CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 19th day of February and the 10th day of June 2010 and the 7th day of April 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of ***Troy Thomas Lee****.*

The said Court finds that Troy Thomas Lee aged 38 years, late of 3 Kooraka Court, Hallet Cove, South Australia died at Hallet Cove, South Australia on the 9th day of April 2008 as a result of acute neck compression due to hanging.

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th day of March and the 10th day of June 2010 and the 7th day of April 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of ***Scott Leslie Matthews****.*

The said Court finds that Scott Leslie Matthews aged 23 years, late of 2 Teal Grove, Semaphore Park, South Australia died at Semaphore Park, South Australia on the 8th day of September 2008 as a result of mixed drug toxicity. The said Court finds that the circumstances of their deaths were as follows:

1. Introduction and reason for Inquests

1.1. Although there is no factual connection between these two deaths, the deaths of Troy Thomas Lee and Scott Leslie Matthews occurred in similar circumstances. Firstly, as I find, both men deliberately took their own lives. Mr Lee died after he deliberately hanged himself and Mr Matthews died after he deliberately took an excessive amount of prescribed medication. No other person was involved in either death. The second

element of commonality between the two deaths was the fact that both men were the subject of home detention as part of the conditions of bail agreements that they had respectively entered into in connection with criminal proceedings in which they were defendants. Both men died on the premises at which they were undergoing home detention, in each case the residence of their parents.

1.2. A death of a person that has occurred during the detention of that person in any place within South Australia under any Act or law providing for home detention is deemed a death in custody pursuant to section 3 of the Coroners Act 2003. Section 21(1)(a) of the Coroners Act 2003 stipulates that it is mandatory for an Inquest to be held into the cause and circumstances of a death in custody. Hence these Inquests.

2. Troy Thomas Lee

2.1. Troy Thomas Lee, who was aged 38 years, died on 9 April 2008. At approximately 9pm that evening Mr Lee's body was located by his parents, Mr George Lee and Mrs Yvonne Lee. Mr Lee was hanging by his neck from a rope that was attached to a tree at the rear of the home of his parents situated at 3 Kooraka Court, Hallet Cove. By the time he was discovered he had already passed away. It is evident that Mr Lee did this to himself while his parents were in the house. Mr George Lee cut his son down and performed CPR. Paramedics of the South Australian Ambulance Service were called but they were unable to resuscitate Mr Lee. Helen Samantha Hayes[1], an Intensive Care Paramedic, pronounced life extinct at 9:15pm.

2.2. A post-mortem examination of Mr Lee's remains was performed by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science SA. In her report[2] Dr Charlwood states that Mr Lee's cause of death was acute neck compression due to hanging. There was no significant natural disease that could have contributed to Mr Lee's death. Toxicology indicated that neither alcohol nor common drugs were detected within his blood. I find that Mr Lee's cause of death was neck compression due to hanging.

2.3. At the time of his death Mr Lee was on bail for alleged offences with respect to his estranged partner, Ms Kylie Schouten. Mr Lee was charged with aggravated assault

[1] Inquest 4/2010, Exhibit C2a
[2] Inquest 4/2010, Exhibit C3a

and with threatening to kill or endanger her life. After a period of remand in custody he was released on home detention bail to be undertaken at the address of his parents.

2.4. Mr Troy Lee and Ms Schouten cohabited for approximately 2 years until January 2008. They resided at 4 Grey Road, Hallet Cove. On 26 January 2008 Ms Schouten left the Hallet Cove premises and moved to the Woodcroft Caravan Park. Ms Schouten made a statement to police on 11 February 2008 in which she made a formal complaint of assault at the hands of Mr Lee and threats to her life including a voice message that Mr Lee had allegedly left on her mobile phone to the effect that he was going to kill her. That alleged message had been received at approximately 5pm on 11 February 2008. Ms Schouten had then made her formal complaint and statement[3]. Ms Schouten successfully applied for a domestic violence restraining order. In a further statement that Ms Schouten provided to police after Mr Lee's death[4], Ms Schouten provided more detail regarding their relationship and its deterioration. She describes a number of incidents in which she alleges that she was assaulted and threatened. The contents of this statement require no further elaboration here.

2.5. The following day, being 12 February 2008, police located Mr Lee in the vicinity of the Woodcroft Caravan Park. They served the domestic violence restraining order on him and arrested him. He was also questioned in relation to the allegations of aggravated assault and threaten life with respect to Ms Schouten [5]. Mr Lee was taken into formal custody that evening and he would remain in custody until his release on home detention bail on 29 February 2008. By the time of Mr Lee's death on 9 April 2008, the charges against him involving alleged assault and threaten life in relation to Ms Schouten had not been finalised.

2.6. In letters that have been received into evidence[6], members of Mr Lee's family, including his parents and Ms Trudy Bartlett, the deceased's sister, have made statements essentially to the effect that Ms Schouten's allegations were false and that the charges against Mr Lee were therefore unfounded. Within the large amount of material that has been tendered to the Court there are a number of statements from family members and acquaintances of Mr Lee that also touch on the relationship between Mr Lee and Ms Schouten. This Court is in no position to resolve any of

[3] Inquest 4/2010, Exhibit C16c
[4] Inquest 4/2010, Exhibit C7a
[5] Inquest 4/2010, See the statement of Sergeant Sean James Conaghty, Exhibit C20a
[6] Inquest 4/2010, Exhibit C35 - Mr George & Mrs Yvonne Lee and Exhibit C36 - Ms Trudy Bartlett - the deceased's sister

those issues. The reasons why Mr Lee came to be arrested and remanded in custody, and then released on home detention bail, cannot be the subject of sensible inquiry in the context of an Inquest such as this. All that needs to be said is that Mr Lee's arrest on 12 February 2008 was manifestly lawful, as was his subsequent remand in custody and release on home detention bail. In addition, the regime of detention that was imposed as part of his bail was also lawful. The lawfulness of Mr Lee's arrest, remand in custody and release on home detention bail is a matter that does not depend upon the merits of the prosecution that had been instigated against him.

