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 23rd, 24th, 25th, 26th and 27th days of June 2003 and the 18th day of December 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Margaret Lindsay.

I, the said Coroner, find that, Margaret Lindsay aged 38 years, late of Northfield Adelaide Women's Prison, Grand Junction Road, Northfield, South Australia died at the Modbury Public Hospital, Smart Road, Modbury, South Australia on or about the 23rd day of May 2001 as a result of neck compression due to hanging.

1. Reason for Inquest

1.1. Margaret Lindsay was taken into custody on Friday, 18 May 2001 when she was arrested in Victoria Square, Adelaide, in relation to an outstanding warrant of apprehension for offences of serious criminal trespass and larceny. She remained in the custody of the police, except during periods when she was at the Royal Adelaide Hospital and at Glenside Hospital, until Tuesday, 22 May 2001, when she appeared in the Adelaide Magistrates Court.

1.2. On 22 May 2001, Ms Lindsay was remanded in custody to appear in the Port Adelaide Magistrates Court on Wednesday, 23 May 2001. A warrant of remand was drawn up giving effect to that order, and Ms Lindsay was conveyed to the Adelaide Women's Prison (AWP) at Northfield, arriving in the early evening.

1.3. Ms Lindsay died in the late evening/early morning of 22/23 May 2001.

1.4. Accordingly, at the time of her death, Ms Lindsay was 'detained in custody within the State pursuant to an Act or law of the 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 11:35pm on 22 May 2001, Correctional Services Officer ('CSO') Cheryl Pitman was performing a check of the prisoners in D Wing at AWP as part of her duties as the Movements Officer. Ms Pitman's description of what occurred is as follows:

> 'At about 11:35pm I started a patrol of 'D' wing. I checked on the prisoner in Room 1, who was asleep. I shone my torch into Room 2 and saw Margaret hanging at the foot of the bed, she had a piece of blue bedding sheet tied around her neck and the other end of the sheet was tied to the support bar of the shelf just over her bed. She was not moving.
>
> I screamed into the radio, 'Alert, alert, code black 'D' wing'. Code black is a medical emergency. I unlocked the door and attempted to hold her up to release the tension on her neck. I can not remember exactly where I grabbed her, I grabbed her and tried to lift her up. Mr Cammerano, Mr Toogood and Miss Shoumack attended at Room 2 immediately.
>
> Mr Cammerano held Margaret while I cut the sheet she was suspended by. We laid her on the bed and commenced cardio-pulmonary resuscitation straight away. I ran to get the oxy viva to assist in the resuscitation. Someone called an ambulance and we continued CPR until the ambulance arrived. We assisted the ambulance crew in their attempt to revive her until they decided to take Margaret to the hospital to revive her. '
>
> (Exhibit C28, p2)

2.2. CSOs Shoumack and John and Toogood also attended as a result of hearing the code black issued by CSO Pitman. Ms Pitman obtained the air-viva equipment from the movement office, and St John Ambulance was contacted at 11:42pm. The CSO's began cardio-pulmonary resuscitation while they awaited the ambulance.

2.3. Ambulance Officer Stephen Tasker states that he and his partner Andrew Shouksmith were tasked to the prison at 11:42pm, and they arrived at 11:51pm. Upon arrival, the ambulance officers took over cardio-pulmonary resuscitation, and after administering adrenalin, obtained some electrical activity from the heart. They attempted to maintain this by mechanical ventilation, and further adrenalin, but were unable to sustain life (exhibit C5a, p1-2).

2.4. Ms Lindsay arrived at the Modbury Hospital at 12:29am on 23 May 2001 where she was seen by Dr Kuliwaba. By that time, Ms Lindsay had no cardiac output, and despite further aggressive attempts at resuscitation, she could not be revived. Dr Kuliwaba pronounced her life extinct at 12:45am on 23 May 2001.

3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, at the Forensic Science Centre, on 24 May 2001. Dr Gilbert diagnosed that the cause of death was 'neck compression due to hanging'. He commented:

> '1. Death was due to neck compression due to hanging.
> 2. Analysis of a specimen of blood obtained at autopsy reportedly showed a blood alcohol concentration of nil. The blood contained subtherapeutic levels of diazepam and its metabolite nordiazepam. No other common drugs were identified.
> 3. There were no injuries or other markings on the body to indicate the involvement of another person in the death.
> 4. No natural disease that could have caused or contributed to the death was identified at autopsy.'
>
> (Exhibit C3a, p5)

3.2. A toxicological analysis of Ms Lindsay's blood disclosed that it contained a sub-therapeutic concentration of diazepam and nordiazepam. None of the other common drugs were detected in the blood (Exhibit C4a).

3.3. I accept the evidence of Dr Gilbert and find that the cause of Ms Lindsay's death was neck compression due to hanging.

4. Background

4.1. Family history

Ms Denise Varcoe is Ms Lindsay's elder sister. She provided a detailed statement to Senior Constable Rethus which very helpfully sets out the details of Ms Lindsay's earlier life (see Exhibit C1b).

4.2. Ms Lindsay's parents had a total of nine children, and their mother had three children by another marriage as well. The family grew up in Point McLeay until 1969 when

they moved to Murray Bridge. They lived there until 1972 when the family moved to Adelaide.

4.3. Ms Varcoe states that her sister was attending school and was a good student, but began to have behavioural problems when she was about 14 years old. She states:

> 'Margaret's behaviour was also changing and she was distancing herself from the family, was not spending a lot of time with us. She started smoking cigarettes and drinking alcohol. She did this away from the family as this behaviour wasn't allowed at home.'
>
> (Exhibit C1b, p3)

4.4. Ms Lindsay became pregnant when she was 15 years of age and the baby was born in December 1979. Her relationship with the father of the child broke down after the baby was born and Ms Lindsay did not cope well after the birth. Ms Varcoe commented that she began to take drugs, mainly marijuana, on a social basis after that. The baby was left with her grandmother after Ms Lindsay left home.

4.5. Ms Lindsay lived in Port Augusta for a while and then in Adelaide, and then moved to Point McLeay where she had another baby in 1981. That relationship also broke down, and the baby also went to the grandmother who provided care.

4.6. Ms Varcoe commented that Ms Lindsay's drinking and drug problems gradually became worse, and her behaviour deteriorated. She commented:

> 'At this time I noticed that Margaret had changed. She was still drinking and smoking cigarettes and marijuana heavily. Her personality was changing. She appeared to be very angry and hated men. She wasn't a very emotional person and kept her feelings to herself. Margaret did however talk to me and she told me her problems and I listened to her. I was trying to get her back on track as she didn't appear to be coping real well. I felt she wasn't improving at all and seemed to be getting worse.'
>
> (Exhibit C1b, p4)

4.7. Ms Lindsay had another child in Port Augusta in 1985 and again this child was brought up by the grandmother.

4.8. After Mrs Lindsay died in 1987, her daughter Frances took over the care of Ms Lindsay's children.

4.9. Ms Varcoe commented that after the death of her mother, Ms Lindsay's behaviour continued to deteriorate and she was more and more dependent on alcohol and drugs.

She also began committing petty crime to buy drugs and was showing signs of psychiatric illness as well.

