



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 15<sup>th</sup>, 29<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> days of July 2009, the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup> and 18<sup>th</sup> days of August 2009 and the 7<sup>th</sup> day of June 2010, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Stanley Walter Peter.*

*The said Court finds that Stanley Walter Peter aged 55 years, late of 14 Alvis Road, Croydon Park, South Australia died at Port Adelaide Police Station, 244 St Vincent Street, Port Adelaide, South Australia on the 15th day of December 2006 as a result of dilated cardiomyopathy. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and reason for Inquest**

- 1.1. Stanley Walter Peter, aged 55 years, died on 15 December 2006. He died in the Port Adelaide Police Station holding cells at Port Adelaide, having been arrested and placed in those cells the previous night. An autopsy was conducted by Dr Gilbert, Forensic Pathologist, on 18 December 2006. Dr Gilbert gave the cause of death as dilated cardiomyopathy<sup>1</sup> and I so find. Dr Gilbert also noted the presence of alcoholic cirrhosis of the liver. Mr Peter's death was a death in custody within the meaning of the Coroners Act 2003 and accordingly an Inquest was conducted as required by section 21(1)(a) of that Act.
- 1.2. Mr Peter's body was discovered at around 5pm on Friday, 15 December 2006 by Ms Karen Edwards, a Senior Escort Officer in the employee of GSL Custodial Services

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<sup>1</sup> Exhibit C56

Pty Ltd (GSL). GSL is a private organisation contracted by the South Australian Government for prisoner transportation management and production at Courts. The Port Adelaide Police holding cells have operated as a joint facility shared by South Australia Police and GSL since 7 June 1999<sup>2</sup>. An ambulance was called at 5:03pm<sup>3</sup>. Ambulance officers arrived at the cells at 5:13pm and noted that Mr Peter was not breathing and did not have a pulse. Efforts to resuscitate him by inserting an OP airway and applying defibrillator pads to his chest were unsuccessful<sup>4</sup>. Dr Gilbert was called and examined the deceased insitu at 6:55pm that day. He noted that the deceased's body was in full rigor mortis and he certified life extinct at 7:05pm. Based on measurements of the cell area, air temperature, the rectal temperature of the deceased and other factors, Dr Gilbert estimated that the most likely time of death was roughly 3:30pm<sup>5</sup>. Dr Gilbert acknowledged that this estimate could vary by an amount of almost 3 hours either side of 3:30pm, but he was confident that Mr Peter had been dead for at least a few hours when he examined him<sup>6</sup>.

- 1.3. There was a CCTV camera in Mr Peter's cell and a system of recording images from that camera was maintained by SAPOL. A booklet of photographs was produced from the CCTV footage<sup>7</sup> and the photographs, adjusted for daylight saving, depict Mr Peter in the same position as that in which he was finally found at 5pm, from 2:30pm. From this I conclude that Mr Peter died at some time around, or shortly after, 2:30pm.
- 1.4. Dr Leo Mahar gave evidence. He is a cardiologist and the Director of Cardiovascular Services at the Royal Adelaide Hospital. Both his evidence and that of Dr Gilbert showed that Mr Peter's collapse and death occurred over a very short space of time. Dr Mahar said there would have been little or no warning of the onset of the event and that there was really little to no chance of effective cardiopulmonary resuscitation. Furthermore, even checks at 15 minute intervals would not be likely to have provided any forewarning of what was to come<sup>8</sup>.

## 2. **Initial police contact with Mr Peter**

- 2.1. At approximately 11pm on 14 December 2006 Mr Peter was arrested on three counts of breaching bail<sup>9</sup>. He was conveyed to the Port Adelaide Police Station and at

