



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th, 5th, and 10th days of August 2005, and on the 27th day of September 2005 by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, a Deputy State Coroner, into the death of Damian John Cook.

The said Court finds that Damian John Cook aged 24 years, late of the Adelaide Remand Centre, Currie Street, Adelaide, South Australia died at the Royal Adelaide Hospital, North Terrace, South Australia on the 6th day of March 2003, as a result of the consequences of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Damian John Cook was an inmate of the Adelaide Remand Centre ('ARC') at the time of his death. The ARC is an institution operated by the South Australian Department for Correctional Services (DCS) and is devoted in the main to the custody of male persons whose matters are pending resolution in the criminal courts of South Australia and who are not on bail. The inmates there are remanded in custody. Inmates on remand at the ARC may have been kept in custody for several months by the time their matters in court are finalised. For the most part, during their time in the ARC, they are neither convicted nor sentenced prisoners. In that respect their futures are uncertain and largely out of their own control
- 1.2. When admitted to the ARC they are subjected to an induction procedure. As part of their induction they are assessed inter alia for security risks, are subjected to stress screening, are assessed for specific needs and undergo a health assessment. As part of

the stress screening process, they are asked a number of questions by an officer of the DCS in an effort to assess their risk of self-harm. These questions include whether the inmate has ever been diagnosed as having a psychiatric disorder, whether they have overdosed on drugs either accidentally or intentionally, whether a member of their family or a close friend has ever committed suicide and whether the inmate has ever tried to commit suicide or self-harm or is harbouring thoughts of the same at present. The assessment is based largely on answers given by the inmate himself but there are a number of questions to be answered by the interviewing officer based upon that officer's own objective assessment of the inmate.

- 1.3. The health assessment also, inter alia, addresses issues of self-harm potential. Together, the stress screening and health assessment address the issue of the inmate's perceived potential for suicide or self-harm as it might exist at the time of these induction procedures, which as I say, occur when the inmate first arrives at the institution. But these assessments, insofar as they might illuminate an existing potential for self-harm or in any way meaningfully inform Corrections staff as to the frame of mind of a recently admitted inmate, are essentially a snap shot in time.
- 1.4. The circumstances of an inmate kept in custody over an extended period of time in the ARC might change. The inmates go to court. They are visited with unfavourable court outcomes. Their hopes as to freedom, rationally held or otherwise, are raised and dashed. Many inmates exert limited control over their personal lives outside of the institution. For instance, a prisoner's personal relationship may deteriorate over time and there is little he can do about it. An inmate's frame of mind and well-being may be vastly different from what it was when he first entered the institution.
- 1.5. Damian John Cook, who hung himself in his cell on 3 March 2003, seems to have been a case in point. There was nothing remarkable about his induction procedure when he entered the ARC as a prisoner remanded in custody on 8 October 2002. It was noted that the deceased's brother had apparently committed suicide three weeks before that date, but nothing said by or observed specifically about the deceased gave rise to any perception that he was at risk of self-harm. It is noted in the Prison Health Services progress notes that he '*denies any thought of self-harm*', but by March 2003 his circumstances were such that he was to develop, and act upon, a strong desire to kill himself.

- 1.6. His evaluation in October 2002 was the only such evaluation during the deceased's custody. No further formal assessment was made of a prisoner's risk of self-harm during the period of a prisoner's custody. Any perception of such a risk would have to be gleaned from the prisoner's own statements or from his observed behaviour and demeanour, from the reports of other prisoners concerned for a fellow inmate's welfare or from the reports of concerned family members or friends. While there are qualified psychologists and social workers who regularly interact with prisoners, there is no guarantee that a prisoner's intent to self-harm or to suicide, unless telegraphed to someone else in authority, will be detected in time for preventative measures to be taken. The telephone calls made by inmates to the outside world were monitored only very occasionally, and a declaration of intention of self-harm in such a conversation would not necessarily be picked up by the Corrections staff.
- 1.7. By the beginning of March 2003 the deceased was in a suicidal frame of mind which was neither detected by nor reported to Correctional Services staff. On the other hand, some of his fellow inmates clearly knew that the deceased was emotionally unstable. He had recently confided that his former partner had not visited with the children and had refused to talk to him on the phone; he was seen by inmates to have been upset and depressed, had cut his wrists and had stated to one that he was going to end it all. But nothing of this was picked up by staff. There was in reality no formal means by which such a frame of mind could be identified.
- 1.8. During the afternoon of 3 March 2003, which was the afternoon preceding the evening of his hanging, the deceased conducted a number of telephone conversations with his former female partner. The conversations were acrimonious and occurred against the background that the deceased was charged with having assaulted her. The deceased's anxiety that his former partner was refusing to visit with their young daughter was the main topic of discussion. The deceased appeared to have been in a bad mood. His former partner hung up on him on more than one occasion. In the last call at about 3pm, he told her that he was going to kill himself. He carried out the threat that same night. He tried to kill himself by hanging himself in the cell which he occupied alone. He died from the attempt on 6 March 2003 at the Royal Adelaide Hospital.
- 1.9. The deceased had occupied a cell at the ARC on his own. The hanging was conducted in that cell with ease and without let or hindrance. He had plenty of time in

