



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 2nd, 28th and 29th days of October 2020, the 18th day of November 2020 and the 28th day of May 2021, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Ian Keith Gibson.

The said Court finds that Ian Keith Gibson aged 46 years, late of no fixed address died at the Adelaide City Watch House, Nelson Lane, Adelaide, South Australia on the 22nd day of August 2017 as a result of congestive cardiac failure due to cardiomyopathy and coronary artery atherosclerosis. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

- 1.1. Ian Keith Gibson was 46 years of age when he died during the night of 21/22 August 2017. His place of death was the South Australia Police (SAPOL) City Watch House (CWH) in Adelaide where he was in police custody. He had been arrested by police earlier that evening.
- 1.2. Mr Gibson had been arrested for allegedly breaching reporting conditions imposed upon him as a result of his registration pursuant to the Australian National Child Offender Register. He was located in Hindley Street in the city by police. Enquiries made via a police mobile PDT terminal established that Mr Gibson was a wanted suspect for having allegedly failed to report his personal details to the Commissioner of Police within seven days of his release from prison on 1 August 2017. I find that Mr Gibson's arrest was lawful.

- 1.3. Having been conveyed by police to the CWH, Mr Gibson was processed and then placed in cell 227 which is an observation cell. He was considered unsuitable to be released on bail at that time. Refusal of bail was appropriate in all of the circumstances.
- 1.4. Mr Gibson was categorised as a High Needs detainee. Hence his placement in an observation cell. His categorisation as a High Needs detainee was based largely on his known medical history.
- 1.5. Mr Gibson was placed in the observation cell at approximately 10:30pm. He was found in that cell in a completely unresponsive state at approximately 12:55am the following morning. I have found that Mr Gibson was in cardiac arrest at that point and was effectively deceased. Resuscitative measures were attempted by both police and then by South Australian Ambulance Service (SAAS) personnel. Unfortunately these attempts were unsuccessful. Mr Gibson was certified deceased by SAAS personnel at 1:39am.
- 1.6. In the period between Mr Gibson's placement in cell 227 and his being found in cardiac arrest within it, a number of observations of him were made by CWH police staff as mandated by police General Orders.
- 1.7. The interior of Mr Gibson's cell, and events and movement within it, were also under constant CCTV surveillance which was capable of being monitored as those events and movement were taking place. The monitor was situated within the cell guard office directly across the corridor from Mr Gibson's cell. The CCTV surveillance was recorded. I have viewed the CCTV recording. For the period under discussion the recording shows Mr Gibson for the most part lying on a bed within the cell covered by a blanket. Times are displayed on the CCTV footage. As is frustratingly common in facilities that accommodate persons detained under the laws of the State, there is reason to believe in this case that the times displayed on the CCTV footage are inaccurate and are approximately four minutes behind real time. CCTV recordings such as these importantly record the activity that takes place within a detention environment and the times at which the activity occurs. In due course the importance of all of this will hopefully dawn on somebody, as will the fact that there is no point in CCTV footage displaying times unless the times displayed are accurate.
- 1.8. At approximately 11:14pm, as displayed on the CCTV footage time counter, Mr Gibson is seen to remove the blanket from his head. This is followed by small movements of

an arm. From that point forward no discernible movement of Mr Gibson can be seen on the CCTV footage. He remained lying on the bed in the same position until he was ultimately found to be in cardiac arrest.

- 1.9. Mr Gibson's death was a death in custody in respect of which an inquest was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.

2. Cause of death

- 2.1. It is necessary to say something of Mr Gibson's extensive medical history. Mr Gibson had a history of poorly controlled diabetes. He also suffered from severe congestive cardiac failure and dilated cardiomyopathy. There is also reference in his medical history to bronchiectasis and a high bilirubin level associated with alcoholic liver disease.
- 2.2. Mr Gibson had a number of hospital admissions. These included an October 2016 admission to the Royal Adelaide Hospital (RAH) with severe congestive cardiac failure together with deranged liver function and community acquired pneumonia. At that time Mr Gibson had a poor cardiac ejection fraction of 17%.
- 2.3. In June 2017, when Mr Gibson had been in custody on an earlier occasion, test results showed deranged liver function. Throughout that month he was admitted to the Adelaide Remand Centre Health Centre and the RAH for pain and concerns relating to liver disease and heart failure with poorly controlled diabetes. On 2 July 2017 Mr Gibson had complained of chest pain when breathing. This resulted in his transfer to the RAH where he was stabilised before being returned to Yatala Labour Prison (YLP).
- 2.4. Following his death, Mr Gibson's body was subjected to a post-mortem examination at Forensic Science South Australia (FSSA). The examination, which consisted of a full autopsy, was performed by Dr Cheryl Charlwood, a forensic pathologist at FSSA. In her post mortem report¹ Dr Charlwood expresses the cause of Mr Gibson's death as:

- '1 a) CONGESTIVE CARDIAC FAILURE
b) CARDIOMYOPATHY AND CORONARY ARTERY ATHEROSCLEROSIS',

¹ Exhibit C2a

which can be stated as congestive cardiac failure due to cardiomyopathy and coronary artery atherosclerosis.

- 2.5. In her report Dr Charlwood describes certain pathological findings. They include evidence of cardiac failure with prominent pulmonary oedema which is congestion of the lungs consistent with cardiac failure. The heart was enlarged and dilated with other pathology.
- 2.6. The deceased's heart was subjected to a specialist anatomical pathology examination performed by Associate Professor Thomas. Associate Professor Thomas reports that diffuse interstitial fibrosis, as well as more discrete scarring, within the left ventricle of the heart are in keeping with a cardiomyopathy with heart enlargement and scarring being sufficient to cause cardiac arrhythmia and sudden unexpected cardiac death.
- 2.7. A post mortem toxicological sample revealed a blood alcohol (BA) concentration of 0.02% with no other drugs detected. This BA level confirmed other evidence demonstrating that prior to the time of his admission to the CWH, Mr Gibson had been consuming alcohol and still had alcohol in his system at the time of his admission.
- 2.8. For the purposes of this inquest the report of an independent specialist consultant cardiologist was commissioned by and on behalf of SAPOL. That consultant cardiologist is Dr Leo Mahar. Dr Mahar's report was tendered to the inquest.² Dr Mahar has examined the CCTV footage of Mr Gibson in his cell. He has also had regard to Mr Gibson's medical history that included severe congestive heart failure with a low ejection fraction of 17%. Dr Mahar notes Associate Professor Thomas' findings that there was cardiomyopathy with hypertrophy and scarring being sufficient to cause a cardiac arrhythmia and sudden unexpected cardiac death. Dr Mahar observes that this is the most common cause of death in cases of severe congestive heart failure where a fatal ventricular arrhythmia is often sudden and unheralded. Dr Mahar indicates in his report that his considered opinion is that the cause of death was a sudden ventricular arrhythmia that did not manifest itself in overt behaviour such as might occur when a person experiences acute or sudden pulmonary oedema, which would trigger gasping for breath and extreme agitation. It is obvious from the CCTV footage that nothing of

² Exhibit C47

that dramatic nature occurred in respect of Mr Gibson. Rather, what is plain from the CCTV footage is that at some point Mr Gibson passed away quietly.