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<sup>2</sup> Exhibit C32a

<sup>3</sup> Exhibit C9

<sup>4</sup> See Exhibit C5a and Exhibit C6a

<sup>5</sup> Transcript, page 55

<sup>6</sup> Transcript, pages 52-54

<sup>7</sup> Exhibit C29g

<sup>8</sup> See Exhibit C57

<sup>9</sup> Exhibit C58a

around 11:30pm was interviewed by the arresting officers in relation to the alleged breaches of bail. Mr Peter was charged on three counts of breaching bail at 11:50pm. Bail was refused by the charging Sergeant. An Alcotest was conducted and the reading obtained was 0.311%<sup>10</sup>. Despite the very high reading on the Alcotest, Mr Peter was not assessed as being at risk by the charging Sergeant, Sergeant Close. Sergeant Close assessed Mr Peter as 'moderately affected' by alcohol. Constable Meyer, who was present during the charging process, assessed Mr Peter as being 'slightly intoxicated'. This may seem incongruous until allowance is made for the fact that Mr Peter was an alcoholic. According to expert evidence provided by Professor Jason White, a person who is accustomed to high concentrations of alcohol develops a tolerance such that they may not show the usual signs of alcohol effect, such as slurred speech, until they reach a concentration much higher than that at which an average drinker may start to slur his or her speech<sup>11</sup>. There is no disputing the fact that the evidence establishes that Mr Peter was an alcoholic and was accustomed to high concentrations of alcohol. In my opinion it was reasonable for Sergeant Close, knowing the characteristics of alcoholics and their high tolerance to significant levels of alcohol, to assess Mr Peter as being only moderately affected by alcohol despite his very high blood alcohol reading. I make no criticism of Sergeant Close in this connection and consider that he carried out his duties appropriately.

- 2.2. The Inquest heard evidence from all relevant police witnesses and I will not refer individually to the evidence of all of them. It is sufficient to note that Mr Peter was checked in his cell by police officers 18 times between the hours of 12:17am and 9:50am on 15 December 2006<sup>12</sup>.

### **3. Mr Peter moves to GSL custody**

- 3.1. It was at 9:50am on 15 December 2006 that Mr Peter was transferred from SAPOL custody to GSL custody. Ms Karen Edwards, Senior Escort Officer GSL, to whom I have already made some reference, signed the SAPOL charge book acknowledging that GSL had assumed responsibility for Mr Peter's custody at that time<sup>13</sup>.
- 3.2. During the morning of 15 December 2006, Mr Peter was escorted from his cell by a GSL officer for the purposes of seeing a lawyer, Ms Hayter, who was then a law clerk working at Lipson Chambers of Port Adelaide. Ms Hayter gave evidence and

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<sup>10</sup> Exhibit C54

<sup>11</sup> Exhibit C61

<sup>12</sup> Exhibit C55e, pages 95-96

<sup>13</sup> See Exhibit C54j

described Mr Peter as being unsteady and very dishevelled. A similar observation was made by the escorting GSL officer, Ms Harvey.

- 3.3. Ms Harvey gave evidence that she provided Mr Peter with his lunch sometime shortly after 11am. She said that when she gave him a drink with his lunch and poured his cordial, Mr Peter was very shaky<sup>14</sup>. As a result of this, Ms Harvey spoke to Ms Edwards and advised that Mr Peter was ‘very shaky’ and she was concerned about him being handcuffed to walk down the stairs to attend the Magistrates Court that afternoon<sup>15</sup>. Ms Harvey did not think it would be safe<sup>16</sup>. Ms Harvey’s next recollection of dealing with Mr Peter was at approximately 1pm when she went past his cell and enquired if he was alright and Mr Peter waved a hand at her<sup>17</sup>.
- 3.4. That would appear to be the last time that Mr Peter was physically sighted by any GSL officer, and the last time he was checked before he was discovered deceased at 5pm.

#### **4. GSL policies and procedures**

- 4.1. GSL were required by their own policies and procedures, and by GSL’s contract with the State Government, to conduct 15 minute checks upon prisoners in their custody. The evidence clearly demonstrated that these policies and procedures simply were not followed.
- 4.2. The GSL staff were required to maintain a prisoner log record recording 15 minute checks. The evidence of the GSL witnesses and particularly that of Mr Dalton, who was the GSL Operations Manager at that time, was that a practice had evolved within GSL that the prisoner log would be completed with a notation to the effect that ‘all appeared correct’ or ‘AAC’ in relation to a prisoner in the absence of any information to the contrary. There was effectively an assumption that someone amongst the GSL staff would be conducting 15 minute checks, although there was no formal assignment of that responsibility to any individual staff member. The evidence in the present case shows that nobody conducted 15 minute checks upon Mr Peter at any time between 2:30pm when he died and 5pm when his body was discovered. In all probability, no 15 minute checks were conducted at any time between 1pm, or thereabouts when he was last seen by Ms Harvey, and 2:30pm when he died.