which to do it unobserved. The cell itself, and its usual contents, provided him with the means necessary to carry into effect the deceased's desire to kill himself.

- 1.10. This was a death in custody. Although this death had been notified pursuant to the provisions of the repealed Coroners Act 1975, it was in my view to be regarded as if it were a notification of a reportable death under the Coroners Act 2003 (see Section 25(3) of the Schedule to the 2003 Act). I have therefore taken the view that all of the provisions of the 2003 Act, including those which define the circumstances in which an inquest under the 2003 Act is mandatory, apply to this death. The deceased's death was a death in custody as defined in Section 3 of the 2003 Act.
- 1.11. Accordingly, an inquest to ascertain the cause or circumstances of the deceased's death was mandatory by virtue of Section 21(1) of the 2003 Act. If I am wrong about that, and the repealed Act still applies, an inquest into the deceased's death was in any event mandatory pursuant to Sections 12(1)(da) and 14(1a) of the repealed Act for the same reasons, namely because the deceased died while he was detained in custody.

2. The circumstances of the deceased's death

- 2.1. The deceased was housed in Unit 4 of the ARC. Unit 4 consisted of 28 cells. Of those cells 14 were single cells, one of which was occupied by the deceased. That was cell 20. At 4:40pm, the inmates were locked down, that is to say they were locked in their cells until the following day.
- 2.2. Patrols of Unit 4 occurred every two hours. Prisoners were required to be sighted by patrol officers, among other things, to ensure that all was well within the cell. There was a patrol conducted between 6pm and about 6:35pm on the evening in question, and there is nothing to suggest that anything untoward was observed in the deceased's cell.
- 2.3. Another patrol was conducted at about 8pm or shortly thereafter. This patrol also served as the Unit's medication round. The medication round involved the institution's nurse delivering inmates' medication to their cells. The nurse was accompanied by the two patrolling officers. Not all inmates were necessarily on medication. Checks of the cells occupied by inmates who did not require medication were nevertheless made by patrolling officers. The deceased was one such inmate.

2.4. The patrol accompanying that night's medication round comprised Correctional Services Officers Copley and Thorpe. Both men gave evidence before me. I found both to be truthful and ingenuous witnesses. It was about 8:15pm when CSO Copley attempted to view the deceased in his cell via a vertical perspex window in the door. He shone his torch through the window and saw what he believed at that time to have been the deceased cleaning his teeth in the vicinity of the sink. His view of the deceased is described as only a '*momentary observation*' (T25). He thought that the cell light was probably off. If the deceased was at that stage hanging, Copley's failure to observe that fact is possibly explicable on the basis that the perspex window may have been crazed through constant abuse by the cell's occupants. On the other hand, CSO Thorpe who located the deceased hanging shortly afterwards had no difficulty looking through the screen. Copley said in evidence that the impression that he gained through the perspex was that the occupant at the time was using motions consistent with him cleaning his teeth. He said:

'Well, that was the impression I got. Yes, he was moving, he was cleaning his teeth.'
(T44)

Although I accept Copley's evidence that this was his genuine belief at the time, the notion that the deceased was in fact cleaning his teeth at that time is naturally an absurd one, given that perhaps only two minutes later he was discovered by Copley's partner, CSO Thorpe, to be hanging. I think the overwhelming likelihood is that Copley saw the deceased hanging but that other factors prevented him from recognising that fact. The fact that, when discovered, the deceased was already cold to the touch seems consistent with him having been hanging for some time. If in fact Copley had observed the deceased to be hanging, and he failed to observe that fact, there is in any event no evidence from which a conclusion could be drawn that an earlier discovery of that unfortunate set of circumstances would have altered the outcome.

2.5. As it transpired, Thorpe looked through the window into the cell perhaps a couple of minutes after Copley's observation. Thorpe found the deceased hanging and immediately recognised that as a fact.

