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 29th and 30th days of April 2014, the 2nd, 5th, 6th, 7th and 16th days of May 2014 and the 6th day of May 2015, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Shane Rene Blunden.

The said Court finds that Shane Rene Blunden aged 18 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 19th day of September 2011 as a result of acute neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Shane Rene Blunden died on 19 September 2011. He was 18 years of age, having been born on 13 January 1993.

1.2. At the time of his death Mr Blunden was an inmate of Yatala Labour Prison (Yatala). On the day of his death he was found alone in his locked cell slumped, but partly standing, near a chair with a ligature around his neck. The ligature, which was a sheet, was secured through the holes of a ventilation grille. Mr Blunden was deceased.

1.3. Mr Blunden had an extensive offender history as a child. However, only a matter of weeks after he turned 18, he was arrested and charged in relation to offences that had occurred in February 2011. By reason of his age he came to be dealt with by the criminal justice system, for the first time, as an adult. Following that arrest Mr Blunden would be remanded in custody in the Adelaide Remand Centre (ARC). He

was ultimately granted home detention bail which he then breached. He was at large, and significantly intoxicated, at the Royal Adelaide Show. He was arrested at that location by police. He was again remanded in custody, this time at Yatala where he would remain until his death. He entered Yatala as a remanded prisoner in custody on 8 September 2011 and was found deceased in his cell on 19 September 2011.

1.4. For the above reasons Mr Blunden's death was a death in custody, meaning that an Inquest into the cause and circumstances of his death was mandatory. These are the findings of that Inquest.

1.5. Mr Blunden's body was subjected to a post-mortem examination that was conducted by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science South Australia. Dr Charlwood's post-mortem report[1] makes it plain that Mr Blunden died, at the scene, as a result of neck compression with the use of the ligature that had been located around his neck. Dr Charlwood expresses the cause of death as acute neck compression due to hanging. I find that to have been the cause of Mr Blunden's death.

1.6. Other relevant findings at post-mortem were that Mr Blunden had numerous linear, both horizontal and vertical, scars that were present to the back of the left hand and forearm, measuring between 1.5cm and 7cm. Occasional scars were present to the anterior aspect of the left forearm and further largely horizontal scars were seen to the back of the right forearm measuring up to 3cm in length which Dr Charlwood indicates is strongly suggestive of previous self-harm. As well, toxicology examination revealed that the active components of cannabis were present in Mr Blunden's blood at the time of his death. Other drugs such as alcohol, amphetamines, cocaine, morphine, benzodiazepines and other common drugs were not detected in his blood.

1.7. A note was located in Mr Blunden's cell. The note appeared to be in his handwriting. It said:

> 'Fuck this life, I love you mum and dad and all my brothers. Jasmine ... death is easy.'

1.8. The evidence is clear in my view that Mr Blunden died as a result of his own intentional act. No other person was involved in the act that caused his death. Mr

[1] Exhibit C3a

Blunden had significant history of unpredictable behaviour including self-harm both in the community and in juvenile detention. Much of his behaviour had been attributed to states of mind other than an intent to end his own life. Much of it, indeed, may have been attention seeking behaviour. On this occasion, however, the act of hanging, taking place as it did alone in his cell, is redolent of an intent to suicide. His note certainly supports that interpretation. I find that Mr Blunden probably intended to end his own life when he performed the act of hanging that caused his death.

1.9. The Inquest examined the issue as to whether Mr Blunden's risk of self-harm had been adequately evaluated at Yatala, whether he had been appropriately accommodated and scrutinised having regard to that risk and whether his death could have been prevented.

2. Mr Blunden's background

2.1. As indicated above, Mr Blunden's first period of incarceration as an adult occurred in July and August 2011. He had an extensive criminal history as a juvenile that had involved a number of significant periods of detention in juvenile institutions such as the Cavan Training Centre. His criminal history commenced in 2003 when he was aged 10 years. During the course of periods of custody as a juvenile, Mr Blunden committed a number of acts of self-harm that involved cutting and the swallowing of objects such as batteries. There were a number of consequent presentations at the Women's and Children's Hospital and at least one presentation at the Royal Adelaide Hospital. These presentations were the subject of a number of hospital discharge summaries that would be made available to the ARC when Mr Blunden was remanded in custody to that institution in July 2011.

2.2. The investigating officer in respect of this death, Detective Brevet Sergeant Peter Moore of SAPOL, has inspected a large number of records involving the interaction between Families SA and the juvenile justice system that reveals that whilst detained within a juvenile detention facilities Mr Blunden was involved in at least 60 incidents of '*at risk/self-harm behaviour*'.

2.3. A psychological assessment in respect of Mr Blunden was prepared for Families SA (Community Youth Justice Program) by Ms Kerry Burke who is a child and clinical psychologist. This assessment took place in 2010. Ms Burke's report was tendered to

the Inquest[2]. This document makes reference to many aspects of Mr Blunden's life and behaviour thus far and makes specific reference to self-reporting that he had deliberately hurt himself in the past with denials of making any suicide attempts. Mr Blunden had also reported that he had problems with impulsivity including drinking excessively and having verbal outbursts. These traits were demonstrated in other incidents that are known.

2.4. Much of the information that was gleaned during Mr Blunden's juvenile justice experiences and his interaction with Families SA would not be made known directly by any of those concerned agencies to DCS in 2011. Much evidence during the course of the Inquest was devoted to that subject. However, regardless of whatever interaction there was or could have been between DCS and other government or non-government entities concerned with Mr Blunden's behaviour before he turned 18, what was clear was that when Mr Blunden was admitted to the ARC in September 2011, much of his history in respect of self-harm and attempted self-harm as known to police would be made available to the Department for Correctional Services (DCS). As well, the hospital discharge summaries to which I have referred were made available to the Prison Health Service (PHS) on this occasion. The PHS is a separate government entity from DCS. The PHS is an arm of SA Health.

3. Mr Blunden is remanded in custody to the Adelaide Remand Centre

3.1. Mr Blunden's time in custody within the ARC in July and August is of some importance when the circumstances of Mr Blunden's death in Yatala in September come to be evaluated, particularly in relation to what was known by both DCS and PHS about Mr Blunden's known self-harm propensities at the time of his admission to the ARC. In this section I will deal with Mr Blunden's admission processes in respect of his custody within ARC and his time within that institution.

3.2. Mr Blunden's admission to ARC occurred in the late afternoon of 19 July 2011. The order for his remand in custody had been made that day at the Adelaide Magistrates Court. He had been in police custody at the Elizabeth police station since the day before. He would remain on remand in custody at ARC until his release on home detention on 23 August 2011. As part of his home detention bail conditions he was required to reside at an address at Brahma Lodge and to wear an electronic home

[2] Exhibit C84

detention ankle bracelet. He would remain on home detention bail until he was re-arrested at the Wayville showgrounds on 7 September 2011.

3.3. On the day of his admission to ARC he was subjected to routine admission processes that included an interview by a DCS corrections officer and an assessment by a registered nurse of the PHS. It is apparent from the DCS computerised records on the Justice Information System (JIS) that DCS already possessed information in relation to Mr Blunden, for the most part concerned with bail supervision, dating back to April 2011. These records were contained within a computerised document known as offender casenotes that are contained within the JIS. The notes did not contain information relating to Mr Blunden's experiences with the juvenile justice system.

3.4. When Mr Blunden arrived at the ARC in the late afternoon of 19 July 2011 he did so together with documentation that had been raised by South Australia Police (SAPOL) during Mr Blunden's police custody following his arrest. The provision of such documentation by SAPOL to DCS is now a routine requirement that is designed to provide DCS with information concerning the circumstances and behaviour of the prisoner while in SAPOL custody, as well as information that is relevant to other issues such as the prisoner's security status and, importantly, the prisoner's assessment of risk of self-harm. The importance of appropriate transmission of information as to risk of self-harm, as between SAPOL and DCS, has been highlighted in previous death in custody coronial Inquests[3].

3.5. A copy of the SAPOL documentation was placed within Mr Blunden's ARC Case Management File[4] that was compiled on the day of his admission. Some of that documentation would also be placed on a file that was commenced by the PHS when he was seen by one of the PHS nurses as part of the admission process.

3.6. The SAPOL documentation that accompanied Mr Blunden upon his admission to ARC included a SAPOL Prisoner Screening Form (PD331), a SAPOL Prisoner Risk Assessment (PD331A), a SAPOL Police Custody Transfer Form (PD346), a SAPOL Record of Prisoner Inspection, Contact and Risk Assessment Review (PD465) and a SAPOL Record of Prisoner Inspection, Contact and Risk Assessment Review (supplement) (PD466). These were all proforma documents that had been completed during Mr Blunden's police custody. In addition to the proforma police

[3] Andrew Stephen Gill and Simon Schaer – Inquest 10/2008
[4] Exhibit C56

documentation, a number of Police Information Management System (PIMS) printed screen dumps relating to SAPOL computerised records in respect of Mr Blunden were also included in the documentation that accompanied him.

3.7. The ARC DCS Case Management File[5] was only obtained at the commencement of this inquiry. In the period since July 2011 it had been microfilmed and retained. A copy of the file, printed from microfilm, was produced by Mr Keane of counsel for DCS. It is apparent that this file, belonging as it did to the ARC, did not accompany Mr Blunden to Yatala when, in September, he was ultimately re-arrested following his intervening period of home detention. This accorded with the usual practice whereby unless there is continuity in incarceration from one DCS institution to another, a wholly new file is started at the DCS institution where a prisoner is newly admitted. The result of this is that there may be multiple DCS files for the same prisoner at various DCS institutions.

3.8. I have mentioned the fact that on the day of Mr Blunden's admission to the ARC a file was also raised by the PHS. This file, like his ARC DCS case management file, would be a wholly new file. This was due to the fact that this represented Mr Blunden's first period of custody in an adult institution. The ARC PHS file was produced to the Inquest[6]. It appears to be the original PHS file from the ARC. In the ordinary course of events, when Mr Blunden came to be incarcerated in Yatala in September 2011 the file should have been sought by, and then couriered to, PHS staff at Yatala. The ARC file should then have been consolidated with the file that was raised by PHS at Yatala such that there should only be the one file for Mr Blunden within PHS. In the event, the ARC PHS file never made its way to Yatala at any time during Mr Blunden's custody during September 2011. Thus there are in fact two separate PHS files in relation to Mr Blunden: one being the ARC PHS file to which I have already referred, and a wholly new and discrete PHS Yatala file[7] which should have been consolidated with his ARC PHS file. The ARC PHS file, like the ARC DCS file, contains many of the SAPOL documents to which I have already referred.

3.9. It is necessary to describe the relevant documentation accompanying Mr Blunden on his admission to the ARC. Although the SAPOL Prisoner Screening Form (PD331) stated that Mr Blunden had not given any indication that since his arrest he might be

[5] Exhibit C56
[6] Exhibit C50s and C50a
[7] Exhibit C51

'At Risk', the SAPOL Prisoner Risk Assessment (PD331A) referred to demonstrated '*very unpredictable behaviour*', to a burst of aggression and irrational behaviour at the charge counter and, in answer to a proforma question as to whether he had entertained thoughts that he would be better off dead or of hurting himself in some way, Mr Blunden was recorded within the document as having answered affirmatively, adding that in the previous week, due to coming down from drugs, he had thought about killing himself by driving a car into a wall. The same document referred to PIMS warnings that Mr Blunden may be suicidal and subject to violent mood swings. In a section in the document designed to describe 'concerns/issues' while in police custody, it stated that Mr Blunden had a high need due to violent outbursts and suicidal thoughts when on drugs and that he should remain under observation until he went to Court. The SAPOL Risk Record of Prisoner Inspection, Contact and Risk Assessment Review (PD465) also referred to an emotional outburst and recent suicidal thoughts as being a reason for him to be placed in a padded cell and to be subjected to prolonged 15 minute checks. The same document described Mr Blunden as drug use dependent and suicidal. The document lists regular 15 minute observations of Mr Blunden from the afternoon of 18 July 2011 to the following morning. It does not describe anything remarkable about Mr Blunden's behaviour or demeanour while in the cells, and states that at one point he was in good spirits and at others that he was asleep.

