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 25th, 26th, 27th and 28th days of February and 20th day of March 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Alexander Wayne Keith Varcoe.

I, the said Coroner, find that Alexander Wayne Keith Varcoe aged 24 years, died at Yatala Labour Prison, Northfield, South Australia on or about the 17th day of December, 2000 as a result of hanging.

1. Reason for Inquest

1.1. Alexander Varcoe's final period of imprisonment commenced on 6 April 2000 when he was arrested on an outstanding first-instance warrant. After he was charged, bail was refused and he was remanded in custody and admitted to the Adelaide Remand Centre that day.

1.2. On 19 April 2000, Mr Varcoe was charged with three counts of rape, threaten life and false imprisonment. The alleged victim in those charges was Cathy Marie Webb, a person with whom he had been having a relationship before he was imprisoned.

1.3. On 2 May 2000 Mr Varcoe was transferred to the Yatala Labour Prison where he remained until his death. While on remand in relation to the charges involving Cathy Webb, he attended the Port Adelaide Magistrates Court, Adelaide Magistrates Court and the District Court for a variety of offences, some of which resulted in sentences of imprisonment.

1.4. On 4 October 2000 the charges involving Cathy Webb were listed for trial on 31 January 2001, and Mr Varcoe was remanded in custody until that date.

1.5. Accordingly, on 16-17 December 2000, Mr Varcoe was 'detained in custody pursuant to an Act or law of the State' within the meaning of Section 12(1)(da) of the Coroners Act, and an Inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

2. Introduction

2.1. At about 1:05am on 17 December 2000, Correctional Services Officer ('CSO') Steven Parsonage was performing a check of the prisoners in E Division at Yatala Labour Prison as part of his duties as second watch officer that evening. Mr Parsonage's description of what occurred is as follows:

> 'At about 1.00am on Sunday 17th of December 2000. I entered E division in order to conduct the check. At 1.05am I checked cell 108 which was occupied at that time by prisoner Alex Varcoe. I approached the peephole and saw that the light to the cell was already on. I knew there was only 1 occupant to that cell because the other occupant, whose surname is Leang had gone to the infirmary and I had seen Leang in the infirmary earlier. I looked into the cell through the peephole and I saw that both bunks in the cell were unoccupied. The 1st thing I noticed was 2 or 3 shoelaces hanging from the air vent. Which is situated to the rear right corner of the cell. The bunk was in between myself and the corner of the room and a towel was draped over the end of the bunks so I couldn't see the corner of the room. I looked down towards the floor and saw a pair of feet, heels facing toward me and toes pointing towards the wall. Initially I thought that someone was standing in the corner. I banged on the door but there was no reaction from inside the cell. I opened the trap and yelled out "hey you" into the cell, again without reaction.
>
> I then closed the trap and walked quickly to the officers station in Unit 1 and called the control room and informed them we had a "Code Black" medical emergency, possible hanging. I didn't go into the cell because it was master locked and the keys to the cell were kept in the control room. I then went to the infirmary which is in the same building, about 60 paces away and advised Nurse Lee Martin and Nurse Margie……..that we had a Code Black possible hanging in Unit 1 of E division. I then returned to E division with the nurses and as I entered the division officer Dan Wright from the control room was also entering the division with the keys to the cell. There were 2 other officers with him Colin Fry and Anthony Mears.' (Exhibit C22)

2.2. The log of the incident records that the cell was opened at 1:08am (Exhibit C15p).

2.3. Once cell 108 was opened, the officers confirmed that Mr Varcoe was hanging by the neck, being suspended by shoelaces attached to the air vent. His feet were just touching the ground. Registered Nurse Martin asked an officer to cut the cord from around Mr Varcoe's neck. The officers cut him down and laid him on the floor. RN's Martin and Viceban tried to resuscitate him but without success. They found no

vital signs, he was cold to the touch and the body was stiff. There was no sign of breathing effort, the eyes were open and the pupils fixed and dilated. RN Martin tried to open his jaw to insert an airway but was unable to move it. The nurses attempted to use a defibrillator machine but the machine indicated that Mr Varcoe was in 'asystole', meaning there was no sign of heart activity.