2.6. Damian Cook did not have to look far for the means with which to kill himself. In his cell there was an overhead vent which was covered by a metal grille. The grille was situated above the shower cubicle. The deceased had torn a strip from bed clothing

and fashioned a ligature out of that piece of material. It was tied through the slats of the grille and then fastened to a shower nozzle that was a few inches below the grille. The ligature was then tied around the deceased's neck.

- 2.7. Upon this discovery, the deceased's cell was unlocked and the ligature around his neck was cut. By then the nurse who had been responsible for the medication round was present. His name was Duncan Tyson. It was observed that the deceased had no pulse and was not breathing. Thorpe and Nurse Tyson immediately commenced CPR. A Code Black, which is the emergency code, was called and another nurse came to the floor with oxygen that was then administered to the deceased. After several minutes of intense resuscitation efforts, a pulse was detected. A cardiac monitor recorded a normal but very rapid heart beat. Although a pulse had been re-established by resuscitation efforts, spontaneous breathing was not restored and so the deceased continued to be artificially ventilated by Corrections staff. Resuscitation had been administered by CSO Thorpe, Nurse Tyson and another nurse by the name of Catherine Watson who had arrived on the scene shortly after the discovery of the deceased.
- 2.8. An ambulance crew also arrived at the scene several minutes after the deceased's pulse was detected as having been re-established. This crew took over the management of the deceased, which included intubation and the insertion of a saline drip. A second crew also arrived. At all times the deceased remained deeply unconscious, cyanosed and hypertensive.
- 2.9. The deceased was taken to the Royal Adelaide Hospital where in the next few days he demonstrated clinical signs of a profound hypoxic brain injury. His neurological state deteriorated further and early on 6 March he was noted to have lost brain stem reflexes with all responses and signs of life absent. He was pronounced dead at 8.40 am with his family in attendance. (Statement of Dr Nick Edwards, Exhibits C2 and C2a).
- 2.10. There is no suggestion other than that both the resuscitation measures delivered at ARC and the medical care delivered at the RAH before the deceased succumbed on 6 March 2003 were adequate and entirely appropriate.
- 2.11. A post mortem examination was conducted by Dr Allan Cala, a Forensic Pathologist. An examination of the deceased's brain confirmed the presence of hypoxic

encephalopathy, no doubt attributable to oxygen deprivation caused by hanging. Dr Cala expresses the cause of death in his post mortem report (Exhibits C3 and C3a) as the consequences of hanging.

- 2.12. At post mortem Dr Cala also observed what he describes as multiple healing incised wounds on the right forearm, which appeared to have been self-inflicted. These cuts were also seen by CSO Thorpe during the resuscitation attempts. As seen earlier, cuts to the deceased's wrists had been observed by other prisoners some time before he hung himself. There is no evidence that this had been drawn to the attention of Correctional staff. However, after the events of the evening of 3 March, police examined and took photographs of the deceased's cell and quite clearly he had very recently inflicted an injury upon himself that had resulted in a small amount of blood loss. There were drops of blood located on the floor and in a bowl, and the scene gave the appearance of the deceased having cut himself with a razor. Although the deceased had made earlier cuts to his wrist or wrists that had been observed by inmates, but which had not been reported to or observed by Correctional staff, there is no warrant for the conclusion that the blood in the deceased's cell to which I have referred should have been detected by Corrections staff and have alerted them to the possibility of the deceased self-harming. I think it more likely than not that the deceased inflicted much of what Dr Cala observed after he had been locked down at 4 pm that afternoon. He was clearly in a self-harming frame of mind as evidenced by his utterances to his partner on the telephone that day and by his efforts at hanging himself. The blood spots were described by Mr Darrell Smedley, Manager of the Intelligence and Investigations Unit of the DCS as being fresh and still wet. (T122). Moreover, the cells were inspected every morning for cleanliness, and again before lock down at 4 pm, and I think it highly unlikely that if the blood had been present for a significant period of time it would not have been detected by Corrections staff. I accept the evidence of CSO Thorpe that action would have been taken in such a circumstance. He was asked:

'Q. Would action be taken if on a routine inspection blood on the floor or blood in a pot like that was detected.

A. Yes, action would be taken, yes.

Q. What sort of action would be taken.

A. You'd question the prisoner where it came from, check his arms and go from there. If he's attempted to slash up you would call the boss in and get him to do whatever he had to do.

Q. So on this particular day there would have been a - the last routine inspection before this man was discovered hanging would have been what, about 4 o'clock.

A. About 4 o'clock.

Q. Now if he cut himself and the blood, if it is blood, let's assume it is blood that we see in those photographs was the product of him having cut himself then from what you've told me are you saying that that would more likely to have occurred after he had been locked down.

