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 4th, 5th, 6th, 7th and 10th days of December 2018 and the 20th day of December 2019, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Martina Morgan.*

*The said Court finds that Martina Morgan aged 60 years, late of 7/1 Clifton Avenue, Morphettville, South Australia died at the Sturt Police Station, 333 Sturt Street, Bedford Park, South Australia on the 20th day of March 2015 as a result of neck compression by ligature strangulation. The said Court finds that the circumstances of her death were as follows:*

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

1.1. These are the Court's findings in relation to an inquest into the death in police custody of Martina Morgan who died on Friday 20 March 2015. She was aged 60 at the time of her death.

1.2. Ms Morgan died in cell 8 of the South Australia Police Sturt Police Station cell complex. She had been arrested for an alleged behavioural offence. In the cell complex she removed the leggings that she had been wearing and then tied them around her neck. The leggings in fact constitute the ligature that is recited in the cause of Ms Morgan's death set out above. The neck compression caused by the fixation of the ligature around her neck caused her death by strangulation.

1.3. Ms Morgan's body was subjected to a post mortem examination carried out by Dr Karen Heath who is a forensic pathologist at Forensic Science South Australia.

Dr Heath's post mortem report was tendered to the inquest[1]. Dr Heath's findings support her opinion that the cause of Ms Morgan's death was neck compression by ligature strangulation. I find that to have been the cause of Ms Morgan's death.

1.4. It is not necessary to recite the contents of Dr Heath's report in detail. However, it is pertinent to refer to the toxicological analysis of a specimen of blood and other bodily fluids that were obtained at autopsy. The blood alcohol concentration was analysed to be 0.23% with the vitreous alcohol concentration being 0.30%. These are high concentrations consistent with significant impairment. In addition, therapeutic concentrations of oxycodone, diazepam, nordiazepam and temazepam were present in the blood. Oxycodone is an opioid drug that is prescribed for pain. Diazepam and temazepam are both benzodiazepines. Benzodiazepines such as diazepam, temazepam and Serepax are prescribed for anxiety, insomnia and other disorders. Tetrahydrocannabinol was also present in the blood and this is consistent with acute intoxication with cannabis.

1.5. It is plain from the whole of the evidence that Ms Morgan was grossly intoxicated both at the time of her arrest and when placed in the cell in which she would die. Indeed, very high breath analysis readings had been taken by police responsible for her custody at the Sturt cell complex. These readings confirmed both in their eyes as well as in fact that Ms Morgan was significantly affected by alcohol. Her behaviour both at the scene of her arrest and in the cell complex was highly indicative of that. It is accepted that Ms Morgan was grossly intoxicated and that this was well understood by officers who had responsibility for her custody and care.

1.6. It is also noted that diazepam was present in Ms Morgan's blood at autopsy. Diazepam is also known as Valium. A subsequent search of Ms Morgan's unit revealed the presence of Valium. It had been prescribed for her. Ms Morgan's gross intoxication and the issue of Valium consumption are matters that will be demonstrated as having relevance to the issues with which this inquest is concerned.

1.7. The entire duration of Ms Morgan's placement in cell 8 at the Sturt cell complex, a period of about one hour and forty minutes, was captured on CCTV. The recorded footage shows Ms Morgan removing her leggings, the affixing of them to her neck and her resultant collapse and death. The CCTV coverage was monitored on a screen in the room known as the charge office which is not far from Ms Morgan's cell. It is apparent

[1] Exhibit C2a

that although Ms Morgan was the subject of mandatory 15 minute physical observations conducted by cell staff, she was not physically sighted between 9:05pm and 9:23pm when she was found to be in cardiac arrest. The intervening events included Ms Morgan's act of removing her leggings and placing them around her neck and then her resulting collapse onto the floor of the cell where she remained motionless until she was found by cell staff. All of those intervening events, as I say fully displayed on the CCTV monitor in the charge office, went unseen by cell staff.

1.8. Adequate but unfortunately unsuccessful attempts at resuscitation of Ms Morgan were carried out. Naturally included within those measures were the summoning of the South Australian Ambulance Service who promptly arrived.

1.9. As Ms Morgan died in police custody a mandatory inquest was conducted into the cause and circumstances of her death.

## 2. The circumstances of Ms Morgan's arrest

2.1. Ms Morgan occupied a housing trust unit at 1 Clifton Street, Morphettville. Ms Morgan occupied unit 7. Ms Morgan had occupied that unit for a number of years. Evidence was adduced in the inquest that Ms Morgan tended to be a disruptive figure within the unit complex. She was a troubled individual who in large part had led an unhappy life that was marred by diagnosed physical and mental difficulties. She was said by other occupants of her unit complex to be violent, offensive and verbally abusive and had generally harassed residents, particularly when she was drinking alcohol. It was said that at one stage a car had been damaged by her. A number of complaints to Housing SA regarding Ms Morgan's behaviour had been made and a number of warning letters had been issued to Ms Morgan in respect of those complaints.

2.2. It is clear that at the time of Ms Morgan's arrest in the late afternoon of Friday 20 March 2015 she was grossly intoxicated. Loud music could be heard emanating from Ms Morgan's unit and Ms Morgan was screaming obscenities from within. She was the only occupant of the unit at that time. A threat was allegedly made to bash a female resident of the complex and as a result the police were called.

2.3. Constables Hogg and Leavold attended the complex at about 6:15pm. The nature of the complaint was that the occupant of number 7 was verbally abusing and threatening another resident of the block.

2.4. I heard oral evidence from Constable Hogg and a witness statement of Constable Leavold was tendered.

2.5. Upon the arrival of the officers, Ms Morgan who at first was standing at the front door to her unit, was verbally abusive towards police telling them among other things to '*fuck off*'. The screen door was open. Ms Morgan retreated into the interior of her unit where she continued her abuse. Ms Morgan turned the volume of her stereo to an even higher level which prompted the officers to investigate the means by which the electricity supply could be cut to her unit. The power box was located and the electricity was cut off. During this period Ms Morgan continued to use abusive language towards police. After the power was disconnected the two officers waited at the side of Ms Morgan's unit with the intention of arresting her if and when she emerged from the unit. Ms Morgan eventually did walk outside where she was told by the officers that she was under arrest for disturbing the peace contrary to section 7(2) of the Summary Offences Act 1953. That provision imposes a maximum fine of $1250 or imprisonment for three months.

2.6. Accepting the evidence of Constables Hogg and Leavold as I do, as well as the statements of the witnesses who described Ms Morgan's behaviour prior to the arrival of police, it is plain that the officers had a reasonable suspicion that Ms Morgan had committed the offence of disturbing the public peace and for that reason were entitled to arrest her for that offence.

2.7. The nature of Ms Morgan's behaviour both in respect of her neighbours and of the police officers who attended would have engendered no confidence on the part of the officers that her behaviour in general and specifically towards her neighbours would have improved merely as a result of any warning issued by the officers. To my mind the arrest of Ms Morgan, as distinct from some other measure, was justified on the basis of the prevention of a continuation of an offence. In my opinion Ms Morgan's arrest was both lawful and appropriate.

## 3. <u>Ms Morgan is conveyed to the Sturt cell complex</u>

3.1. Following Ms Morgan's arrest she was conveyed in the rear of a police cage car to the Sturt cell complex. At about 6:51pm the cage car was reversed into a sally port connected to the cell complex. Two SAPOL members were stationed in the cell complex for that shift. They were Sergeant Roger Sampson who was the officer in

charge of the cell complex and Senior Constable Brent Rogers who was the cell guard. There would be other officers entering the cell complex from time to time, including the officers who arrested Ms Morgan as well as officers who were responsible for the arrest of two other individuals, one of whom, a Mr Z, at some point was also placed in the cells. The responsibility for the care of prisoners was that of Sergeant Sampson and Senior Constable Rogers.