- 2.9. I do not believe that there is any inconsistency between the views of Dr Charlwood, Associate Professor Thomas or Dr Mahar in respect of the mechanism and cause of Mr Gibson's death. In my view the mechanism of his death was, as Associate Professor Mahar postulates, an unheralded cardiac arrhythmia due to Mr Gibson's heart disease. I so find. I further find that the cause of Mr Gibson's death is as Dr Charlwood has stated, namely congestive cardiac failure due to cardiomyopathy and coronary artery atherosclerosis.
- 2.10. I should add here that in Dr Mahar's opinion, having examined the CCTV footage, the timing of Mr Gibson's death cannot be accurately assessed. I do not understand that Dr Mahar has any particular view as to how close to Mr Gibson's being discovered in cardiac arrest that his death had actually occurred. Therefore, on the CCTV evidence and the expert medical evidence, there is little to indicate when it was after Mr Gibson was last seen to move any part of his body, as revealed on the CCTV footage, that he actually died.
- 2.11. When Mr Gibson was discovered he was observed by police to have open eyes and a slack mouth. As already observed, he was totally unresponsive. Mr Gibson's body was still warm to the touch but his hand and wrist were cold to the touch. A pulse could not be detected. It can also be concluded that Mr Gibson was not breathing at this time. In the period before the arrival of the SAAS personnel, which occurred about ten minutes after Mr Gibson was discovered, attempted defibrillation was administered by police. It was unsuccessful due to the lack of electrical activity in the heart. Mr Gibson was in asystole. Further resuscitative measures conducted by SAAS personnel that included the administration of adrenaline were also unsuccessful. All of this in my view leads to the conclusion that when Mr Gibson's cell was entered by police he was already in cardiac arrest. From an analysis of this evidence looked at in isolation, it is not possible to determine with precision for how long that had been the case prior to his cell being entered.
- 2.12. The CCTV evidence depicting Mr Gibson from the moment he was last seen to move (the time of which is displayed on the CCTV footage as 11:14:35) to the time his cell was entered by police when he was discovered to be unresponsive (the time of which

is displayed on the CCTV footage as 12:55:47) is consistent with Mr Gibson being asleep, unconscious or indeed deceased for the whole of that period. The footage itself does not eliminate any of those possibilities.

- 2.13. However, as will be seen, the evidence of police officers who had the responsibility of caring for Mr Gibson while he was in the CWH is to the effect that at various times during the course of the period over which Mr Gibson was in the observation cell he was routinely observed in accordance with the requirements of police General Orders, and that on each occasion, except of course the last, his chest could be seen to rise and fall which is naturally consistent with him breathing. However, it is clear that at no stage was Mr Gibson woken by police or was otherwise awake. In addition, there is no suggestion in the evidence of any of the police officers who made observations of Mr Gibson in the relevant period that he made any sound consistent with life, such as snoring.
- 2.14. I mention these matters in some detail as the time at which Mr Gibson experienced his cardiac arrest and the time at which that was detected by police is relevant to the issue as to whether or not his death could have been prevented. Clearly, the longer the duration between the cardiac arrest and the discovery of that circumstance, the less likely resuscitative efforts were going to be successful.

3. Relevant SAPOL General Orders

- 3.1. Tendered to the Court was the SAPOL ‘General Order – Custody Management’. Compliance with General Orders is mandatory. On page 20 of this document under the sub-heading ‘*Officer in charge of cells receiving detainees*’ it is stipulated as follows:
- mandated minimum detainee checks of not greater than 15 minutes for the first two hours are undertaken when the O/C has completed the initial care plan³
- 3.2. Under a sub-heading of ‘*High need detainees*’ it is stipulated as follows:
- the term ‘high need’ is a risk rating given to a detainee who poses a high risk to themselves, others or their management due to risk of self-harm (or attempt) or other known medical or health reasons. High need detainees will require more

³ Exhibit C40

frequent checks and closer monitoring compared to a detainee who has been assessed at a lower risk⁴

3.3. Under a sub-heading on page 46 ‘*Additional care of high need detainees*’ the following practices are mandated to apply:

- ensure mandated and any other designated checking regimes are maintained and recorded in the Custody record
- where available, ensure the cell is monitored by CCTV surveillance to enable constant observation of the detainee in conjunction with physical checks ⁵

3.4. On page 48 of the document the cell guard duties, among others, are described as follows:

‘When a cell guard is responsible for undertaking detainee checks and observations they must:

- be appropriately briefed about the detainee’s situation, risk assessment, care plan and particular needs
- conduct detainee checks as directed by the O/C cells and displayed in the ‘Obs’ column of the cell white board
- **record detainee checks in the detention log of the Shield Custody record as soon as reasonable (sic) practical after the check was conducted.** Where a detainee check is overdue a reason must be recorded in the detention log (emboldening added)

Where possible, the member who carried out the last detainee check should conduct the next detainee check. Continuous checks by the same member is good practice as it allows evaluation of any changes in the detainee’s condition and identifies additional risks. (emboldening added)

CCTV is a technological aid to detainee management but will not in itself eliminate risk and must not, other than where directed, be used as an alternative to the physical checking of detainees’.⁶

It can be seen from the emboldened passages that it was a requirement that detainee checks be recorded on the Shield Custody Record for the detainee and that it was considered desirable, if not mandatory where possible, that the same member should conduct sequential checks. One can see the good sense in that requirement. When one also examines the actual Shield detainee check section within the Custody Record, it also seems obvious that what is intended is that the officer who conducts the check

⁴ Exhibit C40, page 21

⁵ Exhibit C40

⁶ Exhibit C40

should make the entry on Shield. This is especially so given that there is no provision for the entry of more than one officer's name. All this leads to a conclusion that it would be shoddy practice for one officer to make the observation and for another officer to make the Shield entry.