2.7. There is no material to suggest that Mr Lee had been diagnosed with, or had been treated for, any psychiatric or mental health illness during his life. While some of the material regarding his relationship with Ms Schouten relates to Mr Lee's general behaviour, there is no suggestion that his behaviour was engendered by any psychiatric difficulty. The statements of his parents do not reveal any such difficulties in the life of their son leading up to the time of his arrest. A number of statements from medical practitioners who had treated Mr Lee for various complaints over time do not reveal any history of mental illness and, in particular, depression[7].

2.8. When Mr Lee was arrested on 12 February 2008 and then questioned at some length by detectives, the only note made by police in respect of Mr Lee's demeanour was the fact that he cried at times during the interview and was generally 'despondent'[8]. The description of Mr Lee as being despondent was incorporated within the SAPOL Prisoner Screening Form (PD331) which is a document that eventually makes its way onto custodial authorities' files[9]. Aside from that description there does not appear to have been any other issue of concern identified by police while Mr Lee remained in their custody.

2.9. From 13 February to 21 February 2008 Mr Lee was remanded in custody and was accommodated in the City Watch House. On 21 February he was transferred to the Adelaide Remand Centre where he remained until his release on 29 February 2008. In the period between 13 and 29 February 2008, Mr Lee made a number of bail applications at the Christies Beach Magistrates Court. On each of those occasions Bail Enquiry (Home Detention) Reports were ordered and obtained. Initially, the proposed residence for home detention was Mr Lee's parents' premises at 3 Kooraka

[7] Inquest 4/2010, Exhibits C17a, C18a and C19a
[8] Inquest 4/2010, Exhibit C20c, page 2
[9] Inquest 4/2010, See the evidence of Sergeant Conaghty, Exhibit C20a, page 4

Court, Hallet Cove. However, the opinion was expressed in the first report that the residence was unsuitable as it could not accommodate Mr Lee. Accordingly, to begin with, home detention was not recommended as being appropriate. A further report was prepared in relation to Mr Lee's former premises at 4 Grey Road, Hallet Cove. However, that premises was also deemed unsuitable because the landlord was no longer prepared to make it available to Mr Lee. Ultimately, a third report was prepared in which it was recommended that Mr Lee's parents' premises at 3 Kooraka Court, Hallet Cove would be suitable and that home detention would be appropriate.

2.10. On 29 February 2008 Mr Lee was released on bail by the Christies Beach Magistrates Court, the home detention to be undertaken at 3 Kooraka Court, Hallet Cove. Conditions of his bail included home detention and that he should obey all lawful directions of any supervisor designated to supervise his home detention. As part of that arrangement it was a further condition that Mr Lee reside at the premises at 3 Kooraka Court, Hallet Cove and not absent himself from that address except for the purpose of remunerated employment, necessary medical or dental treatment, to minimise the risk of serious injury or death to himself or to any other person, or for any other purpose approved by his Community Corrections officer. There was a further condition that he not consume or use any drug that was not medically prescribed or otherwise legally available and that he submit to any urinalysis and or breath tests as directed. As part of Mr Lee's home detention, it was a condition that he wear an electronic transmitter that would enable non-compliance with home detention to be detected. The observation should be made that, although ultimately there was a positive recommendation for home detention to be undertaken at 3 Kooraka Court, Hallet Cove and that the recommendation was made by an officer of the Department for Correctional Services (DCS), it was the decision of the Christies Beach Magistrates Court that enabled Mr Lee to be released on bail on the home detention conditions I have described. It will also be observed that the core condition of his bail, as with anyone else's bail, was that he would attend the Christies Beach Magistrates Court at the next and subsequent hearings of his matter in that Court. Accordingly, it would appear that the task of supervision would in the main be directed towards ensuring that this fundamental condition was complied with.

2.11. In their respective letters to the Court, both Ms Trudy Bartlett and Mr Lee's parents assert that prior to Mr Lee's death DCS had been in possession of information that

suggested that Mr Lee was suicidal. Indeed, the letter written by Mr and Mrs Lee asserts that it came to their attention after their son's death that he had been on 'suicide watch' while in DCS custody. Both letters contend that DCS failed to protect their son. The source of the assertion that Mr Lee had been on suicide watch is not identified. The term 'suicide watch' is not a technical one. This Court is familiar with the regimes that are put in place within correctional institutions that are designed to minimise risk of self-harm in respect of prisoners. The files of both the DCS and the South Australian Prison Health Service (SAPHS) were tendered to the Court[10]. I have examined both files. A perusal of the DCS file and that of SAPHS does not reveal any such self-harm regime as having been applicable to Mr Lee. The DCS prison stress screening form that was compiled upon Mr Lee's entry into DCS custody on 13 February 2008 is unremarkable. It is apparent that Mr Lee denied any previous attempts at self-harm and denied any current thoughts of deliberately harming himself. There was no information to suggest that Mr Lee was perceived to have been, or should have been perceived to have been, at risk of self-harm either while in the City Watch House or in the Adelaide Remand Centre.

