



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 30th day of April 2007, the 1st, 2nd, 3rd, 4th, 7th, 8th, 10th, 11th days of May 2007, and the 12th day of July 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Colin Craig Sansbury.

The said Court finds that Colin Craig Sansbury aged 24 years, late of 10 Almont Street, Pooraka died at Lyell McEwin Health Service, Haydown Road, Elizabeth Vale, South Australia on the 17th day of November 2004 as a result of diffuse hypoxic ischaemic encephalopathy due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Colin Craig Sansbury, born 9 January 1980, was 24 years old at the time of his death on Wednesday, 17 November 2004. An autopsy was carried out by Dr Karen Heath, Forensic Pathologist on 18 November 2004. A report was prepared by Dr Heath and a copy was admitted as Exhibit C5a in these proceedings. Dr Heath gave the cause of death as diffuse hypoxic ischaemic encephalopathy due to hanging and I so find.
- 1.2. Mr Sansbury had suspended himself from a ligature which he had fashioned out of a disposable jumpsuit with which he had been provided while a prisoner in custody at the Elizabeth Police Station cells. This occurred on the morning of Monday, 15 November 2004 between the hours of approximately 9:40am and 10:20am in cell C3 at the Elizabeth Police Station cells. As Mr Sansbury was a prisoner at that time

(and, as a matter of law, at the time of his death in the Lyell McEwin Health Service¹ on 17 November 2004) Mr Sansbury's was a death in custody within the meaning of the Coroner's Act 2003 and accordingly this Inquest was held as required by section 21(1)(a) of that Act.

2. **Mr Sansbury's arrest**

- 2.1. Senior Constable Amanda Weaver made a statement for the purposes of this Inquest on 19 January 2005 a copy of which was admitted as Exhibit C25c in these proceedings. She was one of the arresting officers who apprehended Mr Sansbury on 13 November 2004. She states that Mr Sansbury was arrested as part of the operation "Stop Car Theft" which is a police operation intended to detect car thieves. It is run in conjunction with the Royal Automobile Association of South Australia and involves the use of a specially prepared vehicle which is left in targeted locations. The vehicle is set up in such a way that if stolen the engine can be electronically disabled by an independent operator.
- 2.2. At about 1:00pm on Saturday, 13 November 2004 Senior Constable Weaver was on duty in company with Constable Karpany at the Ingle Farm Shopping Centre. She and Constable Karpany had left the "Stop Car Theft" vehicle in the south-western car park of the Ingle Farm Shopping Centre with the keys in the driver's side door. She and Constable Karpany were observing the vehicle from an unmarked van about 100 metres away. They saw a person, later identified as Mr Sansbury, approach the driver's side of the car, remove the keys from the door, unlock it and enter the car. Mr Sansbury started the vehicle and reversed it out of the parking space and then drove it in the general direction of the van. These actions were captured by a video surveillance camera. Senior Constable Weaver and Constable Karpany emerged from the unmarked van and Senior Constable Weaver immobilised the Commodore using a remote control device which she had in her possession. The vehicle rolled to a stop.
- 2.3. The police officers attempted to detain Mr Sansbury and requested that he put his hands on the roof. Instead, Mr Sansbury pulled a stereo set from its position between the front seats and then used it to smash the passenger side rear window of the vehicle. He then started to climb out of the window, and despite being sprayed by

¹ I note that during at least a part of the time when Mr Sansbury was in the Intensive Care Unit at the Lyell McEwin Health Service, Constable Ludgate acted as his "hospital guard" – see Exhibit C54a, statement of Constable Ludgate

Constable Karpany with capsicum or O/C spray, Mr Sansbury continued to climb out of the vehicle and attempt to make off. The officers temporarily detained him but he broke free and ran away.

- 2.4. In the course of his flight Mr Sansbury ran into Walkley's Road and stopped a small silver coloured sedan being driven by a woman. He yelled at the driver to let him in but the female driver locked the doors to the vehicle. The police officers both grabbed Mr Sansbury again and struggled with him in the centre of the median strip of Walkleys Road. He resisted their arrest and eventually broke free by slipping out of the clothing on his upper body. He then continued with his attempt to escape and climbed over a fence into a private house premises.
- 2.5. Mr Sansbury was eventually cornered in the backyard of a dwelling and approached by Senior Constable Weaver and another officer who was one of several police officers who had joined in the operation by that stage. His name was Constable Bachmann. Constable Bachmann had his O/C spray out and as he and Senior Constable Weaver approached Mr Sansbury, Constable Bachmann shouted "get your hands up or I'll spray you" or words to that effect. Mr Sansbury then reached into a nearby bush as if making to grab something at which Constable Bachmann sprayed Mr Sansbury with O/C spray.
- 2.6. Mr Sansbury was then held to the ground and after some further resistance handcuffed by the officers.
- 2.7. It was also alleged against Mr Sansbury that in the course of this attempted flight he assaulted an elderly lady in the backyard of a dwelling near the place of his ultimate apprehension, held a knife to her throat and demanded to be given a motor vehicle.
- 2.8. According to a statement of Senior Constable Shaun Clark which was admitted as Exhibit C26a in these proceedings, he assisted in the aftermath of the arrest of Mr Sansbury. He stated that at about 1:50pm Mr Sansbury was placed into the rear of a cage car which was driven by Senior Constable Clark to the Elizabeth Police Station. They arrived at the Elizabeth Police Station at about 2:10pm. On arrival at the police station Senior Constable Clark took Mr Sansbury into the shower area and removed his handcuffs and clothing and placed him in the shower. He then instructed Mr Sansbury to stand under the shower and wash his eyes out. The purpose of this was to wash the residual capsicum spray from Mr Sansbury's body and particularly

his eyes. Shortly after this police officers Weaver and Karpany arrived at the Elizabeth Police Station and Senior Constable Clark handed Mr Sansbury to their care. He resumed his other patrol duties at about 2:20pm.

3. Events at Elizabeth Police Station between Mr Sansbury's arrival and formal charging

- 3.1. Senior Constable Allan Gollan gave evidence at the Inquest. He also provided a statement which was admitted as Exhibit C92 in these proceedings. He said that on Saturday, 13 November 2004 he heard reports over the police radio that an incident had taken place at Ingle Farm and that there was an Aboriginal suspect and police were giving chase. With his partner, Senior Constable Rodell, Senior Constable Gollan made his way to the location. In his oral evidence Senior Constable Gollan explained that he is a Community Constable and is himself an Aboriginal man. He has the same powers as any other police officer but also has a role in relation to policing matters that touch upon members of the Aboriginal community. He stated that when he heard over the radio that the suspect who was being pursued at Ingle Farm was an Aboriginal person, he attended in the ordinary course of his duties. He stated that if what he described as an "Aboriginal tasking" is called, he and his colleagues will assist as a matter of course because of their knowledge of matters touching upon the Aboriginal community. He stated that members of his unit have what he described as a "free hand" in their role.
- 3.2. He stated that he attended at the scene of the arrest and observed a person who he later realised was Mr Sansbury being detained by police officers. Mr Sansbury was yelling and screaming due to the fact that he had been sprayed². Senior Constable Gollan recognised Mr Sansbury as someone with whom he had had previous dealings and accordingly he made his way to the Elizabeth Police Station with the intention of speaking to Mr Sansbury.
- 3.3. Senior Constable Gollan stated that he had been contacted by other police officers involved in a police operation referred to as "Mandrake 3". This operation concerned a number of crimes involving stolen vehicles in the Adelaide metropolitan area. Mr Sansbury was believed to be a person of interest in relation to the inquiries in Operation Mandrake 3 and officers involved in that operation requested that Senior

² Exhibit C92

Constable Gollan approach Mr Sansbury with a view to “debriefing” Mr Sansbury. Senior Constable Gollan said that the purpose of this was to “see what we could obtain from him in relation to the offence committed that day and whatever information we could obtain in relation to other crimes”³.

- 3.4. Senior Constable Gollan said that he attended at the Elizabeth Police Station cell complex at approximately 2:00pm on 13 November 2004. On his arrival at the station he met with Senior Constable Caskey who was working as an Intelligence Officer in Operation Mandrake. Senior Constable Gollan stated that because Mr Sansbury was an Aboriginal person, he (as a Community Constable) was afforded an opportunity to speak to Mr Sansbury. He stated that “by doing that we're able to source information from prisoners as to the crime committed on the day⁴ or other information that may link other persons to other crimes previously”⁵. Senior Constable Gollan stated that Senior Constable Caskey requested that he obtain from Mr Sansbury whatever information he could in relation to previous offences connected with Operation Mandrake⁶.
- 3.5. Senior Constable Gollan was under the mistaken belief that the arresting officers Weaver and Karpany had finished interviewing Mr Sansbury and that he was available to be interviewed by other officers. He said that had he not had that understanding he would not have sought to interview Mr Sansbury at that stage. He sought permission from the Duty Sergeant to interview Mr Sansbury and the Duty Sergeant asked where Senior Constable Gollan wished to see Mr Sansbury. In the result Senior Constable Gollan saw Mr Sansbury in a room which is referred to as an interview room on Exhibit C64c which is a plan of the Elizabeth Police Station cell area. Senior Constable Gollan stated that Mr Sansbury presented as anxious and concerned. Mr Sansbury admitted his correct identity to Senior Constable Gollan, and referred to Senior Constable Gollan as “uncle”, which is a mark of respect. Senior Constable Gollan stated that Mr Sansbury was “trying everything possible” to express his concern about being returned to prison. Mr Sansbury stated that he was aware of information which might assist police and wished to be released if he provided that

³ Exhibit C92

⁴ I note that this is contrary to the “Policy Statement 29, Prisoner Debriefs” Exhibit C78b, which provided “The prisoner debrief process is not intended to gain further evidence concerning the matter that the person has been charged with”. In fact, at the relevant time, Mr Sansbury had not been charged. It is arguable that the policy did not permit the debrief to take place at all.

⁵ Transcript, page 531

⁶ Transcript, page 533

information. Senior Constable Gollan provided a mobile telephone to Mr Sansbury to make telephone calls for the purposes of obtaining the information he referred to. One of the telephone calls made by Mr Sansbury was to a person who Senior Constable Gollan took to be Mr Sansbury's de facto partner. During that conversation Mr Sansbury said "Well tell my son that I'm dead. I've always been dead and I won't be coming home"⁷.

- 3.6. Senior Constable Gollan gave evidence that he immediately asked Mr Sansbury what he meant by those words and in particular if there was anything wrong. Senior Constable Gollan said that Mr Sansbury said words to the effect, "Uncle, I won't be here in the morning". Senior Constable Gollan then asked Mr Sansbury if he was expressing that he wished to hurt himself. Mr Sansbury just smiled and that was the end of that exchange. Senior Constable Gollan brought this matter to the attention of the Duty Sergeant and understood that Mr Sansbury would be placed in the padded cell⁸.
- 3.7. In his oral evidence Senior Constable Gollan could not remember how long he spent with Mr Sansbury that afternoon, but conceded that it could have been anywhere between half an hour and two hours⁹. Senior Constable Gollan also said that he made no notes about his interview with Mr Sansbury¹⁰.
- 3.8. Senior Constable Gollan acknowledged that it is part of the role of his unit to elicit information from Aboriginal persons who are thought to be involved in crime for intelligence purposes. He acknowledged that he and other Community Constables are able to use their circumstances to establish trust between themselves and the person in custody and this assists in eliciting such information. In effect, he is able to develop a cultural or trusting connection which leads the Aboriginal prisoner to reveal more information than they otherwise would¹¹.

⁷ Exhibit C92, Transcript, page 537

⁸ Transcript, page 538

⁹ Transcript, page 545

¹⁰ Transcript, page 555

¹¹ Transcript, page 559-560

- 3.9. Senior Constable Gollan said that Mr Sansbury was not known to be an offender in relation to Operation Mandrake offences, but that he may have been an associate of some of the offenders¹².
- 3.10. Senior Constable Gollan agreed that he said to Mr Sansbury words to the effect that the offences with which he was charged were of a serious nature and that he would most likely be sentenced to a term of imprisonment between five and ten years¹³. Senior Constable Gollan acknowledged that he told Mr Sansbury that if he gave information which the police thought was useful it might help him in getting bail¹⁴. Senior Constable Gollan denied though that he left Mr Sansbury with the impression that he would in fact be given bail¹⁵.
- 3.11. Senior Constable Gollan stated that at the time of his interview with Mr Sansbury, the latter was wearing a white jumpsuit.
- 3.12. It should be noted that at the time of the interview carried out by Senior Constable Gollan, Mr Sansbury had not been formally charged with any offences. In fact, according to a statement of Sergeant Schwanz which was admitted as Exhibit C85 in these proceedings, Mr Sansbury was not charged until approximately 6:45pm. At that time he was charged with the offences of illegal use, resist police, assault police, aggravated robbery, non-aggravated serious criminal trespass, unlawful possession, possess cannabis, property damage, false name and address and drive unlicensed.

4. Mr Sansbury is interviewed by Officers Weaver and Karpany

Senior Constable Amanda Weaver made an affidavit which was admitted as Exhibit C25 in these proceedings. The affidavit has attached to it a record of interview dated 13 November 2004 between Senior Constable Weaver, Constable Karpany and Mr Sansbury. That record of interview was admitted as Exhibit C25a. It shows that the arresting officers commenced the interview with Mr Sansbury at 5:26pm on 13 November 2004. The interview proper finished at 5:47pm that day and at 5:50pm a further interview was conducted in relation to the carrying out of a forensic procedure. That record of interview was admitted as Exhibit C25b. It finished at 6:03pm that day. A reading of those transcripts conveys the impression that Senior

¹² Transcript, page 563

¹³ Transcript, page 565

¹⁴ Transcript, page 567

¹⁵ Transcript, page 568

Constable Weaver was extremely patient and professional in her approach to the interrogation of Mr Sansbury. That impression is borne out by an audiovisual recording of the interview which I have viewed.

5. **Mr Sansbury is charged**

- 5.1. Sergeant Schwanz gave evidence at the Inquest. He was acting in the position of Cell Sergeant at the Elizabeth Police Station in November 2004. A statement made by him was admitted as Exhibit C85 in these proceedings. He also gave evidence at the Inquest. He said that he started his shift on 13 November 2004 just before 3:00pm¹⁶. He became aware that Mr Sansbury was within the police station complex some time prior to Mr Sansbury being charged. He could recall Senior Constable Gollan telling him that Mr Sansbury had a number of funerals to attend the following week and that he was anxious to attend those funerals so bail would be an important issue to him¹⁷.
- 5.2. I have already noted that Sergeant Schwanz charged Mr Sansbury at approximately 6:45pm. He confirmed that he was satisfied on the allegations made by the arresting officers that it was appropriate to charge Mr Sansbury¹⁸. Sergeant Schwanz stated that Mr Sansbury was afforded an opportunity to apply for bail¹⁹, and he duly did make such an application. Sergeant Schwanz considered the application and decided to refuse bail²⁰. The bail refusal decision was made at 7:40pm²¹.
- 5.3. At the time of the charges being laid, the arresting officers completed a PD331 – Prisoner Screening Form. This form recorded that Mr Sansbury appeared to be under the influence of alcohol or drugs to a slight extent. It recorded that he was in possession of medication which was noted to be “Ducene”. In response to the question whether the prisoner had given any indication that he may be a person at risk, the arresting officer answered “No”. On the reverse side of the PD331 there is a charging sergeant’s questionnaire. This was completed by Senior Constable O’Malley who was assisting Sergeant Schwanz in the charging process. The questionnaire recorded that Mr Sansbury was taking medication which was described as diazepam. It responded negatively for the question whether he had any serious

¹⁶ Transcript, page 63

¹⁷ Transcript, page 71

¹⁸ Transcript, page 76-77

¹⁹ Transcript, page 79

²⁰ Transcript, page 82

²¹ Transcript, page 89

medical including psychiatric problems, whether he had suffered head injuries or experienced loss of consciousness or had sustained other injuries. The PD331 was admitted as part of Exhibit C85a in these proceedings.

