



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 11th and 12th days of November 2008 and the 7th day of August 2009, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Marcielo Marstroianani Sciascia.

The said Court finds that Marcielo Marstroianani Sciascia aged 29 years, late of 19 Mitchell Crescent, Portland, Victoria died at Adelaide Remand Centre, 208 Currie Street, Adelaide, South Australia on the 29th day of April 2007 as a result of acute neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Mr Marcielo Sciascia was 29 years of age when he died in the Adelaide Remand Centre on 29 April 2007. An autopsy was conducted by Forensic Pathologist, Dr Charlwood, the following day and a report of her examination was admitted as Exhibit C2a. Dr Charlwood found the cause of death to be acute neck compression due to hanging and I so find. Mr Sciascia was in custody at the time of his death and, accordingly, this Inquest was held as required by section 21(1)(a) of the Coroners Act 2003.

2. Mr Sciascia's background

2.1. Mr Sciascia was born on 16 September 1977 in Hastings, New Zealand. He was a Maori man. He moved to Australia with his mother in December 1993. In 1996 the family moved to Adelaide where Mr Sciascia gained employment as an airconditioning apprentice. At this time his mother discovered that he was smoking

marijuana and noticed that his personality was changing. While living in Adelaide he committed offences and accumulated a criminal history of fighting and assaults.

- 2.2. In 1997 Mr Sciascia met Leanne Lino with whom he had three children. In 2001 Mr Sciascia and Ms Lino were living in Portland, Victoria with their three children. They had personal problems with their relationship and with drinking and gambling. Mr Sciascia was described as very possessive and jealous about Ms Lino. He also had a history of domestic violence towards her. In 2007, Ms Lino moved to Adelaide with the children to live with her brother. About two weeks later Mr Sciascia followed them to Adelaide.

3. Mr Sciascia's arrest

- 3.1. On the evening of 30 March 2007 Ms Lino, Mr Sciascia and Ms Lino's brother, Paul, were at the house of Paul Lino with whom they were staying. They were drinking. At about 12:30am on 31 March 2007 Ms Lino went to bed. She could hear Mr Sciascia and her brother arguing. She got out of bed and told Mr Sciascia that it was time for him to go to bed. He argued with her and moved towards her in a manner that suggested he was going to hit her. Her brother stepped in between the two of them and the argument continued. Ms Lino and her brother told Mr Sciascia that he had had enough to drink. Ms Lino called the police because she thought that Mr Sciascia was getting very angry and was worried that he would hurt someone. Paul Lino went outside. Ms Lino tried to tell Mr Sciascia that he should go to bed but he hit her with the back of his open right hand, to the right hand side of her face. He also punched the fridge causing it to be damaged. Mr Sciascia moved outside and behaved aggressively towards Paul Lino. Mr Sciascia punched Paul Lino on the face. Paul Lino was then able to restrain Mr Sciascia and, at that point, the police arrived. Mr Sciascia was arrested for aggravated assault and assault and property damage. Police reported that at the time of his arrest he was grossly affected by alcohol. He could not stand up straight and had to be physically restrained and handcuffed. He was conveyed to Holden Hill Police Station. He required medical treatment for a laceration to his head and was taken to the Modbury Hospital for medical attention. He was seen by a doctor at 5am, received a single stitch to the head, and was then cleared as fit for police custody. He was charged at 7:22am that morning and police bail was refused. He appeared in the Holden Hill Magistrates Court on 2 April 2007 and was remanded in custody. He was taken to the Adelaide Remand Centre.

4. Admission to the Adelaide Remand Centre

- 4.1. In the late afternoon of 2 April 2007 Mr Sciascia was placed in the holding cells at the Adelaide Remand Centre. Correctional Officer Seamons, who gave evidence at the Inquest, interviewed Mr Sciascia and completed a prison stress screening form¹. The prison stress screening form sets out a total of 31 questions to be asked of a prisoner. The form requires that a prisoner is to be considered at risk if the total number of affirmative answers to those questions is greater than 8, or if particular questions are answered affirmatively. The total score for Mr Sciascia was 8, but he gave affirmative answers to 2 of the questions that required him to be considered as being at risk. Despite this, Mr Seamons did not tick the box noting that Mr Sciascia should be considered as being 'at risk' in the place provided on the form. Nor did he complete the part of the form that required him to record that he had advised the medical officer that he considered the prisoner to be at risk.
- 4.2. Mr Seamons was unable to provide an explanation as to why he did not tick the appropriate box on Exhibit C37j. However, he did say that his overall impression of Mr Sciascia was that he did not appear to be at risk. In fact, Mr Seamons said that he took some care to develop a rapport with Mr Sciascia and described Mr Sciascia as being 'jovial'.
- 4.3. The prison stress screening form could be more clearly expressed in my opinion. At present it merely states:

'CONSIDER AS AT RISK IF:

- 1 Score is greater than 8; or
- 2 Any of the asterisked (**)/shaded items are ticked; or
- 3 Regardless of the score the interviewing officer feels a further opinion is warranted'

It then contains a box stating 'Advised Medical Officer' and provides for the name of the medical officer to be inserted. In my view Mr Seamons, an experienced correctional officer who had performed some 1,500 prisoner interviews during his career, misunderstood this form. His evidence shows that he had a misunderstanding about the form, and in my opinion the misunderstanding was not unreasonable². In my opinion the prison stress screening form should be revised to contain a clearer

¹ Exhibit C37j

² See Transcript, pages 50-52

statement that the result of the completion of the form was that the prisoner should be regarded as being at risk.

- 4.4. The fact is that in the present case, Mr Seamons' overall impression was that Mr Sciascia did not present as being at risk. I accept Mr Seamons' evidence in that respect. Furthermore, it is clear that Mr Seamons ensured that the nurse who carried out the second part of the admission process was aware of the details of the prison stress screening form, and indeed it was the evidence of Mr Pash, the registered nurse, that he read each of the questions and answers on the prison stress screening form. Mr Pash said that he formed the impression that Mr Sciascia was no more distressed than would be expected of a person who had just been imprisoned. He said that Mr Sciascia did not show indicators of wanting to harm himself and there were no factors about his mental state that he thought needed further exploration at that stage³. He said that Mr Sciascia presented as truthful and forthcoming on all subjects and reacted appropriately⁴.
- 4.5. Following the assessment by Mr Pash, Mr Sciascia was regarded as a routine placement. He was put in a cell with one other person, prisoner Carioti, as is routine practice.
- 4.6. Two days after his admission, Mr Sciascia was examined in a routine follow-up by medical officer Dr Karpinski⁵. Dr Karpinski made a statement that he always asks routine questions to assess a prisoner's mental health state, including an assessment of depression and risk of self-harm. According to Dr Karpinski he was satisfied that Mr Sciascia was not exhibiting any such symptoms.
- 4.7. I consider the weight of the evidence in relation to the admission procedures is that Mr Sciascia was not indicating any signs that he was at risk of self-harm. Three assessments were conducted within a space of two days and none of them picked up any issues. There was an error in relation to the completion of the form by Mr Seamons, however it did not lead to any adverse consequence.

³ Transcript, page 62

⁴ Transcript, page 63

⁵ Exhibit C38a

5. Mr Sciascia's stay in Unit 1 - Adelaide Remand Centre

- 5.1. On 5 April 2007 Mr Sciascia appeared in the Holden Hill Magistrates Court and his application for bail was rejected. He was remanded in custody to appear before the Court again on 22 May 2007. He was returned to Unit 1 at the Adelaide Remand Centre and again placed in a cell with Mr Carioti. In the period following his return, Mr Sciascia reportedly told Mr Carioti that he wanted to kill his brother-in-law and then kill himself. Mr Carioti did not believe what Mr Sciascia told him and stated that the following day they were laughing and joking about it.
- 5.2. On 10 April 2007 Mr Sciascia spoke to prison Social Worker, Karen Butler. He told her of his concerns about not seeing his three children and that he had managed to speak to his brother-in-law who told him that he would never see his children or his partner again. Ms Butler organised a family law adviser to come and speak to Mr Sciascia.
- 5.3. Ms Butler spoke to Mr Sciascia on 12 April 2007 and he was still concerned about his children. In particular, he was worried that Ms Lino would take his children to New Zealand. On 16 April 2007 Ms Butler spoke to Mr Sciascia again, this time in relation to completing a Legal Aid application for family law advice. She said that he was very anxious about what was happening with his children.
- 5.4. On 17 April 2007 an officer of the Legal Services Commission assisted Mr Sciascia to complete papers for filing in the Family Court.
- 5.5. On 19 April 2007 Mr Sciascia and Mr Carioti were shifted from Unit 1 of the Adelaide Remand Centre to Unit 6, where they were placed in cell number 7. They had both asked to remain together and the prison staff accommodated this request. In the cell there was a double bunk bed. Mr Carioti slept in the top bunk and Mr Sciascia in the bottom bunk.

