



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 1st, 2nd, 3rd, 6th and 7th days of August 2007, and the 19th day of September 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Arthur Charles Smith.

The said Court finds that Arthur Charles Smith aged 30 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield died at Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia on the 13th day of January 2005 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Arthur Charles Smith was 30 years of age as at the date of his death on 13 January 2005 at the Yatala Labour Prison. Mr Smith, who was born on 29 April 1974, was an inmate at Yatala Labour Prison at the time of his death having been remanded in custody on charges of indecent assault. Accordingly, Mr Smith's was a death in custody within the meaning of that expression in the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.
- 1.2. Detective Brevet Sergeant Yazarloo conducted a thorough investigation into this matter which is summarised in a statement provided by him together with an investigation summary provided by him in Exhibit C39. He obtained a number of statements from witnesses whose interactions with Mr Smith covered his periods in police custody, his time in custody at the Adelaide Remand Centre and his time in custody at the Yatala Labour Prison. Of the many witnesses from whom statements were obtained in the course of Detective Yazarloo's investigation, oral evidence was provided at Inquest by Dr Craig Raeside, Forensic Psychiatrist who saw Mr Smith

while he was in the Adelaide Remand Centre; Dr Christopher Clohesy who saw Mr Smith at Yatala Labour Prison; Mr Gregory Dayman who attended on Mr Smith in both the Adelaide Remand Centre and the Yatala Labour Prison; Dr Ian Jennings, Psychiatrist, who attended upon Mr Smith in the Yatala Labour Prison; Mr Peter Beaumont, Registered Nurse who saw Mr Smith in the Yatala Labour Prison and Prison Officers Burnell, Flynn, Booth, Newell and Colasante all of whom had dealing with Mr Smith during his period in prison. Finally the Court heard evidence from Dr Danny Sullivan, Consultant Psychiatrist, who never saw Mr Smith but provided an overview of Mr Smith's treatment and care while in custody with particular reference to his medical treatment.

- 1.3. Mr Smith was a 30 year old single man at the time of his death. He was one of five children and his mother, who provided a statement which was admitted as Exhibit C7, reported that his schooling was marked by academic difficulties particularly with literacy. She also reported that Mr Smith's history in the workforce had been erratic after he suffered work related injuries in the course of his employment. Mr Smith's mother reported that he engaged in substance use beginning in his teens, including alcohol, cannabis, amphetamines, benzodiazepines, opiates and volatile solvents. Following back surgery in 2002, he was on a morphine pump for the control of pain and his mother thought that this may have precipitated experimentation with heroin.
- 1.4. Mr Smith was arrested on 9 November 2004 and appeared before a Magistrate in the Adelaide Magistrates Court on 10 November 2004. On that day he collapsed in the precincts of the Court and was taken to the Royal Adelaide Hospital where he was diagnosed as having suffered a grand mal seizure or a pseudo seizure but was returned to custody. On 11 November 2004 he was transferred to the Adelaide Remand Centre.

2. Dr Craig Raeside

- 2.1. A useful summary of Mr Smith's psychiatric history can be gained from a reading of a report prepared by Dr Craig Raeside on 16 November 2004 following Dr Raeside's examination and assessment of Mr Smith in the Adelaide Remand Centre. The report appears within the South Australian Forensic Health Services casenotes in relation to Mr Smith¹. The report notes that Mr Smith was, immediately before his arrest,

¹ Exhibit C47b

employed as a fulltime casual storeman for Big W at Monarto for five weeks but prior to that had been unemployed for four years. Dr Raeside noted a history of depression and previous attempts at self-harm and suicide. The first of these as noted by Dr Raeside was a suicide attempt at the age of 20 which resulted in an admission to Glenside Campus for approximately one month. There were subsequent reports of Mr Smith having cut himself. There were several similar episodes, the most significant of which was an attempt at suicide in March or April 2004.

