



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 8th day of November 2017 and the 30th day of January 2018, by the Coroner's Court of the said State, constituted of Jayne Samia Basheer, Deputy State Coroner, into the death of Heath Ryan Jones.

The said Court finds that Heath Ryan Jones aged 35 years, late of Mobilong Prison, Maurice Road, Murray Bridge, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 4th day of April 2014 as a result of hypoxic-ischaemic encephalopathy (post cardiac arrest) on a background of acute compression of the neck consistent with hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and background

- 1.1. Mr Heath Ryan Jones (hereinafter referred to as Mr Jones or the deceased) was born on 1 February 1979 to Colin and Bonnie Jones (Mr and Mrs Jones). Mr Jones had two siblings, an elder brother (Kane) and a younger brother (Darren).
- 1.2. The Court noted that Mr and Mrs Jones, together with other family members and supporters, were present in court throughout the Inquest.
- 1.3. Mr Jones attended Calvary Primary School at Morphett Vale and Wirreanda High School where he completed Year 10. He started an electrical apprenticeship with his father but he did not complete it. Therefore he could only be employed as a trade's assistant. Mr Jones worked with his father in this capacity for about 8 years.

- 1.4. The evidence is sketchy regarding his employment and life after Mr Jones ceased working with his father. Mr Jones senior said that ‘after a while he became disenchanted and saw that a lot of his friends were earning a lot more money so he just moved on’¹.
- 1.5. Mr Jones visited his family on an irregular basis. Christmas and family birthdays were celebrated together.
- 1.6. It is apparent from the evidence that Mr Jones became involved with the police and was charged with various offences. His parents were concerned that he was using drugs but this was not a topic that Mr Jones would talk about with them².

2. Reason for Inquest

- 2.1. At the time of his death on 4 April 2014 Mr Jones was being held on remand at Mobilong Prison (Mobilong). He was 35 years old.
- 2.2. The death of Mr Jones was a death in custody as defined by section 3 of the Coroner’s Act 2003. Therefore a coronial Inquest to ascertain the cause and circumstances of his death was mandatory by virtue of section 21(1) of that Act.

3. Mr Jones’ incarceration in Mobilong Prison

- 3.1. Mobilong Prison is a medium security open campus prison which is operated by the South Australian Department for Correctional Services (the DCS).
- 3.2. The prison currently holds 327 prisoners. It is predominately designed for sentenced male prisoners of medium security rating, but approximately ⅓ of the population at any time is on remand.
- 3.3. Mobilong has five main living units with cell block accommodation. Each unit has approximately 20 single cells and 25 double bunked calls. There is a common dining and servery area in each unit.
- 3.4. As at 1 April 2014 Mr Jones was housed in the east wing of Light Unit. He was sharing cell 25 with another prisoner (Prisoner Tayler)³.

¹ Exhibit C1b at page 3

² Exhibit C1b at page 3

³ Exhibit C27-Statement of Bernard John Gelston at page 2 and Exhibits 35f (aerial map)

- 3.5. At around 4pm on 1 April 2014 Mr Jones was found alone in cell 25 by his cellmate, slumped on top of the toilet and non-responsive. His head was falling forwards and it was discovered that he had used a prison issue mesh laundry bag as a ligature to self-harm⁴. The ligature was secured to a chrome towel rail which is located immediately above the toilet cistern. The height from the ground to the towel rail is 1060cm⁵.
- 3.6. Prisoner Tayler raised the alarm. Correctional services officers (CSOs) responded immediately. They entered the cell and cut the ligature. Concurrently a 'Code Black' (Medical Emergency) was called and communicated to the Prison Control Room⁶. The Code Black was recorded as being initiated at approximately 1600 hours.
- 3.7. CSOs and SA Prison Health Service (SAPHS) staff commenced cardio-pulmonary resuscitation (CPR) pending the arrival of the South Australian Ambulance Service (SAAS).
- 3.8. At approximately 4.09pm SAAS Intensive Care Paramedics were tasked to attend a priority 1 response at Mobilong. They arrived at the prison around 4:17pm. Mr Jones was examined at 4:20pm. Another SAAS crew arrived at the prison at the same time and emergency first aid was continued. Mr Jones was transferred from the prison to the Murray Bridge Soldier's Memorial Hospital for further treatment and intervention. The arrival time at the hospital was 4:51pm⁷.
- 3.9. The on-call emergency doctor at Murray Bridge, Dr Amy Thomas, attended at the hospital. Medical treatment and intervention was continued there and MedSTAR⁸ was called for advice and retrieval. MedSTAR arrived at 6:10pm and Mr Jones was transferred into their care⁹.
- 3.10. Mr Jones was airlifted to the Flinders Medical Centre (FMC) by the MedSTAR rescue helicopter and placed in the Intensive Care Unit (ICU). The rescue team continued treatment and noted no change in his condition en route to the FMC¹⁰.

⁴ Exhibit C9-Statement of Darcy Jay Tayler

⁵ Exhibit C34-Statement of Shane Garth Wisseman (Murray Bridge Crime Scene)-see photographs SW 21-SW28

⁶ Refer Exhibit C35i-Standard Operating Procedure (SOP 020A)

⁷ Exhibit C22-Statement of Justin Brett Ranford; see also Exhibit C23-Statement of Trevor Paul Matthews

⁸ MedSTAR is the single emergency retrieval service for South Australia. It is controlled by the state government under the Department of Health through the SA Ambulance Service and provides 24 hour emergency retrieval services

⁹ Exhibit C24-Statement of Amy Victoria Thomas at page 3

¹⁰ Exhibit C25-Statement of David John Osborn Teubner;

- 3.11. Dr Santosh Verghese is a medical practitioner who practices critical care medicine at the FMC. He was a member of the team that treated Mr Jones. On admission to the ICU the diagnosis was severe anoxic brain injury and negative pressure pulmonary oedema. He was sedated and ventilated.
- 3.12. Various tests were conducted including a CT scan of his brain and a CTA (CT Angiogram)¹¹.
- 3.13. Sadly, over the coming days Mr Jones' condition deteriorated to the point where the opinion of a neurosurgical team was that no surgical intervention was indicated. The ICU team and Dr Verghese explained the poor prognosis to Mr Jones' family. In consultation with them it was decided that Mr Jones would have wanted to be an organ donor. Hence the organ donation team became involved.
- 3.14. At 5:33pm on 4 April 2014 Dr Santosh Verghese declared lift to be extinct¹².

