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 23rd and 24th days of September, the 7th, 8th, 9th, 12th, and 22nd days of October, the 9th, 10th and 25th days of November, the 14th, 15th, 16th, 21st and 23rd days of December 2020 and the 28th day of June 2021, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Joshua Marek Stachor.

The said Court finds that Joshua Marek Stachor aged 30 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 19th day of November 2017 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Joshua Marek Stachor died on Sunday 19 November 2017 at Yatala Labour Prison.[1] Mr Stachor was 30 years old. He was born on 25 January 1987. His death was a suicide.

1.2. Mr Stachor was remanded in custody by the Elizabeth Magistrates Court[2] on 6 November 2017. This followed his arrest and remand in custody by South Australia Police[3] on 5 November 2017 on charges of domestic violence assaults. It was his second incarceration in 2017, having been arrested on a court issued warrant on 25 January 2017. He was released on bail on 20 June 2017 from the Adelaide Remand

[1] Yatala
[2] EMC
[3] SAPOL

Centre[4] after a transfer from Yatala. I will refer to this earlier period in custody further in this finding as it differed markedly in terms of how he was classified at admission and monitored by the Department for Correctional Services[5] in the remand in which he died.

2. Mr Stachor's death

2.1. At about 11:20am on 19 November 2017, Mr Stachor was placed back into his single cell in B Division Middle East[6] at Yatala.[7] He had moved there on 17 November 2017 from a dual accommodation cell.

2.2. That morning he had been released from his cell and spent time within his BME wing as allowed. CCTV footage shows no unusual behaviour by Mr Stachor that would indicate immediate concern.[8]

2.3. Mr Stachor was provided lunch through the open trap door of his cell which was then shut, consistent with the practice of Yatala. Correctional Officer[9] Swalwell secured Mr Stachor in his cell. At 11:32am the barrier to the wing was secured and the wing was locked down. This is consistent with the practice of COs having a meal break of about 90 minutes.

2.4. At 1:05pm the barrier to the wing was opened by COs and Mr Stachor's cell was opened by CO Chapman. He looked through the inspection glass window into Cell 422 but it was dark and he could not see through it.[10]

2.5. He opened the secure cell door, but due to the darkness he could not immediately see Mr Stachor on his bed. He moved inside. Mr Stachor was:

> '…facing away from the bed with his knees bent but not touching the ground, his feet with the front of each foot on the ground and hunched over forwards, his head was leaning forwards almost with his chin touching his chest.' [11]

Mr Stachor's head was about four feet from the ground and there was a black cord around his neck. The cord was attached to a bracket near the foot of the bed.

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[4] ARC
[5] DCS
[6] BME
[7] Cell 422
[8] Exhibit C20q
[9] CO
[10] Exhibit C1a
[11] Exhibit C1a, paragraph 6

2.6. CO Chapman raised a Code Black and cut Mr Stachor down before taking him out into the wing where CPR began immediately with CO Connor. The medical evidence shows that he was deceased at that time and despite extensive CPR procedures, he was unable to be resuscitated.

2.7. At 3:40pm Professor Roger Byard, a forensic pathologist from Forensic Science South Australia, attended. Professor Byard is of the opinion that Mr Stachor's death was due to neck compression from hanging associated with an underlying fracture of the left superior horn of the thyroid cartilage. No other internal or external injuries were identified in a post-mortem examination. Professor Byard gave his opinion that the cause of death was due to hanging. I accept his opinion and find the cause of death to be hanging.[12]

2.8. Professor Byard observed that Mr Stachor had marked atherosclerosis of two major epicardial coronary arteries which he noted as unusual. A cause of this may be associated with the use of drugs such as amphetamines or steroids, or it might be an inherited situation. He advised that immediate family members should be medically evaluated on this basis.

3. Reason for Inquest

3.1. As Mr Stachor was legally in custody at the time of his death, an Inquest into the cause and circumstances of his death is mandatory.[13]

3.2. It is clear that Mr Stachor's death was suicide. No note was found in his cell consistent with or explaining his reasons for the suicide. A letter to his solicitor had been written about finding an address for a future bail application and a note with his name and mobile phone number was found in a pocket of the shorts he was wearing.[14] A blood sample was taken for toxicological analysis at post-mortem. Prochlorperazine was detected in the blood in non-toxic concentrations. This is consistent with him receiving Compazine in the previous days to treat his expressed anxiety and paranoia.[15]

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[12] Exhibit C2a, post-mortem report
[13] Section 21(1)(a) of the Coroners Act 2003
[14] Exhibit C2a, the 'note' referred to in Professor Byard's report
[15] Exhibit C3a, toxicology report

3.3. A number of issues have arisen from his suicide, namely:

- His admission to Yatala on 6 November 2017;
- His placement on the night of 6 November 2017 and monitoring of his behaviour from 7 November 2017 until his death;
- The comparison between his first remand in custody in 2017 from January to June and this remand;
- Ligature points in cells at Yatala;
- The ligatures found in Mr Stachor's cell;
- The degree of training necessary for COs to conduct admission interviews.

4. General procedures for admission into Yatala as at 6 November 2017

4.1. This is a multi-faceted issue that was the subject of extensive evidence at the Inquest. In order to properly understand and deal with the breadth of this issue, it is important that I briefly set out the standard procedures for admissions to Yatala before dealing with the issues that occurred in the admission of Mr Stachor on the evening of 6 November 2017.

4.2. In 2017 a man remanded in custody from the EMC would be taken to Yatala. On a Monday the number of men remanded in custody from the EMC is usually larger than the other days due to multiple SAPOL arrests and remands without bail over the preceding weekend. This is the same pattern for all Magistrates Courts in South Australia.

4.3. G4S, a private company, is responsible for transporting these men from EMC to Yatala. Upon G4S arriving at Yatala, the remanded prisoners are taken to the holding cells area. G4S are met by the swing shift supervisor, who is a CO with a senior ranking and is responsible for ensuring that the men presented to Yatala are in accordance with the Court orders. Any relevant SAPOL documents, including what was known as the Detainee Transfer Report[16], is also included with the relevant paperwork from EMC.

4.4. The Inquest heard evidence from a now retired senior CO4, Ms Esther Irish, who described this procedure and her role as a swing shift supervisor.[17] It begins with one

[16] DTR

[17] Her evidence about the admission procedure is also supported by CO4 Hills in his affidavit Exhibit C42, paragraphs 16-34

of the G4S officers greeting her at the security door. She will be told how many prisoners are to be admitted and whether any of them are returned prisoners from court hearings or new admissions.

4.5. She expected to be told about any concerns G4S had about any of the men. Any report of erratic behaviour or recalcitrant behaviour would also be given.

4.6. The prisoner is then brought within the holding cells where the swing shift supervisor would speak briefly to the prisoner, ask details about their warrant and check their identification.

4.7. If all is correct, the prisoner will have their photo taken prior to a strip search. The prisoner then showers and is issued with prison clothes. Personal property is also seized. The prisoner is placed in what is called the '*new admit holding tank*'.[18] The next prisoner is presented from the van. An admission interview will take place between a CO and the prisoner to provide an assessment on their physical and mental state. They are then seen by the Yatala nurse on duty for a medical assessment.[19] This is the usual basis for a decision to be made where the prisoner is to be housed initially within Yatala. CO Darren Hills stated '*98%*' of prisoners are initially placed in B Division.

4.8. Ms Irish worked as the swing shift supervisor on 6 November 2017 when Mr Stachor was admitted into Yatala. By workplace standards, only 16 men are to be held in the holding cells at any time.

4.9. On 6 November 2017, 22 new prisoners were admitted to Yatala.[20] Ms Irish has no memory of meeting Mr Stachor that night in accordance with the procedure she described.[21]

5. Justice Information System

5.1. The Justice Information System[22] is a system used to electronically record characteristics, conditions and internal movements of prisoners within Yatala. The JIS is divided into 'green' or 'white'. However, both platforms are fully integrated and

[18] Commonly referred to as 'the tank' in evidence
[19] Exhibit C44
[20] See Exhibit C50
[21] Transcript, pages 410-414
[22] JIS

share information between each other. On admission, the swing shift supervisor would check on the JIS as to any current or past warnings about the prisoner.

5.2. The photograph taken upon admission is placed on the JIS at the time of admission.

5.3. The JIS records reveal that Mr Stachor was admitted at 6:52pm with his photograph being uploaded to the system and documentation being printed at 6:53pm.[23]

5.4. The JIS is important and will be discussed in detail later in these findings concerning what information could have, or should have, been identified with regards to Mr Stachor's admission and subsequent remand period prior to his death.[24]

6. Standard Operation Procedure 001A

6.1. SOP001A governs the principles and duties of the officers involved in the admitting of a prisoner to Yatala. It is a DCS document for all admitting gaols.

6.2. The above narrative of the admissions procedure by the swing shift supervisor is governed within that document.[25] This document will be examined in further detail later in these findings. I note that it has been reviewed and amended since Mr Stachor's death.

7. Placement in holding cells

7.1. This is likely to have occurred at approximately 7pm for Mr Stachor given that he was recorded on the JIS as being admitted at 6:52pm.

8. Admission interview

8.1. The JIS entries show that Mr Stachor's record was accessed by his interviewer at 9:41pm. The next JIS entry is at 10:03pm when his interviewer entered a casenote.[26] The interview forms showed the interview commencing at 10pm. This must be an error if it is accepted that Mr Stachor was seen by the nurse from the South Australian Prison Health Service[27], Ms Dunn, at 10:05pm for his admission assessment. It is likely that this is when his interview finished.

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[23] Exhibit C42, paragraph 35-48
[24] Transcript, pages 414-416
[25] Exhibit C20d
[26] Exhibit C39, page 2 of Annexure TA1
[27] SAPHS

9. Kym Golding

9.1. Mr Golding was the CO who conducted the admission interview of Mr Stachor. Mr Golding has a long career as a CO and holds the rank of CO2. Mr Golding tendered an affidavit and gave oral evidence at the Inquest. Many issues arose regarding Mr Golding's involvement and role as the admission interviewer of Mr Stachor, namely:

- Whether it was appropriate for Mr Golding to have been used as an interviewer;
- Mr Golding's notations on the interview forms;
- Whether a Notice of Concern[28] should have been raised at the interview;
- The format of the interview forms;
- Mr Golding's interaction with Mr Darren Hills, a supervisor in admissions.