- 3.5. The General Order (page 48) contains directions in relation to the carrying out of 'Physical detainee checks'. Under this heading it is stipulated as follows:

'When detainee checks are being conducted, a member must ensure they adhere to the following procedures for awake or sleeping detainees'.

There are then set out certain requirements in relation to both awake and sleeping prisoners. In respect of the sleeping patient it is stipulated as follows:

'When a detainee is asleep, a physical check requires a member to be close enough to be able to see that the detainee has a regular breathing pattern, is lying in a safe position and is otherwise not at risk. Where there are concerns for a detainee's mental or physical wellbeing they must be woken up and further assessed.'

It also relevantly states as follows:

'Always take into account the possibility or presence of other illnesses, injury or mental condition. A person who is drowsy and smells of alcohol or other intoxicants may be suffering from:

- diabetes
- drug intoxication or overdose
- epilepsy
- head injury
- stroke.

A diabetes sufferer may be asleep and unconscious due to hypo/hyperglycaemic episode'.⁷

4. Mr Gibson is processed at the CWH

- 4.1. Tendered to the Court was the SAPOL Custody Record relating to Mr Gibson.⁸ This record is a computerised record which is part of the SAPOL Shield information system.
- 4.2. A risk assessment was undertaken in relation to Mr Gibson. It was recorded in the Custody Record on Shield. As part of that assessment a number of questions were asked of Mr Gibson by the Officer-in-Charge of the CWH. It was recorded in the risk assessment section of the Custody Record that Mr Gibson indicated that he had 'a little

⁷ Exhibit C40, pages 48-49

⁸ Exhibit C38e

bit' of flu and that he was a diabetic. The officer has recorded that Mr Gibson was not talkative but that it sounded like he did not look after himself very well. Mr Gibson also indicated that he had been given medication in prison but had not been taking it since his release. He also indicated that he had an alcohol dependency and had previously experienced seizures.

4.3. Mr Gibson was also examined by a nurse. That nurse was an advanced clinical practice consultant registered nurse, Ms Jennifer Elizabeth King. Ms King's statement was tendered to the inquest.⁹ Ms King was a nurse employed by the South Australian Department of Health. She was currently engaged within Drug and Alcohol Services SA. In her statement Ms King indicates that she provided nursing services to SAPOL prisoners within the CWH. On the day in question she commenced her shift at 2pm.

4.4. In her statement Ms King indicates as follows:

'Ian GIBSON is known to the Watch House and to City Watch House Community Nursing Services (CWHCNS), as a High Needs prisoner due to diagnosis of Type 2 diabetes with non-compliance of medication and history of alcohol dependency with past withdrawal seizures and Asthma'.¹⁰

Ms King indicates that she was advised by CWH staff that Mr Gibson would be remaining in custody overnight, that he had been identified as a High Needs prisoner and that the CWH staff required her collaboration in the formulation of a care management plan. It was understood that a BA screen result for Mr Gibson was 0.103%, which is significant. I am uncertain as to the accuracy of this figure but, as indicated earlier, it is plain that Mr Gibson had alcohol in his system.

4.5. Ms King reviewed Mr Gibson in the observation cell at approximately at 10:37pm which was approximately 2½ hours prior to him being located in an unresponsive state in that cell.

4.6. Ms King's observations were that Mr Gibson appeared settled and cooperative. He did not appear grossly intoxicated and was standing when she made her observations of him. Overall he looked well and appeared to be in considerably better health than when he had last been observed by CWHCNS on 8 September 2016. Mr Gibson confirmed

⁹ Exhibit C10

¹⁰ Exhibit C10, page 2

that he had not been taking his medication since leaving YLP after his most recent incarceration. He allowed Ms King to take his blood sugar level to obtain a baseline which was at 15.1 mmols which is in the higher range, but not acutely significant. He had no ketones and stated that he had eaten that day.

- 4.7. Ms King indicates in her statement that she had seen Mr Gibson on many previous occasions and that he was well-known to their service. While he often presented as physically unwell, on this particular occasion he did not. Ms King viewed this as being consistent with Mr Gibson having recently spent time in Department for Correctional Services' custody and having been cared for in a period of alcohol abstinence. Ms King encouraged Mr Gibson to maintain his fluids and suggested that he could have a meal if he wanted it. Mr Gibson did not display any evidence of obvious alcohol withdrawal – there were no sweats, tremor or signs of agitation. Mr Gibson raised no concerns. He was keen to secure a second blanket and to go to sleep.
- 4.8. Ms King recorded her assessment in the Custody Record on Shield. Under the heading of '*Care Plan*' it is recorded that Mr Gibson was an alcoholic who had stated that he has had seizures. It was for this reason that he was considered to be High Need due to diabetes and seizure concern. The detainee check frequency was therefore to be 15 minutes. As far as the nursing assessment was concerned, it is recorded that Mr Gibson did not look unwell with no signs of chest infection. His blood sugar level was recorded as being '*okay*' and that he did not require medical attention. It was then recorded:

'GUARDS TO WATCH FOR DETERIORATION DURING SHIFT.'

I have accepted Ms King's statement that Mr Gibson did not appear to be acutely unwell. Although Mr Gibson had been accurately categorised as High Need, I do not believe there was any compelling reason for him to have been provided with any further medical assessment or treatment prior to his unexpected death. There was no overt reason as to why he ought to have been considered as not fit for custody. That is not to say, however, that Mr Gibson did not require close observation by his gaolers.

5. The evidence of Senior Constable Michael Ogilvie

- 5.1. On the night in question Senior Constable Ogilvie was a cell guard at the CWH. Mr Ogilvie gave a statement and also gave oral evidence by way of an audio link. When

Mr Ogilvie gave oral evidence to the inquest he was situated in his native Scotland. Mr Ogilvie told the Court that he had been a police officer in Scotland for 27 years rising to the rank of Detective Sergeant. He came to Australia in 2007 and took up an offer to become a police officer in South Australia. Mr Ogilvie was stationed in various locations in this State until he was ultimately assigned duties at the CWH. In May 2019 he retired from SAPOL and returned to Scotland.