3.10. The computerised SAPOL records, including PIMS screen dumps, consist mainly of ancillary reports relating to incidents involving Mr Blunden. This documentation includes warnings that he was a drug user/dependent and may be suicidal[8]. An ancillary report in respect of an incident on 10 May 2010 describes Mr Blunden as having doused himself in petrol and then allegedly making threats to commit suicide by setting fire to himself. A further revelation contained within the report was that he had also swallowed a large amount of different pills. This behaviour had been followed by Mr Blunden becoming very violent at hospital and by threats towards police that he would take their gun and shoot everyone in the head. He had to be restrained on this occasion and was observed to exhibit continuous mood swings during the incident[9]. This SAPOL documentation was common to both the DCS case management file at the ARC as well as the PHS file at the ARC. One particular

[8] Exhibit C56 and Exhibit C50, page 7
[9] Exhibit C56 and Exhibit C50, page 75

document common to both ARC files was a SAPOL PIMS screen dump that summarises the nature of warnings in respect of Mr Blunden in the following manner:

> 'May Be Armed, May Assault Police, May Be Suicidal, Drug User/Dependent, Truant, Conviction Prescribed Kind.' [10]

In September 2011, when Mr Blunden was admitted to Yatala where he would ultimately take his own life, the only SAPOL computerised document that was located either within Mr Blunden's DCS files or his PHS file was a copy of that same SAPOL screen dump in which Mr Blunden was described in terms of 'May Be Suicidal'. This document would make its way onto Mr Blunden's Yatala DCS Dossier[11]. I will deal with the other SAPOL documentation that accompanied Mr Blunden to Yatala in September 2011 in another section.

3.11. When Mr Blunden was admitted to the ARC on 19 July 2011 he was in the first instance interviewed by a corrections officer, Tanya Thorpe, and then by a registered nurse employed by PHS, Ms Jacobie Winter. Both Ms Thorpe and Ms Winter gave oral evidence in the Inquest.

3.12. Evidence was given that a relatively new procedure in respect of risk assessment was then in place at the ARC but not yet in place at Yatala. The procedure dictated that in certain designated circumstances, the raising of a Notification of Concern (referred to in common parlance as a NOC) and an Initial Response Plan was required[12]. In Mr Blunden's case Ms Thorpe raised a NOC[13]. She did so on the basis of a number of criteria including 'self-harm indications' as revealed by SAPOL documentation. In addition, in Ms Thorpe's prison stress screening interview, which gives rise to a numerical score based on the nature of answers provided by the prisoner, Mr Blunden revealed that he had overdosed in the past, that he had been treated psychiatrically and that within the last month he had regularly used drugs including ice, speed, dope and alcohol to relax or block out problems. Additionally, Ms Thorpe established that Mr Blunden had scars on both arms which Mr Blunden attributed to *'stupid stuff'*. The score in Mr Blunden's case as assessed by Ms Thorpe was 9 which of itself was enough to trigger the raising of a NOC. Ms Thorpe noted on the prison stress screening form Mr Blunden's thoughts of self-harm, unpredictable behaviour, high

[10] Exhibit C56 and Exhibit C50, page 78
[11] Exhibit C53, page 15
[12] SOP 90
[13] Exhibit C50, page 2

need and violence. Ms Thorpe ticked a box within the NOC indicating that the admission process had identified Mr Blunden to be at risk of suicide or self-harm. I should add here that the NOC system, although in operation in the ARC, had not at this time, nor in September 2011, come into effect at Yatala. However, the High Risk Assessment Team (HRAT) regime of management was in existence at Yatala at that time. I will mention more of the HRAT consequence in a moment.

3.13. Ms Thorpe did not have access to other material that may have been gathered in respect of Mr Blunden such as material relating to his behaviour during previous juvenile detention or information from Families SA or other mental health institutions.

3.14. As part of the admission process Ms Winter, the registered PHS nurse, assessed Mr Blunden. Ms Winter also had access to the SAPOL documentation that had accompanied Mr Blunden on admission. Ms Winter started the ARC PHS file for Mr Blunden. As I have said this file contains much of the police material as well as a copy of Ms Thorpe's prison stress screening form. It contains other material which all confirms that Mr Blunden was an inmate who required significant and thorough risk assessment. Ms Winter told the Court that she did not have had any access at the time to juvenile health records raised in previous periods of juvenile detention. Ms Winter told the Court in effect that it was she who makes the decision in respect of a prisoner's accommodation within the ARC. In Mr Blunden's case she endorsed the NOC initial response plan on the evening of Mr Blunden's admission. The plan involved double cell accommodation which is in any event standard for the first seven days of a new prisoner's incarceration, both for day and night placement conditions. Ms Winter completed the PHS admission clinical record[14]. She noted that Mr Blunden had overdosed on medication in 2010, had used speed and ice and had suffered from depression. She also noted that Mr Blunden in the past had swallowed razor blades and batteries whilst in juvenile detention. She told the Court that this information was obtained directly from Mr Blunden[15].

3.15. As part of the admission process Ms Winter arranged for Mr Blunden's casenotes from South Australian public health entities such as the Women's and Children's Hospital (the WCH) and the Royal Adelaide Hospital (the RAH), and she secured his

[14] Exhibit C50, pages 4-8
[15] Transcript, page 121

consent to obtain his general practitioner's clinical notes. It is apparent from the ARC PHS file[16] that much of this documentation was ultimately received. A facsimile from the WCH dated 31 August 2011, which was after Mr Blunden's release from the ARC on home detention, attached a number of discharge summaries relating to presentations by Mr Blunden at that hospital. Material from the RAH relating to a presentation in late 2009 appears to have arrived by fax on 29 August 2011, again after Mr Blunden's release. All of this material is nevertheless to Mr Blunden's situation in Yatala of relevance because it would thereafter remain on the ARC PHS file and should have been available from that point forward to any other correctional institution, such as Yatala, that in the future might take Mr Blunden into its custody.

3.16. The material from the hospitals demonstrates a number of matters. In November 2010 he presented to the WCH from the juvenile justice Cavan Training Centre (Cavan) having apparently ingested pens and possibly a small button battery[17]. In August 2010 Mr Blunden had presented to the WCH from Cavan said to have ingested biros. Nothing was located on X-ray, but he swallowed a small screw during admission[18]. In March 2010 he presented at the WCH from Cavan and was said to have ingested a plastic ink filled cartridge[19]. In August 2009 Mr Blunden had presented to the Emergency Department of the WCH from Cavan having ingested batteries and razor blades[20]. In May 2009 he had presented to the Emergency Department from Cavan with two springs and two other pieces of metal in his abdomen[21]. Also in May 2009 there is an incident where he presented to the WCH Emergency Department from Cavan having reportedly swallowed batteries, glass and elastic bands[22]. On that occasion nothing was identified by X-ray. In March 2009 he presented to the WCH from Cavan having ingested batteries. After he passed those, he was suspected of having ingested more while in hospital. The discharge summary contains the following exhortation, '*We would appreciate if batteries are kept out of his reach at Caven* (sic)'[23]. In February 2009 he presented at the WCH from Cavan having swallowed the contents of a battery which gave rise to a concern of alkaline

[16] Exhibit C50 and Exhibit C50a
[17] Exhibit C50, page 24
[18] Exhibit C50, page 30
[19] Exhibit C50, page 31
[20] Exhibit C50, page 22
[21] Exhibit C50, page 23
[22] Exhibit C50, page 25
[23] Exhibit C50, page 32

caustic erosion of the gastrointestinal tract[24]. In September 2008 he had presented with self-inflicted lacerations to the wrists and an attempted throat laceration that were inflicted after being confronted by police for alleged shoplifting[25]. In January 2007 Mr Blunden had presented with the effects of smoke inhalation after setting his mattress alight whilst smoking in bed[26]. The RAH material describes a presentation from Cavan in late December 2009 after Mr Blunden had swallowed pieces of broken antenna wire because he had been feeling angry[27]. While in hospital he ingested three batteries and then barricaded himself into a room threatening self-harm and throwing furniture around. He also used broken pieces of his lunch plate to cut himself on the forearm causing a superficial wound. Within 24 hours after Mr Blunden's discharge, he again re-presented from Cavan having swallowed two more pieces of antenna wrapped in toilet paper.

3.17. It is fair to say that Mr Blunden had a significant history of self-harm incidents while in custody. On some of these occasions he is recorded as having said that he had not attempted to kill himself, but had intended to self-harm[28]. Regardless of his intent, what could be said in respect of incidents such as these is that they were clearly reckless and in some instances must have posed a significant risk to his health. Even if they were not accompanied by an attempt to kill himself, they were certainly events that posed a significant risk to him. Mr Blunden's behaviour was unpredictable. If anything he was certainly an attention seeker who would go to extreme lengths to draw attention to himself. The PHS was cloaked with this knowledge after Mr Blunden's admission to the ARC.

3.18. As a result of the NOC that was raised, Mr Blunden was automatically subject to the regime of the ARC High Risk Assessment Team (HRAT). This meant that he would be required to share a cell, which for the first seven days was required in any event, and would be seen by the PHS medical staff on a daily basis for the duration of the HRAT regime. The clinical progress notes in respect of these daily examinations by medical staff were placed on what at that time was referred to as a 'yellow sheet'. These were effectively the progress notes for Mr Blunden, but differed from other clinical records because they were coloured yellow for the sake of prominence within

[24] Exhibit C50, page 26
[25] Exhibit C50, page 27
[26] Exhibit C50, page 28
[27] Exhibit C50, pages 34-35
[28] Exhibit C50, pages 25-26

the file. The document is entitled 'Suicide risk assessment care plan'. There are entries in relation to Mr Blunden which appear to reflect daily examinations. The notes reveal that Mr Blunden consistently denied thoughts of self-harm. Mr Blunden was removed from the HRAT regime after about ten days. The HRAT minutes in respect of meetings convened by HRAT as contained within Mr Blunden's ARC PHS notes reveal that on 20 July 2011 Mr Blunden had self reported a history of self-harm when residing in Magill, or Cavan, including cutting and swallowing objects and that he reported what has been noted as a '*history of multiple suicide attempts, usually at times of extreme stress*' but that he had not committed such acts for about one year and that his life had changed dramatically for the better. He denied current suicidal ideation, but it was reported that it was thought that that situation might change '*rapidly and unpredictably*'[29]. At that stage the advice was that he should remain on the HRAT list. However, at the meeting on 28 July 2011 it was recommended that he be removed from the list. On this occasion the minutes of the meeting refer to Mr Blunden's current state of mind in which he had no thoughts of self-harm or suicide but that given his youth and emotional instability he was very likely to react adversely if faced with a challenging situation. Having regard to his then relative stability the recommendation that he be removed from the list was carried out. Nevertheless the Court understands that Mr Blunden remained in doubled up cell accommodation for the entirety of his period of custody at the ARC.

3.19. There is no evidence that within the ARC Mr Blunden exhibited any concerning behaviour, but as seen it had been noted that there was concern entertained about his unpredictability and the way he might react if confronted with adversity.

3.20. As indicated earlier none of this written material, including notes of HRAT, would make its way to Yatala, at least as part of a PHS file in which all of this was contained. However, certain entries were made from time to time into the DCS JIS Offender Casenotes which are a continuous computerised record that is and updated from time to time. In addition to Ms Thorpe's entry on admission, which I will describe in a moment, there are a number of other entries relating to Mr Blunden during his period of custody at the ARC between 19 July 2011 and 23 August 2011. A hard copy of these notes were tendered to the Court[30]. Contained within Mr Blunden's casenotes is an account of the HRAT analysis on 20 July 2011 that makes

[29] Exhibit C50, page 15
[30] Exhibit C48r

reference to Mr Blunden's reporting history of self-harm while residing in the Cavan Training Centre including cutting and the swallowing of batteries. It also makes reference to '*multiple suicide attempts usually committed at times of extreme stress*'. It also refers to his unpredictability and the possibility that denials of current ideation could change rapidly. It identifies risk factors including psychiatric history, depression, possible bipolar disease and a history of suicide attempts[31]. It refers to an assessment that he is considered to be at least a moderate risk of self-harm despite denials of current ideation. It states as follows:

> 'Client is young and potentially vulnerable, and exploitation from other prisoners may serve as trigger for self-harm.'

The entry in the DCS Offender Casenotes relating to the HRAT assessment on 25 July 2011 also refers to his previous depression and suicide attempts and to the assessment that he is likely to react adversely if faced with a challenging situation. DCS was thus cloaked with a significant body of knowledge concerning Mr Blunden's propensity for unpredictable behaviour. All of this material would have been available to DCS staff at Yatala in September 2011.