A. I would say so. If it is blood it looks really fresh actually.

Q. Because chances are the blood if it is blood, the blood on the floor and the blood in that pot would have been detected at the last routine inspection at about 4 and action would have been taken.

A. I don't think you'd miss it. Yes.' (T91-T92)

2.13 I also accept the evidence given by various witnesses that DCS staff were not aware of any other evidence from which a conclusion could be drawn that the deceased was likely to harm himself.

3. The principal issue arising at the Inquest – Hanging points

3.1. There was much discussion during the course of the Inquest as to ways and means of predicting, and thereby preventing, self-harming behaviour of the type witnessed here. I will briefly return to some of the suggestions postulated in this regard. Some have merit and some don't. It seems to me that the crucial issue, and an issue by no means unidentified before this Inquest, is the need for the elimination of obvious hanging points from cells, particularly those cells that are habitually utilised for single accommodation. Mr Smedley, to whom I have already referred, has investigated many deaths in custody and has made numerous consequent recommendations. He was asked by counsel assisting me, Ms Shaw,

'Q. Based on your experience what would you identify as the most pressing issues that need to be addressed in firstly, the Remand Centre, in terms of making the cells safer.

A. Hanging points.' (T135)

I agree with that observation. It is an issue of supreme importance, especially when prisoners at risk of self-harm remain unidentified within the prison population.

3.2. It is not overstating the position to say that the hanging point provided by the grille over the air vent was obvious, available and effective. Not only obvious to a prisoner intent on self-harm, but clearly so in my view to anyone. And yet in spite of all the recommendations made in Coronial inquiries held both before and since the events with which this Inquest is concerned, Cell 20 in Unit 4 of the ARC, according to the evidence, remains in the same state, a state of affairs that is as dangerous as it is disappointing.

3.3. It is as well to remind the general public of the nature of previous recommendations.

- 'That D.C.S. urgently reconsider its policy of reliance upon the detection of "at risk" prisoners, and instigate a programme of refurbishment of the cells in "B" Division so that hanging points are minimised to the greatest extent possible consistent with the safety, dignity and comfort of the prisoner.'

(Damien Troy Wakely, Inquest Number 7/95)

- 'All cells in Unit 3, B Division, at Yatala should be modified to eliminate or at least minimize hanging points'

(Simon John Baillie, Inquest Number 24/97)

- 'Recommendations have been made in coronial findings from earlier inquests to the effect that so-called hanging points ought to be removed, or at least minimised. This would include piping in "B" Division. (I refer to the findings of the State Coroner in the matters of Wakely (Inquest No. 7 of 1995), Goldsmith (Inquest No. 6 of 1996) and Bonney (Inquest No. 28 of 1996)). The piping remains, notwithstanding those earlier recommendations.

Whilst recognising the practical difficulties associated with the complete removal of hanging points, not the least being expense, I do not think that the problem can simply be ignored. Prisoners recognised as being at risk of self-harm ought not be housed in cells where there are such obvious means by which suicide can be facilitated. **The problem becomes more complex when it is remembered that many persons who suicide are not seen to be at risk of self-harm prior to killing themselves.** I do not think that the issue is adequately answered by a response to the effect 'you can hang yourself from anything or anywhere in a prison, you can hang yourself six inches off the ground, a person who is determined to kill themselves can find a hanging space anywhere' (see Ms Vardon's evidence, T442). (Emphasis added).

Whilst it might be said that a complete refurbishment of all cells is impractical (the position adopted by the Department for Correctional Services), I cannot help thinking that, at the very least, persons who had been assessed by the prison authorities to be at risk of self-harm, ought not be housed in cells with such obvious hanging points. I recommend accordingly.'

(Daniel Mark McGuire, Inquest Number 46/98)

- '... 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.'

(Laurens Adrian Keith Nobels, Inquest Number 43/00)

- '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.'

(Alexander Wayne Keith Varcoe, Inquest number 2/03)

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

(Margaret Lindsay, Inquest number 13/03)

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

(Brian Keith Dewson, Inquest Number 1/04)

- 'That Group 4 take appropriate steps to ensure that, in accordance with principles developed in the 'safe-cell' project, cells used to accommodate prisoners at Mount Gambier Prison are designed to ensure that hanging points are kept to a minimum.'

(Troy Philip Turner, Inquest number 27/04)

- 'I am unable to say how it could be that Room 1 in the Yatala Labour Prison infirmary could have such an obvious hanging point, especially since it is used for 'at risk' prisoners. I must therefore make a further recommendation that all infirmaries be assessed as part of a comprehensive review of cells controlled by DCS in accordance with the principles of the safe cell project.'