3.2. At that time the function of a SAPOL cell complex such as the Sturt complex was to process arrested prisoners and either admit them to police bail or to hold them in custody pending a court appearance. In Ms Morgan's case the intention was to admit her to bail once police were satisfied that she could be released and was able to look after herself. Shortly after her arrival at the complex a breath analysis revealed a reading of 0.221. A later analysis at about 8:50pm, approximately 35 minutes before her death, revealed 0.169, still a very high reading. There was no further analysis. The aim was that once Ms Morgan descended to 0.10% she would be released. In my view a refusal of immediate bail was justified pursuant to section 10(1)(e) of the Bail Act 1985 on the basis that Ms Morgan required care. Another justification for not immediately releasing Ms Morgan on bail would have been the prospect that in her intoxicated state she would have returned to her home address and have continued to offend, an approach to bail that was justified pursuant to section 10(1)(b)(ii) of the Bail Act. Thus, keeping Ms Morgan in custody from the time of her arrest until the time of her death was lawful and appropriate and I so find. I find that it was explained to Ms Morgan that she would ultimately be released on bail but that she maintained an insistence that she be allowed to go home being angry that she was, in her eyes, being held against her will.

3.3. During the time that Ms Morgan was in her cell she would yell out, as could be heard from her cell, and which can be heard on the audio of the CCTV footage, and she would persistently use the intercom from her cell to the charge office.

3.4. There is one matter that I should deal with at the outset and it concerns the fact that at times which are not completely clear a television was on in the charge office. Evidence was tendered to the Court that a one day international cricket match between Australia and Pakistan, being a quarter final of the World Cup, was being televised live during the course of that evening and that this occasionally was on the television, both picture and sound. Transcripts of the audio of the CCTV footage of the cell area, particularly

in the proximity of the charge office, reveal that at various times the cricket was on the television and that from time to time comment was made by one officer or another about the state of the game. An ESPN Cricinfo analysis of this cricket match was tendered to the Court[2]. This document suggests that the match concluded with an Australia win at approximately 9:10pm that evening. This was approximately 13 or 14 minutes prior to Ms Morgan being located deceased in her cell. I am not entirely certain whether or for how much of the time when Ms Morgan was collapsed on the cell floor the television had been on. At that time the watching of television by officers was only permitted in limited circumstances. I will discuss in further detail the activity of police that was taking place in the cell complex at around the time of Ms Morgan's collapse and death. Suffice it to say for present purposes it appears that for the most part the officers present at the cell complex were occupied with the processing of a prisoner, one D, who had been arrested and brought to the charge counter for processing. I detected no evidence from the oral testimony that was given during the course of this inquest, nor from the video or the audio of the CCTV footage, to suggest that during the period in which Ms Morgan was collapsed on the cell floor officers were distracted by the cricket match on television. While potential distractions such as this are clearly undesirable, there is no evidence that it had any impact on Ms Morgan's care. I would add that the television has since been removed and in any event Sturt cell complex now has a diminished custodial function. The point is that there is nothing to suggest that these officers at any stage were glued to the box and for that reason neglecting their duty of care towards prisoners in the cells. Indeed, there was only one other prisoner actually in the cells at that time apart from Ms Morgan. That person, Z, was a male prisoner who was occupying a different cell in a different corridor of the complex. The officers who had been responsible for that person's arrest had left the cell complex by the time Ms Morgan experienced her fatal collapse.

3.5. When Ms Morgan was brought from the sally port into the cell complex she was at first placed into a holding cell. Shortly after that she was removed from the cell and searched by a female police officer. She was then placed back into the holding cell. At approximately 6:56pm Senior Constable Rogers went into the holding cell and conducted a breath test on Ms Morgan with a handheld alcolizer. Ms Morgan returned

[2] Exhibit C58

a reading of 0.211. This is a significant reading in keeping with Ms Morgan's outward signs of gross intoxication.

3.6. An aborted attempt was made to present Ms Morgan to the officer in charge of the cells, Sergeant Sampson. Ms Morgan's condition and behaviour did not permit this process and so she was virtually immediately returned to the holding cell.

3.7. Ultimately at about 7:09pm she was again presented to Sergeant Sampson who in the course of this presentation compiled the South Australia Police Custody Record which is a computerised document within the SAPOL SHIELD system[3]. Ms Morgan's behaviour ranged from the uncooperative, belligerent and abusive, particularly towards her arresting officers, to the playful. However, her behaviour on the whole and her intoxication were such that the cell guard refrained from photographing and fingerprinting her, an intrinsic part of the charging process.

3.8. By virtue of police General Orders, Sergeant Sampson was mandated to conduct certain procedures in relation to a prisoner including the compiling of a questionnaire which is largely devoted towards an assessment of the prisoner's risk while in custody. A number of those questions concern previous medical history including mental health history, current illnesses or injuries and current medication. There is one question in relation to self-harm, drug dependence and alcohol dependence. Those questions were asked of Ms Morgan and she gave answers that I will come to in a moment.

3.9. However, at this point I should say something about Ms Morgan's history, particularly her recent mental health history all of which would suggest that the unfortunate reality was that Ms Morgan was a particularly vulnerable individual. Tendered to the Court was a volume of case notes relating to Ms Morgan's treatment and admissions at the Flinders Medical Centre[4]. As well, the clinical record of Ms Morgan's general practitioner was tendered[5]. It is apparent from this documentation that Ms Morgan suffered from a number of difficulties including back pain for which she was the recipient of a disability support pension and chronic anxiety with drug and alcohol related issues. A psychiatrist's report within Ms Morgan's general practitioner's notes from 2014 records Ms Morgan's chronic problems with post-traumatic stress disorder that related to recurrent traumatic experiences throughout her life that included

[3] Exhibit C51l
[4] Exhibit C54
[5] Exhibit C53

witnessing adverse events and deaths of persons from drug overdose. It appears that Ms Morgan herself experienced intravenous heroin use and had a long term benzodiazepine habit with recent use of Valium. Also recorded was heavy alcohol dependence with detox admissions. Long term regular cannabis use is also described. Within the psychiatric report Ms Morgan is recorded as having described multiple suicide attempts in the context of psychosocial crises and drug use. The report recorded a diagnosis of chronic post-traumatic stress disorder (PTSD) as well as chronic substance dependence including benzodiazepine and opiate dependence. There were other diagnoses. I am not certain of Ms Morgan's most recent medical consultation prior to her death, although it appears to have taken place in early March with her general practitioner. I will come to that consultation in a moment.

3.10. On 24 June 2014 police had been called to attend Ms Morgan's home address at Morphettville in relation to an incident in which Ms Morgan had threatened to harm others and herself. The statement of SAPOL officer Senior Constable Coulls[6] records that Ms Morgan was intoxicated (0.136). She referred to her PTSD and said she wanted to shoot herself, asserting that she could access a firearm '*in ten minutes*'. In his witness statement Senior Constable Coulls asserts that he attributed this to Ms Morgan '*merely blowing her smoke*'. Ms Morgan had to be restrained when, upon seeing a neighbour, she became physically aggressive. Ms Morgan was detained pursuant to section 56 of the Mental Health Act 2009 and was conveyed by ambulance to the Flinders Medical Centre (FMC). In the general practitioner's notes there is an FMC separation summary from 25 June 2014 in respect of that admission where the principal diagnosis recorded was alcohol intoxication complicated by suicidal ideation with secondary diagnoses including PTSD and chronic benzodiazepine dependence. Ms Morgan had presented with suicidal ideation, complaining that she was '*tired of everything*'. It is recorded that she planned to have an accidental death, possibly by walking in front of car. The involvement of police in these events was not known to Sergeant Sampson when he came to process Ms Morgan after her arrest in March 2015.