3.21. Ms Thorpe's initial entry into the JIS Offender Casenotes on 19 July 2011, the day of Mr Blunden's admission to the ARC, and which reflected a regime of special supervision by means of HRAT involvement, had stated the following:

> 'Warning
> New admission first time in prison. Scored 9 in the initial stress screen. Prisoner has serious SAPOL WARNINGS of self harm and threats to Police. Prisoner is known to be violent and unpredictable behaviour (sic). NOC initiated due to SAPOL warnings. Prisoner is a smoker.'

3.22. A further entry in the JIS Offender Casenotes, made that evening by another officer after Mr Blunden's admission, recorded the fact that Mr Blunden was 'identified as an At Risk prisoner Yellow Tag double up in Unit 1', meaning that Mr Blunden would be accommodated in a double cell with the yellow tag that was placed on the door of the cell signifying that he was at risk. The corresponding assessment and JIS Offender Casenotes entry made at Yatala only a matter of weeks later on 8 September 2011, based as it would be on incomplete information, was starkly anodyne by

[31] Exhibit C48r, pages 4-5

comparison and prompted no special risk avoidance measures in respect of Mr Blunden's circumstances. It would state:

> 'General
> Admitted to YLP on the 8/9/2011 with no obvious signs of distress. He scored 7 on his stress screen and will be goiong (sic) to E division.'

3.23. It is against this background that Mr Blunden's care while in custody at Yatala comes to be evaluated.

4. Mr Blunden is again taken into SAPOL custody

4.1. On 7 September 2011 Mr Blunden was located by police at the Royal Adelaide Show at Wayville. Police documentation that was compiled that day described him as being grossly under the influence of alcohol. An information sheet prepared pursuant to the Public Intoxication Act 1984 described him as heavily intoxicated with slurred speech, glazed eyes and unsteadiness. He was vomiting in a phone booth. No-one was there present to look after him. Because of his history of violence Mr Blunden was deemed to be unsuitable for care in a sobering up centre. Mr Blunden was taken to the City Watch House where he was subjected to an alcohol analysis. This revealed a level of 0.16%.

4.2. Mr Blunden was in breach of his home detention bail conditions insofar as he was absent from his place of detention without leave and because he had removed his electronic bracelet.

4.3. The necessary SAPOL documentation was compiled that evening that included the PD331 and PD331A, that is to say the same type of documentation that had been compiled when he had been arrested prior to his placement in the ARC in July 2011. The PD331 prisoner screening form referred to his intoxication. The document also listed a number of documents from PIMS that reflected PIMS checks that had been conducted by the arresting member. The checks that were conducted were General Enquiries, Warnings, DCS (Warnings) and Relevant 'At Risk' Ancillaries (Self-Harm/Attempt Self-Harm). The PD331 indicated on the form itself that printouts of the PIMS checks were required to be submitted with the PD331. In that sense the attached PIMS printouts could be said to form part of the PD331. The time recorded on the PD331 is 1740 hours on 7 September 2011.

4.4. A PD331A was also compiled. This document purports to have been compiled by the charging member of SAPOL and contains a number of questions and answers. Relevantly, the document refers to the consumption of 12 spirit drinks in the previous 24 hours. As well, it reveals that Mr Blunden must have self-reported an incident of self-harm, in which he cut his arm, that had occurred 12 months previously. In answer to a question as to whether he had thoughts that he would be better off dead or of hurting himself in some way, he indicated an affirmative answer but added that he had not entertained such thoughts '*recently since the above incident*'. The PD331A also reveals as part of its initial risk assessment determination that Mr Blunden had PIMS warnings on the system and was considered to be a '*self-harm risk*'. This determination appears to have been completed at 1832 hours.

4.5. I have already referred to a SAPOL document PD465 which records inspections of the prisoner while in police custody. These inspections had been made at 15 minute intervals when Mr Blunden had been in SAPOL custody prior to his incarceration in the ARC. A similar document was compiled on the occasion of his police custody in September 2011. This document refers to his alcohol analysis and observations. The observations for the most part involve Mr Blunden sleeping until the following morning.

4.6. The PD346 SAPOL custody transfer form records that on the morning of 8 September 2011 Mr Blunden was transferred into the custody of G4S at 10:45am. The document contains a section entitled Prisoner Risk Assessment and Contact History and embodies a requirement that certain listed documents must be provided to the receiving agency where the PD346 identifies such documents. In this case the transfer form identifies the PD331, the PD331A, the PD465 and 'PIMS Warnings (screen print)' as being documents that were purportedly attached to the PD346 SAPOL custody transfer form. This document therefore purports to state that those identified documents, together with the transfer form, would have been provided to G4S, the security company responsible from that point forward for Mr Blunden's custody and ultimate transfer to Yatala. The PD346 SAPOL custody transfer form does not identify precisely what, and how many, PIMS warning documents were attached to the transfer form and therefore placed into the possession of G4S. As indicated however, and as will be seen again, at least one PIMS warning document that appears to have been printed on 7 September 2011 at 1848 hours made its way to

the Yatala Dossier for Mr Blunden[32]. This would be the only PIMS document within the Yatala DCS files or the PHS file at Yatala for Mr Blunden that was located after his death.

4.7. The SAPOL documentation in relation to Mr Blunden reveals that an Officer Williams was responsible for the transfer of Mr Blunden into G4S custody on the morning of 8 September 2011. A statement has been taken from Senior Constable Veronica Williams[33]. This statement was not taken at around the time of Mr Blunden's death, but in April 2014. The statement attaches a bundle of SAPOL documentation that in the ordinary course of events would be the documentation that was handed over to G4S at the time of Mr Blunden's placement into the custody of G4S. There are a number of PIMS documents attached to Ms Williams' statement, many of which purport to be the same PIMS screen dumps that had found their way to the ARC when Mr Blunden had been there in July and August 2011. Included is the single PIMS document that described a warning in terms of '*May Be Suicidal*' which would be the only PIMS document that would be seen on Yatala DCS or PHS documentation. The PIMS documentation appears to have been printed on 7 September 2011 which lends some support to the fact that they were created or printed on that day. The statement of Brook Peter Tombs[34] who is a G4S custodial service prison escort officer, also purports to attach documentation that appears to be suggestive of the fact that all of the police documentation including the PIMS printouts and warning from the day before were attached to the documentation that Mr Tombs received when G4S took custody of Mr Blunden.

4.8. There is no inventory in existence listing in detail, and individually, all of the documentation that was compiled by SAPOL and submitted to G4S with Mr Blunden. In particular no PIMS warning documentation is individually identified. Certainly the statements of Ms Williams and Mr Tombs purport to identify the documentation that should have accompanied Mr Blunden, but having regard to the fact that neither witness now has any independent recollection of the prisoner and of the fact that their statements were not taken contemporaneously with these events, it is not possible for this Court to make any finding as to what documentation was ultimately sent with Mr Blunden to Yatala on 8 September 2011 save and except for the documentation

[32] Exhibit C53
[33] Exhibit C59
[34] Exhibit C60

that would be located within either his Yatala DCS files or his Yatala PHS file. To my mind the evidence does not establish with sufficient clarity and with adequate detail what was sent and received.

4.9. Tendered to the Court were three files from Yatala in respect of Mr Blunden. They are the DCS case management file[35], the DCS Dossier[36] and the PHS file[37]. All three files originated on the day of Mr Blunden's admission on the afternoon of 8 September 2011. Some, but not all, of the SAPOL documentation to which I have referred in previous paragraphs is contained within these three files. In the DCS case management file there is a copy of the PD331[38] SAPOL prisoner screening form and a copy of the PD331A[39] SAPOL prisoner risk assessment form. In the DCS Dossier there is a copy of the PD346[40] SAPOL custody transfer form, the Public Intoxication Act information sheet[41] that I have already referred to, which was compiled by police on 7 September 2011, and one PIMS printout[42] to which I have also already referred, namely the warning that suggests among other things that Mr Blunden '*May Be Suicidal*'. The Dossier should not have housed that PIMS document. The document should have been in the Yatala DCS case management file and possibly also the Yatala PHS file.

4.10. Within the Yatala PHS file there is a copy of the PD465/6[43] SAPOL record of prisoner inspection, contact and risk assessment review, a copy of the PD331A[44] SAPOL prisoner risk assessment and a copy of the PD331[45] SAPOL prisoner screening form.

5. Mr Blunden is admitted to Yatala Labour Prison

5.1. Before discussing Mr Blunden's admission to Yatala it is as well briefly to describe his circumstances in the period between his admission on 8 September 2011 and his death on 19 September 2011. Mr Blunden was admitted to Yatala during the afternoon of 8 September 2011. As part of the admission process he was seen by a DCS officer and a nurse from the PHS. Following his formal admission procedures it

[35] Exhibit C52
[36] Exhibit C53
[37] Exhibits C51 and C51a
[38] Exhibit C52, pages 5-6
[39] Exhibit C52, pages 7-10
[40] Exhibit C53, page 13
[41] Exhibit C53, page 14
[42] Exhibit C53, page 15
[43] Exhibit C51, pages 34-37
[44] Exhibit C51, pages 38-41
[45] Exhibit C51, pages 42-43

was decided that he would be accommodated in E Division. He was accommodated within a double cell as is the usual practice for at least the first seven days of a newly admitted prisoner's accommodation. A document in Mr Blunden's case management file[46] which records the seven day observations of newly admitted prisoners states that during the seven days between 9 September and 15 September 2011 inclusive that Mr Blunden did not appear to have problems adapting to the unit routine, have problems mixing with other prisoners and that he did not appear anxious, withdrawn, upset or tense. The PHS progress notes record that Mr Blunden was seen on the day of his admission, on 9 September 2011, on 13 September 2011 and on 15 September 2011. On 13 September 2011 Mr Blunden was seen by a medical practitioner who recorded that Mr Blunden had no issues and no current thoughts of self-harm. On 15 September 2011 some blood tests were taken. After Mr Blunden completed his first seven days of double cell accommodation in E Division he was transferred to F Division which is a division within Yatala that is devoted to the accommodation of prisoners who work in the prison's various industries. Mr Blunden was accommodated in cell 222 in Unit 2 which was single cell accommodation. Mr Blunden would remain accommodated within this cell until the day of his death. All cells at that time in F Division were single accommodation cells. There are now, since these events, some double cells. The Division was intended to accommodate prisoners who had a low security risk as well as a low risk of self-harm. Within each of the cells in F Division, including that of Mr Blunden, there was a ventilation grille. This object has been identified in previous deaths in custody in Yatala, as found in previous coronial Inquests, as an obvious ligature point and which has been used as such on a number of occasions. The ventilation grilles in some cells have been modified to prevent the attachment of ligatures, but Mr Blunden's cell was not one of them. For the entire duration of Mr Blunden's incarceration at Yatala he was not considered to be at any significant risk of self-harm or suicide and it was for that reason he was accommodated in F Division in a single cell that contained a well known ligature point. It is apparent, and I so find, that DCS staff at Yatala who had responsibility for the care of Mr Blunden had a flawed appreciation of Mr Blunden's actual risk of self-harm or suicide, due for the most part to an inadequate and

[46] Exhibit C52, page 27

incomplete knowledge of his background, a state of affairs that was the complete antithesis of how he had been perceived in the first instance at the ARC.

5.2. I now turn to Mr Blunden's admission procedures. These procedures were governed by a document entitled 'STANDARD OPERATING PROCEDURE - SOP001A CUSTODIAL – ADMISSION – CASE MANAGEMENT'. A standard operating procedure (SOP) is a DCS document that is meant to have universal application to all DCS institutions. However, an SOP for whatever reason might not come into effect in all DCS institutions at the same time. However, there was no suggestion that SOP001A relating to admission procedures was not in operation at Yatala at the time with which this Inquest is concerned. The document[47] had an approval date of 7 June 2011. The document contains various requirements in respect of the admission of a prisoner to a DCS institution. The document describes the duties and responsibilities of DCS officers who are involved in the admissions process and thereafter. The document describes the duties of a '*Supervisor Operations*' who was described in the evidence at the rank of OPS3. The document also describes an '*Admitting Officer*' which I understood could be a n OPS2. In this instance the admitting officer was an acting OPS3. The SOP contains various requirements as part of the admission process. There is a requirement that a prisoner case file be created at the time of admission. This is the file which is known as the case management file[48]. The SOP states that no documents shall be removed from the prisoner case file[49].

