



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Port Lincoln in the State of South Australia, on the 30<sup>th</sup> and 31<sup>st</sup> days of January 2006, the 1<sup>st</sup> and 2<sup>nd</sup> days of February 2006, and the 28<sup>th</sup> day of April 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, a Coroner, into the death of Darryl Kym Walker.*

*The said Court finds that Darryl Kym Walker aged 31 years, late of Port Lincoln Prison, Pound Road, Port Lincoln died at Port Lincoln Prison, South Australia on the 2<sup>nd</sup> day of June 2003 as a result of the consequences of hanging. The said Court finds that the circumstances of his death were as follows:*

### **1. Reason for Inquest**

- 1.1. At the time of Mr Walker's death, he was being detained in Port Lincoln Prison within the State of South Australia. In accordance with section 21(1)(a) of the Coroner's Act 2003 and the transitional provisions of the Schedule to the Coroner's Act, this being a death in custody, an inquest is mandatory. (Part 16 Transitional provisions 25 (3)).
- 1.2. The fact that Mr Walker was an Aboriginal person in custody at the time of his death raises additional considerations touching upon recommendations made following the Royal Commission into Aboriginal deaths in custody in 1991.

### **2. Summary of facts and circumstances surrounding Mr Walker's death**

- 2.1. At 4:27pm on Monday 2 June 2003, Mr Walker was discovered hanging from a bed sheet attached to an open grill above the doorway into the shower block in unit 7 at

Port Lincoln Prison. The last time he was seen alive was said to be during a brief check of the unit, less than 10 minutes earlier, at 4:15pm when he was given some cigarette papers by corrections officer Lindsay Dodd. According to Mr Dodd, Mr Walker appeared relatively calm at this time and gave no indication that he intended to harm himself.

2.2. Mr Walker was at the time of his death, the only prisoner housed in unit 7. This unit was separated from the rest of the prison and was comprised of 4 cells, a small association area and a shower block. Mr Walker was transferred to unit 7 the previous day from the mainstream area, after prison nurse Kathryn Mercer had an encounter with him, which made her concerned that his mental health was deteriorating. Mr Walker suffered from chronic schizophrenia. He was also diabetic. He had virtually no insight into the seriousness of his health problems and without supervision, was non-compliant with prescribed treatments.

2.3. Unit 7 was used as a “management unit” for prisoners requiring different management strategies. It was sometimes used as a punishment and at other times to enable prisoners to have “time out” from other prisoners. Mr Walker had been placed in unit 7 on a number of occasions previously. One such occasion was on 7 May 2003 to try to control his sugar intake and stabilise his blood sugar level. On this occasion Mr Walker was described as “thought blocking and unpredictable” and nurse Christine Resnais noted that a prison officer should be nearby when Mr Walker was being seen by nursing and medical staff. (Exhibit C30e)

2.4. 1<sup>st</sup> June 2003

On Sunday 1<sup>st</sup> June 2003, corrections Officer Leon Earl commenced his shift at 8:00 am. He was supervisor of operations and the officer in charge of the prison. His duties included assisting nurse Kathryn Mercer during the administration of methadone to those prisoners entitled to receive it. Mr Walker was not one of those prisoners. (T121). Mercer was a registered nurse who worked 3-hour morning shifts on weekends on a casual basis at the Prison. As part of her duties, she was required to obtaining a small sample of blood from Mr Walker to measure his blood sugar level. It involved a thumb prick to extract a drop of blood. After doing this test, Mercer spoke to Mr Walker about the results. She warned him of some of the unpleasant things that might happen to his body if he failed to cooperate by reducing his sugar consumption. This was not the first time; a prison nurse had tried to educate

Mr Walker about the dangers of consuming sugar. On this occasion, it provoked an aggressive response from him. (T46)

- 2.5. Nurse Mercer had become familiar with Mr Walker during her casual work at the prison. She had recently obtained her mental health nursing qualifications. Because of her concerns for Mr Walker's mental health, she conducted a partial mental state examination and noted her observations in the prison health notes as follows:

‘Darryl appears agitated & unpredictable today, more so than at other times when I have seen him.

His Zuclopenthixol is not due for 7 days.

Appearance dressed in shorts & green ‘T’ shirt.

Behaviour: restless, suspicious, edgy and easily becoming aggressive in response.

Conversation: good clarity & tone & flow appears slightly preoccupied and takes time to reply.

Affect: hostile in response to questions, labile in mood.

Perception: state (sic) that he is not hearing voices.

Cognition: lacks concentration, appears to be thought blocking.

Rapport difficult to establish without pt becoming agitated.

Minimal insight – co-operative about going into Cell 55 & taking chlorpromazine 200 mg stat. @ 1115 to be observed in cell.’

(Exhibit 30e)

- 2.6. Nurse Mercer believed that in his aggressive state, that Mr Walker should be kept isolated from other prisoners and have a bit of space. She thought he might be vulnerable to reactions from other prisoners and possibly from himself. She didn't really know what he was capable of, but didn't think to question him about whether he had thoughts of self-harm. (T27, T33)
- 2.7. Because Nurse Mercer was due to finish her shift around midday, she was concerned about leaving Mr Walker without nursing supervision in his “unsettled state”. She was aware that Mr Walker had recently shaved his eye brows and so had a “gut feeling” that if he had done this, he might do something else. (T29) Whilst Mercer was unable to recall the name of the officer she spoke with about Mr Walker at this time, other evidence suggests that it was Leon Earl. She claims that she conveyed her concerns to the officer about Mr Walker. There is no independent record of this communication.
- 2.8. Nurse Mercer asked Mr Earl if Mr Walker could have “camera watch” and this was agreeable to the officer as well as Mr Walker. (T30) She issued an instruction that Mr Walker be given some medication to calm him down. Chlorpromazine had been

prescribed by a medical officer on 2 May 2003 on a discretionary basis, up to a maximum dose of 200 mg. Nurse Mercer instructed officer Earl to give him the maximum dose, which was subsequently issued by Mr Earl from a container known as a “Webster pack” at about 11.15am. This container was pre-packed in advance by a pharmacist and contained medications separated out and marked in accordance with administration requirements. (T32 & T123, Exhibit C30e)

2.9. A decision was made to move Mr Walker into cell 55 of unit 7 to enable officers to observe him electronically from a monitor in the control room. Cell 55 was the only cell in unit 7 with an observation camera. Mr Earl claims that he explained to Mr Walker that because of the extra medication that he had been given, he would have to be observed which meant the he would have to be put “under camera in unit 7”. He claimed that Mr Walker was happy to receive the medication and was happy to be placed in unit 7. (Exhibit C32b & T123)

2.10. At about the same time that Nurse Mercer instructed the Chlorpromazine to be administered to calm Mr Walker down, an entry was made in the Case Management system, for the Department for Correctional Services (DCS) allegedly by officer David Redman as follows:

‘Walker came into the unit office stating that he was feeling silly and stupid, and that he needed to go to James Nash House or Glenside. I asked him what he meant and he said ‘do you want me to get the bin and throw it in the office’ in a threatening manner. Over the last few days his moods have been changing from being demanding and aggressive to calm and apologetic (sic)’

Exhibit C32b

2.11. At 11.55am on the same morning, an entry made purportedly by Mr Earl in the case management system data base reads as follows:

‘Darryl has been placed in cell 55 to monitor his behaviuor (sic) as he his (sic) having trouble with his mental state. The prison nurse has given Darryl some of his medication to try and settle him, he will need to be reviewed by the medical team Monday the 2/6/03 to(sic) his medication and placement’.

Exhibit C32b

2.12. It is reasonable to assume that all officers had access to this data base and could keep themselves informed of relevant matters concerning prisoners in their care. On the other hand, this information was not necessarily conveyed to nurses or medical practitioners who relied instead on separate confidential health notes to document their observations and medical management.