(Ian McLeod, Inquest Number 12/05)

3.4. It will be seen from these recommendations that some were made in the context of the suicides of prisoners with a known risk of self-harm. But the highlighted remarks of the previous State Coroner, Mr Wayne Chivell, in the McGuire Inquest concerning prisoners who are not seen to be at risk are in my view valid and bear re-emphasis. At the moment, prisoners at the ARC are formally screened for risk of self-harm only the once, that is when they are inducted to the institution. As seen, Damian Cook's analysis in this regard was unremarkable and yet by March 2003 he was suicidal. He said he was going to kill himself and that this is exactly what he did. In my opinion, it is no answer to say that his behaviour could not be predicted when at the end of the day such obvious means to act out his suicidal thoughts had been made readily available to him.

3.5. The recommendations made in the Turner, Lindsay, McLeod and Dewson Inquests refer to the ‘Safe Cell Project’ or ‘Safe Cell Principles’. The principles underpinning the safe cell concept are embodied in the Victorian Department of Justice, ‘Cell and Fire Safety Guidelines’, Revision 5, September 2003. The cell safety objectives contained within the document are as follows:

- '32. The objective of the Cell Safety Guidelines is to provide prescriptive design provisions on new cellular accommodation in order to reduce the risk of hanging points; self-harm and fire safety within the cell to a level acceptable to key stakeholders. As described earlier in this Guideline, these design provisions have been developed from “Fire Safety Issues and the Removal Obvious Hanging Points from Mainstream Prison cells within the Victorian Correctional System” developed by the building Design Review Project (BDRP), of the office of the Correctional Services Commissioner, June 2001 (the ‘BDRP report’).
33. The cell Safety Guidelines have been provided within the context of Part A: Overview of this document, such that cell safety design should be;
- minimise the risk and consequence of self-harm in prison cells, through application of the cell safety design provisions in this Part B;
 - recognise that the safety of the occupant(s) of the cell of fire origin cannot be guaranteed in the event of a major deliberate cell-based fire, however, the cell design, fuel load and fire safety systems can be designed to minimise the risk. This is not to suggest that high levels of life safety cannot be achieved with cell and fire safety being oriented to reduce the risk and consequences of an accidental or deliberate fire;
 - present a holistic safety risk management approach to project implementation, as described in Part D, allowing reconciliation between potential design conflicts between cell and fire safety solutions in individual (existing) prison facilities;
 - identify and treat design risk within the context of the proposed or existing prison operational environment, recognising requirements of prison operators and other ancillary services providers (such as fire, police and emergency services) to maintain prison security, safety and service integrity;
 - recognise the design should in no way compromise the principal of providing a humane and safe living environment; and
 - develop effective key stakeholder participation and ensure the risk management process is cognisant of the importance of appropriate approvals by key stakeholders and their advisers, at identified stages in the design and construction process.'

(Exhibit C26b)

The document then sets out a number of “Cell Safety Provisions” which illustrate the design specifications of the cell features that ought to provide an acceptable level of

safety. It is worthwhile observing that ventilation grilles are specifically dealt with, the recommended specification being:

'grilles to be unpainted perforated framed stainless steel mesh with 1.6mm diameter holes.'

It is not difficult to understand why grilles should be so configured. A grille that allows for a ligature to be threaded through its slats, as was the case here, provides an obvious hanging point. Such a proposition seems to hardly require stating.

- 3.6. I am told that the relevant Victorian authorities have acted upon the principles and recommendations involved in the safe cell concept. Mr Alan Martin, who is the Director of Financial and Physical Resources for the South Australian DCS, and whose duties include the oversight of the Department's budgetary processes and capital works, told me that Victoria was the first State to implement a comprehensive Safe Cell Project at an estimated cost of about \$55 million, to be allocated over a ten year period.

4. Efforts at funding and implementing safe cell principles in South Australia

- 4.1. By way of contrast to the Victorian position, South Australia's safe cell response appears to have been conducted in an ad hoc fashion. Although I accept Mr Martin's statement in Exhibit C26 that the DCS has been conscious of the issue of hanging points in the prison system for some time, the works have been carried out in the main, it seems, when a specific problem has been identified through a tragic event. In his statement Mr Martin cites examples of where various hanging points have been eliminated or modified after a particular hanging has resulted in the identification of the hanging point. On that basis one would have thought that by this time the grilles in the cells in Unit 4 would have been eliminated. They have not. In this regard I was told by Mr Stephen Raggatt, who is the General Manager of the ARC that the grilles in Unit 4 remain in the same configuration. The obvious ligature point thus remains. It is difficult to see how such a situation can be tolerated. As seen, the Victorian document to which I have referred clearly identifies ventilation grilles as features of concern and recommends mesh with small holes rather than slats. The South Australian experience, based on the events with which this Inquest is concerned, is proof positive that a grille with slats is a hanging point and it gives much impetus to the Victorian recommendation.