- 2.2. Dr Raeside noted the illicit drug use, including heroin. He noted that Mr Smith had engaged in a methadone program at Waranilla for a period of one year while in his mid twenties. Dr Raeside noted that Mr Smith was generally low in mood at the time of the assessment, felt a sense of unreality, dizziness, poor sleeping, low appetite, poor concentration and ongoing suicidal thoughts with impulses to carry suicide into effect. Dr Raeside did not note any psychotic features. Dr Raeside said that Mr Smith was oriented to time and place but flat in affect and generally depressed. Dr Raeside's assessment at that point was that the diagnosis was unclear but there was chronic depression with extensive drug and alcohol abuse and a history suggesting an underlying personality disturbance. Dr Raeside thought Mr Smith was at risk of self-harm and his plan was that Mr Smith remained in the infirmary for observation on a yellow sheet. Dr Raeside commenced Mr Smith on Avanza, an antidepressant, and sought Mr Smith's notes from Glenside Campus and Noarlunga Hospital. He intended to review Mr Smith one week later.
- 2.3. According to Exhibit C67, the yellow sheet referred to above is more formally referred to as a suicide risk assessment care plan. It is maintained on the prisoner's medical record and effectively operates as a signal to all medical staff that the prisoner is at risk of self-harm.
- 2.4. Dr Raeside stated that he saw Mr Smith again at the Adelaide Remand Centre infirmary on 23 November 2004 when he appeared to be feeling a bit better although still with thoughts of self-harm. Dr Raeside ordered that Mr Smith remain in the Adelaide Remand Centre infirmary for another week after which consideration should be given to transferring him to the living units. On 30 November 2004 Dr Raeside assessed Mr Smith again and noted a further improvement over the previous week. Dr Raeside considered that Mr Smith had returned to what Dr Raeside described as his "baseline level" with chronic thoughts of self-harm, boredom and low grade

depression. Dr Raeside considered that Mr Smith was no longer acutely depressed but remained a chronic risk of self-harm. Dr Raeside suggested that he could be transferred to the living units but remain on a yellow sheet regime which required that Mr Smith undergo a daily nursing review by infirmary staff.

- 2.5. Dr Raeside assessed Mr Smith again on 7 December 2004 because Mr Smith had been returned to the infirmary after biting his arm. Dr Raeside said that Mr Smith was unable to provide an explanation for this self-harming behaviour or to point to any specific issue or stress that caused it. However, Mr Smith had been moved from one unit to another following another prisoner having called out his name which prompted Mr Smith to request protection as a result of which he was transferred to Unit 7 which is a close observation unit. It was in Unit 7 that Mr Smith bit himself and was transferred to the infirmary on 1 December 2004.
- 2.6. When seen on 7 December 2004 Mr Smith was fearful of people hurting him but had no thoughts of hurting himself at that time. Dr Raeside noted that it was important that Mr Smith be on protection because of the nature of the charges against him and was prepared for Mr Smith to be discharged from the infirmary so that he could be transferred to the protection unit at the Adelaide Remand Centre and thence transferred to Yatala Labour Prison in the protective regime available at that institution. Dr Raeside was aware that it was not possible to transfer a prisoner to Yatala Labour Prison directly from the Adelaide Remand Centre infirmary, and accordingly he arranged for his transfer to a protective living unit at the Adelaide Remand Centre. He directed that Mr Smith remain on a yellow sheet regime.
- 2.7. Dr Raeside saw Mr Smith again on 14 December 2004 and noted that Mr Smith was feeling relatively normal but had occasional thoughts of self-harm with intent to act on them. Mr Smith was then awaiting transfer to Yatala Labour Prison. Dr Raeside thought that Mr Smith had stabilised to his baseline level and ceased the yellow sheet regime so that daily medical review was no longer required at that point.

3. Mr Smith's transfer to Yatala Labour Prison

3.1. Nurse Susan Rex

Ms Susan Rex is a nurse employed in the South Australia Prison Health Services who worked at Yatala Labour Prison in December 2004. She made a statement which was admitted as Exhibit C32a in these proceedings. According to Ms Rex she was on duty

in the infirmary at the prison on 16 December 2004. At about 4:30 pm that afternoon Mr Smith was examined by her as part of the process of admitting him to the Yatala Labour Prison. He had been transferred from the Adelaide Remand Centre that afternoon. He was to be assessed for protective custody. Ms Rex was aware that Mr Smith's charges were of a sexual nature against a minor. Ms Rex was aware from the documents accompanying Mr Smith that he had been on a yellow sheet at the Adelaide Remand Centre at the recommendation of Dr Raeside. She was also aware that two days prior to Mr Smith's transfer to Yatala Labour Prison, on 14 December 2004, Dr Raeside had directed Mr Smith could be ceased from the yellow sheet regime.