5.3. Under the SOP the admitting officer's duties and responsibilities include:

- To read and take notice of the SAPOL custody transfer form (PD346) and the SAPOL prisoner screening form (PD331)[50];
- To review the PD346 and ensure that any forms identified in the ticked boxes within the 'prisoner risk assessment and contact history' are in the package of paperwork at the time of handover[51]. In the event that any of the forms are not in the document package the supervisor operations has a duty to inform the officer in charge who then informs the duty manager;

[47] Exhibit C67f
[48] Exhibit C52, paragraph 3.3.1
[49] Exhibit C52, paragraph 3.4.3
[50] Exhibit C52, paragraph 3.5.4
[51] Exhibit C52, paragraph 3.5.6

5.4. The supervisor operations has a number of duties and responsibilities at the admission stage including the following:

- To ensure that a complete copy of a number of relevant documents are placed in the prisoner's case file, including the PD331, PD331A, PD346, PD465, PD465A and PD466. The list of documents does not specifically identify SAPOL PIMS documents as attracting this requirement, but it would follow that any such documentation attached to any of those police documents would also have to be placed on the prisoner's case file;
- To ensure as part of a risk needs assessment that an admission interview is conducted with each prisoner and that a number of forms, including the DCS prisoner stress screen are placed on the prisoner case file[52]. There is also a duty to ensure that that form is completed using any supporting information such as the SAPOL prisoner screening form (PD331)[53];
- To ensure that '*relevant information*' is entered onto the JIS prior to the prisoner being placed into an accommodation unit[54];
- To ensure that a copy of the DCS prison stress screening form and the SAPOL prisoner screening form (PD331) are handed directly to the South Australia PHS admitting nurse with the originals placed into the prisoner case file.

5.5. There are other requirements including the provision of the SAPOL documentation, as soon as possible, to PHS staff during the admission process[55]. As I have already mentioned, the supervisor operations also has to ensure that a copy of the DCS prison stress screening form and the SAPOL prisoner screening form (PD331) are handed directly to the PHS admitting nurse with the originals placed into the prisoner case file.

5.6. There is also a requirement that a casenote be entered onto the JIS for each prisoner outlining their admission, prisoner stress screen score, accommodation placement and the fact that they have been seen by PHS with any issues[56].

[52] Exhibit C52, paragraph 3.7.1(c)
[53] Exhibit C52, paragraph 3.7.4
[54] Exhibit C52, paragraph 3.7.1
[55] Exhibit C52, paragraph 3.5.8
[56] Exhibit C52, paragraph 3.14.1

5.7. The SOP also describes a requirement in respect of the assignment of a case officer to a prisoner if the prisoner's period of imprisonment was expected to exceed 28 days from the time of admission, regardless of whether the prisoner is a sentenced prisoner or a remanded prisoner[57]. In this particular case it is understood by the Court that no case officer was assigned to Mr Blunden, or if there was, that person has not been identified. In any case there was no expectation that Mr Blunden would necessarily be in Yatala for a period of 28 days as his remand date was 23 September 2011.

5.8. The admitting officer in respect of Mr Blunden at Yatala was a corrections officer, Mr Paul Cross. At that time Mr Cross' rank was OPS2. On the afternoon in question he was acting as an OPS3 supervisor in the admissions process. Mr Cross gave oral evidence in the Inquest. The suggestion was made during the course of the Inquest that a substantive OPS3 officer was involved in the admissions process that afternoon in a capacity as the OPS3 supervisor substantively. That person's name was Mr Scott Hilliker. Mr Hilliker also gave oral evidence in the Inquest. Statements were not taken from either Mr Cross or Mr Hilliker at the time of, or shortly after, the events in question. I accepted the evidence of both Mr Cross and Mr Hilliker that when they gave evidence in the Inquest they had no recollection of having had any involvement in the admissions process on the afternoon in question, nor specifically of Mr Blunden. Indeed, the evidence that Mr Hilliker was involved in admission duties that afternoon was scant. None of his signatures appear on the relevant admission documentation. I say no more about Mr Hilliker's possible involvement in Mr Blunden's admission. On the other hand, Mr Cross was clearly involved in the process as his signature exists on a number of documents connected with Mr Blunden's admission and, in addition, it is clear that Mr Cross made the entry concerning Mr Blunden's admission into the JIS offender casenotes at 1635 hours on 8 September 2011, that is to say the entry that I have set out in paragraph 3.22.

5.9. Much of what Mr Cross had to say in the course of his evidence was based on a reconstruction of what he would have done unaided by any specific recollection. Mr Cross told the Court that at Yatala the last nine years his major role involved working in the admissions area. He spoke of how busy the task of admission of prisoners can be and that there are time constraints on the admission of prisoners. I accept that. Mr Cross explained the admissions process at Yatala. Mr Cross was

[57] Exhibit C52, paragraph 3.12.1

responsible for compiling the prison stress screening form which is a DCS proforma document used during the admission process[58]. Mr Cross has signed and dated that document in Mr Blunden's case. Mr Cross also explained to the Court the nature of SAPOL documentation that would arrive with the prisoner to be admitted. In this case the organisation G4S was involved in the transfer of Mr Blunden to Yatala. Mr Cross suggested that SAPOL documentation in the first instance would be given to a corrections officer senior to him. One of the purposes of this is to enable a check to be conducted as to the validity of the warrant enabling the prisoner's incarceration. Mr Cross believed that at that stage there can be a separation of documentation received with the prisoner and that the interviewing officer would not necessarily be provided with all documentation that arrives with that prisoner[59]. Indeed, Mr Cross went so far as to suggest that all that he would receive would be the police stress screening form (PD331 and PD331A)[60]. He believed that the balance of SAPOL documents that he did not see would go into a warrant clerks folder and that ultimately they would be included into the prisoners Dossier which he did not have access to as part of the admissions process[61]. When asked as to whether he had ever received any paperwork in the nature of the SAPOL PIMS documentation, Mr Cross suggested that the only recollection he had of the same was receiving the police stress screening documentation that was provided, that is to say PD331 and PD331A[62]. Mr Cross was shown the single SAPOL PIMS screen dump that ultimately was located on Mr Blunden's Dossier[63] which contained the assertion that Mr Blunden '*May Be Suicidal*'. He said that he lacked complete familiarity with such a document although he believed that he had seen something like it. He said that he was more interested in the prisoner's stress screening and copying that document, because to him this would contain the most relevant information as far as his task was concerned[64]. Mr Cross also suggested at one point in his evidence that this was the kind of document that in 2011 would be detached by the admission's supervisor and be sent off to the warrant clerk's file, along with the warrant. If this was the case that would, in Mr Blunden's case, explain why the SAPOL PIMS screen dump suggesting that he may be suicidal was placed on his Dossier together with the warrant, and not

[58] Exhibit C52, pages 15-17
[59] Transcript, page 271
[60] Transcript, page 272
[61] Transcript, page 272
[62] Transcript, pages 286-287
[63] Exhibit C53, page 15
[64] Transcript, page 290

placed on his case management file as should have happened. When asked as to why the person conducting a prisoner stress screening exercise might not receive all of the documentation, Mr Cross said:

> 'I don't know how to answer that. I think that is just maybe a flaw in the system.' [65]

5.10. In his evidence Mr Cross stated, as would be confirmed by other evidence, that unless the prisoner's admission to Yatala involved a direct transfer from one DCS institution to another, any previously existing DCS file in respect of a previous and discrete period of incarceration in another institution would not be made available to Yatala.

5.11. In his evidence Mr Cross also suggested that at that time as an OPS2 officer he would have had limited access to the JIS and that he would not have had any access specifically to warnings contained within that system. In addition, he said that although he made the admission entry into the JIS offender casenotes, he would not have had access to notes that had previously been made in respect of the same prisoner on that system, which would naturally have included the entry made by ARC corrections officers during Mr Blunden's remand at that institution earlier in the year. Evidence was given, which I will discuss in due course, that this perception in respect of access to the JIS was incorrect and that a person in Mr Cross' position could have had access to certain relevant JIS information including past entries made by corrections officers such as Ms Thorpe's admission entry from the ARC as reproduced in para 3.21 herein[66]. Mr Cross also said that he would not have had access to any HRAT entries made in the JIS offender casenotes. This aspect of his evidence was possibly correct as evidence was given that the entries of social workers and psychologists were not readable in full by corrections officers. I would pause to observe that if this is in fact correct, it is a shortcoming that should be addressed.

5.12. However, having acknowledged that he would have had access to the SAPOL PD331 and PD331A, it would follow that Mr Cross ought to have identified during the admission process that it was stated within PD331A that 12 months previously Mr Blunden had committed an act of self-harm in which he had cut his arm and that he had thoughts of being better off dead or of hurting himself, but not recently since that incident. He should also have at least seen within that document that Mr Blunden was described as a '*self-harm risk*'.

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[65] Transcript, page 292
[66] Transcript, page 310

5.13. The DCS prison stress screening form that was compiled by Mr Cross gave rise to a score of 7. As discussed in the preceding section this score differed from the score he had registered at the ARC in July 2011 when his score was 9. The prison stress screening form blank proforma is identical in each case. When one views the two completed documents together there are two significant differences. When Mr Blunden was asked as part of the stress screening exercise at the ARC whether he had ever overdosed either accidentally or intentionally, he had signified an affirmative answer. It will be remembered that within the ARC documentation that was received from the police, there was a reference to an attempt to kill himself by the use of petrol and pills. It is not known for certain what had prompted Mr Blunden to answer truthfully at the ARC. All that can be said is that he had provided an affirmative answer to the overdose issue when questioned at the ARC. When Mr Blunden was interviewed by Mr Cross at Yatala in September 2011 a negative answer is recorded in respect of the overdose question. The other significant difference was that whereas in both screenings Mr Blunden had indicated affirmatively that he had tried to intentionally hurt himself, a check at the ARC of Mr Blunden's person for scars consistent with suicide or self-harm attempts had revealed scars to both arms, in respect of which Mr Blunden was recorded as having admitted to '*stupid stuff*', the same exercise conducted by Mr Cross at Yatala resulted in a negative answer being inserted in respect of that issue. It will be remembered that Mr Blunden's limbs exhibited scarring at post-mortem. Had the overdose been identified by Mr Cross through questioning and had the scars been identified, it would mean that Mr Blunden's score on the prison stress screening would have been 9. This of itself would have resulted in Mr Blunden being considered '*as at risk*' and steps that I will come to in a moment would have been taken to address that risk. Mr Cross did complete a section of the prison stress screening form that is headed '*concerns – advice*' and he wrote '*tried cutting himself 3 to 4 years ago, has no thoughts of self-harm*'.

5.14. There is one other aspect of the stress screening exercise that should be mentioned. In the same question concerning the existence of scars, there is a requirement that if the prisoner had been in prison before, a check of the '*JIS Health History*' for previous self-harm should be conducted. It was clear to Mr Cross that Mr Blunden had been in prison before because he answered negatively in respect to the question of whether this was his first time in prison. During the course of the Inquest it was not

established with precision what JIS 'Health History' as such may have specifically consisted of given that a prisoner's health history was principally the domain of PHS and that records as to that are usually contained within the PHS records, but the evidence demonstrated that the JIS could be searched for evidence of previous history of or suggestions of self-harm, and it will be remembered that the JIS offender casenotes admission entry in July 2011 had made pointed reference to serious SAPOL warnings of self harm, Mr Blunden's unpredictability and the fact that a NOC had been raised on the occasion of his admission to the ARC.

5.15. It is fair to say, I think, that Mr Cross knew very little of the information about Mr Blunden's previous self-harm, save and except possibly for an incident of cutting some time ago. In his evidence Mr Cross made it plain that if Mr Blunden's score had been 9 or above, as it probably should have been, he would have put Mr Blunden into the high security and high risk environment that is G Division and on camera observations. At the very least the reality would have been that Mr Blunden would have been subjected to the HRAT system which existed at Yatala notwithstanding the fact that the NOC system had yet to come into effect at that institution. Similarly, any information that Mr Cross might have received that had involved Mr Blunden having been in an incident where he doused himself with petrol and had taken an overdose would have been regarded as a '*great piece of information*'[67] and that this would also have prompted Mr Blunden being admitted to G Division and on camera observations. There is no evidence that Mr Cross saw that piece of information contained as it was on a SAPOL PIMS document that is not contained within any of Mr Blunden's Yatala files. As to the consequences of being placed in G Division, Mr Cross suggested that this might only have been a temporary measure, perhaps only for the first night of his admission, but clearly he would have remained on the HRAT system. The General Manager of Yatala, Mr Stephen Mann, in his oral evidence confirmed the likelihood of Mr Blunden being placed in G Division in light of the information that should have been known about him.