4. Cause of Death

- 4.1. A post-mortem examination was performed by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science South Australia. In her post-mortem report, verified by affidavit, Dr Charlwood attributed the cause of death to hypoxic-ischaemic encephalopathy (post cardiac arrest) on a background of acute neck compression due to hanging¹³.
- 4.2. Toxicology was undertaken to ascertain any factors relevant to the death¹⁴. Analysis of hospital ante-mortem blood indicated the presence of several medications at levels consistent with therapeutic concentrations and in keeping with therapeutic/medical intervention. These medications included morphine, fentanyl, midazolam, lignocaine, mirtazapine, amitriptyline and nortriptyline.
- 4.3. Also detected was methylamphetamine, an illicit stimulant drug that is sometimes referred to by street names including 'speed', 'meth' and 'ice'. The level was at a low concentration, namely 0.04mg per litre of blood.

¹¹ Exhibit C26-Statement of Santosh George Verghese

¹² Exhibit C26 at page 5

¹³ Exhibit C2a-Post-Mortem report of Dr Cheryl Charlwood dated 7 October 2014; see also Exhibit C4a-Statement of Dr Peter C Blumberg

¹⁴ Exhibit C3a-Toxicology Summary Report of Lauren Geier

- 4.4. Dr Charlwood concluded that given the overall circumstances the level of methamphetamine was not considered to be a direct factor in the death, although it could potentially have some bearing on the deceased's mental state around the time of the initial incident.
- 4.5. I accept the expert opinion as to the cause of death and find it to be hypoxic-ischaemic encephalopathy (post cardiac arrest) on a background of acute neck compression due to hanging.
- 4.6. For the reasons set out herein I find that Mr Jones intended to take his own life and that he did so without the assistance or involvement of any other person.

5. The circumstances of Mr Jones' death

5.1. Background

As stated earlier, at the time of his death Mr Jones was being held on remand at Mobilong Prison.

- 5.2. Prisoners at Mobilong are issued with two standard laundry bags. The bags are made of simple mesh cotton. Some have large long drawstrings and others have Velcro to secure the bag. Others have no tape or Velcro at all and a knot is tied at the end of the bag. The laundry bags are a necessity for the washing process at the prison. It is the only way to manage the smaller personal items of underclothing and to ensure the items are returned to their owner as the washing goes through the bulk wash and drying system in the bag¹⁵.
- 5.3. I have also mentioned that at the time of his death Mr Jones was sharing a cell (cell 25) in the east wing of Light Unit. Each cell has an observation window which enables officers to look inside the cell without opening or unlocking the cell door¹⁶.
- 5.4. So far as supervision is concerned, unless a prisoner has been deemed to be at risk and placed under a close monitoring regime, prisoners are monitored by regular patrols of the wings. It is usual for one officer to go for a walk and the second officer to maintain their station in the unit. It is expected that officers will walk up and down through the wings at least every two hours.

¹⁵ Exhibit C35a-Statement and report of Peter Moore (Investigating Officer) at page 19. See also Exhibit C34- Statement of Shane Garth Wisseman-Photographs SW16, SW18-SW20

¹⁶ Exhibit C34-Photographs SW1, SW2 and SW3

- 5.5. The units are also visited at irregular frequencies throughout the day by the internal security patrol and unit staff are required to conduct daily searches of at least three cells. In addition, the unit supervisor conducts random walks through the unit throughout the course of the day which provides a further opportunity for observing prisoners¹⁷.
- 5.6. Custody records obtained by the investigating officer from the Justice Information System (JIS) and the DCS indicate that the deceased had a history of criminal offending commencing in 1995 with convictions being recorded for offences in various categories including traffic, breach of bail, property, assault, firearms and drug offences.
- 5.7. On 15 November 2011 Mr Jones was convicted and sentenced by the District Court for offences of unlawful possession, breaching a term or condition of bail, trafficking in a controlled drug, simple possession, possession of a prescription drug without lawful authority (3 counts) and possessing a firearm without a licence. He was discharged without penalty for the first two offences. For the remaining offences the Court imposed a head sentence of 2 years and 3 months imprisonment and a non-parole period of 12 months. That sentence was suspended upon Mr Jones entering into a bond to be of good behaviour for a period of 2 years. The bond included a condition that he be under the supervision of a Community Corrections Officer for a period of 2 years and obey all lawful directions of that officer.
- 5.8. On 19 December 2013 Mr Jones was arrested by police officers attached to the South Coast Local Service Area for offences of hinder police, resist arrest, possession of a controlled drug for sale (amphetamine) as well as unlawful possession of cash in the amount of \$7,000 and personal property including six laptop computers. Due to the seriousness of the allegations bail was refused (on 20 December 2013)¹⁸.
- 5.9. At the time of his arrest there was an active bench warrant in existence which had been issued by the District Court of South Australia on 31 October 2013 for non-attendance at court. No doubt this was a relevant matter in the decision to refuse bail.
- 5.10. Mr Jones was placed into the lawful custody of the DCS at Yatala Labour Prison. He was transferred to Mobilong Prison on 30 December 2013.

