



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 10th and 11th days of September 2007, and the 26th day of September 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Robert Allen Johnson.

The said Court finds that Robert Allen Johnson aged 37 years, late of 5 Forster Street, Wasleys died at Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia on the 21st day of September 2005 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Robert Allen Johnson was 37 years of age at the date of his death on 21 September 2005 at the Yatala Labour Prison. Mr Johnson, who was born on 5 October 1967, was an inmate at Yatala Labour Prison at the time of his death, having been remanded in custody on charges of Aggravated Serious Criminal Trespass, Unlawful Detention, Rape and Assault Occasioning Actual Bodily Harm. Accordingly, Mr Johnson's was a death in custody within the meaning of that expression in the Coroner's Act, 2003 and this Inquest was held as required by Section 21(1)(a) of that Act.
- 1.2. Senior Constable First Class Grimaldi conducted a thorough investigation into this matter, which is summarised in a statement provided by him together with an investigation summary. These documents were admitted as Exhibit C26a and C26b respectively in these proceedings. Senior Constable Grimaldi obtained a number of statements from witnesses who had some involvement with Mr Johnson during his periods in police custody, his transport by GSL Custodial Services Limited, and his custody at the Yatala Labour Prison. At the Inquest, oral evidence was taken from

Steven Rapisarda, who was the Acting Supervisor of Admissions at the prison and who carried out a prisoner screening assessment of Mr Johnson on the afternoon of 20 September 2005, nurse Susan Rex, a Clinical Nurse Consultant at Yatala Labour Prison who carried out a nursing assessment of Mr Johnson upon his arrival at Yatala Labour Prison on 20 September 2005, Julie Kerslake, a Correctional Officer in E Division, first watch, on the afternoon of 20 September 2005 who assigned Mr Johnson a cell upon his admission to E Division that afternoon, and Stephen Nash, a Correctional Officer who discovered Mr Johnson suspended from the upper rail of his double bunk in the early hours of 21 September 2005. Mr Johnson was found with his head positioned between the safety rail and the base of the upper bunk of the double bunk in his cell. His body was suspended from that position. Dr Allan Cala, Forensic Pathologist, performed a post mortem examination upon the body of Mr Johnson and gave his cause of death as hanging, and I so find. More particularly, Dr Cala stated:

‘Post mortem examination confirmed a cervical spine injury caused by the extraordinary hanging manoeuvre. There was a fracture of the 4th cervical vertebrae, with transection of the spinal cord. Examination of the larynx showed no abnormality, however a degree of positional asphyxia may also have arisen due to the severely twisted upper airway.’

- 1.3. Mr Johnson was arrested on 19 September 2005. He was not granted police bail, and appeared in the Elizabeth Magistrates Court the following day. He was refused bail again and remanded in custody to appear in court on 2 November 2005. As a result of his remand, Mr Johnson was conveyed by GSL to Yatala Labour Prison where he was admitted to the Yatala holding cells at approximately 4:30 pm on 20 September 2005. He was found dead in his cell in E Division at approximately 3:02 am on 21 September 2005. The allegations against Mr Johnson had been made by his step-daughter and her friend. These young women shared premises that they were renting from Mr Johnson.
- 1.4. It is important to note that it is no part of the function of this court to consider the guilt or innocence of Mr Johnson of the allegations made against him by his step-daughter and her friend. However, I do record that Mr Johnson denied the allegations, that there was a history of disputes between Mr Johnson and his step-daughter of a financial nature over a considerable period, and on the material I have seen, there appeared to be some evidence that would have tended to support the charges, and other evidence that would appear to have been exculpatory. At the time

of his tragic death, Mr Johnson had been convicted of no offence and was entitled to the presumption of innocence.