- 4.2. I find that the DCS has been active in endeavouring to secure funds to improve cell safety across the board. It secured \$560,000 from Government to address several identified risk exposures in the prison system. That funding was additional to its usual budgetary funding. In each of the financial years ending June '04 and '05 respectively, \$200,000 of that figure was spent. In addition, some \$600,000 or so within the DCS' own budget was spent on reducing risk exposure in various DSC institutions in the State. I am told, and I accept the evidence, that all new cells, such as those in the Mobilong institution, are constructed in accordance with the safe cell design and principles.
- 4.3. Bringing existing cells into line with safe cell design is the problem. I accept also that DCS genuinely desires to implement safe cell design in all existing institutions. The creation of a new men's prison and women's prison is seen to be the ideal. On the other hand, the ARC which is the institution we are concerned with here, is by and large a relatively recently built institution and I know of no plan to replace it. Given the Department's expressed fervour for the implementation of safe cell design, all I can say is that it is surprising that cells like Cell 20 in Unit 4, in which cell Damian Cook hung himself, remain the same.
- 4.4. The DCS still has \$160,000 of the \$560,000 to spend. It intends to apply this money towards improving cell design in the current financial year. Recognising the cost of retro-fitting all existing cells to safe cell principle standards, and following the Victorian lead, the DCS conducted an audit and concluded that in order to retro-fit existing cells to incorporate safe cell parameters, it needed an estimated \$40 million to be spent over ten years, that is \$4 million per year. Mr Martin told me that a cabinet submission was prepared and funding was sought from government in accordance with that estimate. I also received in evidence two letters from Mr Peter Severin, who is the Chief Executive of the DCS, that deal with the same issue. One of the letters, (Exhibit C28), is dated 29 June 2005 and is addressed to the State Coroner. The letter deals with the State Coroner's recommendations concerning safe cells in the Dewson Inquest already referred to. It will be remembered that Mr Chivell made the unequivocal recommendation in that Inquest that safe cell principles should be adopted and implemented in prisons in South Australia as a matter of urgency. The other letter, sent by Mr Severin to me in my capacity as Acting State Coroner, and

dated 7 July 2005 (Exhibit C22), addresses certain recommendations made within the DCS following Mr Cook's death. Recommendations 3 and 4 were as follows:

'3. The Director Financial and Physical Resources provide an estimate of cost to convert all prison cells to meet the safe cell guidelines as contained in the 2003 Victorian report.

'4. The Chief Executive upon receipt of this estimate seek appropriate funding from Government to modify all cell accommodation to comply with safe cell design guidelines as contained in the 2003 Victorian Report.

- 4.5. The \$40 million estimate needed to remove hanging points throughout the State over ten years, as described in the previous paragraph, was generated consequent upon these recommendations. Both of Mr Severin's letters make it clear that the subsequent submission to Government for the necessary funding was rejected because, to quote Mr Severin in both pieces of correspondence, it "*did not receive priority over other State Government initiatives*". I accept what Mr Severin has said in these two letters. What he said was essentially confirmed on oath by Mr Martin.
- 4.6. It is not for a Court such as this to indulge in dogmatic platitudes about the manner in which a government should deploy its limited financial resources. But the safe cell concept has been placed on this particular government's agenda for a considerable period of time now and others might be heard to say quite convincingly that the time has come for that issue to be accorded some priority. Mr Martin told me that the total annual budget of the DCS is as much as \$130 million per year approximately, all of which naturally emanates from government coffers. That begs the question as to why an extra \$4 million would be withheld. I asked Mr Martin:

'Q. So when you say about 130 million you're looking for essentially on a yearly basis another four million to add to that.

