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 27th, 28th, 29th and 30th days of August 2002 and the 17th day of January 2003, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Craig Mark Allen.

I, the said Coroner, find that, Craig Mark Allen aged 29 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, died at Northfield, South Australia on the 16th day of October 2000 as a result of hanging.

1. Introduction

1.1. The deceased was admitted as an inmate to the Yatala Labour Prison on 10 October 2000. He had been convicted of having assaulted Tracey Anne Bowden on 25 March 2000. He was sentenced to a term of imprisonment of seven months. However, pursuant to Section 38 (2a) of the Criminal Law (Sentencing) Act, 1998 it was ordered that he be released after having served a period of one month. He was also ordered to enter in to a bond in respect of the remainder of his sentence, the serving of which was suspended pursuant to that bond. The deceased's sentence was imposed on 10 October 2000, the day he was admitted to Yatala.

1.2. At all material times the deceased was housed in E Division at Yatala. At the time of his death the deceased was occupying cell 211 within unit 2 of E Division. He was occupying that cell alone. Cell 211 was throughout the course of this inquest variously referred to as a Management Cell or Change of Regime Cell. There was also reference to it being a 'recal' cell. The purpose of this cell and the circumstances in which the deceased came to be placed in that cell were issues that arose during the course of this inquest.

1.3. On the morning of Tuesday 17 October 2000, Correctional Officers found the deceased hanging in his cell. It is evident that the deceased had fashioned a noose from bed clothing, had attached it to the upper rail of a double bunk and had secured the noose to his neck. The deceased had been dead for a number of hours. This was obvious to both Correctional staff and nursing staff at Yatala. No resuscitation efforts were commenced as a result. A post mortem examination revealed that the deceased had died from hanging. There is no suggestion of the involvement of any other person.

1.4. It is my finding that the deceased deliberately took his own life and died as a result of hanging which he inflicted upon himself.

1.5. At the time of his death the deceased was 'detained in custody within the State pursuant to an Act or Law of the State' as contemplated by Section 12(1)(da) of the Coroners Act 1975, and as a result, this inquest into the cause and circumstances of his death was mandatory pursuant to Section 14 (1a) of the Coroners Act.

2. Background

2.1. The deceased had a previous criminal history. His incarceration in October 2000 was not his first. During the course of this inquest I received a number of statements of witnesses verified by affidavit. Some of those witness statements were given by people who had known the deceased for some time. Many of those statements referred to the deceased's casual attitude to his own imprisonment. In the statement of Tracey Anne Bowden, the complainant in the matter for which he was incarcerated in October 2000, (Exhibit C5a) she states that 'He was used to the prison system, he didn't like it but it was no big deal to him'. The deceased's mother Carmel Marie Allen in her statement (Exhibit C4a) states that her son had been in a lot of trouble with the police since he was about 8 years old and had been in and out of prison in South Australia since before he was 20. She said that her son would tell her that he liked being in prison and that it wasn't a problem. I also received in evidence a record of interview verified by affidavit of a Dr Richard Thompkins, a psychiatrist in private practice who had been treating the deceased for depression since November 1999 (Exhibit C21a). Dr Thompkins stated that in his view the deceased took to gaol 'like a duck takes to water' and that he was more at home in gaol than out of it. He based that opinion on the deceased's own statements and those of Tracey Bowden. Whilst the

deceased's like or dislike of the prison environment was not a matter that particularly concerned me, and is a matter upon which I make no special observation, the point is that the deceased was quite used to the prison environment.

2.2. Tracey Anne Bowden had entered into a relationship with the deceased in October 1998. In about August 1999 she and the deceased became engaged to be married and at about that time the deceased had a tattoo imprinted on his left ring finger with the date 16/10/98 and Ms Bowden's Christian name. This was intended to reflect the fact that it was on that particular date that the deceased had commenced a sexual relationship with Tracey Bowden. It is to be noted that the deceased took his own life during the night of Monday 16 October 2000 and Tuesday 17 October 2000, exactly 2 years since he had begun the sexual relationship with Ms Bowden. As it transpires the fact that the deceased took his own life on the particular date was not a coincidence.

2.3. The relationship between the deceased and Tracey Bowden broke down. In her statement Ms Bowden describes a number of unfortunate events that culminated in the breakdown. She describes the deceased's heavy drinking, amphetamine usage and verbal abuse. The deceased had been imprisoned in January 1999 for several months. He was ultimately released on home detention to Ms Bowden's home address and appeared to be responding favourably to treatment at the hands of Dr Thompkins. At the end of that home detention period Ms Bowden and the deceased moved into the deceased's home at Mawson Circuit, where his behaviour started to deteriorate. By December 1999 she could tolerate the deceased's behaviour no longer and she moved out. She effectively broke off the relationship but it seems that this was something the deceased found hard to accept. He constantly telephoned her, sometimes when drunk, and would start crying on the telephone, seeking a reconciliation. Ms Bowden started seeing the deceased again in February 2000 but did not resume cohabitation. The incident which led to the deceased's imprisonment in October of that year occurred in March 2000. Ms Bowden stated that the deceased assaulted her and she reported the matter to the police. The deceased subsequently apologised to her and stated that he wanted to see her again. However this did not eventuate.

2.4. Ms Bowden stated that during their relationship he had made comments along the lines of 'it's not worth living anymore'. He also said from time to time that he would kill himself by putting a bullet in his head or by overdosing on pills. After the

relationship had broken down at the end of 1998 he rang her at night on one occasion and said goodbye and stated that he was going to kill himself. The next morning he telephoned her and said that he was at the Flinders Medical Centre because he'd overdosed on tablets and alcohol. This incident was confirmed by a woman by the name of Heather Sheppard who provided a statement verified by affidavit to the inquest (Exhibit C6a). She had also conducted a relationship with the deceased and gave birth to his daughter in March 1995. She also stated that it was not unusual for the deceased to 'talk about doing himself in'.

2.5. The flavour of Ms Bowden's statement very much suggests that the deceased never really reconciled himself to the fact that his relationship with her was over, even as of October 2000 when he was incarcerated for having assaulted for.

2.6. The deceased also had some history of psychiatric disturbance. He had been consulting Dr Thompkins at a Bedford Park clinic since November 1999. Dr Thompkins had also been treating Ms Bowden. Dr Thompkins formed the view that the deceased was suffering from depression. During the period from November 1999 to 24 August 2000, which was the last occasion that Dr Thompkins saw the deceased, the deceased had not been in prison. However, it was during that period that the incident in March 2000 that led to his imprisonment in October of that year occurred. Dr Thompkins had prescribed Prozac, an antidepressant, for the deceased's depression. On 24 August 2000 he had prescribed 6 months supply of that drug. The prescription was 40mg per day. He was still taking that drug to Dr Thompkins' knowledge at the time he was imprisoned in October 2000. As it so happens, Dr Thompkins had provided a report for the benefit of the Christies Beach Magistrates Court when the deceased was convicted of having assaulted Tracey Bowden.

2.7. The deceased had attempted to hang himself in the Port Adelaide Police cells about 10 years prior to the October 2000 incarceration.

2.8. The deceased was also a very heavy drinker, consuming a carton a beer a day on his own admission.

2.9. Notwithstanding the deceased's depressive illness, Dr Thompkins expressed surprise at his suicide stating 'if you were to choose a patient from the 400 files that I've got through there, who I would say would not commit suicide in gaol, it would be Craig Allen'.

3. The Issues

3.1 During the course of this inquest I examined a number of different issues in order to determine whether any act or omission on the part of those responsible for the deceased's care in Yatala could have contributed to the unfortunate outcome with which the inquest was concerned. In particular, I examined the following matters; -

- whether in the circumstances it was appropriate for the deceased to have been placed in single cell accommodation,
- whether there was at the material time evidence to suggest that the deceased should have been perceived as at risk of self-harm,
- whether in the circumstances proper scrutiny of the deceased whilst in single cell accommodation was maintained, and
- whether any measures have been or could be taken to avoid a recurrence of the event that was the subject of this inquest.