- 2.13. Nurse Mercer decided to discuss her concerns about Mr Walker's deteriorating mental state with off duty nurse Christine Resnais, who whilst not having any mental health qualifications, was more familiar with Mr Walker's health issues generally because she was the permanent full-time nurse at the prison, working Monday to Friday each week. Mercer telephoned Nurse Resnais at home and described the situation to her. (Exhibit C31 p16) Ms Resnais decided that she would advise Dr O'Brien Forensic Psychiatrist the next day that they could no longer manage Mr Walker at the Port Lincoln prison. (Exhibit C29a p13)
- 2.14. When Mr Walker was moved to unit 7, he was provided with his own clothing, bedding and smoking equipment. In officer Earl's incident report, completed shortly after Mr Walker's death, he stated the following;
- 'I gave him the option to get anything out of his cell he wanted. He went to his cell unescorted, gathered the belongings he wanted and returned to unit 7. While he was doing this I checked unit 7 for any hazards and followed protocol for that area'.  
(Exhibit C32b)
- 2.15. If this check was done, it must have been cursory at best. A glance of the unit as depicted in photographs taken of that area shortly after Mr Walker's death reveal a number of items which were in unit 7 at the time of Mr Walker's death which were potentially hazardous. (Exhibit C23c) This is concerning, given that unit 7 was an area where prisoners such as Mr Walker were sometimes placed because of concerns for their welfare. Included in these items were lengths of cable, a plastic bag, a cigarette lighter, a plastic bucket and a larger metal bin. An obvious hanging point in the association area was the open grille above the doorway into the shower block. Mr Walker was provided with bed sheets and was wearing footwear with shoe laces. He was an aboriginal prisoner in custody, suffering from a deterioration in his mental illness. These two factors increased his risk of committing an act of self harm.
- 2.16. Leon Earl set up a television in the corridor outside of cell 55 on a table, using an upturned metal bin for elevation. This allowed Mr Walker to view it through the trap in his cell door if he was standing up. This gesture demonstrated an awareness by the correctional service officers of the desirability of providing some stimulation for prisoners who are isolated from the mainstream population. The necessity to use this make-shift set-up on this occasion is another illustration of how inadequate the facilities were in unit 7 for separated prisoners.

- 2.17. Robert Moore was a designated peer support prisoner who visited Mr Walker after he was transferred into Unit 7 and supplied him with tobacco. Mr Moore claimed that he heard Mr Walker yelling out to an officer whom he believed was Lindsay Dodd and that he later heard Mr Dodd complaining “I’m not putting up with that shit all day”. (Exhibit C17a) If anything like this did occur, it could not have involved Mr Dodd, because he was not working at the prison that day.
- 2.18. During the afternoon of 1 June, Mr Earl permitted Mr Walker to shower unsupervised and at about 4:30 pm, Mr Earl advised the next shift of officers that Mr Walker was in unit 7 because he was having difficulty with his medication and that the nurse had given him part of his evening medication to settle him. He advised the officers that there was no requirement to have Mr Walker under constant observation. (Exhibit C32b)
- 2.19. When Mr Walker was placed into cell 55, the observation camera was activated, but images were not recorded. There is no record documenting how regularly Mr Walker was being monitored once he was placed in unit 7. Mr Earl secured Mr Walker in his cell after he was showered and claims that Mr Walker was “quite happy about that”.
- 2.20. Before Nurse Mercer left for the day around midday, she saw Mr Walker in his cell and thought that he seemed calmer. Mr Earl observed him at about 5 o’clock before he left for the day and saw that he was lying on his bed and seemed alright. (T127) Mr Walker was due to receive more medication at 8:00 pm that evening, but prison officers reported that they were unable to wake him by calling out to him through the trap and therefore allowed him to sleep. Officer Eric Harrison recorded in the case management system that Mr Walker had no problems by 8.56pm and had been quite calm. (Exhibit C32b)
- 2.21. Monday, 2 June 2003  
Mr Earl returned to work at 8:00 am on Monday, 2<sup>nd</sup> June as supervisor of operations. He assisted Nurse Resnais with the Methadone administration and issued Mr Walker his 8:30 am medication at his cell in unit 7. After releasing Mr Walker from his cell, he let him walk unescorted to the kitchen for breakfast. (Exhibit C32b) Mr Earl claims to have inserted Mr Walker’s name in the “appointments book” to be seen by Nurse Resnais and to discuss the issue of him being seen by the local doctor. (T129)

He had a discussion with the nurse and understood that she was going to discuss the matter with Dr Ken O'Brien.

- 2.22. When Nurse Resnais went to see Mr Walker, she saw him walking around the association area of unit 7. He said hello to her through the window in the doorway dividing unit 7 from the corridor leading to the nurses office. (Exhibit C29b) Because of the conversation she had had the previous evening with Kathryn Mercer, Nurse Resnais raised her concerns with General Practitioner Dr Sam Bouwer, when he attended the prison that morning for his regular consultation.
- 2.23. Dr Bouwer generally spent approximately an hour and a half on Monday mornings at Port Lincoln prison. He shared this task with Dr Krigge who attended on Fridays. Nurse Resnais discussed the issue of Mr Walker's deteriorating mental condition with Dr Bouwer and it was agreed that Mr Walker's recent behaviour represented another episode of agitation and aggression which meant that he needed to have his medication reviewed by Dr O'Brien who had seen him on 22<sup>nd</sup> May 2003 during his monthly visit to Port Lincoln prison. On that occasion, he noted that Mr Walker was becoming a "management problem" at Port Lincoln and may need a transfer to Yatala or James Nash House. (Exhibit C30e)
- 2.24. Dr Bouwer gave evidence during the Inquest. He said that he was not asked to personally examine Mr Walker that Monday morning. He decided that it was unnecessary, given that Mr Walker would soon be reassessed by Dr O'Brien who was more familiar with him. From what he was told by Nurse Resnais and from his previous dealings with Mr Walker, he did not believe that the present conduct represented an episode where he was at high risk of self-harm. He was aware of one previous incident where Mr Walker had threatened to harm himself if he was not provided with cigarettes and Dr Bouwer considered that this type of behaviour made Mr Walker very difficult to handle. (T229) Dr Bouwer explained the medications that were then being prescribed to Mr Walker as follows:
- 'Chlorpromazine 200 mg at night, which is an antipsychotic medication,  
Zuclopenthixol Depot an injectable antipsychotic medication, administered every two weeks.  
Metformin 1000 mg in tablet form, twice daily, which is close to, the maximum dose one can give. This is a diabetic medication.  
Diamicron 80 mg twice daily, also a diabetic medication.  
Olanzapine 20 mg at night is another antipsychotic medication' (T240).

2.25. Whilst it might have been prudent for Dr Bouwer to assess Mr Walker himself, I am not prepared to criticise him for not having done so. Dr Bouwer explained that he did not regard himself as having any particular expertise in psychiatry and therefore preferred that Dr O'Brien manage this particular episode. Dr Bouwer believed from past experience that Mr Walker was capable of calming down quite quickly sometimes, following a period of isolation. He explained the difficulties in managing Mr Walker as follows:

‘The dilemma with Darryl was also that sometimes loneliness is his worst enemy, so by isolating him his agitation would increase. So if there is good company around him he would calm down pretty quickly and you know an incident like with his cigarettes or lack of sugar would go out the window once he is mingling ...’ (T228)

2.26. Dr Bouwer recognised that the situation with Mr Walker had reached the stage where the prison nurses were no longer able to manage his condition in Port Lincoln and that he should be transferred and assessed as soon as it could be arranged.

2.27. Nurse Resnais telephoned Dr O'Brien and informed him of the developments with Mr Walker's behaviour and sought his approval to have arrangements put in place for Mr Walker to be transferred to Yatala Labour prison where Dr O'Brien could review him. The next available time for transfer of prisoners was in two days time, 4 June 2003. When Nurse Resnais spoke with Mr Walker again on 2 June after the decision was taken to have him transferred, Mr Walker appeared to be cooperative and calm and she believed that the episode may have been resolving. Although Nurse Resnais did not perform a mental state examination, she claims that she saw no sign of “suicidal ideation”. (Exhibit C29b) Of course, unless one took the time to inquire about suicidal ideation and had the necessary skill to interpret answers given, then one would not necessarily notice any sign of it. Nurse Resnais was an experienced registered nurse, but had no training in mental health.

