



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 23<sup>rd</sup> day of March, the 21<sup>st</sup> day of May, the 13<sup>th</sup> and 31<sup>st</sup> days of July, the 27<sup>th</sup>, 28<sup>th</sup>, 29<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> days of August, the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup>, 17<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup>, 20<sup>th</sup>, 21<sup>st</sup>, 26<sup>th</sup> and 27<sup>th</sup> days of September, the 1<sup>st</sup> day of November, the 5<sup>th</sup>, 12<sup>th</sup>, 14<sup>th</sup> and 20<sup>th</sup> days of December 2018, the 29<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> days of January, the 1<sup>st</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup> and 22<sup>nd</sup> days of February, the 25<sup>th</sup> day of March, the 6<sup>th</sup> day of May 2019, the 16<sup>th</sup> day of June, the 21<sup>st</sup> and 22<sup>nd</sup> days of July, the 4<sup>th</sup> and 10<sup>th</sup> days of August, the 22<sup>nd</sup> day of December 2020, the 23<sup>rd</sup> day of February, the 4<sup>th</sup> day of March, the 21<sup>st</sup>, 27<sup>th</sup>, 28<sup>th</sup>, 29<sup>th</sup> and 30<sup>th</sup> days of April, the 3<sup>rd</sup>, 4<sup>th</sup>, 7<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup>, 20<sup>th</sup>, 21<sup>st</sup>, 24<sup>th</sup>, 25<sup>th</sup>, 26<sup>th</sup>, 27<sup>th</sup> and 31<sup>st</sup> days of May, the 1<sup>st</sup>, 3<sup>rd</sup> and 8<sup>th</sup> days of June 2021, the 28<sup>th</sup> day of September, the 1<sup>st</sup> day of October 2021 and the 12<sup>th</sup> day of May 2023, by the Coroner's Court of the said State, constituted of Jayne Samia Basheer, Deputy State Coroner, into the death of Wayne Fella Morrison.*

*The said Court finds that Wayne Fella Morrison aged 29 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 26<sup>th</sup> day of September 2016 as a result of hypoxic ischaemic encephalopathy and multi organ failure due to out of hospital cardiac arrest (in the setting of psychological and physical stress, exertion, restraint and coronary artery disease). The said Court finds that the circumstances of his death were as follows.*

## Contents

<b>1.</b>	<b>Introduction</b> .....	<b>6</b>
<b>2.</b>	<b>Mr Morrison’s personal background</b> .....	<b>8</b>
<b>3.</b>	<b>Purpose of a coronial inquest, standard of proof and other matters</b> .....	<b>9</b>
<b>4.</b>	<b>Cause of death</b> .....	<b>11</b>
<b>5.</b>	<b>Issues for determination</b> .....	<b>12</b>
<b>6.</b>	<b>Mr Morrison’s admission to Yatala Labour Prison - 19 September 2016</b> .....	<b>13</b>
6.2.	The DCS interview .....	13
6.9.	Mr Morrison’s DCS admissions interview .....	14
6.17.	Was Mr Morrison identified as Aboriginal during the Specific Needs Assessment?.....	16
6.26.	Mr Morrison’s Stress Screen - was a Notice of Concern raised? .....	18
6.42.	Did a responsible officer co-sign the stress screen form? .....	21
6.47.	Was CO Golding qualified to work as an admissions officer? .....	22
6.54.	Why was CO Golding permitted to continue working as an admissions officer after Mr Morrison’s death?.....	23
6.68.	Mr Morrison’s nursing assessment by the SA Prison Health Service.....	25
6.70.	The Stage 1 assessment .....	25
6.88.	The Stage 2 assessment .....	29
<b>7.</b>	<b>Mr Morrison’s first three days in custody at Yatala (19-22 September 2016)</b> .....	<b>30</b>
7.2.	Was the seven-day observation period commenced and documented? .....	31
7.18.	The medical request forms .....	33
7.24.	Did Mr Morrison complain to correctional officers and/or nursing staff about chest pain? .....	35
<b>8.</b>	<b>Mr Morrison’s transfer to Holden Hill Police Station Cells - 22 September 2016</b> .....	<b>36</b>
8.15.	Cell conditions at Holden Hill .....	39
8.19.	Mr Morrison’s admission at Holden Hill .....	40
8.25.	Prisoner observations of Mr Morrison.....	41
8.29.	The half hourly visual checks - were any concerns about Mr Morrison recorded in the Holden Hill logbook? .....	42
8.32.	Camera observations of Mr Morrison in Cells 2 and 12 .....	42
8.40.	Mr Morrison’s demeanour on the morning of 23 September 2016 .....	43
8.59.	The van journey from Holden Hill to Yatala .....	47
8.64.	Mr Morrison is readmitted to Yatala - Friday 23 September 2016.....	47
<b>9.</b>	<b>Use of Force - Section 86 of the <i>Correctional Services Act 1982 (SA)</i> and Standard Operating Procedures (SOP-079 Use of Force)</b> .....	<b>49</b>

<b>10. The restraint .....</b>	<b>50</b>
10.3. CCTV vision .....	50
10.9. The Privilege Against Self-Incrimination .....	51
10.16. The amended self-incrimination provisions - Coroners (Inquest and Privilege) Amendment Act 2021 (SA) ('the amending Act') .....	52
10.24. The events which led to the restraint of Mr Morrison .....	54
10.27. Evidence of CO Allen Radford .....	54
10.37. Statement of CO Beverly Demopoulos .....	57
10.42. Findings as to the events leading to the initial restraint of Mr Morrison.....	58
10.46. Evidence of CO Hutchinson .....	59
10.50. Evidence of CO Robinson .....	59
10.54. Evidence of CO Shane Crase.....	60
10.58. The initial restraint of Mr Morrison outside of the holding cells.....	60
10.60. Evidence of CO Greenwood .....	60
10.65. The continuing restraint in the mess room corridor.....	61
10.70. The strength of Mr Morrison's resistance .....	62
10.80. Was Mr Morrison punched during the restraint? .....	65
10.88. Why were plastic flexi-cuffs used as leg restraints? .....	66
10.94. The Spit Mask - was Mr Morrison spitting? .....	67
10.105. Was it necessary to use a spit mask? .....	69
10.110. Mr Morrison is lifted and carried from the building .....	70
10.115. Why was Mr Morrison lifted and carried from the building? .....	70
10.119. Why was no restraint belt or body cuff used to support Mr Morrison's body while he was carried?.....	71
10.124. Was any attempt made to bring Mr Morrison to his feet?.....	72
10.130. Was the spit mask adjusted as Mr Morrison was being carried towards Door 10?.....	73
10.136. Did the lifting and carrying of Mr Morrison involve an excessive use of force?..	74
<b>11. Training.....</b>	<b>74</b>
11.5. Two key questions arise in the context of Mr Morrison's restraint: .....	75
11.20. Restraint refresher training.....	78
<b>12. The placement of Mr Morrison in the van and the van journey to G Division.....</b>	<b>82</b>
12.1. Should Mr Morrison have been transferred to G Division?.....	82
12.7. The placement of Mr Morrison in the van.....	83
12.13. Had the subject officers received training in the use of the van, the safe placement of prisoners in the van and monitoring their safety during transit?..	84
12.18. Did too many officers travel in the rear section with Mr Morrison? .....	85
12.26. The van journey.....	87

<b>13. Events in the G Division sally port .....</b>	<b>94</b>
13.5. Mr Morrison is removed from the van at G Division .....	96
13.11. When did the G Division officers realise there was a medical emergency? .....	97
13.17. When was the spit mask removed? .....	98
13.22. The timing of the commencement of chest compressions and CPR .....	99
13.34. Timing of the CPR – Evidence of Dr Flabouris and Dr Charlwood.....	101
13.46. Why was the commencement of chest compressions delayed pending the arrival of resuscitation equipment? .....	103
13.58. The SAPHS medical team .....	106
13.68. Arrival of the paramedics.....	108
13.72. Did officers have current Cardiopulmonary resuscitation (CPR) training? .....	109
<b>14. The forensic evidence.....</b>	<b>111</b>
14.1. Evidence of specialist forensic pathologist Dr Cheryl Charlwood.....	111
14.3. Marked physical exertion, emotional and physical stress .....	111
14.9. Acute psychological stress and stress cardiomyopathy (Takotsubo’s Cardiomyopathy).....	113
14.15. Excited delirium.....	114
14.21. Genetic susceptibility to channelopathies (Long QT Syndrome) .....	115
14.25. A positional element .....	115
14.31. Evidence of pre-existing coronary artery disease .....	117
14.39. Analysis of the forensic evidence in the context of Mr Morrison’s case .....	117
14.49. Did restraint in the prone position cause respiratory compromise or ‘positional asphyxia’? .....	120
14.59. Did the use of a spit mask cause or contribute to Mr Morrison’s death .....	121
14.77. Could the rib fractures observed at autopsy have been caused during the restraint? .....	126
14.83. Could the bruising, swelling and abrasions observed at autopsy have been caused during the restraint or are there other possible causes? .....	127
<b>15. The post incident events.....</b>	<b>128</b>
15.6. The post incident management plan .....	129
15.9. Failure to secure incident scenes .....	130
15.11. The arrival of South Australia Police .....	130
15.22. Events in the Gatehouse and related events .....	132
15.33. The COLF Constitution.....	134
15.57. Validity of the Correctional Officers’ Legal Fund Constitution.....	139
15.59. Reports of Mr Zadow, Mr Don Muller, Detective Senior Sergeant Georg and the Ombudsman.....	139
<b>16. Proposed recommendation for an investigatory body to be established by the State Government.....</b>	<b>139</b>

<b>17. Proposed recommendation to address alleged failures by the Department for Correctional Services to implement and monitor the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) Report.....</b>	<b>142</b>
<b>18. Proposed recommendation for disciplinary and criminal charges against correctional officers and funding of counsel in coronial matters .....</b>	<b>142</b>
<b>19. SUMMARY AND FINDINGS.....</b>	<b>143</b>
<b>20. Key findings.....</b>	<b>144</b>
20.1. Cause of death .....	144
20.2. Mr Morrison’s cardiac arrest.....	144
20.2.5. When did the physiological processes which ultimately led to Mr Morrison’s cardiac arrest commence? .....	145
20.3. The restraint.....	146
20.4. The use of restraint equipment (handcuffs, leg cuffs and the spit mask) .....	147
20.5. Did the manner in which Mr Morrison was removed from the building involve an excessive use of force?.....	149
20.6. The placement of Mr Morrison in the van.....	150
20.7. Did Mr Morrison suffer the cardiac arrest in the van or at an earlier time? .....	151
20.8. Did the spit mask cause or contribute to Mr Morrison’s death during the van journey? .....	152
20.9. Events in the G Division sally port - was there a delay in the commencement of chest compressions and did it cause or contribute to Mr Morrison’s death?.....	152
20.10. CPR training.....	155
20.11. The Yatala admissions process.....	156
20.12. Was CO Golding qualified to conduct Mr Morrison’s DCS admissions interview?.....	156
20.13. The SA Prison Health Service assessment.....	157
20.14. Mr Morrison’s first few days at Yatala Labour Prison.....	158
20.15. Mr Morrison’s transfer to Holden Hill.....	159
<b>21. SUMMARY AND RECOMMENDATIONS.....</b>	<b>160</b>
21.7. Restraint training, first aid and cardiopulmonary resuscitation training (CPR). .....	162
21.8. Holden Hill police cells .....	163
21.9. Yatala Admission Process.....	163
21.10. Security Access to Yatala Labour Prison by South Australia Police.....	164
21.11. Memorandum of Understanding .....	164

## 1. **Introduction**

- 1.1. Wayne Fella Morrison was a 29-year-old Aboriginal man who died at the Royal Adelaide Hospital in the early hours of Monday 26 September 2016.
- 1.2. On 17 September 2016, Mr Morrison had been involved in an altercation at Ingle Farm. The police were called. He was arrested, taken to the Elizabeth Police Station and charged with assault. Police bail was refused. Mr Morrison spent two nights in custody in the police cells at Elizabeth.
- 1.3. On Monday 19 September 2016, Mr Morrison applied for bail before a Magistrate at the Elizabeth Magistrates Court. The Magistrate ordered bail reports and remanded Mr Morrison to appear by Audio Visual Link ('AVL') on Friday 23 September 2016 at 12 noon.<sup>1</sup> After the bail hearing, Mr Morrison was released from police custody and placed into the care of G4S prison security officers for transfer to Yatala Labour Prison ('Yatala'). It was the first time Mr Morrison had been held in a correctional facility. He had no prior criminal history.
- 1.4. On admission, Mr Morrison was placed in E Division where he spent his first three nights in a shared cell with other prisoners. On the fourth day, Mr Morrison was transferred to the Holden Hill Police Station where he remained overnight. He was returned to Yatala the next morning (23 September 2016) to attend his AVL bail hearing.
- 1.5. Mr Morrison and another prisoner who had spent the night at Holden Hill arrived at Yatala shortly after 9am. They were placed in the Yatala holding cells to await their court hearings.
- 1.6. At around 11:30am, Mr Morrison was alone in Cell 5. A correctional officer unlocked Mr Morrison's cell doors to relocate him to an adjacent cell. Once the doors were unlocked, Mr Morrison charged out of the cell and, within a matter of seconds, he had attacked and injured three correctional officers. A Code Yellow (i.e. officer requiring assistance) distress alarm was activated and broadcast over the prison radio network. Multiple officers responded by attending at the holding cells area to provide assistance.

---

<sup>1</sup> Exhibit C65a, page 35; Exhibit C146, pages 4 and 6

- 1.7. Mr Morrison resisted all attempts to restrain him. Ultimately, he was brought to ground in a nearby corridor and restrained by the application of handcuffs, leg cuffs and a spit mask. Mr Morrison was then lifted from the ground by his limbs and carried from the building to a prison escort van for transfer to G Division (maximum security).
- 1.8. Mr Morrison was placed in the rear compartment of the van. He was placed face down, in a prone position, and he was wearing a spit mask. Eight correctional officers accompanied Mr Morrison in the van. Five of the eight officers travelled in the rear compartment.
- 1.9. The van was not equipped with audio/visual recording equipment.
- 1.10. The journey to G Division took just under two minutes. The van reversed into the G Division sally port where G Division officers were awaiting Mr Morrison's arrival.
- 1.11. Shortly before the van doors were opened, a Code Black (medical emergency) distress alarm was activated. When Mr Morrison was removed from the van, he was found to be cyanosed and unresponsive.
- 1.12. Resuscitation equipment was retrieved from the G Division, albeit the location of the equipment resulted in a delay in its retrieval.
- 1.13. When the SA Prison Health Services ('SAPHS') medical team arrived in the sally port the equipment was not there, and chest compressions had not commenced. Dr Farrall directed a correctional officer to commence chest compressions and cardiopulmonary resuscitation ('CPR') and for an ambulance to be called. When the SA Ambulance Service ('SAAS') arrived the SAAS paramedics assumed control of the resuscitation.
- 1.14. A return of circulation was established after about 31 minutes. Mr Morrison was then taken by ambulance to the RAH Intensive Care Unit where he remained unconscious for three days.
- 1.15. Despite intensive medical intervention, Mr Morrison continued to deteriorate. He did not regain consciousness and was declared deceased at 3:50am on Monday 26 September 2016.<sup>2</sup>

---

<sup>2</sup> Mr Morrison was admitted to the RAH under an assumed name 'for the safety of the community and the security of the prisoner': Transcript, page 7512. Members of the Morrison family were initially unable to locate Mr Morrison because they did

1.16. The Court heard evidence from 73 witnesses and received over 300 exhibits. It is not within the scope of this finding to make factual determinations about each and every issue that arose in these proceedings. For example, the circumstances which led to Mr Morrison's arrest on 17 September 2016 at Ingle Farm, his management by South Australia Police ('SAPOL') whilst in police custody, the merits of the refusal of police bail, and the decision of a Magistrate to refuse bail were not examined during the inquest. At the commencement of proceedings, the Court advised counsel that the inquest would focus on the events which occurred after Mr Morrison's admission to Yatala, that is to say, whilst he was in the care and custody of the Department for Correctional Services ('DCS' or 'the Department'). No objection was raised by counsel to this proposed course, and no request was made for witnesses to the earlier events to be made available for cross-examination.<sup>3</sup>

## 2. **Mr Morrison's personal background**

- 2.1. Mr Morrison came from a close family. He was the second eldest of five siblings. His biological father died when he was young and the primary parental figure in his young life was his mother, Caroline Andersen. Mr Morrison had a very close relationship with his mother and siblings. They adored him.<sup>4</sup>
- 2.2. Mr Morrison was a family man. His partner, Sarah Jackson, worked as a child-care centre teacher. They had a daughter who was born in February 2010.<sup>5</sup> Mr Morrison was described as a good father. He worshipped his daughter and played an active role in her life.<sup>6</sup>
- 2.3. Mr Morrison left school at the age of 15 years. He studied and qualified as a chef followed by several years of employment in the hospitality industry. In later years, he sought to gain further qualifications with the aim of work in the mining sector. There

---

not know that he had been admitted under an assumed name. When they did find him there was conflict between some family members and officers who were guarding Mr Morrison. The distress caused to the family has been comprehensively addressed in the report of internal DCS investigator, Mr Don Muller (Exhibit C65aaaay) and by the Ombudsman in his report dated 19 August 2020 (Exhibit C237, pages 28-54, 107-111). I agree with their findings and recommendations and have nothing to add.

<sup>3</sup> Transcript, page 20; For a detailed summary of these events see Exhibit C65a - Final Report of Investigating Officer, Detective Sergeant Cameron Georg, Major Crime Investigation Branch dated 30 April 2018 (271 pages) at pages 25-35 ('the Georg Report'); See also Exhibit C147, pages 46-79 (South Australia Police Detainee Transfer Report)

<sup>4</sup> Refer Statement of Caroline Andersen: Exhibit C153, pages 2-3; Transcript, pages 117-130; Statement of Latoya Rule: Exhibit C154, Transcript, pages 131-144; Statement of Patrick Morrison: Exhibit C1

<sup>5</sup> Refer Statement of Sarah Jackson: Exhibit C11

<sup>6</sup> Exhibits C153, page 4; C154, page 4; C1, page 9

were some periods of unemployment, but it is clear from the evidence that Mr Morrison was keen to advance himself and to support his family's future.

- 2.4. Mr Morrison was artistic and musical. As a self-taught guitarist he was said to possess quite a talent. He enjoyed sport as well, such as martial arts and boxing.<sup>7</sup>
- 2.5. The Morrison family is justifiably proud of him. Mr Morrison was a deeply loved and cherished family member who was respected by his family, friends and the wider community. His death has caused profound pain and grief.

### **3. Purpose of a coronial inquest, standard of proof and other matters**

- 3.1. At the time of his death, Mr Morrison was a prisoner in the custody of the Chief Executive of the Department for Correctional Services. A coronial inquest into the cause or circumstances of his death was therefore mandatory.<sup>8</sup>
- 3.2. Section 25(1) of the *Coroners Act 2003* (SA), requires the Court to 'give its findings in writing setting out as far as has been ascertained the cause and circumstances' of the event the subject of the inquest as soon as practicable after completion of an inquest.
- 3.3. An amendment to section 25(2) which commenced operation on 7 June 2021, allows the Coroners Court to add to its findings any recommendation that in the opinion of the Court-
  - (a) might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest; or
  - (b) relates to a matter arising from the inquest, including (but not limited to) matters concerning—
    - (i) the quality of care, treatment and supervision of the dead person prior to death; and
    - (ii) public health or safety; and
    - (iii) the administration of justice,
 and is, in the circumstances, an appropriate matter on which to make a recommendation.

<sup>7</sup> Exhibit C154, page 2; Transcript, page 128

<sup>8</sup> Section 21(1)(a) of the *Coroners Act 2003* (SA)

- 3.4. Prior to the amendment, the Court's ability to make recommendations was limited to recommendations which, 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 (i.e. s25(2)(a)). There was some debate amongst counsel about whether the expanded provision applies to this inquest, an issue that will be addressed in due course.
- 3.5. There is no burden of proof per se in a coronial inquest. This is due to the investigative nature of the proceedings and the fact that there are no parties to the proceedings. Although there is no onus of proof as such in an inquest, if a particular positive finding of fact is urged upon the coroner, the entity agitating in favour of that finding must point to evidence in support of it. The standard of proof is the civil standard of proof on the balance of probabilities.
- 3.6. If I state in this finding that 'I am satisfied', 'I accept' or 'I find' that a particular fact or matter is proved, it means that the fact or matter has been proved on the balance of probabilities.
- 3.7. The principles of *Briginshaw v Briginshaw*<sup>9</sup> apply to fact-finding in the Coroners Court. I will say more about the Briginshaw principles in this finding. For current purposes, suffice it to say that the degree of satisfaction of a particular fact, and the strength of evidence necessary to establish that fact, may alter according to the nature of the fact sought to be found, or the overall finding that the coroner is considering.
- 3.8. For ease of reference, all findings will be underlined. With the exception of headings, where italics are used, the emphasis has been added.
- 3.9. In making determinations and findings of fact, I have referred only to the statements, oral evidence, and exhibits which I consider most relevant to the issue or issues under consideration. The fact that I may not mention a matter should not be taken to suggest I have not read and considered the whole of the evidence. The same applies to the comprehensive oral and written submissions of counsel made at the conclusion of these proceedings.

---

<sup>9</sup> (1930) 60 CLR 336

#### 4. **Cause of death**

4.1. Dr Charlwood is a specialist forensic pathologist who conducted a post-mortem examination of Mr Morrison on 27 September 2016.<sup>10</sup> Dr Charlwood's opinion as to the cause of death was:

(A) hypoxic ischaemic encephalopathy and multi-organ failure;

(B) out of hospital cardiac arrest (in the setting of psychological and physical stress, exertion, restraint, and coronary artery disease).<sup>11</sup>

4.2. Part (A) of the cause of death refers to the immediate cause of death. Hypoxic ischaemic encephalopathy is brain injury caused by oxygen deprivation to the brain. Multi-organ failure is self-explanatory and refers to the progressive physiological dysfunction and failure of two or more organs in the body.<sup>12</sup>

4.3. Part (B) of the cause of death identifies that the cardiac arrest occurred out of hospital and in a setting of psychological and physical stress, exertion, restraint, and coronary artery disease.

4.4. Due to the circumstances surrounding Mr Morrison's collapse, the cardiac arrest was assessed by Dr Charlwood in the context of a sudden cardiac death. The possibility of a primary respiratory arrest (which occurs when the heart is still pumping but there is a problem with breathing) was considered, but the presence of agonal breathing at the time of the attempted resuscitation indicated some respiratory drive. Accordingly, Dr Charlwood considered it far more likely that Mr Morrison died as a result of a primary cardiac arrest. The possibility of a stroke was excluded for the same reason.<sup>13</sup> Based on the post-mortem examination Dr Charlwood also excluded myocardial infarction (sudden ischaemic cardiac death) as a cause of death.<sup>14</sup>

4.5. As part of the autopsy, Mr Morrison's heart was retained for specialist cardiac pathological examination by Professor Tony Thomas, SA Pathology.<sup>15</sup> The

<sup>10</sup> Exhibit C273 - Post-mortem Report of Dr Cheryl Charlwood dated 3 April 2017 (27 pages)

<sup>11</sup> Exhibit C273, page 6

<sup>12</sup> Transcript, pages 7680-7681

<sup>13</sup> Transcript, pages 7679-7680, 7700, 7718

<sup>14</sup> Dr Charlwood agreed with and adopted the finding of Professor Tony Thomas; see Exhibit C4a Anatomical pathology report of Professor Thomas dated 23 November 2016, page 5

<sup>15</sup> Exhibit C4a - Anatomical pathology report of Tony Thomas (Consultant, SA Pathology)

examination included macroscopic and microscopic examination.<sup>16</sup> While the macroscopic examination showed some level of cardiac disease, the microscopic examination revealed that Mr Morrison had moderate to severe cardiac disease with focal moderate to severe (70%) atheroma of the right coronary artery. This finding was unexpected in a 29-year-old man.

4.6. I accept the expert evidence of Dr Charlwood and agree with her findings as to the cause of death.

## 5. **Issues for determination**

5.1. Key issues for determination include, but are not limited to, the following:

- 5.1.1. Whether Mr Morrison was identified as Aboriginal on admission to Yatala.
- 5.1.2. Whether the failure to raise a Notice of Concern (undisputed) during Mr Morrison's DCS admissions process caused or contributed to his death.
- 5.1.3. Whether the omitted Stage 2 nursing assessment, by the SAPHS, (undisputed) caused or contributed to Mr Morrison's death.
- 5.1.4. Whether the mandatory seven-day observations of Mr Morrison were conducted whilst he was in E Division at Yatala.
- 5.1.5. Whether Mr Morrison reported chest pain to correctional officers or medical staff whilst in E Division.
- 5.1.6. Whether Mr Morrison completed medical request forms and whether any such forms were destroyed by correctional officers.
- 5.1.7. Whether Mr Morrison met the criteria for transfer to the Holden Hill police cells.
- 5.1.8. Whether Mr Morrison's experiences and treatment at Holden Hill caused a decline in his mental health which can be causally linked to his behaviour in the holding cells on the morning of Friday 23 September 2016.

---

<sup>16</sup> Exhibit C273, pages 7, 18, 22-26; Exhibit C4a, pages 3-5

- 5.1.9. Whether Mr Morrison was suffering a psychotic episode on the morning of the incident.
- 5.1.10. Whether the level of force used by correctional officers to restrain Mr Morrison was an excessive use of force.
- 5.1.11. Whether a spit mask should have been used during the restraint of Mr Morrison and whether its use caused or contributed to Mr Morrison's death.
- 5.1.12. Whether the manner in which Mr Morrison was removed from the holding cells area (i.e. lifted from the ground by his limbs and carried without body supports) to a van for transfer to G Division was an excessive use of force.
- 5.1.13. Whether any acts and/or omissions by correctional officers occurred during the van journey to G Division and, if so, whether these acts or omissions caused or contributed to Mr Morrison's death.
- 5.1.14. Whether there was any significant delay in the commencement of chest compressions/CPR at the G Division sally port and, if so, whether the delay caused or contributed to Mr Morrison's death.
- 5.1.15. Identification of the possible factors or mechanisms which may provide an underlying reason or explanation for Mr Morrison's cardiac arrest and whether any single factor or mechanism can be identified as the more likely cause.

## **6. Mr Morrison's admission to Yatala Labour Prison - 19 September 2016**

- 6.1. The admission process is a two-stage process conducted by a DCS Admissions Officer and a registered nurse from the SAPHS.
- 6.2. The DCS interview
- 6.3. Standard Operating Procedure 001A ('SOP-001A') sets out the obligations and procedures to be followed by DCS employees when admitting prisoners to Yatala.<sup>17</sup>

---

<sup>17</sup> Exhibit C65as; SOPs are available to staff by accessing the intranet at the worksite

- 6.4. Standard Operating Procedure 090 ('SOP-090') sets out the duties and responsibilities relating to the assessment of prisoners who may be at risk of self-harm or suicide.<sup>18</sup>
- 6.5. As part of the admissions process, DCS staff must search the Justice Information System ('JIS') to identify whether a prisoner has previously had contact with the Department. The JIS is an electronic computer program which is used to record information about prisoners.<sup>19</sup>
- 6.6. Two things must occur in relation to new prisoners. First, a Prisoner Case Management File and a Prisoner Medical File must be created.<sup>20</sup> Secondly, every new prisoner must have a face-to-face interview with both a DCS Admissions Officer and SAPHS nursing staff on admission.<sup>21</sup> A Joint Systems Protocol has been developed between the Department of Health and DCS to assist in the admissions process. It sets out a range of procedures which are designed to facilitate effective cross agency communication and cooperation.<sup>22</sup>
- 6.7. The DCS process commences with verification of the warrant by the admitting officer/s, the prisoner is photographed, strip searched, and offered one telephone call to a family member or friend.<sup>23</sup>
- 6.8. The Chief Executive of the Department, Mr David Brown, described the admissions process as 'the critical stage'. He did not challenge the suggestion put by counsel for the Morrison family that it is a crucial time to identify the potential complex needs of a person who has entered into their care.<sup>24</sup>
- 6.9. Mr Morrison's DCS admissions interview
- 6.10. Mr Morrison had no previous contact with the Department so he was classified as a new prisoner. His DCS admission interview was conducted by CO Kym Golding.<sup>25</sup>

---

<sup>18</sup> Exhibit C65az

<sup>19</sup> The JIS program utilises shaded green and white computer screens. The green screen which is referred to as 'the green JIS' contains general admission information. The white screen, referred to as 'the white JIS', records information derived from the admissions interview.

<sup>20</sup> Exhibit C65as at [3.1]-[3.2]; A Prisoner case management file and a Prisoner medical file were opened for Mr Morrison

<sup>21</sup> The SAPHS under the management of SA Health, provides health care services within correctional facilities governed by the Department for Correctional Services. The Yatala health care service has a High Dependency Unit which houses prisoners with complex physical and/or mental health needs: Exhibit C65a, page 24

<sup>22</sup> Exhibit C174

<sup>23</sup> Exhibit C65as at [3.5]

<sup>24</sup> Transcript, pages 7457-7458

<sup>25</sup> Exhibit C155; CO Golding gave evidence on two occasions, initially Transcript, pages 149-225 and upon his recall at Transcript, pages 5162-5203

- 6.11. Correctional officers are classified at various levels which are commensurate with their skills and experience. CO Golding was classified as a CO2 (general duties). He did not usually work as an admissions officer, a role which was generally undertaken by supervisors who are classified at the higher CO4 level. It is undisputed that due to the high number of daily admissions at Yatala, CO2 and CO3 officers, including CO Golding, were permitted to 'act up' as admissions officers with a commensurate increase in pay for the shift.
- 6.12. The Court heard evidence about the existence of a list within the DCS which contained the names of correctional officers who were permitted to 'act up' as admissions officers.<sup>26</sup> The list was not produced and tendered as an exhibit, but there was no dispute about its existence, or that CO Golding's name was on that list. It is unclear who compiled the list and/or the criteria, if any, that applied for an officer's inclusion.
- 6.13. On 19 September 2016, CO Golding was requested to do overtime in the holding cells and to 'act up' as an admissions officer. That is how he came to be conducting Mr Morrison's admission interview.
- 6.14. A number of forms must be completed on admission including an Admissions Checklist, a Specific Needs Assessment, a Prisoner Stress Screen, and a Prisoner Interview form. It is the responsibility of the operational supervisor ('the Responsible Officer') to ensure that the forms are accurately completed. These documents must be placed on the prisoner's case file. Certain admission details must also be entered electronically onto the JIS. The white JIS information must be printed, signed, dated, and placed on the prisoner's case file. The green JIS information is retained in electronic form only.<sup>27</sup>
- 6.15. CO Golding said that Mr Morrison's interview commenced at around 9pm on 19 September 2016.<sup>28</sup> He described Mr Morrison as 'happy, easy going, extremely compliant, even jovial'. He said Mr Morrison was keen to be placed in a cell with 'his brothers', a term which CO Golding understood as a request to share a cell with other

---

<sup>26</sup> Transcript, pages 263, 272-273

<sup>27</sup> Transcript, pages 160, 7157-7158

<sup>28</sup> Transcript, page 613

Indigenous prisoners. He said Mr Morrison repeated this request about three times during the interview.<sup>29</sup>

- 6.16. GO Golding gave evidence that he completed ‘some forms’ but candidly stated that he was confused about which forms had to be completed and whether all pages had to be completed.
- 6.17. Was Mr Morrison identified as Aboriginal during the Specific Needs Assessment?
- 6.18. The first anomaly which emerged during CO Golding’s evidence relates to some missing documents. The Specific Needs Assessment form is a three-page document which must be completed, copied and placed on the prisoner’s case file at the conclusion of the interview. However, no hard copy of pages 1 and 2 were located in Mr Morrison’s case file. A signed copy of page 3 was located, but that page relates to information provided to new prisoners about communicable diseases, drugs and alcohol.
- 6.19. The first two pages of the form contains 17 questions which are directed at risk assessment issues. The relevant question for present purposes is Question 4, namely, ‘*Are you Aboriginal, Torres Strait Islander or both? If Yes, referral made to ALO (Aboriginal Liaison Officer)?*’.<sup>30</sup>
- 6.20. Since the relevant pages were missing, CO Golding had no document from which to refresh his memory while giving evidence. His evidence about the missing pages was curious. First, he said he had never filled out pages 1 and 2 of the Stress Screen form manually and had only ever completed page 3. Secondly, he surmised that Mr Morrison’s answers to the questions on pages 1 and 2 may have been recorded directly onto the white JIS at the time of interview (noting that copies of the white JIS information must also be printed and placed on the prisoner’s case file). CO Golding mentioned there had been problems with the printer ‘at around this time’.<sup>31</sup>

---

<sup>29</sup> Statement of Kym Golding: Exhibit C155 at [7]; Transcript, page 153

<sup>30</sup> Refer blank copy of Specific Needs Assessment form (F001/002): Exhibit C155, Annexure 2

<sup>31</sup> Exhibit C155, page 5

- 6.21. When questioned about whether he had any independent recollection of asking question 4 and Mr Morrison's response, CO Golding said if a prisoner told him they were not Aboriginal, his general practice was to leave the 'Yes/No' boxes blank.<sup>32</sup> It was a strange answer. It was unclear why he would not simply mark the 'No' box. When asked whether he had any recollection of asking Mr Morrison the question, CO Golding said that he may have asked the question, but had perhaps forgotten to mark the answer in the relevant box. When pressed on the matter he said, '... to be honest I just don't know'.<sup>33</sup>
- 6.22. Counsel for the Morrison family submitted it is more likely than not that Mr Morrison *would have* identified as Aboriginal if he had been asked the question by CO Golding.<sup>34</sup> Reference was made to the fact that Mr Morrison had earlier disclosed his cultural identity to police at Elizabeth and he had told CO Golding that he wanted to be placed with 'his brothers'. On the face of it, it appears more likely than not that Mr Morrison would have identified as Aboriginal if he had been asked the question. At the same time, Mr Morrison had never been in a prison before. Even Mr Morrison's mother said that her son may not necessarily have identified himself as Aboriginal to a prison officer. The documents that could have resolved the issue could not be located and CO Golding had no independent recollection of the exchange.<sup>35</sup>
- 6.23. On the available evidence, I am unable to determine whether Mr Morrison was asked Question 4 on the Specific Needs Assessment form and, if yes, whether he identified as Aboriginal. Indeed, in the circumstances, I am unable to determine whether Mr Morrison was asked any of the 17 questions on the Specific Needs form. In the circumstances, it is incorrect to suggest that CO Golding 'failed' to identify Mr Morrison as an Aboriginal prisoner.<sup>36</sup> I simply cannot determine the matter one way or the other, except to say that he was not referred to an Aboriginal Liaison Officer ('ALO').
- 6.24. I am satisfied that on the following day ALO Charles Jackson learned from Mr Morrison's sibling, Latoya Rule, that Mr Morrison was an Aboriginal prisoner.

---

<sup>32</sup> Transcript, page 154

<sup>33</sup> Transcript, pages 152-154

<sup>34</sup> Written submissions on behalf of the Morrison family, page 36 (1<sup>st</sup> dot point)

<sup>35</sup> Exhibit C151

<sup>36</sup> See for example written submissions on behalf of the Morrison family, page 36 (Dot points 2-9 inclusive); Closing submissions by Counsel Assisting at [39]-[40]

Mr Jackson entered this information onto the white JIS the next day.<sup>37</sup> Mr Jackson gave evidence that he had planned to see Mr Morrison as soon as possible, but workload pressures prevented him from scheduling a time until the following Friday (the day of the incident). The scheduled meeting never took place.

- 6.25. Counsel for the Morrison family submitted that the staffing of Aboriginal Liaison Officers throughout the prison system is inadequate to meet the needs of the whole Aboriginal prison population.<sup>38</sup> The Court did not receive evidence from witnesses who could attest to the operation of the ALO service and its staffing levels at Yatala. It is therefore not open or appropriate to make any findings about this important issue.
- 6.26. Mr Morrison's Stress Screen - was a Notice of Concern raised?
- 6.27. The Prisoner Stress Screen process is directed at identifying vulnerable prisoners who may be at risk of self-harm or suicide and documenting it on the relevant form.<sup>39</sup>
- 6.28. In certain circumstances a Notice of Concern ('NOC') is mandatory (see below at [6.31]-[6.32]).
- 6.29. A NOC is an important document because, if raised, the prisoner is referred for assessment by medical and other professionals (e.g. social workers, psychologists and/or psychiatrists).<sup>40</sup> Some prisoners are classified as 'high risk' prisoners and are thereafter managed by the High Risk Assessment Team ('HRAT'). These prisoners are subject to closer monitoring than other prisoners. Clearly, accurate identification of the need for a NOC is essential for competent risk management of vulnerable prisoners.
- 6.30. The Stress Screen form contains 31 questions. The form is divided into two columns marked 'A' and 'B'. Numerical weightings are given to the 'Yes' answers in Column A and a stress screen score is given to each prisoner. Questions 21-23 inclusive on the form are shaded so as to highlight the questions. It is noteworthy that a written direction immediately precedes the three shaded questions and states, 'if *any* Questions 21 to 23 are selected a Notification of Concern **MUST** be completed'.<sup>41</sup>

---

<sup>37</sup> Statement of Charles Jackson: Exhibit C161; Transcript, pages 289-339; See also Exhibit C154

<sup>38</sup> Written submissions of counsel on behalf of the Morrison family at [109]-[120]

<sup>39</sup> Exhibit C155/Form No: F001/003, page 2 - This form is the third annexure to CO Golding's affidavit of evidence

<sup>40</sup> Transcript, page 234; Exhibit C65az at 3.2.6

<sup>41</sup> Exhibit C155, pages 12-13

6.31. CO Golding selected Questions 21 and 23 *but he did not raise a NOC*. The relevant questions as completed by CO Golding are these:<sup>42</sup>

If any Questions 21 to 23 are selected a Notification of Concern **MUST** be completed

21	Have you thought about deliberately harming yourself since you were arrested?	Yes / maybe <input checked="" type="checkbox"/>	No <input type="checkbox"/>
22	Do you feel like that now?	Yes / maybe <input type="checkbox"/>	No <input checked="" type="checkbox"/>
23	<p>Have you ever tried to intentionally hurt yourself?                      (If yes, record details below)                      Note Check the prisoner's wrists, arms and neck for scars.</p> <p><b>TRIED TO HANG HIMSELF</b>  <b>20 YRS AGO</b></p>	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

6.32. CO Golding confirmed that he had ticked Questions 21 and 23 and he agreed that he did not raise a NOC. He gave several explanations for the oversight including that he had misunderstood the written instruction on the form.<sup>43</sup> I reject this explanation. The written instruction is clear and unambiguous.

6.33. CO Golding also cited Mr Morrison's jovial presentation as another reason for not raising a NOC:

- 'Q. Do you agree that when you inducted Mr Morrison, you did not comply with what you were told in paras 11 and 12.
- A. That's correct.
- Q. Can you tell her Honour why you did not comply with those rules.
- A. I just thought at the time, the demeanour of him, he was happy, I didn't see any concerns, I would've double checked with him. He wasn't suicidal, when I asked him about that, I'll repeat what he said to me, he said, 'Look, that was a long time ago, I was in a bad place, I'm in a good place and like I said, he was jovial. He just wanted to be celled up with his brother, that's all he kept saying to me, 'Can I get celled up with my brother?' I said 'Look, I can't make those decisions.' So I didn't think, I thought talking in person-to-person, I thought he was in good spirits. Believe it or not, that's probably why I remember him as I do.'<sup>44</sup>

6.34. The above answers demonstrate that CO Golding had not read or understood the instructions on the form. It was not a discretionary decision. In other words, CO Golding's subjective impression of Mr Morrison's demeanour was irrelevant.

6.35. CO Golding said if Mr Morrison had told him he was suicidal, or that he had thought about deliberately harming himself in the last couple of days, he would have raised a

<sup>42</sup> Exhibit C155, Excerpt from Mr Morrison's Stress Screen form; Question 23 has since been amended to apply only to suicide attempts within the last 5 years: Transcript, page 235  
<sup>43</sup> Transcript, pages 162-166, 173-174 and 177  
<sup>44</sup> Transcript, pages 178-179

NOC.<sup>45</sup> I struggle to understand the logic of this answer. Mr Morrison had been arrested two days before (on 17 September) and when asked whether he had thought of deliberately harming himself since his arrest (Q21), CO Golding ticked ‘Yes/Maybe’.

6.36. When pressed on the matter, CO Golding did not address the question directly. Rather, he said he would never have made a decision *not* to raise a NOC on his own.

‘A. I never would have made that decision on my own. What I would have done is, the forms that you’ve shown me, I would’ve got them forms and I would put them on the nurse’s desk and I would’ve said, ‘Just have a bit of a look at this bloke, he said he tried to hang himself 20 years ago and his uncle and, you know, I think he’s okay. Then the nursing staff in the office would work in together on that.