¹⁷ Exhibit C35a at page 19-20

¹⁸ Exhibit C35a at page 12

- 5.11. At this time Mr Jones also had pending court hearings for other alleged offences including driving whilst disqualified, driving with a prescribed drug present in oral fluid or blood (methylamphetamine), hinder police, resist arrest, unlawful possession, breach of bail and possessing a prescription drug without lawful authority. These pending matters were listed as follows:
- a) Christies Beach Magistrates Court (29 April 2014);
 - b) Adelaide Magistrates Court (6 May 2014); and
 - c) District Court (29 May 2014)¹⁹
- 5.12. The deceased had never spent extended periods of time in police custody or in prison. Custody records indicate that the deceased appears to have first been admitted to a Correctional Services facility on 24 April 2009. On this occasion he spent 7 days at Yatala Labour Prison before being released on home detention bail.
- 5.13. On 5 September 2010, whilst in police custody at the Murray Bridge Police Station, the deceased head-butted cell walls. He was placed into a padded cell for his own protection. Whilst in this cell Mr Jones removed his clothing, placed it around his neck and laid down on the floor. There is no suggestion that the clothing was tied around his neck in the form of a ligature.
- 5.14. On 18 August 2013 the deceased was arrested for further offences and admitted to the Adelaide Remand Centre (ARC)²⁰. Due to the 2010 incident he was assessed as 'high need' and placed on mandatory observations every 15 minutes. However, after four hours he was reassessed and observed to be stable in the cell environment.
- 5.15. Police bail was granted and Mr Jones remained at liberty until his arrest on 19 December 2013.
- 5.16. Admission to Yatala Labour Prison on 20 December 2013
On 20 December 2013 an application for bail was refused (for the offences which are referred to at paragraph 5.8 above). Mr Jones was taken to the Yatala Labour Prison.
- 5.17. There was nothing remarkable about the deceased's induction procedure at Yatala Labour Prison. A mandatory 7 day observation and screening was conducted to assess his level of risk whilst in custody. Stage 1 and Stage 2 Admission Assessments on

¹⁹ Exhibit C35a at page 13

²⁰ Exhibit C35a at page 13

20 and 24 December 2013 including risk screening indicated that Mr Jones was a low risk of harm to himself or others.²¹

- 5.18. A low security prisoner is not required to be placed under direct supervision. Such a prisoner requires occasional supervision and sighting²².
- 5.19. During the admission medical review a history of anxiety was noted. It was being managed by an evening dose of Neulactil. It was documented that Mr Jones disclosed no thoughts of self-harm or suicidal intent. There was a past history of cluster headaches, sleep disturbance, sinusitis, asthma (no treatment) and polysubstance abuse and on admission he was withdrawing from methamphetamines. It was noted that he was a long term user²³.
- 5.20. Transfer to Mobilong Prison-30 December 2013
On 30 December 2013 Mr Jones was transferred to Mobilong Prison. Initially he was placed in Sturt Unit (an induction/reception unit) and then transferred to an observation cell for the mandatory 7 day observation. As bed space becomes available the prisoner is then moved to other units.
- 5.21. On 31 December 2013 a nursing assessment was conducted. It was noted that the deceased's anxiety was being managed by medication and that he reported no thoughts of self-harm or suicidal intent²⁴.
- 5.22. It is unclear from the evidence whether Mr Jones remained in Sturt Unit until his transfer to the east wing of Light Unit, or whether he spent an interim period in another unit. Nothing turns on this point.
- 5.23. Events in February 2014
On 19 February 2014 Mr Jones' medication regime was reviewed on account of ongoing anxiety and sleep difficulties²⁵.
- 5.24. It is not uncommon for prisoners on remand or serving a sentence of imprisonment to experience anxiety. However, it is plain from the evidence that, unknown to the DCS

²¹ Exhibit C28-Statement of Elizabeth Sloggett (Nurse Management Facilitator, SAPHS) at page 3

²² Exhibit C35a at page 17

²³ Exhibit C28 at pages 2-3

²⁴ Exhibit C28 at page 3

²⁵ Exhibit C28 at page 3

or the SAPHS, Mr Jones was experiencing significant personal problems in his life in the weeks and days immediately preceding his death.

- 5.25. The existence of personal factors and stressors which were unknown to DCS is a relevant consideration in this matter. I will canvass this aspect of the matter in more detail in due course. For present purposes it is sufficient to foreshadow the nature of these issues.
- 5.26. Firstly, it is apparent from the transcript of recorded telephone conversations between 21 March 2014 and 1 April 2014 that there was significant tension between Mr Jones and his partner of some two years, Ms Eveline Clare McHardy, particularly after 29 March 2014.
- 5.27. Secondly, Mr Jones had accumulated a drug debt of around \$60,000. Ms McHardy was struggling to manage payment of this debt and his legal bills while Mr Jones was in prison. This was causing further pressure in the relationship. The drug debt had apparently also led to threats of harm being made against the deceased's brother, Kane Jones.
- 5.28. Thirdly, it appears that Mr Jones was struggling with withdrawal from the use of illicit drugs. According to Ms McHardy he often asked her to bring some amphetamine into the prison for him but she denied acceding to this request²⁶.
- 5.29. Fourthly, the deceased had accessed the illicit drug methylamphetamine whilst he was in prison.
- 5.30. Events of 22 February 2014
I turn to events of 22 February 2014. On this day Kane Jones and Ms McHardy visited the deceased at Mobilong. During the visit Mr Jones and Ms McHardy argued about the drug debt. Ms McHardy told the deceased that something had to be sold. The visit was terminated by Mr Jones.
- 5.31. After this visit Kane Jones received a recorded voice message from the deceased. The message included a request to 'tell Mum and Dad I love them'. The tone and content

²⁶ For transcripts of Prison Telephone Calls 21 March 2014-1 April 2014 refer Exhibit C35d

of the message raised concerns about Mr Jones' welfare. Ms McHardy was present when the call was received and she rang the prison to report these concerns.