2.12. There is no evidence that Mr Lee was placed under any regime that could be described as 'suicide watch'.

2.13. Mr Lee was also seen by SAPHS on 13 February 2008. The document relating to his assessment on this occasion is again unremarkable. Again, questions posed by SAPHS relating to previous attempts at self-harm and current thoughts in that regard were all answered in the negative. Mr Lee clearly denied any personal or family psychiatric history or any past diagnosis of a mental disorder or treatment for anxiety or depression. The placement recommendation within the institution was characterised as 'routine'. The progress sheet for Mr Lee's contact with SAPHS commenced on 13 February 2008. It is specifically noted on that date that Mr Lee had no self-harm or suicidal ideation.

2.14. Mr Lee was seen by SAPHS staff on further occasions. On 14 February 2008 he complained of a sleep problem. He denied any psychiatric history on this occasion. On 21 February 2008 a nursing note within the progress sheet records Mr Lee as being very teary and shaky on that day. He complained of 'thoughts rushing through head', but stated specifically that he had no thoughts of self-harming. He requested to

[10] Inquest 4/2010, Exhibits C33 and C34

see a medical officer. He did see a medical officer. Mr Lee told the medical officer that he was feeling very stressful and upset. He related that to his most recent Court appearance. He mentioned stressors such as his parents' unwellness, in particular his father's leukaemia. He also expressed concern about his residence having been taken away from him and financial issues. The medical officer reported on this occasion that Mr Lee was flat and low. He is noted to 'have thought about giving up once in prison but he fell asleep and woke up feeling okay again'. He reported constant thoughts of losing his house and worry about his father. It was on 21 February 2008 that Mr Lee was transferred from the City Watch House to the Adelaide Remand Centre. At the Adelaide Remand Centre it was noted on that same day that Mr Lee denied any thoughts of self-harm.

2.15. It does not appear that there was cause for any significant level of concern regarding Mr Lee's risk of self-harm whilst in custody. He did not attempt self-harm while in custody.

3. Mr Lee's home detention and death

3.1. As seen, Mr Lee's bail was subject to a condition that he obey the lawful directions of any supervisor designated to supervise home detention. A supervisor was so designated. On the day of his release from custody, namely 29 February 2008, Mr Lee was met at the premises at 3 Kooraka Court, Hallet Cove by a home detention case manager of DCS by the name of Tamara Blythe. Ms Blythe provided a statement to the Inquest[11]. On this occasion Mr Lee identified to Ms Blythe several issues in his life including problematic alcohol consumption, the difficulty that he was having in coming to terms with the charges alleged against him and the fact that he was now subject to home detention bail. The difficulty posed by the restrictive nature of home detention would be mentioned on other occasions by Mr Lee, but it will be remembered that the alternative for Mr Lee would have been a possibly lengthy and unattractive remand in custody.

3.2. It will be noted that Mr Lee was not the subject of a court imposed Intervention Program pursuant to section 21B of the Bail Act 1985. The imposition of an Intervention Program can be made a condition of a person's bail. It is meant to provide supervised treatment, supervised rehabilitation, supervised behaviour

[11] Inquest 4/2010, Exhibit C15a

management or supervised access to support services, or a combination of those things, that are designed to address behavioural problems, substance abuse or mental impairment. Ms Blythe states that she discussed with Mr Lee his interest in being referred to Intervention through DCS. It appears that what Ms Blythe had in mind here was Mr Lee's possible participation in anger management, victim awareness and alcohol and drug abuse related interventions. Mr Lee indicated that he would like to pursue Intervention. A referral to an Intervention worker at the Edwardstown Community Corrections Centre was later completed and an appointment was made for 13 May 2008 for assessment as to his suitability to participate in the program. There does not appear to be any suggestion that participation in an Intervention Program would be focussed on any mental health issue that Mr Lee had. Mr Lee died before the appointment to which I have referred. I am not certain whether Ms Blythe had a court imposed Intervention Program in mind for Mr Lee.

3.3. Ms Blythe had further contact with Mr Lee over the next few weeks. There was telephone contact on 2 March 2008 that involved, among other things, approval for Mr Lee to attend work on a full-time basis working for a company known as Central Tree and Stump Removal. In fact Mr Lee would work for that firm on a daily basis until his death. As I understood the evidence there was no difficulty placed in Mr Lee's way about his pursuing employment. Ms Blythe reports that Mr Lee was meticulous in his habit of calling DCS on a daily basis to let them know the work site for the particular day. Ms Blythe had further contact with Mr Lee on 17 March 2008. During this telephone discussion Mr Lee spoke about issues in his life and his concerns. This prompted Ms Blythe to suggest that Mr Lee should make an appointment with his general practitioner to discuss his mental health and the medication that might assist in this regard, and as well they discussed securing a referral to counselling. Ms Blythe also suggested that if he felt a need to discuss these issues he could leave a message on the Home Detention answering service and either she or his other case manager, a Mr Ken Mosman, would be happy to call him back. Mr Lee gave no positive indication that he would see a doctor. Ms Blythe's last home visit with Mr Lee occurred on 31 March 2008. He appeared to be coping quite well with issues in his life. The most significant stressor appeared to be his impending Court matters.