CORONER

Q. That’s not what is on the cheat sheet.

A. Yeah, I know.

Q. It doesn’t say there, hand the form to a nurse and ask them to do it, does it.

A. No.

Q. So, is that another example of you exercising your discretion to delegate to the nurse.

A. No.

Q. Were you taught to delegate to the nurse by your supervisor.

A. It’s just common practice. We all work in with each other.<sup>46</sup>

6.37. And further:

‘Q. Would it be because your practice is just to hand these decisions onto the nurse.

A. That’s correct ma’am, that’s what I’m trying to explain.

Q. And you say that’s common practice.

A. Mm, that’s what I’m trying to say.<sup>47</sup>

6.38. I have considered this evidence. I make no criticism if a practice exists whereby discussions occur between the admissions officers and nursing staff. Discussion is one thing. Delegation of decision making is quite another, particularly where mandatory written instructions are included on the form. The DCS and SAPHS interviews are separate processes and are intended to be so. There is nothing in the Joint Systems

<sup>45</sup> Transcript, page 182; see also Transcript, page 5199

<sup>46</sup> Transcript, page 180

<sup>47</sup> Transcript, page 185

Protocol which suggests that joint decision making between the DCS admissions officer and SAPHS nursing staff forms part of the process.<sup>48</sup>

6.39. Registered Nurse Penaflorida had no recollection of such a discussion. He said it was possible that CO Golding spoke with him but, even so, he would have checked the information with Mr Morrison himself and conducted his own independent assessment.<sup>49</sup>

6.40. Even if CO Golding misunderstood the written instructions about the shaded questions 21-23, I find it difficult to understand why he did not raise a NOC in any event. First, the Column A score of '8' was high.<sup>50</sup> Indeed, a score of '9' or more mandates a NOC. Secondly, before he reached the three shaded questions, CO Golding had obtained the following information about Mr Morrison:

- It was his first time in prison (Q1);
- He was facing further charges (Q2);
- He was experiencing family problems (Q6);
- He was 'very much' worried about losing someone important to him, either through the breakup of a relationship or friendship, or through illness (Q15);
- His father and uncles had committed suicide 20 years ago (Q16); and
- He did not feel that he had a lot to look forward to in the future (Q17).

6.41. Counsel for the Morrison family submitted that 'if Mr Morrison had been admitted correctly and a Notice of Concern raised then it is likely that he would not have died'.<sup>51</sup> In my view this is overstating the matter. That said, I cannot eliminate the possibility that intervention at this stage may have prevented Mr Morrison's death.

6.42. Did a responsible officer co-sign the stress screen form?

6.43. It is the responsibility of the operational supervisor to review the admissions forms. Strict adherence to these checking processes is integral to the success of the risk management process so that errors are detected.

---

<sup>48</sup> Exhibit C174; Transcript, pages 640-642

<sup>49</sup> Transcript, page 622

<sup>50</sup> Exhibit C147

<sup>51</sup> Written submissions of counsel on behalf of the Morrison family, page 28 (3<sup>rd</sup> dot point)

- 6.44. Accordingly, the Stress Screen form must be co-signed by two officers, namely the Admissions Officer and a Responsible Officer (e.g. supervisor).<sup>52</sup> However, a perusal of Mr Morrison's Stress Screen form discloses an irregularity. *CO Golding signed the form both as the Admissions Officer and Responsible Officer.* So, in Mr Morrison's case, the errors just slipped through undetected.
- 6.45. Supervisor Ron Joseph is an experienced supervisor. When asked about this irregularity, he candidly stated, 'this is just the way it happens' at Yatala. Despite being a supervisor, he said it was not his usual practice to check the Stress Screen forms and that officers do not request him to complete the 'Responsible Officer' section.<sup>53</sup>
- 6.46. Chief Executive Brown gave evidence that the Stress Screen form should be cross-referenced and checked by the supervisor for the area. He agreed under cross-examination that if the same person signs the form it would not be consistent with Departmental procedures.<sup>54</sup>
- 6.47. Was CO Golding qualified to work as an admissions officer?
- 6.48. The deficiencies in CO Golding's conduct of Mr Morrison's admissions interview raise the question of whether he was suitably qualified to undertake the role.
- 6.49. Supervisor Singh is an experienced supervisor. He gave evidence that to qualify as an Admissions Officer trainees must attend a five-day DCS training course.<sup>55</sup> The Court heard that the trainee sits with a qualified admissions officer during this period and he/she is taken step-by-step through the process. Supervisor Singh said that during the training the importance of SOP-001A (Custodial Admission Case Management) and SOP-090 (Risk of Self-Harm and Suicide) is emphasised.<sup>56</sup> Supervisor Singh's evidence was not challenged by counsel for the Department.

---

<sup>52</sup> Ibid at [3.7.2-3.7.7]

<sup>53</sup> Transcript, pages 1247-1248, 1430

<sup>54</sup> Transcript, pages 7457-7458

<sup>55</sup> Transcript, pages 227-278

<sup>56</sup> Transcript, pages 273-275

- 6.50. Admissions officers are expected to have a working knowledge of the two aforementioned Standard Operating Procedures. Indeed, all correctional officers are required to have a working knowledge of relevant SOPs. When questioned about these SOPs, CO Golding said he was not familiar with SOP-001A and he volunteered that he had never even read SOP-090.<sup>57</sup>
- 6.51. CO Golding had no recollection of receiving any formal training for the role. He was trained for the position by shadowing another admissions officer for about 30 minutes and by being handed a 'Cheat Sheet' to use during the interviews.<sup>58</sup> Given the purpose and importance of the admissions process this is reprehensible.
- 6.52. Counsel for the Morrison family submitted that CO Golding was inadequately trained and that he was an unsuitable person to conduct Mr Morrison's admissions interview.<sup>59</sup> I agree.
- 6.53. CO Golding should not have been permitted to act in the position of Admissions Officer. He did not have the skills, training and/or experience to undertake the role and I so find.
- 6.54. Why was CO Golding permitted to continue working as an admissions officer after Mr Morrison's death?
- 6.55. Given CO Golding's poor performance, one would assume that he would not have been permitted by the Department to continue working as an admissions officer unless and until he was properly qualified. In fact, *it is undisputed that CO Golding continued to work as an admissions officer for around 14 months after Mr Morrison's death*.
- 6.56. Counsel for the Morrison family described this as 'extraordinary'.<sup>60</sup> I agree. It is a fair observation, particularly since Acting General Manager Hosking acknowledged that he had learned of the omission to raise a NOC within a week or two of Mr Morrison's death.
- 6.57. The Court only learned about this irregularity after discovering by chance that CO Golding was the admissions officer for a prisoner named Joshua Marek Stachor

---

<sup>57</sup> See for example Exhibit C155 at [4]-[5] and Form 001/002; Transcript, pages 174-176, 180, 222-224

<sup>58</sup> Exhibit C155b

<sup>59</sup> Written submissions on behalf of the Morrison family, page 12 at [59]

<sup>60</sup> Written submissions on behalf of the Morrison family, page 19 at [76]

who had died by hanging himself in custody around 14 months after Mr Morrison's death.<sup>61</sup> It is unnecessary to examine the circumstance of how this discovery came to light. Suffice it to say that Deputy State Coroner White, who published his findings in Mr Stachor's inquest on 28 June 2021, identified shortcomings that are similar to those identified in Mr Morrison's case.

- 6.58. Counsel for the Morrison family was critical of the evidence given by the Chief Executive and others who said they were waiting for the Ombudsman's Report and this inquest Finding before addressing the identified shortcomings. It was rightly observed by the said counsel that the Georg Report and a report by DCS investigator Mr Don Muller (the Muller Report), were available to the Department well before the completion of the Ombudsman's Report, yet no action was taken to act on the recommendations. Counsel Assisting joined in these submissions. I agree with the observations made by both counsel on this point.
- 6.59. The Department has provided no satisfactory explanation for permitting CO Golding to continue in the role for an additional 14 months without further training.<sup>62</sup>
- 6.60. CO Golding was recalled to give further evidence.<sup>63</sup> He confirmed that after Mr Morrison's death he received no feedback about his performance and said he was never told that he should have raised a Notice of Concern. This evidence was unchallenged by counsel for the Department.
- 6.61. CO Golding's first realisation about performance issues came when some colleagues refused to work with him during admissions (e.g. Supervisor Bell). It was only then that CO Golding realised there was a problem with his work.<sup>64</sup>
- 6.62. I accept CO Golding's evidence on this issue. CO Golding said he tried to work out for himself what he was doing wrong by speaking with nursing staff.<sup>65</sup>

---

<sup>61</sup> Counsel Assisting criticised the fact that CO Golding's legal representatives did not lead their client, nor advise the Court at any time, about the fact that CO Golding had been involved in an admission 14 months after Mr Morrison's admission and that that admission was to be examined in an inquest which was yet to commence. I do not consider it the role of the Court to question such decisions. The Court is not necessarily privy to forensic and/or other reasons for such decisions.

<sup>62</sup> Ibid at page 20, [78]

<sup>63</sup> Transcript, pages 5162-5203

<sup>64</sup> Transcript, pages 5171-5172

<sup>65</sup> Transcript, pages 5169, 5171, 5174-5175, 5184-5187

- 6.63. Counsel Assisting submitted that CO Golding's mistakes should not be attributed solely to inadequate training and that he must accept some personal responsibility for his own mistakes.<sup>66</sup> Counsel for the Morrison family supported the submission.
- 6.64. I agree that CO Golding must accept some personal responsibility for failing to keep abreast of relevant SOPs, however, the woeful lack of training cannot be ignored when assessing the shortcomings in his performance. CO Golding was ill-prepared for the role and the Department must accept responsibility for allowing an officer to undertake such an important risk assessment role without adequate training. CO Golding should not have been placed in that position by his employer and I so find.
- 6.65. CO Golding was not an articulate or erudite witness and he did not profess to be so. At the same time, it is plain that he was deeply distressed about the shortcomings in his performance and accepted responsibility for it.
- 6.66. In the circumstances, I decline to make adverse findings against CO Golding who, in my view, was basically set up to fail.<sup>67</sup>
- 6.67. CO Golding no longer works as an admissions officer.
- 6.68. Mr Morrison's nursing assessment by the SA Prison Health Service
- 6.69. Each prisoner has a confidential SAPHS file. The information obtained from the prisoner during the admissions nursing assessment, as well as medication orders, formal requests for medical assistance received from prisoners, interactions with the SAPHS whilst in custody and medical emergencies, are recorded in this file.
- 6.70. The Stage 1 assessment
- 6.71. The nursing assessment is a two-stage process.<sup>68</sup> The Stage 1 assessment occurs on admission. It is a brief assessment which is conducted by two nurses; one nurse conducts the interview and the other takes observations of vital signs and attends to

---

<sup>66</sup> Written submissions of Counsel Assisting at [25]

<sup>67</sup> Transcript, pages 5167-5169

<sup>68</sup> Statement of Alan Scarborough, Director of Nursing SAPHS: Exhibit C217, Annexure AS3

bookings or paperwork.<sup>69</sup> The information is recorded on a proforma Stage 1 Nursing Assessment form and the completed form is placed on the prisoner's SAPHS file.<sup>70</sup>

- 6.72. A Stage 2 assessment *must*, where practical, occur within 48 hours of the prisoner's admission. A Stage 2 appointment is ordinarily made at the end of the Stage 1 assessment.<sup>71</sup>
- 6.73. RN Penaflorida said the Stage 1 assessment generally takes around 5-10 minutes unless a prisoner discloses medical or mental health history, in which case further questions and assessment is needed.<sup>72</sup>
- 6.74. There was some uncertainty about whether the DCS interview or the nursing assessment was the first in time. The SAPHS progress note records 20:45 as the commencement time, but in cross-examination RN Penaflorida suggested the entry could be wrong and the interview may have commenced at 9:05pm.<sup>73</sup> The timing is relevant because it is unclear whether or not RN Penaflorida had access to the completed DCS Stress Screen form during his assessment.
- 6.75. RN Penaflorida noted from the SAPHS file that Mr Morrison had been identified as 'Aboriginal' by the police. He recorded Mr Morrison's cultural heritage as 'Australian' and 'Aboriginal' adding that he knew that as an Aboriginal person Mr Morrison was at greater risk of self-harm, substance abuse and mental health issues than other inmates. He took these added risks into account during the assessment.
- 6.76. The Court heard that a student nurse measured Mr Morrison's vital signs, namely, his temperature, heart rate and respiration. The results of the observations are not recorded on the SAPHS file. RN Penaflorida said this is not unusual as only abnormal findings are recorded.<sup>74</sup> His evidence was that if Mr Morrison's vital signs had been abnormal he would have been placed under continuous observation or referred for an urgent medical assessment.<sup>75</sup>

---

<sup>69</sup> Transcript, page 579

<sup>70</sup> Exhibit C217, Annexure AS4: Admissions Nursing Assessment - PHS02-Stage 2

<sup>71</sup> Transcript, pages 671, 663-668, 699

<sup>72</sup> Transcript, page 594

<sup>73</sup> Exhibit C147, page 25; Transcript, page 562

<sup>74</sup> Transcript, pages 608, 634-636

<sup>75</sup> The student nurse did not give evidence at the inquest and was not required for cross-examination: Exhibit C173, page 3; Transcript, pages 578-598, 633-635; See also Transcript, page 608

- 6.77. RN Penaflorida gave evidence that he took Mr Morrison through all sections of the Stage 1 assessment form, recorded the relevant information, and placed the completed form on the SAPHS file.<sup>76</sup>
- 6.78. In summary, no abnormalities were detected or recorded:
- No physical or mental health concerns were noted.
  - No cardiovascular and/or respiratory issues were noted nor any irregularities on the mental state examination.<sup>77</sup>
  - There was no sign of depression, impulsivity, impaired judgment/cognition, substance withdrawal, intoxication, mania, agitation, psychosis, or situational crisis.
  - As to drug and alcohol use, he noted only occasional use of cannabis and alcohol.
- 6.79. At 9:15pm, Mr Morrison was given 1gm of paracetamol and an antihistamine, the latter medication being given to all prisoners on admission to assist with sleeplessness.<sup>78</sup>
- 6.80. In cross-examination, RN Penaflorida agreed that Mr Morrison must have complained of pain in order to be prescribed Panadol, however, the reason the medication was given was not recorded in the SAPHS notes.<sup>79</sup>
- 6.81. RN Penaflorida also confirmed in cross-examination that Mr Morrison disclosed a family history of suicide during the Stage 1 assessment, and he learned that Mr Morrison's father had committed suicide by hanging himself when Mr Morrison was five years old. He agreed that Mr Morrison reported his own suicide attempt at the age of about 14 years (by hanging) and that no-one knew about his suicide attempt.<sup>80</sup> RN Penaflorida said that he considered whether to raise a NOC but he saw no reason to do so.<sup>81</sup> If he had thought Mr Morrison was at risk, RN Penaflorida said he would have raised a NOC.<sup>82</sup> Nor did he consider it necessary to refer Mr Morrison for a 'high risk' assessment as he had not reported any current thoughts of self-harm, feelings of

---

<sup>76</sup> Exhibit C147, pages 20-25

<sup>77</sup> Exhibit C147, pages 21, 24

<sup>78</sup> Exhibit C147, page 16

<sup>79</sup> Transcript, pages 584-585, 628-629

<sup>80</sup> Exhibit C147, page 23

<sup>81</sup> Transcript, pages 595, 617, 620-621; see also Transcript, pages 676-678

<sup>82</sup> Transcript, page 643

hopelessness, anger, guilt, anxiety, shame or other such feelings. Nor had he reported any concerns about his impending period of imprisonment.<sup>83</sup>

- 6.82. As to the DCS Stress Screen form, RN Penaflorida could not accurately recall seeing the form at the time of his assessment. He recalled viewing it in preparation for the inquest.<sup>84</sup> He said it was standard practice for him see this form ‘at some point’ in time. The issue remains unclear. Either way, when asked whether he would have raised a NOC if he had been armed with the same information as CO Golding, RN Penaflorida said he would have taken the contents of the Stress Screen form into account, but the decision whether or not to raise a NOC would be determined by his own assessment.<sup>85</sup>
- 6.83. In cross-examination by Mr Edwardson KC, RN Penaflorida agreed that the SAPOL Detainee Transfer Report, which forms part of the SAPHS file, contained no material to suggest that Mr Morrison was at risk. This evidence was not challenged. RN Penaflorida repeated that if he had held such concerns he would have raised a NOC.<sup>86</sup> I have considered the evidence on this point and I find no basis to criticise the decision not to raise a Notice of Concern.
- 6.84. In cross-examination on the topic of the cardiac assessment section RN Penaflorida explained his general approach and gave examples of the type of questions he generally asks. For example, he asks whether the prisoner has any chest pain and the duration of any such pain. If chest pain is reported it is recorded on the case file. If the pain is assessed as ‘cardiac’ in nature a Code Black (i.e. medical emergency) will be called and, if necessary, the patient will be hospitalised. RN Penaflorida said no such issues were reported by Mr Morrison.<sup>87</sup>
- 6.85. There is no reason to infer that RN Penaflorida deviated from his usual practice when conducting Mr Morrison’s cardiac assessment and I so find.
- 6.86. At the conclusion of the Stage 1 assessment RN Penaflorida recommended that Mr Morrison be placed in a ‘routine double-up’ cell, that is to say, a shared cell with

---

<sup>83</sup> Transcript, pages 584-585, 593

<sup>84</sup> Transcript, pages 622-624, 672

<sup>85</sup> Transcript, pages 597-598, 612, 617, 620, 672-674

<sup>86</sup> Transcript, pages 590-594, 643, 648-651

<sup>87</sup> Transcript, pages 589-590, 596-597; Exhibit C147, page 21

other prisoners.<sup>88</sup> I find that it was an appropriate recommendation for a new Aboriginal prisoner.

6.87. It should also be noted that the policy at Yatala is that all new prisoners are placed in a shared cell (*regardless of their cultural heritage*).<sup>89</sup> It is a misunderstanding of the evidence to suggest that this requirement applied to Aboriginal prisoners only.

6.88. The Stage 2 assessment

6.89. As stated above, where practical, prisoners *must*, be given a Stage 2 nursing assessment within 48 hours of admission. It is undisputed that Mr Morrison did not receive a Stage 2 assessment. No booking was made.

6.90. I agree with counsel for the Morrison family and Counsel Assisting that it is a significant oversight. Unlike the brief Stage 1 assessment, the Stage 2 assessment is a pre-booked appointment during which the information the prisoner has provided in the brief initial assessment is reviewed.

6.91. I accept the evidence of RN Penafloresta that apart from a notation on the SAPHS case file and an entry in the calendar, no mechanism is in place that would act as an alert to such an administrative oversight.<sup>90</sup>

6.92. It is noteworthy that RN Penafloresta also attested to the fact that a calendar booking would not necessarily provide a guarantee that a prisoner would receive a Stage 2 assessment within 48 hours. He said it would depend on whether there were ‘more pressing’ issues with other prisoners.<sup>91</sup> Given that the primary aim of the admissions process is to identify vulnerable prisoners who may be at risk of self-harm or suicide, this is clearly unacceptable.

6.93. Mr Edwardson KC suggested that no real prejudice arose because prisoners can access medical request forms if they seek medical assistance. This contention misses the point by shifting the onus onto the prisoner to raise concerns. The Stage 2 nursing assessment

---

<sup>88</sup> Exhibit C147, page 25

<sup>89</sup> Transcript, pages 246-247, 344, 594, 1834, 5104, 6483

<sup>90</sup> Transcript, pages 664-665

<sup>91</sup> Transcript, page 671

is conducted by medical professionals who have the skill to probe and review the initial information provided by the prisoner and to make a risk assessment.

- 6.94. While I agree with Ms O'Connor SC that the booking process was flawed, I do not accept the submission that if the Stage 2 assessment had been undertaken, 'it would have identified the health issues he [Mr Morrison] had been complaining about in his first days in custody', and his distressed behaviour 'would have been apparent'. It is possible but the submission is speculative. No mental health concerns were noted by RN Penafloreda on mental state examination. Similarly, the submission that 'it was likely that Mr Morrison would have been placed' on the HRAT list is based on speculation.
- 6.95. Ms O'Connor SC further submitted that the combination of the failure to raise a NOC (by DCS and SAPHS) and the omitted Stage 2 assessment were 'fatal errors' which caused or contributed to Mr Morrison's death.<sup>92</sup> It is overstating the matter to describe these errors as 'fatal errors'. It is fair to say however that if the mandatory Notice of Concern had been raised by CO Golding, and a Stage 2 nursing assessment undertaken, Mr Morrison may have been classified as a high risk prisoner and subjected to closer monitoring, and his death may have been prevented.
- 6.96. RN Penafloreda was a credible and forthright witness. I accept his evidence in its entirety. I am satisfied that the Stage 1 assessment was competently conducted and that he gave proper consideration to the question of whether or not to raise a NOC. On the information provided by Mr Morrison during the assessment, as stated, there is no basis to criticise his decision not to do so.

## **7. Mr Morrison's first three days in custody at Yatala (19-22 September 2016)**

- 7.1. After being given the 1gm of paracetamol (at 9:15pm) Mr Morrison was moved to Unit 3 of E Division. At 9:23pm he was placed in Cell 6 with two other prisoners where he remained until Thursday 22 September 2016.<sup>93</sup> On that afternoon, at around 1:17pm, Mr Morrison was transferred from Yatala to the Holden Hill police cells where he was

<sup>92</sup> Written submissions on behalf of the Morrison family, pages 12, 52 and 53

<sup>93</sup> Exhibit C65aa is a list of the prisoners housed in E Division at this time - Mr Morrison remained in Cell 6 of Unit 3; Exhibit C65ab is a list of the prisoners who shared Cell 6 with Mr Morrison during this time

placed in a single cell overnight (contrary to the SAPHS recommendation that he be placed in a ‘double-up’ cell).

- 7.2. Was the seven-day observation period commenced and documented?
- 7.3. Following admission or transfer into a DCS facility prisoners are placed under mandatory observation for seven days. Daily observations *must* be documented on a proforma document by correctional officers.<sup>94</sup>
- 7.4. The questions on the seven-day observation form are designed to monitor how each prisoner is adapting to prison life and to identify behaviours of concern.<sup>95</sup> If any concerns are identified a NOC can be raised.<sup>96</sup>
- 7.5. The observation forms for all prisoners are kept in a generic file until the seven-day observation period is complete. On completion, the form is signed off, a case note is completed, and a hard copy must be placed on the prisoner’s case file. There was conflicting evidence about what happens if a prisoner is transferred elsewhere during the seven-day observation period (e.g. to Holden Hill). Some witnesses said the form could travel with the prisoner. Others said that a new observation form could be created at Holden Hill.
- 7.6. As it transpired, Mr Morrison’s seven-day observation form (blank or completed) could not be located or produced at the inquest. *Accordingly, the Court received no documentary evidence of first-hand observations of Mr Morrison, if they were made, during his first three days at Yatala. I am unable to determine* whether this essential risk management process was undertaken and, if so, whether any behaviours of concern were noted. It is evidence that should have been available to the Court.
- 7.7. The Department has provided no explanation for its inability to locate and produce Mr Morrison’s seven-day observation form.<sup>97</sup>
- 7.8. To say this is unacceptable is an understatement. A seven-day observation form is required for all new admittees to Yatala.<sup>98</sup> *It is required for good reason, that is, for*

---

<sup>94</sup> Exhibit C155d: Seven-Day Observation Form (F001/007); Exhibit C65as, page 16; Transcript, pages 230, 239

<sup>95</sup> Transcript, page 362

<sup>96</sup> Transcript, pages 264-265

<sup>97</sup> See for example Transcript, pages 348-349, 361-362, 403, 970-971, 1183, 1187, 1783, 2198-2199

<sup>98</sup> Refer Standard Operating Procedure 001A-Custodial Admission-Case Management

*the purpose of conducting a daily welfare check to ensure that vulnerable prisoners are identified.*

- 7.9. Counsel for the Morrison family highlighted in submissions that several correctional officers gave evidence that they had never seen a seven-day observation form discarded after the seven days. Counsel noted that other witnesses gave evidence that any seven-day observation form would have accompanied Mr Morrison to Holden Hill, or a new form could have been created at Holden Hill. It was submitted that the only logical conclusion is that the form was not completed in Mr Morrison's case.<sup>99</sup> That is one possibility. There are other possibilities. For example, it is possible, as stated by Mr Henschcliffe KC that the completed form may have been lost or thrown away.<sup>100</sup>
- 7.10. The only finding that is open to make is that Mr Morrison's form (blank or partially completed) could not be located after his death and I so find.
- 7.11. The Court received some evidence from prisoners which, if accepted, suggests that Mr Morrison struggled to adapt when he was first placed in custody.
- 7.12. On the evening of Monday 19 September 2016 Mr Morrison shared a cell with prisoners Leslie McKenzie ('Prisoner McKenzie') and Siddhartha Rao.<sup>101</sup> On Tuesday 20 September he shared the cell with Prisoner McKenzie only,<sup>102</sup> and on Wednesday 21 September the cell was shared by Aaron Greenham ('Prisoner Greenham') and Prisoner McKenzie.<sup>103</sup>
- 7.13. Prisoner McKenzie and Mr Morrison were cousins who had known each other since they were children. In his statement to police, Prisoner McKenzie described Mr Morrison as 'a bit agitated' when he first arrived in the cell. He said Mr Morrison was pale, complaining about a sore back and about being locked up. He was depressed, worried about his wife and child, and 'stressing about his family...a lot'.<sup>104</sup> He could not sleep at night because of thoughts of his family and being in jail. Prisoner

---

<sup>99</sup> Written submissions of counsel on behalf of the Morrison family at [191]

<sup>100</sup> Supplementary written closing submissions for members of the Correctional Officers Legal Fund at [27]

<sup>101</sup> Exhibit C65, page 38 Transcript, pages 477-506

<sup>102</sup> Exhibit C168; Transcript, pages 477-506

<sup>103</sup> Exhibit C172; Transcript, pages 555-575

<sup>104</sup> Exhibit C168

McKenzie said he gave Mr Morrison some cigarettes and he tried to calm him down by talking about their families.<sup>105</sup>

- 7.14. I accept Prisoner McKenzie's evidence on this topic noting that it is consistent with information Mr Morrison provided to CO Golding during the Stress Screen interview and it is supported in part by the audio/CCTV recording at the Holden Hill charge counter which shows Mr Morrison complaining of a sore back at Holden Hill and asking for painkillers.
- 7.15. Prisoner Thurstain said he got to know Mr Morrison during association, that is, out of cell time when prisoners are free to mix together in E Division. He said Mr Morrison told him it was his first time in jail and he told police that he thought Mr Morrison was 'doing it fucking hard'.<sup>106</sup>
- 7.16. Prisoner Greenham described Mr Morrison as 'a bit weird...talking to himself a little bit, mumbling under his breath, just weird shit...most of the time'.<sup>107</sup> During his oral evidence he said Mr Morrison was 'talking to himself a lot...just saying some weird stuff like someone that had been in the ice for a long time and stuff like that, like just not right in the head sort of thing'.<sup>108</sup>
- 7.17. I am satisfied that Mr Morrison exhibited signs of distress and that Prisoner McKenzie did his best to support him.
- 7.18. The medical request forms
- 7.19. There are various ways prisoners can seek medical assistance at Yatala. Firstly, they may request a correctional officer to escort them to the infirmary; secondly, if it is after the 3pm daily lockdown, prisoners can use the intercom in their cell to 'buzz up' to an officer and request medical attention or to be placed on the medication round list for the following day and; thirdly, they may fill out a written medical request form.<sup>109</sup> At the time of Mr Morrison's death, the practice was for completed medical request forms

---

<sup>105</sup> Ibid

<sup>106</sup> Exhibit C167, page 2; Transcript, page 563

<sup>107</sup> Exhibit C172, page 2

<sup>108</sup> Transcript, pages 480, 563

<sup>109</sup> Transcript, page 626 (Registered Nurse Penafloida)

to be placed on a trolley next to the officers' station for collection by medical staff or given directly to a correctional officer.<sup>110</sup>

- 7.20. Prisoner McKenzie gave evidence that Mr Morrison completed five medical request forms.<sup>111</sup> In his statement to police, he alleged that it was common for correctional officers to rip up these forms and put them in the bin, albeit he did not name any individual officer who engaged in this practice or accuse any officer of ripping up any of Mr Morrison's completed forms. However, when Prisoner McKenzie gave oral evidence in court (some two years after providing his police statement) he attested to seeing CO Susan Radford and an officer with the surname 'Ho' destroy two of Mr Morrison's completed forms (on different days).<sup>112</sup> He was adamant about their identity. Prisoner McKenzie added that a third officer, a male officer, also ripped up forms, but this officer was not identified by name.<sup>113</sup>
- 7.21. I do not accept this evidence as credible or reliable evidence noting that the Court received other evidence which confirmed that CO Susan Radford was on recreation leave from Monday 19 September to Thursday 22 September 2016 and could not have destroyed the form, a fact that was acknowledged by counsel for the Morrison family.<sup>114</sup>
- 7.22. Counsel for the Morrison family maintained that Prisoner McKenzie was not shaken in his evidence about the forms and that 'the Coroner can only conclude that he is in error with the *name* of the particular officer to whom he attributed the conduct'.<sup>115</sup> I disagree. Apart from the inherent improbability of correctional officers routinely destroying prisoners' medical request forms, there are other inconsistencies in Prisoner McKenzie's evidence which diminish the credibility of his evidence. For example, under cross-examination by Mr Edwardson KC, he said he did not read Mr Morrison's medical request forms and did not know what Mr Morrison was requesting in them.<sup>116</sup> This evidence was in direct conflict with Prisoner McKenzie's earlier statement to the

---

<sup>110</sup> N.B. This practice has changed since Mr Morrison's death and there is a padlocked box for the forms which is only accessible by nursing staff; Transcript, page 1783

<sup>111</sup> Ibid, page 3

<sup>112</sup> Transcript, pages 481, 499

<sup>113</sup> Transcript, pages 480-482, 506

<sup>114</sup> Written submissions on behalf of the Morrison family at [155]; N.B. No statement of CO Ho was received at the inquest and no counsel requested her to be called to give oral evidence

<sup>115</sup> Ibid; It is noted that no reference was made to the application of the *Briginshaw* principles and their importance in the context of allegations that may result in grave consequences for a person

<sup>116</sup> Transcript, page 501

police, namely, that Mr Morrison's forms contained a request to see a doctor to get put on 'sleepers'.<sup>117</sup>

- 7.23. It is unnecessary to consider the evidence of other prisoners in relation to medical request forms. I reject it as implausible, inherently unreliable and unsupported by independent evidence.
- 7.24. Did Mr Morrison complain to correctional officers and/or nursing staff about chest pain?
- 7.25. As to the alleged reports of chest pain, Prisoner McKenzie told the police that Mr Morrison used a cell phone to report chest pain. During one call, he said Mr Morrison reported that he could not breathe but he was just told to 'buzz up' in the morning and ask for Panadol.<sup>118</sup> No further detail of the content of the conversation was provided. Yet some two years later when giving oral evidence in court from memory, Prisoner McKenzie recited the content of each call in sequence.<sup>119</sup> There is no need to repeat the evidence. The evidence was unconvincing. I do not accept the evidence as credible or reliable evidence.
- 7.26. Prisoner Thurstain told the police that he thought Mr Morrison went to the infirmary and he recounted him verbally abusing an officer on his return.<sup>120</sup> He suggested that Mr Morrison was given the drug seroquel (brand name Lyrica) by another prisoner. I reject this evidence. First, the SAPHS file has no record of any infirmary attendance. It is implausible that the attendance would not be documented. Secondly, the evidence shows that an officer who was allegedly abused by Mr Morrison was not even rostered in the E Division cells on the relevant dates.<sup>121</sup> Thirdly, the toxicology analysis of Mr Morrison's ante-mortem blood samples did not detect seroquel in Mr Morrison's system. I reject Prisoner Thurstain's evidence. It is not credible or reliable evidence.
- 7.27. Prisoner Greenham also provided statements to the police.<sup>122</sup> He said Mr Morrison complained of chest pain to other prisoners and 'to nurses' during medication rounds.<sup>123</sup>

---

<sup>117</sup> Exhibit C168

<sup>118</sup> Exhibit C168

<sup>119</sup> Refer Transcript, page 491

<sup>120</sup> Exhibit C167, page 3

<sup>121</sup> Exhibit C181, page 2

<sup>122</sup> Exhibit C172

<sup>123</sup> Exhibit C172, page 2, Transcript, pages 560, 568, 571; In September 2016 medication rounds in E Division occurred between 6pm and 7:30pm

While I cannot speculate about what Mr Morrison may have said to other prisoners, I find there is no record of any report of chest pain in Mr Morrison's SAPHS file. I consider it implausible that a professionally trained nurse in the employ of SAPHS would ignore such a serious complaint. It does not make sense. The evidence, which is unsupported by any independent evidence, must be treated with caution.

- 7.28. Similarly, Prisoner Thurstain's evidence that Mr Morrison complained of chest pain must be treated with caution.<sup>124</sup>
- 7.29. Counsel for the Morrison family described the evidence of the prisoner as 'compelling' and 'consistent'. It was suggested that the fact it was given while the prisoners were still in custody adds to its credibility.<sup>125</sup> I disagree. I did not find the evidence either compelling or consistent. On the contrary, I have serious doubts about the reliability and veracity of the evidence.<sup>126</sup>
- 7.30. The evidence does not support a finding that Mr Morrison's medical request forms were destroyed by correctional officers or that he complained of chest pain to correctional officers or nursing staff.

## **8. Mr Morrison's transfer to Holden Hill Police Station Cells - 22 September 2016**

- 8.1. The *Correctional Services Act, 1982* (SA) provides for the establishment and management of prisons and other correctional institutions in South Australia. Pursuant to Section 18 of the Act the Governor may proclaim premises to be 'a prison' or 'a police prison'.
- 8.2. At the relevant time several police stations, including the Holden Hill police cells, had been proclaimed for use as 'a prison' and could therefore be used to house prisoners. Nineteen solo cells are available at Holden Hill.<sup>127</sup>
- 8.3. CCTV cameras (with audio) are installed at the admissions/charge counter and in each of the cells, albeit the single cells do not have audio recording capacity.

---

<sup>124</sup> Ibid, page 3

<sup>125</sup> Written submissions of counsel on behalf of the Morrison family at [137], [140], [156], [160]

<sup>126</sup> See for example Prisoner McKenzie's incorrect claim that CO A Radford was present in E Division (Exhibit C167, page 3; Exhibit C181, page 2); his claim that Mr Morrison was given the drug Lyrica (at Transcript, page 469) by another prisoner, a claim that is disproved by the toxicological results

<sup>127</sup> Exhibit C268 at [33]

- 8.4. Mr Morrison was transferred to Holden Hill on the afternoon of Thursday 22 September 2016 (his fourth day in custody). A question arises as to why a first time Aboriginal Prisoner would be sent to Holden Hill.
- 8.5. The Court heard evidence that soon after admission all Yatala prisoners are assessed to determine whether they are suitable for transfer to the Holden Hill police cells if the need arises. The eligibility criteria for transfer to Holden Hill were that:
- the prisoner was either a remand prisoner or a full sentence prisoner of less than 15 days;
  - that the prisoner had been medically cleared for transfer;
  - that he was not employed at the prison (so as to minimise disruption to prison industries and kitchen duties);
  - and that HRAT prisoners could only be transferred if they were on a normal regime.<sup>128</sup>
- 8.6. It is undisputed that the process that applied for transfer of a prisoner to the Holden Hill police cells at the time of Mr Morrison's death involved the following steps; a Case Management Coordinator reviewed the overnight paperwork to identify which prisoners were potentially suitable for transfer to Holden Hill; their names were placed on a spreadsheet which was sent by e-mail to the SAPHS Nurse Unit Manager; nursing staff reviewed the suggested names 'on the papers' and by reference to SAPHS records; on completion, the prisoner's name was marked as 'Eligible' or 'Not Eligible'; and the Case Management Coordinator was then advised of the final determination.<sup>129</sup>
- 8.7. It is also undisputed that the Department did not require this process to be formally documented.
- 8.8. The requirement for a 'medical clearance' gives the impression that a face-to-face medical assessment was undertaken to determine whether the prisoner is fit for transfer. In fact, I find that the medical clearance was done 'on the papers' and without any direct

---

<sup>128</sup> Exhibit C261- 'Criteria for Holden Hill Candidates' for full list of criteria; see also Exhibit C143 at [8]; Transcript, pages 345, 6399-6400, 6473-6483, 7077-7078, 7148-7149

<sup>129</sup> Exhibit C143 at [9]; C261 and C261; See also Transcript, pages 352-353; Transcript, pages 6399 (Staples); 7078-7080 (Bales)

assessment of the prisoner.<sup>130</sup> This evidence was not challenged by counsel for the Department.

- 8.9. It was submitted by counsel for the Morrison family that if a NOC had been raised it would have precluded Mr Morrison from being transferred to Holden Hill. This is incorrect. HRAT prisoners could be transferred to Holden Hill in accordance with the DCS eligibility criteria and the policies then in place.<sup>131</sup>
- 8.10. It was further submitted that Mr Morrison should not have been a candidate for transfer because he had been recommended on admission for placement in a shared cell (a double-up). I agree that such prisoners should not have been eligible for transfer to Holden Hill. However, I find that the criteria then in place at Yatala did not preclude such prisoners from transfer to Holden Hill.
- 8.11. Presumably, there exists somewhere in the DCS computer system an e-mail from the SAPHS staff member/nurse who applied the criteria and who confirmed that Mr Morrison was eligible for transfer to Holden Hill. However, no such material was forthcoming. On the available evidence, the Court cannot determine who conducted Mr Morrison's eligibility assessment, what information was considered, or indeed whether they were aware that cells at Holden Hill could not accommodate prisoners in shared cells. It is also unclear whether the assessor realised that Mr Morrison was scheduled to return to Yatala the very next morning for his ongoing bail hearing.
- 8.12. The lack of documentation is unsatisfactory. I agree with counsel for the Morrison family and Counsel Assisting that the process for determining which prisoners were eligible for transfer to Holden Hill was seriously flawed and I so find.
- 8.13. To my mind, no first time prisoner, particularly an Aboriginal prisoner, should have been eligible for transfer to Holden Hill until the seven-day observation period was complete. Nor should any prisoner who had been recommended to share a cell have been sent to Holden Hill. The double-up recommendation is part of risk management. Holden Hill was unable to accommodate such prisoners and that should have been the end of it.

---

<sup>130</sup> Exhibit C143 at [9]; Transcript, pages 352-353, 7067-7103; see also 7080 (Staples)

<sup>131</sup> Exhibit C261; Transcript, pages 7080; See also supplementary written submission of counsel for members of the Correctional Officers Legal Fund at [29]

8.14. I find that the eligibility for transfer to Holden Hill should have precluded any prisoner who was still under the seven-day observation period, and/or who had been recommended for placement in a shared cell, from transfer to Holden Hill.

8.15. Cell conditions at Holden Hill

8.16. The Court heard evidence from several witnesses, including Yatala Manager Mr Matthew Staples, about the conditions under which prisoners are held at Holden Hill.<sup>132</sup> Mr Staples opined that the conditions are ‘not appropriate at all’ for long-term placement, and attested to prisoners self-harming in order to be removed from Holden Hill.<sup>133</sup> The conditions are undoubtedly severe. I find that:

- Prisoners are locked in their cells for up to 24 hours per day;<sup>134</sup>
- There is no natural light;
- Family visits are not permitted;
- There is no television, no books and limited opportunity for exercise or to associate with other prisoners.

8.17. Furthermore, the evidence that some prisoners have engaged in self-harm to secure a transfer out of Holden Hill was not challenged. Nor was it disputed that it was commonplace for prisoners to put their mattresses on the floor to communicate with each other under gaps in the cell doors. Clearly, it was a grim environment.<sup>135</sup>

8.18. I agree with the submission of counsel for the Morrison family that it is an ‘utterly inappropriate environment for a first time Aboriginal prisoner’.<sup>136</sup> I also agree that the Department’s own policies should have protected a first time Aboriginal prisoner who had been recommended for a double-up, to be placed alone in a cell in such appalling conditions.<sup>137</sup>

---

<sup>132</sup> See for example Transcript, pages 353-358, 427, 1465, 6401-6403, 6470-6473, 6479, 7077

<sup>133</sup> Transcript, page 6401

<sup>134</sup> Transcript, page 6472

<sup>135</sup> See for example Transcript, page 6401

<sup>136</sup> Written submissions of counsel on behalf of the Morrison family at [207]

<sup>137</sup> See *ibid* at [236]-[237]

8.19. Mr Morrison's admission at Holden Hill

8.20. On arrival, Mr Morrison was admitted at the Holden Hill charge counter and allocated to Cell 2.<sup>138</sup> A copy of CCTV vision of the admission process and a transcript of the conversation that took place between Mr Morrison and corrections officers at the charge counter was tendered to the Court.<sup>139</sup>

8.21. The vision was played in court. At around 14:19:10, Mr Morrison was escorted into the charging area by three correctional officers. One of the officers was Supervisor Eric Somerfield, an officer of some 17½ years' experience. Supervisor Somerfield recorded Mr Morrison's name on a spreadsheet and allocated him to a cell (Cell 2).<sup>140</sup>

8.22. A verbal exchange between Mr Morrison, Supervisor Somerfield and other officers followed. Mr Morrison requested painkillers for a sore back. The request was ignored. Mocking statements were made by Supervisor Somerfield and other officers which included references to Mr Morrison getting 'a massage', and 'the guys' helping him to get a 'workover' in the shower, or words to that effect. There is laughter and sniggering amongst the officers. The statements clearly carry sexual innuendo. Mr Morrison remained silent and poker faced. He took no part in the exchange.

