



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 20th day of April 2006, the 1st day of December 2006, and the 30th day of January 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Stuart Murray Chalklen.

The said Court finds that Stuart Murray Chalklen aged 38 years, late of 11 Tyne Avenue, Kilburn, died at the Adelaide Remand Centre, South Australia on the 3rd day of June 2005 as a result of ischemic heart disease due to severe coronary atherosclerosis. The said Court finds that the circumstances of his death were as follows:

1. Introduction

- 1.1. Mr Stuart Murray Chalklen died on 4 June 2005. At the time of his death he was 38 years of age. He was remanded in custody at the Adelaide Remand Centre at the time of his death. A post mortem examination was performed by Dr John Gilbert who attributed the cause of death to ischaemic heart disease due to severe coronary atherosclerosis.
- 1.2. Mr Chalklen had been arrested on 5 March 2005 and charged at the Holden Hill Police Station with illegal use of a motor vehicle, unlawful possession, driving a motor vehicle with incorrect registration plates, being an unauthorised person driving a motor vehicle and failing to comply with a bail agreement. He applied unsuccessfully for police bail and then came before the Holden Hill Magistrates Court on 7 March 2005 and again 10 March 2005. Bail was refused and he was remanded

in custody. He was imprisoned at the Adelaide Remand Centre and his next court appearance was set for 1 July 2005.

- 1.3. Mr Chalklen was detained in cell number 1 within Unit 4 at the Adelaide Remand Centre. He shared this cell with another prisoner, Jamie McMahon. From around April 2005 Mr Chalklen had mentioned to Mr McMahon that he had a sore left shoulder. He had also mentioned this to his de facto partner, Elaine Hardie.
- 1.4. The Adelaide Remand Centre medical records do not reveal any indication that Mr Chalklen sought medical attention for his sore shoulder.
- 1.5. Mr Chalklen and Mr McMahon were locked down in their cell at 4:45pm on 3 June 2005. According to a statement provided by Mr McMahon to Senior Constable Pascoe (which was admitted in evidence as Exhibit C19b in these proceedings), he and Mr Chalklen watched television for some time. Late in the evening of 3 June 2005 Mr Chalklen said he felt like a cool shower. He walked to the shower, turned it on and stayed in it for some 40 minutes. According to Mr McMahon while Mr Chalklen was in the shower he was making groaning sounds. When he had been in the shower for approximately 40 minutes Mr McMahon reminded Mr Chalklen of the time and suggested that he finish his shower. Mr Chalklen turned off the shower and dried himself. Mr Chalklen then sat on his bed. At that point Mr McMahon had his back to Mr Chalklen but heard him making “snoring” noises. Mr McMahon then saw that Mr Chalklen appeared to suffer from a “seizure”. Despite Mr McMahon’s attempts to communicate with him, he was unresponsive. Mr McMahon used the intercom within the cell to contact Correctional Officers. He was told that assistance was on its way, and he said words to the effect “you’d better hurry up, cause he’s not breathing.”
- 1.6. Correctional Officers Crompton, Heysen and Beneke then attended at cell 1. Another officer was directed to contact the infirmary. On arrival at cell 1 in Unit 4 Correctional Officer Crompton saw Mr Chalklen lying on the cell bunk through the cell door window and he also saw prisoner McMahon standing nearby. The officers entered the cell but could not obtain any response from Mr Chalklen and noted that his face was turning blue. Correctional Officers Crompton and Heysen attempted to locate a pulse and when they were unable to do so, they and the other staff present commenced cardio pulmonary resuscitation.