3.4. Ms Blythe makes it plain in her statement that none of the issues that she identified with respect to Mr Lee's home detention were out of the ordinary. The stressors that Mr Lee experienced typify the regime of detention on home detention bail. Leave passes had been authorised for him on weekends so that he could leave the house to go for walks. Ms Blythe suggests that Mr Lee's response to home detention was exemplary.

3.5. There is no suggestion that Ms Blythe did identify or ought to have identified any risk of Mr Lee engaging in self-harming behaviour.

3.6. The other case manager, Mr Ken Mosman, also provided a statement to the Inquest[12]. He first spoke to Mr Lee on 20 March 2008. Between that day and 5 April 2008 he had five telephone conversations with Mr Lee. Generally the responses from Mr Lee were that all was well. Mr Lee asked for, and was granted, a number of leave passes to go out shopping and to go for a walk on the beach. On 4 April 2008 Mr Mosman spoke by telephone to Mr Lee. Mr Lee told Mr Mosman that he was finding his home detention bail conditions to be stressful. A number of strategies were discussed to enable Mr Lee to establish a state of positive mental health. To this end Mr Mosman and Mr Lee agreed that leave could be arranged for Mr Lee to pursue his passion for fishing as a possible solution to the stress issue that had been identified. Mr Mosman also made two home visits to the relevant address. The purpose of each visit was to check on Mr Lee's compliance with his bail conditions and on his welfare. On his second and final visit on 5 April 2008, the question of stress was also raised with Mr Mosman. The stressors were the usual, namely the restrictive nature of home detention and the stress occasioned by the impending Court matter. Mr Lee said he was not sleeping very well because he constantly ruminated over matters. There was further talk about fishing leave passes. A number of strategies were also discussed including possible referrals to counselling and support groups to which Mr Lee was non-committal. Mr Mosman recommended that Mr Lee attend his general practitioner who might be able to offer some assistance in relation to relieving stress and anxiety. Mr Lee stated he did have a general practitioner but did not see him very often. He was non-committal about pursuing that option as well. Mr Mosman states that at no time did Mr Lee allude to having a sense of hopelessness or despair.

[12] Inquest 4/2010, Exhibit C14a

3.7. There is no suggestion that Mr Mosman identified, or ought to have identified, any potential or risk for Mr Lee to engage in self-harming behaviour.

3.8. There does not appear to have been any particular reason for either Ms Blythe or Mr Mosman to have raised any concerns as to Mr Lee's welfare with Mr Lee's parents. For instance, there appears to be no reason why either case manager would have needed to raise with Mr and Mrs Lee any concerns that they ought to have had about Mr Lee's potential to self-harm. They did not entertain any such concerns and had been given no reason to do so.

3.9. Mr George Lee, Troy Lee's father, provided a statement to the Inquest[13]. In that statement, which was made on 9 April 2008, Mr George Lee said that his son had been 'a bit stressed' in the first week he had been home, mainly due to his having to wear an electronic transmitter. Other than that, Mr Lee senior states that his son had been his 'normal self'.

3.10. On the other hand Mrs Yvonne Lee, Troy Lee's mother, suggested in her statement[14] that she had noticed that Troy Lee had suffered from mood swings and that he had been very depressed over the Easter weekend. On the Friday before his death, namely 4 April 2008, she describes Mr Lee as being 'testy'. He accused his parents of having 'dobbed him in' to Correctional Services. There were other incidents following this in which Mr Lee demonstrated a measure of irritability. However, on Monday 7 April 2008 Mrs Lee suggests that her son was in the best mood she had seen him in for a long time. She suggested he was the 'old Troy'. He was fine on the following day, namely 8 April 2008.

3.11. There is no suggestion in the statements of Mr Lee's parents that either of them had entertained any concerns about their son self-harming while he remained at their residence. I note that Mrs Lee asserts in her letter to the Court that DCS let them down because at no stage did any officer speak to them regarding their son. In particular, the complaint is made that at no time were they informed that their son was suicidal. The difficulty with that is that there was no material in the possession of DCS staff, and in particular Mr Lee's two case managers, to suggest that Mr Lee entertained thoughts of self-harm that in any way could have been passed on to his parents. Moreover, there is insufficient evidence to suggest that at any time prior to

[13] Inquest 4/2010, Exhibit C1b
[14] Inquest 4/2010, Exhibit C5a

the day of Mr Lee's death he had in fact entertained any thoughts of self-harm or suicide.

3.12. On 9 April 2008 it appears that Mr Lee received a letter from his solicitor at the Legal Services Commission that greatly disturbed him. The letter attached a copy of the statement that had been made by Ms Kylie Schouten on 11 February 2008 in which a number of serious allegations of assault and threats to kill were described. In his statement Mr George Lee confirms that on 9 April 2008 he retrieved the letter from the letterbox and gave it to his son. Mr George Lee later asked his son about it but Mr Lee refused to discuss it. At one point Mr George Lee asked whether his son was alright to which Mr Lee said 'no, I think I'm going to jail'[15]. He started to cry. Mr George Lee said that his son was emotionally upset after reading the letter. He suggests that his son's suicide cannot be explained on any basis other than that having read the letter he thought he was going to jail.