- 3.2. Nurse Rex observed that Mr Smith was depressed and flat in his affect and denied having thoughts of self-harm at that time. He had poor eye contact and Nurse Rex was "worried more about what he was not telling me"². Nurse Rex noted the wound on Mr Smith's left wrist from his self-inflicted biting wound earlier that month. Nurse Rex completed a "Potential Self-Harm Management Notification" form and decided to place Mr Smith on a yellow sheet regime. She discussed Mr Smith with Mr Gibbs, the Corrections Officer who had completed his Prison Stress Screening Form. That form appears in Mr Smith's case management file³ which is designed to provide an assessment of a newly admitted prisoner's risk status. The score for Mr Smith was 11. The form requires that a prisoner be classified as being at risk if the score is greater than 8 or if particular questions relating to thoughts of self-harm are affirmatively answered or if, regardless of the score, the interviewing officer feels that a further opinion is warranted. Mr Smith was assessed as being at risk according to all three of those criteria. Following her discussion with Mr Gibbs, Nurse Rex decided that Mr Smith would be admitted to the infirmary for that night and placed on canvas. This meant that Mr Smith would be subject to constant observation, that he would wear a canvas smock and be provided with canvas bedding. Canvas material is used in this environment because it is difficult if not impossible to tear and thus cannot readily be used by a prisoner to fashion a ligature with which to cause self-harm. According to Ms Rex, Mr Smith was angry when told that he would be staying in the infirmary as he preferred to be accommodated in the cells in the protection unit.

3.3. Dr Christopher Clohesy

² Exhibit C32a

³ Exhibit C47d

Dr Clohesy was employed by the South Australia Prison Health Services as a visiting medical officer in December and January 2004. On 17 December 2004 he assessed Mr Smith in the infirmary at Yatala Labour Prison. Mr Smith was not expressing any suicidal ideation or psychotic features and did not appear to have any significant drug withdrawal symptoms. Mr Smith was asked about his future by Dr Clohesy and responded that he had no definite long term plans but would like to get a job again. Dr Clohesy noted that this indicated that Mr Smith was thinking about his future and thus not suicidal at that time. Dr Clohesy directed that Mr Smith be removed from canvas and constant observations but be kept in the infirmary on a yellow sheet regime⁴. Dr Clohesy also reviewed Mr Smith on 10 January 2005 and 11 January 2005 while Mr Smith was in the Yatala Labour Prison infirmary. Dr Clohesy assessed Mr Smith on both of those occasions as not experiencing any suicidal ideation or self-harming intention. Dr Clohesy determined that Mr Smith should remain in the infirmary on the yellow sheet regime.

3.4. Dr Gregory Dayman

Dr Dayman is a medical practitioner who was employed by the South Australian Prison Health Services at the relevant time. He assessed Mr Smith in the Adelaide Remand Centre infirmary on 3 December 2004. It will be recalled that this was shortly after Mr Smith's deliberate infliction of self-harm by biting his arm on 1 December 2004. Dr Dayman asked Mr Smith about this matter and Mr Smith said that he had a lot of changing moods. He said that he would be fine one day and depressed the next and was unsure how long he had been in such a state. He said that he could change mood from ecstatic highs to flat bottoms within ten minutes. He said that his moods had been all over the place since being in prison. He said that when he bit himself on 1 December 2004 he had not been upset at the time and did not know what was going through his mind. He acknowledged that he should not be engaging in such behaviour. Dr Dayman assessed Mr Smith as having chronic depression and chronic mood instability.

3.5. The next time Dr Dayman saw Mr Smith was on 21 December 2004 at the Yatala Labour Prison infirmary where he had been since 17 December 2004. Dr Dayman

⁴ A yellow sheet regime in the Yatala Labour Prison has the same effect as such a regime at the Adelaide Remand Centre, namely that it is a suicide risk assessment care plan which requires that a prisoner be medically reviewed daily by either a nurse or a doctor. As Mr Smith was to be kept in the infirmary, he would clearly be medically reviewed by a doctor or nurse for as long as he remained there. However, the yellow sheet regime mandated that this would continue to happen even after he was transferred out of the infirmary.