3.2 Before dealing with these issues it is appropriate to describe the chain of events that preceded the deceased's death.

3.3 The deceased was admitted to Yatala on 10 October 2000. As part of the admission process prisoners entering Yatala were subjected to a number of assessments. One such assessment was conducted by a member of the nursing staff and in the deceased's case this was conducted by Joy Tyson whose statement verified by affidavit I received in evidence (Exhibit C22a). As part of the deceased's assessment he was asked, as a matter of routine, whether he had a history of self-harm or attempted suicide. In addition he was asked whether he had harboured any thoughts of suicide either past or present. In addition, questions were asked of the deceased concerning his medical history in general and an assessment was made, based upon information supplied by the him, as to whether or not there was potential for self-harm within the prison environment and whether in the prisoner's circumstances any special accommodation or supervisory needs were indicated. Documentation including an Admission Clinical Record and a Health Assessment form were raised and signed by the examining nursing staff. In the deceased's case Ms Tyson noted in the Admission Clinical Record (Exhibit C22b) that the deceased had a previous psychiatric history including diagnoses of a personality disorder and depression. It was noted that he was under the care of Dr Thompkins. It was also noted that the deceased was taking 40mg of Prozac per day. The fact that he had a daily consumption of a carton of beer was also noted, and in particular the fact that he had last consumed such an amount the day

before i.e. 9 October 2000. Ms Tyson also noted 'reports 2 attempted hangings years ago. Denies currently risk of self-harm'. On the Health Assessment form nurse Tyson has ticked the YES box in relation to 'active emotional problems'. In respect of the YES or NO boxes for 'potential for self-harm' she wrote 'unknown'. In respect of the section of the form which is entitled 'Special Accommodations/Supervisory Needs' Ms Tyson ticked the YES box and specified within that section 'history attempted hanging'. In the section entitled 'Special Medical Recommendation/Comments' she wrote 'shared cell recommended'.

3.4 When a prisoner was newly admitted to Yatala a file known as a 'Case Management file' was raised. The deceased's Case Management file in respect of his incarceration of October 2000 was produced in evidence in the course of the inquest (Exhibit C33). A number of documents that are raised on the prisoner's admission are placed on that file. The file then goes to the particular division where the prisoner is to be accommodated. The Health Assessment Form is placed on the Case Management file. However, other documentation relating to the deceased's health assessment upon admission is not placed on the Case Management File. Thus in the normal course of events Correctional Officers in the division in which the prisoner is accommodated do not see such documentation. The Health Assessment form is an exception to that general state of affairs.

3.5 Another document that is raised on the day of admission and which also goes onto the Case Management file is the 'Prison Stress Screening form'. This document is compiled by a Correctional Services Officer based upon information furnished by the prisoner. There are 31 questions on the form. The questions are designed to enable an assessment to be made as to whether the particular prisoner is at risk within the prison environment. The form does not specifically describe the type of risk involved, but it is obvious to me that it is designed, inter alia, to assess risk of self-harm. Scores are assigned to some of the questions and if the total score based upon the prisoner's answers exceeds 8, or any of the asterisked or shaded items are positive or equivocal, the prisoner is assessed to be at risk. The deceased scored 7 points in his assessment. He did not answer positively or equivocally any or the asterisked or shaded questions. He was thus not assessed to be at risk. The deceased gave negative answers to a number of pertinent questions relevant to the risk of self-harm. These questions included whether he had thought about committing suicide since he had been arrested

or imprisoned, whether he felt like harming himself at the time and whether he had felt that people close to him would be better off if he was dead. He responded to a question concerning his perception of his own future by stating that he looked forward to things. The Correctional Officer's observations are reflected on the form and in this particular instance the officer has recorded negative observations to such things as signs of depression, negative emotional effect and whether the deceased appeared overly anxious, afraid, angry, agitated or confused.

3.6 However, the deceased's Prison Stress Screening form reveals that he told the assessing officer that he had been treated in Glenside, that he had been diagnosed of having a personality disorder, that he had been drinking heavily in the past week, that he had accidentally overdosed on tablets 10 years ago and that he had attempted to commit suicide by hanging 'once ten years ago'. Surprisingly, question No. 18 which asks 'have you ever tried to commit suicide or intentionally hurt yourself?', to which the deceased responded affirmatively, is not an asterisked or shaded question. Some might take the view that this question is as relevant to an assessment of risk of self-harm as the other questions about that subject.

3.7 The deceased was continued on 40mg a day of Prozac whilst in Yatala. This was made available to him on a daily basis. In addition, he was also prescribed Valium to combat the affects of alcohol withdrawal. That the deceased continued to take Prozac is evidenced by the fact that a sample of his blood taken Post Mortem revealed its presence. The Toxicology Summary Report is Exhibit C3a. The report states that the level of Prozac in the deceased's bloodstream detected Post Mortem was higher than therapeutic. However, this does not necessarily imply an overdose because the deceased had an hepatic liver and, according to both Dr Ross James who performed the Post Mortem and indeed the deceased's physiatrist Dr Thompkins, a hepatic liver can affect the metabolism rate of Prozac. In the circumstances there is no material from which a conclusion can be reached that the deceased either had access to or had consumed Prozac in excess of his prescribed dosage.

3.8 The deceased was accommodated in E Division of Yatala, but between 10 October, the day of his admission, and 17 October, the day of his death, he spent some time in the infirmary. He was admitted to the infirmary on Thursday 12 October for alcohol withdrawal. He was commenced on a Valium regime which was maintained by way of him receiving regular doses each night prior to his death. On 13 October he was

given a Maxolan injection as he had been vomiting. On the same day a Dr Robina Creaser, whose statement verified by affidavit (Exhibit C2a) I received in evidence, conducted a routine examination of the deceased. She established that he was taking 40mg of Prozac per day and that he was under the care of Dr Thompkins. The deceased told her of the suicide attempt at the Port Adelaide Police Station 10 years before but stated that he had not attempted suicide since. Dr Creaser noted that on 13 of October he was in good spirits. He sought his own release from the infirmary as he was expecting his ex wife and children to visit on the weekend. He was looking forward to that. Dr Creaser observed no visible signs of alcohol withdrawal and the deceased was released to his division after lunch on that day.

3.9 The deceased was initially accommodated in Unit 3 of E Division at Yatala. There are 3 units in E Division. Each unit is on a separate floor. Unit 3 is on the top floor. E Division is Yatala's primary induction/reception facility. It is the division in which new prisoners are generally accommodated. Prisoners in E Division share a cell, two per cell. Prisoners in E Division are also permitted to associate with each other on a daily basis, for example in showering and exercise. The longest period of cell confinement occurs between the hours of 4pm and 8am the following morning. In Unit 2 of E Division there is, and was at the material time, a cell known as cell 211, the management or change of regime cell. Cell 211, which was on the second level of the division, was basically the same as other cells within that division. It contained a double bunk bed and other accoutrements. However, cell 211 was used exclusively for single occupancy. It was reserved for prisoners whose behaviour was such as to warrant their being singularly accommodated. I will return to the reasons as to why a prisoner might be placed in cell 211 later in these findings. Suffice it to say at this stage cell 211 was utilised to accommodate a recalcitrant prisoner.

