



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 30th day of April 2008, the 2nd and 6th days of May 2008, the 25th day of June 2008, the 15th day of July 2008, the 15th day of August 2008, the 30th and 31st days of October 2008 and the 18th day of March 2009, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Ricky Glen Cox.

The said Court finds that Ricky Glen Cox aged 17 years, late of Cavan Training Centre, Cavan, South Australia died at the Queen Elizabeth Hospital, 28 Woodville Road, Woodville, South Australia on the 24th day of February 2006 as a result of refractory status epilepticus caused by either a viral infection, an underlying epileptic condition or a combination of a viral infection and an underlying epileptic condition. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Ricky Glen Cox was born on 4 July 1988. He died at 10:15am on Friday, 24 February 2006 at The Queen Elizabeth Hospital. At the time of his death he was subject to a sentence of imprisonment which had been served at the Cavan Training Centre until he became ill in early February 2006. Accordingly, Ricky's death was a death in custody within the meaning of the Coroner's Act 2003, and this Inquest was held as required by section 21 of that Act.

2. Background

- 2.1. Ricky was an Aboriginal person who had enjoyed good health prior to February 2006. Ricky's mother, Wanda Cox, was represented by Mr Charles at this Inquest. Mr Charles asked on behalf of Mrs Cox and Ricky's sister that I privately view a piece of artwork which had been created by Ricky during his time at Cavan Training Centre. There was no objection from any other party to me doing so and I viewed the painting in private with Mr Charles, counsel assisting me Dr Gray, Mrs Cox and Ricky's sister. The painting was very beautiful and showed that Ricky was a talented young artist. His mother was justly proud of this precious memento of Ricky's life, and I have no doubt she will rightly treasure it for as long as she lives. The painting was a forceful reminder that Ricky was a person who had things to look forward to in life. It is tragic that he died at such a young age.

3. Events immediately preceding Ricky's admission to The Queen Elizabeth Hospital

- 3.1. Ricky commenced a period of six-month's detention for criminal offences on Monday, 21 November 2005. This was to be served at the Cavan Secure Centre, a juvenile detention facility. Ricky had been in juvenile detention since 23 March 2005 following his arrest.
- 3.2. On 24 January 2006, while Ricky was a resident in Room 8 of Unit Alpha at the Centre, he saw general practitioner Dr Mark Fuller regarding an abscess on his left shoulder. Dr Fuller prescribed dicloxacillin and Nurse Waterhouse¹ dressed the abscess later that day. The antibiotics were commenced on 25 January 2006. Ricky's Child and Youth Health medical history form recorded no allergies or active medical problems. Under the topic of 'family medical history' it was recorded that Ricky's maternal aunt had diabetes and his maternal grandfather had had a stroke.
- 3.3. With the exception of 26 January 2006, Ricky was issued the prescribed antibiotics until 1 February 2006. On that date Ricky was issued two Panadol tablets because of a complaint of headache.

¹ Nurse Waterhouse was a staff nurse at Cavan Training Centre

- 3.4. On 2 February 2006 Ricky reported feeling ill and went to see Cavan Secure Care Centre nurse, Janine Cameron. Nurse Cameron's notes record:

'Ricky feeling unwell this morning. Complaining of being tired, slight headache, shivery, temp checked – 39.4.'

Ricky was advised to rest in bed with increased fluids and Panadol as required.

- 3.5. Later that afternoon Ricky's temperature was taken again and it was noted to be 38.7°C. Nurse Cameron determined that Ricky should continue to rest in bed with fluids and paracetamol with a review in the morning.
- 3.6. At about 7:30am on 3 February 2006 Ricky complained to Nurse Cameron that he still felt unwell. At about 8am he was issued two Panadol and given breakfast in bed. At about 9:25am Ricky appeared to be asleep in his room. Staff held concerns for his condition but neither Ms Cameron nor Dr Fuller were present. Arrangements were made for Ricky to be escorted to Lyell McEwin Hospital by staff.
- 3.7. The Lyell McEwin Hospital records disclose that Ricky arrived in the Emergency Department shortly after 11am. Dr Herman Chua assessed him. Dr Chua's notes refer to an impression of 'no disease' and the plan included 'reassurance' and maintaining fluid intake. The discharge arrangements were for the general practitioner to review Ricky. A discharge letter written by Dr Chua gave a diagnosis of 'dizziness or giddiness - misc social and other'. The letter said that if there were any further concerns then baseline bloods should be organised.
- 3.8. Ricky arrived back at Cavan Training Centre at about 1:15pm that day. Nurse Cameron read Dr Chua's discharge letter. Shortly afterwards she visited Ricky and noted that he did not have an increased temperature at that time. She left medical instructions in the routine log for Ricky to be observed and to have his temperature taken if there was concern. He was to rest and keep his fluids up. Panadol should be offered if his temperature increased above 37.5°C.
- 3.9. On 4 February 2006 the staff noted that Ricky appeared to be better. Staff member Ms Marion Cameron² said that Ricky had more energy and that he interacted with other residents and did chores including cleaning his room.

