CORONERS ACT, 2003

*SOUTH*  *AUSTRALIA*

# FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at in the State of South Australia, on the 11th, 12th and 13th days of September 2012, the 17th day of October 2012 and the 2nd day of July 2013, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Christopher Aaron Smith.*

*The said Court finds that Christopher Aaron Smith aged 30 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Yatala Labour Prison, Northfield, South Australia on the 12th day of July 2010 as a result of compression of the neck consistent with hanging. The said Court finds that the circumstances of his death were as follows:*

## 1. Introduction, cause of death and reason for Inquest

1.1. On Monday 12 July 2010 the deceased, prisoner Christopher Aaron Smith, aged 30 years, was found hanging in his cell at Yatala Labour Prison (YLP). Mr Smith occupied cell number 521 which is situated in the B Division Top West Wing of the prison. He had occupied that cell alone. A ligature made out of a strip of green sheet was around Mr Smith's neck. A large loop had been formed by a fixed knot. The ligature had been attached to the grille of an air vent within the cell. Mr Smith's hands were tied together in front of his body. By the time he was located during a routine cell inspection early that evening, Mr Smith was deceased.

1.2. A post-mortem examination of Mr Smith's body was performed by Dr Neil Langlois, a consultant forensic pathologist at Forensic Science South Australia. In his post-

mortem report[1] verified by affidavit Dr Langlois describes the cause of Mr Smith's death as compression of the neck consistent with hanging. Dr Langlois reports that there were no features to indicate the involvement of any other person in the death.

1.3. There was no evidence that any person had access to Mr Smith's cell at any material time prior to his hanging. The fact that his hands were tied at the front is not inconsistent with Mr Smith himself having tied his hands together without assistance. One can infer that the hands were tied together prior to the act of hanging in order to prevent means by which Mr Smith might have saved himself had he experienced a change of mind. It occurs to the Court that if any assistance had been provided by any other person as far as the act of tying Mr Smith's hands is concerned, it is more likely that they would have been tied at the back.

1.4. Toxicological analysis[2] of the sample of blood obtained at the time of the post-mortem examination revealed the presence of the strong opiate based analgesic Tramadol at a level that was potentially fatal in itself. Prison medical records indicate that Mr Smith had been prescribed Tramadol for back pain and that he had received it on a regular basis. It is not known whether Mr Smith had managed to hoard an excessive quantity of Tramadol or had augmented his supply of it from other sources. Dr Langlois surmises that it is possible that in the first instance Mr Smith stood with the ligature around his neck until he lost consciousness from the effects of the Tramadol. That would then have led to a physical collapse which would have placed pressure on his neck. The fatal results of that compression would then have followed. It seems to the Court that Dr Langlois' posited scenario is a reasonable one, but it also occurs to the Court that regardless of the assistance that the ingestion of Tramadol or any other substance may have provided, Mr Smith had a strong determination to end his own life by hanging.

1.5. Mr Smith also had a non-toxic but therapeutic concentration of the prescription antidepressant Mirtazapine in his bloodstream. It had not been prescribed for Mr Smith and so its source, although clearly not legitimate, is unknown. However, the fact that he sourced this drug without any identified clinical need or prescription gives weight to the suggestion that he may well have obtained an excess of Tramadol from a similar source.

[1] Exhibit C3a
[2] Exhibit C4a

1.6. I find that the cause of Mr Smith's death was compression of the neck consistent with hanging. I further find that Mr Smith was alone responsible for the act that led to his death. No other person was involved. I further find that Mr Smith intended to take his own life.

1.7. Mr Smith was accommodated within the South Australian correctional system at YLP, having been remanded in custody in relation to serious criminal charges that were still unresolved at the time of his death. Accordingly, this was a death in custody which by virtue of the provisions of the Coroners Act 2003 meant that an Inquest into the cause and circumstances of his death was mandatory.

1.8. Mr Smith was a Koorie Aboriginal man by virtue of his natural father's Aboriginality. His maternal aunt, Ms Kaye Louise Smith, provided a statement to the Inquest[3] and gave oral evidence. Much of this material concerned Mr Smith's background. Ms Smith told the Court of efforts that she had made in an endeavour to have Mr Smith remanded at a South Australian correctional facility that was closer to his home in Victoria, specifically Mount Gambier Prison. I will come to the detail of that in due course.

1.9. Ms Smith told the Court that Mr Smith resided in Warrnambool in Victoria. Warrnambool is approximately 185 kilometres or a 2 hour drive from Mount Gambier in South Australia. Mr Smith resided at Warrnambool with his partner Katrina and their three daughters who at the time of his death were aged 3 years, 2 years and 12 months respectively. In fact the third daughter, born on 16 July 2009, was born at a time after Mr Smith's arrest in South Australia and while he was in custody in this State.

1.10. As part of Ms Kaye Smith's description of Mr Smith's history, she recounted that Mr Smith had been incarcerated on a number of occasions in Victoria. Ms Smith stated that one short remand period in Victoria that she knew of had involved Mr Smith finding it very difficult being away from his family. However, she did not believe that he had been involved in any incident of self harm or threatened self harm whilst incarcerated on any occasion in Victoria. There was in existence a psychiatric report that had been compiled in connection with a court appearance in the Victorian County Court in 2007 in which it was asserted that Mr Smith had expressed '*suicidal ideation*

[3] Exhibit C41

*with no attempt prior to self harm in the context of the current offences"*[4]. This appears to be the only known suggestion of suicidality in Mr Smith's history. Ms Smith had retained a copy of this report, but it does not appear to have seen the light of day, as it were, during Mr Smith's period of incarceration in 2009 and 2010. It raises a question as to whether the Department for Correctional Services (DCS) in South Australia should have access to the correctional records of a prisoner who has been incarcerated in another State.

1.11. Ms Smith told the Court that Mr Smith had little or no connection with South Australia except that at one time he had resided in Victor Harbor and in that period had met a man whom she believed was ultimately to be Mr Smith's co-accused in the matters for which he would be arrested in 2009 in South Australia and thereafter kept in custody.

1.12. Ms Smith also mentioned something of a cultural difference in respect of his Aboriginality insofar as Aboriginal persons of Koorie connection in Victoria would not have much in common with their South Australian counterparts.

1.13. Ms Smith told the Court that she had been made aware of Mr Smith's plan to travel to South Australia in advance of him leaving Victoria. She said that at a family day organised by an Aboriginal cooperative he had told her that he was going to South Australia. She stated that although he did not tell her specifically, she had a feeling that he was going to South Australia to involve himself in criminal activity. He was finding it very difficult without work in Victoria. She said:

> '… he would never leave his family otherwise ' [5]

I am not entirely certain as to the extent of Mr Smith's actual connection with South Australia, but it is apparent that he had a greater connection than mere short term residence in Victor Harbor because he had a South Australian criminal history commencing in 1996 with convictions recorded for traffic, breach of bail, behavioural, assault, drug and property offences. He had spent custodial periods in the Adelaide Remand Centre (the ARC) and Mobilong Prison in 1998 and 1999. However, there is no reason to doubt that in 2009 and 2010 Mr Smith's separation from his family due to his then current custodial circumstances had a profoundly adverse emotional effect on him.

