



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 26th, 27th, 28th and 31st days of March 2008, the 1st, 2nd, 3rd, 4th, 7th, 11th, 28th and 29th days of April 2008, the 2nd day of May 2008, the 17th day of June 2008 and the 28th day of November 2008, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Andrew Stephen Gill and Simon Schaer.

The said Court finds that Andrew Stephen Gill aged 26 years, late of 3 Willow Crescent, Elizabeth Vale, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 2nd day of June 2005 as a result of severe closed head injury associated with severe fractures of the cranial vault and base of the skull and fracture dislocation of the cervical spine.

The said Court finds that Simon Schaer aged 70 years, late of the Adelaide Remand Centre, Currie Street, Adelaide died at The Adelaide Remand Centre, South Australia on the 15th day of December 2005 as a result of closed head injury.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction and reason for Inquest

- 1.1. In the early hours of the morning of Sunday 29 May 2005 a male person entered residential premises situated at Seacombe Heights and brutally assaulted the three occupants with a hammer. Each of the three victims of this attack suffered serious

injuries. The three persons allegedly assaulted were the late Andrew Stephen Gill's estranged partner's father Mr Richard Smith, Mr Smith's female partner Ms Bassirat (Bassi) Smith and a male overseas university student who was at that time boarding at the premises. The attack on these persons did not appear to be random or committed with any purpose other than to inflict serious injury. The injuries suffered by Mr Smith were particularly severe. The circumstances of the crimes would suggest that the assailant had deliberately targeted that premises and its occupant or occupants and had entered the premises for the purpose of physically attacking the occupant or occupants. It is clear that Andrew Stephen Gill had for some time borne an abiding resentment towards Mr Smith in particular because of the latter's attitude towards Mr Gill as being an unsuitable partner for his daughter. He blamed Mr Smith for the recent estrangement from his partner and for his consequent separation from his children.

- 1.2. Later that morning Mr Gill was arrested by police in relation to the assaults that had taken place at Seacombe Heights only a matter of hours before. At the time of his arrest, Mr Gill was in the Emergency Department of the Lyell McEwin Hospital (the LMH). Mr Gill had presented there with his father. I discuss the circumstances in which he and his father came to be at the LMH in a moment.
- 1.3. Following his arrest and his subsequent appearance in court, Mr Gill was remanded in custody to the Adelaide Remand Centre (ARC). On the Wednesday following his arrest, Mr Gill jumped from a height at the ARC and died the following day from injuries sustained in the fall.
- 1.4. Inquests into the deaths of Andrew Stephen Gill and Simon Schaer were heard concurrently.
- 1.5. At the time of their deaths both men were prisoners on remand at the ARC. The ARC is an institution operated by the South Australian Department for Correctional Services (DCS) and is devoted in the main to the custody of male persons whose matters are pending resolution in the criminal courts of South Australia and who are not on bail. The inmates there are remanded in custody, for the most part being neither convicted nor sentenced prisoners.
- 1.6. Both of these deaths were deaths in custody as defined in the Coroners Act 2003. It was therefore mandatory for Inquests to be held into their deaths.

- 1.7. The fact that both men were in custody at the time of their deaths was not the only point of commonality. Both men met their deaths when, on separate and unrelated occasions, they jumped head first from the mezzanine floors in the accommodation units at the ARC in which they were respectively accommodated. The height from the tops of the balcony rails from which they respectively fell was approximately 4 metres from the floors below in each instance. Both men died of the serious injuries that were sustained as a result of their impact with the floors below.
- 1.8. The circumstances of each death, in my opinion, lead to the inescapable conclusion that each man deliberately ended his own life. It is also clear that no other person or persons were involved in either death.
- 1.9. The findings of Coroners in the various coronial jurisdictions in Australia are replete with instances in which custodial inmates have committed suicide. However, the method adopted in both of the current instances was, I am told, quite unprecedented, at least in this country. Although there have been further deaths within custodial institutions since these two deaths, none of them have occurred in the manner that I have described.
- 1.10. Although the personal circumstances of Mr Gill and Mr Schaer differed somewhat during the period leading up to their deaths, the similarity of the circumstances in which these deaths occurred gave rise to serious questions as to the level of scrutiny and attention that had been accorded to each prisoner. In addition, the layout of accommodation units, insofar as their configuration was such as to allow prisoners to do what Mr Gill and Mr Schaer did, is also an obvious matter of concern. It was therefore considered appropriate that the Inquests be heard together. That said, the incidents were quite unrelated in terms of circumstance and time. They were separated by a period of approximately 6 months. There is no evidence that either prisoner knew, or knew of, each other except that a reasonable conclusion is available that the second death, that of Mr Schaer, and in particular the method by which it was achieved, may have been influenced by the manner in which Mr Gill had taken his own life earlier in the year. It would be naïve to think that inmates at the ARC in December 2005 when Mr Schaer jumped to his death would not have been aware of the incident involving Mr Gill in June of that year and of the method adopted by him to commit suicide within the institution. Mr Schaer was an inmate in the ARC at the time of Mr Gill's death, although at that time he had been accommodated in a

different unit from Mr Gill. Because the circumstances surrounding each death were unrelated, it is appropriate to deal with the circumstances of each death separately. I will, however, make some general comments about the method of suicide adopted by each man and what might be implemented in order to avoid a repeat of incidents such as these.

2. The death of Andrew Stephen Gill

2.1. Introduction

Mr Gill died at the Royal Adelaide Hospital on Thursday 2 June 2005. He was 26 years of age. On 1 June 2005 he had jumped head first from the mezzanine floor of one of the accommodation units at the ARC. As a result, he suffered severe head and spinal injuries from which he succumbed the following day. Dr John Gilbert, a Forensic Pathologist at Forensic Science SA, conducted a post-mortem examination in relation to Mr Gill's body. Dr Gilbert reports that Mr Gill's cause of death was 'severe closed head injury associated with severe fractures of the cranial vault and base of the skull and fracture dislocation of the cervical spine'¹. I find that to be the cause of Mr Gill's death and I further find that the fatal injuries were caused as a direct result of Mr Gill's impact with the floor having jumped from a height at the ARC.

2.2. Mr Gill had been in custody for only a matter of days. Police had arrested him on Sunday 29 May. The arrest had been carried out while Mr Gill had been a patient at the LMH. Mr Gill was there arrested for having assaulted and injured, during the course of the previous night, the three occupants of the premises at Seacombe Heights.

2.3. There is much material before me, for the most part contained within the statements of members of Mr Gill's family, that concerns the breakdown of Mr Gill's relationship with his partner and the efforts made and anxiety experienced by Mr Gill in the pursuit of his desire to see his children. It has been suggested in certain quarters connected with Mr Gill's family that the authorities failed Mr Gill in his quest to see his children and that as a result some responsibility for Mr Gill's arrest and subsequent death in custody needs to be sheeted home to those authorities. I make no comment about that issue for the following reasons. The focus of this

¹ Exhibit C2a

inquiry is Mr Gill's death in custody. There is no suggestion that his custody was anything other than lawful. The same applies to his arrest in the first instance. A Coronial Inquest is not an inquiry into every conceivable causative event in relation to a death. As Justice Nathan observed in Harmsworth v The State Coroner [1989] VR 989 '*The inquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of 'remoteness' ... Of course the prisoners would not have died, if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant*'. To my mind the factors that may have led to Mr Gill's arrest are too remote from the circumstances of his death to warrant detailed consideration by this Court.

- 2.4. From the time of Mr Gill's arrest on 29 May 2005 he remained in custody until his death on 2 June 2005 at the Royal Adelaide Hospital. In the intervening period he had been kept for a time at the LMH following which he had been transferred to the Elizabeth police station cell complex. He had been taken to Elizabeth Magistrates Court on Monday 30 May and was remanded in custody to the ARC where he arrived later that day.
- 2.5. The circumstances of Mr Gill's visit to the Lyell McEwin Hospital and his arrest
Mr Richard Gill was the father of the deceased, Andrew Gill. Richard Gill gave evidence to the Inquest. Two witness statements as well as a transcript of a record of interview that he had with the police were tendered².
- 2.6. Richard Gill lived with his wife, the deceased's mother Denise Gill, at 3 Willow Crescent, Elizabeth Vale. Sometime between 5am and 5:30am on Sunday 29 May 2005 Richard Gill heard the back gate of his premises open. Richard Gill immediately rose and went to the back door. He found his son Andrew Gill walking around a trailer that was situated in the backyard. Andrew Gill appeared to be upset and is described by Richard Gill as speaking in a nervous, quivering type of voice. Andrew Gill told his father that he needed help. By then Mrs Gill was also present and she asked her son why he needed help. The deceased, Andrew Gill, said words to the effect '*I hurt them. I think I've killed them*'³. He continued to walk in a circle around the trailer as he spoke. He made other utterances such as '*I hurt three*

² Exhibits C112, C112a and C112b

³ Exhibit C112, page 5

*people*⁴. Andrew Gill also shouted at himself, as if he was disappointed in his own behaviour. He repeated that he needed help. Richard Gill noticed that his son had blood on his hands.

2.7. Richard Gill took his son to the LMH. According to Richard Gill's declaration signed 29 May 2005, his son there continued to make statements in an upset manner including '*if only they would let me see my fucking kids*'⁵. He repeated this on a number of occasions. I add here that it is plain from the material before me that one component of the resentment harboured by the deceased in respect of his partner's father was Mr Gill's perception that his partner's father had been responsible for Mr Gill's inability to see his children. Richard Gill also states that later while at the LMH his son started mumbling about a hammer. It is clear that the assailant involved in the incident earlier that night at Seacombe Heights had been in possession of a hammer and that the injuries sustained by the victims were consistent with blows with a hammer. One of the victims specifically asserts that the assailant struck him over the head with a hammer.

2.8. At the time he discovered his son and shortly thereafter, Richard Gill associated his son's demeanour, his son's utterances and specifically the blood on Andrew Gill's hands with the possibility that his son had visited his estranged partner's father and had been looking for his children. Richard Gill states in his declaration:

'I did not know that, I just felt that because of the circumstances and state that he was in.'⁶

2.9. Another fact worthy of note is that when Mr Gill attended his parents' premises early on that Sunday morning, he had parked his vehicle at a location which was different from where he normally parked in relation to that premises. He left his vehicle in a spot that was some distance away from the house. I add here that the police did not find a hammer either in the deceased's possession or in that vehicle. However Richard Gill, as already seen, states that his son was '*mumbling about a hammer*'⁷.

2.10. Andrew Gill was later to tell LMH nurses and doctors that he had no recollection of the events of that night. I do not seek to establish whether or not Mr Gill had been the assailant responsible for the attack on the three individuals at Seacombe Heights.

⁴ Exhibit C112, page 5

⁵ Exhibit C112, page 7

⁶ Exhibit C112, page 7

⁷ Exhibit C112, page 7

That is not a matter that is at issue in this Inquest. However, what is clear is that there was a reasonable conclusion available to persons with whom Mr Gill came into contact that morning that his assertions that he had no recollection of having committed these serious and violent offences were false. This issue is of some relevance when allegations made by Andrew Gill's family that clinical staff at the LMH did not properly evaluate Mr Gill that morning come to be evaluated.

2.11. Police attended the LMH that morning and arrested Mr Gill for the alleged attack at Seacombe Heights.

2.12. Mr Gill's treatment and evaluation at the Lyell McEwin Hospital

Mr Gill and his father attended at the Emergency Department of the LMH at about 5:40am. He was there triaged by a registered nurse Christopher Patterson, who gave evidence before me. Mr Patterson recorded Mr Gill's presenting problem as 'alleged homicide perpetrator' and recorded his triage assessment as 'catatonic state'. Patterson noticed that Mr Gill was covered in what appeared to be blood. Mr Patterson at that stage believed Mr Gill to be in a 'dissociative state'. He was staring blankly. Mr Gill was placed into a cubicle within the Emergency Department and at that point he became more alert and started to insist that he wanted to leave. At one point he made an attempt to stand up on the barouche on which he had been placed and had to be restrained by his father and a security staff member. He kept repeating that he wanted to be leave the hospital. The police were called and arrived quite quickly. Mr Gill's agitated demeanour and consequent restraint is incongruent with the suggestion that he was in some kind of dissociative or catatonic state.

2.13. Mr Gill was given some Clonazepam which is a sedative. It was faintly suggested during the Inquest that the administration of this drug might have meant that his subsequent evaluation by nursing staff and four medical practitioners over a period of several hours was rendered meaningless. I say no more about that other than to say that the suggestion is rejected. There is simply no evidence that a sedative would have rendered any assessment of Mr Gill and his fitness for custody as unreliable. On the contrary, if he had not been sedated and had been assessed in his agitated condition, one wonders what alternative suggestion would have been made in those circumstances.

- 2.14. The other relevant aspect of Mr Patterson's evidence is the fact that when Mr Gill and his father first approached the triage counter, Mr Gill senior said '*we need help, I think my son has murdered three people with a hammer*'. This statement is in keeping with Andrew Gill having told his father that he had seriously injured three people with a hammer. On that analysis, Andrew Gill had a recent recollection of a personal involvement in the assault with a hammer that had taken place in respect of three people.
- 2.15. Mr Gill was next seen by Dr Huynh who at that time was an Emergency Registrar working at the LMH. Dr Huynh also made an assessment of Mr Gill. Dr Huynh's statement was tendered to the Inquest⁸. Dr Huynh recorded information that Mr Gill's partner had left him with the children in the previous week and that Mr Gill was very upset about that. It was recorded that Mr Gill had consumed two beers in the previous evening. Much if not all of this information may actually have been imparted by Mr Gill's father. Dr Huynh has recorded in his statement that Mr Gill was in a very distressed state and was not able to provide any history himself. In any event, the original source of the information given to Dr Huynh and to other members of LMH staff must have been Andrew Gill as told to his father and I so find.
- 2.16. Dr Huynh has also recorded as part of Mr Gill's immediate history that Mr Gill had gone to his children's grandparents' house, had returned home to his father's house that night and had reported that he had killed 'them' with a hammer. Dr Huynh assumes that he also obtained this information from Mr Gill's father. However, if so, it is also a clear reflection of the fact that Mr Gill must have told his father that Mr Gill had gone to his children's grandparents' house. This was a further piece of esoteric knowledge of the events of that night that in my opinion can be sheeted home to Andrew Gill.
- 2.17. Dr Huynh mentions in his statement the administration of the Clonazepam and expresses the view that this would not have altered Mr Gill's mental state. He also expresses the view that there would be no reason why a person who had been sedated with Clonazepam could not be discharged from hospital if otherwise deemed safe for discharge. Put another way, sedation would not in itself provide any sensible reason to prevent a person's discharge from an Emergency Department.

⁸ Exhibit C124

- 2.18. Dr Huynh on examination recorded that Mr Gill was confused and agitated. He refers to the restraint that was utilised. He performed a medical examination and noted dry blood on Mr Gill's hands and jeans. Dr Huynh cleared Mr Gill medically.
- 2.19. At 7:30am a Nurse Crockford is recorded as having examined Mr Gill. At that stage he was recorded as being uncooperative, non-communicative and it is also recorded that the nurse was unable to obtain any information from Mr Gill. It is also recorded in this nursing note that the nurse was unable to assess Mr Gill fully and that he needed review from a psychiatric registrar as soon as possible.
- 2.20. At 8am a psychiatric nurse by the name of Meryl Warren assessed Mr Gill. Ms Warren gave evidence before me. She made a comprehensive note in Mr Gill's clinical record. She has recorded that the police requested a psychiatric review. Ms Warren made a comment in her evidence about feeling somewhat under pressure for time because of the police involvement and interest in Mr Gill and suggested that ideally Mr Gill may have had a better assessment some hours later. However, she made it very clear, and I accept her evidence, that any opinion that she formed about Mr Gill's being placed into the custody of police later that morning was an opinion that she was comfortable with. Ms Warren's opinion was that Mr Gill was fit to be released into custody. As we will see, that opinion was shared by a psychiatric registrar and consultant psychiatrist.
- 2.21. Ms Warren gave detailed evidence in the Inquest about her assessment that was supported by very detailed clinical notes. She conducted her review of Mr Gill in the presence of an Emergency Department medical practitioner, Dr Carson. Mr Gill, amongst other things, told Ms Warren that he could not describe how he had arrived at the hospital saying that he may have walked there. On further questioning as to the reason why Mr Gill was in hospital, Mr Gill did not respond. He told Ms Warren that he could recall having '*several beers*' but was unable to state when, where and with whom he had been drinking. He did not describe any further events of the night. He appeared to be drowsy and having difficulty keeping his eyes open. It is specifically recorded that Mr Gill was 'unable to recall last night's events'. However, he was able to describe in some detail his current family and social circumstances and gave an account of his recent breakdown of his relationship. He also spoke of his frustrations in his attempts to seek assistance through counsellors.