10. Notice of Concern

10.1. A NOC is an extremely important notation concerning an individual prisoner. It can be raised at any time during a prisoner's stay at any DCS prison. A decision whether to raise a NOC for a newly admitted prisoner is the primary focus of the admission interview.

10.2. CO4 Darren Hills, an experienced admissions interviewer, gave evidence in Court that any previous incident of self-harm or a suicide attempt will '*require a NOC*'.[29] A NOC is permanently recorded on the JIS and the first opportunity for this to be considered or reconsidered is admission or readmission of a prisoner to Yatala.

10.3. If a NOC is raised then the prisoner becomes subject to a series of considerations and checks within Yatala by the High Risk Assessment Team.[30] The significance of being placed under the HRAT regime is that there is more intensive scrutiny of the prisoner than a standard seven day observation by COs on admission, usually in B Division, at Yatala.

[28] NOC
[29] Exhibit C42, paragraphs 53-54 and Transcript, page 298
[30] HRAT

10.4. Mr Joe Decicco is the Manager of the Offender Development Unit[31] which governs the HRAT at Yatala. He has been employed by DCS as a qualified social worker since 1986. He has been the Manager of the ODU since 2004. He is a highly qualified and dedicated social worker that deals with the myriad of practical, psychological and crisis issues that are associated with prisoners at Yatala. As he puts it, he has '…*oversight of all the social work functions that happen within the prison*'.[32]

10.5. His unit covers for the care of prisoners where a NOC has been raised. He explained that when a NOC is raised the relevant supervisor, along with the SAPHS:

> '… will do up an initial response plan which is aimed at ensuring that the prisoner is kept safe and placed appropriately to minimise the prospect of self-harm.' [33]

10.6. An email is then sent to a dedicated HRAT email address. Mr Decicco will formally place the prisoner's name on the white JIS which acknowledges the prisoner is under HRAT supervision.

11. HRAT practices and procedures

11.1. In summary the following procedures occur when a NOC is raised, namely:

- The supervisor of the area in which the prisoner is housed is notified;
- That supervisor will arrange an assessment by the SAPHS nurse;
- The SAPHS nurse and supervisor will prepare an Initial Response Plan which sets out an observation and placement regime to manage the level of risk of self-harm;
- Within 24 hours of the NOC, the prisoner must be seen by a social worker from the ODU for assessment and consideration of further measures to ensure the prisoner's safety and provision of ongoing support;
- HRAT meets on a weekly basis to conduct ongoing assessments of prisoners on HRAT and determines whether that should continue or the prisoner is well enough to be removed;
- Each prisoner on HRAT has a specified social worker from ODU.

[31] ODU
[32] Transcript, page 351
[33] Transcript, page 352

11.2. On this night, 6 November 2017, although he was not on duty, Mr Decicco was working from home and looked at the JIS to see whether any NOCs had been raised on the prisoners admitted.

11.3. The purpose was to make a HRAT list to distribute to the supervisors. The JIS records attached to his affidavit show that Mr Decicco browsed the casenotes of Mr Stachor from about 8:22pm through to 9:39pm, as well as his final browse at 10:36pm.[34]

11.4. During this browsing session Mr Decicco had no access to the Prisoner Stress Screening Form nor the Prisoner Interview Form F001/004. Both of these forms are discussed in detail below.

11.5. Although he has no specific memory, Mr Decicco believes he did not speak to Mr Golding on the night of 6 November 2017. This is consistent with Mr Golding's evidence where no mention was made of contact by Mr Decicco.

11.6. In cross-examination, Mr Decicco confirmed that the raising of a NOC does not mean the prisoner automatically ends up in a strict regime of observation in isolation such as in G Division. The prisoner concerned may simply follow a mainstream prisoner's regime with the security of the HRAT procedures, as I have set out, concerning social workers and monitoring by the ODU.[35] Each situation of a prisoner on HRAT will be assessed individually.

11.7. No NOC was ever raised for Mr Stachor in relation to this period of remand in custody. It is therefore convenient to return to Mr Golding's interview with Mr Stachor on the night of 6 November 2017 as it was the first opportunity to consider whether that was the appropriate course of action at that time.

12. Mr Stachor's admission interview forms

12.1. According to the admission forms, the interview of Mr Stachor began at 10pm. As stated earlier, this must be in error when considered in conjunction with the SAPHS form which stated Ms Dunn saw Mr Stachor at 10:05pm. Mr Golding had a number of DCS forms to consider and fill out. These forms are set out in SOP001A.[36] It is best to deal with these completed forms separately to highlight issues associated with each

[34] Exhibit C46, Attachment JD1-Green JIS audit pages 2-3. See also Transcript, pages 359-360
[35] Transcript, pages 367-368
[36] Exhibit C20d at 3.7.1 and Exhibit C30, Annexure HB2

form, including interpretation of key questions relevant to whether a NOC should be raised.

12.2. Admission checklist (F001/001)

This document comprises a checklist of actions to be undertaken by the CO when admitting a prisoner. It also details a checklist of forms which must be completed, with the relevant information entered onto JIS, prior to admission.

12.3. This document[37] was criticised by CO4s Hills and Irish during their evidence.

12.4. Mr Golding admitted ticking every action/issue in the list even though he did not clarify whether those duties had been performed by other officers prior to the interview.[38] He did not check the JIS history but assumed that had been done.[39] This conflicts with the JIS records. On the assumption he did check the JIS history, he would have seen that there was previous HRAT involvement with Mr Stachor during his first remand in 2017. This information was available to him on the Green JIS.[40] He believed that one of the CO4s would have checked that information prior to the interview.

12.5. The form itself states that the Supervisor of Operations/OIC is to ensure that the issues Mr Golding verified had been considered correctly.

12.6. This confusion was a vital component of what was missed in assessing whether Mr Stachor needed a NOC. The errors relevant to this form were multi-layered. It led to assumptions and operational confusion based on poor formatting and expression.

12.7. A further confusion existed as at the time of Mr Stachor's admission, namely that SOP001A and SAPOL paperwork were out of date. The key phrase '*admitting officer*' was not defined within that document. The related topic of '*responsible officer*' was not defined and the admissions checklist was out of date. Finally, SAPOL paperwork referred to old police forms rather than the Detainee Transfer Report.

12.8. I am told, and I accept, that these issues have been examined with the updated SOP001A being presented to the Court.[41]

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[37] Exhibit C32
[38] Transcript, page 57
[39] Transcript, page 57
[40] Transcript, page 59
[41] Exhibit C30, Annexure HB32, affidavit of Ms Helen Bales

12.9. Specific needs assessment (F001/002)

This document deals with disease and drug and alcohol information.[42] This form was uncontroversial and was completed in compliance with its requirements.

12.10. Prisoner stress screening form (F001/003)

This form was subject of much evidence at the Inquest.[43] The PSSF has 26 specific questions along with other important issues for the interviewer, here Mr Golding, to consider and report on.

12.11. The instructions for this document are clear and include that '*where necessary*' the questions should be '*rephrased to suit the individual/cultural needs of the prisoner*'. The interviewer is also instructed to '*observe how the prisoner acts as well as what is said*'.

12.12. The questions are set out in full with two columns, column A for 'yes' and column B for 'no' answers to be recorded. A 'yes' answer means a point is allocated towards the overall score for the interview. The score is a critical factor in determining if a NOC should be raised by the interviewer. A score of nine or more means a NOC must be raised. There are very small spaces for the details of an answer and/or concerns of the interviewer to be recorded. If any one of questions 21–23 concerning self-harm are answered 'yes/maybe' by the prisoner, a NOC must be raised irrespective of the final score for the interview.

12.13. Two other methods exist for a NOC to be raised at admission, namely by reference to SAPOL forms that are part of the documents at admission that identify whether SAPOL had identified the prisoner to be previously at risk of suicide or self-harm '*within previous 7 days*'. The second method relies on the intuition of the interviewer that '*regardless of the score the interviewing officer feels a further opinion is warranted*'.[44]

12.14. One of the key questions concerning self-harm is '*Have you ever tried to intentionally hurt yourself?*'. Mr Stachor's PSSF had 'no' ticked. That was not the truth concerning self-harm but may have been Mr Stachor's literal response. As these are questions from COs to prisoners, 'no' may have been recorded as the literal answer by Mr Stachor even

[42] Exhibit C22, page 44
[43] PSSF
[44] Second page of PSSF incorrectly paginated as page 1 of 1

if that does not reflect the truth. In other words, a reasonable argument exists that a CO would not be incorrect to fill out a prisoner's literal response, even if it was a lie. I pause here to note CO Darren Hills would not follow that procedure in such a situation, but rather rely on the documented evidence. However, CO Shirley Bell would record the literal answer. That difference between two very experienced COs highlights a problem.

12.15. Mr Stachor indicated during the interview that he had a fear of motorcycle gangs. Twice on this form Mr Golding noted in capitals '*KEEP AWAY FROM MOTORCYCLE GANGS*'. It is clear that Mr Golding was greatly concerned by the fear Mr Stachor relayed to him. Mr Golding's solution about this fear of Mr Stachor was that a NOC should be raised. He signed the PSSF to that effect, although he did not follow the correct procedure in following up the requirements of raising a NOC.

12.16. I refer to Mr Golding's note on the JIS at 10:03pm on 6 November 2017:

> 'Stachor stress score was 4 – he informed me that he had a few issues last time here in Yatala – he informed me that he want (sic) to keep away from motorcycle gangs whilst here as last time he was transfered (sic) to the ARC BECAUSE OF THESE/HIS ISSUES – he has been placed in BRAVO.' [45]

12.17. This note is consistent with Mr Golding's account of the admission interview with Mr Stachor. Mr Golding did not note that he had recommended a NOC, or that he should be placed in G Division overnight.