said that Mr Smith reported having taken Avanza medication⁵ without any effect and that he was still having lots of mood fluctuations. Mr Smith felt reasonably happy that day but the previous weekend he had been different. That weekend he had burnt his left arm with a cigarette and again could not explain why he had done so. Dr Dayman noted the burn in the casenotes. Mr Smith told Dr Dayman that he was feeling safer from himself at that time and was denying thoughts of suicide. However he did acknowledge that this could change very quickly and without warning. Dr Dayman assessed Mr Smith as having chronic mood instability with multiple episodes of self-harm and formed the view that Mr Smith was unpredictable and impulsive. Mr Smith had been taken off canvas on 17 December 2004 and then had burnt himself with a cigarette the following day. Dr Dayman noted that Mr Smith would be a chronic high risk prisoner. He ceased the antidepressant drug Avanza as Mr Smith was not willing to take it, but started Mr Smith on the mood stabilising medication Sodium Valproate.

3.6. Dr Ian Jennings

Dr Ian Jennings is a psychiatrist who practises privately and performs forensic psychiatric clinics at the Yatala Labour Prison. Dr Jennings saw Mr Smith in the Yatala Labour Prison infirmary on 12 January 2005. Dr Jennings had not previously seen Mr Smith. Mr Smith informed Dr Jennings that at that time he was feeling quite good but with variable sleep and appetite. Dr Jennings noted that he had “no suicidal or self-harm behaviour at present”⁶. Dr Jennings noted that Mr Smith was no longer taking Avanza and that other past trials of prescribed antidepressants had had limited benefit. Dr Jennings noted that Mr Smith was taking Sodium Valproate as a mood stabiliser. Dr Jennings assessed Mr Smith as suffering from borderline personality disorder and a history of alcohol and amphetamine abuse. Dr Jennings decided to manage Mr Smith by increasing his Sodium Valproate dose and referring him for counselling by a psychologist or psychiatric nurse. He prescribed Chlorpromazine syrup on an “as required” basis and directed that Mr Smith could leave the infirmary but should remain on suicide risk assessment (the yellow sheet regime).

3.7. Mr Smith was in the infirmary on 12 January 2005 having been admitted there on 9 January 2005. He was admitted on that day from accommodation in “B Division Top East”, a protective living unit in Yatala Labour Prison where he had been for the

⁵ It will be remembered that this was prescribed by Dr Raeside on 16 November 2004.

⁶ Exhibit C75

previous three weeks. His admission to the infirmary was the result of a report by a fellow prisoner in whom Mr Smith had confided. Mr Smith had told the fellow prisoner that he was at the end of his tether. This information was passed to correctional staff and Mr Smith was transferred to the infirmary that day.

- 3.8. Dr Jennings noted the observations made by Dr Clohesy on 10 and 11 January 2005 and notes of the nursing staff for the preceding two days according to which Mr Smith was not displaying acute suicide or self-harm intent. At the time of Dr Jennings' assessment on 12 January 2005, and according to the notes from the previous two days, Mr Smith was not displaying any behaviour indicating that he would self-harm or suicide in the near future. Dr Jennings directed that Mr Smith be kept on the yellow sheet regime but authorised that Mr Smith be returned to the general prison population from the infirmary.
- 3.9. Mr Smith had been in the protective unit "B Top East" between 23 December 2004 and 9 January 2005. He had remained on a yellow sheet regime continuously. It is noteworthy that an infirmary nurse reported in the progress notes⁷ on 6 January 2005 that Mr Smith:

'Has other inmates checking on him during the day but feels he is most at risk during night.'

4. Events of 13 January 2005

4.1. Correctional Officer Gordon Burnell

Correctional Officer Burnell gave evidence at the Inquest. He was on duty in the Yatala Labour Prison infirmary on 13 January 2005. He recalled that Mr Smith seemed to be quite cheerful and was asking when he would be returning to his old cell in B Division. Correctional Officer Burnell explained that he was informed by a female nurse at approximately 9 o'clock in the morning on that day that Mr Smith would be moved back to his division. The nurse did not inform Mr Burnell that Mr Smith was on a yellow sheet regime and Mr Burnell was not otherwise aware of that fact. Mr Burnell said that an escort for Mr Smith arrived at the infirmary to transfer him at approximately 3:30 pm that day⁸.

