

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 8<sup>th</sup> and 9<sup>th</sup> days of November, and 4<sup>th</sup> day of December, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Laurens Adrian Keith Nobels.*

*I, the said Coroner, do find that Laurens Adrian Keith Nobels, aged 29 years, late of no fixed place of abode, died at the Adelaide Remand Centre, Currie Street, Adelaide, in the State of South Australia, on the 15<sup>th</sup> day of January, 2000 as a result of hanging. I find that the circumstances of death were as follows:-*

1. **Reason for inquest**

1.1 On 21 December 1999 Laurens Adrian Keith Nobels was arrested at Swan Hill in Victoria and charged with the murder of Cassie Bugg, who died on 30 October 1999 at Evanston Park. On 22 December 1999 Mr. Nobels appeared in the Adelaide Magistrates Court, where he was remanded in custody by Mr. K. Boxall SM to 4 February 2000.

1.2 Accordingly, on 15 January 2000, Mr. Nobels was “detained in custody” pursuant to an Act or law of this State within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

2. **Introduction**

2.1 At about 8.10a.m. on 15 January 2000, Correctional Officers were performing a “head count” in Unit 8 at the Adelaide Remand Centre when Correctional Officer David Demaid looked through the window of Cell No. 5. He saw prisoner Laurens Nobels hanging by a bed sheet tied around his neck and tied to a rail on the top bunk of the bed. The cell was entered, a “Code Black” was called, and emergency measures were

taken to try and resuscitate him. However, these measures were unsuccessful, and at 8.25a.m. Paramedic Neil Clune pronounced his life extinct.

### 3. **Cause of death**

3.1 A post mortem examination on the body of the deceased was carried out by Dr. R.A. James, Forensic Pathologist, on 16 January 2000. Dr. James concluded that the cause of death was hanging.

3.2 Dr. James noted red marks on the back of both wrists consistent with binding, and a brown noose mark extending across the front of the neck. He noted no signs of asphyxia on the facial tissues, and no evidence of ante-mortem injury elsewhere on the body, and in particular, no grip marks.

### 4. **Admission to the Adelaide Remand Centre**

4.1 Mr Nobels was admitted to the Adelaide Remand Centre on 22 December 1999. He was interviewed by a Registered Nurse, and denied that he was at risk of self-harm apart from the obvious factors that it was the first time he had been in prison in South Australia, and that he was charged with murder. He denied that he had any history of drug abuse, apart from nicotine and alcohol, and denied that he had a psychiatric history.

4.2 Mr. Nobels was also interviewed by a Correctional Officer as part of the admission process and gave similar information. He indicated there was some concern that he may be at risk "because of the charges that he has", and so he was transferred from Unit 7 to Unit 8 on 24 December 1999.

4.3 In summary, however, the staff at Adelaide Remand Centre were given no information upon which they might suspect that Mr. Nobels was at risk of harming himself.

### 5. **Circumstances of death**

5.1 Mr. Nobels had been locked in his cell at 4.40p.m. on 14 January 2000. Correctional Officer M. Tolari said that, as he locked him in his cell, he asked "You OK Nobels?", and he replied "Yep" (Exhibit C.8a, p4).

- 5.2 The records indicate that Mr. Nobels' cell, along with the others in Unit 8, was checked at 6.00p.m. and 10.55p.m. A medication round took place at 7.37p.m. and nothing significant was noticed.
- 5.3 At 12.01a.m. on 15 January 2000 the "C" shift commenced and began by an inspection of all cells in the institution and a head count. This inspection was carried out by Correctional Officer Shorter, the shift supervisor, and Correctional Officers Hauswirth and Campbell. Campbell inspected Cells 5 to 8 in Unit 8. Shorter made an entry in the Unit Log (Exhibit C.27) that all was correct.
- 5.4 During the midnight patrol, Shorter also falsely entered in the log that all was correct on the 2.00a.m. patrol. He explained:-

"Of course I'm not supposed to do this but I did it to save the officers the trouble of unlocking the door, going into the unit office, turning on the light and disturbing the prisoner in Cell 8". (Exhibit C.9a, p3).

Making such false entries in official prison records is completely inappropriate, and is not excused by the lame explanation offered by Mr. Shorter. Such entries are intended to provide, among other things, protection for Correctional Officers in case of accusations that they failed to perform their duties. On the evidence before me, there is a strong suggestion that such entries are not unusual (T.24). The fact that such an entry was made by a supervisor makes the behaviour even more serious.