2.28. In the course of making arrangements for transfer of Mr Walker, Nurse Resnais formed the view that Mr Walker should be kept under camera observation over night when he would be alone in his cell, but that during the day he could interact with other prisoners. She has stated her reasoning as follows:

‘From my dealings with Darryl he hated to be alone and needed to interact with other prisoners. It was my recollection that he was the only prisoner in the unit and I thought that it was better for him to be monitored by correctional services officers at night because he suffered from loneliness and, if alone and unobserved during the night, his

agitation may return. I had no concerns that he would attempt suicide.’  
(Exhibit C29b)

- 2.29. Whilst Nurse Resnais may have had these concerns from her previous experience, it seems that they were not conveyed effectively to those officers responsible for his welfare. Nurse Resnais was unavailable to give evidence at inquest and therefore could not clarify the precise nature of communication that she may have had with the officers about how Mr Walker should be dealt with whilst waiting for transfer to Yatala labour Prison. Apart from the confidential health records for Mr Walker, there is no prison record documenting any instructions given to the correctional services officers about this. From evidence heard during the inquest, it seems that some officers may have lacked the cultural awareness which might have alerted them to the potential risk which isolation posed for aboriginal prisoners in particular.
- 2.30. Nurse Resnais summarised her assessment in the prison health services notes as follows:
- ‘Staff increasingly worried about Darryl’s behaviour, erratic, volatile, confused, thought blocking, shaved his eyebrows off last week, & said that it “helped him think”. Rang Dr O’Brien – transfer to YLP on Wednesday for Psychiatric appointment ASAP. Raylee Kinnear & Richard CNC YLP notified, Port Augusta Prison medical staff also notified. I also have suggested camera obs while overnight with them. BSL – 10.8 mmls, allowed to go back to mainstream during the day & in the camera ob cell to sleep.’  
(Exhibit C30e)
- 2.31. Prison health service notes are regarded as confidential and are not available to correctional service personnel. There are sound reasons for maintaining confidentiality concerning health issues for prisoners. But where nursing or medical staff influence the manner in which prisoners are housed or separated from other prisoners, it is incumbent upon them to communicate all relevant information to officers responsible for the prisoner’s welfare in a reliable manner. Equally, it is necessary for officers to carefully document any advice given, for the same reason.
- 2.32. According to Nurse Resnais, when Mr Walker was in unit 7, he was usually fairly demanding of the officers, asking for cigarettes and information about his court dates. Because cell 55 was fairly close to the nurses’ office, she could often hear some of this interaction. (Exhibit C29a).
- 2.33. During Monday 2 June Mr Walker remained in Unit 7 all day but was not confined to his cell. According to Mr Earl, a decision was made that Mr Walker would remain in

unit 7 for monitoring. He claims that he advised unit manager Kevin Dolphin, Case Management Officer Ian Ward and Reception Officer Lindsay Dodd of the arrangements that had been made for Mr Walker's transfer to Yatala on Wednesday. (Exhibit c 32) Lindsay Dodd was in charge of the reception/control room during his shift from 8:00 am on 2 June 2003. He also had responsibility for prisoners housed in unit 7.

- 2.34. Mr Dodd claimed that he was not told about the arrangements made to transfer Mr Walker to Adelaide. (T303) According to Mr Dodd, he was not informed of the reason Mr Walker was placed into unit 7 and assumed that he was there for "time-out", because that is what had occurred on previous occasions, sometimes at Mr Walker's request. (T314) Whilst it is likely that Mr Dodd was given more information than he claims to have been given, I find that the information provided was inadequate. Even if Mr Dodd did not have any formal briefing from Nurse Resnais or any other person concerning Mr Walker's deteriorating mental health, he should have been able to access some relevant information about that by looking at the case management system entries made by officers the previous day. (Exhibit C32b)
- 2.35. Mr Dodd had worked at Port Lincoln prison for approximately 12 years and became familiar with many of the prisoners including Mr Walker. According to Mr Dodd, unit 7 was a small unit which was sometimes used for problem prisoners or prisoners who had been placed on separation orders. He explained how it operated as follows:
- ‘It's really a management unit for four prisoners requiring different regimes and different management strategies, however, it does get used at times as over flow accommodation and it also gives us an opportunity to put prisoners there who just need to get away from the general prison population for a little while and prisoners are often housed there at their own request.’  
(Exhibit C37 p4)
- 2.36. Mr Dodd claimed that Mr Walker didn't get along well with some of the other prisoners in the mainstream part of the prison and sometimes preferred to get 'specialised treatment' in separate accommodation. Mr Dodd was unaware of any previous incidents where Mr Walker had threatened self-harm. (Exhibit C37 p4 & T314) He had been off duty the previous 5 days and when he returned, he was busy carrying out his various duties in the reception/control room, attending to Mr Walker in Unit 7 and other duties. According to Mr Dodd, he was never advised by anyone

that Mr Walker was to be returned to the mainstream area of the prison during the day. (T297) This breakdown in communication is a concern, given that officers are under a legal duty of care and should be properly informed to carry out their responsibilities. (RCADIC)

2.37. On the morning of 2 June Mr Dodd, went to the main cellblock and assisted unlocking prisoners, before supervising prisoners' meals in the dining room. He then supervised the outside workers proceed through the back gate of the prison to the farm area. He returned to the control room by around 8:45 am. When he first saw Mr Walker, he had already been released from his cell and was free to walk about the small association area in unit 7, as well as the shower block area if he chose to. Mr Dodd stated that between 9:00 am and 11:30 am on this day he would have seen Mr Walker about 10 times and spoke to him several times. He claims that on each occasion, Mr Walker seemed "perfectly fine" and better than he had seen him for a long time. He claims that he didn't see any sign of physical aggression in Mr Walker's behaviour on 2 June but was aware that he had behaved aggressively a couple of weeks earlier. (Exhibit C37)

2.38. Mr Dodd accepted that Mr Walker could be demanding at times and that he required repeated explanations regarding his requests about when he had to go to court. He explained the situation as follows in a recorded interview conducted the day after Mr Walker's death:

'Oh, you know, he's, he's, can be demanding at times, not in a, not in a physical type sense but demanding of people's time um, it takes a long time to explain anything to Darryl um, he always has a lot of repeat requests like, he could ask you now about, when do I have to go to court, an hour later he'll ask you the same question.'

'He seems to have these bouts of, I'll call it mental illness 'cos I don't know what else to call it, but from my point of view, I just thought Darryl's mental condition was getting worse and worse every time I saw him, you know, ...losing his grip on reality or something, you know, he's just a bit more vague every time I sort of saw him.'

(Exhibit C37)

2.39. On 2 June, Mr Dodd was responsible for monitoring the pictures captured by the cameras in unit 7 where Mr Walker was housed. Mr Earl advised Mr Dodd that Mr Walker did not require constant observation. (T183) Mr Dodd maintained that he frequently looked at the monitor which displayed the images from 2 cameras in unit 7 in an alternating fashion. (Exhibit C37a) In addition to the camera within cell 55,

another camera was located in the association area of the unit above cell 58. This camera displayed a poor quality incomplete view of the association area. A convex mirror at the opposite end of the unit was relied upon to extend the view of the unit to the entrance of the shower block. The equipment failed to achieve its intended purpose and officers familiar with the equipment must have known that it was inadequate. The entrance to the shower block could not be seen on the monitor in the control room. It was in this “blind spot” that Mr Walker later that day, fashioned a bed sheet to the grill over the doorway and tied the other end around his neck. He hung himself after standing on a plastic bucket, kicking it out from under him.