- 5.4. Sergeant Schwanz described Mr Sansbury's demeanour as being "up and down". At times Mr Sansbury was stable but at other times he was agitated and emotional. Sergeant Schwanz explained that the decision to refuse bail is conveyed to the prisoner on a prescribed bail refusal form. He provided Mr Sansbury with a copy of the form and read its contents to him in their entirety. The form has provision for the prisoner to acknowledge receipt of the form and that was presented to Mr Sansbury²². Mr Sansbury drew a stick figure of a person with a line coming up from the person's head instead of signing the acknowledgement of receipt. This occurred at the charge counter. Sergeant Schwanz said that he asked Mr Sansbury what the drawing was supposed to mean but Mr Sansbury did not respond. Sergeant Schwanz became extremely concerned, stating in evidence, "It concerned me, yes. For the want of a better word, it depicts a person hanging."
- 5.5. As I have already stated, Sergeant Schwanz was particularly concerned by that image apparently depicting a person hanging. He took it to mean that Mr Sansbury might be contemplating self-harm²³. He resolved to make arrangements for a visitor from the Aboriginal Visitors Scheme to attend at the police station. He also said that it was normal practice to advise the Aboriginal Legal Right Movement ("ALRM") of Mr Sansbury's arrest²⁴. The ALRM notification occurred at approximately 7:54pm that night²⁵. Mr Sansbury had requested that the bail refusal be reviewed by a Magistrate in accordance with the Bail Act. Contact was made with the Duty Magistrate at 8:40pm that evening²⁶. Sergeant Schwanz stated that during the telephone consultation between the Duty Magistrate, Mr Sansbury, Mr Sansbury's brother and Sergeant Schwanz, Mr Sansbury became quite emotional. Sergeant Schwanz was fairly certain that Mr Sansbury was crying during this conversation²⁷. The on duty Magistrate, having heard what Mr Sansbury, his brother and Sergeant Schwanz had to say, decided to uphold the bail refusal decision. The on duty

²² Transcript, page 85-86

²³ Transcript, page 87

²⁴ Transcript, page 87

²⁵ Transcript, page 92

²⁶ Transcript, page 92

²⁷ Transcript, page 95

Magistrate asked Sergeant Schwanz to communicate with the prosecution section and request that during Mr Sansbury's first Court appearance, the Court instigate a home detention report with emphasis on Mr Sansbury's eligibility for home detention bail with a monitoring bracelet. Sergeant Schwanz complied with this request by putting a note on Mr Sansbury's prosecution file to that effect²⁸.

- 5.6. After the bail refusal decision had been made by the Magistrate, Sergeant Schwanz allowed Mr Sansbury's brother and another Aboriginal male person to visit with Mr Sansbury in the visitor's room. Sergeant Schwanz placed no time limit on the visit, telling Mr Sansbury and his brother that they could spend as much time as they wished²⁹.
- 5.7. The visitor from the Aboriginal Visitors Scheme, Ms Patricia Mitchell, arrived at the cell complex at 10:15pm³⁰. Mr Sansbury was still in the visitor's room with his brother and the other male visitor when Ms Mitchell arrived³¹. Sergeant Schwanz told Ms Mitchell upon her arrival that he had concerns about Mr Sansbury. He told her that Mr Sansbury was emotional and upset and his mood was swinging. At this stage, Sergeant Schwanz was already giving consideration to having Mr Sansbury medically and psychologically examined to be satisfied that he was fit for police custody³².
- 5.8. While Ms Mitchell was visiting with Mr Sansbury, Sergeant Schwanz entered the room on a number of occasions to check on them. On one of these occasions he remembers Mr Sansbury asking whether he could smoke cannabis in the cell complex. Mr Sansbury laughed at Sergeant Schwanz's (predictable) reaction. On another occasion when Sergeant Schwanz entered the room he actually heard Mr Sansbury saying to Ms Mitchell words to the effect, "I would like six feet of rope".
- 5.9. After some time Sergeant Schwanz had a conversation with Ms Mitchell to discuss Mr Sansbury's condition. She reaffirmed the need to watch Mr Sansbury closely, and expressed the opinion that he was depressed. Sergeant Schwanz informed her that he was going to be transferred to hospital for a physical and psychiatric assessment. He said that he had well and truly made that decision after he heard Mr Sansbury make

²⁸ Transcript, page 97

²⁹ Transcript, page 99

³⁰ Transcript, page 94

³¹ Transcript, page 103

³² Transcript, page 108

the comment about six feet of rope³³. Sergeant Schwanz acknowledged that this event may have transpired slightly differently. It was put to him that Ms Mitchell's recollection was that while she was in the interview room with Mr Sansbury, Sergeant Schwanz entered the room and asked Mr Sansbury how he was feeling. According to Ms Mitchell, Mr Sansbury told Sergeant Schwanz that he felt suicidal and wanted to go to the psychiatric ward. At that point Sergeant Schwanz and Ms Mitchell both agreed that Mr Sansbury should go to the hospital and be assessed. Sergeant Schwanz agreed that this may well have been the way this episode unfolded³⁴.

- 5.10. In any event, some time between 10:15 and 11:30pm Sergeant Schwanz came to the decision that Mr Sansbury should be referred to the Lyell McEwin Health Service for an examination. He then decided to fill in a PD348 – Medical Examination of Prisoner form with the intention that Mr Sansbury be transferred to the Lyell McEwin Health Service for examination as soon as Ms Mitchell had finished visiting with him. In fact, Sergeant Schwanz completed duty for the night before Ms Mitchell left. However, he did fill out the PD348, and a copy of it was identified by him and admitted as Exhibit C85b in these proceedings. The PD348 is headed “Medical Examination of Prisoner” and addressed to the Medical Officer in Charge of the Lyell McEwin Hospital. It states that Mr Sansbury has been referred to the hospital and “Is irrational, has threatened self-harm, unknown if genuine threat. Was arrested in possession of Ducene tablets. Psychiatric assessment if possible. Suspected using cannabis and other unknown illicit drugs. Brother states he is prescribed Ducene by Dr Linda Wong – Pooraka Clinic.” The form is signed by Sergeant Schwanz. The lower half of the form is headed “To be completed by the Medical Practitioner”. I will come to the content of that part of the form later in these findings.
- 5.11. Sergeant Schwanz stated that he handed over at the end of his shift to the oncoming Cell Sergeant, Sergeant Busch at approximately 11:00pm³⁵. In relation to Mr Sansbury, Sergeant Schwanz told Sergeant Busch that he should be watched very closely, and that Sergeant Schwanz had serious concerns for Mr Sansbury's safety. He conveyed the information that was available to him at that time to Sergeant Busch. Furthermore, he had written upon a whiteboard in the cell complex staff office, (being a whiteboard that contains a plan of the layout of the cells, and the name of the

³³ Transcript, page 112

³⁴ Transcript, page 176

³⁵ Transcript, page 117

prisoner that occupies each particular cell), the fact that Mr Sansbury was in the single observation cell. A magnet was placed on the whiteboard by his name labelled “At risk” and in large letters underneath that material, Sergeant Schwanz wrote the word “Watch”³⁶.

- 5.12. Sergeant Schwanz stated that he left the PD348 on the charge counter near the charge book and drew Sergeant Busch’s attention to the PD348. He informed Sergeant Busch that he should get Mr Sansbury to the Lyell McEwin Health Service as soon as his relatives and Ms Mitchell were happy that they had done all they could to assist him³⁷.

6. Handover to Sergeant Busch

- 6.1. Sergeant Desmond Busch gave evidence at the Inquest. He also made a statement which was admitted as Exhibit C86 in these proceedings and was interviewed. A transcription was produced of that interview. It was admitted as Exhibit C86a in these proceedings. Sergeant Busch stated that he has been a police officer for 34 years and worked at the Elizabeth Police Station for approximately 12 years. Sergeant Busch was a cell sergeant at Elizabeth Police Station in November 2004.
- 6.2. Sergeant Busch stated that he was on duty for the night shift commencing at 11:00pm on Saturday, 13 November 2004. He recalled that Patricia Mitchell was present at the Elizabeth Police Station with Mr Sansbury when he commenced his shift that night. He recalled that Sergeant Schwanz advised him that Mr Sansbury was with Pat Mitchell and that he needed to be sent to the Lyell McEwin Health Service for an assessment. He also informed Sergeant Busch that Mr Sansbury had been arrested that day and had attempted to escape from the arresting officers. He also informed Sergeant Busch that Mr Sansbury was experiencing some psychological problems.
- 6.3. Sergeant Busch arranged for a patrol to attend at the station for the purposes of delivering Mr Sansbury to the Lyell McEwin Health Service and guarding him while he was at that hospital³⁸. Sergeant Busch gave evidence that the words “security risk” written in highlighter pen on the PD348 form³⁹ were written by him⁴⁰. He stated that

³⁶ Transcript, page 118

³⁷ Transcript, page 170

³⁸ Transcript, page 202

³⁹ Exhibit C85b

⁴⁰ Transcript, page 203

he wrote this message on the PD348 because he was aware that Mr Sansbury had attempted to escape at the time of apprehension and because hospital visits could often be an occasion when a prisoner might attempt an escape.

- 6.4. When Mr Sansbury was taken by the patrol to the Lyell McEwin Health Service Sergeant Busch made an endorsement to that effect in the charge book recording that officers Anesbury and Elland were his escort. After Mr Sansbury left the station Sergeant Busch continued to charge prisoners that were there and go about his ordinary cell duties.
- 6.5. Sergeant Busch stated that Mr Sansbury was returned to the Elizabeth Police Station at 0259 hours on 14 November 2004. He recorded this in the charge book⁴¹. Sergeant Busch recalled being at the charge counter when Mr Sansbury was returned with his escort. He believed that he spoke to the officers who showed him the PD348 and that he (Sergeant Busch) read the entries on the PD348 written by the doctor. According to Sergeant Busch's statement⁴² he informed Mr Sansbury at the charge counter that the doctor had reported on the PD348 that no special treatment or medication was required. Sergeant Busch did not recall Mr Sansbury having made any particular reply to this.
- 6.6. Sergeant Busch still regarded Mr Sansbury as being a prisoner at risk notwithstanding the fact that he had been examined at hospital⁴³.
- 6.7. Sergeant Busch expressed the view that he was surprised that the doctor at the Lyell McEwin Health Service had not made any indication as to whether Mr Sansbury was at risk of self-harm on the PD348⁴⁴. He agreed that he continued to regard Mr Sansbury as a prisoner at risk notwithstanding the absence of any suggestion to that effect by the Lyell McEwin Health Service staff⁴⁵.
- 6.8. Sergeant Busch then directed that Mr Sansbury be placed in cell C3⁴⁶. Sergeant Busch stated that C3 has a camera from which it can be observed at the charge counter.

⁴¹ Transcript, page 207

⁴² Exhibit C86

⁴³ Transcript, page 208

⁴⁴ Transcript, page 242

⁴⁵ Transcript, page 242

⁴⁶ Transcript, page 209

- 6.9. Sergeant Busch was asked why he did not place Mr Sansbury in the observation cells. He really had no clear recollection of this when giving evidence. However, he speculated that he may have placed Mr Sansbury in a cell away from the noise so that he could get some sleep. He mentioned that on a busy night the observation cells are often rowdy places and it is difficult for prisoners to sleep while placed in them⁴⁷.
- 6.10. Sergeant Busch's recollection in this regard is borne out by a review of the audiovisual recording of the events at the charge counter. At the time of Mr Sansbury's return from the Lyell McEwin Health Service, it is evident from the audiovisual recording that a very rowdy prisoner was present (apparently) in the observation cells because extremely loud banging and yelling could be heard, and the people who are visible at the charge counter area are looking from time to time in the direction of the observation cells. Furthermore, as Mr Sansbury is taken past the doorway to the charge counter/staff office area, Sergeant Busch can be heard saying to him words to the effect that he would be placed with the "general population" because of the noise in the observation cells. Again, there is no sign of any acknowledgement or response from Mr Sansbury to this information.
- 6.11. Sergeant Busch completed this shift at approximately 7:15am when he handed over to Sergeant Watson. He commenced a further shift at 11:00pm on 14 November 2004. He recalled that during this next shift he became aware that another prisoner, Mr Lovegrove, was present in cell C3 with Mr Sansbury⁴⁸. Sergeant Busch made no particular observations of Mr Sansbury during this shift. He finished the shift at approximately 7:30am on 15 November 2004 and handed over the duties of cell sergeant to Senior Constable Ward.
- 6.12. Sergeant Busch was asked about his understanding of the need to make regular checks of prisoners as at November 2004. He stated that when checks were made a corresponding entry would be made in the prisoner journal⁴⁹. He stated that on busy nights it was physically impossible to check prisoners regularly due to the amount of staff available but that at risk prisoners were placed in cells which had video monitoring. He also stated that physical checking of prisoners may be performed during very busy times which are not recorded because officers are going in and out

⁴⁷ Transcript, page 211

⁴⁸ Transcript, page 215

⁴⁹ Transcript, page 205

of the cells booking in other prisoners and would regularly observe the prisoners who are already in the cells on those occasions. However, they would not necessarily make a record of such checks⁵⁰. Sergeant Busch stated that in the early hours of 14 November 2004 after Mr Sansbury returned from the Lyell McEwin Health Service he (Sergeant Busch) regarded checking by means of the video monitor within cell C3 as adequate checking for Mr Sansbury⁵¹. Sergeant Busch stated that it would be most unusual for a prisoner not to be monitored by officers for long periods by means of the television monitor in the cell. He thought it likely that in the normal course an officer would be able to monitor the prisoner at least every five minutes or less⁵².

6.13. Sergeant Busch stated that generally, in November 2004, it was usual practice for the doors between individual cells and the common areas outside those cells to be left open during the course of the day, although not at night when prisoners were locked in their cells⁵³. It should be noted that cell C3 was contained in a group of four cells each of which opened out through its individual door into a common area which itself had a door which was locked during the day. Thus, it was possible for prisoners to be able to move between their individual cell and the common area during daylight hours. A small television set was placed outside the common area. It could be watched and heard through the mesh enclosing the common area by prisoners within the common area. In fact, it was common for prisoners to bring their mattresses from their cells and lie them on the floor of the common area where they could watch the television. It is plain that this practice was occurring at the time of Mr Sansbury's incarceration in the Elizabeth Police Cells in November 2004.