- 2.22. In respect of her mental state examination Ms Warren recorded that that Mr Gill was vague but was oriented in time, place and person notwithstanding that he was unable to recall the events of the previous night. Ms Warren has queried in her notes whether this was because he was unwilling to do so or whether it was as a result of a 'dissociated' state. She recorded that Mr Gill exhibited no perceptual disturbances nor delusional or psychotic themes. Ms Warren formed the view that Mr Gill required further psychiatric review by a medical practitioner prior to any clearance that might be sought in respect of police involvement.
- 2.23. Ms Warren was to remain present throughout the entirety of a psychiatric review of Mr Gill conducted for Dr Shankar and, as indicated, was to form the opinion that the decision to return Mr Gill to police custody was not inappropriate. She did not believe that there was any evidence of an illness that would have required hospital treatment such as a mood disorder or psychiatric disorder.
- 2.24. Ms Warren detected the apparent inconsistency between Mr Gill's lack of response to her in respect of an inability to recall the previous night's events and the stark denial to Dr Shankar that he had earlier told his father that he may have hurt three people.
- 2.25. Dr Carson who was present during Ms Warren's assessment, but who was not present during Dr Shankar's assessment, also observed inconsistency in respect of Mr Gill's statements, in particular the fact that Dr Huynh had been able to elicit some information, albeit possibly second-hand, about Mr Gill's part in the events of the night before on the one hand and his inability to recall the previous night's events when asked about them by Ms Warren on the other.
- 2.26. In due course it was Ms Warren who advised Mr Gill's father that psychiatric staff had formed the view that Andrew Gill was fit for further police procedures. Mr Gill senior exhibited a very distressed reaction to that piece of information. Mr Gill senior mentioned a family history of mental illness. It should be mentioned here that Andrew Gill's brother had committed suicide some years prior to this and had done so within the confines of the LMH as it so happens. A familial history of suicide is regarded as a risk factor in respect of siblings of the suicidal family member. It will be seen that Dr Shankar elicited this piece of information in any event during her psychiatric assessment.

2.27. Dr Sumitra Shankar also gave evidence before me. Dr Shankar is an enrolled trainee with the Royal Australian and New Zealand College of Psychiatrists and is in her fifth year of training. In May 2005 she was a psychiatric registrar at the LMH. Dr Shankar, like Ms Warren who was a very experienced psychiatric nurse, was an impressive witness in my opinion. Dr Shankar's assessment of Mr Gill commenced about 9:30am and it took approximately 45 minutes. Dr Shankar's notes of her examination run to 10 pages of the clinical record. It constitutes a very detailed account of her examination. In the event, Dr Shankar concluded that there was no reason for Mr Gill to be admitted to the LMH for psychiatric inpatient care. She formed the view, which was ultimately shared by a consultant psychiatrist Dr Watson, that Mr Gill was psychiatrically safe for transfer into police custody. At the commencement of her examination of Mr Gill, Dr Shankar advised him that her notes of the examination would be available to the Court. Mr Gill indicated that he understood this. This is interesting especially having regard to the fact that Mr Gill was to be less than forthcoming with information about the events of the previous night. Mr Gill told Dr Shankar during this lengthy interview that the last thing that he remembered was being with his father early in the morning before sunrise which of course is in keeping with other statements that he had made that he had no recollection of the events of that night but inconsistent with other statements that he had made to his father about having been at his children's grandparent's house and having assaulted three people with a hammer. He denied to Dr Shankar that he had any knowledge as to why the police were interested in him and specifically denied having told his father that he may have hurt three people. This inconsistency of course was not lost on Dr Shankar. In addition, although Mr Gill appeared to be sedated, he was variable in his ability to answer questions. When specific questions directed at orientation were asked of Mr Gill he became vague. However, he was able to provide considerable detail as to autobiographical matters about himself and it is obvious from Dr Shankar's notes that he was able to impart to her a great deal of detail about his family circumstances. He was clearly able to articulately describe his feelings in respect of his former partner and his children, and indeed of his partner's father's involvement in his relationship with the partner. Dr Shankar thought that this variability in Mr Gill's ability to answer questions might have indicated that Mr Gill was acting under the influence of the police interest in him. For my part it is not difficult to see why Dr Shankar thought along those lines.

- 2.28. Dr Shankar also performed some limited psychological tests, the results of which indicated to her, again in my opinion not unsurprisingly, that Mr Gill might have been intentionally feigning his cognition difficulties.
- 2.29. Dr Shankar detected the obvious congruity between certain negative statements made by Mr Gill to her in respect of his partner's father and his alleged actions earlier that night.
- 2.30. Dr Shankar did not detect anything about Mr Gill that indicated alcohol intoxication. Nor did Dr Shankar observe anything that indicated that Mr Gill was materially affected by the sedative Clonazepam and saw no reason to delay her examination for that reason.
- 2.31. The focus of Dr Shankar's examination was whether Mr Gill was suitable to be removed from the hospital into police custody. Thus the crux of her inquiry was whether or not she could exclude a major illness in respect of Mr Gill and specifically whether suicidality could be excluded. In this regard, Mr Gill alluded to the fact that his brother had committed suicide in the LMH. Dr Shankar acknowledged in her evidence that this was a matter relevant to suicide risk. Dr Shankar specifically questioned Mr Gill about any thoughts of suicide in respect of himself. To this Mr Gill indicated that he had entertained thoughts that life was not worth living and had experienced thoughts of dying and of suicide like his brother. Dr Shankar has recorded Mr Gill as having said, however, *'I don't want to die, but it's not worth it'*. Dr Shankar formed the view that there was no reason to detain Mr Gill under the Mental Health Act 1993. As to whether Mr Gill needed hospitalisation in any event, Dr Shankar told me that if there had been a clear suicidal plan and perhaps some recent acts or psychotic symptoms, that may have prompted her to recommend immediate hospitalisation. There was no evidence of any of those features in Mr Gill's presentation.
- 2.32. As to the risk of suicide, Dr Shankar told me:
- '... the suicide risk did not appear to be high or acute at that stage. There appeared to be no medical reason to keep him from police custody and no serious psychiatric syndrome at that stage and upon discussion with Dr Watson the feeling was that on balance it was

likely that there was no serious medical or psychiatric condition that would need - I beg your pardon - that would preclude him undergoing police procedures.'⁹

- 2.33. Dr Shankar conceded that at the end of her examination she was had some uncertainty as to what she should do next. Given her level of training she did not feel that she was able to make a decision by herself and so sought consultant assistance which was provided by Dr Watson, the consultant psychiatrist. Suffice it to say, as far as Dr Shankar's examination of Mr Gill is concerned, she did not detect any reason why Mr Gill required detention under the Mental Health Act 1993 or hospitalisation for any other reason.
- 2.34. Dr Watson also gave evidence before me. Dr Watson is a psychiatrist who worked for the Central Northern Adelaide Health Service as the General Manager of Early Intervention and Acute Services within the Mental Health Directorate. In 2005 he was the Clinical Director of Northern Mental Health. The LMH was the principal place where he practised. On the day of Mr Gill's arrest he was the duty psychiatrist. He came to see Mr Gill at about 10:55am. He discussed Mr Gill's presentation with Dr Shankar and then reviewed Mr Gill for himself. Dr Watson formed the view that Mr Gill did not have any difficulty with cognition and his own findings were consistent with the earlier detailed findings recorded by Dr Shankar. Dr Watson was comfortable with Mr Gill being placed into police custody.
- 2.35. Dr Watson also observed what appeared to be inconsistencies in the information that Mr Gill was or was not able to provide about the night's events.
- 2.36. Dr Watson was also aware of the fact that one of Mr Gill's siblings had committed suicide and acknowledged that that was a matter to be taken into account as far as risk of suicide of the remaining siblings is concerned. Dr Watson was asked in effect whether the desire on the part of the police to take Mr Gill into custody had any bearing in relation to his attitude. Dr Watson said that he did not feel under any pressure for time by virtue of the police presence and their obvious desire to take Mr Gill with them as soon as possible. He said:

'Well you've put to me a hypothetical situation. That hypothetical situation when I was doing this work arose all the time. So the type of circumstances arising in this case, younger male, relationship breakdown, presenting with distress, some suicidal ideation is fairly common in this sort of work and I would say that the bulk of those cases would not

⁹ Transcript, page 337

have an admission to a psychiatric unit. In terms of the police involvement and the history of serious events I think its best to say that I would look at those on an individual basis and that's what I did in this case.'¹⁰

- 2.37. Dr Watson suggested that a sentiment expressed by a member of a patient's family to the effect that the patient needs hospitalisation because he might kill himself would not have made any difference in this particular case. He suggested that the question of suicidality had already been explored in some detail. They had all been made aware of the issue of suicidality. For my part this observation is true. The medical staff were aware of the familial suicidality and also had first hand information from Mr Gill himself and it had been taken into proper consideration.
- 2.38. Dr Watson also made certain observations that are indeed hard to resist. He spoke of the not unreasonable expectation that Mr Gill would be safe in police custody. This is not to say that a patient would not be kept in hospital in an appropriate case. However, this was not one of those cases. Dr Watson said this:

'In terms of the institutional environment that you're talking about there, my understanding is that there's a range of obligations when somebody's in custody that either corrections or the police need to provide and I think it's reasonable for me to presume that they will be provided.'¹¹

In saying this Dr Watson made it clear that people in correctional facilities may be at higher risk, but that it was reasonable to expect that persons either in police custody or in a correctional facility would have high quality access to care and would be in a safe environment.

- 2.39. In the light of the unfortunate outcomes in both of these cases, the cynical might take issue with Dr Watson's observation. However, to my mind there is a general entitlement on the part of the community to expect that persons perceived to be at risk of self-harm and who exist within the custodial institutions in this State will be properly identified as such and be provided with appropriate and responsible care and treatment. It is for reasons such as this that Royal Commissions and the Courts, for several years now, have been scrupulous in their endeavours to identify shortcomings within the custodial system as they relate to the safety of prisoners.

¹⁰ Transcript, page 363

¹¹ Transcript, page 368

2.40. In the event, Dr Watson and Dr Shankar made an assessment that there was no reason to prevent or forestall Mr Gill being released into police custody. This of course was naturally on the assumption that he would be kept safe within police custody. That was not an unreasonable assumption. Dr Shankar compiled a letter at the request of the police. The letter is exhibited variously within the papers. An example of it is within Exhibit C39aq. The letter is in these terms:

'29 May 2005

TO WHOM IT MAY CONCERN,

RE: ANDREW STEPHEN GILL DATE OF BIRTH 20/06/1978

Mr. Gill has had a psychiatric review by myself as well as a consultant psychiatrist, Dr Watson. We can find no psychiatric reason to preclude his transfer into police custody.

Due to his not being forensically processed, we have not been able to physically examine him. This should be arranged by yourselves should you feel it necessary.

He is fit for police interview and to submit to standard police procedures.

Thank you.

Yours Sincerely,

(signed)

Dr Sumitra Shankar

Psychiatry Registrar

29/5/05

1105am'

It will be seen that this letter was written with police custody only in mind. In my view the provision of this letter to the police was reasonable in all of the circumstances. There was evidence to suggest that much of Mr Gill's presentation at the LMH lacked both consistency and sincerity, particularly in relation to what he was prepared to discuss as far as the events of the previous night were concerned. His denials to Dr Shankar about what he had told his father concerning those events could reasonably be viewed as wholly disingenuous. Mr Gill did not exhibit any suicidal plans and did not have any psychiatric illness. Having regard to the information that had been provided to the staff of the LMH, and bearing in mind Mr Gill's inconsistent presentation, it is impossible to say that the decision to release Mr Gill into police custody was an unreasonable one. He was thoroughly examined by a number of qualified and experienced nursing and medical practitioners over a long period of time. Indeed, subsequent events that day were to support the notion that Mr Gill's presentation at the LMH may have involved an element of malingering. I refer here

to the fact that when he was being transported by the police from the LMH to the Elizabeth police station, he had to show them the way. He was also seen later that day to be engaging normally and indeed in a friendly manner with other prisoners within the Elizabeth cell complex. Immediately upon the detection of this behaviour he suddenly reverted to his more placid demeanour. In short, there was behaviour exhibited by Mr Gill throughout the course of that day that suggested that limited reliance could be placed on the outwardly dissociative condition he exhibited when he first presented at the LMH.

- 2.41. There is one further matter that requires comment. At the time of their respective examinations, the nursing and medical staff at LMH were not aware of important information about Mr Gill that was discovered by police later that day. I refer here to the discovery of a diary that had been in Mr Gill's possession, and in particular to certain entries that he had apparently recently made which evidenced a desire on his part to end his own life. As I say, that information was not available to staff at the hospital and they cannot be cloaked with any knowledge of this information.
- 2.42. Dr Shankar made one very interesting observation about the letter that she provided to the police. It is clear that in due course the letter was furnished to DCS staff at the ARC where Mr Gill was later that week to take his own life. The letter, however, is clearly confined in its scope to police custody and to the procedures that were contemplated whilst Mr Gill was in police custody. Dr Shankar told me that if she had appreciated the fact that the letter would end up in the hands of the Prison Health Service, and by implication be relied upon by them as some sort of guide in respect of Mr Gill's propensity to self-harm while in prison, she would have included within the letter reference to the fact that Mr Gill had been having suicidal thoughts and have included detail that may have indicated to the health service his vulnerability and the fact that he had displayed some risk behaviour both to others and to himself. She may have also mentioned the possibility that had a personality disorder or some other personality traits.
- 2.43. I deal in the next section with Mr Gill's diary. In the event, when one examines the contents of this document it seems to me that there would have been a very good case for returning Mr Gill to the LMH for further evaluation or at least to have brought a medical practitioner to the Elizabeth cells for his further evaluation there. I develop this point later in these findings.

2.44. Andrew Gill's diary

On the day of Mr Gill's arrest, namely Sunday 29 May 2005, Detectives Pamela Rogers and Gregory Barton of the Sturt Criminal Investigation Branch were assigned to investigate the alleged assaults that had taken place in the early hours of that morning at Seacombe Heights. They were involved in a number of inquiries and investigations during the course of that day. I return to various aspects of their work later in these findings. However, it is as well now to deal with an issue that in my view illuminates Mr Gill's state of mind in respect of his partner's family and also in relation to his own continued existence. I refer here to Mr Gill's personal diary¹².

2.45. Mr Gill had recently been staying with his brother, Mark Gill, following his estrangement from his partner. Detectives Rogers and Barton attended Mark Gill's home at Andrews Farm at about 5:15pm on the Sunday of Andrew Gill's arrest. Mark Gill produced an A4 diary that was situated on the kitchen table. The existence of the diary had been revealed by Andrew and Mark Gill's father. There are a number of daily entries written by Andrew Gill that diarise his thoughts about his current domestic circumstances and in particular his separation from his children, Lily aged 3 years and Sean aged 18 months. It is apparent from the diary entries that Mr Gill was experiencing a large measure of frustration owing to the fact that he had been unable to locate and access his children. The final daily entry prior to Mr Gill's arrest is dated Saturday, 28 May 2005, the day before that arrest. The topic that is noted is the state of his current relationship and the fact that the police and a solicitor had apparently told him to stay away from his family. The frustration that Mr Gill was experiencing at that time leaps from the pages of the diary.

2.46. Of note is the existence of lengthy handwritten notes at the end of the diary that are not assigned to any particular day. It is not entirely clear when these notes were written, but it is safe to assume, and I so find, that they were written at a time since Mr Gill's separation from his partner and their children and were likely compiled very close to the events of the weekend of 28 and 29 May 2005. One topic that seems clear from Mr Gill's writings is that he harboured a great deal of resentment towards his partner's parents, and in particular her father, in respect of what he perceived to be their part in his estrangement from his partner and their children. Some of the notes

¹² Exhibit C123e(1)

appear to be addressed to the world at large. Other notes appear to be addressed to Mr Gill's own parents and others appear to be addressed to his individual children.

- 2.47. In respect of his partner's parents, whose names are Richard and Bassi, he describes in very resentful terms an incident at Christmas in which, notwithstanding the fact that he was the partner of their daughter and the father of their grandchildren, there had been no Christmas presents allocated for him because he was not considered to be family. Reference is also made to his partner's father having indicated to his daughter that she should have had an abortion in relation to one of Mr Gill's children. It was obvious that he had been resentful in relation to that. Mr Gill has also written that *'Richard and Bassie Smith took you guys away from me'*. There follows a diatribe in which he blames them for inculcating in his partner's mind the need to *'run away,'* one assumes from him. There is also a suggestion in the same note that Mr Gill believed that his partner, and by possible extension her parents, were manipulating the family law system. In the same note Mr Gill refers to his partner's parents as *'scum'*. This particular note appears to be addressed to his two children and, given their ages, the inference is that they were intended to be read at some future point in time. The note is calculated in due course to engender in minds of his children hatred towards their mother and grandparents. Another note that is also apparently directed towards the attention of his children states *'hope you have a better life without your mum's dad bringing you down'*.

- 2.48. In another note addressed to Mr Gill's mother he says the following:

'I love you mum U done everything to try and get my baby's back. U brought me up with a grate life as a kid and a adult but U know the truth I know the truth and U know I can't stay around after this because it is not they place I intened ongoing but had know choice but to stop this evil cunt from destroying my kids life anymore.'

In the context of everything else Mr Gill has written in this diary, the person in respect of whom he has used the epithet in the above quoted passage could be none other than his partner's father who was very badly assaulted and injured in the early hours of the morning of 29 May 2005. There is a further reference to this person in the same terms in a note apparently addressed to Mr Gill's own father. In this note, Mr Gill's partner's father is identified as 'Richard'. Mr Gill writes *'I just can't wait and wait for this cunt Richard to hurt them'*, a reference to his children.

- 2.49. Another note refers to persons in the plural taking his children where he says '*now fuck you's Karens family*'. Karen is his partner. Mr Gill then writes:

'Im sorry that this is what is going to happen its planed but so was Karen's idear of pain, hurt, no trust and her dads forcefull way of making me lose my kids they surelly lost the battle of hurting anybody else. I win. Last laugh (HA HA).'

Mr Gill then goes on to express the hope that his children will get through life without coming across '*these type of people*'¹³.

- 2.50. In other notes evidently intended to be read by his children in the fullness of time, Mr Gill makes the following comments:

'I wish I could of stayed around to see you grow up all I ever done was worked to get you's things and food lollies. I hope you see your nana all the time because she love's you guys to piecies.'

