



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7th, 8th, 9th, 10th and 14th days of May 2013, the 6th and 21st days of November 2013, the 29th day of January 2014, the 1st, 19th, 20th, 21st and 30th days of May 2014, the 20th day of June 2014, the 25th, 26th, 27th, 28th and 29th days of August 2014, the 1st day of September 2014 and the 11th day of June 2015, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Mark William Payne.

The said Court finds that Mark William Payne aged 28 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 2nd day of June 2011 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

Part I

The circumstances immediately preceding Mr Payne's death

1. Introduction and cause of death

- 1.1. Mark William Payne was aged 28 years when he died on 2 June 2011. He was a remand prisoner in G Division at Yatala Labour Prison (Yatala) at that time. He was located having hanged himself in his cell at approximately 8pm that day. Despite the administration of CPR Mr Payne could not be saved. In fact, he had been dead for some time before his discovery. An autopsy was carried out by Dr Karen Heath, forensic pathologist, on 3 June 2011. Dr Heath provided a post-mortem report dated

11 October 2011¹ giving the cause of death as neck compression due to hanging, and I so find.

- 1.2. Mr Payne was found to have hanged himself using a canvas smock that he was wearing in his cell. He had made threats of self harm and was accordingly regarded as being at high risk of suicide. The cell had provision for camera observation, but despite this Mr Payne managed to use his canvas smock, hook it to the tap servicing the sink in his cell and then placing his head through the neckline of the smock, thus effecting a ligature. The cells in G Division are probably as free of hanging points as any cells in the State (with the possible exception of padded cells, which are only suitable for temporary accommodation) and the cells in G Division are able to accomplish this standard by reason of their almost complete lack of internal features. They are sparse in the extreme and certainly not a pleasant environment.
- 1.3. Mr Payne's death was a death in custody within the meaning of the Coroners Act 2003 and, accordingly, an Inquest was convened as required by section 21(1)(a) of that Act.

2. **Mr Payne's background**

- 2.1. Prior to 2010 Mr Payne had little interaction with the law. As a juvenile he had been required to participate in a family conference on one occasion for minor offending. He apologised for his actions and was only required to pay court costs.
- 2.2. In August 2006 Mr Payne had a motocross accident and injured his back. He suffered considerably from long term pain from this injury and was heavily reliant on pain medication.
- 2.3. In June 2008 Mr Payne began a relationship with a woman named Rebecca Kearney. She had children from a previous relationship and Mr Payne appears to have been very fond of the children, treating them as his own. Mr Payne and Ms Kearney became engaged in December 2008 and were planning a wedding for early 2010. Ms Kearney made a statement² describing Mr Payne at the commencement of their relationship as a beautiful person, very caring, always happy and always doing things for others.

¹ Exhibit C2a

² Exhibit C4a

- 2.4. Ms Kearney had been involved in Family Court proceedings relating to her ex-partner. Mr Payne became aware that Ms Kearney's children no longer wished to visit their birth father and stay overnight at his house. Mr Payne suspected that the father was cultivating cannabis on the property and made a plan to draw police attention to that activity in the hope that the children may no longer have to see him. Accordingly, on 5 February 2010, Mr Payne entered the house of Ms Kearney's ex-partner without permission looking for drugs. He was arrested for this action and on 8 February 2010 a Family Court order was made barring Mr Payne from seeing Ms Kearney's children. This meant that he had to move out of the house he shared with her and stay in a house owned by his parents. This appears to be the beginning of a decline for Mr Payne.
- 2.5. Following this Mr Payne's relationship with Ms Kearney became strained. Between February 2010 and March 2011 Mr Payne was taking large amounts of pain medication and also commenced the use of illicit substances. He also accumulated a number of police charges, mostly relating to bail, some dishonesty offending and traffic infringements. On 9 March 2011 he had a number of these pending charges dealt with and was given a sentence of imprisonment of 7 months which was suspended on condition that he enter into a good behaviour bond for a period of 2 years. During the term of the bond he was to be supervised by Community Corrections and it was a term of his supervision that he submit himself to random urine and breath testing and psychological counselling for depression and anxiety.
- 2.6. Mr Payne was not entirely compliant with the conditions of his bond. There were occasions when he missed appointments with Community Corrections which he would blame on 'car trouble'. Warning letters were sent to him on 7 April and 21 April 2011 and he was given a verbal warning on 6 May 2011.
- 2.7. In early April 2011 Mr Payne was found by the police inside Ms Kearney's house while she was not at home. A neighbour had called the police to report his presence. Also in early April 2011 he was charged with possessing a controlled substance. On 11 April 2011 he was alleged to have committed property damage by punching a door at the office where Ms Kearney worked and shattering the glass. In the middle of April 2011 he told his Community Corrections worker that his life was terrible and he wanted to end it. He denied suicidal plans but did say that he had been using Oxycontin, Panadeine Forte, steroids and methamphetamine to help him deal with the

stress. He was asked to provide a urine sample and after some prevarication he did so. In early May 2011 he was arrested for the offending relating to the property damage at Ms Kearney's place of work. He was arrested and placed in the police cells and was cautioned for stalking Ms Kearney. He received police bail late on that day. On 6 May 2011 Mr Payne was again observed at Ms Kearney's premises. Following this she sought a restraining order against him. Upon his arrest by police following that episode he made a threat of self harm and the police took him to the Lyell McEwin Hospital. He was assessed the following day and denied suicidal ideation. After further threats of self harm he was returned to the Lyell McEwin Hospital later that day. He was reviewed by a medical officer who confirmed that he was fit for custody and was returned to the Elizabeth police station. Subsequently he was granted bail by the Court on condition that he reside with his parents.

- 2.8. On 21 May 2011 at 5:03am Mr Payne was seen in a house at Munno Para by the occupants of that house. The police were called and Mr Payne was eventually arrested in the vicinity. He was taken to the Lyell McEwin Hospital for assessment. He was detained at the hospital under the Mental Health Act. While in hospital a bedside Court hearing was conducted and an order was made remanding him in custody. On 27 May 2011 the mental health detention order was revoked and Mr Payne was regarded as fit to be placed in correctional custody. Accordingly, he was transferred to Yatala. He was noted to be showing signs of distress and it was noted that this was his first time in prison and that he had made recent threats of self harm. As a result of this he was placed in G Division under camera observation. On 30 May 2011 he was reviewed by a psychiatrist and it was recommended that he be removed from camera observations and progress to a normal prison regime. That commenced on 31 May 2011. On 1 June 2011 Mr Payne informed the high risk assessment team that he had threatened self harm but no longer had any intention of following through. He reported that he had suffered increased levels of anxiety as his life had spiralled out of control over the previous 12 months. He said that he had a supportive family and could live with his parents and that he had not had any trouble prior to abusing drugs. On 2 June 2011 Mr Payne was transported to the Elizabeth Magistrates Court where he had hoped to obtain bail. However, bail was refused and he was remanded in custody with a further bail hearing set for 8 June 2011 pending a psychiatric report to the Court.

- 2.9. Mr Payne's solicitor advised the G4S staff transporting Mr Payne to and from Yatala that Mr Payne was upset and wanted to kill himself when he got back to prison. A note was made and attached to the front of Mr Payne's file. This information was drawn to the attention of staff at Yatala upon Mr Payne's return. Later that evening Mr Payne's solicitor contacted Yatala and repeated his concerns. Mr Payne's mother also called the prison and advised that she was concerned about her son harming himself.
- 2.10. These events culminated in Mr Payne's tragic death as described above.

3. **Lindsay Richardson**

- 3.1. Mr Richardson was an employee of G4S in June 2011 and had contact with Mr Payne for the purposes of transporting him to and from Yatala³. Mr Richardson said that he was aware that Mr Payne had been on "suicide watch" and was therefore observing him closely on the trip to the Court. Mr Richardson noted nothing untoward. Mr Richardson escorted Mr Payne to the courtroom and recalled Mr Payne saying that he was hoping to get home detention bail using his parents home as a the place of residence⁴. However, Mr Richardson said that bail was refused and Mr Payne was remanded in custody. Mr Richardson did not note any particular signs of upset on Mr Payne's part⁵. There is a slight anomaly in the evidence here in that another escort officer with G4S, Mr Ronayne⁶ made a statement suggesting that Mr Richardson had informed him that Mr Payne was upset at bail being refused. In his oral evidence Mr Richardson did not recall that. However, I suspect that this is merely a matter of faulty recollection on Mr Richardson's part. The matter was overtaken by a subsequent event which Mr Richardson clearly did remember. He said that Mr Payne's lawyer came in to the office where he was sitting with Mr Ronayne after Mr Payne's court appearance. The lawyer informed him that Mr Payne had been crying a bit and that he said that he was going to kill himself if he went back to gaol. As a consequence of this Mr Ronayne made a note on a post-it note which he placed on the front of Mr Payne's file⁷.

³ Transcript, page 287

⁴ Transcript, page 291

⁵ Transcript, page 292

⁶ Exhibit C6a

⁷ Transcript, page 300

- 3.2. Mr Richardson reported that on the return journey to Yatala he monitored Mr Payne on the CCTV in the van. He did not note anything unusual in Mr Payne's behaviour. He took Mr Payne from the vehicle into the holding cells area at Yatala and removed his handcuffs. That was the end of Mr Richardson's contact with Mr Payne.
- 3.3. Mr Richardson took Mr Payne's file and handed it to one of the prison officers at the holding cells. He pointed out the information on the post-it note and that Mr Payne had made threats. The prison officer said words to the effect "we are aware of him, he is on suicide watch". Mr Richardson was satisfied that the concerns recorded on the post-it note had been duly conveyed⁸.

4. Scott Hilliker

- 4.1. Mr Hilliker is a correctional officer employed at Yatala. He was an OPS3 Supervisor as at June 2011. Although he never met Mr Payne, he dealt with some of the paperwork relating to Mr Payne's return to Yatala that afternoon. Mr Hilliker was the Supervisor in charge of the holding cells at that time⁹. Mr Hilliker recalled that one of the staff in the holding cell area had received a telephone call about Mr Payne. The information relayed in that telephone call was passed on to Mr Hilliker verbally¹⁰. The information that Mr Hilliker received was that Mr Payne was threatening to harm himself, that he had made statements that if he returned to Yatala that he was likely to commit suicide or harm himself in some fashion. The prison officers were to be made aware of that. Mr Hilliker said that as a consequence of receiving this information he looked at the prisoner cell allocation sheet to find out where Mr Payne was allocated within the prison. He found that he was in G Division. Mr Hilliker then informed the officer in G Division on duty at the time that Mr Payne had threatened to harm himself and consequently, Mr Hilliker was directing that he be put in an observation cell¹¹. The G Division officer to whom he spoke was Ben Fieldhouse. Mr Hilliker added that a prisoner being upset upon return from Court in similar circumstances is not an uncommon event¹².
- 4.2. After speaking to Mr Fieldhouse, Mr Hilliker also spoke with the Officer in Charge of the prison that evening, Mr Victor Ottey. Mr Hilliker told Mr Ottey about the

⁸ Transcript, page 304

⁹ Transcript, page 310

¹⁰ Transcript, page 314

¹¹ Transcript, page 314

¹² Transcript, page 315

situation relating to Mr Payne and advised that Mr Payne needed to be housed in an observation cell. Mr Hilliker knew that Mr Payne would likely be returning to Yatala after hours and that the Officer in Charge would at that time be Mr Ottey and that he would have custody of the keys. He would therefore be able to ensure that Mr Payne was placed in an appropriate cell¹³.

5. Victor Ottey

- 5.1. Mr Ottey gave evidence at the Inquest. He is the Unit Supervisor Grade 4 at Yatala. He confirmed that he was of the Officer in Charge of Yatala on the evening of 2 June 2011. He was based in the control room¹⁴. He said that the start of the shift is usually quite busy because all of the keys from the separate divisions are returned to the control room. They have to be weighed and allocated. All documentation for the day shift has to be completed, radios have to be returned to the control room and be recharged. All the duress alarms have to be tested and put away¹⁵. Mr Ottey said that as at June 2011 there were ordinarily two officers in the control room. However, on this particular night, there were an additional two officers in the control room. That was because an officer was being trained in the ways of the control room by another officer with experience in that area.
- 5.2. Mr Ottey confirmed that he received information at approximately 6.10pm that afternoon that Mr Payne's lawyer had telephoned the prison and advised that the court case had not gone as well as expected and that Mr Payne had threatened self harm if he was returned to the prison¹⁶. Mr Ottey said that it had already been decided by the other staff that Mr Payne would be placed in a camera observation cell when he returned to G Division. This was a course with which Mr Ottey agreed because it meant that Mr Payne would be placed in a cell which supposedly had no hanging points and would be placed in a canvas smock with canvas blankets¹⁷. Apparently Mr Payne was quite angry on receiving this news and denied that he had said anything about self harming¹⁸. Mr Ottey said that the placement of Mr Payne under observation in a camera cell in G Division was the only option that was available to

¹³ Transcript, page 320

¹⁴ Transcript, page 348

¹⁵ Transcript, page 349

¹⁶ Transcript, page 354

¹⁷ Transcript, page 355

¹⁸ Transcript, page 355

him¹⁹. He said that he did not make contact with medical staff and that the placement of prisoners in camera observation cells was the procedure he had been instructed to use for prisoners at risk²⁰.

5.3. Mr Ottey said that on his return to the control room²¹, he had a conversation with one of the other officers in the control room about Mr Payne. Mr Ottey informed the other officer that Mr Payne had been quite angry when he had been returned to his cell. The other officer said that Mr Payne had calmed down quite quickly and eaten his meal and had gone to bed and seemed to be asleep. The other officer was aware of this because he had seen vision from Mr Payne's cell on the monitor set aside for that purpose in the control room. Mr Ottey said that the other officer actually brought the vision for that cell up on the monitor manually at that time, which would have been 15 to 20 minutes after Mr Ottey had left Mr Payne and Mr Payne appeared to be lying on his bed asleep²².