3.13. Mrs Yvonne Lee was also aware on that day that her son had received the solicitor's letter. Mr Troy Lee had told her something of the contents of Ms Schouten's statement. In her statement Mrs Lee[16] suggests that she had never seen any signs that her son would take his own life. She said 'it's just that statement that tipped him, it upset him a lot'.

3.14. There was no possible means by which officers of DCS could have known either that Mr Lee had received the solicitor's letter and Ms Schouten's attached statement or of his reaction to it. No officer of the Department had contact with Mr Lee that day. There was no compelling reason for them to have made contact with him on that particular day.

3.15. Following his death, Mr Lee's mobile telephone was checked for outgoing text messages. It is apparent that he sent SMS messages to Ms Schouten on four occasions suggesting in effect that he was intending to kill himself. A copy of Ms Schouten's statement dated 11 February 2008 was found in Mr Lee's clothing. It had the words 'I'm sorry' written on the reverse side of it.

3.16. I do not need to recite in any detail the circumstances in which Mr and Mrs Lee came to find their son deceased in their backyard.

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[15] Inquest 4/2010, Exhibit C1b, page 3
[16] Inquest 4/2010, Exhibit C5a

3.17. There is no evidence that DCS were in possession of any information that would have suggested that Mr Lee was at risk of self-harm as at the time of his death. Although Mr Lee was subject to home detention, there was no restriction on him seeking and obtaining medical assistance and he was encouraged to do so. He was also permitted to work. It is difficult to see what more DCS could have done for Mr Lee.

4. Scott Leslie Matthews

4.1. Scott Leslie Matthews, who was aged 23 years, died on 8 September 2008. Mr Matthews was located by his former girlfriend, Ms Carol Joan Simons, at about 10:30am. He was in a granny flat situated on premises occupied by his parents at 2 Teal Grove, Semaphore Park. It was evident that Mr Matthews had already passed away. Nonetheless, an ambulance was called. In the meantime, Mr Matthews' stepfather, Mr Geoffrey Craig Matthews[17], performed CPR. Paramedics were unable to resuscitate Mr Matthews. The statement of Kylie Ellson[18], a paramedic, reveals that Mr Matthews was not breathing nor had a pulse at the time of her arrival at the scene.

4.2. A post-mortem examination of Mr Matthews' body was conducted by Dr John Gilbert who is a forensic pathologist with Forensic Science SA. In his report[19] Dr Gilbert states that Mr Matthews' cause of death was mixed drug toxicity (tramadol and alprazolam). There was no natural disease that could have caused or contributed to Mr Matthews' death. His blood contained a lethal level of tramadol (4.7mg/L) and a toxic level of alprazolam (0.4mg/L). Tramadol is alternatively known as Tramal. It is used to treat pain. Alprazolam is alternatively known as Xanax. It is used to treat anxiety. No other common drugs, including alcohol, were detected in Mr Matthews' bloodstream. The amount of tramadol in Mr Matthews' bloodstream in itself could have accounted for his death. When used in combination, tramadol and alprazolam have additive central nervous system and respiratory depressant effects. Both of these substances had been prescribed for Mr Matthews. Neither substance had been illicitly possessed by Mr Matthews. It is evident that Mr Matthews must have ingested a quantity of these substances far in excess of the prescribed therapeutic quantities. I find that Mr Matthews' cause of death was mixed drug toxicity (tramadol and alprazolam).

[17] Inquest 9/2010, Exhibit C1a and C1b
[18] Inquest 9/2010, Exhibit C6a
[19] Inquest 9/2010, Exhibit C3a

4.3. According to Ms Simons' statement[20], Mr Matthews and Ms Simons had been together for approximately 3 years. They had separated just before Mr Matthews was arrested on 22 August 2008 in respect of which he was ultimately placed on home detention bail. Ms Simons was aware that Mr Matthews had been taking painkillers. She knew that he was taking Tramal, steroids and Xanax. After their separation Mr Matthews told Ms Simons that he would commit suicide if she did not get back together with him.

4.4. Sometime prior to these events Mr Matthews had been involved in an incident in which he had been shot in the leg. This incident had occurred on or about 3 March 2008. According to a SAPOL PIR investigation diary relating to the incident[21], Mr Matthews had not been cooperative with police in respect of the ensuing investigation. It is believed that Mr Matthews had been adversely emotionally affected by this incident.

4.5. Mr Matthews was also believed to have suffered a back injury in connection with his work and suffered chronic pain as a consequence.

4.6. Mr Matthews was under the care of Dr David Muirhead, a general practitioner who practised at Royal Park. Mr Matthews began consulting with Dr Muirhead in May 2008. Dr Muirhead provided a statement to police[22]. The first consultation related to the preparation of a general practitioner mental health care plan. Dr Muirhead explains that when he first saw Mr Matthews the latter was suffering from anxiety as a result of the shooting and from an assault that had occurred some years before. Mr Matthews was tired, anxious and depressed, but said nothing of any suicidal tendencies. Dr Muirhead on this occasion prescribed the antidepressant medication Lexapro as well as a sleeping tablet. Dr Muirhead thought that Mr Matthews may have been suffering post traumatic stress disorder in relation to the shooting. He referred Mr Matthews to a psychiatrist and a psychologist for an expert diagnosis, but as far as Dr Muirhead is aware Mr Matthews did not avail himself of those referrals.