In the same note Mr Gill addresses each of his children individually by name. He urges his daughter Lily to be '*smart*' as there are people out there who cause hurt and advises his son Sean to look after his sister and:

'Both go and see your Uncle Mark because he will tell you what I was like and who I was.'

It is in that same note that he also addresses his mother and father in terms that very much suggest that the notes were intended to be read when Mr Gill was gone.

- 2.51. In another note, also addressed to his children by name, Mr Gill tells his children that he loves them and says '*they just won't let me see you guys*'. Mr Gill also refers to the fact that he will cherish every moment that he '*had*' with them. He also makes reference to him not letting '*them hurt use anymore*'. He urges his son to play footy in the fashion that his father would be proud of and addresses his daughter very much in the past tense by saying that she was his '*first*' and that she was the '*star in his eye*'. He says '*but now that Im not here just do what you always one darlin is just dance*'.

¹³ Quotes listed on this page are transcribed from Exhibit C123e(1)

- 2.52. There are two daily diary entries that post date 29 May 2005, the day of Mr Gill's arrest and the day on which the diary was seized by the police. The first date is Monday, 30 May 2005 where it is written to begin with:

'At work minding my own busyness just thinking about the little one's.'¹⁴

Then follows reference to Mr Gill wishing that he had made it to Monday and in which he refers to '*child stealers*' having stolen his children out of his home. The other entry is dated 20 June 2005 which would have been the deceased's next birthday. The entry is in the following terms:

'Im happy I got what I wanted for my birthday give my kids all the kiss and cuddles and tell them that I love them.'

- 2.53. There is no doubt that encapsulated in these notes when examined as a whole, is a desire on Mr Gill's part to stop his partner's parents from having anything further to do with his children and then to take his own life. This is the only inference that can be gleaned from these notes and is, in my view, not derived just with the benefit of hindsight. The deceased's intentions appear to be embodied in this passage:

'... but U know the truth I know the truth and U know **I can't stay around after this** because it is not they place I intened ongoing but had know choice but to **stop this evil cunt** from destroying my kids life anymore.'¹⁵ (emphasis added)

That note was addressed to his mother and that to my mind evinces a clear intention on Mr Gill's part to do whatever he could to prevent his partner's father from having any effect on his children's lives and thereafter to end his own life.

- 2.54. This diary had been in the possession of the police for approximately 70 hours prior to the incident which resulted in Mr Gill's death.
- 2.55. Detective Rogers in her statement dated 25 July 2005 states that at the time the diary was located on the Sunday afternoon she had a '*quick scan*'¹⁶ through it. Whether her reading of the diary was thorough or otherwise, it is clear from Detective Rogers' statement that she interpreted certain entries as indicating an intention on Mr Gill's part of harming his partner's family. Detective Rogers goes on to state that from her brief reading of the diary, it had appeared to her that Mr Gill intended to harm himself

¹⁴ Quotes listed on this page are transcribed from Exhibit C123e(1)

¹⁵ Quotes listed on this page are transcribed from Exhibit C123e(1)

¹⁶ Exhibit C123

after harming his partner's family, and in particular her father Richard. At the time of the police attendance at his home, Mark Gill stated that he had read the diary also and indicated that his interpretation was that Mr Gill was intending to harm himself. He added that he did not think his brother would last two weeks in custody. He shared these thoughts with the officers.

- 2.56. It would be tempting to regard Mr Gill's diary entries as being the subject of accurate interpretation only in hindsight were it not for the fact that Detective Rogers and Mr Gill's brother both harboured prescient interpretations of the diary entries at a time well before Mr Gill took his own life.
- 2.57. On the basis of the diary alone it would have been very difficult on the day of Mr Gill's arrest to regard Mr Gill as anything other than a prisoner within the highest category of risk of self-harm. This view ought to have been reinforced by the fact that on the day following his arrest, the Monday, Detective Rogers photocopied the diary and located further worrying entries that she had apparently not read up until that point. Her belief that Mr Gill had planned to harm his partner's family, and in particular her father, and that after doing that he planned to harm himself, was thereby confirmed. Evidently this view of the matter was entertained by Detective Rogers at a time before Mr Gill, on the Monday afternoon, appeared before the Elizabeth Magistrates Court. She regarded the possibility of self-harm, as evinced by the diary entries, to be another possible ground for bail being refused. Unfortunately, the authorities thereafter treated the intelligence that had been gathered in respect of Mr Gill's desires and intentions in respect of his own life only in the most casual manner.
- 2.58. It does not appear to have occurred to any police officer who had knowledge of the contents of the diary that the decision to subject Mr Gill to the usual custodial processes could have been suspended while further psychiatric evaluation was undertaken, and in particular no thought seems to have been given to whether police could invoke their power under Section 23 of the Mental Health Act 1993, invite a medical practitioner to examine Mr Gill in the Elizabeth cells or to refer Mr Gill back to the LMH.
- 2.59. As will be seen, neither the diary itself nor any of its relevant entries or contents were drawn to the attention of any employee of DCS nor the Prison Health Service. The concerns that the diary generated, and I include here concerns in the minds of police

officers and of Mr Gill's brother, were at no stage conveyed to DCS nor the Prison Health Service who remained at all material times while Mr Gill was at the ARC quite unaware of any risks or perceived risks that may have been engendered by the diary and its contents. Indeed, the interpretations that were derived from the diary that Mr Gill might harm himself as the second part of his overall plan were interpretations that remained within the four walls of SAPOL and went no further.

2.60. It will be seen during the remainder of this finding that the information concerning Mr Gill's risk status for self-harm was information that should have been passed on from SAPOL to DCS, and in particular to staff at the ARC for them to take into account in their own risk assessment. Indeed, there were clear operational procedures in place within SAPOL to ensure that information such as had been obtained from the diary and from Mr Gill's own family members would be passed on to other relevant custodial authorities dealing with Mr Gill. As will be seen these procedures were simply not followed.

2.61. The course of events after Mr Gill was brought to the Elizabeth police station - A summary

In this section I describe in general terms what transpired as far as Mr Gill's processing within the criminal justice system is concerned, up to the point where he took his own life on 1 June 2005. Later in these findings I shall deal with the detail.

2.62. Mr Gill arrived at the Elizabeth police station cell complex at approximately 2:15pm on Sunday, 29 May 2005. He remained within the cell complex for the remainder of that day and into the next. He was accommodated in a single observation cell, although at one point he was permitted to mingle with other prisoners.

2.63. On Monday, 30 May 2005 Mr Gill remained within the Elizabeth police station cell complex until shortly after 3pm when he was removed from the cells and taken into the care of a company by the name of GSL (Global Solutions Limited). GSL is a private corporate entity that for some years now has had a contractual arrangement with the South Australian Government to provide custodial and escort services for prisoners who have been kept in custody by the police and/or remanded in custody by the Courts. I will describe the role of GSL in detail later, but suffice it to say for

current purposes their responsibilities in relation to Mr Gill consisted of taking him into their care and custody on the Monday afternoon prior to Mr Gill's Court appearance and then escorting and conveying him to the ARC following that Court appearance.

- 2.64. Mr Gill appeared before the Elizabeth Magistrates Court at approximately 3:30pm that afternoon and indeed was remanded in custody. There was nothing irregular about the course of Mr Gill's arrest and processing through the courts. It was in accordance with the usual legal requirements. Mr Gill's remand in custody meant that he would be accommodated in the ARC and he was conveyed to that location by GSL at approximately 4:45pm that afternoon.
- 2.65. From that point onwards Mr Gill was kept in the ARC. He was accommodated in Unit 1 where he was ultimately to jump on 1 June 2005 and die on 2 June 2005 at the Royal Adelaide Hospital.
- 2.66. Relevant SAPOL requirements, obligations and procedures in relation to the processing of prisoners
Among the procedural requirements that operated when a prisoner was first brought to a police cell complex such as that at Elizabeth police station, was a requirement that a 'Prisoner Screening Form' be completed. This form was also known as a PD331 and I will refer to this document as such for the remainder of this finding.
- 2.67. The PD331 is essentially in two parts. The first part is to be completed by the arresting police officers at the time the prisoner is brought before the cell sergeant and charged. The second part, which has a number of sub-parts, is completed by SAPOL cell complex staff, and there is also provision for the escort officer or officers to fill in their identities.
- 2.68. In Mr Gill's case Detective Rogers of the Sturt CIB completed the first part of the PD331. It will be recalled that officers Rogers and Barton were the two members of Sturt CIB who were investigating the alleged offences at Seacombe Heights. There is provision for what is described as an 'Arresting Members Questionnaire'. There are 10 questions to be answered by the officer completing the questionnaire. The possible

answers are simply yes or no and there are boxes to be crossed or ticked as the case may be. The following is an excerpt from the form completed by Detective Rogers:

	YES	NO
5. Does prisoner seem despondent	<input checked="" type="checkbox"/>	
6. Does the prisoner appear irrational or disturbed?		<input checked="" type="checkbox"/>
8. Has the prisoner given any indication that he/she may be a person at risk?	<input checked="" type="checkbox"/>	

If 'YES', state reason: Assessed at L.Mc. hosp. Fit for custody '

- 2.69. The other questions and answers are not relevant. At the same time that Mr Gill was deposited at the cell complex, the letter from Dr Shankar that I have already referred to, asserting that Mr Gill was fit for police interview, was also deposited at the same time. It will be noted that the document did not in fact state the reason why Mr Gill was considered to be a person at risk or give any reason as to how he had given any indication that he might be a person at risk. Although the answer to the question as to whether he had given any such indication was in the affirmative, the documented reason simply referred to the fact that he had been assessed at the LMH but that he had been fit for custody. This document of course creates a very clear impression that whatever risk may have been perceived in Mr Gill's case, he was nevertheless fit for custody and that would mean both police and DCS custody unless there was further information documented to the contrary, or which modified or otherwise expanded upon the bald assertion that he was at risk.
- 2.70. The second part of the PD331 consists of, firstly, a 'Sergeant's Questionnaire' in which the cell sergeant is required to ask a number of questions of the prisoner which can be ticked yes or no or refused in the appropriate box. In Mr Gill's case he indicated that he did not have any serious medical problems, including psychological or psychiatric problems. The question whether he had received any medical treatment is answered affirmatively and describes in the sergeant's handwriting 'Lyell McEwin'. The other half of this part of the PD331 consists of a 'Cell Guard's Questionnaire' which is meant to be completed prior to release. One question that can be answered either yes or no is 'Did the prisoner display any intention of endangering him/herself whilst in custody?'. None of the questions in the cell guard's questionnaire, including that question, are completed in Mr Gill's case.

- 2.71. There is also a section entitled 'Information for Prisoner Escort' that again contains a number of questions which could be answered yes or no. One question that is asked is 'Is this prisoner likely to cause self-harm or be suicidal?'. That question can be answered yes or no and also beneath that question is space for 'special instructions'. As I have mentioned earlier, there is provision for the personal details of the escorting officer or officers. The section entitled 'Prisoner Information for Escort' was meant to be completed by the cell sergeant upon the prisoner leaving the cell sergeant's custody. It was not completed in Mr Gill's case.
- 2.72. Mr Gill's PD331 was Exhibit C39ae in the Inquest.
- 2.73. SAPOL have their police General Orders. This voluminous document covers most aspects of police procedure. An extract that deals with the general subject of 'Prisoners' was tendered to the Inquest¹⁷.
- 2.74. While an attempt was made by some officers who were called at the Inquest to describe the General Orders as '*guidelines*', it is clear on the evidence that police General Orders have considerable force and are not mere guidelines. In the event, I do not think any police officer seriously suggested that the relevant General Orders in respect of prisoners were mere guidelines. The effect of the General Orders is in my opinion clearly described in a Memorandum of Understanding directed to all SAPOL employees that was promulgated by the Commissioner of Police, Mr M A Hyde, on 31 August 2004. The Memorandum of Understanding was circulated generally over the police intranet. I quote from one paragraph of the memorandum:
- 'Not all situations encountered by police can be managed without some form of assistance and so some of these orders are as guidelines which should be applied, together with commonsense. Most orders, however, as is indicated by the form in which they are expressed, are mandatory and must be followed. Moreover, at all times you are expected to act ethically and with integrity. Deviation from these orders without justification may attract disciplinary action.'¹⁸
- 2.75. Within the General Order entitled 'Prisoners' there is an order entitled 'Conveyance/transfer'. This order states relevantly for these purposes:
- 'Where a prisoner is to be transferred to another location the OIC must ensure:
- That where the prisoner is being conveyed to a Department of Correctional Services facility, a duplicate of the **PD331 Prisoner Screening Form** is to be transferred with

¹⁷ Exhibit C136

¹⁸ Exhibit C136c

the prisoner, and the 'Information for Prisoner Escort' section is completed before the transfer occurs.' (the emphasis is part of the original text)

The reference to the OIC within that order is a reference to the cell sergeant effectively.

- 2.76. Whether or not there were other orders that could be characterised as guidelines, the requirement in the General Orders relating to conveyance and transfer of prisoners is manifestly mandatory in its terms. Accordingly, having regard to the Commissioner's Memorandum of Understanding, this order must be followed. It mandated the completion of the 'Information for Prisoner Escort' section of the PD331 which included the question 'Is this prisoner likely to cause self-harm or be suicidal?'
- 2.77. The order that I have referred to was in force as at May and June 2005 and was applicable to Mr Gill's situation.
- 2.78. The Elizabeth police station possessed its own 'Cell Standing Orders and Evacuation Plan'¹⁹. At the time with which this Inquest was concerned there was a standing order that related to the PD331. The particular standing order described the duties of certain officers in respect of the completion of the form and its retention. One stipulation is as follows:

'The Station Sergeant will take appropriate action relative to the information contained in the screening form concerning the health, welfare and safety of the prisoner, whilst the prisoner is confined to the police station Cells.'

Another stipulation is as follows:

'If the prisoner is being conveyed to a Department for Correctional Services facility, the duplicate of the PD331, Prisoner Screening Form is transferred with the prisoner.'

This latter stipulation embodied what was a clear responsibility on the part of SAPOL that the PD331, or at least a copy of the same, should travel with the prisoner when the prisoner is transferred out of police custody. The practice was that the PD331 would be given to GSL and then passed on to a DCS facility if the prisoner was remanded in custody. As it transpired, there was no difficulty in Mr Gill's case about a duplicate copy of this document travelling with him at all times, and indeed a copy was received at the ARC when Mr Gill arrived there on 30 May 2005. The Elizabeth police station local Cell Standing Orders regarding the PD331, however, was silent as

¹⁹ Exhibit C136a

to how much of the PD331 form had to be completed. In particular, there was no requirement actually spelt out within the standing order that the section entitled 'Information for Prisoner Escort' had to be completed.

- 2.79. However, the evidence in my view is clear, and no one seriously suggested otherwise, that the absence from the Elizabeth Standing Orders about any requirement to complete that section did not mean that the section did not have to be completed. The police General Orders to which I have already referred constituted the overarching SAPOL document in virtually every facet of its work. The relevant requirement concerning the PD331 and the section entitled 'Information for Prisoner Escort' was clear, namely that it had to be completed by the cell sergeant before the transfer to a DCS facility occurred.
- 2.80. Another document brought into existence during a prisoner's confinement within a cell complex was a 'Prisoner Custody Disposition' form. This document was generated by computer and in fact relates at any given time to all of the prisoners within the cells and in some instances also refers to prisoners who have been recently either released or transferred from the cell complex. The document is not specific to a particular prisoner. The document, as I understood the evidence, can be and is updated from time to time by the cell staff using a computer. It can also be printed out from time to time. In Mr Gill's case I received a number of versions of the Prisoner Custody Disposition form that was in existence during his confinement in the Elizabeth cells²⁰.
- 2.81. The Prisoner Custody Disposition form, amongst other things, records the type of cell accommodation that is assigned to the prisoner, the prisoner's personal details and a brief description of the offence with which the prisoner has been charged. Within the same section as the description of the offence there is what appears to be unlimited space for relevant comments to be recorded about each prisoner. This section of the document is intended to record and bring to the attention of officers such matters as the arresting officer's attitude to bail, the prisoner's medication as well as observations as to the prisoner's risk of self-harm.

²⁰ Exhibit C39ad

- 2.82. At all material times while Mr Gill was in police custody the Prisoner Custody Disposition form, insofar as it related to Mr Gill, recorded in the offence/comments box the following:

'3 x Attempt Murder, Agg. Ser. Crim Tres. File
Rogers Sturt CIB (File to be done by 11:00AM 30/5) BAIL
REFUSED. CT 30/5.
WATCH, AT RISK, maybe SUICIDAL, (from his family
other family members have committed suicidal) Fit for
custody from Lyell McEwin'

This entry was based upon the information that had either come directly or indirectly from Mr Gill's family and there is an obvious reference to the fact that Mr Gill's brother had committed suicide.

- 2.83. There was no SAPOL requirement that the Prisoner Custody Disposition form either travel with the prisoner upon the prisoner's transfer or that it be provided to an escort or to DCS or any of its custodial facilities. There was some evidence in the Inquest to the effect that a copy of the document was provided to GSL for their purposes, because it contained a comprehensive list of the prisoners in custody at any given time and therefore a list of the prisoners whom GSL would be undertaking responsibility for after they left the Elizabeth cell complex. It was also a useful document as far as GSL's purposes were concerned because it also described the offences with which the prisoner was charged. GSL were also quite properly interested to know whether or not a prisoner was regarded as 'at risk' because GSL had its own responsibility to look after the welfare of prisoners whilst they were in GSL custody.
- 2.84. However, the Prisoner Custody Disposition form was never intended to travel with the prisoner as far as a DCS facility, and indeed in my opinion, there was no proper basis for any expectation on the part of SAPOL members that the document would go to a DCS facility. Any expectation that was held by any member of SAPOL in that regard was falsely premised, and indeed I did not understand any police officer who gave evidence in the Inquest to seriously contend otherwise. Certainly, there was no understanding either between SAPOL and GSL, between GSL and DCS or between SAPOL and DCS that this document would be furnished to DCS. In the event, the ARC did not receive the document when Mr Gill was processed there and indeed

none of the information contained within it was ever brought to the attention of DCS or the Prison Health Service.