8.23. When pressed by Counsel Assisting in cross-examination, Supervisor Somerfield said he thought the conversation was jovial. He described it as 'a very light-hearted joke'.<sup>141</sup> It was only when the questioning focused on how Mr Morrison may have perceived the exchange that Supervisor Somerfield acknowledged that the comments were unacceptable.<sup>142</sup> He expressed embarrassment and regret for his conduct and surmised that years of working in a prison environment may have 'desensitised' him, a comment which reflected some capacity for insight.<sup>143</sup> Unsurprisingly, some members of the Morrison family appeared to be deeply offended by the cruelty they witnessed on the

---

<sup>138</sup> Exhibit C158 (File 1) - CD compilation of vision and audio recording of Mr Morrison at the charge counter; Exhibit C163 Annexure A is the transcript of the audio which can be heard upon Mr Morrison's admission

<sup>139</sup> Exhibit C163 (File 1); C158 (File 1-CD/Vision and Audio); C163 Annexure A (Transcript). For details of the CCTV system in place at Yatala, and the technical process by which the provenance of this and other vision tendered during the inquest was established, see Exhibit C65a (the Georg Report), pages 75-80

<sup>140</sup> Exhibit C163, page 2; Transcript, page 354

<sup>141</sup> Transcript, pages 378, 380

<sup>142</sup> Transcript, pages 380-399

<sup>143</sup> Transcript, page 401

recording at the charge counter. Supervisor Somerfield apologised in open court to the Morrison family.

8.24. Suffice it to say that the conduct does not reflect the standards the community would expect of a professionally trained correctional officer. As a supervisor, CO Somerfield had a responsibility to set a positive example to junior officers rather than normalising cruel and insensitive conduct. For a first time Aboriginal prisoner such treatment would undoubtedly have caused considerable emotional and psychological stress. Furthermore, his physical pain was left untreated. On the topic of medication, it is noted that by the time Mr Morrison was admitted to Holden Hill it was early afternoon. The daily nursing rounds had already taken place (between 11:50am and 12:06pm).<sup>144</sup> It is undisputed that correctional officers do not have access or authority to issue medication and that Mr Morrison received no painkillers. Despite this fact I find that no explanation was given to Mr Morrison about when the next medication rounds would take place or what to do if his pain worsened. It would be a frightening situation for anyone.

8.25. Prisoner observations of Mr Morrison

8.26. Prisoner Woods was also at Holden Hill when Mr Morrison arrived. He noticed a difference in him and said, 'He used to be normal. I didn't recognise him at first as he was talking to himself'. He also said Mr Morrison complained to the guards, albeit it was not entirely clear what he complained about. Prisoner Woods basically said that prisoners were treated like dogs at Holden Hill 'so you got nothing'. He said 'you got told to get in your cell and shut the fuck up...'.<sup>145</sup>

8.27. Prisoner Woods subsequently told police that Mr Morrison 'was always crying and talking to himself in the cell'.<sup>146</sup>

8.28. Of all the prisoners who gave evidence at the inquest Prisoner Woods was the only credible one. His evidence was direct, candid, and given without apparent embellishment. Importantly, unlike the evidence of other prisoners, parts of his evidence were supported by independent evidence. I will come back to his evidence in the context of the restraint.

---

<sup>144</sup> Transcript, pages 350-352, 370, 377-378, 393-398

<sup>145</sup> Transcript, page 432

<sup>146</sup> Exhibit C166a at [2]

- 8.29. The half hourly visual checks - were any concerns about Mr Morrison recorded in the Holden Hill logbook?
- 8.30. Supervisor Gavin Gibson was on evening shift at Holden Hill on 22 September 2016.<sup>147</sup> He said that at Holden Hill, two officers are required to conduct mandatory half hourly visual checks on prisoners after lock-up. Any unusual or significant behaviour is recorded in a logbook and must be reported to the supervisor. It is undisputed that the half-hourly checks were conducted and that the entries in the logbook relating to Mr Morrison record 'Nil Concerns'.<sup>148</sup>
- 8.31. Supervisor Gibson gave evidence that another officer reported that 'a new prisoner' appeared to be the subject of ridicule and derision by other prisoners. The prisoner was Mr Morrison. Supervisor Gibson was sufficiently concerned about the report to direct that Mr Morrison be relocated from Cell 2 to Cell 12 at the next half hourly check.<sup>149</sup> The direction was implemented shortly before 18:02 albeit the logbook contains no record of the direction or the reasons for it.<sup>150</sup>
- 8.32. Camera observations of Mr Morrison in Cells 2 and 12
- 8.33. The Holden Hill police cells are each monitored by a camera (no audio). Vision of Mr Morrison at various intervals of time in Cells 2 and 12 was tendered to the Court.<sup>151</sup> The vision was played in court.
- 8.34. Whilst in Cell 2, Mr Morrison can be seen at times sitting and lying on the cell floor (14:28:53-14:29:50); attempting to hang a towel against the door (15:17:36-15:18:39); getting up on the metal sink (15:36:20-15:38:55); removing the mattress from its position and appearing to exercise with a blanket on his head (16:12:49-16:16:11). The blanket is still over his head between 17:55:08-17:55:53.
- 8.35. Whilst in Cell 12, Mr Morrison can be seen with a blanket over his head and moving the mattress onto the ground (18:55:00-18:56:42); moving around after the lights were out (20:02:59-20:03:48); pacing around after lights out with a sheet over his head

---

<sup>147</sup> Exhibit C186 Transcript of Interview of Gavin Gibson; Transcript, pages 1174-1255

<sup>148</sup> Exhibit C65aam, Transcript, pages 350-352, 370, 377-378

<sup>149</sup> Transcript, page 1181

<sup>150</sup> Exhibit C65aam

<sup>151</sup> Exhibit C158 (Files 2-6)

(23:12:14-23:14:22); and on the floor after the light had been turned on in the morning (07:24:50-07:32:19).

- 8.36. It was submitted by Counsel Assisting that the ‘unusual behaviour’ is there to be seen on the vision [and] ought to have been noticed by correctional officers during the half hourly checks. It was submitted that these behaviours should have been recorded in the logbook. Counsel for the Morrison family submitted that it is ‘astounding that a CSO could be watching that vision and not conduct appropriate welfare checks’, and that Mr Morrison’s behaviour on the CCTV vision ‘...is self-explanatory’.<sup>152</sup>
- 8.37. I disagree with these submissions.
- 8.38. First, there is no evidence that the correctional officers directly witnessed the behaviours that are evident on the vision. Secondly, even if there was such evidence, the submissions have insufficient regard to the setting in which the behaviours occurred, that is, a prison. While such behaviours might be considered unusual or bizarre to a lay person, they may quite reasonably, if they were indeed seen at all, be interpreted as unremarkable to persons who work on a daily basis with prisoners.
- 8.39. In short, the submissions to the effect that Mr Morrison’s behaviour was so bizarre and unusual as to warrant a welfare check smack of hindsight bias whereby the behaviours have assumed greater significance because of the known adverse outcome.
- 8.40. Mr Morrison’s demeanour on the morning of 23 September 2016
- 8.41. On the morning of Friday 23 September 2016, correctional officer Daniel James was on day shift at Holden Hill. Day shifts generally commence at around 7am.
- 8.42. Supervisor Somerfield instructed CO James and another officer to bring Mr Morrison to the sally port for transportation back to Yatala.<sup>153</sup> Mr Morrison was removed from Cell 12 at around 8:30am.<sup>154</sup>

---

<sup>152</sup> Written submissions of counsel for the Morrison family at [225]-[230] and page 62 (6<sup>th</sup> dot point)

<sup>153</sup> Exhibit C176; Transcript, pages 680-704

<sup>154</sup> Exhibit C150, page 19 (employee incident report of CO James); Exhibit C20

- 8.43. CO James gave evidence that Mr Morrison came out of the cell ‘with his head down’ and he ‘shuffled’ along. He recalled that Mr Morrison said, ‘I’m not going to hurt anyone’. He also said, ‘Why do you want my family to rape me?’<sup>155</sup>
- 8.44. CO James said Supervisor Somerfield was present when Mr Morrison made the rape comment. When CO James asked Mr Morrison what he meant by the comment he said that Mr Morrison immediately dropped his head and told him not to worry about it.<sup>156</sup>
- 8.45. Significantly, CO James told the Court that Prisoner Woods reported to him that Mr Morrison was ‘hearing voices boss, in his head’. He passed on this information to Supervisor Somerfield because he thought it was significant.<sup>157</sup> He did not mention the rape comment because Supervisor Somerfield had been present when that comment was made.<sup>158</sup> CO James did not recall any reaction from his supervisor but he thought he had taken the report on board. CO James assumed that Supervisor Somerfield would pass on the information to Yatala staff.<sup>159</sup> He did not do so, a matter that is undisputed.
- 8.46. I agree with counsel for the Morrison family and Counsel Assisting that Supervisor Somerfield should, at the very least, have notified the receiving Yatala staff of the rape comment and of the report that Mr Morrison was hearing voices.<sup>160</sup> Best practice would have been to recommend that Mr Morrison be referred for a medical assessment. However, this is a conclusion that is made with the benefit of hindsight and with the knowledge of Mr Morrison’s subsequent deterioration.
- 8.47. In cross-examination by Ms Sibree, CO James said he thought Mr Morrison may have been suffering from ‘mental health issues’, adding that he was not qualified to make such an assessment.<sup>161</sup> He agreed that Prisoner Woods had told him that Mr Morrison was ‘hearing voices boss’, stating that it reaffirmed his suspicion that perhaps Mr Morrison was suffering from a mental illness.<sup>162</sup> When counsel suggested that some

---

<sup>155</sup> Exhibit C176, page 2

<sup>156</sup> Exhibit C176, page 2; Transcript, page 6911

<sup>157</sup> Transcript, page 690

<sup>158</sup> Transcript, page 6911; See also Exhibit C150, page 19

<sup>159</sup> Transcript, page 1383; Exhibit C150, page 19

<sup>160</sup> Written submissions of counsel for the Morrison family at [235] and page 62 (11<sup>th</sup> dot point)

<sup>161</sup> Transcript, page 7690

<sup>162</sup> Exhibit C150, page 19; Transcript, page 698

form of paranoia or schizophrenia was evident, CO James repeated that he was not qualified to make that judgment.<sup>163</sup>

8.48. Ms O'Connor SC suggested that CO James could or should have recorded the information directly onto the JIS or raised a NOC himself. CO James said he believed he had discharged his responsibility by reporting the conversation to his supervisor.<sup>164</sup> I agree. No further action was required by CO James.

8.49. Supervisor Somerfield categorically denied receiving any report from CO James about Mr Morrison hearing voices.<sup>165</sup> Although he had never been asked to recall the conversation since the date of the incident, when giving evidence in court (some two years later), Supervisor Somerfield claimed to have a detailed recollection of the conversation. He said it unfolded like this:

'My recollection of the events are I can't remember exactly what time it was but at the completion of unlock and the court movements, I asked the - well Mr James was there, "Have you got anything to report back regarding the unlock?" and he reported to me that Prisoner Morrison was odd. And I said to him "What do you -", and I probed him on 'odd' and I went down the track of asking "Do you need to raise a NOC?" and he said "No, no, he's just odd" and I said "What do you mean odd", he just said "He's odd". And I said "Are you sure you don't want to raise a NOC? You've got no concerns?". He said "No, I've got no concerns."<sup>166</sup>

When cross-examined about his ability to recall the detail and sequence of the exchange two years later from memory, Supervisor Somerfield said it had burned into his memory.<sup>167</sup>

8.50. The evidence was unconvincing. I formed the view that it was a feeble attempt by the witness to distance himself from the events and to shift responsibility for any oversight onto a junior officer. I find that the conversation did not take place.

8.51. In summary, I agree with the submission made by Counsel Assisting and counsel for the Morrison family regarding Supervisor Somerfield's failure to pass on this information.<sup>168</sup>

---

<sup>163</sup> Transcript, pages 682, 690, 698

<sup>164</sup> Transcript, pages 690-691

<sup>165</sup> Transcript, pages 1386-1387

<sup>166</sup> Transcript, page 1385

<sup>167</sup> Transcript, pages 1386-1389, 1393

<sup>168</sup> Written closing submissions of Counsel Assisting at [50]-[53]

- 8.52. Mr Morrison was handcuffed, taken to the charge counter and pat searched. CO James said he seemed confused about the need for wrist restraints. He recalled hearing Mr Morrison say, 'I'm not going to hurt anyone'. Apart from that comment, he said Mr Morrison was 'calm and compliant' and he followed all instructions. Mr Morrison made no complaint about physical ailments including chest pain.<sup>169</sup> Then he was placed in the van.
- 8.53. Supervisor Murti who drove the escort van described the journey back to Yatala as uneventful.<sup>170</sup>
- 8.54. Counsel Assisting submitted that 'it is reasonable to infer that Mr Morrison's mental health had been adversely affected by his experiences at Holden Hill',<sup>171</sup> and 'If Mr Morrison had been treated with dignity and respect by staff at Holden Hill and his unusual behaviour observed and reported, he may never have behaved as he did in the holding cells'.<sup>172</sup> Counsel for the Morrison family made submissions to similar effect.<sup>173</sup>
- 8.55. I do not accept these submissions insofar as they are intended to suggest that a *causal* link has been established between Mr Morrison's experiences and treatment at Holden Hill and his subsequent conduct in the holding cells at Yatala.
- 8.56. Counsel for Mr Somerfield and members of the COLF accurately observed that no expert psychiatric and/or other expert evidence was placed before the Court to establish such a link, and the factors that led to Mr Morrison's violent outburst in the holding cells, and their relative importance in causing that behaviour, remain unknown.<sup>174</sup>
- 8.57. Dr Charlwood agreed in cross-examination that Mr Morrison's behaviour (as gleaned from the material she had been provided) suggests that he was experiencing 'mental health issues'. However, Dr Charlwood made it clear that she was not qualified to express an opinion on this issue.
- 8.58. On the available evidence, I am satisfied there was a decline in Mr Morrison's overall mental health whilst he was incarcerated at Holden Hill. I cannot be more definitive.

---

<sup>169</sup> Transcript, pages 691-693, 697-698

<sup>170</sup> Exhibit C189, Transcript, page 1572

<sup>171</sup> Written closing submissions of Counsel Assisting at [54]

<sup>172</sup> *Ibid* at [55]

<sup>173</sup> Written submissions on behalf of the Morrison family at [249] and [276]

<sup>174</sup> See for example, written closing submissions for Members of the COLF at [85]

- 8.59. The van journey from Holden Hill to Yatala
- 8.60. Prisoner Woods also had a scheduled AVL court hearing at Yatala on Friday 23 September 2016. He accompanied Mr Morrison in the van back to Yatala.<sup>175</sup>
- 8.61. Prisoner Woods observed that Mr Morrison ‘appeared red-eyed when he went into the van’. During the trip he said Mr Morrison told him he was getting bail and he got the impression that he thought he was going home. He said Mr Morrison behaved unusually in the van, such as talking to himself and talking to someone who was not there. He said Mr Morrison kept saying things like ‘get out of my head; I don’t want to hurt no one’. Prisoner Woods mentioned also that Mr Morrison asked if he [Prisoner Woods] was in for rape and that he appeared to be in distress.<sup>176</sup>
- 8.62. The level of detail provided by Prisoner Woods and the unusual nature of his recollections tends to support the inherent plausibility of his account. The mention of rape by Mr Morrison is also consistent with the question Mr Morrison had asked earlier (i.e. ‘Why do my family want to rape me?’). I accept Prisoner Woods’ account of his observations and his exchanges with Mr Morrison in the van en route to Yatala.
- 8.63. I do not accept the submission of counsel for the Morrison family that the van driver would necessarily have overheard and/or seen disturbing behaviour by Mr Morrison that should have alerted him to the need to take Mr Morrison to the infirmary or to get urgent medical assistance. I agree with Mr Henchcliffe KC that when the relevant evidence is properly considered it is scant and cannot support such an inference.<sup>177</sup>
- 8.64. Mr Morrison is readmitted to Yatala - Friday 23 September 2016
- 8.65. Mr Morrison and Prisoner Woods arrived at the Yatala Admissions Building from Holden Hill at 9:06am on Friday 23 September 2016.<sup>178</sup>

---

<sup>175</sup> Exhibit C166, Statement of Richard Woods dated 29 September 2016; C116a further statement dated 21 October 2016

<sup>176</sup> Exhibit C166; Transcript, page 430

<sup>177</sup> Supplementary closing written submissions for members of the COLF at [35] and [38]; see also written submissions of counsel on behalf of the Morrison family at [239]

<sup>178</sup> Exhibit C193, page 4

- 8.66. Supervisor Joseph was working in the holding cells. He observed that Mr Morrison ‘appeared timid, apprehensive and scared’ on arrival, albeit he did not consider this to be unusual for a prisoner on admission.<sup>179</sup>
- 8.67. Supervisor Joseph gave evidence that if he had been told about Mr Morrison’s behaviour at Holden Hill and the report about hearing voices, he would have contacted the health centre or the social worker to arrange for a medical assessment.<sup>180</sup> I accept this evidence. Supervisor Joseph was a direct and candid witness. He made concessions about his own shortcomings (particularly during the restraint evidence) and his evidence about his likely action if he had been told a prisoner may be hearing voices underscores the importance of communicating such information to those who were receiving Mr Morrison on the morning of 23 September 2016.
- 8.68. The failure of Supervisor Somerfield to report Mr Morrison’s behaviour and, in particular, that he was reportedly hearing voices must be considered in conjunction with Supervisor Joseph’s evidence. If one event in a chain of events is altered, the end result may well be different. If, for example, the Yatala officers had been made aware that Mr Morrison was hearing voices, he may have been referred for an urgent medical assessment and escorted to the infirmary. Such an intervention may have changed the trajectory of events.
- 8.69. I return to the narrative. Initially Prisoner Woods and Mr Morrison were placed in Cell 4. They were moved to Cell 5 a short time later.<sup>181</sup> Both prisoners were waiting for their scheduled AVL court hearings. It will be recalled that Mr Morrison’s court hearing was listed at 12 noon.
- 8.70. Supervisor Joseph and Supervisor Murti were rostered as the two holding cells supervisors on the day of the incident. Supervisor Murti described himself as an ‘assistant supervisor’. I prefer the evidence of Supervisor Joseph on this point, namely, that no hierarchy exists between supervisors and they are expected to work as a team, and I so find.
- 8.71. In terms of training for the supervisory role, Supervisor Joseph gave evidence that he shadowed another supervisor for three shifts. I have no reason to question this

---

<sup>179</sup> Transcript, pages 1348-1349

<sup>180</sup> Transcript, page 1349

<sup>181</sup> Exhibit C139 (Map 1) - Note: The holding cells corridor is marked ‘14’

evidence. It will be recalled that CO Golding shadowed another officer for 30 minutes to qualify as an Admissions Officer. This evidence was not challenged by counsel for the Department. The adequacy of training is an issue that will be further addressed in due course.

8.72. I turn now to the use of force and the relevant Departmental Standard Operating Procedures.

**9. Use of Force - Section 86 of the Correctional Services Act 1982 (SA) and Standard Operating Procedures (SOP-079 Use of Force)**

9.1. Section 86 of the *Correctional Services Act 1982* (SA) provides that correctional officers may ‘*use such force against any person as is reasonably necessary in the circumstance of the particular case*’.

9.2. Standard Operating Procedure SOP-079 (Use of Force) (‘SOP-079’) sets out the procedures to be followed by DCS employees when using force to resolve an incident.<sup>182</sup> Relevantly:

9.2.1. Employees must first gain authority from the General Manager prior to using weapons, chemical agents, *and restraint equipment other than handcuffs* to resolve an incident [3.1.1].

9.2.2. *The use of force must only occur, to prevent or stop any disturbance in which there exists a threat of death, bodily harm, escape or property damage* [3.1.2.a]; *once all reasonable methods of control have been exhausted* [3.1.2.b], or where other methods of control are not the safest and most reasonable intervention given the situational factors [3.1.2.c].

9.2.3. *Only the minimum required amount of force must be used to resolve an incident or restore institutional good order and security* [3.1.3].

9.2.4. Force must not be used to punish a prisoner [3.2.4].

---

<sup>182</sup> Exhibit C65an, SOP-079 Version 08/06/2010

## 10. The restraint

- 10.1. In this Finding, any reference to ‘the restraint’ means the initial restraint outside the holding cells and the ongoing restraint in the mess room corridor.
- 10.2. Once restrained, Mr Morrison was lifted and carried from the building to an awaiting prison van. His removal from the building does not strictly form part of the restraint because by that time Mr Morrison had been subdued by the application of handcuffs, leg restraints and a spit mask.
- 10.3. CCTV vision
- 10.4. The initial incident which led to the restraint of Mr Morrison occurred in the holding cells.<sup>183</sup> It is undisputed that when CO Allen Radford unlocked Cell 5 to relocate Mr Morrison to an adjacent cell, he charged at the unlocked doors, escaped from the cell and attacked several correctional officers.
- 10.5. Ordinarily, the area outside of the holding cells is monitored on CCTV by Camera 104. However, on 23 September 2016, the camera was malfunctioning and it had not returned to its usual home position.<sup>184</sup> Therefore, there is no CCTV vision of the initial incident which led to the restraint of Mr Morrison, or the initial attempts by correctional officers to restrain him outside of the holding cells. The Court relied on written statements tendered in court and oral evidence of witnesses to determine what occurred during the initial restraint.
- 10.6. It is undisputed that during the initial restraint, Mr Morrison was surrounded by correctional officers while he was still on his feet. At the direction of a supervisor he was moved to a corridor situated near the officers’ mess room where he was brought to the ground (‘the mess room corridor’). The restraint in the mess room corridor was captured on CCTV.<sup>185</sup>
- 10.7. In assessing the restraint in the mess room corridor, the Court and counsel were greatly assisted by specialist technical support and enhancement of the vision which was done by placing numbers over each of the persons who appear in the vision. Detective

---

<sup>183</sup> Exhibit C65ao

<sup>184</sup> Exhibit C65a, page 21; Exhibit C180: Statement of Charles Melloy, pages 2-3

<sup>185</sup> Exhibit C137; N.B. It is this part of the restraint that has been repeatedly played by various television and electronic media sources

Sergeant Cameron Georg prepared an appendix to his report (Appendix F) which lists the names and corresponding number of those who appear in the vision.<sup>186</sup>

10.8. By reference to the vision, and other evidence received during the inquest, I am satisfied that the persons who appear in the vision have been accurately identified in Appendix F.

10.9. The Privilege Against Self-Incrimination

10.10. Before I turn to the restraint evidence, it is necessary to mention the privilege against self-incrimination. At the relevant time, section 23(5) of the *Coroners Act 2003* (SA) provided:

‘A person is not required to answer a question, or to produce a record or document under the section if (a) the answer to the question, or the contents of the record or document, would tend to incriminate the person of an offence.’<sup>187</sup>

10.11. The eight officers (‘the van officers’) who accompanied Mr Morrison in the van to G Division relied on the self-incrimination privilege as a basis to decline to answer questions directed at the events leading to the restraint, the restraint itself, Mr Morrison’s carriage from the holding cells area and his placement in the van, the van journey, and events in the G Division sally port including the attempted resuscitation of Mr Morrison (‘the impugned topics’).<sup>188</sup> It was submitted by counsel for each of the van officers that the answer to such questions would tend to incriminate them of an offence (e.g. a criminal offence), or expose them to a risk of a civil penalty (e.g. disciplinary proceedings).

10.12. It was further submitted that the Court should not receive into evidence copies of the van officers’ Employee Incident Reports,<sup>189</sup> and transcripts of mandatory interviews conducted by Departmental investigator, Mr Don Muller,<sup>190</sup> and that the answers to any questions about the contents of these documents, so far as the questions related to the

<sup>186</sup> Exhibit C65a, Appendix F of the Georg Report

<sup>187</sup> Section 23 has since been amended by the addition of a new section 23A. This provision is not retrospective in operation: Refer *Coroners (Inquests and Privilege) Amendments Act 2021* (SA) sections 8 and 9 and Schedule 1, Part 2, s2

<sup>188</sup> The van officers were Supervisor Neale McLeod and COs Derek Kay, Neil Bradford, Martin Crowe, Trent Hall, Liam Mail, Darren Shillabeer, and Jean-Guy Townsend

<sup>189</sup> Supervisor McLeod did not submit an employee incident report as he was awaiting legal advice: Transcript, pages 5897-5901, nor was he subsequently directed to submit an incident report: Transcript, page 5870; Exhibit C182, pages 17, 130

<sup>190</sup> Mr Muller completed a comprehensive report: See Exhibit C65aay (‘the Muller Report’)

impugned topics, would tend to incriminate the van officers of an offence, or expose them to a civil penalty.<sup>191</sup>

10.13. The Court made the following rulings:

10.13.1. The van officers were not required to answer questions about any of the impugned topics.

10.13.2. The employee incident reports and the Muller interview transcripts were admissible but the van officers were not required to answer questions directed at the contents of any such record or document so far as the contents related to the impugned topics.

10.13.3. As to the CCTV vision, the van officers were not required to identify themselves on the vision (by number or otherwise), or to answer any questions about the events depicted in the vision.

10.14. The van officers also sought to rely on the privilege against self-incrimination as a ground to decline to answer questions about the post-incident events, that is, events that occurred after Mr Morrison had been taken by ambulance to the RAH.<sup>192</sup>

10.15. The Court ruled that the self-incrimination privilege had no application to the post-incident events. Thus, the van officers were required to answer questions about a range of post-incident matters, including events in the Yatala Gatehouse between around 1pm-6pm on the afternoon of the incident.

10.16. The amended self-incrimination provisions - Coroners (Inquest and Privilege) Amendment Act 2021 (SA) ('the amending Act')

10.17. I digress for a moment to discuss a significant amendment to the Coroners Act which resulted in the introduction of a new provision relating to the privilege against self-incrimination (i.e. s23A).<sup>193</sup>

---

<sup>191</sup> See for example Transcript, pages 5378, 5387, 5393, 5395, 5453

<sup>192</sup> Transcript, pages 5387, 5575-5576

<sup>193</sup> *Coroners (Inquests and Privilege) Amendment Act 2021 (SA)* ('the amending Act')

- 10.18. At the time this inquest commenced, South Australia was the only state or territory in Australia which did not have a procedure within its coronial jurisdiction which enabled the Court to require a person to answer a question or produce a record or document (if satisfied of certain preconditions) and to issue a certificate to the person which operates to protect the information, document or thing obtained as a direct or indirect consequence of the person having answered a question, or produced a record or document, from being used against them in other proceedings.<sup>194</sup>
- 10.19. Pursuant to the new section 23A(4), *a person may be required to answer a question or produce a record or document* (if the Court is satisfied of certain pre-conditions). If a person is directed by the Court to answer a question or produce a record or document pursuant to subsection (4), the Court *must*, pursuant to section 23A(5), cause the person to be given a certificate in respect of the answer, record or document.
- 10.20. Relevantly, section 23A(8)(a) and (b) protects ‘any answer, record or document produced’, and ‘any information, document or thing obtained as a direct or indirect consequence of the person having answered a question, or produced a record or document’, from being used against the person in any proceeding in a court or before any person or body authorised by a law of this State, or by consent of parties, to hear, receive and examine evidence.
- 10.21. Put simply, if section 23A had been in operation at the commencement of Mr Morrison’s inquest, if satisfied as to the pre-conditions, the Court could have directed the van officers to answer questions about the impugned topics, and certificates could have been issued to prevent the use of any information, documents or things obtained as a result from being used against the van officers in any other proceedings. However, section 23A was not made retrospective in operation and it therefore had no application to Mr Morrison’s inquest.
- 10.22. One can understand the dismay of the Morrison family when they learned of the anomaly that existed in South Australia in relation to the self-incrimination provisions. The family has waited for several years for this inquest to occur with the reasonable expectation that they would hear first-hand from the correctional officers who were

---

<sup>194</sup> Refer section 23A (4), *Coroners Act 2003*

involved in the restraint and, in particular, those who travelled with their loved one in the van to G Division in what turned out to be the last conscious minutes of his life.

10.23. Be that as it may, it cannot be overemphasised that in relying on the self-incrimination privilege, the van officers were exercising a legal right which was enshrined by section 23 of the Coroners Act 2003 (pre-amendment). They were entitled to exercise that right. No adverse inference may be drawn against a person for claiming the privilege.

10.24. The events which led to the restraint of Mr Morrison

10.25. Much of the evidence about the events which led to the restraint is undisputed.

10.26. On the morning of 23 September 2016, Mr Morrison and Prisoner Woods initially shared Cell 5. This cell had no toilet facilities inside the cell.<sup>195</sup> At around 11:20am, CO A Radford escorted Prisoner Woods to Cell 6 to use a toilet as that cell has toilet facilities. Mr Morrison remained alone in Cell 5.<sup>196</sup>

10.27. *Evidence of CO Allen Radford*

10.28. About ten minutes later, CO A Radford went to collect Prisoner Woods from Cell 6 with the intention of returning him to Cell 5 with Mr Morrison. However, when he arrived, Prisoner Woods asked for permission to remain in Cell 6. He said, 'He's fucken mad Mr Radford', a comment that was clearly directed at Mr Morrison. CO A Radford was questioned about the exchange:

'Q. When you told Mr Woods that you were going to put Mr Morrison in the cell with him, did he say anything to you.

A. Yeah, he was pretty jovial. He goes 'He's fucken mad Mr Radford'. And I said-

Q. What did you say to him.

A. I said, 'Who isn't around here', you know because he was showing no signs of, you know, of any aggression or anything.

Q. Did you ask Mr Woods any further questions about what he meant.

A. No.

---

<sup>195</sup> Exhibits C138 and C139a; Transcript, pages 97-98

<sup>196</sup> Exhibit C65a, page 46

Q. Why not.

A. Because as I said, the atmosphere was quite jovial and yeah, probably I was a little bit complacent but everything I could see there was no issues and I hadn't been warned of any issues that day.

Q. In your experience as a corrections officer, is that an unusual thing for one prisoner to say about another.

A. Common.<sup>197</sup>

10.29. When subsequently spoken to by police, Prisoner Woods reported that before he left the cell for his own court appearance, Mr Morrison was saying things like, 'What did they say, and 'I don't want to hurt nobody, I don't want to hurt nobody'. He said Mr Morrison was 'talking to himself' in the cell and that 'he started to go into a mood'.<sup>198</sup> Prisoner Woods postulated that surely one of the officers would have heard this and thought that Mr Morrison needed some help. Due to Mr Morrison's behaviour, Prisoner Woods told police that he began to fear for his own safety.<sup>199</sup> When he returned from his court appearance he said Mr Morrison was 'still talking to himself' and 'appeared to be in distress'.<sup>200</sup> Prisoner Woods thought he 'might have to fight him or he may end up killing me'.<sup>201</sup> I accept the evidence of Prisoner Woods and I find that Mr Morrison was exhibiting behaviours of concern. It is a separate question whether CO A Radford or any other correctional officer observed and/or witnessed this behaviour.

10.30. Counsel for the Morrison family criticised CO A Radford in final submissions because 'he didn't even bother to speak to Mr Morrison' (after speaking to Prisoner Woods). It was described as 'the final missed opportunity for intervention', a submission supported by Counsel Assisting who suggested that Prisoner Woods' comment that Mr Morrison was mad was simply 'laughed off'.<sup>202</sup> Counsel for the Morrison family invited the Court to find that CO A Radford failed to obtain assistance from the SAPHS to ascertain whether Mr Morrison needed an urgent referral for a mental health assessment. It was argued that CO A Radford's explanation for not probing Prisoner Woods further should be rejected, and that his

---

<sup>197</sup> Transcript, page 926

<sup>198</sup> Exhibit C166, page 3

<sup>199</sup> Transcript, page 451

<sup>200</sup> Ibid

<sup>201</sup> Exhibit C166a, page 3

<sup>202</sup> Written submissions of counsel for the Morrison family at [281]; see also written closing submissions of Counsel Assisting

description of Mr Morrison as being ‘jovial’ does not accord with the evidence of Prisoner Woods.<sup>203</sup> It was submitted that ‘it was impossible that Radford and the other officers in the holding cells...failed to observe the things that were apparent to other prisoners in the cells and, if they did notice, they did nothing about it’.<sup>204</sup> It was also suggested that ‘Radford’s outright dismissal of Prisoner Woods’ concerns’ accords with the pattern of behaviour demonstrated by correctional officers in the inquest which, at best, amounts to ignoring prisoner complaints or not taking them seriously; and, at worst, outright ridicule of the prisoner.<sup>205</sup>

- 10.31. I have considered these submissions. I find they are not supported by the evidence.
- 10.32. The cornerstone of the submission rests on the assumption that the information Prisoner Woods subsequently provided to police in his statement was communicated to CO A Radford and/or that he (and other correctional officers) must have witnessed the said behaviours. The evidence cannot support such an inference. In fact, it was not even suggested to CO A Radford in cross-examination that Prisoner Woods had raised these additional concerns with him. Furthermore, that suggestion that ‘it would have been impossible’ for CO A Radford and others not to have noticed the behaviour is based on pure speculation which is not supported by an objective and dispassionate assessment of the evidence.
- 10.33. I do not accept there was a ‘lost opportunity’ as suggested by counsel for the Morrison family. I accept the evidence of CO A Radford that his exchange with Mr Morrison was limited to Prisoner Woods’ comment about Mr Morrison being ‘fucken mad’.
- 10.34. I decline to make the adverse findings sought by counsel for the Morrison family,<sup>206</sup> noting also that two of the eight proposed findings are beyond power.<sup>207</sup>
- 10.35. So far as CO A Radford is concerned, I am satisfied that when he approached Cell 5 to collect Mr Morrison, in his mind, he was simply moving a prisoner from one cell to another. It is important in this context to remember that none of the Yatala officers

---

<sup>203</sup> Written submissions of counsel for the Morrison family at [264]-[265], [267]

<sup>204</sup> Ibid at [267]

<sup>205</sup> Ibid at [267]

<sup>206</sup> Written submissions of counsel on behalf of the Morrison family at page 72 (Dot points 1-6 inclusive) and page 76 (Dot points 1-4 inclusive)

<sup>207</sup> Ibid at page 72 (Dot points 7-8)

had been informed of Mr Morrison's behaviour at Holden Hill or the report that he may be hearing voices.

- 10.36. Returning to the narrative, CO A Radford approached Cell 5. There are two doors fitted at the front of each cell, an inner door and outer door. The inner door is a heavy metal grill/bar construction which allows for officers to have an unobstructed view inside the cell and to communicate with the prisoner. When opened, the inner door swings inwards. The outer door is a heavy metal solid door with only a small window and access port in the centre to allow small items to be passed to the prisoner. This door provides for a restricted view of, and communication with, the prisoner. The outer door opens outwards into the passage area of the holding cells.<sup>208</sup> CO A Radford unlocked both doors. He stated:

‘I unlocked the door to his cell and he let out a ‘growl’, which came from deep within him and *out of the blue*. With this he moved forward towards the cell door and all I remember is having my foot against the door trying to resecure and that’s it. I remember trying to secure the key, looking over and seeing Bev, who was about 5m away... but as I looked towards Bev, there was already blood all over the floor, buckets of it, it seemed. *I don’t remember what happened to me, she was not standing and Morrison was belting her. I moved over towards Morrison, and then I can’t remember anything again. The next thing I remember is coming to, there’s big gaps in my memory.*’<sup>209</sup>

- 10.37. *Statement of CO Beverly Demopoulos*

- 10.38. CO Demopoulos was working in B Division on the day of the incident. She was asked to relieve an officer in the Holding cells and arrived there at around 11am.
- 10.39. In her statement to police, CO Demopoulos said she saw CO A Radford moving a prisoner from one cell to an adjoining cell. She heard ‘Allen’ grimace and then she saw a cell door swinging outwards and hitting him in the right upper arm. *The next thing she remembered was ‘coming to’ on the floor and she was bleeding.* CO Demopoulos felt dazed and she did not know where she was or what had happened.<sup>210</sup>

---

<sup>208</sup> Exhibit C65a, page 19

<sup>209</sup> Transcript, pages 906, 927-929; See also Exhibit C150, page 20 (employee incident report dated 26 September 2016); It is undisputed that CO A Radford suffered a serious shoulder injury (surgery required), the loss of a tooth, and he was subsequently diagnosed with Post Traumatic Stress Disorder (PTSD)

<sup>210</sup> Exhibit C21, page 3; N.B. It is undisputed that CO Demopoulos sustained injuries which included a fractured nose

- 10.40. Prisoner Woods was in Cell 6. He gave evidence that ‘Mr Radford’ fell to the ground. He said Mr Morrison rushed past him and hit Ms Demopoulos ‘a few times’ and ‘stomped’ on her after she fell to the ground. He said she was left sitting in ‘a massive pool of blood’.<sup>211</sup>
- 10.41. CO Demopoulos recalled a prisoner rolling her some toilet paper to assist with her bleeding nose. It is plain from the evidence that the prisoner who assisted her was Prisoner Woods, and I so find. CO Demopoulos subsequently returned Prisoner Woods to his cell without incident.<sup>212</sup> CO Demopoulos has little recollection of the events and she was not required to give oral evidence.<sup>213</sup>
- 10.42. Findings as to the events leading to the initial restraint of Mr Morrison
- 10.43. As to the circumstances leading to the initial restraint, I accept CO A Radford’s evidence as credible and reliable evidence. I find that when he approached Cell 5 to relocate Mr Morrison he had no warning of what was about to occur.<sup>214</sup>
- 10.44. I find that Mr Morrison charged at the opened cell doors, causing the outer door to make forcible contact with CO A Radford’s upper body. I find that CO A Radford saw Mr Morrison attacking CO Demopoulos and that as he approached to assist the bleeding officer, Mr Morrison struck him resulting in CO A Radford going to ground and experiencing a brief loss of consciousness. I am satisfied that CO A Radford also sustained a serious injury to his right shoulder (surgery required) which was caused either as a result of the heavy metal door striking his upper body, or when CO A Radford fell to the ground and lost consciousness.
- 10.45. I find that Mr Morrison punched CO Demopoulos in the face at least once resulting in her falling to the ground, a broken nose and blood loss. She may have been subjected to further violence, but the evidence of Prisoner Woods and CO A Radford was not sufficiently probed to allow for a more definitive finding. I find that CO Demopoulos temporarily lost consciousness and had little recollection of the events.

---

<sup>211</sup> Exhibit C21, page 4; Transcript, page 927

<sup>212</sup> Exhibit C21, page 5; see also evidence of Prisoner Woods, Transcript, pages 446, 452

<sup>213</sup> Exhibit C21

<sup>214</sup> Transcript, page 1002

10.46. *Evidence of CO Hutchinson*

10.47. I turn now to the initial restraint of Mr Morrison.

10.48. Shortly before 11:30am, CO Hutchinson was collecting food and drinks from a small fridge situated in the mess room corridor. He heard a cry for help coming from the holding cells and called out to CO Robinson for assistance. CO Hutchinson ran to the holding cells and CO Robinson followed moments later.<sup>215</sup> On entering, they saw CO A Radford lying on the floor against a wall. He was yelling out for help. Mr Morrison was standing nearby.

10.49. CO Hutchinson had never encountered Mr Morrison before, whom he described as aggressive, wide-eyed and red-faced. He said Mr Morrison was throwing ‘haymaker punches’ indiscriminately into the air.<sup>216</sup> CO Hutchinson pressed his duress alarm, and a Code Yellow (officer requiring assistance) was broadcast over the DCS radio system.<sup>217</sup>

10.50. *Evidence of CO Robinson*

10.51. When CO Robinson arrived, he saw Mr Morrison standing with his fists raised in ‘a boxing style manner’. He said Mr Morrison was ‘moving from side to side on his toes as if spoiling for a fight’. He noted that CO Demopoulos was on the ground. In the split second it took to look down at her, CO Robinson said he was hit in the face. The next thing he recalled was ‘coming round’ and looking up to see Mr Morrison standing at his feet in the boxing stance.<sup>218</sup> Although CO Robinson did not see who hit him, it was obviously Mr Morrison and I so find. I further find that CO Robinson temporarily lost consciousness.

10.52. Three correctional officers had been brought to ground within seconds of Mr Morrison charging from his cell. There is no dispute that Mr Morrison attacked them with such force that it resulted in serious injuries which included a loss of consciousness.