3.11. In mid-February 2015, approximately four weeks prior to her arrest and death, Ms Morgan was referred to Dr Pols, a psychiatrist at the FMC. By way of a letter dated 19 February 2015 Dr Pols reported to the Pain Management Unit at the FMC and described Ms Morgan's pain issues and the suicidal episode which had resulted in

[6] Exhibit C45, Compiled on 2 May 2015 after Ms Morgan's death

detention under the Mental Health Act. She had indicated that her pain leaves her feeling about death and left her wondering whether life was worth living. She had thought seriously about the method that she might use to kill herself and saw overdose as being the most '*humane*' way of achieving it. Dr Pols described Ms Morgan as a stoic lady who had experienced gang rape, heroin dependence, a stabbing and the imprisonment of her partner. He also referred to the '*many other awful things that have happened to her*'. Dr Pols indicated that he would review Ms Morgan in four weeks. Ms Morgan's death intervened before that could occur.

3.12. On 5 March 2015, approximately a fortnight prior to her death, Ms Morgan saw Dr Kee Sing Wong at her general practitioner's surgery where she apparently complained of pain. In the reasons for contact, benzodiazepine dependency, anxiety and depression were also recorded. Ms Morgan was prescribed Panadeine Forte, Valium and Serepax. Valium would be located by investigating police in her unit following her death. There is some suggestion in the medical material that an attempt was being made to wean Ms Morgan off benzodiazepines such as Valium. As seen, Valium was in her blood at the time of her death. I know of no further medical appointment following this consultation.

3.13. I have mentioned these matters in some detail because at the time Ms Morgan was processed at the Sturt cell complex by Sergeant Sampson she accurately made reference to relevant features of her medical and personal history and did so despite her grossly intoxicated state. As a note of caution, however, it is to be acknowledged that the Sturt cell complex staff had no access to Ms Morgan's history and for that reason would have had no means of immediately confirming anything that she would say about herself. However, the case serves as a stark illustration of the need for prisoners' assertions about their history to be taken seriously. In other words, officers processing prisoners cannot afford to ignore or otherwise overlook assertions made by those prisoners about their history or state of mind in spite of what might outwardly be an intoxicated demeanour.

## 4. <u>Ms Morgan is charged and processed</u>

4.1. Sergeant Roger Sampson conducted this process. Sergeant Sampson is now retired. His rank on retirement was that of Sergeant. Sergeant Sampson performed over 45 years of service in the police force. As at 2015 Sergeant Sampson had undergone a

considerable amount of experience as a Sergeant in a cell complex. In addition, Sergeant Sampson had worked in police headquarters as a subject matter expert with respect to custody management and in respect of the introduction of the SHIELD program into SAPOL. The SHIELD program is a computerised program relating to prisoner management.

4.2. Sergeant Sampson gave oral evidence at the inquest. Sergeant Sampson acknowledged that Ms Morgan was grossly affected by alcohol. He basically described her as '*common drunk*'[7]. Sergeant Sampson told the Court that in principle there was no opposition to Ms Morgan receiving bail, but that she would be released from police custody when it was deemed that she was able to look after and manage herself.

4.3. Tendered to the Court were the police General Orders relating to '*Custody Management*' that were in force at the time with which this inquest is concerned. It is well known that compliance with the General Orders is mandatory. Among other things the General Order in question sets out the duties and responsibilities of the officer in charge of the cells when receiving a prisoner. Sergeant Sampson was that officer on the occasion in question. He had commenced his shift at 3pm that day.

4.4. Among the duties of the officer in charge of the cells was to ensure that a risk identification and assessment was conducted before a prisoner was placed into any cell that did not involve the close continuous physical presence and observation of a SAPOL member. The other important requirement was that the officer in charge of the cells must ensure that '*high need*' prisoners were identified.

4.5. There is a particular section in this General Order relating to '*high need*' prisoners. Under that heading it is pointed out that every prisoner in police custody has the potential to commit and/or attempt acts of self-harm and should be treated as '*at risk*' until a risk assessment determines otherwise. The document goes on to require a continuous risk assessment to be conducted on each prisoner to identify and determine treatment options to mitigate identifiable risks in order to ensure that all SAPOL prisoners were held in a safe and secure environment free from injury and harm. As far as a '*high need*' prisoner is concerned, this was the risk rating given to a prisoner held in police custody who '*poses the highest risk to themself or their management due to*

[7] Transcript, page 182

*the risk of self-harm (or attempt) or for other reasons and will require more attention than a prisoner assessed as a lower risk*'.

4.6. Where the officer in charge of the cells believed that a prisoner is a high need prisoner and therefore required additional care, the General Order stipulated that a number of practices should apply. These practices are described under the heading '*Additional care of high need prisoners*'. They included to ensure that mandated and any other designated inspection regimes were maintained, and '*where available, ensure the cell is monitored by CCTV surveillance to enable constant observation of the prisoner in conjunction with physical inspections*'[8]. As indicated earlier, the cell into which Ms Morgan was ultimately placed was monitored by CCTV, the monitoring screen of which was in the charge office. It was capable of enabling constant observation of a prisoner provided, of course, that it was looked at. This stipulation within the General Orders made it plain that a high need prisoner required constant observation. Ms Morgan was not classified as a high need prisoner. Nor was she constantly observed. I will address those topics in due course.

4.7. There were other relevant General Orders. One General Order related to a prisoner's clothing. The order pointed out that any item of clothing had the potential to be used as a ligature and gave as examples belts, ties, cords, socks, stockings and shoe laces, all of which must be removed from the prisoner. Ms Morgan was wearing leggings and underwear beneath the leggings. The leggings were used for self-strangulation. The leggings that were tendered in evidence are not wholly different from stockings in that they have elasticity. They were not removed from her at any time except by herself in the cell.

4.8. Unsurprisingly there were sections in this General Order concerning drug affected or possibly drug affected prisoners. Under the heading of '*Alcohol*' the General Order stated:

> 'A person found drunk and incapable of looking after themselves must be treated as a high need person who is in need of medical assessment.'

I am not entirely clear whether this order applied to a prisoner already in custody within a cell complex as distinct from a person being found by police to be drunk and incapable of looking after him or herself in another place. The order goes on to stipulate that

[8] Exhibit C51b, page 40 GOCM

where a person is detained pursuant to the Public Intoxication Act 1984, officers are mandated to ensure that an intoxicated person is not detained in a police cell complex for longer than necessary. It was not fully argued before me whether this particular section of the General Order mandated a prisoner who has been arrested for an offence and brought to a police cell complex and who was drunk and incapable of looking after themselves needed, and must as a matter of course have been provided with, medical assistance. However, one would have thought that as a matter of common sense it would be axiomatic that such a person would be treated as a high need person when in police custody in a cell complex. As indicated earlier it is obvious that Ms Morgan was treated as a person who at all material times was regarded as being incapable of looking after herself. Indeed, it was for that very reason that she was not released on bail in the first instance.

4.9. As far as drugs and medications were concerned, the General Order pointed out that the use of benzodiazepines and alcohol together could be a dangerous combination because alcohol heightens the effects of benzodiazepines, and when alcohol is combined with benzodiazepines it decreases the protective upper airway reflexes, which increases the risk of inhaling vomit. There is a particular section on benzodiazepines in which it is pointed out that the most common benzodiazepines include Valium, Serepax, Temazepam and other substances. I will return to the issue of benzodiazepines when dealing with the questionnaire that was conducted by Sergeant Sampson at the charge counter which I now come to.