5.16. As part of the admission process Mr Blunden was also examined by a registered nurse of the PHS, in this case registered nurse Tracey Markham. I will come to Ms Markham's overall assessment in a moment but Ms Markham established through her examination, as recorded in the admission clinical record, that Mr Blunden had

[67] Transcript, page 301

overdosed a year ago and had cut his arms, but not, according to Mr Blunden, with the intention of dying. This information which was supplied by Mr Blunden himself contradicted information that he had given Mr Cross insofar as he had denied to Mr Cross that he had ever overdosed, either accidentally or intentionally. Ms Markham, who had a recollection of Mr Blunden when she gave evidence in the Inquest, told the Court that she observed Mr Blunden's arms and that there were small superficial scars on them. This information similarly contradicted the effective suggestion made in Mr Cross' screening form that Mr Blunden did not bear any such scars. This meant that at the admissions process there was information available, although it may not have been conveyed to Mr Cross, that his prison stress screening interview was flawed to the extent that he had either wrong or incomplete information about Mr Blunden that should have made a difference to his score.

5.17. In her oral evidence Ms Markham told the Court that she did not have access to the ARC PHS file but that the ARC file would routinely be sent for as soon as possible. It was the duty of the administrative staff to facilitate this. The request for the ARC file would generally be made the day following the admission. According to Ms Markham the request would be made either by way of facsimile or by email. The notes would then be couriered by DX or possibly be conveyed by a transfer van from the ARC. The usual timeframe for the retrieval of records from the ARC was approximately two days to a week. When received, the ARC file would be consolidated with the temporary file created at Yatala.

5.18. Ms Markham told the Court that as part of the admission process she would receive police records as well as the prison stress screening form that was compiled by the corrections officer, in this case Mr Cross. Ms Markham told the Court that when she assesses a prisoner, she considers a number of matters including risk. In this case Ms Markham did not have access to the significant information that her counterpart had at the ARC when Mr Blunden had been admitted there, nor to any of the information that was gathered from the hospitals at which Mr Blunden had presented and which records were also on the ARC PHS file. The Yatala PHS file does not house any of the police PIMS material that had been made available to both DCS and the PHS at the ARC.

5.19. Ms Markham acknowledged that the information that Mr Blunden provided her and her own observations of scarring meant that his DCS stress screening score would

have been elevated from a 7 to a 9 and that Mr Blunden would have then been subjected to the HRAT process of risk management[68]. However, Ms Markham assessed Mr Blunden's risk of self-harm as '*moderate*'[69], based upon the fact that although Mr Blunden had hurt himself in the past, this had occurred over a year ago and that he had not done anything since and did not entertain any current thoughts of self-harm[70]. Ms Markham said this:

> 'I feel the assessment I did of Mr Blunden at the time was accurate. At the time there wasn't a notification of concern in me speaking to him. He sat and spoke to me openly, he was well-orientated, there was no factors of hopelessness, which is one of the biggest concerns. He told me - he denied self-harm, he had no intention, previous self-harm things that he did were over a period of 12 months or more and he said that he did that out of anger. Sitting in front of me he presented extremely well and he was compliant, cooperative and didn't portray any risk.' [71]

5.20. In her evidence Ms Markham, somewhat surprisingly, suggested that if she had known that Mr Blunden had been the subject of a NOC at the ARC and had been on the HRAT regime it would not have made any difference to her assessment, having regard to the fact that he had settled in well after one week at that institution and had been removed from the HRAT system. Ms Markham also suggested that even if Mr Blunden had been placed under the HRAT regime at Yatala he would probably have been removed from it, possibly as early as his very first HRAT meeting. She was asked by me:

> 'Q. Is it likely that a person would be taken off the HRAT regime, placed in a single cell and placed in a single cell with a ventilation grille.
>
> A. With a?
>
> Q. Ventilation grille; a well-known hanging point in the prison system.
>
> A. I couldn't say I'm aware of that.' [72]

5.21. Also, surprisingly, Ms Markham suggested that even if she had received the ARC PHS file at the time of her assessment of Mr Blunden she would not necessarily have adopted a different course having regard to his presentation. There was also the fact that a doctor later had cleared Mr Blunden at the ARC, he had a mental health nurse and he had been taken of the HRAT regime within a week[73]. When the information

[68] Transcript, page 192
[69] Transcript, page 193
[70] Transcript, page 193
[71] Transcript, page 199
[72] Transcript, page 215
[73] Transcript, page 240

concerning Mr Blunden's history of self-harming incidents at the Cavan Training Centre was drawn to Ms Markham's attention in the course of her evidence, she maintained her position that she would not have done anything differently[74]. When questioned specifically about the possible significance of an incident in which Mr Blunden had doused himself in petrol and had threatened to set fire to himself, and whether that would have made any difference to her approach if she had known about that, she said:

> 'Well once again I would have talked to him about why, what he's done, how he's feeling now, what's changed. I often say what's changed since that time to now, I mean someone's life can settle dramatically in a year so it certainly would have - I certainly would have questioned him about it and had a big discussion about it. Depending on his answers which I can't determine now, would determine if I had a different opinion or not.' [75]

5.22. Dr Peter Frost who is the former Clinical Director of the PHS now retired, in my view gave evidence to the Inquest, which I accept, that when Mr Blunden was incarcerated in Yatala he should have seen a medical officer within the next few days and ideally the ARC PHS notes should have been available and assessed at that stage. Dr Frost acknowledged that there was no procedure in existence that catered for a case where at the time of the examination by the medical officer the notes from another DCS institution had not arrived[76]. Dr Frost told the Court that having reviewed the information that was available from the ARC file, and the notes from the public hospital system that were place on it, he was of the opinion that Mr Blunden had to be considered as at high risk[77]. Dr Frost did not suggest that Mr Blunden necessarily needed to be placed on canvas, but suggested as follows:

> '… but I think they would have identified this man as at risk and needs to be followed and monitored by both corrections and health and by the HRAT system, yes.' [78]

Dr Frost did not consider that Mr Blunden's previous removal from the HRAT regime at the ARC should have influenced any decision that was made at Yatala. He expressed the opinion that:

> 'I don't think the words, 'removed from the list' should have influenced their decision. I think he needed to be assessed and this man's at risk because of his history, a young man, he had a history of being vulnerable and responding poorly to stress with serious

[74] Transcript, page 250
[75] Transcript, pages 262-263
[76] Transcript, page 356
[77] Transcript, page 370
[78] Transcript, page 370

> attempts at self-harm and suicide and that's going - he was going to stay like that while he was in the system. So he may not be sort of grossly depressed and psychotic or acutely unwell but he's certainly vulnerable and at risk. So I think they were the things that should have been taken into consideration, not the fact that three words saying, 'remove from the list'.' [79]

Dr Frost also suggested that the fact that when proper regard was paid to Mr Blunden's history his outward demeanour at the time of his admission of being calm with no signs of stress or intimations of self-harm to Yatala would necessarily reflect his status a week or a month later[80]. Dr Frost acknowledged that although in any case Mr Blunden's suicide may not have been prevented, it may have been delayed. He stated that Mr Blunden was going to be vulnerable during his time in prison, and also when he was released. But he said:

> 'It's a matter of keeping him safe for the duration so he didn't have to be acutely suicidal to be under an HRAT, he needed to be under constant observation for the duration of his time under our care.' [81]

5.23. Dr Frost also told the Court:

> 'I don't think the assessments and our responses to looking after Mr Blunden while he was at Yatala, I don't think there's sort of major criticism of that, but Mr Blunden was high risk because of his juvenile history and he was always going to be at risk because of that. I think if that information were available, that would have changed the way he was cared for.' [82]

He further expressed the view that an assessment of Mr Blunden as being at high risk should probably have remained an indefinite assessment[83]. Dr Frost believed that Mr Blunden was not only at risk of self-harm, but at high risk of attempted suicide. He regarded his actions within the juvenile system of swallowing potentially lethal objects as placing him at risk, even though he may not have had the intent of killing himself[84]. He suggested that Mr Blunden's activities as a juvenile put him at high risk irrespective of what his motivations had been[85].

5.24. I have had regard to the fact that Dr Frost is not a psychiatrically trained specialist. Nor did he at any time see Mr Blunden while the latter was in custody. In forming his opinions Dr Frost essentially had recourse to the information that was known about

[79] Transcript, pages 371-372
[80] Transcript, page 373
[81] Transcript, page 373
[82] Transcript, page 387
[83] Transcript, page 387
[84] Transcript, page 389
[85] Transcript, page 390

Mr Blunden's history. Dr Frost's opinions were very much based upon Mr Blunden's history of self-harm and the risk that it presented. The fact that Mr Blunden exhibited a measure of stability at his admission was in some senses neither here nor there having regard to not only his history, but also his unpredictability. I have preferred the evidence of Dr Frost to that of Ms Markham in this regard and have found that if the information about Mr Blunden that was made available to DCS and PHS staff at the ARC had been made available to the corresponding people at Yatala at the time of Mr Blunden's admission there, he ought to have been considered as being at high risk of self-harm or suicide and that the HRAT system should have been put in place in respect of him. I also take the view that there would have been a strong possibility that he would have initially been accommodated in G Division.

5.25. Mr Stephen Mann, the General Manager of Yatala Prison, gave oral evidence before the Court. He has been the General Manager of Yatala since 2010. Mr Mann gave some general evidence about accommodation procedures and arrangements in the various divisions in Yatala. He explained that E Division, where Mr Blunden was initially placed, was an induction division for prisoners coming into Yatala for the first time. F Division was the employment division. A prisoner identified suitable for work within the industries complex would be accommodated in that division. At that time all cells in F Division were single cells. Mr Mann told the Court that at that time there were few cells at Yatala that were ligature point free. Cell 222 in Unit 2 of F Division, where Mr Blunden was housed, was not a ligature point free cell. The cell did not have a modified air vent in place. He told the Court that F Division primarily houses medium and low security prisoners that are not deemed to be at risk of self-harm. If at the admission stage there were serious concerns of self-harm in respect of a prisoner there would be a likelihood that the prisoner would be accommodated in an observation cell within G Division until he was further assessed the following day by intervention staff such as a medical practitioner. Mr Mann suggested, however, that there are circumstances in which a person identified as being at risk at that level would not necessarily be placed under observation or within G Division. Sharing a cell with another prisoner is a means that may provide support and observation of that prisoner. There was also the HRAT process in place at Yatala. Mr Mann explained that process. He told the Court that although the NOC procedure was not yet in place at Yatala in September 2011, the HRAT system involved a similar regime. The regime would involve Mr Blunden's clinical notes being made on a yellow sheet, he

would be seen daily be medical staff, that he would be on the HRAT list and would be allocated a psychologist or social worker who could perform daily checks on the prisoner and that there would be a weekly review of all HRAT regime prisoners, including Mr Blunden, at a meeting. The prisoner would also be placed in a cell with another prisoner as a matter of course, regardless of the fact that the prisoner had exceeded the seven day observation period. The HRAT prisoner would also not be eligible to go to F Division because of the single cell accommodation that existed in that division. This meant that if Mr Blunden had been placed on HRAT he would have been restricted either to remaining in E Division where he was inducted or to another division if space was available. Thus F Division would have been the only division that was out of bounds for him[86]. Mr Mann did explain that once off the HRAT regime there would be no limitation or restriction on a prisoner's ability to be transferred within the institution. He said there was no '*cooling off period*'. Thus the prisoner would be eligible for transfer into F Division and be accommodated in single cell accommodation[87]. Mr Mann also said that before a prisoner is considered for F Division he must be assessed as not being at risk of self-harm. The difficulty with this in Mr Blunden's case was the fact that when Mr Blunden's eligibility for F Division came to be considered, he had not been under an HRAT regime and there is no evidence that information about his previous history had even then made its way to Yatala. Thus any decision to place him in F Division was flawed to that extent.

5.26. Mr Mann told the Court that Mr Blunden was not identified at the time of admission as being a person at risk. He completed his seven day observation in E Division. At no time during that period was he identified as being at risk of self-harm. Nor did he give any indication to any person that he was thinking of self-harm. He said:

> 'That's correct, the combination of not being identified at the time of admission of being at risk, his security rating score placing at medium security and at no time during that period of seven day observation, did he identify as being someone potentially at risk or demonstrate behaviours that would consider him unsuitable for placement in F Division.' [88]

Mr Mann added that in deciding to remove a prisoner from one division and to place him in another, in this case F Division, no check was undertaken to ensure that the original screening process upon admission had been thorough enough to have

[86] Transcript, page 743
[87] Transcript, page 744
[88] Transcript, page 771

identified whether or not the prisoner was at risk. In addition, no further screening process is undertaken at the end of the seven day period to identify whether, after all, a prisoner may be at risk of self-harm having regard to his prior history[89]. All of this means that any erroneous impression that a particular prisoner is not at risk was perpetuated. I observe that the proforma Prisoner Application for Duties[90] that is used when an application is made by a prisoner to work in the prison industries did not contain specific provision for any kind of risk assessment. One matter of relevance that Mr Mann drew to the Court's attention was that correctional staff within F Division might reasonably assume that a prisoner who was received into that division had been determined through the usual processes that they were fit for that division and live in single cell accommodation, and that there would have been an adjudication of that person as not being at risk[91].