- 5.5 At 3.30a.m. Hauswirth and Campbell swapped duties with Correctional Officers Crompton and Roberts, and they performed subsequent patrols at 4.00a.m. and 6.00a.m. These patrols were entered appropriately in the log book. Although neither of them could specifically recall checking Cell 5, both said that they would have recalled if there was anything amiss and they did not do so. Indeed, on the 6.00a.m. patrol, Roberts checked all eight cells in Unit 8 while Crompton filled out the log book, and then Crompton looked in all eight cells again while he was disengaging the master locks on each cell (T.46).

- 5.6 No further checks were made until just after 8.00a.m., when Correctional Officer Demaid was performing the morning head count, as I mentioned in the introduction. His statement as to what occurred is as follows:-

“Upon looking through the viewing window in the cell door I also saw that Nobels’ hands were at each side of his body. A length of the bed sheet had been torn off and each end of it tied around each of his wrists so that the sheet was behind his back. The length of sheet behind his back was about the same width as his body. Due to the fact that the double bunk bed within the cell is only about 5 feet in height, the lower portion of Nobels legs below his knees were touching the floor and they did not appear to be supporting any of his weight. I could also see Nobels face but it didn’t appear to be of any different pallor to what it should have been and his eyes appeared to be closed. The rest of the room appeared to be in normal condition.

When first seeing Nobels hanging from the bed, I immediately called out to another corrections officer working with me, Andrew Goldsmith, that we had a ‘code black, prisoner hanging’. A code black is what we refer to as when we have a medical emergency. Goldsmith advised the control room on the radio as I unlocked the cell door.

I entered the cell with Goldsmith behind me. Upon entering the cell I could smell the faint odour of human excrement. I then cut the sheet that Nobels was hanging from by the neck and as he slumped forward I took the weight of his body and lowered him to the floor as best I could. I then cut the length of bed sheet that was tied to his wrists and I placed him on his right side. By this time corrections officer Hedger arrived in the cell and immediately started giving Nobels CPR. A short time later or within 2 minutes the nursing staff arrived followed by numerous other staff a short time after that”. (Exhibit C.5a, p2).

- 5.7 Correctional Officer Robert Shepherd said that he cut the sheet from around Mr. Nobels’ neck using a safety knife. He said:-

“The sheet wasn’t particularly tight around Nobels’ neck but I thought it would impede the CPR if we left it on”. (Exhibit C.12a, p1).

- 5.8 Registered Nurse Jordan arrived at the cell soon after the Code Black alarm was sent, and she brought with her the emergency first aid equipment and the portable defibrillator. She administered oxygen while Mr. Hedger continued with CPR, and tried to defibrillate Mr. Nobels but the automatic machine detected no “retrievable rhythm” (Exhibit C.13a, p2).

- 5.9 Paramedics Clune and Holmes were tasked to attend Adelaide Remand Centre at 8.11a.m., and arrived at 8.16a.m., where they noted that Correctional Services and nursing staff were “doing an effective job with the CPR” (Exhibit C.2a, p2). Mr. Clune said:-

“All resuscitation had stopped and I examined the person. I found that there was no pulse. I used a stethoscope to check for heart sounds. There was none. There was no respiratory sound. The pupils were fixed and dilated. He was cyanosed which means he was going blue. I found that there was the start of lividity in the extremities and stiffening of joints though only slightly. He was cold to the touch. I also saw that he had bite marks part way down his tongue.

I pronounced life extinct at 0825 hours”. (Exhibit C.2a, p3).

5.10 On the evidence before me, it seems that as soon as Correctional Officer Demaid noticed that Mr. Nobels was hanging in his cell, access to the cell was gained quickly, resuscitation attempts commenced immediately, and were effective and competent. These attempts continued until such time as appropriately trained staff in the form of paramedics arrived, and discontinued resuscitation in accordance with established protocols. In my opinion, on the basis of this evidence, the staff of the Correctional Services Department and S.A. Forensic Health Service involved in the attempted resuscitation of Mr. Nobels should be commended for their efficiency and professionalism during a very stressful time.

6. **Was there foul play?**

6.1 Correctional Officer John Guppy is employed at the Yatala Labour Prison and has never worked at the Adelaide Remand Centre. Mr. Guppy lived with Cassie Bugg’s mother, Heather.

6.2 Mr. Guppy said that some time in December 1999, he received a telephone call at some time after midnight. His statement reads:-

“Fairly late, definitely after midnight, the phone rang and Heather answered it and said to me ‘Its for you’. I took the phone and I heard a male voice who did not give his name. The voice sounded intoxicated (slurred) and it was unfamiliar to me. The caller said to me words to the effect of, ‘You’ve got nothing to worry about I’ve seen my mates yesterday at visits, he’ll be taken care of’. I did not have a chance to reply before the caller hung up”. (Exhibit C.17a, p3).