4.10. Ms Lindsay adopted an itinerant lifestyle, moving between living on the streets and in detoxification facilities. She rejected attempts from her family to help her and was a regular patient at the Royal Adelaide Hospital, the Modbury Hospital and The Queen Elizabeth Hospital, for drug overdoses and self-harming episodes. Ms Varcoe said:

> 'Margaret had attempted to harm herself on numerous occasions by overdosing of drugs, mixing prescribed drugs with medicines, and slashing her wrists. Margaret suffered from hallucinations when she combined the prescription drugs with drugs and/or alcohol, and she would see things that weren't real. Margaret suffered depression and attempted suicide on a number of occasions. She has been a detained patient at Glenside Hospital on about six occasions. She is well known to local hospitals, especially the Royal Adelaide Hospital and the mental health teams. She was on medication for her depression which she would combine with other drugs and alcohol, and she would take these in very big doses.
>
> From 1992 to 1998 Margaret remained on the streets and in detox. The family did not hear from Margaret over this period. If I hadn't heard from Margaret within a month I would have to track her down on the streets or I would go and bail her out of the police cells, or go and visit her in hospital. Margaret was really wearing me out as I was constantly going to her aid, sometimes a couple of times a week.'
>
> (Exhibit C1b, p6)

4.11. Ms Lindsay met a man in 1998 and formed a relationship with him at Murray Bridge. Ms Varcoe commented that she 'became a new person'. The abuse of drugs and alcohol reduced, and they began living together at Hackham. They had a baby daughter in 1999 and the relationship continued for a couple of years although the problems with drugs and alcohol remained. The baby lived with her parents until January 2000 when she nearly drowned at Noarlunga Beach and the Crisis Care section of the Department of Family and Youth Services became involved and the child was placed in foster care.

4.12. This caused Ms Lindsay great distress, particularly during a period of imprisonment between January and March 2001 when questions of custody of the child were being disputed. She said:

> 'This incident caused undue hardship for Margaret as it opened old wounds and Margaret was suffering. She became depressed again and wanted to end her life. She was really crying out for help but she was not getting any assistance from the Women's Prison. I

> knew that she was not receiving any medication for her depression. She also wanted to see a psychiatrist but they did not arrange this for her.'
>
> (Exhibit C1b, p9)

4.13. Ms Lindsay was released from prison in March 2001 and was placed on home detention and lived within the house at Hackham with her daughter and partner. Unfortunately, their relationship deteriorated, and drug and alcohol abuse continued. Eventually, Ms Varcoe took the daughter into her care, and she was then placed with another step-sister.

4.14. A culmination of all these events was Ms Lindsay's arrest in May 2001 and the events I have already described.

4.15. <u>Previous presentations</u>

The earliest record of Ms Lindsay's contact with the Prison Health Services (PHS) is in June 1988. Even at that time there were indications of drug-seeking behaviour in that she was requesting pethidine for cheekbone pain.

4.16. The first time she appears to have been seen by a psychiatrist in prison was on 29 June 1993 when she was seen by Dr Craig Raeside. His entry in the clinical record indicates that there was no evidence of psychomotor retardation or thought disorder and there were no delusions. He described her as 'cognitively intact'.

4.17. On 29 August 1995 a note records that Ms Lindsay was:

> 'Hearing voices for past 1/52 telling Margaret to hurt one of the inmates. Very stressed/depressed. Not sleeping. Concerned about hurting herself. Would hang herself.'

Ms Lindsay indicated that she would like to go to James Nash House, but when the staff contacted Dr Raeside there he indicated that there were no beds.

4.18. A note for 30 August 1995 indicates that Ms Lindsay was given Chloralhydrate 'with good effect'.

4.19. On 2 September 1995 it was noted that Ms Lindsay was hearing voices, that she felt very depressed and wanted to harm herself. She suggested hanging. It was noted that a medical officer was consulted and he declined to provide her with any further medication because he believed that she may have been drug-seeking.

4.20. On 7 September there is a note by a psychiatrist that Ms Lindsay was hearing voices which were telling her to 'kill yourself Margaret'. Ms Lindsay was admitted to James Nash House as a result of this incident, and she was discharged on 30 September 1995.

4.21. In November 1995 there are several entries relating to her 'hanging out for smack'. On 21 November 1995 Ms Lindsay presented feeling very stressed and angry and unable to sleep since being told of the recent death of her brother from heart disease.

4.22. On 9 January 1996 Ms Lindsay was found by a correctional officer with a strip of sheet under her chin attached to a barrier behind her. Both her feet were on the ground and there was no loss of consciousness. She was placed in the observation ward on canvas blankets. This was described as a 'psuedo attempt at hanging'. On 11 January 1996 the psychiatrist, Dr Wright, had the impression that Ms Lindsay was suffering from a recurrence of a depressive illness.

4.23. Ms Lindsay was transferred to James Nash House until 18 January 1996.

4.24. On 8 February 1996 Ms Lindsay complained of suffering 'pseudo hallucinations' of screaming and voices telling her to harm herself.

4.25. On 15 February 1996 it was noted that Ms Lindsay's 30 year old sister had died and she was suffering deep distress as a result. On 22 February 1996 she again was complaining of voices telling her to harm herself. That was the day of her sister's funeral. She was transferred to Port Augusta Prison shortly after this.

4.26. On 11 March 1996 Ms Lindsay was seen by Dr Ken O'Brien, Consultant Psychiatrist. She was still hearing 'voices' telling her to kill herself but Dr O'Brien noted that she is 'usually able to distract herself'. Dr O'Brien noted that the 'yellow suicide risk form to be continued for several more days and then assessed by MO', and that 'potential self-harm form to remain in place'.

4.27. On 11 April 1996 Ms Lindsay was noted to have been complaining of voices in her head screaming at her to harm herself. On 16 April 1996 she was still complaining of hearing voices and seeing snakes in her room and indicating that she may harm herself or someone else.

4.28. On 21 April 1996 Ms Lindsay slashed her right wrist with a razor. She said that she was hearing voices telling her to harm herself.

4.29. On 10 August 1996 Ms Lindsay again complained of voices telling her to cut herself, but denied that she wanted to die.

4.30. On 4 September 1996 there is a note that Ms Lindsay had been banging her head against the wall the previous night because she had been returned to the main prison. She assured staff that she was not suicidal but had simply reacted angrily to her situation. She was released from prison in early November 1996 and not readmitted until January 1999, withdrawing from 'speed'. By this time she was noted to be pregnant.

4.31. Her next admission was on 23 November 2000 where it was noted that Ms Lindsay admitted that she had been using three caps of heroin per day or methadone given to her by a friend who is on the methadone program. It was noted that her withdrawal symptoms needed to be managed.

4.32. On 26 November 2000 it was noted that Ms Lindsay was 'hearing voices' which were telling her to 'tip up' and that she would not be around for much longer. 'Tip up' is a prison expression meaning to 'cause havoc and play up' (see the evidence of RN McHale at T268).

4.33. On 4 December 2000 it is noted that Ms Lindsay had been in Room 8 'on canvas' the previous evening because of erratic behaviour. It was noted that she had been having thoughts about hanging herself around this time.