4.2. Correctional Officer Nino Colasante

⁷ Exhibit C47b

⁸ Transcript, page 134-137

Correctional Officer Colasante gave evidence at the Inquest. He was on duty in “B Top West” at Yatala Labour Prison on 13 January 2005. His shift was due to finish at 4:00 pm. He said that he and his partner commenced securing all prisoners at approximately 3:40 pm. Between that time and 4:00 pm the prisoners had to be locked in their cells, the cells mastered and the prisoners’ food served to them. Mr Colasante said that Mr Smith was brought into the unit at approximately 3:40 pm just as lock down was proceeding. Mr Colasante said that Mr Smith acknowledged that he was familiar with the “B Top” regime. The escorting officers provided Mr Colasante with no information in relation to Mr Smith. Mr Colasante said that nothing in Mr Smith’s demeanour caused him to suspect that anything was out of the ordinary. He said that if he had noticed anything amiss he would have informed his unit manager.

4.3. Correctional Officers Timothy Freeborn and Thomas Adair escorted Mr Smith from the infirmary to “B Top West”. They were not aware of Mr Smith’s medical assessments. Correctional Officer Freeborn stated that he conveyed Mr Smith’s file back to the unit and gave it to the officers. He did not read the file as he was not required to do so and did not pass on any information to the officers in “B Top West”.

4.4. Mr Peter Beaumont

Mr Peter Beaumont gave evidence at the Inquest. He was employed in the Yatala Labour Prison infirmary at the relevant time as a Clinical Nurse. He commenced duty on 13 January 2005 at 2:30 pm and was scheduled to complete duty at 11:45 pm. At 7:05 pm on that day he commenced the medical rounds in B Division in company with a correctional officer. During the round he issued medication to Mr Smith inside his cell number 514. The medication was issued through a trapdoor in the door of the cell. Mr Beaumont issued Mr Smith with 100mg of Chlorpromazine liquid and with four purple tablets of Sodium Valproate two of which were to be taken that night and two to be taken the following morning. Mr Smith did not appear despondent or irrational at the time of this interaction according to Mr Beaumont⁹.

4.5. Mr Smith’s body is discovered

In “B Top West” at night, the correctional officers conduct prisoner welfare checks at two hour intervals. The first such check was carried out in conjunction with the medication round which I have already described. The second welfare check was

⁹ Exhibit C74

commenced by Correctional Officer Michalski at approximately 8:50 pm. At approximately 9:00 pm he initiated a “Code Black” medical emergency. He did this because he found Mr Smith hanging by his neck from the metal tubing of a utility shelf immediately above his bunk in his cell. Mr Smith had used prison issue sheets to hang himself.

- 4.6. Neither Correctional Officer Michalski nor any of the other officers who attended immediately had a master key to unlock Mr Smith’s cell door. Correctional Officer Gibson stated that he opened the trapdoor in the cell door and yelled out to Mr Smith who did not respond. Correctional Officer Wright stated that when he looked through the trapdoor he saw Mr Smith hanging in a “sitting position”.
- 4.7. Correctional Officer McLeod was the officer of the first watch. He advised that he heard the “Code Black” at approximately 9:08 pm while in the control room. Correctional Officer McLeod stated that he arrived at Mr Smith’s cell at approximately 9:11 pm and opened the cell door with the master key. He steadied Mr Smith while Correctional Officer Gibson cut Mr Smith down with a safety knife. Correctional Officer McLeod then cut the ligature from around Mr Smith’s neck. He checked for a pulse on Mr Smith’s neck but could not detect any although Mr Smith was still warm to the touch.
- 4.8. Nurse Beaumont stated that he was in the infirmary and responded to the “Code Black” at about 9:10 pm in company with Nurse Stones. They examined Mr Smith and no vital signs were detected. Nurse Beaumont scored Mr Smith at 3 on the Glasgow Coma Scale. A brief attempt at cardiopulmonary resuscitation was commenced but it quickly became apparent that Mr Smith was deceased. Dr Christopher Holmwood attended the Yatala Labour Prison and certified life extinct at 10:00 pm that night.