3.10 On the afternoon of Saturday 14 October 2000 an incident occurred involving the deceased that ultimately led to him being placed in cell 211 on the morning of Monday 16 October 2000. On that Saturday Correctional Officer Paul Oldacre, whose record of interview verified by affidavit was received in evidence (Exhibit C10a), noticed that the deceased was wearing a ring on each of his hands. Prison regulations permitted the wearing of a wedding band only. Oldacre approached the deceased and established that he was not married and accordingly formed the view that the wearing of both rings in those circumstances was contrary to regulations. The evidence is

unclear as to whether or not the deceased was required to remove both rings. He was certainly required to remove at least one and when he refused, a more senior officer was summonsed to the cell. There was a further confrontation between the officers. The deceased was still adamant that no one was going to get his ring. He was given some lubricant to enable him to remove the ring or rings and it appears that he may have attempted to remove one of them because he was later that day seen in the infirmary in relation to a cut finger. By Saturday evening, however, the rings had not been removed. Nothing further took place in relation to the rings until Monday morning 16 of October. By this time the Case Manager and Coordinator for Unit 3 in E Division, a Mr Andrew Brian Ford who gave evidence before me, was on duty. When the deceased's cell was unlocked at 8am on the Monday, Correctional Officers Paul Miranda and Philip John Denner, whose records of interview verified by affidavit I received in evidence (Exhibit C11a, C12a), approached the deceased in his cell. The deceased was asked to remove the ring and was informed that if he didn't remove it himself he would be taken to the infirmary where it would be cut off. The deceased resisted this approach and abused the officers who then left. Shortly afterwards, the officers returned to his cell and the deceased performed a demonstration of putting a ring in his mouth and pretending to swallow it. Mr Ford was summonsed to attend at the deceased's cell. He directed the deceased to remove his jewellery. The deceased refused and was 'abrupt, rude and abusive' (T64). At one stage the deceased provocatively exposed his penis and showed Mr Ford a penis ring. It was evident that the deceased was not going to comply with any direction to remove jewellery and so Mr Ford initiated the deceased's transfer from Unit 3 into the management cell in Unit 2, that is cell 211. Mr Ford executed an authorisation for this purpose pursuant to Section 24 (2) of the Correctional Services Act 1982. I will discuss this legislation in more detail later, but essentially the provision authorises the placement of a prisoner in a particular location in the prison and also authorises the imposition of a particular regime of management for a prisoner.

3.11 After the deceased was transferred to cell 211, he was advised that if his refusal to remove the jewellery continued he would be transferred to G Division in Yatala. G Division is Yatala's maximum security facility. It imposes an effective regime of solitary confinement. The deceased's initial reaction to the prospect of G Division was one of compliance. Officer Allan Gallie, whose record of interview verified by affidavit I received in evidence (Exhibit C13), was contacted and was informed that a

prisoner who had been transferred to cell 211 had agreed to remove jewellery. Gallie obtained a pair of pliers and attended the cell. At this stage the deceased informed Gallie that he had changed his mind and that they could 'all go and get fucked'. He was again threatened with transfer to G Division. He was left in cell 211 and a very short time later the deceased informed another officer via the cell intercom that he had changed his mind again and had agreed to remove the jewellery. Gallie and another officer returned to the cell and the deceased removed two rings, one of which had been on his wedding ring finger, and the other on another finger. He also removed the penis ring. The items were placed in an envelope and kept in safe custody. At the time the jewellery was removed the deceased showed Gallie a tattoo on his finger and Gallie noticed that it appeared to depict the date 16 October 1998. The deceased said to Gallie that something had happened on that day as a result of which he had become aggressive. In fact, the deceased apologised to Gallie saying 'I'm sorry to take it out on you guys, but um, I'm just a bit agro' (Exhibit C13a, Page 2). Gallie told the deceased that his occupancy of cell 211 would be reassessed in the afternoon.

3.12 However, it is clear that the deceased remained in cell 211 for the whole of Monday 16 October. He took his own life in the early hours of the morning of Tuesday 17 October in cell 211. From the time of the removal of his jewellery until his suicide there is no suggestion in the evidence that the deceased was exhibiting any recalcitrant or abusive behaviour.

3.13 The deceased spent the night of 16 and 17 October alone in cell 211. There is evidence that he conversed at length with a prisoner named Chambers who was occupying the cell across the corridor from the deceased's cell. That conversation concluded in the early hours of the morning of 17 October. Chambers was probably the last person to converse with the deceased. I will also deal with a number of patrols that were conducted within Unit 2 of E Division throughout the night. The deceased was found to have died when Correctional Officer Stephen Nash, whose record of interview and verifying affidavit was received in evidence (Exhibit C16a), went to Unit 2 to release prisoners responsible for the preparation of the morning meal. Nash looked into the deceased's cell shortly after 7.30am. He initially looked through the door of the cell via an observation window and observed the deceased hanging by the neck from a noose attached to the upper structure of the double bunk. The deceased's cell was unlocked and efforts were made to release him from the noose. It was plain

that he had been dead for some time and this was in due course confirmed by an examination by Dr Ross James who attended the cell later that morning. No resuscitation efforts were conducted by reason of Mr Allen's obvious demise.

4. The confinement of the deceased in cell 211

4.1. Mr Ford, the Unit 3 Case Manager and Coordinator, said in evidence that the philosophy underlying the placement of a prisoner in cell 211 was the 'good order, well-being, safety and security of prisoners and staff in the division' (T128). He expanded upon this by explaining that this philosophy was served by 'taking away the prisoner from the general population, therefore minimising or effectively taking away the threat of any sort of violence against any other prisoner or officer, that was one of its main purposes' (T128). The General Manager of Yatala is Maria Bordoni who told me that the intention behind the placement of a prisoner in cell 211 in E Division was to enable a prisoner, who might require time out or the opportunity to cool off, to get his thoughts together in an environment where he was not going to incite or be incited by the other prisoners in the wing.

4.2. An issue arose in the inquest as to whether or not the provisions of the Correctional Services Act 1982 allowed for the placement of prisoners in a regime of management that life in cell 211 imposed. The authorisation for the placement of prisoners in a cell 211 regime of management was said to be authorised by Section 24(2) of the Correctional Services Act 1982. The Correctional Services Act Section 24(2) states:

> '(2) Subject to this Act, the Chief Executive Officer has an absolute discretion-
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> *(a)* to place any particular prisoner or prisoner of a particular class in such part of the correctional institution; and
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> *(b)* to establish in respect of any particular prisoner, or prisoner of a particular class, or in respect of prisoners placed in any particular part of the correctional institution, such a regime for work, recreation, contact with other prisoners or any other aspect of the day-to-day life of prisoners.'

The Chief Executive of the Department for Correctional Services had delegated his powers under both section 24(2)(a) and Section 24(2)(b) to Case Management Coordinators such as Mr Ford (Exhibit C43). It would seem to me that the power to place a prisoner in cell 211 could emanate from either Section 24 (2)(a) or Section 24

(2)(b). However, Section 36 (1) and (2) of the Act also needs to be considered. It states:-

> '(1) A prisoner must not be kept separately and apart from all other prisoners in the correctional institution except in accordance with this section.
>
> (2) The Chief Executive Officer may direct that a prisoner be kept separately and apart from all other prisoners in the correctional institution if the Chief Executive Officer is of the opinion that it is desirable to do so
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> (a) in the interests of the proper administration of justice where an investigation is to be conducted into an offence alleged to have been committed by the prisoner; or
>
> (b) in the interests of the safety or welfare of the prisoner; or
>
> (c) in the interests of protecting other prisoners; or
>
> (d) in the interests of security or good order within the correctional institution. '

The Chief Executive Officer's power to direct that a prisoner be kept separately and apart from all other prisoners in a Correctional institution was, in the case of Yatala, only delegated as far as the General Manager of that institution, Ms Bordoni. There was no authorisation given by Ms Bordoni, nor the Chief Executive Officer, for the deceased to be placed into cell 211. Ms Bordoni told me that she was not aware of the deceased having been placed in cell 211 (T270).