- 2.40. Prisoner Michael Porter stated in evidence that over a period of some months, he witnessed occasions where Mr Dodd and unit manager Kevin Dolphin displayed an ignorant attitude towards Mr Walker’s requests which included requests for telephone calls. (T256) When this was put to Mr Dodd, he denied the allegation and said that he had developed a good rapport with Mr Walker and felt that because Port Lincoln Prison was a relatively small prison, he was able to get to know the prisoners quite well. In the absence of any other evidence in support of Mr Porter’s criticism of these two officers, I am not prepared to find this allegation proven, although I have no doubt that Mr Walker’s requests would have tested Mr Dodd’s patience. According to Mr Dodd, Mr Walker made several requests via his cell intercom for coffee and cigarettes. He also tapped on the window near the nurses’ office to get attention. Mr Dodd said that Mr Walker was continually going to the locked door to unit 7 in response to Mr Walker’s constant knocking and could see him through the glass panel in the door. (Exhibit C37 p12)
- 2.41. Prisoner Robert Genovese spent some time in the unit that morning, painting furniture. He claims that while he was there, Mr Walker seemed agitated and “sort of was in his own little world”. He saw Mr Walker knock on the shutter of the door to unit 7 a couple of times to get attention and he saw one of the officers, possibly Mr Dodd respond briefly and then leave. (Exhibit C15a)
- 2.42. Prisoner Michael Webber was in cell 58 of unit 7 for 5 days, while maintenance work was carried out in his cell elsewhere in the prison. According to Mr Earl, Mr Weber was rehoused in Mr Walker’s old cell, Number 2 in the mainstream part of the prison at about 11am. (Exhibit C32b) According to Mr Webber, he and Mr Walker were let out of their cells to shower and make phone calls. While they were in the unit

together, Mr Webber thought that Mr Walker seemed normal. He didn't notice any complaints or any sign that he was planning to do anything violent. Mr Webber described the prison officers at Port Lincoln Prison as a "good mob" who talked to Mr Walker and agreed to do things for him like getting the television for him. (Exhibit C16A). From about midday, after Mr Webber was taken back to the mainstream prison area, Mr Walker was the only prisoner left in unit 7.

- 2.43. Before going to lunch at about 12.30pm, Mr Earl was asked by Mr Walker if he had spoken to medical staff and if he was going to be transferred. Mr Earl claims to have told Mr Walker that the nurse had spoken to Dr O'Brien and that it was likely that he would be transferred on Wednesday. This was Mr Earl's last contact with Mr Walker and he noticed that he seemed happy about hearing of his pending transfer from Port Lincoln. (Exhibit C32b)
- 2.44. At 3:45 pm, a direction was given to officers to conduct 15 minute checks of accommodation areas within the prison, following a temporary problem with the fire detection system. Mr Dodd was required to record his fire checks in a log. (Exhibit C37c) It is fairly clear that from this point, Mr Dodd was struggling to cope with the various demands on his time. Mr Walker's 4:00 pm medication due on that day was not given. According to Mr Dodd, he was not sure whether it was his responsibility or someone else's to administer that medication. He stated that if both of them forgot the medications then Mr Walker would not receive it. (T333, Exhibit C38)
- 2.45. When Mr Dodd performed a fire check of unit 7 at 4:00 pm, he walked briefly into the unit and glanced at each cell. On this occasion, Mr Walker requested some cigarette papers. At about the same time, Mr Earl was in the unit office when he heard via the intercom from unit 7, a request by Mr Walker for some cigarette papers. At 4:15 pm, Mr Dodd claims to have briefly entered unit 7 to look for signs of smoke and fire. He gave Mr Walker a pack of cigarette papers saying "here you go Darryl, you can have these for free" (C37a). According to Mr Dodd, Mr Walker seemed 'normal' and he didn't notice anything out of the ordinary. (T278) Part of Mr Dodd's duties included the retrieval of radios and other equipment for the next shift of officers in preparation for handover. Because he was so busy, he decided to conduct his next 15-minute fire check in unit 7 a little early.

- 2.46. When Mr Dodd entered unit 7 at 4:27 pm, he saw Mr Walker hunched in the doorway to the shower block. It was obvious what had happened. The plastic bucket was located on its side near him. Mr Dodd immediately rushed over to Mr Walker and whilst attempting to lift him to release the pressure from the bed sheet around his neck, called for emergency assistance (code black) via his radio. Other officers responded and Nurse Resnais who had just left for the day was called back to assist.
- 2.47. Mr Dodd commenced cardiac compressions after Mr Walker was released from the ligature around the grill and had been placed on the floor. An Air Viva bag and mask was obtained and used to ventilate Mr Walker while Mr Dodd continued cardiac compressions. Oxygen and suction equipment was used in the resuscitation attempt by Nurse Resnais as soon as she returned. An ambulance was called at 4:29 pm and arrived within 10 minutes. Attempts to revive Mr Walker continued until 5:05 pm, but were unsuccessful.

### **3. Post Mortem**

- 3.1. A post mortem examination was conducted on 4 June 2003 by forensic pathologist Dr Alan Cala who observed, “poorly defined bruising to both sides of the neck anteriorly”. Dr Cala saw mottled bruising on the left side of Mr Walker’s neck consistent with creases or pleating from the sheet said to be used as a ligature around his neck. Dr Cala formed the following opinion as to the cause of death:

‘The circumstances surrounding the deceased’s death combined with the post mortem findings would indicate the deceased has died as a result of hanging, which appears to have been self inflicted.’

(Exhibit C3a)

- 3.2. I accept the opinion expressed by Dr Cala in his report. A sample of Mr Walker’s blood was taken and examined by forensic scientist Domenic Vozzo. The analysis undertaken excluded the presence of common drugs such as amphetamines, methadones, opiates and cannabinoids as well as alcohol. Mr Walker’s blood did contain however a higher than therapeutic level of one of his anti psychotic drugs Olanzapine in the amount of 0.12 mg per Litre. A non-toxic/therapeutic level of his diabetic medication was also detected. (Exhibit C4a) These results are consistent with Mr Walker being medicated in accordance with his prescriptions at the relevant time. I find that the presence of the medication in Mr Walker’s blood did not contribute to his death.

#### **4. Personal background**

- 4.1. Mr Walker was the youngest of 8 children, born on 23 February 1972. He was raised in Port Lincoln by his natural parents. He left school at the age of 13 years and began drinking alcohol and smoking cannabis. He began committing offences including break-ins, larceny, property damage cannabis offences and assault. These matters were dealt with in the Children's Court. In March 1993 Mr Walker was first imprisoned as an adult. At 19 years he was in custody in Port Lincoln Prison and was granted permission to visit his ailing mother who subsequently died. The loss of Mr Walker's mother affected him deeply and his sister Debra Flavel noticed a deterioration in his mental state from about this time. From this time until his death, Mr Walker was in and out of prison regularly. The longest stretch of time spent out of prison was a period of 10 months. (Exhibit C20 a)

#### **5. How Mr Walker came to be in custody at the time of his death**

- 5.1. On 22 January 2002 Mr Walker was sentenced to 3 years imprisonment for offences of larceny and aggravated serious criminal trespass in a place of residence. A non-parole period of 15 months was fixed and backdated to commence from 20 July 2001. Mr Walker was released on parole on 18 October 2002. His parole term was due to expire on 19 July 2004. (Exhibit C27a)
- 5.2. On 17 December 2002, the Parole Board received a report from Community Corrections Officer Tony Shillabeer, advising the Board of apparent breaches of parole conditions. Mr Walker had allegedly failed to report to Mr Shillabeer since 15 November 2002, failed to take prescribed medication and failed to attend a follow up appointment with a psychiatrist in Port Lincoln on 16 December 2002. On the same day, he allegedly failed to attend the Magistrates Court in relation to a warrant for outstanding offences. On 16 March 2003, the Presiding Member of the Parole Board authorised the issue of a warrant for the alleged breaches. Mr Walker was arrested and returned to custody at Port Lincoln prison the same day.

#### **6. The progression of Mr Walker's deteriorating mental state following his return to prison**

- 6.1. On 20 April 2003 Registered Nurse Wright made the following entry in the prison health service notes concerning Mr Walker at Port Lincoln Prison:

‘Spoke to guard in charge, we suggested that Darryl may need to come down to Unit 7 to monitor his food, medication, sugar intake. Apparently Darryl has been drinking straight cordial. Guards have gone into town to buy some equal. Darryl will stay in Unit 7 over weekend. For repeat BSL at 1600 hrs.’

(Exhibit C30e)

- 6.2. On 23 April 2003 Mr Walker was being prepared for transfer to Yatala Labour Prison via Port Augusta to facilitate his attendance at a parole board hearing to determine the alleged breaches. Nurse Swaffer made the following entry in the prison health notes about Mr Walker:

‘...this patient needs close supervision of his Diabetes and Mental health. Dr O’Brien was notified yesterday that he is being transferred to YLP for court. His mental state is erratic; demanding attention from Officers regularly, at times he does not respond to questions and then asks a question five minutes after first asking.’