6.14. Sergeant Busch stated that his practice in November 2004 was that he would turn the prisoners cell lights off during the night in order that prisoners could sleep. He was not aware of a change in the practice subsequently. Other evidence established that after Mr Sansbury's death a new practice was instigated at the Elizabeth Police Station which required that cell lights be left switched on at all times during which prisoners were located in the cells, both day and night.

7. Evidence of Patricia Anne Mitchell – Aboriginal Visitors Scheme

⁵⁰ Transcript, page 207

⁵¹ Transcript, page 235

⁵² Transcript, page 237

⁵³ Transcript, page 218

- 7.1. Reference has already been made to the presence of a person by the name of Patricia Anne Mitchell at Elizabeth Police Station on the night of Mr Sansbury's arrest. Ms Mitchell gave evidence at the Inquest. She had also made a statement and that was also admitted as Exhibit C87 in these proceedings. Ms Mitchell stated that she was at the relevant time an employee of the Aboriginal Visitors Scheme which was run under the auspices of the Aboriginal Legal Right Movement. She had been employed within that scheme for a period of nine years. She stated that she and her colleagues would receive a pager message when an Aboriginal detainee came into police custody and they would respond. She stated that she would ring the police station on receiving the pager message and then speak to the sergeant in charge. She would then confirm with the sergeant whether the prisoner actually wished to have a visit. Ms Mitchell stated that it was the practice of the Aboriginal Visitors Scheme workers to record notes of their attendance in a book which contained a pre-prepared form for that purpose. A duplicate of the form would be left at the police station after the visit.
- 7.2. Ms Mitchell remembered her attendances in November 2004 at the Elizabeth Police Station for Mr Sansbury. She stated that when called out, visitors would do what they could to make sure that the arrested person was settled. They would facilitate the making of telephone calls and enquire as to the need for medical attention if that were necessary.
- 7.3. Ms Mitchell stated that she attended at the Elizabeth Police Station at about 10:15pm on 13 November 2004. She had received a pager message regarding Mr Sansbury at about 9:45pm that evening. She had been told that Mr Sansbury was suicidal and had therefore attended as soon as possible. She had also been informed that he had been refused bail, that there had been a bail review and that the bail review had also been refused. When she arrived at the police station she could see Mr Sansbury talking with some people. He appeared to be really upset. She noted that he was in the visitor room and there were two other people in the room with him, one of whom was his relative Mr Edward Sansbury. She did not know who the other person was. She spoke to Mr Sansbury as he was coming out of the room and he told her that he was upset because the police had taken some money from him and he wanted to retrieve it and hand it to Mr Edward Sansbury.

- 7.4. Ms Mitchell stated that Mr Sansbury was taken to the interview room and in the meanwhile she spoke with the sergeant on duty who told her what charges had been laid against Mr Sansbury and the current status of his matter. She then went in and commenced a conversation with Mr Sansbury. She stated that she spoke with Mr Sansbury and after some time she had “settled” him down⁵⁴.
- 7.5. Ms Mitchell stated that after some time one of the sergeants, whom she identified as Sergeant Schwanz, entered the room. She stated that Sergeant Schwanz was “very good with the Aboriginal detainees at getting them calmed down as well”. She stated that Mr Sansbury had been saying to her that he wished to go to the hospital to be assessed⁵⁵. She stated that it was agreed with Sergeant Schwanz that Mr Sansbury would be sent to the hospital for an assessment. She stated that Sergeant Schwanz did not hesitate in deciding to send him to the hospital. She stated that she thought that Mr Sansbury needed to be assessed because he would not calm down. She stated that once he found out that he was going to be taken to the hospital he did settle down⁵⁶.
- 7.6. Ms Mitchell stated that Mr Sansbury requested that she attend at the hospital with him. However she declined to do this because it was not normally a part of her duties to do so. She also stated that by the time Mr Sansbury found out that he was actually going to hospital he had calmed down considerably. This was another reason why she felt it was not necessary for her to attend the hospital too⁵⁷.
- 7.7. Ms Mitchell also gave evidence about a second visit she made to Mr Sansbury the following day, 14 November 2004. She was contacted again that day and requested to attend at the police station. She was told that Mr Sansbury was “stressed out” and that something had happened to his baby and would she be able to attend. She agreed to do so⁵⁸.
- 7.8. Ms Mitchell stated that she found this second visit quite upsetting. She attended at the police station and spoke to the sergeant before seeing Mr Sansbury. She was told that Mr Sansbury had had some telephone calls from his family that day and was now upset. Ms Mitchell then spoke with Mr Sansbury in the same interview room she had used the previous night. She stated that Mr Sansbury was really upset and she became

⁵⁴ Transcript, page 263

⁵⁵ Transcript, page 264

⁵⁶ Transcript, page 266

⁵⁷ Transcript, page 269

⁵⁸ Transcript, page 275

upset as well because Mr Sansbury had been told by a family member that his baby had been born “in the gutter”. The police officers at the station were aware of this information also and were according to Ms Mitchell, upset as well. She stated that the officers were keen to know what was going on too.

- 7.9. Other evidence at the Inquest established that Mr Sansbury had a relationship with a woman called Marissa. Marissa was pregnant to Mr Sansbury at the time of Mr Sansbury’s imprisonment at Elizabeth Police cells and the baby was expected to arrive soon. It was against this background that Mr Sansbury was reacting to the information that the baby had been born in the gutter. Ms Mitchell rang three hospitals on Mr Sansbury’s behalf. She rang the Lyell McEwin, the Women’s and Children’s and the Modbury hospitals and none of those hospitals had heard anything about Marissa. Mr Sansbury also requested that Ms Mitchell contact his grandmother Valerie and one of his aunties. Valerie was not home and there was no answer on that line, but the second number was answered by Marissa. She was able to tell Ms Mitchell that no, she had not had the baby and everything was fine but that she had been to the hospital. Marissa wished to speak to Mr Sansbury so the sergeant allowed that to occur. According to Ms Mitchell she did not overhear what Mr Sansbury was saying to Marissa but she stated that Mr Sansbury was a lot happier after he spoke with her. Ms Mitchell stated that she, and a number of other people present at the police station were relieved to find out that the story about a baby being born in the gutter was not true⁵⁹.
- 7.10. Ms Mitchell stated that she became aware on that second visit that another Aboriginal man had been arrested and was present at the Elizabeth Police cells. This turned out to be Mr Sansbury’s cousin, Mr Lovegrove, and Ms Mitchell suggested that Mr Sansbury and Mr Lovegrove be placed in a cell together so that Mr Sansbury would have someone to talk to. She suggested this to the police after having ascertained from Mr Lovegrove and Mr Sansbury that they would be happy with such an arrangement. She stated that her assumption was that Mr Lovegrove and Mr Sansbury would share a normal cell, and not an observation cell⁶⁰.

⁵⁹ Transcript, page 278

⁶⁰ Transcript, page 283

- 7.11. Ms Mitchell had noted that Mr Sansbury had not been kept in hospital from the visit the previous night. She assumed that he had been released back into custody because the hospital staff regarded him as fit for custody⁶¹.
- 7.12. Ms Mitchell was asked whether there was a difference between Mr Sansbury's demeanour on the first visit and the second visit. She stated:

‘The first time he was very aggressive, the second time he wasn't. He was upset, don't get me wrong, he was totally upset and he was cross because he had the feeling the family were playing mind games on him. But once he found out the baby was fine and Marissa was fine he was fine. He did settle down completely.’⁶²

8. Evidence of the officers who escorted Mr Sansbury to the Lyell McEwin Health Service

- 8.1. Constable Brett Anesbury gave evidence at the Inquest. He also provided two statements which were admitted as Exhibit C88 and C88a respectively. He recalled being assigned the task of escorting Mr Sansbury to the Lyell McEwin Health Service in November 2004. He was on duty with another officer, Constable Elland. He and Constable Elland attended at the Elizabeth Police Station for the purpose of taking Mr Sansbury to the Lyell McEwin Health Service. He stated that he understood his instructions to be that Mr Sansbury was to be escorted to the hospital and there was a possibility that he may abscond because he was a security risk. He could not recall being informed why Mr Sansbury was being transported to the Lyell McEwin Health Service. He stated that Mr Sansbury wore handcuffs while in the vehicle and on arrival at the hospital he was handcuffed to a barouche upon which he was lying by means of two handcuffs, one for each hand.
- 8.2. Constable Anesbury stated that he recalled that a female doctor attended upon Mr Sansbury while he was present. He stated that Mr Sansbury and the doctor had a brief conversation. Mr Sansbury was quite drowsy and Constable Anesbury thought there was not a “huge amount of talking”⁶³. He could not recall if there was any physical examination.
- 8.3. Constable Anesbury stated that he and Constable Elland were relieved at approximately 2:45am by Constables Goreing and McNally.

⁶¹ Transcript, page 281

⁶² Transcript, page 279

⁶³ Transcript, page 315

- 8.4. Constable Goreing gave evidence at the Inquest. He also made a statement which was admitted as Exhibit C89 in these proceedings. He stated that he was in company with Constable McNally and they were told to attend at the Lyell McEwin Health Service to relieve Constables Anesbury and Elland who were guarding Mr Sansbury who was there to be assessed by doctors⁶⁴. He stated that upon arrival at the hospital they found their way to the cubicle where Mr Sansbury was placed and noted that he was handcuffed. They spoke to Constables Anesbury and Elland and then relieved them. According to Constable Goreing's statement they arrived at the hospital at approximately 2:30am on 14 November 2004 and left with Mr Sansbury at approximately 2:55am that day, returning to the Elizabeth cells at approximately 3:10am⁶⁵.
- 8.5. Constable Goreing recalled that Mr Sansbury was lying down and appeared to be asleep upon their arrival. While he and Constable McNally were guarding Mr Sansbury a doctor attended and spoke to Mr Sansbury. The doctor was a male. Constable Goreing believed this took place approximately ten minutes after their arrival at the Lyell McEwin Health Service and placed the event at approximately 2:45am. He stated that he remained in the presence of Mr Sansbury during the examination, keeping sufficient distance to afford some privacy but nevertheless keeping observations on Mr Sansbury. Constable Goreing said that the doctor awakened Mr Sansbury by calling out his name. He did not recall any other conversation between the doctor and Mr Sansbury. According to Constable Goreing's statement⁶⁶, the following occurred:
- ‘I don't remember the exact conversation but not much was said other than the doctor was Sansbury to say his full name which I heard Sansbury stated at this time. I then saw the doctor scrape a small tool lightly across Sansbury's foot (unsure which one) and leave the room. The doctor was in the room for approximately 4 minutes.’
- 8.6. After this, the doctor left the room and Constables Goreing and McNally remained with Mr Sansbury. Shortly thereafter the same doctor returned and it was Constable Goreing's understanding that Mr Sansbury was assessed to be fit to be released into the custody of police. He and Constable McNally then returned Mr Sansbury to the Elizabeth Police cells.

⁶⁴ Transcript, page 343

⁶⁵ Exhibit C89

⁶⁶ Exhibit C89

9. Events at the Lyell McEwin Health Service

9.1. Dr Shanaz Ghanzali

Dr Shanaz Ghanzali made a statement to Senior Constable Thomas on 31 December 2004 which was admitted as Exhibit C67a in these proceedings. According to an affidavit provided by Margaret Craddock, Inquest Support Officer which was admitted as Exhibit C83 in these proceedings, Dr Ghanzali is no longer employed by the Lyell McEwin Health Service and no forwarding address or details for Dr Ghanzali were held by that hospital. It also appears that Dr Ghanzali no longer resides in Australia, having returned to Kelantan, Malaysia.

9.2. According to the statement Exhibit C67a, Dr Ghanzali studied medicine at the University of Adelaide and became medically qualified in 2003. At the time of the death of Mr Sansbury she was an intern employed at the Lyell McEwin Health Service. She stated that she commenced duties on Saturday, 13 November 2004 at 11:00pm in the Emergency Department. She was handed Mr Sansbury's admission record at 2:00am on Sunday, 14 November 2004. She was told (presumably by nursing staff) to be careful of Mr Sansbury as he may be violent and may harm others. She attended cubicle 9 and saw Mr Sansbury lying on the cubicle bed. She remembered that two police officers were present with him and one of them produced to her a document with the heading "Medical Examination of Prisoner". This was the PD348 which had been prepared by Sergeant Schwanz.

9.3. Dr Ghanzali stated that:

'Having received the abovementioned records and after speaking with police and other medical staff I ascertained that the purpose of the examination was to medically clear him. By this, I would examine him to make sure he was medically (physically and mentally) stable prior to sending him off for further psychiatric assessment or to discharge him to wherever he came from.'

I pause to note that this understanding of Dr Ghanzali is clearly at odds with the request in the PD348 that Mr Sansbury be psychiatrically assessed if possible.

9.4. Dr Ghanzali stated that she had a short conversation with Mr Sansbury to gain a history but that he was drowsy and she could not obtain any information from him. She became scared and left the cubicle and spoke to one of the Registered Medical Officers who followed her into the cubicle and said words to the effect, "you've really got to keep a distance with this one, very drowsy, you never know what he's going to

do”. With that unhelpful advice, she then attempted to conduct a medical examination of Mr Sansbury. She tried to examine his pupils and then ask him questions with a view to determining his mental state. She said, “I realised that this was not going anywhere, so I left the cubicle”.

- 9.5. Dr Ghanzali stated that shortly after this she approached Senior Registrar Dr Herman Chua and advised him of the situation. Dr Chua told her that he would conduct an examination of the patient so she went off to attend to other patients.
- 9.6. Dr Ghanzali stated that after she had attended to some three or four other patients Dr Chua approached her and said words to the effect, “Look, I’ve seen your guy. I’ve medically cleared him and he’s fine. He can be sent back to prison”. Dr Ghanzali stated that she was “a little surprised as I thought he would be seen by a psychiatric team. I was not aware of his history however, I didn’t get deeply involved with this patient and I was not present when Dr Chua did a far more thorough examination of him. I then completed the Emergency Department Record on the information provided to me by Dr Chua”.
- 9.7. It is unfortunate that Dr Ghanzali was not available for cross-examination. The suggestion by her that Dr Chua “did a far more thorough examination” of Mr Sansbury is, in my opinion, self serving. Dr Ghanzali had no idea how thorough an examination Dr Chua was able to carry out. As will be seen, Dr Chua was of the understanding that Dr Ghanzali had carried out a thorough examination. Fortunately Dr Chua was available for examination and cross-examination at the Inquest, and was prepared to accept responsibility for his interaction with Mr Sansbury. I will come to his evidence shortly.
- 9.8. Dr Ghanzali stated that she thought that the hospital was discharging Mr Sansbury to a prison which would be a safe place for him, safer than clearing him to go home or to a friend’s house. She was aware that Mr Sansbury “had some risks but prison is a safe place”. Dr Ghanzali was aware of the provisions of the Mental Health Act in relation to the detention of persons who are likely to harm themselves or others. She stated that she did give consideration to those provisions in relation to Mr Sansbury but decided not to detain him under that Act.
- 9.9. Dr Herman Chua

Dr Chua gave evidence at the Inquest. He also provided a statement which was admitted as Exhibit C91a in these proceedings. He currently works at the Lyell McEwin Health Service in the capacity of a Consultant in the Emergency Department. He confirmed that in November 2004, and particularly the night of 13-14 November 2004, he was the Emergency Registrar on duty. He stated that there was also an intern on duty and a Resident Medical Officer. He stated as the Emergency Registrar he was the most senior doctor on duty. He stated that in this capacity his responsibility was to see or at least be aware of all patients in the department who had been seen by junior medical staff.