2.85. GSL requirements and obligations

As indicated earlier, in the context of which we speak here, GSL's responsibility was to escort the prisoner from the Elizabeth police cells to the Elizabeth Magistrates Court holding cells and to keep the prisoner in the holding cells pending his appearance in Court. They also undertook some responsibility for security within Court. Once the prisoner was remanded in custody, it was GSL's responsibility to convey the prisoner to the relevant custodial institution, usually the ARC. That is what happened in Mr Gill's case. The procedure normally was that the prisoner would be taken from the Elizabeth police cells by the GSL escort or escorts shortly before the prisoner's Court appearance so that the prisoner did not have to remain in the Court holding cells for an extended period of time. There was some evidence that was suggestive of the fact that both Elizabeth police station cell staff and GSL officers were under some pressure from the Court to quickly convey prisoners from police cells to the Court.

2.86. The expectation and indeed obligation that was relevant for GSL's purposes was that they would take custody of the prisoner and take possession of such items as the prisoner's property. Specifically, they were under an obligation to take a copy of the PD331 and any documentation that might be appended to that. The appended documentation might consist of a medical report or other relevant letter. In Mr Gill's case it would have appended the letter from Dr Shankar of the LMH which stated that Mr Gill was fit for police interview.

2.87. There was some debate during the course of the Inquest as to whether or not GSL had an obligation regarding the PD331 that extended beyond merely receiving it. It was suggested that GSL were under an obligation to ensure that the relevant SAPOL officers completed the document at the time the particular prisoner was taken into custody by them.

2.88. I heard evidence from Mr Kenneth Dalton who is the Operations Manager in respect of the South Australian prisoner movement and in Court management contract that exists between GSL, whom he represents, and the other entities concerned with the transfer, welfare and movement of prisoners. Among other things, Mr Dalton

appeared to hold the belief that the section of the PD331 entitled 'Information for Prisoner Escort' was confined to situations involving movements from one SAPOL institution to another. In my opinion this view of the matter is erroneous having regard to the clear wording of the relevant SAPOL General Order which I have set out above.

- 2.89. My view of the matter is that there was in place as at May and June 2005 an obligation upon GSL escorts to ensure that a PD331 was completed in its material aspects before they took charge of the prisoner. A set of agreed facts tendered to the Inquest to which GSL were party in my view makes that clear, although that obligation may not have been, for reasons that I need not canvas, clearly understood at the time. There was, however, clear provision in the PD331 for the escorting officer or officers' details to be filled in and one would have thought that there is nothing in the document to suggest the description of 'escort officer' would be confined to an escorting officer who was a member of SAPOL. It would in my view be a universal requirement for the escort, from whatever organisation the escort comes from, to complete that part of the document.
- 2.90. In addition, the document's fundamental purpose is plain. It is meant to be a conduit for relevant information between SAPOL and DCS insofar as it may contain information relevant to the risk status of the prisoner. It was clearly understood, and indeed was a SAPOL General Order requirement, that the document go to DCS and it is not difficult to understand why that requirement ought to have been rigidly adhered to. It was for the protection of the prisoner and for the edification of those within DCS who had some responsibility to ensure that the prisoner's induction was a proper one and that the prisoner was accommodated in the correct circumstances relevant to his risk status. In my view, commonsense would have dictated that a document that was not completed in a material aspect, namely whether or not the prisoner was likely to cause self-harm or be suicidal, would be unacceptable, even to GSL who had some, albeit brief, responsibility for the welfare of the prisoner whilst in their charge.
- 2.91. A booklet entitled 'South Australia Prisoner Movement In-Court Management Operational Instructions' had a section entitled 'Operational Instruction Number 3 – Takeover and Handover of Prisoners'. This document was not tendered to the Inquest but was referred to extensively. There was an objection, which I did not fully understand, taken to its actual public production as an exhibit but the set of agreed

facts that I have already referred to were based on the contents of the document and in my view makes it clear that there was an obligation upon GSL to ensure that the PD331 form was 'completed' insofar as it arose in the context of a movement from SAPOL via a Court to a DCS facility.

2.92. DCS reliance upon PD331

The General Manager of the ARC, Mr Stephen Raggatt, gave evidence in the Inquest. He told me that at the point of admission of a prisoner, the ARC relied heavily upon documentation provided by SAPOL through GSL, particularly in relation to stress screening and risk classification. When asked as to how much emphasis would be placed upon warnings that might be set out on a PD331, he told me that it would be his expectation that such information would be relayed onto the ARC stress screening documentation and also passed on to the Prison Health Service so that they were aware of relevant issues when they interviewed the individual prisoner. He said that the PD331 needs to form part of the prison assessment. He agreed with counsel assisting that ARC staff could only rely on information that was provided by SAPOL and that in the absence of relevant information about a prisoner, ARC staff would assume that there were no issues of concern.

2.93. Mr Gill's processing whilst in SAPOL custody

The manner in which Mr Gill was processed and handled whilst in police custody is to be examined against the background of the requirements that I have identified in the previous section. These requirements were designed, in part, not only to ensure that a prisoner was properly identified as an 'at risk' prisoner whilst in police custody if that were the case, but also to ensure that any intelligence gathered by police in that regard was passed on to other custodial institutions.

2.94. As well, the risk of self-harm at which a prisoner is perceived to be is a dynamic concept that requires, or should require, reassessment from time to time. It will be noted here that although Mr Gill was said to be fit for police interview by LMH clinical staff, this did not necessarily mean that he would remain fit for custody for the entirety of his custody in the hands of the police. Clearly, if new information relevant to Mr Gill's risk were to come to hand, the whole issue as to whether he was fit for custody or not would come to be reassessed. I have already referred to the fact that the Prisoner Custody Disposition form noted that Mr Gill needed to be watched, was at risk and was maybe suicidal. It was specifically noted that this observation was

based on information from Mr Gill's family and in particular the fact that 'other family members' have committed suicide. That was a reference to Mr Gill's brother. The other notation was that he was fit for custody.

- 2.95. The information from the LMH that there was no psychiatric reason to preclude Mr Gill's transfer into police custody and that he was fit for police interview, embodied as it was in Dr Shankar's letter, seems to have immutably underpinned police thinking in respect of the manner in which Mr Gill needed to be processed. There is no evidence that anyone gave any further consideration during Mr Gill's period of police custody as to whether or not any change in circumstance, or any further or new information, warranted any revision of the view that Mr Gill ought to remain in police custody. I speak here in particular of the discovery of Mr Gill's diary. As I understand the evidence, the notations in the Prisoner Custody Disposition form concerning Mr Gill's risk, were made at a time prior to the diary being located.
- 2.96. I accept unreservedly that Detectives Rogers and Barton advised Elizabeth police station cell staff of the significance of Mr Gill's diary entries. It is fair to say, however, that this information did not in any way alter the manner in which Mr Gill was handled. Indeed, there was no alteration to the information noted in the Prisoner Custody Disposition form. The entry relating to Mr Gill never varied except and until he was released into GSL custody when the entry concerning him was deleted.
- 2.97. Detective Gregory Barton, who gave evidence before me, could not recall whether anyone at the Elizabeth cell complex had physically recorded any of the information concerning Mr Gill's diary at the time the Detectives had made cell staff aware of its existence. Detective Barton regarded the diary entries as something of a '*suicide note*'²¹. He was asked whether or not he had said so in terms to the Cell Sergeant and responded:

'We - myself and Detective Rogers - we told the sergeant what we had located and our concerns about his mental state.'²²

²¹ Transcript, page 518

²² Transcript, page 519

However, Detective Barton told me that as far as he was concerned the diary entries, and their message, did not constitute new information. Detective Barton said:

'There was no significant information there to suggest that he would do anything in custody at that time.'²³

For Detective Barton new information would have consisted of, say, an assertion by Mr Gill to a family member that he was going to kill himself whilst in custody. Detective Barton emphasised that the information contained in the diary was information that had been written even before Mr Gill had been assessed at the LMH and taken into custody. It was therefore nothing new. When the entry in the diary that was recorded against Mr Gill's next birthday on 20 June 2005 was pointed out to Detective Barton in cross-examination, he conceded that it suggested that Gill had wished dead the people Gill had been referring to in the diary and that '*he was going to harm himself or kill himself after the incident*'. I assume Detective Barton took this to mean directly after the incident.

- 2.98. The notion that the information contained within Mr Gill's diary was not new in my opinion has to be rejected. Not only was it new information in itself, it also came from a source that was Mr Gill himself. Other information concerning Mr Gill's possible suicidality had emanated from members of his family and from the circumstance that his brother had committed suicide. The diary entries constituted on one interpretation, and in my view a very compelling interpretation, an indication by Mr Gill of an intention to take his own life. It is no wonder that Mr Gill's surviving brother expressed the view that Mr Gill would not last two weeks in custody.
- 2.99. Sergeant Desmond Busch, who was the Cell Sergeant on duty at the Elizabeth police station during the afternoon shift of Sunday 29 May 2005, and was the Sergeant to whom the information about the diary was imparted, also gave evidence in the Inquest. Sergeant Busch acknowledged in his evidence that he had received some information about Mr Gill from Detective Barton which he noted in the charge book. That information consisted of Detective Barton's mobile telephone number. Sergeant Busch could not recall the circumstances in which he received Detective Barton's phone number or the circumstances in which he came to receive it. In particular, Sergeant Busch did not profess to have any recollection of having been told of the diary entries. Sergeant Busch did tell me, however, that if he had received the

²³ Transcript, page 519

information contained within the diary, and in particular if his attention had been drawn to references that indicated that Mr Gill had intended to harm and possibly murder his partner's parents and had thereafter intended to harm himself, he would have checked the information that was already contained on the Prisoner Custody Disposition form. If he felt had any need for the information to be changed, he would have changed it. Having regard to the information that was already recorded in the Prisoner Custody Disposition about Mr Gill's risk of self-harm, Sergeant Busch believes that he would not have changed it in the light of the diary entries:

'Because I believe it was sufficient information or - if I had received that information from the investigating detectives there was sufficient in the comments section that would not have made any change the way I handled Mr Gill when he was in my custody.'²⁴

This attitude was also to my mind surprising for the same reasons that I have mentioned in respect of Detective Barton's attitude. There was no or no convincing evidence that the information about the diary was passed on from one shift to the next.

- 2.100. In my view, the information contained within Mr Gill's diary should have been taken into account by police in determining the way in which Mr Gill should be handled while in SAPOL custody. Although Mr Gill had been certified fit for police interview by clinical staff at the LMH, his continued status as such for the duration of his stay within the Elizabeth cell complex was another matter. Although it was inevitable that Mr Gill would be arrested for the offences that he had allegedly committed, it was by no means settled that he would have had to spend his time within a purely custodial institution such as the cells at the Elizabeth police station. The information contained within the diary, in my opinion, should have enlivened police to a need for Mr Gill to be re-evaluated medically. Section 23 of the Mental Health Act 1993 empowers a member of the police force to apprehend and then take for a medical examination a person whom the member has reasonable cause to believe has a mental illness and that the conduct of the person is, or has recently been, such as to cause danger to him or herself. I do not need to make any observation as to whether as a matter of law this power may be invoked in the case of a prisoner already in custody. But there would be no legal impediment to the officer in charge of a police station sending a prisoner to a medical facility, be it for a physical or suspected psychological difficulty. As well, a medical practitioner could have attended at the Elizabeth police station and assessed Mr Gill there and if need be have detained him under Section 12(1) of the

²⁴ Transcript, page 770

Mental Health Act 1993. I note in this latter strategy had been invoked by police in the matter of Margaret Lindsay whose Inquest²⁵ was held in this Court in 2003. Ms Lindsay had been examined by a medical practitioner in, and was then removed from, the police cells at the City Watch House and taken to the Royal Adelaide Hospital where she remained for some time. Section 12(1) was utilised on that occasion.

- 2.101. In dealing with the suggestion that a Mental Health Act strategy may have been adopted in Mr Gill's case, Detective Barton re-emphasised that the information from the diary was not new information and that Mr Gill had already been psychiatrically assessed. The diary had been written prior to MR Gill's assessment. Having regard to the fact that LMH staff were unaware of the existence of the diary, it is difficult to discern the relevance of the fact that the diary had been written before Gill's assessment at the LMH. Detective Barton conceded that he did not give any thought to the operation of the Mental Health Act 1993. It did not occur to Detective Barton that Mr Gill's susceptibility to be detained under the Mental Health Act 1993 might have been enlivened by what was in effect confirmatory information that the prisoner might harm himself.
- 2.102. In spite of the intelligence that the diary provided about Mr Gill's actual risk of self-harm, no re-assessment of that risk ever took place.
- 2.103. Whether any further invocation of the Mental Health Act 1993 would have made any difference to Mr Gill's eventual fatal behaviour is a difficult matter to determine. Underpinning the operation of the Mental Health Act 1993 is the assumption that the detained person has a mental illness that requires immediate treatment. Whether Mr Gill would have been assessed as having a mental illness in the light of the diary entries will never be known. However, it is fair to say that if Mr Gill was detained and then released back into police custody, or if he was examined in the Elizabeth cells and found not to be detainable, one would have thought that the fact of any such assessment would have been brought to the attention of authorities down the custodial line. I speak here of course of GSL and the authorities at the ARC. It is almost unthinkable that if Mr Gill had been psychiatrically assessed during a period of police custody that that would not have been somehow drawn to the attention of the Prison Health Service once he was remanded in custody to a correctional facility.

²⁵ Inquest 13/2003

- 2.104. This brings me to the quality of the information that was in fact actually passed on to GSL and the ARC.
- 2.105. In the event, we know that very little of the intelligence that police had gathered about Mr Gill's risk status was passed on down the line. Those assessing Mr Gill at the ARC, and in particular Prison Health Service staff, were not made aware of the information that had been gathered by the police. Before I deal with this matter it is as well to make the following observation about the manner in which this death in custody was investigated. To my mind, the major issue of substance in this death in custody was whether there had been a failure by police to impart relevant information about Mr Gill's risk status to GSL or the ARC. This issue was never clearly identified during the course of an otherwise thorough police investigation, an investigation that was conducted over a long period of time. It seems to have been accepted that the original information that was contained within the PD331, which had been inserted by the arresting officers, should have been sufficient to alert DCS personnel as to Mr Gill's risk status. However, as seen, that information was scant and, if anything, suggested that there was no real difficulty about Mr Gill insofar as the information stated that he was fit for custody, especially when the attached letter stated that LMH staff could find no psychiatric reason to preclude his transfer into police custody. The fact that neither the cell guard's questionnaire section nor the information for the escorting officer section of the PD331 was completed does not appear to have been the subject of any meaningful investigation prior to the matter coming before my Court. In particular, statements that were taken from the various Elizabeth police station cell complex staff were for the most part not taken until at least a year after Mr Gill's death. By then, memories no doubt had faded and explanations for whatever perceived shortcomings there were, either in the system generally, or as it applied to Mr Gill, were difficult to glean. In addition, statements were taken from GSL employees for the first time during the course of the Inquest itself. The effect of all of this was that events during the course of the Inquest had to be reconstructed well after the event. In this regard I record my appreciation of the efforts of Ms Amy Davis, counsel assisting me, Mr Brenton Illingworth and Ms Amanda Taylor who represented the Commissioner of Police in this matter and Mr D'Arcy Stratford, who represented GSL, in respect of the gathering of necessary information relevant to this issue.

2.106. The transmission of information concerning a prisoner's risk of self-harm from police to other custodial institutions has for a long time now been regarded as an important matter. The neglect within the Elizabeth cell complex to comply with plain, mandatory requirements is therefore astonishing. One only has to have regard to what transpired in the Margaret Lindsay Inquest to realise that any information that police have in their possession about a prisoner's risk of self-harm, and its transmission to other custodial institutions, is a matter of profound importance. The importance of proper transmission of information between the various custodial authorities was identified long ago in the Royal Commission into Aboriginal Deaths in Custody, and I speak here of recommendation 130 that recommended the following:

'Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody.'

The wisdom of that recommendation in my view need not be confined to Aboriginal persons. It is clearly a universally desirable requirement.

2.107. I have already referred to the clear SAPOL requirements. I was told during the Inquest that the failure to complete the very important police screening form PD331 was commonplace if not the norm at Elizabeth. The important 'Information for escorts' section of the document was rarely, if ever, completed at that station. This Court finds it difficult to comprehend how such an entrenched culture of neglect could have been allowed to evolve. The practice of releasing prisoners into GSL custody, and then DCS custody, without the form being completed in respect of important matters was a practice that involved a significant departure from not only clear and well understood requirements, but from any reasonable standard of care.

2.108. The Cell Guard's Questionnaire and Information for Prisoner Escort sections of the PD331 were designed to impart important information about a prisoner's perceived risk of self-harm. These sections were habitually ignored by Elizabeth cell complex staff. That much was clear from the evidence of a number of SAPOL officers who had responsibility for the operation of the cell complex and who gave evidence in this Inquest. An examination of other PD331 forms compiled around that same period confirms that the practice of releasing prisoners without the form being completed had been well developed by May/June 2005. This institutionalised neglect was in plain contravention of SAPOL General Orders. The explanations and excuses that were

tendered to me during the course of the Inquest as to why the PD331 was habitually neglected were lamentably poor and do not bear repetition here. Suffice it to say, there was simply no justification for the flouting of this important requirement.