5.4. Mr Ottey described the monitoring system for the G Division observation cells. He said that the observations were the responsibility of officers in the control room who looked at a monitor in the control room which showed the remote camera observations from the relevant cells in G Division²³. Mr Ottey said that at that time there were eight monitors in the control room and that the relevant monitor showed four cells simultaneously with a screen divided into four sub-screens²⁴. He said that the clarity of the picture was not good at all and that the vision from the four cells only appeared for five minutes in every thirty minutes on a rotating basis, each half hour²⁵. For the other 25 minutes, the monitor would display other vision, for example, the front drive of the prison²⁶. Mr Ottey said that it was the responsibility of the control room staff to monitor the vision on that monitor but that there was no person specifically designated for that task²⁷. Mr Ottey said that when the idea of camera observations was first introduced to Yatala, it replaced a previous system of constant observations which involved an officer sitting at the door to the cell observing the

¹⁹ Transcript, page 356

²⁰ Transcript, page 357

²¹ The control room is separate and apart from G Division at Yatala

²² Transcript, page 359

²³ Transcript, page 359-360

²⁴ Transcript, page 360

²⁵ Transcript, page 360

²⁶ Transcript, page 360

²⁷ Transcript, page 361

prisoner 24 hours per day²⁸. He said that staff at the control room had originally envisaged that upon the introduction of camera observations they would have an officer designated to sitting in front of a monitor to carry out constant observations by camera²⁹. He thought there would be an additional staff member for that purpose³⁰. Mr Ottey said that it was possible to bring up vision of the observation cells manually but that there was no direction that they were required to do that at any particular intervals³¹. Mr Ottey expressed the opinion that the camera observation system was “definitely flawed”³². He said that it was flawed because the vision came up only for five minutes in half an hour and furthermore, there was nothing to alert the staff that the vision had appeared. He said on the other hand, every other function that needed attention in the control room had an audible alarm that kept going until someone acknowledged it³³. Mr Ottey confirmed that as a group the control room staff were against the introduction of camera observations³⁴.

- 5.5. Mr Ottey confirmed that there was also a monitor in G Division which displayed vision of the observation cells on a full time basis³⁵. However, the purpose of the G Division monitor was to be a back up for the control room monitor³⁶. He also said that no one was assigned to observe the G Division monitor on a full time basis³⁷.

6. **Robin Davis**

- 6.1. Mr Davis was a correctional officer at the Operations 2 level at Yatala in June 2011.
- 6.2. He was assisting Mr Ottey in the control room on that night. He said that by coincidence on that night there were two other members of the department in the control room because there was another supervisor training another correctional officer in the control room systems. Those people were Mr Askins and Mr Brooker³⁸. Mr Davis said that control room staff have various duties to attend to after hours. He gave as an example that calls would come from people who are on home detention who need to contact the On-call Manager with regard to afterhours emergencies for

²⁸ Transcript, page 358

²⁹ Transcript, page 361

³⁰ Transcript, page 362

³¹ Transcript, page 363

³² Transcript, page 363

³³ Transcript, page 363

³⁴ Transcript, page 364

³⁵ Transcript, page 374-375

³⁶ Transcript, page 375

³⁷ Transcript, page 375

³⁸ Transcript, page 388

example, going to hospital. The Yatala control room is the contact point for all of these calls³⁹. He said that in addition to the monitor showing the vision from G Division observation cells, there were seven other monitors. He said:

'Most of our attention was on our computer systems which is in the centre to my left, and also to the two monitors number 5 and 6, which are the ones that activate when internal alarms are activated. The top four monitors also monitor the perimeter alarms, so it's a microwave system activated by rabbits and foxes, birds etc. Cameras are automatically redirected to the area that is in alarm, so most of our attention would be to centre and centre left, looking at those monitors that are actively alarming.'⁴⁰

- 6.3. He said that while those monitors have alarms which alert the operator to some event occurring on those monitors, the G Division observation cell monitor had no such alarm⁴¹. He said that the images from the G Division cells were small images because of the division of the screen into four parts⁴². He said:

'I thought it was totally inadequate. We had gone from constant observations where an officers was sitting outside of a cell looking constantly at a prisoner for his whole shift to a system that came up five minutes every half hour in an area that was already under resourced and extremely busy, at different peak periods, so, as far as I was concerned, totally inadequate.'⁴³

- 6.4. Mr Davis remembered that Mr Askins took a phone call relating to Mr Payne. I suspect that this call may have been from Mr Payne's mother who rang the prison at about that time to express her concerns. Mr Davis said that during the phone call, they brought Mr Payne's cell up on the monitor and were able to confirm for the caller that he was in good health and being observed at that time⁴⁴. They maintained the observations of him in this manual fashion for a few minutes and then stopped doing it when Mr Payne got under the blankets and appeared to go to sleep⁴⁵. Mr Davis said that the next he knew of Mr Payne was at approximately five minutes to 8pm a code black was called in G Division, Unit 1, Cell 1. At that point they manually activated the monitor from Mr Payne's cell⁴⁶.

³⁹ Transcript, page 390

⁴⁰ Transcript, page 391

⁴¹ Transcript, page 392

⁴² Transcript, page 393

⁴³ Transcript, page 393

⁴⁴ Transcript, page 398

⁴⁵ Transcript, page 398

⁴⁶ Transcript, page 398

7. Andrew Askins

- 7.1. Mr Askins gave evidence. He was a supervisor in June 2011. He was not the supervisor in charge of the control room but was there for the purposes of training another officer, Mr Brooker on the evening in question⁴⁷.
- 7.2. Mr Askins recalled receiving a phone call from Mr Payne's mother⁴⁸. He said he received a telephone call and the lady stated that she was Mr Payne's mother. She said that she had concerns for her son because things had not gone well for him in Court and he was distressed. As Mr Askins spoke to her, he looked at the monitor and it happened that the vision was depicting Mr Payne's cell at that time. He switched the monitor on to one of the main screens to give a bigger impression, and he said to Mrs Payne that he was monitoring her son at the time and could not see any issues with him at all. Mrs Payne asked for his name which he was happy to give and that was the end of the phone call⁴⁹.

8. Benjamin Fieldhouse

- 8.1. Mr Fieldhouse was a correctional officer in June 2011 and was working in G Division at that time⁵⁰. He explained that G Division is divided into two areas being the circle and the foyer. He was on duty in the circle. He said that there were two officers on duty in G Division at that time including himself. The other officer was on duty in the foyer area. He said that the officer in the foyer area has responsibility for controlling the doors and admitting prisoners over the phone. The officer in the circle area where he was, is responsible for controlling the movement of prisoners, putting them in the cells and getting bed packs ready for them⁵¹. Mr Fieldhouse said that he recalled Mr Payne being escorted to G Division by the holding cell officers upon his return from Court that evening. He said that the officers advised him that they had concerns for Mr Payne's safety and that he needed to go back on to camera observations⁵². Mr Fieldhouse said that Mr Payne was very reluctant to go on camera observations and protested that he was fine and had no issues⁵³. In the end, Mr Fieldhouse confirmed

⁴⁷ Transcript, page 423

⁴⁸ Transcript, page 423

⁴⁹ Transcript, page 428

⁵⁰ Transcript, page 459

⁵¹ Transcript, page 462

⁵² Transcript, page 463

⁵³ Transcript, page 464

that Mr Payne was placed in cell 101 and was frustrated. Indeed, Mr Payne punched the wall or the door in frustration⁵⁴. Mr Fieldhouse advised Mr Payne to relax, lie down and go to sleep. Mr Payne asked about his medication and Mr Fieldhouse said that he would call the nurses who would come over with it when they could⁵⁵. Mr Fieldhouse did indeed call the nursing staff. However, Mr Payne had been discovered deceased before the nursing staff were able to attend⁵⁶. Mr Fieldhouse did a patrol of G Division after he had dealt with Mr Payne. That patrol would have commenced at approximately 7pm. He went past Mr Payne's cell on that patrol and noted that Mr Payne was lying on his bed with his blankets covering him. Mr Payne heard Mr Fieldhouse go past, and lifted his head and looked at Mr Fieldhouse⁵⁷. Mr Fieldhouse said that at approximately 8pm, Mr May, who was the officer on duty in the G Division foyer, reported noticing something on the camera. It wasn't completely clear because the camera was hard to look at being black and white and split into sub screens. It was thought by Mr May that something looked odd and so Mr Fieldhouse went to check on Mr Payne to see what was going on. Mr Fieldhouse looked into the cell and saw Mr Payne hanging from the tap with his smock around his neck. Mr Fieldhouse then called a code black to let the Officer in Charge know and other officers to assist⁵⁸. Mr Fieldhouse said that he attempted to gain Mr Payne's attention by putting his arm through the trap but he could not reach Mr Payne. He kicked the door in an attempt to attract Mr Payne's attention. When the Officer in Charge arrived shortly afterwards, Mr Fieldhouse reported that they pulled Mr Payne off the tap and out into the middle of the corridor where they could start CPR⁵⁹. Mr Fieldhouse confirmed that the G Division officers were not required to maintain observations on the cell monitor in G Division⁶⁰.

9. Samuel May

9.1. Mr May was a correctional officer in G Division at Yatala on the night of 2 June 2011. He confirmed that he was on duty in the foyer on that night and that another

⁵⁴ Transcript, page 465

⁵⁵ Transcript, page 467

⁵⁶ Transcript, page 469

⁵⁷ Transcript, page 471

⁵⁸ Transcript, page 471

⁵⁹ Transcript, page 472

⁶⁰ Transcript, page 473

officer, Mr Fieldhouse was on duty in the circle. Mr May was aware that Mr Payne had been reported to have threatened self harm⁶¹. Mr May said that it was not part of his duties to monitor the camera observation cells within G Division⁶². Indeed, Mr May had no understanding that even in limited circumstances there might be a responsibility for him to look at the G Division camera observation monitors⁶³. Mr May said that the images depicted by the screen were not very clear because of the split screens⁶⁴. Mr May said that he did not at the time understand that if the Officer in Charge left the control room, that he then had an obligation to look at the monitor and monitor the prisoners in those cells⁶⁵. Mr May said that he did note Mr Payne on the monitor in the early part of the shift. He saw Mr Payne eating some food and talking at the bottom of the door, apparently making contact with other prisoners⁶⁶. Mr May said that later in the evening he needed to go to the toilet which caused him to walk past the monitor. He said that he saw something unusual because Cell 101 was depicted on the screen. He saw Mr Payne with the camera behind him and it looked like Mr Payne was having a drink at his basin but Mr May noted that Mr Payne's canvas smock was raised up and his backside was visible. Furthermore, Mr Payne was not moving. This caused Mr May concern and he asked Mr Fieldhouse to go and physically check the cell⁶⁷. Mr May said that if he had not needed to go to the toilet at that time he might not have seen any of this⁶⁸. Mr May said that one of the difficulties with the camera observations is that staff are unable to determine whether a prisoner is breathing or not by looking at the vision from the camera⁶⁹.

10. Attempts at resuscitation not successful

- 10.1. Attempts were made to resuscitate Mr Payne, but it was too late. He was pronounced life extinct shortly after being found. Ambulance officers attended.

⁶¹ Transcript, page 514

⁶² Transcript, page 515

⁶³ Transcript, page 516

⁶⁴ Transcript, page 519

⁶⁵ Transcript, page 519

⁶⁶ Transcript, page 520

⁶⁷ Transcript, page 520

⁶⁸ Transcript, page 521

⁶⁹ Transcript, page 523

Part II

The move from constant observations to camera observations at Yatala Labour Prison

11. Introduction

- 11.1. It will be apparent from what I have already said in Part 1 of this finding that the vision from the camera in Mr Payne's cell was only displayed in the control room at Yatala for five minutes in half an hour. A great deal of effort was expended in this Inquest in an attempt to discover how it came to pass that the previous system of constant physical observations was replaced by camera observations where the camera vision was only displayed for five minutes every half an hour on the primary monitor.
- 11.2. In fact there was a backup monitor in G Division which was intended for 'passive' observations. It was that monitor that displayed vision continuously on a screen in the G Division foyer that was divided into four parts, one for each cell. The duties of the foyer officer were to maintain 'passive' observations which, taken at their minimum, meant that the officer was to provide a backup to the primary observation station, namely the control room. The responsibility for the G Division foyer officer would be triggered when he or she was alerted by the control room staff that by reason of other duties they were down a person, and accordingly for the period that they were short staffed the G Division foyer officer would provide the necessary backup observations. It was envisaged that this arrangement would occur when an officer needed to go to the toilet or had to leave the control room for some other reason. The control room officers had the primary responsibility of maintaining the observations of the prisoner at risk. This might seem a perverse arrangement given that the vision from the observations cells only came up on one of the eight monitors in the control room for five minutes in every half an hour, yet the so called backup monitor displayed constant vision. Nevertheless, that was the arrangement as it existed in June 2011 when Mr Payne died. It was also the arrangement that had existed for some 3½ years prior to his death. One would have expected that the primary monitor would display a constant stream of vision of the prisoners under observation. One would also expect that of the so called backup monitor, at least when it was called into service by reason of short staffing in the control room. It is particularly bizarre that the system which it replaced was so obviously superior.