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<sup>14</sup> Transcript, page 638

<sup>15</sup> Transcript, page 369

<sup>16</sup> Transcript, page 369 - Following this, the GSL officers and Court staff arranged for Mr Peter to be excused from attending Court that day

<sup>17</sup> Transcript, page 370

- 4.3. The prisoner log record for Mr Peter was duly completed by Ms Edwards, the Senior Escort Officer, recording AAC in all 15 minute time slots up until 5pm on 15 December 2006. The evidence established quite plainly that had a physical check been conducted upon Mr Peter at any time from at least 2:30pm onwards, it would quickly have been determined that he had collapsed and died.
- 4.4. Counsel for GSL frankly conceded that the practice of assuming that all was correct in the absence of hearing anything to the contrary had evolved amongst GLS staff at this time. He also conceded that no staff member was taking responsibility for observing Mr Peter. Counsel for GSL conceded that no member of staff had checked upon Mr Peter as required and no-one was allocated to do so. Counsel for GSL did submit, and I accept, that if GSL had conducted those proper checks Mr Peter's death would not, on the clear evidence of Dr Gilbert and Dr Mahar, have been prevented.

## **5. New GSL processes and procedures**

- 5.1. GSL has implemented significant changes to its monitoring equipment and procedures to better govern prisoner supervision. Prisoner log records now require personal verification by the officer making an observation of the prisoner every 15 minutes<sup>18</sup>.
- 5.2. GSL has CCTV monitoring equipment of its own within the Port Adelaide Police Station cells. In that connection I note that GSL did not have dedicated CCTV monitoring available in the area dedicated to GSL staff at the cells at the time of Mr Peter's death.
- 5.3. GSL has also appointed a dedicated officer to deal with auditing compliance with internal procedures on an ongoing basis<sup>19</sup>.
- 5.4. GSL has introduced new job descriptions for the senior escort officer and a new position of cell guard. The cell guard position requires that the senior escort officer for each shift appoint one of the other escort officers as the cell guard who is personally responsible for making physical checks on prisoners every 15 minutes and for speaking to the prisoner about his or her welfare every hour and noting the prisoner's response in the prisoner log record. This person must also complete the prisoner log record. Furthermore, the senior escort officer is now responsible for allocating a cell guard for each shift, allocating a specific officer to complete prisoner paperwork, answer phones, and monitor the CCTV and to ensure all prisoner logs are

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<sup>18</sup> Exhibit C60a

<sup>19</sup> Transcript, pages 727-728

correct and up to date. The senior escort officer must also ensure that the prisoner log is maintained and that there is an hourly record of a verbal check upon each prisoner.

**6. New SAPOL processes and procedures**

- 6.1. Since December 2006 SAPOL has improved aspects of custody management processes. These are set out in an affidavit of Assistant Commissioner Killmeir<sup>20</sup>. I do not intend to describe these further in this finding as it was my opinion that no aspect of SAPOL's policies or procedures contributed in any way to the death of Mr Peter. It is also my opinion that no act or omission on the part of any SAPOL member made any contribution to Mr Peter's death. Indeed, SAPOL's staff carried out the necessary checks diligently and compassionately.

**7. Conclusions and recommendations**

- 7.1. Mr Peter's death from dilated cardiomyopathy in the Port Adelaide Police Station holding cells on 15 December 2006 was sudden and unexpected. Its onset was so rapid that no practical measure could have been taken to prevent it in the circumstances in which it occurred. All SAPOL members carried out their duties in relation to Mr Peter's custody diligently and carefully. His custody was handed over to GSL mid morning on 15 December 2006 and thereafter GSL did not adequately supervise or check on him. However, GSL's failures in that regard did not contribute to Mr Peter's death in any way.
- 7.2. I have no recommendations to make in this matter.

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<sup>20</sup> Exhibit C77

*Key Words: Death in Custody (police); Monitoring/Observation of Prisoners*

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

*Seal the 7<sup>th</sup> day of June, 2010.*

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*State Coroner*

Inquest Number 16/2009 (1852/2006)