- 2.109. During the course of the Inquest it was suggested in some quarters that a Task Order form that was transmitted from police to GSL and/or the Prisoner Custody Disposition form that was also made available to GSL somehow stood in place of a fully completed PD331. It will be remembered here, however, that the only official document that was transmitted from SAPOL to DCS was the PD331 together with any attached documents such as a medical report. There was no basis, in my opinion, upon which any member of the Elizabeth police cell complex staff could have had a legitimate expectation that either the Task Order form or the Prisoner Custody Disposition form would eventually make its way to the ARC or to any other DCS custodial institution. I did not understand any person who gave evidence before me to seriously suggest that there was such an expectation. In any event, when statements were taken from GSL officers who at the time had responsibility in relation to the Elizabeth cell complex, it not only confirmed the practice of neglect as far as the failure to fill in PD331s was concerned, but established beyond any doubt that documents such as the Task Order form and the Prisoner Custody Disposition form, insofar as they came into the possession of GSL, were only used for GSL's internal purposes and were never transmitted to DCS custodial institutions.
- 2.110. Mr Gill's transfer from police custody into GSL custody took place at around 3:30pm on the Monday. This occurred just before Mr Gill went to Court. To my mind GSL were not informed that Mr Gill would present any particular risk whilst in their custody. It is possible that at some point they received the Prisoner Custody Disposition form which included reference to Mr Gill and his risk of self-harm, but it is unlikely that any particular emphasis was placed on this. The evidence of a number of GSL employees who provided statements to the Inquest was to the effect that although GSL may have sighted the Prisoner Custody Disposition form, they only took possession of the PD331 and any attached documentation such as medical reports. There is no evidence to suggest that Mr Gill's handover was anything other than routine. These conclusions are supported by the fact that Mr Gill was placed by GSL in Cell 7 at the Court complex. If he had been perceived to have been at significant risk, he would have been placed in Cell 6 which is the subject of more

frequent prisoner observations. In any event, the official document namely the PD331, that is to say the document that everyone understood was the only one that would go to the ARC, had not been completed.

2.111. Nevertheless, comment needs to be made about the fact that Mr Gill, as a prisoner, was accepted by GSL staff without a properly completed PD331. The statements taken from GSL staff during the course of the Inquest make it clear that they were aware that the Cell Guard's Questionnaire and Information for Prisoner Escort sections were seldom completed, if at all, but that GSL would accept the prisoner into their custody notwithstanding. Having regard to the undoubted requirement that GSL should take possession of a PD331 at the time they took custody of a prisoner, it is difficult to escape the conclusion that firstly, the form should have been completed and secondly, that they should not have accepted the prisoner without it being completed. The document served little purpose if the Cell Guard's Questionnaire and Information for Prisoner Escort sections remained blank. When one examines the proforma document it is not as if a blank form signifies that a prisoner is not at risk. For example, the question 'this prisoner is likely to cause self-harm or be suicidal?' has to be answered yes or no. If the question remains unanswered, it says nothing at all about a prisoner's potential suicidality. Any suggestion that reliance could be placed upon a blank form as an indication that a prisoner was not at risk would not only be an erroneous suggestion, but a dangerous one. There was no reason why the important information about Mr Gill's risk of self-harm that had been contained within the Prisoner Custody Disposition form could not have been copied onto the PD331.

2.112. Mr Gill was duly transported by GSL to the ARC where he arrived at about 5:22pm on the Monday. When Mr Gill was handed over to ARC staff, GSL had no further role to play in respect of his custody. GSL handed over the documentation that they were meant to hand over which in this case consisted of the incomplete PD331 and the letter from Dr Shankar. There was no further information imparted by GSL to DCS staff that would have modified or qualified the impression about Mr Gill that he was, by and large, a routine prisoner.

2.113. Mr Gill's arrival and processing at the ARC

Upon Mr Gill's arrival at the ARC a raft of clerical procedures were undertaken. Following this, a prison officer interviewed him. The interview was conducted for a

number of purposes. Firstly, it was used as an opportunity for DCS staff to obtain the prisoner's personal details and the prisoner's description. In addition, and perhaps more importantly, a prison stress screening exercise was conducted. For these purposes a form known as a 'Prison Stress Screening Form' (PSSF) was filled out by the officer. The form contains a total of 31 questions that for the most part can be answered yes or no. In respect of some questions there is provision for elaboration. The questions in the main relate to an assessment of the prisoner's current levels of stress. Some of the questions pointedly relate to the prisoner's risk of self-harm. One point is awarded for any question that is answered yes or yes/perhaps. If a total score greater than 8 is achieved, then the prisoner is to be considered 'at risk'.

- 2.114. A prison officer handled Mr Gill's screening process by the name of Sean Bugden who gave evidence before me. Mr Bugden was a prison officer of Operations 2 rank. He has been employed by DCS for since October 2000.
- 2.115. Mr Bugden told me that the whole interviewing and screening process took approximately 15 minutes. Although he could not specifically recall, it is clear that he would have been furnished with a copy of the SAPOL PD331 which, aside from that initial cryptic information about his being at risk but nevertheless fit for custody, was effectively blank. Mr Bugden in his witness statement and also in his evidence suggested at first that in effect the PD331 had very limited relevance to his task, an assertion that I found to be somewhat at odds with the purpose that the PD331 was intended to serve, namely to provide information to DCS officers about the risk status of a prisoner. Nevertheless, Mr Bugden was to acknowledge in due course what was obvious, namely that the document, or at least the information that should be on it, is of considerable importance for DCS purposes. I understood Mr Bugden to be saying that in reality he makes his own assessment of the prisoner. However, clearly the more information about a prisoner's risk of self-harm the more meaningful Mr Bugden's task would be, especially having regard to the fact that the information Mr Bugden obtained from Mr Gill was purely subjective and any assessment that Mr Bugden would have made is based almost entirely upon the truthfulness and accuracy of Mr Gill's responses to the 31 questions. In the event, Mr Gill was to answer one very important question during the stress screening process in a way that differed markedly from what he was to tell nursing staff only a very short time afterwards. I will return to this in a moment.

2.116. The PSSF was completed by Mr Bugden based as I say upon the answers given to him by Mr Gill²⁶. To begin with, Mr Gill answered only 7 questions affirmatively. He gave affirmative responses to the question whether it was his first time in prison. That was a matter of record anyway. He answered affirmatively as to whether the offence or his imprisonment had caused him a great deal of embarrassment or the loss of family or community respect. He answered affirmatively as to whether he had any family problems. He answered affirmatively as to whether he had been drinking heavily in the previous week. He answered affirmatively as to whether anyone in his family or whether a close friend had ever committed suicide. The answer to this question was couched in terms of 'yes/perhaps'. Mr Gill's recorded answer does not distinguish between yes and perhaps, although Mr Bugden believed that there had been an indication that Mr Gill's brother had committed suicide. This was in fact the case. Be that as it may, no detail was recorded on the form as to the identity of the person involved or the circumstances in which that person had committed suicide or when. Mr Bugden records it by way of a tick that Mr Gill answered in an affirmative way to the question whether he had ever tried to commit suicide or intentionally hurt himself. This particular question is followed by the following '(if yes, ask frequency, recency and reason and record below)'. Towards the foot of the second page of this document is a section in which the officer conceivably could include some comment about the assessment and it seems clear enough that this would be the box in which information about the details of any suicidality in the past could be recorded. In Mr Gill's case nothing was recorded.

2.117. Mr Bugden told me that following his assessment Mr Gill became quite emotional particularly when discussing his family circumstances such that although Mr Gill had not at that stage recorded a score greater than 8 on the PSSF, Mr Bugden nevertheless became reasonably concerned about Mr Gill's frame of mind. This development prompted Mr Bugden to go back to the form and change from negative answers to affirmative answers in respect of the following two questions:

27. Did the prisoner appear to show marked signs of depression?

(eg. where they tearful or emotionally flat?)

28. Did the questioning appear to have a markedly negative emotional effect?

²⁶ Exhibit C39ar, page 32

Affirmative answers to these questions meant that Mr Gill achieved a total of 9 and as a result of this he was therefore considered to be at risk.

- 2.118. On the prisoner interview form²⁷ Mr Bugden has in the warnings section circled affirmative answers as to whether Mr Gill's behaviour may be physically violent and whether Mr Gill's behaviour may be unpredictable. They were observations made by Mr Bugden based upon his overall assessment of Mr Gill.
- 2.119. There is evidence from members of Mr Gill's family that Mr Gill had recently been profoundly depressed and upset about his separation from his children. There is an instance described in one of Mr Gill's father's statements in which his son had suffered some form of stabbing injury to his chest following an incident in the past. He also recalls an incident in which his son had severely injured a hand when he had punched a window or a mirror. The injury had required surgical intervention at the Modbury Hospital. Mr Andrew Gill's brother Mark also refers to these incidents in one of his statements. There is also a suggestion in the statements that Andrew Gill had once tried to take his own life by hanging himself from the manhole in the house occupied by Andrew and his partner. Mr Gill's partner, Karen Smith, in a statement that she gave to the police in June 2005²⁸, records an incident in which, after an argument, Mr Gill had tried to hang himself and was found lying on the floor. He had also tried to stab himself and this had required stitches in the chest. There was also the incident in which Mr Gill had injured his hand. It thus appears that there may well have been a strong element of truth in any response made by Mr Gill to Mr Bugden that Mr Gill had tried to commit suicide or intentionally hurt himself in the past. It would have been a worthwhile exercise for Mr Bugden to have explored that affirmative response. As seen, the PSSF itself commanded the prison officer completing the form to ask the prisoner about the frequency, recency and reason for the attempt at suicide or self-harm. One can readily see why that information would be important to record. Firstly, the frequency, recency and reason would be very relevant to the assessment of the prisoner's risk of self-harm. Secondly, the more detail that is elicited from the prisoner, the more difficult it would be for the prisoner to subsequently deny to someone else a history of self-harm.

²⁷ Exhibit C39ar, page 4

²⁸ Exhibit C39av

2.120. One aspect of the PSSF in respect of Mr Gill is worthy of mention. The following question was put to Mr Gill:

- '7. Are you concerned about losing someone important to you, either through the break-up of a relationship or friendship, or through illness?'

Apparently he answered 'minor worries, or no' because that was the box that was ticked. This answer seems very much at odds with Mr Gill's recent history given the fact that he had been demonstrating a high level of anxiety in relation to his children, especially as he had also verbalised regret at the prospect of not being able to see them again in the light of his incarceration. Both Mr Bugden and Registered Nurse Tracey Sparrow, who was to see Mr Gill after Mr Bugden saw him, both told me that prisoners had a propensity to say one thing to the interviewing officer and something quite different to the nurse who sees them immediately afterwards and that there was no reason to think that Mr Gill would be an exception to this sort of behaviour. What the answer to question 7 tends to demonstrate is the complete subjectivity of this stress screening analysis exercise. The information elicited during such an exercise is only as good as the sincerity of the prisoner and the prisoner's willingness to disclose information about themselves. The stress screening exercise to my mind is a very superficial one and insofar as any significant reliance is placed upon it, it is a poor substitute for the hard information that had been in the possession of police. The information that the police were in possession of was far more telling about Mr Gill's propensities concerning self-harm than any information that a 15 minute conversation could ever elicit. That is why it is so important for DCS staff to be fully informed of a prisoner's recent antecedents and propensities.

2.121. Following Mr Bugden's interview with Mr Gill he was seen by RN Sparrow. Ms Sparrow gave evidence before me. She completed a number of documents as well as adding to, or at least beginning, Mr Gill's Prison Health Services progress sheet. It is recorded that she saw Mr Gill at about 6:40pm on the evening of 30 May 2005. It does not seem likely that Ms Sparrow received a copy of PD331. It does not appear that nursing staff routinely saw this document. However, one would have thought that if a correctly completed PD331 had been sighted by someone in the position of Mr Bugden or by his supervisor upon the prisoner's entry into the institution, any material in the document that was relevant to an assessment of risk of self-harm would routinely be brought to the attention of nursing staff. In any event, again, the

nursing assessment is a reasonably subjective one. In Mr Gill's case this is classically illustrated by the fact that he denied to Ms Sparrow any history of self-harm. Ms Sparrow naturally observed that Mr Gill had apparently said something quite different to Mr Bugden only a few minutes beforehand. She noted this discrepancy on Mr Gill's admission clinical record²⁹. Mr Gill denied any current thoughts of self-harm to RN Sparrow. However, Ms Sparrow observed that Mr Gill's demeanour was one in which he appeared to be flat and slightly depressed and she noted that fact. This presentation raised a level of concern in Ms Sparrow's mind such that she immediately placed Mr Gill upon a 'potential self harm management notification'³⁰. She recorded in that document that Mr Gill had exhibited expressions of hopelessness / helplessness, noticeable behaviour changes and a withdrawal from activities / other prisoners. RN Sparrow described the effect of this document as one that involved a precautionary measure to alert nurses and DCS officers just to keep a watch on the prisoner for 'any potential triggers that may occur'³¹.

- 2.122. In evidence before me Ms Sparrow suggested that from the information she had about Mr Gill, limited as it was to her own assessment and the information that had been gleaned during Mr Bugden's interview, Mr Gill would probably be regarded as within a low category of risk.
- 2.123. Ms Sparrow told me that as far as Mr Gill's current situation that evening was concerned, there were a number of possible options for his processing and in particular his short-term accommodation. Firstly, there was the option that was actually undertaken and that was simply to place him upon a 'potential self harm management notification' and put him in doubled up accommodation. Secondly, he could have been placed on what has been described in the evidence as a 'yellow sheet'. This would have placed him under a regime where he would be mandatorily seen by nursing staff every day with potential self-harm issues in mind. Thirdly, he could have been placed immediately in the infirmary. Fourthly, he could have been sent to Unit 7 which is a high security observation unit within the ARC.
- 2.124. Ms Sparrow told me that if she had been in receipt of the information about Mr Gill that had been noted on the SAPOL Prisoner Custody Disposition form, namely that Mr Gill might be suicidal, it certainly would have alerted her to further issues and she

²⁹ Exhibit C39aq, page 5

³⁰ Exhibit C39aq, page 3

³¹ Transcript, page 649

would possibly have placed him on a yellow sheet or even possibly placed him in the infirmary. As for the diary entries, Ms Sparrow was of the view that they probably would have changed Mr Gill's risk factor rating and again would have prompted his placement onto a yellow sheet. As to whether she would have recommended a placement in a more secure environment, say either the infirmary or Unit 7, Ms Sparrow said that she could have done that. She said:

'I can't say it's a definite thing, I most probably would have, but I would have assessed him at the same time.'³²

Ms Sparrow suggested also that another option would have involved Mr Gill being placed in the infirmary 'on canvas'. This is a reference to the prisoner being issued with a canvas smock and canvas bedding that inhibits an attempt at hanging by the use of bedding or clothing. In such a situation the prisoner would remain in the infirmary for 72+ hours. In cross examination by Ms Davis, counsel assisting, Ms Sparrow conceded that a scenario in which Mr Gill had diarised and carried out his apparent intentions to harm his partner's family and had also diarised an intention to harm himself, would have involved Mr Gill being considered at high risk. In that event, Ms Sparrow said:

'My clinical decision would probably would be to put them in unit 7 on canvas, unit 7 because they had cameras and in the infirmary we did not have cameras at that time. The cells are safer in unit 7. And I believe it's part of our protocol policy to go to unit 7, for high risk clients.'³³

2.125. Of course none of this information was made available to Ms Sparrow. In the event, having regard to the information that she had in respect of Mr Gill and his presentation before her, she summed up her assessment by saying:

'This man presented to me with no medical issues, no psychiatric history, he denied thoughts of self-harm, he denied thoughts of ever hurting himself in the past, it was his first time in prison, he stated that he was going to have a long sentence, he presented to me as a normal prisoner with no issues. What I did was just looked at the risk factors of the fact that it was his first time in prison, a long sentence, so I doubled him up, requested he remain doubled up and commenced him on a potential of self-harm form. At that time I don't believe there is anything else I would have done with the information I had presented to me.'³⁴

³² Transcript, page 655

³³ Transcript, page 673

³⁴ Transcript, page 664

2.126. In the light of that answer it is difficult to be critical of anything Ms Sparrow did. The only matter of concern that perhaps ought to have caused Ms Sparrow to question Mr Gill's presentation was his denial that he had indicated to the interviewing officer that he had attempted self-harm in the past. Ms Sparrow challenged him about that and Mr Gill told her that Mr Bugden must have wrongly recorded what he had told Mr Bugden. This answer could have drawn some scepticism. The difficulty was that Mr Bugden had elicited no detail from Mr Gill about any previous attempts at self-harm and so Ms Sparrow really had no basis upon which she could challenge Mr Gill's denials.

2.127. Ms Sparrow's handling of the matter in my view cannot be faulted. She was given imperfect and incomplete information about Mr Gill. Again, the information that had been in the possession of SAPOL would have been highly relevant to the way she would have approached Mr Gill. It is difficult to determine in hindsight what Ms Sparrow may or may not have done as far as Mr Gill's environment within the institution was concerned had she had the relevant information. All that can be said is that she was deprived of information that was highly material to her decision concerning Mr Gill and his placement. The matter was somewhat academic in any event because Mr Gill was due to be seen by the prison doctor the following morning. As far as the evening of 30 May was concerned, Mr Gill was placed in a situation of doubling up that one supposes might deter a prisoner from committing self-harm in the presence of another prisoner within their cell. I do not think Ms Sparrow can be criticised for not placing Mr Gill on a yellow sheet. The environment that he would have been in for the night of 30 May 2005 would have been the same, yellow sheet or not. In any event Mr Gill did not attempt anything on the night of 30 May 2005.