- 9.10. Dr Chua stated that he expected, before a resident or intern brought one of their patients to his attention that they would have obtained a complete history and done a proper examination to come up with a plan of investigation and management of the patient before presenting them to him. He stated that this involves what he described as “a trusting relationship” with the other medical staff because on a night such as that of 13-14 November 2004 it was extremely busy and “you just do not have the time to sit down with every single patient and extract every single detail from the patient”⁶⁷.
- 9.11. Dr Chua stated that the night in question was an extremely busy shift. There were 39 patients who presented during that shift⁶⁸. Dr Chua confirmed that Mr Sansbury was seen initially by Dr Ghanzali⁶⁹. Dr Chua stated that Dr Ghanzali approached him and said she was not sure what to do about Mr Sansbury “in terms of the disposition of the patient” and she asked him to examine the patient because she was having some trouble with him in that regard. Dr Ghanzali told him that Mr Sansbury was accompanied by two police officers, that he had been found in possession of some Ducene tablets and that the police were not sure whether Mr Sansbury had ingested them or not and whether he was affected by them or not and that they had brought him in “for us to medically clear him to make sure that he is okay”⁷⁰.
- 9.12. According to Cr Chua, Dr Ghanzali conveyed to him that Mr Sansbury was in the department for the purposes of being cleared medically or otherwise for return to

⁶⁷ Transcript, page 442

⁶⁸ Transcript, page 447

⁶⁹ Transcript, page 450

⁷⁰ Transcript, page 452-453

police custody⁷¹. Dr Ghanzali did not state to Dr Chua that the police had brought Mr Sansbury into the department because he had expressed threats of self-harm⁷².

- 9.13. Dr Chua stated that he observed that Mr Sansbury was sleeping and that he had to wake him up. Dr Chua shook Mr Sansbury and he woke easily. Dr Chua asked Mr Sansbury what had brought him to the Emergency Department but Mr Sansbury did not respond. Mr Sansbury turned his back towards Dr Chua in what Dr Chua described in evidence as a “purposeful gesture” meaning “don’t disturb me”⁷³. Dr Chua proceeded to carry out the examination as best he could, to the extent that Mr Sansbury allowed him.
- 9.14. Dr Chua was asked what examination he did carry out upon Mr Sansbury. He responded that he “would have” checked vitals signs (temperature, pulse, blood pressure, oxygen saturations, blood sugars, respiration rate). He stated that he would have examined Mr Sansbury’s cardiorespiratory system, would have examined his abdomen, would have noted his conscious state and therefore Glasgow Coma Scale, would have checked his neurological status, would have examined his motor system, would have ascertained whether there was any evidence of lateralising signs, and would have tested his reflexes. This evidence occupied three pages of transcript from T460-462. Dr Chua was asked by his counsel why he was using the words “I would” in answering⁷⁴. He responded that he did in fact do the things that he was describing. However, immediately after that response, he continued to describe his examination of Mr Sansbury using vague and non-specific language more suggestive of reconstruction than clear recollection.
- 9.15. Dr Chua was very frank in his evidence and made a number of concessions of shortcomings in his treatment of Mr Sansbury that night. I do not think that he was consciously attempting, when giving evidence, to suggest that he did more by way of an examination than was in fact the case that night. Nevertheless, I am reluctant to accept that the detailed description of the things he “would have” done as described in evidence in these passages did in fact occur. They are at odds with Constable Goreing’s evidence which described a much more cursory process occupying no more than four minutes or so. Furthermore, Dr Chua made it plain in his earlier evidence

⁷¹ Transcript, page 454

⁷² Transcript, page 455

⁷³ Transcript, page 459-460

⁷⁴ Transcript, page 461

that he “trusted” and relied upon Dr Ghanzali’s examination being thorough and complete. He relied upon Dr Ghanzali to provide him with all that he needed to know. This simply does not make sense when weighed against his account of a reasonably thorough examination that he “would have” conducted. I am of the opinion that Constable Goreing’s recollection of an extremely brief examination lasting no more than four minutes or thereabouts is more likely to be accurate. Indeed, Dr Chua conceded that he may have been in the cubicle for less than four or five minutes under cross-examination⁷⁵.

- 9.16. Dr Chua was asked about Dr Ghanzali’s statement that she was surprised that Mr Sansbury was not seen by a psychiatric team. Dr Chua was shown the PD348 and acknowledged his writing and signature on the lower part of that form. That form as filled out by Dr Chua stated that Mr Sansbury had been examined and was suffering from “no acute medical issues” and “is medically fit to be returned to police custody”. It also stated that Mr Sansbury would require no specific care while in custody. The time shown against Dr Chua’s signature was 2:40am on 14 November 2004. Dr Chua agreed that Dr Ghanzali’s surprise was understandable by reference to the information contained on the PD348 which she had read. He agreed that if he had read the information contained on the PD348 himself he would have been surprised also if anyone had cleared Mr Sansbury to leave the hospital without a psychiatric assessment⁷⁶. He did state that Dr Ghanzali never expressed this reservation or concern to him⁷⁷. The fact remains though that Dr Chua did write upon and sign the bottom half of the PD348 without reading the material contained on the top half of that document, according to his own account. Had he done so, on his own evidence, he would not have discharged Mr Sansbury when he did⁷⁸. Clearly Dr Chua was under considerable pressure that night with many patients to attend to. However, it is a matter of great concern that he would have signed a form such as the PD348, which is a police form and not a hospital form, without having read the material written by the sergeant who had referred the prisoner for examination. This was an opportunity for matters to have taken a different course. The opportunity was lost. There is little point in requiring people to sign forms, or even to create forms, if people do not consider the effect and purpose of the form before simply signing it.

⁷⁵ Transcript, page 485

⁷⁶ Transcript, page 489

⁷⁷ Transcript, page 489

⁷⁸ Transcript, page 491

- 9.17. There was a significant lack of communication between Dr Ghanzali and Dr Chua that night. It is significant that Dr Ghanzali made a notation on the Lyell McEwin Health Service medical record (Exhibit C91a) at the back of page 38a to the effect that she had discussed the matter with the consultant, the patient was medically stable and was discharged ‘back to cell’. She noted under provisional diagnosis “Psychosocial agitation”. She circled the word “Discharged” at the bottom of that page, and initialled next to the part of the form that reads “M.O. Signature”. Therefore it was not Dr Chua who completed that document. Dr Chua conceded that it should have been he that completed the discharge form to which I am referring⁷⁹. Dr Chua accepted that he was on notice that Dr Ghanzali had not been able to get an adequate history in relation to Mr Sansbury⁸⁰.
- 9.18. Dr Chua also accepted the criticisms made by Dr Raeside, who provided an overview of Mr Sansbury’s treatment in this matter, that even if Mr Sansbury was only being assessed to determine whether he had taken an overdose, a psychiatric examination was indicated by that very fact, and further that if it was impossible adequately to assess Mr Sansbury due to confusion, disorientation or sedation then further observation in hospital with a further evaluation in the morning would have been appropriate⁸¹. Dr Chua also accepted that another alternative, when confronted with a prisoner who was proving a difficult historian, would be to contact the sergeant or person in charge of the police station which referred the prisoner⁸².

10. Sunday, 14 November 2004 – Second visit of Senior Constable Gollan

- 10.1. Senior Constable Gollan again attended at the Elizabeth cells to see Mr Sansbury on Sunday, 14 November 2004. He asked the permission of the duty sergeant and was permitted to speak to Mr Sansbury in the interview room⁸³. Senior Constable Gollan stated that the demeanour of Mr Sansbury had improved from the previous day. Senior Constable Gollan asked Mr Sansbury “what he wanted to do in relation to information to the recovery of alleged stolen firearms”. This was a reference to information provided to Senior Constable Gollan the previous day by Mr Sansbury. Senior Constable Gollan asked Mr Sansbury “whether he was just having a go at me

⁷⁹ Transcript, page 484

⁸⁰ Transcript, page 496

⁸¹ Transcript, page 499

⁸² Transcript, page 503-504

⁸³ Transcript, page 539

or he really knew where there was hidden firearms”⁸⁴. In the result, Senior Constable Gollan was unable to obtain any further information from Mr Sansbury on this question, whether because Mr Sansbury had no further knowledge or was not prepared to reveal the knowledge except in return for his release, Senior Constable Gollan could not say. What was clear was that Mr Sansbury was desperate to be released and was attempting to use the supposed information about firearms and their whereabouts in order to procure his release⁸⁵.

- 10.2. During this conversation Mr Sansbury expressed to Senior Constable Gollan a sentiment that he was “dead inside”. He said words to the effect “Uncle, I’ve been dead for years, I’ve been dead inside for years”. Mr Sansbury stated to Senior Constable Gollan that if it were not for his son and his nanna, he would have been “gone” a long time ago. Mr Sansbury stated that they were the only people that he loved and the only two people who cared for him⁸⁶.
- 10.3. Senior Constable Gollan did not take these words to be indicative of an intention on the part of Mr Sansbury to harm himself or to take his own life⁸⁷. Senior Constable Gollan did not take any special steps in relation to this information he had received from Mr Sansbury. His only communication with the sergeant was in relation to any intelligence he had been able to extract from Mr Sansbury⁸⁸. Senior Constable Gollan stated, very sadly, that words similar in effect to those used by Mr Sansbury about being dead inside were words that he was used to hearing from Aboriginal people with whom he spoke. Senior Constable Gollan had heard words to similar effect on many previous occasions and was not particularly surprised or concerned to hear them coming from Mr Sansbury.
- 10.4. Whether or not those words were indicative of a deterioration in Mr Sansbury’s mental state at that time, it is doubtful whether if Senior Constable Gollan had raised the issue at that time the course of events would have changed, bearing in mind that Mr Sansbury remained an “at risk” prisoner and was supposedly subject to the heightened level of scrutiny that this status required.

11. Mr Sansbury shares a cell with Mr Lovegrove – 14-15 November 2004

⁸⁴ Transcript, page 583

⁸⁵ Transcript, page 584

⁸⁶ Transcript, page 541

⁸⁷ Transcript, page 542

⁸⁸ Transcript, page 542

- 11.1. Mr John Lovegrove gave evidence at the Inquest. He also made a statement which was admitted as Exhibit C93 in these proceedings. Mr Lovegrove is an Aboriginal man who was born on 26 March 1980. He was arrested and taken to the Elizabeth Police Station on 14 November 2004. He knew Mr Sansbury very well at that time. According to Mr Lovegrove, Mr Sansbury was generally a happy person. Upon his arrival at the Elizabeth cells, Mr Lovegrove asked the sergeant if there was anyone else there. The sergeant informed him that Colin Sansbury was in the cells and Mr Lovegrove then asked if he could be “celled up” with Mr Sansbury. The sergeant agreed and this happened some time afterwards⁸⁹. When Mr Lovegrove found Mr Sansbury in the cells that day the latter was lying down watching television (I assume this was through the grille in the common area outside cells C3 to C6). Mr Lovegrove shook Mr Sansbury’s hand and hugged him. Mr Lovegrove noted that Mr Sansbury was wearing a shirt and a “white forensic jumpsuit”⁹⁰. Mr Lovegrove said that Mr Sansbury was “stressing out over his woman having a baby or something”⁹¹. According to Mr Lovegrove, Mr Sansbury was crying from time to time and made telephone calls to “the hospital”.
- 11.2. On the Sunday night, when the lights were switched off in the cells and the prisoners were locked down, Mr Lovegrove and Mr Sansbury shared cell C3. Mr Lovegrove stated that some time after this Mr Sansbury took off his forensic jumpsuit and at some point scrunched it up to use it like a pillow. Later, Mr Lovegrove noted that Mr Sansbury had the jumpsuit around his neck. Mr Lovegrove then “hopped up” and said “Hey what are you doing?”. Mr Sansbury said words to the effect “No I’m alright brother” and Mr Lovegrove used the intercom to request the attendance of officers, but officers were at that time charging someone. When the officers arrived Mr Sansbury had removed the suit from around his neck and was simply lying on it as a pillow. When interviewed by the police on the day of Mr Sansbury’s death (Exhibit C93) Mr Lovegrove described the incident about the jumpsuit, but did not say he had called the officers via the intercom, for their attendance. His explanation was, “I was still, like, coming down and I didn’t realise that they’d be able to help”. Mr Lovegrove had earlier stated that he had consumed “speed” before being arrested.

⁸⁹ Transcript, page 609

⁹⁰ Transcript, page 611

⁹¹ Exhibit C93, Transcript, page 613

- 11.3. Mr Lovegrove stated that he was awakened by police at approximately 7:30am the following morning, Monday 15 November 2004. The police brought breakfast. Mr Lovegrove wanted to go outside for a cigarette and asked Mr Sansbury if he wished to go too. Mr Sansbury said he wanted to stay in his cell and sleep in. According to Mr Lovegrove, Mr Sansbury “asked to get the lights switched off and lock the door. I assumed that he just wanted to sleep in more”⁹².
- 11.4. Mr Lovegrove said that he was out in the exercise yard for about half an hour and at that time Mr Sansbury was brought out to the exercise yard with another inmate. According to Mr Lovegrove, Mr Sansbury had two cigarettes and then asked to go back inside the cells. He stated that as Mr Sansbury was leaving to go back inside the cells he said to Mr Lovegrove words to the effect, “I love you brother and take it easy”⁹³. Mr Lovegrove did not take this as an indication that Mr Sansbury was going to harm himself. According to Mr Lovegrove he and the other prisoners remained in the exercise yard and after approximately one hour they asked to go back in but were told that the officers were busy charging someone and the prisoners were left out in the exercise yard for two to three hours. After that period, the officers informed the prisoners in the exercise yard that Mr Sansbury had tried to commit suicide.
- 11.5. Sergeant Adrian Turner gave evidence at the Inquest. He also made a statement shortly after Mr Sansbury’s death which was admitted as Exhibit C94 in these proceedings. At the time of Mr Sansbury’s death Sergeant Turner held the rank of senior constable. He was acting cell sergeant in the Elizabeth Police Station cells on a shift beginning at 3:00pm Sunday, 14 November 2004 and ending shortly before midnight that same day. Sergeant Turner stated that during the first few hours of this shift Mr Sansbury told him that one of Mr Sansbury’s relatives had advised him that his partner was in labour and was at the Women’s and Children’s Hospital. Mr Sansbury made two telephone calls during the first few hours of this shift to try and contact his partner⁹⁴. Sergeant Turner recalled that Ms Mitchell, the Aboriginal Visitor was present later in the shift and that she made a number of telephone calls on behalf of Mr Sansbury in an effort to find out what was happening with his partner. Eventually it was established that Mr Sansbury’s partner was not in labour and was

⁹² Transcript, page 622

⁹³ Transcript, page 626

⁹⁴ Exhibit C94

safely at home⁹⁵. This evidence is clearly consistent with the recollection of Ms Mitchell already referred to.