4.7. Dr Muirhead next saw Mr Matthews in June 2008. The antidepressant medication was being tolerated but the sleeping tablet had not been effective. Mr Matthews indicated that he had taken Xanax in the past to help him sleep. Dr Muirhead

[20] Inquest 9/2010, Exhibit C5
[21] Inquest 9/2010, Exhibit C15d
[22] Inquest 9/2010, Exhibit C8a

prescribed that for him. This was one of the drugs involved in Mr Matthews' fatal drug cocktail. Dr Muirhead was concerned about Mr Matthews' consumption of Xanax given its high risk for dependency. He stressed to Mr Matthews that Xanax should be taken on a short-term basis only. Later in the course of treatment Dr Muirhead recommended that Mr Matthews increase the dosage of the antidepressant in order to reduce the requirement for Xanax. Dr Muirhead believed that Mr Matthews was improving over time.

4.8. Mr Matthews last saw Dr Muirhead on 4 September 2008, four days prior to his death. On this occasion Dr Muirhead issued a script for 50 x 2mg tablets of Xanax to be taken twice a day as needed. The antidepressant was also prescribed, as was tramadol in 50mg capsule form, 20 per pack, to be taken 4 times per day as needed.

4.9. Dr Muirhead explains that all of Mr Matthews' prescriptions were individually capable of causing death in high doses as well as in a mixture.

4.10. Dr Muirhead at no time gained any impression that Mr Matthews was likely to take his own life. Mr Matthews had not made any statements or comments that indicated that suicide was likely.

4.11. Mr Matthews' most recent involvement with DCS was not his first. Mr Matthews was the subject of a 12 month good behaviour bond between December 2006 and December 2007. During this period he was under the supervision of Ms Gina Testa, an officer of DCS. In her statement[23] Ms Testa says that she was aware that Mr Matthews suffered from anxiety, depression and possibly post traumatic stress disorder arising out of loss of employment through injury. Ms Testa again came into contact with Mr Matthews in July 2008 after he had been charged with driving under the influence. At that time Mr Matthews displayed an impression of sadness, apparently generated by his belief that he was going to be imprisoned. He also mentioned the shooting incident that had happened in March and suggested to her that he had become involved with bikies. He also suggested that he was being harassed by police. In her statement Ms Testa makes mention of the fact that during her dealings with Mr Matthews she had made a number of appointments for him to see a psychologist but that Mr Matthews did not keep any of those appointments. Ms Testa did not see Mr Matthews again after the July 2008 communication.

[23] Inquest 9/2010, Exhibit C9a

4.12. On 22 August 2008 Mr Matthews was arrested in relation to alleged offences of trafficking in a controlled drug, dishonestly dealing with property without the owner's consent and possessing a firearm without a licence. He would remain in custody until 29 August 2008 when he was bailed on home detention. Premises at 2 Stacy Street, Hendon, believed to have been occupied by Mr Matthews at that time, were searched by detectives on the day of his arrest. In a room believed to be occupied by Mr Matthews a handwritten note, which has been described by police as a 'suicide message' in which reference was made to a failed relationship, feelings for family members and negative sentiments towards police[24], was located. A list of 24 'goals' that essentially amount to a number of positive aspirations for personal improvement was also located. I do not know whether any of this written material was drawn to the attention of custodial authorities following Mr Matthews' arrest. I have not seen any evidence that would suggest that this was the case. I see no reference to any of this material in any DCS case files. The SAPOL prisoner screening form (PD331) contained within the DCS file[25] makes reference to Mr Matthews' treatment for anxiety and his prescription for Xanax. It also makes reference to Mr Matthews' depression. I see no reference in this document to any of the material that was found at the Stacy Street premises. The transmission to custodial authorities of material in the possession of police that is relevant to a prisoner's risk of self-harm, a suicide note being an example, has been the subject of comment by this Court in the past. This kind of material should routinely be made available to custodial authorities within Police and Correctional Services[26].

4.13. Mr Matthews remained in police custody until 25 August 2008 when he appeared in the Port Adelaide Magistrates Court. On that occasion the Court ordered a Bail Enquiry (Home Detention) Report to be compiled and the matter was adjourned until 29 August 2008. The report that was then prepared by DCS recommended that home detention was suitable for Mr Matthews and that he could reside and be detained at the address at 2 Teal Grove, Semaphore Park. The report made reference to the existence of a current alcohol problem and to a diagnosis of a mental, intellectual or personality disorder. It was indicated in the report that Mr Matthews was suffering from post traumatic stress disorder, depression and anxiety.

[24] Inquest 9/2010, Statement of Senior Constable Rodney Hannam, Exhibit C14a
[25] Inquest 9/2010, Exhibit C18
[26] Andrew Stephen Gill, Inquest 10/2008, delivered 28 November 2008

4.14. From 25 to 29 August 2008 Mr Matthews was held in custody at Yatala Labour Prison. Mr Matthews' induction documents for this institution include a prison stress screening form in questionnaire format. It is indicated in the form that Mr Matthews had been diagnosed with depression and that the assessing officer had observed marked signs of depression at the time of the screening process. Nevertheless, Mr Matthews' score in respect of the prisoner stress screening was not such to indicate that he should be considered at risk. Questions as to whether Mr Matthews had ever tried to hurt himself intentionally, and whether he had thought about deliberately harming himself since he had been arrested, were answered in the negative. A question as to whether or not he had current thoughts of harming himself was also answered in the negative. At the time of Mr Matthews' arrival at Yatala Labour Prison there was no indication that he was at risk of self-harm. His depression was adequately noted. Mr Matthews was seen by a social worker at Yatala. In indicating to the social worker that he was hoping to be granted home detention bail, he denied having any past or current thoughts of self-harm. This was in keeping with the prisoner stress screening exercise the day before.