4.10. The questionnaire that I have referred to is part of the South Australia Police Custody Record[9]. In fact it forms part of the risk assessment contained within the Custody Record. The record of the questions and answers recorded in this computerised document which was created at the time of the conducting of the questionnaire with Ms Morgan is corroborated by the transcript of the audio recording of activity at the charge counter. There is also the CCTV imagery that depicts Sergeant Sampson conducting this question and answer exercise with Ms Morgan at the counter. It is fair to say that Ms Morgan is demonstrably intoxicated in relation to her movement, demeanour and speech. Nevertheless, she was able to give reasonably coherent answers which as I have earlier indicated were largely borne out in fact.

[9] Exhibit C51l

4.11. I will now refer to some of the questions and answers that took place. When Ms Morgan was asked by Sergeant Sampson whether she had any concerns about being in police custody she said that she suffered from post-traumatic stress. She gave the same answer when asked whether she had any illness or injury. As seen earlier Ms Morgan had in fact been diagnosed with PTSD.

4.12. When asked as to whether she had seen a doctor or been to hospital for that illness she indicated that she had seen Dr Pols at the FMC four weeks ago. Again, as seen, this was correct. When asked as to whether she was taking any tablets or medication she indicated Panadeine Forte, Valium and '*DENPAX*'. The transcript of the audio suggests that Sergeant Sampson queried what this last medication was and what is was for, to which Ms Morgan said '*pain*'. Ms Morgan is recorded as having asserted that she had a '*broken back*'. It was the case that she had a back injury from which she suffered pain.

4.13. Sergeant Sampson asked Ms Morgan whether she was suffering from any mental health problems or depression. Ms Morgan answered affirmatively and repeated that she suffered from PTSD. Although not recorded in the custody record risk assessment, Sergeant Sampson asked Ms Morgan what had caused that, to which Ms Morgan replied '*nearly getting murdered and raped*'.

4.14. When asked as to whether she had tried to harm herself, Ms Morgan answered affirmatively and said that a couple of months previously (although Sergeant Sampson recorded her answer as a few weeks ago) she had overdosed on pills. The audio transcript reveals that Sergeant Sampson asked her how she had tried to harm herself and she indicated that she had done so with '*pills*' but that she had not been to hospital in respect of that. Ms Morgan also added, as recorded in the transcript, that she did not want to live anymore. Nothing in the FMC records nor those of her general practitioner about an overdose of pills has been drawn to my attention. The separation summary in relation to Ms Morgan's admission at the FMC in June 2014 wherein she was detained under an Inpatient Treatment Order records her presentation as one involving alcohol and suicidal ideation on the day of presentation where she had indicated that she was '*tired of everything*' and had planned to walk in front of a car.

4.15. Asked as to whether she had any drug or alcohol dependency she answered affirmatively and said that she was an alcoholic.

4.16. Neither the custody record risk assessment nor the audio transcript reveal any question as to whether or not Ms Morgan was experiencing current, as distinct from past, suicidal desires or ideation. There is every reason why such a question should be asked. It stands to reason that if it was relevant to enquire whether she had ever tried to harm herself, it was equally as relevant to ask whether she harboured any such desires at the time of her presentation to the charge counter. I intend recommending that such a question should be asked because it is clearly relevant to any risk assessment.

4.17. Sergeant Sampson recorded in the document that Ms Morgan was grossly affected by alcohol, but that she did not need immediate medical treatment. The final question addressed is as follows '*Do any of the responses above indicate the need to add a Caution?*' to which Sergeant Sampson has recorded '*NO*'.

4.18. Another section in the custody record contains the question '*Has the detainee's behaviour indicated that they may be at risk of self-harm?*' to which Sergeant Sampson recorded '*NO*'.

4.19. In the Care Plan/Care Plan Review Sergeant Sampson has recorded under medical and health concerns '*DETAINEE GROSSLY AFFECTED BY ALCOHOL. TO BE BAILED WHEN SOBER*'. Sergeant Sampson has recorded his view that Ms Morgan's level of risk was '*MEDIUM*', and under '*risk to self*', has recorded '*DETAINEE TO BE WATCHED CLOSELY UNTIL SOBER*'.

4.20. There is one further requirement that I should refer to which relates to one of the duties of the cell guard (but clearly a duty to be supervised by the officer in charge of the cells). It is that inspections of prisoners should occur at intervals not greater than 15 minutes for each prisoner for the first two hours of their incarceration. Another requirement was to conduct physical inspections that were mandated not only by that General Order, but also to conduct additional inspections as directed by the officer in charge of the cells. Further, one of the duties was to utilise CCTV where facilities were installed to observe prisoner behaviour as a support means in addition to the mandatory physical inspections. As seen, CCTV was available in the Sturt cell complex. Lastly, there was a requirement for the cell guard to monitor prisoners as per the risk treatment instructions.

4.21. In his oral evidence Sergeant Sampson told the Court that he assessed Ms Morgan to have been at medium risk. He entered this into the record. He also said that even if

Ms Morgan had been considered to be at high risk, or was a high need person, the frequency of observation being 15 minutely for the first two hours would not have altered[10]. However, Sergeant Sampson stated that if the person was categorised as high risk the officer in charge could choose a more frequent interval of checks. That said, if she had been classified as high risk, Sergeant Sampson said the frequency of checks would have been the same[11]. Alternatively, she may have been placed in the observation cell and could have been observed full-time[12]. He said that he would make the same decision again regarding medium risk assessment even with the benefit of hindsight[13].

4.22. Mr Kalali, counsel assisting, questioned Sergeant Sampson about a number of issues including the answers that Ms Morgan had provided in relation to her health history and history of self-harm. There was the issue regarding Ms Morgan's assertions that she suffered from PTSD, which we know to have been an actual diagnosis in her case. Sergeant Sampson agreed that there had been indications in Ms Morgan's case that she may have had mental health issues[14]. There was also the issue concerning the medication that Ms Morgan asserted she had taken, including benzodiazepines including Valium. There was also the question of her gross intoxication. In that regard, in cross-examination Sergeant Sampson was taken to that part of the General Order that stated in effect that both alcohol and benzodiazepines could give rise to a dangerous situation. When Mr Kalali suggested to Sergeant Sampson that as Ms Morgan was grossly intoxicated and had said that she had taken Valium, and having regard to the General Order that provides guidance about the dangers this possibly presented, she should have been placed in an observation, cell Sergeant Sampson did not agree. He said:

> 'No, because there was no medication at all, she had not taken medication prior to this and the few days before this. She had no medication at home. All she was suffering from was alcohol.' [15]

Sergeant Sampson went on to assert that he was told by arresting officers that no medications had been found in her unit. I do not believe that Sergeant Sampson could have been told that. There was absolutely no basis upon which this could have been

[10] Transcript, page 203
[11] Transcript, page 204
[12] Transcript, page 205
[13] Transcript, page 205
[14] Transcript, page 213
[15] Transcript, page 215

asserted by anybody. There is no evidence that the arresting officers entered Ms Morgan's house. In any event when the house was searched at a later time there was medication in her house. In any event Sergeant Sampson was quite vague about this issue when he said in evidence:

> 'I believe that the information they provided me ... all she was drinking was alcohol and there was no medication in her house. Now I can't recall that exactly.' [16]

Sergeant Sampson was asked by me how when assessing the risk that might be posed by medication in conjunction with alcohol he could have acted on any basis other than that Ms Morgan was telling him the truth about the medication that she had been on. He replied:

> 'Yes, I'm sorry, I made that assessment with that information that I had, that was all.' [17]

Sergeant Sampson was asked whether he would have treated Ms Morgan any differently if he had given credence to the possibility that she was not only affected by alcohol but also had a therapeutic level of Valium in her system. He said:

> 'Yes, if I'd known she'd taken that amount of medicine, medication on top, then I would've sent her to the hospital to get treatment.' [18]

4.23. Ms Morgan had also made the assertion that she had recently overdosed on pills. Sergeant Sampson was asked whether taking that into account as well, Ms Morgan was in truth a high need person. He appeared to agree with that proposition when he said:

> 'You can see that she's high need.' [19]

4.24. In his evidence Sergeant Sampson continued to resist the suggestion that Ms Morgan needed to be observed with greater rigour than what was required by 15 minute observations. However, the difficulty with his stance on this issue was his own notation in the Care Plan/Care Plan Review that Ms Morgan should have been watched closely until sober. In respect of this Sergeant Sampson said that he did not mean that she needed to be watched more closely than the 15 minute physical observation would provide. What he did say was that the closer observation should have been provided by her being monitored on CCTV. However, he said that he did not draw that

[16] Transcript, page 216
[17] Transcript, page 218
[18] Transcript, page 219
[19] Transcript, page 229

requirement, namely to be watched closely until sober, to any other person's attention. Asked by me:

> 'Q. How were they to know that she needed to be watched closely. How was anyone to know that.
>
> A. Yes, that was an oversight, I didn't get a chance to speak to Brett (sic) Rogers about that.' [20]

Brent Rogers, of course, was the cell guard.