2.4. The two nurses concluded, reasonably, that Mr Varcoe was dead and that there was nothing more they could do for him (see Exhibits C8a and C9a).

2.5. Because of the unavailability of the Medical Officer (Dr Kreig), Mr Varcoe's life was not formally certified extinct until 4:25am on 17 December 2000 (see Exhibit C2a). However, I accept the evidence of the Registered Nurses that Mr Varcoe was clearly deceased at the time he was cut down.

3. Cause of Death

3.1. A post mortem examination of the body of the deceased was performed by Professor R W Byard, Forensic Pathologist, at the Forensic Science Centre on 18 December 2000 at my direction. Professor Byard diagnosed the cause of death as 'hanging'. He commented:

> 'Death was due to neck compression from hanging with an obvious parchmented ligature mark around the neck. Although the lower legs were immobilised with a tracksuit top, the deceased could easily to have tied this knot, most likely to prevent movement of his legs from attracting the attention of prison personnel. Analysis of blood revealed no alcohol or basic drugs.' (Exhibit C3a, p2)

3.2. A toxicological analysis of Mr Varcoe's blood did not disclose the presence of any of the common drugs or alcohol (Exhibit C4a).

3.3. I accept the evidence of Professor Byard and find that the cause of Mr Varcoe's death was hanging.

4. Background

4.1. Family history and early offending

Mr Varcoe was born on 10 July 1976. He had two older and four younger siblings. His mother Mrs Merva Varcoe said in her statement that her son had a troubled childhood. She said:-

> 'Alex grew up mainly in Point Pearce and Adelaide. When Alex was about 5 years old I was living in Hindmarsh when Alex's father was spoken to about molesting Alex's sisters. He wasn't arrested for this but the welfare people told me to keep the kids away from Alex's father because they had a lot of evidence on him. Late when Alex found out about this he was very angry and wanted to kill his father. When Alex was about 12 years old he started drinking alcohol. As he got older he started to drink methylated spirits and he had a drinking problem up to the time of the death. I think that in the last year of his life he was injecting drugs. He never did anything in front of me but I heard from people I knew in Victoria Square, Adelaide that he was using needles. Alex got into trouble with the police for different minor things and he went to the boy's home a few times. At one time he was given an 'ink' placement which is like being fostered but not quite the same. From the time he was about 12 he was in that placement. I would see him from time to time and at one time he went to Port McLeay and lived there for a little while and another time he spent a couple of years in Amata.' (Exhibit C1b, p1)

4.2. Mr Varcoe had an extraordinary criminal offending history, dating from January 1991. His offending included dishonesty (breaking, illegal use, larceny) and violence (assault, endanger life, armed robbery, robbery with violence, inflict grievous bodily harm) and sexual offences (indecent assault).

4.3. At the conclusion of the inquest, Mr Charles tendered another affidavit sworn by Mrs Varcoe in which she explains why her son may have taken his life. After explaining difficulties in relation to access to his child, which I will discuss later, she said:-

> 'I refer to my statement of 24th December 2000 to Detective McIntyre. In that statement I said that; "Apart from being in prison I don't know any reason for Alex being depressed".
>
> There is another reason that he was depressed and I now feel able to talk about it.
>
> When he first went to Yatala Labour Prison I believe that my sone was anally raped in the showers. He referred to two Aboriginal prisoners having done it. When he was at home with me at 22 Second Street Wingfield, he said "Mum there is something I need to tell you". I can't remember what year it was that he told me, but it was when Alex was in a relationship with Mary Singh so it must have been some years after the rape that he told me about it. I suggested we go to Pt Adelaide to go shopping. He went to Arndale and I went to Pt Adelaide. We met at the Globe Tavern in Pt Adelaide to discuss it over a few drinks.

He told me that the rape had occurred in the showers at Yatala Labour prison, some years before, in the first time he was imprisoned. He was raped by two Aboriginal prisoners in the showers. I do not know in which division of Yatala it occurred.