4.34. Ms Lindsay saw Dr Maria Tomasic, Psychiatrist, on 19 December 2000. Her assessment was that she was suffering 'chronic dysthyma' (depressed mood) secondary to multiple long-term stressors, the major issue at that time being withdrawal from illicit drugs.

4.35. On 23 December 2000 Ms Lindsay was noted to be hearing voices and a plan was developed that if Ms Lindsay had self-harm ideation she was to be put in Room 8 'for her own safety'.

4.36. On 27 December 2000 she was noted to be hearing voices and that her head was 'ready to explode'. She indicated that she felt as though she might cut herself or attempt to hang herself. It was arranged that she be seen at the Yatala Labour Prison by a doctor.

4.37. On 16 January 2001 Ms Lindsay was seen by Dr Tomasic who noted that she was having hallucinations and was asking to go on the methadone program.

4.38. On 26 January 2001 Ms Lindsay was transferred to the Yatala Labour Prison infirmary due to 'paranoid behaviour and auditory hallucinations'. The nursing note reads 'nil suicidal or homicidal ideation detected'.

4.39. By late January 2001, the medical staff were beginning to suspect that Ms Lindsay was suffering from schizophrenia. There is a note to that effect on 28 January 2001, and a medical review by Dr Geddes on 30 January states:

> 'H-Chronic dysthyma on previous admissions. Possibly chronic schizophrenia. NOT acutely psychotic. Definitely drug seeking.'

Dr Geddes prescribed sodium valproate and sertraline to be added to her medication regime. A review the next day indicated that her condition had improved.

Sertraline is an antidepressant and is also used to treat obsessive-compulsive disorders and panic attacks. Sodium Valproate is known as Epilim. It is an anticonvulsant medication often used in people with epilepsy. It is also used to stabilise mood in people with bipolar disorder.

4.40. The last entries in the PHS medical record prior to Ms Lindsay's last admission where on 9 and 14 February 2001 when her condition was described as 'stable'.

5. Events leading to final period of custody

5.1. As I have already mentioned, Ms Lindsay was arrested in Victoria Square, Adelaide at about 4pm on Friday, 18 May 2001. She was conveyed to the City Watch House and was placed in a holding cell until she was formally charged. While in this holding cell, she appeared to suffer a 'fit'. An ambulance was called and Ms Lindsay was conveyed to the Royal Adelaide Hospital.

5.2. Ms Lindsay was conveyed back to the City Watch House. Accompanying her was a note from a Dr (name indecipherable) which states:

> 'To Whom It May Concern
> I saw Margaret in the ED she may have had a seizure whilst in custody.
> She was intoxicated with alcohol and had no seizures with us.
> She is fit to be in police custody.'
> (Exhibit C23l)

5.3. Because the warrant of apprehension issued for Ms Lindsay was endorsed 'bail excluded', Ms Lindsay was not eligible for bail to be granted by a police bail authority. Accordingly, she remained in police custody until she could appear before a court.

5.4. Constable Amanda Ambagsheer interviewed Ms Lindsay for the purpose of completing the 'Sergeant's Questionnaire' on the Prisoner Screening form. There was also an arresting member's questionnaire filled out by Constable Emery, who initially arrested Ms Lindsay. The following points are noted on the questionnaire:

- She 'may be a person at risk';
- She had a 'confirmed communicable disease';
- She had a 'psychological/psychiatric disorder';
- She was 'slightly' under the influence of alcohol or drugs;
- She stated that she was suicidal;
- She suffered from epilepsy and schizophrenia;
- She had recently received treatment at Glenside Hospital.

(Exhibit C23e)

5.5. Other documentation created at the City Watch House included the Prisoner Custody Disposition (Exhibit C23h) which contains the following notations:

- **May be suicidal, psych disorder, disease suspected, epilepsy, schizophrenia;
- Had a fit before charged and taken to Royal Adelaide Hospital, letter states she is fit for custody;
- Is suicidal;
- **WATCH CLOSELY**;
- AVS and sister to attend over weekend for visits;
- Was released from Glenside 16/5/01;
- Locum attended;
- Script to be filled.

5.6. Ms Lindsay was visited by Ms Beverley Sires of the Aboriginal Visitors Scheme and by her sister Ms Hazel Graham, her cousin Ms Margaret Long and her niece Ms Melissa Graham. Ms Sires filled out a report form which includes the following notation:

> 'She has just got out of Glenside on Wednesday. Said that she can hear voices. She said that she feels like doing harm to herself because of it all. They are going to bring her down so she is near people and talk to them. Will come back if I am needed.'
> (Exhibit C23k)

5.7. At about 10:15pm Ms Sires and the family members left and Dr Asimokopoulos, a locum doctor who had been contacted by a South Australia Police (SAPOL) officer, attended. He prescribed Chlorpromazine and Epilim for Ms Lindsay. There is a note in the Prisoner Custody Disposition (Exhibit C23h) which states:

> 'Don't give any medications other than those collected on 18/05/01 (to avoid double prescribing in the event family find her existing medications).'

5.8. The remainder of the evening passed uneventfully. During the morning of 19 May 2001 Ms Lindsay spoke with Sergeant Filippo DeSanctis, the Watch House Sergeant on Duty, and told him she was feeling despondent, hearing voices, and wanted to go back to Glenside. Sergeant DeSanctis very properly arranged for the attendance of the Police Medical Officer, Dr Flock, to examine her (see Exhibit C14a).

5.9. Dr Flock arrived at about 10am on 19 May 2001. Dr Flock detained Ms Lindsay pursuant to Section 12(1) of the Mental Health Act 1993. He noted the grounds for his opinion on the detention form as follows:

> 'Auditory hallucinations for five days – voices telling her to kill herself. Visualises herself as being in a coffin. Refusing to eat … (fear poisoning) was S/B (seen by) RAH 1805 … was given Chlorpromazine and Epilim. Unfit for police custody (query release from Glenside 16/05/01).'
>
> (Part of Exhibit C23x)

5.10. Ms Lindsay was conveyed to the Royal Adelaide Hospital where she was seen, and then transferred again to the Glenside Hospital where she remained overnight.

5.11. On the morning of Sunday, 20 May 2001 Ms Lindsay was seen by Dr Les Koopowitz, Senior Consultant Psychiatrist at Glenside Hospital. Dr Koopowitz decided to revoke Ms Lindsay's detention pursuant to Section 12(4) of the Mental Health Act 1993.

5.12. Dr Koopowitz found no clinical evidence of psychosis or of an abnormally elevated or low mood, or of clinically significant anxiety and no evidence of alcohol withdrawal. He said:

> 'She appears to have good insight into her present situation, and is not acting in an impulsive or disinhibited manner.'

5.13. In his letter to Dr Flock, Dr Koopowitz said:

> 'As I have documented in my assessment, I can find no evidence of an acute mental illness and, as such, she is not detainable under the terms of the Mental Health Act.
>
> I do feel she is at significant risk of acting out in an attempt to be released from police custody. However, my opinion is that this is reasoned and intentional behaviour that is not driven by an acute mental illness. She will thus need close observation, but this is more appropriately indicated in the legal, as opposed to medical setting.
>
> I note that my opinion is in agreement with many recent psychiatric assessments.'