4.25. The notion that Ms Morgan was a high need detainee is in keeping with the evidence of Assistant Commissioner Peter Harvey of SAPOL. AC Harvey prepared an affidavit in relation to remedial measures that have been taken within SAPOL since Ms Morgan's death. AC Harvey also gave oral evidence. Mr Harvey is Assistant Commissioner, Governance and Capability Service. He has responsibility for custody management and in that capacity has had responsibility for the Custody Management Portfolio since the Governance and Capability Service commenced in March 2017. AC Harvey was not involved in Ms Morgan's arrest or detention at Sturt.

4.26. AC Harvey said in evidence that classifying a prisoner as high need carries significance in terms of the risk awareness of cell staff. He said '*it is an awareness mechanism*'[21]. Asked as to what significance the classification would have in practice, he said:

> 'Well it heightens focus, retains - ideally retains focus and awareness of your environment and alertness to changes in behaviour, demeanour etcetera. It might cause you to rethink the care plan if need be.' [22]

Also in his evidence before the Court AC Harvey in effect opined that Ms Morgan's classification as being at medium risk had been a wrong assessment[23]. Asked as to what consequence would have flowed had Ms Morgan had been classed as high need or high risk, whatever the nomenclature, AC Harvey said that it may have made no difference to the frequency or level of care, but the option could have been exercised for shorter checking times or continual observation as opposed to less than continual observation. AC Harvey stated that risk mitigation strategies are a matter for the discretion of the cell Sergeant. I think he went so far as to suggest that the only way of completely

[20] Transcript, page 239
[21] Transcript, page 334
[22] Transcript, page 334
[23] Transcript, page 334

mitigating the risk posed in respect of a high need prisoner would be to constantly observe them.

4.27. I find that Ms Morgan should have been viewed as a high need individual. She should have been classified accordingly. In my view Ms Morgan needed to be observed more frequently than what could be provided by the standard physical 15 minute observations. Observation should have been maintained by way of more frequent direct observation or at the very least by monitoring the CCTV transmission on a constant basis. The General Order to which I have referred earlier dictated that. Ms Morgan was grossly intoxicated with alcohol and her assertion that she had also taken Valium should have been taken seriously. The same applies to her assertions that she had suffered from and been treated for mental illness. She was, and importantly presented as, a complicated individual whose behaviour could not have been predicted. In my view the benefit of hindsight is not needed to understand that Ms Morgan needed to be watched closely. Her behaviour within the cell could not have been safely assumed to be benign and straightforward.

4.28. I should add here that adjacent to the charge office was an 'observation cell' that would have enabled staff within the charge office to view through clear glass a prisoner in that cell. There was also a padded cell in the complex. In relation to the observation cell it was said that a misbehaving prisoner, due to their behaviour or noise, possibly engendered by the proximity of the prisoner to police cell staff, could constitute an undesirable distraction.

4.29. Senior Constable Rogers was also called to give oral evidence. He was present during Ms Morgan's processing by Sampson. In his oral evidence Senior Constable Rogers was taken to the General Orders as they related to his duties as the cell guard. His attention was drawn to the Order that stipulated that the cell guard must be appropriately briefed about the prisoner's situation, risk assessment and particular needs. Senior Constable Rogers said that although he had been briefed about Ms Morgan's situation by the arresting officers, he was not briefed by the officer in charge who of course was Sergeant Sampson. When asked by Mr Kalali of counsel assisting whether he had been briefed about Ms Morgan's situation, risk assessment and particular needs after Sergeant Sampson had performed the risk assessment, he said that he had not been so briefed, that there had been no oral communication and that Sergeant Sampson did not tell him anything. Senior Constable Rogers stated that the 15 minute observation

requirement was something that he knew as an automatic process with all prisoners. He also understood that more frequent observations could be maintained. When asked if he had checked to see whether Ms Morgan needed more frequent observations, he said that at the time there had been no such requirement because Ms Morgan had been constantly on the buzzer and that in any event initially some checks had been more frequent than 15 minutes. He said that he could not recall whether he had read Sergeant Sampson's risk assessment [24], but accepted that he had said in his interview with investigating police that he had not read the risk assessment. When asked specifically whether he had read that part of the plan that stipulated that Ms Morgan should be watched closely until sober, he said that he could not recall reading that stipulation, but had been aware of it from conversations that had taken place at the charge counter at the time she was being processed. When asked whether from that conversation he had become aware that she needed to be observed closely, he said '*just by her demeanour alone would suggest that*'[25].

4.30. Senior Constable Rogers acknowledged that he was aware of a need for Ms Morgan to be watched more closely than the 15 minute mandatory requirement. Asked as to whether she had been in fact watched more closely than that he said:

> 'During the times I was physically not seeing her, I was able to look at the CCTV footage that we had in the actual sergeant's or the charging office there. Because the fact that she was just not sitting down and she continually moved, she would continually hit the buzzer, I was even speaking with her on the intercom, I could clearly see her at the time I was talking to her as well, so she became quite a distraction at that time where she was forcing me to engage with her quite regularly anyway.' [26]

Senior Constable Rogers said that in effect he had complied with the requirement in the General Orders that mandated him as the cell guard to utilise the CCTV to observe Ms Morgan's behaviour as a support means in addition to the mandatory physical inspection. Having said that, he acknowledged that he did not see Ms Morgan take off her T-shirt and apparently wrap it around her neck, use her leggings in the fashion that she used them and of course he naturally did not observe her collapsed on the floor for those several minutes. He acknowledged that if he had seen her in that position he would have regarded that as abnormal behaviour, even taking into account her

[24] Transcript, pages 269-271
[25] Transcript, page 272
[26] Transcript, page 274

intoxicated state. He would have been alarmed enough to have gone to see what was taking place[27]. There is no question but that all of those acknowledgments are correct.

## 5. Ms Morgan is placed in the cells

5.1. After Ms Morgan was processed at the charge counter she was placed in cell 8. Cell 8 is the furthest cell from the charge office. Ms Morgan was taken away from the charge counter at about 7:43pm and was placed in the cell moments after that. On a number of occasions I have carefully watched the CCTV footage of Ms Morgan's activities in the cell once placed within it.

5.2. At about 7:45pm Senior Constable Rogers went to Ms Morgan's cell and provided her with blankets. Shortly after that he returned with a plastic cup for her.

5.3. At about 7:50pm Ms Morgan can be seen to be sitting on the bed in the cell with her feet on the floor. She removed her T-shirt and exposed her breasts. At one point she appeared to momentarily wrap the T-shirt around her neck. She is then observed to put the T-shirt back on. This went unobserved either by way of physical sighting or by observation of the CCTV monitor. Thereafter Ms Morgan appears to be restless. She discovers the intercom in her cell and uses it on several occasions.