- 5.2. Mr Ogilvie was the officer who found Mr Gibson to be unresponsive and in cardiac arrest.
- 5.3. In his witness statement Mr Ogilvie describes his duties as including the monitoring of the health of detained persons by checking them at regular intervals to ensure that they are alive and well. He asserted that prisoners are not generally woken if they are sleeping, but that personnel should observe either breathing or movement to ensure that life is present. If there is any uncertainty the cell door is opened and a physical check of the prisoner is made. This is what ultimately transpired with Mr Gibson when he was checked by Mr Ogilvie on that final occasion.
- 5.4. Mr Ogilvie indicates that on the night in question he commenced duty at 10:50pm and was briefed by the departing shift in relation to prisoners in custody, and in particular in respect of any medical concerns that were entertained. He was accompanied by Constable Jamie Smith among others. Mr Smith would be the second cell guard for the ensuing shift. Mr Gibson was already in cell 227. Mr Ogilvie understood that Mr Gibson had diabetes and was apparently an alcoholic but that he had been examined by the duty nurse prior to his arrival. He also understood that it was said in respect of Mr Gibson that he had not taken his medication for some time and that he had a BA level. Mr Ogilvie understood that his blood sugar levels were satisfactory. Mr Ogilvie explained that Mr Gibson had been placed on 15 minute checks.
- 5.5. Mr Ogilvie and Mr Smith were stationed in the cell guard office. Observation cell 227 in which Mr Gibson had been placed was situated across a corridor from the cell guard office, a distance of approximately 2.5 metres or 8 feet. During the inquest the Court conducted a site visit of the cell complex at the CWH. The Court made observations from the cell guard office towards observation cell 227. One can see from the cell guard office into the observation cell from where obvious movements of a prisoner could no doubt be detected. The evidence was that the rising and falling of the chest of an

otherwise stationary prisoner lying on the bunk in the observation cell could be detected from the cell guard office. Mr Ogilvie explained as follows:

'We could check them in a cell just through the observation window, you could see through the observation window but obviously they're not in front of the cell guards office we'd have to go through - most of the time we would take a wander around and check everybody but as you can see like, for example, the observation cells as I said are directly in front of the cell guards office and if we could clearly see that they're alive and breathing then that would suffice'.¹¹

Mr Ogilvie was further asked by counsel for the Commissioner of Police, Mr Roberts, as to whether it was possible to observe from within the cell guard office the breathing movement of a person situated in the observation cell. Mr Ogilvie reiterated that if he was not satisfied from observations made from the cell guard office that the prisoner was breathing, he would go and take a closer look at the prisoner and if necessary open the cell door.¹² If he was still not satisfied he would move the blanket or talk to the prisoner in order to obtain a response. Ultimately this is what Mr Ogilvie did in relation to Mr Gibson on the night in question except, of course, that he did not obtain a response from him.

- 5.6. In Mr Ogilvie's witness statement, which was given on the night in question following the fatal incident, he asserted that he did not recall at what times he or Mr Smith had checked the deceased. However, he asserts that on the '*last check*' that he himself had completed, Mr Gibson was lying on his left side under the blankets, his face was visible and his hands were visibly protruding over the side of the bed. Mr Ogilvie said in his statement that during this check he noticed Mr Gibson's hand move slightly which indicated to him that life was still present. The statement does not specifically identify the position from which Mr Ogilvie made those observations. However, in his oral evidence Mr Ogilvie stated that he was fairly certain that this observation was made when he was in the corridor immediately outside the cell. I have accepted that evidence.
- 5.7. In his evidence before the Court, Mr Ogilvie stated that the position that Mr Gibson was in when he checked him during his own penultimate check from the corridor was the position that he was in when he performed the final check and found him to be unresponsive. The CCTV footage confirms this. When one examines the CCTV

¹¹ Transcript, page 82

¹² Transcript, page 82

footage of Mr Gibson's cell at 12:00:53 (as indicated on the time counter on the footage), Mr Ogilvie is seen to look into Mr Gibson's cell for approximately four seconds. At 12:01:27 (as also displayed on the footage) Mr Ogilvie is seen to return to the door of the observation cell and again look into it, this time for approximately six seconds. Mr Ogilvie is then seen to return to the vicinity of the cell guard office. On neither occasion did Mr Ogilvie enter the cell of Mr Gibson. This is the final occasion on which Mr Ogilvie actually approached the cell door and looked into the cell from immediately outside that cell. Mr Ogilvie said in evidence that on the occasion that he had seen Mr Gibson's hand move he had also observed that Mr Gibson was breathing. He agreed that there was no mention of this in his original statement. He said that his check of Mr Gibson was a combination of observing his hand moving and observing his breathing.

- 5.8. On neither of these two occasions on which the CCTV reveals that Mr Ogilvie checked Mr Gibson from the corridor, separated only by about a minute, can any movement of Mr Gibson, including of his hand or indeed of his chest, be seen by the naked eye on the CCTV footage. When the Ogilvie check as revealed by the CCTV footage was played in Court, no counsel challenged my stated observation that I could not detect any movement of the deceased.¹³
- 5.9. There was no further check, as revealed by the CCTV footage, from the vicinity of the cell itself until Mr Ogilvie returned at approximately 12:55am (as indicated on the CCTV footage) when he entered the cell and found Mr Gibson to be unresponsive and in cardiac arrest. It is apparent from that footage that the only observations that could have been made following Mr Ogilvie's observations from the corridor would have needed to be made from the cell guard office. SAPOL records that I will discuss in due course document a number of observations that are contended to have been made of Mr Gibson from that location.
- 5.10. In cross-examination by Mr Plummer, counsel assisting, Mr Ogilvie was asked what it was that had actually prompted him to go to the hallway on the occasion when he found Mr Gibson to be unresponsive. Mr Ogilvie responded that it was time for his check. Mr Ogilvie said that he was not aware of the fact that there had not been any check made from the hallway for approximately an hour. He also said that there was nothing

¹³ Transcript, page 99

in particular that he had observed from the cell guard office that had prompted him to go to the hallway on this occasion. Mr Ogilvie did suggest that what possibly had prompted him to go to Mr Gibson's cell was the fact that the occupant had not moved for a significant period of time.¹⁴

5.11. Mr Ogilvie said that when he went to the cell door on this last occasion he could not see any movement so he opened the cell door and it was then that Mr Gibson was found to be unresponsive and in cardiac arrest.