5.14. Following Dr Koopowitz's decision, Ms Lindsay was returned to the City Watch House, arriving at 12:13pm on 20 May 2001.

5.15. Upon arrival, Sergeant DeSanctis took extensive measures to ensure that Dr Koopowitz's warning should be conveyed to the relevant authorities. He photocopied Dr Koopowitz's letter and accompanying note and placed the documents in the charge book, and he also put copies of those documents, together with the warrant and the Prisoner Stress Screening form so that they would accompany Ms Lindsay to the Port Adelaide Court and be conveyed on to the prison, should that be the outcome of the court appearance (see Exhibit C14a).

5.16. Sergeant DeSanctis put Ms Lindsay in the observation cell for the balance of her stay at the City Watch House.

5.17. At about 5:25pm on 20 May 2001, Ms Lindsay spoke to Sergeant Zimmerman and other staff at the City Watch House telling them that she was feeling suicidal, as a result of which she was placed in a padded cell for about 20 minutes. She subsequently told them that she was feeling better and so she was returned to the observation cell (see Exhibit C12a).

5.18. Monday 21 May 2001 was a public holiday. Ms Lindsay passed the day uneventfully in the City Watch House, apart from receiving a telephone call from her sister.

5.19. On Tuesday 22 May 2001 Ms Lindsay was transferred to the Adelaide Magistrates Court and was remanded in custody to appear in the Port Adelaide Magistrates Court on Wednesday 23 May 2001. As result of that order, Ms Lindsay was transferred to the AWP, arriving in the early evening of Tuesday 22 May 2001.

6. Arrival and assessment at Adelaide Women's Prison

6.1. Accompanying Ms Lindsay to the AWP from the Port Adelaide Magistrates Court were a number of documents attached to the Prisoner Movement Order. These documents were as follows:

- Warrant of Remand from the Adelaide Magistrates Court;
- Warrant of Apprehension from the Port Adelaide Magistrates Court;
- Letter from the Royal Adelaide Hospital dated 18 May 2001;
- Police Prisoner/Psychiatric Hospital Information Form;
- Form filled out by Dr Koopowitz revoking detention;
- Letter from Dr Koopowitz to Dr Flock dated 20 May 2001 together with two further pages of handwritten notes;
- Police Prisoner Screening form dated 18 May 2001.

(Exhibit C23e)

6.2. In combination, these documents should have left the staff at AWP in no doubt that Ms Lindsay had been suicidal on several occasions since 18 May 2001, that she required close observation, and that the police custodial authorities had gone to considerable lengths to ensure that this information was passed on to the Department for Correctional Services (DCS) staff.

6.3. Unfortunately, despite the best efforts of the SAPOL officers, this transfer of information did not occur.

6.4. Ms Lindsay was first seen by CSO Michael Gough, a very experienced Correctional Officer who was fulfilling the role of Security Supervisor that evening.

6.5. CSO Gough told me he entered the information from the warrants onto the DCS computer system (the Justice Information System or 'JIS'). He did not read the documents which accompanied the warrants (T32). He contradicted this when he spoke to the DCS investigation officers (see Exhibit C30, p11), but now insists that he did not see the documents.

6.6. CSO Gough told me that if he had read the documents, he would have referred them to the nurse on duty and discussed the appropriate accommodation for Ms Lindsay

with her (T35). He was unable to explain why he did not read the documents on this occasion (T67).

6.7. CSO Gough said that CSO Maria McRae, who then dealt with Ms Lindsay, was an experienced admissions officer who was familiar with the process (T41).

6.8. CSO Gough could not recall how the documentation was passed to CSO McRae, although it was intended that she should have access to all documentation when conducting the assessment interviews with Ms Lindsay (T50). He said that if anything 'relevant' arose from those interviews, he should have been informed (T51).

6.9. CSO Gough acknowledged that decisions in relation to accommodation were his responsibility, but it did happen that experienced officers would allocate the prisoner's accommodation and he would authorise it after the event (T55). This is what happened in Ms Lindsay's case. He did not inquire why Ms Lindsay was being placed on D Wing, which was used for prisoners with special needs, or persons 'at risk' (T57-59).

6.10. CSO Gough said that he began filling out a 'Movement Order' for the next day so that Ms Lindsay could go to court. The form asks whether the prisoner has a history of suicidal tendencies or self-harm, to which CSO Gough answered 'No'. He said he did so because nobody told him otherwise. He said he assumed that if Ms Lindsay did have such a history, his colleagues would have informed him of this. In that regard, he said:

> 'Q: You're saying that your staff let you down?
> A: On this occasion, in my opinion, yes.' (T99)

6.11. After CSO Gough attended to the formal identification process by checking the warrants, Ms Lindsay was strip-searched and showered, and then CSO McRae conducted an admission or intake interview, during which a number of documents were filled out. These included the Reception Checklist (Exhibit C25a), the Specific Needs Assessment (Exhibit C25b) and the Prison Stress Screening form (PSSF) (Exhibit C25p). CSO McRae said that Ms Lindsay seemed 'pleased to be in gaol', that she 'didn't like being in the police cells for about four days', and that she was 'laughing and talking quite reasonably'.

6.12. These observations are in stark contrast to the answers Ms Lindsay gave while the PSSF was being filled out. These answers include the following:

'Interview

Q5	In the last six months have there been any deaths or other major losses in your family or among your close friends?	Yes
	If yes, how strongly does the loss of that person affect your life now?	Still a major loss
Q6	Do you have major debts that are beyond your control?	Yes
Q7	Are you concerned about losing someone important to you, either through the break-up of a relationship or friendship, or through illness?	Yes
Q11	Have you been assessed or treated in a psychiatric hospital or James Nash House?	Yes
Q12	Have you been diagnosed as having a psychiatric disorder?	Yes
Q13	Has anyone in your family been diagnosed as having a psychiatric disorder? *(If yes, specify who, what disorder)* *Unknown*	Yes
Q14	Have you used drugs regularly to relax or block out problems in the last month?	Yes
Q15	Have you been drinking heavily in the last week?	Yes
Q16	Have you ever overdosed, either accidentally or intentionally?	Yes
Q18	Have you ever tried to commit suicide or intentionally hurt yourself?	Yes
Q19	Note: Check the prisoner's wrists, arms and neck for scars if present, do they appear to have been caused by suicide or self harm attempts?	Yes
	If present, note location and description (seriousness, number, age, etc) - *Marks on the wrist*	
Q20	** Have you thought about committing suicide since you were arrested or imprisoned?	Yes
Q23	Do you have things to look forward to or does the future seem hopeless?	Seems Hopeless
Q24	When answering the last four questions, did the prisoner appear evasive or distressed?	Yes
Q26	Sometimes people find thinking about these things disturbing. Would you like to talk more with someone?	Yes

Review of Observations

Q27	Did the prisoner appear to show marked signs of depression?	

	(eg. were they tearful or emotionally flat?)	Yes
Q28	Did the questioning appear to have a markedly negative emotional effect?	Yes
Q29	Did the prisoner appear overly anxious, afraid, angry, agitated or confused?	Yes'

(Exhibit C23p)

6.13. As a result of these answers, CSO McRae totalled Ms Lindsay's score at 20 points. At the bottom of the form, above CSO McRae's signature are the words:

> 'Consider as at risk if:
> 1 Score is greater than 8; or
> 2 Any of the asterisked (**) / shaded items are positive (Yes or Maybe); or
> 3 Regardless of the score, the interviewing officer feels a further opinion is warranted.'