6. Phone calls

- 6.1. During the period of his imprisonment at the Adelaide Remand Centre Mr Sciascia made 34 telephone calls, the majority of which continued for more than 5 minutes. The calls are described in some detail in Exhibit C37g, which is the report of the

Investigating Officer in this matter, Senior Constable Kirsty Marnane⁶. The phone calls are detailed at pages 13 to 15 inclusive of Exhibit C37g. I will not repeat them in detail. It is sufficient to note that Mr Sciascia was extremely preoccupied with the fact that he was not seeing his children. He was fearful that Ms Lino would take the children from Australia to New Zealand. He also referred to a desire to 'end it all'. However, he did add that his children were a reason for him not doing so.

- 6.2. As time progressed, Mr Sciascia continued to be preoccupied about his separation from his children and his fears in relation to them. He was also upset at the failure by a family member to assist in the service of Family Court documents upon Ms Lino. Between 24 April 2007 and 27 April 2007 he made three phone calls and in each of which he made a reference to having wanted to hang himself, to Ms Lino's brother having wanted him to kill himself and to the pain he felt from his separation from his children and referring to 'hanging on the end of that sheet'⁷.

7. 'Once Were Warriors' DVD

- 7.1. On 28 April 2007 Registered Nurse Pash remembered that the DVD 'Once Were Warriors' was displayed throughout the television monitors throughout the Adelaide Remand Centre on the 'community channel'. Mr Pash believed that the movie was played more than once.
- 7.2. Ms Karen Butler, the Social Worker, made a statement in which she recorded that Mr Carioti informed her that the DVD 'Once Were Warriors' was shown twice on the weekend of Mr Sciascia's death. She reported Mr Carioti as having informed her that he and Mr Sciascia watched the DVD at lunchtime on Saturday and that Mr Sciascia had told Mr Carioti that he identified himself with the main character in the DVD who was violent towards his female partner when he drank alcohol⁸.

8. The evening and early morning of 28-29 April 2007

- 8.1. Mr Carioti and Mr Sciascia were locked in their cell at about 4:30pm on 29 April 2007. Correctional officers conducted a patrol at 6:02pm in which all prisoners in Unit 6 were sighted with no obvious signs of distress being noted. A medical round

⁶ I commend Senior Constable Marnane for the very thorough investigation which has assisted me in the preparation of this Finding

⁷ Exhibit C37g, page 15

⁸ See Exhibit C20a

took place at 6:30pm. Correctional Officer Seamons was involved in that round and observed medication being provided to Mr Carioti. Medication was also provided to Mr Sciascia.

- 8.2. Correctional officers conducted an inspection at 8pm and all prisoners were reported to be sighted with no obvious signs of distress. A further inspection took place at 10pm with similar results. Inspections took place at 12am, 2am and 4am, all with the same result. All prisoners were sighted and there was no sign of distress.
- 8.3. Mr Carioti was interviewed and gave a statement⁹. He said that on the evening of 28 April 2007 he sat on his bed and watched television. Mr Sciascia was on his bed on the lower bunk and Mr Carioti assumed that he was asleep. Mr Carioti watched the World Cup Cricket final which commenced at 11pm. Shortly after 4am, Mr Carioti was still watching the cricket. At that time Mr Sciascia got up to use the toilet. Mr Carioti knew that it was 4am because it was just after the guards had come past the cell to do their regular cell check. At this time he and Mr Sciascia had a short conversation. Mr Sciascia asked if the cricket was still on and Mr Carioti replied that it was. Mr Carioti continued to watch the cricket for approximately another 20 minutes and then turned the television off so that he could go to sleep. He then returned to his bunk and fell asleep almost immediately. He heard nothing until he was awakened when a guard entered his cell sometime around 6am. He said that he did not think that Mr Sciascia would harm himself and had seen no warning of what took place. He did refer to the incident in which Mr Sciascia had said that he wanted to kill his brother-in-law and then himself, but explained that the following day they were laughing and joking about this statement and he believed that Mr Sciascia was simply blowing off steam. Mr Carioti did not take the threats seriously.