5.27. Mr Mann regarded Mr Blunden's history of previous self-harm attempts as extensive[92]. He suggested that Mr Blunden should initially have been placed into G Division under observation awaiting assessment from health intervention staff to determine his appropriate management or treatment plan for his ongoing incarceration[93]. This opinion was based upon the information that Mr Mann now possesses in respect of Mr Blunden's history. The fact that Mr Blunden had been on a HRAT system at the ARC and had been taken off it should not, in Mr Mann's opinion, have made any difference to the approach that should have been taken at Yatala. It will be observed that in this he shares the same view as Dr Frost and takes a different view from Ms Markham. I prefer the view of Mr Mann and Dr Frost.

5.28. Mr Mann was specifically questioned about the appropriateness or otherwise of Mr Blunden being placed in single cell accommodation in F Division in circumstances where his previous history of self-harm and information regarding other risk factors should have been known to DCS staff and taken into account in deciding his accommodation. In answering this Mr Mann acknowledged that it would have been unlikely that with all that information Mr Blunden would not have been placed on HRAT in the first instance[94]. To my mind placement on HRAT would not

[89] Transcript, page 774
[90] Exhibit C72
[91] Transcript, page 788
[92] Transcript, page 801
[93] Transcript, page 802
[94] Transcript, page 805

only have been likely, it would have been inevitable. Mr Mann was specifically asked to consider a scenario involving Mr Blunden, in full knowledge of his antecedents, being placed in single accommodation in a cell in F Division that housed a well known hanging point in the form of a ventilation grille and a division that had a regime of infrequent observation and in circumstances where, say, he had been subject to an HRAT regime and had been removed from it at the end of the first seven days in custody. Mr Mann's reply was as follows:

> 'Having all the information available to us that is before us now, it is unlikely that he would have made it to F Division at that particular point in time, but that once again would still be nonetheless reliant upon whether or not he was determined to still be at risk of self-harm. After completing seven day observations and what was before my staff at that particular point in time, there was nothing at all to suggest at that time that he posed a risk of self-harm.' [95]

The fact that Mr Blunden was removed from the HRAT regime after only ten days at the ARC in the Court's opinion could not be taken as any guide or reference point for his treatment under the HRAT regime at Yatala, or as a guide to the type of accommodation he might be accorded following removal from HRAT at Yatala. It will be remembered that although Mr Blunden was removed from the HRAT regime at the ARC, his offender casenotes nevertheless contained a warning that his physical appearance, youth and emotional instability still needed to be taken into consideration and that it was also acknowledged that he would be very likely to react adversely if faced with a challenging situation. For the Court's part it is inconceivable that a prisoner of Mr Blunden's youth and antecedents, particularly his history of self-harm and unpredictable behaviour, would not only be removed from HRAT after seven days, but as well placed in possibly the riskiest accommodation at Yatala that is imaginable. I accept Mr Mann's assessment that it is unlikely that Mr Blunden would have made it to F Division at that particular point in time in the scenario posed.

5.29. In any event it is clear that the decision to place Mr Blunden in single cell accommodation in F Division where there was an obvious hanging point was flawed insofar as it has to be accepted that his previous propensities were simply not considered at all.

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[95] Transcript, page 804

6. Mr Blunden's regime of scrutiny in F Division

6.1. As indicated earlier F Division was a division that accommodated prisoners who worked in the prison industries. At that time all prisoners in F Division were accommodated in single cells. A prisoner would have to be considered to be at low risk of self-harm to be accommodated in F Division.

6.2. The daily routine from Monday to Friday in F Division was different from that which pertained in other divisions such as E Division in which Mr Blunden had originally been accommodated. Prisoners accommodated in F Division would for the greater part of the day be absent from the division. They would be at work at other places within the prison. I heard evidence that generally speaking prisoners would leave the division for work at approximately 9am. They would return to the division between 3pm and 4pm. Following their return there would be a free period in which prisoners accommodated within F Division could freely associate out of their cells. At 9pm they were all locked down in their cells for the night.

6.3. There would be occasions when some prisoners, for whatever reason, did not attend work. On Monday 19 September 2011 Mr Blunden did not work. This meant that in accordance with the prevailing practice within the division he would be locked in his cell for the day. Prisoners confined to their cells would be released upon the return of the F Division prisoners from work. A prisoner so confined would then be able to associate with all F Division prisoners. Evidence was given that the reason why a prisoner was confined within his locked cell when not attending work was that there was an insufficient number of corrections officers to supervise and facilitate freedom of association of prisoners within the division[96].

6.4. The usual observation procedures that pertained in other divisions that included two hourly patrols and observations did not apply in F Division until such time as all prisoners were locked down for the night at approximately 9pm. Instead, there would be a count early in the morning and then another count at approximately 11:25am at which time the prisoners who remained within the division would have their meals in their locked cells. At the time of the count and the provision of meals the prisoner would be sighted within the cell. The trap of the cell door was meant to remain in the open position. The meals would be placed on the trap door. Following the 11:25am

[96] Transcript, page 477

count there would be no further observation made of the prisoners until the working prisoners returned to the division, at which time the confined prisoners would be allowed out of their cells. Essentially this meant that the only observation that would be made of a confined prisoner during the course of the day would be the count that was made of them at approximately 11:25am. This regime of observation, or more precisely lack of observation, appears to have been due to the fact that prisoners accommodated with F Division were considered to be low security risks and low self-harm risks. Otherwise, they would not be in that division in the first place.

6.5. Thus Mr Blunden remained unobserved on the day of his death between about 11:30am and 3:13pm. There is no doubt that Mr Blunden was alive at approximately 11:30am because when his meal was delivered he was sighted by a corrections officer Mr Ian Stroud at that time. Therefore, he committed the act of hanging sometime between 11:30am and 3:13pm when he was found dead in his cell.

6.6. During the course of the Inquest there was debate in relation to whether at the time there was an existing requirement that prisoners confined in their cells in F Division be physically sighted at two hourly intervals. A document tendered to the Inquest, consisting of the explanatory notes for the divisional Log Book[97], suggested that there was a requirement that, following 'lockdown' and the official count of prisoners where all prisoners must be physical sighted, patrol officers must carry out a patrol within two hours of the completion of the previous patrol. However, evidence was given during the course of the Inquest that appears to reflect a universal understanding within Yatala that the confinement of non-working prisoners in their cells in F Division during the day was not considered to be a 'lockdown'. Therefore, it was believed that the requirement for two hourly sightings of such prisoners did not apply during the day. There is no evidence to suggest that any other understanding should have been entertained. I have found that in Mr Blunden's case there was no failure of compliance with any observation requirement.

6.7. The sighting requirements for F division have been modified since.

6.8. I make the observation that in the case of single cell accommodation even two hourly sightings would still provide a prisoner with the opportunity of inflicting self harm. The question in this Inquest was not so much involved with the appropriateness of the

[97] Exhibit C54

intervals of observation of a prisoner in F Division, but rather the appropriateness of a prisoner such as Mr Blunden being accommodated within such an environment at all.

7. Mr Blunden is located deceased

7.1. Mr Andrew Henderson was a corrections officer working the swing shift in F Division on Monday afternoon, 19 September 2011. At approximately 3:10pm Mr Henderson was in the process of placing prisoners into their units upon their return from work. His attention to Mr Blunden's cell would be drawn by a Mr Habkouk.

7.2. Mr Sam Habkouk[98] was a prisoner occupying cell 209 in F Division. Like Mr Blunden he did not attend work on this particular day. As a result, like Mr Blunden, he had been locked in his cell. Mr Habkouk confirms in his statement that he believed that there had only been the one check during the course of the day and that this had occurred just before lunch. He believes there may have been between five and eight other prisoners left in the unit that day. Mr Habkouk states that he was allowed out of his cell at about 3pm which is in accordance with the usual procedure. Once out of his cell Mr Habkouk made an unsuccessful phone call. As he was returning from the phone station he looked into Mr Blunden's cell. The cell door was halfway open and the trap as down. It appears that Mr Blunden's cell had been opened already, as had Mr Habkouk's, but that the officer who had opened it had not looked inside. When Mr Habkouk looked into Mr Blunden's cell he saw him sitting in the shower. At first he thought nothing of it. Mr Habkouk then made another unsuccessful telephone call attempt. When he returned to the unit he again looked inside Mr Blunden's cell and for the first time realised that something was wrong. He noticed that Mr Blunden was blue in colour and that his head was slumped forward. He also noticed that there was a sheet tied around Mr Blunden's neck with the other end tied to the air vent. Mr Habkouk raised the alarm.

7.3. Mr Henderson and another officer entered unit 2. Mr Henderson signalled a Code Yellow which signifies officer requiring assistance. He approached Mr Blunden's cell. The door was not locked. Mr Blunden was hanging by his neck in the shower cubicle. He called a Code Black which is a medical emergency. Mr Henderson took a few seconds to disperse and secure a large group of prisoners who had congregated outside Mr Blunden's cell. Mr Henderson entered the cell and endeavoured to

[98] Exhibit C5a

remove the tension from the ligature around Mr Blunden's neck. Another officer very quickly cut the ligature. Mr Blunden was removed from the cell where CPR commenced. Mr Blunden was unresponsive and would remain so. Registered Nurse Robynne Lower[99] was on duty in the PHS at Yatala. At approximately 3:20pm her attention was drawn to the Code Yellow that was immediately followed by a Code Black. She, together with a student nurse, collected the resuscitation trolley and immediately attended F Division. At that point, according to her statement, corrections officers were in the process of carrying Mr Blunden from the cell into the corridor. She heard one officer state that Mr Blunden was not breathing. Ms Lower noticed that the patient's mouth was clenched shut and that both hands were clenched. CPR was commenced. Ms Lower states that there was no carotid pulse present and that there were no other obvious signs of life. There was cyanosis of the ears, lips and eyelids. There was also a pooling of blood in the lower abdomen and trunk of the deceased. Oxygen was administered to Mr Blunden. A defibrillator was applied to Mr Blunden's chest but no recordable rhythm was registered. Dr Moskwa, a PHS doctor, attended the scene at 3:37pm. He found that there were no heart beats, pulse nor respirations present. Mr Blunden's pupils were fixed and dilated. Dr Moskwa pronounced life extinct at 3:40pm. I do not need to recite all of what was undertaken in terms of efforts to resuscitate Mr Blunden because it is clear that when he was located within his cell he was already deceased and beyond all resuscitative measures. In any event what measures were attempted appear to have been applied without undue delay.

8. Justice Information System access

8.1. I have already referred to the material that was contained within Mr Blunden's offender casenotes as posted to the JIS. In addition, there were a number of PIMS reports in relation to Mr Blunden that contained warnings and ancillary reports in relation to incidents involving self-harm or threats of self-harm.

8.2. I have already referred to the issue as to whether, and to what extent, correctional services officers had access to information about Mr Blunden contained within the JIS at the time of or after his admission to Yatala.

8.3. Evidence was given by Mr Antonios Antoniou about this matter. Mr Antoniou is an IT professional whose responsibility it is to write the JIS. He is an employee of DCS.