- 5.32. By Standing Operating Procedure (SOP) 090, the DCS provides a process for raising a Notification of Concern (NOC). A NOC is raised when a staff member becomes concerned about the well-being of a prisoner from a self-harm perspective. If the officer deems the prisoner to be at risk of self-harm or observes any behaviour that suggests to them an increase in the risk of suicide or self-harm, the officer must ensure that the Responsible Officer (either the Accommodation Manager during the day or if after hours, the Officer-in-Charge) is verbally notified. The officer must then complete an NOC form immediately and enter a case note²⁷.
- 5.33. A formal NOC was not raised. However, nursing documentation dated 22 February 2014 noted that the DCS requested a review of Mr Jones.
- 5.34. At the review Mr Jones expressly denied any thoughts of self-harm and said that his girlfriend was visiting him on the following day. Nevertheless, Mr Jones was transferred from his single cell to a double bunk cell in the east wing of Light Unit as a precautionary measure²⁸.
- 5.35. There was further follow-up the next day. Nursing documentation dated 23 February 2014 recorded that the visit between Mr Jones and his girlfriend went well. The records indicate they had talked things over and discussed future plans. Double-up cell accommodation was continued²⁹.
- 5.36. On 26 February 2014, at a medical review, Mr Jones was prescribed Mirtazapine to assist with sleeping and anxiety with a follow-up Medical Clinic review booked for 18 March 2014³⁰.
- 5.37. On 18 March 2014 his medication was increased as there had not been much improvement in his symptoms. A further review was booked for 4 April 2014³¹.

²⁷ Exhibit C27-Statement of Bernard John Gelston at page 7

²⁸ Exhibit C35a at page 17

²⁹ Exhibit C28 at page 4

³⁰ Exhibit C28 at page 4

³¹ Exhibit C28 at page 4

- 5.38. Having considered the evidence I am satisfied that the concerns which were reported by Ms McHardy were appropriately managed by the DCS.
- 5.39. The decision to place Mr Jones in a double bunk cell and to order a series of medical reviews was, in my view, a satisfactory response.
- 5.40. In all of the circumstances there is no basis upon which to criticise the DCS for not raising a formal NOC.
- 5.41. Similarly, based on the information provided by Mr Jones to the SAPHS, I am satisfied that prison medical staff provided an appropriate response to his reported medical needs.
- 5.42. I have considered whether the SAPHS should have ordered a psychiatric review of Mr Jones. Although Mr Jones was suffering from anxiety (and receiving treatment) I find that a full psychiatric review was not indicated on the information made available to the SAPHS.
- 5.43. In these factual circumstances I find that there is no basis upon which to criticise the treatment provided by the SAPHS.
- 5.44. Events from 21 March 2014 to 1 April 2014
Whilst in custody the deceased had regular telephone contact with Ms McHardy and spasmodic contact with family and friends.
- 5.45. A perusal of the transcripts of the prison telephone call records between 21 March 2014 to 29 March 2014 reflect relatively 'normal' conversations³².
- 5.46. However, from 30 March 2014 to 1 April 2014 the nature of the conversations changed.
- 5.47. During some of these calls there was discussion about a man called 'Rob'. Ms McHardy admitted that she was attracted to this man. The deceased appears to have become jealous and agitated at the prospect of her being involved with someone else.

³² Refer Exhibit C35d-Transcripts of Prison Telephone Calls from 21 March-1 April 2014

- 5.48. The conversation at 4:21pm on 30 March 2014 reads as quite intense. The deceased appears to be seeking reassurance from Ms McHardy about the level of her commitment to him. On several occasions Ms McHardy reassured the deceased that she loved him³³.
- 5.49. At 9:16am on 31 March 2014 Ms McHardy spoke to deceased's cell mate. He said that Mr Jones was at court and had asked him to pass on a message to arrange a money order in the amount of \$100. Ms McHardy agreed to facilitate this request³⁴.
- 5.50. One of the items of interest which police subsequently located was a Prison Request Form believed to have been handwritten by the deceased. The form is dated 1 April 2014.
- 5.51. The handwritten information on the form included the name and identification number of the deceased, his cell number and a request to see a social worker. It appears that the request was approved and that Mr Jones was advised of the outcome. There is no time stamp on the form and as such no evidence to ascertain the time at which the form was lodged and/or the time at which the deceased was advised that his request had been approved.
- 5.52. There is no suggestion on the form that the request was urgent. On the available evidence I find that the request was approved and processed efficiently. Given that the request had only been made on 1 April 2014 no adverse inference can be drawn from the fact that the deceased had not seen a social worker.
- 5.53. On 1 April 2014 prisoner Tayler rose at about 7:40am and went to work in the prison assembly room until 11:30am. Mr Jones also went to work in the assembly room that morning.
- 5.54. The deceased had four telephone conversations with Ms McHardy on 1 April 2014 (at 08:57am, 11:47am, 12:07pm and 3:11pm respectively)³⁵. These conversations are relevant to assess the deceased's state of mind.

³³ Exhibit C35d-Call 1882994 at pages 86-88

³⁴ Exhibit C35d-Call 1883020 at pages 88-89

³⁵ Exhibit C35d-Call 1883634 at pages 89-90; Call 1883830 at pages 90-94; Call 1883863 at pages 95-98 and Call 884160 at pages 103-105

- 5.55. The deceased also left two voice messages for Ms McHardy on 1 April 2014 (at 2:03pm and 3:42pm)³⁶.
- 5.56. It is noteworthy that during the call commencing at 11:47am Ms McHardy admitted that there had been some form of sexual contact between her and Rob. It is plain from the transcript of the conversation that the deceased was distressed about this disclosure. The conversation ended with the deceased saying 'I love you Clare. Clare I love you, do you love me?' The call was terminated. It is not entirely clear why the call was terminated, or who terminated it.
- 5.57. During the call which commenced at 12:07pm the deceased pressed Ms McHardy to disclose further details about the sexual contact between her and Rob. He accused Ms McHardy of not being in love with him anymore and said that Rob had no respect. This call appears to have been terminated by Ms McHardy while the deceased was mid-sentence.
- 5.58. Lunch is served in the prison at 12 noon. Prisoner Tayler said that he and the deceased returned to their cell after lunch and had a cigarette. It follows that the deceased went to lunch after the phone call with Ms McHardy at 12.07pm. Prisoner Tayler returned to work at 12:30pm. However Mr Jones remained in the cell. When Prisoner Tayler returned to work he described the deceased as 'fine'.
- 5.59. At 2:04pm the deceased left a voice message on Ms McHardy's phone:
- 'Claire, it's Heath, you shouldn't have hung up on me before hey, it wasn't nice, none of this is nice, um I needed to talk to you, I really wanted to talk to ya, you shouldn't have turned your phone off, this is devastating for me and you turn your off so I can't even talk to ya, that's rude , I guess I just have to live with it ay, I love you baby, I don't know why you didn't believe me, you should have fuckin' believed, you should have listened to what I say and believed when I tell you that I love you because I do, so much, I still do and I always will, goodbye.'
- 5.60. At 2:16pm the deceased rang his brother Kane and left a voice message³⁷. After asking whether he was coming in for a visit week he said, inter alia:
- '...fuckin' devastated, fuckin' talked to Clare today, Clare just told me that she fuckin' cheated on me, she hooked up with this other guy, fucked him and like that fuck, fuckin'