- 1.5. Mr Johnson had no history of mental illness. A statement was obtained from his general practitioner, Dr Alan Roberts¹. Dr Roberts had known and treated Mr Johnson since 1978 and believed that he had been Mr Johnson's only general practitioner. Over those years, the only significant illness that Dr Roberts was aware of was a work-related back injury. Dr Roberts saw Mr Johnson for multiple minor complaints such as coughs and colds and minor injuries. He reported seeing Mr Johnson in 2002 and noted that he was suffering with an anxiety state which Dr Roberts thought was probably related to the WorkCover back injury and the legal process related to that injury. The only other matter of note was a diagnosis of sleep apnoea in 2003. Dr Roberts stated that during the time he had known and treated Mr Johnson, he had never had any cause to suspect that Mr Johnson was depressed. Dr Roberts described Mr Johnson as a relatively positive and straightforward citizen. Dr Roberts knew that Mr Johnson's mother had died from chronic kidney failure some time prior to Mr Johnson's death. Dr Roberts speculated that Mr Johnson's suicide may have been a manifestation of some sort of psychiatric reaction to his mother's illness and death.
- 1.6. According to a statement of Jennifer Jane Johnson², she and Mr Johnson had been married for 17 years prior to his death. She described Mr Johnson as a happy-go-lucky person who was rarely depressed or upset.
- 1.7. According to Mrs Johnson, Mr Johnson's mother died one week before Mr Johnson's death in Yatala Labour Prison. It appears that his mother's funeral was to take place on 21 September 2005, that is, the day on which, in the early hours of the morning, Mr Johnson took his own life. Although Dr Roberts was not aware of that fact when he gave the statement to which I have already referred, I would expect that it would have reinforced his tentative view that Mr Johnson's decision to take his own life may have been influenced by factors pertaining to his mother's death, particularly the fact that he would not be present at her funeral that day.

¹ Exhibit C6a

² Exhibit C4a

2. **Mr Steven Rapisarda**

- 2.1. Mr Rapisarda gave evidence at the Inquest. I have already noted that he was the Acting Supervisor of Admissions at Yatala Labour Prison at the time that Mr Johnson was presented there for incarceration pursuant to the warrant for imprisonment. Mr Rapisarda was able to say by reference to Mr Johnson's case management file³, that Mr Johnson was presented at approximately 4:39 pm. Mr Rapisarda saw Mr Johnson and read the warrant of imprisonment to him. Mr Rapisarda completed a reception checklist in relation to Mr Johnson in which he ticked a box designating that Mr Johnson may be potentially suicidal. Mr Rapisarda could not recall at the Inquest, nor when questioned by Senior Constable Grimaldi, the reason why he assessed Mr Johnson as potentially suicidal at that time. He thought that the decision may have been affected by Mr Johnson's demeanour at that time or possibly because of the nature of the charge involving as it did an allegation of a sexual offence against a female family member. In any event, as the evidence will show, Mr Rapisarda conducted a more comprehensive prisoner screening interview with Mr Johnson some 90 minutes later at which he revised this opinion, deciding that Mr Johnson was not then a suicide risk.
- 2.2. After Mr Johnson had been strip-searched and showered he was seen by Nurse Rex whose evidence I will discuss shortly. After being seen by nurse Rex, he was returned for interview by Mr Rapisarda when the prisoner stress screening form contained in the case management file⁴ was completed. The prisoner stress screening form is a standard document in use in the Department for Correctional Services. It is designed to elicit information about the risk of self-harm that may exist for any new prisoner. The responses required to be elicited pursuant to that form did not result in Mr Johnson being assessed as a prisoner at risk of self-harm. I have carefully reviewed the prisoner screening form and considered Mr Rapisarda's evidence upon this point. In my view, he carried out his role appropriately.
- 2.3. Mr Rapisarda said that he made an attempt, at Mr Johnson's request, to contact Mr Johnson's wife. He was aware of the nature of the allegations against Mr Johnson. Mr Rapisarda put to the deceased that his wife may not wish to hear from him in the circumstances but the deceased explained that his wife was "on his

³ Exhibit C26e

⁴ Exhibit C26e

side” and also informed Mr Rapisarda that the alleged victim was “making it up” and “setting him up”. Mr Rapisarda attempted to contact Mrs Johnson to see if she was prepared to receive the call but there was no answer. Accordingly, he asked another officer to make an attempt to contact her on behalf of Mr Johnson later in the day.