² Not to be confused with Nurse Cameron

- 3.10. At about 7:30am on Monday, 6 February 2006 Ricky and other residents were awoken in accordance with unit procedures. Ms Cameron observed that Ricky appeared to have wet his bed and asked another staff member to take him some fresh sheets. Ricky rose from his bed and changed his linen. He did some chores and then joined other residents for breakfast. Nurse Cameron checked on Ricky and he indicated to her that he wanted to go to the learning centre but that he still felt unwell.
- 3.11. In the event, it was decided that Ricky should remain at the residential unit. The other residents attended the learning centre. A staff member remained with Ricky at the unit.
- 3.12. At approximately 10:20am the other residents and staff returned to the unit for morning tea. Ricky remained in his room. At about 10:45am staff and the other residents returned to the learning centre. At approximately 10:55am Ms Cameron returned to the unit to monitor Ricky. She saw that Ricky was lying on the floor beside his bed with a blanket over him and his eyes shut. She entered the room to check on him and in response to her inquiry, Ricky moaned. She felt his shoulder, which she observed to be wet and hot.
- 3.13. At approximately 11am Ms Cameron contacted the nurse (Nurse Cameron) and informed her of Ricky's condition. Nurse Cameron was about to go and see Ricky when she was called to a medical emergency at the learning centre involving another resident who had sliced the end of his finger.
- 3.14. In the meantime, Ms Cameron attempted to take Ricky's temperature but this was made difficult by Ricky moving his head from side to side and clenching and then opening his teeth. It was observed that he had a slight cough and was not speaking. He was moaning and groaning. He got up from the floor, turned off his television, and then lay back on his bed with his blanket.
- 3.15. When other staff attended at the unit at about 11:30am, they were able to take Ricky's temperature and this was found to be in the normal range. He was also able to verbally communicate. At approximately 11:40am Nurse Cameron attended at Unit Alpha. She noted that although Ricky's temperature was normal, he was generally unwell and his skin and the soles of his feet had a jaundiced appearance. Her notes also refer to the fact that he had woken up from dozing with fresh blood spots on the pillow after coughing. Following her assessment Nurse Cameron determined that

Ricky required further examination in a hospital. She prepared a letter to accompany him to the Emergency Department of the Lyell McEwin Hospital.

- 3.16. At approximately 12:30pm staff member Ms Cameron took a meal to Ricky's room. She noted that Ricky was lying on his bed with laboured breathing and was unresponsive. She requested the attendance of the nurse immediately. Nurse Cameron attended and asked that an ambulance be called. The South Australian Ambulance Service patient report form records that the request for attendance was received at 12:35pm, an ambulance was despatched at 12:36pm and arrived at 12:45pm. It left the Cavan Training Centre at 12:50pm and arrived at the Emergency Department of the Lyell McEwin Hospital at 1:13pm.
- 3.17. Ricky was seen by Medical Officer Hunt at 1:30pm. It was noted at that time that he had a generalised tonic clonic seizure lasting for approximately 5 minutes. Arrangements were made for an intensive care assessment and a CT scan. A lumbar puncture was also performed.
- 3.18. Another seizure was witnessed at approximately 6am on 7 February 2006, which lasted for 30 to 40 seconds. Nursing records also described another tonic clonic seizure at 7:50am on 7 February, again lasting for approximately 30 seconds. At about 9:10am on 7 February Ricky had another tonic clonic seizure lasting about 20 seconds.
- 3.19. Further nursing entries for 7 February describe that Ricky continued to have regular tonic clonic seizures. He was intubated and sedated. An MRI scan of the brain was organised and the records described that Ricky had three further seizures after that had been undertaken. Arrangements were made for Ricky to be transferred to The Queen Elizabeth Hospital Intensive Care Unit for EEG monitoring. Status epilepticus was the diagnosis at this point.

