he was awake watching television when Mr. Carter's breathing problems became apparent (Exhibit C.33, p6). The interview was not particularly searching. The questions about the cause of death included:-

"Q36 Do you know whether he was taking any illicit drugs, like you know, marijuana or anything heavy that might have been smuggled into the gaol?

A. I don't know, I don't think so, if he was taking it I didn't know anything about it.

....

Q107 OK, is there anything that you think of that you might know what, what caused what happened tonight, any ideas?

A. Oh I got no clue.

Q108 Did he appear to be pretty good earlier when you were watching TV?

> A. Yeah, he was alright, you know, went out today had a game of soccer and that, come in, we sit and have a smoke, you know, sit around watching the footy and then um he said I'm going to crash now so he crashed ... and that was it". (C.33, p4,11).

Detective Sergeant Linton expressed surprise that "some hard questions weren't asked of Wilson on the night" (T.151).

10.5 If Carter had taken heroin (as we now know he did), it is inescapable that Wilson would have known about it. He now says that he was asleep the whole time, but I think that this is a recent invention. If he was awake, he must have seen Carter inject himself, and he must have either seen him dispose of the syringe and other paraphernalia, or disposed of it himself. There is also a possibility that he too took some of the heroin. Yet these issues were not explored at the time and it was far too late when Detective Sergeant Linton took over the inquiry six months or so later.

10.6 Another issue is whether Wilson should have been directed to supply a sample of urine that night. His cell mate having just died of what Dr. Gilbert clearly thought was a drug overdose, one would have thought that the question of Wilson's role in these events might have been foremost in the minds of the investigating officers, but it appears that this option was not considered. Had the officers requested the correctional officers to do so, they would have had the authority to obtain such a sample from Wilson.

10.7 Finally, after the interview with the police, George Wilson was placed in a cell occupied by James Fricker. It does not seem to have occurred to anybody on the night that if Fricker was involved, as was later alleged by Gray and Rigney and Wells, it was unwise to put Wilson in the cell with him until the situation had been clarified. If the correctional officers were worried about Wilson's emotional state (which I accept that they were), it would have been much more appropriate to accommodate him in the infirmary for the night rather than put him in a cell with Fricker.

10.8 In September 1999 Detective Sergeant P.C. Linton from Holden Hill Investigations Section took over responsibility for this investigation. This followed a letter written by Mr. Charles from the Aboriginal Legal Rights Movement in August 1999 expressing concern at the non-completion of the investigation (T.149). Little progress had been made since May 1998. The allegations by Wells and others that Fricker was involved in the sale of heroin had not been explored, and Fricker had not even been

interviewed since that time. When Fricker was interviewed on 10 September 1999 at YLP , he said:-

> "A. I can't remember what happened last week let alone last year, all I remember is there was a sad guy and a dead guy.
>
> ...
>
> Q. Marshall Carter died from a heroin overdose in his cell, do you know anything about this or how the heroin got there?
>
> A. I don't know anything about that".

(Exhibit C.25b)

Of course, it is absurd to suggest that investigators were likely to find any evidence to incriminate either Wilson or Fricker so long after Marshall Carter's death.

10.9 The performance of the police officers involved in the initial investigation of these events can be described, to use a mild expression, as disappointing. With nine years' experience since the delivery of the final report of the Royal Commission for Aboriginal Deaths in Custody, and the development of a detailed protocol between this office and the Commissioner of Police for the investigation of such deaths, the lack of investigational rigour displayed by those involved here is mystifying.

10.10 What is also mystifying is that the allegations made by Gray and Daniel Carter and Wells amounted to serious criminal behaviour, and yet even that did not seem to be enough to spur the investigators into action. Recommendation 35 of the Royal Commission into Aboriginal Deaths in Custody provides:-

> "That Police Standing Orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:-
>
> a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;".

It is clearly apparent that such an approach was not adopted in this case.

10.11 I do not wish to criticise the individual police officers concerned. I have no knowledge of their workload, or what instructions they may have received as to the degree of priority this investigation should receive. I certainly do not criticise Detective Sergeant Linton, who had no involvement until September 1999. The

Commissioner of Police has statutory responsibility for the performance of his organisation. I draw these comments to his attention.

11. **Recommendations**

Pursuant to Section 25(2) of the Coroners Act, I recommend that:-

(1) The Chief Executive Officer of the Department for Correctional Services consider methods of discouraging or preventing exchange of contraband by means of "lines" between cells;

(2) The Department for Correctional Services should install a system whereby a cell at Yatala Labour Prison may be opened electronically in the event of an emergency;

(3) Standard Operating Procedure 6 in relation to strip-searching after "incidents of death" be amended in accordance with the recommendations of the Department for Correctional Services investigation team in Exhibit C.30, with the added proviso that when such a strip-search cannot be conducted immediately, the prisoner should be separated from others, and observed to ensure that he does not dispose of evidence.

Key Words: death in custody; drug overdose; cell design

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 16th day of June, 2000.

……..……

Coroner