---

<sup>215</sup> The initial response of COs Hutchinson and Robinson was captured on a short piece of vision from a camera located in the mess room corridor. The vision ceases as they enter the holding cells area: Exhibit C234

<sup>216</sup> Exhibit C187, pages 3-4; See also Transcript, pages 1265-1268

<sup>217</sup> Ibid; A Code Yellow is a distress alarm that is activated in a situation where an officer is unable to manage an emergency without assistance, or where they consider their safety is at risk; SOP 020A, page 1; Exhibit C65a, page 22

<sup>218</sup> Transcript, page 1934; See also Exhibit C187, pages 3-4; Transcript, pages 1265-1268

- 10.53. Many correctional officers from other divisions responded to the Code Yellow alarm by attending at the holding cells area to provide assistance.
- 10.54. *Evidence of CO Shane Crase*
- 10.55. CO Crase was walking towards the video court area which adjoins the holding cells area. He heard a female screaming and ran towards the sound. On his way there he pressed his distress alarm (Code Yellow). On entering the holding cells, he saw COs Demopoulos and Robinson on the ground. Both were bleeding and he saw Mr Morrison standing in between them. However, before he had a chance to help, Mr Morrison rushed at him and punched him four to six times in the face.<sup>219</sup>
- 10.56. At around this time, CO Kay heard the Code Yellow. CO Kay was working as a Yankee 5 officer with the escort team, and he was the designated driver of the prison escort van for the shift. On hearing the alarm, he drove the van to the holding cells area and parked it outside of exit door 7.
- 10.57. The evidence of these officers was credible and reliable evidence which I accept in its entirety.
- 10.58. The initial restraint of Mr Morrison outside of the holding cells
- 10.59. Despite the assault, CO Crase managed to stay on his feet and he grabbed Mr Morrison by his shirt to create some distance between them. CO Greenwood arrived moments later.<sup>220</sup> It is at this point in time that the attempt to restrain Mr Morrison begins.
- 10.60. *Evidence of CO Greenwood*
- 10.61. CO Greenwood had heard ‘grunting animal like noises’ coming from the holding cells and went directly to the area. When he entered, he saw CO Crase holding on to Mr Morrison. He said Mr Morrison was ‘swinging haymaker punches’ at CO Crase.<sup>221</sup>

---

<sup>219</sup> Transcript, page 1129

<sup>220</sup> Transcript, pages 1126-1129, 1134, 1139, 2154

<sup>221</sup> Statement of Brian Greenwood, Exhibit C219, pages 1-3; Transcript, pages 3546-3547

- 10.62. CO Greenwood put himself in between Mr Morrison and CO Crase. He placed Mr Morrison in a bear hug to stop him from swinging at CO Crase. They both tried to wrestle Mr Morrison to the ground without success.<sup>222</sup> I accept the evidence of CO Greenwood who presented as an honest and forthright witness.
- 10.63. By this time, Supervisor Gavin Gibson (the video conferencing supervisor) had arrived. CO Hutchinson recalled that Supervisor Gibson directed them to move Mr Morrison into the mess room corridor as it was a more open area in which to conduct a restraint.
- 10.64. More correctional officers responded to the Code Yellow alarm. Some entered the area through exit door 7. Others came from the direction of the video court. At one point around 16 correctional officers were present in the area. The sheer number of officers who attended the area has been criticised by some counsel and I will comment on this matter in due course.
- 10.65. The continuing restraint in the mess room corridor
- 10.66. Mr Morrison remained on his feet during the initial attempt to restrain him. Several officers physically surrounded him and he was pulled towards the mess room corridor by officers holding onto his clothes.<sup>223</sup> One witness described this part of the restraint as ‘a moving scrum’.
- 10.67. Before reaching the mess room corridor, CO Hutchinson found himself physically pushed aside, and Mr Morrison was manoeuvred to the corridor by other officers.<sup>224</sup> The beginning of the restraint vision captures the tail end of the ‘moving scrum’ as it enters the mess room corridor.
- 10.68. There is little dispute about the chronology of events as depicted on the restraint vision.
- The first officers enter the mess room corridor at 11:27:15.<sup>225</sup> CO Hutchinson is holding onto Mr Morrison’s clothing and moving him towards the corridor.

---

<sup>222</sup> Ibid

<sup>223</sup> Exhibit C18, pages 3-4; Transcript, pages 1265-1268; Exhibit C81, page 2; Transcript, page 2134

<sup>224</sup> Refer Exhibit C137 - Maps of the area

<sup>225</sup> All times stated in this section should be read as approximate times on the vision and may vary by a few seconds. It should also be noted that the time stamp on the vision is five seconds faster than the actual time. Nothing turns on this point.

- Mr Morrison is then brought to the ground on his back (primarily by CO Greenwood).
- At around 11:27:21, CO Greenwood is lying across Mr Morrison's upper torso. CO A Radford is also laying across the torso (chest to chest).<sup>226</sup>
- Several officers use their combined body weight to hold Mr Morrison on the ground either directly, or by leaning in against the officers who were directly holding him down.
- Between 11:27:21-11:27:34 the vision shows CO Greenwood's right arm moving backwards and forwards in the area of Mr Morrison's head and upper body.
- Mr Morrison was rolled onto his stomach at 11:28:10.
- By 11:31:02, Mr Morrison's legs had been secured by the use of plastic flexi-cuffs.<sup>227</sup>
- By 11:35:35 a spit mask had been placed over Mr Morrison's head (by CO Kay).
- At 11:33:17, Mr Morrison was lifted by his limbs from the floor and carried from the building to the awaiting prison escort van for transfer to G Division.

10.69. CO Greenwood gave evidence that while Mr Morrison was on his back, he heard an officer say, 'We need to get him on his stomach to cuff him from behind'.<sup>228</sup>

10.70. The strength of Mr Morrison's resistance

10.71. All witnesses who gave evidence about the restraint described Mr Morrison as extremely strong and putting up fierce physical resistance throughout the restraint. I accept this evidence and I find that Mr Morrison resisted all efforts to restrain him by pulling his arms away during the handcuffing process, kicking his legs and moving his body.

---

<sup>226</sup> Transcript, pages 996,1002: N.B. It is undisputed that CO A Radford was subsequently lifted away from scene by other officers as his shoulder prevented him from taking any further part in the restraint.

<sup>227</sup> The decision to use plastic flexi-cuffs as leg restraints and the decision to call for and use a spit mask are discussed further in this Finding

<sup>228</sup> Exhibit C219, page 3; Transcript, page 3590

- 10.72. CO Greenwood said Mr Morrison was trying to punch him the whole time and it was a struggle to get him to the ground. He said he was ‘nearly thrown off’ in the process, stating, ‘I’ve never seen anything like it, he just would not stop, would not comply ... he wouldn’t stop throwing punches’.<sup>229</sup> It was suggested by counsel for the Morrison family in cross-examination that the vision does not support CO Greenwood’s claim of almost being thrown off. CO Greenwood agreed that it is not obvious on the vision. Nothing turns on the point as the subjective experience that CO Greenwood was attempting to describe would not necessarily be clearly evident on the vision.
- 10.73. Witnesses gave varying descriptions of the strength of Mr Morrison’s resistance. CO Radford said he had ‘never seen no one go off as hard as this bloke did’.<sup>230</sup> CO Cahill described Mr Morrison as ‘very aggressive’, ‘non-compliant’ and ‘bucking’ against officers.<sup>231</sup> CO Chapman could not recall an incident where he had felt ‘such a strength of resistance’.<sup>232</sup> Supervisor Joseph said Mr Morrison was ‘exceptionally strong’ and described the situation as volatile and violent.<sup>233</sup> CO Sniatynskj described Mr Morrison’s strength as ‘super-human’.<sup>234</sup> Other witnesses said ‘Mr Morrison was continuously fighting the whole time’,<sup>235</sup> that he was ‘growling’ in an animalistic way and ‘grunting’,<sup>236</sup> and that officers had never seen a prisoner demonstrate such resistance and strength as Mr Morrison did on that day.<sup>237</sup>
- 10.74. CO Hutchinson heard officers instructing Mr Morrison to stop resisting and to place his arms behind his back.<sup>238</sup> CO Teahan recalled officers urging Mr Morrison to relax and calm down. Trainee officer, CO Nickson said they repeatedly told Mr Morrison to stop fighting and to calm down, but he continued to struggle.<sup>239</sup>
- 10.75. Several witnesses gave evidence that Mr Morrison’s physical resistance was accompanied by the use of profanities. CO Sniatynskj recalled him shouting out

---

<sup>229</sup> Exhibit C219, pages 2-4; Transcript, pages 3541, 3544-3545, 3563-3564

<sup>230</sup> Transcript, pages 996

<sup>231</sup> Exhibit C200, page 3

<sup>232</sup> Exhibit C184, page 3

<sup>233</sup> Exhibit C188, page 3; Transcript, pages 1321-1323

<sup>234</sup> Transcript, page 2094

<sup>235</sup> Transcript, page 2292

<sup>236</sup> Exhibit C203, page 3; Transcript, pages 1589, 2172, 2300

<sup>237</sup> Transcript, pages 1754, 2014; see also Transcript, pages 453, 929, 1056-1057, 1201, 1268-1269, 1332, 2078, 2097, 2172, 2292, 2302, 2311, 3306, 3600, 4681 for further descriptions of the strength of Mr Morrison’s physical resistance

<sup>238</sup> Exhibit C187, page 4

<sup>239</sup> Exhibit C203, page 3; Transcript, pages 2300-2306; see also pages 1073, 1201, 1270-71, 1332, 1754, 2904

things like, ‘fucking dogs’ and ‘fucking cunts’.<sup>240</sup> CO Townsend’s transcript of interview with Mr Muller refers to phrases such as ‘dog cunts’ and ‘fuck off’. CO Townsend mentioned a threat made by Mr Morrison, namely, ‘You’re fucking going to die’.<sup>241</sup> Prisoner Woods told police that he heard Mr Morrison shout out, ‘I’ll fucking kill you’ which provides support for CO Townsend’s untested interview.<sup>242</sup> CO Teahan heard an officer say, ‘Shut the fuck up’.<sup>243</sup> She also heard Mr Morrison say, ‘Get the fuck off me’ and ‘Fucking dogs’.

- 10.76. The witnesses maintained these accounts under robust cross-examination by counsel for the Morrison family and Counsel Assisting.
- 10.77. The witnesses who gave evidence about the strength of Mr Morrison’s physical resistance, and the statements that accompanied it, were consistent and compelling witnesses. I accept their evidence in all material respects.
- 10.78. Counsel for the Morrison family was highly critical of the use of the prone position during the restraint. Given the circumstances, I find no basis to criticise the decision to roll Mr Morrison onto his stomach to apply handcuffs. Rear handcuffing is a well-recognised method of restraining a violent, non-compliant prisoner, noting that officers need no permission or special training to use handcuffs and the process was completed by COs Sniatynskj, Greenwood and Chapman in just over one minute (by 11:29:27).<sup>244</sup>
- 10.79. Ms O’Connor SC asked several witnesses whether it occurred to them Mr Morrison may have been struggling to breathe or experiencing a medical episode (as opposed to gratuitously engaging in physical resistance). The effect of the evidence was that none of them turned their mind to such a possibility. Their focus was on restraining a violent, non-compliant prisoner as quickly as possible to protect the safety and welfare of correctional officers. That is hardly surprising given the potentially life threatening situation faced by these officers and the importance of subduing Mr Morrison as quickly as possible. I will come to the evidence of Dr Charlwood in

---

<sup>240</sup> Exhibit C21, page 3

<sup>241</sup> Exhibit C250, page 14; CO Townsend could not be cross-examined about the interview on account of the Court’s ruling on the self-incrimination privilege

<sup>242</sup> Exhibit C160, page 5

<sup>243</sup> Exhibit C84, page 3

<sup>244</sup> CO Sniatynskj (Transcript, page 2107), CO Greenwood (page 3578) and CO Chapman (page 1057)

due course, but it is apposite to mention now that based on her assessment of the material, even if a medical episode was unfolding, such as a cardiac arrhythmic event, it would not necessarily be apparent to a medically untrained person.<sup>245</sup>

10.80. Was Mr Morrison punched during the restraint?

10.81. As previously stated, the vision (at 11:27:21, 11:27:32 and 11:27:34) shows CO Greenwood's right arm moving backwards and forwards towards Mr Morrison's head and upper body.

10.82. In cross-examination, Ms O'Connor SC suggested to CO Greenwood that he was punching Mr Morrison in the head or upper torso. The allegation was denied. When shown the vision, CO Greenwood said appears that he is trying to push Mr Morrison back onto the ground. He repeated his earlier evidence that it was a struggle to keep Mr Morrison down.<sup>246</sup>

10.83. CO Robinson agreed that CO Greenwood may have been in front of him, but he denied seeing any punches being thrown at Mr Morrison by CO Greenwood or any other officer.<sup>247</sup>

10.84. CO Sniatynskj did not see any officer punch Mr Morrison and believes that she would have recalled something 'as abhorrent and anti-everything our workplace stands for'.<sup>248</sup>

10.85. None of the other witnesses who were cross-examined on the topic saw any punching.<sup>249</sup>

10.86. I have viewed the vision of this part of the restraint several times. CO Greenwood's hands are not visible on the vision. It depicts arm and shoulder movement only. I find that the action depicted on the vision is equivocal. The arm and shoulder motion is consistent with the action of punching to the upper body or head area. At the same time, the action is equally consistent with the action of a person attempting to push

---

<sup>245</sup> Transcript, page 7729

<sup>246</sup> Transcript, page 3567

<sup>247</sup> Transcript, pages 1927-1933, 1935

<sup>248</sup> Transcript, page 2115

<sup>249</sup> Transcript, page 2049 (CO Warner); Transcript, page 1225 (CO Gibson); Transcript, page 1289-1290 (CO Hutchinson)

Mr Morrison back onto the ground, as suggested by CO Greenwood. There is no independent or other evidence to support the claim that Mr Morrison was punched.

- 10.87. In short, the evidence falls far short of supporting a finding that Mr Morrison was punched in the face and/or upper torso by CO Greenwood.
- 10.88. Why were plastic flexi-cuffs used as leg restraints?
- 10.89. It is undisputed that standard metal leg restraints are available for use as leg restraints. Standard metal leg restraints consist of two metal ankle cuffs which are joined by a chain. The chain allows prisoners to stand and walk, even when the restraints are secured. Nonetheless, *it is undisputed that Supervisor Joseph and other officers who were involved in the restraint had received no training in the use of leg cuffs and spit masks.*<sup>250</sup>
- 10.90. CO Chapman heard Supervisor Joseph call out for plastic flexi-cuffs.<sup>251</sup> When the first cuff arrived, Supervisor Joseph tried to secure it around Mr Morrison's ankles but he discovered it was too short. He called for a second flexi-cuff which was joined to the first to create sufficient length to reach around Mr Morrison's ankles.
- 10.91. When asked why he called for plastic flexi-cuffs, Supervisor Joseph pointed to the strength of Mr Morrison's resistance, the need to protect staff, and the fact that he knew they were sometimes used to escort prisoners to hospital. It was an unusual answer because this was not a hospital situation where considerations such as the presence of metal during medical imaging processes may be problematic. When pressed on the matter, Supervisor Joseph admitted that *he had never seen plastic flexi-cuffs used in a restraint situation. Furthermore, he acknowledged that once Mr Morrison's ankles were secured by the flexi-cuffs he would have been unable to stand or walk properly.*<sup>252</sup>
- 10.92. This evidence was not challenged by counsel for the Department.
- 10.93. The Court did not hear detailed evidence about plastic flexi-cuffs and their intended use in correctional facilities. It is unclear whether they are ever intended for use as

---

<sup>250</sup> Refer to Section 11.20 of the Finding

<sup>251</sup> Exhibit C184, page 4

<sup>252</sup> Transcript, page 1485

leg restraints or reserved solely for use as wrist restraints in a hospital setting. Nevertheless, given that two cuffs had to be manually joined to create sufficient length to reach around the ankles of an adult male and, that once secured, they render the person unable to walk, I consider it unlikely that plastic flexi-cuffs are intended for use as leg restraints.

- 10.94. The Spit Mask - was Mr Morrison spitting?
- 10.95. The spit mask that was placed on Mr Morrison is trademarked as ‘The Tranzport Hood’. A mask of its type was tendered in court.<sup>253</sup> Spit masks are designed to be used as a temporary protective measure on persons where a risk of exposure to infectious disease is present. The aim is to reduce the risk of the wearer transmitting fluids such as saliva and mucous from the facial area through spitting, coughing or sneezing.<sup>254</sup>
- 10.96. It is self-evident that placing anything over the head of a person has the potential to cause harm to that person. It is noteworthy that a warning is included in the written instructions for the Tranzport Hood, namely, that improper use can cause injury or death.<sup>255</sup>
- 10.97. The first issue to be determined is whether Mr Morrison was in fact spitting.
- 10.98. Supervisor Joseph attested to hearing an officer (believed to be CO Mail) saying ‘Do not spit’, and ‘Stop spitting’.<sup>256</sup> Supervisor Murti and COs Heard and Chapman also heard officers saying Mr Morrison was spitting, but they did not witness the spitting themselves.<sup>257</sup>
- 10.99. Reference to spitting is made in some of the van officers’ employee incident reports and their transcripts of interview with Mr Muller. Due to the Court’s self-incrimination rulings, these witnesses could not be cross-examined about the contents of their incident reports, or the accuracy of the answers recorded in the transcripts of

---

<sup>253</sup> Exhibit C191

<sup>254</sup> Exhibit C65aah SOP-032 (Use of Restraint Equipment), paragraphs 3.14.1 and 3.14.2

<sup>255</sup> Exhibit C191; Spit mask instructions: Exhibit C65aaah

<sup>256</sup> Exhibit C188, page 3; Transcript, pages 1318-1321; See also Exhibit C203, page 3, Exhibit C199, page 4

<sup>257</sup> Exhibit C189, pages 1-2, 4; Exhibit C184, page 4; Exhibit C84, page 4

interview. Nonetheless, it is relevant evidence. The weight of the evidence favours the view that Mr Morrison was spitting.

- 10.100. CO Kay's statement to police includes a report that Mr Morrison was spitting onto the floor.<sup>258</sup> CO Kay said Mr Morrison appeared to be trying to clear his mouth rather than aiming the spittle at anyone and he told Mr Morrison to stop spitting. He said Mr Morrison denied spitting and continued to spit onto the floor.<sup>259</sup> CO Shillabeer's transcript of interview with Mr Muller also refers to Mr Morrison spitting.<sup>260</sup> References are made to spitting by others officers in their employee incident reports. One reports states that the spit mask was required 'to protect others from bodily fluid discharge' (CO Mail);<sup>261</sup> and 'because of the prisoner's violent nature and the spitting of fluids' (CO Shillabeer).<sup>262</sup> CO Bradford reported that Mr Morrison was spitting 'at everybody that he could get his chance on'.<sup>263</sup>
- 10.101. I find that Mr Morrison was spitting during the restraint. However, I am satisfied that he was spitting on the ground and that the spittle was not directed at any particular officer or group of officers.
- 10.102. Supervisor Joseph confirmed that he called for the spit mask.<sup>264</sup> Several officers went to retrieve a spit mask. CO Sniatynskj returned with a mask, but it was not used as another officer had already returned and provided a mask.<sup>265</sup> It is noteworthy that CO Sniatynskj also retrieved a set of standard metal leg restraints of her own volition, but these were not used.
- 10.103. At around 11:31:35, the vision shows the mask being handed from CO Bradford to CO M Chapman, to Supervisor Murti and onto CO Kay.
- 10.104. I find that CO Kay placed the spit mask over Mr Morrison's head shortly after 11:31:35.

---

<sup>258</sup> Exhibit C258, pages 3-4

<sup>259</sup> Exhibit C258, page 4; see also Exhibit C246, page 5

<sup>260</sup> Exhibit C249, page 5

<sup>261</sup> Exhibit C150, page 12

<sup>262</sup> Exhibit C150, page 8; Exhibit C249, pages 5-6

<sup>263</sup> Exhibit C243

<sup>264</sup> Exhibit C188, page 4; Transcript, page 1410

<sup>265</sup> Exhibit C84, page 4; Exhibit C194, pages 6, 9; Transcript, page 2109

- 10.105. Was it necessary to use a spit mask?
- 10.106. As stated, the weight of the evidence favours the view that Mr Morrison was spitting, albeit towards the ground. CO Bradford was the only officer who suggested that Mr Morrison was ‘spitting at everybody that he could get his chance on’. CO Bradford’s account was at odds with the evidence of all other witnesses. Although it could not be tested by cross-examination (due to the Court’s self-incrimination ruling), I consider it likely to be an exaggeration and I prefer the evidence of other witnesses on the spitting issue.
- 10.107. I find that it was necessary to use a spit mask. There is no basis to criticise the decision of Supervisor Joseph to call for the spit mask.
- 10.108. Counsel for the Morrison family submitted that a spit mask was unnecessary.<sup>266</sup> I disagree. *The direction of the spittle is not to the point. The fact that Mr Morrison was spitting at all justified the decision. The risk of transmission of infectious diseases by saliva and other bodily fluids is well known and needs no elaboration. Correctional officers are not required to wait until they are spat at, or on, before taking protective measures, particularly in circumstances where the restraint was ongoing, and Mr Morrison was yelling and shouting.*<sup>267</sup>
- 10.109. I add in passing that I do not propose to address the submissions made by Counsel for the Morrison family regarding the ABC Four Corners Episode aired on 25 July 2016 regarding the NT Don Dale Youth Detention Centre inquiry and the use of spit hoods in youth detention, the NT Royal Commission findings, or the observations made on this topic by the SA Ombudsman.<sup>268</sup> These issues, along with the lobbying by members of the Morrison family to abolish the use of spit masks in South Australian correctional institutions *are not relevant to the determination of whether the use of the spit mask in Mr Morrison’s case caused or contributed to his death.*

---

<sup>266</sup> Written submission of counsel for the Morrison family at [357]-[358], [362]-[363],[368]; see also proposed findings at page 76 (6<sup>th</sup> dot point)

<sup>267</sup> See also supplementary written closing submissions for Members of the COLF at [75]-[82]. I agree with these submissions.

<sup>268</sup> Written submissions of counsel for the Morrison family at [376]-[399]

- 10.110. Mr Morrison is lifted and carried from the building
- 10.111. The vision confirms that after Mr Morrison had been restrained there was no appreciable pause before he was lifted by his limbs and carried from the building to the van through Doors 10, 9, 8 and exit door 7.
- 10.112. The evidence has established that the carrying party was Supervisor Joseph (left leg), A/Supervisor Hall (right leg), CO Greenwood (left arm),<sup>269</sup> CO Shillabeer (right arm) and CO Kay (head support) and I so find.<sup>270</sup>
- 10.113. Mr Matthew Staples is a manager and a member of the Emergency Response Group ('ERG'). During his evidence he opined (based on his ERG experience) that once a prisoner has been restrained, time should be allowed for the restraining officers and the prisoner to calm down so that the adrenalin generated by the incident can subside (for all parties) before decisions are made about the next stage of the process.<sup>271</sup>
- 10.114. Counsel for the Morrison family and Counsel Assisting were critical of the haste in lifting and carrying Mr Morrison from the area. I have considered these submissions. The Court did not receive expert evidence about the application of de-escalation techniques in a restraint situation, in particular, in relation to a restraint involving a violent, non-compliant prisoner and an unplanned use of force. Nor did the Court hear evidence of Mr Staples' experience in managing such restraints; he was not present during Morrison's restraint, and he did not profess to have expertise in the use of de-escalation techniques. In the circumstances, I agree with Mr Henchcliffe KC that little weight can be placed on Mr Staples' opinion.<sup>272</sup>
- 10.115. Why was Mr Morrison lifted and carried from the building?
- 10.116. It is necessary to examine why Mr Morrison was lifted and carried from the building instead of being brought to his feet and walked to the van.

---

<sup>269</sup> Supervisor Gibson initially carried Mr Morrison by the left arm - It is undisputed that he swapped places with CO Greenwood just before the carrying party went through Door 10 and returned to his video conferencing duties

<sup>270</sup> Exhibit C188, page 4; Transcript, page 1324; N.B. Supervisor Gibson returned to video-conferencing duties

<sup>271</sup> Transcript, page 6371

<sup>272</sup> See closing submissions for Members of the COLF (3 August 2021) at [118]-[121]

- 10.117. CO Kay recalled hearing a supervisor give a direction to move Mr Morrison. CO Hutchinson recalled hearing an officer say something like, 'Let's get him up' and 'Clear the passageway'.<sup>273</sup> It is unclear who gave this direction. No witness gave evidence of specifically hearing a direction to 'lift and carry'.
- 10.118. Although it was unclear from the evidence whether such a direction was given, Supervisor Joseph said he thought lifting and carrying Mr Morrison horizontally was the safest way to move Mr Morrison. This evidence tends to suggest that he either gave the direction himself, or supported Mr Morrison being moved in this way.<sup>274</sup>
- 10.119. Why was no restraint belt or body cuff used to support Mr Morrison's body while he was carried?
- 10.120. The vision shows that Mr Morrison was lifted and carried at hip height through Doors 10, 9, 8 and exit Door 7. It is undisputed that no body support equipment was used.
- 10.121. The Court received evidence that a restraint belt (or a body cuff as it is sometimes called) is an item used in special management units to control violent, drug intoxicated or mentally ill prisoners.<sup>275</sup> The body cuff is wrapped around a prisoner's waist and fastened using a seat belt type system. The prisoner's hands and ankles are shackled to the belt which supports the prisoner's body while he is being carried.<sup>276</sup>
- 10.122. The witnesses were not asked directly why Mr Morrison was carried without body support or why a special unit such as the ERG was not called to provide assistance. The most likely explanation is that training in the use of body cuffs was reserved for members of the ERG or special management units (see training section below). On the available evidence, I consider that in the haste to move Mr Morrison, little or no thought was given to the use of a body cuff or restraint belt.
- 10.123. The only witness who appeared to appreciate the inherent danger of a prisoner being carried in this way was Trainee Officer Nickson. He was holding exit Door 7 open

---

<sup>273</sup> Transcript, pages 1326-1328, 1486

<sup>274</sup> Exhibit C187, page 5; Transcript, pages 1485-1486

<sup>275</sup> SOP-032 (Use of Restraint Equipment); Exhibit C65aah, page 7

<sup>276</sup> Ibid

as the carrying party approached. He recalled Mr Morrison bucking his body and pulling against the officers as he was carried through doors 8 and exit Door 7. He recalled thinking it was dangerous because there was a risk that Mr Morrison would be dropped.<sup>277</sup>

10.124. Was any attempt made to bring Mr Morrison to his feet?

10.125. In cross-examination by Counsel Assisting, Supervisor Joseph agreed there were other available options to move Mr Morrison. For example, it was agreed that he could have been lifted to his feet and dragged backwards by the shoulders.<sup>278</sup>

10.126. Conflicting evidence was given about whether any attempt was made to bring Mr Morrison to his feet before being lifted and carried.<sup>279</sup> It is unnecessary to repeat this evidence. Some witnesses appeared to genuinely believe they had seen Mr Morrison ‘on his feet’ (e.g. CO Sniatynskj) or being ‘put back on his feet because he was too heavy to carry’ (CO Shillabeer in the Muller transcript). The latter claim is plainly wrong as the vision clearly shows Mr Morrison being carried from the building to the van.

10.127. As to seeing Mr Morrison on his feet, I believe CO Sniatynskj and CO Shillabeer are mistaken about the sequence of events. I accept that both witnesses appeared to have a detailed recollection of seeing Mr Morrison on his feet. Nevertheless, I find it more likely than not that their descriptions relate to observations of the tail end of the initial restraint when Mr Morrison was in fact still on his feet and surrounded by officers.

10.128. I prefer the evidence of CO Cahill on this topic. CO Cahill told police that he saw a group of officers ‘pick up’ Mr Morrison and ‘attempt to have him stand and walk’.<sup>280</sup> Such a manoeuvre is not clearly discernible on the vision. Nonetheless, the attempt is entirely consistent with Supervisor Joseph’s evidence that once the plastic flexi-cuffs were secured, Mr Morrison would have been unable to stand and walk properly.

---

<sup>277</sup> Exhibit C203, page 4

<sup>278</sup> Transcript, pages 1485-1486

<sup>279</sup> See Exhibit C199, pages 3-5; Transcript, pages 2106, 2135, 2224-1225 (CO Sniatynskj); Exhibit C250, page 16 (CO Townsend); Exhibit C249, page 6 (CO Shillabeer)

<sup>280</sup> Exhibit C200, page 3 (CO Cahill)

- 10.129. In short, I find that an attempt was made to bring Mr Morrison to his feet, but he could not stand and walk. I find that the inability to walk led to the decision to lift and carry Mr Morrison to the awaiting van.
- 10.130. Was the spit mask adjusted as Mr Morrison was being carried towards Door 10?
- 10.131. As Mr Morrison was being carried towards door 10, the vision shows the carrying party pausing briefly (at 11:33:17 and 11:33:19). COs Kay, Shillabeer and Supervisor Murti appear to be doing something at or near Mr Morrison's head.
- 10.132. In cross-examination, questions were directed at the reason for these pauses, what correctional officers were doing and why they were doing it (noting that the two officers who were closest to Mr Morrison's head could not be cross-examined due to the Court's rulings on the self-incrimination privilege).
- 10.133. Ultimately, counsel for the Morrison family invited the Court to find that the spit mask was not in its correct position, and that it was being adjusted during these pauses.<sup>281</sup>
- 10.134. In support of this contention, reference was made to a statement of a prisoner named Aaron Pope. Prisoner Pope can be seen on the CCTV vision at about 11:33.<sup>282</sup> The Court had issued a summons for his attendance, but Prisoner Pope could not be located and the statement was not admitted or tested. There is no other evidence which casts light on the issue.<sup>283</sup>
- 10.135. Having viewed the vision, and taking into account the proximity of the officers to Mr Morrison's head, it seems more likely than not that something was being done with the spit mask. That said, on the available evidence, I cannot say with any level of certainty what was being done or why it was considered necessary. It is certainly not open, as suggested by counsel for the Morrison family, to find that the spit mask had been put on incorrectly and that an adjustment was necessary to return the mask to its correct position. It is equally possible that the officers were simply checking

---

<sup>281</sup> Written submissions of counsel for the Morrison family at [93]

<sup>282</sup> Written submissions of counsel for the Morrison family at [93]

<sup>283</sup> See e.g. Transcript, page 1566

the mask to ensure that it was still in the correct position and/or made minor adjustments. The failure to consider the more favourable inferences that are open on the equivocal evidence is a good example of the inherent risk of hindsight bias.

- 10.136. Did the lifting and carrying of Mr Morrison involve an excessive use of force?
- 10.137. Ms O'Connor SC submitted that once he had been restrained, Mr Morrison was no longer a threat to anyone. I agree. He could not lash out with his arms, he could not kick, and if he did spit the mask prevented the transmission of the spittle.
- 10.138. The question then arises whether lifting Mr Morrison by his limbs and carrying him at waist height from the building was an unnecessary use of force. SOP-079 provides that *the use of force must only occur to prevent or stop any disturbance in which there exists a threat of death, bodily harm, escape or property damage.*
- 10.139. I find that once Mr Morrison had been restrained there was no longer any threat of death, bodily harm, escape or property damage. I further find that *lifting Mr Morrison by the limbs and carrying him from the building was an excessive use of force.* It was not a necessary or reasonable in the circumstances. Furthermore, it exposed Mr Morrison to a risk of physical harm and would have added to the emotional and psychological stress generated by the restraint, particularly since Mr Morrison did not know where he was going, and the spit mask would have obscured his vision.
- 10.140. To my mind there should have been no rush to move Mr Morrison to G Division. It would have been an opportune time to pause, regroup and for standard metal leg cuffs to be retrieved so that Mr Morrison could have been brought to his feet and walked to the van. If this had occurred, Mr Morrison could have travelled in the caged middle section of the van with an officer situated on either side of him.

## 11. Training

- 11.1. Before I consider Mr Morrison's placement into the Yatala internal escort van for transfer to G Division, it is apposite to consider the issue of training in the context of the evidence discussed so far. The Court received statements and oral evidence from Ms Jane Francis (Director of DCS Workplace Planning and Development since May

2016),<sup>284</sup> and Mr Geoff Goodall (Safety Training Coordinator for DCS for the Northern Metropolitan area since 2005).<sup>285</sup> The evidence was unchallenged.

- 11.2. New recruits must undertake a Certificate III in Correctional Practice. The certificate is recognised by DCS which has its own registered training organisation. New recruits must complete an in-service period of six weeks at the prison to which they are allocated. During this period trainees learn the practical components of the job by shadowing qualified correctional officers.<sup>286</sup> After completion of the in-service period the new recruits commence work as a trainee correctional officer.<sup>287</sup> It is the responsibility of supervisors and managers to train officers in respect of any procedures which are particular to the individual institution.<sup>288</sup>
- 11.3. The Certificate III in Correctional Practice is general in nature. So far as specific restraint training is concerned, between 2005 and 2011, it was conducted informally at Yatala by officers from the Emergency Response Group ('ERG').<sup>289</sup> As its name suggests, officers in this unit are trained to deal with emergency situations.
- 11.4. In 2010-2011, a review of the training materials was undertaken. The review led to a formalisation of restraint training, the development of a Facilitators and Participants Manual, and the new Control, Restraint and Defensive Techniques ('CRDT') training program.<sup>290</sup> Since 2014, CRDT refresher training has been incorporated into the DCS training structure.
- 11.5. Two key questions arise in the context of Mr Morrison's restraint:
  - 11.5.1. First, had the correctional officers who were involved in Mr Morrison's restraint been trained in the use of leg restraints and spit masks?

---

<sup>284</sup> Exhibits C177 to Exhibit C177h; Transcript, pages 709-818, 3637-3746

<sup>285</sup> Exhibits C179 to Exhibit C179e, Transcript, pages 820-903, 3840-3890

<sup>286</sup> Transcript, page 715

<sup>287</sup> Transcript, page 717

<sup>288</sup> Transcript, page 780

<sup>289</sup> Transcript, pages 729-730, 3657, 3732-3732

<sup>290</sup> Exhibit C251a

- 11.5.2. Secondly, had these officers completed the DCS Control Restraint and Defensive Training and the mandatory restraint refresher training at the time of Mr Morrison's death?
- 11.6. The Court heard that CRDT training includes specific instruction in a range of restraint methods.<sup>291</sup> So far as training in the use of restraint equipment is concerned, Ms Francis gave evidence that *at the time of Mr Morrison's death, CRDT training did not include training in the use of leg restraints or spit masks.*<sup>292</sup>
- 11.7. Counsel for the Department did not challenge this evidence.
- 11.8. It is essential to examine the decisions made on the day by individual officers against this training vacuum.
- 11.9. For example, Supervisor Joseph called for the plastic flexi-cuffs and the spit mask. Even though he was a supervisor, *Mr Joseph made no secret of the fact that he had virtually no experience in managing non-compliant prisoners.* In fact, when asked about his level of experience with such prisoners he said he had done so 'maybe once'.<sup>293</sup>
- 11.10. Furthermore, he (and many other correctional officers) confirmed that they had received *no training in the use of spit masks.* Supervisor Joseph said that prior to Mr Morrison's incident, he had never called for, or used, a spit mask. He did not know where they were stored; he had never seen a demonstration of how to fit one; and he had never read the written instructions that accompany the Transport Hood or the warning which states: 'WARNING: IMPROPER USE OF THE TRANSPORT HOOD MAY CAUSE INJURY OR DEATH'.<sup>294</sup>
- 11.11. By way of explanation, Ms Francis surmised that the Department anticipates that leg restraints and spit masks would be used by 'senior officers only', such as members of the ERG.<sup>295</sup> If it was the case that emergency situations could only be handled by 'senior officers', the ERG or special units, the lack of training may be understandable but this was not the case. As it transpired, only one of the officers involved in

---

<sup>291</sup> Exhibit C232

<sup>292</sup> Ibid

<sup>293</sup> Exhibit C188, Transcript, pages 1324-1325

<sup>294</sup> Transcript, pages 1324, 1443-1447; Exhibit C191

<sup>295</sup> Transcript, pages 3672-3673

Mr Morrison's restraint had additional ERG training and he played only a peripheral role in the restraint.

- 11.12. When Supervisor Joseph's performance is assessed against this DCS training vacuum, it is unsurprising that when faced with an emergency situation it did not occur to him to call for standard metal leg restraints, or to stop Mr Morrison being lifted and carried without a body cuff.
- 11.13. Supervisor Joseph presented as an honest, direct and forthright witness who made concessions on a range of matters, even some which cast him in a poor light. I accept his evidence as credible and reliable.
- 11.14. *It is a serious failing of the Department for Correctional Services that it required correctional officers to work in an operational capacity which involved contact with prisoners without providing any training in the use of leg restraints or spit masks. Given the environment in which correctional officers work, the lack of training is quite extraordinary. I agree with Mr Henchcliffe KC that the subject officers should never have been placed in this position.*<sup>296</sup>
- 11.15. The evidence also sits uncomfortably with the requirements of SOP-032 (Use of Restraints)<sup>297</sup> which provides at [3.3.3] that Employees *must be trained in the use of restraint equipment prior to use.*
- 11.16. Supervisor Joseph should not be criticised for his candour or pilloried for the identified shortcomings in his performance on the day. *The real question is why the Department for Correctional Services required correctional officers to work in an operational capacity which required prisoner contact, exposure to the risk of violence and unplanned use of force without training in the use of leg restraints, spit masks and/or body cuffs.*
- 11.17. No satisfactory explanation has been provided by the Department.

---

<sup>296</sup> Written closing submissions for Members of the COLF (3 August 2021) at [122]

<sup>297</sup> Exhibit C65aah, SOP-032 (Use of Handcuffs and Other Equipment) (Version 21: 25/10/2013)

- 11.18. Supervisor Murti and other witnesses corroborated the evidence as to the lack of training. It is unnecessary to repeat their evidence.<sup>298</sup>
- 11.19. When questioned about the absence of training, Chief Executive Brown said he was unaware that correctional officers were untrained in the use of spit hoods.<sup>299</sup> In cross-examination, he acknowledged that SOP-079 (Use of Force) contained no reference to safety concerns associated with the use of spit masks and the SOP had not been reviewed on its scheduled review date (October 2014), almost two years before Mr Morrison's death.
- 11.20. Restraint refresher training
- 11.21. The Court heard evidence that attendance at restraint refresher training is mandatory so far as the Department is concerned, albeit the responsibility of ensuring that officers attend refresher training falls to the General Manager of each institution.<sup>300</sup> Ms Francis agreed it is essential for all correctional officers to receive refresher training to update their knowledge, skills and techniques.<sup>301</sup> Mr Goodall confirmed that he is responsible for identifying officers who are due for training, taking them off shift and arranging for their attendance.<sup>302</sup>
- 11.22. Ms Francis was uncertain whether refresher training is offered biennially or triennially (i.e. every two or every three years). She was unable to locate any official policy document to confirm the position. Ms Francis believes the refresher training is held every three years.<sup>303</sup>
- 11.23. During Mr Goodall's evidence some shocking statistics were revealed about the currency of restraint training and refresher training at the time of Mr Morrison's death. Mr Goodall was asked by Counsel Assisting to produce a printout from within the electronic records of the Department of the training records of correctional officers who were understood to be primarily involved in Mr Morrison's incident.<sup>304</sup> The chart below

---

<sup>298</sup> See Transcript, pages 1506-1507, 1555 (Murti); 1755 (Skuse); 1071 (Chapman); 1506-1507; see also 3106-3017 (Kent); 2436 (Connor); 2969-2970 (Fekner); 2316, 2346 (Supervisor Burnell); 5265-5266 (Supervisor Haddington)

<sup>299</sup> Transcript, page 7365

<sup>300</sup> Transcript, pages 3767-3768

<sup>301</sup> Transcript, pages 3669, 3686

<sup>302</sup> Transcript, page 822

<sup>303</sup> Transcript, page 3764

<sup>304</sup> The master printout lists 35 correctional officers. As at the date of the incident with Mr Morrison, only 11 of those officers were up to date with their restraint training, that is to say, only one third of the officers.

is Annexure ‘C’ to his addendum affidavit of 17 December 2018. The relevant columns, for the purpose of this part of the discussion, are Columns A, B and F.<sup>305</sup>

A. Correctional Officer	B. Involved in restraint or carriage to the van?	C. Present in the van?	D. Involved at the sally port?	E. Last date before 23/9/16 when undertook SFA Training	F Last date before 23/9/16 when undertook Restraint Training
Bradford		✓		23/9/15	<b>*21/9/16</b>
Burnell			✓	30/6/15	20/3/13
Chapman	✓			26/2/14	27/2/13
Connor			✓	24/8/16	20/11/13
Crowe		✓		17/12/14	None listed
Gibson	✓			12/8/15	27/3/13
Greenwood	✓			24/9/14	30/9/11
Hall	✓	✓		14/11/15	<b>*31/3/15</b>
Joseph	✓			10/6/15	19/3/13
Kay	✓	✓		23/7/14	23/6/13
Kent			✓	5/7/17	<b>*2/10/14</b>
Mail		✓		22/7/15	None listed
McLeod		✓		2/9/15	20/3/13
Murti	✓			6/8/14	None listed
Shillabeer	✓	✓		19/5/15	None listed
Skuse	✓			14/7/16	24/4/13
Sniatynskj	✓			24/8/16	19/1/12
Townsend	✓	✓		7/11/2017	<b>*2/10/14</b>

11.24. On the assumption that the training is offered triennially, *the only correctional officers who had completed the mandatory refresher training within three years at the time of Mr Morrison’s incident were COs Bradford, Townsend, and A/Supervisor Hall.*<sup>306</sup> Supervisors Joseph and McLeod had not undertaken restraint training since 19 March 2013 and 20 March 2013 respectively and no records were available for Supervisor Murti, and COs Crowe and Shillabeer.