5. Dr Danny Sullivan

- 5.1. I have already made reference to the overview provided in this case by Dr Danny Sullivan. A report was provided by Dr Sullivan dated 3 May 2007. It was admitted as Exhibit C76 in these proceedings. Dr Sullivan also gave evidence at the Inquest. Dr Sullivan provided a very thorough overview in which he considered the treatment provided by each of the medical practitioners who interacted with Mr Smith during his stay in prison. Dr Sullivan was of the opinion that the treatment provided in each

case was appropriate. He was of the opinion that the medications which were prescribed were appropriate, and that they were maintained for a sufficient period to determine whether they were effective or not before any changes were made. Dr Sullivan also considered the prisoner screening tests which were carried out upon Mr Smith at the Adelaide Remand Centre and at the Yatala Labour Prison and was of the opinion that these processes were carried out appropriately, and appropriate assessments were made of Mr Smith's mental state.

5.2. Dr Sullivan, having considered all of the materials, was of the opinion that Mr Smith's diagnoses were of borderline personality disorder, polysubstance abuse and adjustment disorder with depressed mood, in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

5.3. Dr Sullivan commented:

'The management of suicidal ideation or attempts in prison is very difficult. Restriction of access to means of self-harm involves a marked reduction in liberties including rights of association with others, access to personal items, opportunities to smoke and diversions such as television. The cells used in such circumstances are generally austere, and prisoners are usually keen to move out of them. In addition, even in other units, prisoners at risk of self-harm will have a torch shone on their face at regular intervals through the night to ensure that they remain alive. There exists a tension between the provision of a humane environment in prison and the need to reduce the risk of suicide in prisoners.'

5.4. Dr Sullivan considered that the decisions made to transfer Mr Smith from the infirmaries at each establishment appeared to be appropriate. He considered that on each of the occasions that Mr Smith was transferred from the infirmaries he had demonstrated a degree of stability for the days preceding the moves. Dr Sullivan was of the opinion that Mr Smith was correctly perceived as being at high suicide risk by all staff and that appropriate levels of observations were maintained. Dr Sullivan made the following comments in his report:

'The suicide of Mr Smith was in my opinion unlikely to have been prevented by different prison locations, regimes or medications. The issue would appear to have been not only the chronicity of self-harming behaviour, but also a demonstrated poor response to treatment. Although it is possible that he may not have suicided had he remained in the infirmary for the duration of remand, such a course of action is in the longer term impracticable and the restrictions of such a regime are resisted by prisoners who resent limits on their ability to smoke, access to television and association: indeed, the management of suicide risk in a correctional setting often deprives people of the very factors which might improve mental state.

Given the fluctuating nature of Mr Smith's suicidal ideation, it is not clear how long mental health staff should have considered an adequate duration of stability prior to transfer out of an environment such as infirmary, as Mr Smith had demonstrated periods

of time without self-harm but had then harmed himself again. He noted himself that his mood swings were unpredictable. The last entry in the prison notes prior to his death stated “denies thoughts of self harm.” Given that the restrictive conditions of being on suicide watch are not necessarily conducive to improvement in mental health, I cannot see how Mr Smith’s suicide would have been prevented without ongoing management in infirmary, on Yellow Sheet, and possibly “on canvas.”

6. Conclusions and recommendations

- 6.1. Evidence was given at the Inquest in relation to the yellow sheet regime which had existed at all relevant times for Mr Smith. The regime required that he be brought to the infirmary for medical assessment by a nurse or doctor daily, at least when he was not already in the infirmary. When he was in the general prison population, the correctional staff (other than case management coordinators) were not aware, and not required to be aware, of the fact that he was on a yellow sheet regime because of his perceived risk of suicide or self-harming behaviour. That information is not passed over to correctional officers as a matter of course for reasons of prisoner privacy, and also because it is thought that the provision of such information in breach of what might be confidential disclosures to medical staff might result in a prisoner declining to confide in medical staff.
- 6.2. Evidence at the Inquest showed that within the Adelaide Remand Centre a system has been instituted by which prisoners who are on yellow sheet regimes are identified to correctional officers by means of a yellow dot being placed upon the prisoner’s cell door. No further information as to the precise medical history and diagnosis of the prisoner is provided to rank and file correctional officers. However, the presence of a yellow dot alerts the correctional officers to be aware of any signs of mood disturbance in prisoners whose cell is marked by such a yellow dot.
- 6.3. No such arrangement exists at the Yatala Labour Prison. None of the rank and file correctional officers who gave evidence was aware of Mr Smith’s high risk of self-harm. In view of the unpredictable nature of Mr Smith’s condition, and his own inability to predict the sudden mood changes which could plunge him into such despondency that he would harm himself, it is perhaps unlikely that the institution of a yellow dot regime at Yatala Labour Prison would have prevented Mr Smith’s tragic death.
- 6.4. Another option for reducing the risk of self-harming behaviour in a prisoner such as Mr Smith is to place him in a double cell with another prisoner. At the time of