5.12. Asked in cross-examination as to whether he had any recollection of making 15 minute observations from within the cell guard office in the period between his midnight observation and the observation an hour later when he found Mr Gibson to be unresponsive, he said that '*Yes, observations were made, yes*'.¹⁵ Mr Ogilvie was asked:

'Q. Do you swear, do you, that from the cell guard office, any observation that you made from that office, involved seeing his rise and fall of his chest.

A. I am comfortable and I am happy that that is what happened. I have made the observations, my colleague has made the observations for themselves and we can see movement'.¹⁶

5.13. As to the stipulation in SAPOL General Orders that where possible the member who carries out the last detainee check should conduct the next detainee check and that continuous checks by the same member is good practice as it allows evaluation of any changes in the detainee's conditions and identifies additional risks, Mr Ogilvie said that he was not aware of that stipulation but that in any event it was not possible for the same member to perform all the checks of Mr Gibson because the cell staff were carrying out different duties. He argued that on the occasion in question there were only the two cell guards such that they did not have the luxury of being able to look after individual prisoners on a continuous basis. Mr Ogilvie stated that even if the cells that evening had been fully staffed with three guards it would not have been practicable to have conducted continuous checks by the same member,¹⁷ but he did acknowledge the possibility that the reason that some of Mr Gibson's checks were conducted from within the cell guard office was due to time restraints caused by lack of staff.¹⁸ I did

¹⁴ Transcript, page 121

¹⁵ Transcript, page 115

¹⁶ Transcript, page 115

¹⁷ Transcript, pages 122-123

¹⁸ Transcript, page 119

not accept that latter suggestion. The cell guard office was only a matter of a few feet away from Mr Gibson's cell.

5.14. Mr Ogilvie maintained that no-one had suggested that Mr Gibson needed closer observation than 15 minute observations.

5.15. As to the stipulation in Mr Gibson's care plan that guards should watch for deterioration during the shift and why therefore checks were performed from the cell guard office instead of from the hallway immediately outside cell 227, Mr Ogilvie insisted that as long as they could see a regular breathing pattern, this was a sign of life as far as they were concerned. He said '*...the person's okay if he's breathing regularly*'.¹⁹ This of course begs the question as to how one would detect a deterioration in the person's wellbeing from the cell guard office, especially if a different person was making the regular checks. It also overlooks the possibility that a breathing detainee may be clinically unconscious as distinct from merely being asleep. As seen, the relevant SAPOL General Order contemplates this possibility.

5.16. Finally Mr Ogilvie was asked this:

'Q. Do you say, on your oath, that from the cell guard office, you can detect the rise and fall of the prisoner's chest, despite the fact that the prisoner is lying on a bed with a blanket or blankets over them.

A. It's the movement of the blanket that we're detecting. As I said, if you check the blankets, the constructions are, as I said, of quite a robust material and they tend to take up the movement of the detainee and yes, you can see somebody ... has either a deep breath or whatever you can see, movement, yes'.²⁰

That said, I do not understand Mr Ogilvie to lay claim to have personally made any observations of Mr Gibson from the cell guard office at a time after he had made his own penultimate observations from the cell door as revealed by the CCTV footage.

6. The evidence of Constable Jamie Smith

6.1. Mr Smith was the other cell guard on duty on the night of Mr Gibson's detention and death in the cells. When Mr Smith gave oral evidence in the inquest he was on leave from SAPOL and was working in the Metropolitan Fire Service.

¹⁹ Transcript, page 112

²⁰ Transcript, pages 113-114

- 6.2. Mr Smith gave a statement to investigating police on the night in question.²¹ He gave a further statement dated 27 November 2017 that goes into more detail in relation to the circumstances surrounding Mr Gibson's death.²² As indicated, Mr Smith also gave oral evidence.
- 6.3. Before discussing Mr Smith's statements and evidence I should here describe more fully the SAPOL electronic information system known as Shield. The Custody Record on Shield electronically recorded various aspects of Mr Gibson's detention including records made of the times of the regular 15 minute observations made by cell guards in respect of Mr Gibson's welfare. It is apparent from the Shield material that when one marries up certain events described within it with events depicted on the CCTV footage, the time discrepancy of approximately four minutes that I have earlier described becomes apparent. The times recorded on Shield are inherently more likely to be accurate.
- 6.4. For the period between 11:28pm until 12:57am as recorded on Shield, all of the recorded observations of Mr Gibson were purportedly recorded by a 'PD76435 MR SMITH, J'. That is Mr Jamie Smith. Between and including those times there are eight recorded checks. They are all recorded under the name of Mr Smith. Earlier recorded checks are under the name of other officers including Mr Ogilvie, under whose name a check conducted at 11:03pm is recorded.
- 6.5. Of the eight checks under Mr Smith's name the result of each check is recorded as follows:

'Detainee checked, breathing aac'. (the abbreviation aac means '*all appears correct*')

None of the recorded checks refer to any movement on the part of Mr Gibson other than breathing. Nothing else about the detainee's circumstances are recorded. Nor is there any specific record made of the officer who actually conducted the check. The Shield record gives every impression that each of the eight checks was personally conducted by Mr Smith when the evidence suggests that this may not have been the case in every instance. For example, we know that Mr Ogilvie conducted the two checks from the cell door in quick succession at 12:00:53 and 12:01:27, (those times being displayed on the CCTV footage). The corresponding record on the Shield system as recorded by

²¹ Exhibit C42

²² Exhibit C42a

Mr Smith is apparently recorded under the time 00:05:03, a discrepancy of about four minutes. I am satisfied that this Shield entry relates to Mr Ogilvie's checks shortly after midnight. And yet that check is recorded under the name of officer Smith.