4.15. Mr Matthews reattended Court on 29 August 2008 where he was released on home detention bail. Conditions of his bail included that he should obey all lawful directions of any supervisor designated to supervise his home detention. As part of the home detention arrangement it was a further condition that Mr Matthews reside at 2 Teal Grove, Semaphore Park and not absent himself from the residence except for the purposes of remunerated employment, necessary medical or dental treatment or to avert injury or death to himself, unless prior approval to be absent was given by a home detention supervisor from the Department for Correctional Services. There was a further condition that he not consume or use any drug that was not medically prescribed nor consume alcohol and that he should submit to urinalysis and or breath tests as directed. As is common, it was a condition of Mr Matthews' home detention that he should wear an electronic transmitter that would enable non-compliance with home detention to be detected.

4.16. Mr Matthews would remain on home detention bail until his death on 8 September 2008.

5. Mr Matthews' home detention and death

5.1. As already indicated, during his period of home detention Mr Matthews saw Dr Muirhead on the one occasion on 4 September 2008, four days prior to his death. It

was on this occasion that Mr Matthews received his final prescription for Xanax and tramadol. In his statement[27] Mr Matthews' stepfather, Geoffrey Matthews, observed that the medication that Scott Matthews was using made him slur his words and affected his short term memory. Mr Geoffrey Matthews stated that since Mr Scott Matthews' release from Yatala, the latter appeared depressed and scared that people were after him. Mr Geoffrey Matthews suggested that Mr Scott Matthews had been over-medicating for the previous two weeks but that Mr Scott Matthews had said that he could tolerate the extra dosage because of his large build. In her statement Mr Matthews' former girlfriend, Carol Simons, also suggested that Mr Matthews had been very depressed in the week since he had been on home detention and had been crying every day. She had kept in contact with him because she believed him to be emotionally unstable, although she did not contemplate that he would commit suicide; he had promised her that he would obtain help. She believed that he would not break any promise with her, so she did not say anything to anyone about her concerns. She believed that Mr Matthews wanted her back in his life.

5.2. A home detention supervisor from DCS visited Mr Matthews on 29 August 2008 and he was inducted into the home detention system. There was further communication with DCS staff on 2 September 2008 regarding Mr Matthews' imminent appointment with Dr Muirhead. He saw Dr Muirhead two days later. There was no restriction on his ability to do so.

5.3. During his period of home detention Mr Matthews was also supervised by Ms Rosalie Anne Costigan, a home detention officer with DCS. Ms Costigan provided a statement to the Inquest[28]. Ms Costigan visited Mr Matthews at the Teal Grove, Semaphore Park address on 6 September 2008. On this occasion Mr Matthews was polite and friendly and was focussed on endeavouring to get his life back on track. Ms Costigan's impression was that Mr Matthews had the support of family members. During Ms Costigan's visit Mr Matthews mentioned that he wanted to scatter his natural father's ashes at Largs Bay. It appears that on the following day, 7 September 2008, Mr Matthews may have done this. The home detention monitoring device indicated that he had gone out of range from his home address on that day. Mr Matthews later admitted to Ms Costigan that he had left the premises. Ms Costigan did not take any action.

[27] Inquest 9/2010, Exhibit C1b
[28] Inquest 9/2010, Exhibit C16

5.4. Between 29 August and 8 September 2008 there was nothing in any recorded communication with Mr Matthews that would have alerted DCS staff to any suicidal ideation or intention on his part to commit self-harm. Ms Costigan herself was not told by Mr Matthews of any such intention.

5.5. Nevertheless, it is evident from the statement of Ms Simons that by 7 September 2008 Mr Matthews was at a low emotional ebb. It will be remembered that after their relationship had ended, Mr Matthews had threatened to commit suicide. On the afternoon of 7 September 2008 a worrying exchange of text messages took place between Mr Matthews and Ms Simons in which Mr Matthews indicated that he wanted to be buried wearing the watch that she had given him, as well as with a photograph of her. As a result of receiving that message Ms Simons called Mr Matthews. She formed an impression that Mr Matthews was slurring his words and had some memory loss, a condition that was probably the result of excessive medication. But later, in a subsequent call, he seemed happy and in a good mood. That was the last time she spoke to him. Ms Simons did not believe that Mr Matthews would go through with any threat to commit suicide and for that reason she did not communicate any concerns about this.

5.6. Mr Matthews was last seen by his stepfather at approximately 10:30pm on the night of 7 September 2008. Mr Geoffrey Matthews suggested that Mr Scott Matthews appeared to be affected by his medication. When he asked Mr Matthews whether he was alright, Mr Matthews said that he was. This was the last occasion on which Mr Geoffrey Matthews saw his stepson alive.