11.25. As to consequences for non-attendance at refresher training, Ms Francis believes there are no consequences.<sup>307</sup> This evidence was not challenged by counsel representing the DCS. Ms Francis has periodically raised a number of her concerns with the

<sup>305</sup> Exhibit C179e

<sup>306</sup> N.B. Only two of the five officers who travelled in the rear of the van with Mr Morrison had up to date restraint training (A/Supervisor Hall and CO Townsend). CO Bradford had received the most recent training as at the date of Mr Morrison’s incident (i.e. on 21/9/16), but he travelled as the front passenger.

<sup>307</sup> Transcript, page 3720

Investigation Unit, her manager Mr Sexton, and State-wide Operations in the form of minutes, memoranda, emails, reports and conversations.<sup>308</sup> Ms Francis attested to there being strong opposition from the Public Service Association (‘PSA’) regarding the implementation of any consequences for correctional officers who are not up to date in their training.<sup>309</sup>

11.26. Ms Francis said if she learns of non-attendance, she escalates the matter through various channels. She said that is all she can do because, ultimately, it is for the Chief Executive to decide on and enforce consequences.<sup>310</sup> Mr Goodall shared these concerns but said he was not in a position to influence change.<sup>311</sup>

11.27. It was implicit from Ms Francis’ evidence that enforcement of the so-called mandatory refresher training is an ongoing problem at Yatala. The contents of an e-mail sent by a correctional officer to Mr Goodall provides some insight into the difficulties faced by those who are required to enforce refresher training requirements. The e-mail was tendered to the Court. In response to a written direction from the General Manager of Yatala to attend refresher training, Supervisor David Haddington wrote:

‘Without putting you on the spot, and I know this is a DCS garbage initiative, my last defensive training was in Oct 1985 when I was 23 years old, so with this garbage mandatory CRDT crap that we now have to do, my question is exactly what skills am I maintaining???’

*I’ve done quite well over the last 33 years with absolutely NO training,* so as I don’t like wasting my time or others, I’ll kindly decline your invitation, but thanks anyway.

In closing... I’m actually at a loss to know exactly what benefit anyone will receive from a one day so called refresher every two years!!!, except that it’s MANDATORY, if someone can explain the magnificent benefit that we will gain from this then I might change my mind, but as I know that no one can explain any benefit, then I won’t hold my breath waiting, anyway thanks but no thanks...

Cheers

David.<sup>312</sup>

---

<sup>308</sup> Transcript, page 772

<sup>309</sup> Transcript, page 773

<sup>310</sup> Transcript, page 3721

<sup>311</sup> Transcript, page 893

<sup>312</sup> Exhibit C177c, Annexure za, page 11

- 11.28. Supervisor Haddington acknowledged that he should not have sent the e-mail and described it as a ‘bad call’. He has since completed restraint refresher training.<sup>313</sup>
- 11.29. Chief Executive Brown was asked what the Department has done since Mr Morrison’s death to address the non-compliance issue. He said the first response was to ‘codify’ mandatory training obligations. The second was ‘to improve accountability and responsibility for leading and delivering on our training’.<sup>314</sup>
- 11.30. It is unclear what these statements actually mean. Codification of requirements and motherhood statements do nothing to address the issue of enforcement of training. The question remains: Are there meaningful consequences for correctional officers who do not comply with refresher training obligation?
- 11.31. It is noted that the DCS internal investigator, Mr Muller, referred in his report to the position of the Queensland Corrective Services (‘QCS’) and observed that when an officer’s qualification for a particular competency had expired, that officer ‘is not permitted to have contact with any prisoner in a QCS institution until they have successfully completed the required refresher training’.<sup>315</sup> To my mind, it is difficult to argue against the adoption of such a policy. The DCS has a duty of care to prisoners and to its staff. It is essential that correctional officers have up to date knowledge and refresher training in core competencies such as restraint and first aid. I will come to the issue of first aid training and CPR qualifications in due course.
- 11.32. The evidence given by the Chief Executive inspires no confidence. When asked directly by Counsel Assisting whether he supported a policy that correctional officers should be suspended from operational duties if they have not completed restraint refresher training to maintain competency, Mr Brown made it clear that he *did not* support such a policy.<sup>316</sup>
- 11.33. Although the above statistics have improved since Mr Morrison’s death, Ms Francis observed that some of her superiors are still unsatisfied with attendance rates.<sup>317</sup>

---

<sup>313</sup> Transcript, pages 5260-5261

<sup>314</sup> Transcript, pages 7341-7342; Exhibit C268, DB18

<sup>315</sup> Exhibit C64aaay, page 109

<sup>316</sup> Transcript, pages 7343, 7483

<sup>317</sup> Transcript, page 3668; Exhibit C177h; Exhibit C179, pages 3-4; Transcript, pages 3764, 3772

## 12. **The placement of Mr Morrison in the van and the van journey to G Division**

12.1. Should Mr Morrison have been transferred to G Division?

12.2. Counsel for the Morrison family submitted that Mr Morrison should never have been taken to G Division in the first place and that it was done as punishment for his physical attack upon the four correctional officers.

12.3. Section 36 of the *Correctional Services Act, 1982* provides for the separation of prisoners if the Chief Executive is of the opinion that it is desirable to do so.

### **Power to keep prisoner apart from other prisoners**

(1) A prisoner must not be kept separately and apart from all other prisoners in the correctional institution except in accordance with this section.

(a) *in the interests of the proper administration of justice where an investigation is to be conducted into an offence alleged to have been committed by the prisoner;*  
or

(b) in the interests of the safety or welfare of the prisoner; or

(c) in the interests of protecting other prisoners; or

(d) *in the interests of security or good order within the correctional institution.*

12.4. SOP-012 sets out the obligations and responsibilities in relation to the separation of prisoners.

12.5. I am satisfied that it was necessary to separate Mr Morrison from other prisoners and that this was done in compliance with DCS SOP-012 (Separation of Prisoners) and section 36 of the *Correctional Services Act*.<sup>318</sup> There is no evidentiary support for the contention that Mr Morrison should not have been sent to G Division, or that the decision was made as a punitive measure.<sup>319</sup>

12.6. Counsel for the Morrison family further submitted that the van was used ‘to remind prisoners who was in charge’;<sup>320</sup> that the transport to G Division was ‘not transport just for movement but a punishment’;<sup>321</sup> and that ‘no policy which required officers [to travel] in the back of the van with a prisoner could be justified for anything other than

---

<sup>318</sup> See e.g. Supplementary Closing Submissions for Mr Hall at [13]

<sup>319</sup> See written submissions on behalf of the Morrison family, page 90 (1<sup>st</sup> and 2<sup>nd</sup> dot points)

<sup>320</sup> See written submissions on behalf of the Morrison family at [314]

<sup>321</sup> Ibid at [311]

oppressive or threatening practice'.<sup>322</sup> The evidence does not support this claim. G Division is located outside of the geographical perimeters of the Yatala Prison. The escort van is necessary for security purposes. The use of pejorative and emotive language is unhelpful and distracts attention from the evidence. Suffice it to say there is no evidentiary basis for the contention that the van was used as a punishment.

12.7. The placement of Mr Morrison in the van

12.8. It is undisputed that Mr Morrison was carried through exit Door 7 and placed directly into the van.

12.9. CO Sniatynskj saw Mr Morrison being carried through Door 7. She said he was still screaming 'the same abuse at staff'.<sup>323</sup> CO Greenwood observed that Mr Morrison was 'still struggling' and 'possibly bucking'. CO Nickson remembered the bucking and it was one of the factors that alerted him to the risk that Mr Morrison could be dropped by the carrying party.<sup>324</sup> CO Warner also saw ongoing physical resistance as Mr Morrison was carried to the van.<sup>325</sup>

12.10. With the exception of Supervisor Murti, all of the officers who were cross-examined about the placement of Mr Morrison in the van attested to him being put into the rear section head first, face down and in a prone position.<sup>326</sup> Supervisor Murti was the only witness who thought that Mr Morrison's head was tilted to the side.<sup>327</sup> All witnesses agreed that Mr Morrison was wearing the spit mask when he was placed in the van, and it was not removed for the journey.

12.11. The weight of the evidence favours the view that Mr Morrison was carried directly to the van, placed into the rear section head first and face down in a prone position and I so find.

12.12. In cross-examination, Supervisor Joseph agreed that he gave no direction to remove the spit mask. He said that the Yankee 9 supervisor (A/Supervisor Hall) was in charge of

---

<sup>322</sup> Ibid at [314]; see also closing submissions on behalf of Mr Hall in reply to Counsel Assisting's submissions, 3 August 2021 at [29]-[34 and supplementary written closing submissions for Mr Hall at [14]

<sup>323</sup> Exhibit C199, pages 3-5; Transcript, pages 2106, 2135

<sup>324</sup> Exhibit C203, page 4

<sup>325</sup> Exhibit C198, page 4

<sup>326</sup> Transcript, pages 3599-3602 (CO Greenwood); Exhibit C203, page 4 (CO Nickson); Transcript, pages 1326, 1342 (Supervisor Joseph)

<sup>327</sup> Exhibit C189, page 4; Transcript, pages 1570, 1599

the escort and that included any decisions about the spit mask. When pressed about the potential risk of Mr Morrison being placed face down while wearing the mask, Supervisor Joseph candidly stated that he did not consider this at the time.<sup>328</sup>

12.13. Had the subject officers received training in the use of the van, the safe placement of prisoners in the van and monitoring their safety during transit?

12.14. *The evidence received by the Court on this topic revealed another gaping hole in Departmental training and a failure to implement essential Standard Operating Procedures.* The following evidence is undisputed:

12.14.1. That correctional officers received *no training* in the use of the Yatala internal escort van.

12.14.2. That officers received no instruction as to the placement of prisoners in the van and/or how to monitor their safety during transit.

12.14.3. That correctional officers who were responsible for the escort of prisoners were left to work it out for themselves. They had to learn 'on the job'.

12.14.4. That ad hoc practices developed in relation to the van as to where in the van prisoners travelled, how they were placed in the van and the number of officers who would accompany them.

12.14.5. No audit or checks were conducted on these practices and the van was not equipped with audio/visual recording equipment or live feed capacity to the Control Room which may have facilitated such reviews.

12.14.6. That at the time of Mr Morrison's death, no Standard Operating Procedure or Local Operating Procedure had been implemented by the Department to provide guidance and instruction on the van and its use.

12.14.7. That the supervisor who was placed in charge of the escort team on the day of the Morrison incident (A/Supervisor Hall/Yankee 9) had limited experience in the role.

---

<sup>328</sup> Exhibit C188, pages 5, 8; Transcript, pages 1489-1490, 1495-1496

- 12.15. It is unnecessary to revisit the evidence given by the subject officers about the ad hoc practices that had developed in relation to the placement and positioning of non-compliant prisoners in the van. Suffice it to say that the evidence received by the Court related primarily to prisoners who were handcuffed to the rear with no other form of restraint. As I understood the evidence, none of the subject officers had been involved in transporting a violent, non-compliant prisoner who had been restrained by rear handcuffs, leg restraints and a spit mask.
- 12.16. With that proviso, I am satisfied that at the time of Mr Morrison's death, it was not unusual for non-compliant prisoners who were handcuffed to the rear, to be placed face down in a prone position in the rear section of the van.
- 12.17. The only officer who demonstrated some insight into the safety issues was CO Bradford who recalled learning at a training day that if a prisoner is handcuffed to the rear, his head must be placed to the side 'so the prisoner can breathe', and 'the prisoner's head must not be placed face down'.<sup>329</sup> However, on the day of the incident CO Bradford travelled as the front passenger in the van.
- 12.18. Did too many officers travel in the rear section with Mr Morrison?
- 12.19. The Court heard a range of views about how many officers should travel with a non-compliant prisoner, where in the van they should travel, and whether the prisoner sits upright or in a prone position during transit.<sup>330</sup> It is unnecessary to repeat this evidence. The effect of the evidence was that the number of officers who would accompany a prisoner depended on the prisoner's demeanour and his level of non-compliance. My impression of the evidence is that no consistency guided such decisions, and it was not unusual for several officers to travel in the rear section of the van with a prisoner.
- 12.20. Counsel Assisting and counsel for the Morrison family submitted that, given the level of restraint, five correctional officers were simply not required to travel with Mr Morrison in the rear compartment. It was too many, particularly given the narrow confines of the rear compartment.

---

<sup>329</sup> Exhibit C243, page 3

<sup>330</sup> See Exhibit C246, (Kay); Transcript, pages 1492-1493, 1495-1496 (Joseph); Exhibit C243, page 51 (Bradford); C245, pages 14-15 (Hall); Exhibit C247, page 6 (Mail)

12.21. The tenor of the submissions made by counsel for the Morrison family and, to a lesser extent, Counsel Assisting, suggest that a level of mal fides accompanied the decision of the five officers to enter the rear compartment. Supervisors were criticised for ‘allowing’ this to occur and for ‘failing’ to direct a lesser number of officers to travel.

12.22. I have considered these submissions. Particular care must be taken before drawing adverse inferences against individuals without assessing the context in which decisions and the impugned conduct occurred. It is essential to have regard to the fact that at the time of Mr Morrison’s death:

- No Standard Operating Procedure had been implemented by DCS to guide officers about the use of the van.
- Correctional officers received no practical training about the placement of prisoners in the van, the safe monitoring of prisoners during transit or indeed how many officers should travel with a non-compliant prisoner.
- It was not uncommon for handcuffed non-compliant prisoners to be placed in a prone position in the rear of the van.
- Chief Executive Brown was unable to cast any light on how the practice of transporting prisoners in the prone position had developed.<sup>331</sup>
- Ad hoc and inconsistent practices had developed.
- It was not unusual for several officers to travel with a non-compliant prisoner.
- None of the subject officers had been trained in the use of spit masks and none of the officers had read the written instructions which contained a warning about the dangers associated with incorrect use of the spit mask.
- The Yankee 9 supervisor had limited experience in the role.
- The holding cells supervisor, Supervisor Joseph, had virtually no experience in managing non-compliant prisoners.

12.23. Additionally, it must not be forgotten that the Department permitted and indeed required these officers to use the van without being trained.

---

<sup>331</sup> Transcript, page 7359

- 12.24. In short, when assessing the performance of individual officers, especially perceived shortcomings in their performance, *one must consider what was reasonable in the circumstances*. Clearly, emotions would have been heightened and split second decisions had to be made. In the circumstances, rather than demonstrating mal fides, it is entirely possible that in the pressure of the moment the subject officers operated in ‘autopilot’. In other words, they applied the ad hoc procedures they had been using with little or no thought to the number of officers who travelled with Mr Morrison, or the fact that he was still wearing the spit mask. There is certainly no evidentiary support for the suggestion made by counsel for the Morrison family that mal fides accompanied the decisions or that ‘keeping the spit hood on for that journey was ... to serve no purpose other than to punish’.<sup>332</sup> These inflammatory claims are not supported by a balanced assessment of the evidence.
- 12.25. Chief Executive Brown confirmed that an upgrade to Yatala is underway which includes the development of a new wing which will remove the need to use the internal escort van for travel within the prison. In the meantime, a direction has been issued by the Deputy Chief Executive that prisoners are no longer to be transported in the prone position in the internal van.<sup>333</sup> These are welcome practical initiatives but ones which of course provide no comfort to the Morrison family.
- 12.26. The van journey
- 12.27. I turn now to the van journey. A number of issues are not in dispute. The route taken by the van to G Division was tracked through several CCTV cameras by the Control Room staff (‘the van vision’).<sup>334</sup>
- 12.28. Mr Morrison was placed in the van at 11:33:56 and the back door of the van was closed at 11.34.17.
- 12.29. The van commenced its journey at 11:34:36 and came to a halt in the G Division Sally port at 11:36:31, a journey of just under two minutes (i.e. 11:34:36 to 11:36:22).

---

<sup>332</sup> Ibid at [317]

<sup>333</sup> Transcript, page 7311; Email from Deputy Chief Executive to all DCS staff on 6 June 2018 and annexure of instructions: Exhibit C188a, page 4, Transcript, page 7359

<sup>334</sup> Statement of Michael Edwards: Exhibit C23, page 4; Incident Log-Control Room; Exhibit C138 (this exhibit is an overhead photograph depicting the route)

12.30. Mr Morrison was removed from the van and placed on the floor of the sally port at 11:36:42.

12.31. The vision from the external cameras and a map tendered in Court shows the route of travel. The relevant times and van locations are set out in the chart below.

TIME	DESCRIPTION - Van route holding cells area to G Division sally port
*As displayed on the vision time stamp <sup>335</sup>	
11:33:42	The carrying party emerges from exit door 7
11:33:56	Mr Morrison is placed in the back of the van outside of exit door 7 at the holding cells building
11:34:17	The back door of the van is closed
11:34:36	The van begins to drive away, it passes B Division, the Assembly Hall and Recreation Yard
11:35:25	Van passes through Sliding Door 6
11:35:35	Van passes the High Dependency Unit
11:35:39	Van passes through Roller Door 7
11:35:43	Van passes through Roller Door 8
11:35:56	Van turns left into the road from which it will reverse into the G Division sally port
11:36:03	Van disappears from the vision as it begins to prepare to reverse into the sally port
11:36:22	Van reappears in the vision and is in the process of reversing into the sally port
11:36:31	Van has stopped reversing into the sally port and the front passenger door is opened, ready for the passenger to exit the vehicle
11:36:35- 11:36:38	A Code Black (medical emergency) is received and broadcast from the Control Room by CO Edwards <sup>336</sup>
11:36:42	Mr Morrison is removed from the van and placed on the floor of the sally port
11:37:01	Van begins to drive forward out of the sally port

12.32. The practical effect of the Court's self-incrimination rulings was that van officers could not be cross-examined about their role, if any, in Mr Morrison's placement in the van and any aspect of the van journey itself.<sup>337</sup> With the exception of Supervisor McLeod who did not submit a report pending legal advice, the prohibition on cross-examination included any examination of the contents of the employee incident reports of the other seven van officers, so far as the contents related to the impugned topics.

12.33. Counsel for the Morrison family, and Counsel Assisting, submitted that on the available evidence it is open to the Court to find that acts and omissions occurred during the van

<sup>335</sup> N.B. The time stamp on the vision is 5 seconds faster than the actual time: Georg Report, page 20, paragraph 7.6

<sup>336</sup> Refer Exhibit C101 Statement of Dwayne Longbottom, Appendix A - Records the Code Black being called at 11:36:30am; Exhibit C23b supplementary statement of Michael Edwards

<sup>337</sup> As to the Muller interviews, the officers who took part in the interviews declined to answer questions relating to the van journey, citing privilege

journey which caused or contributed to Mr Morrison's death.<sup>338</sup> The nub of the submission is that Mr Morrison became unresponsive in the van; that correctional officers in the rear compartment must have realised he was unresponsive and not breathing; that they failed to call a Code Black (medical emergency) or to direct the van to divert to the medical centre, and failed to render immediate medical assistance themselves by commencing chest compressions/CPR.

12.34. Counsel Assisting invited the Court to find that A/Supervisor Hall did not remain seated during the whole of the journey and that at one point he was standing over Mr Morrison.<sup>339</sup> It was further submitted that the internal dimensions of the rear compartment, together with Mr Morrison's position and the number of officers inside, made it 'inevitable' that the van officers' feet would have been placed on Mr Morrison's body (and by implication would have increased the pressure bearing down on Mr Morrison's body).<sup>340</sup>

12.35. These are very serious allegations. It was acknowledged by both counsel that the submissions rely primarily on inferences being drawn from the van officers' employee incident reports, the contents of which are untested by cross-examination. In seeking to address the issue, Ms O'Connor and Ms Sibree made an unusual submission:

'The family note that *the Coroner can use the scant and untested materials before the Inquest* to made (sic) findings about the conduct of the van [word omitted] and to draw conclusions about the conduct.'<sup>341</sup>

12.36. The submission is plainly a reference to section 24(a) of the *Coroners Act 2003* which provides that, in holding an inquest, the Coroners Court is not bound by the rules of evidence and may inform itself on any matter 'as it thinks fit'.<sup>342</sup>

12.37. That may be so, however, it has to be carefully borne in mind by counsel appearing on behalf of witnesses in a coroner's inquest, or for other persons whose behaviour may be scrutinised and evaluated in the inquest, that the coroner is permitted to receive and

---

<sup>338</sup> See written submissions on behalf of the Morrison family (214 pages) at [311]-[351]; Closing submissions by Counsel Assisting (5 July 2021) at [76]-[89.10]

<sup>339</sup> Ibid at [89.1]

<sup>340</sup> Closing submissions by Counsel Assisting (5 July 2021) at [84]; N.B. Ms O'Connor SC did not support the submission

<sup>341</sup> Written submissions on behalf of the Morrison family at [341]

<sup>342</sup> Section 24(a) of the *Coroners Act 2003*

act upon evidence and material that would not necessarily pass muster in a criminal court. Naturally, the weight to be accorded to material that could be inadmissible in a criminal court will vary and depend on all of the circumstances. Thus, while findings are made in the Coroners Court on the balance of probabilities, the degree of satisfaction of a particular fact, and the strength of evidence necessary to establish that fact, may alter according to the nature of the fact sought to be found or the overall finding that is sought to be made, and indeed to the nature of the evidence in support of the finding.<sup>343</sup>

12.38. The principles of *Briginshaw v Briginshaw* apply in coronial proceedings. The seriousness of an allegation made, or the gravity of the consequence flowing from a particular finding are considerations which must affect the answer to the question of whether an issue has been proved on the balance of probabilities.<sup>344</sup> The correct approach is well summarised by Gordon J in the High Court decision of *In Re Day*:

*‘...the seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether an issue has been proved to the reasonable satisfaction of the tribunal... This does not mean that the standard of persuasion is any higher than the balance of probabilities. It does mean that the nature of the issue necessarily affects the process by which reasonable satisfaction is reached.’*<sup>345</sup>

12.39. As stated by Gordon J, where direct proof is not available and satisfaction depends on inference, *there must be something more than ‘mere conjecture, guesswork or surmise’, more than ‘conflicting inferences of equal degrees of probability so that the choice between them is [a] mere matter of conjecture’.*<sup>346</sup>

12.40. I have examined the van officers’ incident reports, the inferences which I have been invited to draw from their contents, the submissions of counsel for the Morrison family and Counsel Assisting, and the suggested findings as to the alleged acts and omissions attributed to the van officers during the van journey. With respect, the submissions are misconceived.

<sup>343</sup> See *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336; see also supplementary written closing submissions for Mr Hall at [13]-[24]

<sup>344</sup> See for example *Re Day* per Gordon J [2017] HCA 2; 91 ALJR 262; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; see also written closing submissions for Members of the COLF (3 August 2021) at [4]-[14]

<sup>345</sup> *Re Day* per Gordon J [2017] HCA 2; 91 ALJR 262

<sup>346</sup> *Op.cit*

- 12.41. Firstly, in the absence of cross-examination, it is by no means clear what the van officers meant in their employee incident reports by terms such as ‘unresponsive’, ‘non-responsive’ or ‘unresponsive and quiet’ (see e.g. CO’s Townsend,<sup>347</sup> Shillabeer,<sup>348</sup> and Mail).<sup>349</sup> Did they mean that Mr Morrison had been engaging in conversation and then he ceased talking? Did they mean he had stopped breathing or appeared to have stopped breathing? Alternatively, could it mean that an officer was shaking him and getting no physical or verbal response? These issues could not be clarified or tested. They remain unresolved. To compound matters, the submissions of counsel for the Morrison family use the terms ‘unresponsive’ and ‘not breathing’ interchangeably as if their meaning is clear.
- 12.42. Secondly, there are inconsistencies and discrepancies in and between the van officers’ employee incident reports such as *when* in the journey critical observations were made about Mr Morrison’s breathing (e.g. CO Crowe),<sup>350</sup> and when changes in Mr Morrison’s facial colour was observed (e.g. A/Supervisor Hall).<sup>351</sup> For example, if such observations were made early in the journey, legitimate questions might arise as to why a Code Black was not immediately called and/or why Mr Morrison was not taken directly to the High Dependency Unit rather than travelling on to G Division. Alternatively, if the observations were made shortly before the van arrived at G Division (as suggested by A/Supervisor Hall), there would be no basis to criticise the timing of the Code Black or the van proceeding to the G Division Sallyport. To the extent that A/Supervisor Hall’s incident report appears to contradict the statement he made to Supervisor Burnell on arrival, it could not be tested by cross-examination.
- 12.43. Thirdly, other favourable inferences which are reasonably open to be drawn on the available evidence are not addressed in the said submissions.
- 12.44. There are so many other unanswered questions about the van journey (some of which relate to whether Mr Morrison’s cardiac arrest occurred in the van and, if so, when in the journey it occurred). For example: Did Mr Morrison remain face down throughout the journey, or was his head tilted to the side? If he was talking, was his speech

---

<sup>347</sup> Exhibit C150, pages 8-9; Finding, Appendix B

<sup>348</sup> Exhibit C150, page 8; Finding, Appendix B

<sup>349</sup> Exhibit C258, ‘DK1’

<sup>350</sup> Exhibit C150, page 11; Finding, Appendix B

<sup>350</sup> Exhibit C150, page 12; Finding, Appendix B

<sup>351</sup> Refer Exhibit C150

intelligible and coherent? When he stopped talking, did Mr Morrison continue to make noises or did he become suddenly quiet? Was the spit mask adjusted, or removed and replaced during the journey and, if so, why? Could A/Supervisor Hall see ‘through’ the spit mask, as he reported, or was this a careless description of the circumstances in which he observed the change in Mr Morrison’s facial colour? Did any of the officers realise that a medical emergency was unfolding, and/or that CPR was required? Can it be safely inferred that Mr Morrison remained face down for the entire journey?

12.45. *These unanswered questions cannot be ignored and the application of the Briginshaw principles was not addressed in the submissions. Indeed, the said counsel made no reference to Briginshaw at all.*

12.46. In summary, on the available evidence, there is no sound evidentiary foundation to draw the inferences sought by the said counsel or to make the findings that are proposed in relation to the van journey.

12.47. Before I leave the topic of the van journey it is apposite to mention some of the other adverse findings against individuals that have been urged upon the Court. Particular criticism was levelled at the performance of supervisors during the restraint. For example, it was submitted by Counsel Assisting that A/Supervisor Hall ‘failed to provide any supervision to other officers during the restraint process’,<sup>352</sup> that Supervisor McLeod ‘failed to provide any supervision’,<sup>353</sup> and that Supervisor Joseph had responsibility to supervise and manage his staff but he failed to discharge it.<sup>354</sup> Counsel Assisting was particularly critical of Supervisor Murti whom he described as ‘keen in his evidence to deny that he was taking charge of the situation, even though that was his task as a supervisor’.<sup>355</sup> It was suggested that parts of his evidence should be rejected including his ‘denials’ about giving directions to other officers. It was acknowledged that Supervisor Murti assumed some responsibility for supervising staff, but ultimately it was argued that he ‘utterly failed to bring any control or order to the restraint process’.<sup>356</sup> The nub of the submission was that the restraint was ‘ill thought out and

---

<sup>352</sup> Ibid at [61]

<sup>353</sup> Ibid at [62]

<sup>354</sup> Ibid at [62]

<sup>355</sup> Ibid at [64]; see for example Transcript, pages 1508-1509, 1582-1586, 1590-1597

<sup>356</sup> Ibid at [64]

uncoordinated’, and that ‘Each of the supervisors should have done much more than they did’.<sup>357</sup>

- 12.48. I disagree with this analysis. *It is essential not to lose sight of the fact that a coronial inquest is primarily a fact-finding exercise and not a method of apportioning guilt.*<sup>358</sup> This is not to say, however, that individuals or other entities will not be criticised in a coronial finding. If a departure from an appropriate standard of care has been found to have occurred in connection with a death, the Court will robustly say so. It is often necessary to identify fault in order to devise means by which a dangerous practice generally, or the idiosyncratic behaviour on the part of a specific individual, can be corrected by way of coronial recommendation. That said, in the context of this case, given the glaring gaps that have been identified in officer training and other matters, caution must be taken before attributing blame to individuals for perceived shortcomings in their performance on the day. As stated by Mr Henschcliffe KC in written submissions:

‘It is always possible after an event has ceased and with the wisdom of hindsight, to identify some further step or steps that could have been taken to avoid or reduce the risk of injury and use that to thereby draw adverse inferences against a person in relation to their conduct or omissions during the event.

But that is not the task. Such wisdom of hindsight may be useful in this jurisdiction in terms of formulating a recommendation as to policy or training, but that is not what is being sought here...It is unfair...’<sup>359</sup>

- 12.49. When assessing whether the named supervisors have deviated from an appropriate standard in connection with the management of Mr Morrison, I respectfully suggest that when considered in its full context, the submission that Supervisor McLeod ‘failed to provide any supervision’ does not bear scrutiny. First, Supervisor McLeod was rostered as a B Division supervisor. No evidence was led to suggest that a supervisor from another division who responds to a distress alarm in another division is expected to take a supervisory role. Secondly, by the time Supervisor McLeod arrived, the holding cells supervisors were already giving directions and attempting to control the

---

<sup>357</sup> Ibid at [65]

<sup>358</sup> See *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625

<sup>359</sup> Written closing submissions for Members of the COLF at [112]-[113]

restraint. I agree with the submission made on behalf of Supervisor McLeod that if he had started giving directions it would have confused the situation even more.<sup>360</sup>

12.50. It was submitted that A/Supervisor Hall (Yankee 9 supervisor) also failed to take a supervisory role during the restraint. The submission made by counsel on behalf of Supervisor McLeod applies with equal force to A/Supervisor Hall, namely, that if he had started giving directions during the restraint in the holding cells area it would have added confusion to the situation. This conclusion is reinforced by the fact that A/Supervisor Hall's primary role was to lead the Yankee escort team.<sup>361</sup>

12.51. Nor do I accept the submission that the movement of Mr Morrison was 'contrary to all previous training'. That is not correct. *The fact is that with the exception of one correctional officer who played only a peripheral role in Mr Morrison's restraint, none of the other officers had been trained in the use of leg restraints and spit masks.* It is also safe to infer that they had received no training in the use of body cuffs or restraint belts, because such training was reserved for special units (see SOP-079). To compound matters, no Standard Operating Procedure had been implemented by the Department in relation to the duties and obligations of officers during the management of major incidents.

12.52. In summary, the problem was not that the movement of Mr Morrison was 'contrary to all training'; I consider the problem was the gaping hole in the training of correctional officers at Yatala as identified in this Finding, and the many other shortcomings I have mentioned.

12.53. This is the context in which the performance of individuals must be assessed.

### **13. Events in the G Division sally port**

13.1. On 23 September 2016, Supervisor Gordon Burnell was the rostered supervisor for G Division. COs Steve Connor, Mark Feckner, Jason Kent and Kenneth London were the rostered G Division officers on this day.

---

<sup>360</sup> See closing submissions on behalf of Neale McLeod (3 August 2021) at [3.5]-[3.6], [7]-[10]

<sup>361</sup> See also closing submissions on behalf of Mr Hall in reply to Counsel Assisting's Submissions, 3 August 2021 at [23]-[28]

- 13.2. On hearing the Code Yellow, all prisoners in G Division were returned to their cells in anticipation of Mr Morrison's arrival. Supervisor Burnell anticipated that the incoming prisoner would be restrained in some way.<sup>362</sup>
- 13.3. To determine what happened at the sally port the Court relied on enhanced CCTV vision of the events ('the sally port vision'),<sup>363</sup> written statements tendered to the Court, and the oral evidence of several witnesses (noting that the van officers could not be cross-examined about these events due to the Court's rulings on the application of the self-incrimination privilege).
- 13.4. So far as the evidence relates to the sequence of events at the sally port, much of it was undisputed. I am satisfied that the below chart sets out an accurate sequence of events.

TIME	DESCRIPTION - Arrival of van at G Division sally port
*As displayed on the vision time stamp.	
11:36:25	The van arrives at G Division and reverses into the sally port Supervisor Burnell and COs Connor, Kent, Feckner and London are waiting in the sally port to receive Mr Morrison
11:36:32	The rear van door is opened by COs Kent and Connor CO Bradford has exited the front passenger door of the van
11:36:34	CO Crowe exits the rear of the van
11:36:37	CO Mail exits the rear of the van
11:36:38	CO Townsend exits the rear of the van and takes hold of Mr Morrison's feet
11:36:35- 11:36:38	The Code Black for Mr Morrison is called <sup>364</sup>
11:36:42	COs Townsend, Connor, Mail and Shillabeer lift Mr Morrison from the van and place him on the floor of the sally port
11:36:44	A/Supervisor Hall exits the rear of the van Supervisor McLeod exits the van with a radio in his hand
11:36:47	COs Shillabeer, Connor and Mail are crouched near Mr Morrison's head in the sally port CO Townsend appears to be attempting to remove the plastic flex cuffs on Mr Morrison's ankles
11:36:48	Mr Morrison is rolled onto his right side into the recovery position His wrists and ankles are still restrained <sup>365</sup>

<sup>362</sup> Transcript, pages 2325-2327, 2359

<sup>363</sup> Exhibit C65a, Appendix F: I am satisfied that the correctional officers who are depicted in the sally port vision are correctly identified by name and number in the Appendix

<sup>364</sup> The time of the Code Black was established by reference to a recorded telephone call from the Control Room to the South Australian Ambulance Service. This call was recorded and transcribed. The SAAS call commenced at 11:33:41. During the call, a male voice can be heard in the background saying, 'Code Black, G Division sally port'. By reference to the call and the evidence of Brevet Sergeant Dwayne Longbottom and Michael Edwards, I am satisfied that the Code Black was broadcast by Mr Edwards between 11:36:35-11:36:38. Refer Exhibit C101 and Exhibit C23b. I am satisfied that by this time the van had reversed into the sally port and was stationary in the sally port, and that Mr Edwards is mistaken in his recollection that the van was still reversing into the sally port when the Code Black was called. I am also satisfied that CO Kay's recollection of the Code Black being called a few seconds earlier, at 11:36:10 (as reported to police), is erroneous (Exhibit C158). I find that the Code Black was called between 11:36:35 and 11:36:38.

<sup>365</sup> At 11:37:01, the van is driven out of the sally port and parked opposite the entrance where it remains until 12:43:23. The van is moved from its position to its usual parking space at B Division (Exhibit C255).

TIME	DESCRIPTION - Arrival of van at G Division sally port
*As displayed on the vision time stamp.	
11:37:53	Supervisor McLeod brings a defibrillator into the sally port and prepares it with CO Kent Mr Morrison is rolled onto his back by COs Shillabeer, Connor and A/Supervisor Hall
11:39:00	Dr Farrell and nurses Harris and Elstob arrive in the sally port with a medical cart Dr Farrell checks Mr Morrison
11:39:16	CO Connor commences chest compressions
11:47:31	The SA Ambulance Service (SAAS) arrives
11:48:04	The first SAAS paramedics enter the sally port
11:49:50	The paramedics take charge of the resuscitation process
12:25:00	12 lead tracing obtained by paramedics
12:36:00	Mr Morrison is placed into an ambulance and taken to the RAH

- 13.5. Mr Morrison is removed from the van at G Division
- 13.6. I turn to the removal of Mr Morrison from the van.
- 13.7. I am satisfied that the Code Black distress alarm was activated from inside of the van before the van door is opened. I find that it was called by Supervisor McLeod.
- 13.8. The rear van door was opened by COs Kent and Connor at 11:36:32. Supervisor Burnell was present. The evidence has established beyond doubt that on removal from the van Mr Morrison was wearing handcuffs, leg restraints and the spit mask and I so find.
- 13.9. There was a verbal exchange between Supervisor Burnell and A/Supervisor Hall around 20 seconds after Mr Morrison was removed from the van. I accept Supervisor Burnell's evidence that A/Supervisor Hall said something like, 'Hey, he's blue'. Supervisor Burnell thought he seemed surprised at Mr Morrison's condition, as if he had not noticed the change in colour until the van door had opened.<sup>366</sup> However, in his oral evidence, Supervisor Burnell confirmed that A/Supervisor Hall said Mr Morrison had turned blue 'on approach to G Division'.<sup>367</sup> He also recalled him saying that Mr Morrison was not breathing, or words to that effect. This recollection is consistent with Supervisor Burnell's employee incident report (submitted at 13:15 hours on the day of the incident) which states, 'Internal escort supervisor officer Trent Hall informed

<sup>366</sup> Transcript, pages 3070-3071

<sup>367</sup> See also Transcript, pages 2331, 2349; Exhibit C150, page 7

me that the prisoner had just turned blue on them ...on their approach to G Division' and 'he believed the prisoner was not breathing'.<sup>368</sup>

- 13.10. Supervisor Burnell instructed officers to lift Mr Morrison from the van, remove the spit mask and the restraints, lay him in the recovery position and to check for a pulse.<sup>369</sup> These were appropriate directions.
- 13.11. When did the G Division officers realise there was a medical emergency?
- 13.12. COs Connor and Kent were standing at the rear of the van. CO Connor said he noticed that Mr Morrison was in a prone position. CO Connor observed that he was wearing handcuffs and leg restraints, and *he thought Mr Morrison's head might have been tilted to one side*.<sup>370</sup>
- 13.13. COs Connor and Kent said they had tried to talk to Mr Morrison before removing him from the van but there was no response.<sup>371</sup> CO Connor put his hands on Mr Morrison and there was no physical movement or response. When they slid Mr Morrison out of the van and placed him on the ground, CO Connor described him as 'a dead weight'. At some point he recalled hearing A/Supervisor Hall say, 'I think he's turned blue'. CO Connor could not say exactly when he heard that statement being made. His best recollection is that it was made when Mr Morrison was being removed from the van and it was only then that it was realised that immediate assistance was required.
- 13.14. Supervisor Burnell and COs Connor and Kent were honest and credible witnesses who I find were doing their best to recall this sequence of events. I accept that COs Connor and Kent initially thought they were dealing with a violent, non-compliant prisoner and I find they did not register it was a medical emergency until they had removed Mr Morrison from the van.<sup>372</sup>
- 13.15. I am satisfied that the directions given by Supervisor Burnell were appropriate (noting that he also called a Code Black at around this time).

<sup>368</sup> Exhibit C150, page 22 (Employee Incident Report)

<sup>369</sup> Exhibit C150, page 6 (Employee Incident Report)

<sup>370</sup> Transcript, pages 2468-2469: N.B. This piece of evidence, which I accept, is relevant to the earlier issue I have discussed in relation to the Court's inability to make any finding about Mr Morrison's head position throughout the van journey

<sup>371</sup> Transcript, page 2467

<sup>372</sup> Transcript, pages 2327, 2470-2471

- 13.16. I find that after Mr Morrison was placed on the ground he was found to be cyanosed and unresponsive. At this point it was evident to all present that it was indeed a medical emergency.
- 13.17. When was the spit mask removed?
- 13.18. Supervisor Burnell noticed that Mr Morrison was wearing a spit mask when he was removed from the van. He could not recall whether he directed the removal of the spit mask before or after A/Supervisor Hall spoke to him.<sup>373</sup> He recalled seeing the back of Mr Morrison's head and his legs at around this point in time, but he could not see his face or the spit hood being removed.<sup>374</sup>
- 13.19. CO Connor's best recollection was that the spit mask was removed 'at some point' after Mr Morrison was removed from the van. He noticed that Mr Morrison's lips were blue when he was on the ground, but he could not recall who removed the mask, or exactly when that occurred. He did not think it was done by himself or CO Kent.<sup>375</sup>
- 13.20. It is not possible to discern from the sally port vision, or the other evidence, precisely when the spit mask was removed. By reference to the time Mr Morrison was removed from the van (at 11:36:42), the fact that the mask is visible on the ground (at 11:37:59), and the fact that Supervisor Burnell is kicking an item away which I am satisfied was the spit mask (at 11:38:03), I find that the mask was removed sometime between 11:36:42 and 11:37:59. I cannot be more precise.
- 13.21. As to A/Supervisor Hall's employee incident report that the spit mask was removed *before* Mr Morrison was removed from the van, I find this statement is plainly wrong.<sup>376</sup> All of the evidence points against it. I have been urged by counsel for the Morrison family to make an adverse finding against A/Supervisor Hall, namely, that his employee incident report contains a deliberate misstatement of fact. It would be inappropriate to make such a finding in the absence of cross-examination of the author. A/Supervisor Hall could have been mistaken and may well have conceded as much in cross-

---

<sup>373</sup> Transcript, pages 2328, 2350-2351

<sup>374</sup> Transcript, page 2347

<sup>375</sup> Exhibit C205, page 3 and Annexure 1, page 1; Transcript, page 2471

<sup>376</sup> Exhibit C150, page 7

examination. Alternatively, cross-examination may have cast a more sinister light on the matter. I simply do not know.