³⁶ Exhibit C35d-Call 1884002 at page 98 and Call 1884231 at page 105

³⁷ Exhibit C35d-Call 1884027 at page 98

devo man, I just wanted someone to talk to, just hoping you would fuckin' answer so I could say G'day...I'll ring you back tomorrow...'

- 5.61. At 2:27pm the deceased telephoned a person called Peter Yon and left a voice message³⁸. The tone of the conversation, so far as it can be inferred from the written transcript, reflects a significant level of stress. He told Mr Yon that Clare had cheated on him and that he was 'devastated' and 'cut up inside'. Towards the end of the call he said 'I need to talk to you man, I need to talk to someone'.
- 5.62. It is evident that by this time the deceased was desperate to speak with a family member or friend about his situation.
- 5.63. At 2:41pm the deceased telephoned his parents³⁹. They were not at home. He spoke to his brother Darren who said they had gone to Broken Hill and would be away until Thursday. He asked whether his parents were planning to visit him on the coming weekend. Darren said they were planning to visit on the Saturday and that he and Kane intended to visit on the Sunday.
- 5.64. Towards the end of the call he said '...I love you bro, tell Kane I love him and if you see mum and dad, tell them I love them and I'll see you's all on the weekend'. At the end of the call the deceased again said 'tell my love to mum and dad, tell Kane I love him...I love you bro'. Mr Jones made no reference to Ms McHardy during this call.
- 5.65. At 2:47pm the deceased telephoned his father and spoke to both of his parents⁴⁰. They received the call while travelling on a train to Broken Hill. There was discussion about upcoming visits and other general matters.
- 5.66. Mrs Jones told the deceased that they were coming to see him on the following Saturday morning. The deceased told his mother that he loved her and asked her to tell his father that he loved him to which his mother replied '...yeah yeah and Heath come on, be strong...be strong be...don't, don't do anything silly'. It can be inferred from this statement that there was something in the tone of the conversation of her son's demeanour which caused Mrs Jones a level of concern. During this call the deceased did not mention Ms McHardy.

³⁸ Exhibit C35d-Call 1884045 at page 99

³⁹ Exhibit C35d-Call 1884090 at pages 99-101

⁴⁰ Exhibit C35d-Call 1884126 at pages 102-103

- 5.67. It is plain from these conversations that the deceased's mental state was spiralling downwards.
- 5.68. At 3:11pm the deceased spoke to Ms McHardy.⁴¹ He told her that he wanted her to be alone while he spoke with her. He asked her not to hang up and said she would not like what she was going to hear. The following exchange then took place:

MALE Clare, this is the last time you are ever going to speak to me okay, so don't

FEMALE oh the last time

MALE so don't hang up on me because

FEMALE what are you going to do, kill yourself?

MALE no, of course not but listen to me, listen, okay, are you listening?

FEMALE Yep

MALE I want you to give the car that's at your house, both of the cars that are at your house to my little brother, Darren

FEMALE okay, is he going to come with a tow truck?

MALE Yep

FEMALE okay go on

MALE give him both of those cars

FEMALE okay

MALE and tell Kane... That he can have my Lancer and he's not to sell it, he is to keep it, all right

FEMALE what are you going to do, top yourself?

MALE listen, listen, okay, now you told me before that I told you once, I don't care if you get with someone just once, this once of thing ra ra ra ok, yeah and I agreed, I did say that but look what you went and did

FEMALE what did I do

MALE look what you went and did... Look who you hooked up with... This is the last time you are ever going to speak to me okay

FEMALE fine, good

MALE I loved you; you should have believed me when I told you that hey

FEMALE yeah well if it was true, you wouldn't be saying what you're saying now then hey

MALE hey listen,

FEMALE funny how, you can do it, I can't do it though hey...

MALE: I loved you Clare you should have believed me

FEMALE no you don't, because if you did, you wouldn't be saying the shit that you just said...

MALE you don't love me, you've never loved me Clare, you've never loved me

⁴¹ Exhibit C35d-Call 1884160 at pages 103-105

FEMALE oh really

MALE you've never loved me okay... No, you don't, I loved you Clare

FEMALE no, you just answered my questions, for me

MALE okay, I've rang everyone, I've talked to my mum, I've talked to my dad, I've talked to my little bro, I rang Kane he didn't answer I left a message on his message bank

FEMALE oh by the way, I just wanted to let you know I made that whole thing up, sucked in

MALE no you didn't and listen'

- 5.69. It is clear from Mr Jones' response that he did not accept Ms McHardy's claim that she made up the story about her infidelity.
- 5.70. A few minutes later at around 3:15pm a fellow prisoner (Prisoner Marshall) had a chat with Mr Jones and shared a cigarette⁴². Prisoner Marshall was housed in cell 45 which is diagonally opposite cell 25. He fixes the time of his visit by reference to the commencement of medication being dispensed (which takes place at around 3:15pm). He had noticed prisoners going to the medication window⁴³.
- 5.71. Prisoner Marshall described the deceased as 'a little stressed'. Mr Jones told him that he had just had a fight with his girlfriend on the phone. Prisoner Marshall tried to talk to him about the issue and said that tomorrow was a new day. He did not think that Mr Jones appeared to be suicidal, depressed or acting strangely.
- 5.72. Prisoner Marshall said that he left the cell at around 3:55pm. He fixes this time by reference to a TV remote control device. After he left the cell Prisoner Marshall pressed a button on his TV remote control which showed the date and time.
- 5.73. It is noted that no reference is made to the deceased making a telephone call at 3:42pm (the final voice message to Ms McHardy)⁴⁴. It is possible that the deceased left the cell to make the 3:42pm call or that Prisoner Marshall left the cell while that call was being made. However, Prisoner Marshall also makes no reference to leaving the cell during the visit. Another possibility is that the call was made by the deceased in his cell and that Prisoner Marshall is mistaken about the time he saw recorded on his remote control device. If so then he may have left the deceased before 3:42pm.