- 6.6. As seen earlier, after Mr Ogilvie's midnight checks there were no further checks made at the cell door until Mr Ogilvie's final check when he found Mr Gibson to be unresponsive. Mr Smith's statements and his oral evidence deal with the nature of the checks recorded on Shield during the intervening period.
- 6.7. As indicated a moment ago Mr Smith gave investigating police a statement on the night in question when, one would think, the events of that night would have been fresh in his memory, particularly those relating to Mr Gibson. Mr Smith commenced the statement at 3:05am, approximately two hours after Mr Gibson's discovery by Mr Ogilvie in the cell. The statement makes it plain, as one would expect, that Mr Smith had been aware of Mr Gibson's presence in cell 227 during the course of his shift. The statement indicates that Mr Smith believed that Mr Gibson was in that particular cell because he was classed as a High Needs detainee. This was correct. However, the statement goes on to say that at the time Mr Smith was giving the statement he was unaware of the reasons why Mr Gibson had been categorised as a High Needs detainee. This is despite the fact that it is clear from the CCTV footage that Mr Smith was present during the shift handover where matters such as the reasons for a prisoner being High Need were discussed. Mr Gibson's High Need status and the reasons for that categorisation were also recorded on Shield to which Mr Smith had access. Mr Smith said that he was ignorant of Mr Gibson's circumstances despite the fact that his colleague, Mr Ogilvie, knew what the basis of Mr Gibson being classed as a High Needs detainee was. Nevertheless, Mr Smith did understand that Mr Gibson required 15 minute checks. I pause here to observe that given that cell guards have a responsibility in relation to the safety and welfare of prisoners, it is astonishing that someone in Mr Smith's position would purport not to know the reason why a prisoner is High Needs. High Needs can signify a number of different circumstances including medical circumstances as well as self-harm risk. It is difficult to see how a cell guard could do his or her job properly and administer the requisite care without knowing what a prisoner's High Needs were and why the prisoner was so classified.
- 6.8. I was also unimpressed with Mr Smith's assertions in his oral evidence that even if he had known the reasons for Mr Gibson's classification of High Risk he would still have

conducted his checks of Mr Gibson in the same manner, especially when one has regard to the General Order that stipulates that such prisoners will require more frequent checks as well as *'closer monitoring'* and the General Order that points out that a diabetes sufferer may be asleep and unconscious due to a hypo/hyperglycaemic episode, meaning, one assumes, that a cell guard should be alive to the possibility that an apparently sleeping diabetic detainee, even if being seen to breathe, may not necessarily simply be sleeping.

- 6.9. Mr Smith's original statement indicates that he was working with Mr Ogilvie and that he would *'...enter checks onto shield whilst SC/OGILVIE conducts checks on the detainee's (sic) in the cells and vice versa'*. This practice was one that was to my mind unsatisfactory. I will say more about this issue.
- 6.10. The original statement of Mr Smith asserts that he recalled conducting a check on Mr Gibson earlier in the night and observed that he was laying on his back inside the cell. He said that he returned to the cell guard office and entered the check onto Shield. When he conducted the check he observed Mr Gibson to be alive. He said he could not recall what movement he had seen that had indicated he was alive at that specific time, but it was either through general body movement or by observing a rise and fall of the chest to indicate breathing that he was satisfied that Mr Gibson was fine. Regarding the checks recorded under his name on Shield between 23:28 and 00:43, Mr Smith's first statement compiled that night asserts that he could not recall who had conducted those checks on Mr Gibson. These include the three successive checks before the final check when Mr Gibson was discovered deceased by Mr Ogilvie. As to why Mr Smith could not that same night recall whether or not he had been the person to conduct any one of these three checks, especially the third which was the final one before Mr Ogilvie's check, is to my mind inexplicable. Surely the key question in the initial stage of this investigation would have been what the condition of Mr Gibson had been during last the check made before the check in which he was discovered deceased. If that check had been made by Mr Smith, and Mr Gibson had been found to be breathing, it would be astonishing if Mr Smith did not, on the night, claim to remember if he had personally detected this.
- 6.11. Regarding the check at 00:57, this relates to Mr Ogilvie conducting his check, entering the cell and finding Mr Gibson unresponsive. Mr Smith made a record that at that time Mr Gibson was checked and was breathing, but it seems plain enough that he made that

entry seeing Mr Ogilvie at the cell and anticipating that everything was in order when it soon became very apparent that this was not the case.

- 6.12. Mr Smith's second statement signed in November 2017 asserts that due to Mr Gibson being in an observation cell directly across from the cell guard office, some of the checks were conducted from within that office. His statement asserts that as the view to the observation cell is unimpeded, one can physically see from within the cell guard office into the cell and that he could see that Mr Gibson was breathing and moving. Mr Smith said *'It is usual practice to check prisoners in observation cells from the cell guard office. If I was unable to see any signs of life from GIBSON in the observation cells from the cell guard office I would leave the cell guard office and enter the observation cell area until I am able to see a sign of life from him'*.
- 6.13. Mr Smith then went on to assert in this second statement that he could not recall who conducted each particular check from inside the cell guard office, whether it was he or Mr Ogilvie.
- 6.14. The statement then goes on to purportedly describe what took place on each of the checks that are recorded on Shield. When Mr Smith gave his oral evidence he performed a similar exercise.
- 6.15. I have already referred to the last movements made by Mr Gibson as can be observed on the CCTV footage. Those movements consisted of Mr Gibson taking the blanket from his head followed by slight movement of his arms which all occurred at the 11:14pm mark (as depicted on the CCTV video time counter). Following that movement one can see only three actual approaches by police to Mr Gibson's cell. These approaches occurred at 11:24:01 (as displayed on the CCTV time counter), 11:48:50 (as displayed on the CCTV time counter) and at 12:00:52 when Mr Ogilvie checked the cell from the hallway and returned to repeat that check about one minute later.
- 6.16. It is evident that if any further checks were conducted, as recorded in the Shield Custody Record, they were made from the cell guard office.
- 6.17. In Mr Smith's second statement he describes what occurred in relation to his detainee check which in the Shield record was recorded as having occurred at 11:28pm. There is no doubt that this entry corresponds to what can be seen to occur on the CCTV

footage at 11:24:01 (as depicted on the CCTV time counter). In that footage Mr Smith can be seen to look into cell 227 for approximately eight seconds. In his second statement Mr Smith said that when he checked Mr Gibson on this occasion he was displaying a sign of life. He said that he did not recall what he had seen to indicate that Mr Gibson was alive, but that his practice is to check for general body movement or the rise and fall of the chest to indicate breathing. Mr Smith gave oral evidence to the same effect. He agreed that the CCTV footage depicted him looking into the cell.