I have had shown to me the exhibit C 15c.

That document is a history of Alex's times in prison. It discloses that Alex's first period of prison was at Yatala between 27-7-94 and 2-9-94. From what he said to me I think it must have occurred in that period. I don't remember if he told me which year it happened in, but he did say it happened in his first period in gaol and at Yatala.

He was ashamed to talk about it and I know that it really upset him. I believe that I was the first person he told about it. He was distressed when he told me. He said that he had been raped once at Yatala.

I have been shown Alex's prison medical records, Exhibit C15 d. There do not appear to be any records on that file covering the period from July 94 to September 94. The records do disclose that he was suicidal and depressed and had previously slashed up when he was seen by the Prison Medical Service in the Adelaide Remand Centre on 2-12-94. and there are similar things that happened for the period up to 1995.

I remember that Alex smashed up a flat that I lived in for about two years seven or eight years ago in Hampstead Road Clearview. He also smashed up a house I had later at 25 Sixth Street Wingfield. I now think the rape experience had something to do with that behaviour also. He was emotionally disturbed at the time.

I have been thinking about it for a long time and I think the rape had something to do with his violent and destructive behaviour and I think that the rape on him had something to do with his death. I am also aware that he had been charged with the rape of a woman and that he was to face trial on his charges in January 2001, but he died before the trial.

When I was talking about the rape with Alex in the Old Globe Tavern he pointed out a person to me as being one of the rapists. I confronted that Aboriginal person at the Old Globe Tavern on that very day with the allegation. He neither admitted nor denied it but he ran out of the hotel.

Although this story is very shameful for me and my family and for Alex's memory I feel that I must state this to the Coroner. I think Aboriginal people have been silent about rape in gaol for too long. Aboriginal prisoners say that they are staunch in gaol and can cope with it, but they shouldn't rape other people in gaol. Rape in gaol puts people at risk of death in custody.' (Exhibit C1c)

4.4. It is true that Mr Varcoe's medical records (Exhibit C15d) disclose that in December 1994 and January 1995, episodes of self-mutilation by slashing the inside of his forearms with a sharp object were noted by clinic staff. This reoccurred in June 1995.

4.5. On 21 June 1995 Mr Varcoe was seen by Dr Jennings, consultant psychiatrist. Dr Jennings assessed that he had a borderline personality disorder. He prescribed no specific treatment, but noted:-

'Review if required in future. Potential for episodic suicidal behaviour at times of stress.' (Exhibit C15d)

4.6. On 26 July 1995, Dr Jennings prescribed Doxepin (a tricyclic antidepressant) as a trial. On 23 August 1995, Dr Jennings diagnosed an adjustment disorder with depressed mood and increased the dose of Doxepin.

4.7. In November 1995, another episode of 'slashing up' took place, which Mr Varcoe told Dr Jennings was due to "missing his family", "sick of prison" and being "picked on" by his family.

4.8. There were no further episodes of self harm recorded in the casenotes since August 1996 when Mr Varcoe was found in possession of razor blades. He denied any suicidal intent at that time.

4.9. Since that time, Mr Varcoe displayed signs of emotional distress on a number of occasions for which he received attention. Most of these occasions were attributable to particular stressors.

4.10. At no time were the alleged rapes referred to by Mrs Varcoe ever reported to the Department of Correctional Services, not were they ever reported to Dr Jennings. There can therefore be no certainty that Mr Varcoe's behaviour in prison was attributable to this incident, although it may well have been a significant factor in the aetiology of his condition.

4.11. <u>Admission to the Adelaide Remand Centre</u>

When Mr Varcoe was admitted to the Adelaide Remand Centre on 6 April 2000, he was seen in the Admissions section by CSO Ernest Kruger. As part of the admissions process, CSO Kruger filled out a Prison Stress Screening form, which is designed to identify prisoners who are or may be at risk of suicide or self harming behaviour.