12.18. I digress here to make some general comments about Mr Golding.

12.19. Mr Golding in his 14 year career as a CO has had limited supervisory roles. As he put it in a self-deprecating manner, when asked to do work outside of his normal day duties he indicated he was '*a pleb, just helping out*'. It is clear that he struggled with the extensive nature of the paperwork for the admission interview under SOP001A. It is also clear that he has an instinct for observing and recognising issues and concerns about individual prisoners. In this case, he thought Mr Stachor's issue with motorcycle gangs was a serious safety concern.

12.20. His solution for that concern was to advocate for Mr Stachor to spend the night of 6 November 2017 in G Division where he would be under very close supervision and opportunities for self-harm are virtually eliminated due to the structure of a G Division

[45] Exhibit C25, page 2

cell. He had worked in G Division for a number of years and knew that after a prisoner's first night in G Division he would have an interview with the SAPHS nurse the next morning. In a defacto way he was carrying out the procedure described of raising a NOC to seek another opinion. Mr Golding's intent to assist in whatever way he could was genuine and admirable. His manufactured hybrid solution should not have been necessary if there was a much simpler method as to whether or not to register a NOC.

12.21. I am sure he would be seen by many prisoners as a compassionate and caring officer who understands the ways of Yatala life and always tried to help out. That is certainly the view of his colleagues that I heard from in this Inquest. It is consistent with the opinion I formed of him about his general character having watched and listened to him closely in his extensive evidence. He was sanctioned for his behaviour this night but for reasons that will follow his sanction should now be considered in the mitigating light of his inadequate training for this important role.

12.22. Prison interview form (F0001/004)

This is a form that is entered onto the White JIS.[46] Mr Golding gave evidence that the information on this form was entered at the time of the interview after he had gone '*…through all this with him*'.[47]

12.23. The form was then printed and signed and the information recorded on the White JIS. Mr Golding could not remember whether any warnings concerning Mr Stachor were brought up on that system at that stage.

12.24. A key question was '*Do you have any concerns relating to your safety in prison?*' to which the form displayed the answer '*No*'.

12.25. These warnings would have been available on the Green JIS, but Mr Golding did not check this believing:

> '…that's the CO4 supervisors job, that's how I understood it; he checks all that, gives me the folder and that's when he puts what division he is going into'.[48]

There is an obvious contradiction between the two vital forms concerning Mr Stachor's fears.

[46] Exhibit C31 - PIF
[47] Transcript, page 49
[48] Transcript, page 59

12.26. The inconsistency between the PSSF and the PIF over concerns of Mr Stachor was noted in the internal investigation by DCS into Mr Stachor's death.[49] Despite my supportive comments about Mr Golding, he was responsible for this inconsistency.

13. Mr Stachor's initial interview with SAPHS

13.1. Mr Stachor's SAPHS records concerning this admission were tendered.[50] This admission consultation was completed by Ms Michelle Dunn, a SAPHS nurse who was working that night. She provided an affidavit concerning her assessment of Mr Stachor at admission on 6 November 2017.[51] She has no independent memory of the assessment and referred to the standard admission records. This assessment noted standard physical and medical information. He gave a history of denying any previous suicide attempts or self-harming behaviour but that he suffered PTSD '*occasionally*'.[52] Later in the assessment under the heading '*Suicide Risk Assessment on Admission*' she recorded that there had been previous self-harm attempts, but not multiple times.

13.2. A brief note is made about a car accident in 2015. She noted that there had been issues with a couple of friends that year concerning grief. He denied any thoughts of self-harm or suicide. She noted that he did not have any signs of depression, mania psychosis, impulsivity or agitation and that he was '*tired, hungry*'.[53] She recommended that he be placed in a routine double-up cell and noted that a NOC had not been raised.

13.3. She signed the assessment as complete at 10:10pm.[54]

14. SAPOL documents

14.1. Mr Stachor was in SAPOL custody from 5 November 2017 after his arrest. One of the core documents received by Yatala at admission was the SAPOL Detainee Transfer Report, tendered in evidence.[55] A DTR was not referenced in the DCS admission documents as at 6 November 2017.

14.2. This 36 page report highlights his episode in SAPOL custody immediately preceding his admission to Yatala on 6 November 2017. The first page of the document disclosed

[49] Exhibit C21, Report to the Chief Executive of DCS from Mr Don Muller dated 8 October 2018 (at page 19-20) DCS Investigation Report
[50] Exhibit C22
[51] Exhibit C44, dated 23 September 2020
[52] Exhibit C22, pages 4-6
[53] Exhibit C22, page 8
[54] Exhibit C22, page 10
[55] Exhibit C22, pages 46-81

that he had self-harmed or displayed tendencies to self-harm in the past.[56] A summary of cautions for SAPOL officers caring for Mr Stachor in custody appears at page two of the DTR. It outlined he may be at risk in custody, may assault police, may be suicidal, may try to escape and general mental health cautions. There are repeated warnings in the DTR of the 2015 incident of Mr Stachor deliberately driving into a tree in an attempt to self-harm or suicide. This accident was noted by Ms Dunn as mentioned in paragraph 13.2 above.

15. COs Hills and Golding conversation at admissions

15.1. Mr Golding, on noticing that night that Mr Stachor was allocated to B Division, alleged he had a conversation with Mr Hills. Mr Hills has no memory of this conversation but does not deny that it could have occurred. This is consistent with Mr Hills' frankness and genuine attempts to assist the Court in his evidence. Mr Golding said that at the end of the interview he checked where Mr Stachor was to be placed on the white board organised by Mr Hills.

15.2. Upon seeing Mr Stachor was allocated to B Division on the board, Mr Golding yelled out to Mr Hills:

> 'This bloke can't go into Bravo, I'm going to do a NOC on him and he can go to G-Division. He's turned around and said to me…"Who is it?", I've said "It's Stachor". He goes, "No, no, he'll be right, he's been in gaol plenty of times, he'll be fine".' [57]

15.3. As noted earlier, Mr Golding believed that his proposal for the overnight stay in G Division was satisfactory, in the circumstances, for dealing initially with the primary fear of Mr Stachor to stay away from motorcycle gang members in B Division.

15.4. Mr Golding did not initiate any paperwork for that. It may be this was based on the conversation he had with CO Hills. It is also possible Mr Hills did not hear the full content of Mr Golding's words when they were yelled out, and responded without understanding the true nature of the intent of the suggestion. For example, Mr Hills' response is rational if he missed the reference to a NOC.

15.5. Mr Golding knew an admission to G Division was possible under Section 36(2)(b) of the Correctional Services Act which is a common method of admission to that Division.

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[56] Exhibit C22, page 46, Q&A3
[57] Transcript, page 44

Mr Stachor did not fit the criteria for that type of admission, but the procedure for its use forces a medical evaluation by SAPHS the next day. Mr Golding believed this would allow for an assessment by the SAPHS nurse the next day and the interests and welfare of Mr Stachor would be further assessed at that time. It was apparent Mr Golding had that conversation with Mr Hills, with that provision or method in mind.

15.6. The consequences of not raising a NOC meant that Mr Stachor was treated as a mainstream prisoner on remand by Yatala with the proviso of acknowledging that he should be separated from members or associates of outlaw motorcycle gangs.

15.7. This detailed description of the admission procedure is the subject of further comment when reviewing the forms mentioned, Mr Golding's efforts, the training necessary to be involved in admissions, particularly as an interviewer, the roles of supervisors and expectations from DCS and Yatala management for that role compared with practice and procedure that did occur, particularly on busy nights such as this night.

15.8. I also note at this point the basic submission by interested parties concerning whether Mr Stachor's admission as described could be found to have any causation to his ultimate decision to take his own life of 19 November 2017.

16. Seven days of observations in B Division - 7 to 13 November 2017

16.1. The '*tired and hungry*' Mr Stachor was taken from the holding cells to B Division for the beginning of his seven days of observation. As is customary, he was placed in B Division in the Lower East wing. He was given Cell 225.[58]

16.2. This is the induction area of the prison. As is also customary for a mainstream prisoner, he shared a cell with a fellow inmate, Mr Herman Wilson. This was the case until 9 November 2017 when he was moved to BLE 218 which he shared with Daniel Brady.

16.3. The seven day observation form showed that, according to the noted observations of COs, he had no problems adapting to prison routine, relationships with other prisoners, communications, signs of depression, odd behaviour or complaints about health or medications.[59] It also recorded that none of these issues were raised by Mr Stachor with

[58] BLE 225
[59] Form 001/007, Exhibit C20p

the COs. No evidence was obtained from Mr Wilson or Mr Brady concerning their time with Mr Stachor during this period.

16.4. On 12 November 2017, Mr Stachor completed a Standard Request Form to see a doctor at the Yatala Health Centre.[60] In this brief form he stated the reason was a:

> 'Need to see doctor to be placed on my regular medication for intergestion (sic) ASAP. As I am now getting chest pains from being without it for so long now plus having issues with anxiety and paranoia and need my seratide asthma puffer.'

Mr Stachor also completed a Prisoner Request Form on either 14 or 15 November 2017.[61] The form has a brief hand-written note of '*14/11*' before the '*14*' is overwritten with '*15*'.

16.5. I have assumed that Mr Stachor completed all of the handwriting, perhaps except for the date of 14 or 15 November 2017 and indicating his Cell was 225. As already noted he was in Cell 218 having left Cell 225 on 9 November 2017. Whether he did start completing this form on or before 9 November 2017, or was mistaken about his cell number for some reason, cannot be definitively ascertained.

16.6. The notes of this form are only in the hand-written section where Mr Stachor has stated:

> 'please can I see a doctor ASAP. In regards to Astma puffer and Nexium, also discuss my issu (sic) with paranoia.' [62]

16.7. The two mentions of paranoia within the above documents is an extremely serious and an important self-assessment by Mr Stachor given his mental health history.