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[4] Exhibit C42
[5] Transcript, page 50

1.14. On 15 May 2009 Mr Smith was arrested and charged with armed robbery and unlawful possession of firearms committed in South Australia. It was in respect of these unresolved charges that Mr Smith would remain in custody in South Australia until the day of his death. Having regard to Mr Smith's criminal history, particularly in Victoria, that included convictions for armed robbery, assault and firearm offences for which significant terms of imprisonment had been imposed, it was highly unlikely that any application for bail in South Australia would be granted, especially also taking into account his lack of meaningful and legitimate ties with this State. This would prove to be the position in respect of Mr Smith for the entire duration of his remand. Except for an approximate two week period in April and May 2010 when Mr Smith was accommodated in the Mount Gambier Prison, he spent the entirety of his period of remand either at the ARC or YLP, both institutions being in metropolitan Adelaide. Mr Smith did not receive any visits from his immediate family while in Adelaide. Unsurprisingly, his enforced separation from his family placed his relationship with his partner under great strain.

1.15. It is as well to point out that for the entirety of his custodial period in South Australia in 2009 and 2010 Mr Smith was not a prisoner serving a sentence of imprisonment. He had not been convicted of the offences for which he had been arrested and remanded in custody. He had yet to undergo a trial. Indeed, at the time of his death an actual trial date was not even in anyone's contemplation. The evidence would indicate that in the period leading up to his death Mr Smith had intended to plead not guilty to the charges and this would have involved him undergoing a trial in the District Court of South Australia in due course. Convictions for the offences with which Mr Smith was charged would very likely have resulted in him being imprisoned in South Australia for some significant period of time in addition to the time on remand that he had already served and would serve prior to sentencing. None of this would have been lost on Mr Smith.

1.16. I have referred to the fact that Mr Smith was arrested on 15 May 2009. For reasons that are by no means clear, and in the nature of things are probably multi-factorial and beyond the scope of this inquiry to investigate fully, Mr Smith was not committed for trial until 18 June 2010 when a no case to answer submission was rejected. Mr Smith was due for arraignment in the District Court on Monday 19 July 2010. He died on

12 July 2010. Mr Smith would have been required to attend his arraignment in person. The arraignment would have taken place in the District Court sitting in Adelaide. Although the cynic might say that this long and ever-lengthening period of remand was at Mr Smith's election, and that it was a circumstance of his own making, this was a remarkable length of time for a person to be remanded in custody with no resolution of his matter in sight particularly having regard to the fact that, because for the most part he was accommodated at the YLP, he was subjected to the same punitive regime as a convicted prisoner serving a sentence. In fact Mr Smith was at a considerable disadvantage when his plight was compared to the lot of the convicted prisoner insofar as the chances of him during his period of remand being placed in a correctional facility that was closer to his family were significantly less favourable than those of a prisoner serving a sentence. This was due to the fact that remand prisoners are deemed to be more appropriately accommodated in close proximity to the Court at which they will appear. The convenience of their legal advisors is also a relevant consideration in this regard.

1.17. In the whole of the time of Mr Smith's period of remand in institutions in metropolitan Adelaide, the only visits of significance of which the Court is aware were those made by Ms Smith in May 2009 in the period immediately following Mr Smith's arrest. During the two week period at the Mount Gambier institution to which I have referred he received visits from his partner Katrina and his children. It is not entirely clear whether the lack of visits from his partner and children whilst accommodated in institutions in metropolitan Adelaide were due to the tyranny of distance or possibly a lack of inclination on the part of his partner or both.

1.18. Mr Smith was at no stage recognised as being at risk of self-harm during his period of remand. However, his despondent frame of mind was known to other prisoners. They kept this information to themselves. As well, there had been an incident in November 2009 when Mr Smith was accommodated at the ARC in which Mr Smith had attempted to hang himself but had persuaded the authorities that he had sustained the resulting neck injury during exercise. A prisoner co-habiting Mr Smith's cell knew of the attempt but, again, the information went no further than that prisoner.

1.19. In this Inquest I examined a number of issues that included the following:

- Was it reasonable for Mr Smith to have been accommodated in correctional institutions in metropolitan Adelaide except for a two week period in April and May 2010;
- Was it reasonable for Mr Smith to have been accommodated at YLP as on the day of his death, 12 July 2010:
- Can the reasons for Mr Smith's decision to end his own life be identified;
- Were there any indications by which Mr Smith's intent to take his own life, or the risk of him doing so, could have been identified in advance;
- The source of Mr Smith's Tramadol and the role it played in his demise;
- The elimination of hanging points in cells.

## 2. The circumstances of Mr Smith's death

2.1. On the day of Mr Smith's death, which was Monday 12 July 2010, Mr Smith had two telephone conversations with his partner, Katrina Smith. The telephone conversations commenced at 2:27pm and 3:02pm respectively. The calls were recorded on the prisoner telephone system. A telephone in the wing was made available for prisoners.

2.2. The telephone conversations have to be considered against the background of the enforced separation between Mr Smith and his partner. He had last seen his partner when he had been visited by her in Mount Gambier Prison on 1 May 2010. The conversations of 12 July 2010 also have to be examined against earlier telephone conversations in the days preceding the day of his death. Those conversations were also recorded. Parts of those conversations demonstrate a measure of tension between the couple. A search of Mr Smith's belongings that was conducted after his death revealed letters that he had written to his partner and his children[6]. The letter addressed to his partner is dated the day before his death. It is clear from both letters that he contemplated suicide. As I understand the position, these letters remained undisclosed to their intended recipients until just before the commencement of the Inquest. They had not been delivered to nor drawn to the attention of Ms Katrina Smith. This is a circumstance that, save in exceptional circumstances such as the need to preserve the integrity of an investigation, should not be repeated.

[6] Exhibit C55

2.3. In the first conversation on the afternoon of 12 July 2010 commencing at 2:27pm, Mr Smith and his partner discuss in sometimes acrimonious terms their relationship. Katrina Smith uses expressions such as 'we're done' and 'I'm over you'[7]. When Mr Smith pleads for her not to leave him she suggests that she already had. Mr Smith clearly harbours a suspicion that Katrina Smith is having an affair. Ms Smith fails to deny this and, if anything, countenances its possibility. This theme continues throughout the conversation and ultimately Mr Smith, despite persistent questioning, does not obtain a straight answer from her as to whether she is or is not having an affair. In the event, Ms Katrina Smith suggests that they are really finished as she cannot take anymore. The conversation concludes again on the theme of Katrina Smith's infidelity or otherwise and she gives the same non-committal responses. The last exchange between them consists of Mr Smith saying 'Goodbye. Forever. Goodbye' and repeating that[8].

2.4. There is a further telephone conversation between them initiated by Mr Smith and which commences at 3:02pm. In this second and final conversation between Mr Smith and his partner there is further discussion about whether Ms Smith is going to leave him to which she provides non-committal responses. There are similar conversations concerning whether she has been faithful or not. Again she is non-committal in her responses. The telephone conversation occurred in the period immediately prior to the 3:45pm lockup. Mr Smith's questioning is persistent and he evinces some little anxiety – he wants to know the truth about her fidelity or otherwise before he is locked in his cell for the night[9]. At one point Katrina Smith suggests that she may have had some contact with another man but provides little detail except to say that she may have kissed another man. When Ms Smith repeatedly attempts to avoid the issue of her fidelity or otherwise, Mr Smith says:

> 'Nah - please tell me. Don't make me go to the cell like this baby. Coz if I did fucking do something stupid then you can't take that back.' [10]

The conversation then concludes.

2.5. In Ms Katrina Smith's statement to police[11] she acknowledges that in these phone conversations she had told Mr Smith that the relationship was over. As to his

[7] Exhibit C33ae, page 157
[8] Exhibit C33ae, page 165
[9] Exhibit C33ae, page 169
[10] Exhibit C33ae, page 173

persistent questioning about her fidelity or otherwise, she acknowledges that she told him that she had '*played up on him and kissed another guy*'. However, Ms Smith states that the reality was that she had not been involved with another person during Mr Smith's incarceration and that during the final two telephone conversations with him on the day of his death she had been '*just pressing his buttons as I was so angry with him*'. She says that she was never going to leave him. The tone of the conversations as revealed by the transcripts is not inconsistent with Katrina Smith's position that she had merely been taunting Mr Smith out of frustration at their separation.