4.12. Interestingly the form, part of Exhibit C15r, specifies that several questions, identified in bold print, should not be asked of Aboriginal people. Those questions deal with recent deaths of family or close friends, whether the prisoner had ever tried to commit suicide or self harm before, and:-

'Sometimes people feel that those close to them would be better off if you were dead. Have you felt like that recently?' (Exhibit C15r)

CSO Kruger noted that Mr Varcoe answered 'Yes' to that question.

4.13. That being the case, the form indicated that the prisoner should have been considered 'at risk', notwithstanding his answers to the other questions. In those circumstances, Mr Kruger should have notified the Medical Officer or the nurse.

4.14. Mr Kruger acknowledged that he failed to follow the instruction on the form to that effect (see his statement, Exhibit C21, p1).

4.15. In his defence, he stated that he provided the form together with other documents including the Reception Checklist, the Specific Needs form, the initial Security Assessment form, the Prisoner Interview form, and a Phone Registration form to the nurse, who then carried out a health assessment of the prisoner. He said that the Prison Stress Screening form would have accompanied those documents to the nurse.

4.16. In my opinion, this is not an adequate substitute for Mr Kruger using his own intelligence and initiative to interpret the form. I have investigated many deaths in custody where an error has occurred because an assumption has been made that the previous person in the system has done their job adequately. If the nurse failed to notice any signs of distress or suicidal behaviour in the prisoner, he or she might well seek to excuse this on the basis that they were not alerted to the prisoners condition by the officer who filled out the Prison Stress Screening form.

4.17. Another issue in relation to the Prison Stress Screening form is the significance of questions 18 and 19. Question 18 reads:

> 'Have you ever tried to commit suicide or intentionally hurt yourself? (If yes, ask frequency, recency and reason and record below)' (Exhibit C15r)

Ironically, this question is also in bold print, and should not have been asked of Mr Varcoe, an aboriginal prisoner. However, Mr Kruger said that he decided that it was appropriate to get an answer to such an important question (a view with which I agree), so he asked a question in a 'roundabout way' (T127). He recorded Mr Varcoe's answer to the question as 'no'.

4.18. Question 19 on the form reads:-

> 'Note: check the prisoners wrists, arms and neck for scars. If present, do they appear to have been caused by suicide or self harm attempts?

If present, note location and description (seriousness, number, age etc)' (Exhibit C15r)

This question has not been answered at all.

4.19. Mr Kruger explained that he did not check Mr Varcoe's wrists, arms and neck for scars, since the answer to question 18 was 'no'. He said he would only perform such an inspection if the answer to question 18 was 'yes'. Having regard to Mr Varcoe's history, if Mr Kruger had checked his arms he would have found a number of scars from previous acts of self-mutilation. Mr Charles, counsel for Mrs Varcoe, was critical of this failure. However, there is no evidence that Mr Varcoe had engaged in this type of behaviour recently, so it is doubtful that Mr Kruger would have concluded that Mr Varcoe was presently 'at risk' on the basis of old scarring.

4.20. Mr Scott Hilliker, a CSO who performed a similar admission process when Mr Varcoe was transferred to Yatala Labour Prison on 2 May 2000, interpreted the form in the same way Mr Kruger did (T28-29). Mr Steven Johnson, Manager, Custodial Systems, in the Department of Correctional Services, also supported this interpretation of the form (T203-204).

4.21. It would appear that this is an interpretation of the form which has been accepted by the Department though it is not a literal interpretation of the form. The form does not make the duty to inspect the prisoner's wrists arms and neck conditional upon a 'yes' answer to question 18. If the Department for Correctional Services regards it as appropriate that an inspection is only required if the prisoner answers 'yes' to question 18, then the form should be changed.

4.22. <u>The induction process</u>

Following Mr Varcoe's transfer to Yatala Labour Prison on 2 May 2000, he underwent an 'induction process', conducted by CSO Aaron Sweet for the purposes of entry into Unit 1 of E Division. Mr Sweet was also allocated as Mr Varcoe's case officer for the purposes of the case-management system. In that system, each case officer is allocated seven or eight prisoners, and the task is to pay particular attention to the welfare of those prisoners and to conduct regular case interviews and attend to any problems which may arise.