9. **The discovery of Mr Sciascia by correctional officers**

- 9.1. At approximately 6:02am, Correctional Officers Cope, Bogan and Funes-Cruz entered Unit 6. They were performing the routine prisoner check. Ms Funes-Cruz inspected cell number 7. She observed Mr Carioti asleep in the top bunk and then angled her torch to the bottom bunk. She saw Mr Sciascia who appeared to be seated facing the opposite wall of the cell. She then noticed that his feet were behind him and towards the door and it appeared that he was kneeling on the ground. She then noticed a sheet

⁹ Exhibit C8a

tied around his neck and that the sheet appeared to be pulling his head up and backwards. She noted that his mattress was on its side and leaning on the wall. She immediately shouted to the other correctional officers and a Code Black (medical emergency) call was made over the radio by Mr Bogan at between 6:04am and 6:05am.

- 9.2. Mr Bogan and Mr Cope entered the cell. Mr Bogan noted that Mr Sciascia was hanging and found that he was cold to the touch. There was no pulse. He supported the body while Mr Cope cut the bed sheet using a Hoffman tool. Mr Cope found that the sheet was so tight from Mr Sciascia's body weight that upon cutting the sheet it sprang back up and over the rail. The officers supported Mr Sciascia's weight and laid him on the ground. They commenced cardio-pulmonary resuscitation (CPR).
- 9.3. Clinical Nurse Sparrow was in the infirmary when the Code Black was called. She immediately went to the clinical room and grabbed the emergency trolley. She went straight to Unit 6 and observed the correctional officers performing CPR. She assisted with the CPR and checked Mr Sciascia's radial and carotid pulse and his eyes. She could feel no pulse and there was no movement in his eyes.
- 9.4. South Australian Ambulance Service staff were dispatched to the Adelaide Remand Centre at approximately 6:08am. They arrived at Unit 6 at approximately 6:12am. Mr Sciascia had not responded to medical treatment. At 6:27am treatment was ceased and at 6:29am Intensive Care Paramedic Leane certified life extinct.

10. DVD 'Once Were Warriors' – nature of the film

- 10.1. A copy of the film, Once Were Warriors, was tendered¹⁰. I have viewed the film. It is made in New Zealand and it depicts a Maori family. It depicts violence towards women of quite a severe nature. It also depicts sexual violence towards a female child. It contains a scene in which a teenage girl hangs herself. It also depicts physical violence in the form of retribution towards a paedophile.
- 10.2. On any view, this particular film was unsuitable for general distribution in a prison facility. I am not critical of the film itself. I found it to be a powerful depiction of the social damage and trauma associated with domestic violence and alcohol. It is possible that the film might be used as an education aid in a program devised by

¹⁰ Exhibit C40

appropriate mental health professionals in educating men who have been convicted of domestic violence offences in appreciating the gravity and horror of this form of conduct. If used carefully and with discretion in the context of a program such as that, there may be good justification for the display of this film to prisoners in a South Australian prison. However, this is certainly not what happened in the present case. The film was shown as part of the general 'entertainment' available to prisoners within the Adelaide Remand Centre.

- 10.3. There is some indirect evidence that Mr Sciascia appeared to identify himself with the main character of the film. It is tempting to think that Mr Sciascia would find similarities between himself and that main character. After all, they were both of Maori descent, they both had problems in abusing alcohol, and they both were physically violent towards their female partners. However, it is not possible to draw any conclusion about whether the screening of the film, the day prior to Mr Sciascia's death by his own hand, had some significant influence upon his decision to take his own life. I think it likely that there must have been some influence at work. However, I cannot quantify it and it is entirely possible, given Mr Sciascia's distress at his separation from his children and his conversations during his various phone calls, that he may have proceeded to kill himself whether the film had been shown or not.

11. Internal guidelines relating to screening of films

- 11.1. There were, in April 2007, standard operating procedures regulating the access of prisoners to films. The relevant document was dated 20 July 2005 and it provided that prisoners must only be allowed access to films rated M (mature) or lower under the Classification (Publications, Films and Computer Games) Act 1995. Access to MA, R, X or RC films is prohibited. The document also provided that the Manager or his or her delegate:

'... must ensure that all films and electronic games are assessed on an individual basis to determine the presence of excessive acts of violence or sexual explicitness and prohibit prisoner access to materials where deemed necessary.'¹¹

- 11.2. The film 'Once Were Warriors' was rated MA.