2.6. It is evident that many of Mr Smith's co-inmates in B Division Top West were aware of the fact that Mr Smith had been speaking on the telephone with his partner prior to lockdown on the afternoon of his death and that things had not gone well for him. Investigating police took a number of witness statements from several prisoners who had knowledge of Mr Smith and his demeanour during the course of that afternoon. I do not need to go into the detail of all of those statements. It is apparent from nearly all of them that Mr Smith in recent times had conducted a number of telephone conversations with his partner, Katrina Smith, and that many of them had involved acrimonious discussion that had resulted in Mr Smith becoming despondent in the period leading up to his death. This appears to have been common knowledge in Mr Smith's wing. One prisoner[12], Justin Collins, states that Mr Smith experienced a measure of frustration with his partner during telephone conversations with her and that this appeared to stem from her reluctance to discuss various issues with him. He said that on a number of occasions he had seen Mr Smith leave the phone very depressed. However, Mr Collins suggests that Mr Smith's level of depression was not such that Collins would have told any person about it, even though he would not have had any conceptual difficulty about mentioning a prisoner's plight to a guard. In any event it seems plain enough that none of the prisoners who had formed the view that Mr Smith was depressed, despondent or simply not coping very well with the separation from his family had told anyone in authority about this. It is said that there is something of a natural and almost universal reluctance on the part of prisoners to do so, to my mind a questionable generalisation that I will come back to in another section.

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[11] Exhibit C20a
[12] Justin David Collins, Exhibit C33a

2.7. As to the events of the afternoon of 12 July 2010, a prisoner by the name of Christopher Grandinetti[13] states that following a phone call that Mr Smith had conducted with his partner that day, Mr Smith told him that they were breaking up as she had been unfaithful. Mr Smith had seemed to receive that news very badly, and although he did not state specifically that he was going to hang himself, Mr Grandinetti could see by the way he was talking and acting that he was *'going to do something'*[14]. When Mr Grandinetti saw Mr Smith just before lockup at 3:45pm, Mr Smith called him to the trap of his cell door, shook Mr Grandinetti's hand and said goodbye. The prisoner Justin Collins[15] states that during Mr Smith's final telephone conversation with his partner, Mr Smith went extremely quiet on the phone and almost went white in colour. Mr Collins assumed, correctly as it transpires, that Mr Smith's partner had told him that she did not want to continue the relationship with him. At the conclusion of the conversation, Mr Smith hung up the phone, walked directly to his cell and closed the door. According to a prisoner by the name of Nathan Sweeney[16], that after arguing on the phone Mr Smith told him in terms that he was going to hang himself that night. Mr Smith told Mr Sweeney that he was going to hang himself because he and his girl were arguing and that they had broken up as he had discovered that she had cheated on him. Having said that, however, Mr Smith then said that he would see the inmate Sweeney the following morning. Other prisoners were aware of Mr Smith's telephone conversations with his partner that afternoon and they are as one in respect of Mr Smith's extremely despondent demeanour following those calls and just prior to lockup. One prisoner, Mr Stephen Peter, suggests that the topic of Mr Smith's belief that his partner was cheating on him was the matter that ultimately *'tipped him over the edge'*[17]. Another prisoner had an impression in the period leading up to Mr Smith's death that if Mr Smith's fixation with his partner's alleged infidelity was ultimately to be confirmed, it would be too much for him. In the event the same prisoner suggests it therefore did not surprise him that Mr Smith ultimately killed himself[18].

2.8. None of the concerns as entertained by prisoners either in the days before Mr Smith's death or following Mr Smith's telephone conversations with his partner that afternoon, were conveyed to Correctional Services or Prison Health Services staff.

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[13] Exhibit C33d
[14] Exhibit C33d, page 3
[15] Exhibit C33e
[16] Exhibit C33f
[17] Exhibit C33i, page 2
[18] Statement of Mark Trevor Marshall, Exhibit C33j

2.9. When Mr Smith's letter to his partner and his final phone conversations with her are taken together, an impression is created that Mr Smith's state of mind was one in which he was looking for means to legitimise what he was contemplating. As indicated earlier, Ms Katrina Smith states that she had only been stringing Mr Smith along, as it were, in respect of the topic of infidelity. Nevertheless, it appears that Mr Smith had finally determined in his own mind on the afternoon of 12 July 2010 that she had been unfaithful and that the relationship was over. This appears to have acted as the most acute impetus to his decision to end his own life.

2.10. Mr Smith was secured in his cell 521 in B Division Top Floor West at 3:45pm. This was the usual time at which prisoners were secured in their cells. At that time Mr Smith was observed by corrections staff sitting on his cell bunk and was not showing any signs of distress. The cell door was locked and double locked with the master key.

2.11. Mr Smith was discovered hanging during a routine cell inspection. There are variously recorded times at which this cell inspection was conducted and at which a Code Black, which signifies a medical emergency, was called. These discrepancies for the most part are unexplained except by reference to the fact that various times were recorded by different persons. However, I am satisfied that the discrepancies have no materiality. I am further satisfied that Mr Smith was located hanging in his cell at about 5:30pm or within a minute or two afterwards.

2.12. The Correctional Services officer who located Mr Smith was Mr Gregory Hughes. He had last seen Mr Smith alive at about 3:55pm. This is the last known sighting of Mr Smith alive. Mr Hughes' statement[19] to police given that same evening states that he returned to B Division to conduct the 2 hourly prisoner check at about 5:30pm and that at about 5:32pm he arrived at cell 521 which was Mr Smith's cell. In a log he recorded that he commenced the 2 hourly patrol at 1730 hours[20]. Mr Hughes was alone when he conducted this patrol.

2.13. At first, Mr Hughes observed Mr Smith through the peephole of the cell door and then through the trap which allowed greater vision. Mr Smith was hanging. Mr Hughes was not able to open the cell door immediately because he did not have the master key. Patrol officers routinely do not keep possession of the master key. However, I

[19] Exhibit C43a
[20] Exhibit C43b

am satisfied from the evidence that the master key arrived without undue delay. The cell door was opened. Once opened, Mr Smith could be seen hanging from a ventilation grille located above the cell door. His feet were only just touching the ground. A chair was positioned behind him. Fabric from a green cell bed sheet was wrapped around his neck and tied to the grille. Mr Smith was cut down using a safety knife. Other officers arrived on the scene as did nursing staff. The South Australian Ambulance Service were called and attended. There was no undue delay in the arrival of these entities.

2.14. When Mr Smith was cut down and examined by nursing staff he was unresponsive and in cardiac arrest. There was no shockable rhythm detected and so defibrillation was not administered. Mr Smith was effectively deceased at that point. It is not known with precision for how long Mr Smith had been deceased.

2.15. There is no suggestion other than that timely assistance was provided to Mr Smith. There is no suggestion in any event that more timely assistance would have altered the outcome having regard to Mr Smith's condition when located.

2.16. It is clear that between 3:45pm and approximately 5:30pm Mr Smith hanged himself in the manner I have described. No other person had access to his cell in that period of time and so it is conclusively established that no other person was involved in Mr Smith's hanging. It is not possible to determine at what time Mr Smith began his preparations for hanging or at what time the hanging took place. It is thus not possible to determine whether any more frequent patrols or cell inspections would have altered the outcome for Mr Smith. In any event there is no suggestion that Mr Smith's 2 hourly routine observations were anything other than appropriate for his level of risk as it was perceived to be at that time.