6.14. On any objective view of this interview, Ms Lindsay should have been considered as 'at risk' since all three of those criteria were met. Her score grossly exceeded 8, one of the asterisked questions was answered in a positive sense, and the interviewer noticed that she was showing signs of depression, negative emotional affect, anxiety, etc. CSO McRae agreed that Ms Lindsay's score indicated that she was at 'high risk' (T129). She did not recall whether she told CSO Gough about that (T133).

6.15. CSO McRae did not look at the paperwork which came from the police with the warrant. She said:

> 'If there was anything to be told, Mike would have told me and no, I didn't even think about looking at any paperwork.' (T153)

She was well aware of Ms Lindsay's high score, which indicated that she was at 'high risk'. The documents concerned would have confirmed that assessment if they had been read. Instead, CSO McRae mindlessly put them in the dossier without reading them (T155).

6.16. CSO McRae insisted that she did not see the documents, even though she filled out one section of the Reception Checklist (Exhibit C25a) entitled 'Observations/Comments from Authority Delivering Prisoner' with the information:

> 'Potentially suicidal.
> Stressed.'
> (Exhibit C25a)

These answers strongly suggest that CSO McRae did see the accompanying documents, although she maintained her denial and said that these answers were given from her own knowledge and experience (T170). Frankly, I have severe reservations about the truthfulness of that evidence.

6.17. I found CSO McRae's explanations for how she filled out the PSSF confusing and contradictory. She appeared not to be able to comprehend the inconsistencies in the evidence she was giving when these were put to her (T171-175, T184-186).

6.18. CSO McRae said that if the accompanying documents had been brought to her attention, 'there would have been no hesitation on her going into Room 8' (T183).

6.19. There followed a rather convoluted sequence of events involving where Ms Lindsay should be accommodated. There were several phone calls between CSO McRae and CSO Thompson about whether or not Ms Lindsay should be in Room 8, which is the observation cell, but it was eventually decided after some conversation that she would be placed in Room 2. CSO McRae said that she changed her mind about whether Ms Lindsay should be in Room 8 on the basis of her 'quite rational' demeanour after the interview (T130), that she was 'happy' and 'glad to be in gaol' (T153).

6.20. CSO McRae took Ms Lindsay to the infirmary where she was interviewed by RN Elizabeth McHale whose job it was to see all new admissions. CSO McRae said that she could not recall saying anything to RN McHale about Ms Lindsay's condition (T133), or whether she advised her of the score arising out of the PSSF procedure, even though she agreed that a score of 20 was 'alarming' (T190).

6.21. CSO Susan Thompson was the 'Movements Officer' on duty that evening. It was her function to decide where Ms Lindsay would be accommodated. CSO Thompson said that CSO McRae told her that a Mr Alan Slack, the Case Management Coordinator, had indicated that Ms Lindsay should be accommodated in Room 8. CSO Thompson then set about collecting canvas bedding and clothing for Ms Lindsay in anticipation of her arrival.

6.22. CSO Thompson said that later, CSO McRae rang and told her that she had spoken to Ms Lindsay and that she had promised that she would not do anything silly. Interestingly, CSO Thompson said that CSO McRae told her that Ms Lindsay had

scored '19 or 20' on the PSSF, which she described as 'extremely high' (T392). CSO McRae had no memory of any such conversation (T133).

6.23. CSO Thompson instructed CSO McRae to take Ms Lindsay to the Health Centre for assessment before any decisions could be made about her accommodation.

6.24. RN McHale is a Registered Nurse and a Registered Psychiatric Nurse. She has a particular interest in the Aboriginal culture and its interface with Western medicine. She knew Ms Lindsay and believed that she had good rapport with her (T197).

6.25. RN McHale was on duty that evening when Ms Lindsay was brought to the health centre by CSO McRae. She was given no information, either written or otherwise, about Ms Lindsay and had no information about her recent circumstances. She had no warning she was coming and only had the opportunity for a 'quick glance' at the details of her last admission in the clinical record (T203). In particular, she saw none of the information supplied to DCS by the police.

6.26. RN McHale made the following note in the clinical record:

> 'Readmitted 1/7 r/- for court tomorrow. No new medical problems voiced. Claims to have been in BWS (Brentwood South) 2/52 ago. Denies any suicidal ideation but says she is "hearing voice", and seems to be responding to same. Says she has had Respiridone (sic) in the past, doesn't know dose or when last taken. Refused ROI (release of information - from Glenside). Given phone call to sister to arrange for stolen bankcard to be diverted to her address. Obs 120/80, P 80. For R/V by MO if she returns from court. Have requested she be placed in D Wing for observation over night. Given Chlorpromazine 50mg stat (first dose).'
>
> (Exhibit C23y)

6.27. RN McHale said that she requested observation of Ms Lindsay because she was having auditory hallucinations. She considered that placement of Ms Lindsay in D Wing, and being observed half hourly was sufficient to ensure her safety (T211). She described the conditions in Room 8 as 'barbaric', and said that Ms Lindsay's condition did not warrant it, and would have upset her unduly. She said that if Ms Lindsay required closer observation than that, she would have directed that she be accommodated in the infirmary at Yatala Labour Prison (T212-213).

6.28. After the examination, RN McHale accompanied Ms Lindsay back to the admissions area and spoke to CSO McRae. She told CSO McRae that she thought Ms Lindsay should be accommodated in D Wing and suggested Room 1 as it was quieter and

easier for observation. There is a dispute between her and CSO McRae about this, as CSO McRae said that RN McHale agreed that Ms Lindsay should be in Room 2. RN McHale said she had no memory of this and did not believe that she would have agreed with it (T217).

6.29. One extraordinary aspect of RN McHale's dealings with Ms Lindsay is that on the 'Admission Clinical Record' filled out by RN McHale there is a section which asks the question:

> 'DCS Stress Screening Form sighted? ☐ Yes ☐ No'

RN McHale did not fill out that section of the form. She told me that she had been given an instruction that box was 'nothing to do with you' (T219). I find this extraordinary. There is a long history of difficulties between Correctional Services staff and PHS staff about exchange of information, and this issue has been mentioned in many inquests over the years. That particular box was inserted in the Admission Clinical Record to ensure the nurses were aware of the existence of such a form, and to ensure that they sighted it as part of their assessment, following a recommendation made in an inquest in 1999 (see Muller, inquest number 26/99).

6.30. RN McHale told me that PHS staff are now given a photocopy of the PSSF (T220). She said that had she received the information in Exhibit C23e (the information supplied by SAPOL), she would have sent Ms Lindsay to the Yatala Labour Prison infirmary for 24 hour observations (T220). In the absence of a medical or psychiatric condition, the CSOs retain the ultimate say in relation to prisoner placement (T223).

6.31. RN McHale said that she saw Ms Lindsay again about half an hour later when she was performing the nightly medication round, at around 9[m. She said that Ms Lindsay was 'quite bright', sitting in the unit having a cup of coffee (T226).