4. Ricky's treatment at The Queen Elizabeth Hospital

- 4.1. Dr Koblar, a Neurologist, saw Ricky at The Queen Elizabeth Hospital. Dr Koblar gave evidence at the Inquest and described the course of Ricky's treatment. He first saw Ricky on 8 February 2006. Anticonvulsant medication was prescribed. In fact, so grave was the situation and so persistent was Ricky's condition, that Dr Koblar prescribed 8 different anticonvulsants during his hospitalisation. Dr Koblar described

Ricky as being in a refractory status epilepticus, meaning that he was undergoing continuous seizures.

- 4.2. The drugs which were trialled to control Ricky's seizures, were phenytoin, clomazapine, levetiricam, topiramate, thiopentone, propranol, midazolam and finally phenobarbitone³. Dr Koblar said that normally one would not need to use all of those drugs to control a seizure. He said that for him to have gone to the point of using 8 different anticonvulsant drugs indicated the severity of the status epilepticus. As a final resort, thiopentone was used to induce a coma with the intention of stopping as much brain activity as possible. The theory behind this is that the brain will have a chance to rest in the hope that it might 'recalibrate' when the patient is brought out of the coma⁴. Dr Koblar said that this approach was used in Ricky's case after discussion with other epileptologists to whom he spoke both in this State and interstate. Ricky remained in the induced coma for 3 days.
- 4.3. Dr Koblar said that to his dismay, and that of others looking after Ricky at The Queen Elizabeth Hospital, within about four hours after he was brought out of the induced coma, Ricky started twitching and he quickly went back into the same situation of refractory status epilepticus as he had been in prior to the administration of the thiopentone.
- 4.4. Lumbar puncture tests were conducted. A brain scan was conducted on 23 February 2006 and as a result of that scan and the lumbar punctures, it was concluded by Dr Koblar that Ricky's brain had swollen to the point where he suffered pressure coning. As a result, the blood flow to the brain was constricted. On 23 February 2006 Ricky's blood pressure and breathing was noticed to become erratic. This was an indication that he may have coned resulting in damage to the brain stem which controls breathing and blood pressure⁵.
- 4.5. Two investigations were done on 23 February 2006. One was an EEG and the other was a perfusion study of the brain. The latter involves the giving of an injection of a compound to look at blood flow through the brain. The EEG demonstrated that there was no brain activity and the perfusion study of the brain did not demonstrate any active blood flow. Dr Koblar concluded that Ricky was very near death at that point. Dr Koblar discussed Ricky's condition with Ricky's mother and his family and said

³ Transcript, page 293

⁴ Transcript, page 294

⁵ Transcript, page 296

that he wished to wait another day because of Ricky's age. However, on 24 February 2006 Dr Koblar observed that Ricky's control of his blood pressure, his pulse and breathing were still severely impaired and that his brain was not supporting him with those functions. As a result of a further clinical examination he could discern no signs of life and he pronounced life extinct at 10:15am on 24 February 2006.

- 4.6. Overviews were conducted in this matter by Dr Kelly⁶ and Dr Morgan. No criticism was made of the treatment of Ricky at the Cavan Training Centre, the Lyell McEwin Hospital or The Queen Elizabeth Hospital. It is true that Dr Herman Chua saw Ricky in the Lyell McEwin Hospital three days before his collapse. However, the weight of the evidence shows that Dr Chua conducted a reasonable assessment and his decision to discharge Ricky back to the Cavan Training Centre was perfectly understandable in the circumstances. The evidence of Dr Koblar shows that even if Ricky had remained in hospital under close supervision it would be unlikely that the ultimate course of events would have changed.
- 4.7. I have noted that the administration of Ricky's antibiotics by staff at Cavan Training Centre was less than ideal. Some doses were missed. The overwhelming weight of the evidence shows that this had no bearing on Ricky's tragic death. However, it was a matter of concern and the Cavan Training Centre has introduced new protocols to address this deficiency.