A. That was the submission.

Q. Is the department's annual budget revised every year.

A. Is it revised every year?

Q. Yes.

A. It's adjusted every year but not completely revised, yes.

Q. And adjusted upwards I presume.

A. We normally hope so, for wage increases and increases in general costs.

Q. Why can't you factor into your annual budget the increased cost of keeping people safe.

- A. The budget increases we get each year are usually the additional funding we require for wage costs. That 130 million I refer to is expended on the wage and salary costs for the employees and the operating costs of the prisons in terms of all of the requirements for prisoners for food, utility charges, all those sorts of things. The increased funding we get each year is usually just supplementation for normal wage increases and CPI increases, so the funding increases each year wouldn't permit us to set aside if you like that sort of funding to undertake this work.
- Q. So that would be a completely new item of expenditure which would require an additional appropriation.
- A. That's correct.
- Q. But is it fair to say that the four million, the extra four million that would be required, compared to the total annual budget of about 130 million, is not a significant proportion of that total budget is it. I'm not saying it's not a lot of money, but it's not a significant proportion of the total annual budget is it.
- A. Probably if you look at it in percentage terms it mightn't appear so, but I can certainly assure your Honour that the department's budget is very tight indeed and we certainly don't have the capacity to maintain our existing services and find the sort of money that would be required to undertake a project of this nature without cutting back somewhere else in services.
- Q. I appreciate that, you don't want to rob Peter to pay Paul, but if you were to ask for and received another four million a year on top of the approximate figure of 130 million a year, that would not be a huge proportion of what you're already getting from government would it, that extra four million.
- A. I guess not, no.' (T164-166)

4.7. It will be left for others to judge whether that extra \$4 million per year ought to be appropriated given the already significant budget the DCS operates under and the proportion the extra funding would bear to that budget. Mr Martin also said that the DCS intended to revisit the cabinet submission during the course of this financial year. At the time of the Inquest, a more detailed audit undertaken to identify hanging points in cells was reaching completion. When that audit is completed the intention is that the DCS will:

'assess the risk to prisoners presented by the hanging points in each area having regard to the type of prisoners that are kept in the different units within the system and look at a way of prioritising those potential risk exposure for expenditure and to address them'.
(T156)

After these exercises are complete, the matter will be costed and the expectation is that sometime later in the year 2005 the DCS will be in a position to re-present a

submission to Government that again seeks the necessary funding but which will address prioritisation of works. To use Mr Martin's words:

'We will certainly have a better idea of how that money could be best used and then that's a matter that we would raise with our minister' (T157)

4.8. Mr Martin also told me that a submission will be going to Government later this year relating to possible construction of a new men's and women's prison which will ideally incorporate the Victorian safe cell guidelines.

4.9. I return to these issues when I deal with my recommendations.

5. **Other issues arising at the Inquest**

5.1. A number of other issues were canvassed in this Inquest. Some of these issues had no real relationship to Mr Cooke's death. In the main they concerned perceived procedural irregularities such as, by way of example, an issue related to the number of Corrections officers required to be present when a cell is opened. I need say no more about issues such as that.

5.2. I have already mentioned the issue about there having been no further screening of the deceased since his admission to the institution and a lack of perception by DCS staff as to the suicidal frame of mind of the deceased.

5.3. A number of suggestions designed to remedy this situation were proffered at the Inquest. I do not subscribe to the suggestion that when prisoners are admitted to the ARC they should be asked to provide information, as part of their own screening process, about the frame of mind of other prisoners whom they know to be in the institution. I would reject that suggestion for much the same reasons as it was rejected by the witnesses who gave evidence before me. At induction, inmates are generally pre-occupied with their own personal predicament and the last thing on their minds would be the predicament of other inmates. As well, I can readily understand that they would want to avoid being seen as "dobbing" on a fellow inmate as soon as they have arrived at the institution. In any event, such an approach would probably only serve to develop a body of intelligence that was both inaccurate and misleading. This is not to say that inmates should not be encouraged to pass on any concerns that they may have that a fellow inmate is at risk, as and when those concerns arise. Such encouragement seems to be desirable. In this regard, I observe that in 1996 the

former State Coroner Mr Chivell, in the Inquest into the death of Kamahl James Goldsmith (6/96), made a relevant recommendation which I will set out in another section of the findings.

- 5.4. Another suggestion had merit. It is that the families and friends of inmates be encouraged to pass on their concerns about the welfare of those inmates. At present, there is no documented procedure for staff to follow in the event that a visitor expresses concern about the welfare of an individual. As it happens, research reveals that a recommendation covering this issue was made in 1996 in the Inquest into the death of Christopher Mark Bonney (28/1996).
- 5.5. The question of more frequent screening at the ARC is a difficult one. Mr Cook's suicidal frame of mind was simply not detected by DCS staff. On balance, my view is that there ought to be in place, especially at the ARC where inmate's circumstances and frames of mind can be in a constant state of flux, a regime whereby screening for risk of self-harm should occur on a more regular basis. It was suggested during the Inquest that additional screening might take place when an inmate returns from a court appearance, be it favourable or unfavourable, or say, on a monthly basis. It is difficult to be overly emphatic about this because there are resource implications and it has to be conceded that even within a period of a month an inmate's circumstances and frame of mind might change for the worse and still not be detected. I also return to this issue in my recommendations.