16.8. On 13 November 2017, the last day of observations, Fiona Beevor, a social worker, was asked by a CO to speak with Mr Stachor.[63] In the arranged meeting Mr Stachor made three requests to Ms Beevor namely:

- to advocate for him to stay in BLE due to '*issues*' with other prisoners;
- to report some historical sexual abuse on him as a child;
- to contact his lawyer to provide a home detention bail address.

[60] Exhibit C22, page 43
[61] Exhibit C22 page 42, F001/016
[62] Exhibit C22, page 42
[63] Exhibit C9

Ms Beevor managed to provide the potential bail address to his lawyer and speak with DCS staff about the other issues before entering this information on his casenotes.

16.9. Presumably the issues with other prisoners was the same fear he expressed to Mr Golding at admission about '*bikies*'. It certainly seems a logical conclusion to draw.

16.10. 14 November 2017

On 14 November 2017, prisoner Kaine Cadd moved into BLE Cell 218 with Mr Stachor. According to Mr Cadd, Mr Stachor '*…seemed fine and didn't have any issues or problems that he complained about*'.[64] Mr Cadd's assessment does not fully cover how Mr Stachor was feeling, as other prison documents tend to suggest he was starting to deteriorate mentally.

16.11. Consultation with SAPHS on 15 November 2017

A comprehensive consultation was conducted by Dr Hannah Sexton, a general practitioner. This occurred at approximately 1:30pm. An extensive history was taken and she noted no mental health issues.[65] Dr Sexton ordered blood tests concerning his severe stomach irritation and reflux. At 9:10am on 17 November 2017, Mr Stachor's blood was taken to be tested for the ailments mentioned above.[66]

16.12. 18 November 2017

Mr Stachor returned to the Yatala Health Centre after experiencing dry retching, dizziness and nausea. He was given Maxolon which he subsequently vomited up with bile-stained fluid. He was then given Stemetil and ordered to stay in the Health Centre over lunch. There is no further note of any physical discomfort.

16.13. Mr Stachor gave a history of '*issues*' within Yatala and said '*that's why I always request to go to Remand Centre!*' and stated his '*current anxiety level as 4-5 out of 10*'.[67] Dr Pronk, the Medical Head of Unit, stated that dizziness and nausea in combination could be a result of anxiety compounding his reflux. Mr Stachor told the treating nurse and the CO present that he had '*placement issues*' where it was noted at 2:20pm that he was going to discuss his placement with the Case Management Coordinator.

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[64] Exhibit C6, paragraph 3
[65] Exhibit C22, pages 17-19
[66] Exhibit C11, paragraph 18 and Exhibit C22, page 19
[67] Exhibit C22, page 19

16.14. 19 November 2017

Before analysing this day, the following matters should also be noted:

- Mr Stachor was in single cell accommodation of BME Cell 422;
- Mr Stachor's phone credit to call nominated friends and family outside of Yatala was exhausted;
- Mr Stachor wished to be moved to the Adelaide Remand Centre.

16.15. A summary of events that morning is set out in the DCS Investigation Report submitted by Mr Muller, an Investigations Officer for the Ethics, Intelligence and Investigations Unit.[68] The report was co-signed by a William Kelsey, Director, Office of Correctional Services Review on 12 October 2018.

16.16. Mr Stachor presented that morning in an unremarkable manner. As stated earlier, the COs in charge made no observations that could possibly have led to immediate concerns for his own wellbeing.

16.17. CO Swalwell spoke to Mr Stachor that morning about how he was feeling physically given that he was aware of the stomach pains and dizziness Mr Stachor had suffered the preceding day.[69] Mr Stachor responded that he was '*fine but just a little bit dizzy*'. Mr Swalwell locked Mr Stachor in his cell without any concerns for his wellbeing.[70] As stated earlier, this was at 11:27am and was the last time Mr Stachor was seen alive.

16.18. The grim chronology of the events that followed are set out in the DCS Investigation Report. I note that there was a situation stated where the defibrillator had not been charged. Although nothing could be done to save Mr Stachor at that point, the issue with the defibrillator should be addressed so that it is not repeated.

16.19. I have already set out above the circumstances of what CO Chapman witnessed.

[68] Exhibit C21, DCS Investigation Report to the Chief Executive
[69] Exhibit C5, Statement of Mr Swalwell, paragraph 9
[70] Exhibit C5. Paragraph 10

17. Ligature points in Prison cells

17.1. It is convenient now to concentrate on the following aspects of the circumstances of Mr Stachor's death, namely the nature of the cell in which Mr Stachor last lived and the ligatures used by him and found within the cell.

17.2. Before embarking upon this topic, I wish to acknowledge that the issue of ligature points in prison cells has been an ongoing issue and subject of many comments and recommendations in previous coronial Inquests.

17.3. In this Inquest I received a report tabled in Parliament on 9 February 2016 regarding the death in custody of the late Shane Rene Blunden.[71] An Inquest was conducted by Deputy State Coroner Schapel concerning Mr Blunden's death in F Division at Yatala on 19 September 2011. DSC Schapel made 15 recommendations in his findings, including reference to ligature points.

18. B Division Middle East Cell 422

18.1. The features of BME Cell 422 are not subject of comment in the DCS Investigation Report. I note it was not part of the terms of reference and I do not criticise the authors for this omission.[72]

18.2. This cell was described as being part of '*mainstream accommodation, not protected custody, and covers prisoners with a range of security ratings*'.[73] A detailed inspection of the cell was conducted by Brevet Sergeant Brett Allen, a SAPOL Crime Scene Investigator, who attended at 1:50pm on 19 November 2017. I visited this cell during the Inquest. It was the same structure as at 19 November 2017. In his tendered affidavit he noted seeing Mr Stachor in the common area and observed ligature marks around his neck.[74] He took numerous photos including the general view of B Division, Unit 2A, Mr Stachor and BME Cell 422.[75]

18.3. He conducted a thorough examination of BME Cell 422 as well as photographing its features at that time. The cell is 2.8 metres long, 1.19 metres wide with a height of 3.56 metres.[76] Brevet Sergeant Allen took detailed measurements of the bed, desk and shelf, as well as noting the contents of the cell.

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[71] Inquest 10/2014
[72] Exhibit C21
[73] Exhibit C30, paragraph 43
[74] Exhibit C19
[75] Exhibit C19, pages 5-7
[76] Exhibits C19 and C19a

18.4. An unfortunate feature of the cell was the many ligature points that were obvious during my visit to the location. I refer next to comments from this Court by DSC Schapel in his comprehensive finding following the death of Shane Rene Blunden.[77]

19. Mr Blunden's death in custody and Inquest

19.1. Mr Blunden died by hanging himself from a ventilation grille within his single cell accommodation in F Division at Yatala. The comments concerning the use of a ventilation grille as a ligature point also have relevance to Mr Stachor's Inquest as is clear when considering what DSC Schapel stated in the following passage:

> 'The Court needs, once again, to say something about hanging points. The Court repeats what it said about this issue in the matter of Christopher Aaron Smith[78] who died in Yatala after he hanged himself using a ventilation grille as a hanging point:
>
> > The findings of this Court and other Coroners' Courts in Australia are replete with instances of prisoners using hanging points in cells in order to end their own lives. The hanging point in this case was a ventilation grille through which a piece of torn bed sheet was threaded. Ventilation grilles were used as hanging points in other prison deaths that have been the subject of Inquests in this State, for example those concerning prisoners Alexander Wayne Keith Varcoe (ARC 2000), Darryl Kym Walker (Port Lincoln Prison 2003), and Damian John Cook (ARC 2003). For years Coroners' Courts have been urging correctional authorities to eliminate hanging points from cells, and in particular ventilation grilles. It is plain when one reads coronial findings in death in custody cases from the last 10 to 20 years that these recommendations for the most part have been implemented reactively, inconsistently and in a piecemeal fashion. A ventilation grille is such an obvious hanging point. It is also one the most effective given its height off the floor. Some hanging points are more subtly disguised than others, but the hanging point in this case was obvious, has been historically and repeatedly deployed for that very purpose and was readily available in this case. Any prisoner intent on self harm could not have failed to identify it as the perfect means by which to carry out that intent.
>
> To be fair, in the Smith case Mr Mann, the General Manager of Yatala Labour Prison, explained to the Court that at that time ventilation grilles were being replaced at Yatala with devices that ought to prevent the attachment of ligatures. Nevertheless, until all obvious ligature points are removed from cells within the correctional institutions of South Australia, this Court will keep repeating that there is a very urgent need for the removal of ligature points in such cells.' [79]

19.2. It appears that BME Cell 422 had been adapted to fix the ventilation grille ligature point issue, but there were numerous others that remained.

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[77] Inquest 10/2014, Finding published 6 May 2015 - The Blunden Inquest
[78] Inquest 17/2012
[79] Paragraph 11.7

19.3. These ligature points must have been obvious to Mr Stachor. It should not be forgotten that prisoners, whether in single cell or double cell accommodation, spend the predominant part of their time in those cells. A man with increasing mental health problems such as Mr Stachor, being in a single cell at Yatala can obviously lead to developing escalating self-destructive thoughts. There was plenty of time for him to focus and plan to suicide by one of the ligature points.

20. Ligatures

20.1. Two cords were found in BME Cell 422 after Mr Stachor was removed from the cell. These cords were tendered in evidence.[80] The black cord was the ligature used by Mr Stachor in his suicide.

20.2. These cords are contraband at Yatala. Broad brimmed hats capable of having a cord should be cordless at Yatala. There is no evidence as to how Mr Stachor obtained these cords. It will remain a mystery, although a reasonable hypothesis could be he received these from another prisoner.

20.3. Cords are not necessarily contraband at other DCS institutions. Yatala laundry could deal with broad brimmed hats with cords from other institutions. These cords in Tier 3 cells at Yatala can be dangerous for a number of reasons including self-harm, or criminal harm inflicted upon a cell mate. These normally innocuous items should be inaccessible to all prisoners in DCS institutions.

21. Safe Cell policy

21.1. After viewing BME Cell 422, I was taken to a number of '*safe cells*' at Yatala where the features were explained to me as I stood within them. These cells were within the High Dependency Unit.[81]

21.2. The HDU is a 26-bed unit '*designed for the management of prisoners with a range of issues, but primarily serious mental health issues and behavioural problems*', as stated in the evidence taken on the view from Yatala psychologist and Manager of the HDU, Mr Luke Williams.