4.23. Mr Sweet only remained Mr Varcoe's case officer for about a month. The reason why this relationship was terminated was not canvassed when Mr Sweet was cross-

examined. I therefore reject the suggestion made by Mr Charles during his final submissions that Mr Sweet was obviously 'taken off the job' as a result of unsatisfactory performance. There is no evidence of that, and if the submission was to be made, it would have been better if it had been put to Mr Sweet for his comment.

4.24. Mr Sweet said in evidence that he had some difficulties in communicating with Mr Varcoe because Mr Varcoe refused to deal with white Correctional Services Officers, and would only deal with the Aboriginal Liaison Officer. He said that he made numerous attempts to communicate with Mr Varcoe to no avail.

4.25. Mr Sweet impressed me as a conscientious CSO who was generally concerned for Mr Varcoe's welfare. He became visibly upset when being asked to discuss the circumstances of Mr Varcoe's death. I do not accept, on the basis of the evidence before me, that there was any unsatisfactory aspects of Mr Sweet's performance in this matter.

5. Events of 12 December 2000

5.1. On 12 December 2000 CSO Sweet was inspecting cell 18 in K Wing of E Division occupied by Mr Varcoe and Mr Harris, and found that the ventilation vent near the toilet had been removed. On looking inside the vent he found a diagram on how to make a tattoo gun, and also a partially made tattoo gun. He then checked cell 17, the adjoining cell, and found the ventilation vent had also been damaged. The prisoners in that cell were Messrs Reed and Wanganeen. Mr Sweet also inspected the main ventilation system which was outside the two cells and located a rusted 'shiv' or homemade knife.

5.2. As a result of these discoveries, the Prosecution Officer Mr McAllister was notified, and the four prisoners involved were strip-searched and their cells searched thoroughly. The prisoners were then separated and moved to different cells. These measures were all in accordance with standard procedures.

5.3. Mr Varcoe commenced sharing cell 18 with an Asian prisoner, Heng Gau Leang. There is some uncertainty as to when this occurred, but I do not think anything turns on that issue.

5.4. Mr Charles submitted that it was inappropriate that Mr Varcoe was put in a cell with an Asian prisoner, and that he should have immediately been put into a cell with another Aboriginal prisoner. The problem with that submission is that just because prisoners are Aboriginal does not mean that they are compatible to share a cell. Indeed, there are very strong reasons, as Mrs Varcoe outlined, which would have made it very important for Mr Varcoe not to be placed in a cell with certain Aboriginal prisoners. I could see no grounds, on the evidence before me, for criticism of the officers as a result of the events arising out of 12 December 2000.

5.5. Even if their actions could be criticised, there is nothing from which it can be concluded that these events caused Mr Varcoe to hang himself on 16 December 2000. Mr Charles acknowledged this in his submission. The Aboriginal Liaison Officer Mr Alban Kartinyeri, whose function it is to monitor any concerns Aboriginal prisoners may have and advise management so that they can take remedial action, did not think so. He said:-

> 'I saw Alex after the tattoo gun incident. He accepted his punishment.'
> (Exhibit C23, p3)

6. Events of 16 December 2000

6.1. In accordance with usual practice at that time, prisoners at Yatala Labour Prison were locked in their cells at 4:00pm. This happened on 16 December 2000. After lockdown, Mr Leang, who suffers from a mental illness, asked to be transferred to the infirmary. He said:-

> 'I went to the infirmary between 6 and 7 p.m on Saturday the 16th of December 2000. The reason I wanted to go to the infirmary was because I was paranoid about the other inmates saying things about me and doing things to me. No-one had made any threats towards me or indicated that they were going to hurt me in anyway.
>
> After lock-up I mentioned to Alex that I did not feel very well and wanted to go to the infirmary. Alex buzzed the on-duty officer on the intercom and advised them of this. When the correctional officers came to the cell Alex was helping me by complaining to the officers to try and get me to the infirmary. Before I left he seemed ok and he was even laughing with me.' (Exhibit C14a, p3)

6.2. Mr Charles was critical that Mr Varcoe was not immediately placed with another Aboriginal prisoner after Mr Leang was transferred to the infirmary. I consider this criticism unrealistic. These events occurred after lockdown, and it would have been

extremely difficult and disruptive to organise for another prisoner to be shifted at that point in the evening. Additionally, there was no reason to think that Mr Leang would not have returned to his cell the next morning or soon thereafter. There was no urgency about the situation, and Mr Varcoe had not been recently identified as a prisoner at risk. In those circumstances, I consider that criticism of the officers because they did not put Mr Varcoe in a cell with another prisoner at that time is unjustified.