6.32. Having been later shown the information provided by the police, which she did not see that night, RN McHale said:

> 'Yes, I think having read both the doctor's letter and the progress note by the doctor, I would definitely have sent her to Yatala infirmary even though she was only an overnight.' (T230)

6.33. RN McHale also told me that she received information from other Aboriginal prisoners that Ms Lindsay had been given benzodiazepines by another prisoner after

she had been locked in Room 2. RN McHale told me that such medication can have a paradoxical effect and cause rage, disinhibited behaviour, depression and/or intoxication (T225).

6.34. If this is true, it may offer some explanation for Ms Lindsay's behaviour in the cell, and for the presence of diazepam and nordiazepam noted at post-mortem.

6.35. Events following the medical assessment

CSO Thompson said that she received a telephone call from CSO McRae who told her that Ms Lindsay had been to the Health Centre and that the nurse had indicated that she should be accommodated in Room 1, and that she did not need to go to Room 8. CSO Thompson said that she asked CSO McRae what the difference was between Rooms 1 and 2 because she thought that Room 1 was too isolated and knew Ms Lindsay liked contact with other prisoners. She said that CSO McRae told her that she thought Room 2 was a 'good idea' (T396).

6.36. Some time later, Ms Lindsay arrived in company with RN McHale and CSO Thompson took her to Room 2. She said that RN McHale accompanied her to Room 2 and did not indicate that she would have preferred Room 1 for Ms Lindsay (T397). RN McHale had no memory of accompanying CSO Thompson or Ms Lindsay to Room 2 (T251).

6.37. CSO Thompson said that her impression of Ms Lindsay was:

> 'Excellent. Probably the best I had seen her for quite a few years.' (T399)

6.38. CSO Thompson said that Ms Lindsay looked tired at one stage during the evening and told her that she was going to bed. This was at about 11pm. She said that Ms Lindsay had already made her bed by then (T42).

6.39. CSO Thompson was the last person to have any contact with Ms Lindsay as far as the evidence discloses.

6.40. Leanne Feist (nee Godwin) was a prisoner in cell 3 in D Wing that evening. She said that she heard Ms Lindsay talking to other prisoners in the unit, and they were telling her that they would make it a good day for her on her birthday the next Sunday (Exhibit C23u, p5). She said that Ms Lindsay was also singing and saying things like

'I'm sorry, I'm sorry I'm in here, I'll get up again' and 'please forgive me' and 'I love you'. Ms Feist said:

> 'She did sound a bit drunk, she was down and upset, she kept saying she was sorry that she was there and she stuffed up again.' (T308)

6.41. CSO Catherine Murchie said that she saw Ms Lindsay during the medical round later that evening, at around 9:30pm, and her impression was that Ms Lindsay was that she was coming down off a drug. She described her appearance as 'slightly inebriated'. She was sitting on the toilet singing (T337-338).

7. Issues arising at inquest

7.1. I have received a report from the Department for Aboriginal Affairs and Reconciliation (DAARE) which has analysed the information outlined above. This report was prepared pursuant to a protocol developed by DAARE and myself which outlines the process by which this is achieved. DAARE carries a responsibility to monitor law and justice issues across the South Australian Government as they apply to Aboriginal people, particularly with reference to the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). I have been greatly assisted by the very detailed, thoughtful and careful analysis of these issues in the report.

7.2. Emergency response

The DAARE report points out that there is no 24 hour medical service available at AWP, no doubt due to the small size of the institution. The report also criticised some aspects of the record-keeping and other procedures undertaken by DCS staff after Ms Lindsay's body was located.

7.3. Overall, however, it is abundantly clear that Ms Lindsay had been dead for some time before being discovered by staff, and that no amount of emergency action was likely to have saved her. In those circumstances, since these factors cannot be said to have been causatively relevant to Ms Lindsay's death, I am prevented from making recommendations on these issues (see Coroner's Act, Section 25(2)). However, I commend the comments in the DAARE report to DCS management for attention.

7.4. Psychiatric treatment

The DAARE report was also critical of the standard of psychiatric care given to Ms Lindsay at Glenside Hospital, and the fact that her detention pursuant to Section 12 of the Mental Health Act 1993 was not continued by Dr Koopowitz, particularly in light of the fact that Dr Flock and two locums had thought that she was detainable.

7.5. The inquest did not examine the merits of these criticisms, however, because by the time Ms Lindsay was admitted to AWP, which was a much more effective form of detention than what would have been available at Glenside, she was in the care of DCS and the PHS. Both agencies had ample notice of Ms Lindsay's illness, and psychiatric treatment was available to her if required. It was the breakdown in these systems which was causally relevant to Ms Lindsay's death rather than the events at Glenside some three days earlier.

7.6. Intake and risk assessment

It is this area where the most serious and obvious errors in the management of Ms Lindsay's imprisonment took place. Research quoted in the DAARE report discloses that hanging was the leading cause of female deaths in custody between 1980 and 2000 (32%), and that a large proportion of those prisoners were remand, rather than sentenced prisoners.

7.7. Recommendations of the RCIADIC on these issues include the following:

> '**Recommendation 125:**
> That in all jurisdictions a screening form be introduced as a routine element in the reception of persons into police custody. The effectiveness of such forms and of procedures adopted with respect to the completion of such should be evaluated in the light of the experience of the use of such forms in other jurisdictions.
>
> **Recommendation 126:**
> That in every case of a person being taken into custody, and immediately before that person is placed in a cell, a screening form should be completed and a risk assessment made by a police officer or such other person, not being a police officer, who is trained and designated as the person responsible for the completion of such forms and the assessment of prisoners. The assessment of a detainee and other procedures relating to the completion of the screening form should be completed with care and thoroughness.
>
> **Recommendation 130:**
> That:
> a. Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;

b. In developing such protocols, Police Services, Corrective Services and health authorities with Aboriginal Legal Services and Aboriginal Hearth Services should establish procedures for the transfer of such information and establish necessary safe-guards to protect the rights of privacy and confidentiality of individual prisoners to the extent compatible with adequate care;

Recommendation 152:
That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:

i) persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;
ii) intoxicated or drug affected persons, or persons with drug or alcohol related;
iii) persons who have made any attempt to harm themselves or who exhibit … potentially self-injurious behaviour'

(DAARE Report on the Death of Ms Margaret Lindsay, pp 24-26)

7.8. These issues have also been the subject of previous coronial recommendations. For example, in Muller (inquest number 26/99), I recommended:

'That there be appropriate communication between the Department of Correctional Services and the Prison Health Service concerning prisoners at risk of self-harm, and that the Prison Health staff be required to release all relevant information relating to a prisoner at risk.'