13.22. The timing of the commencement of chest compressions and CPR

13.23. Mr Morrison was placed on the ground at 11:36:42. I find that the first chest compressions were not delivered until 11:39:16 (and at the direction of Dr Farrell).

13.24. I will come to the evidence of Dr Flabouris and his opinion about the timing of CPR in a moment. The immediate question is why the chest compressions were not commenced earlier?

13.25. The vision shows that at 11:36:47, COs Shillabeer, Connor and Mail are crouched near Mr Morrison's head. CO Townsend appears to be attempting to remove the leg restraints manually (noting this would not have been possible as plastic flexi-cuffs must be cut to be removed).

13.26. At about 11:36:48, Mr Morrison is rolled onto his right side into the recovery position by COs Shillabeer, Connor and A/Supervisor Hall. His wrists and ankles are still restrained.

13.27. CO Connor gave evidence that he conducted a brief safety check before checking Mr Morrison's breathing and pulse. He did so to ensure there was no danger to staff. Given Mr Morrison's condition, counsel for the Morrison family was critical of the time wasted by the safety check. I find no basis to criticise CO Connor for the few seconds it took to conduct the check. I accept the evidence of Supervisor Burnell that it is standard procedure to conduct this brief check because there are times that prisoners feign unconsciousness, conduct that can place correctional officers at risk of harm or injury.<sup>377</sup>

13.28. COs Connor and Kent's evidence was that they checked Mr Morrison's breathing and pulse. Neither of them could detect a carotid or radial pulse.<sup>378</sup> They called out for all restraints to be removed, and for an Air Viva (i.e. manual resuscitator) and an Automated External Defibrillator to be retrieved.<sup>379</sup> These were appropriate directions.

---

<sup>377</sup> Transcript, pages 2329, 2370, 2423

<sup>378</sup> Exhibit C205, page 3; Annexure 1, page 1; Transcript, pages 2330, 2473; Exhibit C214, page 10, Transcript, page 3063

<sup>379</sup> Transcript, pages 2471-24723

- 13.29. At around the same time, Supervisor Burnell's evidence was that he called for a Hoffman knife to be brought to the sally port so the plastic flexi-cuffs could be cut from Mr Morrison's ankles.<sup>380</sup> This too was an appropriate direction albeit CPR could have commenced without removal of the ankle restraints.
- 13.30. The vision shows that Supervisor McLeod re-entered the sally port with a defibrillator and prepared it for use with CO Kent. Mr Morrison was rolled onto his back while the defibrillator was being prepared.<sup>381</sup>
- 13.31. As to the removal of the plastic leg restraints, the vision shows them being cut off between 11:37:57 and 11:38:12. A short time later, another officer entered the sally port carrying a box which was opened at 11:38:17 (identified by Dr Flabouris as the Air Viva manual device).<sup>382</sup> At this time CO Kent was unravelling cords which were identified by Dr Flabouris as cords which connect defibrillator pads to a defibrillator machine.<sup>383</sup> Mr Morrison's shirt was cut open and the defibrillator pads were placed on his chest.<sup>384</sup>
- 13.32. On the assumption that COs Connor and Kent called for resuscitation equipment at about 11:36:48 (when Mr Morrison was being rolled into the recovery position), I find that just over one minute elapsed before the defibrillator arrived. I further find that no chest compressions were commenced pending arrival of the resuscitation equipment.
- 13.33. An obvious question arises which I will address now. Why did it take over a minute to retrieve this equipment? The answer is simple. The resuscitation equipment (and the Hoffman knife) is kept inside G Division in an area referred to as the G Division Circle. In order to reach this area staff must pass through several locked doorways.<sup>385</sup> Accordingly, the equipment was not immediately accessible.

---

<sup>380</sup> Transcript, page 2330

<sup>381</sup> Transcript, pages 2330, 2472

<sup>382</sup> Transcript, pages 2868-2869

<sup>383</sup> Transcript, page 2870

<sup>384</sup> Exhibit C214, page 10; Transcript, page 2474

<sup>385</sup> Transcript, pages 2472, 3063

13.34. Timing of the CPR – Evidence of Dr Flabouris and Dr Charlwood

13.35. Dr Athanasios Flabouris is an intensive care specialist who provided care to Mr Morrison during his admission to the RAH Intensive Care Unit ('ICU'). He provided two statements to the Court and gave evidence at the inquest.<sup>386</sup>

13.36. Dr Flabouris explained that in the ICU Mr Morrison was suffering unsupportable multi-system organ failure. Despite the intensity of therapy his condition did not substantially improve. By 1am on 26 September 2016, Mr Morrison's condition had deteriorated to a level that led Dr Flabouris to determine that he could no longer be supported or recover from his critical illness. After consultation with family members, treatment was withdrawn and Mr Morrison was transitioned to palliative care. He died soon after at 3:50am.<sup>387</sup>

13.37. Dr Flabouris was requested to provide an opinion regarding the impact of delay in the commencement of CPR. He stated:

'Ideally, cardiopulmonary resuscitation should be started as soon as possible following a cardiac arrest. The chance of survival is reduced exponentially by the time delay in starting resuscitation...

I can't give an accurate time in his circumstances. Based on my knowledge of Morrison's age and previous general health, said to be healthy, I would hope that cardiopulmonary resuscitation began no longer than approximately 4 minutes after he went into cardiac arrest.'<sup>388</sup>

13.38. I accept the evidence of Dr Flabouris that there exists a window of around four minutes, commencing from the point at which it is determined that a person is unresponsive and not breathing, within which chest compressions should be commenced. It is also accepted that chest compressions are the most important part of CPR.

13.39. During his oral evidence, Dr Flabouris reiterated that any delay to resuscitation reduces a person's chances of recovery following a cardiac arrest. In cross-examination, he agreed to this proposition in a slightly different way stating that, 'not delaying [the delivery of CPR] would had (sic) a positive impact on Mr Morrison'.<sup>389</sup> Relevantly,

<sup>386</sup> Refer Exhibits C25 Statement of Dr Flabouris dated 20 October 2016; Exhibit C25c Addendum statement of Dr Flabouris dated 24 August 2018; Transcript, pages 2799-2927

<sup>387</sup> Exhibit C25, pages 5-6

<sup>388</sup> Exhibit C25, pages 7-8; Transcript, page 2874

<sup>389</sup> Transcript, page 2856

*Dr Flabouris did not suggest that earlier commencement of chest compressions would have necessarily have prevented Mr Morrison's death. Some people do survive these events. Others do not survive even with optimally timed intervention.*

- 13.40. Ms O'Connor SC and Counsel Assisting cross-examined Dr Flabouris about whether CPR could/should have occurred inside the van (noting that based on the written statements he had read, Dr Flabouris considered it likely that Mr Morrison was unconscious whilst still in the van).<sup>390</sup> I have already assessed the van journey and the practical impact of the Court's ruling on the application of the self-incrimination privilege. Given the paucity of evidence about the van journey, there is no utility in further discussion of the topic. It is pure speculation to consider what could or should have occurred in the van.
- 13.41. Dr Flabouris gave some evidence about the blue tinge observed on Mr Morrison's lips whilst he was on the ground in the sally port. I mention it for completeness. He said that when a person stops breathing their lips go blue within seconds, but this does not necessarily indicate that a person is in need of CPR.<sup>391</sup> Rather, it shows that the person is hypoxic and in need of oxygen.<sup>392</sup>
- 13.42. Specialist forensic pathologist, Dr Charlwood, agreed that cyanosis (i.e. a bluish-purple tinge to the skin) indicates that oxygenated blood is decreasing near the skin surface. In Mr Morrison's situation, Dr Charlwood opined that it could be indicative of a breathing problem per se, a cardiac arrest, or both.<sup>393</sup>
- 13.43. As to any delay in the commencement of resuscitation, Dr Charlwood agreed that time is of the essence and agreed that some people do survive these kinds of events. Dr Charlwood said that 'in theory' the earlier Mr Morrison was provided with first aid, 'the less likely it was that this was a fatal event'. However, Dr Charlwood made it clear that it was beyond her expertise to proffer any opinion about whether any delay in the commencement of CPR caused or contributed to Mr Morrison's death.<sup>394</sup>

---

<sup>390</sup> See Exhibit C25c at [15]; Transcript, pages 2808-2810, 2855, 2884

<sup>391</sup> Transcript, page 2855

<sup>392</sup> Ibid

<sup>393</sup> Transcript, pages 7667-7668

<sup>394</sup> Transcript, pages 7746-7747

- 13.44. As to the quality of chest compressions, based on the body movements of the officers who were delivering the compressions as depicted in the vision, Dr Flabouris said they appeared adequate. He noted that only two officers were taking turns to administer the compressions and he thought they seemed to tire easily. This opinion was based on his observation of the vigour with which chest compressions were first delivered and then tapered off slightly. Dr Flabouris said a regular cycling of officers to perform the chest compressions was considered preferable to prevent tiring because this can compromise the quality and depth of compressions.<sup>395</sup> At the same time, Dr Flabouris agreed that he could not assess the hand placement or depth of compressions from the vision.<sup>396</sup> In cross-examination by Mr Handshin, he agreed that the clinician on scene was best placed to comment on the performance and the quality of the chest compressions.<sup>397</sup>
- 13.45. As to the frequency of the interruptions in the delivery of the chest compressions, Dr Flabouris observed that CPR stopped and then restarted four times, possibly more. Based on the vision alone he could not see why the CPR stopped. Dr Flabouris agreed there are a number of appropriate reasons why CPR may be stopped which include the delivery of 'rescue breaths'. However, he maintained there were too many interruptions and that such interruptions to CPR should be minimised.<sup>398</sup> In cross-examination by Mr Handshin, Dr Flabouris conceded that Dr Farrall would be best placed to speak about the interruptions and the reasons for them.<sup>399</sup> Dr Flabouris also acknowledged that his reliance on written material and a review of the vision placed some limitations on his ability to interpret the events.
- 13.46. Why was the commencement of chest compressions delayed pending the arrival of resuscitation equipment?
- 13.47. Several witnesses were questioned closely by Ms O'Connor SC about the delay in the commencement of chest compressions. Bundles of still photographs from the vision were put to the witnesses to identify what was occurring at any given time.<sup>400</sup> I refer only to the salient parts of the cross-examination.

---

<sup>395</sup> Transcript, pages 2882, 2875

<sup>396</sup> Transcript, page 2848; Exhibit C25c at [18]

<sup>397</sup> Transcript, page 2875

<sup>398</sup> Transcript, pages 2848, 2852, 2863

<sup>399</sup> Transcript, page 2875

<sup>400</sup> See for example the bundle put to CO Connor: Exhibit C205b

- 13.48. Supervisor Burnell conceded that while it was necessary to remove the spit mask and handcuffs to perform CPR, the ankle flexi-cuffs did not need to be removed for this to occur.<sup>401</sup> It was suggested that CPR could have started within 20 seconds of Mr Morrison's removal from the van. Supervisor Burnell disagreed, albeit he said it might have been possible to start within 30 seconds.<sup>402</sup> He agreed that chest compressions are the most important component of CPR and should be commenced first and, if available, a defibrillator should be used.
- 13.49. So far as the time frame within which CPR should commence, Supervisor Burnell said he had been trained that it should commence within four minutes (as per the evidence of Dr Flabouris). At the same time, he was aware that every second counts.<sup>403</sup>
- 13.50. Supervisor Burnell made several concessions during the cross-examination. He agreed that he could have instructed his officers to perform CPR or performed it himself; he accepted as fair the suggestion that no-one seemed to be in charge of the situation, and candidly stated that prior to watching the sally port vision in court he had believed things had happened more quickly. However, after viewing the vision, Supervisor Burnell agreed that things should have happened sooner, and he accepted responsibility for his role in the delay.<sup>404</sup>
- 13.51. So far as Departmental guidance or review is concerned, Supervisor Burnell gave evidence that he had never been spoken to by anyone after this incident about what occurred, or the quality of his performance on the day.<sup>405</sup> This evidence was not challenged by counsel for the Department.
- 13.52. Supervisor Burnell presented as a sincere, honest and thoughtful witness and one who was willing to make concessions. Nevertheless, as the supervisor of G Division, he must accept some personal responsibility for the delay in the commencement of CPR. He was in a position of authority, he knew that every second counted, and he knew that chest compressions are the most important component of CPR. It is also plain from Supervisor Burnell's evidence that he knew it was not necessary to wait for a defibrillator before commencing chest compressions. In short, he should have taken

---

<sup>401</sup> Transcript, page 2368

<sup>402</sup> Transcript, page 2369

<sup>403</sup> Transcript, pages 2394, 2421

<sup>404</sup> Transcript, page 2343

<sup>405</sup> Transcript, page 2393

charge of the resuscitation. Once no pulse or breathing was detected, he ought to have directed chest compressions to commence. *At the same time, these observations do not mean that Mr Morrison would necessarily have survived if the chest compressions had commenced forthwith.* The likelihood of survival is a complex question which is dependent on a range of other factors.

13.53. I turn now to CO Kent's evidence about the timing of the commencement of CPR. CO Kent confirmed that he had been trained that chest compressions should happen first, regardless of whether a defibrillator is available or not.<sup>406</sup> When asked why CPR did not start before the defibrillation, the following exchange occurred:

‘Q. Is there a reason that CPR didn't start before the defibrillation.

A. The defib got there about the same time as the CPR was due to start ...

Q. At that point chest compression should have started.

A. My fellow officers were conducting the process.

Q. You were relying on other people ...

Q. Did it occur to you to tell someone to start chest compressions.

A. No.

Q. Why not.

A. As I said before, there was a fair bit going on.

Q. Weren't you just waiting for the equipment to arrive.

A. I wasn't standing there thinking about pleasant thoughts, I was standing there waiting for equipment to arrive while fellow officers were in a - well, we were all in quite a traumatic situation and those officers were doing the best they could at the time.

Q. I'm not suggesting it wasn't traumatic, what I'm suggesting is that after he was removed from the van and he was on side and the airways were checked -

A. Yes.

Q. - and it was determined he wasn't breathing, he was blue.

A. Yes.

Q. At that point chest compressions should have started straight away.

A. My fellow officers were conducting the process.

Q. You were relying on other people.

A. I didn't have hands-on at that stage, by the vision.<sup>407</sup>

---

<sup>406</sup> Transcript, page 3095

<sup>407</sup> Transcript, pages 3063, 3088-3089

- 13.54. CO Connor agreed that CPR is higher on the list of priorities than defibrillation, however he believed it was necessary to establish an airway before chest compressions could commence and that a defibrillator was required to establish the airway. CO Connor added that he had been told to do this in other circumstances. He was also concerned about the risk of transmissible diseases.<sup>408</sup> When it was suggested that it was common sense to start chest compressions because earlier commencement increases the chances of a positive outcome, CO Connor said, 'I wouldn't say it is common sense' and 'I didn't know that until you just said it'.
- 13.55. Therein lies the answer to the time that passed before CPR was commenced. CO Kent thought another officer/s had taken charge of CPR and CO Connor *did not realise it was unnecessary to wait for the defibrillator to arrive before starting the chest compressions. On the contrary, he was waiting for the defibrillator to arrive because he believed, albeit erroneously, that it was needed in order to establish an airway, a process which must occur before chest compressions commence.*
- 13.56. COs Connor and Kent were honest and reliable witnesses who I find acted in good faith by coming forward to assist Mr Morrison. With the benefit of hindsight, I believe that faced with the same situation, they would commence chest compressions immediately.
- 13.57. The Court was precluded from any cross-examination of the van officers about the events in the sally port. Accordingly, the van officers could not be asked what they observed in the sally port and/or why they did not come forward to assist. It is unclear why other officers did not come forward. My impression of the sally port vision and other evidence I have mentioned is that once those who were present saw COs Connor and Kent essentially taking charge of the situation, they became observers rather than participants.
- 13.58. The SAPHS medical team
- 13.59. Dr Farrall and nurses Harris and Elstob were attending the injured officers in the holding cells when they heard a Code Black for Mr Morrison. They immediately walked from the holding cells area where they had been attending to injured officers to the G Division sally port. The vision confirms their arrival with the medical cart at

---

<sup>408</sup> Transcript, pages 2475-2476

11:39:00. Dr Farrall provided a statement to the Court and gave oral evidence at the inquest.<sup>409</sup>

- 13.60. Dr Farrall saw Mr Morrison lying unconscious on the ground and noted that CPR was not being performed. She directed Nurse Elstob to call an ambulance.<sup>410</sup> The '000' call was logged at around 11:41:30.<sup>411</sup>
- 13.61. Dr Farrall checked Mr Morrison and on detecting no pulse or respiration she directed 'officer 32' on the vision to start CPR (i.e. CO Connor).<sup>412</sup> The first compressions were delivered at 11:39:16. By this time, Mr Morrison had been on the ground for almost three minutes and I so find.
- 13.62. Dr Farrall said the trigger to commence CPR is an unconscious patient who is not breathing. Having assessed the situation and reviewed the vision, Dr Farrall formed the view that she was the first person to make that assessment 'fully'.<sup>413</sup>
- 13.63. Dr Farrall was satisfied that the CPR was delivered correctly.<sup>414</sup> She was keeping count of the compressions. She said the officers' hands were appropriately positioned, their body positions were right, and the depth of compressions and speed was good.<sup>415</sup> Dr Farrall described CPR as a physically demanding task which requires not only correct technique but also strength.<sup>416</sup> She said the two officers who were performing the chest compressions were swapping over and taking turns for this reason.
- 13.64. As to the pauses or interruptions in the chest compressions, Dr Farrall considered the pauses were appropriate for the delivery of 'rescue breaths'.<sup>417</sup> She described it as 'standard practice' to stop compressions for two breaths to be performed, and for a check to be made whether those who are performing the compressions require a rest.<sup>418</sup>
- 13.65. In relation to the quality of the compressions and the interruptions, I prefer the evidence of Dr Farrall to that of Dr Flabouris who relied entirely on written statements and

---

<sup>409</sup> Exhibit C209 and Transcript, pages 2618-2726; see also Exhibit C91, Statement of Christian Elstob

<sup>410</sup> Transcript, page 2631

<sup>411</sup> Statement of Dwayne Longbottom: Exhibit C101, page 7

<sup>412</sup> Transcript, page 2643

<sup>413</sup> Transcript, page 2645

<sup>414</sup> *Ibid*

<sup>415</sup> *Ibid*

<sup>416</sup> Transcript, pages 2634-2635

<sup>417</sup> Transcript, page 2645

<sup>418</sup> Transcript, pages 2635-2636

viewing the sally port vision to form his opinion. In any event, Dr Flabouris conceded in cross-examination that Dr Farrall was better placed to make this assessment.

13.66. In relation to the delay in an ambulance being called, the Court heard that a protocol exists within the Department whereby all correctional officers must defer to the SAPHS and only call an ambulance at the direction of medical staff. It was described as a directive from prison management.<sup>419</sup> The Department was unable to produce any documentary evidence of such a protocol or directive, but its existence would explain why no ambulance was called until the medical team arrived.

13.67. There was criticism by counsel for the Morrison family and Counsel Assisting about the delayed contact with SAAS. Counsel Assisting described the delay as ‘inexcusable’, albeit it was not suggested that the delay resulted in a worse outcome for Mr Morrison. It is necessary to consider these criticisms in light of the evidence given that it was common practice at Yatala to defer any decision to call an ambulance to the SAPHS medical staff.<sup>420</sup> On reviewing the evidence I am satisfied that correctional officers were reluctant to call ‘000’ because of past issues raised by the SAPHS about who is responsible for bearing the costs of such calls (i.e. DCS or the SAPHS).<sup>421</sup> No correctional officer who is faced with an obvious medical emergency should be dissuaded from calling an ambulance due to concerns about which Department will bear the cost. Mr Morrison was on the ground. He was unresponsive and not breathing. Officers were calling for resuscitation equipment and no medical staff were present. I agree with the submissions that in the circumstances an ambulance should have been called immediately.

13.68. Arrival of the paramedics

13.69. The first ambulance arrived at the sally port at 11:47:31. Intensive care paramedic, Mr Kosmala, entered the sally port at 11:48:04. Mr Kosmala provided a statement to the Court and gave oral evidence.<sup>422</sup>

13.70. On entering the sally port he said the automatic external defibrillator was attached to Mr Morrison. It was removed and replaced with an MRX defibrillator. Mr Kosmala

---

<sup>419</sup> Transcript, page 2364

<sup>420</sup> Transcript, pages 3031, 3062

<sup>421</sup> Transcript, pages 3032-3033

<sup>422</sup> Exhibit C210; Transcript, pages 2730-2741

explained that that the MRX is not available for public use and training is required to understand its operation. The MRX device has a number of advantages which include enabling the operator to charge the monitor to the level required to shock the patient while still performing chest compressions. In other words, the ‘hands off chest time’ is significantly reduced. The MRX also provides additional and more technical information than the AED.<sup>423</sup>

13.71. Mr Kosmala and his colleague worked on Mr Morrison. A return of spontaneous circulation was achieved shortly before 12:25pm. This meant that Mr Morrison had been without spontaneous circulation for at least 31 minutes.

13.72. Did officers have current Cardiopulmonary resuscitation (CPR) training?

13.73. It is a prerequisite that all new CO recruits hold or obtain a Senior First Aid certificate.<sup>424</sup> The CPR component of the training, however, is valid for 12 months only and training providers recommend its renewal every 12 months.

13.74. The training is funded and organised by the Department. The training itself is conducted by private providers such as St John Ambulance or the Red Cross.<sup>425</sup> Notwithstanding the recommendation of annual renewal of the CPR qualification, the Court was told, and I accept, that correctional officers are required to attend refresher training to renew their qualification *only every three years*. The three year renewal requirement has been in place since at least 1985.<sup>426</sup> This evidence was not challenged by counsel for the Department.

13.75. Ms Francis candidly stated that the Department is well aware of the annual renewal recommendation for CPR, but the three year refresher requirement remained in place.<sup>427</sup> As with the restraint refresher training, Ms Francis attested to there being ‘no consequences’ for failure to renew the first aid certificate.

---

<sup>423</sup> Transcript, pages 2735-2740

<sup>424</sup> Transcript, page 711

<sup>425</sup> Transcript, page 726

<sup>426</sup> Transcript, page 893

<sup>427</sup> Transcript, page 3679

13.76. I refer again to the annexure to Mr Goodall's affidavit. The relevant columns for the purpose of this part of the discussion are Columns A, D and E.<sup>428</sup>

A. Correctional Officer	B. Involved in restraint or carriage to the van?	C. Present in the van?	D. Involved at the sally port?	E. Last date before 23/9/16 when undertook SFA Training	F Last date before 23/9/16 when undertook Restraint Training
Bradford		✓		23/9/15	<b>*21/9/16</b>
Burnell			✓	30/6/15	20/3/13
Chapman	✓			26/2/14	27/2/13
Connor			✓	24/8/16	20/11/13
Crowe		✓		17/12/14	None listed
Gibson	✓			12/8/15	27/3/13
Greenwood	✓			24/9/14	30/9/11
Hall	✓	✓		14/11/15	<b>*31/3/15</b>
Joseph	✓			10/6/15	19/3/13
Kay	✓	✓		23/7/14	23/6/13
Kent			✓	See below <sup>429</sup>	<b>*2/10/14</b>
Mail		✓		22/7/15	None listed
McLeod		✓		2/9/15	20/3/13
Murti	✓			6/8/14	None listed
Shillabeer	✓	✓		19/5/15	None listed
Skuse	✓			14/7/16	24/4/13
Sniatynskj	✓			24/8/16	19/1/12
Townsend	✓	✓		See below <sup>430</sup>	<b>*2/10/14</b>

13.77. In order to have current CPR competency, correctional officers would need to have completed refresher training in Senior First Aid within twelve months of the incident date. There are 18 correctional officers listed in the chart. *I find that only three of the officers in the G Division sally port at the time of Mr Morrison's attempted resuscitation had a current CPR qualification, namely, COs Bradford and Connor and A/Supervisor Hall (see Column E\*). No doubt this discovery shocked the Morrison family, and I believe it would shock right thinking members of the community.*

<sup>428</sup> Exhibit C179e: 'SFA' is the note for Senior First Aid

<sup>429</sup> CO Kent became a correctional officer in 2014 - The printout produced by Mr Goodall records the first occasion SFA training was received by CO Kent was on 5/7/17 (he was not involved in the restraint, but he took part in the attempted resuscitation)

<sup>430</sup> CO Townsend became a correctional officer on 2/10/14. The printout produced by Mr Goodall records that his first SFA training was received on 7/11/17

- 13.78. The reason for the recommended annual training in resuscitation is obvious. CPR is a potentially life-saving skill. Such skills naturally dissipate over time, particularly if a person has not been required to apply the skill in the intervening twelve month period. The dissipation of knowledge over time is reinforced by the fact that, despite holding a valid CPR qualification, CO Connor still misunderstood key aspects of CPR.
- 13.79. *In short, at the time of Mr Morrison's death, the Department permitted officers who did not hold a valid CPR qualification to engage in operational duties that required daily contact with prisoners.*
- 13.80. Chief Executive Brown was questioned on the topic. The nub of his evidence was that the CPR component of the training is now 'required' annually. I repeat the comments I have made in relation to the question of whether there are any meaningful consequences for non-compliance with refresher restraint training. I note that officers were 'required' to attend restraint refresher training, but the evidence of the lack of attendance, without consequences, speaks for itself.

#### **14. The forensic evidence**

- 14.1. Evidence of specialist forensic pathologist Dr Cheryl Charlwood
- 14.2. Dr Charlwood gave oral evidence at the inquest. In her post-mortem report, and during her oral evidence, Dr Charlwood gave opinion evidence about several factors or mechanisms which may provide a reason or explanation for sudden cardiac death. While the factors or mechanisms may differ in name, Dr Charlwood emphasised that many have a similar physiological basis.<sup>431</sup>
- 14.3. Marked physical exertion, emotional and physical stress
- 14.4. The first mechanism identified by Dr Charlwood as a possible underlying reason or explanation for sudden cardiac death is marked physical exertion, emotional and physical stress.<sup>432</sup>
- 14.5. Based on the material with which she had been provided for review, Dr Charlwood described Mr Morrison's situation as highly stressful, both physically and emotionally.

<sup>431</sup> Exhibit C273, pages 9-10; Transcript, pages 7634, 7642, 7652-7655, 7772-7775

<sup>432</sup> Exhibit C273, pages 2, 9; Transcript, pages 7635-7636, 7639, 7643-7644 and 7691

She explained that when people are placed in such situations, it results in a catecholamine excess, that is, a surge of hormones such as adrenaline, noradrenaline and neurotransmitters. These hormones have a major effect on the cardiovascular and respiratory systems, and also the brain. The surge of catecholamines triggers a ‘fight or flight’ response. Dr Charlwood added that people in fight or flight often display a level of strength that is extraordinary in the circumstances.<sup>433</sup> The heart rate increases, blood pressure increases and, as ion channels move across the cells, electrical disturbances can be propagated. The workload of the heart is also increased because the heart is trying to beat faster and stronger.<sup>434</sup>

- 14.6. A surge of catecholamines can produce ventricular tachycardia, a condition in which the lower chambers of the heart, the ventricles, beat very quickly and the pumping of blood is ineffective. If this is not corrected within the body, ventricular fibrillation, a life-threatening heart rhythm characterised by a rapid and inadequate heartbeat, may develop. This can lead to asystole where there is no electricity or movement in the heart, often referred to as a ‘flat line’.
- 14.7. In cross-examination, Dr Charlwood explained there can be stages to arrhythmia. In other words, the heart can become dysrhythmic, but it will not stop immediately. Dr Charlwood was unable to nominate a likely time frame between the surge of catecholamines within the body and the heart becoming dysrhythmic, but she agreed it was not beyond the realms of possibility for the process to occur within a five minute time frame, albeit she could not say whether the process would happen more quickly if a person had underlying coronary artery disease or was suffering a psychotic episode.<sup>435</sup>
- 14.8. As to the potential impact of marked physical exertion, Dr Charlwood confirmed that sudden cardiac death is known to occur and often in young males with morphologically normal hearts.<sup>436</sup>

---

<sup>433</sup> Transcript, page 7698

<sup>434</sup> Transcript, pages 7639-7640, 7683-7684

<sup>435</sup> Transcript, pages 7691, 7697

<sup>436</sup> Transcript, pages 7639-7640, 7683-7684; See also Exhibit C4b - Krexi Lydia et al, ‘Sudden Cardiac death with stress and restraint: The association with sudden adult death syndrome, cardiomyopathy and coronary artery disease’, *Medicine, Science and the Law* (2016) Vol 56(2), pages 2-5

- 14.9. Acute psychological stress and stress cardiomyopathy (Takotsubo's Cardiomyopathy)
- 14.10. A second factor or mechanism identified by Dr Charlwood as a possible underlying reason or explanation for sudden cardiac death is acute psychological stress and stress cardiomyopathy. This condition is also known as Takotsubo's Cardiomyopathy.<sup>437</sup> As the title suggests, there is some overlap between stress cardiomyopathy, and marked physical exertion, emotional and physical stress.<sup>438</sup>
- 14.11. Dr Charlwood gave evidence that the association between psychological stress and sudden cardiac death is well established. Chronic and acute psychological influences have been found to play a role in rhythmic disturbances.<sup>439</sup> Dr Charlwood confirmed that sudden cardiac death has been reported in people who have experienced psychological stress per se, without any other factor or mechanism being present.<sup>440</sup>
- 14.12. Dr Charlwood explained that stress cardiomyopathy can arise when acute psychological stress initiates myocardial dysfunction, which can precipitate acute cardiac failure and/or malignant ventricular arrhythmia due to transient ballooning of the left ventricle, and therefore inadequate contractility and function.<sup>441</sup> The condition is thought to be a form of transient catecholamine-induced myocardial stunning with the further sequelae of stress, exertion with sympathetic adrenal activation with increased myocardial workload, hypertension, and potential myocardial ischaemia.<sup>442</sup>
- 14.13. Dr Charlwood explained that the physiological mechanism which occurs as a result of stress cardiomyopathy is similar to that which occurs in the context of marked physical exertion.<sup>443</sup>
- 14.14. Relevantly, Dr Charlwood stated that *the risk of stress cardiomyopathy is higher in a setting of pre-existing coronary disease*.<sup>444</sup> I will come to the pathological examination of Mr Morrison's heart in a moment.

---

<sup>437</sup> Exhibit C273, page 9; Transcript, page 7694

<sup>438</sup> Transcript, page 7688

<sup>439</sup> Transcript, pages 7682-7683

<sup>440</sup> N.B. The Krexi article noted in a setting of personal danger or when there is a perceived threat of injury, high adrenaline surges are a physiological response, and an individual can be 'scared to death' or 'die of fright': Ibid, page 4

<sup>441</sup> Exhibit C273, page 9 (2<sup>nd</sup> dot point)

<sup>442</sup> Ibid

<sup>443</sup> Transcript, page 7644

<sup>444</sup> Exhibit C273, page 9 (3<sup>rd</sup> dot point); Transcript, pages 7644-7645 and 7686-7687; N.B. This condition is sometimes referred to as 'broken heart syndrome': Transcript, pages 7686-7687; See also Exhibit C273b

14.15. Excited delirium

14.16. The third factor or mechanism identified by Dr Charlwood as a possible underlying reason or explanation for sudden cardiac death is a condition known as ‘excited delirium’. Dr Charlwood said it is ‘a controversial syndrome’ which represents a psychiatric or drug-related episode that induces profound agitation and/or aggression, and which may predispose a person to cardiac arrhythmia, potential muscle damage and death. Death is reportedly often seen after the person lapses into a tranquil state.<sup>445</sup> Dr Charlwood said the condition is usually seen in the context of acute illicit substance abuse, but it can also occur in the context of acute mental illness.<sup>446</sup>

14.17. In cross-examination, Dr Charlwood acknowledged that an increased risk of sudden cardiac death exists in psychiatric patients, albeit she said the mechanisms by which acute psychiatric illness can relate to sudden cardiac death are not fully understood.<sup>447</sup> Dr Charlwood cited neuro-biological derangement in the brain as a factor that can affect the heart and breathing centres, as well as the direct effect of catecholamines on the heart, as possible explanations for the production of abnormal cardiac rhythm.<sup>448</sup>

14.18. Dr Charlwood said she was not qualified to provide an opinion on whether Mr Morrison was suffering from an acute psychotic episode at the relevant time. She could only say that it appeared from the material provided that he was experiencing some kind of mental health issue. It was acknowledged that an acute psychotic episode may, of itself, increase the likelihood of an arrhythmia.<sup>449</sup>

14.19. Mr Morrison had no known history of any psychiatric illness, psychological illness, or other mental health issues.

14.20. The Court did not seek and/or receive expert psychiatric evidence about whether Mr Morrison may have been suffering from an acute mental illness or a psychosis at the relevant time, a matter which attracted some criticism.<sup>450</sup> Minds may differ as to the utility of such an opinion. It is possible that a psychiatrist may have opined that

---

<sup>445</sup> Exhibit C273, page 9

<sup>446</sup> Transcript, page 7646

<sup>447</sup> Transcript, page 7644

<sup>448</sup> Transcript, page 7725

<sup>449</sup> Transcript, page 7683

<sup>450</sup> See, for example, written closing submissions of the forensic pathological evidence on behalf of the van officers at [4.23]-[4.24]; written closing submissions for Members of the COLF (3 August 2021) at [42]-[43]

Mr Morrison was suffering from a psychotic episode whilst in custody and, in particular, on the morning of the incident. That said, the weight to be attached to such an opinion would be influenced by the absence of any record of past mental health issues, the lack of any prior consultations with a psychiatrist and/or psychologist and the limited information on which any such opinion would necessarily have been based.

14.21. Genetic susceptibility to channelopathies (Long QT Syndrome)

14.22. The fourth factor or mechanism identified by Dr Charlwood as a possible underlying reason or explanation for sudden cardiac death is genetic susceptibility to an underlying channelopathy.<sup>451</sup>

14.23. Dr Charlwood explained that genetic abnormalities in ion channels are known to precipitate life threatening ventricular arrhythmias per se. The mechanism by which this occurs involves the ion channels on the surface of the cells and the movement of iron, sodium, potassium, calcium, and chloride ions in and out of the cells. Abnormality in this process can result in an arrhythmia, particularly, in some of them, during exercise or stress.<sup>452</sup>

14.24. Genetic abnormalities cannot be diagnosed after death unless genetic testing is undertaken.<sup>453</sup> No such testing occurred in Mr Morrison's case. Dr Charlwood did not consider the absence of testing unusual because it is generally undertaken only in situations where no other 'usual or common' factors are present which might explain the event.<sup>454</sup> Furthermore, even if confirmation of a genetic channelopathy had been received, Dr Charlwood said she would not have cited it as a primary cause of death in Mr Morrison's case *because of the presence of usual or common factors which could provide an explanation or underlying reason for his sudden cardiac death.*<sup>455</sup>

14.25. A positional element

14.26. The fifth factor or mechanism identified by Dr Charlwood as a possible underlying reason or explanation for sudden cardiac death relates to potential respiratory

---

<sup>451</sup> Exhibit C273, page 10; Transcript, pages 7726-7727

<sup>452</sup> Ibid, page 10

<sup>453</sup> Transcript, page 7726

<sup>454</sup> Transcript, pages 7725-7728 and 7656-7657

<sup>455</sup> Transcript, pages 7727-7728

compromise or breathing problems arising from the physical position of a person causing a degree of asphyxia.

- 14.27. *When giving evidence about this this issue Dr Charlwood was at pains to draw a distinction between ‘positional asphyxia’ and the presence of a potential positional element which might lead to respiratory function compromise and a degree of asphyxia. It is an important distinction.*<sup>456</sup>
- 14.28. Dr Charlwood explained that the phrase ‘positional asphyxia’ is a broad term which forensic pathologists generally use only to describe situations in which people get themselves into a position from which they cannot extricate themselves and which causes some obstruction to the airway hindering their ability to breathe.<sup>457</sup> Some examples were provided, namely, when a person is so affected by drugs or alcohol or both that they fall face forward and suffocate, or an epileptic person whose airway is occluded by them collapsing onto soft bedding material.<sup>458</sup>
- 14.29. It is noteworthy that Dr Charlwood made no reference to positional asphyxia in her post-mortem report, a matter which she pointed out when giving evidence.<sup>459</sup>
- 14.30. The importance of this distinction did not become entirely clear until Dr Charlwood had completed her evidence (given towards the end of the inquest). By this stage of the inquest the term ‘positional asphyxia’ had been used frequently by some counsel during cross-examination without reference to the above distinction. Given that Dr Charlwood did not refer to positional asphyxia in her report, Mr Henschcliffe KC was critical of Counsel Assisting’s opening remarks in which reference was made to ‘positional asphyxia’ as a possible cause of Mr Morrison’s death,<sup>460</sup> and the ‘misuse’ of the term by various counsel in cross-examination. It was submitted that much time could have been saved if Dr Charlwood had been called earlier in the inquest. Mr M Abbott KC

---

<sup>456</sup> Exhibit C273, page 9; Transcript, page 7779

<sup>457</sup> Transcript, page 7654

<sup>458</sup> Transcript, pages 7652-7655, 7772-7775: See also Exhibit C273i – Byard, Roger et al, ‘Conditions and circumstances predisposing to death from positional asphyxia in adults’

<sup>459</sup> Transcript, page 7634

<sup>460</sup> See for example, closing submissions on behalf of Mr Hall in reply to Counsel Assisting’s submissions (3 August 2021) at [2]-[4]; written closing submissions for Members of the COLF (3 August 2021) at [33]-[41]

and Ms Kereru shared this view.<sup>461</sup> With the benefit of hindsight there is some merit to these criticisms.

14.31. Evidence of pre-existing coronary artery disease

14.32. As part of the autopsy, Mr Morrison's heart was retained for specialist cardiac pathological examination by SA Pathology (conducted by Professor Thomas who was present at the post-mortem).<sup>462</sup>

14.33. The examination included macroscopic and microscopic examination, along with a detailed examination of the cardiac conduction system. No significant abnormality was detected in the conduction system.<sup>463</sup>

14.34. While the macroscopic examination showed some level of cardiac disease, as stated at the outset, it was the microscopic examination which revealed that Mr Morrison had *moderate to severe cardiac disease with focal moderate to severe (70%) atheroma in the right coronary artery.*

14.35. Mr Morrison had no known history of heart disease.

14.36. Dr Charlwood's evidence was that *Mr Morrison's underlying coronary artery disease placed him at higher risk of sudden cardiac death.*<sup>464</sup>

14.37. I accept Dr Charlwood's evidence in its entirety noting that her evidence as to the potential underlying causes or reasons for sudden cardiac death was not challenged in any material way.

14.38. No contrary expert opinion was received by the Court.

14.39. Analysis of the forensic evidence in the context of Mr Morrison's case

14.40. It is self-evident from the events described in this Finding that Mr Morrison was involved in an incident which involved marked physical exertion on his part. The physical exertion commenced when he charged out of his cell. Within a matter of

---

<sup>461</sup> Ibid at 33-41; Written closing submissions of Ms Kereru on the forensic pathological evidence on behalf of the van officers at [1.5]

<sup>462</sup> Exhibit C4a - Anatomical pathology report of Tony Thomas (Consultant, SA Pathology)

<sup>463</sup> Exhibit C273, pages 7, 18, 22-26; Exhibit C4a, pages 3-5

<sup>464</sup> Exhibit C273, page 6; Transcript, pages 7677-7678, 7686

seconds he had physically attacked four correctional officers with such force that three of them were grounded and sustained a brief loss of consciousness. It will be recalled that two of the three officers sustained serious physical injuries. A fourth officer (CO Crase) managed to stay on his feet, but he was punched in the face several times by Mr Morrison. In short, this violent episode would necessarily have required marked physical exertion.

- 14.41. Based on the expert evidence of Dr Charlwood, which I accept, I am satisfied that even before the restraint commenced, catecholamines would have been surging through Mr Morrison's body. I find that Mr Morrison's heart rate and blood pressure would have increased along with the workload on his heart. I am also satisfied that even before the restraint occurred, Mr Morrison was in a highly charged emotional state which inevitably involved a significant degree of emotional and psychological stress.
- 14.42. When considering Mr Morrison's physical and emotional state prior to the commencement of the restraint, I have carefully considered the undisputed expert evidence, namely, that:
- 14.42.1. Sudden cardiac death is known to occur as a result of marked physical exertion per se, and often in young males with morphologically normal hearts.<sup>465</sup>
- 14.42.2. Sudden cardiac death has been reported in people in a setting of personal danger or where there is a perceived threat, that is to say, as a result of psychological stress per se.<sup>466</sup>
- 14.42.3. The risk of stress cardiomyopathy is higher in a setting of pre-existing coronary disease.<sup>467</sup>
- 14.42.4. Mr Morrison's underlying coronary artery disease placed him at higher risk of sudden cardiac death.<sup>468</sup>
- 14.43. Once the restraint commenced and throughout the restraint, I find that the effects of marked physical exertion and emotional and psychological stress would have increased.