- 11.6. Sergeant Turner recorded in his statement⁹⁶ that according to the prisoner custody disposition sheet there was an entry in relation to Mr Sansbury as follows:

‘Irrational behaviour – seen by AVS checked LMH re psych assess/medication – nil required.’

- 11.7. It became clear through the course of Sergeant Turner’s evidence that he had consulted a folder kept in the cell sergeant’s office which contained printouts downloaded from a computer record which was continuously maintained and which recorded prisoner disposition. This was a further record in addition to the records which were produced at the Inquest and which were admitted as exhibits at the Inquest. The existence of this record had not been ascertained until Sergeant Turner’s evidence. I requested that counsel for the Commissioner of Police make inquiries with a view to ascertaining the availability and whereabouts of this record. Counsel for the Commissioner of Police advised that searches had been made during the course of the Inquest, but had failed to find copies of the computer printout. It subsequently became apparent that this printout was regularly “culled” and that entries in relation to November 2004 have long since been destroyed. However, it also became apparent that this particular record could easily have been found at or about the time of the commencement of the investigation into Mr Sansbury’s death in custody. Relevant parts of the record probably existed for some considerable time thereafter before being culled. It is a poor reflection upon the investigation of a death in police custody that this record was not seized at an early stage of the investigation. It is now too late to have the assistance of that record⁹⁷.

- 11.8. I note that Sergeant Turner was asked about the Elizabeth Police Station Standing Orders and whether he was familiar with them. He stated that he was aware of the Standing Orders and he specifically referred to the fact that those Standing Orders were seized approximately six months prior to Mr Sansbury’s death and that consequently the Standing Orders “weren’t physically there”⁹⁸. Sergeant Turner explained that the Standing Orders were seized following a death in custody at the

⁹⁵ Exhibit C94

⁹⁶ Exhibit C94

⁹⁷ Transcript, page 685-690

⁹⁸ Transcript, page 680

Elizabeth Police Station which had occurred six months prior to Mr Sansbury's death in custody at the same cells. In the earlier case, the prisoner was Julia Marie Baylis. Her death was the subject of an Inquest⁹⁹. This point (the seizure of the Standing Orders for this investigation) was also referred to by at least one other police witness. I find it remarkable that after the seizure of the Standing Orders for the investigation into the death of Ms Baylis, no physical copy of the Standing Orders was present at the Elizabeth Police Station cells for a period of, apparently, at least six months. My impression, listening to Sergeant Turner, was that he regarded the seizure of the Standing Orders as something of an inconvenience. I would have thought that an officer or officers at Elizabeth Police Station should have had the initiative to request that the seized Standing Orders might be made available to be copied so that there could be an opportunity to consult them if necessary until the completion of Ms Baylis' investigation. Instead it seems that no effort was made to replace them. Apparently Sergeant Turner regarded their seizure as something of a personal imposition¹⁰⁰. It does not reflect well upon him, or upon South Australia Police generally, that no officer had the initiative to ensure that there was during the relevant period a copy of the Elizabeth Police Station Standing Orders present at the cells in order that officers could ascertain that which it was their duty to comply with.

12. The understanding of the different police officers as to the requirements of prisoner checking

12.1. The General Orders as in force at 15 November 2004 provided:

'Prisoners are checked at irregular intervals but more frequently if they show signs of being ill, violent, or at risk (carry the keys so you are in a position to act immediately).

The times prisoners are checked, and the fact that the oncoming officer in charge has been given information on each prisoner, is noted in either the PD28, Prisoner Custody Disposition or the PD121, Prisoner's Property Book and Register.'¹⁰¹

⁹⁹ See Inquest number 30/2006 finding dated 18 December 2006.

¹⁰⁰ I have considered the possibility that the reference to the seizure of the standing orders in the Baylis investigation in statements in this investigation was intended to convey that the Baylis investigation was itself an imposition of some kind which disrupted the orderly dispatch of business at the Elizabeth Cells. The absence of the Standing Orders could readily have been overcome by making a photocopy. In that context I would have thought that their absence, if relevant to mention in a statement at all, might simply have been mentioned without further elaboration as to the reason for the absence. There is insufficient evidence to conclude that the irritation of some officers at the absence of the standing orders was due to anything other than a misplaced sense of indignation that the orders had not been replaced by someone else. It seems to me that it was a collective responsibility to replace them with a copy.

¹⁰¹ It is notable that the General Orders referred to a PD28 as a Prisoner Custody Disposition form. Sergeant Turner was asked about his understanding of a PD28. He was not aware of the form. It appears to me that the PD28 was in fact an amalgam of the document Exhibit C85c, and the electronic document which printed at the

12.2. The General Orders as in force on and after July 2006 relevantly provide:

‘All cell guards must conduct mandatory physical inspections and more frequent inspections as required and ensure that inspection is appropriately recorded.

During the first two hours of detention and after charging, prisoners are to be physically checked at intervals not greater than fifteen minutes and thereafter physically checked at intervals not greater than one hour.

Prisoners are inspected at irregular intervals but more frequently than the mandated times if they are suspected to be “at risk”

12.3. From this it can be seen that there was no mandated requirement as to the frequency of checks as at 15 November 2004 at least so far as General Orders were concerned. The requirement that exists now is that checks for prisoners be hourly but more frequent if the prisoners are suspected to be at risk. The following is a table of the officers who gave evidence at the Inquest setting out their understanding of their obligations.

<u>Name</u>	<u>Understanding at to checks</u>
Constable Scott Howe	Required to conduct a minimum of fifteen minute checks on all prisoners that come into the cells regardless of how long the prisoner is kept at the cells ¹⁰² .
Sergeant Adrian Turner	Check at least within every half hour, more frequently for prisoners at risk ¹⁰³ .
Constable Jason Wynne	Prisoners to be checked at regular intervals but at irregular times and a gap of no more than forty minutes in between checks ¹⁰⁴ .
Sergeant Kelvin Ward	Checks to be done every half an hour or so or thirty to forty-five minutes ¹⁰⁵ .
Constable Stephen Coward	Would check every half hour at least ¹⁰⁶ .

12.4. The consensus of the evidence was that the fact of the making of a check would only occasionally be recorded. The evidence was also inconsistent in relation to the specific nature of a check. A number of witnesses stated that a check would be

end of each shift and periodically culled refereed to in the evidence of Sergeant Turner. What is clear, is that despite the fact that the General Orders assume that all police officers would have an understanding of what is a PD28, none of the relevant officers had any understanding of this.

¹⁰² Transcript, page 384-385

¹⁰³ Transcript, page 669, 682

¹⁰⁴ Transcript, page 735

¹⁰⁵ Transcript, page 790

¹⁰⁶ Transcript, page 867

regarded as having been carried out if there had been some interaction with the prisoners as a group. Thus, Sergeant Ward regarded checks as having been made if he was aware that his cell guards were going in and out of the cell area. None of the witnesses had any expectation that these non-specific checks would be recorded anywhere.

- 12.5. I am aware that practices within South Australia Police have changed since late 2004. I am aware of the IMOST training that has been the subject of evidence in previous Inquests¹⁰⁷. I would have thought that following IMOST training, there would have been much greater consistency in the understanding amongst officers as to the requirements of checking and what constituted an adequate regime of checking. I am left with the impression that even as at the time of the hearing of this Inquest, May 2007, a number of officers who gave evidence had no proper appreciation of any regular regime of checking and recording of checking.

13. 15 November 2004 – 7:00am to 10:30am

- 13.1. The day shift for 15 November 2004 commenced duty at 7:00am. The members of the day shift were Sergeant Ward, Probationary Constable Wynne and Constable Coward. From a reading of the evidence of those three witnesses the following is the sequence of events in broad outline that morning. I will deal in a moment with the individual evidence of each of the three witnesses.
- 13.2. As noted the shift began at 7:00am. Sergeant Ward received a handover from the night shift sergeant, Sergeant Busch. The night shift had opened the cell doors to the individual cells before the day shift came on duty. Sergeant Ward familiarised himself with the paperwork required for Court that morning. Constable Coward and Probationary Constable Wynne visited the prisoners in their cells to see what breakfast the prisoners wished to have. They then set about making breakfast and delivering it to the various prisoners. Some of the prisoners, having had their breakfast, went out into the exercise yard. Some of the prisoners were already in the exercise yard when they had their breakfast. Mr Sansbury remained in the ‘C’ cell block area. At approximately 9:18am, Mr Sansbury requested and was permitted to make a telephone call. He stated that it was to his grandmother. He was taken from the cell block to the charge counter area for the purposes of making the telephone call

¹⁰⁷ Stephen Cartwright for example

by Probationary Constable Wynne. This telephone call lasted some fifteen to twenty minutes. After that Probationary Constable Wynne took Mr Sansbury out into the exercise yard where he had a cigarette with the other prisoners including Mr Lovegrove. Shortly after this, Mr Sansbury asked to be returned to the cells and Probationary Constable Wynne escorted him back to the 'C' cell block. This would have been at approximately 9:40–9:45am. Between 9:45am and 10:23am two prisoners came into be charged. The first of these was charged and was then escorted to the exercise yard with the other prisoners. At about this time, an air-conditioning mechanic attended at the cells to effect some repairs to the air-conditioning system. This mechanic was escorted to the roof area of the cell block by Constable Coward who remained with him. A second prisoner, prisoner Fry, was processed at the charge counter area by Sergeant Ward and Probationary Constable Wynne. When this prisoner had been processed, he elected to be taken to the cells. At this time Probationary Constable Wynne escorted him to the 'C' cell block area. On arriving there, Probationary Constable Wynne noted that the door to cell C3 was virtually closed, and he could see a white knot between the upper door frame and the door. He ascertained that Mr Sansbury had apparently hanged himself, and immediately requested assistance from Sergeant Ward and Constable Coward. Resuscitative efforts then ensued.

13.3. Constable Jason Wynne

Constable Wynne gave evidence at the Inquest. He also made a statement on the day of Mr Sansbury's death. The statement was admitted as Exhibit C95 in these proceedings. Constable Wynne was interviewed by Inspector Fellows in March 2005. That interview was recorded and a transcription of it was admitted as Exhibit C95a in these proceedings. Constable Wynne held the rank of probationary constable in November 2004 and commenced duty at 7:00am on Monday, 15 November 2004 in the Elizabeth cells. He recalled that he had a conversation with Constable Mountford who had been a member of the night shift staff. Constable Mountford told him that the doors in the 'C' block area had been opened so that the prisoners could watch television. After the night shift staff left Probationary Constable Wynne went with Constable Coward around to each cell and took breakfast orders¹⁰⁸. Probationary Constable Wynne stated that he looked at the whiteboard that morning but he did not

¹⁰⁸ Transcript, page 726

see the “at risk” magnet against Mr Sansbury’s name¹⁰⁹. By 7:59am the prisoners had all been provided with their breakfasts¹¹⁰.

13.4. Constable Wynne stated that he was requested by Mr Sansbury that Mr Sansbury be allowed to make a telephone call to his grandmother and Constable Wynne facilitated this. He did not notice anything in particular about Mr Sansbury’s demeanour while this was occurring. After the telephone call Constable Wynne asked Mr Sansbury if he would like to go outside to have a cigarette, which Mr Sansbury agreed to, and Constable Wynne escorted him to the exercise yard¹¹¹. Sometime shortly after this Constable Wynne brought Mr Sansbury back inside at his request to go into the ‘C’ block area. Another prisoner, Mr Brook was still in the ‘C’ block area at this time¹¹². Constable Wynne stated that Mr Sansbury just walked into the ‘C’ block common area and Constable Wynne returned to assist Sergeant Ward with charging other prisoners at the charge counter. At some stage the maintenance man attended at the cells and was escorted up to the roof area by Constable Coward¹¹³. After prisoner Fry had been charged and processed, Constable Wynne escorted Mr Fry to the ‘C’ block and it was then that he saw that the C3 cell door had been shut and that he could see a white knot at the top of the door. He had a quick look and could see that Mr Sansbury had hanged himself and Constable Wynne then ran and got Sergeant Ward and Constable Coward and resuscitative efforts were commenced¹¹⁴. At the time when Mr Sansbury was returned to the ‘C’ cell block, another prisoner, Mr Brook was in the ‘C’ cell block but was inside his own cell, cell C4 sitting on his bed. The lights were not on in cell C3 at that time according to Constable Wynne¹¹⁵.

13.5. Constable Wynne stated in evidence that he would have carried out his duties differently in relation to Mr Sansbury if he had been aware that Mr Sansbury was a prisoner at risk. Constable Wynne stated that he would have kept a “closer eye” on Mr Sansbury had he realised he was a prisoner at risk¹¹⁶. In particular, Constable Wynne stated that if he had realised that Mr Sansbury was a prisoner at risk, “I would have possibly just checked prior to beginning the charge process in between Williams

¹⁰⁹ Transcript, pages 750 and 760

¹¹⁰ Transcript, page 733

¹¹¹ Transcript, page 741

¹¹² Transcript, page 742

¹¹³ Transcript, page 744

¹¹⁴ Transcript, page 746

¹¹⁵ Transcript, page 754

¹¹⁶ Transcript, page 735

and Fry”¹¹⁷. He stated that he would have done this by physically going down to the cell block¹¹⁸. He stated that he would have prioritised checks for Mr Sansbury¹¹⁹. The significance of this evidence is that if Constable Wynne had indeed checked upon Mr Sansbury between the charge process for Mr Williams and Mr Fry, he would have discovered Mr Sansbury perhaps fifteen to twenty minutes earlier than was in fact the case. This may have been sufficient to alter the outcome.

- 13.6. Constable Wynne stated that he did not remember Sergeant Ward giving him any instructions in relation to the prisoners or any clear directions about what their status was. In particular, he stated that he was not told that any prisoner was at risk of harm to himself. Constable Wynne stated that there had been previous occasions when he had been informed specifically by his cell sergeant that prisoners were at risk¹²⁰.
- 13.7. In his record of interview¹²¹, Constable Wynne stated that he was aware that Mr Sansbury had been taken to the Lyell McEwin Health Service for assessment and that he had been cleared and fit for custody. He mentioned this at the same time as he also mentioned that he had been told that the cell doors had been opened so that the prisoners could watch television. He was asked in that interview whether prior to Mr Sansbury’s hanging he was aware that Mr Sansbury was an at risk prisoner and answered that he could not remember being told exactly. However, he accepted that he was aware that Mr Sansbury had been taken to the hospital. He was asked if he knew why he had been taken to hospital and replied:
- ‘No, just for an assessment of Mental Health I think.’
- 13.8. It is a little difficult to reconcile Constable Wynne’s appreciation that Mr Sansbury had been taken to the Lyell McEwin Health Service during the weekend for an assessment of mental health issues with his assertion that he was not aware that Mr Sansbury was classed as an at risk prisoner. It may be that Constable Wynne was mistaken when giving his evidence at the Inquest about his knowledge of Mr Sansbury’s “at risk” status, particularly given that many other witnesses observed the “at risk” magnet on the whiteboard. Nevertheless, Constable Wynne was quite

¹¹⁷ Transcript, page 761

¹¹⁸ Transcript, page 761

¹¹⁹ Transcript, page 761

¹²⁰ Transcript, page 759

¹²¹ Exhibit C95a

firm in his evidence at the Inquest that he was not aware that Mr Sansbury was an at risk prisoner.