- 6.18. On the CCTV footage Mr Smith can be seen to next return to the outside of Mr Gibson's cell at 11:48:50 (as displayed on the CCTV time counter). He apparently looks into the room for approximately one second. This observation corresponds to Mr Smith's Shield entry timed at 23:51. The next check would be Mr Ogilvie's final checks made in quick succession from the cell door.
- 6.19. It is obvious that on both of the occasions that Mr Smith can be seen to look into Mr Gibson's cell, Mr Gibson has not in any way moved from one event to the other. Indeed, he does not appear to have moved since 11:14pm (as displayed on the CCTV time counter). It is not possible to detect any movement of Mr Gibson's chest at any stage on the CCTV footage, including on those occasions when Mr Smith observed Mr Gibson from the cell door and when Mr Ogilvie also observed Mr Gibson from the cell door. However, Mr Gibson is covered by a blanket on all of these occasions. Due to its lack of clarity, the CCTV footage itself does not preclude the possibility that the chest was in fact rising and falling and that naked eye observation could have detected it.
- 6.20. According to the Shield record there were the following additional checks all entered by Mr Smith. The times are those recorded on the Shield system and are taken to be accurate:
- 23:40:35
 - 00:18:12
 - 00:31:17
 - 00:43:38
 - 00:57:27

Of the above checks, the three checks conducted at 00:18:12, 00:31:17 and 00:43:38 were conducted in the period between Mr Ogilvie's checks from the cell door at

00:05:03 and Mr Ogilvie's final check at 00:57:27 when Mr Gibson was found unresponsive. I have accepted Mr Ogilvie's evidence that when he conducted his checks from the cell door at 00:05:03 Mr Gibson was seen to be breathing. The three checks conducted after that were not conducted at the cell door and so the assertion is that they must have been conducted from the cell guard office either by Mr Smith or by Mr Ogilvie. The same entry is made in relation to all of these checks namely '*detainee checked, breathing aac*'. Mr Smith's second statement sets out what he asserts occurred on each of these checks. Basically, Mr Smith asserts that all of those checks were made from the cell guard office and that the rise and fall of Mr Gibson's chest to indicate breathing was seen from that location. The question is, who conducted those checks? Mr Smith asserts that it is common practice to take the other cell guard's word on a prisoner's wellbeing at face value and enter a Shield check without checking on the prisoner himself.

- In respect of the 00:18:12 check, Mr Smith asserts that this was conducted from the cell guard office but he could not recall whether he or Mr Ogilvie conducted this check.
- In respect of the 00:31:17 check, this was conducted from inside the cell guard office. Mr Smith could not recall if he conducted the check or if Mr Ogilvie conducted the check.
- In respect of the 00:43:38 check, this was conducted from inside the cell guard office. Mr Smith asserts in the statement that he could not recall whether he conducted the check or if Mr Ogilvie conducted the check.

6.21. In his oral evidence Mr Smith gave a similar account in relation to those checks. Thus the evidence is completely unclear as to the identity of the officer who actually conducted the checks purportedly made from within the cell guard office. Although it is clear that Mr Smith made the relevant entries on Shield, this was not necessarily indicative of the officer who had conducted the actual check. As to who had conducted those checks, Mr Smith said in evidence, '*...either of us could have done it, yes, but I'm not sure who*'.²³ However, accepting as I do Mr Ogilvie's assertions that the final check that he conducted consisted of the two checks made in rapid succession from the cell door just after midnight, inferentially the subsequent checks made from the cell guard

²³ Transcript, page 154

office would have been made by Mr Smith. And yet Mr Smith is not prepared to say in plain terms that he conducted those checks.

- 6.22. So, all that the two officers can say between them is that their usual practice was to make an observation from the cell guard office by relying exclusively on the rise and fall of the prisoner's chest as an indicator of wellbeing and that this must have occurred on each of the occasions that checks were made from within the cell guard office regardless of who it was who had made the check. That would have been the only method of checking Mr Gibson's wellbeing given that he otherwise did not move at all over the relevant period.
- 6.23. Thus it is that neither Mr Ogilvie nor Mr Smith could apply their oath or affirmation to say that they had conducted any specific check that had been made from within the cell guard office. This includes the important penultimate check that occurred at 00:43:38. To my mind this is a grossly unsatisfactory forensic state of affairs and is one that should not recur.
- 6.24. One further matter that troubled the Court was the fact that at the time that Mr Smith made the Shield entries for the checks that were made from the cell guard office, he would have been facing the direction of the observation cell. This then begs the question as to why Mr Smith would have needed to rely on what Mr Ogilvie told him if it had been Mr Ogilvie who had made the observation of Mr Gibson but that it had been Mr Smith who had then recorded it on Shield. Mr Smith could have made his own observation of Mr Gibson regardless of what observation Mr Ogilvie was making. There is no evidence that Mr Ogilvie's position within the cell guard office would have been any better from which to observe Mr Gibson than Mr Smith's position. It would seem to be a rather artificial process for Mr Smith to rely on observations made by Mr Ogilvie when Mr Smith himself could easily look into Mr Gibson's cell and determine for himself whether or not the rise and fall of Mr Gibson's chest could be detected. Yet, Mr Smith's evidence leaves open the possibility, at least in his mind, that this is what happened. The practice adopted by Mr Ogilvie and Mr Smith whereby Mr Ogilvie would make the observation and Mr Smith would record that observation was patently absurd and unhelpful. The practice should not be repeated. The absurdity of this practice is illustrated in the following passage of Mr Smith's evidence:

'Q. But when you're making the entry you're actually looking out towards the cell area, aren't you.

- A. You are, yes.
- Q. Why can't you make your own observation then. Why rely on Ogilvie when you're looking virtually in the direction of the prisoner.
- A. You could, but I'm just taking his word for that the detainee is checked and he's okay. I've done my part and he's doing his part, we're working together to do our job.
- Q. But why take his word when you're perfectly capable yourself of looking out the window and seeing whether he's okay or not.
- A. Because we work together, that's what we do²⁴,

thereby taking the concept of teamwork to ridiculous and unnecessary lengths.