¹¹ Exhibit C37ak

- 11.3. The standard operating procedure that I have referred to was in operation at the date of Mr Sciascia's death. It is clear that the screening of the film by staff of the Adelaide Remand Centre was a breach of the standard operating procedure because the film was rated MA. Furthermore the film, had it been viewed by the Manager or delegate, would surely have been assessed as containing excessive acts of violence or sexual explicitness. It would presumably have been considered unsuitable by a Manager or delegate on that ground also, had it been reviewed for that purpose. The evidence showed that it was not reviewed in that manner and for that purpose. The standard operating procedure to which I have referred was substituted on 5 December 2007 with a new standard operating procedure. The new procedure relevantly provides that a prisoner must only be allowed access to films rated M or lower. It prohibits access to films rated R, X or RC or MA. The heading of the relevant paragraph of the procedure makes it clear that the procedure is not applicable to free to air television, which is available for prisoners to view within the Adelaide Remand Centre.
- 11.4. There is no reference to the requirement of the earlier standard operating procedure that the Manager or his/her delegate should review films on an individual basis to determine the presence of excessive acts of violence or sexual explicitness.
- 11.5. Clearly the more desirable standard operating procedure was the earlier document¹². If I had the power to recommend that the Department for Correctional Services reinstate the earlier standard operating procedure, at least in this respect, I would do so. However, having regard to the judgment of the Supreme Court in Saraf v Johns (2008) 101 SASR 87, I am unable to do so because such a recommendation would not prevent or reduce the likelihood of a recurrence of an event similar to Mr Sciascia's death because, firstly, I cannot find that his death was a result of having watched this film and, secondly, no attempt was made to actually assess the film for content at the time it was screened, even though the then standard operating procedure required that this happen.
- 11.6. The Activity/Program Supervisor at the Adelaide Remand Centre gave evidence at the Inquest. It was he who was responsible for ensuring the compliance with the

¹² Exhibit C37ak

guidelines in relation to the display of films in the Adelaide Remand Centre. He freely admitted that he had made an error in permitting the screening of *Once Were Warriors*. However, it was very clear that the error was an oversight and that the officer concerned had a number of other duties to attend to. It was also clear on his evidence that it would have been impossible for him to have individually assessed each of the films before screening. That said, he was aware of the nature of the content of *Once Were Warriors* and he did not regard it as suitable for screening. The fact was that the officer in question did not turn his mind to the appropriateness of this particular film at the time in question. He simply proceeded on the assumption that all of the films that were being screened were appropriately rated. In this respect, it was acknowledged that there was a systemic failure to ensure compliance with the then applicable standard operating procedure. I make no criticism of the officer in question.

12. **Hanging points**

- 12.1. The photographs in Exhibit C37b show the sheet used by Mr Sciascia to fashion the ligature from which he suspended himself. He tied one end of the sheet to the lower bunk. Because Mr Carioti was occupying the top bunk he was not disturbed by this. Mr Sciascia then threaded the sheet through the upper rungs of the ladder on the bunk bed and made a loop with the free end. He then suspended himself from that loop, and was ultimately freed when a Hoffman knife was used to cut the sheet from around his neck.
- 12.2. Mr Sciascia's suicide is a further example of how simple it is for a person to take his own life in the South Australian prison system. Previous findings have remarked on this. I refer, as I have previously, to the finding of Deputy State Coroner Schapel in the matter of Damian John Cook¹³. I respectfully agree with the Deputy State Coroner's remarks about hanging points in that finding, and adopt them.

¹³ Inquest 18/2005

13. Recommendations

13.1. 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.

13.2. I make the following recommendations:

- 1) That the Department for Correctional Services revise the prison stress screening form to contain a clearer statement that the result of the completion of the form was that the prisoner should be regarded as being at risk.
- 2) I repeat previous recommendations in relation to the elimination of hanging points at the Adelaide Remand Centre.

Key Words: Death in Custody; Hanging; Prisons; Suicide

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

Seal the 7th day of August, 2009.

State Coroner