- 11.3. The system of constant observations that existed prior to the introduction of camera observations was one in which an officer would be required to sit outside the prisoner's cell observing the prisoner constantly for an entire shift. That officer would be replaced at the end of the shift by another officer who would carry out the same duties, and this would continue while the prisoner remained at risk. The clear evidence was that under that system no prisoner had ever harmed himself at all, let alone fatally. The replacement of what might be described as a gold plated foolproof system of constant observations by one in which the person primarily responsible for maintaining the observations could observe the prisoner for a maximum of five minutes every half an hour demanded some explanation. The Inquest devoted a great deal of time and energy to find that explanation. Certainly, no proper explanation was available at the commencement of the Inquest and it is quite plain that the Department for Correctional Services (the Department) had not made a concerted effort to obtain an answer prior to the commencement of the Inquest. It is particularly concerning that the Department would not have done so as soon as possible after Mr Payne's death, and certainly no later than the commencement of the Inquest. In fact, it would seem that the first time a serious effort was made to arrive at an explanation was when the Inquest had started and the Court demanded a proper explanation.
- 11.4. The search for that explanation was unnecessarily circuitous, largely because the Department had never made a proper and appropriate effort to arrive at the truth itself in a timely fashion. In my opinion Mr Payne's death was certainly attributable to the decision to abandon the system of constant observations and replace it with the system that was in place as I have described above. For convenience, I will refer to that inadequate and flawed replacement system as 'the five in thirty system' or the 'five in thirty process' or by other similar words hereafter.
- 11.5. The Inquest was protracted because, initially, counsel appeared for the Department for Correctional Services and a number of its employees, and also appeared for the South Australian Prison Health Service and a number of its staff. Once a serious process of investigation to find an answer to the five in thirty conundrum commenced, it soon became apparent that the interests of those various entities and persons would diverge and conflict. As a result there was a need for multiple adjournments and changes of representation. By the end of the Inquest the one counsel had been replaced by six counsel, one of whom represented the interests of what might be described as the

Prison Health Services and three of its medical staff, one appeared for the Minister and the Department and its present Chief Executive, one appeared for Mr Oxford who was the General Manager of Yatala during the relevant period, one appeared for the Departmental employees Ms Porcelli and Messrs Reynolds, Timmins and Griffiths, one appeared for the Departmental employee Mr Severino and another counsel appeared for Mr Peter Severin who was the Chief Executive of the Department during the relevant period. In addition to those six counsel, Ms Thewlis continued to assist me, Mr Redford continued to act for Mrs Payne and the deceased's family and Mr Bailes continued to act for correctional officers Mr Ottey, Mr Davis, Mr Askins, Mr Fieldhouse and Mr May. This was manifestly inconvenient and meant that the Inquest was unnecessarily protracted. It made the process of writing this finding far more difficult than it need have been and has required that it take longer than it ought to have. It is entirely attributable to the Department's failure to conduct a proper inquiry into the process by which constant human observations were replaced by the five in thirty process. The need for a proper inquiry into that and for its results to be provided to this Court when examining the cause and circumstances of Mr Payne's death is so obvious that the Department's failure to provide it is suggestive of a naïve hope that the obvious question would never be asked, and the Department might thereby escape embarrassing scrutiny and ultimate accountability. In my opinion, ultimately responsibility must rest with the then Chief Executive, Mr Severin, with the then Director of Custodial Services, Ms Bordoni, and the then General Manager, Mr Oxford. Without doubt, others were also involved and may have been even more deserving of specific censure. However, the passage of time and an abysmal failure to document the decision making process rigorously meant that specific accountability and the identification of the individual who originally suggested the five in thirty process, or devised it, could not be identified. If a proper investigation had been conducted soon after Mr Payne's tragic death with a view to ascertaining who it was that came up with the five in thirty process and thought that it was an adequate substitute for constant human observations, that person could have been identified and appropriately disciplined. In my opinion the appropriate sanction for such extraordinary incompetence could only be dismissal.

- 11.6. In short, I cannot find words adequate to express my disgust, horror and dismay at the institution of the five in thirty process in place of the system of constant human observations. I have no doubt that it led directly to Mr Payne's death.

12. **Other aspects of the five in thirty process**

- 12.1. To make matters even worse, it was a characteristic of the five in thirty process that the vision of Mr Payne's cell was displayed in a segmented screen which depicted that cell and three others. The vision came up on monitor number four for five minutes every half an hour. However, the vision would be displaced if there was a perimeter alarm. A perimeter alarm would be activated by motion or other sensors around the perimeter of the prison and the activation of such an alarm would mean that whatever vision was currently showing on the monitor would be replaced with vision depicting the relevant part of the perimeter. If the alarm happened to occur during the five minutes in which vision from the observation cell was being streamed to the monitor, then there would be no vision of the observation cell during that five minute period, or so much of the five minute period as was devoted to the perimeter alarm event.
- 12.2. Furthermore, when the vision appeared on the monitor from the observations cells, there would be nothing to alert the officer in front of the eight monitors to the fact that the observation cell vision had commenced. This is an important point because the officer's attention would necessarily be devoted to all eight of the monitors. It is possible that the officer might be concentrating on another monitor because of a need to activate an electronic gate or door somewhere else in the prison to permit staff movement, or some other form of distraction. Given that the observation cell vision only appeared for five minutes in thirty minutes, two further problems arise. The first is that one is prone to lose track of time, and particularly if distracted by other activities. Thus, an officer may not think to direct his attention to the observation screen at or about the time when it will be coming up for the five minute window. Secondly, the fact that the system accords such a low priority to the vision from the observation cells, might lull a control officer into a false sense that the vision is relatively unimportant compared to all of the other information depicted on screens for greater periods of time. In the case of the monitor devoted to the five in thirty vision, the evidence was that for the other 25 minutes in each half an hour the monitor streamed vision of the outside of the control room door. No explanation was ever provided for why the outside of the control room door was a proper subject for such lengthy observation. It could hardly be a matter of security given that in order to reach the control room door from outside the prison, one has to first gain access to the prison itself and further access to a number of other doors or gates, all of which are

electronically controlled and monitored from the control room also. It is unlikely in the extreme that the control room operators could be taken unawares by some unauthorised intruder suddenly arriving at the door to the control room. Yet the fact remains that the vision was devoted for the most part to that purpose. One could not devise a more ridiculous set of circumstances if one deliberately set out to do so.

13. What were the five minute periods immediately prior to Mr Payne's death and discovery?

- 13.1. Despite the fact that vision of Mr Payne's cell was only being displayed in the control room for five minutes in thirty minutes, it was actually being recorded continuously. As a result it is possible to review the video footage of the period that is relevant. That video demonstrates that at 7:28pm Mr Payne was lying on the bed in his cell. He then got out of the bed, looked in the direction of the cell camera and then took off his canvas smock. He placed the neck of the smock around the tap and climbed up into the smock and lent his head forward over the collar of the smock and bent his legs. At 7:30pm the video shows him lying face down with his legs fully outstretched and his head leaning over the collar of the smock. His body is swaying slightly. The next time that the control room monitor showed camera vision of Mr Payne's cell was at 7:37pm. This was approximately eight minutes after Mr Payne had first acted to harm himself. It would appear that the officers in the control room either did not notice the relevant vision for the five minutes commencing at 7:37pm or it may be that a perimeter alarm had activated for some or all of that five minute window. The evidence at Inquest did not provide any further information on that question. The next scheduled five minutes of vision would have occurred at 8:07pm. However, at 7:58pm the correctional officer Mr May who was in the G Division foyer happened to notice Mr Payne in what he thought was an unusual position on the G Division foyer backup monitor.
- 13.2. To the extent that it might be suggested that the true reason for Mr Payne's death is a failure on the part of the control room officer to observe him on the vision (if any) that was shown in the control room of Mr Payne from 7:37pm to 8:42pm, a short answer can be given. By that time it was already too late. Responsibility for this tragic event rests entirely with the implementation of the five in thirty process and those that were responsible for it.

14. The origins of the five in thirty process

14.1. I start with an explanation of some of the persons who were involved in aspects of the history of this matter, to the extent that it has been ascertainable:

- 1) Peter Severin, Chief Executive Officer from 2003-2012;
- 2) Greg Weir, Executive - Second in Charge;
- 3) Alan Martin, Director of Finance and Asset Services;
- 4) Gary Oxford, General Manager, Yatala Labour Prison;
- 5) Maria Bordoni, Director Custodial Services;
- 6) Renae Porcelli (nee Justice), Custodial Services Directorate;
- 7) Michael Reynolds, General Manager Custodial Services;
- 8) Victor Gibson, G Division Manager;
- 9) Brian Post, Manager of Physical Resources;
- 10) Keith Timmins, Control Room Coordinator.

The following committees were featured in the history of this matter and it is as well that I describe them. The first was the Electronic Security Steering Committee which made decisions approving the installation of electronic security equipment, including cameras and monitors. The other committee that should be mentioned is the Local Consultative Committee at Yatala which was a committee established for the purposes of consulting staff about changes that were taking place in the workplace. That Committee formed various sub-committees including sub-committees which specifically considered the proposal to implement camera observations. Mr Oxford started at Yatala in 2005 as the Acting General Manager. He was formally appointed General Manager in early 2006. From 2005 until 2007 Maria Bordoni was the Director of Custodial Services and Victor Gibson was the G Division Manager and was also the Operations Manager in charge of the control room. Mr Timmins' role as Control Room Coordinator was not a management position, but was effectively a second in charge to Mr Gibson for the purposes of the control room itself. It was explained in evidence that Mr Gibson, as well as managing G Division, had the additional responsibility of managing the control room because the number of staff in G Division were significantly less than those of other divisions of the prison. Responsibility for the control room was added to 'top up' his area of responsibility. On a daily basis the control room was coordinated by Mr Timmins.

- 14.2. It is plain and there is much evidence that Yatala was constantly concerned with funding and cost pressures. For example, Mr Oxford and Ms Bordoni received an email on 1 July 2005 about unfunded core business for Yatala in the previous financial year in the amount of \$134,452 being for constant observations⁷⁰.
- 14.3. The budget report to the Chief Executive for December 2005 shows the Yatala employee expenses as \$256,000 unfavourable with a projected end of year figure of \$400,000 unfavourable⁷¹. Interestingly that reference to over expenditure is attributed to constant observations in G Division and the infirmary. There is a note referring to installation in G Division of cameras for constant observations to help reduce the over spend⁷². In the subsequent monthly budget variance reports this figure increases and the reports contain similar notes relating to the installation of G Division cameras for constant observations. Mr Oxford's statement⁷³ states that he prepared a formal minute to Executive in December 2005 outlining the proposed change to camera observations. He said the minute followed informal conversations that he had had with the Chief Executive, Mr Severin. Those conversations were about the costs that Yatala was spending on personal observations of the prisoners. He said there was:

'Basically a direction by the Chief Executive that I had to stop spending unfunded money and go to camera observation.'

He said the bottom line was that the work practice was required to change because of the financial costs that were not funded within the corporate budget of Yatala. In his oral evidence Mr Oxford said that he would have had two or three conversations with Mr Severin in the lead up to the preparation of that minute. He said one meeting that was fresh in his memory was at a budget review meeting when Mr Severin told him that he needed to stop spending money against the then practice of constant observation of prisoners. Mr Oxford made it quite plain that the impetus for saving the money came from Mr Severin and not him⁷⁴.

⁷⁰ Exhibit C53, GO36

⁷¹ Exhibit C61AM1

⁷² Exhibit C61am1

⁷³ Exhibit C53

⁷⁴ Transcript, pages 707-709

14.4. For his part, Mr Severin held the view that the practice of having a person sitting outside a room 24 hours per day and simply watching someone was not good practice⁷⁵ and that camera observations based on:

'... solid assessment and subsequent combination of constant surveillance, if that is necessary, supported by pro-social interaction with the aim of course to de-escalate that risk and to normalise the behaviour in the context'⁷⁶ represented good practice.

It was never seriously disputed that Mr Severin raised the cost pressures associated with this practice with Mr Oxford. In passing, I note that Mr Severin is clearly an intelligent and well-educated person. He clearly understands management practice at a high level and is an experienced and successful executive. He has a clear understanding of financial matters and a very clear understanding of prison systems. By 2005 he certainly had a very good understanding of the Yatala budget and, indeed, probably a better understanding than Mr Oxford who at that stage had only been acting for several months.

14.5. By contrast, Mr Oxford has a very different set of skills. Mr Oxford appears to have learnt his trade 'on the job'. He presented to me as a man who was out of his depth in the role of General Manager at Yatala. He presented as someone who would have done his best, but who would have found the art of managing a significant workforce in a heavily unionised context to be very challenging. He is not a sophisticated communicator and certainly would not appreciate the subtleties and nuances of conversation about money and prison security in the same way Mr Severin would. In short, there is a world of difference between the two men. While Mr Oxford would not have been able to communicate with Mr Severin on the latter's terms, I have no doubt that Mr Severin was more than capable of appreciating the shortcomings and lack of capacity and understanding in Mr Oxford. It was incumbent on Mr Severin to make due allowance for Mr Oxford's manifest lack of capacity.

14.6. It was not contended by or on behalf of Mr Severin that Mr Oxford was wrong in attributing to Mr Severin concern, and indeed strong concern, at the cost pressure attributable to the practice of constant observations. For his part Mr Severin had a sophisticated understanding of how camera observations might work and had an expert opinion that they were superior to constant observations if properly implemented. On the other hand, Mr Oxford was clearly not motivated to introduce

⁷⁵ Exhibit C63, paragraph 9

⁷⁶ Transcript, pages 1548, 1567 and 1646

camera observations as a management innovation of his own. Without prompting and encouragement it is doubtful he would have ever initiated the process⁷⁷, whether with a view to achieving savings or with a view to improving work practices.

- 14.7. Mr Oxford's minute to the Department's Executive dated 21 December 2005⁷⁸ is brief and business like. It has all the hallmarks of having been written by Mr Oxford. Indeed, it was his evidence that he did write it and there is no suggestion that any other person had any influence on its content. It is notable that in just under 2½ pages the minute makes no mention of the virtues of camera observations as an enhancement on good work practices. The arguments in its favour are entirely financial. It notes that the cost of constant observation for one prisoner over a 24 hour period costs approximately \$1,000 per day. It goes on to say this equates to \$4,000 per day to observe four prisoners. It says that during the current financial year costs for observing prisoners to the end of November was \$151,000. It noted that with the current trend it was forecast that Yatala would spend \$300,000 on this aspect of the business (presumably during the financial year). The minute then goes on to deal with a different issue. Under 'conclusion' it returns to the subject of cameras and recommends that four cells be fitted with infrared cameras at an estimated outlay of \$77,000. Interestingly, Mr Oxford's proposal was that the four cameras be monitored by one officer, thus enabling one officer instead of four to monitor four prisoners. The result over a 24 hour period for four prisoners was that three staff could monitor them rather than twelve, with an effective saving of \$3,000 per day. The minute notes that the costs of the proposal could confidently be expected to be paid back in savings in less than twelve months. It was therefore Mr Oxford's proposal that there would be a single monitor dedicated to the process of monitoring up to four prisoners on a split screen. It was fundamental to his proposal that there would be a dedicated officer constantly monitoring that screen. The minute was clearly prepared by Mr Oxford not to advance a case for an improvement towards best work practices, but to make a cost saving. It has all the hallmarks of something he did not of his own initiative, but because he felt that he had to. In relation to his suggestion that there would be an officer dedicated to monitoring the vision from the observation cells, Mr Oxford's

⁷⁷ Indeed Mr Oxford gave the following evidence at Transcript, page 1766:

'Whilst it might not have been a sensible practice to spend government money that you don't actually have, it was a system that worked extraordinarily well, and then looking at the history there didn't appear to be any prior situations where people might have either attempted to, or self-harmed themselves on that. I recall your Honour asking me a question during my evidence, did I wake up one morning and dream this up; I certainly did not. Had the chief executive at the time, Mr Severin not raised it with me, I wouldn't have touched it because it worked.'