4.3. Ms Bordoni resisted the suggestion that the imposition of a regime or the placement of a prisoner in a particular part of a Correctional institution under Section 24 (2) of the Act would, if such a measure resulted in the prisoner being kept separately and apart from all other prisoners, also require authorisation under Section 36 of the Act (T330). Moreover, Ms Bordoni said that in any event a cell 211 regime did not preclude a prisoner from association with other prisoners. She said that it was not a prerequisite, nor part of cell 211 routine, that a person not associate with other prisoners. She also said that placement in cell 211 was not intended to prevent him from communicating with other people (T270). She also pointed out that the change of regime cell was purely and specifically designed for short-term intervention, that is for periods of 48 hours, but usually 24 hours. She rejected the suggestion that the reality was that a prisoner in cell 211 was isolated from the rest of the prison population (T267). She said that the placement of a prisoner in cell 211 simply meant that he was afforded single cell accommodation in a double cell division (T268). Ms Bordoni contrasted the regime in cell 211 with that in G Division, the maximum

security facility at Yatala. She described the environment in G Division as 'hard cell' accommodation. In G Division all prisoners are maintained separately and apart under Section 36 of the Act.

4.4. In my opinion, the reality of the situation is different from that envisaged by Ms Bordoni. I received in evidence a document entitled 'Routine for Management Cell 211' (Exhibit C18b). This document was promulgated by Mr Vic Gibson who was the manager of E Division at the time. The document was promulgated on 12 October 2000, four days prior to the deceased's placement in cell 211. It describes the routine for the management of a prisoner in cell 211 over a period of 24 hours. The same routine applies today. I set out the routine as it is set out in Exhibit C18b:-

Daily Routine

0745	Breakfast issued.
0800 – 0900	Normal cell inspection and cell cleaning routine except when completed the prisoner is to remain in cell.
0900 – 1100	Confined to cell, prisoner is to shower during this period in K-Wing showers by himself.
1100 – 1130	Exercise in the Unit 2 association area and or use of phone (one call).
1130 – 1300	Secured in cell.
1300 – 1315	Normal afternoon cell inspection and intercom check.
1315 – 1530	Confined to cell.
1530 – 1600	Exercise in Unit 2 association area.
1600 – 0800	Confined to cell.

4.5. The prisoner remains in his cell from breakfast until 11am. He showers in K wing by himself. Exercise periods involve isolation from other prisoners. He is again confined from 11.30am to 3.30pm when he exercises alone for half an hour. He is then confined in the cell until the following morning. Exhibit C18b requires the opening in the cell door, known as the cell trap, to remain closed at all times and a clear Perspex viewing hole in the trap to remain covered. In practice it was covered by a piece of paper. This was the regime under which the deceased was placed.

4.6. Mr Ford told me that the placement of the paper over the Perspex window was part and parcel of the change in the prisoner's regime. He said 'the prisoner in 211 was allowed no contact with any other prisoner in the unit and due to the fact that each unit has 3 unit workers that are constantly going up and down, historically we have found they have stopped at the trap, spoken to these people. So it was deemed – and I

don't know where this direction came from – but that trap be covered up' (T70). As seen, the direction was actually contained in Exhibit C18b. I have already referred to the philosophy of cell 211 as Mr Ford understood it, namely 'taking away the prisoner from the general population'. Ms Bordoni's understanding as to the purpose of placing paper over the Perspex window was to prevent prisoners in the wing 'geeing the person up' in cell 211 (T239).

4.7. Ms Bordoni said that there was no prohibition on a prisoner attempting to converse with a prisoner who was under a cell 211 regime (T239). Mr Vic Gibson the Manager of E Division gave evidence before me. He stated in a record of interview verified by affidavit (Exhibit C18a) that the management cell was used when a prisoner's behaviour was unacceptable but not to the extent that it warranted going to G Division. He acknowledged that prisoners in cell 211 did not mix with other prisoners. Comments made by other Correctional Officers in their records of interview suggest that the reality of the situation was that prisoners were not supposed to talk to the occupants of cell 211 and that separation from other prisoners was the norm. In this regard see Kenneth Taylor (Exhibit C38, p9-10), Ryan Ogilvy (Exhibit C40, p6), Paul Oldacre (Exhibit C10a, p3), Philip Denner (Exhibit C12a, p4), Richard Guppy (Exhibit C14a, p4) and Stephen Nash (Exhibit C16a, p8). There was some evidence to suggest that a blind eye was turned to attempts by prisoners to verbally communicate from their own cells to the deceased's cell through the vents at the bottom of the cell doors. However, this was in a situation where the deceased was confined to his cell and the other prisoners on the wing were confined to theirs. There was little to suggest that whilst a prisoner was under a cell 211 regime he had any immediate and personal contact with any other prisoner. A prisoner at the time, Kemehl Chambers, gave convincing evidence that in practice a prisoner in cell 211 was not allowed to have contact with other prisoners (T54).

4.8. It therefore seems to me that the reality of the cell 211 regime involved the prisoner being kept separately and apart from all other prisoners. The fact that the regime may have been in place for 24 hours only is beside the point. There can be little doubt that Section 24(2) of the Act authorised the placement of the deceased in cell 211. However, if the regime involved him being kept separately and apart from other prisoners then his placement in such a regime would have required authorisation under Section 36 of the Act. In this regard what fell from Justice Perry in **Bromley v**

McGowan and Vardon [1994] SASC 4722 (4 August 1994) is pertinent. His Honour said, 'It would, of course, be wrong to use the powers conferred by Section 24 of the Act to place a prisoner in a particular part of the Correctional institution, and by doing so effect a defacto segregation from all other prisoners of a kind which could only be authorised by Section 36 of the Act.' Ms Bordoni's view that a Section 24 regime would not require Section 36 authorisation, if it resulted in a prisoner being kept separately and apart from other prisoners, is thus erroneous.

4.9. In this particular case there was no authorisation under Section 36 of the Act to place the deceased in a situation where he was, as I find, kept separately and apart from all other prisoners. This is an issue that needs to be addressed by the Chief Executive Officer of the Department for Correctional Services. The practice of placing recalcitrant prisoners in cell 211 continues. If the practice continues in the manner and form demonstrated in this case, it would require the authorisation of the Chief Executive Officer, or his delegate, exercising the power under Section 36 of the Act.

5. The deceased's suicide risk and indicators thereof

5.1. The only documentation relevant to an assessment as to whether the deceased was at risk of self-harm, that was available to the staff of E Division, was the Stress Screening form and the Health Assessment form. As seen, the Health Assessment form referred to an unknown potential for self-harm, a history of attempted hanging and the document contained the recommendation that the deceased occupy a shared cell. The Stress Screening form also referred to his attempted hanging ten years before.

5.2. Mr Ford's first contact with the deceased was on Friday 13 October 2000. He had been involved in a Workplace Assessor's course on the Tuesday, Wednesday and Thursday of that week.

5.3. Mr Ford described his role within E Division. He was responsible for ensuring the ongoing operation of case management within Unit 3 of E Division. His duties included organising program plans, case reviews, conducting all prisoner security ratings based on risk needs assessment, development and other criteria. He was also meant to conduct a security rating of each prisoner within 24 hours of his admission to the prison. He determined a prisoner's security rating based upon his sentence status/remand status, offender history/escape history and other matters. In the case of

the prisoner serving a sentence of 6 months or less, as was the case with the deceased, a sentence plan was drawn up by Mr Ford. This plan determines a prisoner's placement within the various South Australian Correctional institutions.

5.4. On Friday 13 October 2000 Mr Ford conducted prisoner security ratings. He believed that there were nine security ratings to be performed that day. The preparation of a security rating involved him interviewing each prisoner who had recently come into the Unit. He had been away the previous three days and so there had been a backlog of work for him to get through.

5.5. Mr Ford performed the security assessment in relation to the deceased on 13 October. The Security Assessment form that was completed and signed by Mr Ford on that day was part of the Case Management file tendered in evidence (Exhibit C33). The Security Assessment form does not deal with anything concerning risk of self-harm nor the nature of accommodation within the prison environment. The deceased was classified with an initial security classification of medium. On 13 October 2000 a letter was signed by Mr Ford in which it was explained to the deceased that the Case Management Coordinator, in this case Mr Ford himself, was responsible for all aspects of his care and that he was the person whom the deceased should contact in the event that he was not satisfied with any aspects of his case management.