- 2.4. Mr Rapisarda also gave evidence that from his knowledge of the operations of E Division at that time, there was no rule or standard operating procedure that required that newly admitted prisoners to E Division be doubled up with other prisoners. However, he was aware that since Mr Johnson’s tragic death, a direction has been put in place that all new prisoners are to be doubled up in E Division and if that cannot be achieved then a prisoner who cannot be placed with others will be sent to G Division. Mr Rapisarda noted that on occasions a prisoner will be taken from the “3 up” cell and put in with a new prisoner if the numbers cannot otherwise be arranged to achieve that.
- 2.5. Mr Rapisarda also noted that not all correctional officers have access to the email system within the Correctional Services Department. He commented that this can result in some officers not becoming aware of directives issued by management for some time. He suggests a system be devised pursuant to which all incoming memos are placed in a folder and individual officers are required to initial the new memos to indicate that they have read those. This seems to be an eminently sensible proposal, and while I refrain from making a recommendation in relation to this, I commend Mr Rapisarda’s suggestion for consideration by the Department for Correctional Services.

3. Ms Susan Rex

- 3.1. Ms Susan Rex was the Clinical Nurse Consultant who saw Mr Johnson upon his admission at Yatala. She stated that she saw Mr Johnson at approximately 5:00 pm on 20 September 2005. She stated that he was, initially, very angry because he had been remanded in custody until November. He was very angry because he said he should not have been remanded but should have been ‘let off’. However, he stated that he believed that he would be ‘let off’ in November. She took a history from him, which was consistent with the medical history I have set out above. Nurse Rex stated that she conferred with Mr Rapisarda after the latter had interviewed Mr Johnson following her own assessment of him. She checked with Mr Rapisarda that

Mr Johnson had advised that his wife was supportive of him, and Mr Rapisarda confirmed this. Nurse Rex and Mr Rapisarda together decided that Mr Johnson could be admitted to E Division, although she had assumed that this would likely mean that Mr Johnson would be doubled up.

- 3.2. Nurse Rex said that Mr Johnson made very good eye contact with her and he said he had good family support. Mr Johnson was thinking about future events and from this Nurse Rex inferred that he was stable. Nurse Rex stated that by the time she had finished talking with Mr Johnson he had calmed down considerably from his initial anger. She said that that is not an uncommon occurrence.

4. Ms Julie Kerslake

- 4.1. Ms Julie Kerslake has been a Custodial Officer for seven years and was working in E Division in September 2005. She stated that E Division is an induction/reception division. She was working on a shift commencing at 4:00 pm and finishing at 11:00 pm on 20 September 2005. She recalled that Mr Johnson was delivered to E Division at approximately 6:00 pm. She said that he was calm and polite and was escorted to E Division along with two other prisoners who had returned from court appearances that day. According to Ms Kerslake, the holding cells staff who accompanied Mr Johnson and the other two prisoners stated that there would be another three prisoners likely to be delivered that night. She placed Mr Johnson in cell 310 and gave him a ration pack and a bed pack. She said that the other two prisoners were returned to their own cells. Although E Division is an induction and reception centre for the prison, she said that it was not unusual for some prisoners to be in E Division for as long as a year, and that the prisoners returning for court were long stay prisoners. She stated that a further three prisoners were brought into E Division after Mr Johnson and his group. She thought that one of them had special needs and accordingly had to go to Unit 1. The other two were doubled up and that left Mr Johnson on his own.
- 4.2. Ms Kerslake stated that in 2005 if holding cells staff said that a prisoner needed to be doubled up the E Division staff would ensure that occurred even if it meant “unmastering” a cell. However, there was no rule that a prisoner be doubled up, even on first admission. Her practice was to double them up whenever possible.