In that passage Mr Oxford is referring to not wanting to move away from the constant observation system to the camera observation system.

⁷⁸ Exhibit C53 GO1

reasoning was sound. Such a structure would have been effective and would have prevented Mr Payne's death. Yet Mr Oxford clearly never really believed that his suggestion would be taken up by Executive:

'Yes. I tried to be cheeky, I tried to - I realised that, for example in G Division the staff had so much work to do, particularly on what we called the afternoon and night shift where they were static at their positions, that it was a big impost to have them constantly looking at a camera observation of at risk prisoners. So, the idea was I was going to try and be sneaky and get an FTE, if you like, which is full time equivalent in there above and beyond the staffing structure to do that, but that was nipped in the bud very early after I put this memo together and sent to executive.'⁷⁹

14.8. Ms Bordoni told Mr Oxford that there would be no dedicated officer to monitor the observation cells⁸⁰.

15. Mr Oxford's suggestion of a standard operating procedure

15.1. One of Mr Oxford's recommendations in the minute dated 21 December 2005 was that the Custodial Services Directorate develop a standard operating procedure for the constant observation of at risk prisoners. By this he was clearly suggesting that the standard operating procedure would regulate the manner in which the proposed system of camera observations would work.

15.2. In January 2006 Maria Bordoni put the camera observation minute before the Executive including Mr Severin, Mr Weir and Mr Martin and on 5 January 2006 she emailed Mr Oxford to push ahead with his proposal and to get costings for Executive to approve⁸¹. On 25 January 2006 Ms Bordoni sent an email to Mr Oxford as follows:

'Gary, you will need to commence consultation locally and I would suggest the quicker, the better. I thought you already had as Peter in fact asked me today if you were ... a camera policy will take too long given ARC ... PAP and others all use cameras for observation. May I suggest you formulate a LOP like they have in the interim while the larger corporate aspects are dealt with ... Clearly the dept is not going to go to the extent of funding this and have the same work practices remaining ... as you indicated in your brief there are over expenditure issues that will be picked up by this initiative ... clearly you had something in mind when you did the costings on how you see it working ... the precedent is set with others ... better it becomes an issue before they are fitted than afterwards ...! go for it ...'⁸²

⁷⁹ Transcript, pages 716-717

⁸⁰ Transcript, pages 730-732, Exhibit C58KT1 and Exhibit C51JF4 which contains a reference to 'Executive fear a rush for additional staff may transpire if we put a monitor in the centre circle and DCS cannot agree or fund additional resources.'

⁸¹ Exhibit C51JF11

⁸² Exhibit C51JF11

16. January to October 2006

- 16.1. During the period January to October 2006 the concept of camera observations gradually developed. As a result of the email from Ms Bordoni to Mr Oxford, Mr Oxford understood that there would be no standard operating procedure developed by the Department, but instead he was expected to develop a local operating procedure. He proceeded to carry out that task using precedents from other prisons and with some assistance from Ms Porcelli from the Department. Over these months the cameras were in fact installed in the four observation cells in G Division. Mr Oxford also commenced the process of informing staff and the Local Consultative Committee started to examine drafts of the local operating procedure Mr Oxford was developing. Furthermore, during this period Mr Oxford at Ms Bordoni's suggestion made some slight modifications to his original concept which related to the exact part of the G Division building where the proposed monitor for the four cameras would be installed. During this period also, the budget over spend for employee expenses continued to accumulate and in February 2006 it was recorded that Yatala was \$386,000 over its year to date budget for employee expenses and that constant observations in G Division and the infirmary were the reason for this. The report noted that the installation of G Division cameras for constant observations would help to reduce the over spend⁸³. By late February 2006 Mr Oxford had prepared a draft local operating procedure⁸⁴ which provided that constant observations would be conducted in cells 101, 201, 301 and 401 in G Division and all would be fitted with cameras. It said that the officer assigned with observing the prisoner on camera observations must not leave his/her post until relieved by another officer. It said that observations would be conducted using a dedicated split screen monitor and that the officer undertaking constant observation duty would be responsible for a maximum of four prisoners. This draft local operating procedure did not spell out that the vision from the cameras was to be streamed constantly with no interruptions. However, that is implicit in the reference to a dedicated monitor. A dedicated monitor is clearly going to show nothing but the camera vision from the observation cells in a split screen divided into four. It is implicit that the vision would not be interrupted by anything or for any purpose because there would be little point in describing it as a dedicated monitor otherwise.

⁸³ Exhibit C61AM1

⁸⁴ Exhibit C53GO4

- 16.2. On 17 April 2006 the Electronic Security Steering Committee gave approval for four cameras in G Division 'REF to budget savings of \$300,000 for call backs to cover constant obs'⁸⁵. On 24 April 2006 Ms Bordoni emailed Mr Oxford about 'significant over spend' on constant observations in March 2006 and asked about the status of cameras for G Division⁸⁶. In May 2006 arrangements were made to proceed with the installation of the cameras. By late May 2006 Mr Oxford had accepted that Ms Bordoni was informing him that there would be no dedicated officer whose job it would be simply to monitor the vision from the cameras in the observation cells⁸⁷. This acceptance is reflected in other documents⁸⁸.
- 16.3. During June, July and August 2006 Mr Oxford continued to consult. It is interesting to note that on 13 October 2006 Mr Oxford emailed Mr Severin and Ms Bordoni to update them on camera observations. He advised in that email⁸⁹ that cameras have been installed in the relevant cells of G Division, but that a monitor had not been installed in the bunker location of G Division for monitoring purposes. He said that during the planning process a standalone monitor to monitor the four cameras had been requested and that Mr Oxford had believed that would occur. However, he understood that as a result of the processes involving the Electronic Security Steering Committee the monitor was not agreed to. His email stated:

'I still believe that the best way of monitoring these cameras would be on a standalone monitor versus relying on staff to accessing (sic) the specific camera amongst others.'

I accept that Mr Oxford in that email was reflecting his belief that there should, at the very least, be a standalone monitor. At that time the plan was still for the monitoring to occur within the G Division facility – this was later to change. Nevertheless, it demonstrates that he understood that a standalone monitor at the very least was essential to maintain proper surveillance of prisoners at risk of self-harm. As history shows, in the result the monitor that was provided for the purpose in the control room was not a 'stand alone' or 'dedicated' monitor at all, but one of the existing monitors that would contain other feed apart from the vision from the observation cells. As at October 2006 no-one could have predicted that the ultimate result would be that the vision would only be displayed for five minutes in thirty minutes. This does not seem

⁸⁵ Exhibit C51JF5

⁸⁶ Exhibit C53GO6

⁸⁷ Transcript, pages 730-732

⁸⁸ Exhibit C58KT1 and Exhibit C51JF4 which contains a reference to 'Executive fear a rush for additional staff may transpire if we put a monitor in the centre circle and DCS cannot agree or fund additional resources.'

⁸⁹ Exhibit C53GO11

to be something that Mr Oxford could have been contemplating in October 2006 when one has regard to the tenor of the email referred to above.

- 16.4. On 12 October 2006 an email from Ms Bordoni to some other staff stated that the issue of cameras in G Division came up that day at the Yatala budget review and that ‘Peter wants the current observation practices to cease and action taken immediately’⁹⁰. Once again, this is evidence of pressure on the part of Mr Severin to cease the practice of constant physical observations in the context of discussions about budget overruns at Yatala.
- 16.5. On 16 October 2006 Mr Oxford wrote to Mr R Cann, the clinical nurse consultant at the Yatala infirmary. The letter informs Mr Cann about the proposal for camera observations of prisoners at risk and states that, with effect from Monday 23 October 2006, prisoners requiring to be observed for any length of time will be accommodated in G Division and will be monitored by way of camera⁹¹. This appears to be the first notice to the Prison Health Service of the proposal. Mr Cann replied to Mr Oxford’s letter by an email dated 18 October 2006⁹² in which Mr Cann said that the doctors at the Prison Health Service had raised concerns about camera observations ‘following a coronial Inquest in today’s paper’. The email requested a meeting to discuss the matter. On 19 October 2006 Mr Oxford met with two doctors and Mr Cann from the infirmary. In an email reporting on the outcome of that meeting from Mr Oxford to Mr Reynolds, Ms Connors and Ms Bordoni, Mr Oxford states:

‘Dr Clohesy in particular was rather animated and strong indicating that he rejected my proposal vehemently and if introduced on Monday he will not be attending YLP. I tried to explore his issues however he wanted to stress that the current process of managing at risk prisoners is considered ‘GOLD’ process and that any move by me to introduce observation via cameras is a backwards step.’

And later:

‘His closing comment to me was that if camera obs is introduced on Monday – he will not be attending for work.’⁹³

On that same day Dr Nambier, consultant forensic psychiatrist with the Prison Health Service, wrote to Ms Bordoni to express his concern⁹⁴. In that letter he referred to the

⁹⁰ Exhibit C62MB12

⁹¹ Exhibit C30f, page 103

⁹² Exhibit C30f, page 109

⁹³ Exhibit C53GO15

⁹⁴ Exhibit C62MB13

proposal and said that he had strong reservations and stated that a decision of this significance surely required discussion between the Department, the Prison Health Service and the Forensic Mental Health Service. He said no discussion had occurred, but it needed to occur as a matter of urgency before the change was implemented. Ms Bordoni replied by letter dated 23 October 2006⁹⁵ agreeing to a meeting that week. The outcome of the meeting with the medical staff is the subject of an email from Mr Oxford to Ms Bordoni and others dated 26 October 2006⁹⁶. In that email Mr Oxford advised that the meeting with the Health representatives ‘was not very productive’ and that they made it clear that camera observations was not their preferred option. Mr Oxford felt that he did not ‘get anywhere with this meeting’ and that when the Health staff were informed that it was the Department’s position that they would undertake camera observations within G Division, the Health staff said they were concerned about a potential death in custody. Mr Oxford said that he did not know how to progress the issue other than advising the Health staff that camera observations would be introduced anyway.

- 16.6. On the same day Ms Bordoni, Mr Severin and Mr Oxford were advised by Ms Connors, who appears to have had an industrial relations function in the Department, that she had been informed by Marg Jeffries of the Public Service Association the previous afternoon that camera observations in G Division had been ‘placed in dispute’ by the Union on the basis that the consultation had been insufficient⁹⁷. Also on the same day Mr Severin received a letter from the General Secretary of the Public Service Association advising that the Association was not satisfied that the consultation was complete and requesting that the parties work through the grievance and dispute avoidance procedure under the relevant award and that the status quo remain⁹⁸.
- 16.7. On 14 November 2006 a meeting took place between staff of the Department, including Mr Oxford, and staff of the Prison Health Service including the Manager of Prison Health, Dr Nambier, Mr Cann and Dr Clohesy. At this meeting Mr Oxford informed the Prison Health staff that the issue had been placed in dispute by the Public Service Association who had taken the position that camera observations would not be undertaken by the G Division staff, but rather should be done by the

⁹⁵ Exhibit C30f, page 111

⁹⁶ Exhibit C51JF11, page 149

⁹⁷ Exhibit C30f, page 117

⁹⁸ Exhibit C30f, page 138

control room staff. The minutes of the meeting seemed to reflect that by this stage there was a view amongst the corrections staff that camera observations could be undertaken within the control room. Significantly, one of the Prison Health staff, Ms Kinnear the Director of Nursing, is recorded as asking whether the control room officer would have other duties. Mr Oxford confirmed that the officer would have to undertake other duties such as watching other monitors. The Health staff maintained the position that camera observations may not be suitable for all prisoners, particularly those at highest risk. Dr Nambier explained that he saw this group of prisoners as falling just below the population of prisoners requiring detention⁹⁹ and just above the population that could safely be observed using constant observations. The Manager of the Prison Health Service suggested that a permanent position could be created for undertaken constant observations. It is not clear from the minutes whether this was to be a position that would monitor the prisoners via vision on a monitor or directly, but I infer the former. Mr Oxford responded that that was not feasible because he did not have a budget line. The meeting went on to explore the possibility that the infirmary might be a more suitable location for the supervision of high risk prisoners.

- 16.8. I will depart from the present chronological order of the narrative to record that from late 2006 into 2007 the Prison Health Service considered whether cameras could be placed in the infirmary at Yatala. However, on further consideration due to deficiencies of the rooms in the infirmary, including the presence of hanging points and blind spots where prisoners could not be observed, the option was ruled out¹⁰⁰. It was the view of the Prison Health Service that prisoners at high risk of self-harm could be housed in the infirmary provided that there was a correctional officer constantly on watch, but it was not safe to use the infirmary for camera observations¹⁰¹. It would appear that from the position of the Prison Health Service there was considerable opposition to the concept of camera observations at all times. In the result, after the Prison Health Service explored the possibility of camera observations within the infirmary, but then had to rule it out on the basis that it would not be safe, the Prison Health Service had no option but to accept camera observations as conceived and implemented by the Department. I accept without the slightest doubt however that none of the members of the Prison Health Service staff had any

⁹⁹ This is a reference to detention under the Mental Health Act

¹⁰⁰ Exhibit C51JF6

¹⁰¹ Exhibit C51JF6

inking that the ultimate result would be that prisoners would only be observed for five minutes in thirty minutes. There is no doubt that had they been aware of this they would have been horrified and would have protested long and loud. Had they been aware of it I have no doubt that something would have been done to rectify the situation. I now return to the narrative from mid November 2006 when the G Division staff and the Public Service Association were in disputation with the Department.