Mr Smith's death, there was only one double cell in "B Top East". That cell was occupied and so Mr Smith had to be accommodated in a single cell. The position, according to evidence given by Mr Oxford, General Manager, Yatala Labour Prison, is now that there are six double cells in "B Top East" and six in "B Top West". Accordingly, greater scope exists for the "doubling up" of a prisoner such as Mr Smith. On the other hand, according to Mr Oxford's evidence, accommodation in "B Top East" and "B Top West" is at a premium. The number of prisoners requiring protective custody is such that there is no spare capacity in "B Top" at all. At any given time, prisoners who require protection and who cannot be accommodated in "B Top" will be housed in G Division. The regime and conditions in G Division are designed for high security prisoners – it is the highest security division in the South Australia prison system. As a result, there is a great deal of pressure to move prisoners from G Division to "B Top" if the only reason why they are being housed in G Division is for their own protection.

- 6.5. Mr Oxford also gave evidence that the metal framework from which Mr Smith suspended himself was an integral part of the design of the shelf immediately above it and was intended originally for use as a place at which prisoners could hang towels for drying. Mr Oxford frankly stated that the towel rails exist in all of the cells in B Division today in exactly the same format and configuration as they existed on 13 January 2005. Exhibit C66a is an internal report of the Department for Correctional Services into the death of Mr Smith prepared by Mr Smedley, Manager, Investigations and Intelligence Unit within the Department. The report is dated 6 April 2005. The final page of the report contains a recommendation that:

‘The Department pursue the issue of funding bid to re-furbish all cells to “safe cell” standard as a high priority, and as an interim measure remove all existing towel racks from all cells.’

It is clear, and was frankly conceded, by Mr Oxford that this recommendation had not been implemented as at the date of this Inquest.

- 6.6. Dr Raeside expressed the opinion that the South Australian prison system has “an extraordinary shortage of psychologists in the system”¹⁰. Dr Raeside pointed out that there is one psychologist at the Adelaide Remand Centre and he believed that there were one or two at Yatala Labour Prison. By comparison he pointed out that the State of New South Wales had approximately ninety-five psychologists within that State's

¹⁰ Transcript, page 72

prison system. Dr Raeside expressed the view that this is a huge disparity, even allowing for a significant difference in the prison population between the two States¹¹.

- 6.7. Dr Raeside gave disturbing evidence about the mental health of prisoners, particularly those at the Adelaide Remand Centre. He stated that the Adelaide Remand Centre is, to use his words, “probably the largest psychiatric hospital in the State, or at least has a large number of psychiatrically ill people in it”. He stated that the services at the Adelaide Remand Centre are inadequate for the demand and that the situation is getting worse¹². Dr Raeside is obviously extremely concerned about these issues.
- 6.8. Having considered all of the evidence carefully, I am of the opinion that the sheer unpredictability of Mr Smith’s mood swings, and their magnitude, was such that it was likely that he would attempt suicide successfully at some point in his life. The medical treatment which was provided to him within the prison system was in my opinion satisfactory. With the notable exception of the failure to remove the towel rails, which are such obvious hanging points, it is difficult to identify any systematic deficiency which might have contributed towards Mr Smith’s tragic death. I do not consider that the adoption of a yellow dot system within the Yatala Labour Prison would have advantaged Mr Smith in the very brief time he was back in the division prior to taking his own life. It is quite possible that had Mr Smith been “doubled up” he would not have been able to effect his suicide when he did. But I note that the capacity for doubling up on the “B Top” division has increased markedly since Mr Smith’s death. It is most concerning that the towel rails continue to exist notwithstanding the recommendations of Mr Smedley as referred to in Exhibit C66a. I recommend that the Department for Correctional Services make a renewed effort to implement the recommendation of Mr Smedley in relation to the removal of towel rail hanging points. I furthermore reiterate previous recommendations made in inquests in relation to safe cell practices.

¹¹ Transcript, page 72

¹² Transcript, page 47

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

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

Seal the 19th day of September, 2007.

State Coroner

Inquest Number 18/2007 (0162/05)