---

<sup>465</sup> Transcript, pages 7639-7640, 7683-7684

<sup>466</sup> See e.g. the Krexi article which noted that in a setting of personal danger or when there is a perceived threat of injury, high adrenaline surges are a physiological response, and an individual can be 'scared to death' or 'die of fright'

<sup>467</sup> Exhibit C273, page 9 (3<sup>rd</sup> dot point); Transcript, pages 7644-7645 and 7686-7687; N.B. This condition is sometimes referred to as 'broken heart syndrome': Transcript, pages 7686-7687; See also Exhibit C273b

<sup>468</sup> Exhibit C273, page 6; Transcript, page 7677-7678 and 7686

Mr Morrison put up fierce physical resistance to all efforts to restrain him during the initial restraint (while on his feet), and also in the mess room corridor where he was ultimately taken to ground and subdued. It is plain from the evidence and the vision of the restraint that the level of Mr Morrison's resistance necessarily required great physical strength and effort, and the circumstances of the restraint itself are likely to have contributed to the emotional and psychological stress he was experiencing. Furthermore, the number of correctional officers surrounding him and the application of handcuffs, leg restraints and a spit mask are factors which must have added to these stressors.

- 14.44. That said, it is not possible to say *when* the physiological changes which ultimately led to Mr Morrison's cardiac arrest commenced. That is because the arrhythmic process which leads to cardiac arrest (e.g. ventricular tachycardia and ventricular fibrillation) can occur in stages. In other words, the heart can become dysrhythmic but it will not stop immediately. Dr Charlwood was also clear in her evidence that even if a medical event such as this was unfolding, it would not necessarily be apparent to a person who is medically untrained (e.g. correctional officers).<sup>469</sup> Accordingly, there is no basis to suggest that the restraining officers should have turned their minds to this possibility.
- 14.45. The other matter which must be factored into the equation is the effect of Mr Morrison's underlying coronary artery disease.
- 14.46. Given the complexity of the unfolding events, it is *simply not open to make the finding* suggested by counsel for the Morrison family that the circumstances of the restraint and Mr Morrison's movement from the building caused or contributed to his death. *The submission ignores the events that preceded the restraint and the evidence of Dr Charlwood that the physiological changes which ultimately lead to cardiac arrest could have been underway even before Mr Morrison burst from his cell.*
- 14.47. Put another way, the situation cannot be neatly dissected and causation attributed to a particular section of the unfolding events. It is a classic case of trying to unscramble the egg. At the same time, I cannot eliminate the possibility that the physiological events that ultimately led to the cardiac arrest did not commence, for example, until Mr Morrison was lifted and carried from the building. The point is that due to the

---

<sup>469</sup> Transcript, pages 7729-7730

complexity of the unfolding events and the presence of several factors or mechanisms that may have been at play, one simply cannot say.

- 14.48. As to the positional element, I turn now to discuss some of the matters raised during Dr Charlwood's cross-examination.
- 14.49. Did restraint in the prone position cause respiratory compromise or 'positional asphyxia'?
- 14.50. In cross-examination, counsel for the Morrison family asked a range of questions directed at the potential impact of restraining Mr Morrison in the prone position.
- 14.51. 'Prone restraint' generally refers to a person being restrained stomach down on the ground and often with a form of restraint to their arms and to their legs.<sup>470</sup> This position applies of course to Mr Morrison after he was rolled onto his stomach for the application of rear handcuffs.
- 14.52. In preparation for giving evidence, Dr Charlwood undertook research into the effect of the prone maximal restraint position in situations involving stress. Relevant articles which have assessed the prone position in the context of custodial cardiac arrests were provided to the Court and adopted by Dr Charlwood.
- 14.53. The Court heard that historically there was support, amongst some commentators, for a theory that restraint, especially in the face down position, leads to a significant reduction in lung function and deterioration in respiratory or cardiac parameters.<sup>471</sup> *However, Dr Charlwood gave evidence that this historical theory has been largely disproved.*<sup>472</sup> To the extent that slight changes in respiratory and heart parameters were noted in studies of subjects who were restrained in the prone position, Dr Charlwood described the changes as 'not of clinical significance'.
- 14.54. The nub of Dr Charlwood's evidence on this issue was that *the currently accepted scientific position in South Australia, and elsewhere, is that sudden cardiac death is due to a confluence of multiple causes and that maximal restraint in a prone position does*

---

<sup>470</sup> Transcript, page 7748

<sup>471</sup> Exhibit C273, page 9; Transcript, pages 7648-7650, 7653, 7702-7703, 7706, 7708-7709

<sup>472</sup> Transcript, page 7709; N.B. Dr Charlwood confirmed that the authors of the Krexi et al, 'Sudden cardiac death with stress and restraint: The association with sudden adult death syndrome, cardiomyopathy and coronary artery disease' 56(2) Medicine, Science and the Law (2016) 85-90; Krexi article *have now retracted these earlier claims*

*not, of itself, lead to a respiratory deficit or low levels of oxygen in body tissues (i.e. hypoxia).*<sup>473</sup>

- 14.55. In cross-examination, Counsel Assisting suggested there may be an ‘alternate view’ to the literature she had provided and adopted on this topic. This suggestion was rejected by Dr Charlwood who adhered to the view that it is accepted amongst her peers, in South Australia and beyond, that positional asphyxia in the context of a prone maximal restraint, *in itself, is not an accepted cause of death.*<sup>474</sup>
- 14.56. Of a series of several thousand deaths that were examined in the literature relating to the use of prone restraint in policing in the United States, Dr Charlwood observed that only one death occurred, and it was not linked to the use of the prone position.<sup>475</sup>
- 14.57. No expert evidence to the contrary was put before the Court.
- 14.58. Counsel for the Morrison family nevertheless submitted that, given the number of officers involved in the restraint and the effect of their combined weight bearing down on Mr Morrison (directly and indirectly) there must have been a significant degree of respiratory compromise. There is no evidentiary foundation for this submission. In the absence of expert evidence to support this contention it is mere speculation to suggest that a significant level of respiratory compromise occurred. Even if it is accepted that some additional respiratory compromise may have occurred by reason of the number of officers involved, it is impossible to determine whether it was a clinically significant degree of respiratory compromise.
- 14.59. Did the use of a spit mask cause or contribute to Mr Morrison’s death
- 14.60. During cross-examination, counsel for the Morrison family also suggested that the use of the spit mask must have compromised Mr Morrison’s ability to breathe. Ultimately,

---

<sup>473</sup> Exhibit C273, page 9; see Savaser D et al, ‘Effect of the prone maximal restraint position with and without weight force on cardiac output and other hemodynamic measures’ *Journal of Forensic and Legal Medicine* (2013) 13; Sloan C et al, ‘Evaluation of the ventilatory effects of the prone maximum restraint (PMR) position on obese human subjects’ *Forensic Science International* (2014) 237; Karch Steven ‘Positional Asphyxia and Death in Custody’ *Medicine, Science and the Law* (2015); Kroll Mark W, ‘Sudden Cardiac Death from stress’ (2016)

<sup>474</sup> Transcript, pages 7653, 7650-7652; see also Sudden Cardiac Death from Stress, Mark W Kroll, 1 October 2016 which refers to the theory of positional asphyxia as ‘a dying unscientific theory [which ‘still needs a silver dagger in its heart’], at page 3

<sup>475</sup> Transcript, pages 7747-7748; see also page 7778

the Court was invited to find that the use of the spit mask is one of the factors that caused or contributed to Mr Morrison's death.

14.61. Dr Charlwood agreed with a general proposition put to her in cross-examination that it is easier for a person to breathe if they are not wearing a mask. Most people in Australia will have had some direct experience of the effect of wearing masks during the COVID pandemic and would agree with this general proposition. However, particular care must be taken before drawing any inference from such a generalised statement, particularly in light of the standard of proof required of such facts.

14.61.1. First, there is no evidence before the Court to support a finding that wearing a mask per se causes a clinically significant degree of respiratory compromise.

14.61.2. Secondly, no expert evidence was sought to be introduced about the permeability of spit masks and/or the Tranzport Spit Hood worn by Mr Morrison.

14.62. Dr Charlwood did not hold herself out as an expert on the topic of spit masks or their permeability. To the extent that the topic was canvassed, Dr Charlwood's evidence was that while there are *anecdotal* reports of such a link, *she could find no studies which established a positive link between wearing a spit mask and respiratory compromise.*<sup>476</sup>

14.63. It will be recalled also that counsel for the Morrison family invited the Court to find that Mr Morrison travelled face down in the van to G Division for the entire journey. Ultimately it was submitted that the face down position while wearing the spit mask caused or contributed to his death. I do not propose to repeat the remarks I have already made about the paucity of evidence regarding the van journey and Mr Morrison's presentation during the journey. Suffice it to say that the finding is not open on the available evidence, particularly since one of the correctional officers gave evidence, which cannot be ignored, that when the van door opened he thought Mr Morrison's head may have been titled to the side.

14.64. Dr Charlwood said if more information was available about the van journey (e.g. Mr Morrison's head position, whether there was any restriction preventing him from

---

<sup>476</sup> Transcript, page 7732

extricating himself to improve his respiration, and whether he was talking coherently during the van journey), she would be able to be more definitive about the potential causative mechanisms she had identified. She said that such information may have assisted in determining the timeline of Mr Morrison's degree of responsiveness in the van, but Dr Charlwood emphasised that such information does not remove the other circumstances that were present, and it would not change her opinion as to the cause of death.<sup>477</sup>

14.65. In summary, there is no evidentiary foundation to support a finding that wearing a spit mask of itself causes a clinically significant degree of respiratory compromise or that Mr Morrison suffered significant respiratory compromise as a result of wearing the Tranzport spit hood. The evidence of Dr Charlwood, taken at its highest, is that while *the spit mask cannot be excluded as one of several factors which potentially had an effect on Mr Morrison's breathing, it is only one of many factors that may provide an underlying reason or explanation for Mr Morrison's sudden cardiac death.* The other factors which cannot be removed from the equation are, as stated:

- Marked physical exertion (known to cause sudden cardiac death per se);
- Acute emotional and psychological stress (known to cause sudden cardiac death per se);
- Underlying coronary artery disease which, in Mr Morrison's case, included focal moderate to severe (70%) atheroma of the right coronary artery.

14.66. Are one or more of the factors or mechanisms identified by Dr Charlwood more likely to have caused Mr Morrison's cardiac arrest?

14.67. Dr Charlwood opined that the cause of Mr Morrison's cardiac arrest was almost certainly multifactorial in nature. Dr Charlwood stated that any one or all of the factors she had identified 'alone or in combination', could potentially provide a reason for sudden cardiac death:<sup>478</sup>

'There is obvious overlap of the potential conditions that could have led to such an arrhythmia. Therefore, any or all of the above discussed factors, alone or in combination,

---

<sup>477</sup> Transcript, page 7752

<sup>478</sup> Exhibit C273, pages 9-10

could potentially represent an underlying reason for cardiac arrest to occur in Mr Morrison's case but these are not able to be definitively distinguished or identified pathologically.'<sup>479</sup>

14.68. In cross-examination, Mr M Abbott KC suggested that stress cardiomyopathy (Takotsubo's cardiomyopathy) was the 'likely' cause of Mr Morrison's sudden cardiac death.<sup>480</sup> Dr Charlwood repeated that she was unable pathologically to place one of the five possible causes above the other.

14.69. In closing submissions, Ms Kereru submitted that it is unsurprising that a forensic pathologist was unable to provide an opinion on this question and submitted that an expert cardiologist should have been called to address the question.<sup>481</sup> Views may differ about the utility of such evidence, especially given the complexity of the circumstances that surrounded Mr Morrison's death. A cardiologist may have been able to nominate one or more of the factors or mechanisms as the more likely cause of the cardiac arrest. Even so, such an opinion could not alter the fact that other potential underlying factors or mechanisms may have been at play, and/or pinpoint the onset of such factors in relation to the unfolding chain of events.

14.70. Did Mr Morrison suffer the cardiac arrest in the van or at an earlier time?

14.71. It will be recalled that Dr Charlwood's evidence was that the processes of an arrhythmic event can occur in stages.<sup>482</sup> Relevantly, Dr Charlwood stated that a person may be suffering from ventricular tachycardia which, as previously stated, is a condition in which the lower chambers of the heart, the ventricles, beat very quickly, and the pumping of blood is ineffective), but if the person is still getting cardiac output they could be walking, standing and engaging in physical resistance. Once a person is suffering from ventricular fibrillation however (a life-threatening heart rhythm characterised by a rapid and inadequate heartbeat), Dr Charlwood said they would become unconscious quickly albeit not be clinically dead at that stage.<sup>483</sup>

---

<sup>479</sup> Exhibit C273, page 10; Transcript, pages 7643-7644

<sup>480</sup> Transcript, page 7718

<sup>481</sup> Written closing submissions of the forensic pathological evidence on behalf of the van officers at [1.10]-[1.11]

<sup>482</sup> Transcript, page 7685

<sup>483</sup> Ibid

14.72. Dr Charlwood was asked to comment on the relevance, if any, of evidence that Mr Morrison was physically resisting during the restraint as well as shouting and yelling as he was carried from the holding cells area to the van. Dr Charlwood opined that if Mr Morrison was in cardiac arrest, she would not expect him to be able to make comments or to yell at people.

14.73. As to the evidence of physical resistance as he was carried to the van, such as bucking, Dr Charlwood considered it unlikely that Mr Morrison would be in cardiac arrest if the movement was *purposeful* movement (as opposed to involuntary movements caused by seizure activity or involuntary twitching):<sup>484</sup>

‘Q. So, what degree of movement, if you can comment, would be required for you to conclude that the cardiac arrest process had not commenced, and I’m talking about immediately before placement in the van.

A. That’s a very difficult question because some people who go into cardiac arrest don’t move at all, and others may twitch, and others may develop full-blown seizure activity.

Q. If a person appears to be actively resisting so that they are thrashing about or bucking, would that be inconsistent with that person being in cardiac arrest.

A. If it was purposeful movement, yes...

Q. So, if the person’s being carried face down by the limbs and they are tied like Mr Morrison was with his arms behind his back and his ankles tied and he was being carried, would a seizure look like he was thrashing or bucking, or would that be a different kind of image that we would have.

A. I don’t really know...’<sup>485</sup>

And further:

‘Q. I understood your evidence from Thursday was that once the cardiac arrest occurs there is almost an immediate response, like the patient will go into immediate decline and that they won’t be breathing very quickly thereafter; is that right.

A. Yes, normally you would go unresponsive unconscious.

Q. Are we talking seconds.

A. Yes.

Q. So, if he was still moving and responding in the van for some of that journey, he hadn’t gone into cardiac arrest.

A. I wouldn’t expect so, no.

---

<sup>484</sup> Transcript, page 7753

<sup>485</sup> Transcript, page 7753

- Q. So it's the time when the observer observes that he's stopped responding and stops moving that you can say he's gone into cardiac arrest.
- A. I can't say he's definitely gone into cardiac arrest but yes.'<sup>486</sup>

14.74. When asked whether observations of Mr Morrison 'gurgling and dribbling' prior to being placed in the van could be consistent with him suffering a cardiac arrest two to three minutes later, while in the van, Dr Charlwood said, 'Possibly'.<sup>487</sup>

14.75. During parts of the cross-examination by counsel for the Morrison family, Dr Charlwood was also asked to comment on some assumed factual scenarios.<sup>488</sup> For example, Dr Charlwood was asked to assume that Mr Morrison was breathing when he went into the van but not breathing upon his removal from the van, and to comment on what may have caused him to stop breathing. Having regard to all the circumstances Dr Charlwood said, '...the most likely is he's had a cardiac arrest with ensuing cardio-respiratory arrest. In other words, his heart had stopped beating effectively and as part of that he stopped breathing as well'.<sup>489</sup>

14.76. Having considered the evidence, I find it is unlikely that Mr Morrison was in cardiac arrest during the restraint or while he was being carried from the holding cells area to the escort van. The fact that Mr Morrison was continuing to shout out abuse at correctional officers during the restraint and while being carried through exit door 7 to the van indicates that some respiratory drive was present. Several witnesses also observed Mr Morrison bucking his body while he was being carried. It cannot be entirely excluded that the bucking movements may have been the product of involuntary spasms which can occur in the context of a cardiac arrest, however, I find that Mr Morrison's ability to verbalise abuse at that time makes it more likely than not that the bucking actions were purposeful movements and that he was not in cardiac arrest at that time.

14.77. Could the rib fractures observed at autopsy have been caused during the restraint?

14.78. The skeletal examination at autopsy confirmed that sternal and rib fractures were present. No other skeletal fractures were identified.<sup>490</sup>

---

<sup>486</sup> Transcript, pages 7753-7754

<sup>487</sup> Transcript, pages 7760, 7765, 7777-7778

<sup>488</sup> See e.g. Transcript, page 7776

<sup>489</sup> Transcript, page 7669

<sup>490</sup> Exhibit C273, page 16, 18; Transcript, pages 7788-7789

- 14.79. In cross-examination, Dr Charlwood was asked (by Ms O'Connor SC) whether the rib fractures were consistent with Mr Morrison being 'crushed' while he was on the ground on his back. Dr Charlwood's evidence was that crush fractures tend to be more posterior due to a different mechanism of injury. Mr Morrison's fractures, on the other hand, were 'all very anterior and related to costal cartilages'.<sup>491</sup>
- 14.80. No contrary expert opinion was placed before the Court.
- 14.81. Dr Charlwood agreed in cross-examination that if a person's ribs were fractured, it would impact on that person's ability to breathe and render them more susceptible to a cardiac arrest. Ms O'Connor SC then suggested that if Mr Morrison's ribs were fractured before he was placed in the van for transport to G Division it would have impacted his ability to breathe and rendered him more susceptible to a cardiac arrest.<sup>492</sup> Dr Charlwood agreed with the hypothetical proposition, however, the apparent concession was of little probative value because the clear finding at autopsy was that the pattern and distribution of the fractures was in keeping with a prolonged resuscitation attempt.<sup>493</sup>
- 14.82. I find that the sternal and rib fractures observed on Mr Morrison's body at autopsy were not caused during the restraint. I find that the rib fractures were caused by the chest compressions and the prolonged resuscitation attempt.
- 14.83. Could the bruising, swelling and abrasions observed at autopsy have been caused during the restraint or are there other possible causes?
- 14.84. Dr Charlwood gave evidence about the bruising, swelling and abrasions that were observed at autopsy.<sup>494</sup> Dr Charlwood explained that the injuries were difficult to assess because of oedema, swelling, the diffuse patches of subcutaneous haemorrhage which is often related to medical intervention, and complicated by coagulopathy and multi-organ failure.<sup>495</sup> It was concluded that the bruising is consistent with bruising which is commonly seen in circumstances which involve physical violence and forcible

---

<sup>491</sup> Exhibit C273, page 16; Transcript, pages 7765-7766

<sup>492</sup> Transcript, page 7768

<sup>493</sup> Exhibit C273, page 7; For details of the location of the fractured ribs see Exhibit C273, page 16; Transcript, page 7766

<sup>494</sup> Police investigators had attended at the RAH at about 6:30am on Monday 26 September 2016 to commence the coronial investigation. Photographs were taken of Mr Morrison which included photographs of the bruising: Exhibit C133, page 1

<sup>495</sup> Exhibit C273, pages 6, 10-14

restraint, [and] are also commonly observed in situations which involve a prolonged resuscitation attempt, medical intervention and body handling.<sup>496</sup>

14.85. Areas of more discrete bruising were noted (e.g. to the left side of the face, scalp and also to the upper arms and left leg) which were not obviously associated with medical intervention. Dr Charlwood's opinion was that these too 'could certainly be related to the incident that occurred in the prison and would be of the type commonly seen in such circumstances'.<sup>497</sup>

14.86. Dr Charlwood did not resile from her opinion under cross-examination.

14.87. No contrary expert opinion was proffered.

14.88. I accept the opinion of Dr Charlwood. I find that the bruising was consistent with the type of bruising commonly associated with situations which involve physical violence, forcible restraint, prolonged resuscitation attempts, medical intervention and body handling. There is no evidence before the Court which would support an alternative finding.

## 15. **The post incident events**

15.1. The post incident events relate to the institutional response to the incident after Mr Morrison had been taken from the prison by ambulance. These events form part of the broader circumstance of the event which is the subject of the inquiry.

15.2. It is trite to say that the institution was responding to a major incident. A first time Aboriginal prisoner had physically attacked several officers causing serious injury. An ambulance had been called to attend to their injuries. The prisoner had been restrained and placed in a prison van for transfer to G Division. It was generally known that he appeared to be conscious and breathing when placed in the rear compartment with five correctional officers, but on arrival at G Division a short time later he was found to be cyanosed and unresponsive. It was known that the prisoner had been taken from the prison and conveyed by ambulance to hospital.

---

<sup>496</sup> Transcript, pages 7769-7770

<sup>497</sup> Exhibit C273, pages 7-8; see also Transcript, page 7769

- 15.3. To understand the post incident response, it was necessary to receive evidence about the interaction between the police, the Yatala management team and senior correctional officers on that Friday afternoon.
- 15.4. The Court received as an exhibit a compilation of vision from the Gatehouse ('the Gatehouse vision').<sup>498</sup> The vision depicts numerous persons in the non-public area of the Gatehouse at various times over the afternoon.
- 15.5. There was particular criticism by some counsel about the time taken by Counsel Assisting to examine the relevant witnesses and the Court permitting him to play the lengthy Gatehouse vision to each witness. It was a time-consuming but necessary process. I consider the criticisms to be unfair. The time required to examine the events in the Gatehouse could have been substantially reduced if counsel who had been granted leave to represent the interests of individual officers had acceded to the Court's request to play the Gatehouse vision to the witnesses before they gave evidence. However all counsel but one declined to play the vision, or to lead the evidence in chief of the officer they were representing in any meaningful way. Some counsel continued to make spurious objections throughout Counsel Assisting's cross-examination, most of which were overruled. Much time and expense could have been saved had a more co-operative approach been adopted.
- 15.6. The post incident management plan
- 15.7. Mr Hosking was the Acting General Manager on the day of the incident ('A/GM Hosking' or 'Mr Hosking'). He presented a short 'hot debrief' to a group of correctional officers outside the G Division sally port immediately after the ambulance took Mr Morrison to the RAH. He then went to the administration building and was engaged in speaking with the rest of the management team. By 1:30pm, A/G Hosking had established what he described as 'a Management Plan'. A photograph of the whiteboard on which the plan was written was tendered to the Court.<sup>499</sup>
- 15.8. The Management Plan required various members of the management team to undertake certain tasks. Particular tasks were allocated to supervising correctional officers. The

---

<sup>498</sup> Exhibit C216

<sup>499</sup> Exhibit C65aaay, page 80

role of liaising between SAPOL and Management was delegated to internal DCS investigator, Mr Muller.

15.9. Failure to secure incident scenes

15.10. There is no dispute that there was a failure to secure the holding cells area and the G Division sally port as incident scenes. Indeed, the sally port had been partially cleaned up prior to the arrival of police, and the van in which Mr Morrison travelled was placed back into service and was not secured for forensic examination. It is unclear from the evidence why the van was placed back into service or who made that decision.

15.11. The arrival of South Australia Police

15.12. The first police officers arrived at the Gatehouse at about 12:50pm.<sup>500</sup> The first two officers who gained entry were escorted to the holding cells. These were the officers who discovered that the incident scenes and the van had not been secured.

15.13. At about 1:12pm, another five police officers arrived. Four of them gained entry to the prison but Sergeant Palmer was not, at least initially, permitted to enter the Gatehouse.<sup>501</sup> It is unnecessary to repeat the evidence relating to the delay in him gaining entry, or the circumstance which led to the forward command post being set up outside of the prison.

15.14. The first CIB police officers arrived at 1:30pm. An officer from the Police Corrections Unit arrived at 1:40pm. This is a unit within SAPOL which is dedicated to investigations within the correctional system. These officers established themselves in the management building which is located inside the prison proper.

15.15. Shortly before 1:45pm, the Gatehouse vision shows Supervisor Bell escorting Detective Sergeant Pettinau and other police officers into 'the Muster Room' in the Gatehouse. Further uniformed officers arrived at around 2:40pm,<sup>502</sup> and Major Crime officers arrived shortly before 3:30pm.<sup>503</sup> These officers joined other police personnel in the Muster Room.

---

<sup>500</sup> Exhibit C103

<sup>501</sup> Exhibits C49 (Shah); C220 (Menon); C102 (Meznar); C104 (Gamtheff)

<sup>502</sup> Exhibit C107

<sup>503</sup> Exhibits C108 (Prizbilla), C110 (van der Stelt), C57 (Newbury)

- 15.16. Moving between the Gatehouse and the management building required a staff member to unlock and then lock a door to allow access. Splitting the police presence over two locations did little to assist in the smooth liaison between these two groups or their communication with the prison's management team.
- 15.17. The Court heard evidence that the police advised A/GM Hosking to ensure that all relevant correctional officers submitted employee incident reports before the end of shift, and that statements would need to be obtained from at least some of these officers as a matter of urgency.
- 15.18. As events transpired, the identity of the eight van officers was not confirmed until about 3:30pm.<sup>504</sup> It is notable that their identity was ascertained not by anything that the Yatala management team did, but rather because the police sought out and viewed CCTV vision (with the assistance of a Yatala staff member). The staff member, Mr Mellor, identified one of the officers in the van as A/Supervisor Hall. Mr Mellor requested A/Supervisor Hall to contact Detective Kearney. He did so and confirmed that he was one of the officers in the van. The names of the other seven officers were provided to police and Mr Muller, who then passed on the names to Mr Hosking.
- 15.19. Mr Hosking prepared a list of names and directed a manager, Mr Staples, to attend at the Gatehouse to ensure that the persons on the list did not leave the prison. The problem with this direction was that Mr Staples had only been at Yatala for a few weeks and he did not know many officers by sight. Nor was there any apparent understanding on the part of Mr Hosking that the matter was not a coronial investigation at this stage, and the correctional officers were entitled to seek legal advice before submitting employee incident reports or providing any statement to the police. They could not be compelled to provide such statements. Mr Hosking however had given a direction that the subject officers should not leave the prison.
- 15.20. Mr Staples struggled to identify staff and admitted that he was unable to properly execute his allocated task. Another manager, CO Dent, attended at the Gatehouse briefly before leaving the prison. No other managers attended at the Gatehouse that

---

<sup>504</sup> See Exhibit C266 and written submissions of Counsel Assisting at [129]-[130]

afternoon. Given the seriousness of the incident one would expect that senior managers would have been present in the Gatehouse to coordinate events.

15.21. Shortly after 3:45pm, Mr Hosking told the police that the eight van officers had been identified and were ready to provide statements. In fact, an executive member of the Correctional Officers Legal Fund ('COLF') had contacted Tindall Gask Bentley ('TGB') to arrange for the attendance of lawyers to provide legal advice to the subject officers. The officers were waiting to see their lawyers. It is plain from the evidence that Mr Hosking was not aware that arrangements had been made for TGB lawyers to attend the prison. Ultimately, the subject officers declined to provide statements to the police and several officers also declined to submit employee incident reports (on legal advice).

15.22. Events in the Gatehouse and related events

15.23. The Gatehouse vision shows that during the afternoon the Gatehouse was a hive of activity. As stated, senior managers were absent, and it is undisputed that the strict security measures, which require all staff and visitors entering or leaving the Gatehouse to pass through the Xray machine and the eye scanner, were ignored. Rather, a bypass route which is generally only available to authorised personnel such as police and emergency services was used instead. Several people came and went without passing through security. For example, the President of the Public Service Association ('PSA'), Mr Griffiths, arrived and was admitted to the Gatehouse by his wife, Supervisor Bell. Mr Griffiths was not even rostered to work that day. Solicitors also used the bypass route to access the prison later in the day.

15.24. During his evidence, A/GM Hosking expressed frustration that he had not been advised of the arrival of the police and their request to come on site. He was also unaware of the security breaches that were occurring in the Gatehouse.<sup>505</sup>

15.25. The vision shows the police walking through the non-public area of the gatehouse, apparently unaware that some of the officers who Mr Hosking had said were ready to provide statements were in the same area.

---

<sup>505</sup> Transcript, pages 6934-6936, 6942-6943

- 15.26. Supervisor Bell was in charge of the Gatehouse at the time of the incident. After her shift was complete she remained there of her own volition for many hours. The effect of Supervisor Bell's evidence was that she had no option but to stay because she had no confidence in senior management to provide assistance or to support the staff.<sup>506</sup>
- 15.27. It is evident from the vision and the evidence that Supervisor Bell assumed a leadership role in the aftermath of the incident. The vision shows her frequently on the telephone as she moved about the non-public area of the Gatehouse, and she can be seen speaking to many of the correctional officers who were milling around in the area including van officers.
- 15.28. Supervisor Bell made no secret of the fact that she did not initiate or engage in ongoing communication with A/GM Hosking, or any other member of senior management. Supervisor Bell confirmed that she did not report the arrival of police or provide updates to management of what was occurring in the Gatehouse throughout the afternoon. Supervisor Bell was unapologetic. When asked by Counsel Assisting to explain why she did not, for example, convey the arrival of police to management, she said it was not her job to do so and it was the responsibility of management to manage the prison. I do not intend to set out the evidence in detail. Suffice it to say that Supervisor Bell had no confidence in the management team.
- 15.29. CO Penn is a CO2 officer and an executive member of the COLF.
- 15.30. CO Penn arrived for work at around 3:15pm. Although CO Penn was not involved in the incident, shortly after arriving he made two telephone calls to TGB to arrange for lawyers to attend at the prison. CO Penn agreed in cross-examination that he also requested a supervisor (Supervisor Joseph) to cease uploading employee incident reports in circumstances where it is undisputed that A/General Hosking had directed the supervisor to upload these reports.
- 15.31. The thrust of CO Penn's evidence was that he was simply acting as a conduit between the correctional officers who had been involved in the incident and TGB so as to assist his colleagues.

---

<sup>506</sup> Transcript, pages 4141-4145

15.32. It appeared somewhat unusual that a junior ranked CO2 officer liaised directly with a firm of lawyers in relation to an incident in which he had no involvement. It also seemed odd that a supervisor would defer to a request from a CO2 officer to cease uploading employee incident reports, particularly since he had been directed by the A/General Manager to upload the reports. This apparent anomaly led to an examination of the registered COLF Constitution (over objection of counsel for individual officers). It was a legitimate topic for cross-examination, particularly in light of Clause 4 of the registered COLF Constitution.

15.33. The COLF Constitution

15.34. Exhibit C227 is a copy of the Constitution of the Correctional Officers Legal Fund registered with Consumer and Business Services. The relevant clauses are these:

15.34.1. Clause 4(b)(i) prescribes that any COLF members against whom allegations of an offence[s] has been made, 'shall refuse to be interviewed' unless the solicitor then acting on behalf of this Fund, or a representative of that solicitor, is present during the interview'.

15.34.2. Clause 4(c) prescribes that 'Any member of the Fund who witnesses any incident involving another officer, whether or not that other officer is a member of this Fund or not, shall refuse to make any statement, or to be interviewed, until they have been authorized by the Committee'.

15.34.3. Elsewhere in Clause 4(c) it is stated that, 'Any member who disobeys any aspect of this Constitution, may have their membership of the Correctional Officers' Legal Fund cancelled, and be expelled from all rights and privileges available to members of the said Fund'.<sup>507</sup>

15.35. First, no allegations of an offence[s] has been made against any correctional officer or member of staff. Secondly, Clause 4(1)(c) contains a prohibition against providing any statement or interview unless it was authorised by 'the Committee'. Thirdly, there are adverse consequences for any member who 'disobeys' any aspect of the Constitution,

---

<sup>507</sup> See notation in Clause 4(c)

namely, cancellation of COLF membership and expulsion from all the rights and privileges that are available to members.

- 15.36. Ultimately, most correctional officers declined to provide statements to the police and some officers also declined to submit employee incident reports (on legal advice). A question arose as to the role, if any, of the COLF in the decisions made by officers and other potential witnesses not to file reports or speak with the police and whether they had felt pressured by COLF members not to provide such statements or reports.
- 15.37. COs Skuse, Sniatynskj, Greenwood and London and Supervisors Gibson and Murti gave relevant evidence on the topic. They were credible and reliable witnesses. I am satisfied that few, if any officers, had read or considered the COLF Constitution when making their decision not to provide statements to the police.
- 15.38. CO Golding said he did not speak to police because he would have been ‘instructed’ as he always was by the COLF. He said it would not have been his decision not to speak to the police, but rather he would have ‘followed the procedure’ by going through the legal fund representative and TGB would tell him ‘Don’t say nothing’.<sup>508</sup>
- 15.39. CO Chapman spoke with the PSA President, Mr Griffiths, who advised him that the police and legal team were present and that ‘under legal advice we are not giving statements at this stage’.<sup>509</sup>
- 15.40. Supervisor Gibson recalled that CO Penn and Supervisor Bell advised staff of their right to seek legal help.<sup>510</sup>
- 15.41. Supervisor Murti said ‘the information passed through Mr Michael Penn through the legal fund to someone in the holding cells not to submit any reports until legal advice was obtained’. Supervisor Murti said he complied with the direction because CO Penn is the COLF representative.<sup>511</sup>
- 15.42. CO Skuse said that someone in the legal fund told him not to submit his employee incident report.<sup>512</sup>

---

<sup>508</sup> Transcript, pages 217-218

<sup>509</sup> Transcript, page 1107

<sup>510</sup> Transcript, pages 1233-1234

<sup>511</sup> Transcript, pages 1605-1606, 1614

<sup>512</sup> Transcript, page 1788

- 15.43. CO Sniatynskj said that Supervisor Bell spoke to her in the Gatehouse and gave her some advice. After this conversation CO Sniatynskj decided not to submit an incident report until she received legal advice.<sup>513</sup>
- 15.44. CO Kent said he received advice from a member of the COLF but he could not recall the advice or who it was.<sup>514</sup>
- 15.45. CO London said the information not to provide a statement ‘was well and truly around the place’. He agreed in cross-examination that it spread like wildfire. CO London said that on the day of the incident he had received phone calls from representatives of the PSA or the COLF (or potentially both) saying that no statements were to be provided to police.<sup>515</sup>
- 15.46. CO Greenwood was in the car returning from hospital when he learned that the legal fund was involved and no one was to submit an employee incident report.
- 15.47. It seems likely that many officers relied on the information that was spreading through the prison via COLF representatives and others to determine whether or not to provide statements to police and/or to file employee incident reports. In determining whether or not it was reasonable to do so, it is noteworthy that there was no protocol or Memorandum of Understanding in place between the DCS, PSA and the COLF to facilitate prompt access by correctional officers and other staff to legal advice after such an incident.
- 15.48. Ultimately, Counsel Assisting lay much of the blame for the chaos in the Gatehouse at the feet of Supervisor Bell whose conduct was described as a glaring example of the lack of co-operation between senior staff and Management. Criticism was also directed at CO Penn whom, it was submitted, had ‘extraordinary influence’ and had acted in a ‘clandestine and contentious manner’.<sup>516</sup> I do not intend to repeat the criticisms made by Counsel Assisting. Suffice it to say that he was highly critical of both officers.

---

<sup>513</sup> Transcript, page 2330

<sup>514</sup> Transcript, page 3128

<sup>515</sup> Transcript, pages 3292-3293, 3295

<sup>516</sup> Written submissions by Counsel Assisting at [178]

- 15.49. Counsel for Supervisor Bell and CO Penn, Mr Abbott KC, made detailed submissions in response to the criticisms. It is unnecessary to repeat these submissions.<sup>517</sup> Suffice it to say that it was argued that both officers acted in good faith post incident and without any support from management. In the circumstances, it was submitted that the criticisms were unfounded and unfair, and that no adverse findings should be made against Supervisor Bell or CO Penn.
- 15.50. There was certainly a flavour of tension between some senior correctional officers and management. The latent tension was reflected in parts of their evidence, including that of A/GM Hosking. Some would say that parts of Supervisor Bell's evidence reflected blatant disrespect and even contempt for management. Others may say the evidence reflected that of a passionate and fearless correctional officer.
- 15.51. It is easy to find fault in the performance of individuals after minute examination of events in a courtroom setting, however, *it must be borne in mind that a coronial inquest is primarily a fact-finding exercise and not a method of apportioning blame* (unless the impugned conduct of a person deviates from acceptable standards to a significant degree). Ideally, management should have been informed of the arrival of the police and the unfolding events in the Gatehouse. Similarly, CO Penn, Mr Griffiths and/or COLF executive members should have informed management as to the arrangements that were being made for the attendance of solicitors at the prison because it directly impacted on the management of staff post incident. That said, I am mindful that the Court did not receive evidence about the history of the relationship between management and senior officers, the COLF and/or the reasons why officers such as Supervisor Bell had so little faith in management. In the circumstances, one must exercise caution before drawing any adverse inferences or making findings against individual officers such as Supervisor Bell or CO Penn.
- 15.52. I note that on 30 January 2007, former State Coroner for South Australia, Mr Mark Johns, handed down his findings in relation to the death in custody of Mr Stuart Murray Chalken, and recommended that DCS commence negotiations with the Public Service Association ('PSA') and the COLF with a view to achieving greater cooperation with coronial inquiries. It is unclear whether such discussions ever took place. Given the

---

<sup>517</sup> Closing submissions of Michael Abbott QC on behalf of Messrs Penn and Dean at [1]-[57] and Ms Bell in reply to Counsel Assisting's submissions, 3 August 2021

apparent lack of cooperation between the respective groups on the day of Mr Morrison's incident, it would be an opportune time to commence or recommence such discussions.

- 15.53. The officers in the Gatehouse were undoubtedly being flooded with questions by those who were milling around in the area. The absence of senior management on the ground is a relevant factor and their absence compounded an already complex situation. When viewed in this light, it is perhaps unsurprising that officers such as Supervisor Bell, CO Penn, and PSA representatives took matters into their own hands. It is not unusual for a major incident to expose underlying tensions in a workplace as well as individual and organisational shortcomings.
- 15.54. In assessing the events in the Gatehouse I have also reflected on the fact that uniform SAPOL officers had arrived in numbers; CIB detectives then arrived followed by officers from Major Crime. Although no correctional officer or employee was being treated as a suspect by police, or alleged to have committed an offence[s] at that time, the reality of the situation was that van officers and other potential witnesses were being directed by management to stay behind at the end of their shifts, and to provide statements to police in circumstances where it was known that a prisoner had been taken from the prison by ambulance in a cyanosed and unconscious state.
- 15.55. So far as Supervisor Bell and CO Penn are concerned, I decline to make the adverse findings that are sought by counsel for the Morrison family and Counsel Assisting. It has not been demonstrated that they acted with mal fides or engaged in conduct that was designed to frustrate or compromise the police investigation. Their actions are equally consistent with the existence of a dysfunctional workplace at Yatala in which the relationship between senior correctional officers, COLF members, union representatives and management is under considerable strain, as well as a desire to support their colleagues in difficult circumstances. Senior management must also accept responsibility for the ineptitude of the post incident institutional response. Management should have been taking a leadership role in the management of an operational crisis.
- 15.56. It was beyond the scope of this inquest to examine the apparent tensions that appear to exist between these groups, but the evidence was sufficient to demonstrate that a lack

of cooperation between the groups impacted on the institutional response to the crisis. For obvious reasons such issues must be examined and resolved.

15.57. Validity of the Correctional Officers' Legal Fund Constitution

15.58. Mr Brown, the Chief Executive of the Department, was asked some questions by Counsel Assisting directed at the validity of the Constitution and the potential conflict between Clause 4 and the requirements of the *Correctional Services Act* (and also various DCS Standard Operating Procedures). Chief Executive Brown agreed that it would be reasonable for the Department to take legal advice about the validity of the constitution and whether Clause 4, in its present form, is in conflict with other legislative requirements. It is not for this Court to determine whether the contractual obligations sought to be imposed by the registered Constitution upon the members of the COLF are lawful. It is an important issue, but it is for others to determine.

15.59. Reports of Mr Zadow, Mr Don Muller, Detective Senior Sergeant Georg and the Ombudsman

15.60. It is also beyond the scope of this inquest to canvas the detailed findings and recommendations made by Mr Zadow (2017), Mr Don Muller (3/2018), Detective Senior Sergeant Georg (30 April 2018), and the Ombudsman (19 August 2020) both in relation to the substantive events and the post incident management of the incident. Suffice it to say these reports identified many of the shortcomings and deficiencies which have been highlighted in this Finding. Chief Executive Brown confirmed that some of the issues have been addressed or are in the process of being addressed, however, I find that the response by the Department has been extraordinarily slow. Given the dates on which these reports were available, it is no answer to say that the Department was awaiting the outcome of this inquest before finally determining its position. Each of the reports contained valuable findings and recommendations which could and should have been promptly reviewed, applied and implemented.