5.6. Mr Ford told me that at no stage did he have a chance to view the deceased's case file (T117). This meant of course that he did not see the Health Assessment form or the Stress Screening form. It meant that he did not sight any document that referred to a potential for self-harm or history of attempted hanging. Thus he was unaware of the recommendation for shared cell accommodation.

5.7. The decision to place the deceased within cell 211 was made without regard to the material contained in the Health Assessment form and, in particular, the recommendation regarding shared cell accommodation. Mr Ford signed the direction pursuant to Section 24(2) of the Correctional Services Act placing the deceased in cell 211. His reasons set out on that document are as follows: 'that you were abusive towards staff and that you disobeyed a lawful direction (Regulation 27) to remove a ring from your finger'. The heading of the document refers to Section 24(2)(a), although Mr Ford told me that he was acting under Section 24(2)(b). It does not matter. According to the document, the deceased refused to sign it (Exhibit C56).

5.8. Mr Ford acknowledged that risk of self-harm was a major feature underlying the purpose of the Health Assessment form. He agreed that the shared cell recommendation was couched in terms of it being a special medical recommendation. He agreed that an experienced officer would have inferred from that recommendation that an assessment had been made that the deceased was at risk of harming himself. Mr Ford explained that a prisoner in cell 211 was not entitled to wear shoes or retain shoe laces because of their potential use for self-harm. He said, 'We ensured that there was no objects or items that may be used to self-harm'. In addition, certain privileges were removed from prisoners placed in cell 211. They had no television, minimal reading material and 1 hour of exercise per day instead of the usual 6 or 7 or 8 hours out of the cell (T68). I have already referred to the restriction of association involved with a prisoner's incarceration in cell 211. It seems to me that the circumstances in which a prisoner occupied cell 211 bore an element of punishment. I make no comment as to whether that was appropriate in the circumstances, and in particular, whether it was appropriate in the deceased's circumstances. I simply make the observation that the regime within that cell had a punitive air about it and it was therefore necessary for care to be exercised in placing prisoners within that cell. The fact that the material set out in the Health Assessment form was not referred to before the decision placing the deceased in cell 211 was taken was a serious oversight.

5.9. It appears that both Mr Ford and Mr Gibson, the E Division manager both had input into the placement of the deceased in cell 211. Mr Ford suggested that although he plainly generated the paperwork for the placement of the deceased in cell 211, he thought it likely that it had been a joint decision between him and Mr Gibson (T105). Mr Gibson told me that he could recall the deceased being placed in cell 211 but could not remember whether he was placed in there before or after he was informed of the placement (T201). He said that the decision to place him in 211 would have been made by his delegate and he would have read the reports to see whether or not the decision was justified (T202). He said 'it would invariably come down to me because I would need to read the report. The transfer may have occurred but I would need to read the reports to justify that I thought the transfer was warranted'. He said that as well as sighting the Section 24 form, he would have had to have reviewed written reports from involved Correctional Officers. He said that he did not think it possible for a decision to place a prisoner in cell 211 not to have been brought to his

attention (T205). Like Mr Ford, he said that he was not aware of the recommendation on the Health Assessment form that the prisoner have shared cell accommodation.

5.10. Mr Ford and Mr Gibson's evidence varied as to what should have been the effect of the information on the Health Assessment form in terms of the deceased's placement in cell 211. Mr Ford's evidence about this is as follows:-

> 'Q: Are the endorsements that are contained on this form something that would have caused you to alter your approach in what you did in relation to placing Mr Allen in cell 211.
>
> A: I am unsure of that answer. With regards to the history of attempted hanging now being aware of this now that it was 10 years ago, no, that would not have affected my decision. If it was a recommendation for recommended shared cell that recommendation would have gone forward in the unit but if he had displayed no signs be it physical or verbal of self-harm, I believe I still would have placed him in 211.' (T77-78)'

On the other hand Mr Gibson's evidence on this subject was as follows:-

> 'Q: If you had known this information and you had seen this document, if it had been brought to your attention that a decision had been made by the case management coordinator to place Mr Allen in cell No. 211, would that have caused you to make any different decision in relation to that.
>
> A: In that situation, yes.
>
> Q: Do I take it to mean that you would have reconsidered whether it was appropriate for Mr Allen to be placed in cell 211.
>
> A: I would probably reconsider a different location.
>
> Q: Could you expand on that – what other locations would there be?
>
> A: Well in that situation and if I thought the behaviour was warranting it I'd probably look at maybe G Division which is a safer workplace and more stringent observation rules.' (T213)

5.11. It is not being wise after the event to suggest that Mr Gibson's approach should be preferred. This was not a situation where a prisoner was placed in a single cell accommodation as part of a normal routine. There was an element of punishment related to his placement within this cell. There was in my view a regime of solitary confinement. Privileges had been taken away from the deceased, and in addition, he was confined to the cell for several hours beyond what would have been normal prison routine. The deceased was a prisoner who had a history of self-harm in custody and a recommendation that he have shared cell accommodation was based no doubt on that history. The statement of Nurse Tyson makes that clear. In that event, the recommendation that he be kept in shared cell accommodation should have been

given considerable weight. Mr Gibson's evidence in this regard in my view is correct. I would have thought that if such a recommendation was made then only very powerful evidence would have justified the overriding of such a recommendation.

5.12. Another matter for concern was whether or not the deceased had been properly inducted in to the division when he first was admitted to it on 10 October 2000 and whether any consequences flowed from what may have been a failure to induct.

5.13. Mr Ford explained that when a prisoner was admitted to his Unit, he was inducted by Unit staff into the procedures of the Division (T60). He said that the inducting officer would 'take notice of' the Health Assessment Form which, in this case, contained the recommendation for shared cell accommodation. Mr Ford did not know who the inducting officer was or was meant to have been. In the Case Management File (Exhibit C33) the Record of Induction for the deceased bears the deceased's name and the date of 13 October 2000. It has not been signed either by the inducting officer or the deceased. There is provision for both signatures. Mr Ford recognised the possibility that this might indicate that it was never noted by anyone in the Unit that there had been a recommendation that the deceased share a cell. This is probably correct. There does not appear to be any evidence that anyone in E Division was aware of the recommendation, either at the time the decision to place the deceased in cell 211 was made, or subsequently.

5.14. As it transpired, the evidence would suggest that by late in the evening of 16 October, the deceased was in a low mood. The prisoner Kemehl Chambers who occupied cell 218 opposite cell 211 and who conversed with the deceased across the corridor through vents in the cell doors, knew the deceased well. He formed the view that night that the deceased 'was on a small bit of a downer'. He had regretfully referred to the anniversary of 16 October. It is to be remembered that the deceased had the date tattooed on his finger. Chambers had told him to keep his 'chin up'.

5.15. The deceased's father had visited the deceased the day before. He observed the deceased as being 'a bit down'. Other visitors that weekend had made similar observations.

5.16. There is no suggestion on the evidence that the deceased was exhibiting suicidal tendencies on the night in question. He kept any suicidal thoughts to himself. I accept that there was little in his presentation to correctional staff that would have

alerted them to his vulnerability that night. The deceased was a man used to prison and not the type of man to telegraph his thoughts to correctional staff. Chambers, who knew him, told me as much. It is not known when he formed the intent to take his own life. The fact remains, however, that the recommendation that he be kept in shared cell accommodation was not seen by those responsible for his welfare. It should have been and, as Mr Gibson responsibly concedes, it should have been taken into account when the decision to put the deceased in cell 211 was made.