- 1.7. The above events were initiated as I stated by the intercom message from prisoner McMahon informing officers that Mr Chalklen was suffering a seizure. That call was made at 11:59 pm. At 12:02 am on 4 June 2005, some three minutes after the initial call from McMahon, Officer Beneke initiated a “Code Black” from the vicinity of cell 1. It therefore appears that the Correctional Officers’ response to the intercom call from prisoner McMahon was timely.
- 1.8. At 12:04 am the Infirmary Nurse Jan Jordan attended and took over the provision of first aid. At 12:06am Ambulance Officers arrived and assumed responsibility for Mr Chalklen’s resuscitation. At 12:39am the Ambulance Officers advised Correctional Officer Crompton that Mr Chalklen was dead.
- 1.9. The Department of Correctional Services instituted an internal review of the incident. The review was conducted by Mr D Smedley, Manager Investigations and Intelligence Unit. A report was prepared by Mr Smedley and a copy was admitted as Exhibit C16a in these proceedings. Mr Smedley noted that the Correctional Officers who responded to the incident held current first aid certificates but identified that some of those certificates had expired. Mr Smedley recommended that all General Managers ensure that all institution staff hold a current first aid certificate and that each institution hold a current list of staff holding first aid qualifications. Mr Smedley’s recommendation has been accepted and implemented by the Department of Correctional Services.
- 1.10. With the exception of one matter which I will deal with presently, I conclude that the events surrounding Mr Chalklen’s collapse were handled appropriately by the Correctional Officers involved. I find that Mr Chalklen was lawfully imprisoned and that his cause of death was as given by Dr Gilbert.
- 1.11. A matter of concern has arisen in the course of this Inquest. A statement was obtained by Senior Constable Pascoe from Elaine Hardie, Mr Chalklen’s de facto partner. That statement was admitted as Exhibit C15a in these proceedings. In the statement Ms Hardie refers to Mr Chalklen’s complaint about his sore left shoulder. She states that she had told Mr Chalklen to see the prison doctor about his shoulder and stated that she understood that Mr Chalklen had made requests to see the doctor. She stated that she herself had asked one of the guards to make sure that Mr Chalklen went to see the doctor and she stated that the guard, a male, had said he would make

sure this happened. Ms Hardie saw Mr Chalklen on 3 June 2005 (the day of his collapse) and he told her that he was still waiting to see the doctor. The statement from Mr McMahon, Exhibit C19b, refers to the shoulder pain also. In this statement Mr McMahon refers to Mr Chalklen complaining of pain in his lower left neck progressing down his left arm to the region of his bicep.

- 1.12. This Inquest was first opened on 20 April 2006. On that day I requested that Senior Constable Pascoe make further enquiries to ascertain what evidence existed in relation to any contact that Mr Chalklen may have made of any officer in the Adelaide Remand Centre complaining of left shoulder pain and requesting medical assistance. Senior Constable Pascoe duly made further enquiries and the Inquest was called on again on 1 December 2006. A supplementary Investigating Officer's statement was produced by Senior Constable Pascoe and admitted in evidence as Exhibit C19v in these proceedings. Senior Constable Pascoe states that a statement was obtained from Jacqueline Jeffries (Correctional Officer, Operations 2) who had worked regularly on the "visit desk" at the Adelaide Remand Centre during the time that Mr Chalklen was in custody. Ms Jeffries could not remember Ms Hardie coming regularly to visit Mr Chalklen. She stated that no complaint was ever made to her about Mr Chalklen's health nor any request made that he be allowed to see a doctor.
- 1.13. Senior Constable Pascoe obtained a statement from Christine Woodcock (Case Management Coordinator at the Adelaide Remand Centre) who was acting in the position of Unit Manager, middle level, during most of Mr Chalklen's time in custody. During this time she was responsible for the management of prisoners and staff within unit 4 of the Adelaide Remand Centre. She stated that she was not aware of any complaints made by Mr Chalklen about the need for medical assistance nor for having a sore shoulder.
- 1.14. Senior Constable Pascoe seized the doctor's daily worksheets from the Adelaide Remand Centre Infirmary for the period of Mr Chalklen's incarceration. These worksheets showed no record of Mr Chalklen seeing a doctor or attending the Infirmary.
- 1.15. Senior Constable Pascoe received information from a Raylee Kinnear (Director of Nursing for the Department of Correctional Services) that on 2 June 2005 Mr Chalklen attended the Infirmary at the Adelaide Remand Centre for an

appointment with Psychologist Mr Colin Field. The appointment had been arranged so that Mr Field could prepare a psychological report pursuant to orders made in connection with Mr Chalken's prosecution. Senior Constable Pascoe obtained a statement from Mr Field which was admitted as Exhibit C22d in these proceedings. Mr Field stated that he had no recollection of Mr Chalklen making any complaint to him about a sore shoulder or any current health or medical problems. A copy of the report prepared by Mr Field following the appointment with Mr Chalklen was admitted as Exhibit C22a in these proceedings. In that report, Mr Field wrote:

'Mr Chalklen is a man of probably retarded – low border line intellectual endowment. This is part of a long standing intellectual disability, and it is noted that both Mr Chalklen and two of his brothers were required to attend special schools. He has no significant post school work history, having attended a sheltered workshop for a short period as a young adult but found to be unable to adhere to rules and requirements of that post. Nil work history since, and he is now a longstanding DSP recipient.'

Mr Field also noted that Mr Chalklen was functionally illiterate and was able to complete only the most rudimentary reading and writing tasks. It might be suggested that if Mr Chalklen were in fact suffering from shoulder pain or left arm soreness (a recognised symptom of imminent heart failure) he would have complained about this to Mr Field on 2 June 2005. However, Mr Chalklen was clearly of very low intelligence. He was illiterate. He may not have appreciated that his appointment with a psychologist afforded him an opportunity to raise a matter concerning his physical health. There may be many explanations why he failed to mention any physical health problems.

- 1.16. On 21 June 2006 Senior Constable Pascoe received an email from Mr Steve Raggatt, General Manager of the Adelaide Remand Centre providing a list of the names of 127 staff members who had been identified as staff with whom Mr Chalklen may potentially have had contact during the period of his incarceration, and accordingly, who may have been approached by Ms Hardie or Mr Chalklen as suggested in Ms Hardie's statement.
- 1.17. At this point Inspector Barr, who was then relieving as Officer in Charge of Adelaide Criminal Investigation Branch, became involved in the investigation. He provided a statement which was received as Exhibit C24a in these proceedings. In that statement he says that when he was made aware that there were potentially 127 persons with whom the deceased may have had contact and to whom he may have spoken about his

health, Inspector Barr discussed with his officers the various methods that might be utilised to pursue the investigation. He was informed by his officers that they understood that the only method of obtaining this information was for police to interview each of the 127 officers in the presence of a solicitor.

- 1.18. Inspector Barr discussed the matter with Mr Smedley (who, it will be recalled, is employed by the Department of Correctional Services) by telephone. Inspector Barr suggested that the management of the Adelaide Remand Centre might ascertain from its employees if any of them might be able to assist with the investigation, and in particular whether any employee was aware if Mr Chalklen had made a request to visit the Infirmary prior to his death. The discussion canvassed the possibility of a pro-forma statement being completed by each officer. According to Inspector Barr this was discounted by Mr Smedley. Inspector Barr states:

‘I was made aware of Union concerns and that police would be required to interview each officer in the presence of a solicitor. A discussion on the philosophy of this took place.’

- 1.19. On 17 July 2006 Inspector Barr wrote to the Manager of the Adelaide Remand Centre, Mr Raggatt, in the following terms:

‘Dear Mr Raggatt

Re Death in custody of Stuart Murray Chalklen at the Adelaide Remand Centre on 4 June 2005

Adelaide CIB is conducting investigations on behalf of the Coroner in respect of the death of Stuart Chalklen at the Adelaide Remand Centre (ARC) on 4 June 2005. Mr Chalklen was a prisoner in units 1 and 4 when he was remanded in custody for the period 7 March 2005 to 4 June 2005.

The Coroner has received evidence that Mr Chalklen may have complained to a Correctional Services Officer about pain to his left shoulder and wishing to see a medical officer or be taken to the Infirmary in relation to this.

Police have been asked by the Coroner to try and identify any officer who may have had such a conversation with Mr Chalklen. To this end can an email please be sent to all staff, working within the A.R.C between the relevant dates in the following or similar terms;

An Inquest is being conducted by the State Coroner into the death of Stuart Murray Chalklen on 4 June 2005 whilst in custody at the Adelaide Remand Centre.