⁴² Exhibit C10-Statement of Rodney Adam Marshall

⁴³ Exhibit C10 at page 3

⁴⁴ Refer Inquest Findings at [3.75]

- 5.74. The issue is relevant to determine the timeframe within which the deceased placed the ligature around his neck.
- 5.75. Either way I am satisfied that by 3:11pm the deceased's mental state had deteriorated to such point that he was contemplating suicide. By this time the deceased was giving instructions about the distribution of his personal possessions to family members and telling Ms McHardy that this was the last time she was ever going to speak to him.
- 5.76. This conclusion is reinforced by the fact that the police subsequently located a suicide note in the cell⁴⁵. The note reflected the contents of the earlier telephone conversation between the deceased and Ms McHardy:
- 'I loved you Clare McHardy. I thought you loved me. I was wrong. You should have believed me. Goodbye. xoxoxox
See you in the next life.
Please make sure Clare gets this please.'⁴⁶
- 5.77. On leaving the cell Prisoner Marshall noticed that the deceased had shut the cell door and put a towel over the cell observation window. It is a common but not an approved practice for prisoners during unlock hours to close the cell door and placed something over the viewing panel when they use their toilets. The toilet is in direct line of sight of the viewing panel and any person who is walking by, and the towel provides privacy. The Managers' Rule expressly instruct prisoners not to block viewing panels for safety reasons. Staff will challenge any prisoner who blocks a viewing panel⁴⁷.
- 5.78. Prisoner Marshall went to the common area to line up for his evening meal.
- 5.79. At 3:42pm the deceased left a final voice message for Ms McHardy. He said 'see you in the next life Clare McHardy'⁴⁸.
- 5.80. The deceased's cell mate, Prisoner Tayler, says he returned to cell 25 at around 4pm. He noticed the towel over the cell window and assumed that Mr Jones was using the toilet so he went away for 5 to 10 minutes to provide privacy.
- 5.81. On returning the towel was still at the window, something which he thought was strange. Prisoner Tayler knocked on the cell door and said 'are you still on the toilet?'

⁴⁵ Exhibit C34-Photograph SW 31

⁴⁶ Exhibit C34, page 5 and Exhibit C34a, photograph SW 31

⁴⁷ Exhibit C27 at page 17

⁴⁸ Exhibit C35d-Call 1884160 at page 105

There was no response. He opened the door and saw Mr Jones slumped over on the toilet and unresponsive. On discovering the noose around his neck Prisoner Tayler immediately ran for help.

- 5.82. If Prisoner Marshall is correct about the time he left the cell the deceased placed the ligature around his neck sometime between 3:55pm and 4pm. If he is mistaken about that time then it is likely that the deceased placed the ligature around his neck sometime between 3:42pm and 4pm (the latter time being the time at which the Code Black was called).
- 5.83. On the available evidence it is not possible to say whether the outcome may have been different if the towel had not been placed over the window. This would depend on a range of factors including a staff member or prisoner noticing something amiss and raising the alarm. It would be mere speculation to suggest that removal of the towel would have necessarily have led to a different outcome.

6. Medical treatment (Mobilong Prison, Med STAR and Flinders Medical Centre) and response by officers of the Department of Correctional Services

- 6.1. CSOs Tilley, Taylor and Freer were the first to arrive at cell 25⁴⁹. Upon entering the cell they saw Mr Jones slumped forwards. They saw the noose around his neck.
- 6.2. CSO Taylor cut the ligature with a Hoffman knife and released Mr Jones. CSO Freer then controlled the scene and cleared the prisoners from the wing.
- 6.3. CSOs Tilley and Taylor began CPR with the assistance of a self-inflating resuscitator until prison medical staff and SAAS paramedics arrived to provide assistance.
- 6.4. The first SAPHS officers to arrive were nurses Lucy Howard and Diana Badcock⁵⁰. Nurse Howard arrived within minutes of the Code Black being called and assisted with resuscitation efforts until ambulance officers arrived and took over.
- 6.5. It is noted from statements tendered to the Inquest that several other CSOs also responded to the Code Black. Their main role was to assist in securing prisoners at the time of the emergency, escorting medical staff to the area, creating an incident log, strip

⁴⁹ Exhibits C5, C6 and C7

⁵⁰ Exhibit 20 and Exhibit 21

searching Prisoner Tayler and seizing evidentiary items such as the laundry bag, the Hoffman knife and the deceased's clothing and labelling exhibits⁵¹.

- 6.6. I find that the Code Black was called immediately upon the discovery of Mr Jones shortly after 4pm and that resuscitation was commenced without delay. An ambulance was promptly called.
- 6.7. I am satisfied that the CSOs, SAPHS staff and SAAS paramedics did everything they could to resuscitate Mr Jones, and that they responded with professionalism and efficiency. There are no grounds for criticising any of them in relation to this issue.
- 6.8. In relation to the DCS officers, I have read and considered the relevant standard operating procedures and policies of the DCS.
- 6.9. I find that DCS staff acted in accordance with the relevant operating procedures. There is no basis to criticise the timeliness or appropriateness of their response.
- 6.10. Treatment at Murray Bridge Memorial Hospital
I turn now to the medical treatment received at the Murray Bridge Memorial Hospital. As previously stated Dr Thomas was the on-call emergency doctor. She assessed her patient's history and presentation on arrival at hospital and the MedSTAR service was called for advice and retrieval. A morphine/midazolam infusion was commenced in accordance with the advice received.
- 6.11. Prior to being placed into the care of MedSTAR, Mr Jones was administered a dosage of propofol to assist in keeping him sedated for the flight as well as fentanyl for pain relief. He was placed on the MedSTAR ventilator and monitored throughout the flight.
- 6.12. MedSTAR Emergency Retrieval Team
It is apparent from the evidence that the response and treatment provided by the MedSTAR retrieval team en route to the FMC was professional and appropriate. I find no grounds for criticism in relation to the response and treatment provided by this team.
- 6.13. Flinders Medical Centre
Similarly, the treatment received at the Flinders Medical Centre by the critical care team

⁵¹ Refer Exhibits C13, C14, C15, C16-16a, C17 and C18

was of a high standard. There is no basis upon which to criticise any aspect of the medical response.