- 16.9. It appears that in early November 2006 members of the Department met with Ms Jeffries of the Public Service Association and relevant staff of Yatala, including staff from G Division. On that occasion Ms Jeffries indicated that it was the preference of the Public Service Association that camera observations be managed within the control room at Yatala and that there be a secondary monitor placed in the foyer in G Division. This arrangement was said to be similar to existing practices within other institutions.
- 16.10. Ms Jeffries took the position that the monitoring of cameras within G Division would result in an increase in workload for the G Division staff. This contention was refuted by Mr Severin in a reply he sent to the General Secretary of the Public Service Association on 24 November 2006¹⁰². Interestingly, at the meeting a member of the G Division staff noted that it was the staff's understanding that an additional resource would be engaged to monitor the cameras if that function were to be undertaken within G Division. Mr Oxford responded by saying that although there had been some discussion and a proposal that there would be an additional staff member to monitor prisoners within G Division that, to use Mr Severin's words in the letter, referred to above, 'this ultimately was not feasible'. It appears that the meeting ended with the Public Service Association indicating 'in principle' support for camera observations to be monitored within the control room with secondary monitoring being undertaken within the G Division foyer. These matters were referred to in the letter from Mr Severin to the General Secretary of the Public Service Association dated 24 November 2006 referred to above¹⁰³. It is notable that in that letter Mr Severin stated:

'DCS will not employ an additional officer to undertake the monitoring as this does not represent good practice and is highly inefficient.'

¹⁰² Exhibit C30f, page 136

¹⁰³ Exhibit C30f, page 136

16.11. On 12 December 2006 Ms Jeffries of the Public Service Association sent an email to Mr Reynolds of the Department advising that she had met with the G Division staff and that the Public Service Association appeared to accept one of either of the following two options. Firstly, that a monitor be placed in the G Division circle area with an additional officer to observe that monitor or, secondly, that a monitor be placed in the control room but that consultation would need to occur with the control room staff. Under that arrangement the control room would primarily manage the observations and log them and a second monitor would be placed in the G Division foyer for support, without responsibility for logging observations¹⁰⁴. On 13 December 2006 Ms Bordoni forwarded an email to Mr Oxford referring to the email from Ms Jeffries from the Public Service Association that I have already referred to. Ms Bordoni informed Mr Oxford that she had spoken to Ms Jeffries and indicated that the Department 'have been working towards this option anyway'. It would appear that the option she is referring to is the option of monitoring in the control room. This is quite clear from the balance of the email. Ms Bordoni acknowledges that it is necessary for Mr Oxford to carry out local consultation, again the implication is that this will have to be with the control room staff. Ms Bordoni said that she wished to obtain costings for cabling to the control room so that the proposal could be advanced¹⁰⁵. Thus, Mr Oxford was informed by Ms Bordoni that the final position would be a move to the control room as the primary site of the observations.

17. Early 2007 - Mr Oxford commences negotiations with control room staff for camera observations

17.1. It having been determined that the primary responsibility for camera observations would no longer be given to the G Division officers, it was necessary for Mr Oxford to commence consultation with the control room staff with a view to developing a local operating procedure that would see them having that responsibility. At the same time work was proceeding to arrange for the necessary electronic cabling and other work to be done to enable the cameras to be monitored in the control room. On 8 February 2007 Mr Oxford forwarded an email to Brian Post, the Manager of the Asset Services Branch, in which he said that at the second meeting of the Consultative Committee in relation to camera observations being done in the control room, it was suggested that the control room did not have the facility 'of cameras rolling through

¹⁰⁴ Exhibit C30f, page 18

¹⁰⁵ Exhibit C30f, page 51

monitors and Asset Services do not want to install a standalone monitor for say 4 camera being used for observation of at risk prisoners'¹⁰⁶. Mr Post replied on 13 February 2007 by advising that the Yatala control room would need changes to its camera switching and monitor managing systems. The email stated 'it is unknown if an additional monitor will be required or that changes to the current MUX system can take these additional views'¹⁰⁷. The reference to the MUX system is a reference to the system by which vision from various cameras around the Yatala facility are directed to particular monitors within the control room and also involves the facility for the division of monitors into sub screens of four or more divisions. On 20 February 2007 Mr Oxford emailed Mr Post asking whether Asset Services would be open to installing a standalone monitor in the control room to enable monitoring those cells with cameras versus changing the MUX system¹⁰⁸. Clearly this was an attempt by Mr Oxford to obtain a standalone monitor for the vision from the cells in G Division. His use of the word 'versus' in the context of changing the MUX system is clearly meant to convey that the concept of a separate monitor would replace the concept of changing the MUX system which would involve using one of the existing monitors and its capacity to stream vision from different cameras. If Mr Oxford's stand alone monitor had been accepted, it clearly would have been dedicated to monitoring the cells and thus the vision from them would have been continuous.

- 17.2. On 1 March 2007 Mr Post sent an email to Ms Bordoni with a copy to Mr Reynolds informing her that he had determined that a dedicated monitor could be placed in the control room at a cost of about \$3,000. He said that Mr Reynolds had suggested that the Department should assess the availability of using space on the MUX system instead¹⁰⁹.
- 17.3. Minutes of the Electronic Security Systems Steering Committee on 29 March 2007 record that Ms Bordoni provided the Committee with an update of the G Division camera monitoring. She advised that an additional monitor in the control room was 'not part of the scope'¹¹⁰. She advised that Mr Oxford was to follow the matter up.
- 17.4. On 20 April 2007 Mr Oxford forwarded an email to Ms Bordoni and Mr Weir in which he mentioned that he had just completed a consultative meeting with the

¹⁰⁶ Exhibit C53GO38

¹⁰⁷ Exhibit C53GO38

¹⁰⁸ Exhibit C56BP09

¹⁰⁹ Exhibit C60MR04

¹¹⁰ Exhibit C51JF5

control room staff and that he had intended to tell them that the new process would be implemented on 21 May 2007. He advised the control room staff that the cameras would be rolled through the MUX system rather than there being a standalone monitor in the control room. To this the control room staff had responded to Mr Oxford by saying that there were eight monitors in the control room and that monitors 1 to 4 were linked to the perimeter alarm system, monitors 5 and 8 were linked to intercoms, roller doors and gates and monitors 6 and 7 were linked to duress alarms and to record incidents. The staff said that to use one of those monitors for the observation of the four cameras within G Division would mean losing one of the existing functions that the monitors were already devoted to. Mr Oxford said that he needed to obtain advice from Ms Bordoni and others – more probably the technical staff Mr Post and Mr Severino – in order to respond to that concern because he was ‘not an expert in the control room’. Crucially, in this email Mr Oxford directed the following remark to Mr Severino who had been a recipient of the email:

‘Angelo – can you advise me re the monitors in the control room – can we link in 4 more cameras that will appear on screen at least half hourly?’¹¹¹

This reference to the four cameras appearing on screen at least half hourly appears to be the first hint that the vision may not be continuous. It is interesting that it occurs in an email in which Mr Oxford is addressing a concern of staff that in the absence of a dedicated monitor, the vision from G Division observation cells would impact on the information currently being displayed on the eight existing monitors in the control room. The context of the concern clearly is that if an additional dedicated monitor cannot be provided, then ‘one of the functions as outlined above’ would be lost¹¹². The implication of course is that the staff were assuming that one of the eight existing monitors would be devoted to continuous vision from the G Division cells. Yet for reasons that remain unexplained, and that Mr Oxford was never able to address in his evidence, he has introduced a concept of the existing eight monitors having vision from four more cameras appearing ‘on screen at least half hourly’¹¹³. This email was addressed to Ms Bordoni and Mr Weir and was copied to Ms Pitkin and Mr Severino. None of those persons responded by pointing out that there was a fault in Mr Oxford’s reasoning if it meant that the vision from the four cameras would not be continuous. This may be the genesis of the ultimate five in thirty process. Clearly, Mr Oxford was

¹¹¹ Exhibit C30f, page 30

¹¹² Exhibit C30f, page 30

¹¹³ Exhibit C30f, page 30

not alone in the decision making process. It appears to me that Mr Oxford was out of his depth. He explicitly said that he was not an expert in the control room monitoring system and he was seeking advice. All of the recipients of the email should have been alert to the possibility that he may not be fully appreciative of the implications of what he was saying given that he had explicitly said ‘unfortunately am not an expert in the control room so I decided to withdraw – obtain advice and meet again next week to move this issue to an end’¹¹⁴. Mr Severino replied to that email on 23 April 2007. His replied was addressed obviously to Mr Oxford and it was copied to Ms Bordoni. It stated that Mr Severino assumed that Mr Oxford was referring to the four cameras installed in G Division in July 2006 (these being the cameras installed for the purposes of continuous observations in the four cells in G Division). Mr Severino stated that it was possible to provide a view of all four cameras on a ‘quad monitor’ in the control room using an existing monitor. The reference to a quad monitor would appear to be a reference to a single monitor being divided into four sub screens to depict each of the four cameras. Mr Severino went on to say ‘this will provide a view of all four cameras on one monitor either timed to appear every 30 min or as required’. Mr Severino added:

‘Also please note the top four monitors are used to view the perimeter. The monitors will automatically revert to camera preset positions should a breach occur on the perimeter.’¹¹⁵

In referring to the view of four cameras on one monitor ‘timed to appear every 30 min or as required’, Mr Severino was clearly responding to Mr Oxford’s cue in his earlier email. Thus the error was repeated and the risk of it being perpetuated increased. Also, crucially, Mr Severino mentioned that the top four monitors which provided a view of the perimeter, would automatically ‘revert to camera preset positions should a breach occur in the perimeter’. This language was probably not understood by Mr Oxford given his self professed lack of knowledge of the control room, the MUX system and the monitors and the language clearly is quite opaque. In saying that I do not mean to criticise Mr Severino as he was a technical expert in the area and as I learnt when hearing his evidence, he was not adept at explaining the intricacies of the system to people who were non-experts. But Mr Severino was there referring to one of the very deficiencies which manifested itself ultimately, namely that the monitor which was chosen for the display of the observations cells, being monitor 4 and one of

¹¹⁴ Exhibit C30f, page 30

¹¹⁵ Exhibit C56BP11

the 'top four monitors' would automatically display a relevant view of the perimeter if there were a perimeter alarm. While there is no evidence to establish that this occurred on the night of Mr Payne's death, it was clearly a further deficiency in a system intended to safeguard at risk prisoners. This email was addressed to Mr Oxford and copied to Ms Bordoni. It appears unfortunately that it did not ring alarm bells for either of them. This is a poor reflection of two very senior people in the Department – Mr Oxford who was the General Manager of the prison and Ms Bordoni who had previously been the General Manager of Yatala and who was by this time the Director of Custodial Services for the entirety of the prison system in South Australia. It should not be forgotten also that Mr Weir had seen the earlier email from Mr Oxford in which the seed of half hourly intervals was first sown.

- 17.5. The Yatala Institutional Management Meeting minutes for 23 May 2007 record Mr Oxford reporting that Mr Severino had advised that he could program the four cameras to appear on a monitor every half an hour for the observation. This report was given to a meeting which consisted of all of the divisional managers of the various units in Yatala. Without naming them all, there were ten managers within Yatala present on that occasion, including Mr Oxford. It appears that nobody raised any concern at the reference in Mr Oxford's report to the vision from the cameras appearing 'every half hour'¹¹⁶.
- 17.6. While these logistical and technical issues were being resolved, Mr Oxford was also developing the local operating procedure. By this stage (late April 2007) the local operating procedure was up to version 4.0¹¹⁷. This document relevantly stated that there would be four camera observation cells in G Division. It stated that 'the control room officer will conduct camera observations of the prisoners at risk'. It stated that 'backup observation will be conducted by the G Division foyer control officer via a dedicated split screen monitor'. It is notable that this draft draws a distinction between the G Division monitor and the monitoring that will take place in the control room. The G Division monitor is expressly referred to as a dedicated split screen monitor. There is no such specification in relation to the control room monitor. This may reflect Mr Oxford's state of mind at that point that there would be no dedicated monitor in the control room. On the fact of it though there is nothing in the document to suggest that the control room monitor would not contain continuous vision of the

¹¹⁶ Exhibit C51JF9, page 17

¹¹⁷ Exhibit C30f, pages 25-29

prisoners at risk. However, the document is certainly less specific than the very first draft put out by Mr Oxford at the beginning of the process when it was contemplated that the monitoring would occur in G Division itself. That local operating procedure expressly stated that the relevant G Division officer had the responsibility of observing prisoners on camera observations and stated that officer 'must not leave his/her post until relieved by another officer'. It also expressly stated that the observation of prisoners would be conducted via a dedicated split screen monitor¹¹⁸. By the time version 5.0 of the draft local operating procedure appeared in early August 2007 it had changed from version 4.0 in a very significant way. By version 5.0 the following words were introduced into the local operating procedure:

'The observation of prisoners will be a maximum of four prisoners – the four cameras are programmed to monitor four in the control room. This monitor has been programmed to have vision of the four camera cells appear on monitor 4 and half hourly intervals.'

This poorly drafted document was apparently intended to convey that the vision would be displayed on monitor 4 in the control room **at half hourly intervals**. The document also makes it plain that the relevant monitor would be monitor 4 which, as we now know, was one of the top four monitors which Mr Severino had earlier expressly informed Mr Oxford would divert from whatever vision it was currently displaying in the event that there was a perimeter alarm. Therefore, by early August 2007 the deficient system had been enshrined in the latest draft of the local operating procedure and the die was cast. The only thing that is not plain from the local operating procedure was the duration of the crucial vision at half hourly intervals which, as we know now, was to be five minutes¹¹⁹.