13.9. Sergeant Kelvin Ward

Sergeant Ward gave evidence at the Inquest. He also made a statement on the day of Mr Sansbury's death, which was admitted as Exhibit C96 in these proceedings. He was interviewed by Inspector Fellows in March 2005 and a transcription of that interview as made and admitted as Exhibit C96a in these proceedings.

13.10. Sergeant Ward commenced duty at 7:00am on 15 November 2004 in the Elizabeth Police cells. He stated that he conducted a handover with Sergeant Busch who had been the overnight shift sergeant. He said that he ascertained the number of prisoners and what was happening with them. He said that his attention was drawn to the fact that Mr Sansbury was a person at risk. He stated that Sergeant Busch informed him of this and he also noticed it on the whiteboard¹²². He was also told or ascertained that Mr Sansbury had been taken to the Lyell McEwin Health Service and assessed but was passed as fit for custody¹²³. Sergeant Ward said that only he and Sergeant Busch were present for the handover, and that the cell guards usually have their own separate handover¹²⁴. Sergeant Ward confirmed that he was assisted by Constable Coward and Probationary Constable Wynne during that shift.

13.11. Sergeant Ward stated that he then carried out paperwork to ensure that prisoners were ready to go to Court and he also ensured that the cell guards provided the prisoners with breakfast¹²⁵. Significantly, Sergeant Ward stated that he also informed the cell guards of what he had been informed by the night shift sergeant and stated, "In this case it would have been in particular for Mr Sansbury"¹²⁶. Sergeant Ward stated that he recalled telling the cell guards, namely Probationary Constable Wynne and Constable Coward, that "Mr Sansbury was at risk, that he had been to hospital but cleared for custody and just to keep a close watch on him"¹²⁷. Sergeant Ward stated that he gave a direction that a close watch be kept on Mr Sansbury¹²⁸. Sergeant Ward stated that he would have expected that checks would be conducted on Mr Sansbury

¹²² Transcript, page 782

¹²³ Transcript, page 783

¹²⁴ Transcript, page 786

¹²⁵ Transcript, page 789

¹²⁶ Transcript, page 789

¹²⁷ Transcript, page 789

¹²⁸ Transcript, page 789

by the cell guards every half hour or so and at most every forty-five minutes¹²⁹. He also stated that he would expect the cell guards to ensure that Mr Sansbury was not left alone or if he was in the 'C' block area that there was another prisoner in there with him¹³⁰. Sergeant Ward accepted that if Mr Sansbury were in the 'C' block area even with another prisoner he could still be in his cell alone while the other prisoner was somewhere else within the 'C' block area but that he thought that this was a reasonable state of affairs "because the cell door were all open and I thought that was fine"¹³¹.

13.12. Sergeant Ward said that he was not aware exactly of what Constable Coward and Probationary Constable Wynne were doing. He stated that they were "running around" moving prisoners from place to place, between the exercise yard and the cell block area, providing cigarettes and breakfast, and that breakfast was provided at approximately 8:00am¹³².

13.13. Sergeant Ward stated that he expected the cell guards to meet his expectations in relation to checking but he accepted that he could not be certain that those expectations were being met. He said that there was plenty of movement occurring so he would expect that checks were occurring but that he could not say that every single prisoner was being checked and that it would be possible that a prisoner who remained in his cell might be missed when there was a check of prisoners, particularly if the door to the cell was shut¹³³.

13.14. Sergeant Ward remembered that sometime between 9:15 and 9:30am Mr Sansbury was at the charge counter making a telephone call. He was not aware whether it was Probationary Constable Wynne or Constable Coward who escorted him to the charge counter for that purpose¹³⁴. Interestingly, Sergeant Ward thought that Mr Sansbury was taken back into 'C' block after the telephone call. He was not aware of the fact that Mr Sansbury was taken to the exercise area before being returned to 'C' block¹³⁵. Sergeant Ward confirmed that an air-conditioning mechanic attended the cell area at some time around 10:00am and Constable Coward escorted the mechanic to the roof

¹²⁹ Transcript, page 790

¹³⁰ Transcript, page 790

¹³¹ Transcript, page 791

¹³² Transcript, page 792

¹³³ Transcript, page 795

¹³⁴ Transcript, page 796

¹³⁵ Transcript, page 797

area¹³⁶. Sergeant Ward acknowledged that unless anything specific came to his attention he was unlikely to be aware of which prisoners were in the exercise yard and which prisoners were in the cell block¹³⁷. Sergeant Ward stated that at approximately 10:23am Probationary Constable Wynne came running to him to tell him that he believed that Mr Sansbury was hanging himself in C3 and that this discovery was made by Probationary Constable Wynne after he delivered Mr Fry to the ‘C’ block area¹³⁸.

- 13.15. Sergeant Ward could not recall whether Mr Lovegrove was also a prisoner designated as being at risk¹³⁹. He believed that if he had been approached by a cell guard or a prisoner that there were expressed concerns about Mr Sansbury that morning that he would have taken some action in response¹⁴⁰.
- 13.16. Sergeant Ward was adamant that when he attended Mr Sansbury in cell C3 after the hanging that the cell C3 lights were on. In fact, the CCTV footage which I have viewed demonstrates that they were turned off, thus making it difficult, but not impossible, to see what was happening by means of the CCTV monitoring system. Furthermore, Sergeant Ward believed that the door to cell C3 was shut and locked and that he had to unlock it in order to gain access to Mr Sansbury¹⁴¹. This seems also to be an erroneous recollection considering other evidence and the CCTV footage.
- 13.17. Sergeant Ward stated that he “would have” looked at the CCTV monitors when he walked past them on many occasions that morning. He stated that he would have been alerted to something going wrong, “If I took specific notice of it, yes I would have yes”¹⁴². He stated that he would have noticed that something was untoward “if I looked at it properly”¹⁴³. This is significant because of the repeated references in evidence by witnesses in this case to the fact that they “would have” noted the disposition of prisoners in cells by means of the monitoring system. In this passage, Sergeant Ward acknowledges that it is possible not to look “properly” at a monitor, yet to believe that it has been observed in any event.

¹³⁶ Transcript, page 798

¹³⁷ Transcript, page 800

¹³⁸ Transcript, page 801

¹³⁹ Transcript, page 804

¹⁴⁰ Transcript, page 805

¹⁴¹ Transcript, page 816

¹⁴² Transcript, page 820

¹⁴³ Transcript, page 820

13.18. Sergeant Ward stated that he did in fact tell Probationary Constable Wynne that Mr Sansbury was an at risk prisoner that morning¹⁴⁴. He acknowledged that he did not mention this in his statement, but he maintained that he did tell Probationary Constable Wynne this fact¹⁴⁵. When it was put to Sergeant Ward that for forty minutes Mr Sansbury was not checked while in cell C3, and therefore his expectations that Probationary Constable Wynne and Constable Coward would keep a close watch on him by virtue of his at risk status were not being complied with, Sergeant Ward stated:

‘They had been following my directions, that was only 40 minutes.’¹⁴⁶

Yet Sergeant Ward himself had stated that prisoners who were at risk should be checked every thirty minutes, and perhaps between thirty and forty-five minutes during very busy periods. To use the qualification “only” in describing a period of forty minutes, is surprising in view of his earlier, confident, evidence about the frequency of regular checking as a matter of standard practice.

13.19. Sergeant Ward acknowledged the following shortcomings in his statement that he made on 15 November 2004. He failed to mention two of the three occasions on which he observed and interacted with Mr Sansbury prior to discovering Mr Sansbury’s body¹⁴⁷. He failed to include full details of the handover between Sergeant Busch and himself in relation to Mr Sansbury in his statement, contenting himself with only the “basics”¹⁴⁸. He failed to include in his statement on 15 November 2004 the fact (if indeed it was a fact) that he advised Probationary Constable Wynne and Constable Coward that Mr Sansbury was a prisoner at risk¹⁴⁹. Sergeant Ward failed to address in his statement whether the monitors were displaying images of cell C3¹⁵⁰. He failed to address the topic of whether he himself had made any observations of Mr Sansbury on the monitor¹⁵¹.

13.20. It need hardly be stated that these shortcomings in Sergeant Ward’s statement made the same day as Mr Sansbury’s death are extremely unsatisfactory. They reflect

¹⁴⁴ Transcript, page 820

¹⁴⁵ Transcript, page 821

¹⁴⁶ Transcript, page 823

¹⁴⁷ Transcript, page 836

¹⁴⁸ Transcript, page 837

¹⁴⁹ Transcript, page 840

¹⁵⁰ Transcript, page 842

¹⁵¹ Transcript, page 842

poorly upon him, and they also reflect poorly upon the investigation carried out by South Australia Police in relation to this death in police custody.

13.21. Constable Stephen Coward

Constable Stephen Coward gave evidence at the Inquest. He also made a statement on the day of Mr Sansbury's death, a copy of which was admitted as Exhibit C97 in these proceedings. He made a further statement on 24 November 2004, a copy of which was admitted as Exhibit C97a in these proceedings. Constable Coward stated that he had been a police officer for 31 years and had worked at Elizabeth Police Station for some 10 years. He commenced work with the day shift on 15 November 2004 at 7:00am in Elizabeth Police cells with Sergeant Ward and Probationary Constable Wynne¹⁵². He stated that at approximately 7:45am he went with Probationary Constable Wynne to 'C' block to ask the prisoners what they wanted in the way of breakfast. He could not recall receiving any instructions, directions or information from Sergeant Ward that day¹⁵³.

13.22. Constable Coward stated that he noted from the prisoner disposition sheet that Mr Sansbury was an at risk prisoner that morning¹⁵⁴.

13.23. Constable Coward stated that when he went to offer Mr Sansbury breakfast, Mr Sansbury was in cell C3 with his blanket pulled up over his head. Mr Sansbury had to move the blanket out of the way to reply to Constable Coward as to breakfast. Mr Sansbury was sleeping on the bed on the door side of the cell. Constable Coward recalled that the cell light was turned on when he went in. Constable Coward stated that it would have taken approximately ten minutes to prepare breakfast.

13.24. Constable Coward recalled Mr Sansbury making a telephone call that morning. Constable Coward was in a nearby room and could overhear part of the conversation in which Mr Sansbury said words to the effect, "I don't blame you, I blame myself"¹⁵⁵. Constable Coward also recalled the presence of the air-conditioning mechanic that morning and that he took the mechanic up to the roof area and remained with him up there. He recalled that Probationary Constable Wynne came through the door and requested his assistance downstairs because they thought that

¹⁵² Transcript, page 859

¹⁵³ Transcript, page 859

¹⁵⁴ Transcript, page 860

¹⁵⁵ Transcript, page 873

Mr Sansbury had hanged himself¹⁵⁶. Constable Coward followed Probationary Constable Wynne but stopped off in the staff office to pick up the Hoffman knife¹⁵⁷. Constable Coward then attended at 'C' block.

13.25. Constable Coward could not remember any specific checks of Mr Sansbury apart from the breakfast interaction¹⁵⁸. Constable Coward stated that if Sergeant Ward had informed him that Mr Sansbury was identified as a prisoner at risk, he would have recorded that fact in the statement he made that day¹⁵⁹.

13.26. Constable Coward acknowledged that he would not know what Probationary Constable Wynne was doing in relation to a particular prisoner at a given time and nor would Probationary Constable Wynne know what he himself was doing in relation to a particular prisoner at any given time¹⁶⁰. Constable Coward stated that it is almost impossible to see anything on the CCTV monitor for cell C3 if the door is pulled to and the light in the cell is turned off¹⁶¹. Constable Coward acknowledged that apart from incidental interactions with Mr Sansbury and the breakfast interaction in particular, he was not making any regular checks about Mr Sansbury's welfare or his status¹⁶².

14. Overview by Dr Craig Raeside

14.1. Dr Raeside is a Forensic Psychiatrist who provided an overview of this case for the Court. His reports were dated 25 January 2007 and 14 March 2007 and were tendered as one Exhibit C98. Dr Raeside also gave evidence at the Inquest.

14.2. Dr Raeside noted that Mr Sansbury had a long history of difficulties since his childhood with disrupted schooling and an early onset of offending with involvement in the juvenile and adult correctional systems. Dr Raeside was also aware that there was an issue as to Mr Sansbury's second cousin being the mother of his two children and that this had been the cause of longstanding conflict in his family. Dr Raeside noted that Mr Sansbury's father had spent time in custody and had died from a drug overdose. Despite all of this Dr Raeside had found no evidence that Mr Sansbury had

¹⁵⁶ Transcript, page 877

¹⁵⁷ A curved knife designed for removing and cutting ligatures

¹⁵⁸ Transcript, page 877

¹⁵⁹ Transcript, page 882

¹⁶⁰ Transcript, page 887

¹⁶¹ Transcript, page 890

¹⁶² Transcript, page 914

ever really received any psychiatric treatment during his life¹⁶³. Dr Raeside noted that there had been at least one documented episode of a previous suicide attempt when Mr Sansbury fashioned a ligature out of clothes at the Magill Training Centre¹⁶⁴.