6.3 Mr. Guppy reported the matter to the police. Nothing further has eventuated since that time.

6.4 Mr. Nobels’ wrists were bound with a piece of sheet material. In case it might be suggested that this is evidence of foul play, I refer to the evidence of Dr. R.A. James, Forensic Pathologist, on this topic:-

“There’s no doubt that he had something around his wrists. I think the photographs clearly show the marks around his wrists. I was shown the lengths of sheet that were allegedly around his wrists at the time and certainly the lengths of sheet are consistent with those marks around his wrists. It’s unusual but by no means uncommon to find wrist binding. I’ve seen at least one other case in the last few months. The reasons for that are supposition but the finding of wrist binding by no means excludes a self-inflicted act”. (T.69).

- 6.5 Dr. James also found a fracture at the base of the left superior thyroid horn with adjoining haemorrhage into the soft tissues during his examination of the larynx. This is a feature which is sometimes found in manual strangulation. However, Dr. James commented:-

“The hand binding in the presence of hanging is unusual but by no means unique. Equally the fractured laryngeal cartilage is comparatively unusual in domestic hanging although again by no means unique. The presence or otherwise of laryngeal fractures is a function of the ligature used and the level of the ligature impression on the neck. In this case the noose mark carried across the front of the upper thyroid cartilage and is considered responsible for the fractured superior horn. There was no evidence of other neck injury and in particular no asphyxial features were present such as would be expected in cases of neck compression from causes other than hanging” (Exhibit C3a, p6).

- 6.6 I accept Dr. James’ evidence concerning these matters, and find that there is no evidence that foul play was involved in Mr. Nobels’ death. I find that he died as a result of his own act.

## 7. **Time of death**

- 7.1 Dr. James said that, although he found some food in Mr. Nobels’ stomach at post mortem, it is difficult to form any conclusions on the basis of that (T.74).
- 7.2 There was no lividity (red staining) on the skin of the lower legs, which normally happens if a body has been suspended for a substantial period of time. By the time of the post mortem examination (9.15a.m. on 16 January 2000), all the lividity was on the back of the body, which is to be expected of a body which has been lying supine. Dr. James acknowledged that the blood could have redistributed from the lower legs during the time elapsed, but he said that he would have expected some lividity on the front of the legs if the body had been suspended for a substantial period (T.75).
- 7.3 Some of the witnesses noted early signs of rigor mortis in the body. Dr. James explained that rigor mortis normally takes two hours or so to begin developing, and is

usually well-established after six hours or so (T.75). Mr. Clune stated that he was told by one of the Correctional Officers that there were signs of rigidity in Mr. Nobels' fingers at around 8.30a.m. Mr. Clune gave the "rough estimation" that Mr. Nobels had been dead for between one and two hours (Exhibit C.2a, p3).

7.4 Dr. James agreed. He said that, on the evidence available, it was not possible to conclude that Mr. Nobels had been dead for longer than two hours (T.76). There is therefore no evidence to contradict the evidence of the Correctional Officers that they checked him at 6.00a.m.

7.5 Dr. James explained that the best way to determine time of death (although this is not an exact science), is to take a rectal temperature from the body as soon as is practicable and an ambient temperature (T.78). He said that the taking of the temperature does not require particular expertise, although the interpretation of the data thereby obtained is often difficult. If it was not possible to obtain the services of a medical officer or registered nurse at the Adelaide Remand Centre who was prepared to do so, the investigating officers should have called a pathologist to the scene so that the temperature could have been taken.

7.6 Detective Senior Constable Huppertz was the senior officer from Adelaide Investigations called to the scene that morning. He told me that he considered whether a pathologist should have been called to the scene, but decided not to for the following reasons:-

- the Correctional Services staff, the nursing staff and paramedics considered that Mr. Nobels was not obviously dead, and they commenced CPR;
- the patrol carried out by Crompton and Roberts at just after 6.00a.m. was properly logged;
- there were no grounds to suspect that there were any suspicious circumstances surrounding Mr. Nobels' death.

In my view, the first factor overlooks the fact that Correctional Service Department staff and Registered Nurses from S.A. Forensic Health Service do not diagnose death, and routinely proceed with CPR until the arrival of a qualified paramedic. Further, although there were no grounds to consider that there were any suspicious circumstances, the investigation was in its very early stages, and it was not until the police became aware of Mr. Shorter's false entry in the log book for the 2.00a.m. patrol that any doubt about the circumstances became apparent. Of course, by that

time, it was too late to go back and obtain evidence to corroborate the officers' evidence that they inspected the cell at just after 6.00a.m.