## 3. <u>The sites of Mr Smith's custodial accommodation in South Australia</u>

3.1. It is important to remember in this regard that although Mr Smith was indeed isolated from his family and that circumstances were such that it was very difficult for his family to visit him whilst in metropolitan Adelaide, there is no suggestion that Mr Smith was perceived to be at risk of self harm at the time he was admitted to custody within the ARC in the first instance or at the time of his death when accommodated at YLP, although as already alluded to, in November 2009 there was an incident at the

ARC which if the matter had been more rigorously investigated at the time, may well have indicated that at that point in time there was a significant apparent level of risk.

3.2. Mr Smith was an Aboriginal prisoner. Recommendation 168 of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)[21] is as follows:

> '168. That Corrective Services effect the placement and transfer of Aboriginal prisoners according to the principle that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of his or her family. Where an Aboriginal prisoner is subject to a transfer to an institution further away from his or her family the prisoner should be given the right to appeal that decision. (3:310)
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> 169. That where it is found to be impossible to place a prisoner in the prison nearest to his or her family sympathetic consideration should be given to providing financial assistance to the family, to visit the prisoner from time to time. (3:312)' [22]

3.3. The Commonwealth, States and Territories ultimately provided responses to these recommendations. The South Australian response in respect of Recommendation 168 was that the recommendation was supported. Specifically, the response states that placement in an institution as close as possible to the place of residence is a factor considered by the Prisoner Assessment Committee in determining sentence plans. It also stipulates that generally an accepted placement is negotiated with prisoners. It will be observed that the South Australian response states that a prisoner's placement in terms of its proximity to the family's place of residence is a matter to take into account in determining a 'sentence plan'. To my mind this is an indication that the recommendation of the RCIADIC was, as far as this jurisdiction is concerned, for practical purposes to be confined in its application to prisoners serving a sentence and not be applicable in relation to remand prisoners who, generally speaking, are required to attend court from time to time and who need to be accessible to their legal advisors. As to recommendation 169, the South Australian response was that there was no mechanism to support such visits other than by way of providing assistance through bodies such as the Offenders Aid Rehabilitation Scheme.

3.4. Against the background of a perceived lack of risk in respect of Mr Smith, his on-going period of remand and the above RCIADIC recommendations, the following occurred. By way of letter dated 30 June 2009, Mr Smith made a written request that

[21] Exhibit C54
[22] Exhibit C54

he be moved to the Mount Gambier gaol. He cited as reasons in support of his application that he had no family in South Australia, that his wife was in Warrnambool which was an hour and a half drive from Mount Gambier, they had two young daughters as well as a teenage daughter from his wife's previous relationship and that his partner was due to give birth to a third daughter. He cited the hardship involved in being so distant from his family. In this letter Mr Smith pointed out that he had been excused from personally attending his next court appearance on 8 September 2009 and that he did not expect to have to go to court again until the following year. He suggested that his wife and children would be able to regularly visit him in the Mount Gambier Prison but that it was too difficult for them to visit him in an Adelaide institution.

3.5. On 2 July 2009, Mr Smith's maternal aunt, Ms Kaye Smith, wrote to the General Manager of YLP in support of Mr Smith's application for transfer to the Mount Gambier facility. She emphasised the same geographical difficulties that Mr Smith had described in his own letter. In addition, she referred in some detail to the difficulty she herself had experienced in visiting him in Adelaide in May 2009. Ms Smith argued that as a Koorie man he had little in common with South Australian Aboriginal inmates and likened his situation to him being imprisoned in another country. She made specific reference to recommendation 168 of the RCIADIC. She concluded by writing:

> 'In closing, whilst Chris remains in Adelaide, isolated from family and friends and due to the tyranny of distance, I hold grave concerns for his wellbeing. The loss of seeing his family regularly has had a huge, negative impact upon his emotional and physical health. I strongly support his request for transfer to Mt Gambier Correctional Facility, so that his family and cultural connectedness can be maintained. I urge you to consider my letter and the points above, when making your decision.' [23]

3.6. Mr Smith's letter was replied to by the Prisoner Assessment Unit (as it was then known) on 7 July 2009. Ms Smith's letter was replied to on 8 July 2009. Both letters referred to the need for Mr Smith to remain at YLP in order to facilitate future court appearances. The letter to Ms Smith stated it was envisaged that he would remain at YLP until the court matters had been dealt with, but that circumstances might arise whereby a transfer of a prisoner was deemed to be necessary prior to those dates. It was pointed out to Mr Smith specifically that his future institutional placement would

[23] Exhibit C39

be a matter that would be determined, taking into account family and social networks and other special needs. These arrangements were said to be a matter for consideration once he was sentenced.

3.7. In October 2009 Mr Smith again wrote seeking transfer to the Mount Gambier Prison and also specifically requested that consideration be given to that request once he was sentenced. A reply dated 30 October 2009 from the Prisoner Assessment Unit referred to their previous letter, specifically reiterating that consideration would be given to his personal circumstances once he was sentenced.

3.8. In March 2010 Mr Smith again wrote pointing out that he had been on remand for 9 months, that his case was still in the Magistrates Court and that his lawyer had indicated that his court matters would not be finalised for another 12 to 18 months. Mr Smith made the same request for transfer as before.

3.9. I would also point out that a number of other citizens, some prominent, had written letters to the prison that supported Mr Smith's application.

3.10. Mr Smith was transferred to the Mount Gambier Prison on 21 April 2010. He remained there until his transfer back to YLP on 4 May 2010. On this occasion Mr Smith was visited by his partner and children on a number of occasions. Equally, there were occasions when visits had been arranged but where his partner did not attend.

3.11. The reason recorded for Mr Smith's transfer to the Mount Gambier Prison was to enable him to receive visits from his family who resided in Warrnambool. As to the reason why he was transferred back to YLP on 5 May 2010, there is a suggestion as recorded within the Department for Correctional Services' records that Mr Smith was transferred back to YLP because a Mt Gambier prisoner by the name of Rigney had made an allegation of assault against Mr Smith. This allegation is also documented within Mr Smith's own offender casenotes[24], but there is no suggestion in that documentation that this was the actual reason for his transfer out of the Mount Gambier facility. In the event, prisoner Rigney withdrew his allegations against Mr Smith. I heard evidence from Mr Frank McCann who is the Executive Officer of the Sentence Management Unit at the Department for Correctional Services. Mr McCann

[24] Exhibit C40

assured the Court that Mr Rigney's allegation was not the reason for Mr Smith's transfer back to YLP. Rather, Mr Smith had imminent court appearances in Adelaide, and in any event a fortnight period for the purposes of visits was a routine length of time for such purposes[25]. Mr Smith would have court appearances on 1 June 2010 and 18 June 2010, and his arraignment in the District Court was due on 19 July 2010.

3.12. Following Mr Smith's two week period of accommodation at Mount Gambier, he again wrote to the relevant authority in the Department for Correctional Services requesting further consideration be given to accommodating him in Mount Gambier whilst on remand. He stated in a letter dated 16 May 2010 that he expected to be on remand for another 12 to 18 months. He expressed his appreciation for the recent two week period in Mount Gambier. The reply from Mr McCann dated 21 June 2010 was to the effect that his request would be considered but that his placement within the prison system still depended upon the dates of matters still before the court. When Mr McCann gave evidence to the Inquest he told the Court that the door had not been shut, as it were, on any further period of accommodation in Mount Gambier for Mr Smith whilst on remand. However, it is uncertain whether Mr Smith himself held out any such hope or expectation in his own mind. What Mr McCann did tell the Court was that once Mr Smith had been sentenced, it was almost certain that they would have moved him to Mount Gambier on the basis of all of the matters that Mr Smith had asked to be taken into consideration[26].