5.17. It is not for me to impose any view I might have as to whether the isolation of a recalcitrant prisoner in an environment such as cell 211 is appropriate or not. However, as demonstrated by this case, it is a decision to be taken with the utmost care and with regard to all available information as to a prisoner's temperament. Moreover, if a prisoner is placed in the cell 211 environment it behoves those who are responsible for his welfare to maintain close scrutiny of such a prisoner and to leave him in such an environment for no longer than necessary.

6. **Whether appropriate scrutiny was maintained while the deceased was in cell 211.**

6.1. The deceased was placed in cell 211 on the morning of Monday 16 October 2000. The general routine for E Division dictated that prisoners would be confined to their cells from 4 o'clock in the afternoon until 8 o'clock the following morning. The deceased was alone in his cell between those times. Local Operating Procedure No. 26 (LOP26), which was promulgated in January 1999 (Exhibit C18c), detailed the procedures for the observation of prisoners during the first and second watch periods. The first watch period occurred between 4 o'clock in the afternoon and midnight. The second watch period occurred between midnight and 8.00am. LOP26 called for the sighting and counting of prisoners prior to the commencement of each watch period. During watch periods patrolling staff were required, 'operational duties permitting', to conduct a patrol of a division at intervals of not more than 2 hours and to sight each prisoner. The procedure required patrolling officers to observe the prisoner by shining a torch through the Lexan (Perspex) panel and to sight the prisoner through the spy hole in the cell door. The purpose of this procedure was stated to be the following: 'to ascertain if prisoner is showing signs of physical to (sic) mental stress'. The procedure also required patrolling officers to record the following information in the divisional Watch Journal, namely:

- The time the watch officer leaves the work station to commence the patrol

- The time the officer returns from conducting the patrol and
- The patrolling officer sighted all prisoners.

LOP26 was said to apply to all cells in E Division, including cell 211. The 2 hourly patrols were not conducted at fixed times. The requirement was simply that patrols be conducted at intervals of not more that 2 hours. The salient requirement of a patrol was the stipulation that all prisoners be actually seen. At night this would have necessitated either turning a light on in the cell from an outside switch or using a torch.

6.2. As seen earlier, E Division prisoners were accommodated in shared cells. Cell 211 was the exception. In a shared cell situation the scope for one of the occupants to commit an act of self-harm was naturally limited. On the other hand, the ability of a prisoner accommodated in cell 211 to harm himself was only limited by whatever means he may have had at his disposal. Obviously, one of the underlying purposes of an LOP26 observation was to check on the welfare of prisoners accommodated in E Division. However, prisoners could not be constantly observed, unlike in G Division where, as I understand it, there is almost constant monitoring of prisoners within their cells. The fact that prisoners were, in practical terms, observed only every 2 hours meant that there was scope for a prisoner during the periods between patrols to misbehave or inflict self-harm. Mr Gibson told me that in his experience incidents within the cells during the watch periods normally have occurred just after a patrol has been completed. This was due to a perception among prisoners that another patrol would be unlikely to occur before another 2 hours had passed. He told me 'a lot of situation – why I say my experience, a lot of situations that occurred where we found out about incidents, prisoners next door or in the same cell contacting the control room. It's generally just after the patrols have been completed. When I was an officer, quite often you'd turn around and go straight back to respond to a situation' (T227).

6.3. There was an intercom in cell 211 that could enable a prisoner to communicate with Correctional staff. However, a prisoner intent on self-harm was obviously not going to avail himself of that means of communication. There is no camera within cell 211 that would enable the activities of a solitarily confined prisoner to be monitored from a remote position within the prison. This is to be contrasted with the situation in G Division where cameras are mounted in each cell and the activities of prisoners are thus monitored. The desirability or otherwise of placing a remotely monitored CCTV

camera in cell 211 was a matter of considerable debate in the course of the inquest. I will return to that issue later.

6.4. In reality, a prisoner who was intent on committing suicide by hanging had every opportunity to do so within cell 211. He had solitude. He had a suitable hanging point in the form of the top bunk railing. He had bedding with which he could fashion a noose. The fact that the deceased in this case had such an opportunity to commit suicide and had the necessary means to do so is self-evident. LOP 26 patrols, even if carried out to the letter, would not have proved much of a hindrance to a suicidally intent prisoner.

6.5. As it transpires, however, the strict letter of LOP26 was not complied with during the early hours of the morning of 17 October. I return to this issue in a moment, but it is first necessary to have a full appreciation of the evidence as to the estimated time of death of the deceased. Dr Ross James, the Chief Forensic Pathologist, examined the deceased on the morning of 17 October. The details of his examination do not need to be fully repeated. However, his opinion was, and I accept his evidence, that the prisoner had died 'perhaps something like 1 or 2 o'clock in the morning, something of that order' (T191). He said it could have been earlier than 1 o'clock because there was no reliable way to calculate the precise time. He said he was quite happy to accommodate a period of an hour or two on either side of the time frame I have mentioned. Dr James examined the body of the deceased at 10:46am on 17 October. He calculated the approximate time of death by the fact that the deceased had an approximate post-mortem interval of 9 hours prior to the examination.

6.6. Kemehl Chambers was occupying the cell directly opposite the deceased's cell, 211. As seen, Mr Chambers said that he conversed with the deceased until early on the morning of 17 October 2000. The fact that he was conversing with the deceased is corroborated by other evidence which I don't need to set out in detail. I accept Chamber's evidence that he was conversing with the deceased until early that morning. Chambers was able to conduct a conversation with the deceased through vents at the bottom of each of the doors to cell 211 and 218. A record of interview between a police officer and Chambers verified by affidavit was also tendered to me in the course of the inquest (Exhibit C31). The interview was conducted on Tuesday morning 17 October. Chambers said that he was speaking with the deceased until about 1 or 2 in the morning. He did not speak to the deceased again after that time. He

went to sleep straight away and didn't wake up until the following morning. In the course of his evidence he was pressed to give a more accurate estimate of the time he concluded his conversation with the deceased. His answer was 'like I said in the previous interview 1:00-1:30 in the morning' (T38). Asked as to whether it could have been as late as 2 o'clock in the morning he said 'it wouldn't have been much more' (T38).

6.7. There was one Correctional Officer on duty in E Division during the course of the second watch commencing at midnight. That officer was Mr Kenneth Harold Taylor. His duty was to conduct patrols during the second watch. When not conducting a patrol he was stationed in the infirmary on the ground floor of the division. Mr Taylor, for reasons that I will discuss later, failed to sight the deceased in cell 211 when he conducted routine patrols between 1.00am and 1.10am and then 2.50am and 3.00am. He had conducted a count of the whole division between 10.45pm and 11.00pm. The prisoner had been sighted on that occasion. It is plain from the evidence of Dr James that the prisoner took his own life sometime after 11.00pm. Mr Taylor said that he next sighted the prisoner during a patrol conducted between 4.50am and 5.00am. On that occasion he had opened the trap in the cell door and noticed that there was a blanket hanging inside over the aperture of the trap. He had pulled that blanket down and said that he could see the deceased's silhouette positioned such that it seemed that he was either sitting or standing at the bottom of his bunk bed. There can be little doubt on the evidence of Dr James that by this time the deceased had taken his own life. However, Mr Taylor did not think that there was anything untoward about the deceased's well-being on this patrol. He said it was dark and he had not attempted to communicate with the deceased. Later that morning another Correctional Officer, Ryan Scott Ogilvy, who gave evidence before me, also looked into the deceased's cell. He did this about 7.00am. It seemed as if the deceased was standing at the back of the cell behind the bunk. Ogilvy did not think there was anything untoward as far as the well-being of the deceased was concerned. It was not until later that morning that the deceased was discovered in the circumstances that I have already described.

6.8. It is to be observed that Mr Taylor's failure to sight the deceased either between 1.00am and 1.10am, and 2.50am and 3.00am was contrary to LOP26, in so far as it breached the requirement that all prisoners be sighted on all two hourly patrols. Mr

Taylor's failure to sight the deceased must also be looked at in light of an 'Instruction to All Staff' signed by the then Acting General Manager, Mr Gibson, on 1 February 2000. This instruction stated that a recent death in custody had reaffirmed the importance for staff to note in the Watch Journals, on the completion of each patrol, the relevant times of the patrol and the fact that all prisoners were sighted (Exhibit C18e).