6. Conclusions

- 6.1. Damien John Cook was admitted into the ARC as a prisoner on remand on 8 October 2001. He was thereafter at all material times in lawful custody.
- 6.2. By 3 October 2003 his frame of mind had deteriorated to the point where he harboured a strong desire to take his own life. That desire, although known or at least suspected by other inmates, was neither communicated to nor detected by DCS staff.
- 6.3. On 3 October 2003 the deceased occupied cell 20 in Unit 4 at the ARC. This cell had an obvious hanging point, namely the slats of a grille covering an air vent. It's utility as a hanging point was enhanced by the location of a shower rose almost immediately below it.

- 6.4. On 3 October 2003, the deceased deliberately hung himself by tying a ligature to the grille, the shower rose and then his own neck. He did so without the assistance or involvement of any other person.
- 6.5. By the time the deceased was discovered, he had suffered a fatal hypoxic brain injury.
- 6.6. Appropriate resuscitation efforts were applied to the deceased, so much so that his cardiac arrest was reversed. Unfortunately, despite appropriate medical attention furnished by the RAH, he died on 6th March 2003, essentially from the effects of an hypoxic brain injury.
- 6.7. The cause of the deceased's death was the consequences of hanging.
- 6.8. As at the time of this Inquest the obvious hanging points in Cell 20 in Unit 4 still remain.

7. **Recommendations**

- 7.1. Section 25 (2) of the Coroner's Act 2003 empowers the Court to add to its findings any recommendations that might, in the opinion of the Court, prevent, or reduce the likelihood of, a reoccurrence of an event similar to the event that is the subject of this Inquest.
- 7.2. The Court makes the following recommendations:
 - 7.2.1. That the DCS forthwith remove or modify the hanging points in Cell 20, Unit 4 identified in this Inquest so as to eliminate or minimise to the greatest extent possible the risk that they will be used by an inmate for the purpose of self-harm or suicide.
 - 7.2.2. That in so far as those same potential hanging points exists in other cells in the ARC, that the DCS forthwith remove or modify them so as to eliminate or minimise to the greatest extent possible the risk that they will be used by an inmate for the purpose of self-harm or suicide.
 - 7.2.3. That all other hanging points within the cells at the ARC be identified and either removed or modified so as to the eliminate or to minimise to the greatest extent possible the risk of an inmate using them for the purpose of self-harm or suicide.

- 7.2.4. The recommendations made in the Inquest into the deaths of Margaret Lindsay and Brian Keith Dewson are here repeated with emphasis, namely that the “safe cell” principles be adopted and implemented by the DCS in prisons throughout South Australia and done so as a matter of urgency.
- 7.2.5. That the DCS expedite its current audit as described in paragraph 4.7 and then, as a matter of urgency, make a further submission to Government for the necessary funding to implement safe cell principles in prisons throughout South Australia.
- 7.2.6. That the South Australian Government, upon receipt of such further submission from DCS, reconsider its earlier decision not to accord priority to the implementation of the safe cell principles in prisons throughout South Australia.
- 7.2.7. The recommendation made in the Goldsmith Inquest, already referred to herein, is repeated, namely, that continuing efforts should be made by DCS to encourage prisoners to pass on concerns or information they may have that a fellow prisoner may be at risk either to custodial officers, Aboriginal Liaison Officers, or any other appropriate person.
- 7.2.8. The recommendation made in the Bonney Inquest, already referred to herein, is repeated, namely, that the DCS make continuing efforts to educate prisoners, and families, friends and associates, of the urgent need to pass on any concerns about the mental health of a prisoner to the medical or custodial authorities at the prison so that adequate measures can be taken to protect the prisoner from self-harm. In the same regard, I make the following recommendations:
- (i) that the DCS place in visitor’s waiting areas in the ARC information that would enable a visitor or other person concerned for the welfare and safety of an inmate, particularly in relation to the possibility of self-harm, to register formally their concerns, and
 - (ii) that the DCS establish a formal procedure to enable expressions of concern so made to be registered and acted upon by ARC staff.

7.2.9. That the DCS establish a panel to examine the feasibility of introducing a regime whereby inmates at the ARC are formally screened for risk of self-harm on a more regular basis.

Key Words: Death in Custody; Suicide; Prison (cell design)

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

Seal the 27th day of September, 2005.

Deputy State Coroner

Inquest Number 18/2005 (0573/2003)