3.13. It is worthwhile noting that Mr Smith had telephone access whilst on remand and that he regularly spoke on the telephone with his partner, Katrina Smith.

3.14. I find that regardless of whether or not it might be thought that Mr Smith's accommodation in Mount Gambier could reasonably have continued beyond 5 May 2010 notwithstanding an imminent court appearance requiring his attendance on 1 June 2010, as of 12 July 2010 which was a week prior to his District Court arraignment for which he would again be required to attend personally, it cannot be said that there was anything unreasonable about Mr Smith being accommodated in a correctional facility in Adelaide.

[25] Transcript, page 385
[26] Transcript, page 414

## 4. The November 2009 incident

4.1. On 3 November 2009 at a time when Mr Smith was being accommodated at the ARC he was observed to have a mark on his neck that would be described in his offender casenotes[27] as 'a Red Mark around his neck from Ear to Ear and round the front of his Throat Area'. It would also be described in Mr Smith's Prison Health Service file[28] as a 'rope burn to neck … Burn covers ½ circumference of neck, higher on the left than right side'.

4.2. Due to the passage of time since this incident, the recollections of Correctional Services and Prison Health Service staff members concerning this particular incident were less than perfect. The incident was treated as benign at the time, although it did attract some suspicion as an attempt at self harm. However, inquiries that have since been conducted have to my mind established that the injury to Mr Smith's neck was evidence of an attempt by him to hang himself in his cell.

4.3. At the time of the events of 3 November 2009 Mr Smith was occupying a cell together with another prisoner by the name of Galffy.

4.4. It is as well firstly to describe the evidence about this incident that has emerged since the events of November 2009. None of this material was available to either Correctional Services of Prison Health Service staff at the time. Following Mr Smith's death a diary was located in his cell. An entry dated 3 November 2009[29] provided a description of what had taken place in respect of the injury to Mr Smith's neck. The diary entry speaks of Mr Smith's anxiety at being separated from his partner and his daughters, and his yet to be fulfilled desire to be accommodated in Mount Gambier. In the context of these issues he refers to it being easier for everyone if he 'just called it quits' and he also refers to his current emotional fragility. The diary entry then goes on to describe that after his cell mate had gone to sleep during the previous evening, he had consumed a handful of sleeping tablets. He describes having made a rope out of a sheet, having tied it around something connected to the shower, and then having placed it over his neck while standing on a plastic chair. He blacked out and his next recollection is lying on the floor. He describes being revived by his cell mate. He also describes his cell mate having cut

[27] Exhibit C40, page 13
[28] Exhibit C34, page 21
[29] Exhibit C47

the ligature with a razor. There is also reference to the Correctional Services staff attending at the cell but being told that Mr Smith was simply ill. In the diary entry Mr Smith has referred to the injury to his neck and that, as of the time of writing the diary entry, it was causing him pain and looked 'realy (sic) bad'. He refers to his anxiety at the prospect of being put 'in the slot' which one assumes is a reference to a level of higher scrutiny within the prison. Thus he refers to inventing a story to the effect that he had sustained the injury in the gymnasium. He indicates in the diary entry that this was the story that he provided to Correctional Services staff and in particular refers to the fact that he reported the injury to staff in the gymnasium. Although the diary entry does not explicitly describe an intention on Mr Smith's part to kill himself, his described actions taken at face value and his frame of mind as also described in the entry make it clear that he was in fact describing an attempt to take his own life. This is supported by reference in the diary to his having been spared from death. The taking of sedating medication prior to the hanging attempt on this occasion is also a strikingly similar circumstance that would be replicated in the ultimately successful attempt to take his own life some 8 months later.

4.5. Investigating police took a statement from Mr Troy Levi Galffy on 8 April 2011[30]. The statement is attached to the affidavit of Detective Brevet Sergeant Peter Moore of the Police Corrections Section. Mr Galffy's statement is not on oath, but I accept it as an accurate account of what Mr Galffy told Detective Brevet Sergeant Moore in April 2011. As of 3 November 2009, the day of the finding of Mr Smith's neck injury, Mr Galffy and Mr Smith had been jointly occupying a cell for approximately 3 weeks. Mr Galffy stated that at times Mr Smith was despondent because of his geographical separation from his family. However, he did not believe that he would harm himself. Mr Galffy describes an incident during the night of Monday 2 November 2009 in which he had woken up to discover his cell mate, Mr Smith, hanging from the shower head in the cell. Mr Galffy confirms a number of details that are mentioned in Mr Smith's diary entry including the fact that the shower head was utilised, the ligature had been made from a sheet, that he used a razor blade to cut the ligature away from the shower head and that a correctional officer attended but was told that Mr Smith was merely unwell. It is evident that at the time Mr Galffy's statement was taken, he was shown Mr Smith's diary entry dated 3 November 2009. This gave rise to a suspicion that Mr Galffy was merely confirming the contents of the diary if not for the

[30] Exhibit C33r

sake of it, then for purposes other mischievous purposes. However, an addendum statement taken from Detective Brevet Sergeant Moore dated 27 September 2012[31] in which the circumstances of the finding of the diary and of the taking of Mr Galffy's statement are described, asserts that the diary entry was produced to Mr Galffy at the concluding stage of the statement production process. I am prepared to infer from that that Mr Galffy gave his account of the incident at a time before he knew any of the detail of the contents of Mr Smith's diary entry.

4.6. The statement of Ms Katrina Smith[32], Mr Smith's partner, taken in August 2010 and which is verified by affidavit, asserts that at one point during Mr Smith's incarceration the deceased told her that whilst in gaol in Adelaide, she believes it was in the ARC, he had tried to hang himself in his cell and that his cell mate had stopped him. She asserts that at one point she herself saw a scar on his neck.

4.7. The incident involving Mr Smith on 3 November 2009 became the subject of an investigation during the course of that day. There are two entries within Mr Smith's casenotes that are relevant. Both were made by Mr Smith's case management coordinator, Ms Rachael Whiteley. The first notation is timed at 2:35pm and notes that an Officer Bugden had observed the red mark around Mr Smith's neck from ear to ear and that when questioned about this Mr Smith had stated that he had accidentally *'caught it this morning in the Weights Area whilst lifting weights'*. The notation goes on to state that a Mr Palombella, a Correctional Services officer stationed in the gymnasium, had also been spoken to about the matter. The note suggests that Ms Whiteley had conferred with Mr Palombella who had stated that Mr Smith had not been injured but had sustained a mark to his neck, which seems to be a contradiction in itself. In any event Ms Whiteley noted that the mark appeared to be consistent with a possible self harm attempt. It is noted that erring on the side of caution Mr Smith was to be taken to the infirmary to have the mark investigated by medical staff.

4.8. Indeed Mr Smith was that afternoon examined by a registered nurse in the YLP infirmary. The result of that examination was that the mark on Mr Smith's neck was considered to be consistent with accidental infliction within the recreation area as had been claimed by Mr Smith. In addition, Mr Smith had denied any thoughts of self

[31] Exhibit C33am
[32] Exhibit C20a

harm and as a result he was returned to the unit. As I understood the evidence, no further action was taken in respect of this matter and in particular no action was taken in respect of any further risk assessment regarding possible self harm.