18. August to December 2007 – Implementation of camera observations

- 18.1. On 6 August 2007 Mr Oxford sent an email to Ms Bordoni, Ms Somerville, Mr Martin and Mr Weir to advise that he had completed what he considered to be the last consultative meeting about camera observations. The email advised that camera observations would commence with effect from Monday 4 September 2007¹²⁰. Mr Oxford added that he had one task left and that was for Mr Severino to link the four cameras to monitor 4 in the control room 'and program the system to have the 4 cameras appear at ½ hourly intervals'. The email also noted that Mr Oxford was

¹¹⁸ Exhibit C30f, pages 124-127

¹¹⁹ Exhibit C51JF8

¹²⁰ I note that this date is recorded incorrectly and should have read Monday 3 September 2007

still 'battling reps' from both the control room and G Division about how busy they were. It is plain from this email that nothing had changed to alter the notion that the cameras should appear at half hourly intervals in the four months since it was first mooted in April 2007. This notwithstanding that the issue has been raised with Ms Bordoni, Ms Somerville, Mr Martin and Mr Weir. Furthermore, the email made it plain that the staff were maintaining that they were busy. The only conclusion that can sensibly be drawn from this is that the staff were concerned about the extra responsibility of maintaining observations on prisoners at risk via the monitors.

- 18.2. On 9 August 2007 Mr Oxford emailed Mr Severino to say that he had advised staff that camera observations would commence on 3 September 2007. He stated:

'The last requirement is for Keith Timmins to arrange for yourself to program four cameras from G Division onto monitor 4 (I think) in the control room. As I understand – you can program these four cameras to come up on that monitor every 30 minutes.'

- 18.3. By email dated 16 August 2007 Keith Timmins (the Control Room Coordinator) sent an email to Mr Severino which was copied to Mr Oxford. It states as follows:

'Hi Angelo. Our requirements for the programming of monitor 4 are. All cameras in the 01 cells in G Div to appear on Monitor 4 in a MIX screen every 30 minutes for a 5 minute duration. The current normal programming of perimeter alarms to override this screen still to apply.'

I note that this is the first written confirmation that the programmed duration of the prisoners under observation will be only five minutes¹²¹.

- 18.4. On 28 August 2007 Mr Oxford emailed Mr Singh, Mr Timmins, Ms Rex, Mr Rogers, Mr Griffiths and Ms Bordoni to advise that he had not received any feedback on the latest draft of the local operating procedure (version 5.0). He reiterated that camera observations would commence on 3 September 2007 to be monitored by control room staff with backup by the G Division foyer officer. Ms Bordoni forwarded Mr Oxford's email to Mr Weir, Mr Reynolds, Mr Martin and Mr Severino for their information.

- 18.5. On 31 August 2007 Mr Oxford sent an email to Ms Bordoni, Ms Somerville, Ms Dunstan and Mr Weir to advise that five members of the control room staff had attended a meeting and had raised two issues about the proposal for camera observations to commence on 3 September 2007. The first was the issue of monitor 4

¹²¹ Exhibit C60MR06

and the second was the workload of the control room staff. Mr Oxford said that the members of the control room staff appeared to believe that the function of observation should be conducted by G Division staff. They said they did not want the job of monitoring cameras for G Division. Mr Oxford then informed them that he would be directing them to perform the function effective the following Monday morning and asked if they intended to refuse the direction. They responded that they would and that they wished to 'get the Union in'. Later that day Mr Oxford sent another email to the same group of people to advise that he had been formally advised that the Union had been notified and asked that the matter be 'put in dispute'¹²².

- 18.6. On 3 September 2007 Mr Oxford sent an email to Mr Timmins asking him to arrange for Mr Severino to investigate the installation of a standalone monitor for the camera observations in the control room, including the provision of a quote. Mr Timmins in turn contacted Mr Severino by email advising him of Mr Oxford's message¹²³. On 3 September 2007 Mr Oxford sent an email to Ms Bordoni informing her that the control room staff were preparing a document requesting a standalone monitor for the 'four camera cells to be visible at all times'. He said:

'They also intend adding a clause airing their concerns – if anything should happen to a prisoner on camera obs that they will be held responsible.'¹²⁴

On 7 September 2007 Ms Bordoni forwarded an email to Mr Oxford asking him to obtain costings on what it would take to put the camera observations on a standalone monitor. She said once she had the costings she would 'endeavour to get a decision on it for you'¹²⁵.

- 18.7. It appears that a meeting of the Electronic Security Steering Committee decided that a standalone monitor would not be approved for the control room notwithstanding these concerns. This is evidenced by an email from Mr Reynolds to Mr Severino and Ms Bordoni with copies to Mr Oxford, Mr Martin, Mr Raggatt, Mr Hatchard and Mr Timmins on 14 September 2007. It stated that as discussed at the Electronic Security Steering Committee meeting, a standalone monitor 'is not an option'. He noted that he understood that the Department would look at the possibility of replacing monitor 4 with a larger screen 'if it would not affect the setup of the current monitor bank'.

¹²² Exhibit C51JF8

¹²³ Exhibit C53GO41

¹²⁴ Exhibit C51JF9, page 77

¹²⁵ Exhibit C51JF9, page 83

Mr Severino responded advising that he would try and find a solution¹²⁶. An email of Mr Oxford dated 13 September 2007 to Mr Severino, Mr Reynolds and Mr Timmins and copied to Ms Bordoni confirms that the control room staff had been informed that a standalone monitor would not be provided¹²⁷.

- 18.8. On 28 September 2007 Mr Severino sent an email to Ms Bordoni which was copied to Mr Martin, Mr Reynolds and Mr Oxford advising that he and Mr Reynolds had arranged for a larger monitor to be installed in place of the existing monitor 4¹²⁸.
- 18.9. Finally, Mr Oxford notified all staff at Yatala by memo dated 15 October 2007 that following what was described as a comprehensive consultation process, constant observations by camera observation would commence on 17 October 2007 and the process was set out in local operating procedure 104¹²⁹.
- 18.10. Notably, on 16 October 2007 what appears to be all members of the control room staff sent a letter to Mr Severin, Ms Bordoni and Mr Oxford. It reads as follows:

'We the undersigned wish to express our disapproval of the use of camera observations as set out in LOP104 dated and signed by you on the 16-10-07.

This added responsibility has been forced upon the control room staff with next to no consultation on the matter directly with the staff who are to carry out these duties. Because of the serious nature of these new procedures we believe that a consultative meeting with all control room staff would have been paramount from the outset. We have undertaken these added duties under duress and with great reservation.

The camera system you have installed is of poor visual quality and with no sound. It is virtually impossible to make out whether a prisoner is doing something to harm himself or not.

If the Department for Correctional Services was serious about the welfare of prisoners camera observations would cease and constant observations for all prisoners at risk would be reinstated.

However if camera observation are to continue they should not be carried from the control room due to the busy work load already conducted by the staff in that area.

In the best interest for the safety and welfare of the prisoners placed on this regime we believe that the best place for these camera observations to take place should be in G Division as the response time when an emergency occurs will be quicker.'¹³⁰

- 18.11. On 18 October 2007 the Public Service Association was contacted by the control room staff and advised that they were to raise an industrial dispute about the commencement of camera observations. This led to a brief suspension of the use of

¹²⁶ Exhibit C60MR6

¹²⁷ Exhibit C60MR6

¹²⁸ Exhibit C58KT05

¹²⁹ Exhibit C51JF9, page 97

¹³⁰ Exhibit C30f, page 5

camera observations, although the issue appeared to be finalised by a letter from Mr Severin to the Public Service Association dated 18 October 2007¹³¹.

18.12. On 29 October 2007 Mr Oxford forwarded an email to a large number of staff within Yatala, principally from the control room, in the following terms:

'We still have the odd occasion whereby a nurse is demanding that a prisoner be placed on constant obs versus camera obs. As you would all be aware – constant obs is now a practice of the past and has been replaced by camera obs in G Div. This morning I have again advised those in charge of YLP medical to stop insisting the use of constant obs versus camera obs. Effective immediately – I ask you all to be diligent in this area and if asked, directed or otherwise by medical staff to place a prisoner on constant obs – please reinforce with them the current process of camera obs and if they continue to press the issue – refer the matter directly to the duty manager or in their absence – me.'¹³²

On the same day Mr Oxford sent an email to the staff of the Prison Health Service informing them that he was advising all Department supervisors that under no circumstances are they to put a prisoner on constant observations at the request of a nurse. He completed the email with the following:

'Constant obs as we formerly know the work practice are finished – could you please ensure all medical staff in the infirmary are aware.'¹³³

This prompted an email response from Dr Peter Frost, the Clinical Director of the South Australian Prison Health Service. His email was to Mr Oxford on 29 October 2007 and the subject was 'suicide risk'. The contents of the email are as follows:

'I received copies of your e-mail to Peter Beaumont and his reply.

I note you acknowledged past concerns raised by a number of South Australian Prison Health Service staff regarding management of clients thought to be at high risk of attempted suicide.

Your directive clearly authorises Correctional Service officers to ignore health service recommendations. By so doing you accept full responsibility for all adverse outcomes, SAPHS cannot be held accountable.'¹³⁴

This email was forwarded by Mr Oxford to Ms Bordoni and Ms Farrin of the Department the same day¹³⁵. Ms Bordoni replied to Mr Oxford's forwarded email the same day. She expressed the opinion that Dr Frost's response was 'totally

¹³¹ Exhibit C51JF9, page 143

¹³² Exhibit C51JF9, page 155

¹³³ Exhibit C51JF9, page 157

¹³⁴ Exhibit C53GO33

¹³⁵ Exhibit C53GO33

unacceptable'. She suggested that Mr Oxford contact Dr Frost¹³⁶. In my opinion Ms Bordoni's strategy of putting the matter back onto Mr Oxford was a failure to accept responsibility for the matter that she should have accepted herself. This is particularly so given the seniority of Dr Frost as the Clinical Director of the Prison Health Service. In my opinion it would have been far more appropriate for Ms Bordoni to raise the matter with Mr Severin. This is a poor reflection on Ms Bordoni.

- 18.13. On 23 October 2007 Mr David Haddington, a supervisor in the control room, sent an email directly to Mr Severin on the subject of camera observations. After introducing himself as an OPS3 Supervisor in the control room and an employee of nearly 23 years standing Mr Haddington stated that he wished to inform Mr Severin about the concerns the staff in the control room had about the introduction of camera observations. He acknowledged that Mr Severin had every right to implement new work practices but stated that the new procedure raised risks. The final paragraphs of the letter were as follows:

'So Mr Severin, I would like to inform you that whilst we may not be able to prevent this new procedure from being implemented, I would like it noted that we the Control Room Officers of YLP will in no way be held **LIABLE** or **ACCOUNTABLE** for the possible consequences of this new procedure, that being ("Serious Injury" or "Death in Custody"). I do not know who came up with this new procedure but it can only be described as **BADLY ILL-CONCEIVED, BADLY THOUGHT-OUT** and **EXTREMELY HIGH RISK**.

In closing and for your information, in 23yrs service I have never known there to be a "Death in Custody" or "Serious Injury" while a prisoner was on "Constant Observations".¹³⁷

Mr Severin replied to Mr Haddington's email on 31 October 2007. He stated that having worked in prisons since 1980 both in Germany and Australia he was aware of changes in the way prisons conduct their business as a result of new technology. He said that for many years the practice of constant observations had changed from direct supervision to camera supervision. He said that it was grounded on good research and also on the very labour intensive nature of prisoner supervision by staff. He said that as long as prisoner management involved regular and planned prisoner contact with staff, camera surveillance was less intrusive and could be more effective in not aggravating prisoners as much as having a staff member sitting outside of their cell

¹³⁶ Exhibit C53GO34

¹³⁷ Exhibit C30f, page 8

could do. Mr Severin said this had been scientifically proven as long ago as the 1980s. He said that there needed to be a range of measures to deal with prisoners at risk. He said that he was confident that control room staff and supervisors would approach their responsibilities in a professional way¹³⁸.

18.14. On 3 December 2007 Mr Severin replied to the letter that he had received from the control room staff dated 16 October 2007. His letter stated that he understood that the camera observation procedures did not require staff to perform activities that were not already part of existing correctional practice at Yatala. He said:

'I consider that the introduction of camera observation for prisoners at risk of suicide or self-harm in G Division is an appropriate measure and consistent with good practice in prison management. Considerable thought was given to the arrangements prior to introduction. Opportunity for self-harm by a prisoner placed into a camera observation cell is significantly reduced when procedures as detailed in LOP104 are followed and, in particular, any concern relating to the activity of prisoners under observation are communicated to G Division.'¹³⁹

Tellingly, LOP104 as referred to in Mr Severin's letter to Ms McMahon of the Public Service Association dated 18 October 2007 and attached to that letter, and as referred to in Mr Severin's letter to the control room staff dated 3 December 2007, contained the extremely concerning information that the monitor in the control room to which the four cameras were programmed had itself been programmed to have vision of the four camera cells appear 'on monitor 4 and half hourly intervals'¹⁴⁰. As I have already noted the wording is nonsensical. The word 'and' was presumably meant to be 'at'. In any event, a careful reader of this document – and in my opinion Mr Severin should have read the document before forwarding it to the Public Service Association and before replying to the control room staff, given all of the concerns that had been raised – would have appreciated that there was a problem with the prisoner observations appearing at half hourly intervals. This begs the question of what length of time the vision will appear for the half hourly interval. A simple process of enquiry at that point would have revealed to Mr Severin and any other person who had bothered to enquire that the interval was in fact five minutes. This is so clearly inadequate that had Mr Severin acquainted himself with that information he would have been in a position to put it right before the matter went any further. That in itself would have saved Mr Payne's life.