7. Response of South Australia Police (SAPOL)

- 7.1. After the deceased was discovered in his cell several South Australia Police (SAPOL) officers were was tasked to attend at Mobilong and also at the Murray Bridge Hospital⁵².
- 7.2. Prior to their arrival cell 25 in Light Unit had been sealed with exhibit tape to ensure the integrity of the scene. The police engaged in a range of activities including seizing exhibits and conducting interviews with prisoners and DCS staff. A number of statements were taken from potential witnesses.
- 7.3. Senior Constable Shane Wisseman (Murray Bridge Crime Scene) was recalled to duty at around 6:05pm on 1 April 2014⁵³.
- 7.4. I have read and considered the statements of all SAPOL officers including the extensive report and statement of the investigating officer, Brevet Sergeant Peter Moore, as well as the annexures to his statement.
- 7.5. I find that all SAPOL officers acted efficiently and professionally.
- 7.6. There is no basis on which to criticise the SAPOL response or any aspect of the subsequent investigation.

8. Summary and findings

- 8.1. On 20 December 2013 Heath Ryan Jones was taken into the custody at Yatala Labour Prison as a prisoner on remand. He was thereafter at all material times in lawful custody.
- 8.2. The mandatory 7 day observation and screening procedure at Yatala Labour Prison and the assessment of Mr Jones as being at low risk of harm to himself or others was appropriate in light of the available information.

⁵² Refer Exhibits C30, C31, C32, C33

⁵³ Exhibit C34 and 34a

- 8.3. The deceased was transferred from Yatala Labour Prison to Mobilong Prison on 30 December 2014. The mandatory 7 day observation and screening procedure was conducted appropriately.
- 8.4. The transfer of the deceased to a double bunk cell in the east wing of Light Unit on 22 February 2014 was a prudent and appropriate precautionary measure in response to the concerns raised by Ms McHardy. The circumstances, as known to the DCS at that time, did not warrant a formal NOC being raised.
- 8.5. The deceased had regular medical reviews which included a review of medication on 26 February 2014 and an increase in medication on 18 March 2014. A further review was planned for 4 April 2014.
- 8.6. I find that the circumstances and medical symptoms as reported by the deceased did not indicate the need for a full psychiatric assessment whilst he was in custody at Mobilong Prison.
- 8.7. Based on the information available to the prison authorities and medical staff, I find that the treatment provided by the SAPHS was adequate and appropriate.
- 8.8. In relation to the deceased's request to see a social worker (by completion of a Prison Request Form dated 1 April 2014):
- 1) I find that the contents of the application did not indicate any urgency or need for an immediate consultation;
 - 2) I find that the request was approved and that Mr Jones was made aware of this fact;
 - 3) In these circumstances no adverse inference can be drawn from the fact that the deceased did not see a social worker on the same day as the request was made.
- 8.9. On 1 April 2014 CSOs the Code Black was called promptly and in accordance with the Standard Operating Procedures for a Medical Emergency.
- 8.10. I find that the South Australian Ambulance Service (SAAS) was contacted without delay.
- 8.11. I further find that:
- 1) CSOs responded appropriately by cutting the ligature and attempting resuscitation pending the arrival of and assistance of SAPHS;

- 2) The SAAS paramedics acted with skill and professionalism and continued resuscitation efforts pending the transfer of Mr Jones from Mobilong Prison to the Murray Bridge Soldier's Memorial Hospital by ambulance;
 - 3) The on-call emergency doctor at the Murray Bridge Soldier's Memorial Hospital continued treatment, intervention and assessment in a decisive and professional manner and sought prompt advice and retrieval by MedSTAR;
 - 4) The MedSTAR rescue service officers acted with professionalism and skill during the transfer of the deceased by helicopter to the Flinders Medical Centre;
 - 5) The medical team at the FMC Intensive Care Unit acted in a decisive and skilled manner and appear to have acted with sensitivity to the family of the deceased before medical intervention and treatment was withdrawn and the decision was made to facilitate organ donation. There is no doubt that this decision saved the lives of other persons. I hope that the Jones family derives some comfort from this life saving gesture.
- 8.12. Overall, the evidence taken together points to the presence of a number of escalating pressures on Mr Jones, the combined effect of which led him to take his own life. These stressors included his relationship difficulties, the drug debt and his pending court matters and the likelihood of a sentence of imprisonment.
- 8.13. I find that the full extent of these were matters personal to the deceased and not known to the DCS.
- 8.14. I find that between 3:11pm and 3:42pm it is likely that the deceased was reflecting and ruminating about his personal situation and that at around this time he made the decision to end his own life. I find that he did so without the assistance or involvement of any other person.
- 8.15. The discovery that Ms McHardy was sexually involved with another man was likely in my view to have triggered the final decision to use a ligature to self-harm.
- 8.16. Ms McHardy believes that Mr Jones did not intend to die. She reasoned that he attempted suicide to 'make a big statement' about his love for her and in circumstances where 'he knew he would be found'. She said 'I know he didn't mean to go through with it I know that for a fact'⁵⁴.