[80] Exhibits C26 and C27, Transcript, page 15
[81] HDU

21.3. The HDU is a state-wide DCS facility for male prisoners only. It accepts both remand and sentenced prisoners referred from within Yatala and other prisons. I was taken to three cells within the HDU being Cells 101, 102 and 208.[82] Mr Williams essentially described the features of the safe cells that had no ligature points or sharp edges. These cells differed from each other in terms of extent of monitoring and layout dependant on the extent of the mental problems suffered by the prisoner and the varying need as to the intensity of observation required for the prisoner.

21.4. The obvious common feature was that there were no ligature points.

21.5. Following the findings of the Blunden Inquest by DSC Schapel, the Department for Correctional Services prepared a report dated 30 November 2015 that was tabled in the House of Assembly on 9 February 2016.[83] In the report Mr David Brown, Chief Executive stated:

> 'The Department continues to identify and eliminate hanging points from cells and ensure Safe Cell designs are applied throughout prison systems. Resources are targeted towards those accommodation areas that hold prisoners presenting the greatest risk of suicide or self-harm, and newly admitted prisoners of whom DCS has limited knowledge.
>
> The majority of the Department's infrastructure pre-dates the 'Safe Cell' standard introduction. However, since this incident, the Department has strengthened its approach to this practice and has issued a policy that ensures renovations and upgrades of existing prison cells are undertaken in accordance with a risk based approach.
>
> As resources are allocated to renovate cells to 'Safe Cells' standards, the Department refers to the following priority tiering system.'

21.6. Mr Brown described the five tier cell classification:

> 'Tier 1 – Observation cells for prisoners at risk of suicide or self-harm and separated in the interest of safety and welfare.[84]
>
> Tier 2 – Management cells. Cells to manage separated prisoners under Section 36(2) of the Act without observation as for Tier 1.
>
> Tier 3 – Admission/Induction cells.
>
> Tier 4 – Secure cells in high security prisons.
>
> Tier 5 – Secure cells in medium security prisons with induction units as the first priority.'

21.7. As at 30 November 2015, all the Tier 1 and Tier 2 cells had been converted to safe cells.

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[82] As noted in Transcript, pages 22-26
[83] Exhibit C54
[84] Section 36(2) of the Act

21.8. Ms Bales, Acting Manager of the Yatala Labour Prison, gave evidence of that Tier Policy during the Inquest[85] and in her affidavit she annexed the policy headed '*Prioritisation for Implementing Safe Cells*'.[86] This policy was being implemented at the time of her evidence. She confirmed that Tier 3 cells at Yatala had not been upgraded. BME Cell 422 is a Tier 3 cell.

21.9. Ms Bales indicated that Yatala is undergoing '…*a major build program*' with 270 new beds proposed to be available by the end of 2022, all of which will be within safe cell design standards.[87]

21.10. She indicated that future funding will be sought to complete a three-stage plan for building at Yatala. B Division, although likely to change its status to the '…*primary working division*', will continue with Tier 3 cells that have multiple ligature points.[88]

21.11. Ms Angela Gransden, Director of Operational Support and Performance of DCS, gave evidence concerning safe cells. She is one of three senior managers who report to the Deputy Chief Executive of DCS. She has responsibility for the oversight of policy and procedures for state-wide operations and new initiatives or processes. She is the General Manager for the two privately run prisons in South Australia, being Mount Gambier and the Adelaide Remand Centre.[89]

21.12. In effectively supportive evidence to Ms Bales on this topic, she confirmed the plan for the Yatala extension of 270 beds within safe cells for mainstream prisoners. Ms Gransden described in detail the state-wide implementation of safe cells within the prisons.[90] She noted that the ARC has safe cells for newly admitted prisoners. The ARC is now the admission centre for all court remands after police custody. I have not viewed these cells.

22. <u>Correctional Officer training for admission interviews</u>

22.1. This became a considerable issue at the inquest. I have already spoken of Mr Golding's situation making him unsuitable to take the responsibility for the admission interview. However this is not a one dimensional issue. Mr Golding's training was not

[85] Transcript, page 568-570
[86] Exhibit C30, Annexure HB11 Policy 39, see also Exhibit C20o
[87] Transcript, page 640
[88] Transcript, page 641
[89] Transcript, page 1052 and Exhibit C64, dated 21 October 2020
[90] Transcript, pages 1090-1095

documented and by his own admission he had only worked six to ten times in admissions.[91] He also said there was no feedback, either positive or negative, about his previous efforts in this area. For COs apparently approved to be involved in admissions, this was inadequate. An unauthored list was presented to the Inquest that has no provenance or indication as to how, why and who created it.[92] It seems extraordinary to me that in modern software and computer technology that such a list or database did not exist for Yatala at an official level.

22.2. Mr Golding told the Court that in his first night in admissions he was shown the relevant paperwork and admitted one prisoner. There was no evidence of shadowing or mentoring that occurred and Mr Golding received no additional training. Importantly, there was no record of training that detailed this lack of mentoring or shadowing.

22.3. Returning to the unauthorised list, as suggested it is contradictory to the DCS stance concerning the lack of need for additional training for admissions that this list exists at all. As put by Ms Giles, counsel assisting, if anyone can do it why have the need for a roster. The roster is also out of date with some COs named no longer at Yatala.

22.4. I find that the training for Mr Golding was not adequate. I find that he did not properly understand his responsibilities as an interviewing officer, nor why and how to raise a NOC based on the guidelines.

22.5. It was also inappropriate for Mr Golding to be allowed to work as an interviewing officer in admissions given his role at admissions for the late Mr Wayne Fella Morrison. I do not criticise him for volunteering when no barriers were placed on him by DCS.

22.6. These comments are not a criticism of Mr Golding's earnest approach to his work, but rather to highlight the importance that should be placed in selecting the COs for admissions work.

22.7. I heard from Mr Hills and Ms Irish about the intensity of the role for COs in admissions. I accept their evidence that they had little if any time to oversee what others were doing once roles were allocated. This must have been so on the night Mr Stachor was admitted on 6 November 2017.

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[91] Transcript, page 30
[92] Exhibit C49

22.8. I found Mr Hills and Ms Irish to be straight forward, credible and knowledgeable witnesses both generally and on the topic of admissions at Yatala. They both emphasised that to be effective interviewers and workers in the admissions section you need to have experience and be doing this task '*regularly*'.[93] They are supported by CO Shirley Bell who I will deal with later in this finding.

22.9. Ms Bales, the Acting Manager of Yatala and Mr Mark Goodes, Security Manager, both gave evidence that they had no knowledge of the inadequacy of training for Mr Golding in the admissions duties.

22.10. This issue of training is of great importance and has been subject of comment by DSC Schapel in the Blunden Inquest. I quote one of his recommendations on the topic from that Inquest, namely:

> 'That the Chief Executive of the Department for Correctional Services takes steps to identify and appoint Correctional Officers who are specifically dedicated to the task of admitting prisoners to Correctional Institutions in South Australia. These dedicated Correctional Officers should be thoroughly trained in all aspects of the admission process. They should also be thoroughly trained in the use of the Justice Information System and should have full and unrestricted access to the information contained on that system including but not limited to information about the admitted prisoner that has previously been placed on the Offender's Casenotes by DCS staff and members of the High Risk Assessment Team'.[94]

22.11. The logic of the above recommendation is unassailable. Within the large area of duties that COs must perform, it is logical that concentration of a group of COs to a particular duty will make them more efficient and proficient in performing that duty. The entry of prisoners into a correctional institution needs a proper assessment of their status on each occasion. Past history of previous remands or sentences that a prisoner has served should be easy and accessible as to whether relevant issues for those periods in custody need to be considered for the latest entry. This needs to be documented into an easily accessible and workable computer record within the JIS. All the training necessary is contained within DSC Schapel's above recommendation. This area might be seen by some to be easy to learn, but the application of it to a prisoner sitting in front of a CO to be interviewed at admission is not. It involved important decisions to be made under pressure. Training in that task is essential in those circumstances.

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[93] Transcript, page 250

[94] Page 49, paragraph 11.8.2 of the finding

23. Mr Stachor's first remand on 27 January 2017

23.1. As previously indicated, this was a significant issue for consideration at the Inquest. On his first remand Mr Stachor was placed under a HRAT regime upon admission to Yatala. The casenotes of his involvement with HRAT on the first remand were tendered at the Inquest.[95] The casenotes indicate Mr Stachor's total history with DCS, whether within or out of immediate custody. The earliest record is 12 September 2005 and the last being the day of his death on 19 November 2017. Every note is identified by the author and the relevant DCS site that was dealing with him at the time.

23.2. I now turn to his management upon admission to Yatala on 27 January 2017.

23.3. Mr Stachor had been arrested on 25 January 2017. When present in the court cells at EMC on 27 January 2017 he was noted to be:

> '…abusive and aggressive towards court staff, urinated around the cell, stripped naked and laid in his urine, bit an officer and spat towards officers and the cell. He was placed into G Division under a 36(2)(d). Whilst in G Division he was compliant through the process.' [96]

23.4. The following day, 28 January 2017, a casenote was made at 3:10pm. It is useful to set out this note in full as follows:

> 'Prisoner STACHOR has been given an admission interview today after being admitted straight into G Division last night due to his behaviour at the courts yesterday. The prisoner was compliant and remorseful during the interview process. The prisoner scored 7 on the prisoner stress screening form. A NOC has been raised, due to a previous attempt at self harm, albeit 10 years ago (my emphasis) and the prisoner stating no current TOSH[97]
>
> - The prisoner to remain in G Division at management's discretion.' [98]

23.5. On 30 January 2017 at 4:16pm, a large casenote was made by Katrina Daly from HRAT. This detailed note is over two pages long and indicates a thorough interview must have occurred.[99] It included an admission that Mr Stachor was experiencing '*high stress levels*' due to G Division as well as withdrawing from amphetamine use. He further outlined he had suffered the significant loss of two friends having passed away in the last year. He stated that he had a history of suicide attempts whilst in custody 10 years ago, and a recent attempt one year ago with a family history of suicide as well.