7.9. Clearly, these recommendations were not followed in this case.

7.10. When Ms Lindsay arrived at AWP, there were seven documents accompanying her, five of which gave detailed information about her recent medical/psychiatric history. Instead of being received and considered by the CSO whose responsibility it was to consider her assessment and placement, CSO Gough, the following occurred:

- CSO Gough did not read the material – he passed it to CSO McRae;
- CSO McRae did not read the material either – she assumed CSO Gough had done go, and because she was ‘too busy’;
- CSO McRae apparently took no notice of the very high score achieved on the PSSF which, on three different criteria, indicated that Ms Lindsay was ‘at risk’;

- CSO Gough took no further part in the decision-making process whereby Ms Lindsay was placed in Room 2;
- CSO McRae passed on none of the information, either from the police or from the PSSF to RN McHale to assist her with her assessment;
- RN McHale paid no attention to the box on the Admission Clinical Record form which asked if the PSSF had been sighted, because she had been told by some unidentified person that it was 'not applicable';
- RN McHale recommended that Ms Lindsay be put in Room 1 but would have transferred her to Yatala Labour Prison infirmary if she had known about the police information;
- None of the CSOs could explain precisely why Ms Lindsay was placed in Room 2 rather than Room 1, suggested by RN McHale, or Room 8, suggested by Mr Alan Slack, the Case Management Coordinator.

7.11. It is very disappointing to note that after the RCIADIC and all the inquests that have occurred in the years since then when these issues have been dealt with, such stupid errors were still occurring in 2001. Despite the best efforts of the police to provide the information, and of the DCS management to implement strategies such as the PSSF, Correctional Services Officers continue to treat admission procedures as mere routine, rather than carefully undertaking an intelligent and careful risk assessment process. Mr Schapel, counsel for part of the Lindsay family, described the DCS officers' efforts in this case, particularly those of CSO Gough and CSO McRae as 'gross incompetence' and it is hard to disagree.

7.12. This criticism was accepted by the DCS Review into the Death of Margaret Lindsay (Exhibit C30). The review team concluded:

> 'The review team is of the opinion that there was information available from various sources concerning Ms Lindsay's mental state, which collectively, should have raised concerns as to the potential for her to harm herself. Had this information been exchanged and collated, the review team is of the opinion that a different conclusion may have been reached as to her placement and observation. As this does not occur, the review team is also of the opinion that this was a major contributing factor in her death.'
>
> (Exhibit C30, p17)

7.13. Mr Steven Johnson, one of the authors of the DCS report, told me that the completion of the PSSF was considered part of case management, a system which was first

piloted at AWP for the whole of DCS in 1997. Staff received training in this new system at the time. The system is established by DCS in the form of Standard Operating Procedure (SOP) No. 1.

7.14. Mr Johnson told me that SOP1 was in the process of being revamped, and that revamping includes procedures for intake and risk assessment. As part of that process, a psychologist has been retained, part of whose duties is to review the PSSF and redesign it to make it more effective (T461). He said that a direction that the information gathered by DCS staff will be communicated to PHS staff, and information coming back from PHS staff will then complement that information for the benefit of further management of the prisoner (T449). He referred to the recommendations made in the inquest into the death of Varcoe (inquest number 2/03) where these issues were also considered. Mr Johnson said that the PSSF would be complemented by other documentation as well, such as a Health Information Sheet and a revamped Special Needs Assessment form as well (T450).

7.15. As for the placement of the prisoner, Mr Johnson said that the new SOPs will provide for a new document where:

> 'One of the additions that has been made to the case management file is an additional form which will pull together all of the relevant information around the assessments which have been made of the prisoner, and present that information in such a way that the officer in charge now will be required to take that into consideration and then sign off on the appropriate allocation of accommodation.' (T453)

This document will be prepared by custodial staff, and must be signed off by the Officer in Charge to authorise placement of the prisoner.

7.16. The only comment I would make about the implementation of these new procedures is that they are long overdue. The issues of communication between custodial and health staff, and about intake and risk assessment procedures go back to the RCIADIC, and have been the subject of comment in many subsequent inquests. Mr Varcoe died on 20 December 2000, and Ms Lindsay died on 23 May 2001, and these new procedures are still not yet introduced. I note Mr Johnson's comments that the new SOP1 is at an 'advanced stage' of development (T459). I would urge DCS to implement it as a matter of urgency.

7.17. Cell design

This is another issue that goes back to the RCIADIC. Recommendation 165 stated:

> 'The Commission notes that prisons and police stations may contain equipment which is essential for the provision of services within the institution but which may also be capable, if misused, of causing harm or self-harm to a prisoner or detainee. The Commission notes that in one case death resulted from the inhalation of fumes from a fire extinguisher. 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.'
>
> (DAARE Report on the Death of Ms Margaret Lindsay, p26)

It has also been the subject of recommendations in a number of inquests (see Goldsmith 6/96, Bonney 28/96, Carter 23/00, Nobels 43/00, Varcoe 2/03).

7.18. In this case, Ms Lindsay had tied the piece of bedsheet through a space between a steel-framed bookshelf and the wall of the cell. The DCS review report identified that the same method had been adopted by prisoner Brian Dewson when he hanged himself at the Port Augusta Prison on 5 November 2000, six months before Ms Lindsay's death. They observed:

> 'The review team at that time identified that the 1cm gap between the shelving and the cell wall provided a potential hanging point and recommended that Pt August Prison General Manager modify the cell shelving to remove the gap between the shelving and the wall.'
>
> (Exhibit C30, p16)

They recommended:

> 'That General Managers ensure that book shelves and any other furniture attached to cell walls do not have a gap between the fixture and the wall.'
>
> (Exhibit C30, p16)

Mr Dewson's death will be the subject of an inquest in Port Augusta in January 2004.

7.19. Mr Johnson told me that:

> 'Again, at the last inquest that I was involved with a few months ago, this is a topic which was raised and what I'm able to tell the court now - which was additional to that last inquest - is that there's now a finalised document which is the safe cell work that was being undertaken by the Victorian correctional system and in which South Australia was

> involved. That work's now been finalised and it's been taken into account in terms of any new developments or any new cells which are actually being built. And examples are the E Wing development in the women's prison and the new accommodation which is proposed for Mobilong Prison. They've been designed to the safe cell standards. In addition, as recently as the start of this week, I received plans to comment on in relation to the redevelopment of D Wing at the women's prison. And again that would be in line with the safe cell standards.' (T455-456)

7.20. Again, the comment must be made that, while these developments are welcome, they are long overdue and should be pursued with urgency. As Mr Johnson pointed out, by the time of Ms Lindsay's death, it was generally recognised that AWP had 'outgrown its functionality' and was 'bulging at the seams' (T488-489). He said that this recognition had led to the success in obtaining extra funding to upgrade D Wing, where Ms Lindsay's death occurred, and that the 'safe cell' principles referred to earlier will be adopted as part of those processes.

7.21. Exchange of information

RN McHale requested Ms Lindsay to sign a Release of Information from to get her clinical record from Glenside. Ms Lindsay refused, which she said was not unusual. As a result, these records were not obtained. It is clear that they would have been useful in that they would have provided information about her recent condition, as well as copies of the correspondence from Dr Flock and Dr Koopowitz.

7.22. Mr Homburg, counsel for RN McHale, made some further inquiries and confirmed that it was not necessary to obtain Ms Lindsay's consent in order to obtain her file from Glenside, since both Glenside, and the PHS are part of the Department of Human Services, and both are administered by the Royal Adelaide Hospital.

7.23. It is clear that this issue did not have any effect of Ms Lindsay's management in AWP, since she died the same night and the records could not have been obtained soon enough to have made a difference to that outcome.