4.9. During the course of the Inquest three persons who were involved in this incident were called to give oral evidence. They were Mr Palombella, Ms Whiteley and the registered nurse who examined Mr Smith at the infirmary, Ms Alison Simons. Mr Palombella had no recollection of the matter whatsoever. However, his evidence satisfied me that it was highly unlikely that an injury of the kind described could have been accidentally inflicted in the gymnasium, particularly by use of weights or ropes or cables. Ms Whiteley who made the notations in Mr Smith's casenotes also had a limited recollection of the matter. But she did have a recollection of Mr Smith and the mark. She accepted that she must have spoken to Mr Palombella about the matter. It was difficult to reconstruct exactly what Ms Whiteley had been told by Mr Palombella and how strongly she may have entertained doubts about Mr Smith's explanation, but I am satisfied that she took the appropriate action by referring him to the infirmary. As things were to transpire following the examination in the infirmary, as far as Ms Whiteley was concerned there was nothing that could have absolutely refuted Mr Smith's explanation for the injury.

4.10. As to the examination at the infirmary, this was conducted not by a medical practitioner but by a registered nurse who that day was at YLP in her capacity as an agency nurse. As such Ms Simons was not an employee of the Prison Health Service and therefore possibly a person who was not completely familiar with the culture of denial that prisoners such as Mr Smith might embrace when it comes to diverting attention away from their activities. It was difficult for the Court to reconstruct the level of scepticism about Mr Smith's explanation that might have been imparted to Ms Simons either by Ms Whiteley herself or by Mr Smith's escorting officers. It is apparent that Ms Simons more or less took Mr Smith's explanation at face value. She noted that he had claimed that he had accidentally caused the neck injury in the gym while using weights with a nylon rope. She noted that he *'strongly denies self harm'*, She also noted that Mr Smith had a positive affect and that he not only denied self-harm but denied any thoughts of self harm. Ms Simons only had the vaguest

recollection of having conferred with any other staff member about the matter. Ms Simons' position on the matter can be summed up in the following answer:

> 'I was satisfied with his answer and with his presentation and with the nature of his injury. I thought it was congruent with what he was saying.' [33]

4.11. It seems to the Court that the key to this investigation would have been to have given closer scrutiny to Mr Smith's story that he had accidentally suffered this injury in the gymnasium when using weights, and in particular a nylon rope. The evidence of Mr Palombella satisfied me that such an explanation was implausible having regard to the type of equipment in the gymnasium and the level of scrutiny of prisoners within it. The implausibility of Mr Smith's account could have been established at the time, but unfortunately this seems to have gone unregarded. One suspects that this is due to inadequate communication between the participating staff members in this investigation. To my mind too much reliance was placed on the medical examination which, when it was all said and done, was a cursory one and one which relied very heavily on an acceptance of what Mr Smith had said. There seems little doubt that Mr Smith lied to everyone in order to divert attention from his existing frame of mind.

4.12. I am satisfied that Mr Smith had sustained the neck injury as a result of an attempt on his part to hang himself in his cell during the night of 2 and 3 November 2009.

## 5. The significance of the November 2009 incident

5.1. If the November 2009 incident had been appreciated for what it was, namely an attempt by Mr Smith to take his own life, there is no doubt that Mr Smith would have been considered to be a prisoner at significant risk of self harm. This would have attracted the operation of the pertinent procedures and protocols that existed within the YLP at that time. This would have included assessment by the Prison Health Service, placement within a different regime of scrutiny and supervision, regular assessment by the High Risk Assessment Team (HRAT) and insistence on Mr Smith continuing to occupy a cell with another prisoner. Mr Smith occupied a cell at YLP at the time of his death on his own. There was some evidence to suggest that Mr Smith had a tendency to make life difficult for cellmates and that for that reason in due course was allowed to occupy a cell alone.

[33] Transcript, page 319

5.2. The November 2009 incident occurred approximately 8 months prior to his death. It has not been possible to establish with meaningful precision whether or not had Mr Smith's earlier attempt to take his own life been identified as such, and whether consequent more rigorous regime of scrutiny that would have ensued, would have altered the eventual outcome for Mr Smith. Ultimately, if Mr Smith were assessed by the HRAT as being no longer a risk of self harm, Mr Smith would have been removed from the HRAT list. However, Mr Stephen Mann, who is the General Manager of YLP, gave evidence that in that event the fact that Mr Smith had ever appeared on the HRAT list would still be on the Justice Information System as a warning that the person involved had previously been considered at risk of self harm. Whether in the event this would have meant that in July 2010 Mr Smith may have been in a different and more favourable state of mind, or for instance had after all been permitted to occupy a cell alone, is impossible to gauge with certainty. On the other hand one can readily identify circumstances relating to Mr Smith that may have significantly altered had his earlier attempt on his own life been identified. He would have been psychiatrically or psychologically assessed in order to identify the underlying issues. It is conceivable that Mr Smith's concerns about the separation from his family in Victoria would have been acted upon with a greater level of concern. It may well be that consideration would have been given to Mr Smith spending more time in the Mount Gambier Prison. There are, however, too many variables to enable any firm assessment about whether or not Mr Smith's frame of mind in July 2010 would have been such as to prevent him from taking his own life. What can be said is that the chain of events that culminated in Mr Smith's suicide would have been significantly altered if correctional authorities had determined that Mr Smith was a prisoner at high risk of self harm.

## 6. Mr Smith's access to Tramadol

6.1. As seen earlier, at the time of Mr Smith's death he had in his bloodstream what might have been, but for the act of hanging, a fatal level of Tramadol in itself.

6.2. Procedures at the YLP, and in particular those overseen by Prison Health Service staff, were such that a fatal quantity of prescribed Tramadol should not have been capable of accumulation by an individual prisoner. Mr Smith had been prescribed Tramadol, ostensibly for back pain. Regardless of whether or not such a prescription was appropriate, and I will come to that issue in a moment, it certainly should not

have enabled Mr Smith to hoard a quantity of Tramadol that could be taken in one single ingestion. There is a possibility that Mr Smith obtained from an illicit source Tramadol in a quantity over and above what he had been supplied by way of prescription. This scenario is not out of the question having regard to the fact that Mr Smith also had a level of Mirtazapine in his bloodstream and that this medication had not been prescribed for him.

6.3. When Mr Smith first entered the South Australian correctional system in May 2009 he was not on prescription for Tramadol. However, on 11 February 2010 when seen by Dr Alan Moskwa, a medical officer employed by South Australia Prison Health Service, he complained of back pain. He claimed that he had experienced this pain for some years, having fallen from a horse. He added that he had sustained severe fractures and had been prescribed Tramadol for pain relief. He sought a prescription for Tramadol from Dr Moskwa. Quite apart from its therapeutic properties, Tramadol is taken as a drug of abuse as it has certain euphoric characteristics. Thus the suspicion of drug seeking would not infrequently be a live one in a correctional setting such as this, and would especially need to be guarded against where the patient nominates his opiate based analgesic of choice as Mr Smith did. Dr Moskwa endeavoured to confirm Mr Smith's assertions that in the general community he had been prescribed Tramadol for pain relief. To that end Dr Moskwa asked Mr Smith to sign a release enabling the doctor to seek information from two medical practices nominated by Mr Smith as being those from whom he had obtained prescriptions for Tramadol in the past. At that stage Dr Moskwa was not prepared to prescribe Tramadol without such confirmation.

6.4. In the event only one of those medical practices would reply and that was to the effect that Mr Smith had not attended that practice since July 2005. In any case the reply failed to confirm whether or not Mr Smith had ever been prescribed Tramadol.

6.5. Notwithstanding that lack of confirmation, when Mr Smith again presented to Dr Moskwa at the Prison Health Service clinic at YLP on 22 March 2010 Dr Moskwa prescribed Tramadol for Mr Smith's back pain. Accordingly, Mr Smith was furnished with a prescription of Durotram (a commercial name for Tramadol) at a dosage of 200mg every morning. On 28 April 2010 during Mr Smith's period of accommodation at the Mount Gambier Prison, this prescription would be increased to 300mg daily.