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[95] Exhibit C25
[96] Exhibit C25, page 12 - note of Mr Hills made at 7:53pm on 27 January 2017
[97] Thoughts of Self Harm
[98] Exhibit C25, page 14
[99] Exhibit C25, pages 10-12 inclusive

It was recommended he remain on HRAT and that '…*consideration be given into a transfer to the ARC*'.[100]

23.6. On 3 February 2017, consistent with his wishes, Mr Stachor was transferred out of G Division into B Division.

23.7. Mr Stachor had another interview with Ms Daly on 8 February 2017. He indicated that a friend not in custody had been '*bashed to death*' and died on 5 February 2017. At the end of the interview Ms Daly recommended that he continue to remain on HRAT for a further week.

23.8. On 13 February 2017, after a further interview with Ms Daly, it was recommended that he be removed from HRAT. On 16 February 2017, after a HRAT meeting, Mr Stachor was removed from HRAT monitoring.

23.9. The notes indicate that from that point nothing substantial occurred until he reported being assaulted by a fellow prisoner who he refused to name.[101]

23.10. On 9 March 2017, he made a request to be transferred to the ARC and by 8:30pm that night he had been transferred as requested. In the ARC he was placed on HRAT until 16 March 2017 when he was removed. His stay in the ARC was unremarkable save for a request to transfer units due to issues with '*some TSU[102] gang members*' on 25 March 2017. No other remarkable events occur until his release.

23.11. I have gone into some detail about this stay in custody due to the fact that it is clear the HRAT monitoring showed significant expert social worker contact with him. It is also useful to note that his request to transfer to the ARC was honoured and that his past history of suicide attempts was a major factor in dealing with him as described under the HRAT regime.

23.12. That level of monitoring was missing from his November 2017 remand into Yatala. It also seems clear his past history of suicide attempts did not receive the same weight and attention in November 2017 as it had earlier that year in the first remand in deciding how to deal with Mr Stachor.

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[100] Last line of case entry
[101] Exhibit C35, page 6 - see note of Mr Hills made at 6:20pm on 7 March 2017
[102] Try Stopping Us

23.13. We return to the situation of having no direct evidence, by way of a note, as to what drove Mr Stachor to take his own life. I have set out the many facts around his remand of 13 days that do provide signs of his deterioration mentally. His disclosure of being a child sex abuse victim also must have been significant. I do not underestimate the magnitude of this disclosure when considering his mental state.

23.14. Therefore I conclude that there was a failure of Yatala to react to Mr Stachor's presentation before his death. He should have been on HRAT. Whether HRAT would have turned Mr Stachor away from taking his own life is unknown, but the chances of this suicide not happening would have been undoubtedly better if the HRAT regime had been implemented. There were numerous indicators in the days on and from 6 November 2017 that HRAT status was needed for him.

24. Management vs 'The Supervisors'

24.1. This title is apt to describe the tension between senior CO4s and management at Yatala and the corporate level of DCS about the issue of training of COs for admission interviews. I heard evidence from Mr Hills, Ms Irish and Ms Bell, all CO4s, on behalf of those involved in admissions. For want of a better phrase, I have titled them '*the Supervisors*' on this issue. I heard from Ms Gransden, Ms Bales and Mr Goodes on behalf of management.

24.2. Unfortunately there is a significant degree of acrimony between the parties with respect to this issue, particularly evident in Ms Bell's evidence.

24.3. The issue of supervision of less experienced COs during admission of prisoners was the subject of meetings and correspondence from at least 2018. I have received the minutes of the Operational Supervisors' Meetings at Yatala.[103] These meetings were held on a fortnightly basis between management and supervisors. These meetings dealt with issues of security and/or operations. These issues, if not resolved, would carry over to be considered at the next meeting.

24.4. Once an issue or an agenda item is resolved it is noted as such in the minutes and is removed from the agenda for the next meeting.

[103] OSM

25. Holding cell issue in OSMs

25.1. By reference to the minutes, the issue of the holding cells was raised on 18 January 2018. The issue was minuted as follows:

> 'Ongoing issues of B/G staff being rostered in the Holding Cells and not being trained appropriately to do the full job function which creates ongoing issues.
>
> Asked if more structured training could be given to these staff.
>
> HB[104] to provide Duty Statements to Julie Lloyd and Dave Haddington to assist in determining appropriate training periods.
>
> 18/01/2018 – Duty Statement to be created.
>
> 01/02/2018 – Ongoing – Julie Lloyd to create Duty Statement. Also to determine how long the training period should be.
>
> 15/02/2018 – Julie Lloyd working on Duty Statements.' [105]

25.2. Julie Lloyd is a supervisor. She was tasked to create the duty statement which was described as a '*job description*' of sorts.[106]

25.3. This issue remained on the agenda for the meeting of 15 March 2018 where it was noted that Ms Lloyd had sent a copy of the statement to Mr Goodes.[107]

25.4. Earlier minutes acknowledged that as at 21 November 2017 it was '…*understood the workload in the holding cells is high*'.[108] This tension about the work of the holding cells continued as the item remained active at the meeting of 19 July 2018 and at 2 August 2018, where Mr Goodes had already advised the OSM on 19 July 2018 that '…*some training had begun*'…'*in the holding cells over the last couple of weeks. Supervisors not completely happy with the current training program for holding cells*'.[109]

25.5. It was noted on 2 August 2018 that '*this item is to be presented at the next LCC*'. LCC is the Local Consultative Committee which was explained as being '*a PSA forum so that's our formal consultation forum*'.[110]

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[104] Helen Bales
[105] Exhibit C57, page 84
[106] Transcript, page 216
[107] Transcript, pages 816-817
[108] Exhibit C57, pages 41 and 49
[109] Exhibit C57, pages 138 and 146
[110] Transcript, page 851

26. Shirley Bell - email of 29 August 2018

26.1. On 29 August 2018 Ms Bell sent a general email to all DCS supervisors and acting supervisors at Yatala. She copied in Ms Bales and Mr Goodes as well as other DCS personnel. This email is now an exhibit and was subject of cross-examination of Ms Bales, Ms Gransden and Mr Goodes. I set out the text of that email as follows:

> 'To the Supervisor Group.
>
> On Monday the 27-08 2018 we had around 20-25 new admits. Sam May and I were the Supervisors and Sally Barfield was the extra interviewer.
>
> Sally did the best she could but she was not fully trained in the admits process, nor is she able to sign off as the responsible officer. This means that she had to ask myself or Sam who were already extremely busy to stop what we were doing and go through the forms and sign off as the responsible officer.
>
> This is a ludicrous situation, unless as a Supervisor I have fully interviewed the prisoner myself I will not sign off as the responsible officer. If we sign off on someone else's work we are putting ourselves in a precarious position. I urge all Supervisors to take the same stance as myself.
>
> Also at 2100 hrs the nursing staff left again!!!! We still had about seven prisoners they needed to see, we had to ferry them down to the medical centre one at a time. We finished in the holding cells at 0030 in the morning.
>
> Both these situations are no longer good enough. How many more reviews of the holding cells do we need to have before, in particular, the nursing staff situation is fixed. As a group I believe we need to have a meeting regarding the Holding Cell practices forthwith and put into place some sanctions if necessary to have the situation resolved.
>
> Regards Shirley Bell.' [111]

26.2. Ms Bell was also called to give evidence on this email and in general.[112]

26.3. Ms Bell has been a CO for 30 years and approximately eight years ago became a CO4. Almost all of her career has been at Yatala. She completed basic training and has undertaken shadowing when training to be a supervisor. This training included working in the admissions area.

26.4. Ms Bell stated that as at November 2017 the admissions numbers were large just prior to the privatisation of the ARC, as Yatala was the '*main admittance area*'.[113] Prisoners were regularly still awaiting admission in the holding cells after 11pm.[114]

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[111] Exhibit C55, The Bell email
[112] Transcript, pages 868-1017
[113] Transcript, page 876
[114] Transcript, page 877-878

26.5. Her evidence revealed that she was experienced in all facets of admission of a prisoner to Yatala and gave evidence of her work practices in this area. Her evidence shows a good understanding of the intent of the admission documents and how she interprets them to make a decision concerning placement and whether a NOC should be raised. She described the admission holding cells, or as commonly known '*the tank*', as a '*shocking*' operational situation.[115]

26.6. The tank has no toilet facilities and usually no food or water is given to prisoners if they are in there. She has always worked with the understanding that 16 men is the maximum capacity of the tank.

26.7. If more men are waiting to be admitted other than the 16 in the tank, her practice was to not allow them to come into the prison but to wait in the G4S van.[116]

26.8. Ms Bell believed '*that a good interview*' would take a minimum of 40 minutes.

26.9. She identified Exhibit C49 as the list of eligible officers for admissions. She discovered this on the Yatala computer system under the supervisor's folder. She said based on her discussion with fellow supervisors, that they were unaware of this list. She was able to identify some COs on the list including those that no longer work there.[117]

27. Relationship with Mr Golding

27.1. Ms Bell was Mr Golding's union representative at his DCS interviews about this matter. She described her professional relationship with him and was aware that, post 6 November 2017 he had been asked to do overtime as an interviewer in the admission cells. She believed it was in 2020.[118] She was on day shift at the time of the request and expressed frankly:

> '…if he did it I'd kill him, because he wasn't trained and because this had come up I told him that he shouldn't be doing it.'

After this comment she was present when he withdrew his offer to fill in as an interviewer.[119]

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[115] Transcript, page 905
[116] Transcript, page 907
[117] Transcript, page 931, Mr Jantti
[118] Transcript, page 933
[119] Transcript, page 934

27.2. She spoke about Mr Golding in good terms in that he would '*help out anywhere*'[120] and had been '*very accommodating*'. She was aware of his long time in G Division which she described as an '*emotionally draining*' way to work.