⁵⁴ Exhibit C29 at page 6

- 8.17. In my opinion this assertion is speculative and is most likely a response to feelings of guilt associated with the last phone calls (and perhaps the fact that two calls made to her by the deceased including the final call at 3:42pm were left unanswered).
- 8.18. I find that the objective facts including the organisation of his personal affairs, the contents of the voice message at 3:42pm, together with the suicide note, lead to the conclusion that the deceased intended to take his own life.
- 8.19. That said, it would be unfair I think to suggest that Ms McHardy should have realised or foreseen the impact that her words and statements would have on the deceased's mental state. He denied any intention to kill himself even when directly asked the question by Ms McHardy. Neither should it be forgotten that on a previous occasion Ms McHardy had raised concerns for his welfare with the DCS and that her actions led to precautionary measures being put in place (ie the double-up cell). In short, I consider it likely that Ms McHardy would have been genuinely upset and shocked by Mr Jones' death.
- 8.20. The deceased had methylamphetamine in his system (from an unknown source) albeit a low level of the drug (0.04mg in 1L). As stated by Dr Charlwood, given the overall circumstances, the level of methamphetamine cannot be considered to be a direct factor in the death. I make no finding about the presence of methamphetamine except to concur with Dr Charlwood that it could potentially have some bearing on the deceased's state of mind at the relevant time.
- 8.21. There is insufficient evidence to make any finding as to circumstances or source of the drug or the degree to which the low levels detected by toxicology testing may have contributed to the deceased's decision to self-harm.
- 8.22. At the end of the day it must be observed that the deceased was able to hang himself in the cell because of the existence of a hanging point in his cell, namely a towel rail. It is noteworthy that the cell is still the same as when it was commissioned, with a chrome towel rail fitted above the toilet⁵⁵.
- 8.23. It is true that it is very difficult to eliminate prison cell hanging points entirely. That said, it is possible.

⁵⁵ Exhibit C27 at page 14

9. **Conclusions**

9.1. Previous Inquest findings have made many recommendations about the need to remove hanging points in order to render prison cells safe in South Australia in correctional institutions (eg at the Adelaide Remand Centre (ARC), Yatala Labour Prison and Port Augusta Prison).

9.2. On 6 May 2015 the Deputy State Coroner, Mr Anthony Schapel, made findings and recommendations in relation to the death of Shane Rene Blunden⁵⁶ who died at the Yatala Labour Prison. Mr Blunden was aged 18 years at the time of his death. He used a ventilation grille as a hanging point. In the Blunden Inquest the Deputy State Coroner said:

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

9.3. The Deputy State Coroner noted that it had been explained by the General Manager of Yatala Labour Prison that at that time ventilation grilles were being replaced at Yatala with devices that ought to prevent the attachment of ligatures. Nevertheless, he stated that until all obvious ligature points are removed from cells within the correctional institutions of South Australia, this Court will keep repeating that there is a very urgent need for the removal of ligature points in such cells.

9.4. It can equally be said that a towel rail is an obvious hanging point.

⁵⁶ Inquest 10/2014

- 9.5. The Court received into evidence a report tabled on 9 February 2016 before the House of Assembly.⁵⁷
- 9.6. Since the Inquest into the death of Shane Renee Blunden the DCS has re-evaluated its risk management process and has taken steps to act on the recommendation regarding the identification and elimination of hanging points from cells to ensure that safe cell designs are applied throughout the prison system.
- 9.7. The resources are targeted towards those accommodation areas that hold prisoners presenting the greatest risk of suicide or self-harm, and newly admitted prisoners. The DCS has issued a policy that ensures renovations and upgrades of existing prison cells are undertaken in accordance with a risk based approach.
- 9.8. As resources are allocated to renovate cells to ‘safe cell’ standards, the DCS refers to a Priority Tiering System as follows:
- ‘Tier 1 Priorities - Observation Cells used for camera or physical observation of prisoners at risk of suicide or self-harm who have been separated in the interests of their safety and welfare pursuant to section 36(2) of the Correctional Services Act, 1982.
- Tier 2 Priorities - Management Cells used to manage prisoners separated under section 36(2) of the Correctional Services Act, 1982 (and which are not specifically observation cells as defined in Tier 1).
- Tier 3 Priorities - Admission/Induction cells, namely secure prison cells in the administration/induction unit.
- Tier 4 Priorities - Secure cells in High Security Prisons with Secure Zones as first priority and Residential zones as second priority.
- Tier 5 Priorities - Secure cells in Medium Security Prisons with induction units as first priority and all other secure cells as second priority.’⁵⁸
- 9.9. The DCS has completed all Tier 1 and Tier 2 cells and is currently prioritising Tier 3. In recent years additional cell accommodation units have been designed and constructed to meet the principles of safe cells (eg Banksia Unit at Pt Augusta Prison and WaaWoor Unit at Mt Gambier Prison).
- 9.10. It is commendable that the DCS has commenced this process. That said, it appears that cell 25 in the East Wing of Light Unit at Mobilong (and presumably other secured cells) would be categorised as the lowest in priority, that is, a second priority in Tier 5.

⁵⁷ Exhibit C43

⁵⁸ Exhibit C43, page 4

- 9.11. Mr Jones' suicide demonstrates how simple it is for a person to take their own life in such a cell.
- 9.12. The Manager of Security at Mobilong Prison stated that to the best of his recollection Mr Jones' death was 'probably only the second hanging that I can recall in this prison since I commenced here in 1989'. That may be so, but the low statistic can provide no comfort to the grieving family and friends of the deceased.

10. Recommendations

- 10.1. Section 25(2) of the Coroner's Act 2003 empowers the Court to add to its findings any recommendations that might, in the opinion of the Court, prevent, or reduce the likelihood of, a reoccurrence of an event similar to the event that is the subject of this Inquest.
- 10.2. I therefore make the following recommendations directed to the Minister for Correctional Services and the Chief Executive Officer of the Department for Correctional Services:
- 1) That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions.
 - 2) That the Tier 3, 4 and 5 Priorities as set out in the Report to the House of Assembly by the Chief Executive of the Department for Correctional Services dated 9 February 2016 be implemented as a matter of urgency.

Key Words: Death in Custody; Suicide; Hanging Points

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

Seal the 30th day of January, 2018.

Deputy State Coroner