6.6. In his evidence before the Court, Dr Moskwa described the procedure whereby opiate medication such as Tramadol is administered in prison. He said that nursing staff attended at B Division for this purpose. A patient is brought to a room and the patient is closely observed to ensure that he swallows the tablet. Dr Moskwa asserted that the patient's mouth is examined afterwards to ensure that he has swallowed the tablet. Dr Moskwa acknowledged that stockpiling in prisons of drugs such as Tramadol was not unheard of[34]. There was a suggestion that at the Mount Gambier Prison Mr Smith may have had access to Tramadol in excess of a single daily dose delivered by way of a Webster pack. However, I am satisfied that a similar method of administration existed at Mount Gambier Prison, namely the administration of one tablet per day. The possibility that Mr Smith in a single cell would regularly regurgitate a slow release tablet, a practice apparently not unheard of[35], cannot be wholly discounted.

6.7. It is surprising that Dr Moskwa would commence a patient such as Mr Smith, accommodated as he was in a correctional institution, on an opiate drug when in the first instance he had been understandably reluctant to do so without confirmation of previous legitimate usage. Indeed, if anything, Mr Smith's alleged previous legitimate usage had effectively been refuted by one of the nominated medical practices that had been contacted for confirmation.

6.8. Dr Moskwa told me that Tramadol was no longer supplied within the correctional system in South Australia.

6.9. While arguably the prescription of Tramadol in the first instance was inappropriate without such confirmation, it needs to be borne in mind that the evidence demonstrated that Mr Smith was somewhat a manipulative individual and it is not difficult to infer that his assertions of back pain and the need for a strong painkiller could have had outward credibility. In any event, when regard is had to the fact that Mr Smith appears to have sourced another drug from an illicit origin, there is no firm evidence to conclude that the potentially fatal dosage of Tramadol that Mr Smith consumed on the day of his death had been hoarded by him out of his prison prescription.

[34] Transcript, page 116
[35] Transcript, page 452

## 7. Hanging points

7.1. The findings of this Court and other Coroners' Courts in Australia are replete with instances of prisoners using hanging points in cells in order to end their own lives. The hanging point in this case was a ventilation grille through which a piece of torn bed sheet was threaded. Ventilation grilles were used as hanging points in other prison deaths that have been the subject of Inquests in this State, for example those concerning prisoners Alexander Wayne Keith Varcoe (ARC 2000), Darryl Kym Walker (Port Lincoln Prison 2003), and Damian John Cook (ARC 2003). For years Coroners' Courts have been urging correctional authorities to eliminate hanging points from cells, and in particular ventilation grilles. It is plain when one reads coronial findings in death in custody cases from the last 10 to 20 years that these recommendations for the most part have been implemented reactively, inconsistently and in a piecemeal fashion. A ventilation grille is such an obvious hanging point. It is also one the most effective given its height off the floor. Some hanging points are more subtly disguised than others, but the hanging point in this case was obvious, has been historically and repeatedly deployed for that very purpose and was readily available in this case. Any prisoner intent on self harm could not have failed to identify it as the perfect means by which to carry out that intent.

## 8. Conclusions

8.1. The Court makes the following findings and conclusions.

1) Mr Smith was in lawful custody at the time of his death having been remanded in custody on serious criminal charges;

2) On 12 July 2010 Mr Smith deliberately took his own life by means of hanging. He had ingested what in any event could have been a lethal dose of Tramadol, but the actual cause of his death was hanging. No other person was involved in the act of hanging;

3) Mr Smith utilised a ventilation grille in the roof of the cell which he occupied alone. The ventilation grille constituted an obvious hanging point;

4) Mr Smith's risk of self harm had not been identified by Correctional Services staff nor Prison Health Services staff at any time prior to his death. An incident in November 2009 in which I find that Mr Smith attempted to take his own life by

means of hanging was not effectively probed beyond Mr Smith's implausible denials. Had it been more intensively investigated Mr Smith would inevitably have been regarded as being at high risk of further self harm as at November 2009. This would have altered his management. It may well be that Mr Smith's level of anxiety at being geographically separated from his family would have been substantially alleviated if as a result of his being regarded as being at high risk of self-harm he had been kept for longer periods in the Mt Gambier Prison. However, it is not possible to conclude with certainty whether if Mr Smith had been identified as being at high risk of self-harm following his attempted hanging in November 2009 his death would have been prevented in July 2010.

5) While neither Correctional Services staff nor Prison Health Services staff identified any intent on Mr Smith to harm himself in July 2010, there was a body of information shared among the prisoners on his wing that, if imparted to a relevant authority, would have identified Mr Smith as being at high risk of self harm. Even if limited credence were to be given to prisoners' assertions in that regard, an examination of the contents of Mr Smith's final telephone conversations with his partner would have lent weight to those assertions. Undoubtedly in my view, if any of the prisoners to whom I have referred had drawn Mr Smith's frame of mind to the attention of correctional staff, Mr Smith would have been regarded as being at high risk of self harm and the necessary steps would have been taken to mitigate that risk;

6) The most acute factor in Mr Smith's decision to take his own life was the breakdown in his relationship with his partner, Katrina Smith, and in particular the belief on his part that his partner had been unfaithful to him. Another factor involved in his decision was a disturbed frame of mind engendered by his forced geographical separation from his family. This was due in large part to the fact that for the entire duration of his incarceration in 2009 and 2010 Mr Smith was a prisoner on remand as distinct from a prisoner serving a sentence of imprisonment. He was only permitted to be accommodated in the Mount Gambier Prison, which was much closer to his family home in Warnambool, for a 2 week period out of the 60 weeks that he had spent in custody since his arrest;

7) It was reasonable for Mr Smith to have been accommodated at YLP as on the day of his death, 12 July 2010. He was to have been arraigned in the District Court on Monday 19 July 2010 and his personal attendance would have been required;

8) The principal reason for Mr Smith having been kept in metropolitan Adelaide for the overwhelming majority of his period of remand was the perceived need for him to be accommodated at an institution closest to the court where he would be required to appear. On a number of occasions this reason was given to Mr Smith as being the reason for his repeated requests for transfer to Mt Gambier being denied. He was ultimately allowed a 2 week period of accommodation in Mt Gambier.

9) It has not been possible to identify the source of the Tramadol that Mr Smith had taken in a potentially fatal quantity.

## 9. Recommendations

9.1. 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.

9.2. This Inquest identified a number of issues where change has either been implemented to date or where it is required. Those issues are as follows:

- Hanging points;
- Hoarding of medication;
- Assessment of risk of self harm;
- The reluctance of prisoners to identify other prisoners who are at risk of self harm;
- The need for more frequent screening of risk of self harm;
- The desirability of accommodating remand prisoners at correctional institutions closer to their family.

9.3. During the course of the Inquest the General Manager of YLP, Mr Stephen Mann, told the Court that ventilation grilles of the type involved in this matter are still installed at YLP. At the time of Mr Smith's death all cells in B Division were fitted with that particular type of grille[36]. Some have been replaced with a purpose built anti-ligature vent, a diagram of which was tendered to the Court[37]. As at the time of

[36] Transcript, pages 425-426
[37] Exhibit C52

the Inquest it was intended that ventilation grilles of the type with which this Inquest was concerned will be replaced with the anti-ligature type.

9.4. As indicated earlier, Tramadol is no longer prescribed at YLP. It is clear that measures need to be in place to prevent prisoners from hoarding and possessing strong opiate based medication, prescribed or otherwise. While no firm conclusion can be drawn that Mr Smith had hoarded his prescription medication, and that this was the source of the quantity that he ingested on the occasion of his death, it remains a distinct possibility that this was the case. Thus the question of random searches of the cells of prisoners who have been prescribed strong opiate painkilling medications should be considered.