[99] Exhibit C27a

Mr Antoniou gave extensive and detailed evidence about the JIS as it existed in 2011. I do not need to go into the intricacies of this evidence in any great detail. It will be remembered that Mr Cross who was the officer who admitted Mr Blunden to Yatala said that he believed as an OPS2 officer, although acting as an OPS3 on this occasion, would only have had limited access to the JIS material in respect of Mr Blunden. Other corrections officers who gave evidence in the Inquest expressed differing views on the issue. It is clear that Mr Cross had a computer at his disposal during the admission process and that he used it to admit Mr Blunden to Yatala and to enter the admission note on Mr Blunden's offender casenotes on the JIS system. Mr Cross told the Court that he believed that he would not have had access to previous entries within the offender casenotes. To my mind Mr Antoniou demonstrated that this assertion was incorrect. It would have only taken the repeated press of a key to bring up previous entries on the offender casenotes on the JIS. Mr Antoniou told the Court, and I accept his evidence, that there would have been no restriction on a substantive OPS2 officer accessing that material once the prisoner's admission had been entered into the system. In particular there seems little doubt that Mr Cross could have accessed Ms Thorpe's entry of 19 July 2011 in which she noted serious SAPOL warnings of self-harm and threats to police as well as Mr Blunden's unpredictable behaviour[100]. As well, these casenotes would have been available throughout Mr Blunden's period of incarceration at Yatala[101]. I was less certain as to whether or not a correctional services officer would have been able to access the entries made on Mr Blunden's offender casenotes by members of HRAT such as the two psychologists who made entries on 20 and 25 July 2011 respectively. Mr Antoniou suggested that there was restricted access in relation to entries made by professional people of that description[102]. However, it is clear in my view that Ms Thorpe's entry would have been available and this of itself would have warranted further enquiry on the part of any subsequent admission process in any DCS institution. Ms Thorpe's reference to serious SAPOL warnings in and of itself would have dictated such an enquiry. It would also have indicated that Mr Blunden had been the subject of a NOC, meaning that he would have been subjected to the HRAT regime. A natural enquiry to have been made would have been to seek access to HRAT entries and information in respect of Mr Blunden's response to that regime during his period at the ARC. I note that in any case the ARC HRAT entries were also contained in printed form in

[100] Transcript, pages 664-665
[101] Transcript, page 665
[102] Transcript, page 665

Mr Blunden's ARC PHS file[103], a file that in the normal course of events should also have made its way to Yatala within a few days of Mr Blunden's admission.

8.4. In the course of his evidence Mr Antoniou referred to a number of JIS screen dumps that were printed out by the investigating officer, Brevet Sergeant Peter Moore as part of his investigation[104]. These are DCS computerised records on the JIS but which were accessed by a police officer, Mr Moore. There are nine such screen dumps concerning Mr Blunden, some of which record his involvement with HRAT between 20 and 29 July 2011. One screen dump refers to Mr Blunden's status as a drug user, but more significantly a warning that he '*MAY BE SUICIDAL*' with the additional detail that he '*TRYED (sic) TO KILL SELF BY PETROL AND PILLS*'. Mr Antoniou told the Court that these computerised records would have been available to an OPS2 officer in 2011[105].

8.5. In my opinion, when Mr Cross admitted Mr Blunden to Yatala he did not access any of the material on the JIS that would have been available to him including previous offender casenotes or any of the computerised material that is encapsulated in the Exhibit SRB1 that is attached to the statement of Mr Moore. There is simply no evidence from any of the paperwork that was generated at the time of Mr Blunden's admission that gives any hint of access to that material. For instance, there is no reference to any SAPOL warnings of self-harm or of a propensity for violent and unpredictable behaviour. There is certainly no reference to any attempt on the part of Mr Blunden to take his own life by petrol and pills. To my mind the only interaction that Mr Cross had with the JIS occurred when he made the entry in relation to Mr Blunden's admission in the very bland and uninformative terms that he did. It is also plain to me that no further check was made of material contained on the JIS in the days that followed Mr Blunden's admission to Yatala. If there had been any such check, the information that ought to have been garnered as a result would inevitably have placed him under a HRAT regime.

8.6. It may well be that the extent of access to this kind of computerised material was not greatly understood by corrections officers at the time of these events.

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[103] Exhibit C50, pages 14-15
[104] Exhibit SRB1 annexed to the statement of Mr Moore, Exhibit C48as
[105] Transcript, page 679

9. The failure of the Prison Health Service at Yatala to obtain the PHS file from the Adelaide Remand Centre

9.1. As seen, the Yatala PHS file did not contain any of the relevant documentation that was retained within the ARC PHS file. The two files should have been consolidated at a time prior to Mr Blunden's death. They were not consolidated. The statement of registered nurse Robynne Lower[106] taken on 20 September 2011, the day after Mr Blunden's death, states that the PHS case file which was being used by Yatala staff at the time of the incident was a temporary file. Ms Lower states that the ARC PHS file had been archived upon Mr Blunden's release from that institution and that '*we were awaiting its arrival*'. I took that to mean that staff at Yatala PHS as of the day of Mr Blunden's death were expecting Mr Blunden's ARC PHS file to arrive. In an addendum statement taken on 5 May 2014[107] Ms Lower states that following Mr Blunden's death she made a note in the Yatala PHS file about the resuscitation attempts that had been made in respect of Mr Blunden. That note is in the Yatala PHS file[108]. Ms Lower's states that she noticed that the Yatala PHS file was a temporary file.

9.2. The absence of the ARC PHS file at Yatala and its non-consolidation with the Yatala file was a matter that should have been regarded as relevant to this inquiry. During the course of the Inquest it was revealed than an investigation, of sorts, had been undertaken by PHS in relation to whether following Mr Blunden's admission Yatala PHS staff, by some means or other, had sent for the ARC PHS file. This investigation appears to have been conducted by Ms Jane Tyson who is the Administrative Lead in the Business System Unit at Corporate Office within the PHS which is encompassed within the Department of Health and Ageing. The Court received the affidavit of Ms Tyson dated 12 May 2014[109]. Ms Tyson's affidavit reveals that PHS did not have a shared computer network to enable file requests to be made electronically. In 2011 Yatala DCS would provide a handwritten list of prisoners admitted on the previous day to the Yatala PHS administrations services officer (ASO). On recent of the list the Yatala ASO would fax it to the ARC ASO. The ASO had limited JIS 'read only' access at relevant times. This might reveal that prisoners on the list that I have

[106] Exhibit C27a
[107] Exhibit C27b
[108] Exhibit C51, pages 10-11
[109] Exhibit C75

described had been previously incarcerated and therefore had a PHS file. The ASOs did not have access to the prisoner's JIS health information or any casenotes. Ms Tyson explained that on receipt of the fax the ARC ASO would retrieve the health records from a compactus located in the ARC health centre. These files would be retrieved in respect of prisoners who had a star next to their name on the faxed list. The ARC ASO would then retrieve the relevant records and retain them for collection by a courier the next available day. The courier would pick up delivery packages on Mondays, Wednesdays and Fridays. 19 July 2011, which was the day of Mr Blunden's admission to the ARC, was a Tuesday.

9.3. Ms Tyson identified a Ms Karen Petty as the Yatala ASO and a Ms Leonie Parks as the ARC ASO. I do not believe that statements were taken from Ms Petty or Ms parks until this Inquest was underway in 2014. However, during the course of Ms Tyson's investigation which took place in September 2011 she asserts that Ms Petty showed her a copy of a DCS handwritten list with Mr Blunden's name on it and a faxed stamp on the document. Ms Tyson asserts that she does not recall seeing a handwritten date or the printed date on the document indicating when it had been faxed. She also does not recall whether a star had been placed next to Mr Blunden's name on the list. The list was not produced in the course of the Inquest. I assume it no longer exists.

9.4. Affidavits were taken from Ms Petty[110] and Ms Parks[111] in May 2014. Ms Petty describes the process for requesting ARC files that accords with the process as described in Ms Tyson's affidavit. Unfortunately Ms Petty does not recall much at all about Mr Blunden or the documentation that may have been raised in relation to him. She states that she does not even recall Ms Tyson showing her the DCS movement sheet with Mr Blunden's name on it. Ms Parks' statement is similarly bereft of helpful information.

9.5. It is fair to say that this investigation, such as it was, was wholly inadequate in establishing why it was that Mr Blunden's ARC PHS file was never obtained from the ARC. What does seem reasonably clear, however, is that the processes for the retrieval of such files were clumsy, rudimentary and left much to good fortune.

[110] Exhibit C74
[111] Exhibit C73

10. The Court's conclusions

10.1. The Court made the following findings and conclusions.

10.2. On 8 September 2011 Mr Blunden was admitted to Yatala Labour Prison where he would ultimately die

10.3. When Mr Blunden arrived at Yatala he was accompanied by documentation that had been placed into the possession of G4S by SAPOL. It has not been possible to determine precisely the nature of each and every document that accompanied Mr Blunden. It is possible that a number of SAPOL PIMS warning screen dumps accompanied the SAPOL documentation, but as no detailed inventory of the documentation actually sent and received was ever compiled, with one exception the Court is not certain as to whether this material, arrived with Mr Blunden at Yatala. It is clear, however, that one PIMS document came into the possession of DCS at Yatala and that is a SAPOL PIMS screen dump that indicated that Mr Blunden '*May Be Suicidal*'. This document was ultimately located on Mr Blunden's DCS Dossier. The document should have been placed within Mr Blunden's Yatala case management file at the time of his admission and have been taken into consideration in assessing Mr Blunden's risk of self-harm. It should also have been included in Mr Blunden's PHS file at Yatala.

10.4. In the course of Mr Blunden's DCS prison stress screening a question as to whether Mr Blunden had ever overdosed either accidentally or intentionally was erroneously recorded in the negative. Similarly, whether Mr Blunden bore scars on his wrists, arms and neck, and whether they appeared to have been caused by suicide or self-harm, was also erroneously recorded in the negative. When Mr Blunden was seen by Yatala PHS nursing staff it was recorded that he had admitted that he had overdosed in the past and it was revealed that he did have scarring to his arms. Mr Blunden's post-mortem examination confirmed that he had numerous linear both horizontal and vertical scars present to the back of the left hand and forearm as well as horizontal scars to the back of the right forearm that were all strongly suggestive of previous self-harm.

10.5. Mr Blunden's admission process at Yatala miscarried in that the above information was not properly taken into consideration in assessing his risk of self-harm. Upon his admission he should have been considered to be at high risk of self-harm and have been subject of the HRAT regime of risk management.

10.6. Information was available within DCS documentation kept at the ARC when Mr Blunden was imprisoned at that institution in July 2011 that was strongly suggestive that Mr Blunden was at high risk of self-harm. In particular there was information available from police documentation supplied at the time of his admission to the ARC that Mr Blunden may be suicidal and that he had tried to kill himself with petrol and pills. For those reasons Mr Blunden had rightly been considered to be at high risk of self-harm and a NOC was raised in respect of him at the ARC. Similar information was contained within Mr Blunden's ARC PHS file from which the same conclusion about his risk of self-harm could have been drawn. In addition, documentation was received by the PHS at the ARC, at a time after Mr Blunden's release from the ARC, which contained significant information in respect of attempts at self-harm that had taken place at the Cavan Training Centre and elsewhere. Neither the information contained within the DCS ARC file nor the ARC PHS file was ever made available to either DCS or PHS staff at Yatala.

10.7. The ARC DCS file regarding Mr Blunden was archived following his release from that institution and a wholly new file was raised in respect of his incarceration at Yatala. The ARC PHS file should have been obtained by Yatala PHS staff in respect of Mr Blunden. It was not received. The Court has been unable to determine whether or not the file was ever requested, or if requested, whether the request was ever properly received and acted upon.

10.8. At the time of Mr Blunden's admission I find that no adequate check was made in respect of information about Mr Blunden that would have been available on the JIS. A check of the JIS in respect of Mr Blunden upon his admission to Yatala would have revealed that upon his admission to the ARC in July 2011 he was known to have serious SAPOL warnings of self-harm and that he was known to be capable of violent and unpredictable behaviour. It would also have been revealed that a notice of concern had been initiated on that occasion due to the SAPOL warnings. There would also have been information accessible on the JIS that upon Mr Blunden's admission to Yatala would have revealed that he may be suicidal and that he had tried to kill himself with petrol and pills. There was an inadequate check of this material upon Mr Blunden's admission to Yatala. The failure to check this material may owe itself to poor training and poor knowledge on the part of corrections officers as to the availability of this material on the JIS.

10.9. Mr Blunden's flawed admission process at Yatala meant that he was not placed on the HRAT regime. For the first seven days of his incarceration at Yatala he was accommodated in a double cell. On 15 September 2011 Mr Blunden was inducted into F Division where he was accommodated in a single cell. The single cell had a notorious hanging point in the form of a ventilation grille. The decision to place Mr Blunden into this accommodation was flawed insofar as it was based on inadequate information about Mr Blunden's actual risk of self-harm which was high. I do not believe that any further seeking of information about Mr Blunden's actual risk of self-harm was made between the day of his admission and the day of his induction into F Division.