6.9. Mr Taylor's claim that he conducted a patrol of the whole of E Division between 1.00am and 1.10am at first blush is difficult to reconcile with some of the evidence given by the prisoner Chambers. As seen earlier, Chambers said that he had been conversing with the deceased through the vents in the cell doors until a time possibly later than Taylor's patrol of 1.00am to 1.10am. Chambers maintained that he had no recollection of hearing or seeing an officer conducting a patrol at that time. On the evidence that he gave as to times, he no doubt would have been aware of the presence of an Officer in that wing if a Correctional Officer had patrolled between the times Taylor stated. On the other hand, Chambers did not purport to be precise as to times. He said that he fell asleep 'pretty well straight away' after he'd finished conversing with the deceased. It is possible that Chambers and the deceased concluded their conversation before Taylor's patrol between 1.00 and 1.10am. I do not doubt Mr Taylor's evidence that he conducted this patrol of E Division and that he entered the particular wing of E Division that housed the deceased. Mr Taylor made a note of that patrol in the Watch Journal (Exhibit C39) and if he was being dishonest about that issue he could easily have said, consistent with the evidence as a whole, and in particular that of Dr James concerning time of death, that he sighted the deceased during that patrol and that he was at that time alive and well. I find that Mr Taylor did conduct a patrol between 1.00am and 1.10am on the morning of the 17th October 2000. I think the likelihood is that he conducted this patrol after the deceased and Chambers had finished conversing and at a time after Chambers had gone to sleep.

6.10. The precise time at which the deceased took his own life cannot be determined. However, I think the likelihood is that the deceased took his own life sometime after Mr Taylor's patrol at 1.10am and before the commencement of his next patrol at 2.50am. This would fit in with the estimated time of death given by Dr James. There is no evidence from which it can be concluded that if Mr Taylor had endeavoured to sight the deceased during his 1.00am patrol he would have witnessed the deceased

preparing to take his own life, seen the deceased taking his own life or seen the deceased at a time so close to the act of taking his own life that resuscitation efforts could have been successfully made. In any event, I think it is unlikely that the deceased would have been making his preparations at a time when he thought an imminent patrol was possible. There was evidence that patrol officers' footfalls could be heard within the individual cells. Even if Mr Taylor had looked into the cell, the deceased probably would have had sufficient warning to enable him to desist from what he was doing and then recommence his preparatory actions after Mr Taylor had left the wing.

6.11. This is not to say that Mr Taylor's failure to comply with LOP26 can be condoned. Mr Taylor's failure to sight the deceased during the 2 patrols around 1.00am and 3.00am was a serious departure from clearly laid down procedures. His explanation for failing to sight the deceased during his 1.00am and 3.00am patrols was essentially twofold. Firstly, he claimed that he was not aware of the requirement that prisoners be sighted. Secondly, he referred to a situation where Correctional Officers were reluctant to shine torches into a cell directly through the trap for fear of disturbing and aggravating prisoners.

6.12. As to the first of these explanations Mr Taylor gave evidence that he was unfamiliar with the general regime of management within E Division. Mr Taylor told me that he commenced employment as a Corrections Officer in 1990. He had worked in E Division at some time in the 1990s. However he had worked in G Division until August 1999, where, it has to be accepted, procedures are quite different, due to the fact that G Division operates as a maximum-security facility. He had worked in G Division for 3 years prior to August 1999. He had suffered an injury in a scuffle with a prisoner and the injury had required surgery. He underwent surgery in September 1999. In about November he had returned to work in G Division. He sustained another injury in January 2000 and it resulted in a further period of absence from his work place. He remained off work effectively until 2 October 2000. Mr Taylor had experienced a number of difficulties with his health, in particular with depression. Prior to 2 October he had worked on a supernumerary basis for about a week. This had involved him working with another Correctional Officer. Neither during that supernumerary period nor between 2 October and 16 October had Mr Taylor been provided with any training or induction in E Division procedures. His supernumerary

duties had involved him only working a few hours a day and it had originally been intended that he would resume his full-time substantive duties in F Division. Mr Taylor understood his duties within E Division during the second watch to be the following: ‘To do a patrol approximately every 2 hours. Go down all wings, all floors – all wings, listening and looking, and randomly checking cells and prisoners’ (T137-138). Mr Taylor acknowledged that he did not comply with the LOP26 requirement that every prisoner be sighted. He said that during the patrol between 1.00 and 1.10am he randomly sighted certain prisoners but had not looked into cell 211.

6.13. Mr Taylor’s ignorance of the requirement that all prisoners be sighted on each patrol is surprising. Mr Taylor admitted that when he commenced his employment within E Division in early October 2000 he did not refresh his memory about procedures or look at Duty Statements pertaining to the division (T149). Mr Gibson told me that Duty Statements were available in each workstation. Local Operating Procedures were also accessible within the workstations. In addition, information folders that were updated with memos were distributed throughout the institution and were also available (T239). He also told me that each division had their own copy of Duty Statements and in E Division they were kept within a plastic folder. ‘It was just a matter of flipping through and finding out what duty – what you’re supposed to be doing.’ (T240). However, there was no requirement that officers had to read the material. Staff were generally made aware of new requirements at staff meetings and musters. Ms Bordoni told me that she had been personally aware of Mr Taylor’s personal circumstances and was aware of the fact that he was returning to duty at Yatala after a significant layoff. She said that she had the expectation that staff in the area in which he would be working would have inducted him in terms of what was expected of him in that area and that he would have had an adequate opportunity to familiarise himself with the routines (T294). She also said that her expectation was that he would be informed about relevant operating procedures and systems by working side by side with other officers and receiving hands on training. She said that there was ample time for officers to make themselves familiar with particular procedures and the relevant documentation (T295). She referred to the workstations as having the local operating procedures. She also expected that musters would have been yet another source of information for officers to be brought up to date as to procedures relevant to their area of work.

6.14. The issue is by no means free from doubt, but on the balance of probabilities, I accept Mr Taylor's evidence that he was not familiar with the requirement that all prisoners be sighted in E Division on each patrol. The fact that he was unaware of this requirement demonstrates an unsatisfactory state of affairs. I think Mr Taylor should have been instructed in E Division procedures by someone in authority and told to read the relevant material. This is not to say that Mr Taylor should not have to shoulder some of the blame for his woeful ignorance of simple but important procedures. I gained the impression that Mr Taylor had essentially been guessing what his duties and responsibilities were and made no meaningful effort to properly inform himself of the requirements. However, Mr Taylor's education in E Division procedures would not have been helped by the fact that his defective Watch Journal entries from an earlier shift had been endorsed by Mr Gibson, the manager of the Division.

6.15. The other reason proffered by Mr Taylor for not sighting each prisoner was, to use his words in his record of interview, because it was a 'no-no to shine lights on the prisoners during the second watch period.' Prisoners had complained, as he understood it, to the Ombudsman and Visiting Justices about being disturbed in the middle of the night. Mr Taylor in his record of interview also said that it made prisoners 'agro'. There was a difficulty in shining torches through the Perspex panel within the trap. The crazed surfaces of the panels caused the light to be reflected back, and it was necessary to shine the torch directly at the prisoner through the open trap. Mr Gibson was not aware that this had been a problem in sighting prisoners in E Division. Whether it was a problem or not, in my view the situation as described was a lame excuse insofar as it was offered to explain why there was a reluctance to shine torches directly at, and thereby sight, prisoners. The requirement was clear - all prisoners had to be sighted - and if that could not be achieved by shining a torch through the Perspex window then it had to be done by shining a torch through the open trap or by turning on the light in the cell. The requirement that prisoners be sighted was an important one. It was designed not only to maintain good order within the division but was also plainly designed to ensure the well-being and safety of prisoners during watch periods. The inconvenience to the prisoner by having a light shone directly at him had to be balanced against the need to ensure the prisoner's protection. The scales in my view were firmly balanced towards ensuring that all prisoners were regularly sighted. Mr Gibson acknowledged that the prison had a duty

of care towards prisoners and that the paramount duty was to ensure that each prisoner made it through the day. He was of the view, and I agree with him, that this duty overrode the invasive nature of measures adopted in respect of prisoners' surveillance (T227).