¹³⁸ Exhibit C30f, page 6

¹³⁹ Exhibit C30f, page 2

¹⁴⁰ Exhibit C51JF9, page 129

19. Where did the notion of the five minute interval come from?

19.1. Mr Oxford's position when he gave evidence was probably best summarised by the following passage when he was asked whether at any stage of the process he intended to put into operation a system which left a prisoner unobserved for 25 minutes out of 30 minutes:

'Your Honour, it was never my intention. It was always my intention that it was going to be on a stand-alone monitor for 24 hours a day, seven days a week, and I think I tried to indicate recently that once I have digested this over the last few days since I've come down to Adelaide, I am horrified that I have put a system in that has left any prisoner unattended for that length of period of time. I am horrified of my actions.'¹⁴¹

19.2. Mr Oxford was asked what he thought he was conveying to Mr Severino when he asked him by email if 'we could link in four more cameras that will appear on screen at least half hourly'. He was asked whether it registered in his mind that if an image came up only half hourly then for some periods it would not come up. He said he did not make that connection¹⁴². He was asked what he did mean by that email and his response was 'I don't know Your Honour, I really don't know'¹⁴³. He was asked again and he responded 'I don't know what I've done here, I'm horrified to read what I've done, because it was never the intention to have this work practice where the camera would only show vision every half hour'¹⁴⁴. Mr Oxford speculated that he may have confused the requirement to have a journal notation every half an hour as an explanation for what happened¹⁴⁵. I simply do not accept that as a valid explanation. Mr Oxford was unsatisfactory in his evidence on this topic. He claimed to have no memory of reading the email from Mr Timmins in which it was made explicit that the vision would be displayed for five minutes every half an hour¹⁴⁶.

19.3. When Mr Oxford was recalled sometime after giving that evidence he was taken through his earlier responses and acknowledged that the concept of five minutes every thirty minutes had been discussed during the consultation process¹⁴⁷. Mr Oxford said:

'Yes, it was, your Honour, it was raised, but I don't believe anywhere through the consultation there was a decision that we were going to do that. That's why I'm saying I was quite horrified to find that that had actually got its way into the final document. I

¹⁴¹ Transcript, pages 774-775

¹⁴² Transcript, page 758

¹⁴³ Transcript, page 759

¹⁴⁴ Transcript, page 769

¹⁴⁵ Transcript, page 770

¹⁴⁶ Transcript, page 774

¹⁴⁷ Transcript, page 1713

don't believe, I still don't know or believe that we made that decision to go to this five minute observation every half hour.'¹⁴⁸

Mr Oxford maintained that when he signed LOP104 it was his intention that the vision would be displayed constantly, notwithstanding the wording of LOP104¹⁴⁹.

- 19.4. I do not believe that Mr Oxford is a dishonest person. He did his best to explain that which simply defied explanation in his evidence before the Court. Either he was being extremely manipulative or he is manifestly incapable of running a prison. In my opinion the latter of those two options is the proper one.

20. The evidence of Mr Timmins and Mr Griffiths about the five in thirty process

- 20.1. Mr Timmins' evidence was that he was aware of the five in thirty proposal at the time that it was originally thought of¹⁵⁰. He said that he was aware of it in the following passage:

'My instruction from the feedback from the local consultative committee was that five minutes in every 30 had been agreed upon for the vision to appear on the control room monitor and from this email that I was to arrange for monitor 4 to be programmed to activate for that vision every 30 minutes.'¹⁵¹

He was asked who communicated that to him and he replied:

'It was Mr Oxford instructed me that local consultative had agreed for the five minutes every 30 and that would mean verbal at that point.'¹⁵²

Mr Timmins said that he was surprised when Mr Oxford told him about the five in thirty proposal and he told Mr Oxford at the time that he disagreed with it¹⁵³.

- 20.2. Mr Griffiths was a senior correctional officer and a Public Service Association worksite representative. He gave evidence about the five in thirty process. He said first of all that the staff, in advocating to have a dedicated screen, sought to ensure that the prisoner at risk would be displayed continuously¹⁵⁴. Secondly, they wished to avoid the problem that the vision would be interrupted by perimeter alarms on monitor 4¹⁵⁵. Tellingly, Mr Griffiths said that it would come as a surprise to him to

¹⁴⁸ Transcript, page 1714

¹⁴⁹ Transcript, page 1714

¹⁵⁰ Transcript, page 1079

¹⁵¹ Transcript, page 1079

¹⁵² Transcript, page 1080

¹⁵³ Transcript, page 1082

¹⁵⁴ Transcript, page 966

¹⁵⁵ Transcript, page 967

hear that Mr Oxford said that the five in thirty process had come as a shock to him¹⁵⁶. Mr Griffiths made personal notes at consultative meetings¹⁵⁷. He said that he was quite positive that the views that he expressed in those notes would have been expressed at one of the meetings that was held¹⁵⁸. One of those notes was as follows:

'In today's technology, I do not believe that this is not possible for the techos to do and if the bean counters in head office think that the cost to do a separate screen is not worth it, inform them, the Department, that I will not hesitate to ask about it, its worth, when we have our first death in custody by camera obs.'¹⁵⁹

In that context Mr Griffiths was referring to the dedicated screen proposal for the control room.

- 20.3. As I have noted, Mr Griffiths was positive that he raised that point at one of the Local Consultative Committee meetings¹⁶⁰.
- 20.4. Mr Griffiths said that the words about the separate monitor quoted above would have been spoken to the Yatala management team during one of the consultative meetings¹⁶¹. He said that by that he was referring to Mr Oxford and the various unit managers¹⁶².
- 20.5. It was Mr Griffiths' evidence that he would have made the remarks again about the dedicated monitor to Mr Oxford on the morning of Monday 3 September 2007¹⁶³.
- 20.6. For his part, Mr Oxford expressed the view that the five in thirty proposal came from the control room staff¹⁶⁴.
- 20.7. It seems to me likely on all of the evidence that the issue of five in thirty did arise during the consultative process. However, its precise genesis is now obscured with time and a lack of a proper investigation by the Department under Mr Severin's leadership in the immediate aftermath of this tragic event.

¹⁵⁶ Transcript, page 976

¹⁵⁷ Exhibit C57, Appendix D

¹⁵⁸ Transcript, page 977

¹⁵⁹ Transcript, page 980 and Exhibit C57, Appendix D

¹⁶⁰ Transcript, page 977 and Transcript, page 999

¹⁶¹ Transcript, page 983

¹⁶² Transcript, pages 983-984

¹⁶³ Transcript, page 1053

¹⁶⁴ Transcript, page 1745

21. Mr Severin's responsibilities

21.1. Mr Severin was asked whether when he signed off the letter to Ms McMahon he would have read the draft local operating procedure which contained the reference to vision coming on the monitor every thirty minutes. Mr Severin said that he did not read the local operating procedure when he sent that letter and was not aware of the local operating procedure's contents¹⁶⁵. He did not accept that he should have read the local operating procedure. He said:

'I clearly was quite satisfied with the governance arrangements in place, having two senior executive service officers being responsible for the LOP, and Mr Oxford was one of seven. He was the only general manager that was a member of the senior executive service; his director was as well. And I'm not saying that I'm attributing any blame here, but it certainly was my expectation that they would've signed off on this knowing full well what the operational interpretation and the operational application of it was.'¹⁶⁶

Mr Severin said that he had 'every bit of confidence that the local operating procedure dealt with the change to monitoring of at risk people' appropriately¹⁶⁷. He went on to say that 'in that context I was relying, of course on the responsible officer, Mr Oxford, and his line director, Ms Bordoni, as I mentioned, two senior staff, to actually have done that, and there are any number of other people'¹⁶⁸. Mr Severin was asked whether he agreed that the confidence he had in his senior staff was misplaced and responded 'certainly with hindsight, I do'¹⁶⁹.

21.2. Mr Severin said that he was responsible for monitoring Ms Bordoni's performance and that 'generally' her performance was 'okay' while she was with us¹⁷⁰. Mr Severin was asked whether Ms Bordoni ever informed him of any performance issues that she had experienced with Mr Oxford and his reply was:

'We certainly would have reflected on the performance, not just of Mr Oxford, but other senior managers. And yes, there were performance issues with Mr Oxford, which ultimately resulted in me terminating his contract.'¹⁷¹

Mr Severin was asked whether he had confidence in Mr Oxford between 2005 and 2007 and he said that he had 'sufficient confidence for him to remain in his position during that period of time'. Mr Severin said that he had some concerns about 'aspects

¹⁶⁵ Transcript, pages 1598-1599

¹⁶⁶ Transcript, page 1599

¹⁶⁷ Transcript, page 1601

¹⁶⁸ Transcript, page 1602

¹⁶⁹ Transcript, page 1602

¹⁷⁰ Transcript, page 1689

¹⁷¹ Transcript, page 1689

of his management style'. He finally said 'my confidence in Mr Oxford's performance changed over time, and essentially I terminated his employment later on'¹⁷². Counsel for Mr Oxford put to Mr Severin a copy of an email Mr Severin wrote on 2 July 2009, the subject of which was 'General Manager Gary Oxford'. The email stated that Mr Oxford had tendered his resignation on the basis of health and family reasons¹⁷³. Mr Severin was asked how this was consistent with his evidence that Mr Oxford's employment was terminated and he replied that the wording was in order to maintain Mr Oxford's dignity and to avoid any embarrassment. Nevertheless, Mr Severin maintained that if Mr Oxford did tender his resignation he did so in order to avoid being terminated and Mr Severin said:

'I clearly say this and I've obviously terminated his contract initially.'¹⁷⁴

- 21.3. As I have noted elsewhere, Mr Severin is an intelligent and perceptive man with extensive experience of staff management. He would quickly have assessed Mr Oxford's capabilities. In my opinion Mr Severin would have been entirely appreciative of the fact that Mr Oxford was out of his depth in 2007, and certainly by late 2007 when Mr Oxford had been at Yatala for nearly 18 months. Mr Severin should also have had sufficient perception to judge Ms Bordoni as a person who could not be expected to pay sufficient attention to detail to ensure that Mr Oxford made no mistakes.
- 21.4. Neither in his evidence, nor in his statement, nor in his submissions did Mr Severin offer so much as an expression of regret at Mr Payne's death. His demeanour in the witness box and evidence demonstrated a wish to avoid responsibility for what was ultimately the result of predictable incompetence on the part of senior members of his organisation who he sought to describe as members of the senior executive service and therefore people on whom he could rely. His own behaviour in relation to Mr Oxford in the subsequent dismissal of Mr Oxford demonstrates that Mr Severin did not have confidence in him sufficient to justify that assertion. Mr Severin denied that it was he who either directed or requested Mr Oxford to provide him with a proposal for the introduction of camera observations. It will be noted that this is contrary to the evidence of Mr Oxford. I prefer Mr Oxford's evidence in this regard and I reject that of Mr Severin.

¹⁷² Transcript, page 1690

¹⁷³ Exhibit C63b

¹⁷⁴ Transcript, page 1694

- 21.5. It was put to Mr Severin in his evidence that an officer in the control room would be unable to constantly observe the cameras for the high risk cells even if it had been showing constant vision because of the other duties the staff member was required to perform. Mr Severin said that his view was that he would expect the officer to be able to monitor the prisoners while carrying out the rest of his duties¹⁷⁵. He was aware that the staff had raised the question of workload but said that he considered that the additional responsibility of observing prisoners could reasonably be done by the control room staff¹⁷⁶.
- 21.6. Mr Severin maintained that monetary considerations were not the only reason why camera observations were introduced¹⁷⁷. Of course, Mr Severin's evidence was that he regarded the five in thirty process as inappropriate. He also regarded it as inappropriate that the perimeter alarms would override the observations from the observation cells¹⁷⁸. Mr Severin was unable to provide any explanation as to why an additional monitor could be provided after Mr Payne's death, but not before¹⁷⁹. Mr Severin said that he did not consider it appropriate that for 25 minutes in 30 minutes the monitors were displaying the outside of the control room door. He said he would have expected that any number of senior staff would have picked that problem up through regular inspections¹⁸⁰.
- 21.7. Mr Severin said that he did not become aware of the five in thirty issue until after Mr Payne's death. He found out sometime between 2 June 2011 and 17 June 2011¹⁸¹. It was suggested to him that the five in thirty process was an egregious blunder and he agreed¹⁸². He was asked whether anyone had been held to account for it. His response was:

'We did identify that obviously this happened with the concurrence of management at the time. Both the general manager of the day and the director of the day had left the service earlier, and there was - ... we didn't actually proceed to a formal investigation because ultimately they were the two senior people accountable for this being able to happen ...'¹⁸³

¹⁷⁵ Transcript, page 1572

¹⁷⁶ Transcript, page 1577

¹⁷⁷ Transcript, page 1616

¹⁷⁸ Transcript, page 1642

¹⁷⁹ Transcript, page 1643

¹⁸⁰ Transcript, page 1645

¹⁸¹ Transcript, page 1678

¹⁸² Transcript, page 1680

¹⁸³ Transcript, page 1680

It was put to Mr Severin that he could not be satisfied that fault might not exist elsewhere and he agreed¹⁸⁴. He agreed that the entire debacle had the hallmarks of what he learned to be the culture at Yatala in particular¹⁸⁵. He agreed that it happened in the context of a protracted industrial dispute¹⁸⁶. It was put to him that surely the fact that such an alarming and disastrous result could follow from particular worksite practices and a process of negotiation warranted scrutiny at the very highest levels of Government. Mr Severin was not prepared to acknowledge this and said it was a Departmental matter, although he acknowledged that he would have briefed the Minister for Correctional Services on this particular egregious error in the programming of the cameras¹⁸⁷. He said he would have had a Ministerial briefing note prepared. However, despite the extensive efforts undertaken by this Court to identify all documents and the slow and painstaking manner in which they had to be extracted from the Department, no such Ministerial briefing note was ever identified.

- 21.8. It was put to Mr Severin that the Inquest process was far more difficult than it would have been if the matter had been thoroughly investigated and all necessary documentation gathered together in June 2011. He responded that he appreciated that point. He said that he dealt with the immediate issues that were identified and continued:

'We couldn't identify any personal wrongdoing of a person involved in the management of this or failure to observe properly...' ¹⁸⁸

He said:

'There was no evidence that I could point my finger at that was produced to me.'

