CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 9th day of November 2018 and the 30th day of April 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Nicholas Edward Bell.

The said Court finds that Nicholas Edward Bell aged 29 years, late of Mobilong Prison, Maurice Road, Murray Bridge, South Australia died at Murray Bridge, South Australia on the 29th day of April 2015 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Nicholas Edward Bell died on 29 April 2015 in Mobilong prison. Mr Bell's death was therefore a death in custody within the meaning of that expression in the Coroners Act 2003 and this inquest was held as required by section 21(1)(a) of that Act.

1.2. A post-mortem was conducted by Dr John Gilbert who gave the cause of death as neck compression due to hanging[1], and I so find. A toxicology report[2] noted that no relevant substances were found in Mr Bell's system.

2. Background

2.1. Mrs Edwina Robson is Mr Bell's mother. She stated that Mr Bell was born in Adelaide and is the youngest of four brothers. It appears he struggled at school with dyslexia and left school illiterate. To her knowledge, Mr Bell had never worked.

---

[1] Exhibit C2a
[2] Exhibit C3a

2.2. The relationship between Ms Robson and Mr Bell’s father was characterised by domestic violence. His father drank a lot and on a number of occasions Mr Bell and his mother fled to shelters. The relationship between Mr Bell's mother and father took its toll on Mr Bell who apparently became depressed and, according to his mother, commenced antidepressants. Once Mr Bell's mother finally separated from his father Mr Bell moved in with his father. The separation was acrimonious and there followed a breakdown of the relationship between Mr Bell and his mother.

2.3. Mr Bell's criminal history started in 2001 with an offence of larceny as a juvenile. His first imprisonment was in 2003, and he continued to go to prison for various offences with sentences ranging from three months to six years and nine months thereafter.

2.4. At the time of his death Mr Bell was a sentenced prisoner with a sentence of five months 25 days. He was due to be released on 22 September 2015.

2.5. Mr Bell had a documented history of mental illness. He was also noted to have made previous attempts to commit suicide. In May 2008 he was assessed by a doctor as suffering from alcohol abuse disorder. Mr Bell was assessed at various points during his incarceration and whilst on parole, up until his last remand.

2.6. On 24 September 2013 whilst a prisoner at Yatala Prison, he inflicted a one-inch laceration to his wrist using a razor blade. He was taken to the Royal Adelaide Hospital where he was treated. Thereafter, he was regularly assessed by a number of psychiatrists including Dr Jennings, Dr Raeside, and Dr Chiew.

2.7. During 2014, while in the community, Mr Bell was assessed by DASSA and approved for a buprenorphine program. His general practitioner believed he was suffering from a drug induced psychosis with disturbance of thought, along with delusions and hallucinations. He was referred to psychologist, Mr Hare who noted that Mr Bell complained he had been experiencing delusions and hallucinations. He had been actively using methamphetamine and heroin and drinking excessively. However, Mr Bell expressed that he wanted assistance and had stopped taking drugs. Mr Hare diagnosed Mr Bell with adjustment disorder, mixed anxiety and depressive mood. Mr Bell told Mr Hare that he had some transient suicidal ideation, but had not formulated a plan or definitive intention.

2.8. Mr Hare telephoned mental health triage at Noarlunga Emergency Mental Health Services and was concerned that the medication Mr Bell was on was not having any

effect on his hallucinations and delusions. Mr Bell was contacted by the mental health triage to arrange a psychiatric assessment. On 18 July 2014, Mr Bell was seen by Dr Jennings who recommended he continue with his buprenorphine and mirtazapine. Mr Bell failed to keep a number of appointments with Mr Hare, however on 4 September 2014 he did attend. He was still reporting hallucinations and experiencing some paranoia, but this was improving and was less intrusive.

2.9. Elizabeth Sloggett is a registered nurse with the SA Prison Health Service. She stated that when arrested for the offending which led to his last period of imprisonment Mr Bell was taken to Flinders Medical Centre for assessment and cleared with a recommendation for psychiatric review. In the Adelaide Remand Centre his suicidal ideations resulted in a notice of concern being raised and he was placed on the high-risk assessment team list (HRAT). He was also identified as a high priority to be seen by a medical officer.

2.10. On 17 March 2015, Mr Bell was transferred to Mobilong Prison and a nursing note indicated that he had no thoughts of self-harm. He was booked in for a nursing clinic on 19 March 2015.

2.11. On 30 March 2015 Mr Bell was booked in for hepatitis screening. Also on that date he was seen by a medical officer, Dr Rosemary Neild, and this was the last time Mr Bell was seen by any medical staff. Dr Neild said that a nursing assessment had been made and she herself had made an assessment. Mr Bell did not present any concerns to her. His behaviour had not set off any alarms bells. Dr Neild said that Mr Bell had regular contact with nurses and correctional officers and no concern was raised. If any of those people had expressed concern about his mental health, a psychiatric assessment would have been organised.

3. <u>The events of 29 April 2015</u>

3.1. On 29 April 2015 correctional officer Danielle Marchant was working at Mobilong Prison. She was performing a weekday daily routine of a lockdown so that social areas of the prison could be cleaned. Prisoners had the choice of staying in their locked cells or going outside whilst the cleaning was performed. The process of lockdown commenced at about 9:30am.

3.2. Mr Bell was in cell 36. Ms Marchant asked Mr Bell if he was 'In or out'. Mr Bell was alone and decided to remain in his cell. His curtains were drawn and his TV was on. At about 10:45am the cell doors were opened again. Officer Marchant does not recall if she looked into Mr Bell's cell when she unlocked it.

3.3. At about 11am correctional officers Marchant and Green went to Mr Bell's cell and found him hanging from a towel rail with a belt around his neck. A code black was called and CPR administered. A defibrillator was used until the SA Ambulance Service arrived. CPR continued but Mr Bell was pronounced dead.

3.4. A number of inmates have provided statements. Mr Andrew Sokola was Mr Bell's cellmate. He explained that Mr Bell was difficult to converse with as he mainly kept to himself. The night before his death as they were lying on their beds watching TV Mr Bell laughed, and said without any explanation 'Everyone expects me to kill myself'. Apart from this random utterance there was nothing exceptional about Mr Bell's behaviour.

3.5. Overall, the evidence of the other inmates who knew Mr Bell described him as being quiet, well-mannered, and keeping to himself. In short, there was nothing remarkable in Mr Bell's behaviour that caused them concern, or to think that he might take his own life.

4. <u>Conclusion</u>

4.1. Mr Bell clearly had a troubled life and was a user of illicit drugs. Unfortunately there was nothing that could have been done on the evidence before me that might have prevented his tragic death. I have no recommendation to make in this matter.

Key Words: Death in Custody; Prisoner; Natural Causes

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

Seal the 30th day of April, 2019.

State Coroner