7. **Recommendations**

7.1. By virtue of Section 25(2) of the Coroners Act 1975 I am empowered to make recommendations that might, in my opinion, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

7.2. I have already expressed the view that the regime in cell 211 of E Division at Yatala Labour Prison involves the prisoner being kept separately and apart from other prisoners. I received in evidence the current daily routine for the management of prisoners in cell 211 (Exhibit C35). The routine is essentially the same as it was when the deceased occupied that cell in October 2000. If the practice is to continue as it is, consideration will have to be given to whether authorisation under Section 36(2) of the Correctional Services Act 1982 should be obtained. I recommend that consideration be given to that issue.

7.3. The new routine for cell 211 which was promulgated by the Manager of E Division, Mr Stephen Mann, on 29 January 2001 stipulates that:

> 'Within one (1) hour of a prisoner being placed in the management cell full audit of his case file and electronic case notes must have been undertaken by the Unit 2 CMC or Officer 7 in his absence to identify any at risk issues or underlying problems. Any identified problems must be electronically case noted along with what actions have been taken in response.' (Exhibit C35)

No doubt this stipulation owes its existence to the fact that neither Mr Gibson nor Mr Ford, nor for that matter any of the other correctional staff of E Division, were aware of the contents of the Health Assessment Form contained in the deceased's Case Management File. The new routine obligates Correctional staff to view and consider the contents of a prisoner's case file and electronic case notes within an hour of a prisoner's placement in cell 211. In my opinion this is a step in the right direction. However, I was informed during the inquest that the only document relating to a prisoner's health that makes it way onto his Case Management File is the Health Assessment Form, which contains scant information. Detailed information as to the

prisoner's health, both physical and psychological, is generally not made known to Correctional staff operating within the divisions of Yatala. In this particular case the fact that the deceased had been undergoing psychiatric treatment for depression and had been prescribed Prozac for that depression was not known to Correctional staff in E Division. He was also suffering from alcohol withdrawal and taking Valium for it. If staff administering E Division had been made aware of the deceased's psychiatric history, in particular his recent history of depression, the decision to place him in isolation with observations as infrequent as every two hours would in all probability have been different. In my view the time has come for consideration to be given to implementing routine disclosure of medical information by the Prison Health Services to Correctional staff, especially where a medical issue may impact on the prisoner's management. I recommend accordingly. Legislation might be required to overcome any privacy or ethical considerations. It is difficult to perceive of any sensible objection to such disclosure. A prisoner's privacy is already severely compromised within a prison.

7.4. The new routine for the management of prisoners in cell 211 (Exhibit C35) has another difference from the routine formulated by Mr Gibson in October 2000. The new routine calls for hourly observations of a prisoner confined in cell 211. Two hourly checks were manifestly too infrequent. However I take the view that even hourly observations are probably not frequent enough to detect or deter suicidal prisoners confined in cell 211. I can well imagine that a prisoner intent on self-harm could achieve his goal between hourly observations. A number of suggestions have been made to overcome the difficulties involved in maintaining proper scrutiny of a prisoner confined in cell 211. The placement of a prisoner in cell 211 was said to be a last resort before being placed in G Division. The undesirability of placing prisoners in the severe regime that G Division provides, when a 24 hour placement in cell 211 might well overcome his recalcitrance, is obvious. On the other hand, proper scrutiny has to be maintained in relation to prisoners who are confined in cell 211. The idea of electronic surveillance of a prisoner in cell 211 was strongly resisted by the General Manager Ms Bordoni, because:-

> '…it's not an observation cell, it is not a hard cell. We have camera surveillance in G Division, we have a padded cell in G Division. We put people who warrant that sort of intervention into G Division and we also have the observation cell in the infirmary. I

would be saying when there is any question mark in relation to somebody's well-being, that is not what a change in regime cell is for.' (T306)

Ms Bordoni's comments bear careful consideration, but it has to be recognised that inevitably there will be a prisoner in cell 211 who is at risk of self-harm, especially if important information as to his health continues to be withheld from Correctional staff. It will not be possible to identify every such prisoner. For my own part I do not see any difficulty in placing a CCTV camera in cell 211 so that the activities of the prisoner can be monitored. The cell is only used for short periods and the inconvenience and intrusion into the privacy of the prisoner in my view should be a secondary consideration to the prisoner's welfare. No-one suggested that the installation of a remotely monitored CCTV camera in cell 211 is not feasible. The only consideration might be cost. I therefore recommend that consideration be given by the Chief Executive Officer of the Department for Correctional Services to the installation of a remotely monitored CCTV camera in cell 211 and in any other management cell in which prisoners are isolated for substantial periods of time.

7.5. The need to eliminate hanging points within cell 211 is obvious. I am told that the double bunk within that cell has been removed and has been replaced by a single bed. I have not seen the interior of cell 211. However, I make a general recommendation that all hanging points be eliminated from cell 211. They ought to be readily identifiable from past experiences of deaths in custody.

7.6. Finally, the failure of Correctional staff within E Division to properly understand their duties during the second watch needs to be addressed. Mr Taylor's failure to understand his responsibility to actually sight prisoners in E Division at intervals of no greater than two hours, and to note such sighting in the Watch Journal, was in my view partly the fault of those whose responsibility it was to supervise him and partly the fault of Mr Taylor himself. Ms Bordoni produced in evidence a document that has been promulgated since this death in custody. It is entitled 'Staff Induction Checklist'. Ms Bordoni explained that nature of this document in the following terms:-

'Q. You say that you have now formalised that induction process.

A. We have.

Q. What do you mean by 'formalised'; put it in writing.

A. Not only put it in writing but we've actually put in some processes and we've done this for - two-fold reason: one, in relation to this particular scenario and, as I said, some continuous improvement, and the other is in a recognition that particularly in the last five years we've had a number of new recruits come through our system, and in particular to Yatala, new staff, and they need to be inducted in all areas of Yatala. Yatala is like running four prisons in one, there's four distinct different areas, and the induction checklist that's provided here actually reads as it's a checklist designed to assist trainee correctional officers in their transitional period from the training course to their active duties. This checklist is also designed for staff who are transferring into the division from other areas within the department to reinforce training and familiarise employees with local procedures. So it essentially has all the relevant areas that people need to be familiar with, with a box which has to be ticked off. And I believe there are certain things that we're saying this person needs to know in 24 hours of being there and then there are obviously things that they can pick up in a longer duration. So when I say 'formalise' as I've indicated it's not just an instruction that says, 'You will do,' it is actually an active living document that people have to sign off on.' (T295-6)

The checklist is according to its terms designed to ‘reinforce training and familiarise employees with local procedures’ (Exhibit C57). It has provision for the signatures of a Correctional Officer’s supervising officer and training officer. It lists a number of aspects of a Correctional Officer’s duties and responsibilities. It does not, however, refer to patrol duties specifically. It may well be that such duties are covered in an induction in any event, but I do not know. They should be. Correctional Officers should be provided with a package of all Instructions, Duty Statements and LOPs relating to their duties. They should be provided with all updates and sign that they have so received and read them. I recommend accordingly.

Key Words: Death in Custody; Hanging; Psychiatric/Mental Illness; Correctional Services; Prisons.

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

Seal the 17th day of January, 2003.

Coroner

Inquest Number 17/2002 (2689/2000)