16. **Proposed recommendation for an investigatory body to be established by the State Government**

16.1. Before I set out the Court's findings and recommendations it is apposite to mention the proposed recommendation made by Counsel Assisting that an investigatory body be established by the State Government for the purpose of compelling the correctional

officers who travelled in the van with Mr Morrison to answer questions about the events surrounding his medical collapse (with appropriate evidentiary protections).

- 16.2. In essence it was submitted that the exercise of the privilege against self-incrimination by the van officers has resulted in the Court being unable to obtain ‘all relevant information’ and that the Court has been precluded from hearing evidence that would ‘assist to understand better the multiple factors which may have contributed to Mr Morrison suffering a cardiac arrest and their respective roles in such an event’. The unavailability of such evidence was described as regrettable.<sup>518</sup>
- 16.3. Counsel for the Morrison family supported the proposal and the submissions made by Counsel Assisting albeit erroneously suggesting in written submissions that Counsel Assisting had called for a further investigation into ‘the circumstances of Mr Morrison’s death’.<sup>519</sup> As I understand it, Counsel Assisting proposed a much narrower inquiry directed at examining the subject witnesses about the ‘medical collapse’ of Mr Morrison, that is to say, the events inside of the van en-route to G Division and the attempted resuscitation of Mr Morrison at the G Division sally port which, it was submitted, had not been able to be explored in this inquest.
- 16.4. Counsel for the Morrison family annexed a letter written by the Morrison family to the written submissions made on behalf of the family. The letter supports the appointment of an investigatory body to ‘finally and comprehensively establish all the relevant, truthful circumstances leading to and causing Wayne’s death’ and to ‘establish all the circumstances that have enabled the conduct of the CSO[s], the Correctional Officers Legal Fund, the lawyers acting for the officers and the Department for Correctional Services to defeat the effective operation of the coronial investigation and inquest into Wayne’s custody and death’.<sup>520</sup>
- 16.5. Mr Henchcliffe KC was critical of the proposal,<sup>521</sup> and denounced part of the family’s letter as offensive, unfair and inaccurate.<sup>522</sup> Even if the Court determines that the expanded recommendation provisions apply, it was submitted that the proposed

---

<sup>518</sup> Refer closing submissions of Counsel Assisting at page 54, [215.1], [217]-[219]

<sup>519</sup> Refer Appendix X item 20

<sup>520</sup> Written submissions on behalf of counsel for the Morrison family at page 192, [51]

<sup>521</sup> Written closing submissions for Members of the COLF at [168]-[174]

<sup>522</sup> Supplementary written closing submissions for members of the COLF at [114]

recommendation does not relate to a matter arising from the inquest, that is, in the circumstances, an appropriate matter on which to make a recommendation.<sup>523</sup>

- 16.6. Counsel for the Central Adelaide Local Health Network submitted that the proposal ‘lacked sufficient detail’ and failed to set out any power or mechanism by which the inquiry could or would be constituted and conducted.<sup>524</sup>
- 16.7. Counsel for the Department for Correctional Services also opposed such a recommendation.<sup>525</sup>
- 16.8. I decline to make such a recommendation. It is not an appropriate matter on which to make a recommendation. *The practical effect of its implementation would be to circumvent the operation of the privilege against self-incrimination as it applied to coronial inquests at the time of this inquest.*<sup>526</sup>
- 16.9. As stated at the outset of this Finding the self-incrimination provisions in the *Coroners Act 2003* have since been amended. If the new provisions had been in force at the time Mr Morrison’s inquest commenced the van officers could have been directed to answer questions on the impugned topics and certificates could have been issued to prevent the any evidence, documents or information obtained as a result of answering questions being used against the van officers in any other legal proceedings.
- 16.10. The late change in the law in South Australia was undoubtedly deeply frustrating and distressing to the Morrison family. The family and Mr Morrison’s many friends and supporters had waited several years for this inquest and they had reasonably anticipated hearing first-hand from all correctional officers who were involved in the incident, including those who travelled with Mr Morrison in the van in the last conscious minutes of his life. However, the Parliament of South Australia did not make the amended provisions retrospective in operation and the officers’ assertions of the self-incrimination privilege were upheld by this Court. The frustration of the family is reflected in the contents of the annexed letter referred to above. If the letter was intended to suggest that the self-incrimination privilege was used inappropriately or that solicitors or counsel have engaged in impropriety it is unfortunate. It cannot be

---

<sup>523</sup> Supplementary written closing submissions for members of the COLF at [110]-[113]

<sup>524</sup> Supplementary submissions of the Central Adelaide Local Health Network dated 13 September 2021 at [2]-[4]

<sup>525</sup> Submissions on behalf of the Department for Correctional Services and others dated 23 August 2021 at [29]

<sup>526</sup> See for example written closing submissions for Members of the COLF (3 August 2021) at [168]-[174]

overemphasised that in exercising the privilege against self-incrimination, the van officers were exercising a legal right which was enshrined by law. They were entitled to exercise that right. No adverse inference can be drawn against a person for the exercise of legal rights.

**17. Proposed recommendation to address alleged failures by the Department for Correctional Services to implement and monitor the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) Report**

17.1. Counsel for the Morrison family provided detailed submissions directed at the Australian Human Rights and Equal Opportunity Commission ('HREOC') report into Aboriginal Deaths in Custody and a 2017 report of a review by the National Indigenous Australians Agency ('NIAA') and related matters. Reference was made to the NIAA report which concluded that systemic failures to implement the RCADIC recommendations had occurred in South Australia which, had they been implemented, could have prevented Mr Morrison's death.<sup>527</sup>

17.2. Counsel for the Morrison family submit that the Court should recommend the implementation of particular RCADIC recommendations which are said to arise from these proceedings.<sup>528</sup>

17.3. The matters raised by the submissions are clearly important. That said, the examination of the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody at Yatala Labour Prison (or in any other correctional facility in South Australia) was not central to this inquiry and would necessarily require a whole of government approach.

17.4. It is not an appropriate matter on which to make recommendations.

**18. Proposed recommendation for disciplinary and criminal charges against correctional officers and funding of counsel in coronial matters**

18.1. Counsel for the Morrison family proposed that the Department for Correctional Services lay disciplinary charges against individual correctional officers and other members of DCS staff,<sup>529</sup> and that the five van officers who travelled in the rear

<sup>527</sup> Written closing submissions of counsel for the Morrison family at pages 146-147, [602]

<sup>528</sup> Ibid at pages 148-177

<sup>529</sup> Written submission of counsel for the Morrison family at Annexure D [61]-[79]

compartment with Mr Morrison be referred to the Director of Public Prosecutions ('DPP') 'for investigation of criminal charges'.<sup>530</sup>

- 18.2. Section 25(3) of the Coroners Act precludes the Court from making any finding, *or suggestion*, of criminal or civil liability. As stated by Mr Henschcliffe KC, recommendations that disciplinary charges be laid, exposing correctional officers to the imposition of civil penalty, necessarily involve a suggestion of civil liability and are prohibited.<sup>531</sup> Similarly, the suggested referral of the five van officers to the DPP for investigation of criminal charges is beyond power.
- 18.3. The suggested recommendation relating to funding lawyers to represent the interests of family members of a deceased person in coronial inquests<sup>532</sup> is not an appropriate matter on which to make a recommendation.

## 19. SUMMARY AND FINDINGS

- 19.1. The inquest into the death of Wayne Fella Morrison has attracted wide publicity and media attention both locally and overseas.<sup>533</sup> The hearing has also overlapped with the Royal Commission into the Protection and Detention of Children in the Northern Territory,<sup>534</sup> the death of George Floyd in the United States, and protests by the Black Rights Movements regarding black deaths in Australia and overseas.
- 19.2. There has been extensive media coverage of this inquest in South Australia and elsewhere. The coverage has undoubtedly fuelled emotion and public speculation about the cause and circumstances of Mr Morrison's death, a matter which, it should be observed, is solely for the Coroner to determine.
- 19.3. The evidence has revealed a litany of failings and shortcomings at every stage of Mr Morrison's management whilst he was in the care and custody of the Department for Correctional Services. The evidence has also demonstrated that in an operational crisis the management team was unable to coordinate and effectively manage the post incident response. Before I turn to the key findings, it is apposite to re-emphasise that

---

<sup>530</sup> Ibid at [80]

<sup>531</sup> Supplementary written closing submissions for members of the COLF at [120]

<sup>532</sup> Written submission of Counsel for the Morrison family at [709]-[740]

<sup>533</sup> Reference to an article published on Adelaide Now on 25 May 2017 after Mr Morrison's mother and sister had given evidence before a Parliamentary Committee and commented about the bruising they saw on Mr Morrison

<sup>534</sup> An interim report was delivered on 1 March 2017. The Final Report was tabled in the Australian Parliament on 17 November 2017

(a) an inquest is primarily a fact-finding exercise and not a method of apportioning blame and (b) the importance of having regard to hindsight bias when assessing the evidence and potential criticism of individuals.

- 19.4. A description of ‘hindsight bias’ is given in the Australasian Coroner’s Manual, namely, ‘the tendency after the event to assume that events are more predictable or foreseeable than they really were’. It is further stated that:

‘What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person’s reputation.

Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.’

- 19.5. I have been very mindful of both matters when considering the evidence in this inquest and the conduct of correctional officers in the days leading up to the incident and on the day of the incident. For the reasons expressed in this Finding, by and large I have declined to make adverse findings against individuals, including the five officers who travelled in the rear compartment of the prison van with Mr Morrison to G Division. The conduct of individuals must be considered against the whole of the evidence which includes glaring deficiencies in the training of correctional officers at Yatala Labour Prison which were exposed when these officers were called upon to manage a major incident.

## 20. **Key findings**

### 20.1. Cause of death

- 20.1.1. I find that Mr Morrison died as a result of hypoxic ischaemic encephalopathy and multi-organ failure due to an out of hospital primary cardiac arrest (in the setting of psychological and physical stress, exertion, restraint and coronary artery disease).

### 20.2. Mr Morrison’s cardiac arrest

- 20.2.1. I find that no single factor or mechanism can be identified as the sole underlying cause or explanation for Mr Morrison’s cardiac arrest. The potential causes are multifactorial in nature and include the effects of marked

physical exertion, emotional and psychological stress and underlying coronary artery disease.

- 20.2.2. I accept the expert evidence that marked physical exertion, of itself, is known to cause sudden cardiac death and often in young males with morphologically normal hearts.
- 20.2.3. I accept the expert evidence that emotional and psychological stress, of itself, is known to cause sudden cardiac death and that the presence of coronary artery disease placed Mr Morrison at greater risk of sudden cardiac death.
- 20.2.4. I find that at the time of his death Mr Morrison was suffering from coronary artery disease with focal moderate to severe (70%) atheroma of the right coronary artery. I further find that while the underlying coronary artery disease would not of itself account for Mr Morrison's sudden cardiac death, it is a factor which placed him at a greater risk of sudden cardiac death.
- 20.2.5. When did the physiological processes which ultimately led to Mr Morrison's cardiac arrest commence?
- 20.2.6. I find that the physiological processes which ultimately led to the cardiac arrest may have been underway prior to the restraint, that is, before Mr Morrison charged from Cell 5 and/or during his violent attack on the correctional officers in the holding cells. It is also possible that these physiological processes did not commence until Mr Morrison was being restrained, or as he was lifted by his limbs and carried from the holding cells building (without body supports). However, due to the complexity of the unfolding chain of events and the overlapping factors and mechanisms which may have been at play, it is not possible to pinpoint when these processes commenced.
- 20.2.7. It is not open to make the finding suggested by counsel for the Morrison family, namely, that it was the circumstances of the restraint and the manner of Mr Morrison's removal from the building which caused Mr Morrison's death. The stages of the unfolding chain of events cannot be neatly dissected into separate parts with causal factors attributed to any particular stage of the

events. Relevantly, the submission fails to have regard to the events which preceded the restraint, the physical exertion of Mr Morrison during his attack on the four correctional officers in the holding cells, and Mr Morrison's underlying coronary artery disease.

20.3. The restraint

- 20.3.1. I find that when CO Allen Radford unlocked Mr Morrison's cell (Cell 5) he had no warning as to what was about to occur.
- 20.3.2. I find that once the cell doors were unlocked Mr Morrison charged from the cell causing the heavy metal outer door to hit CO Radford in the upper body.
- 20.3.3. I find that within a matter of seconds Mr Morrison had physically attacked four correctional officers (including CO A Radford) with such a degree of force that three of them were grounded and sustained a brief loss of consciousness.
- 20.3.4. I find that a fourth correctional officer was punched in the face several times but he managed to stay on his feet.
- 20.3.5. I find that the situation faced by the responding correctional officers on the morning of 23 September 2016 was a potentially life-threatening situation. I further find that it was essential for Mr Morrison to be restrained as quickly as possible so as to prevent the risk of further bodily injury to correctional officers or death.
- 20.3.6. I find that the techniques and methods used to restrain Mr Morrison were recognised DCS methods of restraint.
- 20.3.7. I find that Mr Morrison put up fierce physical resistance to all efforts to restrain him throughout the restraint. I further find that the level of his resistance required marked physical exertion on his part and would have placed him under significant emotional and psychological stress. These factors increased the risk of sudden cardiac death, particularly in a person such as Mr Morrison who had underlying coronary artery disease.

20.3.8. I find that the level of force used by correctional officers during the restraint was a reasonable and necessary use of force in the circumstances. It was not an excessive use of force.

20.4. The use of restraint equipment (handcuffs, leg cuffs and the spit mask)

20.4.1. As to the use of restraint equipment, I find that it was necessary to handcuff Mr Morrison and that the application of handcuffs to the rear is an accepted DCS method of restraining a non-compliant prisoner.

20.4.2. The evidence does not support a finding that the restraint of Mr Morrison in the prone position in the mess room corridor resulted in any clinically significant degree of respiratory compromise. Nor does the evidence support a finding that the combined weight of the correctional officers who leaned in on Mr Morrison (directly and indirectly) whilst he was in the prone position resulted in any clinically significant degree of respiratory compromise.

20.4.3. I find that it was necessary to call for leg restraints to secure Mr Morrison's ankles due to his ongoing kicking and the inability of officers to apply a standard Figure Four leg lock due to the strength of Mr Morrison's physical resistance.

20.4.4. I find that standard metal leg restraints should have been used to secure Morrison's ankles and the decision made by Supervisor Joseph to use plastic flexi-cuffs as leg restraints was an error of judgment. I further find that plastic flexi-cuffs are not designed for primary use as leg restraints and that once secured around Mr Morrison's ankles he was unable to stand properly or to walk.

20.4.5. I find that the Department for Correctional Services failed to provide any training to correctional officers at Yatala in the use of leg restraints (such training being reserved for members of special units such as the Emergency Response Group). I further find that only one ERG member was present during the restraint and he played a peripheral role.

- 20.4.6. I find that one of the two supervisors who was in charge of the holding cells had virtually no experience in managing non-compliant prisoners. The Department has provided no satisfactory explanation for the lack of training or indeed any explanation for why such a supervisor would be placed in charge of the holding cells where prisoners are frequently being moved about thereby exposing officers to a risk of violence and the need for the unplanned use of force.
- 20.4.7. I find that Mr Morrison was spitting during the restraint, albeit he was spitting onto the floor and not in the direction of any individual officer or group of officers. Despite the direction of the spittle, I find it was necessary to use a spit mask and there is no basis to criticise the decision of Supervisor Joseph to call for a spit mask. The risk of transmission of infectious diseases by saliva and other bodily fluids is well known and needs no elaboration. Correctional officers are not required to wait until they are spat at, or on, before taking protective measures, particularly in circumstances where the prisoner is continuing to resist all efforts to restrain him as well as yelling and shouting, conduct which posed a real risk that spittle could land on the officers' faces or bodies in the ongoing restraint process.
- 20.4.8. I find that at the time of Mr Morrison's death the Department for Correctional Services provided no training to correctional officers in the use of spit masks and/or the dangers associated with incorrect use.
- 20.4.9. No satisfactory explanation has been given by the Department for permitting and indeed requiring correctional officers to work in an operational capacity involving contact with prisoners without receiving training in the use of leg restraints and spit masks.
- 20.4.10. As to proficiency in restraint methods and techniques, I find that a majority of the correctional officers who were involved in the restraint of Mr Morrison had not completed mandatory DCS refresher restraint training. I further find that the Department did not enforce its own refresher training requirements.

- 20.4.11. No satisfactory explanation has been given by the Department for its failure to provide training in essential skills or to enforce its own mandatory refresher restraint training requirements.
- 20.5. Did the manner in which Mr Morrison was removed from the building involve an excessive use of force?
- 20.5.1. I find that the decision to transfer Mr Morrison to G Division was consistent with Standard Operating Procedure-012 and established Departmental protocols for the management of violent prisoners.
- 20.5.2. I find that once Mr Morrison was restrained he posed no appreciable risk to the safety and welfare of any person.
- 20.5.3. I find that an attempt was made to bring Mr Morrison to his feet, but he was unable to stand or walk properly due to the use of the plastic flexi-cuffs as leg restraints.
- 20.5.4. I find that the decision to lift Mr Morrison by his limbs and to carry him at hip height from the building to the van without the use of body supports was an excessive use of force. It was not a necessary or reasonable use of force. I further find that the manner of removal exposed Mr Morrison to a risk of serious physical injury and to further emotional and psychological stress, noting that the spit mask would have obscured his view and he did not know where he was being taken or for what purpose. It would undoubtedly have been a terrifying experience for a person who had never been to prison before.
- 20.5.5. I find that once Mr Morrison was restrained in the holding cells corridor there was no urgency to transfer him to G Division. I find that it was an opportune time to retrieve a set of standard leg restraints and apply them in lieu of the plastic flexi-cuffs. If this had occurred I find that Mr Morrison could be brought to a standing position and he could have been walked to the van.
- 20.5.6. I cannot eliminate the possibility that the physiological processes which ultimately led to Mr Morrison's cardiac arrest commenced after he had been restrained and as he was being carried to the van. This conclusion underscores

the critical importance of ensuring that all correctional officers maintain their skills and the need for rigorous enforcement of refresher restraint training.

20.5.7. The Court received no expert evidence regarding the use of de-escalation techniques in the context of violent, non-compliant prisoners and the unplanned use of force. I make no finding as to other possible options that may have been available to manage Mr Morrison during the restraint and after he was restrained.

20.5.8. On the available evidence I am unable to determine whether any adjustment was made to the spit mask as the carrying party approached Door 10.

20.6. The placement of Mr Morrison in the van

20.6.1. I find that Mr Morrison was carried through exit Door 7 and placed directly in the van head first and face down. I further find that he was wearing the spit mask.

20.6.2. I find that at the time of Mr Morrison's death the Department provided no training to correctional officers in the use of the Yatala internal escort van, the safe placement of prisoners in the van and/or the monitoring of their safety during transit.

20.6.3. To compound matters I find that at the time of Mr Morrison's death, the Department for Correctional Services had not implemented any Standard Operating Procedure setting out the obligations and responsibilities of correctional officers in relation to the van and its use.

20.6.4. I find that at the time of Mr Morrison's death the van was not equipped with visual and/or audio recording equipment.

20.6.5. I find that the Department had allowed ad hoc practices to develop in relation to the transport of prisoners in the van and that inconsistent practices had developed in relation to the placement of prisoners in the van, the area in which they travelled, and the number of officers who were permitted to accompany non-compliant prisoners. Basically, correctional officers were

left to work out for themselves how to manage prisoners in the van without training or written guidelines.

20.6.6. The evidence provides no support for any suggestion of mal fides in relation to the fact that five correctional officers were permitted to travel in the rear compartment with Mr Morrison, or the fact that the spit mask was not removed for the journey. I find it more likely than not that little or no thought was given to the risk of placing Mr Morrison face down in the van while wearing a spit mask and that the pressure of the circumstances, lack of training, and ignorance, played a part in decision making at that time.

20.7. Did Mr Morrison suffer the cardiac arrest in the van or at an earlier time?

20.7.1. Having considered the whole of the evidence I consider it unlikely that Mr Morrison was in cardiac arrest during the restraint or while he was being carried from the holding cells area to the escort van.

20.7.2. While it cannot be entirely excluded that the bucking movements observed by witnesses as Mr Morrison was carried through exit Door 7 were the product of involuntary spasms (which may occur in the context of a cardiac arrest), I find that Mr Morrison's ability to continue shouting out abuse at this time suggests that some respiratory drive was present and that he was not in cardiac arrest at that time.

20.7.3. I find that Mr Morrison suffered the cardiac arrest while he was inside the van.

20.7.4. On the available evidence, I am unable to determine with any level of certainty when in the van journey Mr Morrison suffered the cardiac arrest, that is to say, whether it was shortly after the rear van door was closed and the journey commenced, early in the van journey, or shortly before the van arrived at the G Division sally port.

20.7.5. For the reasons set out in this Finding, the evidence does not support a finding that any acts and/or omissions by the eight van officers during the journey to G Division caused or contributed to Mr Morrison's death.<sup>535</sup>

---

<sup>535</sup> For full discussion see Section 12 of the Finding

20.8. Did the spit mask cause or contribute to Mr Morrison's death during the van journey?

20.8.1. I find that the spit mask was not removed before the van journey commenced. With the benefit of hindsight it would have been prudent to remove the mask noting that if spitting had continued, the spittle would only have landed on the floor of the van or at the officers' feet.

20.8.2. I find that Mr Morrison was wearing the spit mask throughout the journey and it was not removed until he had been lifted from the van and placed on the ground in the G Division sally port.

20.8.3. The evidence does not support the finding sought by counsel for the Morrison family that Mr Morrison travelled face down in the van for the entire journey. The submission is based on speculation about Mr Morrison's presentation and position during the journey and ignores the paucity of evidence about the van journey. It also fails to have regard to the evidence of at least one witness that on arrival at the G Division sallyport Mr Morrison's head may have been tilted to the side.

20.8.4. That said, I find that the spit mask was potentially one of the many factors or mechanisms that may have caused or contributed to Mr Morrison's death. The other factors are marked physical exertion (known to cause sudden cardiac death per se), acute emotional and psychological stress (known to cause sudden cardiac death per se) and Mr Morrison's underlying coronary artery disease, a factor which placed him at greater risk of sudden cardiac death. Put bluntly, it is misleading to suggest that the spit mask was a primary causative factor in Mr Morrison's death. The evidence falls far short of proof of such a fact.

20.9. Events in the G Division sally port - was there a delay in the commencement of chest compressions and did it cause or contribute to Mr Morrison's death?

20.9.1. I find that when Mr Morrison was removed from the van at G Division he was cyanosed and unresponsive.

20.9.2. I find that a direction was given for all restraints, including the spit mask, to be removed.

- 20.9.3. I find that by 11:36:48 Mr Morrison had been rolled into the recovery position and a brief safety check was conducted by CO Connor. There is no basis to criticise CO Connor's decision to conduct the safety check before checking for respiration and a pulse.
- 20.9.4. I find that no respiration or pulse was detected.
- 20.9.5. I find that COs Connor and Kent called for resuscitation equipment and for the removal of all restraints.
- 20.9.6. I find that the plastic ankle restraints could not be removed manually and required a knife for removal.
- 20.9.7. I find that Supervisor McLeod arrived in the sally port with an Automated External Defibrillator at 11:37 and the defibrillator machine was prepared for use.
- 20.9.8. I find that Mr Morrison's spit mask was removed sometime between 11:36:42 and 11:37:59.
- 20.9.9. I find that the ankle restraints were cut off between 11:37:57 and 11:38:12 or thereabouts, and an Air Viva manual resuscitator arrived in the sally port while these restraints were being removed.
- 20.9.10. I find that the SA Prison Health Service medical team arrived at 11:39:00. I find that Dr Farrall directed CO Connor to commence chest compressions.
- 20.9.11. I find that the first chest compressions were delivered at 11:39:16. By this time Mr Morrison had been on the ground for approximately three minutes.
- 20.9.12. I find that the chest compressions could and should have commenced as soon as it was determined that Mr Morrison had no pulse or respiration.
- 20.9.13. I find that valuable time was lost while officers waited for the resuscitation equipment (and the Hoffman knife) to be retrieved.
- 20.9.14. I find that no resuscitation equipment was kept in the G Division sally port. This equipment, as well as the Hoffman knife, was kept in the G Division

Circle which can only be accessed through several locked security doors, noting that it takes time for each door to be opened and closed on entry and exit.

- 20.9.15. I find that although CO Connor held a valid cardiopulmonary resuscitation (CPR) qualification, he held a genuine but mistaken belief that it was necessary to wait for the defibrillator before chest compressions could commence.
- 20.9.16. I find that no other correctional officers came forward to offer assistance at this time or to suggest that chest compressions should commence pending the arrival of the resuscitation equipment.
- 20.9.17. I find that at the direction of Dr Farrall, CO Connor and another officer took turns to administer the chest compressions. I find that once commenced, the chest compressions were performed competently. There is no basis to criticise the hand positions, the depth of compressions or the brief pauses in the delivery of the chest compressions (for the purpose of rescue breaths).
- 20.9.18. I find that the first ambulance arrived at the sally port at around 11:47:31 and that SAAS paramedics assumed control of Mr Morrison's resuscitation.
- 20.9.19. I find that Paramedic Kosmala and his colleagues worked tirelessly on Mr Morrison and achieved a spontaneous return of circulation shortly before 12:25pm. I find that by this time, Mr Morrison had been without spontaneous circulation for at least 31 minutes.
- 20.9.20. I find no basis to criticise the efforts made by the SAAS paramedics at the sally port to resuscitate Mr Morrison.
- 20.9.21. As stated in this Finding, I accept the evidence of Intensive Care Specialist Dr Flabouris on the topic of cardiopulmonary resuscitation. Ideally CPR should be started as soon as possible following a cardiac arrest. I find that the chance of survival is reduced exponentially by time delay in starting resuscitation. As a general rule of thumb, chest compressions/CPR should begin no longer than four minutes following a cardiac arrest.

- 20.9.22. If Mr Morrison suffered the cardiac arrest as he was being placed into the van or shortly after the van commenced its journey, I find that the first chest compressions fell outside of the accepted four minute window. On the other hand, if Mr Morrison did not suffer the cardiac arrest until shortly before the van arrived at G Division, I find that the first chest compressions fell within the accepted four minute window.
- 20.9.23. For the reasons expressed in this Finding, I am unable to determine with any level of certainty when in the journey Mr Morrison suffered the cardiac arrest.
- 20.9.24. While earlier commencement of chest compressions increases a person's chance of survival in such incidents, it does not follow that prompt commencement of CPR will result in survival. I find that many intervening factors come into play which determine the success or otherwise of an attempted resuscitation. These factors include the time for the patient to start breathing again, the adequacy of the heart beating following resuscitation, the patient's blood oxygen and carbon dioxide levels and, in Mr Morrison's case, the impact of his underlying coronary artery disease.
- 20.9.25. The evidence does not support the finding sought by counsel for the Morrison family that the delay in the commencement of chest compressions caused or contributed to Mr Morrison's death. Nor does the evidence support a finding that the delay in calling an ambulance was a factor which contributed to Mr Morrison's death.

#### 20.10. CPR training

- 20.10.1. So far as first aid and CPR are concerned, I find that of the correctional officers who were present at the G Division sally port only three officers held current CPR qualifications (including CO Connor).
- 20.10.2. CPR is a potentially life-saving skill. Such skills naturally dissipate over time, particularly if a person has not been required to apply the skill in the intervening twelve-month period.

20.10.3. The dissipation of skills over time is reinforced by the fact that, despite holding a current CPR qualification, CO Connor still misunderstood a key aspect of CPR.

20.11. The Yatala admissions process

20.11.1. I am unable to determine whether CO Golding failed to identify Mr Morrison as an Aboriginal prisoner. The documents that could verify this information (pages 1 and 2 of the Special Needs Assessment Form) were missing from Mr Morrison's case file.

20.11.2. No satisfactory explanation has been provided by CO Golding or the Department for the inability to locate and produce the missing documents.

20.11.3. I find that Mr Morrison was not referred to the Aboriginal Liaison Officer (ALO) service on the day of admission.

20.11.4. I find that on the following day (20 September 2016), Aboriginal Liaison Officer CO Jackson learned that Mr Morrison was an Aboriginal prisoner, and he recorded that information on the Justice Information System on 21 September 2016.

20.11.5. The evidence does not support a finding that earlier identification of Mr Morrison as an Aboriginal prisoner would have resulted in him being managed any differently by the Department.

20.12. Was CO Golding qualified to conduct Mr Morrison's DCS admissions interview?

20.12.1. I find that CO Golding was not qualified to conduct Mr Morrison's admissions interview. He did not have the knowledge, training and/or experience to competently conduct the interview.

20.12.2. I find that CO Golding made several significant errors during Mr Morrisons's admissions interview.

20.12.2.1. He failed to raise a Notice of Concern in circumstances where it was mandatory to do so.

- 20.12.2.2. He signed the Stress Screen Form both as Admissions Officer and Responsible Officer.
- 20.12.2.3. He had never read SOP-090 which relates to the Risk of Suicide and Self-harm and he had no working knowledge of other Standard Operating Procedures which are directly relevant to the conduct of admissions.
- 20.12.3. I find that if a Notice of Concern had been raised, Mr Morrison would have been referred to an intervention team for assessment by medical professionals. He was entitled to that assessment. I cannot eliminate the possibility that intervention at this time may have prevented Mr Morrison's death.
- 20.12.4. No satisfactory explanation has been provided by the Department for permitting an unqualified officer to work in this important role.
- 20.12.5. Nor has the Department explained why it allowed CO Golding to continue working as an Admissions Officers for 14 months after Mr Morrison's death without giving him any feedback about his performance or further training.
- 20.13. The SA Prison Health Service assessment
- 20.13.1. There is no basis to criticise the competency of the Stage 1 nursing assessment or the decision of RN Penafloresta not to raise a Notice of Concern.
- 20.13.2. I find that:
- 20.13.2.1. No physical or mental health concerns were identified during the Stage 1 assessment.
- 20.13.2.2. No cardiovascular or respiratory issues were identified.
- 20.13.2.3. Mr Morrison exhibited no signs of depression, impulsivity, impaired judgment or cognition, substance withdrawal, intoxication, mania, agitation, psychosis, or situational crisis.
- 20.13.2.4. Mr Morrison was recommended for placement in a shared cell (a 'double up').

20.13.3. I find that Mr Morrison did not receive the mandatory Stage 2 assessment within 48 hours of admission. I find that the oversight occurred due to an administrative error and that the Department had no processes in place to identify such errors.

20.13.4. I cannot eliminate the possibility that a Stage 2 assessment may have changed the trajectory of events for Mr Morrison.

20.14. Mr Morrison's first few days at Yatala Labour Prison

20.14.1. I find that the Department for Correctional Services was unable to locate and produce Mr Morrison's seven-day observation form.

20.14.2. Given the missing document the Court is unable to determine whether Mr Morrison's mandatory seven-day observations were commenced and, if so, whether any behaviours of concern were noted.

20.14.3. No satisfactory explanation has been provided by the Department for its inability to produce documentary evidence of this key risk management process.

20.14.4. Mr Morrison was the very type of prisoner that the seven-day observation process is designed to protect, namely, a first time Aboriginal prisoner. *It is perplexing and disturbing that by the time Mr Morrison was placed into E Division at Yatala, the risk management systems that were put in place to identify vulnerable prisoners had failed in so many ways.*

20.14.5. I find that Mr Morrison was showing signs of distress and difficulty settling into the prison environment during his first few days in custody. I reject the evidence of several prisoners that Mr Morrison complained of chest pains to correctional officers or nursing staff whilst in E Division at Yatala. The evidence is unreliable and not supported by any independent evidence.

20.14.6. Nor does the evidence support a finding that Mr Morrison completed five medical request forms; that two of these forms were destroyed by correctional officers; and/or that it was common practice at Yatala for correctional officers to destroy prisoners' medical request forms.

20.15. Mr Morrison's transfer to Holden Hill

- 20.15.1. I find that the eligibility process for transfer of a prisoner to Holden Hill was seriously flawed.
- 20.15.2. I find that the recommendation made by the SA Prison Health Service for Mr Morrison to be placed in a shared cell (as part of risk management) could not be implemented at Holden Hill. *This fact alone should have precluded Mr Morrison from transfer to Holden Hill.*
- 20.15.3. I am unable to determine who recommended that Mr Morrison was a suitable prisoner for transfer to Holden Hill as the Department did not require the process for determining prisoner eligibility for transfer to be documented.
- 20.15.4. I find that the conditions under which prisoners were kept at Holden Hill are barbaric and inhumane. The conditions are more akin to punishment or solitary confinement. It is shocking that in the 21<sup>st</sup> century any person, including prisoners, would be housed overnight in such appalling conditions. The conditions under which prisoners are kept in the Holden Hill police cells would challenge the most robust of persons, let alone prisoners who are known to be some of the most vulnerable members of our community. The use of such cells to accommodate prisoners overnight should be prohibited.
- 20.15.5. Despite the appalling conditions I find no causal link between the conditions under which Mr Morrison was held at Holden Hill, his treatment there and his subsequent conduct on the morning of 23 September 2016 in the Yatala holding cells.
- 20.15.6. I find that on admission to Holden Hill, Mr Morrison's complaint of a sore back and his request for pain relief was ignored. I find that he was mocked by correctional officers and subjected to taunts that carried sexual innuendo. He was also taunted by other prisoners.
- 20.15.7. I find that Mr Morrison's mental health declined while he was at Holden Hill. On the available evidence however, I am unable to determine whether he was suffering from a psychiatric condition, exhibiting signs of psychosis, or

experiencing a psychotic episode on the morning of his return to Yatala Labour Prison.

20.15.8. I find that on the morning of 23 September 2016, Supervisor Somerfield received a report (at Holden Hill) that Mr Morrison may be hearing voices, but he failed to pass on this information to Yatala personnel who would be receiving Mr Morrison later that morning. I further find that he failed to inform Yatala that Mr Morrison had also been asking bizarre questions which potentially raised questions about his mental health.

20.15.9. The Department has a duty of care to all prisoners. The information received by Supervisor Somerfield potentially related to the health and welfare of a prisoner. The failure of a senior supervisor to communicate this information to the Yatala receiving officers was a serious oversight.

20.15.10. I cannot eliminate the possibility that if the information had been communicated to Yatala personnel, Mr Morrison may have been sent to the infirmary for a mental health assessment instead of being placed in the holding cells. It is possible that intervention at this time may have prevented his death.

## **21. SUMMARY AND RECOMMENDATIONS**

21.1. Section 25(2) of the Coroners Act 2003 provides that the Court may add to its findings any recommendation that, in the opinion of the Court—

- (a) might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest; or
- (b) relates to a matter arising from the inquest, including (but not limited to) matters concerning—
  - (i) the quality of care, treatment and supervision of the dead person prior to death; and
  - (ii) public health or safety; and
  - (iii) the administration of justice,

and is, in the circumstances, an appropriate matter on which to make a recommendation.

- 21.2. Section 25(2) (and sections 13 and 21) of the Coroners Act were amended during the inquest by the *Coroners (Inquest and Privilege) Amendment Act 2021* (SA) (the Amending Act). The addition of section 25(b) expanded the matters on which recommendations may be made, if considered by the court to be appropriate in the circumstances. Prior to the amendment, the court's authority to make recommendations was confined to recommendations that, in the opinion of the court might prevent, or reduce the likelihood of, a recurrent of an event similar to the event that was the subject of the inquest.
- 21.3. There was some debate amongst counsel whether the expanded provision had a retrospective effect on this inquest. I have considered the respective submissions and I am satisfied that the amended provision applies.
- 21.4. As previously stated, the evidence received during this inquest has revealed a litany of serious failings and shortcomings in relation to Mr Morrison's management whilst in the care and custody of the Chief Executive of the Department for Correctional Services. Relevantly, these failings and shortcomings occurred at virtually every stage of Mr Morrison's incarceration. They were reflected during his DCS admissions interview and the failure to raise a Notice of Concern, by the omitted Stage 2 nursing assessment and the inability of the Department to produce records (original or copies) of mandatory risk management processes. The missing documents have never been located. The fact that such documents could not be produced at a coronial inquest into the death of a first time Aboriginal prisoner should ring alarm bells. The process by which Yatala prisoners were deemed eligible for transfer to the Holden Hill police cells has been shown to be seriously flawed, and the Department did not even require the process to be documented. Furthermore, information which potentially related to Mr Morrison's mental health on the morning of 23 September 2016 was not communicated to the Yatala officers who re-admitted Mr Morrison to the holding cells on the morning of the incidents. As stated, I have formed the view that interventions at these key stages may have prevented Mr Morrison's death.
- 21.5. To compound matters, the evidence has revealed serious deficiencies in the training of correctional officers at Yatala and their ability to manage a major incident. A failure by the Department for Correctional Services to enforce refresher training in restraint, first aid and cardiopulmonary resuscitation (CPR) was also a live issue at the inquest.

21.6. The sheer number and nature of the demonstrated failings and shortcomings leads to the conclusion that it is inappropriate for the Department for Correctional Services to be left to remedy its own failings and independent oversight is required. Accordingly, I make the following recommendations:

21.6.1. I recommend the appointment of an independent Board of Inquiry by the Executive Government to undertake a comprehensive review of the key findings and to make recommendations to government with particular emphasis on:

21.6.1.1. The content and delivery of restraint training to correctional officers at Yatala.

21.6.1.2. The content and delivery of training for supervisory roles.

21.6.1.3. Performance review processes (or the lack thereof).

21.6.1.4. The enforcement of refresher training in restraint, first aid and cardiopulmonary resuscitation (CPR).

21.6.1.5. Risk management processes.

21.6.1.6. Record keeping requirements (electronic and hard copy) with particular emphasis on records relating to risk assessment, and the feasibility of moving from paper-based records to electronic records.

21.7. Restraint training, first aid and cardiopulmonary resuscitation training (CPR)

21.7.1. The Chief Executive gave evidence that correctional officers are now 'required' to renew their CPR qualification annually. This claim must be treated with caution. I find that at the time of Mr Morrison's death correctional officers were 'required' by the Department to undertake refresher restraint training, but the evidence has established beyond doubt that the so-called requirement was not enforced.

21.7.2. The need for caution is reinforced by the fact that the Chief Executive of the Department for Correctional Services gave sworn evidence that he does not support a policy whereby correctional officers are suspended from operational

duties involving contact with prisoners unless they have completed refresher restraint training on or before its due date, and they hold a valid first aid and CPR qualification

21.7.3. I recommend that correctional officers be prohibited from undertaking operational duties which require contact with prisoners UNLESS AND UNTIL they have completed the DCS Control Restraint Defensive Training program AND:

21.7.3.1. The correctional officer has completed DCS refresher training on or before the date it falls due.

21.7.3.2. The correctional officer holds a current First Aid certificate.

21.7.3.3. The correctional officer has completed an annual renewal of the CPR component of first aid training and holds a valid CPR qualification on or before the date it falls due.

21.7.4. I recommend that an expiry date for restraint, first aid and CPR training be recorded on the rear of correctional officers' identity tags in tamper proof form.

21.7.5. I recommend that resuscitation equipment including automatic external defibrillators ('AEDs') be placed in all areas of Yatala Labour Prison which manage the arrival of prisoners (e.g. the G Division sally port).

## 21.8. Holden Hill police cells

21.8.1. I recommend the repeal of legislative provisions of the *Correctional Services Act* 1982 which enable the Holden Hill police cells and/or other similar facilities to be declared as 'a prison' or 'a police prison' or proclaimed for such use.

## 21.9. Yatala Admission Process

21.9.1. I recommend that Recommendations 2-10 inclusive made by Deputy Coroner White in the inquest into the death of Joshua Marek STACHOR be implemented in full.

21.9.2. Subject to security and health considerations, I recommend that all first-time Aboriginal prisoners must be placed in a shared cell. I recommend that if for

any reason such prisoners are to be relocated to a single cell the SA Prison Health Service should be immediately notified,

21.9.3. I recommend that information pamphlets and/or other printed material be provided to all Aboriginal prisoners on admission or in their accommodation units setting out in detail the availability and operation of Aboriginal health and liaison services within the correctional facility

21.10. Security Access to Yatala Labour Prison by South Australia Police

21.10.1. Noting that SAPOL officers who are stationed at Holden Hill are usually the first responders to any incidents at Yatala Labour Prison, I recommend that all officers who are inducted into the Holden Hill Local Service Area attend at Yatala for the purpose of their details being entered onto the biometric data base to facilitate entry to the prison during such incidents.

21.11. Memorandum of Understanding

21.11.1. I recommend that the DCS enter into discussions with the Public Service Association and the Correctional Officers Legal Fund with a view to developing a Memorandum of Understanding directed at the implementation of procedures which ensure prompt access to legal advice by correctional officers (and other Department employees) in the event of future incidents at Yatala Labour Prison.

21.12. This brings the inquest into the death of Wayne Fella Morrison to a close. I express my condolences to the Morrison family.

*Key Words: Death in Custody; Prison; Restraint of Prisoners; Training*

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

*Seal the 12<sup>th</sup> day of May, 2023.*

---

*Deputy State Coroner*