2.128. Events of 31 May 2005

On the morning of Tuesday, 31 May 2005 Mr Gill was seen by a medical practitioner, Dr Karpinski, and by another nurse, Mr Paul Wilson. Both gentlemen gave evidence before me. The Senior Social Worker at the ARC, Ms Karen Butler, also saw Mr Gill.

2.129. None of these staff members had been furnished with any of the information that had been in the possession of SAPOL, and I speak here of course of the diary entries.

- 2.130. Dr Karpinski's examination of Mr Gill was central to Gill's regime within the institution. Dr Karpinski made notes of his examination in Mr Gill's Prison Health Service progress sheet which had been commenced the evening before by Ms Sparrow.
- 2.131. It was Dr Karpinski who decided to place Mr Gill onto a 'yellow sheet'. Aside from having the effect that Mr Gill would be seen by one of the nursing staff on a daily basis, and assessed for mental state, risk of self-harm and general orientation, appearance and mood, placement on a yellow sheet meant that he would be assessed at the weekly High Risk Assessment Team (HRAT) meeting where his general situation within the prison and his welfare would be discussed at a high level. At that time HRAT meetings occurred on a Thursday. Mr Gill committed the act of self-harm which led to his death on the Wednesday of that week. So it was that Mr Gill never came to be assessed by the HRAT team. However, the placement upon a yellow sheet on the Tuesday morning of that week meant that he was seen again by nursing staff on the Wednesday morning, the day of his fatal plunge from the balcony.
- 2.132. There is little doubt that Dr Karpinski, and indeed Mr Wilson after him, were deprived of highly relevant information that was material to Dr Karpinski's decision as to Mr Gill's appropriate regime within the ARC. Although Dr Karpinski said that he thought that the PD331 had typically been made available to him, the particular PD331 that related to Mr Gill would not have told him very much and indeed, on one assessment at least, could have misled him insofar as the attached letter from the LMH to said that he had been reviewed psychiatrically and that there was no psychiatric reason to preclude his transfer into police custody. In any event, Dr Karpinski's notes on the Prison Health Service progress sheet do not make any reference to the PD331 or anything attached to it.
- 2.133. Dr Karpinski noted that Mr Gill felt depressed and was anxious at times and not sleeping. However, he denied any thoughts of self-harm and said that he would be 'alright' if he were to obtain some medication. There is a note in Dr Karpinski's handwriting that records that Mr Gill was not keen to go to the infirmary. It appears that he said that in the context of his being alright if he was medicated. The plan instigated for Mr Gill included medication and evaluation by a psychiatrist. In addition, he would be reviewed daily by the registered nurse, and to this end was ordered to be placed on the yellow sheet. He was also to be placed in doubled up

accommodation, although there was nothing particularly unusual about this in the context of a newly arrived prisoner. I was told that every newly arrived prisoner was accommodated in Unit 1 and shared a cell with another prisoner.

- 2.134. Dr Karpinski mentioned more than once during the course of his evidence that he had, in general, very little time to assess prisoners. He suggested that if he were to have as little as half an hour with a prisoner he would be able to make a better assessment and would be able to discover much more about a prisoner's presentation medically. That may well be the case, but the difficulty with Dr Karpinski's examination of Mr Gill, and the consequent plan, was that Dr Karpinski was not provided with complete information about Mr Gill, information that had been available to the police and not passed on to DCS. However, Dr Karpinski had some appreciation of Mr Gill's intrinsic risk which he had gleaned from Ms Sparrow's assessment and from the fact that she had issued the potential for self harm notification.
- 2.135. Specifically, Dr Karpinski told me that he was not made aware of any concerns that had been expressed by Mr Gill's family, nor of the fact that Mr Gill's brother had previously committed suicide. I am not certain about this latter piece of information not being available to Dr Karpinski because, as seen earlier, Mr Bugden seems to have been aware of that fact and the PSSF compiled by Mr Bugden contains an affirmative answer to the question as to whether anyone in Mr Gill's family or a close friend had ever committed suicide. Dr Karpinski conceded that there was a '*good possibility*'³⁵ that he had looked at the admission clinical record in which the nurse had indicated that Mr Gill had recorded a score of 9. I have to say that Dr Karpinski was particularly vague about what information he did or did not have in this regard. In any event, Dr Karpinski agreed that if Mr Gill had told him that a brother had committed suicide by hanging himself at the LMH, his assessment of Mr Gill would have been that he should be classified as high risk³⁶.
- 2.136. Dr Karpinski, I found, was a witness who was quite defensive of his position with respect to Mr Gill. He kept stressing that Mr Gill simply presented as a person with depression for which medication, the yellow sheet regime and his seeing a psychiatrist would be sufficient. He stressed that in his mind the totality of the information that had been made available to him '*was not enough to put him at a high risk and make*

³⁵ Transcript, page 144

*an order to lock him in an observation cell*³⁷. To my mind, Dr Karpinski need not have been so defensive. He was acting on false assumptions that were not of his making. Irrespective of whether Dr Karpinski had information about Mr Gill's brother's suicide or not, he certainly did not have any information about Mr Gill's diary entries or any information that Mr Gill had recently said anything that might shed light on his suicidality. In the event, Dr Karpinski assessed Mr Gill as not being at high risk, but '*probably medium or potential risk*'³⁸. He placed Mr Gill on the yellow sheet and referred him to a psychiatrist. However, Mr Gill did not get to see the psychiatrist before he passed away.

2.137. As to the general concerns expressed or entertained by Mr Gill's family, Dr Karpinski told me that they would never ignore information such as that. Dr Karpinski said:

'Yes. I offered him infirmary based on the information I had, but had I had information about the brother's death and concerns from the family, I would have had basically no choice but to place him under observation until he would be assessed by a psychiatrist, I suppose.'³⁹

The same may have applied if concerns had also been expressed by the SAPOL detectives, whom we know did have concerns. Dr Karpinski in this regard added that many years ago there had been much difficulty in obtaining this type of information from the police but that it had improved and that they now receive this information more frequently.

2.138. Dr Karpinski, of course, did not have any information about Mr Gill's diary entries. Moreover, Mr Gill had not been consistent about whether he had self-harmed in the past. He denied having entertained thoughts of self-harm. What information there was about that issue, if it had been made available to Dr Karpinski, would only have emanated from sources external to Mr Gill himself. Dr Karpinski conceded quite readily that he had basically taken Mr Gill's word at face value in respect of any contribution that Mr Gill made to the discussion about risk of self-harm. When Dr Karpinski was specifically questioned about the significance of the diary, he said:

'It would definitely raise my awareness of him possibly being at high risk but we have lots of patients who make threats out of anger or even to manipulate the system.'⁴⁰

³⁷ Transcript, page 153

³⁸ Transcript, page 122

³⁹ Transcript, page 131

⁴⁰ Transcript, page 164

To my mind the assertion that the diary entries would have raised Dr Karpinski's awareness of Mr Gill possibly being at high risk was something of an understatement. There could be no sensible suggestion that the thoughts expressed in Mr Gill's diary had arisen out of a desire on his part to manipulate the custodial system. The overwhelming probability is that the diary entries reflected a state of mind whereby Mr Gill entertained significant thoughts of self-harm. It was inevitable in my view that the information concerning Mr Gill's brother's suicide and the information from the diary entries would have placed Mr Gill at high risk of self-harm and that he would have been classified accordingly.

2.139. If Mr Gill had been classified as being at high risk of self-harm, it is highly unlikely that he would have been placed simply on the yellow sheet regime and sent into the general prison population. I observe here that the existing SA Prison Health Service guidelines relating to 'Prisoners at high risk of self harm'⁴¹ dictated a regime whereby Mr Gill would have been 'in the first instance ... admitted to the appropriate infirmary at the ARC or Yatala so as to manage the ultimate transfer of him/her back into the general prison population'⁴². Dr Karpinski told me that there were options that included placement in the infirmary or in Unit 7 under constant observation. Although Dr Karpinski pointed out that Mr Gill had been offered the infirmary in any event, he had declined. Dr Karpinski told me that it would be unusual for a prisoner to be placed in an infirmary without the prisoner's cooperation, although he did say that an assessment of high risk would have meant that the prisoner would have had no option in this regard. However, if the prisoner was considered to be at high risk and had refused to go to the infirmary, another option, and perhaps the more likely one, would involve placement in Unit 7 under constant observation. Either way, a high risk patient such as Mr Gill would be placed in an environment where he would be unable to have access to the mezzanine floors of general accommodation units. A stay in the infirmary would involve a stay of at least 72 hours duration. That would have taken Mr Gill through to the Friday of that week. This would have meant that Mr Gill would not have been in Unit 1 and would not have had access to the mezzanine floor. A stay in Unit 7 under constant observation would also have meant that Mr Gill would not have had access to anything that could have afforded an opportunity to cause self-harm. Either way, whether he was placed in the infirmary or

⁴¹ Exhibit C114a

⁴² Exhibit C114a, page 4

in an observation cell, he would have remained there until he was seen by a psychiatrist which in the normal course of events would have taken place on the Friday of that week.

- 2.140. In my opinion the information that was in the possession of police, which included the concerns expressed by his family, a sibling's history of suicidality and the diary entries, if they had been made available to the Prison Health Service, would have dictated a much closer regime of observation of Mr Gill. This information would have kept him out of a general accommodation unit for the time being. Whether this would have merely postponed the opportunity for Mr Gill to self-harm is another matter. It may well be that any thoughts of self-harm that Mr Gill had entertained, even from the time that he first wrote the diary entries, may have been present at varying levels of intensity. We do not know whether ultimately Mr Gill would have been admitted to the general population accommodation units within the ARC, even if he had been kept under very close observation for the first few days of his incarceration. However, it seems likely that the opportunity that he had to self-harm which had been afforded to him virtually immediately after his arrival at the ARC would not have been so afforded had his initial assessment by corrections staff and medical personnel been an informed one.
- 2.141. Following Dr Karpinski's assessment of Mr Gill he was seen by Nurse Wilson. Mr Wilson initiated the yellow sheet system in respect of Mr Gill. Mr Wilson's own observations of Mr Gill were to the effect that the latter was flat and dejected, consequent upon his incarceration for the first time and the loss of his children. Mr Gill also denied any thoughts of self-harm to Mr Wilson.
- 2.142. Events of Wednesday, 1 June 2005
As part of Mr Gill's yellow sheet regime he was again seen by nursing staff on the morning of 1 June 2005. This examination is recorded as having taken place at 9:20am. It is recorded by the nurse that Mr Gill appeared very flat and upset. He denied any thoughts of self-harm as he wanted to see his children. That is the extent of the note for that day.
- 2.143. An education officer as well as a social worker, Ms Butler, also saw Mr Gill. Ms Butler had also seen Mr Gill on the previous day.

- 2.144. In the early afternoon Mr Gill was seen by a solicitor, Ms Amy Ward, whose statement verified by affidavit was tendered to the Inquest⁴³. Ms Ward spoke with Mr Gill for about 15 or 20 minutes. She described him as '*looking devastated, subdued and bewildered*'. He appeared to be upset and he actually cried during the consultation. Ms Ward did not perceive that he was at risk to himself. Ms Ward had arranged to meet Mr Gill's parents at her office following her consultation. As it happened, Mr and Mrs Gill saw their son after Ms Ward following which they attended at her city office. In her statement Ms Ward maintains that she has no recollection of Mr Gill's parents saying anything to her about their having any concerns about Mr Gill hurting himself.
- 2.145. Mr and Mrs Gill's visit of their son had commenced at about 3pm. Mr Gill was clearly concerned about his children and said words to the effect that no matter what was to happen, they should find his children and look after them.
- 2.146. At some point during the course of that afternoon, Mr Gill was visited by a post graduate student by the name of Emma Miller whose statement was tendered to the Inquest⁴⁴. Ms Miller was conducting research for a thesis and to this end had been interviewing prisoners at the ARC on a regular basis. She saw Mr Gill in that capacity on the afternoon of 1 June 2005. Mr Gill's demeanour appeared to change throughout the course of her interview. However, he was always cooperative with her. He expressed frustration at not being able to see his girlfriend. He appeared to be very agitated and depressed, and was close to tears. His demeanour continued to change and he ultimately appeared to be at ease, particularly when he agreed to participate in a study that Ms Miller outlined to him. He signed a consent form and completed a questionnaire. At one point Mr Gill spoke about the long period of detention he was facing and joked that he and Ms Miller might therefore be able to '*form a relationship*'. Ms Miller spent about 15 minutes with Mr Gill. Ms Miller did not detect any indication of an intention on Mr Gill's part to harm himself.
- 2.147. Mr Gill had occupied cell 15 of Unit 1. The cell was situated on the mezzanine floor. He had shared the cell with another prisoner the night before, but sometime during the Wednesday a different prisoner by the name of Michael Blocki had been moved into that cell. Mr Blocki gave evidence to the Inquest. During the afternoon he and Mr

⁴³ Exhibit C31 and C31a

⁴⁴ Exhibits C137 and C137a

Gill discussed the circumstances of the offence with which Mr Gill was charged. Mr Gill maintained that he had no recollection of having committed these offences. Mr Blocki did not detect any anxiety about Mr Gill and the latter gave no indication of what was about to happen that afternoon. Following their conversation, which took approximately 40 or 50 minutes, Mr Blocki left the cell as it was getting on towards mealtime. He went to a table on the bottom floor of the unit. Mr Gill had remained in the cell on his own.

2.148. There were a number of prisoners on the ground floor at the time that Mr Gill jumped from the mezzanine floor. It appears that Mr Gill dived headfirst from the rail of the mezzanine floor onto the floor below. Mr Gill was very badly injured.

2.149. A DCS officer by the name of Cosimo Tassone, who gave evidence at the Inquest⁴⁵, was on duty during the afternoon of 1 June 2005. At about 4pm he was sitting upstairs on the mezzanine floor. At that time the lunch trolley came into the unit and Mr Tassone walked downstairs on the eastern side. As he approached the unit 'lock' on the lower floor, he heard a bang as though something had fallen. He had only seen the object through the corner of his eye. Mr Tassone went to the location where Mr Gill had fallen. Mr Tassone was the first correctional officer to arrive at Mr Gill's side. Mr Tassone immediately called a 'code black' which is a call for urgent medical assistance. One of the other officers used his radio also to call a code black. Nursing staff arrived and attended to the situation. Mr Gill was still breathing, but did not appear to be conscious. The South Australian Ambulance Service (SAAS) was called to the scene. Various statements of the nursing staff and of SAAS staff were tendered to the Inquest. There is no issue as to the rapidity at which first aid was brought to Mr Gill. Mr Gill had clearly suffered a very severe injury. His treatment appears to have been appropriate and there is no suggestion that tardiness on the part of nursing or SAAS staff contributed to his death. There was nothing that could be done for Mr Gill medically.

2.150. I heard evidence that prisoners were allowed out of their cells for approximately 7 hours per day. At other periods of time they would be locked in their cells. When not locked in, prisoners could either move about the unit or remain in their unlocked cells. I was told that prisoners frequently remained in their cells during these periods if for no other reason than to seek respite from their cell mates. Mr Gill had been alone in

⁴⁵ Exhibit C133

his cell in the period immediately leading up to his plunge from the mezzanine floor. The cell door would have been open. There was nothing unusual about this. There was some debate during the Inquest as to whether or not in June 2005 prisoners were permitted to loiter on the mezzanine floor, but that is not what Mr Gill did. While Mr Gill was alone in his cell, his cell mate Mr Blocki was downstairs with other inmates awaiting the late afternoon meal. It appears that Mr Gill jumped from the mezzanine floor immediately after he emerged from his cell. He went straight to the balcony and climbed on to the rail and jumped. This would have given corrections officers no warning of this behaviour and no time to intervene. It was not as if Mr Gill had telegraphed his intentions either to prisoners or to corrections staff and there was nothing in his behaviour, such as lingering on the mezzanine floor, that would have alerted anyone to the possibility that Mr Gill might jump. It would have been unrealistic to require a corrections officer to remain at the door of a prisoner's cell. The only method by which Mr Gill's actions could have been stopped would have been if there had been a corrections officer or officers immediately in the vicinity of Mr Gill's cell or in the immediate vicinity of the location from which he jumped. It seems in reality that the only way behaviour like Mr Gill's could have been prevented was if there had been either a very strong presence of corrections staff on the mezzanine floor, or a regime whereby prisoners would be forbidden from occupying the mezzanine floor during periods in which they were allowed out of their cells. Neither strategy seems realistic in my view. There were only three corrections officers on the floor at any given time.

- 2.151. The fact that Mr Gill was on a yellow sheet does not appear to have had any impact on the level of his scrutiny from corrections officers within Unit 1. Unit 1 was the induction unit for the ARC that accommodated newly admitted prisoners. They were meant to remain within the unit on a doubled up basis for at least 7 days. Therefore, all prisoners within the unit were either new or very recent admissions to the institution. There is no evidence that Mr Gill was treated differently from any other prisoner. Although he was on a yellow sheet, Mr Tassone told me that unless a corrections officer examined every file of every prisoner within the unit, one would not know whether a particular prisoner was on a yellow sheet. In any event, whether that is correct or not, there appears to have been no distinguishing, at least by Mr Tassone, between Mr Gill and any other prisoner in terms of risk. In fact, Mr Tassone's belief was that all prisoners were automatically on the yellow sheet for

their first 7 days in the ARC. I am not entirely certain that this is in fact the case. Certainly they are doubled up for 7 days. Mr Tassone was not aware of any instruction to corrections officers to be vigilant against the possibility of prisoners jumping from the balcony. As has been seen earlier, this method of self-harm seems to have been unprecedented. That said, whilst this type of self-harming behaviour may not have been evident in the past, it is not something that was entirely unforeseeable.