- 4.3. Ms Kerslake had no concerns about Mr Johnson. She was not aware of the offence with which he had been charged but formed the view (incorrectly) that he was in for a “white collar” crime. She said that he was very polite and courteous and was different from most prisoners that she sees.
- 4.4. Ms Kerslake recognised Exhibit C38a which was an instruction issued to all staff on 13 October 2005 by Mr Gary Oxford, the Acting General Manager of Yatala Labour Prison. That memo appears to have followed shortly after Mr Johnson’s death and to have been instigated as a result of his death. It provides that all newly admitted prisoners are to be doubled up for the initial seven days of induction unless otherwise directed by medical staff or the general manager and that where there is no cell mate available, consideration should be given to housing the newly admitted prisoner for overnight purposes on the floor on a mattress in an already doubled up cell, or in the infirmary, or in G Division if beds are available.
- 4.5. Ms Kerslake took Mr Johnson a cup of hot water at approximately 7:10 pm in conjunction with a general patrol at that time. She noted that he was very calm and was showing no signs of agitation at all at that time.

5. Mr Stephen Nash

- 5.1. Mr Stephen Nash has been a Correctional Officer for 15 years. He was on duty in E Division at Yatala on the nightshift commencing at 10:40 pm on 20 September 2005 and finishing the following morning. He conducted patrols to check that all prisoners were present and not showing any signs of distress. When he conducted a patrol at 1:00 am he recalled seeing Mr Johnson lying on the bottom bunk in his cell. However, when he conducted his patrol at 3:00 am he could see that Mr Johnson was in an odd position. Mr Johnson’s hands were by his side, and Mr Nash could not see Mr Johnson’s head. He called out to Mr Johnson through the trapdoor to the cell but obtained no response. At that point Mr Nash noticed that Mr Johnson’s feet were not on the ground and that there was some blood on the floor. He called a “code black” medical emergency. He did this by means of his handheld radio which can be heard in the control room and by other officers by means of their radios. According to Mr Nash, another officer, Mr Hickman, arrived with the master key after a short time. Two nurses from the infirmary also attended, having heard the code black call. One of the nurses tried to take a pulse on Mr Johnson’s right wrist but said that it appeared

that Mr Johnson was dead. Mr Nash resumed his duties for the evening after completing a report upon the incident.

6. Conclusion

- 6.1. I consider that Mr Johnson was appropriately assessed upon admission at the Yatala Labour Prison. I note that Mr Rapisarda initially assessed him as a suicide risk. However, upon closer questioning as required by the prisoner stress form, Mr Rapisarda revised this opinion. He was not surprised to note a change in Mr Johnson's demeanour over a period of 90 minutes or so, because this is not an uncommon phenomenon with persons newly admitted to prison. Furthermore, his assessment coincided with that of Nurse Rex.
- 6.2. I consider that the prison officers and prison health services staff involved with Mr Johnson carried out their duties in an appropriate manner.
- 6.3. The systemic failure which is readily identifiable in this case is the same as that which has been identified in numerous previous Inquests. The double bunk bed in Mr Johnson's cell was not "safe" in the sense that it readily lent itself to an act of self-harm. It afforded ample opportunity for a prisoner bent on self-harm to find a tying point from which to suspend himself upon a ligature, or, to harm himself in the manner chosen by Mr Johnson. As I noted in my finding in relation to John Trenorden, finding number 2/2007, it is a simple matter for a person to take his own life in the general environment at Yatala Labour Prison. Many previous Inquest findings have drawn this same conclusion and I simply adopt and reiterate previous recommendations in that regard without specifically setting them out again. It is a sad fact that the double bunk used by Mr Johnson to take his own life is still in use in Yatala Labour Prison today. It has not been modified, and could be used in precisely the same manner as it was by Mr Johnson at any time.
- 6.4. I refer again to the bunk beds mentioned in the finding into the death of John Trenorden. Mr Johnson's case should serve as a stark reminder of the benefits that could ensue from a speedy implementation of the prototype beds referred to in that finding.

6.5. I refrain from making any recommendation in this case. Recent recommendations of the Court, if implemented, would be sufficient to address the systemic problems identified in this case and which contributed to Mr Johnson's death.

Key Words: Correctional Services; Death in custody; Hanging; Prisons; Suicide risk - assessment of.

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

Seal the 26th day of September, 2007.

State Coroner