(Exhibit C30e)

- 6.3. Mr Walker spent that weekend in unit 7 to monitor his sugar intake before he was transferred to Yatala Labour Prison. At Yatala Labour Prison he was admitted to the infirmary purportedly to observe his mental state, to treat an infection of his penis and to monitor and educate him concerning his diabetes. (Exhibit C30e) On the 25 April, the infirmary nurse noted that Mr Walker was now in a new environment with no radio or television and was in a single cell. He was said to be easily irritated when unable to have his demands met immediately and was to be given chlorpromazine when necessary. The following day, Mr Walker received his depot injection of Zuclopenthixol, 3 days earlier than it was required due to his poor mental state. Nurse Halsall noted that Mr Walker had been demanding cigarettes all day. On 28 April, Mr Walker had not improved and indicated that he wanted to see the psychiatrist, Dr Nambiar. He was given Chlorpromazine to settle him down and was booked to see Dr Nambiar during the week. (Exhibit C30e)

- 6.4. On the 29 April 2003, the Parole Board met in Adelaide to consider Mr Walker’s alleged parole breaches. He was questioned by various members of the Board. His parole officer, Tony Shillabeer, participated in the meeting via a video link from Port Lincoln. The transcript of what took place during this interview demonstrates Mr Walker’s poor insight into his psychiatric and diabetic problems and the simplistic, child-like manner in which he communicated. Mr Shillabeer was asked whether Mr Walker appeared to be in his normal mental state, to which Mr Shillabeer responded, “at the moment it is yes”. Ms Gipslis of the Board remarked that that was

a frightening thing because he didn't appear to look good to her. Mr Shillabeer was questioned further about when Mr Walker was due to be reviewed by the psychiatrist but was unable to assist the board. Board member Mr Tongerie, raised the question as to whether Mr Walker had any "suicidal tendencies" because after watching Mr Walker during the hearing, he was worried about that. Mr Shillabeer said that he was not aware of any recently but hadn't researched the reports. (Exhibits C27g, C27m).

- 6.5. Mr Shillabeer told the Board that Mr Walker had a fresh charge of "carry offensive weapon" arising from the time he was arrested on the parole board warrant. He explained that when Mr Walker was being searched at the police station after his arrest, they found a screw driver in his possession. Mr Walker was due to attend court on 24 June in Port Lincoln in relation to that matter. Mr Shillabeer told the Board that there were other outstanding charges remaining and that it might be appropriate for the Board to obtain a report on the status of those matters before concluding their determination of the parole breaches.
- 6.6. Mr Shillabeer explained to the Board that on previous occasions, when Mr Walker was released into the community on parole, his family was only able to deal with his issues for a limited period time and then he tended to wonder off and was unable to be located. He explained that in Port Lincoln there was an Aboriginal health service available to assist people in need, but they were unable to go and locate people who were unwilling to engage with them. He said that Mr Walker's sister, who lived in the Port Lincoln region, had at least six children and didn't have a dedicated area in her home where Mr Walker could reside and be cared for. Mr Shillabeer informed the board that there was no supported accommodation facility in Port Lincoln where someone with Mr Walker's condition could be adequately housed. He said that Mr Walker appeared to do better in prison because when he was properly medicated, his condition improved. Unfortunately, this last comment turned out to be inaccurate in so far as it misrepresented what was occurring at the time. (Exhibit C27m) The Parole Board deferred its decision, pending the outcome of a case conference, to prepare plans for Mr Walker's release into the community again.
- 6.7. Meanwhile, Mr Walker's mental health remained a challenge for corrections and nursing staff at Yatala Labour Prison. On 1 May 2003, he was noted to be "racing around the room" when a nurse attempted to perform a blood sugar level check.

Mr Walker declined to attend the clinic at 10:00am when Dr Nambiar was due to review him. The following day, Dr Nambiar did manage to review Mr Walker and noted that his symptoms of paranoia and delusion worsened whenever he was moved within the prison system. Dr Nambiar agreed to increase the level of Zyproxa medication and ordered a review of his condition in three weeks. (Exhibit C30e) It was in this state, that Mr Walker was transferred back to Port Lincoln Prison via Port Augusta prison for his final period of incarceration.

- 6.8. Mr Charles, acting for Mr Walker's immediate family members, provided several documents which were received into evidence on the final day of Inquest. One was entitled "Suicidal Behaviour in Prisons, A Literature Review" by researchers from the School of Social work, Australian Catholic University. Of significance in this paper, is an observation concerning the importance of stability in the prison environment. It reads as follows:

‘Destabilizing changes to a prisoners (sic) circumstance such as a rejection of parole or recent transfer have been linked with the likelihood of suicide and self-harm attempts. The New South Wales Department of Corrective Services (1993) claimed that stability promotes contentedness while movement creates uncertainty and anxiety.’  
(Exhibit C47c)

- 6.9. This observation is particularly relevant in Mr Walker's situation when one considers that between March and June 2003, he was moved about from place to place either for Court purposes or for health and "management" purposes.

## **7. Final Period of incarceration in Port Lincoln Prison**

- 7.1. Once Mr Walker had returned to Port Lincoln prison, his chronic illnesses were out of control. He was housed in unit 7 on 7 May in an attempt to "monitor" his blood sugar level. (Exhibit C30e) On 14 May 2003, Mr Walker was taken to the Port Lincoln Magistrate's court to answer outstanding charges.
- 7.2. On 16 May 2003, Tony Shillabeer advised the parole board that Mr Walker's mental state had deteriorated dramatically since his imprisonment. In a memo forwarded to the Board, he advised that Dr Ken O'Brien was due to review Mr Walker at Port Lincoln prison on 22 May 2003. Mr Shillabeer recommended that due to the poor state of his mental health, the existence of serious outstanding charges and of the predicted likelihood of re offending upon release, Mr Walker should not be released until a psychiatric report was received and the outstanding court matters were

finalised. (Exhibit C27g) Mr Walker was due to attend court again on 24 June 2003. The previously planned case conference was deferred, and on 20 May 2003, Deputy Presiding parole board member, Phillip Scales, determined that Mr Walker would remain in custody until a psychiatric report was received and reviewed by the board. (Exhibit C27a). Unfortunately, before a report could be prepared and considered by the Board, Mr Walker had died.

## **8. Psychiatric Management**

- 8.1. Dr Ken O'Brien reviewed Mr Walker for the last time on 22 May 2003. Dr O'Brien is a respected and experienced forensic psychiatrist. He is currently the clinical director of the Forensic Mental Health Service in South Australia. Dr O'Brien had become familiar with Mr Walker's mental health problems since about 1996 and over the following years saw him at Port Lincoln prison, at outpatient clinics in Port Lincoln Hospital and at James Nash House when Mr Walker had been admitted there on four occasions. (T343)
- 8.2. In evidence, Dr O'Brien described Mr Walker as a man suffering chronic schizophrenia as well as significant behavioural problems. Like all prisoners with chronic schizophrenia, he was regarded as a chronic risk of harm to himself. He said that Mr Walker was extremely difficult to manage in any setting because of his lack of insight into the fact that he had schizophrenia, which was a largely persistent and disabling illness. (T344) Dr O'Brien explained that Mr Walker was unpredictable and impulsive, typical of many prisoners he sees in South Australian prisons. (T351) He reiterated that Mr Walker was non compliant with medication, didn't keep appointments, and was a regular abuser of alcohol, cannabis, and amphetamines and to a lesser extent heroin. Dr O'Brien explained that Mr Walker was regarded as a significant management problem wherever he was. Guardianship and treatment orders had been tried in the community, but didn't provide much assistance. According to Dr O'Brien, members of Mr Walker's family found it difficult to understand his illness and were unable to help locate and house him.

'He was mainly a management problem in prison because he had no insight into the fact that he had a chronic mental illness so there was always conflict and confrontation about him taking his medication. He wouldn't take his medication or he wanted different medication or he wanted the dose changed and there were frequent encounters. I had several examples with him, nursing staff had similar examples with him, where he would become animated and he would become verbally aggressive and on those occasions

sometimes he would get up and leave the interview and sometimes he would threaten self-harm.’ (T350).