5.7. Mr Matthews was found the next morning by Ms Simons.

5.8. Police investigators attended the scene at 2 Teal Grove, Semaphore Park. They located empty medication containers. An empty box of tramadol hydrochloride with notations to the clear effect that they had been prescribed to Mr Matthews by Dr Muirhead on 4 September 2008 was located. As well, the container that had held the 50 Xanax / alprazolam tablets that had been prescribed by Dr Muirhead on 4 September 2008 was also empty. If Mr Matthews had taken the Xanax tablets in strict accordance with the prescription between 4 September and 8 September 2008, it would mean that he would have had available to him, and had then taken prior to his

death, upwards of 40 tablets. It is obvious that Mr Matthews deliberately consumed all of what remained of the tramadol and Xanax in his possession.

5.9. In the light of Mr Matthews' stated desires to end his life, his depressed frame of mind and the deliberate ingestion of large quantities of his medication, thereby exhausting his entire supply of it, it is difficult to escape the conclusion that Mr Matthews deliberately took his own life. I so find.

5.10. There is no evidence that DCS were in possession of any information that would have suggested that Mr Matthews was at risk of self-harm as at the time of his death. It will be observed that although Mr Matthews was subject to home detention, there was no restriction on his seeking and obtaining medical assistance. He was able to seek out and obtain that assistance during his period of home detention. Correctional Services were aware that he was seeing his doctor. It is difficult to see what more DCS could have done for Mr Matthews. Mr Matthews' mental health and state of mind was essentially a matter between himself and his general practitioner.

6. Recommendations

6.1. Pursuant to Section 25(2) of the Coroners 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.

6.2. Ms Deidre Butler, who at the time of these events was the Manager of Case Management at the Edwardstown Community Corrections Centre, provided a statement to the Inquest[29]. Her responsibilities included managing all of the staff whose responsibility it is to supervise offenders at the Corrections Centre. She also managed the Home Detention program in the western metropolitan region. Ms Butler's statement speaks of the home detention guidelines. She points out that there are different supervision considerations that might apply to home detainees under the Bail Act 1985 where home detention is a condition of bail as distinct from those that might apply to detainees undergoing home detention imposed as part of a sentence of imprisonment. The implication Ms Butler raises is that there would be a lesser duty of care upon DCS in respect of bailees under home detention, the principal consideration being whether the bailed individual would comply with the bail

[29] Inquest 4/2010, Exhibit C13a

conditions generally and attend Court at all stipulated appearance dates. It has not been necessary for this Court to decide the point as it appears from these findings that regardless of the precise nature and extent of DCS' duty of care, DCS did all they could be expected to do for both Mr Lee and Mr Matthews.

6.3. The deaths of Mr Lee and Mr Matthews were both very capably investigated by SAPOL. Detective Brevet Sergeant De Zilwa of Sturt Criminal Investigation Branch investigated Mr Lee's death. Mr De Zilwa provided a very helpful statement and investigation report in relation to Mr Lee's death. Having analysed the available evidence concerning the death of Mr Lee, Mr De Zilwa suggested a number of recommendations for change that might, in his assessment, prevent or render less likely deaths of this kind occurring again. I set out those recommendations insofar as they might be relevant to the issues in this Inquest.

> 'Troy Thomas LEE made several statements whilst he was on Home Detention to officers from Correctional Services in relation to his frustrations and feelings whilst on Home Detention Bail. These Officers provided him with some solutions and referral advice to seek further treatment for his moods and feelings. It appears that these recommendations were never followed up on.
>
> Whilst a person is on Home Detention Bail the Department of Corrections has no authority to make a person seek treatment, this can only be done by a Court. It is recommended that when a person on Home Detention Bail displays the same signs as LEE some form of regular counselling is able to be enforced to ensure a positive state of mental health.
>
> It is recommended that Department of Correctional Services Home Detention Officers receive appropriate training in the managing and identifying of prisoners likely to be a risk of suicide.' [30]

6.4. I have given consideration to whether I should make those same recommendations having regard not only to the evidence in the case of Mr Lee but also the evidence in the case of Mr Matthews. It is difficult to disagree with the sentiments that would underlie such recommendations insofar as they might protect 'at risk' detainees. However, I have already referred to the regime of intervention that section 21B of the Bail Act 1985 is capable of providing. It seems to me that it would be capable of providing precisely the kind of regime that Mr De Zilwa envisages. It will be noted also that under section 21B of the Bail Act 1985 an Intervention Program cannot be imposed on a bailed person without the consent of that person. One can readily understand why this ought to be the case. A bailed person, who among other things

[30] Inquest 4/2010, Exhibit C27b, page 22

has the presumption of innocence as well as the right not to self-incriminate, is not a convicted prisoner in respect of whom different considerations might apply[31]. It would therefore seem incongruous for DCS staff to be given the power to impose a defacto regime of intervention without either Court sanction or the consent of the individual. That said, DCS officers should regard it as part of their responsibility to draw to the attention of the Court, to the police or to any other relevant person such as a family member, any concerns that they entertain about the welfare or frame of mind of an individual home detainee.

6.5. Whether or not DCS officers should actually be professionally trained to recognise and manage 'at risk' home detainees is a matter that is not free from difficulty. One matter that would require consideration in this regard is whether it would be appropriate for such officers to assume such a high duty of care. In this case there is insufficient evidence to suggest that such formal training would, or might, have altered the outcome in either of these two cases. However, the need for such training is a matter that the Minister for Correctional Services and the Chief Executive of the Department for Correctional Services should consider and I recommend that they do so.

Key Words: Death in Custody; Home Detention; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 7th day of April, 2011.

Deputy State Coroner

[31] Section 21B(2)(a) of the Bail Act 1985