5. Cause of death

- 5.1. As I have already said, the ultimate cause of Ricky's death was the condition known as refractory status epilepticus, which results in continual seizures. This causes swelling of the brain, which results in coning, brain stem damage and the eventual cessation of blood flow. This causes diffuse anoxic encephalopathy and the final result is that there is no blood flow to the brain and brain death results.
- 5.2. An issue which was much debated at the Inquest was the cause of the refractory status epilepticus. The evidence of Dr Koblar, the Forensic Pathologist Dr Heath and another pathologist, Dr Thomas⁷ shows that there are four alternatives for the cause of the refractory status epilepticus. The first possibility was a viral infection, the second was an underlying epileptic condition, the third was the possibility of a drug related cause and the fourth was a combination of one or more of the above.

⁶ Exhibit C22a

⁷ Dr Thomas did not give oral evidence although Drs Koblar and Heath did

- 5.3. A urine test performed at the Lyell McEwin Hospital was negative for a drug related cause. The Investigating Officer thought that it effectively excluded any form of illicit or prescription drug related cause. Not without some hesitation, I leave aside the possibility of a drug related cause.
- 5.4. I am left with the possibilities of a viral infection, an underlying epileptic condition or a combination of those two. I have found myself unable to reach a conclusion as to which of those three possibilities is the more likely. I do not intend to traverse the evidence of Drs Health, Koblar and Thomas in relation to this issue. Section 25(1) of the Coroners Act 2003 requires that I give my finding 'setting out as far as has been ascertained' the cause of the event the subject of an Inquest, in this case, the death of Ricky Cox. On the evidence I have received I have not been able to ascertain, to a requisite level of probability, that any of the three possibilities is more likely than the other. The most I can say is that Ricky's cause of death was refractory status epilepticus caused by either a viral infection, an underlying epileptic condition or a combination of a viral infection and an underlying epileptic condition and, accordingly, that is how I express my finding as to Ricky's cause of death.

6. The police investigation

- 6.1. When counsel assisting opened this Inquest she foreshadowed two issues that were likely to arise in the course of the Inquest. The first was the appropriateness of the treatment that Ricky received at Cavan Training Centre and the Lyell McEwin Hospital and the second was the cause of the status epilepticus. These were indeed two of the issues which arose at the Inquest and I have referred to them above. Counsel assisting's forecast was based upon the Investigating Officer's investigation summary which was admitted as Exhibit C23a in these proceedings.
- 6.2. After three days of hearing, the evidence seemed to have been exhausted, at least so far as might have been anticipated having regard to the Investigating Officer's investigation summary. However, as a result of some questions asked shortly before the adjournment by counsel assisting of the witness Burgess, there was some small doubt about whether further information about the results of an internal investigation at Cavan Training Centre might be forthcoming if further inquiries were made. Furthermore, there was a reference to contraband from Cavan Training Centre given to The Queen Elizabeth Hospital for toxicological analysis. I requested that counsel for the Commissioner of Police make further inquiries in relation to those matters.

- 6.3. As a result of those inquiries, counsel for the Commissioner of Police provided a further affidavit of Alan Avery sworn on 21 May 2008 which was admitted as Exhibit C32c. This affidavit stated as follows:

'I crave leave to refer to my affidavit sworn on 11 April 2008 and specifically paragraphs 19 and 20 therein.

The investigation to which I was referring in paragraph 20 of that affidavit was an investigation undertaken by the Anti-Corruption Branch of the South Australia Police as a result of allegations by an ex-resident that Cavan staff members were supplying illicit drugs to residents. Now produced and shown to me and marked 'ARA1' is a copy of the outcome of that investigation received by the Department for Families and Communities from the South Australia Police.

In making my affidavit sworn on 11 April 2008 I had confused the issues raised in Exhibit C10b of the Coroner's file and the allegations made by LD⁸ with the investigation by the Anti-Corruption Branch of the South Australia Police exhibited to this affidavit.'⁹

- 6.4. The exhibit to the affidavit is a letter from the Officer-in-Charge of the Anti-Corruption Branch to Ms Beth Dunning, Executive Director of the Department of Families and Communities. It is dated 2 November 2006. It reads as follows:

'Re: Allegation of illicit drug use Cavan

In May 2006 you advised this office of allegations made by an ex-resident of the Cavan Secure Care Centre in relation to the supply of illicit drugs to residents of the Centre by staff members.