In my view that is not satisfactory. It was within Mr Severin's power as the Chief Executive to get to the bottom of what occurred had he decided to do so in good time after Mr Payne's tragic death. Mr Severin's use of the expression that no evidence was ever 'produced to me'¹⁸⁹ was unfortunate. The evidence was never going to fall in front of him. At the end of his evidence all he could say was that he could not establish how the five in thirty 'would have been authorised, other than the fact that there was clearly an indication that this was authorised through management at the

¹⁸⁴ Transcript, page 1681

¹⁸⁵ Transcript, page 1681

¹⁸⁶ Transcript, page 1681

¹⁸⁷ Transcript, page 1681

¹⁸⁸ Transcript, page 1682

¹⁸⁹ Transcript, page 1683

time¹⁹⁰. In my view that is a most underwhelming explanation. Mr Severin was also unable to explain how there was a ligature point in the cell that was occupied by Mr Payne¹⁹¹.

21.9. In my opinion, as the head of the organisation at the time, and a person with knowledge of Mr Oxford's manifest inadequacies, and Ms Bordoni's lack of attention to detail, a subject to which I will come in due course, ultimate responsibility for this farcical and tragic event rests with Mr Severin.

22. Mr Oxford did know about the five in thirty concept from the Consultative Committee process

22.1. It is quite obvious that Mr Oxford did know about the five in thirty concept through his consultation with the control room staff. It would seem he was aware of it as early as April 2007. Thus, his claims when giving evidence that he was 'horrified' to discover what he had put in place cannot be accepted. As I have said, he was out of his depth. He was incompetent. He was weak and was not prepared to stand up to the staff. First he appeased the G Division staff by passing the new responsibility to the control room staff. Then he appeased them by tacitly allowing a system to be installed that would mean no-one would truly be responsible for the camera observation because the vision was intermittent. That in itself diminished its importance and broke the chain of accountability – if the vision simply was not there for most of the time, how could anyone be expected to maintain constant observations of at risk prisoners? Thus the contemplated increase in responsibility was avoided and no-one would complain. There would be no industrial action and no disruption in the running of Yatala that would demand that a solution be found. It is a pity that there was not some such crisis, as the matter might have been resolved properly by someone prepared to take the responsibility. Mr Oxford did press for a dedicated monitor, but was then too weak to insist on it when Ms Bordoni and others refused because they were not prepared to spend the few thousand dollars required and because of spurious claims that the extra monitor would involve a departure from control room standardisation across prisons. For all this, Mr Oxford did his best and those above him – Ms Bordoni and Mr Severin, should have known his best was never going to be good enough.

¹⁹⁰ Transcript, page 1683

¹⁹¹ Transcript, page 1685

23. The evidence of Maria Bordoni

- 23.1. As I have mentioned, Maria Bordoni was the Director of Custodial Services at the relevant time. Prior to that she had held the position of General Manager, Yatala Labour Prison for nine years and so she should have had a very good working knowledge of Yatala and the challenges that Mr Oxford was facing.
- 23.2. I found Ms Bordoni to be an unimpressive witness. She claimed that Mr Reynolds was essentially her second in charge in her role¹⁹². She said that Mr Reynolds was responsible for checking all local operating procedures before she signed them and essentially she blamed Mr Reynolds for any defects in LOP104, notwithstanding the fact that she ultimately signed it¹⁹³. Ms Bordoni also claimed in her evidence that Mr Severin was responsible for Mr Oxford's 'performance plans'¹⁹⁴, yet Mr Severin said that that was not correct and that he had never done a performance review or performance plan of Mr Oxford because that was Ms Bordoni's responsibility¹⁹⁵. In this respect I prefer Mr Severin's evidence. Ms Bordoni admitted that she regarded Mr Oxford as needing assistance to the point where his demands on her time became so intense that she sought to delegate some of that assistance to Mr Reynolds¹⁹⁶. She said that she also became increasingly concerned about Mr Oxford's mental and physical wellbeing in undertaking the role of General Manager of Yatala¹⁹⁷.
- 23.3. Ms Bordoni was keen to divert responsibility for what happened as much as possible in her evidence. She even suggested that she was not asked about the idea of going from constant observations to camera observations and that that was a matter only between Mr Severin and Mr Oxford¹⁹⁸, yet in the balance of her evidence it was obvious that she had many conversations with Mr Oxford on this subject, and furthermore she was involved in email exchanges with him in which she was urging him to get on with the task. It is simply not credible for her to suggest that she was some kind of bystander watching an event play out between Mr Oxford and Mr Severin. Bearing in mind that she was Mr Oxford's immediate line manager, it would have been inappropriate for her to devolve herself of all responsibility in any event.

¹⁹² Transcript, page 1371

¹⁹³ Transcript, page 1418

¹⁹⁴ Transcript, page 1383

¹⁹⁵ Transcript, pages 1688-1689

¹⁹⁶ Transcript, page 1384

¹⁹⁷ Transcript, page 1385

¹⁹⁸ Transcript, page 1392

Interestingly, she eventually acknowledged that she had agreed with the decision to move to camera observations¹⁹⁹. This pattern of inconsistency in her evidence repeated itself again and again. At transcript, page 1399-1400 she acknowledged that she read LOP104 when she signed it. On the matter of the words in LOP104 that referred to half hourly intervals, Ms Bordoni attempted to explain this as if she had an awareness that ‘something was going on at half hourly intervals’²⁰⁰. She acknowledged that she first became aware of the thirty minute interval in or about April 2007²⁰¹. She could hardly deny this given that she was the recipient of an email that Mr Oxford sent her and a number of others on 20 April 2007 in which he said ‘can we link in four more cameras that will appear on screen at least half hourly’²⁰². She had to admit that when she finally saw LOP104 and signed it she was not surprised to see that there was something occurring at thirty minute intervals in the area that had prime responsibility²⁰³. Ms Bordoni was asked to explain what she meant when she said ‘something was going on at half hourly intervals’. She responded by saying that she was not a technical person²⁰⁴. She said that she had no understanding of computers or technical equipment and then mentioned the MUX system. She claimed that even when giving her evidence she had no idea what a MUX system was²⁰⁵. She was the General Manager of Yatala for 9 years. Security is one of the highest priorities at Yatala and the control room has monitor screens which Ms Bordoni must have seen many, many times. She must have appreciated that the MUX system was a system which was designed to stream vision to the bank of eight monitors that were setup in the control room where the officers were given the task of observing the monitors. In my view it simply is not credible that she could have been in the role of General Manager of Yatala and then Director of Custodial Services for a total period of over a decade and not have had any appreciation whatsoever of what was meant by the MUX system, a system that was used not only in Yatala but in all of the other prisons. Then to attempt to avoid an understanding of something happening at half hourly intervals on the basis that it was a technical expression was plainly

¹⁹⁹ Transcript, page 1394

²⁰⁰ Transcript, page 1401

²⁰¹ Transcript, page 1484

²⁰² Exhibit C30f, page 30

²⁰³ Transcript, page 1484

²⁰⁴ Transcript, page 1408

²⁰⁵ Transcript, page 1408

disingenuous and an attempt to deflect responsibility²⁰⁶. After a considerable amount of questioning around the topic of the half hourly intervals, she mentioned for the first time that she recalled:

'... feeling appeased somewhat when I raised the question about the monitor in G Division and its role in all of this. That aspect I do recall. The reason that I raise it is my understanding was that the monitor in G Division, when we refer to backup ... was that that monitor was on at all times. So my understanding in signing this document, albeit I cannot recall what Andrew would have explained to me about how often it was coming up in the control room, I know that whatever I was feeling uncomfortable about at the time was comforted by the fact of knowing that the monitor in G Division was to be on.'²⁰⁷

That passage of evidence strikes me as inherently implausible. It is notable that she did not mention the issue of her 'discomfort' when she was first being questioned about the half hourly intervals and she responded by acknowledging that she understood that 'something was happening half hourly'. It was not until sometime later in her evidence that she admitted that she had felt discomfort at that notion and then claimed that her discomfort was 'appeased' when she learnt that the G Division monitor would be providing backup. She gave further evidence on that topic²⁰⁸ and she was no more credible under cross-examination than she had been earlier in her evidence. Counsel for Ms Porcelli, Mr Reynolds, Mr Timmins and Mr Griffiths submitted that her response defied credulity, and I agree. Counsel for Mr Oxford submitted that Ms Bordoni sought to downplay her role in the introduction of camera observations²⁰⁹. However, it was clear from the outset that she was involved in guiding Mr Oxford on how to manage the issues that arose²¹⁰, from submitting Mr Oxford's original minute to the Executive²¹¹ to suggesting a camera location change²¹² to dealing with the industrial and medical fallout²¹³.

23.4. There was another important respect in which Ms Bordoni tried to deflect accountability. That was in her evidence about the subject of the standalone monitor. The documentary evidence showed that there were two separate attempts to ensure that the control room would have a standalone monitor for the G Division observation

²⁰⁶ Transcript, page 1409

²⁰⁷ Transcript, page 1412

²⁰⁸ Transcript, pages 1485-1486

²⁰⁹ Transcript, pages 1386, 1392 and 1402

²¹⁰ Transcript, pages 1395- 1396

²¹¹ Exhibit C62, paragraph 36

²¹² Exhibit C62, paragraphs 40, 53 and Transcript, page 1443

²¹³ Annexures MB07, MB09 and MB12 to Exhibit C62 and Annexures GO09, GO18 and GO34 to Exhibit C53

cells. The first was when Mr Oxford emailed Mr Post on 20 February 2007 requesting a standalone monitor rather than having vision from one of the 'MUX' monitors being lost²¹⁴. That attempt was when Mr Reynolds told Ms Bordoni the separate monitor would cost \$3,000 and they should use the MUX system instead²¹⁵. Ms Bordoni then told the Electronic Security Steering Committee on 29 March 2007 that an additional monitor in the control room was 'not part of the scope'²¹⁶.

- 23.5. The second attempt was in early September 2007 when Mr Oxford informed Ms Bordoni that the control room staff were requesting a standalone monitor²¹⁷. Ms Bordoni was well aware that this attempt was also unsuccessful because she was the recipient of an email dated 14 September 2007 advising that the Electronic Security Steering Committee (of which she was a member) had decided that a standalone monitor 'is not an option'²¹⁸.
- 23.6. The oral evidence of Ms Bordoni at the Inquest was completely at odds with that documentary trail. In her evidence she said 'I was very clear that I expected they have a separate monitor'²¹⁹. Yet the documentary evidence showed that Ms Bordoni actively thwarted both attempts to obtain a separate monitor. In this passage of evidence she demonstrated her unreliability as a witness. She also demonstrated her unsuitability to hold the office of Director of Custodial Services.
- 23.7. Ms Bordoni conceded that she was not confident in Mr Oxford's expertise and competence, but sought to deflect responsibility onto the rest of her staff²²⁰. Ms Bordoni said that not one person alerted her to any difficulty with what was being proposed by Mr Oxford²²¹. This appears to me to be Ms Bordoni's attitude. She expected to be able to avoid descending into detail in her capacity as Director of Custodial Services and expected everybody else to draw to her attention matters that required her attention. Yet she well knew that Mr Oxford was out of his depth. In my opinion Ms Bordoni must bear a level of responsibility for the debacle that ensued with the implementation of camera observations at Yatala. I do accept however her denial that she actually realised that vision from the observation cells would only be

²¹⁴ Exhibit C56BP09

²¹⁵ Exhibit C60MR04

²¹⁶ Exhibit C51JF5

²¹⁷ Exhibit C51JF9, page 77

²¹⁸ Exhibit C60MR6

²¹⁹ Transcript, page 1413

²²⁰ Transcript, page 1490

²²¹ Transcript, page 1498

displayed for five minutes in half an hour²²². Nevertheless this does not absolve her of responsibility. It just means that she was not flagrantly culpable in her avoidance of responsibility. The fact of the matter is that she was aware of the business of half hourly intervals and that should have put her on the alert. She should have chased the matter with the responsible manager, namely Mr Oxford, until she was satisfied that a matter as crucial as the observation of prisoners who required constant monitoring because they were at risk of self-harm, would be undertaken appropriately. The mere reference to something happening at half hourly intervals in that context should be enough to raise alarm bells and prompt questions until satisfactory answers are provided. Ms Bordoni never undertook that responsibility and in that sense she was a contributor to the final tragic outcome.

- 23.8. In summary, I consider that Ms Bordoni did not devote herself with sufficient diligence to the task of ensuring that Mr Oxford properly managed Yatala Labour Prison. Of course, she was also being supervised ultimately by Mr Severin and he himself should have been well aware of Ms Bordoni's limitations. He was certainly well aware of Mr Oxford's.

24. Conclusions

- 24.1. I find that Mr Payne's death was preventable. It was directly attributable to the five in thirty process, to the lack of a dedicated officer to monitor cameras and the lack of a standalone monitor. As to the last of those, I note that a standalone monitor was installed in the days following Mr Payne's death. The first issue – the five in thirty process – was also put right very soon after his death. As to the last – the use of a dedicated officer to monitor the vision – the Department has resisted this obviously sensible measure to the last. I intend to recommend that the Department provide a dedicated officer in the future.
- 24.2. It will be recalled that the video footage of Mr Payne's final moments showed that he looked – quite deliberately – directly at the camera in his cell before proceeding to carry out the act that led to his death. Although we can never know the truth of the matter, I was left with a strong impression that he thought he was being monitored by someone who could observe the vision from his camera. If that were correct it may be that Mr Payne was not intending to take his life, but was hoping to be rescued and,

²²² Transcript, page 1497

perhaps, placed elsewhere as he made it very clear that he did not want to be in G Division on canvas. That possibility makes even more poignant an already tragic set of circumstances.

25. Recommendations

- 25.1. 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.
- 25.2. I recommend that the Department for Correctional Services assign a dedicated officer(s) for the purpose of twenty-four hour constant, continuous monitoring of vision streamed by the cameras responsible for monitoring at risk prisoners in the observations cells of G Division. This recommendation is directed to the Minister for Correctional Services, the Chief Executive of the Department for Correctional Services and the Chief Executive of Yatala Labour Prison.

Key Words: Death in Custody; Monitoring/Observation of Prisoners; Suicide

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

Seal the 11th day of June, 2015.

State Coroner