9.5. As to the question of the identification of risk of self harm, Mr Mann explained to the Court that a revised Standard Operating Procedure 90 has been designed to provide a multi-disciplinary approach to the assessment of prisoners at risk and to establish a formal process that would enable any employee or any other person entering a correctional institution to formally provide advice to a responsible person as to any concern they may have about the welfare of a prisoner. This is achieved through what is known as a 'notice of concern'. From a practical point of view Mr Mann explained that if a prisoner is making overtures that they are highly distressed or are showing obvious signs of the same, a staff member would interview the prisoner and raise a notice of concern to ensure that a responsible person is made aware of the difficulty and that appropriate assessments of the prisoner are undertaken in order to look after that prisoner's welfare[38]. Mr Mann explained that any person, be they a correctional officer, volunteer or a member of the nursing staff, may raise a notice of concern. If a prisoner possesses information concerning a distressed or at risk prisoner, the prisoner may report their concern to a correctional officer who is then obliged to complete the notice of concern. Mr Mann explained that these procedures are also designed to correct a circumstance that occurred in this particular case, namely an agency nurse unfamiliar with prison circumstances being the only person effectively making any meaningful assessment of risk of self-harm. The new procedure would dictate that a multidisciplinary approach be adopted in respect of the assessment of risk of self harm and would remove responsibility from the individual.

9.6. The question of the encouragement of prisoners to report concerns that they may entertain about the frame of mind of a co-prisoner needs to be addressed. The Inquest

[38] Transcript, page 249

heard evidence that suggested that there is a general reluctance on the part of prisoners to do this. It is said that there is a perception among the prison population that a prisoner whose risk of self harm is identified as a result of information provided by another prisoner, will inevitably be accommodated in YLP G Division which is said to involve a particularly oppressive regime of both security and scrutiny, or be placed within some other adverse environment within the prison system. Another perception is that such a report might also involve recriminations against the reporting prisoner. All this seems to the Court to be an unwarranted generalisation. Although in this particular case no prisoner reported Mr Smith's distressed frame of mind, it does not mean that in another case other prisoners might not report this kind of information. It is to be acknowledged that some prisoners will have an intractable fundamental difficulty in providing information of any kind about another prisoner. But that does not mean to say that all prisoners will adopt that attitude. When it is all said and done, whether a prisoner is prepared to share a concern about another prisoner might in any case simply depend upon the humanity of that individual prisoner. To my mind encouragement should be given to prisoners to report concerns that they may have in relation to another prisoner and for them to receive a measure of assurance that there should be no recriminations against them for having done so. Such encouragement may have made all the difference in Mr Smith's case.

9.7. Mr Mann told the Court that formal stress screening of a prisoner is confined to the occasion on which a prisoner first enters the particular institution in which he will be accommodated. Such a formal stress screening is only repeated where a prisoner is transferred from one institution to another. Thus if a prisoner remains within the same institution throughout a long period of remand, there will only be the one formal stress screening. Mr Mann explained, however, that the new Standard Operating Procedure 90 exists to ensure that DCS capture at any stage throughout a prisoner's term of incarceration any at risk behaviour to ensure that there is a sound process to assess and manage that risk. This applies to both remand and sentenced prisoners. Of course that would only apply where some circumstance exists that raises in the case of a particular prisoner the issue of risk. The subject of routine prisoner stress screening has been the subject of coronial commentary in the past. I here refer to the Inquest into the death of Damian John Cook[39]. In Cook this Court considered the need for more frequent prisoner stress screening in respect of remand prisoners kept in custody

[39] Inquest 18/2005

over an extended period of time during which their frame of mind may fluctuate depending upon a number of factors, including the limited control that they exert over their personal lives outside of the institution and the outcomes of court appearances. In Cook the Court recommended that the Department for Correctional Services establish a panel to examine the feasibility of introducing a regime whereby inmates are formally screened for risk of self harm on a more regular basis than at the time of their entry into the institution. I will repeat the same recommendation below.

9.8. I refer to the fact that for an extended period of time, that inevitably would only have grown longer, Mr Smith was for the most part accommodated at institutions remote from his family. If periods of custodial remand are routinely to remain as prolonged as this one was, it will be necessary for the authorities to consider whether allowing a prisoner to spend a mere 2 weeks out of a 60 week remand period in an institution closer to his family is reasonable or not. To this end I would urge the relevant authorities to consider whether in reality it is essential for prisoners to be kept in geographically proximate locations to the court in which they will from time to time appear, or whether prisoners can participate in their court hearings remotely by way of closed circuit television video conferencing to the satisfaction of all. Further, it seems that in cases such as this, involving as it did an Aboriginal prisoner, consideration should be given to revising the South Australian response to recommendation 168 of the RCIADIC to include remand prisoners within its purview. After all, a period on remand of 13 months would in the case of a sentenced prisoner equate to a substantial sentence of imprisonment in its own right.

9.9. I make the following <u>recommendations</u>:

1) That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions and, in particular, to replace all ventilation grilles, air-conditioning vents and similar with anti-ligature vents;

2) That the Department for Correctional Services take the necessary steps to ensure that prisoners do not have an ability to hoard or stockpile excessive quantities of prescribed or illicitly obtained medication in their cells. In this regard consideration should be given to the implementation of random cell searches in order to deter such hoarding or stockpiling;

3) That the Department for Correctional Services continue to develop operating procedures that will ensure that evidence of a prisoner who is suspected of having attempted self harm is properly evaluated by the appropriate person or entity so as to eliminate the possibility that the attempt at self harm will not be properly identified or acted upon. In particular it should be regarded as inappropriate for agency nursing staff to make any such assessment without other professional assistance;

4) That the Department for Correctional Services implement procedures whereby prisoners on remand are regularly formally screened for risk of self harm. Such screening procedures could occur at times when a remand prisoner is returned from Court or where some other identifiable adverse change of circumstance has occurred in respect of that prisoner. I repeat the recommendation made in the Inquest into the death of Damian John Cook, namely that the Department for Correctional Services establish a panel to examine the feasibility of introducing a regime whereby inmates at South Australian correctional institutions are formally screened for risk of self harm on a more regular basis than at the time of their entry into an institution;

5) That in respect of a prisoner incarcerated in South Australia, the Department for Correctional Services routinely make enquires of the equivalent Departments in other States and Territories as to the history of risk of self-harm in respect of that prisoner during any period of incarceration in those other States and Territories;

6) That the Department for Correctional Services educate the prison population in this State to the effect that genuine expressions of concern in respect of their fellow prisoners, as imparted to persons in authority, will not involve adverse consequences either to the prisoner who is the subject of the report or to the reporting prisoner;

7) That the Department for Correctional Services give consideration to routinely accommodating remand prisoners at correctional institutions in close proximity to their families, taking into account the current stage which their matters have reached within the criminal justice system, the duration of the period on which they have been or are expected to be on remand, the availability of video conferencing as a means of securing their participation in court proceedings in which they are required to participate and the convenience of their legal advisers;

8) That the Minister for Correctional Services give consideration to revising the South Australian response to recommendation 168 of the Royal Commission into Aboriginal Deaths in Custody to include remand prisoners within the recommendation's field of operation, such that Correctional Services affect the placement and transfer of Aboriginal prisoners, both those on remand and those serving a sentence of imprisonment, according to the principle that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of his or her family.

*Key Words: Death in Custody; Suicide; Hanging Points*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 2nd day of July, 2013.*

*Deputy State Coroner*