The allegation was that between December 2005 and April 2006, GM¹⁰ and RC¹¹, staff members at the CSCC, were supplying residents in the Centre with cannabis and amphetamine. Furthermore, these illicit drugs may have contributed to the death in custody of Ricky Cox in February 2006.

An investigation was conducted by the Anti-Corruption branch and it was determined that RC has not worked at Cavan since 2910/2004 and is no longer employed in the Public Sector. No evidence was found to support the allegation that GM or any other staff member at the Centre was supplying residents with illicit drugs nor, that there was any connection between these allegations and the death of Ricky Cox.

There were indications cannabis was supplied to residents by unknown members of the public during visits being made to residents and by the cannabis being placed under Unit fences.

It is recommended internal reviews are conducted regarding the perimeter security and supervision of visits to the Centre to ensure appropriate measures are implemented in order to reduce the opportunity for any persons to introduce illicit drugs into the Centre.

⁸ I have deleted reference to the names of these people, because the allegations have never been substantiated

⁹ Exhibit C32c

¹⁰ I have deleted reference to the names of these people, because the allegations have never been substantiated

¹¹ I have deleted reference to the names of these people, because the allegations have never been substantiated

It is also recommended internal policies and procedures in the Centre be reviewed to assist in protecting staff against such allegations.'

- 6.5. Prior to the receipt by the Court of Mr Avery's affidavit there was no hint of the existence of an investigation by the Anti-Corruption Branch into allegations by an ex-resident that Cavan staff members were supplying illicit drugs to residents and that furthermore these illicit drugs may have contributed to the death in custody of Ricky Cox.
- 6.6. There had been no hint in any of the materials provided to the Court before this that any such allegations had been made, or that any investigation, separate to the death in custody investigation, was being conducted within SAPOL by the Anti-Corruption Branch. As a matter of fact, the Inquest was very nearly closed without this information having been divulged to the Court. But for the request to counsel for the Commissioner of Police to provide further information on what appeared to be a relatively uncontroversial issue, this matter would never have come to light.
- 6.7. In the result, it is plain that the Anti-Corruption Branch investigation did not establish the truth of the allegations that a staff member had brought illicit drugs into the Cavan Training Centre, provided them to inmates there and that these had contributed to Ricky Cox's death. However, the very fact that the allegations had been made and had been investigated by the Anti-Corruption Branch should most certainly have been revealed to the Court by the Investigating Officer in the Investigating Officer's report.
- 6.8. The Court issued a Direction to the Commissioner of Police to provide a copy of the investigation file of the Anti-Corruption Branch. The file was produced. With appropriate masking, it was admitted as Exhibit C46.
- 6.9. The fact of the Anti-Corruption Branch file and the existence of the letter from the Officer-in-Charge of the Anti-Corruption Branch to Beth Dunning about the outcome of the investigation should most certainly have been provided to me at some point long before the Inquest commenced, let alone after it had nearly finished. The Investigating Officer was called to give evidence and asked to explain why he had not revealed the existence of the Anti-Corruption Branch investigation in the report of his own investigation. He admitted that he was aware of that investigation and had cooperated with the investigators. Indeed, he had provided a copy of his own investigation to the Anti-Corruption Branch officers. His explanation for his failure to disclose the Anti-Corruption Branch investigation in the report of his own

investigation was that he did not consider it relevant to the death in custody investigation¹². He elaborated that Ricky's urine analysis to which I have made previous reference had ruled out illicit drugs as having been connected with his death¹³.

- 6.10. It should not need to be said that an Investigating Officer has no right to make a decision to exclude from the report he makes to the Coroner in a death in custody investigation, or for that matter in any other investigation, information about allegations which, if they were proved true, would clearly be relevant. The very making of the allegation itself is a matter of relevance and the very fact that the Anti-Corruption Branch within SAPOL had taken the matter sufficiently seriously to investigate it at length was a matter of relevance also. The fact of the matter is that the Coroner has a statutory duty to investigate all matters relevant to a death in custody. The Coroner may have chosen not to accept the conclusions of the Anti-Corruption Branch for all the Investigating Officer knew: in that event, the Coroner would need to see the Anti-Corruption Branch file in order to review the investigation and pursue lines of inquiry that may not have been pursued by the Anti-Corruption Branch.