5.4. I was satisfied that Senior Constable Rogers conducted a visual inspection of Ms Morgan at 7:51pm from the breezeway leading to Ms Morgan's cell, at 7:56pm when he conducted a check and had a brief conversation with Ms Morgan through the closed cell door, at 8:05pm when Senior Constable Rogers looked through the breezeway window into Ms Morgan's cell and conducted a visual check and at 8:13pm when another visual check was conducted. I was satisfied that at 8:16pm Senior Constable Rogers entered the breezeway to cell 8, opened the cell door and checked Ms Morgan. At 8:21pm Senior Constable Rogers entered the breezeway to cell 8, opened the cell door and checked Ms Morgan. At 8:35pm Senior Constable Rogers conducted a visual check on Ms Morgan and returned to the charge area.

5.5. At 8:50pm Senior Constable Rogers entered Ms Morgan's cell and conducted the alcotest which revealed the positive reading of 0.169.

[27] Transcript, page 291

5.6. All throughout this period of time Ms Morgan appears to be restless and awake. She used the intercom on a number of occasions and was yelling out.

5.7. The last physical sighting of Ms Morgan occurred at approximately 9:05pm when Senior Constable Rogers opened the cell door. Ms Morgan was awake and unharmed at this point. Her leggings were still being worn.

5.8. Ms Morgan continued to yell from her cell. The last sound that was heard from her occurred at about 9:09pm.

5.9. At 9:10pm Ms Morgan removed her leggings. This can plainly be seen on the CCTV footage. She was sitting on the bed at that point. She can then be seen on the CCTV footage to tie the leggings around her neck. It is evident that by this time the prisoner D had been brought to the Sturt cell complex by Officers Toby Shaw and Steven Parker. At the time at which Ms Morgan can be seen to be removing her leggings, D is apparently in a holding cell with Officer Parker. From what can be seen in the CCTV video at this point Sergeant Sampson, Senior Constable Rogers and Officer Shaw are in the charge office. The conversation within the charge office concerns police matters. I see or hear no evidence of officers being distracted by anything other than police work. Although the monitor within the room would have clearly shown that Ms Morgan's behaviour was concerning, it went unseen.

5.10. Following the tying of the garment around her neck Ms Morgan's behaviour is not overtly extraordinary for the next few minutes, although it is now plain enough that she has removed her leggings. Her bare legs are now quite visible.

5.11. Ms Morgan can be seen to lie on the bed with bare legs. It is apparent that at this point there does not appear to be any respiratory compromise occasioned by the garment around her neck. While she is lying on the bed Officer Parker approaches the charge counter and converses with Officer Shaw, who is within the charge office, about their investigation, presumably of D. The conversation is conducted through the charge counter window. Sergeant Sampson can be seen at the charge counter facing outwards from the charge office. Sergeant Sampson participates in conversation about the prisoner arrested by Officers Shaw and Parker, namely D. While this is taking place Ms Morgan gets off the bed and it is apparent that the leggings have been moved from her neck. However, while on the bed Ms Morgan again places the leggings around her neck. This activity also apparently goes unseen. While this takes place the officers are

conversing about police matters. This includes Sergeant Sampson who is at the charge counter.

5.12. The placement of the garment around Ms Morgan's neck at this stage does not appear to compromise her wellbeing in any way. Officer Parker, who during this period is in the vicinity of the charge counter, can then be seen to leave the charge counter area and proceed probably towards the holding cell where D is situated. Ms Morgan then sits on the toilet. Sergeant Sampson is still at the charge counter apparently working. Senior Constable Rogers and Officer Shaw are still apparently within the charge office. The conversation concerns police matters. Sampson directs that D be brought to the charge counter. While Ms Morgan is on the toilet she appears to adjust the garment around her neck. Almost simultaneously, the prisoner D is brought to the charge counter by Officer Parker. At about the same time Senior Constable Rogers leaves the charge office in preparation for the photographing and fingerprinting of D. At that stage Sergeant Sampson and Officer Shaw are in the charge office. From this point the next few minutes are occupied with the processing of the prisoner D.

5.13. At 9:15pm Ms Morgan rises from the toilet and attempts to get on to the bed. However, she collapses onto the cell floor between the toilet and the bed where she remains until found by Senior Constable Rogers at 9:23pm. At that same moment Senior Constable Rogers can be seen to place paperwork on a counter outside at the charge window and from that point is occupied with the preparation for and the eventual carrying out of the photography and fingerprinting of the prisoner D. Officer Parker is at the charge counter with D. Sergeant Sampson is questioning D about various matters connected with his arrest. Officer Shaw is apparently in the charge office at this point. I do not believe that any person, including Sergeant Sampson and Officer Shaw, could be witnessing on the CCTV monitor within the office Ms Morgan's position within the cell. She is lying on the cell floor with bare legs and her underwear around her lower thighs. There is no evidence that either Officer Shaw or Office Parker had any responsibility in relation to the monitoring of prisoners.

5.14. While Senior Constable Rogers is photographing and fingerprinting D, Sergeant Sampson, Officer Shaw and now Officer Parker are in the charge office. There is no evidence that any of the officers are distracted by anything other than police work. Sergeant Sampson can be seen at the charge counter facing outwards.

5.15. At approximately 9:19pm Sergeant Sampson leaves the charge office and walks down the corridor towards a meals preparation room. Although unseen on CCTV footage, I am satisfied that at that time he was occupied with preparing a meal for the other prisoner in the cells, Z. Sampson can then be seen to emerge from the room and proceed to a row of cells off a different corridor from that where Ms Morgan is accommodated. I find that Sampson there gave Z his meal.

5.16. At 9:22pm Sergeant Sampson can be seen returning to the charge office where he continues the charging process of the prisoner D. During the period Sergeant Sampson is out of the charge office, Ms Morgan is still in the position of collapse on the cell floor. The processing of the prisoner D continued. It is apparent that no officer could have observed what was on the CCTV monitor in respect of Ms Morgan.

5.17. As seen, at 9:22pm Sergeant Sampson returned to the charge office. By that stage Officer Shaw has left the charge office and at about the time of Sergeant Sampson's return, Officer Parker leaves the charge office. Senior Constable Rogers is in the process of fingerprinting D outside the charge office. Ms Morgan is still in the position of collapse on the cell floor. At the time that Sergeant Sampson resumes his position at the charge counter, Officer Shaw re-enters the charge office. In the next few seconds there is discussion between Sergeant Sampson, who is accompanied by Officer Shaw in the charge office, and Officer Parker and prisoner D on the other side of the charge counter. Officer Shaw is then seen to leave the charge office. At that time Senior Constable Rogers approaches Ms Morgan's cell and discovers her collapsed at 9:23pm. Ms Morgan is in exactly the same position as she was when she had originally collapsed. She has been in that position for approximately eight minutes.

5.18. Ms Morgan had been silent from approximately 9:09pm. It seems plain enough that either her silence was not noticed or if it was, its significance was not appreciated. The silence from Ms Morgan's cell must have been quite a contrast to her previous yelling and use of the intercom, and not an unwelcome contrast at that. It is surprising that her silence did not prompt anybody to look at the CCTV monitor. But it is plain that nobody did.

5.19. I accept the evidence that was given that from Sergeant Sampson's standing position at the charge counter, a position that he occupied for the most part during this event, he would not have had a direct view of the CCTV monitors. He would have had to move

back to enable him to do so. It appears that at no material time Sergeant Sampson did that.

## 6. Ms Morgan's ligature

6.1. The ligature that Ms Morgan used to strangle herself was an item of her own clothing. They were the leggings that she had been wearing when she was arrested, when she had been searched, when processed at the charge counter and when placed in the cells.