In order to assist the Coroner, information is sought as to whether any Correctional Services Officer was spoken to by Stuart Chalklen (or his partner Elaine Hardie on his behalf) complaining of left shoulder pain and requesting to see a medical officer

or be taken to the Infirmary. The conversation might have differed slightly however this was the gravamen of it.

Should any officer have had or be aware of any such conversation they are directed to advise the undersigned by close of business Tuesday 25 July 2006.

Thank you for your assistance with this matter.

Signed

Manager

Adelaide Remand Centre.

I would appreciate if you could confirm to me in writing that an email has been sent to each member working at the ARC within the time frame Mr Chalklen was a prisoner. The Inquest is adjourned until police provide this information to the Coroner so I will need to be advised of any response received by close of business Wednesday 26 July 2006. Police are available at any time to conduct further follow up enquiries should any officer be forthcoming.

Thank you in anticipation.'

- 1.20. Following the dispatch of this letter, Inspector Barr was informed by Mr Raggatt that email was not available to all staff at the Adelaide Remand Centre. Inspector Barr wrote again to Mr Raggatt on 3 August 2006 in the following terms:

'I refer to my letter of 17 July 2006 regarding this matter. I also note our phone conversation following the letter where you advised me email was not available to all staff and were taking steps to disseminate the information by other means.

Since that time the Inquest has been before the Coroner again. The Coroner emphasised that it was expected that police would receive pro-active assistance in respect to their investigations into these matters by other government agencies. The Coroner was advised of the steps taken including my letter to you seeking information from staff and that your department was assisting with the investigation.

So that I might accurately report to the Coroner on the progress of this line of enquiry to ascertain any staff member that may have information that might assist the Inquest I would be grateful if you could provide a written response outlining what attempts have been made to identify any officers with information that might assist the Inquest. Should any such officers be identified SAPOL will arrange for an interview in accord with normal protocols.

I look forward to your early response.'

- 1.21. Mr Raggatt replied by letter dated 8 August 2006. In that letter Mr Raggatt advised:

'An attempt was made on my part to have these questions posed to all staff here at the Remand Centre. However, on advice from the Correctional Officers Legal Fund, I was advised that staff would only respond to the questions if interviewed by SAPOL in the company of legal representation from the fund. This information was passed onto your self by Mr Darrell Smedley, Senior Investigations Officer DCS. Staff indicated that they

would be more than happy to answer any questions posed by police provided they had their legal representation present.’

- 1.22. Mr Raggatt went on to advise that a notice to all staff was placed on all notice boards at the Adelaide Remand Centre on 21 July 2006 with no result. The notice was in the following terms:

‘Adelaide Remand Centre 21 July 2006.

Notice to all staff

Re Inquest – Death in Custody

An Inquest is being conducted by the State Coroner into the death of Stuart Murray Chalklen on 4 June 2005 whilst in custody at the Adelaide Remand Centre.

In order to assist the Coroner, information is sought as to whether any Correctional Services Officer was spoken to by Stuart Chalklen (or his partner Elaine Hardie on his behalf) complaining of left shoulder pain and requesting to see a medical officer or be taken to the Infirmary.

Should any officer have had or be aware of any such conversation they are to advise the General Manager by close of business Tuesday 25 July 2006.

Thank you for your assistance with this matter.

S Raggatt General Manager.’

- 1.23. Inspector Barr made the following remarks in his statement Exhibit C24a in relation to the events set out above:

"The Correctional Services Department in acquiescing to the wishes of the Correctional Services Officers' Legal Fund, that all officers be interviewed by police in the presence of a solicitor, did not contribute towards a timely and efficient inquiry. This investigation perceived a lack of ability or resolve of Correctional Services Management to take a pro-active role in assisting the inquiry.

It was difficult to comprehend that a government employer could not readily ascertain from employees whether they had information that may assist a coronial inquiry. This would then have enabled finite police resources to be focused and proceed in an efficient and effective manner."