7. **The 'contraband'**

- 7.1. As a result of the filing of Mr Avery's affidavit, a further witness, Karen Barry, was called. She was able to explain the reference in the Cavan Training Centre contraband log to contraband having been given to Queen Elizabeth Hospital 'toxicology' on 10 February 2006¹⁴. It appears that Ricky's mother had said something to a member of the Cavan Training Centre staff that caused the staff member to think that a deodorant bottle in Ricky's room should be tested to see whether it contained any illicit substance that might have caused his seizures. Accordingly, Ms Barry took the deodorant bottle to The Queen Elizabeth Hospital and conveyed the bottle and the information about it to a person believed by Ms Barry to be a doctor. That person declined to receive the bottle, saying that it was unnecessary to test it for the purposes of Ricky's treatment¹⁵. Ms Barry returned the deodorant bottle to Ricky's room at Cavan, from which it was eventually returned to his family. Any chance of pursuing the matter further has now been lost.

¹² Transcript, pages 461 and 487

¹³ Transcript, page 462

¹⁴ See Exhibit C9n

¹⁵ Transcript, pages 507-508

- 7.2. The Investigating Officer was asked whether he made any inquiries as a result of seeing the reference in the contraband log to contraband having been given to Queen Elizabeth Hospital 'toxicology' on 10 February 2006. He said he did¹⁶. He said that he concluded that the contraband referred to an incident involving another inmate at Cavan Training Centre having been caught smoking from a bong¹⁷. He was unable to explain how he connected these two items of information apart from the fact that they both appeared on the same line in the contraband log. However, the bong entry was related to an incident that occurred on 30 January 2006, and its appearance on the same line as the other entry may have been coincidental. The evidence of Ms Barry shows that the Investigating Officer was wrong in this conclusion.
- 7.3. It was put to the Investigating Officer that he made no other inquiries in relation to the contraband entry. He acknowledged this. When asked why, he said that the urine analysis of 6 February 2006 was 'negative'. In effect, he closed his mind to further lines of inquiry that might have provided any link between Ricky's death and illicit drugs in Cavan Training Centre. This was completely unsatisfactory in my view.

8. Conclusions as to the possible involvement of illicit drugs in Ricky's death

- 8.1. The evidence of Dr Koblar, taken as a whole, provides some measure of assurance that 'illicit' drugs were unlikely to be involved in Ricky's death. However, the lack of rigor that characterised this investigation has left me with misgivings. On the evidence, such as it is, I am forced to express the cause of death in the manner referred to above.
- 8.2. It is notable that Dr Heath was never informed of the allegations concerning illicit drugs and their possible involvement in Ricky's death. Had the Investigating Officer raised the matter with Dr Heath other lines of inquiry may have been explored. For example, the deodorant bottle may have been seized and subjected to analysis.
- 8.3. It is a matter of concern that Ms Barry was given short shrift by a doctor at The Queen Elizabeth Hospital in relation to the deodorant bottle and her associated concerns. Unfortunately, by the time she gave her evidence at Inquest, she could not recall the identity of the doctor. Had the Investigating Officer pursued this issue more rigorously he may have interviewed Ms Barry when her memory was fresher and that issue may have been resolved. I am unable to take it further now.

¹⁶ Transcript, page 490

¹⁷ Transcript, page 490

9. South Australia Police's position on the investigation

9.1. I make no particular criticism of the Investigating Officer in this matter. It appears to me that his training must be inadequate if he could have formed the view that the Anti-Corruption Branch investigation was not relevant and therefore did not need to be disclosed to the Coroner. The responsibility for the efficient discharge of police investigations rests with the Commissioner. I requested counsel for the Commissioner to provide me with the view of the Commissioner as to the withholding of the Anti-Corruption Branch material. Counsel for the Commissioner responded as follows:

'In preparing material for a coronial inquest officers will be guided by the test of relevance and there will need to be judgments in which there may be differing opinions. Having regard to the approach to these issues in Coroners inquests it is preferable to take a broader view of the test of relevance in preparing reports. In this case for completeness it would have been preferable to advise the Coroner of the Anti-Corruption Branch Investigation although ... [the Investigating Officer's] evidence is understandable in the circumstances.'¹⁸

9.2. In my opinion, it does not require a broad view of the test of relevance to see the need to apprise the Coroner of the existence of allegations as serious as those made in this particular case in relation to the Cavan Training Centre, allegations which had prompted an extensive Anti-Corruption Branch investigation. It is disturbing that SAPOL is only prepared to go so far as to say for completeness it would have been preferable to advise the Coroner of this matter but to add that the Investigating Officer's evidence was 'understandable in the circumstances'. I do not know what circumstances are being referred to. For my part I can see no circumstance that would justify the withholding of material as cogent and relevant as the existence of an Anti-Corruption Branch investigation into allegations that illicit drugs had been supplied by staff members to inmates at Cavan Training Centre including Ricky Cox and that these may have contributed to his death. It is no answer to say that the Anti-Corruption Branch investigation, or even the death in custody investigation, had not substantiated these allegations. The person whose duty it is to investigate deaths in custody is the State Coroner. It is entirely inappropriate to withhold information of this nature from the Coroner. This is not a matter of what would have been desirable for completeness sake, nor a matter of what would have been preferable. In my opinion, there is no reasonable basis for asserting that the Investigating Officer's evidence was understandable in the circumstances.

¹⁸ Transcript, pages 637-638

- 9.3. What should have been readily forthcoming from South Australia Police in this matter was a concession that the Investigating Officer was wrong to withhold the Anti-Corruption Branch file. That this may have been due to a lack of training or ordinary human weakness is another matter. There is no need to infer that because the Investigating Officer was wrong, he is in some way culpable – that is not the purpose of this exercise. The purpose of the Court is to ensure that future death in custody investigations are thorough and comprehensive and that under no circumstances should material as cogent as the Anti-Corruption Branch file in the present case be withheld from the Coroner.
- 9.4. Regrettably, counsel for South Australia Police submitted that it would be inappropriate for me to include in my finding a reference to the inadequacy of the investigation. This was based upon the premise that my jurisdiction, which is to ascertain the cause and circumstances of Ricky Cox's death, necessarily precludes me making any finding or comment upon the adequacy of the police investigation upon which my finding is based. This notion must be comprehensively dispelled once and for all. I reject the notion that I am unable to comment upon the adequacy of an investigation that has been prepared on my behalf in order that I may carry out my function of making a finding under the Coroners Act 2003. This much is absolutely clear from the Royal Commission into Aboriginal Deaths in Custody reports which were replete with criticisms of inadequate police investigations. Indeed, the very purpose of the Royal Commission was to examine the adequacy of death investigation for Aboriginal prisoners.
- 9.5. Criticism by the State Coroner of police investigations is nothing new. For example, in relation to the death in custody of Marshall Freeland Carter¹⁹ which was handed down on 16 June 2000, Mr Chivell, the then State Coroner, said:
- 'The performance of the police officers involved in the initial investigation of these events can be described, to use a mild expression, as disappointing.'
- He added that:
- '. . . the lack of investigational rigour displayed by those involved here is mystifying.'

¹⁹ Inquest 23/2000

Furthermore, he said:

'I do not wish to criticise the individual police officers concerned. I have no knowledge of their workload, or what instructions they may have received as to the degree of priority this investigation should receive ... The Commissioner of Police has statutory responsibility for the performance of his organisation. I draw these comments to his attention.'

- 9.6. I, like the former State Coroner, draw the comments I have made in relation to the present case to the attention of the Commissioner of Police. I do hope that there will be no repetition of the manifest inadequacies identified by me in the investigation in this matter.
- 9.7. This investigation was done in 2006. SAPOL as a whole, and the Major Crime Investigation Branch in particular, have made considerable efforts to improve the quality of coronial investigation since then. I acknowledge these efforts. This case highlights the need for continual improvement.

10. Recommendations

- 10.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Police (investigation)

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

Seal the 18th day of March, 2009.

State Coroner