6.2. The General Order mandated the officer in charge of the cells to ensure that shoes and shoe laces, lengths of cord, clothing, jewellery and any other item that may be used to assist the prisoner to escape, inflict injury or harm to the prisoner or any other person or cause criminal damage are removed from the prisoner[28]. In addition, under the heading '*Clothing*' the General Order reminded those performing duties in relation to prisoners that '*any item of clothing*' has the potential to be used as a ligature. The Order as promulgated at the time cited as examples belts, ties, cords, socks, stocking and shoe laces. These items, it was said, '*must be removed from the prisoner*'[29].

6.3. Clearly belts, ties and shoe laces, depending on their length of course, are obvious examples of a ligature that might be used either in conjunction with a hanging point or as an item for self-strangulation. Stockings due to their elasticity would naturally be another such item.

6.4. Sergeant Sampson was questioned by Mr Kalali, counsel assisting, about Ms Morgan's leggings. He acknowledged that he had observed that Ms Morgan was wearing colourful leggings when she was brought to the charge counter. However, he said that he had not given any consideration to whether the leggings needed to be removed from Ms Morgan[30]. He regarded the leggings as being in the same category as jeans and slacks in respect of which there was no requirement for removal[31]. In his evidence the General Order regarding items including stockings being possibly used as a ligature was drawn to Sergeant Sampson's attention. Sergeant Sampson acknowledged that stockings could easily be tied around a person's neck[32].

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[28] Exhibit C51b, page 19
[29] Exhibit C51b, page 41
[30] Transcript, page 208
[31] Transcript, page 208
[32] Transcript, page 211

6.5. I find that it did not occur to Sergeant Sampson that Ms Morgan's leggings could be used as a ligature. I should note here that having observed the interior of Ms Morgan's cell during the Court's site visit of the Sturt complex, and having observed the CCTV footage of her within it, there does not appear to be any obvious hanging point. Nevertheless, the possibility of self-strangulation is one that can never be overlooked when a garment such as stockings or leggings are available to a prisoner. Clearly, since these events police have been on notice that leggings are a means by which self-strangulation can be effected.

6.6. I have examined Ms Morgan's leggings[33]. While not as elastic as stockings or pantyhose, there is plainly elasticity within them. Naturally this property is reasonably obvious when worn.

6.7. When AC Harvey gave oral evidence in the inquest he indicated that in his opinion leggings should have been specifically mentioned in the General Orders and also indicated that he has requested that inclusion of such garments within the Order's purview be effected immediately. He agreed that the elasticity of the garment was the most important consideration. He indicated that leggings would be included for specific mention in the next version of the General Order.

## 7. Conclusions

7.1. The Court reached the following conclusions.

7.2. Ms Morgan's arrest for disturbing the peace contrary to section 7(2) of the Summary Offences Act 1953 was lawful and appropriate.

7.3. The decision of Sergeant Sampson not to immediately release Ms Morgan on bail upon presentation to him was lawful and appropriate and was justified on two bases, namely that she required care due to her level of intoxication[34], and secondly on the basis that if immediately released the likelihood of her re-offending was high[35].

7.4. Due to a number of factors including Ms Morgan's level of intoxication, her assertion that she had consumed alcohol and a number of drugs including diazepam in combination, her own admission that she suffered from PTSD, her assertion that she

[33] Exhibit C59
[34] vide Section 10(1)(e) of the Bail Act
[35] vide Section 10(1)(b)(ii) of the Bail Act

had overdosed on pills and, importantly, Sergeant Sampson's own correctly formed view that her condition and behaviour was such that she was not capable of looking after herself, Sampson's assessment that Ms Morgan was at medium risk was incorrect. I find that Ms Morgan was a high need prisoner and was manifestly so at the time she presented to Sergeant Sampson. I find that Ms Morgan required a regime of care and scrutiny that could not be provided solely by 15 minute physical observations. Ms Morgan required either more frequent physical observations or constant observation by way of the available CCTV monitoring.

7.5. I find that it did not occur to Sergeant Sampson that Ms Morgan's leggings could be used as a ligature and for that reason did not consider removing them from her possession. Leggings were not specifically mentioned in the SAPOL General Order in relation to prisoner custody and management.

7.6. In maintaining a regime of care and scrutiny in respect of Ms Morgan some reliance was placed on the fact that Ms Morgan frequently could be heard yelling out from her cell and from her frequent use of the intercom to communicate with officers in the charge office. However, this was no proper substitute for physical scrutiny and scrutiny by way of viewing the CCTV monitor. Despite Ms Morgan's habit of yelling out and using the intercom, at one point she was able, unseen, to remove her T-shirt and appear to place it around her neck. This act would have been visible on the CCTV monitor and would have required investigation had it been viewed at the time this incident occurred.

7.7. Ms Morgan's act of removing her leggings and tying them around her neck went unobserved. Clearly, such an act would have created alarm. It would have required investigation and the removal of that garment from her possession. Other clothing could have been provided. This act would also have dictated a regime of constant observation until her release. Indeed, it may well have caused a revision of the plan to release Ms Morgan at all and may have dictated a course of action that saw her being provided with medical evaluation.

7.8. Ms Morgan was not observed nor heard after approximately 9:09pm. In the period between 9:09pm and 9:23pm when she was located unresponsive on the floor of her cell, Sergeant Sampson and Senior Constable Rogers were appropriately occupied with police work including the processing of a prisoner who had been presented to the charge

counter at around the time that Ms Morgan collapsed. I do not believe it occurred to either Sergeant Sampson or Senior Constable Rogers to ask one of the officers who had arrested and presented this prisoner to maintain an observation of Ms Morgan on the CCTV monitor in the charge office. In any event there is no evidence that such monitoring would have been part of the duties and responsibilities of either of those two officers. The duty of care towards Ms Morgan was that of Sergeant Sampson and Senior Constable Rogers.

7.9. Although from time to time within the charge office a television was on which depicted an international cricket match, and that comment was occasionally passed by officers in relation to the state of play in that match, there is no evidence that the television constituted an undue distraction or that Ms Morgan's care was compromised as a result of the television being on.

7.10. Appropriate resuscitative measures were employed in relation to Ms Morgan after she was discovered collapsed in her cell. The South Australian Ambulance Service was promptly called and promptly attended.

## 8. Recommendations

8.1. Pursuant to section 25(2) of the Coroner's 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.

8.2. In the detailed report of the investigating police officer, Detective Sergeant Justin Ganley of the Major Crime Investigation Branch, he has listed a number of possible recommendations for change which I here set out:

> '19.1 Consider a review of the current staffing levels within SAPOL cell complexes and the establishment of a documented framework in relation to those staffing roles and levels.
>
> 19.2 Explore the implementation of Radio Frequency Identification (RFJD) Scanners on each cell door for prisoner inspections. A designated scanning pad for cell staff to scan their personal police ID during inspections would allow real time detainee inspection records to be updated automatically onto the SHIELD custody record. This would negate late check entries or no entry at all and also ensure checks are being done physically, instead of relying on CCTV or intercom.

19.3 Consideration of amendment to SHIELD to ensure automatic categorisation of detainee's as 'high need' if the detainee provides a positive response to any of the questions in their risk assessment relating to self-harm.

19.4 Consideration for SHIELD Program Innovations and Solutions Branch to review and implement change to the SHIELD program so custody records cannot be progressed until DSR and SAPPS have been viewed prior to Risk Assessments being conducted.

19.5 Cell staff utilise the 'time' field option on SHIELD as mentioned by White when conducting prisoner checks.

19.6 Consider amending General Order Custody Management to include any clothing of similar nature to leggings in the definition of items to be removed from a detainee as capable of use to cause self-harm. This should have extra application to the detainee's classified as 'high need.' However consideration should be given to the provision of alternative clothing, the dignity of the detainee and the presence of an appropriate gender police officer in the cells at the time of clothing removal.

19.7 The CCTV cell monitors in the Sturt cells charge office be relocated to the western wall to allow easier access of monitoring prisoners by all cell staff.