- 2.152. It appears that the act of loitering or lingering on the mezzanine floor had been discouraged. However, there was no official recognition of the undesirability of prisoners loitering on the mezzanine floor until a Manager's Memorandum was issued following Mr Schaer's death in December 2005. On 22 December 2005 the General Manager of the ARC, Mr Stephen Raggatt, issued a memorandum that advised that prisoners were not permitted to loiter on the upper level mezzanines within the living units unless they were cooking toast. The permission to cook toast on the mezzanine floor was later withdrawn as the toasters and tables were shifted to the lower floor. The same memo directed control room staff to monitor on an ongoing basis all areas of the prison via CCTV and to advise unit staff if prisoners were observed loitering on the mezzanine levels. This did not alter the entitlement of prisoners to remain within their cells during open periods.
- 2.153. Mr Raggatt gave evidence in the Inquest. He told me that in 2005 there was no generalised scrutiny of people's activities on mezzanine floors. He said that staff would have kept an eye on the unit's prisoners, but that they were very frequently occupied with other duties. Mr Raggatt at first rejected the suggestion that correctional officers would not have known whether an individual prisoner was on a yellow sheet or not. There is in place a system whereby prisoners on yellow sheets have yellow name tags accorded to them and an indication is placed on the door of the cell that they occupy. Mr Raggatt said that even prior to that system being introduced, invariably the case management coordinator maintained a unit count board in the office and if someone was being managed under the HRAT process there would be an indication on the board. However, when it was suggested to him that in mid 2005 a prisoner's status in this regard was not necessarily a matter known to correctional officers, Mr Raggatt stated that he was not sure of the date upon which this new system was introduced. In any event, as I say, the fact that a prisoner was on

a yellow sheet or was subject to HRAT meetings, was not something that necessarily dictated a closer regime scrutiny of the prisoner's behaviour within the unit. I add here that Mr Raggatt could not recall whether between the deaths of Mr Gill and Mr Schaer there had been any direction given to staff that they should be vigilant against the possibility of a prisoner emulating Mr Gill's behaviour.

2.154. Attempts by Mr Gill's family to advise ARC staff as to their concerns

I have already referred to the concerns of Mr Gill's family members in another context, namely the time Mr Gill was at the LMH and in the Elizabeth police station cell complex. There was also the comment made by Mr Gill's brother to police that he would not last two weeks in custody. I do not need to go into the concerns as they were expressed at that time. Suffice it to say the concerns were recorded in the prisoner custody disposition documentation at the Elizabeth cell complex. The difficulty of course was that that was where that information remained.

2.155. There were a number of efforts made by members of Mr Gill's family to acquaint ARC staff with their not unreasonable concerns.

2.156. In the findings in respect of the Inquest of Christopher Mark Bonney⁴⁶, a recommendation was made by the coroner that the DCS should make continuing efforts to educate prisoners and families, friends and associates of prisoners of the urgent need to pass on any concerns about the mental health of a prisoner to the medical or custodial authorities at the relevant prison so that adequate measures can be taken to protect the prisoner from self-harm. There does not appear to have been any formalised structure at the ARC within which the concerns of prisoners' families, friends and associates could be expressed or recorded. While the good sense of the Bonney recommendation could not be denied, in practice, as evidenced by what transpired in Mr Gill's case, any action taken upon concerns expressed by interested associates of a prisoner appears to have been ad hoc. Mr Raggatt, the General Manager, agreed that there had been no system in place at the ARC to record general phone calls that were made by members of the public to correctional officers at the ARC. When asked as to why in May 2005 there was no procedure in place at the ARC that would have enabled concerned family members to formally voice their concerns to DCS staff about a particular prisoner, Mr Raggatt said:

⁴⁶ Inquest 28/1996

'I took over the Adelaide Remand Centre in February 2005 and I really can't answer that. I think it was probably one of those things that was taken for granted that we as correctional staff have a duty of care for the wellbeing of prisoners and that that would be a given. So that's the only comment I could make as to why there wasn't actually a documented process in place.'⁴⁷

2.157. In the Inquest of Damian John Cook⁴⁸, in which the findings were delivered on 27 September 2005, I made a recommendation that the DCS establish a formal procedure that would enable expressions of concern held by family members in respect of a prisoner's safety to be registered and acted upon by ARC staff. It will be seen that this recommendation was made at a time after Mr Gill's death. On 16 February 2006 Mr Raggatt promulgated a Manager's Memorandum⁴⁹ entitled 'Information Received in Relation to Concerns for the Wellbeing of Prisoners'. This document set up a protocol to facilitate the recording of information concerning the wellbeing of prisoners received from concerned persons. The information has to be recorded in the OIC (officer in charge) Journal. Upon the receipt of a call, staff must transfer the call to the OIC or the security coordinator, depending upon the day of the week. The information must then immediately be brought to the attention of the relevant unit manager, the case management officer or the officer in charge who must immediately take the appropriate action to ensure the wellbeing of the prisoner is not compromised, for example, by way of notification to the Prison Medical and High Risk Assessment Team. The memorandum commanded sighting of the OIC Journal and its endorsement by the OIC / Duty Manager confirming that appropriate action had been taken. In addition, a brochure was for the first time placed in the public area of the ARC that advised visitors to immediately notify the prison, by calling the appropriate contact number listed in the brochure, if a visitor entertained concerns about the risk of self-harm in respect of a prisoner. These measures were not in place at the time of Mr Gill's death.

2.158. There was material placed before me to suggest that concerns had been communicated to ARC staff by a number of members of Mr Gill's family during the period in which Mr Gill was accommodated in the ARC. I do not need to go into any great detail about this except to say that the evidence in some instances was by no means clear. In any event, any concerns that were expressed by family members do not appear to

⁴⁷ Transcript, page 1176

⁴⁸ Inquest 18/2005

⁴⁹ Exhibit SAR-05

have made their way to any person who had any ability, or was inclined, to do anything about it. This may have resulted from the lack of any proper structure in which this could reliably be achieved and/or a lack of any effective line of communication that would have ensured that concerns expressed by family members were passed on.

2.159. Similarly, there was an issue in respect of a letter that had been written to Mr Gill by a family member which apparently did not make its way to Mr Gill before he committed the fatal act on Wednesday, 1 June. I do not need to resolve the issue. Suffice it to say it is highly desirable that written communications that might serve to enhance the morale of a prisoner make their way to the prisoner as expeditiously as possible, subject of course to issues of security. This would especially be so in the case of prisoners who have either newly arrived within the institution or are first time prisoners or both.

2.160. Conclusions concerning the death of Andrew Gill

On 29 May 2005 Mr Gill was arrested in respect of an alleged assault committed at Seacombe Heights. The alleged victims were his estranged partner's father, his partner's father's spouse and a visiting overseas student. The arrest was effected at the LMH where Mr Gill was a patient. The Detectives investigating these alleged offences were keen to take Mr Gill into their custody.

2.161. When Mr Gill had arrived at the LMH earlier that morning in the company of his father, he at first appeared to be in a state that was described as a dissociative state. Later, he became agitated and as a result he was sedated. Mr Gill was examined by numerous of nursing and medical staff at the LMH. A conclusion was reached by a psychiatric registrar and a psychiatrist that Mr Gill was not suffering from any psychiatric illness and that he was fit to undergo a police interview and police procedures generally. This was not an unreasonable conclusion. The psychiatric registrar, Dr Shankar, furnished police with a letter that stated that there was no psychiatric reason that precluded Mr Gill's transfer into police custody and that he was fit for police interview and could be submitted to standard police procedures.

2.162. Mr Gill was subsequently released into police custody. He was conveyed to the Elizabeth police station where he was deposited in the cells. Mr Gill's potential for

suicidal behaviour was noted by cell complex staff in a Prisoner Custody Disposition form.

- 2.163. On the afternoon of 29 May 2005 detectives investigating the alleged assaults at Seacombe Heights located a diary that had been compiled by Mr Gill. The diary constituted evidence that Mr Gill had planned the attack upon the occupants of the premises at Seacombe Heights. The contents of the diary were also strongly suggestive of an intention on Mr Gill's part to end his own life once he had carried out the attack at Seacombe Heights. The existence of this diary was brought to the attention of the officer in charge of the Elizabeth cell complex. However, neither the diary nor its significance was documented in the Police Custody Disposition form. No consideration was given to the question as to whether Mr Gill should be medically re-assessed in the light of the discovery of the diary.
- 2.164. On 30 May 2005 Mr Gill was released by police into the custody of Global Solutions Limited (GSL). At that time GSL took possession of the police PD331 and a copy of a letter written by Dr Shankar of the LMH that suggested that Mr Gill was fit for police interview and could undergo police procedures. According to police General Orders, the section of the PD331 entitled 'Information for Prisoner Escort', and in particular that portion of the document that related to a prisoner's risk of self-harm, should have been filled out by police. In Mr Gill's case it was not completed.
- 2.165. Mr Gill appeared before the Elizabeth Magistrates Court on the afternoon of 30 May 2005 and he was remanded in custody.
- 2.166. Members of GSL staff conveyed Mr Gill to the Adelaide Remand Centre (ARC). The incomplete PD331 and the letter from Dr Shankar were handed over to ARC staff.
- 2.167. The only information contained within the PD331 concerning Mr Gill's risk status was an affirmative answer within the 'Arresting Member's Questionnaire' to the effect that the prisoner had given an indication that he might be a person at risk. There was a further very brief notation that Mr Gill had been assessed at the LMH and was fit for custody. Other than that, police had failed to provide DCS with any meaningful information about the perceived propensity on Mr Gill's part to commit suicide or self-harm. This failure was a significant departure from proper police practice and was also a contravention of police General Orders. The failure to

provide GSL, and through GSL the Department for Correctional Services, was an entrenched practice among SAPOL staff at the Elizabeth Police Station cell complex.

- 2.168. Upon being assessed by ARC corrections staff, and by clinicians within the Prison Health Service, Mr Gill was placed on a yellow sheet regime which meant that he would have been seen by nursing staff on a daily basis. He was, however, immediately placed within the general prison population and in particular into Unit 1 where there was a mezzanine floor. Mr Gill's cell was on the mezzanine floor.
- 2.169. I find that had ARC staff, and in particular members of the Prison Health Service staff, been made aware of the information concerning Mr Gill's potential for self-harm that had been in the possession of the police, namely the concerns that had been expressed by his family and especially the entries in Mr Gill's diary, Mr Gill would have been considered at high risk of self-harm and therefore not been accommodated in the general prison population and in particular in Unit 1.
- 2.170. On Wednesday, 1 June 2005 Mr Gill jumped head first from the balcony railing of the mezzanine floor of Unit 1. This resulted in Mr Gill sustaining mortal head injuries from which he died the following day. He gave no warning of this behaviour either to correctional officers responsible for his security nor to members of the Prison Health Service.
- 2.171. Had Mr Gill's potential for self-harm been assessed having regard to the information that was in the possession of police to which I have already referred, it is highly unlikely that he would have been accommodated in Unit 1 as at Wednesday, 1 June 2005. It is more likely than not that he would have been either accommodated in the infirmary or in Unit 7 which is a high security unit. If he had been accommodated in the infirmary or in Unit 7, it is highly unlikely that he would have had a similar opportunity to commit self-harm. Certainly, he would not have had access to any location such as the balcony of a mezzanine floor.
- 2.172. Given the serious nature of the charges that had been laid against Mr Gill, police must have realised that it was inevitable that he would be remanded in custody to the ARC. In my opinion Mr Gill's death could have been avoided if relevant information about Mr Gill's potential for self-harm that had been in the possession of SAPOL had been made available to ARC staff. I therefore find that there is a causative connection

between the failure of police to furnish ARC staff with that information and Mr Gill's death.

- 2.173. There is no suggestion other than that the first aid that was provided to Mr Gill after he had suffered his serious head injury and the medical attention that he was provided with at the Royal Adelaide Hospital was anything other than appropriate.

3. The death of Simon Schaer

3.1. Introduction and background

On Wednesday, 17 November 2004 Simon Schaer, at that time aged 69 years, fatally shot his estranged wife in the Myer store in Rundle Mall, Adelaide where she worked as a sales assistant. On the same day the police took him into custody. Mr Schaer went to Court and was remanded in custody. Mr Schaer remained in custody until the date of his death over a year later on Thursday, 15 December 2005. He was at all material times held in custody at the Adelaide Remand Centre (ARC).

- 3.2. On 21 October 2005 Mr Schaer pleaded guilty in the Adelaide Magistrates Court to the murder of his wife. He was remanded to the Supreme Court for sentencing. Up to that point Mr Schaer appears to have been represented by counsel from the Legal Services Commission.

- 3.3. However, upon Mr Schaer's first appearance before Justice Vanstone in the Supreme Court on 21 November 2005, his counsel informed Her Honour that his instructions had been terminated and he successfully applied for leave to withdraw from the case. The effect of this was that from that point forward Mr Schaer was unrepresented. This state of affairs appears to have arisen at Mr Schaer's own election. Mr Schaer acted on his own behalf throughout the rest of November 2005 and indeed up to and including Mr Schaer's last appearance before the Supreme Court on 8 December 2005.

- 3.4. Mr Schaer appeared before the Supreme Court as I have already indicated on 21 November 2005 and again on 8 December 2005 and was next due to appear on 16 December 2005. However, Mr Schaer took his own life on 15 December 2005.

- 3.5. In Mr Schaer's appearances before the Supreme Court on the dates that I have mentioned he maintained his pleas of guilty to his wife's murder. Of course, a

sentence of life imprisonment was mandatory but the length of Mr Schaer's non-parole period was at issue. Given the gravity of his crime and having regard to his age, Mr Schaer could well have entertained the not unreasonable expectation that he would eventually die in prison. Following Mr Schaer's counsel's withdrawal from the case, on 21 November 2005 Justice Vanstone indicated that she was inclined to seek a psychiatric report in relation to Mr Schaer. It is fair to say that the deceased was unenthusiastic about that idea, but he nevertheless told Her Honour that he would cooperate with the psychiatrist. The matter was adjourned until 8 December 2005.

- 3.6. On 8 December 2005 Mr Schaer, who spoke on his own behalf, provided Justice Vanstone with a lengthy discourse of the history of his marriage and of the circumstances leading up to his actions in respect of his estranged wife in November 2004. It seems reasonably clear from the transcript of these proceedings, which forms part of Exhibit C88w, that Mr Schaer was lucid during this court appearance. Mr Schaer continued to express a lack of enthusiasm about any manoeuvre that might bring into question his mental competence. He endeavoured to make it clear that he was sane and that his actions towards his wife had been those of a sound mind. He told Justice Vanstone on that occasion:

'I certainly don't want somebody saying that I'm insane. I'm not insane, I am a sane person.'⁵⁰

Mr Schaer indicated to Her Honour that he wanted to withdraw from any psychiatric assessment so that he could '*get on with my life*'⁵¹. He also indicated that as far as he was concerned he was in a far worse position being alive than dead. On the other hand, he told Her Honour that he was studying trigonometry and geometry at that time and wanted to get on with his life. I pause here to observe that it is evident from the papers that were tendered to me during the Inquest, and in particular from statements of other prisoners, that within the ARC Mr Schaer had intimated that he was concerned about spending the rest of his life in a psychiatric institution and being medicated for a psychiatric disorder. He appears to have mentioned this more than once and to more than one person. He raised the subject with visitors on the very day of his death. The deceased was further remanded to 16 December 2005. It seems unlikely that Mr Schaer would have been sentenced at that next appearance because

⁵⁰ Exhibit C88w, page 27

⁵¹ Exhibit C88w, page 28

the question as to whether or not Mr Schaer would be psychiatrically evaluated had not been fully resolved.

- 3.7. Mr Schaer committed suicide by jumping head first from the mezzanine floor of Unit 3 at the ARC on the morning of 15 December 2005, the day before he was due to next appear in the Supreme Court.
- 3.8. Mr Schaer's attitudes and demeanour during the course of his remand in custody
Mr Schaer was inducted at the ARC on 18 November 2004. On 19 November 2004 it is recorded that Mr Schaer was assessed by a doctor and placed onto canvas in an observation cell within the infirmary due to threats of self-harm. I am not entirely certain as to the length of time that he spent in that environment, but it is clear that in due course he was placed among the general population at the ARC and that in any event by 29 November 2004 when he was psychologically evaluated, he was noted to be coping well and was 'future oriented'. He was said to be eating and sleeping well and had some plans for future education. He was interacting satisfactorily with other prisoners and indicated that he had the support of friends.
- 3.9. Entries in his casenotes over the ensuing period appear for the most part to be unremarkable. However, on 27 July 2005 it is recorded that at the morning un-lock Mr Schaer was discovered by unit staff still to be lying on his bunk and that when an attempt was made to rouse him, he was found to be disoriented and his speech was slurred. It appears that he had taken an excessive quantity of Panadeine Forte. As a result of this, an ambulance was called and Mr Schaer was taken to the Royal Adelaide Hospital for treatment. It is not entirely clear whether or not this was an attempt at self-harm. On 28 July 2005 Mr Schaer was readmitted to the ARC from the Royal Adelaide Hospital and was placed in the infirmary under observation. He was also subsequently placed on a yellow sheet. A HRAT meeting was held on 1 August 2005 and Mr Schaer's situation was discussed. On 2 August 2005 Mr Schaer was cleared by a psychiatrist to leave the infirmary. He was taken off the yellow sheet on the same day. On 3 August 2005 a senior correctional services officer spoke to Mr Schaer. On that occasion he explained that he suffered from severe migraines and indicated that he had taken the excessive medication over a period of several hours in an attempt to quell a migraine. He indicated to the officer that he had a positive outlook even though he was resigned to the fact that he would be remaining in custody.