10.10. It is unlikely that if Mr Blunden had been placed on a HRAT regime he would have been removed from it and placed directly into single cell accommodation in F Division. Even if Mr Blunden was not to be considered as at risk of suicide, his previous history of self-harm meant that he should have seen as at risk at least of further self-harm and for that reason alone he should not have been accommodated in F Division.

10.11. At the time with which this Inquest is concerned prisoners accommodated within F Division and who were not sent to work on a particular day were kept locked in their individual cells. There was no procedure in place whereby prisoners locked in their cells would regularly be observed for the duration of any period in which they were locked in their cells other than at the meal time distribution at approximately 11:30am and at night. On the day of Mr Blunden's death he was seen at the time of meal distribution at about 11:30am when he was locked in his cell. He was seen to be alive at that time. He was not observed again until approximately 3pm when he was found deceased. Mr Blunden took his own life in the intervening period. Mr Blunden used the obvious and available hanging point in the form of the ventilation grille. I find that no other person was involved in his death.

10.12. I find that Mr Blunden's death probably would have been prevented if:

- there had been adequate liaison between DCS staff and PHS staff at the time of his admission to Yatala, revealing as it would have that Mr Blunden had overdosed in the past and that he had evidence of scarring on his arms, in which case Mr Blunden would have been placed upon the HRAT regime;

- the contents of Mr Blunden's DCS ARC case management file had been available to DCS Yatala staff at the time of his admission to Yatala or at any time before his death;
- material in the PHS file had been made available to PHS staff at Yatala either upon admission or at some subsequent time before the day of Mr Blunden's death, in which case he would have been considered to be at high risk and placed on the HRAT regime;
- a proper and adequate search on the JIS in relation to Mr Blunden had been made at the time of his admission to Yatala, in which case he would have been placed on the HRAT regime;
- between the day of his admission and the day of his death adequate enquiry, either by DCS staff or PHS staff, had been made about Mr Blunden's previous risk assessment at the ARC, and if the documentary material that would have supported that risk assessment had been obtained;
- Mr Blunden had not been admitted to F Division accommodation, which event should not have occurred having regard to what should have been known about Mr Blunden's risk of self-harm.

11. Recommendations

11.1. 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.

11.2. Evidence was given during the course of the Inquest regarding a number of measures that have been adopted both within the correctional services and prison health environments. Since the events with which this Inquest is concerned legislation has been enacted in the form of Section 85CA of the Correctional Services Act 1982 which mandates the provision of personal information about a prisoner, including information about previous health care and mental health care, as might be reasonably required for the treatment, care or rehabilitation of a prisoner, to the Chief Executive of the Department for Correctional Services. The provision also allows for the establishment of protocols or guidelines for those purposes. This amendment to the Correctional Services Act 1982 came into operation on 31 August 2012. I observe that a coronial recommendation in this State relating to the transfer of such personal

information about a prisoner was made in 2003 in the matter of the death of Craig Mark Allen[112]. The recommendation suggested that legislation might be required to overcome any privacy considerations. It appears that the legislation is now in. Tendered to the Court was a draft protocol for the exchange of information between SA Health and the Department for Correctional Services for the treatment, care or rehabilitation of a prisoner. I do not need to go into the detail of this protocol, except to point out that the sharing of information is contemplated to occur at various times in a prisoner's passage through the prison system including admission. In addition, the urgent sharing of information is said to be required, appropriately, in cases of high risk prisoners. It will be hoped that the sharing of information pursuant to the protocol will not be attended by undue formality.

11.3. There is also now in existence a memorandum of administrative arrangement between the Department for Communities and Social Inclusion (Youth Justice) and the Department for Correctional Services that is designed to facilitate information exchange arrangements between, and to enhance the capacity of, the Department for Communities and Social Inclusion (Youth Justice) and the Department for Correctional Services in respect of the provision of coordinated services and support to young people making a transition between a juvenile and adult, or adult and juvenile, correctional settings. One of the stated objectives in the document is to support the concept that the safety and wellbeing of young people must be safeguarded when decisions are being made to transition them between juvenile and adult, or adult and juvenile, correctional settings. One of the stated principles within the document is that a young person's right to safety overrides an individual's right to privacy, which is a refreshing development. This document appears to have been endorsed and therefore have come into operation on 28 April 2014.

11.4. The Court was also informed of a number of other measures that concern internal Department for Correctional Services' procedures. Some of these relate to the frequency of prisoner observations within the divisions at Yatala, including a requirement that in F Division prisoners who are kept within their cells during the course of the day must be observed at 1pm. It will be remembered that Mr Blunden was not seen between approximately 11:30am and 3pm. It is not certain whether this measure would have prevented Mr Blunden's death. He should not have been in F Division in the first place.

[112] Inquest 17/2002

11.5. Other measures of which the Court was informed concern the operation of the JIS, to be implemented on 11 June 2014. The first alteration would enable the admissions officer, when entering the name, birth date and gender of the admitted prisoner, to immediately and automatically view a JIS screen that lists any warning flags. The admissions officer is then able to consider these warnings during the admission assessment process. In other words, the admissions officer will be forearmed with JIS information about the risk status of a prisoner at a time before he interviews the prisoner rather than after the interview, or as was seen in Mr Blunden's case, not at all. If a warning flag pertaining to self-harm or suicide history is active for the admitting prisoner, the system is designed to generate automatically an email advising of the prisoner's potential risk. The automated email will be forwarded to site staff who are listed within the local HRAT team distribution list. Upon receipt of the automated email supervisors and managers can arrange for an appropriate risk assessment prior to placement considerations. The second alternation concerns continued references on the system to HRAT involvement, even after the prisoner's removal from the HRAT list.

11.6. There have also been alterations in the admission requirements as far as Prison Health Service involvement is concerned. In this regard I received into evidence the affidavit of Andrew Mark Wiley[113] who was the Nursing Director of the South Australia Prison Health Service. The affidavit explains that there are now two stages of assessment. It explains that there is a preference that nurses should review the SA Health Open Architecture Clinical Information System (OACIS) and the Mental Health Community Based Information System (CBIS) at the time of admission. It is not a mandatory requirement as the nursing staff may not have time to review those systems. If the staff member is not able to access and read the information on OACIS or CBIS before conducting the initial assessment, then such access becomes mandatory for the second stage of assessment which is conducted between 24 hours and 28 days after the first assessment, depending upon whether the prisoner's triage as to urgency of assessment. A second stage of the assessment also has the advantage of providing the nurses with an opportunity to review the patient with further information that may have been provided by the Adelaide Remand Centre or retrieved from OACIS or CBIS. In his affidavit Mr Wiley explains that all electronic records of SA Health are intended to be integrated on a new electronic system known as Enterprise Patient Administration System (EPAS). EPAS is intended to replace

[113] Exhibit C76

OACIS. At the moment the South Australia Prison Health Service is not on the current schedule for the EPAS rollout. Mr Wiley also explains that Prison Health staff have been trained to use the JIS, but have limited read only access to prisoner information of a routine nature. As Dr Frost explained in his evidence, the Prison Health Service did not have access to OACIS until after these events. In addition, all Prison Health Service files were paper based. I am not certain whether the evidence in this case establishes whether, for example, at the admission stage of a prisoner's incarceration there is now immediate access electronically to previous information kept about the same prisoner in Prison Health Service files. If not, there should be such access so as to avoid the unsatisfactory aspects of the uncertain paper record retrieval systems that existed at the time of Mr Blunden's death.

11.7. The Court needs, once again, to say something about hanging points. The Court repeats what it said about this issue in the matter of Christopher Aaron Smith[114] who died in Yatala after he hanged himself using a ventilation grille as a hanging point:

> '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.'

To be fair, in the Smith case Mr Mann, the General Manager of Yatala Labour Prison, explained to the Court that at that time ventilation grilles were being replaced at Yatala with devices that ought to prevent the attachment of ligatures. Nevertheless, until all obvious ligature points are removed from cells within the correctional institutions of South Australia, this Court will keep repeating that there is a very urgent need for the removal of ligature points in such cells.

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[114] Inquest 17/2012

11.8. The Court makes the following recommendations directed to the attention of the Minister for Correctional Services, the Chief Executive of the Department for Correctional Services, the Minister for Health, the Chief Executive of SA Health and the Commissioner of Police.

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 Chief Executive of the Department for Correctional Services take steps to identify and appoint correctional officers who are specifically dedicated to the task of admitting prisoners to correctional institutions in South Australia. These dedicated correctional officers should be thoroughly trained in all aspects of the admission process. They should also be thoroughly trained in the use of the Justice Information System and should have full and unrestricted access to the information contained on that system including but not limited to information about the admitted prisoner that has previously been placed on the Offender Casenotes by DCS staff and members of the High Risk Assessment Team;

3) That the Chief Executive of the Department for Correctional Services ensure that all documentation that is received at the time of the arrival of a prisoner at a correctional institution in this State is seen and examined by the admitting officer and that a copy of all such documentation is placed within the prisoner's case management file. A copy of the entirety of the documentation should be provided to the Prison Health Service upon admission of the prisoner. No document should be removed from the bundle of documentation that is received at the time of admission. An inventory listing all individual documents that are intended to accompany the prisoner to a DCS institution should be created by SAPOL before the prisoner is removed from SAPOL custody. The inventory should also accompany the prisoner. A further inventory should be created by DCS staff when the SAPOL documentation arrives at the DCS institution;

4) That the Chief Executive of the Department for Correctional Services ensure that there are procedures in place at all correctional institutions in South Australia to ensure that at the time of admission of prisoners aged below 20 years of age, enquiries are made in respect of the behaviour of the prisoner during any period of the prisoner's interaction with the juvenile justice system,

and in particular to ascertain whether any information in respect of risk of self-harm is contained within records held within juvenile custodial institutions;

5) That the Chief Executive of the Department for Correctional Services ensure that all newly admitted prisoners below the age of 20 years are assigned a case officer, regardless of whether the prisoner's period of imprisonment is expected to exceed a period of 28 days or not and regardless of whether the prisoner is a remanded prisoner or sentenced prisoner;

6) That the procedure whereby a newly admitted prisoner is mandated to undergo shared accommodation within the first seven days be continued, and that a renewed prisoner stress screening process be conducted in respect of all prisoners at the conclusion of that seven day period, taking into account all further information that may have been gathered in the intervening period about that prisoner's risk of self-harm;

7) That the Chief Executive of the Department for Correctional Services ensure that no prisoner is placed in single accommodation in any cell that contains an obvious hanging point, and in particular in a cell that contains a ventilation grille of the kind that was utilised by Mr Blunden;

8) That in no circumstances should a prisoner who is removed from the HRAT regime be immediately accommodated in single cell accommodation;

9) That the Chief Executive of the Department for Correctional Services ensure that when a prisoner is placed in single cell accommodation, a prisoner stress screening procedure is conducted afresh. Such a process should obligate the officer performing the prisoner stress screening to make the necessary Justice Information System enquiries and to identify all information that is or may be relevant to the prisoner's risk of self-harm. This process should apply to, but not be limited to, prisoners who have applied to be accommodated in F Division in single cell accommodation;

10) That the Chief Executive of the Department for Correctional Services ensure that prisoners admitted to F Division are in the first instance accommodated in double cell accommodation within that division;

11) That the Chief Executive of the Department for Correctional Services ensure that there is complete and immediate access to all information gathered about a

prisoner by the Department for Correctional Services and within the juvenile justice system;

12) That the Chief Executive of SA Health ensure that there are proper and appropriate procedures for the conveyance of Prison Health Service files in respect of a prisoner from one correctional institution to another;

13) That the Chief Executive of SA Health establish an electronic database, whether included in EPAS or not, that enables Prison Health Service staff to view the entire health records of a prisoner, regardless of the institution or institutions in which that prisoner has been previously accommodated and regardless of whether the previous institution was an adult institution or a juvenile justice institution,

14) That the Chief Executive of the Department for Correctional Services and the Chief Executive of SA Health establish procedures whereby staff of the Prison Health Service have access to the Justice Information System, particularly in relation to information contained on that system regarding the risk of self-harm of a particular prisoner.

15) That the Chief Executive of the Department for Correctional Services and the Chief Executive of SA Health together establish procedures relating to the sharing of information between DCS officers and PHS staff who are involved in the admission process of prisoners in DCS institutions in this State to determine whether, at the time of admission, information recorded in the DCS Prisoner Stress Screening Form is consistent with information given by the prisoner to PHS staff.

Key Words: *Death in Custody; Suicide; Suicide Risk - Assessment Of; Monitoring /Observation of Prisoners; Screening Procedures*

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

Seal the 6th day of May, 2015.

Deputy State Coroner