19.8 A full review of the operability of the Intercom System at Sturt cells.' [36]

8.3. Since the conclusion of the inquest the Commissioner of Police has provided the Court with written submissions including an outline of changes made since Ms Morgan's death. The submission also signifies SAPOL's official response to various recommendations Some of these matters are not particularly pertinent to either the Sturt cell complex or SAPOL custodial facilities in general. However, the pertinent measures include the following:

- Where bail is refused upon charging, the prisoner in question is to be held at the Christies Beach cell complex, the City Watch House, the Elizabeth cell complex or the Port Adelaide cell complex which are now the major custodial facilities. At the City Watch House and Elizabeth cell complex, staffing consists of one Sergeant, one Brevet Sergeant and three cell guards. At the Christies Beach and Port Adelaide cell complexes the staffing level is one Sergeant, one Brevet Sergeant and one cell guard. As I understand the situation there would now be no circumstance in which a person who has been refused bail and is held in a police cell complex would only have one Sergeant and one cell guard responsible for his or her custody and care. As I have found, at the time Ms Morgan was collapsed on the floor of the cell both Sergeant Sampson and Senior Constable Rogers were distracted by other legitimate

[36] Exhibit C51a, page 71

duties. In my view there is a need for SAPOL to eliminate periods during which prisoners may not be under observation due to the pressures occasioned by cell staff dealing with the processing of new prisoners. I recommend accordingly.

- The Commissioner's submission indicates that it is proposed that a revised 'General Order – Mental Incapacity' will mandate SAPOL officers to complete a PD145 Mental Health Assistance Form and to record in the SHIELD system the occurrence of any mental health incident. When completing the occurrence in the SHIELD system the officer is prompted to enter a warning that the person has a mental illness. The information entered pertaining to the mental health incident and the warning will then be available in SHIELD to any other officer conducting a background/history/mental health check on that person. That check could now be carried out in a cell complex. I understand that an occurrence such as that of 24 June 2014 where police attended an incident involving Ms Morgan and which resulted in her being detained under the Mental Health Act would be recorded within SAPOL holdings and be available to officers responsible for any future custody and care of that same person.

8.4. Notwithstanding the staff levels that now exist in the reduced number of SAPOL cell complexes, the Commissioner's submission indicates that there would be significant resource and cost implications if constant monitoring of high need detainees, even by way of CCTV, was mandated. It is pointed out that the presence of multiple high need detainees in a cell complex is a routine and common circumstance. There are said to be logistic difficulties associated with the constant monitoring of multiple high need prisoners. The difficulty with this stance is, as seen above, the General Orders already appear to dictate constant observation of high need prisoners by way of CCTV.

8.5. I have already referred to the evidence of Assistant Commissioner Peter Harvey.

8.6. AC Harvey provided some statistical evidence relating to police custody. His affidavit reveals that in the 2014-2015 financial year, the year in which Ms Morgan's death occurred, SAPOL processed 32,518 prisoners of which 2,347 prisoners were charged at the Sturt Police Station. At that time the Sturt Police Station cell complex could accommodate prisoners who had been refused bail and before they were taken to Court. This is no longer the case. The Sturt cell complex is now exclusively devoted to the processing of prisoners who are to be admitted to bail. The other relevant statistical

matter that has been emphasised is that prior to Ms Morgan's death there had not been a death in police custody within cell complexes since 2004.

8.7. Aside from re-designating the function of the Sturt Police Station cell complex, AC Harvey indicates in his affidavit that the CCTV monitors have been replaced with larger screens and that the top monitor has been affixed to an adjustable bracket which enables the monitor to be moved and angled for easier viewing, remembering that from Sergeant Sampson's position at the charge counter he could not see the monitor screens without moving backwards. In addition, the television was removed to prevent distraction. A perspex screen in the charge counter window has cut-outs for improved communication with detainees. The changes at Sturt possibly do not illustrate a full enough picture insofar as there are other cell complexes in South Australia that would probably require similar modification, especially those that have a function of accommodating prisoners for extended periods.

8.8. AC Harvey's affidavit also refers to the topic of risk assessment. The affidavit indicates that the level of risk is to be determined by the officer in charge of the cells who will classify the risk level of a prisoner as no risk, low risk, medium risk or high risk. Detainees who are seriously drug and/or alcohol affected should not be rated at a level of medium risk. On the other hand, a high rating must be used where there are risks that are imminent or if there is significant recent or historical evidence suggesting that such a rating is required. Detainees who are seriously drug and/or alcohol affected but who do not require medical attention must still be rated at this high level. Such a dichotomy would have captured Ms Morgan. The risk analysis process section of the 2018 version of the General Orders indicates that members responsible for the care, custody and overall management of detainees must be aware that the first 24 to 48 hours a person is in custody may be associated with an increased risk of self-harm, drug and alcohol withdrawal and deterioration of medical conditions. The definition of high need detainee in the 2018 version is similar to that within the version that governed Ms Morgan's detention, but with the addition of a requirement that a continuous risk assessment must be conducted on each detainee to identify and determine treatment options to mitigate identifiable risks. There is a case for arguing that the definition of '*high need*' in the 2014 version was vague and did not really address the issue at stake. A '*high need*' prisoner would more appropriately be defined as a '*person who has displayed or voiced past or current suicidal ideation or is otherwise considered to be*

*at risk of self-harm and would include any person in respect of whom due to their intoxication, demeanour or condition their behaviour cannot be safely predicted, or who are incapable of looking after themselves. Such a prisoner requires close observation and a continuous risk assessment in order to determine treatment options to mitigate identifiable risks*'. I recommend accordingly.

8.9. I was informed during the inquest that leggings would now be specifically identified within SAPOL General orders as a garment that poses risk and should be removed from a prisoner.

8.10. As far as roles and responsibilities of cell complex staff are concerned, the 2018 version of the General Orders specifically states that cell guards are not to engage in any duties that may distract them from the primary responsibility towards safely and securely managing detainees. It will be recalled that Senior Constable Rogers was specifically taken away from the CCTV monitoring area by the need to photograph and fingerprint the prisoner D.

8.11. In his oral evidence AC Harvey saw the value of a suggestion that in conducting the questionnaire with the prisoner, the prisoner should be asked whether he or she is entertaining any current thoughts of self-harm, a question similar to that posed in Department for Correctional Services prisoner screening exercises[37]. I recommend accordingly.

8.12. In his oral evidence AC Harvey spoke of the SAPOL response in relation to some of the recommendations identified in the Ganley report to which I have referred.

8.13. As to recommendation 19.3, namely that consideration be given to ensuring automatic categorisation of detainees as '*high need*' if the detainee provides a positive response to any of the questions in their risk assessment relating to self-harm, AC Harvey indicated that at first he was minded to support it but others thought, as I understand the argument, that it might lead to an over-categorisation of high risk, presumably meaning that prisoners who are in reality only at medium risk might be subjected to a level of scrutiny that could detract from the ability to properly scrutinise those prisoners who are genuinely at high risk. In my view this is not a valid objection to the recommendation. If a prisoner indicates that they have self-harmed in the past,

[37] Transcript, page 328

particularly if they have attempted to kill themselves, or have indicated a state of mind whereby they might be experiencing current suicidal ideation, it is difficult to see how they could be characterised as anything other than being at '*high need*' or '*high risk*', whatever nomenclature the degree of risk is given. The default position should be that a positive response in respect of both past and current suicidality should dictate that the prisoner be considered as being a high need prisoner and should be subjected to a level of scrutiny that exceeds the 15 minute physical observations. I recommend accordingly and repeat what I have said at para 8.8 concerning the definition of a '*high need prisoner*'.

*Key Words: Death in Custody; Police; Hanging; Monitoring*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 20th day of December, 2019.*

*Deputy State Coroner*