- 1.24. I would anticipate the vast majority of the 127 officers and employees identified as potentially having had contact with Mr Chalklen would provide a negative response if asked whether he had ever made a complaint to them of shoulder pain or requested to see a doctor. Indeed, it may be that all 127 would have a negative response. It might be suggested that the obtaining of a negative response from all of these staff members would not have furthered this inquiry and therefore would have been fruitless. I do not accept any such suggestion. The matter having been raised by Ms Hardie, there

was a line of inquiry that needed to be pursued. For my part, I can see no reason why the 127 officers involved could not have been requested to provide a response to an inquiry in the form of that contained in the letter from Inspector Barr dated 17 July 2006. A number of options presented themselves. It would have been possible for the department to have given a direction to its employees requiring them to provide a response. Of course, an employee could not be made to provide a response that might have incriminated himself or herself. Nevertheless, it would have been possible for answers to be obtained from, as I said, the vast majority of employees, negating them as possible further lines of enquiry. Another option would have been to make participation voluntary: each staff member might be requested to provide a response one way or the other, or to specifically decline to respond. In short, any measure which might have reduced the number of officers required to be interviewed from 127 to some more manageable number would have been welcomed.

- 1.25. In my opinion, the position adopted by the management of the Adelaide Remand centre, the relevant officers or those of them who were aware that such a request had been made, and the governing members of the Correctional Services Legal Fund has created a situation in which it is impractical to take the inquiry any further. Of course, it would be possible for Senior Constable Pascoe to interview each and every one of the 127 officers in the presence of a solicitor provided by the Correctional Services Officers legal Fund. I have no doubt that such an exercise would take an extremely long time to complete. For that reason, and having regard to the fact that police resources are, to use Inspector Barr's word, "finite", I have not insisted that the Investigating Officer pursue this line of inquiry. Another option would have been to issue process to each of the 127 officers requiring him or her to come before the Court and provide a response under oath. Once again, such an approach would take a very long time, and I have elected not to pursue it. Of course, in adopting this approach, I bear in mind that pursuant to section 26(1) of the Coroner's Act 2003, this Court may reopen an Inquest at anytime, and must do so if the Attorney General so directs.

2. Conclusion

- 2.1. I find that Mr Chalklen died in lawful custody of ischaemic heart disease due to severe coronary atherosclerosis. As noted by Dr Gilbert in his post mortem report which was admitted as Exhibit C3a in these proceedings, 38 years of age is a relatively young age for a person to die of ischaemic heart disease. I suspect that Mr

Chalklen was experiencing symptoms which, if properly investigated medically, may have been treatable. Such treatment may have prevented his death. I am unable to say whether Mr Chalklen did request medical attention during his stay in the Adelaide Remand Centre. Bearing in mind his low intelligence, it is possible that he himself failed to recognise the seriousness of his symptoms. On the other hand, Ms Hardie's evidence was to the effect that a complaint was made. If so, then an officer or officers failed to carry out the simple duty of ensuring that he attend the Infirmary for medical examination.

- 2.2. I recommend pursuant to Section 25(2) of the Coroner's Act 2003 that the Department for Correctional Services commence negotiations with the Public Service Association and the Correctional Officers Legal Fund with a view to developing a protocol under which some greater level of cooperation with coronial inquiries might be achieved. A simple expedient would be for officers to advise that they do or do not have any useful information to provide, always reserving the right to decline to answer questions that might incriminate them. This could be achieved without the need for each officer to be interviewed by a police officer in the presence of a solicitor, most obviously in cases where the officer has no knowledge or information to impart. If such a protocol cannot be settled upon within the time at which a report is required pursuant to section 25(5)(a) of the Act to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of this recommendation, I further recommend that a subsequent report be laid before each House of Parliament at a point where such a protocol exists or efforts to negotiate for one have been abandoned by the Department for Correctional Services. A copy of any such further report should also be provided to the State Coroner.

Key Words: Correctional Services; Death in custody; Ischaemic heart disease; Prisons

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

Seal the 30th day of January, 2007.

State Coroner