- 14.3. Dr Raeside never treated Mr Sansbury but having regard to the documentary records available to the Court, was of the opinion that Mr Sansbury had a number of psychiatric symptoms including depression and suicidal thinking. Apart from longstanding depression Dr Raeside could not find any evidence of any other longstanding psychiatric disorder. He did think that Mr Sansbury had a personality disorder and that this was further complicated by social factors, drug abuse and a complicated childhood. This resulted in a significant impairment in his functioning in daily life¹⁶⁵. Dr Raeside stated that he was of the view that formal psychiatric treatment would not be likely to have made a big difference in Mr Sansbury's life. He commented that an unfortunate aspect of the intersection of the criminal justice system and the mental health service is that practitioners in the mental health services tend to view people involved in the criminal justice system as having a "non-psychiatric" problem, and are perhaps less deserving of the services that are available than non-criminal justice patients¹⁶⁶.
- 14.4. Dr Raeside was of the opinion that the treatment by police leading up to Mr Sansbury's attendance at the Lyell McEwin Health Service was appropriate¹⁶⁷. He noted that the PD348, Exhibit C85b, identified clearly what the concerns were regarding self-harm, including possible medication use. He noted that the form specifically stated that the police requested psychiatric assessment if possible, and that there was comment about medication and that the form also identified a local doctor from whom more information might be acquired. Dr Raeside commented that from his perspective this was not only adequate but "very good"¹⁶⁸.
- 14.5. Dr Raeside stated that once Dr Ghanzali became involved with Mr Sansbury the actual reasons for his presentation began to become a "bit more diffuse"¹⁶⁹. According to Dr Raeside, his perception was that Dr Ghanzali thought that the issue

¹⁶³ Transcript, page 919

¹⁶⁴ Transcript, page 920

¹⁶⁵ Transcript, page 921

¹⁶⁶ Transcript, page 923

¹⁶⁷ Transcript, page 925

¹⁶⁸ Transcript, page 931

¹⁶⁹ Transcript, page 932

was whether Mr Sansbury had taken a drug overdose and there was a shift away from the question of self-harm. Dr Raeside noted the difficulties expressed by Dr Ghanzali in not being able to obtain a cooperative history from Mr Sansbury. Dr Raeside commented that, if Mr Sansbury's physical state was such that it was difficult to assess his mental state because of confusion or drowsiness, then it would have been appropriate to leave him in the Emergency Department for a period under observation and then when his level of intoxication or whatever it was which was impairing the giving of a proper history improved, then his mental state should be evaluated at that time, and possibly a psychiatric assessment if the clinicians considered that necessary¹⁷⁰. Dr Raeside commented that this was particularly so in light of the specific request by police for a psychiatric assessment if possible, and stated that that should not have been dismissed lightly¹⁷¹. Dr Raeside noted that Dr Ghanzali had stated that she was a little bit scared of Mr Sansbury and this may have influenced her level of assessment. He also stated that this might have affected the judgement of other staff as well¹⁷². Dr Raeside stated:

‘I think it would be reasonable to leave him in the emergency department for a few hours until he's settled. But I acknowledge that if he was very disruptive then they may not have been prepared to just leave him in that setting.’¹⁷³

- 14.6. Of course, the evidence shows that Mr Sansbury was anything but disruptive while in the Emergency Department. If anything, he was drowsy and sleeping for most of his time while in that setting and there would have been no inconvenience or difficulty occasioned by his demeanour had he been permitted to remain until a proper history could have been taken. Furthermore, Dr Raeside noted that young Aboriginal men with histories such as Mr Sansbury will tend to withdraw rather than engage in medical hospital settings, that they are not likely to open up easily with strangers, and particularly when police are standing around. Dr Raeside repeated that “the wiser thing to do” would have been to reassess Mr Sansbury in the morning¹⁷⁴.
- 14.7. Dr Raeside commented that the medical practitioners in an Emergency Department dealing with a prisoner such as Mr Sansbury have four sources of information available to them. There is the patient himself, then there are the police officers who are escorting the patient, then there is the sergeant at the police cells to whom a

¹⁷⁰ Transcript, page 933

¹⁷¹ Transcript, page 934

¹⁷² Transcript, page 936

¹⁷³ Transcript, page 936

¹⁷⁴ Transcript, page 938

telephone call can always be made, and finally there is the option of contacting family members¹⁷⁵. On the evidence available to me in this case it seems that only the first and second of these options were pursued by either Dr Ghanzali or Dr Chua. This is a further reason why Mr Sansbury should have been kept in the Emergency Department until the following morning.

- 14.8. Dr Raeside commented that even though the focus of Dr Ghanzali and Dr Chua seemed to be upon whether Mr Sansbury had any medical problem resulting from a potential overdose, the issue as to why he might have taken an overdose should still have raised the same issues that a more psychiatrically based line of inquiry would have raised¹⁷⁶. Dr Raeside commented that all medical practitioners are trained in conducting basic psychiatric history and examinations and that in his opinion that should have occurred in this case. He stated that:

‘..this is a young Aboriginal man in police custody and there’s questions about self-harm. I think it would be appropriate that people are aware that that's a high-risk situation not just for the prisoner but heightened awareness around those type of issues would be expected of most medical practitioners as well.’¹⁷⁷

Unfortunately, the evidence shows that there was no heightened awareness in either Dr Ghanzali or Dr Chua.

- 14.9. Dr Raeside commented that if Mr Sansbury had remained in the Emergency Department for several hours and been assessed in the morning when he was awake and more alert, in all probability he would have been cleared for return to police custody at that point, that is on the Sunday¹⁷⁸. Dr Raeside later acknowledged that this was speculative. He stated that all would have depended upon what Mr Sansbury might have said to a psychiatrist or other practitioner on the Sunday. Had he expressed thoughts of self-harm at that point he may well have been detained, but had he not, it is likely that he would have been returned to police custody¹⁷⁹.
- 14.10. Dr Raeside stated that he had a fairly favourable opinion of what the police did subsequently in relation to Mr Sansbury in continuing to regard him as a prisoner at risk. Dr Raeside noted that the police had Ms Mitchell visit Mr Sansbury again on the Sunday, and noted that the Community Constable visited him on the Sunday also.

¹⁷⁵ Transcript, page 940

¹⁷⁶ Transcript, page 943

¹⁷⁷ Transcript, page 944

¹⁷⁸ Transcript, page 946

¹⁷⁹ Transcript, page 1004-1005

However, Dr Raeside was not aware of the precise nature of the interactions between Mr Sansbury and Senior Constable Gollan that have been traversed earlier in these findings. Dr Raeside stated that if Mr Sansbury had been given some false hope that caused him to believe that he might get bail, and that this did not occur, it would have increased Mr Sansbury's distress and agitation and despondency. He said that Mr Sansbury would have been likely to have "latched on" to any inducement to cooperate¹⁸⁰. Dr Raeside commented that someone in Mr Sansbury's situation with his past history would be more easily influenced by a Community Constable from an Aboriginal background than he would have by other persons. Given Mr Sansbury's distrust of authority, Dr Raeside said that seeing another Aboriginal person who was "not quite police but sort of police" would make Mr Sansbury more susceptible to influence by such a person¹⁸¹.

- 14.11. Dr Raeside was asked about the sort of observations which should have been maintained upon Mr Sansbury, and the form of cell in which he should have been placed. Dr Raeside commented that cells that are monitored with CCTV cameras can create a "false sense of security" because there is an assumption that these cells are safer. However, Dr Raeside made the obvious point that the safety of such cells is entirely dependent on how vigilant the officers are in observing things on the monitor¹⁸². Dr Raeside commented that the frequency of checking upon a prisoner such as Mr Sansbury depended upon how readily he could be observed at all times. He stated that if he was observable at all times, then checking was, in a sense, happening continuously. He stated that if a prisoner such as Mr Sansbury was not able to be observed by a camera or more directly, then his view was that 15 minutely checks with some form of interaction would have been appropriate¹⁸³. Dr Raeside was asked whether this would have to persist over a period of 36 hours during a weekend, the implication being that the longer the prisoner is in custody, the more likely that any risk of self-harm has abated. Dr Raeside maintained that 15 minutely checking was still appropriate in such a situation¹⁸⁴ and he specifically stated that it was not valid to suggest that the longer Mr Sansbury was in custody the lower the risk of self-harm because, "The longer he stayed in the more despairing he might have become about his future. ...just simply that he'd been there for two and a half days

¹⁸⁰ Transcript, page 982

¹⁸¹ Transcript, page 983-984

¹⁸² Transcript, page 956

¹⁸³ Transcript, page 958

¹⁸⁴ Transcript, page 959-960

and nothing had - or nearly two days and nothing had happened, doesn't mean that the risk was getting less during that time.”¹⁸⁵.

15. SA Police’s corporate response – the evidence of Deputy Commissioner Burns

15.1. Deputy Commissioner Burns gave evidence at the Inquest. He also made a statement that was admitted as Exhibit C104 in these proceedings. He provided a considerable amount of material that was admitted as Exhibit C104a in these proceedings. He stated that there have been a number of responses by SA Police (SAPOL) to prisoner management of recent times. The first is that prisoner management duties have been incorporated as a distinct module into recruit training at the Police Academy. The second strategy is that prisoner management has been incorporated into IMOST (Incident Management Operational Safety Training) which is a course undertaken each year by operational SAPOL officers and which must be undertaken yearly in order for the officers to remain operational. A third strategy is that any member of the police force can have electronic access to the information about custodial management electronically. Furthermore, there was a separate course available for officers to undertake at the local level. The purpose of this according to Deputy Commissioner Burns was:

‘That’s to make sure that all of our officers receive training and up-to-date training.’¹⁸⁶

Deputy Commissioner Burns stated that cell guards are required to have IMOST training and they must have done the prisoner management course. Thus, if an officer in charge of a local service area wishes a police officer to be performing cell guard duties, then that officer “must be up-to-date with this course and local instructions as well”¹⁸⁷.

15.2. Deputy Commissioner Burns also referred to the Custodial Safety Review Project which is being undertaken by Inspector Twilley and is due for completion in July 2007¹⁸⁸.

15.3. Deputy Commissioner Burns referred also to a pilot project which is underway at the City Watch House in Adelaide which involves the placement of a registered nurse at the City Watch House with obvious benefits to prisoner health and safety¹⁸⁹.

¹⁸⁵ Transcript, page 963

¹⁸⁶ Transcript, page 1012

¹⁸⁷ Transcript, page 1013

¹⁸⁸ Transcript, page 1013

- 15.4. Deputy Commissioner Burns stated that there is no external auditing of the Custodial Safety Review Project, that there are no external consultants such as psychologists or psychiatrists involved in the project, there are no persons with expertise in relation to Aboriginal culture involved in the project, there is no involvement by members of the Aboriginal Legal Rights Movement in the project, and that there is no involvement of persons with a knowledge of safety or health from outside of SAPOL involved in the project¹⁹⁰.
- 15.5. During the course of Deputy Commissioner Burns' evidence, objection was taken by Counsel for the Commissioner to the description of the computer generated record of prisoner disposition which I have described earlier in these findings as a "PD28" form. This deserves some comment in these findings. The Elizabeth Police Station Local Standing Orders made reference at the time to a document called a PD28. The General Orders that were in operation at the time also made reference under the eighth dot point under the heading "Custody" to a PD28 which was further elaborated in the General Order as a "Prisoner Custody Disposition" and I have come to the clear conclusion that both the exercise book, Exhibit C85, and the electronic record which was not produced at the Inquest, both fell within the description recognised by SAPOL as PD28. Counsel for the Commissioner contended that a PD28 was not "a necessary form"¹⁹¹. Yet the General Order to which I have just referred stated:

'The times prisoners are checked, and the fact that the oncoming officer in charge has been given information on each prisoner, is noted in either the PD28, Prisoner Disposition or the PD121, Prisoners Property Book and Register.'

It stated that these matters are things which must be ensured by the officer in charge of the station. The Police Act 1998 states that a police officer must comply with the General Orders. Thus this had the force of law and the existence or non-existence of the PD28, and precisely what constituted it was an important issue at this Inquest. Unfortunately it was never cleared up. It became apparent to me during this Inquest that there is a disconnection between the expectations of the senior management of SAPOL as to the effectiveness of General Orders, and the reality on the ground. A graphic illustration of this was the evidence of Constable Howe. Constable Howe admitted that he had never read the General Orders in their entirety. He

¹⁸⁹ Transcript, page 1018

¹⁹⁰ Transcript, page 1023-1024

¹⁹¹ Transcript, page 1027

acknowledged that he was required to comply with police General Orders. I set out below a question which I asked Constable Howe and his reply:

‘Q. How do you go about complying with orders that you haven't read.

A. Unable to answer that question.’¹⁹²

- 15.6. This requires no elaboration, but demonstrates that even in a recently trained officer such as Constable Howe, who appeared to have a better understanding than some of the other witnesses at this Inquest of police procedures, there is a significant problem. Much effort is devoted by SAPOL to the improvement of General Orders. They are constantly, it seems, under review and scrutiny. However, General Orders are of little or no value if those required to comply with them have not read and understood them.
- 15.7. Furthermore, I was concerned by a general lack of consistency in the understanding of good practices in relation to prisoner management by the various witnesses who gave evidence at this Inquest. Yet, each of those witnesses should have been trained under the IMOST program within the last twelve months, or more recently than that. In those circumstances, I would have expected a reasonably consistent level of understanding between each of the witnesses on such matters as frequency of prisoner checks and other fundamental aspects of prisoner management. Yet this was clearly lacking. It is plain that Deputy Commissioner Burns genuinely believes that the systems and training programs that have been put in place and to which he referred in his evidence will be effective. Yet the evidence of the witnesses at this Inquest causes me to doubt the effectiveness of these programs.
- 15.8. Deputy Commissioner Burns stated of the Custodial Safety Review Project being undertaken by Inspector Twilley:

‘He's personally inspected the majority of the cells in the State. I can't go in-depth into what he's doing in his project, ... but we've had contact with other interstate jurisdictions, we've made sure that we've got information provided by other inquests from interstate and we're trying to take that all into account in developing a general order that will be at best practice.’¹⁹³

It is almost as if Deputy Commissioner Burns belongs to a different organisation from those more junior officers who gave evidence about prisoner management duties at the Inquest.

¹⁹² Transcript, page 435

¹⁹³ Transcript, page 1030-1031

15.9. Deputy Commissioner Burns obviously has a genuine belief that the initiatives referred to in his evidence will be effective in minimising the chances of a repetition of Mr Sansbury's tragic death. I regret that I do not share his confidence. It has been more than sixteen years since the findings of the Royal Commission into Aboriginal Deaths in Custody were handed down. A generation of Aboriginal prisoners has grown up and has been through the custodial system during that period. Yet in the case of Mr Sansbury there was a significant period of inattention as to his welfare on the morning of Monday, 15 November 2004. Sergeant Ward described this as a period of "only" 40 minutes. This should be compared with the opinion of Dr Raeside, who considered that 15 minutely checks were necessary even at that point. Clearly, they were necessary. The CCTV camera that was relied upon as some assurance of Mr Sansbury's safety and welfare could not clearly depict what was happening in his cell during the relevant time because the lights were off in the cell. Therefore the opportunity for a passing glance to alert any of the officers on duty that morning to what was happening was lost. No physical check occurred during that period. It was only by happenstance that Mr Sansbury was detected after 40 minutes had expired because prisoner Fry was being escorted by Constable Wynne to the cell blocks. The attitude of Sergeant Ward that a period of 40 minutes could be described as a comparatively short period is indicative of an attitude of complacency. I did not detect any sense of urgency from the officers who gave evidence, other than Deputy Commissioner Burns, about the need to ensure prisoner safety. There is, it seems to me, a significant gulf between the expectations of Deputy Commissioner Burns, and presumably, other senior managers within SAPOL, and the reality of the culture amongst operational officers in charge of SAPOL's cells, at least as represented by the officers who gave evidence in this matter.

16. The role of Aboriginal Community Constables

16.1. The evidence in this case as to the role of Senior Constable Gollan was troubling. He interviewed Mr Sansbury before the latter was charged. He took no notes of his interview. No audio or audio visual record was made. The interview lasted for perhaps as long as two hours. Senior Constable Gollan told Mr Sansbury that he would be facing a long period in custody as a result of his behaviour earlier in the day - between five and ten years imprisonment. He then went about attempting to gain information from Mr Sansbury. Not only information about the matters for which he

had been arrested, but also more generally in relation to Mandrake 3. We have no way of knowing what Mr Sansbury told Senior Constable Gollan, beyond the rather scant recollection of the latter. We do know that Mr Sansbury provided some information as to stolen guns, but that it was not particularly useful from Senior Constable Gollan's perspective. It is clear that Mr Sansbury was, in Senior Constable Gollan's mind, "desperate" to gain freedom through the bail process. According to Senior Constable Gollan, Mr Sansbury was prepared to do almost anything for that purpose. He was told by Senior Constable Gollan that cooperation might be rewarded. I can only speculate about the impact of these interactions on Mr Sansbury. Did he tell Senior Constable Gollan something that he regretted? Did he feel guilty as a result of having imparted information? Was that guilt compounded by the fact that he did not obtain bail, and thereby, freedom? Not only did Senior Constable Gollan interview him alone once, he did so on the following day, albeit after Mr Sansbury had been charged. On that occasion, the only possible reason, on the evidence, was for Senior Constable Gollan to obtain information from Mr Sansbury.