6.3. At 2245 (10:45pm), CSO Steven Parsonage came on duty. He was the 'second watch officer' that evening, which gave him responsibility for the prisoners in the Infirmary and in E Division.

6.4. When he came on duty, Mr Parsonage conducted a check of all the prisoners in both E Division and the Infirmary, which involved sighting approximately 116 prisoners. He made a note in the E Division log book that all prisoners were sighted and correct from which it can be inferred that Mr Varcoe was still alive and well at that point. I have no evidence to the contrary, as I will presently discuss.

6.5. Mr Parsonage performed his next cell inspection at 1:00am on Sunday 17 December 2000 when he found Mr Varcoe hanging in the cell. I have already described those events in some detail.

7. The Investigation

7.1. Following the discovery of Mr Varcoe's body, the police were called and Detectives MacIntyre and Rethus attended at about 1:30am that morning. They were soon joined by the State Duty Officer, Inspector Webber. A decision was made not to call a pathologist from State Forensic Science to the scene, as it was considered unnecessary 'due to the non-suspicious circumstances surrounding Varcoe's death' (see Exhibit C15a, p9).

7.2. As a result of all this, the temperature of the body and the ambient temperature were not taken. A crime scene examiner from Holden Hill Police Station attended at about 2:30am but this was not considered part of his brief. As a result of that, it has not been possible to establish the time of Mr Varcoe's death. It has therefore not been possible to verify Mr Parsonages' evidence that when he checked Mr Varcoe at 10:45pm, he was still alive and well. In my opinion, this is a serious omission. If a

medical practitioner was unable to attend for this purpose, then alternative arrangements should have been made.

7.3. A protocol has been developed between my office, the Commissioner of Police, and the Department of Correctional Services which clearly outlines the steps to be taken during the investigation of a death in custody. In my findings following the inquest into the death of Laurens Adrian Keith Nobels (Inquest number 43 of 2000), I recommended:-

> 'The protocol between the Commissioner of Police and myself should be amended to ensure that a pathologist is called to the scene of a death in custody wherever possible, and where that is not possible, give directions as to the alternative arrangements that can be made to determine the time of death'
>
> (Exhibit C)

7.4. It seems to me that it is a central plank of any investigation of a death in custody to determine the time of death. How were the investigators to know whether the death was 'suspicious' or not, if they had no idea when it occurred?

7.5. Investigators should understand that their function when investigating a death in custody is not simply to determine whether the death is 'suspicious' or not. Surely since the report of the Royal Commission into Aboriginal Deaths in Custody (which was first published in 1991) should have made this clear to investigators by now.

8. Assessment of suicide risk

8.1. Admission procedures

I have already mentioned that CSO Kruger failed to notice the significance of Mr Varcoe's answer to question 22 of the Prison Stress Screening form in April 2000. From this answer, it might have been determined that Mr Varcoe was 'at risk' of suicidal or self harming behaviour. Mr Charles argued that had he done so, a chain of events might have been set off, in accordance with local operating procedure No. 29 at the Adelaide Remand Centre, in which the question of suicide risk could have been adequately investigated.