28. Issues arising from Ms Bell's email

28.1. I have already set out this email in full. Ms Bell explained that Sam May was one of the supervisors and that Salle Barfield was a CO2 who, according to Ms Bell, had no training regarding the holding cells and had come from the Adelaide Women's Prison.

28.2. She stated the two biggest issues at the time, namely '*getting trained staff and … the nursing staff leaving at 2100*'.[121]

28.3. She received no email reply from management, nor any face to face or phone contact.[122]

28.4. Her motivation for sending the email involved being there until very late and that she believed it was best to put things in writing.

28.5. A further issue arose about the PSSF. Ms Bell's practice was to take out the revised PSSF and go with the '*old*' form. This was an unsatisfactory solution even allowing for the fact that they were still noted in OSM as being in dispute.[123]

28.6. She highlighted a NOC she placed on a young Aboriginal prisoner who was admitted on the Friday night of a long weekend. She gave him a PSSF score of 18 and decided to place him on constant observations in G Division.[124] She stated there was a query by Mr Goodes about the necessity of her actions regarding this prisoner and that he tried to get her to downgrade the prisoner's classification to being placed in a camera cell. She stated that Ms Bales rang her about an hour later. She believed the contact by Mr Goodes and Ms Bales was motivated by financial and budget issues although that was not stated to her.[125] Ms Bales had made her concern known about the budget in the OSM on 7 November 2017.[126]

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[120] Transcript, page 934
[121] Transcript, page 950
[122] Transcript, page 951
[123] Exhibit C57, minutes of 19 December 2017 meeting, item 3 at page 71
[124] Transcript, page 961
[125] Transcript, page 963
[126] Exhibit C57, page 36

28.7. Ms Bell noted that in admissions there is no time to oversee work as the supervisors are '*time poor*'.[127] Ms Bell is an experienced and passionate CO. She made it plain that the relationship between her and the managers, particularly Ms Bales and Mr Goodes, is poor. The issue of training is at the forefront of her criticism of management.

28.8. Ms Gransden dealt with the issue of the recommendation for training made by DSC Schapel in the Blunden Inquest as saying:

> '…Trainee correctional officers, or as we now call them probationary correctional officers, undergo an intensive 12-month process. They have in-house training; they do a workplace WAG that they have to do; they spend six weeks on the job basically as supernumerary working through the different divisions and they have performance reviews, so that's a very comprehensive training process that equips them to undertake the role of a correctional officer. Through the whole of that case management through as I've described before from the admission through to the release process'.[128]

28.9. The dispute between supervisors and management did occupy some time at this Inquest. The evidence of Ms Bell, Ms Irish and Mr Hills demonstrates what I would classify as experienced officers, all of CO4 rank, outlining the basic view that this system of admissions requires either previously well-experienced officers or inexperienced officers who have done training far more than the basic training done by all officers at the beginning of their careers. In other words, their opinions are consistent with DSC Schapel from the Blunden Inquest.

28.10. Ms Gransden's response in the paragraph above led me to closely examine the recommendation about training in the Blunden Inquest and refer back to Mr Stachor's admission interview. As previously indicated, DSC Schapel's recommendation on this issue is compelling.

28.11. I believe the interview of Mr Stachor has to be classified as being carried out by someone not trained to the level recommended in the Blunden Inquest. That may be the second example of that situation involving Mr Golding.

29. <u>Mr Golding/Morrison Inquest</u>

29.1. During this Inquest I received extracts from the report of Mr Don Muller into the death of Wayne Fella Morrison, whose death in custody in 2016 is subject to an ongoing

[127] Transcript, page 972
[128] Transcript, page 1177

Inquest conducted by DSC Basheer at the time of publishing this finding.[129] In receiving these extracts I made it plain I was not attempting to influence DSC Basheer into any relevant finding she will make into the cause and circumstances of the late Mr Morrison's death. Nor do I attempt to interfere with her right to make recommendations she feels necessary based on the evidence in that Inquest.

29.2. The purpose of receiving these extracts is to note that Mr Golding was permitted to conduct these admission interviews when the relevant training for understanding and applying SOP90 had not been done.

29.3. It emphasises the unsuitability of Mr Golding to deal with Mr Stachor in 2017 as an interviewer at admission, particularly in light of the fact that there were allegations of a failure to raise a NOC for Mr Morrison based on his admission interview. Again in a candid fashion, Mr Golding stated that at the time of Mr Morrison's interview on 19 September 2016 and Mr Stachor's interview on 6 November 2017 he did not have a proper understanding of when a NOC needed to be raised.[130] As he put it:

> 'I'm 61 years of age, so I've – as a lot of people here would know – at our age, I'm not very good on the computer, unfortunately, and that's why I'm just – I had trouble – that's why I'm just the Ops2 and, like I said, the computer – the CO4s handle all the computer stuff and all that stuff, if you know what I mean'.[131]

29.4. This passage is not set out to humiliate Mr Golding, rather than to emphasise the perils of inexperience when dealing with such an important task unsupervised and without any feedback.

29.5. It also brings into focus the submission about the best training for admissions and the recommendation concerning personnel conducting admissions in the Blunden Inquest. The need for that is due to the argument of DCS management that basic training is sufficient and that with proper techniques of supervision of the inexperienced, by reviewing their work shortly after completion or by the technique of the inexperienced shadowing the experienced, admissions should be performed up to standard.

29.6. This is the view expressed by in evidence of Ms Bales and Ms Gransden.[132]

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[129] Exhibits C34 and C45
[130] Transcript, page 110
[131] Transcript, page 111
[132] Including in her affidavit, Exhibit C64

29.7. As seen from the very brief summary above, the gap between the respected positions of supervisors and management is vast.

29.8. I will now outline the '*management*' view of training and supervision in a summary of the evidence from Ms Gransden and Ms Bales. I do acknowledge in December 2019 that Yatala stopped taking admissions directly from the courts. The ARC is now the DCS facility for male remand prisoners. This issue is relevant for ARC admissions in my view.

29.9. It is helpful to set out a lengthy answer from Ms Gransden given in the Inquest to her expectation as to how the procedures should evolve with regards to admitting a prisoner. This answer also deals with the various roles within the personnel, namely supervisors, or as she would describe a CO4, as a '*middle level manager*'. The position of CO4 means to her that those people are:

> 'Responsible for the custodial officers and the advanced custodial officers and the day-to-day operations and running of the institution, so that is very much their role around that supervision and that leadership on a day-to-day basis'.[133]

29.10. In dealing with the following issues of supervisors conducting admissions differently to another, interpretation of forms and questions and how they conform or relate to SOPs she stated:

> 'I'll take that in, I think, several bites. There are very clear standard operating procedures that are in place that identify and document the key requirements or the key outcomes that need to occur. As you can imagine, it's a decentralised model. We have more than one prison, we have more than one supervisor. The supervisors receive specialist training. They, in addition to the Cert III, also undertake a Certificate IV in custodial practice which provides them with additional skills. I think, yes, at sites and each supervisor may conduct the process in a slightly different manner. As long as they are undertaking all of the requirements of the SOP and completing the relevant paperwork, if they choose to do it in a different order or approach the prisoner in a different way because they may have a rapport with that prisoner or the prisoner may be known, that is, I think, just a reality of how that system will work. I don't think it's any different to other occupations either. If you think about teachers or nurses or doctors, if you're admitted into a hospital you go through a range of processes but sometimes you might see one person first, someone else might see you in a different order, so as long as from a departmental point of view the requirements of the SOP are fulfilled, if they're done in a slightly different order or if the supervisor may have a relationship with the prisoner conducts the interview or chooses to undertake that interview, that's their prerogative and they're able to do it. At the end of the day, the supervisor is, as the title indicates, responsible for the supervision and the leadership and through the admission process they are required to sign off a number of the

[133] Transcript, page 1067

> forms to satisfy themselves and they make the determination for new admissions and also for transfers in on that placement of that prisoner. So, it would be incumbent for the supervisor, regardless of how that process is being undertaken, to review the key documents and satisfy themselves they've got the relevant information and then work to make that placement decision.' [134]

29.11. I will also set out a detailed answer regarding her view of training of both supervisors and CO2s and whether she believed that was adequate with the respect to admissions:

> 'The Learning Academy is a new concept that's been implemented in the last two or three months. There's been two major reviews of training and development in Corrections over the last few years. The first started in around 2017 and that was reviewing the core mandatory training requirements for custodial staff and that has led to reconfirming those core competencies and the training that's required. Following on from that has been a review of the organisational arrangements for how training is delivered as a separate review. That review was undertaken by an external consultant and made a number of recommendations which I understand executive have adopted. One of those is the creation of what is now our Learning Academy. As I said, the implementation of that has recently started with the appointment of a new director that has specialist skills in training and development. Part of the establishment of the Learning Academy is some additional resources to oversee and implement the new requirements of the Learning Academy. It is also looking to replace the current E-learning capability that we have. A number of our training packages that are provided are provided online. We have a bit of a clunky, antiquated system so part of the Learning Academy is a business case to review and update and improve that and that will also better capture what training has been undertaken, by whom and when…
>
> All training and development now is recorded on CHRIS21 and previously it had been recorded on different systems but the intent is that it is all now recorded on CHRIS21…
>
> The Learning Academy, again, part of that establishment is an oversight committee. I think it's going to be called a governance or a steering committee. I believe it's met twice so far and a key part of their meetings will be getting regular reportings on training that's occurred where the gaps are so that there's some executive level visibility around training delivery in the organisation which hasn't existed, from my perspective, to date. There's been training but it's not that high level visibility with executive. So that's a major improvement that we'll see.' [135]

30. DCS HRAT review 2018-2019

30.1. A HRAT review of 2018-2019 was conducted by DCS. The author of this report, Mr John Strachan, delves into the full range of issues and duties with HRAT and sets out answers to a number of key questions concerning NOCs and the HRAT regime. He also publishes results from a survey of HRAT workers. The HRAT workers believed

[134] Transcript, pages 1068-1069
[135] Transcript, pages 1069-1070, See also Exhibit C64, paragraph 87

that there was a lot of '*unnecessary NOCs raised on admission, would be beneficial to have health trained individuals on rotation to assist with assessment*'.[136]

30.2. If this statement by Mr Strachan is correct, then a reasonable explanation for the situation might be the reaction by COs in admissions to err in favour of creating an unnecessary NOC as a consequence of the deaths of Mr Morrison and Mr Stachor in 2016 and 2017 respectively, and the issue of NOCs for those men at their admission to Yatala. Whilst it is comforting that some NOCs might be '*unnecessary*' rather than having too few, I acknowledge the drain on valuable resources on the HRAT team in providing their services to the prisoners.