- 3.10. On 12 August 2005 Mr Schaer was admitted into Unit 3 and placed in a single cell. He was to remain in this accommodation until the date of his death.
- 3.11. On 10 November 2005, which was exactly a week prior to the anniversary of Mr Schaer's wife's murder, the detective investigating that murder, Senior Constable Bradley Molony of Adelaide CIB, personally contacted ARC staff both by phone and by email and expressed a concern that Mr Schaer was at risk of self-harm because of the imminent anniversary to which I have referred. Of concern to Senior Constable Molony was the fact that it had become apparent by then that Mr Schaer had dismissed his lawyer. Senior Constable Molony's concerns are encapsulated in the email that he sent to Ms Karen Butler, Social Worker at the ARC, when he wrote:

'Considering what has occurred I am a little concerned that it may be an indication that SCHAER may self-harm with everything coming to a head and his fall out with Kelly. I have nothing else to substantiate these concerns but thought you should be aware.' (Kelly is a reference to Mr Schaer's legal counsel) ⁵²

These concerns were recorded in Mr Schaer's casenotes and it appears that the email was forwarded to the General Manager and to a number of other persons in authority at the ARC. On the other hand, it does not appear to have been drawn to the attention of the Prison Health Service. However, one result of the email appears to be that at the HRAT meeting of the same day Mr Schaer was added to the list, although not put on a yellow sheet. The opinion expressed at the meeting was that Mr Schaer did not present as a risk of self-harm but that staff would monitor and report any concerns to the CMC/Unit Manager. Senior Constable Molony's responsible actions in bringing to the attention of the ARC personnel his concerns about Mr Schaer starkly contrast with the failure of police to express their concerns about Mr Gill in similar circumstances, and this is especially so given that the concerns about Mr Gill had a sounder basis in fact.

- 3.12. In the event, the anniversary of Mr Schaer's wife's murder passed without incident. In fact on that day, 17 November 2005, a contact discussion was conducted with Mr Schaer and it is recorded that he identified no issues at that time. However, due to the concerns that had been expressed in connection with the anniversary of his offence, on 22 November 2005 a HRAT meeting decided that Mr Schaer would remain on the HRAT list although not on a yellow sheet.

⁵² Exhibit C109b

- 3.13. On 24 November 2005 correctional officers reported that they had observed Mr Schaer shaking hands with several prisoners. A Mr Rowell spoke with Mr Schaer about this. Mr Schaer said that he was in the habit of doing this with those he associated with in the unit. As a precautionary measure, medical staff assessed Mr Schaer. It is reported that staff had no concerns with Mr Schaer at that time and he was returned to Unit 3. It is recorded 'Schaer does not appear to display any indications of self-harm at this time'. One interpretation of his behaviour that has been suggested is that Mr Schaer was farewelling his fellow inmates prior to taking his own life. That seems to be a long bow to draw even in hindsight. It is some weeks prior to the day of his death and it appears from other evidence that he would quite frequently acknowledge his fellow inmates with a handshake. He was evidently a universally liked inmate.
- 3.14. On 29 November 2005 Mr Schaer was taken off the HRAT list as he had displayed no signs of distress or self-harm.
- 3.15. On 2 December 2005 again there were no obvious signs of distress. Observations recorded on 5 December 2005 are along similar lines.
- 3.16. By 15 December 2005 it appears that Mr Schaer was neither on the HRAT list nor on a yellow sheet which meant that there was, in terms of his scrutiny, no reason to distinguish him from any other member of the ARC population.
- 3.17. In the period leading up to 15 December 2005 there was nothing particularly alarming about Mr Schaer's behaviour or his outward frame of mind. It is difficult to envisage what Correctional Services or Prison Health Services staff could or should have done in response to Senior Constable Molony's observations regarding the anniversary of Mr Schaer's wife's murder and its possible sequelae. I make that observation bearing in mind that the anniversary had well passed by 15 December 2005. For the most part, the statements taken from fellow inmates from Unit 3 demonstrate that there was nothing untoward about Mr Schaer's behaviour or state of mind in the period leading up to 15 December 2005, although he had vouchsafed to some that he was very concerned about the possibility that he might spend his remaining days in a psychiatric institution.

3.18. The events of 15 December 2005

Mr Schaer received visitors on the morning of the day of his death. They were a Mr and Mrs Tonkin who had been friends with Mr Schaer and Mr Schaer's wife for several years. It is quite evident from their statements⁵³ that they knew Mr Schaer very well and were quite familiar with Mr Schaer's marital history and its difficulties. Although Mr and Mrs Tonkin were given no inkling as to what was going to transpire later that morning, it seems clear from both their statements that Mr Schaer's demeanour and conversation suggested that he was at a very low ebb. I should point out here that this was the first time that Mrs Tonkin had seen Mr Schaer since he had been taken into custody more than a year before. Both Mr and Mrs Tonkin make the observation that Mr Schaer vigorously eschewed the suggestion that he be treated as criminally insane. He also expressed a fear of spending the rest of his life in a mental institution. This visit lasted about 40 minutes and at no time did Mr Schaer give any positive indication that he intended to end his own life. That said, he described his own current existence in quite negative terms and his future in even more negative terms. Neither Mr Tonkin nor his wife spoke to correctional services officers about any concerns they may have entertained in respect of Mr Schaer. It is fair to say that they did not entertain a specific concern of Mr Schaer ending his own life.

3.19. In their respective witness statements, some of Mr Schaer's fellow inmates have referred to Mr Schaer's mood that morning as being nothing out of the ordinary. He had expressed regret to a Mr Pope about recent negative publicity about himself⁵⁴. A Mr Franco claims that he had been concerned that Mr Schaer might '*attempt something*' as he had expressed some anxiety to him about being sent to a psychiatric institution and being medicated⁵⁵. Mr Franco suggests that in the days prior to his death Mr Schaer's mood had become quieter. On the morning of his death, Mr Schaer had failed to greet Mr Franco in the usual way. Mr Franco does not claim to have passed on any concerns to correctional services officers. I do not make that observation critically. Another fellow inmate, Mr Osmond, who coincidentally had at one time lived across the road from Mr Schaer, observes that on the day before his death, Mr Schaer had told him that he had been concerned about ending up in James Nash House under strong medication. He told Osmond that this had been the reason why he had stressed to the Court that he had known what he was doing when he had

⁵³ Exhibit C81a and C82a

⁵⁴ Exhibit C94b

⁵⁵ Exhibit C103a

shot his wife⁵⁶. On the morning of Mr Schaer's death, Mr Osmond had been greeted by Mr Schaer on several occasions which Mr Osmond thinks in hindsight may have been slightly out of the ordinary. However, about 40 minutes before Mr Schaer took the fatal plunge in Unit 3, he had approached Mr Osmond and had hugged him, had patted him on the back and had urged him to look after Mr Osmond's mother upon Mr Osmond's possible imminent release. Again, Mr Osmond can only view the matter with hindsight. It does not appear that he drew any of this behaviour to the attention of correctional services officers. Again, I do not make that observation critically.

- 3.20. There is nothing in the evidence to suggest that Mr Schaer exhibited any unusual behaviour to correctional services officers within Unit 3 on the morning of his death. As seen earlier in these findings, the evidence suggested that after Mr Gill's death there had been no direction to staff to more closely scrutinise the behaviour of prisoners in units that possessed a mezzanine floor. One thing that was slightly out of the ordinary was the fact that Mr Schaer was undertaking some cleaning work on the mezzanine floor which he had not been rostered to do. He was to use this as an opportunity to jump from that mezzanine floor.
- 3.21. The fatal incident occurred at about 10:50am on 15 December 2005. An inmate by the name of Mr Varney says that Mr Schaer had been mopping the floor on the mezzanine⁵⁷. At one point Mr Schaer asked Mr Varney to help him move the Unit's toaster table to a position close to the balcony rail. Mr Varney, of course, had no idea what Mr Schaer's intention was. Shortly after the table was moved, Mr Schaer climbed onto it and then used it to climb onto the balcony rail from where he jumped. The height of the rail was 3.88 metres from the floor below.
- 3.22. Mr Schaer's fall was witnessed by any number of inmates who were on the floor below. I do not need to discuss the finer detail of their observations. It is quite apparent, however, that Mr Schaer was mortally injured as a result of the impact with the ground, particularly as a consequence of impact with his head. Inmates and correctional services officers went to his aid. An ambulance was called. It is clear from the evidence that Mr Schaer had suffered a fatal injury and that he died very quickly and in any event at a time before any nursing or medical assistance could

⁵⁶ Exhibit C107a

⁵⁷ Exhibit C92b

reasonably be brought to bear. There was really nothing that could be done for Mr Schaer in the light of his very serious head injury.

- 3.23. A post-mortem examination conducted by Dr Alan Cala revealed that Mr Schaer's cause of death was as a result of closed head injury. I so find.
- 3.24. The balcony from which Mr Schaer jumped was almost identical to that in the Unit in which Mr Gill had been housed. A head first contact with the floor below in each instance had resulted in a fatal injury to both men.

4. Recommendations

- 4.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 4.2. Although the two deaths with which this Inquest was concerned are the only known deaths that have involved deliberate falls from a height within a custodial institution, there is no reason to suppose that at some point in time this behaviour will not be repeated. So long as there is a mezzanine floor with a balcony rail that can be mounted, there is potential for an act of self-harm to be committed by its use. Certainly, no modification to the configuration of the mezzanine floors has taken place since Mr Schaer's death. Mr Raggatt told me in evidence that a proposal had been made that the mezzanine floors be enclosed by the extension of the balcony rails to the ceiling. As well, the proposal included extending the hand rails of the staircases to the ceiling. This would mean that the mezzanine floor and the staircases thereto would be surrounded by bars from the floor of the mezzanine to the ceiling. Other possible alternatives included enclosing the mezzanine floors with transparent perspex. This was rejected because it would probably interfere with the air-conditioning, whereas bars would allow appropriate ventilation. Mr Raggatt told me that the enclosing of the mezzanine floor by bars was estimated to cost in excess of \$370,000 which Mr Raggatt regarded as reasonable. From a personal point of view, Mr Raggatt was very unenthusiastic about enclosing the mezzanine floors with bars because it would heighten the already oppressive atmosphere of the accommodation units. He told me that as far as is possible attempts were made to keep the environment of a remand prisoner as least oppressive as possible. One has to wonder

about that observation. Having inspected the accommodation units at the ARC in the course of this Inquest it is difficult to escape the conclusion that they already have a punitive air about them. Prisoners are locked in their cells for 17 hours of the day. Within Unit 1 there are two prisoners to a cell and there is only one exposed toilet within the cell. For the most part, cell mates are, at least to begin with, complete strangers. It seems to me that in any balancing exercise which involves a consideration of the safety of prisoners on the one hand and preserving a habitable environment on the other, the balance falls firmly in favour of the former. I did not understand Mr Raggatt to disagree with that proposition⁵⁸.

4.3. Mr Raggatt told me that a submission had been forwarded seeking funding for the erection of bars on the mezzanine floors of the ARC and, as at the time of the Inquest, he had not received a response. Mr Raggatt tended to the view that the lack of response could be taken as a negative. The risk of a prisoner emulating Mr Gill's and Mr Schaer's behaviour is still there. Although some time has passed since Mr Schaer's actions, the potential for a person to jump from a mezzanine floor still exists. I intend to recommend that the mezzanine floors be enclosed.

4.4. In his evidence before me Mr Dalton of GSL expressed a belief that the Justice Information System (JIS), as it existed in May/June 2005, would have enabled DCS staff to access information that had been placed on it by SAPOL, and in particular information about persons in custody including their perceived risk of self-harm. I am satisfied that that was not the case as at May/June 2005. Mr Raggatt told me, and I accept his evidence, that none of the participating agencies in JIS have access to any information posted onto it by other participating agencies. He was asked this question:

'Q. So is each of those departments that have sections applicable to them within the system, able to enquire as to the information contained on the other. Example, can Correctional Services access the JIS system relating to SAPOL.

A. No they can't.'⁵⁹

⁵⁸ Transcript, page 1191

⁵⁹ Transcript, page 1117

As far as Mr Raggatt was aware, there was no overarching entity that had access to information posted by all participating agencies. Mr Raggatt said:

'At the time of both of these deaths, there were no systems in place to exchange information between the agencies.'⁶⁰

- 4.5. Mr Raggatt advised me that within the previous two to three weeks before he gave evidence to the Inquest he had been made aware of an ability on the part of SAPOL now to electronically post a warning that would also be input into DCS systems. However, it appeared to me that Mr Raggatt had only a fairly sketchy appreciation of what that was about.
- 4.6. It is somewhat surprising with all of the technological aids that are now available that there is no centralised electronic database in which warnings that are posted by one custodial institution about persons in their custody could not be accessed by another custodial institution. For example, if there was an electronic system in place in which police could input information about a prisoner's risk of self-harm and which could be accessed by DCS upon the admission of that prisoner to one of their institutions, deaths such as Mr Gill's could possibly be avoided. No-one suggested to me that such a system was not feasible. I shall make a recommendation about the use of technology in this regard.
- 4.7. Mr Illingworth for the Commissioner of Police spoke of a revised system within SAPOL in which better avenues for the communication of information between SAPOL and DCS could be established. Senior Sergeant Thomas Nyenhuis told the Inquest that as a result of recent Inquests, including that of Colin Sansbury⁶¹, SAPOL had conducted a custodial management project under the direction of an Assistant Commissioner. As a result of that project, documentation associated with the custody of prisoners within the police custodial system had been completely revamped, including the PD331. I was provided with some detail about that new system but of course I have not seen it in operation. Clearly police procedures concerning custodial management of prisoners in SAPOL custody need to be revised. This new measure is to be applauded, but it would still not mitigate the egregiousness of the flouting of what were, at the time of Mr Gill's death, clear General Order requirements. Be that

⁶⁰ Transcript, page 1118

⁶¹ Inquest 10/2007

as it may, it is refreshing to hear that the police intend to tighten procedures as far as the flow of information between police and other custodial institutions is concerned.

4.8. In my view, the importance of a proper flow of information between custodial institutions cannot be understated. This was recognised in the Royal Commission into Aboriginal Deaths in Custody. I have already referred to the relevant recommendation. Mr Raggatt for his part said that he could not think of any sensible objection to the formation of a working group to examine and improve current practices relating to the transfer of information from one custodial entity to another. Mr Illingworth for the Commissioner of Police supported the establishment of such a group.

4.9. With all of that in mind I **recommend** the following:

- 1) That the Commissioner of Police, the Chief Executive of the Department for Correctional Services, the General Manager of the Adelaide Remand Centre, the relevant Officer of GSL, the State Courts Administrator for the Courts Administration Authority, the Chief Executive of the Department of Health, the senior officer of the Prison Health Service and a relevant person from the Aboriginal community establish and maintain on an ongoing basis a working group to consider, establish and invigilate the operation of procedures that are designed to ensure the transfer of relevant information between one custodial entity and another custodial entity concerning the risk of self-harm relating to a prisoner, and that the working group regularly review such procedures.
- 2) That the Commissioner of Police, the Chief Executive of the Department for Correctional Services, the General Manager of the Adelaide Remand Centre, the relevant Officer of GSL, the State Courts Administrator for the Courts Administration Authority, the Chief Executive of the Department of Health and the senior officer of the Prison Health Service give consideration to the establishment, either through the Justice Information System or some other electronic medium, of a means by which information concerning the risk of self-harm of a prisoner that is posted by one custodial entity can be immediately accessed by another custodial entity.

- 3) That the Chief Executive of the Department for Correctional Services and the General Manager of the Adelaide Remand Centre continue to develop and improve formal procedures through which expressions of concern for the welfare of prisoners that are entertained and voiced by the families, friends and associates of those prisoners, are registered, properly acknowledged and acted upon by ARC corrections staff and Prison Health Service staff.
- 4) That the Commissioner of Police remind members of SAPOL of the mandatory nature of General Orders and of the consequences of departure therefrom.
- 5) That the Commissioner of Police ensure that all police officers who are engaged in maintaining the custody of prisoners are made aware of the need to continually monitor and document any evidence that is relevant to a prisoner's risk of self-harm.
- 6) That the Commissioner of Police remind officers engaged in the maintaining of persons in custody to be vigilant to the possible need for prisoners to be psychiatrically or medically examined whilst in police custody if the circumstances require it.
- 7) That the Chief Executive of the Department for Correctional Services and the General Manager of the Adelaide Remand Centre take the necessary steps to enclose the mezzanine floors and staircases in the accommodation units of the Adelaide Remand Centre with bars to the ceiling.
- 8) That the Chief Executive of the Department for Correctional Services and the General Manager of the Adelaide Remand Centre apply to the South Australian Government for the necessary funding to enclose the mezzanine floors and staircases in the accommodation units of the Adelaide Remand Centre with bars to the ceiling.
- 9) That the Chief Executive of the Department for Correctional Services and the General Manager of the Adelaide Remand Centre take the necessary steps to ensure that medical practitioners who are employed within the Adelaide Remand Centre to examine newly admitted prisoners are afforded more time in which to examine those prisoners.

- 10) That the Chief Executive of the Department for Correctional Services and the General Manager of the Adelaide Remand Centre take the necessary steps to ensure that social workers who are employed within the Adelaide Remand Centre to examine newly admitted prisoners are afforded more time in which to interview those prisoners.

Key Words: Death in Custody; Suicide; Suicide Risk - Assessment Of; Monitoring /Observation of Prisoners; Prison Medical Service; Screening Procedures

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

Seal the 28th day of November, 2008.

Deputy State Coroner