7.24. The issue should be clarified for PHS staff in future, in case a delay causes difficulties for staff in accessing valuable information.

7.25. Quality of treatment – Prison Health Services

Mr Schapel, counsel for part of Ms Lindsay's family, submitted that RN McHale had a sufficient overview of Ms Lindsay's history, as documented in the PHS clinical record, to put her on notice that Ms Lindsay was at risk and required special measures

to be taken. He cross-examined her in some detail about the previous incidents in the clinical record (T264-273).

7.26. In the absence of the extra information from the police, however, I think that this criticism is unfounded. There was nothing in Ms Lindsay's demeanour which distinguished this presentation from many previous occasions. In the absence of evidence of recent symptoms, I do not think that RN McHale could be criticised for failure to take measures beyond what she did.

7.27. The only area in which criticism is justified is RN McHale's failure to take any notice of the 'DCS Stress Screening Form sighted?' question on the Admission Clinical Record. How an experienced Registered Nurse could regard such a question as not applicable beggars belief, unless she received an instruction to that effect from a supervisor, which is not the case here. The question had only been on the form for a short period, it was a PHS form, and it was placed there following a death in a prison.

7.28. I note that a copy of the PSSF is now routinely provided to PHS staff (see the evidence of CSO Gough at T42 and RN McHale at T244). It is tragic that it took the death of Ms Lindsay to correct such a stupid mix-up. Had RN McHale seen the PSSF that night, Ms Lindsay's death might have been avoided.

7.29. <u>Unrecorded observations</u>

When Ms Lindsay was placed in Room 2 of D Wing, the regime was 30 minute 'unrecorded' observations. The practice of 'unrecorded observations' had apparently survived at AWP over time, and was unique to that establishment. It was contrary to the DCS instructions, and had been abandoned in other institutions years earlier. It was criticised in the RCIADIC, and in several inquest findings since that time.

7.30. Mr Johnson told me that the practice had been discontinued, and that AWP had fallen into line with other South Australian prisons in this area (T446). That is appropriate. The practice was inappropriate and lacked accountability. It is surprising that it was permitted to survive at AWP at long as it did.

7.31. <u>Cell sharing</u>

The DCS review report written by Messrs Smedley and Johnson (Exhibit C30), drew attention to Recommendation 144 of the RCIADIC which said that, unless there are substantial grounds for believing that the well-being of the detainee or others would

be prejudiced, Aboriginal detainees should not be placed alone in a police cell, and that, wherever possible, an Aboriginal detainee should be accommodated with another Aboriginal person. The recommendation added:

> 'Where placement in a cell alone is the only alternative the detainee should thereafter be treated as a person who requires careful surveillance.'
>
> (Exhibit C30, p16)

7.32. Clearly, that recommendation was not complied with in Ms Lindsay's case. It was pointed out that the cells in D Wing were equipped with only one bed (T58), but there were two prisoners in Room 4 which CSO McRae attributed to overcrowding (T138). Mr Johnson said that he had not been able to discern a reason, from his investigation, why Ms Lindsay could not have been placed in a shared cell.

7.33. I note that the authors of Exhibit C30 specifically recommended, among many other things, that the Officer in Charge should specifically consider the need to cell-share as part of the Admissions / Screening process.

8. Conclusions

8.1. Ms Lindsay died on 22 May 2001 as a result of neck compression due to hanging. It is clear that she died by her own hand and that no foul play was involved.

8.2. I am satisfied that she was already deceased by the time she was discovered by DCS staff at about 11:35pm, and that although resuscitation was attempted, there was little chance of revival.

8.3. Ms Lindsay had a tragically troubled life, with a longstanding history of psychiatric illness, drug and alcohol abuse, domestic violence and petty crime. There were several episodes of self-harm and suicide attempts.

8.4. When she was arrested on 18 May 2001, Ms Lindsay was treated appropriately and with professionalism by the police custodial officers. They arranged treatment for her at the Royal Adelaide Hospital, and arranged for her to be examined by a doctor when she reported hearing voices and was despondent. She was detained and sent to Glenside Hospital, but the detention was not confirmed.

8.5. The police accumulated quite comprehensive information in written form about Ms Lindsay's condition, and noted several times that there was a need for special

measures to be taken to ensure her safety. This written information was sent to DCS to assist them manage her at AWP.

8.6. Despite the best efforts of the police, the information was not read or considered by any of the DCS officers charged with the responsibility of caring for Ms Lindsay, nor did it reach the Registered Nurse who assessed her. No special measures were taken to ensure her safety.

8.7. Despite the fact that DCS had established a comprehensive Assessment / Screening process for new prisoners, the Correctional Service Officers failed to take any notice of the information elicited by the process, which, by itself, was enough to indicate that special measures should have been taken. It is clear that CSO McRae approached the Admissions process without any intelligent analysis of the information she was eliciting, and then substituted her own superficial impression of Ms Lindsay's mood for the results she obtained. She was not adequately briefed or supervised by CSO Gough as part of his function.

8.8. Had the CSOs mentioned above fulfilled their duties adequately, the probability is that Ms Lindsay would have been transferred to the infirmary at Yatala Labour Prison where she would have been observed by medical staff. There is no guarantee that her death would have thereby been avoided, but there is a substantial chance that it would have been.

8.9. Other areas where defects in prison regime identified as long ago as the RCIADIC were still present include:

- An obvious and previously identified hanging point had not been removed:
- Exchange of information between DCS and PHS, and between PHS and Glenside Hospital, was ineffective;
- CSOs were not recording observations;
- Cell sharing was not considered.

8.10. Although I have been advised by Mr Johnson that these issues have been addressed, it has been more than ten years since the RCIADIC, and there have been many inquests since. The fact that these issues continue to arise should be a matter of great public concern.

9. Recommendations

9.1. In view of the fact that SOP1 is being totally revamped, the CEO of the DCS should consider the need for an extensive training program to ensure that staff have a full appreciation of their responsibilities pursuant to the new arrangements.

9.2. The issue of communication between DCS staff and PHS staff of information which is important for the management of 'at risk' prisoners, remains problematic. Improvements have been made, in that the PSSF is now provided to PHS staff, but I am far from convinced that there is an exchange of information in the true sense. The attitude of staff from both agencies seems to remain compartmentalised and mechanistic. The training referred to in recommendation 1 hereof should concentrate on developing useful and thoughtful dialogue between the two agencies.

9.3. The 'safe-cell' principles should be adopted and pursued in prisons throughout South Australia as a matter of urgency.

9.4. The issue of cell sharing should receive consideration as part of the admission/screening process for Aboriginal prisoners, particularly remandees.

9.5. In general terms, many of the issues arising from the RCIADIC and subsequent inquests into death in custody do not seem to have been considered to have been applicable to AWP. For example, the concept of unrecorded observations were permitted in defiance of all recommendations and instructions to the contrary. I recommend that the CEO of DCS consider whether enough has been done to ensure that AWP is managed according to the same standards as apply to the rest of the prison system in South Australia.

Key Words: Death in Custody; Hanging; Suicide Risk - Identification of; Cell Design; Information Exchange; Cell Sharing; Psychiatric Treatment

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

Seal the 18th day of December, 2003

Coroner