7.7 A protocol has been developed pursuant to recommendations of the Royal Commission into Aboriginal Deaths in Custody to guide the investigation into such deaths. The protocol was developed in consultation with the Commissioner of Police. In Section 7 of the protocol, entitled "Role of Police Officers attending the scene of death", the following passage appears:-

"7.2 **Tasks of the attending officer:**

- ...
- ...
- assess the circumstances - sight body if possible - and make the following decisions and direct where appropriate:-
  - \* ...
  - \* attendance of pathologist
  - \* ...".

As it stands, Detective Huppertz complied with that direction.

7.8 In retrospect, I think that the protocol should give a more positive suggestion to the investigating officer to call the pathologist. In my view, when investigating a death in custody, the pathologist should be called to the scene except where it is obviously impracticable to do so. The attendance of the pathologist will have many advantages, but the relevant one for present purposes is the ability to take accurate temperature measurements in order to attempt an estimate of the time of death. The investigating officer will not know in advance whether or not this will be an important factor. As to circumstances where it is not practicable to call a pathologist (for example in country areas), the investigating officer should make telephone contact with a pathologist and discuss the situation with him or her. Decisions can then be made whereby, for example, the local Police Medical Officer could be called to the scene for the purpose of taking the relevant measurements. Alternatively, a registered nurse or another medical practitioner might be able to do so.

## 8. Cell design

8.1 In their Departmental Review into this incident, Messrs Smedley and Leggat noted that the design of the double-bunk beds provides a hanging point in the cell. They also noted that:-

"ARC management cannot recall a previous incident which involved a prisoner hanging from the rail of a bunk bed". (Exhibit C.19a, p6).

8.2 Messrs. Smedley and Leggat also noted that Mr. Nobels was not considered at risk of self-harm. If he had been considered at risk, I accept that further steps would have been taken, including placement in different accommodation.

8.3 Recommendation 165 made following the Royal Commission into Aboriginal Deaths in Custody provides:-

“Whilst recognising the difficulties of eliminating all such items which may be potentially dangerous the Commission recommends that Police and Corrective Services Authorities should carefully scrutinise equipment and facilities provided at institutions with a view to eliminating and/or reducing the potential for harm. Similarly, steps should be taken to screen hanging points in police and prison cells”.

8.4 In view of that, Messrs Smedley and Leggat recommended that:-

“Either all bunk beds be removed or the Physical Resources Branch review the construction of bunk beds, with the view to removing obvious hanging points”.

8.5 This has been the subject of much previous discussion in relation to ‘B’ Division at Yatala Labour Prison, and the subject of previous recommendations (see Wakely Inquest No.7/95, Goldsmith Inquest No. 6/96 and Baillie Inquest No. 24/97).

8.6 I note that the Chief Executive Officer, Mr J Paget, has noted on the Departmental report:

“OK but doubtful. See Waller Report on NSW suicides”.

8.7 I have now seen the Waller Report. It is a report to the Attorney-General of New South Wales, entitled “Suicide and other Self Harm in Correctional Centres”, and was written in 1993 by a committee chaired by Mr. Kevin Waller AM, the former State Coroner of New South Wales.

8.8 I am unable to find a reference to the issue of elimination of hanging points in the report. However, after noting a number of opinions that it is impossible to completely prevent suicide in prison, the Committee wrote:-

“The Committee accepts the opinions of the experts that it is not possible to entirely eliminate suicide from correctional centres. However, the Committee also believes, from studying the 22 cases in our survey, that an opportunity exists to substantially reduce the number. In retrospect, most of the suicides studied were preventable. Proper communication of risk factors between Corrections Health Service and DOCS staff, and between inmates and Corrections Health Service and DOCS staff, will enable timely intervention during the progress towards self-destruction. This sort of advice, and the

implementation of the other recommendations made in this report, should diminish the level of suicides within the system to a bare minimum". (p.36).

8.9 I see no inconsistency between the approach of the Waller Committee and the recommendations made by Messrs. Smedley and Leggat. I agree with them, and will adopt them for the purposes of Section 25(2) of the Coroners Act, 1975 (South Australia).

## 9. **Recommendations**

Pursuant to Section 25(2) of the Coroners Act, 1975, I make the following recommendations:-

- (1) The Department for Correctional Services reinforce with custodial staff that the making of false entries in logs is an extremely serious matter which should not be tolerated by other staff;
- (2) The protocol between the Commissioner of Police and myself should be amended to ensure that a pathologist is called to the scene of a death in custody wherever possible, and where that is not possible, gives directions as to the alternative arrangements that can be made to determine the time of death;
- (3) the Department for Correctional Services review all bunk beds with a view to minimising obvious hanging points, or if this is not possible, bunk beds in all cells should be removed.

*Key Words: death in custody; hanging; suicide risk; police investigation; cell design*

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

*Seal the 4th day of December, 2000.*