- 8.3. Dr O’Brien observed that Mr Walker was a man who if he didn’t get what he wanted, would sometimes make threats of self-harm. I accept Dr O’Brien’s explanations which illustrate why Mr Walker was so difficult for correctional staff and nurses to manage. When Dr O’Brien saw Mr Walker for the last time on 22 May 2003, during his monthly visit to the prison, he noted the following:

‘Mental state remains variable. He is disorganised and periodically aggressive. Currently, in my view, he’s on sufficient medication as he’s a management problem at Port Lincoln, they may consider transferring him to another jail, possibly to Port Augusta. In the meantime, I have placed him on the James Nash House waiting list with a ‘B’ priority – I am not optimistic that a bed will be available in the near future. See next visit – if transferred to another jail, will need to be seen by visiting psychiatrist as soon as possible.’

(Exhibit C30e)

- 8.4. In evidence, Dr O’Brien stated that on the 2<sup>nd</sup> June, 2003, he had concerns about Mr Walker’s general mental health and behaviour but didn’t feel that he needed to be detained under the Mental Health Act. He explained that a decision to detain Mr Walker would not be taken lightly and if he was judged to be “detainable”, he would have required urgent transfer to Adelaide, probably by air, and admission to a suitable mental health facility. As of 22 May 2003 Dr O’Brien did not regard Mr Walker as having an acute health issue, but recognised that if the management of his condition at Port Lincoln was becoming too difficult and the nurse felt no longer able to manage him, then he had to be moved out.
- 8.5. According to Dr O’Brien, on the information obtained by talking with Nurse Resnais, on 2 June 2003, he believed that Mr Walker’s mental state was deteriorating, requiring more intensive management, but that he was not actively suicidal. (T351) Dr O’Brien’s assessment is necessarily qualified by his reliance upon the accuracy and completeness of information passed on to him by the nurse. I find that it is unlikely that Dr O’Brien would have considered Mr Walker “detainable” under the Mental Health Act, had he personally examined Mr Walker on the morning of the 2<sup>nd</sup> June 2003.
- 8.6. Dr O’Brien described the mental health presence in Port Lincoln prison as “extremely meagre”. (Exhibit C39) Ideally, someone in Mr Walker’s condition might be managed in a hospital setting like James Nash House. But the small number of beds

available at James Nash House for mentally ill prisoners was in Dr O'Brien's opinion, most unsatisfactory and he could not count on one becoming available for Mr Walker. According to Dr O'Brien, since the introduction of the *Mental Impairment Legislation*, of the 30 beds available at James Nash House, the vast majority are taken up by persons being detained after being found to have committed crimes whilst mentally impaired or incompetent. This leaves less available hospital beds for other mentally ill prisoners than were available ten years ago. (T359) Dr O'Brien believed that there has been a steady increase in the numbers of prisoners suffering mental illness in recent years.

- 8.7. When questioned about the nursing support available at Port Lincoln prison, Dr O'Brien explained that he had a high regard for Nurse Resnais. She was a competent registered nurse, but because she had no formal mental health training, Dr O'Brien tried to make sure that she wasn't overwhelmed or out of her depth when managing mentally ill prisoners. Dr O'Brien was critical of the fact that to his knowledge, there is not one dedicated mental health nursing position in any prison in South Australia. (T346) Whilst he acknowledged that there may be some individual nurses who have mental health training or qualifications, the majority of nurses do not and therefore the medical staff, particularly visiting psychiatrists, carry the responsibility for the management of prisoners with mental illness. Dr O'Brien explained that to deal with this problem, he encouraged Nurse Resnais and other nurses in her position to telephone him whenever she had a concern.
- 8.8. This was well understood by Nurse Resnais and he was not surprised to receive her call concerning Mr Walker on 2 June, to discuss her concerns about him. Dr O'Brien had confidence in her assessment of the situation and agreed to the plan to transfer Mr Walker to Yatala Labour Prison for psychiatric review. He agreed with Nurse Resnais that overnight, Mr Walker would be under camera observation but during the day he could be in the general prison population. (T349, T355) Dr O'Brien explained that he would have expected the nurses to inform the corrections officers about the concerns for Mr Walker's mental health, given the relatively intimate size of the Port Lincoln prison which made it possible to convey information directly. Dr O'Brien expected that corrections officers would be "looking for any attempts at self-harm or any bizarre behaviours which would have indicated significant deterioration in his mental health." (T355)

- 8.9. When asked to comment upon the desirability of isolating Mr Walker in unit 7 to control his sugar intake and reduce his blood sugars level, Dr O'Brien acknowledged that in Mr Walker's case, there were competing problems such as mental health problems and on the other hand, potentially life threatening unstable diabetes. He said that it was a judgement call by staff as to which of those two conditions had priority on a particular day. He acknowledged that at Yatala Labour Prison, there is 24 hour nursing care and an infirmary. According to Dr O'Brien, the facilities at Yatala would have been more conducive to routine orthodox medical management of Mr Walker's diabetic issues. The only other infirmary in a correctional institution in South Australia is in the Adelaide Remand Centre
- 8.10. Dr O'Brien was asked to speculate as to how Mr Walker might have appeared relatively calm at 4:15 pm on the day of his death and within 12 minutes had hung himself. Dr O'Brien offered three possible explanations. He said that a person deciding to kill themselves can sometimes appear serene, having made the decision close to the time of acting upon it. Secondly, it was suggested that Mr Walker may have responded to an "auditory hallucination telling him to kill himself and that auditory hallucination was so intensive and persuasive that he couldn't resist it". According to Dr O'Brien, this could occur during a sudden deterioration or exacerbation in his psychosis. (T354) The third explanation postulated by Dr O'Brien was that the suicide had less to do with his psychosis and more to do with his abnormal personality structure.
- 'We see that often with people with significant personality disorders where they can be apparently calm and composed one minute and the next minute they are threatening suicide; and there is an unpredictability and an impulsivity about them which is related to their personality, not to any act of mental illness.' (T354)
- 8.11. If he had to choose between the three theories, he preferred that it had more to do with his "disorganised personality and personality disorder". Dr O'Brien agreed that it was prudent for the nurse to decide that overnight, Mr Walker be confined to a cell with camera observation because at that time, being isolated from people he would have time to reflect on his life and his thoughts. With less interaction with staff and other inmates, according to Dr O'Brien, it was prudent to take that precaution.
- 8.12. Whilst it is not possible to be confident about which explanation accurately describes the circumstances of Mr Walker's behaviour in the minutes leading to his death, the third explanation postulated by Dr O'Brien, appears most likely. When one considers

the pattern of Mr Walker's behaviour documented in the prison health notes, together with the evidence from Dr O'Brien, nurse Mercer and corrections officers, a common theme emerges. Mr Walker was becoming more agitated, demanding and unpredictable. He needed to be housed in a protected environment. He ended up in a place where he was able to hang himself, out of view of those responsible for his welfare.

**9. Adequacy of Mental Health facilities in Port Lincoln**

Dr O'Brien gave a vivid description of the mental health presence in country prisons in South Australia. According to Dr O'Brien, in non-metropolitan prisons, there are no psychologists, social workers who have mental health experience, or dedicated mental health nurses available to handle mentally ill prisoners. Whilst this multidisciplinary mental health team structure exists in the community, it is not available in country prisons. Medical practitioners and nurses are not employees of the DCS and may only offer their services to prisoners who are entitled to refuse if they wish. Dr O'Brien explained that nurses and doctors therefore resort to a mixture of persuasion and cajoling to gain the co-operation of prisoners such as Mr Walker. (T361)

- 9.1. Dr O'Brien emphasised that the present situation whereby mentally ill prisoners are seen once a month is completely inadequate. He states that there are simply too many prisoners to be seen in a short period of time during those clinics. Despite previously bringing the problem to the attention of government ministers and his superiors, he claims that there has been no improvement over 25 years in the numbers of people he must see in a short period of time. His colleagues in private practise may spend 45 minutes to an hour with every patient they see, whereas Dr O'Brien has an average of about 7–10 minutes with each prisoner he sees in his clinics. According to Dr O'Brien, this is partly the reason why it is so impossible to get psychiatrists to work in prison health service or to attend prisons.
- 9.2. The work done by Dr O'Brien and his colleagues is difficult work and it is commendable that people of Dr O'Brien's calibre and dedication, have continued to work in a system where there is inadequate support. Dr O'Brien expressed his views as follows:

‘I think it is scandalous that there aren’t an adequate number of funded mental health nursing positions in South Australian gaols, and it is scandalous that most gaols do not have a psychologist and there is nothing resembling an adequate mental health service in our prisons.’ (T398)

- 9.3. Dr O’Brien suggested that the priority should focus upon having professional mental health workers in all South Australian Prisons. In his view, the situation in Port Lincoln and Port Augusta prisons has deteriorated and they have fewer resources now than in previous years. (T399) He explained the situation as follows:

‘If we had mental health staff, we could then triage out the people who do not have an active mental illness, who have personality problems, behavioural problems, they could be managed by another mental health professional and the psychiatrist can concentrate on the acutely unwell, or those with significant mental illnesses. But that can't be done in the absence of any other staff. So, the first thing I have to do when I go to a country gaol is to sit down with the nurse. When I was in Port Lincoln 10 days ago, I had 20 people to see. That is one third of the gaol population I was asked to see. If you translate that to Yatala, I would be seeing a hundred people. This is in a two-and-a-half-hour clinic. So, I then have to sit down with the nurse, we have got to go through and prioritise - and I'm very dependent on the advice she gives me - about who in her judgment is more pressing of the need, and then I see those people and, if time permits, I see the remainder, and if I cannot see them, they are given priority for the next list.’ (T400)

- 9.4. As to the role played by visiting general practitioners, Dr O’Brien said that his experience of general practitioners in country towns is that they may have little or no interest in mental health. The level of knowledge and competency varies amongst general practitioners providing services to country prisoners. In Dr O’Brien’s experience, those who do have the interest, often don’t have the training and it is difficult for him to work out which practitioners are comfortable about dealing with mental health issues and which practitioners are not. (T401)

- 9.5. When asked about the availability of supported mental health accommodation, Dr O’Brien remarked that the lack of suitable facilities is a significant problem in Australia compared to other countries. Dr O’Brien acknowledged the positive contribution made by a program called “exceptional needs program” which has provided some accommodation and subsidised day-time carers in the community. Under this programme, a management assessment panel takes referrals for people who have multiple diagnoses and who “in the past have fallen down in the cracks between different agencies” because previously no agency was prepared to take primary responsibility for their management. (T402) Dr O’Brien explained how he

recently tried to obtain accommodation in Port Lincoln for a mentally impaired offender after being requested to organise it by a judge. Notwithstanding a good deal of discussion with community corrections, mental health teams and others, he was not able to come up with any suitable short term accommodation. The criteria, which had to be satisfied, was too difficult to achieve quickly enough to be useful. (T403)

- 9.6. In Dr O'Brien's opinion, a person with Mr Walker's background would have needed almost 24 hour supervised accommodation in the community to ensure compliance with prescribed medication, attendance at appointments and abstinence from alcohol and illicit drugs. (T403) Dr O'Brien emphasised that there was a need for 24 hour a day dedicated and specialised supervision in the community, for people with Mr Walker's problems, because generally, mentally ill prisoners coming out of prison find themselves in half way houses, bail hostels and other facilities with inadequate support. (T404)
- 9.7. The director of nursing of South Australian Prison Health Service, Raylee Kinnear, gave evidence during the inquest about the nursing facilities available at Port Lincoln Prison. Ms Kinnear stated it was very difficult to recruit nursing staff to work in the prison because it is a difficult environment to work in. Ms Kinnear explained that there is ongoing discussion within the Prison Health Service about the need for better management of mentally ill prisoners within the prison system. One suggestion yet to be acted upon is the establishment of a unit at Yatala Labour Prison described as a "safe unit" for housing prisoners like Mr Walker to avoid the development of a crisis situation by providing better access to psychiatric management.
- 9.8. Ms Kinnear is an experienced registered nurse who acquired postgraduate mental health training in recent years because it became obvious to her that the number of mentally ill prisoners was increasing over time and she needed to equip herself with expertise to support nursing staff who were having to deal with these problems. Ms Kinnear claimed that almost 60% of prisoners across the State would have some form of mental health issue. (T206) According to Ms Kinnear, prisoners with chronic mental illness are difficult to manage partly because they are unpredictable and easily upset. Ms Kinnear explained that she tried to recruit experienced staff with mental health training, but these nurses were in scarce supply and difficult to attract. (T205)

9.9. Ms Kinnear described a new “self harm” assessment form, which was being developed to alert correctional staff to the potential self harm of various prisoners in their care. Following Mr Walker’s death, weekly “high-risk assessment team” meetings now take place between correctional service officers and health staff to discuss management of prisoners who are deemed at “high-risk”. (T210) If a meeting had taken place to discuss Mr Walker’s management in the weeks before the 2<sup>nd</sup> June 2003, it is possible that corrections staff may have become aware of the undesirability of keeping him isolated from other prisoners, especially when he was not under effective camera observation

## **10. Hanging Points within Port Lincoln Prison**

10.1. Following an internal investigation into the circumstances of Mr Walker’s death, a report was prepared by Darrell Smedley, manager, investigations and intelligence unit of the DCS. The report, dated 7 July 2005, contained a number of recommendations, one of which urged that “all hanging points in the association area of Unit 7 be either removed or screened as a priority. (Exhibit C40) According to a letter to the State Coroner from Peter Severin, chief executive of the DCS, dated 12 January 2006, the following action was taken in response to this recommendation:

‘all obvious hanging points have been addressed, including the cells in the unit 7 area which have been upgraded to meet the recognised safe cell standards. This work was completed approximately 14 months ago, and included: fine mesh fitted to cover grille above ablution block entry door to eliminate this as a ligature point; bathroom areas fitted with safe cell type fittings; see through observation door fitted to shower area to allow for improved supervision; solid bed blocks to replace framed style in cells.’  
(Exhibit C40a)

10.2. On the second day of inquest, the court visited Port Lincoln prison and inspected changes made to the facilities in unit 7, since Mr Walker’s death. Whilst inspecting the improvements, it was alarming to discover recently installed large black rubber doorstops protruding at head height adjacent each door in the association area of the unit. These door stops were obvious potential hanging points and should never have been installed in that manner. After the problem was brought to Darryl Smedley’s attention during the inquest, arrangements were made for their removal and replacement at a more suitable level close to the ground. On the fourth day of inquest, Mr Smedley informed the Court that the door stops had been removed.

- 10.3. Within cell 55 there is now a television, permanently installed in a safe manner. This is a desirable improvement consistent with the philosophy arising out of the Royal Commission into Aboriginal Deaths in Custody, which recognised the need for stimulation when prisoners are housed in isolation cells.
- 10.4. Another recommendation from Mr Smedley's report concerned the replacement of the defective camera in the association area of unit 7 with a new camera which clearly depicts the entire area. According to the letter from Peter Severin, the following action was taken in response to this recommendation:
- ‘all electronic security has been upgraded to the unit 7 area to meet the recognised safe cell standards, including: upgrade to the camera to provide coverage of the entire wing: infra red cameras fitted to the observation cell and the ‘soft’ cell.’  
(Exhibit C40a)
- 10.5. In the association area adjacent the cells in unit 7 is a new camera which when activated displays a much clearer image than previously and has the capacity to rotate to capture images from the association area including the area where Mr Walker hung himself. A demonstration of the upgraded camera facilities at the prison during the inquest, satisfied me that prisoners housed in unit 7 may be adequately monitored electronically when they are in the association area.
- 10.6. The court has been informed that staffing changes have been introduced so that when a prisoner is housed in unit 7, a dedicated officer is rostered to supervise the unit. Cell 55 is now required to be monitored when occupied and when prisoners are in the association area of unit 7, an officer is required to be present to supervise. (T95)

## 11. **Adequacy of resuscitation attempts**

On the available evidence, I am satisfied that there is no basis upon which criticism can be made of any person involved in attempting to resuscitate Mr Walker after he was discovered hanging in Unit 7 at 4:27 pm on 2 June 2003. Corrections officers, Nurse Resnais and ambulance officers acted appropriately and as swiftly as possible.