- 6.25. In cross-examination by Ms Waite on behalf of Mr Gibson's family, Mr Smith was asked whether he conceded that Mr Gibson may not have been breathing at the previous 15 minute check. Mr Smith's response was one of insistence that they had conducted the check and at that point it was observed that Mr Gibson was breathing. However, Mr Smith also had to acknowledge that he could not recall who had conducted that check and in the light of that it was suggested to him that he would have to concede it was possible that Mr Gibson was not breathing at that stage. Mr Smith's response was '*No, because the check was conducted*'.²⁵
- 6.26. Mr Smith was cross-examined on a number of subject matters by Mr Plummer, counsel assisting. Mr Smith still maintained that he had no idea as to why Mr Gibson had been considered as a High Needs detainee and appeared to suggest that he did not in reality need to know because he would have conducted his checks in the same manner regardless of the reason Mr Gibson was considered to be High Needs.²⁶ To the requirement in General Orders that staff were mandated to check for a '*regular breathing pattern*', Mr Smith said he was not aware of that requirement. I am not certain what that expression is meant to convey over and above the need to check whether the detainee is breathing or not. If the detainee is breathing in the same manner from one 15 minute check to the next, I am not certain whether that would be characterised as anything other than a regular breathing pattern.
- 6.27. By conducting the checks in the way that they did, and by not actually approaching the cell itself so they could be seen on CCTV to conduct the check, Mr Ogilvie and Mr Smith have laid themselves open to a suspicion that they did not make any checks

²⁴ Transcript, page 155

²⁵ Transcript, page 171

²⁶ Transcript, pages 175-176

from the cell guard office, or that if they did make those checks they saw nothing to suggest that Mr Gibson was breathing.

7. Conclusions

- 7.1. Mr Gibson died on 22 August 2017 in cell 227 at the SAPOL CWH. I take the date of Mr Gibson's death from the time of SAAS certification that he was deceased, namely at 1:39am on 22 August 2017.
- 7.2. Earlier that night Mr Gibson had been arrested by police in Hindley Street in the city. I find that his arrest was lawful. Similarly, I find that his being taken into and being kept in custody at the CWH was lawful and appropriate.
- 7.3. The cause of Mr Gibson's death was congestive cardiac failure due to cardiomyopathy and coronary artery atherosclerosis.
- 7.4. Prior to his death in cell 227, Mr Gibson had been examined by a registered nurse. Mr Gibson's current condition and his medical history were properly taken into account by the nurse examining Mr Gibson. There is no suggestion other than that the examination was appropriately conducted and that Mr Gibson was fit to be accommodated in the CWH overnight.
- 7.5. Mr Gibson was rightly considered to be a High Needs prisoner.
- 7.6. Observation checks made at approximately 15 minute intervals were conducted in respect of Mr Gibson. From approximately 11:14pm onwards Mr Gibson did not overtly move as shown by constant CCTV surveillance of cell 227. It is not possible to determine one way or the other on the CCTV footage whether Mr Gibson is breathing at any point from approximately 11:14pm onwards. It is also not possible from the CCTV footage to determine at what stage Mr Gibson stopped breathing and died.
- 7.7. I have accepted Mr Ogilvie's evidence that his two consecutive checks within a minute that occurred shortly after midnight and which were made from the cell door revealed that at that time Mr Gibson was displaying a rising and falling of his chest which signified that at that time he was breathing. It is not possible to determine whether at that point in time Mr Gibson was asleep or unconscious. Mr Gibson showed no signs of being awake or of being conscious at any stage following his last movement as seen on the CCTV footage.

- 7.8. Following Mr Ogilvie's sighting of Mr Gibson from the cell door shortly after midnight, three further checks on Mr Gibson were recorded within his Custody Record on the SAPOL Shield system. They were recorded as having occurred at 00:18:12, 00:31:17 and 00:43:38. These entries were recorded by SAPOL officer Constable Jamie Smith. Neither Mr Ogilvie nor Mr Smith in their oral evidence before the Court could attest from their independent memories that they had actually conducted checks of Mr Gibson at those times. The CCTV footage does not reveal the attendance of either officer in the vicinity of the cell at those times. Any checks that were conducted at those times would have had to have been conducted from the cell guard office. Only by a line of inferential reasoning could one conclude that it was Mr Smith who had conducted those checks. Mr Smith does not lay claim to having an actual recollection of conducting those checks. He asserts that even on the night in question he could not so recollect. I make no findings in relation to whether or not those checks were conducted and what the results of those checks were.
- 7.9. At 00:57:27 Mr Ogilvie checked on Mr Gibson from the door of cell 227. Mr Ogilvie on this occasion decided to enter Mr Gibson's cell. Mr Gibson was found to be in cardiac arrest at that time. I make no finding as to when it was that Mr Gibson experienced his cardiac arrest. Accordingly, I make no finding as to whether or not resuscitative efforts were timely.
- 7.10. In any event I do not believe that Mr Gibson's death was necessarily preventable. Even assuming that the 15 minute checks were conducted in strict accordance with the SAPOL General Orders, and that Mr Gibson was found to be breathing on those checks, his cardiac arrest may have occurred immediately following a check in which case his chances of successful resuscitation commencing at the next check could not have been assured. Also, I do not believe that in cases such as that of Mr Gibson, constant observation for evidence of breathing or for the purposes of detecting a cardiac arrest would be appropriate. If a person was at risk as to warrant such scrutiny, he or she should be removed from custody and be provided with professional medical assistance in an appropriate facility.
- 7.11. Accordingly, the Court does not make any recommendation in this matter that would be designed to prevent or render less likely events such as Mr Gibson's death.

7.12. However, I think the Commissioner of Police would be well advised to consider the following:

- 1) To remind staff working within SAPOL cell complexes that an apparently sleeping prisoner may be in a state of unconsciousness and that wellness cannot simply be assumed by the fact that the prisoner appears to be asleep.
- 2) Checks on High Need prisoners should be conducted by officers who are in close proximity to the prisoner, especially in relation to prisoners whose health may be compromised and especially when they are apparently sleeping. Checks should not be made remotely from another room across a corridor or purely by way of CCTV. The checks should also be made from a location at which CCTV coverage will demonstrate that the checks have been made by the officer conducting them.
- 3) Cell guards and other SAPOL personnel operating in cell complexes should demonstrate knowledge of and a proficiency in the requirements set out in SAPOL General Order Custody Management.
- 4) SAPOL personnel working in cell complexes should be instructed and/or reminded that the officer who conducts an observation check on a prisoner must be the officer under whose name the record of that check is made. I note that this issue has been the subject of a SAPOL directive requiring that the person conducting a check is the person who is to complete the Shield Custody Management entry. In addition, I understand from counsel for the Commissioner of Police that the details of what is actually observed is now required to be entered into the check record. I would observe that *'breathing aac'*, meaning that the person is breathing and that all appears to be correct, should not be regarded as an appropriate and sufficient record.

Key Words: Death in Custody; City Watch House; SAPOL

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

Seal the 28th day of May, 2021.

Deputy State Coroner