8.2. While acknowledging the force of this submission, I think that there is an abundance of evidence that by December of that year, Mr Varcoe no longer constituted an overt suicide risk. The evidence of the prisoners and CSO's who had dealings with him

during that period suggests that he was in a good frame of mind and quite unlikely to hurt himself. The evidence is as follows:-

- For the time I spent with Alex we seemed to get along all right. Alex appeared to be a pretty happy person and joking all the time. He spoke about his family and his children. He also spoke about his concerns for doing 10 to 15 years in jail. He didn't talk about what he was in custody for, but he spoke about how his woman had him charged for rape. He only mentioned it and didn't go into details. He spoke about his newborn daughter but he mentioned that he had never seen her, or whether he was going to see her. As far as I knew he never had many visitors. I did notice that he wasn't a very emotional person. I never saw any sign of aggression or mood swings. He didn't appear to have any problems.' (Heng Gan Leang - Exhibit C14a, p2)

- A 'happy go lucky bloke……he didn't come across as being depressed. I was surprised when I heard the news about Varcoe's death. (Rory Cullen - Exhibit C14b).

- Alex seemed pretty happy leading up to his death. I didn't think Alex would do anything like this. I was talking to Alex on that day before lock-up and he was joking around and he seemed no worries.' (Daniel Smith - Exhibit C14c)

- He was ok, nothing out of the ordinary – I was speaking to him earlier that day and he was laughing and joking…..I never thought Alex would do anything like this. I am very surprised when I found out about Alex's death.' (Greg Tarasenko - Exhibit C14d)

- Alex didn't seem depressed or upset over it, he just laughed it off like he normally does. I was playing basketball with Alex on Saturday, and the day before that, and he was fine. He gave me no indication that he was going to do this. I am surprised when I heard the news about Alex.' (Gary Harris - Exhibit C14e)

- After lock-up on the Saturday I was talking to Alex through the vent. This was about 6-7 o'clock as this was the time he kicked his cellmate out. I heard the intercom and then officers come down. I asked Alex where his cellmate was going and he told me that he was going to the infirmary as he was stressing out. We were then talking about what was on tellie and he was making jokes and laughing. He was carrying on and just being himself. There was no indication that he was going to do this to himself. He is not the type of person that would hang himself.' (Daniel Hook - Exhibit C14f)

8.3. Prisoner Ricky Lambert alleged that a day or so before he died, Mr Varcoe asked CSO Aaron Sweet to move him out of the cell he was sharing with Mr Leang and 'into a cell with his brother or cousin'. He alleged that Mr Sweet gave him a somewhat abusive reply (see Exhibit C14g, p3). I have decided not to investigate this issue further. None of the other prisoners made similar allegations, even prisoners who were closer friends with Mr Varcoe than Mr Lambert was. None of them

mentioned this incident. Prisoners make allegations against prison officers for a variety of reasons, and I would not be prepared to act on the uncorroborated word of Mr Lambert in these circumstances. I make no adverse finding against Mr Sweet arising out of Mr Lambert's evidence.

8.4. Family issues

I heard evidence from Mr Alban Kartinyeri, who was an Aboriginal Liaison Officer employed by the Department of Correctional Services stationed at Yatala Labour Prison at the time of Mr Varcoe's death.

8.5. Mr Kartinyeri described his duties as follows:-

> 'My position as an ALO was to support and liaise on behalf of aboriginal prisoners. I would see aboriginal prisoners as soon as practical after their arrival at the institution. I would let them know that our services were available and what we actually did, to notify families and to assist with problems that may arise.' (Exhibit C23, p1)

8.6. Mr Kartinyeri told me that Mr Varcoe made a number of enquiries about his family. For example, he had a son who lived with his mother in Canberra. Mr Kartinyeri tried to make contact via the mothers uncle in October 2000, but received a message that she did not want to make contact with Mr Varcoe. Mr Kartinyeri said that he 'seemed ok' when he received this information (Exhibit C23, p2).

8.7. Mr Kartinyeri said that Mr Varcoe also thought that he was the father of a baby girl born to his ex-girlfriend Mary Singh, and he wanted to make contact with her and get photographs of the baby. Mr Kartinyeri was able to get some photographs of the baby through Mr Varcoe's mother, Merva. Mr Varcoe also indicated that he would like a visit from this baby girl, but Mr Kartinyeri was unable to arrange this, as the baby's mother had fostered the child out to a family in Murray Bridge.