## 12. **Separation Policies for Aboriginal Prisoners**

- 12.1. One factor which may have contributed to Mr Walker's decision to hang himself, was his isolation from other people. His presence alone within unit 7 on the day of his

death was arguably contrary to recommendation 144 of the Royal Commission to Aboriginal Deaths in Custody which provides as follows:

‘That in all cases, unless there are substantial grounds for believing that the well being of the detainee or other persons detained would be prejudiced, an Aboriginal detainee should not be placed alone in a police cell. Wherever possible an Aboriginal detainee should be accommodated with another Aboriginal person. The views of the Aboriginal detainee and such other detainee as may be affected should be sought. Where placement in a cell alone is the only alternative the detainee, should thereafter be treated as a person who requires careful surveillance.’ (Volume 5. p100-101)

- 12.2. Mr Severin has advised in his letter to the State Coroner that all general managers of prisons in this State have confirmed that they have reinforced “Recommendation 144” with all staff. (Exhibit C40a) Whether the method of staff reinforcement is effective remains to be seen. According to Mr Smedley, opportunities for further staff training in regional areas, on topics such as “cultural awareness” is limited.
- 12.3. Changes to staffing of unit 7 and monitoring of prisoners within the unit will remedy some of the concerns arising in this inquest. But educational reinforcement of cultural issues relevant to the management of Aboriginal prisoners, rather than directives from managers, may prove more effective in the long term. Educational videos or DVDs might be considered as a potential resource for staff training in regional areas.
- 12.4. It is most desirable that where an Aboriginal prisoner is isolated for any reason, that he or she be kept in contact with an Aboriginal Liaison officer or other prisoners preferably of Aboriginal descent. There was at the time of Mr Walker’s death a relatively ad hoc system in place at Port Lincoln prison for the separation of prisoners into unit 7. Sections 24 and 36 of the Correctional Services Act 1982 govern the procedures for separating prisoners within South Australian Prisons.
- 12.5. Section 24 provides that the Chief Executive Officer of a prison has custody of prisoners and has an absolute discretion as follows:
- ‘(1) The Chief Executive Officer has the custody of a prisoner, whether the prisoner is within, or outside, the precincts of the place in which he or she is being detained, or is to be detained.
  - (2) Subject to this Act, the Chief Executive Officer has an absolute discretion—
    - (a) to place any particular prisoner or prisoner of a particular class in such part of the correctional institution; and
    - (b) to establish in respect of any particular prisoner, or prisoner of a particular class, or in respect of prisoners placed in any particular part of the correctional institution, such a

regime for work, recreation, contact with other prisoners or any other aspect of the day-to-day life of prisoners,

as from time to time seems expedient to the Chief Executive Officer.’

12.6. Section 36 of the Correctional Services Act governs the power to keep a prisoner apart from all other prisoners and provides the Chief Executive Officer with power to direct that a prisoner be kept separately from all other prisoners as follows:

- ‘(1) A prisoner must not be kept separately and apart from all other prisoners in the correctional institution except in accordance with this section.
- (2) The Chief Executive Officer may direct that a prisoner be kept separately and apart from all other prisoners in the correctional institution if the Chief Executive Officer is of the opinion that it is desirable to do so—
  - (a) in the interests of the proper administration of justice where an investigation is to be conducted into an offence alleged to have been committed by the prisoner; or
  - (b) in the interests of the safety or welfare of the prisoner; or
  - (c) in the interests of protecting other prisoners; or
  - (d) in the interests of security or good order within the correctional institution.
- (3) A direction given pursuant to subsection (2)(a) has effect for such period, not exceeding 30 days, as may be specified in the direction.
- (4) Any other direction under subsection (2) has effect until revoked by the Chief Executive Officer.
- (5) A direction cannot be given more than once pursuant to subsection (2)(a) in respect of the incident giving rise to the alleged offence.
- (6) A direction given under subsection (2)—
  - (a) must be in writing; and
  - (b) may be revoked at any time by the Chief Executive Officer.
- (7) A copy of a direction given under subsection (2) must be served personally on the prisoner within 24 hours of being so given.
- (8) Despite the fact that a direction under subsection (2) is in force in respect of a prisoner, the Chief Executive Officer may permit the prisoner to have contact with such other prisoners on such occasions as the Chief Executive Officer thinks fit.
- (9) The Chief Executive Officer must, as soon as reasonably practicable after giving a direction under subsection (2), furnish the Minister with a report of the circumstances in which the direction was given.
- (10) On receiving a report under subsection (9), the Minister may review the matter and may confirm or revoke the direction.’

In Mr Walker’s case, his transfer to unit 7 appears to have taken place without written direction from the chief executive officer or his delegate. The provisions of section

36 suggest that Parliament intended the process of separation of prisoners be undertaken with some degree of formality and accountability rather than in the informal, casual manner in which it occurred in Mr Walker's case.

12.7. The Court was informed that a new standard operating procedure governing the separation of prisoners was introduced at Port Lincoln Prison from 23 May 2005. Standard operating procedure number 12 stipulates that prisoners who are separated pursuant to the current procedure are to be reviewed daily and observed. Section 3.6 of the standard operating procedure stipulates as follows.

- '(1) that all prisoners placed on separation are monitored;
  - (2) daily observation and human contact is made with all separated prisoners;'
- (Exhibit C46, p4)

12.8. It is unclear how prison managers intend to implement human contact with all separated prisoners and Aboriginal prisoners in particular. Under section 3.7A of the new standard operating procedure the unit manager or delegate must ensure the following:

- '1. that a Review of Separation is completed each week for each prisoner held under a separation direct regarding the appropriateness of the separation;
- 2. that the prisoner is shown the documented review and given an opportunity to make written comment;
- 3. any written comment made by the prisoner is attached to the Review of Separation;
- 4. that the supervising officer makes a written note on the Review of Separation stating that the prisoner does not wish to make a written comment;
- 5. the prisoner is provided with a copy of the Review of Separation; and
- 6 that the Review of Separation is forwarded to the General Manager for consideration.'

(Exhibit C46, p4)

12.9. Where a prisoner such as Mr Walker is separated and has limited capacity to participate in any meaningful review process, it may be a futile exercise to provide documents for written comment. It is also regrettable that the separation procedure introduced, makes no provision for a liaison with members of the nursing staff or visiting medical staff at the prison. The recently introduced weekly meetings for managing high-risk prisoners is a welcome improvement, but even this system may overlook those prisoners who are not regarded as at high risk, but when separated, may then become at risk of self harm.

### 13. Communication Issues

Because of the need to keep medical records confidential, this has the potential to act as a barrier to effective communication between nursing and DCS staff concerning prisoners who have serious health issues. To some extent the weekly meetings will remedy this problem. But there remains the potential for relevant information arising between these weekly meetings to be kept from officers, which may compromise their ability to care for those prisoners under their control

#### **14. Recommendations**

- 14.1. In accordance with the provisions of Section 25 (2) of the Coroner's Act 2003, the following recommendations are made in anticipation that they might prevent or reduce the likelihood of or recurrence of an event, similar to the event, the subject of this Inquest.
- 14.2. That the DCS implement an audit system which facilitates regular inspections of all South Australian prisons to identify and eliminate potential hanging points where possible, not only within cells, but also in unsupervised areas and areas without clear camera surveillance.
- 14.3. That the DCS, in conjunction with the Prison Health Service, develop and implement a system by which prison nurses document relevant information about prisoners with health concerns and make this information available to corrections officers to assist them in the day to day management of those prisoners in their care.
- 14.4. That the Minister for Mental Health consider strategies to attract nurses with mental health training into the Forensic Mental Health Service. If necessary, incentives should be considered, including a higher rate of remuneration, in recognition of the special difficulties for nurses working in a prison environment.
- 14.5. That the Minister for Mental Health do what is reasonably necessary to secure funds for the provision of mental health workers, such as psychologists and social workers with mental health training, in prisons in South Australia, particularly in regional areas.
- 14.6. That the Minister for Mental Health, consider ways of providing supported accommodation, especially in regional areas, for prisoners suffering mental illness following their release from prison.

*Key Words: Aboriginal Deaths; Correctional Services; Death in Custody; Hanging; Prisons*

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

*Seal the 28th day of April, 2006.*

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*Coroner*

Inquest Number 4/2006 (1430/2003)