30.3. In Appendix 1 of the report a cohesive description of how HRAT operates is outlined. Mr Strachan comments that the:

> 'complexity and diversity of prisoners' mental health issues create a very challenging environment for prison staff. And … by far the most difficult decision in suicide prevention is determining when a prisoner is no longer at risk.'

30.4. In commenting on preventing further suicide and self-harm he also noted:

> 'It is widely suggested across the literature that it is not sufficient to only screen prisoners on admission, advising that screening be conducted at regular intervals throughout a prisoner's period of incarceration. Studies recommend that assessment should occur periodically as well as at times when prisoners' circumstance have changed, such as court proceedings/outcomes, relationship or family difficulties or transfer to another area within the institution or other facilities.'

He then considered staff training and noted:

> 'Suicide awareness and skills training should include the development of a common language and understanding between different sectors to improve consistency of response at all points of contact … Correctional officers maximise their contribution to multidisciplinary mental health care in prisons where they have a basic understanding of mental illness, remain alert to the signs and symptoms of mental illness, show a willingness to refer cases to mental health and/or health staff and use appropriate flexibility in managing mentally ill inmates. Studies show that the ability to identify those at immediate high risk and respond sympathetically and safely to be important preventative measures that will effectively reduce the rates of suicide in custody. It is also suggested that having a correctional officer serve as a trainer can make the other officers feel that the training is applicable to their jobs and is worthwhile.'

[136] Question 14 of survey

30.5. These are important statements concerning training and the issues that are at the forefront of this Inquest. This review still identifies the admission into prison as a key point for these issues. Therefore the effectiveness of training, regular mental health assessments and knowledge of mental health issues is a vital continuing need for COs and continuing education is vital.

31. Submissions

31.1. I received oral and written submissions concerning the evidence of the Inquest and recommendations sought by interested parties. I thank all counsel for their assistance with this matter and I take into account the information submitted.[137] A number of interested parties agreed with the statements and proposed recommendations submitted by Ms Giles, counsel assisting the Court, which can be briefly summarised as follows:

1. Endorsing the recommendation of DSC Schapel for specialised training of COs for admission.
2. The admission paperwork both from SAPOL and DCS had significant flaws.
3. A prisoner's previous NOCs need to be easily identifiable on the paperwork and in the JIS system.
4. Ms Bell, Ms Irish, Mr Golding and Mr Hills all urge the Court to find that the admission of Mr Stachor is not a direct cause or circumstance of his death. This is also the submission of DCS.
5. Ms Bell, Ms Irish, Mr Golding and Mr Hills all urge the Court to reject DCS' view that the current system of training is adequate for COs to properly perform admissions, in particular interviews. They also seek the Court to reject the submission of DCS that supervisors, despite the volume of admissions, still must supervise CO2s.
6. Ms Bell urges that the Court find the management at Yatala by Mr Goodes and Ms Bales not adequate concerning admissions and that there has not been a proper acknowledgement of the position of the supervisors' position that is impractical for them to take a full supervisory role as well as their own duties in admissions.
7. Ms Irish, although not now employed with DCS, suggested that the PSSF should be completely re-written and allow for adequate space within the document for the

[137] Including counsel assisting the Court

interviewer to record answers if necessary, in a longer narrative than the PSSF currently allows.

8. She also suggests that '*single cells should be searched more frequently than monthly*'.[138]

32. The Court's conclusions

32.1. I am mindful of the obligation of an Inquest '*to enquire into all facts which may have operated to cause the death of the deceased as well as to inquire into the wider circumstances surrounding the death of the deceased*'.[139] With that comment in mind, I wish to make the following findings of fact and importance concerning the cause and circumstances of Mr Stachor's death.

32.2. A NOC should have been raised at admission for Mr Stachor on 6 November 2017. By 12 November 2017, Mr Stachor's mental health, by his own description, was starting to deteriorate and he was suffering anxiety and paranoia.

32.3. The first known self-description of anxiety and paranoia occurred on 12 November 2017 when Mr Stachor requested to see a doctor for a variety of physical issues for '*anexiety (sic) and paranoia*'.[140]

32.4. During his stay in BLE Cell 225 up to 9 November 2017 he also mentioned his wish to discuss his issue with paranoia.[141]

32.5. On 13 November 2017 Mr Stachor disclosed that he was a victim of sexual abuse as a child.

32.6. On 15 November 2017 Dr Hannah Sexton had an extensive consultation with Mr Stachor. No mental health issues were noted. Mr Stachor did not repeat his disclosure of sexual abuse to her in the consultation.

32.7. On 18 November 2017 Mr Stachor returned to the Yatala Health Centre and stated he had '*placement issues*'.

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[138] Paragraph 32 of Ms Irish's written submission, dated 13 January 2021
[139] WRB Transport and others v Chivell [1998] SASC 7002 at paragraph 31 per Lander J
[140] Exhibit C22, page 43
[141] Exhibit C22, page 42

32.8. In light of the summary of the above events a NOC should have been raised at some stage due to the disclosures made above. If a NOC had been raised it is unlikely Mr Stachor would have been in a single cell such as Cell 422 on 19 November 2017.

32.9. I am not able to find that a NOC would have prevented Mr Stachor taking his own life, but the likelihood of it happening would have been less due to the HRAT regime.

32.10. In this case Mr Stachor had been subject to HRAT in early 2017, but that fact was not sufficiently prominent on any of the admission documents.

32.11. The admissions section of Yatala or any admitting prison needs to be comprised of COs specifically trained for the task of conducting admission interviews.

32.12. Mr Golding was not a suitable person to conduct the interview of Mr Stachor at admission. Mr Golding's training was inadequate and despite his best efforts and attitude of helping his colleagues at all times, he was overwhelmed by the task of conducting an admission interview.

32.13. There was no suitable supervision for Mr Golding that night due to the fact supervisors were working simultaneously and therefore had no opportunity to supervise the interview.

32.14. The exact motivation for Mr Stachor's suicide is not known.

32.15. I find that Ms Bales, Ms Gransden and Mr Goodes do honestly hold the belief that adequate training occurs for all COs to undertake the role in admissions, including conducting the interviews.

33. Recommendations

33.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

33.2. Before making these recommendations, I acknowledge that many of these endorse recommendations made by this Court on previous occasions, in particular by Deputy State Coroner Schapel in his findings in the Blunden Inquest.

33.3. The Court makes the following recommendations directed to the attention of the Minister for Correctional Services, the Chief Executive of the Department for Correctional Services, the Minister for Health, the Chief Executive of SA Health and the Commissioner of Police.

1) That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional facilities.[142]

2) That the Chief Executive of the Department for Correctional Services takes steps to identify and appoint correctional officers who are specifically dedicated to the task of admitting prisoners to correctional institutions in South Australia. These dedicated correctional officers should be thoroughly trained in all aspects of the admission process. They should also be thoroughly trained in the use of the Justice Information System and should have full and unrestricted access to the information contained on that system including, but not limited to, information about the admitted prisoner that has previously been placed on the Offender Casenotes by DCS staff and members of the HRAT.[143]

3) That the officers who specialise in admissions be subject to continuing education and training relevant to their work. This scheme would involve a mandatory number of hours of continuing education per calendar year to be eligible to continue in the role. Training should incorporate concentration on Notices of Concern and the duties involved in understanding operating procedures regarding admissions[144] and raising Notices of Concern.[145] It should also cover education on the basics of mental health afflictions and common physical signs of mental health problems.

4) That the admission documents for a prisoner must clearly and easily highlight and catalogue any prisoner's previous placement onto the HRATs regime.

5) That the Chief Executive of the Department for Correctional Services mandate that a second Prisoner Stress Screening Form interview be conducted upon completion of the first seven days observation to assess and/or gain further information about the prisoner's risk of self-harm for the future.[146] An interview should be conducted when a prisoner is proposed to be placed in single cell

[142] As recommended by DSC Schapel in the Blunden Inquest, paragraph 11.8, recommendation 1
[143] As recommended by DSC Schapel in the Blunden Inquest, paragraph 11.8, recommendation 2
[144] Currently SOP 001A
[145] SOP 90
[146] This essentially mirrors recommendation 11.8, paragraph 6 of DSC Schapel in the Blunden Inquest

accommodation that has not been subject to being modified under the safe cells policy, or when transferring to a new Division of a DCS facility or a new facility.

6) That all forms needed for the admission of a prisoner, whether in electronic or paper format, be reviewed to improve their ease of use for the correctional officer and the prisoner.

7) That the preferred method for admission be by computer records that are easily accessible and formatted.

8) That HRAT team members be present for all admission interviews and have input into whether a NOC should be raised on admission.

9) That in the alternative, HRAT is automatically notified every time a prisoner previously under the care of HRAT is readmitted into immediate custody. HRAT should then be required to take a formal assessment of whether that prisoner should be under the care of the HRAT again upon readmission.[147]

10) That an electronic Prisoner Stress Screening Form be created for use at the admissions interview which would include an automatic alert when a Notice of Concern needs to be raised based on the answers to particular questions that have been given. The electronic form should then automatically and instantly be brought to the attention of the HRAT for consideration by the end of the next day.

11) Items that have the potential to act as ligatures should be classified as contraband within the Department for Correctional Services institutions, or at least within DCS custodial facilities that have not had cells updated in compliance with the safe cells policy.

Key Words: Death in Custody; Suicide; Prison; Hanging Points; Safe Cells

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of June, 2021.

Deputy State Coroner

[147] This did not occur for Mr Stachor