8.8. A number of the prisoners said that Mr Varcoe was disappointed about this (see Smith Exhibit C14c, Tarasenko Exhibit C14d and Harris Exhibit C14e).

8.9. I find that there were no grounds upon which it should have been concluded that on or about 16 December 2000, Mr Varcoe should have been considered a suicide risk. His behaviour in 1995-6, and his answer to question 22 on the Prison Stress Screening form in April 2000, were so remote in time that they can be discounted as causative factors.

8.10. I do not accept the breadth of Mr Charles submission that these events should have put the CSO's on notice. It cannot be said that once a prisoner has displayed behaviour which puts him at risk, that the prisoner should be regarded as being at risk forever afterwards.

8.11. All prisoners should be regarded as potentially at risk, but it is not feasible to take special measures for all of them unless they display particular behaviour which indicates that the risk is more immediate. Mr Varcoe did not do that.

8.12. Cell Design

Recommendation 165 of the Royal Commission into Aboriginal Deaths in Custody provides:-

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

8.13. It is perfectly obvious from the photographs of Mr Varcoe's cell (Exhibit C15j) taken after his death, that there were many "hanging points" he could have used. As it happened, he chose the grille over the air vent in the ceiling of the cell.

8.14. The question arises whether it would have been more appropriate if the grille had been designed so that it was not possible to thread a cord through it, or so that it was unable to bear Mr Varcoe's weight. Such design considerations were the subject of a detailed study in Victoria by the Department of Justice called the Building Design Review Project, November 2000, subtitled "Fire Safety Issues and the Removal of Obvious Hanging Points from Mainstream Prison Cells within the Victorian Correctional System".

8.15. This Project undertook a detailed evaluation of design issues involved in constructing safer cells, and the project team developed a "prototype cell". The specifications include that any grille should have 1.6 mm diameter holes, which would prevent a shoelace being passed through it.

8.16. The Project referred to a finding I made following the inquest into the death of Damien Wakely (Inquest Number 7 of 1995) in which I said:-

> '…..any cell in which all hanging points have been effectively eliminated……would be so sterile and inhumane that it would be likely to create more problems than it solves.'

8.17. The difficulties of eliminating hanging points in cells designated for dual occupancy, with bunk beds, are even greater. This was acknowledged in my finding following the inquest into the death of Christopher Bonney (Inquest Number 28 of 1996). Notwithstanding these difficulties, I recommended, pursuant to Section 25(2) of the Coroners Act, that:-

> 'The Department of Correctional Services carry out an upgrading of cells in E division at Yatala with a view to reducing the number of hanging points.'

8.18. In my finding following the inquest into the death of Laurens Adrian Keith Nobels (Inquest Number 43 of 2000), and on the basis of a recommendation by Messrs Smedley and Leggatt (who also conducted the Departmental review in this matter), I recommended:-

> 'The Department for Correctional Services review all bunk beds with a view to minimising obvious hanging points, or if this is not possible, bunk beds in all cells should be removed.'

8.19. It is obvious that little has been done to reduce hanging points in mainstream (as distinct from "special" cells for "at risk" prisoners) cells in South Australian prisons. I am sure that new cells built in recent years are an improvement, but there are many old cells, such as those in E division at Yatala Labour Prison, which are still in need of attention.

9. Recommendations

Pursuant to Section 25(2) of the Coroners Act, 1975, I recommend as follows:-

(1) That the Department of Correctional Services review the Prison Stress Screening form in light of the issues discussed in this inquest (I note that Mr Johnston said that this is already under way, but the particular issues raised here should be addressed);

(2) As recommended in Bonney in 1996, the design of cells in E division at Yatala Labour Prison, and indeed all older cells in the prison system in South Australia, should be the subject of a comprehensive review along the lines of the Victorian Building Design Review Project;

(3) That the Commissioner of Police reinforce with investigating officers and supervisors the need to comply with the protocol for investigation of deaths in custody, particularly in relation to the time of death.

Key Words: Death in Custody; Hanging; Aboriginal Prisoners; Cell Design; Police Investigation.

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

Seal the 20th day of March, 2003.

Coroner