- 16.2. I do not know whether the interventions of Senior Constable Gollan made Mr Sansbury's state of mind worse than it was already. However, he was always regarded as a person at risk. I would have thought that Senior Constable Gollan's interventions could only increase his anxiety, particularly after the passage of time with no grant of bail. That view was quite clearly taken by Dr Raeside, who thought that an inducement offered by a person in a position of trust such as Senior Constable Gollan that did not achieve anything positive from Mr Sansbury's point of view would make matters significantly worse.
- 16.3. The matter of "Prisoner Debriefs" is the subject of a specific policy for the Elizabeth Local Service Area, Policy Statement 29, a copy of which was admitted as Exhibit C78b in these proceedings. That document provides that the "prisoner debrief process is not intended to gain further evidence concerning the matter that the person has been charged with". It will be recalled that Senior Constable Gollan stated in his evidence that one of his objects in debriefing Mr Sansbury was to gain further information in relation to the "offences committed that day..."¹⁹⁴. Of course, at the time that Senior Constable Gollan questioned Mr Sansbury, the latter had not been charged. Nevertheless, it is clear that Senior Constable Gollan's intention, so far as it related to

¹⁹⁴ Exhibit C92

the offences committed that day, constituted a breach of the policy. Whether he actually questioned Mr Sansbury on the topic of the offences committed that day, we do not know, and never will, the interview not having been recorded, nor any proper notes of it having been made by Senior Constable Gollan.

- 16.4. The Policy Statement “Prisoner Debriefs” Exhibit C78b also states, “To comply with section 78 of the Summary Offences Act, where persons are in custody, the debrief should be conducted within the custody of the member in charge of the police station. Personal supervision of the O/C police station is not required. A removal from the custody of the O/C of the Police Station, to another building for example, may make the process contrary to Section 78 SOA and therefore unlawful”. The policy goes on to state, “Bail is not to be delayed for purpose of a prisoner debrief... Debriefing must not delay delivery into custody..”. It is clear in this case that Mr Sansbury arrived at Elizabeth Police Station at 2.10pm. He was charged at 6.42pm. Thus a period exceeding the period of four hours prescribed by section 78 of the Summary Offences Act was allowed to expire¹⁹⁵. Some of that delay, indeed in all probability a large part of the delay, was occasioned by Senior Constable Gollan’s debriefing. Thus, not only was there a breach of the Summary Offences Act in that the prescribed period was exceeded by a significant amount, but there was also a breach of the policy, in that delivery into custody was delayed. No doubt, Sergeant Schwanz became aware of Mr Sansbury’s presence at the cells some time earlier than the time of charging. But in my opinion, the policy was breached in the sense that the debrief was not conducted “within the custody of the member in charge of the police station”. In my opinion that policy contemplated that debriefing would occur after, not before, charging. In the result, not only did the debriefing delay delivery into custody, (in the sense in which that expression is used in the policy, namely custody of the charging officer), but it also delayed bail, or any consideration of bail. It is no answer in that

¹⁹⁵ In submissions filed on behalf of the Commissioner, it is submitted that ALRM was called at 16.30 hours, and that no legal representative attended so at 17.26 hours the formal interview process commenced. The submission argues that there is no evidence to indicate that the 54 minutes did not elapse in anticipation of attendance of a legal representative. This is disingenuous. After a length investigation of this matter by Inspector Fellows there was no evidence to show that the “clock was stopped” in the sense that the arresting officers were waiting for the arrival of a solicitor. I do not accept this as an explanation that would justify the detention without charge for a period exceeding 4 hours. It is notable that Inspector Fellows did not mention it in her report when she attempted to argue that the period in detention without charge could be regarded as being 3 hours and 50 minutes if one excluded the time taken to decontaminate Mr Sansbury. It will be apparent that I do not regard the time taken for decontamination as being a period that can legitimately be subtracted from the total period in detention prior to charging for the purposes of section 78 SOA. Finally, the Commissioner’s submissions suggested that “the question of compliance with s78 SOA is not relevant to the cause of death” and that, presumably I ought not to comment upon it. I disagree. It might not be relevant to the actual cause of death, but it was certainly a most relevant circumstance in the period immediately preceding death.

regard that bail was not ultimately granted. The policy could not reasonably be construed as providing for a delay in an application for delay which is permissible if bail is refused, but impermissible if granted.

- 16.5. It was submitted by counsel for Valerie Sansbury and Edward Sansbury that the deployment of an Aboriginal Community Constable in the manner that occurred in this case, that is to use his position of trust to obtain intelligence from an Aboriginal detainee, was contrary to the purpose of the role as envisaged by the Royal Commission into Aboriginal Deaths in Custody (Chapter 29.7). I do not think there is any doubt about this. While the RCADC did not specifically speak against the use of community constables for this purpose, I consider that one cannot assume that the Commissioners would have condoned the practice. At the time of the writing of the RCADC report, it was an advance merely to have community constables, and the notion that they might be used (if they came into being) for a negative or destructive purpose was not within contemplation. I am confident that the Commissioners would have disapproved of any such notion. In my opinion, it is inappropriate that Community Constables be deployed for the purpose of intelligence gathering, or “debriefing”.
- 16.6. In written submissions lodged on behalf of the Commissioner, it was pointed out that the former State Coroner, Mr Chivell (as he then was) referred to the use of Community Constables in acting as intelligence officers in the inquest into the deaths of Kunmanara Ken, Kunmanara Hunt and Kunmanara Thompson in the finding published on 6 September 2002. In fact, Mr Chivell stated that, “The Community Constable Scheme is a worthwhile initiative, and could be improved with further training of Community Constables. However the scheme has significant limitations because of cultural constraints, and the fact that the Community Constables are members of very small communities. Their strengths lie in diffusing acute situations, and acting as liaison and intelligence officers”¹⁹⁶. That was in a very different context, dealing as it was with the remote Anangu community and the special problems presented in such a community. I take Mr Chivell to be referring to the “intelligence” that might come from Community Constables as to the family relationships between particular individuals in the community, and perhaps also to intelligence that might prevent the importation into the community of drugs and other

¹⁹⁶ See paragraph 11.61 of that Finding

substances for illicit purposes. I do not believe that His Honour had in mind the use of Community Constables in an urban environment for purposes such as have been considered in this case. Obviously there is a considerable difference between the use of Community Constables in policing to prevent importation of harmful substances to remote communities, and to assist in providing information about particular familial relationships, and the use of Community Constables to obtain information from a person under arrest in a manner that makes use of cultural ties to establish a relationship of trust to induce the detainee to provide information in the hope, held out by the Community Constable, that the detainee might obtain bail.

17. The matter of representation and the Commissioner of Police

- 17.1. Initially, Counsel sought leave to appear on behalf of the South Australia Police. I refused leave for “South Australia Police” to appear, because there is no such entity in fact or law. It is true that the Police Act 1998 refers collectively to the Commissioner, the Deputy Commissioner, the Assistant Commissioners and all other members of the police force, as SA Police, or South Australia Police. But it does not designate that amorphous group as one entity in law. Instead, the Act provides in section 6 that the Commissioner of Police is responsible for the control and management of SA Police. In all previous inquests in which the Commissioner of Police has had a clear and obvious interest by virtue of the fact that acts or omissions of police officers are relevant to the cause and circumstances of the event the subject of the inquest, there has never been any question about the matter. The Commissioner of Police of the day has invariably sought leave to appear. That is clearly appropriate and proper. If some act or omission requires examination, the Commissioner will be in a position to give an organisational, or corporate, perspective. He will be able to explain that the act in question is in compliance with his understanding of police processes or not, as the case may be. He will be able to advise the court whether he considers, as the person responsible for the police force in this State, whether he regards the acts or omissions under examination to be acceptable or not, to be up to the standard he expects, or not. He will be able to inform the court what action he has taken to prevent a recurrence of action that he might have found to be unsatisfactory. This will inform the Court of crucial information about the exercise of the Court's power under section 25(2) of the Act to make recommendations to “prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest”. This power of

recommendation is now regarded, almost universally amongst Australian Coroners, as perhaps the most important part of their work. It is essential, in framing a recommendation intended to prevent a recurrence of something caused by a particular agency, to know what action that agency has already taken of its own initiative to prevent a recurrence. It is essential to know whether the agency even acknowledges that there is a need to take any action at all. If the person responsible for the agency has not appeared (personally or by counsel) then the task of framing recommendations becomes much less focused, and less useful.

- 17.2. In the result, the Commissioner of Police did ultimately seek leave to appear by Counsel¹⁹⁷.

18. The claim that material be suppressed

- 18.1. In this case there was a Commissioner's Inquiry as well as a coronial inquiry. They were both conducted by Chief Inspector Fellows¹⁹⁸. Certain material was presented in both the Commissioner's inquiry report and the coronial investigation report relating to the methods adopted by SA Police in the Stop Car Theft program. That material was quite extensive. It was obviously considered relevant to both inquiries by Chief Inspector Fellows.
- 18.2. Approximately a month before the Inquest was due to begin, and some year or more after the provision to the State Coroner of the various reports in this matter, notice was given of an application by the Commissioner of Police for the material to which I have referred to be removed from the report material to be tendered at the Inquest. This was the subject of a preliminary hearing on 20 April 2007. Extensive submissions were made by Counsel appearing for Valerie Sansbury and Edward Sansbury, relatives of the deceased, about the application. From that material it became apparent that the vast bulk of the material sought to be withdrawn was already in the public arena, having been extensively referred to in *Harvey v Police* [2006] SASC 222, a judgement of Justice DeBelle. Counsel for the Commissioner then abandoned the claim in relation to most of the material, and in the result, the only material that was withdrawn was mobile telephone numbers for particular police officers.

¹⁹⁷ Transcript, pages 1-7

¹⁹⁸ Exhibit C105

18.3. Therefore the application to suppress the material had been made without proper thought. The material was already in the public arena, having been published in the judgement in *Harvey v Police*, a case to which the Commissioner of Police was obviously a party, and of which he, or his counsel, should have been well aware. Fortunately this application did not delay the inquest, having been dealt with as a preliminary matter.

19. Conclusions

19.1. Clearly there were shortcomings in the treatment of Mr Sansbury.

1. The doctors at the Lyell McEwen health Service should have kept Mr Sansbury in overnight for proper psychiatric assessment.
2. There was inadequate communication between Doctors Ghanzali and Chua.
3. Dr Chua endorsed the PD348 without having read it.
4. The relevant police officers did not properly understand their obligations as to prisoner checking.
5. There was inadequate communication between the officers on duty on the morning shift on 15 November, and some of those responsible for Mr Sansbury's care were not aware that he was identified as an "at risk" prisoner.
6. One officer was preoccupied with escorting an air conditioning mechanic at a time when the Elizabeth cells were extremely busy, thus reducing the available staff to supervise prisoners.
7. As a result, Mr Sansbury was alone for 40 minutes with no check, even though he was regarded as an "at risk" prisoner.
8. The CCTV monitor in Mr Sansbury's cell, on which the relevant officers placed great reliance, could not clearly monitor him in the cell, because the cell lights were off. His ability to pull the door shut reduced the visibility on the monitor even further.
9. Mr Sansbury was left with his disposable jumpsuit after it should have been removed from his possession. It was the jumpsuit which enabled him to fashion a ligature with which he hanged himself.

10. An Aboriginal Community Constable induced Mr Sansbury to believe that if he provided information, he might be released on bail.
 11. Mr Sansbury placed significant trust in the word of the Aboriginal Community Constable, referring to him as “uncle”.
 12. Mr Sansbury would have been particularly disappointed when the information he provided to the Aboriginal Community Constable did not result in a grant of bail.
 13. As a result of the debriefing by the Aboriginal Community Constable, Mr Sansbury was held without charge at the Elizabeth Police Station for a period exceeding that permitted by the Summary Offences Act, in breach of that Act.
 14. As a result of the debriefing by the Aboriginal Community Constable, Mr Sansbury’s delivery into custody of the charging officer was delayed, contrary to the “Debriefing Policy”.
 15. As a result of the debriefing by the Aboriginal Community Constable, Mr Sansbury’s opportunity to apply for bail was delayed, contrary to the “Debriefing Policy”.
- 19.2. In my opinion there were also shortcomings in the investigation carried out by SAPOL into this matter. Those included the failure to locate the hard copy of the computerized prisoner disposition information before it was destroyed, the length of time taken to obtain witness statements from some of the key witnesses, the analysis of compliance with section 78 Summary Offences Act, which was in my opinion flawed. Finally, there was the finding in relation to the disposable jumpsuit that although Mr Sansbury should not have been left with the suit, “the retention of the overalls should not of its own be considered as a significant factor in his death” because he “could have used some other article of clothing”¹⁹⁹. These things add some force to the submission made on behalf of Valerie and Edward Sansbury that “the Commissioner of Police and SAPOL should not have the prime investigative role in a case where there has been a death in police custody or which concerns the conduct of serving police officers”. It will be recalled that the Commissioners in the RCIADIC stopped short of recommending that the function of investigating deaths in

¹⁹⁹ Exhibit C23a, page 82

police custody on behalf of the coroner should be removed from police, in part because of the lack of expertise for that purpose otherwise than in the police force. It may be that the time has come when it would be appropriate for the different jurisdictions to enter into arrangements with each other such that a death in a particular jurisdiction is investigated by or under the supervision of police from another jurisdiction, including the Federal Police.

- 19.3. The notion of police from another jurisdiction, or Federal Police, investigating deaths in police custody in this jurisdiction is not as challenging as may at first appear, particularly bearing in mind the deployment of Australian Police Forces overseas in various roles of recent times. If such deployments can be arranged relatively easy, albeit for humanitarian reasons in most cases, a deployment to another State to investigate a death in police custody in that State should be relatively simple to organize. What small inconvenience might be occasioned would be well justified by the removal of any chance that an investigation might be regarded as defensive, or lacking in enthusiasm, where an officer is investigating his or her own colleagues, with the risk that there may be recriminations in the event that the investigator is critical of the actions of the various protagonists.

20. Recommendations

- 20.1. I recommend that the deployment of Aboriginal Community Constables for the purposes of “debriefing” as that concept is used in the debriefing policy, Exhibit C78b, be discontinued.
- 20.2. I recommend that the Attorney General raise with his State and Commonwealth counterparts the proposal that the States and the Commonwealth enter into an arrangement with each other such that a death in the custody of the police force of a particular jurisdiction is investigated by or under the supervision of police from another jurisdiction, including the Federal Police.

Key Words: Aboriginal Deaths; Death in custody; Hanging; Inadequate examination; Monitoring/Observation of prisoners; Suicide risk - assessment of.

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

Seal the 12th day of July, 2007.

State Coroner

Inquest Number 10/2007 (3482/04)